OBAMACARE’S NEW FRONTIER
Alaska blazes a trail to bolster health insurance
Twin Peaks

Alaska, the state with the highest health care costs, has a plan that’s drawing high praise and facing steep challenges
UNEAU, Alaska — It’s hard to get excited about a health insurance premium spike. But for Lori Wing-Heier, Alaska’s blunt but friendly state insurance commissioner, the decision by the state’s Blue Cross Blue Shield plan to raise its rates by just 7 percent was a moment of joy. “I was just so relieved,” she recalled, smiling, in an office overlooking the tiny sliver of a town that serves as the largest state’s capital.

That 7 percent increase — finalized last August — was the first sign that her plan had worked. After a grueling slog with a state legislature of reluctant Republicans throughout the spring, Wing-Heier had put in place a program designed to prevent Alaska’s only remaining Obamacare insurer from raising its rates a whopping 42 percent, one of the highest projected hikes in the country.

At a time when nearly every state was seeing their Obamacare rates jump, some by 20, 30, even 50 percent before subsidies lowered consumers’ costs, Alaska kept its spike in
check. Its health insurance costs are already the highest in the nation.

Suddenly Wing-Heier — whose lilting accent at least subtly resembles Sarah Palin's — became the most popular insurance commissioner in the country. The Obama administration openly praised her plan, a surprise for a red state. Then the incoming Trump transition team did, too — a rare area of bipartisan agreement on not just health care policy, but on the controversial law known as Obamacare, the Affordable Care Act. Policy experts, too, have lauded Alaska as the first state to “fix” the health care law.

Commissioners across the country asked for the details of her success. Minnesota and Idaho set up similar programs, and policymakers in Maine introduced legislation modeled on the idea. Other states like California, New Hampshire, Ohio and Oklahoma are eyeing the program for 2019 and later.

It seems like a simple solution based on the concept of reinsurance, transferring a portion of risk to another entity. The program really did reduce consumers’ expected premiums, which are at the center of so many complaints over the health law. The idea isn’t nakedly partisan, like so many other health proposals, and doesn’t alienate the hospitals, doctors or insurance companies that often fight changes to their business models.

It comes with an even more attractive twist, too: the federal government might be persuaded to pick up some of the tab.

But the real story is more complicated — and portends the arduous path the program would face in any other state weighing the idea.

Alaska not only had a unique need for the program thanks to its outlandishly high premiums, but it also had the budget reserves to fund it without making any cuts or adding any taxes.

It should have been easy — or at least easier here than anywhere else. But interviews with dozens of state lawmakers and industry officials show that the path was anything but. This isn’t an Affordable Care Act “fix” that will breeze through state capitals, regardless of its merits.

Nor is it clear, in the end, that the program is a true remedy to the price hikes that have alienated so many Americans. In many ways, the program is a limited, stopgap solution to the underlying issue plaguing American health care: high costs. It does lower premiums, but only by throwing more federal and state funds toward the problem.

Alaska’s experience serves as a lesson not only for other states considering the same solution, but for congressional Republicans, who are mulling a similar idea in their own efforts to repeal and replace the 2010 law. At the outset, the House Republican bill may not contain as much funding as needed to replicate the success of Alaska’s program — and the costs will only grow over time.

The Idea: Lowering Sky-High Premiums

Alaska isn’t known for policy experimentation. But Wing-Heier embarked on her rescue mission because she had no choice. Like just about everything else in Alaska, health care costs in the Frontier State are bigger. In this case, the costs are orders of magnitude higher than those in the Lower 48.

Alaska — a state with a geography so vast that people keep float planes docked behind their waterfront homes instead of motorboats — faces the same dynamics that have driven up insurance costs and reduced insurer competition in a host of other rural areas. It sees limited provider competition and a small population to share costs. It just feels them that much more acutely.

In some ways, Alaska goes beyond “rural.” Even New Hampshire has more miles of road than Alaska, despite its immense size. Many homes are accessible only by snowmobile or
ATV, depending on the time of year. Anchorage, the most cosmopolitan city, boasts a population of just 300,000, and moose still share the streets with cars.

“Alaska’s always the crack at the end of the whip,” says state Sen. John Coghill, a long-serving Republican from the Fairbanks area. “Everything has an exponential effect up here.”

Alaska’s insurance premiums are no different — they dwarf those in any other state. In Anchorage, the average benchmark plan this year costs $904 per month before subsidies. The next highest city is Charlotte, N.C., where costs are $572 per month. The national average hovers around $361 per month.

The differences are most pronounced for older Americans like Ray Jakubczak, a gregarious, 55-year-old biologist who delights in $361 per month. His household has a $5,250 deductible for any care they need. It’s more than any other expense in their budget. Now, despite his deep love for his mountain views and his local coffee shop, he’s thinking about moving south.

“You wouldn’t think that if you plan and budget responsibly, you have a 20-plus-year professional career, it’s going to be so high as to drive you out of state. But more than $30,000 a year? And you can’t even use it, because the deductibles are so high,” he lamented on a recent drive through the mountains where he and his wife built their home 17 years ago.

The Jakubczaks’ bill is high, even for Alaska. Their financial pain is particularly acute because they make too much to qualify for the health care law’s subsidies for people who earn up to four times the poverty level.

Enter Wing-Heier, with a plan to bring down those sky-high health insurance costs, or at least to keep them from spiking again: the wonky idea of reinsurance.

The concept is based on the basic premise of insurance: healthy people paying into the system will help offset the costs of any sick people. A reinsurance program relies on a separate pool of money to fund the care for some of the sickest people in the group — effectively lowering the prices everyone else must pay.

Under Alaska’s program, people who suffer from 33 relatively expensive conditions, like end-stage renal disease, hemophilia or cerebral palsy, would still buy their plan from the state’s Blue Cross plan, Premera, and pay the same premiums as anyone else who relies on HealthCare.gov. But behind the scenes, their health care claims would be paid out of a $55 million state pool of reinsurance money, rather than Premera’s own funds.

The program is aimed directly at reducing costs for people like Jakubczak and his wife — relatively healthy people who face especially high premiums, because they are older or too wealthy to qualify for subsidies, or both — and who are bearing costs for sicker, more expensive enrollees.

The tactic works especially well in small markets like Alaska’s, where just shy of 20,000 people buy their insurance through HealthCare.gov, compared to more than 1 million each in states like California or Texas. The District of Columbia alone has enrolled more people than the entire Frontier State. Any especially expensive health care service — like cancer or multiple sclerosis treatment — is shared by far fewer individuals.

Jakubczak didn’t know about the reinsurance program, but it actually saved him almost $10,000 this year. Without it, his $2,659 premiums could have topped $3,500 per month.

People like Jakubczak — who face sky-high rates with little benefit — exist all across the country. That commonality makes reinsurance an attractive option. So does its simplicity. Throwing more money at a targeted problem is easier than rewriting the entire health care policy landscape, especially when changes to the system necessarily create some winners and losers. Reinsurance, at least on its face, doesn’t.

But as Alaska’s experience shows, even a straightforward reinsurance program can be a brutally punishing policymaking effort for a state legislature.

Getting It Through

The idea came to them last April, in a Friday night emergency meeting in a cramped office of Alaska’s small but statey Capitol building, just as the sun was setting behind Mt. Juneau, the towering seaside peak that looms over the tiny town.

Wing-Heier was nearly hopeless, she remembers. She’d logged meeting after meeting in the Capitol, where three or four staffers essentially play Tetris to jam their desks, filing cabinets and mini-fridges in spaces meant for one.

The lawmakers were beginning to grasp the severity of the potential 42 percent premium spike and what it would mean for the people who rely on those health plans. There were already signs that the other insurer in Alaska’s

CASH CRUNCH: Jakubczak’s premiums are sky-high.
A Red State Nervously Eyes GOP Health Talks

ANCHORAGE, Alaska — It was a woman in the Providence Alaska Medical Center billing department, not one of its doctors or nurses, who saved Drew Cato’s life, he says.

Belinda Wright signed up the recovering meth addict for insurance under the 2010 Affordable Care Act, giving the 57-year-old coverage for the first time since he was a kid.

Cato had been in and out of jail for years and was living in a halfway house when he found his way to the hospital in 2015. She got him into a behavioral health program that helped him get new housing and, eventually, a set of dentures. “She did everything, because I wasn’t capable at that time to do anything,” he says. “It was more than nice. It changed my life.”

Now, two years later, Cato is quick to show off the high school diploma he’s earned since he got clean. He’s even quicker to pull out pictures of his 14-year-old son, with whom he’s developed such a good relationship that the teen may move into Cato’s apartment. Cato jumps at the chance to show off the bed-frame he’s building himself, with Alaskan timber, or the protein powder his personal trainer recommended.

Without the health care law, he says, “I’d probably be dead. I think my spirit would have died and my body would have followed.”

“It’s been an amazing journey,” he adds.

It is stories like Cato’s that Republicans in Congress — in particular, Alaska Sens. Lisa Murkowski and Dan Sullivan — keep in mind as they work to repeal and replace the health care law. They must now weigh the impact of the legislation — which only narrowly passed the House of Representatives last month — on the people who rely on the law’s subsidies or its expansion of the Medicaid program. Alaska was one of 32 states, including the District of Columbia, that broadened the program’s eligibility.

In Alaska, if the House bill becomes law, the outlook is dire. “Our state would be the most negatively affected if the proposed legislation is signed into law as is,” independent Gov. Bill Walker acknowledged in a statement last month. “This bill could be a game-changer.”

Outsized Impact

No other state will see such a large drop in federal money flowing its way per person if the House-passed plan takes effect.

The biggest change for the state will be the law’s tax credits. Under the 2010 health care law, tax credits for people who get insurance through their jobs vary by age, income and geography to help people who make less than 400 percent of the federal poverty level afford their insurance. Older people and those living in high-cost areas get more money to help buy insurance.

Because Alaska has the highest costs in the nation, its insurance premiums are heavily subsidized. Premiums under the health care law in Alaska average about $927, compared to a national average of $361 per month for an individual. But people earning $30,000 a year pay roughly the same premium under Obamacare no matter the ZIP code. Alaskans would lose out on average $10,500 per person in federal assistance in the year 2020 — and even more if they were older or poorer, according to the left-leaning Center on Budget and Policy Priorities.

Less federal help will mean some healthy people would forego insurance — and in a tiny insurance market like Alaska’s, that could have serious ramifications. If only sicker people remain, even fewer people will share the costs, driving up prices in a potentially exacerbating cycle. “There’s a real risk that Alaska’s individual market would unravel because the first people to drop coverage are healthier people,” says Aviva Aron-Dine, a CBPP senior fellow. “There’s a mythology about a death spiral under the ACA, but you could get a real death spiral here … It’s more at risk than any other state.”

For the state’s 27 hospitals — 14 of which are considered critical access hospitals in rural areas — the bill’s biggest impact will likely come from provisions that effectively end the Medicaid expansion for adults earning up to 138 percent of the federal poverty line, as well as its policies to transition the broader Medicaid program.
to a system that provides only a set amount of money per person. The nonpartisan Congressional Budget Office estimates that change will strip $834 billion from the program over 10 years.

The state hospital association estimates non-tribal hospitals would lose about $1.5 billion in reduced Medicaid revenues. At the same time, they’d be on the hook for $500 million in increased costs related to treating the uninsured.

“My first concern is always for our critical access hospitals. They operate on very, very narrow margins and in communities that are often only accessible by plane,” says Becky Hultberg, president of the state association. “What does it mean when a critical access hospital closes in a community with no road access? It means expensive medevacs, it means treatment is delayed and it means there’s a human cost.”

Another Alaskan quirk: The state is one of the few places in the country where Medicaid reimburses doctors more highly than Medicare — so for now, people receiving Medicaid have few problems getting appointments. Drastic cuts to the program, through either an end to the expansion or the legislation’s proposed per capita caps, could change that.

“What we’ll probably do is put further cuts on the rates hospitals charge, that clinics charge, that doctors charge, that Medicaid will pay for. That will probably lead some providers to drop covering people on Medicaid,” says Mark Regan, legal director at the Disability Law Center of Alaska. “It hasn’t been that much of a problem here, but it’s going to start being a problem as we cut rates.”

Only in Alaska

Providers across the country face similarly massive budget cuts and closures because of the legislation’s Medicaid changes. The bill would make it harder for states, including Alaska, to address a burgeoning opioid crisis or to keep their uninsured rates at their historically low levels.

But few other states have a tribal health system that is as robust and respected as Alaska’s. Here, a consortium of 229 tribes banded together to run a network of hospitals and village clinics themselves, rather than relying on the Indian Health Service. A hub hospital in most regions of the state coordinates care for patients in farther-flung villages, working with trained locals known as “community health aides” to care for patients across a vast geography.

It’s no small feat. The system cares for about 20 percent of the state’s population exclusively, and offers services to those in rural areas where its clinics are the only providers for hundreds of miles. It is the second-largest health employer in the state.

The system is especially reliant on Medicaid for its funding. It takes a lump sum from the Indian Health Service to fund its hospitals, but the majority of its patients are Medicaid beneficiaries. Even more have signed up since the expansion.

The bill “negatively impacts Alaska Natives and rural Alaskans on a far greater level than the rest of the country,” says Julie Kitka, president of the Alaska Federation of Natives that represents many of the tribes.

She pledges to work “very, very closely” with Murkowski and Sullivan to improve the legislation.

And those two are ready to do exactly that, they said in interviews. They acknowledge that taken together, the policies proposed in the House-passed health care legislation will adversely affect the state’s health system and much of its economy. And they say it’s animating them to change the bill.

“We are always the measure that is most high or most low, and dramatically so,” says Murkowski, referring to analyses of the bill’s impact. “A fix that is going to help everybody else doesn’t necessarily help Alaska.”

She’s asked her team to find solutions for her state and its people — whether it’s the fisherman, the bankers or the state employees, she says. But the task is big. She is quick to say she hopes to move the debate at a deliberate pace.

“I want to take the time to do it right, do it right for Alaska and do it right for the country.” — E.M.
Obamacare market, Moda, would soon drop out. It did, later that spring, leaving only Premera Blue Cross Blue Shield and its massive requested increase.

But as she pitched her plan, Wing-Heier was running into a wall of resistance from the Teamsters Union and other employers, which were sending email blasts of opposition and logging their own meetings to push against the proposal.

Their central issue: Wing-Heier and her closest Capitol ally, Republican Rep. Kurt Olson, a former insurance broker, wanted to finance their program by hiking taxes on all the insurance plans in the state, including employer plans. Those plans and their lobbyists saw it as a new $20 per member monthly tax, and they weren’t having it.

“I felt like we’d lost,” Wing-Heier remembers. “We’d given it our all ... but we were running out of options.”

So Wing-Heier and Olson huddled with their closest staffers late that Friday, brainstorming other funding mechanisms. They tossed out ideas until Olson alighted on a solution: The department could use the revenue it was already bringing into the state’s general fund. Alaska already required insurers — including health, auto and homeowners’ insurers — to pay a 2.7 percent tax. It wasn’t being used for a specific project — meaning they might be able to tap into it without alienating any other industry with a “cut.” No new taxes, no cuts to programs: It was a win for everyone.

“It was our breakthrough moment,” she says.

That breakthrough helped reinvigorate Wing-Heier and Olson’s legislative push and get the bill to the governor’s desk.

But other states might not have a pair of such dogged insurance wonks leading the charge. And they almost certainly won’t be able to stumble on a pool of money to bankroll the program, the way Wing-Heier and Olson did.

“There’s definitely a lot of interest in other states, but almost every time, you get hung up when you mention that the funding has to come from somewhere, like a tax on all premiums,” says Joel Ario, a former Health and Human Services Department official and Manatt Health consultant who helped other states consider reinsurance programs. “It’s hard to make that work. It’s hard for a lot of people to get beyond that.”

Indeed, states are seeking different combinations of financing mechanisms, mostly to minimize the pain on their industries. Minnesota’s plan, for example, is funded by a combination of the state’s budget reserves and a 2 percent medical provider tax — not a tax on premiums in the state.

Red states like Alaska, where the health care law remains decidedly unpopular, will have further partisan obstacles to overcome.

Wing-Heier and Olson had to convince a legislature that had just months before sued its own governor over his effort to expand Medicaid under the health care law. Former Democratic Sen. Mark Begich lost his seat in Congress partially because of his vote for the law; he was defeated in 2014 by Republican Dan Sullivan, who vowed to repeal it. That same dynamic plays out across the country.

The even bigger challenge in Alaska, according to dozens of state lawmakers: convincing the legislature to divert the $55 million the program would require in the middle of one of the state’s worst budget crises. The legislature was trying to salvage a $3 billion hole in the state budget, a result of declining oil revenues — bad news for a state that’s so dependent on the industry that its people drop casual references to the current price of a barrel, even in bar stool conversations.

The same budget gaps have been bedeviling state legislatures across the country for years. Indeed, Alaska has it easier than most because of its storied oil revenues, which have insulated residents even from an income tax for most of the state’s history.

In the end, the costs pushed Alaska’s legislature over the edge.

“We knew in my office it had to be done,” says state Sen. Mia Costello, a Republican and one of the bill’s sponsors. “There was a lot of trust that the [Department of Insurance] wouldn’t call it a crisis unless it was one.”

Once they convinced lawmakers they could avert that crisis, the path to passage was relatively simple.

Premera filed its first rates in July, about a month later after enactment, and Wing-Heier breathed her sigh of relief: their 7 percent increase was less than they’d expected. The program launched in January, and paid about $5 million worth of claims in the first quarter of this year.

The Best Part: Federal Funding Help

That sigh of relief isn’t the only thing that’s making other insurance commissioners jealous. Wing-Heier, at the encouragement of former Centers for Medicare and Medicaid Services Administrator Andy Slavitt, found a way to fund most of the program, at least after its first two years, with a lot of federal help.

The plan centers on a waiver Alaska is requesting from the

### Costly Care

Many medical procedures are double in Alaska what they would be in the continental U.S.

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Based on 2014 average provider billing to private insurance.

Source: Premera
Trump administration. At its heart is a simple idea: If premiums had gone up 42 percent, the subsidies the government pays to keep coverage affordable for low-income Alaskans under the health care law would have risen, too. Since the state saved the federal government millions, it wants a portion of those funds back. It’s a big portion: Alaska is asking for about $49 million in 2018 alone. By 2022, they expect to get back $66 million.

Despite that price tag, every indication from both federal and state officials suggests that the waiver will be approved as early as this month, ahead of a mid-July deadline.

Late in May, the Trump administration even released a checklist to help speed the process for states interested in pursuing a similar option.

Other states are taking notice. Both Ario, the Manatt Health consultant, and Wing-Heier, who’s been bombarded with questions from fellow commissioners, predict scores of other states will pursue the waiver if Alaska’s gets approved.

“A lot of states want to see it get approved before they move forward themselves,” Ario suggested. He’s heard of interest in states as diverse as California, New Hampshire, New York, Ohio and Oregon.

Developing and implementing the program, however, will require the same grueling fight that nearly knocked out Alaska’s, including the partisanship, the lobbying lift and the budgetary brawls.

“States are saying, we don’t have the money up front,” Wing-Heier admits. “Here in Alaska, we funded the first year so we could show the savings. But other states are saying, we don’t have the money like Alaska did.”

**Costs Over Time**

The so-called 1332 waiver makes the program more attractive, but the path forward for reinsurance remains uncertain at best. That’s true everywhere — even in Alaska.

To start, the federal waiver won’t pay for everything. The costs associated with the program are expected to continue to increase — and Alaska will have to keep upping its own contributions. Granted, their contribution is less than it is now: If the feds “pass through” as much funding as Alaska has requested, the state contribution will be $11 million in 2018, up to $14 million in 2022.

But lawmakers caution that oil prices are not rising, and the state’s finances are not improving. Appropriating that money will not be easy in a state that “usually fights over hundreds and thousands of dollars, let alone millions,” as one state House Republican put it.

“We initially thought it was one year. We found out it’s not,” says Sen. Mike Dunleavy, a conservative from Wasilla who was among the few to vote against the package and the latest budget. “If they give us the funds … we still, every year, in the best-case scenario, every year we’re going to be adding $11 million, $12 million, $14 million. … This is not fixing the problem. This is managing the problem.”

Adding insult to that funding request was a bombshell from insurer Premera. Despite executives’ warnings it would leave Alaska’s market entirely without the reinsurance program, Premera actually made an $18 million profit in Alaska in 2016. That was partly because of federal payments it hadn’t been expecting and partly because of a 2015 claims estimation error. Nevertheless, the profit makes legislators much less willing to help buy down high premiums in the future, they suggested in interviews.

The future funding challenges could be even tougher elsewhere. States that don’t get a federal subsidy as high as Alaska’s — which is every state — also would see far less money come in through a similarly designed 1332 waiver, according to Oliver Wyman actuaries. That might leave them facing an even bigger responsibility for the costs.

**The Root of the Problem**

There’s a reason the costs of a program like reinsurance keep going up and the contributions from both the federal and state governments must increase. In fact, it’s much the same reason health insurance costs continue escalating: Health care costs in the United States keep rising. (For more on Alaska’s astronomical health care costs, see page 17.)
The Sky’s the Limit on Costs

CORDOVA, Alaska —

Your fourth air ambulance ride is easier than your first. It’s not something most people know. But John Renner lives in a small fishing town in southeastern Alaska that’s off the road system in the Frontier State. It’s essentially an island: To get in or out, you’ll need a boat or a plane.

There is a small emergency clinic in Cordova, but for any major health care services, medevac is a fact of life. And that reality drives up medical costs.

The 61-year-old commercial fisherman is calmer on the tarmac than you’d expect as the paramedics, nurses and pilot work to load his wife Dawn into the Beechcraft King Air that will whisk them all to the hospital in Anchorage. He’s relaying to the two nurses what the doctors in Cordova told him about his wife’s symptoms, which look like meningitis — an illness you especially don’t want to get in a remote part of the world.

He’s also tallying costs in the back of his head, he reflects later. Renner knows how much the emergency department visit in Cordova’s tiny clinic that prepped Dawn for the ride will cost ($10,000). He knows what he’ll be billed for the 39-minute ride to Anchorage ($25,000 to $30,000). And he’s keeping his fingers crossed that those Anchorage health care services won’t run up a tab as high as last time (close to $160,000).

He knows because he’s still paying off the $200,000 bill he got for his wife’s last medevac ride, even as he boards again. And that’s not even the first time a ride like this has put him in serious debt.

“The costs are astronomical. But that’s Alaska,” he says later. “What are you going to do? You can’t get mad and you can’t cry about it. It’s where we live.”

In Alaska, the Renners aren’t the only ones facing these costs. Many of the state’s smaller villages and towns are accessible only by air or boat. Only a handful of communities have their own nurse- or nurse-practitioner-run clinics, let alone hospitals. Much of the state relies on a lauded tribal health system — and pricey medevac rides — to access health care services.

All of that feeds into the cost of health care in the Frontier State. Most insurance companies in Alaska cover the cost of at least one trip. Only some cover the cost of a return trip home, and only some cover a caregiver or family member’s travel, too. The state’s several medevac companies — including LifeMed, which transported John and Dawn Renner — offer their own insurance program. A small annual fee ($49 per year, in LifeMed’s case) will guarantee you don’t pay out of pocket for your ride.

“Anybody who’s either had a few occurrences or is aware of it certainly carries the insurance,” Renner says. “All it takes is one occurrence where you have to pay $30,000 — then you’ll have medevac insurance.”

Transportation costs certainly drive up insurance premiums and the out-of-pocket health care costs for consumers in the state. But as Renner knows, that’s not the only thing that costs more in Alaska.

Nearly every health care service — from a knee replacement to a simple MRI — is pricier in Alaska.

Cost-of-living is a factor. Just as a gallon of milk costs more in Alaska than in Alabama, so do hospital and physician supplies. Whether it’s the steel parts for construction projects or their MRI machines, everything must be shipped by barge.

But the state’s unique provider landscape — where doctors are scarce and specialists even scarcer — undoubtedly plays a role in the prices, too. The community of physicians that work in Alaska is highly consolidated. There is just one orthopedic surgery group, and after a recent merger, just one cardiology group. Fewer than 10 neurosurgeons live in the entire state.

That scarcity gives providers incredible leverage over insurance companies. A 2011
Sky High
The costs that go into a medical flight
By Randy Leonard and Erin Mershon

On April 15 LifeMed transported Dawn Renner from Cordova to Anchorage for treatment of possible meningitis. Here are the line items that add up to thousands of dollars for the 39-minute ride (plus the trip there to pick her up and later to drop her off) and the hundreds of flights like it every month.

LifeMed April 15 flight 39 mins.
For one leg. In the course of a month, the company made more than 400 similar medevac or support flights to more than 50 airports.

King Air 200 lease* $660/day
*Market data based on $14K to $25K per month lease. The company would not disclose negotiated rate, but leases 12 aircraft with a total market value of $17.3M.

Hanger lease $75-433/day
LifeMed rents hangers in Wolf Lake, Soldotna, Fairbanks and Juneau.

Medical supplies $37 minimum/day
Each aircraft is equipped with $95K in medical equipment and supplies, $20K of which needs to be used or discarded every 1 to 3 years.

Jet fuel $770/round trip
Jet fuel costs 30% more in Alaska than the national average.

Paramedic, Nurse $2,560/day
The company has 8 flight nurses and 10 paramedics in the air daily.

Maintenance, pilot $454/hr
*Market data based on typical $400/hr maintenance fees and $77K average pilot and $65K mechanic salaries plus benefits. The company would not disclose rates for contracted pilots or mechanic.

study by Milliman, an actuarial firm, found that Alaskan physicians were reimbursed by commercial plans with rates 69 percent higher in Alaska than in comparison states, including Idaho, North Dakota and Wyoming. Nationally, premiums are about 15 percent higher in places where there are just one or two hospitals, versus areas served by at least four. That can mean a $2,000 difference for each visit, according to a 2015 National Bureau of Economic Research study.

Health industry experts in the state — including some physicians — admitted that doctors are notoriously independent, even in Alaska, where some joke a libertarian streak is practically a citizenship requirement. Many avoid contracting with insurance companies. Some moved to Alaska just to avoid the managed care movements that swept the country in the 1980s and 1990s. All of that drives up prices.

“Just like everywhere else, there are docs that are bad actors: Some people cherry-pick the Blue Cross and Aetna patients and don’t see Medicare, Medicaid, and charge a lot and do a lot of procedures and they make a fortune up here,” says Graham Glass, a neurosurgeon who is president of the state’s medical society. Glass says, however, that the high salaries and reimbursement rates have to do with recruitment.

“Neurologists don’t want to move up here. They want to go to the symphony. They don’t want to go moose hunting,” he says. “You have to convince them to stay in Anchorage, and one of the things that convinces them is money.”

Richard Mandsager, CEO of the Providence Hospital, echoed that sentiment in an interview in his Anchorage office.

“We wouldn’t be able to keep many people, career-wise, at any lower rates,” he says.

For many Alaskans — and providers without competition command high prices. It might be easier to drive to a nearby hospital in the Lower 48 states, but the nine-hour drive between Boise and Billings is still wildly different than the 20 minutes it takes to drive from D.C. to Arlington, Va., to find a cheaper provider. It may be less expensive in other remote areas to fly to a faraway provider and pay for the travel

BY LAND AND AIR: Emergency teams meet on the tarmac in Cordova.

bipartisan, bicameral efforts to write price transparency legislation — one from a House Democrat and another from a Republican senator. The bills essentially require doctors and hospitals to disclose their prices to consumers and encourage comparison shopping.

Supporters say there’s a new drive to actually tackle real changes, in part because the insurance market is more

stable and the state legislature is focused on reducing costs to help resolve the state’s budget trouble. At least so far, they aren’t facing major opposition from either providers or others in the industry.

“Health care is a huge cost driver for every state, but particularly for ours. If we don’t get ahold of it, no amount of fiscal discipline can solve that,” says Rep. Ivy Spohnholz, a Democrat whose bill on price transparency legislation has already passed the state House.

“Continuing to let it operate as it is now is just not acceptable,” she says. “We’ve reached a crisis point.”

— E.M.
Alaska’s program doesn’t change that. It simply blunts the impact of the price increases by throwing more money at the problem.

Health care expenditures have grown by a little more than 5 percent annually in recent years — an increase that gets baked into every premium increase, whether you buy your insurance on the health law’s exchanges or through your employer.

It’s why Dunleavy, scribbling furiously at the whiteboard in his Juneau office, was so upset about the reinsurance program. He says it doesn’t solve the real problem of high costs.

While reinsurance spreads the costs of the sickest, it’s still asking someone to pay up for those sicker customers, either through their tax bill, their auto-insurance bill or some other charge. And it leads to the question: Should they have to pay?

It’s the main reason that Sen. Anna MacKinnon, a no-nonsense Republican from Eagle River area, led the successful drive to add a provision to the program that requires the state to help manage the care of any high-cost individuals with hemophilia or other diseases that qualify for reinsurance payments.

“Can we work with these individuals to make sure they stay healthy, so we don’t find them in expensive situations where they’re receiving emergency care?” she asks. “What can we do to help them have more personal responsibility?”

“We don’t want people to not have access to health care, but at the same time, you have to look at the cost of it for the state of Alaska,” MacKinnon adds.

Federal Uncertainty

Adding to the difficult path ahead in any state are congressional Republicans’ efforts to repeal and replace the 2010 law that set up the insurance markets and established tax credits for premiums.

The House Republican bill that passed in May would shift away from a credit based on the cost of a person’s monthly premium — relying instead on a credit based on age and income alone. Alaska’s waiver, which depends on the federal “savings” the reinsurance program achieves, would be defunct: The reinsurance program would no longer be “saving” the federal government any money since the credits wouldn’t cost less if premiums came down — making it a much less attractive or reliable funding mechanism.

There are no immediate plans to keep the funding structure that enables Alaska’s waiver in the Senate version of the bill.

House Republicans in D.C. have what they say is a simple solution: They’ve included in their bill federal money that many expect would be used for reinsurance programs like Alaska’s. The package ultimately includes about $100 billion over 10 years that will likely be used for state-based reinsurance programs, and another $15 billion for nine years’ worth of a federal reinsurance program.

It’s not clear, however, that those funds will indeed be used for reinsurance. They could be used for costlier high-risk pool programs or other changes; the language is vague.

Nor is it clear that even those amounts will be enough to support programs like Alaska’s in all 50 states, given the package’s other massive changes to the structure of existing tax credits and its changes to the Medicaid program.

Alaska’s program alone costs about $55 million per year to implement — and while costs are higher than in other states, there are far fewer enrollees in the program than elsewhere. Minnesota’s copycat program is expected to cost two to three times as much, about $542 million for two years, and its program is contingent on receiving a 1332 waiver.

“Under the House bill, the tax credits are wholly inadequate, so there’s not enough reinsurance money allocated to solve the problems. You’re just going to see massive amounts of people without insurance,” says Slavitt, who directed CMS under President Barack Obama. “Unless a state is willing to come up with multiples of the amount of money that Alaska came up with, it’s not going to be possible.”

Even Alaska might have to come up with multiples of the amount of money it’s relying on now. The Republican plan would ask them to pay half of the reinsurance costs by 2024 — a far bigger percentage than they’re hoping to pay under the current program.

Wing-Heier points to actuarial calculations that show Alaska would ultimately receive millions less for its reinsurance program under the House bill than under existing law.

So now Wing-Heier is doing exactly what she did when she was staring down that 42 percent rate hike: crunching the numbers, and preparing to make her case that the House bill’s funding is inadequate.

This time, though, she’s taking her fiery persistence to Capitol Hill in Washington. “Right now, based on medical trends, it’s not going to work,” she says. “But it’s certainly something we’re bringing up with our delegation.”

FRONTIER WOMEN: MacKinnon, left, listens to fellow state Sen. Mia Costello during a 2016 session in the Alaska Capitol.