THE STATE of ALASKA
GOVERNOR BILL WALKER

Department of
Health and Social Services

OFFICE OF THE COMMISSIONER

Anchorage
3601 C Street, Suite 902
Anchorage, Alaska 99503-5923
Main: 907.269.7800
Fax: 907.269.0060

Juneau
350 Main Street, Suite 404
Juneau, Alaska 99801-1149
Main: 907.465.3030
Fax: 907.465.3068

MEMORANDUM

DATE: May 12, 2015

TO: The Honorable Representative Steve Thompson, Co-Chair
House Finance Committee

FROM: Jon Sherwood, Deputy Commissioner
Department of Health & Social Services

SUBJECT: Response to House Finance Questions for May 12, 2015 Medicaid Expansion and Reform Hearing

1. What are the measured standards or goals of Medicaid expansion?

For FY 2016:
25% reduction in number of uninsured Alaskans
20% reduction in uncompensated care costs
For FY 2016 forward:
GF savings equal to or exceeding GF contribution for expansion
New federal revenues equal to or exceeding fiscal note projections

2. What assurances are there of cost containment?

Medicaid cost containment is an ongoing effort. Reforms currently underway – including generic drugs, increased fraud and abuse prevention activities and enhanced tribal health services -- have contributed to a significant reduction in the long term program growth projections. The Department reduced its FY2016 budget request by an additional $20 million GF as a result of cost containment efforts.

Data from states that expanded Medicaid demonstrate significant savings. Included in Attachment A is copy of the April 2015 State Health Reform Assistance Network Report summarizing savings in other states.

Another cost containment assurance in HB148 is a provision making Alaska's participation contingent on the federal government maintaining at least a 90 percent match.

3. The administration proposes changing language to increase eligibility to 203% and 200% for children and pregnant women, how can you assure us that this does not result in an increase in the number of covered individuals? How does the MAGI change impact eligibility for children and pregnant women?

These adjustments were mandated in the Affordable Care Act along with a new methodology for determining income eligibility using modified adjusted gross income (MAGI) as the basis for eligibility determination. Under the old regulations, certain categories of income were not included – or were disregarded – for purposes of eligibility. Under new federal regulations, the "disregards" were eliminated and, in lieu of those disregards, eligibility standards were increased. The standards in the bill are the same standards in use today.

The eligibility outcomes are similar to those under the previous method for determining countable income. The Department saw little to no impact on the number of pregnant women covered.

4. Do you plan to provide the same benefit package to the expansion population group as you provide to traditional Medicaid? If so, please explain the Department's rational.

The Department plans to start with the existing benefit package in FY2016 in order to take maximum advantage of the 100% federal funding. The Department, through internal review as well as the Technical Assistance RFP, will be considering alternative benefit packages or other options under a waiver that will bring efficiencies for both the existing Medicaid program and the expansion population.

5. Why should there be a hold-harmless clause for able-bodied adults who receive Medicaid?

Section 2 of HB 148 specifically excludes the expansion population from the provisions of the Permanent Fund Dividend (PFD) Hold Harmless Program. This means the dollar amount of the PFD will be considered for the expansion population when applying for Medicaid.

6. HB 148 provides significant details on expansion and the covered population, but very little detail on reform, a most important feature if expansion is going to be supported. Can

you detail some of the reforms you will undertake and when? (The timeline on the fiscal notes point to most reforms not being in place or seeing savings till FY18)

Expansion is a specific definition for a coverage group. Reform initiatives require detailed planning that includes provider input, beneficiary impact and cost/benefit analysis. Reform initiatives may also require federal approval of a Medicaid State Plan amendment and/or waiver which can take time as the state negotiates the proposal(s) with the Centers for Medicare and Medicaid Services (CMS). Reforms also require the development of more extensive state regulations including a public review and comment process.

Specific reforms initiatives are identified in HB 148. In addition, the bill includes broad authority necessary to pursue other reform initiatives. For example, the Medicaid Redesign and Expansion Technical Assistance RFP requests that five to ten different reform initiatives be identified, "…including potential demonstration projects, with the greatest potential for payment reform and service delivery, care model, and benefit plan reforms that meet the goals of optimized enrollee health and access, improved value in health care service delivery, and Medicaid cost containment."

7. Would DHSS be able to implement reforms on a quicker timeline if there were additional short-term dedicated regulation support staff at Department of Law? How many staff and at what cost?

As explained above, processes outside the regulation effort drive much of the timeline for reform implementation. Some additional support in the form a contractual regulation writer may help facilitate that portion of the process. We would roughly estimate this would cost in the range of $75,000 to $100,000, half of which the federal government would reimburse with 50% federal match.

8. Many see expansion as an opportunity to expand the use of managed care techniques in Alaska Medicaid, yet HB 148 is largely silent on the delivery model. Do you see expansion happening as we provide Medicaid today, or do you see innovative delivery models being introduced? If so, what opportunities do you see going forward?

The Department sees opportunities for innovative delivery models that restructure the way we deliver and pay for services. Other states have used a variety of different models. We need to be sure that the model or models we use fit Alaska. What works in Indiana, California or Arizona may not work for Alaska. The Medicaid Redesign and Expansion Technical Assistance RFP requests five to ten different reform initiatives be identified, "… payment reform and service delivery, care model, and benefit plan reforms that meet the goals of optimized enrollee health and access, improved value in health care service delivery, and Medicaid cost containment."

We view Medicaid expansion as an opportunity to support meaningful reforms. We are not alone in this. The Alaska State Hospital and Nursing Home Association views federally funded Medicaid expansion as a source of capital to support a health care transformation in Alaska.

9. The provider community involvement is essential to moving forward with meaningful reform and expansion. What have you been doing to enlist their input and counsel? Are any provider groups against expansion?

We are not aware of any provider groups that are against expansion. Many providers and provider groups and have sent letters or resolutions of support including: Alaska Behavioral Health Association, Alaska Native Tribal Health Consortium, Alaska Nurses Association, Alaska Pharmacists Association, Alaska Physical Therapy Association, Alaska Physicians & Surgeons, Alaska Primary Care Association, Alaska Psychological Association, Alaska State Hospital & Nursing Home Association, Alaska State Medical Association, Anchorage Community Mental Health Services, Anchorage Neighborhood Health Center, The Arc of Anchorage, Bartlett Regional Hospital, Bristol Bay Area Health Corporation, Catholic Community Services, Catholic Social Services, Central Peninsula Hospital, Community Connections, Cordova Community Medical Center, Fairbanks Community Mental Health Services, Family Centered Services of Alaska, Hope Community Resources, Inc., Juneau Alliance for Mental Health, Inc., Juneau Youth Services, Mat-Su Health Services, Inc., NAMI, Narcotic Drug Treatment Center, Inc., North Star Behavioral Health, Norton Sound Health Corporation, Peninsula Community Health Services of Alaska, Petersburg Mental Health Services, Inc., Railbelt Mental Health & Addictions, Rainforest Recovery Center, SeaView Community Services, Sitka Counseling & Prevention Services, Southcentral Foundation, Southeast Alaska Regional Health Consortium, South Peninsula Behavioral Health Services, Inc., Tanana Valley Clinic, Valley Medical Care, and Yukon-Kuskokwim Health Corporation.

A full list of organizations and municipalities that support Expansion and Reform can be found at http://gov.alaska.gov/Walker/priorities/accessible-healthcare/support-for-medicaid.html

10. Both the Governor and the Department have referred to a study that states expansion will generate 4,000 new jobs. Can you provide some details on where these jobs are? If they are mostly in healthcare, do we have the capacity to meet the increased demand?

The study referenced is *Fiscal and Economic Impacts of Medicaid Expansion in Alaska* by Northern Economics, released Feb. 1, 2013 The report can be found at http://www.anthctoday.org/news/Final%20Report-Fiscal%20and%20Economic%20Impacts%20of%20Medicaid%20ExpansioninAlaska.pdf

The 4,000 jobs are expected to be generated over six years, not all at once. The jobs will be combination of health care and other associated sectors. The new jobs will be spread all around the state. We anticipate they will be is a similar geographic proportion as the expansion group itself. By regions, that would be:

Northern: 12%

Interior: 14%
Southwest: 3%
Gulf Coast: 14%
Anchorage/Mat-Su: 51%
Southeast: 6%

We expect the health care system to accommodate the new enrollees. They are not expected to all enroll at once and systems will build as they do. As care shifts from uncompensated hospital care to compensated clinic and other types of more appropriate care, there will be shifts in types of providers. We will continue to work with the Alaska Health Work Coalition and others to enhance Alaska's provider capacity.

11. What benefits are provided to Medicaid recipients compared to those provided by the State Healthcare policy? What benefits are provided compared to Tri-care, Medicare, and the Veterans' Administration?

Medicaid covers most of the same primary and acute care that private health insurance and Medicare covers. Medicaid also covers Nursing Home care and other long term care services where other coverage has little to no coverage of long term care. Medicaid does not cover care when traveling outside of the U.S. while others do.

The Veterans' Administration has different coverage depending on whether the individual is retired or has a service connected disability. If they have a service connected disability they can only receive services related to the disability. If they have retirement services, their coverage is similar to Medicaid. The Veterans Health Administration (VHA) manages the provision of hospital care and medical services through an enrollment system based on a system of priorities. Veterans are classified into eight enrollment Priority Groups based on an array of factors, including service-connected disabilities or exposures, prisoner of war (POW) status, receipt of a Purple Heart or Medal of Honor, and income.

12. How can we be sure that the MMIS system, which that was recently identified as having 2 critical defects, 3 high defects, 81 moderate defects, and 1 low defect is functioning properly before we add 20,000 – 40,000 new Alaskans to the Medicaid roster? Why should we not wait until we have the system certified and a SSAE 16 report? What would it cost the state should we have to carry the expansion costs, until the system is certified?

The system is now processing more than 90 percent of new claims without suspension; i.e., claims are paid or denied the first time they are submitted. The system is also meeting and exceeding timeliness standards. No claims processing system in the country pays claims 100% correctly.

The majority of the remaining defects do not affect claims processing and payment. The remaining defects range from a spelling error on a page to those that affect claims payment.

Please see DHSS' Medicaid Claims Payment System: Background and Status, published May 11, 2015 for more information. (Please see Attachment B)

Typically states have their systems running for six months with claims pricing and paying correctly prior to requesting certification.

For the SSAE16 report, Xerox has already put an RFP out to bid and we should have reports for FY 14 and FY 15 this summer.

Federal reimbursement for Medicaid services is not contingent on MMIS certification. The State would be eligible for the federal match for the expansion population immediately upon expansion.

13. Is it true that the Federal Government will not make any provider payments until such time as the system is certified and we have a clean SSAE report? Does this mean that the State would have to carry all payments until the system is certified?

It is not true. The only funding contingent on Enterprise certification is funding of maintenance and operation of the system by the fiscal agent. Until certification, those expenditures are claimed at 50% federal match instead of 75% federal match. Upon certification, we will be eligible to retroactively claim the additional funds back to start of the new system.

All current claims continue to be reimbursed by the federal government at the agreed-upon FMAP rates: 100% for IHS, 90% for Family Planning, 65% for Breast and Cervical Cancer and CHIP, and finally, 50% for Medicaid.

Please see #12 for additional information.

14. Both the new eligibility system and the MMIS have encountered challenges in implementation. Have you spent additional funds, or do you anticipate spending additional funds to prepare for accepting the additional enrollees. If so, how much general funds do you believe are necessary?

The Department anticipates a total cost of $3.4 million in additional design, development and implementation costs in MMIS. Of this, $340,296 would be general fund and $3.1 million federal funds. These system development costs are covered 90 percent by the federal government.

The Department does not anticipate spending additional funds to prepare the new eligibility system (ARIES) for accepting the additional enrollees. System modifications required for the expansion population are covered under the current system development contract and within the current budget allocation.

15. What happens if we need to make changes to the demonstration waivers? The following changes have been denied in other states?

- ***AZ – Wanted cost sharing increases***
- ***CA – Wanted to increase co-pay***
- ***CT – Wanted to raise asset tests to limit eligibility***
- ***IN – Wanted to implement personal responsibility for failing to meet co-pay***
- ***OK – enrollment caps***

Demonstration waivers must always be negotiated with the Centers for Medicare and Medicaid Services (CMS), the agency responsible for ensuring federal law is followed. They have allowance to approve, or waive, certain provisions of law, but not others. For instance, CMS has taken the position that cost sharing maximums cannot be waived although they can be restructured.

16. Have Medicaid reimbursements been held at the same match rates. How much have they varied over the years and why? Please provide a chart for all reimbursement rates for service categories from 1990 to the present.

The federal medical assistance percentage, or FMAP, is applied to categories of eligibles and some specific services (family planning, tribal). The basic formula has remained steady for years. However, Congressional action has resulted in adjustments. Senators Frank Murkowski and Ted Stevens secured an enhanced rate for a few years and it was also temporarily increased through the American Recovery and Reinvestment Act of 2009 (ARRA). We started tracking this in electronic format in 1996. Attachment C is a chart of the historical match rates SFY 1996 through 2016 for Medicaid.

17. What is the cost of a private health insurance policy that would cover all of the items covered under Medicaid? What impact does Medicaid payments have on private plans?

The Department would need time to research these questions. It would be very difficult to make this a direct comparison because Medicaid provides coverage for long term care services which private insurance generally does not cover.

18. What happens if enrollment numbers exceed the forecasted numbers, as has happened in other states?

We have attached two charts to answer this question. Attachment D depicts what would happen if all 41,910 potential eligibles signed up on day one. The analysis shows that under HB 148, with full expansion enrollment and reforms, the State will save $329 million by the year 2022. If 60,000 Alaskans enroll on day 1, under HB 148 the projected state savings would be $286 million. (Please see Attachment E)

19. If we see a higher rate of enrollment than anticipated, say from 40,000 to 60,000 or 80,000, can the department handle it and can we afford it? It appears that all of the fiscal notes have been drafted with an expectation of enrollment of 20,000 Alaskans. What would the fiscal notes look like at 40,000 new enrollees and 60,000 new enrollees respectively? What happens after 2020? What assurances does the State of Alaska have that Medicaid expansion rates will not go to 50% - 60%?

See answer for #18 and the attached full enrollment chart. The analysis included additional administrative expense for a potential full enrollment. The Department does not anticipate 60,000 newly eligible under expansion. Neither the American Community Survey nor Evergreen Economics analysis estimate anything close to that number.

Although some states underestimated enrollment, others did not. Additionally, many of the actual enrollment figures for states in 2014 include the "woodwork effect" – the people who were already eligible for another type of Medicaid that came into the system because of the publicity of open enrollment and tax penalty for not having health care coverage. Alaska has already seen the increase associated with the "woodwork effect" following the first two open enrollment periods of the Affordable Care Act (ACA).

We would also expect the additional federal revenue would contribute to a larger positive economic impact that the currently expected 4,000 new jobs, $1.2 billion in wages and salaries and $2.5 billion in increased economic activity.

Federal law requires at least 90 percent federal match. A change would require an act of Congress and consent of the President.

20. What is the cost of the state's projected 50% of administrative expenses for administration of the Medicaid program?

Alaska's state share of Medicaid administrative expenses in FY2014 was $65 million which is 47% of the total. Medicaid administrative expenditures include a composition of expenditures associated with MMIS information technology allowable at 90% and operations at 75% federal reimbursement; Skilled Professional Medical Personnel (SPMP) allowable at 75% federal; and other types of Medicaid administrative expenditures allowable at 50%.

21. What is the financial effect of Alaska's 27 additional optional services not required by expansion on present enrollees and expansion enrollees? Should all enrollees take cuts or just new enrollees?

Cuts to services are not anticipated with expansion. The majority of the cost of optional services are for long-term care supports (home and community based waivers, personal care services). The Department does not anticipate the expansion group to require access to these services to any great degree which is why the cost-per-person estimate for the expansion population is lower than the current adult Medicaid recipient.

22. We know that Medicare has been the lowest payer in Alaska and this has created challenges for seniors on Medicare to get access to care. What will ensure that seniors on Medicare and tri-care veterans will not become secondary to Medicaid recipients with a higher medical pay? How will the Department address this?

There is no evidence that this has happened in other states, even in those states where Medicaid pays higher than Medicare. Private insurance and TRICARE also pay at higher rates than either Medicare or Medicaid. Alaska physicians are compassionate providers who also are responsible for running a small business. Providers have told us, to ensure a sustainable business model, they must allocate certain percentages of patients with private pay/TRICARE/Medicare/Medicaid and they do not plan to change that with expansion.

The Alaska Primary Care Association, an organization that represents health clinics across the state, has polled it members on this. A large percentage replied and 100% stated that clinics will continue to see Medicare beneficiaries. The Alaska State Hospital and Nursing Home Association also points out that hospitals have stepped up to meet the need for Medicare services.

A recent study by the US Government Accountability Office (GAO) found that people who have coverage prior to aging into Medicare are healthier when they become eligible for Medicare. This means lower costs and greater sustainability for the Medicare program. Please see Attachment F for a copy of that study.

The benefits of Medicaid expansion for older Alaskans have led Alaska's leading senior advocates to support Medicaid reform and expansion. AARP, Alaska Commission on Aging and AGENet are all on record in support.

23. When does the Department anticipate beginning to cover the expansion population should the legislature approve it?

The Department supports the August 1, 2015 start date in CSHB 148 and will be ready to implement at that time.

24. If the Department applies for a section 1115 waiver, are you going to focus on travel for this waiver? Do you anticipate assigning IHS beneficiaries that receive Medicaid to an IHS facility for their primary care?

The Department intends to approach an 1115 waiver in two phases. The first phase will focus primarily on providing and managing medically necessary transportation. This service will include arranging air and ground travel, accommodations, food, and case management of the service delivery, referral and follow up.

Phase two would look to have tribal health providers serve as medical homes for IHS beneficiaries. Federal law requires that we provide freedom of choice of providers to all Medicaid recipients. We may be able to waive this requirement under an 1115 waiver or take advantage of other cost effective alternatives to direct IHS beneficiaries to tribal health providers.

25. How does the Department envision Medicaid expansion interacting with Indian Health Services?

Indian Health Service (IHS) beneficiaries who are in the expansion group will be able to access medically necessary services in the same facilities as current Medicaid beneficiaries. Medicaid expansion will provide tribal facilities with additional revenues, which will allow them to expand and enhance the tribal health care system. Alaska's tribal health providers are some of the state's strongest supporters of Medicaid expansion and reform.

26. Currently Indian Health Care is federally covered at 100%, under Medicaid the State of Alaska has to pick up 10% of the costs. How much will this cost the state and how does this benefit the state? How many tribal beneficiaries currently do not use tribal facilities for Medicaid covered services?

When a Medicaid beneficiary is also an IHS beneficiary and is seen in an IHS facility (including Alaska's tribally operated facilities), Alaska is reimbursed at 100 percent federal funds. This will not change as a result of Medicaid expansion.

Historically, many services covered by Medicaid, such as nursing facilities, Residential Psychiatric Treatment Centers, Home Community Based waivers, and Personal Care Attendants were not funded through the IHS and have largely been provided by non-tribal facilities. However, the additional revenue provided by Medicaid expansion may assist tribal health organizations to expand into these categories of service, which could result in additional Medicaid expenditures eligible for 100% federal reimbursement.

27. With the lack of health care providers in Alaska, how can the Department ensure that emergency room visits will not increase?

The majority of the expansion group is expected to have minimal health care needs. The Feb. 6, 2015 Evergreen Economics report (Attachment G) includes a survey result that over 90% of the group rate themselves in "good" to "excellent" health. Those that use the emergency room inappropriately will be referred to the Department's "Super Utilizer" program for care management.

With more covered people, we would expect a small increase in emergency room visits, and these would be paid rather than uncompensated. Arkansas, one state that expanded under the ACA, saw total visits to emergency rooms increase by less than 2%, and reported a 35.5% decline in emergency room visits by uninsured patients.

28. Will existing Medicaid eligible recipient groups with a lower Federal match of 50 – 65% suffer more cuts because the expansion group is covered at a higher 100 - 90% rate?

No.

29. What assurances does Alaska have that once we expand Medicaid we can change our mind, or have we entered into a legally binding agreement with the Federal Government?

Following the discussion about this at the March 5, 2015 Medicaid Expansion House Finance hearing, we requested and received clarification from US Department of Health and Human Services Secretary Sylvia Burwell. She states: "…Alaska may take up the Medicaid coverage expansion and then later drop it at state option. There is not requirement for a state to maintain coverage for the new adult group." (Please see Attachment H for a copy of the letter)

30. At this time what are the costs to set-up and administer this program for DOC since a sizeable number of inmates will now be qualified for coverage?

No additional administrative costs are anticipated. The dollar amount of the covered care is high, but the number of actual enrollees is low – the $7 million in annual GF savings is expected to come from in-patient hospitalizations for only about 160 enrollees.

31. Please provide a timeline on how Medicaid expansion would work, were it to be approved today? How long before we would start to receive Federal funds and what would be the shared match if our MMIS is not certified and we have not received a SSAE 16 report?

The Department is on track to implement August 1, 2015. We would begin accepting applications in July 2015. System changes and policy changes are on track to be complete by July as well. The second part of this question is addressed in the answer #12 and #13 .

32. What is the status of the State's lawsuit against Xerox and is the state still claiming as of today that we are currently accruing damages due to the system's defects?

The case before the Office of Administrative Appeals is currently stayed while the parties meet to discuss resolution of any outstanding work, defects, or change requests necessary for completion of the DDI phase of the contract. The parties are also developing performance

measures and credits for the operations and turnover phases of the contract. Additional delay credits (liquidated damages) are not being assessed during this time.

33. What is the current status of other lawsuits against the Department of Health and Social Services related to the current Medicaid population? Please list the cases and the main issue of each case.

Filipino American Assisted Living Providers Association v. DHSS: This class action complaint for injunction, damages, and declaratory relief related to the Department efforts to engage in cost base rate setting for assisted living home operators.

Putnam and Brown v. State of Alaska, DHSS, DSDS: Litigation filed on behalf of two Medicaid nursing home recipients, requesting a preliminary injunction, and declaratory and injunctive relief arguing that the notices sent by the Department violated due process because they did not engage in a material improvement analysis/process similar to what is done when terminating a person from a home and community based waivers under AS 47.07.045.

Henderson v. DHSS, DHCS: Litigation related to the Department's protocols regarding the approval for prior authorization for the hepatitis C drug Sovaldi violated federal and state law. The drug in question is Sovaldi, a relatively new treatment for hepatitis C with a high rate of success in patients with the disease, along with a cost of $84,000 for each course of treatment. At issue is whether the criteria were properly adopted under the Administrative Procedures Act, whether the policy unjustly discriminates in violation of 42 CFR 440.230(c), and whether the notice of denial comports with due process.

Nafalhu v. SDS: Litigation related to the Division of Senior and Disabilities Services (SDS) alleging that the process used by SDS to determine eligibility for personal care services violates due process because eligibility is not based solely upon the assessment but is put through a quality control system to assure the accuracy of the assessment in light of all other factors, such as medical diagnoses and medical records.

34. Currently, those who work at minimum wage earn $20,293 per year. Eligibility for Medicaid Expansion caps income at $20,314 per year. At proposed eligibility level by 2017 all full-time minimum wage workers in Alaska will be ineligible. This will force workers to choose between full-time work and Medicaid coverage. What solution do you see for this issue?

Workers will not need to make this choice. The Affordable Care Act was designed so that people are supported in their transition from Medicaid to the Marketplace. Those at the lower income scale, such as the people in this question, will transition to the Marketplace where they will receive significant subsidies to reduce their monthly insurance premiums as well as cost-

sharing reductions to lower their out-of-pocket expenses when they receive health care services. Attachment I is an explanation of how this works called "Pathway off Medicaid."

35. With a shortage of providers and lower reimbursement rates for Medicare patients, some seniors are having difficulty finding a physician to care for them. In Interior Alaska this has proven true. Texas, for example, found that doctors willing to take new Medicare patients dropped by 50% in the last two years. What solution do you see for this problem?

There has been misinformation about the dire effects of Medicaid expansion in Texas where seniors could not find doctors. Texas has not expanded Medicaid.

Please see question #22 for additional detail.

36. Does the administration support changing the current law to allow Alaska licensed physicians, who live outside of Alaska, to work in a Telemedicine roll by coordinating with medical professionals here?

The administration supports increased access to health care, and the Department of Health & Social Services intends to enhance telemedicine capability under the reform initiatives outlined in HB 148. Through this reform initiative the department will investigate and address barriers to telemedicine, including legal barriers. The department does not have a position on existing law or pending legislation at this point in time.

37. One of the primary concerns is the fiscal implication for the future. Medicaid is the fastest growing formula program in our state budget. Some estimates claim that by 2032 Medicaid funding (without expansion) will consume the lion's share of the state's budget. Other states who have expanded Medicaid have found that small employers drop health insurance for their employees, knowing that they now have another option which has resulted in some cases of up to 50 percent higher rate of enrollment than estimated. What solution do you see to prevent low-income employees from losing their employer-provided health care?

Please be aware that the 2012 - 2032 Medicaid long-term forecast is now updated with the 2014 – 2034 forecast which shows a reduced Medicaid growth projection from the prior reports. The lowered projection is due to cost containment actions, slower growth in healthcare price inflation and slower population growth projected by the Alaska Department of Labor.

Legislative Finance Director David Teal testified to the House Finance Committee last week that the proportion of the state's budget dedicated to health care and education has remained roughly constant over the past decade, at 60 percent.

We know of no studies that tie employers dropping of health insurance to ACA related Medicaid expansion. Surveys done in 2014 by the Employee Benefit Research Institute and the Society of

Human Resource Management found the Affordable Care Act had not prompted employers to drop health benefits. We do know that employers have been steadily reducing health insurance coverage for at least two decades. Increases in the cost of health care and more people working part time or on contract are considered to be contributing factors. We expect that lowering the rates of uncompensated care in Alaska will contribute to lower health care costs.

38. HB 148 has a proposal to authorize a provider tax up to the maximum extent allowed by federal law to offset some of the cost of the Medicaid program, on Private Health Care Providers which includes: nursing services, chiropractors, doctors, nurse practitioners, opticians,, laboratories, home health care agencies, nursing homes, hospitals, physical therapists, pharmacies, etc. Is the maximum extent 6%? How will this effect small providers?

HB 148 does not authorize a provider tax. Rather it directs the Department to procure a contractor who will work with the Department and stakeholders (this will be primarily providers) to present a proposal to the Legislature in January 2016 for consideration. No tax would become law without legislative approval.

Federal law requires that provider taxes be broad-based, uniformly imposed, and not hold providers "harmless." In most States, provider taxes are no more than 6% of provider revenue because any tax less than or equal to 6% is considered to not hold providers harmless.

Provider taxes typically do not affect small providers. Here is a link to a Kaiser Family Foundation report that provides information on provider taxes across the country: http://kff.org/medicaid/state-indicator/medicaid-provider-taxes-in-place/

Governor Walker has stated that he would not propose any tax that would result in a loss of medical providers in Alaska.

39. How much has been spent to date on eliminating the backlog of Medicaid applications due to issues with the Enterprise system?

The backlog of Medicaid applications is unrelated to the Enterprise system. The eligibility backlog was caused by the delayed implementation of ARIES and issues with the federal exchange that did not refer individuals eligible for Medicaid in a timely fashion.

40. What expansion has already been implemented, if any?

The only expansion of Medicaid from the Affordable Care Act has been to implement the mandatory provision that Medicaid cover those who have "aged out" of foster care until age 26.

41. How many Alaskans are currently enrolled in Medicaid and how many use services?

The most accurate answer to this is to refer to the unduplicated numbers for FY 2014. In that year, the unduplicated number of Medicaid enrollees was 157,484. Of that number, 139,755 received services. (Note this statistic was developed in March 2015. Because it can take up to a year for incurred services to be submitted for reimbursement and processed, the number may rise when final data is compiled in July or August of 2015.)

ATTACHMENT A

State Health Reform Assistance Network
Charting the Road to Coverage

ISSUE BRIEF
March 2015

Medicaid Expansion States See Significant Budget Savings and Revenue Gains

Early Data From Two States Shows More Than $1 Billion in Savings

*Prepared by **Deborah Bachrach**, **Patricia Boozang**, and **Dori Glanz**, Manatt Health Solutions*

Kentucky and Arkansas, two states that expanded Medicaid to cover adults up to 133 percent FPL, are seeing significant savings in their state budgets that will cover all expansion-related costs well beyond state fiscal year (SFY) 2021.

- **Kentucky estimates saving $820 million**, net of costs, from SFY '14 to SFY '21
- **Arkansas estimates saving $370 million**, net of costs, from SFY '14 to SFY '21

For states that are considering Medicaid expansion, Kentucky and Arkansas are examples of how expansion can produce savings in tax dollars and generate new revenue for state budgets.

As states continue to look for new ways to balance their budgets, early results from states that have expanded Medicaid show significant state budget savings after just the first year of expansion. Twenty-six states have expanded Medicaid—this brief focuses on the budget impact in two states: Kentucky and Arkansas.[i] Both states report expansion-related savings and Arkansas reports new revenues. When projected forward, these financial gains are likely to exceed expansion-related costs for years to come. These early savings point to Medicaid expansion paying for itself at least through SFY 2021—while generating major gains in coverage and reducing the number of uninsured.

ABOUT STATE NETWORK
State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit *www.statenetwork.org*.

ABOUT MANATT HEALTH SOLUTIONS
Manatt Health Solutions (MHS) is an interdisciplinary policy and business advisory division of Manatt, Phelps & Phillips, LLP, one of the nation's premier law and consulting firms. MHS helps clients develop and implement strategies to address their greatest challenges, improve performance and position themselves for long-term sustainability and growth. For more information visit *www.manatt.com/manatthealthsolutions.aspx.*

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION
For more than 40 years the Robert Wood Johnson Foundation has worked to improve health and health care. We are striving to build a national Culture of Health that will enable all to live longer, healthier lives now and for generations to come. For more information, *www.rwjf.org*. Follow the Foundation on Twitter at *www.rwjf.org/twitter* or on Facebook at *www.rwjf.org/facebook*.

For more information, please contact Patricia Boozang at *PBoozang@manatt.com* or 212-790-4523, or Deborah Bachrach at *DBachrach@manatt.com* or 212-790-4594.

Robert Wood Johnson Foundation

While data is still limited, the savings and increased revenue seen in expansion states fall into three major categories:

1. **STATE SAVINGS FROM USING NEW FEDERAL FUNDS:** Historically, many states have supported programs and services for the uninsured—mental and behavioral health programs, public health programs, and inpatient health care services for prisoners—with state general fund dollars. With expansion, virtually all of the beneficiaries of these programs and services are able to secure Medicaid coverage in the new adult category, which means states can fund these services with federal—not state—dollars. **Kentucky saved $9 million in 2014 as enrollees in behavioral and mental health programs were fully covered by Medicaid.**

2. **STATE SAVINGS FROM ENHANCED FEDERAL MATCHING:** States are saving money as they are now able to cover those most in need with 100 percent federal funding. In the past, states often used waivers or specialized Medicaid eligibility categories to provide at least some coverage to high-need enrollees, such as "medically needy" individuals, pregnant women, and the disabled. They typically had to pay between 30 and 50 percent of the cost of covering such individuals. With expansion, these individuals are now eligible for full Medicaid coverage—which means they (and the state) will save money while receiving full Medicaid benefits. **Arkansas saved $17.5 million in 2014 by accessing the 100 percent federal match for adults previously enrolled in waiver programs and targeted categorical eligibility groups who transitioned to the new adult group.**

3. **REVENUE GAINS:** Many states raise revenue through assessments or fees on providers and health plans. As provider and health plan revenue increases with expansion, this translates into additional revenue for states. **Arkansas saw revenue gains of $4.7 million in 2014.**

The following chart summarizes early results on savings and revenue gains in Kentucky and Arkansas. Many other states are beginning to report comparable economic information, and all states are finding additional benefits ranging from significant drops in the number of uninsured to a reduction in uncompensated care costs to the creation of tens of thousands of jobs.

State Savings and Revenue Gains Related to Medicaid Expansions in Kentucky and Arkansas[ii]				
	Kentucky[iii]		Arkansas[iv]	
Year	SFY 2014 7/1/13 – 6/30/14 6 months of actual savings	SFY 2015 Projected savings based on 2014 results	SFY 2014 7/1/13 – 6/30/14 6 months of actual savings	SFY 2015 Projected savings based on 2014 results
Medicaid Budget (State Share Only)	$1,980 million[v]	$2,080 million[vi]	$1,541 million	$1,537 million
Regular Federal Matching Rate	69.83%	69.94%	70.10%	70.88%
State Savings From Using New Federal Funds				
	Kentucky		Arkansas	
Year	SFY 2014	SFY 2015	SFY 2014	SFY 2015
TOTAL SAVINGS	**$18.4 million**	**$49.8 million**	**$13.3 million[vii]**	**$33.4 million**
Mental/Behavioral Health Programs	$9 million	$21 million	N/A	$7.1 million
Inpatient Costs of Prisoners	$5.4 million	$11 million	N/A	$2.8 million
Public Health Programs	$4 million	$6 million	N/A	$6.4 million
Uncompensated Care Funding to Hospitals	N/A	$11.8 million[viii]	N/A	$17.2 million
State Savings from Enhanced Federal Matching				
	Kentucky		Arkansas	
Year	SFY 2014	SFY 2015	SFY 2014	SFY 2015
TOTAL SAVINGS	**$7.4 million**	**$33.3 million**	**$17.5 million**	**$55.4 million**
Medically Needy Spend Down	$2.4 million	$14 million	$1.7 million	$6.6 million
Disabled Adults	$1.7 million	$7.9 million	$2.2 million	$9.0 million
Breast and Cervical Cancer Treatment Program	$0.4 million	$1.3 million	$2.2 million	$4.4 million
State Transitional Assistance Program	$1.9 million	$9 million	N/A	N/A
Pregnant Women	N/A	N/A	$4.9 million	$19.6 million
Family Planning	N/A	N/A	$0.8 million	$1.6 million
Waiver Programs for Adults	N/A	N/A	$5.7 million[ix]	$14.2 million[x]
Revenue Gains				
	Kentucky		Arkansas	
Year	SFY 2014	SFY 2015	SFY 2014	SFY 2015
TOTAL REVENUE GAINS	**N/A**	**N/A**	**$4.7 million**	**$29.7 million**
Revenue From Insurer Assessments	N/A	N/A	$4.7 million	$29.7 million
Revenue From Provider Assessments	N/A	N/A	N/A	N/A

End Notes

[i] This report is the first in a two-part series examining the impact of Medicaid expansion on state budgets.

[ii] All figures are estimates, based on early expansion experience.

[iii] Kentucky figures were sourced from the February 2015 Commonwealth of Kentucky Medicaid Expansion Report, available online at *http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf*.

[iv] All Arkansas figures were sourced from interviews with state budget experts and leaders.

[v] 2014-2016 Budget of the Commonwealth, Operating Budget Volume I (Part B), Page 158. Available online at: *http://www.osbd.ky.gov/NR/rdonlyres/64166014-AA66-4D99-90E7-9269F99E4B30/0/1416BOCVolumeIBcorrected.pdf*.

[vi] Id.

[vii] The breakout for this category of savings is not available for SFY 2014.

[viii] This line item reflects reductions in budgeted funding for the Kentucky Quality Care Charity Trust Funds, to cover economically disadvantaged populations.

[ix] Savings reflect reductions in spending on the ARHealthNetwork waiver population.

[x] Id.

ATTACHMENT B

Medicaid Claims Payment System: Background and Status

Background

In October 2013, the Alaska Medicaid program deployed a new Enterprise system developed by Xerox Corporation to replace its 25-year-old claims processing system. These systems are known as Medicaid Management Information Systems (MMIS).

There were significant and widespread performance problems with the new system; large numbers of claims were either suspended or denied in error, causing providers to experience serious difficulties getting paid.

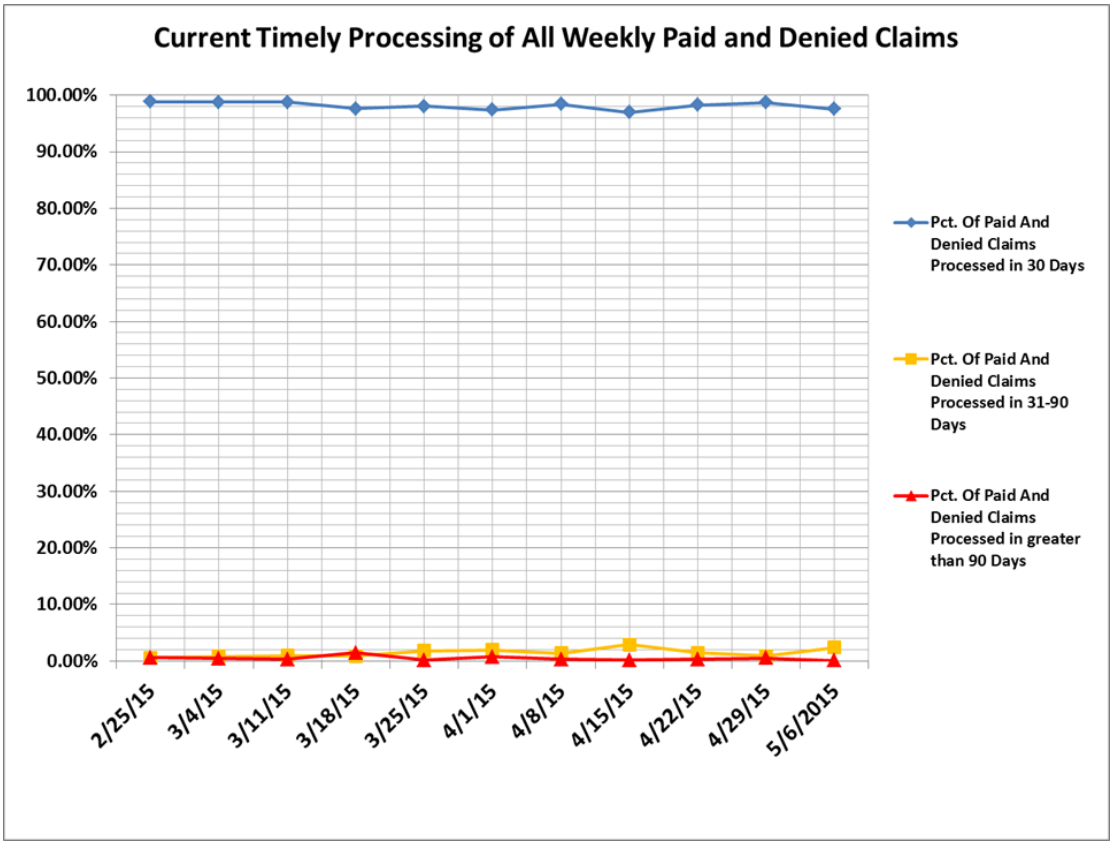
While Xerox worked to fix the system, the State issued advance payments to providers on request to provide financial stability. To date, the State has made over $165 million in advance payments. Of that, the State has recouped $70 million as of May 1, 2015.

Please see page 4 of this report for a timeline of relevant events.

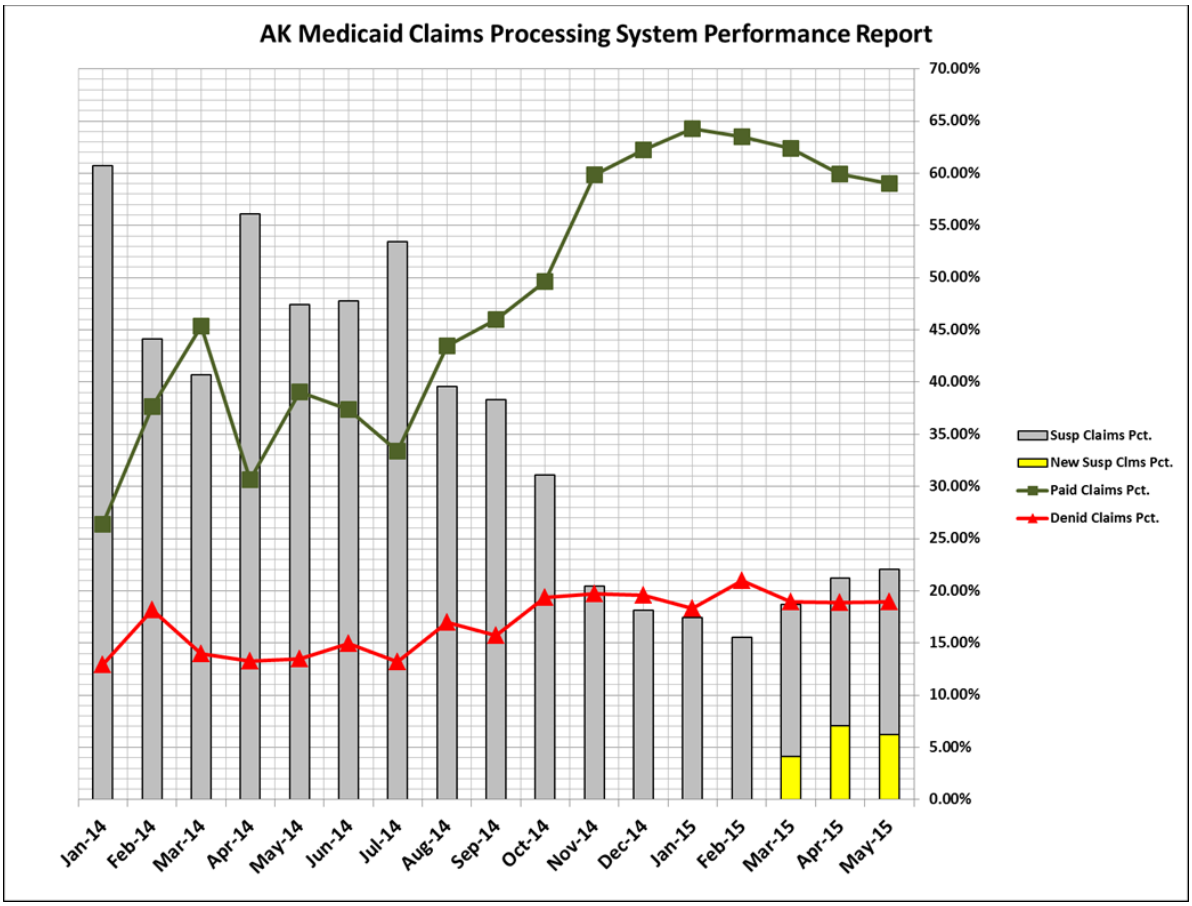
Status of claims processing

Since December 2014, Xerox has made significant improvement. The system is now processing more than 90 percent of *new claims* without suspension; i.e., claims are paid or denied the first time they are submitted. This is better performance than the old legacy system.

The system is also meeting and exceeding timeliness standards. The chart below shows timeliness of paid and denied claims since February 25, 2015.



The chart below shows the disposition of claims from January 2014 through May 2015. "Suspended claims" includes both old claims that are continuing to suspend, and new claims, which are suspending at a much lower rate. The State began tracking old and new claims separately in March. *Please see page 3 for definitions.*



Of the 9 percent of new claims that are suspending, many are suspending correctly. A certain percentage of claims should suspend, because certain types of claims require manual review:

- **School-based services** are set to suspend pending payment of the school district's state match. The claim is paid once payment is received.
- **Durable medical equipment** claims are set to suspend for manual review of the invoices to verify amounts due.
- Claims that require **medical necessity justification** suspend until payment is authorized.
- Claims that were first **billed to insurance** suspend until any insurance payments are reviewed.

Payment Process and Definitions

When a provider submits a claim to MMIS, the claim can be *paid, denied,* or *suspended*.

Paid: The claim is paid.

Denied: The claim is not paid. To be reconsidered, it must be resubmitted or reprocessed.

Suspended: The claim is not paid or denied, but is flagged for further review. It is automatically reprocessed each time claims are run, until it goes into paid or denied status.

Each of these outcomes can occur *correctly* or *in error*.

Timeliness:

- **Timely Claims Filing**: Providers have up to 12 months from the date of service to bill, so it is possible to pay a claim timely more than a year after a service has been provided.
- **Timely Claims Processing**: To be considered timely-processed, 90 percent of most claims must be paid or denied within 30 days of the date of receipt. Ninety-nine percent of most claims must be paid or denied within 90 days of the date of receipt.

Backlog

Xerox is working through a backlog of incorrectly suspended claims that developed when the system was deployed in October 2013.

The State advanced payments to providers so as not to penalize providers for a faulty system. Xerox has now worked through the bulk of the backlog of suspended claims. The State currently makes about 5 advance payments a month due to system-related delays system. The remaining backlog involves reprocessing previously submitted claims that were paid or denied in error. The State anticipates this reprocessing will be completed by the end of the calendar year.

Readiness for Expansion

The State's Medicaid payment system currently processes claims for more than 150,000 beneficiaries. Expansion is expected to add 20,000 beneficiaries in the first year, an increase of 13 percent. Actual claims are anticipated to increase at a lower rate, because the expansion population is expected to use fewer services per person than those individuals currently covered by Medicaid. This is because the expansion population is comprised of non-disabled adults without dependents. Those currently covered are the disabled, children, and adults with dependents including pregnant women.

The Walker administration is proposing to expand Medicaid effective August 1, 2015. Given the progress that has been made over the past six months with the Medicaid payment system, its current level of function, and ongoing system improvements, the State and Xerox believe the payment system will be able to handle the additional claims generated by Medicaid expansion without adversely impacting providers.

Timeline

October 2013 – Xerox deploys new Medicaid claims payment system with widespread performance problems. State suspends payments for MMIS Enterprise work.

August 2014 – State finds Xerox in breach of contract due to performance problems.

September 2014 – Mediation between State and Xerox fails; State requests hearing before an administrative law judge on liquidated damages. State suspends payment for Xerox fiscal agent operations.

October 2014 – Xerox agrees to corrective action plan with March 2015 deadline for resolving all major defects. Plan stipulates that Xerox will not be paid until it satisfactorily meets the terms of the corrective action plan.

December 2014 – Governor Walker sworn in; appoints Commissioner Valerie Davidson; Governor meets personally with top Xerox officials.

February 2015 – Administrative hearing on liquidated damages. Decision pending; next hearing scheduled for August 2015.

March 2015 – Xerox makes significant progress but does not meet March deadline and remains under corrective action plan. Of 17,000 defects identified, fewer than 100 remain. Ninety percent of new claims are processing correctly.

May 2015 – As of May 1, the system is suspending claims at a lower rate than at any time since the system was deployed, at a rate of 9 percent. Following Xerox's deployment of fixes in April, 74 defects remain, with 3 rated critical.

ATTACHMENT C

Alaska Department of Health and Social Services
Historical Federal Medical Assistance Percentage (FMAP) by State Fiscal Year
May 11, 2015

		SFY Average							
SFY	**Final or Preliminary**	**XIX**	**XXI**	**BCC**	**Fam Plan**	**IHS**	***Regular FMAP**	**ARRA FMAP**	**IV-E**
SFY96	F	50.00	n/a	n/a	n/a	100	50.00	n/a	50.00
SFY97	F	50.00	n/a	n/a	n/a	100	50.00	n/a	50.00
SFY98	F	57.35	71.86	71.86	90	100	57.35	n/a	50.00
SFY99	F	59.80	71.86	71.86	90	100	59.80	n/a	51.70
SFY00	F	59.80	71.86	71.86	90	100	59.80	n/a	53.66
SFY01	F	60.05	72.03	72.03	90	100	60.05	n/a	55.56
SFY02	F	58.07	70.65	70.65	90	100	58.07	n/a	57.05
SFY03	F	58.79	71.15	71.15	90	100	58.79	n/a	54.84
SFY04	F	61.31	72.92	72.92	90	100	61.31	n/a	53.99
SFY05	F	57.78	70.45	70.45	90	100	57.78	n/a	53.42
SFY06	F	57.58	70.31	70.31	90	100	57.58	n/a	50.93
SFY07	F	57.58	70.31	70.31	90	100	57.58	n/a	50.84
SFY08	F	53.76	67.63	67.63	90	100	53.76	n/a	52.13
SFY09	F	57.74	65.71	65.71	90	100	51.02	57.74	57.13
SFY10	F	61.79	65.84	65.84	90	100	51.21	61.79	58.68
SFY11	F	60.54	65.25	65.25	90	100	50.36	60.54	56.68

SFY12	F	50.00	65.00	65.00	90	100	50.00	n/a	50.00
SFY13	F	50.00	65.00	65.00	90	100	50.00	n/a	50.00
SFY14	F	50.00	65.00	65.00	90	100	50.00	n/a	50.00
SFY15	F	50.00	65.00	65.00	90	100	50.00	n/a	50.00
SFY16	P	50.00	65.00	65.00	90	100	50.00	n/a	50.00

KEY:

XIX	Regular Title 19 Medicaid
XXI	Children's Health Insurance Program Medicaid Title 21
BCC	Breast and Cervical Cancer
Fam Plan	Family Planning Services
IHS	Indian Health Services
ARRA	American Recovery and Reinvestment Act – Replaced XIX FMAP

Prior to FFY1998, Alaska's FMAP was 50%, while IHS services received 100% federal reimbursement. Since that time, Alaska's FMAP has varied due to the per capita personal income of Alaskans in comparison to those in the rest of the country; special legislation, courtesy of our Congressional delegation (Senator Ted Stevens), and stimulus funds.

How FMAP Rates are Calculated:

The Federal Medical Assistance Percentage (FMAP) formula compares each state's per capita income relative to U.S. per capita income. The formula provides higher reimbursement to states with lower incomes (with a statutory maximum rate of 83%) and lower reimbursement to states with higher incomes (with a statutory minimum of 50%).

The Department of Health and Human Services usually publishes FMAP rates for an upcoming fiscal year in the Federal Register during the preceding November. This time lag between announcement and implementation provides an opportunity for states to adjust to rate changes.

Table A-1 (in the report link below) shows regular FMAP rates for each of the 50 states and the District of Columbia from FY2016 – FY2014.

https://www.fas.org/sgp/crs/misc/R42941.pdf

ATTACHMENT D

Alaska Department of Health & Social Services
MEDICAID EXPANSION & REFORM: STATE SAVINGS & FEDERAL REVENUE
Assumption: Full Enrollment with HB 148-H Reforms
Except for Spending per Enrollee, Costs/Savings are in Thousands

			FY 2016	FY2017	FY2018	FY2019	FY2020	FY2021	Total
	Newly Eligibles		41,910	41,980	42,050	42,120	42,190	42,260	
	Spending per Enrollee *(in whole dollars)*		$7,248	$7,495	$7,752	$8,018	$8,293	$8,433	
	Federal Medical Assistance Participation (FMAP) [1]		100%	97.8%	95.2%	94.3%	92.6%	91.3%	
EXPANSION	Health Care	Federal Revenue	$303,763.7	$307,718.0	$310,325.0	$318,468.2	$323,990.4	$325,373.6	**$1,889,638.9**
		State Spending	$0.0	$6,922.1	$15,646.6	$19,250.0	$25,891.3	$31,005.0	**$98,715.0**
	Administrative Costs	Federal Revenue	$1,538.5	$1,526.0	$664.7	$664.7	$664.7	$664.7	**$ 5,723.3**
		State Spending [2]	$0	$1,526.0	$664.7	$664.7	$664.7	$664.7	**$4,184.8**
	Savings from CAMA, Corrections and Behavioral Health Grants	State Savings	($6,583.6)	($13,300.0)	($20,901.0)	($24,999.7)	($28,027.6)	($28,055.7)	**($121,867.6)**
REFORM	Administrative Costs [3]	Federal Revenue	$561.7	$474.8	$648.3	$343.1	$343.1	$343.1	**$2,714.1**
		State Spending	$481.5	$394.7	$568.1	$343.1	$343.1	$343.1	**$2,473.6**
	Primary Care Case Management [3]	Federal Savings	($3,124.1)	($3,408.2)	($3,408.2)	($3,408.2)	($3,408.2)	($3,408.2)	**($20,165.1)**
		State Savings	($3,124.1)	($3,408.1)	($3,408.1)	($3,408.1)	($3,408.1)	($3,408.1)	**($20,164.6)**
	1115 Waiver for Tribal Partnerships [3]	Federal Revenue	$0.0	$6,500.0	$26,000.0	$56,500.0	$56,500.0	$87,000.0	**$232,500.0**
		State Savings	$0.0	($6,500.0)	($26,000.0)	($56,500.0)	($56,500.0)	($87,000.0)	**($232,500.0)**
	Home & Community-Based Services 1915(i) and 1915(k) Options [3]	Federal Revenue	$0.0	$0.0	$19,472.4	$19,507.5	$19,995.3	$20,034.7	**$79,009.9**
		State Savings	$0.0	$0.0	($15,117.4)	($15,117.4)	($14,762.0)	($14,759.2)	**($59,756.0)**
		Total New Federal Revenue	**$302,739.8**	**$312,810.6**	**$353,702.2**	**$392,075.3**	**$398,085.3**	**$430,007.9**	**$2,189,421.1**
		Total State General Fund Savings	**($9,226.2)**	**($14,365.3)**	**($48,547.1)**	**($79,767.4)**	**($75,798.6)**	**($101,210.2)**	**($328,914.8)**

[1] = FMAP based on federal calendar year rates: 2015 - 100%; 2016 - 100%; 2017 - 95% ; 2018 - 94%; 2019 - 93%; 2020 & beyond - 90%
The FMAP is adjusted to reflect the 100% FMAP rate received when Indian Health Service beneficiaries receive services at a tribal health facilities.

[2] = MHTAAR funds of $1,538.5 will cover FY2016 adminstrative costs

[3] = From CSHB148 (HSS) fiscal notes

5/7/2015

ATTACHMENT E

Alaska Department of Health & Social Services

MEDICAID EXPANSION & REFORM: STATE SAVINGS & FEDERAL REVENUE

Assumption: 60,000 Enrollment with HB 148-H Reforms

Except for Spending per Enrollee, Costs/Savings are in Thousands

			FY 2016	FY2017	FY2018	FY2019	FY2020	FY2021	Total
		Newly Eligibles	60,000	60,000	60,000	60,000	60,000	60,000	
		Spending per Enrollee *(in whole dollars)*	$7,248	$7,495	$7,752	$8,018	$8,293	$8,433	
		Federal Medical Assistance Participation (FMAP) [1]	100%	97.8%	95.2%	94.3%	92.6%	91.3%	
EXPANSION	Health Care	Federal Revenue	$434,880.0	$439,807.0	$442,794.0	$453,658.0	$460,759.0	$461,960.0	**$2,693,858.0**
		State Spending	$0.0	$9,893.0	$22,326.0	$27,422.0	$36,821.0	$44,020.0	**$140,482.0**
	Administrative Costs	Federal Revenue	$1,923.1	$1,907.5	$830.9	$830.9	$830.9	$830.9	**$7,154.1**
		State Spending [2]	$0.0	$1,907.5	$830.9	$830.9	$830.9	$830.9	**$5,231.0**
	Savings from CAMA[3], Corrections and Behavioral Health Grants	State Savings	($6,583.6)	($13,300.0)	($20,901.0)	($24,999.7)	($28,027.6)	($28,055.7)	**($121,867.6)**
REFORM	Administrative Costs [4]	Federal Revenue	$561.7	$474.8	$648.3	$343.1	$343.1	$343.1	**$2,714.1**
		State Spending	$481.5	$394.7	$568.1	$343.1	$343.1	$343.1	**$2,473.6**
	Primary Care Case Management [4]	Federal Savings	($3,124.1)	($3,408.2)	($3,408.2)	($3,408.2)	($3,408.2)	($3,408.2)	**($20,165.1)**
		State Savings	($3,124.1)	($3,408.1)	($3,408.1)	($3,408.1)	($3,408.1)	($3,408.1)	**($20,164.6)**
	1115 Waiver for Tribal Partnerships [4]	Federal Revenue	$0.0	$6,500.0	$26,000.0	$56,500.0	$56,500.0	$87,000.0	**$232,500.0**
		State Savings	$0.0	($6,500.0)	($26,000.0)	($56,500.0)	($56,500.0)	($87,000.0)	**($232,500.0)**
	Home & Community-Based Services 1915(i) and 1915(k) Options [4]	Federal Revenue	$0.0	$0.0	$19,472.4	$19,507.5	$19,995.3	$20,034.7	**$79,009.9**
		State Savings	$0.0	$0.0	($15,117.4)	($15,117.4)	($14,762.0)	($14,759.2)	**($59,756.0)**
		Total New Federal Revenue	**$434,240.7**	**$445,281.1**	**$486,337.4**	**$527,431.3**	**$535,020.1**	**$566,760.5**	$2,995,071.0
		Total State General Fund Savings	**($9,226.2)**	**($11,012.9)**	**($41,701.5)**	**($71,429.2)**	**($64,702.7)**	**($88,029.0)**	**($286,101.6)**

[1] = FMAP based on federal calendar year rates: 2015 - 100%; 2016 - 100%; 2017 - 95% ; 2018 - 94%; 2019 - 93%; 2020 & beyond - 90%
The FMAP is adjusted to reflect the 100% FMAP rate received when Indian Health Service beneficiaries receive services at a tribal health facilities.

[2] = MHTAAR funds of $1,538.5 will cover FY2016 adminstrative costs

[3] = Chronic & Acute Medical Assistance Program

[4] = From CSHB148 (HSS) fiscal notes

5/7/2015

ATTACHMENT F

United States Government Accountability Office

Report to Congressional Requesters

December 2013

MEDICARE

Continuous Insurance before Enrollment Associated with Better Health and Lower Program Spending

GAO-14-53

December 2013

MEDICARE

Continuous Insurance before Enrollment Associated with Better Health and Lower Program Spending

GAO Highlights

Highlights of GAO-14-53, a report to congressional requesters

Why GAO Did This Study

Nearly 7 million individuals aged 55 to 64—more than 18 percent of the pre-Medicare population—lacked health insurance coverage in the first half of 2012. Health insurance protects individuals from the risk of financial hardship when they need medical care, and uninsured individuals may refrain from seeking necessary care because of the cost. If they forgo medical care beforehand, these individuals may be in worse health and need costlier medical services after enrolling in Medicare compared to those with prior insurance.

GAO was asked to review the effects of having prior health insurance coverage on Medicare beneficiaries. This report examines the health status, program spending, and use of services of Medicare beneficiaries with and without continuous health insurance coverage before Medicare enrollment. To examine the effects of beneficiaries' prior insurance coverage, GAO used data from the Health and Retirement Study and Medicare claims to conduct two types of multivariate analysis. GAO predicted probabilities of beneficiaries' reporting being in good health or better and values for program spending and beneficiaries' use of services.

In comments on a draft of this report, the Department of Health and Human Services highlighted a key finding in GAO's report that beneficiaries with prior insurance used fewer or less costly medical services in Medicare compared with those without prior insurance.

View GAO-14-53. For more information, contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

What GAO Found

Beneficiaries with continuous health insurance coverage for approximately 6 years before enrolling in Medicare were more likely than those without prior continuous insurance to report being in good health or better during the first 6 years in Medicare. In particular, having prior continuous insurance raised the predicted probability that a beneficiary reported being in good health or better by nearly 6 percentage points during the first 6 years in Medicare.

Beneficiaries with prior continuous insurance had lower total program spending during the first year in Medicare compared with those without prior continuous insurance. Specifically, during the first year in Medicare, beneficiaries with prior continuous insurance had approximately $2,300, or 35 percent, less in average predicted total spending than those without prior continuous insurance. Similarly, beneficiaries with prior continuous insurance had lower institutional outpatient spending—for example, spending for services provided in a hospital outpatient setting—during the first and second years in Medicare compared with those without prior continuous insurance. In contrast, physician and other noninstitutional spending—spending for services provided by physicians, clinical laboratories, free-standing ambulatory surgical centers, and other noninstitutional providers—were similar during the early years in Medicare for beneficiaries with and without prior continuous insurance. However, during the fourth and fifth years in Medicare, beneficiaries with prior continuous insurance had physician and other noninstitutional spending that was about 30 percent higher than beneficiaries without prior continuous insurance.

Beneficiaries with prior continuous insurance had more physician office visits during the first 5 years in Medicare compared with those without prior continuous insurance. Specifically, during the first 5 years in Medicare, the difference in the average predicted number of physician office visits between beneficiaries with and without prior continuous insurance ranged from 1.3 to 2.5, or 23 to 46 percent. This utilization pattern may indicate that, even after Medicare enrollment, beneficiaries with prior continuous insurance continued to access medical services differently from those without prior continuous insurance. The number of institutional outpatient visits was similar for beneficiaries with and without prior continuous insurance for the first 5 years after Medicare enrollment.

Taken together, GAO's results show that, consistent with those of some other researchers, beneficiaries with prior continuous insurance used fewer or less costly medical services compared with beneficiaries without such insurance during the early years in Medicare, because they either were in better health or were accustomed to accessing medical services differently. This suggests that the extent to which individuals enroll in private insurance before age 65 has implications for beneficiaries' health status and Medicare spending.

Contents

Figures

Abbreviations

CMS	Centers for Medicare & Medicaid Services
HRS	Health and Retirement Study

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

December 17, 2013

The Honorable Max Baucus
Chairman
Committee on Finance
United States Senate

The Honorable Tom Harkin
Chairman
Committee on Health, Education, Labor, and Pensions
United States Senate

The Honorable Sheldon Whitehouse
United States Senate

Nearly 7 million individuals aged 55 to 64, the pre-Medicare population, lacked health insurance coverage in the first half of 2012, accounting for more than 18 percent of this population.[1] The health insurance coverage of pre-Medicare individuals may have implications for the Medicare program. Health insurance protects individuals against the risk of financial hardship when they need medical care, and uninsured pre-Medicare individuals may refrain from seeking necessary care because of the cost. As a result, these individuals may be in worse health and may require more costly medical services after Medicare enrollment compared with those who were insured. They also may, out of habit, continue to seek care differently. Previous research has produced inconclusive results concerning the extent to which, if at all, health insurance coverage before Medicare enrollment affects beneficiaries' spending and use of services after enrollment.[2]

[1]Agency for Healthcare Research and Quality, *Table 1: Health Insurance Coverage of the Civilian Noninstitutionalized Population: Percent by Type of Coverage and Selected Population Characteristics, United States, First Half of 2012*, accessed July 12, 2013, http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/hc/hlth_insr/2012/t1_a12.pdf.

[2]See, for example, Sandra L. Decker et al., "Health Service Use among the Previously Uninsured: Is Subsidized Health Insurance Enough?" *Health Economics* (October 2012); J. Michael McWilliams et al., "Medicare Spending for Previously Uninsured Adults," *Annals of Internal Medicine*, vol. 151, no. 11 (December 2009).

You asked us to provide information on the effects of Medicare beneficiaries' health insurance coverage before enrollment on their health status, spending, and use of services after enrollment.[3] This report compares (1) the health status of Medicare beneficiaries with and without continuous health insurance coverage before enrollment and (2) the spending and use of services by Medicare beneficiaries with and without continuous health insurance coverage before enrollment.

To examine the effects of continuous health insurance coverage before Medicare (our independent variable of interest) on beneficiaries' health status, spending, and use of services (our dependent variables of interest), we used data from the Health and Retirement Study (HRS) and Medicare claims. HRS is a longitudinal panel study that surveys a representative sample of more than 26,000 Americans aged 50 and older every 2 years. From HRS, we obtained information from 1996 through 2010 on beneficiaries' self-reported health insurance coverage before Medicare, self-reported health status in Medicare, and demographic and health-related characteristics. From the Medicare data, we obtained information from 2001 through 2010 on multiple categories of beneficiaries' Medicare spending (total, institutional outpatient, and physician and other noninstitutional spending) and services (institutional outpatient and physician office visits).[4]

[3]For this report, we use "spending" to refer to Medicare program spending, not beneficiary spending.

[4]We worked with Acumen, LLC, to link beneficiaries' HRS data with their Medicare data and to conduct statistical analyses of their spending and use of services based on programming specifications provided by GAO. HRS, which is administered by the University of Michigan with support from the National Institute on Aging and the Social Security Administration, partners with Acumen to link Medicare beneficiaries' HRS data to their Medicare data and to provide analytical support for these linked data. Total spending refers to Medicare's spending per beneficiary for all covered services: durable medical equipment, home health, hospice, inpatient, institutional outpatient, physician and other noninstitutional, and skilled nursing facility. Institutional outpatient spending refers to Medicare's spending per beneficiary for outpatient services provided by institutional providers, such as hospital outpatient departments, rural health centers, renal dialysis facilities, and outpatient rehabilitation facilities. Physician and other noninstitutional spending refers to Medicare's spending per beneficiary for services provided by certain noninstitutional providers, such as physicians, clinical laboratories, and free-standing ambulatory surgical centers. Institutional outpatient visits refer to services provided by institutional providers on an outpatient basis. Physician office visits refer to services provided by noninstitutional providers, such as physicians. We also examined home health and institutional inpatient spending and hospital stays, but the number of beneficiaries with data for these categories was too low to provide meaningful results.

Unlike other studies, we performed our analysis for multiple groups of Medicare beneficiaries categorized by their length of Medicare enrollment. This approach enabled us to maximize the number of beneficiaries in our study groups and to measure the effects of prior continuous insurance on health status, spending, and use of services at several points in time after Medicare enrollment. About 4,500 HRS respondents met our initial criteria that they were in their first, second, third, fourth, fifth, or sixth year of Medicare enrollment between 2001 and 2010 and provided information about their insurance coverage in each of the three consecutive HRS surveys preceding Medicare enrollment. Unlike some other studies on this topic that have categorized prior insurance based on a single point in time, we categorized beneficiaries as having prior continuous insurance only if they reported receiving private insurance in the three consecutive HRS surveys before Medicare enrollment at age 65—a period spanning approximately 6 years.[5] We excluded additional respondents who were enrolled in Medicare or Medicaid prior to Medicare enrollment at age 65 because their enrollment in these programs may have been due, at least in part, to poor health, which could bias our results.[6] We also excluded respondents who had missing or incomplete data for important variables. Our final study sample size ranged from 3,201 to 1,152, depending on the analysis.

Our analyses of health status relied on HRS data that were provided every other year. Therefore, for these analyses, we defined three distinct groups of beneficiaries who were in (1) their first and second years of Medicare, (2) their third and fourth years of Medicare, and (3) their fifth and sixth years of Medicare from 2001 through 2010 (see fig. 1 in app. I). We classified beneficiaries as being in good health or better if they

[5]Approximately 80 percent of the beneficiaries in our study populations were categorized as having prior continuous insurance.

[6]Researchers have noted that because declines in health may lead to changes in employment and health insurance status, there is a strong possibility of a reverse relationship between health and health insurance status. See Decker et al., “Health Service Use among the Previously Uninsured,” 1155-1168.

reported in HRS that they were in excellent, very good, or good health.[7] We used logistic regression analysis to estimate these beneficiaries' self-reported health status and predict probabilities of their reporting being in good health or better assuming both that they did and that they did not have prior continuous insurance.

Our analyses of spending and use of services used Medicare data that were available each year. Therefore, for these analyses, we defined five distinct groups of beneficiaries who were in their first, second, third, fourth, and fifth years of enrollment between 2001 through 2010 (see fig. 2 in app. I). We used generalized linear models to estimate beneficiaries' spending and use of services and predict values for these variables assuming both that they did and that they did not have prior continuous insurance.

We included the following independent variables in all of our analyses: prior continuous insurance, demographic characteristics (census division, education level, income, marital status, race, and sex), potential health risk factors (body mass index and smoking status), and ever having had a diagnosis of any of eight health conditions (arthritis, cancer, diabetes, heart problems, high blood pressure, lung problems, psychological problems, and stroke). For our analyses of spending and use of services, we also included a variable for the number of months a beneficiary was alive during the year to control for partial-year spending and use of services. In addition, for our spending analyses, we adjusted spending to calendar year 2011 constant dollars. Differences in health status, spending, and use of services that are discussed in the text of this report are based on results that were statistically significant at a 95 percent

[7]We chose to use the self-reported health status measure alone for its clarity of meaning and ease of interpretation. Some researchers have noted that beneficiaries without prior insurance have a higher rate of mortality than those with prior insurance—and that therefore mortality should be included in measures of health status. See Daniel Polsky et al., "Response to McWilliams Commentary: 'Assessing the Health Effects of Medicare Coverage for Previously Uninsured Adults: A Matter of Life and Death?'" *Health Services Research*, vol. 45, no. 5 (October 2010). Other researchers have noted that combining the HRS self-reported health status measure with mortality may produce misleading results. See J. Michal McWilliams et al., "Commentary: Assessing the Health Effects of Medicare Coverage for Previously Uninsured Adults: A Matter of Life and Death?" *Health Services Research*, vol. 45, no. 5 (October 2010). We checked our sample to see if mortality was associated with not having prior continuous insurance and determined that there was not a consistent pattern and that inclusion of mortality in our health status analyses was not warranted.

confidence level. The tables display all of our analytical results—whether or not the results were statistically significant at conventional confidence levels—and indicate the level of statistical significance.

Our methodology had some important limitations. Because we used multiple exclusion criteria to define our study populations, our results might not be representative of the entire Medicare population. However, we compared certain characteristics of our study populations with those of the entire Medicare population and noted only small differences. In addition, like other researchers, we were limited in our ability to control for instances where individuals' poor health led to the loss of insurance rather than the loss of insurance leading to poor health. To address this issue, we controlled for potential health risk factors and diagnoses of eight health conditions in all of our analyses, and we excluded beneficiaries who were enrolled in Medicare or Medicaid before age 65 because their enrollment in these programs may be due, at least in part, to poor health. Furthermore, because HRS does not collect health insurance plan information, we were unable to control for variations in health plan benefits and coverage options in our analyses. Moreover, although we structured our analyses to capture as many beneficiaries as possible, the number of beneficiaries in our study populations may not be large enough to find significant differences for some variables. We ensured the reliability of the HRS and Medicare data used in this report by reviewing related documentation, performing appropriate electronic data checks, and discussing the data with officials from Acumen, LLC. We found the data were sufficiently reliable for the purpose of our analyses. (See app. I for additional details about our scope and methodology.)

We conducted this performance audit from July 2011 to December 2013 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Among the pre-Medicare population, the primary source of health insurance is private coverage. In the first half of 2012, nearly 69 percent of individuals in this population were privately insured. An additional 13 percent of individuals obtained coverage through government programs such as Medicaid. However, a significant portion—more than 18 percent—was uninsured.[8]

Previous research has demonstrated that individuals with health insurance coverage tend to be in better health than individuals without coverage.[9] However, research regarding the extent to which having prior health insurance coverage affects spending and use of medical services after enrolling in Medicare has produced inconsistent results. For example, one group of researchers found that having prior insurance was linked to lower spending and lower rates of hospitalization after enrolling in Medicare,[10] while another group of researchers found that having prior insurance had no effect on beneficiaries' spending or rates of hospitalization after Medicare enrollment.[11] This latter group of researchers found, however, that beneficiaries without prior insurance were less likely to visit physician offices and more likely to visit hospital emergency and outpatient departments after enrolling in Medicare, which could indicate that beneficiaries without prior insurance continued to access the health care system differently after Medicare enrollment.

[8]Agency for Healthcare Research and Quality, *Table 1: Health Insurance Coverage of the Civilian Noninstitutionalized Population: Percent by Type of Coverage and Selected Population Characteristics, United States, First Half of 2012*.

[9]See Institute of Medicine, *America's Uninsured Crisis: Consequences for Health and Health Care* (Washington, D.C.: 2009).

[10]See McWilliams et al., "Medicare Spending for Previously Uninsured Adults," 757-766. The researchers found that adjusted annual total Medicare spending was $1,023 higher for beneficiaries without prior insurance ($5,796 vs. $4,773). Additionally, among relevant clinical subgroups, beneficiaries without prior insurance had higher adjusted annual hospitalization rates for complications related to cardiovascular disease or diabetes (9.1 percent vs. 6.4 percent) and for joint replacements (2.5 percent vs. 1.3 percent).

[11]See Decker et al., "Health Service Use among the Previously Uninsured," 1155-1168. Although the researchers did not find statistically significant differences in Medicare expenditures or in the number of hospitalizations for beneficiaries with and without prior insurance, they found that beneficiaries without prior insurance had 16 percent fewer physician offices visits but 18 percent and 43 percent more hospital emergency room visits and outpatient department visits, respectively.

Subsequent commentary and analysis by both research groups suggests that the conflicting results may be primarily attributable to different definitions of prior insurance and different analytical approaches to control for differences in beneficiaries with and without prior insurance.[12] The group that found that having prior insurance was linked to lower spending used a more rigorous definition of prior insurance based on a longitudinal assessment of insurance coverage before age 65 rather than a point-in-time assessment. This group included beneficiaries who were enrolled in Medicare, Medicaid, and other government health programs before age 65 in its analysis and used a statistical weighting methodology to control for the possibility of reverse causality between health status and insurance coverage. More specifically, some individuals may have experienced declining health before age 65 that led to loss of employment, loss of private insurance coverage, and subsequent enrollment in government health programs. The group that did not find that having prior insurance was linked to lower spending criticized the inclusion of these beneficiaries, noting that many individuals transition to government health programs before age 65 because of poor health, thereby resulting in an overestimate of the effect of having prior insurance on their Medicare spending after age 65. These researchers also criticized the statistical weighting methodology used to control for the possibility that beneficiaries entered these programs because of poor health, contending that the data used in the weighting methodology were not sufficiently detailed to adequately adjust for this possibility.

[12]See Daniel Polsky and Sandra L. Decker, "Would Insuring Near-Elderly Persons Reduce Medicare Spending in Patients Aged 65 Years or Older?" *Annals of Internal Medicine*, vol. 152, no. 7 (April 2010) and J. Michael McWilliams et al., "In Response: Would Insuring Near-Elderly Persons Reduce Medicare Spending in Patients Aged 65 Years or Older?" *Annals of Internal Medicine*, vol. 152, no. 7 (April 2010).

Beneficiaries with Continuous Insurance before Medicare Were More Likely to Report Better Health after Medicare Enrollment than Those without Continuous Insurance

Beneficiaries with prior continuous insurance were more likely than those without prior continuous insurance to report being in good health or better in the 6 years after Medicare enrollment. On average, the predicted probability of reporting being in good health or better in the first 2 years in Medicare was approximately 84 percent for beneficiaries with prior continuous insurance and approximately 79 percent for beneficiaries without prior continuous insurance. Although the predicted probabilities of beneficiaries who reported being in good health or better decreased over time for both those with and without prior continuous insurance, the percentage point difference increased slightly. In total, having prior continuous insurance raised the predicted probability that a beneficiary reported being in good health or better by nearly 6 percentage points in the first 6 years after Medicare enrollment. (See table 1.)

Table 1: Predicted Probability of Beneficiaries with and without Prior Continuous Insurance for 6 Years before Medicare Reporting Good Health or Better in Medicare

Reporting period	Beneficiaries with prior continuous insurance (percent)	Beneficiaries without prior continuous insurance (percent)	Percentage point difference
First and second years in Medicare	84.2%[a]	78.7%[a]	5.6[a]
Third and fourth years in Medicare	82.9[a]	77.2[a]	5.7[a]
Fifth and sixth years in Medicare	81.0[a]	75.1[a]	5.9[a]

Source: GAO analysis of Health and Retirement Study (HRS) data.

Notes: The table is a summary of results from three models. The models included the following independent variables: prior continuous insurance, demographic variables (census division, education level, income, marital status, race, and sex), potential health risk factors (body mass index and smoking status), and ever having had a diagnosis of any of eight health conditions (arthritis, cancer, diabetes, heart problems, high blood pressure, lung problems, psychological problems, and stroke). The number of beneficiaries in each group ranged from 3,201 for the first and second years in Medicare to 2,001 for the fifth and sixth years in Medicare.

[a]Effect of prior continuous insurance significant at the .01 level.

According to previous research, there are reasons why Medicare beneficiaries with prior continuous insurance may be healthier than those without prior continuous insurance. Because of financial constraints, beneficiaries without prior continuous insurance may have difficulty accessing medical services that could help them improve their health before they enroll in Medicare. In addition, being uninsured before Medicare may have effects on beneficiaries' health that remain for some time. For example, if a beneficiary without prior continuous insurance is diagnosed with diabetes and has inadequate access to care before Medicare, the beneficiary may develop complications that increase the risk for adverse health events for years to come, even after the diabetes is controlled.

Beneficiaries with Continuous Insurance before Medicare Had Lower Program Spending and More Physician Office Visits after Medicare Enrollment than Those without Continuous Insurance

There were differences in Medicare spending and use of services between beneficiaries with and without prior continuous insurance. In particular, compared with beneficiaries without prior continuous insurance, beneficiaries with prior continuous insurance had significantly lower total spending during the first year in Medicare.[13]

Beneficiaries with Prior Continuous Insurance Had Approximately $2,300 Less in Estimated Total Spending during the First Year in Medicare than Those without Prior Continuous Insurance

Beneficiaries with prior continuous insurance had lower total program spending during the first year in Medicare compared with those without prior continuous insurance.[14] Specifically, during the first year in Medicare, average predicted total spending for beneficiaries with and without prior continuous insurance was $4,390 and $6,733, respectively—a difference of $2,343, or 35 percent. Because the difference in total spending was the greatest during the first year in Medicare, it is possible that beneficiaries without prior continuous insurance had a pent-up demand for medical services in anticipation of coverage at age 65. Table 2 shows predicted spending, as well as the difference in predicted spending, during the first 5 years in Medicare for beneficiaries with and without prior continuous insurance.

[13]Differences in health status, spending, and use of services that are discussed in the text of this report are based on results that were statistically significant at a 95 percent confidence level. The tables display all of our analytical results—whether or not the results were statistically significant at conventional confidence levels—and indicate the level of statistical significance.

[14]Total spending included inpatient, institutional outpatient, durable medical equipment, skilled nursing facility, home health, hospice, and physician and other noninstitutional spending.

Table 2: Predicted Total Medicare Spending for Beneficiaries with and without Continuous Private Insurance for 6 Years before Medicare

	Average predicted spending by year of Medicare enrollment (dollars)				
Type of spending	**First year**	**Second year**	**Third year**	**Fourth year**	**Fifth year**
Beneficiaries with prior continuous insurance	$4,390	$5,223	$6,129	$6,093	$6,068
Beneficiaries without prior continuous insurance	6,733	6,316	7,311	5,227	6,630
Difference	(2,343)[a]	(1,093)[b]	(1,183)	865	(562)

Source: GAO analysis of Health and Retirement Study (HRS) and Centers for Medicare & Medicaid Services (CMS) data.

Notes: The table is a summary of results from five models and compares average predicted spending, by year of Medicare enrollment, for beneficiaries who reported having continuous private insurance in the 6 years before Medicare with that for beneficiaries who reported not having continuous private insurance. For example, during the first year in Medicare, predicted total spending for beneficiaries with prior continuous insurance would be, on average, $2,343 less than for beneficiaries without prior continuous insurance.

The models included the following independent variables: prior continuous insurance, demographic variables (census division, education level, income, marital status, race, and sex), potential health risk factors (body mass index and smoking status), the number of months a beneficiary was alive during the year, and ever having had a diagnosis of any of eight health conditions (arthritis, cancer, diabetes, heart problems, high blood pressure, lung problems, psychological problems, and stroke). The number of beneficiaries in each group ranged from 1,592 for the first year of enrollment to 1,152 for the fifth year of enrollment.

Total spending includes inpatient, institutional outpatient, durable medical equipment, skilled nursing facility, home health, hospice, and physician and other noninstitutional spending.

[a]Effect of prior continuous insurance significant at the .01 level.

[b]Effect of prior continuous insurance significant at the .10 level.

Similar to our results for total spending, beneficiaries with prior continuous insurance had lower institutional outpatient spending during the first and second years in Medicare compared with those without prior continuous insurance. Specifically, during the first year in Medicare, average predicted institutional outpatient spending was $513 (or 32 percent) less for beneficiaries with prior continuous insurance (see table 3). During the second year in Medicare, average predicted institutional outpatient spending was $609 (or 33 percent) less for beneficiaries with prior continuous insurance.

Table 3: Predicted Institutional Outpatient and Physician and Other Noninstitutional Medicare Spending for Beneficiaries with and without Continuous Private Insurance for 6 Years before Medicare

	Average predicted spending by year of Medicare enrollment (dollars)				
Type of spending	**First year**	**Second year**	**Third year**	**Fourth year**	**Fifth year**
Institutional outpatient					
Beneficiaries with prior continuous insurance	$1,068	$1,229	$1,354	$1,063	$1,400
Beneficiaries without prior continuous insurance	1,580	1,838	1,544	1,038	1,628
Difference	(513)[a]	(609)[a]	(190)	26	(229)
Physician and other noninstitutional[b]					
Beneficiaries with prior continuous insurance	1,870	2,161	2,235	2,522	2,320
Beneficiaries without prior continuous insurance	2,251	1,944	2,071	1,934	1,808
Difference	(381)[c]	217	163	589[d]	511[d]

Source: GAO analysis of Health and Retirement Study (HRS) and Centers for Medicare & Medicaid Services (CMS) data.

Notes: The table is a summary of results from 10 models and compares average predicted spending, by year of Medicare enrollment, for beneficiaries who reported having continuous private insurance in the 6 years before Medicare with that for beneficiaries who reported not having continuous private insurance. For example, during the first year in Medicare, predicted institutional outpatient spending for beneficiaries with prior continuous insurance would be, on average, $513 less than for beneficiaries without prior continuous insurance.

The models included the following independent variables: prior continuous insurance, demographic variables (census division, education level, income, marital status, race, and sex), potential health risk factors (body mass index and smoking status), the number of months a beneficiary was alive during the year, and ever having had a diagnosis of any of eight health conditions (arthritis, cancer, diabetes, heart problems, high blood pressure, lung problems, psychological problems, and stroke). The number of beneficiaries in each group ranged from 1,592 for the first year of enrollment to 1,152 for the fifth year of enrollment.

[a]Effect of prior continuous insurance significant at the .01 level.

[b]Physician and other noninstitutional spending refers to Medicare's per beneficiary spending for services provided by noninstitutional providers, such as physicians, clinical laboratories, and free-standing ambulatory surgical centers.

[c]Effect of prior continuous insurance significant at the .10 level.

[d]Effect of prior continuous insurance significant at the .05 level.

In contrast to our results for total spending and institutional outpatient spending, physician and other noninstitutional spending were similar during the early years in Medicare for beneficiaries with and without prior continuous insurance. However, during the fourth and fifth years in Medicare, beneficiaries with prior continuous insurance had higher physician and other noninstitutional spending. Specifically, during the fourth and fifth years in Medicare, average predicted physician and other noninstitutional spending was $589 (or 30 percent) and $511 (or 28 percent) more, respectively, for beneficiaries with prior continuous insurance.

Beneficiaries with Prior Continuous Insurance Had More Physician Office Visits during the First 5 Years in Medicare than Those without Prior Continuous Insurance

Beneficiaries with prior continuous insurance had more physician office visits during the first 5 years in Medicare than those without prior continuous insurance. Specifically, during the first 5 years in Medicare, the difference in the average predicted number of physician office visits between beneficiaries with and without prior continuous insurance ranged from 1.3 to 2.5, or 23 to 46 percent (see table 4). This utilization pattern may indicate that, even after Medicare enrollment, beneficiaries with prior continuous insurance continued to access medical services differently compared with those without prior continuous insurance. For example, beneficiaries with prior continuous insurance may have been more likely to have physician office visits before Medicare if their insurance covered these visits.

Table 4: Predicted Service Use for Beneficiaries with and without Continuous Private Insurance for 6 Years before Medicare

	Average predicted number of services used by year of Medicare enrollment				
Type of service	**First year**	**Second year**	**Third year**	**Fourth year**	**Fifth year**
Physician office visit					
Beneficiaries with prior continuous insurance	6.3	6.8	7.1	7.2	7.8
Beneficiaries without prior continuous insurance	4.9	5.4	5.8	5.3	5.4
Difference	1.4[a]	1.5[a]	1.3[a]	2.0[a]	2.5[a]
Institutional outpatient visit					
Beneficiaries with prior continuous insurance	2.8	3.1	3.2	3.1	3.5
Beneficiaries without prior continuous insurance	2.9	3.1	3.1	3.0	3.4
Difference	(0.1)	(0.1)	0.1	0.2	0.0

Source: GAO analysis of Health and Retirement Study (HRS) and Centers for Medicare & Medicaid Services (CMS) data.

Notes: The table is a summary of results from 10 models and compares average predicted service use, by year of Medicare enrollment, for beneficiaries who reported having continuous private insurance in the 6 years before Medicare with that for beneficiaries who reported not having continuous private insurance. For example, during the first year in Medicare, the predicted number of physician office visits for beneficiaries with continuous insurance before Medicare would be, on average, 1.4 more than that of beneficiaries without continuous insurance. All values in the table are rounded to the nearest one-tenth.

The models included the following independent variables: prior continuous insurance, demographic variables (census division, education level, income, marital status, race, and sex), potential health risk factors (body mass index and smoking status), the number of months a beneficiary was alive during the year, and ever having had a diagnosis of any of eight health conditions (arthritis, cancer, diabetes, heart problems, high blood pressure, lung problems, psychological problems, and stroke). The number of beneficiaries in each group ranged from 1,592 for the first year of enrollment to 1,152 for the fifth year of enrollment.

[a]Effect of prior continuous insurance significant at the .01 level.

According to our analyses, the number of institutional outpatient visits was similar for beneficiaries with and without prior continuous insurance. However, because we found that beneficiaries without prior continuous insurance had higher institutional outpatient spending, it is possible that they required more costly outpatient care than beneficiaries with prior continuous insurance.

Concluding Observations

Previous research regarding the extent to which health insurance coverage prior to Medicare enrollment affects beneficiaries' spending and use of services after enrollment has been inconclusive, possibly because of different definitions of prior insurance and different approaches for dealing with the potential for reverse causality between health status and health insurance coverage. Like researchers who did not find significant differences in Medicare spending between beneficiaries with and without prior insurance coverage, we excluded individuals who were enrolled in government health programs prior to age 65 from our analysis because of the possibility that they lost insurance coverage because of poor health, which could have resulted in an overestimate of the effect of having prior insurance on Medicare spending after age 65. However, like researchers who did find significant differences in Medicare spending between these groups, we used a more rigorous definition of prior insurance based on a longitudinal assessment of insurance coverage before age 65 rather than a single point in time. Using our methodology, we found significant differences in Medicare spending between beneficiaries with and without prior continuous insurance.

This study adds to the body of evidence suggesting that beneficiaries with prior insurance used fewer or less costly medical services in Medicare compared with those without prior insurance, because they either were in better health or were accustomed to accessing medical services differently. In particular, we found that beneficiaries with prior continuous insurance were more likely than those without prior continuous insurance to report being in good health or better in the 6 years after Medicare enrollment. Additionally, we found that beneficiaries without prior continuous insurance had higher total and institutional outpatient spending but did not have higher spending for physician and other noninstitutional services, suggesting that they required more intensive medical services or that they were accustomed to visiting hospitals more than physician offices. This suggests that the extent to which individuals enroll in private insurance before age 65 has implications for beneficiaries' health status and Medicare spending.

Agency Comments

We provided a draft of this report to the Department of Health and Human Services for review. In written comments, reproduced in appendix II, the department highlighted a key finding in our report that beneficiaries with prior insurance used fewer or less costly medical services in Medicare compared with those without prior insurance.

As arranged with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to appropriate congressional committees and the Administrator of the Centers for Medicare & Medicaid Services (CMS). The report also will be available at no charge on GAO's website at http://www.gao.gov.

If you or your staffs have any questions regarding this report, please contact me at (202) 512-7114 or cosgrovej@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix III.

James Cosgrove
Director, Health Care

Appendix I: Data and Methods

This appendix describes the data and methods we used to address our research objectives. We used data from the Health and Retirement Study (HRS) and Medicare claims. HRS is a longitudinal panel study that surveys a representative sample of more than 26,000 Americans over the age of 50 every 2 years.[1] We used a subset of HRS data from 1996 through 2010 to obtain information on beneficiaries' health insurance coverage before Medicare, health status in Medicare, demographic characteristics, potential health risk factors, and diagnoses of health conditions. Because HRS data are survey data, these data were self-reported. We also used data from the Medicare Beneficiary Annual Summary Files and the Medicare Denominator Files from 2001 through 2010 to obtain information on Medicare spending and use of services. We worked with Acumen, LLC, to link beneficiaries' HRS data with their Medicare data and to conduct statistical analyses of their spending and use of services.[2] We assessed the reliability of the HRS and Medicare data and determined that the data were adequate for our purposes. We conducted our work from July 2011 to December 2013 in accordance with generally accepted government auditing standards.

Data Sources

Health and Retirement Study

To determine whether Medicare beneficiaries had continuous health insurance coverage before Medicare, we used HRS data to develop a composite measure. We categorized beneficiaries as having prior continuous insurance if they reported receiving private insurance through their employer or their spouse's employer in the three consecutive HRS surveys before Medicare enrollment at age 65—a period spanning approximately 6 years. To analyze beneficiaries' health status in Medicare, we collapsed the HRS self-reported health status measure, which uses a scale from 1 (excellent) to 5 (poor), to two categories. We classified beneficiaries as being in good health or better if they reported being in excellent, very good, or good health. We also used HRS data to

[1]HRS is administered by the University of Michigan with support from the National Institute on Aging and the Social Security Administration. The RAND Center for the Study of Aging prepares a publicly available subset of HRS data for use by researchers.

[2]HRS partners with Acumen, LLC, to link Medicare beneficiaries' HRS data to their Medicare data and to provide analytical support for these linked data. Precautions were taken to ensure compliance with applicable confidentiality agreements with HRS.

develop a set of independent variables for our analyses. Specifically, we used data on demographic characteristics (census division, education level, income, marital status, race, and sex), potential health risk factors (body mass index and smoking status), and ever having had a diagnosis of any of eight health conditions (arthritis, cancer, diabetes, heart problem, high blood pressure, lung problem, psychological problem, and stroke).

Medicare Data

To analyze beneficiaries' spending and use of services, we used data from the Medicare Beneficiary Annual Summary Files. In particular, we obtained data on total, institutional outpatient, institutional inpatient, home health, and physician and other noninstitutional spending; institutional outpatient and physician office visits; and hospital stays.[3] We also used enrollment data from the Beneficiary Annual Summary Files and Medicare Denominator Files to determine which beneficiaries to include in our analyses of spending and use of services.

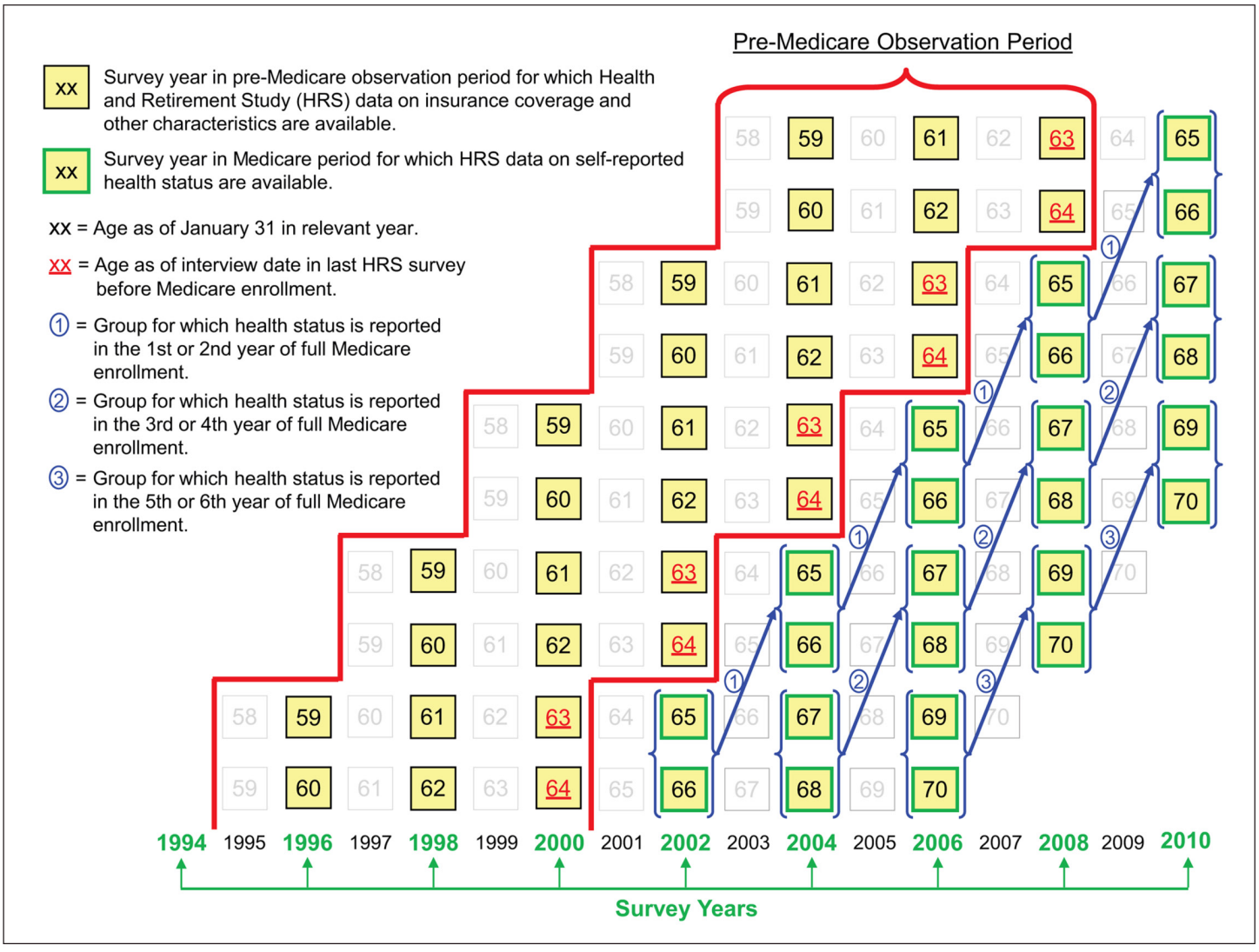
Study Populations

Health Status Analyses

Because we used HRS data on beneficiaries' self-reported health status that were collected about every 2 years, we defined three groups of beneficiaries, drawn from multiple survey years spanning 2001 through 2010, who were in (1) their first and second years of Medicare, (2) their third and fourth years of Medicare, and (3) their fifth and sixth years of Medicare (see fig. 1). This approach allowed us to measure the effect of prior continuous insurance on self-reported health status at three points in time after Medicare enrollment.

[3]Total spending refers to Medicare's spending per beneficiary for all covered services: durable medical equipment, home health, hospice, inpatient, institutional outpatient, physician and other noninstitutional, and skilled nursing facility. Institutional outpatient spending refers to Medicare's spending per beneficiary for outpatient services provided by institutional providers, such as hospital outpatient departments, rural health centers, renal dialysis facilities, and outpatient rehabilitation facilities. Physician and other noninstitutional spending refers to Medicare's spending per beneficiary for services provided by certain noninstitutional providers, such as physicians, independent clinical laboratories, and free-standing ambulatory surgical centers. Institutional outpatient visits refer to services provided by institutional providers on an outpatient basis. Physician office visits refer to services provided by noninstitutional providers, such as physicians.

Figure 1: Study Populations for Health Status Analyses

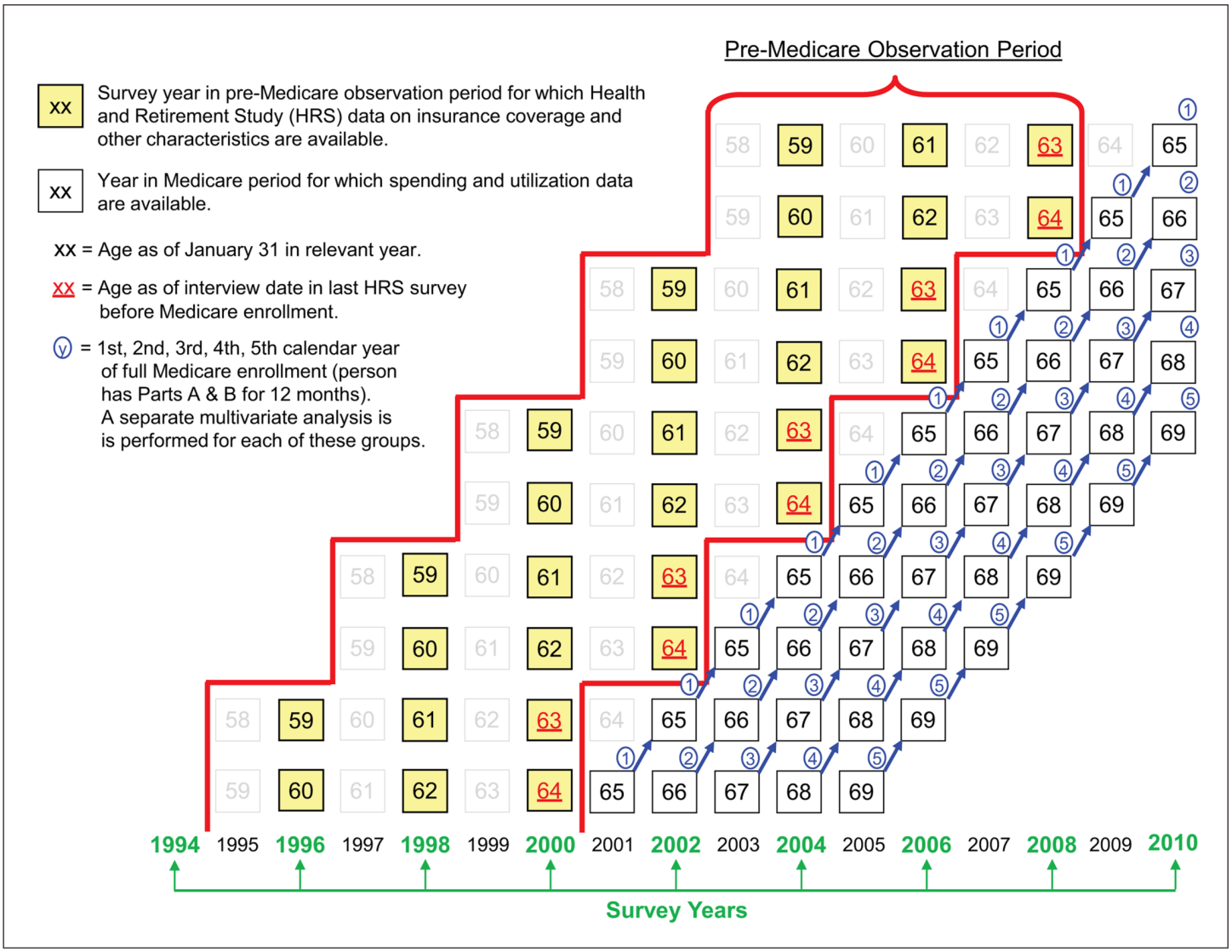


Source: GAO.

Analyses of Spending and Use of Services

Because we used Medicare data on beneficiaries' program spending and use of services that were collected every year, we defined five groups of beneficiaries who were in their first, second, third, fourth, and fifth years of enrollment from 2001 through 2010 (see fig. 2). This approach allowed us to measure the effect of prior continuous insurance on spending and use of services for beneficiaries in each of the first 5 years of Medicare enrollment.

Figure 2: Study Populations for Analyses of Spending and Use of Services



Source: GAO.

Exclusion Criteria

For all of our analyses, we excluded beneficiaries from our study populations because of missing data and design and methodological issues. Specifically, we excluded beneficiaries who died before age 65; beneficiaries who were over age 65 as of January 31, 2001; beneficiaries who did not participate in all three HRS surveys in their pre-Medicare period; and beneficiaries who did not respond to relevant HRS questions

about insurance during their pre-Medicare period. We excluded beneficiaries who were enrolled in Medicare or Medicaid before age 65 because their enrollment in these programs may have been due, at least in part, to poor health, which would indicate that their health status affected their insurance coverage rather than the other way around. We chose to exclude these beneficiaries to avoid overestimating the effects of having prior continuous insurance on health status, spending, and use of services. In addition, we excluded beneficiaries who reported receiving coverage from the Veterans Health Administration before age 65 because their Medicare spending and use of services might not fully represent their overall use of medical services.

For our analyses of spending and use of services, we applied additional exclusion criteria to define our study populations. We excluded Medicare Advantage beneficiaries because they did not have fee-for-service data that could be linked to HRS data.[4] In addition, we excluded beneficiaries who were not enrolled in both Medicare Parts A and B for all months they were alive during a given year because we did not have complete information on their spending and use of services.

After the exclusions, the number of beneficiaries in our three study populations for our health status analyses ranged from 3,201 for the first group to 2,001 for the third group. The number of beneficiaries in our five study populations for our analyses of spending and use of services ranged from 1,592 for the first group to 1,152 for the fifth group.

Modeling Health Status

To examine the relationship between Medicare beneficiaries' prior continuous insurance and their self-reported health status, we used logistic regression analysis. In particular, we modeled beneficiaries' self-reported health status during three periods after Medicare enrollment. We also predicted probabilities of their reporting being in good health or better assuming both that they did and that they did not have prior continuous insurance. In all of our analyses, we included the following independent variables: prior continuous insurance, demographic characteristics,

[4]About three out of four beneficiaries are enrolled in Medicare's traditional fee-for-service program, and the rest are enrolled in private health plans under the Medicare Advantage program. Medicare fee-for-service consists of Medicare Part A, which covers hospital and other inpatient services, and Medicare Part B, which is optional insurance and covers physician, outpatient hospital, home health care, and certain other services.

potential health risk factors, and ever having had a diagnosis of any of eight health conditions. See table 5 for an example of results from one of the three models that we conducted for our analyses of health status.

Table 5: Multivariate Analysis of the Effect of Prior Continuous Insurance on Self-Reported Health Status for Beneficiaries in Their First or Second Year of Medicare Enrollment

Variable	Measure of variable	Coefficient	Significance level
Prior insurance coverage	Continuous[a]	0.4590	0.0009
	Not continuous (reference group)	n/a[b]	n/a[b]
Sex	Male	-0.3194	0.0049
	Female (reference group)	n/a[b]	n/a[b]
Race	White	0.2790	0.0532
	Nonwhite (reference group)	n/a[b]	n/a[b]
Education level	High school graduate	0.7699	<.0001
	Not a high school graduate (reference group)	n/a[b]	n/a[b]
Marital status	Married	-0.2572	0.0566
	Single (reference group)	n/a[b]	n/a[b]
Smoking status	Smoker	-0.8466	<.0001
	Nonsmoker (reference group)	n/a[b]	n/a[b]
Body mass index[c]	Continuous	-0.0219	0.0403
Diagnosed with diabetes[d]	Yes	-1.1175	<.0001
	No (reference group)	n/a[b]	n/a[b]
Diagnosed with heart problem[d]	Yes	-0.8250	<.0001
	No (reference group)	n/a[b]	n/a[b]
Diagnosed with high blood pressure[d]	Yes	-0.3419	0.0028
	No (reference group)	n/a[b]	n/a[b]
Diagnosed with stroke[d]	Yes	-1.1711	<.0001
	No (reference group)	n/a[b]	n/a[b]
Diagnosed with arthritis[d]	Yes	-0.6312	<.0001
	No (reference group)	n/a[b]	n/a[b]
Diagnosed with cancer[d]	Yes	-0.4766	0.0036
	No (reference group)	n/a[b]	n/a[b]
Diagnosed with lung problem[d]	Yes	-0.8484	<.0001
	No (reference group)	n/a[b]	n/a[b]
Diagnosed with psychological problem[d]	Yes	-0.6955	<.0001
	No (reference group)	n/a[b]	n/a[b]

Variable	Measure of variable	Coefficient	Significance level
Income quintile	1st (lowest)	-1.1602	<.0001
	2nd	-0.7519	<.0001
	3rd	-0.3581	0.0548
	4th	-0.6174	0.0006
	5th (reference group)	n/a[b]	n/a[b]
Census division[e]	New England	0.5489	0.0857
	Middle Atlantic	0.5301	0.0164
	East North Central	0.5788	0.0035
	West North Central	0.5005	0.0395
	South Atlantic	0.4725	0.0095
	East South Central	0.3128	0.2091
	West South Central	-0.0258	0.9021
	Mountain	0.2602	0.3410
	Pacific (reference group)	n/a[b]	n/a[b]
	Intercept	2.9111	<.0001
	Number of observations	3,201	

Source: GAO analysis of Health and Retirement Study (HRS) data.

Notes: We used logistic regression to examine the effect of having prior continuous insurance on beneficiaries' self-reported health status during their first or second year of Medicare enrollment. The model also controlled for other variables that could affect beneficiaries' health status. Data for all of the variables were from HRS. The following variables were measured as of the last HRS survey prior to Medicare enrollment: marital status, smoking status, body mass index, health conditions, income quintile, and census division.

[a]We defined prior continuous insurance coverage as self-reported continuous private health insurance coverage during approximately 6 years before Medicare enrollment.

[b]Not available because the method calculates coefficients for the included groups relative to the reference group.

[c]Body mass index is a measure of body fat based on height and weight.

[d]Respondents reported whether or not a physician ever told the respondent that he or she had a particular health condition.

[e]Census divisions are groupings of states that subdivide the United States.

Modeling Medicare Spending and Use of Services

To examine the relationship between Medicare beneficiaries' prior continuous insurance and their spending and use of services, we used generalized linear models because our spending and service variables had skewed distributions and a high proportion of zero values.[5] For example, for beneficiaries in their first year of Medicare enrollment, 30 percent of beneficiaries in our study population had no institutional outpatient visits and therefore no institutional outpatient spending. We modeled total, institutional outpatient, and physician and other noninstitutional spending and institutional outpatient and physician office visits for beneficiaries in each of the first 5 years of Medicare enrollment.[6] We predicted values for these variables assuming both that beneficiaries did and that beneficiaries did not have prior continuous insurance. In all of our analyses, we included the following independent variables: prior continuous insurance, demographic characteristics, potential health risk factors, ever having had a diagnosis of any of eight health conditions, and the number of months a beneficiary was alive during the year. For our spending analyses, we used the price index from the Personal Health Care Expenditure component of the CMS National Health Expenditure Accounts to express all spending in 2011 dollars. This approach adjusted for inflation by removing the effects of health care price-level changes between 2001 and 2010. See table 6 for an example of results from 1 of the 25 models that we ran for our analyses of spending and use of services.

[5]We used a generalized linear model with a log link function with a gamma distribution to model spending and a log link function with a negative binomial distribution to model service use.

[6]We also modeled beneficiaries' home health and institutional inpatient spending and hospital stays, but the number of beneficiaries with data for these categories was too low to provide meaningful results.

Table 6: Multivariate Analysis of the Effect of Prior Continuous Insurance on Total Medicare Spending for Beneficiaries in Their First Year of Medicare Enrollment

Variable	Measure of variable	Coefficient	Significance level
Prior insurance coverage	Continuous[a]	-0.4277	0.0002
	Not continuous (reference group)	n/a[b]	n/a[b]
Sex	Male	0.0147	0.8542
	Female (reference group)	n/a[b]	n/a[b]
Race	White	0.0317	0.7934
	Nonwhite (reference group)	n/a[b]	n/a[b]
Education level	High school graduate	0.2478	0.0401
	Not a high school graduate (reference group)	n/a[b]	n/a[b]
Marital status	Married	-0.1107	0.2413
	Single (reference group)	n/a[b]	n/a[b]
Smoking status	Smoker	0.1030	0.3461
	Nonsmoker (reference group)	n/a[b]	n/a[b]
Body mass index[c]	Continuous	0.0118	0.1414
Diagnosed with diabetes[d]	Yes	0.6338	<.0001
	No (reference group)	n/a[b]	n/a[b]
Diagnosed with heart problem[d]	Yes	0.3159	0.0044
	No (reference group)	n/a[b]	n/a[b]
Diagnosed with high blood pressure[d]	Yes	0.0175	0.8278
	No (reference group)	n/a[b]	n/a[b]
Diagnosed with stroke[d]	Yes	-0.3952	0.1157
	No (reference group)	n/a[b]	n/a[b]
Diagnosed with arthritis[d]	Yes	0.4153	<.0001
	No (reference group)	n/a[b]	n/a[b]
Diagnosed with cancer[d]	Yes	0.3979	0.0011
	No (reference group)	n/a[b]	n/a[b]
Diagnosed with lung problem[d]	Yes	0.6581	<.0001
	No (reference group)	n/a[b]	n/a[b]
Diagnosed with psychological problem[d]	Yes	0.2633	0.0351
	No (reference group)	n/a[b]	n/a[b]
Income quintile	1st (lowest)	-0.1330	0.3566
	2nd	-0.1737	0.1727
	3rd	-0.0723	0.5436
	4th	-0.1775	0.1296
	5th (reference group)	n/a[b]	n/a[b]

Variable	Measure of variable	Coefficient	Significance level
Census division[e]	New England	0.0744	0.7462
	Middle Atlantic	0.0215	0.9013
	East North Central	-0.2209	0.1467
	West North Central	-0.1201	0.4881
	South Atlantic	0.1686	0.2438
	East South Central	-0.1622	0.3953
	West South Central	-0.4300	0.0147
	Mountain	-0.3703	0.1232
	Pacific (reference group)	n/a[b]	n/a[b]
Number of months the beneficiary was alive during the year	1	0.6810	0.6240
	2	0.3342	0.8101
	3	2.6074	0.0621
	4	0.3284	0.8152
	5	2.1419	0.0301
	6	n/a[f]	n/a[f]
	7	n/a[f]	n/a[f]
	8	0.9526	0.4951
	9	n/a[f]	n/a[f]
	10	-1.0094	0.4669
	11	2.0772	0.0367
	12 (reference group)	n/a[b]	n/a[b]
	Intercept	7.8474	<.0001
	Number of observations	1,592	

Source: GAO analysis of Health and Retirement Study (HRS) and Centers for Medicare & Medicaid Services (CMS) data.

Notes: We used a generalized linear model to examine the effect of having prior continuous insurance on total Medicare spending for beneficiaries in their first year of Medicare enrollment. The model also controlled for other variables that could affect beneficiaries' Medicare spending. Data for all of the independent variables other than the number of months the beneficiary was alive during the year were from HRS. Data for the number of months the beneficiary was alive during the year were from Medicare claims. The following variables were measured as of the last HRS survey prior to Medicare enrollment: marital status, smoking status, body mass index, health conditions, income quintile, and census division.

[a]We defined prior continuous insurance coverage as self-reported continuous private health insurance coverage during approximately 6 years before Medicare enrollment.

[b]Not available because the method calculates coefficients for the included groups relative to the reference group.

[c]Body mass index is a measure of body fat based on height and weight.

[d]Respondents reported whether or not a physician ever told the respondent that he or she had a particular health condition.

[e]Census divisions are groupings of states that subdivide the United States.

[f]Not available because there were no beneficiaries alive for the corresponding number of months.

Data Reliability

Comparison with the Entire Medicare Population

Because we used multiple exclusion criteria to define our study populations, our results might not be representative of the entire Medicare population. To compare our study populations with the entire Medicare population, we examined certain characteristics of these populations—gender, race, and census division (see tables 7 and 8).[7] We selected these characteristics because data on these characteristics were available in each of the data sources that we used. Because we only had access to Medicare Denominator File data for 2003 through 2010, we compared characteristics for beneficiaries in their first or second year of Medicare enrollment from 2003 through 2010. On the basis of this analysis, we determined that our study populations and the entire Medicare population were comparable. However, we noted small differences between the populations. For example, compared with the entire Medicare population, our study populations included slightly higher percentages of females.

[7]Because we could not determine which beneficiaries in the entire Medicare population were enrolled in Medicaid or the Veterans Health Administration before age 65, we compared the entire Medicare population to our study populations before we excluded these individuals.

Table 7: Beneficiaries in Study Population for Health Status Analyses in Their First or Second Year of Enrollment Compared with All Medicare Beneficiaries in Their First or Second Year of Enrollment, 2003-2010

Characteristic	Study population (percent)	All Medicare beneficiaries (percent)
Gender		
Male	41.4%	46.8%
Female	58.6	53.2
Race		
White	84.3	85.3
Nonwhite	15.7	14.7
Census division		
New England	4.4	4.9
Middle Atlantic	10.9	13.6
East North Central	16.7	15.8
West North Central	9.1	7.0
South Atlantic	24.9	20.3
East South Central	6.7	6.2
West South Central	9.5	10.6
Mountain	5.7	6.9
Pacific	12.2	14.8

Source: GAO analysis of Health and Retirement Study (HRS) and Centers for Medicare & Medicaid Services (CMS) data.

Table 8: Beneficiaries in Study Population for Analyses of Spending and Use of Services in Their First Year of Enrollment Compared with All Medicare Beneficiaries in Their First Year of Enrollment, 2003-2010

Characteristic	Study population (percent)	All Medicare beneficiaries (percent)
Gender		
Male	40.6%	45.4%
Female	59.4	54.6
Race		
White	85.5	87.5
Nonwhite	14.5	12.5
Census division		
New England	3.7	4.8
Middle Atlantic	9.3	11.5
East North Central	17.4	17.3
West North Central	9.6	7.3
South Atlantic	27.0	22.1
East South Central	7.3	7.0
West South Central	11.1	11.9
Mountain	4.4	6.5
Pacific	10.3	11.6

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data.

Supplementary Analyses

We excluded Medicare beneficiaries who were enrolled in Medicaid before age 65 from our primary analyses because their enrollment in this program may have been due, at least in part, to poor health. To determine the effect, if any, of removing these beneficiaries from our analyses, we conducted supplementary analyses of Medicare spending and use of services that included these beneficiaries. Results for most of the dependent variables (e.g., total spending, physician and other noninstitutional spending, physician office visits, and institutional outpatient visits) were similar to our original results. However, beneficiaries with prior continuous insurance only had lower institutional outpatient spending during the first year in Medicare, rather than during the first and second years in Medicare, when we included these beneficiaries.

Appendix II: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

NOV 27 2013

James Cosgrove
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Mr. Cosgrove:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "Medicare: Continuous Insurance before Enrollment Associated with Better Health and Lower Program Spending" (GAO-14-53).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "MEDICARE: CONTINUOUS INSURANCE BEFORE ENROLLMENT ASSOCIATED WITH BETTER HEALTH AND LOWER PROGRAM SPENDING" (GAO-14-53)

The Department appreciates the opportunity to review and comment on this draft report.

GAO reviewed the effects of having prior health insurance coverage on Medicare beneficiaries, the health status spending, and use of services of Medicare beneficiaries with and without continuous health insurance coverage before Medicare enrollment. GAO's findings suggest that beneficiaries with prior insurance used fewer or less costly medical services in Medicare compared with those without prior insurance.

HHS believes a focus on prevention will not only improve the health of Americans, but also help to reduce health care costs and improve quality of care. The Affordable Care Act works to address these factors. Prevention and access to care will strengthen Americans' health during their lives, including when they are eligible for Medicare.

For additional information on building healthier communities and investing in prevention, go to the following link:
http://www.hhs.gov/healthcare/facts/factsheets/2011/09/prevention02092011.html

1

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

James Cosgrove, (202) 512-7114 or cosgrovej@gao.gov

Staff Acknowledgments

In addition to the contact listed above, Christine Brudevold, Assistant Director; George Bogart; David Grossman; Elizabeth T. Morrison; Aubrey Naffis; and Eric Wedum made key contributions to this report.

ATTACHMENT G

Ted L. Helvoigt, Ph.D.
Vice President

333 SW Taylor Street, Suite 200
Portland, OR 97204

helvoigt@evergreenecon.com
evergreenecon.com

MEMORANDUM

February 06, 2015

To: Valerie Davidson, Commissioner, Alaska Department of Health and Social Services

Re: Projected Population, Enrollment, Service Costs and Demographics of Medicaid Expansion Beginning in FY2016

This memorandum presents preliminary results of Evergreen Economics' analysis of enrollment and spending impacts of expanding Medicaid in Alaska under the Affordable Care Act (ACA). It is our understanding that Governor Walker has directed the Department to prepare for expansion, which is to commence July 2015—the first month of State Fiscal Year 2016 (FY2016). The expansion population is comprised of adults, ages 19 to 64, who are currently not otherwise eligible for Medicaid or Medicare.

In this memorandum, we describe the data sources we relied upon and the analysis we conducted to develop a six-year projection of the newly eligible adults in Alaska, the number of this population we believe will actually enroll in the Medicaid program, total spending on Medicaid services for these new enrollees, and the state and federal portions of this spending. Table 1 summarizes the findings of our analysis.

Table 1: Projected Spending on Medicaid Expansion Services by Fiscal Year

Spending	2016	2017	2018	2019	2020	2021
Newly Eligible Adults	41,910	41,980	42,050	42,120	42,190	42,260
Newly Eligible Persons that Enroll in Medicaid*	20,066	23,273	26,492	26,535	26,580	26,623
----------Costs in Thousands of Dollars----------						
Spending on Services	**$145,435**	**$174,438**	**$205,368**	**$212,747**	**$220,433**	**$224,514**
Federal Spending	$145,435	$170,633	$195,514	$200,683	$204,087	$204,928
State Spending	$0	$3,804	$9,854	$12,064	$16,346	$19,587

Source: Analysis by Evergreen Economics of data from various sources
* Represents the unduplicated count of newly eligible enrollees in that fiscal year; annual counts are not cumulative

We present our analysis in the following three sections:

A. Our projection of the expansion population for FY2016 through FY2021
B. Our estimates of the per-enrollee cost of providing Medicaid services for the expansion population for FY2016 through FY2021
C. Our estimates of total spending on services for the Medicaid expansion and the state's share of this spending

EVERGREEN ECONOMICS

A. The Expansion Population

We are aware of only two other analyses that estimate the number of persons in the expansion population. These are:

1. ***An Analysis of the Impact of Medicaid Expansion in Alaska***, prepared for DHSS by The Lewin Group, completed in April 2013 and released to the public in November 2013
2. ***Medicaid in Alaska under the ACA***, prepared by The Urban Institute, February 2013

Table 2 shows the counts from the two studies. The Lewin study includes counts of newly eligible adults as well as counts of those predicted to actually enroll in Medicaid. The study from the Urban Institute includes only estimates of the number of newly eligible persons that actually enroll. Both studies assume that Alaska would initiate expansion on January 1, 2014.[1] The two studies differ in their estimates of Medicaid enrollment of newly eligible persons in each year through 2020, with the Lewin study projecting 5,000 to 8,000 more enrollees than the Urban Institute projects.

Between 2014 and 2020, the Lewin Group projects that the average annual growth rate of the newly eligible population will be about 1.4 percent, far greater than the growth rate projected by the Alaska Department of Labor and Workforce Development (ADLWD) for the 19 to 64 population over that same period (0.04%).[2]

Table 2: Lewin Group and Urban Institute Projections of Newly Eligible Population, Calendar Year Estimates Based on the Assumption of January 2014 Medicaid Expansion

Report	Population	2014	2015	2016	2017	2018	2019	2020
Lewin Group	Newly Eligible	63,986	64,713	65,619	66,571	67,496	68,560	69,684
	Enrollment*	30,806	35,944	41,286	41,853	42,401	43,029	43,687
Urban Institute	Newly Eligible	----------Not Reported----------						
	Enrollment	18,200	27,400	33,100	36,700	37,100	37,300	37,500

Sources: *An Analysis of the Impact of Medicaid Expansion in Alaska*, Lewin Group, April 2013, Figure B-3; *Medicaid in Alaska under the ACA*, prepared by The Urban Institute, February 2013, Figure 3

* Lewin enrollment estimates based on assumption of 63 percent take-up rate and enrollment lag-rate rates of 76 percent in first year, 88 percent in second year, and 100 percent each subsequent year.

In the Lewin study, the authors utilized the Health Benefits Simulation Model (HBSM) and data from the Current Population Survey (CPS) for the years 2008-2010 to estimate the number of people who would become newly eligible for Medicaid through Medicaid expansion in Alaska.

[1] In fact, the Lewin Group study also includes estimates of enrollment by newly eligible adults under the assumption of expansion beginning in January 2015 and in January 2016.

[2] It is not possible to determine the estimated growth rate in the expansion population assumed in the Urban Institute analysis, however, based on their estimates of enrollment by the newly eligible adults, it appears that the study assumes a lower population growth rate than does the Lewin study.

EVERGREEN ECONOMICS

To develop estimates of enrollment by newly eligible persons, the Urban Institute relied on demographics and health care coverage data from the American Community Survey (ACS) for 2008, 2009, and 2010. Because the ACS lacks the information necessary to develop estimates of the newly eligible population, the authors imputed unavailable characteristics such as Medicaid eligibility, employer offers of coverage, and immigration status.

Evergreen Estimates of the Expansion Population

While data do exist on particular aspects of the expansion population (e.g., estimates of the number of Alaskans by age and gender), neither federal nor state agencies collect data on the expansion population *per se*. Instead, we relied on two Alaska data sources and a small number of assumptions to estimate the size of the expansion population.

To estimate the number of persons newly eligible for Medicaid expansion, we relied on information collected by the Division of Public Health through the Behavioral Risk Factor Surveillance System (BRFSS) survey for 2012 and 2013 and population estimates and projections reported by the ADLWD. The BRFSS survey is a statewide household survey that collects detailed demographic, household, and health-related information on Alaskans. In this survey, adult respondents are asked their age, the number of other adults living in the home, the presence and ages of any dependent children living in the home, and household income.

The primary enrollees of Medicaid expansion are working-age adults 21–64 years of age who are not caring for dependent children, are not disabled or pregnant, and are at or below 138 percent of Federal Poverty Level (FPL).[3] This group is currently not eligible for Medicaid in Alaska. In addition, Medicaid expansion affects a small number of other adults, 19–64 years of age, that do not meet current income limits for Medicaid eligibility.[4]

Based on our analysis of the BRFSS data for 2012 and 2013, our midpoint estimate of the number of persons in the Medicaid expansion population is 41,910 for FY2016. Our lower and upper bound estimates of the expansion population are 34,833 and 48,988.

Table 3 shows ADLWD projection of the adult population (ages 19-64), the Medicaid Budget Group's draft projection of (currently eligible) Medicaid enrollees 19–64 years of age, and our projection of the newly eligible population (also 19-64 years of age). For each year through 2021, our projection of the newly eligible population is lower than the counts reported in the Lewin study and increases at a slower rate.[5]

---

[3] The income eligibility threshold is 133% FPL with a 5% income disregard, making the threshold effectively 138% of FPL.

[4] Specifically, expansion also affects the following adults:

- Non-disabled, ages 19-20, between 123% and 138% of FPL
- Disabled, ages 18-64, between 102% and 138% of FPL who do not receive Medicare

We estimate that these groups will represent less than 3 percent of the expansion population.

[5] In comparison to the Lewin study, which relies on aggregated data from the CPS, various data imputations, and Lewin's national simulation model, we developed our estimate of the newly eligible population from the direct responses of Alaskan households from the BRFSS and population projections from ADLWD.

Table 3: Projected Population of Alaskan Adults from ADLWD, Projected Medicaid Enrollment of Currently Eligible, and Projected Number of Newly Eligible Adults by Fiscal Year

Report	2016	2017	2018	2019	2020	2021
Population ages 19-64*	471,668	472,394	472,483	471,937	471,391	470,845
Growth Rate	0.15%	0.15%	0.02%	-0.12%	-0.12%	-0.12%
Current Medicaid Enrollees 19-64**	60,767	61,201	61,419	61,618	61,798	61,961
Count of Newly Eligible 19-64	**41,910**	**41,980**	**42,050**	**42,120**	**42,190**	**42,260**
Below 100% FPL	23,344	23,383	23,422	23,461	23,500	23,539
100% to 138% FPL	18,566	18,597	18,628	18,659	18,690	18,721

Source: Analysis by Evergreen Economics of data from 2012 - 2013 BRFSS surveys, Alaska Department of Health and Social Services, Division of Public Health

*Analysis by Evergreen Economics of data from *Alaska Population Projections 2012 to 2042*, Alaska Department of Labor and Workforce Development, http://laborstats.alaska.gov/pop/popproj.htm

**Projected unduplicated count of Medicaid enrollees from *Long-Term Medicaid Forecast 2014-2034*, currently in draft and being reviewed.

Table 4 shows our projection of the newly eligible population by region. We estimate that just over half of all newly eligible persons live in the Anchorage Mat-Su region, which is currently home to about 54 percent of Alaskans.

Table 4: Projected Newly Eligible Population by Region and Fiscal Year

Region*	2016	2017	2018	2019	2020	2021
Anchorage-Mat-Su	21,124	21,161	21,197	21,231	21,266	21,302
Gulf Coast	5,830	5,839	5,849	5,859	5,869	5,878
Interior	5,787	5,796	5,806	5,816	5,825	5,835
Northern	1,347	1,349	1,351	1,353	1,356	1,358
Southeast	5,184	5,193	5,201	5,210	5,219	5,227
Southwest	2,638	2,642	2,646	2,651	2,655	2,660
Total Count of Newly Eligible	**41,910**	**41,980**	**42,050**	**42,120**	**42,190**	**42,260**

Source: Analysis by Evergreen Economics of data from 2012 - 2013 BRFSS surveys, Alaska Department of Health and Social Services, Division of Public Health

* Regional designations used by Alaska Division of Public Health and Alaska Department of Labor and Workforce Development

Table 5 shows the distribution of the expansion population with respect to existing health insurance coverage.[6] As the table shows, approximately 43 percent of newly eligible adults do not have health insurance. Of those with health insurance, the most common forms of coverage are employer

[6] The 2012 BRFSS questionnaire only asked whether the respondent had any type of health insurance, not what type they had. Therefore, this table only provides responses for those individuals that completed the 2013 BRFSS questionnaire and were identified as newly eligible.

sponsored (19.6%) and partial coverage (29.3%).[7] Another 3.4 percent did not know or refused to disclose if they had insurance. It is important to note that anyone with Medicare is not eligible for Medicaid through the expansion.

Table 5: Health Insurance Status of the Expansion Population, Survey Year 2013

Health Coverage	Percent of Responses
None	43.3%
Employer	19.6%
Purchased	4.3%
Partial Coverage*	29.3%
Not Sure, Don't Know, Refused	3.4%

Source: Analysis by Evergreen Economics of data from the BRFSS survey

*Partial coverage includes health insurance coverage through TRICARE and the U.S. Military, as well as healthcare services provided by tribal health facilities, and possibly other sources.

Table 6 shows the employment status of the expansion population in 2012 and 2013. The majority of newly eligible adults were in the labor force, with nearly 44 percent of this group employed and 30 percent unemployed. Unemployed persons include those not working, but currently looking for work, as well as those not working due to seasonal employment. Another 21 percent were not in the labor force, which could be due to retirement, enrollment in school, family obligations, frustration with job search and no longer looking for employment, or simply by choice. Just under 6 percent of the expansion group stated they were unable to work.

Table 6: Employment Status of the Expansion Population, Survey Years 2012-2013

Employment Status	Percent of Responses
Employed	43.8%
Unemployed*	29.8%
Not in Labor Force**	21.0%
Unable to Work	5.5%

Source: Analysis by Evergreen Economics of data from the BRFSS survey

* Unemployed consists of individuals who are not currently working, but are looking for work, as well as seasonal employees, not currently working.

** Persons not in the workforce include those who have no job and are not looking for a job (often because they are in school, retired, or have family responsibilities) and persons in institutions.

Our assumption of growth in the expansion population through 2020 is consistent with but slightly faster than ADLWD's most recent projection for the 19–64 population.[8]

[7] Those covered by employer-sponsored insurance may be covered by their own employer or by the employer of another person. Partial coverage includes health insurance coverage through TRICARE and the U.S. Military, as well as healthcare services provided by tribal health facilities, and possibly other sources.

EVERGREEN ECONOMICS

B. Per-Enrollee Spending on Medicaid Services for Newly Eligible Adults

Because Alaska's Medicaid program does not currently serve the expansion population, we do not know with certainty how much expansion to the newly eligible enrollees will cost. There are, however, working-age adults enrolled in the Medicaid program who are a good proxy for the expansion population. The majority of these enrollees are enrolled through the Family Medicaid eligibility category, which is comprised of non-disabled adults who are eligible for Medicaid services due to being low income with dependent children.[9] With the exception of having dependent children, we believe these enrollees are a good proxy for the expansion population.[10]

Based on our analysis of data from the Department's Medicaid Budget Group, between FY2009 and FY2013, average spending per enrollee for adults in Family Medicaid grew on an average annual basis by just 1.0 percent to $6,560 in FY2013 (see Table 7). Over this same period, average spending per enrollee was little changed for all working-age adults (growing from $12,282 to $12,374). The substantial difference in average spending per enrollee is due to the fact that the overall working-age population includes individuals who are disabled or pregnant.

Table 7: Historical Average Per-Enroll Cost of Services

Fiscal Year	Adults in Family Medicaid *	All Working-Age Adults
2009	$6,359	$12,282
2010	$6,708	$13,079
2011	$6,934	$13,301
2012	$6,593	$12,684
2013	$6,560	$12,374
Annual % Growth	***1.0%***	***0.2%***

Source: Analysis by Evergreen Economics of data from Alaska DHSS, Medicaid Budget Group

* Based on Family Medicaid eligibility, ages 19–64

Our estimated annual cost of Medicaid services for the expansion population varies by gender and age (see Figure 1). For men, cost of service rises substantially from about $3,500 per enrollees for those under 35 to just under $7,200 for those between 55 and 64. For women, costs do not vary

---

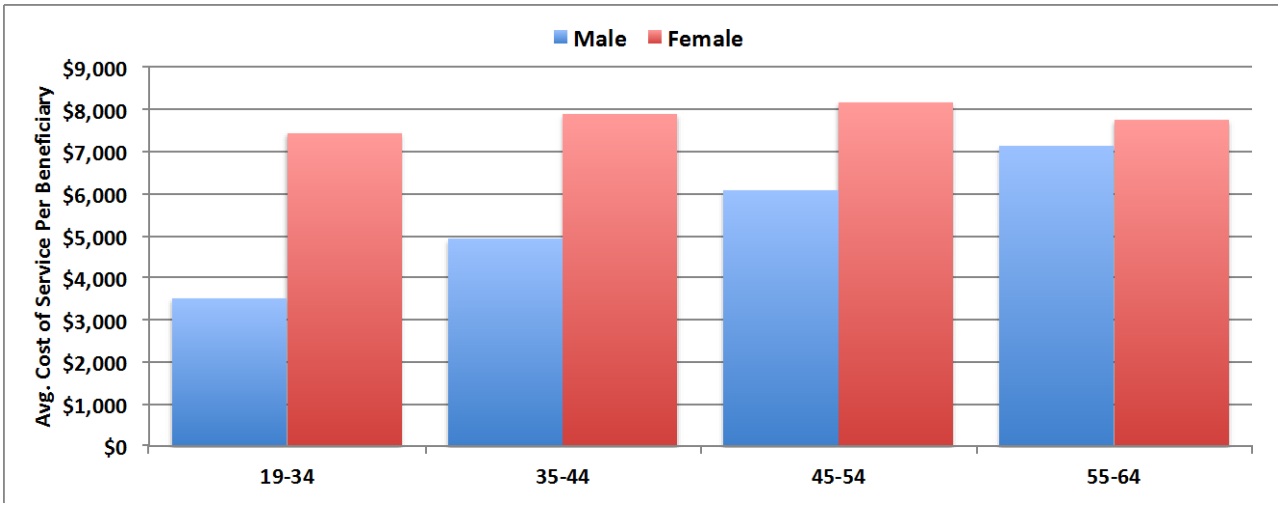
[8] ADLWD uses a cohort component technique to "age" over time sub-populations based on gender and age. The demographers then add in projected births and in-migrants and subtract out projected deaths and out-migrants. ADLWD expects the working-age population to grow by 14 percent between 2012 and 2042, slower than the children and elderly populations.

[9] There are also a small number of disabled adults in the expansion population. We relied on data for Medicaid enrollees 19–64 years of age, enrolled through the SSI/APA, Medicare, and Other Disabled eligibility categories in developing estimates of Medicaid costs for the expansion population.

[10] We base this conclusion on our comparative analysis of data from the 2012 and 2013 BRFSS surveys on the health status of the expansion population and the current Medicaid-eligible population. Please see the tables in the appendix of this memo to see the comparison in health status between the expansion population, current Medicaid enrollees, and Alaskan adults not in Medicaid and not in the expansion population.

substantially by age, ranging from about $7,500 for women under 35 to just under $8,200 for women between 45 and 54.

Figure 1: Average Annual Cost of Medicaid Services Per Enrollee, Working-age Family Medicaid Eligibility Only, FY2012-13



Source: Analysis by Evergreen Economics of data from Alaska DHSS, Medicaid Budget Group

Distribution of the Expansion Population by Gender and Age

Table 8 shows our estimated distribution of newly eligible adults in the expansion group by age and gender. We believe this group will be mostly male (54%) and that about 21 percent of this group will be males between the ages of 19 and 34. This is important because, as Figure 1 shows, this demographic group has significantly lower per-enrollee spending than all other gender-age cohorts.

Table 8: Estimated Distribution of Expansion Group With Respect to Gender and Age

Gender	Ages 19-34	Ages 35-44	Ages 45-54	Ages 55-64	All Ages
Male	20.1%	5.2%	13.6%	14.4%	**54%**
Female	12.6%	5.8%	13.8%	14.5%	**46%**
Total	**32.7%**	**11.0%**	**27.4%**	**28.9%**	**100%**

Source: Analysis by Evergreen Economics of data from BRFSS surveys, ADHSS, Division of Public Health

Estimated Spending Per Enrollee Weighted by Gender and Age

Table 9 shows our projected annual per-enrollee costs for the expansion population. We estimate that the average cost of services per newly eligible Medicaid enrollee for FY2016 will be about $7,250, growing to $8,400 by FY2021. Over this same period, we project that the per-person cost for currently eligible, non-disabled adult Medicaid enrollees will be several hundred dollars less each year. The difference in costs is due to the expansion population likely containing a relatively small number of persons with disabilities.

Table 9: Projected Cost of Service Per Newly Eligible Medicaid Enrollee by Fiscal Year, Weighted by Expected Gender and Age Distribution of the Expansion Population

Parameter	2016	2017	2018	2019	2020	2021
Per Enrollee Cost	$7,248	$7,495	$7,752	$8,018	$8,293	$8,433

Source: Analysis by Evergreen Economics of data from Alaska DHSS, Medicaid Budget Group

C. Estimated Costs of Medicaid Expansion

Table 10 shows estimated costs of Medicaid services and the state share of spending for fiscal years 2016 through 2020. Row 1 shows our estimate of the newly eligible population. Rows 2 shows the factor (the "take-up rate") we used to convert the count of newly eligible adults to our estimate of the new Medicaid enrollees (which are shown in row 3). The take-up rate represents the proportion of the newly eligible population that will enroll through the Medicaid expansion that year.[11] The take-up rate assumptions shown in Table 10 are from the 2014 study conducted by the Lewin Group for the State of Alaska.[12] The Lewin assumption of the take-up rate is consistent with the few studies we are aware of that were conducted prior to the CY2014 expansion.

According to a study conducted in 2012 by the Kaiser Family Foundation, Medicaid participation rates in the HIPSM (health insurance policy simulation model) average 60.5 percent among newly eligible people.[13] Similarly, in 2012 Sommers et al estimated that Medicaid participation averaged 62.6 percent among eligible adults without private insurance, with state-level estimates ranging from 43 percent to 83 percent.[14] Another study by Kenny et al. in 2012 found that the average participation rate for Medicaid-eligible adults was 67.4 percent.[15]

Row 4 shows our estimates of the per-enrollee cost of service, which is a weighted average based on cost data for current Medicaid enrollees and our expectations of the distribution of the expansion population with respect to gender, age, and disability status.[16] Row 5 shows our estimated total cost of service, which is calculated by multiplying the count of new enrollees by the average estimated spending per enrollee.

Row 6 shows our estimate of the percent of spending by the newly eligible Medicaid enrollees that would qualify for 100 percent federal match under either the ACA or IHS FMAP.[17] When an IHS

---

[11] For example, our estimate of newly eligible adults for FY2016 is 41,910 and the estimated take-up rate for FY2016 is 47.9%; thus, we estimate 41,910 × 47.9% = 20,066 newly eligible adults will enroll in Medicaid in FY2016.
[12] The take-up rate used in our analysis is the product of the take-up rate and lag-rate show in Table B-3 of the Lewin report.
[13] http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8384.pdf
The HIPSM does not make assumptions about participation; instead it uses data and literature about Medicaid participation based on factors such as income, race, education, and previous sources of health coverage to determine the likelihood of participation.
[14] http://content.healthaffairs.org/content/31/5/909.abstract
[15] http://www.nhchc.org/wp-content/uploads/2011/09/Kenney-MedicaidEligibilityEnroll-2012.pdf
[16] We estimate that about 1.5% of the expansion population is disabled.
[17] The Federal Medical Assistance Percentage (FMAP) rates for the ACA expansion are as follows: CY2015 – CY2020 are as follows: 100%, 100%, 95%, 94%, 93%, 90%. For our analysis, we modified these rates from calendar year to state fiscal

beneficiary, who qualifies for Medicaid, receives care at a tribal health facility, the federal match is 100%. This is important because after FY2016, the FMAP under the ACA expansion begins to decrease each year until FY2021, when it will remain at 90 percent. The IHS FMAP continues at 100 percent. We estimate that about 13 percent of spending by the newly eligible enrollees will continue to receive the 100 percent match rate from the federal government through the IHS FMAP.

Rows 7 and 8 show our estimates of federal and state spending on Medicaid services for the newly eligible population.

Table 10: Projected Spending on Medicaid Expansion Services by Fiscal Year

Row	Spending	2016	2017	2018	2019	2020	2021
1	**Newly Eligible Adults**	41,910	41,980	42,050	42,120	42,190	42,260
2	**Take-up Rate***	47.9%	55.4%	63%	63%	63%	63%
3	**New Enrollees**	20,066	23,273	26,492	26,535	26,580	26,623
4	**Spending Per Enrollee**	$7,248	$7,495	$7,752	$8,018	$8,293	$8,433
	----------Costs in Thousands of Dollars----------						
5	**Total Spending on Expansion Services**	**$145,435**	**$174,438**	**$205,368**	**$212,747**	**$220,433**	**$224,514**
6	*Federal Participation***	100%	97.8%	95.2%	94.3%	92.6%	91.3%
7	**Federal Spending**	**$145,435**	**$170,633**	**$195,514**	**$200,683**	**$204,087**	**$204,928**
8	**State Spending**	**$0**	**$3,804**	**$9,854**	**$12,064**	**$16,346**	**$19,587**

Source: Analysis by Evergreen Economics of data from various sources

* From *An Analysis of the Impact of Medicaid Expansion in Alaska*, Prepared by The Lewin Group, April 12, 2013. The Take-up Rate shown Table 10 is the product of the *take-up rate* and the *lag rate* shown in Figure B-3 of the Lewin report; it represents the estimated percent of newly eligible adults that will enroll in Medicaid in that year.

** The federal participation rates shown in Table 10 incorporate the following two adjustments:

1. Federal financial participation rates for Medicaid expansion are based on calendar year. Because we conducted our analysis based on the state fiscal year, which begins on July 1 and ends on June 30, we averaged the calendar rates to approximate the fiscal year FMAP rates.
2. We estimate that 29% of newly eligible Medicaid enrollees will be either Alaska Native or American Indian. Based on recent historical data from the Medicaid Budget Group, 44% of Medicaid expenses incurred by Alaska Natives and American Indians are provided by a tribal health facility and, therefore are eligible for the 100% federal match under the IHS FMAP (Percent IHS Qualify = 29% * 44% ≈ 12.8%). As the federal match rate under Medicaid expansion decreases between FY2014 and FY2020, an increasing amount of Medicaid spending (by Alaska Natives and American Indians at tribal health facilities) will shift to the 100% tribal FMAP rate.

year. In addition, we factored in a tribal FMAP adjustment to account for Medicaid services provided to Alaska Natives and American Indians at tribal health facilities.

EVERGREEN ECONOMICS

Appendix Tables: Health Status Comparison Between Expansion Population, Current Medicaid Enrollees, and All Other Alaskan Adults

The following tables are based on analysis of the 2012 and 2013 BRFSS survey years and are intended to show the extent to which the newly eligible population differs from the currently Medicaid-eligible adult population and other Alaskan adults (those neither newly eligible for Medicaid under the expansion, nor currently eligible for Medicaid). It is important to note that individuals we identified as "Currently Eligible" within the BRFSS data are not necessarily enrolled in Medicaid. Rather, they are identified as eligible for Medicaid, but may or may not be actually enrolled. For each of the following tables, the three comparison groups are defined as:

- **Newly Eligible:** Alaskans 19 to 64 years of age who are eligible for Medicaid through the expansion.
- **Currently Eligible:** Alaskans 19 to 64 years of age who are currently eligible for Medicaid but may or may not be enrolled in Medicaid
- **Other Adults**: Alaskans 19 to 64 years of age who are not Newly Eligible or Currently Eligible

Table 11: Gender Distribution of Newly Eligible, Currently Eligible, and Other Adults

Gender	Newly Eligible	Currently Eligible	Other Adults
Male	53.3%	45.2%	54.6%
Female	46.7%	54.8%	45.4%

Source: Analysis by Evergreen Economics of data from BRFSS surveys, ADHSS, Division of Public Health

Table 12: Age Distribution of Newly Eligible, Currently Eligible, and Other Adults

Gender	Newly Eligible	Currently Eligible	Other Adults
19-34	32.6%	44.0%	30.8%
35-44	11.1%	27.8%	21.1%
45-54	27.4%	18.3%	24.8%
55-64	28.9%	9.9%	23.2%

Source: Analysis by Evergreen Economics of data from BRFSS surveys, ADHSS, Division of Public Health

Table 13: Labor Force Participation by Newly Eligible, Currently Eligible, and Other Adults

Employment Status	Newly Eligible	Currently Eligible	Other Adults
Employed	43.8%	51.1%	76.0%
Unemployed	29.8%	13.7%	5.4%
Not in work force	21.0%	20.5%	16.4%
Unable to work	5.5%	14.7%	2.3%

Source: Analysis by Evergreen Economics of data from BRFSS surveys, ADHSS, Division of Public Health

Table 14: Proportion Alaska Native of Newly Eligible, Currently Eligible, and Other Adults

Designation	Newly Eligible	Currently Eligible	Other Adults
Alaska Native or American Indian	28.7%	30.2%	12.4%

Source: Analysis by Evergreen Economics of data from BRFSS surveys, ADHSS, Division of Public Health

Table 15: Self-Reported Health Status by Newly Eligible, Currently Eligible, and Other Adults

General Health	Newly Eligible	Currently Eligible	Other Adults
Excellent	17.3%	16.2%	21.9%
Very Good	19.8%	25.6%	38.7%
Good	35.0%	36.7%	30.2%
Fair	20.3%	13.5%	7.3%
Poor	7.7%	8.2%	1.8%

Source: Analysis by Evergreen Economics of data from BRFSS surveys, ADHSS, Division of Public Health

Table 16: Self-Reported Physical Health Status by Newly Eligible, Currently Eligible, and Other Adults

Days Last Month Physical Health Was Not Good	Newly Eligible	Currently Eligible	Other Adults
Average Number of Days	5.7	5.6	2.5
Reported 0 days	56.9%	56.5%	68.6%
Reported 1-7 days	23.2%	22.4%	22.9%
Reported 8-14 days	3.5%	5.0%	2.6%
Reported >14 days	16.4%	16.1%	5.9%

Source: Analysis by Evergreen Economics of data from BRFSS surveys, ADHSS, Division of Public Health

Table 17: Self-Reported Mental Health Status by Newly Eligible, Currently Eligible, and Other Adults

Days Last Month Mental Health Was Not Good	Newly Eligible	Currently Eligible	Other Adults
Average Number of Days	4.8	5.0	2.5
Reported 0 days	59.0%	56.9%	69.5%
Reported 1-7 days	21.7%	21.4%	20.6%
Reported 8-14 days	4.3%	6.6%	3.4%
Reported >14 days	15.1%	15.1%	6.4%

Source: Analysis by Evergreen Economics of data from BRFSS surveys, ADHSS, Division of Public Health

ATTACHMENT H

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAR - 6 2015

The Honorable Bill Walker
Governor of Alaska
Juneau, AK 99811

Dear Governor Walker:

Thank you for your efforts regarding Medicaid expansion in Alaska. In follow up to our staffs' discussions, I wanted to provide you with the following information on the Medicaid coverage expansion provision of the Affordable Care Act.

As you know, the law provides that the federal government will pay 100 percent of the amounts expended by the state for medical assistance for such newly-eligible adult beneficiaries through 2016. The federal contribution gradually declines beginning in 2017, but it is never less than 90 percent of the cost of care. In previous guidance, we notified states of the opportunity to extend coverage, and the absence of federal financial penalties if a state does not do so, or if it does so and later drops such coverage. See question and answer 25 of the Frequently Asked Questions on Exchanges, Market Reforms and Medicaid, issued on December 10, 2012, and available at: http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf.

Consistent with that guidance, Alaska may take up the Medicaid coverage expansion, and then later drop it at state option. There is no requirement for a state to maintain coverage for the new adult group. We generally encourage states that eliminate any coverage category elected at state option to plan for a smooth transition process for phasing out that coverage. For that reason, states' 1115 demonstrations include a standard phase out term and condition. This includes requiring that any individuals who may continue to be eligible for Medicaid in other eligibility categories are notified and given the opportunity to continue coverage through that alternative category. We also note that if Alaska expands Medicaid coverage and then drops such coverage at a later point, there would be no resulting financial penalty and no reduction to the federal matching dollar rates otherwise available to Alaska for its Medicaid program.

I hope this information is useful in your efforts to help low-income Alaska residents gain coverage and to reduce uncompensated care for Alaska health care providers. Please do not hesitate to contact me if you have any further thoughts or concerns.

Sincerely,

Sylvia M. Burwell

ATTACHMENT I

Pathway off Medicaid

Alaska Department of Health and Social Services

April 15, 2015

The Affordable Care Act was designed so that people are supported in their transition from Medicaid to the health insurance marketplace. Following is an example of how a person might make this transition.

Once a person's income exceeds Medicaid eligibility limits, he or she becomes eligible to purchase subsidized insurance through the health insurance marketplace.

Example: Dylan, 30, works at a small business* in Anchorage. Dylan works full time (40 hours per week) and makes $20,000 annually. Dylan is eligible for Medicaid expansion due to the fact he earns less than $20,314 annually.

Dylan is offered a promotion at work and will get a $.50 per hour raise. **Dylan is now making $21,040 annually.** His income now exceeds Medicaid eligibility requirements. However, Dylan is referred to the health insurance marketplace to purchase a health care plan. Because he qualifies for subsidies and cost sharing reductions on out-of-pocket expenses, his raise will allow him to earn more money and maintain health coverage.

Based on his income, Dylan is eligible for a subsidy of $421.39 each month to reduce his monthly insurance premium.

Dylan selects the cheapest silver plan. **His premium cost, after the subsidy, is $13 per month**. By selecting a silver plan, Dylan's maximum out-of-pocket expenses when he goes to the doctor for the year will be $500.

Since Dylan's income is less than 250% of the federal poverty level, he also qualifies for cost sharing reductions. Cost sharing reductions means Dylan will pay reduced costs for his co-pays when he goes to the doctor and will have reduced out-of-pocket maximums for the year. But, he must select a silver plan to get the cost sharing reductions.

Dylan could select a bronze plan where his monthly premium would be $0 per month, but he would have to pay up to $6,600 in out-of-pocket expenses. Dylan is an avid outdoorsman and enjoys hiking, hunting and skiing, so he wants to make sure he doesn't have to pay too much should he get injured. Dylan makes the decision that is right for his lifestyle and for what he knows he can afford.

Dylan's raise means he is earning an additional $1,040 each year. His health insurance premiums for the year total $156 plus up to an additional $500 in co-pays for medical care he may receive during the year. He ends up with more money in his pocket, and begins the experience of purchasing and managing his own health insurance plan on the commercial market.

***** = Businesses with less than 50 FTE's are not required to offer health insurance for their employees. The Alaska Department of Labor in 2012 reported that 96% of Alaska firms in 2011 had fewer than 50 FTEs, and 40% of Alaskans worked for these small firms.