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Report to Congressional Committees

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Across-the-Board Physician Rate Increase Would be Costly and Unnecessary

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The Department of Defense (DOD) offers health care to its 8.3 million active duty personnel, retirees, and their dependents through its managed health care program called TRICARE. About 75 percent of this care is provided through DOD medical centers, hospitals, and clinics. Civilian physicians, hospitals, and clinics provide the remaining care. Civilian physician care is provided through DOD contracted regional networks or from nonnetwork physicians who are willing to accept TRICARE's reimbursement rates. DOD reimburses both network and nonnetwork physicians using TRICARE's established reimbursement rates, which generally equal Medicare rates. However, prior to 1991, when the Congress directed DOD to gradually move its rates to Medicare levels, DOD's reimbursement rates had been on average 50 percent higher than Medicare's.

Military beneficiaries in some locations, such as rural Alaska, are having difficulty obtaining care from civilian physicians, especially certain types of specialty care, and some specialists are seeking reimbursements higher than what TRICARE allows. In areas where access is impaired, DOD can increase TRICARE rates to encourage physicians to treat military beneficiaries. It has done this in rural Alaska because it determined the problem was most severe there. However, continued congressional concerns over beneficiary access to care led the Congress, in the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 (P.L.106-398), to require DOD to designate higher physician reimbursement rates in localities where it determines that without payment of such rates access to health care services would be severely impaired. Further, the act requires that we determine and report on the financial and management impact of increasing rates. This report describes (1) the potential cost increase if TRICARE's reimbursement rates were set nationally at the 70th percentile of physician-billed charges rather than the current rate[1] and (2) whether

[1]The act instructed us to report on the utility of limiting reimbursement to 70 percent of usual and customary rates rather than DOD's current maximum. However, because industry and DOD representatives told us that usual and customary is not universally defined or widely used, we agreed with the committees of jurisdiction to use the 70th percentile of billed charges as a substitute.

DOD's use of existing authorities to increase rates has improved physicians' willingness to accept TRICARE beneficiaries in Alaska.

To conduct our work, we interviewed representatives from DOD, physician and beneficiary interest groups, DOD's TRICARE civilian contractors, the Health Care Financing Administration (HCFA), and the Department of Veterans Affairs (VA). We also visited military treatment facilities in Alaska and analyzed DOD's databases to determine the effect of increased reimbursement rates on health care access in Alaska and to estimate the cost of moving rates to the 70th percentile of billed charges. We conducted our work from September 2000 through April 2001 in accordance with generally accepted government accounting standards. (See app. I for details on our scope and methodology.)

Results In Brief

Changing the TRICARE reimbursement rate nationally to the 70th percentile of billed charges would be costly, inflationary, and largely unnecessary. We estimate that such an increase could cost DOD and its beneficiaries an additional $604 million annually with most of this being paid by DOD. Moreover, an across-the-board increase is unnecessary at this time because the vast majority of military beneficiaries are obtaining the care they need through military physicians and civilian physicians who accept TRICARE's reimbursement rates.

Nevertheless, access is impaired in some remote and rural areas. DOD's use of its existing authority to increase reimbursement rates in one of those areas—rural Alaska—has not encouraged civilian physicians to treat TRICARE beneficiaries. In February 2000, DOD increased its reimbursement rates for rural Alaska by 28 percent,[2] yet the number of civilian physicians willing to accept military patients in rural areas has not increased, nor has the volume of patients seen. For nonemergency care, the number of civilian physicians treating TRICARE beneficiaries actually fell by 14 percent after the rate increase was implemented. DOD's proposed regulations, which would permit further rate increases in areas where access is severely impaired, may alleviate access problems to some extent. However, some access problems will likely continue in rural Alaska because of transportation difficulties, negative attitudes towards

[2] DOD estimates that the 28 percent increase returned reimbursement rates to those in effect in rural Alaska in 1992 when DOD began lowering its reimbursement rates to Medicare levels.

government programs, and the lack of some specialty physicians. We requested comments from DOD on a draft of this report, but none were provided.

Background

DOD has an annual health care budget of about $16 billion. The department's primary medical mission is to maintain the health of 1.6 million active duty service personnel and provide them health care services during military operations. DOD also offers health care to 6.7 million nonactive duty beneficiaries, including dependents of active duty personnel, military retirees, and dependents of retirees. Until recently, DOD's responsibility for its over-65 population was limited to providing space-available care.[3] However, with the advent of the TRICARE for Life program for these beneficiaries in October 2001, DOD will assume additional responsibilities for their care, including supplementing their Medicare entitlement to cover Medicare cost-sharing and deductibles and to provide TRICARE benefits not covered by Medicare.[4]

About 75 percent of care under TRICARE is provided in military-operated health care facilities worldwide with the remaining care supplied by civilian physicians, hospitals, and clinics. TRICARE is a triple-option benefit program designed to give beneficiaries a choice among a health maintenance organization (TRICARE Prime), a preferred provider organization (TRICARE Extra), and a fee-for-service benefit (TRICARE Standard).[5] In all states except Alaska, TRICARE's civilian contractors must create civilian networks of physicians in designated locations for the Prime option. Beneficiaries who do not enroll in Prime can use network physicians to obtain care under TRICARE's Extra option. During network development, contractors recruit physicians, negotiate reimbursement rates, and verify professional credentials. In Alaska, DOD is responsible for these tasks.

[3] Currently, active duty and other beneficiaries enrolled in TRICARE's networks have priority for care at military treatment facilities. All others—including the over age 65 population—are eligible for care at military treatment facilities when space and professional services are available.

[4] The Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 (P.L. 106-398) establishes the TRICARE for Life program.

[5] Beneficiaries are not required to enroll in the Extra option or to exclusively use network physicians but may use network physicians on a case-by-case basis. Under the Extra option, beneficiaries receive a discount when they choose a physician from the contractor's network.

To reimburse civilian physicians, DOD has established a fee schedule—the CHAMPUS maximum allowable charge (CMAC) rates—which is the highest amount DOD will pay civilian network physicians for providing medical services to TRICARE patients.[6] The contractors may negotiate with network physicians to accept a payment below the CMAC rate. Nonnetwork physicians are paid at the CMAC rate, but they are allowed to charge TRICARE Standard patients an additional fee, to "balance bill" up to 15 percent above the allowed CMAC rate.[7] The contractors directly reimburse network physicians or those physicians who agree to accept the CMAC rate as payment in full. For those physicians who balance bill, contractors reimburse the patients, who are then responsible for ensuring that the physicians receive payment.

DOD is statutorily required to use HCFA's Medicare fee schedule to set its CMAC rates.[8] The Medicare fee schedule is developed by assigning relative weights to medical procedures, reflecting the resources required to perform them. The weights are multiplied by a dollar amount—the conversion factor—to determine payments. HCFA annually calculates the conversion factor based on a congressionally mandated formula designed to control overall spending over time while accounting for cost factors. DOD's CMAC rates are always at least equal to the current Medicare physician fee schedule, although network physicians may agree to accept reductions from CMAC amounts in exchange for network referrals and the potential for increased numbers of patients.

In response to a series of public laws beginning with the Department of Defense Appropriations Act, 1991 (P.L. 101-511), DOD began reducing its rates to Medicare levels by a maximum of 15 percent a year. This transition is not quite complete and as of February 2001, 4 percent of the national CMAC rates remained higher than Medicare's rates.[9] Both

[6] Prior to TRICARE, DOD provided civilian health care through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Although this program no longer exists, the term is still used when establishing reimbursement rates.

[7] If a TRICARE Prime patient is referred to a nonnetwork physician who balance bills, then DOD, rather than the beneficiary, pays the additional amount.

[8] 10 U.S.C. 1079(h).

[9] The higher rates were on average about 5 percent higher than Medicare's rates, and they account for only 1 percent of services provided. We determined that DOD's methods for transitioning CMAC rates to the Medicare payment level complied with statutory requirements. See *Defense Health Care: Reimbursement Rates Appropriately Set; Other Problems Concern Physicians* (GAO/HEHS-98-80, Feb. 26, 1998).

Medicare and DOD adjust their national rates for geographic differences in practice costs to develop locality-based rates. The Medicare and CMAC rates are higher in Alaska than in any other area of the country.

In addition to making adjustments for geographical differences, DOD has the authority to increase rates up to its estimated 1992 levels in areas where access is impaired to encourage civilian physician participation.[10] Proposed regulations would permit DOD to establish a higher payment rate in areas where adequate access to health care services is severely impaired. These regulations also would allow DOD to reimburse network physicians up to 115 percent of the CMAC rate where necessary to ensure an adequate number and mix of qualified network physicians in a specific locality.[11]

Increasing Rates To 70th Percentile Of Billed Charges Would Be Costly, Inflationary, And Unnecessary

A national across-the-board rate increase to a level such as the 70th percentile of billed charges could cost DOD and its beneficiaries about $604 million annually.[12] Moreover, such a change is not needed because the vast majority of beneficiaries are obtaining needed medical care through TRICARE's networks of civilian physicians, through other civilian physicians who accept TRICARE Standard, or through military treatment facilities. Also, DOD has the authority to increase rates on a locality basis as needed.

Based on our simulation, raising reimbursement limits to the 70th percentile of billed charges could increase outlays for TRICARE civilian physician services by about $604 million—about 60 percent above

[10] Prior to 1992, when DOD began using a fee schedule for CMAC rates, CMAC rates had been established by calculating the 80th percentile of physicians' billed charges. The 28 percent rate increase that was authorized for rural Alaska in February 2000 represents the average difference between 1999 CMAC rates and 1992 CMAC rates in rural Alaska.

[11] The proposed rule was published May 30, 2000 (65 Fed. Reg. 34423). The final rule is expected later this year.

[12] This estimate includes physicians only. If other health care providers—such as nurse practitioners and physical therapists—were included, potential costs would be higher. A detailed discussion of our assumptions and methodology is contained in app. I.

reimbursements at the current CMAC rate.[13] The long-term effect of increasing rates to the 70th percentile could be even greater as this system would base future payments on current charges—encouraging physicians to increase their charges now to receive higher payments in the future. Such billing changes could force rates to spiral upwards—increasing each year at a faster rate than the current policy—as was occurring prior to DOD's move to Medicare rates. In addition, changing the methodology for rate-setting to a charge-based system—such as one based on the 70th percentile of billed charges—would uncouple TRICARE rates from Medicare rates, which are based on expenses and resources used by various physician specialties.

Furthermore, an across-the-board rate increase is not necessarily needed to encourage physicians to treat military beneficiaries. In a June 1999 report to the Congress, DOD stated that its networks are generally adequate.[14] Also, 96 percent of the time, civilian physicians who treat TRICARE beneficiaries accept the CMAC amount as payment in full—the highest level in history. Further, DOD officials told us that beneficiaries' inability to access care only existed within certain physician specialties. Moreover, rate increases—regardless of their size—would not improve access in areas where no physicians in a specialty practice.[15] Our March 2000 report confirmed that DOD's networks were generally adequate except for spotty deficiencies in rural areas—particularly those that are considered medically underserved and those with low managed care penetration.[16]

[13] According to DOD's consultant responsible for setting CMAC rates, beneficiary copayments and deductibles along with other health insurance have historically been about 25 percent of CMAC rates. With the elimination of copayments for active duty dependents enrolled in Prime as directed by the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 (P.L.106-398), DOD will be responsible for a greater portion of the costs.

[14] Department of Defense report to the Congress: *TRICARE Head Injury Policy and Provider Network Adequacy*, June 17, 1999.

[15] For example, according to a DOD official in Fairbanks, the following specialties lack a civilian specialist in the Fairbanks area: allergy, cardiology, endocrinology, gastroenterology, infectious disease, neonatology, nephrology, nuclear medicine, preventive medicine, rheumatology, colorectal surgery, neurosurgery, and cardio-thoracic surgery.

[16] *Military Health Care: TRICARE's Civilian Provider Networks* (GAO/HEHS-00-64R, Mar.13, 2000).

DOD has processes in place to monitor and resolve access problems. DOD assigns a lead agent in each region primary responsibility for monitoring certain aspects of TRICARE contracts to ensure that network adequacy is maintained. Contractors report on network adequacy to their respective lead agents quarterly. As problem areas are identified, contractors work to recruit additional physicians into their networks. Also, the commanders of military treatment facilities work with contractors to resolve any problems and sometimes are able to bring in additional military physicians to help with the workload.

DOD's Increased CMAC Rates In Alaska Have Had Little Effect On Patient Access To Care

Visits to Alaska by DOD officials in 1999 highlighted access problems and other care issues that had been under review by DOD since 1997. To address these problems, in February 2000, DOD returned CMAC rates to estimated 1992 levels in rural Alaska—an increase of 28 percent above the current Medicare rate.[17] At about the same time, the Coast Guard terminated its practice of paying close to billed charges for active duty personnel stationed in rural Alaska and began reimbursing at CMAC rates—a reduction for which the 28 percent increase did not fully compensate. Overall, beneficiary access to care in rural Alaska has not improved since these rate changes.

Since the implementation of the across-the-board 28-percent rate increase in rural Alaska, fewer Alaskan physicians have accepted TRICARE patients even though DOD personnel reported that each physician had been notified of the rate increase. (See table 1.) DOD data show that the number of those physicians decreased more in rural Alaska, where rates were increased, than in Anchorage, where rates remained at Medicare levels. Further, the number of patient visits in rural Alaska has decreased, while the number of patient visits increased in Anchorage. Overall, the number of Alaska physicians and the number of TRICARE beneficiaries have essentially remained constant since the rate increase.

[17] DOD used its authority to grant special locality-based waivers for the 28 percent increase in rural Alaska. Rates in Anchorage remain at Medicare levels. Proposed regulations will give DOD the authority to raise rates beyond 1992 levels for network and nonnetwork physicians and to reimburse network physicians up to 115 percent of CMAC in areas without an adequate number and mix of qualified network physicians.

Table 1: Access Indicators for Nonemergency Care, Before and After Rural Alaska Rate Increase

	Anchorage			Rest of Alaska		
	March to August 1999	March to August 2000	Percent change	March to August 1999	March to August 2000	Percent change
Number of patient/civilian physician encounters	6,296	6,634	5	6,543	6,255	-4
Number of patients using civilian care	1,987	1,868	-6	2,758	2,695	-2
Number of civilian physicians treating TRICARE patients	417	380	-9	454	389	-14

Source: GAO analysis of DOD data.

While CMAC reimbursement rates in rural Alaska are now higher than Medicare's, access may not have improved because the rates are still low compared to those paid by private insurers, VA, and the Indian Health Service, which usually pay billed charges. For example, the rural Alaska CMAC rates for 31 high-cost and high-volume procedure codes averaged 57 percent of a private insurer's rates. (See app. II for a comparison of these 31 rates.) In addition, the number of civilian physicians treating patients may have been affected by changes in the Coast Guard's civilian physician reimbursement rates. In early 2000 the Coast Guard, to get its reimbursement rates in line with CMAC, began to reduce reimbursement—from close to billed charges to CMAC rates—for the majority of civilian physicians treating its 1,700 active duty personnel stationed in rural Alaska. According to DOD officials, some civilian physicians in rural Alaska are refusing to accept Coast Guard patients because the 28 percent increase does not fully compensate for the reduction from billed charges.

DOD's increased reimbursement rates in rural Alaska also may have had little effect on beneficiaries' access to care because of the unique challenges in obtaining health care there. For example, a small number of physicians serve a very large area,[18] roads are often impassable or nonexistent, and if health care is not available locally, patients—private as well as military—must be transported by air to other locations.

The Alaska Medical Association, DOD representatives, and a private insurer told us that the high demand for health care services in Alaska

[18] Alaska is about 19 percent as large as the size of the combined lower 48 states. About 1,128 physicians provided health care for this area in 1998, about 1 physician for 506 square miles and about 1 physician per 545 residents. In comparison, the lower 48 states have about 1 physician per 4.5 square miles and about 1 physician per 411 residents.

allows physicians to be selective in accepting patients. For example, the private insurer in Alaska told us that it had to pay reimbursement rates at or near physicians' billed charges to ensure access for beneficiaries. Further, in discussions with private physicians and DOD and medical association officials, it became apparent that Alaska's culture of self-reliance and independence contributes toward many physicians' reluctance to become involved with government programs and managed care arrangements. Alaska physicians also view TRICARE patients as transient and believe that DOD should provide care for them through the military health system or pay physicians' billed charges. While physicians also consider Medicare reimbursements inadequate and sometimes refuse to accept them, they told us they are more receptive to accepting Medicare beneficiaries because of community obligations and long-standing relations with these patients.

Conclusions

Accessing health care—especially specialty care—for active duty personnel and their family members stationed in remote areas is not a widespread problem. In areas where access is a problem, one solution is to increase reimbursement rates. Although DOD's across-the-board rate increase in one locality has not improved access to care, pressure remains for further increases. However, DOD must be judicious about using such rate increases because they will be costly. Problems with access to care are infrequent and primarily related to specialty care, yet across-the-board increases would raise rates for all types of physicians. Rate increases, targeted to localities where access to care is severely impaired, may improve access to care, but other problems such as the scarcity of physicians and transportation difficulties are likely to remain. Responding to physician demands to pay based on billed charges—a practice DOD abandoned in 1992 when its health care costs were spiraling upward—would not only increase current program costs but also has the potential to further inflate government outlays, as physicians would likely raise rates over time, pushing TRICARE rates higher.

Agency Comments And Our Response

We requested comments from DOD on a draft of this report, but none were provided.

We are sending copies of this report to the Honorable Donald H. Rumsfeld, Secretary of Defense; appropriate congressional committees; and other interested parties. We will also make copies available to others upon request.

If you or your staff have any questions about this report, please contact me at (202) 512-7111 or Michael T. Blair, Jr., at (404) 679-1944. Lois L. Shoemaker and William R. Simerl made key contributions to this report.

Stephen P. Backhus
Director, Health Care—Veterans'
and Military Health Care Issues

List of Committees

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Appendix I: Scope and Methodology

We obtained information on DOD's procedures for setting its reimbursement rates from DOD officials and DOD's contractor that analyzes rate data. Because DOD rates are based on Medicare rates, we interviewed a Health Care Financing Administration (HCFA) official to determine how HCFA sets the Medicare rates.

To determine the extent that military beneficiaries are unable to obtain access to health care, we interviewed DOD officials and representatives from both the National Military Family Association and the American Medical Association. We also analyzed DOD participation data and our previous work in this area.

To determine how increased DOD reimbursement rates would affect physicians' willingness to treat military beneficiaries and to determine the basis of physician complaints about CMAC rates and TRICARE, we spoke to members of the local medical societies, private insurers, and VA personnel in Alaska. To determine whether and how physicians' concerns were being addressed, we interviewed local military officials and contractors as well as DOD officials at TRICARE Management Activity.

To determine how military health care reimbursement rates compare to those of other insurers, we selected six specialty areas for which DOD and contractors in Alaska were having difficulties obtaining care—dermatology, plastic surgery, otolaryngology, orthopedic surgery, gastroenterology, and allergy. For each of these specialties we determined DOD's six highest volume and six highest overall cost procedures and identified a total of 31 high-cost or high-volume procedures. For these codes we obtained CMAC reimbursement rates in Anchorage, Alaska, and rural Alaska. We compared these rates with Medicare rates, private insurance rates, the VA average amounts paid, and physicians' average billed charges for these high-cost or high-volume procedures. We also calculated the CMAC rate as a percentage of the private insurer's rate.

To determine whether increased rates would improve access to care, we studied the effect of DOD's Alaska rate increase. We obtained DOD's health care service record file containing records of completed claims for health care in Alaska that were processed from March 1, 1999 through October 31, 2000. We eliminated claims for emergency room care from these data. We excluded these claims because the Emergency Medical Treatment and Active Labor Act requires physicians to evaluate all patients who come for care and treat emergencies regardless of patients' ability to pay for the care. We analyzed data for both Anchorage and rural Alaska for care delivered from March 1, 1999 through August 31, 1999, and

March 1, 2000 through August 31, 2000, a 6-month period before the rate increase and a similar 6-month period after the February 2000 increase. Because claims can be submitted for payment any time up to a year after care is delivered, we allowed equal times for claims processing after each 6-month period—calculating claims processed for the first 6 months by October 31, 1999, and for the second by October 31, 2000. For these periods and locations, we determined the number of civilian physicians who treated TRICARE patients, the number of TRICARE patients who were treated by civilian physicians, and the overall number of TRICARE patient encounters with civilian physicians. To eliminate duplicate provider records, we manually matched each physician number in our data with DOD's physician file, a process that sometimes required a judgmental decision. Our work did not provide information on the number of beneficiaries who were unable to obtain civilian care following the rate increase. While we did not independently verify the accuracy of the data, we conducted reliability tests to ensure consistency of the data against documentation provided by DOD.

70th Percentile Cost Simulation

To calculate the effect on costs of changing reimbursement rates from the CMAC rate to the 70th percentile of billed charges, we enlisted the assistance of DOD's contractor responsible for determining annual CMAC rates. We asked the contractor to use its database of civilian claims from the period July 1, 1999 through June 30, 2000, to simulate total nationwide payments of claims for physician services as if they were paid at the 2001 national CMAC rates.[1] Next, we asked the contractor to simulate the total nationwide payments for these claims as if they had been paid at the 70th percentile of physicians' billed charges calculated for the same period to determine a national prevailing charge for each CMAC rate. The contractor's simulations were done on an individual claim basis, considering the actual billed charge, for the best estimate of payment amounts, because DOD would only pay the lesser of billed charges or the payment limitation. We calculated the difference between the 2001 CMAC and the 70th percentile of billed charges simulation to estimate the potential cost of increased reimbursement authorities.

Our simulations were calculated with a national 70th percentile charge rather than locality-specific 70th percentile charges. Results would have differed if rates had been calculated at the locality level. Also, results

[1]DOD used this database to calculate the 2001 CMAC rates.

could differ because of physicians' negotiated discounts. Further, although most of the claims had been processed at the time of our analysis, some had not. Results could differ if these claims had been available for inclusion.

We performed our work from September 2000 through April 2001 in accordance with generally accepted government accounting standards.

Appendix II: Comparison of CMAC Rates with Private Insurers' and Other Government Programs' Rates and with Billed Charges

Table 2: Rate Comparison for Anchorage, Alaska

Procedure code	Procedure code description	Anchorage Alaska CMAC	Alaska Medicare (all of Alaska)	VA average paid FY00 (all of Alaska)	Private insurer (Anchorage rate)	Average billed charge, July 1999 through June 2000	CMAC as percentage of private insurer's rate
11100	Biopsy of skin	$78.44	$78.44	$122.26	$152.12	$137.49	52
14060	Adjacent tissue transfer	$721.39	$721.40	$1,852.25	$1,992.46	not available	36
17000	Destruction of first benign lesion	$56.82	$56.82	$95.02	$117.91	$103.42	48
17003	Destruction of each additional benign lesion	$14.99	$14.99	$96.84	$32.95	$89.71	45
19318	Breast reduction mammaplasty	$1,239.98	$1,239.97	not available	$3,872.26	not available	32
19357	Breast reconstruction with tissue expander	$1,366.44	$1,366.44	not available	$3,741.98	$6,909.00	37
19361	Breast reconstruction with latissimus dorsi flap	$2,368.09	$1,576.18	not available	$5,081.36	not available	47
19367	Breast reconstruction with free flap	$1,939.18	$1,939.18	not available	$5,745.02	not available	34
20610	Introduction or removal/major joint	$83.51	$83.50	$136.74	$131.88	$160.14	63
27447	Arthroplasty, knee	$1,855.68	$1,855.68	not available	$5,914.55	$5,696.25	31
29881	Arthroscopy, knee, surgical	$704.25	$704.25	$1,839.02	$2,556.81	$2,530.50	28
43239	Gastrointestinal endoscopy with biopsy	$277.87	$277.87	$656.92	$730.26	$771.15	38
43243	Gastrointestinal endoscopy with injection sclerosis	$344.76	$344.76	$963.33	$1,045.06	not available	33
43244	Gastrointestinal endoscopy with band ligation	$309.46	$309.46	$736.13	$852.62	$1,000.00	36
45378	Colonoscopy	$383.65	$383.65	$789.90	$840.37	$795.73	46
45380	Colonoscopy with biopsy	$415.89	$415.90	$812.53	$986.84	$994.67	42
45385	Colonoscopy with lesion removal	$530.81	$530.81	$1,096.78	$1,287.32	$1,102.00	41
69436	Tympanostomy	$171.32	$171.33	$432.83	$538.28	$633.33	32
88305	Surgical pathology	$86.97	$86.97	$273.24	$238.70	$223.97	36
95004	Allergy tests: percutaneous	$4.86	$4.86	$312.29	$11.21	$8.41	43
95024	Allergy tests: intracutaneous	$7.01	$7.00	$211.00	$16.63	$9.99	42
95115	Allergen immunotherapy, single injection	$18.30	$18.30	$19.00	$43.00	$15.00	43

Procedure code	Procedure code description	Anchorage Alaska CMAC	Alaska Medicare (all of Alaska)	VA average paid FY00 (all of Alaska)	Private insurer (Anchorage rate)	Average billed charge, July 1999 through June 2000	CMAC as percentage of private insurer's rate
95117	Allergen immunotherapy, two or more injections	$23.45	$23.46	not available	$54.92	$12.50	43
95165	Supervision/provision of antigens	$10.62	$10.63	$108.99	$17.74	$12.42	60
99202	Office visit/new patient: low to moderate severity	$71.28	$71.28	$87.75	$126.06	$97.04	57
99203	Office visit/new patient: moderate severity	$99.89	$99.89	$118.69	$171.98	$125.42	58
99212	Office visit/established patient: not severe	$38.83	$38.82	$60.99	$69.42	$63.41	56
99213	Office visit/established patient: low to moderate severity	$52.97	$52.97	$81.13	$98.93	$83.25	54
99214	Office visit/established patient: moderate to high severity	$81.56	$81.56	$117.52	$148.19	$131.65	55
99242	Office consultation: low severity	$103.22	$103.23	$137.25	$213.70	$171.02	48
99243	Office consultation: moderate severity	$131.27	$131.26	$142.87	$275.87	$193.59	48
					Average percentage of private rate		44

Table 3: Rate Comparison for the Rest of Alaska

Procedure code	Procedure code description	Rest of Alaska CMAC	Alaska Medicare (all of Alaska)	VA average paid FY00 (all of Alaska)	Private insurer (Fairbanks rate)	Average billed charge, July 1999 through June 2000	CMAC as percentage of private insurer's rate
11100	Biopsy of skin	$100.48	$78.44	$122.26	$160.77	$122.45	62
14060	Adjacent tissue transfer	$924.10	$721.40	$1,852.25	$2,105.80	$1,594.00	44
17000	Destruction of first benign lesion	$72.79	$56.82	$95.02	$124.61	$95.08	58
17003	Destruction of each additional benign lesion	$19.20	$14.99	$96.84	$34.82	$36.56	55
19318	Breast reduction mammaplasty	$1,588.41	$1,239.97	not available	$4,092.52	$3,361.46	39
19357	Breast reconstruction with tissue expander	$1,750.41	$1,366.44	not available	$3,954.83	not avail	44
19361	Breast reconstruction with latissimus dorsi flap	$3,033.52	$1,576.18	not available	$5,370.40	not avail	56
19367	Breast reconstruction with free flap	$2,484.09	$1,939.18	not available	$6,071.80	$8,553.67	41
20610	Introduction or removal/major joint	$106.98	$83.50	$136.74	$134.57	$133.94	79
27447	Arthroplasty, knee	$2,377.13	$1,855.68	not available	$6,250.98	$6,572.00	38
29881	Arthroscopy, knee, surgical	$902.14	$704.25	$1,839.02	$3,009.86	$2,422.80	30
43239	Gastrointestinal endoscopy with biopsy	$355.95	$277.87	$656.92	$829.84	$857.98	43
43243	Gastrointestinal endoscopy with injection sclerosis	$441.64	$344.76	$963.33	$1,043.06	not available	42
43244	Gastrointestinal endoscopy with band ligation	$396.42	$309.46	$736.13	$835.86	$1,093.00	47
45378	Colonoscopy	$491.46	$383.65	$789.90	$932.11	$826.41	53
45380	Colonoscopy with biopsy	$532.76	$415.90	$812.53	$1,017.35	$1,038.92	52
45385	Colonoscopy with lesion removal	$679.97	$530.81	$1,096.78	$1,472.18	$1,415.50	46
69436	Tympanostomy	$219.46	$171.33	$432.83	$538.28	$584.67	41
88305	Surgical pathology	$111.41	$86.97	$273.24	$219.78	$157.48	51
95004	Allergy tests: percutaneous	$6.23	$4.86	$312.29	$9.16	$8.19	68
95024	Allergy tests: intracutaneous	$8.98	$7.00	$211.00	$13.59	$10.53	66
95115	Allergen immunotherapy, single injection	$23.44	$18.30	$19.00	$35.14	$35.05	67

Procedure code	Procedure code description	Rest of Alaska CMAC	Alaska Medicare (all of Alaska)	VA average paid FY00 (all of Alaska)	Private insurer (Fairbanks rate)	Average billed charge, July 1999 through June 2000	CMAC as percentage of private insurer's rate
95117	Allergen immunotherapy, two or more injections	$30.04	$23.46	not available	$44.88	$19.54	67
95165	Supervision/provision of antigens	$13.60	$10.63	$108.99	$14.50	$8.00	94
99202	Office visit/new patient: low to moderate severity	$91.31	$71.28	$87.75	$132.86	$97.19	69
99203	Office visit/new patient: moderate severity	$127.96	$99.89	$118.69	$181.26	$132.55	71
99212	Office visit/established patient: not severe	$49.74	$38.82	$60.99	$73.16	$60.06	68
99213	Office visit/established patient: low to moderate severity	$67.85	$52.97	$81.13	$104.26	$81.60	65
99214	Office visit/established patient: moderate to high severity	$104.48	$81.56	$117.52	$156.18	$119.23	67
99242	Office consultation: low severity	$132.22	$103.23	$137.25	$174.64	$169.79	76
99243	Office consultation: moderate severity	$168.16	$131.26	$142.87	$242.22	$227.41	69
				Average percentage of private rate			57

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