

**HB**

**228**

**HFIN**

**FILE**

# HOUSE COMMITTEE REPORT

(11)

Date Referred to Committee: April 16, 2007

FURTHER REFERRALS:

Date of Committee Action: 4/25/07

The FINANCE Committee considered:

HB 228

HOUSE BILL NO. 228

WORKERS' COMP. MEDICAL TREATMENT FEES

"An Act relating to fees for certain medical treatment and service under the Alaska Workers' Compensation Act; and providing for an effective date."

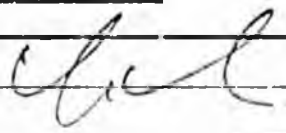
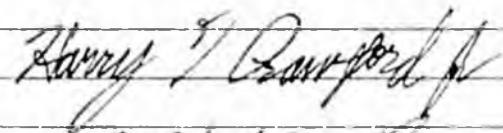
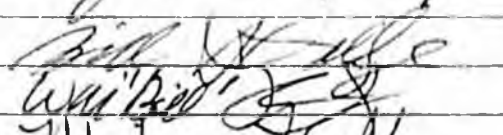
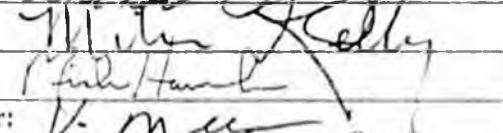
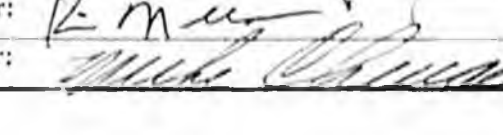
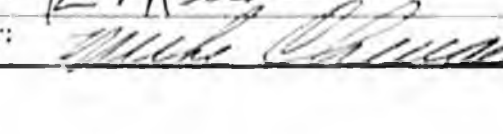

Recommends it be replaced with  HCS or  CS for HB 228 (LTC)  
 For Senate Bills with new title:  Technical Title  New Title: HCR \_\_\_\_\_  Same Title  New Title

- attach amendments
- add new referral to \_\_\_\_\_ Committee
- Letter of Intent \_\_\_\_\_ Committee

- List of Abbrev for Depts.:
- ADM
  - CED
  - COR
  - CRT
  - EED
  - DEC
  - DFG
  - GOV
  - HSS
  - LWF
  - LAW
  - LEG
  - MVA
  - DNR
  - DPS
  - REV
  - DOT
  - UA

<u>NEW FISCAL NOTES</u>				
*Assigned by Chief Clerk's Office				
List by Dept(s):	*FN#	Fiscal	Indet.	Zero

<u>PREVIOUS FISCAL NOTES</u>				
List by Dept(s):	FN#	Fiscal	Indet.	Zero
ADM	#1			✓
LWF	#7			✓

<u>Signing with recommendations</u>	Printed Last Name	DP	DNP	NR	AM
	Garcia	<input checked="" type="checkbox"/>			✓
	CRAWFORD			X	
	<del>3/27/20</del> Therrell	<del>X</del>		X	
	KELLY	X			
	Hawker	*			
Chair: 	Meyer	✓			
Chair: 	Chenault	✓			

# FISCAL NOTE

STATE OF ALASKA  
2007 LEGISLATIVE SESSION

Fiscal Note Number: 1  
Bill Version: CSHB 228(L&C)  
(H) Publish Date: 4/16/07

Revision Date/Time (Note if correction): 4/13/2007 Dept. Affected: Administration  
Title An act relating to fees for medical treatment RDU Risk Management  
under the Alaska Workers' Compensation Act Component Risk Management  
Sponsor Representative Kelly  
Requester House Labor and Commerce Component No. 71

**Expenditures/Revenues** (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
<b>TOTAL OPERATING</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

<b>CAPITAL EXPENDITURES</b>						
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<b>CHANGE IN REVENUES ( )</b>						
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**FUND SOURCE** (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
<b>TOTAL</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

Estimate of any current year (FY2007) cost: 0.0

Mark this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal:

**POSITIONS**

Full-time						
Part-time						
Temporary						

**ANALYSIS:** (Attach a separate page if necessary)

This bill extends the current medical fee schedule from 8/1/2007 to 3/31/2009 with a new adjustment based on the Anchorage area Consumer Price Index medical care component.

Risk Management administers the self insurance program providing workers' compensation protection for all State employees. Future Risk Management's workers' compensation assessments to State agencies will reflect costs incurred as premiums charged each agency are developed from actual claims expenses incurred.

Without this new indexed fee schedule the current schedule sunsets. Therefore this agency anticipates a zero fiscal impact.

Prepared by: J. Brad Thompson, Director Phone 465-5723  
Division Risk Management Date/Time 4/13/2007 2:00 p.m.  
Approved by: Kevin Brooks, Deputy Commissioner Date 4/13/2007  
Agency Department of Administration

# FISCAL NOTE

STATE OF ALASKA  
2007 LEGISLATIVE SESSION

Fiscal Note: 2  
Bill Version: CSHB 228(L&C)  
(H) Publish Date: 4/16/07

Revision Date/Time (Note if correction): \_\_\_\_\_ Department: Labor and Workforce Development  
Title: Workers' Comp. Medical Treatment Fees RDU: Workers' Compensation  
Sponsor: Representative Kelly Component: Workers' Compensation  
Requester: House Labor and Commerce Component Number: 344

**Expenditures/Revenues (Thousands of Dollars)**

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
<b>TOTAL OPERATING</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

<b>CAPITAL EXPENDITURES</b>						
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<b>CHANGE IN REVENUES ( )</b>						
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**FUND SOURCE (Thousands of Dollars)**

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
<b>TOTAL</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

Estimate of any current year (FY2007) cost: None  
Mark this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal:

**POSITIONS**

Full-time						
Part-time						
Temporary						

**ANALYSIS:** (Attach a separate page if necessary)

There is no anticipated fiscal impact to the department as a result of this legislation.

Prepared by: Paul F. Lisankle, Director Phone: 465-6059  
Division: Workers' Compensation Date/Time: 4/12/07 4:23 PM  
Approved by: Click Bishop, Commissioner Date: 4/12/2007  
Agency: Department of Labor and Workforce Development

# Alaska State Legislature

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## Member

House Finance Committee  
Legislative Budget & Audit

## Representative Mike Kelly

*House District 7*

### Sponsor Statement

#### HB 228

In 2005 the Alaska Legislature passed SB 130 which was a rework of the Workers Compensation statutes. As part of this rework, medical payments were frozen at the 2004 fee schedule so that a review could be done of the underlying reasons for premium increases. This review was to be jointly done by a special Workers Compensation Legislative Taskforce in concert with the Department of Labor & Workforce Development Medical Review Committee. Two important tasks of the committee were to look at program design problems and to study the underlying reasons for medical cost increases experienced in the program. Following this, the taskforce was to develop recommendations to moderate program increases in the future. As part of the conditions of the medical rate freeze, the Taskforce was to have completed their review by February of 2006 and the rate freeze would sunset in August of 2007 (to be replaced by a new fee schedule).

The Taskforce did not complete its report by February of last year and we are facing the sunset of the medical rate freeze in August of this year. There is not yet a plan for the post rate freeze sunset period and that is why this legislation was introduced.

Under HB 228, the medical rate freeze would be extended two years to allow time for recommendations to be developed. It implements an annual rate increase based on the CPI index. This extension of the freeze should allow time for the insurance companies to compile and submit their analysis and recommendations after reviewing care costs for injured workers so that the Legislature can address the underlying reasons for premium increases.

Alaska Timber Insurance Exchange  
Workers' Compensation Medical Cost Concerns  
March 2, 2007

Introduction:

Employers in Alaska have experienced significant increases to their workers' compensation premiums over the last several years. The Oregon Workers' Compensation Premium Rate Ranking released in January 2007 by the State of Oregon Department of Consumer and Business Services reports that Alaska has the highest workers' compensation premium rates in the United States. This report was based upon premium rates in effect during 2006.

Workers' compensation rates in Alaska decreased for 2007 but it is anticipated that this will be short lived since the cost of providing medical care for injured workers is expected to escalate significantly when the use of the current workers' compensation medical fee schedule is discontinued in August 2007.

This paper outlines the history of workers' compensation medical fee schedules in Alaska; it then addresses why there should be concern about not having a workers' compensation medical fee schedule after August 2007 and then offers a solution to this problem.

Background:

In 1988 the Alaska Legislature passed Senate Bill 322 (SB 322). SB 322 contained changes to the Alaska Workers' Compensation Act that were designed to reduce workers' compensation costs for Alaskan employers. One provision of SB 322 required that the Alaska Workers' Compensation Board (AWCB) adopt usual, customary and reasonable workers' compensation medical fee schedules at least once each year.

The AWCB, through regulation, specified that workers' compensation medical expenses were to be paid at the 90<sup>th</sup> percentile of the usual, customary and reasonable fees. Each year a new medical fee schedule was created with updated fees (usually higher) and any new medical procedure codes that might have been created during the past year.

Senate Bill 130 (SB 130), which became law in August 2005, repealed and replaced the existing medical fee language found in Alaska Statute 23.30.095(f). AS 23.30.097(a)(1), the replacement statute, specified that the fee schedule to be used to determine amounts paid for medical fees and services would be the fee schedule specified by the AWCB in its published bulletin dated December 1, 2004.

Section 75 of SB 130 repeals the medical fee schedule replacement language, AS 23.30.097(a)(1), in August 2007.

Essentially, the amount paid to medical providers for procedures listed in the medical fee schedule are "frozen" from August 2005 to August 2007.

The Reason For Concern:

In August 2007 when the medical fee schedule statute sunsets, there will be no cap on the amount that can be charged to workers' compensation insurers and self-insured employers, including the State of Alaska, for the medical services provided for workers' compensation claimants.

Recent medical bills received by ATIE indicate that a significant increase in medical care costs is expected if no cap exists on the amount paid for medical services. The following table illustrates this:

<u>Procedure</u>	<u>Billed Amount</u>	<u>Fee Schedule Amount</u>	<u>Increase</u>	
			<u>Amount</u>	<u>%</u>
Office Visit Moderate to High Severity 25 Minutes	\$ 306	\$ 184	\$ 122	66%
Emergency Dept Visit Moderate Severity	345	212	133	63%
Laminotomy with decompression, 1 interspace lumbar	1,682	1,345	337	25%
Office Visit Moderate to High Severity 25 Minutes	278	184	94	51%

Another concern is that the expected increase in medical care costs due to not having a workers' compensation medical fee schedule was not included in the 2007 workers' compensation loss cost (rate) filing with the Alaska Division of Insurance. If the average medical costs that ATIE is required to pay increase by 20% in August 2007, the rates being charged for workers' compensation insurance by ATIE and other workers' compensation insurers should be approximately 11% higher than they currently are to compensate for this increase.

Possible Solution:

In an Informal Opinion regarding SB 130 dated July 18, 2005, the State of Alaska, Department of Law stated in footnote 91, "Even if subsec. (a)(1) is repealed, the general power of the board to regulate medical charges, contained in AS 23.30.097(a), authorizes the board to adopt regulations setting fees lower than those allowed by AS 23.30.097(a)(2) or (3)."

AS 23.30.097(a) states, "All fees and other charges for medical treatment or service are subject to regulation by the board consistent with this section."

The AWCB, with its statutory authority to enact regulations addressing fees for medical treatment, should exercise its power and enact regulations to replace the expiring medical fee schedule as quickly as possible.

For further information or questions regarding the above please contact either Michael Hinchey or Pamela Scott at 907-225-9451.

# Alaska State Legislature

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Member  
House Finance Committee  
Legislative Budget & Audit

## Representative Mike Kelly

*House District 7*

### MEMORANDUM

**DATE:** April 10, 2007  
**TO:** Representative Mike Kelly  
**FROM:** Derek Miller  
**RE:** Sectional Analysis for HB 228  
(Version No. 25-LS0773\E)

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A sectional summary of a bill should not be considered an authoritative interpretation of the bill. The bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

**Section 1.** Specifies that fees and other charges for medical treatment or service provided before August 1, 2007 do not exceed the fees in the fee schedule specified by the Workers' Compensation Board in its published bulletin dated December 1, 2004. Specifies that fees and other charges for medical treatment or service provided after August 1, 2007, but before March 31, 2009 is the percentage change between 2004 and 2006 in the medical care component of the Consumer Price Index for the Anchorage metropolitan area.

**Section 2.** Repeals AS 23.30.097(a)(1), specifying fees and other charges for medical treatment or service may not exceed the fees in the fee schedule specified by the Workers' Compensation Board in its published bulletin dated December 1, 2004.

**Section 3.** Allows the Department of Labor and Workforce Development to adopt regulations necessary to implement this act.

**Section 4.** Section 3 of this act takes effect immediately.

**Section 5.** Section 1 and 2 of this act take effect July 31, 2007.

**Who Does ASHSHA Represent?**

The *Alaska State Hospital and Nursing Home Association* membership includes 24 acute care hospitals, 2 behavioral health facilities, 6 assisted living facilities (Alaska Pioneer Homes), and 5 free-standing nursing facilities. Nine of our 24 acute care hospitals also provide nursing home services. We believe ASHSHA's rich composition of private, federal, state, and tribal health care facilities provides a balanced viewpoint on important health care policy matters. ASHSHA's membership authorized the position expressed in this testimony.

**ASHSHA STRONGLY SUPPORTS CSHB 228:**

ASHSHA members' strong support for CSHB 228 stems from their unique dual role as both providers and employers within their communities. Alaska's employers will experience a major increase in workers compensation premiums unless action is taken to modify and extend the provider rate freeze implemented under SB 130 during the 2005 legislative session. Legislation is needed because the Administration had indicated they cannot extend this freeze by administrative regulation.

In 2005, ASHSHA agreed to compromise legislation that froze medical payments for two years pending review of the underlying reasons for premium increases, including both medical costs and general program design problems. This review was to be done jointly by a special Worker's Compensation Legislative Taskforce working in concert with the Department of Labor & Workforce Development's Medical Review Committee.

The rate freeze enacted by SB 130 is scheduled for sunset in 2007 yet the Legislative Taskforce did not complete its work before its authority expired earlier this year, in part because the medical cost analysis has not been provided by insurers. Allowing the rate freeze to sunset without adopting well thought out permanent reform to take its place will lead to severe financial losses by workers compensation insurers and ultimately significant increases in employer premiums. This will impact small and medium employers most dramatically as most large employers are self-insured.

Passage of CSHB228 will extend the sunset date for the rate freeze along with a modest fee adjustment based on the medical CPI to give time for comprehensive reform recommendations to be developed and presented to the Legislature.

ASHSHA members urge your support of CSHB 228 and passage from this Committee.

**This Testimony is on Behalf of the Following Alaska Health Care Facilities**

Alaska Regional Hospital, Alaska Native Medical Center, Alaska Pioneer Home System, Bartlett Regional Hospital, Bassett Army Community Hospital, Central Peninsula General Hospital, Cordova Community Medical Center, Denali Center Nursing Home, Fairbanks Memorial Hospital, Heritage Place Nursing Home, Kakanak General Hospital, Ketchikan General Hospital, Maniilaq Health Center, Mary Conrad Center, Mat-Su Regional Hospital, Mt. Edgecumbe Hospital SEARHC, Norton Sound Regional Hospital, Petersburg Medical Center, Providence Alaska Medical Center, Providence Extended Care Center, Providence Kodiak Island Medical Center, Providence Seward Medical & Care Center, Providence Valdez Medical Center, Sitka Community Hospital, South Peninsula Hospital, St. Elias Specialty Hospital, USAF 3<sup>rd</sup> Medical Group- Elmendorf, Wrangell Medical Center, Yukon Kuskokwim Delta Regional Hospital, Alaska Psychiatric Institute, North Star Behavioral Health System, Wildflower Court Nursing Home.





807 G Street, Suite 356, Anchorage, AK 99501

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March 30, 2007

The Honorable Mike Kelly  
House of Representatives  
Alaska State Legislature  
State Capitol  
Juneau, Alaska 99801-1182

Dear Representative Kelly:

The Alaska Municipal League Joint Insurance Association (AMLJIA) supports House Bill 228.

The AMLJIA is a not-for-profit self-insurance pool for approximately 152 cities, boroughs and school districts organized under AS 21.76. Member local government entities self-insure for the first \$500,000 of each workers' compensation loss and purchase reinsurance to statutory limits.

By its design, the pool is considered an efficient risk-financing mechanism because there is no pressure to generate shareholder profit. Rates are calculated to cover expected losses, loss development from prior years, any incurred but not reported losses, the cost of reinsurance and administrative overhead (claims handling, etc.).

As you are obviously aware, when the Alaska State Legislature passed the workers' compensation reform package in 2005, medical costs were frozen at 2004 rates until August of 2007. As August approaches and the session has reached its half-way point, I have become increasingly concerned about the thawing of the 2004 rate freeze. Although I'm not a legal scholar, it appears to me that this important issue can only be resolved by a legislative action this session.

Shortly after the passage of SB130, the Medical Services Review Committee was resurrected to advise the Alaska Workers' Compensation Board and the Department of Labor in matters involving the appropriateness, necessity, and cost of medical and related services under the Alaska Workers' Compensation Act. I was appointed to this committee along with eight others. Throughout 2005, the committee met to formulate recommendations specifically surrounding this issue. The report was provided to the legislative task force chaired by then Senator Seekins. I felt there were several good recommendations in the report. The report is available from the Division of Workers' Compensation and I encourage you to review it during the interim as we forge ahead to solve Alaska's Workers' Compensation problems.

While I lack sufficient knowledge to recommend what adjustment is appropriate, it does seem fair to me to provide for some inflationary protection for the providers.

Thank you for addressing this critical issue. Please let me know if I can be of further help.

Sincerely,

Kevin Smith  
Executive Director

RECEIVED  
APR 0 2007

PROTECT

A SERVICE of the ALASKA MUNICIPAL LEAGUE

**Alaska Physicians & Surgeons, Inc.**

4120 Laurel Street, Suite 206

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Website: [www.apsdoctors.org](http://www.apsdoctors.org)**Board of Directors**

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April 13, 2007

The Honorable Representative Mike Kelly  
State Capitol Building  
Juneau Alaska 99801

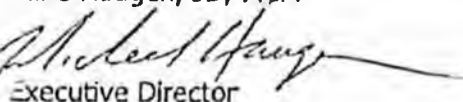
Re: HB228

Dear Representative Kelly,

Alaska Physicians & Surgeons recognizes that the Workers Compensation system in Alaska has been in need of a comprehensive fix for several years, and in 2005 agreed that a freeze in provider rates was the best short term solution to allow for further study of the system's many problems. The rate freeze is set to expire this summer. Given the lack of progress in finding a long term solution, my board of directors feels that an additional extension of the rate freeze with a cost of living adjustment is a better short term solution than letting the system suffer the potential effects of no fee schedule at all. Therefore we are in support of HB228, as the only viable solution in the short run.

If the physician community's participation in formulating a permanent fix is to occur, the insurance industry's 3 year lack of production of data, identifying the cost drivers in the Workers Compensation system, must somehow be addressed in the next year.

Mike Haugen, JD, MBA

  
Executive Director



central peninsula hospital

# heritage place

April 6, 2007

Rep. Kurt Olson, Chair  
House Labor and Commerce Committee  
Alaska State Legislature  
State Capital (MS 3100)  
Juneau, Ak. 99801-1182

Re: HB 228—Worker's Compensation

Dear Kurt:

I am writing today to ask for your assistance concerning HB 228, "An Act relating to fees for certain medical treatment and service under the Alaska Worker's Compensation Act; and providing for an effective date." I see that Labor and Commerce is the first committee of referral.

I'm pleased that this legislation has been introduced by Rep. Kelly. It is my understanding that without the passage of this legislation the Dept. of Labor does not have adequate direction with respect to the fee structure for medical providers under the worker's compensation program in Alaska.

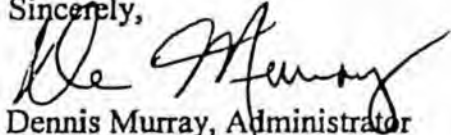
As you are aware, I was appointed to serve on the Medical Review Committee within the Div. of Worker's Compensation in 2004. Although authorized by regulation, Labor did not have a committee in place when the administration and legislature were considering changes to the Alaska Statutes on Worker's Compensation. Our committee met several times in 2004-5 to address the questions raised by the Worker's Compensation Taskforce with respect to the medical component of the program. The committee made recommendations to the Taskforce. Unfortunately, the taskforce was not able to complete it's work.

As well, our committee has not met for more than a year. It had been our intent to examine the underlying questions with the increases in the cost of medical care under worker's compensation. We had made important progress in engaging the Worker's Compensation Insurers in methodology to obtain information about the specifics of where expenses have changed. The committee had discussed requesting of the taskforce and the legislature funding to complete an analysis of the data provided by the Insurers.

I believe the legislation is a good first step, but it does not resolve the underlying questions that the legislature and administration had posed during their work in 2004-5. The legislation would certainly be strengthened if language was added that required the medical advisory committee to complete its work and provide an analysis of the reasons for the medical cost increases over the past several years.

Thank you for the opportunity to provide input on this important legislation. I hope it receives favorable consideration in this year's legislature. Without it, there may likely be more problems with the program.

Sincerely,



Dennis Murray, Administrator  
CPH-HP

cc. Rep. Mike Kelly  
Ryan Smith, CEO-CPH-HP  
Mr. Rod Betit, President, ASHNHA

# Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

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April 13, 2007

Honorable Kurt Olson  
State Capitol, Room 408  
Juneau, AK 99801

Transmitted by Fax: 907-465-3835

RE: HB228 – Workers Compensation Fee Schedule

Dear Representative Olson:

The Alaska State Medical Association (ASMA) represents physicians statewide and is primarily concerned with the health of all Alaskans.

First, ASMA must state that these comments pertaining to HB228 represent what its leadership's best guess is as to the reaction of its members. ASMA is not and can not be a "union" binding its individual members to anything.

ASMA has been involved with the efforts to examine the workers compensation system and to work towards appropriate and meaningful change. ASMA is represented on the Medical Services Review Committee (MSRC) and was represented on the Workers Compensation Task Force. All along the physician community has held that good data is necessary to conduct a meaningful review and study of the medical care component of the workers compensation system. ASMA believes that all stakeholders in the system agreed to that necessity. This request for data began in the Fall of 2004.

SB130 was enacted in 2005 which provided for a "freeze" in the payment schedule for all medical care providers at the schedule set on December 1, 2004. (It is ASMA's understanding that this fee schedule was established using claims data with the most recent data coming from 2003). The "freeze" ends on August 1, 2007.

It is ASMA's contention that its members acceded to this "freeze" on the belief that meaningful data would be provided in time to conduct a thorough review before its expiration. The data was to include claims data for a period of 5 years – first broken down by provider type (e.g. hospital, physician, physical therapist, chiropractor, etc); and secondarily broken down by CPT code for the physician claims. Finally, a "data call" was instituted by the State Division of Insurance in early December, 2006. The data was to be collected by the National Council on Compensation Insurance (NCCI) and provided in June 2007. ASMA recently learned that this data will not be provided until late 2007. ASMA expects that this circumstance will not be favorably viewed by its members.

It must be pointed out that it is ASMA's understanding that physicians do not have a different fee schedule for injured workers than for other patients. Their practice overhead expenses continue to increase just like any other employer yet they have gone along with the "freeze".

ASMA expects that the increase in the payment schedule proposed in HB228 will be appreciated by the physician community. But, again that schedule is set for 20 months (8/1/07 – 3/31/09). ASMA believes that its membership will skeptically view this new freeze. An amendment to tie in the provision of meaningful data could be expected to ameliorate some of the building skepticism. One possibility would be to mandate the yearly reporting of data to the MSRC along with a clear mandate for the Department of Labor to establish the appropriate fee schedules by regulation to be effective on a calendar year basis.

The system used prior to the current freeze set the fee schedule on a "Usual, Customary, and Reasonable" basis using the 90<sup>th</sup> percentile as the cut-off point. It is ASMA's understanding that this was based on workers compensation claims data. The new approaches seem to be moving toward a governmentally set fee. ASMA expects that many of its members will find this objectionable. One only needs to look to the access to care problems involving Medicare beneficiaries and the federal workers compensation system.

ASMA urges you to not take action that will adversely impact an injured worker's access to care.

Sincerely,



By: Roland Gower, MD, President  
For: The Alaska State Medical Association

**ANALYSIS OF THE SUNSET OF THE ALASKA PHYSICIAN FEE SCHEDULE  
EFFECTIVE AUGUST 1, 2007**

NCCI estimates that the August 1, 2007 sunset of the Alaska physician fee schedule, as currently provided in AS 23.30.097(a), will result in an overall workers compensation system cost increase in Alaska of between +4.5% and +5.8%.

Summary

The current workers compensation medical fee schedule in Alaska became effective December 1, 2004. This fee schedule based the maximum allowable reimbursements (MARs) on the 90<sup>th</sup> percentile of usual, customary and reasonable fees for similar services as reported to Ingenix at the time the fee schedule was established. Senate Bill 130, enacted in 2005, froze the medical fee schedule at the December 2004 levels until August 1, 2007, after which time the fee schedule would sunset.

Actuarial Analysis

The methodology used to price the sunset of the physician fee schedule is as follows:

Charges for various medical procedures under the physician fee schedule were obtained from medical transaction data. These charges were adjusted to reflect changes from past price levels to the price levels projected to be in effect once the fee schedule sunsets on August 1, 2007. Trend factors used for the projections were based on the U.S. and Western region professional components of the medical consumer price index (MCPI), along with the U.S. and Anchorage MCPI (all medical components) for the period 2004-2006, shown in the following table:

Year	U.S. MCPI (Prof. Component)		Western Region MCPI (Prof. Component)		U.S. MCPI (All Medical Components)		Anchorage MCPI (All Medical Components)	
	Value	Change	Value	Change	Value	Change	Value	Change
2003	261.16	2.9%	245.17	3.3%	297.08	4.0%	N/A	N/A
2004	271.48	4.0%	255.52	4.2%	310.13	4.4%	N/A	N/A
2005	281.70	3.8%	264.65	3.6%	N/A	N/A	344.20	N/A
2006	289.33	2.7%	271.54	2.6%	N/A	N/A	356.10	3.5%

Source: [Economy.com](http://Economy.com); N/A = Not Available

Based on the changes to the above indices, annual trend factors of +2.5% to +4.5% were applied to medical transaction data for physician services performed in 2003-2004 to project the price levels that would be in effect after the fee schedule sunsets. The lesser of the projected charge and the current maximum allowable fee was used to determine the current cost level for each procedure.

Total current physician costs were calculated by multiplying the current cost level for each procedure, as determined above, by the frequency for that procedure. Total current physician costs are the sum of these costs for all procedures.

Similarly, the overall physician charges after the schedule sunsets is the product of the average charge for each procedure adjusted to the cost levels estimated to be in effect on August 1, 2007 (using trends described above) multiplied by the frequency for that procedure. Estimated total physician costs after the schedule sunsets are the sum of these projected costs for all procedures. Our methodology does not contemplate additional changes in billing practices (i.e. change in utilization) that may accompany the fee schedule sunset.

The estimated impact on physician costs was determined to be an increase of between +9.7% and +12.5%. This was calculated as the ratio of the total projected costs of procedures after the fee schedule sunsets to the total projected costs of procedures under the current (12/1/2004) fee schedule.

This impact was then multiplied by the estimated ratio of physician costs to medical costs in Alaska (66.4%) to yield an increase on medical costs of between +6.4% and +8.3%. The impact on medical costs was then multiplied by the projected ratio of medical costs to total benefit costs in Alaska (70.2%) to yield an overall increase of between +4.5% and +5.8%.

The results are summarized in the table below:

	Impact
(1) Impact on Physician Costs	+9.7% to +12.5%
(2) Physician Costs as % of Medical Costs in Alaska	66.4%
(3) Impact on Medical Costs = (1) x (2)	+6.4% to +8.3%
(4) Medical Costs as % of Total System Costs in Alaska	70.2%
(5) Impact on Overall Workers Compensation System Costs in Alaska = (3) x (4)	+4.5% to +5.8%



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## Measuring Price Change for Medical Care in the CPI

Medical care is one of eight major groups in the Consumer Price Index (CPI). There are two medical care groups, medical care commodities (MCC) and medical care services (MCS), each containing several item categories (strata). This fact sheet focuses on the four medical care categories—prescription drugs, professional services, hospital services and health insurance—that generate the most questions and concerns.

MCS, the larger component of medical care in sample size and expenditure levels, is organized into three expenditure categories (EC):

- professional services;
- hospital and related services; and
- health insurance.

MCC, the other major component of medical care, includes:

- prescription drugs and medical supplies; and
- nonprescription drugs and medical supplies.

Table 1 gives the specific definitions for all published categories of the medical care group, along with each category's relative importance (see below) and the number of quotes, or sampled prices, in the current CPI sample.

**Table 1. Definitions of published medical care indexes, the number of unique price observations (quotes), and relative importance as of December 2005.**

Item	Definition	Number of quotes	Relative importance (percent)
Medical care	Medical care commodities and medical care services.	7,205	6.281
Medical care commodities	Prescription drugs, nonprescription over-the-counter-drugs, and other medical equipment and supplies.	2,606	1.446
Prescription drugs	All drugs dispensed by prescription. Mail order outlets are included. Prices reported represent transaction prices	1,222	1.018

	between the pharmacy, patient, and third party payer, if applicable.		
Nonprescription drugs and medical supplies	All nonprescription medicines, vitamins, dressings, equipment, and supplies.	1,384	.428
Internal and respiratory over-the-counter drugs	Nonprescription medicines taken by swallowing, inhaling, and as suppositories and enemas (i.e. aspirin, cough medicine, and vitamins).	889	.294
Nonprescription medical equipment and supplies	Nonprescription medicines and dressings used externally, contraceptives, and supportive and convalescent medical equipment (i.e. adhesive strips, heating pads, athletic supporters, and wheelchairs).	495	.135
Medical care services	Professional medical services, hospital services, nursing home services, and health insurance imputation.	4,599	4.834
Professional services	Physicians, dentists, eye care providers, and other medical professionals.	2,445	2.817
Physicians' services	Services by medical physicians in private practice, including osteopaths, which are billed by the physician. Includes house, office, clinic, and hospital visits. (Excludes ophthalmologists. See Eyeglasses and eye care.)	647	1.616
Dental services	Services performed by dentists, oral or maxillofacial surgeons, orthodontists, periodontists, or other dental specialists in group or individual practice. Treatment may be provided in the office or hospital.	763	.721
Eyeglasses and eye care	Services provided by opticians, optometrists, and ophthalmologists. Includes eye exams, dispensing of eyeglasses and contact lenses, office visits, and surgical procedures in the office or hospital.	682	.225
Services by other medical professionals	Services performed by other professionals such as psychologists, chiropractors, physical therapists, podiatrists, social workers, and nurse practitioners in or out of the office.	353	.255
Hospital and related services	Services provided to inpatients and outpatients. Includes emergency room visits, nursing home care and adult day care. Includes transaction	2,154	1.630

	prices only.		
Hospital services	Services provided to patients during visits to hospitals, ambulatory surgical centers, or other similar settings.	1,628	1.542
Inpatient* hospital services	Services for inpatients. Includes a mixture of itemized services, DRG-based services, per diems, packages, or other bundled services.	N/A	N/A
Outpatient* hospital services	Services provided to patients classified as outpatients in hospitals, free standing services facilities, ambulatory surgery, and urgent care centers.	N/A	N/A
Nursing home and adult day care services	Charges for residential care at nursing homes, nursing home units of retirement homes, and convalescent or rest homes. Also includes non-residential adult day care, a newer item with few price observations at this time.	526	.089
Health Insurance	Indirect approach based on retained earnings method. See health insurance section.	N/A	.386

N/A: Data not adequate for publication.

\* Substratum index.

Although medical insurance premiums are an important part of consumers' medical spending, the direct pricing of health insurance policies is not included in the CPI. As explained below, BLS reassigns most of this spending to the other medical categories (such as Hospitals) that are paid for by insurance. The extreme difficulty distinguishing changes in insurance quality from changes in its price forces the CPI to use this indirect method.

### General Information on CPI Medical Care

The CPI measures inflation at the retail level, and reflects the average price change over time for a constant quality, constant quantity market basket of goods and services. In most cases it approximates what households spend *out-of-pocket* on goods and services used for day-to-day living. Therefore, medical care indexes are limited to items with an out-of-pocket expenditure, although in the case of medical care the term out-of-pocket includes any health insurance premium amounts that are deducted from employee paychecks.

The Consumer Expenditure Survey (CE) collects annual consumer spending for each CPI category; this provides the basis for the item category weights. BLS replaces these weights every two years with ones based on more recent Consumer Expenditure Surveys. To obtain the category weights, BLS combines expenditures from the CE's for two years and updates them for price change to the December before their first use in the CPI. For example, the expenditures reported on CE's for 2001 and 2002 updated to December 2003 became the basic weights for use in the CPI from January 2004 through December 2005. Every month, to compute that month's index, BLS updates the base weights for price change from the

previous month. Every year, the BLS publishes *relative importances* for the previous December; these are base weights updated for price change and expressed as a percentage of total weight. Weights for components with greater than average price change will increase more than those with smaller than average price change. As a result, the change in a component's relative importance from one December to the next reflects its price change relative to that of all other categories as well as every two years, the biennial weight replacement.

For the medical care categories the CE collects information on household out-of-pocket expenses. These may include data such as healthcare services received, who received it, the amount of payment made, and insurance reimbursements received. Medical care expenditures eligible for the CPI include out-of-pocket expenses paid by the consumer. These include fees (not recouped through health insurance) that consumers paid directly to retail outlets for medical goods and to doctors and other medical providers for medical services, as well as health insurance premiums that consumers paid (including Medicare Part B). To arrive at the consumer out-of-pocket medical expense, the CE nets out direct insurance reimbursements to the consumer from the total amounts paid by the consumer.

Since medical care only includes consumers' out-of-pocket expenditures (and excludes employer provided health care), its share in the CPI is smaller than its share of gross domestic product (GDP) and other national accounts measures.

#### **Medical Care Outlet and Item Selection**

Throughout the year, the Bureau conducts household Point-of-Purchase surveys (POPS) in the CPI pricing areas. The POPS provides the sampling frame of outlets or retail businesses for most CPI item categories including those in the medical care indexes. BLS selects the outlet sample for each item category in each pricing area using probability proportional to the reported expenditure. Approximately one quarter of the outlets "rotate" annually so that over a four year period the entire outlet sample is reselected. This keeps the sample up to date and replenishes outlets lost to refusals and going out-of-business. BLS sends its field staff to the selected outlets to select a sample of items that the outlet sells in each assigned category; thus, the item sample rotates over the four year period. The field staff uses probability proportional to reported outlet sales for sampling goods and services priced in the CPI. During the initial visit to a business, the field staff verifies that the outlet carries the item category to be priced, proceeds to select a small sample of items in the category based on the outlet's estimated or actual revenue, and records all price-determining features for the selected items. Some medical care items, such as prescription drugs or hospital services, require special sampling procedures to reduce the burden on the outlets' respondents. Additionally, specific items, such as prescription drugs, are re-sampled more frequently due to frequent innovation and new product introduction.

#### **Prescription Drugs**

The *prescription drugs* index is comprised of drugs one may purchase by prescription at a retail, mail order or Internet pharmacy. However, prescription drugs that are primarily consumed and paid for as part of hospital visits are not included in this sample.

*Item sampling:* This index employs a streamlined sampling method. At each of the pharmacies selected, the BLS field staff selects a specific item for each of the assigned number of items to be priced. To do this, the field staff obtains a list of the last 20 prescriptions dispensed. This "last 20 list" serves as a proxy for *all* the prescription drugs dispensed at that pharmacy, and a price is obtained for each prescription on the list. The

price includes both patient and insurance contributions to the pharmacy, and the sum of all 20 prices makes up total spending (by the consumer at this pharmacy). Thus, each price represents an observed share of total spending, and the probability of any one prescription being selected is proportional to its share in total spending. The more frequently a certain drug shows up in the "last 20 list" and the more expensive it is, the more likely it is to be selected for the index. This item selection procedure is done for every outlet when it is initiated for pricing. In addition, in each outlet prescription drugs are re-sampled after two years to capture current consumer purchase behaviors and bring new goods and services into the *medical care* index.

#### *Special pricing procedures for prescription drugs:*

*Drugs losing patent protection:* When a brand-name drug in the sample loses its patent protection, generic versions of the drug receive a one-time chance to replace the original, brand-name drug even if the sample pharmacy continues to sell the brand name drug. Six months after a drug in the sample loses patent protection, CPI field staff selects among all drugs (including the original) that the Food and Drug Administration deems to be therapeutically-equivalent. Delaying the reselection for six months allows emerging generic drugs an opportunity to gain market share. The chance of drug selection is proportional to the number of prescriptions sold for each version of the drug over the previous 3 months. If a generic is selected, the CPI treats any price difference between the original drug and its selected substitute as a price change, and reflects this change in the index in the month when the procedure was performed.

When prescription drugs become available over-the-counter (OTC), the CPI continues to price them in the *prescription drug and medical supplies* index until they rotate out under normal rotation procedures. They are not transferred to the *non-prescription drugs and medical supplies* index. The observations remain in the prescription drug sample, and any price change is reflected in the *prescription drug and medical supplies* index. Similarly, if any over-the-counter drugs were to change so they required prescriptions, they would remain in the *non-prescription drugs and medical supplies* index until the next rotation and any resulting price change would occur in that index.

### **Professional Services**

The *professional services* index covers services that are performed and billed by private-practice medical doctors, dentists, eye care providers, and other medical providers. Physicians' and dental services have most of the weight for this category. Below is an example of initiating physicians' services, but the methodology applies to all providers in this EC.

*Item sampling:* At the initial visit CPI field staff establishes the practitioner's specialty, disaggregates to an appropriate service, and describes the characteristics of the selected visit and any related procedures on a CPI-specific checklist. Current Procedural Terminology (CPT) codes are collected to help describe the item accurately. Unless the selected combination of services changes or the CPT code is modified, the item descriptions remain fixed for pricing. The *physicians' services* index includes consumer out-of-pocket payments, Medicare B payments, and insurance reimbursements. The total fee reported for each priced service reflects the amount the physician expects to receive from the patient and/or insurance carrier.

### **Hospital Services**

There is a growing consensus that the most appropriate way to measure hospital services is by tracking treatment outcomes rather than medical inputs consumed. From this vantage point, a day spent occupying a hospital room and the time in an operating room are not separate consumer services, but individual components of *one* hospital visit which may be all or part of a medical treatment. The current CPI method follows medical treatments, a method that lies between the old medical-inputs method and the ideal medical-outcomes method. Measuring the value of different treatment outcomes is the subject of research in the industry, but not yet a feasible methodology for the CPI medical care indexes.

*Item sampling:* Hospital services include inpatient and outpatient services. The pricing unit is the hospital visit, defined by a date of admission, a date of discharge as documented on a hospital bill, and the specific diagnosis or medical condition. At the initial visit CPI field staff works with the respondent to select a hospital bill based on revenues generated by eligible payers (i.e. privately insured and uninsured patients). Then, the field staff describes the item in terms of the bundle of goods and services consumed during that visit, or the physical (or mental) state required for the patient to be discharged from the hospital. Bills used for the CPI are sanitized of patient-identifying characteristics and do not contravene the Health Insurance Portability and Accountability Act of 1996 (HIPPA) confidentiality mandates.

The objective of sampling for the hospital stratum is to identify a specific eligible payer to follow over time. The sampling is based on hospital revenue. The items are distinguished by their reason(s) for admission to the hospital (i.e. heart attack, emergency visit, scheduled surgery, chronic illness, diagnostics, etc.), and associated primary diagnosis type. They are further broken down by the insurers' reimbursement arrangements in the contract (i.e. itemized charges, diagnosis related group-DRG, case rate, per diem, etc.) and the patients' expected payments (if any).

The goal of the *hospital services* index is to follow the transaction prices of selected services over time while keeping price-determining characteristics constant. The transaction price is the reimbursement received by the provider from all eligible sources; it is the amount paid by the insurance carrier (if applicable) and/or patient's out-of-pocket payments. With the exceptions of fee-for-service and fee schedule, each type of reimbursement reflects a lump sum payment based on the diagnosis, the type of procedure performed, or a flat fee per unit of service. Only quotes with payer-based transaction prices are eligible for inclusion in the priced sample of hospital services.

### Health Insurance

The CPI does not publish a *health insurance* index, although BLS is testing its feasibility with an experimental index. The weights in the CPI do not include employer-paid health insurance premiums or tax-funded health care such as Medicare Part A and Medicaid. Currently, the index employs an indirect method for measuring price changes for health insurance premiums. Under this indirect method, the *medical care* index will not be affected by changes in policy characteristics, such as modifications to policy benefits and utilization changes. The approach implicitly assumes that the level of service from individual carriers is strictly a function of benefits paid. While other components may affect the index, such as more convenient claims handling or a 24-hour nurse line, their effects are probably small. This indirect approach factors medical insurance premiums into two parts:

- Changes in the prices of medical care items covered by health insurance policies
- Changes in the cost of administering policies, maintaining reserves and, as appropriate, profits.

Most expenditure for health insurance goes to the first item above, and reflects insurers' payments for medical treatments. The CPI allocates this portion to the indexes that account for medical care items (i.e. physicians' services). Thus, the weights for most of MCS indexes reflect out-of-pocket expenditures plus allocated health insurance benefit payments. (It is for this reason that provider's reimbursements from insurance companies are valid prices for the CPI's MCS indexes.)

The price change that the CPI uses for the remaining weight, changes in the retained earnings of health insurance carriers (the second item above), is the product of two relatives of change:

- The change in the retained earnings ratio, and
- The change in the cost of medical items from elsewhere in *CPI medical care*.

Retained earnings ratios are calculated based on data obtained from various industry sources. BLS acquires calendar year data on premium income, benefits payments, and retained earnings from national non-profit health insurance carriers and from Bests Insurance for commercial carriers. The relative of change is calculated by dividing the previous year's ratio by the current year's ratio. The relative of change is then converted to a monthly relative (by taking its twelfth root), and these changes are used monthly to reflect retention margins.<sup>1</sup> The second relative reflects price change for the eight medical care items whose basic weight includes allocated health insurance premiums.

**Challenges to pricing *health insurance*** The current indirect method for measuring health insurance premium changes does not mimic the way consumers pay for health care and it forces the medical care indexes to measure changes in what medical care providers receive from insurance companies rather than what consumers pay for the medical items out of pocket. A direct measure that would have an index for health insurance premiums along with out-of-pocket indexes for the various medical items would be an ideal way to measure medical care price change—provided that BLS could produce an accurate constant-quality index for health premiums. A 1984-85 test of the feasibility of directly pricing health insurance policies showed that there were major barriers to obtaining data on changes in quality variables such policy benefits and utilization (the number of claims per insured). Consequently, BLS was unable to produce consistent constant-quality premiums for health insurance policies for use as CPI prices. BLS plans further research to find more appropriate ways to price this index and currently the CPI is again re-testing the direct pricing of health insurance.

Further information may be obtained from the Office of Prices and Living Conditions, Bureau of Labor Statistics, 2 Massachusetts Avenue, NE., Room 3615, Washington, DC, 20212, or by calling (202) 691-6985.

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(1) A hypothetical example of the calculation of the change in retained earnings for commercial carriers:

Year	Income	Benefit	Retention	Retention-benefit ratio
1	\$100,000	\$94,000	\$6,000	.063830
2	\$108,000	\$100,000	\$8,000	.080000

Year 2 adjustment for change in retentions:

- a. Year 2 ratio / Year 1 ratio =  $.080000 / .063830 = 1.253329$  relative of change, or 25.33 percent, which is the annual increase in the retention to benefits ratio.
- b. Spreading this annual change equally over 12 months is done as follows: take the 12th root of the 12 month change of 1.253329, which equals 1.018995 or 1.9 percent per month.

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## How Does the Producer Price Index Differ from the Consumer Price Index?

It is often assumed that the direction and magnitude of price change in the Producer Price Index (PPI) for finished goods anticipates a similar change in the Consumer Price Index (CPI) for all items. When this assumed relationship is contradicted by the actual movements of the two series, as it often is, many data users ask why the PPI and CPI show different price movements.

The answer is that conceptual and definitional differences between the PPI and CPI--differences which are consistent with the uses of the two measures--contribute to the differences in their price movements. A primary use of the PPI is to deflate revenue streams in order to measure real growth in output. A primary use of the CPI is to adjust income and expenditure streams for changes in the cost of living. The different uses cause definitional differences that can be categorized into two critical areas: (1) the composition of the set of commodities and services they include and (2) the types of prices collected for these items.

### Compositional differences

The Producer Price Index for Finished Goods tracks the average change in prices over time of domestically produced and consumed commodities. The index is comprised of prices for both consumer goods and capital equipment, but excludes prices for services. Weights for the finished goods PPI are currently based on the value of shipments of products as reported by producers for the 1997 economic census.

The All Items CPI measures the average change in prices over time of goods and services purchased for personal consumption by urban U.S. households, regardless of the item's country of origin. This index is comprised solely of prices for consumer goods, thus it excludes prices for capital equipment. In addition, CPI weights correspond to the Consumer Expenditure Survey (currently for the years 2001-2002).

### Differences in the type and timing of prices collected

*Sales and excise taxes.* The price collected for an item included in the PPI is the revenue received by its producer. Sales and excise taxes are not included in the producer price because they do not represent revenue to the producer. The price collected for an item included in the CPI is the out-of-pocket expenditure by a consumer for the item. Sales and excise taxes are included in the price because they are necessary expenditures by the

consumer for the item. As a consequence, changes in the tax rates on cigarettes or alcoholic beverages, for example, can cause the CPI to move relative to the PPI.

*Distribution costs.* The price (revenue) received by a producer for a particular product may differ from the price paid by a consumer for that same product for important reasons besides taxes. The product in question, such as food or apparel, may have followed a distribution path from producer through wholesaler and retailer before its final sale to the consumer. In this case, the price paid by the consumer for the product likely reflects intermediate markups to cover the costs of shipping it from one party to another, as well as the costs of doing business by both the wholesaler and retailer.

*Timing of collection.* Another possible source for discrepancies in price movements between the PPI and CPI is the difference in the timing of data collection in the two programs. The PPI uses primarily a mail survey, which is sent to respondents on a monthly basis. In contrast, the CPI collects price quotes by telephone or personal visits by BLS representatives. Because respondents sometimes do not return PPI survey forms on a timely basis, indexes are routinely subject to revision 4 months after original publication to reflect late reports and price corrections. Once revised, PPI indexes are considered final. When PPI indexes are first released, they are typically based on a substantial portion of the total number of prices that will eventually be received from respondents; hence, subsequent revisions are normally minor. The CPI, on the other hand, does not routinely revise indexes.

The PPI targets the price of goods on a specific date, the Tuesday of the week containing the 13th of the month. CPI prices are typically collected throughout the first 18 working days of each month. If a particular event or pricing decision occurred late in the month, it is possible that it would be reflected in the CPI prior to the PPI.

Prices for some product and service categories in the CPI are collected every other month. Because of this "bi-monthly" price collection, the CPI reflects the price movement for some items over a 2-month period. In the PPI, all price quotations are collected monthly.

In addition, different methods may be employed for the introduction of new models of priced goods. In the PPI, a new model is priced when the producer stops selling the previous model. Most items in the CPI are priced at the outlet until they are no longer available for sale, although for some items, such as new cars and trucks, the new model is first priced when it out-sells the previous model. Therefore, in some cases, a new model might be priced in the PPI well before it shows up in the CPI. For example, in the PPI most new passenger cars are introduced in October; for the CPI, new models are introduced over a longer period (4 to 6 months beginning in September), as dealers close out old inventory and begin selling the newer models.

#### **"Pass through" of price change from the PPI to the CPI**

Some assume that a price change recorded in a particular component of the PPI will eventually and directly be seen in the same or most similar component of the CPI. In reality, it is difficult to project whether, and to what extent, an increase in the PPI will "pass through" to the CPI. For example, an increase in the price paid to a producer for a good may not be passed on by a retailer if conditions in the retail market preclude such an action. Alternatively, the retailer may increase the selling price for the good in question, but not by the full extent of the increase in the price paid to the producer.

For a more detailed discussion of price pass through relating to the PPI and CPI stage of

processing price system see <http://www.bls.gov/opub/mlr/2002/11/art1full.pdf>.

### Summary

The conceptual and definitional distinctions of the PPI and CPI are consistent with the uses of these two major economic indicators. The PPI is used to deflate revenue to measure real growth in output and the CPI is used to adjust income and expenditures for changes in the cost of living. In brief, the CPI includes services, imports, and sales taxes, whereas the PPI excludes them. Distribution costs are included in the CPI but not in the PPI. Finally, the PPI includes capital equipment and the CPI does not.

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# Alaska State Medical Association

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April 24, 2007

Honorable Kevin Meyer, Co-chair, House Finance Committee  
Honorable Mike Chenault, Co-chair, House Finance Committee  
State Capitol, Room 515  
Juneau, AK 99801-1182

RE: CSHB228 – Workers Compensation Fee Schedule

Dear Representatives Chenault and Meyer:

The Alaska State Medical Association (ASMA) represents physicians statewide and is primarily concerned with the health of all Alaskans.

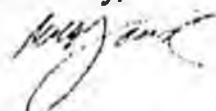
Attached is a copy of the written testimony provided to the House Labor and Commerce Committee. ASMA realizes that the critical element at this point in time is to enact legislation that will define a new payment schedule for medical services because of the current schedule being eliminated on August 1, 2007. As such ASMA supports the passage of CS HB228. Furthermore, ASMA commends Representative Kelly for introducing HB228 and seeing it through the process.

The requested data regarding the medical payments under the workers compensation system is necessary to appropriately evaluate and work towards any warranted changes. The cost, in general terms, is the result of multiplying the price (charge) for a service times the number of the times that services is provided. This data obviously is important to evaluate the price aspect but is absolutely necessary when evaluating the utilization element (i.e. the number of times a service is provided). It is critical that evaluations of the utilization element be done by those most familiar with what the appropriate standard of care is for that service. ASMA and its members have and will continue to volunteer to assist in such evaluation for the services provided by physicians.

ASMA only requests one clarification be made. That clarification is relative to CS HB228, page 2, line 2. The adjustment basis is defined as the "medical care component" of the CPI. The clarification is whether that refers to the component identified on the U.S. Department of Labor, Bureau of Labor statistics website as the "U.S. Medical Care, 1982-84 = 100 - CUUR0000SAM" or the "U.S. Medical Care Services, 1982-84 = 100 - CUUR0000SAM2". It is ASMA's understanding that the "U.S. Medical Care" component contains prescription and non-prescription drugs and prescription and non-prescription medical equipment which are not elements affected by the change made in the payment schedule under CS HB228. ASMA views such clarification as "editorial" and would support the Committee's and Representative Kelly's determination as to the most appropriate index.

ASMA asks you to expeditiously address and pass CS HB228.

Sincerely,



By: Roland Gower, MD, President  
For: The Alaska State Medical Association

**HB 228**

**House Finance**

**April 25, 2007**

**Division of Insurance**

**I. BILL PURPOSE**

**A. PROBLEM**

1. 2005 Workers' Compensation Reform Bill
  - a. Limited medical service fee schedule to that adopted by the Work Comp Board on December 1, 2004
  - b. Freeze repealed effective August 1, 2007
2. Effect – On August 1, 2007 there will be no limitation on medical fees which will likely result in medical costs escalating

**B. SOLUTION**

1. Some legislation to re-establish maximum allowable reimbursements
2. Bill – Provides for a cap adjusted for inflation for provider fees

**II. COST**

**A. SYSTEM (ATTACHMENT 1 & 2)**

1. Medical
2. Indemnity

**B. PREMIUM**

1. Loss Cost
  - a. Historical System Cost
  - b. Trending
2. Expense – Individual Carrier Component

### **III. RATE HISTORY**

#### **A. NATIONAL RANKING**

1. 2004 Oregon Study (ATTACHMENT 3)
2. 2006 Oregon Study (ATTACHMENT 4)

#### **B. ALASKA RATES (ATTACHMENT 5)**

### **IV. IMPACT (ATTACHMENT 6)**

#### **A. WITHOUT CAP**

1. NCCI estimate
2. No certainty or stability or ability to predict
3. Costs continue to grow

#### **B. WITH CAP**

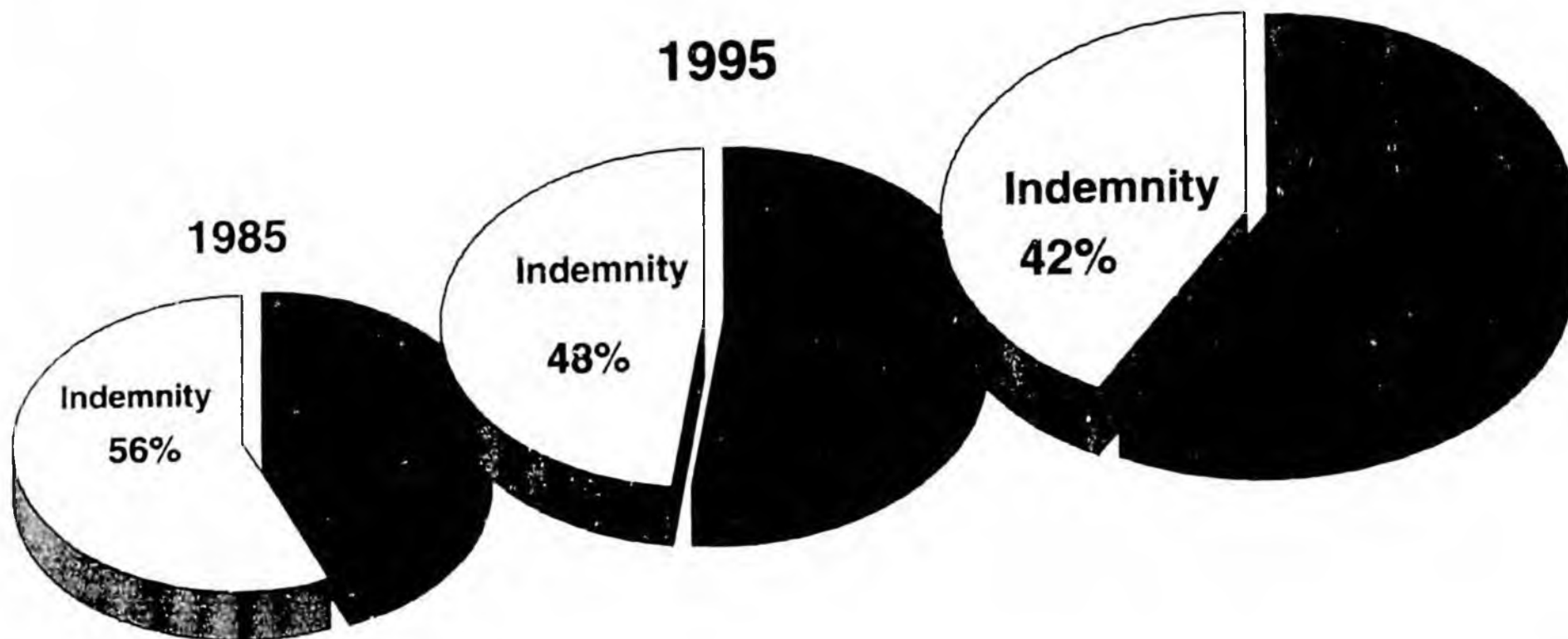
1. NCCI estimate
2. EMPHASIS – NOT mean no rate increase or decrease – just one component of rate making

#1 STATES  
All

# Workers Compensation Losses

All Claims—NCCI States

2005p



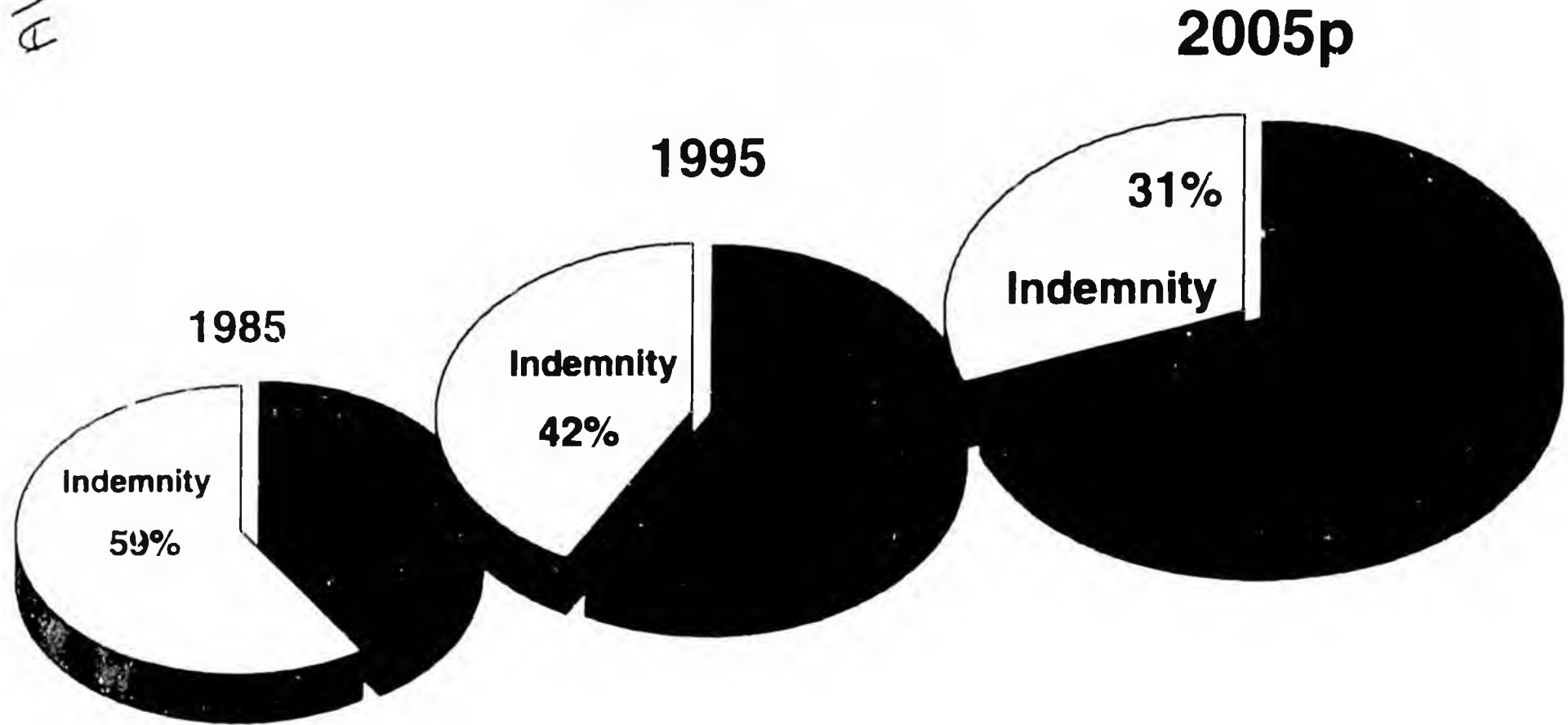
2005p: Preliminary based on data valued as of 12/31/05  
1985, 1995: Based on data through 12/31/04, developed to ultimate  
Based on the states where NCCI provides ratemaking services  
Excludes the effects of deductible policies



# Workers Compensation Losses in Alaska

All Claims—Alaska

#2  
ALASKA



2005p: Preliminary based on data values as of 12/31/05

1985, 1995: Based on data through 12/31/04, developed to ultimate

Based on the states where NCCI provides ratemaking services

Excludes the effects of deductible policies



#3 - 2004  
Oregon

Table 2. Workers' compensation premium rate ranking

2004 Ranking	2002 Ranking	State	Index Rate	Effective Date
1	1	California	6.08	January 1, 2004
2	15	Alaska	4.39	January 1, 2004
3	2	Florida	4.20	October 1, 2003
4	3	Hawaii	3.73	January 1, 2004
5	14	Ohio	3.59	July 1, 2003
6	18	Kentucky	3.48	September 1, 2003
7	4	Delaware	3.44	December 1, 2003
8	10	Montana	3.41	July 1, 2003
9	7	Louisiana	3.37	January 1, 2004
10	17	District of Columbia	3.28	November 1, 2003
11	13	Connecticut	3.23	January 1, 2004
12	18	New Hampshire	3.19	January 1, 2004
13	8	Maine	3.08	January 1, 2004
14	5	Texas	3.08	January 1, 2003
15	18	Oklahoma	3.07	2/1/02 State Fund, 1/1/04 private
16	6	Rhode Island	3.01	November 1, 1998
17	25	Vermont	2.99	April 1, 2003
18	9	New York	2.97	December 1, 2003
19	12	Alabama	2.88	March 1, 2004
20	23	Pennsylvania	2.82	April 1, 2003
21	22	Minnesota	2.74	January 1, 2004
22	28	Missouri	2.67	January 1, 2004
23	20	Illinois	2.65	January 1, 2004
24	24	West Virginia	2.64	July 1, 2003
25	29	Tennessee	2.62	March 1, 2003
26	11	Nevada	2.58	January 1, 2004
27	38	New Mexico	2.56	January 1, 2004
28	38	Wyoming	2.43	January 1, 2004
29	31	New Jersey	2.38	January 1, 2004
30	30	Michigan	2.34	January 1, 2004
31	21	Colorado	2.33	January 1, 2004
32	34	North Carolina	2.32	August 29, 2003
33	32	Wisconsin	2.27	October 1, 2003
34	27	Idaho	2.25	January 1, 2004
35	45	Washington	2.20	January 1, 2004
36	33	Mississippi	2.19	March 1, 2003
37	28	Georgia	2.14	November 1, 2001
38	39	Nebraska	2.10	February 1, 2003
39	42	South Carolina	2.08	January 1, 2004
40	40	Maryland	2.08	January 1, 2004
41	48	South Dakota	2.05	July 1, 2003
42	36	OREGON	2.05	January 1, 2004
43	43	Iowa	1.91	January 1, 2004
44	41	Kansas	1.81	January 1, 2004
45	37	Massachusetts	1.70	September 1, 2003
46	44	Utah	1.63	December 1, 2003
47	49	Virginia	1.57	April 1, 2003
48	47	Arkansas	1.57	July 1, 2001
49	46	Arizona	1.49	October 1, 2003
50	50	Indiana	1.24	January 1, 2004
51	51	North Dakota	1.06	July 1, 2003

Based on updated information, the 2002 ranking has been revised since it was originally published.

Although some states may appear to have the same index rate, the ranking is based on calculations prior to rounding to two decimal places. The index rates reflect appropriate adjustments for the characteristics of each individual state's residual market. Rates vary by classification and insurer in each state. Actual cost to an employer can be adjusted by the employer's experience rating, premium discount, retrospective rating, and dividends.

Employers can reduce their workers' compensation rates through accident prevention, safety training, and by helping injured workers return to work.

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440-2082 (12/04/COM)

# 4  
Oregon 2006

Table 2. Workers' compensation premium rate ranking

2006 Ranking	2004 Ranking	State	Index Rate	Percent of study median	Effective Date
1	2	Alaska	5.00	201%	January 1, 2006
2	1	California	4.13	166%	January 1, 2006
3	7	Delaware	3.91	158%	December 1, 2005
4	6	Kentucky	3.78	152%	October 1, 2005
5	8	Montana	3.69	149%	July 1, 2005
6	3	Florida	3.32	134%	January 1, 2006
7	17	Vermont	3.24	130%	April 1, 2005
8	13	Maine	3.21	129%	January 1, 2006
9	19	Alabama	3.17	128%	March 1, 2005
10	18	New York	3.15	127%	October 1, 2005
11	9	Louisiana	3.10	125%	September 1, 2005
12	5	Ohio	3.00	121%	July 1, 2005
13	15	Oklahoma	2.98	119%	2/1/06 State Fund, 7/1/05 Private
14	11	Connecticut	2.90	117%	January 1, 2006
15	4	Hawaii	2.89	116%	January 1, 2006
16	10	District of Columbia	2.86	115%	November 1, 2005
17	14	Texas	2.84	114%	January 1, 2006
18	20	Pennsylvania	2.80	113%	April 1, 2005
19	12	New Hampshire	2.75	111%	January 1, 2006
20	23	Illinois	2.69	108%	January 1, 2006
21	21	Minnesota	2.69	108%	January 1, 2006
22	16	Rhode Island	2.68	108%	January 1, 2006
23	29	New Jersey	2.52	102%	January 1, 2006
24	22	Missouri	2.50	101%	January 1, 2006
25	39	South Carolina	2.50	101%	July 1, 2004
26	25	Tennessee	2.48	100%	July 1, 2005
27	27	New Mexico	2.41	97%	January 1, 2006
28	28	Wyoming	2.40	96%	January 1, 2006
29	31	Colorado	2.40	96%	January 1, 2006
30	26	Nevada	2.36	95%	January 1, 2005
31	36	Mississippi	2.29	92%	March 1, 2005
32	34	Idaho	2.29	92%	January 1, 2006
33	28	Nebraska	2.25	91%	February 1, 2005
34	24	West Virginia	2.20	88%	January 1, 2006
35	33	Wisconsin	2.18	88%	October 1, 2005
36	35	Washington	2.17	88%	January 1, 2006
37	32	North Carolina	2.17	87%	April 1, 2005
38	46	Utah	2.06	83%	December 1, 2005
39	30	Michigan	2.05	82%	January 1, 2006
40	40	Maryland	2.03	82%	January 1, 2006
41	37	Georgia	2.02	82%	July 1, 2005
42	42	OREGON	1.97	79%	January 1, 2006
43	44	Kansas	1.84	74%	January 1, 2006
44	41	South Dakota	1.83	74%	July 1, 2005
45	43	Iowa	1.75	71%	January 1, 2006
46	49	Arizona	1.73	70%	October 1, 2005
47	45	Massachusetts	1.70	68%	September 1, 2005
48	48	Arkansas	1.59	64%	July 1, 2005
49	47	Virginia	1.52	61%	November 1, 2005
50	50	Indiana	1.24	50%	January 1, 2006
51	51	North Dakota	1.10	44%	July 1, 2005

Although some states may appear to have the same index rate, the ranking is based on calculations prior to rounding to two decimal places. The index rates reflect appropriate adjustments for the characteristics of each individual state's residual market. Rates vary by classification and insurer in each state. Actual cost to an employer can be adjusted by the employer's experience rating, premium discount, retrospective rating, and dividends.

Employers can reduce their workers' compensation rates through accident prevention, safety training, and by helping injured workers return to work.

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440-2082 (10/06/COM)

#5  
Rate  
History

### Historical Workers Comp Rate Changes in Alaska

Date	Total Premium Level Change	Change Due to Experience	Effect of Law and other changes	Cumulative Change
8/1/1959	6.0%	0.854	1.241	1.060
12/1/1960	-1.3%	0.986	1.001	1.046
12/31/1961	6.2%	1.062	1.000	1.111
12/31/1962	-0.4%	0.993	1.003	1.106
12/31/1963	-5.4%	0.946	1.000	1.047
10/1/1964	15.1%	1.096	1.050	1.204
9/1/1965	-0.3%	0.987	1.000	1.201
10/1/1966	-11.8%	0.870	1.014	1.059
11/1/1967	-3.1%	0.969	1.000	1.027
1/1/1969	7.2%	1.049	1.022	1.101
11/1/1969	1.6%	1.061	0.958	1.119
10/1/1970	5.4%	0.988	1.067	1.179
4/1/1972	-5.2%	0.948	1.000	1.118
8/15/1972	15.6%	1.000	1.158	1.295
3/1/1973	-3.1%	0.969	1.000	1.254
6/1/1974	34.2%	1.207	1.112	1.884
6/1/1975	46.3%	1.109	1.320	2.464
11/1/1976	3.7%	0.918	1.130	2.556
2/1/1977	0.6%	1.000	1.060	2.709
9/1/1977	-18.6%	1.000	0.814	2.205
3/1/1978	-3.6%	1.040	0.927	2.127
6/1/1978	-0.8%	1.000	0.992	2.110
10/1/1978	13.1%	1.131	1.000	2.386
12/1/1979	1.8%	0.985	1.034	2.430
4/1/1980	-5.9%	1.000	0.941	2.287
1/1/1981	9.8%	1.100	0.998	2.510
1/1/1982	4.5%	1.034	1.011	2.624
1/1/1983	-4.6%	0.954	1.000	2.503
1/1/1984	-8.0%	0.893	1.030	2.303
7/1/1984	5.0%	1.000	1.050	2.418
1/1/1985	0.1%	1.001	1.000	2.420
5/1/1985	7.3%	1.000	1.073	2.597
3/1/1986	0.0%	1.000	1.000	2.597
1/1/1987	14.3%	1.143	1.000	2.968
1/1/1988	25.1%	1.251	1.000	3.713
7/1/1988	-5.7%	1.000	0.943	3.501
1/1/1989	0.0%	1.000	1.000	3.501
1/1/1990	-4.1%	0.959	1.000	3.358
1/1/1991	-6.2%	0.983	1.000	3.301
1/1/1992	-3.2%	0.968	1.000	3.195
1/1/1993	-8.5%	0.915	1.000	2.924
1/1/1994	2.4%	1.024	1.000	2.994
1/1/1995	2.6%	1.026	1.000	3.072
1/1/1996	-7.1%	0.929	1.000	2.853
1/1/1997	-10.3%	0.897	1.000	2.560
1/1/1998	-8.3%	0.917	1.000	2.347
1/1/1999	-8.5%	0.915	1.000	2.148
1/1/2000	0.0%	1.000	1.000	2.148
7/1/2000	7.9%	1.000	1.079	2.317
1/1/2001	0.0%	1.000	1.000	2.317
1/1/2002	10.2%	1.100	1.002	2.554
1/1/2003	3.5%	1.035	1.000	2.643
1/1/2004	21.2%	1.212	1.000	3.204
1/1/2005	12.0%	1.120	1.000	3.588
1/1/2006	7.0%	1.070	1.000	3.839
1/1/2007	-10.5%	0.895	1.000	3.436
Cumulative Change		1.565	2.452	

\*In 1999 NCCI began filing loss costs for the voluntary market

\*\*NCCI implemented a new methodology for determining the assigned risk expense load

\*\*\*Includes change in methodology for maritime classes

**ANALYSIS OF THE CHANGES TO THE ALASKA PHYSICIAN FEE SCHEDULE  
PROPOSED IN CSHB 228 (L&C), AS AMENDED, TO BE EFFECTIVE AUGUST 1, 2007**

NCCI estimates that the changes to the physician fee schedule proposed in House Bill (HB) 228, as amended, will result in an overall workers compensation system cost increase in Alaska of between +0.8% and +1.3% (\$3.7 M to \$6.0 M).

If there is no change to the current law, the existing physician fee schedule will sunset on August 1, 2007, with no replacement. NCCI estimates that the impact of the fee schedule sunsetting, with no replacement schedule, would result in an overall workers compensation system cost increase in Alaska of between +4.5% and +5.8%.

**Background**

The current workers compensation medical fee schedule in Alaska became effective December 1, 2004. This fee schedule was based on the 90<sup>th</sup> percentile of usual, customary and reasonable fees for similar services as reported to Ingenix at the time the fee schedule was established. Senate Bill 130, enacted in 2005, froze the medical fee schedule at the December 2004 levels until August 1, 2007.

Alaska HB 228, as amended, proposed to be effective August 1, 2007, increases the maximum allowable reimbursements (MARs) from the December 1, 2004 physician fee schedule by the change in the medical care component of the U.S. Consumer Price Index for all urban consumers from 2004 to 2006. This proposed fee schedule would apply to services provided on or after August 1, 2007 but before March 31, 2009.

**Actuarial Analysis**

The methodology used to estimate the cost impacts due to the changes proposed in HB 228, as amended, is as follows:

Charges for various medical procedures under the physician fee schedule were obtained from medical transaction data. These charges were adjusted to reflect changes from past price levels to the price levels projected to be in effect on August 1, 2007. Trend factors used for the projections were based on the U.S. and Western region professional components of the medical consumer price index (MCPI), along with the U.S. and Anchorage MCPI (all medical components) for the period 2004-2006, shown in the following table:

Year	U.S. MCPI (Prof. Component)		Western Region MCPI (Prof. Component)		U.S. MCPI (All Medical Components)		Anchorage MCPI (All Medical Components)	
	Value	Change	Value	Change	Value	Change	Value	Change
2003	261.16	2.9%	245.17	3.3%	297.08	4.0%	N/A	N/A
2004	271.48	4.0%	255.52	4.2%	310.13	4.4%	N/A	N/A
2005	281.70	3.8%	264.65	3.6%	323.20	4.2%	344.20	N/A
2006	289.33	2.7%	271.54	2.6%	336.20	4.0%	356.10	3.5%

Source: Economy.com; N/A = Not Available

#6  
8.2

Based on the changes in the above indices, annual trend factors in the range of +2.5% to +4.5% were applied to medical transaction data for physician services performed in 2003-2004 to project the price levels that would be in effect on August 1, 2007. The lesser of the projected charge and the current maximum allowable fee was used to determine the current cost level for each procedure. Similarly, the lesser of the projected charge and the proposed maximum allowable fee was used to determine the proposed cost level for each procedure. The proposed maximum allowable fees were determined by increasing the current maximum allowable fees by the change in the U.S. MCPI from 2004 to 2006 of 8.4% ( $= 336.20 / 310.13 - 1$ ).

The estimated impact on physician costs was determined to be an increase of between +1.8% and +2.9%. This was calculated as the ratio of the total projected costs of procedures under the proposed fee schedule to the total projected costs of procedures under the current fee schedule.

This impact was then multiplied by the estimated ratio of physician costs to medical costs in Alaska (66.4%) to yield an increase on medical costs of between +1.2% and +1.9%. The impact on medical costs was then multiplied by the projected ratio of medical costs to total benefit costs in Alaska (70.2%) to yield an overall increase of between +0.8% and +1.3%.

The results are summarized in the table below:

	Impact
(1) Impact on Physician Costs	+1.8% to +2.9%
(2) Physician Costs as % of Medical Costs in Alaska	66.4%
(3) Impact on Medical Costs = (1) x (2)	+1.2% to +1.9%
(4) Medical Costs as % of Total System Costs in Alaska	70.2%
(5) Impact on Overall Workers Compensation System Costs In Alaska, based on 8.4% Increase to current 12/1/2004 physician fee schedule = (3) x (4)	+0.8% to +1.3%

April 24, 2007

Representative Mike Kelly  
State Capital Room 513  
Juneau, Alaska 99801

Representative Kelley,

The Alaska State Chamber of commerce strongly supports HB 228, temporarily capping medical costs for worker's compensation. The Alaska State Chamber of Commerce has been working towards lowering the costs associated with worker's compensation insurance for many years. The current cap on medical costs enacted when workers compensation reforms were adopted in 2005 was a stop-gap measure. The cap will sunset this fall. The 2005 cap was put into effect as a temporary measure in lieu of fundamental changes addressing the system's cost drivers. Until fundamental changes occur, passage of HB 228 is paramount to controlling costs.

Medical costs are the largest cost driver in the Alaska workers compensation system. Substantive reforms are needed to get at the quality of medical utilization and other factors such as frequency, severity of accidents and costs associated with particular accidents. When SB 130 passed in 2005, two committees were appointed, the Workers Compensation Legislative Taskforce and the Department of Labor and Workforce Development Medical Review Committee. Two important tasks of the committees were to look at program design problems and to study underlying reasons for medical cost increases. The committees were to develop recommendations to ease rate increases going forward. The committees were to have completed their work by February of 2006 and the medical rate freeze would sunset in August of 2007, replaced with a newly recommend rate fee.

The Taskforce has not completed their work and submitted it to the legislature for further review. The task force ended via a sunset provision in the 2005 legislation. The task force did not submit a HB 228 would extend the medical rate freeze until March 2009. It includes an annual rate increase based on the Consumer Price Index. The extension will allow time for the committee to complete its data gathering and analysis and develop their recommendations. This will allow sufficient time for the Legislature to address the underlying reasons for premium increases.

The medical review committee is in effect within the Dept of Labor. The committee is still waiting for research and data compilation associated with the worker's compensation system. The committee is expected to meet sometime later in the summer and work towards substantive recommendations and reform after reviewing the data. Until the committee meets and makes recommendations to the legislature, substantive changes to the worker's compensation system cannot occur. Therefore it is of great importance to all businesses that costs associated with worker's compensation insurance be controlled through passage of HB 228.



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CHAMBER  
OF COMMERCE

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In a recent study, Alaska's employers are paying the highest premium rates in the nation- more than twice the national median rate. Without substantive reforms, Alaska businesses will continue to struggle to meet the high-costs associated with worker's compensation insurance. HB 228, may only be a stop-gap measure, without it Alaska's employers may be forced to lay off employees or close their doors altogether.

We are hopeful the legislature can move this bill quickly through the legislative process.

Sincerely,

A handwritten signature in cursive script, appearing to read "Wayne A. Stevens".

Wayne A. Stevens  
President/CEO

