Actuarial Summary
for Required Rates in Plan 65 Non-Group Filing
For February 1, 2010, March 1, 2010, and April 1, 2010 Billing Cycles

➢ ***General Methodology***

The methodology for rating Plan 65 has several different components. This actuarial summary will describe the processes for calculating the Plan 65 required rates for our Medigap and Select plans. References to specific schedules in the rate calculations are underlined. Generally, the schedules work from back to front in the development of the required rates.

The required rate per contract per month (PCPM) for every Medigap and Select plan consists of two parts. These parts are the projected claims expense, or projected pure premium, and the retention components. The retention components encompass the administrative expenses, system replacement expenses, investment income credit, contribution to corporate reserve, federal taxes, and state taxes. The projected pure premium is calculated by projecting the claims expense for each benefit into the rate year through the use of projection factors and adding the appropriate benefit components together to get the total projected pure premium for each plan. The projected pure premium is added to the retention components to obtain the required rate. Then, the required rate is divided by the present weighted average subscription income to produce the required rate adjustment factor. The present rates within each rate band are multiplied by this factor to derive the required rates for each product. These processes will be described in more detail later in the summary.

The claims base consists of two pools. These pools are the Medigap and Select plans. These two groups are pooled separately to take into account the different risk characteristics of each pool. The Select products have a hospital network constraint (local to Rhode Island) while the Medigap products do not. Medigap and Select also have differing enrollment eligibility guidelines. For these reasons, Medigap and Select are pooled separately. The plans themselves in the Medigap set are pooled together due to the fact that two of the three plans are too small to be fully credible. Enrollment in Medigap Plans A and B represent only 3% of the total Medigap enrollment. Similarly, since Select Plans B and L only represent 5% of total enrollment for Select plans, Plans B and L are pooled with Select C.

Pooling the claims in this manner implies that the projected pure premium for a benefit in a given plan is the same as another plan in the same pool. For example, referring to schedule 11, columns 7 and 8, the 2010 projected pure premium for the Part A Deductible is the same for Select Plan B and Select Plan C, which is $0.82 per contract per month. Note that effective June 1, 2010, a hospice benefit will be added to all benefit plans as required by the recent Medigap redesign. This benefit will cover the 5% co-insurance for inpatient respite care and the co-payment (up to $5) for outpatient prescriptions during a hospice stay. Currently, this benefit is available only on Select

Plan L. We have determined that the impact of adding the hospice benefit is minimal and have not included a provision in rates for this benefit.

The claims base represents calendar year 2008 payment data for all benefits except for the Part A Co-payment, 365 Additional Days, and Foreign Travel Emergency benefits. Due to the erratic nature of these benefits, their pure premiums cannot be projected by normal means. The projection of the Part A Co-payment and Foreign Travel Emergency benefits uses an average of the 2005 through 2008 pure premiums for Medigap and Select price projected to calendar year 2008. The projection of the 365 Additional Days benefit uses an average of the 2004 through 2007 pure premiums for Medigap and Select price projected to calendar year 2008. CY 2008 claims data is not considered for the 365 additional days benefit since the claims runout is much longer for this benefit and CY 2008 was not considered reliable enough to use at the time of rate calculation. Note also that Medigap and Select claims were pooled together for the purposes of projecting 365 additional days PCPM since any difference in claims experience is likely attributable to random fluctuation rather than inherent morbidity. These benefits represent only 2.7% of Medigap claims and 2.0% of Select claims.

➢ ***Projected Pure Premium***

The projected pure premiums for all plans are calculated by projecting the claims expense PCPM from the base year 2008 into 2009, 2010, and 2011 through the use of composite projection factors. Since rates are effective for February 1, 2010, March 1, 2010, and April 1, 2010 billing cycles, we must project claims to both 2010 and 2011. These composite factors reflect changes in benefits, provider fees, and utilization/mix of services from year to year. For example, according to schedule 19, columns 2 through 6, the Medigap Part B outpatient co-insurance claims expense for calendar year 2008 was $31.66, and there was a no increase in the co-insurance itself, a 2.63% increase in provider fees, and a projected 1.00% increase in utilization. The total increase is projected to be 1.0000 x 1.0263 x 1.0100 = 1.0366. Therefore, the projected pure premium increase is 3.66% and the projected pure premium for the Medigap Part B co-insurance for 2009 is $32.82, which is shown in schedule 19, column 7. Benefit change factors and their supporting calculations pertaining to Part A benefits and the Part B Deductible can be found in the footnotes of the relevant schedules, while all other supporting calculations pertaining to projection factors can be found in schedules 25 through 33.

Benefit Changes

Benefit changes reflect the change in Medicare deductibles and co-payments for each benefit in a Medigap or Select plan. In most cases, the benefit change factor is the projection year deductible or co-payment divided by the deductible or co-payment from the previous year. The benefit changes for each benefit are shown below. Medigap and

Select have the same benefit changes with the exception of the Part B Co-payment, as explained below.

- Since the Part A Co-payment and Skilled Nursing Facility (SNF) Co-payment are directly proportional to the Part A Deductible, all three benefits will increase at the same rate. Therefore, they share the same benefit change factors. The Part A Deductible, Part A Co-payment, and SNF Co-payment benefit change factor from base period 2008 to 2009 is 1.0430, based on the Part A Deductible increase per 73 Federal Register (FR) 55087 September 24, 2008: $1,068 (CY 2009) / $1,024 (CY 2008). The benefit change factor from 2009 to 2010 is 1.0412, per the 2009 Trustee's Report released on May 12, 2009: $1,112 (CY 2010) / $1,068 (CY 2009). The benefit change factor from 2010 to 2011 is 1.0432, per the 2009 Trustee's Report released on May 12, 2009: $1,160 (CY 2011) / $1,112 (CY 2010).

- The 365 Additional Days benefit change factor from 2008 to 2009 is 1.0360, per 73 FR 55087 September 24, 2008. The payment-weighted average rate increase is used instead of the total hospital increase since the nature of this benefit implies that mix of services does not significantly impact this benefit (i.e. there are few services for which a member would be hospitalized for more than 150 days, when this benefit would begin to be utilized). The payment-weighted average rate increases for 2010 and 2011 are 1.0309 and 1.0329, respectively. These increases are consistent with the payment-weighted average rate increase assumptions in the Trustee's Report released on May 12, 2009.

- The Part B Deductible benefit change factor for 2009 over 2008 is 1.0000, per 73 FR 55089 September 24, 2008. The 2010 and 2011 factors are projected to be 1.0815 and 1.1712, respectively. These factors were developed as an average of the Medicare Economic Index (MEI) and 0% physician fee update scenarios shown in "Projected Medicare Part B Expenditures under Two Illustrative Scenarios with Alternative Physician Payment Updates," published by the CMS Office of the Actuary on May 12, 2008 in conjunction with the Trustee's Report. This scenario is more realistic than the 21.5% decrease in physician payments mandated by current law under the sustainable growth rate formula for 2010. Congress has overridden similar decreases for 2005 through 2009.

- The benefit change factor for the Part B co-insurances is the estimated decrease in Part B co-insurance claims cost due to the estimated increase in the Part B Deductible and are developed separately for Medigap and Select. This decrease is attributed to the fact that an increase in the Part B Deductible will result in a decrease in the Part B co-insurance, since the co-insurances for Part B services are made only after the Part B Deductible is met. This calculation is shown for each benefit change factor on their respective schedules. The Medigap 2009, 2010, and 2011 benefit change factors are 1.0000, 0.9982, and 0.9961, respectively. The Select benefit change factors for 2009, 2010, and 2011 are 1.0000, 0.9980, and 0.9956, respectively. These factors are applied to co-insurances for physician

and outpatient services.

- There is no change in the Foreign Travel Emergency benefit.

Provider Fees

The provider fees factor represents fee changes in physician services and outpatient services that affect the respective Part B co-insurances. This year, for the first time, we are trending the Part B physician and outpatient co-insurance benefits separately. The reason for this change is the fact that the utilization trends have differed greatly between the two benefits. The utilization patterns of Part B physician and outpatient services are described in the next section of this summary.

The physician services fee increases for January of 2009, 2010, and 2011 can be found on schedule 25, titled "Calculation of Part B Physician Fee Change Factors Effective January 1, 2009, January 1, 2010, and January 1, 2011." The physician fees are based on the actual and projected increases in the Part B physician conversion factor. The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, passed by Congress on July 15, 2008, increased physician fees by 1.1% for CY 2009. Also, as part of MIPAA, the co-insurance for behavioral health services will gradually decrease from the current 50% to 20% over the next several years. In 2010, for example, the behavioral health co-insurance is scheduled to be reduced from 50% to 45%. The change in the behavioral health co-insurance is reflected in the physician fee change factor calculations on Schedule 25. Current law calls for a 21.5% reduction to physician fees. Given that Congress has historically overridden similar decreases since 2005, this scenario is highly improbable. Therefore, the recommendation that Medicare Payment Advisory Commission (MedPAC) made in a report to Congress published in March 2009 was utilized. It recommends a 1.1% increase in the conversion factor for 2010. That increase is assumed to roll over for 2011.

Payments to physicians under Medicare are also adjusted by region by multiplying them by a Geographical Adjustment Factor (GAF). The change in the GAF for Rhode Island is shown on schedule 25 of the filing document. As explained in footnote D of schedule 25, the change in the GAF for 2009 is based on factors found in 73 FR 70157 November 19, 2008. The change in GAF for 2010, as explained in footnote E of schedule 25, is based on factors found in 74 FR 33803 July 13, 2009. Final comparable factors for 2011 have not yet been published and are assumed not to change.

- The estimated provider fee change factors effective for Medigap and Select Part B physician co-insurance beginning January of 2009, 2010, and 2011 are 1.0258, 1.0100, and 1.0110 respectively, per schedule 25, column 4.

The institutional services change factor reflects the expected change in the outpatient services co-insurance cost, and is calculated in detail on schedule 26. This factor is impacted by the implementation of the hospital Outpatient Prospective Payment System (OPPS) on August 1, 2000. Before the OPPS was introduced, the member co-insurance for Part B Outpatient services was calculated as twenty percent of billed charges. This often resulted in the member paying much more than twenty percent of the Medicare allowed amount, sometimes as much as fifty percent or more. When the OPPS was introduced, one of the intentions was to, over time, reduce the member co-insurance to be equal to twenty percent of the Medicare allowed amount. That level of co-insurance will be achieved by holding the member cost-sharing per service at a fixed dollar level until it is equal to twenty percent of the Medicare allowed amount for that service. At that time, the member co-insurance will increase at the same rate as the Medicare allowed amount, by way of the increase in the conversion factor, thus preserving the member co-insurance ratio at twenty percent.

Initially, the impact of the OPPS on member cost-sharing was minimal and we had assumed in previous filings that there was essentially no dollar increase in member cost-sharing. However, with this filing there is a change in the methodology used in calculating the price factors for Part B outpatient services. In order to more accurately reflect increases in Part B outpatient cost-sharing, we have included the impact of the year-to-year increases in the Part B outpatient conversion factor. Using published Medicare utilization data and the current Part B Outpatient co-payments and Medicare allowed amounts, we have estimated that approximately 36% of the outpatient co-insurance dollars is at twenty percent of Medicare allowed amounts in 2009. Thus 36% of the co-insurance dollars will increase along with the outpatient conversion factor in 2010. The percentage of outpatient co-insurance dollars at 20% of Medicare allowed is expected to increase as more outpatient services reach that level.

Existing factors that influence the outpatient co-payment (i.e. geographic and inflation factors) are still included in the calculation of the outpatient co-insurance price factors. These calculations are detailed and documented in schedule 26.

- The estimated provider fee change factors effective for Medigap and Select Part B outpatient co-insurances beginning January of 2009, 2010, and 2011 are 1.0263, 1.0227, and 1.0174 respectively, per schedule 26, line 10.

Utilization/Mix

The utilization/mix trend factor represents the increase in utilization of services from year to year and the changes in the mix of services used. This factor is calculated using trend analysis for each benefit. Five years of claims experience per contract per month is used to create trend lines. Since this factor only measures change in utilization and mix of services, all benefits are converted to their calendar year 2004 price level by dividing out the price factors for each year relative to calendar year 2004. This process is known as "de-pricing," and it assures that any changes in pure premium from year to year are

attributed only to changes in utilization and mix of services. Trend lines are fit to sets of data points utilizing the method of linear least-squares, which is a statistical technique for quantifying trend levels. Linear least-squares has been used for calculating trends for past rate filings. The principle of least squares states that the line of best fit to a series of observed values is the line where the sum of the squares of the deviations (the deviations between the line and the actual values) are the minimum or "least" possible. While it is possible to subjectively draw a line that best fits the data, this method provides a completely objective way of drawing that line. Following standard Blue Cross procedures, calculations are made to determine the line that best fit the data points with a minimum of the most recent two years of data (the most recent five data points or more). If there does not exist an r-squared value higher than 0.7 with five or more 12-month moving points, or the data is otherwise not conducive to this test, then actuarial judgment is used to select a trend. Medigap and Select are assumed to have the same utilization trends for each benefit for every year. The trend graphs produced by this method can be found on schedules 27 through 32. The annual utilization trends are as follows:

- The annual utilization trend factor for Part A Deductible is 1.0000, representing an assumed zero percent increase in utilization. Due to the unreasonableness of the indicated trend, actuarial judgment warrants the replacement of the calculated trend, -2.34% with an r-squared value of 0.90 and ten 12-month moving points, with a trend of 0.00%, or no change.

- The annual utilization/mix trend factor for the Part A Co-payment is 1.0000, representing an assumed zero percent increase in utilization and mix. Due to the unreasonableness of the indicated trend, and the erratic nature of the benefit, actuarial judgment warrants the replacement of the calculated trend, 35.64% with an r-squared value of 0.86 and five 12-month moving points, with a trend of 0.00%, or no change.

- The annual utilization/mix trend factor for 365 Additional Days is 1.0000; representing an assumed zero percent change in utilization and mix. This assumption is based on actuarial judgment, due to a lack of sufficient, stable data to evaluate trends, since by their nature these claims are infrequent and can fluctuate widely.

- The annual utilization trend factor for the Skilled Nursing Facility Co-payment is 1.0000, representing an assumed zero percent utilization. Due to the unreasonableness of the indicated trend, actuarial judgment warrants the replacement of the calculated trend, -8.94% with an r-squared value of 0.95 and ten 12-month moving points, with a trend of 0.00%, or no change.

- The annual utilization/mix trend factor for the Part B Deductible is 1.0000; representing an assumed zero percent change in utilization and mix. Actuarial judgment is warranted by the cyclical nature of this benefit. This is due to the fact that the Part B Deductible is relatively small and usually met in the beginning of

the year by most subscribers, resulting in a non-linear payment pattern.

- The annual utilization/mix trend factor for the Part B physician co-insurance is 1.0397, representing a 3.97% increase in utilization and mix. This increase is based on the calculated regression trend with an r-squared value of 0.97 and seventeen 12-month moving points.

- The annual utilization/mix trend factor for the Part B outpatient co-insurance is 1.0100, representing a 1.00% increase in utilization and mix. The calculated trend is 2.41% with an r-squared value of 0.63 and five 12-month moving points. However, this trend's r-squared falls below the 0.7 guideline that we apply to the trend calculation. Given that the Part B outpatient co-insurance utilization has increased steeply since March 2008, we feel that the 1.00% trend represents a reasonable utilization trend to assume for this benefit.

- The annual pure premium trend factor for the Foreign Travel Emergency benefit is 1.0000, which represents an assumed zero percent change in pure premium. This assumption is based on actuarial judgment, due to a lack of sufficient, stable data to evaluate trends, since by their nature these claims are infrequent and can fluctuate widely.

Once the benefit change, provider fee, and utilization/mix factors have been obtained, they are multiplied together to get the composite projection factor. The composite projection factor represents the overall increase in the pure premium for each benefit from year to year, as shown on schedules 17 through 19 and schedules 10 through 12 for Medigap and Select, respectively. After the pure premium for each benefit has been projected into calendar years 2010 and 2011, these projected values are aggregated to obtain the total projected pure premium for each benefit plan for calendar years 2010 and 2011. Since the rate year contains months in both calendar years 2010 and 2011, the pure premium for each of the two years is then weighted by the number of months in each calendar year. Subsequently, the pure premiums for the three billing cycles are weighted by the enrollment in each billing cycle, yielding the projected pure premium for the rating year. These computations are shown on schedules 15 and 16 for Medigap and schedules 8 and 9 for Select.

➢ ***Retention***

The retention component of the required rate is made up of four parts; the administrative expenses, system replacement expenses, Investment Income Credit, and Contribution to Reserve/Tax.

The administrative expenses represent our expected costs for administrating the Medigap and Select products during the rate year. The projected costs for calendar years 2010 and

2011 are shown on schedule 34. Similar to the claims expense, these calendar year administrative expenses must be weighted together to convert them to expected costs during the rate year. These calculations are shown on schedules 15 and 16 for Medigap and schedules 8 and 9 for Select. The administrative expenses during the rate year are $19.97 and $19.95 PCPM for Medigap and Select, respectively.

The system replacement expenses represent expenses associated with the core computer system replacement project (i.e. TriZetto Facets) that will replace the current LSRP system. These expenses are intended to recoup, over a fifteen year period beginning in 2008, extraordinary expenses necessitated by the installation of the new BCBSRI core operational computer system. BCBSRI is collecting an assessment of 0.34% of premiums from all lines of business, including Plan 65. Thus, 0.34% of the Plan 65 Non-group rates effective February 1, 2010 will contribute toward these expenses.

The Investment Income Credit component represents the reduction of the required subscription income PCPM due to the anticipated return on invested funds. This credit is calculated by looking at the contingency reserves, prepaid subscriptions, and claim reserves and is applied as a percentage of the projected pure premium plus the administrative expenses per contract per month. This percentage is calculated to be 0.67%.

The Contribution to Reserve/Tax factor of 0.9550 represents a 2% reserve contribution plus an additional 2.5% to account for federal income taxes (0.5%) and the state premium tax (2.00%). A state premium tax of 1.1% was originally passed on June 21, 2007, and was increased to 1.75% by the RI General Assembly on June 26, 2008. The state premium tax is currently 2.00%, per section 44-17-1 of the RI general laws. This factor would produce a 2% contribution to reserve on a post-tax basis. As of June 30, 2009, BCBSRI surplus levels are at 20% of annual premium. This level is below the minimum (23%) of the range recommended by the Lewin group. BCBSRI must also meet Risk-Based Capital requirements mandated by Blue Cross and Blue Shield Association. Given the current reserves of the Corporation, we believe a reserve contribution level of 2% is appropriate. Even with a 2% reserve contribution, BCBSRI reserves are not expected to get back to the 23% threshold level for several years. The resulting rate components for Medigap and Select are shown on schedules 14 and 7 respectively.

The administrative expenses, system replacement expenses, investment income, taxes, and reserve contributions components cover the retention portion of the required rate.

➢ ***Required Rate Adjustment Factor***

The projected pure premium plus the retention portions yield the required rates. The required rate adjustment factor for a given plan is calculated as the required subscription income divided by the present weighted average subscription income.

The present rate of income (PRI) for each plan is calculated first by dividing the total Plan 65 PRI at April 2009 without age-in credit by the total Plan 65 PRI at April with age-in credit. This divisional factor is then applied to the PRI without age-in credit for each plan to yield the PRI used for rating purposes. This process ensures an equitable distribution of age-in credit savings for rating purposes. This calculation can be found on schedule 21. It is important to note that this process does not change the overall required rate increase, but simply distributes the impact of the existing age-in rates evenly across all plans.

The methodology of using weighted average present rates to calculate required rate adjustment factors is one that is commonly used in the insurance industry to set appropriate premium levels. The weighted average present rate method discussed above recognizes the age-in discounts already being received by members but does not make any projection for future enrollment growth. Any failure to recognize these premium discounts when setting premium rates would make the age-in credit program unsustainable.

After calculating the PRI, the required rate is divided by the PRI for each plan yielding the rate adjustment factor for each plan. The rate adjustment factor represents the required increase to the present rates. This factor is multiplied by the present monthly subscription rates in each plan to derive the required monthly subscription rates.

➢ ***Conclusion***

In conclusion, the pure premium and retention portions of each Medigap and Select plan comprise the total rate for this year's rate filing. The pure premium is projected from calendar year 2008 to 2009, 2010, and 2011 using factors accounting for benefit changes, provider fees, and utilization/mix. The pure premiums for calendar years 2010 and 2011 are then converted to the rate year pure premium. The retention components encompass our expected administrative expenses, system replacement expenses, investment income credit, and reserve contribution and tax liability. The sum of these components yields the required subscription income. The required subscription income divided by the adjusted present rate of income yields the required rate adjustment factor for each plan. That factor is then applied to each plan individually to yield the required rates for each product.

➢ ***Affordability Update***

Age-in Credit

The Age-in Credit was introduced in the Plan 65 Non-Group rate filing effective February 1, 2007 in order to moderate future claims trends by attracting younger members. The program gives members who enroll in Plan 65 within the first six months

of Medicare Part B eligibility discounts on their rates for the first three years of their enrollment. The first, second, and third year discounts are 30%, 20%, and 10% respectively. After the third year, the member pays the full premium associated with their plan. The Age-in Credit is currently only applicable to Medigap A, Medigap C, Select C, and Select L plans, since Medigap B and Select B are closed to new enrollment. Effective June 1, 2010, we propose to close Select L to new enrollment and replace it with new Medigap N and Select N plans (these new plans are described later in this section).

Since the age-in credit program has not yet fully matured, is still too early to tell whether or not this program has indeed lowered the claims base for Plan 65 Non-Group. However, the increase in age-in enrollment has been encouraging, and utilization trends have moderated since the previous filing. Since the introduction of the program, the average age of the Plan 65 non-group population has dropped by approximately 1.2 years from 79.6 in January 2007 to 78.4 in July 2009. During that time, the Plan 65 utilization rating trends have moderated from 4.0% (approved in the February 2007 filing) to 1.9% (current filing).

There are currently approximately 3,300 members enrolled in the age-in program as of July 31, 2009. We shall continue to monitor this program and its impact on Plan 65.

Introducing Medigap N and Select N and closing Select L

This filing proposes to introduce two new Plan 65 products; Medigap N and Select N. Plan N is a new plan that was developed by the National Association of Insurance Commissioners and recently adopted by the Office of the Health Insurance Commissioner to be available to sell starting June 1, 2010. Plan N offers simple flat-dollar co-payments of $20 and $50 for office and emergency room visits (or 20% of the Medicare-allowed cost of the service, whichever is lesser), respectively, after the beneficiary meets his/her Part B deductible. The Part A Deductible, Part A Co-payments, 365 additional fully-paid inpatient days, skilled nursing facility co-payments, and Foreign Travel Emergency claims are also covered under both N plans. Plan N should be a popular option for subscribers who prefer the flat-dollar cost-sharing similar to Commercial and Medicare Advantage plans. The Plan N subscriber cost-sharing provisions allow us to price our Medigap N and Select N products about 20% less than our corresponding Plan C products, which enhances affordability. Medigap N will be open throughout the year to all eligible subscribers without medical underwriting requirements. Select N will require medical underwriting, unless guaranteed issue rules apply. Both N plans will have age-in discounts for those that qualify.

The filing also proposes to close Select L to new enrollment effective June 1, 2010. Since Select Plan L was introduced on February 1, 2007, its enrollment has not grown as much as we have hoped. As of July 31, 2009 there are only 239 subscribers enrolled in this product. These subscribers would be given the option to remain in the plan; however, Select Plan L would no longer be available to new subscribers effective June 1,

2010. Keeping Select L open until June 1, 2010 would give subscribers a low cost option until Medigap N and Select N become available.

Medigap N and Select N Rate Calculation

The rate development for Medigap N and Select N follows the procedure used for calculating the required rates for other Plan 65 plans with a few exceptions.

For Medigap N and Select N, Plan 65 claims were used for all benefits. However, the Plan 65 Part B co-insurance claims were adjusted to the Plan N level of benefit using benefit factors. The projected Part B physician and outpatient co-insurance claims were multiplied by these benefit factors to adjust for the introduction of $20 co-payments for office visits and $50 co-payments for emergency room visits. This benefit factor accounts for both the cost-sharing and the decrease in utilization due to the increase in cost-sharing.

In order to develop the benefit factors, overall utilization adjustment factors were developed for both physician and outpatient services. These utilization adjustment factors reflect the anticipated reduction to the number of services utilized by members due to the introduction of the cost-sharing provisions of Plan N. These are based on Milliman Health Cost Guidelines for the types of services impacted by the cost-sharing. These utilization adjustment factors were then applied to the projected Plan 65 claims expense for Part B physician and outpatient. Next, the value of the Plan N cost-sharing was calculated on a PCPM basis. For each type of service, the projected number of visits per 1,000 members was multiplied by the applicable co-payment (the lesser of twenty percent of Medicare allowed and $20 for office visits or $50 for emergency room visits) and divided by 12,000 to arrive at the co-payment PCPM. After that, the cost-sharing PCPM was subtracted from the adjusted claims to yield the net adjusted claims. This process converts the total liability for Plan 65 Part B physician and outpatient co-insurance claims from the fully-paid level to the Plan N level of benefits. Dividing the Plan N level claims by the total Plan 65 unadjusted claims yields the benefit factors by year (2010 and 2011) and benefit (outpatient and physician).

BCBSRI Medicare Advantage (MA) claims data was used as a surrogate for Plan 65 when calculating the projected cost-sharing and utilization adjustments. Since Plan 65 claims come to BCBSRI via crossover from our Medicare intermediary, the level of detail needed to identify the types of services that are impacted by the introduction of the flat-dollar co-payments is not available. Since both the Plan 65 and MA populations share similar risk characteristics (i.e. they are both retiree populations over age 65), we felt the MA claims data served as a reasonable proxy.

The development of the benefit factors for Plan N can be found on schedules 22 through 24.