

Response to Questions: Potential Effects on Alaska of Proposed Health-Care Reform Legislation

By Mark Foster and Rosyland Frazier

Note No. 6 • November 2009

Revised January 2010



Mark Foster of Mark A. Foster and Associates (MAFA) is a consultant to ISER, and Rosyland Frazier is an ISER research associate. Both the authors have broad experience studying health-care issues in Alaska, and they have recently been looking at the problems Alaska's Medicare patients face in getting primary-care doctors to see them.

They prepared this note to respond quickly to questions from and discussions with the Office of the Governor in Washington, D.C. and Alaska's Congressional delegation. Those questions and discussions were about the possible implications for Alaska's Medicare patients of provisions in health-care reform legislation the U.S. Congress is considering, as well as about the broader potential effects on Alaska of the proposed legislation. This is by no means a full analysis of the many complex issues associated with health-care reform.

A working paper by the same authors—examining the Medicare-access problem and related health-policy issues in more detail—will be available soon.

The findings and conclusions of this note are those of the authors. If you have questions, get in touch will Rosyland Frazier at: anrrf@uaa.alaska.edu

Alaska's health-care system and economy could be affected by several provisions of health-care reform legislation Congress is now considering. In response to questions from and discussion with policymakers, we did a preliminary analysis of some of the potential effects.

We want to emphasize that we support health-care reform: we believe changes are vital, and that the millions of uninsured Americans need affordable access to health care. But as we'll discuss, different circumstances in Alaska mean that the effects of proposed changes could be different here than in many other states.

Potential Effects on Medicare Beneficiaries

Reports by the Congressional Budget Office (29 October) and the Center for Medicare and Medicaid Services (13 November) looked at potential effects of the House bill. Using those reports as starting points, we found that the proposed expansion of Medicaid and the public-option insurance pool would not be a good fit for Alaska.

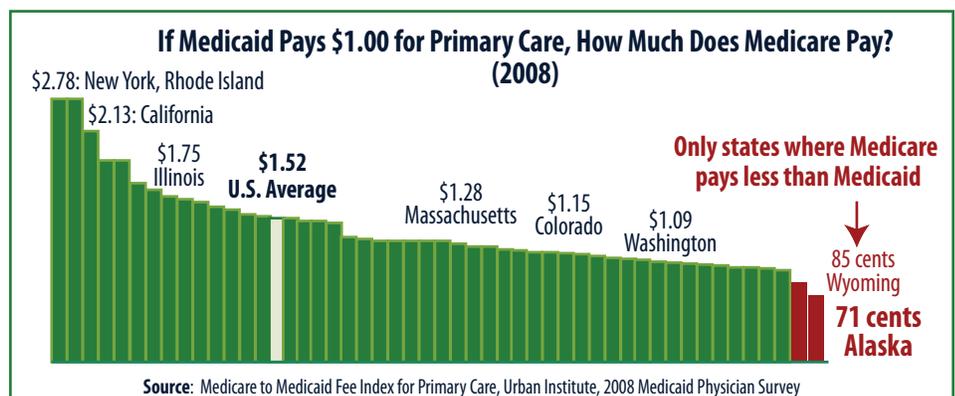
• *The proposed Medicaid expansion could exacerbate access problems for older Alaskans.* That's because (as the figure at the bottom of the page shows) Alaska is one of only two states where Medicaid pays substantially better than Medicare. (Medicaid is the joint federal-state insurance program for low-income people.) Medicare pays considerably better than Medicaid in almost all other states. So an expansion of Medicaid is less likely to have significant effects on Medicare patients' access to health care in most states.

But in Alaska, if the proposed Medicaid expansion and public-option are available to previously uninsured (or underinsured) Alaskans, thousands of additional Alaskans will essentially move ahead of Medicare beneficiaries in the line for health care—because both will pay doctors more than Medicare does.

• *Provisions of the House bill that explicitly aim to reduce geographic disparities in Medicare reimbursements could also make a bad situation worse for Alaska's Medicare patients.* (See §1158 of HR 3962.)

Doctors in Alaska have historically been paid more than the U.S. average for seeing Medicare patients, because of Alaska's higher costs. (Medicare is the federal insurance program for Americans 65 and older.) But even with the higher geographic differential, Medicare payments have not kept up with the rest of the Alaska market—and a growing number of Alaska's primary-care doctors will no longer see new Medicare patients.

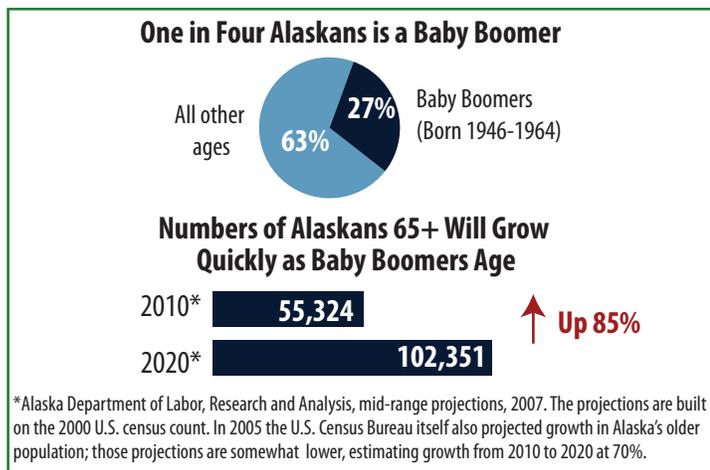
About two-thirds of older Alaskans are concentrated in just a few urban areas. Nearly 40% live in Anchorage, another 12% in the neighboring Mat-Su Borough, and 11% live in Fairbanks. A recent ISER survey found that in Anchorage only 17% of primary-care doctors will see new Medicare patients, in the Mat-Su Borough 57%, and in Fairbanks 70%.¹



And in the next few years there will be a lot more Medicare enrollees in Alaska. The number of Alaskans 65 and older has historically been small, with many older residents leaving the state when they retired. But the number of residents over 65 has been growing fast for 20 years. It more than doubled between 1990 and 2008, as more retirees stayed on, more older people moved here, and as the population in general aged.²

The number of older Alaskans is projected to increase another 85% between 2010 and 2020, just a decade away, as many baby boomers (the huge generation of Americans born between 1946 and 1964) reach Medicare age.³ In both Alaska and the U.S. as a whole, one in four residents is a baby boomer.

As the figure shows, the Alaska Department of Labor projects that the number of Alaskans 65 and older will increase from about 55,000 to more than 100,000 by 2020. (Still, while that's a very big increase in numbers of Medicare beneficiaries potentially looking for doctors, it's useful to keep it in perspective: Alaska's population is still younger than the national average. About 8% of residents are 65 or older, compared with 13% nationally.)



Already, the few primary-care providers who will accept new Medicare patients are seeing big increases. Numbers of patients 65 and older at the Anchorage Neighborhood Health Center and Anchorage's VA facilities have jumped on the order of 50% within a few years. There is also substantial evidence that independent nurse practitioners are taking on a growing share of primary-care for older Alaskans.

And just recently older Alaskans have also been visiting the emergency room at Providence Hospital in growing numbers. Through early 2008, visits by older residents were growing just slightly—less than 3% a year over the past five years. But from May 2008 to September 2009, the number of visits increased at an annualized rate of 12%.

Potential Effects on Health-Care Costs

Other health-care reform provisions Congress is considering could increase health-care costs in Alaska. Costs of medical care in Alaska have been increasing at 5% above the rate of basic inflation and population growth.⁴ Both public and private insurers have reacted by shifting costs to others or limiting coverage.

The proposed expansion of Medicaid and the establishment of public-option insurance pools are likely to increase medical costs even faster. What might that mean for Alaska?

- *Alaska could be exposed to policies that attempt to control geographic cost differentials across the country by focusing narrowly on cost per enrollee.* Alaska's geography makes it expensive to provide basic services—like water and sanitation—and to buy medical equipment and build and maintain facilities. Alaska could be better served by measures that attempt to increase effectiveness and efficiency by taking into account both population risk factors and local market conditions.

- *Alaska is in many ways still a remote, frontier environment, and it has to pay a premium to attract and retain a health-care workforce.* If costs for health personnel grow and reimbursement is squeezed, Alaska might not be able to keep the health-care professionals we currently have or attract the many more we will need to treat Alaska's growing population.

Potential Economic Effects

Health-care reform, as currently proposed, could also have effects on Alaska beyond the health-care system.

- *Alaska's economy could be hurt, compared with economies of other states, if we have to pay more and get less back.* The increased taxes to pay for the new programs could fall more heavily on higher income states like Alaska. Also—even though the number of Alaskans over 65 has been growing fast—Alaska still has a relatively young population, and the subsidies going into the proposed insurance “exchanges” favor an older demographic.

- *Alaska's many small employers could find it hard to comply with a mandate for employer health insurance, if it applied to those with annual payrolls of \$500,000.* Nearly 40% of Alaska workers are employed by firms with fewer than 50 employees, and under the Senate bill those employers would not be subject to the employer insurance mandate.

The House bill, by contrast, would apply to firms with annual payrolls of \$500,000. Wages in Alaska have historically been higher than the U.S. average, and costs of employee benefits are also higher. Therefore businesses in Alaska with fewer than 50 employees might be more likely than those in other states to have annual payrolls of \$500,000. So the House provision, if enacted, could fall more heavily on Alaska, compared with states that have lower costs and fewer small employers.

• *Designing and administering an insurance plan for Alaska's seasonal workers will pose special challenges.* That will be true regardless of whether it's public or private insurance, or self-insured employers using third-party administrators. As typically structured, health-insurance plans are linked to year-round employment—so many seasonal workers are currently uninsured. Alaska has the highest share of seasonal workers in the country, and those workers are a mobile, heterogeneous group.⁵ They include thousands in commercial fishing, but also many in construction, tourism, and other industries. Like other Alaskans, seasonal workers should have health-insurance available to them—but it's not clear that policymakers working on health-care reform are considering their special circumstances.

Conclusions

We want to emphasize again that we support health-care reform—but we hope those with a stake in seeing effective health-care reform for Alaska will consider amendments to the proposed legislation. For example, it may be useful to consider an “opt-out” provision—not only for Alaska but for any state—that, at the very least, would enable continued federal funding for Medicaid, Medicare, and TriCare, as well as the subsidies for those with private insurance, under the proposed “exchanges.”

Such a provision would explicitly allow states to design simpler, locally appropriate systems of federal and state health-care payments to providers.

One example of this approach is the Maryland “all-payer” reimbursement system for hospital services, under which all payers—private or public—pay the same for the same service. That allows local health-care providers to focus on delivering care, rather than dealing with the complicated interplay of the disparate payment systems of Medicaid, Medicare, other government programs, and private health insurance.

Overall, given Alaska's special circumstance, we believe the state would be better served if it had the option of designing health-care reforms that are a better fit for Alaska. We hope policymakers will be willing to give Alaska—and other states, if they choose—that option.

Endnotes

1. Rosyland Frazier and Mark Foster, “How Hard Is It for Alaska's Medicare Patients to Find Family Doctors?” *UA Research Summary* No. 14, Institute of Social and Economic Research, University of Alaska Anchorage, March 2009.
2. Scott Goldsmith and Jane Angvik, “\$1.5 Billion A Year and Growing: Economic Contribution of Older Alaskans.” *UA Research Summary* No. 7, Institute of Social and Economic Research, University of Alaska Anchorage, September 2006.
3. Mid-range projections of Alaska Department of Labor and Workforce Development, July 2007.
4. Mark Foster and Scott Goldsmith, “Alaska's \$5 Billion Health-Care Bill—Who's Paying?” *UA Research Summary* No. 6, Institute of Social and Economic Research, University of Alaska Anchorage, March 2006.
5. Rosyland Frazier and Virgene Hanna, “No Health Insurance: How Do Alaskans Cope?” *UA Research Summary* No. 9, Institute of Social and Economic Research, University of Alaska Anchorage, December 2007.