Washington Healthcare News

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Third Party Administrators - Service Providers to Self-Funded Health Plans

By David Snodgrass, CLU, ChFC
President and CEO
Healthcare Management Administrators

The topic of Third Party Administrators of health benefits directly relates to self-funding of health benefits. Group health plans represent the core of employer-sponsored employee benefit plans, with the cost of providing group health benefits second only to the cost of wages for each employee. A high percentage of the plans offered by employers of 100 employees or fewer are fully insured and administered by health carriers and insurance companies. However, as the size of the employer group increases above 100 employees, the percentage of employers that chooses to self-fund their health benefit plans increases as well. Data from the Kaiser/HRET 2007 Survey of Employer-Sponsored Health Benefits (below) shows that 12% of plans covering fewer than 200 employees self-fund while 86% of firms over 5,000 employees use self-funding to provide health benefits. In addition, the survey shows the overall percentage of workers in firms that self-fund health benefits has steadily increased from 44% in 1999 to 55% in 2007.[1]

When it comes to plan administration, self-funded plans have several options. Third Party Administrators (TPAs), insurance carriers and health plans (Carriers) can administer self-funded health plans. When a Carrier provides third party administration services to a health plan on a self-funded basis it is commonly known as an ASO (administrative services only)

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Percentage of Covered Workers in Partially or Completely Self-Funded Plans by Firm Size, 1999-2007*

	1999	2000	2001	2002	2003	2004	2005	2006	2007
3-199 Workers	13%	15%	17%	13%	10%	10%	13%	13%	12%
200-999 Workers	51	53	52	48	50	50	53	53	53
1,000-4,999 Workers	62	69	66	67	71	78	78	77	76
5,000 or More Workers	62	72	70	72	79	80	82	89	86
ALL FIRMS	44%	49%	49%	49%	52%	54%	54%	55%	55%

*Table recreated from Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2007, Exhibit 10.1.
Kaiser/HRET report's accompanying notes state "Tests found no statistical difference from estimate for the previous year shown (p<.05). Due to a change in the survey questionnaire, funding status was not asked of firms with conventional plans in 2006. Therefore, conventional plan funding status is not included in this figure for 2006. For definitions of Self-Funded and Fully Insured plans, see the introduction to Section 10 [of the report]."

Inside This Issue

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Letter from the Publisher and Editor

Dear Reader,

We are extremely grateful to David Snodgrass for submitting this month's article on Third Party Administrators. David is well known in this sector of health care and is one of the pioneers of the Third Party Administrator business as it is known today.

The fact that more employers self-fund than fully insure their benefit plans is significant. I often hear from health plan CFOs that the statistics shown on page 27 of this edition only tell part of the story of plan financial results. Premera, for example, is reported on our schedule as having 700,000 fully insured enrollees. According to Kent Marquart, their CFO, Premera provides self-funded Third Party Administration services for an additional 800,000 people not shown on the schedule. The News doesn't report activity for self-funded plans because it is not publicly and independently available.

There are many reasons employers choose self-funded plans over fully insured plans. Some of the most obvious include:

- There are no premium taxes
- There are no State benefit mandates
- Employers can greatly customize benefit plans
- Surpluses (and deficits) accrue to the employer
- Administrative costs are more transparent
- Claim payments can be deferred for several months
- There is a higher level of employer control

We can expect to see large employers continue their migration to self-funded plans. This will continue the erosion of fully insured plan enrollment and, subsequently, accelerate their level of risk and premium.

David Peel, Publisher and Editor

Washington Healthcare News 2008 Editorial Calendar

Month and Year	Theme of Edition	Space Reservation	Distribution Date
January 2008	Healthcare Public Policy	December 3, 2007	December 21, 2007
February 2008	Urban Medical Clinics	January 7, 2008	January 25, 2008
March 2008	Rural Hospitals	February 4, 2008	February 22, 2008
April 2008	Insurance Carriers	March 3, 2008	March 21, 2008
May 2008	Healthcare IT	April 7, 2008	April 25, 2008
June 2008	Rural Medical Clinics	May 5, 2008	May 23, 2008
July 2008	Healthcare Facilities	June 2, 2008	June 22, 2008
August 2008	Healthcare Human Resources	July 7, 2008	July 25, 2008
September 2008	Community Health Centers	August 4, 2008	August 22, 2008
October 2008	Third Party Administrators	September 8, 2008	September 26, 2008
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December 2008	Urban Hospitals	November 3, 2008	November 21, 2008

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Third Party Administrators - Service Providers to Self-Funded Health Plans

<TPA

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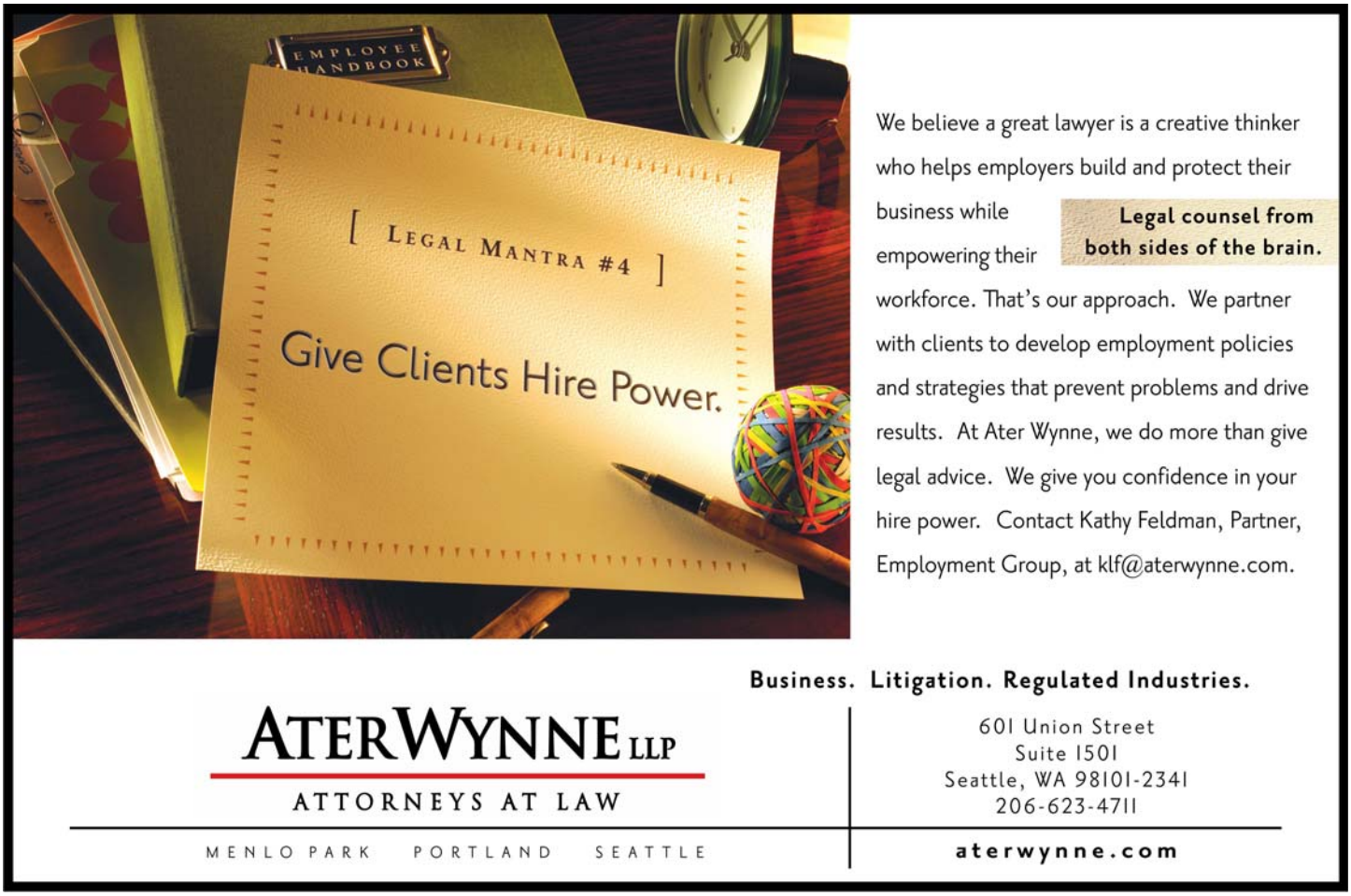
arrangement to distinguish the financial arrangement from the insured plans that Carriers provide. Employers that purchase ASO arrangements from Carriers are generally purchasing a package from a single source. In most cases, this means administrative services, healthcare management services, stop-loss insurance, pharmacy benefits, provider network access and other claim services from the single Carrier. The ASO arrangement is similar to the insured plan options offered by a given Carrier, but using a self-funding financial approach. It tends to be the Carrier's plan administered on a self-funded basis. Generally the larger the plan, the more a given Carrier is willing to customize the components for the large employer.

As is the case with Carriers, TPAs range from very small serving only a few thousand covered lives to very large serving several million lives. The range of services offered is equally diverse. There are estimated to be over 400 TPAs that provide administration for self-funded group health plans. TPAs may be independently owned or may be subsidiaries of Carriers or other corporate entities. About 90% of TPA's belong to the Society of Professional Benefit Administrators (SPBA), the professional TPA trade association headquartered in Washington, D.C. While both TPAs and Carriers provide services to self-funded health plans, in either case employers remain the Plan Sponsors.

Regulations governing fully insured plans versus self-funded plans differ. Fully insured plans are regulated by the various state insurance departments while most single employer self-funded plans (including ASO) are not state-regulated, but covered under the federal ERISA law (Employee Retirement Income Security Act of 1974). ERISA is the enabling legislation that allows most employers to sponsor their own self-



funded health plans. The exceptions are single employer self-funded plans sponsored by government entities, churches and Indian Tribes, which fall under other state and federal regulations, not ERISA.

TPA Services and Self-funded Plan Components

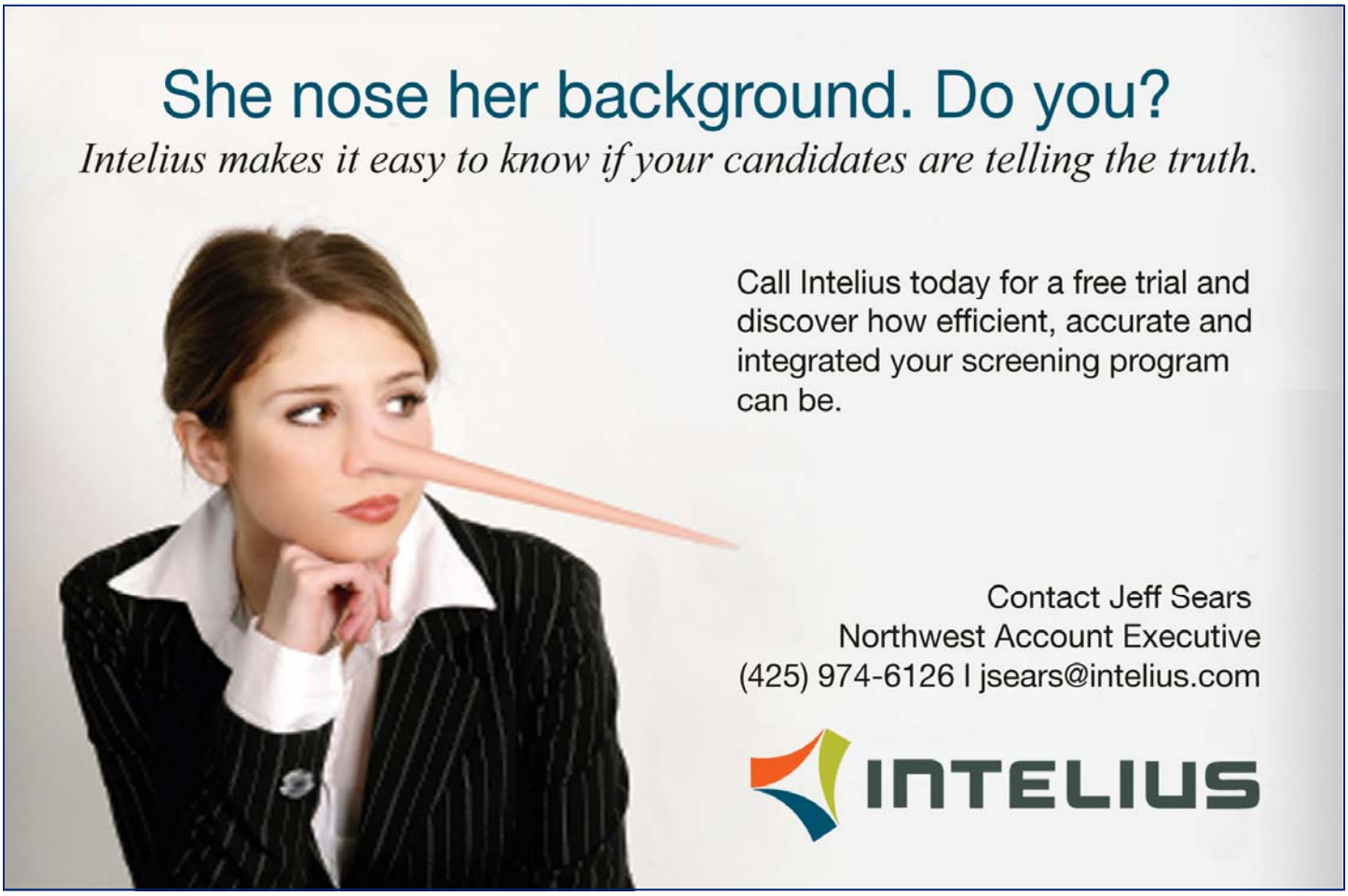
TPAs are efficiency experts that cater to employers who sponsor their own self-funded health plans. Often the employer needs personalized, flexible services that may come from a variety of sources yet can be integrated by the TPA. For the smaller to mid-sized self-funded plans, TPA administration is particularly beneficial, as services are generally provided at lower administrative cost than comparable ASO plans from Carriers.

In most cases, the employer retains a benefit consultant to advise them on important plan decisions such as TPA selection. Choosing the right TPA is crucial given that it directly affects the plan's options and influences overall value in areas such as:

- Plan design options for Consumer Engagement
- Claims, Utilization & Case Management services
- Disease Management & Wellness Programs
- PPO network access and discounts
- Rx design and administrator (PBM) options
- Stop-loss insurance options
- Reporting services & analytics
- Compliance services for COBRA, HIPAA, ERISA, etc.
- Administration of FSA, HRA and HSA accounts

Ideally, the employer, consultant and TPA work in partnership to design the plan so it provides the best overall value to the covered individuals. Value is determined by cost and quality. Outlays for administration, stop-loss insurance and health claims drive the cost of providing health benefits, and in any given self-funded plan, over 90% of those costs derive from stop-loss insurance and health claims expenditures. Identifying these cost drivers and managing them as effectively and strategically as possible is normally

Please see> TPA, page 6



Third Party Administrators - Service Providers to Self-Funded Health Plans

<TPA

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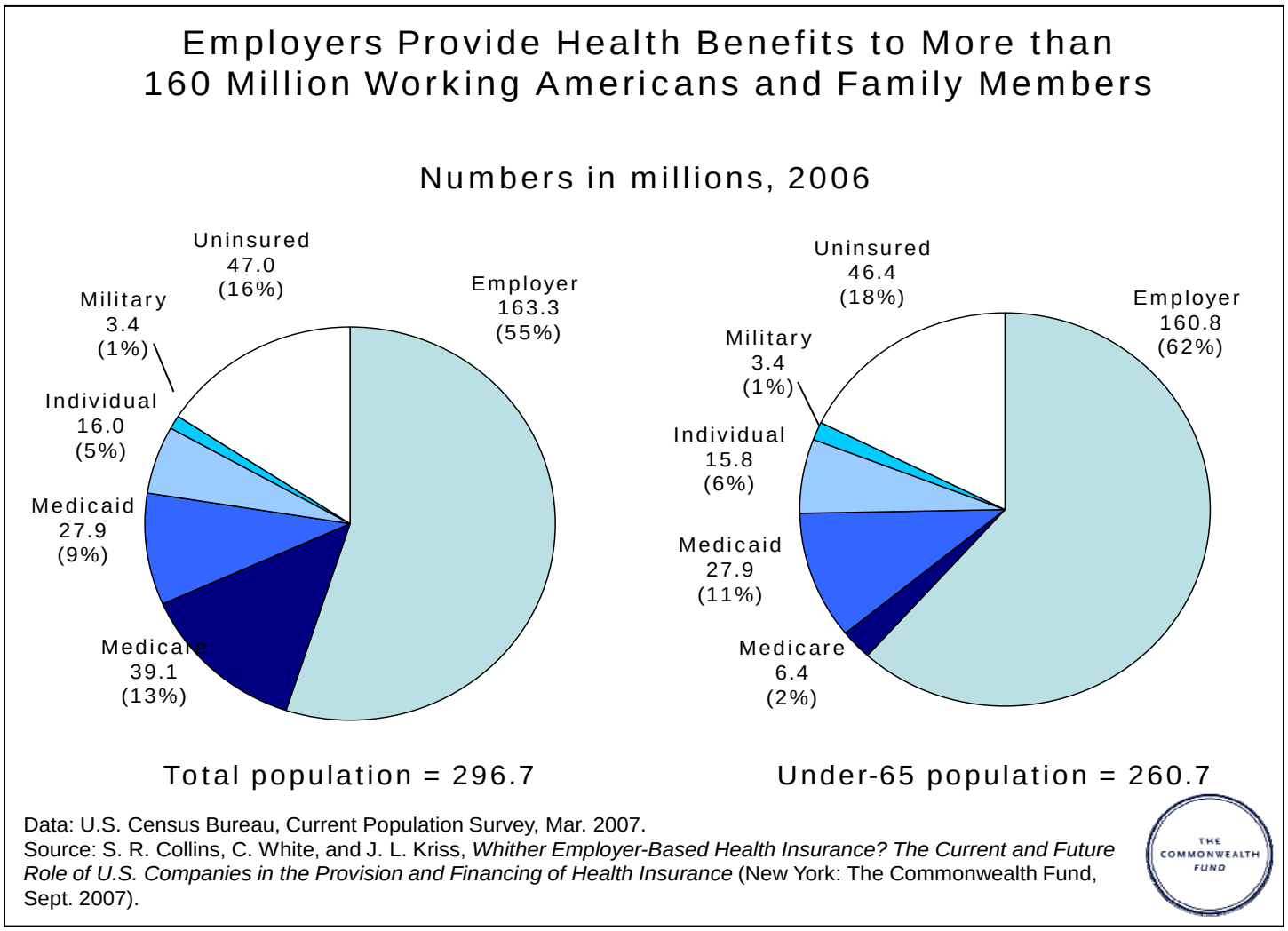
an objective of the self-funded employer.

Healthcare Reform – What is the Future of TPAs, Self-funding and Employer-sponsored health plans?

We are currently in the middle of an important national election and healthcare reform continues to be hotly debated as it has been for many years. The answers to these questions are obviously open to a great deal of speculation and debate. Rather than try to make predictions, let's look at data about where Americans under age 65 currently obtain their health benefits (see graph below, right).

The Commonwealth Fund chart displays data from the most recent Census Bureau Current Population Survey indicating that those individuals with private health benefits total about 177 million. Of that total, about 161 million are covered by employer-sponsored health plans and only 16 million by individual and other plans.[2] The data shows that employer-sponsored plans cover over 91% of private health benefits for the under age 65 population. The Kaiser/HRET data, on page 1 shows over half of these workers are covered by self-funded plans and that the percentage in self-funded continues to grow.

The Commonwealth chart also shows that uninsured individuals now total over 47 million (below, left). Healthcare reform hopefully includes ways to eliminate lack of coverage for this large number of people. The objective of universal coverage for everyone in our system is one issue; how this is best accomplished is a separate, more fundamental matter. As Kaiser Family Foundation's CEO reminds us, unless the public buys into changes, chances are they



won't succeed. A recent Foundation tracking poll asked people with employer-based coverage whether they felt self-purchase would make it easier or harder to obtain good health coverage. On a number of measures, between 63 and 81 percent said it would not.[3] This tells us that while consumers want control, they perceive changes to how they obtain coverage as potentially complicated. Given that employer-sponsored plans are the primary avenue for 163 million individuals in the U.S. to obtain health benefits, and that of those plans, over 50% are self-funded and that TPA administration is one of the primary ways that employers deliver medical benefits through their self-funded plans it seems unlikely in the foreseeable future that employer's sponsorship, self-funding and TPA administration of these plans would be eliminated from the health benefit options for working Americans. As to the future, to paraphrase Mark Twain – the reports of the demise of employer-sponsored health plans, self-funding and TPAs may be greatly exaggerated.

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[1] www.kff.org/insurance, Employer Health Benefits 2007 Annual Survey, The Kaiser Family Foundation and Health Research and Educational Trust; chart page 147, figure 10.1.

[2] www.commonwealthfund.org, S. R. Collins and J. L. Kriss, Envisioning the Future: The 2008 Presidential Candidates' Health Reform Proposals, The Commonwealth Fund, January 15, 2008, Volume 82; chart page 2, figure 3.

[3] www.kff.org/pullingittogether/062608_altman.cfm, "Pulling It Together" column, Kaiser Family Foundation CEO Drew Altman, June 26, 2008.

David Snodgrass, CLU, ChFC, is President and CEO of Healthcare Management Administrators, a leading TPA that works with clients to design, implement and administer self-funded employee benefit plans specifically targeted to include Preferred Provider Options and other Managed Care approaches. Mr. Snodgrass can be reached at david.snodgrass@accesstpa.com or 425.289.5112.

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Law Creates Brutal Tax on Many Types of Severance Arrangements

By John Walch
Employee Benefits and Executive Compensation Practice Leader
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Congress recently enacted §409A of the Internal Revenue Code (the "Code") to tax "deferred compensation." Previously, most severance arrangements were not taxed as deferred compensation. As a result, many employers are not aware that severance pay is now taxed as deferred compensation unless certain exceptions apply.

And that taxation is brutal: failing to comply with §409A can accelerate taxation of several years' worth of deferred compensation into a single year and subject it to interest and a 20% penalty tax. Although the recipient, not the employer, pays the income tax, interest and penalty, the IRS may impose the tax due to the *presence* of the arrangement. That means current executives might have substantial income tax liabilities for payments that they have never received.

Types of Severance Covered by Code §409A

Obtaining a legally binding right to a compensatory payment in one tax year that is payable in a future tax year creates deferred compensation, even if it is subject to a substantial risk of forfeiture. Describing severance payments in an offer letter, employment agreement or company policy might create deferred compensation.

Severance Arrangements Exempt from Code §409A

Several exemptions allow certain types of severance arrangements to avoid becoming deferred compensation, including:

- Payments made due to an *involuntary* termination that do not exceed the lesser of (i) two times the employee's annual compensation or (ii) $460,000 (for calendar year 2008). The payments also cannot extend beyond the second calendar year following the year of termination. Certain "good reason" terminations may qualify as involuntary, as discussed further below.
- Reimbursement of certain expenses, including (i) those otherwise excludible or deductible from the individual's gross income, (ii) reasonable outplacement and moving expenses, and (iii) medical expenses. This exemption applies to both cash and in-kind reimbursements. Some types of reimbursements are limited to expenses incurred by the individual before the end of the second calendar year following the year of termination.
- Severance payments that do not exceed $15,500 (during 2008).

Many executive agreements provide for "good reason" terminations, where reductions in the authority, title, duties or compensation of the executive constitute an involuntary termination. The IRS provides a safe harbor definition of "good reason" that may allow such terminations to qualify for the involuntary termination exception above.

Arrangements that pay an individual their full amount of severance within 2½ months of the taxable year that the individual first obtained the right to severance are not deferred compensation. For example, an employer offers an immediate lump sum payment to a terminating employee in exchange for a release of claims. If before making the offer the employer had no contractual obligation to make such a payment, there is no deferred compensation

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Medical Stop-Loss Carriers' Cost-Containment Measures

Julie Adams
Medical Stop-Loss Representative
Physicians Insurance
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Health care costs continue to rise at rates far in excess of general inflation. In 2007, national health expenditures rose 6.9%, twice the rate of inflation. Washington State businesses have experienced health insurance premium increases of about 32% over the past three years. Understanding these statistics, some companies choose to assume financial risk by self-funding their health benefit plans. Employers often find that customizing benefit plans better meets the heath care needs of their employees while also saving costs. Yet too much risk and poor benefit plan management can leave self-funded employers financially crippled when employees' catastrophic claims exceed the company's reserves.

The risk of catastrophic medical claims is one that self-funded employers carefully manage. Medical stop-loss insurance can help address this risk. Thorough investigation of how effectively a medical stop-loss carrier incorporates cost containment measures is a critical factor in determining the carrier's ability to meet an employer's needs. A carrier's case management resources, access to catastrophic medical networks, and comprehensive, reliable claims management are all important factors that allow employers to optimize outcomes and control ultimate costs.

Third party administrators (TPAs) are instrumental in assisting employers to custom design health benefit plans. TPAs work closely with medical stop-loss carriers whose flexible underwriting options and responsive service can best meet a self-funded employer's catastrophic coverage requirements. Cost savings is the focal point, but pricing of medical stop-loss is just the first step in assessing ultimate probable cost. An employer's analysis should also include an assessment of a carrier's products, underwriting options, case management capability, access to networks for catastrophic care, A. M. Best industry rating, and responsive service.

Robin Brown, CIC, a reinsurance consultant with MedRisk, LLC, in Bellevue, Washington, supports this thinking. "It isn't wise to try to save premium expenditures for something as critical as medical stop-loss," she advised, "because you'll probably end up assuming increased risk for lower-cost products. As your liability goes up, you'll pay more for a catastrophic claim, and probably expect less in reimbursements." Another point to bear in mind is this: In contrast to premiums paid to fully-insured carriers, what self-funded employers don't spend on healthcare costs and management fees, they keep.

Here are some helpful cost-containment guidelines for self-funded employers and their TPAs to consider as they shop for medical stop-loss carriers.

Transplant Networks

Transplant procedures have doubled in the last seven years. A stop loss carrier's contract with a transplant network can save thousands on transplant claims. Transplant networks' emphasis on outcomes at Centers of Excellence (pre-selected providers with track records of fewer pre- and post-procedural complications) results in lower overall treatment costs. In a recent case, a TPA contacted a carrier about a cardiac disease patient who was referred to a network provider. The patient was hospitalized for 70 days, and re-

ceived a VAD device to sustain his life. The hospital bills exceeded $698,000. Because the transplant rate included pre-transplant care, the employer enjoyed a 65% savings.

Case Management Services

For catastrophic cases, such as cancer, neonatal, and transplant claims, a medical stop-loss carrier should offer retrospective and prospective case management services. Employers must realize that premature births have increased 27% in the past two decades, and cancer treatment (1.4 million cases in 2007 in the U.S.) comprises some 15% of overall healthcare costs. Case managers keep tabs on complex and high-cost cases by working with TPAs and medical professionals in coordinating the patient's care. Prospectively, they offer patients options for care and provide oversight of case expenditures for treatment plans. They also track patients' post-procedural care and outcomes, as well as provide hospital bill audits when necessary.

Pharmaceutical Drug and Dialysis Provider Networks

Pharmaceutical costs remain a significant portion of a medical benefit plan. Self-funded employers find that pharmaceutical networks can offer lower prescription costs by negotiating set fees for specific drugs. In one case, a hospital charged a patient $92,000 per week for a rare disease medication. At the recommendation of a carrier's claims administrator, the patient switched to an in-network

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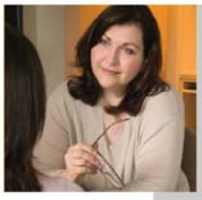

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Law Creates Brutal Tax on Many Types of Severance Arrangements

<Law

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since the right to payment and its receipt both occur in the same taxable year. Note that this exception, unlike the involuntary severance payments discussed above, is not limited in amount. "Voluntary" terminations may also qualify for this exception.

Termination of Employment – Or Not

Employees often enter into an arrangement to continue providing services after the normal employment relationship ends. The IRS presumes that a termination (triggering the severance payment) occurs only if the employee provides "insignificant services" to the employer. "Insignificant services" means services provided and compensation received are less than 20% of the amounts before the termination.

Where an individual continues to provide post-termination services in a non-employee capacity (e.g., a former CEO becomes a consultant or director), the IRS presumes that no termination occurs if the former employee continues to work and get paid at a rate of 50% or more of his or her pre-termination levels. If post-termination services are between 20% and 50% of earlier levels, no presumption applies and facts and circumstances determine whether a termination has occurred.

Severance Payments to Key Employees

For "key employees" of public companies (and certain affiliates), severance payments subject to §409A are subject to a six month delay after a termination of employment. Key employees are determined similarly to the top-heavy testing requirements applicable to tax-qualified retirement plans.

Consultants and Directors

Section 409A does not limit its scope to just employers and employees. Payments to consultants, directors, partners or LLC members are potentially subject to §409A. The above rules and exceptions apply to "deferred compensation" regardless of whether the recipient is an employee.

Conclusion

Code §409A does not prohibit severance pay. Rather, it imposes an additional income tax penalty that applies to non-exempt severance arrangements. Employers will need to analyze severance arrangements to decide if they can be structured to fit into an exclusion, and if not, whether to structure the payments to comply with the new rules.

John Walch is the Employee Benefits and Executive Compensation Practice Leader at Ater Wynne LLP, a West Coast law firm with offices in Seattle, Portland, Menlo Park and Salt Lake City. John can be reached at jdw@aterwynne.com or (503) 226 -1191.

Medical Stop-Loss Carriers' Cost-Containment Measures

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pharmacy, which lowered the claim cost to $17,000 per week.

Dialysis can average $30,000 and up per month. In one case, a carrier's relationship with a dialysis network provider saved an employer more than 45% in claims for an end-stage renal disease patient. After five months of treatment, the patient's bill was $142,000, but a case administrator negotiated the substantial reduction in eventual costs.

In Conclusion

Self-funding is not for everyone. However, with the aid of an experienced TPA and medical stop-loss insurer, employers may be able to better manage their health care costs and continue to provide high quality benefits to their employees through a self-funded program.

Dedicated to the medical community in the Pacific Northwest, Physicians Insurance (www.phyins.com) has provided stop-loss insurance to medical practices choosing to self-fund their medical benefits since 2002. Julie Adams is a medical stop -loss representative at Physicians Insurance. She can be reached at (206) 343-73 or Julie@phyins.com.

St. Anthony Hospital: A New Day in Health Care for Gig Harbor and Beyond

By Roberta Greenwood
Contributing Writer
Washington Healthcare News

The year 2009 brings a new hospital to Gig Harbor and the surrounding cities on the Peninsula - an event that Chief Operating Officer Carole Peet says will bring enhanced medical treatment, much needed emergency services, and a holistic approach to health care to thousands of residents who formerly relied on facilities that were often difficult to reach.

St. Anthony Hospital, the newest member of the Franciscan Health System, opens its doors in late February, 2009. The 217,000 square foot, 80 bed hospital will provide 24-hour emergency care, medical, surgical, and critical care units, a heart catheterization and vascular laboratory, outpatient cancer therapy, outpatient physical, speech and occupational therapies, and advanced diagnostic imaging services.

"Planning began six years ago," Peet explains, "and our hospital was designed to provide a unique, holistic approach to medical care and recovery. Our current staff assisted in designing a system that improves patient flow and clinical care, as well as improving the patient experience." The St. Anthony campus is located at 11567

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Artists Rendering of
St. Anthony Hospital in Gig Harbor, Washington

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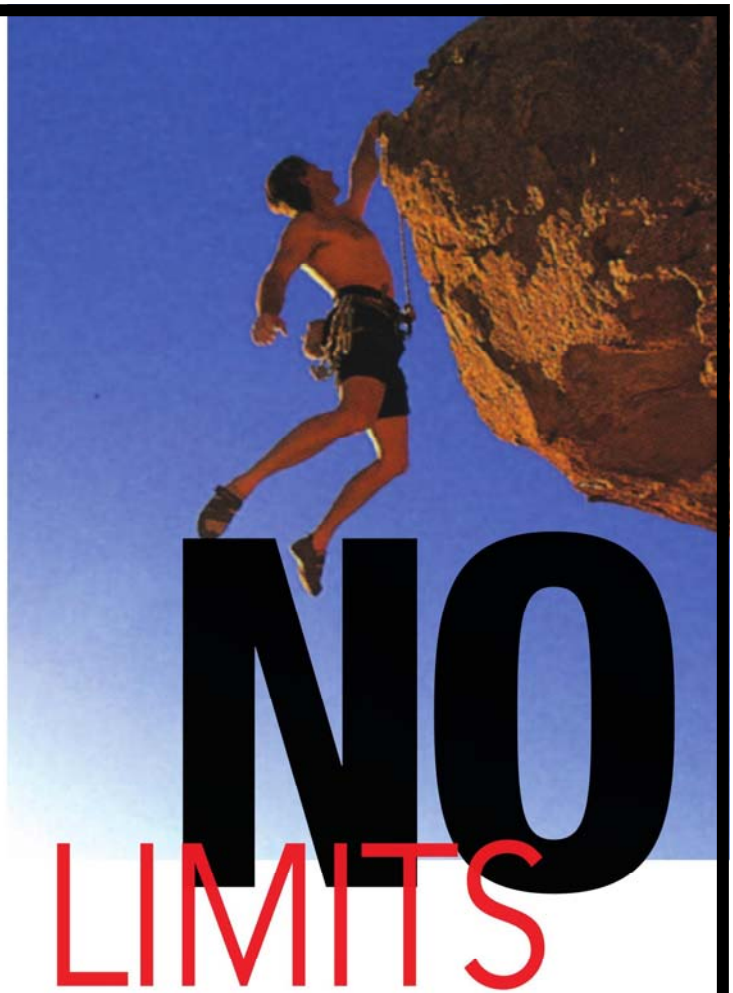

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St. Anthony Hospital: A New Day in Health Care for Gig Harbor and Beyond

<St. Anthony

From page 14

Canterwood Boulevard, Gig Harbor, and sits on 30 acres. Patients and staff have views of forested lands, a central courtyard, and a healing garden. Built with an environmentally-sensitive design, the facility features natural stone, glass and wood, expansive access to natural light, a fireplace in the lobby and a chapel that is available to all faiths.

Many structural elements represent the maritime heritage of Gig Harbor: wave-like wall and ceiling features, a lighthouse-evoking main entrance, and the curvature of a ship's hull is evident in the design. Even the name shares a maritime significance; St. Anthony of Padua is the Catholic patron saint of sailors and fishermen. Built at a cost of approximately $160 million, St. Anthony is only the second hospital to be approved by the Washington State Department of Health since the mid-1980's. According to Peet, the approval process was extremely rigorous and the community came forward to support the plans for development. "We had hundreds of residents speak to the need for our facility at public meetings," she says, "with many more writing letters recounting personal stories that supported our belief that the community deserved a multi-functional hospital."

Gale Robinette, Media Relations Manager, agrees. "The 'certificate of need' application detailed that while the Peninsula and surrounding cities may be close in miles, travel time is lengthy. We collected data demonstrating that commutes often took up to one hour from some rural areas; in emergency situations that just wasn't acceptable. Medical care will now be available to our residents in a timely fashion – and we will have state-of- the-art technology as well." Licensed to provide Level 1 trauma care, St. Anthony will include a 19-bed emergency room, full service trauma room and a separate entrance for patients needing emergency care.

All 80 in-patient rooms are private and are large enough to support visiting family members; each room has a settee that converts to a bed. Additionally, Peet explains, the entire facility is infused with natural light and windows that look out on the central healing garden, allowing patients to have a visual connection with nature – an experience that has been shown to improve recovery. "Being in the hospital is stressful for everyone," says Robinette, "and our facility offers peace and solace to both patient and family members. We've designed St. Anthony to encourage people to relax and find a quiet place for contemplation and reflection."

A sky-bridge connecting the hospital to a medical office building, a large cafeteria with courtyard seating and free Wi-Fi access all combine to make St. Anthony a facility offering ease, comfort and the highest level of patient care available on the Peninsula, according to Peet. Seven hundred parking spaces, convenient access to Highway 16, and a passenger drop-off area improve accessibility and the hospital design includes space on the 5th floor for 32 additional beds for future use.

Nurses' stations were designed to place caregivers near their patients and provide line-of-sight views. Additionally Vocera communication technology will offer caregivers access to patient information while maintaining contact between team members, without the need for pagers and cell phones. "Vocera has been proven to increase efficiency," explains Peet, "and this technology gives our staff another tool to provide the highest level of patient care."

Although St. Anthony follows the Catholic tradition of caring for body, mind, and spirit, Robinette stresses that pastoral care is available to all faiths. Recently, members of twelve different religious groups came to the chapel at St. Anthony to inscribe words of healing, support and inspiration on its walls – a step which Robbinette believes demonstrates the inclusive and holistic nature of the care that will soon be available at St. Anthony.

Roberta Greenwood is a contributing writer of the Washington Healthcare News and can be reached at rgreenwood@wahcnews.com.

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Washington Healthcare News Publishes 2009 Editorial Calendar

The Washington Healthcare News recently released its 2009 Editorial Calendar. The News publishes an Editorial Calendar for several reasons.

- Many writers of articles in the News are Consultants specializing in particular sectors of health care. The calendar helps writers choose the editions they would like their articles published.
- Many advertisers make purchases in those editions their customers are most likely to read.
- The calendar provides a quick and easy way to communicate important deadlines.

The 2008 editions that won't be repeated in 2009 had Public Policy, Third Party Administration and Insurance Broker and Agent themes.

Washington Healthcare News readers do have interest in Pubic Policy related articles but there are several other publications available that provide more comprehensive coverage of these issues. The 2008 editions with Third Party Administration and Insurance Broker and Agent themes didn't stimulate significant reader or advertiser interest.

Replacing those themes in 2009 will be the Senior Living and Finance editions, with Human Resources having two editions dedicated to the popular topic.

The Senior Living sector of health care is making a significant impact on our health care system. In addition, several hundred senior living health care leaders were recently added to the distribution of the News.

A Finance themed edition was added because the News recently added hundreds of health care finance professionals to its distribution. In 2009, the News is increasing its finance related content by publishing articles from financial firms Moss Adams and Financial Consultants of Alaska and Washington. In addition, an article from Prime Advisors, Inc., a firm that manages large bond portfolios for insurance companies and hospitals, will be published in the near future.

A second Human Resources edition was added after the overwhelmingly positive reception to the August 2008 edition on Human Resources. There are over 500 health care human resources leaders on the distribution of the News and many articles are targeted towards these readers. A second edition in 2009 will allow expanded coverage for the many issues that can't be covered in only one edition.

Washington Healthcare News 2009 Editorial Calendar

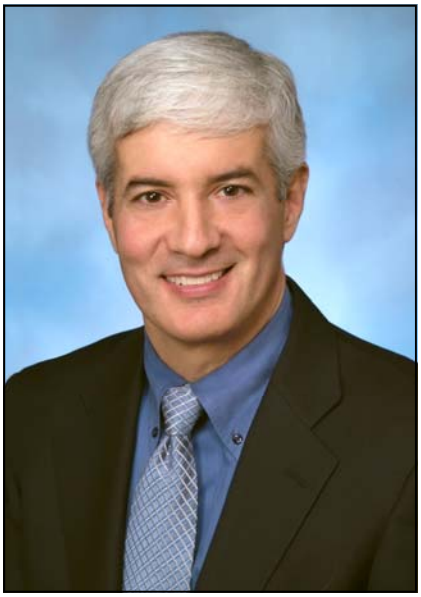
Month and Year	Theme of Edition	Space Reservation	Distribution Date
January 2009	Urban Medical Clinics	December 1, 2008	December 22, 2008
February 2009	Human Resources	January 2, 2009	January 19, 2009
March 2009	Rural Hospitals	February 2, 2009	February 23, 2009
April 2009	Insurance Carriers	March 2, 2009	March 23, 2009
May 2009	Information Technology	April 1, 2009	April 20, 2009
June 2009	Rural Medical Clinics	May 1, 2009	May 25, 2009
July 2009	Facilities	June 1, 2009	June 22, 2009
August 2009	Human Resources	July 3, 2009	July 20, 2009
September 2009	Finance	August 3, 2009	August 24, 2009
October 2009	Community Health Centers	September 1, 2009	September 21, 2009
November 2009	Senior Living	October 1, 2009	October 19, 2009
December 2009	Urban Hospitals	November 2, 2009	November 23, 2009

Washington Healthcare News Reader Demographics

	Industry Sector							
Position Type	**Hospitals & Senior Living Facilities**	**Medical Clinics**	**Other Providers**	**Govern-ment**	**Insurance Agencies**	**Insurance Companies**	**All Other Industries**	**Demo-graphic Totals**
Executive								
Chief	308	126	41	9	358	25	248	1,115
Operations	97	55	14	2	4	23	19	214
Finance	212	57	17		2	33	23	344
Medical Director	57	19	4	1		18	6	105
Marketing & Sales	113	33	11	2	48	44	107	358
Human Resources	159	41	15		1	8	18	242
IT	104	32	7			17	6	166
Nursing	138	14	1			10	4	167
Other	537	40	11	20	2	41	49	700
Total Executive	**1,725**	**417**	**121**	**34**	**415**	**219**	**480**	**3,411**
Managerial & Professional								
Practice Manager	56	314						370
Operations	232	27	26	7	13	59	28	392
Finance	139	10	3	5		28	19	204
Marketing & Sales	56	11	16	5	367	44	131	630
Human Resources	228	47	15	6	1	16	23	336
IT	91	24	11			23	4	153
RN Managers	346	17	5			5		373
Total Managerial & Professional	**1,148**	**450**	**76**	**23**	**381**	**175**	**205**	**2,458**
State Senator or Representative				**145**				**145**
Grand Total	**2,873**	**867**	**197**	**202**	**796**	**394**	**685**	**6,014**

Premera Versus Proliance: Competition and Healthcare

By Gus Kiss
Principal
Baldwin Resource Group, Inc.



Competition, as defined by Webster's New Collegiate Dictionary is, "the effort of two or more parties acting independently to secure the business of a third party by offering the most favorable terms." Our country has been built on competition and everywhere you look there is advertising for the sale of goods and services, which in turn drives down cost and increases quality. However, with health care, we are flying blind. And it's not just patients that are in the dark--ask a physician how much they charge for an office visit, and you will get a dozen different numbers. In order for competition to work for health care, we need transparency which will create informed providers and patients.

The latest Proliance/Premera squabble further illustrates the problem. Proliance is a large, well-respected independent physician group that employs orthopedic specialists, general ear-nose-throat surgeons and other health-care professionals. They own and operate freestanding ambulatory surgery centers, lab and x-ray centers, and therapy centers. Premera Blue Cross is a large well-respected health insurance carrier that provides health plans to a large number of Washington State residents.

> *"Maybe we need a new approach. How about one that involves informed providers competing for informed individual patients? Sounds too simple to be true, but that is competition and it is how our country was built."*
>
> Gus Kiss
> Principal
> Baldwin Resource Group, Inc.

Proliance/Premera contract negotiations recently failed and their agreement terminated on August 1st. After years of successful contracting with Premera, the relationship has ended according to Proliance, over "a modest 5% increase in fees." Premera contended it was paying Proliance 20-30% more in fees than similar health care providers in the area, and rather than grant an increase, wanted a 6% reduction.

Are these the competitive forces that reduce costs and drive up quality? Maybe. To decide, we need to answer additional questions:

1. Will terminating Proliance have a bigger impact on premiums or Premera's profits?
2. Is the quality of care from Proliance providers worth 20-30% more than similar providers?

Although Premera and Proliance have opinions on these issues, objective information is just not available. Someday patients may have more information, but today they just pay the bills for copays, coinsurance, and premiums.

Maybe we need a new approach. How about one that involves informed individual providers competing for informed individual patients? Sounds too simple to be true, but that is competition and it is how our country was built.

Gus Kiss is a Principal at Baldwin Resource Group, Inc., in Bellevue, WA. He can be reached at 1-877-455-5640 or at gkiss@baldwinrgi.com.

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New or Recently Promoted Healthcare Leaders

Last Name	Middle Name	First Name	Title	Effective Date	Organization	New or Promoted Leader
Batistich	A.	David	Regional Manager	04/08	Hawes Financial Group	New
Bauman	Rogers	Ruth	VP, Actuarial and Underwriting Services	08/08	Clear Choice Health Plans	New
Boyle CPA		Darci	Health Care Tax Partner	10/08	Moss Adams LLP	Promoted
Brown		Jeff	VP, Marketing and Sales	08/08	Clear Choice Health Plans	New
Fornadley RN		Elisa	VP & Administrator	07/08	Allenmore Hospital	New
Fucillo		Dawn	Director of Oncology Services	08/08	United General Hospital	New
Grannum CPA		Robert	Partner, Cost Segregation Services	10/08	Moss Adams LLP	Promoted
Jenkins		Michelle	Marketing and Sales Representative	07/08	Medical Imaging Northwest	New
Kimball MHA FACHE CMPA		Joshua	Chief Operating Officer	06/08	Oregon Medical Group	New
Krishnamachari RRT		Jaime	Respiratory Care Director	09/08	Central Washington Hospital	New
Landrie CPA		Lars	Partner, Investment Advisor, Wealth Services Group	10/08	Moss Adams LLP	Promoted
Martel		Denise	Administrator	07/08	Sound Family Medicine	Promoted
Miller	L.	Robert	Director of Insurance Services	08/08	Washington Dentists' Insurance Agency	New
Miller		Todd	Account Executive	08/08	TRUEbenefits	New
Norr		Pamela	Director, Provider Recruiting and Development	08/08	Bend Memorial Clinic	New
Reese		Cherise	Account Manager	08/08	TRUEbenefits	New
Risk		Coleen	Office Manager	08/08	Mercer Island Pediatric Associates., Inc. P.S.	New
Sherman	R.	Lawrence	Chief Executive Officer	07/08	Pulmonary Consultants PLLC	New
Simonson CPA		Wes	Chief Financial Officer	08/08	Oregon Medical Group	New
Stapleton		David	Sales Executive	07/08	Kibble & Prentice	New

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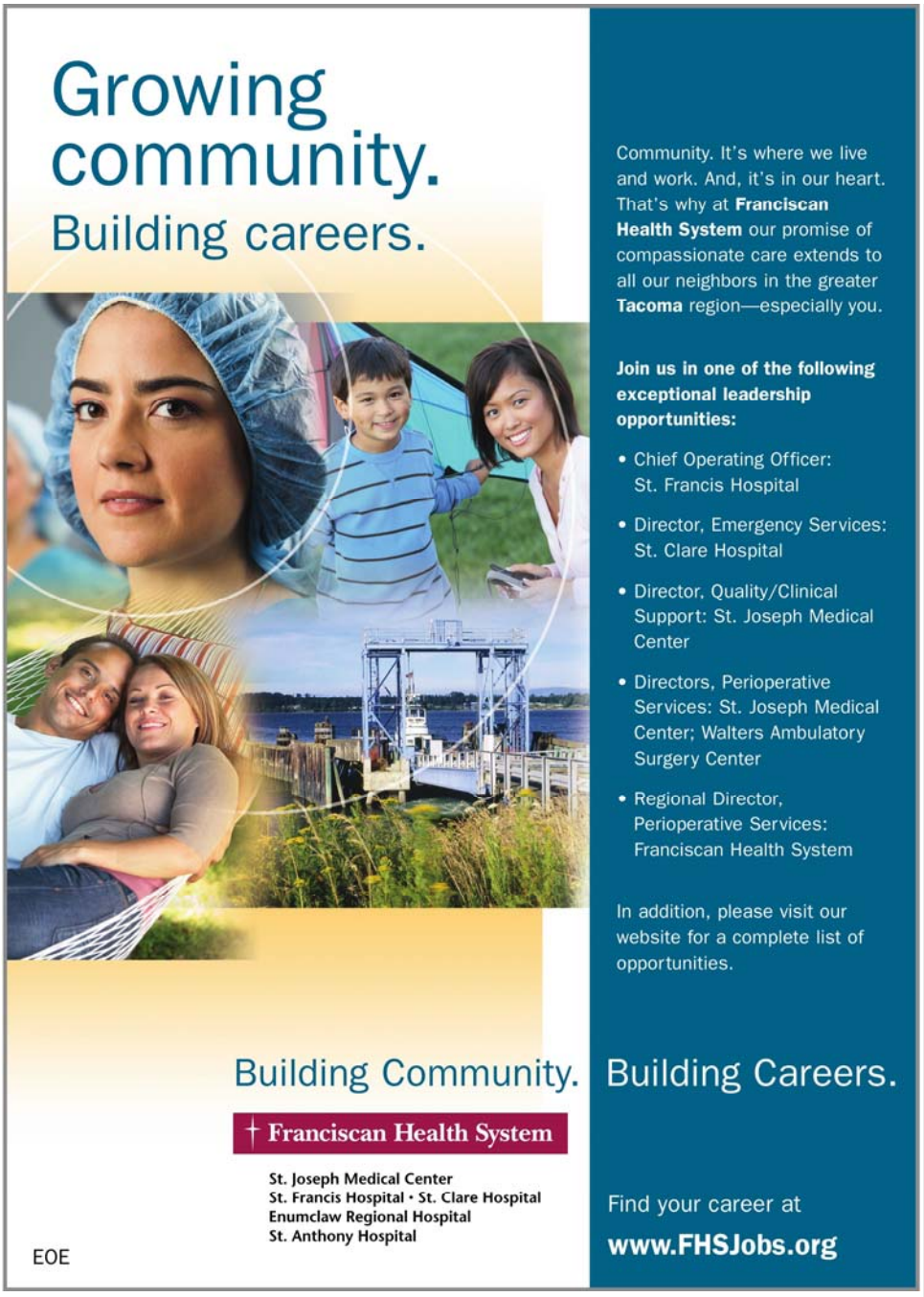

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Requirements: Bachelor's degree or an equivalent combination of education and experience. Knowledge of medical terminology, CPT, ICD, and HCPCS, in addition to knowledge of payer coding, billing, documentation, and reimbursement standards. Direct experience in a healthcare billing organization preferred. PC Proficiency with Windows based software, Microsoft Office Suite products with proficiency in Microsoft Access and Microsoft Project in a network environment; proficient at Internet research. Knowledge and experience with MD Audit Compliance Data System preferred.

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Plan and Hospital Financial Information

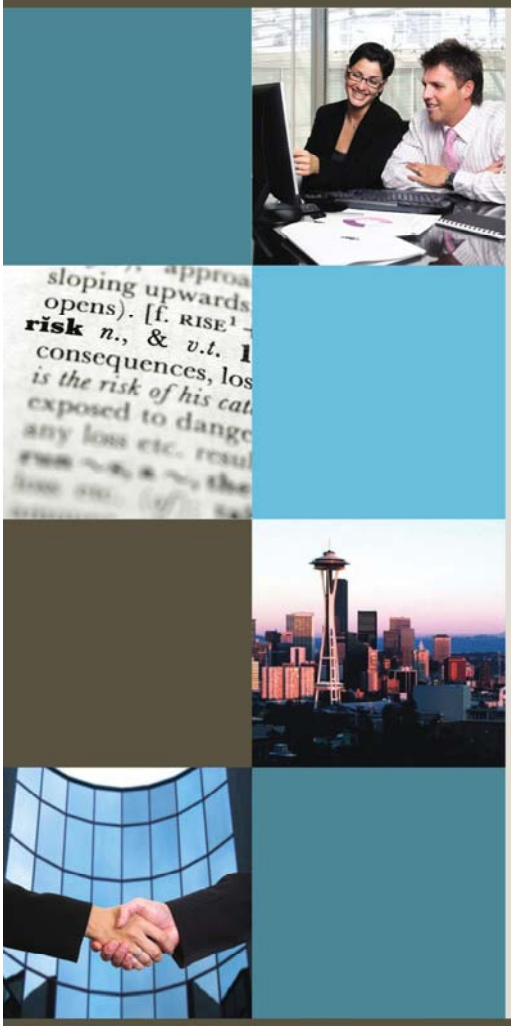
Financial Results for the 15 Largest Health Plans in the Pacific Northwest (Ranked by Total Revenues)[1]

Plan Name	State of Domicile	Total Revenues Qtr End 06-30-08	Net Income Qtr End 06-30-08	Net Income/ Total Revenues 06-30-08	Statutory Capital As of 06-30-08	Enrollment As of 06-30-08
Regence BCBS of Oregon	Oregon	$1,339,423,817	$3,757	0.0%	$536,726,207	1,013,851
Premera Blue Cross	Washington	$1,290,771,147	$26,309,269	2.0%	$788,857,086	697,911
Group Health Cooperative	Washington	$1,177,929,986	$74,803,760	6.3%	$760,346,297	396,598
Kaiser Foundation HP of the NW	Oregon	$1,161,173,186	$14,401,695	1.2%	$510,726,207	468,603
Regence BlueShield	Washington	$1,131,527,307	($4,167,871)	(0.4%)	$880,603,181	808,176
Blue Cross of Idaho Health Service	Idaho	$500,324,776	$21,048,190	4.2%	$269,690,217	430,833
Providence Health Plan	Oregon	$432,387,797	$11,874,037	2.7%	$346,083,758	186,291
Molina Healthcare of Washington	Washington	$352,505,614	$16,926,978	4.8%	$115,143,975	295,558
Community Health Plan of WA	Washington	$261,496,109	$82,518	0.0%	$77,240,330	233,379
Blue Cross Blue Shield of Montana	Montana	$260,004,498	$3,817,336	1.5%	$141,335,982	226,734
Regence BlueShield of Idaho	Idaho	$251,516,376	$5,582,462	2.2%	$128,151,741	212,260
Pacificsource Health Plans	Oregon	$240,721,859	$700,909	0.3%	$115,277,985	143,601
PacifiCare of Washington, Inc.	Washington	$224,213,912	$29,124,539	13.0%	$257,785,424	45,398
Health Net Health Plan of Oregon	Oregon	$209,423,940	$1,496,914	0.7%	$64,443,346	129,208
PacifiCare of Oregon, Inc.	Oregon	$144,074,363	$18,707,791	13.0%	$65,242,599	30,212

Financial Results for the 15 Largest Hospitals in Washington & Oregon (Ranked by Total Discharges)[2]

Hospital Name	State	Total Charges Qtr End 03-31-08	Total Margin Qtr End 03-31-08	Total Margin/ Total Charges 03-31-08	Total Discharges Qtr End 03-31-08	Total Days Qtr End 03-31-08
Swedish Medical Center-Seattle	Washington	$561,587,425	$9,149,369	1.6%	8,349	36,910
Sacred Heart Medical Ctr.-Spokane	Washington	$391,071,302	$2,804,485	0.7%	7,931	40,831
Providence St. Vincent Medical Ctr.	Oregon	$308,877,000	$30,000,000	9.7%	7,850	36,663
OHSU Hospital	Oregon	$382,207,044	$13,346,812	3.5%	7,198	38,864
Sacred Heart Medical Ctr.-Eugene	Oregon	$199,002,616	$13,446,846	6.8%	6,686	30,219
Providence Everett Medical Center	Washington	$315,975,769	$5,601,930	1.8%	6,298	26,651
St. Joseph Medical Center—Tacoma	Washington	$385,415,876	$17,297,432	4.5%	5,784	24,572
Providence Portland Medical Center	Oregon	$247,235,000	$1,935,000	0.8%	5,714	26,717
Southwest Washington Medical Ctr.	Washington	$264,391,255	$2,051,919	0.8%	5,040	21,783
University of Washington Med Ctr.	Washington	$250,246,553	$8,970,394	3.6%	5,024	28,076
Salem Hospital	Oregon	$182,601,633	$10,147,269	5.6%	5,018	23,144
Providence St. Peter Hospital	Washington	$242,327,750	$8,983,621	3.7%	4,961	22,124
Legacy Emanuel Hosp. & Health Ctr.	Oregon	$221,483,935	($1,080,819)	(0.5%)	4,837	26,914
Tacoma General Allenmore Hospital	Washington	$408,358,844	$16,572,683	4.1%	4,600	21,430
Harborview Medical Center	Washington	$295,731,000	$6,989,000	2.4%	4,543	34,057

[1]Source: National Association of Insurance Commissioners. [2]Sources: Washington State Department of Health, Oregon Health Policy & Research.



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