

Summer 2009



Medical Group
Management
Association

MGMA®

Oklahoma
A State Affiliate

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Name This Newsletter!

Dear OKMGMA Member,

We are currently searching for the perfect title to our quarterly newsletter, and we need your help! Please submit suggestions for the newsletter title to ssoltis@cmmanage.com by August 1, 2009. The winner will receive a \$25 gift card and the opportunity to have their creativity showcased!

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Don't be Hung on the RAC

By Teresa Bolden

"Pay It Right!" That has been Medicare's slogan for more than a decade. To ensure that claims are paid right the first time, Medicare contractors have been instructed to establish effective "Provider Outreach and Education" programs that demonstrate measurable results. In addition, Medicare claims fall subject to audits conducted by Medicare contractors, the Comprehensive Error Rate (CERT) program, the Program Integrity (PI) contractor, and the Office of Inspector General (OIG), who work in concert to achieve the same goal – "Pay It Right!"



In light of recent legislation, the Centers for Medicare & Medicaid Services (CMS) has expanded their efforts to aggressively find and prevent waste, fraud and abuse in Medicare through the use of new program integrity contractors. These new *incentivized* contractors are called Recovery Audit Contractors (RACs), who are looking at billing trends and patterns across Medicare. They are focusing on companies and individuals whose billings for Medicare services are higher than the majority of healthcare providers and suppliers in the community.

What is the RAC looking for?

According to the Scope of Work (SOW) outlined for the RAC, they may attempt to identify improper payments that result from any of the following:

- Incorrect payment amounts (exception: in cases where CMS issues instructions directing contractors to not pursue certain incorrect payments made); *(cont'd pg 4)*

Ways to Maximize Effective Collections

By Tracy L. Spears

Accounts receivable are a major concern for medical practices in today's world. Many practices struggle with how to deal with self-pay patients and insurance companies who don't pay on time, or not at all. A clearly defined and carefully communicated, yet diplomatic payment policy may help avoid difficult collections situations. By following these simple steps, you can watch your practice thrive while retaining good, professional relationships with your patients.

Developing and implementing a sound collection policy is vital to running a successful practice. If staff is not well informed, and clients are not educated on payment expectations, chances of late or non-payment increase. Ensure that your practice's terms of payment are clearly stated in writing for both staff and *(cont'd on pg. 3)*

A Word from Our President...

Dear Members,

Now more than ever, we are challenged to find economical ways to improve our practice operations as well as our professional development. It is my belief that when faced with these types of challenges we have a tendency to question what our participation in associations like the OKMGMA has to offer us.



I am really excited to have this opportunity to highlight a few of the wonderful aspects of the OKMGMA. I would first like to point out the goals of the association:

- Be a primary resource on the current issues that affect health care
- To provide educational opportunities geared to improving financial, administrative and clinical operations.
- To provide a statewide network of health care professionals to share ideas and information
- To be an advocate of legislative issues affecting health care on a national and state level
- To achieve unity in the medical management field through the strengthening of OKMGMA
- To support the local affiliated chapters & national MGMA

Secondly, our Spring Conference was a prime example of our commitment to these goals. We offered a wonderful line up of national and local speakers. National speaker and author, Judy Capko presented "How to Recession Proof Your Practice". In addition, we had a local favorite Rhett Laubach who presented a wonderful motivational session "R.A.R.E." that inspired us to stretch ourselves in our leadership role allowing us to reach new heights.

Lastly, we introduced the OKMGMA/InLight Education Grant. This is a special partnership between OKMGMA and InLight Risk Management to help increase educational opportunities for our members by reducing the financial burden to their practice. This grant provided members Margie Teel (Tulsa) and Catrena Alford (Tulsa) with grants at a set limit of \$2,250 each for the purpose of attending the National MGMA Conference which will be held October 11th-14th, 2009 in Denver, CO. This provides funds for the National MGMA Conference registration fee, first year National MGMA membership fee, 3 nights hotel accommodations and round-trip transportation. Two additional grants will be offered to current members each year until 2011. The eligibility requirements are that you be a current member of the OKMGMA regardless of chapter, must be engaged in the day-to-day operations of a healthcare facility or medical provider and be present at the conference drawing.

I would like to conclude by stating that I am continually impressed by the resourcefulness and dedication of our practice leaders in their effort to be successful in the healthcare industry. This is a direct result of our ability to rise to the occasion when presented with challenges. I would like to challenge you to reach out to your colleagues and encourage them to join the ever growing networking of successful fellow leaders that are members of the OKMGMA. I am sure they will find it to be a rewarding and valuable experience.

Sincerely,

Christy Vanderbilt

2009 OKMGMA President

Effective Collections *(cont'd from pg. 1)*

patients. If you don't have a systematic invoice and billing system, get one. The faster you mail invoices, the sooner you'll be paid. An invoice should clearly show the amount due and when payment is expected, or else they may fall to the bottom of the patient's payment stack.

In addition to your policy and billing procedures, contacting late payers every 10-14 days enables you to diplomatically remind the customer of your terms of payment. Remember when evaluating accounts to use the data on your aging sheet, not your feelings because if you're not being paid, someone else probably is. In the event that a patient has moved without providing you the new address, the United States Postal Service will re-search their information and provide you with the change of address, if available, so make sure that your outgoing envelope states 'Address Service Requested'.

For more difficult situations, make sure the staff trained in a way to be firm, yet courteous when dealing with patients. Train your collections staff on customer service because they must "sell" your patients on the idea that you expect to be paid in a timely manner while at the same time maintain good relations. And, if your practice makes a mistake, quickly admit it and correct it. Denying an obvious error only fans the flames of resentment your patient may already feel.

(cont'd on pg 6)

How to Choose a Health Care Plan that is Right for You

By Rebecca Foster

Chocolate or vanilla. Coffee or tea. Everyone loves to have a choice, but when it comes to choosing a health plan, the numerous options can be overwhelming. That's especially true if your company offers the relatively new Consumer-Driven Health Plan (CDHP) with a Health Savings Account (HSA) option. Before evaluating the pros and cons of this new choice, consider the following three major factors to provide a foundation for your analysis:

- **Doctors and Hospitals.** First things first. If you have a doctor you like, ask what insurance plans she or he accepts. That may point you toward a specific insurance option. Then, consider how important it is to you to have a plan that allows you to choose your doctors and hospitals going forward. While Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) usually require you to select a primary care physician from the plan network and utilize specific hospitals, you may already be using and satisfied with those hospitals. However, keep in mind that some plans do not pay for out-of-network services.
- **Prescriptions.** Make a list of all the current prescriptions you and your family use and check that these medications are included in each plan's list of covered medications. How much will you pay for each prescription? Read the fine print. Sometimes a plan covers only the cost of the generic version of a drug. If so, you'll need to ask your doctor if the substitute would be acceptable for you.

(cont'd on pg 10)

"The faster you mail invoices, the sooner you'll be paid."





RAC's *(cont'd from pg 1)*

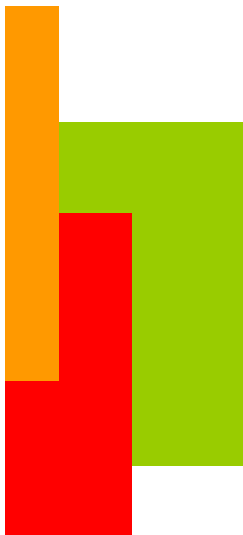
- Non-covered services (including services that are not reasonable and necessary under section 1862(a)(1)(A) of the social Security Act);
- Incorrectly coded services (including DRG miscoding);
- Duplicate services;
- Medicare claims through the complex post payment review process where it is probable that a duplicate primary payment was made. This includes situations where Medicare paid a claim to a provider as the primary payer and another group health plan insurer paid the claim as the primary payer; and
- Medicare claims through the complex post payment review process where it is probable that a Medicare Secondary payer situation has occurred.



- **The RAC may not attempt to identify improper payments arising from any of the following:**
 1. Services provided under a program other than Medicare Fee-for-Service;
 2. Cost report settlement process;
 3. Evaluation and Management (E&M) services that are incorrectly coded (CPT codes 99201 – 99499);
 4. Claims more than 1 year pass the date of the initial determination (medical necessity reviews only);
 5. Claims more than 3 years past the date of the initial determination;
 6. Claims where the beneficiary is liable for the overpayment because the provider is without fault with respect to the overpayment;
 7. Random selection of claims;
 8. Claims identified with a special processing number; and
 9. Prepayment review.

RAC Medical Record Request Limits

- Inpatient Hospital, Inpatient Rehabilitation Facility, Skilled Nursing Facility, Hospice
 - 10% of average monthly Medicare claims (max of 200) per 45 days
 - Other Part A Billers (Outpatient Hospital, Home Health)
 - 1% of average monthly Medicare services (Max of 200) per 45 days
 - Physicians
 - Solo Practitioner: 10 medical records per 45 days
 - Partnership of 2-5 individuals: 20 medical records per 45 days
 - Group of 6-15 individuals: 30 medical records per 45 days
 - Large Group (16+ individuals): 50 medical records per 45 days
- (cont'd on pg. 5)*



RAC's *(cont'd from pg. 4)*

- Other Part B Billers (DME, Ambulance, Lab)
 - 1% of average monthly Medicare services (Max of 200) per 45 days

Example:
 360,000 Medicare paid services in 2008
 Divided by 12 = average 30,000 Medicare paid services per month
 x 1% = 300
 Limit = 200 records/45 days (capped at the maximum)



Important Survival Tips!

- Assign the responsibility of responding to RAC requests to one or two individuals who are committed to working together in responding to these requests.
- Keep a log of each request.
 - When the request was received
 - Type of services involved
 - When and how was the response sent
- After pulling the records for the service(s) in question, make sure that all services billed are clearly documented.
 - Pay particular attention to the number of units billed.
 - Make sure that the patient's name and date of service is on every page, even if the page is a double sided document.
- Respond to the RAC requests within 40 days.
 - If the RAC does not receive the requested information in their office within forty-five (45) days from the date of their request, then the service(s) in question will be considered paid in error.
- Most importantly - if you do not agree with the RAC's final decision, request an appeal!

Since the RAC is focusing on aberrant billing patterns, now may be a good time for Oklahoma healthcare providers to obtain a Comparative Billing Report from TrailBlazer. This FREE report will reveal how their evaluation and management services rank among their peers nationally. To obtain this educational report, fax a request on your business letterhead to (903) 463-0621. If there is more than one physician in your practice, a separate request should be made for each physician. Your faxed request must include:

1. The physician's name;
2. The physician's National Provider Identifier (NPI);
3. The physician's Provider Transaction Access Number (PTAN) – this is their Medicare Provider Identification Number;
4. The last five digits of their tax identification number – if on file with Medicare;
5. The physician's signature; and
6. A return fax number.

Hopefully these tips will help you successfully avoid getting hung on the RAC!

Who are the RAC Contractors?

Region A:

Diversified Collection Services, Inc. of Livermore, California.

Region B:

CGI Technologies and Solutions, Inc. of Fairfax, Virginia.

Region C:

Connolly Consulting Associates, Inc. of Wilton, Connecticut

Region D:

HealthDataInsights, Inc. of Las Vegas, Nevada

Effective Collections *(cont'd from pg. 3)*

There may be a point in which your internal procedures are not enough. A third party can motivate a customer to pay, simply because the demand for payment is coming from an outside agency. Before paying a percentage to a collection agency, or using small claims court or an attorney, check into using a flat fee, diplomatic pre-collection service.



Always remember that in many states, practices are governed by the same collection laws as collection agencies. If you're not sure, call your state's department of finance or consult an attorney.

In the end, remember that even with a carefully designed and administered collection plan, there are some accounts that will never be collected. By identifying these accounts early, you will save your practice time and money while benefiting from improved cash flow from the vast majority of accounts that will pay.

How Are Your Payers Performing?

By Laura Morrow

The Medical Group Management Association (MGMA) recently surveyed medical practices regarding their satisfaction with payers in the MGMA Practice Perspectives on Payer Performance which ranks Oklahoma health plans in the areas of:

- Overall satisfaction
- Payments, denials and appeals
- Communications
- Negotiations
- Credentialing
- Pay-For-Performance

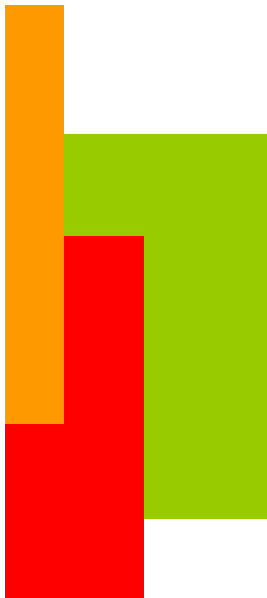
Summary

BCBSOK got top marks in 8 of 14 categories including overall satisfaction, disclosure of fee schedule and payment policies, understanding why claims are denied, satisfaction with the appeals process, accuracy and consistency of responses to questions, and satisfaction with the credentialing process. BCBSOK did not receive the low score in any category.

Coventry was the most frequent low scorer, receiving the lowest ranking in 9 of 14 categories. Areas of concern included overall satisfaction, disclosure of fee schedules and payment policies, timely response to questions, the payer's website as a means of conducting business and contract negotiations. Coventry was not the high scorer in any category.

Medicare Part B (traditional) got high marks for disclosure of fee schedules and payment policies, promptness of claims payments and your understanding of why claims are denied or modified.

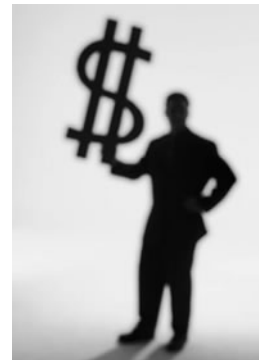
(continued on pgs.7 & 8)



Payer Performance *(cont'd from pg. 6)*

Overall Satisfaction with Payers

Sixty one percent of medical practices responding indicated that they were moderately or completely satisfied with BCBSOK and 51% were completely or moderately dissatisfied with Coventry. Medical practices were also asked how they would describe the change, if any, in their overall satisfaction with the payer over the past 6-12 months. Mild to significant improvements were reported for the following plans; UHC/PacifiCare (17%), Aetna (17%) and BCBSOK (17%). The most significant decline was reported for Coventry with 36% of respondents reporting a mild to significant decline in their satisfaction. UHC/PacifiCare had a mild to significant decline of 32%.



Payments, Denials and Appeals (aka... Flying Blind!)

Would you provide services without knowing how much you will be paid (fee schedule) and without knowing the policies of the "black box" utilized to process that payment? Would Wal-Mart, Home Depot, Walgreen's or any other retailer accept those terms? Better yet, would payers accept the same ambiguity when collecting insurance premiums?

Significant dissatisfaction stems from the lack of transparency of contracted fees and payment policies. Providers deserve to know exactly how much a payer will reimburse and what claim edits will reduce payments.

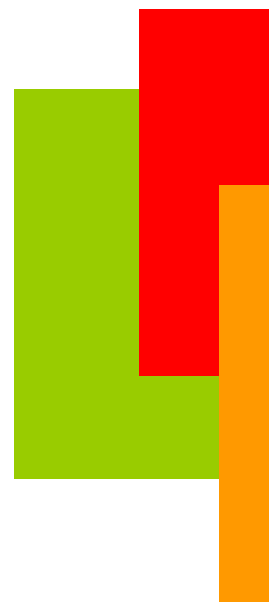
"Providers deserve to know exactly how much a payer will reimburse and what claim edits will reduce payments."

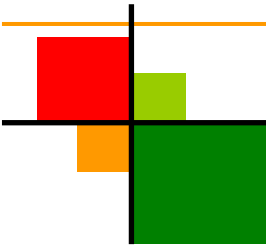
When asked about the willingness of a payer to disclose the fee schedule utilized to reimburse practices under the terms of the contract, you told us that 63% of the medical practices were moderately or completely satisfied with BCBSOK. Nearly half (42%) of medical practices were completely or moderately dissatisfied with Coventry. Thirty five percent of providers are completely or moderately satisfied with the BCBSOK appeals process, whereas only 58% are completely or moderately dissatisfied with UHC/PacifiCare.

Your satisfaction that the payer fully disclosed its payment policies to medical practices indicated that 57% were moderately or completely satisfied with Medicare Part B (traditional) and 33% for UHC/PacifiCare. Fifty six percent of surveyed medical practices were completely or moderately dissatisfied with Coventry.

Promptness of claims payment has always been a big issue for providers. Sixty percent of the medical practices were moderately or completely satisfied with the promptness of claims payment from Medicare Part B (traditional) and 54% for BCBSOK. Thirty seven percent of the medical practices were completely or moderately dissatisfied with the promptness of claims payment from UHC/PacifiCare.

Medical practices don't always understand why their claims are denied or modified. Fifty four percent of medical practices were moderately or completely satisfied with BCBSOK and Medicare Part B (traditional.) Thirty six percent were completely or moderately dissatisfied with Coventry.





Payer Performance *(cont'd from pg 7)*

In 4 out of 5 payment measures, BCBSOK ranked highest. Medicare Part B (traditional) received the highest ratings for fee schedule and payment policy disclosure, and promptness of claims payment. Coventry ranks lowest on 3 of 5 payment measures and UHC/PacifiCare ranks lowest on 2 of 5 payment measures.

Communications and Interactions

BCBSOK ranks highest in 2 of the communication metrics whereas Coventry ranks lowest in 2 metrics in this category. UHC/PacifiCare gets the highest ratings in satisfaction with payer's website for conducting business transactions. However, they fall short in satisfaction with the accuracy and consistency of response to questions. Fifty Eight percent of Oklahoma respondents are completely or moderately satisfied with BCBSOK's timely response to questions although 59% of respondents are completely or moderately dissatisfied with Coventry.



Negotiations

How much leverage do you have during the contract negotiation? UHC/PacifiCare received the highest ratings at 41% while Aetna followed at 39% for complete, considerable or moderate leverage. The low score for private insurers goes to Coventry, in fact 61% report having no or slight leverage in negotiations. Medicare, which makes no pretense of negotiating with providers, received the lowest score at 69%.

All of the payers receive low marks for conducting two-way, good faith negotiations during the contracting process. Respondents are completely or moderately dissatisfied with the payers as follows: Coventry 54%, Aetna, BCBSOK and Community Care 41% and United HealthCare/PacifiCare 39%. Providers are less dissatisfied with Medicare at 36% although Medicare has the least negotiated fee schedule and the schedule that has declined most significantly over the last few years.

Credentialing

Ineffective credentialing processes are expensive for both providers and payers. Forty three percent of respondents reported that they were moderately or completely satisfied with BCBSOK. Thirty nine percent of respondents reported being completely or moderately dissatisfied with UHC/PacifiCare. Medicare ranked lowest with 42% of respondents reporting complete or moderate dissatisfaction.

What did we learn?

Results tell us two things; BCBSOK leads in provider satisfaction (61%) scoring highest in 8 of 14 categories however since 39% are not satisfied with even the highest ranking payer additional works needs to be completed to align incentives and improve processes. Coventry has significant work ahead as it strives to improve processes and foster better working relationships with providers. Areas for improvement include transparency of fee schedules and payment policies, clarity regarding why claims are modified or denied, timely response to provider questions, the website as a means of conducting business and conducting two way good faith negotiations.

You can provide feedback to payers by participating in the next annual payer survey. Complete results are available on the OKMGMA website.

Note: Percentages were rounded in this summary.

Payer Performance *(cont'd from pg 8)*

	LOW RANKING	HIGH RANKING
SATISFACTION		
What is your overall current satisfaction with the payer?	Coventry 51%	BCBSOK 61%
Over the past 6-12 months, how would you describe the change, if any, in your overall satisfaction with the payer?	Coventry 36%	UHC/PC 17% Aetna 17% BCBSOK 17%
PAYMENTS, DENIALS AND APPEALS		
How willing is payer to disclose the fee schedule to reimburse your practice under the terms of your contract?	Coventry 42%	BCBSOK 63% Medicare Part B 67%
How satisfied are you that the payer fully disclosed its payment policies?	Coventry 56%	UHC/PC 33% Medicare Part B 57%
How satisfied are you with the promptness of claims payment?	UHC/PC 37%	BCBSOK 54% Medicare Part B 60%
How well do you understand why your claims are denied or modified?	Coventry 36%	BCBSOK 54% Medicare Part B 54%
How satisfied are you with the appeals process?	UHC/PC 58%	BCBSOK 35%
COMMUNICATIONS		
How satisfied are you with the amount of time it takes to respond to your questions?	Coventry 59%	BCBSOK 58%
How satisfied are you with the accuracy and consistency of the payer's response to your questions?	UHC/PC 54%	BCBSOK 64%
How satisfied are you with the payer's website as means of conducting business transactions (i.e. claims submission, eligibility verification)?	Coventry 35%	UHC/PC 50%
NEGOTIATIONS		
How much leverage do you have during the contract negotiation process?	Coventry 61% Medicare Part B 70%	UHC/PC 41%
How satisfied are you that the payer conducts two-way, good faith negotiations during the contracting process?	Coventry 54%	BCBSOK 41% Aetna 41% CC 41%
CREDENTIALING AND PAY-FOR-PERFORMANCE		
How satisfied are you with the credentialing process?	UHC/PC 39% Medicare Part B 42%	BCBSOK 43%
How transparent to you are the cost and quality measures used by the payer for its physician rating and/or pay-for-performance programs?	Community Care 35%	UHC/PC 26% Medicare Part B 38%

Choosing a Health Plan *(cont'd from pg 3)*

- **Costs and Coverage.** Do you visit the doctor frequently for chronic conditions or will you use the plan only for annual care, or in the event of a hospitalization or major illness? Check if the plan has yearly or lifetime maximum benefit amounts or if it limits the amount of coverage for each hospital stay. Make sure the plan would provide enough coverage if you or a family member became seriously ill or injured.



While research shows that Americans say that “quality” is the most important consideration when choosing a health plan, and because “quality” means something different to everyone, it’s difficult to offer rules of thumb for choosing a health plan. Considering the factors above can help you identify a plan that will work well for you. As you continue your evaluations, set aside advertisements, brochures, or conversations with insurance representatives and invest your time reading each plan’s handbook. Also, you might want to investigate to see how those currently enrolled in the plan rate it. Finally, acknowledge that it’s unlikely you’ll find a perfect choice and you may need to compromise. For example, you might decide to give up some of your freedom to choose a doctor or hospital for a lower cost. While your health plan choices were once neatly divided between traditional and managed care, some firms now offer CDHP that typically combines a High-

Deductible Health Plan (HDHP) with a tax-advantaged HSA that can be used to pay deductibles and other out-of-pocket expenses.

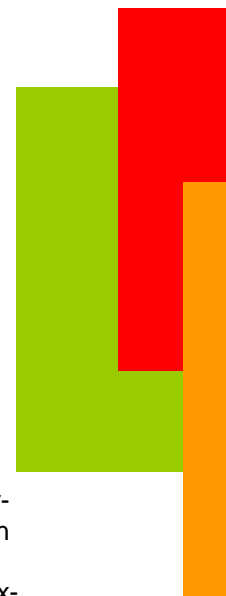
CDHPs were introduced in 2001 with the goal of decreasing the number of uninsured, encouraging cost-consciousness among consumers, and increasing the amount of information on the cost and quality of providers. However, the plans have been controversial because of the criticism that they favor wealthy and healthy participants at the expense of those with lower incomes and poorer health status.

Just what is a HDHP? Generally, this is health insurance that does not cover first-dollar medical expenses. For calendar year 2008, federal law requires that the health insurance deductible be at least \$1,100 for self-only coverage and \$2,200 for family coverage. In addition, annual out-of-pocket expenses under the plan (including deductibles, co-pays, and co-insurance) cannot exceed \$5,600 for self-only coverage and \$11,200 for family coverage. In general, the deductible must apply to all medical expenses (including prescriptions) covered by the plan. However, plans can pay for “preventive care” services on a first-dollar basis (with or without a co-pay). Note that “preventive care” can include routine pre-natal and well-child care, child and adult immunizations, annual physicals, mammograms, pap smears, etc.

For 2009, the minimum deductibles for HDHPs increase to \$1,150 for self-only coverage and \$2,300 for family coverage. And 2009’s maximum annual out-of-pocket amounts for HDHP self-coverage increase to \$5,800 for individuals and \$11,600 for families.

Again, these HDHPs are generally paired with tax-advantaged HSAs, a new player on the health insurance field. Often described as an individual retirement account for medical expenses, HSAs have been billed as the elixir to rising health care costs. Authorized in 2003 by the Medicare Prescription Drug, Improvement, and Modernization Act, HSAs allow qualified individuals choosing a HDHP to deposit tax-deductible funds into an account that they can use to cover medical costs. The result is a health insurance option designed both to help an individual pay for current health care needs and to save for future medical bills.

(cont'd on pg 11)



Choosing a Health Plan *(cont'd from pg 10)*

How much can you contribute to an HSA? For 2009, the maximum annual HSA contribution for an eligible individual with self-only coverage increases to \$3,000. For family coverage, the maximum annual HSA contribution for 2009 is \$5,950.

It's important to understand that you can use the money in your HSA to pay only for "qualified medical expenses" permitted under federal tax law. This includes most medical care and services, dental and vision care, and also includes over-the-counter drugs such as aspirin or cough medicine. What's more, you can use the money in the account to pay for medical expenses of yourself, your spouse, or your dependent children, even if they are not covered by your HDHP. Note that any amount used for purposes other than to pay for "qualified medical expenses" are taxable as income and subject to an additional 10% tax penalty. However, after you turn age 65, the 10% additional tax penalty no longer applies. Also, if you become disabled and/or enroll in Medicare, the account can be used for other purposes without paying the additional 10% penalty.

Note that if you have additional questions on HSAs, the U.S. Treasury's web site at www.ustreas.gov is a great place for unbiased information.

Today, HSAs are a growing, and somewhat controversial, part of employment-based insurance offerings. Supporters believe that such plans encourage consumers to become better informed, more cost-conscious users of health care. On the other hand, critics worry that patients will obtain fewer necessary and non-essential services alike. HSAs also have been criticized for favoring the wealthy who can afford to pay for their health care out-of-pocket. That is, if you can afford to pay for your annual health care expenses, you have an attractive opportunity for dollars in your HSAs to grow tax-deferred. However, at almost all wealth levels, if you are unhealthy, or not able to pay for health care out of general cash flow, nothing accumulates in your HSA. The "savings" account has a revolving door.



How great an impact are CDHPs and HDHPs having? The March 2008 *EBRI Issue Brief* offers interesting data drawn from a study conducted by the Employee Benefit Research Institute (EBRI). Overall, the survey showed:

- Enrollment in consumer-driven plans with a tax-advantaged account was 2% of the privately insured adult population in 2007, up from 1% the previous year. The 2% of the population represents 2.3 million adults ages 21–64 with private insurance.
- Enrollment in high-deductible plans stood at 11% of the privately insured adult population in 2007, up from 7% the previous year. The 11% with high deductible plans represents 12.5 million people ages 21–64.
- The percentage of consumer-driven plan enrollees with household incomes above \$100,000 increased to 31% in 2007, from 22% in 2005, according to the survey. Just 19% of adults with consumer-driven plans were in households with incomes of under \$50,000 in 2007, down from 33% in 2005. In addition, the survey found that 23% of high-deductible plan enrollees were in higher-income households in 2007, up from 15% in 2005. There was little change in the income levels of those enrolled in more comprehensive plans.
- As in 2005 and 2006, individuals in consumer-driven plans and high deductible plans continue to be less satisfied with various aspects of their health plan than individuals in more comprehensive plans. However, individuals in consumer-driven plans were somewhat more satisfied with their plans in 2007 than they were in 2006, and there was a significant increase in the share of consumer-driven plan enrollees who said they would recommend their plan to a friend or co-worker and stay in their plan if they had the opportunity to change.

In his conclusion to the EBRI report, Richard Ostuw, an EBRI fellow and retired senior health care consultant for Towers Perrin, a global professional services firm writes, "CDHPs and HDHPs are perhaps at a tipping point. The level of enrollment in these plans has grown significantly relative to previous years, but is still modest in absolute terms. That suggests that both workers and employers remain skeptical of them. These attitudes will change only if both the substance and perception are positive. (cont'd pg 12)

Choosing a Health Plan *(cont'd from pg 11)*

If employers and workers change their mindsets, CDHPs and HDHPs can become a significant part of the U.S. health care financing system. But, if there are no changes in employers' and workers' attitudes and behaviors, they will remain as a niche type of plan or decline in the future."

Certainly, future data gathered on CDHPs and HDHPs – including the debate inspired by the presidential election about what to do about the 47 million Americans without health insurance, concerns about escalating health care costs, and coordinate care for those with coverage – will keep health care options in the news. If you have specific questions as you evaluate your options, please don't hesitate to contact us.



Securities offered through LPL Financial Member FINRA/SIPC

In Your Corner

News from the Local Chapters



Dear Members,

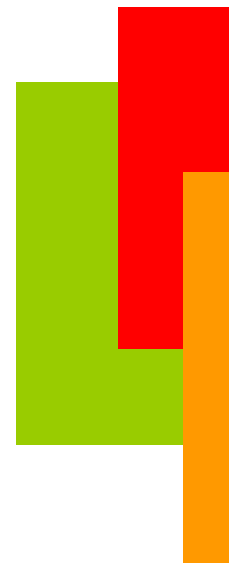
The OKMGMA Board has just completed the Spring Conference, which was held on May 14 and 15th in Tulsa. However, this year registration was lower than in previous years. We are fully aware of the economic pinch our offices are in, but this is money well spent. Now is the time for Managers to be networking, sharing cost saving ideas and looking for new and innovative ways to bring revenue into our practices. I want everyone to consider attending our fall conference in Oklahoma City, because it's a wonderful opportunity.

In the Southern Chapter, our new President Vanessa McNeill is doing an exceptional job. She introduces very interesting speakers to our group and we learn a great deal from each other. Sometimes, we benefit more by holding "round table discussions". Each manager presents a problem they are having in their practice, and more than likely there is the same problem in another practice. This is just one way we share solutions among ourselves.

Everyone keep up the good work, and hope to see you at the Fall Conference.

Sincerely,

Connie Barker, OKMGMA Board Member



Thank You...

The EOMGMA would like to thank all of its members for their support. In an effort to maximize your membership dollars, the membership voted to move our meeting location, beginning July 15, 2009, to the Embassy Suites – Tulsa. We will kick off at our new location with a presentation from a Human Resources Attorney, and in August, a session on Business Etiquette. [We'll have a joint meeting with Tulsa County Medical Society in September and an panel of insurance reps in October.](#) Watch for our meeting notices to RSVP for these exciting sessions! If you are not on our mailing list, please call us to join (contact UPAL at 747-5585). We also invite your feedback and suggestions. Please feel free to email one of your Tulsa chapter officers: bgraves@tulsaobgyn.com, rdust@surgeryinc.com, or amanda-smith@ouhsc.edu.



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Stimulus Package Alters HIPAA Rules for Business Associates

By Steve Harris

The American Recovery and Reinvestment Act, better known as the stimulus bill, is notable for the \$19 billion it offers for incentives to adopt and use health information technology. But it also expands the reach of the Health Insurance Portability and Accountability Act.

Specifically, the stimulus bill expands the reach of privacy and security rules implemented under HIPAA to cover business associates and covered entities.

It's been six years since you were first required to understand those terms for following HIPAA. But in case you need a refresher, a covered entity is a health plan, health care clearinghouse (billing services, community health information system and the like), or a hospital or physician who transmits health information in electronic form.

A business associate is someone who, on behalf of a covered entity, performs an activity involving the use of disclosure of individuals' health care information. That includes the performance of legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for a covered entity.

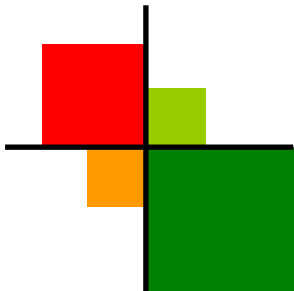
These expansions under the stimulus bill are different from the Federal Trade Commission's red flag rules that impose certain duties on financial institutions and creditors with the goal of curtailing identity theft.

Unlike those rules, which the AMA and others fought because they expanded the definition of a creditor to physicians, these HIPAA expansions were explicitly directed to physicians in the legislation.

So what is new?

Under the stimulus bill, several HIPAA security provisions now apply to business associates in the same manner that those provisions apply to covered entities. That means business associates of covered entities will now have an affirmative duty to protect the confidentiality of electronic protected health information created, received, maintained or transmitted in performing services for or on behalf of covered entities. *(cont'd on pg 14)*

Stimulus Package *(cont'd from pg 13)*



So your business associates will need to implement written policies to, among other things, prevent, detect, contain and correct security violations of electronic information, and develop safeguards to limit access.

While HIPAA already requires business associates and covered entities to enter into a written contract, be sure that you are not relying on an old agreement that does not take into account this new law.

Also under the stimulus bill, if in the course of their relations a covered entity will be disclosing protected health information to a business associate and/or allowing the business associate to create or receive such information on its behalf, the business associate may use and disclose the information only if such use or disclosure complies with the written contract requirements under the privacy provisions of HIPAA.

Additionally, business associates now have an affirmative duty, and this duty must be stated in the written contract. Under the new law, if a business associate is aware of a pattern of activity or practice of the covered entity that constitutes a material breach of the covered entity's obligations under the contract, the business associate must take reasonable steps to cure the breach.

However, if the business associate takes reasonable steps and such steps are unsuccessful, he or she must either terminate the contract with the covered entity (if feasible) or report the problem to the secretary of Health and Human Services.

If you find this confusing, you are in the vast majority. Legislators recognize this and require the HHS secretary to issue annual guidance on complying with the new law.




"While HIPAA already requires business associates and covered entities to enter into a written contract, be sure that you are not relying on an old agreement that does not take into account this new law."

Harris, a partner at McDonald Hopkins, formerly Harris Kessler & Goldstein, in Chicago, concentrates on health care law and has counseled physicians, physician networks and health care groups nationally. The author and publisher are not rendering professional advice and assume no liability in connection with its use. He can be reached at 312-280-0111, or by e-mail (sharris@mcdonaldhopkins.com).


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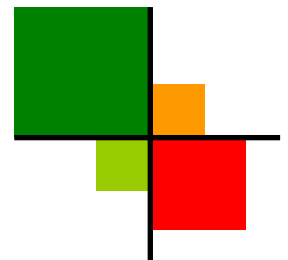
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Special Thanks For Your Contributions

We would like to take this opportunity to Thank everyone for submitting these informative articles .

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