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May 18, 2012

Mr. Christopher F. Koller
Health Insurance Commissioner
Office of Health Insurance Commissioner
1511 Pontiac Avenue, Bldg. 69-1
Cranston, Rhode Island 02920

Subject: 1) Rating Factors Applicable to Small Group Subscription Rates for New and Renewal Business Effective January 1, 2013 through December 1, 2013;

2) Rating Factors Applicable to Rhode Island Builders Association Subscription Rates for New and Renewal Business Effective November 1, 2013;

3) Rating Factors Applicable to HealthPact Plan Subscription Rates for New and Renewal Business Effective January 1, 2013 through December 1, 2013 (Forms on file)

Dear Commissioner Koller:

This letter and the attached documents comprise a rate factor filing by Blue Cross & Blue Shield of Rhode Island (BCBSRI or Blue Cross) of claims projection trends, reserve contribution factors, and related rating information to be used in commercial rating of small employer groups, Rhode Island Builders Association groups, and HealthPact Plan groups for the upcoming calendar year.

Filing Overview

BCBSRI recognizes that providing affordable healthcare is critical to our customers, members, and the Rhode Island economy. To facilitate this, BCBSRI has undertaken a significant number of initiatives designed to aggressively transform its business strategy, improve internal operations and moderate both medical and administrative expense trends. As a result of these efforts BCBSRI is filing medical trends and rate increases that are appreciably below the levels filed in recent years. As detailed in Exhibit 1 Part 2, the effective annual medical trend in this filing is 3.0% for 2013 over 2012. The estimated average rate increase resulting from this filing, not including federal taxes and assessments, is 2.1%. These new federal taxes and assessments will result in an additional increase of as much as 4.3% as further discussed below and in the Exhibits to this filing.

Addressing Affordability

BCBSRI continues to intensify efforts to moderate healthcare costs by transforming the local healthcare delivery system. Through investments in patient-centered medical homes, electronic health records and care coordination programs, among other efforts, BCBSRI is taking bold steps to transform the local healthcare delivery system and improve our members' health, which will ultimately moderate long-term costs.

In addition, BCBSRI continues to pursue a comprehensive claims reduction strategy designed to address our financial shortfalls, and address affordability, while continuing to ensure high quality of care. Programs developed as part of this strategy successfully reduced claims expense for commercially insured group business by $12 million in 2010 and by $51 million in 2011. These savings carry forward and will reduce claims expense and premium in 2012 and 2013. In addition we have identified $19 million in new claims expense reductions for 2012.

Savings programs for 2012 include (1) formulary, plan design, and pharmacy pricing changes that will result in a reduction in insured group Prescription Drug spend of approximately $28 million annually; (2) changes in payment policies and management for imaging services which will result in approximately $5 million in savings annually; and (3) enhanced inpatient management of hospitalized members to save about $4.5 million annually.

Medical Trends

While the medical trend components of this rate filing are well within the target of 4% adopted by the Health Insurance Advisory Council, it is important to note that this rate filing reflects the escalating cost of medical care. Reasons for these increasing costs include medical provider price increases, expensive new medical technology, increases in the cost of prescription medications and a general increase in the number of medical services obtained by our members. The ongoing increase in costs results in higher medical care cost projections into the future, which translate to higher health insurance premiums.

This filing takes into account a major new pharmacy benefit management contract to be effective in January 2013 that is expected to reduce pharmacy claims cost by 14%. For the typical group benefit plan, this would result in premium savings of approximately 2.7%. Trends are addressed in more detail in the actuarial assumptions, Exhibit II.

Administrative Expenses & Reserves

Blue Cross is spending increasing amounts of administrative dollars to lower the cost of medical care while improving its quality. For example, one of our highest priorities continues to be our commitment to helping Primary Care Physicians improve both their operating infrastructure and quality of care. The cost of complying with Federal mandates (e.g. ICD-10 and HIPAA 5010) is also putting upward pressure on expenses. Blue Cross implemented additional cost reduction strategies in 2011 to offset the added costs noted above. The company eliminated an additional 45 positions in November 2011, modified our employee benefit program and expanded continuous improvement efforts. The net result of these efforts is a 2012 corporate budget that is $4 million lower than actual 2011 expenditures and a projected budget for 2013 that is $27 million lower than 2011 actual.

Our 2011 financial results continued to be unfavorable, particularly for group business, although far less severe than previous years. The improving trend outlook permitted BCBSRI to release the remaining $92.7 million premium deficiency reserve it had originally established in 2009, which benefitted our corporate reserve position. Our reserves are still below the safety ranges recommended by several actuarial studies conducted by independent nationally recognized firms, including one commissioned by the Office of the Health Insurance Commissioner (OHIC). In light of the current situation and the significant uncertainties as to the impact PPACA will have, we are filing for no change to our reserve contribution factor. We therefore request approval in this filing for reserve contribution factors to 3% of premium, plus the previously approved 0.34%

for the funding of the core operating system replacement project. Additional support for this request is discussed in Exhibit II of this filing.

State and Federal taxes and assessment mandates continue to increase in their share of health insurance costs, in particular where such costs can only be assessed on fully insured plans. Self-funded employers can meanwhile legally avoid such costs while still enjoying the benefits of programs funded by assessments. BCBSRI is supporting bills now before the state legislature to spread the cost of taxes and assessments more equitably on the basis of claims rather than premiums. In the event of enactment, BCBSRI would be pleased to amend the administrative cost components of this filing and reduce our premiums accordingly.

Federal Taxes & Assessments

The federal Patient Protection & Affordable Care Act (PPACA) prescribes new federal taxes and assessments on health insurance carriers starting with CY 2013 premiums, to be paid starting in 2014. Based on information currently available, we are projecting BCBSRI's first assessment will be nearly$75 million, of which the insured group share is $43 million, or approximately 4.3% of premium. We have received conflicting guidance from HHS, CMS, and NAIC as to the accounting treatment of this liability for 2013 and 2014. Specifically, early guidance from NAIC stated that the expense should be accrued for 2013, while the federal government indicated that such liability could not be treated as a deduction from the medical loss ratio determination for 2013. We understand that this guidance is still developing and subject to change, but since BCBSRI must now submit its 2013 rate filing, we are including the provision for these assessments starting in 2013 rates at 4% of premium.

Based upon OHIC's instructions of May 7, 2012, we have included two scenarios in this filing to address these federal taxes and assessments. The first scenario assumes no change in the NAIC instructions, thus increasing the average rate increase by 4.3% in order to account for these federal taxes and assessments. The second scenario assumes that the NAIC instructions change and includes an additional average rate increase of 1.9% for federal taxes and assessments. We ask that you approve both scenarios and allow us to apply the appropriate factor once final guidance is issued.

Filing Fee

In accordance with the filing fee requirements contained in Section 42-14-18 of the General Laws of Rhode Island, an electronic funds transfer (EFT) transaction in the amount of $125 is submitted via the SERFF system. Policy forms pertaining to this filing are listed in Attachment 1 to this letter.

Actuarial Support and Certification

The exhibits included in this filing, detailed in Attachment 2 to this letter, display the required rating factors and detailed actuarial documentation supporting this filing, including those prescribed pursuant to your Office's filing instructions letter of April 19, 2012 as supplemented on May 7, 2012 and May 16, 2012.

The actuarial assumptions underlying this filing have been developed by my staff and reviewed by myself. I certify that this rate filing was developed utilizing sound actuarial assumptions and methodologies.

Conclusion

In summary, BCBSRI is pleased to file for the lowest trends and average rate increases for its large group plans in several years. Absent the new federal taxes and assessment charges, and excluding the HealthPact Plan, the average rate increase for small group is estimated to be 2.1%.

As stated above, BCBSRI is committed to making healthcare affordable in Rhode Island. We continue to participate in the community effort to redesign our healthcare system while transforming the company. However, without adequate rates to cover our medical and administrative expenses and improving our reserve position, we could potentially jeopardize our financial stability and contribution to our community.

We respectfully ask for your timely consideration and approval of the proposed rating factors as submitted. Blue Cross & Blue Shield of Rhode Island believes that the proposed rating factors are in the best interest of both the public and the Corporation and consistent with the proper conduct of our business. As always, we shall be pleased to respond promptly to any questions you, your staff, or your office's consulting actuary, Mr. DeWeese, may have.

Sincerely,

John Lynch, F.S.A., M.A.A.A.
Chief Actuary

cc: Monica A. Neronha, Esq.

Attachment 1: Policy Forms

Policy forms pertaining to this filing are as follows:

FRONT GRP (09-10);
SUMMARY GRP (09-10);
INTRODUCTION GRP (09-10);
ELIGIBILITY GRP (09-10);
COVERED GRP (09-10);
EXCLUSIONS GRP (09-10);
HOW WE PAY GRP (09-10);
COB GRP (09-10);
APPEALS GRP (09-10); and
GLOSSARY GRP (09-10).

Attachment 2: List of Exhibits

Exhibit I, *Small Group Rate Filing Template*

Exhibit II, *Actuarial Assumptions for Small Group Commercial Rating,* outlines the underlying methodology and assumptions used to develop the claims projection trends and reserve contribution factors.

Exhibit III, *Rhode Island Annual Health Statement Supplement*

Exhibit IV, *Areas of Medical Expense Variation Form*

Exhibit V, *Provider Contracting Practices and Hospital Contracting Conditions Verification Questionnaire*

Exhibit VI, *Administrative Costs Request*

Exhibit VII, *Health System Improvements Survey*

Exhibit VIII, *BCBSRI Small Group Rate Manual for 2013* (confidentiality requested)

Blue Cross & Blue Shield of Rhode Island
Small Group Rate Filing Template: May 2012 Filing

Part 1. Historical Information

Experience Period for Developing Rates

From	To
1/1/2009	12/31/2011

Total Small Group and Rhode Island Builders Association

Quarter	End Date	IP Days	Member Months	Earned Premium	Incurred Claims Total	Incurred Claims IP	Incurred Claims OP	Incurred Claims Primary Care	Incurred Claims Other M/S	Incurred Claims Rx	Loss Ratio	Quality Improvement Expense*	Other Cost Containment Expense*	Other Claim Adjustment Expense*	Other Operating Expense*	Investment Income	State Premium Tax	Commissions	Contribution to Reserves
1 (Oldest)	3/31/2009	6,617	240,651	$89,628	$75,647	$16,792	$17,375	$3,376	$23,109	$13,954	84.4%	$543	$958	$3,800	$8,049	$771	$1,705	$1,710	($2,014)
2	6/30/2009	5,691	233,280	$87,709	$76,748	$16,573	$17,517	$3,376	$24,541	$13,723	87.5%	$539	$897	$3,634	$6,825	$1,596	$1,731	$1,403	($2,472)
3	9/30/2009	5,027	227,667	$86,406	$72,443	$15,006	$16,231	$3,560	$22,840	$13,617	83.8%	$520	$922	$3,650	$6,978	$1,257	$1,766	$1,461	($77)
4	12/31/2009	4,863	220,642	$85,468	$72,437	$13,743	$17,031	$3,752	$23,043	$13,707	84.8%	$498	$718	$3,855	$10,925	$124	$1,777	$1,366	($5,984)
5	3/31/2010	2,872	214,763	$83,767	$72,903	$17,929	$17,711	$3,135	$20,764	$13,363	87.0%	$530	$742	$2,391	$6,884	$230	$1,744	$2,349	($3,546)
6	6/30/2010	4,543	214,394	$85,759	$73,424	$14,085	$14,643	$3,039	$26,400	$15,258	85.6%	$530	$742	$2,391	$6,883	$230	$1,744	$2,349	($2,075)
7	9/30/2010	4,543	212,340	$85,961	$75,022	$15,920	$17,302	$3,090	$23,520	$15,190	87.3%	$530	$742	$2,391	$6,883	$230	$1,744	$2,349	($3,471)
8	12/31/2010	4,318	208,951	$88,639	$76,857	$13,580	$14,810	$3,199	$29,237	$16,031	86.7%	$530	$742	$2,391	$6,883	$230	$1,744	$2,349	($2,628)
9	3/31/2011	6,164	205,736	$84,447	$72,438	$18,099	$17,121	$3,148	$18,989	$13,715	85.8%	$612	$768	$2,253	$5,459	$189	$1,707	$1,607	($209)
10	6/30/2011	5,237	203,734	$83,825	$71,615	$15,384	$17,660	$3,164	$19,665	$14,376	85.4%	$590	$741	$2,172	$5,263	$199	$1,716	$1,887	$40
11	9/30/2011	5,533	201,333	$85,912	$70,063	$15,331	$17,208	$3,093	$18,641	$14,254	81.6%	$594	$745	$2,186	$5,297	$185	$1,701	$1,886	$3,625
12	12/31/2011	4,707	199,769	$81,796	$70,258	$14,603	$17,501	$3,360	$18,643	$14,615	85.9%	$667	$837	$2,455	$5,948	$166	$1,793	$1,683	($1,679)

HealthPact Groups

Quarter	End Date	IP Days	Member Months	Earned Premium	Incurred Claims Total	Incurred Claims IP	Incurred Claims OP	Incurred Claims Primary Care	Incurred Claims Other M/S	Incurred Claims Rx	Loss Ratio	Quality Improvement Expense*	Other Cost Containment Expense*	Other Claim Adjustment Expense*	Other Operating Expense*	Investment Income	State Premium Tax	Commissions	Contribution to Reserves
1 (Oldest)	3/31/2009	44	2,129	$639,770	$482,978	$164,127	$86,541	$30,332	$107,541	$94,437	75.5%	$3,877	$6,841	$27,127	$57,456	$5,504	$12,172	$12,203	$42,621
2	6/30/2009	13	1,832	$578,053	$315,747	$42,787	$71,112	$26,106	$92,559	$83,184	54.6%	$3,551	$5,911	$23,950	$44,980	$10,519	$11,411	$9,246	$173,776
3	9/30/2009	11	1,667	$540,999	$389,053	$136,262	$59,298	$26,268	$93,131	$74,094	71.9%	$3,255	$5,774	$22,852	$43,690	$7,868	$11,059	$9,148	$64,037
4	12/31/2009	13	1,732	$562,745	$291,615	$61,490	$57,037	$21,794	$77,270	$74,024	51.8%	$3,280	$4,725	$25,381	$71,932	$817	$11,700	$8,996	$145,933
5	3/31/2010	9	1,730	$574,413	$229,352	$11,133	$57,786	$18,706	$66,322	$75,404	39.9%	$3,636	$5,088	$16,394	$47,204	$1,574	$11,956	$16,109	$246,249
6	6/30/2010	15	1,743	$581,267	$249,797	$31,166	$44,749	$19,292	$68,397	$86,193	43.0%	$3,592	$5,029	$16,206	$46,656	$1,556	$11,821	$15,921	$233,801
7	9/30/2010	81	1,862	$617,412	$484,556	$218,527	$52,173	$27,131	$96,193	$90,531	78.5%	$3,807	$5,329	$17,173	$49,440	$1,649	$12,526	$16,872	$29,358
8	12/31/2010	26	2,027	$667,802	$522,807	$60,238	$143,615	$46,644	$165,374	$106,937	78.3%	$3,993	$5,590	$18,014	$51,859	$1,729	$13,139	$17,697	$36,432
9	3/31/2011	30	2,502	$802,153	$460,062	$91,663	$109,468	$45,524	$123,745	$89,662	57.4%	$5,815	$7,296	$21,404	$56,015	$1,795	$16,212	$15,268	$221,875
10	6/30/2011	38	3,028	$992,980	$579,063	$64,060	$168,612	$58,635	$148,064	$139,691	58.3%	$6,940	$8,707	$25,544	$66,849	$2,340	$20,173	$22,187	$265,858
11	9/30/2011	92	3,357	$1,080,991	$875,531	$271,339	$163,345	$65,453	$215,817	$159,577	81.0%	$7,603	$9,540	$27,986	$73,239	$2,368	$21,774	$24,141	$43,545
12	12/31/2011	100	4,123	$1,375,539	$735,053	$105,381	$151,757	$70,670	$224,360	$182,885	53.4%	$10,863	$13,630	$39,987	$104,645	$2,704	$29,212	$27,413	$417,440

* These categories should conform generally to the reporting in the NAIC statement Underwriting & Investment Exhibit Part 3- Analysis of Expenses and/or to the Supplemental Health Care Exhibit, Lines 6.3 and 8.1
If any of the historical information reported is different from that period as reported in the prior rate filing, please provide a reconciliation and explanation showing the amount of each element of difference.

Part 2. Prospective Information (Small Groups and Rhode Island Builders Association only)

A. Trend Factors for Projection Purposes (Annualized)

	2013 / 12							2014 / 13					
	IP	OP	Primary Care	Other M/S	Rx	Weighted Total		IP	OP	Primary Care	Other M/S	Rx	Weighted Total
Total	**7.22%**	**9.36%**	**9.44%**	**6.20%**	**6.80%**	**7.48%**	**Total**	**5.69%**	**8.16%**	**13.52%**	**6.23%**	**8.84%**	**7.44%**
Price Only	5.61%	5.12%	5.19%	2.08%	1.27%	**3.61%**	**Price Only**	4.10%	3.96%	9.11%	2.11%	3.21%	**3.56%**
Utilization	0.00%	3.50%	3.50%	3.50%	3.90%	**2.78%**	**Utilization**	0.00%	3.50%	3.50%	3.50%	3.90%	**2.78%**
Mix	1.00%	0.00%	0.00%	0.00%	0.00%	**0.23%**	**Mix**	1.00%	0.00%	0.00%	0.00%	0.00%	**0.23%**
Leveraging	0.52%	0.52%	0.52%	0.52%	1.50%	**0.72%**	**Leveraging**	0.52%	0.52%	0.52%	0.52%	1.50%	**0.72%**
Weights	23%	24%	5%	28%	20%	**100%**	**Weights**	23%	24%	5%	28%	20%	**100%**

Note: The above factors together with the new PBM impact and normalizing for an expected demographic change of 1.68%, produce an effective 2013 over 2012 trend of 3.0%.

Blue Cross & Blue Shield of Rhode Island
Small Group Rate Filing Template: May 2012 Filing

Scenario A - New PPACA Taxes Accrue in 2013

B. The following items for the period to which the rate filing applies, by quarter:

Quarter	Beginning Date	Average % Rate Increase	Expected Pure Medical Cost Ratio	Expected Contribution to Reserves %	Quality Improvement Expense %*	Other Cost Containment Expense %*	Other Claim Adjustment Expense %*	Other Operating Expense %*	Average Commissions %*	Investment Income Credit %	Premium Tax %	PPACA Tax %
1	1/1/2013	6.4%	80.0%	3.3%	0.6%	0.8%	2.5%	5.0%	2.1%	-0.2%	2.0%	4.0%
2	4/1/2013	6.6%	79.9%	3.3%	0.6%	0.8%	2.5%	5.0%	2.1%	-0.2%	2.0%	4.0%
3	7/1/2013	6.8%	79.9%	3.3%	0.6%	0.8%	2.5%	5.0%	2.1%	-0.2%	2.0%	4.0%
4	10/1/2013	6.7%	79.9%	3.3%	0.6%	0.8%	2.5%	5.0%	2.1%	-0.2%	2.0%	4.0%
Weighted Average		**6.6%**	**79.9%**	**3.3%**	**0.6%**	**0.8%**	**2.5%**	**5.0%**	**2.1%**	**-0.2%**	**2.0%**	**4.0%**

* These categories should conform generally to the reporting in the NAIC statement Underwriting & Investment Exhibit Part 3 - Analysis of Expenses and to the Supplemental Health Care Exhibit, Lines 6.3 and 8.1
The sum of the expenses, commissions, contributions to reserves, investment income credit, taxes and the medical loss ratio should be 100%.

C. Average Rate Increase Components

The following items should reconcile to the Weighted Average Percent Rate Increase for the year:

	Price	Utilization, Mix	Total
Inpatient	1.1%	0.3%	1.4%
Outpatient	1.0%	0.8%	1.9%
Physician	1.0%	0.8%	1.8%
Pharmacy	0.4%	0.7%	1.0%
NEW PBM Effect			-2.3%
Admin Expense (Aggregated)			0.5%
Contribution to Reserves			0.2%
Taxes and Assessments			0.4%
NEW PPACA Taxes			4.3%
Prior Period Adjustment (+/-)			-2.6%
Total			**6.6%**

Scenario B - New PPACA Taxes Do Not Accrue in 2013

B. The following items for the period to which the rate filing applies, by quarter:

Quarter	Beginning Date	Average % Rate Increase	Expected Pure Medical Cost Ratio	Expected Contribution to Reserves %	Quality Improvement Expense %*	Other Cost Containment Expense %*	Other Claim Adjustment Expense %*	Other Operating Expense %*	Average Commissions %*	Investment Income Credit %	Premium Tax %	PPACA Tax %
1	1/1/2013	2.4%	83.1%	3.3%	0.6%	0.8%	2.6%	5.3%	2.1%	-0.2%	2.0%	0.3%
2	4/1/2013	3.6%	82.2%	3.3%	0.6%	0.8%	2.6%	5.2%	2.1%	-0.2%	2.0%	1.3%
3	7/1/2013	4.9%	81.3%	3.3%	0.6%	0.8%	2.6%	5.2%	2.1%	-0.2%	2.0%	2.3%
4	10/1/2013	6.0%	80.5%	3.3%	0.6%	0.8%	2.5%	5.1%	2.1%	-0.2%	2.0%	3.3%
Weighted Average		**4.1%**	**81.8%**	**3.3%**	**0.6%**	**0.8%**	**2.6%**	**5.2%**	**2.1%**	**-0.2%**	**2.0%**	**1.8%**

* These categories should conform generally to the reporting in the NAIC statement Underwriting & Investment Exhibit Part 3 - Analysis of Expenses and to the Supplemental Health Care Exhibit, Lines 6.3 and 8.1
The sum of the expenses, commissions, contributions to reserves, investment income credit, taxes and the medical loss ratio should be 100%.

C. Average Rate Increase Components

The following items should reconcile to the Weighted Average Percent Rate Increase for the year:

	Price	Utilization, Mix	Total
Inpatient	1.1%	0.3%	1.4%
Outpatient	1.0%	0.8%	1.9%
Physician	1.0%	0.8%	1.8%
Pharmacy	0.4%	0.7%	1.0%
NEW PBM Effect			-2.3%
Administrative Expense (Aggregated)			0.5%
Contribution to Reserves			0.1%
Taxes and Assessments			0.5%
NEW PPACA Taxes			1.9%
Prior Period Adjustment (+/-)			-2.6%
Total			**4.1%**

Part 3. Retrospective Reconciliation of Experience with Filed Factors (Small Groups and Rhode Island Builders Association only)

	Filed Data[1]					PMPM Increase[2]		Standard Plan PMPM[3]		Standard Plan Increase[4]		Approved		Loss Ratio[5]	
Year	Member Months	Earned Premium	Incurred Claims Total	Premium PMPM	Claims PMPM	Premium	Claims	Premium	Claims	Premium	Claims	Trend Increase%	Contrib to Reserves%	Actual%	Filed%
2009	922,240	349,211	297,275	$378.65	$322.34			$377.56	$321.41			9.4%	1.3%	85.1%	84.3%
2010	850,448	344,126	298,206	$404.64	$350.65	6.9%	8.8%	$402.33	$348.65	6.6%	8.5%	8.8%	2.0%	86.7%	84.0%
2011	810,572	335,980	284,374	$414.50	$350.83	2.4%	0.1%	$435.73	$371.66	8.3%	6.6%	9.7%	2.3%	84.6%	85.0%

[1] Corresponds to historical Information data in Part 1 above

[2] Percent increase compared to prior year

[3] For most commonly held plan of benefits in 2010 and for the same plan of benefits in 2011

[4] Percent increase compared to prior year

[5] Represents claims loss ratio, claims divided by premium, which differs from the Federal MLR calculation for potential rebate determination

BLUE CROSS & BLUE SHIELD OF RHODE ISLAND

ACTUARIAL ASSUMPTIONS FOR SMALL GROUP COMMERCIAL RATING

Applicable Group Rate Effective Dates

- Small Group new and renewal business for rating periods commencing January 1, 2013 through December 1, 2013
- Rhode Island Builders Association new and renewal business for rating periods commencing November 1, 2013
- Group HealthPact Plan new and renewal business for rating periods commencing January 1, 2013 through December 1, 2013

Utilization Projections

The determination of the projection trends contained in this filing utilizes the Corporation's standard methodology. This methodology assumes the annual trend represented by the best-fit linear regression line, based on the percentage rate of increase for the period January 2011 through December 2011 over the period January 2010 through December 2010 and continuing into the future in a geometric progression so that the actual trend (percentage increase) is constant over time. Where in past years BCBSRI has determined utilization/mix trends based on combined large group and small group data, this year we have observed a significant sustained differential in trend results between large group and small group. This is apparently due to differing rates of change in the demographics of the respective covered populations. We have elected to file the differing trend results, with small group running consistently higher trends than large group.

For **Hospital Inpatient utilization**, the days per thousand rate and admissions per thousand rate are slightly negative. Hospitals are being converted, and will continue to convert, their inpatient reimbursement basis from per-diem to per-case. We also note that Butler Hospital has been approved for 25 additional beds. For these reasons it is our actuarial judgment to use a hospital inpatient utilization trend of 0%, the same as that submitted in last year's filing.

For **Hospital Inpatient mix** trend, we performed several measures of depriced cost/day and depriced cost/admission with some results indicating a negative trend. However, we are expecting the current financial difficulties that some hospitals within Rhode Island currently face are likely to lead to admissions at more costly facilities and/or contract re-negotiation in the near future for those struggling hospitals that remain open, with slightly higher costs resulting. Therefore it is our actuarial judgment for this filing to use a 1.0% inpatient annual mix adjustment.

For **Hospital Outpatient utilization/mix** trend, the standard methodology on insured small groups produces an annual trend of 7.6%, but with more recent experience emerging at somewhat lower trends. It is our actuarial judgment to use a 3.5% outpatient annual utilization/mix trend. This trend is 0.3% lower than the outpatient trend approved last year.

Utilization/mix trends for Primary Care and Other Medical/Surgical were determined on a combined basis as one Surgical/Medical utilization/mix trend, consistent with our customary

practice in previous filings. The determination of separate trends continues to produce results that are not credible, and the resulting combined trend result is judged to be a reasonable expectation for both segments. The Surgical/Medical regression result of 2.55% is extremely low compared to results seen for earlier periods. We anticipate some risk of increased utilization by specialists due to restricted increases in reimbursement rates anticipated over the next few years and the corresponding upward "pull" inherent in the fee for service system. Therefore we request approval of an annual trend of 3.5%, which, while higher than the regression results, is the same as that approved last year and also below historical average utilization trend we have seen in this service category.

For **Prescription Drugs price/utilization/mix (**prior to adjustments for one-time changes in claim costs), the standard methodology regression uses 13 data points with a calculated trend of 11.29% for small groups. More recent data suggest continuation of the trend and our latest actual observation (CY 2011 over CY 2010) trends is 11.09%. We are skeptical that this high trend is sustainable in current conditions, so it is our actuarial judgment to use a trend of 8.0% as the baseline for small groups for this filing. Adjustments for one-time changes in claim costs, such as ongoing cost reductions for new generic drugs coming to market and plan formulary changes, are expected to offset this trend by 2.6%, yielding a 5.2% effective drug trend (before the pharmacy contract change adjustment). For **Prescription Drugs utilization,** a separate regression analysis was run for the number of scripts per 1,000 members.

The **composite of utilization/mix factors** across all service categories in this filing amounts to 3.0%. While this composite is the aggregation of the different assumptions made in the various service categories as discussed above, we also considered its reasonableness in total. In evaluating the appropriateness of the composite trend assumption one should consider that utilization trend is impacted by demographic, technology and morbidity changes as well as by changes in provider practice.

Our composite utilization/mix assumption must also provide for the effects of ongoing technological changes in healthcare delivery. We note that a 2008 Congressional Budget Office (CBO) Study concluded that "roughly half of the increase in health care spending during the past several decades was associated with the expanded capabilities of medicine brought about by technological advances." It is reasonable to expect that we will continue to see utilization and mix increases related to technology changes.

The rise in the prevalence of chronic conditions and obesity in the population has contributed to the increases in the utilization of medical services we have seen in the past and will doubtless continue to be a driver of still further increases in the future. Furthermore, in our current health care system, health care providers generally receive payments for each service they render, and consequently their incomes are tied to the number of services they provide and/or bill for. Many experts have concluded that this arrangement creates incentives to provide more technical and more expensive services and to upcode and unbundle in their billing practices so as to optimize reimbursement. While we are working to eliminate these incentives, their effects will continue to be felt for some time. In view of all of these cost drivers and our historical experience, we believe that the utilization/mix factors we are filing are in the aggregate reasonable and represent a fair prediction of experience we are likely to see in 2013 and beyond.

Price Projections

Hospital price projections reflect estimated hospital price increases based on existing reimbursement contracts and anticipated payment levels in the future. New reimbursement contracts have been signed in compliance with last year's OHIC payment reform terms for hospital contracting.

The **RI Primary Care** price projections reflect the provider fee adjustments as well as other provider payments required by the OHIC Primary Care Spend standard.

The **Other Medical/Surgical** projection trends reflect a series of provider fee adjustments and initiatives through the subject rating periods.

The **composite of price factors** across all service categories in these filing amounts to 3.6%, the aggregation of the different assumptions made in the various service categories as discussed above. This value is being driven largely by the hospital price projections, as well as the primary care required increases. Admittedly, this increase is high when compared to most other price increases outside healthcare, but it is lower than we have experienced in recent years and will continue to decline as new agreements are reached with hospitals. To mitigate the impact of unit price inflation on premium costs, BCBSRI approaches all provider negotiations with the goal of achieving the lowest rates consistent with quality care. For the subject rating periods, we believe the price factors we are filing are a fair prediction and reasonable expectation.

Benefit Leveraging

With the increasing prevalence of benefit plans featuring sizable fixed dollar deductibles and copays, BCBSRI is anticipating a significant impact on trends due to benefit leveraging. Trends calculated for rating purposes are determined from allowed claims dollars, or claims paid including member cost sharing of deductibles and co pays. However, to derive an appropriate pricing trend we need to adjust for the leveraging impact of fixed co pays and deductibles. For Small Groups, we expect factors of 0.5% and 1.5% to be necessary for medical and drug service categories respectively.

Effective Medical Trend

The trend factors we have quoted in Exhibit I include the effects of the demographic changes we have seen in our covered population and exclude the impact of the significant savings that will arise from the new pharmacy benefit contract that will become effective on January 1, 2013. Over the 2007-2011 period the demographic factor across our entire Small Group (SG) insured segment has increased at the cumulative average per annum rate of 1.7%. This is consistent with the ongoing "graying" of America and also reflects changes in the insured population due to layoffs, market shrinkage, etc. This demographic driven cost escalation is inherent in the Exhibit I trends we have quoted. We estimate the impact of the new PBM contract will result in an average benefit savings of 2.7% in 2013. Reflecting both the PBM and demographic impacts, our effective 2013 over 2012 trend in the SG segment is 3.0%.

Experience Adjustment

Claims experience has emerged in 2011 and is expected to emerge in 2012 at trends lower than we had anticipated in last year's rate filing, leading to two favorable impacts on future rate increases needed. First, as noted above, we are able to reduce the overall trends being proposed for rating. Secondly, the claims component of rates made effective with previously approved trends are now expected to prove to be somewhat over-adequate when the next renewal rates are calculated. This over-adequacy results in a favorable experience adjustment that is quantified when the rate increase is broken down into its contributing components (see Part 2c of Exhibit I). Note that this favorable experience is directly related to the comprehensive claims reduction strategy we have embarked on as described earlier in this filing. Based on the rate increase estimates developed for this filing, this experience adjustment is estimated to reduce required rate increases an average of 2.6% for small groups.

Reserve Contribution Factor

Due in large part to our success in reducing our administrative and medical expenses our reserve position has significantly improved over what it was at the time we submitted last year's filing. However our reserves remain about 15% below the minimum level recommended in the Lewin study that was commissioned by OHIC. In light of this and the uncertain impacts as we move toward full implementation of the federal health care reforms we feel it is necessary to maintain the reserve contribution factor at its current level of 3% plus the additional 0.34% included to continue funding extraordinary expenses necessitated by the installation of a new BCBSRI core operational computer system over the span of its anticipated useful life. There are uncertainties around the impact of the new rating and underwriting restrictions that will come into effect with the federal reforms. There is also the impact of the unknown volume and morbidity level of the currently uninsured that are expected to come into the market. There is significant uncertainty around the willingness of employers to continue their current level of financial support for group insurance programs. It is also clear that we will have to set our rates before we know the level of the new PPACA taxes and so this represents a significant financial risk to carriers. The advent of the state based exchanges and the possible entry of new competitors also adds additional risk. Increased risk translates into a need for additional reserves. Furthermore it is worth remembering that for a nonprofit health carrier like BCBSRI there is an important non-solvency component to reserves. Since we do not have access to the capital markets our reserves are our source for the development funds required to finance technology upgrades, new initiatives and other programs necessary to maintain our vitality as a business in a rapidly changing environment.

Administrative Expense

Blue Cross is spending increasing amounts of administrative dollars to lower the cost of medical care while improving its quality. A key piece of Blue Cross' transformation program to become an effective leader in health care cost control is to establish the infrastructure necessary to do the job. The cost of complying with Federal mandates (e.g. ICD-10 and HIPAA 5010) is also putting upward pressure on expenses. Blue Cross implemented several cost reduction strategies in 2011 to offset the added costs noted above. The company eliminated 45 positions in November 2011, modified our employee benefit program and implemented multiple continuous improvement efforts. The net result of these efforts is a 2012 corporate budget that is $4 million lower than actual 2011 expenditures, and the current projection for 2013 is $27 million lower than 2011.

There remains a gap between our proposed administrative charges and projected cost levels. Our intention is to seek to close the gap through expense reduction efforts so as to minimize increases in future charge levels.

Please refer to the enclosed documents "Administrative Costs Documentation" (Exhibit VI) for explanation and justification of the administrative charge rate components shown in Exhibit I. Administrative charges set forth in these documents include provisions for broker commissions, federal income taxes, and state premium tax. State assessments on the Corporation resulting from the Children's Health Account (covering Comprehensive Evaluation, Diagnosis, Assessment, Referral and Re-evaluation (CEDARR), Child Intervention Services and Home Services), the State Child Immunization Fund, and adult influenza vaccine are now incorporated into projected claims costs as per the instruction of OHIC.

New PPACA Taxes

Beginning in 2014, as part of the PPACA, new federal Health Insurer and Transitional Reinsurance Program fees will be imposed that are currently estimated to amount to about 4% of premium. While these fees will first be payable in 2014, proposed federal rules indicate they will be assessed based on 2013 premiums. The NAIC's current position is that these fees should be accrued for over the 2013 calendar year. For BCBSRI this accrual would amount to about $75 million, of which about $40 million would be on group business. This would represent an unacceptable reserve strain if we are not permitted to fund for it in premium rates. Insurance industry groups are attempting to convince the NAIC to change its position and not require a 2013 accrual.

In light of this uncertainty about the proper accounting treatment of these new taxes, OHIC has directed the carriers to file two sets of proposed rate actions. Scenario A reflects our proposal in the event that the NAIC requires a 2013 accrual of these costs. Scenario B reflects our proposal if the NAIC reverses its position and does not require any 2013 accrual, with liability commencing January 1, 2014.

Under Scenario A the premiums quoted for all 2013 rate effective dates will reflect a full load for these new federal fees which we currently estimate to be 4% of the final rate. Under Scenario B we are assuming that the NAIC will not require carriers to accrue these costs in our 2013 financial statements. However the rate years we will be quoting in 2013 will for other than January cases include parts of both the 2013 and 2014 calendar years. Accordingly we propose to include in our 2013 rating a charge for these new fees equal to the proportion of the rate year that falls into the 2014 calendar year. For example for a 4/1/2013 renewal we will build in a 1% provision for these new federal fees, i.e. one fourth of our full year 4% estimate. It is also possible that the Health Insurer fee will require an accrual in 2013 while the Transitional Reinsurance fee would not. In this case the Health Insurer fee (2.2%) would follow according to Scenario A, while the Transitional Reinsurance fee (1.8%) would follow according to Scenario B.

Note that the ACA permits states establishing a reinsurance program to add to the promulgated federal rate and/or to modify other elements of the reinsurance program. Accordingly if Rhode Island elects to assess additional state fees and/or if a better estimate of the cost of the federal fees becomes available BCBSRI requests that carriers be allowed to adjust this PPACA rating factor.

The federal Department of Health and Human Services (HHS) has indicated that its current intention is that it will not allow carriers to deduct any PPACA fee provision in determining a carrier's 2013 rebate liability. We do not expect the HHS will change its position on this matter. Accordingly under Scenario B in our Large Group market we will quote 12 month rates on all business written or renewed in 2013 but we propose to bill different 2013 and 2014 rates as our standard practice. We propose to include no provision for these new PPACA fees in the 2013 rates we bill Large Group cases and a full load in the rates that fall in the 2014 calendar year, i.e. the two sets of rates will differ by 4%. We will quote equivalent 12-month composite rates to all cases so as to assist them in determining employee contribution requirements. On an exception basis we will agree to bill customers on this basis but we will attempt to convince them to accept our proposed two step approach.

Under Scenario B in our Small Group market we propose to uniformly quote and bill composite 12 month rates that reflect the appropriate proportion of the federal fees based on the rate effective date. The reason for the different treatment relates to the administrative complexity a two rate approach would entail for us, brokers and customers. We point out that we have almost 10,000 small group cases but only 425 large group accounts. We are also unsure as to whether or not the Small Group statutes and regulations would permit a two step rate approach.

The above described Health Insurer fees arise from Section 9010 of PPACA. It imposes an annual fee on health insurance carriers in the aggregate of $8 billion in 2014, increasing to $14.3 billion in 2018 and increasing thereafter by the rate of premium growth. These fees are nondeductible for federal tax purposes and accordingly need to be grossed up to reflect actual plan costs, i.e. the tax on the tax.

Section 1341 of PPACA establishes the Transitional Reinsurance Program. The program is to be funded through contributions from health insurers and TPAs for self-funded plans. Aggregate reinsurance contributions are to be determined on a national basis in the amount of $10 billion in 2014, $6 billion in 2015 and $4 billion in 2016. Additional contributions to the Treasury are required in the amounts of $2 billion in 2014, $2 billion in 2015 and $1 billion in 2016. Furthermore states may assess additional fees for reinsurance claims and administrative expenses.

Given the significant size of these fees we feel strongly that if the NAIC does not reverse its current position we need to be allowed to implement the higher Scenario A rates. Alternatively we would ask that the State of Rhode Island grant us as a permitted practice the right to deviate from NAIC standard accounting in the preparation of our financial statements, i.e. do not require us to accrue for these costs even if that remains the NAIC position.

Small Group Re-Rate Factor Submission

Due to the operational necessity to deliver small employer group rates between 75 days prior to renewal date for the brokers and 60 days prior to renewal date for groups, the enrollment used in the calculation of group rates is captured 4 to 5 months prior to a group's renewal date.

BCBSRI allows small employers to request a re-quote of their rates up to 30 days after their renewal date. The purpose of re-rates is to allow a small group to request adjustments to their renewal rate because of demographic changes. After reviewing their renewal rate, if the group

discovers that the demographics used to calculate the rate have changed (or will change prior to the effective date), the re-rate request and supporting documentation may be submitted to the Small Group Underwriting Department.

If the ensuing rate calculation is lower, the rate quote is lowered; if higher than the group's initial rate then the first rate is honored. Over the last two years approximately 8% of small employers have received a re-rate, resulting in an average rate decrease of 6.3%. **This practice has resulted in an overall decrease to small group premium of 0.8%** (summary table below)**.**

Small Group Re-Rates by Quarter					
Quarter	Total Contracts	Contracts Rerated	Pct. Groups Rerated	Average Rate Reduction	Quarter Premium Impact
3rd Qtr 2012	5,882	974	5.9%	-3.1%	-0.5%
2nd Qtr 2012	6,600	666	9.6%	-8.3%	-0.8%
1st Qtr 2012	11,211	1,117	7.4%	-6.4%	-0.6%
4th Qtr 2011	10,285	1,289	10.2%	-7.1%	-0.9%
3rd Qtr 2011	6,164	1,210	11.6%	-5.8%	-1.1%
2nd Qtr 2011	6,872	1,207	12.2%	-7.2%	-1.3%
1st Qtr 2011	11,454	1,249	6.7%	-5.6%	-0.6%
4th Qtr 2010	11,845	1,012	4.1%	-6.4%	-0.6%
Totals	**70,313**	**8,724**	**8.1%**	**-6.3%**	**-0.8%**

Each quarter BCBSRI adjusts base rates to ensure community rated premium targets are achieved. In the past no adjustment to this calculation has been made for the re-rate practice.

BCBSRI believes this practice is beneficial to the small employer population, giving each group an opportunity to have rates reflect current demographics. However in order to continue this liberal re-rate policy we need to recover the cost of the rate concessions that arise from it. Thus we are proposing to institute a 0.5% factor to our base rating methodology to bring the final rates in line with the required increase. BCBSRI believes 0.5% is conservative given the average over the last two years. Our proposal requests an ongoing 0.5% adjustment which we think will still fall slightly short of the average concession cost going forward. We will continue to monitor this activity to ensure this factor is not over-compensating the actual re-rate adjustments.

Absent such a modification to our current rating practice BCBSRI may be forced to tighten our rerate policy which we feel is not in the best interests of the small group marketplace.

Projected Average Rate Increases

The average rate increase values displayed in Section 2B of Exhibit 1 are our current projection of the average rate increases that will result from the application of the proposed rating factors in this filing and our approved rating formula. Our Small Group (SG) rating formula calls for us to apply the rating factors approved in this filing to the current experience on in-force SG cases as they come up for renewal. There is no rating discretion in the SG market and so a carrier's compliance with its approved rating formula and its approved rating factors would be relatively easy to monitor. BCBSRI would be agreeable to providing ongoing reports on the average rate increases

being implemented. In fact on a number of occasions in the past we have provided such reports to OHIC.

It has always been our understanding that the average rate increase estimates included in our group rate factor filings were for informational purposes only and that it is the factors themselves that are subject to approval. The actual rate increases that will go into effect can differ from these estimates due to changes in the way actual claim experience unfolds and due to changes in the mix and composition of the SG cases renewing over the upcoming rate year. We point out that the trend factors we are filing are materially below currently approved factors and are also relatively low by historical standards. If carriers are going to be required to be held to the estimated average rate increases included in these factor filings then rationally they should be allowed to build in a margin for the inevitable estimation error. In the interests of both soundness and affordability we believe a better approach is to continue to allow carriers to apply the approved rating factors to the updated experience on the actual mix of cases renewing over the rate year covered by the filing. We think it is in everyone's best interests that the SG rates we put into effect be based on current experience and enrollment whether this results in an increase or decrease in the resulting average rate increase. We would welcome the opportunity to discuss this matter further with OHIC.

HealthPact Plan Rate Increase

In the past, HealthPact has been addressed in a separate filing, after the completion of the Group filing. This has led to timing issues in getting the HealthPact rates adjusted in time for renewal notices. The growing enrollment in this product has made it more important that an earlier decision is made, so it is being included in this year's Group filing. The OHIC has informed us that they do not intend to make any changes to the benefit design since the products to be offered on the RI Health Insurance Exchange beginning in January of 2014 are likely to assume the policy objectives of this program.

The current loss ratio is adequate for the product, but this is attributable to selection. HealthPact rates are materially below what they would be if they were set on the basis of the adjusted community rating methodology carriers are required to use in rating other Small Group (SG) benefit plans. The growing discrepancy between the rating of HealthPact and the balance of our SG portfolio is resulting in significant increases in its enrollment. This is changing the selection dynamic, as less healthy individuals will be choosing HealthPact simply based on price. HealthPact is a sophisticated product with yearly member requirements. When individuals make choices based on cost without fully understanding their obligations, they may be faced with severe benefit reductions in the second year or a large rate increase when they choose another product.

The increase required to rate HealthPact on a basis consistent with the balance of our SG portfolio would be 15.8%. We believe this is too large a rate increase to impose. Therefore, we are requesting an increase of 9.90% for each renewal cycle in 2013. This will close some of the pricing gap that exists today, and also help to mitigate the rate shock that HealthPact members will see in 2014.

Rhode Island Health Statement Supplement

Cover Sheet

Company Name	Blue Cross & Blue Shield of Rhode Island		
Enter NAIC#	53473	**Reporting Year**	2011
Enter DBR registration # (TPAs)			

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Office of the Health Insurance Commissioner
1511 Pontiac Ave, Building #69 first floor
Cranston, RI 02920
(401) 462-9517
(401) 462-9645 (fax)
HealthInsInquiry@ohic.ri.gov

Field		Line of Business Exhibit	1 Comprehensive/Major medical			2 ASO/TPA			3 Stop loss/ Excess loss/Reinsurance			4 Medicare Part C			5 Medicare Part D		
			RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All
1		**Membership Data**															
		Number of Polices or Certificates	74,861	28,626	103,487	54,145	42,183	96,328			-	31,755	195	31,950			-
		Number of Covered Lives	149,186	55,683	204,869	130,470	89,670	220,140			-	31,755	195	31,950			-
		Member Months	1,794,840	663,092	2,457,932	1,566,564	1,076,694	2,643,258			-	381,049	2,534	383,583			-
		Number of Polices or Certificates	72,338	20,401	92,739	39,001	8,204	47,205			-	30,257	187	30,444			-
		Number of Covered Lives (**Plans**	145,542	43,938	189,480	96,204	20,345	116,549			-	30,257	187	30,444			-
		Member Months (**Plans with PD**	1,750,794	520,794	2,271,588	1,153,963	245,148	1,399,111			-	362,552	2,425	364,977			-
2		**Premiums/Claims**															
		Premium			988,024,244			947,024,013			3,981,127			382,690,929			14,198,310
		Claims/Medical Expenses	598,071,485	225,342,807	823,414,291	583,141,907	316,107,001	899,248,908	1,815,393	-	1,815,393	343,432,595	2,864,703	346,297,298	12,086,291		12,086,291
3		**Inpatient Facility**															
		Hospital															
	1	In-state	107,342,248	9,737,526	117,079,775	99,279,504	5,398,245	104,677,749			-	101,185,948	703,133	101,889,081			-
	2	Out-of-state	26,172,146	47,792,254	73,964,401	22,804,736	81,603,179	104,407,915			-	6,767,781	131,000	6,898,782			-
	3	Total (Lines 1 + 2)	133,514,394	57,529,781	191,044,175	122,084,240	87,001,424	209,085,664	-	-	-	107,953,729	834,134	108,787,863	-	-	-
		SNF															
	4	In-state	2,028,414	97,842	2,126,256	1,908,117	106,721	2,014,838			-	32,159,701	514,746	32,674,447			-
	5	Out-of-state	56,496	372,160	428,657	64,762	794,274	859,036			-	87,627	15,391	103,018			-
	6	Total (Lines 4 + 5)	2,084,910	470,002	2,554,912	1,972,880	900,995	2,873,874	-	-	-	32,247,328	530,137	32,777,465	-	-	-
		Other															
	7	In-state	-	-	-	-	-	-			-	-	-	-			-
	8	Out-of-state	-	-	-	-	-	-			-	-	-	-			-
	9	Total (Lines 7 + 8)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	10	**Total Inpatient Facility (Lines 3 + 6 + 9)**	135,599,305	57,999,783	193,599,087	124,057,120	87,902,419	211,959,538	-	-	-	140,201,057	1,364,270	141,565,327	-	-	-
4		**Outpatient Facility**															
		Hospital															
	11	In-state	105,756,854	6,803,973	112,560,827	110,638,292	6,140,973	116,779,265			-	43,246,502	209,509	43,456,011			-
	12	Out-of-state	28,091,095	46,054,564	74,145,659	22,530,764	78,396,182	100,926,947			-	2,518,590	37,868	2,556,457			-
	13	Total (Lines 11 + 12)	133,847,949	52,858,536	186,706,486	133,169,056	84,537,155	217,706,212	-	-	-	45,765,092	247,377	46,012,469	-	-	-
		SNF															
	14	In-state	6,398	2,730	9,128	18,195	-	18,195			-	1,412,810	61,896	1,474,706			-
	15	Out-of-state	452	4,543	4,995	-	7,827	7,827			-	1,918	-	1,918			-
	16	Total (Lines 14 + 15)	6,850	7,273	14,123	18,195	7,827	26,022	-	-	-	1,414,729	61,896	1,476,625	-	-	-
		Freestanding Ambulatory Care Facility															
	17	In-state	18,700,907	1,124,126	19,825,032	21,615,418	1,185,121	22,800,538			-	6,549,538	32,576	6,582,115			-
	18	Out-of-state	3,915,482	5,351,240	9,266,722	4,275,959	7,598,818	11,874,777			-	1,607,729	11,599	1,619,328			-
	19	Total (Lines 17 +18)	22,616,389	6,475,366	29,091,755	25,891,377	8,783,938	34,675,315	-	-	-	8,157,267	44,176	8,201,443	-	-	-
		Other															
	20	In-state	6,876,917	555,516	7,432,433	5,898,870	122,502	6,021,372			-	17,206,087	116,680	17,322,767			-
	21	Out-of-state	1,623,464	4,868,120	6,491,584	1,634,386	7,331,740	8,966,126			-	279,255	21,983	301,239			-
	22	Total (Lines 20 + 21)	8,500,381	5,423,636	13,924,017	7,533,255	7,454,242	14,987,497	-	-	-	17,485,343	138,664	17,624,006	-	-	-
	23	**Total Outpatient Facility (Lines 13 + 16 +**	164,971,569	64,764,811	229,736,380	166,611,883	100,783,162	267,395,046	-	-	-	72,822,430	492,112	73,314,542	-	-	-
5		**Primary Care**															
	24	**Total Primary Care**	30,655,783	2,922,304	33,578,087	29,915,118	2,285,373	32,200,491			-	11,293,214	88,341	11,381,556			-
6		**Pharmacy**															
	25	**Total Pharmacy**	111,959,953	29,382,454	141,342,408	98,963,134	18,991,512	117,954,646			-	31,182,377	263,823	31,446,200			-
7		**Medical/Surgical other than primary care**															
	26	In-state	117,333,079	7,703,001	125,036,080	137,243,627	7,398,320	144,641,947			-	65,758,629	416,266	66,174,895			-
	27	Out-of-state	23,234,501	57,909,679	81,144,181	23,107,877	97,954,899	121,062,776			-	4,646,619	93,889	4,740,507			-
	28	**Total Other Medical/Surgical (Lines 26 + 2**	140,567,580	65,612,680	206,180,260	160,351,504	105,353,219	265,704,723	-	-	-	70,405,247	510,155	70,915,402	-	-	-
8		**All other payments to medical providers**															
	29	**Total**	14,317,294	4,660,775	18,978,069	3,243,147	791,317	4,034,464	1,815,393		1,815,393	17,528,269	146,001	17,674,270	12,086,291		12,086,291

6			7			8			9			10			11		
Medicare Supplement Policies			Medicaid/Other public			Student blanket			Dental Only			Other Medical Non-Comprehensive			Total (Across all lines of business)		
RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All
22,468	3,019	25,487			-			-	42,711	9,140	51,851			-	225,940	83,163	309,103
22,468	3,019	25,487			-			-	78,834	19,850	98,684			-	412,713	168,417	581,130
269,788	37,494	307,282			-			-	939,836	230,530	1,170,366			-	4,952,077	2,010,344	6,962,421
293	57	350			-			-	-		-			-	141,889	28,849	170,738
293	57	350			-			-	-		-			-	272,296	64,527	336,823
3,532	679	4,211			-			-	-		-			-	3,270,841	769,046	4,039,887
		52,710,055			-			-			27,946,531			98,931,536	-	-	2,515,506,745
38,614,920	6,023,333	44,638,253			-			-	18,206,157	4,442,242	22,648,399	95,745,806		95,745,806	1,691,114,553	554,780,086	2,245,894,639
3,775,927	187,450	3,963,377			-			-			-			-	311,583,627	16,026,354	327,609,981
661,086	673,357	1,334,443			-			-			-			-	56,405,750	130,199,790	186,605,540
4,437,013	860,807	5,297,819	-	-	-	-	-	-	-	-	-	-	-	-	367,989,376	146,226,145	514,215,521
4,140,691	182,206	4,322,897			-			-			-			-	40,236,923	901,515	41,138,438
163,151	448,102	611,253			-			-			-			-	372,036	1,629,928	2,001,964
4,303,842	630,309	4,934,151	-	-	-	-	-	-	-	-	-	-	-	-	40,608,960	2,531,442	43,140,402
-	-	-			-			-			-			-	-	-	-
-	-	-			-			-			-			-	-	-	-
-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
8,740,855	1,491,115	10,231,970	-	-	-	-	-	-	-	-	-	-	-	-	408,598,336	148,757,587	557,355,923
5,810,550	155,383	5,965,933			-			-			-			-	265,452,198	13,309,837	278,762,036
977,855	733,890	1,711,745			-			-			-			-	54,118,304	125,222,504	179,340,808
6,788,405	889,273	7,677,677	-	-	-	-	-	-	-	-	-	-	-	-	319,570,502	138,532,342	458,102,844
2,982	-	2,982			-			-			-			-	1,440,384	64,626	1,505,010
1,032	5,682	6,715			-			-			-			-	3,403	18,053	21,455
4,014	5,682	9,696	-	-	-	-	-	-	-	-	-	-	-	-	1,443,787	82,679	1,526,466
358,014	9,133	367,146			-			-			-			-	47,223,877	2,350,955	49,574,832
12,798	19,941	32,739			-			-			-			-	9,811,968	12,981,598	22,793,566
370,812	29,073	399,885	-	-	-	-	-	-	-	-	-	-	-	-	57,035,845	15,332,553	72,368,398
1,454,206	17,726	1,471,932			-			-			-			-	31,436,080	812,424	32,248,503
66,832	138,754	205,586			-			-			-			-	3,603,937	12,360,598	15,964,535
1,521,037	156,480	1,677,517	-	-	-	-	-	-	-	-	-	-	-	-	35,040,016	13,173,021	48,213,038
8,684,268	1,080,508	9,764,777	-	-	-	-	-	-	-	-	-	-	-	-	413,090,151	167,120,594	580,210,745
1,403,786	63,447	1,467,233			-			-			-			-	73,267,902	5,359,464	78,627,366
1,303,633	466,451	1,770,084			-			-			-			-	243,409,099	49,104,239	292,513,338
14,524,892	469,524	14,994,415			-			-			-			-	334,860,226	15,987,111	350,847,337
3,957,485	2,452,288	6,409,774			-			-			-			-	54,946,482	158,410,755	213,357,237
18,482,377	2,921,812	21,404,189	-	-	-	-	-	-	-	-	-	-	-	-	389,806,709	174,397,866	564,204,575
		-			-			-	18,206,157	4,442,242	22,648,399	95,745,806		95,745,806	162,942,357	10,040,335	172,982,692

Field		Market Exhibit (For Comprehensive/Major Medical Line of Business)	1 Individual			2 Small Group			3 Large Group			4 Association		
			RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All
1		**Membership Data**												
		Number of Polices or Certificates	9,598	81	9,679	28,850	4,826	33,676	36,413	23,719	60,132			-
		Number of Covered Lives	14,932	126	15,058	56,059	10,550	66,609	78,195	45,007	123,202			-
		Member Months	174,845	2,241	177,086	682,122	128,450	810,572	937,873	532,396	1,470,269			-
		Number of Polices or Certificates (**Plans with PD benefits**)	9,598	81	9,679	28,850	4,826	33,676	33,890	15,494	49,384			-
		Number of Covered Lives (**Plans with PD benefits**)	14,932	126	15,058	56,059	10,550	66,609	74,551	33,262	107,813			-
		Member Months (**Plans with PD benefits**)	174,845	2,241	177,086	682,122	128,450	810,572	893,827	390,098	1,283,925			-
2		**Premiums/Claims**												
		Premium			65,879,516			335,980,222			586,164,506			-
		Claims/Medical Expenses	53,996,443	755,993	54,752,436	234,434,546	47,302,184	281,736,730	309,640,496	177,281,884	486,922,381	-	-	-
3		**Inpatient Facility**												
		Hospital												
	1	In-state	9,392,569	78,038	9,470,607	38,984,116	3,747,470	42,731,586	58,965,563	5,912,019	64,877,581			-
	2	Out-of-state	3,557,898	108,522	3,666,420	11,775,423	8,215,856	19,991,279	10,838,825	39,467,877	50,306,701			-
	3	Total (Lines 1 + 2)	12,950,467	186,560	13,137,028	50,759,539	11,963,325	62,722,865	69,804,388	45,379,895	115,184,283	-	-	-
		SNF												
	4	In-state	413,458	-	413,458	562,642	42,563	605,205	1,052,314	55,279	1,107,593			-
	5	Out-of-state	7,789	-	7,789	43,133	45,622	88,754	5,575	326,538	332,113			-
	6	Total (Lines 4 + 5)	421,247	-	421,247	605,774	88,185	693,959	1,057,889	381,817	1,439,707	-	-	-
		Other												
	7	In-state	-	-	-	-	-	-	-	-	-			-
	8	Out-of-state	-	-	-	-	-	-	-	-	-			-
	9	Total (Lines 7 + 8)	-	-	-	-	-	-	-	-	-	-	-	-
	10	**Total Inpatient Facility (Lines 3 + 6 + 9)**	13,371,714	186,560	13,558,274	51,365,314	12,051,510	63,416,824	70,862,277	45,761,712	116,623,990	-	-	-
4		**Outpatient Facility**												
		Hospital												
	11	In-state	7,823,285	20,348	7,843,633	39,756,180	2,275,058	42,031,238	58,177,389	4,508,500	62,685,890			-
	12	Out-of-state	3,092,333	108,271	3,200,605	13,002,180	8,400,421	21,402,600	11,996,582	37,545,510	49,542,092			-
	13	Total (Lines 11 + 12)	10,915,618	128,619	11,044,237	52,758,359	10,675,479	63,433,838	70,173,972	42,054,010	112,227,982	-	-	-
		SNF												
	14	In-state	-	-	-	195	2,730	2,925	5,098	-	5,098			-
	15	Out-of-state	1,105	-	1,105	452	4,213	4,665	-	330	330			-
	16	Total (Lines 14 + 15)	1,105	-	1,105	647	6,943	7,590	5,098	330	5,428	-	-	-
		Freestanding Ambulatory Care Facility												
	17	In-state	1,108,087	7,002	1,115,089	6,853,124	407,977	7,261,101	10,739,695	708,888	11,448,583			-
	18	Out-of-state	169,768	2,408	172,176	1,664,661	741,342	2,406,003	2,081,054	4,607,490	6,688,543			-
	19	Total (Lines 17 + 18)	1,277,855	9,410	1,287,265	8,517,785	1,149,319	9,667,104	12,820,749	5,316,377	18,137,126	-	-	-
		Other												
	20	In-state	1,024,290	2,903	1,027,193	2,140,539	399,394	2,539,933	3,712,087	153,220	3,865,307			-
	21	Out-of-state	321,810	8,459	330,270	851,009	668,437	1,519,446	450,645	4,191,224	4,641,869			-
	22	Total (Lines 20 + 21)	1,346,101	11,362	1,357,462	2,991,548	1,067,830	4,059,379	4,162,732	4,344,444	8,507,176	-	-	-
	23	**Total Outpatient Facility (Lines 13 + 16 + 19 + 22)**	13,540,679	149,390	13,690,069	64,268,340	12,899,571	77,167,911	87,162,551	51,715,161	138,877,712	-	-	-
5		**Primary Care**												
	24	**Total Primary Care**	2,474,677	17,666	2,492,343	11,746,444	1,019,377	12,765,822	16,434,662	1,885,260	18,319,922			-
6		**Pharmacy**												
	25	**Total Pharmacy**	11,869,143	210,145	12,079,288	46,054,173	7,385,514	53,439,687	54,036,638	21,784,954	75,821,592			-
7		**Medical/Surgical other than primary care**												
	26	In-state	8,699,027	56,065	8,755,092	45,525,544	2,702,459	48,228,003	63,108,508	4,944,262	68,052,770			-
	27	Out-of-state	2,948,210	121,191	3,069,401	9,801,854	10,230,391	20,032,246	10,484,437	47,558,096	58,042,534			-
	28	**Total Other Medical/Surgical (Lines 26 + 27)**	11,647,237	177,257	11,824,494	55,327,398	12,932,850	68,260,248	73,592,945	52,502,359	126,095,304	-	-	-
8		**All other payments to medical providers**												
	29	**Total**	1,092,994	14,975	1,107,969	5,672,877	1,013,362	6,686,239	7,551,424	3,632,437	11,183,861			-

5			6			7			8		
Trust			Federal Employee Health Benefit Plan			Other Health Market			Total (Across all markets)		
RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All
		-			-			-	74,861	28,626	103,487
		-			-			-	149,186	55,683	204,869
		-			-			-	1,794,840	663,087	2,457,927
		-			-			-	72,338	20,401	92,739
		-			-			-	145,542	43,938	189,480
		-			-			-	1,750,794	520,789	2,271,583
		-			98,931,536			-	-	-	1,086,955,780
-	-	-	95,745,806	-	95,745,806	-	-	-	693,817,291	225,340,062	919,157,353
		-			-			-	107,342,248	9,737,526	117,079,775
		-			-			-	26,172,146	47,792,254	73,964,401
-	-	-	-	-	-	-	-	-	133,514,394	57,529,781	191,044,175
		-			-			-	2,028,414	97,842	2,126,256
		-			-			-	56,496	372,160	428,657
-	-	-	-	-	-	-	-	-	2,084,910	470,002	2,554,912
		-			-			-	-	-	-
		-			-			-	-	-	-
-	-	-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	135,599,305	57,999,783	193,599,087
		-			-			-	105,756,854	6,803,906	112,560,760
		-			-			-	28,091,095	46,054,201	74,145,297
-	-	-	-	-	-	-	-	-	133,847,949	52,858,107	186,706,057
		-			-			-	5,293	2,730	8,023
		-			-			-	1,557	4,543	6,100
-	-	-	-	-	-	-	-	-	6,850	7,273	14,123
		-			-			-	18,700,907	1,123,866	19,824,773
		-			-			-	3,915,482	5,351,240	9,266,722
-	-	-	-	-	-	-	-	-	22,616,389	6,475,106	29,091,495
		-			-			-	6,876,917	555,516	7,432,433
		-			-			-	1,623,464	4,868,120	6,491,584
-	-	-	-	-	-	-	-	-	8,500,381	5,423,636	13,924,017
-	-	-	-	-	-	-	-	-	164,971,569	64,764,123	229,735,692
		-			-			-	30,655,783	2,922,304	33,578,087
		-			-			-	111,959,953	29,380,613	141,340,566
		-			-			-	117,333,079	7,702,786	125,035,865
		-			-			-	23,234,501	57,909,679	81,144,181
-	-	-	-	-	-	-	-	-	140,567,580	65,612,465	206,180,046
		-	95,745,806		95,745,806			-	110,063,100	4,660,775	114,723,875

Blue Cross & Blue Shield of Rhode Island

Areas of Medical Expense Variation

BCBSRI performs periodic comparisons, or "benchmarking ", of its claims utilization and cost experience with those of other health plans. The comparative benchmarks are derived from a data set called Blue Health Intelligence (BHI). This data set is made up of claims and enrollment from a large number of Blue Cross and Blue Shield plans from across the country. For our benchmarking we selected an aggregated data set for five Blue Cross plans located in the northeast United States. BHI allows us to organize our claims data and that of the selected benchmark plans (and members of other Blue plans residing in their service areas) into equivalent groups of services for purposes of cost and utilization comparison.

The membership used for BCBSRI encompasses our members living within our state as well as our members residing in the service areas of the benchmark plans.

Benchmarking by PMPM Percent Variation					
Item	**BCBSRI pmpm**	**Variation from Benchmark**	**Percent Variation**	**Dollar Variation (in millions)**	**Comments**
IP Behavioral Health	$6.40	$3.37	111%	$6.0	Driven by admits
Professional BH	$10.53	$5.14	95%	$9.1	Utilization driven
NICU	$4.88	$2.09	75%	$3.7	Price and Utilization
Lab/Pathology	$23.39	$7.16	44%	$12.7	Price and Utilization
Standard Imaging	$14.95	$4.33	41%	$7.7	Price and Utilization

Blue Cross & Blue Shield of Rhode Island

Areas of Medical Expense Variation

Benchmarking by Total Dollar Variation					
Item	**BCBSRI pmpm**	**Variation from Benchmark**	**Percent Variation**	**Dollar Variation (in millions)**	**Comments**
Lab/Pathology	$23.39	$7.16	44%	$12.7	Price and Utilization
Professional BH	$10.53	$5.14	95%	$9.1	Utilization driven
Standard Imaging	$14.95	$4.33	41%	$7.7	Price and Utilization
IP Surgical	$38.32	$3.51	10%	$6.2	Price and Utilization
IP Behavioral Health	$6.40	$3.37	111%	$6.0	Driven by admits

Blue Cross & Blue Shield of Rhode Island
Group Rate Factor Review
Provider Contracting Practices and Hospital Contracting Conditions Verification Questionnaire

Part 1. Hospital Inpatient Services

Please fill out one row in the chart below for each general service institution (no specialty care, no rehab) with whom you contract in RI. Institution means hospital system if all contractual terms other than $ amounts apply identically across all inpatient facilities in the contract. Incentives refer to activities or measures resulting in additional payments by the insurer.

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Com-ments
1	**1**	**X** DRG **(effective 2012)** **X** Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting **X** Others (please specify) **Case Rates, Implant Cost**	**Yes**	If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [3] **3.0%**	__ admission reductions __ day reductions **X** process/structural changes (e.g. discharge practices) __Others (please specify)	**Yes**	

[1] Examples include supplemental payments beyond base fees for Bridges to Excellence Measure, Medicare Compare measures, HIT adoption, or customer satisfaction measures.
[2] Attach analysis and relevant documentation from contracts to demonstrate compliance status.
[3] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[4]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[5]	Com-ments
2	**3**	__DRG __Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting **X** Others (please specify) **Global Liability**	**No**	If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [6] **None**	**X** admission reductions **X** day reductions **X** process/structural changes (e.g. discharge practices) __Others (please specify) **By nature of the global/fixed reimbursement, provider directly benefits from any efficiencies gained.**	**No – contract predates the conditions**	
3	**3**	**X** DRG **X** Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	**No**	If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [7] **Hospital earned 1.4% of possible 2% in fiscal 2011**	__ admission reductions __ day reductions **X** process/structural changes (e.g. discharge practices) __Others (please specify)	**In negotiation – it is anticipated that the final agreement in 2012 will incorporate the OHIC conditions**	

[4] Examples include supplemental payments beyond base fees for Bridges to Excellence Measure, Medicare Compare measures, HIT adoption, or customer satisfaction measures.
[5] Attach analysis and relevant documentation from contracts to demonstrate compliance status.
[6] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[7] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[8]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[9]	Com-ments
4	**1**	**X** DRG **(effective 2012)** **X** Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting **X** Others (please specify) **Implant Cost**	**No**	If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [10] **3.0%**	__ admission reductions __ day reductions **X** process/structural changes (e.g. discharge practices) __Others (please specify)	**Yes**	
5	**4**	__DRG **X** Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting **X** Others (please specify) **Case Rates**	**No**	If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [11] **Hospital earned 1% of 1.2% eligible%**	__ admission reductions __ day reductions __ process/structural changes (e.g. discharge practices) __Others (please specify)	**No – contract predates conditions**	

[8] Examples include supplemental payments beyond base fees for Bridges to Excellence Measure, Medicare Compare measures, HIT adoption, or customer satisfaction measures.
[9] Attach analysis and relevant documentation from contracts to demonstrate compliance status.
[10] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[11] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[12]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[13]	Com-ments
6	**6**	__DRG **X** Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting **X** Others (please specify) **Case Rates**	**No**	If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [14] **None**	__ admission reductions __ day reductions __ process/structural changes (e.g. discharge practices) __Others (please specify)	**No – hospital under special mastership**	
7	**4**	__DRG **X** Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	**No**	If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [15] **1.2%**	__ admission reductions __ day reductions **X** process/structural changes (e.g. discharge practices) __Others (please specify)	**No – contract predates conditions**	

[12] Examples include supplemental payments beyond base fees for Bridges to Excellence Measure, Medicare Compare measures, HIT adoption, or customer satisfaction measures.
[13] Attach analysis and relevant documentation from contracts to demonstrate compliance status.
[14] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[15] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[16]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[17]	Com-ments
8	**3**	**X** DRG **X** Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	**Yes, outlier per diems paid for cases which exceed length of stay parameters**	If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [18] **1.0%**	__ admission reductions __ day reductions __ process/structural changes (e.g. discharge practices) __Others (please specify)	**In negotiation – it is anticipated that the final agreement in 2012 will incorporate the OHIC conditions**	
9	**4**	**X** DRG **(effective 2012)** **X** Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting **X** Others (please specify) **Case Rates, Implant Cost**	**Yes**	If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [19] **3.0%**	__ admission reductions __ day reductions **X** process/structural changes (e.g. discharge practices) __Others (please specify)	**Yes**	

[16] Examples include supplemental payments beyond base fees for Bridges to Excellence Measure, Medicare Compare measures, HIT adoption, or customer satisfaction measures.
[17] Attach analysis and relevant documentation from contracts to demonstrate compliance status.
[18] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[19] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[20]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[21]	Com-ments
10	**1**	**X** DRG __Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting _Others (please specify)	**No**	If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [22] **3.0%**	_ admission reductions _ day reductions **X** process/structural changes (e.g. discharge practices) __Others (please specify)	**Yes**	
11	**3**	**X** DRG **X** Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting **X** Others (please specify) **Case Rates**	**Yes**	If yes - %of total payments for inpatient services in CY 2011 spent on quality incentive payments. [23] **Hospital earned 1.9% of 2.5% eligible**	__ admission reductions __ day reductions **X** process/structural changes (e.g. discharge practices) __Others (please specify)	**Will be renegotiated this year – it is anticipated that the final agreement in 2012 will incorporate the OHIC conditions**	

[20] Examples include supplemental payments beyond base fees for Bridges to Excellence Measure, Medicare Compare measures, HIT adoption, or customer satisfaction measures.
[21] Attach analysis and relevant documentation from contracts to demonstrate compliance status.
[22] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[23] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

Additional Questions for Hospital Inpatient Services

List the five most common areas of quality and service incentives in your company's inpatient contracts:

i. **CMS Core Measures**
ii. **HCAPHS**
iii. **Transitions of Care**
iv. **CPOE**
v. **National Surgical Improvement Program**

Note: Items i, ii, & iii are part of our standard program as of 2009

Estimated Percent of total payments to RI Hospitals for inpatient services in CY 2011 spent on quality incentive payments. **1.9%**

Estimated Percent of total payments to RI Hospitals for inpatient services in CY 2011 paid through units of service based on efficient resource use (i.e. DRG, Capitation, Bundled Service or partial/global budgeting): **25% (66% as of first quarter 2012)**

Estimated Payments in first six months of CY 2011 for Inpatient Services to Hospitals as % of what Medicare would have paid for similar set. of services: **166% (calculation based on Oct 2010 – Sep 2011 time period** (add comments or caveats)

Other Comments on Quality/Efficiency Incentives in Hospital Inpatient Contracting:

Part 2. Hospital Outpatient Services

Please fill out one row in the chart below for each general service institution (no specialty care, no rehab) with whom you contract in RI. Institution means hospital system if all contractual terms other than dollar amounts apply identically across all inpatient facilities in the contract. Outpatient Services include any services not involving an admission and covered under the contract with the institution.

Institution/ System	Unit of Payment for Outpatient Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[24]?	Utilization Incentives in Contract: (check all that apply)	Comments
1	__Procedure-based methodology – using plan, provider or industry coding. . **X** APC Code (effective 2012) __Other (please specify)	If yes - % of total payments for outpatient services in CY 2011 spent on quality incentive payments. [25] **3.0%**	__ Visit/Volume Reduction **X** Others (please specify) **efficiencies gained**	
2	**X** Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	If yes - % of total payments for outpatient services in CY 2011 spent on quality incentive payments. [26] **1.2%**	__ Visit/Volume Reduction __ Others (please specify)	
3	__Procedure-based methodology – using plan, provider or industry coding. . __APC Code **X** Other (please specify) **Global Liability**	If yes - % of total payments for outpatient services in CY 2011 spent on quality incentive payments. [27] **Gateway to global funding to ensure patient quality**	**X** Visit/Volume Reduction **X** Others (please specify) **By nature of the global/ fixed reimbursement, provider directly benefits from any efficiencies gained.**	

[24] Examples include supplemental payments beyond base fees for structural changes such as HIT, process measures or customer satisfaction.
[25] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[26] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[27] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

Institution/ System	Unit of Payment for Outpatient Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[28]?	Utilization Incentives in Contract: (check all that apply)	Comments
4	**X** Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	If yes - % of total payments for outpatient services in CY 2011 spent on quality incentive payments. [29] **Hospital earned 1.4% of 2% eligible**	__ Visit/Volume Reduction __ Others (please specify)	**In negotiation – it is anticipated that the final agreement in 2012 will incorporate the OHIC conditions**
5	**X** Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	If yes - % of total payments for outpatient services in CY 2011 spent on quality incentive payments. [30] **Hospital earned 1% of 1.2% eligible**	__ Visit/Volume Reduction __ Others (please specify)	
6	_Procedure-based methodology – using plan, provider or industry coding. . **X** APC Code **(effective 2012)** __Other (please specify)	If yes - % of total payments for outpatient services in CY 2011 spent on quality incentive payments. [31] **3.0%**	__ Visit/Volume Reduction __ Others (please specify)	
7	**X** Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	If yes - % of total payments for outpatient services in CY 2011 spent on quality incentive payments. [32] **1.0%**	__ Visit/Volume Reduction __ Others (please specify)	**In negotiation – it is anticipated that the final agreement in 2012 will incorporate the OHIC conditions**

[28] Examples include supplemental payments beyond base fees for structural changes such as HIT, process measures or customer satisfaction.
[29] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[30] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[31] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[32] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

Institution/ System	Unit of Payment for Outpatient Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[33]?	Utilization Incentives in Contract: (check all that apply)	Comments
8	__Procedure-based methodology – using plan, provider or industry coding. . **X** APC Code (effective 2012) __Other (please specify)	If yes - %of total payments for outpatient services in CY 2011 spent on quality incentive payments. [34] **3.0%**	__ Visit/Volume Reduction __ Others (please specify)	
9	**X** Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	If yes - % of total payments for outpatient services in CY 2011 spent on quality incentive payments. [35] **Hospital earned 1.9% of 2.5% eligible**	__ Visit/Volume Reduction __ Others (please specify)	**In negotiation – it is anticipated that the final agreement in 2012 will incorporate the OHIC conditions**
10	__Procedure-based methodology – using plan, provider or industry coding. . **X** APC Code **(effective 2012)** __Other (please specify)	If yes - % of total payments for outpatient services in CY 2011 spent on quality incentive payments. [36] **3.0%**	__ Visit/Volume Reduction __ Others (please specify)	
11	**X** Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	If yes - % of total payments for outpatient services in CY 2011 spent on quality incentive payments. [37] **None**	__ Visit/Volume Reduction __ Others (please specify)	

[33] Examples include supplemental payments beyond base fees for structural changes such as HIT, process measures or customer satisfaction.
[34] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[35] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[36] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[37] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

Additional Questions for Hospital Outpatient Services

List the five most common areas of quality and service incentives in your company's hospital outpatient contracts:
i. ***Current quality measures relate to inpatient services only***
ii.
iii.
iv.
v.

Percent of total payments to RI Hospitals for outpatient services in CY 2011 spent on quality incentive payments. **1.9%**
Percent of total payments to RI Hospitals for outpatient services in CY 2011 paid through units of service based on efficient resource use (i.e APC, Bundled Services or partial/global budgeting**): 10% (57% as of first quarter 2012)**

Estimated Payments in first six months of CY 2011 for Outpatient Services to Hospitals as % of what Medicare would have paid for similar set of services: **171% (calculation based on Oct 2010 – Sep 2011 time period)** (add comments or caveats)

Other Comments on Quality/Efficiency Incentives in Hospital Outpatient Contracting:

Part 3: Professional Groups

- "Professional Groups" is defined as non institutional/non facility groups with a valid contract and a single tax id number.
- Please provide information for the top 10 groups (measured by $ paid in 2010), filling in one row per group (10 rows in the table total).

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[38]?	Utilization Incentives in Contract: (check all that apply)	Comments
1	**PCP**	**X** Procedure-based methodology – using CPT, plan, provider or other coding. __APC Code __ Full/ Partial Capitation __Other (please specify)	If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. [39] **Yes (18%)**	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ over all efficiency of care **X** use of pharmacy services __ Others (please specify)	
2	**Radiology**	**X** Procedure-based methodology – using CPT, plan, provider or other coding. __APC Code __ Full/ Partial Capitation __Other (please specify)	If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. [40] **No**	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ over all efficiency of care __ use of pharmacy services __ Others (please specify)	
3	**PCP**	**X** Procedure-based methodology – using CPT, plan, provider or other coding. __APC Code __ Full/ Partial Capitation __Other (please specify)	If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. [41] **Yes (20%)**	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ over all efficiency of care **X** use of pharmacy services __ Others (please specify)	

[38] Examples include supplemental payments beyond base fees for EMR adoption, structural changes, accreditation, process measures or patient satisfaction.
[39] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[40] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[41] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[38]?	Utilization Incentives in Contract: (check all that apply)	Comments
4	**Orthopedics**	**X** Procedure-based methodology – using CPT, plan, provider or other coding. __APC Code __ Full/ Partial Capitation __Other (please specify)	If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. [42] **No**	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ over all efficiency of care __ use of pharmacy services __ Others (please specify)	
5	**Surgery**	**X** Procedure-based methodology – using CPT, plan, provider or other coding. __APC Code __ Full/ Partial Capitation __Other (please specify)	If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. [43] **No**	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ over all efficiency of care __ use of pharmacy services __ Others (please specify)	
6	**Radiology**	**X** Procedure-based methodology – using CPT, plan, provider or other coding. __APC Code __ Full/ Partial Capitation __Other (please specify)	If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. [44] **No**	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ over all efficiency of care __ use of pharmacy services __ Others (please specify)	

[42] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[43] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[44] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[45]?	Utilization Incentives in Contract: (check all that apply)	Comments
7	**PCP & Multi-specialty**	**X** Procedure-based methodology – using CPT, plan, provider or other coding. __APC Code __ Full/ Partial Capitation __Other (please specify)	If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. [46] **Yes (2%)**	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ over all efficiency of care **X** use of pharmacy services __ Others (please specify)	
8	**OB**	**X** Procedure-based methodology – using CPT, plan, provider or other coding. __APC Code __ Full/ Partial Capitation __Other (please specify)	If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. [47] **No**	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ over all efficiency of care __ use of pharmacy services __ Others (please specify)	
9	**Radiation Oncology**	**X** Procedure-based methodology – using CPT, plan, provider or other coding. __APC Code __ Full/ Partial Capitation __Other (please specify)	If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. [48] **No**	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ over all efficiency of care __ use of pharmacy services __ Others (please specify)	

[45] Examples include supplemental payments beyond base fees for EMR adoption, structural changes, accreditation, process measures or patient satisfaction.
[46] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[47] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[48] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[49]?	Utilization Incentives in Contract: (check all that apply)	Comments
10	**Gastro-enterology**	**X** Procedure-based methodology – using CPT, plan, provider or other coding. __APC Code __ Full/ Partial Capitation __Other (please specify)	If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. [50] **No**	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ over all efficiency of care __ use of pharmacy services __ Others (please specify)	

Additional Questions for Professional Groups

1. List the five most common areas of quality and service incentives in your company's professional group contracts:
   - **i. Electronic medical records**
   - **ii. HEDIS**
   - **iii. NCQA Certification**
   - **iv. Management of complex members**
   - **v. Generic prescribing**

2. Percent of total payments to these ten professional groups in CY 2010 spent on quality incentive payments. **~7.7%**

[49] Examples include supplemental payments beyond base fees for EMR adoption, structural changes, accreditation, process measures or patient satisfaction.
[50] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

Below please find BCBSRI's Supplemental Response to the Provider Contracting Practices Survey as required by Footnote 2. This is intended to provide documentation of our compliance with Exhibit A, Section A to OHIC's 2011 Rate Factor Approval (RH 2011-2).

Note that this Exhibit includes redacted versions of the contractual provisions which demonstrate compliance. Unredacted versions will be submitted under separate cover.

We are requesting confidential treatment of the unredacted provisions as they contain proprietary trade secret information. These provisions include:

1. With respect to Condition #1, provisions relating to the timeframe for implementation of DRGs and APCs; and
2. With respect to Condition #3, provisions relating to the specific rates of reimbursement for quality measures.

With respect to Condition #1, no timeframe for implementation is specified in the conditions. Each hospital and carrier may have individual administrative capabilities that may warrant longer or shorter periods for implementation. This information constitutes trade secret information pursuant to RIGL Section 6-41-1 because (1) it is not generally known to the public or disclosed by either BCBSRI or the respective hospitals to the public or to third parties (other than those representing either party or to the OHIC pursuant to the Conditions), (2) has independent economic value to the parties to the contracts (for the hospitals, it may impact their financials; for BCBSRI, we derive financial benefit from having the hospital in our network and converting to DRGs and APCs in a mutually acceptable timeframe), and (3) others, particularly our competitors and other hospitals in the State, may benefit from the knowledge of this information by using it to negotiate similar provisions with BCBSRI (in the case of other hospitals) or with these and other hospitals (in the case of our competitors). Therefore, we believe this information is exempt from public disclosure under RIGL Section 38-2-2(4)(B) as it constitutes "Trade secrets and commercial or financial information obtained from a person, firm, or corporation which is of a privileged or confidential nature."

With respect to Condition #3, the hospital conditions require "at least [an] additional two percentage points" for quality metrics. Because the conditions allow for a carrier and hospital to agree to percentages over 2%, we believe that public disclosure of the actual percentages may put BCBSRI at a competitive disadvantage in the marketplace. This information constitutes trade secret information pursuant to RIGL Section 6-41-1 because (1) it is not generally known to the public or disclosed by either BCBSRI or the respective hospitals to the public or to third parties (other than those representing either party or to the OHIC pursuant to the Conditions), (2) has independent economic value to the parties to the contracts (for the hospitals, it is payment information; for BCBSRI, we derive financial benefit from having the hospital in our network and from the improved quality metrics achieved by the hospitals), and (3) others, particularly our competitors and other hospitals in the State, may benefit from the knowledge of this information by using it to negotiate similar provisions with BCBSRI (in the case of other hospitals) or with these and other hospitals (in the case of our competitors). Therefore, we believe this information is exempt from public disclosure under RIGL Section 38-2-2(4)(B) as it constitutes "Trade secrets and commercial or financial information obtained from a person, firm, or corporation which is of a privileged or confidential nature."

Therefore, we request that the unredacted version of this Exhibit be held from public disclosure pursuant to Rhode Island law. In the event a request for public disclosure is made to the OHIC

for these documents, we respectfully request that we be notified of such request so that we may pursue such remedies as may be available at law.

Summary of Compliance

Lifespan:

BCBSRI's contracts with each of the Lifespan hospitals comply with the Conditions. A description of the contract provisions demonstrating compliance are included below.

South County Hospital:

BCBSRI's contract with South County Hospital complies with the Conditions. A description of the contract provisions demonstrating compliance are included below.

Landmark Medical Center:
As the Commissioner is aware, Landmark Medical Center is currently engaged in a Special Mastership proceeding. During the course of that proceeding, BCBSRI and Landmark have agreed to extend the current contract for short durations. The current extension expires July 16, 2012. As we have verbally advised the Commissioner, we have not implemented all of the Conditions as part of the extensions. Landmark has received increases consistent with the CMS National Prospective Payment System Hospital Input Price Index; however, the other Conditions have not been adopted at this time.

During the course of conversations with bidders in the Mastership proceeding, BCBSRI has advised such organizations that any future contract with a successor organization will be in accordance with the Conditions.

Westerly Hospital:
BCBSRI's contract with Westerly Hospital is currently under negotiation. Once finalized, we will provide documentation consistent with that attached hereto.

Other Hospitals:

Our contracts with other hospitals have not yet been subject to the Conditions as specified in the July 2011 decision based on the hospitals' contract renewal cycle.

Alignment Lifespan Contract to Hospital Conditions

Condition:

1. Utilize unit of service payment methodologies for both inpatient and hospital outpatient services that realign payment to provide incentives for efficient use of health services, and are derived from nationally utilized payment practices other than fee for service, e.g. inpatient Diagnosis Related Groupings (DRGs) and outpatient Ambulatory Payment Classifications (APCs) in a form substantially derived from CMS. Nothing in this requirement prevents contract terms that provide additional or stronger payment incentives toward quality and efficiency such as performance bonuses, bundled payments, global payments or the formation of supporting functions such as Accountable Care Organizations.

Contract Provision: (Conversion to DRGS and APC based fees has occurred. The following represents contract language that we are currently formalizing to support the OHIC condition. The existing provision is also included).

The following payment provisions will be effective for inpatient admissions on or after [date redacted]:

Inpatient acute claims will be paid on the basis of Diagnosis Related Groups (DRGs).

The following payment provisions based on APC relativity based fees will be effective for dates of services on or after [date redacted]:

Existing Contract Provision:

Blue Cross and the Hospital agree to transition to Diagnostic Related Grouping (DRG) payments. [specifics redacted]

Blue Cross and the Hospital will mutually agree on a methodology to transition outpatient reimbursement on a revenue neutral basis using an agreed upon base to an APC relativity based fee. [specific redacted]

Condition:

2. Limit average annual effective rates of price increase for both inpatient and outpatient services to a weighted amount equal to or less than the Centers for Medicare and Medicaid Services (CMS) National Prospective Payment System Hospital Input Price Index ("Index"), for all contractual and optional years covered by the contract.[i] The Index applicable to the new contract year will be based on the most recent Hospital 4 Quarter Moving Average Percent Change published and available as of the signing of the contract. For renewal and optional years it will be based on the applicable most recent Index 4 Quarter Moving Average Percent Change period available prior to the new contract year.

Contract Provision:

The "Price Increase" is the most recent actual Hospital 4 Quarter Moving Average Percent Change published and available from the Centers for Medicare and Medicaid Services National Prospective Payment System Hospital Input Price Index. As of [date redacted] 2011, the Price Increase factor is [rate redacted].

Condition:

3. Provide the opportunity for hospitals to increase their total annual revenue for commercially insured enrollment under the contract by at least two (2) additional percentage points over the previous contract year by improving or attaining mutually agreed-to performance levels for no less than three nationally-accepted clinical quality, service quality or efficiency-based measures. The measures, performance levels and payouts must be articulated in the contract.

Contract Provision:

The total CY 2012 QMPIP will be [rate redacted] of the 2011 base rates. [specifics redacted]

Of the [rate redacted] %, [number redacted] percentage points will be applied [specifics redacted]that will continue for 2012 and will be based on the same quality measures currently in place[specifics redacted], with incremental modifications to the Program's expected performance as agreed to by the parties that demonstrate the parties' commitment to annual improvement in the Hospital's quality of care and outcomes.

Condition:

4. Include terms that define the parties' mutual obligations for greater administrative efficiencies, such as improvements in claims and eligibility verification processes, and identify commitments on the part of each. On or before January 1, 2012 [carrier name] shall file with OHIC, in a format approved by the Commissioner, a report identifying and describing for each hospital or hospital system contract subject to these Conditions pursuant to Para. A, above, the specific and substantive programs or initiatives designed to achieve greater administrative efficiencies, the benchmarks used to measure progress, the progress achieved by the carrier and the hospital or hospital system during the previous calendar year with respect to each program or initiative, and the planned activities of the carrier and the hospital or hospital system during the succeeding calendar year. The report shall include a demonstration that the hospital or hospital system has had an opportunity to participate in and review the report, and shall include any comments of the hospital or hospital system concerning the report. In the event a contract with a hospital or hospital system is not executed before October 1, 2011, [carrier name] shall have 90 days from the date the contract is sighed to submit a report in accordance with this Condition with respect to such contract.

Contract Provision:

Both parties agree that any opportunity to achieve greater administrative efficiencies involving the interactions between Blue Cross and Hospital could provide tangible benefits to each party and the health care delivery system. In this context, the Hospital and Blue Cross agree to engage in formal discussions in order to identify administrative efficiency opportunities, including but not limited to claims processing and eligibility verification processes.

The parties will continue to work collaboratively to establish initiatives and formalize a process to monitor and measure progress including the application of any relevant benchmarks.

Condition:

5. Include terms that promote and measure improved clinical communications between the hospital and each patient/member's designated primary care physician, specialist physicians, long term care facility, or other providers using standards developed by Quality Partners of

Rhode Island, the Beacon Program of the Rhode Island Quality Institute, or other nationally-accepted sources. On or before January 1, 2012 [carrier name] shall file with OHIC, in a format approved by the Commissioner, a report identifying and describing for each hospital or hospital system contract subject to these Conditions pursuant to Para. A, above, the specific and substantive programs or initiatives designed to achieve improved clinical communications, the benchmarks used to measure progress, the progress achieved by the carrier and the hospital or hospital system during the previous calendar year with respect to each program or initiative, and the planned activities of the carrier and the hospital or hospital system during the succeeding calendar year. The report shall include a demonstration that the hospital or hospital system has had an opportunity to participate in and review the report, and shall include any comments of the hospital or hospital system concerning the report. In the event a contract with a hospital or hospital system is not executed before October 1, 2011, [carrier name] shall have 90 days from the date the contract is sighed to submit a report in accordance with this Condition with respect to such contract.

Contract Provision:
The parties will also initiate collaborative efforts to promote and measure improved clinical communications between the Hospital and each patient/member's designated primary care physician, specialist physicians, long term care facility, or other providers. Blue Cross and the Hospital will work together to develop a process to evaluate opportunities, develop recommendations and implement efforts to achieve the aforementioned improvements.

The parties will rely on those standards developed by Quality Partners of Rhode Island, the Rhode Island Quality Institute or other nationally accepted sources.

Condition:
6. Include terms that relinquish the right of either party to contest the public release of the any and all of these five specific terms by state officials or the participating parties to the agreement; provided that the carrier or other affected party may request the Commissioner to maintain specific contract terms or portions thereof as confidential, if properly supported with legal and factual analysis justifying confidentiality.

Contract Provision:
For so long as the Hospital Contracting Conditions issued by the Office of the Health Insurance Commissioner on or about July 2, 2010 ("Conditions") (as renewed, re-issued and/or amended in future years) remain enforceable or applicable to the Agreement, each party expressly agrees to relinquish the right to contest the public release of any and all of the five specific terms of said Conditions by state officials or participating parties; provided, however, that each party may make a request to the Office of Health Insurance Commissioner to maintain specific contract terms or portions relating to said Conditions as confidential. Each party will notify the other party if such a request is being made.

Alignment South County Hospital Contract to Hospital Conditions

Condition:

1. Utilize unit of service payment methodologies for both inpatient and hospital outpatient services that realign payment to provide incentives for efficient use of health services, and are derived from nationally utilized payment practices other than fee for service, e.g. inpatient Diagnosis Related Groupings (DRGs) and outpatient Ambulatory Payment Classifications (APCs) in a form substantially derived from CMS. Nothing in this requirement prevents contract terms that provide additional or stronger payment incentives toward quality and efficiency such as performance bonuses, bundled payments, global payments or the formation of supporting functions such as Accountable Care Organizations.

Contract Provision:

The parties agree that effective [date redacted] 2012 Hospital shall be reimbursed for fee for service according to MS-DRG for inpatient services and Ambulatory Payment Classification ("APC") for outpatient services [specifics redacted]

Condition:

2. Limit average annual effective rates of price increase for both inpatient and outpatient services to a weighted amount equal to or less than the Centers for Medicare and Medicaid Services (CMS) National Prospective Payment System Hospital Input Price Index ("Index"), for all contractual and optional years covered by the contract.[ii] The Index applicable to the new contract year will be based on the most recent Hospital 4 Quarter Moving Average Percent Change published and available as of the signing of the contract. For renewal and optional years it will be based on the applicable most recent Index 4 Quarter Moving Average Percent Change period available prior to the new contract year.

Contract Provision:

Effective [date redacted] 2012, the parties agree that the mutually agreed upon increase to the fee for service rates (e.g. MS-DRG and APC) for Commercial lines of business shall be as follows [specifics redacted] The annual rate increases will be attributed as follows between the base rate increase and quality in compliance with the OHIC Hospital Conditions. [specifics redacted]

Note that for [date redacted], the formula will be adjusted accordingly based on the then current finalized CMS Index as of [date redacted]. For [date redacted'] the formula will be adjusted accordingly based on the then current finalized CMS Index as of [date redacted].

Condition:

3. Provide the opportunity for hospitals to increase their total annual revenue for commercially insured enrollment under the contract by at least two (2) additional percentage points over the previous contract year by improving or attaining mutually agreed-to performance levels for no less than three nationally-accepted clinical quality, service quality or efficiency-based measures. The measures, performance levels and payouts must be articulated in the contract.

Contract Provision:
In accordance with Office of Health Insurance Commissioner Hospital Contracting Conditions, the annual Quality-based increases [specifics redacted] will be applied prospectively to the base rates and earned consistent with the Quality Program terms for the applicable year as mutually agreed. BCBSRI Quality Program shall use industry standard criteria to determine fair and reasonable measures and targets for Hospital.

Condition:
4. Include terms that define the parties' mutual obligations for greater administrative efficiencies, such as improvements in claims and eligibility verification processes, and identify commitments on the part of each. On or before January 1, 2012 [carrier name] shall file with OHIC, in a format approved by the Commissioner, a report identifying and describing for each hospital or hospital system contract subject to these Conditions pursuant to Para. A, above, the specific and substantive programs or initiatives designed to achieve greater administrative efficiencies, the benchmarks used to measure progress, the progress achieved by the carrier and the hospital or hospital system during the previous calendar year with respect to each program or initiative, and the planned activities of the carrier and the hospital or hospital system during the succeeding calendar year. The report shall include a demonstration that the hospital or hospital system has had an opportunity to participate in and review the report, and shall include any comments of the hospital or hospital system concerning the report. In the event a contract with a hospital or hospital system is not executed before October 1, 2011, [carrier name] shall have 90 days from the date the contract is sighed to submit a report in accordance with this Condition with respect to such contract.

Contract Provision:
The parties agree to develop a Joint Operating Committee ("JOC") to monitor performance of the Agreement. This JOC will at minimum:

1. Meet quarterly to discuss operational, financial, and quality performance.
2. Assess membership increases and/or decreases.
3. Evaluate other changes which may impact the financial and quality performance of the Agreement, including case mix, utilization, and health status of the area population.
4. Other issues as needed.

Condition:
5. Include terms that promote and measure improved clinical communications between the hospital and each patient/member's designated primary care physician, specialist physicians, long term care facility, or other providers using standards developed by Quality Partners of Rhode Island, the Beacon Program of the Rhode Island Quality Institute, or other nationally-accepted sources. On or before January 1, 2012 [carrier name] shall file with OHIC, in a format approved by the Commissioner, a report identifying and describing for each hospital or hospital system contract subject to these Conditions pursuant to Para. A, above, the specific and substantive programs or initiatives designed to achieve improved clinical communications, the benchmarks used to measure progress, the progress achieved by the carrier and the hospital or hospital system during the previous calendar year with respect to each program or initiative, and the planned activities of the carrier and the hospital or hospital system during the succeeding calendar year. The report shall include a demonstration that the hospital or hospital system has had an opportunity to participate in and review the report, and shall

include any comments of the hospital or hospital system concerning the report. In the event a contract with a hospital or hospital system is not executed before October 1, 2011, [carrier name] shall have 90 days from the date the contract is sighed to submit a report in accordance with this Condition with respect to such contract.

Contract Provision:
The parties agree to develop a Joint Operating Committee ("JOC") to monitor performance of the Agreement. This JOC will at minimum:

1. Meet quarterly to discuss operational, financial, and quality performance.
2. Assess membership increases and/or decreases.
3. Evaluate other changes which may impact the financial and quality performance of the Agreement, including case mix, utilization, and health status of the area population.
4. Other issues as needed.

Condition:
6. Include terms that relinquish the right of either party to contest the public release of the any and all of these five specific terms by state officials or the participating parties to the agreement; provided that the carrier or other affected party may request the Commissioner to maintain specific contract terms or portions thereof as confidential, if properly supported with legal and factual analysis justifying confidentiality.

Contract Provision:
For so long as the Hospital Contracting Conditions issued by the Office of the Health Insurance Commissioner on or about July 2, 2010 (the "Conditions") remain enforceable or applicable to the Agreement, each party expressly agrees to relinquish the right to contest the public release of any and all of the five specific terms of the Conditions by state officials or the participating parties Notwithstanding this provision, the parties will strive to promote transparency as it relates to areas involving clinical quality and clinical communication/collaboration.

Blue Cross & Blue Shield of Rhode Island
Group Rate Factor Filing of May 2012
Administrative Costs Request

1. 2011 Actual expenses agree with those in the Supplemental Health Care Exhibit with one adjustment. The Federal Employee Plan data is included in "Large Group" in the Supplement in accordance with NAIC instructions. However, the exhibit below does not include this data because the FEP plan is not covered by this rate factor filing. Note that there will be approximately two years of inflationary increases between 2011 Actual and 2013 Proposed values. Additionally, BCBSRI is spending increasing amounts of administrative dollars to lower the cost of medical care. Lastly, declines in enrollment result in a smaller base over which to spread fixed expenses, having an unfavorable effect on unit cost levels.

	2011 Actual		2013 Proposed[(1)]		% Change	
	Small Group	Large Group	Small Group	Large Group	Small Group	Large Group
Total Estimated Member Months	816,413	1,472,976	825,640	1,365,147	1.1%	-7.3%
Total Estimated Premiums ($pmpm)	$411.53	$395.83	$505.94	$470.32	22.9%	18.8%
Total General Administrative Expense ($pmpm)	$46.19	$38.08	$45.11	$36.63	-2.3%	-3.8%
Total Cost Containment Expense ($pmpm)	$6.80	$6.32	$6.64	$6.08	-2.3%	-3.8%
Total Other Claim Adjustment Expense ($pmpm)	$11.11	$12.82	$10.85	$12.33	-2.3%	-3.8%
Total Admin Expense ($pmpm)	$64.10	$57.22	$62.60	$55.04	-2.3%	-3.8%
Breakdown of General Administrative Expense ($ pmpm)						
a. Payroll and benefits	$14.99	$10.79	$14.64	$10.38	-2.3%	-3.8%
b. Outsourced Services (EDP, claims etc.)	$5.17	$5.06	$5.05	$4.87	-2.3%	-3.8%
c. Auditing and consulting	$2.23	$1.85	$2.18	$1.78	-2.3%	-3.8%
d. Commissions	$8.65	$6.72	$8.45	$6.47	-2.3%	-3.8%
e. Marketing and Advertising	$0.39	$0.33	$0.38	$0.31	-2.3%	-3.8%
f. Legal Expenses	$0.26	$0.21	$0.25	$0.20	-2.3%	-3.8%
g. Taxes, Licenses and Fees	$8.88	$8.61	$8.67	$8.28	-2.3%	-3.8%
h. Reimbursements by Uninsured Plans						
i. Other Admin Expenses	$5.62	$4.50	$5.48	$4.33	-2.3%	-3.8%

[(1)] For comparison purposes 2013 proposed charges represent 1st Quarter 2013 rates.

Blue Cross & Blue Shield of Rhode Island
Group Rate Factor Filing of May 2012
Administrative Costs Request

2. The following table details actual calendar year 2007-2011 fully insured commercial administrative costs. This is consistent with the annual statement filings to OHIC for administrative costs using the categories defined by NAIC financial statement and as allocated to commercially insured business only.

Fully Insured Commercial Administrative Cost History (Comprehensive Column)					
	2007	2008	2009	2010	2011
Total Premiums	**1,108,466,606**	**1,079,151,863**	**1,025,508,205**	**994,470,562**	**984,903,252**
Total General Administrative Expense	100,746,665	121,463,184	132,106,574	133,474,919	121,420,201
General Admin Exp. Ratio	9.09%	11.26%	12.88%	13.42%	12.33%
Total Fully Insured Member Months	**3,326,346**	**3,049,827**	**2,775,423**	**2,603,304**	**2,468,947**
General Administrative Expense ($pmpm)	$30.29	$39.83	$47.60	$51.27	$49.18
Breakdown of General Administrative Expenses ($ pmpm)					
a. Payroll and benefits	$17.53	$17.40	$21.04	$18.84	$19.82
b. Outsourced Services (EDP, claims etc.)	$9.28	$8.93	$8.62	$12.13	$10.75
c. Auditing and consulting	$2.20	$5.75	$6.38	$6.18	$4.55
d. Commissions	$5.49	$6.06	$6.78	$6.96	$7.21
e. Marketing and Advertising	$0.81	$0.99	$0.89	$0.72	$0.76
f. Legal Expenses	$1.02	$0.33	$0.25	$0.32	$0.40
g. Taxes, Licenses and Fees	$0.10	$3.68	$7.49	$7.79	$8.28
h. Reimbursements by Uninsured Plans [(1)]	($11.59)	($12.49)	($10.76)	($11.78)	($11.59)
i. Other Admin Expenses	$5.44	$9.18	$6.90	$10.11	$8.98
Cost Containment Expense	$4.10	$4.30	$5.73	$7.58	$7.82
Other Claim Adjustment Expense	$10.06	$13.38	$18.19	$17.42	$20.04
Total Self Insured Member Months for all affiliated companies doing business in RI	2,409,639	2,474,355	2,677,918	2,448,365	2,625,181

[(1)] Includes total reimbursements from uninsured plans, not just the portion allocated to general administrative expenses, therefore the breakdown of general expenses does not match the total listed above. The differential is the portion of self funded fees that are treated as a contra expense for cost containment and other claim adjustment expenses.

Blue Cross and Blue Shield of Rhode Island
Group Rate Factor Filing
Administrative Costs Request

3. At the request of OHIC's Health Insurance Advisory Council, please provide brief answers to the following questions:

   a. In general and net of new taxes and fees, why should the rate of increase in Health Plan administrative costs exceed the general inflation rate?

      There are a number of reasons why Health Plan Administrative Expenses might increase at a pace greater than the general rate of inflation. Major corporate infrastructure upgrades, such as the implementation of new information technology systems and the modification of operating processes, procedures and systems to comply with new Government mandates (i.e. ICD 10 and Federal Healthcare Reform), can add significantly to the level of Administrative Expenses incurred in any particular year. Initiatives designed to limit the growth of medical expenses and/or improve the quality of care (e.g. efforts to control fraud and abuse, to improve care coordination, to promote more efficient use of services, etc.) all require spending administrative dollars to control claims expense.

      In addition, significant drops in membership can have a material impact on the level of Administrative Expenses on a per member per month basis as many Administrative Expenses are fixed in nature and don't decrease as enrollment decreases.

   b. What percentage of administrative costs does your organization consider fixed for the next five years? Provide detail by expense category.

      About 56% of the expenses are fixed. The following items are variable: Staff costs for Customer Service, Medical Management, Actuarial & Underwriting Services, Sales & Marketing, Grievance & Appeals, Vendor Fees (Claims and Enrollment), Broker Commissions, Printing & Postages and BlueCard/ Consortium Fees.

   c. What administrative services are used by fully insured members that are not used by self-insured clients (e.g. broker commissions) and what are the estimated total costs ($pmpm) for those services?

      Self-insured clients use most of the same services that our fully insured customers use except for Broker Commission and Underwriting. Our average self-insured group is more than twenty times larger than our average insured Large Group customer which means that many of the expense categories will naturally cost much less on a per member basis. Also, premium taxes cannot be charged to self-insured groups.

   d. What does your plan use as its pmpm benchmarks or price points for commercial insurance administrative costs and why?

      There are a number of considerations that go into deciding on the level of administrative charges to be built into rates. The first of course is our actual expense level. In the current circumstances we are incurring significant expenses associated with the development and installation of a new core computer system. We call this project BlueTransIT. As discussed in

Blue Cross and Blue Shield of Rhode Island
Group Rate Factor Filing
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prior filings we are not attempting to fully build these expenses into current rates but instead are amortizing these development costs over the expected useful life of the system. We feel this approach is more equitable to current customers and also a practical necessity for competitive reasons.

Even after excluding the expenses for the Blue TransIT our expense levels are beyond what we consider an affordable level. So rather than set our pricing assumptions at our current projected expense levels, we have elected to set our administrative charge levels at what we consider appropriate marketplace levels and to work at finding operational efficiencies to close the gap between our proposed pricing and actual expenses. We have embarked on a plan to close this gap.

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Health System Improvements Survey

The State of Rhode Island Office of the Health Insurance Commissioner Regulation 2 lists standards to be used by the Health Insurance Commissioner (Commissioner) for the assessment of the conduct of commercial health insurance issuers in Rhode Island for their efforts aimed at improving the efficiency and quality of health care delivery and increasing access to health care services. The standards include the following issuer activities:

1. Directing 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 these three goals

2. Participating in the development and implementation of public policy issues related to health

To assist the Commissioner in this assessment, as part of the 2012 small and large employer group rate factor review process for commercial health insurance issuers in Rhode Island, please itemize and quantify your organization's contributions of finances and other material assets to these efforts in Rhode Island in calendar year 2011 in the following table.[1]

System-wide Improvement Activity	Brief Description of Activity and How it Promotes Health Care System Quality, Access or Efficiency	Value of 2011 Issuer Contributions
Primary Care Infrastructure Support	BCBSRI provides: • Financial and in-kind support for primary care practices to transform into Patient Centered Medical Homes (PCMH). Support is inclusive of: o Infrastructure support (e.g., Nurse Care Manager (NCM), Physician Champion, Project Management, training, Behavioral health co-location, etc.) o Care management payment – payment for the added time required	~$11M

[1] The contributions can be to any entity other than a provider to improve medical and prevention services for all Rhode Islanders and to promote a coherent, integrated, and efficient statewide health care system.

System-wide Improvement Activity	Brief Description of Activity and How it Promotes Health Care System Quality, Access or Efficiency	Value of 2011 Issuer Contributions
	to appropriately manage the needs of the 'complex' members within the practice o Pay for Performance – Retrospective payment for all BCBSRI patients based on the achievement of nationally recognized clinical process and outcome measures o In kind practice transformation and redesign assistance – PCMH practices are offered added support services through BCBSRI and/or TransforMED (through a contract with BCBSRI) to facilitate practice redesign, leading to more efficient PCMH practices grounded in the principles of PCMH including team based care and pre-visit planning. Assistance is also provided in the proper and consistent use of EHR systems to complement this effort.	
CSI-RI	BCBSRI provides: • PMPM payment which covers NCM, care coordination and quality based outcomes components • In-kind support through participation in CSI Steering, Executive, and Data and Evaluation Committees	~$1.2M
Rhode Island Primary Care Educational Loan Repayment Program	BCBSRI provides: • Lump sum payment for student loan forgiveness • Participation in development of selection criteria and selection of applicants	$350,000
EHR Grant Program	BCBSRI provides:	$267,280

System-wide Improvement Activity	Brief Description of Activity and How it Promotes Health Care System Quality, Access or Efficiency	Value of 2011 Issuer Contributions
	• Financial support for both new and existing users of EHR technology. • $2,500 per practice funding for an EHR pre-implementation readiness assessment to prepare for successful implementation. • $5,000 per physician support to pay for the purchase of a certified EHR. • Additional specific program created for Community Health Centers adopting EHRs	
Quality Counts program	BCBSRI provides: Financial support for EHR adoption and quality metric reporting and results	$129,450
Blue Cross Community Flu Initiative	BCBSRI provides: • A program designed to vaccinate the uninsured in Rhode Island against Influenza • Runs Sept. - November 2011 • Results (to date- program runs through next week): □ 864 total vaccines administered □ 614 out of 864 (71.06%) were uninsured RI'ers •	$13,000
BCBSRI Wellness Van	BCBSRI provides: • Greater healthcare accessibility to all Rhode Islanders—at no cost for visitors. • Offers health screenings, on-site health and wellness services, health education, and information regarding insurance options. • Staffed by a qualified community health educator. • Year Round programming • Results (to date - programming through year end): □ 84 programs held at local nonprofit organizations □ 1567 people screened and/or educated □ 771 of those were uninsured • Free health screenings and	In Kind Approximately $13,000

System-wide Improvement Activity	Brief Description of Activity and How it Promotes Health Care System Quality, Access or Efficiency	Value of 2011 Issuer Contributions
	prevention information to approximately 9,000 Rhode Islanders, including more than 900 uninsured. • Free flu vaccination for Rhode Island's uninsured.	
Rhode Island Regional Extension Center (R REC) / currentcare Health Information Exchange	BCBSRI provides: • Financial support • Subject matter expertise on a variety of steering committees. • Provider Relations staff promote RI REC provider enrollment and assist in event planning/promotion. • Jim Purcell, former President & CEO of BCBSRI is the Chair of the Board of Directors and serves on several committees including the RIQI Operations Committee. • Peter Andruszkiewicz, President & CEO of BCBSRI, is a member of the Board of Directors.	$310,000 In Kind In Kind
ICU Collaborative	BCBSRI provides: Financial and professional support	$242,758
Rhode Island Free Clinic	BCBSRI provides: • Volunteer Support—Dr. Gus Manocchia, BCBSRI's Chief Medical Officer • Board of Directors – Mark Waggoner, VP of Contracting • Financial support for operations • Financial incentives to recruit new volunteers and expand physician volunteer network • BCBSRI Community Wellness Van offers free screenings every monthly "Lottery" night.	$50,000 In Kind
Clinica Esperanza / Hope Clinic	BCBSRI provides: • Financial support for operations • Hosted grand opening celebration in and coordinated media attention for new free clinic • BCBSRI Community Wellness Van offers free screenings at every event	$20,000
WellOne (formerly	BCBSRI provides:	$25,000

System-wide Improvement Activity	Brief Description of Activity and How it Promotes Health Care System Quality, Access or Efficiency	Value of 2011 Issuer Contributions
Northwest Community Health Center)	• Financial support of program to provide co-located behavioral health services in PCP setting	
Rhode Island Kids Count – Covering Kids RI	BCBSRI provides: • BCBSRI is Coalition Member • Participated in the Leadership Roundtables for Children with Special Health Care Needs and the DHS RIte Care Consumer Advisory Committee • Development of an Issue Brief on Preterm Births • Work to close racial and ethnic gaps in health outcomes for children and youth; will issue brief in 2011 • Ongoing support of fundraising events •	$22,500, plus In Kind support
Women's Cancer Screening Program with the RI DOH	BCBSRI provides: • Financial gift to help restart the program after increased demand caused a temporary shutdown.	TBD
Beacon Community Project	BCBSRI provides: ▪ Subject Matter expertise at a number of committee meetings aimed at aligning our PCMH program with the Beacon Community. Support is provided by Provider Relations, Medical Director, and Health Analytics staff.	In Kind
Rhode Island Health Literacy Project	BCBSRI provides: ▪ Staff support at 1 meeting per month.	In Kind
Healthy RI: National Health Reform Implementation Task Force	BCBSRI provides: ▪ Staff support at 1 meeting per month.	In Kind
Rhode Island Primary Care Educational Loan Repayment Program	BCBSRI provides: Participation in development of selection criteria and selection of applicants	In Kind
RI Breastfeeding Coalition	BCBSRI provides: • Staff support at 12 meetings per year. • Sr. level manager on board of directors. • BCBSRI is a breastfeeding friendly workplace.	In Kind

System-wide Improvement Activity	Brief Description of Activity and How it Promotes Health Care System Quality, Access or Efficiency	Value of 2011 Issuer Contributions
	Acknowledged by RIBC as a Silver level employer.	
Participation on Boards of various non-profit organizations	Executive leaders serve on a number of non-profit boards of organizations aimed at improving the health of Rhode Islanders, such as: the Rhode Island Community Food Bank, Amos House, Family Service Rhode Island, Greater Providence of YMCA, Crossroads RI, Rhode Island Free Clinic, American Red Cross, and Gateway Healthcare.	In Kind

Thank you for your cooperation.

500 Exchange Street, Providence, Rhode Island 02903-2699
(401) 459-1000 www.BCBSRI.com

May 18, 2012

Mr. Christopher F. Koller
Health Insurance Commissioner
Office of Health Insurance Commissioner
1511 Pontiac Avenue, Bldg. 69-1
Cranston, Rhode Island 02920

Subject: Rating Factors Applicable to Large Group Subscription Rates for New and Renewal Business Effective January 1, 2013 through December 1, 2013, including Required Early Notice Accounts Effective January 1, 2014 (Forms on file)

Dear Commissioner Koller:

This letter and the attached documents comprise a rate factor filing by Blue Cross & Blue Shield of Rhode Island (BCBSRI or Blue Cross) of claims projection trends, reserve contribution factors, and related rating information to be used in commercial rating of large groups for the upcoming calendar year.

Filing Overview

BCBSRI recognizes that providing affordable healthcare is critical to our customers, members, and the Rhode Island economy. To facilitate this, BCBSRI has undertaken a significant number of initiatives designed to aggressively transform its business strategy, improve internal operations and moderate both medical and administrative expense trends. As a result of these efforts BCBSRI is filing medical trends and rate increases that are appreciably below the levels filed in recent years. As detailed in Exhibit 1 Part 2, the effective annual medical trend in this filing is 2.9% for 2013 over 2012. The estimated average rate increase resulting from this filing, not including federal taxes and assessments, is 4.2%. These new federal taxes and assessments will result in an additional increase of as much as 4.3% as further discussed below and in the Exhibits to this filing.

Addressing Affordability

BCBSRI continues to intensify efforts to moderate healthcare costs by transforming the local healthcare delivery system. Through investments in patient-centered medical homes, electronic health records and care coordination programs, among other efforts, BCBSRI is taking bold steps to transform the local healthcare delivery system and improve our members' health, which will ultimately moderate long-term costs.

In addition, BCBSRI continues to pursue a comprehensive claims reduction strategy designed to address our financial shortfalls, and address affordability, while continuing to ensure high quality of care. Programs developed as part of this strategy successfully reduced claims expense for commercially insured group business by $12 million in 2010 and by $51 million in 2011. These

savings carry forward and will reduce claims expense and premium in 2012 and 2013. In addition we have identified $19 million in new claims expense reductions for 2012.

Savings programs for 2012 include (1) formulary, plan design, and pharmacy pricing changes that will result in a reduction in insured group Prescription Drug spend of approximately $28 million annually; (2) changes in payment policies and management for imaging services which will result in approximately $5 million in savings annually; and (3) enhanced inpatient management of hospitalized members to save about $4.5 million annually.

Medical Trends

While the medical trend components of this rate filing are well within the target of 4% adopted by the Health Insurance Advisory Council, it is important to note this rate filing reflects the escalating cost of medical care. Reasons for these increasing costs include medical provider price increases, expensive new medical technology, increases in the cost of prescription medications and a general increase in the number of medical services obtained by our members. The ongoing increase in costs results in higher medical care cost projections into the future, which translate to higher health insurance premiums.

This filing takes into account a major new pharmacy benefit management contract to be effective in January 2013 that is expected to reduce pharmacy claims cost by 14%. For the typical group plan, this would result in benefit savings of approximately 2.7%. Trends are addressed in more detail in the actuarial assumptions, Exhibit II.

Administrative Expenses and Reserves

Blue Cross is spending increasing amounts of administrative dollars to lower the cost of medical care while improving its quality. For example, one of our highest priorities continues to be our commitment to helping Primary Care Physicians improve both their operating infrastructure and quality of care. The cost of complying with Federal mandates (e.g. ICD-10 and HIPAA 5010) is also putting upward pressure on expenses. Blue Cross implemented additional cost reduction strategies in 2011 to offset these added costs. The company eliminated an additional 45 positions in November 2011, modified our employee benefit program and expanded continuous improvement efforts. The net result of these efforts is a 2012 corporate budget that is $4 million lower than actual 2011 expenditures and a projected budget for 2013 that is $27 million lower than 2011 actual.

Our 2011 financial results continued to be unfavorable, particularly for group business, although far less severe than previous years. The improving trend outlook permitted BCBSRI to release the remaining $92.7 million premium deficiency reserve it had originally established in 2009, which benefitted our corporate reserve position. Our reserves are still below the safety ranges recommended by several actuarial studies conducted by independent nationally recognized firms, including one commissioned by the Office of the Health Insurance Commissioner (OHIC). In light of the current situation and the significant uncertainties as to the impact PPACA will have, we are filing for no change to our reserve contribution factor. We therefore request approval in this filing for reserve contribution factors of 3% of premium, plus the previously approved

0.34% for the funding of the core operating system replacement project. Additional support for this request is discussed in Exhibit II of this filing.

State and Federal taxes and assessment mandates continue to increase in their share of health insurance costs, in particular where such costs can only be assessed on fully insured plans. Self-funded employers can meanwhile legally avoid such costs while still enjoying the benefits of programs funded by assessments. BCBSRI is supporting bills now before the state legislature to spread the cost of taxes and assessments more equitably on the basis of claims rather than premiums. In the event of enactment, BCBSRI would be pleased to amend the administrative cost components of this filing and reduce our premiums accordingly.

Federal Taxes and Assessments

The federal Patient Protection and Affordable Care Act (PPACA) prescribes new federal taxes and assessments on health insurance carriers starting with CY 2013 premiums, to be paid starting in 2014. Based on information currently available, we are projecting BCBSRI's first assessment will be nearly $75 million, of which the insured group share is $43 million, or approximately 4.3% of premium. We have received conflicting guidance from HHS, CMS, and NAIC as to the accounting treatment of this liability for 2013 and 2014. Specifically, early guidance from NAIC stated that the expense should be accrued for 2013, while the federal government indicated that such liability could not be treated as a deduction from the medical loss ratio determination for 2013. We understand that this guidance is still developing and subject to change, but since BCBSRI must now submit its 2013 rate filing, we are including the provision for these assessments starting in 2013 rates at 4% of premium.

Based upon OHIC's instructions of May 7, 2012, we have included two scenarios in this filing to address these federal taxes and assessments. The first scenario assumes no change in the NAIC instructions, thus increasing the average rate increase by 4.3% in order to account for these federal taxes and assessments. The second scenario assumes that the NAIC instructions change and includes an additional average rate increase of 1.7% for federal taxes and assessments. We ask that you approve both scenarios and allow us to apply the appropriate factor once final guidance is issued.

Filing Fee

In accordance with the filing fee requirements contained in Section 42-14-18 of the General Laws of Rhode Island, an electronic funds transfer (EFT) transaction in the amount of $125 is submitted via the SERFF system. Policy forms pertaining to this filing are listed in Attachment 1 to this letter.

Actuarial Support and Certification

The exhibits included in this filing, detailed in Attachment 2 to this letter, display the required rating factors and detailed actuarial documentation supporting this filing, including those prescribed pursuant to your Office's filing instructions letter of April 19, 2012 and supplemented on May 7, 2012 and May 16, 2012.

The actuarial assumptions underlying this filing have been developed by my staff and reviewed by myself. I certify that this rate filing was developed utilizing sound actuarial assumptions and methodologies.

Conclusion

In summary, BCBSRI is pleased to file for the lowest trends and average rate increases for its large group plans in several years. Absent the new federal taxes and assessment charges, the average rate increase for large groups is estimated to be 4.2%.

As stated above, BCBSRI is committed to making healthcare affordable in Rhode Island. We continue to participate in the community effort to redesign our healthcare system while transforming the company. However, without adequate rates to cover our medical and administrative expenses and improving our reserve position, we could potentially jeopardize our financial stability and contribution to our community.

We respectfully ask for your timely consideration and approval of the proposed rating factors as submitted. Blue Cross & Blue Shield of Rhode Island believes that the proposed rating factors are in the best interest of both the public and BCBSRI and consistent with the proper conduct of our business. As always, we shall be pleased to respond promptly to any questions you, your staff, or your office's consulting actuary, Mr. DeWeese, may have.

Sincerely,

John Lynch, F.S.A., M.A.A.A.
Chief Actuary

Attachments (2)

cc: Monica A. Neronha, Esquire

Attachment 1: Policy Forms

Policy forms pertaining to this filing are as follows:

FRONT GRP (09-10);
SUMMARY GRP (09-10);
INTRODUCTION GRP (09-10);
ELIGIBILITY GRP (09-10);
COVERED GRP (09-10);
EXCLUSIONS GRP (09-10);
HOW WE PAY GRP (09-10);
COB GRP (09-10);
APPEALS GRP (09-10); and
GLOSSARY GRP (09-10).

Attachment 2: List of Exhibits

Exhibit I, *Large Group Rate Filing Template*

Exhibit II, *Actuarial Assumptions for Large Group Commercial Rating*, outlines the underlying methodology and assumptions used to develop the claims projection trends and reserve contribution factors.

Exhibit III, *Rhode Island Annual Health Statement Supplement*

Exhibit IV, *Areas of Medical Expense Variation Form*

Exhibit V, *Provider Contracting Practices and Hospital Contracting Conditions Verification Questionnaire*

Exhibit VI, *Administrative Costs Request*

Exhibit VII, *Health System Improvements Survey*

Blue Cross & Blue Shield of Rhode Island
Large Group Rate Filing Template: May 2012 Filing

Part 1. Historical Information

Experience Period for Developing Rates

From	To
1/1/2009	12/31/2011

Utilization/Experience Data by Quarter (Last 12 Available Quarters)

Quarter	End Date	IP Days	Member Months	Earned Premium	Incurred Claims Total	Incurred Claims IP	Incurred Claims OP	Incurred Claims Primary Care	Incurred Claims Other M/S	Incurred Claims Rx	Loss Ratio	Quality Improvement Expense*	Other Cost Containment Expense*	Other Claim Adjustment Expense*	Other Operating Expense*	Investment Income	Premium Tax	Commissions	Contribution to Reserves
1 (Oldest)	3/31/2009	12,162	429,123	$155,380	$134,430	$30,771	$32,731	$4,843	$41,497	$22,731	86.5%	$1,017	$1,731	$7,683	$10,698	$1,420	$2,996	$3,270	($5,025)
2	6/30/2009	12,116	431,342	$158,566	$142,168	$32,875	$34,461	$4,974	$44,853	$23,123	89.7%	$1,040	$1,770	$7,856	$7,849	$2,939	$3,043	$3,000	($5,219)
3	9/30/2009	11,243	422,964	$154,023	$137,342	$30,374	$33,879	$5,203	$43,227	$22,448	89.2%	$1,010	$1,719	$7,630	$8,391	$2,314	$3,104	$3,142	($6,000)
4	12/31/2009	10,808	424,918	$155,426	$133,890	$28,102	$32,207	$5,710	$42,588	$23,046	86.1%	$1,031	$1,755	$7,791	$14,521	$228	$3,122	$3,051	($9,507)
5	3/31/2010	6,889	405,840	$154,278	$134,067	$33,441	$34,099	$4,815	$39,315	$22,398	86.9%	$1,028	$1,443	$5,625	$8,716	$426	$3,045	$2,037	($1,256)
6	6/30/2010	9,978	405,459	$151,992	$134,327	$26,587	$28,765	$4,583	$49,558	$24,834	88.4%	$1,028	$1,443	$5,625	$8,716	$426	$3,045	$2,037	($3,803)
7	9/30/2010	9,803	395,911	$149,395	$132,518	$28,028	$31,712	$4,523	$44,556	$23,700	88.7%	$1,028	$1,443	$5,625	$8,716	$426	$3,045	$2,037	($4,592)
8	12/31/2010	10,194	388,546	$146,897	$132,179	$24,322	$27,898	$4,588	$50,748	$24,622	90.0%	$1,028	$1,443	$5,625	$8,716	$426	$3,045	$2,037	($6,750)
9	3/31/2011	11,279	368,670	$146,381	$121,082	$30,421	$29,877	$4,553	$33,939	$19,642	82.7%	$949	$1,333	$4,628	$8,359	$331	$2,979	$2,254	$5,127
10	6/30/2011	10,250	365,863	$149,128	$124,908	$29,555	$31,604	$4,513	$36,202	$20,384	83.8%	$944	$1,326	$4,606	$8,319	$345	$2,994	$2,646	$3,728
11	9/30/2011	10,256	367,421	$141,139	$122,812	$29,433	$30,993	$4,473	$34,857	$20,074	87.0%	$930	$1,306	$4,536	$8,192	$313	$2,969	$2,645	($1,937)
12	12/31/2011	9,219	368,315	$146,395	$123,494	$27,215	$31,599	$4,780	$35,902	$21,016	84.4%	$1,048	$1,473	$5,115	$9,238	$369	$3,130	$2,360	$906

* These categories should conform generally to the reporting in the NAIC statement Underwriting & Investment Exhibit Part 3- Analysis of Expenses and/or to the Supplemental Health Care Exhibit, Lines 6.3 and 8.1
If any of the historical information reported is different from that period as reported in the prior rate filing, please provide a reconciliation and explanation showing the amount of each element of difference.

Part 2. Prospective Information

A. Trend Factors for Projection Purposes (Annualized)

	2013 / 12							2014 / 13					
	IP	OP	Primary Care	Other M/S	Rx	Weighted Total		IP	OP	Primary Care	Other M/S	Rx	Weighted Total
Total	**7.36%**	**7.92%**	**8.20%**	**5.00%**	**5.50%**	**6.53%**	**Total**	**5.82%**	**6.73%**	**12.24%**	**5.03%**	**7.51%**	**6.44%**
Price Only	5.61%	5.12%	5.19%	2.08%	2.76%	**3.95%**	**Price Only**	4.10%	3.96%	9.11%	2.11%	4.72%	**3.86%**
Utilization	0.00%	2.00%	2.20%	2.20%	1.45%	**1.47%**	**Utilization**	0.00%	2.00%	2.20%	2.20%	1.45%	**1.47%**
Mix	1.00%	0.00%	0.00%	0.00%	0.00%	**0.24%**	**Mix**	1.00%	0.00%	0.00%	0.00%	0.00%	**0.24%**
Leveraging	0.65%	0.65%	0.65%	0.65%	1.20%	**0.75%**	**Leveraging**	0.65%	0.65%	0.65%	0.65%	1.20%	**0.75%**
Weights	24%	25%	5%	28%	19%	**100%**	**Weights**	24%	25%	5%	28%	19%	**100%**

Note: The above factors together with the new PBM impact and normalizing for an expected demographic change of 0.79%, produce an effective 2013 over 2012 trend of 2.9%.

Scenario A - New PPACA Taxes Accrue in 2013

B. The following items for the period to which the rate filing applies, by quarter:

Quarter	Beginning Date	Average % Rate Increase	Expected Pure Medical Cost Ratio	Expected Contribution to Reserves %	Quality Improvement Expense %*	Other Cost Containment Expense %*	Other Claim Adjustment Expense %*	Other Operating Expense %*	Average Commissions %*	Investment Income Credit %	Premium Tax %	PPACA Tax %
1	1/1/2013	8.7%	80.5%	3.3%	0.6%	0.7%	2.5%	4.9%	1.7%	-0.2%	2.0%	4.0%
2	4/1/2013	8.7%	80.5%	3.3%	0.6%	0.7%	2.5%	4.9%	1.7%	-0.2%	2.0%	4.0%
3	7/1/2013	8.7%	80.5%	3.3%	0.6%	0.7%	2.5%	4.9%	1.7%	-0.2%	2.0%	4.0%
4	10/1/2013	8.7%	80.5%	3.3%	0.6%	0.7%	2.5%	4.9%	1.7%	-0.2%	2.0%	4.0%
Weighted Average		**8.7%**	**80.5%**	**3.3%**	**0.6%**	**0.7%**	**2.5%**	**4.9%**	**1.7%**	**-0.2%**	**2.0%**	**4.0%**

* These categories should conform generally to the reporting in the NAIC statement Underwriting & Investment Exhibit Part 3 - Analysis of Expenses and to the Supplemental Health Care Exhibit, Lines 6.3 and 8.1
The sum of the expenses, commissions, contributions to reserves, investment income credit, taxes and the medical loss ratio should be 100%.

C. Average Rate Increase Components

The following items should reconcile to the Weighted Average Percent Rate Increase for the year:

	Price	Utilization, Mix	Total
Inpatient	1.1%	0.3%	1.5%
Outpatient	1.0%	0.6%	1.6%
Physician	0.9%	0.5%	1.4%
Pharmacy	0.4%	0.5%	0.9%
NEW PBM Effect			-2.3%
Administrative Expense (Aggregated)			0.4%
Contribution to Reserves			0.3%
Taxes and Assessments			0.5%
NEW PPACA Taxes			4.3%
Prior Period Adjustment (+/-)			0.0%
Total			**8.7%**

Blue Cross & Blue Shield of Rhode Island
Large Group Rate Filing Template: May 2012 Filing

Scenario B - New PPACA Taxes Do Not Accrue in 2013

B. The following items for the period to which the rate filing applies, by quarter:

Quarter	Beginning Date	Average % Rate Increase	Expected Pure Medical Cost Ratio	Expected Contribution to Reserves %	Quality Improvement Expense %*	Other Cost Containment Expense %*	Other Claim Adjustment Expense %*	Other Operating Expense %*	Average Commissions %*	Investment Income Credit %	Premium Tax %	PPACA Tax %
1	1/1/2013	4.4%	83.8%	3.3%	0.6%	0.8%	2.6%	5.2%	1.7%	-0.2%	2.0%	0.3%
2	4/1/2013	5.6%	82.9%	3.3%	0.6%	0.8%	2.5%	5.1%	1.7%	-0.2%	2.0%	1.3%
3	7/1/2013	6.7%	82.0%	3.3%	0.6%	0.8%	2.5%	5.0%	1.7%	-0.2%	2.0%	2.3%
4	10/1/2013	7.9%	81.1%	3.3%	0.6%	0.8%	2.5%	5.0%	1.7%	-0.2%	2.0%	3.3%
Weighted Average		**5.9%**	**82.6%**	**3.3%**	**0.6%**	**0.8%**	**2.5%**	**5.1%**	**1.7%**	**-0.2%**	**2.0%**	**1.6%**

* These categories should conform generally to the reporting in the NAIC statement Underwriting & Investment Exhibit Part 3 - Analysis of Expenses and to the Supplemental Health Care Exhibit, Lines 6.3 and 8.1
The sum of the expenses, commissions, contributions to reserves, investment income credit, taxes and the medical loss ratio should be 100%.

C. Average Rate Increase Components

The following items should reconcile to the Weighted Average Percent Rate Increase for the year:

	Price	Utilization, Mix	Total
Inpatient	1.1%	0.3%	1.5%
Outpatient	1.0%	0.6%	1.6%
Physician	0.9%	0.5%	1.4%
Pharmacy	0.4%	0.5%	0.9%
NEW PBM Effect			-2.3%
Administrative Expense (Aggregated)			0.4%
Contribution to Reserves			0.2%
Taxes and Assessments			0.5%
NEW PPACA Taxes			1.7%
Prior Period Adjustment (+/-)			0.0%
Total			**5.9%**

Part 3. Retrospective Reconciliation of Experience with Filed Factors

	Filed Data[1]					PMPM Increase[2]		Standard Plan PMPM[3]		Standard Plan Increase[4]		Approved		Loss Ratio[5]	
Year	Member Months	Earned Premium	Incurred Claims Total	Premium PMPM	Claims PMPM	Premium	Claims	Premium	Claims	Premium	Claims	Trend Increase%	Contrib to Reserves%	Actual%	Filed%
2009	1,708,347	623,395	547,829	$364.91	$320.68			$369.22	$324.47			9.2%	1.4%	87.9%	87.2%
2010	1,595,756	602,562	533,091	$377.60	$334.07	3.5%	4.2%	$384.94	$340.56	4.3%	5.0%	8.7%	2.0%	88.5%	86.0%
2011	1,470,269	583,044	492,296	$396.56	$334.83	5.0%	0.2%	$425.36	$363.04	10.5%	6.6%	9.6%	2.3%	84.4%	86.8%

[1] Corresponds to historical Information data in Part 1 above

[2] Percent increase compared to prior year

[3] For most commonly held plan of benefits in 2010 and for the same plan of benefits in 2011

[4] Percent increase compared to prior year

[5] Represents claims loss ratio, claims divided by premium, which differs from the Federal MLR calculation for potential rebate determination

BLUE CROSS & BLUE SHIELD OF RHODE ISLAND

ACTUARIAL ASSUMPTIONS FOR LARGE GROUP COMMERCIAL RATING

Applicable Group Rate Effective Dates

Large Group new and renewal business for rating periods commencing January 1, 2013 through December 1, 2013, including required Early Notice accounts effective January 1, 2014.

Utilization Projections

The determination of the projection trends contained in this filing utilizes the Corporation's standard methodology. This methodology assumes the annual trend represented by the best-fit linear regression line, based on the percentage rate of increase for the period January 2011 through December 2011 over the period January 2010 through December 2010 and continuing into the future in a geometric progression so that the actual trend (percentage increase) is constant over time. Where in past years BCBSRI has determined utilization/mix trends based on combined large group and small group data, this year we have observed a significant sustained differential in trend results between large group and small group. This is apparently due to differing rates of change in the demographics of the respective covered populations. We have elected to file the differing trend results, with small group running consistently higher trends than large group.

For **Hospital Inpatient utilization**, the days per thousand rate and admissions per thousand rate is slightly negative. Hospitals are being converted, and will continue to convert, their inpatient reimbursement basis from per-diem to per-case. We also note that Butler Hospital has been approved for 25 additional beds. For these reasons it is our actuarial judgment to use a hospital inpatient utilization trend of 0%, the same as that submitted in last year's filing.

For **Hospital Inpatient mix** trend, we performed several measures of depriced cost/day and depriced cost/admission with some results indicating a negative trend. However, we are expecting the current financial difficulties that some hospitals within Rhode Island currently face are likely to lead to admissions at more costly facilities and/or contract re-negotiation in the near future for those struggling hospitals that remain open, with slightly higher costs resulting. Therefore it is our actuarial judgment for this filing to use a 1.0% inpatient annual mix adjustment.

For **Hospital Outpatient utilization/mix** trend, the standard methodology on insured large groups produces an annual trend of 2.0%, which in our judgment represents a reasonable expectation for the next two years. This trend is 1.8% lower than the outpatient trend approved last year.

Utilization/mix trends for Primary Care and Other Medical/Surgical were determined on a combined basis as one Surgical/Medical utilization/mix trend, consistent with our customary practice in previous filings. The determination of separate trends continues to produce results that are not credible, and the resulting combined trend result is judged to be a reasonable expectation for both segments. The Surgical/Medical regression result of 0.96% is extremely low compared to results seen for earlier periods. We anticipate some risk of increased utilization by specialists due to restricted increases in reimbursement rates anticipated over the next few years and the corresponding upward "pull" inherent in the fee for service system. Therefore we request approval

of an annual trend of 2.20%, which, while higher than the regression results, is 1.3 percentage points lower than that approved last year and also below historical average utilization trend we have seen in this service category.

For **Prescription Drugs price/utilization/mix (**prior to adjustments for one-time changes in claim costs), the standard methodology regression uses 19 data points with a calculated trend of 6.74%. More recent data suggest slight acceleration of the trend, such that the 13 data points regression has a calculated trend of 7.09%, and our latest actual observation (CY 2011 over CY 2010) trends at 7.00%. It is our actuarial judgment to use the latest actual trend of 7.0% as the baseline for large groups for this filing. Adjustments for one-time changes in claim costs, such as ongoing cost reductions for new generic drugs coming to market and plan formulary changes, are expected to offset this trend by 2.6%, yielding a 4.2% effective drug trend (before the pharmacy contract change adjustment). For **Prescription Drugs utilization,** a separate regression analysis was run for the number of scripts per 1,000 members.

The **composite of utilization/mix factors** across all service categories in this filing amounts to 1.7%. While this composite is the aggregation of the different assumptions made in the various service categories as discussed above, we also considered its reasonableness in total. In evaluating the appropriateness of the composite trend assumption one should consider that utilization trend is impacted by demographic, technology and morbidity changes as well as by changes in provider practice.

Our composite utilization/mix assumption must also provide for the effects of ongoing technological changes in healthcare delivery. We note that a 2008 Congressional Budget Office (CBO) Study concluded that "roughly half of the increase in health care spending during the past several decades was associated with the expanded capabilities of medicine brought about by technological advances." It is reasonable to expect that we will continue to see utilization and mix increases related to technology changes.

The rise in the prevalence of chronic conditions and obesity in the population has contributed to the increases in the utilization of medical services we have seen in the past and will doubtless continue to be a driver of still further increases in the future. Furthermore, in our current health care system, health care providers generally receive payments for each service they render, and consequently their incomes are tied to the number of services they provide and/or bill for. Many experts have concluded that this arrangement creates incentives to provide more technical and more expensive services and to upcode and unbundle in their billing practices so as to optimize reimbursement. While we are working to eliminate these incentives, their effects will continue to be felt for some time. In view of all of these cost drivers and our historical experience, we believe that the utilization/mix factors we are filing are in the aggregate reasonable and represent a fair prediction of experience we are likely to see in 2013 and beyond.

Price Projections

Hospital price projections reflect estimated hospital price increases based on existing reimbursement contracts and anticipated payment levels in the future. New reimbursement contracts have been signed in compliance with last year's OHIC payment reform terms for hospital contracting.

The **RI Primary Care** price projections reflect the provider fee adjustments as well as other provider payments required by the OHIC Primary Care Spend standard.

The **Other Medical/Surgical** projection trends reflect a series of provider fee adjustments and initiatives through the subject rating periods.

The **composite of price factors** across all service categories in these filing amounts to 3.95%, the aggregation of the different assumptions made in the various service categories as discussed above. This value is being driven largely by the hospital price projections, as well as the primary care required increases. Admittedly, this increase is high when compared to most other price increases outside healthcare, but it is lower than we have experienced in recent years and will continue to decline as new agreements are reached with hospitals. To mitigate the impact of unit price inflation on premium costs, BCBSRI approaches all provider negotiations with the goal of achieving the lowest rates consistent with quality care. For the subject rating periods, we believe the price factors we are filing are a fair prediction and reasonable expectation.

Benefit Leveraging

With the increasing prevalence of benefit plans featuring sizable fixed dollar deductibles and copays, BCBSRI is anticipating a significant impact on trends due to benefit leveraging. Trends calculated for rating purposes are determined from allowed claims dollars, or claims paid including member cost sharing of deductibles and co pays. However, to derive an appropriate pricing trend we need to adjust for the leveraging impact of fixed co pays and deductibles. For Large Groups, we expect factors of 0.7% and 1.2% to be necessary for medical and drug service categories respectively.

Effective Medical Trend

The trend factors we have quoted in Exhibit I include the effects of the demographic changes we have seen in our covered population and exclude the impact of the significant savings that will arise from the new pharmacy benefit contract that will become effective on January 1, 2013. Over the 2007-2011 period the demographic factor across our entire Large Group (LG) insured segment has increased at the cumulative average per annum rate of 0.8%. This is consistent with the ongoing “graying” of America and also reflects changes in the insured population due to layoffs, etc. This demographic driven cost escalation is inherent in the Exhibit I trends we have quoted. We estimate the impact of the new PBM contract will result in an average benefit savings of 2.7% in 2013. Reflecting both the PBM and demographic impacts, our effective 2013 over 2012 trend in the LG segment is 2.9%.

Experience Adjustment

Claims experience has emerged in 2011 and is expected to emerge in 2012 at trends lower than we had anticipated in last year’s rate filing, leading to two favorable impacts on future rate increases needed. First, as noted above, we are able to reduce the overall trends being proposed for rating. Secondly, the claims component of rates made effective with previously approved trends are now expected to prove to be fully adequate when the next renewal rates are calculated. This full adequacy results in a neutral experience adjustment that is quantified when the rate increase is broken down into its contributing components (see Part 2c of Exhibit I). Note that this favorable

experience is directly related to the comprehensive claims reduction strategy we have embarked on as described earlier in this filing.

Reserve Contribution Factor

Due in large part to our success in reducing our administrative and medical expenses our reserve position has significantly improved over what it was at the time we submitted last year's filing. However our reserves remain about 15% below the minimum level recommended in the Lewin study that was commissioned by OHIC. In light of this and the uncertain impacts as we move toward full implementation of the federal health care reforms we feel it is necessary to maintain the reserve contribution factor at its current level of 3% plus the additional 0.34% included to continue funding extraordinary expenses necessitated by the installation of a new BCBSRI core operational computer system over the span of its anticipated useful life. There are uncertainties around the impact of the new rating and underwriting restrictions that will come into effect with the federal reforms. There is also the impact of the unknown volume and morbidity level of the currently uninsured that are expected to come into the market. There is significant uncertainty around the willingness of employers to continue their current level of financial support for group insurance programs. It is also clear that we will have to set our rates before we know the level of the new PPACA taxes and so this represents a significant financial risk to carriers. The advent of the state based exchanges and the possible entry of new competitors also adds additional risk. Increased risk translates into a need for additional reserves. Furthermore it is worth remembering that for a nonprofit health carrier like BCBSRI there is an important non-solvency component to reserves. Since we do not have access to the capital markets our reserves are our source for the development funds required to finance technology upgrades, new initiatives and other programs necessary to maintain our vitality as a business in a rapidly changing environment.

Administrative Expense

Blue Cross is spending increasing amounts of administrative dollars to lower the cost of medical care while improving its quality. A key piece of Blue Cross' transformation program to become an effective leader in health care cost control is to establish the infrastructure necessary to do the job. The cost of complying with Federal mandates (e.g. ICD-10 and HIPAA 5010) is also putting upward pressure on expenses. Blue Cross implemented several cost reduction strategies in 2011 to offset the added costs noted above. The company eliminated 45 positions in November 2011, modified our employee benefit program and implemented multiple continuous improvement efforts. The net result of these efforts is a 2012 corporate budget that is $4 million lower than actual 2011 expenditures, and the current projection for 2013 is $27 million lower than 2011.

There remains a gap between our proposed administrative charges and projected cost levels. Our intention is to seek to close the gap through expense reduction efforts so as to minimize increases in future charge levels.

Please refer to the enclosed documents "Administrative Costs Documentation" (Exhibit VI) for explanation and justification of the administrative charge rate components shown in Exhibit I. Administrative charges set forth in these documents include provisions for broker commissions, federal income taxes, and state premium tax. State assessments on the Corporation resulting from the Children's Health Account (covering Comprehensive Evaluation, Diagnosis, Assessment,

Referral and Re-evaluation (CEDARR), Child Intervention Services and Home Services), the State Child Immunization Fund, and adult influenza vaccine are now incorporated into projected claims costs as per the instruction of OHIC.

New PPACA Taxes

Beginning in 2014, as part of the PPACA, new federal Health Insurer and Transitional Reinsurance Program fees will be imposed that are currently estimated to amount to about 4% of premium. While these fees will first be payable in 2014, proposed federal rules indicate they will be assessed based on 2013 premiums. The NAIC's current position is that these fees should be accrued for over the 2013 calendar year. For BCBSRI this accrual would amount to about $75 million, of which about $40 million would be on group business. This would represent an unacceptable reserve strain if we are not permitted to fund for it in premium rates. Insurance industry groups are attempting to convince the NAIC to change its position and not require a 2013 accrual.

In light of this uncertainty about the proper accounting treatment of these new taxes, OHIC has directed the carriers to file two sets of proposed rate actions. Scenario A reflects our proposal in the event that the NAIC requires a 2013 accrual of these costs. Scenario B reflects our proposal if the NAIC reverses its position and does not require any 2013 accrual, with liability commencing January 1, 2014.

Under Scenario A the premiums quoted for all 2013 rate effective dates will reflect a full load for these new federal fees which we currently estimate to be 4% of the final rate. Under Scenario B we are assuming that the NAIC will not require carriers to accrue these costs in our 2013 financial statements. However the rate years we will be quoting in 2013 will for other than January cases include parts of both the 2013 and 2014 calendar years. Accordingly we propose to include in our 2013 rating a charge for these new fees equal to the proportion of the rate year that falls into the 2014 calendar year. For example for a 4/1/2013 renewal we will build in a 1% provision for these new federal fees, i.e. one fourth of our full year 4% estimate. It is also possible that the Health Insurer fee will require an accrual in 2013 while the Transitional Reinsurance fee would not. In this case the Health Insurer fee (2.2%) would follow according to Scenario A, while the Transitional Reinsurance fee (1.8%) would follow according to Scenario B.

Note that the ACA permits states establishing a reinsurance program to add to the promulgated federal rate and/or to modify other elements of the reinsurance program. Accordingly if Rhode Island elects to assess additional state fees and/or if a better estimate of the cost of the federal fees becomes available BCBSRI requests that carriers be allowed to adjust this PPACA rating factor.

The federal Department of Health and Human Services (HHS) has indicated that its current intention is that it will not allow carriers to deduct any PPACA fee provision in determining a carrier's 2013 rebate liability. We do not expect the HHS will change its position on this matter. Accordingly under Scenario B in our Large Group market we will quote 12 month rates on all business written or renewed in 2013 but we propose to bill different 2013 and 2014 rates as our standard practice. We propose to include no provision for these new PPACA fees in the 2013 rates we bill Large Group cases and a full load in the rates that fall in the 2014 calendar year, i.e. the two sets of rates will differ by 4%. We will quote equivalent 12-month composite rates to all cases so as to assist them in determining employee contribution requirements. On an exception

basis we will agree to bill customers on this basis but we will attempt to convince them to accept our proposed two step approach.

Under Scenario B in our Small Group market we propose to uniformly quote and bill composite 12 month rates that reflect the appropriate proportion of the federal fees based on the rate effective date. The reason for the different treatment relates to the administrative complexity a two rate approach would entail for us, brokers and customers. We point out that we have almost 10,000 small group cases but only 425 large group accounts. We are also unsure as to whether or not the Small Group statutes and regulations would permit a two step rate approach.

The above described Health Insurer fees arise from Section 9010 of PPACA. It imposes an annual fee on health insurance carriers in the aggregate of $8 billion in 2014, increasing to $14.3 billion in 2018 and increasing thereafter by the rate of premium growth. These fees are nondeductible for federal tax purposes and accordingly need to be grossed up to reflect actual plan costs, i.e. the tax on the tax.

Section 1341 of PPACA establishes the Transitional Reinsurance Program. The program is to be funded through contributions from health insurers and TPAs for self-funded plans. Aggregate reinsurance contributions are to be determined on a national basis in the amount of $10 billion in 2014, $6 billion in 2015 and $4 billion in 2016. Additional contributions to the Treasury are required in the amounts of $2 billion in 2014, $2 billion in 2015 and $1 billion in 2016. Furthermore states may assess additional fees for reinsurance claims and administrative expenses.

Given the significant size of these fees we feel strongly that if the NAIC does not reverse its current position we need to be allowed to implement the higher Scenario A rates. Alternatively we would ask that the State of Rhode Island grant us as a permitted practice the right to deviate from NAIC standard accounting in the preparation of our financial statements, i.e. do not require us to accrue for these costs even if that remains the NAIC position.

Projected Average Rate Increases

The average rate increase values displayed in Section 2B of Exhibit 1 are our current projection of the average rate increases that will result from the application of the proposed rating factors in this filing and our approved rating formula with two exceptions. The projected average increases do not reflect the impact of new business written in 2012 and furthermore exclude the effect of our largest fully insured customer.

We have no credible experience on the new business we have written thus far in 2012 and we do not know how much additional business we will write over the balance of the calendar year. Therefore we have no practical way of estimating what the 2013 renewal increase will be on this business or of how to weigh it into our projection of our overall average rate increase.
Our largest fully insured customer is a unique case in a number of respects. It represents over 12% of our insured enrollment, and so a misestimate on this case would have a material effect on our overall average. The case renews in January each year and requires early notification. This puts it in the special early notice category, meaning this filing covers its January 2014 renewal. However, we have not yet set its January 2013 rating and therefore we do not know the “present” rates that will be used to measure its 2014 rate increase. The 2014 rates that we will have to present to this case will be based on the medical experience that will develop over the next twelve

months. This experience will be different than any current projection we can make. Lastly this case has a unique benefit design. Most of the enrollment under this account is covered for relatively low benefit maximums. Given the size of this case, its unique benefits and the inevitability of forecasting errors in estimating both its 2013 and 2014 rates we believe it is best to exclude this account from the estimated average rate increase projections we are providing to OHIC and that is what we have done.

Other than the two exceptions noted above, the estimated average rate increases included in this filing have been developed by applying our proposed rating factors to the most current information available to us at the present time. However our approved rating formula, good business practice and the expectations of our customers require us to develop the actual rates we present to accounts based on the most current experience available at the time the renewal rates are calculated. That actual experience will inevitably be different than our current projections. There will also be changes in the mix and composition of the groups renewing due to cancellations, changes in funding arrangements, shifts in covered populations, etc.

In the Large Group (LG) market customers and their brokers require that the rates they are offered be based primarily on their own experience. While the estimation difficulties described above for our largest insured account are particularly problematic they are hardly unique. While we have over 400 LG cases, our largest 10 groups account for more than 30% of our insured enrollment in the LG segment. Nearly all of these cases are "early notification" accounts that haven't yet had their "present" rates finalized.

We point out that for LG cases self funding is an increasingly attractive option. Over the recent past the migration to self funding has occurred more than proportionately among cases being offered lower than average rate increases. Groups that have had favorable recent experience tend to place less value on the cost guarantees of an insured arrangement. The removal of these well performing cases from the insured pool has the effect of increasing the required average rate increase across the pool of cases remaining insured.

It has always been our understanding that the average rate increase estimates included in our group rate factor filings were for informational purposes only and that it is the factors themselves that are subject to approval. We point out that the trend factors we are filing are materially below currently approved factors and are also relatively low by historical standards. If carriers are going to be required to be held to the estimated average rate increases included in these factor filings then rationally they should be allowed to build in a margin for the inevitable estimation error. In the interests of both soundness and affordability we believe a better approach is to continue to allow carriers to apply the approved rating factors to the updated experience on the actual mix of cases renewing over the rate year covered by the filing in accordance with our approved rating formula. We would welcome the opportunity to discuss this matter further with OHIC.

Rhode Island Health Statement Supplement

Cover Sheet

Company Name	Blue Cross & Blue Shield of Rhode Island		
Enter NAIC#	53473	**Reporting Year**	2011
Enter DBR registration # (TPAs)			

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Office of the Health Insurance Commissioner
1511 Pontiac Ave, Building #69 first floor
Cranston, RI 02920
(401) 462-9517
(401) 462-9645 (fax)
HealthInsInquiry@ohic.ri.gov

Field		Line of Business Exhibit	1 Comprehensive/Major medical			2 ASO/TPA			3 Stop loss/ Excess loss/Reinsurance			4 Medicare Part C			5 Medicare Part D		
			RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All
1		**Membership Data**															
		Number of Polices or Certificates	74,861	28,626	103,487	54,145	42,183	96,328			-	31,755	195	31,950			-
		Number of Covered Lives	149,186	55,683	204,869	130,470	89,670	220,140			-	31,755	195	31,950			-
		Member Months	1,794,840	663,092	2,457,932	1,566,564	1,076,694	2,643,258			-	381,049	2,534	383,583			-
		Number of Polices or Certificates	72,338	20,401	92,739	39,001	8,204	47,205			-	30,257	187	30,444			-
		Number of Covered Lives (**Plans**	145,542	43,938	189,480	96,204	20,345	116,549			-	30,257	187	30,444			-
		Member Months (**Plans with PD**	1,750,794	520,794	2,271,588	1,153,963	245,148	1,399,111			-	362,552	2,425	364,977			-
2		**Premiums/Claims**															
		Premium			988,024,244			947,024,013			3,981,127			382,690,929			14,198,310
		Claims/Medical Expenses	598,071,485	225,342,807	823,414,291	583,141,907	316,107,001	899,248,908	1,815,393	-	1,815,393	343,432,595	2,864,703	346,297,298	12,086,291		12,086,291
3		**Inpatient Facility**															
		Hospital															
	1	In-state	107,342,248	9,737,526	117,079,775	99,279,504	5,398,245	104,677,749			-	101,185,948	703,133	101,889,081			-
	2	Out-of-state	26,172,146	47,792,254	73,964,401	22,804,736	81,603,179	104,407,915			-	6,767,781	131,000	6,898,782			-
	3	Total (Lines 1 + 2)	133,514,394	57,529,781	191,044,175	122,084,240	87,001,424	209,085,664	-	-	-	107,953,729	834,134	108,787,863	-	-	-
		SNF															
	4	In-state	2,028,414	97,842	2,126,256	1,908,117	106,721	2,014,838			-	32,159,701	514,746	32,674,447			-
	5	Out-of-state	56,496	372,160	428,657	64,762	794,274	859,036			-	87,627	15,391	103,018			-
	6	Total (Lines 4 + 5)	2,084,910	470,002	2,554,912	1,972,880	900,995	2,873,874	-	-	-	32,247,328	530,137	32,777,465	-	-	-
		Other															
	7	In-state	-	-	-	-	-	-			-	-	-	-			-
	8	Out-of-state	-	-	-	-	-	-			-	-	-	-			-
	9	Total (Lines 7 + 8)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	10	**Total Inpatient Facility (Lines 3 + 6 + 9)**	135,599,305	57,999,783	193,599,087	124,057,120	87,902,419	211,959,538	-	-	-	140,201,057	1,364,270	141,565,327	-	-	-
4		**Outpatient Facility**															
		Hospital															
	11	In-state	105,756,854	6,803,973	112,560,827	110,638,292	6,140,973	116,779,265			-	43,246,502	209,509	43,456,011			-
	12	Out-of-state	28,091,095	46,054,564	74,145,659	22,530,764	78,396,182	100,926,947			-	2,518,590	37,868	2,556,457			-
	13	Total (Lines 11 + 12)	133,847,949	52,858,536	186,706,486	133,169,056	84,537,155	217,706,212	-	-	-	45,765,092	247,377	46,012,469	-	-	-
		SNF															
	14	In-state	6,398	2,730	9,128	18,195	-	18,195			-	1,412,810	61,896	1,474,706			-
	15	Out-of-state	452	4,543	4,995	-	7,827	7,827			-	1,918	-	1,918			-
	16	Total (Lines 14 + 15)	6,850	7,273	14,123	18,195	7,827	26,022	-	-	-	1,414,729	61,896	1,476,625	-	-	-
		Freestanding Ambulatory Care Facility															
	17	In-state	18,700,907	1,124,126	19,825,032	21,615,418	1,185,121	22,800,538			-	6,549,538	32,576	6,582,115			-
	18	Out-of-state	3,915,482	5,351,240	9,266,722	4,275,959	7,598,818	11,874,777			-	1,607,729	11,599	1,619,328			-
	19	Total (Lines 17 +18)	22,616,389	6,475,366	29,091,755	25,891,377	8,783,938	34,675,315	-	-	-	8,157,267	44,176	8,201,443	-	-	-
		Other															
	20	In-state	6,876,917	555,516	7,432,433	5,898,870	122,502	6,021,372			-	17,206,087	116,680	17,322,767			-
	21	Out-of-state	1,623,464	4,868,120	6,491,584	1,634,386	7,331,740	8,966,126			-	279,255	21,983	301,239			-
	22	Total (Lines 20 + 21)	8,500,381	5,423,636	13,924,017	7,533,255	7,454,242	14,987,497	-	-	-	17,485,343	138,664	17,624,006	-	-	-
	23	**Total Outpatient Facility (Lines 13 + 16 +**	164,971,569	64,764,811	229,736,380	166,611,883	100,783,162	267,395,046	-	-	-	72,822,430	492,112	73,314,542	-	-	-
5		**Primary Care**															
	24	**Total Primary Care**	30,655,783	2,922,304	33,578,087	29,915,118	2,285,373	32,200,491			-	11,293,214	88,341	11,381,556			-
6		**Pharmacy**															
	25	**Total Pharmacy**	111,959,953	29,382,454	141,342,408	98,963,134	18,991,512	117,954,646			-	31,182,377	263,823	31,446,200			-
7		**Medical/Surgical other than primary care**															
	26	In-state	117,333,079	7,703,001	125,036,080	137,243,627	7,398,320	144,641,947			-	65,758,629	416,266	66,174,895			-
	27	Out-of-state	23,234,501	57,909,679	81,144,181	23,107,877	97,954,899	121,062,776			-	4,646,619	93,889	4,740,507			-
	28	**Total Other Medical/Surgical (Lines 26 + 2**	140,567,580	65,612,680	206,180,260	160,351,504	105,353,219	265,704,723	-	-	-	70,405,247	510,155	70,915,402	-	-	-
8		**All other payments to medical providers**															
	29	**Total**	14,317,294	4,660,775	18,978,069	3,243,147	791,317	4,034,464	1,815,393		1,815,393	17,528,269	146,001	17,674,270	12,086,291		12,086,291

6			7			8			9			10			11		
Medicare Supplement Policies			Medicaid/Other public			Student blanket			Dental Only			Other Medical Non-Comprehensive			Total (Across all lines of business)		
RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All
22,468	3,019	25,487			-			-	42,711	9,140	51,851			-	225,940	83,163	309,103
22,468	3,019	25,487			-			-	78,834	19,850	98,684			-	412,713	168,417	581,130
269,788	37,494	307,282			-			-	939,836	230,530	1,170,366			-	4,952,077	2,010,344	6,962,421
293	57	350			-			-	-		-			-	141,889	28,849	170,738
293	57	350			-			-	-		-			-	272,296	64,527	336,823
3,532	679	4,211			-			-	-		-			-	3,270,841	769,046	4,039,887
		52,710,055			-			-			27,946,531			98,931,536	-	-	2,515,506,745
38,614,920	6,023,333	44,638,253			-			-	18,206,157	4,442,242	22,648,399	95,745,806		95,745,806	1,691,114,553	554,780,086	2,245,894,639
3,775,927	187,450	3,963,377			-			-			-			-	311,583,627	16,026,354	327,609,981
661,086	673,357	1,334,443			-			-			-			-	56,405,750	130,199,790	186,605,540
4,437,013	860,807	5,297,819	-	-	-	-	-	-	-	-	-	-	-	-	367,989,376	146,226,145	514,215,521
4,140,691	182,206	4,322,897			-			-			-			-	40,236,923	901,515	41,138,438
163,151	448,102	611,253			-			-			-			-	372,036	1,629,928	2,001,964
4,303,842	630,309	4,934,151	-	-	-	-	-	-	-	-	-	-	-	-	40,608,960	2,531,442	43,140,402
-	-	-			-			-			-			-	-	-	-
-	-	-			-			-			-			-	-	-	-
-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
8,740,855	1,491,115	10,231,970	-	-	-	-	-	-	-	-	-	-	-	-	408,598,336	148,757,587	557,355,923
5,810,550	155,383	5,965,933			-			-			-			-	265,452,198	13,309,837	278,762,036
977,855	733,890	1,711,745			-			-			-			-	54,118,304	125,222,504	179,340,808
6,788,405	889,273	7,677,677	-	-	-	-	-	-	-	-	-	-	-	-	319,570,502	138,532,342	458,102,844
2,982	-	2,982			-			-			-			-	1,440,384	64,626	1,505,010
1,032	5,682	6,715			-			-			-			-	3,403	18,053	21,455
4,014	5,682	9,696	-	-	-	-	-	-	-	-	-	-	-	-	1,443,787	82,679	1,526,466
358,014	9,133	367,146			-			-			-			-	47,223,877	2,350,955	49,574,832
12,798	19,941	32,739			-			-			-			-	9,811,968	12,981,598	22,793,566
370,812	29,073	399,885	-	-	-	-	-	-	-	-	-	-	-	-	57,035,845	15,332,553	72,368,398
1,454,206	17,726	1,471,932			-			-			-			-	31,436,080	812,424	32,248,503
66,832	138,754	205,586			-			-			-			-	3,603,937	12,360,598	15,964,535
1,521,037	156,480	1,677,517	-	-	-	-	-	-	-	-	-	-	-	-	35,040,016	13,173,021	48,213,038
8,684,268	1,080,508	9,764,777	-	-	-	-	-	-	-	-	-	-	-	-	413,090,151	167,120,594	580,210,745
1,403,786	63,447	1,467,233			-			-			-			-	73,267,902	5,359,464	78,627,366
1,303,633	466,451	1,770,084			-			-			-			-	243,409,099	49,104,239	292,513,338
14,524,892	469,524	14,994,415			-			-			-			-	334,860,226	15,987,111	350,847,337
3,957,485	2,452,288	6,409,774			-			-			-			-	54,946,482	158,410,755	213,357,237
18,482,377	2,921,812	21,404,189	-	-	-	-	-	-	-	-	-	-	-	-	389,806,709	174,397,866	564,204,575
		-			-			-	18,206,157	4,442,242	22,648,399	95,745,806		95,745,806	162,942,357	10,040,335	172,982,692

Field		Market Exhibit (For Comprehensive/Major Medical Line of Business)	1 Individual			2 Small Group			3 Large Group			4 Association		
			RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All
1		**Membership Data**												
		Number of Polices or Certificates	9,598	81	9,679	28,850	4,826	33,676	36,413	23,719	60,132			-
		Number of Covered Lives	14,932	126	15,058	56,059	10,550	66,609	78,195	45,007	123,202			-
		Member Months	174,845	2,241	177,086	682,122	128,450	810,572	937,873	532,396	1,470,269			-
		Number of Polices or Certificates (**Plans with PD benefits**)	9,598	81	9,679	28,850	4,826	33,676	33,890	15,494	49,384			-
		Number of Covered Lives (**Plans with PD benefits**)	14,932	126	15,058	56,059	10,550	66,609	74,551	33,262	107,813			-
		Member Months (**Plans with PD benefits**)	174,845	2,241	177,086	682,122	128,450	810,572	893,827	390,098	1,283,925			-
2		**Premiums/Claims**												
		Premium			65,879,516			335,980,222			586,164,506			-
		Claims/Medical Expenses	53,996,443	755,993	54,752,436	234,434,546	47,302,184	281,736,730	309,640,496	177,281,884	486,922,381	-	-	-
3		**Inpatient Facility**												
		Hospital												
	1	In-state	9,392,569	78,038	9,470,607	38,984,116	3,747,470	42,731,586	58,965,563	5,912,019	64,877,581			-
	2	Out-of-state	3,557,898	108,522	3,666,420	11,775,423	8,215,856	19,991,279	10,838,825	39,467,877	50,306,701			-
	3	Total (Lines 1 + 2)	12,950,467	186,560	13,137,028	50,759,539	11,963,325	62,722,865	69,804,388	45,379,895	115,184,283	-	-	-
		SNF												
	4	In-state	413,458	-	413,458	562,642	42,563	605,205	1,052,314	55,279	1,107,593			-
	5	Out-of-state	7,789	-	7,789	43,133	45,622	88,754	5,575	326,538	332,113			-
	6	Total (Lines 4 + 5)	421,247	-	421,247	605,774	88,185	693,959	1,057,889	381,817	1,439,707	-	-	-
		Other												
	7	In-state	-	-	-	-	-	-	-	-	-			-
	8	Out-of-state	-	-	-	-	-	-	-	-	-			-
	9	Total (Lines 7 + 8)	-	-	-	-	-	-	-	-	-	-	-	-
	10	**Total Inpatient Facility (Lines 3 + 6 + 9)**	13,371,714	186,560	13,558,274	51,365,314	12,051,510	63,416,824	70,862,277	45,761,712	116,623,990	-	-	-
4		**Outpatient Facility**												
		Hospital												
	11	In-state	7,823,285	20,348	7,843,633	39,756,180	2,275,058	42,031,238	58,177,389	4,508,500	62,685,890			-
	12	Out-of-state	3,092,333	108,271	3,200,605	13,002,180	8,400,421	21,402,600	11,996,582	37,545,510	49,542,092			-
	13	Total (Lines 11 + 12)	10,915,618	128,619	11,044,237	52,758,359	10,675,479	63,433,838	70,173,972	42,054,010	112,227,982	-	-	-
		SNF												
	14	In-state	-	-	-	195	2,730	2,925	5,098	-	5,098			-
	15	Out-of-state	1,105	-	1,105	452	4,213	4,665	-	330	330			-
	16	Total (Lines 14 + 15)	1,105	-	1,105	647	6,943	7,590	5,098	330	5,428	-	-	-
		Freestanding Ambulatory Care Facility												
	17	In-state	1,108,087	7,002	1,115,089	6,853,124	407,977	7,261,101	10,739,695	708,888	11,448,583			-
	18	Out-of-state	169,768	2,408	172,176	1,664,661	741,342	2,406,003	2,081,054	4,607,490	6,688,543			-
	19	Total (Lines 17 + 18)	1,277,855	9,410	1,287,265	8,517,785	1,149,319	9,667,104	12,820,749	5,316,377	18,137,126	-	-	-
		Other												
	20	In-state	1,024,290	2,903	1,027,193	2,140,539	399,394	2,539,933	3,712,087	153,220	3,865,307			-
	21	Out-of-state	321,810	8,459	330,270	851,009	668,437	1,519,446	450,645	4,191,224	4,641,869			-
	22	Total (Lines 20 + 21)	1,346,101	11,362	1,357,462	2,991,548	1,067,830	4,059,379	4,162,732	4,344,444	8,507,176	-	-	-
	23	**Total Outpatient Facility (Lines 13 + 16 + 19 + 22)**	13,540,679	149,390	13,690,069	64,268,340	12,899,571	77,167,911	87,162,551	51,715,161	138,877,712	-	-	-
5		**Primary Care**												
	24	**Total Primary Care**	2,474,677	17,666	2,492,343	11,746,444	1,019,377	12,765,822	16,434,662	1,885,260	18,319,922			-
6		**Pharmacy**												
	25	**Total Pharmacy**	11,869,143	210,145	12,079,288	46,054,173	7,385,514	53,439,687	54,036,638	21,784,954	75,821,592			-
7		**Medical/Surgical other than primary care**												
	26	In-state	8,699,027	56,065	8,755,092	45,525,544	2,702,459	48,228,003	63,108,508	4,944,262	68,052,770			-
	27	Out-of-state	2,948,210	121,191	3,069,401	9,801,854	10,230,391	20,032,246	10,484,437	47,558,096	58,042,534			-
	28	**Total Other Medical/Surgical (Lines 26 + 27)**	11,647,237	177,257	11,824,494	55,327,398	12,932,850	68,260,248	73,592,945	52,502,359	126,095,304	-	-	-
8		**All other payments to medical providers**												
	29	**Total**	1,092,994	14,975	1,107,969	5,672,877	1,013,362	6,686,239	7,551,424	3,632,437	11,183,861			-

5			6			7			8		
Trust			Federal Employee Health Benefit Plan			Other Health Market			Total (Across all markets)		
RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All
		-			-			-	74,861	28,626	103,487
		-			-			-	149,186	55,683	204,869
		-			-			-	1,794,840	663,087	2,457,927
		-			-			-	72,338	20,401	92,739
		-			-			-	145,542	43,938	189,480
		-			-			-	1,750,794	520,789	2,271,583
		-			98,931,536			-	-	-	1,086,955,780
-	-	-	95,745,806	-	95,745,806	-	-	-	693,817,291	225,340,062	919,157,353
		-			-			-	107,342,248	9,737,526	117,079,775
		-			-			-	26,172,146	47,792,254	73,964,401
-	-	-	-	-	-	-	-	-	133,514,394	57,529,781	191,044,175
		-			-			-	2,028,414	97,842	2,126,256
		-			-			-	56,496	372,160	428,657
-	-	-	-	-	-	-	-	-	2,084,910	470,002	2,554,912
		-			-			-	-	-	-
		-			-			-	-	-	-
-	-	-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	135,599,305	57,999,783	193,599,087
		-			-			-	105,756,854	6,803,906	112,560,760
		-			-			-	28,091,095	46,054,201	74,145,297
-	-	-	-	-	-	-	-	-	133,847,949	52,858,107	186,706,057
		-			-			-	5,293	2,730	8,023
		-			-			-	1,557	4,543	6,100
-	-	-	-	-	-	-	-	-	6,850	7,273	14,123
		-			-			-	18,700,907	1,123,866	19,824,773
		-			-			-	3,915,482	5,351,240	9,266,722
-	-	-	-	-	-	-	-	-	22,616,389	6,475,106	29,091,495
		-			-			-	6,876,917	555,516	7,432,433
		-			-			-	1,623,464	4,868,120	6,491,584
-	-	-	-	-	-	-	-	-	8,500,381	5,423,636	13,924,017
-	-	-	-	-	-	-	-	-	164,971,569	64,764,123	229,735,692
		-			-			-	30,655,783	2,922,304	33,578,087
		-			-			-	111,959,953	29,380,613	141,340,566
		-			-			-	117,333,079	7,702,786	125,035,865
		-			-			-	23,234,501	57,909,679	81,144,181
-	-	-	-	-	-	-	-	-	140,567,580	65,612,465	206,180,046
		-	95,745,806		95,745,806			-	110,063,100	4,660,775	114,723,875

Blue Cross & Blue Shield of Rhode Island

Areas of Medical Expense Variation

BCBSRI performs periodic comparisons, or "benchmarking ", of its claims utilization and cost experience with those of other health plans. The comparative benchmarks are derived from a data set called Blue Health Intelligence (BHI). This data set is made up of claims and enrollment from a large number of Blue Cross and Blue Shield plans from across the country. For our benchmarking we selected an aggregated data set for five Blue Cross plans located in the northeast United States. BHI allows us to organize our claims data and that of the selected benchmark plans (and members of other Blue plans residing in their service areas) into equivalent groups of services for purposes of cost and utilization comparison.

The membership used for BCBSRI encompasses our members living within our state as well as our members residing in the service areas of the benchmark plans.

Benchmarking by PMPM Percent Variation					
Item	**BCBSRI pmpm**	**Variation from Benchmark**	**Percent Variation**	**Dollar Variation (in millions)**	**Comments**
IP Behavioral Health	$6.40	$3.37	111%	$6.0	Driven by admits
Professional BH	$10.53	$5.14	95%	$9.1	Utilization driven
NICU	$4.88	$2.09	75%	$3.7	Price and Utilization
Lab/Pathology	$23.39	$7.16	44%	$12.7	Price and Utilization
Standard Imaging	$14.95	$4.33	41%	$7.7	Price and Utilization

Blue Cross & Blue Shield of Rhode Island

Areas of Medical Expense Variation

Benchmarking by Total Dollar Variation					
Item	**BCBSRI pmpm**	**Variation from Benchmark**	**Percent Variation**	**Dollar Variation (in millions)**	**Comments**
Lab/Pathology	$23.39	$7.16	44%	$12.7	Price and Utilization
Professional BH	$10.53	$5.14	95%	$9.1	Utilization driven
Standard Imaging	$14.95	$4.33	41%	$7.7	Price and Utilization
IP Surgical	$38.32	$3.51	10%	$6.2	Price and Utilization
IP Behavioral Health	$6.40	$3.37	111%	$6.0	Driven by admits

Blue Cross & Blue Shield of Rhode Island
Group Rate Factor Review
Provider Contracting Practices and Hospital Contracting Conditions Verification Questionnaire

Part 1. Hospital Inpatient Services

Please fill out one row in the chart below for each general service institution (no specialty care, no rehab) with whom you contract in RI. Institution means hospital system if all contractual terms other than $ amounts apply identically across all inpatient facilities in the contract. Incentives refer to activities or measures resulting in additional payments by the insurer.

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Com-ments
1	**1**	**X** DRG **(effective 2012)** **X** Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting **X** Others (please specify) **Case Rates, Implant Cost**	**Yes**	If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [3] **3.0%**	__ admission reductions __ day reductions **X** process/structural changes (e.g. discharge practices) __Others (please specify)	**Yes**	

[1] Examples include supplemental payments beyond base fees for Bridges to Excellence Measure, Medicare Compare measures, HIT adoption, or customer satisfaction measures.
[2] Attach analysis and relevant documentation from contracts to demonstrate compliance status.
[3] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[4]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[5]	Com-ments
2	**3**	__DRG __Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting **X** Others (please specify) **Global Liability**	**No**	If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [6] **None**	**X** admission reductions **X** day reductions **X** process/structural changes (e.g. discharge practices) __Others (please specify) **By nature of the global/fixed reimbursement, provider directly benefits from any efficiencies gained.**	**No – contract predates the conditions**	
3	**3**	**X** DRG **X** Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	**No**	If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [7] **Hospital earned 1.4% of possible 2% in fiscal 2011**	__ admission reductions __ day reductions **X** process/structural changes (e.g. discharge practices) __Others (please specify)	**In negotiation – it is anticipated that the final agreement in 2012 will incorporate the OHIC conditions**	

[4] Examples include supplemental payments beyond base fees for Bridges to Excellence Measure, Medicare Compare measures, HIT adoption, or customer satisfaction measures.
[5] Attach analysis and relevant documentation from contracts to demonstrate compliance status.
[6] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[7] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[8]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[9]	Com-ments
4	**1**	**X** DRG **(effective 2012)** **X** Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting **X** Others (please specify) **Implant Cost**	**No**	If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [10] **3.0%**	__ admission reductions __ day reductions **X** process/structural changes (e.g. discharge practices) __Others (please specify)	**Yes**	
5	**4**	__DRG **X** Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting **X** Others (please specify) **Case Rates**	**No**	If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [11] **Hospital earned 1% of 1.2% eligible%**	__ admission reductions __ day reductions __ process/structural changes (e.g. discharge practices) __Others (please specify)	**No – contract predates conditions**	

[8] Examples include supplemental payments beyond base fees for Bridges to Excellence Measure, Medicare Compare measures, HIT adoption, or customer satisfaction measures.
[9] Attach analysis and relevant documentation from contracts to demonstrate compliance status.
[10] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[11] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[12]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[13]	Com-ments
6	**6**	__DRG **X** Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting **X** Others (please specify) **Case Rates**	**No**	If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [14] **None**	__ admission reductions __ day reductions __ process/structural changes (e.g. discharge practices) __Others (please specify)	**No – hospital under special mastership**	
7	**4**	__DRG **X** Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	**No**	If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [15] **1.2%**	__ admission reductions __ day reductions **X** process/structural changes (e.g. discharge practices) __Others (please specify)	**No – contract predates conditions**	

[12] Examples include supplemental payments beyond base fees for Bridges to Excellence Measure, Medicare Compare measures, HIT adoption, or customer satisfaction measures.
[13] Attach analysis and relevant documentation from contracts to demonstrate compliance status.
[14] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[15] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[16]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[17]	Com-ments
8	**3**	**X** DRG **X** Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	**Yes, outlier per diems paid for cases which exceed length of stay parameters**	If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [18] **1.0%**	__ admission reductions __ day reductions __ process/structural changes (e.g. discharge practices) __Others (please specify)	**In negotiation – it is anticipated that the final agreement in 2012 will incorporate the OHIC conditions**	
9	**4**	**X** DRG **(effective 2012)** **X** Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting **X** Others (please specify) **Case Rates, Implant Cost**	**Yes**	If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [19] **3.0%**	__ admission reductions __ day reductions **X** process/structural changes (e.g. discharge practices) __Others (please specify)	**Yes**	

[16] Examples include supplemental payments beyond base fees for Bridges to Excellence Measure, Medicare Compare measures, HIT adoption, or customer satisfaction measures.
[17] Attach analysis and relevant documentation from contracts to demonstrate compliance status.
[18] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[19] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[20]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[21]	Com-ments
10	**1**	**X** DRG __Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting _Others (please specify)	**No**	If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [22] **3.0%**	_ admission reductions _ day reductions **X** process/structural changes (e.g. discharge practices) __Others (please specify)	**Yes**	
11	**3**	**X** DRG **X** Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting **X** Others (please specify) **Case Rates**	**Yes**	If yes - %of total payments for inpatient services in CY 2011 spent on quality incentive payments. [23] **Hospital earned 1.9% of 2.5% eligible**	__ admission reductions __ day reductions **X** process/structural changes (e.g. discharge practices) __Others (please specify)	**Will be renegotiated this year – it is anticipated that the final agreement in 2012 will incorporate the OHIC conditions**	

[20] Examples include supplemental payments beyond base fees for Bridges to Excellence Measure, Medicare Compare measures, HIT adoption, or customer satisfaction measures.
[21] Attach analysis and relevant documentation from contracts to demonstrate compliance status.
[22] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[23] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

Additional Questions for Hospital Inpatient Services

List the five most common areas of quality and service incentives in your company's inpatient contracts:

i. **CMS Core Measures**
ii. **HCAPHS**
iii. **Transitions of Care**
iv. **CPOE**
v. **National Surgical Improvement Program**

Note: Items i, ii, & iii are part of our standard program as of 2009

Estimated Percent of total payments to RI Hospitals for inpatient services in CY 2011 spent on quality incentive payments. **1.9%**

Estimated Percent of total payments to RI Hospitals for inpatient services in CY 2011 paid through units of service based on efficient resource use (i.e. DRG, Capitation, Bundled Service or partial/global budgeting): **25% (66% as of first quarter 2012)**

Estimated Payments in first six months of CY 2011 for Inpatient Services to Hospitals as % of what Medicare would have paid for similar set. of services: **166% (calculation based on Oct 2010 – Sep 2011 time period** (add comments or caveats)

Other Comments on Quality/Efficiency Incentives in Hospital Inpatient Contracting:

Part 2. Hospital Outpatient Services

Please fill out one row in the chart below for each general service institution (no specialty care, no rehab) with whom you contract in RI. Institution means hospital system if all contractual terms other than dollar amounts apply identically across all inpatient facilities in the contract. Outpatient Services include any services not involving an admission and covered under the contract with the institution.

Institution/ System	Unit of Payment for Outpatient Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[24]?	Utilization Incentives in Contract: (check all that apply)	Comments
1	__Procedure-based methodology – using plan, provider or industry coding. . **X** APC Code (effective 2012) __Other (please specify)	If yes - % of total payments for outpatient services in CY 2011 spent on quality incentive payments. [25] **3.0%**	__ Visit/Volume Reduction **X** Others (please specify) **efficiencies gained**	
2	**X** Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	If yes - % of total payments for outpatient services in CY 2011 spent on quality incentive payments. [26] **1.2%**	__ Visit/Volume Reduction __ Others (please specify)	
3	__Procedure-based methodology – using plan, provider or industry coding. . __APC Code **X** Other (please specify) **Global Liability**	If yes - % of total payments for outpatient services in CY 2011 spent on quality incentive payments. [27] **Gateway to global funding to ensure patient quality**	**X** Visit/Volume Reduction **X** Others (please specify) **By nature of the global/ fixed reimbursement, provider directly benefits from any efficiencies gained.**	

[24] Examples include supplemental payments beyond base fees for structural changes such as HIT, process measures or customer satisfaction.
[25] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[26] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[27] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

Institution/ System	Unit of Payment for Outpatient Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[28]?	Utilization Incentives in Contract: (check all that apply)	Comments
4	**X** Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	If yes - % of total payments for outpatient services in CY 2011 spent on quality incentive payments. [29] **Hospital earned 1.4% of 2% eligible**	__ Visit/Volume Reduction __ Others (please specify)	**In negotiation – it is anticipated that the final agreement in 2012 will incorporate the OHIC conditions**
5	**X** Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	If yes - % of total payments for outpatient services in CY 2011 spent on quality incentive payments. [30] **Hospital earned 1% of 1.2% eligible**	__ Visit/Volume Reduction __ Others (please specify)	
6	_Procedure-based methodology – using plan, provider or industry coding. . **X** APC Code **(effective 2012)** __Other (please specify)	If yes - % of total payments for outpatient services in CY 2011 spent on quality incentive payments. [31] **3.0%**	__ Visit/Volume Reduction __ Others (please specify)	
7	**X** Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	If yes - % of total payments for outpatient services in CY 2011 spent on quality incentive payments. [32] **1.0%**	__ Visit/Volume Reduction __ Others (please specify)	**In negotiation – it is anticipated that the final agreement in 2012 will incorporate the OHIC conditions**

[28] Examples include supplemental payments beyond base fees for structural changes such as HIT, process measures or customer satisfaction.
[29] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[30] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[31] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[32] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

Institution/ System	Unit of Payment for Outpatient Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[33]?	Utilization Incentives in Contract: (check all that apply)	Comments
8	__Procedure-based methodology – using plan, provider or industry coding. . **X** APC Code (effective 2012) __Other (please specify)	If yes - %of total payments for outpatient services in CY 2011 spent on quality incentive payments. [34] **3.0%**	__ Visit/Volume Reduction __ Others (please specify)	
9	**X** Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	If yes - % of total payments for outpatient services in CY 2011 spent on quality incentive payments. [35] **Hospital earned 1.9% of 2.5% eligible**	__ Visit/Volume Reduction __ Others (please specify)	**In negotiation – it is anticipated that the final agreement in 2012 will incorporate the OHIC conditions**
10	__Procedure-based methodology – using plan, provider or industry coding. . **X** APC Code **(effective 2012)** __Other (please specify)	If yes - % of total payments for outpatient services in CY 2011 spent on quality incentive payments. [36] **3.0%**	__ Visit/Volume Reduction __ Others (please specify)	
11	**X** Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	If yes - % of total payments for outpatient services in CY 2011 spent on quality incentive payments. [37] **None**	__ Visit/Volume Reduction __ Others (please specify)	

[33] Examples include supplemental payments beyond base fees for structural changes such as HIT, process measures or customer satisfaction.
[34] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[35] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[36] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[37] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

Additional Questions for Hospital Outpatient Services

List the five most common areas of quality and service incentives in your company's hospital outpatient contracts:
i. ***Current quality measures relate to inpatient services only***
ii.
iii.
iv.
v.

Percent of total payments to RI Hospitals for outpatient services in CY 2011 spent on quality incentive payments. **1.9%**
Percent of total payments to RI Hospitals for outpatient services in CY 2011 paid through units of service based on efficient resource use (i.e APC, Bundled Services or partial/global budgeting**): 10% (57% as of first quarter 2012)**

Estimated Payments in first six months of CY 2011 for Outpatient Services to Hospitals as % of what Medicare would have paid for similar set of services: **171% (calculation based on Oct 2010 – Sep 2011 time period)** (add comments or caveats)

Other Comments on Quality/Efficiency Incentives in Hospital Outpatient Contracting:

Part 3: Professional Groups

- "Professional Groups" is defined as non institutional/non facility groups with a valid contract and a single tax id number.
- Please provide information for the top 10 groups (measured by $ paid in 2010), filling in one row per group (10 rows in the table total).

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[38]?	Utilization Incentives in Contract: (check all that apply)	Comments
1	**PCP**	**X** Procedure-based methodology – using CPT, plan, provider or other coding. __APC Code __ Full/ Partial Capitation __Other (please specify)	If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. [39] **Yes (18%)**	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ over all efficiency of care **X** use of pharmacy services __ Others (please specify)	
2	**Radiology**	**X** Procedure-based methodology – using CPT, plan, provider or other coding. __APC Code __ Full/ Partial Capitation __Other (please specify)	If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. [40] **No**	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ over all efficiency of care __ use of pharmacy services __ Others (please specify)	
3	**PCP**	**X** Procedure-based methodology – using CPT, plan, provider or other coding. __APC Code __ Full/ Partial Capitation __Other (please specify)	If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. [41] **Yes (20%)**	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ over all efficiency of care **X** use of pharmacy services __ Others (please specify)	

[38] Examples include supplemental payments beyond base fees for EMR adoption, structural changes, accreditation, process measures or patient satisfaction.
[39] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[40] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[41] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[38]?	Utilization Incentives in Contract: (check all that apply)	Comments
4	**Orthopedics**	**X** Procedure-based methodology – using CPT, plan, provider or other coding. __APC Code __ Full/ Partial Capitation __Other (please specify)	If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. [42] **No**	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ over all efficiency of care __ use of pharmacy services __ Others (please specify)	
5	**Surgery**	**X** Procedure-based methodology – using CPT, plan, provider or other coding. __APC Code __ Full/ Partial Capitation __Other (please specify)	If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. [43] **No**	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ over all efficiency of care __ use of pharmacy services __ Others (please specify)	
6	**Radiology**	**X** Procedure-based methodology – using CPT, plan, provider or other coding. __APC Code __ Full/ Partial Capitation __Other (please specify)	If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. [44] **No**	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ over all efficiency of care __ use of pharmacy services __ Others (please specify)	

[42] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[43] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[44] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[45]?	Utilization Incentives in Contract: (check all that apply)	Comments
7	**PCP & Multi-specialty**	**X** Procedure-based methodology – using CPT, plan, provider or other coding. __APC Code __ Full/ Partial Capitation __Other (please specify)	If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. [46] **Yes (2%)**	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ over all efficiency of care **X** use of pharmacy services __ Others (please specify)	
8	**OB**	**X** Procedure-based methodology – using CPT, plan, provider or other coding. __APC Code __ Full/ Partial Capitation __Other (please specify)	If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. [47] **No**	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ over all efficiency of care __ use of pharmacy services __ Others (please specify)	
9	**Radiation Oncology**	**X** Procedure-based methodology – using CPT, plan, provider or other coding. __APC Code __ Full/ Partial Capitation __Other (please specify)	If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. [48] **No**	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ over all efficiency of care __ use of pharmacy services __ Others (please specify)	

[45] Examples include supplemental payments beyond base fees for EMR adoption, structural changes, accreditation, process measures or patient satisfaction.
[46] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[47] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[48] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[49]?	Utilization Incentives in Contract: (check all that apply)	Comments
10	**Gastro-enterology**	**X** Procedure-based methodology – using CPT, plan, provider or other coding. __APC Code __ Full/ Partial Capitation __Other (please specify)	If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. [50] **No**	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ over all efficiency of care __ use of pharmacy services __ Others (please specify)	

Additional Questions for Professional Groups

1. List the five most common areas of quality and service incentives in your company's professional group contracts:
   - **i. Electronic medical records**
   - **ii. HEDIS**
   - **iii. NCQA Certification**
   - **iv. Management of complex members**
   - **v. Generic prescribing**

2. Percent of total payments to these ten professional groups in CY 2010 spent on quality incentive payments. **~7.7%**

[49] Examples include supplemental payments beyond base fees for EMR adoption, structural changes, accreditation, process measures or patient satisfaction.
[50] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

Below please find BCBSRI's Supplemental Response to the Provider Contracting Practices Survey as required by Footnote 2. This is intended to provide documentation of our compliance with Exhibit A, Section A to OHIC's 2011 Rate Factor Approval (RH 2011-2).

Note that this Exhibit includes redacted versions of the contractual provisions which demonstrate compliance. Unredacted versions will be submitted under separate cover.

We are requesting confidential treatment of the unredacted provisions as they contain proprietary trade secret information. These provisions include:

1. With respect to Condition #1, provisions relating to the timeframe for implementation of DRGs and APCs; and
2. With respect to Condition #3, provisions relating to the specific rates of reimbursement for quality measures.

With respect to Condition #1, no timeframe for implementation is specified in the conditions. Each hospital and carrier may have individual administrative capabilities that may warrant longer or shorter periods for implementation. This information constitutes trade secret information pursuant to RIGL Section 6-41-1 because (1) it is not generally known to the public or disclosed by either BCBSRI or the respective hospitals to the public or to third parties (other than those representing either party or to the OHIC pursuant to the Conditions), (2) has independent economic value to the parties to the contracts (for the hospitals, it may impact their financials; for BCBSRI, we derive financial benefit from having the hospital in our network and converting to DRGs and APCs in a mutually acceptable timeframe), and (3) others, particularly our competitors and other hospitals in the State, may benefit from the knowledge of this information by using it to negotiate similar provisions with BCBSRI (in the case of other hospitals) or with these and other hospitals (in the case of our competitors). Therefore, we believe this information is exempt from public disclosure under RIGL Section 38-2-2(4)(B) as it constitutes "Trade secrets and commercial or financial information obtained from a person, firm, or corporation which is of a privileged or confidential nature."

With respect to Condition #3, the hospital conditions require "at least [an] additional two percentage points" for quality metrics. Because the conditions allow for a carrier and hospital to agree to percentages over 2%, we believe that public disclosure of the actual percentages may put BCBSRI at a competitive disadvantage in the marketplace. This information constitutes trade secret information pursuant to RIGL Section 6-41-1 because (1) it is not generally known to the public or disclosed by either BCBSRI or the respective hospitals to the public or to third parties (other than those representing either party or to the OHIC pursuant to the Conditions), (2) has independent economic value to the parties to the contracts (for the hospitals, it is payment information; for BCBSRI, we derive financial benefit from having the hospital in our network and from the improved quality metrics achieved by the hospitals), and (3) others, particularly our competitors and other hospitals in the State, may benefit from the knowledge of this information by using it to negotiate similar provisions with BCBSRI (in the case of other hospitals) or with these and other hospitals (in the case of our competitors). Therefore, we believe this information is exempt from public disclosure under RIGL Section 38-2-2(4)(B) as it constitutes "Trade secrets and commercial or financial information obtained from a person, firm, or corporation which is of a privileged or confidential nature."

Therefore, we request that the unredacted version of this Exhibit be held from public disclosure pursuant to Rhode Island law. In the event a request for public disclosure is made to the OHIC

for these documents, we respectfully request that we be notified of such request so that we may pursue such remedies as may be available at law.

Summary of Compliance

Lifespan:

BCBSRI's contracts with each of the Lifespan hospitals comply with the Conditions. A description of the contract provisions demonstrating compliance are included below.

South County Hospital:

BCBSRI's contract with South County Hospital complies with the Conditions. A description of the contract provisions demonstrating compliance are included below.

Landmark Medical Center:
As the Commissioner is aware, Landmark Medical Center is currently engaged in a Special Mastership proceeding. During the course of that proceeding, BCBSRI and Landmark have agreed to extend the current contract for short durations. The current extension expires July 16, 2012. As we have verbally advised the Commissioner, we have not implemented all of the Conditions as part of the extensions. Landmark has received increases consistent with the CMS National Prospective Payment System Hospital Input Price Index; however, the other Conditions have not been adopted at this time.

During the course of conversations with bidders in the Mastership proceeding, BCBSRI has advised such organizations that any future contract with a successor organization will be in accordance with the Conditions.

Westerly Hospital:
BCBSRI's contract with Westerly Hospital is currently under negotiation. Once finalized, we will provide documentation consistent with that attached hereto.

Other Hospitals:

Our contracts with other hospitals have not yet been subject to the Conditions as specified in the July 2011 decision based on the hospitals' contract renewal cycle.

Alignment Lifespan Contract to Hospital Conditions

Condition:

1. Utilize unit of service payment methodologies for both inpatient and hospital outpatient services that realign payment to provide incentives for efficient use of health services, and are derived from nationally utilized payment practices other than fee for service, e.g. inpatient Diagnosis Related Groupings (DRGs) and outpatient Ambulatory Payment Classifications (APCs) in a form substantially derived from CMS. Nothing in this requirement prevents contract terms that provide additional or stronger payment incentives toward quality and efficiency such as performance bonuses, bundled payments, global payments or the formation of supporting functions such as Accountable Care Organizations.

Contract Provision: (Conversion to DRGS and APC based fees has occurred. The following represents contract language that we are currently formalizing to support the OHIC condition. The existing provision is also included).

The following payment provisions will be effective for inpatient admissions on or after [date redacted]:

Inpatient acute claims will be paid on the basis of Diagnosis Related Groups (DRGs).

The following payment provisions based on APC relativity based fees will be effective for dates of services on or after [date redacted]:

Existing Contract Provision:

Blue Cross and the Hospital agree to transition to Diagnostic Related Grouping (DRG) payments. [specifics redacted]

Blue Cross and the Hospital will mutually agree on a methodology to transition outpatient reimbursement on a revenue neutral basis using an agreed upon base to an APC relativity based fee. [specific redacted]

Condition:

2. Limit average annual effective rates of price increase for both inpatient and outpatient services to a weighted amount equal to or less than the Centers for Medicare and Medicaid Services (CMS) National Prospective Payment System Hospital Input Price Index ("Index"), for all contractual and optional years covered by the contract.[i] The Index applicable to the new contract year will be based on the most recent Hospital 4 Quarter Moving Average Percent Change published and available as of the signing of the contract. For renewal and optional years it will be based on the applicable most recent Index 4 Quarter Moving Average Percent Change period available prior to the new contract year.

Contract Provision:

The "Price Increase" is the most recent actual Hospital 4 Quarter Moving Average Percent Change published and available from the Centers for Medicare and Medicaid Services National Prospective Payment System Hospital Input Price Index. As of [date redacted] 2011, the Price Increase factor is [rate redacted].

Condition:

3. Provide the opportunity for hospitals to increase their total annual revenue for commercially insured enrollment under the contract by at least two (2) additional percentage points over the previous contract year by improving or attaining mutually agreed-to performance levels for no less than three nationally-accepted clinical quality, service quality or efficiency-based measures. The measures, performance levels and payouts must be articulated in the contract.

Contract Provision:

The total CY 2012 QMPIP will be [rate redacted] of the 2011 base rates. [specifics redacted]

Of the [rate redacted] %, [number redacted] percentage points will be applied [specifics redacted]that will continue for 2012 and will be based on the same quality measures currently in place[specifics redacted], with incremental modifications to the Program's expected performance as agreed to by the parties that demonstrate the parties' commitment to annual improvement in the Hospital's quality of care and outcomes.

Condition:

4. Include terms that define the parties' mutual obligations for greater administrative efficiencies, such as improvements in claims and eligibility verification processes, and identify commitments on the part of each. On or before January 1, 2012 [carrier name] shall file with OHIC, in a format approved by the Commissioner, a report identifying and describing for each hospital or hospital system contract subject to these Conditions pursuant to Para. A, above, the specific and substantive programs or initiatives designed to achieve greater administrative efficiencies, the benchmarks used to measure progress, the progress achieved by the carrier and the hospital or hospital system during the previous calendar year with respect to each program or initiative, and the planned activities of the carrier and the hospital or hospital system during the succeeding calendar year. The report shall include a demonstration that the hospital or hospital system has had an opportunity to participate in and review the report, and shall include any comments of the hospital or hospital system concerning the report. In the event a contract with a hospital or hospital system is not executed before October 1, 2011, [carrier name] shall have 90 days from the date the contract is sighed to submit a report in accordance with this Condition with respect to such contract.

Contract Provision:

Both parties agree that any opportunity to achieve greater administrative efficiencies involving the interactions between Blue Cross and Hospital could provide tangible benefits to each party and the health care delivery system. In this context, the Hospital and Blue Cross agree to engage in formal discussions in order to identify administrative efficiency opportunities, including but not limited to claims processing and eligibility verification processes.

The parties will continue to work collaboratively to establish initiatives and formalize a process to monitor and measure progress including the application of any relevant benchmarks.

Condition:

5. Include terms that promote and measure improved clinical communications between the hospital and each patient/member's designated primary care physician, specialist physicians, long term care facility, or other providers using standards developed by Quality Partners of

Rhode Island, the Beacon Program of the Rhode Island Quality Institute, or other nationally-accepted sources. On or before January 1, 2012 [carrier name] shall file with OHIC, in a format approved by the Commissioner, a report identifying and describing for each hospital or hospital system contract subject to these Conditions pursuant to Para. A, above, the specific and substantive programs or initiatives designed to achieve improved clinical communications, the benchmarks used to measure progress, the progress achieved by the carrier and the hospital or hospital system during the previous calendar year with respect to each program or initiative, and the planned activities of the carrier and the hospital or hospital system during the succeeding calendar year. The report shall include a demonstration that the hospital or hospital system has had an opportunity to participate in and review the report, and shall include any comments of the hospital or hospital system concerning the report. In the event a contract with a hospital or hospital system is not executed before October 1, 2011, [carrier name] shall have 90 days from the date the contract is sighed to submit a report in accordance with this Condition with respect to such contract.

Contract Provision:
The parties will also initiate collaborative efforts to promote and measure improved clinical communications between the Hospital and each patient/member's designated primary care physician, specialist physicians, long term care facility, or other providers. Blue Cross and the Hospital will work together to develop a process to evaluate opportunities, develop recommendations and implement efforts to achieve the aforementioned improvements.

The parties will rely on those standards developed by Quality Partners of Rhode Island, the Rhode Island Quality Institute or other nationally accepted sources.

Condition:
6. Include terms that relinquish the right of either party to contest the public release of the any and all of these five specific terms by state officials or the participating parties to the agreement; provided that the carrier or other affected party may request the Commissioner to maintain specific contract terms or portions thereof as confidential, if properly supported with legal and factual analysis justifying confidentiality.

Contract Provision:
For so long as the Hospital Contracting Conditions issued by the Office of the Health Insurance Commissioner on or about July 2, 2010 ("Conditions") (as renewed, re-issued and/or amended in future years) remain enforceable or applicable to the Agreement, each party expressly agrees to relinquish the right to contest the public release of any and all of the five specific terms of said Conditions by state officials or participating parties; provided, however, that each party may make a request to the Office of Health Insurance Commissioner to maintain specific contract terms or portions relating to said Conditions as confidential. Each party will notify the other party if such a request is being made.

Alignment South County Hospital Contract to Hospital Conditions

Condition:

1. Utilize unit of service payment methodologies for both inpatient and hospital outpatient services that realign payment to provide incentives for efficient use of health services, and are derived from nationally utilized payment practices other than fee for service, e.g. inpatient Diagnosis Related Groupings (DRGs) and outpatient Ambulatory Payment Classifications (APCs) in a form substantially derived from CMS. Nothing in this requirement prevents contract terms that provide additional or stronger payment incentives toward quality and efficiency such as performance bonuses, bundled payments, global payments or the formation of supporting functions such as Accountable Care Organizations.

Contract Provision:

The parties agree that effective [date redacted] 2012 Hospital shall be reimbursed for fee for service according to MS-DRG for inpatient services and Ambulatory Payment Classification ("APC") for outpatient services [specifics redacted]

Condition:

2. Limit average annual effective rates of price increase for both inpatient and outpatient services to a weighted amount equal to or less than the Centers for Medicare and Medicaid Services (CMS) National Prospective Payment System Hospital Input Price Index ("Index"), for all contractual and optional years covered by the contract.[ii] The Index applicable to the new contract year will be based on the most recent Hospital 4 Quarter Moving Average Percent Change published and available as of the signing of the contract. For renewal and optional years it will be based on the applicable most recent Index 4 Quarter Moving Average Percent Change period available prior to the new contract year.

Contract Provision:

Effective [date redacted] 2012, the parties agree that the mutually agreed upon increase to the fee for service rates (e.g. MS-DRG and APC) for Commercial lines of business shall be as follows [specifics redacted] The annual rate increases will be attributed as follows between the base rate increase and quality in compliance with the OHIC Hospital Conditions. [specifics redacted]

Note that for [date redacted], the formula will be adjusted accordingly based on the then current finalized CMS Index as of [date redacted]. For [date redacted'] the formula will be adjusted accordingly based on the then current finalized CMS Index as of [date redacted].

Condition:

3. Provide the opportunity for hospitals to increase their total annual revenue for commercially insured enrollment under the contract by at least two (2) additional percentage points over the previous contract year by improving or attaining mutually agreed-to performance levels for no less than three nationally-accepted clinical quality, service quality or efficiency-based measures. The measures, performance levels and payouts must be articulated in the contract.

Contract Provision:
In accordance with Office of Health Insurance Commissioner Hospital Contracting Conditions, the annual Quality-based increases [specifics redacted] will be applied prospectively to the base rates and earned consistent with the Quality Program terms for the applicable year as mutually agreed. BCBSRI Quality Program shall use industry standard criteria to determine fair and reasonable measures and targets for Hospital.

Condition:
4. Include terms that define the parties' mutual obligations for greater administrative efficiencies, such as improvements in claims and eligibility verification processes, and identify commitments on the part of each. On or before January 1, 2012 [carrier name] shall file with OHIC, in a format approved by the Commissioner, a report identifying and describing for each hospital or hospital system contract subject to these Conditions pursuant to Para. A, above, the specific and substantive programs or initiatives designed to achieve greater administrative efficiencies, the benchmarks used to measure progress, the progress achieved by the carrier and the hospital or hospital system during the previous calendar year with respect to each program or initiative, and the planned activities of the carrier and the hospital or hospital system during the succeeding calendar year. The report shall include a demonstration that the hospital or hospital system has had an opportunity to participate in and review the report, and shall include any comments of the hospital or hospital system concerning the report. In the event a contract with a hospital or hospital system is not executed before October 1, 2011, [carrier name] shall have 90 days from the date the contract is sighed to submit a report in accordance with this Condition with respect to such contract.

Contract Provision:
The parties agree to develop a Joint Operating Committee ("JOC") to monitor performance of the Agreement. This JOC will at minimum:

1. Meet quarterly to discuss operational, financial, and quality performance.
2. Assess membership increases and/or decreases.
3. Evaluate other changes which may impact the financial and quality performance of the Agreement, including case mix, utilization, and health status of the area population.
4. Other issues as needed.

Condition:
5. Include terms that promote and measure improved clinical communications between the hospital and each patient/member's designated primary care physician, specialist physicians, long term care facility, or other providers using standards developed by Quality Partners of Rhode Island, the Beacon Program of the Rhode Island Quality Institute, or other nationally-accepted sources. On or before January 1, 2012 [carrier name] shall file with OHIC, in a format approved by the Commissioner, a report identifying and describing for each hospital or hospital system contract subject to these Conditions pursuant to Para. A, above, the specific and substantive programs or initiatives designed to achieve improved clinical communications, the benchmarks used to measure progress, the progress achieved by the carrier and the hospital or hospital system during the previous calendar year with respect to each program or initiative, and the planned activities of the carrier and the hospital or hospital system during the succeeding calendar year. The report shall include a demonstration that the hospital or hospital system has had an opportunity to participate in and review the report, and shall

include any comments of the hospital or hospital system concerning the report. In the event a contract with a hospital or hospital system is not executed before October 1, 2011, [carrier name] shall have 90 days from the date the contract is sighed to submit a report in accordance with this Condition with respect to such contract.

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1. Meet quarterly to discuss operational, financial, and quality performance.
2. Assess membership increases and/or decreases.
3. Evaluate other changes which may impact the financial and quality performance of the Agreement, including case mix, utilization, and health status of the area population.
4. Other issues as needed.

Condition:
6. Include terms that relinquish the right of either party to contest the public release of the any and all of these five specific terms by state officials or the participating parties to the agreement; provided that the carrier or other affected party may request the Commissioner to maintain specific contract terms or portions thereof as confidential, if properly supported with legal and factual analysis justifying confidentiality.

Contract Provision:
For so long as the Hospital Contracting Conditions issued by the Office of the Health Insurance Commissioner on or about July 2, 2010 (the "Conditions") remain enforceable or applicable to the Agreement, each party expressly agrees to relinquish the right to contest the public release of any and all of the five specific terms of the Conditions by state officials or the participating parties Notwithstanding this provision, the parties will strive to promote transparency as it relates to areas involving clinical quality and clinical communication/collaboration.

Blue Cross & Blue Shield of Rhode Island
Group Rate Factor Filing of May 2012
Administrative Costs Request

1. 2011 Actual expenses agree with those in the Supplemental Health Care Exhibit with one adjustment. The Federal Employee Plan data is included in "Large Group" in the Supplement in accordance with NAIC instructions. However, the exhibit below does not include this data because the FEP plan is not covered by this rate factor filing. Note that there will be approximately two years of inflationary increases between 2011 Actual and 2013 Proposed values. Additionally, BCBSRI is spending increasing amounts of administrative dollars to lower the cost of medical care. Lastly, declines in enrollment result in a smaller base over which to spread fixed expenses, having an unfavorable effect on unit cost levels.

	2011 Actual		2013 Proposed[(1)]		% Change	
	Small Group	Large Group	Small Group	Large Group	Small Group	Large Group
Total Estimated Member Months	816,413	1,472,976	825,640	1,365,147	1.1%	-7.3%
Total Estimated Premiums ($pmpm)	$411.53	$395.83	$505.94	$470.32	22.9%	18.8%
Total General Administrative Expense ($pmpm)	$46.19	$38.08	$45.11	$36.63	-2.3%	-3.8%
Total Cost Containment Expense ($pmpm)	$6.80	$6.32	$6.64	$6.08	-2.3%	-3.8%
Total Other Claim Adjustment Expense ($pmpm)	$11.11	$12.82	$10.85	$12.33	-2.3%	-3.8%
Total Admin Expense ($pmpm)	$64.10	$57.22	$62.60	$55.04	-2.3%	-3.8%
Breakdown of General Administrative Expense ($ pmpm)						
a. Payroll and benefits	$14.99	$10.79	$14.64	$10.38	-2.3%	-3.8%
b. Outsourced Services (EDP, claims etc.)	$5.17	$5.06	$5.05	$4.87	-2.3%	-3.8%
c. Auditing and consulting	$2.23	$1.85	$2.18	$1.78	-2.3%	-3.8%
d. Commissions	$8.65	$6.72	$8.45	$6.47	-2.3%	-3.8%
e. Marketing and Advertising	$0.39	$0.33	$0.38	$0.31	-2.3%	-3.8%
f. Legal Expenses	$0.26	$0.21	$0.25	$0.20	-2.3%	-3.8%
g. Taxes, Licenses and Fees	$8.88	$8.61	$8.67	$8.28	-2.3%	-3.8%
h. Reimbursements by Uninsured Plans						
i. Other Admin Expenses	$5.62	$4.50	$5.48	$4.33	-2.3%	-3.8%

[(1)] For comparison purposes 2013 proposed charges represent 1st Quarter 2013 rates.

Blue Cross & Blue Shield of Rhode Island
Group Rate Factor Filing of May 2012
Administrative Costs Request

2. The following table details actual calendar year 2007-2011 fully insured commercial administrative costs. This is consistent with the annual statement filings to OHIC for administrative costs using the categories defined by NAIC financial statement and as allocated to commercially insured business only.

Fully Insured Commercial Administrative Cost History (Comprehensive Column)					
	2007	2008	2009	2010	2011
Total Premiums	**1,108,466,606**	**1,079,151,863**	**1,025,508,205**	**994,470,562**	**984,903,252**
Total General Administrative Expense	100,746,665	121,463,184	132,106,574	133,474,919	121,420,201
General Admin Exp. Ratio	9.09%	11.26%	12.88%	13.42%	12.33%
Total Fully Insured Member Months	**3,326,346**	**3,049,827**	**2,775,423**	**2,603,304**	**2,468,947**
General Administrative Expense ($pmpm)	$30.29	$39.83	$47.60	$51.27	$49.18
Breakdown of General Administrative Expenses ($ pmpm)					
a. Payroll and benefits	$17.53	$17.40	$21.04	$18.84	$19.82
b. Outsourced Services (EDP, claims etc.)	$9.28	$8.93	$8.62	$12.13	$10.75
c. Auditing and consulting	$2.20	$5.75	$6.38	$6.18	$4.55
d. Commissions	$5.49	$6.06	$6.78	$6.96	$7.21
e. Marketing and Advertising	$0.81	$0.99	$0.89	$0.72	$0.76
f. Legal Expenses	$1.02	$0.33	$0.25	$0.32	$0.40
g. Taxes, Licenses and Fees	$0.10	$3.68	$7.49	$7.79	$8.28
h. Reimbursements by Uninsured Plans [(1)]	($11.59)	($12.49)	($10.76)	($11.78)	($11.59)
i. Other Admin Expenses	$5.44	$9.18	$6.90	$10.11	$8.98
Cost Containment Expense	$4.10	$4.30	$5.73	$7.58	$7.82
Other Claim Adjustment Expense	$10.06	$13.38	$18.19	$17.42	$20.04
Total Self Insured Member Months for all affiliated companies doing business in RI	2,409,639	2,474,355	2,677,918	2,448,365	2,625,181

[(1)] Includes total reimbursements from uninsured plans, not just the portion allocated to general administrative expenses, therefore the breakdown of general expenses does not match the total listed above. The differential is the portion of self funded fees that are treated as a contra expense for cost containment and other claim adjustment expenses.

Blue Cross and Blue Shield of Rhode Island
Group Rate Factor Filing
Administrative Costs Request

3. At the request of OHIC's Health Insurance Advisory Council, please provide brief answers to the following questions:

   a. In general and net of new taxes and fees, why should the rate of increase in Health Plan administrative costs exceed the general inflation rate?

      There are a number of reasons why Health Plan Administrative Expenses might increase at a pace greater than the general rate of inflation. Major corporate infrastructure upgrades, such as the implementation of new information technology systems and the modification of operating processes, procedures and systems to comply with new Government mandates (i.e. ICD 10 and Federal Healthcare Reform), can add significantly to the level of Administrative Expenses incurred in any particular year. Initiatives designed to limit the growth of medical expenses and/or improve the quality of care (e.g. efforts to control fraud and abuse, to improve care coordination, to promote more efficient use of services, etc.) all require spending administrative dollars to control claims expense.

      In addition, significant drops in membership can have a material impact on the level of Administrative Expenses on a per member per month basis as many Administrative Expenses are fixed in nature and don't decrease as enrollment decreases.

   b. What percentage of administrative costs does your organization consider fixed for the next five years? Provide detail by expense category.

      About 56% of the expenses are fixed. The following items are variable: Staff costs for Customer Service, Medical Management, Actuarial & Underwriting Services, Sales & Marketing, Grievance & Appeals, Vendor Fees (Claims and Enrollment), Broker Commissions, Printing & Postages and BlueCard/ Consortium Fees.

   c. What administrative services are used by fully insured members that are not used by self-insured clients (e.g. broker commissions) and what are the estimated total costs ($pmpm) for those services?

      Self-insured clients use most of the same services that our fully insured customers use except for Broker Commission and Underwriting. Our average self-insured group is more than twenty times larger than our average insured Large Group customer which means that many of the expense categories will naturally cost much less on a per member basis. Also, premium taxes cannot be charged to self-insured groups.

   d. What does your plan use as its pmpm benchmarks or price points for commercial insurance administrative costs and why?

      There are a number of considerations that go into deciding on the level of administrative charges to be built into rates. The first of course is our actual expense level. In the current circumstances we are incurring significant expenses associated with the development and installation of a new core computer system. We call this project BlueTransIT. As discussed in

Blue Cross and Blue Shield of Rhode Island
Group Rate Factor Filing
Administrative Costs Request

prior filings we are not attempting to fully build these expenses into current rates but instead are amortizing these development costs over the expected useful life of the system. We feel this approach is more equitable to current customers and also a practical necessity for competitive reasons.

Even after excluding the expenses for the Blue TransIT our expense levels are beyond what we consider an affordable level. So rather than set our pricing assumptions at our current projected expense levels, we have elected to set our administrative charge levels at what we consider appropriate marketplace levels and to work at finding operational efficiencies to close the gap between our proposed pricing and actual expenses. We have embarked on a plan to close this gap.

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Health System Improvements Survey

The State of Rhode Island Office of the Health Insurance Commissioner Regulation 2 lists standards to be used by the Health Insurance Commissioner (Commissioner) for the assessment of the conduct of commercial health insurance issuers in Rhode Island for their efforts aimed at improving the efficiency and quality of health care delivery and increasing access to health care services. The standards include the following issuer activities:

1. Directing 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 these three goals

2. Participating in the development and implementation of public policy issues related to health

To assist the Commissioner in this assessment, as part of the 2012 small and large employer group rate factor review process for commercial health insurance issuers in Rhode Island, please itemize and quantify your organization's contributions of finances and other material assets to these efforts in Rhode Island in calendar year 2011 in the following table.[1]

System-wide Improvement Activity	Brief Description of Activity and How it Promotes Health Care System Quality, Access or Efficiency	Value of 2011 Issuer Contributions
Primary Care Infrastructure Support	BCBSRI provides: • Financial and in-kind support for primary care practices to transform into Patient Centered Medical Homes (PCMH). Support is inclusive of: o Infrastructure support (e.g., Nurse Care Manager (NCM), Physician Champion, Project Management, training, Behavioral health co-location, etc.) o Care management payment – payment for the added time required	~$11M

[1] The contributions can be to any entity other than a provider to improve medical and prevention services for all Rhode Islanders and to promote a coherent, integrated, and efficient statewide health care system.

System-wide Improvement Activity	Brief Description of Activity and How it Promotes Health Care System Quality, Access or Efficiency	Value of 2011 Issuer Contributions
	to appropriately manage the needs of the 'complex' members within the practice o Pay for Performance – Retrospective payment for all BCBSRI patients based on the achievement of nationally recognized clinical process and outcome measures o In kind practice transformation and redesign assistance – PCMH practices are offered added support services through BCBSRI and/or TransforMED (through a contract with BCBSRI) to facilitate practice redesign, leading to more efficient PCMH practices grounded in the principles of PCMH including team based care and pre-visit planning. Assistance is also provided in the proper and consistent use of EHR systems to complement this effort.	
CSI-RI	BCBSRI provides: • PMPM payment which covers NCM, care coordination and quality based outcomes components • In-kind support through participation in CSI Steering, Executive, and Data and Evaluation Committees	~$1.2M
Rhode Island Primary Care Educational Loan Repayment Program	BCBSRI provides: • Lump sum payment for student loan forgiveness • Participation in development of selection criteria and selection of applicants	$350,000
EHR Grant Program	BCBSRI provides:	$267,280

System-wide Improvement Activity	Brief Description of Activity and How it Promotes Health Care System Quality, Access or Efficiency	Value of 2011 Issuer Contributions
	• Financial support for both new and existing users of EHR technology. • $2,500 per practice funding for an EHR pre-implementation readiness assessment to prepare for successful implementation. • $5,000 per physician support to pay for the purchase of a certified EHR. • Additional specific program created for Community Health Centers adopting EHRs	
Quality Counts program	BCBSRI provides: Financial support for EHR adoption and quality metric reporting and results	$129,450
Blue Cross Community Flu Initiative	BCBSRI provides: • A program designed to vaccinate the uninsured in Rhode Island against Influenza • Runs Sept. - November 2011 • Results (to date- program runs through next week): □ 864 total vaccines administered □ 614 out of 864 (71.06%) were uninsured RI'ers •	$13,000
BCBSRI Wellness Van	BCBSRI provides: • Greater healthcare accessibility to all Rhode Islanders—at no cost for visitors. • Offers health screenings, on-site health and wellness services, health education, and information regarding insurance options. • Staffed by a qualified community health educator. • Year Round programming • Results (to date - programming through year end): □ 84 programs held at local nonprofit organizations □ 1567 people screened and/or educated □ 771 of those were uninsured • Free health screenings and	In Kind Approximately $13,000

System-wide Improvement Activity	Brief Description of Activity and How it Promotes Health Care System Quality, Access or Efficiency	Value of 2011 Issuer Contributions
	prevention information to approximately 9,000 Rhode Islanders, including more than 900 uninsured. • Free flu vaccination for Rhode Island's uninsured.	
Rhode Island Regional Extension Center (R REC) / currentcare Health Information Exchange	BCBSRI provides: • Financial support • Subject matter expertise on a variety of steering committees. • Provider Relations staff promote RI REC provider enrollment and assist in event planning/promotion. • Jim Purcell, former President & CEO of BCBSRI is the Chair of the Board of Directors and serves on several committees including the RIQI Operations Committee. • Peter Andruszkiewicz, President & CEO of BCBSRI, is a member of the Board of Directors.	$310,000 In Kind In Kind
ICU Collaborative	BCBSRI provides: Financial and professional support	$242,758
Rhode Island Free Clinic	BCBSRI provides: • Volunteer Support—Dr. Gus Manocchia, BCBSRI's Chief Medical Officer • Board of Directors – Mark Waggoner, VP of Contracting • Financial support for operations • Financial incentives to recruit new volunteers and expand physician volunteer network • BCBSRI Community Wellness Van offers free screenings every monthly "Lottery" night.	$50,000 In Kind
Clinica Esperanza / Hope Clinic	BCBSRI provides: • Financial support for operations • Hosted grand opening celebration in and coordinated media attention for new free clinic • BCBSRI Community Wellness Van offers free screenings at every event	$20,000
WellOne (formerly	BCBSRI provides:	$25,000

System-wide Improvement Activity	Brief Description of Activity and How it Promotes Health Care System Quality, Access or Efficiency	Value of 2011 Issuer Contributions
Northwest Community Health Center)	• Financial support of program to provide co-located behavioral health services in PCP setting	
Rhode Island Kids Count – Covering Kids RI	BCBSRI provides: • BCBSRI is Coalition Member • Participated in the Leadership Roundtables for Children with Special Health Care Needs and the DHS RIte Care Consumer Advisory Committee • Development of an Issue Brief on Preterm Births • Work to close racial and ethnic gaps in health outcomes for children and youth; will issue brief in 2011 • Ongoing support of fundraising events •	$22,500, plus In Kind support
Women's Cancer Screening Program with the RI DOH	BCBSRI provides: • Financial gift to help restart the program after increased demand caused a temporary shutdown.	TBD
Beacon Community Project	BCBSRI provides: ▪ Subject Matter expertise at a number of committee meetings aimed at aligning our PCMH program with the Beacon Community. Support is provided by Provider Relations, Medical Director, and Health Analytics staff.	In Kind
Rhode Island Health Literacy Project	BCBSRI provides: ▪ Staff support at 1 meeting per month.	In Kind
Healthy RI: National Health Reform Implementation Task Force	BCBSRI provides: ▪ Staff support at 1 meeting per month.	In Kind
Rhode Island Primary Care Educational Loan Repayment Program	BCBSRI provides: Participation in development of selection criteria and selection of applicants	In Kind
RI Breastfeeding Coalition	BCBSRI provides: • Staff support at 12 meetings per year. • Sr. level manager on board of directors. • BCBSRI is a breastfeeding friendly workplace.	In Kind

System-wide Improvement Activity	Brief Description of Activity and How it Promotes Health Care System Quality, Access or Efficiency	Value of 2011 Issuer Contributions
	Acknowledged by RIBC as a Silver level employer.	
Participation on Boards of various non-profit organizations	Executive leaders serve on a number of non-profit boards of organizations aimed at improving the health of Rhode Islanders, such as: the Rhode Island Community Food Bank, Amos House, Family Service Rhode Island, Greater Providence of YMCA, Crossroads RI, Rhode Island Free Clinic, American Red Cross, and Gateway Healthcare.	In Kind

Thank you for your cooperation.