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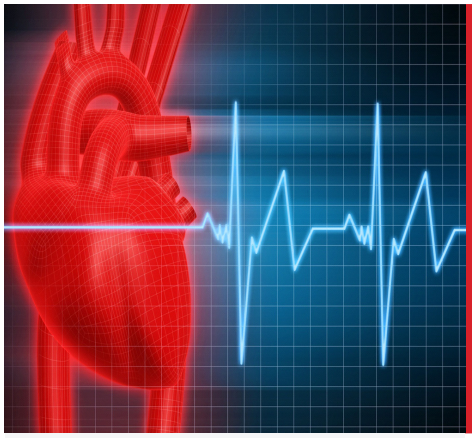

Healthcare Law Alert

A Corporate Department Publication

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This Healthcare Law Alert is intended to provide general information for clients or interested individuals and should not be relied upon as legal advice. Please consult an attorney for specific advice regarding your particular situation.

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Ohio's Healthcare Simplification Act Seeks To Place Healthcare Providers And Insurers On Equal Footing

Governor Strickland recently signed H.B. 125, the Ohio Healthcare Simplification Act. The Act, sponsored by the Ohio State Medical Association, has two main goals: to improve the contracting process between healthcare providers and insurers and to standardize the credentialing process that insurers require of healthcare providers.

Impact on Contracting Process

The Act imposes several requirements on insurers that contract with healthcare providers for the provision of healthcare services. To begin, insurers must give healthcare providers a fee schedule that includes information about the manner of payment and procedure codes. Insurers also must prepare a summary disclosure form for providers that highlights key provisions of the contract in understandable terms. In addition, insurers must now give healthcare providers written notice of any material amendments to the contract 90 days before those amendments become effective to allow healthcare providers an opportunity to object. Material amendments include anything that decreases the healthcare provider's compensation, significantly increases the healthcare provider's administrative expenses, or adds a new product. (Notice is also required for non-material amendments — including administrative changes, compensation changes based on changes to Medicaid or Medicare fee schedules, etc. — but that notice must be given just 15 days before the non-material amendments become effective.)

The Act, moreover, restricts the use of certain contract provisions and practices. Insurers may now sell, rent, or give their contract rights to the following third parties under specified circumstances: healthcare-providing employers who have contracts with insurers; affiliates or subsidiaries of insurers; or parties — such as third-party administrators or preferred provider networks — that provide electronic claims transport. Even then, insurers are required to maintain a website or toll-free number where healthcare providers can obtain a list of all such third parties. Insurers must also require that all third parties comply with the terms of the original contract between the healthcare provider and the insurer.

To even the playing field between insurers and healthcare providers, the Act bans altogether certain common contract terms. "All products" and "future products"

clauses attempt to force healthcare providers to offer all of the services offered by the insurer as well as any services the insurer may offer in the future. The Act prohibits insurers from requiring healthcare providers to abide by these terms but leaves the parties free to agree to them voluntarily. Along the same lines, the Act bans "most favored payer" clauses, which force healthcare providers to contractually guarantee that they will not offer other insurers lower fees for services performed.

Taken together, the Act's provisions concerning contracts between healthcare providers and insurers are intended to address some of the most common issues between these two key players in the healthcare industry.

Impact on Credentialing Process

The Act's other intended consequence is to standardize the credentialing process used by insurers to select healthcare providers in Ohio. In particular, the Act requires the Department of Insurance to adopt the credentialing application form used by the Council on Affordable Quality Healthcare (CAQH) for all physician credentials. The Act further directs the Department of Insurance to adopt a simple and straightforward application form for all other types of healthcare providers. Upon receipt of credentialing forms, insurers must notify the healthcare provider of any deficiencies within 21 days and complete the credentialing process within 90 days (unless the healthcare provider is a hospital). The Act imposes a $500 per day civil penalty for each day over the 90-day period that it takes to grant or deny a credentialing application or retroactive reimbursement per the contract for all health care services performed after 90 days but before the credentialing application is granted or denied.

Other Matters

The Act also created the Advisory Committee on Eligibility and Real Time Claim Adjudication to recommend steps that would allow healthcare providers to correspond in a more efficient manner about patient eligibility matters. Specifically, the Committee will examine whether the Internet or coverage card magnetic strips, for example, could improve provider/insurer communication. The Committee's report is due January 1, 2009.

We'll keep you posted!

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