



Long-Term Forecast of Medicaid Enrollment and Spending in Alaska: FY2019–FY2039

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Table of Contents

EXECUTIVE SUMMARY	1
1 INTRODUCTION.....	6
1.1 AFFORDABLE CARE ACT LEADS TO SIGNIFICANT CHANGES TO ALASKA’S MEDICAID PROGRAM.....	7
1.1.1 Medicaid Expansion.....	7
1.1.2 Modified Adjusted Gross Income	7
1.1.3 No Wrong Door	8
1.1.4 Insurance Mandate.....	8
1.2 RECENT INITIATIVES THAT MAY AFFECT ALASKA’S MEDICAID PROGRAM IN THE NEXT FEW YEARS	9
1.2.1 Coordinated Care Demonstration Projects.....	9
1.2.2 Behavioral Health System Reform	9
1.2.3 Senior and Disabilities Services Reforms	10
1.2.4 Tribal Health	10
1.3 THE LONG-TERM MEDICAID FORECAST.....	11
1.4 RECENT HISTORICAL TRENDS IN MEDICAID SPENDING	12
1.4.1 Recent Historical Trends in State Medicaid Spending.....	13
1.4.2 The Role of Medicaid in Providing Health Insurance to Alaskans.....	14
1.4.3 Medicaid Enrollment and the Economy	17
2 OVERVIEW OF PROJECTIONS: FY2019-FY2039	19
2.1 LONG-TERM POPULATION PROJECTIONS	19
2.1.1 Regional Trends in Population.....	21
2.2 ENROLLMENT IN THE MEDICAID PROGRAM.....	24
2.3 UTILIZATION OF MEDICAID SERVICES	28
2.4 INTENSITY OF USE OF MEDICAID SERVICES	29
2.5 TOTAL SPENDING ON MEDICAID SERVICES.....	30
2.5.1 State Spending on Medicaid Services.....	36
2.5.2 Comparison to the First Long-Term Medicaid Forecast.....	39
2.5.3 Other Medicaid Payments and Offsets	42
3 APPENDIX TABLES.....	44

List of Tables

Table 1: Projected State and Federal Spending on Medicaid Services (in Millions \$).....	4
Table 2: Alaska’s Projected Population by Age Cohort for Selected Years 2019–2039	21
Table 3: Historical and Projected Future Population by Region of Alaska	23
Table 4: Average Annual Growth in Enrollment by Age Cohort Through FY2039	25
Table 5: Medicaid Enrollment by Age Cohort for Selected Fiscal Years 2014–2039.....	25
Table 6: Medicaid Enrollment for Selected Eligibility Groups FY2019–2039	27
Table 7: Service Category Designations Used in the Long-Term Medicaid Forecast	28
Table 8: Most Frequently Utilized Medicaid Service Categories for Selected Fiscal Years..	29
Table 9: Medicaid Spending by Age Cohort for Selected Fiscal Years (Millions \$).....	31
Table 10: Spending on Medicaid Services for Selected Fiscal Years (Millions \$).....	35
Table 11: Projected State and Federal Spending on Medicaid Services (in Millions \$).....	38
Table 12: Medicaid Spending for Selected years FY2019–FY2039.....	43
Table 13: Medicaid Service Category Descriptions for Long-Term Forecast	44
Table 14: Medicaid Eligibility Classification Descriptions	45
Table 15: Forecast of Population by Demographic Group	46
Table 16: Forecast of Enrollment by Demographic Group.....	47
Table 17: Forecast of Spending by Demographic Group (Millions \$)	48
Table 18: Forecast of Total Spending on Medicaid (Millions \$)	49
Table 19: Forecast of State Spending on Medicaid (in Millions \$)	50

List of Figures

Figure 1: Spending on Medicaid Services – Actual and Projected.....	1
Figure 2: Medicaid Enrollment – Actual and Projected.....	2
Figure 3: Medicaid Spending per Enrollee – Actual and Projected	2
Figure 4: Medicaid Enrollment as a Proportion of Alaska’s Population for Selected Fiscal Years 2014–2039	3
Figure 5: Spending on Medicaid Services by Component of Growth	4
Figure 6: Average State and Federal Spending Per Medicaid Enrollee by Fiscal Year*	5
Figure 7: Total Cost of Medicaid Services by Fiscal Year in Which Service Occurred.....	13
Figure 8: Recent Spending on and Enrollment in Alaska’s Medicaid Program	14
Figure 9: Recent Trends in Medicaid Enrollment and Employer-Provided Health Coverage	15
Figure 10: Total Healthcare Expenditures and Medicaid Spending in Alaska	16

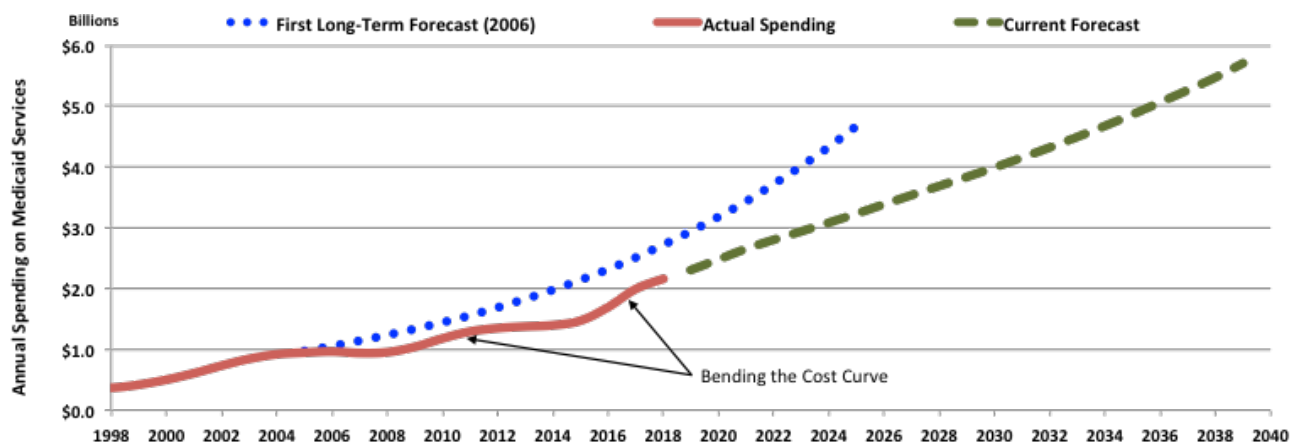
Figure 11: Per-Capita and Per-Medicaid Enrollee Spending on Healthcare in Alaska.....	17
Figure 12: Alaska Gross State Product and Healthcare Spending as a Percent of GSP	18
Figure 13: The Five Steps to Develop the Alaska Long-Term Medicaid Forecast	19
Figure 14: Alaska's Population and Annual Growth Rates from 1950–2040	20
Figure 15: Regional Boundaries Used in Alaska Long-Term Medicaid Forecast	22
Figure 16: Historical and Projected Population for Anchorage/Mat-Su and.....	22
Figure 17: Cumulative Population Growth by Region Since 1990.....	23
Figure 18: Medicaid Enrollment by Age Cohort, Annual Unduplicated Count.....	26
Figure 19: Medicaid Enrollment as a Proportion of Alaska’s Population for Selected Fiscal Years 2014–2039	27
Figure 20: Total Spending on Medicaid Claims by Age Cohort FY2019–2039.....	31
Figure 21: Projected Annual Growth in Spending on Medicaid Services by Age Cohort....	32
Figure 22: Total Spending on Medicaid Services by Age Cohort, FY1997–2039.....	32
Figure 23: Average Per Enrollee Spending on Medicaid Services by Age Cohort, For Selected Fiscal Years	33
Figure 24: Average Annual Growth in Spending by Medicaid Service Category	34
Figure 25: Spending on Medicaid Services by Component of Growth	36
Figure 26: Average State and Federal Spending Per Medicaid Enrollee by Fiscal Year*	39
Figure 27: Spending on Medicaid Services – Actual and Projected.....	40
Figure 28: Medicaid Enrollment – Actual and Projected.....	41
Figure 29: Comparing Projected Spending per Enrollee from Current Forecast to Per- Enrollee Projection from First Long-Term Medicaid Forecast Completed in 2006	42

Executive Summary

This is the twelfth update to the *Long-Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025*, which was released in February 2006. In this update, we develop long-term forecasts of enrollment in and spending on services provided by Alaska’s Medicaid program for FY2019 through FY2039. The projections presented in this report are based on Medicaid policies, services offered, and eligibility requirements in place today, as well as on the assumption that they will remain in place throughout the forecast period. While it is likely that Alaska’s Medicaid program will experience changes during the projection period, the purpose of the forecast is to inform decision makers about how Medicaid spending in Alaska will likely evolve given the structure of the program as it exists today.

Figure 1 shows actual spending on Medicaid services from FY1998 through FY2018 (solid red line), projected spending from the first long-term Medicaid forecast (blue dotted line), and the current projection of Medicaid spending (green dashed line). Actual spending on Medicaid services in FY2018 was about \$560 million less than was projected in the first long-term Medicaid forecast. Much of this difference is attributable to cost savings efforts by the Alaska Legislature and the Alaska Department of Health and Social Services (DHSS), which helped “bend the cost curve” on Medicaid spending.

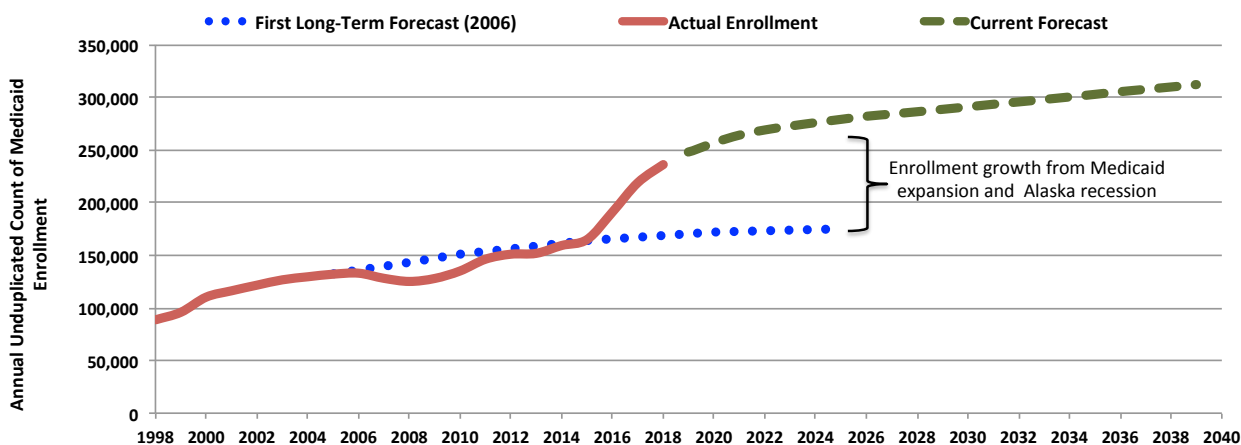
Figure 1: Spending on Medicaid Services – Actual and Projected



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Figure 2 shows actual Medicaid enrollment from FY1998 through FY2018 and projected enrollment from the first long-term Medicaid forecast and the current forecast. Between FY2006 and FY2015, actual Medicaid enrollment tracked closely to predicted enrollment. However, with the initiation of Medicaid expansion in September 2015, other components of the Patient Protection and Affordable Care Act, or the ACA (e.g., the individual mandate), and the Alaska economic recession that began in late 2014 or early 2015, enrollment in Medicaid increased considerably. For the current forecast, we expect enrollment to continue to grow, but at a decreasing rate through the projection period.

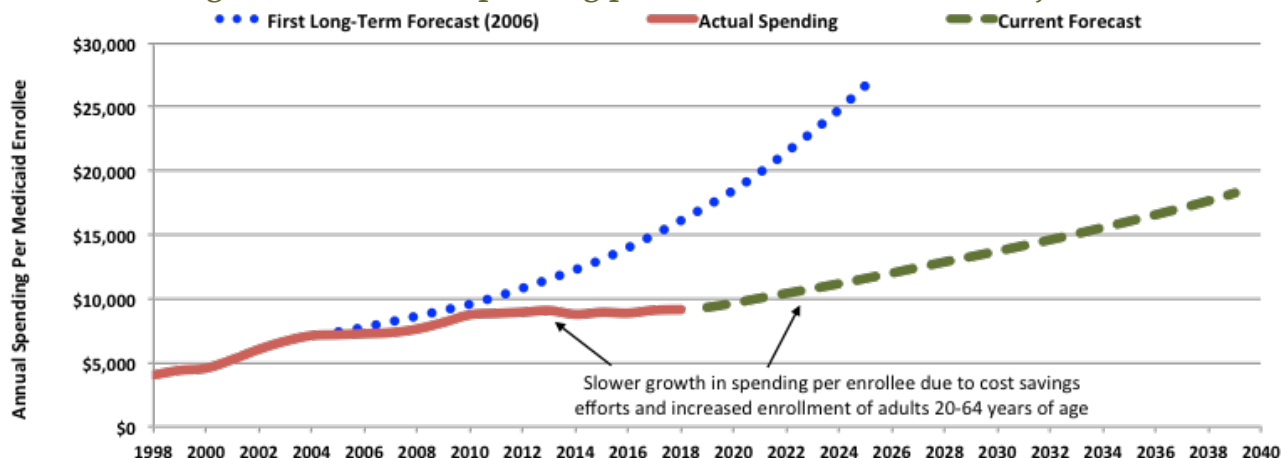
Figure 2: Medicaid Enrollment - Actual and Projected



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Spending on Alaska’s Medicaid program is considerably less today than was projected in the first long-term Medicaid forecast. At the same time, Medicaid enrollment is much greater today than was predicted. The net effect of lower than projected spending and greater than projected enrollment is much lower than projected average spending per Medicaid enrollee. Figure 3 shows actual average annual spending per enrollee, as well as projected spending per enrollee from the current and the first long-term Medicaid forecasts. Due to cost savings efforts by the Alaska Legislature and DHSS, and proportionally more adults 20-64 years of age than was expected when the first long-term forecast was released, spending per Medicaid enrollee is currently well below the earlier forecast and is projected to continue to grow at a much slower rate.

Figure 3: Medicaid Spending per Enrollee - Actual and Projected

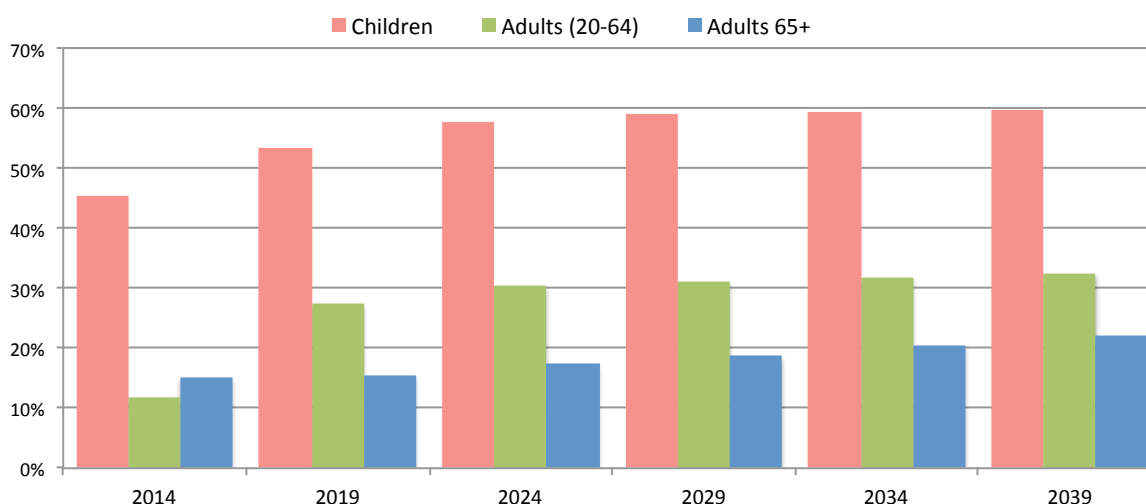


Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Across all age cohorts, the proportion of Alaskans enrolled in Medicaid has grown, and we expect it to continue to grow throughout the projection period due to expected increases in the take-up rate for those eligible for Medicaid and to projected growth in the Medicaid-

eligible population across all ages. Figure 4 shows the proportion of Alaska children, adults under 65 years of age, and seniors enrolled in Medicaid in FY2014 and projected to be enrolled in Medicaid in selected future years. Due primarily to Medicaid expansion, the proportion of adults under 65 years of age enrolled in Alaska’s Medicaid program grew from about 12 percent in FY2014 to nearly 28 percent in FY2019. We project that this proportion will continue to grow, albeit much more slowly over the next 20 years, reaching about 33 percent by 2039. We project that the proportion of seniors enrolled in Medicaid, currently about 15 percent, will grow to 22 percent by FY2039. Currently, just over half of all children are enrolled in Medicaid (or the Children’s Health Insurance Program [CHIP]), and we expect this proportion to grow to about 60 percent by 2039.

Figure 4: Medicaid Enrollment as a Proportion of Alaska’s Population for Selected Fiscal Years 2014–2039

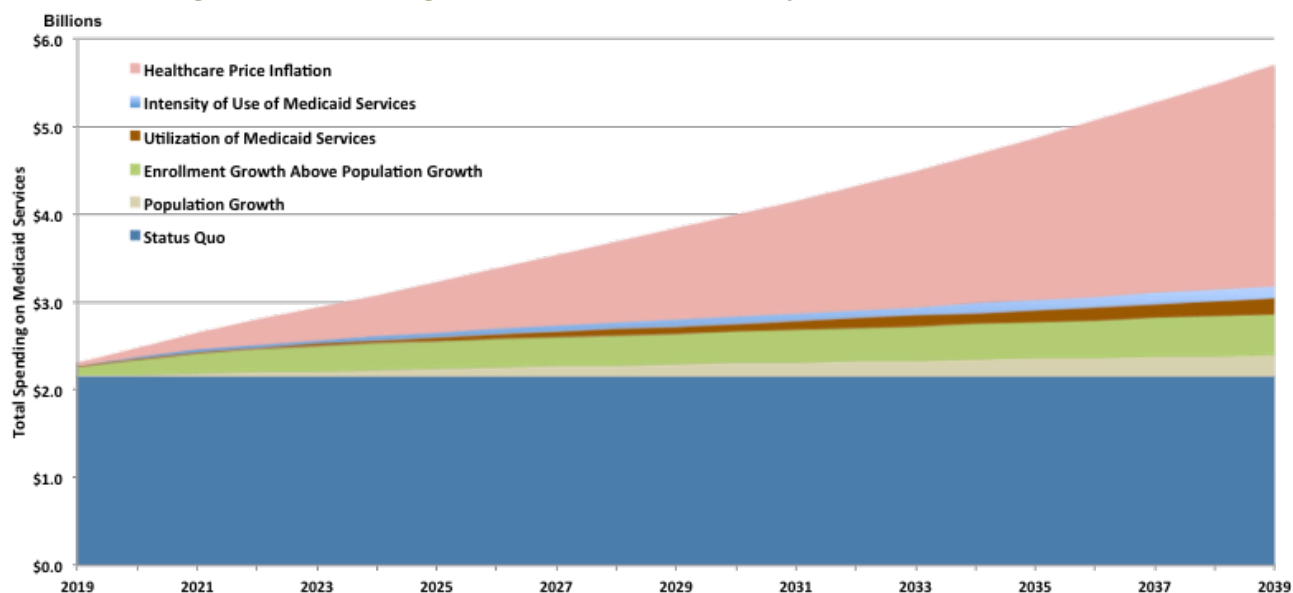


Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

We project that total Medicaid spending will increase on average by 4.6 percent per year between FY2019 and FY2039, reaching \$5.7 billion by 2039. This projected rate of growth in Medicaid spending is substantially lower than the projected growth rate from the first long-term forecast completed in 2006. In that forecast, spending on Medicaid services was projected to grow on an annual average basis by 7.8 percent, reaching \$4.7 billion by CY2025.

As Figure 5 shows, we expect healthcare price inflation to be the primary driver of spending growth in Alaska’s Medicaid program, accounting for about 70 percent of additional spending in FY2039. While healthcare price inflation may not directly impact what DHSS pays providers for services in any given year, DHSS has processes in place to work with providers to periodically update the schedule of rates paid for Medicaid services. Rates typically adjust (generally upward) every one to four years, roughly in line with the rate of healthcare price inflation affecting providers.

Figure 5: Spending on Medicaid Services by Component of Growth



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Relative to healthcare price inflation, each of the other components of spending growth will have a relatively small impact on the Medicaid program over the next 20 years. Nevertheless, by FY2039, we project that growth in the population, growth in the take-up rate for Medicaid, and growth in utilization and intensity of Medicaid services will combine to increase spending on the Medicaid program by more than \$1.0 billion.

The proportion of the cost of a Medicaid service that the state and federal governments are responsible for, respectively, is a function of the eligibility status of each Medicaid recipient and, in certain cases, the facility in which the recipient receives care. We project that spending by the State of Alaska on Medicaid services will grow on average by 4.4 percent per year through FY2039, and federal spending will grow slightly faster at 4.7 percent per year (see Table 1).

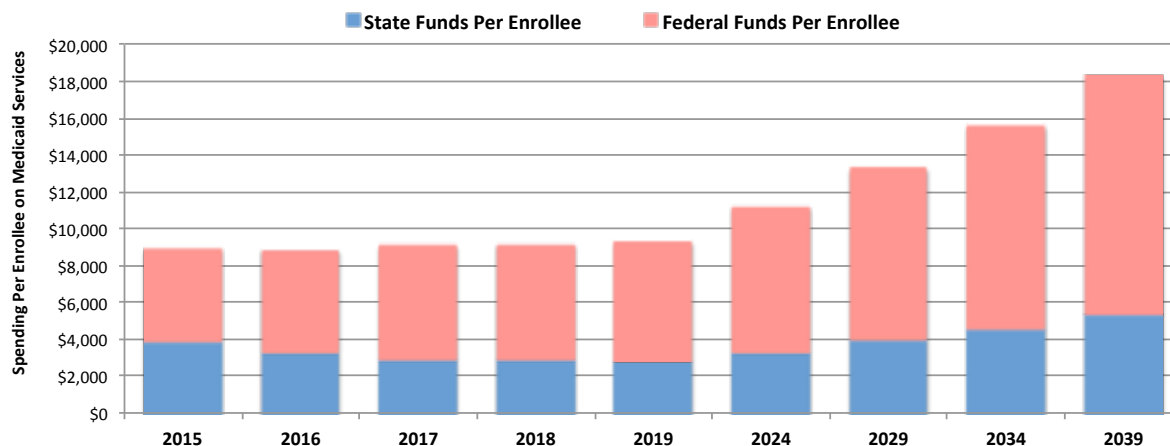
Table 1: Projected State and Federal Spending on Medicaid Services (in Millions \$)

Fund Source	2019	2024	2029	2034	2039	Annual Growth
State and Other Match Funds	\$684	\$896	\$1,106	\$1,341	\$1,625	4.4%
Federal	\$1,623	\$2,190	\$2,732	\$3,336	\$4,081	4.7%
Total Spending	\$2,307	\$3,086	\$3,838	\$4,677	\$5,706	4.6%

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Figure 6 shows recent actual and projected future average spending per Medicaid enrollee. Between FY2015 and FY2018, spending per Medicaid enrollee was flat and the proportion paid with state general funds actually decreased. Over the next 20 years, we project average spending per enrollee will increase by about 3.4 percent per year due to growth in healthcare price inflation and the expected aging of Alaska’s population.

Figure 6: Average State and Federal Spending Per Medicaid Enrollee by Fiscal Year*



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

* FY2015 - FY2017 are actuals, FY2018 is estimated based on payments to date for services received in FY2018, and FY2019 - FY2039 are projected.

I Introduction

Medicaid is an entitlement program established by Title XIX of the Social Security Act in 1965 to provide payment for healthcare services for low-income citizens. Medicaid is jointly funded by the federal government and individual states, with each state managing its own program. Participation in the Medicaid program is optional, but all states choosing to participate in the program must follow certain federal guidelines pertaining to eligibility and services provided. The federal government covers at least 50 percent of the cost of most services.¹ In state fiscal year (FY) 2014 and FY2015, the federal government paid approximately 58 percent of the cost of Alaska's Medicaid program.² Federal participation increased to 63 percent in FY2016 and to 68 percent in FY2017 and FY2018. We project federal participation will be approximately 67 percent throughout the 20-year projection period (through 2039).

People qualify for Medicaid by meeting income standards and specified eligibility requirements related to age, family status, and disability status. Traditionally, Medicaid covered only aged,³ blind, or disabled persons, children, and adults with dependent children. Medicaid expanded coverage in 1998 through the Children's Health Insurance Program (CHIP) to children whose family income is too high to qualify for regular Medicaid, but too low to afford private health insurance. In Alaska, the Division of Health Care Services administers CHIP and the Division of Public Assistance manages enrollment for regular Medicaid and CHIP.⁴ Alaska Medicaid reimburses hospitals, physicians, and other healthcare providers for providing healthcare services to Medicaid enrollees. It operates as a fee-for-service program, meaning that it reimburses (pays) providers per unit of service rendered according to established rates of payment. This is in contrast to managed care, where a healthcare organization receives a monthly payment for each Medicaid recipient enrolled in the plan. In a managed care arrangement, the healthcare organization is responsible for ensuring that the enrollees have access to a comprehensive range of medical services.

¹ The few services for which the federal government does not cover at least 50 percent of the cost are referred to as "state-only" services.

² The overall rate of federal financial participation (58%) is an average of multiple Federal Medical Assistance Percentage (FMAP) rates weighted by the amount of spending associated with each rate. See Section 2.5.1 for a discussion of the rate of federal financial participation associated with each FMAP.

Unless otherwise stated, all references to fiscal year are state fiscal year, which begins July 1 and ends June 30. In comparison, federal fiscal years begin October 1 and end September 30.

³ Under Medicaid descriptions of eligibility, "aged" refers to persons 65 years of age or older. Throughout this report, we refer to this population as "seniors" except when referring to Medicaid eligibility.

⁴ Both divisions are within the Department of Health and Social Services (DHSS).

1.1 Affordable Care Act Leads to Significant Changes to Alaska's Medicaid Program

President Obama signed the Patient Protection and Affordable Care Act (ACA) into law in March 2010, which significantly affected many aspects of the U.S. healthcare system, including the Medicaid program.

1.1.1 Medicaid Expansion

In January 2014, the ACA extended Medicaid eligibility to adults under 65 years of age without dependent children who are not disabled and meet certain income requirements (commonly referred to as “Medicaid expansion”). The federal government would bear 100 percent of the cost of Medicaid services for this newly eligible population through calendar year (CY) 2016, after which time the rate of federal participation would decrease each year until 2020, where it will remain at 90 percent. Alaska did not expand its Medicaid program at that time. However, Governor Bill Walker expanded Medicaid in September 2015. In CY2016, the federal government paid 100 percent of the cost of Medicaid services provided to those enrolled through expansion. In CY2017, federal participation dropped to 95 percent and to 94 percent in CY2018. It will drop to 93 percent in CY2019, and finally to 90 percent in CY2020, where it is scheduled to remain.⁵

Medicaid expansion may also have impacted the Alaska Medicaid program indirectly by allowing individuals with disabilities to enroll in Medicaid through Medicaid expansion eligibility (i.e., by being below the income threshold) rather than waiting for a disability determination. Prior to Medicaid expansion, adults under 65 years of age without dependent children could only qualify for Medicaid based on being determined as having a qualified disability and meeting income requirements specific to the individual's living arrangement.⁶

1.1.2 Modified Adjusted Gross Income

The ACA also included changes in the way that financial eligibility is determined for children, parents and other caretakers, and pregnant women. For these groups, as well as for those who enroll in Medicaid through expansion, financial eligibility for Medicaid is now determined based on the Modified Adjusted Gross Income (MAGI) standard, which is consistent across states and is tied to how people report income on their taxes. The

⁵ Many adults enrolled through Medicaid expansion are American Indians and Alaska Natives (AI/ANs). When these enrollees receive services from a qualifying Medicaid provider, the federal government reimburses the State of Alaska 100 percent of the cost of the services. Thus, even as the federal financial participation rate for Medicaid expansion decreases each year until CY2020, the State of Alaska still receives 100 percent reimbursement from the federal government for many of the services provided to recipients enrolled through expansion.

⁶ For information on income eligibility for Medicaid, see <http://dhss.alaska.gov/dpa/Pages/medicaid/>

MAGI standard simplifies the process for determining Medicaid eligibility by moving the process online for most applications, eliminating documentation requirements with applicant attestation, and eliminating the asset test for most non-senior applicants.⁷ The likely result for Alaska's Medicaid program is that the MAGI standard has led to higher rates of Medicaid enrollment.

1.1.3 No Wrong Door

The “no wrong door” provision of the ACA allows an individual to complete a single streamlined application in order to determine eligibility for a host of entitlement programs, including Medicaid, CHIP, and qualified health plans (QHP) available on the federal or individual state health exchanges, as well as other assistance programs. Rather than apply individually for these programs, the single application is screened for eligibility into multiple programs, ensuring that it does not go through a “wrong door.” Thus, some low-income individuals who apply for individual insurance through the federal health exchange may learn they are eligible for Medicaid and/or other assistance programs. The likely result for Alaska's Medicaid program is that the no wrong door provision has led to higher rates of Medicaid enrollment.

1.1.4 Insurance Mandate

The ACA restricts the ability of insurance companies to set insurance rates based on an individual's preexisting medical condition or on the expected healthcare needs of the individual. Recognizing that this restriction will be a financial burden to insurance providers, the ACA included the individual mandate requiring most Americans to have a basic level of health insurance coverage. The rationale for the individual mandate was that by requiring all individuals to maintain a basic level of health insurance, the financial risks associated with providing health insurance would be spread across a wider population even though healthcare utilization and costs are heavily weighted toward seniors and those with chronic medical conditions. Without the individual mandate, many younger, healthier adults would forego health insurance coverage because of the cost, leaving those with greater medical needs in the insurance pool. Congress repealed the individual mandate in December 2017, though it is still in effect for CY2018.⁸ The likely result for Alaska's Medicaid program is that the insurance mandate has led to higher rates of Medicaid enrollment. We anticipate that the repeal of the insurance mandate will have a moderating effect on enrollment growth beginning in the second half of FY2019, which we incorporated into the enrollment forecast.

⁷ Each state is responsible for conducting third-party verification for a certain proportion of applicants. Prior to 2014, Medicaid eligibility determination also considered the value of the applicant's assets. The MAGI standard also includes a 5 percent disregard of income.

⁸ For information on the ACA individual mandate to purchase health insurance, please see <http://kff.org/infographic/the-requirement-to-buy-coverage-under-the-affordable-care-act/>

1.2 Recent Initiatives That May Affect Alaska's Medicaid Program in the Next Few Years

The Alaska Legislature initiated a major overhaul of Alaska's Medicaid program in 2016 through the passage of Senate Bill (SB) 74. Outlined in this section are four major initiatives of SB 74 that will provide improvements in the quality and cost effectiveness of the program. While some of these initiatives may appear to grow the Medicaid program by adding new services, these changes allow the state to secure a federal match, save state general fund dollars in other program areas, and improve access to the appropriate type and level of care for recipients. More information and updates on these initiatives are available on the Alaska Department of Health and Social Services (DHSS) Medicaid Redesign website.⁹

1.2.1 Coordinated Care Demonstration Projects

Alaska's Medicaid program currently operates primarily on a fee-for-service provider reimbursement basis. The Coordinated Care Demonstration Project Initiative is intended to test new healthcare delivery and payment models to determine the most cost effective and highest quality approach for Alaska. The Medicaid program recently awarded a contract to a provider to test the Patient-Centered Medical Home model in Anchorage, and is in negotiations with a company to demonstrate a Managed Care Organization model in Anchorage and the Mat-Su Valley. If successful, these demonstration projects could bend the Medicaid cost curve down while improving outcomes for recipients.

1.2.2 Behavioral Health System Reform

There are significant gaps in the continuum of care in Alaska's behavioral health system, both on the prevention and lower acuity treatment side of care, and in terms of a shortage of in-patient treatment beds. The resulting lack of access to these services ripples through the Medicaid program, as recipients who might improve with lower level services end up in crisis, and those with high acuity needs end up in hospital emergency departments rather than receiving appropriate treatment. SB 74 directed DHSS to apply for an 1115 waiver¹⁰ to improve access to services, improve population health outcomes, contain costs, and increase the types of behavioral health providers that may enroll in Medicaid. DHSS submitted the 1115 waiver application in January 2018 and is currently in negotiations with the Centers for Medicare and Medicaid Services (CMS), an agency within the U.S.

⁹ http://dhss.alaska.gov/HealthyAlaska/Pages/Redesign/Redesign_news.aspx

¹⁰ Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to waive certain requirements of Medicaid and to allow states to use federal Medicaid funds in ways that are not otherwise allowed under federal rules. The authority is provided at the Secretary's discretion for demonstration projects that the Secretary determines promote Medicaid program objectives. <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8196.pdf>

Department of Health and Human Services. Another prong of the behavioral health system reform initiative is to improve accountability and the use of evidence-based practices through a contract with an Administrative Services Organization, planned for implementation during CY2019. Finally, the department recently went through a rate-rebasing process for community behavioral health clinics to update Medicaid rates to better support these providers through the reform process.

I.2.3 Senior and Disabilities Services Reforms

SB 74 authorized the Alaska Medicaid program to implement two new State Plan options for long term services and support: 1915(k) Community First Choice and the 1915(i) Home and Community-Based Services benefit. After a thorough analysis and with community stakeholder involvement, the department moved forward with the 1915(k) option, but decided not to implement 1915(i) due to budgetary concerns. In lieu of the 1915(i) option, the department has implemented a new 1915(c) waiver. Both initiatives have been approved by the federal government and are in the process of being implemented during FY2019. The Community First Choice option provides enhanced personal care services, including skills training to foster independence and self-care, for recipients who meet institutional level of care criteria. The new 1915(c) waiver – the Individualized Supports Waiver – provides services under a per-individual annual dollar cap to recipients with intellectual and developmental disabilities who meet institutional level of care criteria.

I.2.4 Tribal Health

Medicaid services provided to American Indians and Alaska Natives (AI/ ANs) through a federal or tribal health facility are reimbursed to the state at 100 percent Federal Financial Participation (FFP). In February 2016, CMS issued State Health Official Letter #16-002, which updated its policy regarding federal funding for services “received through” a federal/tribal facility and provided to Medicaid-eligible AI/ ANs. This change in federal policy authorizes 100 percent federal funding for services provided to AI/ AN Medicaid recipients in a non-federal/tribal facility if the recipient’s tribal health organization has a care coordination agreement established with the non-tribal facility and there is documentation of a referral and an exchange of records for the care received. SB 74 directed DHSS to fully implement this policy. To-date, the department has been able to save over \$80 million in state general funds through implementation of this new policy.

1.3 The Long-Term Medicaid Forecast

In this study, we develop long-term forecasts of spending for 20 categories of services provided through Alaska's Medicaid program. We also develop forecasts of spending by gender, American Indian or Alaska Native (AI/AN) status,¹¹ and for twelve age groups. This document presents the results of the FY2019-FY2039 projection of enrollment in and spending on the Medicaid program in Alaska. It is the twelfth update to the original long-term Medicaid forecast, which the Alaska Department of Health and Social Services (DHSS) engaged the Lewin Group to conduct in April 2005.

The purpose of this forecast is to inform the Alaska Legislature and DHSS of the projected long-term trends in Medicaid enrollment and spending under the assumption that the current mix of Medicaid services remains constant and that eligibility criteria do not change.¹² The forecast does not assume or consider possible future changes in Medicaid policies, services offered, or eligibility requirements; rather, we develop the forecast as if the policies, services offered, and eligibility requirements in place today will remain in place throughout the forecast period. While it is likely Alaska's Medicaid program will experience changes during the projection period, the assumption of no change is necessary to show how Medicaid spending in Alaska will likely evolve given the structure of the program as it exists today.

Changes to the Long-Term Medicaid Forecasting Process

Beginning with this update to the long-term Medicaid forecast, four materially important changes were made to the forecasting process.

1. The most fundamental change is that the forecast is now conducted on a state fiscal year basis. The original long-term forecast, completed in 2006, and all forecast updates before this one were conducted on a calendar year basis.¹³
2. The long-term forecast is now completed and released at the end of the fiscal year. All prior forecasts were released at the beginning of the calendar year.

¹¹ Alaska Native, American Indian, and other race categories are based on self-identification of Medicaid enrollees. In FY2017, 81,490 Medicaid enrollees reported their race as either Alaska Native or American Indian. Of these, 3,184 (3.9%) identified as American Indian.

¹² The long-term Medicaid forecast includes the impacts of Medicaid expansion, which in Alaska began in September 2015.

¹³ The annual Medicaid spending data used for this and all previous long-term Medicaid forecasts are based on date of service, while the Medicaid budget and fiscal year accounting is based on date of payment. This current forecast differs from previous long-term Medicaid forecasts only in that the projection of future spending on Medicaid services is now by fiscal year instead of calendar year. These projections are still based on the date the Medicaid service was provided.

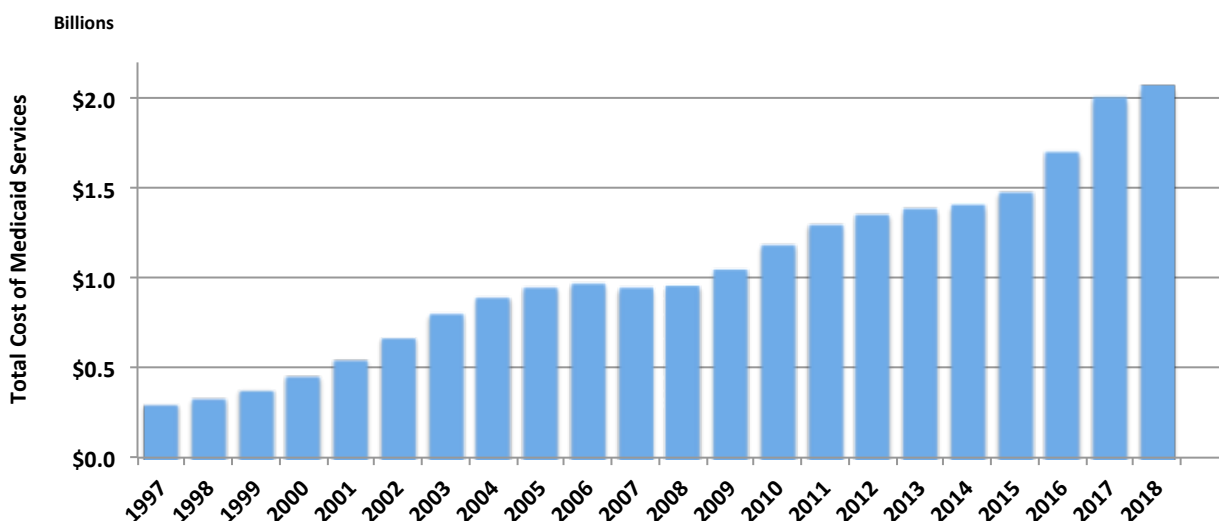
3. Based on population data available from the Alaska Department of Labor and Workforce Development, our population and enrollment forecasts for AI/ ANs now consist of persons identified as Alaska Native or American Indian alone or in combination with one or more other races. In prior forecasts, our population and enrollment forecasts for AI/ ANs consisted of individuals who identified as AI/ AN alone and only a portion of individuals who identified as AI/ AN *and* one or more other races. The impact of this change is to increase the forecasted AI/ AN population and enrollment.
4. The long-term forecast now segments senior enrollees into three age segments: 65-74, 75-84, and 85+. Prior forecasts only had two age cohorts for senior enrollees: 65-74 and 75+. This further segmentation accounts for the rapid growth in Medicaid enrollees 85 years of age and older who *on average* have greater care needs than those between 75 and 84 years of age.

I.4 Recent Historical Trends in Medicaid Spending

Spending on Alaska's Medicaid program grew rapidly from FY1997 through FY2005, increasing an average of 16 percent per year (see Figure 7).¹⁴ The rate of growth in spending slowed greatly beginning in FY2006 due at least in part to program changes put in place by DHSS following the release of the *Long-Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025* in January 2006. However, due at least in part to the severe national economic recession beginning in 2008, enrollment in and spending on Medicaid again increased rapidly in Alaska. Between FY2008 and FY2011, spending on Medicaid increased on average by 10.7 percent per year before slowing again in FY2012.

¹⁴ FY1997 is the earliest year for which we had data on spending.

Figure 7: Total Cost of Medicaid Services by Fiscal Year in Which Service Occurred



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Note: Due to issues with the new Medicaid Management Information System (MMIS) during FY2014, it is likely that the cost of some services provided in FY2014 was recorded as having been provided in FY2015.

Between FY1997 and FY2014, spending on Medicaid increased on an average annual basis by 9.4 percent. Part of this growth—3.5 percentage points—is due to growth in Medicaid enrollment, which grew from 90,130 (annual unduplicated count) in FY1997 to 162,059 in FY2014. In addition, approximately 4.1 percentage points of the 9.4 percent average annual spending increase is due to healthcare price inflation.¹⁵ While the cost of medical services provided to Medicaid enrollees may differ from prices paid by private insurance, the long-run trend in price inflation is essentially the same.

The remainder—1.8 percentage points—is due to growth in utilization and intensity of use of Medicaid services.¹⁶ For our purposes, we define utilization as the number of Medicaid service categories an enrollee uses during a fiscal year (regardless of “how much” of the service the enrollee uses), and we define intensity of use as the amount of a service category the enrollee uses during the year.

1.4.1 Recent Historical Trends in State Medicaid Spending

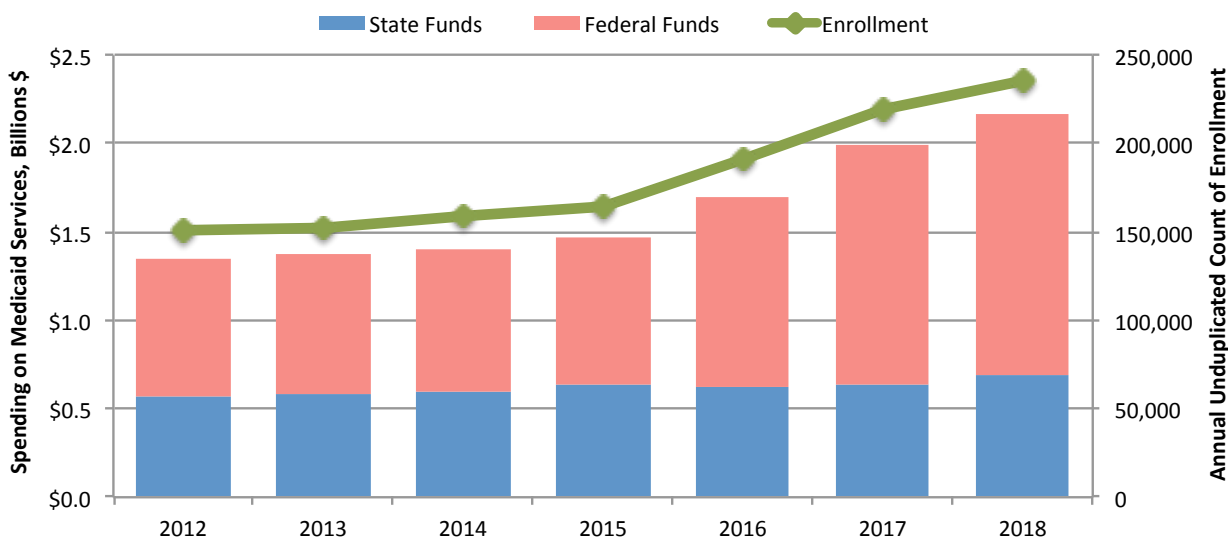
While total spending on Medicaid services has increased significantly in the past few years, general fund spending by the State of Alaska has grown slowly. Figure 8 shows

¹⁵ Healthcare price inflation (also commonly referred to as medical care cost inflation) is a measure of growth in prices charged for healthcare services.

¹⁶ The remainder is computed as $9.4 - 3.5 - 4.1 = 1.8$ percentage points.

total spending on Medicaid services for FY2012 through FY2018, broken out by state and federal funding, and the trend in enrollment over this same period.¹⁷

Figure 8: Recent Spending on and Enrollment in Alaska’s Medicaid Program



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

As was discussed in Section 1.2.4 Tribal Health, the State of Alaska has been able to shift a greater portion of spending on services for AI/AN beneficiaries to the federal government. In addition, Medicaid expansion has resulted in increased Medicaid enrollment, with 94 percent or more of all costs for Medicaid services provided to recipients enrolled through expansion being paid by the federal government.¹⁸

1.4.2 The Role of Medicaid in Providing Health Insurance to Alaskans

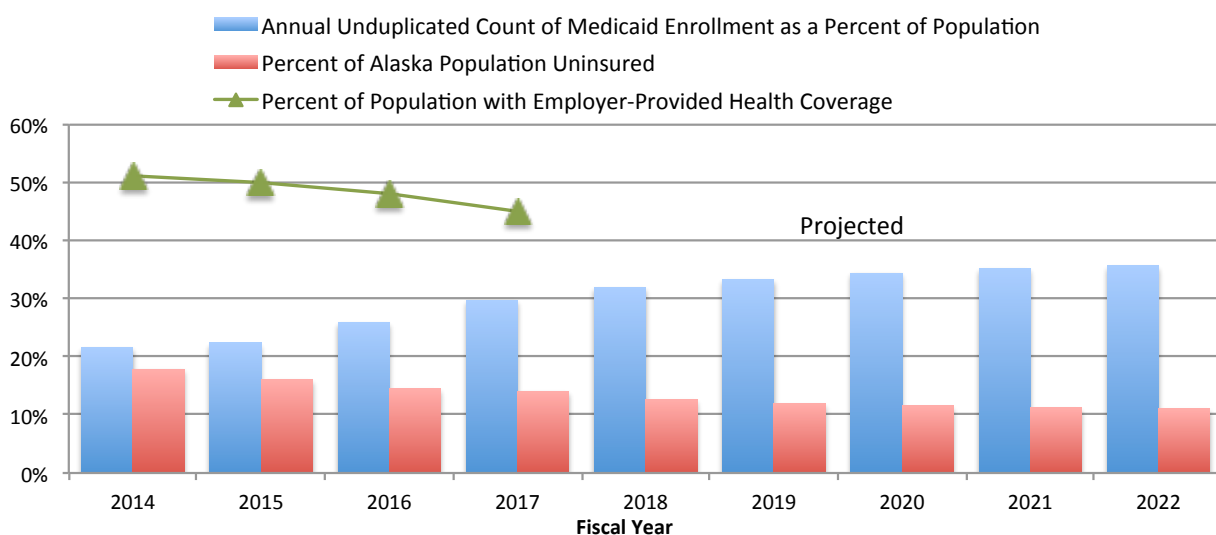
Medicaid is an increasingly important provider of healthcare insurance in Alaska. In FY1998, 14 percent of Alaskans were enrolled in Medicaid all or part of the year, and by FY2018, the proportion of Alaskans enrolled in Medicaid had grown to 31 percent. Due to Medicaid expansion and other components of the ACA, growth in the proportion of Alaskans enrolled in Medicaid was especially strong between FY2015 and FY2018. Over this same period, the proportion of Alaskans receiving employer-provided health insurance coverage decreased, as did the proportion of Alaskans without health insurance (see Figure 9).

¹⁷ State spending includes Unrestricted General Fund, Designated General Fund, and Other; Enrollment is annual unduplicated count.

¹⁸ The rate of federal financial participation will decrease in January 2019 to 93 percent and in January 2020 to 90 percent.

A key objective of the ACA was that all Americans have a defined minimal level of health insurance coverage. Data from the Kaiser Family Foundation indicate that the proportion of uninsured Alaskans decreased from 18.5 percent in CY2013 to 14 percent in CY2016.¹⁹ Evergreen Economics projects that the proportion of Alaskans without health insurance coverage will continue to decline to about 10 percent in FY2022. The proportion of Alaskans receiving health insurance through an employer decreased from 52 percent in CY2013 to 46 percent in CY2016.²⁰ Potential reasons for the decline in employer-provided health insurance coverage include the on-going economic recession in Alaska and shifting by employees to the federal health insurance exchange or to the Medicaid program.²¹

Figure 9: Recent Trends in Medicaid Enrollment and Employer-Provided Health Coverage



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group and the Kaiser Family Foundation (<https://www.kff.org/state-category/health-coverage-uninsured/>)

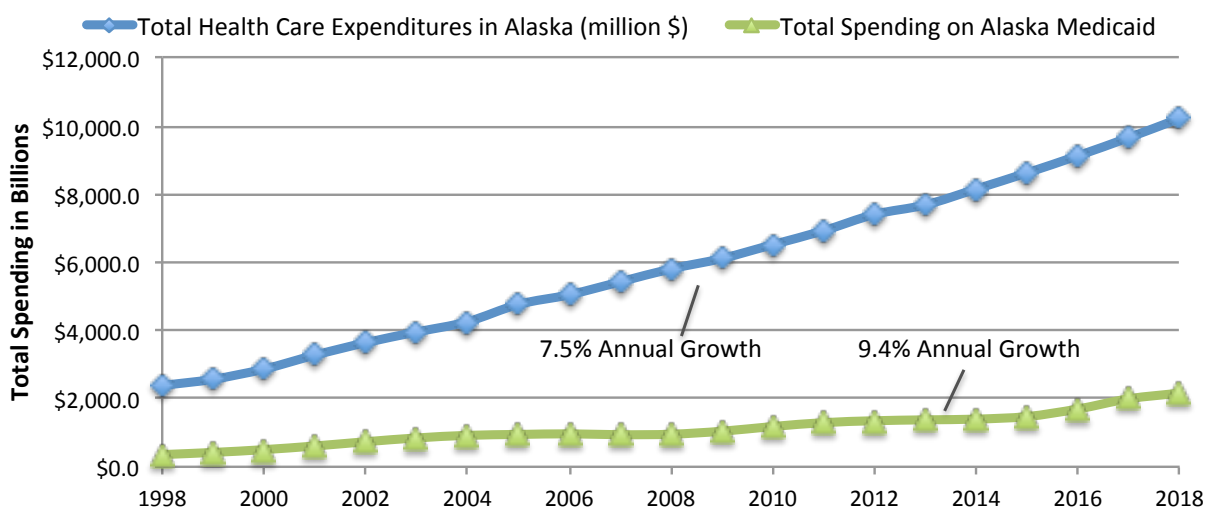
¹⁹ Henry J. Kaiser Family Foundation. "State Health Facts: Health Coverage & Uninsured." <https://www.kff.org/state-category/health-coverage-uninsured/>

²⁰ Ibid.

²¹ A 2016 analysis by the Employee Benefit Research Institute (EBRI) found that the proportion of smaller employers (those with fewer than 100 employees) offering health insurance declined between 2008 and 2015, while there was no change in the percentage of larger employers that offered health insurance. Among the reasons for the drop in the proportion of smaller firms offering health insurance speculated by the author is: "Workers with smaller firms could get health coverage in ACA-mandated public exchanges where they could not be denied coverage for pre-existing conditions, premiums would not vary with health status, subsidies would be available for those with income below 400 percent of the federal poverty level, and in many cases there would be more plan choices than smaller employers are typically able to provide." Paul Fronstin, "Fewer Small Employers Offering Health Coverage; Large Employers Holding Steady," *EBRI Notes* 37, no. 8 (2016): 4. https://www.ebri.org/pdf/notespdf/ebri_notes_07-no8-july16.small-ers.pdf

Figure 10 shows total healthcare expenditures and total spending on Medicaid services in Alaska.²² In 1998, total healthcare expenditures were just over \$2 billion and accounted for 10 percent of Alaska’s gross state product (GSP). By 2018, total healthcare expenditures had surpassed \$10 billion and accounted for 18 percent of GSP, which is nearly identical to the national rate. Between 1998 and 2018, total healthcare expenditures increased by 7.5 percent per year, while spending on Medicaid services increased by 9.4 percent per year. In FY1998, Medicaid accounted for 15 percent of healthcare spending in Alaska, but with Medicaid’s higher relative rate of growth, it now accounts for 21 percent of healthcare spending. The greater rate of growth in spending for Medicaid is not surprising. Over this period, Medicaid enrollment grew much faster than Alaska’s population, resulting in nearly one-in-three Alaskans being enrolled in Medicaid in FY2018 compared to about one-in-seven Alaskans in FY1998.

Figure 10: Total Healthcare Expenditures and Medicaid Spending in Alaska



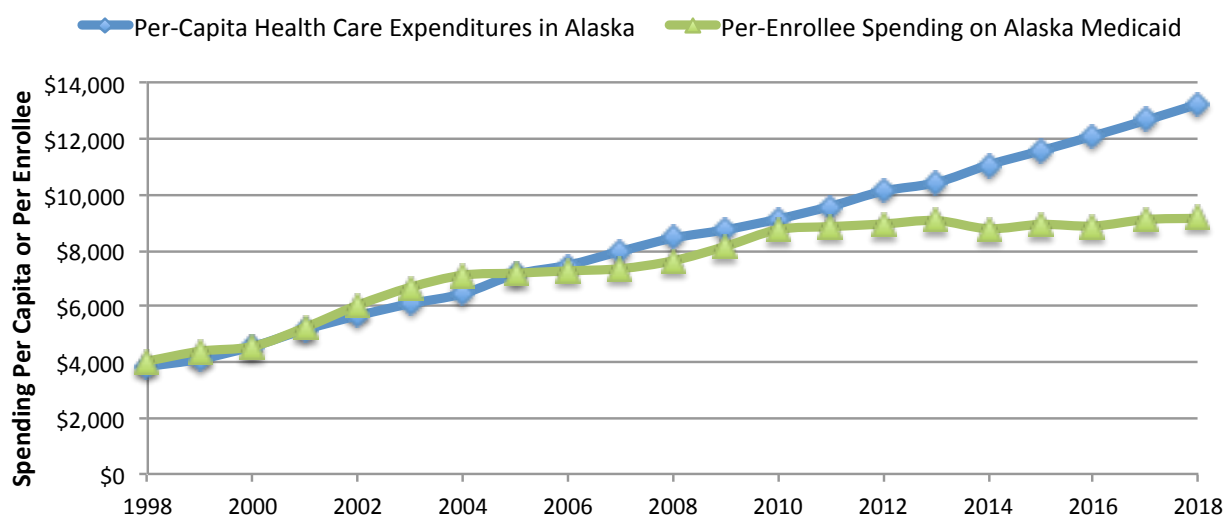
Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group and the Kaiser Family Foundation (<https://www.kff.org/state-category/health-coverage-uninsured/>)

Figure 11 shows per-capita spending on healthcare services in Alaska and per-enrollee spending on Medicaid services from 1998 through 2018.²³ After 2010, the two spending trajectories diverge as per-capita spending continued to grow and per-enrollee spending on Medicaid services has remained flat.

²² The Kaiser Family Foundation reports total healthcare expenditures on a calendar year basis, while DHSS records spending on Medicaid services on a fiscal year basis. The difference in the year basis does not impact the ability to compare the two spending trends over the 20-year period. Total healthcare expenditures include spending on Medicaid services adjusted (by the Kaiser Family Foundation) from fiscal to calendar year.

²³ Ibid.

Figure 11: Per-Capita and Per-Medicaid Enrollee Spending on Healthcare in Alaska



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group and the Kaiser Family Foundation (<https://www.kff.org/state-category/health-coverage-uninsured/>)

1.4.3 Medicaid Enrollment and the Economy

As an entitlement program that provides payment for healthcare services for low-income citizens, it stands to reason that enrollment in the Medicaid program and spending on Medicaid services is affected by local, regional, and national economic conditions. During periods of strong economic growth, labor force participation grows, average hours worked increases, and wages rise. Likewise, when the economy experiences a downturn, employment decreases, those still employed may work fewer hours, and wages for many employees may stagnate. At such times, individuals and families are more likely to qualify for Medicaid. Alaska may finally be exiting the recession that began in 2015.²⁴ Nevertheless, Alaska's annualized GSP for the first quarter of 2018 was 12.3 percent smaller in real terms than it was in 2012 when Alaska's economy was at its peak.²⁵ In 2012, average monthly employment in Alaska was 335,400, while through the first six months of 2018, employment averaged 328,400, a decrease of 2.1 percent from 2012 levels.

The changes to the healthcare system mandated by the ACA began to take effect in January 2014, prior to Alaska entering its current recession. Alaska initiated Medicaid expansion in September 2015, relatively early in the recession. Enrollment in Alaska's Medicaid program grew substantially in CY2014 through CY2017. Much of the growth over this period is due to the ACA, especially the Medicaid expansion component.

²⁴ Though academic, there is debate as to whether Alaska's current recession began in 2014 or 2015.

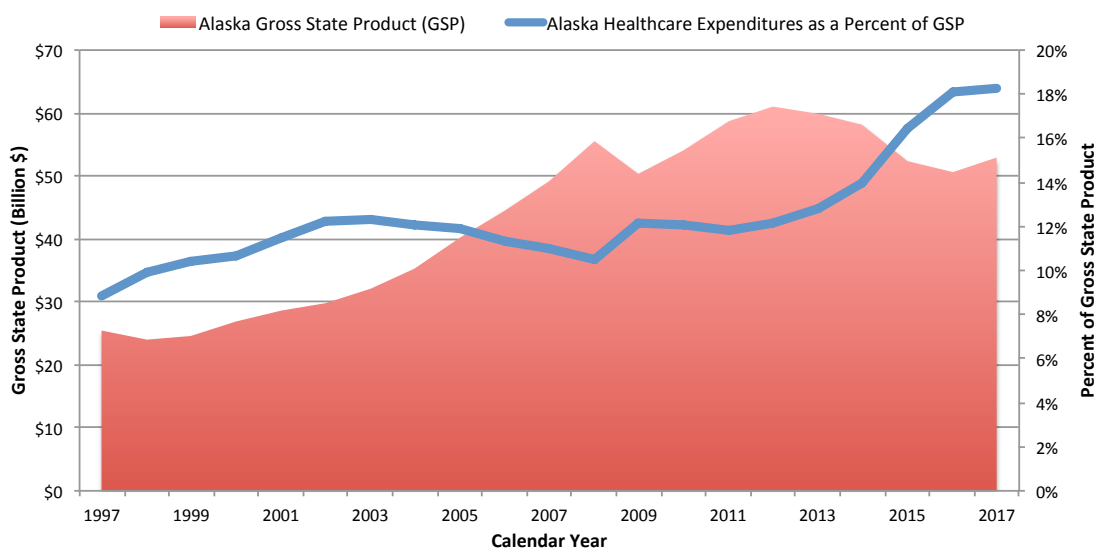
²⁵ Alaska's annualized GSP (in 2009 dollars) was \$54.6 billion in the second quarter of 2012 versus \$47.9 billion in the first quarter of 2018.

Nevertheless, it is likely that Alaska’s economic downturn intensified growth in the Medicaid program for all eligibility categories.

Figure 12 shows the Alaska GSP from CY1997 through CY2017 and healthcare spending in Alaska as a proportion of GSP. In the past five years, this proportion has grown rapidly, reaching 18.3 percent in 2017.²⁶ This rapid growth is due to shrinkage in Alaska’s overall economy – especially the value of oil and gas production – coinciding with strong investment in the healthcare sector and growth in private and public spending on healthcare services.

This growth in Alaska’s healthcare sector has softened the impact of Alaska’s recession, and Medicaid expansion has been especially beneficial to the state, as nearly all of the growth in spending on Medicaid services has been paid for with federal funds. In FY2014, the federal government contributed \$840 million or 57.6 percent of the cost of Medicaid services paid to providers. Federal participation has increased each year since, and in FY2018, the federal government contributed \$1.44 billion of the \$2.07 billion paid to providers (69.4 percent of total spending). Over this same period, general fund spending on Medicaid services by the State of Alaska was basically flat, and the state cut or avoided costs for healthcare services in other areas (e.g., behavioral health grants, corrections) because of the state-implemented Medicaid expansion.

Figure 12: Alaska Gross State Product and Healthcare Spending as a Percent of GSP



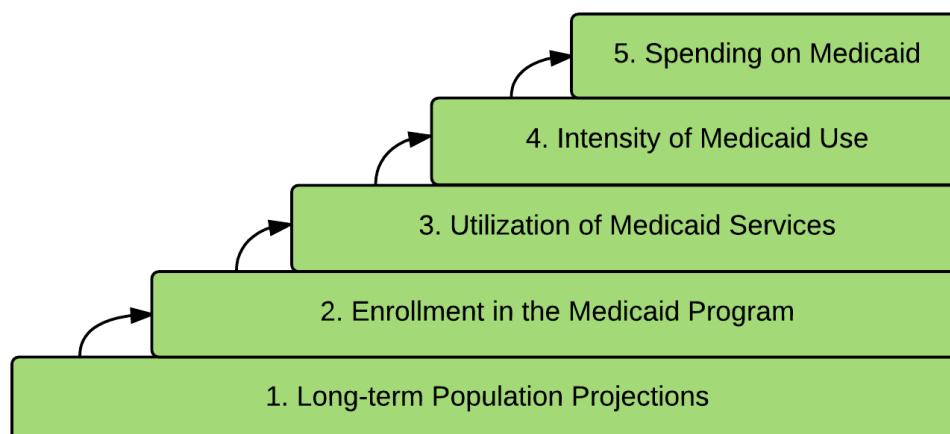
Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group and the U.S. Bureau of Economic Analysis.

²⁶ This is the approximately the same as healthcare’s share of the national economy (17.9% in CY2016). <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>

2 Overview of Projections: FY2019-FY2039

The long-term Medicaid forecast follows a highly structured modeling approach in which we develop annual estimates of spending on Medicaid services in five steps, with each successive step building on the results of the previous step.²⁷ As Figure 13 shows, the foundation of the Medicaid spending forecast is the long-term projection of Alaska’s population, which, for this update, is based on the Alaska Department of Labor and Workforce Development’s (DOLWD) most recent population forecast.²⁸ In subsequent steps, we project enrollment in the Medicaid program, utilization of Medicaid services, intensity of use of Medicaid services, and finally, total spending on Medicaid. We summarize the results of each step of the long-term Medicaid forecasting in the same systematic fashion.

Figure 13: The Five Steps to Develop the Alaska Long-Term Medicaid Forecast



2.1 Long-Term Population Projections

The population of Alaska has changed substantially in the years since statehood. In 1960, one year after Alaska became a state, the population was 230,400,²⁹ and about one in five Alaskans (44,237) lived in Anchorage.³⁰ By the time Alaska started its Medicaid program

²⁷ A detailed discussion of the analytical methods used to develop the forecast is contained in *Long-Term Forecast of Medicaid Enrollment and Spending in Alaska: Appendix of Methods*.

²⁸ Alaska Department of Labor and Workforce Development. *Alaska Population Projections 2017 to 2045*. June 2018. <http://live.laborstats.alaska.gov/pop/projections.cfm>

²⁹ Alaska Department of Labor and Workforce Development. *Alaska Population Overview: 2010 Census and 2011 Estimates*. October 2012. <http://live.laborstats.alaska.gov/pop/estimates/pub/1011popover.pdf>

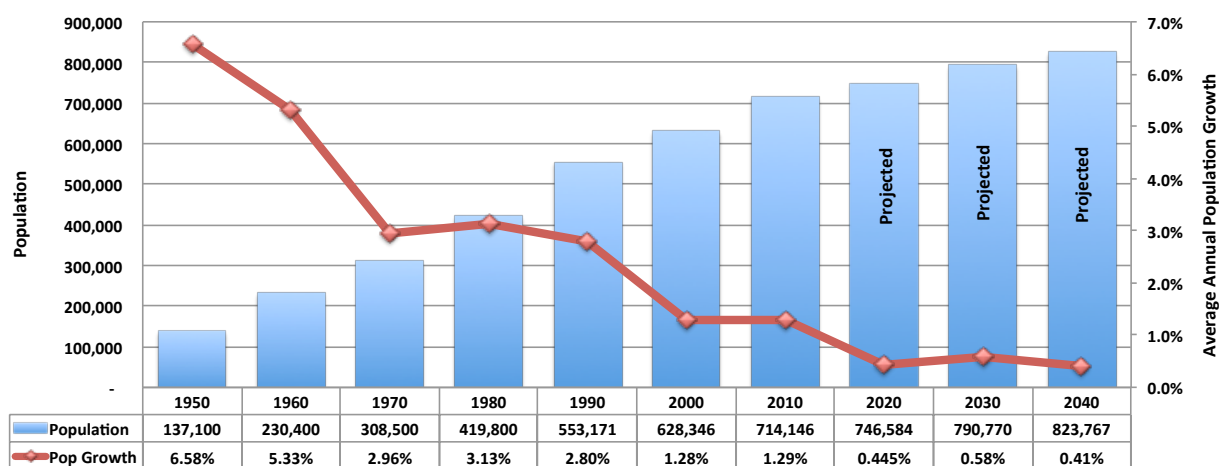
³⁰ U.S. Department of Commerce Bureau of the Census. *1960 Census of Population, Advance Reports: General Social and Economic Characteristics*. 1962.

<http://www2.census.gov/prod2/decennial/documents/15611103.pdf>

in 1972, the population of the state had increased to about 330,000.³¹ Population continued to grow quickly through the 1970s and 1980s in part due to the construction of the Trans-Alaska Pipeline from 1975 to 1977 and other projects related to the oil industry.³² By 1990, the state’s population had grown to 553,171, and two in five Alaskans (226,338) lived in Anchorage.³³

As Alaska’s population has grown, its rate of growth has continued to slow (see Figure 14). Between 1990 and 2010, population growth averaged just less than 1.3 percent per year, but slowed further to 0.45 percent per year between 2010 and 2017. The Alaska DOLWD projects population will grow by about 0.58 percent annually through 2030 and by 0.41 percent per year between 2030 and 2040.³⁴ While the ratio of males to females has moved closer to the national average over the past decades, there were still about 106 males in Alaska for every 100 females in 2017; by 2040, the Alaska DOLWD projects there will be 104 males for every 100 females.³⁵

Figure 14: Alaska's Population and Annual Growth Rates from 1950–2040



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

The Alaska DOLWD projects the distribution of residents by gender and age to change over the next two decades as the female population grows slightly faster than the male

³¹ See the Alaska Department of Labor and Workforce Development’s report *Alaska Population Overview 2009 Estimates*, p13, available at <http://live.laborstats.alaska.gov/pop/estimates/pub/09popover.pdf>

³² For more information on the impact of the Trans-Alaska Pipeline, see <http://alyeska-pipeline.com/TAPS/PipelineFacts>

³³ U.S. Department of Commerce Bureau of the Census. *1990 Census of Population and Housing: Population and Housing Unit Counts, Alaska*. 1992. <http://www.census.gov/prod/cen1990/cph2/cph-2-3.pdf>

³⁴ Alaska Department of Labor and Workforce Development. *Alaska Population Overview: 2010 Census and 2011 Estimates*. October 2012. <http://live.laborstats.alaska.gov/pop/estimates/pub/1011popover.pdf>

³⁵ Ibid; nationally, there are 103 females for every 100 males.

population and the overall population ages. We expect this to affect the Medicaid program as adult females, who tend to incur higher average annual costs than adult males, enroll in the Medicaid program at a greater rate.³⁶ In addition, the senior population is growing at a faster rate than the population as a whole and, though seniors enroll in Medicaid at a much lower rate than children and at a slightly lower rate than adults under 65 years of age, the per-enrollee costs associated with caring for seniors are higher than for children or adults under 65 years of age.

Table 2: Alaska’s Projected Population by Age Cohort for Selected Years 2019–2039

Age Group	2019	2024	2029	2034	2039	Avg. Annual Change
Children (0-19)	208,418	212,396	213,351	215,776	219,633	0.26%
Adults (20-64)	441,969	436,204	439,649	450,646	464,966	0.25%
Seniors (65+)	92,489	116,130	132,960	137,754	135,375	1.92%
Total Population	742,876	764,730	785,960	804,176	819,974	0.49%

Source: Analysis by Evergreen Economics of data from the Alaska Department of Labor and Workforce Development.

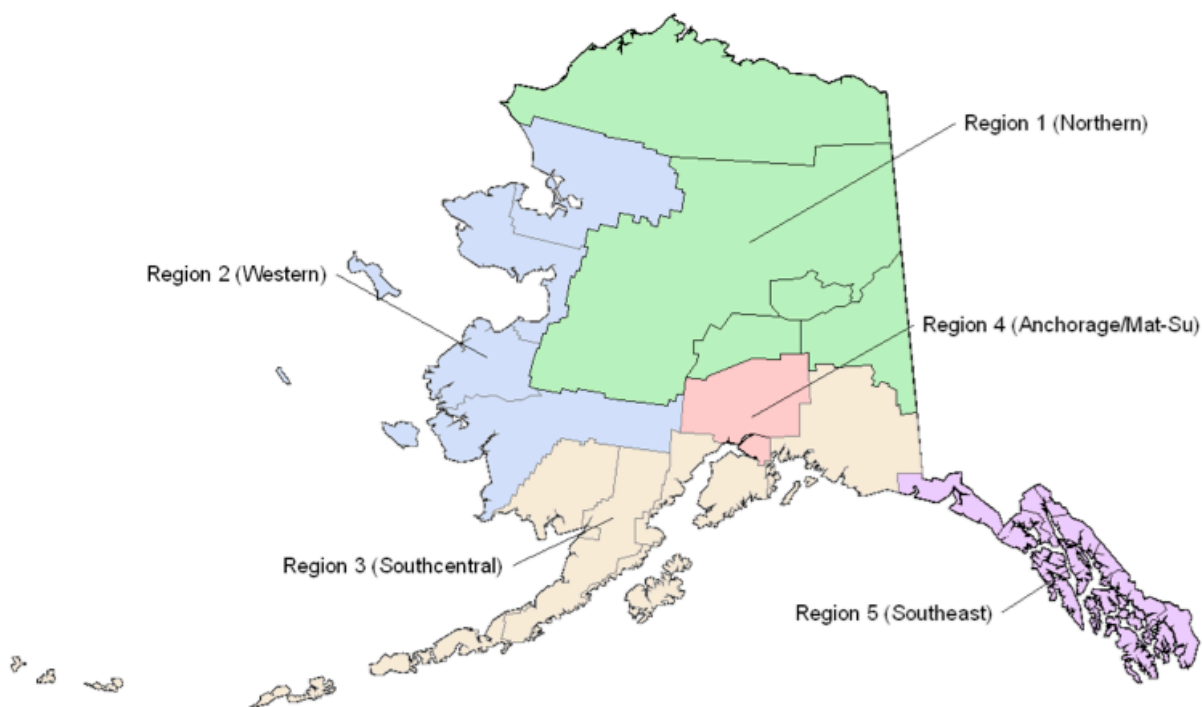
2.1.1 Regional Trends in Population

In the first long-term Medicaid forecast completed in 2006 and in each subsequent update, population, Medicaid enrollment, and Medicaid spending data were organized into the five regions shown in Figure 15. These regions differ considerably with respect to a number of characteristics including population, degree of urbanization, and climate.

Over the past three decades, growth in Alaska’s population has varied considerably by region of the state and, based on analysis by the Alaska DOLWD, variations in the rates of growth by region are expected to continue. In 1990, 48 percent of Alaskan lived in the Anchorage/Mat-Su region (see Figure 16). Today, the proportion of Alaskans living in Anchorage/Mat-Su has grown to 55 percent and by 2039, the Alaska DOLWD projects it will be nearly 58 percent.

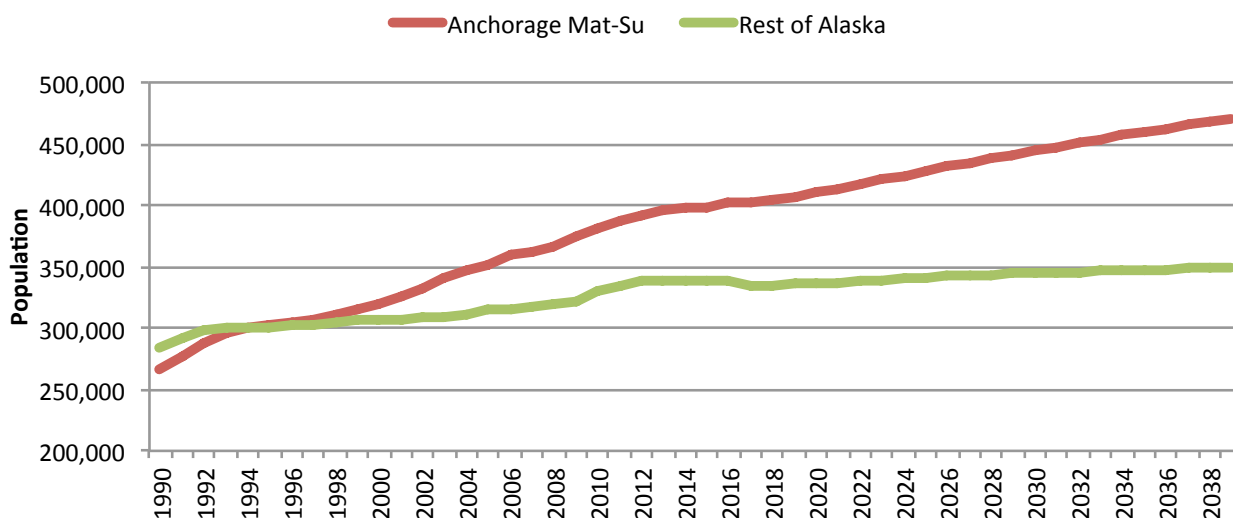
³⁶ There is little difference in average annual spending on Medicaid services for male and female children. For adults under 65 years of age, higher average annual spending on females is due primarily to pregnancy and post-pregnancy services. For seniors, higher average annual spending on females is due to a greater average lifespan of women and the high cost of senior care for Medicaid enrollees 85 years of age and older.

Figure 15: Regional Boundaries Used in Alaska Long-Term Medicaid Forecast



Source: Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025, Prepared for State of Alaska, Department of Health and Social Services by Lewin Group and ECONorthwest, February 2006.

Figure 16: Historical and Projected Population for Anchorage/Mat-Su and Rest of Alaska

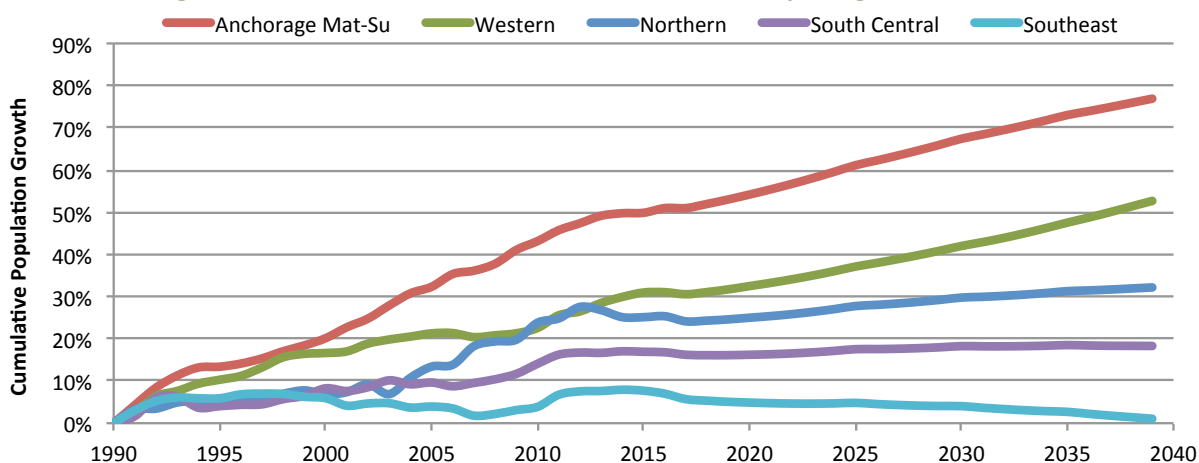


Source: Analysis by Evergreen Economics of data from the Alaska Department of Labor and Workforce Development.

Even while Anchorage/Mat-Su grew faster than the other regions, there were considerable differences in the rate of population growth between the other regions (see Figure 17). The

Western region, while the smallest of the five regions with respect to population, experienced greater population growth through 2018 than all other regions except Anchorage/Mat-Su and is expected to continue to experience a higher relative rate of growth. At the other extreme, the population of the Southeast region was only slightly greater in 2018 than it was in 1990 and is expected to shrink to nearly its 1990 population by 2039.

Figure 17: Cumulative Population Growth by Region Since 1990



Source: Analysis by Evergreen Economics of data from the Alaska Department of Labor and Workforce Development.

Table 3 shows the population for each of the five regions for selected historical and future years. There are many factors – both at the state and national levels – that could impact the distribution of population growth in Alaska over the next 20 years. Nevertheless, each of the population forecasts published by the DOLWD over the past 10 or more years has suggested the same general trend in the distribution of Alaska’s future population growth.

Table 3: Historical and Projected Future Population by Region of Alaska

Year	1990	2000	2010	2020	2030	2039
Northern	98,090	104,802	121,451	122,612	127,294	129,647
Western	33,848	39,479	41,487	44,846	48,063	51,682
South Central	83,095	89,964	94,808	96,573	98,269	98,308
Anchorage Mat-Su	266,021	319,605	380,821	410,191	445,369	470,616
Southeast	68,989	73,082	71,664	72,363	71,776	69,720
Alaska	550,043	626,932	710,231	746,585	790,771	819,974

Source: Analysis by Evergreen Economics of data from the Alaska Department of Labor and Workforce Development.

2.2 Enrollment in the Medicaid Program

Enrollment refers to the number of individuals who both meet the eligibility requirements for Medicaid and register to receive Medicaid services. There are three primary factors that determine growth in Medicaid enrollment: (1) population growth, (2) changes in the demographic characteristics of the population, and (3) changes in Medicaid eligibility requirements. For the purposes of this report, we assume that eligibility requirements as they exist today will remain constant over the 20-year projection period.

Between FY2005 and FY2010, enrollment in Medicaid grew on average by only 0.4 percent per year. The slow growth in overall enrollment was due entirely to a reduction in enrollment by children (-0.23 percent per year), while growth in the adults under 65 years of age cohort and the senior cohort increased by 1.8 percent and 2.0 percent per year, respectively. Medicaid enrollment grew by 4.1 percent per year between FY2010 and FY2015 and was due in part to a “snapback” response to enrollment declines for children that occurred in FY2008 and FY2009.

Medicaid enrollment increased rapidly between FY2014 and FY2018, due primarily to the introduction of the Affordable Care Act (ACA), which led to increases in Medicaid enrollment across the country. The ACA included changes to the Modified Adjusted Gross Income (MAGI) standard used to determine Medicaid and CHIP eligibility, which made it easier for individuals to qualify for either program. In addition, the insurance mandate in the ACA³⁷ and the “no wrong door” feature of the federal healthcare exchange allowed consumers to complete a single streamlined application to determine eligibility for a subsidized health plan, CHIP, or Medicaid. In September 2015, the State of Alaska launched Medicaid expansion, which led to a substantial increase in enrollment of adults under 65 years of age. Alaska has also been in an economic recession since late 2014 or early 2015. Two recently published studies found that participation in and spending on Medicaid services increased during economic recessions.³⁸

We expect Medicaid enrollment to slow considerably between FY2019 and FY2024 (see Table 4) as the effects of Medicaid expansion and other ACA-based changes to the Medicaid program will largely have already occurred. Over the 20-year projection period, we believe Medicaid enrollment will grow on average by about 1.2 percent per year.

³⁷ For information on the ACA “individual mandate” to purchase health insurance, please see <http://kff.org/infographic/the-requirement-to-buy-coverage-under-the-affordable-care-act/>

³⁸ Benitez, J.A., V. Perez, and E. Seiber. “Medicaid as a Safety Net: Does Medicaid Generosity Mitigate the Effects of Unemployment During Economic Downturns?” Proceedings from the 7th Conference of the American Society of Health Economists, June 12, 2018.

Snyder, L., and R. Rudowitz. “Trends in State Medicaid Programs: Looking Back and Looking Ahead.” The Kaiser Family Foundation, June 21, 2016.

However, the rate of growth for seniors (3.7 percent per year) will continue to outpace the rate of growth for children (0.8 percent) and adults under 65 years of age (1.1 percent).

Table 4: Average Annual Growth in Enrollment by Age Cohort Through FY2039

Period	Children (0-19)	Adults (20-64)	Seniors (65+)	All Enrollees
FY2014 – FY2019	3.4%	17.5%	5.9%	9.2%
FY2019 – FY2024	2.1%	1.7%	7.0%	2.2%
FY2024 – FY2029	0.5%	0.7%	4.3%	0.9%
FY2029 – FY2034	0.4%	0.9%	2.5%	0.8%
FY2034 – FY2039	0.4%	1.0%	1.1%	0.8%
FY2019 – FY2039	0.8%	1.1%	3.7%	1.2%

Source: Alaska Department of Labor and Workforce Development.

Table 5 shows the forecast of enrollment levels by age cohort for selected years through 2039. Between FY2019 and FY2039, we expect Medicaid enrollment to increase by about 65,000 persons. Most of the growth in enrollment (about 70 percent) will be adults under 65 years of age or seniors. Approximately all children in Alaska *eligible* for Medicaid were enrolled in Medicaid at some point in FY2018. This represents more than half of all Alaska children. Comparatively, only one-in-four adults were enrolled in Medicaid in FY2018. It is likely that some eligible adults were not enrolled in Medicaid in FY2018 due to having health insurance from another source or, despite the insurance mandate provision of the ACA, were uninsured. Over the next 20 years, the ODLWD projects a similar rate of population growth for children and adults under the age of 65, but a faster rate of growth in the senior population. We expect growth in Medicaid enrollment to outpace growth in population for all age cohorts, but given the greater opportunity for growth in the adult population (20 and older), we anticipate more adults enrolling in Medicaid than children.

Table 5: Medicaid Enrollment by Age Cohort for Selected Fiscal Years 2014–2039

Age Cohort	2014	2019	2024	2029	2034	2039
Children (0-19)	94,011	111,189	123,133	126,203	128,544	131,351
Adults (20-64)	54,431	121,771	132,593	137,416	143,602	150,997
Seniors (65+)	10,835	14,438	20,240	24,974	28,193	29,778
Total Enrollment*	159,277	247,397	275,966	288,593	300,338	312,126

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

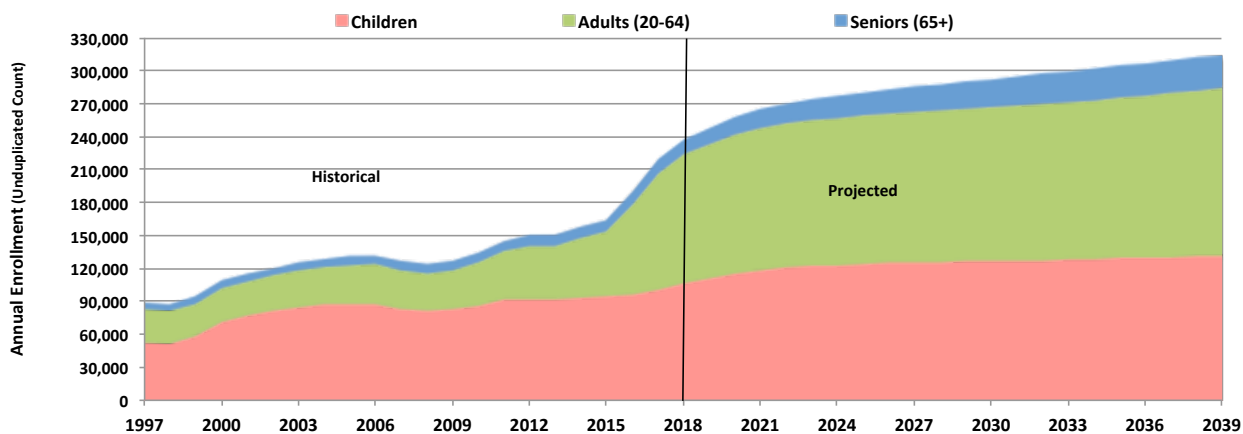
* Due to rounding, some totals may not precisely match the sum of components shown in table.

The number and distribution of Medicaid enrollees by age has changed considerably over the past two decades and will continue to do so in the future (see Figure 18). The share of

children as a percentage of all participants enrolled in Medicaid increased in the late 1990s and continued to increase until 2004, when children accounted for 67 percent of enrollees. Growth in enrollment over this period was due in part to the introduction of Denali KidCare (DKC) in 1999, which expanded Medicaid eligibility for persons under 18 whose families met certain income requirements. In 2003, DKC eligibility standards were reduced, and between FY2004 and FY2007, the income eligibility requirements were not adjusted for inflation, resulting in some individuals losing eligibility for Medicaid.

With the rapid growth in enrollment by adults under 65 years of age in FY2016, FY2017, and FY2018 due to Medicaid expansion, the proportion of Medicaid enrollees who are children has since dropped, and for FY2017 was about 46 percent. With slower projected growth over the next 20 years, we project the children’s share of enrollment will slowly decrease to 43 percent by FY2039. The share of Medicaid enrollees who are adults under the age of 65 was about 48 percent in FY2017. We expect this proportion to remain steady over the projection period, decreasing only slightly to 47 percent by FY2039. In comparison, we project the senior cohort's share of Medicaid enrollment will grow from about 6 percent in FY2017 to 10 percent by FY2039.

Figure 18: Medicaid Enrollment by Age Cohort, Annual Unduplicated Count



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Table 6 shows the enrollment forecast by broad eligibility category. On a percentage basis, enrollment growth will be greatest for the aged or disabled eligibility group. Comparatively, we expect enrollment through Medicaid expansion eligibility to grow at about the same rate as overall enrollment.

Table 6: Medicaid Enrollment for Selected Eligibility Groups FY2019–2039

Eligibility Group	2019	2024	2029	2034	2039	Annual Growth
Aged or Disabled	34,972	42,613	47,763	52,245	55,776	2.4%
Medicaid Expansion*	44,888	46,814	48,530	50,008	51,531	0.7%
All Other Eligibilities	167,537	186,540	192,300	198,085	204,819	1.0%
Total**	247,397	275,966	288,593	300,338	312,126	1.2%

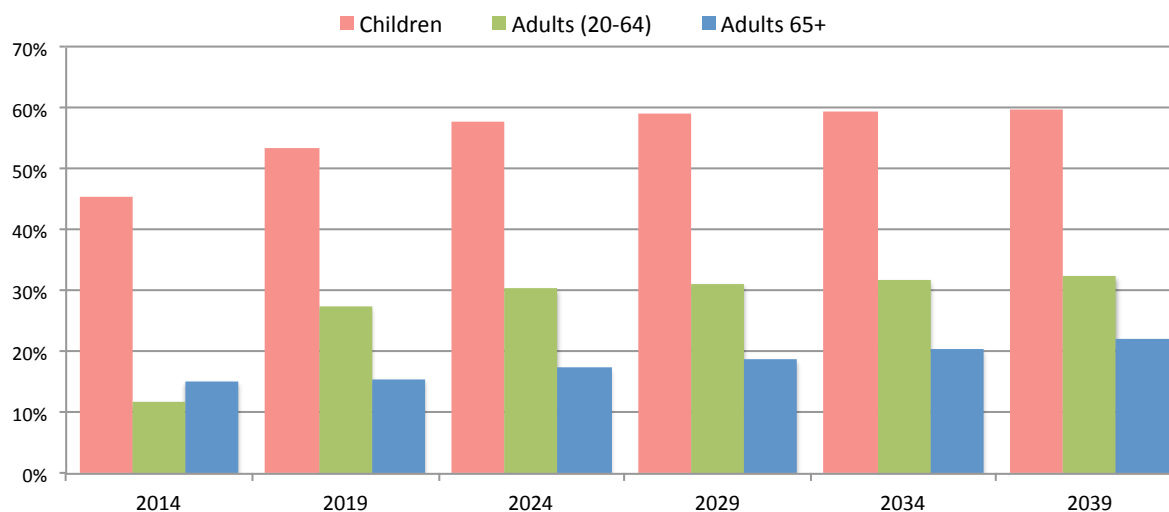
Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

* An individual’s Medicaid eligibility can change through a fiscal year. For instance, approximately 5,800 individuals were enrolled for at least one month in FY2017 through Medicaid expansion and were also enrolled for at least one month through another, non-expansion eligibility category.

** Due to rounding, some totals may not precisely match the sum of components shown in table.

Across all age cohorts, the proportion of Alaskans enrolled in Medicaid has grown, and we expect it to continue to grow throughout the projection period due to expected increases in the take-up rate for those eligible for Medicaid and to projected growth in the Medicaid-eligible population across all ages. Figure 19 shows the proportion of Alaska children, adults under 65 years of age, and seniors enrolled in Medicaid in FY2014 and projected to be enrolled in Medicaid in selected future years.

Figure 19: Medicaid Enrollment as a Proportion of Alaska’s Population for Selected Fiscal Years 2014–2039



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Due primarily to Medicaid expansion, the proportion of adults under 65 years of age enrolled in Alaska’s Medicaid program grew from about 12 percent in FY2014 to nearly 28 percent in FY2019. We project that this proportion will continue to grow, albeit much more slowly over the next 20 years, reaching about 33 percent by 2039. We project that the

proportion of seniors enrolled in Medicaid, currently about 15 percent, will grow to 22 percent by FY2039. Currently, just over half of children are enrolled in Medicaid (or CHIP), and we expect this proportion to grow to about 60 percent by 2039.

2.3 Utilization of Medicaid Services

The term “utilization” has multiple meanings in healthcare. For our purposes, we define utilization as the annual unduplicated count of Medicaid enrollees who received a particular Medicaid service during a fiscal year. We refer to a Medicaid enrollee who received a Medicaid service as a recipient, and we count an enrollee as a recipient only once per year for any given service category regardless of the number of times during the year the individual utilized the service or the intensity of the service received.³⁹ For the long-term Medicaid forecast, we project the number of Medicaid enrollees who will use each Medicaid service category – without regard for the intensity of use – during each of the 20 years of the forecast period.⁴⁰

In the first long-term Medicaid forecast completed in February 2006 and in each subsequent forecast, Medicaid services were organized into the same 20 Medicaid service categories. These categories are listed in Table 7 and are described in the appendix of this report.

Table 7: Service Category Designations Used in the Long-Term Medicaid Forecast

Dental	Inpatient Hospital	Pharmacy
DME ⁴¹ / Supplies	Inpatient Psychiatric	Physician / Practitioner
EPSDT ⁴²	Lab / X-Ray	Residential Psychiatric / BRC ⁴³
Family Planning	Nursing Home	Therapy / Rehabilitation
HCB ⁴⁴ Waiver	Outpatient Hospital	Transportation
Health Clinic	Outpatient Mental Health	Vision
Home Health / Hospice	Personal Care	

Table 8 shows the five service categories projected to experience the greatest level of utilization through the projection period. However, with the exception of the Pharmacy

³⁹ In any given year, 5 percent to 10 percent of Medicaid enrollees are not recipients. That is, though enrolled in the Medicaid program, they did not utilize any Medicaid services. We count an enrollee as a recipient if he or she used a Medicaid service that resulted in a paid claim.

⁴⁰ We consider “intensity of use” in the subsequent step of the long-term Medicaid forecast.

⁴¹ Durable Medical Equipment

⁴² Early and Periodic Screening, Diagnosis, and Treatment

⁴³ Behavioral Rehabilitation Centers

⁴⁴ Home and Community Based Waiver

service category, we project that utilization of services within these categories will grow slightly slower than the overall rate of service utilization for the Medicaid program.

Table 8: Most Frequently Utilized Medicaid Service Categories for Selected Fiscal Years

Service Category	2019	2024	2029	2034	2039	Annual Growth
Physician/Practitioner	143,217	151,743	159,378	168,423	178,900	1.1%
Outpatient Hospital	130,171	138,745	146,109	154,425	163,767	1.2%
Pharmacy	115,845	126,650	136,498	147,342	159,390	1.6%
Dental	90,508	96,770	101,088	105,295	109,751	1.0%
Health Clinic	57,053	61,931	65,457	68,811	72,168	1.2%
All Medicaid Services*	794,903	864,283	917,345	968,971	1,022,079	1.3%

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group; counts shown in the table represent the number of Medicaid enrollees who received services from the respective service category at least once during the fiscal year.

* Due to rounding, some totals may not precisely match the sum of components shown in table.

There is and we believe there will continue to be substantial variability among enrollees in the rate of service utilization, with approximately 5 percent to 10 percent of enrollees not utilizing any Medicaid services during a fiscal year and a small number of enrollees utilizing 10 or more different service categories. Some of this variability is explained by age, with children utilizing on average two Medicaid service categories per year, adults under 65 years of age utilizing about four categories, and seniors utilizing on average just over five categories each year. Projected growth in the utilization of Medicaid services over the next 20 years is due in large part to enrollment growth, but is also a function of the greater healthcare needs of an aging Medicaid population.

Between FY1998 and FY2005, the average number of Medicaid service categories utilized by a Medicaid enrollee grew from 2.6 to 3.1 (of the 20 service categories). In FY2017, enrollees utilized 3.3 service categories on average and, though slowing, we project that by 2039, the average rate of service utilization will reach nearly 3.5 Medicaid service categories per enrollee.

2.4 Intensity of Use of Medicaid Services

While utilization refers to the number of different Medicaid service categories a recipient uses, intensity of use refers to the *amount* of a particular service a recipient receives. To estimate intensity of use, we analyzed spending per Medicaid enrollee for each of the 20 service categories for each fiscal year from 1997 through 2017. Over this period, Alaska and the rest of the U.S. experienced substantial healthcare price inflation, which averaged around 4 percent per year, but fluctuated year-to-year with a low of 2.4 percent in FY1998 to a high of 5.9 percent in FY2004. To isolate the effects of intensity of use, we removed the

price effects associated with inflation, resulting in annual estimates of spending as if there were no increases in healthcare prices. With inflation removed, year-to-year differences in average spending per Medicaid enrollee represent changes in the intensity of service provided to enrollees.⁴⁵

We used the resulting inflation-adjusted spending data to develop statistical models to explain intensity of use as a function of (1) demographic characteristics and (2) a time-trend. We then used the coefficients estimated in these models to predict intensity of use for each of the 20 service categories through FY2039. On a weighted average basis across the 20 service categories, we project intensity of use will increase on average by only about 0.21 percent per year through FY2039. It is worth noting that, while these estimates of average growth in the intensity of Medicaid services are very small relative to historical (and expected future) growth in Medicaid price inflation, separating the inflation component from the intensity of use component is challenging given the aggregate level at which healthcare price inflation is measured.⁴⁶

2.5 Total Spending on Medicaid Services

The final step (see Figure 13) of the Alaska long-term forecasting model is to develop estimates of total spending for each Medicaid service category through FY2039. To do this, we first project the annual rate of healthcare price inflation for Alaska through FY2039. We then integrate these estimates of healthcare price growth into our annual estimates of growth in population (Step 1 of Figure 13), enrollment (Step 2), utilization (Step 3), and intensity of use (Step 4) to obtain a projection of total spending on Medicaid services for each year through FY2039. We project that total Medicaid spending will increase on average by 4.6 percent per year between FY2019 and FY2039 (see Table 9 and Figure 20), reaching \$5.7 billion by 2039.

This 4.6 percent estimated rate of growth in Medicaid spending is substantially lower than the projected growth rate from the original Alaska Medicaid long-term forecast completed in 2006. In that forecast, spending on Medicaid services was projected to grow on an annual average basis by 7.8 percent, reaching \$4.7 billion by CY2025.⁴⁷ For the current forecast, we project spending in FY2025 will be \$3.23 billion. Efforts by the Alaska Legislature and DHSS to slow growth in Medicaid spending in conjunction with slower actual and projected population growth have acted to check the rapid and unsustainable growth in Medicaid spending.

⁴⁵ We used calendar year 2000 as the base year. The choice of base year does not impact the estimates of healthcare price inflation.

⁴⁶ We relied on the Medical Care component of the All Urban Consumer Price Index for Anchorage as the measure of historical healthcare price inflation. www.bls.gov/cpi

⁴⁷ Recall that the first long-term forecast and all subsequent updates until this one were done on a calendar year basis.

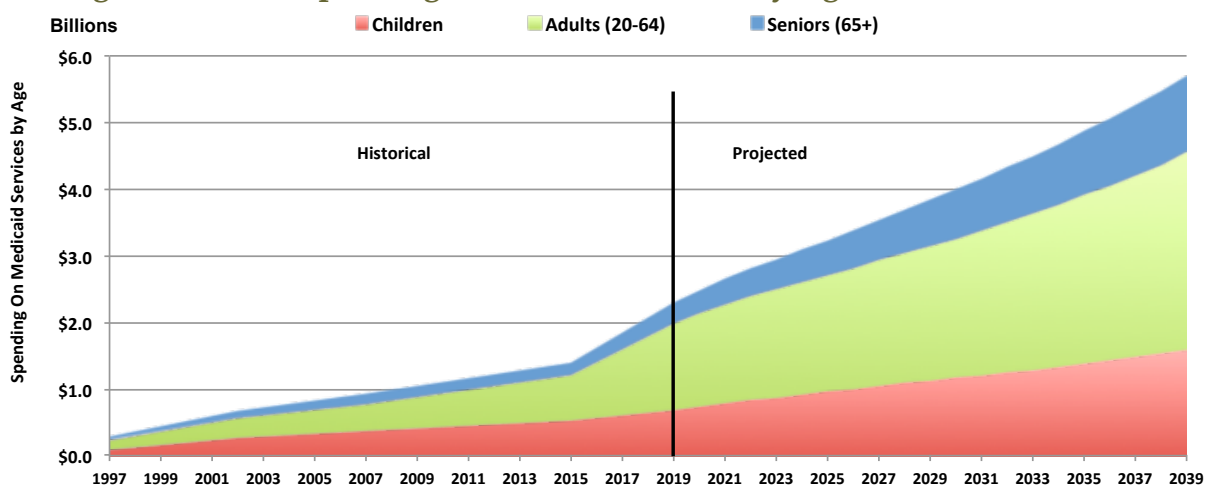
Table 9: Medicaid Spending by Age Cohort for Selected Fiscal Years (Millions \$)

Age Group	2019	2024	2029	2034	2039	Annual Growth
Children (0-19)	\$702	\$940	\$1,149	\$1,352	\$1,610	4.2%
Adults (20-64)	\$1,297	\$1,667	\$2,006	\$2,419	\$2,947	4.2%
Seniors (65+)	\$308	\$479	\$683	\$906	\$1,149	6.8%
Total	\$2,307	\$3,086	\$3,838	\$4,677	\$5,706	4.6%

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Another noteworthy difference between the current and the original forecasts is in regards to Medicaid enrollment. In the current forecast, we project the unduplicated count of enrollment will reach 279,074 in FY2025. Comparatively, in the 2006 study, the projected unduplicated count of enrollment for CY2025 was 175,073. Thus, not only has growth in total Medicaid spending been slower, the Medicaid program is covering many more Alaskans than was projected in the first long-term forecast. It is possible and even likely that cost control measures currently being developed and implemented by the Alaska Legislature and DHSS will further slow the growth in Medicaid spending. Nevertheless, this updated forecast does not consider any future potential changes to the Medicaid program intended to reduce costs.

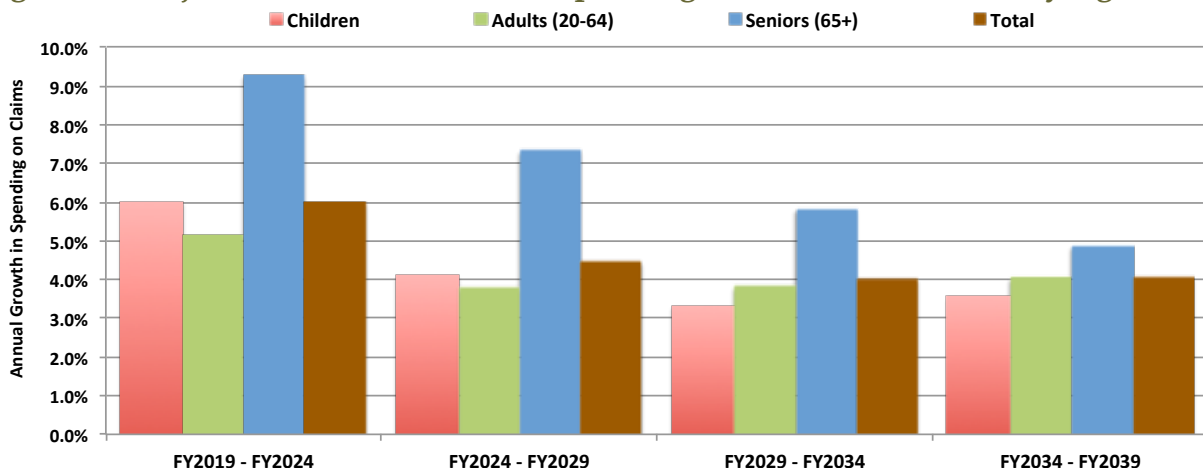
Figure 20: Total Spending on Medicaid Claims by Age Cohort FY2019-2039



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

We expect the annual rates of growth in Medicaid spending to differ for children, adults under 65 years of age, and seniors and to generally decrease over the forecast period (see Figure 21).

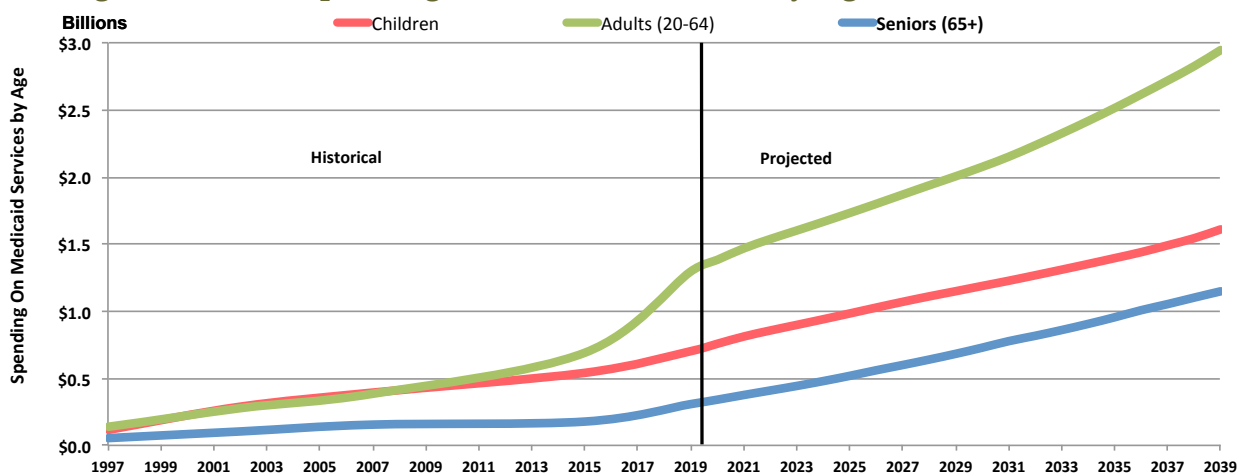
Figure 21: Projected Annual Growth in Spending on Medicaid Services by Age Cohort



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Figure 22 shows historical and projected spending on Medicaid services by age group from FY1997 through FY2039. Through much of the historical period, total annual spending on children and adults under 65 years of age was about the same. However, by FY2013, the two trend lines began to diverge as spending on Medicaid services for adults under 65 years of age grew faster than spending on children.

Figure 22: Total Spending on Medicaid Services by Age Cohort, FY1997-2039



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

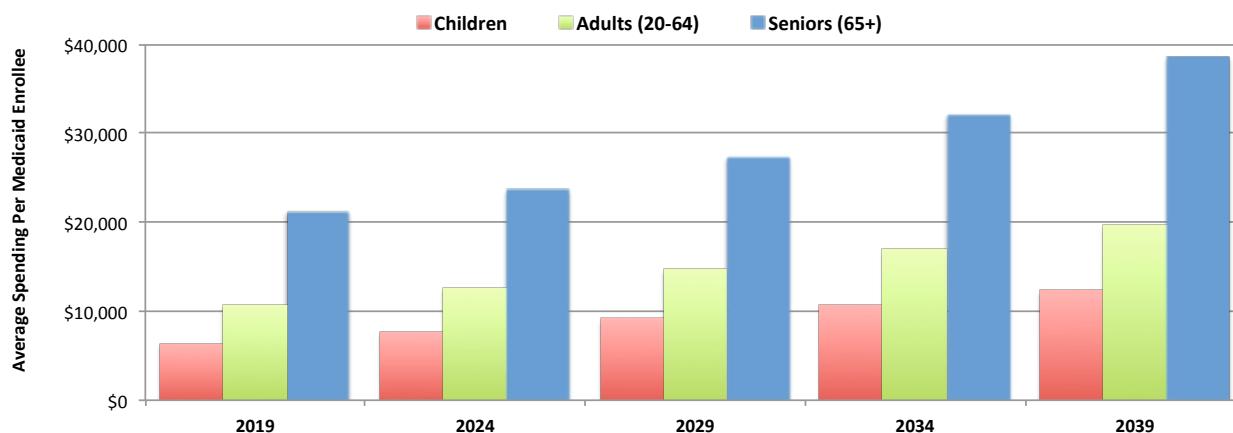
With Medicaid expansion in September of 2015, the gap widened significantly, and we expect the gap in spending to continue to widen through the projection period. We also expect the rate of growth in spending on seniors to outpace spending on children. However, our projection of growth in spending on seniors is lower than in any previous long-term forecast due to cost containment efforts by the Alaska Legislature and DHSS

over the past decade and slower projected growth in Alaska’s senior population as forecast by the Alaska DOLWD.

Figure 23 shows projected spending per Medicaid enrollee by age group for selected years. This figure is extremely informative, as it shows the important role age plays in the cost of healthcare services. For FY2019, we estimate the average per-enrollee cost of Medicaid services for children and adults under 65 years of age will be about \$6,300 and \$10,600, respectively. Comparatively, the average cost per senior enrollee will be about \$21,300—twice the cost per the average adult under the age of 65 and more than three times the cost per the average child. By FY2039, we project average spending per child will be about \$12,300, the average cost per adult under the age of 65 will be \$19,500, and the average cost per senior enrollee will be \$38,600. Most of the increase in spending per enrollee is due to growth in medical price inflation.

As Alaska’s population ages, its Medicaid population also ages. Without any increases in the number of persons enrolled in Medicaid, the cost of providing Medicaid services will rise due to the positive relationship between age and spending on healthcare services. In FY2000, the average age of a Medicaid enrollee in Alaska was 21 and the median age was 14; in FY2015, the average age was 23 and the median age was 16. We project that by FY2039, the average age of a Medicaid enrollee will be 30 and the median age will be 25.

Figure 23: Average Per Enrollee Spending on Medicaid Services by Age Cohort, For Selected Fiscal Years



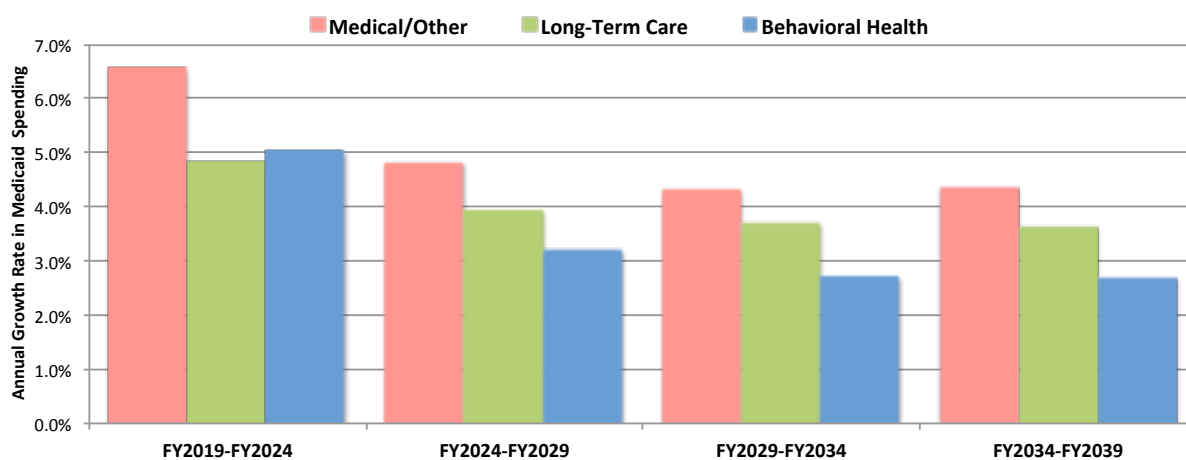
Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

More than half of Alaska children were enrolled in the Medicaid program during all or some portion of FY2018, compared to only one-in-four adults under 65 years of age and one-in-seven senior Alaskans. Nevertheless, with components of the ACA going into effect in January 2014—including Medicaid expansion in September 2015—the focus of the Medicaid program has expanded to cover a much wider swath of the population. Since

FY2016, the Alaska Medicaid program has covered more adults (those under 65 years of age plus seniors) than children, and we expect this to continue through FY2039.

Figure 24 shows historical and projected rates of growth in spending, and Table 10 shows projected levels of spending by broad service group: medical/other, long-term care, and behavioral health.⁴⁸ Between FY2019 and FY2024, we expect spending on medical/other services will grow by about 6.6 percent per year, while spending on long-term care and behavioral health services will each grow by about 5 percent. The greater expected growth in medical/other services is due to Medicaid expansion, which has led to a significant increase in enrollment of non-disabled adults under 65 years of age. Throughout the projection period, we project growth in spending on medical/other services will continue to outpace spending on long-term care and behavioral health services, but the difference will continue to shrink. Overall, we project total spending will increase on average by 4.6 percent per year through FY2039.

Figure 24: Average Annual Growth in Spending by Medicaid Service Category



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Note: All spending on Medicaid services is categorized into one and only one of the three service groups.

As Table 10 shows, we project that total spending on Medicaid services will grow to \$5.7 billion by FY2039 with spending on medical/other services growing the fastest of the three broad service categories. We expect medical/other services will constitute 70 percent of spending on Medicaid services (increasing from approximately 54 percent in FY2014). Comparatively, we project spending on long-term care and behavioral health services will each approximately double over the projection period, but will, nevertheless, shrink as a share of total spending on Medicaid services.

⁴⁸ See Table 13 in the appendix for a description of the services contained within each broad service category.

Table 10: Spending on Medicaid Services for Selected Fiscal Years (Millions \$)

Service	2014	2019	2024	2029	2034	2039	Annual Growth*
Medical/Other	\$755	\$1,504	\$2,066	\$2,615	\$3,230	\$3,999	5.0%
Long-Term Care	\$468	\$551	\$699	\$847	\$1,016	\$1,216	4.0%
Behavioral Health	\$176	\$251	\$321	\$376	\$430	\$492	3.4%
Total**	\$1,399	\$2,307	\$3,086	\$3,838	\$4,677	\$5,706	4.6%

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

* Average annual growth rate between FY2019 and FY2039.

** Due to rounding, some totals may not precisely match the sum of components shown in table.

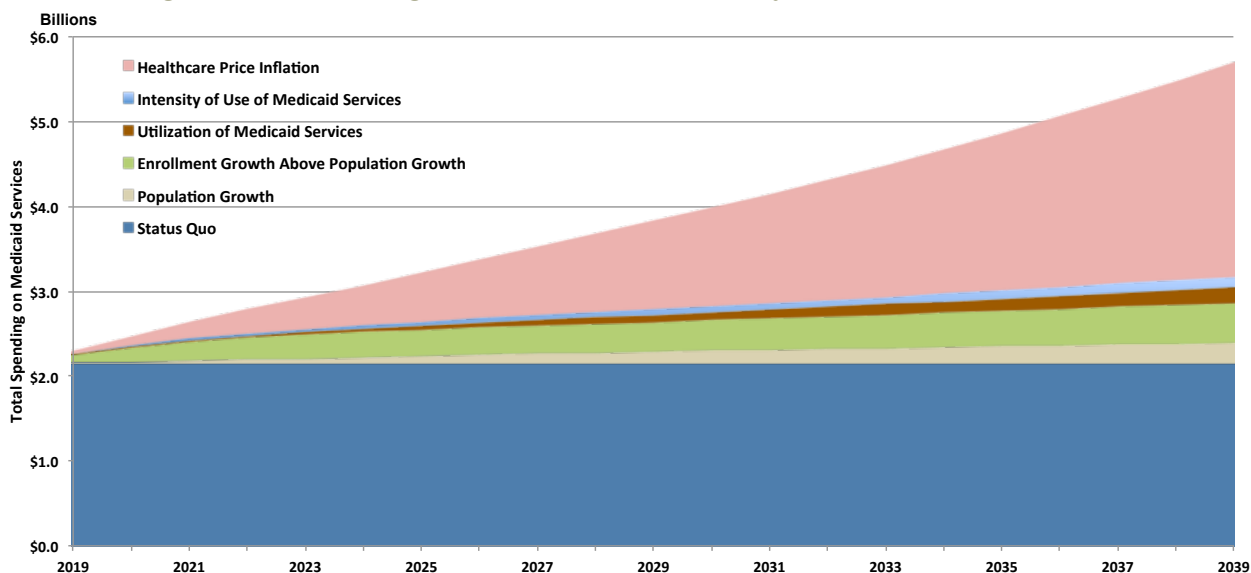
Figure 25 shows our forecast of total spending on Medicaid services by factor affecting spending growth. The figure begins with the *status quo*, which is simply the unchanging level of spending if there were no external or internal factors affecting spending over the next 20 years. The status quo assumes that everything about the Medicaid program remains unchanged from FY2019 to FY2039. Figure 25 then shows how the spending forecast builds off of this base. The components of spending growth are as follows:

- **Population Growth** represents the additional spending due to growth in the population under the assumption that the rate of Medicaid participation will remain the same for each of the 240 sub-populations considered in the forecast.
- **Enrollment Growth Above Population Growth** is the incremental effect on Medicaid spending due to growth in the rate at which Alaskans enroll in Medicaid.
- **Utilization of Medicaid Services** represents the incremental impact on spending associated with Medicaid enrollees using, on average, a greater number of Medicaid services.
- **Intensity of Use of Medicaid Services** represents the incremental impact on spending associated with greater use of specific Medicaid services possibly, but not necessarily, due to changes in medical technology or practices, or increases in the scope of medical services within a Medicaid service category.
- **Healthcare Price Inflation** is the rate at which prices for medical services increase over time not related to changes in the scope or scale of the service provided.

As Figure 25 shows, we expect healthcare price inflation to be the primary driver of spending growth in Alaska's Medicaid program, representing nearly 45 percent of total spending and 70 percent of additional spending in FY2039. Healthcare price inflation may not directly impact what DHSS pays providers for services provided to Medicaid recipients in any given year. Rather, DHSS has processes in place to work with providers to periodically update the schedule of rates paid for Medicaid services. Rates typically

adjust (generally upward) every one to four years, roughly in line with the rate of healthcare price inflation affecting providers.

Figure 25: Spending on Medicaid Services by Component of Growth



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Relative to healthcare price inflation, each of the other components of spending growth will have a relatively small impact on the Medicaid program over the next 20 years. Nevertheless, by FY2039, we project that growth in the population, growth in the take-up rate for Medicaid, and growth in utilization and intensity of Medicaid service will combine to increase spending on the Medicaid program by more than \$1.0 billion.

2.5.1 State Spending on Medicaid Services

So far, the focus of our spending analysis has been Alaska’s Medicaid program as a whole. However, the state and federal governments share the funding of the Medicaid program. The proportion of the cost of a Medicaid service that the state and federal governments are responsible for, respectively, is a function of the eligibility status of each Medicaid recipient and, in certain cases, the facility in which the recipient receives care. For example, if a Medicaid recipient who is also American Indian or Alaska Native and receives services through a facility of the Indian Health Service (IHS), including tribal health organizations, the federal government will pay 100 percent of the cost of the services. However, if that

same Medicaid recipient received services from a non-IHS facility, then the federal government will likely pay a smaller portion of the cost of the service.⁴⁹

Each Medicaid service received by an enrollee is eligible for one or more of the following Federal Financial Participation (FFP) rates:

- Regular FMAP (Federal Medical Assistance Percentage):⁵⁰ 50 percent FFP
- Enhanced FMAP for CHIP:⁵¹
 - 88 percent FFP through Federal Fiscal Year (FFY) 2019
 - 65 percent FFP beginning in FFY2020
- Breast and Cervical Cancer (BCC): 65 percent FFP
- Family Planning: 90 percent FFP
- Indian Health Service (IHS): 100 percent FFP
- Medicaid Expansion:⁵²
 - CY2016: 100 percent FFP
 - CY2017: 95 percent FFP
 - CY2018: 94 percent FFP
 - CY2019: 93 percent FFP
 - CY2020 and beyond: 90 percent FFP
- State-Only Services: 0 percent FFP

When a Medicaid service received by a Medicaid recipient is eligible for more than one FFP rate, DHSS receives the rate with the highest federal participation. The majority of Medicaid spending receives the Regular FMAP rate of 50 percent federal reimbursement;

⁴⁹ In State Health Official Letter #16-002 dated February 26, 2016, the Centers for Medicare and Medicaid Services (CMS) updated its policy regarding federal funding for services “received through” an IHS/Tribal facility and furnished to Medicaid-eligible American Indians and Alaska Natives. This change in federal policy on tribal Medicaid reimbursement authorizes 100 percent federal funding for services provided to American Indian and Alaska Native (AI/AN) individuals eligible for Medicaid. The new federal policy allows the state to claim 100 percent federal reimbursement for Medicaid services provided to AI/AN Medicaid recipients in non-tribal facilities if the recipient’s tribal health organization has a care coordination agreement established with the non-tribal facility and there is documentation of a referral and an exchange of records for the care received. Projected spending by the State of Alaska in this forecast accounts for this change in policy by CMS.

⁵⁰ CMS sets each state’s FMAP rate based on a three-year average of state-level per capita personal income, ranked among states.

⁵¹ Before federal fiscal year 2016, the enhanced FMAP rate was 65 percent.

⁵² Recipients enrolled through Medicaid expansion who are also Indian Health Service beneficiaries will always receive 100 percent FFP for qualifying services (see footnote 49).

however, most of the growth in Medicaid spending has received either the Medicaid expansion or IHS FMAP rate. FFP rates are set at the federal level and, though they do change periodically, are largely outside of state control. We assume the FFP rates shown above will not change during the projection period.

We project that spending by the State of Alaska on Medicaid services will grow on average by 4.4 percent per year through FY2039, and federal spending will grow slightly faster at 4.7 percent per year (see Table 11). The primary reasons for the projected lower rate of growth for the State of Alaska relative to the federal government are (a) the shifting of some services received by AI/AN adults enrolled through Medicaid expansion from the FFP rates associated with expansion to the 100 percent federal match rate associated with IHS, and (b) a change in CMS policy regarding care coordination agreements established between tribal health organizations and non-tribal facilities.⁵³

Table 11: Projected State and Federal Spending on Medicaid Services (in Millions \$)

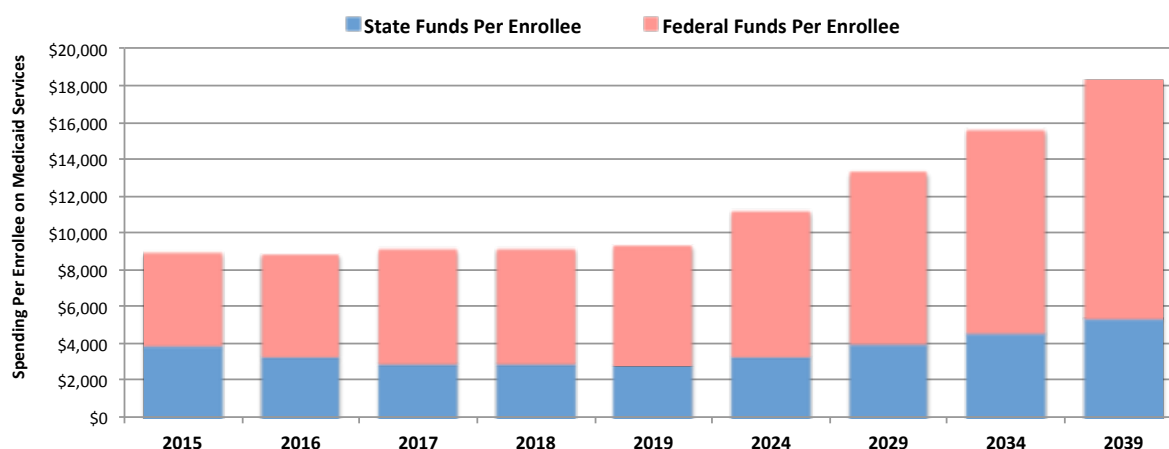
Fund Source	2019	2024	2029	2034	2039	Annual Growth
State and Other Match Funds	\$684	\$896	\$1,106	\$1,341	\$1,625	4.4%
Federal	\$1,623	\$2,190	\$2,732	\$3,336	\$4,081	4.7%
Total Spending	\$2,307	\$3,086	\$3,838	\$4,677	\$5,706	4.6%

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Figure 26 shows recent actual and projected future average spending per Medicaid enrollee. Between FY2015 and FY2018, spending per Medicaid enrollee was flat, and the proportion paid with state general funds actually decreased. Over the next 20 years, we project average spending per enrollee will increase by about 3.4 percent per year due primarily to healthcare price inflation and the expected aging of Alaska’s population.

⁵³ Ibid.

Figure 26: Average State and Federal Spending Per Medicaid Enrollee by Fiscal Year*



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

* FY2015 – FY2017 are actuals, FY2018 is estimated based on payments to date for services received in FY2018, and FY2019 – FY2039 are projected.

In FY2018, the average per-enrollee rate of financial participation was about 68 percent. We project that even with the decrease in the rate of federal participation for services provided to Medicaid recipients enrolled through expansion and the decrease in the enhanced FMAP for those enrolled through CHIP from the current 88 percent FFP back to 65 percent FFP, the overall rate of federal participation for the Medicaid program will be about 70 percent by 2039.⁵⁴

2.5.2 Comparison to the First Long-Term Medicaid Forecast

As stated at the beginning of this report, the long-term forecast assumes Medicaid policies, services offered, and eligibility requirements in place today will remain in place throughout the forecast period. While it is likely that Alaska’s Medicaid program will experience changes during the projection period, the purpose of the forecast is to inform decision makers about how Medicaid spending in Alaska will likely evolve given the structure of the program as it exists today.

In the 12 years since the first long-term forecast, Alaska’s Medicaid program has experienced many changes. For example, immediately following the release of the first forecast, the Alaska Legislature and DHSS implemented measures to slow the growth in costs of long-term care services. Between FY1998 and FY2004, spending on long-term care services grew by 18 percent per year (from \$81 million to \$238 million).⁵⁵ Following the

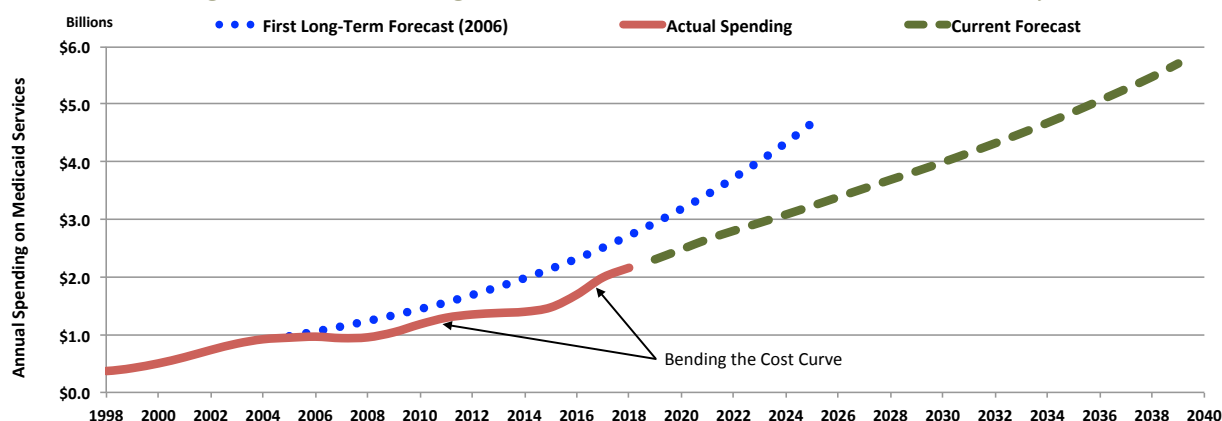
⁵⁴ In federal fiscal years 2016 through 2019, the CHIP matching rate was increased by 23 percentage points for all states, ranging from 88 percent to 100 percent.

⁵⁵ For our purposes, long-term care services include nursing homes, HCB Waiver, and personal care attendant services.

release of the first long-term forecast in February 2006, growth in spending on long-term care services decreased markedly, growing by 8.4 percent per year between FY2006 and FY2012.⁵⁶ Alaska’s population has also grown slower than the Alaska DOLWD projected in 2005, and the DOLWD’s most recent population forecast is for continued slowing in population growth over the next 20 years.

Figure 27 shows actual spending on Medicaid services from FY1998 through FY2018 (solid red line), projected spending from the first long-term Medicaid forecast (blue dotted line), and the current projection of Medicaid spending (green dashed line). Actual spending on Medicaid services in FY2018 was about \$560 million less than was projected in the first long-term Medicaid forecast. Much of this difference is attributable to cost savings efforts by the Alaska Legislature and DHSS, which helped “bend the cost curve” on Medicaid spending. In addition, Alaska experienced slower growth in its senior population than was projected by the Alaska DOLWD in 2005, and the rate of healthcare-specific inflation between 2005 and 2018 was slightly slower than was assumed in the first long-term Medicaid forecast.

Figure 27: Spending on Medicaid Services – Actual and Projected



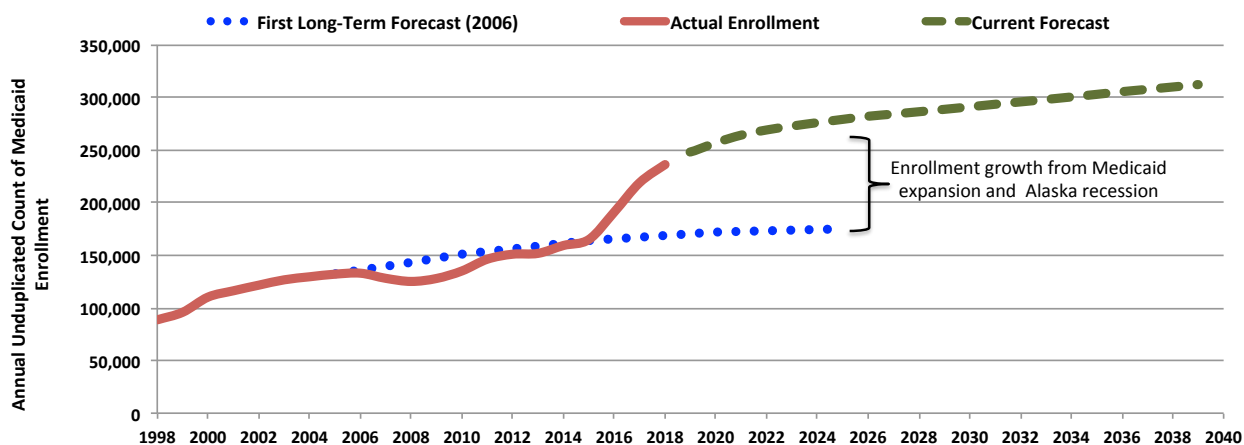
Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Slower growth in the senior population had a corresponding impact on Medicaid enrollment. For FY2018, actual Medicaid enrollment of seniors was about 4,000 lower than projected in the first long-term Medicaid forecast. This variance is particularly important given the relatively high per-enrollee cost of providing Medicaid services to seniors.

Figure 28 shows actual Medicaid enrollment from FY1998 through FY2018 and projected enrollment from the first long-term Medicaid forecast and the current forecast.

⁵⁶ Between FY1998 and FY2004, enrollment by seniors into Medicaid grew by 4.4 percent per year; between FY2006 and FY2012, enrollment grew by 3.6 percent per year.

Figure 28: Medicaid Enrollment – Actual and Projected



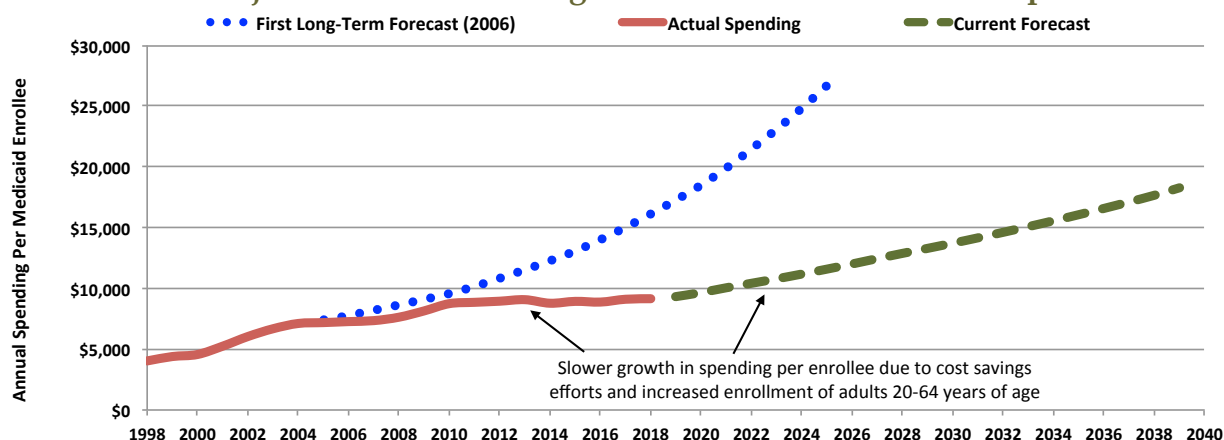
Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Between FY2006 and FY2015, actual Medicaid enrollment tracked closely to predicted enrollment. However, with the initiation of Medicaid expansion in September 2015, other components of the ACA (e.g. the individual mandate), and the economic recession that began in late 2014 or early 2015, enrollment in Medicaid increased considerably. By FY2018, the annual unduplicated count of Medicaid enrollment was about 65,000 persons greater than was projected in the first long-term Medicaid forecast.⁵⁷ For the current forecast, we expect enrollment to continue to grow, but at a decreasing rate through the projection period.

Due to a number of factors, spending on Alaska’s Medicaid program is considerably less today than was projected in the first long-term Medicaid forecast. At the same time, Medicaid enrollment is much greater today than was predicted. The net effect of lower than projected spending and greater than projected enrollment is much lower than projected average spending per Medicaid enrollee. Figure 29 shows actual average annual spending per enrollee, as well as projected spending per enrollee from the current and the first long-term Medicaid forecasts. Due to cost savings efforts by the Alaska Legislature and DHSS, and proportionally more adults 20-64 years of age than was expected when the first long-term forecast was released, spending per Medicaid enrollee is currently well below the earlier forecast and is projected to continue to grow at a much slower rate.

⁵⁷ In addition to expansion, Alaska’s Medicaid program experienced substantial growth in other eligibility categories.

Figure 29: Comparing Projected Spending per Enrollee from Current Forecast to Per-Enrollee Projection from First Long-Term Medicaid Forecast Completed in 2006



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

2.5.3 Other Medicaid Payments and Offsets

Throughout this report, we have focused on enrollment in the Medicaid program, utilization and intensity of use of Medicaid services, and spending on services provided to Medicaid recipients. There are, however, other payments associated with the Medicaid program that are not directly tied to services provided to individual recipients. These other costs can be broadly classified into two categories:

1. Premium payments for Medicare Part A and Part B; and
2. Supplemental Hospital Payments including disproportionate share hospital (DSH) and upper payment limit programs paid to qualifying hospitals that serve a large number of Medicaid or uninsured individuals, continuing care agreement payments, and tribal dental encounter payments made to IHS and Tribal clinics.

The share of total Medicaid spending attributed to these other payments varies from year to year, but has trended downward over the past 14 years. For example, in FY2005, other costs and payments accounted for 13 percent of total Medicaid spending. In more recent years, these other payments have accounted for around 7 percent of total Medicaid spending. In addition, there are offsetting recoveries such as third-party liability collections and drug rebates, which are credited to the Medicaid program and are roughly equal to about 2 percent of annual spending on Medicaid services.

It is likely that the Medicaid program will experience more changes in the future, and

payments allowed by CMS today may be disallowed in later years.⁵⁸ DSH payments were supposed to be phased out with implementation of the ACA, but this has not happened and likely will not happen in the near future. As an estimate of the combined impact of other Medicaid payments and offsetting recoveries in the future, we increase the annual forecast of spending on Medicaid services by 5 percent (see Table 12).

Table 12: Medicaid Spending for Selected years FY2019–FY2039

		2019	2024	2029	2034	2039
Spending on Medicaid Claims	Federal	\$1,623	\$2,190	\$2,732	\$3,336	\$4,081
	State Match	\$684	\$896	\$1,106	\$1,340	\$1,625
	Total	\$2,307	\$3,086	\$3,838	\$4,677	\$5,706
Other Medicaid Payments	Federal	\$58	\$77	\$96	\$117	\$143
	State Match	\$58	\$77	\$96	\$117	\$143
	Total	\$115	\$154	\$192	\$234	\$285
Total Spending on Medicaid	Federal	\$1,681	\$2,267	\$2,828	\$3,453	\$4,224
	State Match	\$742	\$973	\$1,202	\$1,457	\$1,768
	Total*	\$2,422	\$3,241	\$4,030	\$4,911	\$5,992

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

* Due to rounding, some totals may not precisely match the sum of components shown in table.

⁵⁸ FairShare and ProShare are two examples of supplemental payment programs that have been discontinued in recent years.

3 Appendix Tables

Table 13: Medicaid Service Category Descriptions for Long-Term Forecast

Broad Category	Service Category	Description
Behavioral Health	Inpatient Psychiatric Hospital	Inpatient psychiatric hospital services
	Outpatient Mental Health	Outpatient mental health services, psychology services, and drug abuse centers
	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.
	Home Health/Hospice	Home health services, hospice care, nutrition services, and private duty nursing
	Nursing Home	Skilled nursing and intermediate care facilities including intermediate-care facilities for the intellectually disabled; and temporary long-term care services
	Personal Care	Personal care attendant services including agency-based and consumer-directed programs
Medical/Other	Dental	Dental services for children and adults
	Durable Medical Equipment/Supplies	Durable medical equipment (DME), medical supplies, prosthetics, and orthotics
	Early & Periodic Screening, Diagnosis & Treatment	Early, periodic screening, diagnosis and treatment (EPSDT) including preventive health checkups, immunizations, and medically necessary treatment.
	Health Clinic	Health clinic services including rural health clinics, federally-qualified health clinics and tribal health clinics
	Inpatient Hospital	Inpatient hospital services
	Laboratory/X-Ray	Laboratory, x-ray and diagnostic services
	Other Services	Other services not classified elsewhere
	Outpatient Hospital	Outpatient hospital services, outpatient surgery services, and end-stage renal disease services
	Pharmacy	Prescription drugs
	Physician/Practitioner Services	Physician, podiatrist, advanced nurse practitioner, and midwifery services
	Therapy/Rehabilitation	Outpatient rehabilitation, physical therapy, occupational therapy, speech therapy, audiology, and chiropractic services
	Transportation	Emergency and non-emergency medically necessary transportation and accommodation
	Vision	Optometrist services and eyeglasses

Table 14: Medicaid Eligibility Classification Descriptions

Eligibility Class	Description
AFDC & Related	Eligible for AFDC-based Family Medicare or Transitional Medicaid
Alien (Foreign)	Illegal, sponsored, or amnesty alien
Exams	Disability, waiver, or pregnancy determination pending
Kids in Custody	Children in custody of DHSS
LTC Non-cash	Aged or disabled individual not receiving SSI or cash supplement
Medicare	Eligible for Medicare cost-sharing assistance only
Other Disabled	Working disabled or eligible due to breast/cervical cancer screening
Pregnancy/Post Partum	Eligible during pregnancy and for 60 days after giving birth
SSI/APA/LTC Cash	Eligible for SSI or other state cash supplement
Title XIX Kids	Children under age 19 not eligible for coverage under CHIP
Title XXI Kids	Children under age 19 eligible for coverage under CHIP
Expansion	Non-disabled adults 18 – 64 without dependent children

Table 15: Forecast of Population by Demographic Group

	Fiscal Year					Percent Change
	2019	2024	2029	2034	2039	
State	742,876	764,730	785,960	804,176	819,974	0.5%
Gender						
Male	381,947	392,348	402,471	411,106	418,718	0.5%
Female	360,929	372,382	383,489	393,070	401,255	0.5%
Native Status						
Native	151,213	157,714	163,633	169,049	174,179	0.7%
Non-Native	591,663	607,016	622,327	635,127	645,795	0.4%
Region						
Northern	122,222	124,609	126,769	128,361	129,647	0.3%
Western	44,584	46,044	47,693	49,506	51,682	0.7%
South Central	96,490	97,333	98,046	98,353	98,308	0.1%
Anchorage/Mat-Su	407,096	424,518	441,657	457,001	470,616	0.7%
Southeast	72,484	72,226	71,795	70,955	69,720	-0.2%
Age Group						
0-4	52,630	53,393	53,840	54,972	56,497	0.4%
5-9	53,058	52,910	53,636	54,101	55,242	0.2%
10-14	53,434	53,009	53,120	53,851	54,321	0.1%
15-19	49,296	53,084	52,755	52,852	53,572	0.4%
20-24	47,541	50,995	55,104	54,780	54,884	0.7%
25-34	111,909	104,618	103,864	111,319	115,150	0.1%
35-44	98,803	110,054	111,418	105,528	104,966	0.3%
45-54	86,898	85,532	95,524	106,433	107,852	1.1%
55-64	96,818	85,005	73,739	72,586	82,113	-0.8%
65-74	62,906	75,071	76,355	66,568	56,590	-0.5%
75-84	22,722	32,676	45,312	54,717	55,655	4.6%
85+	6,861	8,383	11,293	16,469	23,130	6.3%

Source: Analysis by Evergreen Economics of data from the Alaska Department of Labor and Workforce Development.

Table 16: Forecast of Enrollment by Demographic Group

	Fiscal Year					Percent Change
	2019	2024	2029	2034	2039	
State	247,397	275,966	288,593	300,338	312,126	1.2%
Gender						
Male	120,634	133,836	139,090	143,974	149,032	1.1%
Female	126,763	142,131	149,503	156,364	163,094	1.3%
Native Status						
Native	91,526	103,225	108,192	112,514	116,835	1.2%
Non-Native	155,872	172,741	180,402	187,824	195,291	1.1%
Region						
Northern	30,871	34,313	35,578	36,745	37,993	1.0%
Western	31,288	35,260	37,054	38,704	40,378	1.3%
South Central	32,879	35,962	37,031	37,998	38,976	0.9%
Anchorage/Mat-Su	129,369	145,511	153,492	161,013	168,500	1.3%
Southeast	22,990	24,921	25,439	25,879	26,279	0.7%
Age Group						
0-4	32,041	35,402	36,172	36,999	38,133	0.9%
5-9	29,127	31,273	32,155	32,675	33,339	0.7%
10-14	26,593	29,280	29,771	30,483	30,924	0.8%
15-19	23,428	27,178	28,105	28,388	28,955	1.1%
20-24	16,962	18,985	20,683	21,609	22,314	1.4%
25-34	38,268	40,245	40,703	43,209	45,966	0.9%
35-44	26,355	31,350	33,260	33,294	33,646	1.2%
45-54	20,044	21,262	23,252	26,002	27,565	1.6%
55-64	20,142	20,751	19,517	19,488	21,505	0.3%
65-74	8,795	12,015	13,392	12,792	11,392	1.3%
75-84	4,055	6,168	8,869	11,467	12,689	5.9%
85+	1,588	2,058	2,713	3,934	5,696	6.6%

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Table 17: Forecast of Spending by Demographic Group (Millions \$)

	Fiscal Year					Percent Change
	2019	2024	2029	2034	2039	
State	\$2,307.0	\$3,086.4	\$3,838.3	\$4,676.7	\$5,706.4	4.6%
Gender						
Male	\$1,221.3	\$1,623.5	\$2,000.5	\$2,415.7	\$2,929.5	4.5%
Female	\$1,085.8	\$1,462.9	\$1,837.8	\$2,261.0	\$2,776.9	4.8%
Native Status						
Native	\$1,011.1	\$1,353.1	\$1,681.3	\$2,043.7	\$2,483.9	4.6%
Non-Native	\$1,295.9	\$1,733.3	\$2,156.9	\$2,633.1	\$3,222.5	4.7%
Region						
Northern	\$268.2	\$358.4	\$445.1	\$540.3	\$656.5	4.6%
Western	\$288.5	\$386.1	\$479.6	\$586.3	\$717.5	4.7%
South Central	\$337.4	\$442.0	\$542.4	\$654.2	\$792.2	4.4%
Anchorage/Mat-Su	\$1,171.2	\$1,585.0	\$1,989.8	\$2,442.4	\$2,995.4	4.8%
Southeast	\$241.8	\$314.9	\$381.4	\$453.5	\$544.8	4.1%
Age Group						
0-4	\$211.3	\$282.9	\$345.0	\$407.7	\$489.4	4.3%
5-9	\$129.1	\$168.9	\$207.7	\$243.7	\$289.0	4.1%
10-14	\$161.6	\$214.6	\$261.1	\$308.3	\$364.2	4.1%
15-19	\$200.5	\$274.0	\$335.6	\$392.7	\$467.7	4.3%
20-24	\$119.1	\$158.2	\$198.7	\$241.6	\$293.4	4.6%
25-34	\$344.2	\$433.4	\$522.7	\$657.2	\$831.7	4.5%
35-44	\$257.5	\$358.2	\$448.9	\$501.4	\$571.4	4.1%
45-54	\$267.6	\$339.4	\$423.1	\$541.8	\$663.5	4.6%
55-64	\$308.4	\$377.6	\$412.9	\$476.6	\$587.6	3.3%
65-74	\$123.8	\$193.6	\$258.8	\$288.6	\$312.0	4.7%
75-84	\$123.8	\$193.6	\$258.8	\$288.6	\$312.0	4.7%
85+	\$104.9	\$164.6	\$244.6	\$353.0	\$458.4	7.7%

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Table 18: Forecast of Total Spending on Medicaid (Millions \$)

Service Category	Fiscal Year					Annual Percent Change
	2019	2024	2029	2034	2039	
Dental	\$118.3	\$163.0	\$205.1	\$250.3	\$306.0	4.9%
DME/Supplies	\$24.9	\$34.4	\$43.8	\$54.2	\$66.9	5.1%
EPSDT	\$19.7	\$25.3	\$28.2	\$29.7	\$30.2	2.2%
HCB Waiver	\$294.9	\$355.4	\$406.3	\$458.3	\$513.6	2.8%
Health Clinic	\$117.5	\$161.5	\$202.2	\$245.8	\$298.5	4.8%
Home Health/Hospice	\$12.7	\$18.0	\$23.0	\$27.4	\$31.9	4.7%
Inpatient Hospital	\$374.4	\$530.1	\$689.4	\$870.7	\$1,100.3	5.5%
Inpatient Psychiatric	\$26.1	\$33.6	\$39.2	\$44.7	\$51.0	3.4%
Lab/X-ray	\$5.2	\$7.2	\$9.3	\$11.8	\$14.8	5.4%
Nursing Home	\$172.1	\$231.0	\$299.4	\$388.2	\$501.7	5.5%
Other Services	\$0.4	\$0.6	\$0.9	\$1.2	\$1.5	6.8%
Outpatient Hospital	\$279.4	\$376.4	\$469.4	\$574.1	\$705.5	4.7%
Outpatient Mental Health	\$190.6	\$244.1	\$287.6	\$330.9	\$381.0	3.5%
Personal Care	\$71.8	\$94.4	\$118.5	\$142.6	\$168.3	4.4%
Pharmacy	\$158.3	\$220.3	\$283.8	\$357.7	\$451.2	5.4%
Physician/Practitioner	\$227.1	\$304.2	\$379.3	\$466.0	\$576.7	4.8%
Residential Psychiatric/BRC	\$34.7	\$43.6	\$49.7	\$54.7	\$59.8	2.8%
Therapy/Rehabilitation	\$43.6	\$58.9	\$72.6	\$86.7	\$103.2	4.4%
Transportation	\$123.7	\$168.4	\$210.9	\$257.8	\$315.1	4.8%
Vision	\$11.5	\$15.7	\$19.7	\$23.9	\$28.9	4.7%
Total Spending on Medicaid Services	\$2,307.0	\$3,086.4	\$3,838.3	\$4,676.7	\$5,706.4	4.6%
Other Medicaid Payments*	\$115.4	\$154.3	\$191.9	\$233.8	\$285.3	4.6%
Total Spending on Medicaid Program	\$2,422.4	\$3,240.7	\$4,030.2	\$4,910.6	\$5,991.7	4.6%

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

* Includes offsets received by DHSS for drug rebates, third-party liability collections, or other reasons.

Table 19: Forecast of State Spending on Medicaid (in Millions \$)

Service Category	Fiscal Year					Annual Percent Change
	2019	2024	2029	2034	2039	
Dental	\$30.2	\$42.7	\$53.7	\$65.5	\$80.1	5.0%
DME/Supplies	\$10.8	\$14.7	\$18.8	\$23.3	\$28.7	5.0%
EPSDT	\$4.7	\$6.0	\$6.7	\$7.1	\$7.2	2.2%
HCB Waiver	\$143.5	\$168.8	\$193.0	\$217.7	\$243.9	2.7%
Health Clinic	\$6.4	\$7.7	\$9.6	\$11.7	\$14.2	4.0%
Home Health/Hospice	\$6.0	\$8.3	\$10.6	\$12.6	\$14.7	4.6%
Inpatient Hospital	\$93.0	\$131.4	\$170.9	\$215.8	\$272.7	5.5%
Inpatient Psychiatric	\$11.6	\$15.6	\$18.1	\$20.7	\$23.6	3.6%
Lab/X-ray	\$1.5	\$2.2	\$2.8	\$3.5	\$4.4	5.5%
Nursing Home	\$70.7	\$92.6	\$120.0	\$155.5	\$201.0	5.4%
Other Services	\$0.2	\$0.3	\$0.4	\$0.5	\$0.7	6.7%
Outpatient Hospital	\$50.3	\$67.4	\$84.1	\$102.9	\$126.4	4.7%
Outpatient Mental Health	\$53.4	\$68.2	\$80.4	\$92.5	\$106.5	3.5%
Personal Care	\$35.2	\$45.3	\$56.9	\$68.4	\$80.7	4.2%
Pharmacy	\$42.9	\$60.4	\$77.8	\$98.1	\$123.8	5.4%
Physician/Practitioner	\$66.4	\$89.9	\$112.0	\$137.7	\$170.4	4.8%
Residential Psychiatric/BRC	\$17.1	\$21.0	\$23.9	\$26.3	\$28.7	2.6%
Therapy/Rehabilitation	\$17.9	\$24.7	\$30.4	\$36.3	\$43.3	4.5%
Transportation	\$17.9	\$23.0	\$28.8	\$35.2	\$43.0	4.5%
Vision	\$4.3	\$6.1	\$7.6	\$9.2	\$11.1	4.9%
Total Spending on Medicaid Services	\$684.1	\$896.2	\$1,106.4	\$1,340.5	\$1,625.2	4.4%
Other Medicaid Payments*	\$57.7	\$77.2	\$96.0	\$116.9	\$142.7	4.6%
Total Spending on Medicaid Program	\$741.8	\$973.3	\$1,202.4	\$1,457.4	\$1,767.9	4.4%

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

* Includes offsets received by DHSS for drug rebates, third-party liability collections, or other reasons.