ALASKA LEGISLATURE COMMITTEE FILES 2007-2008 SL&C 12646

DIVISION OF BUSINESS PARTNERSHIPS
ALASKA DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
State Training & Employment Program (STEP)

Success Story
South Central Alaska

Jon had dropped out of high school after completing the 10th grade. He had a seasonal work history in the fishing industry and needed training to be employed full-time in the maritime field. With STEP funding, he completed courses at the Alaska Vocational Technical Center (AVTEC) in Seward, including Safe Food Handling, Basic Safety Training, Basic Engineering Indoctrination Topics, Deck Indoctrination Topics, Proficiency in Survival Craft, and Tankship Dangerous Liquids. At the completion of the training he was interviewed by Polar Tanker, Inc., and selected for a six-month on-the-job training (OJT). Jon completed his OJT in February and has become a full-time permanent employee of Polar Tankers, Inc. He was requested to complete his GED prior to beginning his training, which he did within three months.

DIVISION OF BUSINESS PARTNERSHIPS
ALASKA DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
State Training & Employment Program (STEP)

Success Story
Interior and Northern Alaska

Amy is now starting her third year as a carpenter apprentice in Fairbanks and has received training through a STEP grant to the Carpenters Local 1243. The union reports Amy has done very well in her class, has high scores, is productive and very interested in succeeding in her career, asks many questions of her instructors, and developed a strong work ethic. The union reports Amy's monthly hours evaluations have many positive comments, and would be recommended for employment with any of their contractors. As a whole, Amy has leadership qualities and is an asset to the union.

DIVISION OF BUSINESS PARTNERSHIPS
ALASKA DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
State Training & Employment Program (STEP)

Success Story
Southeast Alaska

Robin completed two classes under the 2006 University of Alaska Southeast – Ketchikan/Alaska Ship and Drydock STEP grant: a 40 Hour Hazwoper Training Course and the Shipyard Competent Person Training. Robin received three raises of 50 cents per hour each either during or shortly after completing training. Robin has made very good progress in the Alaska Ship and Drydock and is now a top performer in the Corrosion Control program. His employer reports Robin's strong work ethic and capacity for learning new knowledge, skills, and abilities qualifies him as a top candidate for additional training. A goal of the Alaska Ship and Drydock is to develop a stable workforce, which in shipbuilding and repair is a multi-skilled workforce. Robin has all of the attributes required to become a multi-skilled shipbuilder and repairer.

Alaska Department of Labor and Workforce Development

April 5, 2007

Fiscal Year 2006 State Training and Employment Program (STEP) Expenditures

STEP FY 2006 Authorization		**6,614,700**
Grants to training vendors	3,406,456	
Reimbursable Service Agreement, (RSA), for services provided by the Employment Training & Services component in DOLWD for Individual Training Accounts.	849,507	
RSA to provide match funding for the federal funding received by DOLWD for the Work Services Program and the Senior Community Service Employment Program (STEP match for these programs was designated by the Legislature in the FY 06 budget).	207,132	
Training Funds		**4,463,094**
RSA for services provided by the Unemployment Insurance, (UI), component in DOLWD associated with the collection of revenue for the STEP program. This is a shared cost paid by the STEP program as required in a federally negotiated cost allocation plan.	111,745	
RSA for services provided by the Data Processing component in DOLWD to provide support and maintenance to the computer applications used by the UI component associated with the collection of revenue for the STEP program.	50,132	
Revenue Collection Costs		**161,877**
Workforce Investment Board operations support	48,000	
STEP program administrative costs	532,682	
STEP Program Support Costs		**580,682**
RSA for services provided by the Research and Analysis Section in DOLWD to support data collection for the occupational database which is used to track STEP participants and provide information for the STEP annual report.	152,500	
Research and Performance Monitoring Costs		**152,500**
Unused STEP funds retained for FY 07 STEP Activities		**1,256,547**

Alaska Department of Labor and Workforce Development
Division of Business Partnerships
STATE TRAINING AND EMPLOYMENT PROGRAM (STEP) GRANTS
REQUEST FOR GRANT APPLICATIONS (RGA) PROCESS

RGA Process

- Review boilerplates and revise, if necessary, to align with RGA
- Identify impacts desired and performance outcomes sought
- Draft of RGA approved
- Announcement and distribution of RGA
- Pre-Application Teleconference with potential applicants to respond to Questions (Q & A)
  - **Updated Procedure** – Pre-Application teleconference will include a discussion of updated grant application procedures and performance expectations
- Publish teleconference proceedings and Q & A
- Select independent review committee and prepare instructions
- Receive applications
- Division review of application responsiveness to the RGA
  - **Updated Procedure** – Assure applicants' responsiveness to the RGA requirements and complete or update due diligence on all applications (currently due diligence is done after the grant is awarded)
- **Updated Procedure** – Past performance assessment – Applicants that are prior grantees will have their past performance assessed with more scrutiny
- Review Committee Meeting, Application Evaluation
  - **Updated procedure** – Committee scope of authority limited to evaluating applications in accordance with instructions provided by the Division
  - **Updated Procedure** -Division staff review applications for allocation of STEP funds as part of statewide distribution of the Department's training funding for workforce investment
- Award recommendations to Director and Commissioner based on committee evaluation and division staff allocation recommendations
- Commissioner approves the final awards
- Letters of Notice of Intent to Award and Notice of Denial issued
- Respond to Denial inquiries
- Appeals – must be submitted within 10 calendar days of date of Notices of Intent to Award and Denial – appeals are decided within 14 calendar days of receipt
- Issue press release
- Notify Technical Unit for input to Management Information System (MIS)

- Provide technical assistance to non-awardees to improve future applications

Alaska Department of Labor and Workforce Development
Division of Business Partnerships
STATE TRAINING AND EMPLOYMENT PROGRAM (STEP)

GRANT NEGOTIATIONS

- Negotiation Areas
  - Project activities
  - Location of training
  - Training timelines and schedule
  - Target population
  - Number to be served
  - Performance measures, method of measurement, targets, products
  - Budget
    - Fund sources
    - Cost categories (e.g. training versus support services)
    - Budget line items (e.g., personnel, travel, contractual, etc.)
    - Matching, in-kind contribution or leveraged funds
    - Reasonableness of costs (value) and specific cost items
    - Consistency with other grants
  - Reporting requirements (content, format and frequency)
  - Period of performance
  - Data collection and input decision (who inputs) and timeliness
  - Advance payments

Title 23. LABOR AND WORKERS' COMPENSATION
Chapter 23.15. EMPLOYMENT SERVICES

Sec. 23.15.620. State training and employment program.

There is created in the department a program to finance and award grants to employment assistance and training entities. Employment assistance and training entities shall give appropriate state agencies full access to accounting records concerning grants received to assure compliance with program standards.

Sec. 23.15.625. Employment assistance and training program account.

The employment assistance and training program account is established in the general fund. The commissioner of administration shall separately account for money collected under AS 23.15.630 that the department deposits in the general fund. The annual estimated balance in the account may be appropriated by the legislature to the department to implement AS 23.15.620 - 23.15.660. The legislature may appropriate the lapsing balance of the account to the unemployment compensation fund established in AS 23.20.130.

Sec. 23.15.630. Special employee unemployment credit and contributions for program.

(a) In the manner provided in AS 23.20, the department shall collect from each employee an amount equal to one-tenth of one percent of the wages, as set out in AS 23.20.175, on which the employee is required to make contributions under AS 23.20.290 (d). The department shall remit to the Department of Revenue, in accordance with AS 37.10.050, money collected under this subsection.

(b) Notwithstanding AS 23.20.290 (d), the department shall credit each employee with an amount equal to the amount collected from the employee under (a) of this section against unemployment contributions owed by the employee under AS 23.20.

(c) The department shall assess and collect, under AS 23.20.185 - 23.20.275, interest and penalties for delinquent reports and payments due under this section. Interest and penalties collected shall be handled in accordance with AS 23.20.130 (d).

Sec. 23.15.635. People to be served.

Within the limits of its grant, an employment assistance and training entity receiving a grant under AS 23.15.651 shall provide services set out in AS 23.15.640 (a) to state residents who, immediately before beginning training or receiving benefits under a grant financed by this program,

(1) are unemployed and

(A) are receiving unemployment insurance benefits; or

(B) have exhausted the right to unemployment insurance benefits within the past three years;

(2) are employed, but liable to be displaced within the next six months because of

(A) reductions in overall employment within a business;

(B) elimination of the worker's current job; or

(C) a change in conditions of employment requiring that, to remain employed, the employee must learn substantially different skills that the employee does not now possess; or

(3) have worked in a position covered by AS 23.20 at any time during the last three years, and are not currently eligible for unemployment insurance benefits because

(A) their employment has been seasonal, temporary, part-time, or marginal;

(B) their qualifying wages are insufficient because of limited job opportunity; or

(C) they are employed but, because they are underemployed, they are in need of employment assistance and training to obtain full employment.

Sec. 23.15.640. Services for eligible people; repayment.

(a) Subject to the limits of its grant, an entity receiving a grant under AS 23.15.651 shall provide one or more program elements. The program elements include

(1) industry-specific training;

(2) on-the-job training;

(3) institutional or classroom job-linked training;

(4) support services, including allowances;

(5) relocation assistance; or

(6) provisions of necessary tools, work-related clothing, safety gear, or other necessities to obtain or retain employment.

(b) A granting entity may award a grant that includes a program element listed in (a)(4), (a)(5), or (a)(6) of this section only if all funds from other assistance or aid programs or grants for that purpose are either not available to the granting entity or have been exhausted.

(c) The department shall require an individual who participated in a program that was funded at least in part by a grant under AS 23.15.651 and that included as a program element the provision of necessary tools, work-related clothing, safety gear, or other necessities to obtain or retain employment under (a)(6) of this section to reimburse the department for the portion of the grant that was spent on an element listed in (a)(6) of this section. Repayment shall begin no later than six months after the individual completes or leaves the state training and employment program and may not be less than $25 each calendar month. The department shall separately account for receipts under this subsection. The annual estimated receipts may be used by the legislature to make appropriations to the department to the employment assistance and training program account (AS 23.15.625) for grants under AS 23.15.651 . The department shall institute collection procedures on outstanding promissory notes for amounts due under this subsection. Collection procedures must include obtaining a judgment for default on a promissory note. The department shall seek satisfaction of the judgment from an individual's permanent fund dividend to the extent possible under AS 43.23.065 until the judgment has been satisfied. The department shall implement this subsection by regulation.

(d) In this section, a support service under (a)(4) of this section means a service provided to an individual participating in a training program described in (a)(1) - (3) of this section to enable the individual to participate in the training.

Sec. 23.15.645. Duties and powers of the department.

(a) The department shall award a grant to the board to

(1) administer a state training and employment program; and

(2) award grants to qualified entities.

(b) When a grant is awarded to the board, the department shall annually provide to the board a priority list of targeted projects or services, based on unemployment statistics, unemployment insurance claims, occupational and industrial projections, availability of other training and employment programs, and other relevant data. The department shall also provide annually to the board a priority list of criteria for eligibility to maximize services to those people most in need of training under AS 23.15.620 - 23.15.660. In developing the priority list for targeted projects and services, the department shall solicit comments from the Department of Education and Early Development, the Department of Commerce, Community, and Economic Development, the University of Alaska, organized labor, and the board. The department shall give preference to projects and services that train individuals in industries identified in the resident hire report required under AS 36.10.130 as employing a disproportionate percentage of nonresident individuals.

(c) The department may adopt regulations necessary to implement this chapter.

(d) The board, by regulation, shall establish grant administration requirements, including accounting procedures, that apply to qualified entities and their grantees.

(e) In making a grant under this section, the board shall require that the qualified entity and grantees of the qualified entity limit the amount of the grant proceeds spent on administration so that the total spent on administration from the proceeds of the employment assistance and training program account, including amounts spent by the board itself, does not exceed 20 percent of program expenses in the prior fiscal year.

Sec. 23.15.650. Work Incentive Program for Welfare Recipients. [Repealed, Sec. 7 ch 128 SLA 1990].

Repealed or Renumbered

Sec. 23.15.651. Duties of Alaska Workforce Investment Board; grants; eligible entities.

(a) In implementing this program under a grant received under AS 23.15.645, and subject to the limit of its grant, the board shall award grants, in accordance with the priority list established by the department under AS 23.15.645 (b), to employment assistance and training entities. A training entity is eligible for a grant under this section if the entity meets program requirements and can demonstrate that

(1) its accounting systems include controls adequate to check the accuracy and reliability of accounting data, promote operating efficiency, and assure compliance with program requirements and generally accepted accounting principles; and

(2) its activities do not replace or compete in any way with a federally approved apprenticeship program or any other existing training programs.

(b) The board may not award a grant if the grant would displace money available through existing public or private training programs.

(c) *[Repealed, Sec. 6 ch 49 SLA 2003].*

(d) The board shall annually provide the department with financial and performance reporting on the activities of the program and recommendations concerning continuation of funding.

Sec. 23.15.660. Definitions.

In AS 23.15.620 - 23.15.660,

(1) "board" means the Alaska Workforce Investment Board established in AS 23.15.550;

(2) *[Repealed. Sec. 6 ch 49 SLA 2003].*

(3) "program" means the state training and employment program established in AS 23.15.620 – 23.15.660.

(4) *[Repealed, Sec. 46 ch 86 SLA 2002].*

ABC Leadership for the Future

Associated Builders and Contractors, Inc.

January 29, 2008

Senator Johnny Ellis
Chairman
Senate Labor and Commerce

Dear Senator Ellis:

As you consider HB 226 in your committee, please be aware of the following information in regard to the State Training and Employment Program (STEP).

The current version of the bill requires the department of labor to conduct a review of the STEP program and report back to the legislature by June 30, 2008. Extending the life of the program prior to that review and report should not be considered without a close look at what has happened with the program in the last 10 months, since the review and report requirement was added to the legislation.

The Request for Grant Applications (RGA) issued by the department of labor and dated May 8, 2007, contains what appear to be some serious problems. For instance, under the Scope of Services it states:

The department is allocating STEP grant funds for the following services. **Industry Specific Training.** Industry specific training is for industries that need trained workers by industry. . . This includes union and non-union journeyman training and apprenticeships. . .

Though it appears that STEP funds may, in some cases, be used for apprenticeship training, it is very clear that a journeyman does not fit within that definition. Workers who are qualified to be classified as journeymen are already well trained and working in some of the highest paying jobs in Alaska. While they sometimes have to receive training to keep certifications current, STEP funds should never be used for this type of training when we have so many other Alaskan who do not earn anywhere near the average annual wage in Alaska because they do not have the training necessary to get jobs that pay these types of wages.

Further the Due Diligence section of the RGA states:

Due Diligence Standards: In order to be considered for a grant award pursuant to this request, all applicants must. . . 5. Not be in violation ***or have matters pending with*** the Departments' Occupational Health and Safety, Workers Compensation, Wage and Hour, and Unemployment Insurance Requirements . . .

While those who have been found to be in violation of the referenced statutes should be disqualified from receiving grants, it is inappropriate and likely illegal to disqualify an applicant who has a matter pending with the referenced departments. This seems to be an attempt to debar an applicant from a STEP grant in such a way this is in direct conflict with the debarment provisions of the Alaska Procurement Code.

In addition, the **Ownership of Grant Applications** section is a direct violation of the Public Records Act. A public entity like the Department of Labor and Workforce Development cannot give out public money taken from a public trust fund and refuse to disclose the applications and documents related to the review and grant process. While there might be some limited section of a grant that an applicant could argue is proprietary, it is totally inappropriate to give applicants the impression that the entirety of the application and attachments can be deem proprietary and not accessible to the public.

Finally, the most recent RGA brought up two new issues that must be addressed. To begin with, the RGA indicated that grants would be denied based on layout and typographical issues, rather than merit. This resulted in a large number of grants being denied. The outcry from those applicants who were denied required the department to reconsider those grants, thus delaying the release of grants by several months. That in turn led to a reduced amount of time for awardees to use the grant funds and complete their training. At least one entity rejected the grant they were awarded due to these constraints. In addition, the RGA indicated that the department reserved the right to "renew" grants at their discretion, without a competitive proposal process. This does not bode well for anyone, given the history of this program.

Thank You for Your Consideration-

Rebecca Logan
President
ABC Alaska

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Thank You for Your Consideration-

Rebecca Logan

Rebecca Logan
President
ABC Alaska

HB 228

SENATE COMMITTEE REPORT

DATE: 5/3/07

FURTHER:

DATE TURNED IN TO OFFICE: 5/8/07

Labor and Commerce Committee considered CS FOR HOUSE BILL NO. 228(L&C)

HB 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."

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____Letter of Intent

[ ] further referral to _____Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Under	Zero	FN#

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Under	Zero	FN#
LABOR	4/12/07			✓	
ADMIN	4/13/07			✓	

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS	PRINTED LAST NAME	DO PASS	DO NOT PASS	NOT	
Burns	Burns	✓			
B DAVIS	DAVIS	✓			
[illegible]	[illegible]	X			
CHAIR: [illegible]	ELLIS	✓			

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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.

ASHNHA Position on CSHB 228 - Worker Compensation Act Dealing with Fees to Providers
Prepared by: Rod Betit, President/CEO // April 13, 2007

Who Does ASHNHA 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 ASHNHA's rich composition of private, federal, state, and tribal health care facilities provides a balanced viewpoint on important health care policy matters. ASHNHA's membership authorized the position expressed in this testimony.

ASHNHA STRONGLY SUPPORTS CSHB 228:

ASHNHA 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, ASHNHA 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.

ASHNHA 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, Kanakanak 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 3rd Medical Group- Elmendorf, Wrangell Medical Center, Yukon Kuskokwim Delta Regional Hospital, Alaska Psychiatric Institute, North Star Behavioral Health System, Wildflower Court Nursing Home.

Alaska State Medical Association

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

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 – CUUR 0000SAM2". 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

Alaska Physicians & Surgeons, Inc.
4120 Laurel Street, Suite 206
Anchorage, Alaska 99508
Phone: 907-561-7705 Fax: 907-561-7704
Website: www.apsdoctors.org

April 13, 2007

The Honorable Representative Mike Kelly
State Capital 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 may 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

807 G Street, Suite 356 Anchorage, AK 99501
P907.258.2625 F907.279.3615 Toll Free in AK 1.800.337.3682 www.amljia.org

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

PROTECT
A service of the ALASKA MUNICIPAL LEAGUE

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.

ALASKA STATE
CHAMBER
OF COMMERCE

Headquarters

Regional Office

www.alaskachamber.com

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,

Wayne A. Stevens
President/CEO

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 90th 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 23.23.30.097(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:

Procedure	Billed Amount	Fee Schedule Amount	Increase Amount	Increase %
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 Hinchen or Pamla Scott at 907-225-9451.

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 .bility to predict
3. Costs continue to grow

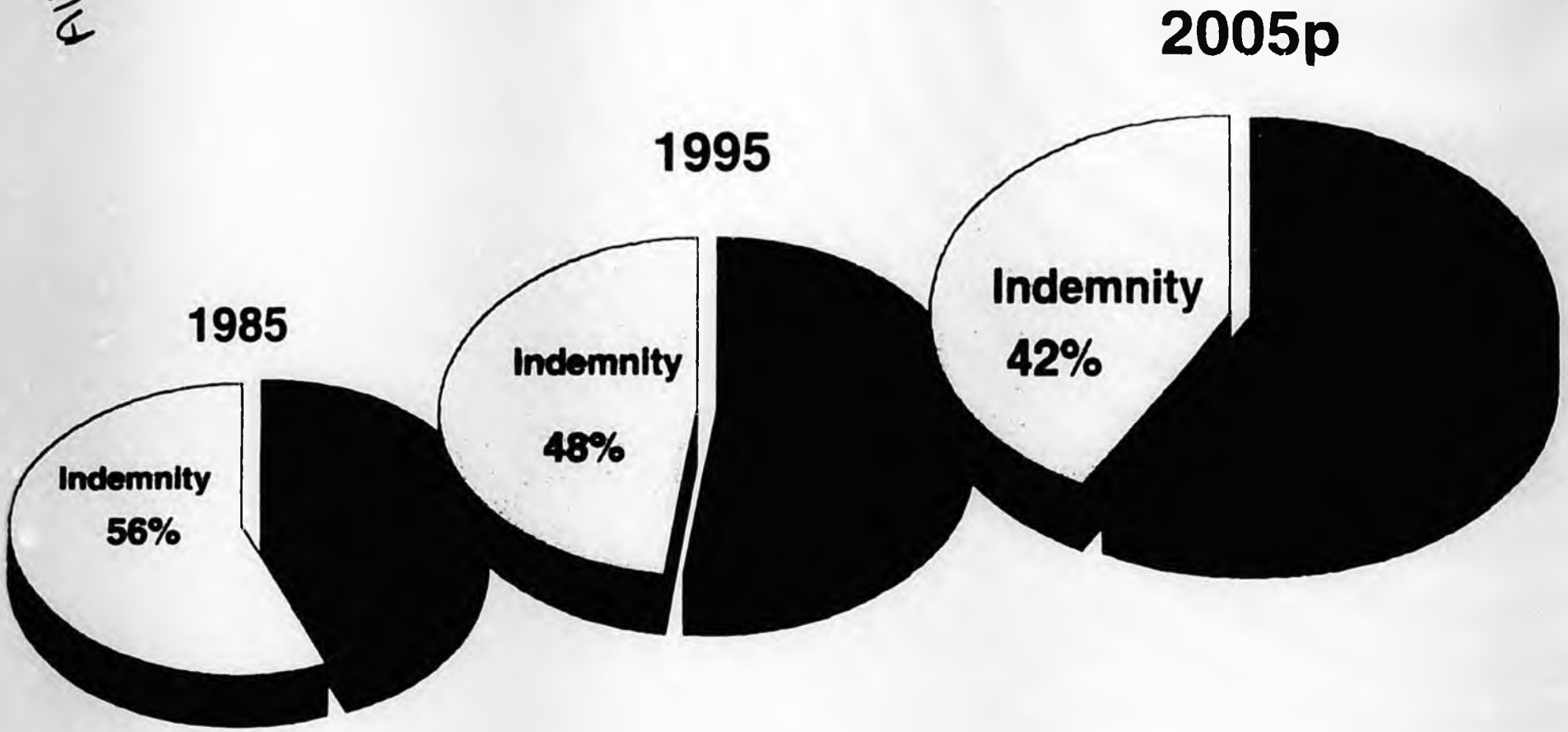
B. WITH CAP

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

All States

Workers Compensation Losses

All Claims—NCCI States

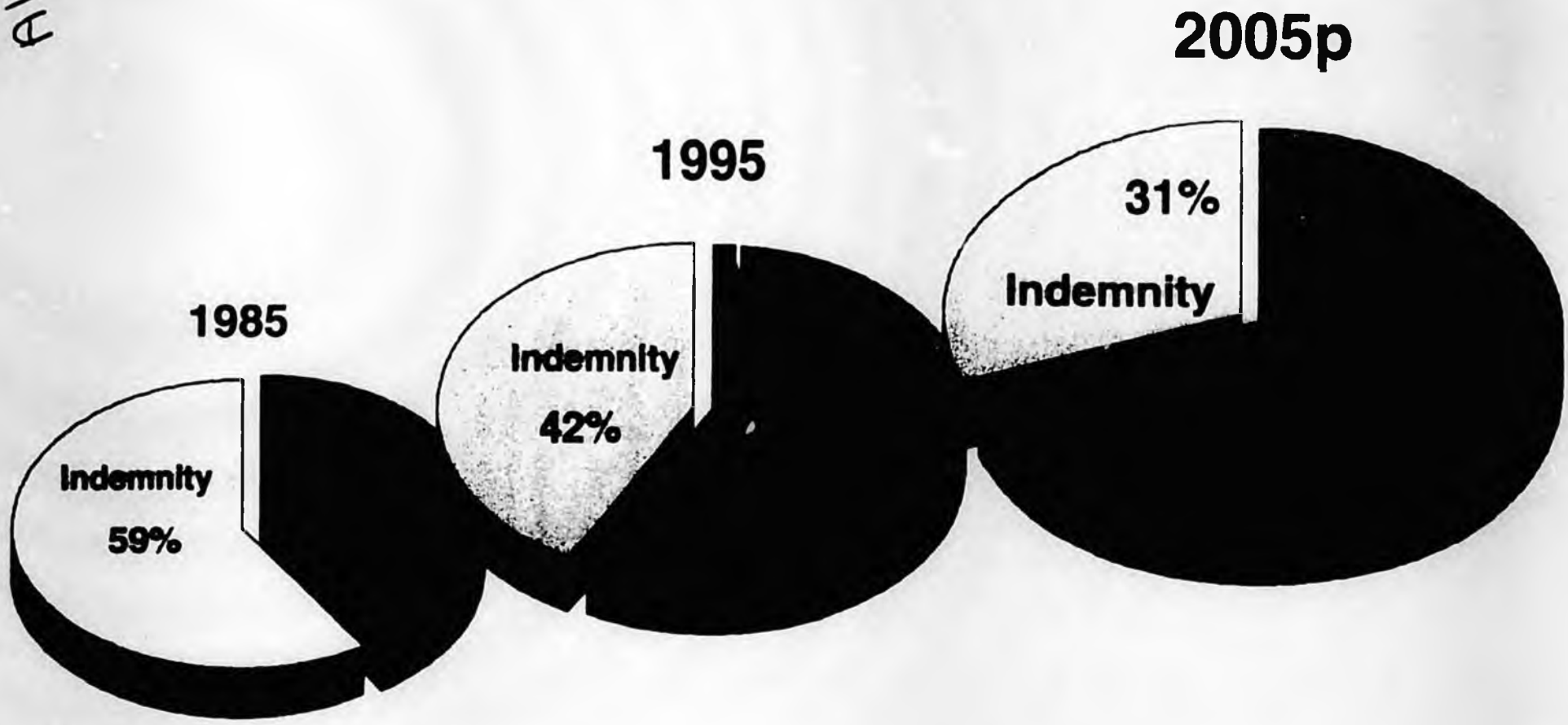


2005p: Preliminary based on data valued as of 12/31/05
1985, 1995: Based on data through 12/31/04, developed to ultimate
Based on the states where NCCI provides ratemaking services
Excludes the effects of deductible policies

Workers Compensation Losses in Alaska

#2 Alaska

All Claims—Alaska



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

Oregon

Table 2. Workers' compensation premium rate ranking

2004 Ranking	2003 Ranking	State	Index Rate	Effective Date
1	1	California	6.08	January 1, 2004
2	15	Alaska	4.38	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	16	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	19	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	26	Missouri	2.67	January 1, 2004
23	20	Illinois	2.66	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	28	New Mexico	2.58	January 1, 2004
28	38	Wyoming	2.43	January 1, 2004
29	31	New Jersey	2.36	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 28, 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	2.06	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	35	Indiana	1.24	January 1, 2004
51	51	North Dakota	1.08	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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P.O. Box 14480
Salem, OR 97309-0405
(503) 378-8254

440-2082 (12/04/COM)

Oregon 2006

Table 2. Workers' compensation premium rate ranking

2006 Rank	2005 Rank	State	Index Rate	Percent of U.S. Average	Effective Date
1	2	Alaska	5.00	201%	January 1, 2006
2	1	California	4.13	166%	January 1, 2006
3	7	Delaware	3.81	153%	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, 2006
8	13	Maine	3.21	129%	January 1, 2006
9	19	Alabama	3.17	128%	March 1, 2006
10	18	New York	3.15	127%	October 1, 2005
11	9	Louisiana	3.10	125%	September 1, 2006
12	5	Ohio	3.00	121%	July 1, 2005
13	15	Oklahoma	2.95	119%	2/1/06 State Fund, 7/1/06 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, 2006
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	26	New Jersey	2.55	103%	January 1, 2006
24	22	Missouri	2.50	101%	January 1, 2006
25	30	South Carolina	2.50	101%	July 1, 2006
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	29	Nevada	2.36	95%	January 1, 2006
31	36	Mississippi	2.29	92%	March 1, 2006
32	34	Idaho	2.29	92%	January 1, 2006
33	38	Nebraska	2.25	91%	February 1, 2006
34	24	West Virginia	2.20	88%	January 1, 2006
35	33	Wisconsin	2.18	88%	October 1, 2006
36	35	Washington	2.17	88%	January 1, 2006
37	32	North Carolina	2.17	87%	April 1, 2006
38	46	Utah	2.08	83%	December 1, 2005
39	39	Michigan	2.05	82%	January 1, 2006
40	40	Maryland	2.03	82%	January 1, 2006
41	37	Georgia	2.02	82%	July 1, 2006
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	1.78	71%	January 1, 2006
46	49	Arizona	1.73	70%	October 1, 2005
47	45	Massachusetts	1.70	68%	September 1, 2006
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.

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440-2082 (10/06/COM)

Historical Workers Comp Rate Changes in Alaska

Rate History

	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%	0.948	1.000	1.047
	10/1/1964	16.1%	1.098	1.050	1.204
	9/1/1966	-0.3%	0.997	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%	0.969	1.067	1.179
	4/1/1972	-5.2%	0.948	1.000	1.118
	6/16/1972	15.6%	1.009	1.158	1.296
	3/1/1973	-3.1%	0.969	1.000	1.254
	6/1/1974	34.2%	1.207	1.112	1.684
	6/1/1975	46.3%	1.109	1.320	2.464
	11/1/1976	3.7%	0.918	1.130	2.558
	2/1/1977	0.6%	1.000	1.060	2.709
	9/1/1977	-18.6%	1.000	0.814	2.206
	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	15.1%	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.

#6
2 pages

NCCI National Council on Compensation Insurance, Inc.

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 90th 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)	Change	Western MCPI (Prof. Component)	Change	U.S. MCPI (All Medical Components)	Change	Anchorage MCPI (All Medical Components)	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

Prepared 4/16/2007

NCCI National Council on Compensation Insurance, Inc.

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:

(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%**

Prepared 4/16/2007

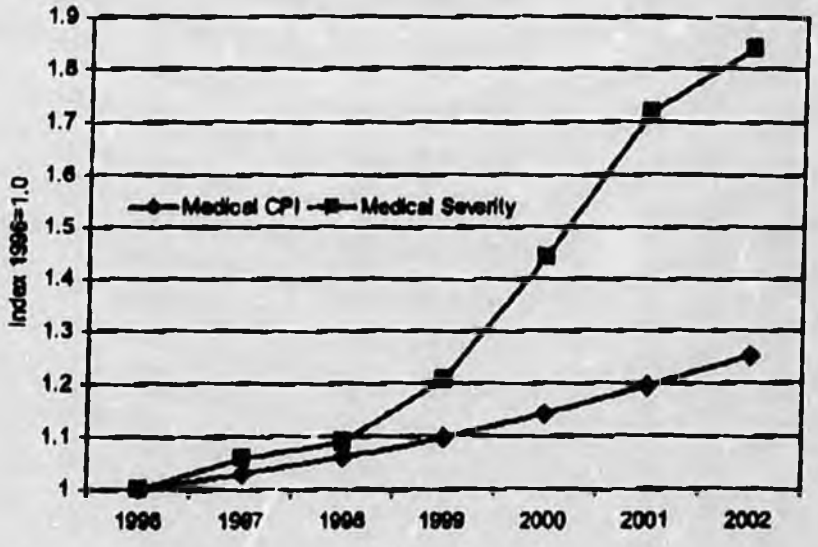
NCCI Holdings, Inc.

Measuring the Factors Driving Medical Severity: Price, Utilization, Mix

Introduction

It is clear that in recent years, workers compensation medical claims severities have been increasing at a faster rate than would be expected based on medical inflation alone (see Chart 1). Over the 1996/1997 to 2001/2002 period,[1] the medical care component of the Consumer Price Index increased by 21% compared with an increase of 73% for paid medical severity on lost-time claims closed within 24 months of date of injury.[2] This paper seeks to identify and quantify factors other than price inflation that contribute to the significant increase.[3]

Chart 1—Medical Severity Has Increased Significantly Faster Than the Medical Consumer Price Index



Accident Years 1996–2002 for NCCI Paid Medical Severity on Lost-Time Claims Closed Within 24 Months of Date of Injury and Calendar Years 1996–2002 for the Medical CPI From the Bureau of Labor Statistics

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[1] Throughout the text, all years refer to calendar years when referring to the consumer price index and accident years when referring to medical severity. The calendar year period 1996/1997 is the period from 1/1/1996 to 12/31/1997. The accident year period 1996/1997 includes data on claims for injuries that occurred from 1/1/1996 to 12/31/1997.

[2] In this study, we have chosen to work with lost-time claims closed within 24 months of date of injury. As indicated later and highlighted in the appendix, while some other measures of medical severity show increases over this period that are lower than the measure used here, they are still higher than the rate of medical inflation.

[3] This study is based on data licensed to NCCI by insurers for purposes of this study for the seven accident years from 1996–2002. This study covers lost-time claims. Countrywide, losses from lost-time claims comprise 94% of total losses since medical-only claims cover only 6% of losses.

The key findings include the following[4]:

- There has been a shift to relatively more severe injuries. The share of closed lost-time claims at 24 months with diagnosis codes with high medical severity increased by 2 percentage points from 1996 to 2002, while the share with low severity declined by 6 percentage points over the same period. Among the top 10 leading diagnoses, there was a shift toward more higher-cost sprains of rotator cuffs and fewer lower-cost sprains of the lumbosacral.
- This shift to more serious injuries led to a modest increase (about 10%) in medical severities from accident years 1996/1997 to 2001/2002.
- The key driver, accounting for approximately a 35% increase in medical severities over the years studied, is the markedly higher number of treatments within each diagnosis and a different mix of treatments across service categories. For example, there might be a shift from diagnostic radiology to complex diagnostic testing or from complex surgery to physical therapy.
- A combination of price increases for medical services and additional changes in the treatment mix accounts for about a 25% increase in medical severity over the time period.[5] In this case, we capture treatment mix shifts within a service category. For example, within the broad service category "drugs, supplies, and durable medical equipment," there might be a relative shift from lower-priced drugs to high-priced durable medical equipment or a shift within "complex surgery and anesthesia" from one type of complex surgery to another.

Identifying and Quantifying Drivers of the Medical Severity Increase

As mentioned previously, the increase in medical severity has been significant over the last several years. The challenge lies in identifying and quantifying the factors that explain that overall increase.

To aid in this we define a simple "model" of claims costs as follows:

$$\text{Cost} = \text{Price} \times \text{Utilization},$$

where utilization consists of both quantity and mix.[6] We examined the impacts of:

- "Mix"—Differences in diagnosis mix
- "Quantity"—Differences in the average number of treatments by service category within individual diagnoses
- "Price"—Differences in the average price of treatments by service category within individual diagnoses

Medical severity will change because of the following factors:

1. Changes in prices by service category—i.e., inflation
2. Changes in the number of treatments within a service category—e.g., more physical therapy sessions
3. Changes in the mix of service categories—e.g., a relative increase in "complex surgery"
4. Changes in the mix of diagnoses—e.g., from low cost lumbosacral sprain to higher cost rotator cuff injuries
5. Changes in the mix of treatments within service categories—e.g., from an established generic to a new brand name drug

In the current high level analysis, some of these factors are combined. For example, numbers 2 and 3 are jointly reported as changes in the number of treatments while numbers 1 and 5 are both captured as a change in price. Future research will focus on separating out these more detailed effects.

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[4] In most cases, our results will be rounded to the nearest 1 percentage point or the nearest $100 to avoid suggesting greater precision than is appropriate statistically.

[5] The price inflation for this portion is roughly comparable to the medical consumer price index.

[6] As an illustration of the concept of changes in "mix," consider the following example:

Johnny goes to the store to buy some apples.

On Monday he buys:
- 3 Golden Delicious at $0.50 each, and
- 4 Macintosh at $0.25 each.
- Total cost = (3 x $0.50) + (4 x $0.25) = $2.50.

On Wednesday he buys:
- 4 Golden Delicious at $0.50 each, and
- 3 Macintosh at $0.25 each
- Total cost = (4 x $0.50) + (3 x $0.25) = $2.75.

Both the total quantity and actual prices were unchanged, but the average price paid for "apples" increased because the mix of specific purchases changed.

U.S. Department of Labor
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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. [1] 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 2 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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Do you have Other comments?