Washington Healthcare News

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New Washington State Law to Create Challenges for HR Executives

By Melanie K. Curtice
Partner
Stoel Rives LLP

Most employer-sponsored group health plans offer coverage for employees, their spouses and dependent children. Coverage for dependent children is usually only offered to unmarried dependent children, up to age 19, or to age 23 if they are full-time students at accredited educational institutions.

On January 1, 2009, Washington State will extend this age to 25 for children eligible to receive dependent coverage under insured group medical insurance contracts, including those issued by Washington disability insurers, health care services contractors, health maintenance organizations (HMOs) (collectively "Carriers"), and under Washington State Health Care Authority plans. This increase in the limiting age for unmarried children is due to a Bill adopted during the 2007 legislative session. The change in the limiting age does not appear to apply to stand-alone insured group dental or vision contracts. It doesn't apply to private employers sponsoring self-funded medical plans.

If an employer offers fully-insured group medical or HMO benefits to its employees, the employer, by agreeing to purchase an insurance policy issued by a carrier licensed and regulated by Washington state, has essentially agreed to subject itself to the State's insurance law mandates, such as this new law. An employer cannot escape the issues created by the new law, by, for example, narrowing the definition of dependent to provide that only full-time students between the ages of 19 and 25 are eligible for medical insurance coverage. The new law, therefore, creates issues for many Washington employers, including those related to the cost of medical insurance coverage. First, it appears to allow for a different contribution arrangement for children over age 23. Second, it creates tax issues because some of the children eligible for this extended coverage do not qualify as "dependents" of the employee under the Internal Revenue Code (the "Code").

This article explores these issues and describes the reasons employers and employees must address the law's consequences.

Contribution Issues

Although this new law extends the age from 23 to 25, it does not appear to require employers to pay for the cost of coverage for these older children. Because the law, as applied to Carriers, is silent on this point, the cost may likely be passed along to the employee. This is a welcome feature of the new law, because prior law, either as interpreted or as mandated, generally required a uniform contribution strategy for all

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LETTERS TO THE EDITOR

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

Letter from the Publisher and Editor

Dear Reader,

Now that the Washington Healthcare News has successfully increased its distribution to 5,900 by expanding into Oregon, Idaho, Montana and Alaska, we are focused on finalizing our 2008 articles and developing 2009 editorial content.

In September 2008 we will be publishing a new monthly section called "Healthcare Facilities". Roberta Greenwood, an award winning writer, will author these articles. Each month we will feature a facility that has been recently constructed or significantly improved. If you would like us to write about your new or recently improved facility then contact me at dpeel@wahcnews.com.

We wanted to augment our coverage on health care finance issues and will have regular articles from Moss Adams LLP, Financial Consultants of Alaska & Washington, and Prime Advisors, Inc. We will continue to pursue firms that have the resources and experience to provide these articles and hope to bring at least one more firm into the fold in 2009. These articles will appear in the "Healthcare Finance" section.

One of the fastest growing sectors of health care is senior living. We have several hundred executives in this sector on our distribution and will reach out to them for future articles. Our best articles are authored by experts in their fields and we look forward to hearing from these health care leaders in the future. We will also devote one of our 2009 editorial themes to the senior living industry.

We are always trying to improve the content of our publication and welcome any ideas you have to help us do this. Until next month.

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
November 2008	Insurance Brokers and Agents	October 6, 2008	October 24, 2008
December 2008	Urban Hospitals	November 3, 2008	November 21, 2008

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Bill Naubert and Mark Naubert, Owners
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dependents up to age 23. Under the new law, it seems as though employers can require their employees to pay for the full (or greater) cost of coverage for unmarried dependent children between the ages of 23 and 25; they do not have to extend any existing premium subsidy they have for younger children to these older dependent children. Although this is good news for employers, a bifurcated cost-sharing structure can create administrative complications, such as adding new payroll codes for processing purposes and revising medical coverage election forms and other employee communications.

Tax Issues

By way of background, employer contributions for employer-provided medical coverage are generally not includable in the gross income of the employee. In addition, employer-provided coverage for an employee's spouse and dependents is also excludable from the employee's income. On the other hand, employer-provided medical insurance coverage for children who are not the employee's "dependents" under the Code is a taxable benefit to the employee.

For tax years after 2005, status of a child as an employee's dependent for purposes of employer-provided medical insurance coverage is determined under Code sections 105(b), 106 and 152, pursuant to Internal Revenue Service Notice 2004-79. A child between the ages of 23 and 25 qualifies as a dependent under the Code for medical insurance coverage purposes if one of the two following tests are met: (1) the employee can claim as an exemption on his or her federal income tax return for the child for the year; or (2) the child (a) receives more than one-half of his or her support from the taxpayer (employee) for

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the year, and (b) is a citizen or resident of the United States, Canada or Mexico (with certain exceptions for adopted children). If the child does not qualify as a dependent under one of these two tests, the employee must include in gross income the fair market value of the medical coverage provided by the employer (the full premium amount for the coverage) less the amount paid after-tax by the employee for that coverage. Please note that there is an additional method, called the "qualifying child" test, under which children under the age of 19, or between the ages of 19 and 23 if they are full-time students, or disabled children of any age may qualify as an employee's dependent for medical insurance coverage and other federal income tax purposes.

Thus, even though the new law provides older children access to medical insurance coverage, employers and employees need to understand the tax implications relating to the cost of the coverage. Employers can provide medical insurance coverage for employees' children on a tax-favored basis only if the children qualify as the employees' dependents under the Code, as described above. If the children do not qualify, the employee must be taxed on the cost, or the value, of the medical insurance coverage provided to such children, minus any after-tax contributions made by the employee for the coverage.

Example: Employee A elects coverage for his or her Child B, who is age 24. Child B does not meet either of the two tests described above to qualify as Employee A's dependent for medical insurance coverage purposes under the Code. The cost of dependent coverage for Employer C's medical insurance plan is $300 per month per dependent. Employer C contributes $200 per month toward the cost of coverage. Employee A pays for the remaining cost of coverage, which is $100.

"Thus, even though the new law provides older children coverage, employers need to understand the tax implications relating to the cost of the coverage."

Melanie K. Curtice
Partner
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In this example, Employer C must impute $200 per month to Employee A's taxable income (and withhold federal income and employment taxes from Employee A's salary relating to this imputed income). Employee A pays his or her share of the contribution, $100 per month, with after-tax dollars. In other words, the total annual cost, or value of coverage, is $3,600: Employee A pays for $1,200 of the cost with after-tax dollars and has $2,400 added to his or her taxable income for the year. However, the actual benefits paid under the medical insurance coverage are not taxable to Employee A or Child B.

It will be important for Washington employers to help employees determine if their older dependent children can receive medical insurance coverage on a tax-favored basis. Employers should ask employees to complete a form, separate from the insurance carrier's enrollment form, verifying that their older dependent children meet one or the other of the tests described above. Employers who receive certifications from their employees as to the tax-dependency of the employees' children are entitled to rely on these certifications for purposes of federal and income tax withholding.

Melanie Curtice leads the Employee Benefits section of the Stoel Rives Business Services group. She focuses her employee benefits practice primarily on health and welfare benefit plan matters and the tax, ERISA, HIPAA and other compliance issues that arise in connection with such arrangements. She can be reached a mkcurtice@stoel.com.

Ms. Curtice extends special thanks to Ms. Carol Wilmes of the Association of Washington Cities for her contribution to this article.

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Termination of the High Profile and/or Hostile Employee

By Bob Zech
Partner
Miller Nash LLP

Any employee termination can be a stressful and difficult event. Some terminations, however, are clearly more difficult to manage than others. When the individual being terminated is a high-level administrator or an individual who has been publicly critical of the institution, a new layer of issues and problems arises. If a terminated employee has expressed hostility, or perhaps even made threats of violence, additional concerns, and perhaps obligations, present themselves.

Preparation and planning are the keys to navigating these situations. This planning begins in the hiring process, continues as the possibility of such a termination emerges, and crystallizes when the necessity of the termination becomes evident. Rarely are these situations navigated perfectly, but without advance preparation, the likelihood of errors or other unfortunate results increases significantly.

Managing Risk at the Hiring Phase

Define the role and responsibilities of the employee. Many problems can be avoided when employees know exactly what is expected of them. Be clear about the essential functions of the job, but allow for necessary flexibility.

> ***"The best organizations recognize when termination is appropriate and ensure that employee separations are undertaken with due consideration and professionalism."***

Follow the proper hiring process. Avoid informal processes or shortcuts and spend the resources to hire the right person. Always follow appropriate candidate sourcing procedures, train interviewers to be thorough, and allow sufficient time for due diligence, including reference and background checks. Gather input from the key stakeholders.

Negotiate a detailed and fair employment agreement. Give special consideration to provisions establishing standards of conduct and performance, confidentiality and non-disparagement, dispute resolution, and separation terms.

Considering and Planning Termination

Carefully and candidly evaluate all reasons for the termination before taking action. Who is going to oppose the termination? What do the operative policies or agreements provide? How consistent is this course of action with past history? How will the terminated person respond? What does the employer not know?

Conduct a thorough investigation. Assign an appropriate fact-gatherer to assemble background documents and interview persons knowledgeable about the matter. Ensure that decision-makers keep an open mind and actually consider new issues and information arising from the investigation.

Take time for due diligence and deliberation. Will this decision be supported? Has the employee been given a fair opportunity to respond? Are there other alternatives to termination that should be explored? Has a communication plan been developed? What reports should be created? Should counsel be involved? Are there conversations or documents that should be protected by the attorney-client privilege? The best answers to these questions vary from case to case, so it is important

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Replacing the Irreplaceable: Executive Succession Planning

By Randy Ohlendorf
Human Capital Consultant
AON Consulting

Healthcare leaders have a disproportionate influence on their organizations – on the services offered, competitive positioning, and perhaps most importantly, on the people of the organization. So, they are not only important in and of themselves, but for the influence they have on the rest of the human capital in the enterprise. Considering the leadership shortage – one that is likely to grow with the impending retirement of baby boomers – people are being pushed into leadership positions for which they are not yet ready, and they are making mistakes because their experience has not prepared them to function at this level.

A Risky Business

Enterprise risk management is the proactive execution of a senior-management sponsored, entity-wide assessment and response to the collective risks that impact an organization's ability to maximize stakeholder value. While many acknowledge that developing a leadership pool is critical for business, few see the lack of leadership or lack of succession planning as a business risk. Our research suggests that the lack of strong leadership and succession planning can have a profound effect on the organization's performance.

"Succession planning assures near-term leadership continuity by thoughtful consideration of the availability, readiness, and development of internal talent to assume critical, priority leadership roles."

Succession Planning – Take a Look Inside

Succession planning ensures successors are qualified to assume higher level organizational roles as the needs arise. Succession planning assures near-term leadership continuity by thoughtful consideration of the availability, readiness, and development of internal talent to assume critical, priority leadership roles. There are some basic practices in succession planning that improve leadership "bench strength".

First, systematically assess leadership talent. Organizations that rely exclusively on their own internal talent reviews may not be doing a complete, holistic job of assessing leadership potential. Managers can benefit from supplemental assessment against the requirements of those more senior positions. People tend to evaluate their employees against the requirements of their current challenges and responsibilities rather than the potential to assume leadership roles.

Next, address the gaps through systematic development – create a disciplined approach to nurturing talent up and down the leadership pipeline, including, but not limited to: High impact on-the-job activities linked to accelerated development (stretch assignments), and targeted development programs including business simulations that allow participants to experience the consequences of their decisions.

Then, manage the pipeline and process: recognizing that there is a pipeline – as one moves from level to level, there are new skills, new ways to budget time, and new values that are required to perform effectively at the next level that are not part of the current level of experience.

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Recruiting – Take a Look Outside

The majority of current corporate recruiting models are reactive in nature – an important position opens, either through attrition or new business need, and then HR reaches into the labor market to advertise the opening or call an executive search firm. In order to strategically handle the talent crunch, organizations need to shift from a reactive recruitment model to a proactive external talent pooling model.

The Corporate Executive Board research confirms that corporate recruiters typically tap into only 50 percent of the potential labor market by not having the capacity to continuously reach out to passive candidates and develop meaningful relationships.

Executive Onboarding Coaching – Insuring the Hiring Investment

Whether your future leadership

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to reflect on the potential implications of particular circumstances rather than to follow a rote process.

Prepare a carefully crafted notice of termination. Within the notice of termination, recite the applicable policies and procedures, provide appropriate background facts and the actual reasons for termination, but state them broadly enough that additional details may be added in the future, and describe your efforts to make the situation successful. Ensure that the tone of the notice is businesslike and suitable for possible public disclosure.

Deliver the message with sensitivity. Consider the timing and setting, and who will attend the termination. Determine what needs to be done to maximize safety, security, and confidentiality, which may include witnesses, security personnel, retrieving keys, or shutting down computer access.

Develop a communication plan. Decide on your message and identify a contact person. If publicity is likely, consider consulting with public-relations professionals about how best to proactively manage inquiries from the media.

The Aftermath

Learn your lesson. One of the most important issues following an employee termination is to ensure that the organization learns from the experience. Terminations can expose gaps in employment policies, blind spots in hiring practices, and deficiencies in performance management.

Protect your reputation. If discussion about the event must be held internally or in public, choose a designated speaker with recognized integrity and a clear, confident message. Any severance or separation agreements with a departing employee should include commitments not to disparage the organization and to keep the terms of departure confidential.

Avoid protracted litigation. A colleague once described litigation as "a money-burning firestorm." Because lawsuits are typically a disaster for all parties, they should be managed like a disaster. Select the best possible counsel, and manage them. Seek insurance coverage. Keep the key stakeholders fully engaged. Develop and pursue a strategy for early, cost-effective dispute resolution.

Exercise caution, not paralysis. Retaining poor performers and employees who commit serious misconduct does more damage to organizations than the effects of mishandled terminations. The best organizations recognize when termination is appropriate and ensure that employee separations are undertaken with due consideration and professionalism.

Bob Zech is an employment and health care attorney and partner of Miller Nash LLP, a multispecialty law firm with offices in Seattle and Vancouver, Washington, and Portland, Prineville, and Bend, Oregon. Mr. Zech can be reached at (206) 622-8484 or at robert.zech@millernash.com.

9 Tips for Developing Extraordinary Managers

By Betty Noyes
President
Noyes & Associates, Ltd.

Organizations question: "How do I develop Extraordinary Managers?"

This article offers 9 tips for you when addressing tactical skills training for first line managers.

Organizations take high performing staff level employees and promote them into management with the expectation that they will transform miraculously into extraordinary managers capable of leadership and mastery of management skills. The expectations are that they will walk on water. This is unrealistic. Exceptional staff are not miraculously Extraordinary Managers when their title changes.

Here are the 9 Tips when considering a Management Education Program to build managerial competency.

1. Expect the Unexpected. Do assessments in the areas of Self Confidence, Knowledge and Job satisfaction. Develop three surveys: to measure present levels of self confidence in performing individual tasks, knowledge base required by those tasks and job satisfaction including intention to stay in your employment. These same surveys should be done at the end of any educational endeavor to measure the impact of the training. Assuring anonymity is critical! Managers will not risk their jobs by sharing their lack of self-confidence.

"The expectations are that they will walk on water. This is unrealistic. Exceptional staff are not miraculously Extraordinary Managers when their title changes."

2. Get Clear with Yourself. Clarify the difference between Orientation, Skills Based Management Education programs and a theoretical Academic pursuit. The goals of Management Education are to build a management team who can effectively address the implementation of strategic goals, objectives and tactics with a minimum of oversight. Management Education is aimed at providing engaged and competent managers capable of doing their jobs.

Orientations provide overviews and do not address the basic tactical skills of "how do I do" this task.

Management Education is teaching a skill set. It is technical skills training taught by credible, non-threatening faculty.

Management Education is not an academic theoretical curriculum that does not relate to the immediate daily activities.

3. Plan Curriculum with Intention. Adult Learners want to learn skills that they can immediately apply. Your curriculum should address the skills of the trade related directly to the job description. It needs to address the specifics for each responsibility. Classes should be provided in dedicated time away from the department. Learning requires concentration, practice and safe dialogue with trusted faculty who do not have hierarchical positions within the organization or who may have the power to influence others on participant performance reviews.

4. Identify a Mentor for each Participant. Train them in mentoring skills. A trusted internal mentor who knows the organization and who can help the manager break down barriers, guide practice, and provide new experiences within the organization is essential to

skills application.

Mentors need to be:

- Good listeners; not the Command and Control authority figures.
- Have had a positive mentoring experiences in their own career.
- Be willing to commit the time and energy.

5. Customize the Text. Content should use the exact forms, policies, procedures that are used in your organization. Do not use text book versions. Use your working documents, keeping in mind that the goal is for the novice manager to be able to skillfully use the tools and resources tomorrow on their job.

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9 Tips for Developing Extraordinary Managers

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6. Mix up the Learning Venues & Participants. Form a cohort of approximately 35 managers representing all departments.

Venues: Classroom sessions should be intensive all day sessions with action activities to afford networking with classmates and significant skill practice.

Online learning activities should support class work between class sessions.

A participants schedule in each month should include work in both venues and a mentor meeting.

7. Give up the hope for a Quick Fix. Provide a program that spans time. For a program to have "sticking-power" it needs to be spaced over time. We recommend that a management education program span approximately eight months. Management Education is changing behaviors, establishing new roles and identities for those you are entrusting your mission and margin to. This is not a "flavor of the month" and is not a quick fix.

8. Learning Project. A self selected and approved project gives an opportunity for each participant to make a difference and provide you an ROI. The mentor serves as guiding coach. Culminate the program with a "graduation" at which time each participant presents their project to the Executive Team thereby offering an additional skill of public speaking and creating Powerpoint slides.

9. Be Happy. You will be thrilled with the results you achieve when you are able to retain and recruit managers in your organization and see the measurable effect on staff retention, financial performance and job satisfaction. The ripple effect to staff and in patient care will be palpable.

Developing a team of extraordinary managers does take time and money. Your ROI will be bigger and better then you imagine. We have seen it in over 1000 participants.

Betty Noyes is the President of Noyes & Associates, Ltd. an Illinois corporation. They specialize in Management Education Courses for first line managers. Betty can be reached at noyes@noyesconsult.com.

Replacing the Irreplaceable: Executive Succession Planning

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talent is nurtured from within or recruited from the outside, there are still many risks to mitigate once the leader is in the new position. There is a fifty percent probability that a new executive will quit or be fired within the first three years. Forty percent fail within the first eighteen months, taking with them an investment of many thousands of dollars. In addition, the cost of replacing a newly recruited employee could be anywhere from 1.5 times to 20 times that position's salary. So there is real risk to be managed.

There are many "derailers" common to new leaders, including: lack of understanding and alignment regarding performance expectations; hiring manager's lack of full accountability for successfully onboarding the new leader; lack of resources to help the new leader navigate trough the organization.

To effectively address these derailers, coaching for executive onboarding must take an approach that is very different from traditional coaching. In an effective coaching relationship, an external coach is assigned to help the executive address defined skill areas targeted for improvement, and over the course of several months, the coach works one-on-one with the leader to increase effectiveness.

Protect the Risk

Given the imminent leadership shortage and the influence leaders have on business outcomes and organizational effectiveness, now is the time to review succession plans, consider all available talent, and nurture the guardians of your organization's lifeblood.

Randy Ohlendorf serves as Business Development and Growth leader for Aon's Human Capital Practice in the Pacific Northwest Region. He can be reached at randall_ohlendorf@aon.com.

An Interview with Kristen Fox, SPHR, President-Elect of the Washington State Healthcare Human Resources Association

Kristen Fox, SPHR is President-Elect of the Washington State Healthcare Human Resources Association. She is also Human Resources Director of Kadlec Medical Center. This interview was held in Richland, Washington.

Editor: What is your background and how did you become the President-Elect of the Washington State Healthcare Human Resources Association (WSHHRA)?

Fox: I graduated from the University of Washington with an undergraduate degree in Political Science. I was planning to go to law school when a neighbor suggested I take an entry level job in human resources at a Bellevue company. I found my passion for human resources in that job and knew that would be where I would spend my career.

I moved to Wisconsin and took my first health care industry human resources position in the late nineties. From there I took a position with a large regional health care organization in Colorado. I was in charge of human resources for ten facilities and I provided consulting services for their thirty state area. It was in this job I got a really good feel for how complex health care can be; the recruiting component, the labor component, and the shortages that were starting to exist. I took a couple of years off to get my MBA and afterwards returned to Washington State where I took a human resources position out of health care. I missed health care though and when this opportunity at Kadlec opened up I took it.

I was promoted from a Manager to a Director and received my SPHR or Senior Professional in Human Resources Certificate here as well.

I was elected to the President-Elect position of WSHHRA late last year.

"In health care, our Mission walks down the hall every day."

Kristen Fox, SPHR

Editor: What is the Vision and Mission of WSHHRA?

Fox: WSHHRA's Vision is to establish itself as a leader in the health care industry, such that human resource professionals consider membership and participation essential to their professional success.

WSHHRA's Mission is that we are determined that services to its membership will set the standard for excellence for other professional organizations. Its conference and other offerings will be seen as the best of their kind, providing participants with cutting-edge information that will establish them as centers of influence in their organizations and in the industry at large.

Editor: How many people belong to WSHHRA?

Fox: We currently have over 190 members.

Editor: What types of organizations and people are WSHHRA members?

Fox: Members are primarily people that serve in personnel, labor relations or human resources functions at health care facilities. Our members work at hospitals, medical clinics, health care consulting organizations, recruiting organizations and many other types of health care organizations.

Editor: What are the benefits of WSHHRA membership?

Fox: The networking opportuni-

ties are substantial.

For example, Kadlec Medical Center has been transforming from a community medical center into a regional hospital system for the past several years. With the opening of our new medical tower, we are expecting to generate 400 new jobs over the next five years. Through my WSHHRA membership, I will be able to call on the experience of people in human resources that have gone through this kind of significant growth.

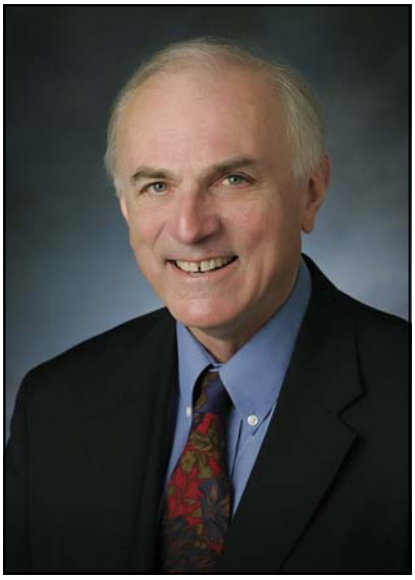
Our two conferences each year provide great educational opportunities for our membership. Our speakers are always noted authorities that present interesting and timely topics. For example, our Spring 2008 Conference featured a presentation by Mark Busto, a Partner with Sebris Busto and James that covered the important legal developments in the areas of employment and labor laws. This included state and federal court decisions and legislation as well as case studies. These conferences provide additional networking opportunities in an informal and comfortable environment.

Editor: How much does it cost and how would someone join WSHHRA?

Fox: The cost depends on when someone joins. It's not more than $90 annually for one person in an organization. The second person would be $60 annually and if three or more join it's $175 for the entire organization. Details on joining can be found on the

Fixing Health Care: The Oregon Health Fund Board at Work

By Jonathan Ater
Chairman & Senior Partner
Ater Wynne LLP
Vice Chair
Oregon Health Fund Board



Oregonians have the opportunity to create a health care system that is the equal of any in the world, in terms of both cost and quality

That's the challenge facing the Oregon Health Fund Board. The Board, created by the 2007 Legislature, has a broad charter: to create affordable health care for all Oregonians.

America's health care system is broken for at least two key reasons: First, the way in which we deliver health care is fragmented, inefficient, expensive, error-prone, and fails to achieve quality outcomes for many individuals and for our population. Second, the way we pay for health care is byzantine, inequitable, expensive, and provides incentives for bad decisions by both patients and providers.

Moreover, we are not training a workforce to continue the present business model even if it were working well. We have no meaningful plans to provide life-enhancing care to our increasingly aging population in ways which will help them stay healthy and out of the high-cost medical intervention system.

Our broken health care system is not primarily a financing problem. The problem is not simply Medicare and Medicaid or the uninsured. Health care doesn't work for America – all of us. Our health care system is broken as an industrial model. We have to find collaborative ways to fix it. Fixing it is critical to the overall economic health of our society.

It is not enough to simply call for universal or affordable health care. We have to talk about what needs to happen if we are to create a truly effective, high quality, affordable health care system in the United States.

In my view, to fix American health care, we have to deal with five problems simultaneously:

First, we need a new vision of

Please see> Fixing, P22

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<Fixing

From page 20

health care. We need to tap the creative and entrepreneurial energies of Americans to create a better way of keeping ourselves healthy.

Health care is not about selling pills and procedures. It is not about short encounters with people in white coats when we are sick. It is not about hospital care and miracle drugs.

Health care is about individuals getting well and staying well.

We know from innovators in this country and more importantly, from many other countries that there are ways to provide health care services that keep people healthy, care for the sick sensibly, and spend money wisely. Doing things differently should mean doing things better — and also less expensively.

Second, we have to get a financing system that allows everyone to get the health care they need when they need it. We can and must control health care costs by reinventing what we do. But, we also must protect individuals and society from the costs of serious medical care by sharing that cost over the entire population.

Nationally, more than 46 million Americans have no health insurance, not even Medicaid. But, that is not the worst of it!

The rest of us are *under*insured: deductibles and co-pays are too expensive for many individuals, especially those with "high-deductible" plans. Lifetime caps - typically less than $2 million - are far less than the costs of treating many catastrophic and chronic conditions. And, sick people lose their jobs and employer insurance. In 2003 and 2004, more than 50% of all personal bankruptcies in the US were driven by too little or loss of medical insurance.

We must find a new financing model which does not expose people to financial ruin — or even skipping lunch — when they get sick or injured.

Third, to have a sensible, effective, and affordable health care system, we must integrate financing and care for mental and physical illnesses, and we must expand our vision of care to include support such as housing and food for those who need it.

Health care must be provided by a team of people with a variety of skills, sharing a commitment to each patient as a whole person. We must pay for these services, recognizing that they have value to us as a society and because they save money compared to what we do today.

Fourth, technology can be used to reduce costs and improve outcomes, not as a profit center for health care providers. We need to pay for outcomes, not units of service. In other sectors of the economy, improved technology typically improves quality and lowers costs. We have to change our thinking about technology in health care.

Fifth, as individuals and as a society, we need to commit to making our lives healthier in every sense of that word. In many ways, this is the most difficult challenge. No system, doctor, or government agency can mandate that we change our individual or collective lifestyles. But, a remodeled health care system – centered on individual patients and their needs – can help us address these societal issues.

Changing health care in America – or even in Oregon - is a big order, but it is not an impossible task. If we view fixing health care as a shared responsibility, we can create a new, robust, affordable, accessible health care system. But, we have to envision transformational change. Each step we take has to move toward a dramatically new health care system. We don't have a lot of time to fool around. That's why the work of the Oregon Health Fund Board is so exciting.

Jonathan Ater is the chairman and senior partner of Ater Wynne LLP, a West Coast law firm with offices in Seattle, Portland, Menlo Park and Salt Lake City. He is a graduate of Yale College and Yale Law School. He is one of seven members and a vice chair of the Oregon Health Fund Board. Ater Wynne provides legal services to health care professionals and organizations. The views expressed are Mr. Ater's personal views, not necessarily those of his clients, the firm or fellow Board members.

Opinions expressed by Mr. Ater are not necessarily the opinions of the Washington Healthcare News.

New or Recently Promoted Health Care Leaders

Last Name	Middle Name	First Name	Title	Effective Date	Organization	New or Promoted Leader
Anderson		Ginger	Assistant Director, Sales Operations	04/08	Regence BlueShield	Promoted
Anderton		C. Ned	Account Executive	06/08	Conover Insurance, Employee Benefits Division	New
Andrist MBA		Laurinda	Director of Operations	04/08	Oregon Imaging Centers	New
Beers		Ken	President	07/08	South Sound Association of Health Underwriters[1]	New
Brown RN		Laurie	Vice President & Chief Nursing Officer	06/08	Franciscan Health System	Promoted
Burg		John	Territory Sales Manager for WA, ID, AK, MT	06/08	Imedica Corporation	New
Busby		Jeanette	President	07/08	Northwest Association of Health Underwriters[1]	New
Bush		Peter	VP of Physician Services	06/08	Southwest Physician Services	New
Chapman		Katerie	Vice President	06/08	Virginia Mason Medical Center	Promoted
Charlton		Geoff	Chief Operations Officer	05/08	Clarus Eye Centre	New
Cheh		Frank	Director, Healthcare Initiatives	06/07	ProModel Corporation	New
Chilson		Sheila	Chief Executive Officer	06/08	Moses Lake Community Health Center	Promoted
Davis		James	Chair, Department of Family Medicine	11/08	UW School of Medicine	New
Eland		Jennifer	Provider Outreach Manager	06/08	Southwest Physician Services	New
Field		Dulcye	Director of Quality	06/08	Columbia Basin Health Association	Promoted
Fletcher		Alan	Executive Director	06/08	Skyline at First Hill	New
Fuhrman	M.	Shannon	Individual and Medicare Sales	04/08	Regence BlueShield	Promoted
Gill		Pam	Executive Director	06/08	Evergreen Neuroscience Institute	New
Goldsmith		James	SVP, Senior Client Manager	06/08	Bank of America	Promoted
Grindeland		Sherry	Media and Communications Coordinator	06/08	Evergreen Healthcare	New
Hamilton		Nancy	Manager, Employment	07/08	Evergreen Healthcare	New
Hamming		Cindy	Director of MSO & SBH	03/08	United General Hospital	Promoted
Holland		Robert	President Elect	07/08	WA State Association of Health Underwriters[1]	New
Jackson DMD MS PhD		Douglass	Chief of Center for Diversity & Health Equity	07/08	Children's Hospital & Regional Medical Center	New
Johnson		Todd	VP of Facilities	06/08	Children's Hospital & Regional Medical Center	New
Lotsko		Joe	Dir. of Critical Care and Emergency Services	06/08	Highline Medical Center	Promoted
Martin, Esq.		Deborah	Assistant Administrator/Human Resources	05/08	Skagit Valley Hospital	New
Martin		Tom	Senior VP of Strategic and Support Services	06/08	Evergreen Healthcare	Promoted
McCliment		Sean	Performance Report Analyst	05/08	Performance Report Analyst	Promoted
McHugh		Mary	VP of Admin. Operations & Ext. Relationships	09/08	Northwest Kidney Centers	New
McKay		Lisa	President	07/08	Central WA Association of Health Underwriters[1]	New
McWilliams		Mary	Executive Director	06/08	Puget Sound Health Alliance	New
Ogden		Jermaine	Senior Consultant	07/08	Moss Adams LLP	New
Onstad		Karen	Director of Health Information	06/08	Puget Sound Health Alliance	New
Peet		Carole	Chief Operating Officer	06/08	St. Anthony Hospital	New
Pierce		Al	President	07/08	Spokane Association of Health Underwriters[1]	New
Pineda		Al	Account Executive	05/08	Conover Insurance, Employee Benefits Division	New

[1]This is an Association Board position. This individual is actually employed by a separate organization.

New or Recently Promoted Health Care Leaders

Last Name	Middle Name	First Name	Title	Effective Date	Organization	New or Promoted Leader
Pricco		Shelly	Director, Patient Care Services	06/08	Enumclaw Regional Hospital	Promoted
Ray		Jerilyn	Human Resources Manager	06/08	Enumclaw Regional Hospital	Promoted
Sebo		Erin	Manager New Sales & Renewals	04/08	Regence BlueShield	Promoted
Sheehan		Patti	VP of Human Resources	06/08	Evergreen Healthcare	New
Simon		Donna	Treasurer/Secretary	07/08	WA State Association of Health Underwriters[1]	New
Smith RT MBA		Mark	Director of Operation and Org. Integrity	01/08	Oregon Imaging Centers	Promoted
Stenberg		Megan	Human Resources Manager	07/08	The Everett Clinic	New
Teng		Bing	VP/General Manager	07/08	Practice Partner, McKesson	Promoted
Thomas RN		Vanessa	Administrator	12/07	Cascade Park Gardens	Promoted
Thompson		Laron	President	07/08	Tri-County Association of Health Underwriters[1]	New
Thompson		Nancy	President	07/08	WA State Association of Health Underwriters[1]	New
Ury MD		Andy	Chief Medical Officer	07/08	Physician Practice Solutions, McKesson	Promoted
Vincent		Suzann	Director, Sales and Service Large Accounts	06/08	Regence BlueShield	New
Wessells		Hunter	Chair, Department of Urology	07/08	UW School of Medicine	Promoted
Wright MBA CMPE		Julie	Chief Executive Officer	07/08	Southlake Clinic	New
Wright		Tony	VP of Human Resources	06/08	Virginia Mason Medical Center	New

[1]This is an Association Board position. This individual is actually employed by a separate organization.

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Career Opportunities

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- An article by award winning writer Roberta Greenwood on the new Swedish Orthopedic Institute facility
- Our regular sections on Healthcare Law, Administration and Finance

Career Opportunities

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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 03-31-08	Net Income Qtr End 03-31-08	Statutory Capital As of 03-31-08	Enrollment As of 03-31-08
Regence BCBS of Oregon	Oregon	$664,297,147	$12,497,497	$548,550,374	1,011,613
Premera Blue Cross	Washington	$640,285,347	$17,391,917	$775,781,448	711,199
Group Health Cooperative	Washington	$587,664,637	$28,109,047	$726,108,841	397,763
Kaiser Foundation HP of the NW	Oregon	$582,850,617	$6,287,125	$499,062,450	471,903
Regence BlueShield	Washington	$568,759,264	$285,070	$888,050,920	822,735
Providence Health Plan	Oregon	$215,001,106	$2,891,546	$338,309,273	183,527
Molina Healthcare of Washington	Washington	$175,044,293	$8,318,143	$121,745,281	289,207
Blue Cross Blue Shield of Montana	Montana	$130,291,715	$1,111,145	$144,612,952	229,725
Community Health Plan of WA	Washington	$129,151,418	$1,422,070	$78,834,043	227,328
Regence BlueShield of Idaho	Idaho	$124,914,311	$931,619	$124,629,528	210,793
Pacificsource Health Plans	Oregon	$121,126,455	$785,151	$112,095,216	See note [1]
PacifiCare of Washington, Inc.	Washington	$117,194,761	$15,965,846	$244,986,575	45,835
Health Net Health Plan of Oregon	Oregon	$104,431,497	$1,575,659	$68,320,647	125,597
LifeWise Health Plan of Oregon	Oregon	$74,446,969	($2,740,257)	$67,511,870	105,236
Blue Cross of Idaho Health Service	Idaho	See note [1]	See note [1]	See note [1]	See note [1]

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

Hospital Name	State	Total Charges CY 12-31-07	Total Margin CY 12-31-07	Total Discharges CY 12-31-07	Total Days CY 12-31-07
Swedish Medical Center-Seattle	Washington	$2,023,262,137	$101,027,578	34,208	143,492
Providence St. Vincent Medical Ctr.	Oregon	$1,190,848,000	$132,075,000	32,539	144,060
Sacred Heart Medical Ctr.-Spokane	Washington	$1,320,906,441	$69,153,314	29,503	149,640
OHSU Hospital	Oregon	$1,439,008,183	$39,511,642	27,744	144,235
Sacred Heart Medical Ctr.-Eugene	Oregon	$753,619,352	$51,346,157	26,036	114,067
Providence Everett Medical Center	Washington	$1,178,904,174	$30,321,510	24,674	100,545
Providence Portland Medical Center	Oregon	$919,017,000	$61,591,000	22,594	101,599
St. Joseph Medical Center—Tacoma	Washington	$1,438,379,738	$73,744,228	21,802	92,323
Southwest Washington Medical Ctr.	Washington	$974,184,166	$30,890,264	20,886	85,285
Salem Hospital	Oregon	$661,611,020	$19,685,011	20,492	91,132
University of Washington Med Ctr.	Washington	$948,997,861	$31,441,957	19,775	97,450
Legacy Emanuel Hosp. & Health Ctr.	Oregon	$889,675,890	$23,459,988	18,708	107,362
Harborview Medical Center	Washington	$1,156,062,000	$18,045,000	18,662	135,303
Providence St. Peter Hospital	Washington	$898,500,849	$24,444,980	18,162	83,281
Virginia Mason Medical Center	Washington	$1,149,485,689	$18,452,019	17,383	86,009

[1]Source: National Association of Insurance Commissioners. Blank cells indicate information wasn't available from the National Association of Insurance Commissions at press time. [2]Sources: Washington State Department of Health, Oregon Health Policy & Research.

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