

MINUTES OF THE SENATE COMMERCE COMMITTEE

The meeting was called to order by Chairperson Karin Brownlee at 8:40 A.M. on January 16, 2007 in Room 123-S of the Capitol.

All members were present except:

Jean Schodorf- excused
David Wysong- unexcused
Susan Wagle- excused

Committee staff present:

Kathie Sparks, Kansas Legislative Research Department
Norm Furse, Revisor of Statutes
Jackie Lunn, Committee Assistant

Conferees appearing before the committee:

Laurel Murdie, Post Audit

Others attending:

See attached list.

Chairperson Brownlee called the Committee's attention to two handouts for their review: *Benchmarks for Designing Worker's Compensation Medical Fees 2006* from the Division of Workers Compensation, (Attachment 1); and *County Economic Research Institute (CERI) Johnson County Indicators*, (Attachment 2), making note for the Committee to check on how the housing and building construction has done. Chairperson Brownlee then introduced Laurel Murdie from Post Audit to review the Performance Audit Report on Workforce Development. (Copy on file)

Ms. Murdie began by stating Post Audit answered four questions and the first three had to do with the Workforce Investment Act and the fourth question was to determine what other programs beside the Workforce Investment Act meet the definition of Workforce Development and what level of coordination exist for those programs.

Ms. Murdie stated that at the state level a lot of the programs are housed in the Kansas Department of Commerce. The Workforce Investment Act deals with three targeted groups: adults; dislocated workers; and disadvantaged youth. The intent of the Workforce Investment Act is to streamline access to workforce services.

She stated Kansas has five local workforce investment areas covering the state, and the report includes several recommendations for ensuring that the Workforce Network of Kansas fulfills its responsibilities, insuring that the Department of Commerce improves the effectiveness of its monitoring efforts. In addition, it includes recommendations for ensuring that the contracting process for services provided with the Workforce Investment Act money is open to competition, as well as recommendations for improving the coordination that exists among workforce development programs in Kansas.

Ms. Murdie began the review with Question 1: *Does the administrative structure Kansas has established for the Workforce Investment Act comply with the requirements of the act?*

She stated even though the overall administrative structure in Kansas conforms to the requirements of the Workforce Investment Act, the Post Audit identified several problems related to administration at the state and local levels. The following are the problems at the State level:

- The Workforce Network of Kansas Board has not met on a regular basis.
- The State's efforts to monitor workforce development programs needs improvement.
- The Kansas Department of Commerce serves as the administrator for Local Area III and Local Area V, creating a conflict of interest.

Ms. Murdie stated that since the Post Audit, Local Area III has retained another administrative entity and

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Local Area V is moving in the same direction.

- The one-stop centers in three of the five local areas are not fully in compliance with the Workforce Investment Act.

Ms. Murdie stated that each local workforce area should have a one-stop center with core services, intensive services, and training services made available by partners in the one-stop center.

Ms. Murdie stated the following recommendations were being made by Legislative Post Audit regarding Question 1, to ensure that it is fulfilling its responsibilities under the Workforce Development Act, the Workforce Network of Kansas Board should do the following:

- Schedule and hold meetings frequently enough to take an active role in the planning and coordinating of Workforce Investment Act programs.
- Develop a plan that specifies the steps needed for Kansas to have comprehensive One Stop Centers that meet the intent of the Workforce Investment Act.

Ms. Murdie also stated that to address concerns raised in the federal reviews regarding the ineffectiveness of Kansas' monitoring program, the Department of Commerce should do the following:

- Develop a regular schedule of monitoring efforts that will be carried out to ensure that the Workforce Investment Act moneys are appropriate and that performance goals are met.
- Determine an appropriate number of staff to carry out that function, and staff the monitoring unit accordingly.

Ms. Murdie stated to insure that the Department of Commerce is not in the position of monitoring its own performance, it should work with Local Areas III and V to find another administrative entity for their program.

Also, to ensure that board members in all Local Areas have the information they need to make budgetary and spending decisions, the Kansas Department of Commerce should work with the local board members to come up with a report format that will serve the needs of both the Department of Commerce and the Local Area Board members and ensure those reports are provided to local officials on a timely basis.

Question 2: How much of the Workforce Investment Act Funding is being spent on administration and oversight, and how much is being spent directly on worker training and assistance activities.

Ms. Murdie stated that states are required to report their spending to the U.S. Department of Labor in two categories: administrative costs and program costs. Program costs generally means money spent on job seekers.

In fiscal years 2004 and 2005, an average of 11 percent of the Workforce Invest Act moneys was spent on administration, with the most administrative money being spent on salaries and wages for employees administrating the program and for professional services such as accounting and consulting services. For a variety of reasons, the total expenditures per job seeker can vary significantly from area to area and from year to year. Federal and State monitoring reviews have pointed out a number of problems related to fiscal procedures in recent years, including significant problems with Local Area I's administrative entity, inadequate documentation for some expenditures, inadequate contract provisions, and poor cash management procedures. Other issues that were noted related to a new building lease in Local Area IV and the Department's use of rent money from space it has leased in Local Area V to other agencies. Legislative Post Audit also noted that three of the five workforce investment areas have had difficulty meeting their performance measures.

Ms. Murdie stated spending slightly more than \$2 million out of nearly \$17 million in Workforce Invest Act money on administrative costs such as salaries, professional services, and travel may seem high to some, but that amount falls within the federal limits for administrative spending. It also has to be considered in light

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of fairly top-heavy administrative structure required by the Act. Of equal importance is the way processes and procedures are set up to safeguard program funds and ensure they are being spend appropriately. Over the years, Federal and State monitoring reviews have identified such things as open-ended contracts, inadequate fiscal procedures, and a lack of supporting documentation.

Moving on to Question 3: *What Types of Contracts Are in Place To Provide Training or Job-Assistance Services, What Are Their Terms, and Have They Been Awarded Competitively?*

Ms. Murdie stated at the time of the audit, the Department of Commerce had 14 active service contracts totaling about \$1 million. The contracts were funded with Workforce Investment Act money and were for such things as consultants and customized training for Department employees. Nine were awarded on a sole-source basis. For most of those sole-source contracts the Department hadn't adequately documented the research it undertook to ensure there were no other vendors who could supply those services. In addition, one \$234,000 contract was sole-sourced without the Division of Purchases approval and it likely should have been competitively bid.

Post Audit reviewed 31 active contracts at the Local Area level. These contracts were with entities to provide case-management services or programs to youth, adults and dislocated workers which is the job seekers targeted by the Workforce Investment Act. All but one of these were competitively awarded. In addition, one Local Area is operating with expired contracts, and one inappropriately paid a contractor additional incentive payments. For six contracts at the Local Area level, a member of the Local Investment Board had or currently has an interest in the entity the board has contracted with, but those board members did not vote on these contracts.

Ms. Murdie stated that overall, Post Audit found few problems with the way Local Areas were handling their contracts, but the Department does need to improve its process for awarding contracts by seeking competitive bids or by providing justification for sole-source contracting when competition does not exist.

Ms. Murdie moved on to Question 4: *What Other Programs in Kansas Meet the Definition of Development Adopted by the Joint Committee on Economic Development in 2005, and What Level of Coordination Exists for Those Programs?*

Ms. Murdie stated Post Audit identified 35 State and Federally funded workforce development programs that meet the Joint Committee on Economic Development definition of Workforce Development with most programs being managed by four state agencies. They also identified about 700 business partnerships with the State's post-secondary institutions, and multiple certificate or associate in applied science degree programs and short courses offered by educational institutions that appear to fit the definition.

Despite attempts to coordinate workforce programs in Kansas, on the whole they've not been well coordinated with the Local Area Workforce Investment Boards being slow to create comprehensive One-Stop Centers.

A 2005 study found that most states have tried to coordinate their workforce programs, most commonly by linking together two of the largest programs, Temporary Assistance to Needy Families and Workforce Investment Act. At least three states had consolidated all workforce programs under a single agency, but one of them later reversed their decision.

Ms. Murdie stated despite the attempts to coordinate workforce development programs in Kansas, many problems exist. She stated the following entities are responsible for coordinating workforce development programs in Kansas: The Workforce Network of Kansas, the Department of Commerce, and the Local Workforce Investment Boards. To help improve the coordination among workforce development programs in Kansas, Post Audit made the following recommendations.

- Solicit ideas from staff in the local workforce areas on specific ways they could share staff or other resources without violating federal program requirements. Such steps could include surveying staff, setting up working groups, or the like.

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- Establish a mechanism such as a newsletter or web link for local workforce investment areas to be able to share ideas for coordination on an ongoing basis.
- Provide information to the Workforce Network of Kansas to be used in developing State plans and establishing overall policies and goals for the State.

Upon the conclusion of Ms. Murdie's review, Chairperson Brownlee stated that she would give the Kansas Department of Commerce time to respond to the Post Audit Report at the meeting in the morning due to the time.

Chairperson Brownlee adjourned the meeting at 9:30 a.m., with the next scheduled meeting tomorrow, Wednesday, January 17th at 8:30 a.m. in room 123S.

*Benchmarks for
Designing Workers'
Compensation
Medical
Fee Schedules:
2006*

Stacey M. Eccleston
Te-Chun Liu

**Workers
Compensation
Research
Institute**

Senate Commerce Committee
January 16, 2007
Attachment 1-1

BENCHMARKS FOR DESIGNING WORKERS'
COMPENSATION MEDICAL FEE SCHEDULES: 2006

**BENCHMARKS FOR DESIGNING WORKERS'
COMPENSATION MEDICAL FEE SCHEDULES: 2006**

STACEY ECCLESTON

TE-CHUN LIU

WC-06-14

November 2006

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CAMBRIDGE, MASSACHUSETTS

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Stacey M. Eccleston
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Cambridge, Massachusetts
November 2006

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BENCHMARKS FOR DESIGNING WORKERS' COMPENSATION MEDICAL FEE SCHEDULES: 2006

BACKGROUND

This study updates a previous WCRI study (Eccleston et al., 2002) that provides benchmarks for evaluating workers' compensation medical fee schedules. This study provides data as of July 2006. A medical fee schedule is one of the most common tools used in workers' compensation medical cost containment. Forty-three jurisdictions¹ used some form of medical fee schedule in the middle of 2006. As with the prior version of the study, only nonhospital/nonfacility fee schedules are covered in this report.

The methodology used in this study is the same as in the 2002 study. The major differences between the two studies are:

- The fee schedules for workers' compensation and for Medicare areas are as of July 2006. The earlier study used similar information as of October 2001. Many states have changed their fee schedules over the period. Some states change their fee schedule rates annually; others do so periodically.
- Two states have joined the ranks of fee schedule states since the earlier WCRI study. Tennessee established a medical fee schedule that became effective July 1, 2005, and the new fee schedule in Illinois became effective on February 1, 2006.

The rankings for many states are relatively similar for the two reports. For states that have changed significantly, there are typically two reasons. First, some states made major changes to their fee schedules. Second, Medicare continued to phase in the full resource-based relative value scales (RBRVS) after 2001. So even states that made no changes to their workers' compensation fee schedules will see changes in their benchmarks relative to Medicare in their state.

¹ This study reports on 42 state fee schedules. We were unable to obtain a fee schedule from District of Columbia. We do not include states that maintain a database of charge-based maximum rates as in Wisconsin.

This study presents the comparisons of workers' compensation medical fee schedules to state Medicare fee schedules as of July 2006. It does not analyze how the states have changed since 2001. A future publication will describe the changes and analyze what drove the changes in states with significant change.

Workers' compensation fee schedules vary greatly across the states in all aspects, including development, updating, structure, and basis used for setting rates (Tanabe and Murray, 2001). Not surprisingly, these different methods yield very different results in the level of rates set, overall and for different groups of providers and services. The construction of a medical fee schedule in workers' compensation involves a delicate balance. If rates are set too high, savings will be negligible and the fee schedule will not achieve its cost containment goal. Conversely, setting rates too low makes treating injured workers uneconomical for providers and jeopardizes workers' access to quality care.

This report helps to ground the debates about fee schedules in analytic facts, rather than anecdotes or partisan claims. The study provides an important benchmark for the design of fee schedules in workers' compensation. This is especially important since the development or update of a fee schedule is often subject to considerable political pressure from payors and providers. One way to analyze whether workers' compensation fee schedules are cost efficient, but still provide financial incentive for providers to treat injured workers is to compare workers' compensation fee schedules to a benchmark that reflects the relative costs of delivering care. In this study, as with its predecessor, we use the state's Medicare fee schedules as a benchmark, recognizing that the optimum level of fee schedule rates is likely not the same as Medicare. The Medicare RBRVS (not the rates themselves but the relative values) provides us a good benchmark for evaluating the relationship between fee schedule rates and the costs of providing services. The Medicare RBRVS relied on extensive research on the relative resource costs of providing particular services in specific areas as they apply to a general population. Provider practice expenses differ from state to state based on differing malpractice expenses, office rent, staffing costs, etc. It serves to reason then that the cost of delivering health care differs across states. The Medicare RBRVS is designed specifically to take these practice expense factors into account. A rational workers' compensation fee schedule design

would mean that higher workers' compensation fee schedules are found in states with higher provider practice expenses. The resource based relative value scale allows us an opportunity to quantify those differences in practice expenses and serve as a standardization mechanism across states and across services within a state. Therefore, this report focuses on the relative comparisons between workers' compensation fee schedules and Medicare fee schedules.

In the prior edition of this study, the relative values used in Medicare were still in a transitional stage. In 2006, the relative values have been fully transitioned, although Medicare annually adjusts its conversion factor. In addition to the overall workers' compensation premium over Medicare, we report the premium over Medicare for five major service groups: surgery, radiology, general medicine, physical medicine, and evaluation and management. General medicine is largely composed of neurology and neurological testing.

MAJOR FINDINGS

The following are some of the major findings in the study:

- There are substantial differences in fee schedule rates from state to state. The highest state's fee schedule rates are on average 3.5 times higher than the lowest state's fee schedule rates.
- Alaska and Illinois have the highest average fee schedules, while Massachusetts has the lowest average fee schedule.
- The interstate variation is not rationally related to the interstate variation in the expenses that medical providers incur in producing the services—e.g., malpractice expenses and office practice expenses.
- Most state fee schedules create financial incentives to underuse primary care and overuse invasive and specialty care. A few states avoid this by following a reasonably fully transitioned RBRVS and setting a similar conversion factor across the different service groups within their state. These states include Hawaii, Texas, Washington, Michigan, West Virginia, South Carolina, Maine, Florida, Massachusetts and

Maryland. Although only Hawaii, Texas, Washington, Michigan, and West Virginia have nearly exactly the same premium² above Medicare for each service group.

- Several states have fee schedules that may be higher than necessary. The most likely candidates are state fee schedules that are double or more the state's Medicare rates. For surgical services, twenty-three states set their workers' compensation fee schedule more than double the state's Medicare fee schedule. They include (from highest to lowest) Alaska, Illinois, Connecticut, Idaho, Nevada, Rhode Island, Alabama, Nebraska, Tennessee, Arizona, Oregon, Montana, New Mexico, Georgia, Mississippi, Oklahoma, South Dakota, Arkansas, New York, Wyoming, North Carolina, Kentucky, and Louisiana. Among these states, fourteen have fee schedule rates that are double or more the state's Medicare rates for radiology. They include (from highest to lowest), Alaska, Illinois, Nevada, Nebraska, Idaho, Montana, Arkansas, Wyoming, Connecticut, Louisiana, New Mexico, Georgia, South Dakota, and Tennessee. Only four states (Alaska, Illinois, Connecticut, and Oregon) have fee schedule rates that are double or more the state Medicare rate for general medicine and only Alaska has fee schedule rates that are double or more Medicare rates for physical medicine and evaluation and management.
- A few states may have fee schedules or groups of fee schedule rates that are so low as to raise concerns about access to quality care. The most likely candidates are state fee schedules that are near or below the state's Medicare rates. For surgery, only Massachusetts and Hawaii have fee schedule rates that are within 10 percent of the state's Medicare rates. For radiology, we add California, Maryland, and Florida to the list. Each of those states except California also has fee schedules that are within 10 percent of the state's Medicare rates for general medicine and physical medicine. For physical medicine, two additional states, North Carolina and New York, have fee schedule rates that are within 10 percent of the Medicare rates or lower in their state. Thirteen states (New York, Vermont, California, Ohio, Massachusetts, South Dakota, Montana, North Carolina, Pennsylvania, Maryland, Wyoming, Hawaii, and Florida)

² In Michigan and West Virginia differs by no more than 2 percentage points.

have fee schedule rates that are within 10 percent of state Medicare rates or lower for evaluation and management services.

- Currently, more than half of the 42 states base their workers' compensation fee schedule on the RBRVS system, at least in part.
- The RBRVS system that underlies Medicare is a good metric of the optimal *relative* fee schedule rate—the fee schedule rate for one medical procedure compared to a different procedure. However, absent multi-state measures of workers' health outcomes and access to quality health care, it is difficult to say what is the optimal absolute fee schedule rates for a given state.

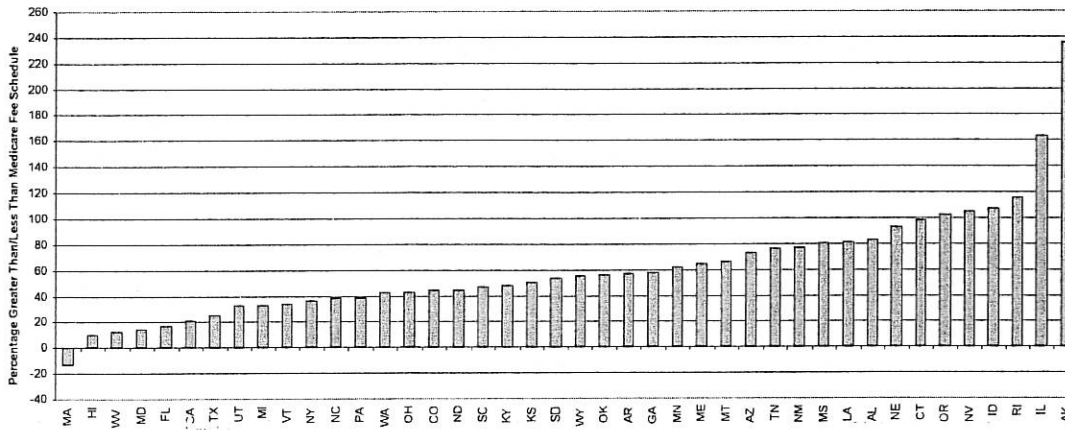
We elaborate on each of the study findings below.

There are substantial differences in fee schedule levels from state to state.

The fee schedule levels vary widely from state to state. To illustrate this, we provide two types of information. First, we analyze how each state workers' compensation fee schedule compares with that state's Medicare fee schedule (Figure 1). Since the workers' compensation fee schedules are typically higher, we refer to the “premium over Medicare” for each state. This measure is very useful since Medicare rates for a given medical procedure control for interstate differences in office practice expenses and malpractice insurance premiums. Second, we provide a few illustrations of the actual fee schedule amounts, state by state, for several medical procedures commonly delivered to injured workers and the range in the fee schedule amounts across states (Table 1).

The premiums over Medicare vary widely from state to state—from more than three and a third times the Medicare rates in Alaska to 13 percent less than Medicare in Massachusetts. (Figure 1). Given this enormous range, it is unlikely that all of the states have struck an optimal balance between savings to employers and good access to quality care for workers. Only 5 states out of 42 set average fee schedule rates that are within 20 percent (plus or minus) of the Medicare fee schedule in their states. About half of the 42 states have fee schedules that range from 30 to 65 percent above the state's Medicare rates. And in 7 states, the fee schedule rates average double or even triple the state's Medicare rates.

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.

Table 1 presents the workers compensation fee schedule rates for five commonly billed procedures—one in each of the major service groups. The fee schedule rate for an arthroscopic knee surgery (CPT code 29881) ranges from a low of \$619 in Massachusetts to a high of \$4,181 in Alaska. Even the 2nd highest (Illinois) and 2nd lowest (West Virginia) states exhibit a very wide range in fee schedule rates from \$661 to \$3,779. For a cervical MRI (CPT code 72141) the highest state (Alaska) fee schedule rate of \$2,339 is more than four times higher than the lowest state's rate of \$525 (West Virginia). A sensory nerve conduction test (CPT code 95904) ranges from a low of \$46 to a high of \$219 in Alaska. The second highest fee schedule rate for this service is \$165 found in Illinois (Chicago)³. For a therapeutic physical medicine procedure or exercise (CPT code 97110), the lowest fee schedule rate of \$22 (Massachusetts) is nearly four times lower than the highest fee schedule rate of \$83 found in Alaska and nearly three times lower than the second highest rate found in Illinois (Chicago) (\$61). For a low complexity established patient office visit (CPT code 99213) the lowest state's fee schedule rate is \$41 (Ohio) compared to a high of \$127 in Alaska or the 2nd highest rate of \$95 in Oregon.

Alaska and Illinois have the highest fee schedules, while Massachusetts has the lowest fee schedule. In Massachusetts, the workers' compensation fee schedule is, on average, 13 percent less than Medicare fee schedule rates in Massachusetts. Other states with lower average fee schedule rates are Hawaii, West Virginia, Maryland, and Florida, where the fee schedule levels are at most 10 to 20 percent above Medicare rates in each state.

The highest fee schedules are found in Alaska (236 percent above its Medicare rates) and Illinois⁴ (on average, 163 percent above Illinois Medicare rates). The next highest group of fee schedules are found in Rhode Island, Idaho, Nevada, Oregon, and Connecticut and are double or more the Medicare rates in each state.

The interstate differences are greatest for surgical and specialty care and smallest for primary care and physical medicine services. For example, Table 2 shows that the highest surgical fee schedule (Alaska) has a premium over Medicare that is 423

³ Illinois has 29 different geographic fee schedules. The second highest fee here refers to the fee schedule for the Chicago area (zip code area 606xx).

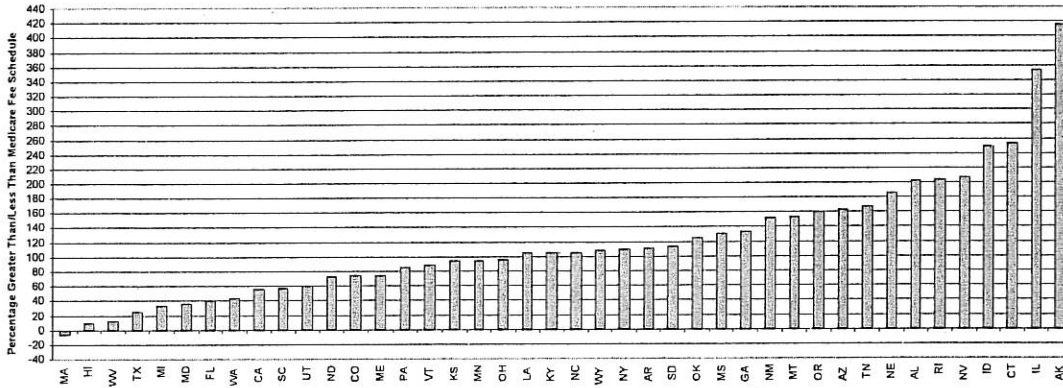
⁴ Illinois has 29 different fee schedules according to geographic area. For comparisons to Medicare we use a weighted average of all 29 areas.

percentage points higher than the lowest surgical fee schedule (Massachusetts).⁵ By contrast, the highest fee schedule rate for evaluation and management services is 146 percentage points higher than the lowest. Similarly, the interstate variation in fee schedules for radiology and for general medicine (largely neurology) is much greater than for physical medicine or for evaluation and management services. Figures 2 through 6 provide a picture that shows the premium over Medicare ranging from the lowest state to the highest state for each of the service groups. Table 3 presents the premium over Medicare for each of the states for each service group. The bottom of the table lists the premium over Medicare for each service group for the median state. The median state is the average of the states ranked 21st and 22nd for a given service group.

State	Percentage Greater Than or Less Than Medicare Fee Schedule					
	Overall	Surgery	Radiology	General Medicine	Physical Medicine	Evaluation and Mgmt.
Highest	236 (Alaska)	417 (Alaska)	273 (Alaska)	287 (Alaska)	153 (Alaska)	127 (Alaska)
Second highest	163 (Illinois)	354 (Illinois)	175 (Illinois)	170 (Illinois)	91 (Illinois)	85 (Idaho, Oregon)
Median	55	106	82	43	26	23
Second lowest	10 (Hawaii)	10 (Hawaii)	5 (California)	7 (Maryland)	5 (New York)	-17 (Vermont)
Lowest	-13 (Massachusetts)	-6 (Massachusetts)	-7 (Massachusetts)	-5 (Massachusetts)	-23 (Massachusetts)	-19 (New York)
	Percentage Point Difference between Two States					
Highest/lowest	249	423	280	292	176	146
Second highest/second lowest	153	344	170	163	86	102
<p><i>Notes:</i> General medicine is largely composed of neurology and neurological testing. 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.</p>						

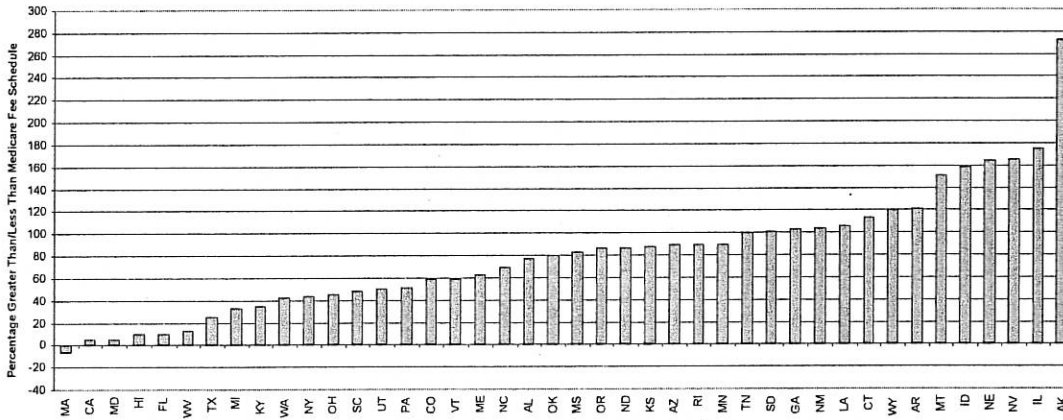
⁵ This difference is not explained by interstate differences in the expenses of providers of producing these services—office practice expenses and malpractice premiums. First, by analyzing the “premiums over Medicare” in each state, we are controlling for the major components. Moreover, the provider expenses in Alaska are slightly lower than in Massachusetts.

Figure 2 Workers' Compensation Fee Schedule Premium over Medicare Fee Schedule for Surgical Services, July 2006



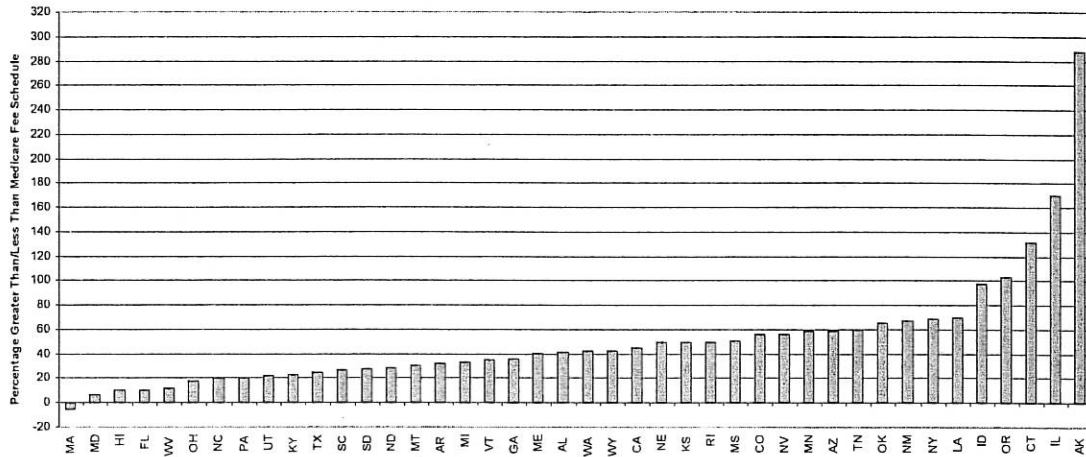
Notes: Florida, Illinois, New York and Pennsylvania have distinct fee schedules for different parts of the state. For each, we created a single statewide index by averaging the different sub-state fee schedules using employment in each sub-state region as weights. Medicare establishes distinct sub-state 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.

Figure 3 Workers' Compensation Fee Schedule Premium over Medicare Fee Schedule for Radiology Services, 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.

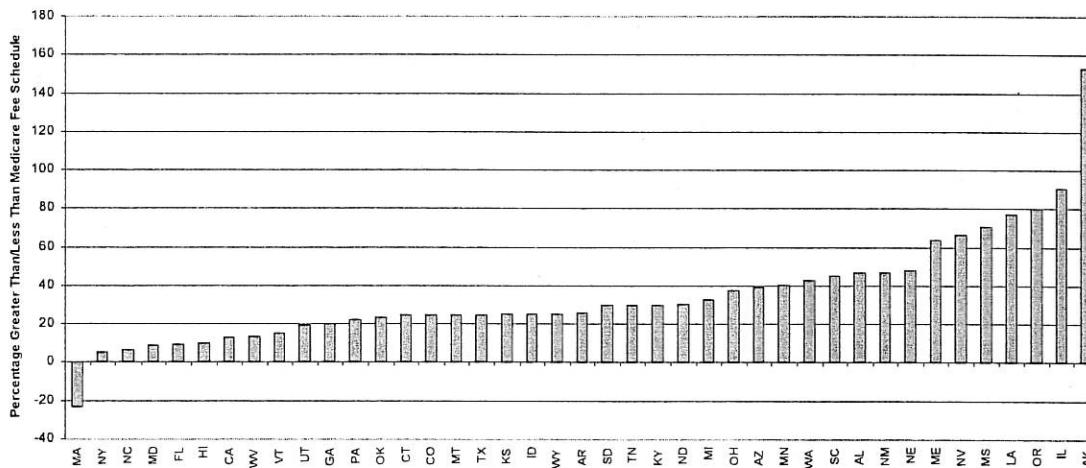
Figure 4 Workers' Compensation Fee Schedule Premium over Medicare Fee Schedule for General Medicine Services, July 2006



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

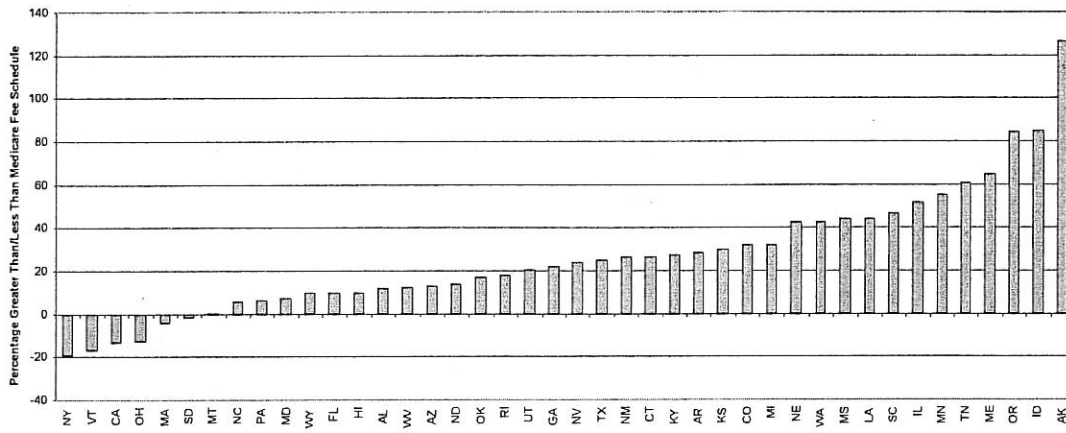
Florida, Illinois, New York and Pennsylvania have distinct fee schedules for different parts of the state. For each, we created a single statewide index by averaging the different sub-state fee schedules using employment in each sub-state region as weights. Medicare establishes distinct sub-state fee 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.

Figure 5 Workers' Compensation Fee Schedule Premium over Medicare Fee Schedule for Physical Medicine Services, 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. Therefore, Rhode Island is not included in this figure.

Figure 6 Workers' Compensation Fee Schedule Premium over Medicare Fee Schedule for Evaluation and Management Services, 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 3 Workers' Compensation Fee Schedule Premium over Medicare Fee Schedule, by Service Group, July 2006

State	Percentage Greater Than or Less Than Medicare Fee Schedule					
	Overall	Surgery	Radiology	General Medicine	Physical Medicine	Evaluation and Management
Alabama	83	203	77	42	47	12
Alaska	236	417	273	287	153	127
Arizona	73	163	89	59	39	13
Arkansas	57	111	121	32	26	29
California	21	56	5	46	13	-13
Colorado	45	74	59	56	25	32
Connecticut	99	253	114	132	25	27
Florida ^a	17	40	10	10	10	10
Georgia	58	134	103	36	20	22
Hawaii	10	10	10	10	10	10
Idaho	108	249	159	98	25	85
Illinois ^a	163	354	175	170	91	52
Kansas	51	94	88	50	25	30
Kentucky	48	106	34	23	30	28
Louisiana	81	106	106	70	77	44
Maine	65	75	63	41	64	65
Maryland	15	36	6	7	9	7
Massachusetts	-13	-6	-7	-5	-23	-4
Michigan	33	33	33	33	33	32
Minnesota	62	94	90	59	40	55
Mississippi	81	131	83	51	71	44
Montana	67	153	151	31	25	0
Nebraska	93	186	164	50	48	43
Nevada	105	207	166	56	67	24
New Mexico	77	152	104	68	47	27
New York ^a	36	110	43	69	5	-19
North Carolina	39	106	69	21	7	6
North Dakota	45	72	87	29	30	14
Ohio	43	96	45	18	37	-13
Oklahoma	57	124	80	65	24	17
Oregon	102	161	86	103	80	85
Pennsylvania ^a	39	85	51	21	23	6
Rhode Island ^b	116	204	90	50	N/C	18
South Carolina	47	58	48	26	45	46
South Dakota	54	114	101	28	30	-2
Tennessee	77	188	100	60	30	61
Texas	25	25	25	25	25	25
Utah	33	60	50	22	20	21
Vermont	34	89	59	35	15	-17
Washington	43	43	43	43	43	43
West Virginia	13	12	13	12	14	13
Wyoming	55	108	120	43	26	10
Median state	55	106	82	43	26	23

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

^a 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.

^b 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.

Key: N/C: noncomparable.

The premium over Medicare for evaluation and management services is 20 percent or less in 19 of the 42 states. The median state's premium over Medicare is 23 percent for evaluation and management. Only 1 state (Alaska) has premiums that are more than double the Medicare rates for evaluation and management. For evaluation and management services, the difference between the highest premium over Medicare (127 percent in Alaska) and the lowest premium over Medicare (-19 percent in New York) is 146 percentage points.

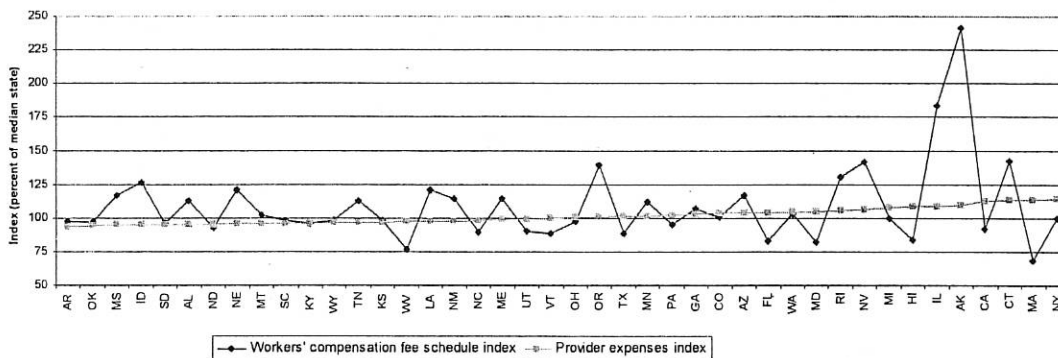
In contrast, the premium over Medicare for surgical services is 20 percent or less in only three states (Massachusetts, Hawaii, and West Virginia). The median state's premium over Medicare is 106 percent for surgical services. Twenty-three out of 42 states have premiums that are more than double the state Medicare fee schedule rates for surgical services. In Idaho, Connecticut, Illinois, and Alaska, surgeons could be paid 3.5 to 5.2 times more when they treat injured workers than when they treat the elderly. For surgical services, the difference between the highest premium over Medicare (417 percent in Alaska) and the lowest premium over Medicare (-6 percent in Massachusetts) is 423 percentage points.

Many argue that workers' compensation reimbursements may require certain premiums over Medicare due to the special administrative requirements, the focus on return to work, and other issues unique to occupational health. Ironically, this should have a greater impact (e.g., higher premium) for office visits procedures, where greater documentation and targeted procedures would be required, rather than standard surgical procedures.

The interstate differences are not related to the expenses incurred by health care providers in producing the services. A rational system of fee schedules would provide for higher reimbursements in states where it costs providers more to deliver their services—higher office expenses and malpractice premiums—and vice versa. This does not occur with workers' compensation fee schedules. Interstate differences in the Medicare fee schedule rates explicitly reflect how costs to providers (e.g., practice expenses, malpractice insurance) vary from state to state. However, Figure 7 shows that states with high provider practice expenses are not necessarily states with higher workers' compensation fee schedules. Overall, the highest Medicare fee schedule is 23 percent

greater than the lowest. However, the highest workers' compensation fee schedule is 254 percent higher than the lowest. For example, the Medicare fee schedule rates in Connecticut and Massachusetts are, on average, 13 to 14 percent greater than the Medicare fee schedule rates in the median state. By contrast, the Massachusetts workers' compensation fee schedule is 32 percent less than the median state, but the workers' compensation fee schedule rates in neighboring Connecticut are 42 percent greater than the median state. Idaho is another example. The Idaho Medicare fee schedule is 5 percent lower than the Medicare fee schedule in the median state. However, the Idaho workers' compensation fee schedule (as revised in 2006) is 27 percent greater than the workers' compensation fee schedule in the median state.

Figure 7 Workers' Compensation Fee Schedule Index Compared to Provider Expense^a Index, July 2006



Notes: Florida, Illinois, New York, and Pennsylvania have distinct workers' compensation 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.

^a The provider expense index is based on Medicare's resource-based relative value scale which reflects the provider's costs to produce services.

Most state fee schedules create financial incentives to underuse primary care and overuse invasive and specialty care. A few states follow the Medicare approach and avoid such incentives. If all services are reimbursed at the same premium over Medicare, the utilization incentives are neutral—not rewarding the provider more for the use of certain services over others. As can be seen from Table 3, few states have little or no difference in the relative reimbursement across service groups as they compare to

Medicare. Five states—Hawaii, Michigan, Texas, West Virginia, and Washington—reimburse each provider or service group at relatively the same premium over Medicare, thus their utilization incentives are truly neutral. Other states too provide a relatively neutral incentive across service groups. In Massachusetts the premium is also relatively the same for all service groups except physical medicine where the premium is about 19 percentage points lower than other service groups. In South Carolina and Maine, the premium above Medicare is similar across all service groups except general medicine where it is lower and surgery where it is slightly higher. And in Florida and Maryland, the premium above Medicare is relatively the same for most service groups except surgery where it is higher by design.

However, unequal premiums over Medicare—and the resulting distortion of utilization incentives—are common among state workers' compensation fee schedules. In 20 out of 42 states, the difference between the highest premium over Medicare and the lowest premium over Medicare among the five service groups is more than 100 percentage points. North Carolina, for example, pays an overall 39 percent premium over Medicare, ranging from 6 percent greater than Medicare for evaluation and management to 106 percent greater than Medicare for surgical services. Even Connecticut, which on average pays almost double the Medicare rate (99 percent higher), pays close to the Medicare levels for physical medicine services (25 percent greater than Medicare levels); but it pays a much higher premium for surgery (253 percent). Two states—Alaska and Illinois⁶—treat their providers in various service groups most unequally with about 300 percentage points difference among the different service groups within each state.

The RBRVS system that underlies Medicare is a good metric of the optimal relative fee schedule rates—the fee schedule rate for one medical procedure compared to a different procedure. However, absent multi-state measures of workers' health outcomes and access to quality health care, it is difficult to say what are the optimal absolute fee schedule rates for a given state. The underlying question in most state public policy debates about fee schedules is “What are the optimal fee schedule rates?” Most would agree that the optimal fee schedule rates are those that

⁶ The range of difference in premium over Medicare in Illinois is even greater if considering each of the 29 area fee schedules within Illinois separately. (See Eccleston, 2006)

provide access to quality care in the most cost-efficient manner. No one can say that the Medicare fee schedule rates are necessarily optimal for workers' compensation. However, the RBRVS system that underlies Medicare and several state workers' compensation fee schedules was designed to provide appropriate incentives for utilization of both primary care and specialty care to a general population. It therefore provides a good measure of the relative differences in costs across states and across service types. Studies of the impact of alternative fee schedule rates on worker outcomes and access to quality care are few but much needed to assist public officials in the quest for the optimal rates. WCRI studies have found that states with higher medical costs do not necessarily have better workers outcomes and/or better access to care and vice versa (Fox, Victor, and Liu, 2006).

Several states have fee schedules that may be higher than necessary. Absent outcome measures for each state, it is difficult to say which fee schedules may be too high or too low. However, one can conclude that a significant number of state fee schedules may be higher than necessary to support quality medical care. Table 4 shows a number of states where fee schedule rates are more than double the Medicare fee schedule rates in their state for each service group. It is not unreasonable to suggest that a premium that high should have a clear public policy justification in terms of substantial higher expenses incurred by providers to deliver services and/or improved health outcomes for injured workers, when compared to the typical fee schedule state. Twenty-three of 42 states have premiums over Medicare that are more than 100 percent for at least one service group. These 23 states have surgical fee schedule levels that are double the Medicare rates in the state, and 2 states (Illinois and Alaska) have surgical fee schedule rates that are 4.5 to 5.2 times the corresponding Medicare rates. For radiology, the fee schedule is more than double Medicare in 14 states and for general medicine, 4 states have fee schedule rates that are more than double Medicare. For physical medicine services and evaluation and management services, Alaska is the only state that has fee schedule rates that are more than double Medicare.

Table 4 States with Workers' Compensation Fee Schedules That are at Least Double Medicare Fee Schedule Levels, July 2006				
Surgery	Radiology	General Medicine	Physical Medicine	Evaluation and Management
Louisiana (106)	Tennessee (100)	Oregon (103)	Alaska (153)	Alaska (127)
Kentucky (106)	South Dakota (101)	Connecticut (132)		
North Carolina (106)	Georgia (103)	Illinois (170) ^a		
Wyoming (108)	New Mexico (104)	Alaska (287)		
New York (110) ^a	Louisiana (106)			
Arkansas (111)	Connecticut (114)			
South Dakota (114)	Wyoming (120)			
Oklahoma (124)	Arkansas (121)			
Mississippi (131)	Montana (151)			
Georgia (134)	Idaho (159)			
New Mexico (152)	Nebraska (164)			
Montana (153)	Nevada (166)			
Oregon (161)	Illinois (175) ^a			
Arizona (163)	Alaska (273)			
Tennessee (168)				
Nebraska (186)				
Alabama (203)				
Rhode Island (204) ^b				
Nevada (207)				
Idaho (249)				
Connecticut (253)				
Illinois (354) ^a				
Alaska (417)				
<i>Note: Percentage greater than or less than Medicare is in parentheses.</i>				
^a 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.				
^b 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.				

A few states may have fee schedules that are so low as to raise concerns about access to quality care. Again, this question cannot be definitively answered without additional outcome measures. However, policymakers should certainly pay attention to questions of access to primary care services in the states where the fee schedule rates are, at least, less than the Medicare reimbursement levels. There may also be concern in states

where fee schedule rates are within 10 percent of Medicare if that “premium” is insufficient to cover whatever added costs are incurred to treat injured workers. We regularly hear from health care providers that treating injured workers takes more time and effort than treating similar injuries for patients covered by group health or Medicare—and hence it is more costly. Thus some premium over Medicare may be appropriate.

This raises the question about access to care in states where the fee schedule is equal to or lower than Medicare. Table 5 shows states where the workers’ compensation fee schedule rates are near (within 10 percent) or less than the state Medicare rates for each service group. There are more states in the evaluation and management service group than in any of the other service groups. Thirteen of 42 states have a 10 percent (or smaller) premium over Medicare for evaluation and management services. In fact, 6 states have evaluation and management fee schedules that are less than the Medicare level in their state. In Ohio, California, Vermont, and New York, evaluation and management fee schedule rates are 13 percent to 19 percent less than Medicare levels.

Table 5 States with Workers' Compensation Fee Schedules within 10 Percent of Medicare Fee Schedules or Lower, July 2006				
Surgery	Radiology	General Medicine	Physical Medicine	Evaluation and Management
Massachusetts (-6)	Massachusetts (-7)	Massachusetts (-5)	Massachusetts (-23)	New York (-19) ^a
Hawaii (10)	California (5)	Maryland (7)	New York (5) ^a	Vermont (-17)
	Maryland (6)	Hawaii (10)	North Carolina (7)	California (-13)
	Hawaii (10)	Florida (10)	Maryland (9)	Ohio (-13)
	Florida (10)		Hawaii (10)	Massachusetts (-4)
			Florida (10)	South Dakota (-2)
				Montana (0)
				North Carolina (6)
				Pennsylvania (6) ^a
				Maryland (7)
				Wyoming (10)
				Hawaii (10)
				Florida (10)
<p><i>Notes:</i> Percentage greater than or less than Medicare is in parentheses. 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.</p>				
<p>^a 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.</p>				

Currently, more than half of the 42 states base their workers' compensation fee schedule on the RBRVS system, at least in part. Since 2001, Idaho, Kansas, Maryland, Mississippi, Oklahoma, Tennessee, and Texas, joined the ranks. A few states explicitly set their workers' compensation fee schedules to some percentage above Medicare. In some cases, the percent above Medicare is the same across all service groups (Texas for example). In the majority of states that tie their fee schedules to Medicare's relative value units (RVUs), the percent above Medicare varies across the services groups (as with Tennessee's, Florida's or Maryland's for example) because different conversion factors are set across services. Some states even use Medicare's RVUs to establish their own RVU by adjusting Medicare's geographic practice cost index (GPCI) provided by Centers for Medicare and Medicaid Services (CMS). See Table 6.

Most states that tie their fee schedules to Medicare adjust their fee schedules annually as Medicare rates change. A few states decoupled their Medicare-based fee schedules from the annual changes in Medicare rates. Pennsylvania, for example, ties annual changes to the change in the state average weekly wage. This is an important choice, since Medicare rates are adjusted annually based on some factors (e.g. the needs and politics of the federal budget) that have little relevance for public policy decisions in workers' compensation.

SCOPE OF STUDY

This report is an update to a prior WCRI publication which provides benchmarks for comparing workers' compensation fee schedules (Eccleston et al., 2002). The goal of the study is to give policymakers some useful benchmarks so they can compare their states' workers' compensation fee schedule rates with measures of the relative costs of providing services with fee schedules in other states. Two states have joined the ranks of fee schedules states since WCRI's earlier study which looked at fee schedules in place as of October 2001. Tennessee established a medical fee schedule that became effective July 1, 2005, and Illinois' new fee schedule became effective on February 1, 2006. They are both included in the analysis here. In addition, many states have changed their fee schedules over the period October 2001 to July 2006. For example, Idaho adopted a medical fee

schedule based on resource-based relative value scale and the relative value unit. This new fee schedule became effective on April 1, 2006. In fact, some states change their fee schedule rates annually. Table 6 lists the characteristics of the medical fee schedule and the latest effective date for each state. This study simply presents the comparisons of workers' compensation medical fee schedules to state Medicare fee schedules as of July 2006. It does not directly analyze the differences in the statistics presented in this version compared to the 2001/2002 edition. A future publication will likely focus on how these state rankings have changed from 2001/2002 to 2006.

Table 6 Characteristics of Workers' Compensation Fee Schedules for Nonfacility Providers, July 2006		
Jurisdiction	Relative Value Scale Used	Last Effective Date of Fee Schedule and/or Conversion Factors
Alabama	The initial fee schedule was based on BC/BS RVS in 1992. It is annually adjusted no more than annual increase in cost of living as reflected by the US Department of Labor consumer price index.	May 19, 2006
Alaska	UCR. Senate Bill 130 limits fees to the fee schedule established by the workers' compensation board on December 1, 2004 through 2007.	December 1, 2004
Arizona		October 1, 2005
Arkansas	RBRVS	April 1, 2006
California	CRVS. For physician services rendered on or after July 1, 2004 the maximum allowable reimbursement amount set forth in the OMFS 2003 for each procedure code is reduced by 5 percent, except that those procedures that are reimbursed under OMFS 2003 at a rate between 100-105% of the Medicare Rate will be reduced between zero and 5% so that the OMFS reimbursement will not fall below the Medicare rate. "OMFS Physician Services Fees for Services Rendered on or after May 15, 2005" lists the maximum reimbursable fee (=OMFS RVU x OMFS CF X reduction percent) for each individual procedure code.	May 14, 2005
Colorado	2005 RVP	January 1, 2006
Connecticut		May 1, 2006
Florida	Medicare RBRVS: 40% above Medicare for surgery , 10% above Medicare for other procedures	April 28, 2006
Georgia	UCR	April 1, 2006
Hawaii	Medicare RBRVS: 10% above Medicare	January, 2006
Idaho	RBRVS	April 1, 2006
Illinois	Fee Schedule amounts were formulated by determining the 90% of the 80th percentile from healthcare provider fees from 8/1/02 through 8/1/04. Fee schedules were established for 29 geo-zips. An initial 4.96% increase was applied to the fee schedule amount for the period of 8/1/04 through 9/30/05. The Commission will automatically increase or decrease the maximum allowable payment based upon the CPI-U on an annual basis.	February 1, 2006
Kansas	RBRVS	December 1, 2005
Kentucky	2004 GPCI-adjusted RBRVS unit value	March 16, 2006

Table 6 Characteristics of Workers' Compensation Fee Schedules for Nonfacility Providers, July 2006 (continued)		
Jurisdiction	Relative Value Scale Used	Last Effective Date of Fee Schedule and/or Conversion Factors
Louisiana		March 1, 2004
Maine	RBRVS	July 1, 2002
Maryland	Medicare RBRVS: 44% above 2004 Medicare for orthopedic and neurological surgical procedures, 9% above 2004 Medicare except for orthopedic and neurological surgical procedures and the services rendered at ambulatory Surgical Centers	June 5, 2006
Massachusetts	The rates are determined by a regulatory process.	September 1, 2004
Michigan	RBRVS. Michigan creates their own RVU by adjusting GPCI from CMS	March 10, 2006
Minnesota		October 1, 2005
Mississippi	RBRVS	November 1, 2002
Montana	RVP	January 1, 2006
Nebraska	RBRVS. Nebraska uses GPCI adjusted relative value units.	July 1, 2006
Nevada	RVP	February 1, 2006
New Mexico		December 31, 2005
New York	New York relative value units	April 1, 2006
North Carolina	RBRVS	March 1, 2006
North Dakota	RVP	December 1, 2005
Ohio	RBRVS	January 1, 2006
Oklahoma	RBRVS	January 25, 2006
Oregon	RBRVS	April 1, 2006
Pennsylvania	RBRVS. Prior to January 1, 1995, the medical fees were capped at 113% of the Medicare. Medical fee update on and after January 1, 1995 are calculated based on the percentage changes in the Statewide average weekly wage annually. These updates shall be effective on January 1 of each year, and they are cumulative.	July 15, 2006
Rhode Island		July 1, 2006
South Carolina	RBRVS	January 1, 2003
South Dakota	RVP	June 14, 2006
Tennessee	Medicare RBRVS: 30% above Medicare for chiropractic care, 60% above Medicare for evaluation and management, 100% above Medicare for emergency care, radiology, and general surgery, 175% above Medicare for neurosurgery and orthopedic surgery. It must also be used with Medical Cost Containment Program Rules and the In-Patient Hospital Fee Schedule Rules.	May 1, 2006
Texas	Medicare RBRVS: 25% above Medicare	January, 2006
Utah	RBRVS	July 11, 2006
Vermont	A blend of several Blue Cross/Blue Shield fee schedules	May 15, 2006
Washington	RBRVS	July 1, 2006
West Virginia	RBRVS	January 1, 2006
Wyoming	RVP	September 30, 2005
Key: CRVS: California relative value studies, 1974; RBRVS: resource-based relative value scale (Medicare); RVP: Relative Value for Physicians, published by Ingenix, Inc.; UCR: usual, customary, and reasonable.		

Even where states have not changed their workers' compensation fee schedules, comparisons to state Medicare rates will be different from this publication to the prior one simply due to the changes in the state Medicare fee schedule rates made over the time period. Among the changes in workers' compensation fee schedules, four states moved to explicitly set their workers' compensation fee schedules to some percentage above Medicare. Florida sets its workers' compensation fee schedule rates to 10 percent above Medicare for physicians' services and 40 percent above for surgeons⁷. Maryland sets its workers' compensation commission reimbursement explicitly at 44 percent above the 2004 Medicare for orthopedic and neurosurgical procedures and 9 percent above for all other procedures. Tennessee also sets its medical fee schedule rates to a different percent above Medicare for different services. For example, the rates are set to 60 percent above Medicare for general medicine and evaluation and management, 100 percent above for emergency care and general surgery, and 175 percent above for orthopedic surgery and neurosurgery. Texas sets its workers' compensation fee schedule rates to 25 percent above Medicare.

It is important to note that this study, like its predecessors, covers only nonhospital fee schedules and expenditures. In most states, payments made to hospitals account for between 26 percent and 49 percent of total workers' compensation medical expenditures (Eccleston and Zhao, 2005). The analysis in this report affects the remaining 51 percent to 74 percent of total medical expenditures. WCRI may publish future studies that analyze hospital pricing and regulation under workers' compensation.

As we state throughout this report, the analysis here does not attempt to define the appropriate fee schedule rates in each state. Rather, we provide a benchmark for comparison. In economic terms, the appropriate fee schedule rate is where market demand meets supply. In other words, the fees physicians are paid, on average, would allow injured workers to receive quality medical care for a price that providers on average still find profitable. The difficulty with this concept is designing measures that objectively define and measure quality care at an affordable price. Detailed studies that incorporate all the necessary measures simply do not exist at this time due to data and

⁷ The workers' compensation fee schedule rates are rounded to one dollar.

methodological limitations (see Kane, 1998, for detailed information on the literature). Therefore, we have to assert some basic assumptions about what optimal fee schedule rates are, the intent of fee schedules and their application, and the Medicare RBRVS as a measure of the relative costs of providing services.

We assume the following:

- Medical providers may be influenced to change billing or practice behavior in response to changes in reimbursement schemes.
- Fee schedule rates set at levels that cover the costs of providing the service while affording some level of profit deemed adequate by the provider will ensure access to quality health care.
- The optimal fee schedule rate is the lowest level at which access to quality health care can be ensured.
- The methodology and results of the Medicare RBRVS are consistent with the optimal *relative* fee schedule rates across services and across states. That is, the RBRVS provides an accurate measure of the relative differences in the costs of providing services and therefore provides an estimate of relative differences in optimal fee schedule rates. We do not assert, however, that the base rate (the result of applying the Medicare conversion factor) does or does not yield the optimal fee schedule level.

STUDY LIMITATIONS

We acknowledge that our approach is subject to certain limitations. The purpose of the report is to provide timely information on how existing fee schedules compare to Medicare fee schedules. In this particular study, we do not analyze whether states or certain payors within states negotiate fees greater than or less than the fee schedule. Other questions of policy interest, such as the effect of changes in fee schedule rates on access to quality care and changing patterns of utilization are also not considered here. For more information on changing utilization patterns in the workers' compensation systems, see the WCRI publication *The Anatomy of Workers' Compensation Medical Costs and Utilization, 5th Edition* (Eccleston and Zhao, 2005). Additionally, if a jurisdiction has

very different utilization patterns than is seen overall in the thirteen states used to create the marketbasket, the results could be different. If, for example, a state is a much higher user of certain types of physical medicine services and a lower user of surgery, the marketbasket weights might overweight surgery and underweight physical medicine as applicable for that state. We found, however, that in the utilization patterns found in the group of thirteen very diverse states used to create the marketbasket, there would have been little impact on the study's findings if we had used each state's utilization pattern separately.

TECHNICAL APPENDIX

DATA COLLECTION AND METHODOLOGY

We requested and received physician fee schedules from the various workers' compensation agencies to update fee schedule rates for procedures in our marketbasket. Fee schedule rates in the analysis are current as of July 2006. Although 42 states and the District of Columbia had a physician fee schedule in the middle of 2006, our analysis contains 42 states.¹ In addition to the District of Columbia, we excluded Wisconsin from the analysis because that state uses certified databases based on charges, which is not considered a traditional workers' compensation fee schedule.

We also obtained Medicare fee schedules for each state with workers' compensation fee schedules from the Centers for Medicare and Medicaid Services.² For Medicare fee schedules, we also used 2006 fee schedules.

In the analysis, medical expenditures reflect actual payments made to medical providers. Medical expenditure data come from WCRI's detailed benchmarking and evaluation (DBE) database for claims from injury years 2000 to 2003 and services were delivered in calendar years 2002 and 2003. The database contains data from a wide array of sources, including national and regional insurers, third-party administrators, and state funds. Currently, the DBE contains more than 22 million open and closed claims from 25 states for accident years 1995 to September 2004. The data represent approximately 39–69 percent of the total claims in each accident year, making the database a very powerful tool for analysis.

¹ We were unable to obtain a fee schedule from the District of Columbia.

² Available at <http://www.cms.hhs.gov/PhysicianFeeSched/PFSCSF/list.asp#TopOfPage> (accessed November 1, 2006).

RESEARCH APPROACH

The methodology in this report follows those in the earlier WCRI studies of fee schedules. It compares workers' compensation fee schedules to Medicare fee schedules by creating an index, similar to the consumer price index, for a representative collection of goods and services. The WCRI fee schedule index measures the relative fee schedule amounts of a representative collection of nonhospital medical procedures that are commonly provided to injured workers. We use the same representative group of medical services (in the same proportions) to create the indices for all states—workers' compensation fee schedule indices and Medicare fee schedule indices. Further detail on methodology is provided below and also can be found in previous WCRI studies (Eccleston, 2002 and Wang, 2003). We also make comparisons of workers' compensation fee schedule rates to the state's Medicare fee schedule rates and express that in terms of the workers' compensation fee schedule percentage above (or in some cases below) Medicare.

THE MARKETBASKET: A REPRESENTATIVE COLLECTION OF MEDICAL SERVICES FOR INJURED WORKERS

The marketbasket of representative services provided to injured workers is created from detailed medical bill payment data from thirteen states: Arkansas, California, Florida, Illinois, Indiana, Louisiana, Massachusetts, Maryland, North Carolina, Pennsylvania, Tennessee, Texas, and Wisconsin. We include 250 diverse medical procedures (CPT codes) that make up 73 to 87 percent of the total nonhospital medical expenditures in each service group, except for general medicine, which are 62 percent.³ These 250 codes are listed and defined in Table TA.1. We include the five major medical service groups as were included in WCRI's earlier fee schedule benchmark study: surgery, radiology,

³ The detailed medical bill data from insurers and self-insurers are included in the WCRI detailed benchmarking and evaluation (DBE) database for claims from injury years 2000 to 2003 and services were delivered in calendar years 2002 and 2003. For general medicine, 29 codes are included that make up 62 percent of payments in that category. Several frequently billed codes in this category must be excluded because they do not generally have set fees in Medicare or in many state fee schedules are billed as "by report" procedures.

general medicine, physical medicine, and evaluation and management. We exclude anesthesiology, pathology, and laboratory codes because states vary in coverage of services within their fee schedules, and laboratory codes are a relatively small fraction of total costs. We also exclude procedures where rates are determined “by report” or were missing in most states. Occasionally, an omitted CPT code can represent a nontrivial share of expenditures. For example, supplies make up a significant percentage of expenditures in the general medicine group; however, supplies do not have rates set in state fee schedules.

Table TA.1 Procedures in Each Service Category in the Market Basket	
CPT Code	Description
Surgery	
11010	Debridement, removal of foreign material associated with open fracture(s)
11012	Debridement, removal of foreign material associated with open fracture(s), skin, muscle and bone
11042	Debridement, removal of foreign material associated with open fracture(s), skin and subcutaneous tissue
11043	Debridement, removal of foreign material associated with open fracture(s), skin and subcutaneous tissue and muscle
11044	Debridement, removal of foreign material associated with open fracture(s), subcutaneous tissue and bone
11760	Repair of nail bed
12001	Repair, simple, superficial wound of scalp
12002	Repair, simple, superficial wound of scalp, 2.6–7.5 cm
20550	Injection, tendon sheath, ligament
20552	Injection, single or multiple trigger point(s), one or two muscle(s)
20600	Arthrocentesis, aspiration and/or injection
20605	Arthrocentesis, intermediate joint
20610	Arthrocentesis, major joint or bursa
20670	Removal of implant, superficial (e.g., buried wire, pin, screw, rod)
20680	Removal of implant, deep (e.g., buried wire, pin, screw, rod)
22505	Manipulation of spine requiring anesthesia, any region
23120	Claviclectomy, partial
23130	Acromioplasty or acromionectomy
23350	Injection procedure for shoulder arthrography
23700	Manipulation under anesthesia, shoulder joint
24685	Open treatment of ulnar fracture proximal end

Table TA.1 Procedures in Each Service Category in the Market Basket (continued)	
CPT Code	Description
25000	Incision, extensor tendon sheath
25111	Excision, lesion of tendon sheath, forearm and/or wrist
25115	Radical excision of bursa
25600	Closed treatment of distal radial fracture
25605	Closed treatment of distal radial fracture, with manipulation
25611	Percutaneous skeletal fixation of distal radial fracture
25620	Open treatment of distal radial fracture
26055	Tendon sheath incision
26145	Synovectomy, tendon sheath, radical
26615	Open treatment of metacarpal fracture
26735	Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with or without internal or external fixation, each
26746	Open treatment of articular fracture
26765	Open treatment of distal phalangeal fracture, finger or thumb
27096	Injection procedure for sacroiliac joint
27244	Treatment of intertrochanteric
27524	Open treatment of patellar fracture
27535	Open treatment of tibial fracture
27536	Open treatment of tibial fracture, bicondylar, with or without internal fixation
27759	Treatment of tibial shaft fracture
27786	Closed treatment of distal fibular fracture
27792	Open treatment of distal fibular fracture
27814	Open treatment of bimalleolar ankle fracture
27822	Open treatment of trimalleolar ankle fracture
28415	Open treatment of calcaneal fracture
28470	Closed treatment of metatarsal fracture
28615	Open treatment of tarsometatarsal joint dislocation
62263	Percutaneous lysis of epidural adhesions using solution injection
62282	Injection/infusion of neurolytic substance, epidural, lumbar, sacral
62284	Injection procedure for myelography
62287	Aspiration or decompression procedure
62290	Injection procedure for diskography, each level; lumbar
62291	Injection procedure for diskography, cervical or thoracic
62292	Injection procedure for chemonucleolysis, including diskography
62310	Injection, single, not including neurolytic substances
62311	Injection, single, not including neurolytic substances, lumbar, sacral
62319	Injection, including catheter placement, lumbar, sacral
62350	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter

Table TA.1 Procedures in Each Service Category in the Market Basket (continued)	
CPT Code	Description
64483	Injection, anesthetic agent, lumbar or sacral, single level
64450	Injection, other peripheral nerve or branch
64622	Destruction by neurolytic agent, paravertebral facet joint nerve, lumbar or sacral, single level
64623	Destruction by neurolytic agent, paravertebral facet joint nerve, lumbar or sacral, each additional level
64640	Destruction by neurolytic agent, pudendal nerve, other peripheral nerve or branch
64784	Excision of neuroma, major peripheral nerve, except sciatic
14040	Adjacent tissue transfer or rearrangement
15000	Surgical preparation or creation of recipient site by excision of open wounds
15100	Split graft, trunk, arms, legs
15240	Full thickness graft-free
20937	Autograft for spine surgery, morselized
22554	Arthrodesis
22558	Arthrodesis, anterior interbody, lumbar
22585	Arthrodesis, each additional interspace
22612	Arthrodesis, lumbar (with or without transverse technique)
22614	Arthrodesis, each additional vertebral segment
22630	Arthrodesis, posterior interbody technique
22830	Exploration of spinal fusion
22840	Posterior nonsegmental instrumentation, pedicle fixation across one interspace
22842	Posterior segmental instrumentation, pedicle fixation
22845	Anterior instrumentation, 2 to 3 vertebral segments
22851	Application of intervertebral biomechanical device
23410	Repair of ruptured musculotendinous cuff
23412	Repair of ruptured musculotendinous cuff, chronic
23420	Reconstruction of complete shoulder cuff avulsion
23455	Capsulorrhaphy, with labral repair
24342	Reinsertion of ruptured biceps or triceps tendon
24356	Fasciotomy, with partial osteotomy
25320	Capsulorrhaphy or reconstruction
26356	Repair or advancement
26418	Repair, extensor tendon
26951	Amputation, finger or thumb
26952	Amputation, finger or thumb, with local advancement flaps (V-Y, hood)
27425	Lateral retinacular release
27447	Arthroplasty, medial and lateral compartments
29806	Arthroplasty, shoulder, surgical; capsulorrhaphy

Table TA.1 Procedures in Each Service Category in the Market Basket (continued)	
CPT Code	Description
29807	Arthroplasty, shoulder, surgical; capsulorrhaphy, repair of SLAP lesion
29822	Arthroscopy, debridement, limited
29823	Arthroscopy, shoulder, debridement, extensive
29824	Arthroscopy, shoulder, debridement, distal claviclectomy
29826	Arthroscopy, shoulder
29827	Arthroscopy, shoulder, surgical, with rotator cuff repair
29846	Arthroscopy, excision
29848	Endoscopy, wrist, surgical, with release of transverse carpal ligament
29875	Arthroscopy, synovectomy, limited
29876	Arthroscopy, synovectomy, major
29877	Arthroscopy, debridement
29879	Arthroscopy, abrasion arthroplasty
29880	Arthroscopy, with meniscectomy
29881	Arthroscopy, knee with meniscectomy
29882	Arthroscopy, with meniscus repair
29888	Arthroscopically aided anterior cruciate ligament repair
29898	Arthroscopy, ankle, debridement, extensive
49505	Repair initial inguinal hernia
49585	Repair umbilical hernia
49650	Laparoscopy, surgical, repair initial inguinal hernia
63030	Lumbar laminectomy
63035	Laminotomy, each additional interspace
63042	Laminotomy, lumbar
63047	Laminectomy, lumbar
63048	Laminectomy, each additional segment
63056	Transpedicular approach with decompression of spinal cord, lumbar
63075	Discectomy, anterior
63076	Discectomy, cervical, each additional interspace
63081	Vertebral corpectomy
63090	Vertebral corpectomy, partial or complete, transperitoneal or retrosperitoneal approach with decompression of spinal cord
63650	Percutaneous implantation of neurostimulator
64708	Neuroplasty, major peripheral nerve
64718	Neuroplasty, ulnar nerve at elbow
64721	Neuroplasty at carpal tunnel
64722	Decompression, unspecified nerve
64831	Suture of digital nerve

Table TA.1 Procedures in Each Service Category in the Market Basket (continued)	
CPT Code	Description
Radiology	
70450	Computerized axial tomography, head or brain, without contrast material
70551	MRI, brain
71010	Radiologic exam, chest, single view, frontal
71020	Radiologic exam, chest, two views, frontal and lateral
72020	Radiologic exam, spine, single view, specify level
72040	Radiologic exam, spine, cervical, two or three views
72050	Radiologic exam, spine, cervical, minimum of four views
72052	Radiologic exam, complete, including oblique and flexion and/or extension studies
72070	Radiologic exam, spine, thoracic, two views
72100	Radiologic exam, spine, lumbosacral, two or three views
72110	Radiologic exam, minimum of four views
72114	Radiologic exam, complete, including bending views
72120	Radiologic exam, spine, lumbosacral, bending views
72131	Computerized axial tomography, lumbar spine, without contrast material
72132	Computerized axial tomography, lumbar spine, with contrast material
72141	MRI, spinal canal cervical
72146	MRI, spinal canal and contents, thoracic, without contrast material
72148	MRI, spinal canal lumbar
72156	MRI, spinal canal and contents, without contrast material
72158	MRI, with and then without contrast material
72170	Radiologic exam, pelvis, one or two views
72240	Myelography, cervical
72265	Myelography, lumbosacral, radiological supervision and interpretation
72295	Diskography, lumbar, radiological supervision and interpretation
73030	Radiologic exam, complete, minimum of two views
73040	Radiologic exam, shoulder, arthrography
73070	Radiologic exam, elbow, two views
73080	Radiologic exam, elbow, complete, minimum of three views
73090	Radiologic exam, elbow, forearm, two views
73100	Radiologic exam, wrist, two views
73110	Radiologic exam, wrist, minimum of three views
73120	Radiologic exam, hand, two views
73130	Radiologic exam, hand, minimum of three views
73140	Radiologic exam, finger, minimum of two views
73221	MRI, upper extremity joint
73510	Radiologic exam, complete, minimum of two views
73560	Radiologic exam, knee, one or two views

Table TA.1 Procedures in Each Service Category in the Market Basket (continued)	
CPT Code	Description
73562	Radiologic exam, three views
73564	Radiologic exam, complete, four views
73590	Radiologic exam, tibia and fibula, two views
73600	Radiologic exam, ankle, two views
73610	Radiologic exam, ankle, minimum of three views
73620	Radiologic exam, foot, two views
73630	Radiologic exam, foot, minimum of three views
73721	MRI, lower extremity joint
76000	Fluoroscopy, up to one hour physician time
76003	Fluoroscopic guidance for needle placement
76005	Fluoroscopic guidance and localization of needle or catheter tip
76800	Ultrasound, spinal canal and contents
76880	Ultrasound, extremity, non-vascular
78306	Bone or joint imaging, whole body
78315	Bone or joint imaging, three phase study
78465	Myocardial imaging, tomographic
General Medicine	
90801	Psychiatric diagnostic interview examination
90806	Individual psychotherapy
90807	Individual psychotherapy insight oriented-50 minutes
90808	Individual psychotherapy, insight oriented, behavior modifying and/or supportive
90853	Group psychotherapy
90862	Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
90901	Biofeedback training by any modality
92002	Ophthalmological services, medical exam
92004	Ophthalmological services, medical exam and evaluation, comprehensive, new patient, one or more visits
92012	Ophthalmological services, medical exam and evaluation
93000	Electrocardiogram, routine, with at least 12 leads, with interpretation and report
93005	Electrocardiogram, tracing only, without interpretation and report
93010	Electrocardiogram, interpretation and report
95831	Muscle testing
95832	Muscle testing, hand, with or without comparison with normal side
95851	Range-of-motion measurements and report
95852	Range-of-motion measurements and report, hand
95860	Needle electromyography with or without related paraspinal areas
95861	Needle electromyography

Table TA.1 Procedures in Each Service Category in the Market Basket (continued)	
CPT Code	Description
95864	Needle electromyographic recording, four extremities with or without related paraspinal areas
95900	Nerve conduction amplitude and latency
95903	Nerve conduction amplitude with F-wave study
95904	Nerve conduction sensory/mixed
95920	Intraoperative neurophysiology testing
95925	Short-latency somatosensory evoked potential study
95926	Short-latency somatosensory evoked potential study, in lower limbs
95927	Short-latency somatosensory evoked potential study, stimulation of nerves or skin sites, in the trunk or head
95934	H-reflex
99183	Physician attendance and supervision of hyperbaric oxygen therapy, per session
Physical Therapy	
97001	Physical therapy re-evaluation
97012	Application of a modality to one or more areas, traction, mechanical
97018	Application of a modality to one or more areas, paraffin bath
97022	Application of a modality to one or more areas, whirlpool
97032	Application of a modality to one or more areas; electrical stimulation, each 15 minutes
97033	Application of a modality to one or more areas; iontophoresis, each 15 minutes
97035	Application of a modality to one or more areas; ultrasound, each 15 minutes
97036	Application of a modality to one or more areas; Hubbard tank, each 15 minutes
97110	Therapeutic procedure/exercises
97112	Therapeutic procedure, neuromuscular reeducation of movement
97113	Therapeutic procedure, aquatic therapy with therapeutic exercises
97124	Modality, massage
97140	Manual therapy techniques
97530	Therapeutic activities to improve function
97750	Physical performance test or measurement
98940	Chiropractic manipulative treatment
98941	Chiropractic manipulative treatment, spinal, three to four regions
98942	Chiropractic manipulative treatment, spinal, five regions
Evaluation and Management	
99202	New patient office visit, an expanded problem focused history
99203	New patient office visit, detailed history, low complexity
99204	New patient office visit, comprehensive history, moderate complexity
99205	New patient office visit, comprehensive history, comprehensive exam, high complexity
99211	Established patient office visit, may not require the presence of a physician

Table TA.1 Procedures in Each Service Category in the Market Basket (continued)	
CPT Code	Description
99212	Established patient office visit, straightforward medical decision making
99213	Established patient office visit/expanded problems, low complexity
99214	Established patient office visit/detailed exam, moderate complexity
99215	Outpatient visit, detailed history-moderated complexity
99232	Subsequent hospital care, per day, for the evaluation of a patient
99242	Office consultation for a new patient, problem focused
99243	Office consultation for a new patient, detailed
99244	Office consultation, comprehensive history, moderate complexity
99245	Office consultation, comprehensive history, high complexity
99281	Emergency department visit for the evaluation of a patient, problem focused
99282	Emergency department visit for the evaluation of a patient, expanded
99283	Emergency visit, detailed history, moderate complexity
99284	Emergency visit, detailed history, detailed
99285	Emergency visit, detailed history, high complexity
99354	Prolonged physician service in the office
^a A time limit of 15 minutes is specified for most physical medicine procedures. In California, the time specified is 30 minutes.	

The marketbasket represents 76 percent of total nonhospital medical expenditures. Each of the 250 procedures in the marketbasket is weighted to represent its share of total frequency of procedures within its service group to compute the fee schedule indices for each individual service group. Each of the five service groups is then weighted to represent its share of total covered medical expenditures to derive the overall state fee schedule indices. Table TA.2 shows the distribution of total nonhospital medical expenditures by service group in the full database vs. the marketbasket.

Table TA.2 Distribution of Total Nonhospital Medical Expenditure by Service Group (full dataset vs. marketbasket)		
Service Group	Percentage of Total Nonhospital Expenditure in Dataset	Percentage of Total Nonhospital Expenditure of the Procedures in the Marketbasket
Surgery	22	23
Radiology	10	11
General medicine	7	7
Physical medicine	41	43
Evaluation and management	14	15
Anesthesia	6	Excluded from the fee schedule analysis
Pathology	<1	Excluded from the fee schedule analysis
<i>Notes:</i> The dataset contains all services on claims in the WCRI detailed benchmarking and evaluation (DBE) database. The claims are from injury year 2000 to 2003 and services were delivered in calendar years 2002 and 2003 from 13 states, Arkansas, California, Florida, Illinois, Indiana, Louisiana, Massachusetts, Maryland, North Carolina, Pennsylvania, Tennessee, Texas, and Wisconsin. Nonhospital expenditures generally make up 51–74 percent of total medical expenditures in workers' compensation.		

We believe the marketbasket is representative of workers' compensation medical care covered by the typical fee schedule. First, it represents a very large share of total covered expenditures. Second, the distributions of expenditures in the marketbasket and in the total population are very similar. And third, the results change little if using the weights from any one of the 13 very diverse states individually. This suggests that the results are applicable to states beyond those from which the marketbasket was derived. Each of these points is demonstrated in the Technical Appendix of the previous edition of this study (Eccleston, 2002).

WEIGHTS USED IN CREATING THE INDICES

Using the DBE database, two kinds of weights have been used to compute the fee schedule indices: CPT code weight (frequency weight) and service group weight (expenditure weight). The CPT code weight is created to reflect the relative importance of each procedure within its service group. The weight applied is the frequency of the

procedure as a percentage of the total service group frequency in the marketbasket. The service group weight is created to reflect the relative importance of a service group over all service groups. The weight applied is the service group expenditure as a percentage of total expenditures in the system. More detail along with formulae can be found in the earlier study (Eccleston, 2002).

CREATING SERVICE GROUP AND OVERALL INDICES

For comparison to Medicare for each service group, we first apply the CPT code weight to each procedure to get the weighted average of the workers' compensation fee schedule levels by service group for each of the 42 states. We also apply the CPT code weight to each procedure to get the weighted average of the Medicare fee schedule levels by service group for each of the 42 states. Second, we compute premium over Medicare for each service group. The base is the fee schedule level set by that state's Medicare fee schedule rather than the state workers' compensation fee schedule. In other words, the workers' compensation fee schedule from each state is compared to that state's Medicare fee schedule rate by service group.

To compute the overall index level for each state with a fee schedule, we apply service group weights to each of the service group indices to represent their relative share of total medical expenditures. The overall index is, therefore, a sum of the weighted averages of service group indices.

INTERPRETING THE BENCHMARK INDICES

The benchmark compares the workers' compensation fee schedule in a given state to the Medicare fee schedule in the same state. For comparisons to Medicare, we compare the state workers' compensation fee schedule rates to the rates set by that state's Medicare fee schedule. The result is most often expressed as the percentage difference from Medicare (the premium over Medicare). Because both the workers' compensation index and the Medicare index use the same set of services, they are fully comparable.

Note that the workers' compensation fee schedule index is designed to measure only fee schedule rates. It is not a measure of medical costs or actual medical prices paid, which may differ from the fee schedule.

Medicare as a Benchmark for Workers' Compensation Fee Schedules

Policymakers have shown increasing interest in Medicare as a benchmark to measure workers' compensation fee schedule rates. The Medicare resource-based relative value scale (RBRVS) can provide a useful guide to help design workers' compensation fee schedules. But it is important to distinguish two parts of the Medicare fee schedule: the fee schedule level (called the conversion factor) and the RVUs. The RBRVS determines the relative costs of providing different types of services—that is, the cost of a laminectomy relative to another type of surgery, a CT scan, or a physical medicine procedure. The fee schedule rate for an individual service (e.g., \$750) are the product of the individual RVUs (e.g., 30 units) and the conversion factor (e.g., \$25 per unit).

Because of the RBRVS methodology, the Medicare RBRVS neutralizes the incentives for providers to practice medicine in an unnecessarily costly and invasive manner by setting relative fee schedule rates according to the costs incurred by health care providers in delivering medical services. The RBRVS takes into account the required provider time, expertise, office practice expenses, malpractice insurance costs, and so on, and reflects how these differ for different types of services in different geographic locations. The study design is based on a general population, not specific to a Medicare population or to an injured worker population. In doing so, the Medicare RBRVS fee schedule seeks to equalize the economic returns across all services, thereby eliminating incentives to overuse certain types of services because they produce a higher economic return.

The Medicare fee schedules differ across states (and areas within states) according to careful research measures of differences in three elements of the costs of producing medical services: the physician's time and effort, the expense involved in running a physician's office, and malpractice costs. These provide reasonable measures of how costs incurred by providers to deliver different services vary from state to state.

We use the *relative* differences in the Medicare RBRVS across different services and regions as an indicator of the *relative* market prices (that is, the differences in fees across service types and regions). The Medicare RBRVS goes a long way to define the relative differences in the costs of delivering services across different service types and, combined with geographical adjustment factors, across different regions. It can therefore provide a good measure of the relative rates at which profitability can be equalized across different services and regions. We do not use the Medicare fee schedule rates themselves (that is, the relative values coupled with Medicare conversion rates) to determine the optimal fee schedule rates.

STATES WITH MULTIPLE REGIONAL WORKERS' COMPENSATION FEE SCHEDULES

Most states have one workers' compensation fee schedule for the entire state. However, different workers' compensation fee schedules are published for 3 geographic regions in Florida, 29 geographic regions in Illinois, and 4 geographic regions in New York and in Pennsylvania. To make Florida, Illinois, New York, and Pennsylvania comparable to other states with a single fee schedule, we created a composite index number and fee schedule rate by service group for these four states, using employment population data from the latest US Census and Bureau of Labor Statistics as weights.⁴ We present the premiums over Medicare for each of the 3 Florida regions and each of the 4 Pennsylvania and New York regions in Table TA.3. For Illinois, we present the downtown Chicago area's premiums over Medicare as well as the highest, lowest, and median of the 29

⁴ We created a composite index number as follows: Pennsylvania's workers' compensation fee schedule defines fee schedule rates for four regions—Philadelphia; Suburbs of Philadelphia and Pittsburgh; Harrisburg and Vicinity; and rest of State—based on zip codes of localities. Using this information we mapped each zip code into a county and the counties into the four areas for which fee schedule rates were available. Next we pulled employment population data from the 2005 Bureau of Labor Statistics by county and created weights that we applied to the fee schedule rates by region. We followed the same methodology for Florida and New York State. In Florida, physician fee schedule rates are published for the following regions: Dade and Monroe counties; Broward, Collier, Indian River, Lee, Martin, Palm Beach, and St. Lucie counties; and rest of state. In New York, physician fee schedule rates are published for the following regions: Manhattan, Bronx, and Queens; New York City Suburbs and Long Island; Poughkeepsie and Suburbs; and rest of State. Illinois's workers' compensation fee schedule defines fee for 29 3-digit-zip-code regions. Therefore, we used employment population data from 2000 U.S. Census by 3-digit-zip-code

different fee schedule areas in that state. Because Florida is based on Medicare, the premium over Medicare is the same for each of its regions. The differences in premium over Medicare across regions in New York and Pennsylvania are relatively small. However, in Illinois, the difference between the premium over Medicare in the highest and lowest areas within the state is more than 100 percentage points. Another WCRI study details the comparisons for each of the 29 regions in Illinois (Eccleston, 2006).

Similar to the workers' compensation fee schedules that publish separate rates for distinct geographic regions in Florida, Illinois, New York, and Pennsylvania, the Centers for Medicare and Medicaid Services publishes Medicare fee schedule rates for multiple geographic areas in 14 states including those four states. Using zip code and county information, we also created a single statewide index using employment population weights of the regions as defined in the states' Medicare fee schedules. Medicare fee schedule rates are published for 3 regions in Florida, 4 regions in Illinois, 5 regions in New York, and 2 regions in Pennsylvania. Before creating the composite Medicare index for New York and Pennsylvania, we had to match the geographic areas in the Medicare fee schedules to those in the states' workers' compensation fee schedules. Using zip code and county information, we determined that fee schedule rates in Medicare's Manhattan and Queens regions can be compared to the rates of New York City in the workers' compensation fee schedule. Also, we determined that metropolitan Philadelphia's Medicare fee schedule rates could be compared to those in Philadelphia and the suburbs of Philadelphia, as defined by the state's workers' compensation fee schedule. The fee schedule rates for the rest of Pennsylvania in Medicare was comparable to the rates in Harrisburg and vicinity and the rest of the state in the worker's compensation fee schedule in Pennsylvania.

region. Then, we followed the same methodology to create weights and a composite index number and fee schedule rates by service group for Illinois.

Table TA.3 Florida, Illinois, New York and Pennsylvania Workers' Compensation Fee Schedule Premium Over Medicare Fee Schedule by Service Group, July 2006

a. Florida						
Service Group	Percentage Greater Than or Less Than Medicare					
	Dade and Monroe Counties	Broward, Collier, Indian River, Lee, Martin, Palm Beach, and St. Lucie Counties	Rest of State		Florida Composite of All Areas	Spread between the Highest and Lowest Percentage Difference
Surgery	40	40	40		40	0
Radiology	10	10	10		10	0
General medicine	10	10	10		10	0
Physical medicine	10	10	10		10	0
Evaluation and management	10	10	10		10	0
Overall	17	17	17		17	0
b. Illinois*						
Service Group	Percentage Greater Than or Less Than Medicare					
	The Largest of 29 Fee Schedule Regions [3-Digit-Zip-Code Region 606 (Chicago)]	The Fee Schedule Region with the Highest Premium Over Medicare [3-Digit-Zip-Code Region 618 (Champaign/Urbana)]	The Fee Schedule Region with the Median Premium Over Medicare [3-Digit-Zip-Code Region 609 (Kankakee)]	The Fee Schedule Region with the Lowest Premium Over Medicare [3-Digit-Zip-Code Region 622 (East St. Louis)]	Illinois Composite of All Areas	Spread between the Highest and Lowest Percentage Difference
Surgery	372	429	358	228	354	201
Radiology	151	313	237	119	175	194
General medicine	179	302	100	101	170	202
Physical medicine	104	108	77	80	91	31
Evaluation and management	62	84	46	30	52	54
Overall	173	217	158	114	163	103
c. New York						
Service Group	Percentage Greater Than or Less Than Medicare					
	New York City	New York City Suburbs and Long Island	Poughkeepsie and Suburbs	Rest of State	New York Composite of All Areas	Spread between the Highest and Lowest Percentage Difference
Surgery	116	94	96	111	110	22
Radiology	44	30	35	51	43	21
General medicine	73	57	57	68	69	16
Physical medicine	10	0	-3	0	5	13
Evaluation and management	-16	-24	-25	-22	-19	9
Overall	40	27	26	34	36	14
d. Pennsylvania						
Service Group	Percentage Greater Than or Less Than Medicare					
	Philadelphia	Philadelphia Suburbs	Harrisburg and Vicinity	Rest of State	Pennsylvania Composite of All Areas	Spread between the Highest and Lowest Percentage Difference
Surgery	75	72	87	85	85	15
Radiology	38	36	55	52	51	19
General medicine	13	12	23	22	21	11
Physical medicine	21	16	25	24	23	9
Evaluation and management	4	1	5	4	6	4
Overall	33	30	41	39	39	11

Notes: For New York, we determined that fee levels in Medicare's Manhattan and Queens regions are comparable to the fee level in New York City in the workers' compensation fee schedule. We also determined that the fee level in metropolitan Philadelphia in Medicare was comparable to Philadelphia and its suburbs in the workers' compensation fee schedule. Fee levels in the rest of Pennsylvania in Medicare were comparable to those in Harrisburg and vicinity and in the rest of the state in Pennsylvania's workers' compensation fee schedule. Medicare geographic areas in Florida are (1) Miami, (2) Fort Lauderdale and (3) Rest of State. Medicare geographic areas in Illinois are (1) Chicago, (2) Suburban Chicago, (3) East St. Louis, and (4) Rest of State. Medicare geographic areas in New York State are (1) Manhattan and Queens, (2) New York City Suburbs and Long Island, (3) Poughkeepsie and Suburbs, and (4) Rest of State. Medicare geographic areas in Pennsylvania are (1) Metropolitan Philadelphia and (2) Rest of State.

* For Illinois, See (Eccleston, 2006) for detail on all 29 area fee schedules.

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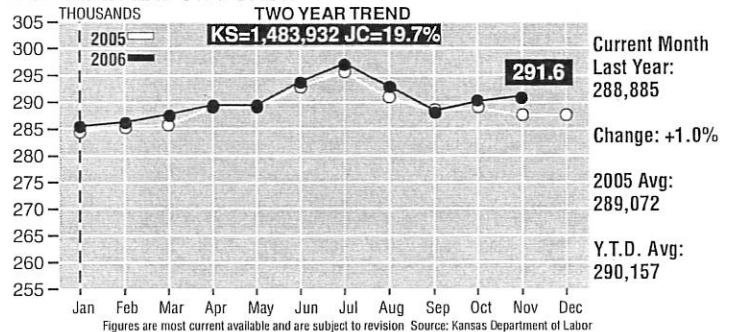
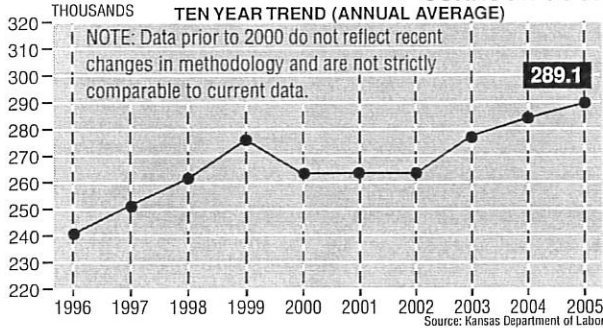
CERI

COUNTY ECONOMIC RESEARCH INSTITUTE

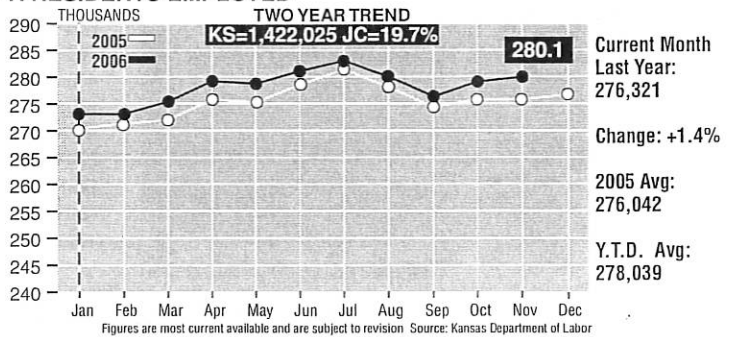
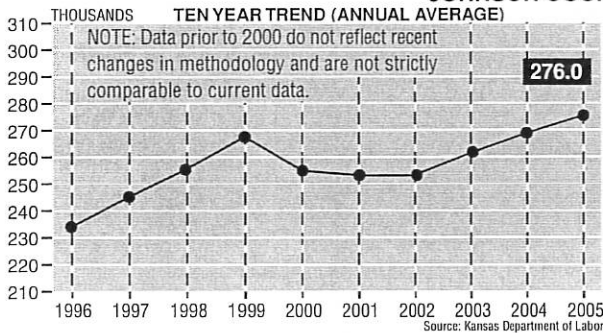
JOHNSON COUNTY INDICATORS

January 2007

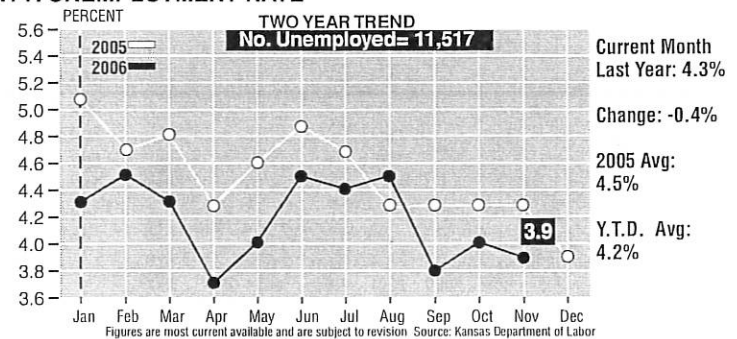
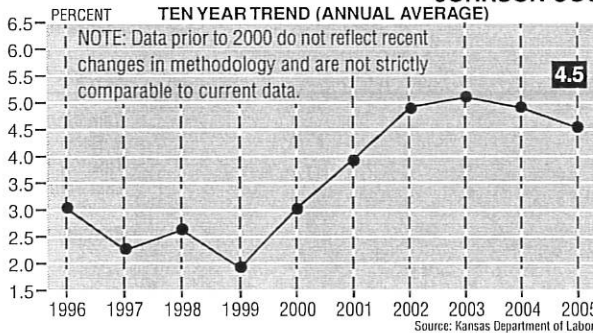
JOHNSON COUNTY: CIVILIAN LABOR FORCE



JOHNSON COUNTY: RESIDENTS EMPLOYED



JOHNSON COUNTY: UNEMPLOYMENT RATE



SELECTED STATES AND METRO AREAS: UNEMPLOYMENT RATES - November 2006

United States..... 4.3%	Michigan..... 6.5%	Kansas City..... 4.8%	Miami..... 3.4%
Kansas..... 4.2%	Minnesota..... 3.6%	Atlanta..... 4.2%	Minneapolis/St. Paul..... 3.5%
Arizona..... 3.9%	Missouri..... 4.8%	Boston..... 4.3%	New Orleans..... 5.0%
Arkansas..... 4.7%	Nebraska..... 2.8%	Charlotte..... 4.8%	New York..... 4.1%
California..... 4.5%	New Jersey..... 4.2%	Chicago..... 3.7%	Omaha..... 3.0%
Colorado..... 3.9%	New York..... 4.0%	Columbus..... 4.4%	Phoenix..... 3.3%
Florida..... 3.3%	N. Carolina..... 4.9%	Dallas..... 4.5%	Pittsburgh..... 4.4%
Georgia..... 4.4%	Ohio..... 5.1%	Denver..... 4.1%	St. Louis..... 4.8%
Illinois..... 3.7%	Oklahoma..... 3.7%	Des Moines..... 2.9%	San Francisco..... 4.0%
Iowa..... 3.2%	Pennsylvania..... 4.4%	Detroit..... 6.8%	Seattle..... 4.6%
Louisiana..... 4.2%	Texas..... 4.6%	Little Rock..... 3.9%	Tulsa..... 3.5%
Massachusetts..... 4.6%	Washington..... 5.0%	Los Angeles..... 3.9%	Wichita..... 4.2%

Not Seasonally Adjusted

CERI

Senate Commerce Committee

Bureau of Labor Statistics

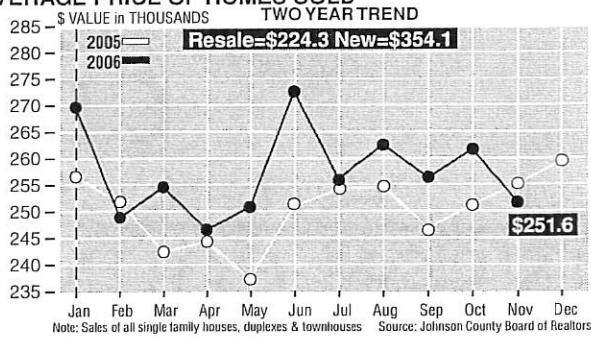
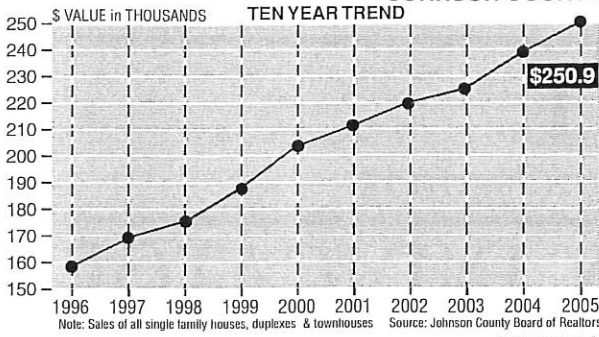
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January 16, 2007

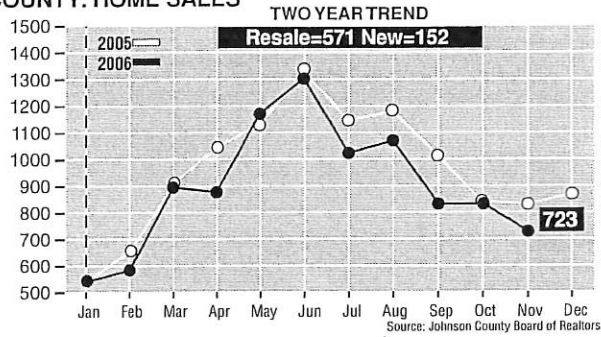
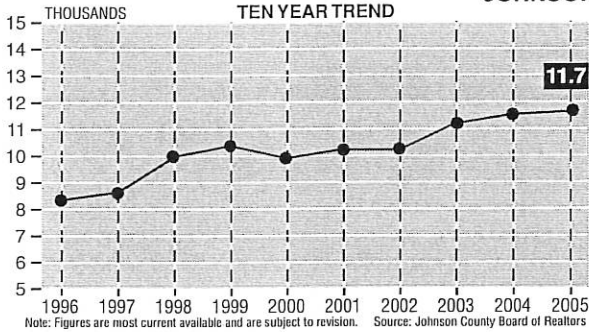
Page 1

Attachment 2-1

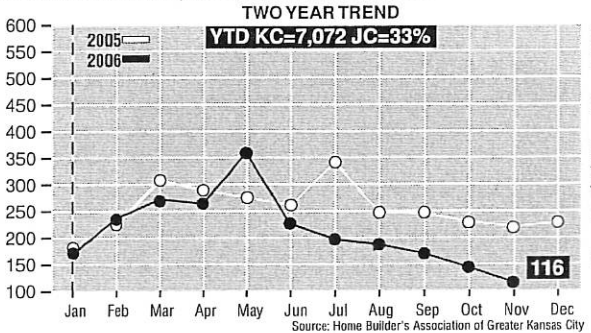
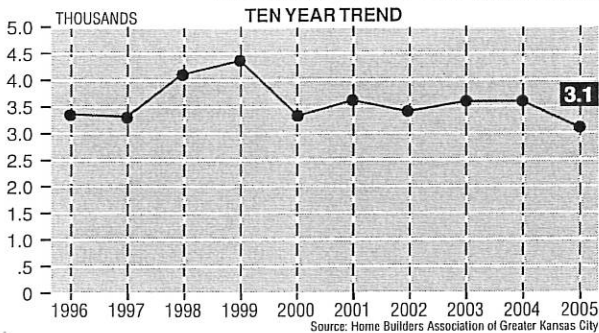
JOHNSON COUNTY: AVERAGE PRICE OF HOMES SOLD



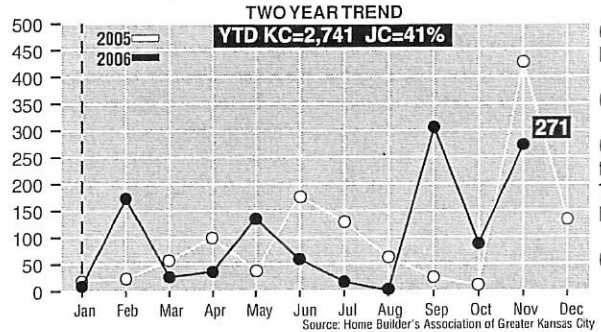
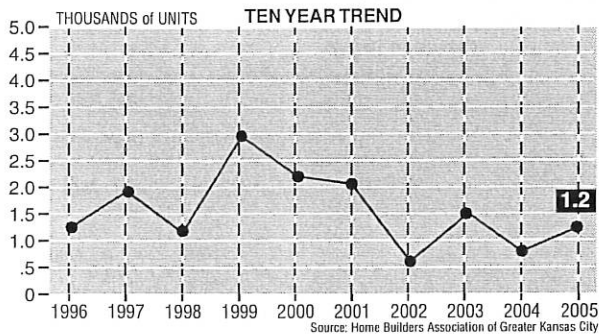
JOHNSON COUNTY: HOME SALES



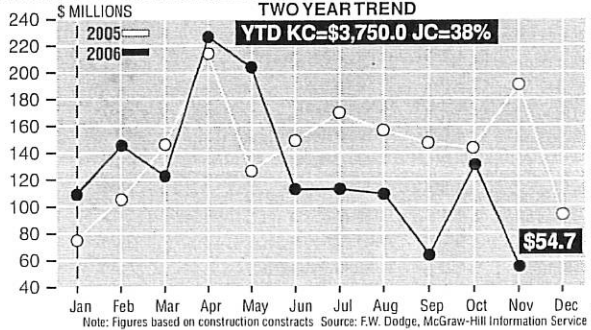
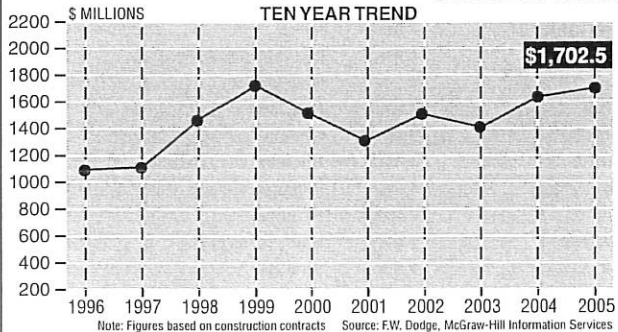
JOHNSON COUNTY: RESIDENTIAL BUILDING PERMITS, SINGLE FAMILY UNITS



JOHNSON COUNTY: BUILDING PERMITS, MULTI-FAMILY UNITS

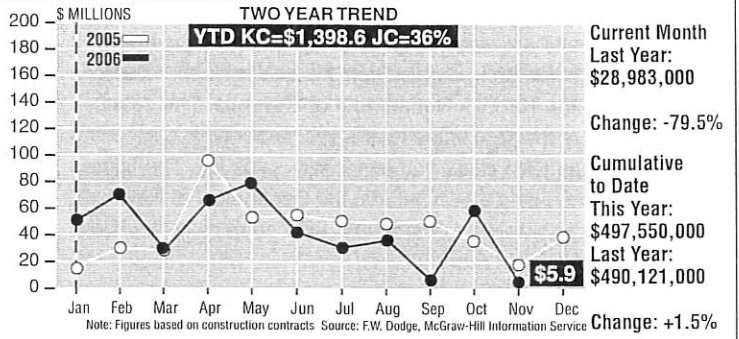
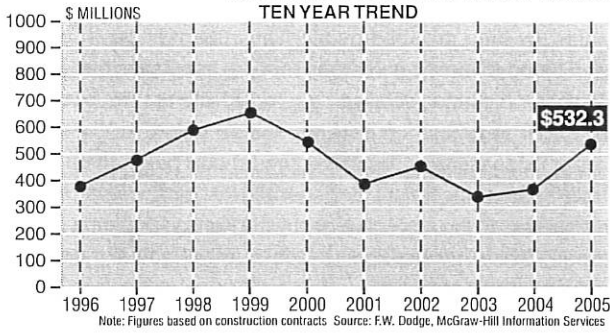


JOHNSON COUNTY: VALUE OF CONSTRUCTION

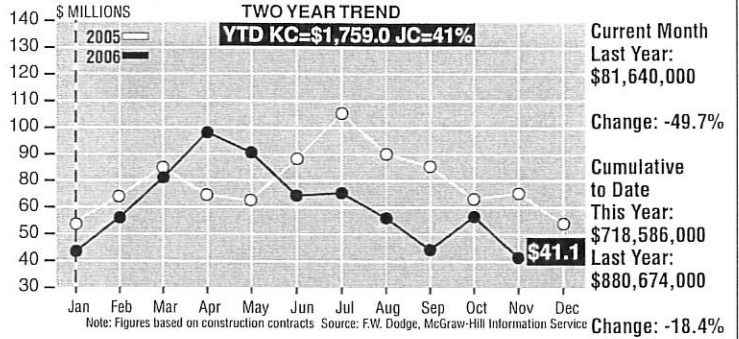
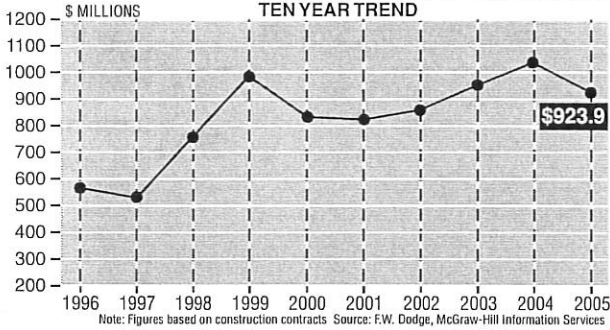


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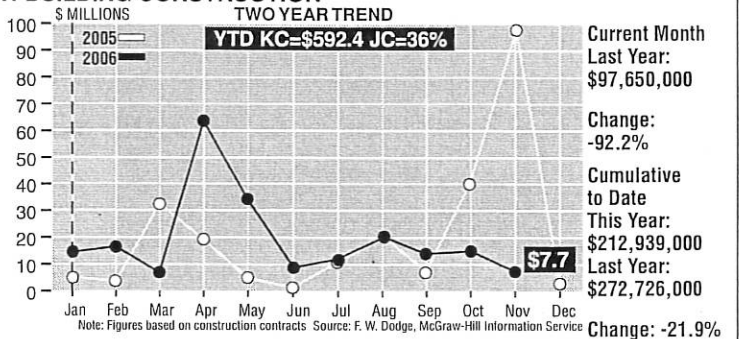
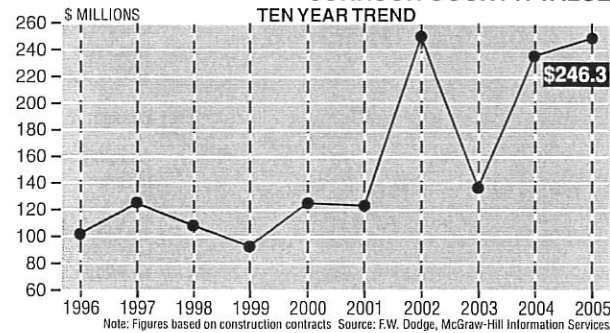
JOHNSON COUNTY: VALUE NON-RESIDENTIAL BUILDING CONSTRUCTION
TEN YEAR TREND



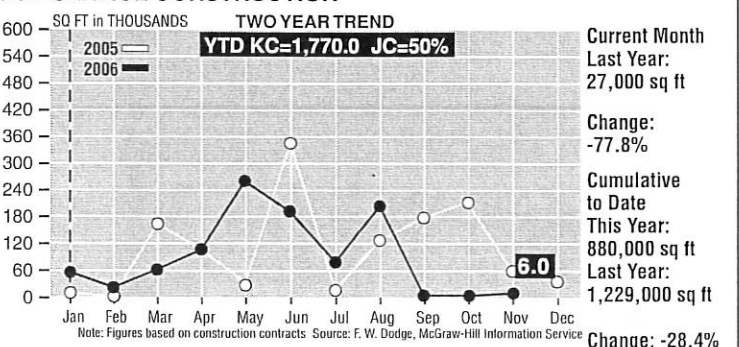
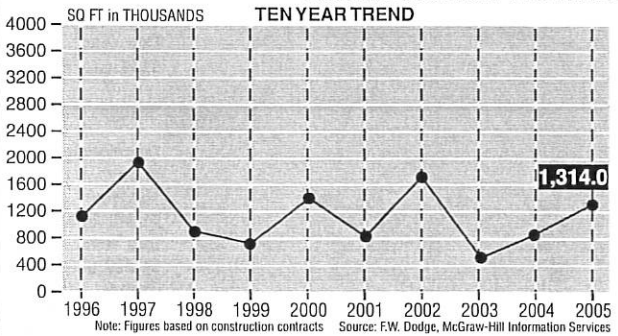
JOHNSON COUNTY: VALUE RESIDENTIAL BUILDING CONSTRUCTION
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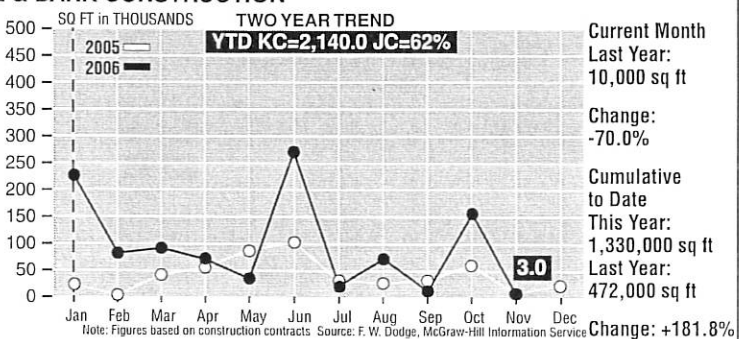
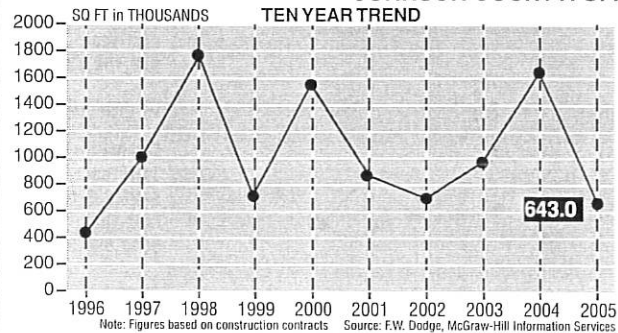
JOHNSON COUNTY: VALUE NON-BUILDING CONSTRUCTION
TEN YEAR TREND



JOHNSON COUNTY: STORE & FOOD SERVICE CONSTRUCTION
TEN YEAR TREND



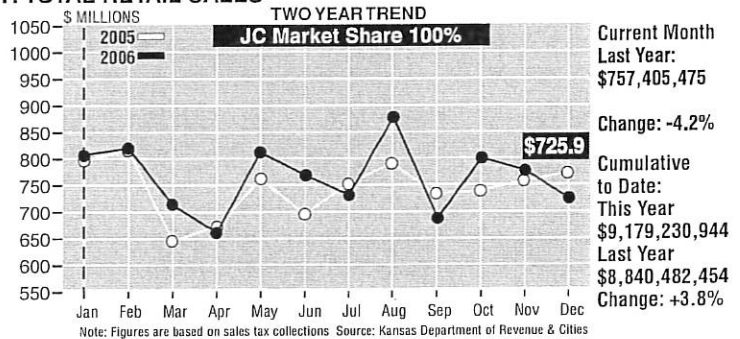
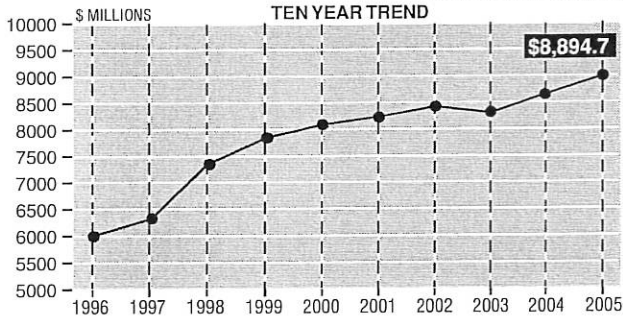
JOHNSON COUNTY: OFFICE & BANK CONSTRUCTION
TEN YEAR TREND



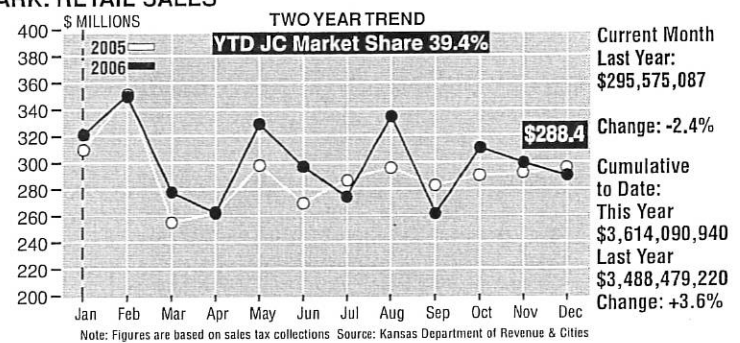
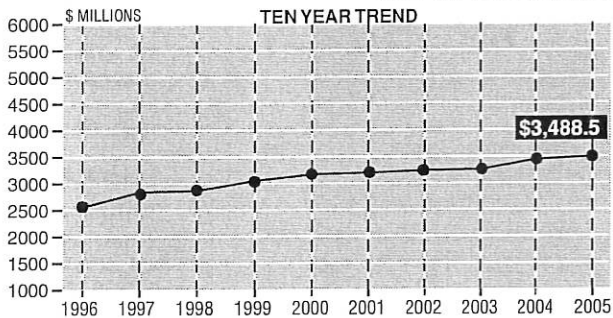
NOTE: The retail sales figures for Johnson County's thirteen largest cities shown below are calculated from the local sales tax collections reported by the Kansas Department of Revenue. The Johnson County total is the sum of the retail sales made within each of the county's seventeen cities that levy a city sales tax. The figures shown are the latest available from the Department of Revenue. They are considered preliminary and subject to revision.

Retail sales tax data provided by the Department of Revenue have been found to exhibit numerous random anomalies due to reporting and/or recording delays or errors. No attempt has been made by CERI to adjust the data presented below for these anomalies or for seasonality. Monthly figures should be interpreted as the retail sales necessary to generate the local sales tax revenue dispersed to the respective city by the Kansas Department of Revenue. They correspond to actual retail sales made two months prior to distribution.

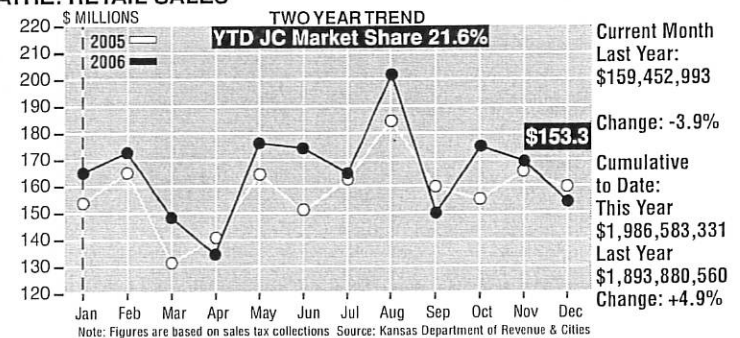
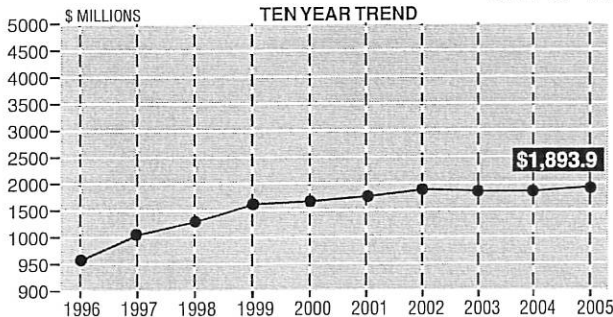
JOHNSON COUNTY: TOTAL RETAIL SALES



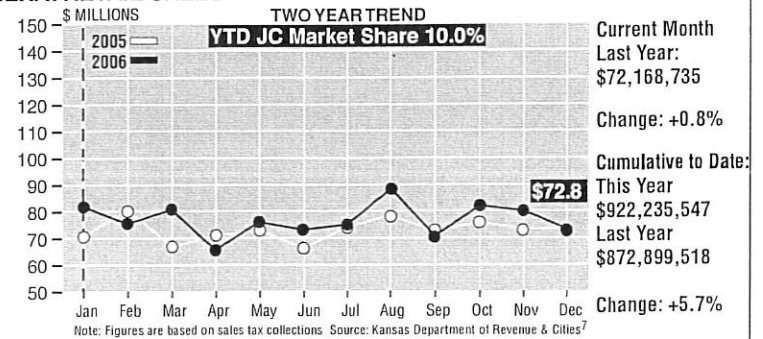
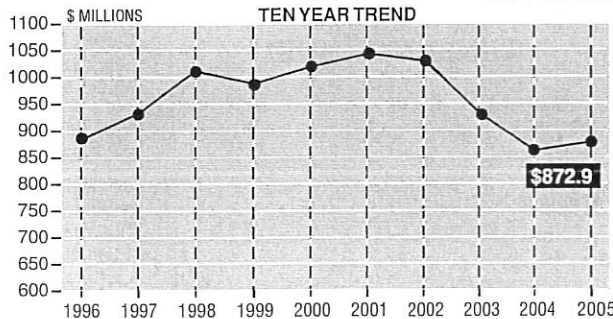
CITY OF OVERLAND PARK: RETAIL SALES



CITY OF OLATHE: RETAIL SALES

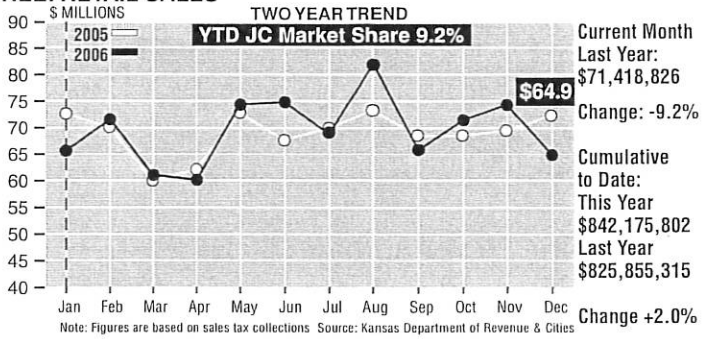
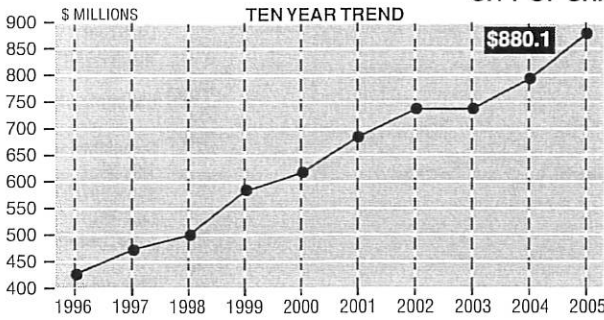


CITY OF LENEXA: RETAIL SALES

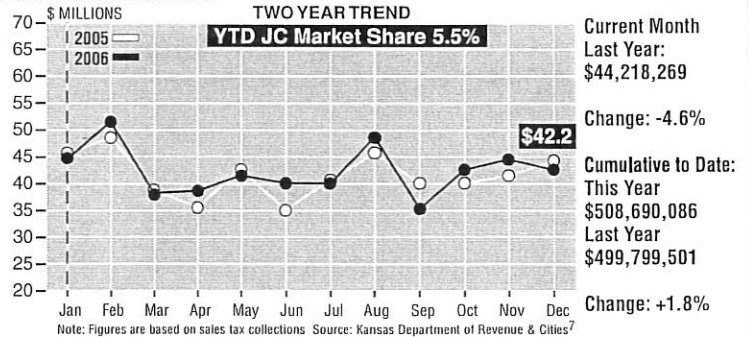
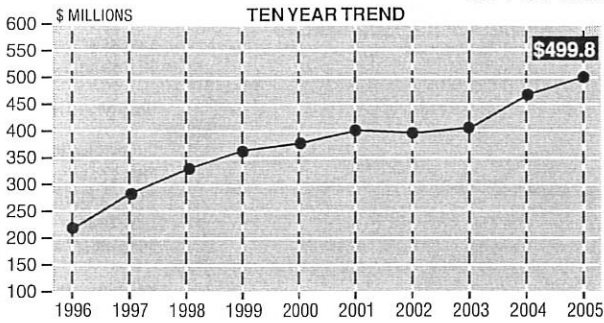


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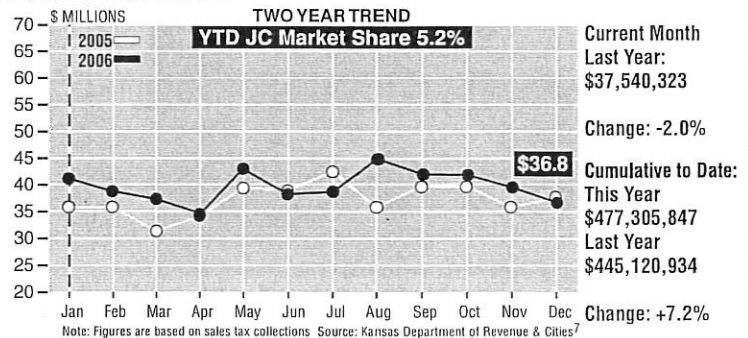
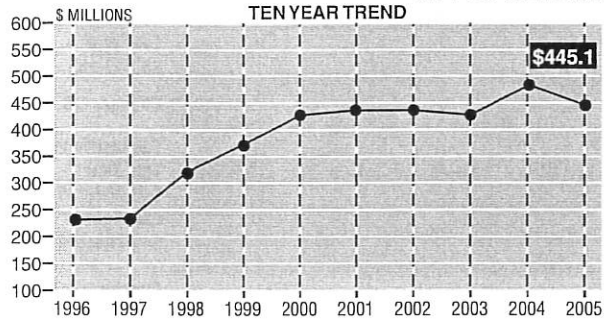
CITY OF SHAWNEE: RETAIL SALES



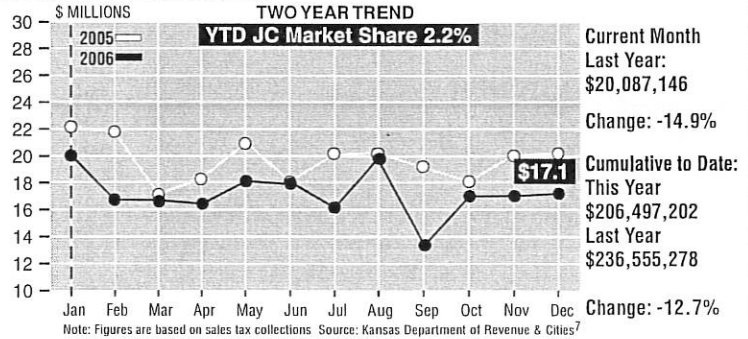
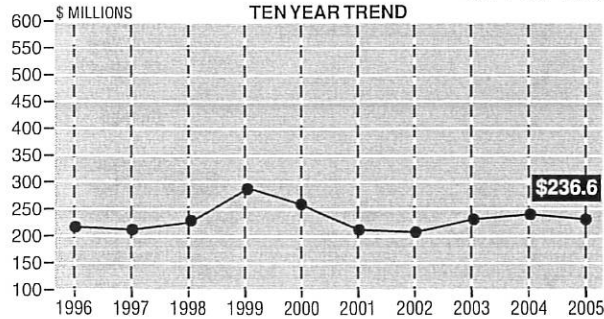
CITY OF LEAWOOD: RETAIL SALES



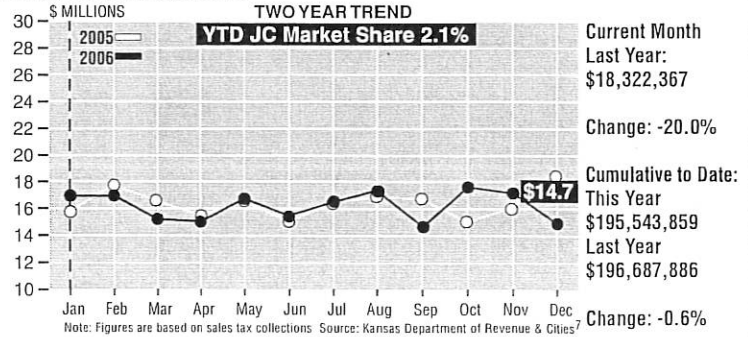
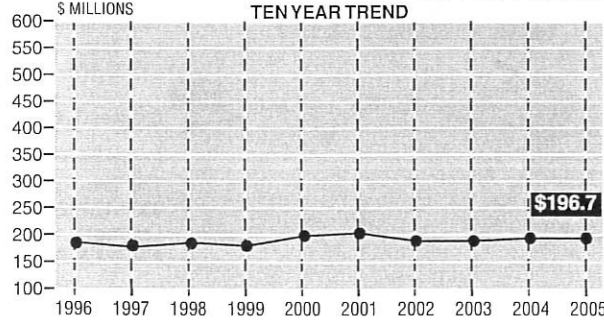
CITY OF MERRIAM: TOTAL RETAIL SALES



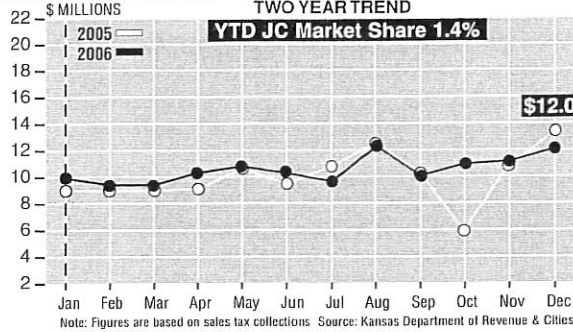
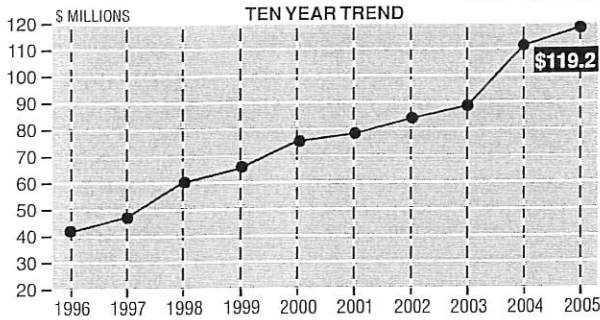
CITY OF MISSION: TOTAL RETAIL SALES



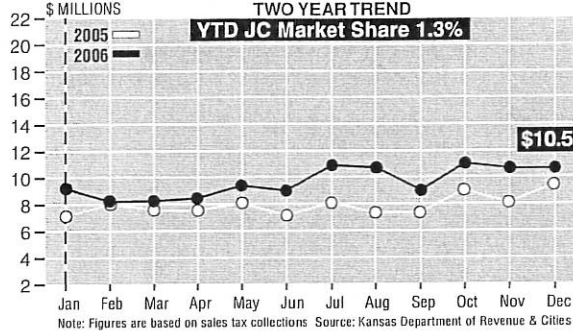
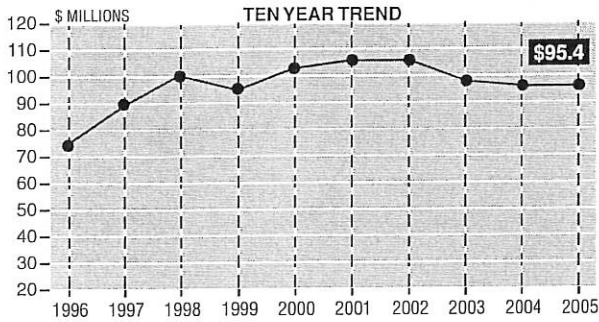
CITY OF PRAIRIE VILLAGE: RETAIL SALES



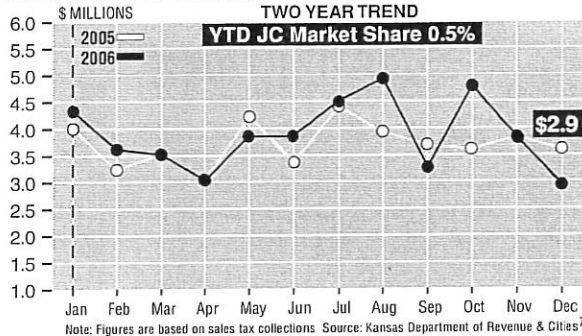
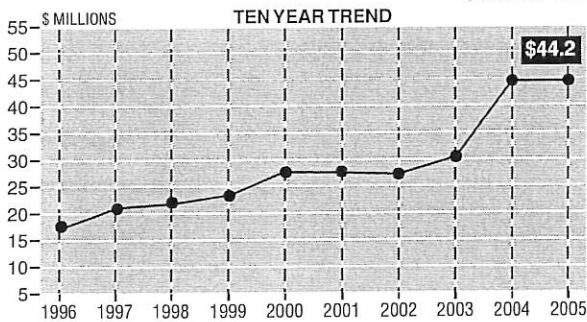
CITY OF GARDNER: RETAIL SALES



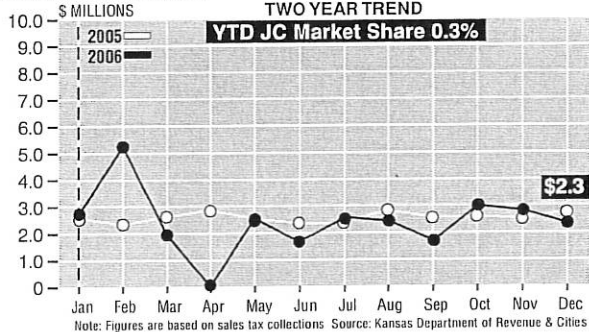
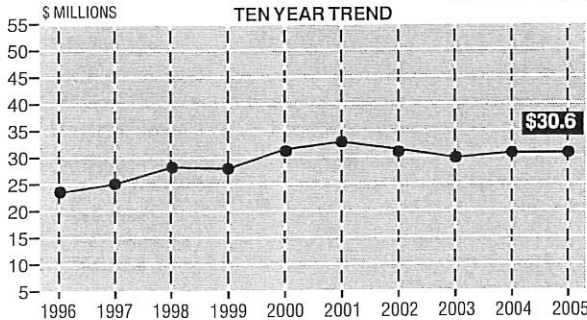
CITY OF ROELAND PARK: RETAIL SALES



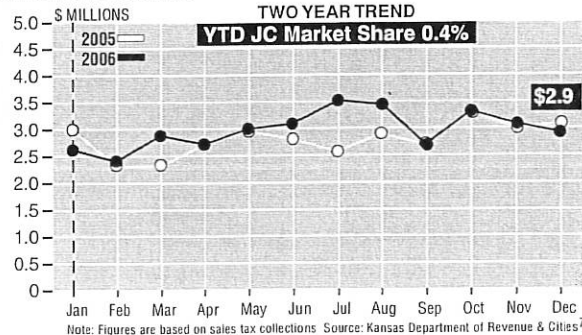
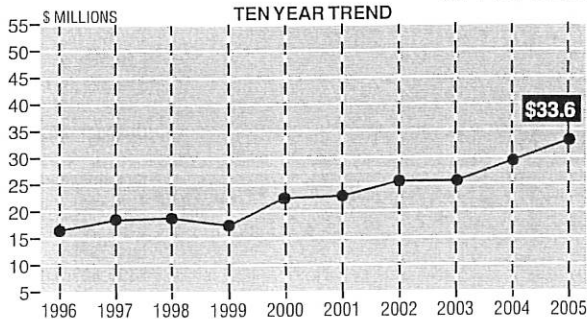
CITY OF SPRING HILL: RETAIL SALES



CITY OF FAIRWAY: RETAIL SALES

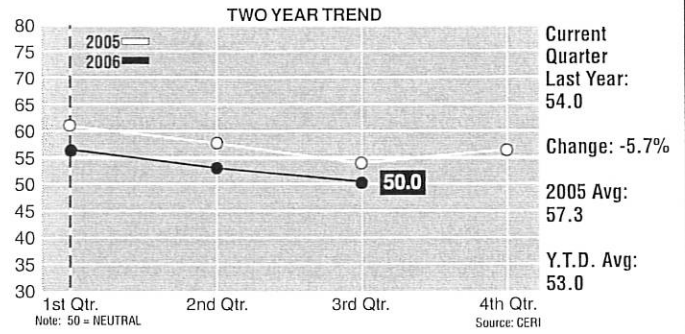
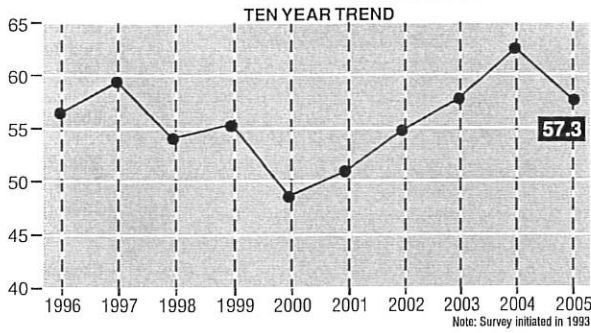


CITY OF DE SOTO: RETAIL SALES

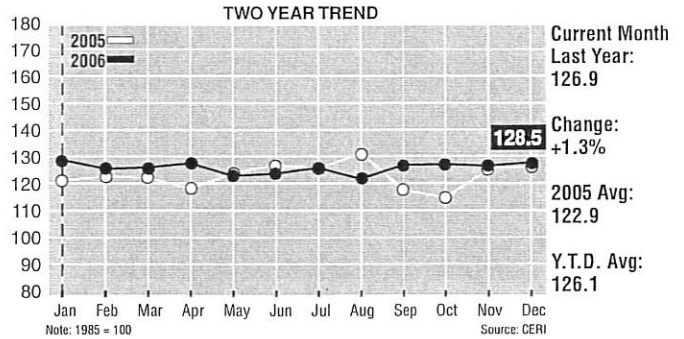
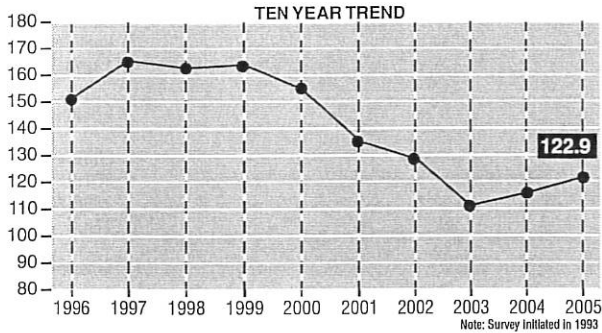


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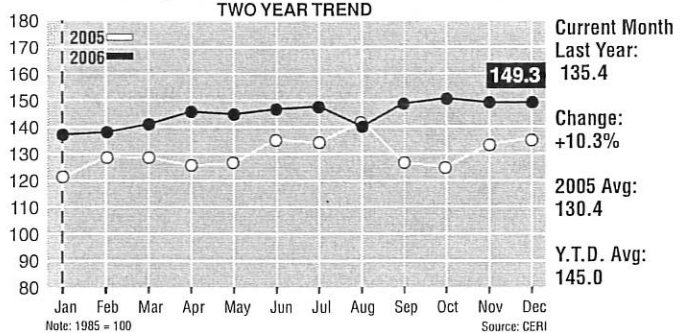
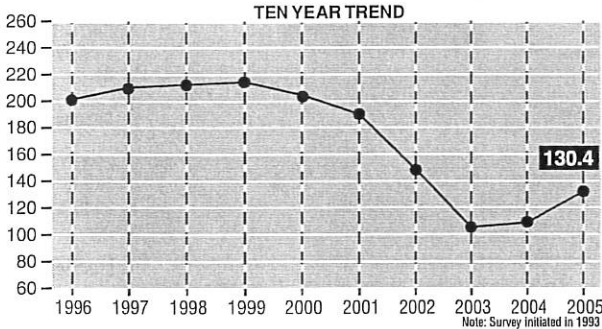
JOHNSON COUNTY: BUSINESS EXECUTIVES' CONFIDENCE



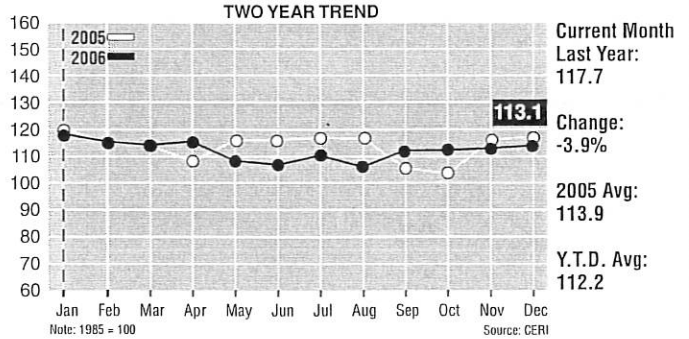
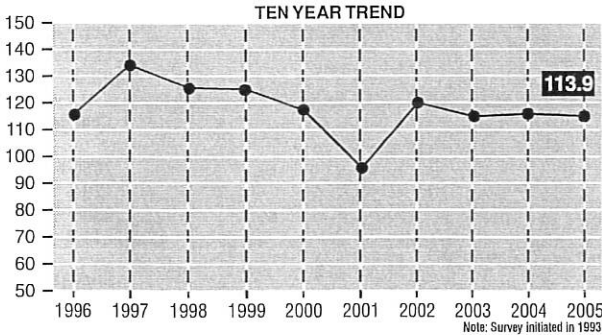
JOHNSON COUNTY: INDEX OF CONSUMER CONFIDENCE



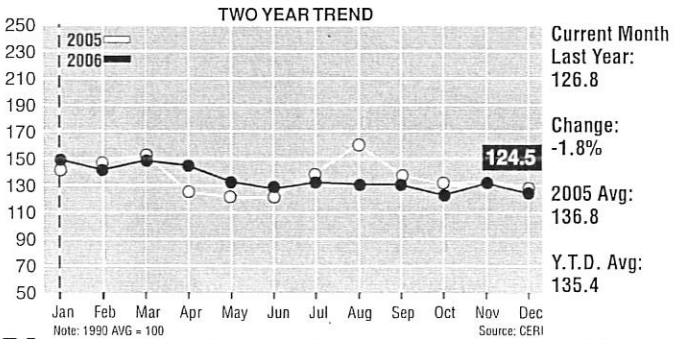
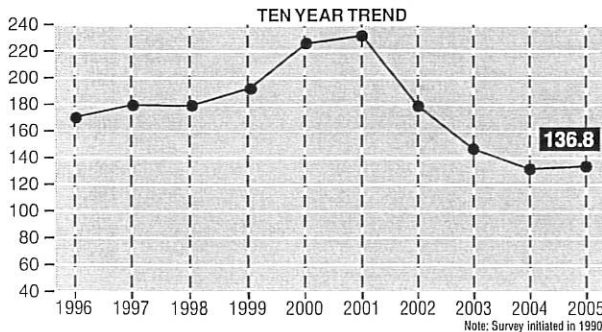
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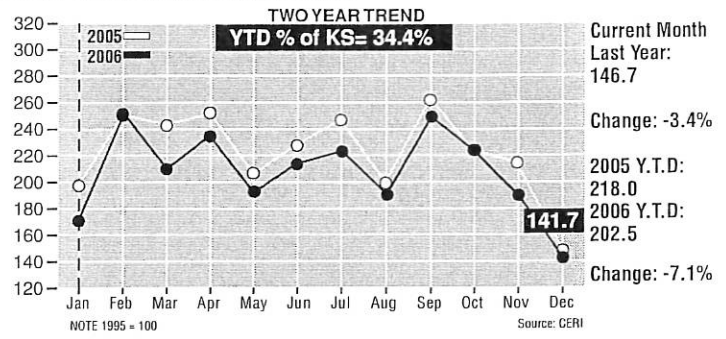
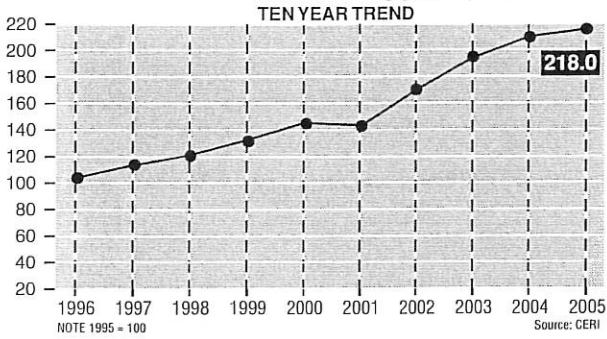
JOHNSON COUNTY: INDEX OF CONSUMER CONFIDENCE (Future Expectations)



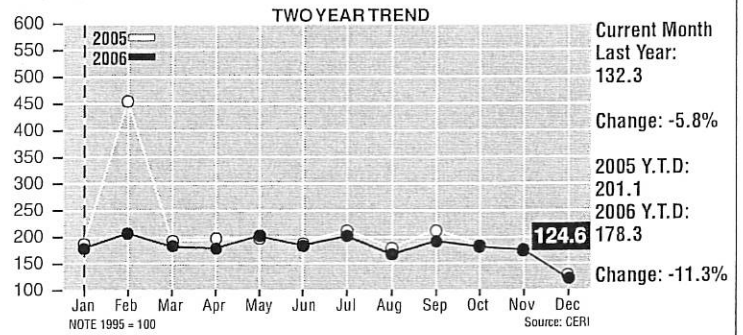
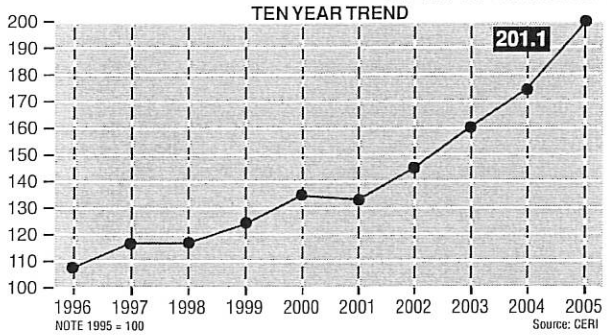
JOHNSON COUNTY: INDEX OF HELP WANTED ADVERTISING



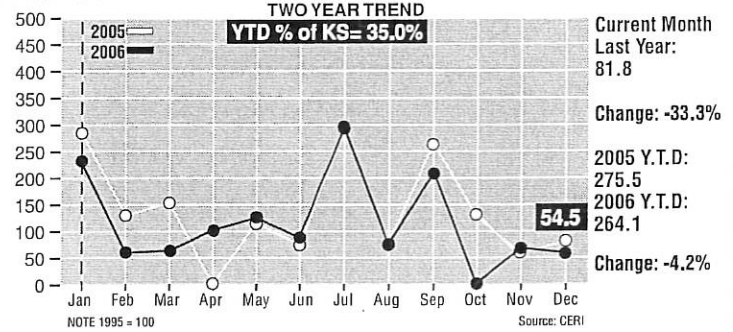
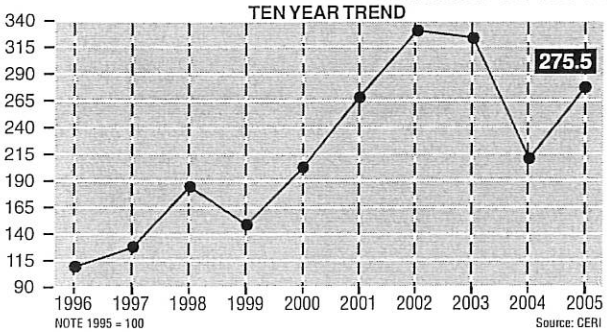
JOHNSON COUNTY: INDEX OF CORPORATE FORMATION



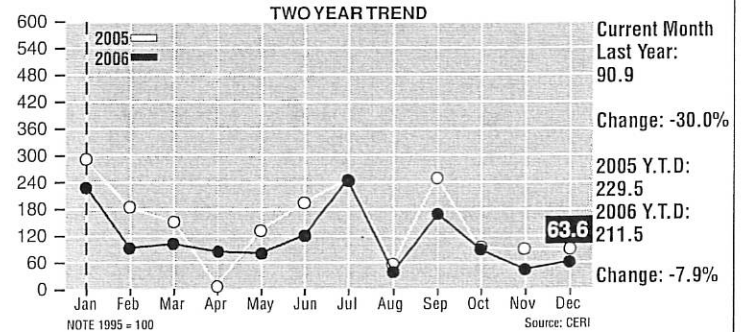
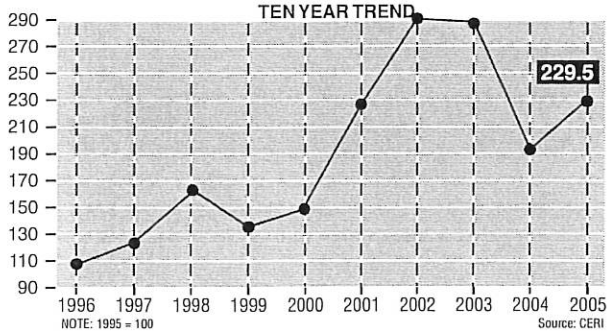
STATE OF KANSAS: INDEX OF CORPORATE FORMATION



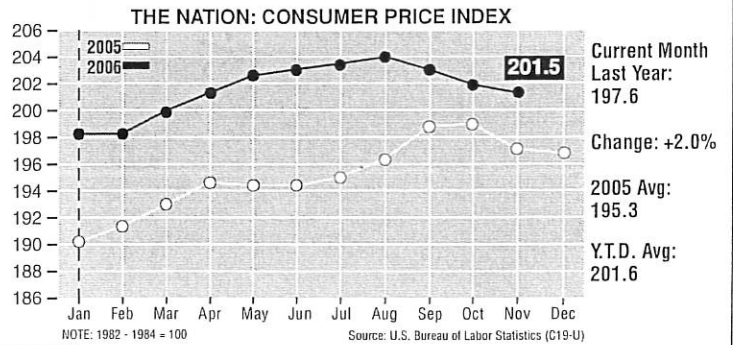
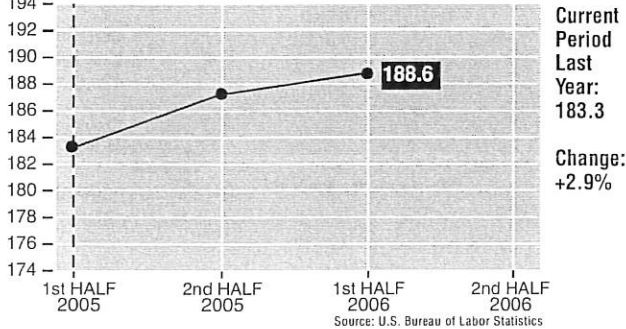
JOHNSON COUNTY: INDEX OF CORPORATE FORFEITURE



STATE OF KANSAS: INDEX OF CORPORATE FORFEITURE



KANSAS CITY METRO: CONSUMER PRICE INDEX





To: Subscribers, Johnson County Indicators
From: Doug Davidson, CERI Inc.
Date: January 10, 2007
Subject: Selected Data Analysis, January 2007 Edition of the Johnson County Indicators

LABOR FORCE AND EMPLOYMENT

This month's report presented preliminary labor force and employment data for November 2006.

Unemployment rate, November 2006	3.9%
Average unemployment rate same month previous 5 years	4.64%
Highest unemployment rate same month previous 5 years	5.1% (2003)
Lowest unemployment rate same month previous 5 years	4.3% (2005)

RESIDENTIAL REAL ESTATE

This month's report presented preliminary residential real estate data for November 2006.

Number of Johnson County homes sold by realtors, November 2006	723
Average number of homes sold same month previous 5 years	788
Largest number same month previous 5 years	837 (2005)
Smallest number same month previous 5 years	737 (2003)
Number of Johnson County homes sold by realtors, year-to-date, 2006	9,988
Average number of homes sold same period previous 5 years	10,213
Largest number same period previous 5 years	10,819 (2005)
Smallest number same period previous 5 years	9,472 (2002)
Real (inflation-adjusted) change in price of homes sold from Nov. 2005 to Nov. 2006	-3.6%
Average real annual change in price of homes sold same period previous 5 years.....	+0.2%

RESIDENTIAL BUILDING PERMITS

This month's report presented the number of residential building permits issued in Johnson County during November, 2005.

Number of single-family building permits issued, November 2006	116
Average number of single-family building permits issued same month previous 5 years.....	259
Largest number same month previous 5 years	331 (2001)
Smallest number same month previous 5 years	228 (2005)
Number of single-family building permits issued year-to-date, 2006	2,317
Average number of single-family building permits issued same period previous 5 years	3,164
Largest number same period previous 5 years	3,289 (2004)
Smallest number same period previous 5 years	2,842 (2005)
Number of multi-family building permits issued, November 2006	271
Average number of multi-family building permits issued same month previous 5 years.....	121
Largest number same month previous 5 years	424 (2005)
Smallest number same month previous 5 years	27 (2001)
Number of multi-family building permits issued year-to-date, 2006	1,115
Average number of multi-family building permits issued same period previous 5 years.....	1,101
Largest number same period previous 5 years	1,768 (2001)
Smallest number same period previous 5 years	563 (2002)

VALUE OF CONSTRUCTION

This month's report presents the value of construction contracts recorded during November, 2006.

Total value of construction contracts let year-to-date, 2006	\$1,429,075,000
Average real (inflation-adjusted) value of construction contracts same period previous 5 years	\$1,535,900,229
Largest real (inflation-adjusted) value same period previous 5 years	\$1,675,958,914 (2005)
Lowest real (inflation-adjusted) value same period previous 5 years	\$1,409,000,676 (2001)

VALUE OF CONSTRUCTION (continued)

Value of Non-Residential construction contracts let year-to-date, 2006	\$497,550,000
Average real (inflation-adjusted) value of construction contracts same period previous 5 years	\$409,976,725
Largest real (inflation-adjusted) value same period previous 5 years.....	\$499,794,441 (2005)
Lowest real (inflation-adjusted) value same period previous 5 years	\$328,999,808 (2003)
Value of Residential construction contracts let year-to-date, 2006	\$718,586,000
Average real (inflation-adjusted) value of construction contracts same period previous 5 years	\$916,877,280
Largest real (inflation-adjusted) value same period previous 5 years.....	\$1,003,645,126 (2004)
Lowest real (inflation-adjusted) value same period previous 5 years	\$857,449,515 (2001)
Value of Non-Building construction contracts let year-to-date, 2006	\$212,939,000
Average real (inflation-adjusted) value of construction contracts same period previous 5 years	\$209,128,686
Largest real (inflation-adjusted) value same period previous 5 years.....	\$278,108,750 (2005)
Lowest real (inflation-adjusted) value same period previous 5 years	\$133,297,816 (2001)

RETAIL SALES

This month's report presented an estimate of the retail sales made in Johnson County based on city sales and use tax disbursements from the Kansas Dept. of Revenue to cities from January 2006 through December 2006. These disbursements corresponded to taxes collected for retail sales made November 2005 through October 2006.

Total retail sales, November 2005 – October 2006	\$9,179,230,944
Average real (inflation-adjusted) retail sales same period previous 5 years	\$9,222,775,801
Nominal (not adjusted for inflation) change in retail sales same period previous year	+3.8%
Average nominal annual change in retail sales same period previous 5 years	+1.6%

JOHNSON COUNTY INDEX OF CONSUMER CONFIDENCE

This month's report presented the December 2006 Johnson County Index of Consumer Confidence

Johnson County Index of Consumer Confidence, December 2006	128.5
Direction of change from previous month	Positive
Length of trend	1 Month
Average for month previous 5 years	122.5
Highest level, same month previous 5 years	133.1 (2001)
Lowest level, same month previous 5 years.....	112.1 (2003)

JOHNSON COUNTY INDEX OF HELP WANTED ADVERTISING

This month's report presented the December 2006 Johnson County Index of Help Wanted Advertising

Johnson County Index of Help Wanted Advertising, December 2006	124.5
Direction of change from previous month	Negative
Length of trend	1 Month
Average for month previous 5 years	127.7
Highest level, same month previous 5 years	146.8 (2001)
Lowest level, same month previous 5 years.....	112.6 (2002)

JOHNSON COUNTY INCORPORATIONS & CORPORATE FORFEITURES

This month's report presents the Johnson County Indices of Corporate Formation and Corporate Forfeiture based on the articles of incorporation filed or forfeited with the Kansas Secretary of State in December 2006.

Articles of Incorporation filed year-to-date, 2006	4,426
Average for period previous 5 years.....	4,119
Largest number same period previous 5 years.....	4,765 (2005)
Smallest number same period previous 5 years	3,165 (2001)
Change in number of articles of incorporation filed same period previous year	-7.1%
Average annual change in number of filings same period previous 5 years	+10.8%
Articles of Incorporation forfeited year-to-date, 2006	2,979
Average for period previous 5 years.....	3,099
Largest number same period previous 5 years.....	3,715 (2002)
Smallest number same period previous 5 years	2,369 (2004)
Change in number of articles of incorporation forfeited same month previous year	-4.2%
Average annual change in number of forfeitures same period previous 5 years	+3.7%