Rector & Associates, Inc.

Insurance Regulatory Consulting

BLUE CROSS & BLUE SHIELD OF RHODE ISLAND

REPORT ON
HOSPITAL PARTICIPATION AGREEMENTS WITH
THE CARE NEW ENGLAND HEALTH SYSTEM

RECTOR & ASSOCIATES, INC.

TO

THE STATE OF RHODE ISLAND
OFFICE OF HEALTH INSURANCE COMMISSIONER

as of

January 1, 2009

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APPENDIX A: Blue Cross Financial Condition
APPENDIX B: Blue Cross' Statutory Authority to Enter into 2009 Amendments

October 12, 2010

The Honorable Christopher F. Koller
Health Insurance Commissioner
State of Rhode Island
Providence, Rhode Island

Dear Commissioner Koller:

In compliance with your instructions and pursuant to the provisions of R.I. General Laws Chapter 27-13.1, a targeted examination of certain affairs of

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a non-profit hospital service and medical service corporation chartered by the State of Rhode Island (and hereinafter referred to as "Blue Cross"), has been performed as of January 1, 2009. The report of such examination, submitted herewith, is the result of a targeted examination, and as such is not intended to communicate all matters of importance for an understanding of Blue Cross' financial condition. The last full scope examination of Blue Cross was performed as of December 31, 2005.

I. Introduction

A. Targeted Examination

Blue Cross is a non-profit, charitable, hospital and medical service corporation chartered under the laws of Rhode Island. The Rhode Island Office of Health Insurance Commissioner (the "OHIC") is the primary regulator of Blue Cross.[1]

On or about February 9, 2009, the OHIC issued a Warrant and Notice of Examination and Appointment ordering a targeted financial examination of Blue Cross pursuant to Rhode Island General Laws Chapter 13.1 of Title 27. The examination relates to certain Hospital Participation Agreements entered into by and between Blue Cross, on the one hand, and The Care New England Health System, a Rhode Island corporation ("CNE") and three subsidiary hospitals of CNE (the "CNE Hospitals" or the "Hospitals"), on the other, effective January 1, 2005 (the "Original CNE Agreements"), as those Original CNE Agreements were amended effective January 1, 2009 (the "2009 Amendments"). The Original CNE Agreements, as amended by the 2009 Amendments, are hereinafter referred to as the "CNE Agreements" or the "Agreements." The purposes of the examination include:

1. To assess the potential financial and market impact of the 2009 Amendments on Blue Cross;

2. To determine whether Blue Cross possessed the statutory authority to enter into the 2009 Amendments; and

3. To assess the potential impact of the 2009 Amendments on health insurance affordability, accessibility, provider fairness and other regulatory objectives of the OHIC.

The warrants appointed Joseph Torti, III and John Aloysius Cogan Jr. as examiners. In addition, OHIC retained Rector & Associates, Inc. ("Rector") to assist with this targeted examination.[2] The purpose of this Report is to provide an analysis of the 2009 Amendments and conclusions regarding the foregoing examination purposes. This Report is subject to Rhode Island General Laws Section 27-13.1-5(f), which gives confidential treatment to certain work papers and other information produced by or disclosed to the DBR and OHIC in connection with the examination of an insurer.

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[1] The OHIC was created by the Rhode Island Health Care Reform Act of 2004 – Health Insurance Oversight [R.I. Gen. Laws §§42-14.5-1, *et seq.*] (the "Health Reform Act"). Under the Health Reform Act, the OHIC has exclusive jurisdiction over health insurance matters, including the regulation of Blue Cross. The Department of Business Regulation, Division of Insurance ("DBR") provides infrastructure and expert staff to the OHIC.

[2] Neither the examiners nor Rector are acting as attorneys in producing this Report. Nothing in this Report is or should be construed as legal advice or as offering legal conclusions.

B. Regulatory Framework

In conducting our review and preparing this Report, we have been guided by the OHIC's regulatory framework, including its regulatory objectives. As noted above, the Health Reform Act gives the OHIC exclusive jurisdiction over health insurance matters. The Health Reform Act requires the OHIC to discharge its powers and duties to:

1. Guard the solvency of health insurers;

2. Protect the interests of consumers;

3. Encourage fair treatment of health care providers;

4. Encourage policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and

5. View the health care system as a comprehensive entity and encourage and direct insurers toward policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access.

[R.I. Gen. Laws §42-14.5-2]

The Health Reform Act also gives the OHIC the power and duty to enforce the Rhode Island Insurance Code (R.I. Gen. Laws, Title 27) with respect to health insurance. [R.I. Gen. Laws §42-14.5-3(e)] In enforcing the Insurance Code with respect to health insurance, the OHIC has incorporated the DBR's prior practices, policies and regulations related to health insurance, to the extent that those practices are not inconsistent with the Health Reform Act.

C. Scope of Our Review

In conducting our review and analysis, we have, among other things:

1. Reviewed the CNE Agreements and the 2009 Amendments;

2. Reviewed certain Blue Cross internal memoranda and actuarial models relating to the 2009 Amendments provided by Blue Cross in connection with the examination;

3. Reviewed the form of Blue Cross License Agreement and Blue Shield License Agreement of the Blue Cross and Blue Shield Association, and the related Blue Cross and Blue Shield Association Financial Responsibility Standards (as amended through 03/19/09), each as provided to us by Blue Cross;

4. Reviewed Blue Cross' Original Articles of Incorporation dated February 27, 1939 and Blue Cross' current Bylaws effective as of September 4, 2008, each as provided to us by Blue Cross;

5. Reviewed (a) the DBR's Report of Examination of Blue Cross as of December 31, 2005; (b) the Blue Cross Audited Statutory Financial Statements as of December 31, 2007 and December 31, 2006; (c) the Blue Cross Audited Statutory Financial Statements as of December 31, 2008 and December 31, 2007; and (d) the Annual Statements of Blue Cross for the years ended December 31, 2008, 2007, 2006, 2005 and 2004, as provided to us by the DBR, by Blue Cross, or as otherwise publicly available on the DBR's website;

6. Conducted multiple telephone interviews with representatives of Blue Cross;

7. Conducted one telephone interview with representatives of CNE;

8. Reviewed applicable provisions of Rhode Island General Laws, Chapter 6 of Title 7 (the "Non-Profit Corporation Laws");

9. Reviewed applicable provisions of Rhode Island General Laws, Chapter 19, Chapter 19.2, and Chapter 20 (the "Hospital and Medical Service Corporation Laws") of Title 27; and

10. Reviewed such other provisions of Rhode Island General Laws, Title 27, and such additional material, as we determined appropriate.

When reviewing information regarding the negotiations between Blue Cross and CNE that led to the 2009 Amendments, we have not attempted to "second guess" Blue Cross' strategy or contracting decisions. Stated otherwise, our goal has not been to determine whether Blue Cross could have, or should have, negotiated more favorable terms (or alternatively refused to renew the Original CNE Agreements). Rather, our goal has been to ascertain whether Blue Cross had the statutory authority to enter into the 2009 Amendments on the terms to which it ultimately agreed, and to assess certain potential effects of the 2009 Amendments.

Likewise, in reviewing the actuarial models, estimates, and projections provided to us by Blue Cross, we have not attempted to "second guess" Blue Cross' assumptions or methodology, nor have we independently verified Blue Cross' calculations.

Finally, it is our understanding that Blue Cross is subject to certain laws governing charitable institutions enforced by the Rhode Island Attorney General. Please note that we have not reviewed or considered such laws in conducting our analysis or reaching our conclusions.

II. Overview of the CNE Agreements

A. General

The CNE Agreements consist of the following three agreements:

1. **The W&I Agreement:** Hospital Participating Agreement dated December 14, 2004 by and between Blue Cross, Women & Infants Hospital ("W&I Hospital"), and CNE, as amended by a First Amendment thereto dated December 22, 2008;

2. **The Butler Agreement:** Hospital Participating Agreement dated December 14, 2004 by and between Blue Cross, Butler Hospital, and CNE, as amended by a First Amendment thereto dated December 22, 2008; and

3. **The Kent County Agreement:** Hospital Participating Agreement dated December 14, 2004 by and between Blue Cross, Kent County Hospital, and CNE, as amended by a First Amendment thereto dated December 22, 2008.

It is our understanding that W&I Hospital is the premier maternity hospital in Rhode Island, accounts for approximately 70% of infant deliveries in Rhode Island, and has the only Level 3 Neonatal Intensive Care Unit in the state. We further understand that W&I is a leading provider of treatment for female related cancers in Rhode Island.

It is our understanding that Butler Hospital is the only general psychiatric hospital in Rhode Island, and that it provides approximately 50% of all adult and adolescent behavioral health and substance abuse inpatient days in the state.

It is our understanding that Kent Hospital is an acute care community hospital that does not provide any unique services.

In general, the CNE Agreements require the Hospitals to provide "covered services" to Blue Cross subscribers. The "subscribers" covered by the CNE Agreements include:

1. **Commercial Subscribers:** Individuals entitled to Blue Cross coverage as a result of individual "direct pay" policies or as a result of Blue Cross agreements with employer/association groups. This category includes:

    a. Groups fully insured by Blue Cross;

    b. Individuals with Direct Pay coverage fully insured by Blue Cross;

c. Self-insured groups administered by Blue Cross; and

d. Subscribers of a Blue Cross and Blue Shield plan in another state (a "Blues Plan"), in cases where such a subscriber accesses covered services at a CNE Hospital ("HOSTS Groups").

2. **Medicare Subscribers:** Individuals eligible for and enrolled in Blue Cross' "BlueCHip for Medicare Program" (i.e., Blue Cross' Medicare Advantage coverage).

3. **RIte Care Subscribers:** Individuals for whom Blue Cross has agreed to provide access to certain covered services in accordance with an agreement between Blue Cross and the State of Rhode Island (i.e., Medicaid-type coverage).

The CNE Agreements require Blue Cross to reimburse the Hospitals for providing covered services in accordance with the compensation rates set forth in, or determined in accordance with, the CNE Agreements.

B. The Original CNE Agreements

The Original CNE Agreements had a four-year term (from January 1, 2005 through December 31, 2008). The Original CNE Agreements required Blue Cross to pay the CNE Hospitals base rates for covered services related to commercial business, Medicare Advantage business and Rite Care. The base rates for those lines of business increased at various rates from January 1, 2005 through December 31, 2008.

The parties began negotiating the renewal of the Original CNE Agreements in mid-2008. The negotiations ultimately led to the 2009 Amendments, which amended and renewed the Original CNE Agreements for an additional five-year term, beginning January 1, 2009.

C. The 2008 Negotiations

The negotiations resulting in the 2009 Amendments appear to have been lengthy and contentious. It is our understanding that, when negotiations began in or around June of 2008, Blue Cross sought a multi-year contract extension with annual rate increases comparable to those in the Original CNE Agreements. CNE, on the other hand, initially sought a one-year contract extension (for 2009 only) and a rate increase that was significantly higher than the annual rate increase in the Original CNE Agreements. According to Blue Cross, approximately half of the rate increase proposed by CNE was intended to compensate CNE for alleged past government under-funding of the Medicare and Medicaid programs and to provide a contingency for possible future Hospital losses based on alleged government payor shortfalls.

As negotiations intensified and the deadline for reaching a deal grew near, each party offered justification to the press and the public for its position. For its part, CNE argued that Blue Cross enjoyed rates lower than any other commercial insurer with which CNE contracts; that CNE was struggling with the cost of "charity care" and allegedly inadequate Medicare and Medicaid reimbursement rates; that it was a "community responsibility" to deal with this problem and that Blue Cross needed to pay its "fair share." Blue Cross, conversely, argued that its status as the largest insurer in Rhode Island, and as a nonprofit, legitimated any lower reimbursement rates it might pay, and that, despite CNE's protestations to the contrary, CNE enjoyed a 6% to 8% profit on its total Blue Cross book of business. Blue Cross also argued that CNE's demand that Blue Cross raise its reimbursement rates if CNE's alleged Medicare and Medicaid losses grew in the future unreasonably asked Blue Cross to have an "open checkbook." [*See* Providence Business News article *Deadline looms for BCBSRI, Care New England deal*, posted November 3, 2008 on PBN.com, and quoting CNE President and CEO John J. Hynes and Blue Cross President and CEO James E. Purcell, respectively.]

The significant "cost-shifting" (from governmental payors to Blue Cross) included in the CNE proposal concerned Blue Cross for at least two reasons. First, Blue Cross expressed concern that other hospitals would follow suit. Second, Blue Cross expressed concern that CNE might not impose the same level of increase on Blue Cross' competitors, adversely affecting Blue Cross' competitive position.[3]

Blue Cross appears to have seriously considered allowing the CNE Hospitals to drop out of its network rather than to agree to the terms proposed by CNE. However, it ultimately decided that the cost of not renewing the CNE Agreements (not only in pure financial terms, but also in terms of likely public outcry and lost business) would be greater than the cost of renewing them, even on less than ideal terms. In this regard, an internal actuarial analysis produced by Blue Cross during the CNE negotiations estimated $6 to $7 Million in additional commercial claims expense per month (or $72 to $84 Million annually) if the Hospitals had "non-participating" status, of which $4 to $5 Million per month (or $48 to $60 Million annually) would be for fully-insured business. Blue Cross also indicated that the $4 to $5 Million per month (or $48 to $60 Million annually) would come largely out of reserves in 2009 since this added expense would not have been put into 2009 premium rates.[4] The remainder would be attributable to increased claims expense paid by self-insured accounts. The analysis assumed that if the CNE Hospitals were out of network, Blue Cross would pay "at charge"[5] for claims

[3] Representatives of CNE indicated to us that Blue Cross enjoys more favorable terms than its competitors with the CNE Hospitals. We have not independently verified this representation but have included it to illustrate the mindset of the parties as they negotiated and entered into the 2009 Amendments .

[4] Premium rates for 2009 would have been calculated and quoted prior to the execution of the 2009 Amendments.

[5] The "charge" is a hospital's full, undiscounted price. The "charge" is the price charged to uninsured individuals and individuals whose insurance company does not have a contract with the hospital. The "allowance" is the discounted price that contracted insurance companies pay. The allowance is often substantially less than the charge.

involving (1) emergency care; (2) care in the course of treatment; and (3) services not otherwise available in the state. Approximately 80% of the additional monthly cost would be attributable to the W&I Hospital (e.g., for neo-natal and high risk pregnancy services not otherwise available in Rhode Island).

CNE's strong market position appears to have made the option of "non-renewal" virtually unworkable for Blue Cross. As noted above, W&I Hospital provides high risk pregnancy and neonatal services that are not otherwise available in Rhode Island. Even diverting low-risk pregnancies and deliveries to non-CNE providers would have been challenging for Blue Cross (and very problematic for its pregnant subscribers) because of the lack of sufficient non-CNE hospital maternity beds and because W&I Hospital employs many obstetricians and gynecologists in the Blue Cross network (meaning that if W&I Hospital fell "out of network," a number of obstetricians and gynecologists would as well).[6] Further, because of Butler Hospital's status as the only general psychiatric hospital in Rhode Island, Blue Cross believed it was unlikely that other facilities would have the excess capacity to absorb Butler's market share. These factors appear to have combined to give CNE a significant level of bargaining power in its negotiations with Blue Cross – Blue Cross simply could not walk away.

D. The 2009 Amendments

Ultimately, Blue Cross was able to negotiate renewals of the Original CNE Agreements.

The 2009 Amendments renew the Agreements for an additional five (5) year term (from January 1, 2009 through December 31, 2013). While the 2009 Amendments leave most of the substantive provisions of the Original CNE Agreements intact, they include material changes to the calculation and amount of the compensation to be received by the Hospitals, including larger annual rate increases during the first two years of the contract than had been previously in place for commercial business, but lower rate increase during the remaining three years of the contract. In addition, unlike the Original CNE Agreement, in which Medicare Advantage and Medicaid (RIte Care) rates were tied to CMS and state payment rates, the 2009 Amendments subject Medicare Advantage and Rite Care [redacted].

The 2009 Amendments also include provisions for payments that are not specifically tied to services provided by the Hospitals. One such provision provides for lump-sum payments to be made by Blue Cross to CNE during the first two years of the renewal period. Another provision requires Blue Cross to pay increased reimbursement rates for covered services provided by the Hospitals to Blue Cross subscribers in the event that

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[6] Blue Cross has advised us that the only non-CNE hospital in Rhode Island within 15 miles of Providence is Memorial Hospital, which has a 20 bed maternity unit (compared to W&I's 92 bed maternity unit). Blue Cross also has advised us that a substantial number of OB/GYN physicians at W&I Hospital are hospital employees.

governmental payors (including Medicaid and Medicare) take certain actions that reduce CNE's revenues or increase CNE's expenses (the "Cost Shifting Provision"). Blue Cross' potential liability under the Cost Shifting Provision is wide ranging. Under a "best case scenario," Blue Cross' liability would equal zero. Under a "worst case scenario," Blue Cross' liability could exceed tens of millions of dollars over the life of the contract.[7]

If the Cost Shifting Provision is not triggered, Blue Cross expects its aggregate claims payments to the CNE Hospitals over the life of the 2009 Amendments to increase by approximately [redacted] Million, from approximately [redacted] Billion (the amount Blue Cross would expect to pay in claims over the life of the 2009 Amendments had CNE's 2008 base rates remained in effect without any increase) to approximately [redacted] Billion. Further, according to Blue Cross calculations, CNE will enjoy a 20% profit margin on the 2009 Amendments in 2009 and a 23.6% profit margin on the 2009 Amendments in 2010.[8] If the Cost Shifting Provision is triggered, the cost of the 2009 Amendments could be significantly higher.

III. Blue Cross Financial Position – Pre-2009 Amendments

It is our understanding that Blue Cross experienced financial difficulties during the mid- to late-1990's, losing over $70 Million in a three-year period. Blue Cross' financial condition appears to have significantly improved during recent years, and (with a few exceptions) Blue Cross has experienced steady annual growth. From 2005 to 2008, Blue Cross' reserves (i.e., capital and surplus) increased from $315.9 Million to $414.8 Million, and its admitted assets increased from $594.4 Million to $710.6 Million.

Blue Cross experienced some slight negative trends in 2008, compared to 2007. As of December 31, 2008, Blue Cross had reserves of $414.8 Million and net income of $46.1 Million (compared to $428.8 Million in reserves and $61.3 Million net income as of December 31, 2007). Total enrollees at December 31, 2008 were approximately 499,000, a modest decline from approximately 513,000 enrollees at December 31, 2007. Net annual premium also declined slightly during 2008, from $1.769 Billion in 2007 to $1.756 Billion in 2008.

Blue Cross has maintained Risk Based Capital (RBC) in excess of 500% in each of the last five calendar years. Its 2008 RBC was 742.67%, down slightly from its 2007 RBC of 762.30%.

Please see Appendix A for a more detailed summary of Blue Cross' pre-2009 Amendment financial condition.

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[7] The 2009 Amendments also include more stringent confidentiality requirements. These confidentiality provisions purport to give CNE the right to limit or delay regulatory access to the 2009 Amendments.

[8] We have not independently verified Blue Cross' cost or profit calculations. We have included the calculations both to illustrate the mindset of the parties as they entered into the 2009 Amendments and to provide a starting point for quantifying the potential impact of the 2009 Amendments on Blue Cross and its subscribers.

IV. Potential Effects of 2009 Amendments on Blue Cross Financial Position

In the analysis that follows, we assess the impact of 2009 Amendments from a variety of perspectives in an effort to parse, as closely as possible, the "true" impact of the 2009 Amendments on Blue Cross. Please note that, because RIte Care (Medicaid) accounts for a relatively insignificant piece of Blue Cross' costs under the CNE Agreements, and because the annual increase to the CNE Hospital rates for Medicaid subscribers is relatively low, we do not provide analysis of the impact of the 2009 Amendments on Blue Cross' Medicaid costs.[9]

As discussed in greater detail below, we anticipate that the 2009 Amendments will almost certainly have a negative impact on:

- Blue Cross' reserves (that is, reserves will likely decrease);
- Premium rates charged to subscribers (that is, Blue Cross insureds will likely pay more);
- Self-insured plans administered by Blue Cross (that is, those self-insured plans will likely be faced with higher costs);
- Out of state Blues Plans whose subscribers are treated at the CNE Hospitals (that is, those Blues Plans will likely be faced with higher costs); and
- Blue Cross' bargaining position in future hospital negotiations – the so called "rising tide" effect (that is, Blue Cross' concessions to CNE, particularly with respect to the Cost Shifting Provision, create a precedent that might affect future negotiations both with CNE and with other hospitals).

A. Direct Impact on Reserves

It appears clear that the 2009 Amendments will have a direct and negative impact on Blue Cross' reserves. Information provided by Blue Cross suggests that the 2009 impact of the 2009 Amendments on Blue Cross' reserves could total approximately $6.7 Million, and that the 2010 impact of the 2009 Amendments on Blue Cross' reserves could total approximately $3.2 Million.[10]

The 2009 impact figure includes $4.1 Million of the CNE rate increase not factored into Blue Cross' existing commercial, fully-insured premium rates and $1.6 Million not factored into Blue Cross' existing Medicare Advantage premium rates, and an additional

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[9] Blue Cross has advised us that approximately 2.8% of claims under the Original CNE Agreements were attributable to RIte Care (Medicaid).

[10] We have not independently verified Blue Cross' calculations. Instead, we have assumed that its calculations are accurate and have included them as a starting point for quantifying the potential impact of the 2009 Amendments on Blue Cross and its subscribers.

[redacted] not factored into any 2009 rates.[11] The 2010 impact figure includes $2.2 Million of the CNE rate increase not factored into Blue Cross' existing commercial, fully-insured premium rates, and an additional $1 Million not factored into any 2010 rates.[12] Accordingly, during 2009-2010, it seems reasonable to anticipate, based on information provided by Blue Cross, that the 2009 Amendments could negatively impact Blue Cross' reserves by approximately $9.9 Million (approximately 2.4% of reserves as of December 31, 2008).

The figures above exclude any potential negative impact on reserves arising from the Cost Shifting Provision or from the "rising tide" effect. While we have not quantified the exact amount of the potentially negative impact on reserves arising from the Cost Shifting provision and from the rising tide effect, information provided by Blue Cross suggests that when the negative impact on reserves potentially arising from these additional considerations are factored into the estimate, the 2009-2010 negative impact on Blue Cross' reserves might range from $17.4 Million to in excess of $33.4 Million (approximately 4.2% to in excess of 8.1% of reserves as of December 31, 2008).[13]

B. Direct Impact on Premium Rates

A key factor that any insurer considers in establishing premium rates is its expenses. Higher provider reimbursement rates generally result in higher expenses, and these higher expenses in turn typically will be passed on to insurance consumers in the form of higher premium rates. Because the 2009 Amendments require Blue Cross to reimburse the CNE Hospitals at materially higher rates than under the Original CNE Agreements, it appears clear that the 2009 Amendments will directly and negatively impact future premium rates imposed on Blue Cross' subscribers. While we have not quantified the impact of the 2009 Amendments on future premium rates, information provided by Blue Cross suggests that Blue Cross' commercial subscribers could pay approximately [redacted] Million more, and that Blue Cross' Medicare Advantage subscribers could pay approximately [redacted] Million more, in premiums in 2010 than they otherwise would have, as a direct result of the concessions made by Blue Cross to the CNE Hospitals in the 2009 Amendments.[14]

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[11] Blue Cross has advised us that it will recoup some portion of this $[redacted] amount from the self-insured plans it administers under the terms of its administrative agreements with those plans (making the ultimate impact on reserves something less than the full $[redacted]).

[12] Again, Blue Cross has advised us that it will recoup some portion of this $[redacted] amount from the self-insured plans it administers under the terms of its administrative agreements with those plans (making the ultimate impact on reserves something less than the full $[redacted]).

[13] Of course, a portion of these potential additional costs might be recouped through premium increases, thereby reducing the aggregate negative impact on reserves. *See* Subsection B below. We have not independently verified Blue Cross' calculations. Instead, we have assumed that its calculations are accurate and have included them to provide a starting point for quantifying the potential impact of the 2009 Amendments on Blue Cross and its subscribers.

[14] We have not independently verified Blue Cross' calculations. Instead, we have assumed that its calculations are accurate and have included them to provide a starting point for quantifying the potential impact of the 2009 Amendments on Blue Cross and its Subscribers.

The foregoing estimates do not include any additional upward adjustment to premium rates made by Blue Cross in an effort to recoup part or all of the $9.9 Million anticipated "hit" to reserves (discussed in Subsection A above) or to address the "rising tide" impact (discussed in Subsection D below). Additionally, the foregoing estimate assumes that Blue Cross will experience fairly minimal liability under the Cost Shifting Provision. In the event of a "worst case scenario" under the Cost Shifting Provision, Blue Cross would be forced to make up the difference between the amount it builds into the premiums and the actual amount of its liability from its reserves and/or additional premium increases in subsequent years. Because of these additional factors, it appears likely that the foregoing estimates provide simply a starting point for increased premiums, and that the actual increase to premiums resulting from the 2009 Amendments could, over time, be much more significant.

Further, as noted previously, claims payments made to the CNE Hospitals are expected to increase by an estimated [redacted] million over the life of the 2009 Amendments even if the Cost Shifting Provision is never triggered. If one assumes that this entire amount eventually will be passed on to insurance consumers through premium rate increases, the aggregate premium rate increase over the life of the 2009 Amendments attributable to the CNE Agreements alone (and again, without reference to the Cost Shifting Provision) would be approximately 3.6%. While this aggregate increase might appear to be modest, it is important to note that it only reflects cost increases attributable to a single provider system (CNE) with three hospitals. When one considers that Blue Cross presently contracts with eleven hospitals in addition to the three CNE Hospitals – each of which is likely to raise its own rates – and that hospital costs are just one component considered by Blue Cross in setting its premium rates (other provider costs, administrative costs, the need to supplement reserve levels, and inflation being other potential components), a 3.6% premium increase over a 5 year period attributable to a single provider contract could result in significant regulatory concern.[15]

We also note that Blue Cross filed its proposed 2010 commercial trend factors for its commercial rates with the OHIC on or about May 15, 2009, but that, at the request of the OHIC, Blue Cross agreed to withdraw that filing for a period of six months. On January 22, 2010, Blue Cross refiled its proposed 2010 commercial trend factors for its commercial rates. On March 10, 2010, Blue Cross received approval of trend factors. The delay of approved of Blue Cross' commercial trend factors likely lessened or eliminated the financial impact of the 2009 Amendments on Blue Cross subscribers. On the other hand, the financial impact of the 2009 Amendments to Blue Cross' reserves likely increased. Prior to the resubmission of its trend factors, Blue Cross informed the OHIC that the withdrawal of its trend factor rate filing will likely have a significantly negative financial impact to Blue Cross in that it could generate losses of as much as $32 Million after tax.

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[15] Blue Cross has advised us that, historically, approximately 40% of its claims expense is attributable to hospital providers. Of the claims expense attributable to hospitals, 20% is attributable to the CNE Hospitals. This means that, historically, $0.08 out of every claims dollar has been paid to CNE.

C. Potential Impact of the Cost Shifting Provision

As noted above, the 2009 Amendments include a Cost Shifting Provision that provides for a contingent rate increase in the event that governmental payors take certain actions that reduce CNE's revenues or increase its expenses. If the Cost Shifting Provision is triggered, Blue Cross would be required to pay the CNE Hospitals increased reimbursement rates for covered services provided to Blue Cross subscribers.

Although the formula for determining Blue Cross' liability under the Cost Shift Provision is complex, in general, Blue Cross' potential annual liability could range from $0 to in excess of $4.3 Million. Further, over the life of the 2009 Amendments (2009 to 2013), Blue Cross' potential aggregate liability under the Cost Shifting Provision ranges from:

- $0 (under a "best case scenario"); to
- $21.5 Million (under a "bad case scenario"); to
- An unknown amount in excess of $21.5 Million (in a "worst case scenario").

While Blue Cross and CNE are likely to take the position that the "worst case scenario" and the "bad case scenario" – are improbable, they are possible. Indeed, if such scenarios were not possible, CNE would not have asked for the inclusion of these provisions in the 2009 Amendments. Further, whether Blue Cross incurs liability under this provision, and the amount of that liability, is entirely outside of Blue Cross' control. We also note that the Cost Shifting Provision is so broad that CNE could potentially attempt to invoke it for events other than governmental rate cuts. For example, if a CMS audit of past Medicare payments to CNE (including payments unrelated to BCBS subscribers) showed a major overpayment to CNE in past years, and CMS recouped that overpayment through lowering current payments to CNE, the Cost Shifting Provision is broad enough to potentially be triggered.[16]

D. Potential Indirect Impact of "Rising Tide" Effect

Blue Cross has provider agreements with approximately eleven hospitals in addition to the three CNE Hospitals. Historically, because of Blue Cross' relatively superior bargaining position, it has been able to negotiate lower rates with the non-CNE hospitals than those it has negotiated with the CNE Hospitals. Blue Cross has indicated that hospitals increasingly are attempting to require commercial insurers (and their subscribers) to subsidize alleged shortfalls in governmental payments. If the types of cost

[16] Although this contingency may not have been contemplated by the parties (we have no information to suggest that it was or was not expressly contemplated by either party), the language is sufficiently broad that an argument could be made that the Cost Shift Provision would be triggered by a determination of Medicare overpayments.

shifting provisions demanded by CNE become the norm rather than the exception in hospital negotiations, the collective impact of a global "rising tide" effect could be more significant to Blue Cross and its subscribers than the 2009 Amendments themselves.

E. Potential Impact on Self-Insured Plans

Self-insured groups administered by Blue Cross will have to absorb the increased costs associated with the 2009 Amendments as well. Although we have not attempted to quantify the impact of the 2009 Amendments on self-insured groups, information provided by Blue Cross suggests that there could be a potential negative direct impact on self-insured plans of approximately $800,000 in 2009 and $1.6 Million in 2010. Blue Cross also has indicated that it intends to allocate a portion of the lump sum payments made to the CNE Hospitals under the 2009 Amendments to self-insured groups, likely adding several hundred thousand dollars to the CNE-related costs borne by self-insured groups.[17]

Blue Cross does not fund self-insured groups, and, in general, will not cover these increased costs. Rather, these costs will be passed on to self-insured groups. However, under a provision contained in the Original CNE Agreements (and retained in the 2009 Amendments), [redacted][18]

F. Potential Impact on HOSTS Plans

As mentioned above, the CNE Hospital rates apply not only to Blue Cross' subscribers, but also to the subscribers of out-of-state Blues Plans that Blue Cross "hosts" when they obtain CNE Hospital services (e.g., a subscriber of a New York Blues Plan who is traveling through Rhode Island and requires hospital services would be charged Blue Cross' "in network" rates). Although we have not attempted to quantify the negative impact on HOSTS plans, information provided by Blue Cross suggests that the potential negative direct impact on HOSTS plans could be approximately $1.2 Million in 2009 and approximately $2.3 Million in 2010.[19]

It is our understanding that while Blue Cross provides "host" services in such an instance, Blue Cross passes the cost of services provided to the "hosted" individual on to

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[17]We have not independently verified Blue Cross' calculations. Instead, we have assumed that its calculations are accurate and that they provide a starting point for quantifying the potential impact of the 2009 Amendments on Blue Cross and its Subscribers.

[18] [redacted]

[19]We have not independently verified Blue Cross' calculations. Instead, we have assumed that its calculations are accurate and that they provide a starting point for quantifying the potential impact of the 2009 Amendments on Blue Cross and its Subscribers.

the applicable out-of-state Blues Plan. As such, while these additional costs will potentially contribute to the increased cost of health care and health insurance in other states, they will not be borne by Blue Cross or Rhode Island residents.

V. Blue Cross' Statutory Authority to enter into the 2009 Amendments

As a non-profit hospital and medical service corporation, Blue Cross is authorized to establish, maintain, and operate health plans for the purpose of providing medical and hospital services to its subscribers. [R.I. Gen. Laws §§27-19-1(3) & (4); 27-20-1(4), (5) & (6)] In addition, Blue Cross is permitted to underwrite any of the services or benefits that may be provided by nonprofit dental service corporations, nonprofit legal service corporations, or nonprofit optometric service corporations. [R.I. Gen. Laws §27-19-5(b)] Blue Cross also may administer self-insured or partially self-insured health benefit plans sponsored by employers, associates and other third parties, and may underwrite stop loss or catastrophe insurance in connection therewith. [R.I. Gen. Laws §27-19-5(a)(4)]. Finally, Blue Cross may underwrite life insurance, disability insurance, long-term care insurance, employee assistance programs and/or other health related programs, but only through a subsidiary or by third party contract. [R.I. Gen. Laws §27-19-5.3]

Within the confines of the foregoing lines of business, Blue Cross has broad statutory authority to enter into contracts and to incur liabilities. Specifically, Blue Cross has the authority to contract with eligible hospitals with respect to "the nature and extent" of services to be rendered by the hospitals to its subscribers, and to establish the rates payable for those hospital services "by agreement" with the hospitals "from time to time." [R.I Gen. Laws §§27-19-5 & 27-19-7]

Blue Cross' broad power to enter into hospital contracts must be viewed, however, in light of the statutory mandates imposed on it by the Hospital and Medical Service Corporation Laws. As a non-profit hospital and medical service corporation, Blue Cross is required to (1) employ pricing strategies that enhance the affordability of health care coverage; and (2) protect its financial condition. [R.I Gen. Laws §27-19.2-10] Blue Cross' mission also must include "to provide affordable and accessible health insurance;" and to "promote integration, efficiency and coherence of a statewide health care system," among others. [R.I Gen. Laws §27-19.2-3]

Likewise, Blue Cross' broad power to enter into hospital contracts must be viewed in light of the effect of those terms on premium rates charged to subscribers. As a non-profit hospital service corporation, Blue Cross' premium rates must be sufficient to maintain total reserves in a dollar amount sufficient to pay claims and operating expenses for not less than one month. At the same time, Blue Cross' rates must be "consistent with the proper conduct of its business and with the interests of the public." [R.I Gen. Laws §27-19-6]

These statutory mandates require Blue Cross to achieve a tenuous balance: Enhancing affordability of health insurance, for example, acts in natural tension with maintaining

financial strength. Whether, and how effectively, the 2009 Amendments achieve this balance can be viewed from at least two perspectives:

1. Compared to the "status quo" (the Original CNE Agreements), it appears that Blue Cross will be less able to enhance affordability, maintain its financial strength, and otherwise achieve its statutory mission. While the ultimate cost of the 2009 Amendments will not be fully known until the end of the renewal term (2013) (because Blue Cross' costs depend in material part on contingencies that might or might not develop), the net effect – relative to the status quo – is clearly negative. The 2009 Amendments increase Blue Cross' costs, which will be passed on to insurance consumers. However, it should be recognized that any contract renewal that resulted in increased payments to the CNE Hospitals, even on terms much more favorable to Blue Cross than those in the 2009 Amendments, would generate increased costs to subscribers and would therefore leave Blue Cross products less affordable.

2. Compared to the alternative of not renewing the Original CNE Agreements (and thereby letting the CNE Hospitals fall "out-of-network"), it appears that Blue Cross will be better able to enhance affordability, maintain its financial strength, and otherwise achieve its statutory mission. As discussed previously, based on Blue Cross' internal actuarial analysis, Blue Cross would have incurred an additional $6 to $7 Million in commercial claims expense per month (or $72 to $84 Million annually) if it had declined to renew the Original CNE Agreements, of which $4 to $5 million per month (or $48 to $60 Million annually) would be for fully-insured business. Even under a "worst case scenario," it appears highly improbable that Blue Cross' costs under the 2009 Amendments would ever approach such catastrophic levels. So, again, while the ultimate cost of the 2009 Amendments will not be fully known for at least five (5) years, the net effect – relative to the alternative of non-renewal – is most probably positive. However, it should be recognized that entering into a contract on terms that may ultimately be less expensive for Blue Cross than the alternative (not entering into the contract) only really enhances affordability in relative rather than absolute terms.

Given the broad statutory power provided to non-profit hospital service corporations to enter into compensation agreements with hospitals, and in light of the fact that Blue Cross appears to have done more to enhance affordability, maintain its financial strength, and to otherwise achieve its statutory mission by renewing the Original CNE Agreements – even on less than ideal terms – than would have been possible if it had refused to

renew, we believe that (with two caveats, discussed below) Blue Cross possessed the statutory power to enter into the 2009 Amendments.[20]

Our first caveat concerns the "insurance-like" features of the Cost Shifting Provision. As noted above, Blue Cross may only underwrite certain types of risks. Had CNE asked Blue Cross to issue an insurance policy in which benefits would be paid to CNE in the event of certain future governmental actions that increased CNE's costs or decreased its revenues, Blue Cross could not have done so within its statutory authority. And yet this is, for all practical purposes, what the Cost Shifting Provision accomplishes: Blue Cross has agreed to bear CNE's risk of financial loss if certain contingencies occur within the contract period. The "insurance-like" features of the Cost Shifting Provision also include the facts that the contingencies (a) are unrelated to the actual costs incurred by the CNE Hospitals of providing covered services to Blue Cross subscribers, and (b) are calculated on a system-wide basis (that is, a governmental payor action that adversely affects any entity within the CNE group of companies could potentially trigger the Cost Shifting Provision, even if the CNE Hospitals are not directly affected).

Given that nonprofit hospital and medical service corporations have broad authority to establish hospital rates "by agreement . . . from time to time," we are unprepared to conclude that Blue Cross lacked the authority to agree to a variable pricing structure, even though a variable pricing structure, by its nature, involves a transfer of risk between the parties. However, the variable pricing structure here is so integral to the 2009 Amendments, and bears so many "insurance-like" features, that we question whether it is consistent with the limitations on the types of risks that Blue Cross is authorized to underwrite.

Our second caveat concerns the open-ended nature of the Cost Shifting Provision. In a "worst case scenario," the rates payable to the CNE Hospitals for covered services could increase by many millions of dollars, and on very short notice. Furthermore, the Cost Shifting Provision allows the contract to be reopened under certain circumstances, with the amount of Blue Cross' liability under the Cost Shifting Provision being submitted to binding mediation. In this respect, Blue Cross has essentially ceded ultimate control over the rates it pays the CNE Hospitals to an unknown third party (the mediator). Further, there is no "outside limit" to its liability and no "escape clause" in the event the increased rates would cause it to suffer material financial harm. While we acknowledge that this "doomsday" scenario is unlikely, the salient point is that it is possible, and that Blue Cross has contractually agreed to submit to the results, however catastrophic. We question whether the open-ended nature of the Cost Shifting Provision is consistent with Blue Cross' statutory mandates (particularly the mandate that it "protect" its financial condition).

[20] This statement is in no way meant to suggest an opinion by R&A or the examiners that Blue Cross should (or should not have) entered into the 2009 Amendments. We are only addressing the apparent absence of a statutory prohibition against renewing the Original CNE Agreements on the terms ultimately agreed to by the parties.

Please see Appendix B for additional information on selected Rhode Island statutes addressing Blue Cross' authority to enter into the 2009 Amendments.

VI. Potential Impact of the 2009 Amendments on Insurance Marketplace – Affordability, Accessibility, & Provider Fairness

As noted above, the OHIC's statutory duties include encouraging the fair treatment of health care providers and encouraging and directing insurers toward policies "that advance the welfare of the public through overall efficiency, improved quality, and appropriate access." [R.I. Gen. Laws §42-14.5-2] Although we have touched on most of these concepts in our discussions above, we will briefly consider them here.

A. Provider Fairness

As noted previously, the 2009 Amendments most likely widen the historical gap between the rates paid by Blue Cross to many non-CNE hospitals and the rates paid by Blue Cross to the CNE Hospitals. Even if the "rising tide" effect reduces this gap, it is unlikely to close it altogether (and doing so – which would involve paying all Rhode Island hospitals at the new CNE levels – would be extremely expensive for Blue Cross). Accordingly, while the rate concessions made to CNE in the 2009 Amendments might well enable CNE to better serve the public, they also likely place other hospitals at a competitive disadvantage vis a vis the CNE Hospitals. For smaller hospitals that might already be less able than CNE to absorb alleged governmental under-funding of Medicaid and Medicare, the disadvantage might be significant.

B. Public Welfare: Efficiency, Improved Quality, and Appropriate Access

Keeping the CNE Hospitals "in network" by entering into the 2009 Amendments likely advances accessibility of health care for Blue Cross subscribers by giving them in-network access to the CNE Hospitals. However, the payment methodology under the 2009 Amendments does little to change the underlying inflationary tendencies generally considered to be inherent in the current fee-for-service methodology.

Access to health care, of course, is in part directly tied to affordability of health insurance. As noted previously, Blue Cross' premium rates, and the claims expense of self-funded plans, will rise as a direct result of the increased costs associated with the 2009 Amendments. While we acknowledge that the alternative might well have limited access to and affordability of the CNE Hospitals to Blue Cross subscribers to an even greater degree, the overall effect of the 2009 Amendments on access and affordability is likely to be negative.

VII. Summary of Key Findings and Conclusions

1. CNE's market share (particularly with respect to the neo-natal and high risk pregnancy services provided exclusively at W&I Hospital, and the specialized services provided by Butler Hospital) gave it enormous bargaining power in the negotiation of the 2009 Amendments. The option of simply "walking away" from the contract appears not to have been viable from Blue Cross' perspective, and this fact appears to have put Blue Cross at a competitive disadvantage.

2. The Cost Shifting Provision imposes contingent liabilities on Blue Cross that are entirely outside of Blue Cross' control, are largely unpredictable, and have no cap or other outside limit. While it is unlikely that Blue Cross' liability under the Cost Shifting Provision will be catastrophic, it is at least in theory possible.

3. The 2009 Amendments will almost certainly have a negative impact on:

    a. Blue Cross' reserves (that is, reserves will likely decrease);

    b. Premium rates charged to subscribers (that is, Blue Cross insureds will likely pay more);

    c. Self-insured plans administered by Blue Cross (that is, those self-insured plans will likely be faced with higher costs);

    d. Out of state Blues Plans whose subscribers are treated at the CNE Hospitals (that is, those Blues Plans will likely be faced with higher costs); and

    e. Blue Cross' bargaining position in future hospital negotiations – the so called "rising tide" effect (that is, Blue Cross' concessions to CNE, particularly with respect to the Cost Shifting Provision) – create a precedent that might affect future negotiations both with CNE and with other hospitals.

4. The 2009 Amendments are on terms materially more favorable to Blue Cross than the option of non-renewing the Original CNE Agreements (and thereby allowing the CNE Hospitals to fall "out-of-network").

    a. Blue Cross estimated additional aggregate commercial claims cost for 2009 of approximately $72 to $84 Million if CNE had "non-participating" status. This estimate does not measure the potential

additional cost of lost business and the public outcry that might have accompanied the non-renewal of the CNE Agreements.

b. Even under a "worst case scenario," it appears highly improbable that Blue Cross' costs under the 2009 Amendments would ever approach such catastrophic levels. While the ultimate cost of the 2009 Amendments will not be fully known for at least five (5) years, the net effect—relative to the alternative of non-renewal—is almost certainly positive.

5. We believe that (with two caveats, discussed below) Blue Cross possessed the statutory power to enter into the 2009 Amendments.

6. Our first caveat to Item #5 relates to the Cost Shifting Provision. We question whether the "insurance like" features of the Cost Shifting Provision are consistent with the statutory limitations on the types of risks that Blue Cross is authorized to underwrite.

7. Our second caveat to Item #5 also relates to the Cost Shifting Provision. We question whether the open-ended nature of that provision is consistent with Blue Cross' statutory mandates (particularly the mandate that it "protect" its financial condition).

8. While the rate concessions made to CNE in the 2009 Amendments could place other hospitals at a competitive disadvantage vis a vis the CNE Hospitals, especially smaller hospitals that might have less bargaining power than CNE.

9. Keeping the CNE Hospitals "in network" by entering into the 2009 Amendments likely advances accessibility of health care for Blue Cross subscribers.

10. Blue Cross' premium rates, and the claims expense of self-funded plans, will almost certainly rise as a direct result of the increased costs associated with the 2009 Amendments. While we acknowledge that the alternative might well have limited access and affordability to an even greater degree, the overall effect of the 2009 Amendments on access and affordability is likely to be negative.

VIII. Recommendations

Based on the foregoing analysis and conclusions, we recommend that the OHIC take one of the following steps to monitor, and to potentially mitigate, the negative effects of the 2009 Amendments:

1. If the OHIC determines that Blue Cross lacked the legal authority to enter into the Cost Shifting Provision based upon (a) the "insurance like" features of the Cost Shifting Provision; (b) the open-ended nature of the Cost Shifting Provision; and/or (c) any other finding made by the OHIC as a result of its review and consideration of this report or otherwise, we recommend that the OHIC order Blue Cross not to make any payments arising under the Cost Shifting Provision and, in lieu thereof, to use its best efforts to renegotiate the Cost Shifting Provision in a manner consistent with its legal authority.

2. If the OHIC determines that Blue Cross possessed the legal authority to enter into the Cost Shifting Provision, we recommend that OHIC order Blue Cross to mitigate the negative effects thereof as follows:

    a. Prohibition against "Open Ended" Contingencies: We recommend that Blue Cross be prohibited from entering into any new provider contract which does not "cap" any contingent liability at a known level, without obtaining the OHIC's consent.

    b. Enhanced Reporting (Cost Shifting Provision): We recommend that Blue Cross be required to promptly report to the OHIC if it receives notice from CNE that the Adverse Events provision has been triggered, and to provide the OHIC with pro forma financial statements showing the anticipated impact thereof.

    c. Enhanced Reporting ("Rising Tide"): We recommend that Blue Cross be required to advise the OHIC before entering into any new or renewal hospital provider agreement that would require it to directly or indirectly undertake contingent risk for governmental under-funding.

IX. Conclusion

The 2009 Amendments are likely to negatively impact Blue Cross and its subscribers in multiple ways, including the following:

- Reserves (i.e., surplus) will likely decrease;
- Premium rates charged to subscribers will likely increase;
- Self-insured plans administered by Blue Cross will likely be faced with higher costs;
- Out of state Blues Plans whose subscribers are treated at the CNE Hospitals will likely be faced with higher costs; and
- Blue Cross' bargaining position in future hospital negotiations will likely be affected negatively.

In this Report, we have provided recommendations that we believe, if implemented, will help to mitigate the potential negative effects of the 2009 Amendments.

We would like to thank Blue Cross and its staff for their assistance and cooperation in connection with this targeted examination.

Rector & Associates, Inc.

RECTOR & ASSOCIATES, INC.

Appendix A: Blue Cross Financial Condition

A. Overview

It is our understanding that Blue Cross experienced financial difficulties during the mid- to-late 1990's, losing over $70 Million in a three-year period. Blue Cross' financial position has significantly improved in the last decade. In 2008, however, Blue Cross experienced modest declines in assets, reserves, premium volume, members, and net income.

The following is an overview of Blue Cross' financial position as of December 31, 2008, 2007, 2006 and 2005, respectively:

	2008	2007	2006	2005
Admitted Assets	$710.6 Million	$728.7 Million	$659.5 Million	$594.4 Million
Capital & Surplus (Reserves)	$414.8 Million	$428.8 Million	$371.8 Million	$315.9 Million
Net Annual Premium	$1.756 Billion	$1.769 Billion	$1.697 Billion	$1.586 Billion
Reserves as % of Net Annual Premium	23.6%	24.2%	21.9%	19.9%
RBC	742.67%	762.30%	685.18%	613.94%
Net Income	$46.1 Million	$61.3 Million	$50.0 Million	$31.1 Million
Total members enrolled at end of period	499,151	512,798	465,262	443,447
Total member months	5,979,122	6,137,377	5,188,278	5,305,000

[Blue Cross' Annual Statements, 2004 – 2008]

B. Adequacy of Reserves (Capital & Surplus)

1. Ratio of Reserves to Annual Premium

It is our understanding that in 1999, Milliman USA concluded that Blue Cross' reserves were inadequate and recommended that Blue Cross maintain reserves equal to between 20% and 30% of annual premium. [Blue Cross subscriber publication titled "Today's Health Care Costs: Where Do Your Health Dollars Go?" dated March 2004] As reflected in the chart above, Blue Cross has been within this recommended range for four out of the past five years, although it has tended to be on the lower end of the range.

2. Reserves as measure of Liquidity

Blue Cross is required to maintain total reserves in a dollar amount sufficient to pay claims and operating expenses for not less than one month. [R.I. Gen. Laws §27-19-6]. At December 31, 2008 and 2007, Blue Cross' statutory reserves provided for 2.90 and 3.03 months, respectively, of claims and operating expenses. [Blue Cross Audited Statutory Financial Statements as of December 31, 2008 and December 31, 2007, Notes to Financial Statements, Note 8]

C. Blue Cross and Blue Shield Association Financial Responsibility Requirements

Pursuant to the Blue Cross and Blue Shield Association (the "BCBSA") License Agreements with Blue Cross, Blue Cross is required to satisfy certain financial responsibility standards in order to maintain its BCBSA licenses in good standing. Based on our review of the financial responsibility standards and the information provided by Blue Cross, it appears that Blue Cross satisfied the BCBSA financial responsibility standards as of December 31, 2008.

Appendix B: Blue Cross' Statutory Authority to Enter into the 2009 Amendments

Blue Cross is a non-profit, charitable, hospital and medical service corporation incorporated under Rhode Island General Laws §§27-19-1, *et seq.* and §§27-20-1, *et seq.* Following is a brief summary of key statutory provisions that impact upon Blue Cross' authority to enter into the 2009 Amendments.

A. Non-Profit Corporation Law

Blue Cross is subject to the Rhode Island Non-Profit Corporation Law (the "Non-Profit Law") to the extent the Non-Profit Law is not inconsistent with provisions of the Insurance Code applicable to Blue Cross. [R.I. Gen. Laws §7-6-3] The Non-Profit Law gives Blue Cross broad general powers to, *inter alia*, "make contracts and guarantees and incur liabilities" and to "exercise all powers necessary or convenient to effect . . . the purposes" for which it is organized. [R.I. Gen. Laws §7-6-5(8) & (15)]

Our review of the Non-Profit Law revealed nothing that appears to limit or prohibit Blue Cross' power to enter into and to exercise its rights and obligations under the 2009 Amendments.

B. Hospital and Medical Service Corporation Laws

1. Authorized Lines of Business

As a non-profit hospital and medical service corporation, Blue Cross is authorized to establish, maintain, and operate health plans for the purpose of providing medical and hospital services to its subscribers. [R.I. Gen. Laws §§27-19-1(3) & (4); 27-20-1(4), (5) & (6)] Medical services means "those professional services rendered by persons duly licensed . . . to practice medicine, surgery, chiropractic, podiatry, and . . . services rendered by a licensed midwife, certified registered nurse practitioners, and psychiatric and mental health nurse clinical specialists, and appliances, drugs medicines, supplies and nursing care necessary in connection with the services, or the expense indemnity [for the foregoing.]" [R.I. Gen. Laws §27-20-1(4)]

In addition, Blue Cross is permitted to underwrite any of the services or benefits that may be provided by nonprofit dental service corporations, nonprofit legal service corporations, or nonprofit optometric service corporations. [R.I. Gen. Laws §27-19-5(b)] Blue Cross also may administer self-insured or partially self-insured health benefit plans sponsored by employers, associates and other third parties, and may underwrite stop loss or catastrophe insurance in connection therewith. [R.I. Gen. Laws §27-19-5(a)(4)]. Finally, Blue Cross may underwrite life insurance, disability insurance, long-term care insurance, employee assistance programs and/or other health related programs, but only through a subsidiary or by third party contract. [R.I. Gen. Laws §27-19-5.3]

2. General Requirements

As a non-profit hospital and medical service corporation, Blue Cross is required to (1) employ pricing strategies that enhance the affordability of health care coverage; and (2) protect its financial condition. [R.I. Gen. Laws § 27-19.2-10] It also must adopt the following missions, *inter alia*:

- To provide affordable and accessible health insurance to insureds;
- To promote integration, efficiency and coherence of a statewide health care system that meets the needs of all Rhode Island residents;
- To contribute through its operations, procedures and investments to the improvement of medical and prevention services delivered in Rhode Island;

  and

- To provide affordable and accessible health insurance to a comprehensive range of consumers, including business owners, employees and unemployed individuals.

[R.I. Gen. Laws § 27-19.2-3]

3. Power to Enter Contracts

Each non-profit hospital service corporation may contract with its subscribers and with any eligible hospital for hospital service to be rendered by the contracting hospital to the subscribers and as to the nature and extent of those services. [R.I. Gen. Laws § 27-19-5] The rates charged by contracting hospitals to any non-profit hospital service corporation for hospital services rendered by the hospitals to the subscribers of the hospital service corporation shall be established from time to time by agreement between the contracting hospitals and the corporation.[21] [R.I Gen. Laws § 27-19-7]

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[21] In reaching the conclusion that this provision applies to the CNE Contracts, please note that we are aware of, and have considered, the potential impact of R.I. General Laws §§ 27-19-14 & 27-19-15, which state as follows:

> **§ 27-19-14 Negotiation of hospital cost.** – The state, acting through the budget officer or his or her designated representative, hospitals, and hospital service corporations incorporated under this chapter shall be parties to annual budget negotiations held for the purpose of determining payment rates for hospital costs by the state and those corporations. The parties to the negotiations shall know the total operating expenses for hospitals. The negotiations shall commence no later than one hundred eighty (180) days prior to the beginning of each hospital fiscal year. The negotiations, which shall be considered collective bargaining for the purposes of § 42-46-5(a)(2), shall be held for each hospital fiscal year and individual budget negotiations shall commence not later than ninety (90) days prior to the beginning of each hospital fiscal year. The parties shall employ mediation and arbitration services as an aid to the negotiations.

4. Premium Rate Standards

The rates proposed to be charged or a rating formula proposed to be used by any non-profit hospital service corporation to employers, the state or any political subdivision of the state, or individuals, shall be filed by a non-profit hospital service corporation with the OHIC. At any OHIC hearing, the applicant shall be required to establish that the rates proposed to be charged or the rating formula to be used are consistent with the proper conduct of its business and with the interest of the public. [R.I. Gen. Laws § 27-19-6]

5. Reserve Requirements

Rates proposed to be charged by any hospital service corporation shall be sufficient to maintain total reserves in a dollar amount sufficient to pay claims and operating expenses for not less than one month. [R.I. Gen. Laws § 27-19-6]

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§ 27-19-15 Agreement on budgets. – (a) The budgets and/or each hospital's projected expenses and related statistics shall be agreed upon not later than thirty (30) days prior to the beginning of each hospital fiscal year. The agreement shall be prima facie evidence that the budgets and related statistics are:

(1) Consistent with the proper conduct of the business of the corporations and the interest of the public to the extent that the budgets constitute in the aggregate a component of hospital service rates filed for approval in any rate hearing; and

(2) Reasonable as a component of rates paid by the state as a purchaser of hospital services.

(b) Each hospital shall file its proposed budget to the state budget office which shall include projected expenses for the current fiscal year and planned expenses for the next fiscal year. Each hospital will also file with the state budget office a copy of its audited financial statements with rates within thirty (30) days of acceptance by the hospital's board of trustees.