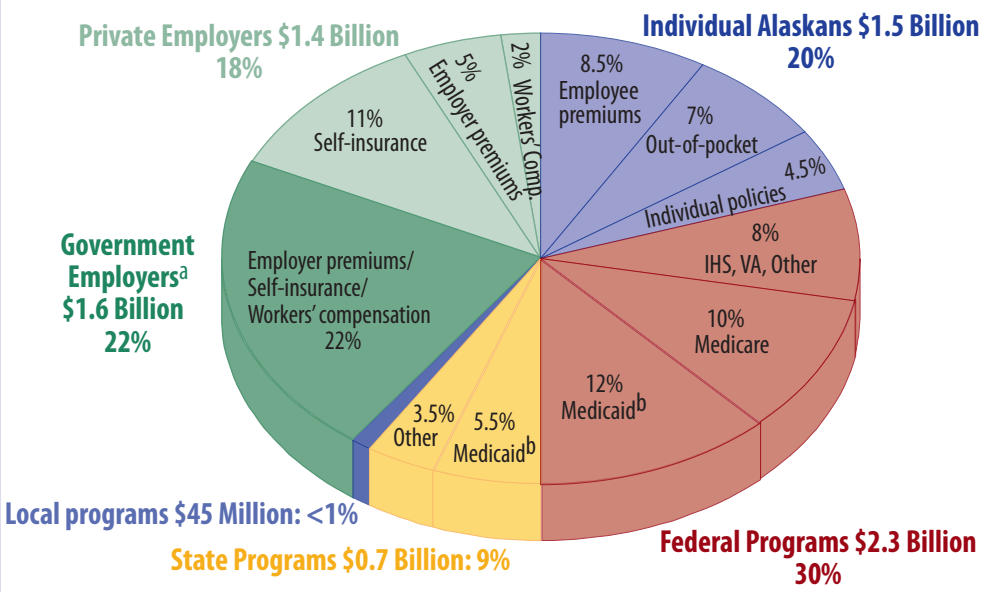
Alaska's Health-Care Bill: $7.5 Billion and Climbing

By Mark A. Foster and Scott Goldsmith

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Figure 1. Who Pays for Health Care in Alaska?
(2010 Spending: $7.5 Billion)



[a]Insufficient data to break out categories
[b]The federal and state governments share the cost of Medicaid.

Source: Authors' estimates

Health-care spending for Alaskans reached about $7.5 billion in 2010. For comparison, that's close to half the wellhead value of all the oil produced in Alaska that year. It's also roughly equal to half the wages Alaskans collected in 2010.

The state's health-care spending has been rising fast, tripling since 1990 and jumping 40% just between 2005 and 2010—and at current trends it could double by 2020, reaching more than $14 billion.

Here we report on who's paying the bills, what we're buying, what's contributing to the growth, and other aspects of health-care spending. We conclude with a discussion of how Alaska could get better value for its health-care dollars.

• ***Who pays the bills?*** Individual Alaskans directly pay about 20%, state and federal programs around 40%, and private and government employers another 40% (Figure 1 and page 2).

• ***What's the biggest cost?*** Medicaid is the largest single expense, making up nearly 18% of all Alaska health-care spending. But that's down from 20% of total spending in 2005. Why? Because spending for Medicaid didn't grow as fast as other kinds of spending (page 3).

• ***Are costs shifting?*** Every category of spending increased since 2005—but because spending by individuals and private employers increased faster, their shares of total spending increased (page 4).

• ***What are we buying?*** Hospitals and doctors account for nearly 60% of total spending—but the next largest cost is the 10% that goes for administering private and government health insurance (page 4).

• ***What's driving spending*** Over the past 50 years, technology, income growth, medical-price inflation, changing insurance coverage, and a growing, aging population have driven health-care spending (page 5).

• ***How many Alaskans are uninsured?*** The answer varies depending on how "uninsured" is measured and when. But recent estimates say about 18% of adults and 9% of children are uninsured. Based on 2010 census figures, that would be about 17,000 children and 94,000 adults (page 6).

• ***How many Alaska businesses offer health insurance?*** More than 90% of large firms offer insurance, compared with just 30% of small businesses—and that's down from 35% in 2003 (page 7).

• ***Are prices higher in Alaska?*** Yes. But Alaska's isolation, small markets, and other factors contribute to those higher prices—a day in the hospital costs on average 50% more than in the U.S. as a whole, and costs for common procedures are roughly 35% higher (page 8).

• ***How is spending distributed?*** Just 10% of Americans are responsible for two-thirds of all health-care spending in an average year (page 9).

• ***What about the future?*** Expanded insurance coverage; an aging population; and continued growth in technology, incomes, and medical prices will keep driving growth in health-care spending in the coming years. Controlling that growth will be an ongoing challenge (page 11).

Who Pays the Bills?

Individuals, private employers, and governments share the direct costs of health care in Alaska (Figure 1 and Table 1).

Individual Alaskans spent about $1.5 billion for health care in 2010—20% of total spending.

- *Alaskans with employer-based insurance—both private and government—paid about $640 million* for premiums, and those with individual policies spent $350 million.
- *Out-of-pocket costs for Alaskans totaled about $545 million* in 2010. That includes deductibles and co-pays—the part of medical bills insurance doesn't pay. It also includes costs for services not covered by insurance, and money that uninsured Alaskans spent for medical bills.

Private employers spent about $1.4 billion—18% of total spending.

- *Alaska businesses spent around $835 million to self-insure* in 2010. They set aside money to pay medical bills themselves, rather than pay insurance premiums. They're betting that the medical bills will be less than the premiums they would have paid—and that their reserves will be enough to cover annual variation in claims. Many self-insured firms carry "stop loss" insurance, to protect them against very large claims. At first only large firms self-insured, but as insurance costs climbed, smaller businesses have also begun self-insuring.
- *Businesses spent about $400 million for insurance premiums* in 2010. That's only about half what businesses spent to self-insure, showing how widespread the practice of self-insuring is.
- *Medical bills of employees injured at work cost businesses about $150 million* in 2010. State law requires employers to pay for such injuries.

Government employers spent $1.6 billion for health benefits in 2010.

- *Local government employers—including school districts—spent about $630 million,* the federal government nearly $590 million, and the state $410 million.
- *Like businesses, many public employers self-insure, rather than pay insurance premiums*—but we don't have enough data to separate out those costs. The federal government also pays medical costs for active-duty and retired military personnel and veterans.

Governments spent nearly $3 billion for health programs in 2010.

- *Medicaid spending was nearly $1.3 billion in 2010*—$871 million in federal money and $409 million in state money. Medicaid is a federal program, but the state administers it and shares the costs (see page 3).
- *Medicare spending was $733 million in 2010*, accounting for nearly 10% of all health-care spending. Medicare is a federal program for people 65 and older and those with certain disabilities. Medicare spending is expected to grow rapidly in the next decade, as older Alaskans make up an ever-growing share of the population (see page 5).
- *The federal government spent close to $650 million for other health programs* in 2010, including the Indian Health Service, which provides medical care for Alaska Natives, and the Veterans Administration, which provides care for military veterans. Spending for these programs depends somewhat on enrollment, but it's also constrained by Congressional appropriations.
- *Besides its share of Medicaid, the state government spent about $260 million* for a variety of other programs in 2010, including grants to local governments, the state-operated Pioneer Homes for older Alaskans, and the Alaska Psychiatric Institute.

Table 1. Health-Care Spending in Alaska, 2010
(Total Spending: $7.5 Billion)

Individuals	**$1,529 million**
Employee premiums	$637
Out-of-pocket costs	$544
Individual policies	$348
Private Employers*	**$1,384 million**
Insurance premiums	$395
Self-insurance costs	$836
Workers' compensation medical	$153
Government Employers*	**$1,625 million**
Federal	$586
State	$408
Local	$631
Federal Health Programs	**$2,250 million**
Medicare	$733
Medicaid	$871
IHS, VA, Community Health Centers, public health, K-12 health	$646
State Health Programs	**$670 million**
Medicaid	$409
Local grants, API, Pioneer Homes, K-12 health, WAMI, Department of Corrections	$261
Local Health Programs	**$45 million**
Hospital and health program support	$40
Other local	$5

*Includes coverage for current and retired employees.

Source: Authors' estimates. See page 12 for a description of what's included in health-care costs.

- *Local health programs are much smaller,* at around $45 million in 2010, largely support for hospitals and health programs.

And finally, keep in mind that even though governments and businesses pays most of the *direct* costs of health care, individual Alaskans and other Americans *indirectly* pay all the costs of health care—because they buy goods and services, own businesses, and pay taxes.

Is There Also Spending Outside Alaska?

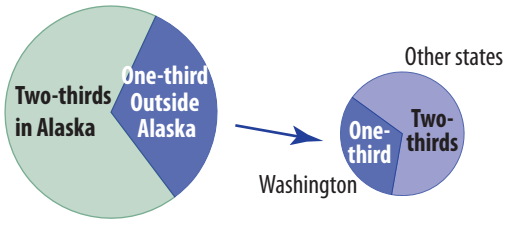
Our estimates are for health-care spending *in* Alaska. The health-care industry has been one of the state's fastest-growing sectors for decades, and it provides a broad range of care. But long-time Alaskans can remember when getting anything other than basic care required leaving Alaska. So some people wonder how much Alaskans spend for health care outside Alaska these days.

We know Alaskans still travel for some care—like very advanced cancer treatments available only in a few locations in the Lower 48. Also, some Alaskans go to other states—or even other countries—where medical prices are lower.

We don't have enough data to estimate overall health-care spending outside Alaska. In 2004, the federal Centers for Medicare and Medicaid Services estimated that the difference between spending *in Alaska* and spending *for Alaska residents* was roughly 2%.[1]

And Premera-Alaska, which has about 57% of the Alaska health-insurance market,[2] recently analyzed claims paid under one of its large group plans. Premera estimates that in a recent two-year period, a third of payments under that group plan went to providers outside Alaska. And of that third, one-third was paid to providers in Washington state and two-thirds to providers in other states (Figure 2).

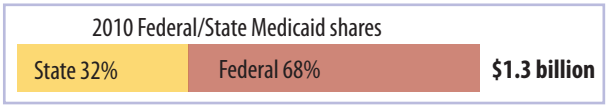
Figure 2. Estimated Shares of Premera-Alaska's Payments For Care, Inside and Outside Alaska



Source: Jeff Davis, Premera-Alaska, based on analysis of recent claims of one of its large groups.

We can't generalize to other payers—like the Veterans Administration or the Indian Health Service or even other private insurers—that might have quite different spending patterns. Still, the Premera estimate offers interesting evidence that for at least some segments of the market, significant spending outside Alaska continues.

Largest Single Cost: Medicaid

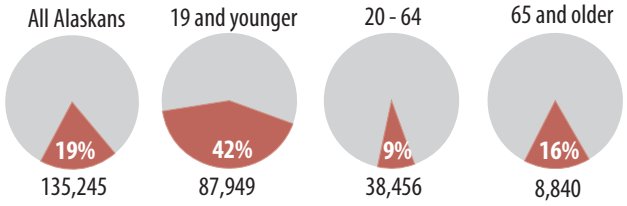


The federal and state governments spent nearly $1.3 billion for Medicaid in 2010, making it by far the largest single health-care expense in 2010. So just what is Medicaid, and how many Alaskans benefit from it?

Medicaid is a joint federal-state health insurance program, administered by the state. The cost split has varied somewhat over the years, but it's typically closer to 50-50 than it was in 2010, when the American Recovery and Reinvestment Act (now expired) boosted the federal share.

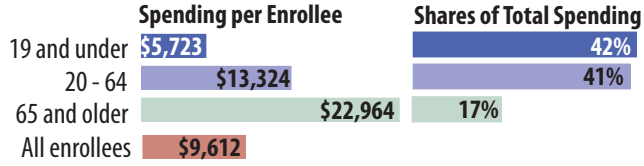
Medicaid is for low-income families; adults with certain disabilities; and increasingly, long-term care in nursing homes for people who have spent down all their own assets and home-based services for those who meet specific disability criteria.[3]

Figure 3. Share of Alaskans in Medicaid, 2010



Sources: Alaska Department of Health and Social Services; 2010 U.S. census

Figure 4. Alaska Medicaid Spending by Age of Enrollee, 2010



Source: Alaska Department of Health and Social Services, Medicaid Budget Group, January 2011

There's also an expansion of Medicaid, called Denali KidCare, which covers children and pregnant women from families with incomes somewhat too high to qualify them for traditional Medicaid. Spending for both standard Medicaid and Denali KidCare are included in the $1.3 billion.

More than 135,000 of Alaska's 710,000 residents were enrolled in Medicaid and Denali KidCare in 2010—close to 20% of all Alaskans. Most of those—about 88,000—are children and teenagers. That means more than four in ten of all Alaskans 19 or younger are enrolled (Figure 3). About 38,500, or 9%, of working-age Alaskans are enrolled, as are nearly 9,000—or 16%—of Alaskans 65 or older.[4]

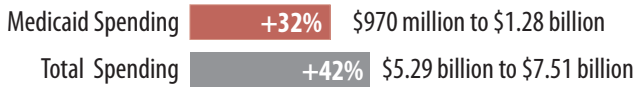
As Figure 4 shows, Medicaid spending is much different for younger and older enrollees. The average spending per child was under $6,000 in 2010—but because they make up so much of the enrollment, 42% of total spending was for them.

By contrast, average spending per enrollee 65 or older was close to $23,000. But because there aren't nearly as many older enrollees, they accounted for only 17% of total Medicaid spending. Some of those older Alaskans are in nursing homes, where care is expensive.

Enrollment in Alaska's Medicaid program increased about 23% over the past decade—but, as Figure 5 shows, Medicaid spending did not grow as fast as total health-care spending from 2005 to 2010. Medicaid spending was up about 32%, compared with 42% for total spending. The state held down cost increases in various ways in recent years—for example, by directing providers to prescribe generic rather than brand-name drugs whenever possible.

Still, spending for Medicaid and all other health-care expenses grew fast in recent years, and health-care spending is projected to continue growing fast in the coming years. In a later section we look at the factors contributing to that growth.

Figure 5. Increases in Medicaid and Total Health-Care Spending, 2005-2010



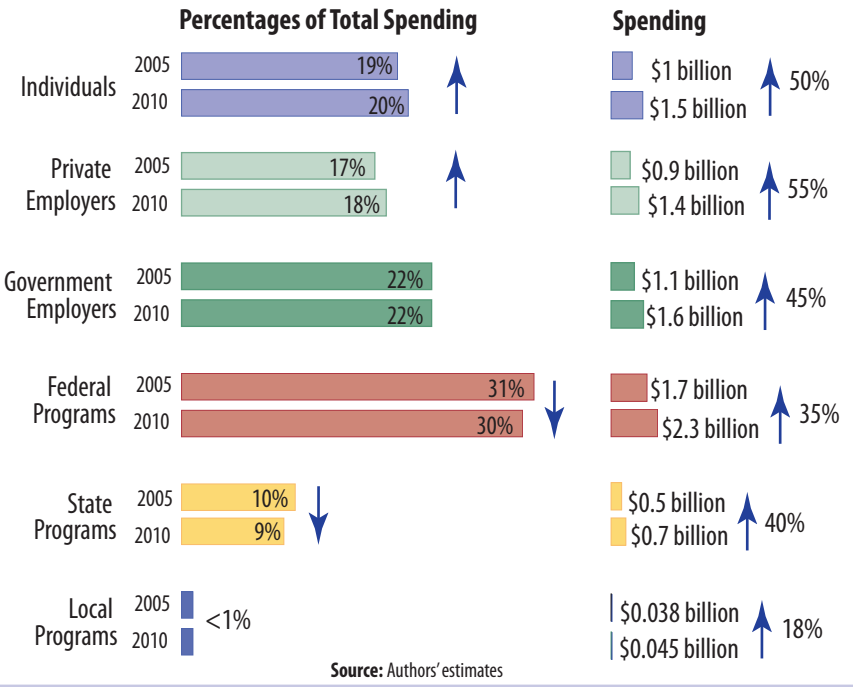
Sources: Alaska Department of Health and Social Services and authors' estimates

How Have Patterns of Spending Changed?

Every category of health-care spending increased between 2005 and 2010, but the shares of spending shifted slightly among the various payers. We don't have enough information to say exactly what caused this shift—but several things likely contributed, as we describe below.

- *Individuals paid 20% of Alaska's health-care bills in 2010, up from 19% in 2005*. As costs of health-care benefits increased rapidly, employers shifted more of those costs to employees (see page 7). Also, prices for policies individuals buy directly increased significantly.
- *Private employers' share of spending increased from 17% to 18%*. That increase was in part because private industry added nearly four times more jobs than governments did since 2005—and at least some of that bigger base of employees had health-care coverage.
- *Government employers' share of spending was about the same, at 22%.*
- *Government health programs accounted for a somewhat smaller share of spending, down from about 41% to 39%.* The federal and state governments have attempted to hold down growth in costs of health programs—but federal programs alone continue to make up nearly a third of all Alaska's health-care spending. Local government spending for health programs remains small, relative to that of the state and federal governments, and the increase in local spending was smaller as well.

Figure 6. Changes in Who Pays for Alaska Health-Care, 2005-2010



Source: Authors' estimates

How About Health-Care Jobs?

This summary looks at health care from the perspective of spending for care—but it's important to remember that the spending also supports jobs for Alaskans. As the Alaska Department of Labor and Workforce Development reports in its August 2011 *Alaska Economic Trends*:

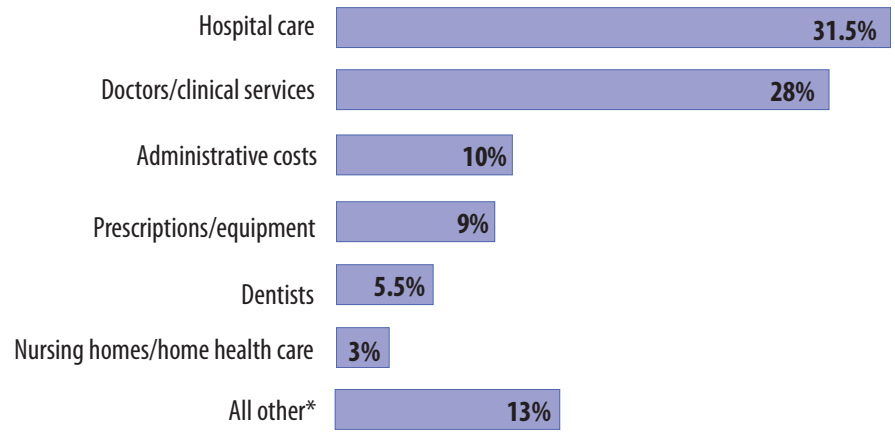
- Health-care spending directly supports 31,800 jobs in Alaska. That's one in ten of all wage and salary jobs—in hospitals, offices of doctors and other providers, nursing homes, and many other places.
- Many additional jobs related to health care—in government agencies, and among the self-employed—aren't included in that total.
- Alaska employment in health care has been increasing at an annual rate of 4.3% for the past decade.

What Do Health-Care Dollars Buy?

Alaska's $7.5 billion health-care bill includes everything from visits to doctors and dentists to prescriptions and nursing-home care.[5] Figure 7 summarizes what Alaska's health-care dollars bought in 2010.

- *Hospital care was the largest expense,* followed closely by payments for doctors and related clinical services—together they accounted for about 60% of Alaska health-care spending in 2010.
- *Administering private and public insurance plans cost one of every ten dollars* spent for Alaska health care in 2010. That's more than spending for prescriptions and medical equipment, and nearly twice the spending for dentists.
- *Spending for nursing homes and home-health care made up only about 3%* of total spending, even though spending for home health care has increased rapidly in the past decade. Much of this care is paid for under Medicaid.

Figure 7. What Do Alaska's Health-Care Dollars Buy?
(2010 Spending: $7.5 Billion)



*Other personal and professional care and public health activities.

Source: Mark A. Foster and Associates estimates, based on Centers for Medicare and Medicaid Services, National Health Expenditure accounts

What's Been Driving Growth in Health-Care Spending?

Health-care costs in Alaska are higher than U.S. averages partly because of small markets and other conditions specific to Alaska (see page 8). But the factors that have been driving *growth* in spending are common to Alaska and the rest of the country. Some of these are general factors—that is, factors that add to spending not only for health care but for everything. Others are specific to health-care spending.

General Growth Factors

Some factors have contributed to growth in spending for all sorts of things, including health care:

• *More people and more older people.* Alaska's population was up 13% in the past decade, and it's projected to increase nearly 10% in the next (Figure 8). And the percentage of Alaskans 65 and older is rising—up from 6% to 8% since 2000 and projected to reach 12% by 2020 (Figure 9). Older people have more health problems and so higher medical costs.

• *General inflation.* The Anchorage consumer price index recorded an increase of nearly 14% from 2005 to 2010 (Figure 10).

• *Growing incomes.* As the economy grew, Alaskans and other Americans spent more not only for health care but for most goods and services.

Factors Specific to Health-Care

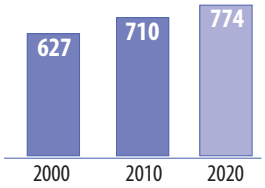
Other factors that have been driving up spending are specific to health care:

• *Faster inflation in health-care costs.* The health-care industry has been growing fast, in Alaska and nationwide, putting upward pressure on prices of many things that make up overall health-care costs. That partly explains why costs of medical care as reported in the Consumer Price Index (CPI) have been rising faster than general inflation (Figure 10). But the CPI also reflects some of the costs of new health-care technologies. It's impossible to sort out how much each factor contributes to growth in the CPI for medical-care—but it's important to recognize that the CPI is measuring not only changes in prices but changes in what is being priced.

• *New technologies and drugs.* Health care is not a fixed commodity but rather is continually changing as new technologies and drugs are developed. Some of these certainly make care more effective, while others may not—but adopting them adds to the price of health care.[6]

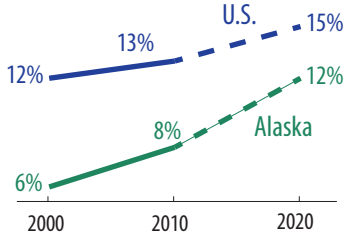
• *More use of medical services.* Alaskans and other Americans are making more visits and having more procedures, partly because they have new options but also because more are older. The changing prevalence of disease—some illnesses are more common and some less so—may also be increasing use of services. And a broad increase in insurance coverage in the past several decades may also have added to use.

Figure 8. Historical and Projected Alaska Population
(In Thousands)



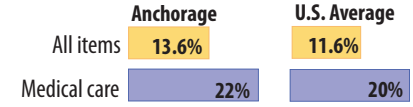
Sources: U.S. Bureau of the Census; Alaska Department of Labor and Workforce Development

Figure 9. Percentage of Population 65 or Older



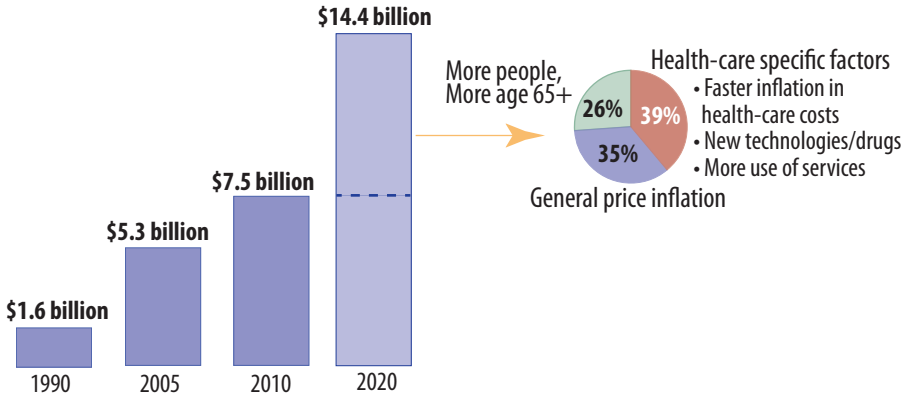
Sources: U.S. Census Bureau, 2010 population projections; Alaska Department of Labor, 2010 population projections

Figure 10. Increase in Consumer Price Index, Anchorage and U.S. Average, 2005 to 2010



Source: U.S. Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers

Figure 11. Alaska Health-Care Spending Could Double by 2020, At Current Trends: What's Driving Growth?



Source: Mark A. Foster and Associates estimates, based on Centers for Medicare and Medicaid Services, National Health Expenditure accounts

What's Ahead?

Looking forward, Alaska's health-care spending could double in the next decade. Why? As Figure 11 shows:

• *General factors will likely account for about 61%* of growth between 2010 and 2020—with general price inflation accounting for 35% and a growing and aging population 26%.

• *The remaining 39% of projected growth can be traced to health-care specific factors*. But sorting out how much of that 39% can be traced to any specific factor—like more use of services—is impossible.

What Health-Coverage Do Alaskans Have?

Here we look at how individual Alaskans cover health-care costs. Many Alaskans have more than one type of coverage. The figures here are from two sources, which ask slightly different questions and use different definitions.

Figure 12 shows coverage for children for the period 2006 to 2008. It's from the American Academy of Pediatrics, based on the Current Population Survey (CPS), but with an important adjustment for Alaska.

Alaska Native children are eligible for care through the Indian Health Service, at IHS-supported clinics and hospitals; many also have coverage through Medicaid or private insurance. For some reason we don't understand, the CPS classifies children with *only* IHS coverage as "uninsured."

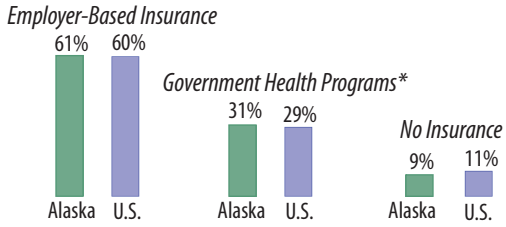
But the Academy of Pediatrics takes these IHS-only children out of the uninsured category, because they in fact have medical coverage. Classifying them as "uninsured" substantially increases the share of Alaska children shown as having no coverage. So keep in mind that the unadjusted CPS figures—which are often cited and used for comparisons across states—show a larger share of Alaska children as uninsured.[7]

Figure 12 shows 9% of Alaska children were uninsured in recent years. Based on 2010 census figures, that would be roughly 17,000 children. Children are less likely than adults to be uninsured. Denali KidCare—the Medicaid expansion for children and pregnant women—provides coverage for many children. The estimated share of uninsured children is smaller in Alaska than nationwide—9% versus 11%—in part because of IHS coverage.

Figures 13 and 14 show coverage for adult Alaskans, reported in a joint federal-state survey. That survey asks respondents to name only the coverage that pays *most* of their bills—but again, many Alaskans have more than one type of coverage.

- *Nearly one in five adults reported being uninsured in 2008*— based on 2010 census figures, that would be about 85,000 adults. Lack of insurance is most common among young adults, especially men.
- *Alaska's large number of military personnel and veterans is reflected in the 11%* of adults—mostly men—who report having coverage through either the military or the Veterans Administration.
- *About 9% of adults rely on Medicare*. But in Anchorage and other large Alaska communities, most primary-care doctors don't accept new Medicare patients.[8] So older Alaskans who have other options are using them—as the figure below shows.
- *Only 3% of adults in Alaska report relying on Medicaid,* while state figures show a substantially larger percentage (page 3). That discrepancy could be due to several things. Many Medicaid enrollees self-report themselves as uninsured. Also, some of those eligible for care through the Indian Health Service but also enrolled in Medicaid may have cited IHS as their principal source of coverage.

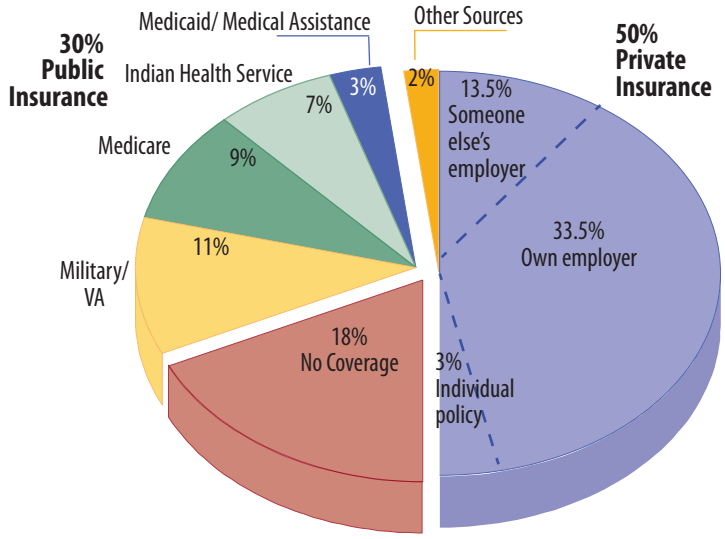
Figure 12. Health-Care Coverage for Children (18 and Under), Alaska and U.S.
(Average 2006-2008)



*Includes children enrolled in Medicaid and children eligible for care through the Indian Health Service and not covered by private insurance or Medicaid.

Source: American Academy of Pediatrics, based on Current Population Survey

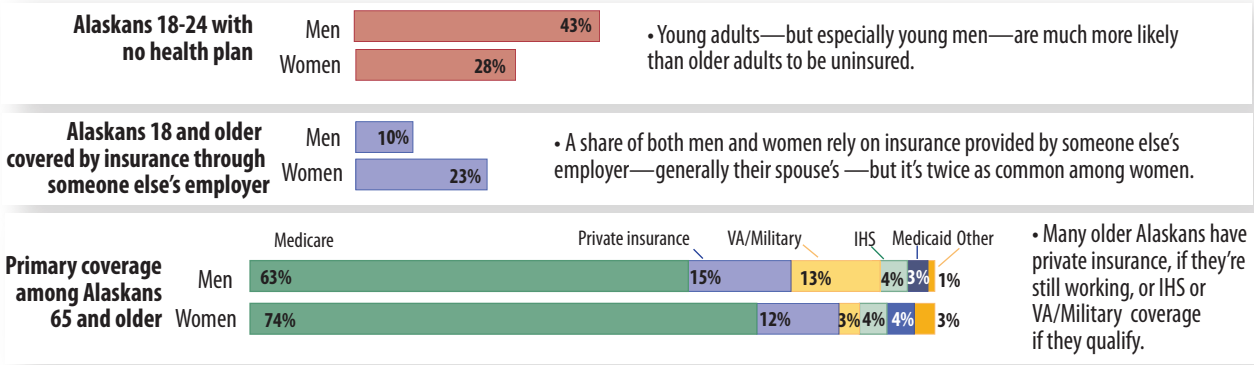
Figure 13. Health-Care Coverage by Type Among Alaskans 18 and Older, 2008*



*Type of coverage that pays most medical bills. Some Alaskans have more than one type of coverage; the survey asks respondents to list only the coverage that pays most of the bills.

Source: Behavioral Risk Factor Surveillance System survey, 2008

Figure 14. Differences in Coverage among Adult Alaskans, by Age and Sex



Source: Behavioral Risk Factor Surveillance System survey, 2008

Finally, uninsured Alaskans do have access to some care. Government-funded community health centers provide care and charge according to income, and federal law requires hospital emergency rooms to see all patients who come in. Also, annual insurance status is measured at a specific time; some people gain or lose coverage during the year.

How Many Alaska Businesses Offer Health-Insurance?

About 50% of adults in Alaska report using private insurance as their primary coverage (Figure 13). Here we report how many Alaska businesses offer insurance and how much it costs, based on a federal survey.

Figures 15 and 16 show that in the face of fast-rising premiums in recent years, businesses in Alaska and nationwide have been shifting more of the costs of insurance to their employees—and many small businesses have been dropping coverage altogether.

Premiums remain higher in Alaska, especially for single-person coverage. On the other hand, Alaska employees still pay a smaller share of premiums than the average U.S. employee.

But keep in mind that premiums are only part of employee health-care costs. Employees pay not only their share of premiums, but also deductibles and co-pays. It's likely that many employers have also raised deductibles—the amount employees have to pay before insurance kicks in—as costs increased. Deductibles can be thousands of dollars.

Patterns of increase in premiums were not consistent between Alaska and the U.S. as a whole in recent years—and in Alaska, premiums for single-person coverage increased much faster than premiums for family coverage. We don't have enough data to explain what caused those differences.

Also, comparisons over time are complicated by changes in who's paying and what's being covered. So while the figures here are useful for showing patterns, remember that many things can affect premiums.

• *Almost all large businesses in Alaska offer employee health insurance*—but that share dropped from 95% in 2003 to 93% by 2010. Nationwide, the share of large businesses offering insurance actually blipped up, from 95% to 96%.

• *Relatively few small Alaska businesses offered employee insurance in 2003*, and that share got even smaller by 2010, dropping from 35% to 30%. The share of small businesses nationwide offering insurance also dropped, but at 39% it's still higher than in Alaska.

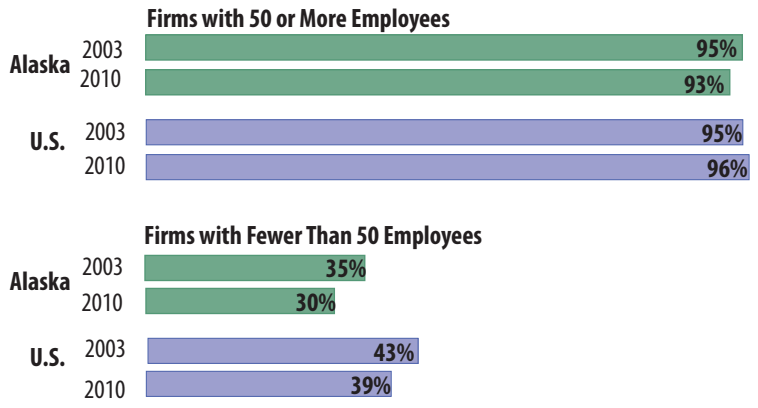
• *Premiums for single-person coverage in Alaska went up more than 50%* from 2003 to 2010, compared with a 40% increase around the country. Premiums were already higher in Alaska in 2003, and the gap widened in recent years. Single-person premiums in Alaska were 15% higher than the U.S. average in 2003, but 23% higher by 2010.

• *Family coverage in Alaska cost 35% more in 2010 than in 2003.* But around the U.S., premiums for family coverage jumped 50%. And because of that faster growth nationwide, by 2010 premiums for family coverage in Alaska were only about 3% higher than the U.S. average.

• *Private employees in Alaska paid about 14% of premium costs* for single coverage in 2010, up from 11% in 2003. In the U.S. as a whole, the employee share for single coverage went from 17% to 21%.

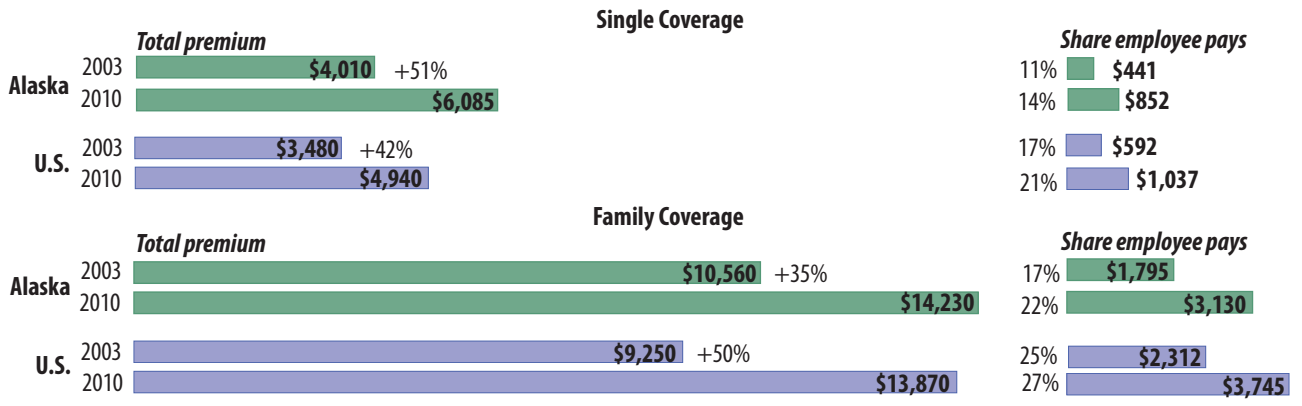
• *The employee share for family coverage in Alaska was 22% in 2010,* up from 17% in 2003. Around the country, the employee share for family coverage was 27% in 2010, up from 25%. Still, even though Alaskans saw a bigger percentage increase, their payments for family coverage in 2010 remained below the U.S. average—$3,130, compared with $3,745.

Figure 15. Percentage of Private Firms Offering Health Insurance, Alaska and U.S. Average, 2003 and 2010



Source: Medical Expenditure Panel Survey, 2003, 2010

Figure 16. Health Insurance Premiums at Private Firms, U.S. and Alaska, 2003 and 2010



Note: Figures are not adjusted for possible differences in coverage provided.

Source: Medical Expenditure Panel Survey, 2003, 2010

How is Alaska Different?

Health-care spending of $7.5 billion is a lot for a population of around 710,000. We can't entirely explain why that health-care bill is so high, but we know that special characteristics of Alaska contribute.

• Costs of most things remain higher than the U.S. average, because of Alaska's distance from the Lower 48, its many small, remote communities, and other factors. Improved transportation and growing urban markets have sharply reduced but not eliminated that historical difference in living costs.

• Alaskans have higher incomes than the U.S. average, and more work for government. People with more income tend to spend more for health care. Also, about one-quarter of Alaska jobs are in federal, state, or local government. Government jobs usually have good health insurance.

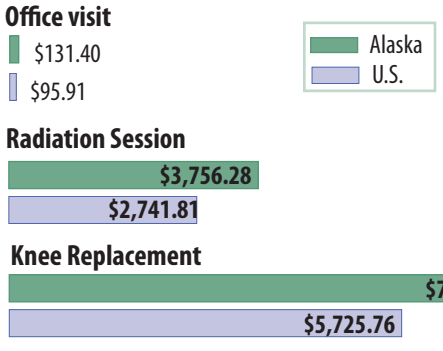
• Alaska's health-care system also faces conditions that tend to keep prices for care higher, relative to other U.S. places. Those include:

Alaska has to compete for doctors and other health-care professionals —and Alaska continues to be at a competitive disadvantage with other states. It's isolated; it has long, harsh winters; and many of its communities aren't even on the road system. To attract health-care workers, Alaska often has to offer them the opportunity to earn more or have other benefits.

Small, isolated Alaska hospitals tend to have higher staffing levels per patient than facilities in other states. Alaska hospitals outside urban areas are small and more isolated than small hospitals in other states. The number of patients in small Alaska hospitals can move up and down quickly—but they need to maintain enough capacity to meet times of high demand.

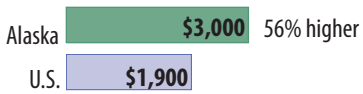
Small markets. Roughly half of all Alaskans live in Anchorage and nearby areas, but Alaska has hundreds of small communities—and the small markets in those places mean providers can't take advantage of economies of scale and have limited competition.

Figure 17. Private Insurance Payments to Doctors, Alaska and U.S., 2011



Source: Ingenix, 2011 National Fee Analyzer

Figure 18. Hospital Costs per Inpatient Day, 2009



Sources: Ingenix Almanac of Hospital Financial Operating Indicators; Medicare Cost Reports, Median Values

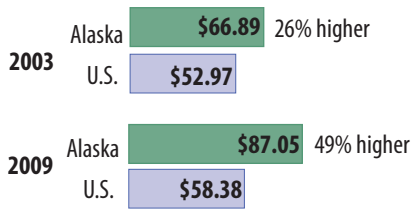
Those factors don't entirely explain Alaska's high health-care spending, but they help put it in context. Figures 17-19 show examples of price differences for medical care in Alaska and the U.S. as a whole.

• *Doctor's fees are in the range of 35% higher* for common procedures in Alaska, as Figure 17 shows. For example, private insurance might pay on average $3,700 for a radiation session in Alaska, compared with about $2,700 nationwide.

• *Average hospital costs per day are 56% higher in Alaska* (Figure 18).

• *Prescriptions on average cost 50% more in Alaska* in 2009, up from 26% in 2003 (Figure 19). At least part of that growing difference in price may be that generic drugs—which cost considerably less than brand-names—are not used as much in Alaska. There is also some evidence that Alaska's medical practitioners tend to quickly adopt new drugs, which are typically expensive.

Figure 19. Average Price of Prescriptions, Alaska and U.S., 2003 and 2009



Source: Kaiser Family Foundation, State Health Facts, Special Report

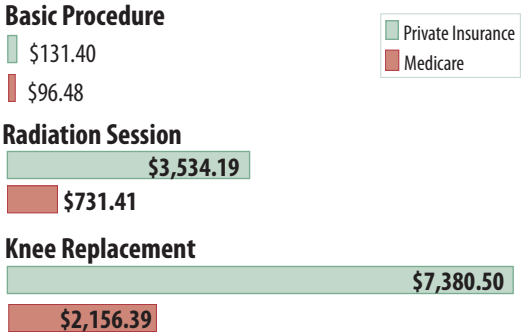
Gap in Medicare and Private Insurance Payments

Another health-care issue that's gotten a lot of attention in the past few years—especially in Alaska but also in the country as a whole—is the shortfall between what Medicare pays doctors and what private insurance pays them. Figure 20 provides examples of procedures, with Medicare paying only 30% to 77% of what private insurance pays.

And Medicare payments to doctors are scheduled to be reduced, as the federal government tries to hold down spending for the huge Medicare program.[9]

It's far outside the scope of this paper to discuss the possible future path for Medicare. Here we just want to note that if Medicare pays providers less than their actual costs, providers will attempt to recoup some of those costs by charging higher prices for those with private insurance. But we don't have data on providers' actual costs.

Figure 20. Alaska Doctor's Fees, Private Insurance and Medicare, 2011



Source: Ingenix, 2011 National Fee Analyzer

How is Spending Distributed?

Health-care needs differ across Alaskans and other Americans: some of us are born with genetic predispositions to certain illnesses; some of us take better care of ourselves; some of us are older and have costly, chronic ailments; some of us are just lucky.

We don't have figures specifically for Alaskans, but patterns of spending for Alaskans are not likely to be much different from those for all Americans. Here we look at average spending in the U.S. by type of ailment; by shares of the population; and by age.

Keep in mind that we're looking at how much the health-care system as a whole spends for certain groups—not how much individual Americans spend directly.

• *Patients with major acute ailments—like heart attacks or strokes—make up only about 8% of all patients treated across the U.S. but account for more than 22% of the cost.* Similarly, patients with major chronic ailments—like heart disease or diabetes—make up only about 5% of patients in the U.S. but account for 34% of costs (Figure 21).

• *By contrast, those with minor acute ailments make up 28% of all patients but are responsible for only 8%* of the costs. Those with minor chronic ailments—which don't require as intense care—make up 41% of patients but account for just 35% of costs.

• *Just 10% of Americans are responsible for 65% of all health-care spending in a typical year*—and the 1% of most expensive patients alone account for 20% of all spending (Figure 22).

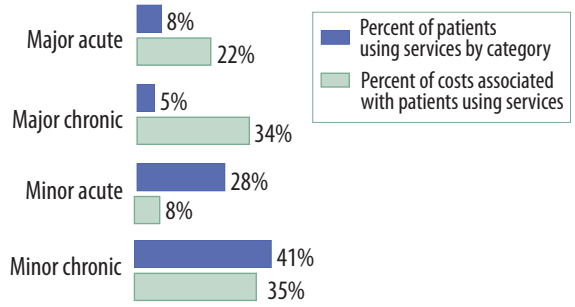
• *At the other extreme, half the population is responsible for only 3%* of health-care expenses—and 15% of Americans have no expenditures at all.

• *Americans with the highest expenses are disproportionately older, women, and White*. The uninsured make up only a tiny share (2%) of the patients with the highest medical bills—but those costs are covered either by government support or through higher prices for those with insurance.

• *Americans with very small health-care costs are mostly young* and one-quarter are uninsured—and many are Black or Hispanic men.

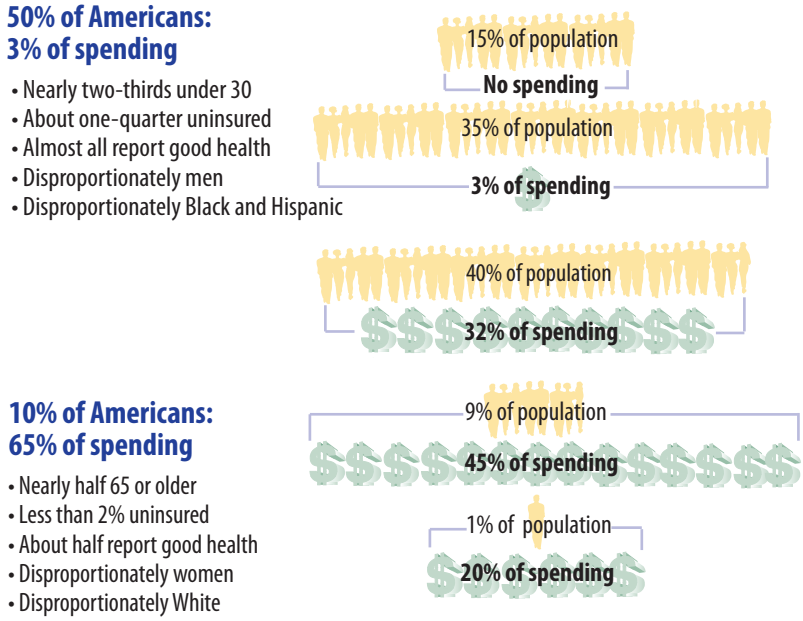
• *Health-care spending routinely increases with age—although among infants it's driven up* by the high costs of care for premature babies. Spending is at its lowest among children, increases somewhat through the 20s and 30s, and then begins a steep climb so that spending among those 85 years old averages nearly 10 times as much as among children (Figure 23).

Figure 21. Use and Costs Among Patients with Acute and Chronic Ailments in U.S.



Source: Adapted from Harold S. Luft, *Total Cure*, Harvard University Press, 2008

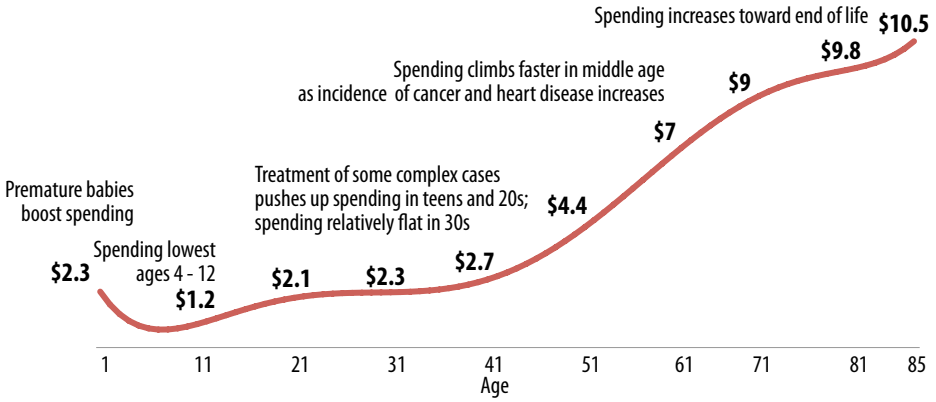
Figure 22. Distribution of Health-Care Spending per Person, U.S., 2008



Note: health-care spending here is defined as payments to hospitals, doctors, dentists, other health-care providers, and pharmacies by individuals or by private or government health insurance.

Source: MEPS Statistical Brief 309, *The Concentration and Persistence in the Level of Health Expenditures Over Time*, Agency for Healthcare Research and Quality, December 2010

Figure 23. Average Health Care Expenditures Among Americans, by Age, 2008
(In Thousands of Dollars)



Source: Medical Expenditure Panel Survey, 2008

Are Alaskans Healthier?

On a number of broad measures, Alaskans are healthier now than they were 20 years ago—and in some cases healthier than other Americans, as Figure 24 shows.

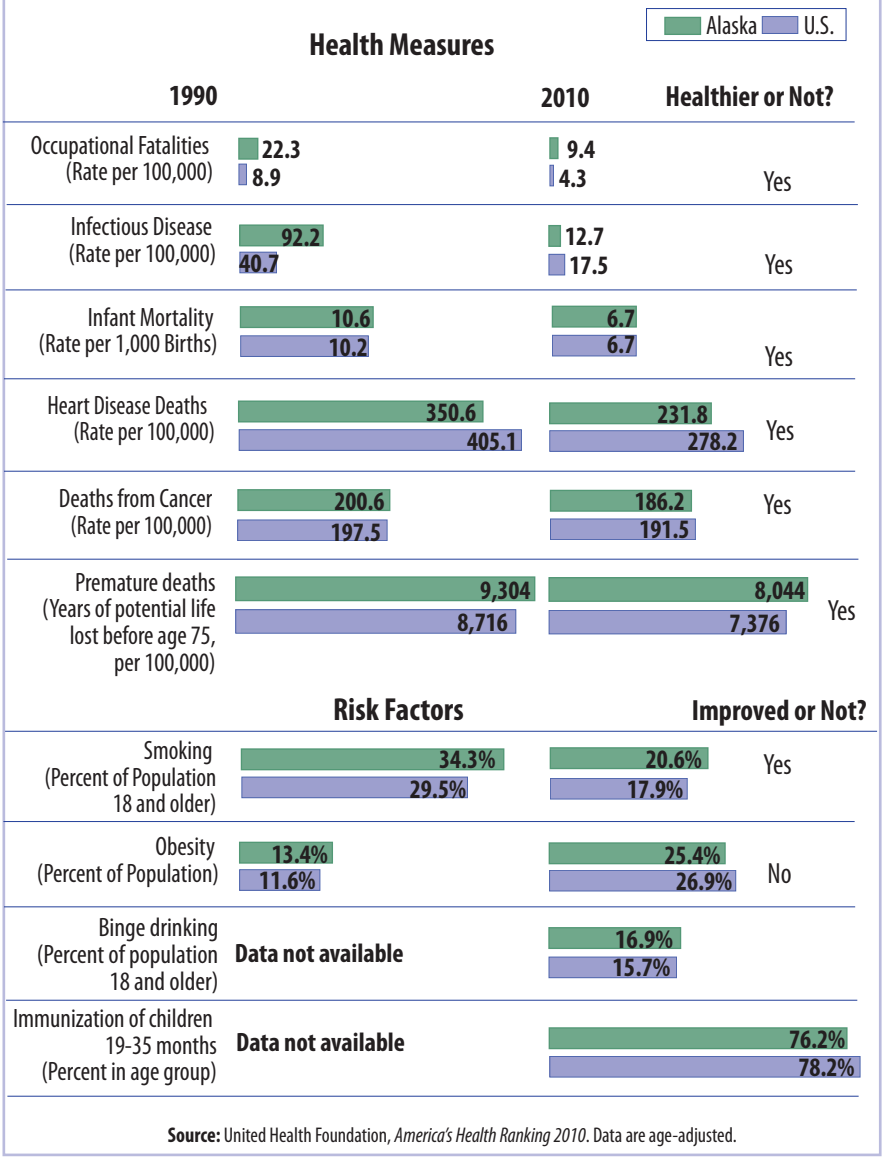
• *Deaths on the job are less than half as common* in Alaska now as in 1990, dropping from 22 per 100,000 to about 9 per 100,000—reflecting improved safety measures in many occupations, as well as the fact that a bigger share of Alaskans now work in generally safer jobs, like in retail stores. But many Alaskans still work in dangerous jobs—commercial fishing, for instance—so Alaska's rate of occupational fatalities remains twice that of the U.S. as a whole.

• *The rate of infectious disease in Alaska is now a small fraction* of what it was in 1990—down from 92 per 100,000 to under 13. Several things probably account for that, including higher rates of immunization. But a lot of credit also goes to federal and state programs that are building safe water and sewer systems in remote rural communities. The Alaska Department of Environmental Conservation reports that as recently as 1994, less than 40% of rural Alaska households had adequate sanitation systems. By 2005, nearly 80% had running water and flush toilets.[10]

And it's worth noting that the hundreds of millions of dollars the federal and state governments have spent for these sanitation systems is *not* defined as health-care spending—and so it's not included in our estimates.

• *Infant mortality has dropped sharply in both Alaska and the U.S. since 1990*, down from more than 10 infant deaths per 1,000 births to under 7. Experts say that infant survival is tied not only to the health of the mother but also to social and economic conditions in the communities where they're born, public health practices, and the availability of health care.[11]

Figure 24. Changes in Health Measures and Risk Factors, 1990 -2010



Source: United Health Foundation, *America's Health Ranking 2010*. Data are age-adjusted.

• *Rates of death from heart disease and cancer—but especially heart disease—are down from 1990s levels* in both Alaska and the country as a whole. Treatments for those conditions have improved, and fewer Americans are smoking—which is a big risk factor for heart disease and cancer. Death rates for both heart disease and cancer are lower in Alaska than nationwide, even when adjusted for Alaska's younger population.

• *Alaskans are less likely to die prematurely now than they were in 1990,* but still more likely than other Americans to lose years off their lives—partly due to higher rates of occupational and other injury deaths.

• *The percentage of adult Alaskans who smoke has dropped from 34% in 1990 to about 21%*—but that remains above the national average, and means that one in five of all adult Alaskans still smokes.

• *Obesity is almost twice as common in Alaska now as in 1990*. Analysts link obesity to higher rates of diabetes, heart disease, and other illnesses.

• *Nearly 17% of adults in Alaska report binge drinking*—somewhat higher than the 16% among all Americans.

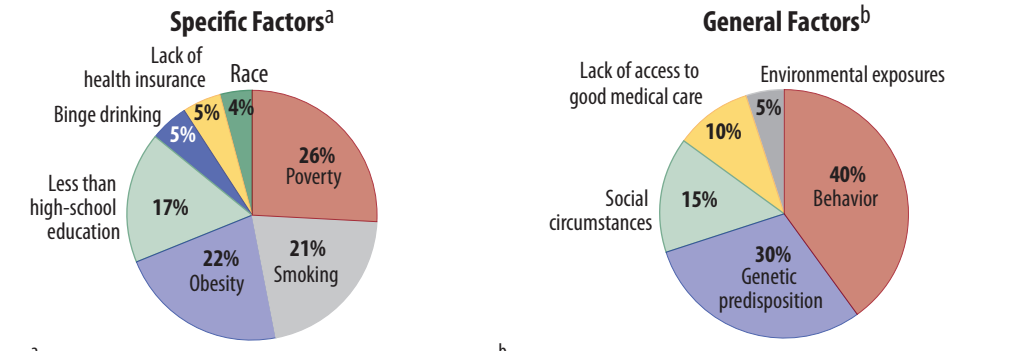
• *About one-quarter of Alaska children don't have all the recommended immunizations* before age three. The U.S. rate is only slightly better.

It's beyond the scope of this study to provide a detailed comparison of the quality of health care in Alaska with that in the rest of the U.S. or other countries. Measuring the quality of health care has many dimensions, and comparisons are influenced by many factors.

Still, even though comparisons across countries are fraught with complexity, it's worth pointing out that data collected by the World Health Organization currently rank the U.S. number 31 in "healthy life expectancy"—the number of years that a person can expect to live in "good" health. With an expectancy of 70 years, the U.S. is 6 years behind the perennial leader, Japan, where healthy life expectancy is 76 years.

Some of the difference is due to a higher U.S. infant mortality rate, compared with that of other developed countries—but the higher mortality rate among Americans persists throughout the adult years. Some of the difference can also be traced to the high homicide rate in the U.S.—double that of most European countries.

Figure 25. What Contributes to Early Deaths of Americans?



[a]Based on mean number of years lost by age 65

Source: *American Journal of Public Health*, Vol. 100, No. 9, " The Relative Health Burden of Selected Social and Behavioral Risk Factors in the U.S.," September 2010

[b]Based on a wide range of studies, listed in the *Health Affairs* article cited below.

Source: *Health Affairs*, Volume 21, Number 2, "The Case for More Active Policy Attention to Health Promotion," March/April 2002

What Contributes to Longevity?

Analysts are continuing to explore how important various factors are in making Americans live longer, healthier lives. They have looked at the issue in different ways, with different emphases. Figure 25 shows results from two assessments of what subtracts years from our lives. One assigns weight to specific factors—like smoking or lack of education—and the second generalizes to broader categories, like behavior and social circumstances.

The two ways of looking at the question aren't parallel, but they also aren't mutually exclusive. For instance, obesity—cited in the left-hand pie as one of the big contributors to early death—can be influenced by several factors in the right-hand pie: behavior (what people eat, as well as how much they eat); genetic predisposition; and social circumstances—for example, people without much money may eat more starchy, high-sugar foods that are cheaper but unhealthier.

What both sets of analysts do agree on is that lack of health insurance, or lack of access to good medical care, play relatively small roles in the overall longevity of Americans. That's not to say medical care isn't important: it saves thousands of lives daily.

But in the big picture, there are also many other individual, community, and social factors that affect health.

What About Health-Care Reform?

An obvious question, as we close this discussion of Alaska's current health-care spending and likely future growth, is how the 2010 federal health-care reform law might affect spending and coverage in Alaska.

We're not going to discuss that very complex question in this paper. The health-care reform law—formally, the Patient Protection and Affordable Care Act—runs to hundreds of pages and calls for substantial changes in health insurance and health-care sectors over the next decade. There is still uncertainty about how all the provisions will play out, or how they might be affected by any future changes in the law.

One of the authors of this paper has taken a preliminary look, in a separate paper, at the broad possible economic effects of the law in Alaska over the next decade. That paper finds that by 2019 overall health-care spending in Alaska is likely to be somewhat higher than it would otherwise have been—perhaps in the range of 3% to 4% higher—mostly because the new law will expand health-care coverage.[12]

Getting Good Value for Health-Care Spending

Analysts generally agree that the hundreds of billions of dollars Americans spend for health care are not giving us as much value as we should expect. Among the problems commonly cited are unnecessary care, fraud, system inefficiencies, failure to coordinate care, and care that could have been avoided, through preventive measures.[13] Spending per capita on health care is higher in the U.S. than in other developed countries, and yet by some measures the quality of care is lower.

Some researchers even believe we may be at a point where increased health-care spending is not translating into significant reductions in rates of illness and death. And clearly, fast growth in the nation's health-care bill limits our ability to pay for other important needs.

A growing, aging population and general inflation will continue to drive up the health-care bill in Alaska and across the country, as they have in the past. Rising incomes among Americans, and adoption of new technologies, will also add to future spending.

No one is suggesting that the U.S. try to curb health-care spending by reducing the development and implementation of new technologies that might provide real advances in health care. But we do need to think about how to rein in the growth in spending and get the best value from our health-care dollars.

What can we do? Many people inside and outside the health-care system agree on some general guidelines for change.

• *Consumer activism and improved transparency*. Patients should become more careful consumers of health care, and doctors and other providers should provide better information on alternate treatments and their comparative effectiveness.

• *System improvements and care coordination.* Hospitals, doctors, and other health-care providers should promote integrated delivery systems that put the patient at the center of the process. Building shared electronic medical record systems will be an important part of that.

• *Medical homes and culture of health*. Providers and patients should think of themselves as in a partnership, with the patients and the caregivers each taking an active part. Patients should take more responsibility for managing their own health—by paying attention to their own behavior, taking steps to try to prevent disease, and getting appropriate care for chronic diseases.

• *Patient safety and quality improvement*. The health-care industry should support initiatives to improve the quality of care and encourage a culture that continually strives to improve care.

• *Simplify reimbursement and reduce opportunities for fraud*. Providers, administrators, and patients should join together to help find ways of making the billing process easier and eliminating fraud, as well as recognizing those who demonstrate integrity in both billing and paying.

With those general guidelines in mind, many analysts suggest there are two areas of systemic reform that could help make the health-care system more efficient and cost-effective, and also moderate the rate of growth in future health-care spending. Those reforms are: changing how we pay for care, and changing how care is provided.

The current payment system is dominated by "fee-for service," which means payments to health-care providers are directly related to the volume of services they provide. So there's little incentive to reduce unnecessary care. By contrast, under a "bundled payment" approach, multiple providers are paid a single sum for all the services related to one episode of care—for example, a hospitalization plus a period of post-acute care. Some providers are adopting that payment system.

The current system for providing health care doesn't have mechanisms to screen treatments for either their medical effectiveness or their cost effectiveness. Many people agree that a reasonable step would be closer analysis of what treatments and technologies are worth the cost.

The challenge, of course, is that while many people believe the health-care system needs to be reformed, they disagree about how to make the changes. Also, the hurdles in reforming a system with very powerful vested interests will be formidable. But the savings from making the kinds of changes we just discussed could be in the range of 3% to 10% over 10 years.[14]

Given this national context, what about Alaska? Alaska's health-care system will always face challenges created by its special circumstances—remoteness and small, widely disbursed population—that will add to the cost of health care here, compared with other states.

Reducing that cost differential will require special programs—for example, investing in a "home-grown" supply of health-care workers. But Alaska has also already put into effect a number of initiatives to improve the value we get for our health-care spending.

One example is the Southcentral Foundation (serving Alaska Natives) which operates a patient-centered primary care system—NUKA—that the foundation reports has reduced per patient costs.[15] Another example is the recent training of dental technologist to do certain kinds of dental work in rural areas, to reduce the need to either fly dentists into remote villages of fly dental patients out. The state government also reduced the rate of growth in Medicaid spending in recent years, and the legislature recently expanded the state's authority to review increases in health-insurance rates.

Alaska's total health-care bill will continue to go up in the coming years, given that much of the bill is driven by population and general inflation. But potential systemic reforms—along with more initiatives like those we've just discussed—can make inroads in that growth, and give Alaskans more confidence that we're getting better value for our health-care dollars.

Endnotes

1. Centers for Medicare and Medicaid Services, *Health-Care Expenditures by State of Provider; Health Expenditures by State of Residence*, 2004.

2. Reported by Alaska Division of Insurance, FY 2010 Annual Report, Statistical and Financial Data, Accident and Health Market Share, Total Market, Direct Percent of Market, page 78.

3. See Family Medicaid Eligibility Manual, Alaska Department of Health and Social Services, Division of Public Assistance: http://dpaweb.hss.state.ak.us/manuals/fam-med/fmem.htm.

4. Here we use enrollment estimates of the Alaska Department of Health and Social Services, Medicaid Budget Group. Those estimates are not directly comparable to figures commonly found on the Kaiser State Health Facts website, which are from the Centers for Medicare and Medicaid Services and are based on enrollment counts for federal fiscal years. Reconciling the differences, typically less than 10%, was beyond the scope of this analysis.

5. We define health-care costs based on what's included in the National Health Expenditure accounts of the Centers for Medicare and Medicaid Services. These accounts include: hospital care; physician and clinical services; other professional services; dental services; other personal health care; home health care; nursing care facilities and continuing care retirement facilities; prescription drugs; durable medical equipment; non-durable medical products; government administration and net cost of private health insurance; government public health activity; and research structures and equipment.

6. Analysts often disagree about the effectiveness of new treatments. See, for example A. Rosen, et al., "The Value of Heart-Disease Care for the Elderly," *Health Affairs*, Vol. 26, No. 1, 2007; and M. Rothberg et. al., "Little Evidence of Correlation Between Growth in Health-Care Spending and Reduced Mortality," *Health Affairs* , Vol. 29, No. 8, August 2010.

7. The CPS also shows a smaller share of Alaska children—around 30%—relying on Medicaid in the 2006-2008 period than 2010 state figures show—about 40%. This may be because the figures are from different periods, or because the CPS is an underestimate.

8. Mark A. Foster and Rosyland Frazier, "How Hard Is It for Medicare Patients to Find Family Doctors," *Understanding Alaska* Research Summary No. 14, Institute of Social and Economic Research, University of Alaska Anchorage, March 2009.

9. Mark A. Foster and Associates, Medicare section, *Estimated Economic Effects of the Patient Protection and Affordable Care Act, As Amended, in Alaska*. May 2011. Also, the recent Congressional agreement to raise the U.S. debt limit includes requirements for future budget cuts that could also affect Medicare reimbursement levels.

10. Alaska Department of Environmental Conservation, Village Safe Water program. See www.dec.state.ak.us/water/vsw/index.htm

11. B. Hamilton, J. Martin, S. Ventura, "Births: Preliminary Data for 2007," National Vital Statistics Reports, Volume 57, National Center for Health Statistics, 2009.

12. See note 9.

13. See, for example, B. Kelley and R. Fabius, *A Path To Eliminating $3.6 Trillion in Wasteful Health-Care Spending*, White Paper, Thomson Reuters, June 2010, at factsforhealthcare.com.

14. See, for example, Hussey, et al., "Controlling U.S. Health-Care Spending—Separating Promising from Unpromising Approaches," *New England Journal of Medicine* 2009, 361: 2109-2111, November 26, 2009; and B. Kelley and R. Fabius, cited in note 13.

15. See http://southcentralfoundation.com/files/nuka.pdf

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www.iser.uaa.alaska.edu

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