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Washington Health Plans Report Mixed Financial Results for Year End 2011

By David Peel
Publisher and Editor
Washington Healthcare News

Fifteen of the largest health plans in Washington recently reported 2011 annual financials and the results were mixed with five reporting a loss. Eleven plans reported a lower underwriting gain (or bigger loss) and nine of the fifteen plans reported lower net income or a greater loss than the same period in 2010.

Our report, shown on page six, shows total revenues, net underwriting gain (loss), investment gain (loss), other income and net income (loss) for fourteen domestic health plans and one national health insurance company operating in Washington for the periods ending December 31, 2011 and December 31, 2010. We also present member months, the combined total of month ending membership for each twelve 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.

All information in this report was obtained through publicly available reports filed with the National Association of Insurance Commissioners (NAIC). Information not required to be filed with the NAIC (self-insured and some Washington insured business from smaller, non-domestic carriers) is not included in this report nor is it referenced in this article.

Comments from Industry Representatives

We asked representatives of the plans to confirm figures in the report and to provide insight into their financial results. Some plans chose not to reply to our request. However, others provided valuable comments and these follow, sorted by plan size in descending order.

Premera Blue Cross

Strong financial results continued for Premera Blue Cross with increases in every category except investment gain (loss) and other income. Spokesperson Eric Earling said, "Premera had a strong year 2011 based on several factors. We had significant growth in member-

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LETTERS TO THE EDITOR

If you have questions or suggestions regarding the News and its contents, please reply to dpeel@healthcarenewssite.com.

Letter from the Publisher and Editor

Dear Reader,

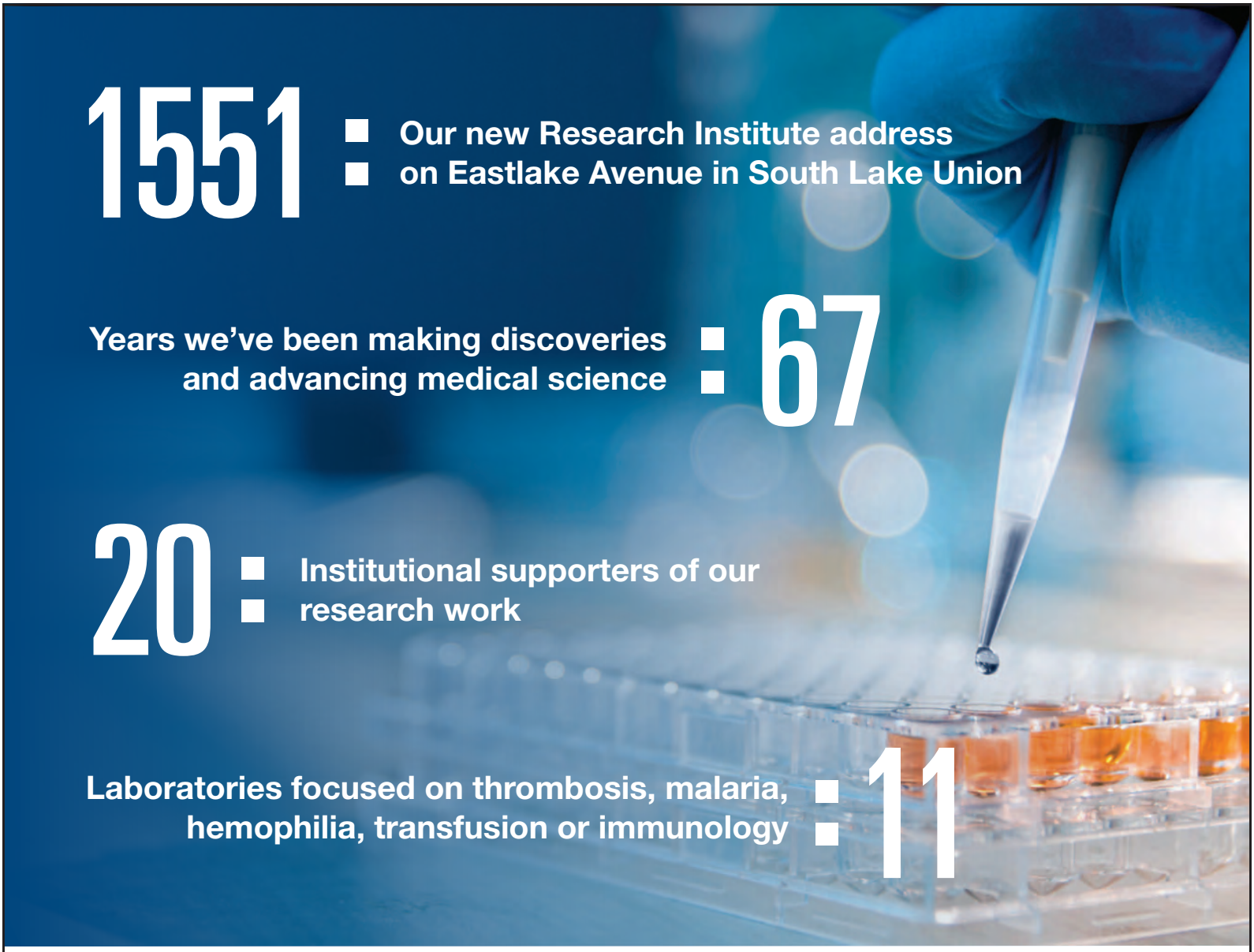
The Consultant Marketplace is an online directory of consultants, attorneys and vendors to the healthcare industry offered on all Healthcare News web sites since 2008. It is a fast, free and comprehensive place to find external resources when there are short-term and, in some cases, long-term business needs. For example, let's say you need to hire an advertising agency to advise you on how best to recruit new staff. You would go to one of the Healthcare News web sites and click on the Consultant tab in the blue navigation bar at the top of the page. Once at the Consultant Marketplace, you search for recruitment advertisement agencies and find a half dozen well known firms.

For years we've restricted Consultant Marketplace participation to those companies who paid a monthly fee. So, while fast, the selection was neither free nor comprehensive. We recently changed this so all consultants, attorneys and vendors who service the healthcare industry receive a Consultant Marketplace listing at no charge. At this edition's print date, we have over 150 companies in the Consultant Marketplace and expect it to grow to over 600 by the end of the year. Check it out by visiting our web site at wahcnews.com. Until next month,

David Peel, Publisher and Editor

Washington Healthcare News 2012 Editorial Calendar

Month and Year	Theme of Edition	Space Reservation	Distribution Date
January 2012	Hospitals	December 1, 2011	December 26, 2011
February 2012	ASCs	January 3, 2012	January 30, 2012
March 2012	Hospitals	February 1, 2012	February 27, 2012
April 2012	Insurance	March 1, 2012	March 26, 2012
May 2012	Clinics	April 1, 2012	April 30, 2012
June 2012	Human Resources	May 1, 2012	May 28, 2012
July 2012	Hospitals	June 1, 2012	June 25, 2012
August 2012	Hospitals	July 2, 2012	July 30, 2012
September 2012	Clinics	August 1, 2012	August 27, 2012
October 2012	Human Resources	September 3, 2012	September 24, 2012
November 2012	Hospitals	October 1, 2012	October 29, 2012
December 2012	Clinics	November 1, 2012	November 26, 2012



1551 : Our new Research Institute address on Eastlake Avenue in South Lake Union

Years we've been making discoveries and advancing medical science : **67**

20 : Institutional supporters of our research work

Laboratories focused on thrombosis, malaria, hemophilia, transfusion or immunology : **11**

Numbers tell a story, but few as sobering as this: 2,500

It's the lives taken by heart attack and stroke in the U.S. every day.

That's why we're investigating unwanted blood clotting — the leading cause of heart attacks and strokes.

Our blood research saves lives. Perhaps even yours. To learn more, visit **psbc.org/research**

Puget Sound Blood Center

research | medicine | blood & tissue services

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ship. We had success in our work to control rising medical costs, by holding cost increases below the average of our fellow Blue plans nationally. And, we have continued to show results in keeping our own administrative costs low. All of those factors contributed to strong financial performance for the year."

Earling continued, "Looking forward, we believe that leaves Premera well-positioned to implement federal healthcare reform for its customers & weather related market uncertainty that may follow. We expect to continue to operate on a narrow margin in a challenging environment. For context, our operating margin across our family of companies has been 2.0% over the last five years. Understanding that, our focus continues to be on addressing the issue of rising medical costs, which represent 86 cents on the premium dollar over the last five years. We believe that's a critical issue and everyone in the healthcare system has a role to play in addressing that challenge."

Regence of Washington

Regence had a difficult 2011 with decreases from 2010 in every category of our report. Spokesperson Rachelle Cunningham summed it up this way, "We attribute the loss of membership to continuing effects of the slow economy. Our overall financial results demonstrate that Regence is managing to its nonprofit values."

Group Health Cooperative

Group Health Cooperative also had a difficult 2011 although, due largely to investment gains, reduced their 2011 loss by $19 million. Scott Boyd, Vice President of Finance, said this about Group Health's decrease in net underwriting loss, "(our) Expense trends were higher than anticipated."

When asked why there was a large increase in Group Health Cooperative investment income, Boyd replied, "We captured some gains from the sale of securities in late 2011 as we made some changes in our investments."

KPS Health Plans

Although total revenues were lower by $23 million in 2011, KPS Health Plans reported a $2 million profit, up from a loss of $600 thousand in 2010. CEO Jim Page explained, "Enrollment losses

were due to our exit from the small group market and some net losses of medium and large commercial groups."

When asked about the KPS improved financial performance, Page said, "Overall improvement in financial performance was attributable to more favorable claims expense trends and more efficient administrative cost structures."

Concluding Comments

Although too early to say conclusively, Washington plans may already have been negatively impacted by the early stages of healthcare reform. Member months are up, something not seen in many years, and are probably attributed to parents adding children aged 26 and below to their policies. However, since eleven of fifteen plans reported an unfavorable change in net underwriting gain (loss), the costs associated with this new enrollment appear higher than expected.

Look for plan actuaries to put additional margin into rates until it's clear the costs of healthcare reform are known. Unfortunately, it will require years of predictable claims history before the costs of healthcare reform can be quantified.

Washington State Health Insurance Company Financial Results[1]

For the Twelve Months Ended 12/31/11 compared to the Twelve Months Ended 12/31/10

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

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	Member Months[3]			Total Revenues			Net Underwriting Gain (Loss)[4]			Investment Gain (Loss) & Miscellaneous			Other Income[5]			Net Income (Loss)		
Health Plan Name	**12/11**	**12/10**	**Change**	**12/11**	**12/10**	**Change**	**12/11**	**12/10**	**Change**	**12/11**	**12/10**	**Change**	**12/11**	**12/10**	**Change**	**12/11**	**12/10**	**Change**
Dollars																		
Premera Blue Cross[8]	8,017	6,791	1,226	2,501,043	2,375,361	125,682	96,295	74,322	21,973	45,307	58,009	-12,702	-1,471	4,660	-6,131	119,164	119,011	153
Regence BlueShield[8]	7,412	8,296	-884	2,209,782	2,320,200	-110,418	-53,975	10,481	-64,456	54,629	68,806	-14,177	-4,159	-19,351	15,192	-10,200	51,295	-61,495
Group Health Cooperative[8]	4,259	4,303	-44	1,973,238	1,874,011	99,227	-85,896	-78,165	-7,731	72,344	45,281	27,063	0	0	0	-13,551	-32,884	19,333
Group Health Options[8]	2,789	2,609	180	1,015,869	862,265	153,604	6,399	10,002	-3,603	4,817	2,649	2,168	52	0	52	7,871	7,436	435
Molina Healthcare of WA	4,170	4,141	29	834,782	757,620	77,162	39,188	40,037	-849	1,142	1,113	29	0	0	0	25,911	26,628	-717
Community HP of WA	3,363	3,233	130	706,398	610,158	96,240	6,121	16,027	-9,906	3,853	5,359	-1,506	1,442	0	1,442	11,416	21,385	-9,969
UnitedHealthcare Ins. Co.[6]	4,369	3,383	986	568,949	650,902	-81,953	22,333	822	21,511	5,682	5,299	383	0	0	0	26,545	3,832	22,713
UnitedHealthcare of WA	657	550	107	510,567	440,435	70,132	36,625	39,123	-2,498	2,546	2,204	342	12	0	12	25,549	27,168	-1,619
Arcadian Health Plan	501	480	21	406,023	379,651	26,372	-8,237	1,776	-10,013	4,256	2,311	1,945	0	0	0	-2,337	3,626	-5,963
LifeWise HP of WA[8]	1,233	1,016	217	287,031	220,415	66,616	-11,760	5,577	-17,337	5,190	4,523	667	127	266	-139	-4,645	6,942	-11,587
Asuris NW Health[8]	922	988	-66	259,657	246,568	13,089	1,604	5,081	-3,477	2,582	2,019	563	-282	-533	251	2,762	4,082	-1,320
Columbia United Providers	722	548	174	136,786	103,334	33,452	6,087	6,231	-144	124	208	-84	0	0	0	4,137	4,224	-87
KPS Health Plans[8]	352	422	-70	126,571	149,163	-22,592	2,497	-1,900	4,397	117	1,790	-1,673	-197	-558	361	2,372	-558	2,930
SoundPath Health	137	85	52	50,118	51,713	-1,595	-1,455	20	-1,475	240	148	92	-115	-161	46	-1,330	-5	-1,325
Timber Prod. Mfg. Trust	140	166	-26	25,201	26,431	-1,230	2,127	-341	2,468	123	266	-143	0	0	0	2,250	-75	2,325
Per Member Per Month[7]																		
Premera Blue Cross[8]	8,017	6,791	1,226	312	350	-38	12	11	1	6	9	-3	0	1	-1	15	18	-3
Regence BlueShield[8]	7,412	8,296	-884	298	280	18	-7	1	-9	7	8	-1	-1	-2	2	-1	6	-8
Group Health Cooperative[8]	4,259	4,303	-44	463	436	28	-20	-18	-2	17	11	6	0	0	0	-3	-8	4
Group Health Options[8]	2,789	2,609	180	364	330	34	2	4	-2	2	1	1	0	0	0	3	3	0
Molina Healthcare of WA	4,170	4,141	29	200	183	17	9	10	0	0	0	0	0	0	0	6	6	0
Community HP of WA	3,363	3,233	130	210	189	21	2	5	-3	1	2	-1	0	0	0	3	7	-3
UnitedHealthcare Ins. Co.[6]	4,369	3,383	986	130	192	-62	5	0	5	1	2	0	0	0	0	6	1	5
UnitedHealthcare of WA	657	550	107	777	801	-24	56	71	-15	4	4	0	0	0	0	39	49	-11
Arcadian Health Plan	501	480	21	810	791	19	-16	4	-20	8	5	4	0	0	0	-5	8	-12
LifeWise HP of WA[8]	1,233	1,016	217	233	217	16	-10	5	-15	4	4	0	0	0	0	-4	7	-11
Asuris NW Health[8]	922	988	-66	282	250	32	2	5	-3	3	2	1	0	-1	0	3	4	-1
Columbia United Providers	722	548	174	189	189	1	8	11	-3	0	0	0	0	0	0	6	8	-2
KPS Health Plans[8]	352	422	-70	360	353	6	7	-5	12	0	4	-4	-1	-1	1	7	-1	8
SoundPath Health	137	85	52	366	608	-243	-11	0	-11	2	2	0	-1	-2	1	-10	0	-10
Timber Prod. Mfg. Trust	140	166	-26	180	159	21	15	-2	17	1	2	-1	0	0	0	16	0	17

Notes:

1. All information from the National Association of Insurance Commissioners 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 12/11, monthly membership for January through December is added together to get a combined total.
4. Net Underwriting Gain (Loss) is Net Income prior to Income taxes, Investment Gains and Losses and Miscellaneous revenues and expenses. It is a thought to be an accurate measure of the adequacy of premium revenue and can be a good predictor of future premium increases or decreases.
5. A negative Other Income number means it was an expense.
6. Figures from the Supplemental Health Care Exhibit - Part 1 of the carrier's annual statement.
7. Per Member Per Month is any of the financial figures divided by Member Months for the particular plan.
8. Figures confirmed by healthplan management.

Any Color You Want, So Long As It's Red

By Dr. James P. AuBuchon
President and CEO
Puget Sound Blood Center

"Tell me Jim, what's *new* in the blood world? Still offering it in only one color?" I smiled when my neighbor asked this question, though maybe I was just gritting my teeth. "Yes, you can have any color you want, so long as it's red," I replied. "But in answer to your first question, there is a whole lot new in the world of blood." And there is.

When people think of Puget Sound Blood Center, they conjure up an image of donors on cots. There's truth in that: with the help of a quarter million registered donors we collect, test and provide blood to more than 70 hospitals in Western Washington. Or they imagine patients in hospitals having surgery, organ transplants, cancer treatment, therapy for blood disorders– all depending on our blood components, in-house transfusion and laboratory expertise. A true picture, too.

But what people *don't* think of is our Research Institute that recently moved into new facilities at 1551 Eastlake. When we say there's "new blood" in the South Lake Union hub of biomedical research in Seattle, it's literally true. We have 40 scientists focused on thrombosis and stroke prevention, hemophilia and hemostasis therapies, transfusion medicine and immunology.

Research was part of our mission from the very beginning, 68 years ago. Today, we're collaborating with some outstanding local partners: UW Medicine, Seattle Children's, Fred Hutchinson Cancer Research Center, Seattle Cancer Care Alliance, and many private companies, including Bayer and Biogen Idec.

Let's consider just three areas with dramatic change and new discoveries underway: genomic testing of donor and patient blood; sickle cell research; and preventing thrombosis, the leading cause of heart attacks and stroke.

Many people will need a red blood cell transfusion sometime during their lives. Traditional blood typing tests for only a limited number of blood types, even though more than 200 red cell types have been identified. New genetic typing technologies enable deep and precise blood typing to match more specifically defined blood groups with individual patients.

Our lab is among the first in the country using genomic blood typing of some donor blood so we can more closely match it to patient antibodies – better reflecting the individual needs of patients, and the growing ethnic diversity of our communities. Closer matching between donor and patient blood types further reduces the possibility of adverse immune system reactions arising from blood transfusion, especially for patients needing multiple transfusions. What we have introduced here is helping to define a new model for blood typing and transfusion worldwide.

Our Research Institute includes many outstanding leaders in blood research--recognized nationally and internationally. A recent NIH grant of $3.73 million to Dr. José López and Dr. Barbara Konkle to advance research investigations into Sickle Cell Disease (SCD) is one example. SCD is a genetic blood disorder caused by an abnormal type of hemoglobin, which

can cause red cells to assume crescent ("sickle") shapes and become more "sticky." These misshapen cells get stuck in small blood vessels and interrupt blood flow, causing organ and tissue damage, pain and sometimes stroke. SCD affects eight to 10 percent of African Americans and some people from South and Central America, the Caribbean and Middle East.

This latest grant builds on recent PSBC studies demonstrating that SCD patients have high concentrations of hyper-adhesive von Willebrand factor (VWF), a plasma protein. It is expected that these investigations will yield significant benefits for individuals who have SCD, potentially producing a new therapy that's safe and inexpensive. The research is cutting edge, complex, and occurring right here in the Pacific Northwest.

The third area of "what's new in blood" is perhaps the biggest challenge we've taken on in our history. What do stroke, heart attacks, cancer, diabetes, malaria and lupus have in common? Thrombosis, or pathologic blood clotting. Stroke and heart attacks are the leading cause of premature death in the world, and thrombosis is the common mechanism linking them. By conducting new research on blood clotting, our researchers will be seeking to identify, prevent and avoid events or conditions that lead to thrombosis.

So, there is a lot new in the blood world! We know more about blood, and are applying genomic technology to type it. We're improving therapies and treatment for disorders like SCD. We continue to discover new things about blood, with potential and far-reaching benefits for prevention of heart attacks and strokes. And yes, red is still the only color. We do provide components in other colors, mind you: there's plasma, platelets, cryoprecipitate…but that's a story for another time.

James P. AuBuchon, MD, FCAP, FRCP (Edin) joined PSBC in 2008 as president and CEO. Prior to coming to Seattle, he spent 18 years at Dartmouth-Hitchcock Medical Center as Medical Director of the Blood Bank and Transfusion Service, and later as Chair of Pathology and Professor of Medicine at Dartmouth College. AuBuchon's research focus includes transfusion safety and blood components. He is immediate past president of AABB. A University of Michigan graduate, he trained at the National Institutes of Health.

The Balancing Act: Medical Plan Cost Control Programs & Member (dis) Satisfaction

By Andrew Sutton
Strategic Account Executive
Healthcare Management Administrators

Given the steady upward trend of healthcare costs, plan sponsors continue to face the challenge of offering plans that are both cost effective and market competitive relative to industry/community benchmarks. Plans make changes to try to impact trend and improve outcomes. Plans communicate new programs at open enrollment and through other media. Despite our concerted efforts, I still get the sense that most members (including my own family at times) just want their medical plans to pay their claims. Because of this all too common reality, we are seeing a rising tide of member dissatisfaction. This dissatisfaction leads me to ask; do our members understand the benefits of and need for our current programs before we attempt to add new ones like wellness and disease management? How do we design plans and programs that seek to control costs and direct care to the best potential outcomes without creating barriers to receiving recommended care? The following three examples happen on a daily basis and can be prevented through a re-prioritization of member education and re-visiting plan design strategy.

Utilization Review & Prior Authorization

As more medical procedures are available for multiple conditions and indications, we are seeing an increase in member and provider dissatisfaction with reviews for medical necessity, particularly around experimental and investigational treatments. This classic cost control program which seeks to confirm that proposed treatment meets the standards of nationally set criteria is the first place where cost and outcome management strategies collide with the member's expectation that the plan will cover the care their physician recommends to improve their health. Are we (re)educating members as to why these programs are in place? Where was this covered in your last open enrollment presentation and is it highlighted in your benefit summaries? Have you reconsidered your strategy around whether or not your plan recommends, requires, or requires utilization review with a financial penalty, for example?

Specialty Pharmacy Programs & Formulary Management

Given that specialty medications will be the primary trend drivers in pharmacy spend over the next 5+ years, many employers are trying to get in front of this risk and to manage their cost exposure. Many of our pharmacy benefit manager partners are recommending mandatory specialty programs that combine prior authorization and a single source approach to managing this risk. In many instances, specialty medications are being prescribed for alternative indications (not FDA approved or not on the label) and being denied. In other situations, members are dissatisfied with the manner in which they have to access these medications for very serious medical conditions (mail order, next day delivery). Secondly, as many drugs are becoming generic and other brand drugs are competing against other medications proven to be more effective and less expensive, members are being told that their medication is no longer covered on the formulary. Despite the significant amount of

research and consideration by the pharmacy benefit manager and our directive to them to manage costs and our clients' formularies, there continues to be a good amount of plan and member resistance. Are we covering the cost and savings benefits of these programs and the importance of formulary management when we cover the co-pays at open enrollment and on our benefit summaries?

Isn't My Diagnostic Procedure Preventive?

Even before Health Care Reform, most of our plans had a benefit differential where plans paid more for what the industry calls "preventive" care. From a health risk management prioritization perspective, this is problematic and from a member's perspective, it doesn't make intuitive sense. Members with chronic or acute conditions who need to adhere to recommended care guidelines (doctor's visits, lab and diagnostic tests set by nationally recognized experts like the American Diabetes Association) represent a greater financial risk to a self-funded plan. While it is important to keep our healthy members healthy, isn't it more important to keep our sick members from getting sicker? Next, as more and more medium size groups are implementing or managing a disease management program, members are shaking their heads as they review plan benefits. "The nurse is telling me to get my recommended care for my diabetes, but the care I need is too expensive for me to get, particularly if I have multiple conditions and when compared to what is considered 'preventive'." Isn't my recommended care ***preventing*** further illness? We need to give consideration to our plan design structures and how they complement our health promotion initiatives. Is there continuity between our programs and our plan designs?

Final Thoughts

As more plans consider health promotion programs like wellness or disease management, we need to make sure that we work on the foundational plan management programs that our members engage in on a daily basis. If our members do not have an understanding for how these programs work and why they are important, they will not be receptive to additional programs that we offer to manage their health. We may not have gained their trust and partnership in the management of their health. We need utilization review and specialty pharmacy programs, for example, to free up the dollars to remove the barriers for our members to receive recommended care. We need to re-energize our combined efforts around employee education and consumerism to maintain and build upon existing programs and by doing so, set-up new programs for success.

Andrew Sutton is the Strategic Account Executive for Healthcare Management Administrators, Inc. (HMA). HMA's Benefit administration services and solutions provide one-stop shopping for organizations that self-fund benefits. Contact HMA at proposals@accesstpa.com or visit their web site at www.accesshma.com.

TGBa Helps Overlake Bring Care Convenience to Redmond Retail Areas

By Nora Haile
Contributing Editor
Washington Healthcare News

Overlake Hospital Medical Center's newest clinics promote the trend of locating healthcare within the convenience of a retail environment. The Primary Care Clinic at Redmond Town Center will provide adult internal medicine supported by an on-site lab.The Urgent Care Clinic at Overlake Medical Clinics Redmond, in the Creekside Crossing Shopping Center, provides a lower cost alternative to an emergency room for non-life threatening injuries and includes outpatient imaging with CT, Ultrasound and X-ray immediately adjacent for convenience.

Taylor, Gregory, Broadway Architects (TGBa) has partnered with the Eastside healthcare organization several times over the years, most recently on three retail-area clinics. They see the location choice as a growing trend. "Over the past year, we've built-out five projects in a retail setting for two different healthcare clients," stat-

Reception Area of Primary Care Clinic at Redmond Town Center

ed Kent Gregory, TGBa Principal. "Care needs to be accessible and convenient to the healthcare consumer, and organizations like Overlake are acting on that knowledge."

Not yet mainstream, the retail-based care setting brings challenges, as many landlords and city regulating bodies are unfamiliar with the concept. As Gregory explained, "Jurisdictional design guidelines are not yet current with this new model of professional and medical services. What's been generally acceptable for retail doesn't reflect what's happening in the marketplace today, particularly in healthcare."

Overlake's Kelly Piger, director of Overlake Medical Clinics Development, reiterated that point and added, "Having opened several clinics in retail settings, our team tries to anticipate issues in advance and work closely with landlords and other approval bodies." Additional hurdles for permitting and approvals can increase clinic opening timelines and increase costs. Some of the requirements include adherence with the visual look and feel typical of retail establishments, which means creative design that satisfies codes yet preserves the privacy inherent in healthcare environs.

TGBa's Melissa Kelii, an IIDA interior designer, and Jennifer Seibert added that for the Urgent Care Clinic project, Department of Health licensing called for original drawings of the space (previously a Blockbuster video store) to assure the structure itself was compliant with DOH regulations. Both recommend that healthcare clients consider a jurisdictional research and feasibility study before diving into the retail-based environment. Another set of retail requirements came with the Primary Care Clinic build-out in Redmond Town Center, happening neck-and-neck with the UCC build-out.

To address the privacy issue yet comply with both retail center requirements, the TGBa team used strategically placed design elements, such as frosted glass, in the areas viewable from the street. When entering the clinics, patients see high quality wall coverings, banked soffits, and at the Urgent Care Clinic, custom glass blown textures and inset tiles. The two Redmond-based clinics share commonalties with their six sister Eastside Overlake clinics. "Beginning with the Issaquah Urgent Care and Primary Care Clinics, we've used the strong curved soffit as a distinct architectural element in Overlake clinics," Kelii shared. "It became a favorite feature of Overlake's marketing department early on, to the point they incorporated it into the Overlake outpatient clinic branding."

The meandering, organic shape draws the eye through and around the two Redmond clinics. Whether walking or driving, people inevitably notice the strong curvature, which accentuates the flow created within the clinic space. Once inside, continuity in colors – tranquil greens and warm earth tones – project a calming environment, while splashes of orange and gold in fixtures and accent decor add cheerful color. Art by Henry Domke, a retired physician who creates nature pieces for healthcare organizations, decks the walls.

Because of the longtime relationship between TGBa and Overlake, the design process was down to a science. "They help us create the best product at moderate costs, and are proactive in helping us resolve issues that could turn into delays or increase costs," said Piger. The Center pulled together a workgroup of leaders, physicians and clinical staff to work with TGBa through multiple design sessions around patient and staff workflow. Lean processes helped evaluate creative design solutions.

The results reflect the team's focus, with a progressive layer of spaces. As Gregory described, "Each is a little different. Patients enter a welcoming, pleasant space, then move to the carefully planned (onstage) clinical care area that isn't cluttered with a lot of equipment. The offstage area gives medical care staff a designated work area that's outside of the patient flow." Iterative process has led TGBa to the onstage and offstage design model, which encourages the physicians to sit with their team and collaborate without worry of disruption.

Successful expansion requires a strong partner, and TGBa gets full marks. "TGBa takes the time to understand what our clinical staff needs as well as what patients need," complimented Piger. "They lead the team to answers that are outside of our norm."

Nora Haile is a Contributing Editor to the Washington Healthcare News. She has extensive experience covering healthcare issues. Haile can be reached at 206-650-3308 or nhaile@healthcarenewssite.com

Shifting Standards: Washington's Regulation of Nonsurgical Cosmetic Procedures

By Dana Kenny
Healthcare Attorney & Partner
Miller Nash LLP

By Danielle Cross
Attorney
Miller Nash LLP

The administration of Botulinum Toxin Type A (more commonly known as Botox) was the most frequently performed nonsurgical cosmetic procedure in 2011, with over 2.6 million procedures performed by physicians in the United States.[1] Factor in the number of Botox injections performed not only by physicians, but also by physician assistants and nurse practitioners, and this number skyrockets to 4 million.[2] The injection may remain the same, but in Washington, the type of practitioner performing the procedure can have a major impact on policies and procedures relating to its administration.

Background

In 2007, the Medical Quality Assurance Commission ("MQAC") began drafting the state's first, and still only, regulation specifically relating to the administration of Botox. The rules were a result of an increasing number of complaints regarding the administration by individuals with little or no training and without proper licensure.[3] Commentators questioned whether the proposed regulation was simply a reiteration of the standard of care. In response, MQAC asserted that, regardless of the standard of care, it was still receiving complaints demonstrating that the standard was not being met. It stated that "while it is true that these requirements are the standard of care in our state, [MQAC] wants to make these requirements explicit in this area of medicine."[4]

In 2010 the rules became effective. Although commentators questioned why the rules did not address advanced registered nurse practitioners ("ARNPs"), and urged that the rules be rewritten to include them, ultimately MQAC had to decline.[5] MQAC has no authority to create and adopt rules regarding ARNPs; such authority rests with the Nursing Care Quality Assurance Commission ("NCQAC"). Thus, the rules adopted in 2010 apply to only two types of practitioners: physicians and physician assistants.

Physician Regulations[6]

The injection of medication or substances for cosmetic purposes, or the use of prescriptive devices for cosmetic purposes, constitutes the practice of medicine under Washington law. In addition to requiring that a physician be fully and appropriately trained in performing nonsurgical cosmetic medical procedures, the regulations also require the physician to:

- Keep a record on his or her

training in the office and available for review;

- Take a history;
- Perform an appropriate physical examination;
- Make an appropriate diagnosis;
- Recommend appropriate treatment;
- Obtain a patient's informed consent;
- Provide instructions for emergency and follow-up care; and
- Prepare an appropriate medical record.

The physician is also required to ensure that there is a quality assurance program at the facility regarding the selection and treatment of patients.

Once a physician has met these requirements, he or she may delegate the procedure to a properly trained physician assistant, registered nurse ("RN"), or licensed practical nurse ("LPN"). Among other delegation requirements, the physician must maintain a written protocol for the delegation and must ensure that the patient signs a consent form before the procedure that, among other information, identifies the delegate performing the procedure. The physician must be reachable by phone and able to respond within 30 minutes when delegating the procedures using medications approved by the Food and Drug Administration (the "FDA") and approved for the particular purpose for which they are used. If the procedure calls for substances not approved by the FDA, or not approved for the particular purpose for which they are being used, the physician must be on site.

Regardless of who performs the procedure, the physician is ultimately responsible for the safety of the patient.

Physician Assistant Regulations[7]

Physician assistants may perform a nonsurgical medical cosmetic procedure only after MQAC approves a practice plan permitting the physician assistant to perform the procedure. Further, among other requirements such as specific training, the physician assistant must ensure that the supervising or sponsoring physician is in full compliance with regulations governing physician practice found at WAC 246-919-606. Additional requirements are set forth in WAC 246-918-126.

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Is Your Practice Making Value-Based Decisions?

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Former Health and Human Services secretary Mike Leavitt once said about change, "You can fight it and fail; you can accept it and survive; or you can lead it and prosper."

As everyone knows, the business of health care is undergoing significant change. Medicare spending is a major topic on Capitol Hill, and this will continue as everybody tries to figure how to control costs that are becoming an expanding part of the federal budget.

As the health care reform initiatives begin to take hold, all stakeholders are looking for ways to maintain or increase their market share, and contain costs, by forming strategic alliances. As such, seeking relationships with partners that add value to their services has become paramount in the minds of industry leaders. Through years of experience, we've observed that acquisition focuses all efforts on integration over innovation. Partnering just makes sense.

While so many struggle to define value in health care, we're all driven by value-based decisions in our daily lives. If you've recently had a nice dinner at a local restaurant, shopped for a television, or purchased a new car, you've been faced with a value dilemma—benefit minus cost.

Why do you make these typical purchasing decisions? Because you've placed a value on past service, the reviews of others, and, most important, you've taken all this information and developed an educated opinion that the "brand" has demonstrated value in terms of service, reliability, and responsiveness—and provided it all at a cost that doesn't overshadow the benefit.

If health care can follow the models that have allowed the marketplace to thrive for generations, then it's time to realize that reducing costs is inevitable. But what demonstrates value are your actions, your desire to seek out quality partners, the benefit you can provide to your payers' networks, your quantifiable efforts to improve the performance of your specialty across all components of the care continuum, and the role you take to be recognized as a leader in creating improved outcomes for suppliers and consumers alike.

Payers and employers have never been more willing to recognize beneficial change in health care delivery. Emphasis is slowly shifting from treatment to prevention and from a reactive to proactive practice of medicine. Providers are also now leveraging technology widely used in other industries, and they're embracing incentive programs to support value-based partnerships that provide efficient, accountable care at a more affordable cost.

In addition, new initiatives promote information sharing and interactive provider collaboration in an effort to improve patient care and quality outcomes. And while the current outcome-reporting measures and payer-developed protocols are being developed by the larger stakeholders in health care, the best ideas for change are coming from the providers that work with patients every day.

For some, all this activity to redefine the delivery of healthcare remains something that needs to be part of a long-term strategy. But if you look around and tally the high-priority agendas evident within the industry, you'll note that the payers are defining their focus on incentives now. Physician groups are looking to expand their networks and influence, and health systems are actively addressing access concerns with strategic outreach programs to improve their community brand by aligning themselves with physicians through service-line marketing, clinical connectivity, and targeted acquisition opportunities.

Health care reform is a long process. But the best way to remain in front of large employer economic demands, payer strategies, and health system branding at the local level is to join the conversation now, while it's still in its formative stages. Doing so creates huge opportunities for the best-run medical practices to demonstrate their value. And those that can do so at a cost that doesn't overshadow the benefit will be the ones who prosper in the future.

Here are a few ways to create your brand:

- Identify ways to provide quality services with high patient satisfaction.
- Make suggestions for health systems to save money.
- Enter into meaningful dialogue with payers to gather current data about your care.
- Streamline practice expenditures.
- Consider strategic alliance opportunities:
  - With same-specialty groups (to gain operational efficiencies)
  - With complimentary specialties (to create centers of excellence)
  - With hospitals (to create measurable opportunities for high-value care)

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ARNP Regulations

In contrast to physicians and physician assistants subject to MQAC's regulations, ARNPs performing the same procedures are not subject to specific regulations regarding the administration of Botox. NCQAC has declined to create and adopt rules and regulations governing an ARNP's performance and delegation of nonsurgical cosmetic procedures.[8]

ARNPs are authorized to "perform specialized and advanced levels of nursing as recognized jointly by the medical and nursing professions,"[9] and may "perform procedures or provide care services that are within the scope of practice according to the [NCQAC] approved certification program."[10] Although the administration of Botox can fall within the scope of practice for ARNPs, these practitioners are left with less explicit care requirements regarding performance and delegation. ARNPs are guided by the general principle that an "ARNP functions within his or her scope of practice according to the [NCQAC] approved certification program and standards of care developed by professional organizations."[11]

Conclusion

Although the nonsurgical cosmetic procedure itself does not vary, the rules and regulations regarding its performance are vastly different depending on the practitioner involved. Whereas physicians and physician assistants are highly regulated, an ARNP's performance is guided only by more general standard-of-care principles. To ensure legal compliance in the performance of any nonsurgical cosmetic procedure, practitioners need to be aware of their specific licensure requirements. It will be interesting to see whether, as time passes, the MQAC regulations became the standard of practice for all practitioners engaged in the administration of nonsurgical cosmetic procedures.

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Miller Nash is a multispecialty law firm with 114 attorneys in offices in Seattle and Vancouver, Washington, and Portland and central Oregon. To learn more about Miller Nash, visit www.millernash.com. To read about new or proposed healthcare legal developments, visit our blog at www.healthlawinsights.com.

Notes:

[1]American Society for Aesthetic Plastic Surgery, 2011 Statistics on Cosmetic Surgery.

[2]*Id.*

[3]Concise Explanatory Statement for WAC 246-919-606 and WAC 246-918-126, Nonsurgical Medical Cosmetic Procedures.

[4]*Id.*

[5]*Id.*

[6]Regulations pertaining to physicians' duties in the administration and delegation of nonsurgical cosmetic procedures are found at WAC 246-919-606.

[7]Regulations pertaining to physician assistants' duties in the administration of nonsurgical cosmetic procedures are found at WAC 246-919-126.

[8]NCQAC has, however, released a position statement regarding the administration of Botox by RNs and LPNs. The position statement makes it clear that the administration of Botox is within the scope of practice for RNs and LPNs so long as certain guidelines are met. WAC 246-246-919-606 makes clear that a physician may delegate the procedure to either a RN or an LPN; however, the position statement points out that the administration of Botox does not authorized to diagnose or prescribe.

[9]RCW 18.79.250.

[10]WAC 246-840-300(6)(h).

[11]WAC 246-840-300(4).

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- With payers (to recognize and act on value-based opportunities)

Albert Einstein is widely credited with saying, "Not everything that counts can be counted, and not everything that can be counted counts." Let's work together to do what counts.

Irv Barnett has more than 25 years of experience helping physicians build successful practice performance through business development, strategic planning, and effective governance. He leads process implementation efforts to measure, monitor, and manage net income objectives to meet the unique needs of each practice. He can be reached at (916) 503-8112 or irv.barnett@mossadams.com.

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Career Opportunities

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Email: **rvadset@nwhsea.org**
Fax: (206) 368-6101
Phone: (206) 368-6116

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