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Articles, Interviews and Statistics for the Healthcare Executive

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Federal Healthcare Reform Begins for Health Plans

By Howard Bye
of Counsel
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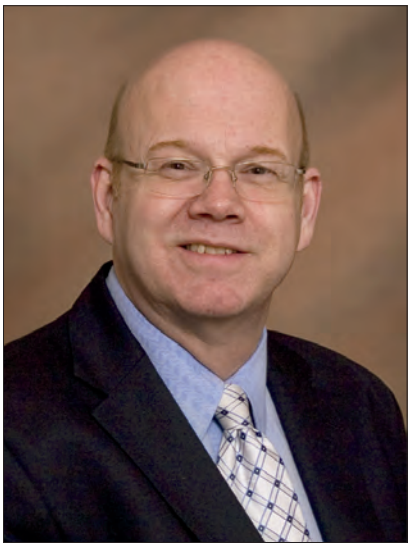

By Erin Lennon
Associate
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The passage of federal healthcare reform in 2010 marks a new era for employer-sponsored health plans. Along with the requirements of other recently passed laws, group health plans must comply with several new provisions of the Patient Protection and Affordable Care Act ("PPACA") summarized below. This article only addresses the impact of PPACA on employer-sponsored group health plans, and not the many issues for hospitals, doctors, and other medical providers. Unless otherwise noted, these changes took effect after September 23, 2010 (January 1, 2011 for calendar year plans).

One of the first health care reform changes to take effect was the change in the taxation of health coverage for children, effective March 30, 2010. Prior to health care reform, the taxation of health coverage of children depended on whether the children qualified as tax dependents for health care purposes under complicated definitions of "qualifying child" or qualifying relative." Now, health care coverage can be provided on a tax-free basis for children (including adopted children, children placed for adoption, stepchildren and foster children) through the calendar year in which the child turns 26. This rule applies regardless of the marital status of the child, the residence of the child, or whether the child is financially dependent upon the employee or the employee's spouse.

PPACA requires group health plans that cover children to extend the children's eligibility until the child's 26th birthday. Eligibility for children under age 26 cannot depend on the child's student, marital, dependency or employment status. The only allowable exception is that certain grandfathered plans may exclude

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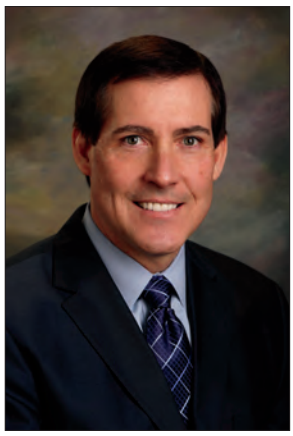
Letter from the Publisher and Editor



Dear Reader,

Reports continue to be published that healthcare employers have increased hiring.

In a December 15, 2010 article, Chen May Yee of the Star Tribune (Minneapolis) wrote, "While the pace of new jobs remains far below that of a few years ago, healthcare organizations have more job postings up right now than they have for months."

On December 1, 2010, The Conference Board, a well known source for national online job board activity and other economic data, reported online job postings for healthcare positions totaled 667,000 in November 2010 versus 607,000 in November 2009.

If you're now ready to advertise your open jobs consider using the Washington Healthcare News. Our thirty day postings are inexpensive and include participation in a monthly email announcement to over 19,500 healthcare professionals. You can learn more about our online job board services by visiting www.wahcnews.com. Until next month,

David Peel, Publisher and Editor

Washington Healthcare News 2011 Editorial Calendar

Month and Year	Theme of Edition	Space Reservation	Distribution Date
January 2011	Hospitals	December 1, 2010	December 27, 2010
February 2011	Human Resources	January 4, 2011	January 24, 2011
March 2011	Hospitals	February 1, 2011	February 21, 2011
April 2011	Insurance	March 1, 2011	March 21, 2011
May 2011	Clinics	April 1, 2011	April 18, 2011
June 2011	Human Resources	May 2, 2011	May 23, 2011
July 2011	Hospitals	June 1, 2011	June 20, 2011
August 2011	Hospitals	July 5, 2011	July 18, 2011
September 2011	Clinics	August 1, 2011	August 22, 2011
October 2011	Human Resources	September 1, 2011	September 19, 2011
November 2011	Hospitals	October 3, 2011	October 24, 2011
December 2011	Clinics	November 1, 2011	November 21, 2011

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adult children who have access to employer-sponsored coverage, but this exception only applies until 2014. Regulations adopted under PPACA also require that plans treat all children under age 26 the same, including charging the same premium for all children under age 26. PPACA does not require plans to cover the child's spouse or the child's own children.

In a significant change for consumer-driven health care, over-the-counter drugs will not be reimbursable through health savings accounts ("HSAs"), health flexible spending accounts and health reimbursement arrangements ("HRAs"), unless the drugs are prescribed or are insulin.

PPACA requires that employers with more than 200 employees automatically enroll full-time employees into health plans when they are first eligible to join the plan and automatically continue enrollment of current employees. Employees will have a right to opt out of the coverage. This provision takes effect when the Department of Labor issues regulations clarifying the details of this requirement, such as what benefit option will be subject to the rule for employers offering multiple health plans or health plan options.

PPACA prohibits aggregate lifetime limits and lifetime limits on "essential health benefits." Essential health benefits will be defined by the Secretary of Health and Human Services and must include, at a minimum, benefits in the following categories:

- Ambulatory patient services;
- Emergency services;
- Maternity and newborn care;
- Prescription drugs;
- Hospitalization;
- Laboratory services;
- Mental health and substance use disorder services;
- Rehabilitative and habilitative services and devices;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

Regulations interpreting the meaning of these terms have not been released at the time of this writing. The regulatory agencies have indicated that they will take into account good-faith efforts to comply with a reasonable interpretation of the term "essential health benefits" until additional guidance is issued. Lifetime and annual limits on non-essential health benefits are still allowed, as are exclusions for benefits for specific conditions.

PPACA also prohibits most aggregate annual dollar limits on essential health benefits. However, regulations allow an annual dollar limit on essential health benefits for plan years starting between September 23, 2010 and September 23, 2011, if the annual dollar limit is at least $750,000. This minimum annual limit increases to $1.25 million for 2012 and $2 million for 2013. These limits apply to each individual, not to each family.

Plans can no longer have preexisting condition exclusions for children under age 19. Preexisting condition exclusions are any limitations or exclusions based on the fact that the condition was present before the date of coverage. For example, a plan may not exclude benefits for surgery resulting from an injury that occurred prior to the effective date of coverage. Beginning January 1, 2014, the prohibition on preexisting condition exclusions expands to include participants and beneficiaries age 19 and over.

PPACA imposes a number of new requirements on "new" plans, which are plans that are not "grandfathered." Grandfathered plans are plans that were in existence on March 23, 2010 and have not been amended in a way that causes them to lose their grandfathering status. Changes that will cause a loss of grandfathering status include:

- Eliminating all or substantially all benefits for a particular condition;
- Increasing the percentage of cost-sharing for non-fixed amounts (such as changing coinsurance from 10 percent to 20 percent);
- Certain increases to fixed-amount requirements, such as co-payments or deductibles;
- Decreasing the employer contribution percentage; or
- Adding or reducing annual dollar limits.

New plans are subject to the following requirements:

- New plans must provide preventive services without cost-sharing such as copayments or coinsurance. This includes all preventive care, screenings, immunizations and services recommended by certain governmental agencies; however, plans may refuse to cover or may impose cost-sharing for out-of-network services.
- New plans must meet new in-

ternal and external review process standards, including:

  - o both ERISA and non-ERISA plans must comply with ERISA claims procedures;
  - o plans must comply with new internal claims procedures, including issuing determinations on urgent care claims within 24 hours and ensuring the independence and impartiality of decision makers; and
  - o plans must comply with an external review process that meets certain minimum consumer protection standards modeled on standards of the National Association of Insurance Commissioners.
- New plans must pay the same benefits for emergency care, whether provided in-network or out-of-network.
- New plans must allow the designation of any primary care physician or pediatrician as the primary care physician.
- New plans cannot require authorization or referral for obstetrics/gynecology services or emergency care.
- New insured plans must meet nondiscrimination requirements.

Plans will be carefully considering the costs and benefits of losing grandfathered status in light of these requirements.

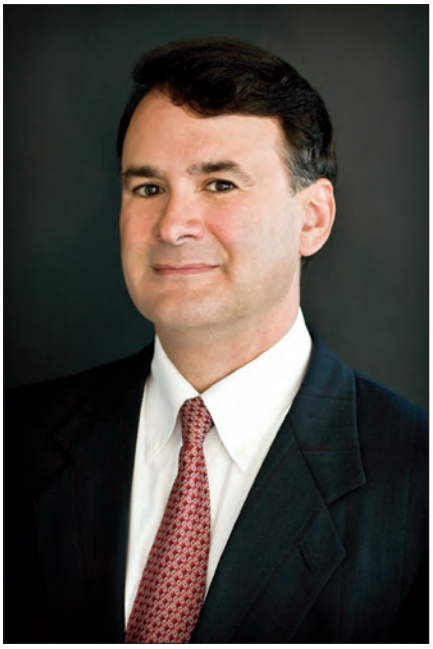
Complying with health care reform will be the main focus for group health plans this year and for the next several years. In addition to implementing required plan design changes and sending out required notices, plans and employers will be carefully monitoring health coverage costs.

Howard Bye is of counsel in the Seattle office of Stoel Rives LLP. He assists clients with employee benefit matters relating to health, cafeteria, and other welfare plans. Mr. Bye has both written and spoken on health care reform, HIPAA, Medicare Part D, wellness programs, ERISA, the Americans with Disabilities Act, and other state and federal law benefit topics. He can be reached at (206) 386-7631 or hdbye@stoel.com.

Erin Lennon is an associate in the Seattle office of Stoel Rives LLP. Her practice includes all areas of employee benefits law, including qualified retirement plans, nonqualified deferred compensation plans, health and welfare plans, and fringe benefit plans. She can be reached at (206) 386-7554 or ellennon@stoel.com.

Essentials of Physician Reimbursement

By Dwight Johnson, FHFMA
Executive Director of Provider Contracting, Coopersmith Health Law Group



Physician reimbursement has been central to the extensive debate over health care reform. Understanding the essentials of physician reimbursement is fundamental to understanding healthcare finance, the recently approved changes to our health care system, and how to respond as those changes take effect.

Any examination of physician reimbursement should begin with a discussion of Medicare.

When it was initiated in 1966, Medicare paid physicians based on physicians' usual and customary charges. The program was originally intended to cover only acute illnesses. The federal government worked with physicians to develop the Current Procedural Terminology (CPT) coding system, which became the standard for submitting physician billing to Medicare.

After two decades, the government realized that the charge-based system it developed was performing a poor job of cost control. In 1989, Congress abandoned the usual and customary charge Medicare payment format, and instead started paying physicians according to variation in the services performed, the costs of providing services and the potential liability expense related to services provided. In essence, the federal government shifted from paying physicians based on what they charged per service to the actual and expected resources expended in the delivery of services. The new payment methodology developed was called the resource based relative value scale (RBRVS). The RBRVS system, like its hospital correlate the DRG system, was only peripherally concerned with charges. In addition, at the direction of the Congress, the RBRVS system engendered a monetary shift away from invasive surgical procedures toward primary care services.

The commercial insurance industry, seeing clearly the gain to be realized by moving away from a charge-based reimbursement structure, quickly adopted RBRVS. The RBRVS system became the standard for physician reimbursement in America, both commercial and governmental.

Payments under RBRVS are similar to the DRG system and its variants in that reimbursement occurs as the result of a weight assigned to care delivered multiplied by a dollar conversion factor. In general, the weighting assigned to a particular service is comprised of a physician's total work (50%); practice costs (45%); and malpractice costs (5%). Total work is captured by six characteristics: technical skill; time; mental effort; physical effort; stress and judgment. Practice costs are overhead expenses including office rent, equipment, supplies, and non-physician salaries.

The RBRVS weighting version is typically updated annually by CMS for Medicare and Medicaid use. Most commercial carriers use the CMS updated versions directly, or with certain carrier specific modifications applied. The commercial carriers tend to use differing RBRVS versions, some may use the current version, others may use older iterations. Typically, the commercial carriers will not use versions that are more than 2-3 years old, although exceptions

may occur. Note that reimbursement can then vary widely, depending on the conversion factor and RBRVS version utilized. The result can be extensive negotiations between the commercial carriers and providers, both over the conversion factor and the RBRVS version.

In 1997, Congress initiated the sustainable growth rate, or SGR, for the Medicare program. The SGR either increases or decreases physician reimbursement annually based on a comparison of total overall expenditures on physician services to per capita gross domestic product. In recent years the annual calculation has consistently called for decreases in payments to physicians for services provided to Medicare enrollees, with subsequent political debate and ultimately the elimination of planned decreases in payments. On June 25, 2010 President Obama signed legislation postponing the planned 21.3 percent cut in Medicare payments retroactive to June 1 and through November 30, 2010. This action also gave a 2.2 percent increase in Part B reimbursement for services delivered from June 1 through November 30.

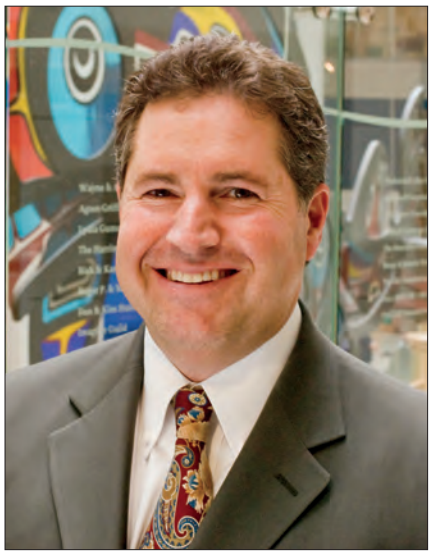
Many believe that the current RBRVS based system is flawed, for a variety of reasons. The annual Medicare updates under SGR clearly do not keep pace with practice costs, and the annual drama surrounding the Medicare/SGR/Congressional process only heightens physician frustration. Momentum is building behind adaptation of reimbursement based on episodic care, or a medical home approach. Under this approach, reimbursement would reflect the value of care provided beyond that delivered in an individual patient/physician encounter, instead spanning the entirety of the spectrum of care delivered and providers participating in treating patients and keeping them well. There are many pilot projects existing at present related to medical home, but at present the traditional RBRVS system remains the standard.

In conclusion, physician reimbursement has been a complex and controversial issue for many decades. While the nature of physician reimbursement in the future may be uncertain, it is certain that the complexity and controversy surrounding it will continue.

Dwight Johnson is the Executive Director of Provider Contracting at Coopersmith Health Law Group. He can be reached at 206-343-1000 or dwight@coopersmithlaw.com.

Key Human Resource Strategies Within a Healthcare Organization

By Steven Hurwitz
Vice President of Human Resources
Seattle Children's



A true differentiator between a Personnel and Human Resource function is the level of focus on Strategy. To move from a Personnel function to a Human Resource function it's critical to have an emphasis on *planning for the future*. At Seattle Children's, our Human Resource function supports daily operational needs while at the same time develops strategies to ensure organization success well into the future. Two key Human Resource Strategies practiced at Seattle Children's are Workforce Planning and Succession Planning.

Workforce planning gets quite a bit of attention these days. Future labor shortages loom on the 5 – 20 year horizon fueled by retiring Baby Boomers, lower birth rates, and increased demand for healthcare services. Much is happening on the state and federal levels to address these shortages, but individual healthcare organizations require proactive, multi-year strategies to ensure competitiveness.

Most healthcare organizations engage in business or strategic planning and financial planning, but how many engage in people planning? The goal of strategic workforce planning is to provide the *right talent* for the organization in the *right job* at the right time for the *right cost*. Clearly, human resources has a significant role to play in this work, but workforce planning cannot be conducted solely by HR. We must partner with operational leaders to provide assessments, forecasts and strategies that are relevant to their business.

At Seattle Children's we have been engaged in workforce planning for approximately two years. "We began our efforts in a single division, inpatient nursing, to develop our workforce planning capacity. We chose nursing because leadership was already attuned to workforce needs. Within the first year, we had developed a forecasting tool that operational leaders can use for budget planning" stated Pam Cowles, Workforce Planning Manager. The second year we focused our workforce planning efforts on the new Bellevue Ambulatory and Surgery Center we opened in July 2010. The clinic was 97% staffed on the first day, and the majority of staff who transferred to Bellevue from other departments had been backfilled. When operational leaders were asked what they learned about recruiting for a new facility, they said, "Start early!"

Every business plan has a talent need, and the best business plans can be derailed by inadequate workforce planning. Many organizations engage in 1-year to 3-year workforce planning for budget purposes. If this is where workforce planning is in your organization today, make it a priority to raise it to a strategic level and plan for the next 5 to 10 years.

Succession Planning is another area that is getting more and more attention within Healthcare organizations. From a national perspective, a large percentage of Executives will be exiting the workforce within the next 5 years. Human Resources play a large role in implementing a succession plan that ensures ready successors for all executive and critical leadership roles.

At Seattle Children's we presented our first Succession Plan to the board in 2009, it focused on our CEO and his Executive team. The plan outlined successors, a timeline of readiness and a development plan. Additionally, we iden-

tified successors in the case of an emergency.

In 2010, we updated the above plan and added a Succession Plan for the next level of senior leaders. We now have a plan of successors for our Vice Presidents and above. As we think about the future, we will take the strategy of succession planning deeper into the organization and to critical jobs that will have future labor shortages identified from our workforce planning efforts.

Human Resources play a large role in developing and implementing Strategies within a Healthcare Organization. Two Strategic areas are Workforce Planning and Succession Planning. At Seattle Children's we have placed a focus on these key HR strategies while also developing strategies around Compensation and Benefits Management, Leadership Development, Occupational Health Services, Talent Acquisition, HRIS, and HR business partnerships, and Employee Engagement. It's a great time to be in Human Resources within a Healthcare Organization.

Steven Hurwitz is currently the Vice President of Human Resources for Seattle Children's. Steven joined Children's in this role March, 2008. Steven has overall responsibility for the Human Resource organization supporting the Hospital, Research Institute and Foundation. Steven ensures strategic alignment with his executive counterparts to ensure that integrated and leveraged solutions are realized throughout the organization.

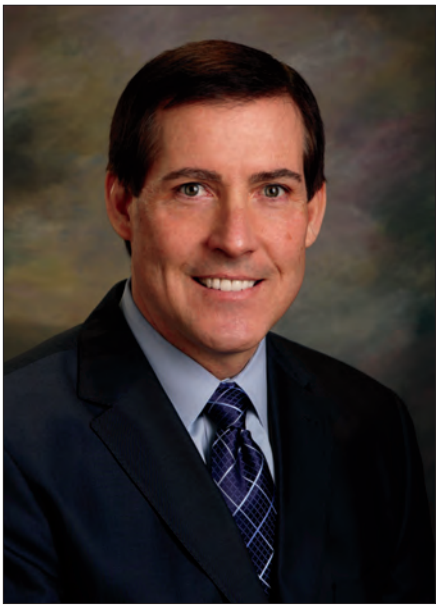
Prior to joining Children's, Steven worked at Starbucks Coffee for 9 years with his last role being Vice President, Human Resources. Steven also brings diverse HR experience from working at Macromedia Corporation, Nabisco Biscuit Company, and Harris Corporation. In these previous roles, Steven led major projects in the areas of Performance management, Succession planning, HR strategic planning, Global compensation, Organization development and Employee/union relations.

Steven earned a Bachelor's degree in Psychology from Hofstra University and both an MBA in General Business and Master's degree in Organization Development from the Florida Institute of Technology. He served on the board of Big Brothers Big Sisters for many years, supports numerous charitable organizations, and currently sits on the board of Providence Senior and Community Services as their Human Resource Executive support.

Washington Health Plans Report Mixed 2010 Financials

Investment Income Rebound Helps Premera Blue Cross and Regence Blue Shield Increase Profitability

By David Peel
Publisher and Editor
Washington Healthcare News



Washington domestic health plans recently reported third quarter financial results and four of the largest five plans posted higher net income compared to the same period in 2009. However, the other, smaller plans reported mixed results and two plans, KPS Health Plans and Timber Products Manufacturing Trust, reported losses.

Our report, shown to the right on page eleven, shows total revenues, investment income (loss) and net income (loss) for the 14 domestic health plans operating in Washington for the periods ending September 30, 2010 and September 30, 2009. We also present member months which is the total of month ending membership for each nine month period. When the financial figures are divided by member months, a monthly average over the period is obtained that is valuable in comparing one plan to another. Financial statement users can then make apples to apples comparisons of health plans.

Comments from Industry

We asked representatives of the plans to give us insight into their financial results.

Premera Blue Cross spokesperson Eric Earling said, "At Premera, changes in member months and total revenue were largely due to the effects of a challenging economy and higher unemployment. Changes in investment income were due to continued recovery in market conditions affecting the conservative investment portfolio utilized for our reserves. Changes in net income were due to both improved market conditions for investment income as well as lower than expected utilization of medical services. While utilization itself continues to rise and the cost of medical care continues to be a challenge, utilization of medical services has been increasing at a more moderate rate than expected – including because of a less severe flu season."

Earling also noted that Premera administers benefits for an additional 800+ thousand members not reflected in the reports. These members are covered under ERISA plans, regulated by the Federal Government, and the same level of public reporting isn't required.

According to Earling, "Premera Blue Cross has nearly 822,000 members in self-funded plans in Washington as of our October enrollment data, including companies such as Microsoft, Starbucks, Weyerhaeuser, PACCAR, and the Alaska Air Group."

Earling also commented on the financial results of *LifeWise of Washington*, a domestic plan owned by Premera, "Changes in member months and total revenue were due to increased membership, based on growing sales in a popular portfolio of individual products. LifeWise started the year with just under 77,000 members and has grown to nearly 85,500 through September – and we have seen even stronger growth in membership since then."

Regence Blue Shield of Washington reported decreased revenues of $55 million but increased net income of $56 million during the two time periods. According to Samantha Meese, spokesperson for Regence, "Our net income can be attributed to several factors: overall decline in membership and premium, a favorable claims experience as members switched

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Washington State Domestic Health Plan Financial Results[1]

For the Nine Months Ended 09/30/10 compared to the Nine Months Ended 09/30/09

Full Service Medical Plans Only - Sorted by Total Revenues - 000's Omitted[2]

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	Member Months[3]			Total Revenues			Investment Income (Loss)			Net Income (Loss)		
Health Plan Name	**09/10**	**09/09**	**Change**	**09/10**	**09/09**	**Change**	**09/10**	**09/09**	**Change**	**09/10**	**09/09**	**Change**
Dollars												
Premera Blue Cross	5,109	5,551	(442)	1,780,529	1,843,051	(62,522)	43,259	(20,501)	63,760	76,137	1,743	74,394
Regence BlueShield	6,285	6,850	(565)	1,746,148	1,800,992	(54,844)	50,966	32,053	18,913	57,303	1,131	56,172
Group Health Cooperative	3,232	3,242	(10)	1,413,511	1,460,711	(47,200)	17,362	45,431	(28,069)	1,158	311	847
Group Health Options	1,918	1,474	444	627,665	470,806	156,859	2,041	243	1,798	4,914	753	4,161
Molina Healthcare of WA	3,080	2,850	230	561,760	545,649	16,111	873	1,873	(1,000)	18,759	20,977	(2,218)
Community HP of WA	2,414	2,201	213	455,468	419,515	35,953	4,176	(890)	5,066	14,939	635	13,758
PacifiCare of WA (United Healthcare)	411	384	27	333,304	319,264	14,040	1,630	6,169	(4,539)	18,736	33,438	(14,702)
Arcadian Health Plan	356	253	103	282,255	202,345	79,910	1,968	1,922	46	4,940	10,410	(5,470)
Asuris NW Health	742	695	47	183,794	162,880	20,914	1,512	1,187	325	5,716	(6,920)	12,636
LifeWise HP of WA	736	718	18	161,629	159,524	2,105	3,474	3,382	92	6,138	7,478	(1,340)
KPS Health Plans	317	354	(37)	112,598	114,138	(1,540)	756	(121)	877	(2,269)	(902)	(3,171)
Columbia United Providers	409	370	39	77,001	72,839	4,162	177	21	156	2,642	3,411	(769)
Puget Sound Health Partners	63	40	23	44,164	40,804	3,360	118	92	26	757	520	237
Timber Products Mfg. Trust	127	158	(31)	19,993	21,630	(1,637)	222	361	(139)	(30)	(1,911)	1,881
Per Member Per Month[4]												
Premera Blue Cross	5,109	5,551	(442)	349	332	16	8	(4)	12	15	0	15
Regence BlueShield	6,285	6,850	(565)	278	263	15	8	5	3	9	0	9
Group Health Cooperative	3,232	3,242	(10)	437	451	(13)	5	14	(9)	0	0	0
Group Health Options	1,918	1,474	444	327	319	8	1	0	1	3	1	2
Molina Healthcare of WA	3,080	2,850	230	182	191	(9)	0	1	0	6	7	(1)
Community HP of WA	2,414	2,201	213	189	191	(2)	2	0	2	6	0	6
PacifiCare of WA (United Healthcare)	411	384	27	811	831	(20)	4	16	(12)	46	87	(41)
Arcadian Health Plan	356	253	103	793	800	(7)	6	8	(2)	14	41	(27)
Asuris NW Health	742	695	47	248	234	13	2	2	0	8	(10)	18
LifeWise HP of WA	736	718	18	220	222	(3)	5	5	0	8	10	(2)
KPS Health Plans	317	354	(37)	355	322	33	2	0	2	(7)	(3)	(4)
Columbia United Providers	409	370	39	188	197	(9)	0	0	0	6	9	(3)
Puget Sound Health Partners	63	40	23	701	1,020	(319)	2	2	0	12	13	(1)
Timber Products Mfg. Trust	127	158	(31)	157	137	21	2	2	(1)	0	(12)	12

Notes:

1. All information from the State of Washington, Office of Insurance Commissioner web site.

2. 000's omitted means the last three digits of each figure is removed. For example, the number 1,000 becomes 1.

3. Member Months is the combined total of each month's ending membership. For example, to get Member Months through 09/10, monthly membership for January, February, March, etc. is added together to get a combined total.

4. Per Member Per Month is any of the financial figures divided by Member Months for the particular plan. For example, Premera Blue Cross Total Revenues at 09/10 of 1,780,529 divided by Member Months of 5,109 equals a Per Member Per Month Total Revenue figure of 349.

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to higher deductible plans and a reduction in our total operating expenses, all of which yielded improved underwriting gains. This combined with the investment income, and slightly offset by an increase in taxes, accounts for the total change in net income."

The Group Health organization consists of *Group Health Cooperative*, *Group Health Options* and *KPS Health Plans*.

Mike Foley, spokesperson for Group Health Cooperative and Group Health Options said, "The Group Health Cooperative financial and enrollment results were according to plan. Our enrollment was stable and our net income was just above break-even."

He continued, "We were pleased with how Group Health Options performed. We planned to increase enrollment in our individual line of business and we achieved that. We also increased net income, certainly within industry standards, as the result of the increased enrollment growth."

Jim Page, Chief Financial Officer of KPS Health Plans told us, "Our membership was lower because we decided to not make as many price concessions as in the past and consequently lost business because of it. Also, we are exiting the small group market and are losing that enrollment as those groups come up on end of their contract years."

Page continued with this comment on the KPS decline in net income, "While our net income shows a decline between the years, after adjusting for actual claims run-out, 2010 is much better than 2009 through the first three quarters."

Zachary Smulski, Chief Financial Officer of Puget Sound Health Partners, offered this insight into his company's financial situation, "Our overall enrollment increased from approximately 4,400 to 7,200 members in the last 12 months and this contributed to our growth in net income."

Per Member Per Month Analysis

One of the more interesting ways to analyze health plan financial results is by reviewing per member per month statistics. As mentioned previously, this allows apples to apples comparisons of plan financial information. For example, one of the more revealing pieces of information is to find out how much money a health plan makes on each person it insures. If an employer pays $600 a month to provide insurance for their employees then how much profit does the insurance company make on each employee?

In United Healthcare's (formerly PacificCare of Washington) case, it's quite a bit. United Healthcare's domestic health plan focuses on senior health insurance through its Secure Horizon Medicare Advantage products. They reported a profit of $46 per member per month through September 30, 2010, down from $87 during the same time period in 2009. That can be contrasted with Regence Blue Shield of Washington's $9 per member per month profit through September 20, 2010.

David Peel is the Publisher and Editor of the Washington Healthcare News. He has held executive positions at several health care organizations throughout his twenty five year career. David can be reached at dpeel@wahcnews.com or 425-577-1334. Visit the Washington Healthcare News web site at www.wahcnews.com.

Career Opportunities

Founded in 1936, The Vancouver Clinic is a multi-specialty clinic located in Vancouver Washington, just north of Portland Oregon. The Clinic is a privately held, physician-owned clinic, with over 700 staff members and 190 providers. The Clinic is one of the region's principal health care providers, offering extensive services to our patients. We are currently seeking the following key positions.

Assistant Director Clinical Operations

The Assistant Director of Clinical Operations is an experienced and effective healthcare leader. It is imperative to possess superior leadership skills, as well as exceptional processing and strategic abilities. The successful candidate will have a minimum of 10 years of experience in clinic management in a medical office setting. Prefer those with a combination of education and experience equal to a baccalaureate degree. Graduate degree preferred.

Clinic Manager, Senior

Responsible for the administration and execution of daily operations of the Family Medicine Departments at all locations. Responsible for meeting strategic initiatives as established by the Assistant Director of Clinical Operations. The successful candidate will have a minimum of 5 years of experience in clinic management in a medical office setting. Prefer those with a combination of education and experience equal to a baccalaureate degree.

Clinic Manager

We are looking for energetic, experienced professionals to lead a team of staff providing compassionate medical care. Must have in-depth experience w/ developing business objectives, budgets, and financials. The manager will oversee the daily operations of specialty departments: Special Procedures Suite, Oncology, Infusion, and Rheumatology. The successful candidate will have a minimum of 2-3 years of management experience in a medical office setting. Prefer those with a Bachelors degree or equivalent combination of education and experience.

Clinic Manager

We are looking for energetic, experienced professionals to lead a team of staff providing compassionate medical care. Must have in-depth experience w/ developing business objectives, budgets, and financials. The manager will oversee the daily operations of specialty departments: Cardiology, Echocardiography, and Anti-Coagulation. The successful candidate will have a minimum of 2-3 years of management experience in a medical office setting. Prefer those with a Bachelors degree or equivalent combination of education and experience.

The Vancouver Clinic

To apply for any of these positions visit www.tvc.org/careers.ashx or call 360-397-3273 for information.

Morton General Hospital

Information Technology Director

(Morton, WA)

Would you like to live and work where others vacation?

Morton General Hospital is a progressive Critical Access Hospital looking for a Full-time **IT Director** that is interested in growing with us. We are one of nine hospital's in a collaborative of rural hospitals that work together on special IT like HIE and other projects. Must have healthcare experience. Competitive wage and benefit package.

Please send resume to:

skelly@mortongeneral.org

or

Morton General Hospital
Att: Shannon Kelly
PO 1138
Morton WA 98356

Hill Physicians
Your health. It's our mission.

Contracts Manager - Healthcare

(San Ramon, CA)

Come join a growing company that is making a difference in the delivery and management of healthcare services. Hill Physicians Medical Group (HPMG) offers access to one of the most extensive medical networks in Northern California.

Manage the process for health plan and provider contracting, supporting the Director of the Contracts and Network Development Department. Key responsibilities include analyzing, negotiating, implementing and monitoring HMO, physician group, hospital and ancillary provider contract terms. Works as a key partner to the Director in negotiating complex Health Plan agreements. Fills in for the Director in his/her absence.

Requirements

Bachelor's degree required; Masters preferred. Exceptional written and verbal communication skills, including public speaking and facilitation skills. Strong desktop application skills including Word, Excel, and PowerPoint, database management skills a plus. Minimum five (5) years' experience in managed care, with experience in capitated contract environments. Must have working knowledge of provider & health plan contract operations. Ability to identify and define work process issues and work collaboratively to find solutions. Strong demonstrated financial analysis and auditing skills.

For additional information and to apply online, go to

www.HillPhysicians.com/careers
OR
Send resume to
PriMed
P.O. Box 1161
San Ramon, CA 94583
Fax: 925-327-6656

Willapa Harbor Hospital
Working together for a healthier community

Chief Nursing Officer (South Bend, WA)

Willapa Harbor Hospital is a small Rural Critical Access Hospital, licensed for 26 beds, with 10 beds currently set up for patients. The hospital is located in South Bend, WA. The CNO will be responsible for Med/Surg, ER, Surgery, Endoscopy and PAR. The nursing team consists of the Charge Nurse; LPN's and Certified Nursing Assistants. Our employees take pride in providing great patient care in this small Southwest WA community. We are looking for the right individual who has excellent management & interpersonal skills. The applicant must have current Washington RN license with previous experience as a CNO preferred or minimum of 5 years as a nurse supervisor in acute care, preferably a critical access facility. South Bend is a beautiful rural location with easy access to beach combing, camping, hiking, fishing and hunting. We offer a competitive salary and a comprehensive benefits package. For a complete job description and to apply please contact Krisy Funkhouser, HR, **kfunkhouser@willapa.net** or mail resume to: Willapa Harbor Hospital, PO Box 438 South Bend, WA 98586. EOE

Career Opportunities

We think

You should feel good about where you work.

If you want a career where you're excited about doing what you do everyday; where loving to go to work beats having to go to work — there just may be an opportunity here for someone like you.

Why work at Group Health?

We offer an environment where your ideas matter more than your title. And what you do everyday makes a positive impact on the lives of others. The national average of people staying at a job is about four years. At Group Health, it's nine. If you want Mondays to feel as good as Fridays, opportunity's knocking.

We are currently recruiting the following key positions:

Tacoma

- Ambulatory Surgery Manager (Job 101297)
- Assistant Manager - Ambulatory Surgery Center (Job 102535)

Seattle

- Assistant Manager - Ambulatory Surgery Center (Job 102535)

Bellevue

- Assistant Manager - Ambulatory Surgery Center (Job 102536)
- RN- Clinical Operations Manager (Job 102512)

To apply and learn more visit www.ghc.org/careers. Call Becky P. with questions at 206-448-6079.

Group Health is an Equal Opportunity Employer committed to a diverse and inclusive workforce

Coalinga Regional Medical Center

Serving the Community since 1938

Coalinga Regional Medical Center is nestled in the coastal mountain range of California, just 70 miles from the Pacific Coast and 60 miles west of Fresno, California.

Coalinga Regional Medical Center is the single most important component of the health care delivery system in the City of Coalinga. Established in 1938, the hospital provides the following essential health care services to the community:

- Acute Care
- D.O.T. Exams
- Emergency Medicine
- Industrial Medicine
- California Licensed Laboratory
- Physical Therapy
- Radiographic and Fluoroscopy Studies
  - MRI - CT Scans
  - Mammography - Sonography
- Respiratory Therapy
- Skilled Nursing Facility

We are currently seeking the following key positions:

- Biller/Collector
- Clinical Lab Scientist
- Dietician
- Director of Nursing – Skilled Nursing Facility
- Information Technology Manager
- Nurse Manager – ER and MedSurg
- Nurse Practitioner – Rural Health Clinic
- Physician's Assistant – Rural Health Clinic
- Patient Financial Services Manager
- Respiratory Care Practitioner
- RN – Emergency Room
- RN Supervisor – SNF
- Speech Pathologist (per diem only)

For job postings and applications, please visit:

www.coalingamedicalcenter.com
Email: **jobs@coalingahospital.com**
Phone: 559.935.6420
Fax: 559.935.6512

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To learn about ways the Washington Healthcare News can help recruit your new leaders contact David Peel at 425-577-1334 or dpeel@wahcnews.com

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