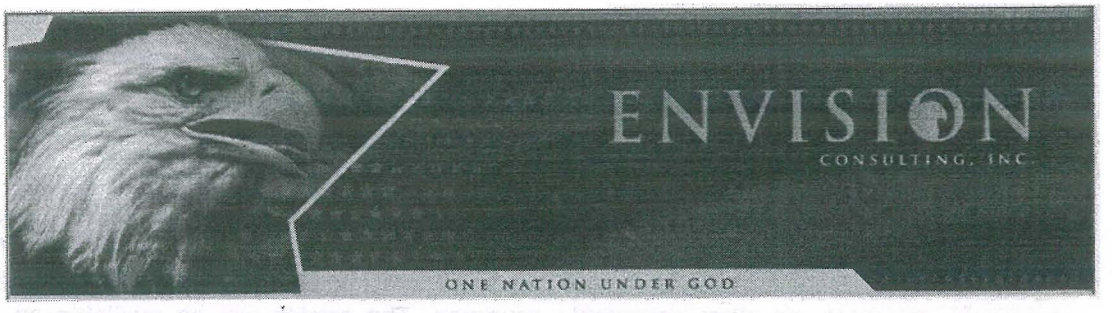

May 5, 2010

Dear Client,

I'm writing to give you a brief overview of the key tax changes affecting individuals in the recently enacted health reform legislation. Please call our offices for details of how the new changes may affect your specific situation.

Individual mandate. The new law contains an "individual mandate"—a requirement that U.S. citizens and legal residents have qualifying health coverage or be subject to a tax penalty after 2013. Under the new law, those without qualifying health coverage will pay a tax penalty of the greater of: (a) $695 per year, up to a maximum of three times that amount ($2,085) per family, or (b) 2.5% of household income over the threshold amount of income required for income tax return filing. The penalty will be phased in according to the following schedule: $95 in 2014, $325 in 2015, and $695 in 2016 for the flat fee or 1.0% of taxable income in 2014, 2.0% of taxable income in 2015, and 2.5% of taxable income in 2016. Beginning after 2016, the penalty will be increased annually by a cost-of-living adjustment. Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, aliens not lawfully present in the U.S., incarcerated individuals, those for whom the lowest cost plan option exceeds 8% of household income, those with incomes below the tax filing threshold (in 2010 the threshold for taxpayers under age 65 is $9,350 for singles and $18,700 for couples), and those residing outside of the U.S.

Premium assistance tax credits for purchasing health insurance. The health care legislation provides tax credits to low and middle income individuals and families for the purchase of health insurance. Specifically, for tax years ending after 2013, the new law creates a refundable tax credit (the "premium assistance credit") for eligible individuals and families who purchase health insurance through an Exchange. The premium assistance credit, which is refundable and payable in advance directly to the insurer, subsidizes the purchase of certain health insurance plans through an Exchange. Under the provision, an eligible individual enrolls in a plan offered through an Exchange and reports his or her income to the Exchange. Based on the information provided to the Exchange, the individual receives a premium assistance credit based on income and IRS pays the premium assistance credit amount directly to the insurance plan in which the individual is enrolled. The individual then pays to the plan in which he or she is enrolled the dollar difference between the premium assistance credit amount and the total

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premium charged for the plan. For employed individuals who purchase health insurance through an Exchange, the premium payments are made through payroll deductions.

The premium assistance credit will be available for individuals and families with incomes up to 400% of the federal poverty level ($43,320 for an individual or $88,200 for a family of four, using 2009 poverty level figures) that are not eligible for Medicaid, employer sponsored insurance, or other acceptable coverage. The credits will be available on a sliding scale basis.

Higher Medicare taxes on high-income taxpayers. High-income taxpayers will be subject to a tax increase on wages and a new levy on investments.

Higher Medicare payroll tax on wages. The Medicare payroll tax is the primary source of financing for Medicare's hospital insurance trust fund, which pays hospital bills for beneficiaries, who are 65 and older or disabled. Under current law, wages are subject to a 2.9% Medicare payroll tax. Workers and employers pay 1.45% each. Self-employed people pay both halves of the tax (but are allowed to deduct half of this amount for income tax purposes). Unlike the payroll tax for Social Security, which applies to earnings up to an annual ceiling ($106,800 for 2010), the Medicare tax is levied on all of a worker's wages without limit. Under the provisions of the new law, which take effect in 2013, most taxpayers will continue to pay the 1.45% Medicare hospital insurance tax, but single people earning more than $200,0000 and married couples earning more than $250,000 will be taxed at an additional 0.9% (2.35% in total) on the excess over those base amounts. Self-employed persons will pay 3.8% on earnings over the threshold.

Medicare payroll tax extended to investments. Under current law, the Medicare payroll tax only applies to wages. Beginning in 2013, a Medicare tax will, for the first time, be applied to investment income. A new 3.8% tax will be imposed on net investment income of single taxpayers with AGI above $200,000 and joint filers over $250,000. Net investment income is interest, dividends, royalties, rents, gross income from a trade or business involving passive activities, and net gain from disposition of property (other than property held in a trade or business). Net investment income is reduced by properly allocable deductions to such income. However, the new tax won't apply to income in tax-deferred retirement accounts such as 401(k) plans. Also, the new tax will apply only to income in excess of the $200,000/$250,000 thresholds. So if a couple earns $200,000 in wages and $100,000 in capital gains, $50,000 will be subject to the new tax.

Floor on medical expenses deduction raised from 7.5% of adjusted gross income (AGI) to 10%. Under current law, taxpayers can take an itemized deduction for unreimbursed medical expenses for regular income tax purposes only to the extent that those expenses exceed 7.5% of the taxpayer's AGI. The new law raises the floor beneath itemized medical expense deductions from 7.5% of AGI to 10%, effective for tax years beginning after Dec. 31, 2012. The AGI floor for individuals age 65 and older (and their spouses) will remain unchanged at 7.5% through 2016.

Limit reimbursement of over-the-counter medications from HSAs, FSAs, and MSAs. The new law excludes the costs for over-the-counter drugs not prescribed by a

doctor from being reimbursed through a health reimbursement account (HRA) or health flexible savings accounts (FSAs) and from being reimbursed on a tax-free basis through a health savings account (HSA) or Archer Medical Savings Account (MSA), effective for tax years beginning after Dec. 31, 2010.

Increased penalties on nonqualified distributions from HSAs and Archer MSAs. The new law increases the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20% (from 10% for HSAs and from 15% for Archer MSAs) of the disbursed amount, effective for distributions made after Dec. 31, 2010.

Limit health flexible spending arrangements (FSAs) to $2,500. An FSA is one of a number of tax-advantaged financial accounts that can be set up through a cafeteria plan of an employer. An FSA allows an employee to set aside a portion of his or her earnings to pay for qualified expenses as established in the cafeteria plan, most commonly for medical expenses but often for dependent care or other expenses. Under current law, there is no limit on the amount of contributions to an FSA. Under the new law, however, allowable contributions to health FSAs will capped at $2,500 per year, effective for tax years beginning after Dec. 31, 2012. The dollar amount will be indexed for inflation after 2013.

Dependent coverage in employer health plans. Effective on Mar. 30, 2010, the new law extends the general exclusion for reimbursements for medical care expenses under an employer-provided accident or health plan to any child of an employee who has not attained age 27 as of the end of the tax year. This change is also intended to apply to the exclusion for employer-provided coverage under an accident or health plan for injuries or sickness for such a child. A parallel change is made for VEBAs and 401(h) accounts. Also, self-employed individuals are permitted to take a deduction for the health insurance costs of any child of the taxpayer who has not attained age 27 as of the end of the tax year.

Excise tax on indoor tanning services. The new law imposes a 10% excise tax on indoor tanning services. The tax, which will be paid by the individual on whom the tanning services are performed but collected and remitted by the person receiving payment for the tanning services, will take effect July 1, 2010.

Liberalized adoption credit and adoption assistance rules. For tax years beginning after Dec. 31, 2009, the adoption tax credit is increased by $1,000, made refundable, and extended through 2011. The adoption assistance exclusion is also increased by $1,000.

I hope this information is helpful. If you would like more details about these provisions or any other aspect of the new law, please do not hesitate to call.

Very truly yours,

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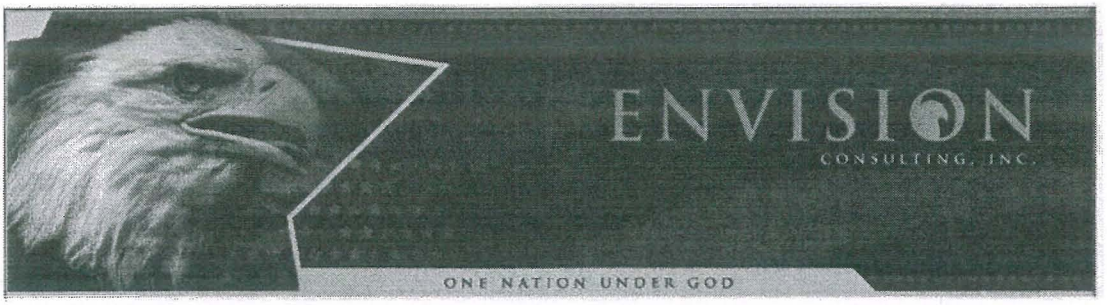

May 5, 2010

Dear Client,

The recently enacted health overhaul legislation requires certain employers to offer and contribute to their workers' health insurance or pay a penalty. Under the new law, effective for months beginning after Dec. 31, 2013, a large employer that does not offer coverage for all its full-time employees, offers minimum essential coverage that is unaffordable, or offers minimum essential coverage that consists of a plan under which the plan's share of the total allowed cost of benefits is less than 60%, is required to pay a penalty if any full-time employee is certified to the employer as having purchased health insurance through a state exchange with respect to which a tax credit or cost-sharing reduction is allowed or paid to the employee. Here are the details:

Who is subject to the employer mandate? Only an "applicable large employer," defined as someone who employed an average of at least 50 full-time employees during the preceding calendar year, is subject to the requirement to offer coverage. Most small businesses, since they have fewer than 50 employees, are thus exempt from the employer requirement. In counting the number of employees for purposes of determining whether an employer is an applicable large employer, a full-time employee (meaning, for any month, an employee working an average of at least 30 hours or more each week) is counted as one employee and all other employees are counted on a pro-rated basis. However, even an employer with 50 or more employees isn't subject to the penalty for not offering coverage if the employer doesn't have any full-time employees who are certified to the employer as having purchased health insurance through a state exchange with respect to which a tax credit or cost-sharing reduction is allowed or paid to the employee. In other words, if an employer doesn't have any full-time employees who have a lower income that might qualify him or her to receive a subsidy when purchasing a health plan in the proposed health insurance exchange, the employer will not pay a "pay or play" penalty.

Penalty for employers not offering coverage. An applicable large employer who fails to offer its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an employer-sponsored plan for any month is subject to a penalty if at least one of its full-time employees is certified to the employer as having enrolled in health insurance coverage purchased through a state exchange with respect to which a premium tax credit or cost-sharing reduction is allowed or paid to the employee. The penalty for any month is an excise tax equal to the number of full-time employees over a 30-employee threshold during the applicable month (regardless of how many employees are receiving a premium tax credit or cost-sharing reduction) multiplied by one-twelfth of $2,000. For example, if an employer fails to offer minimum essential coverage and has 60 full-time employes, ten of whom receive a tax credit for the year for enrolling in a state exchange-offered plan, the employer will owe $2,000 for each employee over the 30-employee threshold, for a total penalty of $60,000 ($2,000 multiplied by 30 (60 minus 30)). This penalty is assessed on a monthly basis.

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Penalty for employers that offer coverage but have at least one employee receiving a premium tax credit. An applicable large employer who offers coverage but has at least one full-time employee receiving a premium tax credit or cost-sharing reduction is subject to a penalty. The penalty is an excise tax that is imposed for each employee who receives a premium tax credit or cost-sharing reduction for health insurance purchased through a state exchange. For each full-time employee receiving a premium tax credit or cost-sharing subsidy through a state exchange for any month, the employer is required to pay an amount equal to one-twelfth of $3,000. The penalty for each employer for any month is capped at an amount equal to the number of full-time employees during the month (regardless of how many employees are receiving a premium tax credit or cost-sharing reduction) in excess of 30, multiplied by one-twelfth of $2,000. For example, if an employer offers health coverage and has 60 full-time employees, 15 of whom receive a tax credit for the year for enrolling in a state exchange-offered plan, the employer will owe a penalty of $3,000 for each employee receiving a tax credit, for a total penalty of $45,000. The maximum penalty for this employer is capped at the amount of the penalty that it would have been assessed for a failure to provide coverage, or $60,000 ($2,000 multiplied by 30 (60 minus 30)). Since the calculated penalty of $45,000 is less than the maximum amount, the employer pays the $45,000 calculated penalty. This penalty is assessed on a monthly basis.

Requirement to offer "free choice vouchers." After 2013, employers offering minimum essential coverage through an eligible employer-sponsored plan and paying a portion of that coverage will have to provide qualified employees with a voucher whose value could be applied to purchase of a health plan through the Insurance Exchange. Qualified employees would be those employees: who do not participate in the employer's health plan; whose required contribution for employer sponsored minimum essential coverage exceeds 8%, but does not exceed 9.8% of household income; and whose total household income does not exceed 400% of the poverty line for the family. The value of the voucher would be equal to the dollar value of the employer contribution to the employer offered health plan. Employers providing free choice vouchers will not be subject to penalties for employees that receive a voucher.

I hope this information is helpful. If you would like more details about these provisions or any other aspect of the new law, please do not hesitate to call.

Very truly yours,

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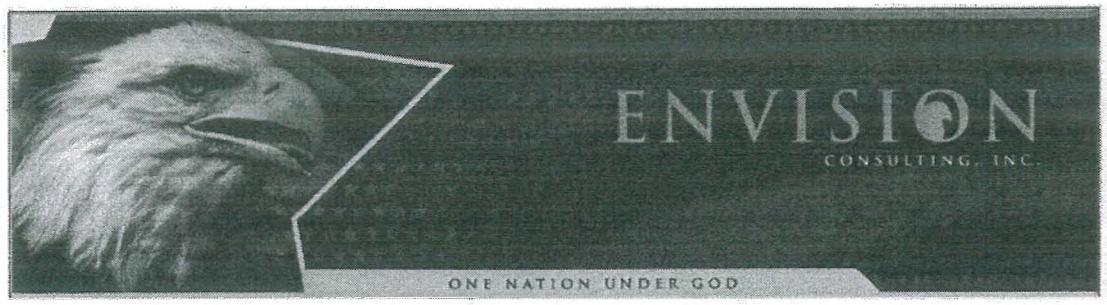

May 5, 2010

Dear Client,

For owners of small businesses and their workers, the recently enacted health reform legislation has some key provisions to pay attention to. The major ones include: tax credits; excise taxes; and penalties. But whether a business will be affected by them depends on a variety of factors, such as the number of employees the business has. I'm writing to give you an overview of the provisions in the new law with the biggest impact on small business. Please call our offices for details of how the new changes may affect your specific business.

Tax credits to certain small employers that provide insurance. The new law provides small employers with a tax credit (i.e., a dollar-for-dollar reduction in tax) for nonelective contributions to purchase health insurance for their employees. The credit can offset an employer's regular tax or its alternative minimum tax (AMT) liability.

Small business employers eligible for the credit. To qualify, a business must offer health insurance to its employees as part of their compensation and contribute at least half the total premium cost. The business must have no more than 25 full-time equivalent employees ("FTEs"), and the employees must have annual full-time equivalent wages that average no more than $50,000. However, the full amount of the credit is available only to an employer with 10 or fewer FTEs and whose employees have average annual full-time equivalent wages from the employer of less than $25,000.

Years the credit is available. The credit is initially available for any tax year beginning in 2010, 2011, 2012, or 2013. Qualifying health insurance for claiming the credit for this first phase of the credit is health insurance coverage purchased from an insurance company licensed under state law. For tax years beginning after 2013, the credit is only available to an eligible small employer that purchases health insurance coverage for its employees through a state exchange and is only available for two years. The maximum two-year coverage period does not take into account any tax years beginning in years before 2014. Thus, an eligible small employer could potentially qualify for this credit for six tax years, four years under the first phase and two years under the second phase.

Calculating the amount of the credit. For tax years beginning in 2010, 2011, 2012, or 2013, the credit is generally 35% (50% for tax years beginning after 2013) of the employer's nonelective contributions toward the employees' health insurance premiums. The credit phases out as firm-size and average wages increase.

Special rules. The employer is entitled to an ordinary and necessary business expense deduction equal to the amount of the employer contribution minus the dollar amount of the credit. For example, if an eligible small employer pays 100% of the cost of its employees' health insurance coverage and the amount of the tax credit is 50% of that cost (i.e., in tax years beginning after 2013), the employer can claim a deduction for the other 50% of the premium cost.

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Self-employed individuals, including partners and sole proprietors, two percent shareholders of an S corporation, and five percent owners of the employer are not treated as employees for purposes of this credit. There is also a special rule to prevent sole proprietorships from receiving the credit for the owner and their family members. Thus, no credit is available for any contribution to the purchase of health insurance for these individuals and the individual is not taken into account in determining the number of full-time equivalent employees or average full-time equivalent wages.

Most small businesses exempted from penalties for not offering coverage to their employees. Although the new law imposes penalties on certain businesses for not providing coverage to their employees (so-called "pay or play"), most small businesses won't have to worry about this provision because employers with fewer than 50 employees aren't subject to the "pay or play" penalty. For businesses with at least 50 employees, the possible penalties vary depending on whether or not the employer offers health insurance to its employees. If it does not offer coverage and it has at least one full-time employee who receives a premium tax credit, the business will be assessed a fee of $2,000 per full-time employee, excluding the first 30 employees from the assessment. So, for example, an employer with 51 employees who doesn't offer health insurance to his employees will be subject to a penalty of $42,000 ($2,000 multiplied by 21). Employers with at least 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit will pay $3,000 for each employee receiving a premium credit (capped at the amount of the penalty that the employer would have been assessed for a failure to provide coverage, or $2,000 multiplied by the number of its full-time employees in excess of 30). These provisions take effect Jan. 1, 2014.

The "Cadillac tax" on high-cost health plans. The new law places an excise tax on high-cost employer-sponsored health coverage (often referred to as "Cadillac" health plans). This is a 40% excise tax on insurance companies, based on premiums that exceed certain amounts. The tax is not on employers themselves unless they are self-funded (this typically occurs at larger firms). However, it is expected that employers and workers will ultimately bear this tax in the form of higher premiums passed on by insurers.

Here are the specifics: The new tax, which applies for tax years beginning after Dec. 31, 2017, places a 40% nondeductible excise tax on insurance companies and plan administrators for any health coverage plan to the extent that the annual premium exceeds $10,200 for single coverage and $27,500 for family coverage. An additional threshold amount of $1,650 for single coverage and $3,450 for family coverage will apply for retired individuals age 55 and older and for plans that cover employees engaged in high risk professions. The tax will apply to self-insured plans and plans sold in the group market, but not to plans sold in the individual market (except for coverage eligible for the deduction for self-employed individuals). Stand-alone dental and vision plans will be disregarded in applying the tax. The dollar amount thresholds will be automatically increased if the inflation rate for group medical premiums between 2010 and 2018 is higher than projected. Employers with age and gender demographics that result in higher premiums could value the coverage provided to employees using the rates that would apply using a national risk pool. The excise tax will be levied at the insurer level. Employers will be required to aggregate the coverage subject to the limit and issue information returns for insurers indicating the amount subject to the excise tax.

I hope this information is helpful. If you would like more details about these provisions or any other aspect of the new law, please do not hesitate to call.

Very truly yours,

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Special Feature

American Medical Group Association[1] | Cejka Search | Daniel Stern & Associates | Delta Physician Placement | Hay Group | Hospital & Healthcare Compensation Service | Jackson & Coker | LocumTenens.com | Martin, Fletcher

ANESTHESIOLOGY

Compensation ranges from $327,600 to $413,806

		% change 2008-09
MGMA	$413,806	3.5%
Cejka	$387,000	(1.3)
Medicus	$382,000	3.0
AMGA	$370,107	2.0
Locum	$355,264	5.6
Martin	$350,000	(5.7)
HHCS	$347,887	(22.2)
Sullivan	$347,819	2.6
Merritt	$344,000	2.4
Jackson	$342,628	(5.4)
Delta	$337,800	5.0
Pacific	$337,195	(7.4)
Hay	$327,600	5.1
Daniel	NA	NA

CARDIOLOGY (invasive)

Compensation ranges from $387,600 to $496,068

		% change 2008-09
HHCS	$496,068	2.4%
MGMA	$482,858	5.7
Merritt	$475,000	7.2
Medicus	$464,000	(1.1)
Sullivan	$463,694	25.4
Delta	$461,211	NA
Martin	$450,000	(4.1)
Cejka	$435,000	11.8
Pacific	$421,356	(15.1)
Hay	$387,600	(3.4)
AMGA	NA	NA
Daniel	NA	NA
Jackson	NA	NA
Locum	NA	NA

EMERGENCY MEDICINE

Compensation ranges from $224,200 to $327,384

		% change 2008-09
Pacific	$327,384	21.3%
HHCS	$300,906	10.5
AMGA	$282,856	5.8
Cejka	$274,000	9.6
Jackson	$260,790	1.2
MGMA	$258,292	0
Sullivan	$252,820	9.9
Daniel	$252,690	1.1
Delta	$251,553	2.7
Locum	$251,342	NA
Martin	$250,000	6.4
Medicus	$247,000	3.3
Merritt	$244,000	1.7
Hay	$224,200	3.4

FAMILY PRACTICE

Compensation ranges from $166,848 to $212,032

		% change 2008-09
AMGA	$212,032	5.1%
HHCS	$191,612	(6.2)
Sullivan	$189,907	14.6
Jackson	$187,953	8.9
Medicus	183,000	4.0
MGMA	$181,944	3.4
Martin	$178,000	7.9
Delta	$177,083	5.2
Pacific	$176,089	1.5
Merritt	$173,000	0
Hay	$172,500	5.5
Cejka	$170,000	0
Locum	$166,848	10.7
Daniel	NA	NA

HOSPITALIST

Compensation ranges from $183,200 to $226,902

		% change 2008-09
AMGA	$226,902	4.5%
Pacific	$212,891	(1.0)
HHCS	$211,805	4.1
MGMA	$206,875	6.3
Cejka	$205,000	3.5
Merritt	$201,000	11.0
Jackson	$200,831	9.0
Delta	$200,387	4.4
Medicus	$194,000	1.6
Sullivan	$192,820	7.1
Martin	$192,000	5.5
Hay	$183,200	5.2
Daniel	NA	NA
Locum	NA	NA

INTENSIVIST

Compensation ranges from $255,874 to $299,023

		% change 2008-09
Pacific	$299,023	NA
Jackson	$297,555	NA
AMGA	$266,961	NA
Sullivan	$255,874	0%
Cejka	NA	NA
Daniel	NA	NA
Delta	NA	NA
Hay	NA	NA
HHCS	NA	NA
Locum	NA	NA
Martin	NA	NA
Medicus	NA	NA
Merritt	NA	NA
MGMA	NA	NA

Note: Figures represent average total annual cash compensation, which includes salary and bonuses. Percentages rounded. Zero percentage change indicates increase or decrease of less than 1%. NA=Not available.

[1]Company provided preliminary data. [2]Company provided medians, not averages.

OBSTETRICS/GYNECOLOGY

Compensation ranges from $240,700 to $321,746

		% change 2008-09
AMGA	$321,746	5.6%
HHCS	$312,990	19.5
Jackson	$302,362	16.5
Medicus	$291,000	1.7
MGMA	$285,812	1.8
Delta	$277,705	9.7
Martin	$275,000	3.8
Cejka	$269,000	10.7
Merritt	$266,000	4.3
Pacific	$256,921	(10.6)
Sullivan	$252,778	16.0
Locum	$252,477	9.1
Hay	$240,700	0
Daniel	NA	NA

ONCOLOGY (including hematology)

Compensation ranges from $301,820 to $408,000

		% change 2008-09
Medicus	$408,000	0%
Martin	$375,000	20.0
Hay	$374,100	26.2
[illegible]	[illegible]	2.6
Delta	$362,105	4.7
AMGA	$357,246	3.4
Jackson	$353,070	NA
Sullivan	$341,311	19.0
Cejka	$337,000	(6.6)
Merritt	$335,000	(8.2)
Pacific	$302,183	(1.2)
HHCS	$301,820	(16.0)
Daniel	NA	NA
Locum	NA	NA

PEDIATRICS

Compensation ranges from $150,000 to $217,000

		% change 2008-09
AMGA	$217,000	7.1%
HHCS	$208,814	17.8
Jackson	$196,936	16.2
Cejka	$187,000	1.6
MGMA	$186,641	2.1
Medicus	$185,000	6.3
Sullivan	$182,052	10.6
Pacific	$178,052	(7.2)
Delta	$177,712	3.1
Merritt	$171,000	7.5
Locum	$165,805	7.4
Martin	$150,000	7.1
Daniel	NA	NA
Hay	NA	NA

PLASTIC SURGERY

Compensation ranges from $327,000 to $445,575

		% change 2008-09
HHCS	$445,575	(43.7%)
AMGA	$426,884	9.2
Cejka	$425,000	21.4
Hay	$384,200	(1.6)
MGMA	$371,669	0
Pacific	$353,622	(5.0)
Sullivan	$341,971	(3.7)
Merritt	$327,000	4.8
Daniel	NA	NA
Delta	NA	NA
Jackson	NA	NA
Locum	NA	NA
Martin	NA	NA
Medicus	NA	NA

RADIOLOGY

Compensation ranges from $391,000 to $483,000

		% change 2008-09
Medicus	$483,000	(1.6%)
Jackson	$470,939	6.6
AMGA	$461,863	5.4
MGMA	$457,081	(2.0)
Martin	$450,000	4.0
Cejka	$438,000	9.2
Delta	$434,884	1.2
HHCS	$434,126	(11.0)
Pacific	$429,610	(9.1)
Sullivan	$427,723	6.9
Hay	$400,700	(4.2)
Locum	$395,571	2.3
Merritt	$391,000	(2.5)
Daniel	NA	NA

UROLOGY

Compensation ranges from $328,846 to $502,311

		% change 2008-09
Jackson	$502,311	47.5%
HHCS	$434,787	12.6
Medicus	$421,000	3.4
AMGA	$410,832	0
Merritt	$401,000	3.6
Cejka	$400,000	4.7
Martin	$400,000	(2.4)
[illegible]	[illegible]	(2.1)
MGMA	[illegible]	(1.3)
Delta	$377,286	(1.5)
Sullivan	$371,686	6.2
Hay	$336,100	3.4
Locum	$328,846	NA
Daniel	NA	NA

Source: Modern Healthcare's 2009 Physician Compensation Survey

■ Medical Group Management Association[1,2]
■ Medicus Partners
□ Merritt, Hawkins & Associates
■ Pacific Companies
▨ Sullivan Cotter & Associates[1]

CARDIOLOGY (noninvasive)

Compensation ranges from $342,840 to $432,498

		% change 2008-09
AMGA	$432,498	2.9%
MGMA	$427,708	4.1
Merritt	$419,000	6.9
Jackson	$418,451	12.3
Cejka	$390,000	6.8
Martin	$375,000	(1.3)
Sullivan	$373,179	2.7
Pacific	$369,830	(2.7)
Hay	$366,200	10.0
HHCS	$342,840	(12.2)
Daniel	NA	NA
Delta	NA	NA
Locum	NA	NA
Medicus	NA	NA

DERMATOLOGY

Compensation ranges from $297,000 to $401,613

		% change 2008-09
HHCS	$401,613	39.5%
Jackson	$400,834	21.7
AMGA	$393,675	5.9
Martin	[illegible]	(4.9)
MGMA	$355,847	0
Delta	$345,083	(5.5)
Sullivan	$338,605	20.0
Cejka	$320,000	(1.8)
Hay	$317,200	7.6
Merritt	$297,000	(5.7)
Daniel	NA	NA
Locum	NA	NA
Martin	NA	NA
Medicus	NA	NA

GASTROENTEROLOGY

Compensation ranges from $358,300 to $478,000

		% change 2008-09
Medicus	$478,000	0%
Pacific	$452,647	(9.2)
Jackson	$451,625	13.9
MGMA	$449,014	7.4
AMGA	$428,640	1.8
Martin	$420,000	2.4
Delta	$407,480	6.8
Merritt	$393,000	3.7
Cejka	$390,000	18.2
HHCS	$364,481	(4.0)
Sullivan	$363,423	6.1
Hay	$358,300	0
Daniel	NA	NA
Locum	NA	NA

GENERAL SURGERY

Compensation ranges from $287,520 to $369,898

		% change 2008-09
AMGA	$369,898	3.6%
HHCS	$353,661	5.0
Sullivan	$339,585	21.0
Jackson	$339,362	9.9
Medicus	$328,000	3.8
Martin	$325,000	2.2
Cejka	$324,000	19.6
Merritt	$321,000	0
MGMA	$320,287	1.1
Hay	$311,500	8.7
Delta	$310,781	3.0
Pacific	$306,512	1.8
Locum	$287,520	1.2
Daniel	NA	NA

INTERNAL MEDICINE

Compensation ranges from $179,958 to $222,377

		% change 2008-09
AMGA	$222,377	6.0%
HHCS	$214,928	13.1
Pacific	$208,160	7.8
Jackson	$201,603	11.1
Cejka	$201,000	9.2
Medicus	$197,000	5.3
Sullivan	$195,743	15.1
MGMA	$191,221	0
Delta	$187,951	2.2
Merritt	$186,000	5.7
Martin	[illegible]	(6.0)
Hay	[illegible]	4.7
Locum	$179,958	0
Daniel	NA	NA

NEONATOLOGY

Compensation ranges from $230,900 to $290,006

		% change 2008-09
Pacific	$290,006	NA
AMGA	$286,346	NA
Sullivan	$261,893	16.0%
Cejka	$235,000	NA
Hay	$230,900	NA
Daniel	NA	NA
Delta	NA	NA
HHCS	NA	NA
Jackson	NA	NA
Locum	NA	NA
Martin	NA	NA
Medicus	NA	NA
Merritt	NA	NA
MGMA	NA	NA

Source: Modern Healthcare's 2009 Physician Compensation Survey

- American Medical Group Association[1]
- Cejka Search
- Daniel Stern & Associates
- Delta Physician Placement
- Hay Group
- Hospital & Healthcare Compensation Service
- Jackson & Coker
- LocumTenens.com
- Martin, Fletcher
- Medical Group Management Association[1,2]
- Medicus Partners
- Merritt, Hawkins & Associates
- Pacific Companies
- Sullivan Cotter & Associates[1]

NEUROLOGY

Compensation ranges from $211,500 to $295,342

		% change 2008-09
Pacific	$295,342	(1.1%)
Merritt	$258,000	12.2
Cejka	$226,872	16.4
Jackson	$255,000	(5.1)
AMGA	$251,363	1.1
Medicus	$249,634	3.3
Martin	$249,000	NC
Delta	$245,000	0
MGMA	$244,064	3.6
HHCS	$235,881	(10.2)
Sullivan	$221,338	7.0
Hay	$215,300	6.0
Locum	$211,500	NA
Daniel	NA	NA

ORTHOPEDIC SURGERY

Compensation ranges from $363,600 to $615,637

		% change 2008-09
HHCS	$615,637	37.4%
AMGA	$512,938	6.1
Medicus	$508,000	1.2
Delta	$493,678	(2.5)
Merritt	$481,000	16.5
Jackson	$462,658	9.5
Martin	[illegible]	6.4
Pacific	[illegible]	2.1
Cejka	$445,000	11.0
Daniel	[illegible]	(6.3)
Sullivan	$423,722	1.9
Locum	$395,163	5.6
Hay	$363,600	(2.4)
Daniel	NA	NA

PATHOLOGY

Compensation ranges from $223,739 to $334,192

		% change 2008-09
AMGA	$334,192	7.4%
MGMA	$310,093	0
Cejka	$298,000	0
Sullivan	$295,441	41.7
Merritt	$283,000	18.4
HHCS	$278,866	(16.0)
Hay	$264,700	5.2
Pacific	$223,739	(17.0)
Daniel	NA	NA
Delta	NA	NA
Jackson	NA	NA
Locum	NA	NA
Martin	NA	NA
Medicus	NA	NA

PSYCHIATRY

Compensation ranges from $184,908 to $232,084

		% change 2008-09
Pacific	$232,084	(6.5%)
AMGA	$221,889	2.6
Cejka	$215,000	2.4
Delta	$214,203	3.4
Locum	$201,683	10.1
Medicus	$201,000	(2.0)
Jackson	$200,518	3.8
Merritt	$200,000	5.8
MGMA	$197,598	2.8
Martin	$195,000	7.1
HHCS	$190,202	0
Hay	$187,000	7.6
Sullivan	$184,908	8.8
Daniel	NA	NA

RADIATION ONCOLOGY

Compensation ranges from $377,800 to $501,258

		% change 2008-09
MGMA	$501,258	8.2%
Martin	$475,000	NA
Cejka	$457,000	0
AMGA	$424,555	7.7
[illegible]	[illegible]	(6.0)
HHCS	$391,857	2.7
Sullivan	$385,752	3.8
Hay	$377,800	(18.4)
Daniel	NA	NA
Delta	NA	NA
Jackson	NA	NA
Locum	NA	NA
Medicus	NA	NA
Merritt	NA	NA

Note: Figures represent average total annual cash compensation, which includes salary and bonuses.
Percentages rounded. Zero percentage change indicates increase or decrease of less than 1%. NA=Not available.
[1]Company provided preliminary data. [2]Company provided medians, not averages.

Table 1.8 Physician Compensation (More than 1 Year in Specialty) by Geographic Section for Single Specialty Practices

Specialty	Midwest				
	Mean	Std. Dev.	25th %tile	Median	75th %tile
Allergy/Immunology	*	*	*	*	*
Anesthesiology	$443,048	$216,246	$355,055	$437,135	$539,370
Anesthesiology: Pain Management	$415,935	$190,378	$300,000	$389,582	$533,555
Anesthesiology: Pediatric	*	*	*	*	*
Cardiology: Electrophysiology	$557,355	$191,723	$391,507	$561,414	$665,994
Cardiology: Invasive	$474,501	$149,713	$404,505	$445,020	$516,673
Cardiology: Inv-Intvl	$543,751	$264,585	$376,214	$480,107	$643,702
Cardiology: Noninvasive	$470,907	$162,416	$370,928	$470,144	$598,524
Critical Care: Intensivist	*	*	*	*	*
Dentistry	*	*	*	*	*
Dermatology	$553,278	$263,787	$366,895	$546,075	$680,340
Dermatology: Mohs Surgery	*	*	*	*	*
Emergency Medicine	$315,070	$118,222	$236,598	$338,065	$410,132
Endocrinology/Metabolism	*	*	*	*	*
Family Practice (w/ OB)	$227,855	$75,414	$167,807	$209,527	$279,620
Family Practice (w/o OB)	$200,985	$87,583	$135,395	$179,281	$251,889
Family Practice: Amb Only (no inpatient work)	*	*	*	*	*
Family Practice: Sports Med	*	*	*	*	*
Gastroenterology	$506,048	$275,449	$384,383	$517,940	$606,458
Gastroenterology: Hepatology	*	*	*	*	*
Genetics	*	*	*	*	*
Geriatrics	*	*	*	*	*
Hematology/Oncology	$677,050	$411,271	$401,290	$694,041	$1,130,947
Hematology/Oncology: Onc (only)	*	*	*	*	*
Hospice/Palliative Care	*	*	*	*	*
Hospitalist: Family Practice	*	*	*	*	*
Hospitalist: Internal Medicine	$211,630	$44,803	$185,126	$209,958	$245,045
Hospitalist: IM-Pediatric	*	*	*	*	*
Hospitalist: Pediatric	*	*	*	*	*
Infectious Disease	*	*	*	*	*
Internal Medicine: General	$197,500	$68,210	$142,839	$182,453	$253,278
Internal Medicine: Amb Only (no inpatient work)	*	*	*	*	*
Internal Medicine: Pediatric	*	*	*	*	*
Nephrology	*	*	*	*	*
Neurology	$326,609	$106,917	$253,095	$312,000	$381,054
Obstetrics/Gynecology: General	$305,586	$111,643	$220,000	$288,955	$383,675
OB/GYN: Gynecology (only)	*	*	*	*	*
OB/GYN: Gyn Oncology	*	*	*	*	*
OB/GYN: Maternal & Fetal Med	*	*	*	*	*
OB/GYN: Repro Endocrinology	*	*	*	*	*
OB/GYN: Urogynecology	*	*	*	*	*
Occupational Medicine	*	*	*	*	*
Ophthalmology	$417,226	$220,436	$297,990	$348,969	$412,921
Ophthalmology: Corn & Ref Surg	*	*	*	*	*
Ophthalmology: Pediatric	*	*	*	*	*
Ophthalmology: Retina	*	*	*	*	*
Orthopedic (Nonsurgical)	*	*	*	*	*
Orthopedic Surgery: General	$566,032	$238,489	$390,195	$528,484	$731,185
Orthopedic Surgery: Foot & Ankle	$560,587	$276,409	$276,927	$529,182	$699,841
Orthopedic Surgery: Hand	$637,122	$323,647	$396,676	$569,563	$853,776
Orthopedic Surgery: Hip & Joint	$611,124	$313,769	$376,009	$527,659	$796,032
Orthopedic Surgery: Pediatric	*	*	*	*	*
Orthopedic Surgery: Spine	$901,876	$654,572	$381,394	$740,685	$1,040,527
Orthopedic Surgery: Trauma	*	*	*	*	*
Orthopedic Surgery: Sports Med	$831,697	$329,250	$639,333	$843,099	$1,032,257

Table 1.8 Physician Compensation (More than 1 Year in Specialty) by Geographic Section for Single Specialty Practices

Specialty	Midwest				
	Mean	Std. Dev.	25th %tile	Median	75th %tile
Otorhinolaryngology	$337,705	$157,889	$225,172	$321,485	$393,412
Otorhinolaryngology: Pediatric	*	*	*	*	*
Pain Management: Nonanesthesia	*	*	*	*	*
Pathology: Anatomic & Clinical	$378,757	$219,138	$242,125	$342,553	$376,454
Pathology: Anatomic	*	*	*	*	*
Pathology: Clinical	*	*	*	*	*
Pediatrics: General	$210,333	$95,291	$139,537	$188,189	$277,934
Pediatrics: Adolescent Medicine	*	*	*	*	*
Pediatrics: Cardiology	*	*	*	*	*
Pediatrics: Child Development	*	*	*	*	*
Pediatrics: Critical Care/Intensivist	*	*	*	*	*
Pediatrics: Emergency Medicine	*	*	*	*	*
Pediatrics: Endocrinology	*	*	*	*	*
Pediatrics: Gastroenterology	*	*	*	*	*
Pediatrics: Genetics	*	*	*	*	*
Pediatrics: Hematology/Oncology	*	*	*	*	*
Pediatrics: Infectious Disease	*	*	*	*	*
Pediatrics: Neonatal Medicine	*	*	*	*	*
Pediatrics: Nephrology	*	*	*	*	*
Pediatrics: Neurology	*	*	*	*	*
Pediatrics: Pulmonology	*	*	*	*	*
Pediatrics: Urgent Care	*	*	*	*	*
Physiatry (Phys Med & Rehab)	$302,353	$181,974	$174,650	$216,892	$416,147
Podiatry: General	*	*	*	*	*
Podiatry: Surg-Foot & Ankle	*	*	*	*	*
Podiatry: Surg-Forefoot Only	*	*	*	*	*
Psychiatry: General	*	*	*	*	*
Psychiatry: Child & Adolescent	*	*	*	*	*
Pulmonary Medicine	*	*	*	*	*
Pulmonary Medicine: Critical Care	*	*	*	*	*
Pulmonary Med: Gen & Crit Care	*	*	*	*	*
Radiation Oncology	*	*	*	*	*
Radiology: Diagnostic-Invasive	$458,574	$94,386	$450,000	$495,938	$510,000
Radiology: Diagnostic-Noninvasive	$403,308	$121,347	$355,793	$466,407	$479,264
Radiology: Nuclear Medicine	*	*	*	*	*
Rheumatology	*	*	*	*	*
Sleep Medicine	*	*	*	*	*
Surgery: General	$393,718	$169,509	$232,292	$309,690	$570,034
Surgery: Bariatric	*	*	*	*	*
Surgery: Cardiovascular	$535,381	$192,243	$351,171	$550,634	$687,805
Surgery: Cardiovascular-Pediatric	*	*	*	*	*
Surgery: Colon & Rectal	*	*	*	*	*
Surgery: Neurological	*	*	*	*	*
Surgery: Oncology	*	*	*	*	*
Surgery: Oral	*	*	*	*	*
Surgery: Pediatric	*	*	*	*	*
Surgery: Plastic & Reconstruction	*	*	*	*	*
Surgery: Thoracic (primary)	*	*	*	*	*
Surgery: Transplant	*	*	*	*	*
Surgery: Trauma	*	*	*	*	*
Surgery: Vascular (primary)	*	*	*	*	*
Urgent Care	*	*	*	*	*
Urology	$413,386	$139,553	$317,974	$412,338	$498,170
Urology: Pediatric	*	*	*	*	*

2010 LARGE CLINIC PHYSICIAN COMPENSATION REPORT

COMPENSATION

Greater Than 4 Years

	Your Clinic				*Other Clinics*		
	# of Providers	Median	Mean	# of Clinic Responses	# of Providers	Median	Mean
Allergy	1		224,984	32	93	230,770	239,146
Cardiology				41	373	361,094	380,940
Cardiology - Branch				4	11	508,365	529,337
Cardiology - Cath Lab	1		563,037	36	164	472,387	508,534
Cardiology - Echo Lab/Nuclear				12	112	414,500	408,026
Cardiology - Electrophysiology Pacemaker				28	122	439,325	457,986
Critical Care Medicine				16	109	264,750	277,324
Dermatology	1		428,173	40	224	335,816	361,937
Dermatology - Branch							
Dermatology - Mohs				16	32	510,604	530,032
Endocrinology	1		154,281	41	207	211,716	216,048
Family Medicine	3	178,644	169,319	41	1481	192,924	204,412
Family Medicine - Branch	4	144,117	152,847	14	384	191,872	194,464
Family Medicine with Obstetrics	11	205,032	208,241	15	181	204,336	212,095
Family Medicine with Obstetrics - Branch	12	187,737	202,762	9	90	199,231	206,158
Gastroenterology	1		675,069	43	406	365,432	405,462
Gastroenterology - Branch							
Genetics				7	11	200,000	191,325
Geriatrics	1		140,667	21	74	185,975	194,598
Hematology & Medical Oncology	3	468,920	441,292	44	385	308,500	325,570
Hospitalist	2	299,948	299,948	44	724	210,097	217,489
Hypertension & Nephrology				27	170	238,750	252,121
Infectious Disease				36	149	218,032	215,851
Internal Medicine	1		150,667	45	1898	203,375	212,327
Internal Medicine - Branch	8	157,568	195,054	15	180	196,831	206,781
Internal Medicine - Office Only				6	67	196,324	204,174
Neurology	2	225,889	225,889	45	433	236,500	232,810
Occupational / Environmental Medicine				23	98	212,330	214,548
Orthopedic - Medical				6	16	188,060	185,268
Palliative Care				6	18	189,035	199,076
Pediatrics & Adolescent - General	4	235,042	235,993	45	891	188,926	200,262
Pediatrics & Adolescent - Allergy							
Pediatrics & Adolescent - Branch				14	116	178,228	189,484
Pediatrics & Adolescent - Cardiology				16	59	237,010	244,969
Pediatrics & Adolescent - Developmental/Behavioral				9	14	151,171	150,889
Pediatrics & Adolescent - Endocrinology				14	25	180,000	177,556
Pediatrics & Adolescent - Gastroenterology				13	46	219,944	226,472
Pediatrics & Adolescent - Hematology/Oncology				14	36	190,353	191,021
Pediatrics & Adolescent - Hospitalist				14	37	165,981	169,847
Pediatrics & Adolescent - Infectious Disease				9	12	171,612	185,371
Pediatrics & Adolescent - Intensive Care				12	25	241,942	245,371
Pediatrics & Adolescent - Internal Medicine				6	40	244,779	241,045
Pediatrics & Adolescent - Neonatology				23	101	260,028	273,401
Pediatrics & Adolescent - Nephrology							
Pediatrics & Adolescent - Neurology				17	37	218,000	229,227
Pediatrics & Adolescent - Pulmonary				10	17	175,725	171,379
Pediatrics & Adolescent - Urgent Care				4	15	175,252	174,988
Physical Medicine & Rehabilitation	1		330,737	33	168	236,500	250,544
Psychiatry	2	311,174	311,174	31	288	198,500	201,873
Psychiatry - Inpatient				4	13	265,000	260,027
Psychiatry - Outpatient				5	26	197,622	199,448
Psychiatry - Child				25	73	208,071	207,903
Pulmonary Disease	2	510,957	510,957	38	190	260,000	289,320
Reproductive Endocrinology				11	27	301,945	313,781
Rheumatologic Disease				43	169	209,186	219,733
Sleep Lab				13	26	259,351	276,744
Sports Medicine	1		227,909	16	40	235,877	257,811
Urgent Care	3	167,352	171,104	21	324	219,146	227,366

NAIC National Association of Insurance Commissioners & The Center for Insurance Policy and Research

May 26, 2010

The Honorable George J. Keiser
State Capitol
600 East Boulevard
Bismarck, ND 58505

Dear Chairman Keiser,

Thank you again for the opportunity to testify before the Business, Industry and Labor Committee on April 28. This letter is in response to a number of questions posed by members of the Committee that I did not have immediate responses to at the hearing.

1) *Which reforms contained in the Patient Protection and Affordable Care Act (PPACA) will apply to self-insured plans, and which are limited to fully insured plans?*

   As I noted during the hearing, many reforms in the legislation will apply to both fully-insured and self-insured health plans. I have attached a chart that outlines the applicability of each health insurance provision to self-insured and fully-insured plans. Please note that although the requirement that a plan include essential benefits and meet limitations on cost-sharing applies only to fully-insured plans, large employers are separately required to provide coverage that meets these requirements or pay a penalty.

2) *Could treatment of a pre-existing medical condition, which was originally covered by a workers' compensation insurance policy, be excluded under a major medical insurance policy under PPACA?*

   Under §2704 of the Public Health Service Act (PHSA), as amended by §1002 of PPACA, plans will be prohibited from imposing any preexisting condition exclusions beginning in 2014. §2702 of the PHSA, as amended by the same section of PPACA prohibits plans from denying coverage to an individual based upon any health status factor beginning in 2014. Consequently, health insurance plans would not be permitted to deny coverage to an individual or impose a preexisting condition exclusion for a workplace injury. However, nothing in the new law would prevent a health plan from specifying, as most do today, that their coverage of such a claim is secondary to the worker's compensation insurance policy.

3) *Will health plans be permitted to impose lifetime limits for non-essential benefits, such as fertility treatments?*

   §2712 of the PHSA, as added by §1001 of PPACA prohibits the application of lifetime limits or unreasonable annual limits. It does specify, however, that that restriction should not be construed to prohibit "annual or lifetime per beneficiary limits on specific covered benefits that are not essential health benefits…to the extent that such limits are otherwise permitted under Federal or State law." Therefore, assuming that fertility treatments, or any other services, are not included in the essential benefits package, plans would be permitted to impose specific lifetime limits on those services.

Again, thank you for the invitation to speak with the Committee, and please let me know if you or the Committee have any further questions.

Sincerely,

Joshua Goldberg
Health Policy & Legislative Analyst

cc: Adam Hamm, North Dakota Commissioner of Insurance

EXECUTIVE OFFICE	444 N. Capitol Street, NW, Suite 701	Washington, DC 20001-1509	p | 202 471 3990	f | 816 460 7493
CENTRAL OFFICE	2301 McGee Street, Suite 800	Kansas City, MO 64108-2662	p | 816 842 3600	f | 816 783 8175
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Patient Protection and Affordable Care Act of 2009

Applicability of Provisions to Fully-Insured and Self-Insured Plans

	Provision	Fully-Insured	Self-Insured	Notes	PPACA Section	Statutory Section
Immediate Implementation Provisions	**Prohibition on Annual Limits**	Yes	Yes	Grandfathered individual market plans exempted	1001	PHSA 2711
	Prohibition on Lifetime Limits	Yes	Yes		1001	PHSA 2711
	Restrictions on Rescissions	Yes	Yes		1001	PHSA 2712
	Coverage of preventive health services	Yes	Yes	Grandfathered plans exempted	1001	PHSA 2713
	Extension of adult dependent coverage	Yes	Yes		1001	PHSA 2714
	No preexisting condition exclusions for children	Yes	Yes	Grandfathered individual market plans exempted	1201 & 10103(e)	PHSA 2704
	Uniform explanation of coverage documents and standardized definitions	Yes	Yes	Grandfathered plans exempted	1001	PHSA 2715
	Provision of additional information	Yes	Yes	Grandfathered plans exempted	1001	PHSA 2715A
	Prohibition on discrimination based on salary	Yes	No	Grandfathered plans and individual market plans exempted	1001	PHSA 2716
	Ensuring quality of care	Yes	Yes	Grandfathered plans exempted	1001	PHSA 2717
	Bringing down the cost of health care	Yes	No		1001	PHSA 2718
	Appeals process	Yes	Yes	Grandfathered plans exempted	1001	PHSA 2719
	Patient Protections	Yes	Yes	Grandfathered plans exempted	1001	PHSA 2719A
	Ensuring that consumers get value for their	Yes	No	Grandfathered plans	1003	PHSA

	Provision	Fully-Insured	Self-Insured	Notes	PPACA Section	Statutory Section
	dollars			exempted		2794
	Administrative simplification requirements	Yes	Yes		1104	SSA 1171
2014 Implementation Provisions	**No preexisting condition exclusions for adults**	Yes	Yes	Grandfathered plans exempted	1201	PHSA 2704
	Fair health insurance premiums	Yes	**No**	Non-grandfathered fully-insured small group and individual plans. Fully insured large group plans in states that allow them to purchase through the Exchange.	1201	PHSA 2701
	Guaranteed availability of coverage	Yes	No	Grandfathered plans exempted	1201	PHSA 2702
	Guaranteed renewability of coverage	Yes	No	Grandfathered plans exempted	1201	PHSA 2703
	Prohibiting discrimination in wellness programs against individual participants and beneficiaries based on health status	Yes	Yes	Grandfathered plans exempted	1201	PHSA 2705
	Non-discrimination in health care	Yes	Yes	Grandfathered plans exempted	1201	PHSA 2706
	Requirement to provide essential benefits Comprehensive health insurance coverage	Yes	No	Grandfathered plans and large group plans exempted	1201	PHSA 2707
	Requirement to limit cost sharing	Yes	No	Grandfathered plans exempted	1201	PHSA 2707(b)
	Prohibition on excessive waiting periods	Yes	Yes	Individual market plans exempted	1201	PHSA 2708
	Coverage for individuals participating in approved clinical trials	Yes	Yes	Grandfathered plans exempted	1201	PHSA 2709
	Essential Health Benefits Requirements	Yes	No	Exchange plans only	1302	
	Transitional reinsurance program for individual market in each state	Yes	Yes	All plans must make payments into reinsurance fund. Individual market plans may collect payments.	1341	
	Establishment of risk corridors for plans in individual and small group markets	Yes	No	Individual and small group Exchange plans only	1342	
	Risk adjustment	Yes	No	All non-grandfathered individual and small group plans	1343	
	Requirement to maintain minimum essential coverage			Individuals	1501	IRC 5000A
	Requirement to provide minimum essential coverage to employees			Employers with at least 50 FTEs	1512	IRC 4980H

March 2010

The Benefits of Health Care Reform In North Dakota

Committee on Energy and Commerce

The U.S. House of Representatives will soon vote on health care reform legislation. This legislation will make health care affordable for the middle class, provide security for seniors, and guarantee access to health insurance for the uninsured Ð while reducing the federal deficit by over $100 billion over the next decade. This analysis examines the benefits of the legislation in the North Dakota, which is represented by Rep. Earl Pomeroy.

In North Dakota, the health care reform bill will:

¥ Improve coverage for 437,000 residents with health insurance.

¥ Give tax credits and other assistance to up to 178,000 families and 19,000 small businesses to help them afford coverage.

¥ Improve Medicare for 106,000 beneficiaries, including closing the donut hole.

¥ Extend coverage to 27,500 uninsured residents.

¥ Guarantee that 8,200 residents with pre-existing conditions can obtain coverage.

¥ Protect 600 families from bankruptcy due to unaffordable health care costs.

¥ Allow 66,000 young adults to obtain coverage on their parentsÕ insurance plans.

¥ Provide millions of dollars in new funding for 22 community health centers.

¥ Reduce the cost of uncompensated care for hospitals and other health care providers by $76 million annually.

Affordable High-Quality Health Care for the Middle Class

Essential health insurance reforms. Approximately 68% of the state (437,000 residents) receives health care coverage from an employer or through policies purchased on the individual market. Under the legislation, individuals with insurance can keep the coverage they have now, and it will get better. The insurance reforms in the bill prohibit annual and lifetime limits, eliminate rescissions for individuals who become ill while insured, ban coverage denials for pre-existing conditions, and

reduce the cost of preventive care. To rein in soaring insurance costs, the reforms also limit the amount insurance companies can spend on administrative expenses, profits, and other overhead.

Historic health care tax cuts. Those who do not receive health care coverage through their employer will be able to purchase coverage at group rates through the new health insurance exchange. To make this insurance affordable, the legislation contains the largest middle-class tax cut for health care in history, providing middle class families with incomes up to $88,000 for a family of four with tax credits to help pay for coverage in the exchange. For a family of four making $50,000, the average tax credit will be approximately $5,800. There are 178,000 households in the state that could qualify for these credits if they purchase health insurance through the exchange or, in the case of households with incomes below 133% of poverty, receive coverage through Medicaid.

Coverage for individuals with pre-existing conditions. There are 8,200 uninsured individuals in the state who have pre-existing medical conditions like cancer, heart disease, and diabetes. Under the billÕs insurance reforms, they cannot be denied affordable coverage.

Financial security for families. There were 600 health care-related bankruptcies in the state in 2008, caused primarily by the health care costs not covered by insurance. The bill caps annual out-of-pocket costs at $6,200 for individuals and $12,400 for families who purchase insurance through the exchange or who are insured by small businesses. It also eliminates annual and lifetime limits on all insurance coverage. These reforms ensure that no family will have to face financial ruin because of high health care costs.

Security for Seniors

Improving Medicare. There are 106,000 Medicare beneficiaries in the state. The legislation improves their benefits by providing free preventive and wellness care, improving primary and coordinated care, and enhancing nursing home care. The bill also strengthens the Medicare Trust Fund, extending its solvency from 2017 to 2026.

Closing the Part D donut hole. Each year, 13,800 Medicare beneficiaries in the state enter the Part D donut hole and are forced to pay the full cost of their prescription drugs. Under the bill, these beneficiaries will receive a $250 rebate in 2010, 50% discounts on brand name drugs beginning in 2011, and complete closure of the donut hole within a decade. A typical beneficiary who enters the donut hole will see savings of over $700 in 2011 and over $3,000 by 2020.

New Coverage Options for Young Adults

New lower-cost health care options for young adults. The legislation will allow

young adults to remain
on their parentsÕ policies until they turn 26. There are 66,000 young adults in the state who could benefit
from this option. For individuals under age 30, the bill creates new, inexpensive policies that allow them
to obtain protection from catastrophic health care costs.

Helping Small Businesses

Helping small businesses obtain health insurance. Under the legislation, small businesses with 100
employees or less will be able to join the health insurance exchange, benefiting from group rates and a
greater choice of insurers. There are 20,900 small businesses in the state that could benefit from this
provision.

Tax credits for small businesses. Small businesses with 25 employees or less and average wages of less
than $50,000 will qualify for tax credits of up to 50% of the costs of providing health insurance. There
are up to 19,000 small businesses in the state that could qualify for these credits.

Covering the Uninsured

Coverage of the uninsured. The legislation would extend coverage to 95% of all Americans. If this
level of coverage is reached in the state, 27,500 residents who currently do not have health insurance will
receive coverage.

Relieving the burden of uncompensated care. In 2008, health care providers in the state provided
uncompensated care to individuals who lacked insurance coverage and were unable to pay their bills.
Under the legislation, these costs of uncompensated care will be reduced by $76 million.

Supporting community health centers. There are 22 community health centers in the state that provide
health care to the poor and medically underserved. Nationwide, the legislation would provide $11 billion
in new funding for these centers. If the community health centers in the state receive the average level of
support, the 22 centers will receive $28.6 million in new assistance.

Deficit Responsibility

No deficit spending. The cost of health care reform under the legislation is fully paid for, in large part by
eliminating waste, fraud, abuse, and excessive profits for private insurers. The legislation will reduce the
deficit by $130 billion over the next ten years, and by about $1.2 trillion over the second decade.

This analysis is based upon the following sources: the U.S. Census (data on insurance rates, small
businesses, and young adult population); the Centers for Medicare and Medicaid Services (data on
Medicare and Part D enrollment); the Department of Health and Human Services (data on health care-

related bankruptcies, uncompensated care, and pre-existing conditions); the Health Resources and
Services Administration (data on community health centers); and the Congressional Budget Office
(estimates of the percentage of citizens with health insurance coverage under health care
reform legislation).

North Dakota County Government White Paper
Federal Health Care Reform Effects – Preliminary Analysis

Employee Health Benefits

Counties have approximately 3,400 full-time staff and all 53 counties have a formal health plan. 38 counties provide health insurance through NDPERS to about 1,865 (55%) of county employees. The remaining counties either contract directly with BlueCross/Blue Shield (10 counties), or are self-insured (5 counties) with BC/BS as the third-party administrator. In all but one of the 53 counties, the county pays in excess of 70% of a "single-plan" premium and 38 counties pay 100% of a single plan premium (the average is 95%). 14 counties pay 100% of "family-plan" premium but the average paid for a family plan is 73%. Collectively, county government contributes approximately $2 million annually to employee health insurance premiums.

NDPERS Executive Director, Sparb Collins, at the April 2010 meeting of the Industry Business & Labor Committee, estimated that NDPERS health premium costs (beginning in 2011) could increase by $5.50/month due to the changes required by federal health insurance reform legislation. Assuming health insurance costs increase proportionately for those 15 counties that are self-insured or insured directly through BC/BS, counties could anticipate a statewide annual increase of $250,000 of which (under the current premium sharing arrangements) county government would be responsible for about $200,000.

County Social Services

GRANT COSTS

Counties currently contribute to Medicaid grant costs in only one, very small, area – therapeutic services for foster care youth ($425,000/biennium). Since foster care youth are categorically eligible for Medicaid, the new poverty thresholds will likely have little impact on this caseload. This fact, the relatively minimal involvement and the "county pass-through protections" of the federal law suggest that the impact of the projected Medicaid enrollment increase to county grant costs will likely be small.

ADMINISTRATIVE COSTS

Administrative cost increases could be fairly significant. Currently counties employ approximately 325 FTEs dedicated to the determination of eligibility for all economic assistance programs. Annual salaries plus payroll tax and fringe benefit costs as well as indirect costs such as space, supplies, equipment and general supervision brings county economic assistance administration costs to $19.9 Million (FY09). Of this total, based on the Random Moment Time Study (RMTS) of county social service workers, it is estimated (in a very rough manner), that the portion directly driven by the current Medicaid program is approximately $11.2 million.

This portion of county administrative costs would be expected to increase at approximately the same percentage that the Department projects the current Medicaid recipients (~65,000) to grow due to health care reform. For initial analysis, the (year-old) Lewin Group estimate of 35,000 new recipients was used. This 53% increase in recipients could therefore increase county administrative costs by $6 million. As incremental increases in individual counties may, or may not, trigger staffing increases, a more detailed county-by-county analysis will be necessary to refine this projection. It should be noted that since the State (DHS) retains the federal reimbursement generated by this property tax funded administration, $6 million of additional county costs will increase State revenues by about $3 million at current federal reimbursement rates.

The Department of Human Services has indicated that a rewrite of the State's Medicaid eligibility system will be essential for the implementation of the Medicaid provisions of health care reform. Counties have long supported the rewrite and consolidation of the multiple economic assistance eligibility computer systems as a means of reducing the administrative burden. If a comprehensive eligibility systems improvement is undertaken, it could have some mitigating effects on the anticipated staff increases.

Jail Inmate Medical Care

State law and federal court decisions require counties to ensure that jail inmates are provided "adequate medical care" regardless of their financial means or insurance coverage. Counties have seen their costs in this area grow dramatically. Particularly frustrating to counties is the policy of Medicaid, Medicare, and the Veteran's Administration to terminate health benefits for clients in correctional custody – even if the client is only charged and not yet convicted of a crime. Although it is not likely to have an immediate financial benefit, the federal provisions requiring the "health exchanges" to maintain coverage of individuals in correctional custody who are charged, but not yet convicted of a crime, is a step in the right direction.

Local Public Health

Every county operates a local health unit or participates in the operation of a multi-jurisdictional health unit. While the scope and extent of local health services varies, they range from immunization and family planning to tobacco cessation and environmental health inspections. The most likely effect of the federal health reform legislation will be the opportunity to support these services with additional grant funds that have been included in the legislation to promote federal priorities. Some priorities, like home nurse visitation for pregnant and young families focus are areas of great interest to North Dakota Health Units. As past experience has shown, the State Department of Health is often the conduit for federal health-related grant programs. The ultimate impact of the federal legislation to local public health will therefore be dependent upon the State's level of participation.