

Nebraska Medicine

Spring 2012 | Volume 11, Number 1

The Affordable Care Act's Health Insurance Exchange

What you need to know



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Foreword

by Chuck Gregorius, MD
President
Nebraska Medical Association

This issue of Nebraska Medicine provides a concise review of insurance exchanges: what they are, who establishes and manages them, how they work, and who determines the benefit packages and options.

The ultimate goals of exchanges are 1) reduce the number of uninsured, 2) make medical/health insurance as affordable as possible, 3) provide more options in benefit packages than what might be found in a national program so the insured get more tailored benefits for the premium cost and 4) provide subsidies for those with qualifying income levels.

In this issue Bruce Ramge, director of the Nebraska Department of Insurance, points to the complexities of design,

management, and on-going monitoring of the exchanges that will be necessary. We also hear from the payor side as Michaela Valentin (BCBSNE) describes the four possible models, two of which include control by the federal government which, personally, I do not believe is in the best interest of Nebraska stakeholders. Mark Intermill with AARP gives us insight on compliance and quality concerns that providers would probably find familiar if they are already seeing Medicare and Medicaid patients.

The remaining articles in this issue of Nebraska Medicine focus on Nebraska legislative activity and the need for Nebraska to create an exchange before federal deadlines are missed. If we aren't able to establish our own exchange we will receive a federal exchange by default, whether or not it is what's best for Nebraska. Governor Heineman has

taken a wait-and-see approach in anticipation of a ruling by the U.S. Supreme Court on the constitutionality of the individual mandate in the Affordable Care Act. That decision may not be known until close to the first deadline for action. Fortunately, the stakeholders who will be involved in a Nebraska insurance exchange are already working on this complex and critical project.

I commend this issue to your reading and will close with a personal opinion. Regardless of the Supreme Court action, I think that an exchange would serve Nebraska well in addressing all the goals listed at the beginning of this introduction, and therefore our state government should get this project started; the sooner the better. □



Nebraska Department of Insurance and Health Insurance Exchanges

by Bruce Ramge
Director of Insurance
Nebraska Department of Insurance

In 2010, the United States Congress passed and the President signed the Patient Protection and Affordable Care Act (PPACA) into United States law. One of the key provisions in the law was the ability for each state to develop a health insurance exchange, or to default to a federally facilitated exchange.

A health insurance exchange is a government regulated insurance marketplace with a single point of entry for

individuals and small business to shop for and purchase federally qualified healthcare plans and Medicaid. Under the ACA, individuals applying through the exchange who meet modified adjusted gross income (MAGI) levels of less than 133 percent of the federal poverty levels will be able to enroll in a new Medicaid benchmark plan. For most individuals with modified adjusted gross income between 133 – 400 percent of the federal poverty level, federal subsidies would be available to help purchase a qualified health insurance plan through the exchange.

Under ACA, individuals or small businesses could purchase a qualified plan, or maintain a “grandfathered” healthcare plan to avoid mandated tax penalties. In order to sell a qualified healthcare plan, insurers must offer plans that meet the federal essential health benefit design standard. The essential benefit standard has yet to be determined and is still under study and development. Exchanges would be required to operate a web-based insurance portal, a brick and mortar facility
(continued on Page 3)



Nebraska Department of Insurance and Health Insurance Exchanges *(continued)*

for walk-in customers, and a toll-free telephone call center.

The ACA allows sales to be made through the existing network of insurance agents and also creates a navigator program that is envisioned to help inform hard to reach individuals about available coverage options. One persistent misunderstanding about exchanges is that the healthcare plans offered through an exchange would be government underwritten plans. Except for the Medicaid expansion, the health insurance plans would continue to be placed with insurance companies.

Operating an exchange is an extremely complicated and sophisticated task. States electing to operate one will need to separately track Medicaid enrollees that qualify for a benchmark plan and those that would qualify under existing Medicaid eligibility rules. Managing the churn or movement of individuals through various eligibility criteria will be challenging. Leveraging technology between insurers, Medicaid systems, payers and the federal government will be a time consuming process. Managing the differing roles and qualifications of brokers and navigators will fundamentally change how people enroll in coverage. Another consideration is that each exchange would need to be financially self-sustaining; meaning no further federal grant money would be made available after 2015.

There are numerous functions that must be included in a health insurance exchange including: accommodating affordability and mandate exemptions, managing income verification, tracking disqualification due to eligibility for enrollment in employer sponsored

plans, arranging for premium aggregation for small employer plans, handling qualified individual and employer appeals, implementing quality rating systems, incorporating multi-state plans, delivering treasury tax credits, managing an adequate risk adjustment program, certifying qualified health care plans and ensuring data protection and privacy standards. These are just some of the functions that will need to be done to meet the mandates set by the federal government. All of this must be accomplished by January 1, 2014. However, enrollments are set to begin in October 2013 so in reality the timeline is pushed up significantly. It is doubtful that any state will meet this extremely ambitious timeline.

Needless to say, enactment of the ACA was not without controversy. Nebraska is one of 26 states that is challenging the constitutionality of the law to prevent implementation of the ACA, including the individual mandate penalty. The suit was successful in a Florida District Court and was appealed to the United States Supreme Court where most anticipate a decision by the U.S. Supreme Court in June 2012.

One of the other issues that further compounds the uncertainty surrounding the outcome of the court case is that many of the necessary regulations to properly administer the ACA have not yet been finalized or have even been issued by the Center for Consumer Information and Insurance Oversight (CCIIO) at the U.S. Department of Health and Human Services.

The Nebraska Department of Insurance recognizes that unless the ACA is overturned by the Court, or

subsequently amended by Congress, it is the law of the land. As such, the Department views the exchange with a three-prong approach, if state policy makers so decide. Our steps are to plan, design, and, if necessary, build.

The Department of Insurance held stakeholder meetings, met with interested parties and vendors, coordinated activities with the Nebraska Medicaid Division, monitored new information promulgated by the federal government, shared information with other states and contracted with consultants to evaluate demographics, sustainability, estimated participation, information technology gaps and estimated costs to build and operate an exchange. In October the planning report was presented to the Governor and Nebraska Legislature. It is available on-line at http://www.doi.ne.gov/healthcarereform/exchange/Health_Insurance_Exchange_Planning.pdf.

The Department is moving into the design phase and among other things, plans to examine options available for technology, business process flows, and numerous other exchange functions. The Department is in the process of evaluating the essential health benefit options along with associated expected costs with an actuarial study. The Department will continue to put the state in a position of maximum flexibility concerning exchange implementation. We will leave all viable options, while remaining prepared to implement a state-based exchange if necessary. We will continue to monitor the status of the court case, federal regulations, proposed rulemaking, and all other necessary developments in order to best protect Nebraska's consumers. □

Making the Case for a State-based Health Insurance Exchange

by *Michaela Valentin*
Director of Government Affairs
Blue Cross Blue Shield of Nebraska

Beginning in 2014, millions of Americans will purchase health insurance through new health insurance marketplaces called exchanges. The Patient Protection and Affordability Care Act (PPACA) created two separate exchange models to assist both individuals and small businesses in purchasing insurance. These new exchange marketplaces will become the only source of billions of dollars in premium assistance and tax credits for individuals and small businesses meeting eligibility standards. Based on household income data collected by the U.S. Census, more than half of Nebraskans will qualify for subsidies in the exchange. The individual and small business subsidies are only offered in the exchange to drive consumers to this new marketplace.

Originally there were three exchange structures recommended in PPACA from which a state could choose. Those options included federal, regional and state-based exchanges. The federal model is commonly referred to as the “federal fallback” and would allow the federal government to step in and set up a federal exchange if it determines a state has failed to make progress by January 1, 2013. The perceived danger with this model is that it could be overly prescriptive as a “one-size-fits-all” model. The regional exchange would serve multiple states and therefore would have the unenviable task of

coordinating different insurance markets and state insurance laws.

The state-based exchange would give a state the most regulatory, financial and political control of all the models proposed.

In September 2011, the Center for Consumer Information and Insurance Oversight (CCIIO) released a fourth model, the federal-state partnership model that allows a state and the federal government to collaborate in operating the exchange. The exchange is divided into five core functions: plan management, consumer assistance, eligibility, enrollment, and financial management. Under the partnership model, the state can choose to oversee plan management, consumer assistance, or both plan management and consumer assistance. Choosing both functions would allow the state to control two of the five core functions of the exchange. The other remaining functions would be controlled by the federal government.

States are the primary regulators of the insurance market and already have the infrastructure to design, oversee, and enforce regulations. Allowing even some federal control of the exchanges would represent a significant expansion of federal regulatory authority. Some of the federal law’s exchange requirements may even apply to health plans that are sold outside of the exchange marketplace. In choosing to design its exchanges, Nebraska can create more efficient marketplaces – promoting competition, choice and transparency to empower consumers and small

businesses to select the health plans that best suit them.

Beyond the private health insurance market, exchanges will also play an important role in shaping Nebraska’s future Medicaid and Children’s Health Insurance programs. Nebraska will be required to expand Medicaid in 2014. To the extent a state can control the exchange’s administration and design, eligibility, enrollment systems and policy, the state can better control the cost associated with the exchange.

Nebraska can take advantage of federal assistance until 2015 to help defray the cost of exchange development. The U.S. Department of Health and Human Services has pledged to fully fund necessary exchange start-up costs. However, future federal funding will be based on meeting certain milestones and the progress a state has made in implementing the exchanges. In order to receive the next level of federal grant funding, Nebraska must enact legal authority to establish and operate an exchange that complies with federal requirements at the time of the application.

Currently, there are two legislative bills, LB 835 and LB 838, which propose state-based exchange models. These bills were introduced to start a discussion on exchanges while the U. S. Supreme Court is preparing to hear oral arguments on the constitutionality of the individual mandate in late March.

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A Health Insurance Exchange for Nebraska

by *Dennis Butler*
Association Benefit Advisors /
Daubert & Butler Associates

Health insurance exchanges - state-based organized marketplaces where people and small businesses can compare and buy health insurance - are a centerpiece of the federal health reform law known as the Affordable Care Act (ACA). While aspects of the ACA face political opposition and legal challenges (including a lawsuit filed by Nebraska and 25 other states) planning for the state's exchange continues. The Nebraska Department of Insurance has received over \$5 million from the federal government and continues to evaluate Nebraska's options for establishing an exchange. Progress is slow due to excessive federal guidelines and reluctance to provide the "guidance" necessary for compliance.

As exchange coordinator for the Nebraska Association of Health Underwriters, I have represented the role agents and brokers play in providing a variety of insurance services for individuals and small business in Nebraska.

Besides an insurance marketplace, state exchanges are to provide other services. Those include: determining eligibility for Medicaid, premium tax credits, and cost-sharing subsidies for private insurance coverage; provide information about and certify plans in the exchange meet required standards; and apply a quality rating system for plans in the

exchange. Performing these functions involves gathering income information, citizenship status, employment records and current coverage levels. Needless to say this portion of the exchange function is creating a huge information technology issue for states to retrieve this kind of information at all especially in the era of HIPAA compliance.

The ACA law requires that health insurance plans, with few exceptions, guarantee coverage to all who apply, including people with pre-existing conditions beginning in 2014. Qualified health plans must also eliminate cost-sharing for preventive care, and cover government-defined "essential health benefits." In a recent meeting with state regulators, they voiced their concern with the affordability of the law since they have applied essential benefits packages to our state's premium averages and are finding their cost may be beyond the reach of many Nebraskans.

After spending a recent week of attending sessions with HHS in Washington, D.C., visiting Congress, and taking the pulse of insurance professionals from around the country, there are concerns with the sustainability of the ACA. The concerns arise from the cost of providing the subsidies for buying health coverage to anyone up to 400 percent of federal poverty levels. That amounts to \$88,000 for a family of four; a lot of Nebraskans fall in this range. A study by our Nebraska Department of Insurance says between 60-70 percent of Nebraskans may qualify, which is a big number. The funding for ACA is in

question - where will the money come from? Almost any provider will tell you the continued squeeze from federal reimbursements can't continue without severe future consequences.

Part of the new exchange will be a Small Business Health Options Program, or the SHOP Exchange. The SHOP will be a marketplace for employers with less than 50 employees to compare health plan options for their employees. Most medical practices fall into this size category, and don't maintain full-time human resource staff. Many rely on their insurance broker to help find alternatives and suitable coverage for their staff and themselves. Under the SHOP exchange, I expect brokers to continue this relationship. The exchange will be one more option the broker can utilize by accessing plan information/cost for each employee which is a service most people will not want to try themselves. Qualified brokers can also assist in communicating benefits so employees can fully utilize their preventive benefits, initiate wellness plans, and keep managers abreast of the constant change ahead as a result of new rules and regulations.

My industry has taken some hits from the ACA and its effect on our markets. Our efforts and diligence have kept our role as advisers to insurance buyers alive in the new exchanges; at least in Nebraska it appears to be a means for agents to further serve our clients. A licensed, qualified insurance professional will be there when you or your business practice needs help navigating the new insurance exchange marketplace. ☐



Using the Exchange to Improve Nebraskans' Health

by Mark Intermill
Associate State Director for Advocacy
AARP Nebraska

I often encounter Nebraskans who have experienced tremendous benefits from the healthcare system. To a layman, these results are nothing short of miraculous. But as often as I hear stories about positive medical outcomes, I hear about frustration with the healthcare financing system.

Our current financing system does not work well. It's inefficient. We spend an inordinate amount on administrative overhead. It's ineffective. It excludes too many people from realizing the full benefit of medical practice. Too many Nebraskans don't get timely treatment or preventive care because they don't have health insurance.

AARP Nebraska is interested in the development of a health benefit exchange to provide better access to affordable healthcare coverage. As an association of people over the age of 50, our members who buy coverage in the individual market pay remarkably high rates due to Nebraska's policy of allowing unlimited age rating of health insurance premiums. For those who have a pre-existing condition that prevent them from buying coverage in the marketplace, there is a high-risk pool that allows them to get coverage, but at an extraordinary cost.

As we move toward January 1, 2014, when the health benefit exchanges authorized by the Affordable Care Act will become operational, Nebraska will make a number of decisions that will determine the effectiveness of our

health benefit exchange. We have an opportunity to create a healthcare financing system that is worthy of medical practice. Or we can fall back into the familiar patterns of healthcare financing mediocrity.

The mission of an exchange is to create a well-functioning health insurance marketplace providing an array of affordable, high-quality health insurance plans to individuals and small businesses. These exchanges will provide access to Medicaid and federal subsidies. Crafted skillfully, a state-operated exchange will be flexible and responsive to the needs of the marketplace and consumers and will promote the health of Nebraskans.

We need to develop a state-operated exchange in which insurers compete on the basis of healthcare outcomes and quality rather than on risk selection. Consumers will be best served by creation of an exchange large enough to alter the health insurance marketplace and strong enough to foster active negotiation with the plans that wish to be included in the exchange to make sure we get the best health outcomes for the dollars expended.

To make the market more accessible to individuals buying coverage in the exchange, we will need ongoing education and outreach that is based on accurate, understandable consumer information about coverage options, plan benefits, plan outcomes and costs. This will require a major communications and marketing campaign. Based on experience in states that have undertaken reform efforts, devoting resources to

marketing the exchange and its products and outreach initiatives must be a part of the planning, not an after-thought. The ACA does authorize the establishment of a navigator program to encourage consumer participation in the insurance marketplace. Navigators must be selected who can communicate with diverse groups that may be harder to reach due to language and cultural differences or that lack familiarity with health insurance. AARP will do our part to educate our members, as we did when the Medicare drug benefit began.



Including functions beyond those required by the ACA will serve the interests of Nebraskans and foster a robust marketplace that can meet the diverse needs of our state. Examples of those functions include the following:

- The exchange should have the authority to permit only high-quality plans and to negotiate with insurers over characteristics such as benefits, premiums, provider networks and timely payment of claims;
- The ability to reward quality through innovative payment and incentive programs;
- The authority to require compliance with uniform quality reporting measures that are consumer friendly and allow members of the public to compare plan performance – particularly in prevention and management of the most common chronic disease categories. Uniform care quality

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Creating a Health Insurance Exchange for Nebraskans by Nebraskans

*by State Senator Jeremy Nordquist
Legislative District 7 –
Downtown and South Omaha*

Nebraska has a tremendous opportunity to create greater choice, transparency, value and competition in our health insurance market by designing and implementing a health insurance exchange in our state. As part of the federal Affordable Care Act (ACA), Nebraska must develop an exchange that would facilitate comparison shopping among health plans in a transparent marketplace for individuals and small businesses, thus encouraging competition among insurance options and increasing the value of the plans available for purchase.

Health benefit exchanges are easy-to-use web sites that allow consumers and small businesses to compare plans to find the one that best meets their needs and their budget. A health insurance exchange has often been compared to online travel websites that allow consumers to evaluate flight, hotel or rental car information based on price, quality and other characteristics that are important to the consumer. The Heritage Foundation, a conservative think tank, has called the exchange concept an "innovative mechanism to promote real consumer choice" and compared the idea to a stock exchange, where a single market organizes the sale of equities and securities.

A state-based health insurance exchange holds great potential to

empower Nebraska consumers. With an economy that rests firmly on a foundation of small business, an exchange can offer simplified benefits management, more predictable costs, and more choice to small employers and their employees. While an exchange offers benefits for all consumers, our rural population stands to benefit the most, as rural Nebraskans are more likely to be uninsured, more likely to be employed by a small business that doesn't offer health benefits, and more likely to purchase their health insurance in the costly and unpredictable individual market.

Not only will an exchange provide consumers with more choices, but they also will be able to make better-informed choices among health insurance plans by comparing "apples-to-apples." Another advantage of an exchange is that it will allow consumers to "own" the plan, without fear of losing coverage as a result of a layoff or switching jobs. Combined with other insurance reforms in the ACA, the exchanges can eliminate the loopholes and technicalities that we all fear when purchasing health insurance — so the consumers know exactly what they are and are not buying.

Under the federal Affordable Care Act, the power to design and implement health insurance exchanges is wisely ceded to the states. Unfortunately, some opponents of health care reform are encouraging states to not move forward with a state-based approach. This inaction would require the federal government to step in and create an exchange for us, dictating the parameters of its operation. Rather than cede this power

back to the federal government, Nebraska should seize this opportunity and assert our state's right to implement our own health insurance exchange.

Because I firmly believe we should create a health insurance marketplace that is designed for Nebraskans by Nebraskans, I have been working with a diverse group of stakeholders to draft legislation that would achieve the great potential of a health insurance exchange in our state. This legislative session, I introduced Legislative Bill 835, which would create a governance board composed of consumers, small businesses, health care providers, health insurers and agents that would be responsible for collectively making the decisions about what an exchange should look like in Nebraska. LB 835 creates an open and transparent process, bringing knowledgeable stakeholders to the table, to give everyone a say in the future of our health insurance marketplace in Nebraska.

A state-based Nebraska health benefit exchange can bring greater choice, transparency, value and competition into our health insurance marketplace. An exchange can increase consumer choice and portability of health insurance. It can provide affordable options to small businesses to purchase private health insurance for their employees. And it can empower consumers to compare plans and make more informed decisions about their health care and coverage. Nebraska should take advantage of this opportunity to create a health insurance marketplace in Nebraska that competes on the basis of price, quality, service, and other innovative efforts. □



Nebraska Hospital Association Supports LB 835

by *Laura Redoutey*
President
Nebraska Hospital Association

I often encounter Nebraskans who have experienced tremendous benefits from the healthcare system. To a layman, these results are nothing short of miraculous. But as often as I hear stories about positive medical outcomes, I hear about frustration with the healthcare financing system.

The state of Nebraska faces a very important decision.

Will Nebraska maximize government start-up funds and create a sustainable program to ensure all Nebraskans have the same opportunity to have health insurance or will it leave itself without choices and vulnerable to decisions made in Washington?

In 2010, the Patient Protection and Affordable Care Act (PPACA) mandated the creation of health insurance exchanges to serve as the exclusive vehicle for providing subsidized insurance coverage to individuals and families with incomes of 133–400 percent of the federal poverty level (FPL).

When you consider that means a family of four making nearly \$90,000 and doesn't have health insurance would be eligible, private market health

insurance is put in the reach of hard-working Nebraskans who would go without otherwise.

According to the law, each state is required to establish an exchange by Jan. 1, 2014. If a state decides not to create an exchange, the federal government will step in and run a federal exchange.

As recently as the end of January, the governor has said he wants Nebraska to wait until the U.S. Supreme Court issues a ruling on health reform. Some expect that decision in June, but no one knows when the decision will be issued.

The simple truth is that Nebraska does not have time to wait in making this decision.

We must apply for the next round of federal grants by June 29, 2012 to receive an estimated \$60-85 million needed to build our health insurance exchange. Nebraskans are best suited for finding the best long-term exchange solution - not Washington. Nor should we be poor stewards of our tax payer's money by requiring a special session to address the health insurance exchange.

To protect hardworking taxpayers, this plan tasks an 11 member governing board to develop an exchange meeting the needs of patients, providers and taxpayers. It also creates a funding mecha-

nism that will help lower the cost for everyone that purchases their health insurance through the exchange. The board is comprised of consumers, small business, providers, carriers, agents and state representatives.

In its uncompromising commitment to ensure all Nebraskans have access to high quality health care the Nebraska Hospital Association (NHA) supports LB 835 and is committed to helping the Legislature advance this measure through the legislative process. This bill rises above politics; it has broad legislative support with 11 co-sponsors and extensive industry support, growing out of collaborative meetings with legislators, providers, payers and the state.

We encourage you to join our 89 member hospitals, their 43,000 employees and the more than 11,000 patients they provide care to each day in support of LB 835. Please contact your state senators to tell them LB 835 is the most responsible approach to developing a state-based health insurance exchange.

This piece first appeared in the Omaha World-Herald on February 20, 2012. □

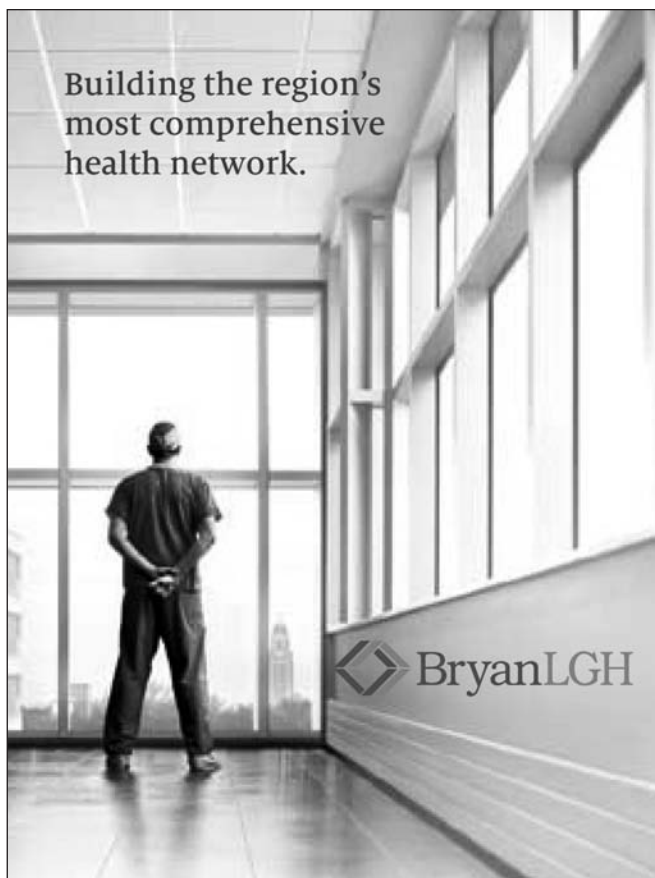


Making the Case for a State-based Health Insurance Exchange *(continued)*

The Court will issue its decision by late June. Governor Heineman has indicated that he would prefer to wait until the U. S. Supreme Court has ruled on the constitutionality issue before enacting state law. It is anticipated that HHS will delay the Level Two grant funding deadline set for

June 29 as there are time constraints between when the Supreme Court's opinion will be issued and the federal grant deadline. Until then, our policy-makers, the Nebraska Department of Insurance, and industry experts are hard at work collaborating on research, design and planning for an exchange.

EDITOR'S NOTE: For more information about a state-based health insurance exchange for Nebraska, visit: www.nebraskahealthcarealliance.org. Blue Cross and Blue Shield of Nebraska and the Nebraska Medical Association are partners of the Nebraska Health Care Alliance. □



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Using the Exchange to Improve Nebraskans' Health

(continued)

reporting among all plans and delivery options in the exchange will facilitate insurer competition on the basis of price and outcome-improving delivery innovations. Competition will enhance consumer choice among different care delivery options offered by the plans and among similar delivery options offered by different insurers on the basis of price, value, and quality. This information will moderate insurance premium growth and promote care quality;

- The ability to modify or adapt state purchasing decisions based upon consumer input and satisfaction reports; and
- The ability to accommodate a variety

of health delivery models under the exchange. This could include models such as patient-centered medical homes, community-centered medical homes, or transitional chronic care models.

Exchanges should be able to limit the number of plans available. Limiting the number of plans participating in the exchange can help reinforce several policy imperatives. It would set high standards, rather than a "least common denominator" approach that all can meet; it provides a strong basis for negotiation; it rewards with greater market share those plans that meet the highest standards; and it provides real choice for consumers rather than a

confusing array of options that complicate consumer decision-making.

Two bills have been introduced in the Unicameral that would authorize the establishment of a Nebraska health benefit exchange. Each includes concepts that deserve greater attention. As we consider those two bills during the legislative session, we need to make sure that we establish a basic framework for our exchange that promotes positive health care outcomes and that facilitates consumer selection of the plan that best meets his or her needs. In short, we need to establish a healthcare financing system that is worthy of medical practice. □

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Provided by the Foster Group

The winds of change are blowing and the gusts of uncertainty add an element of fear. Physicians today are experiencing an historical precipice – a defining moment. Never before has there been a greater struggle between the values of the profession and the economics of the business. Retaining patient trust and maintaining a viable business and livelihood requires physicians be successful at both. In the final analysis, the latter is completely dependent on the former.

Physicians, both prospective and existing, are giving serious consideration to their next steps. The reins are tightening. Scrutiny in the industry is at its peak. Costs are sky-rocketing. Government debt and fiscal policy are collapsing reimbursement rates. Healthcare reform further squeezes physicians' bottom line. The ONLY certainty is that things will continue to change and may get more difficult, financially.

Do the math . . . the majority of physicians indicate they lose money when seeing a Medicare patient. This patient population has never been more

numerous and will only grow as baby-boomers reach 65 and life-expectancies climb. Reimbursement rates, pressured by SGR legislation and US government fiscal challenges, are flat to downward-trending. Increasing numbers of physicians are electing to leave the profession and prospective physicians are discontinuing their pursuit of a medical career due to the current climate. Both place more patient volume on the physicians who remain. Healthcare reform and added regulation require more time be spent on business management, leaving less time available for patient care. Stress on those continuing to practice will likely increase. The picture is not a pretty one, for physicians or their patients.

Consider some empirical data collected through multiple industry studies over the past six months from the likes of Merritt Hawkins, Jackson & Coker and the American Medical Group Association:

- 29 percent of current residents would choose to go into another field instead of medicine, up from 18 percent only two years ago.
- 56 percent indicated they received no

formal instruction on medical business issues during medical training; 48 percent feel ill-prepared to handle the business side of medicine.

- 94 percent expressed a preference to work in communities of 50,000 people or more, leaving the vitality and health of our rural communities in potential peril.
- 52 percent of physicians who planned on retiring within the next five to ten years have changed those plans due to the economic downturn.
- Every geographic region across the country in 2010 suffered operating losses within the aggregate medical practice community.

Finding, and using, a voice of leadership and advocacy has never been more important at both professional and personal levels. The challenge of realizing goals, dreams and security in one's business and personal financial situation has never been greater. So, what's the answer? NMA and Foster Group are uniquely positioned to better equip you in this journey, bringing clarity, expertise, confidence and resolution. *Just raise your hand.* □



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