

SENATE FINANCE COMMITTEE
March 12, 2025
9:02 a.m.

[9:02:05 AM](#)

CALL TO ORDER

Co-Chair Hoffman called the Senate Finance Committee meeting to order at 9:02 a.m.

MEMBERS PRESENT

Senator Lyman Hoffman, Co-Chair
Senator Bert Stedman, Co-Chair
Senator Mike Cronk
Senator James Kaufman
Senator Jesse Kiehl
Senator Kelly Merrick

MEMBERS ABSENT

Senator Donny Olson, Co-Chair

ALSO PRESENT

Emily Ricci, Deputy Commissioner, Department of Health;
Lori Wing-Heier, Director, Division of Insurance,
Department of Commerce, Community and Economic Development;
Senator Cathy Giessel.

SUMMARY

^MEDICAID LEVERS and FEDERAL MARKETPLACE

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EMILY RICCI, DEPUTY COMMISSIONER, DEPARTMENT OF HEALTH, discussed the presentation, "Medicaid Program Levers, Senate Finance Committee" (copy on file).

Ms. Ricci addressed slide 2, "Medicaid Basics":

- Medicaid is a **joint federal and State public health insurance** program for low-income individuals and families

- The program is **designed to support vulnerable populations**, including children, pregnant women, seniors, individuals with disabilities, and other low-income groups
- **States have flexibility** in designing and administering Medicaid programs within federal guidelines
- Eligibility is based on **financial** (income) and **categorical** (age, disability, pregnancy) **criteria**

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Ms. Ricci pointed to slide 3, "Federal Financial Participation":

- Medicaid is **jointly funded** by the state and federal government
- The percentage of costs paid by the federal government is known as the Federal Medical Assistance Percentage (FMAP)
 - **Varies across states**, by eligibility category for beneficiaries, by medical service type, and across operational activities
 - The lower limit for FMAP is 50 percent

Ms. Ricci noted that FMAP payment across the country varied by per capita income averages. She shared that, historically, Alaska received regular FMAP funding of 50.00 percent, but this had changed over the previous two years and was currently 51.54 percent and was scheduled to increase to 52.42 percent in the coming fiscal year.

Ms. Ricci looked at slide 4, "Federal Financial Participation." The slide illustrated participation categories of who received FMAP funding by eligibility type and administration type.

Eligibility Type

Regular Medicaid - 51.54 percent
 Children's Health Insurance Program (CHIP) - 66.08 percent
 Expansion Population - 90.00 percent
 Indian Health Services - 100.00 percent

Administrative Type

General Administration - 50.00 percent
 IT System Maintenance & Operations - 75.00 percent

IT System Design & Development - 90.00 percent

Ms. Ricci explained that regular Medicaid included individuals who were not eligible for any other enhanced match due to their eligibility. She said that if an individual went to the doctor and received a service, and the doctor billed the state through the Medicaid program, the federal government would pay 51.54 percent and the state would pay the remainder. She spoke to the other eligibility categories listed, four were included on the slide but others existed that had a smaller impact on the program. She noted that children's programs and the Medicaid expansion population were covered a higher level. She relayed that the federal government reimbursed the state 100 percent of costs associated with certain Indian Health Services. These included individuals who were both tribal members, and who were covered by the Medicaid program. She said that when these individuals received a service, either directly, through a tribal health organization, or through another provider outside of the tribal health system with a care coordination agreement, 100 percent reimbursement could be sought by the state for the federal government to cover the cost. She related that these numbers were tracked very closely because in FY2024, total costs associated with the IHS services in the Medicaid program was over \$1 billion and accounted for 35 percent of the state's total Medicaid program spend. She noted that Administrative Costs were also closely tracked and included the costs of IT systems and other administrative costs associated with administering the system.

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Senator Kaufman wanted to know the net financial impact to the state related to IHS billing.

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Ms. Ricci replied that the issue was complex. She said that when a tribal member went to a tribal health organization there were specific rates that Medicare and Medicaid programs were required to pay tribal health organizations when an individual that was covered by the Medicaid or Medicare program used services provided by those organizations. The rates were published in the financial register annually and changed overtime. She furthered that

when a Medicaid eligible tribal health member used tribal health services, the organization billed Medicaid based on the federally established rate. She said that in those cases the state was eligible to receive 100 percent federal funding to cover costs. She relayed that in some cases where a non-tribal member, also covered by Medicaid, used tribal health services - the state would pay the encounter rate, but the federal match would depend on the eligibility type. She said that analysis was being conducted to track the various payment numbers.

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Senator Kaufman remarked that the financial impact should be considered.

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Ms. Ricci displayed slide 5, "Mandatory and Optional Eligibility Groups":

Federal

Title XIX of the Social Security Act mandates Medicaid coverage certain groups including low-income:

- Families and individuals
- Individuals with disabilities
- Pregnant women
- Children
- Individuals receiving supplemental security income

State

Alaska Statute 47.07.020 outlines eligibility groups for the Alaska Medicaid program:

- Requires coverage of all mandatory eligibility categories in Title XIX of the Social Security Act
- Lists additional optional eligibility groups covered by Alaska Medicaid
 - Example: Home and Community Based Services waiver recipients

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Ms. Ricci highlighted slide 6, "Medicaid Expansion":

- Alaska adopted Medicaid Expansion in 2015
- The Affordable Care Act (2010) allowed states to expand Medicaid coverage to low-income adults (ages

19-64) up to 138 percent of the federal poverty level who were not otherwise Medicaid-eligible

Nearly 1 in 10 Alaskans are covered through Medicaid Expansion

Ms. Ricci drew attention to the chart on the bottom of the slide. She cited that in FY2024, there were a total of 80,000, who at one point in the year were enrolled in the Medicaid Expansion program. She explained that when looking at average monthly participation in the expansion group, there were between 72,000 and 74,000 enrollees monthly. She said that 66 percent of those individuals were receiving care; not everyone enrolled in the program necessarily went to the doctor or sought services. She furthered that the difference between enrollees and recipients was the difference between those who had insurance through Medicaid and those who received actual services.

Mr. Ricci stated that in FY2024, the total cost in claims to the Medicaid Expansion program was \$765 million and accounted for 20 percent of the total cost of Medicaid claims for Alaska's Medicaid program for that time. The states share was \$51 million with a remainder of \$714 million. She said that the federal match for the expansion population was 90 percent, and the state match was 10 percent. She pointed out that the aforementioned totals of \$51 million and \$714 million did not equate to 10 percent. She said that this was due in part to the 100 percent funding that the state received through IHS. She stated that just over 7,000 individuals in the Medicaid expansion population in FY2024 were also Tribal members, so the state was able to receive 100 percent federal match for individuals who received services through Tribal health organizations. She added that 33,000, or 66 percent, were not Tribal members.

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Ms. Ricci pointed to slide 7, "Mandatory and Optional Services":

Federal:

- Title XIX of the Social Security Act mandates Medicaid coverage for certain services
 - Early and Periodic Screening, Diagnostic, and Treatment program for children under 21
- Affordable Care Act Essential Health Benefits

State:

AS 47.07.030(a) requires that Alaska Medicaid cover all mandatory services under Title XIX of the Social Security Act

AS 47.07.030(b) lists additional optional services Alaska Medicaid may cover. Examples include:

Prescription drugs

Emergency hospital services

Ms. Ricci discussed overlaps between state and federal requirements for Medicaid. She explained that the federal government could mandate coverage for specific services for specific coverage groups, in particular broad protections for children mandated at the federal level. She discussed the state mandatory and optional services. She argued that the term "optional" was a misnomer as the statute had not been updated since the passage of the Affordable Care Act. She noted that some services considered "optional" could be critical to a person's ability to access healthcare, such as prescription drugs and emergency hospital services. She said that the federal level requirements overlapped with several state services listed as optional and that the issue of services that were deemed "optional" by state statute were sometimes mandatory on the federal level.

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Ms. Ricci looked at slide 8, "Medicaid State Plan":

The Medicaid State Plan is an agreement between the State and the federal government that outlines how the State will administer its Medicaid program.

Defines who is eligible for Medicaid services

Specifies the types of services covered

Details how providers are reimbursed for services

Explains how the State will administer the program

Ms. Ricci thought it was important to understand that any change to the Medicaid program must be approved in the state a state plan and much go through a state plan amendment process. She stated that this was important because federal matching funds were only provided for services that were approved in the state plan or through

the waiver program. Additionally, because the program was joint federal and state, changes to the program could not be made unilaterally by the state.

Ms. Ricci pointed to slide 9, "State Plan Amendment Process":

Changes to the Medicaid State Plan are called State Plan Amendments (SPAs) and must be reviewed and approved at the federal government by the Centers for Medicare and Medicaid Services (CMS).

The amendment process flowed as follows:
Public Notice and Tribal Consultation (60 days - 30 day minimum requirement)
SPA Submission to CMS
CMS Review (90 days)
CMS Decision
Effective Date

Ms. Ricci said that if CMS took no action within 90 days the SPA would be considered approved and become enforced. She said that in Alaska once a state plan amendment was underway it typically required regulatory changes to align with the submissions.

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Ms. Ricci looked at slide 10, "Waivers":

The U.S. Secretary of Health and Human Services may grant waivers to certain Medicaid provisions, allowing states to test and implement innovative approaches.

Demonstration Waivers
Example: Section 115 Demonstration Waivers

Program Waivers
Example: Section 1915(c) Home and Community-Based Service Waivers

Ms. Ricci discussed slide 11, "Reimbursement Rates":

Medicaid reimbursement rates are developed at the state level, subject to federal approval.

Types of Rates

Per Diem
Encounter
Fee-for-Service
Percent of Charges
Diagnosis Related Groups

Rate Adjustments

Inflation
Rebasing
Legislative
Federal

Ms. Ricci directed committee attention to the column on the right of the slide. She said that rate adjustments could occur routinely and included annual inflationary adjustments that did not require regulatory or statutory action. She furthered that periodic rebasing investigated the underlying costs for providers based on a cost basis and updated them for coming years. She continued that the adjustments included possible legislative direction and federal changes and/or federal requirements. She stated that some of the rates that were established in the Medicaid program were benchmarked to federally established rates. She noted that Encounter Rates were determined by IHS and were published annually, sometimes months after they had taken effect. She stressed that considering all the levers was especially important when discussing programmatic changes to Medicaid.

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Senator Kiehl asked how the rate setting mechanisms, whether federal or state, worked.

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Ms. Ricci replied that it was different for every service type and every provider type. She spoke to behavioral health rates, which had four different rates that had all been established differently and had different rate adjustment factors. She suggested that the committee examine the state's rate adjustments and the nature of inflationary effects, and all the various levers that could be tweaked to effectuate change in the Medicaid program. She mused that the issue was nuanced, which was frustrating but also allowed for flexibility.

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Senator Kiehl thought that there were a variety of approaches to making changes in the Medicaid system. He asked whether there were other things that affected rates that were not listed on slide 12.

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Ms. Ricci said she would add Diagnosis Related groups. She suggested that one approach would be to step back and examine, depending on the goal, the services that aligned with achieving the goal, and the underlying adjustment mechanisms that supported rates for those services. She thought then, based on that information, one could consider what changes would be helpful or useful to achieve the goal.

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Senator Kaufman understood that the federal government was looking to move from block grants to a fee-for-service model. He wondered how that would tie into the Medicaid system.

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Ms. Ricci responded that Alaska's system currently functioned on a fee-for-services basis. She offered that no state in the country worked under a block grant financing method. She related that the Medicaid was currently financed by the joint sharing of administrative and claims costs by the state and the federal government. She shared that there were discussions happening at the national level and block grants had been discussed for over a decade. She said that Congress had provided no clear guidance over action they may or may not take.

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Ms. Ricci highlighted slide 12, "Changes to the Medicaid Program":

Medicaid Program Levers

Federal Financial Participation
Eligibility
Services

Rates

Federal Mechanisms

Statutory changes
Appropriations Acts
Rulemaking

State Mechanisms

Statutory changes
Regulatory changes
State Plan Amendments

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Ms. Ricci remarked that there were continuous changes made by the federal government, either through statutory changes or appropriations acts, that often when unnoticed until repercussions were directly felt. She spoke to the Consolidated Appropriations Act of 2022, which reduced enhanced federal match to the state. The state learned of the act in December 2022, the reductions took effect in April 2023, at which time the department was not able to incorporate the change into their standard budgetary process. The same act created new requirements for coverage and the provision of services to new groups in the Medicaid program, specifically Justice Involved Youth. The requirements took effect in January 2025, which the department was currently working to incorporate into state practice. She added that changes could also take place through rulemaking, which took the form of federal regulations and sub regulatory guidance. She relayed that the guidance could be impactful and included new IT requirements or guidance related to administrative policy goals. She spoke to the state mechanisms for making changes to the Medicaid program. She reiterated that changes were constant.

Ms. Ricci related that Alaska had joined the Medicaid program in 1972 and that the program had evolved continually since that time. She said that the program would continue to evolve and change, and the department would focus on using the \$3 billion to improve health outcomes for Alaskans.

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Co-Chair Hoffman asked about the state's financial exposure as the program evolved under the current federal administration.

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Ms. Ricci responded that there had been no clear guidance from Congress and that there were many disparate ideas under discussion. She noted that state statute outlined the actions that must be followed during tight budgetary times. AS 47.07.036 required the department to, first, take reasonable steps to avoid limiting eligibility or scope of services. She said this could include implementation of utilization reviews, changes in payment rates, and the addition of precertification requirements. If those steps were not fruitful the department would consider optional services and eligibility, which were considered optional to the extent authorized under federal law. She thought this was why defining "optional" was important.

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Co-Chair Hoffman voiced concern about the state's financial liability due to changes made on the federal level. He wondered whether the state would need to make statutory changes or would the administration be able to make changes to protect the state's exposure under federal changes.

Ms. Ricci reiterated that there was no clear guidance coming from Congress. She noted that there were many different arguments benign made that voiced varying opinions.

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Senator Kaufman asked about waste and fraud. He thought that there had been some successes in lowering the error rate. He asked whether the department had the resources to continue to bring down the error rates.

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Ms. Ricci replied that the error rates had been a focus for the department. She stated that the error rates were broken down into two categories: the error rates in the actual payments made to providers, and error rates related to eligibility. She said that the error rates in payment set

providers were low. She relayed that eligibility error rates were higher but were dropping as improvement in services increased. She said that error rates would continue to be examined.

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Senator Kaufman asked about the financial impacts of the error rates.

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Ms. Ricci agreed to follow up on the question.

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AT EASE

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RECONVENED

[9:50:01 AM](#)

LORI WING-HEIER, DIRECTOR, DIVISION OF INSURANCE, DEPARTMENT OF COMMERCE, COMMUNITY AND ECONOMIC DEVELOPMENT, introduced herself, and Ms. Carpenter. She discussed the presentation, "Division of Insurance, Senate Finance, Committee Overview." She addressed slide 2, "What does Alaska look like with so many payers?" She shared that healthcare in Alaska was extremely fragmented.

[9:51:00 AM](#)

Ms. Wing-Heier discussed slide 3, "Eyes on Washington, D.C.":

Working with the Department of Health, we are continually monitoring the proposed actions coming from Washington, D.C.

- Section 1332 Waivers -Alaska Reinsurance Program
- Advanced Premium Tax Credits
- Enhanced Advanced Premium Tax Credits
- Cost Sharing
- Work Requirements -Medicaid
- Changes to Medicare and impact to Alaska's health care system

- Changes to the Individual Market and/or Medicaid due to Federal layoffs or buyouts

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Ms. Wing-Heier discussed slide 4, "Affordable Care Act - 2010":

- The Affordable Care Act, passed by Congress in 2010, the full ACA Market Reforms became effective in 2014.
- As this was a new program that did not allow underwriting to consider lifestyle or preexisting conditions, many states found that the rates that were approved for the 2014 year were insufficient. Alaska was amongst those states.
- In Alaska, rates were significantly increased for 2015 but even with the increase, insurers were hesitant to commit to remaining in Alaska -a solution needed to be found to stabilize the market.

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Ms. Wing-Heier pointed to slide 5, "The ACA Individual Market Rates -History." The slide provided individual market rates from 2014 through 2025, under Premera and Moda, and provided an average between the two. She noted that between 2015 and 2016 the state recognized that the rates were a problem. Between 2017 and 2019, Moda left the market for lack of profit, with Premera planning to do the same.

Ms. Wing-Heier looked at slide 6, "The Alaska Reinsurance Program":

- Due to market conditions, the legislature passed HB374 which funded the program for one year with a \$55 million appropriation under the condition that the division seek a Section 1332 State Innovation Waiver for future funding from the United States Department of Health and Human Services/Centers for Medicare and Medicaid and the United States Department of Treasury.
- The waiver was reliant upon the Advanced Premium Tax Credits (APTC), provided in the Affordable Care Act.

- The Affordable Care Act provided that enrollees in the individual market would be subsidized, based on their income. As it was based on income, some enrollees were 100 percent subsidized and some were subsidized at a lesser amount.

Ms. Wing-Heier displayed slide 7, "The Alaska Reinsurance Program":

- The concept of the Alaska Reinsurance Program (ARP) identifies 33 high risk conditions, which would be paid by the program, thereby removing the claims from the insurer.
- Going forward, this would reduce the premiums that the insurer would need to pay claims and, at the same time, reduce the amount of the federally funded Advanced Premium Tax Credits.
- If we could demonstrate that this was possible, would the federal government allow us to use the difference to fund the Alaska Reinsurance Program?

Ms. Wing-Heier asserted that the program had been very successful and had served the state well and lamented that under the current federal administration the Alaska Reinsurance Program was "on the chopping block".

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Co-Chair Hoffman announced that Ms. Wing-Heier had introduced the idea of the Alaska Reinsurance Program to the legislature and that many states had followed suit. He felt credit was due to Ms. Wing-Heier for her contribution to the success of the program.

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Ms. Wing-Heier highlighted slide 8, "How the ARP funding works.":

Projected 2024 APTC without waiver - \$343,804,489
Projected 2024 APTC with waiver - \$228,747,896
Projected 2024 APTC savings - \$115,056,593
Total 2024 PTC subsidy/APTC - 98.25 percent
Projected total PTC subsidy savings - \$112,966,100

Ms. Wing-Heier addressed slide 9, "Advanced Premium Tax Credits (APTC)":

- The Affordable Care Act requires a percentage payment from enrollees for a silver plan based on their household income and size, which determines their Federal Poverty Level (FPL). The amount between the second lowest cost silver plan (2LCSP) and this contribution amount is a household's subsidy, also known as APTC.
- During COVID in 2021, the American Rescue Plan reduced the contribution level to make premiums more manageable for 2021 and 2022 (Enhanced Subsidies). The Inflation Reduction Act continued this level assistance for 2023, 2024, and 2025.
- With no change in law, the "enhanced" subsidy levels will expire December 31, 2025.

Ms. Wing-Heier discussed slide 10, "Single Adult Example." The slide showed the numbers for a single, 50-year-old adult on the Silver and Bronze plans. She said that with the Enhanced APTC and a household income of \$58,650, their premium was \$282/month. She shared that under the original tax credits the monthly premium went up to \$407/month. Under the Bronze plan a single person, making \$78,396 would pay \$9/month premium with the Enhanced APTC, but with the original APTC the monthly premium would rise to \$881/month.

Ms. Wing-Heier pointed to slide 11, "Family of Four - Example." She said that a family of four, at 300 percent federal poverty level, would see an increase of \$250/month. A family of four at 400 percent federal poverty level, where there would be no subsidy, would see a premium increase \$2,070/month. She said that people under the plan would be paying a health insurance premium equal to their mortgage, if not greater.

Ms. Wing-Heier reiterated that it was unknown what would happen with the funding for the reinsurance program. She said it could be cancelled, underfunded, or not funded at all. She said if the tax credits went away, she was unsure how the \$140 million would be realized. She expressed concern for the future of the program and said that the department was taking things day to day. She relayed that

insurance companies had to file rates annually and the filing for 2026 would begin in June. She said she was expected to tell insurance companies the reinsurance rates in June 2025, but she would not know until after the federal budget was passed in September of 2025. She said contingencies were being discussed.

Ms. Wing-Heier asserted that loss of the reinsurance program would result in a 67 percent increase in insurance rates.

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Co-Chair Hoffman asked whether individuals receiving IHS services would be affected by the loss of the reinsurance program.

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Ms. Wing-Heier replied in the affirmative.

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Co-Chair Hoffman explained that Ms. Wing-Heier had been brought to the committee to enlighten members on the workings of the program and the exposure to the state should the program be compromised.

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Senator Kaufman asked for the definition of APTC.

Ms. Wing-Heier reiterated that APTC was an acronym for Advanced Premium Tax Credit.

Co-Chair Hoffman thanked the testifiers.

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ADJOURNMENT

[10:02:46 AM](#)

The meeting was adjourned at 10:02 a.m.