

# **Long-term Forecast of Medicaid Enrollment and Spending in Alaska: *Supplement 2010–2030***

**Sean Parnell, Governor  
State of Alaska**

**William J. Streur, Commissioner  
Department of Health and Social Services**

**Prepared by: Medicaid Budget Group  
Finance and Management Services  
Department of Health and Social Services  
January 2011**





---

---

## TABLE OF CONTENTS

<b>EXECUTIVE SUMMARY</b>	<b>1</b>
<b>INTRODUCTION</b>	<b>4</b>
Comparison to Other States	6
Summary of Methodology	7
<b>ALASKA MEDICAID FORECAST: 2010-2030</b>	<b>9</b>
Enrollment	10
Total Medicaid Claims Spending	14
State Claims Spending	22
Other Medicaid Payments	25
Health Care Reform	27
Summary	31
<b>APPENDICES</b>	<b>32</b>
Appendix A: Medicaid Eligibility Classification Descriptions	32
Appendix B: Medicaid Service Category Descriptions	33
Appendix C: Detailed Tables of 2010-2030 MESA Forecast	34

---

---

## TABLE OF FIGURES

<b>Figure 1: Before adjusting for ACA, total Medicaid spending in 2030 is projected to reach \$4.5 billion</b>	<b>2</b>
<b>Figure 2: After adjusting for ACA, total Medicaid spending in 2030 is projected to reach \$5.1 billion</b>	<b>3</b>
<b>Figure 3: Alaska’s total spending growth is projected to be slower than the national average, but General Fund spending is projected to grow faster</b>	<b>6</b>
<b>Figure 4: Enrollment growth slows down over time. The elderly remain the fastest-growing group</b>	<b>11</b>
<b>Figure 5: Enrollment increases are projected to be modest</b>	<b>12</b>
<b>Figure 6: Percentage of enrollees who are elderly will increase in the future</b>	<b>12</b>
<b>Figure 7: Growth in total spending will slow down with time</b>	<b>14</b>
<b>Figure 8: By 2030, claims spending for the elderly will converge with that of working-age adults</b>	<b>15</b>
<b>Figure 9: Each elderly enrollee costs about four times as much as a child</b>	<b>16</b>
<b>Figure 10: Total spending in 2030 will be almost four times the 2010 value</b>	<b>16</b>
<b>Figure 11: Growth in total spending has slowed dramatically in recent years</b>	<b>17</b>
<b>Figure 12: Spending on Long-term Care services will increase as a share of total spending</b>	<b>18</b>
<b>Figure 13: Home and Community Based Waivers and Personal Care are the fastest growing service categories</b>	<b>19</b>
<b>Figure 14: Inflation accounts for the largest part of increased claims spending</b>	<b>20</b>
<b>Figure 15: After stimulus funds end in June 2011 and the FFP changes, state and federal spending growth rates are roughly equal</b>	<b>23</b>

---

---

## TABLE OF TABLES

<b>Table 1: Elderly enrollment is projected to grow faster than other age groups</b>	<b>10</b>
<b>Table 2: Enrollment levels of eligibility groups associated with the elderly tend to grow faster than the 1.4 percent average</b>	<b>13</b>
<b>Table 3: Spending on the elderly grows nearly twice as fast as spending on other age groups</b>	<b>14</b>
<b>Table 4: Long-Term Care is projected to be the fastest-growing service group</b>	<b>18</b>
<b>Table 5: State share of Medicaid funding increases throughout the forecast period</b>	<b>22</b>
<b>Table 6: Other Medicaid payments will increase total Medicaid spending in 2030 to \$4.5 billion</b>	<b>25</b>
<b>Table 7: Medicaid cost sharing for newly-eligible individuals</b>	<b>28</b>
<b>Table 8: The federal government will pay for most of the costs of Medicaid expansion</b>	<b>29</b>
<b>Table 9: Changes to the CHIP program due to the Affordable Care Act will lead to cost shifting</b>	<b>29</b>
<b>Table 10: Including spending for the Affordable Care Act increases total Medicaid spending in 2030 to \$5.1 billion</b>	<b>30</b>
<b>Table 11: Forecast of Population by Subpopulations</b>	<b>34</b>
<b>Table 12: Forecast of Enrollment by Subpopulations</b>	<b>35</b>
<b>Table 13: Enrollment Levels by Eligibility Groups</b>	<b>35</b>
<b>Table 14: Forecast of Utilization by Subpopulations</b>	<b>36</b>
<b>Table 15: Forecast of Utilization by Service Category</b>	<b>37</b>
<b>Table 16: Forecast of Nominal Spending by Subpopulations (in millions)</b>	<b>38</b>
<b>Table 17: Forecast of Nominal Spending by Service Category (in millions)</b>	<b>39</b>
<b>Table 18: Forecast of Real Spending by Subpopulations (in millions of 2010 dollars)</b>	<b>40</b>
<b>Table 19: Forecast of Real Spending by Service Category (in millions of 2010 dollars)</b>	<b>41</b>
<b>Table 20: Forecast of State Spending by Service Category (in millions)</b>	<b>41</b>
<b>Table 21: Historical Enrollment by Demographic Group</b>	<b>42</b>
<b>Table 22: Historical Spending by Demographic Group (in millions)</b>	<b>42</b>
<b>Table 23: Historical Spending by Service Category Group (in millions)</b>	<b>43</b>

## Executive Summary

This is the fifth update to the *Long-Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025* (the “baseline forecast”). In this update, we develop long-term forecasts of Medicaid program enrollment, utilization, and spending from 2010 to 2030. Most of the projections presented in this report are based on the Medicaid program as it currently exists, though adjustments are made in a later section for some of the provisions of the Affordable Care Act (ACA).

### **Without adjusting for the Affordable Care Act (ACA):**

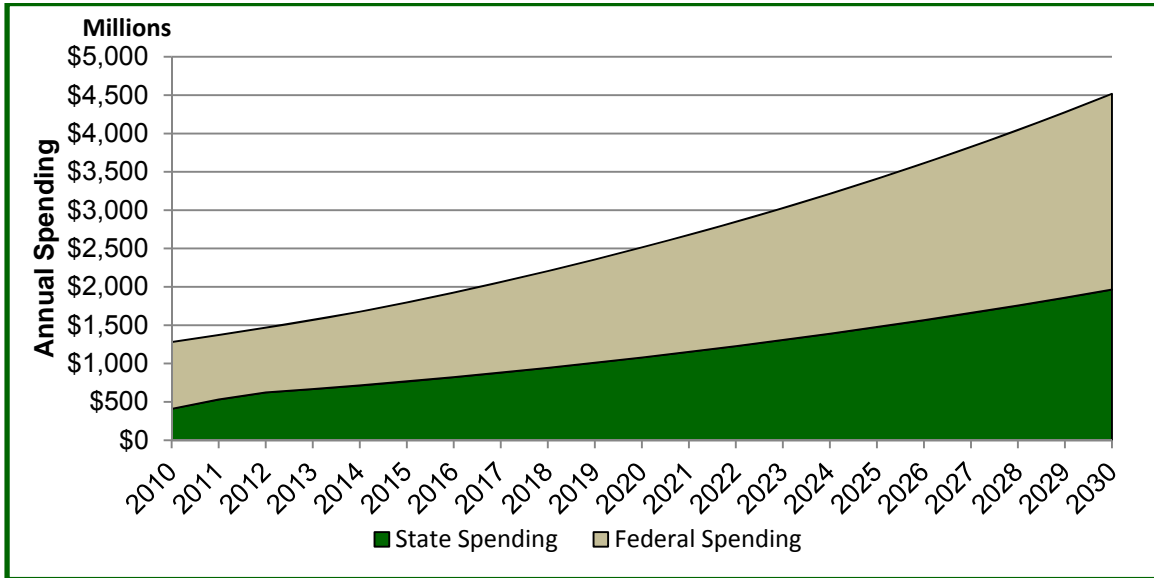
Today Medicaid spending for the elderly (ages 65 years and older) accounts for 17 percent of total Medicaid claims spending, while spending for working-age adults (ages 20-64 years) accounts for about 42 percent and spending for children (ages 0-19 years) accounts for 41 percent. This distribution of spending will change substantially over the next 20 years; by 2030 spending for the elderly and working-age adults will each make up 32 percent of total Medicaid claims spending, while spending for children will make up the balance of 36 percent. This is a shift in the expected outcome from the baseline 2005-2025 forecast, which projected spending on the elderly would exceed spending for either working-age adults or children in 2018. The shift is caused by changes in policies related to the Alaska Medicaid program and slower population growth projections for the elderly, developed by the Alaska Department of Labor and Workforce Development (ADLWD), made subsequent to the development of the baseline forecast.

Total Medicaid spending in 2030 is expected to reach \$4.5 billion. The average annual rate of growth in spending is projected to be between 6 and 7 percent for the overall program; however, state spending for Medicaid is projected to grow at a little more than 8 percent due to anticipated reductions in federal financial participation.

Spending per enrollee is projected to increase from \$9,500 in 2010 to \$25,400 in 2030. The projected growth in spending per enrollee can be attributed to two main factors: (1) inflation in the prices of medical goods and services, and (2) an increase in the proportion of enrollees who are elderly – enrollees who are, on average, more costly than children or working-age adults. State spending per enrollee is projected to increase from \$3,000 in 2010 to \$11,100 in 2030.

**Figure 1: Before adjusting for ACA, total Medicaid spending in 2030 is projected to reach \$4.5 billion**

PROJECTED ANNUAL FEDERAL AND STATE SPENDING<sup>1</sup> ON MEDICAID



Source: Medicaid Budget Group, MESA Model. See Table 6, page 25.

We project the rate of growth for enrollment will slow throughout the forecast period due to slower expected population growth in later years<sup>2</sup>. The average annual rate of growth for enrollment for the forecast period is just over 1 percent -- faster than the projected population growth rate, which is just under 1 percent. The elderly (65 and older) are the fastest growing age group, with enrollment expected to grow at about 5 percent annually. The enrollment for children (0-19) and working-age adults (20-64) is projected to grow slower than overall enrollment.

Utilization of Medicaid services is forecast to have the highest average annual growth rate in Home and Community Based Waivers, which we project will have utilization growth of approximately 5 percent per year. Personal Care and Health Clinic are also projected to experience utilization growth of almost 5 percent per year.

<sup>1</sup> All spending figures are nominal unless otherwise noted. Nominal or actual spending is the projected future value without adjusting for inflation. Please see Table 18 and Table 19 in Appendix C for real spending figures.

<sup>2</sup> According to estimates provided by the Alaska Department of Labor and Workforce Development, the population is projected to grow by 1.0 percent annually from 2010 to 2015 and slow down to 0.8 percent from 2025 to 2030.

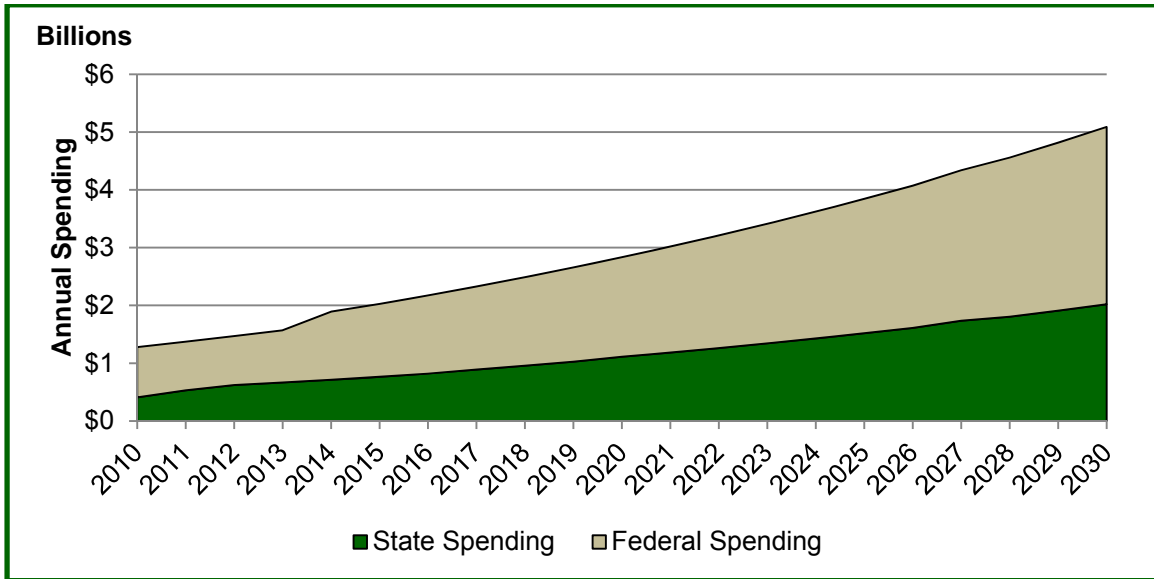
**After adjusting for the Affordable Care Act:**

There are several provisions in the Affordable Care Act (ACA) that will have an effect on the Medicaid program. Even though not every piece of the legislation is explored in this report, an effort was made to look at the costs of Medicaid expansion to all individuals below 133 percent of the Federal Poverty Guidelines, which will have a major impact on Medicaid in upcoming years. The effects of changes to the Children’s Health Insurance Program (CHIP) are also included.

It is estimated that an additional 32,000 individuals will become eligible, and may enroll in Medicaid in 2014. The \$220 million price tag for these individuals will be paid for entirely with federal funds. In 2017 the costs for these newly-eligible individuals will start to be shifted to the state. The federal share will be 95 percent in 2017, 94 percent in 2018, and 93 percent in 2019. Starting in 2020, 90 percent of the costs for the newly-eligible enrollees will be paid by the federal government. By 2030 population growth will add another 3,000 individuals to the rolls, and the costs for the 35,000 newly-eligible individuals will cost a total of \$570 million, with federal funds paying for \$520 million and state general funds paying the remaining \$50 million.

**Figure 2: After adjusting for ACA, total Medicaid spending in 2030 is projected to reach \$5.1 billion**

PROJECTED ANNUAL FEDERAL AND STATE SPENDING ON MEDICAID



Source: Medicaid Budget Group, MESA Model. See Table 10, page 30.

<sup>3</sup>We also assumed that some of these newly-eligible enrollees will receive 100 percent IHS reimbursement.



## Introduction

This report presents and discusses the annual update to the long-term forecast of Medicaid Enrollment and Spending in Alaska (MESA). In this update, we develop a 20-year outlook of Medicaid<sup>4</sup> program enrollment, utilization, and spending from 2010-2030. MESA was first prepared in 2005 by The Lewin Group and ECONorthwest on behalf of the State of Alaska Department of Health and Social Services (DHSS) and the Alaska Legislature.

The original MESA report covered the twenty-year period from 2005-2025. In each successive year, the department's Alaska Medicaid Budget Group, with consultation from ECONorthwest, has updated the underlying enrollment and claims data on which the MESA forecasting model depends, and has re-estimated the model to project enrollment and spending over the successive 20-year period. By integrating a successive year of data into the MESA model, we update the Medicaid program's *status quo* with respect to eligibility, enrollment trends, and spending. Thus, as changes are made to the Medicaid program by DHSS or the Legislature, MESA provides estimates of the long-term impact of the changes.

The purpose of the MESA forecast is to provide a long-term view of future enrollment and spending in the Alaska Medicaid program under the current mix of Medicaid services and the current criteria for enrollment in the Medicaid program<sup>5</sup>. MESA provides department executives and the Alaska State Legislature with information on the direction and approximate magnitude of growth in enrollment and state matching fund spending for the Medicaid program. It is particularly helpful to pay attention to growth rates as opposed to focusing on values, because growth rates allow for the comparison of expected changes across regions (e.g. comparing Alaska with the nation).

The projections of spending presented in this report assume that the mix of Medicaid services remains constant, and that eligibility criteria do not change in the future. These assumptions are necessary to show how Medicaid spending in Alaska would grow under the program as it exists today (i.e. the *status quo*). As a result of these assumptions, the forecast does not take into consideration the dynamic nature of Medicaid policy and changing funding mechanisms that may take place throughout the forecast period.

---

<sup>4</sup> In this report, the term "Medicaid" includes both Title XIX Medicaid and the Title XXI Children's Health Insurance Program (CHIP) Medicaid expansion.

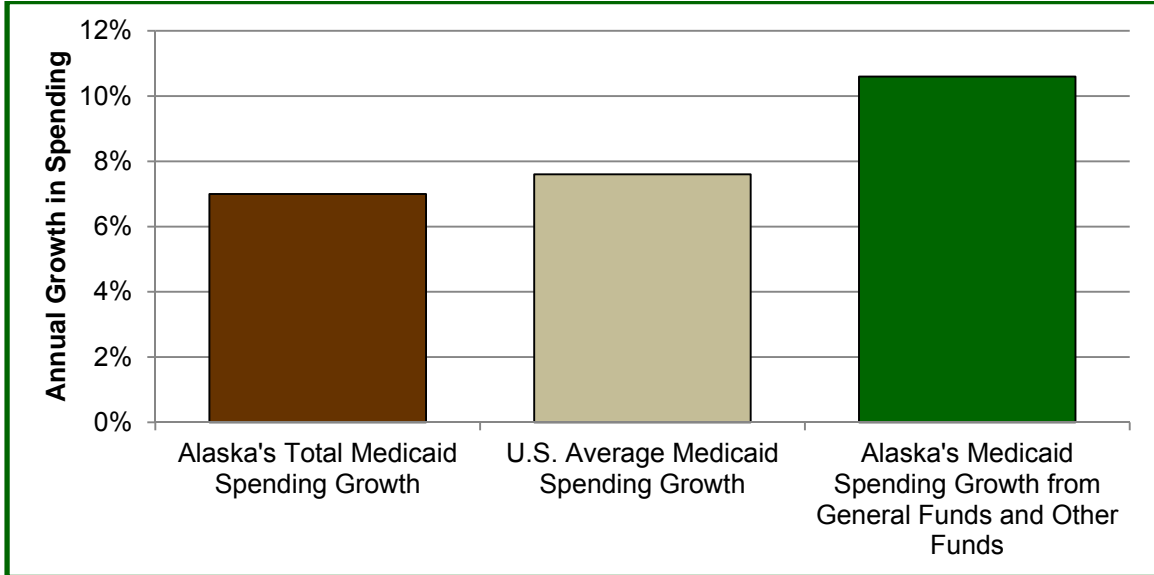
<sup>5</sup> We have included a section in this report that includes adjustments for Medicaid expansion and other aspects of the Affordable Care Act.

We realize that the value of economic analysis depends on the quality of the data and assumptions employed. We have worked carefully to ensure the quality of our work and the accuracy of our data. We have undertaken considerable effort to validate the forecast and to confirm the reasonableness of the data and assumptions on which the forecast is based. Nonetheless, we acknowledge that any forecast of the future is uncertain. The fact that we view the forecasts in this report as reasonable does not guarantee that actual enrollment in, utilization of, and spending on the Alaska Medicaid program will equal the projections in this report. Administrators and Alaska's elected representatives must recognize the inherent uncertainty that surrounds forecasts in considering the long-term Medicaid spending projections.

## Comparison to Other States

**Figure 3: Alaska’s total spending growth is projected to be slower than the national average, but General Fund spending is projected to grow faster**

ANNUAL GROWTH IN MEDICAID SPENDING FROM 2010 TO 2019



Source: Medicaid Budget Group, MESA Model

According to the Centers for Medicare and Medicaid Services, national Medicaid spending is projected to increase at an average annual growth rate of 7.6 percent between 2010 and 2019.<sup>6</sup> In comparison, Alaska’s total Medicaid spending<sup>7</sup> is projected to increase at 7.0 percent per year over the same period and by 6.5 percent per year over the entire forecast period (through 2030). At least part of the lower expected growth rate in Alaska’s Medicaid spending can be attributed to the cost control measures implemented by the department and the legislature in recent years.

Since the federal government will be shifting a larger share of the cost of Alaska’s Medicaid program back to the state<sup>8</sup>, Medicaid spending from general funds<sup>9</sup> and other non-federal funds is projected to grow at 10.6 percent annually from 2010 to 2019.

<sup>6</sup> Christopher Truffer, et al. “Health Spending Projections Through 2019: The Recession’s Impact Continues.” *Health Affairs*. Vol. 29, no.3 (2010), p 4.

<sup>7</sup> See Table 12, Appendix C.

<sup>8</sup> The costs will be shifted back to the state because of a lower Federal Medical Assistance Percentage. Stimulus funds from the American Recovery and Reinvestment Act of 2009 are currently set to expire in June 2011. See the State Spending section.

<sup>9</sup> See Table 20, Appendix C.

## Summary of Methodology

The MESA forecasting model has multiple, linked components or steps, which successively build upon each other. The first step in developing the model is the distribution of the long-term population projections developed by the Alaska Department of Labor and Workforce Development into individual forecasts for regional and demographic subgroups. The next step is projecting enrollment for each demographic group based on historical trends. Logistic regression models of historic enrollee-level claim data are then developed to estimate the probability that a Medicaid enrollee with a particular set of demographic characteristics (e.g. gender and age) will use a Medicaid service. Finally, total spending by service category and demographic group is projected, from which state general fund spending is allocated based on known and projected future federal financial participation rates.<sup>10</sup>

Throughout the analysis, we rely upon the best available information, including historic Medicaid claim data, the state of Alaska’s official population forecast, and nationally recognized information on trends in medical prices. In no instance do we impose any speculation on future Medicaid policies or procedures. Rather, we develop the long-term forecast as if the policies and practices of today will be the *status quo* throughout the forecast period.

The main factors responsible for growth in state spending on Medicaid services are

- Growth in Alaska’s resident population and changes in demographic composition;
- Changes in the Medicaid enrollment rates for each demographic component;
- Changes in the use of Medicaid services by Medicaid enrollees;
- Personal healthcare-specific services specific price inflation; and
- Changes in federal financial participation.

Our methodology entails detailed analysis of each of these factors to formulate a series of statistical models to project total and state spending on Medicaid services based on demographic characteristics (age, gender, Native/non-Native status) and for five regions of the state – a total of 220 subpopulations. Spending is projected for 20 categories of service provided under the Alaska Medicaid program<sup>11</sup>. In addition, we project enrollment in 11 eligibility groups<sup>12</sup>.

---

<sup>10</sup> For detailed information on the development of the MESA forecast, please see “Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025”.

<sup>11</sup> See Appendix B for a list of Medicaid service categories.

<sup>12</sup> See Appendix A for a list of eligibility groups.

Although results are presented at state-level for all residents, analysis is conducted on a regional basis for demographic subgroups of the population.

Population forecasts for five regions of Alaska were based on historical Census population estimates and statewide population forecasts developed by the Alaska Department of Labor and Workforce Development (ADLWD). ADLWD produced an updated population projection in 2007 for years 2008 through 2030. The statistical models of Medicaid enrollment, service utilization, and spending used in the MESA model were developed using the 2007 population projections from ADLWD along with historical Medicaid enrollment and claims data maintained by the Department of Health and Social Services for the years 1997-2009. Only complete fiscal years based on dates of service are used in the Medicaid forecast. Many of the claims incurred during 2010 will not be paid until fiscal year 2011; therefore, data for 2010 are excluded. Please see *Appendix C* for historical spending data.

## **ALASKA MEDICAID FORECAST: 2010-2030** <sup>13</sup>

The 2010-2030 Alaska Medicaid forecast integrates the most recent enrollment and spending data for the Alaska Medicaid program with the Alaska Department of Labor and Workforce Development (ADLWD) population forecast, developed in 2007. The 2007 ADLWD population forecast projects a slower rate of growth in the elderly population over the next 20 years than did the 2005 ADLWD forecast. The slower anticipated growth in the elderly population results in slightly slower projected growth in Medicaid enrollment among the elderly and, more importantly, slower projected growth in Medicaid spending relative to the 2005 Medicaid forecast. The average annual enrollment growth rate is projected to be 1.3 percent over the 20-year forecast period. Average annual spending growth is projected to be 6.5 percent between 2010 and 2030 and 6.8 percent from 2010 to 2025, which is less than the annual increase of 8.1 percent that the 2005 Medicaid forecast was projecting from 2010 to 2025. The slower projected growth in population, in combination with cost containment and programmatic changes, has led to slower projected growth in Medicaid spending.

---

<sup>13</sup> The projected growth rates for enrollment and spending that are mentioned on this page do not include the effects of the Affordable Care Act. We have included a separate section that contains information on the Affordable Care Act.

**Enrollment** <sup>14</sup>

The elderly population will continue to have a dramatic impact on the Medicaid program through 2030. We project the growth in enrollment among the elderly will average 5.0 percent per year through the forecast period, causing the elderly’s share of enrollment to more than double by 2030, reaching 13 percent of total enrollment. During the same period, the annual growth rate in enrollment among children is projected to be 1.1 percent and working-age adults<sup>15</sup> at 0.8 percent. The rate of growth in enrollment across the entire population will slow from 2.1 percent annually between 2010 and 2015 to 0.7 percent annually between 2024 and 2029.

Enrollment refers to the number of individuals who both meet the requirements and are registered to receive Medicaid services. The growth in enrollment is determined by two primary factors: (1) changes in the demographics of the population; (2) changes in eligibility requirements. For the purposes of this report, enrollment changes are primarily driven by changes in the demographics of the population, since the present eligibility requirements are already incorporated into the current enrollment figures.

**Table 1: Elderly enrollment is projected to grow faster than other age groups**

MEDICAID ENROLLMENT BY AGE GROUP FOR SELECTED YEARS, 2010-2030

Age Group	2010	2015	2020	2025	2030	Average Annual Change
<b>Children (0-19)</b>	87,949	96,822	104,268	107,819	109,242	1.1%
<b>Working Age Adults (20-64)</b>	38,456	41,074	42,313	43,501	44,818	0.8%
<b>Elderly (65+)</b>	8,840	11,940	15,977	20,258	23,671	5.0%

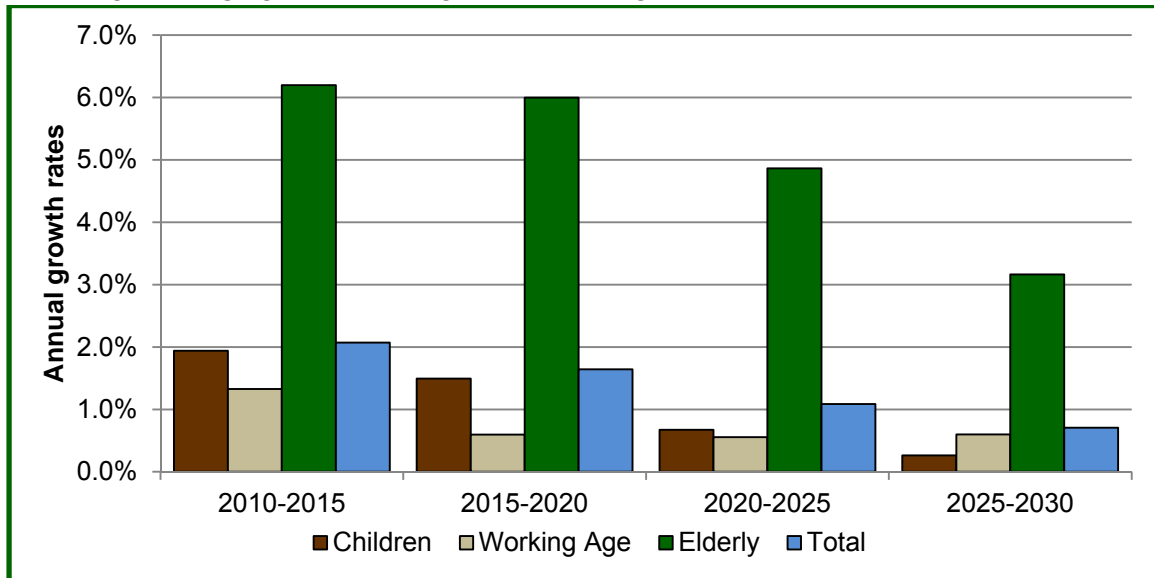
Source: Medicaid Budget Group, MESA Model. See Table 12, Appendix C.

<sup>14</sup> Additional details about enrollment can be found in the Tables 12 and 13 of Appendix C. The effects of the Affordable Care Act are not included in this section, but will be discussed later.

<sup>15</sup> The entire enrollment projection in this section is based on the Medicaid program as it exists today. The individuals who will be newly-eligible for Medicaid starting in 2014 because of Health Care Reform will primarily be working-age adults.

**Figure 4: Enrollment growth slows down over time. The elderly remain the fastest-growing group**

YEAR-TO-YEAR GROWTH IN ENROLLMENT BY AGE



Source: Medicaid Budget Group, MESA Model. See Table 1, page 10 and Table 12, Appendix C.

Figure 4 shows that enrollment growth for the entire population will slow over time, and that the elderly (age 65 and older) will experience the highest growth rate over the forecast period. We forecast that the growth rate in enrollment for children (age 0-19) will be faster than that of working-age adults (age 20-64) for the first ten years of the forecast. They will be roughly equal to each other from 2020 through 2025, and after 2025 the growth rate in enrollment for working-age adults is expected to exceed the growth rate for children.

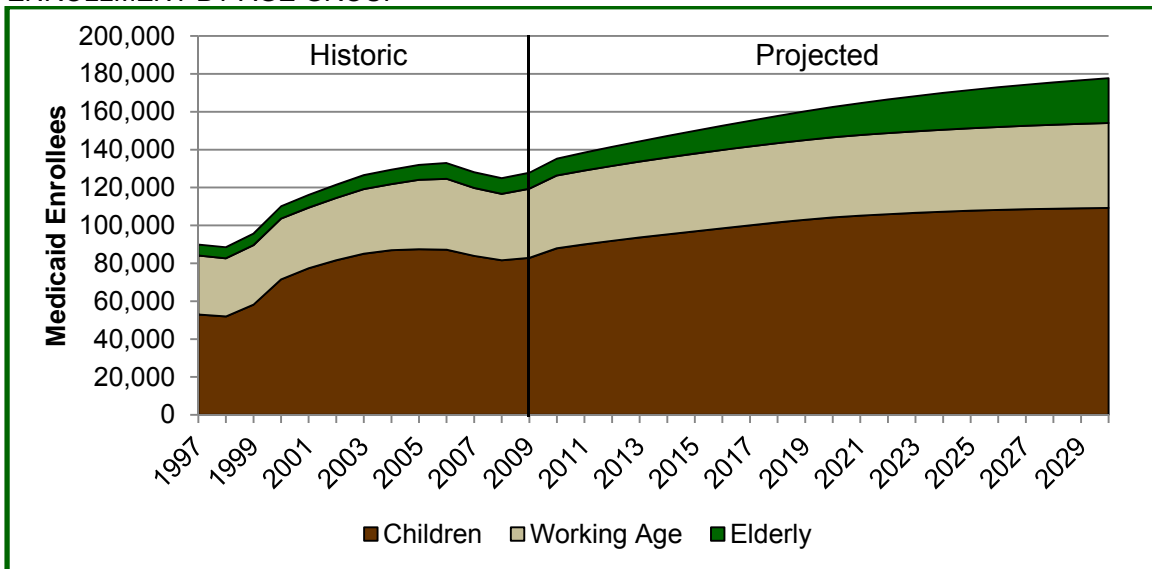
The demographic characteristics of Medicaid enrollees have changed<sup>16</sup> and will continue to do so in the future. The share of children as a percent of all participants enrolled in Medicaid increased in the late 1990s and continued to increase in the beginning of this past decade until 2004, when they accounted for 67 percent of enrollees. This coincided with the introduction of Denali KidCare, which expanded Medicaid to more pregnant women and individuals. From 2004 to 2007, the household income eligibility requirements for Denali KidCare were locked into place instead of being adjusted for inflation, so some individuals fell off the rolls. The proportion of Medicaid enrollees who are children has since dropped to 65 percent. With a 1.1 percent projected annual growth rate from 2010 to 2030, children's share of enrollment will continue to fall; by 2030, enrollment is projected to include 109,200 children, accounting for 61 percent of total Medicaid enrollment.

<sup>16</sup> See Table 21, Appendix C.



**Figure 5: Enrollment increases are projected to be modest**

ENROLLMENT BY AGE GROUP

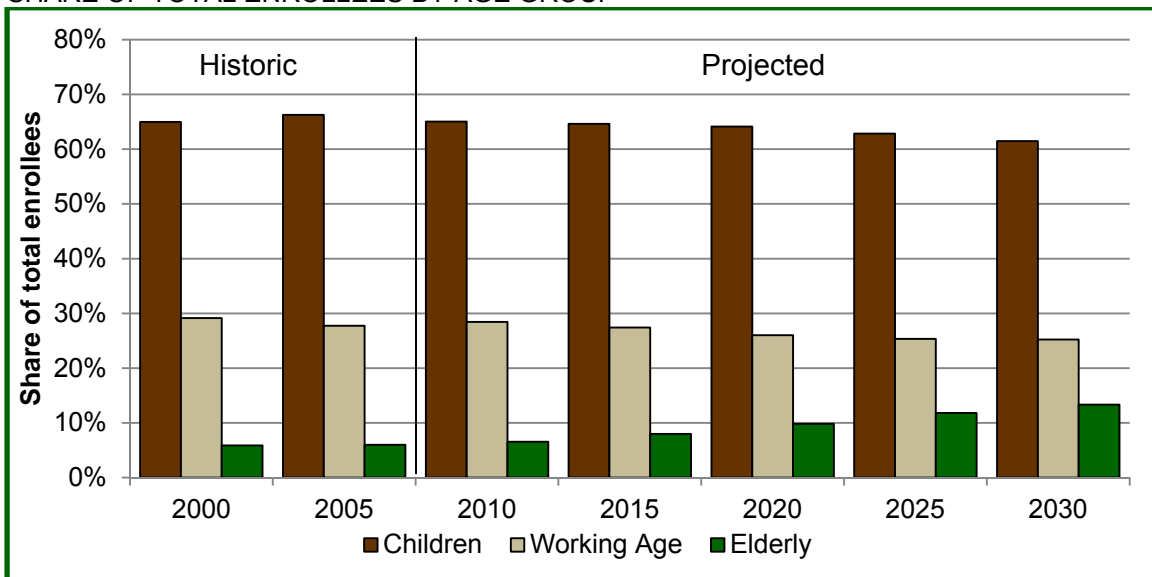


Source: Medicaid Budget Group, MESA Model. See Table 1, page 10 and Table 12, Appendix C.

The proportion of Medicaid enrollees who are working-age adults decreased from 35 percent of enrollment in 1997 to 27 percent of enrollment in 2002. Enrollment of working-age adults is projected to grow over the forecast period at 0.8 percent per year. The share of enrollees who are working-aged adults is projected to decrease throughout the forecast period, from 28 percent in 2010 to 25 percent in 2030.

**Figure 6: Percentage of enrollees who are elderly will increase in the future**

SHARE OF TOTAL ENROLLEES BY AGE GROUP



Source: Medicaid Budget Group, MESA Model. See Table 1, page 10 and Table 12, Appendix C.

With more people in the Baby Boom Generation approaching retirement age, the elderly will account for a larger share of Medicaid enrollees over the forecast period, increasing from 6 percent of enrollment to an estimated 13 percent in 2030. Enrollment of elderly is expected to grow at an annual rate of 5.0 percent over the 20 year period, from 8,800 in 2010 to 23,700 in 2030.

The gender balance is projected to remain stable throughout the forecast period, with 55 percent female enrollees and 45 percent male enrollees. Both males and females have a projected annual enrollment growth of 1.3 percent. The racial makeup of enrollees will see a slight shift; Alaska Natives currently make up 37 percent of Medicaid enrollees, but that figure is expected to drop to 36 percent by 2030. Enrollment for Alaska Natives is projected to grow by 1.2 percent per year, while enrollment for non-Natives is projected to grow by 1.3 percent per year.

We project increases in enrollment levels for all eligibility groups, with the largest growth tending to be in eligibility groups that have a larger share of the elderly. These groups include **Long Term Care Non-Cash** and **Supplemental Security Income/Adult Public Assistance/Long-Term Care Cash (SSI/APA/LTC Cash)**, which are projected to grow annually at 3.2 percent and 2.5 percent, respectively. **SSI/APA/LTC Cash** is the eligibility group that is projected to have the largest growth in total enrollees and is projected to grow from 23,200 to 37,800 enrolled in 2030, an increase of 14,600 enrollees.

**Table 2: Enrollment levels of eligibility groups associated with the elderly tend to grow faster than the 1.4 percent average**

MEDICAID ENROLLMENT FOR SELECT ELIGIBILITY GROUPS

Eligibility group	2010	2015	2020	2025	2030	Annual Change
<b>Title XIX Kids</b>	45,485	49,907	53,355	55,015	55,808	1.0%
<b>Title XXI Kids</b>	6,557	7,109	7,475	7,784	8,083	1.1%
<b>SSI/APA/LTC Cash</b>	23,171	27,180	31,340	35,084	37,829	2.5%
<b>LTC Non-cash</b>	2,026	2,396	2,835	3,336	3,803	3.2%

Source: Medicaid Budget Group, MESA Model

The **Title XIX Kids** eligibility group is currently the largest eligibility group. It is projected to maintain that distinction even though its 1.0 percent average annual growth rate is lower than the average growth rate for all enrollees.

### Total Medicaid Claims Spending<sup>17</sup>

Total Medicaid spending is expected to increase by 6.5 percent annually between 2010 and 2030. This projection is based on the program as it currently exists, and does not consider policy changes that may occur throughout the forecast period. Service categories that primarily serve the elderly are projected to have the highest growth during the forecast period. These services also tend to have the highest average per capita costs.

**Table 3: Spending on the elderly grows nearly twice as fast as spending on other age groups**

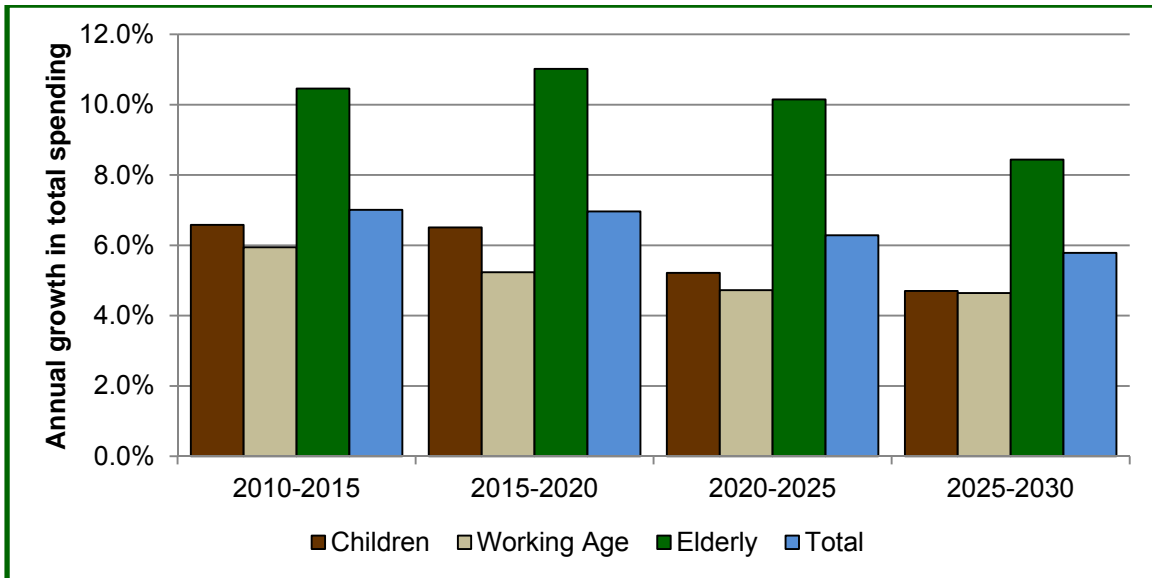
MEDICAID SPENDING BY AGE GROUP FOR SELECTED YEARS, 2010-2030 (IN MILLIONS)

Age Group	2010	2015	2020	2025	2030	Annual Growth
Children (0-19)	\$503.3	\$692.2	\$948.8	\$1,223.4	\$1,539.5	5.7%
Working Age Adults (20-64)	\$512.4	\$683.9	\$882.7	\$1,111.8	\$1,394.9	5.1%
Elderly (65+)	\$203.0	\$333.9	\$563.0	\$913.0	\$1,368.8	10.0%
<b>Total</b>	<b>\$1,218.7</b>	<b>\$1,710.0</b>	<b>\$2,394.5</b>	<b>\$3,248.2</b>	<b>\$4,303.2</b>	<b>6.5%</b>

Source: Medicaid Budget Group; MESA Model. See Table 16, Appendix C.

**Figure 7: Growth in total spending will slow down with time**

ANNUAL GROWTH IN TOTAL SPENDING BY AGE GROUP

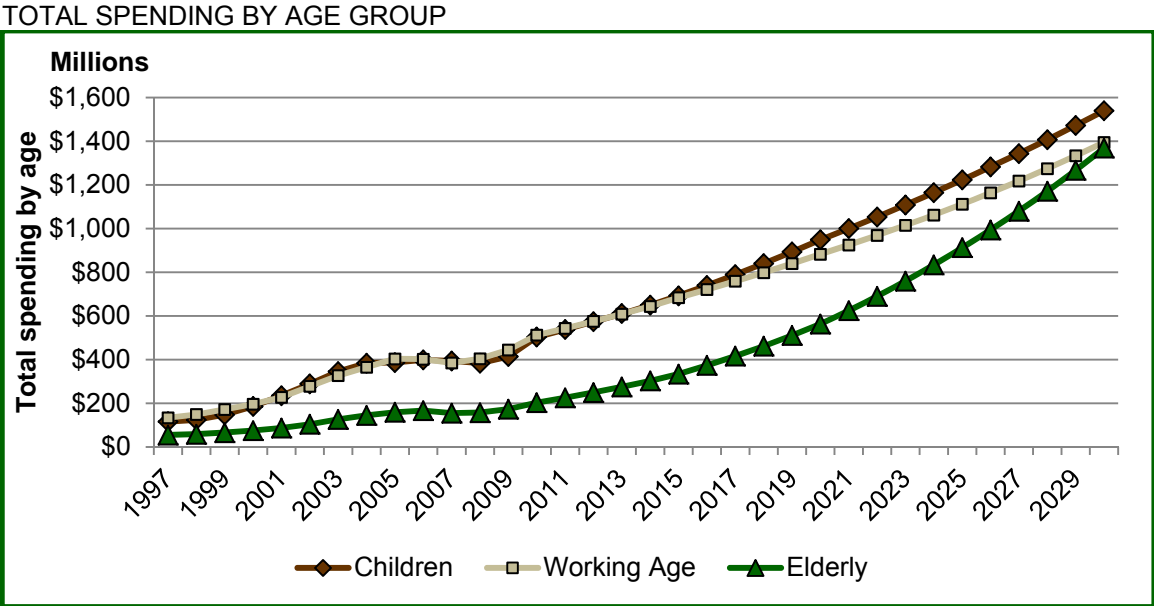


Source: Medicaid Budget Group, MESA Model

<sup>17</sup> All tables and figures are nominal unless otherwise noted. Nominal, or actual spending, is the projected future value without adjusting for inflation. Please see Tables 18 and 19 in Appendix C for real spending tables. The effects of the Affordable Care Act will be addressed in a separate section.

The higher projected growth rates in enrollment for the elderly will result in higher growth rates in spending for the elderly in comparison to spending on other groups. The average annual growth rate in spending for the elderly is projected to be 10.0 percent, compared to a projected average annual growth of 5.7 percent for children and 5.1 percent for working-age adults. Claims-based spending for all groups is expected to grow from \$1.2 billion in 2010 to \$4.3 billion in 2030, for an annual growth rate of 6.5 percent.

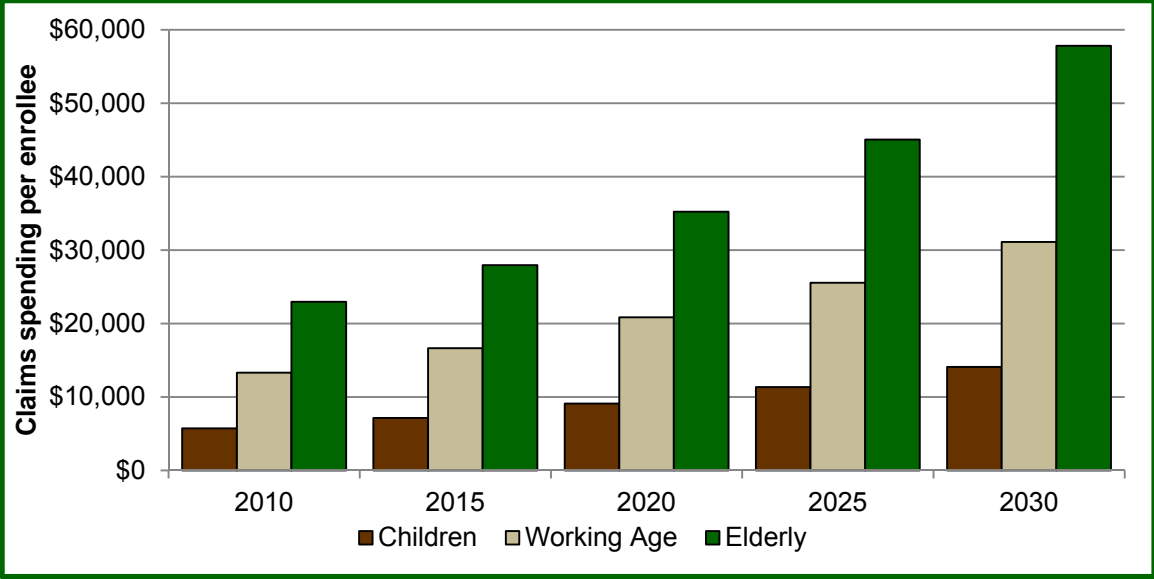
**Figure 8: By 2030, claims spending for the elderly will converge with that of working-age adults**



Source: Medicaid Budget Group: MESA Model. See Table 3, page 14.

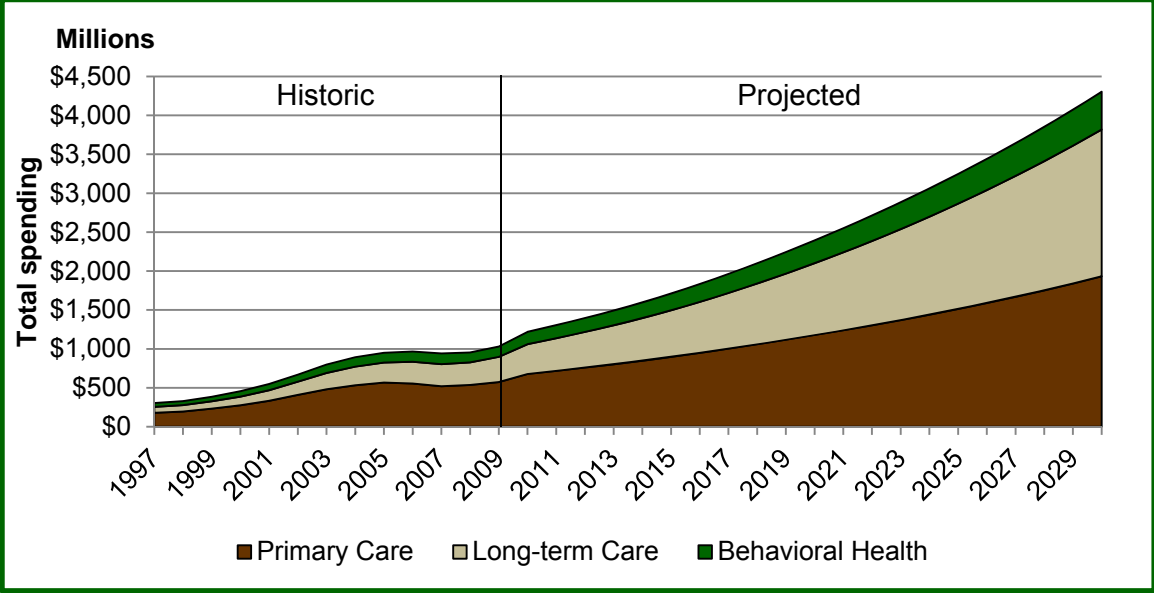
The higher costs of caring for the elderly will increase the total share of Medicaid spending dedicated to elderly care. By 2030, spending for the elderly account for 32 percent of total spending, even though the elderly will account for only 13 percent of Medicaid enrollees.

**Figure 9: Each elderly enrollee costs about four times as much as a child**  
 AVERAGE TOTAL CLAIMS SPENDING PER ENROLLEE



Source: Medicaid Budget Group: MESA Model. See Table 3, page 14.

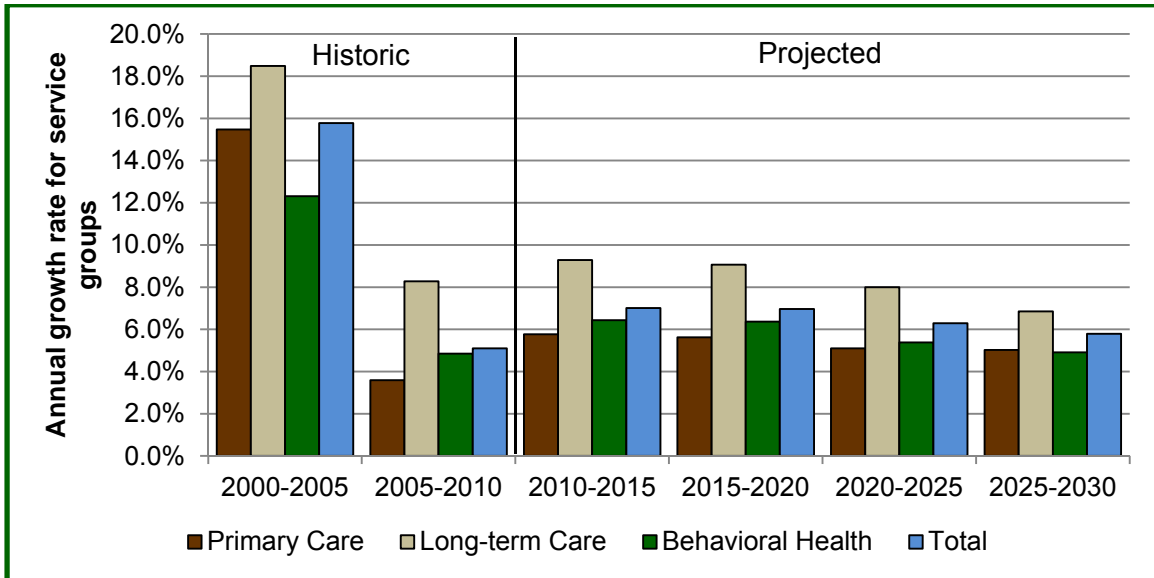
**Figure 10: Total spending in 2030 will be almost four times the 2010 value**  
 TOTAL SPENDING BY SERVICE GROUP



Source: Medicaid Budget Group: MESA Model. See Table 17 and Table 23, Appendix C. See Appendix B for category groupings.

**Figure 11: Growth in total spending has slowed dramatically in recent years**

ANNUAL GROWTH IN SPENDING BY SERVICE GROUP



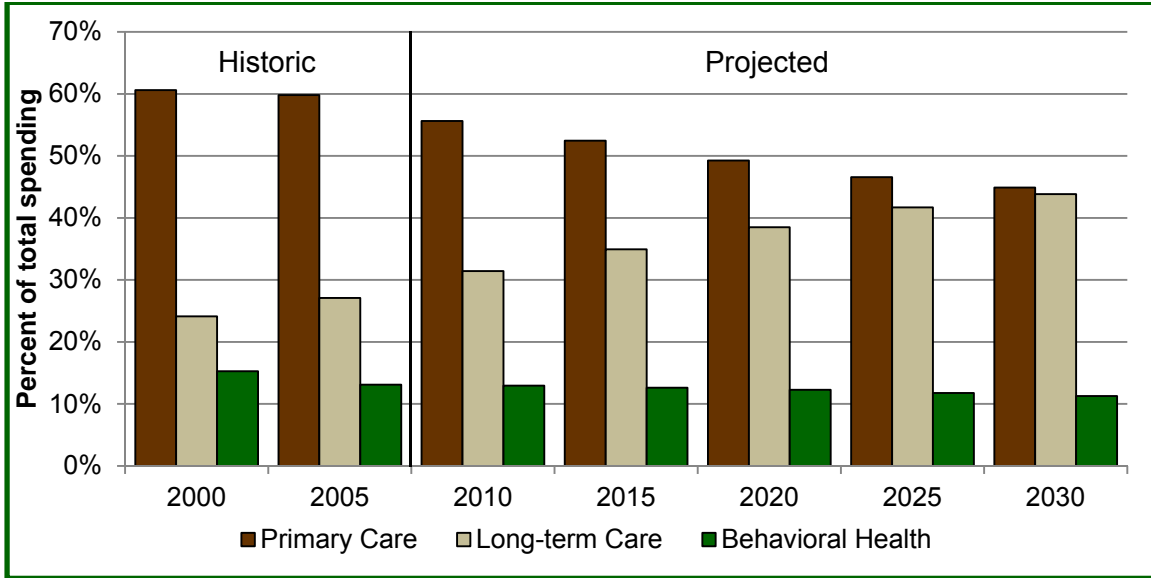
Source: Medicaid Budget Group: MESA Model. See Table 17, Table 23, Appendix C. See Appendix B for category groupings.

Figure 11 shows the growth rate in Alaska’s historical and projected Medicaid spending. Spending on Medicaid increased rapidly from 2000 to 2005; annual growth rates in spending were above 10 percent during four of these five years and averaged 15.8 percent annually for the period. The large spending increases of the late 1990s and early 2000s were brought under control from 2006 through 2008. The slowing down of the growth in spending from 2006 to 2008 was partially due to program changes put in place, by the Legislature and Department following the release of the *Long-Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025* in January 2006. However, an economic recession hit the country in 2008, and in 2009 we saw increases in Medicaid enrollment and spending. Medicaid claims spending in 2009 increased by 8 percent over 2008.

Spending on **Long-term Care** services, such as **Home and Community Based (HCB) Waiver** and **Personal Care**, is projected to grow faster than spending on **Primary Care** and **Behavioral Health**. **Long-term Care**, which is expected to grow from 31 percent to 44 percent of total spending, has a larger share of recipients over the age of 65 than either **Primary Care** or **Behavioral Health**.

**Figure 12: Spending on Long-term Care services will increase as a share of total spending**

PERCENT OF TOTAL SPENDING BY SERVICE GROUP



Source: Medicaid Budget Group: MESA Model. See Table 4 below.

**Table 4: Long-Term Care is projected to be the fastest-growing service group**

MEDICAID SPENDING BY SERVICE GROUP FOR SELECTED YEARS (IN MILLIONS)

Service	2010	2015	2020	2025	2030	Annual Growth
Behavioral Health	\$157.9	\$215.7	\$293.7	\$381.6	\$485.0	5.8%
Long-Term Care	\$383.0	\$597.2	\$921.6	\$1,354.1	\$1,886.0	8.3%
Primary Care	\$677.8	\$897.1	\$1,179.3	\$1,512.5	\$1,932.2	5.4%
<b>Total</b>	<b>\$1,218.7</b>	<b>\$1,710.0</b>	<b>\$2,394.5</b>	<b>\$3,248.2</b>	<b>\$4,303.2</b>	<b>6.5%</b>

Source: Medicaid Budget Group, MESA model. See Table 17, Appendix C and Appendix Bs.

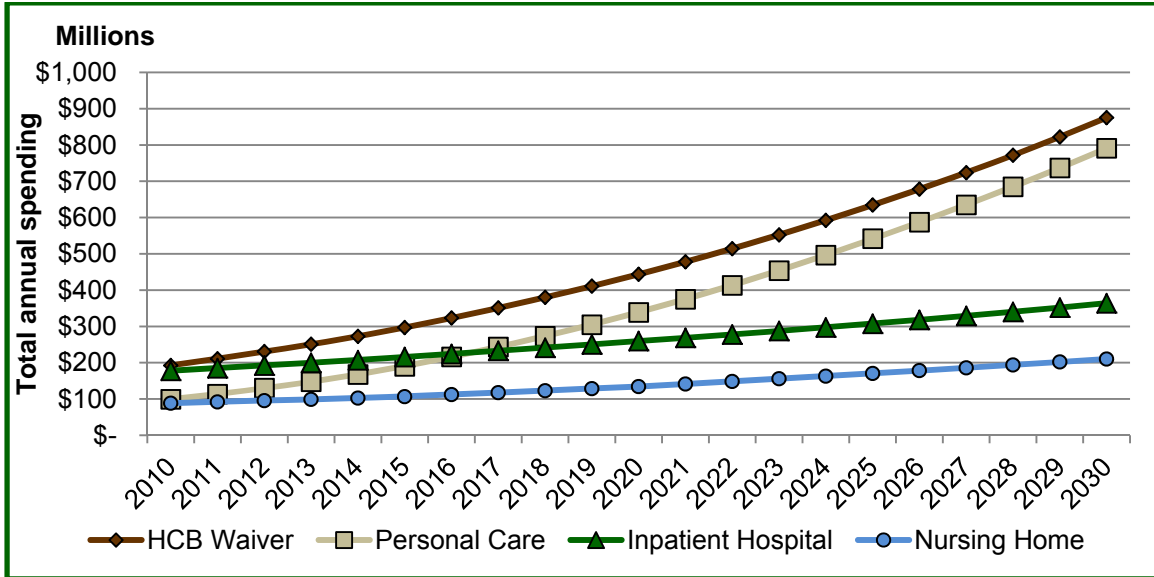
Total Medicaid spending is projected to grow at an average annual rate of 6.5 percent through the forecast period. There is, however, substantial variation in the growth rates of the 20 service categories<sup>18</sup> of spending. **HCB Waiver** spending is projected to grow by an average annual rate of 7.9 percent. **Personal Care** is projected to grow by 10.9 percent per year. By 2030 **HCB Waiver** is projected to account for \$875 million or 20 percent of Medicaid claims spending, up from the current 16 percent. **Personal Care** will also make large gains, with a forecasted increase from 8 percent of total claims spending (\$100 million) in 2010

<sup>18</sup> See Appendix B for a listing of the service categories.

to 18 percent of spending (\$790 million) in 2030. Spending in both of these programs is driven largely by growth in enrollment of the elderly.

**Figure 13: Home and Community Based Waivers and Personal Care are the fastest growing service categories**

TOTAL SPENDING FOR SELECT SERVICE CATEGORIES



Source: Medicaid Budget Group, MESA model. See Table 17, Appendix C.

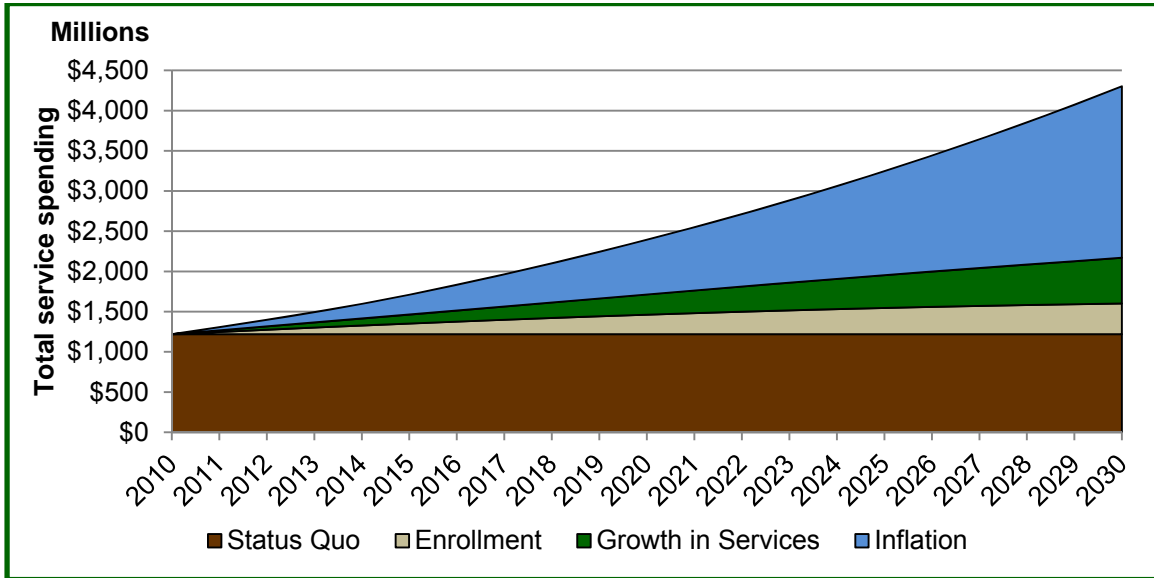
Conversely, **Inpatient Hospital** is currently one of the largest categories for spending in 2010, second only to **HCB Waiver**, and is not as heavily influenced by growth in the enrollment of the elderly. Inpatient Hospital spending is projected to grow by 3.6 percent annually, resulting in a decrease in share of Medicaid spending from 15 percent in 2010 to 5 percent in 2030.

Despite the relatively high rate of growth in the elderly population, the rate of spending growth for **Nursing Homes** is projected to be slower than the growth in spending for Medicaid as a whole. As a result, the **Nursing Home** category will drop from 7.3 percent of total Medicaid spending in 2010 to 4.9 percent by 2030. The data suggests that recipients are shifting from **Nursing Homes**, where services are received in an institutional setting, to **Personal Care** and **Home and Community Based Waivers**, where care is received in one’s own home.



**Figure 14: Inflation accounts for the largest part of increased claims spending**

SPENDING DECOMPOSED INTO GROWTH COMPONENTS



Source: Medicaid Budget Group, MESA model

Figure 14 shows the growth in total spending by components that affect spending growth. The components of spending growth are as follows:

- *Status Quo* refers to what would happen if there were no growth in healthcare-specific price inflation, no growth in population, no change in the demographic profile of the state, and no growth in the use and intensity of services provided. The status quo assumes that everything in future years remains exactly the same as in 2010.
- *Enrollment Growth* is the additional cost on top of the status quo resulting from growth in enrollment. Only the increase in total enrollment is taken into account and not demographic changes such as an aging population.
- *Growth in Services* includes the additional spending associated with a greater use and intensity of services provided. Growth in services is the result of an aging population and other demographic changes, as well as the change in amount, duration, and scope of services provided from an increase of technology.
- *Inflation* is the rate at which the price of a given medical service is expected to increase over time.

The component that will have the largest influence on total spending is healthcare-specific inflation. Without inflation, we project Medicaid claims spending would increase from \$1.2 billion to \$2.2 billion in 2030<sup>19</sup>, an average

<sup>19</sup> See Table 18 and Table 19, Appendix C.

annual growth rate of 2.9 percent. Inflation, however, increases the amount of spending in 2029 by an additional \$2.1 billion for a total cost of \$4.3 billion – a combined annual increase of 6.5 percent over the forecast period.

**State Claims Spending** <sup>20</sup>

State spending is projected to grow at 8.2 percent annually for the forecast period, compared to a 5.5 percent projected annual growth in federal spending. Across the U.S., Medicaid spending is expected to grow at an annual rate of 7.6 percent from 2010 to 2019<sup>21,22</sup>, but Alaska’s total Medicaid spending is projected to grow at 7.0 percent over the same timeframe. The federal financial participation (FFP) rate that applies to the majority of spending on Medicaid services levels off at 50 percent in July 2011 and is expected to continue at approximately the same level throughout the forecast period. This projection is based on spending patterns of today and is not intended to consider possible changes to federal participation in the future.

Medicaid is jointly funded by the federal and state government. Federal financial participation (FFP) rates are set at the federal level, and are largely outside of state control. The state’s portion of Medicaid Service costs differs according to the recipient’s Medicaid eligibility group, category of Medicaid service, provider of Medicaid-related service, and Native/Non-native status. For most Medicaid eligibility groups and services, the portion of state Medicaid benefits paid by the federal government is called the Federal Medical Assistance Percentage (FMAP).

**Table 5: State share of Medicaid funding increases throughout the forecast period**

Medicaid Spending by Fund Source as a Percent of Total Spending for Selected Years, 2010-2030

<b>Fund Source</b>	<b>2010</b>	<b>2015</b>	<b>2020</b>	<b>2025</b>	<b>2030</b>
<b>State and Other Match Funds (Percent of Total)</b>	32.0%	42.6%	43.0%	43.3%	43.5%
<b>Federal (Percent of Total)</b>	68.0%	57.4%	57.0%	56.7%	56.5%

Source: Medicaid Budget Group, MESA model. See Table 17 and Table 20, Appendix C.

The FMAP is based on a three-year average of per capita personal income, ranked among states. While each state has its own FMAP, it can be no lower than 50 percent. Although the majority of benefits are reimbursed at the regular

<sup>20</sup> Additional details on State spending are provided in Table 20 of Appendix C. Estimates provided in this section do not include the effects of the Affordable Care Act. The Affordable Care Act is addressed in a separate section.

<sup>21</sup> Christopher Truffer, et al. “Health Spending Projections Through 2019: The Recession’s Impact Continues.” Health Affairs. Vol. 29, no.3 (2010), p 4.

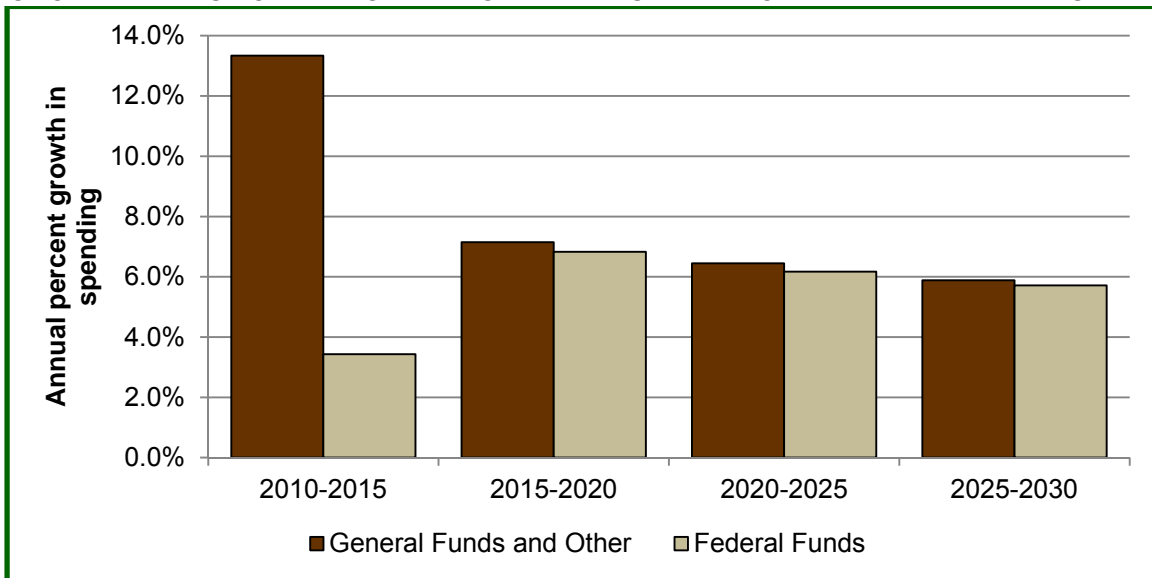
<sup>22</sup> The authors only conduct a 10-year forecast. Thus we are only able to compare MESA to the 10 years provided in their forecast.

FMAP rate, certain subgroups have higher reimbursement rates (e.g., qualified Indian Health Services claims are reimbursed 100 percent). Where possible, the state contains costs by taking advantage of higher reimbursement rates.

Alaska benefited from special legislation passed in the Deficit Reduction Act of 2005, which allowed the FMAP to remain at the FFY 2005 level of 57.58 percent for FFY 2006 and 2007. This special rate expired October 1, 2007. More recently, Alaska has benefitted from the American Recovery and Reinvestment Act of 2009 (commonly known as the stimulus bill), which was passed in the spring of 2009. This bill increased Alaska’s FMAP to 58.68 percent, retroactive to October 1, 2008. A provision in the stimulus bill enables states to receive additional federal funds if the unemployment rate within the state reaches certain thresholds. Because of this provision, Alaska’s FMAP increased to 61.12 percent for a few quarters and then increased to 62.46 percent for a few quarters, where it remained through the end of calendar year 2010. The FMAP will drop down from this level from January through June 2011. Alaska’s Medicaid FMAP is scheduled to drop to 50.00 percent starting in July 2011. The enhanced FMAP rate, which is used for the reimbursement rate for Title XXI and some other services, was not affected by the stimulus bill. It expected to remain at around 65.00 percent in upcoming years. These changes contribute to the increase in state spending relative to federal funds.

**Figure 15: After stimulus funds end in June 2011 and the FFP changes, state and federal spending growth rates are roughly equal**

GROWTH RATES FOR MEDICAID BY GENERAL FUND AND OTHER AND FEDERAL FUND



Source: Medicaid Budget Group, MESA model. See Table 17 and Table 20, Appendix C.

The decrease of the federal financial participation rate leads to a higher growth rate in Alaska's share of Medicaid spending than the federal government's share. We project the state will have average spending growth of 8.2 percent, compared to 5.5 percent for the federal government. When we compare the year-to-year growth in spending, however, the growth in federal and state Medicaid spending are nearly equal with the exception of the current transition year, when the FMAP is adjusting down to 50 percent; a larger share of the costs is shifted to the state.

## Other Medicaid Payments

In previous sections we projected Medicaid enrollment, utilization, and spending for the next twenty years based on historical claims payments from the Alaska Medicaid program and population projections from the Alaska Department of Labor and Workforce Development. The forecast showed that payments for services provided to individuals account for most of the Medicaid spending. There are other Medicaid payments and offsets which are not tied to services provided for any individual Medicaid enrollee. The share of total spending attributed to the special payments and offsets varies from year to year. For example, in 2005 the special payments accounted for 13 percent of total Medicaid spending, compared to 5 percent during 2009.

These additional payments and offsets include the following: Medicare Part A and Part B premium payments for seniors who are enrolled in both Medicare and Medicaid, drug rebates, and judgments from the Centers for Medicare and Medicaid Services (CMS). Supplemental payments are made to hospitals that serve a large number of the poor (Disproportionate Share Hospital payments or DSH payments); to health clinics for Alaska Native tribes (continuing care agreement payments and tribal dental encounter settlement payments). Supplemental payments to hospitals and health clinics usually make up the majority of the payments that don't go through the claims payment system.

**Table 6: Other Medicaid payments will increase total Medicaid spending in 2030 to \$4.5 billion**

MEDICAID SPENDING BY FUND SOURCE AS A PERCENT OF TOTAL SPENDING FOR SELECTED YEARS, 2010-2030 (IN MILLIONS)

		2010	2015	2020	2025	2030
<b>Claims payments</b>	<b>Federal</b>	\$829.3	\$981.7	\$1,366.0	\$1,842.7	\$2,432.7
	<b>State Match</b>	\$389.4	\$728.2	\$1,028.5	\$1,405.5	\$1,870.6
	<b>Total</b>	\$1,218.7	\$1,710.0	\$2,394.5	\$3,248.2	\$4,303.2
<b>Other Payments</b>	<b>Federal</b>	\$41.5	\$49.1	\$68.3	\$92.1	\$121.6
	<b>State Match</b>	\$19.5	\$36.4	\$51.4	\$70.3	\$93.5
	<b>Total</b>	\$61.0	\$85.5	\$119.7	\$162.4	\$215.2
<b>Total Payments without ACA</b>	<b>Federal</b>	\$870.8	\$1,030.8	\$1,434.3	\$1,934.8	\$2,554.3
	<b>State Match</b>	\$408.9	\$764.7	\$1,079.9	\$1,475.8	\$1,964.1
	<b>Total</b>	\$1,279.7	\$1,795.5	\$2,514.2	\$3,410.6	\$4,518.4

Source: Medicaid Budget Group: MESA Model. See Table 17 and Table 20, Appendix C.

There is uncertainty about the magnitude of the effect that special payments will have on Medicaid spending in the future. The Medicaid program is always changing, and payments that are acceptable one year may be disallowed by CMS

in later years<sup>23</sup>. The special payments are represented in this forecast by adding an additional 5 percent onto the forecast, based on claims data. In any given year, the forecast assumes that the share of total spending paid by the federal government will be the same for these special payments as it was for the claims payments.

---

<sup>23</sup> FairShare and ProShare are two examples of supplemental payment programs that have been discontinued in recent years.

## Health Care Reform

Some of the opportunities and challenges that the Alaska Medicaid program will face in upcoming years are related to the Affordable Care Act, which was passed by the U.S. Congress and signed by President Obama in the spring of 2010. There are a number of provisions in the Affordable Care Act that will affect the Medicaid program. Some of these provisions include the moving of certain eligibility groups from the Title XXI Child Health Insurance Program (CHIP) to Medicaid, additional federal financial participation for CHIP<sup>24</sup>, adjustments to the prescription drug rebates<sup>25</sup>, and the creation of a Health Information Exchange. However, the greatest financial impact to the Medicaid program will come from the expansion of Medicaid eligibility to all individuals above 133 percent<sup>26</sup> of the Federal Poverty Guidelines.

Beginning in January 2014<sup>27</sup>, Medicaid eligibility will be open<sup>28</sup> to all individuals below 133 percent of Federal Poverty Guidelines (FPG). At the present time, an individual must fit into a particular eligibility category (each of which has a different income standard) to be eligible for Medicaid. Generally the categories of eligibility are children, pregnant women, families with dependent children, disabled adults, or persons age 65 or older. This leaves out many people, such as single adults who are not disabled and who do not have children at home. These people cannot presently qualify for Medicaid even if they are low income and have large medical bills. Beginning in January 2014, anybody with an income below 133 percent FPG will qualify for Medicaid services.

From 2014 through 2016, the federal government will pay for 100 percent of the medical expenses of newly-eligible individuals. The federal government's share of spending will decrease over succeeding years until it reaches 90 percent in 2020.

---

<sup>24</sup> See Section 2101 of the Patient Protection and Affordable Care Act.

<sup>25</sup> See Section 2501 of the Patient Protection and Affordable Care Act.

<sup>26</sup> There is also a 5 percent income disregard, so sometimes publications talk about expansion to 138 percent FPG.

<sup>27</sup> States also have the option of expanding eligibility prior to January 2014 and receiving their regular FMAP match rate from the federal government for payments made before January 2014.

<sup>28</sup> See Section 2001 of the Patient Protection and Affordable Care Act.



**Table 7: Medicaid cost sharing for newly-eligible individuals**

MEDICAID COST SHARING PERCENTAGES FOR INDIVIDUALS MADE ELIGIBLE FOR MEDICAID BY THE AFFORDABLE CARE ACT

	Prior to 2014	2014-2016	2017	2018	2019	2020 and later
<b>Federal share</b>	≈ 50%	100%	95%	94%	93%	90%
<b>State share</b>	≈ 50%	0%	5%	6%	7%	10%

Developing cost estimates for the effects of health care reform are difficult because of the complexity of the situation and the lack of historical data to draw upon. For example, there is a question about how much one individual will cost. Are the health needs of childless, single adults, who have not been covered by Medicaid in the past, different than the health needs or their peers who have children? Will they use different services? Will they use fewer services?

In addition to the challenges in estimating costs, there are also challenges in estimating the number of newly-eligible enrollees. Even though there are surveys that can provide information about health insurance coverage by income level, these surveys do not provide other essential pieces of information, such as whether individuals have dependent children or fit into another Medicaid eligibility category.

The Alaska Medicaid Budget Group has created cost estimates for the newly-eligible individuals based on information from the Current Population Survey about the insurance status of individuals between the ages of 18 and 64 whose income is below 138 percent<sup>29</sup> of the Federal Poverty Guidelines. Adjustments were made to account for individuals who may already qualify for Medicaid, but who haven't signed up. It was assumed that the average newly-eligible individual would cost the same as the average working-age adult within the Alaskan Families with Dependent Children and Related<sup>30</sup> eligibility class and the Exams eligibility class. Additional changes were made to federal financial participation to account for recipients of IHS services.

It is estimated that 32,000 newly-eligible individuals will be covered by Medicaid starting in 2014 at a cost of almost \$220 million. All of the expenses for these individuals will be paid by the federal government for the first three years. In 2017 these newly-eligible individuals will cost the state almost \$12 million in general funds. By 2020, that figure will increase to almost \$29 million in general funds, with the federal government paying an additional \$293 million.

<sup>29</sup> We included the 5 percent income disregard.

<sup>30</sup> See Appendix A for a list of all the eligibility classes.

**Table 8: The federal government will pay for most of the costs of Medicaid expansion**

COST ESTIMATES FOR INDIVIDUALS MADE ELIGIBLE FOR MEDICAID BY THE AFFORDABLE CARE ACT

	<b>New individuals covered</b>	<b>Cost per person</b>	<b>Total cost (in millions)</b>	<b>Federal cost (in millions)</b>	<b>State cost (in millions)</b>
<b>2014</b>	32,240	\$6,751	\$217.7	\$217.7	\$0.0
<b>2015</b>	32,401	\$7,151	\$231.7	\$231.7	\$0.0
<b>2016</b>	32,563	\$7,610	\$247.8	\$247.8	\$0.0
<b>2017</b>	32,726	\$8,090	\$264.7	\$253.0	\$11.8
<b>2018</b>	32,889	\$8,596	\$282.7	\$267.6	\$15.1
<b>2019</b>	33,054	\$9,128	\$301.7	\$283.0	\$18.8
<b>2020</b>	33,219	\$9,684	\$321.7	\$293.1	\$28.6
<b>2025</b>	34,058	\$12,752	\$434.3	\$395.7	\$40.8
<b>2030</b>	34,918	\$16,363	\$571.3	\$520.6	\$50.8

Source: Medicaid Budget Group

In addition to the increased enrollment of newly eligible, changes will be made to the CHIP program. Under the Affordable Care Act, one of the three benefit groups that currently receives the Title XXI Enhanced FMAP will be moved to regular Medicaid in 2014 and receive a lower match rate. From October 2015 through September 2019, the children remaining in the CHIP program will receive a 23 percentage point increase to their federal match rate. These changes will not affect total spending, but will shift spending between the federal and state governments.

**Table 9: Changes to the CHIP program due to the Affordable Care Act will lead to cost shifting**

COST SHIFTING FOR THE CHIP PROGRAM

	<b>Children moved to regular Medicaid</b>	<b>Cost per child</b>	<b>Change in federal spending (in millions)</b>	<b>Change in state spending (in millions)</b>
<b>2014</b>	6,320	\$2,033	(\$1.9)	\$1.9
<b>2015</b>	6,370	\$2,145	(\$0.8)	\$0.8
<b>2016</b>	6,421	\$2,263	\$3.1	(\$3.1)
<b>2017</b>	6,472	\$2,387	\$3.3	(\$3.3)
<b>2018</b>	6,524	\$2,519	\$3.5	(\$3.5)
<b>2019</b>	6,576	\$2,657	\$2.1	(\$2.1)
<b>2020</b>	6,629	\$2,803	(\$2.7)	\$2.7
<b>2025</b>	6,898	\$3,664	(\$3.8)	\$3.8
<b>2030</b>	7,179	\$4,788	(\$5.2)	\$5.2

Source: Medicaid Budget Group

In 2014 and 2015 the moving of the S2 benefit group<sup>31</sup> from the CHIP program to regular Medicaid will lead to a loss of almost \$3 million in federal funds, which

<sup>31</sup> The S2 eligibility group includes children between the ages of 6 and 18 who are between 100 and 133% FPG.

the state will have to cover with general funds. However, from 2016 to 2019, the state will experience some general fund cost savings due to the increased match rate for the children remaining on CHIP. This will offset the additional costs that the state will need to pay for the children who switch from CHIP to regular Medicaid. After the 23 percentage point increase to the CHIP federal match rate expires, the state will again need to come up with more general funds than it would under the current system.

There are other aspects of health care reform that have financial aspects, which are not quantifiable at this time:

- Health Information Exchange: The state and federal governments are investing millions of dollars in setting up a Health Information Exchange (HIE). The HIE will reduce the costs associated with the duplication of tests, and help providers be more efficient.
- Drug rebates: In order to help pay for the Affordable Care Act, a larger share of Medicaid drug rebates will be going to the federal government, instead of to the states. The state will need to provide additional general funds, to compensate for the lower drug rebate.
- The “woodwork effect”: Medicaid may see a larger-than-expected increase in enrollment, due to currently-eligible-but-not-enrolled individuals suddenly coming out of the woodwork, and starting to utilize Medicaid services. These individuals are not eligible for the increased match rate that newly-eligible individuals will receive.

**Table 10: Including spending for the Affordable Care Act increases total Medicaid spending in 2030 to \$5.1 billion**

TOTAL MEDICAID SPENDING INCLUDING SOME AFFORDABLE CARE ACT PROVISIONS FOR SELECTED YEARS, 2010-2030 (IN MILLIONS)

		2010	2015	2020	2025	2030
<b>Total</b>	<b>Federal</b>	\$870.8	\$1,030.8	\$1,434.3	\$1,934.8	\$2,554.3
<b>Payments before ACA</b>	<b>State Match</b>	\$408.9	\$764.7	\$1,079.9	\$1,475.8	\$1,964.1
	<b>Total</b>	\$1,279.7	\$1,795.5	\$2,514.2	\$3,410.6	\$4,518.4
<b>Costs for Newly Eligible</b>	<b>Federal</b>	N/A	\$231.7	\$293.1	\$395.7	\$520.6
	<b>State Match</b>	N/A	\$0.0	\$28.6	\$40.8	\$50.8
	<b>Total</b>	N/A	\$231.7	\$321.7	\$434.3	\$571.3
<b>CHIP Cost Shifting</b>	<b>Federal</b>	N/A	(\$0.8)	(\$2.7)	(\$3.8)	(\$5.2)
	<b>State Match</b>	N/A	\$0.8	\$2.7	\$3.8	\$5.2
	<b>Total</b>	N/A	\$0.0	\$0.0	\$0.0	\$0.0
<b>Total Payments</b>	<b>Federal</b>	\$870.8	\$1,261.7	\$1,724.7	\$2,326.7	\$3,069.7
	<b>State Match</b>	\$408.9	\$765.5	\$1,111.2	\$1,520.4	\$2,020.1
	<b>Total</b>	\$1,279.9	\$2,027.2	\$2,835.9	\$3,844.9	\$5,089.7

Source: Medicaid Budget Group: MESA Model

## Summary

Before making adjustments for the Affordable Care Act, total spending is forecasted to reach \$4.5 billion by 2030 (see Table 6, page 28), growing at an average annual rate of 6.5 percent. State spending is expected to grow at 8.2 percent. Aside from inflation, growth in total spending through 2030 is primarily the result of the following factors:

- Population growth – expected to average 0.9 percent per year
- Enrollment growth – expected to average 1.3 percent per year

The population forecast includes assumptions about the changing demographic profile of Alaska. The average annual growth rate in enrollment of the elderly (65 and older) is expected to be 5.0 percent, which is higher than the growth rate for other age groups. As a result, the overall focus of the Medicaid program will shift from a child-based program to programs more evenly distributed between the elderly, working-age adults, and children. This demographic change affects spending, because spending on the elderly is growing at a rate almost double that of children and working-age adults; this growth is likely to continue. The expected shift in spending towards the elderly is still likely to occur, but the timing will probably be delayed compared to earlier forecasts.

Services used more heavily by the elderly, such as Personal Care and Home and Community Based Waivers, will experience the highest spending growth throughout the forecast period.

Adjustments were made to the projections, to account for a couple of pieces of the Affordable Care Act. Starting in 2014, approximately 32,000 individuals will be added to the Medicaid rolls. By 2030 the newly-eligible population is estimated to grow to 35,000, and add another \$570 million in spending, of which the federal government will pay \$520 million, and state general funds will pay the remaining \$50 million. These adjustments bring total spending for 2030 up to an estimated \$5.1 billion.

The purpose of this forecast is to enable policy makers and the Department of Health and Social Services to see where Medicaid is headed, based on key growth components. By looking farther into the future, policy can be based more on proactive rather than reactive measures.

## Appendices

### Appendix A: Medicaid Eligibility Classification Descriptions

<b>Eligibility Class</b>	<b>Description</b>
<b>AFDC &amp; Related</b>	Eligible for AFDC-based Family Medicare or Transitional Medicaid
<b>Alien (Foreign)</b>	Illegal, sponsored, or amnesty alien
<b>Exams</b>	Disability, waiver, or pregnancy determination pending
<b>Kids in Custody</b>	Children in custody of DHSS
<b>LTC Non-cash</b>	Elderly or disabled individual not receiving SSI or cash supplement
<b>Medicare</b>	Eligible for Medicare cost-sharing assistance only
<b>Other Disabled</b>	Working disabled or eligible due to breast/cervical cancer screening
<b>Pregnancy/Post Partum</b>	Eligible during pregnancy and for 60 days after giving birth
<b>SSI/APA/LTC Cash</b>	Eligible for SSI or other state cash supplement
<b>Title XIX Kids</b>	Children under age 19 not eligible for coverage under M-SCHIP
<b>Title XXI Kids</b>	Children under age 19 eligible for coverage under M-SCHIP

## Appendix B: Medicaid Service Category Descriptions

Service Group	Service Category	Description
Behavioral Health	Inpatient Psychiatric Hospital	Inpatient psychiatric hospital services
Behavioral Health	Outpatient Mental Health	Outpatient mental health services, psychology services, and drug abuse centers
Behavioral Health	Residential Psychiatric/Behavioral Rehabilitation Services	Residential psychiatric treatment centers and behavioral rehabilitation services (BRS)
Long-term Care	Home & Community Based Waiver	Home and community based long-term care services offered through Medicaid Waivers including Alaska Pioneer Homes, assisted living homes, respite care, adult day care, chore services, residential and day habilitation, nutrition, and meals.
Long-term Care	Home Health/Hospice	Home health services, hospice care, nutrition services, and private duty nursing
Long-term Care	Nursing Home	Skilled nursing and intermediate care facilities including intermediate-care facilities for the mentally retarded; and temporary long-term care services
Long-term Care	Personal Care	Personal care attendant services including agency-based and consumer-directed programs
Primary Care	Dental	Dental services for children and adults
Primary Care	Durable Medical Equipment/Supplies	Durable medical equipment (DME), medical supplies, prosthetics, and orthotics
Primary Care	Early & Periodic Screening, Diagnosis & Testing	Early, periodic screening, diagnosis and treatment (EPSDT) including preventive health checkups, health screenings and immunizations
Primary Care	Health Clinic	Health clinic services including rural health clinics, federally-qualified health clinics and tribal health clinics
Primary Care	Inpatient Hospital	Inpatient hospital services
Primary Care	Laboratory/X-Ray	Laboratory, x-ray and diagnostic services
Primary Care	Other Services	Other services not classified elsewhere
Primary Care	Outpatient Hospital	Outpatient hospital services, outpatient surgery services, and end-stage renal disease services
Primary Care	Pharmacy	Prescription drugs
Primary Care	Physician/Practitioner Services	Physician, podiatrist, advanced nurse practitioner, and midwifery services
Primary Care	Therapy/Rehabilitation	Outpatient rehabilitation, physical therapy, occupational therapy, speech therapy, audiology, and chiropractic services
Primary Care	Transportation	Emergency and non-emergency medically necessary transportation and accommodation
Primary Care	Vision	Optometrist services and eyeglasses

## Appendix C: Detailed Tables of 2010-2030 MESA Forecast

Table 11: Forecast of <b>Population</b> by Subpopulations						
	Calendar Year					Percent Change
	2010	2015	2020	2025	2030	
<b>State</b>	698,158	735,011	772,389	807,430	840,329	0.9%
<b>Gender</b>						
<b>Male</b>	355,978	373,638	391,624	407,971	423,455	0.9%
<b>Female</b>	342,180	361,373	380,765	399,460	416,873	1.0%
<b>Native Status</b>						
<b>Native</b>	114,993	122,413	129,869	136,719	143,660	1.1%
<b>Non-Native</b>	583,164	612,598	642,520	670,711	696,669	0.9%
<b>Region</b>						
<b>Northern</b>	116,133	121,460	126,267	130,949	135,570	0.8%
<b>Western</b>	41,954	44,291	46,692	48,979	51,729	1.1%
<b>South Central</b>	91,469	93,952	95,847	96,829	97,038	0.3%
<b>Anchorage/Mat-Su</b>	379,598	406,931	436,254	464,916	491,648	1.3%
<b>Southeast</b>	69,003	68,379	67,329	65,756	64,345	-0.3%
<b>Age Group</b>						
<b>0-4</b>	58,618	62,361	64,981	66,601	68,675	0.8%
<b>5-9</b>	56,030	57,902	61,677	64,118	65,769	0.8%
<b>10-14</b>	53,800	58,126	60,190	64,042	66,509	1.1%
<b>15-19</b>	54,462	52,222	56,497	58,486	62,258	0.7%
<b>20-24</b>	46,260	45,333	43,505	47,441	49,281	0.3%
<b>25-34</b>	94,513	107,339	114,604	111,802	114,329	1.0%
<b>35-44</b>	94,286	94,315	99,982	113,347	120,715	1.2%
<b>45-54</b>	104,445	93,026	85,099	84,971	90,124	-0.7%
<b>55-64</b>	80,268	89,060	86,418	75,572	67,993	-0.8%
<b>65-74</b>	35,631	51,741	68,405	76,715	74,529	3.8%
<b>75+</b>	19,844	23,587	31,030	44,334	60,146	5.7%

	Calendar Year					Percent Change
	2010	2015	2020	2025	2030	
<b>State</b>	135,246	149,836	162,557	171,578	177,730	1.3%
<b>Gender</b>						
<b>Male</b>	61,299	67,838	73,772	77,767	80,348	1.3%
<b>Female</b>	73,947	81,998	88,785	93,811	97,382	1.3%
<b>Native Status</b>						
<b>Native</b>	49,863	54,371	58,551	61,610	64,153	1.2%
<b>Non-Native</b>	85,382	95,465	104,006	109,968	113,577	1.3%
<b>Region</b>						
<b>Northern</b>	17,168	19,069	20,503	21,456	22,100	1.1%
<b>Western</b>	19,447	21,293	22,976	24,252	25,477	1.3%
<b>South Central</b>	18,239	19,727	20,933	21,483	21,400	0.7%
<b>Anchorage/Mat-Su</b>	67,718	76,523	84,668	91,086	95,817	1.6%
<b>Southeast</b>	12,674	13,224	13,477	13,301	12,935	0.0%
<b>Age Group</b>						
<b>0-4</b>	29,920	33,919	36,218	36,966	37,166	0.9%
<b>5-9</b>	21,424	23,422	25,432	26,216	26,284	0.9%
<b>10-14</b>	18,954	21,661	22,944	24,314	24,618	1.2%
<b>15-19</b>	17,651	17,820	19,673	20,323	21,173	0.9%
<b>20-24</b>	7,233	7,280	7,028	7,723	8,101	0.6%
<b>25-34</b>	11,032	13,121	14,336	14,015	14,299	1.1%
<b>35-44</b>	8,048	8,211	8,941	10,426	11,211	1.6%
<b>45-54</b>	6,946	6,421	5,928	5,919	6,361	-0.4%
<b>55-64</b>	5,196	6,041	6,080	5,418	4,846	-0.5%
<b>65-74</b>	4,568	6,751	9,064	10,360	10,233	3.6%
<b>75+</b>	4,273	5,189	6,913	9,898	13,437	5.7%

Eligibility Group	2010	2015	2020	2025	2030	Percent Change
<b>AFDC &amp; Related</b>	39,766	43,216	45,949	47,804	49,180	1.1%
<b>Exams</b>	848	929	1,020	1,140	1,263	2.0%
<b>Kids in Custody</b>	4,403	4,793	5,149	5,346	5,444	1.1%
<b>LTC Non-cash</b>	2,026	2,396	2,835	3,336	3,803	3.2%
<b>Medicare</b>	500	544	568	577	580	0.7%
<b>Other Disabled</b>	362	470	590	689	744	3.7%
<b>Pregnancy/Post Partum</b>	12,127	13,292	14,276	14,804	14,996	1.1%
<b>SSI/APA/LTC Cash</b>	23,171	27,180	31,340	35,084	37,829	2.5%
<b>Title XIX Kids</b>	45,485	49,907	53,355	55,015	55,808	1.0%
<b>Title XXI Kids</b>	6,557	7,109	7,475	7,784	8,083	1.1%
<b>Total (Unduplicated Count)</b>	135,246	149,836	162,557	171,578	177,730	1.4%



<b>Table 14: Forecast of Utilization by Subpopulations</b>						
	<b>Calendar Year</b>					<b>Percent Change</b>
	<b>2010</b>	<b>2015</b>	<b>2020</b>	<b>2025</b>	<b>2030</b>	
<b>State</b>	394,849	465,695	546,160	621,759	690,700	2.8%
<b>Gender</b>						
<b>Male</b>	161,678	192,293	226,937	258,589	286,753	2.9%
<b>Female</b>	233,172	273,402	319,223	363,169	403,947	2.8%
<b>Native Status</b>						
<b>Native</b>	125,328	146,110	170,179	192,786	214,829	2.7%
<b>Non-Native</b>	269,521	319,585	375,981	428,973	475,871	2.9%
<b>Region</b>						
<b>Northern</b>	52,685	62,515	73,004	82,718	91,654	2.8%
<b>Western</b>	49,525	57,931	67,641	76,963	86,666	2.8%
<b>South Central</b>	51,325	59,232	68,118	75,658	81,150	2.3%
<b>Anchorage/Mat-Su</b>	205,663	246,338	293,619	339,683	382,318	3.1%
<b>Southeast</b>	35,651	39,679	43,778	46,736	48,911	1.6%
<b>Age Group</b>						
<b>0-4</b>	74,464	87,852	99,740	109,193	118,569	2.4%
<b>5-9</b>	56,618	65,913	77,227	85,524	91,762	2.4%
<b>10-14</b>	50,311	61,164	69,985	79,774	86,415	2.7%
<b>15-19</b>	44,332	47,422	56,403	62,667	69,864	2.3%
<b>20-24</b>	20,915	22,126	22,786	26,718	29,834	1.8%
<b>25-34</b>	35,462	44,506	52,043	54,321	58,974	2.6%
<b>35-44</b>	27,448	29,542	34,462	42,910	49,072	2.9%
<b>45-54</b>	23,168	22,557	22,284	23,726	27,076	0.8%
<b>55-64</b>	22,320	27,378	29,388	27,837	26,418	0.8%
<b>65-74</b>	22,578	35,255	50,713	61,788	64,626	5.4%
<b>75+</b>	17,234	21,981	31,130	47,301	68,090	7.1%

Table 15: Forecast of **Utilization** by Service Category

Service	Calendar Year					Annual % Change
	2010	2015	2020	2025	2030	
Dental	44,039	52,198	62,346	71,353	79,396	3.0%
DME/Supplies	11,397	13,342	16,158	19,062	21,775	3.3%
Family Planning	556	579	628	674	718	1.3%
HCB Waiver	5,387	7,134	9,438	11,803	13,873	4.8%
Health Clinic	31,856	41,833	54,128	65,990	76,953	4.5%
Home Health/Hospice	950	1,147	1,418	1,692	1,943	3.6%
Inpatient Hospital	15,047	15,439	16,454	17,250	17,825	0.9%
Inpatient Psychiatric	872	967	1,108	1,234	1,350	2.2%
Lab/X-ray	12,945	12,818	13,206	13,452	13,518	0.2%
Nursing Home	961	962	1,033	1,112	1,148	0.9%
Outpatient Hospital	59,263	66,200	76,293	85,769	94,600	2.4%
Outpatient Mental Health	11,191	11,624	12,600	13,456	14,183	1.2%
Personal Care	3,819	5,190	6,870	8,479	9,726	4.8%
Pharmacy	66,131	71,778	80,935	89,526	97,544	2.0%
Physician/Practitioner	87,501	97,081	110,926	123,584	135,222	2.2%
Residential Psychiatric/BRC	851	998	1,143	1,224	1,259	2.0%
Therapy/Rehabilitation	8,033	9,761	12,009	14,159	16,094	3.5%
Transportation	22,945	26,409	31,273	36,010	40,556	2.9%
Vision	23,935	30,215	38,183	45,924	53,016	4.1%

<b>Table 16: Forecast of Nominal Spending by Subpopulations (in millions)</b>						
	<b>Calendar Year</b>					<b>Percent Change</b>
	<b>2010</b>	<b>2015</b>	<b>2020</b>	<b>2025</b>	<b>2030</b>	
<b>State</b>	\$1,218.7	\$1,710.0	\$2,394.5	\$3,248.2	\$4,303.2	6.5%
<b>Gender</b>						
<b>Male</b>	\$528.7	\$747.9	\$1,053.6	\$1,430.4	\$1,891.8	6.6%
<b>Female</b>	\$690.0	\$962.1	\$1,341.0	\$1,817.7	\$2,411.4	6.5%
<b>Native Status</b>						
<b>Native</b>	\$410.7	\$569.9	\$792.7	\$1,070.1	\$1,422.0	6.4%
<b>Non-Native</b>	\$808.0	\$1,140.1	\$1,601.9	\$2,178.1	\$2,881.2	6.6%
<b>Region</b>						
<b>Northern</b>	\$138.1	\$195.3	\$272.9	\$369.0	\$488.6	6.5%
<b>Western</b>	\$138.4	\$192.9	\$269.4	\$365.9	\$492.4	6.6%
<b>South Central</b>	\$177.8	\$244.5	\$336.3	\$445.9	\$571.5	6.0%
<b>Anchorage/Mat-Su</b>	\$624.0	\$890.8	\$1,270.0	\$1,753.8	\$2,358.7	6.9%
<b>Southeast</b>	\$140.5	\$186.4	\$246.0	\$313.5	\$392.0	5.3%
<b>Age Group</b>						
<b>0-4</b>	\$164.6	\$232.0	\$311.7	\$395.8	\$495.2	5.7%
<b>5-9</b>	\$71.7	\$99.8	\$138.4	\$177.7	\$219.7	5.8%
<b>10-14</b>	\$109.2	\$158.7	\$214.9	\$284.1	\$354.6	6.1%
<b>15-19</b>	\$157.8	\$201.7	\$283.9	\$365.8	\$470.0	5.6%
<b>20-24</b>	\$74.8	\$94.6	\$115.3	\$156.8	\$201.8	5.1%
<b>25-34</b>	\$110.2	\$165.2	\$228.6	\$276.8	\$346.2	5.9%
<b>35-44</b>	\$103.5	\$133.1	\$183.7	\$265.3	\$349.6	6.3%
<b>45-54</b>	\$123.2	\$143.3	\$167.6	\$206.9	\$272.1	4.0%
<b>55-64</b>	\$100.7	\$147.6	\$187.5	\$206.0	\$225.2	4.1%
<b>65-74</b>	\$71.5	\$133.4	\$227.0	\$320.8	\$386.7	8.8%
<b>75+</b>	\$131.5	\$200.5	\$336.0	\$592.1	\$982.2	10.6%

Note: Spending is for claims payments only.

Table 17: Forecast of **Nominal Spending** by Service Category (in millions)

Service	Calendar Year					Annual % Change
	2010	2015	2020	2025	2030	
Dental	\$48.0	\$70.0	\$99.5	\$134.6	\$178.4	6.8%
DME/Supplies	\$16.9	\$23.6	\$33.0	\$44.9	\$59.3	6.6%
Family Planning	\$0.23	\$0.30	\$0.37	\$0.45	\$0.57	4.5%
HCB Waiver	\$192.5	\$296.8	\$443.6	\$634.9	\$875.3	7.9%
Health Clinic	\$36.0	\$55.2	\$80.5	\$110.9	\$149.3	7.4%
Home Health/Hospice	\$2.5	\$3.4	\$4.9	\$6.7	\$9.3	6.8%
Inpatient Hospital	\$177.8	\$215.9	\$259.7	\$307.7	\$364.1	3.6%
Inpatient Psychiatric	\$18.9	\$25.3	\$33.7	\$43.5	\$55.6	5.6%
Lab/X-ray	\$2.2	\$2.6	\$3.1	\$3.7	\$4.3	3.4%
Nursing Home	\$88.4	\$106.5	\$134.2	\$170.4	\$210.1	4.4%
Outpatient Hospital	\$115.6	\$153.0	\$201.4	\$258.6	\$332.1	5.4%
Outpatient Mental Health	\$97.5	\$123.1	\$157.4	\$196.7	\$245.2	4.7%
Personal Care	\$99.6	\$190.5	\$338.9	\$542.0	\$791.2	10.9%
Pharmacy	\$77.0	\$99.4	\$128.4	\$163.3	\$207.9	5.1%
Physician/Practitioner	\$120.2	\$160.0	\$211.3	\$272.6	\$351.2	5.5%
Residential Psychiatric/BRC	\$41.5	\$67.3	\$102.5	\$141.4	\$184.2	7.7%
Therapy/Rehabilitation	\$21.1	\$30.1	\$42.5	\$57.3	\$75.7	6.6%
Transportation	\$57.5	\$79.1	\$107.7	\$141.8	\$185.5	6.0%
Vision	\$5.3	\$8.1	\$11.9	\$16.5	\$22.2	7.4%
<b>Total Spending</b>	\$1,218.7	\$1,710.0	\$2394.5	\$3,248.2	\$4,303.2	6.5%

Note: Spending is for claims payments only.

<b>Table 18: Forecast of Real Spending by Subpopulations (in millions of 2010 dollars)</b>						
	<b>Calendar Year</b>					<b>Percent Change</b>
	<b>2010</b>	<b>2015</b>	<b>2020</b>	<b>2025</b>	<b>2030</b>	
<b>State</b>	\$1,218.7	\$1,462.1	\$1,716.1	\$1,953.6	\$2,170.3	2.9%
<b>Gender</b>						
<b>Male</b>	\$528.7	\$639.5	\$755.1	\$860.3	\$954.1	3.0%
<b>Female</b>	\$690.0	\$822.7	\$961.0	\$1,093.3	\$1,216.1	2.9%
<b>Native Status</b>						
<b>Native</b>	\$410.7	\$487.3	\$568.1	\$643.6	\$717.2	2.8%
<b>Non-Native</b>	\$808.0	\$974.9	\$1,148.0	\$1,310.0	\$1,453.1	3.0%
<b>Region</b>						
<b>Northern</b>	\$138.1	\$167.0	\$195.5	\$222.0	\$246.4	2.9%
<b>Western</b>	\$138.4	\$164.9	\$193.1	\$220.1	\$248.3	3.0%
<b>South Central</b>	\$177.8	\$209.1	\$241.0	\$268.2	\$288.2	2.4%
<b>Anchorage/Mat-Su</b>	\$624.0	\$761.7	\$910.2	\$1,054.8	\$1,189.6	3.3%
<b>Southeast</b>	\$140.5	\$159.4	\$176.3	\$188.5	\$197.7	1.7%
<b>Age Group</b>						
<b>0-4</b>	\$164.6	\$198.4	\$223.4	\$238.1	\$249.8	2.1%
<b>5-9</b>	\$71.7	\$85.3	\$99.2	\$106.9	\$110.8	2.2%
<b>10-14</b>	\$109.2	\$135.7	\$154.0	\$170.9	\$178.8	2.5%
<b>15-19</b>	\$157.8	\$172.5	\$203.5	\$220.0	\$237.0	2.1%
<b>20-24</b>	\$74.8	\$80.9	\$82.6	\$94.3	\$101.8	1.5%
<b>25-34</b>	\$110.2	\$141.3	\$163.8	\$166.5	\$174.6	2.3%
<b>35-44</b>	\$103.5	\$113.8	\$131.6	\$159.6	\$176.3	2.7%
<b>45-54</b>	\$123.2	\$122.6	\$120.1	\$124.5	\$137.2	0.5%
<b>55-64</b>	\$100.7	\$126.2	\$134.4	\$123.9	\$113.6	0.6%
<b>65-74</b>	\$71.5	\$114.0	\$162.7	\$193.0	\$195.0	5.1%
<b>75+</b>	\$131.5	\$171.4	\$240.8	\$356.1	\$495.3	6.9%

Note: Spending is for claims payments only.

Table 19: Forecast of **Real Spending** by Service Category (in millions of 2010 dollars)

Service	Calendar Year					Annual % Change
	2010	2015	2020	2025	2030	
Dental	\$48.0	\$59.9	\$71.3	\$80.9	\$90.0	3.2%
DME/Supplies	\$16.9	\$20.1	\$23.6	\$27.1	\$30.7	3.0%
Family Planning	\$0.23	\$0.25	\$0.27	\$0.27	\$ .28	1.0%
HCB Waiver	\$192.5	\$253.8	\$317.9	\$381.9	\$441.5	4.2%
Health Clinic	\$36.0	\$47.2	\$57.7	\$66.7	\$75.3	3.8%
Home Health/Hospice	\$2.5	\$2.9	\$3.5	\$4.0	\$4.7	3.2%
Inpatient Hospital	\$177.8	\$184.6	\$186.2	\$185.1	\$183.6	0.2%
Inpatient Psychiatric	\$18.9	\$21.6	\$24.2	\$26.1	\$28.1	2.0%
Lab/X-ray	\$2.2	\$2.2	\$2.2	\$2.2	\$2.2	0.0%
Nursing Home	\$88.4	\$91.1	\$96.1	\$102.5	\$106.0	0.9%
Outpatient Hospital	\$115.6	\$130.8	\$144.3	\$155.5	\$167.5	1.9%
Outpatient Mental Health	\$97.5	\$105.3	\$112.8	\$118.3	\$123.6	1.2%
Personal Care	\$99.6	\$162.9	\$242.9	\$326.0	\$399.0	7.2%
Pharmacy	\$77.0	\$85.0	\$92.0	\$98.2	\$104.9	1.6%
Physician/Practitioner	\$120.2	\$136.8	\$151.4	\$164.0	\$177.1	2.0%
Residential Psychiatric/BRC	\$41.5	\$57.5	\$73.5	\$85.1	\$92.9	4.1%
Therapy/Rehabilitation	\$21.1	\$25.7	\$30.5	\$34.5	\$38.2	3.0%
Transportation	\$57.5	\$67.6	\$77.2	\$85.3	\$93.5	2.5%
Vision	\$5.3	\$6.9	\$8.5	\$9.9	\$11.2	3.8%
<b>Total Spending</b>	\$1,218.7	\$1,462.1	\$1,716.1	\$1,953.6	\$2,170.3	2.9%

Note: Spending is for claims payments only.

Table 20: Forecast of **State Spending** by Service Category (in millions)

Service	Calendar Year					Annual % Change
	2010	2015	2020	2025	2030	
Dental	\$13.8	\$26.1	\$37.0	\$50.1	\$66.4	8.2%
DME/Supplies	\$6.3	\$11.7	\$16.3	\$22.4	\$30.2	8.2%
Family Planning	\$0.21	\$0.26	\$0.33	\$0.40	\$0.50	4.6%
HCB Waiver	\$70.2	\$144.0	\$215.3	\$308.1	\$424.8	9.4%
Health Clinic	\$2.4	\$4.8	\$6.9	\$9.6	\$12.9	8.9%
Home Health/Hospice	\$0.8	\$1.4	\$2.0	\$2.7	\$3.8	8.3%
Inpatient Hospital	\$50.2	\$80.7	\$97.2	\$115.1	\$136.2	5.1%
Inpatient Psychiatric	\$7.0	\$12.3	\$16.5	\$21.2	\$27.2	7.0%
Lab/X-ray	\$0.8	\$1.3	\$1.5	\$1.8	\$2.1	4.9%
Nursing Home	\$31.5	\$50.6	\$63.7	\$80.9	\$99.8	5.9%
Outpatient Hospital	\$28.2	\$49.1	\$64.6	\$83.0	\$106.6	6.9%
Outpatient Mental Health	\$33.3	\$55.3	\$70.7	\$88.4	\$110.2	6.2%
Personal Care	\$37.4	\$95.1	\$169.3	\$270.7	\$395.1	12.5%
Pharmacy	\$24.1	\$41.2	\$53.2	\$67.6	\$86.1	6.6%
Physician/Practitioner	\$39.3	\$68.6	\$90.7	\$117.0	\$150.7	6.9%
Residential Psychiatric/BRC	\$15.4	\$33.0	\$50.3	\$69.3	\$90.3	9.2%
Therapy/Rehabilitation	\$7.4	\$13.9	\$19.6	\$26.4	\$34.9	8.1%
Transportation	\$19.3	\$35.0	\$47.7	\$62.8	\$82.1	7.5%
Vision	\$2.0	\$3.9	\$5.7	\$8.0	\$10.8	8.8%
<b>Total Spending</b>	\$389.4	\$728.2	\$1,028.5	\$1,405.5	\$1,870.6	8.2%

Note: Spending is for claims payments only.

**Table 21: Historical Enrollment by Demographic Group**

Year	Non-Native		Female	Male	Children	Working Age		Elderly	Total
	Native								
1997	59,555	30,309	51,981	37,883	52,940	31,196	5,728	89,864	
1998	57,939	30,555	50,828	37,666	51,959	30,676	5,859	88,494	
1999	62,872	32,818	54,301	41,389	58,207	31,391	6,092	95,690	
2000	72,728	37,351	61,789	48,290	71,522	32,082	6,475	110,079	
2001	76,626	39,507	64,535	51,598	77,403	31,995	6,735	116,133	
2002	80,468	41,008	67,130	54,346	81,590	32,903	6,983	121,476	
2003	83,945	42,606	69,755	56,796	85,097	34,080	7,374	126,551	
2004	84,824	44,592	71,230	58,186	86,936	34,904	7,576	129,416	
2005	87,452	44,514	72,710	59,256	87,454	36,601	7,911	131,966	
2006	86,705	45,588	73,187	59,736	87,206	37,419	8,298	132,923	
2007	81,047	47,027	70,579	57,495	83,929	35,829	8,316	128,074	
2008	78,647	46,311	68,638	56,320	81,575	35,072	8,311	124,958	
2009	80,554	47,251	70,111	57,694	82,864	36,513	8,428	127,805	

**Table 22: Historical Spending by Demographic Group (in millions)**

Year	Non-Native		Female	Male	Children	Working Age		Elderly	Total
	Native								
1997	\$238.9	\$65.0	\$172.0	\$131.9	\$115.8	\$133.6	\$54.4	\$303.9	
1998	\$248.7	\$81.8	\$188.4	\$142.1	\$123.8	\$148.6	\$58.1	\$330.5	
1999	\$280.5	\$104.5	\$221.9	\$163.0	\$147.8	\$171.6	\$65.6	\$384.9	
2000	\$326.9	\$129.9	260.5	\$196.2	\$186.6	\$196.1	\$75.5	\$456.7	
2001	\$383.4	\$165.6	\$310.6	\$238.6	\$234.7	\$227.5	\$86.9	\$549.1	
2002	\$455.7	\$214.4	\$384.1	\$286.1	\$288.7	\$277.5	\$103.9	\$670.2	
2003	\$533.5	\$265.0	\$458.5	\$340.2	\$345.3	\$326.8	\$126.5	\$798.6	
2004	\$589.6	\$304.1	\$506.3	\$387.4	\$383.6	\$365.4	\$144.7	\$893.7	
2005	\$654.8	\$294.5	\$539.6	\$409.6	\$386.6	\$403.5	\$159.1	\$949.2	
2006	\$647.1	\$320.0	\$550.3	\$416.8	\$398.8	\$401.9	\$166.4	\$967.1	
2007	\$618.3	\$315.0	\$526.9	\$406.5	\$393.8	\$384.8	\$154.8	\$933.4	
2008	\$626.8	\$317.9	\$536.4	\$408.3	\$383.4	\$404.0	\$157.3	\$944.7	
2009	\$682.0	\$349.4	\$584.2	\$447.3	\$414.0	\$444.2	\$173.2	\$1,031.5	

Note: Spending is for claims payments only.

<b>Table 23: Historical Spending by Service Category Group (in millions)</b>				
<b>Year</b>	<b>Behavioral Health</b>	<b>Long-Term Care</b>	<b>Primary Care</b>	<b>Total</b>
1997	\$48.3	\$76.3	\$179.2	\$303.9
1998	\$52.0	\$82.1	\$196.4	\$330.5
1999	\$57.6	\$93.6	\$233.8	\$384.9
2000	\$69.7	\$110.2	\$276.8	\$456.7
2001	\$80.3	\$135.4	\$333.4	\$549.1
2002	\$90.8	\$169.7	\$409.6	\$670.2
2003	\$107.7	\$209.7	\$481.3	\$798.6
2004	\$121.3	\$239.1	\$533.3	\$893.7
2005	\$124.6	\$257.3	\$567.3	\$949.2
2006	\$132.9	\$278.7	\$555.5	\$967.1
2007	\$136.6	\$283.0	\$513.7	\$933.4
2008	\$126.7	\$286.0	\$532.1	\$944.7
2009	\$132.8	\$323.8	\$573.8	\$1,031.5

Note: Spending is for claims payments only.





**Long-term Forecast of  
Medicaid Enrollment  
and  
Spending in Alaska:  
*Supplement 2010–2030***

**For more information on this report, contact:**

Alaska Department of Health and Social Services  
Finance and Management Services  
350 Main Street  
P.O. Box 110650  
Juneau Alaska 99811-0650  
Phone: (907) 465-3331  
Fax: (907) 465-1850

**This report is available on the Internet at:**

<http://dhss.alaska.gov/fms>

Material in this publication is public information and, with appropriate credit, may be reproduced without permission.