

MEMORANDUM

TO: Deborah Erickson, Alaska Health Care Commission

FROM: Mark A. Foster, MAFA

DATE: December 8, 2011

RE: Response to Questions & Comments regarding Health Care Spending in Alaska

Summary

Health care spending in the U.S. and Alaska continues to grow markedly faster than the overall economy - raising questions about long term sustainability of health care spending growth.

In addition health care spending as a percentage of the economy in Alaska continues to grow faster than another prominent resource development state with a significant oil and gas sector, Wyoming, raising questions about Alaska's long term competitiveness.

Background

Health care spending as a proportion of the economy – U.S.

One frequently used measure to gage health care spending is *national health care expenditures* (NHE) as a percentage of gross domestic product (GDP). The CMS baseline projection prior to the passage of the PPACA assumed that *National Health Expenditures* would grow from 17.8% to 20.8% from 2010 to 2019 – a *rate of increase of 3 percentage points of GDP per decade* – prior to consideration of the passage of the PPACA.¹ The continued rapid increase in health care spending as a percentage of the national economy has raised serious and substantial concerns about whether the current health care spending trajectory is sustainable.

Much of the recent health care reform debate has focused on achieving budget neutrality over a 10-year period, but this goal is less important than the reform's long-run fiscal sustainability.

If the rate of growth of health care spending continues to exceed the rate of income growth by its historic margin of 2 percentage points, the consequences for beneficiaries, federal and state budgets, and the entire economy – given the implied increase in tax rates and foregone consumption - will be dire.²

¹ See Table 5, *Estimated Increase (+) or Decreases (-) in National Health Expenditures under the Patient Protection and Affordable Care Act, as Enacted and Amended, in billions*, CMS Office of the Actuary, Richard Foster, Chief Actuary, *Estimated Financial Effects of the "Patient Protection and Affordable Care Act", As Amended*, April 22, 2010.

² "Ensuring the Fiscal Sustainability of Health Care Reform", Chernew, Sabik, Chandra and Newhouse, *New England Journal of Medicine*, 362; 1; January 7, 2010. See also "Assessing Health Reform's Impact on Four Key Groups of

Health care spending as a proportion of the economy – Alaska & Wyoming

The Centers for Medicare and Medicaid (CMS) also develops estimates of *personal health care expenditures* (PHE) by state.³ CMS recently released an update to its 2004 estimates of *personal health care expenditures* by State – bringing those estimates forward to 2009.

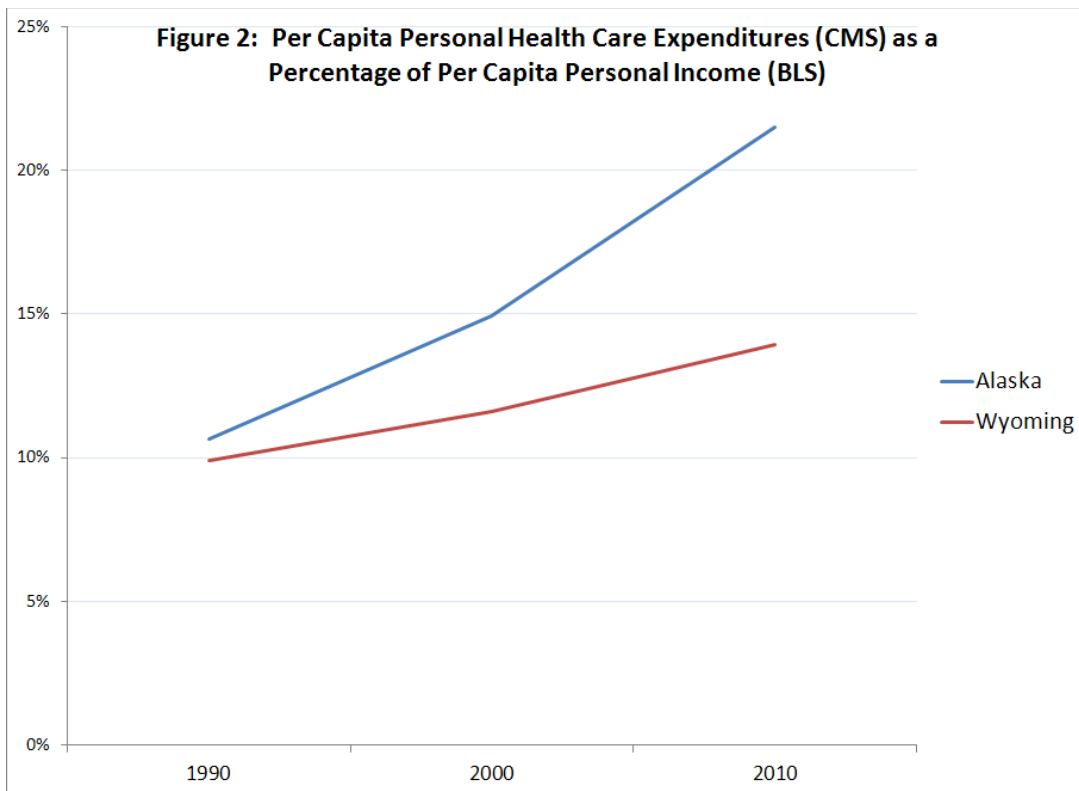
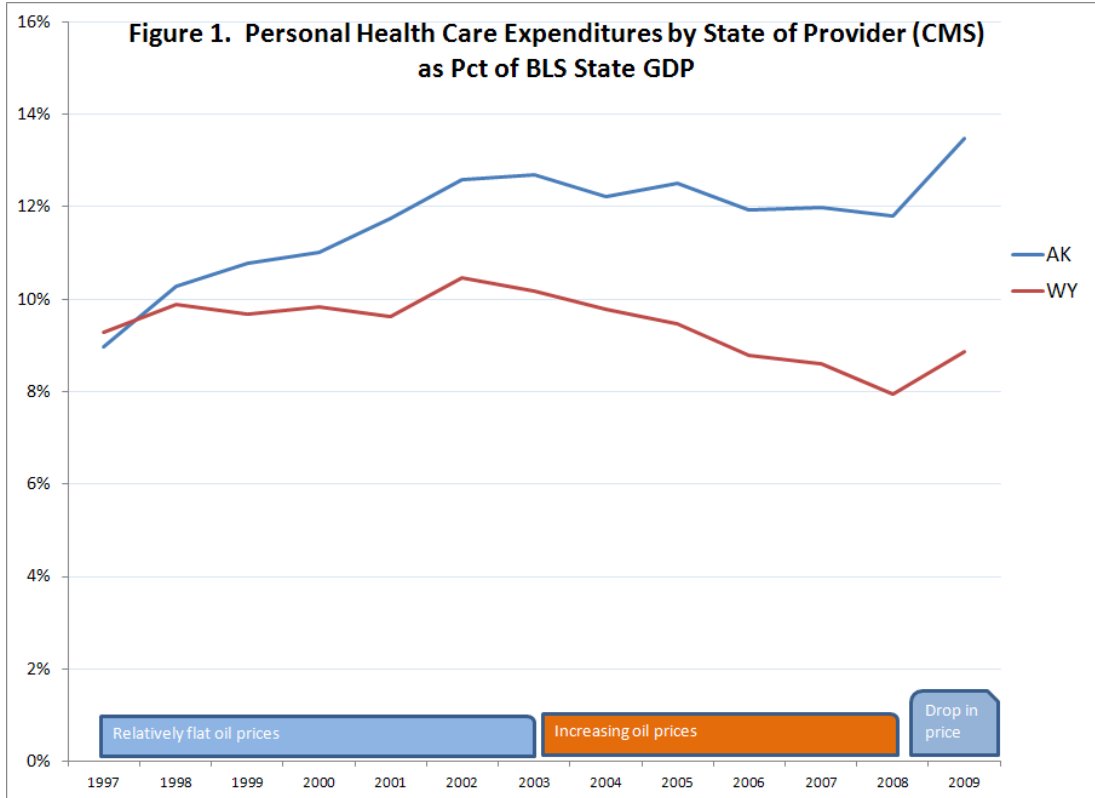
Of all the 50 states, the closest potential benchmark for Alaska for health care spending *as a proportion of a State economy* is most likely Wyoming due to *general* similarities in population, rural character and reliance on a natural resource economy that includes a large contribution from high value oil and gas development. In addition, Wyoming also makes for an interesting comparison case because Alaska and Wyoming share the unique characteristic among the 50 states that their State Medicaid fee for service reimbursements have exceeded fee for service reimbursements for Medicare in their respective states – a potential reflection of the high value of oil resources for a State economy that has enabled State government to reimburse local providers of Medicaid services at more generous rates than other states.

We note that as oil prices were relatively flat during the late 1990s/early 2000's, Alaska's personal health care spending as a percentage of Bureau of Labor Standards (BLS) State GDP grew from being roughly comparable with Wyoming at 9% in 1997 to 12.7% in 2003, a gain of almost 4 percentage points in six years for Alaska compared to just less than 1 percentage point for Wyoming. As oil prices rose from 2004-2008, personal health care spending as a percentage of State GDP in Alaska lost just under one percentage point vs. losing 2.3 percentage points in Wyoming. And as oil prices dropped from the third quarter of 2008 into 2009, personal health care expenditures as a percentage of GDP jumped 1.7 percentage points in Alaska vs. 1.0 percentage points in Wyoming. See Figure 1 below.

Turning to *per capita personal health care expenditures* as a percentage of *per capita personal income* as an indicator of how large health care has become relative to income, we find that in 1990 Alaska and Wyoming were both at roughly 10%. But by 2010, Alaska's per capita personal health care expenditures had grown to 21.5% of per capita personal income – an increase of 11 percentage points of “health care market share” of income in 20 years - while Wyoming saw an increase of only 4 percentage points of “health care market share” of income over the same period. The rapid increase in the proportion of per capita personal health care expenditures as a percentage of per capital personal income for Alaska, especially when compared to Wyoming, raises questions of whether the Alaska economy can sustain that level of spending growth and be competitive. See Figure 2.

Americans”, Joseph P. Newhouse, Health Affairs, Vol. 29, No. 9 (September 2010), Exhibit 4, which describes “implied U.S. Federal Tax Rates by 2050” if GDP-health care cost growth exceeds income growth by 2.5% per year as reaching 26%-92% for the lowest to highest income tax brackets.

³ Please note that the CMS estimates of personal health care expenditures do **not** include Government administration, net cost of private health insurance and government public health activities which were included in the ISER Research Summary on the Cost of Health Care in Alaska (2011).



Potential limitations of comparisons between Alaska and Wyoming

While Alaska and Wyoming may share many general similarities, they also have a number of noteworthy differences that may limit the usefulness of a comparison of health care expenditures as a percentage of State GDP.

On the health care spending side, notable differences that merit consideration for a normalization adjustment include the federal investment in Alaska associated with the Alaska Native Tribal Health Consortium along with VA and military facilities and programs over the past 20 years.⁴

On the other hand, the proportion of the Wyoming population that is over 65 is higher than the proportion of the Alaska population that is over 65. Adjusting for the age difference in the population would suggest per capital health care expenditures as a percentage of per capita income would be even higher than reported in Figure 2 and appears likely to become an even more significant consideration if the rapid growth in proportion of the over 65 demographic continues in Alaska.

On the per capita personal income side, notable differences that may be worthy of additional consideration for normalization adjustments include the very large coal sector in Wyoming.

Finally, we note that as with any comparison between two political subdivisions and associated geography and economies, e.g., Anchorage vs. Mat-Su, Anchorage vs. Fairbanks, Anchorage vs. Spokane, Alaska vs. Wyoming, U.S. vs. other OECD countries, any number of differences can be highlighted to suggest that each community of interest is unique and the comparisons between them may be of limited value. Nonetheless, we believe that it is important to continue to search for and refine potential benchmark comparisons between Alaska and its subdivisions and other jurisdictions in order to ensure that policy makers, businesses and households have some basis to make an informed judgment about Alaska's economy and the size and value of its health care sector relative to potential competitors and to enable policy makers to consider whether Alaska's health care sector and economy remains competitive.

⁴ We note that while this adjustment may be useful for historic comparison purposes, it begs the question of what happens over the next 20 years if federal support in Alaska diminishes relative to historic practice. Who will pay for the local health care capacity that has been built if federal support becomes flat or declines in real terms? Given relatively modest competition in the health care sector in Alaska, at least by national standards, there may be some risk that a reduction in federal support for health care may result in attempts to shift provider costs back toward private insurance or the State of Alaska.

Alaska economy vulnerabilities

Oil is the primary economic driver of the Alaska economy and remains a very large proportion of the economy in Alaska compared to other states. Goldsmith estimates that the oil sector in Alaska may support, directly and indirectly, roughly half of the jobs in Alaska.⁵

Going forward, Goldsmith estimates that the maximum sustainable yield in State spending (including Permanent Fund Dividends) based on current savings and future petroleum wealth may be on the order of \$5 billion. Total FY2012 projected petroleum wealth spending was estimated at \$6.1 billion. Goldsmith estimates actual spending exceeds the maximum sustainable spending by about \$1.1 billion or 20%.⁶

The federal government has been a large portion of the Alaska economy for decades. Over the past several decades, federal spending grew substantially. As recently as 1995-2005, federal spending in Alaska doubled in current dollar terms.⁷ However, the growth in federal spending per capita in subsequently slowed to only 6.5% over the four year period 2004-2008.⁸ In July 2008, Goldsmith postulated that Alaska could be vulnerable to federal spending cuts in the range of \$450 million to \$1.25 billion (5-14% of then current spending).⁹

In the summer of 2008 when Goldsmith published his “vulnerability analysis”, the annual federal deficit as a percentage of GDP was projected to be -3.2% (FFY08) and total federal debt held by the public was projected to reach roughly 40% at the end of Federal FY08. In Federal FY2011 (Oct 2010 – Sept 2011), the annual federal deficit as a percentage of GDP was projected to be -10.9% and the total federal debt held by the public was projected to reach 73% at the end of September 2011. Given the relatively large increase in annual and accumulated deficits since his estimate was formulated, we believe that Goldsmith’s analysis of Alaska’s vulnerability to federal spending reductions on the order of 5-14% may be optimistic.

Thus, the Alaska economy appears increasingly vulnerable to both a substantial turn-around in revenues from petroleum wealth plus a reduction in federal government support.

It may be prudent to consider what steps can be taken today to mitigate against continued rapid growth in health care spending whose momentum may result in foregone consumption and higher taxes for Alaskans especially in light of the potential for petroleum wealth and federal spending in Alaska to see real reductions.

⁵ “Oil Pumps Alaska’s Economy to Twice the Size – But What’s Ahead?”, Scott Goldsmith, UAA ISER Research Summary No. 17, February 2011

⁶ “Revising the State Fiscal Plan to Account for Petroleum Wealth”, Scott Goldsmith, UAA ISER Web Note No. 9, May 2011, page 11.

⁷ “How Vulnerable is Alaska’s Economy to Reduced Federal Spending”, Scott Goldsmith, UAA ISER Web Note No. 2, July 2008

⁸ U.S. Census Bureau, Consolidated Federal Funds Report, 2004, 2008.

⁹ “How Vulnerable is Alaska’s Economy to Reduced Federal Spending”, Scott Goldsmith, UAA ISER Web Note No. 2, July 2008

The Economics of Smarter Health Care Spending

Katherine Baicker and Amitabh Chandra delivered a paper entitled “Aspirin, Angioplasty, and Proton Beam Therapy: The Economics of Smarter Health Care Spending” at the Jackson Hole Economic Policy Forum on August 26, 2011.¹⁰ Their abstract succinctly outlines the challenges and opportunities facing health care in the U.S. that are also the challenges facing health care in Alaska. Quoting the abstract in full:

The growing share of the U.S. economy devoted to health care spending is cause for concern both because of the share that is publicly financed and because of the inefficiency with which those resources are used. Fueled in part by demographic transitions, unchecked increases in entitlement spending will necessitate some combination of tax increases, the elimination of other public spending, or public debt levels that far exceed those currently observed in Greece. Despite these spending levels, highly cost-effective treatments like aspirin and flu shots are underused, while angioplasty is used in both lifesaving and inappropriate cases and exorbitantly unproven procedures such as proton beam therapy are generously reimbursed by public programs. Driven by expenditures on such expensive care, public insurance spending is rising unsustainably at the same time that a fifth of the population goes uninsured. In an efficient system, more spending on health care would not be a cause for concern. Achieving this means improving the incentives and infrastructure for providers to deliver – and patients to consume – high-value care, as well as wrestling with the difficult question of whom to cover versus what to cover in public insurance programs. But the wide prevalence of inefficiencies offers hope, for there is scope for fundamental reforms to improve the productivity of health care spending and the fiscal health of the U.S.

Conclusion

Health care spending in the U.S. and Alaska continues to grow faster than the overall economy - raising questions about long term sustainability of health care spending.

In addition health care spending as a proportion of the economy in Alaska continues to grow faster than in other resource development jurisdictions raising questions about Alaska’s long term competitiveness.

Collaborative efforts that focus on achieving substantial increases in the value of health care in Alaska are timely and necessary to ensure Alaska’s long term competitiveness.

¹⁰ The paper is dated August 8, 2011.