STATE OF RHODE ISLAND
AND PROVIDENCE PLANTATIONS

OFFICE OF THE HEALTH INSURANCE COMMISSIONER

IN RE:	BLUE CROSS & BLUE SHIELD OF RHODE ISLAND CLASS DIR November 20, 2009	: : :

PRE-FILED DIRECT TESTIMONY OF
AUGUSTINE MANOCCHIA, MD

Q. Please state your name, title, and area of responsibility.

A. Augustine Manocchia, MD, Vice President of Provider Relations and Chief Medical Officer ("CMO") of Blue Cross & Blue Shield of Rhode Island ("Blue Cross"). I report directly to the Chief Operating Officer. I oversee Provider Relations, and am also responsible for Blue Cross' company-wide efforts to address health insurance affordability.

Q. Within your scope of responsibility, do you have any input into how rates are developed at Blue Cross?

A. Yes. I am involved at various stages of the rate development and setting process, particularly with respect to addressing pricing strategies that enhance the affordability of health insurance coverage.

Q. How does enhancing affordability of health insurance coverage factor into rate setting?

A, According to the Kaiser Family Foundation, between 1999 and 2009, overall inflation increased 28%, workers' earnings increased 38%, and health insurance premiums

increased 131%. This is not a problem limited to Blue Cross or Rhode Island; rather, it is an issue currently dominating the national political debate.

No single health insurer can solve the affordability issue nor make health insurance affordable with a single rate filing. As Commissioner Koller stated in July, "If employers and individuals do not want to see the relentless increases in their health insurance premiums, we must change the way medical services are organized, paid for, and used."

However, affordability is part of the vision and mission of Blue Cross, and Blue Cross makes significant efforts and investment of resources in pricing strategies, benefit designs, and use of its resources to enhance the affordability of health insurance. The vision of Blue Cross is to improve the quality of life of our customers and of the people of Rhode Island by improving their health. The mission of Blue Cross is to provide members peace of mind and improved health by representing them in their pursuit of affordable, high-quality healthcare. Blue Cross can not solve the issue of affordability of health insurance on its own, but it does attempt to enhance affordability as well as meeting the other aspects of its mission.

Specifically, we address affordability by (1) addressing the drivers of increased health insurance cost, to the best of our ability and (2) advancing the affordability priorities set by the Office of Health Insurance Commissioner (OHIC). With respect to cost drivers, I, along with my staff and members of the health management team, continually review and consider the latest utilization trends and their drivers, particularly to identify their impact on affordability, quality, access, and efficiency in the healthcare market. We then work with Blue Cross actuarial staff to further analyze any concerning trends and health insurance cost drivers, identify the way in which these factors affect health insurance rates, and verify that Blue Cross has processes and initiatives in place – or develops new or modified processes and initiatives - to address these trends and drivers to improve affordability. With respect to OHIC affordability priorities, I

communicate with OHIC on the priorities OHIC has mandated for health plans in Rhode Island to adopt and fund, and oversee those affordability priority programs.

Q. You mentioned utilization trends and their drivers. Can you provide some examples of the key drivers of the affordability of the proposed health insurance rates for Blue Cross, particularly those of which the public might not be aware, in order to make informed choices?

A. Certainly. Some utilization trends are driven by new technology being introduced, such as new drug therapies. Others, such as inpatient hospitalizations, may have various contributing factors. As indicated in our most recent Affordability Reports, the primary drivers for Blue Cross rates are:

- **Brand name pharmacy costs**: As more drug classes include generic alternatives, brand manufacturers are struggling to maintain profits. The per-script cost trend increased 13.5% in 2007 and in 2008, and is projected to increase at a similar rate moving forward.
- **Advances in technology**: Both the Robert Wood Johnson Foundation and the Congressional Budget Office (CBO) have stated that the cost driver with the greatest impact on health insurance premium growth is the development and diffusion of medical technology. This includes medical devices, "specialty" pharmaceuticals, imaging, and similar advances. Specialty drugs are high-cost injectable, infused, oral or inhaled medications that typically result from advances in drug development research, technology, and design. They have been the fastest growing segment of drug spending. At the current growth rate, it is anticipated that specialty drug spend will double over the next four years, accounting for more than 25% of all outpatient pharmacy spend in the next few years. In addition to new technology being

introduced, added uses for existing technology will increase utilization, thus increasing costs.

- **Hospital payments**. Reimbursement increases to hospitals are expected to continue as a major cost driver in the Rhode Island market. Over the last several years we have seen very modest increases overall in hospital volumes, shortfalls in payments from Medicare and Medicaid programs, increases in the need/demand for charity care, and declines in the value of endowments. Commercial payors are the only major source to make up these shortfalls and cover increasing costs and, in Rhode Island, Blue Cross most likely is the biggest subsidizer of this cost shifting due to its market share. This is not a Blue Cross phenomenon; according to the Price Waterhouse Coopers Health Research Institute, in 2009 nearly 1 in every 4 dollars paid by private payers on hospital services is due to reimbursement for such shortfalls.

Q. How has Blue Cross attempted to address these three key trends and drivers to enhance the affordability of health insurance?

A. We continually analyze trends and health driver factors and drill down to determine whether or not we can impact the trend. With respect to brand name drugs, technological advances, and hospital payments, Blue Cross has done the following:

Brand Name Drugs: Blue Cross pays an incentive rate to certain physicians meeting target goals. One goal is generic prescribing rate above the Blue Cross network average. As a result of this initiative one large physician groups increased their generic utilization up to 76.5% and the entire network has increased from 60% to almost 69% since 2007.

In addition, Blue Cross continues its partnership with a company called MedVantx to install ATM-like machines known as Sample Centers in physicians' offices across the state. The

Sample Center facilitates dispensing of a free 30-day sample of generic medications. Participating physicians receive the Sample Center in their offices at no cost. Blue Cross pays an administrative fee to MedVantx and also pays for the cost of the claim. Currently, there are 37 sample centers installed within 35 practice locations with approximately 220 providers having access to generic samples. In 2009, the sample centers began to offer selected brand name drugs within the program in order to offer a more comprehensive selection of drugs to cover more therapeutic classes. On average, there are 1,400 samples dispensed per month. Through the first 9 months of 2009, a total of 12,608 samples have been dispensed by participants. The MedVantx Program increases the dispensing of generic drugs and decreases the utilization of brand name medication leading to a reduction in the overall drug expenditures and a reduction in member's out-of-pocket expenses. Our overall generic dispensing rate has reached 69 % across all lines of business through September 2009, an increase of 3.4% from 2008. This program targets practices with three or more providers in order to maximize use of the sample center. Typically Family Medicine and Internal Medicine are the primary participants, rather than specialists; however, we have recently begun to expand our outreach to several cardiology practices and specialty practices.

Technological Advances: Not all of the cost attributable to technological advances is avoidable, or should be avoided, however, as it represents a shift in the standard of care. Some of these breakthroughs allow the treatment of previously untreatable conditions, or otherwise improve medical care. For example, using colonoscopy vs. sigmoidoscopy, Avastin for chemotherapy, or newly-available rheumatoid arthritis drugs are technological advances that improve detection of disease, treatment of disease, and the quality of life of our members, but also add new sources of spending.

Blue Cross began April 1, 2008, to attempt to manage the utilization of specialty drugs by directing specialty drug volume through a limited distribution network. This initiative will maximize opportunities to reduce the unit cost of the drugs, improve the clinical management of specialty medications, and ensure appropriate utilization. Administration of the formulary of drugs designated for inclusion in the Specialty Pharmacy Program is overseen by local physician specialists that join the Specialty Pharmacy & Therapeutics Committee. The Committee reviews and approves appropriate medical criteria required for coverage to insure that the application of criteria is consistent with accepted standard of care guidelines. Program growth to date has reached more than 65% of total membership with more than 205,000 Blue Cross members with the Specialty Pharmacy benefit. A recent analysis demonstrated that estimated annual savings as a result of the Specialty Pharmacy benefit equal $2,000,000.

In addition, Blue Cross has launched an initiative to educate physicians regarding the established guidelines for appropriate use of high-end imaging while at the same time reducing the number of clinically inappropriate studies performed. This program has allowed us to accurately monitor and track the high-end imaging ordering practices of our network physicians. Beginning January 1, 2008, medical necessity review has now become a requirement for high-end radiology services. Year one total preliminary estimates of savings for CY2008 are projected to result in a net savings in excess of $6 million. Blue Cross is seeing trends for Group and Direct Pay combined, BlueCHiP for Medicare and RIte Care (which historically have been 6%, 7%, and 13% respectively), significantly reduced through 2008.

Hospital Payments: The hospital contracts that are due for renewal in 2010 will be closely evaluated, and Blue Cross will seek to negotiate an appropriate rate of increase taking into account premium affordability, hospital margins, efficiencies, approved Certificate of Need

projects, and many other factors. Blue Cross is committed to avoid, to the extent possible, negotiation of automatic price increases.

Blue Cross will continue to negotiate the best discounts reasonably possible from hospital charges. All of our subscribers - including our Direct Pay subscribers – benefit from our discounts in several ways: through reduced claims costs, through reduced out-of-pocket costs when they pay for hospital and physician services falling within their deductible responsibility, and when they need services out of state, through the Blue Cross Blue Shield Association. The current savings associated with the current discounts for this out-of-state hospital program amount to $300,000,000 on an annual basis corporate-wide.

In addition, Blue Cross has instituted a Hospital Pay for Performance (P4P) program which provides financial incentives for specific quality improvement initiatives, focusing on improvements related to systems, process and outcomes. The program emphasizes quality improvement efforts endorsed by key stakeholder groups, e.g. CMS, The Leapfrog Group, Institute for Healthcare Improvement. The program is coordinated through Blue Cross' clinical staff who works closely with the hospital's quality improvement staff and clinicians. For example, we may focus on opportunities for improvement relating to adult smoking cessation counseling (CMS), percent of surgery patients whose preventative antibiotic(s) are stopped within 24 hours (CMS) or promoting computerized physician order entry systems (Leapfrog Group). Each initiative has a defined quality improvement target that must be achieved within a specified timeline. Blue Cross provides incentive funding if the hospital achieves that specific quality improvement target.

Finally, Blue Cross continues to promote the establishment of Blue Distinction Centers for Specialty Care in Rhode Island to reduce the migration of members to institutions located outside of the state. As a result of this national program, studies have shown a significant

decrease in readmission rates between designated Blue Distinction Cardiac Centers and non-designated cardiac centers. We have also found the cost per cardiac event to be less at designated Blue Distinction Cardiac Centers than non-designated cardiac centers. Structure, process, and outcomes are measured and weighed to earn the designated distinction. Currently, two Rhode Island hospitals have qualified for cardiac care and complex and rare cancers, one hospital has qualified for bariatric surgery, and three have qualified for orthopedic care.

Q. The areas discussed above are the top three drivers for Blue Cross. Does Blue Cross have a more global approach to providing high-quality health insurance with pricing strategies that enhance affordability?

A. Yes. Currently, Blue Cross is undergoing a transformation from a traditional health insurer to a health management company, meaning that it proactively assists members in navigating through the healthcare system and works even more closely with the provider community. The health management strategy will incorporate multiple approaches that include benefit design and incentives, integrated health management, member communication, and significant provider engagement and incentives. Through this transformation, Blue Cross aims to improve the health of all our members, including Direct Pay members, while reducing their healthcare costs.

Q. Do these initiatives, particularly the transformation to a health management company, address the concept of affordability as enunciated by OHIC?

A. Yes. OHIC, together with the Health Insurance Advisory Council (HIAC), has identified four system-wide priorities for improving the affordability of health insurance. They are:

- Expand and improve the primary care infrastructure in the state – with limitations on ability to pass cost on in premiums;

- Spread adoption of the Chronic Care Model Medical Home;
- Standardized electronic medical record (EMR) incentives; and
- Work toward comprehensive payment reform across the delivery system.

Blue Cross has addressed each of these four priorities in its affordability initiatives and they are key components of its transformation into a health management company.

Q. Does addressing these affordability priorities affect current rates?

A. Yes. Blue Cross agrees in principle with the affordability priorities and programs required by OHIC, since they are consistent with the responsibilities of Blue Cross as set forth in its enabling act as well as in its own vision and mission statements. Blue Cross has committed to support these priorities with funding and in-kind assistance. Indeed, Blue Cross already had implemented, or intended to implement, programs that promote or are similar to the OHIC affordability priorities, although Blue Cross did not necessarily intend to proceed at the funding level or the pace at which the OHIC is requiring Blue Cross to act.

That being said, each of the affordability priorities mandated by OHIC has an immediate, tangible cost, particularly at the funding level and pace required by the OHIC. Since Blue Cross is a nonprofit organization with no shareholder equity or out-of-state businesses to subsidize the Rhode Island market, the only sources to pay for these outlays of funds are reduction of reserves (which are already below the low end of the range suggested by the Lewin report) or increases in premium.

The cost savings from the OHIC affordability priorities generally are not guaranteed, concrete, or immediate. The CBO recently examined the potential cost savings for adoption of health information technology (such as the EMR incentive affordability priority). CBO acknowledged the potential of EMR to increase efficiency, quality of care, and outcomes. Nevertheless, CBO indicated that the fixed costs for implementing EMR are quite high, the

evidence of potential to reduce premium cost is unclear, and the potential for any significant premium savings due to EMR adoption is unlikely in many settings because the incentive to use EMR to control costs is not strong.

One particular example of how the OHIC affordability priorities affect premium rate increases is the requirement that Blue Cross (and other commercial payers) increase their spending on primary care by 1% per year over the next five years. While this may sound innocuous, "1%" means increasing the total dollars spent on primary care from 5.9% to 10.9% of the total dollars spent by Blue Cross on medical care. For Blue Cross, this means – even using the most conservative estimates – a spending commitment of an average of nearly $46,000,000 per year, and a total of over $231,000,000 for the first five years. For the Direct Pay market alone, this means an additional spending commitment of over $1.3 million per year.

In contrast, any savings to be generated by the primary care investment program are more long-term and uncertain, and therefore will not be reflected in current premiums. While Blue Cross hopes and expects that today's investment in primary care infrastructure ultimately will make health insurance more affordable, the currently required additional cost to the system does not have any current offsetting reduction. Commissioner Koller has acknowledged this by saying that " '[b]ending the cost curve' will take years of coordinated policies", presumably meaning that the savings resulting from the affordability priorities, if realized at all, will not be realized until some point in the future. Since the mandated OHIC affordability priorities create immediate fixed costs – amounting to nearly $46,000,000 per year for compliance with just one of those standards - and the projected savings are long-range and not guaranteed, compliance with those priorities necessarily increases the cost to Blue Cross of providing health insurance coverage, unless Blue Cross reduces its spending in other areas by many millions of dollars.

Q. Please describe the Blue Cross initiatives related to the first OHIC affordability priority: namely, expanding and improving the primary care infrastructure in the state – with limitations on ability to pass cost on in premiums.

A. The primary standard for meeting this priority is the agreement to increasing the portion of Blue Cross' medical budget spent on primary care from 5.9% to 10.9% between 2010 and 2014. This additional spending must be reviewed by OHIC, and should be spent on items such as fee increases, incentive dollars, payment reform, EMR, medical home projects, loan forgiveness, and practice coaching.

Blue Cross recognizes the value of the primary care practice and is providing significant support to ensure financial stability and practice efficiency. It will increase medical spending on primary care by the mandated amount – approximately $46,000,000 per year. This spending will be allocated among various Blue Cross programs, particularly the seven (7) major steps outlined below to expand and improve Rhode Island's primary care infrastructure.

1. **Patient Centered Medical Homes (PCMH):** A key component of Blue Cross' transformation to a health management company, and its strategy to improve and expand primary care infrastructure, involves placing the primary care physician at the center of patient care, through the Patient Centered Medical Home (PCMH) model. Blue Cross is confident that efficiency in the healthcare system will be greatly improved under the PCMH model. By changing the infrastructure of the primary care office, these physicians will be better able to address the varying needs of their complex and chronic patients, help prevent hospital and Emergency Department admissions, and have time to address those medical issues which currently result in a referral to specialists simply due to time constraints. Through the implementation of PCMHs, Blue Cross expects to see;

   - Improved member/patient health outcomes

- Decreased member/patient medical cost trends
- Improved member/patient experience and participation in care
- Improved physician satisfaction
- Improved coordination between providers
- Aligned reimbursements, incenting the "right" care at the "right" time

Because Blue Cross believes so strongly in the PCMH model, it has put its money where its mouth is, by providing extensive infrastructure funding and in-kind support to PCPs that transform to PCMH, along with a modified reimbursement structure that will reward physicians that provide increased services to complex and chronic Blue Cross patients in their practices. In 2010, Blue Cross will provide approximately 150 primary care physicians with extensive incentives to transform their practices, through funding for infrastructure and care management. An integral part of the PCMH contracts to be signed in 2010 include a retrospective pay for performance payment based on the ability for the practices to achieve clinical, structural, and procedural outcomes measures. This newly designed payment structure will work toward a migration from a strictly fee-for-service payment structure to one aimed at incentivizing physicians to provide the "right" care at the "right" time.

2. **PCP Collaboration Program:** Blue Cross also recognize the value that results from the case manager and physician having a discussion around the member's plan of care and a review of medications, and we have extended our existing program to include reimbursement to nurse practitioners and physician assistants as well. In 2009, we changed our PCP collaboration incentive to the primary care physician from eligibility for reimbursement one time per member per year to unlimited times per member per year in order to facilitate regular physician collaboration for members who require ongoing

coordination and collaboration. In addition, to accommodate our members' schedules, we have extended our availability to 6:30 pm. Last, we survey members who have participated in our programs to measure member satisfaction.

3. **PCP Recruitment:** Blue Cross is pursuing opportunities to work with physician groups and medical schools to provide funding for recruitment of new PCPs in Rhode Island.
4. **PCP Loan Forgiveness**: Blue Cross supports primary care infrastructure by supporting PCP loan forgiveness programs to level the playing field for new physicians choosing between primary care and more lucrative specialty work. Blue Cross provides monetary and in-kind collaboration with the Rhode Island Foundation PCP Loan Forgiveness program. Blue Cross donated $500,000 for this cause and continues to sit on the planning and selection committee for awarding funds to qualified applicants.
5. **Increase in PCP Fee Schedule:** As discussed in more detail in the section regarding payment reforms, Blue Cross recognizes the importance of the primary care physician and, in 2007, began to provide increases in reimbursement specifically to primary care physicians. These increases brought primary care physician reimbursement to parity with the reimbursement levels in Massachusetts (targeting the same percentage of regional Centers for Medicare & Medicaid Services ("CMS") fee schedule) in July of 2009. These targeted increases will continue for several years.
6. **Funding for Electronic Medical Records Infrastructure:** As discussed in more detail in the section discussing EMR incentives, in addition to fee increases, Blue Cross continues to provide funding for PCPs transitioning to, implementing, and testing electronic medical record infrastructures. Blue Cross, through its Quality Counts and EMR Grant Program, assists the funding of qualified EMRs and provide readiness assessments to practices.

7. **Chronic Care Sustainability Pilot Program:** As discussed in more detail in the section regarding chronic care medical home, Blue Cross is very active in the implementation of the Chronic Care Sustainability Initiative ("CSI") Pilot Program which launched on October 1, 2008. Since the launch of the CSI program, we have supported the 25 PCPs involved with monetary support, in addition to the increased reimbursement, EMR, and other incentives described above, for medical management of members. Payment is made on a per member per month basis, calculated on the number of members each payer has in the selected PCP practices each month.

Q. Please describe the Blue Cross initiatives related to the second OHIC affordability priority: namely, spreading adoption of the Chronic Care Model Medical Home.

A. The standard for compliance with this affordability priority is for payors, jointly, to expand the Chronic Care Sustainability Initiative (CSI) by an additional 20 physicians by June 2010 and to pay their proportionate share of the fees of Deidre Gifford LLC, the entity chosen by OHIC and HIAC to provide project management services for CSI.

As indicated, Blue Cross is very active in the implementation of CSI, which launched on October 1, 2008. The goal of this project is to align chronic care improvement goals with financial incentives for the delivery of high quality chronic care. The 25 PCPs involved in the CSI pilot program are required to redesign their practice infrastructure to incorporate the elements of the "Advanced Medical Home/Chronic Care Model" of care, including but are not limited to better use of non-physician team members, enhancements to information systems, links to effective community resources, self-management support, group visits, and "brown bag" medication review. Each practice will also be staffed with a Nurse Care Manager.

Blue Cross provides financial incentives to participants in the CSI pilot program by providing an additional supplemental per member per month payment to each participating

physician, as well as funding, together with other payers, the cost of the Nurse Manager for each practice. Payments are made on a per member per month basis, calculated on the number of members Blue Cross has in the selected PCP practices each month. Blue Cross will agree to fund its share of the expansion of CSI to an additional 20 physicians by June 2010 as well as its share of the approximately $320,000 in payments to Deidre Gifford, LLC.

In addition to support of the CSI pilot program, Blue Cross has continued its Chronic Condition Management (DM) Programs, which are targeted at diseases which are cost drivers for inpatient and outpatient services and for which interventions likely can reduce emergency room visits and/or unnecessary hospitalizations. The goal of our programs is to provide our members with the information, tools, and resources to effectively self-manage their condition, assure they receive appropriate medical care, and maintain optimal wellness. This is similar to the HIAC stated goal of funding programs designed to change consumer behavior through a focus on reducing preventable illnesses and increasing personal responsibility for lifestyle choices.

Blue Cross has developed and implemented comprehensive disease management programs for Asthma, Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Diabetes, and COPD (Emphysema). Interventions have also been introduced to educate members on conditions such as high blood pressure, cholesterol management, tobacco treatment, depression, eating disorders, Attention Deficit Hyperactivity Disorder, and low back pain.

Members are systematically identified for DM outreach through several methods. Medical and pharmacy claims are analyzed to identify members who meet established criteria for respective diseases and conditions. Predictive Modeling analysis is conducted on a weekly basis to identify members who have an increased probability of incurring high cost medical expenses in the future. Data from completed Personal Health Assessments, a tool available to all members on-line, also are utilized to identify at risk members. Members may also be identified through

the Care Management Software System as a result of an inpatient stay, multiple emergency room visits, or based upon their specific diagnosis. In addition, a provider may refer a patient or a member may self refer into our programs.

Identified members are referred and stratified to complex case management, health coaching and/or other applicable interventions based on their condition and its severity:

- All identified members are included in education and awareness campaigns for their respective conditions. These typically consist of educational newsletters or a series of mailings containing helpful self-management tips, information on proper use of medication, and tips on nutrition and physical activity.
- Members with Asthma, CAD, CHF, COPD, and Diabetes who are identified as moderate to high risk, (e.g., inpatient stay or emergency room visit), receive a letter and 3 telephone calls inviting them to participate in telephonic health coaching offering a member-centric educational and self-management program with a registered nurse or registered dietician. Licensed social workers and behavioral health case managers are additional disciplines available to the member. Members who enroll in Health Coaching also receive a Self-Management Kit containing tools and resources used by the health coach in coaching the member how to self-manage their condition. The Health Coach also outreaches to the member's physician to collaborate with the physician in developing an action plan with the member and to conduct medication reconciliation.

During calendar year 2008, Blue Cross conducted approximately 299,370 outreaches to members to help them manage their chronic illness. Blue Cross received a Recognition of Excellence in Disease Management Outcomes Award from the Disease Management Purchasing Consortium (DMPC) in recognition of our performance in achieving the most improved

outcomes among organizations included in the DMPC database for inpatient and emergency room avoidance for Asthma & Coronary Artery Disease.

Q. Please describe the Blue Cross initiatives related to the third OHIC affordability priority: namely, standardizing EMR incentives.

A. The standard for compliance with this affordability priority is to put in place at least one incentive that pays for a portion of the start-up and ongoing costs of certified EMR on or before January 1, 2010.

Blue Cross continues to support the adoption and implementation of fully functional electronic medical records ("EMR") into physician practices in Rhode Island. Many national studies over the last several years support the concept that widespread use of EMRs lead to improvements in quality of care and patient safety while at the same time potentially reducing the overall cost of care. Certified EMR and similar infrastructure changes to increase efficiency are key to Blue Cross' PCMH and health management model. As a result, to promote and facilitate transition to and implementation of EMR, Blue Cross has provided the following support for the adoption of certified EMRs. "Certified" means certified by the Commission for Healthcare Information Technology and registry functionality to promote patient tracking as described in the NCQA PPC-PCMH standards for medical homes. All of the following programs are in place or will be in place on or before January 1, 2010:

1. **EMR Grant Program:** During 2009, Blue Cross launched a new EMR program to provide funding for both new and existing users of qualified EMR technology. Providers can also use the funding for a pre-implementation readiness assessment. The program is open to primary care providers as well as select specialists. As of September 2009, over $500,000 in funding has been allocated to physician practices as part of this program.

2. **Quality Counts**: Our Quality Counts program was designed to incentivize PCPs to purchase, implement, and utilize EMRs in their practices. The program now has 80 physicians in various stages of EMR implementation and outcome reporting. Program activity in 2008 consisted of EMR implementation completion, quality improvement processes within the physician practices to improve workflows and data entry, and preparing for reporting of outcome measures. Through its EMR Grants and Quality Counts programs, Blue Cross has supported, in total, over 300 PCPs with their purchase and implementation of an EMR.
3. **Rhode Island Quality Institute (RIQI):** This organization, along with the Rhode Island Department of Health, has taken the lead in the development of the statewide Health Information Exchange (HIE). We are very much involved with the activities of RIQI. Our Chief Executive Officer, Mr. James Purcell, is the chair of the Board of Directors, and we support this group's activities financially with the largest annual contribution of any stakeholder. In 2009, we provided RIQI with $300,000 in unrestricted funding and $570,000 for the buildout of the HIE.
4. **Increased Fee Schedule for EMR users:** Blue Cross continues to provide an increased fee schedule for PCPs that have and utilize a "qualified" EMR in their office at a differential of approximately 15% overall. Providers are required to complete an annual application regarding their EMR and frequency of use of various EMR functionalities to qualify for the fee schedule. There are currently over 150 providers that are receiving the higher EMR fee schedule.

The Blue Cross EMR incentives are equivalent in value to $5,000 per physician (up to $15,000 per practice) to subsidize the acquisition cost of EMR.

Q. Please describe the Blue Cross initiatives related to the fourth OHIC affordability priority: namely, working toward comprehensive payment reform across the delivery system.

A. The standard for compliance with this affordability priority is participation in conversations, when convened, on payment reform. Blue Cross is always willing to engage in dialogue on issues of public health policy in Rhode Island, and is committed to participate in the state-facilitated process to explain, assess, recommend, and adjust reforms regarding payment for health care services in Rhode Island. This commitment does not, of course, necessarily mean that Blue Cross will accept or implement the suggestions or recommendations, but does mean that Blue Cross will actively engage as a member of the stakeholder body to be convened and to promote a non-competitive environment in which the deliberations will be held.

Moreover, as described above, Blue Cross has several programs in place to provide payment practices that promote cost-effective, appropriate, and quality care to its members, while promoting the affordability priorities enunciated by the OHIC. These payment reforms include:

- Increase reimbursement fee schedule for PCPs;
- Increased reimbursement fee schedule for physicians using EMR;
- CSI pilot program supplemental payments; and
- Expanding the PCP collaboration incentives.

In addition to the payment reforms described above, in 2010, Blue Cross will initiate and/or expand other payment reforms to promote cost-effective, quality, affordable care for its members, including its Direct Pay members. These payment reforms include the following:

Patient Centered Medical Home: As described earlier, Blue Cross' PCMH program will provide approximately 150 primary care physicians with extensive incentives to transform their practices, through funding for infrastructure and care management. PCMH will help Blue

Cross migrate from a strictly fee-for-service payment structure to one that motivates physicians to provide the "right" care at the "right" time. The infrastructure developed through the PCMH will allow practices to pilot global payment schemes going forward.

Provider Contracting and Discounts: As mentioned earlier, Blue Cross negotiates contracts with physicians, providers, facilities and a pharmacy benefit manager with the goal of obtaining discounts which will reduce our overall claims expenditure. Blue Cross reviews contracts and fee schedules annually with the goal of maintaining the most reasonable fees and discounts possible, encouraging cost effective utilization, addressing the underlying cost of healthcare and resulting in simple and effective administrative processes. Both hospital and physician payment strategies have guiding principles that incorporate a component that focuses on paying for improved performance from a clinical (quality of care) and from an efficiency (lower cost) standpoint.

Pay for Performance (P4P) Programs: Blue Cross has implemented Pay for Performance (P4P) programs for hospitals and other providers.

As described earlier, the hospital P4P program provides financial incentives for hospital that meets specific quality improvement initiative targets, focusing on improvements related to systems, process and outcomes.

In addition, Blue Cross also has used P4P contracting with a number of PCP groups over the last four years. These programs involve incentives to doctors to provide high quality, cost-effective care, with measurable results. This activity has expanded over the last year, with more dollars at stake and more physicians involved in our programs. In general, our P4P contracts tie financial incentives to meeting all the principles of affordability outlined below.

- The implementation of EMR, as discussed above.

- Generic prescribing rate above the Blue Cross network average. As a result of this initiative one large physician groups increased their generic utilization up to 76.5% and the entire network has increased from 60% to almost 69% since 2007.
- Frequency of electronic prescribing: Through contract incentives one group has been able to submit 74% of their prescriptions electronically in 2008. (38.4% e-prescribed, 35.4% fax).
- Childhood immunization scores: Blue Cross continues to work with large PCP groups and provide incentives for them to exceed the 90% target in their current contracts.
- Evidence based care of patients with diabetes: Blue Cross continue to offer performance measures that improve the quality of care for members with chronic disease, such as diabetes (HgbA1c testing) and coronary artery disease (lipid profiles). In order to meet the contractual target, physician groups have implemented administrative processes to verify the proper testing for their chronically ill patients, as per evidence based guidelines. Examples include: building reports using real-time EMR data, sending lists of patients in need of testing to physicians, entering reminders into the EMR, mailing letters to patients, following up with specialist offices to obtain test results.
- Discussions with members regarding end of life care/advance directives: Blue Cross continues to work with PCPs to incentivize them to discuss advanced directives with members.

In 2008, the PCP P4P program allowed participating practices to identify gaps in care, change workflows to reduce those gaps, and focus on clinical areas for improvement in their patient populations, such as obesity screening. These lessons are considered instrumental in

improving the quality of care delivered to our members and we expect to see reductions in cost (as a result of physicians conducting measurement) and improvement in population health.

Blue Distinction Centers: Finally, as indicated earlier, Blue Cross continues to promote the establishment of Blue Distinction Centers for Specialty Care in Rhode Island, which has reduced readmission rates and cost per cardiac event at those centers. Blue Cross also has expanded this program to complex and rare cancers, bariatric surgery, and orthopedic services, and anticipates additional expansion to promote quality, cost-effective care.

Q. Can you describe Blue Cross' efforts to promote the dissemination of information, increase consumer access to health care information, and encourage public policy dialog about increasing health care costs and solutions.

A. Certainly. Across all plans and products, including Direct Pay, Blue Cross provides the following reminders and education resources, which help members proactively manage their health:

- Childhood immunization and well-visit reminders
- Adolescent immunization and well-visit reminders
- Colorectal cancer screening reminders
- Cervical cancer screening reminders
- Mammography reminders
- Flu and pneumonia reminders to older adults

These reminders are provided to members through mail and telephonic outreach. In addition, Blue Cross provides programs for all life stages and the unique requirements of those stages. Below are brief overviews of these programs. With the exception of the Little Steps® Prenatal Program, Blue Cross members are automatically enrolled in the following programs.

- **Little Steps Maternity Program:** The Maternity Program has been expanded to include preconception planning as well as at risk/low risk pregnant members. Identified members are invited to participate in telephonic health coaching and receive education, tools, and an incentive to participate to improve the health status of women who are considering pregnancy, assist pregnant women to deliver at full term, and follow-up with women in the postpartum period and consequently improve the health of newborns. Members who are identified or who self refer are offered the services of a health coach. The health coach provides individualized counseling based on a comprehensive assessment of the member's needs from preconception through the post partum period. The health coach develops a plan with the member that facilitates appropriate prenatal care, such as lifestyle modifications when appropriate (e.g., diet and exercise). Through the assessment process the health coach gauges the member's health literacy level and performs a needs assessment to identify triggers for stress and factors that may impede a member's ability to access care. The coach will also outreach to the member post delivery to stress the importance of the postpartum follow up visit, identifying and understanding the signs of postpartum depression and family planning methods.
- **Little Steps Newborn:** The Newborn program waives co-payments for well-baby visits during the first 15 months of life. This program also includes benefit information and postpartum visit reminders, signs and symptoms of postpartum depression as well as a childhood immunization chart and a lead screening brochure. All eligible members are automatically enrolled in this program after the child is added to the parents' insurance.

- **Little Steps Toddler:** This program sends parents of children aged 12 to 24 months information about the importance of immunizations, lead screens, and well-care visits. In addition to the Little Steps programs, parents also receive a telephone call reminding them to schedule well-care visits with their child's healthcare provider within the first 15 months of life.
- **Women's Health:** As women have unique health concerns, Blue Cross provides them with a comprehensive guide that delineates appropriate health screenings for their age and answers common health questions women of all ages may have about screenings and tests. This guide is sent to members who have been non-compliant for one or more health screening. These members will also receive telephonic reminders to schedule appropriate screenings with their healthcare provider.

Blue Cross also offers comprehensive educational tools on our website, bcbsri.com. Members accessing the website have access to provider finders, medical and pharmacy claims trackers, and hospital comparison tools. Throughout the condition-oriented sections of the Health & Wellness Center, the member can learn about their health, fill out a personal health assessment, and be directed to Blue Cross' suite of health management services including back care, nutrition, stress and weight management, smoking cessation, and education for asthma, diabetes, and other conditions. This is available to all members, including Direct Pay members.

Collectively, during calendar year 2008, Blue Cross made approximately 184,136 outreaches to members to remind them of screenings and other steps that they could take to maintain and promote their health. Blue Cross tracks member utilization and compliance with preventive screenings by running claims data approximately 6 to 8 months after a telephonic or mail reminder intervention has taken place. This data is reviewed and based on that review; modifications may be made to the following year's programs. In 2009, Blue Cross integrated the

Prevention Strategy programs into the Health Management Programs to ensure a whole person approach to health and provide reminders to members during the case management and health coaching member calls as well as at the overall member population level with mail and telephonic reminders.

Q. Describe Blue Cross' efforts to develop benefit design and payment policies that enhance the affordability of products (as defined by the OHIC), encourage more efficient use of existing resources, promote appropriate and cost effective acquisition of health care technology and expansion of existing infrastructure, advance development and use of high quality health care centers, and prioritize use of limited resources.

A. As indicated above, Blue Cross has implemented payment policies that enhance affordability, encourage more efficient use of existing resources, promote appropriate and cost effective acquisition of health care technology and expansion of existing infrastructure, advance development and use of high quality health care centers, and prioritize use of limited resources. Examples include incentives re: brand name drug use and acquisition/implementation of EMR; utilization management of specialty drugs and high-end imaging; the Quality Counts, Pay for Performance, and Center of Excellence programs and incentives; and the Patient Centered Medical Home program.

With respect to plan designs, Blue Cross offers a variety of comprehensive health plans to meet market needs in terms of benefit levels and price points. The majority of our plan designs offer tiered copayments which are designed to focus on primary care, prevention and wellness as well as to encourage members to seek care in the appropriate setting. In addition, Blue Cross covers certain preventive services pre-deductible at 100% and while other preventive services may apply to the deductible, members benefit from Blue Cross negotiated discounts with participating providers during that deductible period.

In addition, Blue Cross is developing products which are based on the premise that in healthcare, the most important measure of value is not cost, but health itself. Using built-in financial incentives, value-based benefits will help remove many of the financial barriers to getting the proper treatment and will reward healthy choices. We believe this increased engagement of members will result in a real return on investment in the form of improved employee/member health, reduced sick days and disability, and better controlled medical costs.

Moreover, Blue Cross offers AccessBlue, a premium assistance program, which provides financial assistance to qualifying Direct Pay members as described in the testimony of John Lynch. AccessBlue has provided millions of dollars in financial assistance since its inception, making coverage more affordable for the 26% of the Direct Pay population that qualified, such as Rhode Island's unemployed and underemployed population.

Q. Describe Blue Cross' efforts to promote collaboration among the state's health insurers to promote standardization of administrative practices and policy priorities.

A. Blue Cross has been an active participant in the HIAC, and has actively and willingly participated in every effort by OHIC to facilitate collaboration and standardization. In addition, Blue Cross always has cooperated with OHIC and HIAC, providing all of the information and data requested by OHIC to evaluate and make recommendations on these issues.

Q. Describe how Blue Cross directs resources, including financial contributions, toward system-wide improvements in the state's health care system related to quality, access and efficiency, including providing support to local collaboratives, organizations and initiatives that promote quality, access and efficiency.

A. As described above, Blue Cross provided $300,000 to RIQI for the HIE and other state-wide health care improvement initiatives. Blue Cross also supports this effort by having its

CEO, James Purcell, actively participate on the Board of RIQI. The Blue Cross website also provides a link to currentcare.com, the HIE portal for individual enrollment.

Blue Cross also is one of the major supporters of The Rhode Island Network of Care. This online resource, located at rinetworkofcare.com, is designed to be a single starting point for behavioral health information and services in Rhode Island. The site is geared towards individuals, families, providers, and agencies with behavioral health-related interests. This project was created by RIQI and is sponsored by Blue Cross, Rhode Island Hospital, Bradley Hospital, Butler Hospital, Gateway Healthcare, Inc., NRI Community Services, Inc., Neighborhood Health Plan of Rhode Island, The Providence Center, RI Health and Education Building Corporation, Rhode Island Council of Community Mental Health Organizations, and the Rhode Island Parent Information Network. The site was launched on June 25, 2009, and contains the following valuable resources: a comprehensive behavioral health service and provider database/directory; communication and advocacy tools; behavioral health news and legal information; links to related websites; and community message boards. Information about the Network of Care, and a link to its website, is on the Blue Cross public access website.

Blue Cross also is an active participant and the primary source of funding for the Rhode Island Intensive Care Unit Collaborative (ICU Collaborative), which is led by Quality Partners of Rhode Island, RIQI and the Hospital Association of Rhode Island. The ICU Collaborative has an overall goal of improving the care of adult ICU patients to reduce length of stay and associated costs; prevent complications; improve patient, family and staff satisfaction. Blue Cross provided $162,000 for the ongoing operations of the ICU Collaborative. Since 2005, the ICU Collaborative has achieved the following results:

- Statewide blood stream infection rate reduced 62% from the baseline.

- Statewide ventilator-associated pneumonia (VAP) rate reduced 21% from the baseline. VAP rate for the second quarter of 2009 was the lowest it has been since the launch of the ICU Collaborative in 2005.
- Sepsis quality indicator compliance improved in all ten measures.

Blue Cross also provided free access to health and wellness services across the state, including educational programs and preventive screenings, through its Health and Wellness Van visits. In 2008, BCBSRI conducted approximately 100 van visits, provided hundreds of free screenings and thousands of health messages to more than 2,500 people, including more than 500 uninsured.

Q. Explain how Blue Cross participates in the development and implementation of public policy issues related to health.

A. Blue Cross is represented on the Health Services Council, and as a result is actively involved in the public policy issues raised by all Certificate of Need proposals. Blue Cross represents its members and the state-wide health care system in evaluating proposals on community need, affordability, and financial demand on the system as a whole.

Q. Explain Blue Cross' efforts to increase the effectiveness of its communications with Direct Pay subscribers.

A. Blue Cross is always working to improve the effectiveness of our communications with our current and prospective members. We welcome feedback from our members and strive to incorporate it into our member communications. On an annual basis we revise our Direct Pay Sales Kits to ensure that they are clear, concise and current. In addition, we revise materials on an as needed basis.

We also strive to provide members with options for obtaining information about our plans. For example, during Open Enrollment, Blue Cross conducts several educational seminars

in Rhode Island communities for prospective members to learn more about our plans and to find a plan that fits their needs. This year eighteen prospective members attended and provided positive feedback about how helpful the meeting was to them in making their decision.

This summer in conjunction with the Blue Cross and Blue Shield Association, we launched AskBlue, an online tool, which provides consumers with a general overview on basic health insurance fundamentals and the coverage options (including COBRA) available in their state. AskBlue is a web-based experience that educates consumers and identifies families of insurance products that fit their personal needs, based on the responses they provide. It does this by conducting a high-touch "conversation" with consumers, asking high-level questions and learning about their general healthcare requirements. It responds to predicted questions within the program's logic, but does not engage in "live" conversation (via email, phone, or otherwise). At the end of the conversation, AskBlue makes an initial product recommendation based on the available Blue Cross Blue Shield products and encourages them to contact our Individual Sales Department or visit BCBSRI.com for more information about what is available to them and to enroll in our plan.

The Blue Cross website has complete consumer information regarding coverage, benefits, appeals, claims, and complaints, including forms, contact information, its medical policies, and plain language explanations. The website also includes a monthly installment called "Today's Healthcare Costs" that provides in-depth information on the key drivers that affect healthcare expenses. In addition, Blue Cross offers its consumers an online Hospital Comparison Tool and links to the Rhode Island Department of Health, National Quality Forum, the Leapfrog Group for Patient Safety, Agency for Healthcare Research and Quality, and the official U.S. government site for people with Medicare. Blue Cross also provides information to consumers through its

print publication, *Choices*, which it sends out to each member each month and which is available in the print and interactive issues on the Blue Cross website.

Blue Cross also provides insureds access to Coverage Advisor, a decision support tool from Subimo, LLC. Coverage Advisor helps members effectively evaluate their healthcare needs and plan options before selecting a health plan. The tool creates a customized profile of the member and each family member, including an estimator for annual use of services and a side-by-side comparisons of the Blue Cross plan options, with the estimated costs and benefits of each plan.

Q. Describe how Blue Cross addresses the interests of the state's health care providers, including Blue Cross' efforts to make its policies, procedures and practices with respect to provider reimbursement, claims processing, dispute resolution, and contracting processes understandable and transparent and its efforts undertaken to enhance communications with providers.

A. Blue Cross has been an active participant in the Professional Provider-Health Plan Work Group subcommittee of the HIAC. This group is intended to have providers and plans work together to improve administrative efficiencies between health plans and providers. One initiative has been to make facility specific data and other medical service-specific data available in reasonably consistent formats to patients regarding quality and costs. This information would help consumers make informed choices regarding the facilities and/or clinicians or physician practices at which to seek care. Among the items considered would be the unique health services and other public goods provided by facilities and/or clinician or physician practices in establishing the most appropriate cost comparisons.

Blue Cross also engages in many initiatives in which provider input and leadership is sought. Blue Cross holds a number of committees, which seek provider input on a variety of

topics. For example, as described above, administration of the formulary of drugs designated for inclusion in the Blue Cross Specialty Pharmacy Program is overseen by the Specialty Pharmacy & Therapeutics Committee, a group of local physician specialists, including gastroenterology, rheumatology, oncology, endocrinology and pulmonology. The Committee seeks advisory input from other specialists as necessary to review drug products in a comprehensive manner for inclusion on the formulary, then reviews and approves appropriate medical criteria required for coverage to insure that the application of criteria is consistent with accepted standard of care guidelines.

Additionally, the Health Care Community Exchange Council is a multi-specialty provider group, which meets every other month to discuss a variety of topics, including Blue Cross strategic direction, health care trends, and ad hoc topics requested by the committee. Blue Cross also maintains select specialty specific committees as well to discuss topics pertinent to an individual specialty, such as medical policy and coverage guidelines. Most recently, as a result of the Integrated Health Management initiative, Blue Cross developed an advisory panel comprised of PCPs, Behavioral Health providers, Nurse Case Manager, and Practice Management staff. This committee has been instrumental in finalizing the design on Blue Cross's PCMH initiative. The advisory panel has met at least once a month since July 2009.

These initiatives appear to have borne results. In the 2009 OHIC Survey of Providers, providers rated Blue Cross as dealing fairly with providers in virtually all categories. Indeed, "[p]roviders were particularly satisfied with BCBSRI's additional payment strategies, with greater than 55% of respondents indicating 'very good' or 'good' performance in these categories. 27.7% of providers noted improvement in rate adequacy from April 2008 to April 2009 for BCBSRI."

Q. Do Blue Cross product choices create appropriate incentives for consumers, providers and Blue Cross itself to decrease cost, such as a focus on primary care, prevention and wellness, active management procedures for the chronically ill population, encouraging use of the least cost, most appropriate settings; and promoting use of evidence based, quality care, and that have simple and cost effective administrative processes for providers and consumers?

A. Yes. Blue Cross programs focusing on primary care, prevention and wellness, disease management, and active management of the chronically ill population are discussed earlier.

In addition, Blue Cross products include case management: Episodic case management is provided to members who are experiencing a "single" and/or uncomplicated medical event where providing support, direction and education are needed for a limited time, typically 1-4 weeks. Complex case management programs are provided to those members that have experienced a complex, acute catastrophic illness, or have multiple disease conditions, such as cancer, renal conditions, organ transplant, stroke, neurological conditions, rare diseases, newborns or children with a complex medical condition, or behavioral health conditions such as depression, anxiety, eating disorders, substance abuse, or bipolar disorder. Complex case management involves comprehensive assessments, personalized plans of care utilizing evidenced based medicine, member action plans, and monitoring of the progress and changing needs of the member. Over the past two years we have doubled the number enrolled in case management using predictive modeling to screen and provide outreach to potential candidates.

To assure the use of the least cost, most appropriate setting, Blue Cross performs utilization review on many services including inpatient hospitalizations and acute inpatient rehabilitation to ensure the most appropriate setting of services. In addition, Blue Cross performs utilization review on other selected services such as durable medical equipment, certain

injectable drugs and new technology. During calendar year 2008, Blue Cross observed $ .93 pmpm net savings for our Utilization Review programs.

To support the use of evidence based, quality care, the Blue Cross Medical Policy Department develops and maintains guidelines and criteria for coverage of medical services and ensures that our policies are aligned with plan benefits, national standards, new state and federal mandates, and new technology. Medical policies are reviewed annually to ensure that they are up-to-date, and may be modified after solicitation of feedback from local providers as part of the policy development process. To further ensure that our medical policies reflect current standard of care, our Medical Directors meet at least monthly to review reasons for overturned determinations. As part of our ongoing effort to be responsive to member concerns, if we find a consistent pattern of overturned determinations on a particular policy, the policy is reviewed again to be sure it is within current evidenced based guidelines. Net savings from our medical policy for calendar year 2008 were calculated to be $.76 pmpm.

In addition, Provider Profiling is the process in which individual providers or groups of providers are compared to others in their same specialty with regard to total annual claims cost and overall outpatient service utilization. The data reviewed fall into several large categories, including office visit services, diagnostic imaging, laboratory testing, and surgical/procedural services. Individual providers are provided with an analysis of their practice utilization data. If an analysis detects patterns of service utilization and cost that vary significantly from the doctor's peers and cannot be justified, we work with the doctor to demonstrate how he or she can practice more efficiently and in accordance with evidence-based guidelines. Our Provider Profiling program helps to reduce instances of medically unnecessary testing which leads to lower costs of care and ultimately to improvements in the overall quality of care provided. When providers improve their efficiency and reduce the variability in their practice, unnecessary expenditures are

avoided and the quality of care may improve. Blue Cross has found this program to have a definite return on investment over the last several years. In 2008 we contacted over 291 physicians as part of this process, either through site visits or educational letters with an average savings of $3,700 per year for each physician educated through the program.

In addition, in cases of extreme outliers, the Provider Profiling program makes referrals to our Special Investigations Unit for analysis of potential fraud issues. In several instances those issues have been confirmed and have led to referral to the RI Attorney General's Medicaid Fraud Unit and/or the U.S. Attorney's office for prosecution.

Q. Does Blue Cross employ provider payment strategies to enhance cost effective utilization of appropriate services?

A. Yes. For example, our Utilization Management and Medical Policy processes facilitate the use of the least costly, most appropriate setting for care and the use of evidence based medicine, respectively. Chronically ill members are assessed, stratified and actively managed through our Health Management programs. Our Provider Profiling program also promotes cost effective use of resources. Last, our Pay for Performance programs, including "Quality Counts," and our participation in statewide efforts to promote primary care, demonstrate our support for this important element of the health care delivery system. Collectively, these health management programs are available to all members, including our Direct Pay members.

In addition, as indicated above, Blue Cross provides significant support and incentives to physicians to promote prevention, detection, early intervention, and wellness, which reduces reliance on high-cost or inappropriate use of services. Our comprehensive wellness programs, which have been integrated with our health management programs to facilitate the whole person approach to managing health along the continuum of care, address all cost-effective utilization of

appropriate services for all of our members, including our members with existing chronic and complex issues, that will lead to improvements in the health of these populations and ultimately to a reduction in the cost of care.

Moreover, as a part of our existing and ongoing efforts, Blue Cross' Health Management programs are continuously evaluated and updated accordingly to meet our member health needs while addressing affordability. Our Health Management and Integration Division is staffed by clinical (nurses, social workers, dietitians, and board certified physicians) and non-clinical (support) personnel who work to ensure quality, cost effective care.

Q. Does Blue Cross address consumer need for cost information through increasing the availability of provider cost information and promoting public conversation on trade-offs and cost effects of medical choices?

A. Yes. Through its active participation in the Professional Provider-Health Plan Work Group subcommittee of the HIAC, Blue Cross worked with other plans and providers to provide consumers data in reasonably consistent formats regarding quality and cost to help consumers make informed choices regarding the facilities and/or clinicians or physician practices at which to seek care. In addition, as described earlier, Blue Cross provides on its website a monthly installment called "Today's Healthcare Costs" that provides in-depth information on the key drivers that affect healthcare expenses.

Q. Do the programs you have described directly benefit the Direct Pay population?

A. Yes. These programs benefit all subscribers, including Direct Pay.

Q. Are the corporate-wide savings you alluded to above for programs and initiatives relevant to the Direct Pay class?

A. Yes. All of the programs are applicable to Direct Pay and should benefit the affordability of Direct Pay rates.

Q. How does Blue Cross attempt to balance the sometimes conflicting responsibilities to remain financially solvent, protect consumers, treat providers fairly, and make efforts to improve the affordability, quality and accessibility of the health care system, particularly in these difficult economic times?

A. It is Blue Cross' statutory and corporate responsibility to protect the financial condition of Blue Cross as well as employ pricing strategies that enhance the affordability of coverage. OHIC and the Department of Health have recognized that both financial solvency and affordability are of equal importance, having stated in the July 17, 2007 press release announcing the *Health of Rhode Island Health Insurers* report that "financially solvent insurers are better able to fulfill their other statutory obligations to consumers, health care providers, and the system as a whole" and to "drive system improvement".

Blue Cross has taken significant steps to balance the rate increase needed with additional protection for consumers, improved fair treatment of providers, and its efforts to improve the affordability, quality, and accessibility of its products and of the system as a whole.

Blue Cross provides free resources and services to its members to promote prevention and wellness, such as education materials, hospital and coverage selection tools, and the PCMH model. Blue Cross then actively manages its members' chronic illness, episodic illness, and use of brand name drugs, specialty drugs, and new technology.

Blue Cross provides significant incentives to providers to assist them with EMR, primary care and chronic care practice sustainability, and involves them in the initiatives and programs designed to effect change in the system. Blue Cross then incentivizes systemic and quality changes with its EMR and Quality Counts programs, its Blue Distinction Centers, and its Provider Profiling programs.

The program initiatives and pricing strategies to enhance affordability – both those required by OHIC and those initiated by Blue Cross - have been recounted in detail above, together with Blue Cross' investment of its resources into community organizations to affect public health policy on a state-wide basis. To balance these initiatives, however, requires recognition of the fact that there is a cost today that is not offset by immediate savings, and therefore must be reflected, in some fashion, in premium rate increases.