Blue Cross Blue Shield of Rhode Island

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May 10, 2011

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, 2012 through December 1, 2012;

2) Rating Factors Applicable to Rhode Island Builders Association Subscription Rates for New and Renewal Business Effective November 1, 2012;

3) Rating Factors Applicable to Large Group Subscription Rates for New and Renewal Business Effective January 1, 2012 through December 1, 2012, including Required Early Notice Accounts Effective January 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 group commercial rating 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 during 2010 and 2011. Longer term, BCBSRI is also intensifying 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.

For instance, BCBSRI embarked on 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 $10 million in 2010 and are on track to reduce claims for insured group products by at least $45 million in 2011. Much of these savings will carry forward and reduce claims expense and premium in 2012. These programs include:

- Formulary, plan design, and pharmacy pricing changes that will result in a reduction in insured group Prescription Drug spend of approximately $18 million annually. These reductions will be incorporated into premium calculations for accounts subject to this filing. Groups renewing under this filing will see increases in the pharmacy portion of their rates in the vicinity of 5% rather than the 11-12% in the underlying trend. Moreover, the increased use of appropriate generic drugs will result in member savings through lower co-pays.

- Changes in payment policies and management for imaging services which will result in approximately $3 million in savings annually.

- Enhanced inpatient management of hospitalized members at 5 local hospitals is also expected to save about $2.3 million annually.

Additional programs to effectively moderate costs are currently under development and scheduled to be launched later in 2011 and in 2012.

This rate filing also 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. For every group premium dollar paid to Blue Cross, about 83 cents is expected to be paid to hospitals, physicians and other healthcare providers. Note that this is equivalent to a Federal MLR of about 86%.

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 several cost reduction strategies in 2010 to offset the added costs noted above. The company eliminated 102 positions in July 2010, modified our employee benefit program and implemented multiple continuous improvement efforts. The net result of these efforts is a 2011 corporate budget that is $2 million lower than actual 2010 expenditures.

Recent regulatory decisions to reduce rating trends along with existing rate inadequacies have resulted in insufficient premium levels for the benefits being provided. Thus, BCBSRI continues to incur financial losses and draw down its contingency reserves. Average rate increases less than or equal to claims trend will not be sufficient to stop these losses and will further contribute to BCBSRI's deteriorating financial stability.

Our 2010 financial results were unfavorable. While less severe than the losses we suffered in 2009, they caused our reserves to fall by $50 million since the end of 2009. As of December 31, 2010 our reserve position has fallen to 15.2% of premium. This is well 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). We therefore request approval in this filing to increase reserve contribution factors to a total of 3% of premium, plus the previously approved 0.34% for the funding of the core operating system replacement project. The reasons for this are discussed further in Exhibits I and II of this filing.

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 appreciate your consideration for our rate filing and look forward to improving healthcare affordability and quality together.

**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 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).

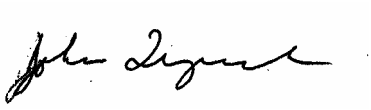
**Conclusion**

Exhibits displaying the required rating factors and detailed actuarial support documenting the factors are enclosed, including those prescribed pursuant to your Office's filing instructions letter of April 8, 2011. The exhibits and attachments for this filing are listed at the end of this letter.

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.

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

Attachments:

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

Exhibit II, *BCBSRI Group Reserve Contribution Requirements,* provides further justification for the requested reserve contribution factors.

Exhibit III, *Large Group and Small Group Rate Factor Template* as prescribed by OHIC.

Exhibit IV, *Administrative Costs Documentation*

Exhibit V, *Comparison of RI Premiums and Trends with those in other New England States*

Exhibit VI, *Provider Contracting Practices Survey*

Exhibit VII, *Resources for Health System Improvements Survey*

cc: Ms. Monica Neronha, Esquire

# BLUE CROSS & BLUE SHIELD OF RHODE ISLAND

## ACTUARIAL ASSUMPTIONS FOR GROUP COMMERCIAL RATING

### Applicable Group Rate Effective Dates

- Small Group new and renewal business for rating periods commencing January 1, 2012 through December 1, 2012
- Rhode Island Builders Association new and renewal business for the rating period commencing November 1, 2012
- Large Group new and renewal business for rating periods commencing January 1, 2012 through December 1, 2012, including required Early Notice accounts effective January 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 2010 through December 2010 over the period January 2009 through December 2009 and continuing into the future in a geometric progression so that the actual trend (percentage increase) is constant over time.

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. Regression results were impacted by a reduction in surgical cases in part caused by the movement of certain cardiac stenting procedures from inpatient to outpatient venues. This is a one-time change rather than part of a trend. In addition, we saw a decrease in maternity cases in 2009 and 2010 which we expect to rebound as the economy improves. We note also that Butler Hospital has been approved for additional beds. For these reasons it is our actuarial judgment to use a hospital inpatient utilization trend of 0%, a 1% decrease from 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. Therefore it is our actuarial judgment to use a 0.0% inpatient annual mix adjustment, the same as that approved last year.

For **Hospital Outpatient utilization/mix** trend, the standard methodology produces an annual trend of 2.79%. This is a historically low trend that we do not expect to see continue into the future. Part of this regression result stems from high trends in 2009 followed by moderating trends in 2010. Avastin costs were down by 40% due, we believe, to increased controversy within the medical community in 2010 over its use as a breast cancer therapy. In December 2010 the FDA withdrew its approval of this drug for use in breast cancer treatment. Therefore, we expect this reduction in use to be almost fully reflected in experience periods used to rate 2012 renewals and not a contributor to trend going forward. We also saw a marked reduction in CT Scans which we view as a result in large part of the tightened controls we have put in place

for imaging services. These reductions are one-time events. They represent ongoing savings but do not reduce the underlying trend in medical care costs. Therefore it is our actuarial judgment to use a trend of 3.8% which, while higher than the regressions results, is 1.4% lower than the outpatient trend approved last year and below the longer term historical average utilization trend we have experienced.

**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 2.24% is very low compared to results seen for earlier periods. Similar to the situation noted for Outpatient Hospital, higher trends experienced in 2009 followed by moderation in 2010 appear to have caused a regression result that is lower than it should be. 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. In addition we saw a significant reduction in use of CT Scans at free standing facilities. We believe this is a function of the imaging controls we have put in place which will produce ongoing savings but not a reduction in underlying trend. Therefore we request approval of an annual trend of 3.50%, which, while higher than the regression results, is 1.4 percentage points lower than that approved last year and also below historical average utilization trend we have seen in this service category.

For **Major Medical**, the projection factor has been determined by a meld of Surgical/Medical price/utilization/mix trend and Large Group Prescription Drug price/utilization/mix trend, consistent with an analysis of the percentage of Major Medical group claims in each category.

For **Prescription Drugs price/utilization/mix (**prior to adjustments for one-time changes in claim costs), separate trends were determined for Large Groups and Small Groups based on the predominant copayment configuration sold in each segment ($7/$30/$50/$75 for Large Groups; $10/$35/$60/$100 for Small Groups). The Small Group trend follows the standard methodology, using a linear regression of the most recent 13 points of 12-month moving PMPMs. For Large Group, the regression corresponding to the same number of points (13) has an identical R-Squared value (0.990), and so is used for consistency. 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 3.2%. 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.

Over the last 3 years we have seen changes in the age and gender makeup of our covered population sufficient to drive cost increases of 1% per annum. We expect this trend to continue since it is related to the ongoing "graying" of America as a whole as well to the ongoing shrinkage in the portion of the population covered by group plans.

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 2012 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 with one major hospital system and one local community hospital 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 4.5%, 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 copays. However, to derive an appropriate pricing trend we need to adjust for the leveraging impact of fixed copays and deductibles. For Large Groups, we expect factors of 0.65% and 1.75% to be necessary for medical and drug service categories respectively, and for Small Group analogous factors of 0.44% and 2.51%.

Experience Adjustment

Claims experience has emerged in 2010 and is expected to emerge in 2011 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 III). 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 1.7% for large groups and 1.3% for small groups.

Reserve Contribution Factor

As mentioned in the filing letter, the reserve contribution factors in this filing are 3.0% for both large and small group accounts, plus an 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. As detailed in Exhibit II of this filing, these factors are filed with the objective of gradually rebuilding corporate reserves to ensure the financial viability and stability of Blue Cross & Blue Shield of Rhode Island for the future, and in compliance with Risk Based Capital requirements of the Blue Cross and Blue Shield Association.

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 heath 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 2010 to offset the added costs noted above. The company eliminated 102 positions in July 2010, modified our employee benefit program and implemented multiple continuous improvement efforts. The net result of these efforts is a 2011 corporate budget that is $2 million lower than actual 2010 expenditures.

There is currently 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 IV) for explanation and justification of the administrative charge rate components shown in Exhibit III. 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.

Projected Average Rate Increases

Average rate increase values displayed on page 4 of Exhibit III are current estimates utilizing the latest available claims experience base. Actual rates for the subject rating periods will be determined using updated claims experience, and thus the resulting average rate increases are not guaranteed.

Exhibit II

# Blue Cross & Blue Shield of Rhode Island

## Group Reserve Contribution Requirements

In recent years, three separate actuarial firms have completed studies of appropriate reserve levels for Blue Cross & Blue Shield of Rhode Island (BCBSRI). All three studies concluded that BCBSRI's minimum reserve position as a percent of premium should be 23% or higher.

Appropriate reserve levels are needed for a number of reasons, but most important, to protect BCBSRI members. That's why BCBSRI's reserves must be at a level to withstand a multi-year unfavorable business cycle. There can be, and often are, many different factors that cause an unfavorable business cycle. The most significant is related to predicting the cost of future medical services.

At this point, BCBSRI is facing many challenges, including:

- An economic recession, which is straining Rhode Island's healthcare system
- A rapidly growing uninsured population
- New competition
- Decreasing enrollment
- Increasing healthcare medical trends
- Federal healthcare reform
- Cost shifting from Government payors

While recent trends have improved, commercial premium rates for current renewals are not adequate to cover expenses. This continues to strain BCBSRI's reserves.

BCBSRI has not been able to reflect premium tax and state assessments in Direct Pay rates. This shortfall must be covered by reserves. Additionally, the funding for AccessBlue will be depleted in early 2012. The AccessBlue program has been funded through grants authorized by our Board of Directors when they judged our financial circumstances allowed for such. Continuation of this important program will require further funding from reserves. With the current reserve level, the future of AccessBlue is at risk.

As of December 31, 2010, BCBSRI's reserve position is 15.2%. By any measure, this level of reserves is too low. Without adequate reserve contributions from our commercial block of business, the reserve position will deteriorate, placing the company and its members at risk.

With all of this in mind, BCBSRI is filing a 3 percent baseline contribution to reserves for Small Group and Large Group. Consistent with previous filings, BCBSRI is adding a contribution load to amortize the cost of developing and implementing a new core computer processing system. This charge will remain at 0.34 percent, and will continue until the cost of the system has been fully recouped.

Thus, the total reserve component in this filing is 3.34 percent for Small Group and Large Group.

May 10, 2011

# Blue Cross & Blue Shield of Rhode Island
## Small/Large Group Rate Filing Template
**May 2011 Filing**

**Part 1. Historical Information**

| Experience Period for Developing Trends | | Experience Period for Developing Rate Estimates | |
|---|---|---|---|
| From | To | From | To |
| 1/1/2008 | 12/31/2010 | 12/1/2009 | 11/1/2010 |

Utilization/Experience Data by Quarter (Last 12 available quarters)

**Large Group**

(000's)

| Quarter | End Date | IP Days | Member Months | Earned Premium | Incurred Claims Total | Incurred Claims IP | Incurred Claims OP | Incurred Claims RI Primary Care | Incurred Claims Other M/S | Incurred Claims Major Medical | Incurred Claims Rx | Loss Ratio |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 (oldest) | 3/31/2008 | 14,118 | 501,225 | $172,746 | $146,311 | $32,466 | $33,460 | $5,688 | $47,618 | $237 | $25,222 | 84.7% |
| 2 | 6/30/2008 | 13,269 | 480,011 | $167,644 | $142,569 | $33,212 | $32,557 | $5,309 | $46,742 | $298 | $24,001 | 85.0% |
| 3 | 9/30/2008 | 11,574 | 448,580 | $155,592 | $131,431 | $28,598 | $31,324 | $4,839 | $42,120 | $132 | $22,572 | 84.5% |
| 4 | 12/31/2008 | 12,780 | 452,803 | $158,767 | $142,590 | $33,977 | $33,049 | $5,081 | $44,524 | $125 | $23,974 | 89.8% |
| 5 | 3/31/2009 | 12,162 | 429,123 | $155,380 | $134,430 | $30,771 | $32,731 | $4,843 | $41,396 | $101 | $22,731 | 86.5% |
| 6 | 6/30/2009 | 12,116 | 431,342 | $158,566 | $142,168 | $32,875 | $34,461 | $4,974 | $44,725 | $128 | $23,123 | 89.7% |
| 7 | 9/30/2009 | 11,243 | 422,964 | $154,023 | $137,342 | $30,374 | $33,879 | $5,203 | $43,116 | $112 | $22,448 | 89.2% |
| 8 | 12/31/2009 | 10,808 | 424,918 | $155,426 | $133,890 | $28,102 | $32,207 | $5,710 | $42,461 | $127 | $23,046 | 86.1% |
| 9 | 3/31/2010 | 6,889 | 405,840 | $154,278 | $134,067 | $33,441 | $34,099 | $4,815 | $37,338 | $1,977 | $22,398 | 86.9% |
| 10 | 6/30/2010 | 9,978 | 405,459 | $151,992 | $134,327 | $26,587 | $28,765 | $4,583 | $47,245 | $2,313 | $24,834 | 88.4% |
| 11 | 9/30/2010 | 9,803 | 395,911 | $149,395 | $132,518 | $28,028 | $31,712 | $4,523 | $41,508 | $3,048 | $23,700 | 88.7% |
| 12 | 12/31/2010 | 10,194 | 388,546 | $146,897 | $132,179 | $24,322 | $27,898 | $4,588 | $49,524 | $1,224 | $24,622 | 90.0% |

(000's)

| Quarter | End Date | Quality Improvement Expense* | Other Cost Containment Expense* | Other Claim Adjustment Expense* | Other Operating Expense* | Investment Income | State Premium Taxes | Commissions | Contribution to Reserves |
|---|---|---|---|---|---|---|---|---|---|
| 1 (oldest) | 3/31/2008 | $910 | $1,510 | $6,449 | $11,793 | $3,059 | $2,082 | $3,295 | $3,455 |
| 2 | 6/30/2008 | $882 | $1,463 | $6,248 | $11,027 | $2,616 | $2,020 | $2,533 | $3,519 |
| 3 | 9/30/2008 | $818 | $1,358 | $5,798 | $8,742 | $1,835 | $1,884 | $3,004 | $4,392 |
| 4 | 12/31/2008 | $835 | $1,385 | $5,914 | $11,116 | ($4,228) | $1,918 | $3,091 | ($12,309) |
| 5 | 3/31/2009 | $1,017 | $1,731 | $7,683 | $10,698 | $1,420 | $2,996 | $3,270 | ($5,025) |
| 6 | 6/30/2009 | $1,040 | $1,770 | $7,856 | $7,849 | $2,939 | $3,043 | $3,000 | ($5,219) |
| 7 | 9/30/2009 | $1,010 | $1,719 | $7,630 | $8,391 | $2,314 | $3,104 | $3,142 | ($6,000) |
| 8 | 12/31/2009 | $1,031 | $1,755 | $7,791 | $14,521 | $228 | $3,122 | $3,051 | ($9,507) |
| 9 | 3/31/2010 | $1,028 | $1,443 | $5,625 | $8,716 | $426 | $3,045 | $2,037 | ($1,256) |
| 10 | 6/30/2010 | $1,028 | $1,443 | $5,625 | $8,716 | $426 | $3,045 | $2,037 | ($3,803) |
| 11 | 9/30/2010 | $1,028 | $1,443 | $5,625 | $8,716 | $426 | $3,045 | $2,037 | ($4,592) |
| 12 | 12/31/2010 | $1,028 | $1,443 | $5,625 | $8,716 | $426 | $3,045 | $2,037 | ($6,750) |

* These categories conform generally to the reporting in the NAIC statement.
Note: State Assessments for 2008 and 2009, which are included in the Incurred Claims Total, are corrected from last year's filing.

# Blue Cross & Blue Shield of Rhode Island
## Small/Large Group Rate Filing Template
**May 2011 Filing**

**Part 1. Historical Information (cont.)**

| Experience Period for Developing Trends | | Experience Period for Developing Rate Estimates | |
|---|---|---|---|
| From | To | From | To |
| 1/1/2008 | 12/31/2010 | 1/1/2010 | 12/31/2010 |

Utilization/Experience Data by Quarter (Last 12 available quarters)

**Small Group and Rhode Island Builders Association**

(000's)

| Quarter | End Date | IP Days | Member Months | Earned Premium | Incurred Claims Total | Incurred Claims IP | Incurred Claims OP | Incurred Claims RI Primary Care | Incurred Claims Other M/S | Incurred Claims Major Medical | Incurred Claims Rx | Loss Ratio |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 (oldest) | 3/31/2008 | 6,412 | 260,838 | $92,367 | $79,501 | $17,902 | $16,914 | $3,467 | $25,716 | $465 | $14,194 | 86.1% |
| 2 | 6/30/2008 | 6,315 | 258,652 | $92,345 | $78,847 | $17,002 | $17,421 | $3,424 | $25,913 | $458 | $14,386 | 85.4% |
| 3 | 9/30/2008 | 6,180 | 255,948 | $92,255 | $77,586 | $16,684 | $16,866 | $3,500 | $24,584 | $330 | $14,569 | 84.1% |
| 4 | 12/31/2008 | 6,116 | 252,875 | $92,750 | $77,395 | $15,689 | $17,405 | $3,559 | $24,698 | $144 | $14,861 | 83.4% |
| 5 | 3/31/2009 | 6,617 | 240,651 | $89,628 | $75,647 | $16,792 | $17,375 | $3,376 | $23,097 | $12 | $13,954 | 84.4% |
| 6 | 6/30/2009 | 5,691 | 233,280 | $87,709 | $76,748 | $16,573 | $17,517 | $3,376 | $24,541 | $0 | $13,723 | 87.5% |
| 7 | 9/30/2009 | 5,027 | 227,667 | $86,406 | $72,443 | $15,006 | $16,231 | $3,560 | $22,840 | $0 | $13,617 | 83.8% |
| 8 | 12/31/2009 | 4,863 | 220,642 | $85,468 | $72,437 | $13,743 | $17,031 | $3,752 | $23,043 | $0 | $13,707 | 84.8% |
| 9 | 3/31/2010 | 2,872 | 214,763 | $83,767 | $72,903 | $17,929 | $17,711 | $3,135 | $20,764 | $0 | $13,363 | 87.0% |
| 10 | 6/30/2010 | 4,543 | 214,394 | $85,759 | $73,424 | $14,085 | $14,643 | $3,039 | $26,400 | $0 | $15,258 | 85.6% |
| 11 | 9/30/2010 | 4,543 | 212,340 | $85,961 | $75,022 | $15,920 | $17,302 | $3,090 | $23,520 | $0 | $15,190 | 87.3% |
| 12 | 12/31/2010 | 4,318 | 208,951 | $88,639 | $76,857 | $13,580 | $14,810 | $3,199 | $29,237 | $0 | $16,031 | 86.7% |

(000's)

| Quarter | End Date | 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) | 3/31/2008 | $427 | $753 | $2,988 | $9,629 | $1,630 | $1,102 | $1,749 | ($2,152) |
| 2 | 6/30/2008 | $517 | $861 | $3,490 | $7,870 | $1,394 | $1,107 | $1,608 | ($562) |
| 3 | 9/30/2008 | $387 | $687 | $2,718 | $7,666 | $978 | $1,111 | $1,243 | $1,835 |
| 4 | 12/31/2008 | $468 | $675 | $3,560 | $8,060 | ($2,253) | $1,117 | $1,629 | ($2,407) |
| 5 | 3/31/2009 | $543 | $958 | $3,800 | $8,049 | $771 | $1,705 | $1,710 | ($2,014) |
| 6 | 6/30/2009 | $539 | $897 | $3,634 | $6,825 | $1,596 | $1,731 | $1,403 | ($2,472) |
| 7 | 9/30/2009 | $520 | $922 | $3,650 | $6,978 | $1,257 | $1,766 | $1,461 | ($77) |
| 8 | 12/31/2009 | $498 | $718 | $3,855 | $10,925 | $124 | $1,777 | $1,366 | ($5,984) |
| 9 | 3/31/2010 | $530 | $742 | $2,391 | $6,884 | $230 | $1,744 | $2,349 | ($3,546) |
| 10 | 6/30/2010 | $530 | $742 | $2,391 | $6,883 | $230 | $1,744 | $2,349 | ($2,075) |
| 11 | 9/30/2010 | $530 | $742 | $2,391 | $6,883 | $230 | $1,744 | $2,349 | ($3,471) |
| 12 | 12/31/2010 | $530 | $742 | $2,391 | $6,883 | $230 | $1,744 | $2,349 | ($2,628) |

* These categories conform generally to the reporting in the NAIC statement.
Note: State Assessments for 2008 and 2009, which are included in the Incurred Claims Total, are corrected from last year's filing.

# Blue Cross & Blue Shield of Rhode Island
## Small/Large Group Rate Filing Template
**May 2011 Filing**

**Part 2. Prospective Information**

**a. Trend Factors for Projection Purposes (Annualized)**

**Large Group**

| *2012/2011* | IP | OP | RI Primary Care | Other M/S | Major Medical[3] | Rx | Wtd Total |
|---|---|---|---|---|---|---|---|
| **Total** | ***6.38%*** | ***10.07%*** | ***14.10%*** | ***6.79%*** | ***9.60%*** | ***11.38%*** | ***8.73%*** |
| **Price** [1] | 5.69% | 5.36% | 9.53% | 2.51% | | 3.70% | 4.51% |
| **Utilization[2]** | 0.00% | 3.80% | 3.50% | 3.50% | | 5.56% | 3.16% |
| **Mix[4]** | 0.00% | | | | | | |
| **Benefit Leveraging** | 0.65% | 0.65% | 0.65% | 0.65% | | 1.75% | 0.86% |

| *2013/2012* | IP | OP | RI Primary Care | Other M/S | Major Medical[3] | Rx | Wtd Total |
|---|---|---|---|---|---|---|---|
| **Total** | ***6.32%*** | ***10.02%*** | ***13.86%*** | ***6.81%*** | ***9.46%*** | ***11.10%*** | ***8.64%*** |
| **Price** [1] | 5.63% | 5.31% | 9.30% | 2.53% | | 3.44% | 4.43% |
| **Utilization[2]** | 0.00% | 3.80% | 3.50% | 3.50% | | 5.56% | 3.16% |
| **Mix[4]** | 0.00% | | | | | | |
| **Benefit Leveraging** | 0.65% | 0.65% | 0.65% | 0.65% | | 1.75% | 0.86% |

| **Weights[5]** | **22.8%** | **25.1%** | **4.7%** | **28.5%** | **0.1%** | **18.8%** | |
|---|---|---|---|---|---|---|---|

**Small Group and Rhode Island Builders Association**

| *2012/2011* | IP | OP | RI Primary Care | Other M/S | Major Medical[3] | Rx | Wtd Total |
|---|---|---|---|---|---|---|---|
| **Total** | ***6.16%*** | ***9.84%*** | ***13.86%*** | ***6.56%*** | ***9.60%*** | ***12.21%*** | ***8.73%*** |
| **Price** [1] | 5.69% | 5.36% | 9.53% | 2.51% | | 3.70% | 4.46% |
| **Utilization[2]** | 0.00% | 3.80% | 3.50% | 3.50% | | 5.56% | 3.23% |
| **Mix[4]** | 0.00% | | | | | | |
| **Benefit Leveraging** | 0.44% | 0.44% | 0.44% | 0.44% | | 2.51% | 0.84% |

| *2013/2012* | IP | OP | RI Primary Care | Other M/S | Major Medical[3] | Rx | Wtd Total |
|---|---|---|---|---|---|---|---|
| **Total** | ***6.09%*** | ***9.79%*** | ***13.62%*** | ***6.59%*** | ***9.46%*** | ***11.93%*** | ***8.65%*** |
| **Price** [1] | 5.63% | 5.31% | 9.30% | 2.53% | | 3.44% | 4.38% |
| **Utilization[2]** | 0.00% | 3.80% | 3.50% | 3.50% | | 5.56% | 3.23% |
| **Mix[4]** | 0.00% | | | | | | |
| **Benefit Leveraging** | 0.44% | 0.44% | 0.44% | 0.44% | | 2.51% | 0.84% |

| **Weights[5]** | **21.3%** | **24.7%** | **4.9%** | **29.8%** | **0.0%** | **19.3%** | |
|---|---|---|---|---|---|---|---|

[1] Price trend also incorporates Mix for Rx.
[2] Utilization trend also incorporates Mix for Outpatient, Primary Care, and Other M/S.
[3] Major Medical is in total only, not broken down into Price, Utilization, and Mix.
[4] Inpatient Mix is the measure of the effect on average cost per unit of changes in average intensity of service, type of service, and hospital provider.
[5] For illustration purposes; not used in rating.

# Blue Cross & Blue Shield of Rhode Island
## Small/Large Group Rate Filing Template
**May 2011 Filing**

**Part 2. Prospective Information (cont.)**

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

| Large Group | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Quarter | Beginning Date | Average % Rate Increase[1] | Expected Pure Medical Cost Ratio | Expected Contribution to Reserves % [2] | Quality Improvement Expense %* | Other Cost Containment Expense %* | Other Claim Adjustment Expense %* | Other Operating Expense %*[4] | State Premium Tax % | Average Commissions %* | Investment Income Credit % |
| 1 | 1/1/2012 | 10.1% | 83.7% | 3.34% | 0.7% | 0.9% | 3.5% | 4.6% | 2.0% | 1.4% | -0.2% |
| 2 | 4/1/2012 | 9.1% | 84.0% | 3.34% | 0.7% | 0.9% | 3.4% | 4.4% | 2.0% | 1.4% | -0.2% |
| 3 | 7/1/2012 | 10.0% | 84.0% | 3.34% | 0.7% | 0.9% | 3.3% | 4.5% | 2.0% | 1.4% | -0.2% |
| 4 | 10/1/2012[3] | 11.6% | 84.0% | 3.34% | 0.7% | 0.9% | 3.2% | 4.8% | 2.0% | 1.4% | -0.2% |
| **Wtd Average** | | **10.5%** | **84.0%** | **3.34%** | **0.7%** | **0.9%** | **3.3%** | **4.6%** | **2.0%** | **1.4%** | **-0.2%** |

| Small Group | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Quarter | Beginning Date | Average % Rate Increase[1] | Expected Pure Medical Cost Ratio | Expected Contribution to Reserves % [2] | Quality Improvement Expense %* | Other Cost Containment Expense %* | Other Claim Adjustment Expense %* | Other Operating Expense %*[4] | State Premium Tax % | Average Commissions %* | Investment Income Credit % |
| 1 | 1/1/2012 | 12.1% | 82.2% | 3.34% | 0.8% | 1.0% | 3.7% | 4.4% | 2.0% | 2.8% | -0.2% |
| 2 | 4/1/2012 | 10.2% | 82.1% | 3.34% | 0.8% | 1.0% | 3.6% | 4.6% | 2.0% | 2.7% | -0.2% |
| 3 | 7/1/2012 | 9.7% | 82.1% | 3.34% | 0.7% | 1.0% | 3.6% | 4.8% | 2.0% | 2.7% | -0.2% |
| 4 | 10/1/2012 | 9.5% | 82.1% | 3.34% | 0.7% | 0.9% | 3.4% | 5.0% | 2.0% | 2.6% | -0.2% |
| **Wtd Average** | | **10.5%** | **82.1%** | **3.34%** | **0.8%** | **1.0%** | **3.6%** | **4.7%** | **2.0%** | **2.7%** | **-0.2%** |

| Rhode Island Builders Association | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Quarter | Beginning Date | Average % Rate Increase[1] | Expected Pure Medical Cost Ratio | Expected Contribution to Reserves % [2] | Quality Improvement Expense %* | Other Cost Containment Expense %* | Other Claim Adjustment Expense %* | Other Operating Expense %* | State Premium Tax % | Average Commissions %* | Investment Income Credit % |
| 1 | 11/1/2012 | 9.5% | 82.1% | 3.34% | 0.7% | 0.9% | 3.4% | 5.0% | 2.0% | 2.6% | -0.2% |

* These categories conform generally to the reporting in the NAIC statement.

[1] Rate Increases are estimated based on current experience and rates. Actual increases will differ due to use and consideration of updated experience, cancellations, new business, etc.

[2] Reserve contribution includes 3% baseline plus 0.34% to aid in the funding of ongoing capital projects.

[3] Includes January 2013 early notice renewals that utilize the same claim experience periods.

[4] Includes Rx rebates, in contrast to NAIC categorization used on Page 1 which includes rebates in claims expense.

# Blue Cross & Blue Shield of Rhode Island
## Small/Large Group Rate Filing Template
**May 2011 Filing**

**Part 2. Prospective Information (cont.)**

**c. Average Rate Increase Components**

| Large Group | Price [1] | Utilization, Mix | Total |
|---|---|---|---|
| Hospital Inpatient | 1.24% | 0.00% | 1.24% |
| Hospital Outpatient | 1.32% | 0.83% | 2.15% |
| Primary Care | 0.42% | 0.14% | 0.56% |
| Med/Surg Other than Primary Care | 0.83% | 0.87% | 1.70% |
| Pharmacy[1] | 0.91% | 0.91% | 1.82% |
| **Subtotal: Claims Component** | | | **7.47%** |
| Favorable Experience Adjustment[2] | | | -1.72% |
| Administrative Expense (aggregated) | | | 2.41% |
| Contribution to Reserves | | | 1.35% |
| Federal Taxes and Assessments | | | 0.79% |
| State Premium Tax | | | 0.21% |
| Legally Mandated Changes | | | 0.00% |
| Prior Period Adjustment (+/-) | | | 0.00% |
| **Total** | | | **10.50%** |

| Small Group | Price [1] | Utilization, Mix | Total |
|---|---|---|---|
| Hospital Inpatient | 1.09% | 0.00% | 1.09% |
| Hospital Outpatient | 1.23% | 0.80% | 2.02% |
| Primary Care | 0.48% | 0.17% | 0.65% |
| Med/Surg Other than Primary Care | 0.78% | 0.86% | 1.64% |
| Pharmacy[1] | 1.04% | 0.92% | 1.96% |
| **Subtotal: Claims Component** | | | **7.36%** |
| Favorable Experience Adjustment[2] | | | -1.32% |
| Administrative Expense (aggregated) | | | 2.11% |
| Contribution to Reserves | | | 1.35% |
| Federal Taxes and Assessments | | | 0.79% |
| State Premium Tax | | | 0.21% |
| Legally Mandated Changes | | | 0.00% |
| Prior Period Adjustment (+/-) | | | 0.00% |
| **Total** | | | **10.50%** |

[1] Pharmacy Price includes Mix.
[2] Reflects savings anticipated from MET (Medical Expense Team) efforts referred to in this filing's cover letter.

**Part 3. Retrospective Reconciliation of Experience with Filed Factors**

| Large Group | Filed Data[1] | | | | | PMPM Increase[2] | | Standard Plan PMPM[3] | | Standard Plan Increase[4] | | Approved | | Loss Ratio | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Year | Member Months | Earned Premium (000) | Incurred Claims Total (000) | Premium PMPM | Claims PMPM | Premium | Claims | Premium | Claims | Premium | Claims | Trend Increase% | Contrib to Reserves% | Actual% | Filed% |
| **2008** | 1,882,619 | 654,749 | 562,901 | $347.79 | $299.00 | | | $348.43 | $299.55 | | | 8.40% | 1.35% | 86.0% | 87.4% |
| **2009** | 1,708,347 | 623,395 | 547,829 | $364.91 | $320.68 | 4.9% | 7.3% | $369.22 | $324.47 | 6.0% | 8.3% | 9.18% | 1.35% | 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% | 8.67% | 2.00% | 88.5% | 86.0% |

| Small Group and Rhode Island Builders Association | Filed Data[1] | | | | | PMPM Increase[2] | | Standard Plan PMPM[3] | | Standard Plan Increase[4] | | Approved | | Loss Ratio | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Year | Member Months | Earned Premium (000) | Incurred Claims Total (000) | Premium PMPM | Claims PMPM | Premium | Claims | Premium | Claims | Premium | Claims | Trend Increase% | Contrib to Reserves% | Actual% | Filed% |
| **2008** | 1,028,313 | 369,717 | 313,329 | $359.54 | $304.70 | | | $354.90 | $300.77 | | | N/A[5] | N/A[5] | 84.7% | N/A[5] |
| **2009** | 922,240 | 349,211 | 297,275 | $378.65 | $322.34 | 5.3% | 5.8% | $377.56 | $321.41 | 6.4% | 6.9% | 9.38% | 1.33% | 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% | 8.82% | 2.00% | 86.7% | 84.0% |

[1] Corresponds to Historical Information data in Part 1
[2] % increase compared to prior year
[3] For most commonly held plan of benefits in 2008, and for the same plan of benefits in 2009 and 2010
[4] % increase compared to prior year
[5] Small Group rate factors were not subject to filing for 2008.

**Blue Cross & Blue Shield of Rhode Island**
**Small/Large Group Rate Filing Template**
**May 2011 Filing**

2010 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 2010 Actual and 2012 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.

| | 2010 Actual | | 2012 Proposed[(1)] | | % Change | |
|---|---|---|---|---|---|---|
| | Small Group | Large Group | Small Group | Large Group | Small Group | Large Group |
| **Total Estimated Member Months** | 850,448 | 1,595,756 | 828,540 | 1,323,518 | -2.6% | -17.1% |
| **Total Estimated Premiums ($pmpm)** | $404.64 | $377.60 | $507.46 | $470.75 | 25.4% | 24.7% |
| **Total General Administrative Expense ($pmpm)** | $51.63 | $34.59 | $45.51 | $36.51 | -11.9% | 5.6% |
| **Total Cost Containment Expense ($pmpm)** | $5.98 | $6.19 | $9.12 | $7.90 | 52.4% | 27.6% |
| **Total Other Claim Adjustment Expense ($pmpm)** | $11.24 | $14.10 | $18.91 | $16.38 | 68.2% | 16.2% |
| **Total Admin Expense PMPM** | $68.86 | $54.88 | $73.54 | $60.80 | 6.8% | 10.8% |
| | | | | | | |
| Breakdown of General Administrative Expense ($ pmpm) | | | | | | |
| a. Payroll and benefits | $12.54 | $8.46 | | | | |
| b. Outsourced Services (EDP, claims etc.) | $10.78 | $7.28 | | | | |
| c. Auditing and consulting | $3.98 | $2.69 | | | | |
| d. Commissions | $11.05 | $5.11 | | | | |
| e. Marketing and Advertising | $0.41 | $0.28 | | | | |
| f. Legal Expenses | $0.23 | $0.15 | | | | |
| g. Taxes, Licenses and Fees | $8.20 | $7.63 | | | | |
| h. Reimbursements by Uninsured Plans | | | | | | |
| i. Other Admin Expenses | $4.44 | $2.99 | | | | |

[(1)] For comparison purposes 2012 proposed charges represent 1st Quarter 2012 rates.

**Blue Cross & Blue Shield of Rhode Island**
**Small/Large Group Rate Filing Template**
**May 2011 Filing**

2. The following table details actual calendar year 2006-2010 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) | | | | | |
|---|---|---|---|---|---|
| | 2006 | 2007 | 2008 | 2009 | 2010 |
| **Total Premiums** | **1,074,800,337** | **1,108,466,606** | **1,079,151,863** | **1,025,508,205** | **994,470,562** |
| Total General Administrative Expense | 86,531,511 | 100,746,665 | 121,463,184 | 132,106,574 | 133,474,919 |
| General Admin Exp. Ratio | 8.05% | 9.09% | 11.26% | 12.88% | 13.42% |
| **Total Fully Insured Member Months** | **3,393,617** | **3,326,346** | **3,049,827** | **2,775,423** | **2,603,304** |
| General Administrative Expense ($pmpm) | $25.50 | $30.29 | $39.83 | $47.60 | $51.27 |
| | | | | | |
| Breakdown of General Administrative Expenses ($ pmpm) | | | | | |
| a. Payroll and benefits | $14.69 | $17.53 | $17.40 | $21.04 | $18.84 |
| b. Outsourced Services (EDP, claims etc.) | $6.81 | $9.28 | $8.93 | $8.62 | $12.13 |
| c. Auditing and consulting | $2.09 | $2.20 | $5.75 | $6.38 | $6.18 |
| d. Commissions | $5.43 | $5.49 | $6.06 | $6.78 | $6.96 |
| e. Marketing and Advertising | $0.83 | $0.81 | $0.99 | $0.89 | $0.72 |
| f. Legal Expenses | $0.40 | $1.02 | $0.33 | $0.25 | $0.32 |
| g. Taxes, Licenses and Fees | $0.14 | $0.10 | $3.68 | $7.49 | $7.79 |
| h. Reimbursements by Uninsured Plans [(1)] | ($18.62) | ($18.94) | ($20.42) | ($17.59) | ($18.94) |
| i. Other Admin Expenses | $6.50 | $5.44 | $9.18 | $6.90 | $9.87 |
| | | | | | |
| Cost Containment Expense | $4.13 | $4.10 | $4.30 | $5.73 | $6.12 |
| Other Claim Adjustment Expense | $8.94 | $10.06 | $13.38 | $18.19 | $12.99 |
| Total Expense PMPM | $38.57 | $44.44 | $57.50 | $71.52 | $76.27 |
| Total Expense PMPM excluding IHM / Blue TransIT | $38.57 | $44.44 | $53.89 | $64.64 | $67.84 |
| | | | | | |
| | | | | | |
| 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.

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. HIPAA, ICD 10, Federal Healthcare Reform and Medicare Regulations), 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 incurring administrative expenses.*

   *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 65% of the expenses are fixed. We can provide details assuming the following items are variable: Staff costs for Customer/Provider Service, Medical Management, Actuarial & Underwriting Services, 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 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. Additionally we are expending significant monies with our Integrated Health Management (IHM) initiative. This is an effort aimed at transforming the local health care*

*system and is expected to produce significant long term savings in medical expenses and also better health outcomes for our members. However since current costs exceed current savings we have decided that we should not build these expenses into the administrative charges we use in rating.*

*Even after excluding the expenses for the two major projects discussed above 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 5-year plan to close this gap. The administrative charge levels we are proposing to implement with this filing are comparable with the level of administrative costs being incurred by other health carriers in the New England region after adjusting for Rhode Island's heavier premium tax levels.*

# Blue Cross and Blue Shield of Rhode Island

## Comparison with Other New England Plans

The filing instructions ask us to compare the PMPM costs and rates of increase on our standard plan with their analogs for the most comparable plans in other New England states. We cannot specifically comply with this request. Other carriers' rating information is proprietary and is not available to BCBSRI. Instead we offer the following comparison drawn from the Commonwealth Funds' study *Realizing Health Reforms Potential* published in December 2010. It provides a high level comparison of average health insurance premiums and their rates of increase across New England.

For 2009, Rhode Island rates are equivalent or below the other New England states. Additionally, rate increases in Rhode Island compare favorably to the rest of New England over this time period. Note that this comparison does not adjust for benefit changes that have occurred over this time period. We do not have sufficient information to make such adjustments.

| | 2003 | | 2009 | | Percent Incr 2003-2009 | |
|---|---|---|---|---|---|---|
| State | Single | Family | Single | Family | Single | Family |
| Connecticut | $3,676 | $10,119 | $4,909 | $14,064 | 34% | 39% |
| Maine | $3,852 | $10,308 | $5,119 | $13,522 | 33% | 31% |
| Massachusetts | $3,496 | $9,867 | $5,268 | $14,723 | 51% | 49% |
| New Hampshire | $3,563 | $9,776 | $5,227 | $13,822 | 47% | 41% |
| **Rhode Island** | **$3,725** | **$9,460** | **$5,059** | **$13,608** | **36%** | **44%** |
| Vermont | $3,596 | $9,483 | $5,001 | $14,558 | 39% | 54% |

**Blue Cross & Blue Shield of Rhode Island**

Large and Small Group Rate Factor Review
Survey: Provider Contracting Practices.

*Background*
*The Health Insurance Advisory Council of the Office of the Health Insurance Commissioner has promulgated Affordability Standards for Commercial Health Insurers in Rhode Island:*

*Health plans will improve the affordability of health care in Rhode Island by focusing their efforts upon provider payment reform, beginning with primary care. Achievement of this goal will not add to overall medical spend in the short-term, and is expected to produce savings thereafter. Specific areas of focus in support of this goal are as follows:*

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

*Spread Adoption of the "Chronic Care Model" Medical Home*

*Standardize electronic medical record (EMR) incentives*

*Work toward comprehensive payment reform across the delivery system*

To support standard four, OHIC has issued in connection with its review of 2010 large and small group rate factors six conditions for health insurer contracts with hospitals in Rhode Island, to be implemented by health insurers upon contract execution, renewal or extension (see OHIC's July 2010 Rate Factor Decision – Additional Conditions, for the complete text of the conditions)**:**

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.
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
3. Provide the opportunity for hospitals to increase their total annual revenue for commercially insured enrollment under the contract by at least an additional two 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.
4. Include terms that define the parties' mutual obligations for greater administrative efficiencies,
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.
6. Include terms that explicitly 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.

Part 1. Hospital Inpatient Services

| 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 2010 Rate Factor Decision – Additional Conditions?[2] | Comments |
|---|---|---|---|---|---|---|---|
| 1 | 4 | __ DRG<br>X Per Diem<br>__ % of Charges<br>__ Bundled Services<br>__ Capitation or other budgeting<br>X Others (please specify) Case Rates, Implant Cost | Claims above a specified charge threshold were paid at a percent of charge through 12/31/2010 – this provision was eliminated as of 1/1/2011. | If yes - % of total payments for inpatient services in CY 2010 spent on quality incentive payments. [3]<br>0.40% | admission reductions<br>__ day reductions<br>X process/structural changes (e.g. discharge practices)<br>__ Others (please specify) | Yes<br>A new agreement in effect for 2011 incorporated provisions that comply with the OHIC conditions, including conversion to DRG fee schedules in 2011 | |

[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 2010 Rate Factor Decision – Additional Conditions?[5] | Comments |
|---|---|---|---|---|---|---|---|
| 2 | 3 | __ DRG<br>__ Per Diem<br>__ % of Charges<br>__ Bundled Services<br>__ Capitation or other budgeting<br>X Others (please specify) Global Liability | No | If yes - % of total payments for inpatient services in CY 2010 spent on quality incentive payments. [6]<br><br>None | X admission reductions<br>X day reductions<br>X process/structural changes (e.g. discharge practices)<br>__Others (please specify)<br><br>By nature of the global/fixed reimbursement, provider directly benefits from any efficiencies gained. | Yes<br>A new agreement in effect for 2011 incorporated provisions that comply with 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.

| 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)[7]? | Utilization Incentives in Contract: (check all that apply) | Does this contract comply with OHIC's July 2010 Rate Factor Decision – Additional Conditions?[8] | Comments |
|---|---|---|---|---|---|---|---|
| 3 | 3 | X DRG<br>X Per Diem<br>__ % of Charges<br>__ Bundled Services<br>__ Capitation or other budgeting<br>__ Others (please specify) | No | If yes - % of total payments for inpatient services in CY 2010 spent on quality incentive payments. [9]<br>1% -<br><br>Hospital earned 1% of possible 2% in fiscal 2010. | __ admission reductions<br>__ day reductions<br>X process/structural changes (e.g. discharge practices)<br>__ Others (please specify) | N/A | |

[7] Examples include supplemental payments beyond base fees for Bridges to Excellence Measure, Medicare Compare measures, HIT adoption, or customer satisfaction measures.
[8] Attach analysis and relevant documentation from contracts to demonstrate compliance status.
[9] % 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)[10]? | Utilization Incentives in Contract: (check all that apply) | Does this contract comply with OHIC's July 2010 Rate Factor Decision – Additional Conditions?[11] | Comments |
|---|---|---|---|---|---|---|---|
| 4 | 4 | __ DRG<br>X Per Diem<br>__ % of Charges<br>__ Bundled Services<br>__ Capitation or other budgeting<br>X_Others (please specify) Implant Cost | Claims above a specified charge threshold were paid at a percent of charge through 12/31/2010 – this provision was eliminated as of 12/31/10 | If yes - % of total payments for inpatient services in CY 2010 spent on quality incentive payments. [12]<br><br>0.40% | __ admission reductions<br>__ day reductions<br>X process/structural changes (e.g. discharge practices)<br>__ Others (please specify) | Yes<br>A new agreement in effect for 2011 incorporated provisions that comply with the OHIC conditions, including conversion to DRG fee schedules in 2011 | |

[10] Examples include supplemental payments beyond base fees for Bridges to Excellence Measure, Medicare Compare measures, HIT adoption, or customer satisfaction measures.
[11] Attach analysis and relevant documentation from contracts to demonstrate compliance status.
[12] % 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)[13]? | Utilization Incentives in Contract: (check all that apply) | Does this contract comply with OHIC's July 2010 Rate Factor Decision – Additional Conditions?[14] | Comments |
|---|---|---|---|---|---|---|---|
| 5 | 3 | __ DRG<br>X Per Diem<br>__ % of Charges<br>__ Bundled Services<br>__ Capitation or other budgeting<br>X Others (please specify) Case Rates | No | If yes - % of total payments for inpatient services in CY 2010 spent on quality incentive payments. [15]<br><br>3.0% | __ admission reductions<br>__ day reductions<br>__ process/structural changes (e.g. discharge practices)<br>__ Others (please specify) | N/A | |

[13] Examples include supplemental payments beyond base fees for Bridges to Excellence Measure, Medicare Compare measures, HIT adoption, or customer satisfaction measures.
[14] Attach analysis and relevant documentation from contracts to demonstrate compliance status.
[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 2010 Rate Factor Decision – Additional Conditions?[17] | Comments |
|---|---|---|---|---|---|---|---|
| 6 | 5 | __ DRG<br>X Per Diem<br>__ % of Charges<br>__ Bundled Services<br>__ Capitation or other budgeting<br>X Others (please specify) Case Rates | No | If yes - % of total payments for inpatient services in CY 2010 spent on quality incentive payments. [18]<br><br>None | __ admission reductions<br>__ day reductions<br>__ process/structural changes (e.g. discharge practices)<br>__ Others (please specify) | In negotiation – it is anticipated that the final agreement in 2011 will incorporate the OHIC conditions, including conversion to DRG reimbursement, and also including agreement on quality. | |

[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.

| 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)[19]? | Utilization Incentives in Contract: (check all that apply) | Does this contract comply with OHIC's July 2010 Rate Factor Decision – Additional Conditions?[20] | Comments |
|---|---|---|---|---|---|---|---|
| 7 | 3 | __ DRG<br>X Per Diem<br>__ % of Charges<br>__ Bundled Services<br>__ Capitation or other budgeting<br>__ Others (please specify) | No | If yes - % of total payments for inpatient services in CY 2010 spent on quality incentive payments. [21]<br><br>3.0% | __ admission reductions<br>__ day reductions<br>_X process/structural changes (e.g. discharge practices)<br>__ Others (please specify) | N/A | |

[19] Examples include supplemental payments beyond base fees for Bridges to Excellence Measure, Medicare Compare measures, HIT adoption, or customer satisfaction measures.
[20] Attach analysis and relevant documentation from contracts to demonstrate compliance status.
[21] % 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)[22]? | Utilization Incentives in Contract: (check all that apply) | Does this contract comply with OHIC's July 2010 Rate Factor Decision – Additional Conditions?[23] | Comments |
|---|---|---|---|---|---|---|---|
| 8 | 2 | X DRG<br>X Per Diem<br>__ % of Charges<br>__ Bundled Services<br>__ Capitation or other budgeting<br>__ 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 2010 spent on quality incentive payments. [24]<br><br>1.0% | __ admission reductions<br>__ day reductions<br>__ process/structural changes (e.g. discharge practices)<br>__ Others (please specify) | N/A | |

[22] Examples include supplemental payments beyond base fees for Bridges to Excellence Measure, Medicare Compare measures, HIT adoption, or customer satisfaction measures.
[23] Attach analysis and relevant documentation from contracts to demonstrate compliance status.
[24] % 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)[25]? | Utilization Incentives in Contract: (check all that apply) | Does this contract comply with OHIC's July 2010 Rate Factor Decision – Additional Conditions?[26] | Comments |
|---|---|---|---|---|---|---|---|
| 9 | 4 | __ DRG<br>X Per Diem<br>__ % of Charges<br>__ Bundled Services<br>__ Capitation or other budgeting<br>X Others (please specify) Case Rates, Implant Cost | Claims above a specified charge threshold were paid at a percent of charge through 12/31/2010 – this provision was eliminated as of 1/1/2011. | If yes - % of total payments for inpatient services in CY 2010 spent on quality incentive payments. [27]<br><br>0.40% | __ admission reductions<br>__ day reductions<br>X process/structural changes (e.g. discharge practices)<br>__ Others (please specify) | Yes<br>A new agreement in effect for 2011 incorporated provisions that comply with the OHIC conditions, including conversion to DRG fee schedules in 2011. | |

[25] Examples include supplemental payments beyond base fees for Bridges to Excellence Measure, Medicare Compare measures, HIT adoption, or customer satisfaction measures.
[26] Attach analysis and relevant documentation from contracts to demonstrate compliance status.
[27] % 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)[28]? | Utilization Incentives in Contract: (check all that apply) | Does this contract comply with OHIC's July 2010 Rate Factor Decision – Additional Conditions?[29] | Comments |
|---|---|---|---|---|---|---|---|
| 10 | 3 | __ DRG<br>__ Per Diem<br>__ % of Charges<br>__ Bundled Services<br>__ Capitation or other budgeting<br>X Others (please specify) Global Liability | No | If yes - % of total payments for inpatient services in CY 2010 spent on quality incentive payments. [30]<br><br>None | X admission reductions<br>X day reductions<br>X process/structural changes (e.g. discharge practices)<br>__ Others (please specify)<br><br>By nature of the global/fixed reimbursement, provider directly benefits from any efficiencies gained. | Yes<br>A new agreement in effect for 2011 incorporated provisions that comply with the OHIC conditions. | |

[28] Examples include supplemental payments beyond base fees for Bridges to Excellence Measure, Medicare Compare measures, HIT adoption, or customer satisfaction measures.
[29] Attach analysis and relevant documentation from contracts to demonstrate compliance status.
[30] % 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)[31]? | Utilization Incentives in Contract: (check all that apply) | Does this contract comply with OHIC's July 2010 Rate Factor Decision – Additional Conditions?[32] | Comments |
|---|---|---|---|---|---|---|---|
| 11 | 3 | X DRG<br>X Per Diem<br>__ % of Charges<br>__ Bundled Services<br>__ Capitation or other budgeting<br>X Others (please specify) Case Rates | Yes | If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. [33]<br><br>2.5% | __ admission reductions<br>__ day reductions<br>X process/structural changes (e.g. discharge practices)<br>__ Others (please specify) | N/A | |

[31] Examples include supplemental payments beyond base fees for Bridges to Excellence Measure, Medicare Compare measures, HIT adoption, or customer satisfaction measures.
[32] Attach analysis and relevant documentation from contracts to demonstrate compliance status.
[33] % 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)[34]? | Utilization Incentives in Contract: (check all that apply) | Does this contract comply with OHIC's July 2010 Rate Factor Decision – Additional Conditions?[35] | Comments |
|---|---|---|---|---|---|---|---|
| | | __ DRG<br>__ Per Diem<br>__ % of Charges<br>__ Bundled Services<br>__ Capitation or other budgeting<br>__ Others (please specify) | | If yes - % of total payments for inpatient services in CY 2010 spent on quality incentive payments. [36]<br><br>_____ | __ admission reductions<br>__ day reductions<br>__ process/structural changes (e.g. discharge practices)<br>__ Others (please specify) | | |

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: 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 2010 spent on quality incentive payments: 1.3% (reflects total quality dollars divided by total payments). CY 2011 estimated to increase to 2.2%

Estimated Percent of total payments to RI Hospitals for inpatient services in CY 2010 paid through units of service based on efficient resource use (i.e DRG, Capitation, Bundled Service or partial/global budgeting): 16.4% (projected to increase to 64% by the end of CY 2011)

Estimated Payments in first six months of CY 2010 for Inpatient Services to Hospitals as % of what Medicare would have paid for similar set. of services: ___152% (calculation based on Oct 2009 – Sep 2010

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

Part 2. Hospital Outpatient Services

| Institution/ System | Unit of Payment for Outpatient Services (check all that apply) | Are there Quality or Customer Service Incentives in Contract (y/n)[37]? | Utilization Incentives in Contract: (check all that apply) | Comments |
|---|---|---|---|---|
| 1 | __ Procedure-based methodology – using plan, provider or industry coding. .<br>__ APC Code<br>X Other (please specify) Global Liability | If yes - % of total payments for outpatient services in CY 2010 spent on quality incentive payments. [38] Gateway to global funding to ensure patient quality<br><br>None | X Visit/Volume Reduction<br>X Others (please specify)<br>By nature of the global/fixed reimbursement, provider directly benefits from any efficiencies gained. | A new agreement in effect for 2011 incorporated provisions that comply with the OHIC conditions. |

| Institution/ System | Unit of Payment for Outpatient Services (check all that apply) | Are there Quality or Customer Service Incentives in Contract (y/n)[39]? | Utilization Incentives in Contract: (check all that apply) | Comments |
|---|---|---|---|---|
| 2 | X Procedure-based methodology – using plan, provider or industry coding. .<br>__ APC Code<br>__ Other (please specify) | If yes - % of total payments for outpatient services in CY 2010 spent on quality incentive payments. [40]<br><br>3.0% | __ Visit/Volume Reduction<br>__ Others (please specify) | |

[37] Examples include supplemental payments beyond base fees for structural changes such as HIT, process measures or customer satisfaction.
[38] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[39] Examples include supplemental payments beyond base fees for structural changes such as HIT, process measures or customer satisfaction.
[40] % 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)[41]? | Utilization Incentives in Contract: (check all that apply) | Comments |
|---|---|---|---|---|
| 3 | __ Procedure-based methodology – using plan, provider or industry coding. .<br>__ APC Code<br>X Other (please specify)<br>Global Liability | If yes - % of total payments for outpatient services in CY 2010 spent on quality incentive payments. [42]<br>Gateway to global funding to ensure patient quality | X Visit/Volume Reduction<br>X Others (please specify)<br>By nature of the global/fixed reimbursement, provider directly benefits from any efficiencies gained. | A new agreement in effect for 2011 incorporated provisions that comply with the OHIC conditions. |

| Institution/ System | Unit of Payment for Outpatient Services (check all that apply) | Are there Quality or Customer Service Incentives in Contract (y/n)43? | Utilization Incentives in Contract: (check all that apply) | Comments |
|---|---|---|---|---|
| 4 | X Procedure-based methodology – using plan, provider or industry coding.<br>__ APC Code<br>__ Other (please specify) | If yes - % of total payments for outpatient services in CY 2010 spent on quality incentive payments. 44<br><br>1% - hospital earned 1% of possible 2% in fiscal 2010 | __ Visit/Volume Reduction<br>__ Others (please specify) | |

[41] Examples include supplemental payments beyond base fees for structural changes such as HIT, process measures or customer satisfaction.
[42] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[43] Examples include supplemental payments beyond base fees for structural changes such as HIT, process measures or customer satisfaction.
[44] % 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)45? | Utilization Incentives in Contract: (check all that apply) | Comments |
|---|---|---|---|---|
| 5 | X Procedure-based methodology – using plan, provider or industry coding.<br>__ APC Code<br>__ Other (please specify) | If yes - % of total payments for outpatient services in CY 2010 spent on quality incentive payments. 46<br><br>3.0% | __ Visit/Volume Reduction<br>__ Others (please specify) | |

| Institution/ System | Unit of Payment for Outpatient Services (check all that apply) | Are there Quality or Customer Service Incentives in Contract (y/n)[47]? | Utilization Incentives in Contract: (check all that apply) | Comments |
|---|---|---|---|---|
| 6 | X Procedure-based methodology – using plan, provider or industry coding. .<br>__ APC Code<br>__ Other (please specify) | If yes - % of total payments for outpatient services in CY 2010 spent on quality incentive payments. [48]<br><br>0.40% | __ Visit/Volume Reduction<br>__ Others (please specify) | A new agreement in effect for 2011 incorporated provisions that comply with the OHIC conditions, including conversion to APC fee schedules in 2011 |

| Institution/ System | Unit of Payment for Outpatient 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 |
|---|---|---|---|---|
| 7 | X Procedure-based methodology – using plan, provider or industry coding.<br>__ APC Code<br>__ Other (please specify) | If yes - % of total payments for outpatient services in CY 2010 spent on quality incentive payments. [50]<br><br>1.0% | __ Visit/Volume Reduction<br>__ Others (please specify) | |

[45] Examples include supplemental payments beyond base fees for structural changes such as HIT, process measures or customer satisfaction.
[46] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[47] Examples include supplemental payments beyond base fees for structural changes such as HIT, process measures or customer satisfaction.
[48] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[49] Examples include supplemental payments beyond base fees for structural changes such as HIT, process measures or customer satisfaction.
[50] % 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)[51]? | Utilization Incentives in Contract: (check all that apply) | Comments |
|---|---|---|---|---|
| 8 | X Procedure-based methodology – using plan, provider or industry coding. .<br>__ APC Code<br>__ Other (please specify) | If yes - %of total payments for outpatient services in CY 2010 spent on quality incentive payments. [52]<br><br>0.40% | __ Visit/Volume Reduction<br>__ Others (please specify) | A new agreement in effect for 2011 incorporated provisions that comply with the OHIC conditions, including conversion to APC fee schedules in 2011 |

| Institution/ System | Unit of Payment for Outpatient Services (check all that apply) | Are there Quality or Customer Service Incentives in Contract (y/n)[53]? | Utilization Incentives in Contract: (check all that apply) | Comments |
|---|---|---|---|---|
| 9 | X Procedure-based methodology – using plan, provider or industry coding. .<br>__ APC Code<br>__ Other (please specify) | If yes - % of total payments for outpatient services in CY 2010 spent on quality incentive payments. [54]<br><br>2.5% | __ Visit/Volume Reduction<br>__ Others (please specify) | |

| Institution/ System | Unit of Payment for Outpatient Services (check all that apply) | Are there Quality or Customer Service Incentives in Contract (y/n)[55]? | Utilization Incentives in Contract: (check all that apply) | Comments |
|---|---|---|---|---|
| 10 | X Procedure-based methodology – using plan, provider or industry coding. .<br>__ APC Code<br>__ Other (please specify) | If yes - % of total payments for outpatient services in CY 2010 spent on quality incentive payments. [56]<br><br>0.40% | __ Visit/Volume Reduction<br>__ Others (please specify) | A new agreement in effect for 2011 incorporated provisions that comply with the OHIC conditions, including conversion to APC fee schedules in 2011. |

[51] Examples include supplemental payments beyond base fees for structural changes such as HIT, process measures or customer satisfaction.
[52] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[53] Examples include supplemental payments beyond base fees for structural changes such as HIT, process measures or customer satisfaction.
[54] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[55] Examples include supplemental payments beyond base fees for structural changes such as HIT, process measures or customer satisfaction.
[56] % 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)[57]? | Utilization Incentives in Contract: (check all that apply) | Comments |
|---|---|---|---|---|
| 11 | X Procedure-based methodology – using plan, provider or industry coding. .<br>__ APC Code<br>__ Other (please specify) | If yes - % of total payments for outpatient services in CY 2010 spent on quality incentive payments. [58]<br><br>None | __ Visit/Volume Reduction<br>__ Others (please specify) | In negotiation – it is anticipated that the final agreement in 2011 will incorporate the OHIC conditions, including conversion to APC reimbursement, and also including agreement on quality. |

[57] Examples include supplemental payments beyond base fees for structural changes such as HIT, process measures or customer satisfaction.
[58] % 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 2010 spent on quality incentive payments. %1.3% (reflects total quality dollars divided by total payments). CY 2011 estimated to increase to 2.2%
Percent of total payments to RI Hospitals for outpatient services in CY 2010 paid through units of service based on efficient resource use (i.e APC, Bundled Services or partial/global budgeting): 9.4% (projected to increase to 60.8% by the end of CY 2011)

Estimated Payments in first six months of CY 2010 for Outpatient Services to Hospitals as % of what Medicare would have paid for similar set. of services: _165% (calculation based on Oct 2009 – Sep 2010 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)[59]? | Utilization Incentives in Contract: (check all that apply) | Comments |
|---|---|---|---|---|---|
| 1 | PCP | X Procedure-based methodology – using CPT, plan, provider or other coding. .<br>__APC Code<br>__ Full/ Partial Capitation<br>__Other (please specify) | If yes - % of total payments in CY 2010 spent on quality incentive payments. [60]<br><br>Yes Approx 11% | __ Visit/Volume Reduction<br>__ use of ancillary/referred services<br>__ use of diagnostic tests<br>__ over all efficiency of care<br>X use of pharmacy services<br>__ Others (please specify) | |

[59] Examples include supplemental payments beyond base fees for EMR adoption, structural changes, accreditation, process measures or patient satisfaction.
[60] % 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)[61]? | Utilization Incentives in Contract: (check all that apply) | Comments |
|---|---|---|---|---|---|
| 2 | Radiology | X Procedure-based methodology – using CPT, plan, provider or other coding.<br>__ APC Code<br>__ Full/ Partial Capitation<br>__ Other (please specify) | If yes - % of total payments in CY 2010 spent on quality incentive payments. [62]<br><br>None | __ Visit/Volume Reduction<br>__ use of ancillary/referred services<br>__ use of diagnostic tests<br>__ over all efficiency of care<br>__ use of pharmacy services<br>__ Others (please specify) | |

| Group | Specialty Type | Unit of Payment for Services (check all that apply) | Are there Quality or Customer Service Incentives in Contract (y/n)[63]? | Utilization Incentives in Contract: (check all that apply) | Comments |
|---|---|---|---|---|---|
| 3 | Ortho | X Procedure-based methodology – using CPT, plan, provider or other coding.<br>__ APC Code<br>__ Full/ Partial Capitation<br>__ Other (please specify) | If yes - % of total payments in CY 2010 spent on quality incentive payments. [64]<br><br>None | __ Visit/Volume Reduction<br>__ use of ancillary/referred services<br>__ use of diagnostic tests<br>__ over all efficiency of care<br>__ use of pharmacy services<br>__ Others (please specify) | |

| Group | Specialty Type | Unit of Payment for Services (check all that apply) | Are there Quality or Customer Service Incentives in Contract (y/n)[1]? | Utilization Incentives in Contract: (check all that apply) | Comments |
|---|---|---|---|---|---|
| 4 | PCP | X Procedure-based methodology – using CPT, plan, provider or other coding. .<br>__ APC Code<br>__ Full/ Partial Capitation<br>__ Other (please specify) | If yes - % of total payments in CY 2010 spent on quality incentive payments. [1]<br><br>Yes: Approx 4.2%:<br>Primarily Quality in nature | __ Visit/Volume Reduction<br>__ use of ancillary/referred services<br>__ use of diagnostic tests<br>__ over all efficiency of care<br>X use of pharmacy services<br>__ Others (please specify) | |

[61] Examples include supplemental payments beyond base fees for EMR adoption, structural changes, accreditation, process measures or patient satisfaction.
[62] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[63] Examples include supplemental payments beyond base fees for EMR adoption, structural changes, accreditation, process measures or patient satisfaction.
[64] % 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)[65]? | Utilization Incentives in Contract: (check all that apply) | Comments |
|---|---|---|---|---|---|
| 5 | Surgery | X Procedure-based methodology – using CPT, plan, provider or other coding. .<br>__ APC Code<br>__ Full/ Partial Capitation<br>__ Other (please specify) | If yes - % of total payments services in CY 2010 spent on quality incentive payments. [66]<br><br>None | __ Visit/Volume Reduction<br>__ use of ancillary/referred services<br>__ use of diagnostic tests<br>__ over all efficiency of care<br>__ use of pharmacy services<br>__ Others (please specify) | |

| Group | Specialty Type | Unit of Payment for Services (check all that apply) | Are there Quality or Customer Service Incentives in Contract (y/n)[67]? | Utilization Incentives in Contract: (check all that apply) | Comments |
|---|---|---|---|---|---|
| 6 | Multi-spec & PCP | X Procedure-based methodology – using CPT, plan, provider or other coding.<br>__ APC Code<br>__ Full/ Partial Capitation<br>__ Other (please specify) | If yes - % of total payments in CY 2010 spent on quality incentive payments. [68]<br><br>Yes: Approx 15% | __ Visit/Volume Reduction<br>__ use of ancillary/referred services<br>__ use of diagnostic tests<br>__ over all efficiency of care<br>X use of pharmacy services<br>__ Others (please specify) | |

[65] Examples include supplemental payments beyond base fees for EMR adoption, structural changes, accreditation, process measures or patient satisfaction.
[66] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[67] Examples include supplemental payments beyond base fees for EMR adoption, structural changes, accreditation, process measures or patient satisfaction.
[68] % 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)[69]? | Utilization Incentives in Contract: (check all that apply) | Comments |
|---|---|---|---|---|---|
| 7 | Rad Onc | _X_ Procedure-based methodology – using CPT, plan, provider or other coding. .<br>__APC Code<br>__ Full/ Partial Capitation<br>__Other (please specify) | If yes - % of total payments in CY 2010 spent on quality incentive payments. [70]<br>None | __ Visit/Volume Reduction<br>__use of ancillary/referred services<br>__ use of diagnostic tests<br>__ over all efficiency of care<br>__ use of pharmacy services<br>__ Others (please specify) | |

| Group | Specialty Type | Unit of Payment for Services (check all that apply) | Are there Quality or Customer Service Incentives in Contract (y/n)[71]? | Utilization Incentives in Contract: (check all that apply) | Comments |
|---|---|---|---|---|---|
| 8 | OB/GYN | X Procedure-based methodology – using CPT, plan, provider or other coding. .<br>__ APC Code<br>__ Full/ Partial Capitation<br>__ Other (please specify) | If yes - % of total payments in CY 2010 spent on quality incentive payments. [72]<br><br>None | __ Visit/Volume Reduction<br>__ use of ancillary/referred services<br>__ use of diagnostic tests<br>__ over all efficiency of care<br>__ use of pharmacy services<br>__ Others (please specify) | |

[69] Examples include supplemental payments beyond base fees for EMR adoption, structural changes, accreditation, process measures or patient satisfaction.
[70] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.
[71] Examples include supplemental payments beyond base fees for EMR adoption, structural changes, accreditation, process measures or patient satisfaction.
[72] % 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)[73]? | Utilization Incentives in Contract: (check all that apply) | Comments |
|---|---|---|---|---|---|
| 9 | Surgery | X Procedure-based methodology – using CPT, plan, provider or other coding.<br>__ APC Code<br>__ Full/ Partial Capitation<br>__ Other (please specify) | If yes - %of total payments in CY 2010 spent on quality incentive payments. [74]<br><br>None | __ Visit/Volume Reduction<br>__ use of ancillary/referred services<br>__ use of diagnostic tests<br>X over all efficiency of care<br>__ use of pharmacy services<br>__ Others (please specify) | |

| Group | Specialty Type | Unit of Payment for Services (check all that apply) | Are there Quality or Customer Service Incentives in Contract (y/n)[75]? | Utilization Incentives in Contract: (check all that apply) |
|---|---|---|---|---|
| 10 | PCP | X Procedure-based methodology – using CPT, plan, provider or other coding.<br>__ APC Code<br>__ Full/ Partial Capitation<br>__ Other (please specify) | If yes - %of total payments in CY 2010 spent on quality incentive payments. [76]<br><br>Yes 17%<br><br>Quality-focused only | __ Visit/Volume Reduction<br>__ use of ancillary/referred services<br>__ use of diagnostic tests<br>__ over all efficiency of care<br>__ use of pharmacy services<br>__ Others (please specify) |

| Group | Specialty Type | Unit of Payment for Services (check all that apply) | Are there Quality or Customer Service Incentives in Contract (y/n)77? | Utilization Incentives in Contract: (check all that apply) |
|---|---|---|---|---|
| 11 | Multi-Specialty | _X_ Procedure-based methodology – using CPT, plan, provider or other coding. .<br>__ APC Code<br>__ Full/ Partial Capitation<br>__ Other (please specify) | If yes - %of total payments in CY 2010 spent on quality incentive payments. 78<br><br>Yes 1.4% | __ Visit/Volume Reduction<br>__ use of ancillary/referred services<br>__ use of diagnostic tests<br>__ over all efficiency of care<br>X use of pharmacy services<br>__ Others (please specify) |

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

Additional Questions for Professional Groups
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

Percent of total payments to these ten professional groups in CY 2010 spent on quality incentive payments. 5.0%

Percent of total payments to these ten professional groups in CY 2010 paid through units of service based on efficient resource use (i.e APC, Bundled Services or partial/global budgeting): <1.0%

Estimated Payments in first six months of CY 2010 for Professional Group Services as % of what Medicare would have paid for similar set. of services: 119%

Other Comments on Quality/Efficiency Incentives in Professional Group Contracting:

**Blue Cross & Blue Shield of Rhode Island**

To: Health Plan Contacts for Rate Factor Filings
From: Herb Olson, Legal Counsel Office of the Health Insurance Commissioner
Date: April 8, 2011

Re: Resources for Health System Improvements - Survey

OHIC Regulation Two lists standards to be used by the Health Insurance Commissioner for the assessment of the conduct of Health Plans 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 plan 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 the rate factor filing process, please itemize and quantify your organization's contributions of finances and other material assets to these efforts in Rhode Island in calendar year 2010 in the following table[1].

[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 healthcare system.

| System-wide improvement activity | Brief description of activity | Value of 2010 Plan contributions |
|---|---|---|
| Primary Care Infrastructure Support | BCBSRI provides:<br>• Financial and in-kind support for primary care practices to transform into Patient Centered Medical Homes (PCMH). Support is inclusive of:<br>o Infrastructure support (e.g., Nurse Care Manager (NCM), Physician Champion, Project Management, training, Behavioral health co-location, etc.)<br>o Care management payment – payment for the added time required to appropriately manage the needs of the 'complex' members within the practice<br>o Pay for Performance – Retrospective payment for all BCBSRI patients based on the achievement of nationally recognized clinical process and outcome measures<br>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. | ~ $8 M |
| CSI-RI | BCBSRI provides:<br>• Financial support for nurse care manager, project management, and care management PMPM<br>• In-kind support through participation in CSI Steering committee and Co-chair of Training and Support committee | $1.24M |
| EHR Grant Program | BCBSRI provides:<br>• Financial support for both new and existing users of EHR technology.<br>• $2,500 per practice funding for an EHR pre-implementation readiness assessment to prepare for successful implementation.<br>• $5,000 per physician support to pay for the purchase of a certified EHR. | $259,636 |

| System-wide improvement activity | Brief description of activity | Value of 2010 Plan contributions |
|---|---|---|
| Quality Counts program | BCBSRI provides:<br>• Financial support for EHR adoption and quality metric reporting and results | $229,600 |
| BCBSRI Wellness Van | BCBSRI provides:<br>• Free health screenings and prevention information to approximately 9,000 Rhode Islanders, including more than 900 uninsured.<br>• Free flu vaccination for Rhode Island's uninsured. | $190,000 |
| Rhode Island Quality Institute (RIQI) | BCBSRI provides:<br>• Financial support<br>• Staff Technical Assistance—working and steering committees<br>• Jim Purcell, President & CEO of BCBSRI is the Chair of the Board of Directors and serves on several committees including the RIQI Operations Committee. | $200,000 |
| ICU Collaborative | BCBSRI provides:<br>• Financial and professional support | $324,000 |
| Rhode Island Free Clinic | BCBSRI provides:<br>• Volunteer Support—Dr. Gus Manocchia<br>• Financial support for operations<br>• Financial incentives to recruit new volunteers and expand physician volunteer network<br>• BCBSRI Community Wellness Van offers free screenings every monthly "Lottery" night. | $50,000 |
| Clinica Esperanza / Hope Clinic | BCBSRI provides:<br>• Financial support for operations<br>• Hosted grand opening celebration and coordinated media attention for new free clinic<br>• BCBSRI Community Wellness Van offers free screenings at every event | $15,000 |
| HealthRIte | BCBSRI provides:<br>• Financial support | $15,000 related to drafting legislation for the improvement of the Certificate of Need process |

| System-wide improvement activity | Brief description of activity | Value of 2010 Plan contributions |
|---|---|---|
| WellOne (formerly Northwest Community Health Center) | BCBSRI provides:<br>• Financial support of program to provide co-located behavioral health services in PCP setting | $25,000 |
| Rhode Island Kids Count – Covering Kids RI | BCBSRI provides:<br>• BCBSRI is Coalition Member<br>• Participated in the Leadership Roundtables for Children with Special Health Care Needs and the DHS RIte Care Consumer Advisory Committee<br>• Development of an Issue Brief on Preterm Births<br>• Work to close racial and ethnic gaps in health outcomes for children and youth; will issue brief in 2011<br>• Ongoing support of fundraising events | $20,000 |
| RIMS Physician Health Program | BCBSRI provides:<br>• Financial support | $10,000 |
| March of Dimes | BCBSRI provides:<br>• Financial support to this annual forum.<br>• Senior level manager on the Board of Directors | $3000 |
| Women's Cancer Screening Program with the RI DOH | BCBSRI provides:<br>• Financial gift to help restart the program after increased demand caused a temporary shutdown. | $100,000 |
| Rhode Island Task Force on Prematurity | BCBSRI provides:<br>• Committee representation | N/A |
| Healthy Eating Active Living Collaborative | BCBSRI provides:<br>• Staff support at 1-2 meetings per month. | N/A |
| Rhode Island Heart Disease and Stroke Prevention Worksite, Community and Prevention Workgroup | BCBSRI provides:<br>• Staff support at 1 meeting per month. | N/A |

| System-wide improvement activity | Brief description of activity | Value of 2010 Plan contributions |
|---|---|---|
| Beacon Community Project | BCBSRI provides:<br>• 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:<br>▪ Staff support at 1 meeting per month. | In kind |
| Healthy RI: National Health Reform Implementation Task Force | BCBSRI provides:<br>▪ Staff support at 1 meeting per month. | In kind |
| DOH Minority Health Advisory Committee | BCBSRI provides:<br>▪ Staff support at 1 meeting per month.<br>▪ BCBSRI staff on Advisory Committee.<br>▪ BCBSRI staff on Data Subcommittee | In kind |
| Rhode Island Primary Care Educational Loan Repayment Program | BCBSRI provides:<br>• Participation in development of selection criteria and selection of applicants | In kind |
| RI Breastfeeding Coalition | BCBSRI provides:<br>• Staff support at 12 meetings per year.<br>• Sr. level manager on board of directors.<br>• BCBSRI is a breastfeeding friendly workplace. Acknowledged by RIBC as a Silver level employer. | In kind |
| currentcare Health Information Exchange (HIE) | BCBSRI provides:<br>• Provider Relations staff assists in the distribution of the message regarding the importance of currentcare and the processes involved of enrolling to provider practices across the state. | In kind |