HOUSE FINANCE COMMITTEE
February 18, 2020
1:36 p.m.

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CALL TO ORDER

Co-Chair Foster called the House Finance Committee meeting to order at 1:36 p.m.

MEMBERS PRESENT

Representative Neal Foster, Co-Chair
Representative Jennifer Johnston, Co-Chair
Representative Dan Ortiz, Vice-Chair
Representative Ben Carpenter
Representative Andy Josephson
Representative Gary Knopp
Representative Bart LeBon
Representative Kelly Merrick
Representative Colleen Sullivan-Leonard
Representative Adam Wool

MEMBERS ABSENT

Representative Cathy Tilton

ALSO PRESENT

Adam Crum, Commissioner, Department of Health and Social Services; Ted Helvoight Ph.D., Vice President, Evergreen Economics.

PRESENT VIA TELECONFERENCE

None

SUMMARY

PRESENTATION: LONG-TERM FORECAST OF MESA: MEDICAID ENROLLMENT AND SPENDING IN ALASKA

Co-Chair Foster reviewed the meeting for the day.

^PRESENTATION: LONG-TERM FORECAST OF MESA: MEDICAID ENROLLMENT AND SPENDING IN ALASKA

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ADAM CRUM, COMMISSIONER, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, introduced Dr. Helvoight. He indicated the importance of the subject of Medicaid. He thought the presentation would be very informative. The commissioner provided some background information on Dr. Helvoight. Evergreen Economics had been under contract with the Department of Health and Social Services (DHSS) since 2011 when Dr. Helvoight co-founded Evergreen Economics. Prior, the department contracted for his services through ECONorthwest. He was responsible for preparing the Medicaid Enrollment and Spending in Alaska Report (MESA). The report was a 20-year forecast updated annually and was developed based on more than 20 years of enrollment and claim level data from DHSS.

Dr. Helvoight was the lead author of the first long-term Alaska Medicaid forecast conducted by the Lewin Group in 2005 and presented to the legislature in 2006. Since then, the department had engaged him to conduct annual updates of the long-term Medicaid forecast and to develop short-term forecasts that assisted DHSS with fiscal year planning and budgeting. He also provided training and support to the Medicaid budget group. He conducted numerous other analyses for the department including the cost of eight chronic conditions to the Alaska Medicaid Program, the potential savings to the program from diabetes self-management, the forecast of enrollment and spending on Medicaid expansion, the trends in Alaska's senior population, and the enrollment in programs and spending on services for Alaska's seniors. He suggested that in looking towards the future at Alaska's long-term budget issues, the topic of Medicaid would need to be addressed together. He thanked the committee.

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TED HELVOIGHT PH.D., VICE PRESIDENT, EVERGREEN ECONOMICS, introduced the PowerPoint Presentation: "Long-Term Forecast of MESA: Medicaid Enrollment and Spending in Alaska." He began with slide 2 containing an outline of what he would be discussing in the meeting. He explained that his report

was an update of his original study produced in 2006. He invited members to ask questions during the presentation.

Dr. Helvoight turned to slide 3 regarding the background of MESA. The forecast assumed that Medicaid, as it was presently, would exist into the future. In the early forecast he had no idea there would be the Affordable Care Act (ACA) Medicaid expansion. He did not predict recessions, policy changes, or changes to Federal Medical Assistance Percentages (FMAP) rates. It assumed the program existed today. The forecast would help the legislature and department leadership to understand what spending and enrollment would look like 20 years from the present day given the programs currently in place. He asserted things would change that Alaska could not control such as actions of the federal government and population changes. The department could control certain other things such as services offered and eligibility requirements. The forecast provided a benchmark against the future. The idea was to provide a picture of what Medicaid would look like in the future. It would help the legislature and the department make the changes necessary to ensure that the spending projections did not come true in many cases.

Dr. Helvoight continued that the forecast focused on population demographics and rates of enrollment for different groups such as men, women, children, the elderly, the working, and the different regions of the state. Utilization and intensity of Medicaid services and the increase in prices of medical services were also a focus.

Dr. Helvoight reviewed some key terms used in his forecast on slide 4. The slide was strictly for reference. He might come back to it later.

Dr. Helvoight turned to the Mesa Modeling Approach on slide 5. He started with the state's population determined by the Department of Labor and Workforce Development. He used the information pertaining to the regions of focus and the demographic subcomponents. He also considered enrollment for all of the different groups in the Medicaid Program. He then looked at the utilization of services. The Medicaid Program offered several different services. Since the original forecast to the present day, segmenting the services into 20 different categories, he considered the individual service categories and individual-touched

services which had changed over time. The earliest years of data he had were from 1997. He reported that on average the typical Medicaid enrollee utilized fewer than three (2.7) of the available services. Currently the number of services was about 3.5 to 3.6 services. Individuals were touching more services presently. In addition, the intensity of Medicaid use had grown over time. He spoke of the elephant in the room, price inflation. Price inflation was added to create a spending forecast.

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Dr. Helvoight moved to slides 6 and 7 to discuss recent historical trends. He highlighted that from FY 12 through FY 19 Medicaid enrollment had grown by 51 percent. The percent change in the number of recipients had grown slightly slower. The difference between the two was that a recipient was a Medicaid enrollee that received services and a Medicaid enrollee was anyone enrolled in Medicaid. Federal spending grew very rapidly and had almost doubled over the period at 93 percent while general fund (GF) spending increased by less than 6 percent over the same timeframe.

Representative Sullivan-Leonard asked if Dr. Helvoight had the data to show why the enrollment had increased by 51 percent. She wondered if the recipients had options other than Medicaid.

Dr. Helvoight responded that the Senate Finance Committee had a similar question. More specifically, the question was about how much of the increase resulted from expansion, changes in the economy, and the effect of the Affordable Care Act. He could determine who was on Medicaid through expansion but could not establish the reason. However, he could ascertain what a person's eligibility category was when they applied such as being disabled, because of expansion, or for other reasons. He could make some estimations about how much of the increase was due to expansion because some individuals were not eligible beforehand. Other aspects of the ACA such as "No wrong door" and insurance mandates might have influenced people to enroll in Medicaid. He would not know why a person enrolled in Medicaid but could determine their eligibility category. He could also make some estimates based on statistical analysis of the economic impacts of the recession which influenced enrollment.

Representative Sullivan-Leonard thought she was hearing that because of the failure of the ACA, recipients that would normally pursue private health insurance were being forced to enroll in Medicaid for their healthcare coverage.

Dr. Helvoight responded, "Not exactly." He assumed that in many cases individuals did not have access to insurance through a private marketplace. He indicated there were two types of individuals that would have joined Medicaid when it expanded: Previously uninsured individuals and individuals that had private insurance who dropped it when they became eligible through expansion. However, the information was not captured in the enrollment data.

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Representative Knopp asked the speaker to go back to Medicaid 101. He asked when Medicaid expansion was adopted in Alaska. Dr. Helvoight confirmed that it was in 2016.

Representative Knopp asked what the expansion did. Dr. Helvoight responded that Medicaid expansion went into effect September 1, 2015 (FY 16) and expanded Medicaid eligibility to adults who were not disabled and who did not have dependents. The three criteria were important. Prior to expansion a person would have been eligible as an adult with dependent children or a working-age adult with a disability. Expansion opened eligibility to adults without dependents and working-age adults without a disability. Expansion applied to adults from the ages of 19 to 64.

Representative Knopp commented that the number of people that enrolled in Medicaid after expansion was significant. He wondered about Medicaid eligibility criteria. Dr. Helvoight responded that all factors were considered including income levels. Medicaid was essentially healthcare for the poor.

Representative Knopp asked if the eligibility requirements changed with expansion. Dr. Helvoight responded that the traditional eligibility requirements had not changed. The change was the addition of one new eligibility group. He remarked that, independent of the expansion portion of the ACA, there was the "No wrong door" stipulation. He explained that when a person came in for a service, even unrelated to Medicaid, they would have a single application

process. If they were eligible for Medicaid, they could be signed up. He referred to the insurance mandate resulting from the ACA. A person might not be able to get private insurance but could get Medicaid. He reported an increase for children and other adults.

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Dr. Helvoight continued to slide 8: "Per-Enrollee/Recipient Spending Is Flat." The chart showed three different categories and spanned between 2010-2019. The green line showed the Per-enrollee growth in spending on Medicaid. On a per-enrollee basis spending had been very flat with Medicaid growing less than 1 percent per year. He indicated that for recipients (enrollees that were using services), the spending per Medicaid recipient had increased by 1.5 percent per year. The blue line represented everyone in Alaska. On a per-capita basis, healthcare expenditures had increased 4.5 percent annually. He noted that people who had insurance through their employer were familiar with percentage jumps over the past 9 or 10 years. He summarized that the Medicaid Program overall had done a good job of controlling spending growth. Although the enrollment had increased, the per-individual spending had not grown substantially.

Dr. Helvoight moved to slide 9 highlighting that the healthcare's share of economy has grown. He explained that the bars represented gross domestic product (GDP) for Alaska in nominal terms from 2010 to 2019. The blue line represented healthcare expenditures as a portion of the GDP – the percentage of GDP made up by healthcare. The recession in Alaska started late 2014 or early 2015. The bar showed a steep decline in GDP for a couple of years. The healthcare portion had increased from 15 percent before 2015 to nearly 20 percent presently. He concluded that the economy got smaller but healthcare did not. In addition, Medicaid expansion had driven up demand for healthcare services. Currently, the healthcare percentage of the economy in Alaska was nearly 20 percent which was about the same as the United States overall.

Dr. Helvoight emphasized that healthcare costs had risen quickly as denoted on slide 10. He indicated the red line represented medical price inflation for the Anchorage area. The orange dashed line represented medical price inflation for the U.S. overall. He went back to 1984 to show that the

red and orange dashed lines were on the same projection until late 2009 when they started to diverge substantially. It meant that medical prices in Alaska were growing much faster than the U.S overall.

Dr. Helvoight continued to explained the chart. He pointed to the dark blue line and the dashed light blue line. The dark blue line represented Alaska's consumer price index (CPI), while the dashed light blue line showed the entire U.S. During the same period of time. The growth in prices for all products and services consumed by Alaskans had grown slightly slower than the U.S. overall. He included the blue lines to show that the steep increase in medical prices in Alaska relative to the U.S. overall was not explained by a higher growth rate in the CPI. Instead, there were other factors at work driving up prices that were already higher than anywhere else in the U.S. The chart showed that the rate of change in healthcare prices was growing faster.

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Representative Sullivan-Leonard asked about healthcare price inflation. She mentioned in previous committee work there had been constructive conversations with different hospital providers and physicians about how to lower costs in the healthcare industry in Alaska. She noted that part of the reason for the high costs had to do with competition among providers and healthcare facilities. She provided a hypothetical scenario. She thought providers were setting rates as they pleased. In such circumstances she wondered how to bring costs down.

Dr. Helvoight agreed with Representative Sullivan-Leonard that providers had significant market power in Alaska. He looked at the U.S. and Alaska price inflation periodically. He admitted it had been a few years since he had reviewed it because they typically tracked the same. He had not expected to see such a deviation. Initially, he thought it was a small data series. However, it was not the case, as it was too consistent of a series divergence. As an economist he quickly assumed that it was an instance in which there was a small market, spatially isolated, and a market place that had consolidated significantly over the previous decade. He mentioned talking to an economist at Oregon Health and Sciences University. They agreed that doctors in Alaska were price-setting. He also mentioned

that the lower 48 had a much better insurance market because of there being more providers. At a high level, it appeared price-setting was occurring. He suggested that other states had similar problems. Publishing prices might help open up scrutiny. He noted that managed care was not permitted in Alaska and was uncertain it would work in the state. He indicated he was not looking at a Medicaid issue, rather, it was an Alaska healthcare issue. He clarified that the chart showed private healthcare spending rather than Medicaid. He asserted that Medicaid prices, although they would be lower, tracked along with private healthcare prices.

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Dr. Helvoight moved to the topic of the FY 20 - FY 24 projection on slide 11. He directed attention to the chart on slide 12 which showed population for the past, present, and future. He reported that population had increased very rapidly years ago. However, it had slowed down becoming negative. He predicted it would slowly increase again at about .5 percent per year through the following 20 years.

Dr. Helvoight reviewed the fact that Alaska's population was aging on slide 13. He indicated the population had changed and was growing older. He reported the growth rate for people 65 and older would grow more than 1.5 percent per year. The traditional working age adult population was growing much slower, and the child population was growing at an even slower rate. He thought the growth of the aging population in Alaska was higher than in the rest of the U.S.

Dr. Helvoight moved to slide 14 to highlight that the ACA was no longer impacting enrollment growth. He pointed to the age cohort between FY 15 through FY 20 (the fiscal year before Medicaid expansion to the current year). There was an overall growth rate in enrollment of 9 percent per year. Going forward the rate would be much slower – slightly more than 1 percent per year. He noted that currently Medicaid covered many more adults than it did children. It was not the case when he started in his position 15 years prior. He reported that in FY 00 the median age of enrollees was 14. In other words, half of Medicaid enrollees were 14 years old and younger and half were over 14. Presently, the median age was 23. He thought the median age would creep up to 25 by FY 40.

Dr. Helvoight turned to slide 15 showing the long view of Medicaid enrollment. The slide reflected from FY 97 through FY 40. The black line represented FY 19. Enrollment had been increasing through the period. He highlighted the rapid growth of the working adult population over the previous 5 years largely due to Medicaid expansion. He surmised that growth would slow but would continue over the following 20 years.

Dr. Helvoight moved to slide 16 and reported that spending was expected to slow but would keep growing. He pointed out that everything to the right of the black line got larger which reflected the power of compounding interest and growth rates. In 2000, the Medicaid Program was well below $1 billion. Currently, the program was at $2 billion. The program would push above $5.5 billion in 20 years. His analysis was based on population, demographics, potential enrollment, and medical price inflation.

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Representative Sullivan-Leonard asked if the aging population numbers were affected by Medicare dollars or whether he was only highlighting Medicaid. Dr, Helvoight responded, "Yes."

Representative Sullivan-Leonard asked about those recipients on Medicare, ages 65 and older, and why they were also on Medicaid. Dr. Helvoight responded that many individuals, ages 65 and older, were dual eligible for Medicaid and Medicare. Often, individuals enrolled in Medicare had their premiums paid for by the Medicaid Program. Medicare would then be the first payer on services. The slide only showed Medicaid dollars.

Representative Wool asked about the graph on slide 16 that increased to $5 billion in 20 years. He wondered how much of the increase had to do with price increases versus population growth. Dr. Helvoight would address the representative's question in 3 slides.

Representative Wool brought up the median age rising since Medicaid expansion. He wondered if Dr. Helvoight took into account those individuals eligible at age 21 who might not need Medicaid in their thirties. Dr. Helvoight thought Representative Wool brought up an important point. He was

not assuming enrollment was simply cumulative. The enrollment portion of the forecast was based on a set of statistical models examining 240 subgroups. The subgroups were based on 12 age cohorts, gender, Alaska Native Status, and 5 regions. The models considered the probability that an individual would enroll in Medicaid based on historical data and trends.

Representative Merrick asked about younger people and the Denali Kid Care Program. She asked if it was a part of the Medicaid Program. Dr. Helvoight confirmed that the Denali Kid Care Program was a part of the Medicaid Program. He reported that Medicaid was very complicated. He indicated that all kids on Medicaid or in the Children's Health Insurance Program (CHIP) were included. They would be enrolled through different eligibility categories.

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Dr. Helvoight discussed the notion that healthcare spending increased with age on slide 17. The slide showed the average Medicaid spending per enrollee. He suggested that it was no surprise more money was spent on seniors than working age adults and children. The trend would continue into the future.

Dr. Helvoight reviewed slide 18 having to do with federal spending versus GF spending. He reported that the forecast for FY 20 estimated just under $670 million in GF spending versus almost $1.6 billion in federal spending. Both types of spending would grow at the rate through FY 40. He mentioned that the long-term forecast was based on claims from the date of service rather than the date of payment. Typically for budgeting purposes the date of payment was more important. However, over the long-term, they would be the same. He added that he assumed there would be no changes in federal medical assistance percentages (FMAPS).

Co-Chair Johnston asked that with Medicaid Expansion there was a step-down of the federal reimbursement. However, the growth in federal spending was close to the growth in state spending. She asked if she was accurate. Dr. Helvoight answered affirmatively. He explained that the first half was with the FMAP for the expansion population of 93 percent. The second half was at 90 percent. Even with the step-down of expansion the state ended up at about the same growth rate.

Representative Merrick asked how the FMAP was calculated and how Alaska compared to other states. Dr. Helvoight responded that there were several calculations involved. He argued that the FMAP was very slow. He reported Alaska was at the lowest FMAP, 50 percent. Representative Merrick was interested in seeing the comparison of other states.

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Dr. Helvoight turned to slide 19 to answer Co-Chair Johnston's question about items contributing to growth rates. He pointed to the blue horizontal band at the bottom representing present day spending. It assumed the Medicaid population would stay the same without enrollees aging for the following 20 years – an unrealistic scenario. The very light sand colored band showed population growth. There would be slow population growth which would lead to more enrollment in Medicaid. Next, he pointed to the green band which showed enrollment growth above population growth. He expected that the proportion of the population enrolled would increase slightly over time.

Dr. Helvoight continued to the utilization of Medicaid services represented in dark brown. He reemphasized that all the services offered through Medicaid were aggregated into 20 different service categories. Over time individuals enrolled in Medicaid were using more of the different services. He provided an example. The utilization of Medicaid services had grown historically and would continue to grow. The light blue band represented the intensity of services. In the past, individuals with knee pain would get an x-ray, in following years they would get an MRI instead. Intensity of services could be due to technology or changes in the care provided which occurred over time. The change was not significant. He pointed to the mauve band showing healthcare price inflation which would drive cost up in the future. Medical price inflation was high everywhere in the U.S. and particularly high in Alaska. Prices paid to providers were contracted. However, the providers wanted to contract for higher prices all of the time. They wanted the increases to be comparable to what they were receiving in the private marketplace. Although he did not think the prices could get much higher in Alaska, medical price inflation would remain the largest cost driver in the future.

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Representative Carpenter thought there was an economy of scale problem. He suggested that there were not enough patients for the number of doctors in Alaska to continue increasing doctors and healthcare facilities adding to the state's bottom line.

Dr. Helvoight did not agree. He argued that Alaska had always had a small population. Other states had small populations without having the increases in healthcare prices as great as those seen in Alaska. Additionally, there was a small population purchasing energy, food, and other goods and services, yet the overall CPI was growing slightly slower in Alaska than the rest of the U.S. He observed one sector of the economy, the healthcare sector, that had a significant amount of power because people could not shop around. At best it was an opaque market. Prices were not posted in the emergency room and a patient would not know whether an anesthesiologist was in network, for example. He asserted that scale issues were not driving growth in prices. Rather, they were impacting what a patient was paying relative to the rest of the U.S. but were not driving prices up faster. He indicated something else was going on. He assumed the market power of providers was the source of impact.

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Representative Carpenter asked if Dr. Helvoight had broken down price inflation to show how competition in the lower 48 between states or metropolitan areas impacted prices compared to Alaska. He reiterated the severe increase in healthcare price inflation in Alaska and the lack of competition. He asked how Dr. Helvoight would delineate how much of the price inflation was due to Alaska's remoteness and lack of provider competition. He suggested that because of Alaska's small population there would never be sufficient competition to drive prices down. Additional people would not fly to Alaska for healthcare. The opposite occurred where Alaskans flew out of state for medical care. Alaska's competition existed outside the state but was a small number. If the number was larger, the competition would be greater.

Dr. Helvoight replied that instead of using a projection of medical price inflation for Alaska, it would be better to

take a medical price inflation forecast for the U.S overall and compare it to Alaska. The difference would equate to an Alaska premium. He spoke to the notion of Alaskans flying out of state for medical care. He thought it was a reaction to the price setting behavior of providers in the state. He noted price inflation had not always been a factor. Previously, medical price inflation in the U.S. had been similar to Alaska. The delineation occurred in 2009 or 2010 and had continued to grow. He suggested looking service-by-service comparing several other places around the state. He acknowledged that, because it was Alaska, there could be reasons why care would be more expensive. He argued that even if costs were 10 times higher in Alaska than Seattle or San Francisco, Alaska was a less expensive place to live. He was aware of limits to the expectation for an Alaska premium.

Representative Carpenter agreed that there were other places that were more expensive. However, those other places had larger populations. He argued that the economy of scale problem was that healthcare was more expensive, but there were more people needing healthcare.

Dr. Helvoight countered that it would impact the current cost. However, he did not think it would influence the change in cost over time. He indicated that it should not drive costs to grow faster. It might result in costs being higher, but the change over time should not be different. The difference in CPI was not that costs were higher in Alaska than the lower 48. It showed that the growth in costs was higher in Alaska than the lower 48. He reemphasized that the overall CPI costs had grown slower in Alaska with a smaller population. He suggested that in other sectors of the economy they were servicing the smaller population without experiencing the same rate in price growth.

Representative Carpenter asked if Dr. Helvoight had a graph showing when the increase in federal dollars was funneled into the healthcare industry and any related trends. He mentioned services growing. Dr. Helvoight replied that services growing also occurred in the rest of the U.S. He noted that federal dollars flowed into healthcare in every state. Every state had a Medicaid Program and individual Medicare. He continued that expansion occurred in certain states well before it did in Alaska. Montana expanded about the same time as Alaska. He noted that the federal dollars

were not included in the CPI (private dollars only). The increase in provider rates would be increased by medical price inflation.

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Representative Carpenter asked if Dr. Helvoight was suggesting that Alaska had a higher percentage of greedy people - some sort of healthcare greed in the state. In other words, providers jacked up their prices because they could. Dr. Helvoight, as an economist, saw market power. He did not look at the difference in prices, rather, he looked at the change in prices. In a place like Anchorage, a relatively small spatially isolated metro area compared to many other places throughout the U.S., he saw what looked like providers setting prices. He continued that Alaska might not have a strong insurance network to push back against them. He concluded that the healthcare price inflation was driving a large portion of costs in Alaska. He thought it was an issue beyond Medicaid; it was a statewide issue. He indicated that 10 years prior healthcare was 14 percent of Alaska's economy. Presently, it was 20 percent. Part of the reason for the percentage increase was that other parts of Alaska's economy had shrank including oil. There were other issues as well.

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Co-Chair Johnston recommended looking at reports from the Institute of Social and Economic Research (ISER) regarding out-of-network costs in Alaska. She realized the chart reflected a point in time. She mentioned the state's medical costs and retirement costs for its employees having dropped. She asked if Dr. Helvoight had built the information into the model. Dr. Helvoight responded, "I have not." He clarified that she was asking about state employees.

Co-Chair Johnston responded that she was talking about state employees and the state's retirement community. She noted the unfunded liability of state pension funds which was very large because of medical costs. However, medical costs had dropped significantly. She remarked there were a couple of other public insurance programs in which medical costs had also dropped.

Representative Wool asked if Dr. Helvoight had evaluated the eightieth percentile rule in Alaska. He encouraged him to explain it. Dr. Helvoight responded that it was not included in the forecast.

Representative Wool noted Dr. Helvoight had talked about Alaska prices, market power, and the reimbursement rate which did not apply to Medicaid directly as it did to private insurers. Dr. Helvoight had inferred a parallel. He wondered if he had analyzed the information. Co-Chair Johnston referred Representative Wool to the ISER study.

Representative Josephson thought there would be a connection if the private sector healthcare provider had exorbitant rate. The legislature might feel compelled to offer rate adjustments and inflation adjustments because of a concern of diminishing the interest in the Medicaid provision. He thought there was some connection.

Dr. Helvoight responded, "Absolutely." He elaborated that while Medicaid rates were negotiated and sometimes went down, most of the time they went up. The rate of increase was tied to medical price inflation which was why it was an integral part of the forecast. If medical price inflation was significantly low, Medicaid prices would not increase rapidly. His assumption was that Medicaid pricing would roughly parallel with increases of all healthcare prices.

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Representative LeBon referred to the chart and asked if the relationship between state-paid Medicaid and federally-paid Medicaid assumed no change over time. In a growth scenario, he wondered if the state portion and the federal portion would remain the same. He asked if the relationship was neutral.

Dr. Helvoight responded that the only change would be with respect to the individuals being enrolled in Medicaid. He reported that the 65 and over population in Medicaid was growing faster than the working population. Therefore, people who were 65 and older would have an FMAP of 50 percent. No one 65 and older would be part of the Medicaid expansion population. The state would receive a 50 percent FMAP for them rather than a 90 percent FMAP. The forecast accounted for the adjustments in rates associated with an

individual's age and the likelihood of their eligibility category.

Representative LeBon asked if he could expect the state's share to grow with the aging population. Dr. Helvoight replied, "Yes, for sure, all else being equal. Yes." He expounded that at the same time there had been rebasing. A few years prior, many Alaska Native beneficiaries of Medicaid received a 100 match from the federal government for 65 percent of the services they received. Currently, the percentage of services receiving a 100 percent match was 10 to 14 percent higher. The state was still benefiting. The forecast acknowledged the benefit of the shift in federal spending.

Representative LeBon recalled the debate in 2015 to take on the expansion. He had heard that the federal government would pick up the majority of expanded costs for a benefit. He asked if the state could expect the relationship with the federal government to remain consistent. Dr. Helvoight responded that the question was beyond his pay grade. The forecast assumed no change in the structure.

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Representative Josephson mentioned that at the time of deliberations, Becky Hultberg of the Alaska State Hospital and Nursing Home Association gave a presentation making a strong case that the state would come out ahead. He wondered if Dr. Helvoight had seen the numbers. Dr. Helvoight imagined that Ms. Hultberg's point was that the state was getting people covered, and the federal government was paying $.90 on $1.00. It meant many hundreds of thousands of dollars would be coming into the economy every year. He concurred with the economic view that there were certainly benefits to Alaska. He was agnostic about expansion but thought there was a logical argument for it.

Dr. Helvoight moved to slide 20: "Bending the Cost Curve." He explained that for each slide, the red represented actual spending. The blue dots showed what was predicted in the 2006 forecast, and the green dots represented the current forecast. In the 2006 forecast presented to the legislature he predicted that there would be extremely rapid growth in Medicaid spending over the following 20 years given the construct of the program at the time and how spending was moving. He reported that the red showed

what happened since 2006. The legislature and the department made some immediate changes in personal care attendant services and other parts of the Medicaid Program and flattened spending growth for a few years. In 2015 and 2016 the Affordable Care Act and Medicaid expansion came into play. He pointed to the red line which indicated bending the cost curve from where the expectation of the prices would go. The green line showed what actually happened. He was looking at total spending.

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Dr. Helvoight spoke of many more Alaskans receiving Medicaid services on slide 21. The number of people receiving services through Medicaid was much greater presently than he predicted in 2005 because of the ACA. He highlighted that the actual number of recipients tracked very closely with the forecast until Medicaid expansion, at which time it grew substantially. Currently, there were many more people receiving Medicaid services than he predicted due to expansion.

Dr. Helvoight turned to the last graph on slide 22 which showed spending was much lower than expected. Although many more people were receiving services than anticipated, spending per recipient was much lower than he originally forecasted. The red line showed what actually happened. Immediately following the first forecast spending per recipient decreased for a couple of years and had been relatively flat until 2020. He expected it to increase over time. He observed that the legislature and the department had accomplished slowing the growth of the Medicaid Program even while the program had grown substantially.

Representative Wool noted Dr. Helvoight had predicted fewer people covered at a much higher cost, yet the opposite occurred. More people were being served at a lower cost. He wondered why Dr. Helvoight's predictions were off.

Dr. Helvoight responded that the forecast of the number of people covered did not anticipate any expansion in the future. The forecast was in line with what actually occurred until expansion. Regarding spending, the impact was a result of a combination of the population projection at the time and a greater growth in the elderly population. The aging population had grown but not at the rate that was expected. Additionally, he thought the seniors that would

be staying in the state or coming into the state would be similar to seniors in the past. However, seniors of the current day were wealthier making them less eligible for Medicaid. He argued that while seniors contributed to the growing number of people enrolled in the program, their rate of growth in Medicaid was slower than their population growth. The spending growth had been impacted because not as many seniors received expensive services like he had anticipated.

Dr. Helvoight continued that the largest factor in his predictions being off had to do with deeper oversight of such services as providing personal care attendants, a service growing at a rate of 15 percent to 25 percent per year. Currently, services were only growing at a rate of 2 percent to 3 percent per year - similar to other parts of the Medicaid Program. There were several changes that occurred with the department.

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Representative Merrick asked if Medicaid recipients paid a copay or deductible. Dr. Helvoight replied, "My understanding is, not in Alaska."

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Dr. Helvoight moved to the topic of chronic conditions and Medicaid on slide 23. He reported that the overall structure of the long-term forecast had been consistent each year with a few changes that made it better. The one thing he added in the current year and would continue to include in the future was to look at the issue of chronic conditions. The department considered cost drivers in Medicaid more frequently.

Dr. Helvoight reviewed the bar chart on slide 24 that showed the FY 18 chronic conditions and age of recipients. He indicated there was much more in the report about chronic conditions including all of the chronic conditions he looked at within the Medicaid population. He found that most people on Medicaid did not have diagnosed chronic conditions. He noted the different age groupings included on the chart. The blue portion of the bar reflected recipients without a diagnosed chronic condition. The orange bar showed recipients with chronic conditions. He reminded members that the chart only reflected recipients

(people who received Medicaid services in 2018) rather than enrollees. He reported there were approximately 40,000 other individuals enrolled in Medicaid who received no services in the same period.

Dr. Helvoight turned to slide 25 to discuss the impact of age on chronic conditions. Over time with age, the proportion of individuals on Medicaid with diagnosed chronic conditions increased and was greater than those without chronic conditions. He concluded that chronic conditions were closely related to age. The graph showed, by age, the prevalence of diagnosed chronic conditions in the Medicaid population increasing over time.

Dr. Helvoight turned to slide 26: "Chronic Conditions Drive Spending, FY2008." He explained the columns on the slide. Column A reflected the twelve different age groups he focused on in doing the long-term forecast. Column B showed the average spending in FY 18 for recipients of the corresponding age group. He highlighted that spending per recipient increased with age. Column C showed the average spending per recipient for recipients with a chronic condition. Aside from the youngest and the oldest age groups there was not a notable difference in spending based on age.

Dr. Helvoight shifted attention to Column D which represented the average spending per recipient for individuals with a chronic condition. Again, there was not much of a difference in spending except for the 85 years or older, even though Column B showed that as individuals aged spending per recipient increased substantially. He concluded that the prevalence of chronic conditions increased with age which explained why age had an effect on spending. Column E showed the incremental costs of chronic conditions which was calculated by taking the average spending for a person with a chronic condition minus the average spending for a recipient without a chronic condition. The question came down to how much a Medicaid recipient with a chronic condition cost. On average it was about $21,000 more per year in FY 18 for those with a chronic condition.

2:56:27 PM

Representative Carpenter asked if there was a stratification in costs based on age. He provided an

example. Dr. Helvoight did not believe so but could not answer definitively.

Dr. Helvoight advanced to the chart on slide 27 which displayed the incremental cost of chronic conditions in FY 18. He reported that Column A was the same as Column A in the previous table. Column B was the same as Column E in the previous table. The age categories and the incremental costs for recipients with a chronic condition were the same. Column F represented the number of recipients diagnosed with a chronic condition in FY 18 with one or more diagnosed chronic conditions. Column G equaled the total incremental cost to the Medicaid Program associated with chronic conditions. The total spending in FY 18 based on the date of service was about $2.2 billion, of which $1.3 billion had to do with the additional costs paid to treat recipients with chronic conditions. The amount was well over the total spending of $2.2 billion. The cost of chronic conditions was a large issue in healthcare in the U.S. and the Medicaid Program in Alaska. He also thought it was a growing issue with Alaska's aging population.

Dr. Helvoight continued to his final slide, slide 28: "Cost Impact of Chronic Conditions Will Grow." He reported that presently about 73 percent of Medicaid spending was on beneficiaries diagnosed with one or more chronic conditions. He noted that providers were supposed to report a diagnosis code for the Medicaid Management Information System (MMIS) to use for payment. It was also used to determine whether a condition was chronic. Some claims were not required to have diagnostic codes such as pharmacy claims. Some other claims simply did not have a code. Based on the Medicaid population over the following 20 years, the amount of Medicaid spending on beneficiaries with chronic conditions would rise to about 78 percent by FY 40. The information was based on what he saw in the database. About $4 of every $5 would be spent on individuals with chronic conditions. It would be a very large and increasing problem in the Medicaid Program.

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Co-Chair Johnston asked Dr. Helvoight to define "chronic condition." Dr. Helvoight replied that a chronic condition was a medical condition that lasted 3 or more months. Another definition was a medical condition that lasted a long time. There was another definition of a medical

condition that lasted a year or more. There was ambiguity in the definition. He relayed that for the purpose of the forecast there was a list of diagnostic codes used in the MMIS to identify a chronic condition.

Co-Chair Johnston asked whether, in looking at any population, a cost driver of 6 percent to 7 percent attributed to chronic conditions. Dr. Helvoight responded in the affirmative. However, he noted that a chronic condition could exist from birth. It could also be related to age, strokes, falls, and heart disease. There were also chronic conditions including drug addiction, smoking, and alcohol abuse. There were several chronic conditions related to choices. The chronic conditions sometimes compounded such as obesity and diabetes. He added that the longer a person lived, the more likely they would experience a chronic condition.

Co-Chair Johnston thought the story could change through some access to managed care. She suggested that having a wellness coordinator or living a healthy lifestyle could have a significant impact on costs related to chronic conditions. Dr. Helvoight commented that although he had not studied the issue, it seemed like a logical conclusion. He was not sure how practical it would be for the Medicaid Program to implement such a thing.

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Co-Chair Johnston also noted the importance of a person being diagnosed early with time to provide early intervention. Dr. Helvoight responded that he had looked at prevention as it related to diabetes. Data suggested that there could be savings to the program associated with diabetes self-management. However, the ease of implementation was unknown.

Representative Carpenter asked for the resource for chronic conditions. Dr. Helvoight responded that it was a report done for the Division of Public Health and it was posted to the department's website in December 2018. He offered to send it to him. Representative Carpenter thought it would be interesting to be familiar with the chronic conditions. He suspected if people made different lifestyle choices the problems would not exist. Dr. Helvoight concurred.

Representative Merrick asked if Medicaid recipients received dental, vision and prescription coverage. Dr. Helvoight was aware of pharmaceutical services, vision care for children, dental care within healthcare services, and the adult dental program (a preventative program).

3:07:30 PM

Representative Wool asked if cancer was considered a chronic illness. Dr. Helvoight responded affirmatively. He suggested there should be further subcategories of chronic conditions. Many of the conditions were not preventable.

Representative Josephson asked if one of the drivers of care for the elderly and the Medicaid Program was that it covered long-term disability. If someone had the wisdom in their thirties or forties to purchase it, it was incredibly expensive. Therefore, they typically punted, relying on Medicaid. He asked if he was accurate. Dr. Helvoight agreed that long-term care was expensive, and rates could climb. He personally had not paid for long-term disability because of not knowing what he was really investing in.

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Representative Wool returned to the discussion of chronic care and the costs increasing because of the population aging. He had mentioned cancer because some things were unavoidable. He mentioned lifestyle choices influencing health such as smoking, and drinking. He did not believe the trend was that people were getting healthier. On the contrary, people were getting less healthy. He wondered if the issue was factored into the forecast. He thought people had become more sedentary over time and were increasing their chronic conditions regardless of age. He inquired about Dr. Helvoight's opinion.

Dr. Helvoight responded that the forecast accounted for growth in the rate of enrollment in the Medicaid Program which would be driven by a number of factors. Some of the factors included issues of chronic conditions leading to a person becoming disabled. He responded to Representative Wool's question about people not getting healthier. He had read several articles that concurred that obesity rates had steadily climbed.

Representative Carpenter asked if there was a component of Medicaid that encouraged personal responsibility. He was speaking to behaviors that contributed to developing chronic conditions which could otherwise be avoided with making different choices. He wondered if a mechanism existed. Dr. Helvoight did not know.

Co-Chair Johnston indicated she would be recessing the meeting until Wednesday at 10:00 A.M. at which time the committee would close out the budget for the University of Alaska.

^RECESSED TO THE CALL OF THE CHAIR: THE MEETING RECONVENED ON WEDNESDAY, FEBRUARY 19, 2020 AT 10:00 A.M.

3:14:19 PM

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ADJOURNMENT

3:14:19 PM

The meeting was adjourned at 3:14 p.m.