STATE OF RHODE ISLAND
AND PROVIDENCE PLANTATIONS

OFFICE OF THE HEALTH INSURANCE COMMISSIONER

IN RE:	BLUE CROSS & BLUE SHIELD OF	:
	RHODE ISLAND CLASS DIR	:
	FILED NOVEMBER 19, 2010	:

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 Executive Vice President and General Counsel. 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. Does enhancing affordability factor into rate setting, particularly with respect to Direct Pay rates?

A. "Affordability" is part of the vision and mission of Blue Cross for all of its subscribers, and Blue Cross makes significant efforts and investment of resources in pricing strategies, provider network reimbursement strategies, benefit designs, a host of

innovative programs, and traditional utilization review to enhance the affordability of health insurance.

With regard to Direct Pay subscribers in particular, Blue Cross takes very seriously its role in this state as insurer of last resort. With no other players in the individual market, combined with the fact that many direct pay subscribers cannot finance health insurance through pre-tax contributions or employer subsidies, Blue Cross understands the importance of our affordability efforts for this market in particular. Blue Cross responds to that need through Access Blue subsidies (for the neediest population) and increased affordability efforts for Direct Pay products.

Q. How specifically does Blue Cross factor enhancing affordability into rate setting, particularly with respect to Direct Pay rates?

A. 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 regard to cost drivers, we are focused on how to effectively curb medical cost trend. Our newly-established Medical Expense Team (MET) is a cross functional team charged with identifying trend drivers and resulting opportunities to reduce cost. MET evaluates opportunities in all cost areas, including hospital, physician, ancillary, and pharmacy. To date, decisions made within MET have resulted in significant pharmacy formulary and benefit changes as well as modifications to our existing radiology program that will ensure more appropriate ordering of high end radiology services.

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 I oversee those affordability programs at Blue Cross.

Q. You mentioned cost 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. The major trend drivers continue to be new technology, such as biotech drug therapies, payments made to hospitals, and waste and inefficiency in the health care system itself. In more detail, the major cost drivers can be outlined as follows:

- **Inefficiency/Waste:** Inefficiency and waste within the current health care delivery system is a major cost driver. It has been suggested that up to 30% of health care spending can be attributed to inefficiency and waste. Inefficiency and waste includes the overuse, underuse, and misuse of treatment and services. Our fragmented system of care, as well as variation in treatment and care from evidence based guidelines, are significant contributing factors to inefficiency and waste. These factors are endemic to the current infrastructure of the health care system, and will require a concerted multi-faceted approach over a period of time to achieve tangible improvements.
- **Pharmacy costs** – Prescription drug costs currently account for about 20% of our Direct Pay members' claims. Those costs increased approximately 10 to 12% in Direct Pay for both 2008 and 2009, and are

projected to rise again at that level this year. As generics of popular "blockbuster" drugs have become available, pharmaceutical companies have raised prices on their remaining brand name drugs in an attempt to maintain revenue..

- **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, biotech drugs, diagnostic imaging, and similar advances. Biotech drugs have been the fastest growing segment of drug spending and currently account for 16.2% or Direct Pay pharmacy spend.
- **Hospital Spending:** Hospital spending increases continue to be a major cost driver. Over the last several years we have seen very modest increases overall in hospital utilization, but shortfalls in payments from Medicare and Medicaid programs, increases in the need/demand for charity care, and declines in the value of endowments have led to decreased hospital revenue. As hospitals look to maintain their revenue levels, the commercial payors are typically considered a key funding source to subsidize these shortfalls and cover increasing costs. 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. However, Blue Cross, due to its market share, is often the primary focus of

this cost- shifting subsidization in Rhode Island. Regardless of the historical context in hospital spending, the reality is that increases over and above benchmarks, such as CPI cannot be sustained.

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

A. **Inefficiency/Waste:** Blue Cross has a number of programs aimed at addressing inefficiency and waste in the system. All are elaborated in greater detail throughout this testimony, but are listed below for your reference:

- Patient Centered Medical Home (PCMH)
- Health Information Technology (HIT) Adoption (including Electronic Health Records (EHR), Health Information Exchange (HIE), and e-prescribing)
- Radiology Management Program
- Specialty Pharmacy Program
- Medvantx Generic Sample Center
- Care Coordination enhancements
- Utilization Management activities
- And others

Pharmacy costs: In November 2010, Blue Cross rolled out its Premier Formulary, which aims to drastically reduce pharmacy spending through changes in coverage and benefit design. A significant number of brand name drugs will now no longer be covered, due to the availability of generic or over-the-counter (OTC)

alternatives. Examples of drugs that will no longer be covered include non-sedating antihistamines, and all brand name sedative/hypnotics.

These changes to the Blue Cross formulary will offer immediate cost savings to many members that use these drugs, including a significant portion of the Direct Pay population, given the lower copays for generic versus brand name drugs. Longer term, tackling prescription drug costs in this way is intended to address prescription drugs as primary driver of healthcare costs in order to help make healthcare more affordable for our Direct Pay subscribers and all of our other members.

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. This program targets practices with three or more providers in order to maximize use of the Sample Center. Typically, family medicine and internal medicine practices, rather than specialists, are the primary participants; however, we have recently begun to expand our outreach to several cardiology practices and other specialty practices.

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 sample centers installed within 35 practice locations with approximately 213 providers having access to generic samples. Twenty of these locations represent Patient Centered Medical Home sites. Annually, 15,000 generic samples are dispensed with an additional 2,000 OTC medications, including aspirin, Prilosec OTC, and vitamins. In 2011, Medvantx machines will be updated to include new generic

products focusing on migraines, diabetes, depression, osteoporosis, contraception, and prostate health.

Both the Premier Formulary and the MedVantx Program increase the dispensing of generic drugs and decrease the utilization of brand name medications, 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 73% for our Direct Pay population through June 2010, compared to 69% in June of 2009. It was as low as 50% just five years ago.

Advances in technology: Not all of the cost attributable to technological advances is avoidable, or should be avoided, as technological advances represent 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, the expansion of diseases treated by multiple biotech drugs and added indications for high tech services improve the quality of life of our members, but they also add new sources of spending.

Blue Cross continues to manage two of its biggest technological cost drivers through utilization review with its Specialty Pharmacy and Radiology Management programs, both incorporated into Direct Pay plan designs. Effective January 1, 2011, Blue Cross will modify its Radiology Management program to further encourage the proper ordering of high-end imaging. These changes include mandating that the ordering physician, not the facility, initiates the prior authorization request and eliminating the 'gold card' process currently in place for cardiologists for nuclear cardiac imaging. These changes are expected to result in savings in excess of $2 million in 2011, approximately 3% of which is directly attributable to the Direct Pay market.

Hospital Spending: In these difficult economic times, it is more critical than ever that consumers have access to a sustainable health care delivery system built on the concepts of affordability and accountability. While Blue Cross cannot create such a system on its own, it has promoted internal programs and advocated for and supported public policy changes to enact systemic reforms.

In the context of hospital spending, our relationship with hospitals must move beyond a narrow deliberation on cost and extend to a well-articulated understanding on how the delivery of care must be transformed to be more efficient and effective. To do so, we have launched a hospital engagement strategy that advocates sustainable unit cost increases and compensation models that reward quality, better health, and more effective care. This new hospital contracting model will require hospitals to meet agreed-upon quality standards and operational efficiencies, which will result in continuously improved patient care and have a positive impact on the hospitals' finances and cost of care. The continued transition to industry-standard payment methodologies such as inpatient DRGs will further support the alignment of financial incentives with appropriate care. Our approach will be consistent, data-driven, and respectful of the urgent need to confront these unsustainable medical trends.

Blue Cross has begun to implement the affordability standards put forth by OHIC earlier this year as part of our hospital contracting model. Our goal is to stabilize costs and strive for an overall inflation trend at the medical Consumer Price Index and improve the affordability of health care in Rhode Island.

In addition to the hospital contracting model, Blue Cross is already in the process of implementing an enhanced and standardized network Hospital Quality Program

emphasizing a greater alignment between funding and performance. This program will address all of the key "conditions" placed on Rhode Island payers regarding our contracts with Rhode Island hospitals by OHIC. Our efforts in this area will lay the foundation for serious discussions in the areas of improved clinical communication, quality improvement, and transparency, as well as opportunities to address greater administrative efficiencies involving the interactions between Blue Cross and our network hospitals.

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, two hospitals have qualified for bariatric surgery, and four have qualified for orthopedic care.

Q. How is Blue Cross addressing the four affordability standards adopted by OHIC?

A. For its entire membership, and its Direct Pay population in particular, Blue Cross has established or adopted affordability initiatives that address each of the four OHIC affordability standards, namely:

- 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.

Expand and improve the primary care infrastructure in the state— with limitations on ability to pass costs to premiums: The primary standard for meeting this priority is the agreement to increase the portion of Blue Cross's medical budget spent on primary care from 5.9% to 10.9% between 2010 and 2014. On a regular basis, I meet with OHIC to review the steps Blue Cross is taking to achieve this goal.

Blue Cross recognizes the value of the primary care practice and is providing significant support to ensure financial stability and practice improvement. In fact, Blue Cross demonstrated its commitment to primary care many years before OHIC required it of all payers in 2009. In 2010, it is expected that we will spend an additional $8 million in total primary care spend versus 2008 spending, with total primary care spending increasing from approximately $38 million to approximately $46 million. By continuing to comply with the PCP spending mandate, it is expected that primary care spending will increase an additional $6 million to $8 million in 2011.

This spending was, and will continue to be, allocated across various areas, with the overall goal being to see greater "value" in the care provided to our members and purchasers. Examples of these initiatives are highlighted below:

- **Patient Centered Medical Homes (PCMH):** Blue Cross remains committed to the PCMH concept, through both its involvement in the CSI-RI program as well as the expansion to our own program beginning in November 2009. In 2010, Blue Cross supported approximately 160 primary care providers that

converted to this model of care. Support will continue into 2011 with the addition of more than 100 more physicians to the Blue Cross program. Further details are outlined under the expansion of the chronic care model standard, below.

- **Health Information Technology:** Blue Cross supports the adoption and proliferation of HIT within Rhode Island in a number of ways. A major component of this adoption is included in the "expansion of EHR section" below. Additionally, Blue Cross supports overall improvement of HIT infrastructure in the state, through support of public policy changes surrounding EHR, and through funding of existing EHR programs, namely the RI Quality Institute, the vendor overseeing three main HIT grants within the state: The Regional Extension Center, The Beacon Community, and the Health Information Exchange. Through contracting efforts, Blue Cross is also furthering connectivity between physicians and labs and pharmacies through support of available EHR interfaces, which make bi-directional connectivity possible.
- **Accountable Care Organizations:** Accountable Care Organizations (ACOs) are a new healthcare model that rewards providers for improving patient outcomes and slowing cost growth. The goal is to support groups to create appropriate infrastructure and care coordination capabilities to function and succeed in a global payment system by encouraging payers and providers to work more closely, and introducing incentives for physicians to collaborate and to meet or exceed quality benchmarks. Blue Cross is developing

programs and initiatives to enhance existing PCMH practices to become primary care ACOs in Rhode Island.

- **Data –** In order for physicians to be able to make well informed decisions around referral to the most efficient specialists and hospitals, it is necessary that they have the appropriate data on the referral network. To date, the accuracy and utility of the limited data publicly available has been suspect. Blue Cross is concentrated on capturing this information correctly and offering more transparency in the marketplace. As more physicians use EHRs, they also may produce some data on their own. Once this information is in place, Blue Cross will be able to place greater accountability on participating providers and potentially create preferred networks offering more efficient, high quality care for our members. In fact, our PCMH physicians have been asking us for this data to help them reach their goal of providing high quality cost effective care.
- **Quality –** Through the Blue Cross PCMH programs, Blue Cross will be promoting and monitoring consistent quality care through its Hospital Quality program aimed at achieving uniformity in hospital quality improvement and patient safety efforts across our hospital network. Currently, Blue Cross supports a variety of quality initiatives in place at multiple hospitals across the state, but they tend to be specific to individual hospitals. Our goal is to have all of the hospitals involved in many of the same quality improvement projects so that we can compare one hospital against another in how they perform. In designing our program, we have been careful to include all of the

requirements of payers set forth by OHIC earlier this year. For example, one of the key elements will be the "Safe Transitions" project, which will support the work hospitals must do in ensuring a safe transition from hospital to home.

- Utilizing several nationally-recognized standardized areas for improvement, the quality program will focus on improvement in hospital quality structure, administrative and clinical processes, and results or outcomes of the care delivered. These initiatives should also have an impact on affordability, as we should see a decrease in 30 day readmission rates. The full migration into this standard program is expected to be complete in 2012.

In addition to areas where we will increase spending to primary care, we will also work to affect the percentage of total spend allocated to primary care by decreasing overall spending. This will primarily be achieved through the newly-established MET, described above. Cost-containment projects being implemented by the MET include significant changes to the existing formulary as well as modifications to the Radiology Management program (as discussed earlier), as well as programs aimed at decreasing spend within the ancillary network, through activities surrounding physical and occupation therapy, durable medical equipment, and laboratory services.

Spread adoption of the "chronic care model" medical home – The standard for compliance with this affordability priority is for payors, jointly, to expand the Chronic Care Sustainability Initiative – Rhode Island (CSI-RI) spearheaded by OHIC 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. Blue Cross has exceeded the requirements of this

affordability priority by expanding its own PCMH program, which complements and strengthens the work performed by CSI-RI .

Blue Cross continues to support the expansion of medical homes in Rhode Island through its involvement in the multi-payor CSI-RI, as well as the introduction of its own PCMH program in November 2009. To date, Blue Cross supports more than 160 providers involved in both of these programs, with a commitment to dramatically expand over the next few years.

Support of participating physician practices through the CSI-RI program involves funding for a nurse care manager and the care management activities associated with improved care coordination. The Blue Cross PCMH program offers those same supports, as well as added reimbursement for a "physician champion," focused on leading transformation within the practice, which ultimately results in better care coordination and more efficient care for our members. Another component of the Blue Cross PCMH program includes a pay-for-performance (P4P) program, which focuses on the achievement of clinical outcomes for all a PCMH's Blue Cross patients based on nationally-recognized standards.

As part of a long-term commitment to the PCMH model of care, Blue Cross recognizes that the most difficult challenge for practices is the transformation efforts involved in becoming a PCMH. Given that, Blue Cross partnered with TransforMED, a nationally recognized company specializing in practice transformation, and well known for their involvement in the National Medicare Demonstration Project on PCMH to assist with practice transformation in our PCMHs. TransforMED's role is twofold: first, to lead transformation efforts in our PCMH practices, and second, to train Blue Cross Provider

Relations employees as practice coaches to sustain this function as Blue Cross continues to invest in and promote the adoption of PCMHs.

Finally, in an effort to differentiate PCMH providers, Blue Cross will be offering a higher fee schedule for providers that are part of either the CSI-RI or Blue Cross PCMH programs effective December 1, 2010.

Standardize electronic health record (EHR) initiatives – 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 has met or exceeded this standard through its continued support of the purchase, implementation, and optimal use of EHR in physician practices in Rhode Island. Many national studies over the last several years support the concept that widespread use of EHRs lead to improvements in quality of care and patient safety while at the same time reducing the overall cost of care.

The use of certified EHR solutions is critical to Blue Cross' PCMH and health management model, as the technology allows for data aggregation, process measurement, and outcomes-based quality reporting. As a result, to promote and facilitate transition to and implementation of EHRs, Blue Cross has provided the following supports for the adoption of EHRs that are certified by the Certification Commission for Healthcare Information Technology to promote patient tracking as described in the NCQA PPC-PCMH standards for medical homes ("certified EHRs"):

- **EHR Grant Program:** In 2010, Blue Cross continued the EHR Grant program, providing funding for both new and existing users of certified EHRs. Providers can also use the funding for a pre-implementation EHR readiness

assessment. In 2009, $107,000 in funding was disbursed to physician practices as part of this program. As of September 2010, $625,500 has been allocated and $154,000 has been disbursed to physician practices. In total, Blue Cross has approved funding for fifty-eight Rhode Island based primary care and specialist physician practices since the program's inception in 2009. Blue Cross also recently launched a new version of the program targeted to the specific needs of Rhode Island community health centers.

- **Quality Counts**: Our Quality Counts program was designed to incentivize PCPs to purchase, implement, and optimize the use of EHRs in their practices. The 80 physicians who participated or are participating in the program have all completed the EHR implementation phase. Program activity in 2010 consisted of standardization of data entry, quality improvement processes to improve workflows, and reporting of clinical quality measures. Blue Cross has received baseline and re-measurement data on the process and outcome measures from the majority of physician practices enrolled in the program. The clinical quality pay for performance component of the program led to the formation of quality improvement processes in the practices that can be continued into the future.

Through its EHR Grants and Quality Counts programs, Blue Cross has supported, in total, over 400 PCPs with their purchase and implementation of an EHR.

- **Rhode Island Quality Institute (RIQI):** The RIQI is the designated Regional Health Information Organization (RHIO) for Rhode Island. As such, the RIQI is leading the development of current*care*, Rhode Island's Health

Information Exchange (HIE). In February 2010, RIQI received federal funding to establish a Regional Extension Center (REC) for Health Information Technology and implement a "Beacon" Community to advance health care quality through health information technology in Rhode Island.

Blue Cross supports the work of the RIQI through strong executive level representation on several RIQI Committees. Our Chief Executive Officer, Mr. James Purcell, is the chair of the Board of Directors. Our Chief Information Officer, Mr. William Wray, is a member of the Technical Solutions Group. I am a member of the HIT Physician Advisory Committee.

We also support this group's activities financially, providing the largest annual contribution of any stakeholder. In 2010, we provided RIQI with $200,000 in unrestricted funding and $570,000 earmarked for the continued development of HIE technical infrastructure and consumer enrollment activities.

In 2010, Blue Cross Provider Relations staff collaborated with the RIQI to encourage providers to enroll their patients in current*care*. Through our financial support, RIQI was able to provide a $3 per member reimbursement directly to the physician. Blue Cross has also assisted RIQI in the enrollment of primary care providers into the Regional Extension Center. In addition, Blue Cross has collaborated with RIQI on the recruitment of PCMHs for the Beacon Communities Program in order to ensure alignment with our PCMH Program. In 2011, our collaboration efforts with RIQI and the Regional Extension Center will continue as we align our EHR incentive programs to the

CMS standards for meaningful use of health information technology in accordance with the Health Information Technology for Economic and Clinical Health Act (HITECH).

- **Increased Fee Schedule for EHR users:** Blue Cross continues to provide an increased fee schedule for PCPs that have and utilize a qualified EHR in their office at a differential of approximately 12-13% overall. Providers are required to complete an application regarding their EHR and frequency of use of various EHR functionalities to qualify for the higher fee schedule. There are currently over 360 providers that are receiving the higher EHR fee schedule.

Work toward comprehensive payment reform across the delivery system: The standard set by OHIC 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 every suggestion or recommendation, but does mean that Blue Cross will actively engage as a member of the stakeholder body.

Moreover, as described above, Blue Cross has several payment programs in place to 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.

Q. Please describe an affordability program that has been somehow modified or eliminated in the last year based on your monitoring of that program.

A. At the inception of the Radiology Management program in January of 2008, Blue Cross mandated that the ordering physician obtain prior authorization from MedSolutions, our Radiology Management vendor. Shortly thereafter, Blue Cross amended its policy to allow radiology facilities to obtain authorization on behalf of the ordering provider. Additionally, Blue Cross also instituted a gold carding process for cardiologists for the ordering of nuclear cardiology tests.

However, as a result of monitoring of ordering patterns and utilization rates compared to regional benchmarks, Blue Cross recently made the decision to revert back to the original intentions of the program, requiring that the ordering provider initiate prior authorization (rather than the facility) and eliminating the cardiology gold carding program. Both of these changes will become effective January 1, 2011. Blue Cross is confident that placing the onus on the ordering physician will ensure a more accurate prior authorization process.

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 carriers 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 well 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 Congressional Budget Office (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 – an additional spending commitment of at least $6 to $8 million per year over 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 additional fixed costs – amounting to at least $6 to $8 million 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. Does Blue Cross have programs to actively manage chronically ill members?

A. Blue Cross's Care Coordination program seeks to provide chronically ill members with the information, tools, and advocacy to effectively manage chronic illness, improve health outcomes, and ultimately reduce medical expenses. The Care

Coordination program incorporates both individual member care coordination as well as population-based interventions.

Care Coordination: The Care Coordination program targets members with complex chronic medical and behavioral health illnesses who are identified using Ingenix Episode Treatment Groupers (ETG) which analyze claims data. Members are further prioritized for Care Coordination outreach using triggers such as hospital inpatient utilization, high readmission rates, ER use, multiple narcotic prescriptions, noncompliance with recommended condition-specific tests and exams, and predictive modeling scores. Additional referral sources include Blue Cross and Beacon Health Strategies (behavioral health utilization review vendor) utilization review clinicians.

The goals of member outreach are to improve member health and to decrease claims costs by preventing avoidable inpatient admissions and ER visits, thereby utilizing healthcare services appropriately, at the right time and the right place. The Care Coordinator program seeks to achieve these goals by providing the following:

- A multi-disciplinary Care Coordination team consisting of nurses, social workers, behavioral health specialists, medical director, psychiatrist and dieticians to assist in developing the most comprehensive plan of care.
- Member-centric care plans developed with the members, which highlight health goals and steps to achieve these goals. All members receive a copy of the care plan to enhance investment in the goals and action items.
- Medication reconciliation.

- Use of monetary incentives to engage members and promote healthy behavior change such as incentives for completion of a personal health assessment as well as copay reductions for drugs associated with certain chronic conditions.
- Mobilization of community resources to address barriers to self management.
- Provider collaboration through the provider's preferred communication channel to facilitate medication reconciliation, care plan development, and promote member investment in Care Coordination.
- Education, coaching, and support to provide members with timely and essential information to make informed healthcare decisions.
- Ongoing support, monitoring, and advocacy from a Health Advocate once the health goals established with the Care Coordinator are met. The Health Advocate services are intended to facilitate timely referrals back to Care Coordination for members who may be struggling with maintaining health goals as well as to provide the ongoing support and monitoring needed to sustain these goals.

Pharmacy consultation: In 2010, Blue Cross added a pharmacist to the Care Coordination department. The pharmacist is instrumental in facilitating medication reconciliation, mitigating medication access issues, providing consultation on the impact of medications on health status, identifying potential medication interactions, and addressing polypharmacy issues that impact member health.

Congestive Heart Failure (CHF) Teleheath program: Blue Cross continues to offer CHF Telehealth services to CHF members through partnerships with home health agencies. Program goals are to improve member health and to decrease avoidable

inpatient admissions and emergency room visits for CHF. The number of patients involved and the time spent in this program does not allow for adequate projections in savings at this time, however, indications point to positive results.

Population Health Interventions for Members with Chronic illness: In addition to individualized member outreach, the Blue Cross Disease Management and Prevention program provides an innovative, integrated approach for our members with chronic conditions. Members are provided the information, tools, and resources to effectively self-manage their disease, facilitate a positive relationship with their physician, and assure they are receiving appropriate medical care to maintain optimal wellness. These goals are accomplished through a comprehensive series of interventions, including educational mailings and compliance reminders to both members and physicians. The diseases and conditions targeted through the program include:

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Coronary Artery Disease (CAD)
- Depression
- Diabetes
- Hypertension
- Hyperlipidemia
- Low Back Pain
- Maternity & Pregnancy Planning

Members identified with the chronic illnesses listed above may receive one or more of the following interventions:

Compliance Programs – Members who are non-complaint with recommended screenings or test, or prescribed medication regiments receive reminders in an effort to

get them back on track. Reminders and reports are also forwarded to the members' physicians.

Educational Mailings – Members receive targeted educational mailing(s) containing general educational literature and tools and information on applicable disease management programs and services.

Living Well program - Blue Cross is currently a licensed site for the Living Well program. This program was developed through Stanford University and designed for persons living with a chronic condition or caring for someone with a chronic condition. The Living Well program teaches the skills needed in the day to day management of chronic illness as well as to maintain and/or increase life's activities. The program runs one time per week for six weeks. Each week discusses a different topic such as nutrition, exercise, fatigue, stress management techniques, and communication.

Q. Does Blue Cross provide any interventions for members that may not have a chronic illness but experience an acute illness?

A. Yes. The Utilization Management area is actively involved when a member experiences an acute illness in the inpatient setting. The patient's progress is monitored throughout the inpatient stay, which enables us to better prepare and serve the member. The Blue Cross nurse or on-site review nurse assists the facility discharge planner in coordinating discharge plans. Care Coordination may become involved to assist with the complex needs of the member and family. The Utilization Management area also ensures continuity of care by presenting opportunities for frequent monitoring of the member's condition and need for ongoing treatment.

In addition, our utilization management (UM) programs facilitate appropriate delivery, coordination, and management of acute illnesses, including high cost and catastrophic care. UM also help us to ensure that:

- Medically necessary health services are provided.
- The level of care is appropriate for the patient's medical needs.
- Uniform standards of care are objectively applied.
- Case management screening is universally conducted.
- Medically necessary care is coordinated following a member's discharge from the hospital.
- Case management eligibility is assessed.

Q. Does Blue Cross evaluate these programs?

A. Yes. Process metrics evaluate the number of members referred, enrolled, and engaged in the Care Coordination program on a monthly basis. These metrics are used as a proxy for potential member health improvement and claims impact. In addition, the types of healthy behavior changes are also evaluated to identify the Care Coordinators' greatest areas of impact. The overall impact of Care Coordination is evaluated by monitoring changes in inpatient admissions and ER utilization for members enrolled in the program. Blue Cross also measures its provider collaboration success rate. To date, we are successful in our collaboration attempts over 61% of the time. Additionally, member enrollment in care coordination programs has increased approximately 15% since implementing changes surrounding member outreach and engagement incentives. The overall decrease in ER utilization and inpatient admissions as a result of care coordination activities is 3.72% and 3.83%, respectively.

Q. What programs does Blue Cross have in place to assure the use of the least cost, most appropriate setting?

A. 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, high end imaging and new technology.

Q. Please explain how Blue Cross supports use of evidence-based, quality care.

A. As noted previously, Blue Cross employs Utilization Management activities based on evidence-based guidelines. Whenever available, evidence-based clinical guidelines are used in the development of medical policies used by Blue Cross. In addition, through programs like Radiology Management and Specialty Pharmacy, coverage decisions are based on clinical guidelines. Physicians are given the opportunity to discuss these decisions with their peers to better understand the logic behind coverage criteria. These guidelines are reviewed on a regular basis and updated accordingly, given any applicable changes.

Recently, Blue Cross has deployed a suite of member education tools that are available online and in print through a partnership with Healthwise, an organization that specializes in providing evidence-based member educational materials and tools. This effort is designed to provide tools to enable our members to become informed, actively-engaged, better consumers of healthcare by empowering them in discussions with their

physician in order to arrive at a decision that is most beneficial for the member considering the member's own health, spiritual, and cultural beliefs weighed with the physician's knowledge of evidenced-based medicine. The self-management tools also assist members to track and monitor their health. This suite of products is available to members and providers.

Finally, one of the major reasons Blue Cross supports the adoption of EHRs is due to the clinical decision making capabilities offered through these programs. Through Blue Cross's ongoing funding and support of EHR adoption, Blue Cross has in turn expanded the presence of these tools for more than 400 physicians in Rhode Island.

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. Blue Cross supports system-wide improvements through both financial contributions and in-kind assistance. 2010 financial contributions toward system-wide improvements exceed $9 million. A detailed outline of all Blue Cross' allocation of resources and supports toward system-wide improvements is delineated in the health systems improvement report which is Exhibit 3 of the filing.

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. 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 has developed a product which is based on the premise that in healthcare, the most important measure of value is not cost, but health itself. HealthMate Coast-to-Cost Plan 1000/2000 uses built-in financial incentives and value-based benefits that helps remove many of the financial barriers for members getting the proper treatment and rewards healthy choices. This plan offers 100% coverage for preventive care, certain over the counter preventative medications, nutrition counseling, smoking cessation counseling and diabetes and asthma management. This also includes 100% coverage for one annual eye and foot exam for members with diabetes. It financially rewards our member for completing a personal health assessment (PHA), and for working with one of our care coordinators by providing reduced copayments on medications to help treat chronic conditions. All members that choose this plan receive a welcome call from an engagement specialist that goes over their plan benefits, explains the incentive programs they are eligible for, and makes referrals into our health programs

including web programs, discount programs, case management and wellness programming. We believe this increased engagement of members will result in a real return on investment in the form of improved member health, reduced sick days and disability, and better controlled medical costs. Consumer response to this plan exceeded our expectations, with total membership equaling 860 members as of September 2010, compared to our annual enrollment goal of 600 members.

Moreover, Blue Cross offers a Direct Pay Premium Assistance Program (known as AccessBlue). This program provides members whose income is less than 350% of the federal poverty level financial assistance in paying their health insurance premiums. AccessBlue has provided millions of dollars in financial assistance since its inception, making coverage affordable for the nearly 29% of the Direct Pay population that qualified, such as Rhode Island's unemployed and underemployed population.

Additionally, to address the needs of those uninsured individuals with pre-existing conditions, Blue Cross has contracted with the U.S. Department of Health & Human Services to administer the Temporary High Risk Pool under the Patient Protection & Affordable Care Act. We began accepting applications in August for this program, which we call the Pre-Existing Insurance Plan for Rhode Island (PCIPRI), with coverage going into effect in October 2010. In accordance with PPACA, to qualify for the plan, an applicant must:

- Be uninsured for at least six months prior to application;
- Be a resident of Rhode Island who is lawfully present in the United States;
- Not be eligible for employer sponsored coverage, Medicaid, Medicare, or other programs; and

- Be dignosed with one of 34 qualifying chronic conditions;

PCIPRI is similar to our Healthmate Coast-to-Coast Direct Plan 1000/2000. It features out-of-pocket maximums and set copayment amounts for routine office visits and prescription drugs

PCIPRI also includes access to our Care Coordinators, who will help members manage their pre-existing medical conditions. In fact, members are required to either participate in our Care Coordination Program or choose a primary care physician who participates in one of our PCMHs

Because PCIPRI is offered under a federal contract, it is not part of this filing. My purpose for discussing this program is to highlight it as one of the many things Blue Cross is doing to improve access to affordable health insurance and to demonstrate our commitment in this area.

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, watch online health related video content, track their exercise and calorie consumption and can 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.

Additionally, 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 quarter and which is available in interactive form on the Blue Cross website. Blue Cross also provides insured 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.

Collectively, during calendar year 2009, Blue Cross made approximately 390,000 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.

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

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. Additionally, during Open Enrollment, Blue Cross conducted 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 110 prospective members attended and provided positive feedback about how helpful the meeting was to them in making their decision.

We also strive to provide members with options for obtaining information about our plans. For example, this year we launched a new product for Direct Pay members – the Healthmate Coast to Coast Direct 1000/2000 Plan (HMC2C 1000/2000). Blue Cross developed a mailing for Direct Pay members that included information about the new product and an invitation to attend a member meeting to learn more about all of Blue

Cross' Direct Pay plan offerings. This was also the first year Blue Cross used clinical segmentation data to create communications to our Direct Pay members who suffer from specific chronic conditions educating them about the benefits of the new HMC2C 1000/2000 product and why they may want to consider switching to that plan.

Blue Cross also offers in person wellness programs that are available to direct pay members though our Good Health Benefit Program. This program includes various community based seminars including weight management and stress management, as well as health fairs where direct pay members can have their cholesterol, blood pressure and glucose levels tested.

Finally, in July of 2010, Blue Cross also implemented a social networking site that is available to Direct Pay members where they can share like experiences with other Blue Cross members throughout the country on a variety of topics such as weight loss, nutrition, chronic care, and cancer.

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

A. Blue Cross recognizes its special role in Rhode Island's healthcare system and our obligation to participate in discussions to improve the system. To that end, our associates have been active in many state-wide workgroups to discuss the impact of the Patient Protection & Affordable Care Act on Rhode Island. We have also developed and shared materials and presentations with various stakeholder groups to generate discussion. In addition, our associates regularly attend meetings held by public interest groups such as the Rhode Island Business Group on Health and HealthRIte on various health policy issues.

Blue Cross is also engaged, as described throughout my testimony, in efforts being coordinated by the OHIC such as CSI-RI. We also attend and participate in Health Insurance Advisory Council meetings.

At BCBSRI, we recognize our obligation and duty to participate in the development and implementation of public policy issues related to health, because we believe the greatest opportunity to truly reform healthcare is at the local level where care is actually delivered.