Office of the Health Insurance Commissioner
State of Rhode Island and Providence Plantations

In re 2013 Rate Factor Review	**)**	
[issuer name] SERFF Tr Num: [ ]	**)**	**OHIC-2013-6**

Rate Approval Conditions

I. For all health insurance issuer contracts between hospitals licensed in Rhode Island and [issuer name] which expire between July 1, 2013 and July 1, 2014, or which would expire but for the amendment or renewal of the contract, subsequent contracts for commercially-insured enrollment shall include the following terms. The Commissioner, upon petition by [issuer name] for good cause shown, or in his or her discretion as necessary to carry out the purpose of the laws and regulations administered by the Office, may modify or waive one or more of the requirements of these Conditions. Nothing in these Conditions is intended to require that [issuer name] must contract with all hospitals licensed in Rhode Island. Consistent with statutes enforced by the Department of Health, health insurers must demonstrate the adequacy of their hospital network. Such health issuer contracts shall:

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

2. Include a quality incentive program. The quality incentive program shall include payment for attaining or exceeding mutually agreed-to performance levels for all or a subset of measures in the CMS Hospital Value-Based Purchasing Program for Medicare. The quality incentive program shall include measurement of the effectiveness of the "transitions of care" element of the program, as developed by the designated Medicare Quality Improvement Organization. An issuer's quality incentive program may also include one or more of the following: (i) other nationally accepted clinical quality, service quality, or efficiency-based measures; (ii) mutually agreed upon metrics of clinical quality that may have no clear precedent nationally, and (iii) mutually agreed upon clinical quality improvement activities that support new models of care coordination. The measures, performance levels, payment levels, and payment mechanisms must be articulated in the contract. A issuer may make interim payments in the event that interim measures of performance have been met; provided that the interim payments must be commensurate with the achievement of the interim measures; and provided further that a final settlement may only occur after the measurement period; and provided further that if the annual measures of performance have not been achieved, the hospital shall be required to remit interim payments back to the issuer.

3. Include a provision that:

(a) agrees on rates, and quality incentive payments for the next contract year, such that review and prior approval by the Office of the Health Insurance Commissioner shall be required if either: (i) the average rate increase, including estimated quality incentive payments, is greater than the Centers for Medicare and Medicaid Services (CMS) National Prospective Payment System Hospital Input Price Index (“Index”), plus one percent or (ii) less than 50% of the average rate increase is for expected quality incentive payments.

(b) agrees to a similar provision for subsequent contract years if the contract is effective for multiple contract years; and

(c) agrees on measures that protect the consumer from increased premiums due to changes in procedure and diagnosis documentation practices. The provision shall require the issuer to notify the Office of the Health Insurance Commissioner if the issuer can document that provider coding practices have changed when compared to prior years' practices and that those changes in coding practices have created financial consequences for the issuer that negatively impact its rates.

The Index applicable to the new contract year will be based on the most recent Hospital 4 Quarter Moving Average Percent Change published and available as of the signing of the contract. For renewal and optional years it will be based on the applicable most recent Index 4 Quarter Moving Average Percent Change period available prior to the new contract year. Upon written request of an issuer, supported by the hospital's written agreement with the issuer's request, the Commissioner may approve exceptions to the Index limit for those hospital contracts which the issuer demonstrates, to the Commissioner's satisfaction, align significant financial responsibility for the total costs of care for a defined population and set of services in manners generally consistent with the alternative Medicare payment mechanisms proposed under the Affordable Care Act. Issuers are encouraged to file such requests.

4. Include terms that define the parties' mutual obligations for greater administrative efficiencies, such as improvements in claims and eligibility verification processes, and identify commitments on the part of each, and that require the parties to actively participate in OHIC's Administrative Simplification Work Group.

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

II. By March 1, 2014 [issuer] shall develop, in discussion with the State of Rhode Island Health Benefits Exchange if the issuer intends to offer the plan in the Small Business Health Insurance Options Program (SHOP), and file for approval with the Commissioner at least one affordable health insurance plan in the small group market, and shall begin to market the small group plan by May 1, 2014. The new plan shall be priced at least 15% less than the price of a plan with comparable benefits. The plan shall further health care delivery system reform by incorporating financial incentives for [issuer] subscribers to use health care providers that have agreed with the issuer to offer health care services with price discounts and utilization procedures designed to achieve the plan's affordability goal. The plan shall include, but need not be limited to, a plan design with financial incentives for utilizing health care providers affiliated with one or more health systems.

III.(a) A health insurance issuer shall not enforce a provision in any participating provider agreement which purports to obligate the health insurance issuer or health care provider to keep confidential price information requested by a designated health care provider for the purpose of making cost-effective clinical referrals, care coordination, or treatment decisions.

(b)(i) At the request of a designated health care provider, a health insurance issuer shall disclose in a timely manner to the health care provider such price information as is reasonably necessary for the designated provider to make cost-effective clinical referrals, to engage in care coordination activities, or to make other treatment decisions.

(ii) A health insurance issuer may adopt reasonable policies and procedures designed to limit the disclosure of price information for purposes other than those identified in Para. (b)(i), above.

(c) Disclosure of price information to consumers and other providers. On or before April 1, 2014, each health insurance issuer shall file for the Commissioner's approval its Comprehensive Price Transparency Plan. A Comprehensive Price Transparency Plan shall empower consumers and all health care providers to make informed and cost-effective health care decisions. In developing its Plan, the issuer shall:

(i) establish a time-line for implementation of the Plan;

(ii) identify the health care services, products and supplies subject to price disclosure under the Plan, including but not limited to hospital in-patient and out-patient services, physician services, other health care provider services, medical imaging services, laboratory services, prescription drug prices, durable medical equipment, and medical supplies;

(iii) identify the health services, products and supplies, if any, that are not subject to price disclosure under the Plan;

(iv) establish the issuer's policies and procedures designed to limit disclosure of price information for purposes that would negatively impact the public interest in transparency, competition, and affordability;

(v) disclose price information with respect to services reimbursed on a fee-for service basis, as well as services reimbursed by alternative reimbursement mechanisms;

(vi) demonstrate to the Commissioner that the issuer has solicited and considered the comments and recommendations of consumers, employers, health care providers, health care facilities, and other stakeholders in developing its Plan; and

(vii) submit to the Commissioner progress reports on the development of its Plan during August, 2013 and during January, 2014.

Consent of [issuer name]

I. Upon the filing of these Conditions with OHIC, and the approval by the Commissioner of the modified rates incorporated into this filing, [issuer name] understands and agrees that these Conditions constitute valid obligations of [issuer name], legally enforceable by the Commissioner.

II. [Issuer name] waives its rights to an administrative hearing with respect to the above-referenced 2013 Rate Factor filing and with respect to the enforceability of these Conditions; provided, however, the [issuer name] shall have a right to a hearing on any charge or allegation brought by OHIC that the [issuer name] failed to adhere to, or violated any of the requirements of these Conditions, and the [issuer name] shall have the right to appeal any adverse determination resulting from such charge or allegation.

III. [Issuer name] waives its right to judicial review with respect to the above-referenced 2013 Rate Factor filing and with respect to the enforceability of these Conditions; provided, however, the [issuer name] shall have a right to a hearing on any charge or allegation brought by OHIC that the [issuer name] failed to adhere to, or violated any of the requirements of these Conditions, and the [issuer name] shall have the right to appeal any adverse determination resulting from such charge or allegation.

IV. [Issuer name] acknowledges and agrees that it consents to the legal obligations imposed by these Conditions, and that it does so knowingly, voluntarily and unconditionally.

By: _____ Date: _____

Title: [ ]