



Presentation on Coventry Legislative Affairs and Legislation Affecting the Workers' Compensation Industry

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**This information is intended solely for informational purposes
and is not intended as legal advice**

Government Affairs Overview



- Mission: To ensure Coventry's awareness of and positive influence upon significant legislative, regulatory and policy issues
 - State Level Activities:
 - Actively participate in legislative process
 - Develop and maintain positive relationships with State legislators and regulators
 - Manage team of retained counsel/lobbyists
 - Provide information to Coventry colleagues and customers

State Government Affairs Activities



Health care is on most state legislative agendas

- Key Issues Include:
 - Access
 - Affordability
 - Role of Government, Private Sector
 - Market Regulation

Market Regulation

Regulation of the Secondary Market in Physician Discounts

- AMA and State Medical Associations seek legislative solutions to:
- *Address perceived “unregulated” activity in secondary market (central premise: PPOs are unregulated)*
 - Rental Networks
 - Expanded Access to PPOs
 - Additional Payers
 - Repricers/Aggregators
 - Secondary or “wrap” networks

Market Regulation - AMA Agenda



Two overarching goals

- *Level the playing field between providers and managed care organizations*
 - Provider control over products and payers
 - Provider control over essential terms of the contract
 - Prohibition on “take it or leave it” contracts

- *Increase transparency and uniformity in contracting process*
 - Summary fee, edit and other disclosures
 - Notice of network rental, payer lists and EOR disclosures
 - Clarity regarding amendment, termination and policies & procedures

Secondary Market – AMA's Principles



AMA has developed a set of core principles to govern activity in the secondary market

- Only network with direct contract with provider may sell or lease network
- Network information may be sold or leased only to *payers*
 - No Network Aggregators/Resellers/Repricers
 - No Network Wraps
 - No Single-Market/National PPO Partnerships
- Payers to whom network information is sold or leased must abide by all terms and conditions of the underlying contract
 - Payment – fees, time frames
 - Dispute resolution
 - Amendment and termination procedures

Secondary Market – AMA’s Principles



- Payers to whom network is sold or leased must be named in the contract and approved by provider in advance
 - Unique networks by client
 - Lead time to “approve” new clients; may reject on individual basis
 - Significant costs to manage
- Pre- and post-service notice requirements
 - Payer lists and other pre-service disclosures
 - Identification of source contract and payer on EOBs or remittance advice
 - Web-based enrollment verification systems
- Disclosure of remuneration for access to network

Secondary Market – AMA's Principles

AMA's Principles are driving activity on several fronts

- NCOIL: Health, Long Term Care and Health Retirement Issues Committee considering adoption of AMA's Model Act encompassing core Principles. Tabled in February 2008 pending continued Task Force negotiations.
- AMA/Industry Task Force working to develop agreed Principles
 - *AAPPO, AHIP, BCBSA, CAHI, Coventry*
- State legislative initiatives
 - Proposed bills in several states in 2007 and 2008
 - Many would apply to workers' compensation PPOs and contracts

State Legislative Initiatives



- In 2007 and 2008, more than a dozen state legislatures have considered bills reflecting AMA's Principles, including (but not limited to)
 - Texas HB 839; HB 2016/SB 1170
 - Ohio HB 125/SB 127*
 - Colorado SB 79*
 - New York AB 7591/SB 3804
 - Idaho HB 522*
 - Indiana SB 159*
 - Tennessee HB 3214; SB 445* (limited to WC)
 - Pennsylvania HB 933

* *Passed and Signed into law or passage imminent*

State Legislation - Colorado

Colorado SB 79



- Reflects “compromise”
- Key Provisions:
 - Access to network information/network rental
 - Contract must state that it applies to sale, lease, rental of network information
 - Entities granted access must comply with terms of underlying contract
 - Information about where claims and inquiries may be sent
 - Contract amendments
 - Requires 90 days’ conspicuous notice; providers may selectively reject
 - No termination based on provider’s rejection of proposed new product
 - Mandatory claims adjudication disclosures
 - Summary disclosures, includes fee schedules/reimbursement methodology

Status: **Enacted**, making Colorado the first state to legislate the content of contracts between providers and managed care organizations.

State Legislation - Ohio

Ohio HB 125/SB 127

- Heard in Civil and Commercial Law Committee
- As Introduced:
 - Prohibits Network Rental
 - Mandates use of CAQH Credentialing form; establishes tight timeframe for credentialing; retroactive reimbursement “penalties”
 - Multiple product contracts prohibited as condition of contracting
 - Prohibits Most Favored Nation clauses (more than 20% market share)
 - Mandatory summary disclosures; includes full fee schedules
 - Requires creation of web-based eligibility verification system



Status: Pending as revised by negotiations; expected to pass

Implications for PPOs

- Limits or prohibits efficient and positive business arrangements
 - No national/local network partnerships
 - No secondary networks/wraps

- Hampers ability to adjust fees, policies and procedures
 - Up to 120 day's advance notice of material changes interrupts business flow
 - Selective rejection rights create patchwork of individualized contracts
 - Material changes often defined to include routine code changes

- Impacts network operations and business decisions
 - Mandatory Credentialing Guidelines and timeframes raise quality concerns
 - Rigid amendment procedures limit flexibility and responsiveness
 - Explanation of payment methodology may require disclosure of proprietary information
 - Payer notice and approval requirement impede ability to control relationships with customers
 - Multiple product prohibitions cause loss of ability to “bundle” products
 - Future products prohibitions stifle development of new products (consumer-driven)

Implications for Payers



- Reduced Savings
 - Individual payers may be excluded from beneficial relationships at prerogative of provider
 - Fewer network choices available

- Fewer Choices for Customers
 - 64% of Americans with health care coverage are covered through PPOs (AAPPO, 2007)
 - Will see fewer PPOs generally - product may no longer be available in rural or sparsely populated areas
 - Product portfolio will stagnate as development of new products is hampered

- Increased Access Fees
 - Increased administrative costs will be passed on

- Elimination of Advantageous Business Partners and Arrangements
 - Rental to repricers/aggregators prohibited
 - Non-logo business prohibited

Implications for Consumers

- Fewer choices for consumers
 - Fewer Provider Networks
 - Prohibition/limitation on rental and transfer of information
 - Increased administrative costs
 - Fewer Products Offered by Existing Networks
 - Physician Opt-out Rights
 - Future Product clause prohibitions
 - Provider right to reject addition of new and innovative products (i.e., consumer-driven)
- Higher costs for consumers and employers
- Increased vulnerability of “undesirable” patient populations, including injured workers

What can you do?



- Stay Informed
 - National Trade Organizations
 - State Legislative Web Sites
 - AMA and State Medical Association Web Sites

- Join/Support National, State and Local Organizations
 - AAPPO, AHIP, State Health Plan and TPA Associations
 - State and Local Chambers of Commerce
 - NGA, NCSL

- Participate in Legislative Process
 - Know and Visit your Legislators
 - Testify/Participate in Stakeholders' Groups