

We first reported in 2009 that most of Anchorage’s primary-care doctors—and many in the Mat-Su Borough and Fairbanks—won’t take new patients who use Medicare, the health insurance for older Americans.<sup>1</sup> They say Medicare doesn’t pay them enough (Figure 1).

We don’t have an estimate of just how many older Alaskans in urban areas are having trouble getting the primary care they need. But the growing pressure on the few providers who still take older patients is clear evidence of the problem (see page 2).

Here we discuss the causes and effects of the access problem and describe options policymakers are considering to resolve it.<sup>2</sup> Keep in mind that it is almost entirely in urban Alaska—especially Anchorage—where doctors aren’t accepting Medicare patients. Rural Alaskans also have health-care access issues, but those issues are different.

The access problem for Medicare patients isn’t confined to Alaska, although it seems more widespread here. The new health-care reform law includes a temporary 10% incentive bonus for primary-care providers who see Medicare patients.<sup>3</sup> It also calls for more tests of the “medical home” model, which is intended to provide broader primary care and uses a different payment system (see page 3).

### WHAT DO WE KNOW?

- Only 13 primary-care doctors in Anchorage accept new Medicare patients, and only a handful of those are in traditional private practices (Figure 2). Around 20,000 people 65 and older—about 40% of all older Alaskans—live in Anchorage.
- The number of Alaskans 65 and older increased 50% in the past decade and is expected to nearly double by 2020—so the problem could get worse quickly, if nothing changes.

### WHAT CONTRIBUTES TO THE MEDICARE PROBLEM IN ALASKA?

- All other major insurers pay more. For every \$1 private insurance pays primary-care doctors for common office visits, Medicaid (for low-income people) and TRICARE (for military personnel) pay about 81 cents and Medicare pays 63 cents. That puts Medicare patients in Alaska at the back of the primary-care bus (Figure 3). In almost all other states, Medicare currently pays better than Medicaid—putting poor people instead of older people at the back of the bus.<sup>4</sup>
- Medicare patients are a small share of patients. The number of older Alaskans is growing fast, but they still make up a small share of the population. Only about 8% of Alaskans are Medicare enrollees, compared with 15% of Americans nationwide. Doctors have many other potential patients with better-paying insurance.
- Medicare patients tend to be high-cost, because many have complex, time-consuming medical problems. Nearly half the Alaska primary-care doctors who don’t accept new Medicare patients cite the “high clinical burden” as a contributing reason for not seeing them (Figure 1).

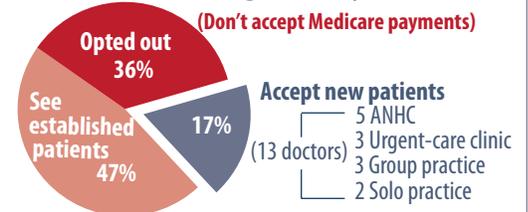
We don’t currently have information on what it costs private primary-care doctors to see Medicare patients, compared with what

**Figure 1. Why Alaska Primary-Care Doctors Aren’t Accepting New Medicare Patients**  
 (Percent of Doctors Citing Reason)



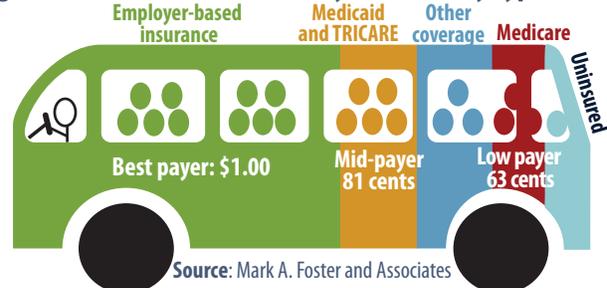
Source: ISER survey of 229 Alaska primary-care doctors, 2008/2009

**Figure 2. Medicare Policies, Anchorage Primary-Care Doctors\***



\*ISER survey of 75 primary-care doctors in Anchorage, 2008/2009, adjusted to reflect 7 doctors we are aware of who previously saw established patients but by 2010 had opted out of Medicare.

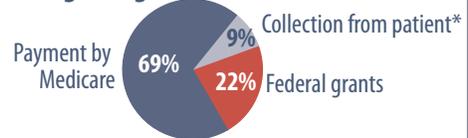
**Figure 3. Alaskans on the Primary-Care Bus, by Type of Insurance**



Source: Mark A. Foster and Associates

Notes: Proportions of bus represent estimated proportions of Alaskans with various coverage. Revenues are based on 2009 payments for common visits to primary-care doctors. TRICARE (for military personnel) usually pays at Medicare level, but the federal government increased Alaska TRICARE payments 35% at least through 2010.

**Figure 4. Who Pays for Medicare Patients at Anchorage Neighborhood Health Center?**



Average cost per visit, 2009: \$172

Source: Anchorage Neighborhood Health Center. \*Patients with incomes below 200% of federal poverty line pay on sliding-fee schedule.

Medicare pays them. But we do have figures from the Anchorage Neighborhood Health Center, which was established to provide primary care for the poor and uninsured—and it receives federal grants to help pay for that care. But it is required to accept all patients, and is treating more and more Medicare patients (see page 2).

The clinic reports that in 2009 the average cost of a Medicare visit was \$172—22% more than it collected from Medicare and patients (Figure 4). It used federal grants to cover the shortfall—but those grants are limited and are mainly for poor and uninsured patients.

## WHO IS COVERED BY MEDICARE?

Medicare is for Americans 65 and older and younger people with disabilities. Most older Americans qualify for Medicare because they paid enough Medicare payroll taxes while they were working—and most have to use it as their primary health insurance, once they retire.<sup>5</sup>

About 80% of Alaska's 57,000 Medicare enrollees are 65 or older. Almost all Medicare enrollees in Alaska are in the fee-for-service program—meaning Medicare pays doctors for individual services.<sup>6</sup>

## WHERE ARE ANCHORAGE'S OLDER RESIDENTS GETTING CARE?

Primary care is routine, comprehensive, preventive care. That's especially important for older people, who often have multiple, chronic problems. In Alaska, Anchorage's older residents face the biggest problem getting primary care—so where are they getting care? We can't fully answer that question. But we know what types of health-care coverage they have, and we know where some are going for care.

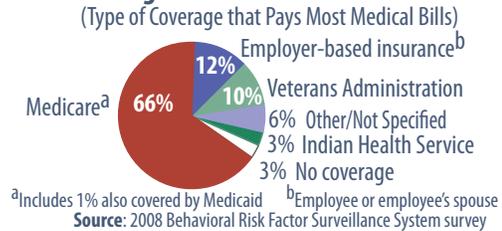
### Types of Coverage

- *About two-thirds of Anchorage's older residents use Medicare.* But those who have other options are using them (Figure 5).
- *About 12% use employer-based insurance.* Those who still work, or have spouses who work, can often delay using Medicare until they retire.
- *Around 10% get care through the Veterans Administration.* Qualified military veterans can get care at VA clinics and hospitals.
- *About 3% use Indian Health Service facilities.* Alaska Natives and American Indians are entitled to care through IHS.
- *Roughly 3% have no coverage.*

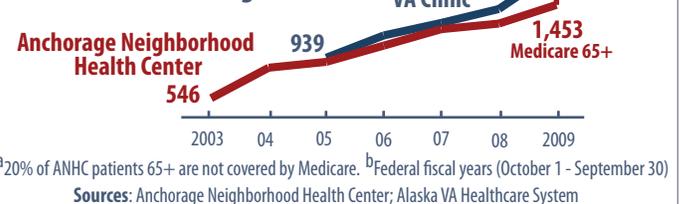
### Types of Providers

- *Some of Anchorage's older residents still have primary-care doctors.* We don't have an estimate of how many, but it's likely quite a few. Some pay the doctors' bills themselves; as long as they do that, doctors who have opted out of Medicare can see them. Some still work and can use private insurance. Others have family doctors who still accept Medicare payments.
- *Nurse practitioners have broad authority to treat patients and prescribe medicine, and those with their own practices may see about 10% of the city's older residents.*<sup>7</sup> Most accept new Medicare patients, but Medicare pays them only 85% as much as primary-care doctors—so they typically limit the number they accept.<sup>8</sup>
- *The Anchorage Neighborhood Health Center treats close to 10% of Anchorage's older residents.* ANHC sees nearly three times as many older Medicare patients now as in 2003, and it also treats hundreds of older people who aren't covered by Medicare (Figure 6).
- *Anchorage's VA Clinic treats about 9% of the city's older residents.* The clinic has seen the number of patients over 65 nearly double since 2005. It expanded primary care and other services in recent years, and has just opened a new, larger facility. More veterans of all ages are using the clinic, but the number of older vets has grown fastest. (Figure 6).
- *Other Anchorage providers.* A residency program for primary-care doctors accepts some Medicare patients.<sup>9</sup> Some urgent-care clinics also accept Medicare, but we don't know how many patients use the clinics for primary rather than urgent care. At Providence Hospital's emergency room, the number of Medicare patient visits is up (Figure 7)—but so is the total number of visits.<sup>10</sup>

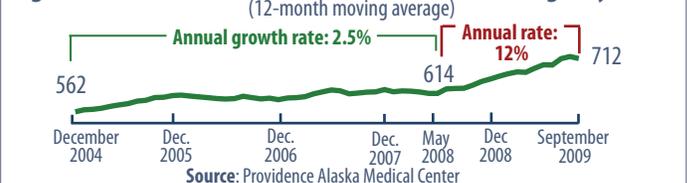
**Figure 5. Medical Coverage for Anchorage/Mat-Su Residents 65 and Older**  
(Type of Coverage that Pays Most Medical Bills)



**Figure 6. Patients 65 and Older at ANHC and Anchorage VA Clinic**



**Figure 7. Medicare Patient Visits, Providence Emergency Room**  
(12-month moving average)



## HOW MIGHT ACCESS BE IMPROVED?

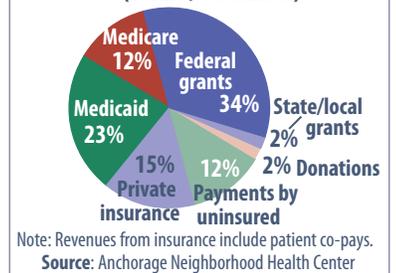
Here we discuss some—certainly not all—of the options policymakers are considering to help older people get care. Keep in mind that Medicare is governed by federal rules. Broadly speaking, current rules prohibit doctors and other primary-care providers in private practice from being paid more than Medicare allows, for any service Medicare covers.

### 1. Option: Increasing Capacity of ANHC

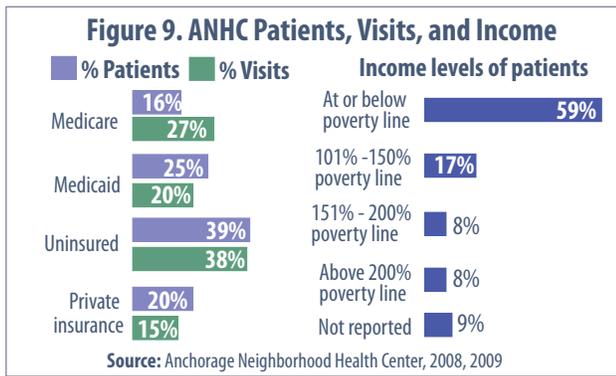
As one relatively quick way to help older Alaskans get primary care, some policymakers have discussed helping the Anchorage Neighborhood Health Center increase its capacity. As we've seen, ANHC is already treating many older patients.

ANHC is one of thousands of community health centers in the U.S. that are required to accept all patients but were originally established to provide basic care for the poor and the uninsured. Federal grants subsidize the costs. Patients with incomes up to 200% of the poverty line pay on a sliding-fee scale. Federal grants made up a third of ANHC's income in 2009 (Figure 8).

**Figure 8. ANHC Revenues, 2009**  
(Total: \$9.8 Million)



Most ANHC patients are low-income—nearly 60% have incomes below the poverty line—and around 40% are uninsured. But Medicare patients now make up 16% of ANHC's patients—and 27% of all visits (Figure 9). Older patients tend to have more medical problems and so need more frequent care than other patients.



Two constraints ANHC faces in seeing more Medicare patients are the capacity of the existing facility and the cost of treating patients.

- *Capacity.* ANHC is raising money for a new, larger facility but is now limiting the number of new patients—Medicare and all others—at its existing facility to two per primary-care provider per day.<sup>11</sup>

ANHC has \$13 million of the \$27 million it needs to build a new facility, including \$10 million in state funds. The 2010 state capital budget includes another \$9 million, but as of mid-May, the governor had not yet approved that grant.

- *Cost.* In 2009, ANHC's reported average cost of seeing Medicare patients was \$172, while the average collection from Medicare (including patients' co-pay) was \$134—a gap of 22% (Figure 4). A big factor increasing costs of treating Medicare patients is the time for work Medicare doesn't pay for—like phone calls, e-mails, coordinating with others, and taking extra time for complex cases.<sup>12</sup>

How might the costs be covered?

- *Federal funds.* Although ANHC uses federal grants to help cover its Medicare costs, those grants are limited and are primarily to cover costs for ANHC's many uninsured and low-income patients. The new health-care reform law will temporarily double federal funds for community health centers nationwide over the next five years—but we don't know how much may come to centers in Alaska or specifically to ANHC.

A consideration for ANHC is how to balance treating Medicare patients and uninsured patients, both of whom now have limited options for getting primary care elsewhere.

- *State grants.* State lawmakers have several times considered—but haven't approved—grants to community health centers as a way of helping more older patients get care. Medicare does allow additional state funding for health centers.

## 2. Option: A Medicare Clinic<sup>13</sup>

A group of Anchorage doctors has formed a non-profit corporation to establish a clinic specifically for Medicare patients. A \$1 million grant to help pay start-up costs is in the state's 2010 capital budget, but as of mid-May the governor had not yet approved that grant. The group also hopes to get \$500,000 in federal money, and an additional \$200,000 in private money, to cover costs for the first two years. The organizers project that after two years the clinic would be self-sustaining. It might be the first such clinic in the U.S.; the organizers haven't found any others like it.

Clinic organizers believe there will be sufficient demand, given the scarcity of primary-care doctors who take Medicare patients and the growing number of older Alaskans. It would likely start with one primary-care doctor, a nurse practitioner, and several nurses or medical assistants.

But how could a clinic seeing only Medicare patients survive, and potentially make money, when most of Anchorage's primary-care doctors—and ANHC as well—report losing money on Medicare patients? The answer, according to organizers, is that it would do business much differently from the traditional family doctor's office.

- *Minimizing overhead costs.* The clinic would be in rented space, with just enough equipment to treat common outpatient illnesses.

- *Minimizing costs Medicare doesn't cover.* Medicare pays only for medical care—so, for instance, the clinic wouldn't mail bills to patients; the medical staff wouldn't answer patient questions over the phone.

- *More patients, shorter visits.* The clinic doctor would see patients for 5 to 10 minutes, for diagnosis and proposed treatment. Other professional medical staff would do the patient work-up—taking histories, for example—for a single doctor, so the doctor could see more patients in less time.

- *One problem per visit.* The clinic would deal with just the most urgent problem in a single visit; patients with multiple medical problems would have to make additional appointments.

- *Accepting only patients able to help with their own care.* That means, for example, patients who can collect any necessary records or tests results themselves, and make follow-up appointments with specialists.

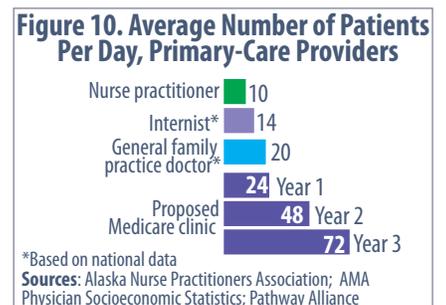
What challenges might the proposed clinic face?

- *Uncertainty of payments.* Congress is currently deciding how to set future Medicare payments for doctors (see endnote 2). A clinic that depends solely on Medicare payments would be especially vulnerable to cuts.

- *New model.* It's unknown how many patients will accept—or be able to accept—the clinic's way of providing care. Patients with limited mobility, for example, or complex medical conditions, may find it hard to make multiple visits, or to be unable to talk with the medical staff on the phone.

On the other hand, most primary-care doctors in Anchorage won't see new Medicare patients—and people who can't get any other provider may welcome a clinic that accepts Medicare payments, offers basic care, and provides referrals.

- *Patient volume.* Organizers say the clinic can succeed only if it sees many patients quickly. In traditional practices, providers typically see anywhere from 10 to 20 patients a day. The Medicare clinic projects it would see 24 patients per day in the first year, building to 72 by the third.<sup>14</sup>



## 3. Option: Patient-Centered Medical Home

The agency that administers Medicare, and some private insurers, have been testing a model called the "patient-centered medical home"; the health-care reform law also calls for demonstration projects.<sup>15</sup> This is a different approach than the proposed Medicare clinic; it is similar to the traditional family doctor's practice. Patients have regular primary-care providers who—along with their staffs—are responsible for comprehensive care: routinely monitoring patients' health, making appointments on short notice, consulting by phone and e-mail, teaching patients to be more involved in their own care, and coordinating with specialists.

Payment is also different from the standard Medicare fee-for-service. Providers are typically paid a monthly amount per patient, adjusted for the complexity of a patient's problems. Supporters say this system will save money by improving patients' health and making care more efficient. Others say it is too early to tell how the model will work.

But Anchorage has a similar model that's been in place for a decade—the Southcentral Foundation (which serves Alaska Natives) was a pioneer in developing a patient-centered primary-care model; it reports that system has improved the health and satisfaction of its patients and reduced per capita costs.<sup>16</sup> And just as this summary was being published, Providence Alaska Medical Center announced it would open (and help subsidize) a senior care center, structured as a medical home.<sup>17</sup>

#### 4. Option: Incentives to Providers

**Bonuses:** The health-care reform law offers a temporary 10% bonus to primary-care providers (doctors and others) nationwide who see Medicare patients.<sup>18</sup> But that seems unlikely to persuade many of Anchorage's primary-care doctors to change their minds, given that a 28% increase in Medicare payments for Alaska doctors in 2009 had little effect.<sup>19</sup>

**State grants:** Alaska legislators have considered but haven't approved using state money to persuade private primary-care providers to see older patients. Such a state program would have to comply with federal Medicare rules (which ban outright supplements to Medicare payments).

#### 5. Option: Increasing the Supply of Providers

Some people believe recruiting more primary-care providers is the long-term solution for the access problem older Alaskans face. Alaska is in fact training more medical professionals locally. But it is a remote and in some ways still frontier environment—which continues to make it harder to recruit doctors and other providers. Also, many analysts see a looming shortage of primary-care doctors nationwide.<sup>20</sup>

#### 6. Option: All-Payer System

Another option being discussed nationally is an "all-payer" system: all insurance—private, Medicare, Medicaid—would pay the same. Maryland started such a system for its hospitals in the 1970s. It has a special Medicare waiver that allows a state regulatory commission to determine hospital rates for Medicare and other payers, including the uninsured.<sup>21</sup> Supporters say such a system for providers would (1) eliminate the incentive for them to choose one payer over another—which could benefit Medicare patients—or to shift costs among payers; and (2) reduce costs over the long run, by simplifying billing and reducing overhead.<sup>22</sup>

Creating an all-payer system in Alaska would require, among other things, creating a new regulatory system and getting a Medicare waiver that would allow state—rather than federal—regulators to decide what Medicare pays. Such a waiver could initially increase Medicare rates (to put them more in line with local market conditions)—but at the same time the state would have to commit to containing cost growth and providing value for all payers. Growth in Medicare costs for Maryland hospitals was in fact less than growth nationwide over the past three decades.<sup>23</sup>

### CONCLUSIONS

Ten years from now, there could be nearly twice the number of older Alaskans as there are today, as more and more baby boomers reach 65. It seems reasonably likely that ANHC will open a larger facility, and that a Medicare clinic may be established. But even if both those things happen, they won't meet all the demands of a growing older population. How—and how much—Medicare pays for primary care will remain central to determining older Alaskans' practical access to basic care.

We're not advocating any of the options we've discussed. But these options, and others we didn't have room to discuss, can help Alaskans (and other Americans) think about the kinds of features that might be included in an effective system of primary care for older patients, who are far more likely than younger people to have complex medical problems.

Any solution to the primary-care problem will also be taking place in the context of implementation of Medicare provisions of the health-care reform law—which include some tests of different Medicare payment systems but also cost-cutting measures. And any attempts to improve access to care for older people will be affected by how—and how frequently—Congress decides to revise future Medicare payment levels.

### ENDNOTES

1. See Rosyland Frazier and Mark Foster, "How Hard Is It For Alaska's Medicare Patients to Find Family Doctors?" *Understanding Alaska Research Summary* No. 14, March 2009. ISER, University of Alaska Anchorage.
2. Also keep in mind the broader array of issues Medicare faces—(1) its financing problems (see National Academy of Social Insurance, "Medicare's Financial Problems," at [www.nasi.org/learn/medicare/financial-problems](http://www.nasi.org/learn/medicare/financial-problems)); (2) the cost-cutting provisions of the health-care reform law (see Emily Walker, "What's in the Healthcare Reform Law," [www.medpagetoday.com](http://www.medpagetoday.com), April 1, 2010); and (3) the looming question of what Congress will do about scheduled cuts in Medicare payments for doctors. Annual changes in Medicare payments for doctors are based on the Sustainable Growth Rate formula, which links growth in Medicare spending for doctors with growth in the overall economy. For years, that formula has called for cutting payments, because spending for doctors has grown faster than the economy. But Congress has repeatedly delayed cuts—including a scheduled 21% cut in 2010. Many observers think payments for doctors are unlikely to be cut, but in spring 2010 it's not clear how Congress will resolve the situation.
3. Critics say Medicare's payment system underestimates the complexity of providing primary care—and therefore underpays for primary care—and tends to overestimate the complexity of specialty care. For a discussion of this issue see *Annals of Internal Medicine*, <http://www.annals.org/content/146/4/301.abstract>.
4. Only in Alaska and Wyoming does Medicaid currently pay better than Medicare. But the new health-care reform law provides for increasing Medicaid payments for primary care to Medicare rates for 2013 and 2014, with the federal government funding the increases (Public Law 111-152; HR 4872 as enacted, Section 1202, page 24).
5. The general requirement to qualify for Medicare Part A (hospital care), at age 65, with no premiums, is paying sufficient Medicare payroll taxes for at least 40 quarters. Medicare beneficiaries can also enroll in Part B, for office visits and other medical costs, but must pay premiums for that coverage. See: [www.Medicare.gov](http://www.Medicare.gov).
6. Nationwide, about one-quarter of Medicare beneficiaries are enrolled in Medicare Advantage programs, which are private health plans; Medicare pays the plans a set monthly amount for each enrollee.
7. Better information about how many older people see nurse practitioners will be available later in 2010, when an ISER survey of Anchorage nurse practitioners is complete. Alaska's nurse practitioners typically hold master's degrees and sometimes doctorates in nursing specialties and are not required to work under the supervision of doctors.
8. Barbara Berner, Alaska Nurse Practitioners Association, 2009 ANPA survey.
9. The Alaska Family Medicine Residency Program has capped the number of Medicare patients it accepts.
10. Based on information provided by Providence Alaska Medical Center, this is a clarification from what we initially published about visits to Providence's emergency room.
11. Interview with Joan Fisher, executive director of ANHC, April 9, 2010.
12. Interview with Tom Hunt, June 1, 2009; at that time he was medical director for ANHC. Health centers across the nation also report that Medicare payments don't cover treatment costs. See National Association of Community Health Centers, *Health Centers and Medicare*, August 2008.
13. Unless otherwise noted, information on the proposed Medicare clinic is from an interview with George Rhyneer, March 23, 2010.
14. Pathway Alliance, Draft Executive Summary Report, Alaskans for Access to Health Care, Business Plan (Undated)
15. See [healthreform.gov/newsroom/factsheet/medical\\_homes.html](http://healthreform.gov/newsroom/factsheet/medical_homes.html).
16. See <http://southcentralfoundation.com/files/nuka.pdf>.
17. Tom Hunt, executive director of physician services, Providence Alaska Medical Center, June 5, 2010.
18. Public Law 111-148, HR 3590 as enacted, Section 5501(a). The Medicare program already offers a 10% bonus for primary-care providers enrolled in the Medicare system and working in "Health Professional Shortage Areas."
19. See Frazier and Foster, note 1.
20. The new health-care law includes provisions intended to encourage more medical students nationwide to go into primary care, to help meet the expected growth in demand around the country.
21. See Maryland Health Services Cost Review Commission, *Report to the Governor*, fiscal year 2009.
22. "Saving Billions Of Dollars—And Physicians' Time—By Streamlining Billing Practices," *Health Affairs*, by Bonnie B. Blanchfield, et al., April 29, 2010; <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.2009.0075>
23. See note 21.

This summary is based on a report, *Improving Health-Care Access for Older Alaskans: What Are the Options?* by Rosyland Frazier, Mark Foster, and Linda Leask. It will be available on ISER's website (see below). The findings and conclusions are those of the authors. Rosyland Frazier is an ISER research associate with broad experience in health-services delivery. Mark Foster, of Mark A. Foster and Associates, is a consultant who has analyzed Alaska health-care issues for many years. Linda Leask is ISER's editor.

The authors thank many people for their help, but in particular Joan Fisher, executive director of ANHC; Richard Neubauer, MD; George Rhyneer, MD; Matthew Berman, professor of economics, ISER, and Scott Goldsmith, professor of economics, ISER.

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