New BCBSND Contracts — What Does It Mean?

Annual Meeting Highlights

2009 Session Update

North Dakota Medical News
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Physicians...heal thy health care system!

Did you know health care spending in 2008 was estimated at 2.4 trillion dollars? That amount of money calculates to $7,900 spent for every single person that year in the United States. Alone, that much money would comprise the sixth largest economy in the world; bigger than the gross domestic product of the United Kingdom, France, or Italy!

Knowing that, the obvious question should be, “What do we get for that money?” Surely you would expect with this much spending we would have the best care in the world. I regret to say that at the present time we are losing ground on most of the generally accepted indicators for overall population health: infant mortality, ischemic heart disease mortality, life expectancy after age 65, etc. We are not investing enough in prevention or chronic disease management, which leads to the highest legacy costs to the health care system. What we are increasingly spending it on are the expensive things like new technology, intensive end of life care, and pharmaceuticals. Unfortunately, this isn’t improving the overall health of the majority of the people.

If you start to look at the geography of spending, outcomes, and mortality across the United States, you will soon see a pattern. That pattern shows us that where there are more specialists per capita, there is more spending. This is not a big surprise, but what is a surprise to many is that there is a pattern of significantly higher severity adjusted mortality compared to areas with a higher proportion of primary care physicians! Furthermore, the Congressional Budget Office has estimated that the United States spends more than $700 billion per year on health care that does not improve outcomes. Economists would call this waste, though this “waste” is often defended by organized medicine as a reaction to external variables such as consumer demand, defensive medicine, and so forth. There is likely truth in some of those claims; however, we are still responsible for delivering the right kind of care to our patients. In the end, isn’t that what we are all about?

This conversation is not meant to denigrate specialists or to imply that physicians are consciously doing anything wrong. It is the system and the processes that are leading to these outcomes that need to be addressed. This so called system, or lack thereof, is what needs serious reforming.

North Dakota is a state, among several others, that defies this gravity. North Dakota has superb quality outcomes, accompanied by a relatively low cost. If you accept that value = quality/cost, then it is logical to state that North Dakota delivers high value care. I believe this is due to the way we are generally structured, in that we have integrated delivery networks of coordinated care with a strong primary care base. North Dakotans tend to be humble. But, at the risk of having hubris, I believe we can show other parts of the country how to do better. Unfortunately, we fulfill the notion that “no good deed goes unpunished.” We are at the bottom for reimbursement nationally.

I believe the key reason the United States got off track was by discouraging the growth of primary care. The incentives for physicians, and the burden put on our primary care colleagues, is driving many of them to further limit their practices or quit altogether. Not only is the present supply of primary care physicians dwindling, but the pipeline is drying up as well. Data set after data set continues to confirm that fewer medical students are interested in becoming primary care physicians. This “perfect storm” of a decreasing supply in the face of increasing demand for primary care access couldn’t come at a worse time.

The motto of the modern physician is “First, do no harm.” As physicians, we are responsible for the majority of the care delivered in this country. How can we stand by knowing the aforementioned facts and not lead? We know a stable network of primary care doctors saves lives and costs less. We cannot ignore these facts, nor can we expect policy makers, or the public, to respect our constant drumbeat that in the end it is all about the patient. We need to lead and be part of the solution that stresses social responsibility. These commitments to society must include a willingness to look at the global health of our citizens by supporting vaccination, preventive care, willingly covering emergencies in our local hospitals, and allowing the changes to occur that lead to better care. In short, we must be willing to listen, change, and innovate.

Organized medicine has always supported the patient-physician relationship, which I believe to be sacred. However, we cannot continue to defend a system that is not leading to the best outcomes. Our patients and the public expect nothing less of us.

We have watched our economy slip and it is a very scary time. Health care is not immune from any of this, and for us to expect that things can be managed by using the same old tactics and strategies is frankly not rational. I believe physicians are in the unique position to innovate and start to change the way we deliver care. Those solutions must be physician led, or someone will foist changes upon us, which might not be solutions at all.

Remember, during these turbulent times, no institution or system is too big to fail. That includes our health care system.
The 2009 ND Legislative Assembly as this edition of Checkup goes to print is moving toward the crossover point of surviving bills moving to the second chamber. NDMA focuses on bills that impact the practice of medicine, urging legislators to cast their votes in favor of sound health care policy.

The Legislative Assembly will have to complete its work by April 29, which would be Day 80 – the most number of days allowed under the state constitution for a regular session.

A special thanks to all physicians who provided coverage to the NDMA Doctor of the Day program at the capitol. The program is popular with legislators, providing needed consultation and services and giving the visiting physician an interesting legislative experience.

The NDMA legislative agenda was adopted by NDMA members, participating as delegates from their District Medical Society to the NDMA House of Delegates, at the 2008 NDMA annual meeting in Grand Forks. The NDMA Commission on Legislation, chaired by Dale Klein, MD, recommended policy priorities and worked with members of the NDMA Council to refine the agenda prior to the session and take positions on other bills as they were introduced.

NDMA priorities include rebasing Medicaid physician payments to cost, imposing fair contract standards on commercial health insurance companies, supporting initiatives that strengthen the UND School of Medicine & Health Sciences as well as our residency programs, protecting our medical liability reforms including the current cap on non-economic damages, addressing minor consent issues with prenatal and other pregnancy-related care, opposing inappropriate expansions of allied professional scope of practice including psychologist prescribing, protecting and improving the physician practice environment, improving the health of the public, and much more.

The NDMA website at www.ndmed.org provides legislative news, hearing schedules and bill summaries, all linked to the Legislative Assembly bill status system. NDMA also provides policy updates throughout the year by e-mail through the e-Checkup. Please call the NDMA office or drop us an e-mail at staff@ndmed.com if you would like to receive the e-Checkup.

Medicaid Rebase Tops 2009 Issues

On January 26, NDMA President Robert Thompson testified before the Human Resources Division of the House Appropriation Committee on the need for an equitable rebase of physician Medicaid payments. Last session, NDMA and NDHA shepherded legislation through that appropriated dollars for the Department of Human Services to hire consultants to develop methodologies for determining what it would take for Medicaid to rebase physician, hospital, and other traditional Medicaid providers to cost. The consultant, The Public Consulting Group, concluded that physicians currently are receiving only 51% of what it costs to provide medical care to Medicaid patients.

Dr. Thompson testified that Medicaid patients receive care from a North Dakota health care system that is rec-
ognized nationally as a high-quality, efficient health care system. However, we have unique healthcare workforce recruitment and retention challenges occurring in our state that are driven by our demographics, payor reimbursement policies and other practice issues. Our capital needs continue to grow, with aging facilities, technology and equipment – we have the oldest age of plant in the country. Our costs for medical equipment, new technology and supplies continue to increase.

Dr. Thompson testified that one of our challenges is that, across the board, we are a “poor payor state.” The commercial market through BlueCross BlueShield of North Dakota pays for medical and hospital services at levels considerably less in North Dakota than by commercial insurers in other states in our region. In Medicare, there is substantial geographic disparity in patient services and physician reimbursement levels which is having an increasingly negative impact on patient care and access in North Dakota.

Said Thompson in written testimony, “As physicians, we are very concerned that this continuing trend of poor payment does not bode well for the future of health care in North Dakota, and in time the access and quality in health care enjoyed in the state will deteriorate rapidly as health care resources become increasingly scarce and health care workforce and capital needs are not met. We are working on all these avenues that provide resources to sustain our health care system. We suggest that the Medicaid program must do its part to ensure fair payment for the actual cost of medical care received by its Medicaid patients, just as commercial insurers and the federal government must do their part.”

A rebase at 100% of what the consultant said it would take to bring physician payments to actual cost would cost an additional $14,699,550 in general funds for the biennium, in addition to the $4,899,850 already budgeted. At this level, physician payments would rebase from 51% to about 100% of cost.

Our ask: The North Dakota Medical Association supports the Governor’s budget and the proposed increase that brings payment for physician services closer to cost (64% of cost). However, to rebase at less than cost only continues a pattern of inequitable payment that will continue to hinder our ability to maintain a health care system in our state that provides higher quality at less cost than most other states in the country. Said Thompson, “We encourage you to consider further investments that would better reflect the intent to rebase to cost, and a legislative commitment to ensuring future access to care for Medicaid patients.”

The bill, HB No. 1012, the appropriations bill for the Department of Human Services, would appropriate $4,899,850 in state general funds ($13,250,000 in total state and federal funds) to rebase Medicaid physician payments closer to actual cost. Physicians would receive a 20.66% increase in the first year of the 2009-11 biennium (% change from the 2007-09 appropriation). The bill would also appropriate $8,140,450 in general funds ($22,013,114 in total state and federal funds) to rebase Medicaid hospital payments to 100% of actual cost.
Hospitals would receive a 14.05% increase in the first year. Both physician and hospital payments would be increased by 7% in the second year of the 2009-11 biennium.

As the Checkup went to print, the Human Resources Division voted on Feb. 10 to reduce the physician rebase to 20% of what it would take for a 100% rebase, and to reduce the hospital rebase from 100% to 90% of cost. With a new budget forecast and pending federal stimulus package, these amendments are only the first challenge in a lengthy process that will include deliberation in the full House Appropriations Committee, the Senate, and in the conference committee in April.

Health Groups Oppose Effort to Repeal Damage Cap

A bill was introduced that would repeal the current $500,000 cap on noneconomic damages in medical liability actions. NDMA aggressively opposed the legislation, HB 1390, and has garnered support from state specialty societies, hospitals, and long-term care organizations, and from the business community through the ND Chamber of Commerce.

A body of economic research links tort reforms, such as caps on noneconomic damages, to slower growth in indemnity payments and premiums. The North Dakota law, on the books since 1995, applies to all physicians and other health professionals, hospitals, clinics and long-term care facilities. North Dakota’s current, relatively stable medical liability insurance market would be put at grave risk by HB 1390, impacting insurance premium rates and our ability to recruit and retain physicians and other health care professionals, and taking more resources from patient care.

On another medical liability issue, Representative Larry Klemin introduced HB 1302 on behalf of NDMA, which would amend section 28-01-46 (which requires the plaintiff to serve the defendant an affidavit containing an expert opinion within three months of commencing a medical liability action) to address the result of an opinion by the North Dakota Supreme Court in Scheer v. Altru that resulted in an indefinite time or filing a motion for serving the affidavit at a later time. The bill would require that the motion for extension be made with the three-month period after commencing a medical liability action. The bill passed the House and will now be heard in the Senate.

Fair Insurance Carrier Contracts Sought

SB 2397 as introduced by Senator Jerry Klein on behalf of NDMA, would establish fair contracting standards for health insurer contracts with physicians, hospitals and other providers and authorize those standards to be enforced through the Insurance Commissioner or by private cause of action. The bill would grant the Commissioner authority to approve contracts used by insurers and also impose restrictions on profiling activities. This issue is review by NDMA General Counsel Dean Haas on page 12.

Psychologists Seek Legislative Approval to Prescribe Psychotropics

The ND Psychiatric Society, NDMA, and the ND Board of Medical Examiners oppose HB 1488, which would allow a “medical psychologist” to prescribe medications “customarily used in the diagnosis, treatment, and management of an individual with a psychiatric, a mental, a cognitive, a nervous, an emotional, or a behavioral disorder.” Psychologist prescribing bills have been defeated in twenty states over the past years on the conclusion that psychologists – who are not medically trained and who are not physicians – are not qualified to prescribe psychotropic medications. The bill was defeated.

Ophthalmologists Work for Bottle Rocket Ban, NDMA Supports Tobacco and Other Public Health Initiatives

NDMA and other physician organizations are involved in supporting numerous public health initiatives consistent with the NDMA mission to improve the health of the pub-
lic, in addition to monitoring issues associated with the Health Department budget.

The ND Society of Eye Physicians and Surgeons along with NDMA have again raised the issue of the toll taken each year by bottle rocket injuries. SB 2366 introduced by Sen. Dave Oelke would prohibit the sale and distribution of small bottle rockets, which are inherently dangerous and erratic. The Senate passed the legislation.

NDMA also supports SB 2063 which would implement Measure 3 approved by ND voters this past November, establishing a comprehensive tobacco prevention and control program for the state. Recently, Dale Klein, MD, of Mandan was appointed by Governor John Hoeven to serve on the comprehensive tobacco control advisory committee established by the initiated measure. NDMA also supports HB 1213 which would expand the state’s smoke-free workplace law to bars and motels and hotels.

Third Time a Charm? Minor Consent Again Considered

SB 2394 as introduced for the third time by Senator Karen Krebsbach on behalf of NDMA, would allow a physician to rely on the consent of a minor for pregnancy testing, prenatal care and pain management related to pregnancy. This issue has been controversial in the past, particularly in the House where concerns over maintaining parental control have trumped legitimate concerns over the welfare of the pregnant minor and her unborn child. The Senate passed versions of the bill in both 2005 and 2007.

Drs. Shari Orsen and Jerry Obritsch testified in support of the bill. SB 2394 is about fulfilling a physician’s ethical obligation by creating an appropriate legal environment for providing access by a pregnant minor to prenatal care and other pregnancy care that ensures the best possible outcome for her unborn child, when that pregnant minor is not yet ready to involve her parents.

Medical School Bills Address Performance Audit; Executive Budget Excludes Some Initiatives

SB 2003 is the appropriation bill for the North Dakota University System which includes funding for the UND School of Medicine & Health Sciences. The bill includes a base level general fund appropriation of $34,027,701 with enhancements of $5,905,174 for a total general fund appropriation of $39,932,875 for the 2009-11 biennium. The bill also includes one-time funding projects that include an electronic medical records system for UNDSMHS ($225,000). There are several additional budget requests approved by the State Board of Higher Education that were not included in the Governor’s budget, including:
• College affordability funding to limit tuition increases ($767,427).
• Funding for planning, land acquisition, and construction of a new facility for the Bismarck Center for Family Medicine (over $5 million).
• Funding to retire the bond debt of the Minot Center for Family Medicine ($4 million).
• Establishment of an enhanced geriatrics training and care delivery program ($1,074,450).
• Establishment of an MPH degree program ($1,133,600), and development of a comprehensive health care delivery plan for ND ($707,850).

In addition, three bills were introduced by the State Board of Higher Education as a result of action by the Medical Center Advisory Council in response to the UNDSMHS performance audit. NDMA supports all three bills.

First, SB 2079 would revise the statutory purpose of the UND School of Medicine & Health Sciences and also change statutory references to the UND “State Medical Center” to the “UND School of Medicine & Health Sciences.” As amended in the Senate, the new statutory purpose would state: “The primary purpose of the UNDSMHS is to educate physicians and other health professionals and to enhance the quality of life in North Dakota. Other purposes include the discovery of knowledge that benefits the people of this state and enhances the quality of their lives.”

The second bill, SB 2081, would revise the name and duties of the State Medical Center Advisory Council, changing the name to the UND School of Medicine & Health Sciences Advisory Council. The bill would require the Advisory Council, in consultation with the medical school and other entities represented on the Council, to study and make recommendations regarding UNDSMHS strategic plans, programs and facilities. The Advisory Council would be required to submit a biennial report to the entities represented on the Council and the ND Legislative Council, including recommendations for implementing strategies for addressing the health care needs of the people of the state and information regarding the state’s health care workforce needs.

Finally, SB 2077 would revise the current UNDSMHS student loan fund as recommended in the UNDSMHS performance audit. The bill would create a revolving loan fund and increase the amount of an allowable loan from $6,000 to $10,000, as well as make other technical changes in the loan fund statutes.

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After Voters Pass Initiated Measure, Legislators Greeted with Dozens of Workers Compensation Bills

The Industry, Business & Labor committees of both chambers are busy with workers compensation bills addressing structural reform and performance, benefits, and WSI presumptions and procedures. NDMA supports HB 1561 which would require WSI to give controlling weight to the injured employee’s treating doctor’s opinion, if the doctor’s opinion on the issues of the nature and severity of the injured employee’s medical condition is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the injured employee’s record. NDMA is closely monitoring all WSI bills, and weighing in as appropriate on several bills on behalf of physician interests.

And More ….

There were 1084 bills and resolutions introduced in this session, with over 100 bills monitored or actively worked on by NDMA. Bills include changes to the state’s coroner laws, health information technology initiatives, health insurance coverage mandates and exclusions, pharmacy ownership issues, creation of a health care directive registry, regulation of Internet pharmacies, changes to the state’s peer review law, mental health issues, and more.

One bill opposed by NDMA and defeated in the House would have required physicians applying or renewing their medical license to complete a geriatrics course.

Check the next issue of Checkup after the session, with a run down on how it all turns out.
When a child is critically ill or injured, they need immediate help. That help is available twenty-four hours a day, seven days a week. A single call can link you to our in-house, board certified pediatric intensivists and a full range of pediatric and surgical subspecialists, all supported by state-of-the-art technology and diagnostic equipment. For physician-to-physician consults, referrals or admissions, there’s one place to call: one number. Anytime.

www.ChildrensOmaha.org
In addition to adopting a preliminary legislative agenda for the 2009 ND Legislative Assembly, the 2008 NDMA annual meeting included speakers focused on the topic of physician leadership and recognition of Dr. Bernie Hoggarth as the recipient of the 2008 Physician Community and Professional Services Award. The Alerus Center provided an excellent environment for our annual meeting.

The program included a somewhat rancorous exchange between Insurance Commissioner candidates Jasper Schneider and Adam Hamm, featuring several unannounced yet spirited guests from the insurance industry and good discussion regarding the process and issues surrounding the dispute between the Insurance Department and BlueCross BlueShield of North Dakota over proposed premium increases and the ability of the carrier to unilaterally impose payment withholds or payment adjustments.

As for the “business of medicine,” the House led by NDMA Speaker of the House Steven Strinden, MD, accepted several officer reports that included support for Measure #3, the initiated measure for a CDC-based tobacco prevention and cessation program which later passed by the Voters. The following resolutions were adopted by the House:

**Resolution #1** (Ninth District Medical Society). A resolution urging NDMA to investigate methods to retain and improve satisfaction among physicians working in rural settings, and to seek assistance as necessary from the UND Center for Rural Health and other organizations

**Resolution #2** (Commission on Socio Economics) Support for Medicare Payment Reforms A resolution expressing appreciation to the North Dakota Congressional Delegation for their support of a temporary Medicare physician payment fix and to urge continued work on Medicare payment reform that permanently addresses both the Sustainable Growth Rate (SGR) and unfair disparities in payment caused by geographic practice cost indices (GPCIs) and the hospital wage index.

**Resolution #3** (Commission on Socio Economics) Support Efforts to Correct Deficiencies in the Medicare Physician Practice Expense GPCI A resolution supporting the effort of the Geographic Equity in Medicare (GEM) Coalition to correct deficiencies in the Medicare physician practice expense geographic practice cost index (GPCI).

**Resolution #4** (Commission on Socio Economics) Support Rebase of Medicaid Physician Payments to Actual Cost A resolution urging the Governor and the 2009 North Dakota Legislative Assembly to support steps to rebase Medicaid physician payments to actual cost based on the findings and conclusions of the state's consultant.

**Resolution #5** (Commission on Medical Education) Study and Develop ND Physician Workforce Report A resolution supporting continued study and development of a report on North Dakota’s physician workforce and urging policymakers to consider any resulting recommendations.

**Resolution #6** (Commission on Socio Economics) Encourage Improvement in WSI Physician Fee Schedule and WSI Relationship with Physicians A resolution urging Workforce Safety & Insurance to continue work on improving the physician reimbursement system by developing a more appropriate rebase of the reimbursement system comparable to the commercial market in the region, and on improving the WSI relationship with the North Dakota Medical Association and physicians.
Resolution #7 (NDMA Council)  
Commercial Health Insurer Premium Rates and Contracts  
A resolution urging commercial health insurers and the North Dakota Commissioner of Insurance, in review of premium rates for health insurance policies, to more formally consider appropriate statewide standards for physician and hospital payments consistent with regional commercial market, and for the Commissioner of Insurance to consider standards for commercial insurer contracts with physicians and hospitals that facilitate a fair implementation of insurer policy changes.

Resolution #8 (Dale Klein, MD and James Brosseau, MD on behalf of ND Academy of Family Physicians and North Dakota Chapter of the American College of Physicians)  
Medical Home Concept A resolution urging NDMA to support the concept of a patient-centered medical home as a means to improve the quality of care and reduce health care costs; and to continue to study the various medical home proposals and take appropriate advocacy action that best serves the interests of North Dakota physicians and patients.

SAVE THE DATE!  
The 2009 NDMA Annual Meeting will be held in Bismarck on Thursday-Friday, September 24-25.

Dr. Hoggarth Recognized for Community and Professional Service

The North Dakota Medical Association presented its 2008 Physician Community and Professional Services Award to long-time Grand Forks pediatrician Bernard J. Hoggarth, MD. The award recognizes outstanding Association members who serve as role models, active in both their profession and in their community.

Dr. Hoggarth was nominated for the award by the Third District Medical Society, and presented the award by NDMA President Robert Thompson. In nominating “Bernie,” the Third District said:

“Bernie is a tireless worker who never shirks his responsibility. Quite to the contrary, he goes far above and beyond the norm in advocating for children and for all who are disadvantaged and who might fall through the cracks of our medical system. He stays current in his field and is always up to standard in his practice. He is a loyal colleague and a friend to all.

“Dr. Hoggarth is a practitioner, a researcher, an advocate for those who have no voice, a teacher, and a community leader. He exemplifies all that is right and admirable about being a doctor and is an inspiration for all who know him. Given all these attributes and accomplishments, we of the 3rd District Medical Society feel there could be no one more worthy of the Community and Professional Services Award than Dr. Bernard Hoggarth.”
Recently, Insurance Commissioner Adam Hamm announced that he had entered into an agreement with BlueCross BlueShield of North Dakota for changes in BCBSND contracts with physicians, hospitals and other health professionals and institutions. Since 2000, NDMA has focused on concerns over BCBSND contracts as merely an annual “unilateral announcement of terms.” This take-it or leave-it approach to contracting and total reliance on BCBSND to do the right thing on reimbursement has resulted in reimbursements today that are substantially less than what commercial carriers pay in neighboring states. Much has been said about the delay resulting from BCBSND’s premium rate filings that were denied, in part, for consideration of BCBSND contracts that allow the carrier to unilaterally impose a withhold of payments or reduce payments. This article explains why the agreement between Commissioner Hamm and BCBSND is important to physicians and hospitals, and why additional legislation was introduced in SB 2397 to expand on that agreement.

The Problem

In past years, a number of states have developed some type of “fair contracting” laws that afford physicians protection in the contract negotiation or modification process. This is because states recognize that most physicians face a true David and Goliath battle when negotiating with health insurers. Health insurance markets continue to consolidate—nationally, domination of a health insurance market is measured by 30% market share—and in North Dakota, this situation is taken to the extreme: BCBSND is able to exercise monopsony power with about 90% of the commercial health insurance business, and unilaterally set contract terms.

This problem is not of recent origin; NDMA has been concerned about these adhesion contracts since 2000. While a number of factors contribute to the payment problems faced by physicians, the root of the problem lies in the provider contract. Artfully drafted, these contracts put physicians at the mercy of the insurer; in North Dakota, physician contracts have historically allowed BCBSND to unilaterally change reimbursement and other terms.

Physicians often fail to seek redress because of the lack of a clear legal remedy.

While ostensibly physicians have the right to agree only to the contract terms and reimbursement levels that benefit them, this is not the case where monopsony power prevails, which lowers the price paid for physician service below the price that would prevail in a competitive market. BCBSND often claims that it is subject to “cost-shifting,”
but in reality BCBSND is a poor payor relative to the region, but is simply not as poor a payor as are Medicaid, Medicare, and other ND payors.

Monopsony power can also lead to unfair contracting practices, which include a number of payment reduction strategies, ranging from relatively straightforward methods such as contractually-based discounts to complex strategies including bundling/editing and “rental” of lower rates to other organizations. For example, just last spring BCBSND attempted to take advantage of its adhesion contracts, announcing an across-the-board “withhold.” Your NDMA had engaged in a multi-step strategy along with the ND Healthcare Association to induce nothing more than a fair contract, drawing the attention of the Insurance Department, engaging the agency in extensive discussions regarding the language in the new BCBSND contracts.

The Commissioner’s Intervention

Engaging the Insurance Commissioner in the issue has had good results. In July 2008, the Insurance Commissioner disapproved BCBSND’s 14.8% premium rate request submitted on May 6, 2008, for individual policies, largely because the contracts allowed it to unilaterally reduce payments to health care providers. This pressure eventually resulted in new provider contracts for physicians and hospitals, incorporating some significant fair contracting principles. Insurance Commissioner Hamm announced his satisfaction, “I am pleased that BlueCross BlueShield has agreed to give up its ability to unilaterally change payments.” According to Hamm, the “new contract will bring a significant change to the way BlueCross BlueShield of North Dakota does business with health care providers and institutions, and ensures the company will have to keep its promises.” Hamm simultaneously assured North Dakota citizens that they “can be assured that BlueCross BlueShield is in good financial shape.”

Specifically, the contracts garnered by the Commissioner require BCBSND to reimburse the provider for covered services according to the payment schedule, which must be set forth in a Reimbursement Notice that fully identifies the BCBSND payment scheme and, with limited exceptions, can only be changed once each year. Thus, the contracts protect against future unilateral withholds to the reimbursement system. Each provider contract must include:

- The specific manner of compensation and payment.
- The fee schedule for physician services, and inpatient and outpatient services, and the methodology used to calculate any fee schedule, such as coding practice or relative value unit system and conversion factor, percentage of Medicare payment system, or percentage of billed charges.
- The methodology disclosure must include, as applicable, the name of any coding practices, relative value system, its version, edition, or publication date, and any applicable conversion or geographic factor.
- Disclosure regarding the effects of edits, adjustments and fee schedule amendments, if any, on payment or compensation.

You can review the new physician and institutional contracts on the NDMA and BCBSND websites.
The Fair Contracting Legislation

While the new contracts assist us, the medical community response must continue on multiple tracks. In an effort to ensure that fair contracting principles exist over the long term, NDMA requested introduction of fair contracting legislation in SB 2397. In addition, in the past few years unfair payment practices have been addressed in several high profile physician class action lawsuits against many of the nation’s major managed care organizations. We are monitoring such litigation, as BCBSND is a party to a national class action lawsuit that is currently being negotiated (Love v. Blue Cross and Blue Shield Association, et al).

Because contracting is governed by state law, it is critical to secure greater legislative protections for physicians in the contracting process. It is really no more than common sense that contracts result from an offer and acceptance—a negotiation—not as it is currently, where physicians are presented with take-it-or-leave it contracts.

The fair contracting legislation in SB 2397 is specifically tailored to address the issues faced by North Dakota physicians. In sum, the legislation requires entities that contract with health care providers to abide by fair contracting provisions, and invalidates provisions that conflict. The bill would:

- Provide that all contracts entered into after January 1, 2010, must comply with fair contracting provisions enacted by the legislature, and invalidates provisions that conflict.
- Require the Insurance Commissioner to review and approve the contracts to ensure conformity and fairness, and to enforce all fair contracting laws through fine and injunction.
- Consistent with the recently negotiated BCBSND contracts, require disclosure of the terms governing payment; fee schedules, and the methodology used to calculate it; and the effects of edits on reimbursement (i.e., payment for some but not all codes; payment of a different code; or a reduced payment).
- Require that the provider be given an opportunity to terminate the contract before a material change becomes effective, that a health insurer provide written reasons before terminating a contract, and require use of a peer review mechanism to resolve such issues.
- Require that credentialing information be requested in a uniform format, with a decision within 45 days of the completed application.
- Preclude a health insurer from retroactively denying reimbursement after 6 months, except if justified in writing, and if it results from the common coordination of benefits, the name and address of the entity acknowledging responsibility must be provided.
- Prohibit “any products” clauses that require providers participating in one product to participate in others.
- Preclude carriers from giving access to the provider’s discounted rates to another entity (a/k/a a “rental clause”), absent the provider’s express consent.
- Create a private cause of action for providers to remedy violations of any fair contracting standard. Creating a legal cause of action for providers to remedy violations is crucial, because it is the only mechanism likely to reduce the incidence of unwarranted denials of coverage.
- Prohibit health insurers from publishing profile rankings based solely on costs, and provides a peer-review mechanism to resolve practitioner complaints.

BCBSND and the insurance industry vigorously opposed SB 2397 in a hearing on February 10, before the Senate Industry, Business, and Labor Committee. While the bill, coming close on the heels of Commissioner Hamm’s efforts, was deemed unnecessary at this time by legislators, the areas identified in the bill are areas of needed improvement in the future.

NDMA is seeking significant amendments to a bill introduced on behalf of BCBSND, SB 2274, which would require providers to exhaust “all internal appeal processes” prior to accessing the never-used independent external review mechanism enacted in 2005. The first amendment would specify that the exhaustion requirement must be the internal utilization review process detailed by N.D.C.C. § 26.1-26.4-04. The second, most significantly, would amend the bill by shifting the costs of the independent external review from the non-prevailing party to the health insurer. Taken together, the amendments could compel carriers to provide a true review process, and fewer denials.

NDMA is pleased with the progress made by the Insurance Commissioner with the new provider contracts. Good public policies and principles support ways to standardize contract terms, require adequate disclosure, and prohibit certain unfair contracting practices.
What's Fair?

Since BlueCross BlueShield of North Dakota sought to unilaterally withhold physician and hospital payments in May 2008, Insurance Commissioner Adam Hamm has worked to make BCBSND contracts with physicians and institutions fairer, without the ability of the carrier to withhold or reduce payments previously promised. In January, Commissioner Hamm announced an agreement with BCBSND on language discussed with NDMA and the ND Healthcare Association.

In this edition of Checkup, NDMA's new general counsel Dean Haas describes the importance of this effort, and why physicians should be concerned that they, and the facilities where they treat patients, have fair contracts with insurance companies. In addition to Commissioner Hamm’s efforts, NDMA introduced fair contracting legislation in SB 2397. NDMA first raised the notion of fair contracts over a decade ago. While legislators decided the bill was unnecessary on the heels of Commissioner Hamm’s effort, the bill highlights other areas for contract improvement.

Even before the Blues unilaterally imposed the 2.5% payment withhold plan last spring, NDMA had objected to events that led us to this current predicament, including the substantial premium rebate that was granted in 2006. Even before all the controversy over rate filings, rebates and take-it-or-leave-it contracts, BCBSND has consistently used its monopsony power to lower the price paid for health care in our state to a price below the price that would prevail in a competitive market, as borne out in a recent study.

Last fall, the six major health systems in North Dakota, NDMA and BCBSND contracted with the consulting firm Milliman to prepare a report comparing health insurance premiums and provider reimbursement levels in North Dakota against other nearby states. Milliman was tasked with a comparison against other states in CMS’ West North Central Region (Iowa, Kansas, Minnesota, Missouri, Montana, Nebraska and South Dakota). In general, Milliman found that North Dakota has lower premiums, provider costs and provider reimbursement levels than the benchmark comparison states.

The BCBSND average premium of $332 compares to the other states’ average of $399, or a BCBSND premium that is only 83% of the premium in other states in our region. The BCBSND Private Payer Hospital Reimbursement per RVU (geographically adjusted) is $66 compared to the rest of the region’s average of $96, or only 69% of that compared to other states in the region. The Private Payer Physician Reimbursement as a percentage of Medicare (geographically adjusted) is 152% of Medicare compared to the rest of the region’s average of 164%, or 93% of that compared to the rest of the region. Hospital costs are 91% of that compared to the rest of the region; however, hospital margins are considerably less at 1.8% compared to 6.9% in the rest of the region.

If you would like a copy of the full Milliman study, please contact the NDMA office.

Health Initiatives Included in Stimulus

President Obama is expected to sign H.R. 1, the “American Recovery and Reinvestment Act of 2009,” into law. The House of Representatives passed the bill on February 13 by a vote of 246-183, with no Republican support; 7 Democrats voted against the bill. Later that evening, the Senate passed the bill 60-38, with 3 Republicans voting in support.

Provisions in the final bill pertaining to health information technology (HIT) mirror those passed earlier last week by the Senate, with a larger ($18,000) bonus in the first year for the earliest physician users of HIT. The maximum amount a physician can collect in HIT bonuses is $44,000 over a five-year period. Penalties for not adopting HIT begin in 2015 (for those who failed to report in 2014), with a -1% reduction in Medicare physician payments that phases to -3% in 2017 and beyond. The final comparative effectiveness research (CER) provisions include clarifying language intended to address concerns about the duties of the new Federal Coordinating Council for CER. This advisory council would be prohibited from mandating coverage, reimbursement, or other policies for any public or private payer.

Additionally, the bill provides states with increased Medicaid funding to address budget shortfalls, and expands

Continued...
At the Annual Conference this fall we discussed at length the financial condition of NDMGMA. Attendance at our Annual Conference was at its lowest level ever. Vendor support is intrinsically tied to the number of attendees at the conference. These two factors have left NDMGMA with a significant financial burden. Those attending the Annual Conference asked that every effort be made to keep the organization intact. You also asked that the current officers stay in place for another year. Fortunately, all of the officers agreed.

The following actions have been taken by the Board to improve our financial position.

1. We have negotiated with NDMA to allow us to carry over $7,500 of the 2008 payment due into 2009. We have also negotiated a reduced fee for 2009. The reduced fee is coupled with reduced services, so you will be asked to become more active in the planning and execution of the Annual Conference.
2. A Membership Committee has been formed and is actively working to recruit new members. You can help by referring colleagues to the NDMGMA for membership information.
3. Very soon a Vendor Relations Committee will be activated to improve vendor support at the Annual Conference.
4. We are working with members of the Midwest Section and national MGMA to help us address these issues as well.

If you are interested in becoming more involved in your professional organization, please contact one of the current officers or the NDMA. We are seeking interested members for the secretary/treasurer and vice president position. We are also seeking interested members for the Vendor Relations and Conference Committees.

Save the Date - Annual Conference in Bismarck September 24-25, 2009

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Earlier this month, President Obama signed legislation reauthorizing the State Children’s Health Insurance Program (SCHIP) and extending it to cover an additional four million children. The bill removes the five-year waiting period currently in place for legal immigrants. States are allowed to create a dental-only option for families who have private medical coverage. Additionally, the bill expands the federal matching rate to states up to 300 percent of the federal poverty level, with an option to go beyond that. The expansion will be financed through an additional federal tax on cigarettes.

COBRA eligibility and subsidization to address the health needs of unemployed individuals and their families. The bill also includes a long list of public health investments, including $1 billion for health and wellness promotion, $500 million to support the training of primary care providers, and $500 million to modernize Indian Health Service facilities.

The AMA supports the goal of enabling millions of Americans to maintain health insurance coverage during the economic crisis. The stimulus effort may take a significant step toward the development of a nationwide HIT infrastructure by establishing interoperability standards and providing significant financial resources to physicians who use HIT systems.
The AMA House of Delegates convened in Orlando, November 8-11. Alternate Delegate Robert Beattie, NDMA President Robert Thompson and NDMA Vice President Kimberly Krohn participated with me in policy deliberations of the House as well as in the work of our regional caucus, the North Central Medical Conference.

The AMA House of Delegates remembered the life of AMA Immediate Past President Ronald M. Davis, MD, who passed away shortly before the start of the meeting after a courageous nine-month fight against pancreatic cancer.

Physicians paid a final tribute to Dr. Davis, including a poignant video tribute that included images of Dr. Davis throughout his career, from his time as a medical student member of the AMA to his stirring speech in June during the Annual Meeting of the AMA House of Delegates. Later, AMA President Nancy H. Nielsen, MD, urged physicians to continue to stand together despite the increased challenges the medical profession will face in the upcoming months.

Growing cuts to Medicare physician payments, a worsening economy, the rising rate of job loss and 46 million uninsured Americans are a few reasons the stakes have risen. Another is cost—something Dr. Nielsen pointed to as the driving factor behind the national health care debate. “It is high time we do something about it,” Dr. Nielsen said of the nation’s broken health care system. That something is “fundamental change—for ourselves, for our patients, for our nation,” she said.

She challenged physicians to advocate for comparative effectiveness research, work within specialty societies and develop appropriate measures of care. Dr. Nielsen also pointed to returning to the core values and themes that brought physicians to medicine in the first place: serving humanity with humility, self-awareness and a commitment to excellence. “I believe that we can and should have the best health care system in the world,” Dr. Nielsen said. “I believe that we have the talent and dedication to build that health care system. I believe we have the courage to do it now.”

On the policy front, the House adopted policies in a number of areas, summarized below.

**Ethics and Behavior**

- The AMA adopted ethics policy that offers specific guidance pertaining to legally permissible contractual arrangements that provide opportunities for self-referral.
- The AMA resolved to work with the Joint Commission and other interested parties to develop a definition of disruptive behavior by a physician to include the actions that would rise to the level of true abusive behavior, and to include rules for an appeals process that comply with due process for physicians accused of disruptive behavior. The AMA also resolved to work to ensure that allegations of disruptive behavior by a physician will be handled by the organized medical staff through its established bylaws.
- The AMA adopted policy to help medical staffs and hospitals identify disruptive behavior and differentiate it from other types of conduct. In addition, the AMA will convey to the Joint Commission that a one-year moratorium on a new standard regarding disruptive behavior is necessary to provide a feasible time frame for medical staffs to bring their bylaws into compliance. The standard, scheduled to take effect Jan. 1, requires hospital administrators to define such disruptive behavior and develop procedures to discipline inappropriate conduct by individuals working at all levels of an organization.

**Legislation**

- The AMA resolved to support state and federal legisla-
tion that bans the use of artificial trans fats in restaurants and bakeries in the United States.

• The AMA voted to encourage physicians to educate their patients regarding the public health risks of text messaging while operating motor vehicles or machinery. The AMA will also advocate for state legislation prohibiting the use of hand held communication devices to text message while operating motor vehicles or machinery.

• The AMA resolved to continue to advocate for improvements in the Physician Quality Reporting Initiative (PQRI), including early education and outreach to physicians by CMS. The AMA also will advocate for the provision of confidential interim and final feedback reports from CMS to physicians on potential problems in their PQRI reporting, easier access to feedback reports, development of meaningful dispute resolution processes and the provision to the AMA of the 2007 PQRI data set file.

• The AMA voted to establish a strategic priority of requiring all children to have adequate health insurance.

Medical Services

• The AMA adopted a set of principles to guide in the creation of a centralized comparative effectiveness research (CER) entity. The principles state that a federally sponsored entity should be an objective, independent authority that produces valid, scientifically rigorous research; the entity should have secure and sufficient funding to maintain the necessary infrastructure and resources to produce quality CER; and that CER should be conducted using rigorous scientific methods to ensure that conclusions from such research are evidence-based and valid for the population studied. The principles also state that the processes for setting research priorities, establishing accepted methodologies, selecting researchers or research organizations, and disseminating findings must be transparent and provide a central and significant role for physicians and researchers.

• The AMA resolved to adopt the “Joint Principles of the Patient-Centered Medical Home” of the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association, and to continue to study the patient-centered medical home concept.

Public Health

• The AMA adopted recommendations from the Council on Science and Public Health to support responsible waste management policies, including the promotion of appropriate recycling and waste reduction; the use of ecologically sustainable products, foods and materials when possible; and the development of products that are non-toxic, sustainable and ecologically sound. The AMA also adopted recommendations to support building practices that help reduce resource utilization and contribute to a healthy environment, as well as communitywide adoption of “green” initiatives and activities by organizations, businesses, homes, schools, and government and health care entities.

• The AMA adopted policy recommending that medical schools consider in their planning elements of diversity—including gender, race, culture and economy—that reflect their patient population. The AMA will also support developing new programs and enhancing existing programs that will identify and prepare underrepresented students from the high school level onward and to enroll, retain and graduate increased numbers of underrepresented students.

• The AMA resolved to provide materials on vaccine safety and efficacy to states and to encourage them to enact more stringent requirements for parents and legal guardians to obtain personal belief exemptions from state immunization requirements. The AMA also resolved to develop educational materials that can be distributed to patients and their families clearly articulating the benefits of immunizations and highlighting the exemplary safety record of vaccines. The AMA also resolved to communicate and work with other concerned organizations about effective ways to continue to support immunizations while rejecting claims that have no foundation in science.

• After hearing mixed testimony on a pair of resolutions concerning marijuana medical use and research and marijuana reclassification, the AMA voted to refer both for further study. One resolution asked that the AMA support reclassification of marijuana’s status as a Schedule I controlled substance into a more appropriate schedule.

North Central Medical Conference in Minneapolis, March 7-8

Each year our North Central Medical Conference meets in Minneapolis for a continuing medical education program that features regional speakers on topics of interest to the caucus, as well as a presentation from AMA leadership and a business meeting. This year the Conference will hold its meeting March 7-8 at the Marriott Airport Hotel beginning on Saturday at 1:00 p.m. and concluding at noon on Sunday. Anyone interested may attend. Please let the NDMA office know if you are interested.
The year 2009 promises to be an interesting one with a new president in the White House and health care reform on the horizon. Staying informed on the issues is very important to all of us as members of the medical family.

The American Medical Association Alliance (AMAA) has several upcoming opportunities for you to become educated. The National Advocacy Conference (NAC) will take place in Washington DC March 9-11, 2009. For more information and to register for the conference go to www.amaalliance.org/site/epage/42060_625.htm. (Please note separate registration for Monday and Tuesday)

On February 13-15, 2009, the AMA’s Political Action Committee (AMPAC) will host the annual Candidate Workshop in Pentagon City, Virginia. AMPAC will conduct its annual Campaign School April 15-19, 2009, also in Pentagon City. For more information on these programs or an application, please contact Jim Wilson, Political Education Programs Manager, at 202-789-7465 or jim.wilson@ama-assn.org.

It is important that we stay informed on issues in our own North Dakota Legislature. Go to NDMA’s new website: www.ndmed.org. From the homepage of the NDMA website you can click on Latest Legislative News for the latest on health care bills including bill hearing schedules, access the status on health care bills organized by Bill Category, and access ND Legislative Assembly resources.

As this article goes to press, the North Dakota Legislature recently introduced a bill prohibiting discrimination based on sexual orientation (SB 2278). One of Fargo’s Alliance members, Maren Ortmeier, has written a heartfelt letter to the editor in support of this legislation which will likely appear in newspapers across North Dakota.

Domestic Partners as a national Alliance membership category will be re-introduced at the Alliance annual meeting in June. Several states and counties already have this category of membership. A little history – in 2006, the AMA Advisory Committee on Gay, Lesbian, Bisexual and Transgender (GLBT) Issues, asked the Alliance to consider membership for unmarried partners in committed relationships so that these physician couples could support the good work of the Alliance. The issue was first considered by the 2006-2007 Bylaws Committee and presented to the 2007 House of Delegates. A vote was not taken. Instead, the House referred it to the 2007-2008 Bylaws Committee and presented to the 2008 House of Delegates. A vote was not taken. Instead, the House referred it to the 2007-2008 Bylaws Committee so that “late changing” states would have an opportunity to discuss it with their state delegations. The issue was reintroduced at the 2008 House for a vote. The result was a simple majority (105-88) in favor of the resolution, but not the two-thirds majority required for a Bylaws amendment.

It is clear from the 2008 vote that a majority of Delegates want this change to happen. The AMA Alliance Board of Directors unanimously approved and supported the following resolution in August 2008:

Resolved that the Board of Directors vote their support for the Domestic Partner category of membership and bring this issue before the 2009 House of Delegates.

With this resolution, the Alliance Board considers it the right thing to do to recognize and welcome the currently diverse backgrounds, culture and construction of medical families in America today and supports both the Alliance mission and the American Medical Association’s mandate for non-discrimination in the medical community, both in practice and in life. All officers of the AMA and AMA Alliance are committed to having an open dialogue with members who have questions or concerns.

Please take the time to support non-discrimination in the state of North Dakota, and with the American Medical Association and Alliance.

Dinah Goldenberg
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Director, AMA Alliance
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Could You Benefit from a Cash Balance Retirement Plan?

Physicians and other highly compensated professionals are constantly on the lookout for effective ways to limit their current taxable income, reduce their current tax liability and better position their assets for retirement.* Yet, many such professionals rely entirely on a 401(k) defined contribution plan to help them meet these goals—a strategy that may fall far short of the intended mark.

The problem for physicians and other highly compensated professionals is that their income, and frequently the cost of their daily lifestyle, dwarfs the percentage of their compensation they are allowed to save in a 401(k); for 2009, the maximum employee contribution is limited to $16,500 for those under age 50 and $22,000 for those 50 and older. Yet, with annual paychecks that often range from $250,000 to well into the millions of dollars, many of these professionals would like a way to save 10, 15, even 20 percent of their income—a level that would allow them the opportunity to maintain their lifestyle during their golden years. Perhaps you are one of them.

For starters, you may want to consider adding a profit sharing component to your 401(k) plan. The profit sharing provision allows the employer (the physician or physician’s group) to make additional discretionary contributions to the 401(k)/profit sharing plan. The profit sharing contributions are calculated based on the age and salary of the employee. Generally, the physician/employer will receive the largest percentage of the profit sharing contribution because he or she has the highest income and is generally several years older than most of the employees. The combination of both the 401(k) salary deferral and profit sharing contributions cannot exceed an aggregate limit of $49,000 for those younger than 50, or $54,500 for those older than 50 (2009). This is a big improvement, but still may not accommodate those who are really interested in tax-deferred savings.

A physician’s practice generally becomes more efficient and profitable as he or she moves beyond age 50. This may afford the physician both the desire and the cash flow to contribute more than $54,500 per year to his or her retirement plan—much more in some cases. For those individuals, the addition of a cash balance defined benefit retirement plan may allow for significantly higher contributions.

Essentially, a cash balance defined benefit retirement plan has some features that resemble a defined contribution plan, or 401(k). It is often referred to as a “hybrid” of a traditional defined benefit plan and a defined contribution plan. Like a traditional defined benefit plan, cash balance plans pay a specified benefit amount at retirement. However, like a defined contribution plan, participants have individual (albeit hypothetical) accounts, allowing for easy tracking of accrued benefits.

The value of a cash balance defined benefit plan can grow in two ways. First, the account accrues employer contribution credits. Second, the account value can increase with an interest credit, which is guaranteed (and not dependent on the plan’s investment performance). Following is an overview of some of the key features of a cash balance plan.

**The saving potential is greater than with other plans:** Cash balance plans generally allow for larger contributions and tax deductions than 401(k) plans and other defined contribution plans. The larger deductions may provide significant tax benefits to the employer*—in this case, the physician or physician’s group—as contributions to a cash balance plan are not included in the employee’s current taxable income. Of course, when a participant begins to receive benefits from the plan, those benefits are taxable. But, beyond the issue of required minimum distributions, you control how much and how quickly you withdraw money from your account during retirement.

**Each participant has an individual (hypothetical) account.** Each participant’s account tracks his or her contribution credits and interest credits. Because it is a defined benefit plan, the interest credit is guaranteed to the participant and is not dependent on the plan’s investment performance. Participants in a cash balance plan have no say over the underlying investments selected. Plan assets are held in a pension trust that the employer establishes, contributes to, and uses to pay benefits when participants retire or terminate their employment.

**Contributions are paid by the employer:** The hypothetical account is funded by employer contributions, which are determined by the benefit formula in the plan document. The contribution is typically a percentage of the participant’s salary. It tends to favor more highly compensated employees. Generally, $245,000 (2009) is the maximum amount of salary that can be considered in the calculations.
• **Benefits may be portable:** Many such plans allow an employee who is leaving the organization to take his or her benefits with them—as a lump sum or a rollover into an IRA. This feature is similar to other more familiar retirement plans. Meanwhile, for those considering actual retirement, cash balance plans typically offer the choice of an annuity benefit or a lump sum benefit.

• **A word to the wise:** Cash balance plans obligate the employer to make annual contributions to the plan. So, your practice should have predictable cash flows that will enable you to fund the plan for at least five years or more. Discontinuing a cash balance plan within the first five years could have significant negative implications. Here’s how a cash balance plan looks in action:

**The need:** A group of physicians (who are over age 40 and are partners in the practice) are interested in setting aside more money each year than the defined contribution 401(k)/profit sharing limit of $49,000 each. They are also interested in protecting more of their income from current taxation.

**The solution:** In addition to their firm’s existing 401(k)/profit sharing plan, they adopted a cash balance plan.

**The results:**
- Average tax-deferred contributions for each partner within the practice increased from $37,500 to 72,600 per year—basically doubling the annual additions to their tax-deferred retirement savings.
- Annual tax-deferred contributions are now approaching $125,000 for several physicians who are older than 50.
- Meanwhile, contributions for staff increased from 4 percent to 6 percent of salary in order for the firm to pass the IRS non-discrimination testing—a small price to pay for the benefits reaped by the physicians/business owners.

*This is a hypothetical illustration only and is not a statement of actual results. Please contact a qualified tax advisor for advice relating to your specific situation.*

So, could you benefit from a cash balance retirement plan? A cash balance plan can offer substantial value to both the organization’s professionals/business owners and the other employees. Remember, however, to work with a qualified retirement plan consultant and your tax advisor to determine whether a cash balance plan would be appropriate for your practice.

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A missed or lost test result or a mix-up in laboratory reports can contribute to patient injury and lead to a malpractice claim. One of the leading causes of these errors, particularly in physician offices, is a failure to have a standardized system for flagging and managing laboratory and imaging results including critical test results.

To reduce this risk to your patients, determine how your practice defines a critical test result. Many clinics have not yet identified what tests are critical test results. Typically, critical test results include stat tests, panic value reports and any other results requiring an urgent response. Additionally, any test results that take more than two days to receive are at higher risk to be lost or forgotten.

The following risk management strategies can help prevent patient injury from a delay or missed diagnosis because of imperfect follow-up systems for critical test results:

1. Assess how your office handles critical test results:
   a. Establish a list of critical test results
   b. Implement a policy and procedure for monitoring critical test results
   c. Verify that your policy is always followed
   d. Confirm that your office is immediately notified of a critical test result
   e. Identify which lab and imaging results are likely to get lost
   f. Instruct laboratories and imaging facilities to call a designated phone number at your office with critical test results

2. Maintain a log of all tests sent internally and externally:
   a. Identify one person to track, receive and process diagnostic findings
   b. Read back all telephone-reported critical test results

3. Flag medical records that have pending test results.

4. Require that provider review and sign off on all diagnostic results before filing in the medical record.

5. Notify patients when to expect test results and instruct them to contact the clinic if they are not notified within a timely fashion.

Failing to communicate test results is a prime reason for delayed and missed diagnosis. Critical test results require a timely response. Having an effective plan to relay and manage these results will decrease the likelihood of a patient injury leading to a malpractice claim.
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