NOVEMBER 2009 REPORT OF THE WORKERS' COMPENSATION MEDICAL SERVICES REVIEW COMMITTEE[1]

I. HISTORY. In 2005 the legislature amended AS 23.30.095(j) by expanding the make-up and scope of the Medical Services Review Committee (the committee). Its new mission was "to assist and advise the department [of Labor and Workforce Development (DOLWD)] and the board in matters involving the appropriateness, necessity and cost of medical and related services" provided under the Alaska Workers' Compensation Act.

The committee consists of nine members appointed by the Commissioner of the DOLWD as follows:

1. one member from the Alaska State Medical Association;
2. one member from the Alaska Chiropractic Society;
3. one member from the Alaska State Hospital and Nursing Home Association;
4. one member who is a health care provider as defined in AS 09.55.560;
5. four members who are not within the definition of health care provider; and
6. the commissioner's designee who serves as chair.

Also in 2005, the legislature enacted AS 23.30.097 concerning fees for medical treatment and services. Subsection (a) of the statute was intended to provide temporary cost control measures while the committee investigated and developed a more permanent solution. The statute mandated reimbursement of medical treatment and services to reflect:

> the lesser of
> (1) the usual, customary, and reasonable fees for the treatment or service in the community in which it is rendered, not to exceed the fees in the fee schedule specified by the board in its published bulletin dated December 1, 2004;
> (2) the fee or charge for the service when provided to the general public; or
> (3) the fee or charge negotiated by the provider and the employer under (c) of this section.
> ....
> (c) An employer or group of employers may negotiate with physicians and other treatment service providers under this chapter to obtain reduced fees and service charges and may take the fees and charges into account when forming a list of preferred physicians and providers. In no event may an employer or group of employers attempt to influence the treatment, medical decisions, or ratings by the physicians in the course of the negotiations of such a preferred physician and provider fee plans.

The above limitations were to sunset on August 1, 2007. The committee was unable to develop a permanent solution to Alaska's rising medical costs by 2007 so the sunset provisions were extended

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1 This report is based upon numerous studies by various workers' compensation research groups and national organizations as cited herein as well as information received from guest speakers appearing before the committee. For background information on the various groups and organizations as well as an index of the articles and publications reviewed, please see Exhibit 1.

and an 8.416% increase in the 2004 fee schedule was put into effect through March 31, 2009. No permanent solutions were developed by December 2008, and the sunset provisions were again extended to December 31, 2010, adding another 8.986% increase to the 2004 fee schedule.[2]

Two other possible cost control methods were provided in AS 23.30.097. Subsection (b) allowed employers to establish a list of preferred physicians for treatment of injured workers. Subsection (c) allowed employers to negotiate with providers to obtain reduced fees and service charges. An employee's use of the employer's physicians was, however, voluntary.

The committee has performed significant research and investigation and has developed permanent solutions to address medical cost containment in workers' compensation. This report details the problem, available solutions and the committee's findings and recommendations.

II. PROBLEM.[3] In 2002 Alaska's workers' compensation premium rates ranked fifteenth in the nation. By 2004, Alaska had climbed to number 2, second only to California who drastically overhauled their system that same year. Since 2005, California's premium rates have dropped and Alaska has ascended to the "Number One" position, a position it continues to maintain.[4] While the frequency of injuries in Alaska has steadily declined over the past 20 years, the average medical cost per injury has risen at a rate of 8.5% per year.[5] The average medical cost per injury in 2004 was $29,000. Alaska medical costs now average $40,000 per injury as compared to a nationwide average of $26,000.[6] Average hospital costs per stay in Alaska climbed from $12,000 in 1994 to $27,171 in 2007 as compared to a nationwide increase from just over $8,000 to $15,455 during the same time period.[7] In 1988, medical costs comprised 52% of all Alaska workers' compensation benefits. They now comprise 72%. The nationwide average is 58%.[8]

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2 The two increases totaling 17.402% were based on the medical consumer price index for all U.S. urban consumers as determined by the U.S. Department of Labor. The increase in the Anchorage medical consumer price index during this period was 14.569% and the overall increase in the U.S. consumer price index was 12.05%.

3 One of the problems the committee has recognized is the lack of comprehensive data collection. The medical cost data available in Alaska is limited to that gathered by the National Council on Compensation Insurance (NCCI) which receives cost data submitted by Alaska's workers' compensation insurers. Thus, while the available data is representative of Alaska's workers' compensation medical costs, it does not include medical costs incurred by self-insured's which represent some of Alaska's largest employers.

4 Exhibit 2: 2004, 2006 and 2008 Oregon Workers' Compensation Premium Rate Ranking Summaries.

5 Exhibit 3: NCCI State Advisory Forum 2008, p. 21; NCCI Alaska State Advisory Forum 2009, p. 37. The annual CPI increase during this same period has been less than half the annual medical cost increase.

6 Exhibit 4: NCCI State Advisory Forum 2009, p. 35.

7 Exhibit 5: NCCI State Advisory Forum 2008, p. 81.

8 Exhibit 6: NCCI Alaska State Advisory Forum and 2009, pp. 31-32.

III. INTRODUCTION. Medical cost containment became a focus for many states in the early 1990s when the medical portion of the workers' compensation benefit dollar began to grow more quickly than other claim costs. The factors in the upward spiral of medical costs were not just price but utilization with utilization being the dominant force making workers' compensation injuries more and more expensive to treat.[9] Higher prices and utilization pushed workers' compensation medical costs higher than Group Health particularly in specialty areas such as radiology and surgery.[10] This focus led to growth in the development of cost containment strategies which included the adoption of fee schedules, the creation or adoption of evidence-based medical treatment guidelines and the development of return to work programs through a grass-roots approach to workers' compensation systems.[11] Each of these three strategies is discussed below followed by Alaska's current cost containment model. These discussions are followed by the committee's findings and recommendations for controlling medical costs in Alaska.

IV. FEE SCHEDULES. Workers' compensation medical fee schedules specify maximum allowable payment amounts for medical procedures and services covered under workers' compensation insurance. All but seven states currently employ a workers' compensation medical fee schedule as one method of controlling medical costs. A variety of approaches are used to construct and maintain these schedules. Some specify their medical fee schedule in their statutes as percentages of Medicare but the majority of states give authority to an agency such as the Department of Labor. These agencies then typically rely on an advisory committee or hire an outside consultant to draft a proposed medical fee schedule.[12]

A. Medical Provider Fees Schedules. These schedules provide maximum payment amounts for medical providers and do not, therefore, include hospital or facility charges. The schedules utilize a system of coding which has been developed over the years to identify each current medical procedure. The system is known as the Current Procedural Terminology (CPT) code and identifies thousands of medical procedures. The code is maintained by the American Medical Association (AMA) and is universally utilized by medical providers.

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9 Utilization is not just the number of treatments per injury but the types of treatment as well (i.e., from simple diagnoses to more "complex" diagnoses which are paid at higher rates.) For a thorough illustration of the impact of utilization on medical costs, see *The Cost Conundrum,* The New Yorker, Atul Gawande, June 1, 2009, attached as Exhibit 7.

10 *Measuring the Factors Driving Medical Severity: Price, Utilization, Mix,* Restrepo, Shuford and Beaven, NCCI Research Brief, January 2007; *Effectiveness of WC Fee Schedules: A Closer Look,* Lipton, Corro, Moore and Robertson, NCCI Research Brief, February 2009.

11 *Workers' Compensation Medical Cost Containment: A National Inventory,* Workers Compensation Research Institute, February 2009; *Introduction to the New Work Disability Prevention Paradigm,* Dr. Jennifer Christian, Chair, The 60 Summits Project, March 2009; *Preventing Needless Work Disability by Helping People Stay Employed,* American College of Occupational and Environmental Medicine, September 2006.

12 *Workers' Compensation Medical Cost Containment: A National Inventory,* p. 2, Workers Compensation Research Institute, February 2009.

Because some services are not reflected in the CPT codes, Medicare developed a secondary set of procedure codes known as the Health Care Procedure Coding System (HCPCS). This system includes such services as supplies, materials, injections and emergency transportation services and other services not included in the CPT codes. From these codes, two general types of fee schedules have emerged.[13]

i. Usual and Customary Rate (UCR). This method aligns the particular CPT code with the usual and customary charge for that service in the area in which it is rendered. The fee schedule is then geared to require payment at a certain percentile of the usual and customary charge. States employing this method require the collection of payment data for each CPT code to create their fee schedule which is usually updated annually. Alaska's current fee schedule utilizes this method. (*See* pp. 8-9, *infra.*)

Problems with UCR schedules include high maintenance costs as constant data collection and revision is necessary to update the usual and customary charges. Prior to 2005, the Alaska fee schedule was updated annually at a cost of $60-$65,000.00. Annual user costs are in excess of several thousand dollars. In addition, despite the cost control measures intended by this method, upward pressure in price is constantly applied. Once a fee schedule is published, charges tend to rise to and above the level of payment thereby guaranteeing an annual increase in the usual and customary charge. Studies reveal this method to be the least effective in controlling medical costs.[14]

ii. Resource Based Relative Value Scale Method (RBRVS). This method was created in 1988 by a multi-disciplinary team of researchers from Harvard University which included statisticians, physicians, economists and measurement specialists. The RBRVS system now constitutes the basis for Medicare and Medicaid's payment schedule as well as nearly all group health, health maintenance organizations as well as 26 state workers' compensation systems. The American Medical Association (AMA) owns and updates the RBRVS periodically. As of May 2003, the AMA had submitted over 3,500 corrections to Medicare.[15]

Under this method, the AMA assigns a value (relative value unit or RVU) to each CPT code. The RVU is based on three separate factors: estimated physician work/time (52%), physician expense associated with the procedure (44%) and malpractice expense (4%).[16] The RVU is then adjusted by geographic region to reflect the variation in provider costs (a provider performing a procedure in Manhattan has greater overhead costs than a provider performing the same procedure in El Paso). This value is then multiplied by a fixed conversion factor set by the state to determine the amount of payment. For example, in 2005 a 99213 CPT code (office visit for an existing patient) was worth

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13 CPT and HCPCS codes do not apply to hospitals. Hospital payments are therefore discussed elsewhere in this report.

14 *Effectiveness of WC Fees Schedules, A Closer Look,* Lipton, Corro, Moore and Robertson, NCCI Research Report, February 2009.

15 *Making Workers Compensation Medical Fee Schedules More Effective,* Appendix 1, Robertson and Carro, NCCI Research Brief, December 2007.

16 *Id.*

1.39 relative value units, or RVUs. Adjusted for North Jersey, it was worth 1.57 RVUs. Using the 2005 Conversion Factor of $37.90, Medicare paid 1.57 X $37.90 for each 99213 performed in North Jersey or $59.50. In 2009, Medicare utilizes a conversion factor of $36.0666 for each relative value unit.

Because the work and expense factors that make up an RVU are provider factors, the RBRVS system is criticized because it does not include consumer factors such as outcomes, quality of the service or demand. Critics maintain that payment based on *effort* rather than *effect* skews incentives, leading to overuse of complicated procedures without consideration for outcomes. [Contrast this method with evidence-based medicine (EBM) which is based on outcomes as discussed below.] According to this critique, the RBRVS system misaligns incentives because the medical value to the patient of a service is not considered and thus there is no financial incentive to help the patient nor to minimize costs. Rather, payment is partly based on difficulty of the service (the "physician work" component) and thus a profit-maximizing physician is incentivized to provide maximally complicated services, with no consideration for effectiveness.

iii. Comparison of Fee Schedules. Studies of state fee schedules reveal the following:[17]

a.) There are substantial differences in fee schedule rates from state to state. In 2006, Alaska, with the highest fee schedule rates, was on average 3.5 times higher than Massachusetts, the state with the lowest fee schedule rates.

b.) This interstate variation is not related to interstate variations in expenses incurred by providers in producing the services. In fact, provider expenses in Alaska are slightly *lower* than in Massachusetts.[18]

c.) Most state fee schedules create financial incentives to underuse primary care and overuse invasive and specialty care given the significant price variations between those groups. For example, primary medical in Alaska is paid at 185% above Medicare rates. Surgery, however, is reimbursed at levels 482% above Medicare and radiology at 312%.[19] Some states avoid

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17 The two most noteworthy studies are the 2006 and 2009 Workers Compensation Research Institute studies entitled *Benchmarks for Designing Workers' Compensation Medical Fee Schedules: 2006,* Eccleston, Liu, Workers Compensation Research Institute, 2006; and *Workers' Compensation Medical Cost Containment: A National Inventory,* Workers Compensation Research Institute, February 2009.

18 Although the study was based on data from July 2006, there is no evidence to suggest the cost of doing business in Massachusetts has suddenly decreased or that costs in Alaska have suddenly increased. *Benchmarks for Designing Workers' Compensation medical Fee Schedules: 2006,* p. 9, n.5; Eccleston, Liu, Workers Compensation Research Institute, 2006.

19 These figures are based on the 2009 fee schedule for the various provider groups. The Workers Compensation Research Institute study revealed payments for these groups was lower in 2006 with surgery at 417% greater than Medicare and radiology at 273%. Primary care was divided into three categories: general medicine, physical medicine and evaluation and management. Costs above Medicare for these groups were 287%, 153% and 127%, respectively. *Id.* at 9. Exhibits 8,9.

these financial incentives by following a RBRVS fee schedule system and setting one conversion factor across all different service groups within their state.

d.) The most effective fee schedules are those based on the RBRVS system and a conversion factor which sets the maximum allowable fees at no more than 40% above Medicare.[20]

e.) While fee schedules provide some element of control over medical costs, they are ineffective in controlling utilization. Moreover, their effectiveness is declining as the proportion of workers' compensation medical costs subject to physician fee schedules is declining by about one percentage point per year due in part to a growing proportion of reimbursements going to hospitals and ambulatory surgical centers not subject to physician fee schedules.[21]

B. Outpatient Facilities and Hospitals Fee Schedules. Facilities and hospitals pose technical difficulties to the development of fee schedules given that a host of procedures, providers and equipment is involved in every hospital stay or outpatient facility use. Medicare requires facilities to assign Diagnosis Related Groups (DRG's) to inpatient care and Ambulatory Payment Classifications (APC's) to outpatient surgery. The National Hospital Association therefore develops DRG's and APC's and assigns a relative value to each group or classification much as the AMA develops the RBRVS. Currently, Medicare utilizes a fixed conversion factor for each DRG and APC value. Alaska, however, uses an average daily rate for hospitals and facility fees. (*See* pp. 8-9, *infra.*)

V. EVIDENCE-BASED MEDICAL TREATMENT GUIDELINES. Fee schedules have a very limited impact on utilization and therefore are, by themselves, ineffective in controlling medical costs. Therefore, as states began to adopt fee schedules and other mechanisms in an attempt to control escalating medical costs, utilization increased.[22] This inverse relation between cost and utilization is best illustrated by the observation in one study that when Medicare lowers its reimbursement rates for a particular geographic area, some providers modify their practice to offset the cost reduction either by switching to more highly compensated procedures or performing more procedures.[23] Given the increased utilization, states began to focus not just on the price of medical services but on the effectiveness of the treatment through the creation and/or adoption of medical treatment guidelines.

Medical treatment guidelines have evolved in the medical community in response to the emergence of a significant body of evidence developed through clinical study and research. From this body of research providers have developed the practice of evidence-based medicine (EBM), defined as the integration of clinical expertise, patient values, and the best evidence into the decision making

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20 *Id.*; *Effectiveness of WC Fees Schedules, A Closer Look,* Lipton, Corro, Moore and Robertson, NCCI Research Report, February 2009.

21 *Id.*

22 *Measuring the Factors Driving Medical Severity: Price, Utilization, Mix,* Restrepo, Shuford and Beaven, NCCI Research Brief, January 2007; *Effectiveness of WC Fee Schedules: A Closer Look,* Lipton, Corro, Moore and Robertson, NCCI Research Brief, February 2009.

23 *Making Workers Compensation Medical Fee Schedules More Effective,* p.9, Robertson and Carro, NCCI Research Brief, December 2007.

process for patient care.[24] Thus, new or experimental procedures which have not been clinically studied or procedures which studies have shown to be ineffective are less apt to be utilized if at all in the practice of evidence-based medicine.[25] The focus of EBM is to improve patient outcomes utilizing the best evidence available.

Washington was the first state to investigate the effectiveness of various treatments and in 1989 published its first treatment guideline detailing recommended treatment for low back fusions. Other states soon followed. In 1989 the Texas legislature authorized the development of treatment guidelines. Colorado and Minnesota soon followed.[26] California's 2004 workers' compensation reform included adoption of a national guideline created by the American College of Occupational and Environmental Medicine (ACOEM). Today, some 26 states and every Canadian Province have adopted or created treatment guidelines.[27]

The use of guidelines in workers' compensation aims to achieve optimal patient outcomes. From these efforts to review and standardize treatment in workers' compensation, two national guidelines have emerged: *Official Disability Guidelines – Treatment in Workers' Compensation* developed by the Work Loss Data Institute (ODG Treatment Guidelines) and the *Occupational Medicine Practice Guidelines* developed by the American College of Occupational and Environmental Medicine (ACOEM Practice Guidelines). Both guidelines are developed and updated annually through a systematic physician review of the medical literature.[28]

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24 The most common definition of EBM is taken from Dr. David Sackett. EBM is "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research." EBM is the integration of clinical expertise, patient values, and the best evidence into the decision making process for patient care. Clinical expertise refers to the clinician's cumulated experience, education and clinical skills. The patient brings to the encounter his or her own personal and unique concerns, expectations, and values. The best evidence is usually found in clinically relevant research that has been conducted using sound methodology. The evidence, by itself, does not make a decision for you, but it can help support the patient care process. The full integration of these three components into clinical decisions enhances the opportunity for optimal clinical outcomes and quality of life. Sackett, D.L. et al. (1996) Evidence Based Medicine: What It Is and What It Isn't. BMJ 312 (7023), 13 January, 71-72).

25 *ACOEM Occupational Medicine Practice Guidelines,* Lee S. Glass, M.D., IAIABC Journal, Vol. 41, No. 2, Fall 2004.

26 *Treatment Guidelines for Workers' Compensation,* Gregory Krohm, IAIABC Research and Reports, October 2004.

27 *Jurisdictional Adoptions of Treatment Guidelines in North America,* Workers Compensation Research Institute, 2008; *Workers' Compensation Medical Cost Containment: A National Inventory,* Table 18, Workers Compensation Research Institute, February 2009.

28 *Evaluating Medical Treatment Guideline Sets for Injured Workers in California,* Rand Institute for Civil Justice and Rand Health, 2005. Although Rand found a total of five guideline sets which met their screening criteria, only ODG and ACOEM were comprehensive enough in scope to be practical in a workers' compensation context.

There is concern that claims adjustors and case managers may not have the necessary skills to interpret guideline recommendations and apply them to control treatment expenditure.[29] California therefore implemented an expensive utilization review process which has eliminated some of the medical cost savings realized by use of treatment guidelines. Implementation of guidelines has therefore been most effective in those states that have invested in an expert medical director to manage the development and implementation of the guidelines over the course of several years. To be effective, EBM needs to be introduced and the local practitioners and medical associations need to be educated by a credible advocate before implementation.

VI. DEVELOPMENT OF RETURN TO WORK/STAY AT WORK MODELS. Through their study of medical literature and drafting of the 2nd Edition of the ACOEM Treatment Guidelines, ACOEM physicians realized another major component of workers' compensation had been largely ignored: educating physicians and other key players to prevent needless work disability. In an attempt to bring the focus to finding better ways of handling non-medical aspects of the process that affect disability, ACOEM physicians authored a paper entitled *Preventing Needless Work Disability by Helping People Stay Employed.*[30] Out of the article developed a grass-roots effort aimed at transforming workers' compensation systems by involving all stakeholders with a goal of addressing how employers and insurers can work more effectively with healthcare providers to reduce the disruptive impact of injury and illness on people's daily lives and work to help them remain actively employed.[31] The effort is promoted and lead by an occupational and environmental medicine physician who started The 60 Summits Project aimed at holding a summit in each of the 50 states and 10 Canadian Provinces to implement the process.[32] Some 15 states have either held summits or are preparing to do so. Through the process, the participants come to agreement on a set of common goals and set about transforming the way the workers' compensation system operates in order to reach those goals. A successful 60 Summits process creates a widespread openness to active return to work/stay at work programs thereby achieving a reduction in medical and disability costs while bringing the focus of the system back to limiting the impact of injuries on the lives of America's workers.

VII. ALASKA'S MEDICAL COST CONTROL MEASURES. Prior to 2004, Alaska utilized only a UCR based fee schedule to control medical costs.[33] The schedule was created by a third party vendor and medical provider reimbursements were limited to the 90th percentile of the usual,

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29 *Practical Implementation of Treatment Guidelines in a Workers' Compensation Environment – A New Approach,* Stanhop and Ford, IAIAC Journal, Vol. 45, No. 1, Spring, 2008.

30 Journal of Occupational and Environmental Medicine, September 2006.

31 There is a wealth of epidemiological studies of the impact of unemployment on physical and mental illness and mortality. *See, Journal of Epidemiological Community Health 2005;* 58:501-506*; American Journal of Independent Medicine 2004;* 45:408-416*; Occupational Environmental Medicine 2001;* 58 (1): 52-57*; American Journal Public Health 1999;* 89 (6): 893-898.

32 The physician, Dr. Jennifer Christian, is a former Alaskan occupational medicine physician and past president of the Alaska State Medical Association.

33 *See* former AS 23.30.095(f), 2004, repealed in Sec. 74 Ch. 10 FSSLA 2005.

customary and reasonable fee charged. The fee schedule was updated annually until 2005 when Alaska's cost control measures were expanded through the adoption of AS 23.30.097(a) which limited provider fees to the lesser of 1) the 2004 fee schedule; 2) the fee charged to the general public; or 3) the fee or charge negotiated by the provider and the employer. Since 2005, the fee schedule has undergone two legislative price increases and provider costs are now reimbursed at the rate identified in the 2004 schedule times 17.402%.[34] Hospital services are paid at an average daily rate of $8,906.00 for medical/surgical rooms and $17,701.81 for ICU/CCU rooms plus medical supplies and surgical implants (reimbursed at 20% above the invoice price).[35] There is no fee schedule for medi-vac and other emergency transportation services.[36]

VIII. FINDINGS.

A. Objectives. Throughout this process, the committee has recognized the dual purpose of its mission: 1.) to develop permanent solutions to escalating medical costs in Alaska's workers' compensation system while 2.) ensuring that access to medical care will not be compromised either by setting the maximum allowable reimbursement of medical fees and services too low or by overburdening providers with paperwork and other administrative requirements thereby complicating the provision of medical services to injured workers.

The committee finds California's 2006 study following its 2004 workers' compensation reform experience a good method of tracking the above objectives. California's reform introduced ACOEM Medical Treatment Guidelines and significantly reduced fee schedule reimbursement rates for medical services. A 2006 study conducted by UCLA Center for Health Policy Research for the California Department of Industrial Relations did not find evidence of access problems for most injured workers in California, nor did the study find large numbers of physicians to be limiting or giving up their workers' compensation practices.[37] To measure the effects of reform in Alaska, the committee finds a similar study should be undertaken five years after the adoption of any changes to assess the impact of those changes upon medical costs and access to medical care and outcomes.

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34 The 17.402% increase was built into the 2007 and 2009 legislative extensions of the 2005 sunset provision in AS 23.30.097(a). The increase in the U.S. consumer price index during the same period was just 12.05% and the increase in the Anchorage medical consumer price index was 14.569%.

35 The Alaska hospital payment system requires employers to pay twice for medical supplies: once in the average daily rate and again as a separately billed item. Unlike Alaska's workers' compensation, Medicare and group health "bundle" medical supplies into the hospital procedure group rate and thus do not pay extra for medical supplies. In addition, although implants are paid at 20% over the invoice price, some implant providers forego payment altogether rather than reveal the invoiced price.

36 The attached correspondence regarding the costs associated with a recent emergency medical evacuation from the North Slope to Seattle illustrates the problem which has emerged from the lack of any medical cost containment mechanisms in this area. Exhibit 10.

37 *Access to Medical Treatment in the California Workers' Compensation System,* Kominski, Pourat, Roby and Cameron, 2006.

B. Alaska's Fee Schedule. The committee finds that Alaska's medical costs continue to rise at an average of 8.5% per year despite implementation of a fee schedule and other cost control measures. Based on the research and data currently available, Alaska's workers' compensation pays an average of between 185 - 482% above Alaska's Medicare rates and that this differential does not correlate to any interstate variations in provider expense.[38] The committee further finds that Alaska's hospital and facility costs are the highest in the nation also with no evidence of correlation to provider expense. Finally, the committee finds that any fee schedule must cover all medical services and treatment including emergency medical transportation services, supplies and other services as identified in the Health Care Procedure coding System (HCPCS).

Based on these findings and the committee's research, the committee concludes that Alaska's UCR based fee schedule and its average daily hospital/facility rates should be discarded and a fee schedule utilizing a value based system (RBRVS for providers and outpatient hospital charges and DRG for inpatient hospital/facility charges) should be adopted. The committee further concludes that the schedule must also include cost control measures for emergency medical transportation services as well as pharmaceutical and durable manufactured equipment.

Moreover, given the large cost differences among provider groups (surgery vs. general medicine), the committee recognizes that adoption of a single conversion factor would drastically cut costs of some user groups (surgery and radiology[diagnostic imaging]) while likely increasing others (general medicine). Although a majority of the committee agrees with the recommendations of those who have studied fee schedules that only one conversion factor be utilized, the committee recognizes that to do so may make any change politically improbable given the huge disparities in payment values among the various provider groups. Thus, a majority of the committee concludes that at least initially multiple conversion factors will need to be assigned. Others on the committee recognize that this distorts the entire basis for the RBRVS system and continues to foster the overutilization patterns of surgery, diagnostic imaging and other high cost diagnostic testing.

C. Alternative Cost Control Methods. The committee finds that the additional cost control mechanisms adopted in 2005 (limiting fees to that charged the general public or as negotiated by the provider and employer) are ineffective as the department and employers lack access to the fees charged the general public or negotiated in order to enforce the statute. In addition the employers are unable to negotiate with providers given the small size of their market share. Moreover, the committee finds that although employers may establish a list of preferred physicians for treatment of injured workers, the employee's use of a preferred physician is voluntary and, thus, no such lists have been established. The committee therefore finds the cost control measures outlined in AS 23.30.097(a) – (c) have had little, if any, impact on reducing medical costs in Alaska.

Based on the studies cited herein, the committee finds the adoption of a fee schedule to be but one small component in the management of rising workers' compensation medical costs. One study suggests that a reduction in costs through a fee schedule may actually incentivize providers to increase utilization thereby further increasing costs. As utilization is the primary driver in the rise of workers' compensation costs, the committee finds the ultimate adoption of a single RVU fee

38 Surgery accounts for 53% of Alaska's overall medical costs. Radiology and laboratory services account for another 13%. General medicine, accounts for 27% of overall costs. The remaining 8% represents medications and durable medical equipment.

schedule conversion factor and the education and promotion of EBM as defined by Sackett and the ultimate adoption of EBM treatment guidelines are necessary to effectively control medical costs.

The committee also finds, however, the adoption of EBM treatment guideline requires greater study and public involvement than this committee has managed to garner. It may be wise to view this as a public health intervention since it will affect thousands of people, thus requiring careful thought, planning and attention to public perception and buy-in. Selection and adoption of treatment guidelines with over-emphasis on cost control without explicit focus on the benefits of changes to workers, coupled with overly-hasty and poorly-planned implementation can cause widespread confusion, needless system disruption and delays, and resistance by system participants who might otherwise cooperate as occurred in California. Further study with more public involvement and discussion of the purpose, anticipated benefits and intended outcomes of guidelines adoption is likely needed before practice guidelines can be implemented.

D. Other Methods for Improving Workers' Compensation. During its study of various medical cost control methods employed in other jurisdictions, the committee has realized the vital role advisory councils play in the development and improvement of workers' compensation systems throughout North America. Although Alaska has attempted to promote change through the efforts of an informal *ad hoc* group, the committee believes that a formal advisory council should be statutorily created to monitor the performance of the Alaska workers' compensation system and, on an on-going basis, make recommendations to reduce injuries and improve the effectiveness of care delivered to injured workers and the overall outcomes produced for injured workers, their employers and the state's overall economic and social well-being. The establishment of such a council would not only assist in providing the public involvement necessary to implement treatment guidelines but could play a central role in the improvement of Alaska's workers' compensation system as a whole through adoption of the framework, model, and process offered by The 60 Summits Project. The minority while in favor of creating an advisory council believes that a medical services review committee that is more medically dominated is important to maintain to address areas requiring more specialized knowledge and medical consensus. The minority suggests that joint meetings could be utilized where needed as in a 60 Summits process.

IX. RECOMMENDATIONS. Based on the above, the committee recommends as follows:

A. Medical Costs. The committee was not unanimous on all sections listed below. One member abstained from the fee schedule language in (b) below and although all members agree with the concept of evidence-based medicine and treatment guidelines, two believed the language contained in section (c) should be eliminated.

Amend AS 23.30.097 to take effect January 1, 2011 to read as follows:

(a) All fees and other charges for medical treatment or service are subject to regulation by the board consistent with this section. A fee or other charge for medical treatment or service may not exceed the lowest of

(1) the fee schedule as published by the department under (b) of this section; [THE USUAL, CUSTOMARY, AND REASONABLE FEES FOR THE TREATMENT OR SERVICE IN THE COMMUNITY IN WHICH IT IS RENDERED, FOR TREATMENT OR SERVICE, (A) PROVIDED BEFORE AUGUST 1, 2007, NOT TO EXCEED THE FEES IN THE FEE

SCHEDULE SPECIFIED BY THE BOARD IN ITS PUBLISHED BULLETIN DATED DECEMBER 1, 2004; (B) PROVIDED ON OR AFTER AUGUST 1, 2007, BUT BEFORE MARCH 31, 2009, NOT TO EXCEED THE FEES OTHERWISE APPLICABLE IN (A) OF THIS PARAGRAPH ADJUSTED BY THE PERCENTAGE CHANGE FROM 2004 TO 2006 IN THE MEDICAL CARE COMPONENT OF THE CONSUMER PRICE INDEX FOR ALL URBAN CONSUMERS COMPILED BY THE UNITED STATES DEPARTMENT OF LABOR, BUREAU OF LABOR STATISTICS]

(2) the fee or charge for the treatment or service when provided to the general public; or

(3) the fee or charge for the treatment or service negotiated by the provider and the employer under (c) of this section.

(b) **The department shall annually establish a schedule of fees by bulletin on or before December 1 of each year to take effect on January 1 the following year. The fee schedule rates shall be established in consultation with the Medical Services Review Committee or its successor as a subcommittee of the advisory council and be based on the following standards as adopted by the Centers for Medicare and Medicaid services in effect at the time the services are provided, regardless of where services are provided:**

(1) The American Medical Association Current Procedural Terminology Codes (CPT);
(2) the Healthcare Common Procedure Coding System (HCPCS);
(3) the Medicare Severity Diagnosis-Related Groups (MS-DRG);
(4) the Ambulatory Payment Classifications;
(5) the Relative Value Units as adjusted annually using the most recently published resource-based relative value scale;
(6) The Average Wholesale Price as obtained from the current Medispan, Drug Topics Red Book or other national publication as determined by the department.

(c) **The department may establish by regulation in consultation with the Medical Services Review Committee or its successor as a subcommittee of the advisory council evidence based utilization and treatment guidelines for medical services. There is a rebuttable presumption that the utilization and treatment guidelines established by the department are correct medical treatment for injured workers.**

(d) An employer or group of employers may establish a list of preferred physicians and treatment service providers to provide medical, surgical, and other attendance or treatment services to the employer's employees under this chapter; however,

(1) the employee's right to chose the employee's attending physician under AS 23.30.095 (a) is not impaired;

(2) when given to the employee, the employer's preferred physician list must clearly state that the list is voluntary, that the employee's choice is not restricted to the list, that the employee's rights under this chapter are not impaired by choosing an attending physician from the list, and that, if the employee chooses an attending physician from the list, the employee may, in the manner provided in AS 23.30.095 , make one change of attending physician, from the list or otherwise; and

(3) establishment of a list of preferred physicians does not affect the employer's choice of physician for an employer medical examination under AS 23.30.095.

(e) An employer or group of employers may negotiate with physicians and other treatment service providers under this chapter to obtain reduced fees and service charges and may take the fees and charges into account when forming a list of preferred physicians and providers. In no event may an employer or group of employers attempt to influence the treatment, medical decisions, or ratings by the physicians in the course of the negotiations of such a preferred physician and provider fee plans.

(f) An employer shall pay an employee's bills for medical treatment under this chapter, excluding prescription charges or transportation for medical treatment, within 30 days after the date that the employer receives the provider's bill or a completed report as required by AS 23.30.095 (c), whichever is later. **All bills, invoices or charges for medical treatment or services must be tendered to the employer, insurance carrier or third party administrator as applicable, within one year from the date of service or claim acceptance or the charges will be denied as untimely and cannot be billed to or paid by the employee as provided in AS 23.30.097(f).**

(g) A physician or other provider of treatment services under this chapter, including hospital services, that submits a bill for medical treatment to the insurer or self-insured employer shall also submit a copy of the bill to the employee to whom the treatment was provided. An employee who notifies the insurer or self-insured employer's adjuster in writing of an overcharge in the bill that was not previously identified by the insurer or self-insured employer's adjuster shall be entitled to a reward equal to 25 percent of the billing reduction or reimbursement achieved due to the employee's report. This reward does not apply to overcharges of an amount under $100 if the insurer or self-insured employer's adjuster elects not to pursue correction of the bill.

(h) An employee may not be required to pay a fee or charge for medical treatment or service provided under this chapter.

(i) Unless the employer controverts a charge, the employer shall reimburse an employee's prescription charges under this chapter within 30 days after the employer receives the health care provider's completed report and an itemization of the prescription charges for the employee. Unless the employer controverts a charge, an employer shall reimburse any transportation expenses for medical treatment under this chapter within 30 days after the employer receives the health care provider's completed report and an itemization of the dates, destination, and transportation expenses for each date of travel for medical treatment. If the employer does not plan to make or does not make payment or reimbursement in full as required by this subsection, the employer shall notify the employee and the employee's health care provider in writing that payment will not be made timely and the reason for the nonpayment. The notification must be provided not later than the date that the payment is due under this subsection.

B. Workers' Compensation Advisory Council. While in favor of creating an advisory council, a minority believes that a medical services review committee that is more medically dominated is important to maintain to address areas requiring more specialized knowledge and medical consensus. The minority suggests that joint meetings could be utilized where needed as in a 60 Summits process. The minority does not approve of sunsetting the MSRC and suggests we

should minimally recognize the need for a Medical subcommittee of the advisory council and create such if sunsetting prevails.

A majority recommends sunsetting the Medical Services Review Committee on December 31, 2010 and enlarge the scope and purpose of the committee through amendment of Title 23 Chapter 30 by adding a new section creating a Workers' Compensation Advisory Council comprised of:

a. 4 employee representatives from organized labor;
b. 4 employer representatives to include at least one self-insured representative, one oil industry representative and one general contractor representative;
c. 2 insurer representatives;
d. 1 department representative;
e. 2 ex officio legislators; and
f. 3 medical providers. One representative from the Alaska Medical Association, one representative from the Alaska Chiropractic Society and one representative from the Alaska State Hospital and Nursing Home Association.

Voting members shall include employer and employee representatives. Although a simple majority of the committee recommends the medical providers be given a vote on the council, the committee as a whole was unable to agree on whether medical provider representatives should be given voting power. The committee unanimously agreed that voting rights should not be extended to any of the other representatives listed in (c), (d) and (e) above.

All council recommendations or decisions shall be by a 3/4 majority of the voting members present.

Representatives shall be appointed by the Commissioner of the Department of Labor and Workforce Development for a five year term with initial terms ranging from 3-6 years. Failure of a representative to attend three consecutive meetings shall result in the removal of the representative from the Council. In the event of removal of a representative, another shall be appointed to serve for the unexpired portion of the removed representative's term. Legislative members shall be appointed annually by the Speaker of the House and the President of the Senate.

The Council should be empowered to submit recommendations to the department and the legislature regarding amendments to the Alaska Workers' Compensation Act and any other state laws, regulations, court and commission decisions that affect the design, function, operation, and outcomes of the state's workers' compensation system.

C. 60 Summits. Enlist the services of the 60 Summits at the next Governor's worker safety and training conference. Allow the Advisory Council and the Department to use the framework recommended by The 60 Summits Project as a way to identify and make needed improvements in return to work/stay at work provisions and policies, investigate EBM guidelines and consider other mechanisms for the improvement of the outcomes being produced for injured workers, employers and the state's overall economic and social welfare by Alaska's workers' compensation system.

D. Data Collection. Require by statute that the division collect medical cost information from employers: In addition, mandate reporting by the State of Alaska's group health third-party administrator medical costs paid under group health by the State of Alaska to aide the division in its

efforts to bring medical costs in line with group health. Require agencies within the State of Alaska to coordinate, integrate and share health information technology efforts.

E. Study. Legislative intent should require the division to contract with an independent research organization to study the effects of the changes adopted in AS 23.30.097(b) and (c) above. The study shall assess the effect on medical costs, employee access to medical care and outcomes over a certain period following implementation of the changes.

DATED, this _____ day of November, 2009.

MEDICAL SERVICES REVIEW COMMITTEE

_____
Dr. R. J. Hall, AMA Member

_____
Dr. Andrew Mayo, AHNHA Member

_____
Kevin Smith, Lay Member (self-insured)

_____
Pam Scott, Lay Member (industry)

_____
Vince Beltrami, Lay Member (labor)

_____
Tammi Lindsey, Lay Member (industry)

_____
Dr. William Pfeifer, ACS Member

_____
Trena L. Heikes, Designated Chair

1

INFORMATION SOURCES

Information provided has been obtained from the sources listed below. Although it is believed that all recent (2005 to present) relevant articles/papers/reports have been included in the materials provided, members are encouraged to conduct further research to provide additional relevant information to the committee at the websites provided. Upcoming events and background information is also included where available.

1. NATIONAL COUNCIL ON COMPENSATION INSURANCE, INC. (NCCI)

www.ncci.com

National Council on Compensation Insurance, Inc., based in Boca Raton, FL, manages the nation's largest database of workers compensation insurance information. NCCI analyzes industry trends, prepares workers compensation insurance rate recommendations, determines the cost of proposed legislation, and provides a variety of services and tools to maintain a healthy workers compensation system. Provided below are some relevant excerpts from their March 2009 digest.

MARCH 2009 – Regulatory Digest

Workers Comp Medical Reforms: What Is Just Over the Horizon?—Tuesday, June 16, at 3:00 p.m. ET

As the ongoing growth in medical severity exerts continuing upward pressure on premiums, medical costs are coming to dominate workers comp benefit payments. Workers comp is not alone in facing this financial challenge. Research suggests that without reform, medical spending countrywide may grow from the current 17% to exceed a third of GDP in the United States by 2050. In this course, we will discuss some of the new reforms or new approaches to provider reimbursement that are currently being considered. These reforms provide insight into the likely direction of medical cost reforms in workers compensation over the next decade.

Changes on Med Fee Schedule Implications of 2009 Medicare Pricings

The 2009 Medicare changes will likely affect states having Medicare-based physician fee schedules. The magnitude of the impacts will vary by state.

For states that adopt the 2009 Medicare Resource Based Relative Value Scale (RBRVS) and Budget Neutrality Adjustor (BNA), but have their own state-specific conversion factors, absent a change in the conversion factor, the Medicare change would have a significant impact on their medical costs. Physician costs could increase by almost 8%.

For states where the physician fee schedules are based on a percent of Medicare, which adopt both the RBRVS and the conversion factors (CFs), these changes would have a less significant impact on their medical costs. Physician costs could increase by approximately 2%.

For states that adopt the 2009 Medicare RBRVS, but not the BNA, and have their own state-specific conversion factors, these changes would not have a significant impact on medical costs.

2. WORK LOSS DATA INSTITUTE

www.worklossdata.com

Work Loss Data Institute (WLDI) is an independent database development company focused on workplace health and productivity, with offices in California and Texas. WLDI products include *Official Disability Guidelines* (ODG), now in its 14th edition, which provides evidence-based disability duration guidelines and benchmarking data for every reportable condition. New medical treatment guidelines for work-related conditions are also available with ODG in a complete integrated product, *ODG Treatment,* currently in its 7th annual edition. Both put evidence-based medicine to work for those involved in workers' comp and non-occupational disability, including insurers, TPA's, health care providers, case managers, employers, benefits administrators, risk managers and claims attorneys in the management of return-to-work and utilization of medical services following illness and injury. Each are available in various electronic and textbook formats, including data licensing for seamless integration with existing claims systems. Special Studies on illness and injury affecting the workforce have also been released, extracted from ten million cases or more within the ODG database. Other guidelines available from Work Loss Data Institute include the *IAIABC Impairment Guides* (available on Web versions of ODG), and the *CCGPP Chiropractic Practice Guidelines* (currently in development). Finally, WLDI publishes the *Employer Health Register,* a complete directory of products and services used to improve the health and productivity of working people.

3. INTERNATIONAL ASSOCIATION OF INDUSTRIAL ACCIDENT BOARDS AND COMMISSIONS (IAIABC)

www.iaiabc.org

The International Association of Industrial Accident Boards & Commissions (IAIABC) is a not-for-profit trade association representing government agencies charged with the administration of workers' compensation systems throughout the United States, Canada, and other nations and territories. Founded in 1914, the IAIABC is the world's oldest trade association dedicated to promoting the advancement of workers' compensation systems throughout the world through education, research, and resource management. A dynamic group of members encompassing specialties in a variety of workers' compensation areas are united by annual memberships. The IAIABC represents workers' compensation professionals, medical providers, insurers, and corporate agencies with 60 jurisdictions and over 150 associate corporate members. Many of the most influential and committed leaders in the field of workers' compensation are active members of the IAIABC.

Committee work is the heart of the IAIABC. Individuals from a number of jurisdictions and corporations combine their special on-going administrative interests to form over 30 committees and subcommittees. The committee research and work products are invaluable to the IAIABC and workers' compensation industry. Many are continuous projects that provide

ongoing support for workers' compensation systems, such as self insurance and EDI.

The IAIABC organizes and sponsors four major annual events: the Annual Convention, the Medical Institute, the Workers' Compensation College, and the All Committee Conference.

4. WORKERS' COMPENSATION RESEARCH INSTITUTE (WCRI)

www.wcrinet.org

The Workers Compensation Research Institute is an independent, not-for-profit research organization providing high-quality, objective information about public policy issues involving workers' compensation systems. Organized in late 1983, the Institute does not take positions on the issues it researches; rather, it provides information obtained through studies and data collection efforts, which conform to recognized scientific methods. Objectivity is further ensured through rigorous, unbiased peer review procedures.

The Institute's work takes several forms:

Original research studies of major issues confronting workers' compensation systems (for example, permanent partial disability, disability management and litigiousness).

Studies of individual state systems where policymakers have shown an interest in change and where there is an unmet need for objective information.

Studies of states that have undergone major legislative changes to measure the impact of those changes and draw possible lessons for other states.

Research briefs that report on significant new research, data and issues in the field.

Presentations on research findings to legislators, workers' compensation administrators, industry groups and others interested in workers' compensation.

5. RAND INSTITUTE.

Rand.org

Since 1948, RAND has operated as an independent nonprofit organization. RAND's research is commissioned by a wide range of sources. Federal, state, and local government agencies provide the largest share of the funding; however, RAND also conducts projects for foundations, foreign governments, and private-sector firms. Contributions from individuals, charitable foundations, and private firms, as well as earnings from RAND's endowment, offer a steadily growing pool of funds that allow RAND to address problems not yet on the policy agenda. RAND's revenue in FY08 was $230.07 million.

The Rand Center for Health and Safety in the Workplace is a subsidiary of Rand. It's mission is to conduct research and analysis that helps improve worker health and safety and reduce the

economic costs of workplace accidents and illnesses. The Center provides rigorous, objective analysis and a neutral venue in which to convene stakeholders from government, industry, and labor.

RAND currently has 13 ongoing research projects in the field of occupational safety and health. About half deal with prevention topics and half with workers' compensation issues, including return to work and medical guidelines for treatment of injured workers. In addition to these research studies, RAND has been working under contract with NIOSH to assist staff there with strategic planning and with preparation of evidence packets for review by the National Academy of Science. Funding for the research projects comes from the California Commission on Health, Safety and Workers' Compensation; the Commonwealth of Pennsylvania, NIOSH, Zenith Insurance, Duke Energy Foundation, the Alcoa Corporation, the Walt Disney Company, and the Department of Defense.

Further information and access to publications can be obtained at:

http://www.rand.org/multi/chsw/

6. MEDICAL PRACTICE GUIDELINES.

a. American College of Occupational and Environmental Medicine

http://www.acoem.org/practiceguidelines.aspx

b. Occupational Disability Guidelines.

We have been authorized by Work Loss Data Institute (see above) to review access to the ODG Guidelines on the Web at:

URL: www.odgtreatment.com

Username: alaska (lowercase)
Passcode: 2525

Once on the site, the ODG treatment guidelines are found under Section A of the Contents Page -- the most important piece of each chapter is the Procedure Summary -- while the ODG return-to-work guidelines with links to the UR Advisor are found under Section B.

MEDICAL FEE RESEARCH

INDEX OF ARTICLES

11 *Narcotics in Worker's Compensation*. NCCI Annual Issue Symposium 2009.

12 *Medicare's Impact on Workers' Compensation*. NCCI Annual Issues Symposium 2009.

13 *Prescription Drug Study*. NCCI November 2008.

14 2008 Oregon Workers' Compensation Premium Rate Ranking Summary

15 Medical Services Review Committee Sample Hospital Billing, Misty Steed, Corvel Corporation, August 21, 2009.

16 *Workers' Compensation Medical Cost Containment: A National Inventory* February 2009. Workers' Compensation Research Institute.

17 NCCI Alaska State Advisory Forums 2009, pp. 20-35.

18 *Introduction to the New Work Disability Prevention Paradigm*, Dr. Jennifer Christian, Chair, the 60 Summits Project.

19 *Preventing Needless Work Disability by Helping People Stay Employed*, American College of Occupational and Environmental Medicine, September 2006.

20 *The Cost Conundrum*, Atul Gawande, The New Yorker, June 1, 2009.

21 *Access to Medical Treatment in the California Workers' Compensation System*, Kominski, Pourat, Roby and Cameron, 2006.

MEDICAL TREATMENT GUIDELINES

INDEX OF ARTICLES

11 *Analysis of California Workers' Compensation Reforms: Medical Utilization & Reimbursement Outcomes Accident Years 2002 – 2006.* California Workers' Compensation Institute, Dec. 2007.

12 7/24/09 ODG power point presentation and notes

13 *Chiropractic Management of Low Back Disorders: Report From a Consensus Process.*

14 *Evaluating Medical Treatment Guidelines Sets for Injured Workers in California* – Rand Corporation, 2005.

15 Treatment Guidelines by Jurisdiction

16 *A Study of the Effects of Legislative Reforms on California Workers' Compensation Insurance Rates.* California Department of Industrial Relations, Division of Workers' Compensation. January 2006.

17. *Medical Treatment Authorization Guidelines California Sample.* September 2, 2009.

18. *Do Treatment Guidleines Change Provider Behavior and Result in More Cost Effective Treatment.* Powerpoint Presentation, Dr. Maja Jurisic, IAIABC Conference, September 23, 2009, Minneapolis, MN.

19. *Evidence based medicine: what it is and what it isn't.* Sacket,, Rosenberg, Gray, Hanes, Richardson, BMJ 1996; 312 (7023): 71-72.

20. *The Path to Change in the US Healthcare System: Chiropractic Cost-Effectiveness Supplement.* American Chiropractic Association, et al.

2

2008 Oregon Workers' Compensation Premium Rate Ranking Summary

Department of Consumer & Business Services — October 2008

By Mike Manley and Jay Dotter

Oregon employers in the voluntary market pay, on average, the 39th highest workers' compensation premium rates in the nation.

Oregon's premium rate index is $1.88 per $100 of payroll, or 83 percent of the national median. National premium rate indices range from a low of $1.08 in North Dakota to a high of $3.97 in Alaska, with a median value of $2.26. No jurisdictions have an index rate above $4; 6 are in the $3.00-$3.99 range; 31 are in the $2.00-$2.99 range; and 14 have indices under $2.00. Indices are based on data from 51 jurisdictions, for rates in effect as of January 1, 2008.

Figure 1. 2008 Workers' compensation premium index rates

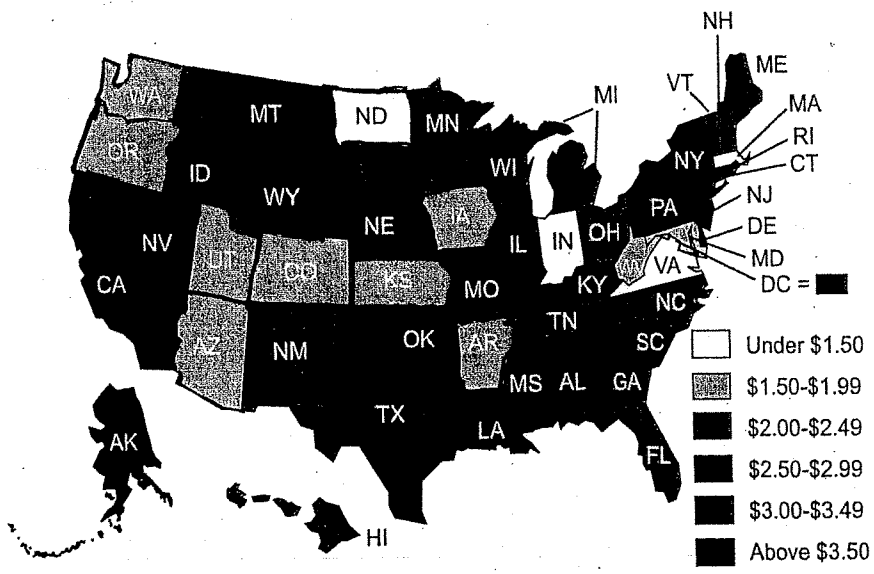

Table 1. Oregon's ranking in the top 10 classifications

Occupation	Ranking
Clerical office employees NOC	49
Salespersons – Outside	47
College: Professional employees & clerical	41
Physician and clerical	38
Restaurant NOC	45
Store: Retail, NOC	40
Hospital: Professional employees	40
Automobile service/repair center & drivers	34
Trucking: NOC – All employees & drivers	25
Health care employees – Retirement, nursing, convalescent	32

Classification codes from the National Council on Compensation Insurance (NCCI) were used in this study. Of approximately 450 active classes in Oregon, 50 were selected based on relative importance as measured by share of losses in Oregon. To control for differences in industry distributions, each state's rates were weighted by 2002-2004 Oregon payroll to obtain an average manual rate for that state. Listed in Table 1 are Oregon's rankings in the top 10 of the 50 classifications used.

Table 2 (on the back) contains the premium rate ranking for all 51 jurisdictions.

Table 2. Workers' compensation premium rate ranking

2008 Ranking	2006 Ranking	State	Index Rate	Percent of study median	Effective Date
1	1	Alaska	3.97	176%	January 1, 2008
2	5	Montana	3.50	155%	July 1, 2007
3	12	Ohio	3.32	147%	July 1, 2007
4	7	Vermont	3.14	139%	April 1, 2007
5	19	New Hampshire	3.06	136%	January 1, 2008
6	8	Maine	3.04	135%	January 1, 2008
8	3	Delaware	2.96	131%	December 1, 2007
8	4	Kentucky	2.96	131%	October 1, 2007
9	9	Alabama	2.90	129%	March 1, 2007
10	13	Oklahoma	2.89	128%	8/1/07 State Fund, 1/1/08 Private
11	21	Illinois	2.79	124%	January 1, 2008
12	11	Louisiana	2.76	122%	October 1, 2007
13	25	South Carolina	2.74	121%	May 7, 2007
14	2	California	2.72	121%	January 1, 2008
15	18	Pennsylvania	2.68	119%	April 1, 2007
16	23	New Jersey	2.66	118%	January 1, 2008
17	17	Texas	2.61	116%	January 1, 2008
18	30	Nevada	2.58	115%	March 1, 2007
19	10	New York	2.55	113%	October 1, 2007
20	14	Connecticut	2.46	109%	January 1, 2008
21	26	Tennessee	2.44	108%	July 1, 2007
22	37	North Carolina	2.43	108%	April 1, 2007
24	21	Minnesota	2.33	103%	January 1, 2008
24	32	Mississippi	2.33	103%	March 1, 2007
25	41	Georgia	2.29	102%	August 3, 2007
26	22	Rhode Island	2.26	100%	February 1, 2007
28	6	Florida	2.20	98%	January 1, 2008
28	25	Missouri	2.20	97%	January 1, 2008
29	16	District of Columbia	2.16	96%	November 1, 2007
32	27	New Mexico	2.15	95%	January 1, 2008
32	39	Michigan	2.15	95%	January 1, 2007
32	33	Nebraska	2.15	95%	February 1, 2007
34	35	Wisconsin	2.12	94%	October 1, 2007
34	32	Idaho	2.12	94%	January 1, 2008
36	15	Hawaii	2.08	92%	January 1, 2008
36	44	South Dakota	2.08	92%	July 1, 2007
37	29	Wyoming	2.06	91%	January 1, 2008
38	37	Washington	1.98	88%	January 1, 2008
39	**42**	**OREGON**	**1.88**	**83%**	**January 1, 2008**
41	34	West Virginia	1.86	83%	July 1, 2007
41	45	Iowa	1.86	82%	January 1, 2008
42	43	Kansas	1.77	78%	January 1, 2008
43	29	Colorado	1.76	78%	January 1, 2008
44	40	Maryland	1.72	76%	January 1, 2008
45	46	Arizona	1.67	74%	January 1, 2008
46	38	Utah	1.63	72%	December 1, 2007
47	48	Arkansas	1.61	71%	January 1, 2008
48	49	Virginia	1.43	63%	April 1, 2007
49	47	Massachusetts	1.39	62%	September 1, 2007
50	50	Indiana	1.23	55%	January 1, 2008
51	51	North Dakota	1.08	48%	July 1, 2007

Notes: Starting with the 2008 study, when two or more states' Index Rate values are the same, they now are assigned the same ranking. 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 quickly.

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440-2082 (10/08/COM)

2006 Oregon Workers' Compensation Premium Rate Ranking Summary

Department of Consumer & Business Services — October 2006

By Derek Reinke and Mike Manley

Oregon employers in the voluntary market pay, on average, the 42nd highest workers' compensation premium rates in the nation.

Oregon's premium rate index is $1.97 per $100 of payroll, or 79 percent of the national median. National premium rate indices range from a low of $1.10 in North Dakota to a high of $5.00 in Alaska, with a median value of $2.48.

Two jurisdictions have an index rate above $4; 10 are in the $3.00-$3.99 range; 29 are in the $2.00-$2.99 range; and 10 have indices under $2.00. Indices are based on data from 51 jurisdictions, for rates in effect as of January 1, 2006.

Classification codes from the National Council on Compensation Insurance (NCCI) were used in this study.

Figure 1. 2006 Workers' compensation premium index rates

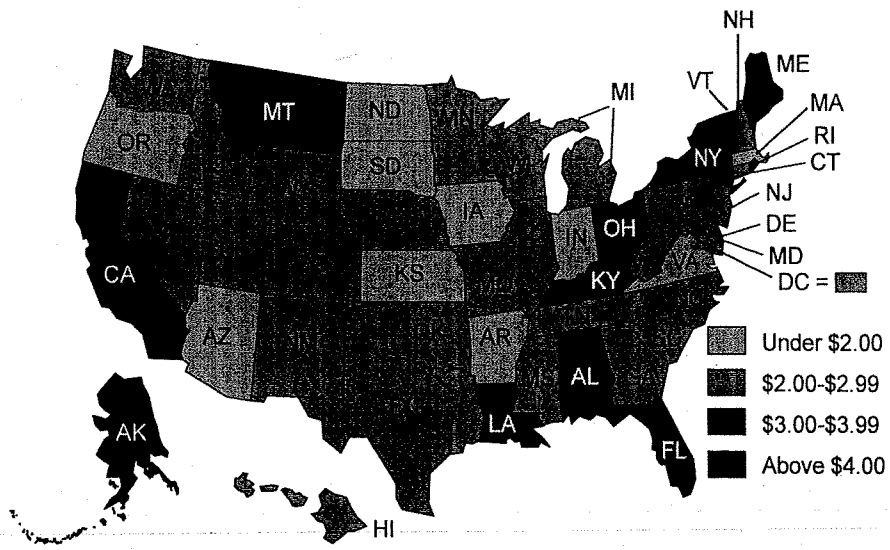

Table 1. Oregon's ranking in the top 10 classifications

Clerical office employees NOC	48
Salespersons - Outside	47
College: Professional employees & clerical	45
Physician and clerical	37
Restaurant NOC	39
Store: Retail NOC	45
Hospital: Professional employees	36
Automobile service/repair center & drivers	36
Trucking: NOC - All employees & drivers	30
Electrical wiring - Within buildings & drivers	49

Of the approximately 450 active classes in Oregon, 50 were selected based on relative importance as measured by share of losses in Oregon. To control for differences in industry distributions, each state's rates were weighted by 2000-2002 Oregon payroll to obtain an average manual rate for that state. Listed in Table 1 are Oregon's rankings in the top 10 of the 50 classifications used.

Table 2 (on the back) contains the premium rate ranking for all 51 jurisdictions.

Table 2. Workers' compensation premium rate ranking

1	2	Alaska	5.00	201%	January 1, 2006
2	1	California	4.13	166%	January 1, 2006
3	7	Delaware	3.91	158%	December 1, 2005
4	6	Kentucky	3.78	152%	October 1, 2005
5	8	Montana	3.69	149%	July 1, 2005
6	3	Florida	3.32	134%	January 1, 2006
7	17	Vermont	3.24	130%	April 1, 2005
8	13	Maine	3.21	129%	January 1, 2006
9	19	Alabama	3.17	128%	March 1, 2005
10	18	New York	3.15	127%	October 1, 2005
11	9	Louisiana	3.10	125%	September 1, 2006
12	5	Ohio	3.00	121%	July 1, 2005
13	15	Oklahoma	2.96	119%	2/1/06 State Fund 7/1/05 Private
14	11	Connecticut	2.90	117%	January 1, 2006
15	4	Hawaii	2.89	116%	January 1, 2006
16	10	District of Columbia	2.86	115%	November 1, 2005
17	14	Texas	2.84	114%	January 1, 2006
18	20	Pennsylvania	2.80	113%	April 1, 2005
19	12	New Hampshire	2.75	111%	January 1, 2006
20	23	Illinois	2.69	108%	January 1, 2006
21	21	Minnesota	2.69	108%	January 1, 2006
22	16	Rhode Island	2.68	108%	January 1, 2006
23	29	New Jersey	2.62	102%	January 1, 2006
24	22	Missouri	2.50	101%	January 1, 2006
25	39	South Carolina	2.50	101%	July 1, 2004
26	25	Tennessee	2.48	100%	July 1, 2005
27	27	New Mexico	2.41	97%	January 1, 2006
28	28	Wyoming	2.40	96%	January 1, 2006
29	31	Colorado	2.40	96%	January 1, 2006
30	26	Nevada	2.36	95%	January 1, 2005
31	36	Mississippi	2.29	92%	March 1, 2005
32	34	Idaho	2.29	92%	January 1, 2006
33	38	Nebraska	2.25	91%	February 1, 2005
34	24	West Virginia	2.20	88%	January 1, 2006
35	33	Wisconsin	2.18	88%	October 1, 2005
36	35	Washington	2.17	88%	January 1, 2006
37	32	North Carolina	2.17	87%	Apr. 1, 2005
38	46	Utah	2.06	83%	December 1, 2005
39	30	Michigan	2.05	82%	January 1, 2006
40	40	Maryland	2.03	82%	January 1, 2006
41	37	Georgia	2.02	82%	July 1, 2005
42	**42**	**OREGON**	**1.97**	**79%**	**January 1, 2006**
43	44	Kansas	1.84	74%	January 1, 2006
44	41	South Dakota	1.83	74%	July 1, 2005
45	43	Iowa	1.75	71%	January 1, 2006
46	49	Arizona	1.73	70%	October 1, 2005
47	45	Massachusetts	1.70	68%	September 1, 2005
48	48	Arkansas	1.59	64%	July 1, 2005
49	47	Virginia	1.52	61%	November 1, 2005
50	50	Indiana	1.24	50%	January 1, 2006
51	51	North Dakota	1.10	44%	July 1, 2005

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

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440-2082 (10/06/COM)

2004 Oregon Workers' Compensation Premium Rate Ranking Summary

Department of Consumer & Business Services December 2004

By Derek Reinke and Mike Manley

Oregon employers in the voluntary market pay, on average, the forty-second highest workers' compensation premium rates in the nation.

Oregon's premium rate index is $2.05 per $100 of payroll. National premium rate indices range from a low of $1.06 in North Dakota to a high of $6.08 in California. Three jurisdictions have an index rating above $4.00; 13 are in the $3.00-$3.99 range; 26 are in the $2.00-$2.99 range; and nine have indices under $2.00. Indices are based on data from 51 jurisdictions, for rates in effect as of January 1, 2004.

Classification codes from the National Council on Compensation Insurance (NCCI) were used in this study. Of the approximately 450 active classes in Oregon, 50 were selected based on relative importance as measured by share of losses in Oregon. To control for differences in industry distributions, each state's rates were weighted by 1998-2000 Oregon payroll to obtain an average manual rate for that state. Listed in Table 1 are Oregon's rankings in the 10 largest (by payroll) of the 50 classifications used.

Table 2 (on the back) contains the premium rate ranking for all 51 jurisdictions.

Figure 1. 2004 Workers' compensation premium rates

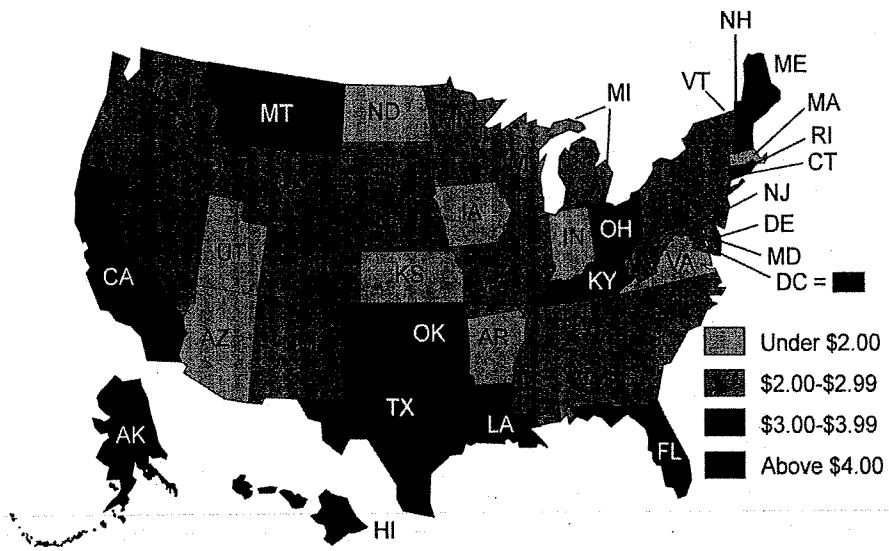

Table 1. Oregon's ranking in the top 10 classifications

Clerical office employees NOC	46
Salespersons - outside	47
College: Professional employees and clerical	44
Physician and clerical	31
Restaurant NOC	37
Store: Retail NOC	43
Automobile service/repair center and drivers	33
Hospital: Professional employees	29
Trucking: Local and long haul - all employees & drivers	25
Television/radio/telephone/telecommunication device	45

Table 2. Workers' compensation premium rate ranking

1	1	California	6.08	January 1, 2004
2	15	Alaska	4.39	January 1, 2004
3	2	Florida	4.20	October 1, 2003
4	3	Hawaii	4.03	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	3.26	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	26	Pennsylvania	2.82	April 1, 2003
21	22	Minnesota	2.74	January 1, 2004
22	28	Missouri	2.67	January 1, 2004
23	20	Illinois	2.65	January 1, 2004
24	24	West Virginia	2.64	July 1, 2003
25	29	Tennessee	2.62	March 1, 2003
26	11	Nevada	2.58	January 1, 2004
27	36	New Mexico	2.56	January 1, 2004
28	33	Wyoming	2.43	January 1, 2004
29	31	New Jersey	2.38	January 1, 2004
30	30	Michigan	2.34	January 1, 2004
31	21	Colorado	2.33	January 1, 2004
32	34	North Carolina	2.32	August 29, 2003
33	32	Wisconsin	2.27	October 1, 2003
34	27	Idaho	2.25	January 1, 2004
35	45	Washington	2.20	January 1, 2004
36	23	Mississippi	2.19	March 1, 2003
37	28	Georgia	2.14	November 1, 2001
38	35	Nebraska	2.10	February 1, 2003
39	42	South Carolina	2.08	January 1, 2004
40	40	Maryland	2.06	January 1, 2004
41	48	South Dakota	2.05	July 1, 2003
42	38	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	1.65	December 1, 2003
47	49	Virginia	1.57	April 1, 2003
48	47	Arkansas	1.57	July 1, 2001
49	46	Arizona	1.49	October 1, 2003
50	50	Indiana	1.24	January 1, 2004
51	51	North Dakota	1.06	July 1, 2003

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

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

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

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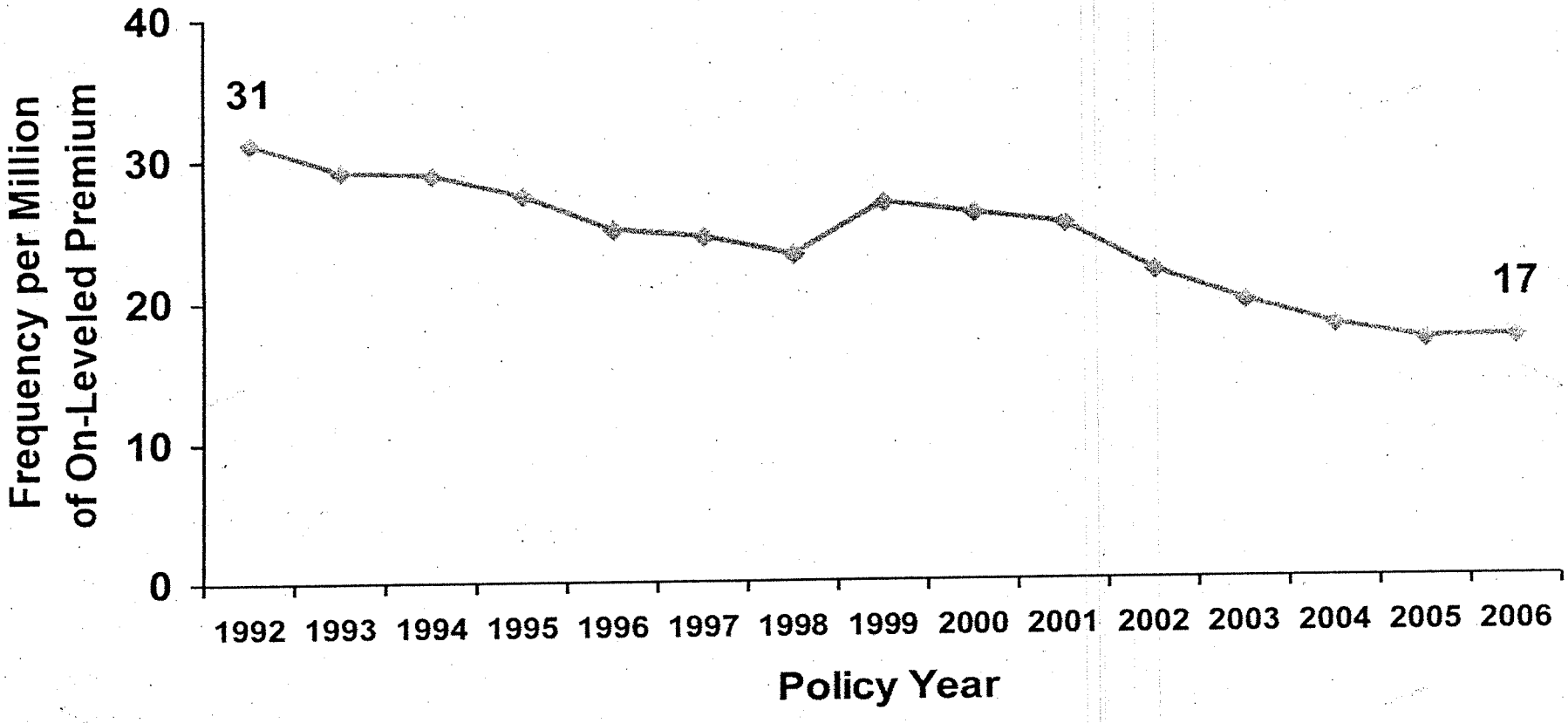
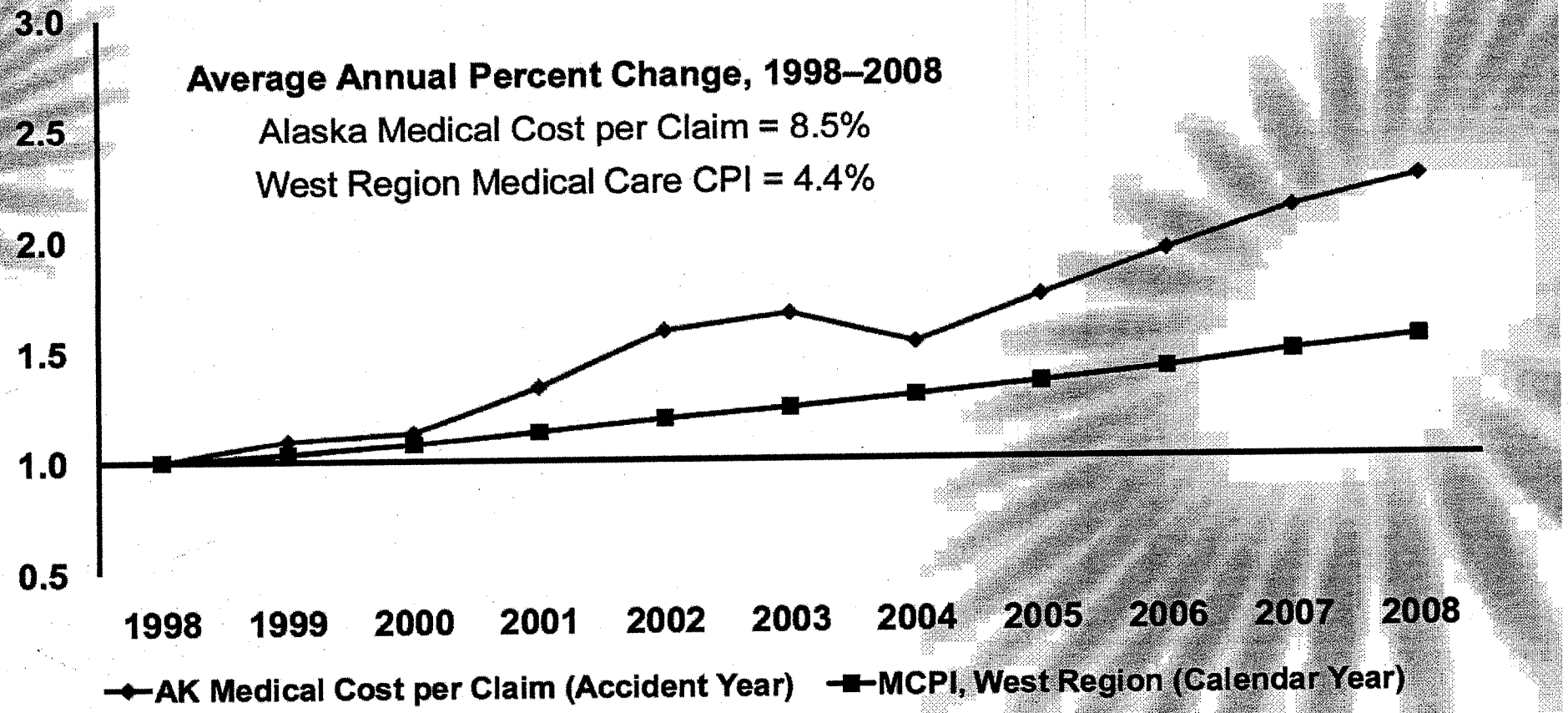
Alaska Claim Frequency



Based on NCCI's financial data.
Frequency of lost-time claims.

Medical Severity in Alaska Is Outpacing the Regional Medical CPI

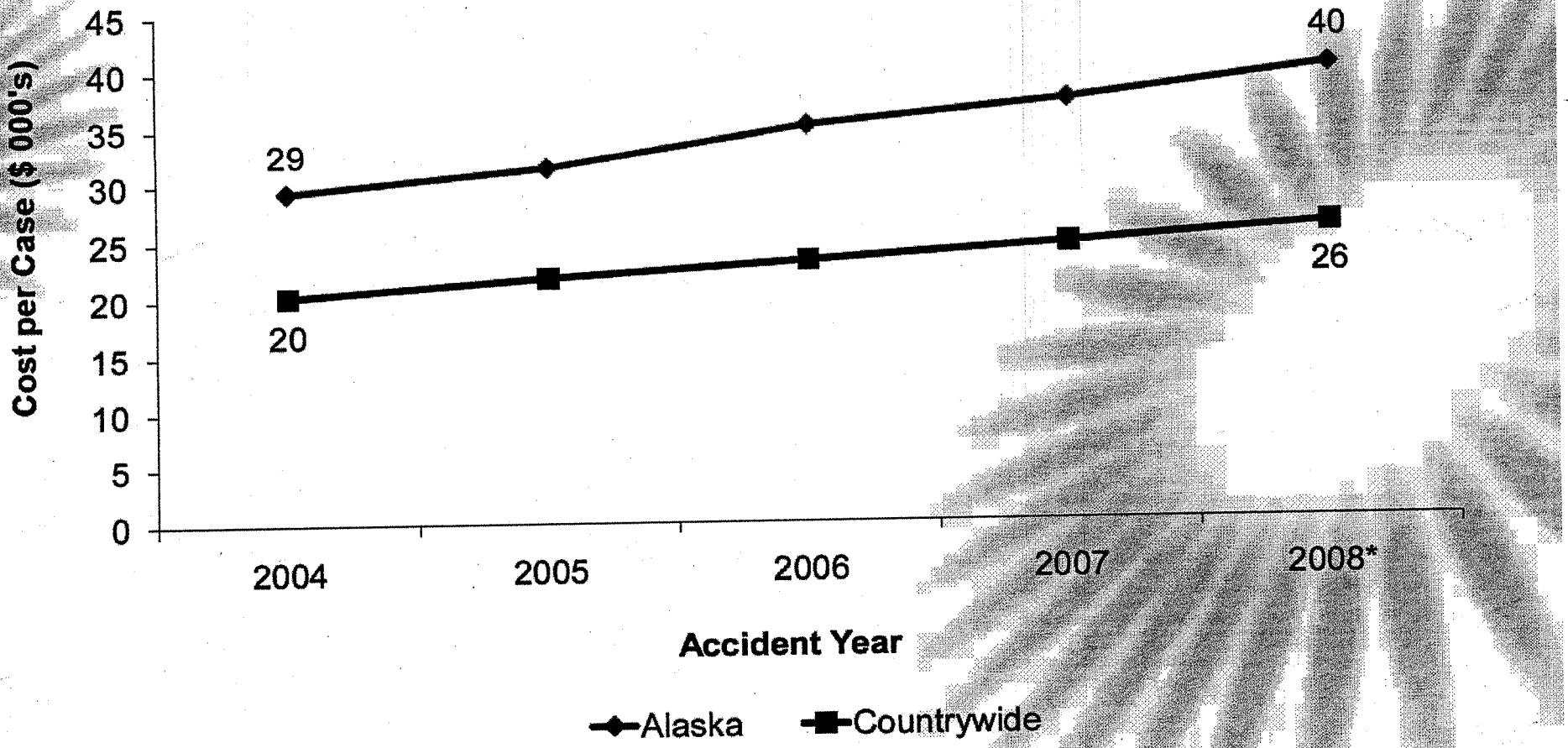
Indexes of Medical Severity*
and Medical Care CPI, 1998 = 1.0



* Lost-time claims
Based on data through 12/31/2008, developed to ultimate
Medical Severity is represented above as unlimited medical losses at ultimate without adjustments for either wage or benefit changes
Excludes high deductible policies
Source: NCCI; US Bureau of Labor Statistics

4

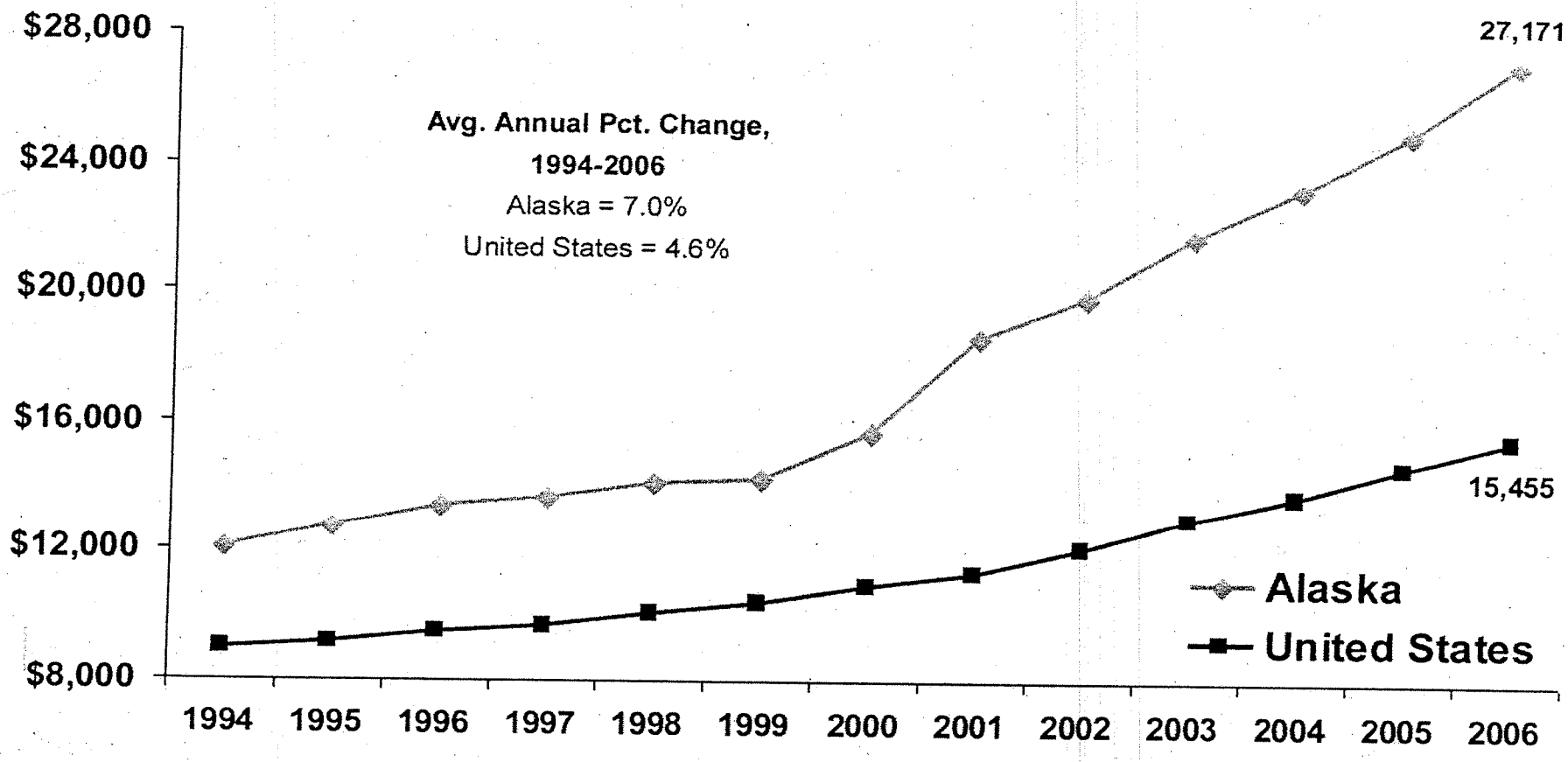
Alaska Medical Average Cost per Case vs. Countrywide



* Countrywide figure is preliminary
Source: NCCI financial data valued as of 12/31/08

5

Avg. Hospital Cost per Stay in Alaska

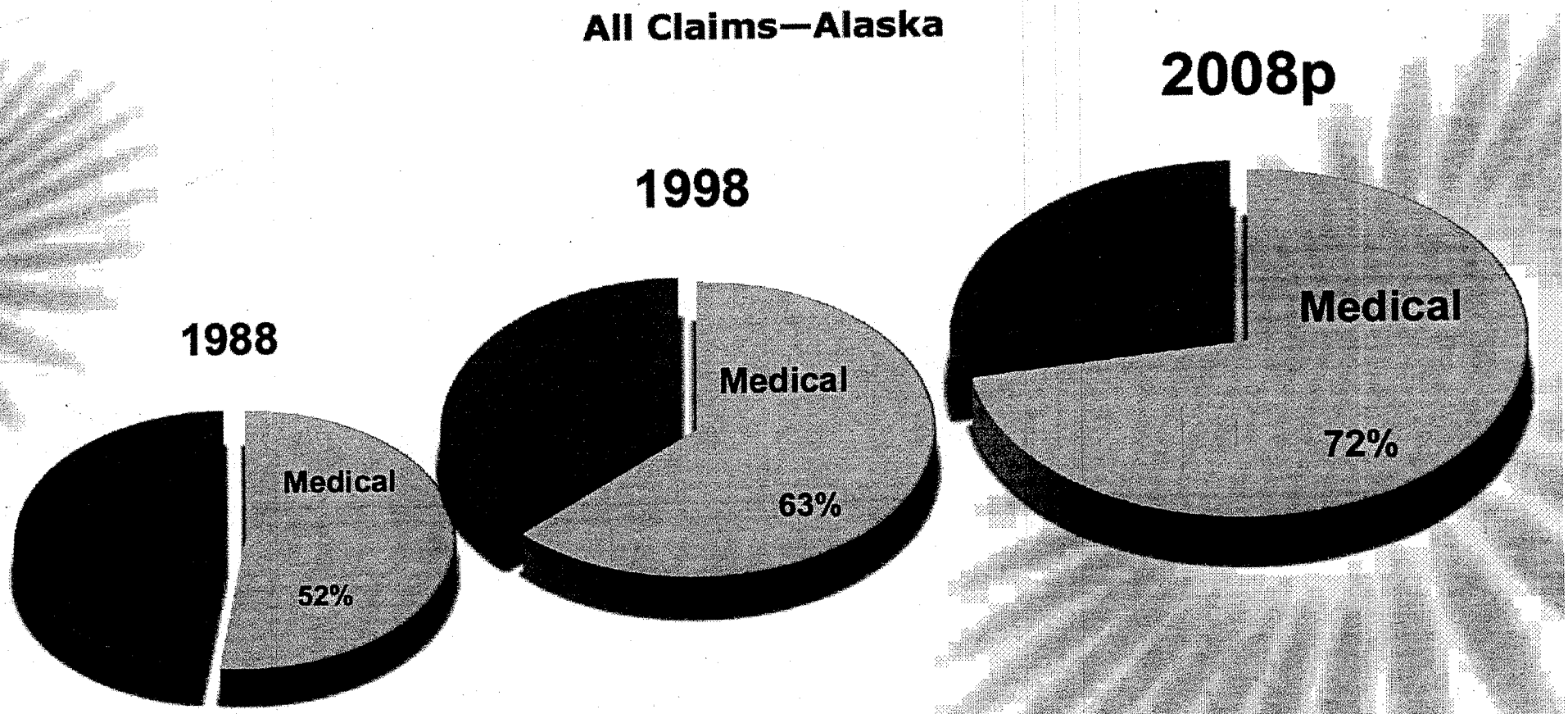


Source: American Hospital Association

6

Workers Compensation Benefit Split in Alaska

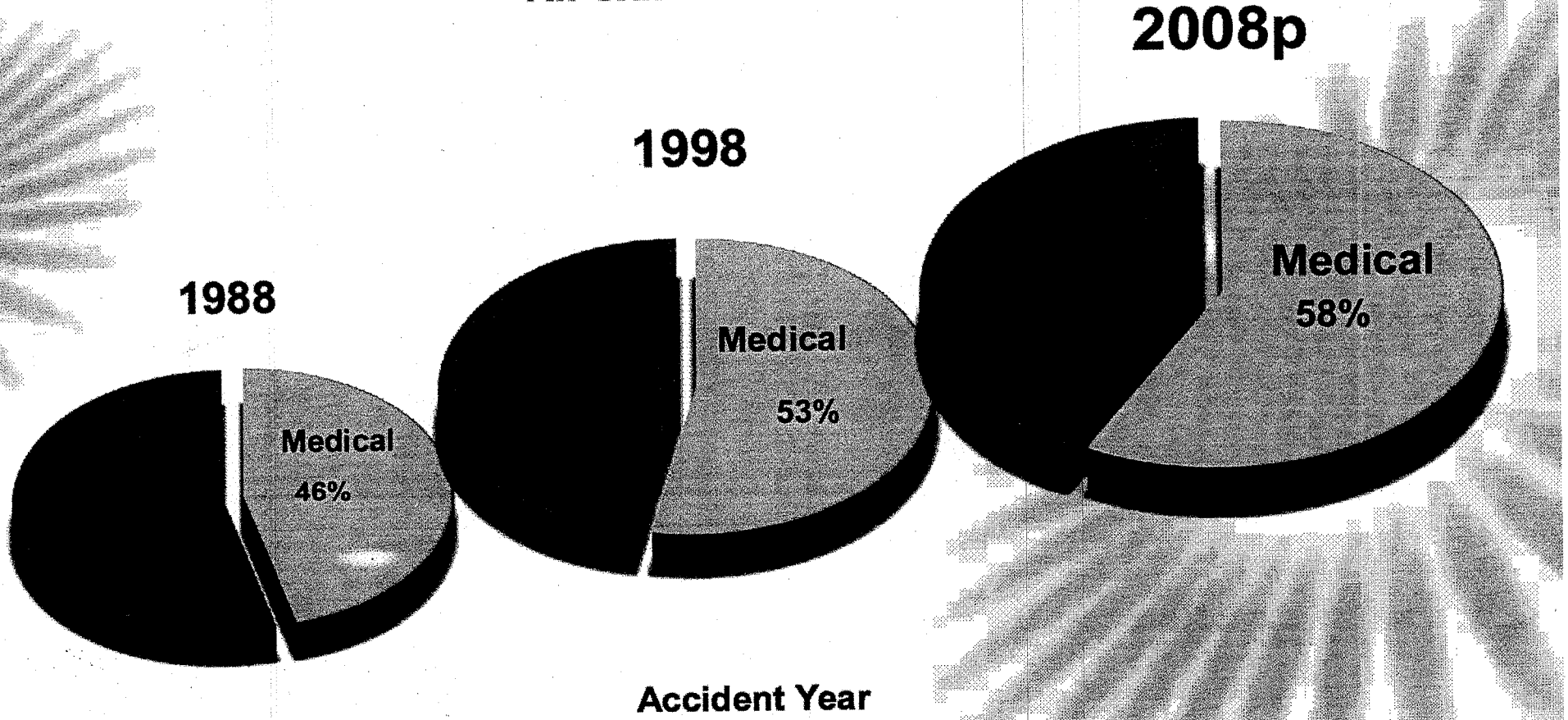
All Claims—Alaska



2008p: Preliminary based on data valued as of 12/31/2008
1988, 1998: Based on data through 12/31/2007, developed to ultimate
Based on the states where NCCI provides ratemaking services, including state funds
Excludes high deductible policies

Workers Compensation Medical Losses Are More Than Half of Total Losses

All Claims—NCCI States



2008p: Preliminary based on data valued as of 12/31/2008
1988, 1998: Based on data through 12/31/2007, developed to ultimate
Based on the states where NCCI provides ratemaking services, including state funds
Excludes high deductible policies

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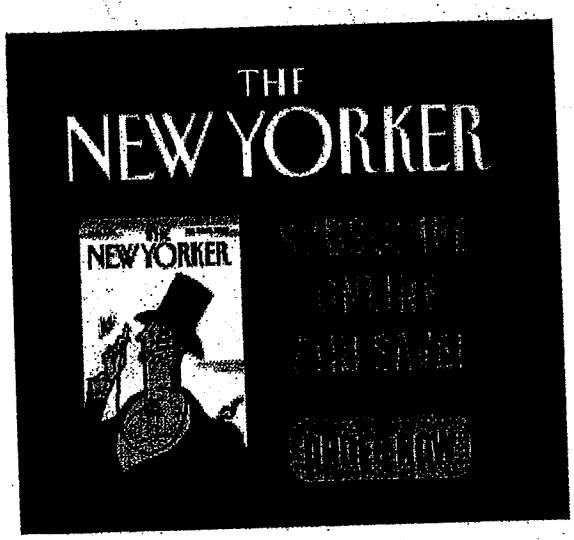
THE NEW YORKER



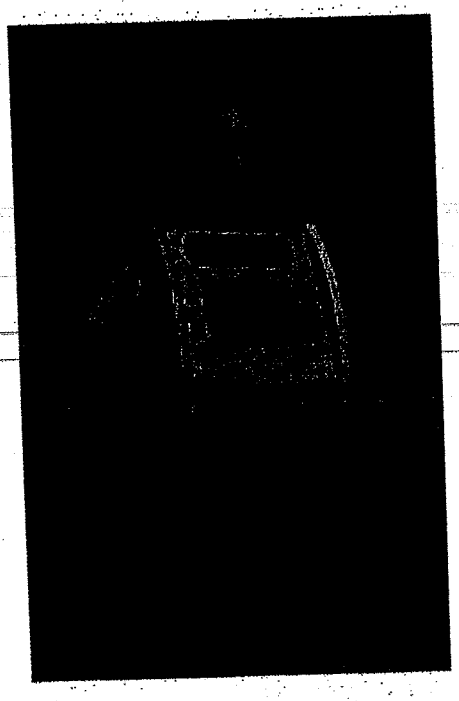
ANNALS OF MEDICINE

THE COST CONUNDRUM

What a Texas town can teach us about health care.

by Atul Gawande

JUNE 1, 2009



Costlier care is often worse care. Photograph by Phillip Toledano.

t is spring in McAllen, Texas. The morning sun is warm. The streets are lined with palm trees and pickup trucks.

McAllen is in Hidalgo County, which has the lowest household income in the country, but it's a border town, and a thriving foreign-trade zone has kept the unemployment rate below ten per cent. McAllen calls itself the Square Dance Capital of the World. "Lonesome Dove" was set around here.

McAllen has another distinction, too: it is one of the most expensive health-care markets in the country. Only Miami—which has much higher labor and living costs—spends more per person on health care. In 2006, Medicare spent fifteen thousand dollars per enrollee here, almost twice the national average. The income per capita is twelve thousand dollars. In other words, Medicare spends three thousand dollars more per person here than the average person earns.

The explosive trend in American medical costs seems to have occurred here in an especially intense form. Our country's health care is by far the most expensive in the world. In Washington, the aim of health-care reform is not just to extend medical coverage to everybody but also to bring costs under control. Spending on doctors, hospitals, drugs, and the like now consumes more than one of every six dollars we earn. The financial burden has damaged the global competitiveness of American businesses and bankrupted millions of families, even those with insurance. It's also devouring our government. "The greatest threat to America's fiscal health is not Social Security," President Barack Obama said in a March speech at the White House. "It's not the investments that we've made to rescue our economy during this crisis. By a wide margin, the biggest threat to our nation's balance sheet is the skyrocketing cost of health care. It's not even close."

The question we're now frantically grappling with is how this came to be, and what can be done about it. McAllen, Texas, the most expensive town in the most expensive country for health care in the world, seemed a good place to look for some answers.

From the moment I arrived, I asked almost everyone I encountered about McAllen's health costs—a businessman I met at the five-gate McAllen-Miller International Airport, the desk clerks at the Embassy Suites Hotel, a police-academy cadet at McDonald's. Most weren't surprised to hear that McAllen was an outlier. "Just look around," the cadet said. "People are not healthy here." McAllen, with its high poverty rate, has an incidence of heavy drinking sixty per cent higher than the national average. And the Tex-Mex diet has contributed to a thirty-eight-per-cent obesity rate.

One day, I went on rounds with Lester Dyke, a weather-beaten, ranch-owning fifty-three-year-old cardiac surgeon who grew up in Austin, did his surgical training with the Army all over the country, and settled into practice in Hidalgo County. He has not lacked for business: in the past twenty years, he has done some eight thousand heart operations, which exhausts me just thinking about it. I walked around with him as he checked in on ten or so of his patients who were recuperating at the three hospitals where he operates. It was easy to see what had landed them under his knife. They were nearly all obese or diabetic or both. Many had a family history of heart disease. Few were taking preventive measures, such as cholesterol-lowering drugs, which, studies indicate, would have obviated surgery for up to half of them.

Yet public-health statistics show that cardiovascular-disease rates in the county are actually lower than average, probably because its smoking rates are quite low. Rates of asthma, H.I.V., infant mortality, cancer, and injury are lower, too. El Paso County, eight hundred miles up the border, has essentially the same demographics. Both counties have a population of roughly seven hundred thousand, similar public-health statistics, and similar percentages of non-English speakers, illegal immigrants, and the unemployed. Yet in 2006 Medicare expenditures (our best approximation of over-all spending patterns) in El Paso were $7,504 per enrollee—half as much as in McAllen. An unhealthy population couldn't possibly be the reason that McAllen's health-care costs are so high. (Or the reason that America's are. We may be more obese than any other industrialized nation, but we have among the lowest rates of smoking and alcoholism, and we are in the middle of the range for cardiovascular disease and diabetes.)

Was the explanation, then, that McAllen was providing unusually good health care? I took a walk through Doctors Hospital at Renaissance, in Edinburg, one of the towns in the McAllen metropolitan area, with Robert Alleyn, a Houston-trained general surgeon who had grown up here and returned home to practice. The hospital campus sprawled across two city blocks, with a series of three- and four-story stucco buildings separated by golfing-green lawns and black asphalt parking lots. He pointed out the sights—the cancer center is over here, the heart center is over there, now we're coming to the imaging center. We went inside the surgery building. It was sleek and modern, with recessed

lighting, classical music piped into the waiting areas, and nurses moving from patient to patient behind rolling black computer pods. We changed into scrubs and Alleyn took me through the sixteen operating rooms to show me the laparoscopy suite, with its flat-screen video monitors, the hybrid operating room with built-in imaging equipment, the surgical robot for minimally invasive robotic surgery.

I was impressed. The place had virtually all the technology that you'd find at Harvard and Stanford and the Mayo Clinic, and, as I walked through that hospital on a dusty road in South Texas, this struck me as a remarkable thing. Rich towns get the new school buildings, fire trucks, and roads, not to mention the better teachers and police officers and civil engineers. Poor towns don't. But that rule doesn't hold for health care.

At McAllen Medical Center, I saw an orthopedic surgeon work under an operating microscope to remove a tumor that had wrapped around the spinal cord of a fourteen-year-old. At a home-health agency, I spoke to a nurse who could provide intravenous-drug therapy for patients with congestive heart failure. At McAllen Heart Hospital, I watched Dyke and a team of six do a coronary-artery bypass using technologies that didn't exist a few years ago. At Renaissance, I talked with a neonatologist who trained at my hospital, in Boston, and brought McAllen new skills and technologies for premature babies. "I've had nurses come up to me and say, 'I never knew these babies could survive,' " he said.

And yet there's no evidence that the treatments and technologies available at McAllen are better than those found elsewhere in the country. The annual reports that hospitals file with Medicare show that those in McAllen and El Paso offer comparable technologies—neonatal intensive-care units, advanced cardiac services, PET scans, and so on. Public statistics show no difference in the supply of doctors. Hidalgo County actually has fewer specialists than the national average.

Nor does the care given in McAllen stand out for its quality. Medicare ranks hospitals on twenty-five metrics of care. On all but two of these, McAllen's five largest hospitals performed worse, on average, than El Paso's. McAllen costs Medicare seven thousand dollars more per person each year than does the average city in America. But not, so far as one can tell, because it's delivering better health care.

One night, I went to dinner with six McAllen doctors. All were what you would call bread-and-butter physicians: busy, full-time, private-practice doctors who work from seven in the morning to seven at night and sometimes later, their waiting rooms teeming and their desks stacked with medical charts to review.

Some were dubious when I told them that McAllen was the country's most expensive place for health care. I gave them the spending data from Medicare. In 1992, in the McAllen market, the average cost per Medicare enrollee was $4,891, almost exactly the national average. But since then, year after year, McAllen's health costs have grown faster than any other market in the country, ultimately soaring by more than ten thousand dollars per person.

"Maybe the service is better here," the cardiologist suggested. People can be seen faster and get their tests more readily, he said.

Others were skeptical. "I don't think that explains the costs he's talking about," the general surgeon said.

"It's malpractice," a family physician who had practiced here for thirty-three years said.

"McAllen is legal hell," the cardiologist agreed. Doctors order unnecessary tests just to protect themselves, he said. Everyone thought the lawyers here were worse than elsewhere.

That explanation puzzled me. Several years ago, Texas passed a tough malpractice law that capped pain-and-suffering awards at two hundred and fifty thousand dollars. Didn't lawsuits go down?

"Practically to zero," the cardiologist admitted.

"Come on," the general surgeon finally said. "We all know these arguments are bullshit. There is overutilization here, pure and simple." Doctors, he said, were racking up charges with extra tests, services, and procedures.

The surgeon came to McAllen in the mid-nineties, and since then, he said, "the way to practice medicine has

changed completely. Before, it was about how to do a good job. Now it is about 'How much will you benefit?' "

Everyone agreed that something fundamental had changed since the days when health-care costs in McAllen were the same as those in El Paso and elsewhere. Yes, they had more technology. "But young doctors don't think anymore," the family physician said.

The surgeon gave me an example. General surgeons are often asked to see patients with pain from gallstones. If there aren't any complications—and there usually aren't—the pain goes away on its own or with pain medication. With instruction on eating a lower-fat diet, most patients experience no further difficulties. But some have recurrent episodes, and need surgery to remove their gallbladder.

Seeing a patient who has had uncomplicated, first-time gallstone pain requires some judgment. A surgeon has to provide reassurance (people are often scared and want to go straight to surgery), some education about gallstone disease and diet, perhaps a prescription for pain; in a few weeks, the surgeon might follow up. But increasingly, I was told, McAllen surgeons simply operate. The patient wasn't going to moderate her diet, they tell themselves. The pain was just going to come back. And by operating they happen to make an extra seven hundred dollars.

I gave the doctors around the table a scenario. A forty-year-old woman comes in with chest pain after a fight with her husband. An EKG is normal. The chest pain goes away. She has no family history of heart disease. What did McAllen doctors do fifteen years ago?

Send her home, they said. Maybe get a stress test to confirm that there's no issue, but even that might be overkill.

And today? Today, the cardiologist said, she would get a stress test, an echocardiogram, a mobile Holter monitor, and maybe even a cardiac catheterization.

"Oh, she's *definitely* getting a cath," the internist said, laughing grimly.

To determine whether overuse of medical care was really the problem in McAllen, I turned to Jonathan Skinner, an economist at Dartmouth's Institute for Health Policy and Clinical Practice, which has three decades of expertise in examining regional patterns in Medicare payment data. I also turned to two private firms—D2Hawkeye, an independent company, and Ingenix, UnitedHealthcare's data-analysis company—to analyze commercial insurance data for McAllen. The answer was yes. Compared with patients in El Paso and nationwide, patients in McAllen got more of pretty much everything—more diagnostic testing, more hospital treatment, more surgery, more home care.

The Medicare payment data provided the most detail. Between 2001 and 2005, critically ill Medicare patients received almost fifty per cent more specialist visits in McAllen than in El Paso, and were two-thirds more likely to see ten or more specialists in a six-month period. In 2005 and 2006, patients in McAllen received twenty per cent more abdominal ultrasounds, thirty per cent more bone-density studies, sixty per cent more stress tests with echocardiography, two hundred per cent more nerve-conduction studies to diagnose carpal-tunnel syndrome, and five hundred and fifty per cent more urine-flow studies to diagnose prostate troubles. They received one-fifth to two-thirds more gallbladder operations, knee replacements, breast biopsies, and bladder scopes. They also received two to three times as many pacemakers, implantable defibrillators, cardiac-bypass operations, carotid endarterectomies, and coronary-artery stents. And Medicare paid for five times as many home-nurse visits. The primary cause of McAllen's extreme costs was, very simply, the across-the-board overuse of medicine.

This is a disturbing and perhaps surprising diagnosis. Americans like to believe that, with most things, more is better. But research suggests that where medicine is concerned it may actually be worse. For example, Rochester, Minnesota, where the Mayo Clinic dominates the scene, has fantastically high levels of technological capability and quality, but its Medicare spending is in the lowest fifteen per cent of the country—$6,688 per enrollee in 2006, which is eight thousand dollars less than the figure for McAllen. Two economists working at Dartmouth, Katherine Baicker and Amitabh Chandra, found that the more money Medicare spent per person in a given state the lower that state's quality ranking tended to be. In fact, the four states with the highest levels of spending—Louisiana, Texas, California, and Florida—were near the bottom of the national rankings on the quality of patient care.

In a 2003 study, another Dartmouth team, led by the internist Elliott Fisher, examined the treatment received by a million elderly Americans diagnosed with colon or rectal cancer, a hip fracture, or a heart attack. They found that patients in higher-spending regions received sixty per cent more care than elsewhere. They got more frequent tests and procedures, more visits with specialists, and more frequent admission to hospitals. Yet they did no better than other patients, whether this was measured in terms of survival, their ability to function, or satisfaction with the care they received. If anything, they seemed to do worse.

That's because nothing in medicine is without risks. Complications can arise from hospital stays, medications, procedures, and tests, and when these things are of marginal value the harm can be greater than the benefits. In recent years, we doctors have markedly increased the number of operations we do, for instance. In 2006, doctors performed at least sixty million surgical procedures, one for every five Americans. No other country does anything like as many operations on its citizens. Are we better off for it? No one knows for sure, but it seems highly unlikely. After all, some hundred thousand people die each year from complications of surgery—far more than die in car crashes.

To make matters worse, Fisher found that patients in high-cost areas were actually less likely to receive low-cost preventive services, such as flu and pneumonia vaccines, faced longer waits at doctor and emergency-room visits, and were less likely to have a primary-care physician. They got more of the stuff that cost more, but not more of what they needed.

In an odd way, this news is reassuring. Universal coverage won't be feasible unless we can control costs. Policymakers have worried that doing so would require rationing, which the public would never go along with. So the idea that there's plenty of fat in the system is proving deeply attractive. "Nearly thirty per cent of Medicare's costs could be saved without negatively affecting health outcomes if spending in high- and medium-cost areas could be reduced to the level in low-cost areas," Peter Orszag, the President's budget director, has stated.

Most Americans would be delighted to have the quality of care found in places like Rochester, Minnesota, or Seattle, Washington, or Durham, North Carolina—all of which have world-class hospitals and costs that fall below the national average. If we brought the cost curve in the expensive places down to their level, Medicare's problems (indeed, almost all the federal government's budget problems for the next fifty years) would be solved. The difficulty is how to go about it. Physicians in places like McAllen behave differently from others. The $2.4-trillion question is why. Unless we figure it out, health reform will fail.

I had what I considered to be a reasonable plan for finding out what was going on in McAllen. I would call on the heads of its hospitals, in their swanky, decorator-designed, *churrigueresco* offices, and I'd ask them.

The first hospital I visited, McAllen Heart Hospital, is owned by Universal Health Services, a for-profit hospital chain with headquarters in King of Prussia, Pennsylvania, and revenues of five billion dollars last year. I went to see the hospital's chief operating officer, Gilda Romero. Truth be told, her office seemed less *churrigueresco* than Office Depot. She had straight brown hair, sympathetic eyes, and looked more like a young school teacher than like a corporate officer with nineteen years of experience. And when I inquired, "What is going on in this place?" she looked surprised.

Is McAllen really that expensive? she asked.

I described the data, including the numbers indicating that heart operations and catheter procedures and pacemakers were being performed in McAllen at double the usual rate.

"That is *interesting*," she said, by which she did not mean, "Uh-oh, you've caught us" but, rather, "That is actually interesting." The problem of McAllen's outlandish costs was new to her. She puzzled over the numbers. She was certain that her doctors performed surgery only when it was necessary. It had to be one of the other hospitals. And she had one in mind—Doctors Hospital at Renaissance, the hospital in Edinburg that I had toured.

She wasn't the only person to mention Renaissance. It is the newest hospital in the area. It is physician-owned. And it has a reputation (which it disclaims) for aggressively recruiting high-volume physicians to become investors and send patients there. Physicians who do so receive not only their fee for whatever service they provide but also a percentage of the hospital's profits from the tests, surgery, or other care patients are given. (In 2007, its profits totalled thirty-four million dollars.) Romero and others argued that this gives physicians an unholy temptation to overorder.

Such an arrangement can make physician investors rich. But it can't be the whole explanation. The hospital gets barely a sixth of the patients in the region; its margins are no bigger than the other hospitals'—whether for profit or not for profit—and it didn't have much of a presence until 2004 at the earliest, a full decade after the cost explosion in McAllen began.

"Those are good points," Romero said. She couldn't explain what was going on.

The following afternoon, I visited the top managers of Doctors Hospital at Renaissance. We sat in their boardroom around one end of a yacht-length table. The chairman of the board offered me a soda. The chief of staff smiled at me. The chief financial officer shook my hand as if I were an old friend. The C.E.O., however, was having a hard time pretending that he was happy to see me. Lawrence Gelman was a fifty-seven-year-old anesthesiologist with a Bill

Clinton shock of white hair and a weekly local radio show tag-lined "Opinions from an Unrelenting Conservative Spirit." He had helped found the hospital. He barely greeted me, and while the others were trying for a how-can-I-help-you-today attitude, his body language was more let's-get-this-over-with.

So I asked him why McAllen's health-care costs were so high. What he gave me was a disquisition on the theory and history of American health-care financing going back to Lyndon Johnson and the creation of Medicare, the upshot of which was: (1) Government is the problem in health care. "The people in charge of the purse strings don't know what they're doing." (2) If anything, government insurance programs like Medicare don't pay enough. "I, as an anesthesiologist, know that they pay me ten per cent of what a private insurer pays." (3) Government programs are full of waste. "Every person in this room could easily go through the expenditures of Medicare and Medicaid and see all kinds of waste." (4) But not in McAllen. The clinicians here, at least at Doctors Hospital at Renaissance, "are providing necessary, essential health care," Gelman said. "We don't invent patients."

Then why do hospitals in McAllen order so much more surgery and scans and tests than hospitals in El Paso and elsewhere?

In the end, the only explanation he and his colleagues could offer was this: The other doctors and hospitals in McAllen may be overspending, but, to the extent that his hospital provides costlier treatment than other places in the country, it is making people better in ways that data on quality and outcomes do not measure.

"Do we provide better health care than El Paso?" Gelman asked. "I would bet you two to one that we do."

It was a depressing conversation—not because I thought the executives were being evasive but because they weren't being evasive. The data on McAllen's costs were clearly new to them. They were defending McAllen reflexively. But they really didn't know the big picture of what was happening.

And, I realized, few people in their position do. Local executives for hospitals and clinics and home-health agencies understand their growth rate and their market share; they know whether they are losing money or making money. They know that if their doctors bring in enough business—surgery, imaging, home-nursing referrals—they make money; and if they get the doctors to bring in more, they make more. But they have only the vaguest notion of whether the doctors are making their communities as healthy as they can, or whether they are more or less efficient than their counterparts elsewhere. A doctor sees a patient in clinic, and has her check into a McAllen hospital for a CT scan, an ultrasound, three rounds of blood tests, another ultrasound, and then surgery to have her gallbladder removed. How is Lawrence Gelman or Gilda Romero to know whether all that is essential, let alone the best possible treatment for the patient? It isn't what they are responsible or accountable for.

Health-care costs ultimately arise from the accumulation of individual decisions doctors make about which services and treatments to write an order for. The most expensive piece of medical equipment, as the saying goes, is a doctor's pen. And, as a rule, hospital executives don't own the pen caps. Doctors do.

If doctors wield the pen, why do they do it so differently from one place to another? Brenda Sirovich, another Dartmouth researcher, published a study last year that provided an important clue. She and her team surveyed some eight hundred primary-care physicians from high-cost cities (such as Las Vegas and New York), low-cost cities (such as Sacramento and Boise), and others in between. The researchers asked the physicians specifically how they would handle a variety of patient cases. It turned out that differences in decision-making emerged in only some kinds of cases. In situations in which the right thing to do was well established—for example, whether to recommend a mammogram for a fifty-year-old woman (the answer is yes)—physicians in high- and low-cost cities made the same decisions. But, in cases in which the science was unclear, some physicians pursued the maximum possible amount of testing and procedures; some pursued the minimum. And which kind of doctor they were depended on where they came from.

Sirovich asked doctors how they would treat a seventy-five-year-old woman with typical heartburn symptoms and "adequate health insurance to cover tests and medications." Physicians in high- and low-cost cities were equally likely to prescribe antacid therapy and to check for H. pylori, an ulcer-causing bacterium—steps strongly recommended by national guidelines. But when it came to measures of less certain value—and higher cost—the differences were considerable. More than seventy per cent of physicians in high-cost cities referred the patient to a gastroenterologist, ordered an upper endoscopy, or both, while half as many in low-cost cities did. Physicians from high-cost cities typically recommended that patients with well-controlled hypertension see them in the office every one to three months, while those from low-cost cities recommended visits twice yearly. In case after uncertain case, more was not necessarily better. But physicians from the most expensive cities did the most expensive things.

Why? Some of it could reflect differences in training. I remember when my wife brought our infant son Walker to visit his grandparents in Virginia, and he took a terrifying fall down a set of stairs. They drove him to the local community hospital in Alexandria. A CT scan showed that he had a tiny subdural hematoma—a small area of bleeding in the brain. During ten hours of observation, though, he was fine—eating, drinking, completely alert. I was a surgery resident then and had seen many cases like his. We observed each child in intensive care for at least twenty-four hours and got a repeat CT scan. That was how I'd been trained. But the doctor in Alexandria was going to send Walker home. That was how he'd been trained. Suppose things change for the worse? I asked him. It's extremely unlikely, he said, and if anything changed Walker could always be brought back. I bullied the doctor into admitting him anyway. The next day, the scan and the patient were fine. And, looking in the textbooks, I learned that the doctor was right. Walker could have been managed safely either way.

There was no sign, however, that McAllen's doctors as a group were trained any differently from El Paso's. One morning, I met with a hospital administrator who had extensive experience managing for-profit hospitals along the border. He offered a different possible explanation: the culture of money.

"In El Paso, if you took a random doctor and looked at his tax returns eighty-five per cent of his income would come from the usual practice of medicine," he said. But in McAllen, the administrator thought, that percentage would be a lot less.

He knew of doctors who owned strip malls, orange groves, apartment complexes—or imaging centers, surgery centers, or another part of the hospital they directed patients to. They had "entrepreneurial spirit," he said. They were innovative and aggressive in finding ways to increase revenues from patient care. "There's no lack of work ethic," he said. But he had often seen financial considerations drive the decisions doctors made for patients—the tests they ordered, the doctors and hospitals they recommended—and it bothered him. Several doctors who were unhappy about the direction medicine had taken in McAllen told me the same thing. "It's a machine, my friend," one surgeon explained.

No one teaches you how to think about money in medical school or residency. Yet, from the moment you start practicing, you must think about it. You must consider what is covered for a patient and what is not. You must pay attention to insurance rejections and government-reimbursement rules. You must think about having enough money for the secretary and the nurse and the rent and the malpractice insurance.

Beyond the basics, however, many physicians are remarkably oblivious to the financial implications of their decisions. They see their patients. They make their recommendations. They send out the bills. And, as long as the numbers come out all right at the end of each month, they put the money out of their minds.

Others think of the money as a means of improving what they do. They think about how to use the insurance money to maybe install electronic health records with colleagues, or provide easier phone and e-mail access, or offer expanded hours. They hire an extra nurse to monitor diabetic patients more closely, and to make sure that patients don't miss their mammograms and pap smears and colonoscopies.

Then there are the physicians who see their practice primarily as a revenue stream. They instruct their secretary to have patients who call with follow-up questions schedule an appointment, because insurers don't pay for phone calls, only office visits. They consider providing Botox injections for cash. They take a Doppler ultrasound course, buy a machine, and start doing their patients' scans themselves, so that the insurance payments go to them rather than to the hospital. They figure out ways to increase their high-margin work and decrease their low-margin work. This is a business, after all.

In every community, you'll find a mixture of these views among physicians, but one or another tends to predominate. McAllen seems simply to be the community at one extreme.

In a few cases, the hospital executive told me, he'd seen the behavior cross over into what seemed like outright fraud. "I've had doctors here come up to me and say, 'You want me to admit patients to your hospital, you're going to have to pay me.' "

"How much?" I asked.

"The amounts—all of them were over a hundred thousand dollars per year," he said. The doctors were specific. The most he was asked for was five hundred thousand dollars per year.

He didn't pay any of them, he said: "I mean, I gotta sleep at night." And he emphasized that these were just a handful of doctors. But he had never been asked for a kickback before coming to McAllen.

Woody Powell is a Stanford sociologist who studies the economic culture of cities. Recently, he and his research team studied why certain regions—Boston, San Francisco, San Diego—became leaders in biotechnology while others with a similar concentration of scientific and corporate talent—Los Angeles, Philadelphia, New York—did not. The answer they found was what Powell describes as the anchor-tenant theory of economic development. Just as an anchor store will define the character of a mall, anchor tenants in biotechnology, whether it's a company like Genentech, in South San Francisco, or a university like M.I.T., in Cambridge, define the character of an economic community. They set the norms. The anchor tenants that set norms encouraging the free flow of ideas and collaboration, even with competitors, produced enduringly successful communities, while those that mainly sought to dominate did not.

Powell suspects that anchor tenants play a similarly powerful community role in other areas of economics, too, and health care may be no exception. I spoke to a marketing rep for a McAllen home-health agency who told me of a process uncannily similar to what Powell found in biotech. Her job is to persuade doctors to use her agency rather than others. The competition is fierce. I opened the phone book and found seventeen pages of listings for home-health agencies—two hundred and sixty in all. A patient typically brings in between twelve hundred and fifteen hundred dollars, and double that amount for specialized care. She described how, a decade or so ago, a few early agencies began rewarding doctors who ordered home visits with more than trinkets: they provided tickets to professional sporting events, jewelry, and other gifts. That set the tone. Other agencies jumped in. Some began paying doctors a supplemental salary, as "medical directors," for steering business in their direction. Doctors came to expect a share of the revenue stream.

Agencies that want to compete on quality struggle to remain in business, the rep said. Doctors have asked her for a medical-director salary of four or five thousand dollars a month in return for sending her business. One asked a colleague of hers for private-school tuition for his child; another wanted sex.

"I explained the rules and regulations and the anti-kickback law, and told them no," she said of her dealings with such doctors. "Does it hurt my business?" She paused. "I'm O.K. working only with ethical physicians," she finally said.

About fifteen years ago, it seems, something began to change in McAllen. A few leaders of local institutions took profit growth to be a legitimate ethic in the practice of medicine. Not all the doctors accepted this. But they failed to discourage those who did. So here, along the banks of the Rio Grande, in the Square Dance Capital of the World, a medical community came to treat patients the way subprime-mortgage lenders treated home buyers: as profit centers.

The real puzzle of American health care, I realized on the airplane home, is not why McAllen is different from El Paso. It's why El Paso isn't like McAllen. Every incentive in the system is an invitation to go the way McAllen has gone. Yet, across the country, large numbers of communities have managed to control their health costs rather than ratchet them up.

I talked to Denis Cortese, the C.E.O. of the Mayo Clinic, which is among the highest-quality, lowest-cost health-care systems in the country. A couple of years ago, I spent several days there as a visiting surgeon. Among the things that stand out from that visit was how much time the doctors spent with patients. There was no churn—no shuttling patients in and out of rooms while the doctor bounces from one to the other. I accompanied a colleague while he saw patients. Most of the patients, like those in my clinic, required about twenty minutes. But one patient had colon cancer and a number of other complex issues, including heart disease. The physician spent an hour with her, sorting things out. He phoned a cardiologist with a question.

"I'll be there," the cardiologist said.

Fifteen minutes later, he was. They mulled over everything together. The cardiologist adjusted a medication, and said that no further testing was needed. He cleared the patient for surgery, and the operating room gave her a slot the next day.

The whole interaction was astonishing to me. Just having the cardiologist pop down to see the patient with the surgeon would be unimaginable at my hospital. The time required wouldn't pay. The time required just to organize the system wouldn't pay.

The core tenet of the Mayo Clinic is "The needs of the patient come first"—not the convenience of the doctors, not their revenues. The doctors and nurses, and even the janitors, sat in meetings almost weekly, working on ideas to make the service and the care better, not to get more money out of patients. I asked Cortese how the Mayo Clinic made this possible.

"It's not easy," he said. But decades ago Mayo recognized that the first thing it needed to do was eliminate the financial barriers. It pooled all the money the doctors and the hospital system received and began paying everyone a salary, so that the doctors' goal in patient care couldn't be increasing their income. Mayo promoted leaders who focussed first on what was best for patients, and then on how to make this financially possible.

No one there actually intends to do fewer expensive scans and procedures than is done elsewhere in the country. The aim is to raise quality and to help doctors and other staff members work as a team. But, almost by happenstance, the result has been lower costs.

"When doctors put their heads together in a room, when they share expertise, you get more thinking and less testing," Cortese told me.

Skeptics saw the Mayo model as a local phenomenon that wouldn't carry beyond the hay fields of northern Minnesota. But in 1986 the Mayo Clinic opened a campus in Florida, one of our most expensive states for health care, and, in 1987, another one in Arizona. It was difficult to recruit staff members who would accept a salary and the Mayo's collaborative way of practicing. Leaders were working against the dominant medical culture and incentives. The expansion sites took at least a decade to get properly established. But eventually they achieved the same high-quality, low-cost results as Rochester. Indeed, Cortese says that the Florida site has become, in some respects, the most efficient one in the system.

The Mayo Clinic is not an aberration. One of the lowest-cost markets in the country is Grand Junction, Colorado, a community of a hundred and twenty thousand that nonetheless has achieved some of Medicare's highest quality-of-care scores. Michael Pramenko is a family physician and a local medical leader there. Unlike doctors at the Mayo Clinic, he told me, those in Grand Junction get piecework fees from insurers. But years ago the doctors agreed among themselves to a system that paid them a similar fee whether they saw Medicare, Medicaid, or private-insurance patients, so that there would be little incentive to cherry-pick patients. They also agreed, at the behest of the main health plan in town, an H.M.O., to meet regularly on small peer-review committees to go over their patient charts together. They focussed on rooting out problems like poor prevention practices, unnecessary back operations, and unusual hospital-complication rates. Problems went down. Quality went up. Then, in 2004, the doctors' group and the local H.M.O. jointly created a regional information network—a community-wide electronic-record system that shared office notes, test results, and hospital data for patients across the area. Again, problems went down. Quality went up. And costs ended up lower than just about anywhere else in the United States.

Grand Junction's medical community was not following anyone else's recipe. But, like Mayo, it created what Elliott Fisher, of Dartmouth, calls an accountable-care organization. The leading doctors and the hospital system adopted measures to blunt harmful financial incentives, and they took collective responsibility for improving the sum total of patient care.

This approach has been adopted in other places, too: the Geisinger Health System, in Danville, Pennsylvania; the Marshfield Clinic, in Marshfield, Wisconsin; Intermountain Healthcare, in Salt Lake City; Kaiser Permanente, in Northern California. All of them function on similar principles. All are not-for-profit institutions. And all have produced enviably higher quality and lower costs than the average American town enjoys.

When you look across the spectrum from Grand Junction to McAllen—and the almost threefold difference in the costs of care—you come to realize that we are witnessing a battle for the soul of American medicine. Somewhere in the United States at this moment, a patient with chest pain, or a tumor, or a cough is seeing a doctor. And the damning question we have to ask is whether the doctor is set up to meet the needs of the patient, first and foremost, or to maximize revenue.

There is no insurance system that will make the two aims match perfectly. But having a system that does so much to misalign them has proved disastrous. As economists have often pointed out, we pay doctors for quantity, not quality. As they point out less often, we also pay them as individuals, rather than as members of a team working together for their patients. Both practices have made for serious problems.

Providing health care is like building a house. The task requires experts, expensive equipment and materials, and a huge amount of coördination. Imagine that, instead of paying a contractor to pull a team together and keep them on track, you paid an electrician for every outlet he recommends, a plumber for every faucet, and a carpenter for every cabinet. Would you be surprised if you got a house with a thousand outlets, faucets, and cabinets, at three times the cost you expected, and the whole thing fell apart a couple of years later? Getting the country's best electrician on the job (he

trained at Harvard, somebody tells you) isn't going to solve this problem. Nor will changing the person who writes him the check.

This last point is vital. Activists and policymakers spend an inordinate amount of time arguing about whether the solution to high medical costs is to have government or private insurance companies write the checks. Here's how this whole debate goes. Advocates of a public option say government financing would save the most money by having leaner administrative costs and forcing doctors and hospitals to take lower payments than they get from private insurance. Opponents say doctors would skimp, quit, or game the system, and make us wait in line for our care; they maintain that private insurers are better at policing doctors. No, the skeptics say: all insurance companies do is reject applicants who need health care and stall on paying their bills. Then we have the economists who say that the people who should pay the doctors are the ones who use them. Have consumers pay with their own dollars, make sure that they have some "skin in the game," and then they'll get the care they deserve. These arguments miss the main issue. When it comes to making care better and cheaper, changing who pays the doctor will make no more difference than changing who pays the electrician. The lesson of the high-quality, low-cost communities is that someone has to be accountable for the totality of care. Otherwise, you get a system that has no brakes. You get McAllen.

One afternoon in McAllen, I rode down McColl Road with Lester Dyke, the cardiac surgeon, and we passed a series of office plazas that seemed to be nothing but home-health agencies, imaging centers, and medical-equipment stores.

"Medicine has become a pig trough here," he muttered.

Dyke is among the few vocal critics of what's happened in McAllen. "We took a wrong turn when doctors stopped being doctors and became businessmen," he said.

We began talking about the various proposals being touted in Washington to fix the cost problem. I asked him whether expanding public-insurance programs like Medicare and shrinking the role of insurance companies would do the trick in McAllen.

"I don't have a problem with it," he said. "But it won't make a difference." In McAllen, government payers already predominate—not many people have jobs with private insurance.

How about doing the opposite and increasing the role of big insurance companies?

"What good would that do?" Dyke asked.

The third class of health-cost proposals, I explained, would push people to use medical savings accounts and hold high-deductible insurance policies: "They'd have more of their own money on the line, and that'd drive them to bargain with you and other surgeons, right?"

He gave me a quizzical look. We tried to imagine the scenario. A cardiologist tells an elderly woman that she needs bypass surgery and has Dr. Dyke see her. They discuss the blockages in her heart, the operation, the risks. And now they're supposed to haggle over the price as if he were selling a rug in a souk? "I'll do three vessels for thirty thousand, but if you take four I'll throw in an extra night in the I.C.U."—that sort of thing? Dyke shook his head. "Who comes up with this stuff?" he asked. "Any plan that relies on the sheep to negotiate with the wolves is doomed to failure."

Instead, McAllen and other cities like it have to be weaned away from their untenably fragmented, quantity-driven systems of health care, step by step. And that will mean rewarding doctors and hospitals if they band together to form Grand Junction-like accountable-care organizations, in which doctors collaborate to increase prevention and the quality of care, while discouraging overtreatment, undertreatment, and sheer profiteering. Under one approach, insurers—whether public or private—would allow clinicians who formed such organizations and met quality goals to keep half the savings they generate. Government could also shift regulatory burdens, and even malpractice liability, from the doctors to the organization. Other, sterner, approaches would penalize those who don't form these organizations.

This will by necessity be an experiment. We will need to do in-depth research on what makes the best systems successful—the peer-review committees? recruiting more primary-care doctors and nurses? putting doctors on salary?—and disseminate what we learn. Congress has provided vital funding for research that compares the effectiveness of different treatments, and this should help reduce uncertainty about which treatments are best. But we also need to fund research that compares the effectiveness of different systems of care—to reduce our uncertainty about which systems work best for communities. These are empirical, not ideological, questions. And we would do well to form a national institute for health-care delivery, bringing together clinicians, hospitals, insurers, employers, and citizens to assess, regularly, the quality and the cost of our care, review the strategies that produce good results, and

make clear recommendations for local systems.

Dramatic improvements and savings will take at least a decade. But a choice must be made. Whom do we want in charge of managing the full complexity of medical care? We can turn to insurers (whether public or private), which have proved repeatedly that they can't do it. Or we can turn to the local medical communities, which have proved that they can. But we have to choose someone—because, in much of the country, no one is in charge. And the result is the most wasteful and the least sustainable health-care system in the world.

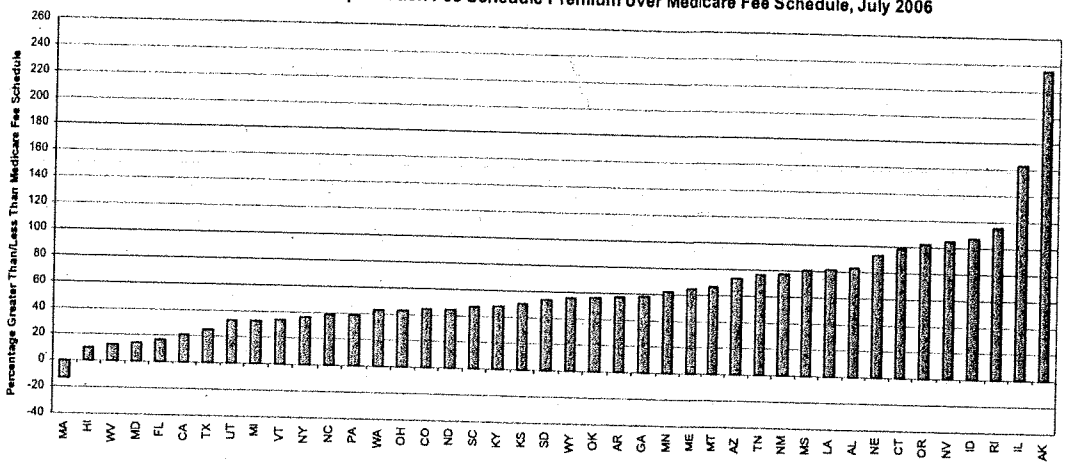
Something even more worrisome is going on as well. In the war over the culture of medicine—the war over whether our country's anchor model will be Mayo or McAllen—the Mayo model is losing. In the sharpest economic downturn that our health system has faced in half a century, many people in medicine don't see why they should do the hard work of organizing themselves in ways that reduce waste and improve quality if it means sacrificing revenue.

In El Paso, the for-profit health-care executive told me, a few leading physicians recently followed McAllen's lead and opened their own centers for surgery and imaging. When I was in Tulsa a few months ago, a fellow-surgeon explained how he had made up for lost revenue by shifting his operations for well-insured patients to a specialty hospital that he partially owned while keeping his poor and uninsured patients at a nonprofit hospital in town. Even in Grand Junction, Michael Pramenko told me, "some of the doctors are beginning to complain about 'leaving money on the table.' "

As America struggles to extend health-care coverage while curbing health-care costs, we face a decision that is more important than whether we have a public-insurance option, more important than whether we will have a single-payer system in the long run or a mixture of public and private insurance, as we do now. The decision is whether we are going to reward the leaders who are trying to build a new generation of Mayos and Grand Junctions. If we don't, McAllen won't be an outlier. It will be our future. ♦

8

Figure 1 Workers' Compensation Fee Schedule Premium over Medicare Fee Schedule, July 2006



Notes: Florida, Illinois, New York and Pennsylvania have distinct fee schedules for different parts of the state. For each, we created a single statewide index by averaging the different sub-state fee schedules using employment in each sub-state region as weights. Medicare establishes distinct sub-state fee schedules in 14 states. For each, we created a single statewide index using the same procedure. Rhode Island has different billing codes for physical medicine than other states. For Rhode Island the overall index is based on the fee schedule levels for only surgery, radiology, general medicine, and evaluation and management.

Table 1 Workers' Compensation Fee Schedule Rates for Five Commonly Billed Procedures, July 2006					
State	Surgery: 29881 (arthroscopy, knee with meniscectomy)	Radiology: 72141 (MRI, spinal canal cervical)	General Medicine: 95904 (nerve conduction sensory/mixed)	Physical Medicine: 97110 (therapeutic procedure/exercises)	Evaluation and Management: 99213 (established patient office visit/expanded problems, low complexity)
Alabama	$2,318	$756	$47	$40	$57
Alaska	$4,181	$2,339	$219	$83	$127
Arizona	$2,135	$880	$76	$36	$59
Arkansas	$1,125	$981	$65	$33	$62
California	$1,294	$646	$81	$33	$48
Colorado	$1,365	$931	$74	$26	$71
Connecticut	$2,885	$1,298	$123	$30	$72
Florida: Dade and Monroe Counties[a]	$960	$642	$65	$32	$61
Georgia	$1,576	$1,061	$75	$34	$64
Hawaii	$693	$634	$66	$32	$61
Idaho	$2,089	$1,192	$103	$33	$90
Illinois: Region 606 (Chicago)[a]	$3,779	$1,417	$165	$61	$92
Kansas	$1,090	$883	$77	$32	$64
Kentucky	$1,369	$622	$61	$34	$63
Louisiana	$1,387	$976	$64	$43	$68
Maine	$1,043	$802	$61	$44	$83
Maryland	$847	$569	$60	$31	$57
Massachusetts	$619	$577	$61	$22	$56
Michigan	$881	$730	$75	$38	$71
Minnesota	$1,244	$984	$66	$36	$79
Mississippi	$1,314	$828	$61	$44	$70
Montana	$1,850	$1,274	$56	$26	$50
Nebraska	$1,737	$1,221	$74	$39	$70
Nevada	$2,496	$1,615	$76	$38	$69
New Mexico	$1,818	$1,079	$59	$36	$67
New York: New York City[a]	$2,013	$880	$106	$34	$49
North Carolina	$1,354	$830	$46	$25	$51
North Dakota	$1,234	$946	$55	$28	$57
Ohio	$1,218	$727	$63	$38	$41
Oklahoma	$1,573	$890	$78	$30	$56
Oregon	$1,505	$953	$110	$49	$95
Pennsylvania: Philadelphia[a]	$1,335	$817	$51	$31	$58
Rhode Island[b]	$2,355	$985	$61	N/C	$70
South Carolina	$904	$695	$53	$38	$72
South Dakota	$1,513	$1,023	$55	$27	$49
Tennessee	$1,535	$936	$80	$34	$79
Texas	$749	$630	$66	$34	$64
Utah	$932	$743	$65	$33	$61
Vermont	$1,360	$812	$73	$27	$42
Washington	$869	$769	$81	$40	$76
West Virginia	$661	$525	$55	$30	$55
Wyoming	$1,532	$1,128	$62	$27	$55
Range (lowest to highest)	$619 - $4,181	$525 - $2,339	$46 - $219	$22 - $83	$41 - $127
Range (2nd lowest to 2nd highest)	$661 - $3,779	$569 - $1,615	$47 - $165	$25 - $61	$42 - $95

Note: General medicine is largely composed of neurology and neurological testing.

[a] Florida has distinct fee schedules for 3 different parts of the state. Illinois sets different fee schedules for 29 regions. Both New York and Pennsylvania also have distinct fee schedules for 4 different regions of the state. We only show the fee schedule amount of one region for these 4 states in this table.

[b] Rhode Island has different billing codes for physical medicine. Therefore, 97110 is not listed in Rhode Island Workers' Compensation Fee Schedule.

Key: N/C: noncomparable.

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Table 4 Comparison of Selected Fee Schedule Allowances by CPT Code as of January 1, 2008

This table provides a comparison of fees for selected procedure codes often used in workers compensation cases. Note that a number of states have different fees allowed within the state. Those states have chosen one specific code of all those available and footnoted which fees they are using. The CPT codes used here are standardized "current procedural terminology" published by the American Medical Association. In a number of cases the professional component and the technical component have been added together to get one fee for the listed service.

State	CPT 29881 - Arthroscopy	CPT 63030 - Lumbar Laminotomy	CPT 64721 - Neurolysis at Carpal Tunnel	CPT 71020 - Chest X-Ray, Two Views	CPT 72131 - CAT Scan, Lumbar without Contrast	CPT 95904 - Nerve Conduction Testing	CPT 97110 - Therapeutic Procedure, One or More Areas, Each 15 mins.	CPT 97140 - Manual Therapy Techniques	CPT 99205 - Office Visit, New Patient, Comprehensive Exam	CPT 99213 - Office Visit, Established Patient, Expanded Exam	CPT 99284 - Emergency Care, Initial Visit, Detailed History
Alabama	$2,366.58	$3,035.84	$942.38	$75.26	$361.65	$47.58	$42.39	$30.37	$200.15	$58.11	$102.33
Alaska	$4,533.26	$7,293.43	[illegible]	$165.76	[illegible]	$237.70	[illegible]	[illegible]	[illegible]	[illegible]	$243.23
Arizona	$2,135.00	$3,800.00	$940.00	$108.00	$790.00	$106.00	$36.00	$36.00	$231.00	$63.00	$171.00
Arkansas	$1,112.80	$1,724.80	$719.80	$58.80	$506.50	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
California	$1,293.62	$1,962.23	$726.75	$45.13	$366.94	$80.63	$33.21 for each 30 min.	$44.28 9 (1)	$186.73	$56.93	$130.01
Colorado	$1,400.94	$2,729.10	$764.15	$55.23	$448.76	$75.80 each nerve	$27.85	$33.42 each 15 minutes	$220.22	$78.23	$211.75
Connecticut	Chose not to participate in the study this year.										
Delaware	No fee schedule to cover these services as of 1/1/08										
District of Columbia	The statute provides for 113% reimbursement of Medicare's fee schedule to medical providers.										
Florida (2)	$944.00	$1,451.00	[illegible]	$42.00	$295.00	$52.00	$31.00	$29.00	$208.00	$66.00	$129.00
Georgia	$1,675.17	$2,466.02	$1,083.28	$72.11(3)	$601.71 (3)	$73.50 each nerve (4)	$34.85	$32.52 (4)	$232.20	$78.19	$149.34
Hawaii	$1,143.71	$1,583.46	$867.45	$57.82	$452.79	$86.50	[illegible]	$29.11	$234.78	$73.79	$167.82
Idaho	$2,277.68	$3,819.20	$1,285.00	$71.40	$675.75	$85.40	$34.76	$32.12	$311.22	$107.73	$199.08
Illinois (5)	$3,999.42	$7,416.91	[illegible]	$129.38	$1,199.93	[illegible]	[illegible]	[illegible]	$301.85	[illegible]	[illegible]
Indiana	No fee schedule to cover these services										
Iowa	No fee schedule to cover these services										
Kansas	$1,301.43	$1,915.84	$841.59	$56.45	$471.03	$76.08	$33.57	$31.33	$218.56	$66.33	$122.16
Kentucky	$1,388.68	$2,618.36	$909.41	$58.22(3)	$428.62(3)	$85.47(3)	$36.16	$31.82	$206.17	$62.75	$118.62
Louisiana	$1,387.00	$1,906.00	$688.00	$68.00	$548.00	$64.00	$43.00	$44.00	$229.00	$68.00	$173.00
Maine	$962.40	$1,398.50	$621.80	$57.80	$460.00	$66.20	$44.40	$42.00	$274.60	$63.40	$158.60
Maryland (6)	$915.06	$1,361.65	$448.64	$38.53	$339.29	$57.85	$31.97	$29.87	$207.18	$70.89	$131.65
Massachusetts	No fee schedule to cover these services										
Michigan	$929.09	$1,377.99	$572.28	$51.71	$417.16	$76.81	$39.16	$35.64	$243.47	$72.29	$139.56
Minnesota	$1,284.23	$1,953.74	$891.08	$69.03	$580.76	$87.48	P.T. $36.96, D.C. $36.72	P.T. $41.02, D.C. $34.07	M.D. $263.70	M.D. [illegible] D.C. $66.06	$192.35
Mississippi	$1,501.95	$2,206.85	$977.55	$57.79 (7)	$485.14 (7)	$81.42 each nerve	$44.80	$42.24 every 15 mins.	$233.82	$79.29	$146.96
Missouri	No fee schedule to cover these services										
Montana	$1,057.71	$1,557.06	$683.99	$59.01	$492.37	$89.46	$47.59	$44.42	$312.81	$105.33	$201.14
Nebraska	$1,736.63	$2,488.22	$707.29	$65.14	$686.00	$74.47	$39.26	[illegible]	[illegible]	[illegible]	[illegible]
Nevada	$2,595.98	$5,057.10	$1,415.99	$97.60 (total)	$794.04 (total)	$79.20	$39.60	$47.52	$205.92	$71.28	$198.00
New Hampshire	No fee schedule to cover these services										
New Jersey	No fee schedule to cover these services										
New Mexico	$1,554.00	$1,916.66	$840.91	$65.43	$603.66	$56.96	$35.56	$26.57	$230.62	$67.07	$157.17
New York (8)	$2,013.26	$3,185.95	$957.39	$78.29	$581.90	$106.47	$33.55	$35.74	$154.30	$49.26	$168.58
North Carolina	$1,353.81	$2,193.32	$708.59	[illegible]	$467.46	$46.48	$25.19	$26.79	$173.89	$51.76	$131.83
North Dakota	$987.00	$1,473.00	$636.60	$54.00	$412.20	$81.00	$45.60	$42.60	$295.80	$100.80	$190.20
Ohio	$1,218.66	$1,788.99	$762.11	$50.44	$406.15	$82.96	$38.13	$35.17	$197.97	[illegible]	$177.77
Oklahoma	$1,525.41	$2,841.95	$795.74	$51.57	$420.22	$78.39	$30.12	$28.50	$196.29	$63.15	$139.88
Oregon	$1,561.31	$2,298.41	$1,069.65	$63.24	$527.68	$105.61	$46.34	[illegible]	$294.75	$99.25	[illegible]
Pennsylvania (9)	$1,321.13	$1,932.12	$643.78	$58.13	$453.35	$54.92	$31.79	$32.64	$167.88	$58.87	$113.37
Rhode Island	$2,406.35	$4,346.97	[illegible]	$51.37	$605.73	$62.66	Not applicable	Not applicable	$229.71	$92.65	$145.25
South Carolina	$904.00	$1,255.00	$596.00 in office	$48.00	$389.00	$53.00	$38.00	$35.00	$239.00	$72.00	$133.00
South Dakota	$1,512.90	$2,947.20	$825.22	$56.52	$453.60	$64.00	$32.00	$38.40	$202.80	$70.29	$195.00
Tennessee (10)	$1,253.00	$1,869.97	$808.16	$68.55	$600.22	$82.27	$43.42	$40.56	$300.43	$102.38	$241.46
Texas (11)	$753.04	$1,123.85	$489.94	$42.68	$319.14	$64.16	$34.50	$32.05	$222.05	$76.35	$138.38

Table 4 Comparison of Selected Fee Schedule Allowances by CPT Code as of January 1, 2008

This table provides a comparison of fees for selected procedure codes often used in workers compensation cases. Note that a number of states have different fees allowed within the state. Those states have chosen one specific code of all those available and footnoted which fees they are using. The CPT codes used here are standardized "current procedural terminology" published by the American Medical Association. In a number of cases the professional component and the technical component have been added together to get one fee for the listed service.

State	CPT 29881 - Arthroscopy	CPT 63030 - Lumbar Laminotomy	CPT 64721 - Neurolysis at Carpal Tunnel	CPT 71020 - Chest X-Ray, Two Views	CPT 72131 - CAT Scan, Lumbar without Contrast	CPT 95904 - Nerve Conduction Testing	CPT 97110 - Therapeutic Procedure, One or More Areas, Each 15 mins.	CPT 97140 - Manual Therapy Techniques	CPT 99205 - Office Visit, New Patient, Comprehensive Exam	CPT 99213 - Office Visit, Established Patient, Expanded Exam	CPT 99284 - Emergency Care, Initial Visit, Detailed History
US Federal Programs - FECA	Fee schedule is based on geographic area of billing provider.										
US Federal Programs - Longshore	Fees are limited to prevailing charges for the same services in the community. State fee schedules may be used as a guide. The FECA WC Medical Fee Schedule is to be used in the event of a fee dispute.										
Utah	$966.86	$1,423.32	$625.24	$49.29	$411.28	$62.04	$33.00	$30.80	$216.92	$74.70	$139.48
Vermont (12)	$1,716.04	$2,992.11	$1,192.82	[illegible] w/ mod 26 $25.32/w mod TC $36.92	$388.73/w mod 26 $138.17	[illegible]/w mod TC $87.84 & mod 26 $56.80	$48.21	83% of billed charge	$225.57	$66.70	$151.39
Virginia	No fee schedule to cover these services										
Washington	[illegible]	$1,488.72	[illegible]	$55.38	$486.47	$83.07	$46.75	[illegible]	$302.11	$103.37	$192.59
West Virginia	$798.90	$1,256.13	$502.07	$39.12	$358.32	$55.98	$38.15	$35.11	$241.07	$81.68	$161.43
Wisconsin	No fee schedule to cover these services										
Wyoming	$1,531.99	$2,984.40	$835.63	$65.60	$533.00	$61.50	$26.60	$31.92	$159.90	$55.35	$153.75

Notes:

1 **California** - California regulators say they don't use this code, their equivalent is 97250 and this is the fee for that code. Codes and fees vary for osteopathic or chiropractic manipulation see also fees for 98925 ($36.22) ,98926 ($54.34), 98927 ($64.27), 98928 ($74.78), 98929 ($81.21), 98940 ($36.22), 98941($46.16), 98942 ($56.67), 98943 ($33.89).

2 **Florida** - Has different fees according to geographical location. Fees quoted here are those for locality 04, which is Dade and Monroe counties. The major city in this region is Miami.

3 **Georgia and Kentucky** - Total for both professional and technical components.

4 **Georgia** - Each 15 min; only 4 time units allowed/visit.

5 **Illinois** - Fees vary by location and there are actually 29 different schedules. The ones listed are for the Chicago area.

6 **Maryland** - These maximum reimbursable allowances (MRA's) are the ones effective 5-16-08 for the Baltimore area.

7 **Mississippi** - Reinbursment for hospital outpatient CPT 71020 is $63.57 and for CPT 72131 is $533.65.

8 **New York** - These fees are based on those paid in region 4, the New York City metropolitan area. Our fees vary by geographic location of service.

9 **Pennsylvania** - Fees vary by location and these are examples of the fees paid in the Harrisburg region.

10 **Tennessee** - the surgical fees are stated at the general surgery rate; a board certified or board eligible neuro or ortho would be able to collect a higher amount (i.e., 29881 would be $1722.96, 63030 would be $2571.36, and 64721 would be $1108.14. Also, the rate listed for the CT scan is for a non-hospital setting and it includes the technical and professional amount. If the CT scan had been performed in a hospital setting it would have been paid at 150% of Medicare's OPPS which was $287.67. Physical therapy was also paid on a sliding scale until March of 08, these calculations are based on the current 130% of Medicare. Previously, reimbursement was determined by the number of PT visits (0-6 being the highest at 150% of Medicare, then 7-12 at 130% of Medicare, and visits 13 and beyond at 100% of Medicare). In March of 08, our fee schedule changed not only to pay all PT at 130% of Medicare, but all professional fees changed from a percent of the national Medicare to a percent of Tennessee Medicare (Tennessee Medicare is slightly less than the national amount due to our GPCI's). There were also a few other changes to the MFS in March. The TN MFS changed the reimbursement for professional fees in March 2008 to include the Medicare Geographic Price Cost Index for Tennessee.

11 **Texas** - Fees vary by provider geographical location and place of service setting. The fees provided are for services performed in a non-facility setting in the Dallas area prior to 03/01/2008. Texas adopted new fees effective 03/01/2008.

12 **Vermont** - Mod 26 means "modifier 26" which is the professional component of these fees and mod TC means "modifier for technical fees".

10

Liberty Northwest

PO Box 243849
Anchorage, AK 99524-3849

Tel: 907.561.2030
Fax: 800.254.5728
www.libertynorthwest.com

September 3, 2009

VIA FACSIMILE: 866-335-0242
Attn: Shane*** Alaska Billing

Guardian Flight Inc
PO Box 71410
Fairbanks, AK 99707

RE: [redacted]
Claim # [redacted]

Dear Sirs:

As you know, we are the insurance company handling [redacted] reported June 27, 2009 injury and Workers Compensation claim.

We are in receipt of your billing for transportation services your company rendered June 28, 2009 totaling $157,255.00.

We would appreciate your time and attention to the following proposal and your ability to work with us on a reduction of these fees and charges.

At this time we would propose paying the amount of $78,627.50 which is 50% of the total amount charged.

If you are able to accept this proposal and waive 50% of your billing, please contact me at once for immediate payment. We will be able to process payment within 48 hours of your contact.

Valorie) This is not reductions to Be taken on this or any future W/c Claims. The state of Alaska W/c fee Schedule for Ambulance Services is payment in full of Charges - Also, pd within 30 days per Alaska Statues.

Please process payment accordingly

Sincerely,

Valorie J. Moore

Liberty Northwest Insurance
Valorie Moore
Analyst, Agency Markets

Cc: File

6B1870900300000

JUL-02-2009 16:56 From:866 335 0248 6B1870900300 Page:1/7

1500

HEALTH INSURANCE CLAIM FORM

FAX (800)254-5728 Attn: Valerie

LIBERTY NORTHWEST
PO BOX 243849
ANCHORAGE AK 99524

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID) [X]			1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) [redacted]
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [redacted]	3. PATIENT'S BIRTH DATE [redacted] SEX M [X] F [ ]		4. INSURED'S NAME (Last Name, First Name, Middle Initial) [redacted]
5. PATIENT'S ADDRESS (No., Street) [redacted]	6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]		7. INSURED'S ADDRESS (No., Street) [redacted]
CITY [redacted] STATE WA	8. PATIENT STATUS Single [ ] Married [ ] Other [X]		CITY [redacted] STATE [redacted]
ZIP CODE [redacted] TELEPHONE (Include Area Code) [redacted]	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]		ZIP CODE [redacted] TELEPHONE (INCLUDE AREA CODE) [redacted]
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]		a. INSURED'S DATE OF BIRTH [redacted] SEX M [X] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State) AK		b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [X]		c. INSURANCE PLAN NAME OR PROGRAM NAME LIBERTY
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
READ BACK OF FORM BEFORE COMPLETING AND SIGNING THIS FORM.
SIGNED SIGNATURE ON FILE DATE 06/28/09

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY 06 28 2009 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) INJURY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE STAFF OTHER	17a. [redacted] 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 805.07 2. E816.1 3. V80.0 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER 99709

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. Place of Service	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL	J. RENDERING PROVIDER ID #
06 28 09	06 28 09	42		A0430	II	123	17125 00	1		NPI	1154375764
06 28 09	06 28 09	42		A0435	II	123	139680 00	155	2	NPI	1154375764
06 28 09	06 28 09	42		A0398	II	123	450 00	1		NPI	1154375764
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE $ 157255.00	29. AMOUNT PAID $	30. BALANCE DUE $ 157255.00
[redacted]		[X]	[redacted]				

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	BILLING PROVIDER INFO & PH # (877)3465286
SIGNATURE ON FILE SIGNED DATE 07/02/09	FAIRBANKS AK 99709 SEATTLE WA a. [redacted]	GUARDIAN FLIGHT PO BOX 71410 FAIRBANKS AK 99707 a 1154375764 b [redacted]

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PLEASE PRINT OR TYPE

efforts to bring medical costs in line with group health. Require agencies within the State of Alaska to coordinate, integrate and share health information technology efforts.

E. Study. Legislative intent should require the division to contract with an independent research organization to study the effects of the changes adopted in AS 23.30.097(b) and (c) above. The study shall assess the effect on medical costs, employee access to medical care and outcomes over a certain period following implementation of the changes.

DATED, this ________ day of November, 2009.

MEDICAL SERVICES REVIEW COMMITTEE

Dr. R. J. Hall, AMA Member	Dr. Andrew Mayo, AHNHA Member
Kevin Smith, Lay Member (self-insured)	Pam Scott, Lay Member (industry)
Vince Beltrami, Lay Member (labor)	Tammi Lindsey, Lay Member (industry)
Dr. William Pierce, ACS Member	Dana L. Heikes, Designated Chair