

Managed Care Report

The publication of record for managed care since 1986

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CONSUMER-DRIVEN HEALTH PLANS

4 Lessons From The Consumer-Driven Battleground

► *Here's what the early adopters have learned.*

Health insurers are scrambling to offer new consumer-driven health plan products, but the road to success has many a pitfall.

Although a growing number of employers are turning to CDHPs, most consumers are still perplexed by the new offerings. At the recent National Managed Health Care Congress in Washington, health plan executives and vendors shared their experiences from the CDHP front lines, offering the following lessons to those who want to follow in their footsteps:

- **Beef up customer service.** As obvious as it may sound, health insurers need to ensure that consumers understand the new plan designs, said **Lawrence Leisure of Kaiser Permanente**. Early experiences show that consumers are often confused and dismayed by their new plans.

Remember that most people spend about five minutes choosing a health plan — or they don't even have a choice and are simply stuck with whatever their employer offers, said **David Compton of Harvard Pilgrim Health Care**. As a result, they may understand very little about what makes CDHPs different from traditional coverage.

Harvard Pilgrim has offered a CDHP since early 2003, and its most common customer service question from CDHP members, amazingly, is "What's a deductible?" People simply did not understand their benefits, Compton said.

- **Get members involved.** The best way to get members involved right off the bat is to pay them to do a health risk assessment, Leisure said. The results of the assessment will point them towards health improvement programs or, if they're really at risk, to disease management programs.

Insurers will also need their CDHPs to provide meaningful discounts if they want to hold on to members. Many consumers have been surprised by how expensive health services can be when they don't benefit from managed care discounts, Leisure said. CDHPs should be structured so that members can use pre-tax dollars on health care so they don't feel the financial pinch as acutely.

- **Improve information outreach.** CDHPs represent a paradigm shift in which the targeted consumers are no longer employers but individual consumers, said **Robert**

Tavares of HealthShare Technology, which builds a hospital comparison tool for consumers. Insurers need to alter their outreach strategies accordingly.

"Look outside the industry for benchmarks and ideas," Tavares advised. Instead of benchmarking your customer outreach against other health plans — who themselves aren't very good at it at the moment — you should benchmark yourself against companies like **Travelocity, Orbitz and Fidelity**. These companies have mastered how to provide consumers with information so that they can make the wisest decisions in a market with seemingly infinite options.

Although studies show that people have little faith in the information they receive from health insurers, insurers can't afford to throw up their hands and insist there's nothing they can do to win trust, Compton said. They need to focus on the goal and take baby steps to improve.

Recent surveys show that only 24 percent of CDHP enrollees used insurers' decision-support tools and services to make health care decisions in the last year, said **Katherine Bimms** of pollster **Harris Interactive**. But even that is an improvement, showing that plans and consumers are making progress.

Bottom Line: Insurers should not underestimate consumers' demand for information — a demand that has not yet been met by the marketplace, Tavares said.

- **Address chronic conditions.** CDHPs need to do something to help people with chronic conditions, Leisure said. "Let's not be so naïve as to think we can reverse [the cost] trend via a wholesale switch to CDHPs," he said. CDHPs mainly save money via cost-shifting, but members with serious health conditions will be in difficult situations if their insurer hasn't figured out how to address their needs.

Indeed, recent surveys show that CDHP members are more likely than traditional health plan members to have a medical problem and not see a doctor (33 percent to 17 percent), to not seek a physical (25 percent to 19 percent), and not to take their medications as often as they should (29 percent to 14 percent), Bimms said.

Bottom Line: To be a successful solution, CDHPs must show that they can work even when people are sick. ■

MEDICARE

With Docs Threatening To Leave Medicare, Your Networks Could Start Shrinking

► *Providers have cried wolf before, but the impending cuts might finally push them too far.*

Medicare payments are on the way up for health plans, but will cuts to physician reimbursement cancel that out?

The good news: The **Centers for Medicare & Medicaid Services** announced April 4 that Medicare health plans will receive a minimum pay increase of 4.8 percent over current rates. That's nearly a percentage point higher than the estimate CMS had predicted earlier this year. The extra reimbursement should make the program even more appealing to health plans, who will be able to offer more enhancements to attract beneficiaries, **America's Health Insurance Plans** said in a statement.

The bad news: Physicians face a much more uncertain future, as physician reimbursement is slated for a 26-percent cut over the period 2005 to 2011. The newly issued Medicare Trustees Report indicates that, unless Congress intervenes, physicians will face annual cuts of 4 to 5 percent in each of the next six years.

As a result of the slated cuts, physicians are saying they may have little choice but to decrease the number of

Medicare patients they treat — a development that could make it much harder for Medicare Advantage plans to adequately staff their networks.

The **American Medical Association** released results from a new survey in which 38 percent of physicians said they would decrease the number of Medicare patients they treat due to the impending cuts.

Of course, the AMA has issued similar warnings in the past, yet there hasn't been an exodus of docs fleeing Medicare. But observers say the size of these new cuts demonstrate that the AMA isn't just crying wolf.

"How much can you keep cutting doctors?" asks **Vicki Gottlich**, an attorney with the **Center for Medicare Advocacy**. "I fully expect that there will be some doctors who decide that they can no longer afford to take new Medicare patients."

The CMA is concerned that beneficiaries will have a harder time finding physicians, Gottlich said. She admitted,

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PAY-FOR-PERFORMANCE

National Standards Spur Plan Interest In 'Bridges' Program

► *Here's why more health plans are crossing the Bridges to Excellence.*

Pay-for-performance continues to be one of the hottest trends in health care.

CareFirst BlueCross BlueShield in Maryland announced March 28 that it is launching a Bridges to Excellence program in which it will pay providers financial rewards for making information technology improvements to their practices. Rather than paying docs with money supplied by employers, CareFirst will also be the first health plan in the BTE program to pay for the rewards itself.

Large employers were the first supporters of BTE because they had the money, says **Brian Schilling** of the **National Commission for Quality Assurance**, which developed the quality standards on which BTE is based. Now that health plans are strongly in the black, they'll pick up their share of the tab. "I don't think it will be

just employers who are footing the bill in the future," Schilling predicts.

BTE is comprised of three different P4P programs: diabetes care, cardiac care or IT improvement. Participating employers and health plans can customize the programs for their markets, Schilling says.

"Plans are coming to the table because they have to be responsive to employers," says **Andy Webber**, president and CEO of the **National Business Coalition on Health**. Employers want to find ways to lower costs and improve quality, and pay-for-performance offers the promise of achieving both goals, he says.

CareFirst was attracted to BTE's Physician Practice Connection program because it uses a set of national standards that NCQA developed, explains Dr. **Jon**

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IMAGING

Do You Have High Standards For Imaging Providers?

► *MedPAC report points out the need for new standards.*

Having a hard time staying on top of rising costs for high-tech imaging? Medicare could be on the verge of extending a helping hand.

The **Medicare Payment Advisory Commission** issued a report March 17 recommending that Medicare institute quality guidelines for “providers who bill Medicare for performing and/or interpreting diagnostic imaging studies.” Under the proposal, the government would draw up the quality standards, such as requiring that providers are accredited by the **American College of**

Radiology or the **American Institute for Ultrasound in Medicine**. Medicare would then hire independent vendors to verify that providers meet the criteria.

If Congress follows MedPAC’s recommendations, that would be “a very positive and monumental first step in addressing the spiraling inflationary trends” in imaging, says **John Donahue**, president and CEO of **National Imaging Associates**.

What it means for health plans: Although the guidelines would only apply to Medicare, private health plans would still benefit from the process since they too would be able to specify, if they wished, that they would only pay for imaging services furnished by Medicare-approved providers.

Quality assessment programs are a typical part of radiology benefit management, a growing field in which vendors help health plans control their imaging costs. In addition to quality assessment, radiology benefit managers also conduct preauthorization — in which physicians must call in to receive permission before performing certain services — and privileging, in which the vendor conducts site visits and determines which providers should be allowed to perform which services, explains **Neepa Patel**, vice president of business development and marketing for **American Imaging Management**.

Private health plans have been focused on controlling imaging costs for several years, so it’s about time Medicare caught up, Donahue says. MedPAC’s report is “a vote of confidence and a good-housekeeping seal of approval on what we’ve been doing in the private sector for the past several years,” he says.

But only a quarter of health plans currently use some radiology benefit management, Patel says. Of these, roughly half do some sort of quality assessment, she says.

Policy Would Give Health Plans ‘Cover’

Many health plans have been hesitant to take certain steps to control imaging costs for fear of angering providers. Any move by Medicare would ripple across the health plan industry, Donahue says, as previously reluctant plans would finally step up their efforts to control costs.

“Plans don’t want to be perceived as outliers doing something that’s not considered a national standard,” says

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Donald Ryan, president and CEO of **CareCore National**. A new Medicare program would “give them cover” from accusations that their programs are overly stringent, he explains.

“This is gaining so much momentum — there’s a real movement afoot throughout this industry to adopt this quickly,” Donahue says.

Warning: Medicare might be reluctant to move forward for the same reason some health plans are: fear of alienating providers. For example, AIM typically sends quality applications to providers, and if the providers choose not to complete the forms, the plan could choose to drop them from the plan’s network, Patel explains. It all depends on how stringent the plan wants to be, and whether they can afford to drop certain providers due to geographic and access issues, especially in rural areas.

Any Medicare QA effort would face these same hurdles. Some providers are already marshalling their forces against such a plan. A new report by the **Lewin Group** consulting

firm argues that physician office imaging usage is merely replacing more expensive and more invasive services that have traditionally been offered in hospitals. Imaging represents “a sea change in the way medicine is practiced,” says **Patrick Brady** of the **Coalition for Patient-Centered Imaging**, which commissioned the report.

The Coalition is lukewarm to the idea of Medicare standards, says spokesman **Patrick Brady**. He notes that Medicare does not set quality guidelines for other physician services, and that it would be unfair to single out imaging.

The Lewin Group report also refutes the claim that physician self-referral has led to the overuse of imaging services, and it says that the rate of cost growth for imaging has been comparable to the growth of all Part B services.

Ryan says the report is flawed by the Coalition’s pro-physician bias and that physician ownership of imaging equipment does indeed foster overuse. “It’s impossible to refute that — the data’s too strong,” he says. ■

E-PRESCRIBING

E-Prescribing Still Challenging For IT Pioneers

► *Here’s what WellPoint has learned from its industry-leading experience.*

One of the first health plans to launch a major e-prescribing initiatives is claiming some success, but also offering warnings to other plans hoping to follow suit.

In preliminary results, **WellPoint, Inc.’s** trial of e-prescribing shows that connecting physicians via computer to prescription-drug data helps hold down costs, largely by increasing prescription of generics. But many hurdles still must be overcome before e-prescribing can be deemed a success, **Leo Barbaro**, regional vice president of WellPoint Northeast, said at the recent Health Information Technology Summit West.

In WellPoint’s much-hyped e-prescribing project, physicians’ prescriptions per member per month rose by just over 8 percent from the third quarter of 2002 to the third quarter 2003, compared to a more than 12-percent rise in prescriptions by a control group. Generic prescriptions were up by over 4 percent among e-prescribing physicians, compared to a 1 percent rise in the control group.

Nevertheless, the findings probably aren’t widely generalizable, since the e-prescribing docs were part of a “relatively sophisticated” group of primary-care physicians, said Barbaro. “Smaller, less sophisticated” physicians likely would not yield such positive results, Barbaro hypothesized.

Although e-prescribing uptake has not been overwhelming, there continues to be a steady trickle of health plans giving the technology a try. **Blue Cross of Northeastern Pennsylvania** recently announced that it is distributing 250 handheld devices containing information on drug interactions, copay levels and other information. The devices will not enable physicians to send e-prescriptions, but Blue Cross is hoping the project will serve as a stepping stone toward that goal, a spokesman tells **MCR**.

And a new **Forrester Research** study gives health plans good news and bad news on e-prescribing. Physicians are five times as likely as other consumers to use handheld computers, the study says, but they rarely use the devices to practice medicine. Only 5 to 7 percent of respondents said they used PDAs to order meds, access medical records or search for lab results.

Hoping to encourage the practice, the PBM lobbying group **Pharmaceutical Care Management Association** April 6 called on Medicare to create national e-prescribing standards. In a letter to the **Centers for Medicare & Medicaid Services**, PCMA said that if Medicare doesn’t institute national guidelines, a 50-state patchwork of standards would hinder adoption of e-prescribing.

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E-PRESCRIBING

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Meanwhile, WellPoint's pioneering experience in e-prescribing offers the following lessons:

- To implement e-medicine, "aligning economic interests" across the delivery system "will be a critical success factor," Barbaro said. E-prescribing is a definite money-saver for health insurers, but to get buy-in from providers and pharmacies, insurers need to explain what the value proposition is for these other players.

- Physicians don't want health plans to control the computers. Docs have "significant concerns" about health plans delivering and designing clinical IT, Barbaro said. There are "high levels of distrust in [the] physician community that a payer could or would or should be involved with clinical information technology solutions," he said.

- When it comes to clinical IT, "free is not cheap enough." WellPoint famously supplied 19,000 contracting network physicians with computer infrastructure to promote e-prescribing and paperwork reduction.

Nevertheless, a "significant percent of physicians" were concerned about the costs of maintaining the system after one year, Barbaro said.

- Even though it's getting press, e-prescribing still "is not high on most physicians' radar screen," Barbaro explained. There's a "significant gulf between literature reports and out actual experience."

"Office managers do not understand nor value e-prescribing," he said. And getting past the managers to reach "the actual physician requires a thoughtful approach." ■

PAY-FOR-PERFORMANCE

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Shematek, medical director for quality improvement. Because the standards were not invented by the health plan, they have more credibility and are more acceptable to physicians, he says.

It's vitally important that health plans get behind uniform measures of quality, says Dr. **Jeffrey Kang**, senior vice president and chief medical officer for **Cigna Healthcare**, which announced April 5 that it will be licensing the BTE program in Arizona, North Carolina and Houston, TX. If health plans all crafted their own quality

measures, providers wouldn't be able to keep up with them, he says. Plans should compete on quality incentives and rewards, not the measures themselves.

BTE also is a voluntary program, which fits in with the **American Medical Association's** request that P4P programs not be mandatory, Shematek points out.

Shematek confirms that "a number of Blues plans" have spoken to the insurer about following its lead and will be closely watching its progress. "This could be a very attractive program to health plans," he says. ■

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however, that CMA has not yet received many such complaints from beneficiaries.

How Physician Cuts Affect Plans

Even surveyed physicians who indicated that they would continue to see Medicare patients said they would have to make other sacrifices, such as deferring the purchase of new equipment, an AMA spokesperson tells **MCR**. If physicians have to cut corners, it will be harder for Medicare Advantage plans to show that they can increase quality in the program.

It behooves plans to show that the revamped Medicare Advantage can be a success, says AHIP spokesman **Mohit Ghose**. "Our responsibility is to work with physician groups to make sure that we're paying them to the best of our ability to meet their costs and to meet their needs," he says.

Yet plans also must hold down costs in the health care system, Ghose notes.

The AMA has launched a major lobbying campaign to sway Congress into reversing the pay cuts. The physician reimbursement formula is fundamentally flawed, and until it is replaced, crises like the current one will continue to flare up, the AMA spokesperson said. ■

REGULATORY ROUNDUP

States Using Various Strategies To Increase Access

► *Rising cost of coverage prods lawmakers into action.*

Legislators have tired of waiting for health plans to come up with more affordable offerings.

Across the country, states are crafting new proposals for increasing access, using everything from tax breaks and tax credits to mandates that employers offer coverage.

Legislators in Minnesota are crafting bipartisan legislation that would require consumers to buy at least minimal coverage, and would require health insurers to offer such plans.

Similarly, in Massachusetts, Gov. **Mitt Romney** (R) has predicted that everyone in the Bay State will be covered by January 2009 thanks to his plan to allow health plans to offer cheaper, stripped-down products. His plan — which is being championed by many Democrats in the state legislature — would also let consumers purchase individual policies with pre-tax dollars.

Critics say that won't be enough to create universal coverage, however, and that the only solution is to require employers to offer coverage.

That line of thought is evident in California, where a Senate committee approved a universal coverage bill

similar to one that voters defeated in a referendum five months ago. The bill would create a universal coverage health care system run by a state administrator and would abolish private health plans.

A less extreme version of employer mandates is being considered in Maryland, where legislators approved a bill that would require organizations with more than 10,000 employees to spend at least 8 percent of their payroll on health coverage. **Wal-Mart**, the only company large enough to be affected by the bill, says it would cost the state jobs.

Rather than forcing large employers' hands, Illinois is hoping to aid small employers. The state has launched a study into whether the state would benefit from the creation of a small-employer health purchasing pool, which proponents claim would offer employers predictable premiums and make them more likely to offer coverage.

The Bottom Line: Health plans' rising rates have left legislators and governors feeling like they have no option but to take matters into their own hands. ■

NEW PLANS AND PRODUCTS

- **Independence Blue Cross** in Pennsylvania is posting provider quality ratings, patient safety data and hospital cost information so that plan members can make more informed decisions. The online tool has been launched in conjunction with Web vendor **HealthGrades, Inc.** The site will use hospital discharge data to rate facilities' performance on more than 300 services, will use Leapfrog data on patient safety, and will cull cost information from publicly available claims data, IBC says.

- And consumers aren't the only people who need online tools. **Blue Shield of California** has launched its Provider Connection service, a set of online tools designed to help providers check eligibility, research benefits and track claims.

- **Cigna HealthCare** is offering its health savings accounts to smaller employers in Connecticut, Maine, New Hampshire, New Jersey and Vermont. Cigna

Choice Fund HSA plan, formerly available only to employers with more than 200 employees, is now being offered to companies with 51-200 workers.

- **Blue Cross and Blue Shield of Illinois** is offering two new HSAs, BlueEdge Individual HSA and Blue Edge Individual HSA 5000. The plans offer a wide variety of deductible levels, with individual members able to choose between \$1,000, \$1,750, \$2,600 and \$5,000. The plans also contain optional coverage for maternity, prescription drugs and adult wellness benefits.

- **Blue Cross and Blue Shield of Oklahoma and CommunityCare Managed Healthcare Plans of Oklahoma** are planning to jointly offer a Medicare PPO. Pending federal approval, the plan will be available June 1, 2005. The collaboration could be evidence that the increased funding for Medicare Advantage is helping the program spread to more rural areas. ■

INDUSTRY NOTES

Medicare Posts Hospital Comparison Data

► Consumers will get accustomed to researching provider quality info.

Health plans hoping to provide more information to consumers have a new ally — the federal government.

Medicare has launched its Hospital Compare Web site, which posts data on 17 quality measures for treating heart attack, heart failure and pneumonia. The site compares hospitals' data against their peers and against state and national averages.

The move is in concert with **Centers for Medicare & Medicaid Services** Administrator **Mark McClellan's** stated goals of increasing the focus on quality and eventually paying providers based on their performance.

Health plans have been increasing their efforts to get quality data into consumers' hands and thus enable them to make the wisest, most efficient health care decisions. The publicity around Hospital Compare should get consumers used to the idea of using such information.

- The funny thing about competition: Everyone agrees it's good for business, but no one wants to have any for *their* business.

A new study of 341 HMOs in multiple markets by **Penn State University** puts a new spin on this paradox. The study concludes that less competition, not more, leads to improved health plan performance, UPI reports.

Study author **Dennis Scanlon** admits that the finding is counterintuitive, but posits that intense competition makes it difficult for health plans to focus on quality initiatives. The study is published in the journal *Medical Care*.

- Add Ohio to the growing list of states hoping to move their Medicaid system over to managed care.

Ohio House Republicans say that moving nearly all Medicaid consumers to managed care would save the state \$360 million annually. Gov. **Bob Taft's** (R) budget calls for only a slight expansion of managed Medicaid, so it remains to be seen how much the managed care rolls will grow in Ohio.

- Virginia Gov. **Mark Warner** (D) signed a bill that will allow employers to offer group plans that cover employees' domestic partners, adult children, or any other class of persons that the employers and their health insurers agree upon.

- Once the Medicare drug benefit kicks in, states will not be permitted to decide which prescription drug plan beneficiaries should enroll in, the Bush administration said.

Some states that already operate prescription drug plans had hoped they could steer beneficiaries into these existing PDPs, which they believe offer a superior benefit to the incoming Medicare PDPs. But the Bush administration issued a memorandum to state officials saying that such steering would be contrary to Medicare's goal of providing choice to seniors.

Steering beneficiaries into one PDP would harm other PDPs, and would pose kickback risks if the states tried to keep the rebates that the PDP negotiated with drug manufacturers, Medicare officials said.

In other PDP news, Mark McClellan told a Senate hearing April 5 that he expects PDP enrollment to grow slowly as beneficiaries learn about the new program. ■

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