

03 / 21 / 15
MEDICAID
WORKING
GROUP

<TARGET><BILL></BILL><SUBJECT>03-21-15 MEDICAID WORKING
GROUP</SUBJECT><COMM>HHSS29</COMM></TARGET>

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REPRESENTATIVE LIZ VAZQUEZ
District 22 - Jewel Lake, Sand Lake, Dimond & Kincaid

MEMORANDUM

Date: Sunday, March 15, 2015

To: Members of the 29th Alaska Legislature

From: Representative Liz Vazquez

Re: Dramatic discrepancies in forecasted costs for Medicaid expansion

Attached is a set of slides showing the dramatic differences¹ in projected costs for Medicaid expansion, along with the source documents for your review. I directed my staff to compile this information after hearing projections of Medicaid expansion enrollment and costs in the House Health & Social Services Committee that differed startlingly from previously reported cost estimates.

Apart from the calculated percentages, all of the data in the attached slides are taken from reports commissioned by the Alaska Department of Health & Social Services (DHSS) and the presentation made by the DHSS Commissioner.

The attached data raise serious questions about the real costs of Medicaid expansion.

These materials are provided for your review. Please contact me or my staff Joshua Walton with any questions at 465-3892.

Attachments:

1. "Medicaid Expansion: Discrepancies between the Lewin Report and Evergreen Economics Report Enrollee and Cost Projections". Prepared by the Office of Representative Liz Vazquez.

Source documents:

¹ For example, there is a 77.1 % difference in projected total state costs between the two reports commissioned by the Alaska Department of Health & Social Services.

2. "Healthy Alaskans Plan". March 5, 2015. Presentation before the House Committee on Health & Social Services. Presented by Valerie Davidson, Commissioner, Alaska Department of Health & Social Services.
3. "An Analysis of the Impact of Medicaid Expansion in Alaska: Final Report". April 12, 2013. Report prepared for the Alaska Department of Health & Social Services by The Lewin Group.
4. "Projected Population, Enrollment, Service Costs and Demographics of Medicaid Expansion Beginning in FY2016". February 6, 2015. Report prepared for the Alaska Department of Health & Social Services by Evergreen Economics.

MEDICAID EXPANSION:

DISCREPANCIES BETWEEN THE LEWIN REPORT AND EVERGREEN ECONOMICS REPORT ENROLLEE AND COST PROJECTIONS

March 9, 2015

Distributed by the Office of Rep. Liz Vazquez

(907) 465-3892

REPORTS OF COSTS AND ENROLLMENT

- The Department of Health & Social Services (DHSS) commissioned two reports that estimate enrollment and costs of the proposed Medicaid expansion:
 - Lewin Group, April 2013
 - Evergreen Economics, February 2015
- In presentations before the House Health & Social Services Committee, the Department has calculated costs relying solely on the estimates presented in the Evergreen Economics report and their own administrative cost projections.

DIFFERENCES IN METHODOLOGY

- The method used by the Lewin Report accounts for the “crowding-out” effect, medical cost trends, and currently eligible adults that are not presently enrolled but are likely to enroll in the expanded program.
- The Evergreen Economics report incorporates neither the “crowding-out” effect nor medical cost trends.
 - Evergreen Economics discusses currently eligible adults that are not enrolled briefly, but does not appear to incorporate their effects into their analysis.

DIFFERENCES IN ESTIMATED RESULTS

- These reports differ dramatically in their forecasts in general, and particularly in their estimates of:
 - Projected new enrollees in the expanded Medicaid program (“New Medicaid Enrollees”, see Table 1); and
 - State health care costs of the Medicaid expansion, resulting in dramatically different forecasts of total costs (see Tables 2-4).¹

¹ With respect to expansion costs, the Lewin Group forecasts the state shares of health care costs, administrative costs, and total costs. The Evergreen Economics report forecasts only the health care costs (see Table 2). DHSS provides their own calculations of the state’s share of administrative costs (see Table 3). DHSS then adds these to Evergreen Economics’ forecasts of state health care costs to calculate the Evergreen/DHSS total costs to the state (Table 4).

DISCREPANCIES IN PROJECTIONS OF NEW MEDICAID ENROLLEES

Table 1. New Medicaid Enrollee Projections, 2016-2020

	<u>2016</u>	<u>2017</u>	<u>2018</u>	<u>2019</u>	<u>2020</u>
Lewin Group*	41,286	41,853	42,401	43,029	43,687
Evergreen Economics†	20,066	23,273	26,492	26,535	26,580
Differences in Projections	21,220 (51.4%)	18,580 (44.4%)	15,909 (37.5%)	16,494 (38.3%)	17,107 (39.2%)

* Lewin Group forecasts provided in Lewin Group report, Figure B-6, page 56.

† Evergreen Economics forecasts provided in Evergreen Economics report, Table 1, page 1.

DISCREPANCIES IN PROJECTIONS OF STATE HEALTH CARE COSTS

Table 2: Comparisons of Projected Costs - Health Care Costs (State Share)

<u>State Share of Costs</u>	<u>2016</u>	<u>2017</u>	<u>2018</u>	<u>2019</u>	<u>2020</u>	<u>Cumulative through 2020</u>
Lewin Group*	\$ (51,236)	\$ 18,807,069	\$ 27,275,635	\$ 33,949,419	\$ 51,744,876	\$ 131,725,763
Evergreen Economics†	\$ -	\$ 3,804,000	\$ 9,854,000	\$ 12,064,000	\$ 16,346,000	\$ 42,068,000
Differences in Projected Costs	\$ (51,236) (100%)	\$ 15,003,069 (79.8%)	\$ 17,421,635 (63.9%)	\$ 21,885,419 (64.5%)	\$ 35,398,876 (68.4%)	\$ 89,657,763 (68.1%)

* Lewin Group forecasts provided in Lewin Group report, Figure B-6, page 56.

† Evergreen Economics forecasts provided in Evergreen Economics report, Table 10, page 9.

DISCREPANCIES IN PROJECTIONS OF STATE ADMINISTRATIVE COSTS

Table 3: Comparisons of Projected Costs - Administrative Costs (State Share)

<u>State Share of Costs</u>	<u>2016</u>	<u>2017</u>	<u>2018</u>	<u>2019</u>	<u>2020</u>	<u>Cumulative through 2020</u>
Lewin Group*	\$ 11,204,996	\$ 13,783,193	\$ 16,637,246	\$ 17,737,301	\$ 18,917,668	\$ 78,280,404
DHSS†	\$ -	\$ 1,392,000	\$ 1,478,000	\$ 1,499,000	\$ 1,600,000	\$ 5,969,000
Differences in Projected Costs	\$ 11,204,996 (100%)	\$ 12,391,193 (89.9%)	\$ 15,159,246 (91.1%)	\$ 16,238,301 (91.5%)	\$ 17,317,668 (91.5%)	\$ 72,311,404 (92.4%)

* Lewin Group forecasts provided in Lewin Group report, Figure B-6, page 56.

† DHSS forecasts presented before House Health & Social Services Committee, March 5th 2015. Refer to DHSS presentation, slide 14.

DISCREPANCIES IN PROJECTIONS OF TOTAL STATE HEALTH CARE COSTS

Table 4: Comparisons of Projected Costs - Total Costs (State Share)

<u>State Share of Costs</u>	<u>2016</u>	<u>2017</u>	<u>2018</u>	<u>2019</u>	<u>2020</u>	<u>Cumulative through 2020</u>
Lewin Group*	\$ 11,153,760	\$ 32,590,262	\$ 43,912,881	\$ 51,686,720	\$ 70,662,544	\$ 210,006,167
Evergreen Economics/DHSS†	\$ -	\$ 5,196,000	\$ 11,332,000	\$ 13,563,000	\$ 17,946,000	\$ 48,037,000
Differences in Projected Costs	\$ 11,153,760 (100%)	\$ 27,394,262 (84.1%)	\$ 32,580,881 (74.2%)	\$ 38,123,720 (73.8%)	\$ 52,716,544 (74.6%)	\$ 161,969,167 (77.1%)

* Lewin Group forecasts provided in Lewin Group report, Figure B-6, page 56.

† DHSS provides their own calculations of the state's share of administrative costs (see Table 3). DHSS then adds these to Evergreen Economics' forecasts of state health care costs (see Table 2) to calculate the figures given here. Refer to DHSS March 5th presentation before House Health & Social Service, slide 14.



VISION
ALASKA INDIVIDUALS, FAMILIES AND COMMUNITIES ARE SAFE AND HEALTHY
MISSION
TO PROMOTE AND PROTECT THE HEALTH AND WELL-BEING OF ALASKANS

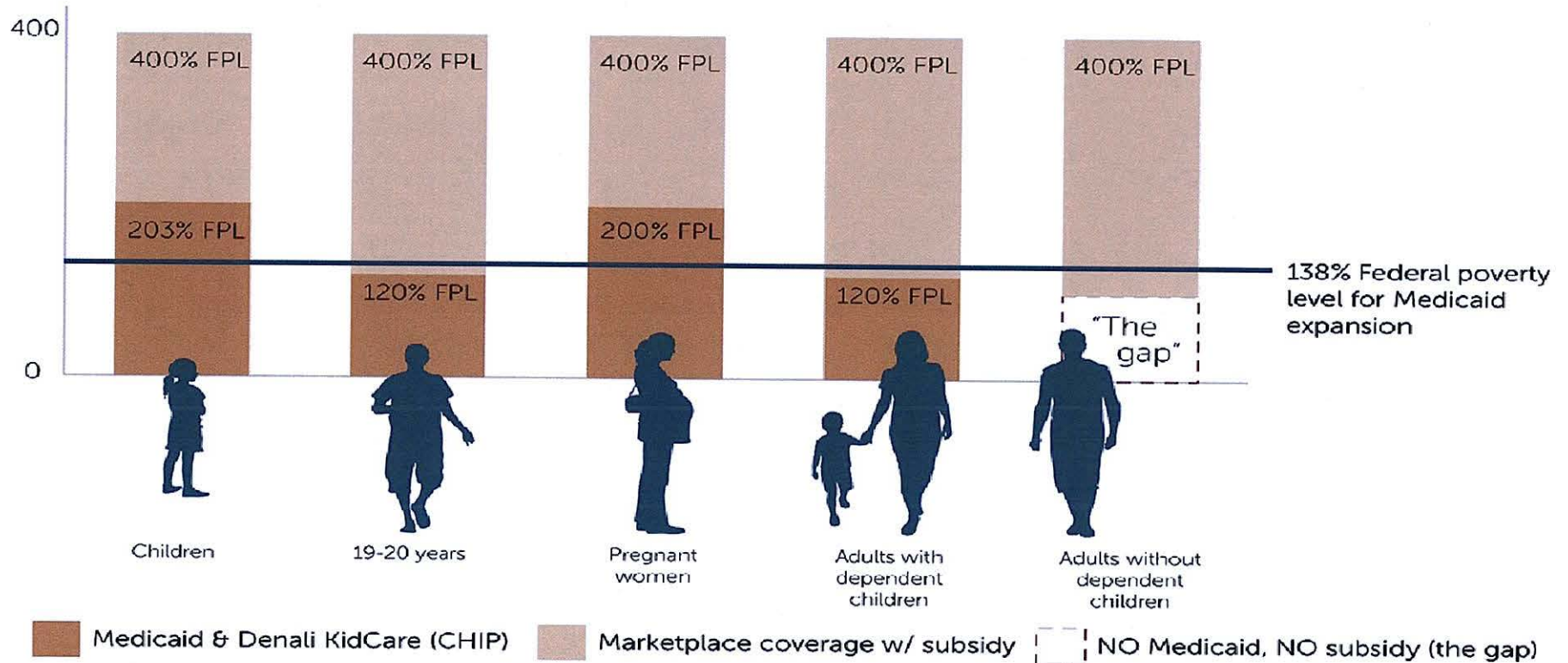
House Health & Social Services Committee

Healthy Alaska Plan

Valerie Davidson, Commissioner

March 5, 2015

Healthy Alaskans Who is covered now?



Medicaid Expansion

- Higher Federal Match

	2014	2015	2016	2017	2018	2019	2020 & Beyond
Federal match under expansion	100%	100%	100%	95%	94%	93%	90%

- Reducing Uncompensated Care
 - Reducing the number of uninsured
 - More than \$90 Million in 2013
- Saves the State money



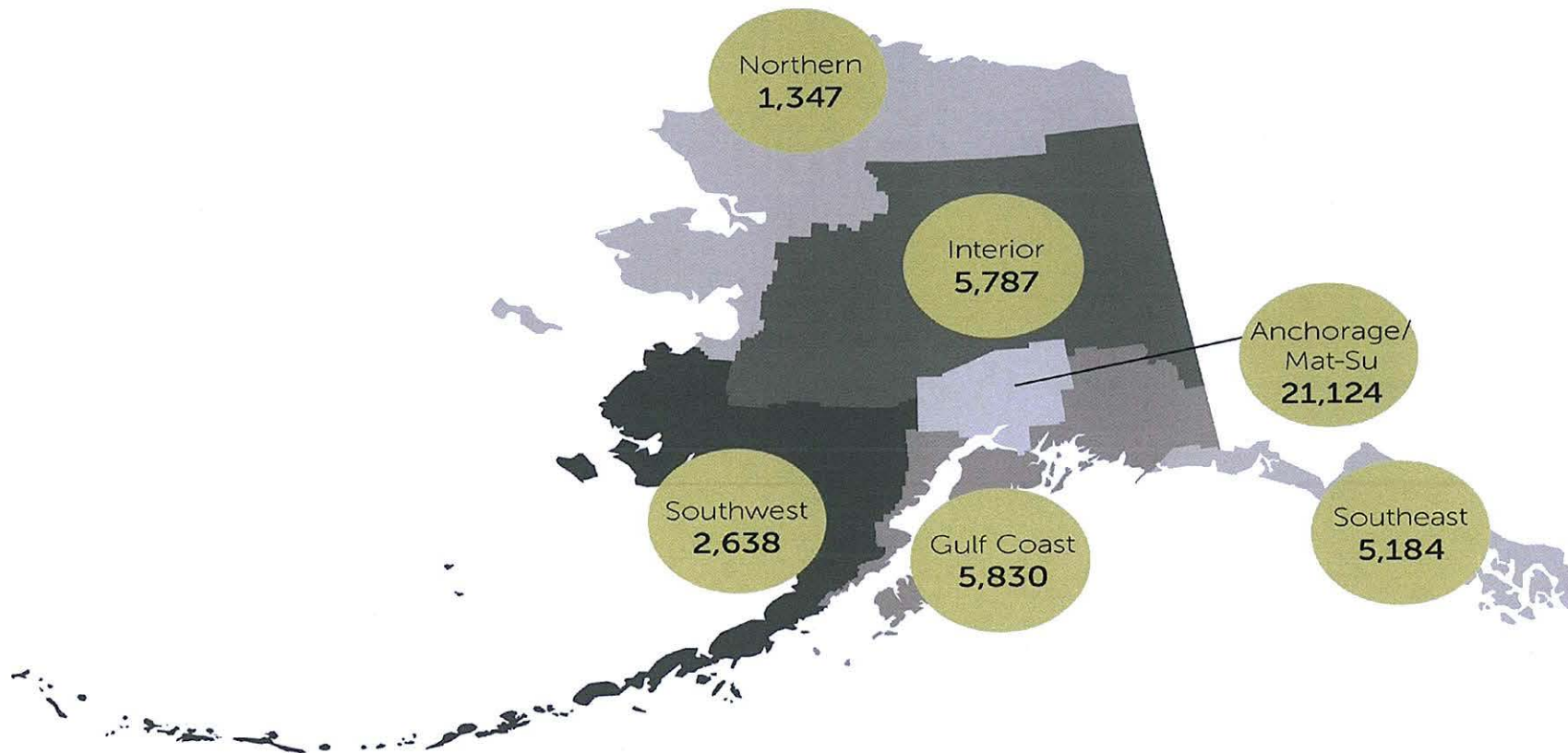
Healthy Alaskans

Who would be covered by Expansion?

- Adults without dependent children
- Ages 19 – 64
 - Not otherwise eligible for Medicaid or Medicare
- Earning up to 138% of the Federal Poverty Level (FPL)
 - Single adults earning up to \$20,314 per year
 - Married couples earning up to \$27,490 per year

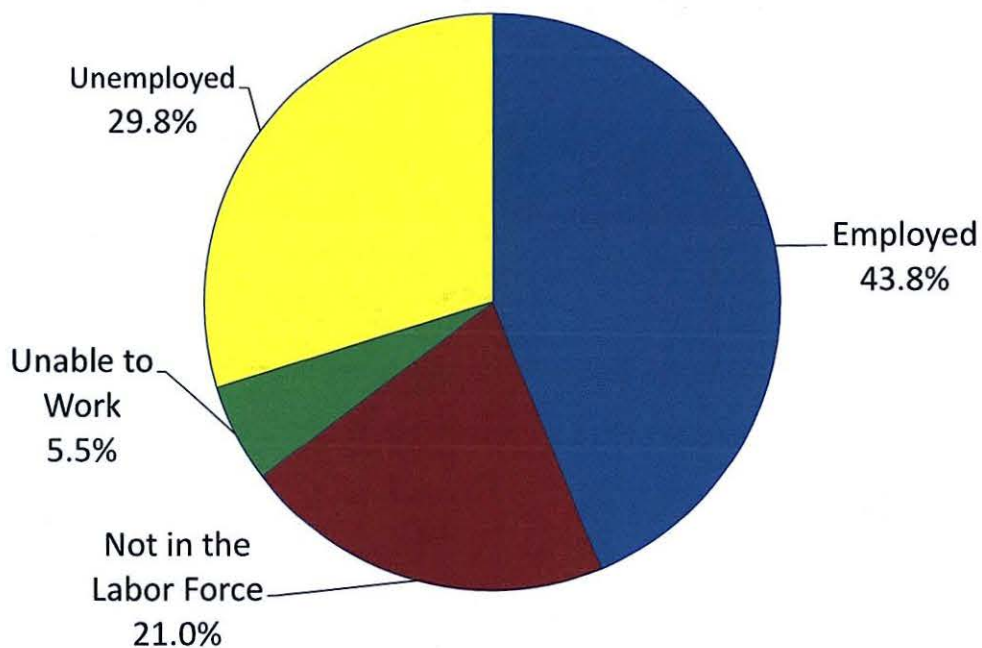


Healthy Alaskans Where are they?



Healthy Alaskans The Expansion Population

Employment Status of Alaska's Medicaid Expansion Population



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 healthcare services provided by tribal health facilities and possibly other sources.



Healthy Alaskans

How many will sign up?

	2016	2017	2018	2019	2020	2021
Newly Eligible Adults	41,910	41,980	42,050	42,120	42,190	42,260
Take-up Rate	47.90%	55.40%	63%	63%	63%	63%
New Enrollees	20,066	23,273	26,492	26,535	26,580	26,623



Healthy Alaskans Cost Per Enrollee

- Projected Cost of Service Per Newly Eligible Medicaid Enrollee

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

- Weighted by Expected Gender and Age Distribution of the Expansion Population

Gender	Ages 19-34	Ages 35-44	Ages 45-54	Ages 55-64	All Ages
Male	20.10%	5.20%	13.60%	14.40%	54%
Female	12.60%	5.80%	13.80%	14.50%	46%
Total	32.70%	11.00%	27.40%	28.90%	100%



Healthy Alaskans

Reducing Recidivism

2015 Recidivism Reduction Plan

http://www.legis.state.ak.us/basis/get_documents.asp?session=29&docid=1372

- Convicted felons who completed a DOC substance program:
 - 12% recidivated compared to the control group in which 20% recidivated within 12 months of being released
- Institute of Social and Economic Research (ISER) report:
 - With no change in policies, the number of Alaska inmates is likely to double by 2030
 - From 5,300 to 10,500
 - With an additional \$4 million a year to expand the education and substance abuse programs, the prison population in 2030 would be 10% smaller than projected
 - About 1,050 fewer inmates
- Continued access to substance abuse programs following release is key



Healthy Alaskans

Improving Health

Access to health care means improved health outcomes and increased productivity and independence

- The number of uninsured Alaskans would be reduced by half
- More Alaskans would receive preventative and primary care, including behavioral health services and help in managing costly chronic diseases
- Alaska's statewide mortality rate would drop
- Health care access for survivors of domestic violence and sexual assault
- Access to health care is already showing a positive difference for the homeless population in other states
 - Improving capability to gain employment



Healthy Economy
New Federal Dollars

- Higher Federal Contribution under Expansion

	2014	2015	2016	2017	2018	2019	2020 & Beyond
Federal match under expansion	100%	100%	100%	95%	94%	93%	90%

- \$1.12B in new federal revenue

	2016	2017	2018	2019	2020	2021
Federal Match*	\$145,435.0	\$170,633.0	\$195,514.0	\$200,683.0	\$204,087.0	\$204,928.0

* Costs in Thousands of Dollars



Healthy Budgets Saves Money

- Costs to the State

	2016	2017	2018	2019	2020	2021
State Match for Health Care Costs	\$0	\$3,804.0	\$9,854.0	\$12,064.0	\$16,346.0	\$19,587.0
Administrative Costs for Expansion (State General Fund)	\$0*	\$1,392.0	\$1,478.0	\$1,499.0	\$1,600.0	\$1,625.0
State Costs:	\$0	\$5,196.0	\$11,332.0	\$13,563.0	\$17,946.0	\$21,212.0

* FY16 Administrative Cost is being funded by the Alaska Mental Health Trust Authority

Costs in thousands



Healthy Budgets Saves Money

- Offsets to the State Budget

	2016	2017	2018	2019	2020	2021
Chronic & Acute Medical Assistance (CAMA)	\$1,000.0	\$1,300.0	\$1,400.0	\$1,500.0	\$1,500.0	\$1,500.0
Corrections	\$4,100.0	\$7,000.0	\$7,000.0	\$7,000.0	\$7,000.0	\$7,000.0
Behavioral Health Grants	\$1,500.0	\$5,000.0	\$9,000.0	\$13,000.0	\$16,000.0	\$16,000.0
State Offsets:	\$6,600.0	\$13,300.0	\$17,400.0	\$21,500.0	\$24,500.0	\$24,500.0

Costs in thousands



Healthy Budgets Saves Money

		2016	2017	2018	2019	2020	2021
C O S T S	State Match for Health Care Costs	\$0	\$3,804.0	\$9,854.0	\$12,064.0	\$16,346.0	\$19,587.0
	Administrative Costs for Expansion (State General Fund)	\$0*	\$1,392.0	\$1,478.0	\$1,499.0	\$1,600.0	\$1,625.0
State Costs:		\$0	\$5,196.0	\$11,332.0	\$13,563.0	\$17,946.0	\$21,212.0
O F F S E T S	Chronic & Acute Medical Assistance (CAMA)	\$1,000.0	\$1,300.0	\$1,400.0	\$1,500.0	\$1,500.0	\$1,500.0
	Corrections	\$4,100.0	\$7,000.0	\$7,000.0	\$7,000.0	\$7,000.0	\$7,000.0
	Behavioral Health Grants	\$1,500.0	\$5,000.0	\$9,000.0	\$13,000.0	\$16,000.0	\$16,000.0
State Offsets		\$6,600.0	\$13,300.0	\$17,400.0	\$21,500.0	\$24,500.0	\$24,500.0
Net Savings to State GF		(\$6,600.0)	(\$8,104.0)	(\$6,068.0)	(\$7,937.0)	(\$6,554.0)	(\$3,288.0)
Federal Match		\$145,435.0	\$170,633.0	\$195,514.0	\$200,683.0	\$204,087.0	\$204,928.0

* FY16 Administrative Cost is being funded by the Alaska Mental Health Trust Authority



Reform is Necessary

Reform is necessary

- State of the Budget Address
 - Identify 25% cuts over the next several years
- Minimize the impact to those we serve
- Efficiencies, Improvements and Innovations are critical to bend the cost curve

DHSS Budget = \$2.7B

- Medicaid = \$1.7B

The current Medicaid program is not sustainable



Catalyst for Reform

Building on Reforms Underway

- Control overutilization of hospital emergency room services
- Increased fraud and abuse prevention and control efforts
- Activities to reduce waste
- Home and community-based service improvements
- Coordination with Patient-Centered Medical Home initiatives
- Coordination with the Alaska tribal health system
- Investigating waiver options



Catalyst for Reform

Additional Reforms

Recently identified reforms:

- Continued partnership with Tribal Health
- Change eligibility for Personal Care Assistance (PCA) services
- Possible savings in Durable Medical Equipment, Vision, and Hearing
- Increase number in the Super Utilizer contract for management of care
- Dental
- Implement utilization control for Behavioral Health services
- Transportation



Catalyst for Reform

Designing Reform

- Funding from the Alaska Mental Health Trust Authority
 - March 18, 2015: Deadline for Proposal Submission
 - <https://aws.state.ak.us/OnlinePublicNotices/Notices/View.aspx?id=175783>
- Technical Assistance for Reform
 - Building an Alaskan Model
 - Current Program
 - Expansion
 - Reform efforts/Best practices in other states
 - Stakeholder process
 - Identifying the approval process
 - Regulation, Statutory, Budgetary, State Plan Amendments, waivers



Catalyst for Reform

Additional Reform Options

Building blocks to achieving meaningful reform

- Payment Reform
- Strengthened Primary Care
- Care Management
- Workforce Innovation
- Maximizing federal matching fund opportunities
- Improved Telehealth Capability



Catalyst for Reform

Additional Reform Options

Reform strategies for increasing prevention and shared responsibility

- Cost-sharing options
- Health Savings Accounts (HSAs)
- Services to direct patients to the appropriate level of care
- Incentives for healthy behaviors
- Increased access to preventative services
- Work assistance benefits for the expansion group



Healthy Economy Impact to the Economy



nearly 42,000
uninsured
ALASKANS
eligible for basic health
care coverage*



\$1.1
BILLION
in new federal
revenue for Alaska*



4,000
new
JOBS**



\$1.2
BILLION
more in wages
and salaries
paid to Alaskans**



Questions?

Thank You





HEALTH CARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING—WITH REAL-WORLD PERSPECTIVE.

An Analysis of the Impact of Medicaid Expansion in Alaska

Final Report

Prepared by:

Megan Cole, MPH, Randy Haught, Mengxi Shen, Lauren Cardick, MPH, MSW
The Lewin Group

Updated April 12, 2013

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Executive Summary

Following the June 2012 United States Supreme Court ruling on the Affordable Care Act (ACA), states now have the option to opt out of the Medicaid expansion provision of the ACA without compromising their current federal Medicaid funding. As a result of this ruling, the Alaska Department of Health and Social Services (DHSS) commissioned The Lewin Group to explore the potential financial impacts of expanding or not expanding its Medicaid program.

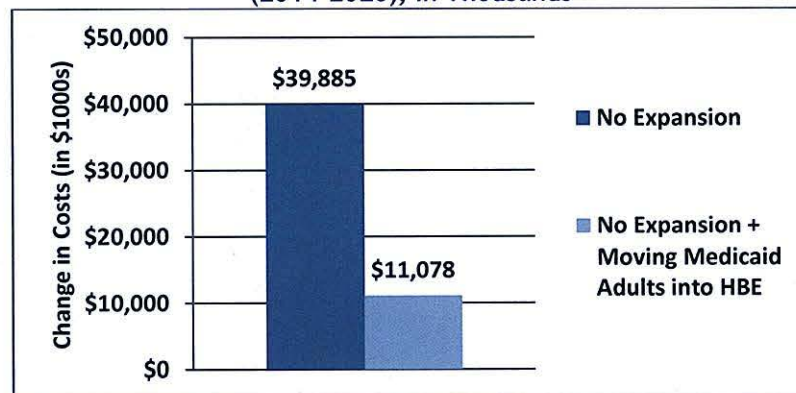
This report provides estimates on Medicaid costs and enrollment under the option of not expanding Medicaid compared to the option of expanding Medicaid under various program design options. We also include a discussion of impact on administrative costs, on additional offsets due to elimination or changes in existing programs, and on additional cost control measures of interest to the state.

Option to Not Expand Medicaid

The ACA includes coverage provisions that will affect Alaska's Medicaid program regardless of any changes made to the current program. These provisions include reforming the individual insurance markets by eliminating pre-existing condition exclusions, guaranteeing coverage and renewability of coverage, establishing Health Benefit Exchanges (HBEs), an individual mandate, subsidizing health insurance for people between 100 and 400 percent of the federal poverty level (FPL), and a mandate for large employers to offer health insurance.

Accounting for these changes, if the state decides not to expand Medicaid, we estimate it would cost the state \$39.9 million over the 2014 to 2020 period, compared to pre-ACA projects, due to other effects of the ACA. It will also result in an enrollment increase of 779 individuals, compared to pre-ACA projections. As an option, the state may also elect to cap eligibility for poverty-level adult pregnant women at 138 percent of FPL and move those above 138 percent of FPL into the HBE, where they can obtain subsidized private health insurance coverage. This would cost the state \$11.1 million from 2014 to 2020 and would result in an enrollment increase of 402 individuals, compared to pre-ACA projections (*Figure E-1*). However, these individuals would now be subject to premiums and additional cost-sharing. Additionally, if Alaska opts not to expand Medicaid, about 19,900 individuals will remain uninsured who would have otherwise gained coverage under Medicaid expansion.

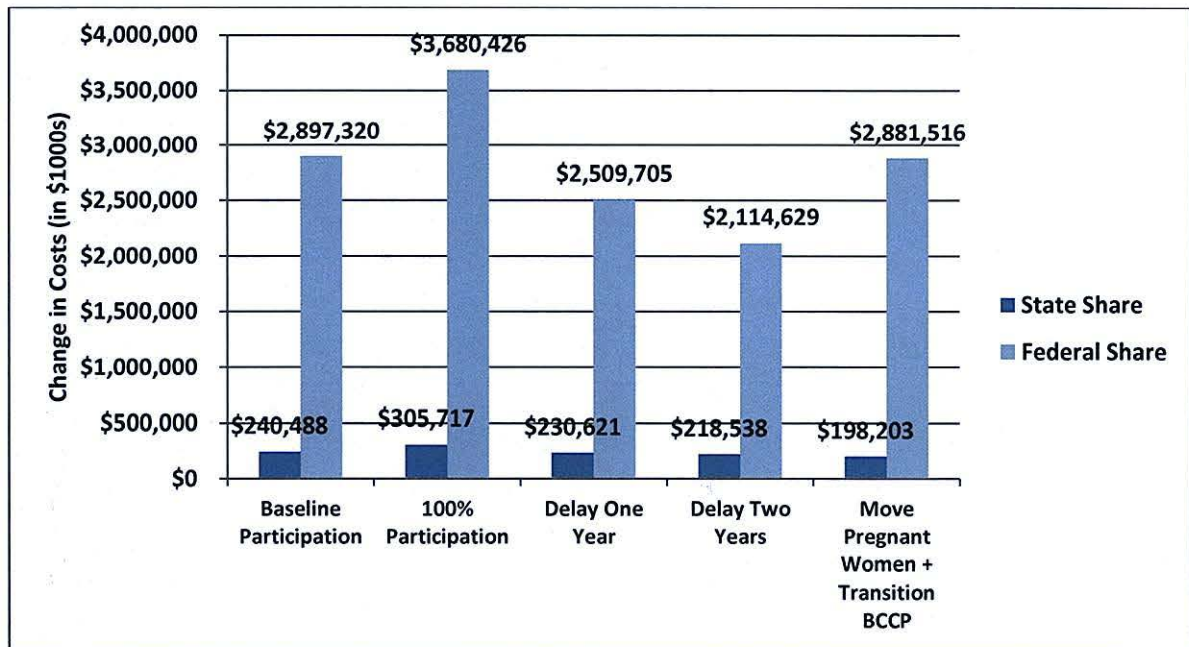
Figure E-1. Comparison of No Expansion Scenarios: Cumulative Change in Alaska Medicaid Costs (2014-2020), in Thousands



Option to Expand Medicaid

Under different participation rates and design options, expanding Medicaid to all adults below 138 percent of FPL would result in an increase in state Medicaid spending between \$198.2 million and \$305.7 million over the 2014 to 2020 period, compared to projected spending in the absence of ACA.¹ However, the expansion would result in additional federal funding between \$2.1 billion and \$3.7 billion over this same period. These options are summarized in *Figure E-2* and are explained in greater detail in the body of this report.

Figure E-2. Comparison of Cumulative Alaska Medicaid Cost Effects of Medicaid Expansion Options (2014-2020), in Thousands^{1/ 2/}



^{1/}Baseline participation scenario includes participation rates of 73.5 percent for newly eligible previously uninsured, 39.0 percent for newly eligible previously insured, and 21.4 percent for currently eligible but not enrolled.

^{2/}100 Percent Participation scenario includes participation rates of 100 percent for newly eligible previously uninsured and a proportional increase for all other groups.

Total enrollment and uninsured rates will also vary based upon the expansion design option. In our baseline expansion estimate, we estimate 43,316 additional Medicaid enrollees by 2020 compared to pre-ACA projections. Due to the uncertainty around program participation, we also provide estimates assuming 100 percent of the newly eligible previously uninsured adults participate in the program. This would result in 56,364 additional Medicaid enrollees by 2020. Under both one year and two year delayed implementation options, change in enrollment by 2020 would be 43,316 compared to pre-ACA projections. If the state were to move pregnant women over 138 percent of FPL to the HBE while transitioning the Breast and Cervical Cancer

¹ The \$305.7 million cost estimate is a high-end estimate that assumes 100 percent Medicaid participation amongst newly eligible previously uninsured individuals, which is an unlikely participation rate for the program. However, we provide this as an illustration of maximum program costs.

Program (BCCP) enrollees from current to newly eligibles, enrollment would increase by 42,938 by 2020, while minimizing state cost.

In addition, under the Medicaid expansion option, many individuals currently receiving care in state-funded or subsidized programs will have the opportunity to enroll in Medicaid. This will produce additional savings for Alaska that are not captured in the scenarios above. These additional savings are summarized in *Figure E-3* below.

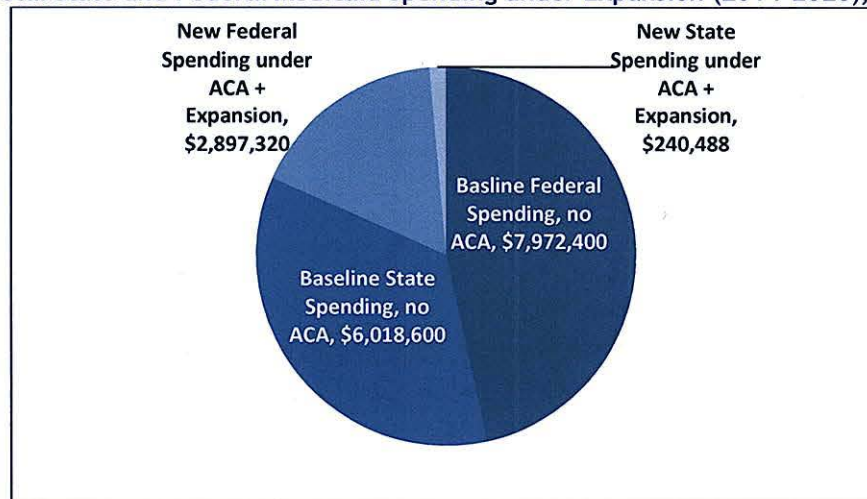
Figure E-3. Summary of Impact on Other State Programs Due to Expanding Medicaid in Alaska (in \$1,000s for 2014-2020)

Program	Without Medicaid Expansion	With Medicaid Expansion
Denali KidCare Program	(\$6,637)	(\$6,637)
CAMA Program	--	(\$11,258)
State Employee Health Benefits Program	--	(\$22,515)
Total Offsets	(\$6,637)	(\$40,410)

Source: Lewin Group estimates using the Alaska version of the Health Benefits Simulation Model.

Ultimately, there are both benefits and drawbacks to consider when determining whether or not to expand Medicaid in Alaska. State costs, incoming federal funds, and total number of uninsured individuals hinge on the state's decision. If Alaska decides to expand Medicaid, it may do so under a number of implementation timelines and design options, which result in various levels of state costs and additional federal funds. Under our baseline participation assumptions, expanding Medicaid would cost the state \$200.6 million more over the 2014 to 2020 period, compared to not expanding Medicaid, for a total increased cost of \$240.5 million. However, the state would receive \$2.9 billion in additional federal funds and fewer individuals would remain uninsured. Additionally, this new cost would comprise only 1.4 percent of total Medicaid costs from 2014 to 2020 (*Figure E-4*). To minimize state costs under expansion, the state could also elect to implement expansion under a number of alternative design scenarios.

Figure E-4. Total State and Federal Medicaid Spending under Expansion (2014-2020), in thousands^{1/}



1/ Pre-ACA baseline state and federal costs exclude administrative costs

I. Introduction

In March 2010, the U.S. Congress passed the Patient Protection and Affordable Care Act (ACA), a sweeping piece of legislation designed to overhaul the country's health care system and extend health insurance to millions of uninsured Americans. The law includes several approaches to accomplish this goal, including the establishment of Health Benefit Exchanges (HBEs), insurance market reforms, an individual mandate to obtain coverage, subsidized health insurance, and a mandate for large employers to offer health insurance. One of the key provisions of the Act was a mandatory expansion of Medicaid in all 50 states and the District of Columbia.

As originally written, each state was required to expand its Medicaid program to cover all adults under age 65 whose household incomes are less than or equal to 138 percent of the federal poverty level (FPL) or face losing all federal funding for their Medicaid programs. For these newly eligible individuals, the federal government would cover 100 percent of the health care costs between 2014 and 2016. This percentage would gradually decrease from 100 percent to 90 percent between 2017 and 2020.

However, in June 2012, the United States Supreme Court ruled that the federal government could not require individual states to expand their Medicaid programs for adults and declared this part of the ACA unconstitutional. States will now have the option to opt out of the Medicaid expansion provision of the Act without compromising their current federal Medicaid funding.

As a result of this ruling, the Alaska Department of Health and Social Services (DHSS) contracted with The Lewin Group to explore the potential financial impacts of expanding or not expanding its Medicaid program. The ultimate purpose of this report is to estimate the impact of expanding versus not expanding Alaska's Medicaid program.

To adequately determine the cost and coverage impacts of expanding versus not expanding Medicaid in Alaska, we include the following considerations in our analyses:

- Current and past annual costs of health care benefits for persons enrolled in Medicaid from 2008-2012, by demographic categories, type of service, and federal and state shares
- Current and past eligibility counts from 2008 to 2012, by demographic categories, including comparisons of current participants versus those currently eligible who do not participate
- Estimated costs of the current Medicaid program without enactment of the ACA from 2012 to 2020
- Cost effects of new federal requirements on the Medicaid program
- Estimated costs for the population not currently categorically eligible who will become eligible due to the expansion, including:
 - Consideration of factors that account for historical experience with Medicaid

- Determination of whether costs for the newly eligible will be similar to those currently enrolled
- Estimates assuming all newly eligible previously uninsured individuals enroll in the Medicaid program
- Estimates assuming 74 percent of newly eligible previously uninsured and 39 percent of the newly eligible previously insured enroll in the Medicaid program
- Consideration of whether individuals with incomes above eligibility minimums may take purposeful steps to become eligible

This report first provides background on historical Medicaid costs and eligibility counts in Alaska, and using this historical data, projects costs and eligibility through 2020 in absence of the ACA. We next provide estimates on Medicaid enrollment and state and federal costs under the option of not expanding Medicaid, taking into account the numerous ACA provisions that will affect costs whether or not the state decides to expand. We also estimate state costs under no expansion if the state were to cap eligibility for pregnant women at 138 of FPL and move those above 138 of FPL into the HBE.

Under Medicaid expansion, we provide estimates of Medicaid enrollment and state and federal costs under various program options and scenarios for the state. We illustrate costs and enrollment under a baseline participation scenario, under a 100 percent participation scenario amongst newly eligible previously uninsured individuals, under a one year implementation delay option, under a two year implementation delay option, and under an option to move pregnant women above 138 of FPL into the HBE while transitioning enrollees out of the Breast and Cervical Cancer Program.

The report then explores impact of change on administrative costs, additional state savings due to reduction of or change in existing programs, secondary economic effects of expanding the Medicaid program, and cost control measures of interest to the state.

The final section of the analysis and results summarizes and compares the various design options presented in the report.

The methodology used to produce the enrollment and cost estimates is described in the final section of the report. Detailed tables for each of the scenarios described in this report are presented in Appendix B.

II. Background on Costs and Enrollment in Alaska Medicaid

In determining projected costs and enrollment for Alaska's Medicaid program post-ACA, it is important to first understand historical and future costs and eligibility counts in the absence of the ACA. Using 2008 to 2012 data provided by Alaska DHSS, we observed a substantial rise in eligibility counts over the past five years. A particularly accelerated rate of growth is seen between 2009 and 2011, during which average monthly eligibility counts increased by nearly 19 percent (*Figure 1*).

Over the 2008 to 2012 period, the total cost of the Alaska Medicaid program rose steadily from \$1.0 billion in 2008 to more than \$1.3 billion in 2012. During this time, state and federal shares of the total cost have fluctuated due to changes in the Federal Medical Assistance Percentage (FMAP) and temporarily increased federal funding under the American Reinvestment and Recovery Act (ARRA).

Figure 1. Historical Costs Eligibility Counts for Alaska Medicaid (2008-2012)

Historic					
	2008	2009	2010	2011	2012
Eligibility Counts	96,534	98,931	109,040	117,515	122,688
Total Costs (\$1,000s)					
State Share	\$397,142	\$364,201	\$397,241	\$538,752	\$569,626
Federal Share	\$615,801	\$699,083	\$788,367	\$715,582	\$773,738
Total	\$1,012,943	\$1,063,284	\$1,185,608	\$1,254,334	\$1,343,363

Source: Alaska DHSS historical Medicaid cost and eligibility count data. Excludes administrative costs.

We projected eligibility counts through 2020 using a trending factor based on the Alaska Medicaid program's demographic and historical characteristics. This methodology is further described in the Appendix. Based on our assumptions, by state fiscal year (SFY) 2020, the eligibility count for the current program would reach 151,213 individuals, precluding effects of the ACA. This represents a 23 percent increase from 2012 (*Figure 2*).

In projecting total annual costs of the current program to SFY 2020, the 2012 state and federal proportions of total costs were assumed. Total cost of the current program, before adjusting for effects of the ACA, is projected to reach \$2.5 billion by 2020. This represents a 75 percent total increase compared to 2013.

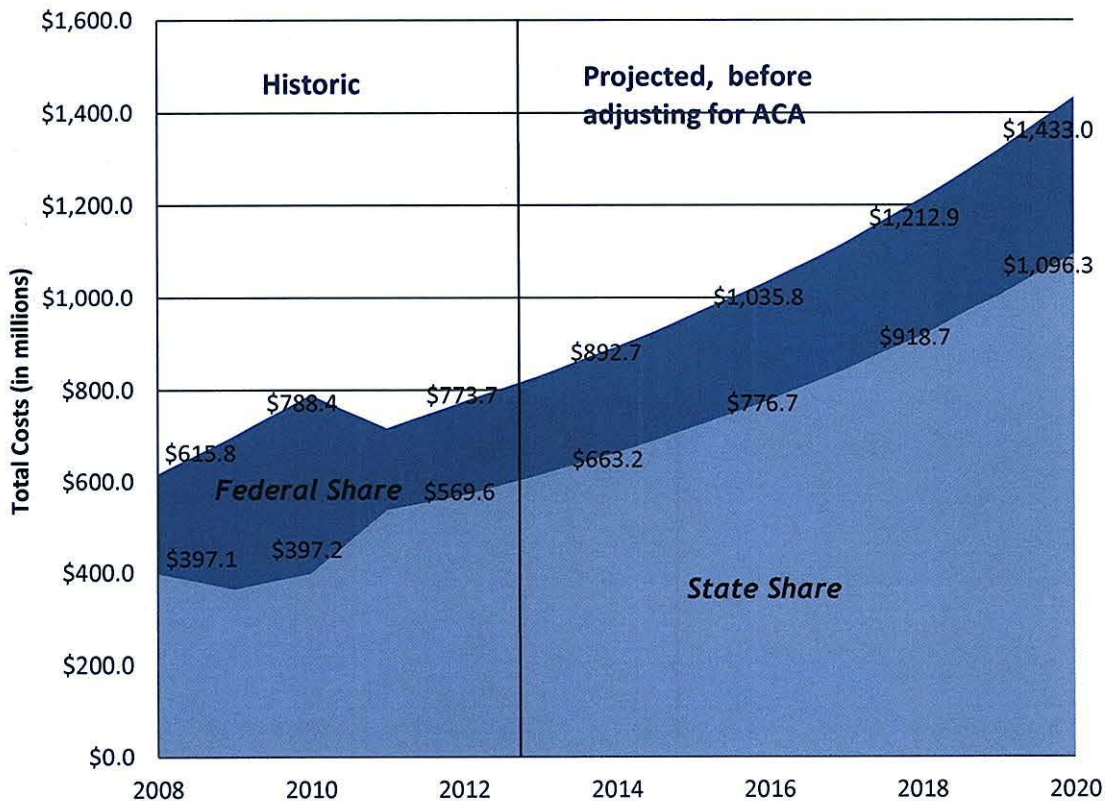
Figure 2. Projected Costs Eligibility Counts for Alaska Medicaid (2013-2013), without ACA

Projected, Before Adjusting for ACA								
	2013	2014	2015	2016	2017	2018	2019	2020
Eligibility Counts	125,855	129,148	132,575	136,089	139,769	143,572	147,367	151,213
Total Costs (\$1,000s)								
State Share	\$614,160	\$663,226	\$717,677	\$776,701	\$843,168	\$918,667	\$1,002,820	\$1,096,335
Federal Share	\$830,461	\$892,715	\$961,475	\$1,035,766	\$1,119,139	\$1,212,935	\$1,317,418	\$1,433,015
Total	\$1,444,621	\$1,555,942	\$1,679,152	\$1,812,467	\$1,962,307	\$2,131,602	\$2,320,237	\$2,529,351

Source: Alaska DHSS historical Medicaid cost and eligibility count data. Excludes administrative costs.

By 2020, absent the ACA, the federal government would be responsible for \$1.4 billion of the \$2.5 billion total cost, with the state contributing \$1.1 billion. A continuum of historical and projected Medicaid costs, by state and federal share, is shown in Figure 3 below.

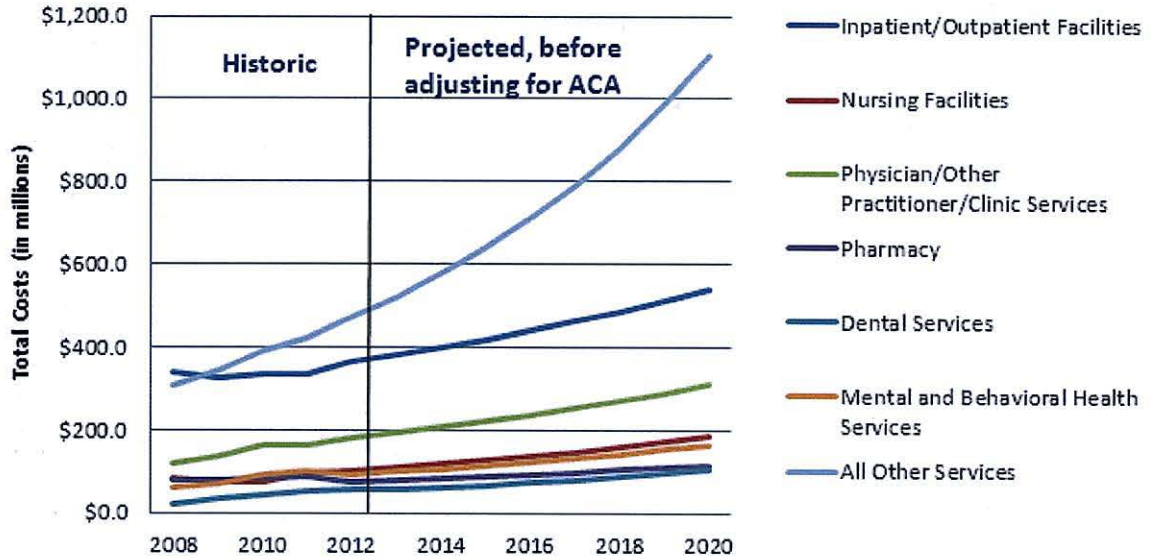
Figure 3. Historical and Projected State and Federal Medicaid Spending in Alaska, Without ACA (2008-2020)



As the state considers options for improving upon its current Medicaid program in light of ACA provisions, it may be beneficial to consider the trajectory of projected costs of the current program by benefit type, demographic characteristics, and the state's share of total expenses. From 2008 to 2012, total costs for all benefit types have shown a steady rate of growth, with a

notable exception for the cost of the combined total of all services that fall outside the six most-utilized benefit type categories. This particular benefit type (“All Other Services”) is projected to increase at a rate substantially higher than that of other benefit types, indicative of a rapid rise in certain non-ambulatory services. By SFY 2020, total costs for this “All Other Services” category, which includes waiver services, may reach over \$1.1 billion, representing nearly 44 percent of the total Medicaid health care costs in Alaska (Figure 4).

Figure 4. Historic and Projected Medicaid Total Costs by Benefit Type (2008-2020)



Detailed projections of cost by benefit type and demographic characteristics are provided in the Appendix.

III. Analysis and Results

The following sections present our estimates of the impact on state and federal Medicaid spending under various options for expanding and not expanding Medicaid in Alaska.

A. Estimated Costs of Medicaid Program under the ACA, Without Expansion

As noted, the state has the option of not expanding Medicaid as originally required under the ACA without facing a financial penalty. However, other aspects of the ACA will affect Alaska's Medicaid program regardless of any changes made to the current program. These other provisions include the following:

- **Individual mandate:** The ACA requires all U.S. citizens to obtain health insurance coverage or pay a penalty. By 2016 the penalty will be the greater of \$695 per person (capped at \$2,085 per family) or 2.5 percent of income. However, exemptions apply to people below the federal tax filing threshold and to families where coverage is unaffordable (i.e., premiums that exceed 8 percent of family income). Most Alaska residents with incomes below 138 percent of FPL will be exempt from the penalty. However, the mere existence of the individual mandate may incent some people who are currently eligible to obtain Medicaid or CHIP coverage to satisfy the mandate. This is part of what is often referred to as the "woodwork effect." We estimate there will be 9,869 children and adults in Alaska that are eligible for Medicaid but uninsured and 1,810 will enroll to satisfy the mandate.
- **Simplified Medicaid eligibility procedures:** The ACA requires states to simplify their Medicaid eligibility procedures, which is unaffected by the Supreme Court's decision. Beginning in 2014, the state will be required to use Modified Adjusted Gross Income (MAGI) to determine financial eligibility and use streamlined application and enrollment procedures, such as eliminating asset tests. Experience in states that have eliminated asset tests has shown increased enrollment of between 3 and 10 percent for the affected populations.^{2,3} Based on these results, we estimate 1,362 adults will become newly eligible and enroll in Medicaid.
- **Larger employer mandate:** The ACA requires all large employers with more than 50 workers to offer qualified health insurance or pay a penalty. The Act also provides certain small employers with tax credits to incentivize offering coverage to their employees. We estimate that some employers will begin to offer coverage due to these provisions, which may become available to lower wage workers and their dependents that are currently enrolled in Medicaid. We assume that some of these workers will decide to take the employer's offer of coverage, which will reduce Medicaid enrollment. We estimate that in 2014, over 2,400 adults and children will leave Medicaid for these new options under the ACA. This number will increase to about 2,800 by 2020.

² Utah Department of Health, "Medicaid Asset Limit Study," October 2005.

³ National Academy for State Health Policy, "Maximizing Kids' Enrollment in Medicaid and SCHIP," February 2009.

- Increase in CHIP FMAP:** As an incentive for states to retain their CHIP programs through 2019, the ACA provides states with a 23 percentage point increase in their enhanced Federal Medical Assistance Percentage (FMAP) rate for CHIP beginning in federal fiscal year 2016, regardless of whether the state decides to expand Medicaid. However, the state is also required to move children below 133 percent of FPL from CHIP to Medicaid. We estimate this would result in a net savings to the state of \$6.6 million from 2014 through 2020 assuming that the state would have continued the CHIP program in the absence of the ACA.

We estimate that these provisions required by the ACA will result in a net increase in Medicaid enrollment of 779 individuals by 2020, compared to enrollment projections precluding the effects of ACA (*Figure 5*). In total, inclusive of health care and administrative costs, we estimate that it would cost the state \$39.9 million over this period, compared to a baseline of no ACA. The federal government will only contribute an estimated \$40.5 million to Alaska's Medicaid program over this period if the state chooses to forgo Medicaid expansion.

Figure 5. Impact on Alaska Medicaid Spending if Medicaid is Not Expanded Under the ACA (2014-2020)

	2014	2015	2016	2017	2018	2019	2020	2014-2020
Change in Enrollment	577	667	758	761	765	772	779	
Total Costs (in \$1,000s)								
State Share	\$4,091	\$4,441	\$5,402	\$5,799	\$6,231	\$6,705	\$7,216	\$39,885
Federal Share	\$4,158	\$4,514	\$5,491	\$5,894	\$6,334	\$6,815	\$7,336	\$40,543
Total	\$8,249	\$8,955	\$10,894	\$11,693	\$12,565	\$13,520	\$14,552	\$80,428

Source: Lewin Group estimates using the Alaska version of the Health Benefits Simulation Model. Please refer to Appendix B, Figure B-1 for further detail.

As an option, the state could examine the impact of capping certain eligibility categories for adults at 138 percent of FPL and moving enrollees to the Health Benefits Exchange (HBE) where they can obtain subsidized private health insurance coverage and under which they would be guaranteed coverage and renewability for that coverage in the future. For illustrative purposes, we assumed that the state caps Medicaid eligibility at 138 percent of FPL for poverty level pregnant women as an eligibility category. Poverty level pregnant women are currently eligible up through 175 percent of FPL.

This option would result in moving 242 enrollees to the HBE in 2014 (*Figure 6*). If the state decided to implement this option, the state's share of Medicaid costs would be an additional \$11.1 million over the 2014 to 2020 period, compared to no ACA. This represents a \$28.8 million savings compared to the no expansion option where this eligibility category remains covered under Medicaid.

Figure 6. Impact on Alaska Medicaid Spending if Medicaid is Not Expanded Under the ACA (2014-2020) and Capping Eligibility for Pregnant Women at 138 Percent of FPL

	2014	2015	2016	2017	2018	2019	2020	2014-2020
Change in Enrollment	242	325	409	405	403	402	402	
Total Costs (\$1,000s)								
State Share	\$553	\$726	\$1,502	\$1,703	\$1,931	\$2,189	\$2,475	\$11,078
Federal Share	\$562	\$738	\$1,526	\$1,731	\$1,963	\$2,225	\$2,516	\$11,261
Total	\$1,115	\$1,463	\$3,028	\$3,434	\$3,893	\$4,415	\$4,991	\$22,339

Source: Lewin Group estimates using the Alaska version of the Health Benefits Simulation Model. Please refer to Appendix B, Figure B-2 for further detail.

We found that the federal government would also share in the savings to Medicaid resulting from capping eligibility for this category and moving individuals into the HBE, since the federal government currently pays 50 percent of the cost for these individuals. These circumstances will cost the federal government \$11.3 million between 2014 and 2020 – a savings of \$29.3 million compared to the no expansion options where this eligibility category remains covered under Medicaid. However, we do not show the new federal cost for providing premium and cost-sharing subsidies for these individuals.

This analysis does not quantify the additional cost to enrollees moved to the HBE who would be required to pay a portion of the premium, ranging from 3 percent of income for those at 138 percent of FPL to 9.5 percent of income for those at 400 percent of FPL. Also, individuals who are working full-time for an employer that offers affordable coverage would be ineligible for subsidized coverage through the Exchange and would be required to enroll in the employer’s health plan.⁴ Health benefit plans offered in the Exchange or by the employer may also require these individuals to pay deductibles and copayments that may exceed their current cost-sharing requirements under Medicaid.

B. ACA Provisions that Affect the Medicaid Program Regardless of Expansion

The ACA, in conjunction with the Centers for Medicare & Medicaid Services (CMS), sets forth a number of requirements with cost implications for those currently eligible for Medicaid. As above, these requirements may affect state spending whether or not the state elects to expand Medicaid, and thus, are incorporated into both no expansion scenarios above and the expansion scenarios below. These changes include the following:

1. Rebates for Prescription Drugs

Effective January 1, 2010, the ACA increased the rebate percentage for covered outpatient drugs dispensed to Medicaid patients based on drug type and source (multiple versus generic). The Medicaid drug rebate percentage increased to 23.1 percent for brand name prescription drugs (with certain exceptions) and to 13 percent for generic prescription drugs. Additionally, the

⁴ An affordable employer plan must have an actuarial value of at least 60 percent, and enrollees’ share of the premium must not exceed 9.5 percent of income.

ACA requires manufacturers that participate in the drug rebate program to pay rebates for drugs dispensed to individuals enrolled with a Medicaid managed care organization (MCO) if the MCO is responsible for drug coverage. The ACA also changes the non-federal share of rebates. Here, the amount of savings resulting from the increases in the rebate percentages is remitted to the federal government. Accordingly, CMS is offsetting the non-federal share of the difference between the rebate percentages in effect on December 31, 2009 and January 1, 2010. The offset amount is based on the drug type and source category determining the drug rebate percentage. In February 2012, CMS published a Proposed Rule to implement the Medicaid Drug Rebate Program (MDRP) provisions of the ACA, which revised the definitions and methods for calculating the AMP and Best Price (BP), while making a series of changes beyond the ACA provisions.

Of these provisions, while the federal government experiences savings associated with all of these changes, measurable savings to states derive primarily from rebates for Medicaid MCO drugs. However, this change will not benefit the state of Alaska, which does not operate a Medicaid managed care program.

2. Changes in Payment Levels to Primary Care Physicians

Effective January 1, 2013, through December 31, 2014, as Medicaid programs and providers prepare for an increase in patient volume resulting from expanded coverage, the ACA requires states to reimburse primary care physicians at no less than 100 percent of Medicare's payment rates for primary care services. Pediatricians, general internists, family physicians, and those who work under their supervision will receive this enhanced rate. The federal government will fully fund the difference between current state payment levels and this new reimbursement rate. However, this provision will not affect Alaska since Medicaid payment rates for primary care providers are already above Medicare payment levels.

3. Reductions in Disproportionate Share Hospital (DSH) payments

Disproportionate Share Hospital (DSH) payments are federal funds that serve to compensate hospitals for some of the uncompensated care provided to indigent patients. As more of the currently uninsured gain coverage under the ACA, there is an assumed reduction in uncompensated care. On this premise, the ACA reduces DSH payments in states by a total of \$500 million in FY2014, \$600 million in FY2015 and FY 2016, \$1.8 billion in FY2017, \$5 billion in FY2018, \$5.6 billion in FY2019, and \$4 billion in FY2020. This represents approximately a 50 percent reduction from current allotments in 2020. The Secretary of Health and Human Services is tasked with developing a methodology for reducing federal DSH allotments to each state. The methodology will impose the largest percentage reductions on states that (1) have the lowest percentages of uninsured individuals during the most recent year, and (2) do not target their DSH payments on hospitals with high volumes of Medicaid patients and uncompensated care (excluding bad debt).

From 2008 to 2011, based on CMS 64 reported data, Alaska used 44 percent of its DSH allotment on average. Given that the state is not currently using the majority of its allotment, the reduction in DSH payments starting in 2014 is unlikely to have a significant financial impact on Alaska.

4. Modification to Denali KidCare Program

Effective October 1, 2015 the state will receive a 23 percent increase in the federal funding matching rate (from 66 percent to 89 percent) for the state's Denali KidCare (DKC) Program. This enhanced matching rate will continue through September 30, 2019. However, Alaska will be required to provide Medicaid coverage to children between 100 and 133 percent of the FPL, which will receive Alaska's current federal Medicaid match rate of 50 percent. These changes will generate a net savings for the state of \$6.6 million from 2014 to 2020 (details on the calculation for these estimates are presented in the Methodology section of the report).

C. Impact of Expanding Medicaid under the ACA on the Uninsured

The coverage provisions in the ACA will dramatically change health insurance coverage in Alaska when it is fully implemented in 2014. These provisions include reforming the individual insurance markets by eliminating pre-existing condition exclusions, guaranteeing coverage and renewability of coverage, establishing Health Benefit Exchanges, an individual mandate, subsidizing health insurance for people between 100 and 400 percent of FPL, and a mandate for large employers to offer health insurance.⁵

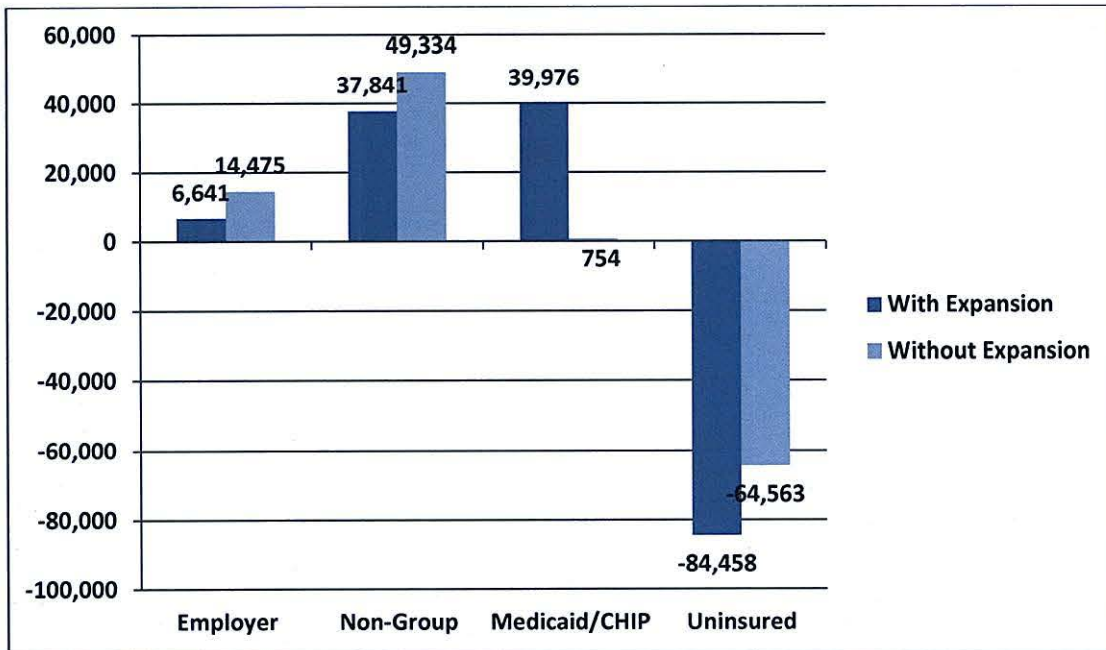
Additionally, if the state decides to expand Medicaid coverage as originally designed under the ACA, then all state residents below 400 percent of FPL will have access to subsidized coverage. However, if the state does not expand Medicaid, many of the lowest income adults (below 100 percent of FPL) will not have access to subsidized coverage because premium subsidies through the Exchange are only available for individuals between 100 and 400 percent of FPL.

We estimate that there will be about 144,983 uninsured in Alaska in 2014 in the absence of the ACA. Taking into account all other provisions of the ACA, our estimates show that if the state expands Medicaid, the number of uninsured would be reduced to 60,435 – an 84,548 total decrease, or a 58.3 percent change (*Figure 7*). However, if the state decides not to expand Medicaid, then the number of uninsured would decrease by a lesser amount – a 64,563 total decrease, or 44.5 percent change. This means that under the no expansion option, about 19,900 individuals will remain uninsured that would otherwise have coverage under Medicaid expansion.

Of the uninsured, it is those under 138 percent of FPL who would primarily be affected under the decision to expand Medicaid. Those remaining uninsured will continue to strain the finances of other public health programs and safety net providers for their care, while likely forgoing or reducing necessary care and risking a drain on personal finances.

⁵ Under the ACA, states have the option of establishing a fully state-based exchange, a state-federal partnership exchange, or default into a federally-facilitated exchange. As Alaska's governor has declined to run a state-based exchange, it is anticipated that the federal government will run the exchange in Alaska.

Figure 7. Change in Coverage Source under the ACA in Alaska (2014)



Source: Lewin Group estimates using the Alaska version of the Health Benefits Simulation Model

D. Estimated Costs of Medicaid Program under the ACA, With Expansion under Various Design Options

We estimated the impact on Medicaid enrollment and state spending under the option that the state expands Medicaid to all adults in the state up to 138 percent of FPL beginning in 2014. In 2014, we estimate there will be about 64,000 adult legal residents below 138 percent of FPL who would be newly eligible for the expansion. Of these, 44,500 would have been previously uninsured and 19,500 would have some form of health insurance (*Figure 8*). In addition, we estimate there are 2,400 children and adults who are currently eligible for Medicaid or CHIP but are uninsured that may potentially enroll to satisfy the individual mandate.

Figure 8. Estimate of Individuals Eligible and Who Will Enroll in a Medicaid Expansion to 138 Percent of FPL in Alaska in 2014 ^{1/}

	Eligible	Enroll	Participation Rate
Newly Eligible - Previously Uninsured	44,470	32,674	73.5%
Newly Eligible - Previously Insured	19,519	7,610	39.0%
Currently Eligible but Uninsured	9,869	2,111	21.4%
Leave Medicaid for New Offer of Employer Coverage	n/a	2,419	n/a
Net Change in Medicaid Enrollment	n/a	39,976	n/a

1/Assumes full implementation and ultimate enrollment in 2014

As described in our methodology below, we estimate that about 73 percent of the uninsured will ultimately enroll in a Medicaid expansion and about 39 percent of those that would have had private insurance in the absence of the expansion would also enroll. Due to the individual mandate and parents enrolling in Medicaid, we estimate that about 21 percent of the currently eligible but uninsured will ultimately enroll. It may take up to 2 years to reach this ultimate enrollment level as people learn about the program and their eligibility over time. Based on national estimates produced by the Congressional Budget Office (CBO), we assume that the program will reach 76 percent of ultimate enrollment in the first year, 88 percent in the second, and 100 percent by the third year. As described in the section above, we estimate that in 2014, about 2,400 adults and children will leave Medicaid for newly offered employer coverage due to the employer-related provisions of the ACA. We do not include estimates for individuals with incomes above eligibility minimums who would take purposeful steps to become eligible. This is because these individuals would be eligible for an Exchange subsidy, which, for individuals right above the 138 FPL threshold, would cost only 3 percent of their annual income. Most individuals would have to spend-down more than it would cost to purchase the subsidized insurance.

Expanding Medicaid to all adults below 138 percent of FPL would result in a net increase in Medicaid enrollment of 43,300 individuals by 2020 (*Figure 9*). Total Medicaid costs, including health care and administration, would increase by \$3.1 billion from 2014 through 2020, compared to an environment without the ACA. The federal government will pay 100 percent of the health care costs for newly eligible adults from 2014 through 2016. By 2020, the percent paid by the federal government will drop to 90 percent. However, the state will only receive the current federal matching rate for health care costs for new enrollees that are eligible under current Medicaid eligibility criteria. The additional cost of administering Medicaid eligibility and coverage for these new enrollees will be matched by the federal government at the current matching rate for program administration.

Figure 9. Impact on Alaska Medicaid Spending if Medicaid is Expanded Under the ACA (2014-2020) - Baseline ACA Analysis ^{1/}

	2014	2015	2016	2017	2018	2019	2020	2014-2020
Change in Enrollment	30,570	35,664	40,957	41,513	42,051	42,668	43,316	
Total Costs (\$1,000s)								
State Share	\$10,617	\$12,065	\$14,603	\$36,941	\$43,913	\$51,687	\$70,663	\$240,488
Federal Share	\$296,276	\$346,468	\$418,938	\$425,224	\$448,308	\$473,080	\$489,026	\$2,897,320
Total	\$306,893	\$358,533	\$433,541	\$462,165	\$492,221	\$524,766	\$559,688	\$3,137,808

^{1/} Assumes implementation January 1, 2014, current Medicaid eligible above 138 percent of FPL remain in the program and all current eligibility categories are retained.

Source: Lewin Group estimates using the Alaska version of the Health Benefits Simulation Model. Please refer to Appendix B, Figure B-3 for further detail.

Based on the federal matching methods for these new enrollees, we estimate that the state's share of the cost between 2014 and 2020 would be about \$240 million, which would be about 7.7 percent of the total cost of expanding Medicaid. This does not include the 23 percentage point increase in their enhanced FMAP rate for CHIP beginning in federal fiscal year 2016, which we

estimate would save the state \$6.6 million over this period, as described below. The federal government, on the other hand, will spend an estimated \$2.9 billion between 2014 and 2020, to cover the cost of the increased federal matching rates for the newly eligible enrollees.

1. Alternative Take-Up Rate for Newly Eligible Group

For illustrative purposes, we have also estimated costs and total enrollment if 100 percent of the newly eligible but previously uninsured group enrolls in Medicaid. Other groups would experience a proportional increase in enrollment. This would result in a net increase in enrollment of 56,000 individuals by 2020 (*Figure 10*). Total additional Medicaid costs, including health care and administration, would increase to \$4.0 billion from 2014 to 2020. This is an increase of \$848 million, compared to our baseline participation assumptions (*Figure 11*). Based on federal matching methods, we estimate that the state's share of costs between 2014 and 2020 would be \$306 million, or about 7.7 percent of the total cost of additional Medicaid spending compared to no ACA. The federal government, on the other hand, will spend an estimated \$3.7 billion between 2014 and 2020 if the state were to experience a 100 percent participation level.

Figure 10. Comparison of Participation Assumptions (2014)^{1/}

	Baseline Assumption	100% Assumption
<i>Newly Eligible - Previously Uninsured</i>		
Eligible	44,470	44,470
Enroll	32,674	44,470
Participation	73.5%	100%
<i>Newly Eligible - Previously Insured</i>		
Eligible	19,519	19,519
Enroll	7,610	10,405
Participation	39.0%	53.3%
<i>Currently Eligible but Uninsured</i>		
Eligible	9,869	9,869
Enroll	2,111	3,261
Participation	21.4%	33%
<i>Leave Medicaid for New Offer of Employer Coverage</i>		
Leave Medicaid	2,419	2,419
<i>Net Change in Medicaid Enrollment</i>		
Net Change	39,976	55,718

1/ Assumes that all provisions are fully implemented and ultimate enrollment is reached in 2014.

**Figure 11. Impact on Alaska Medicaid Spending if Medicaid is Expanded Under the ACA (2014-2020)
- Sensitivity Analysis - 100% Participation Assumption^{1/}**

	2014	2015	2016	2017	2018	2019	2020	2014-2020
Change in Enrollment	35,590	46,207	53,098	53,862	54,609	55,466	56,364	
Total Costs (\$1,000s)								
State Share	\$13,383	\$15,310	\$18,538	\$46,912	\$55,813	\$65,760	\$89,999	\$305,717
Federal Share	\$375,362	\$439,241	\$531,432	\$539,872	\$569,742	\$601,893	\$622,883	\$3,680,426
Total	\$388,745	\$454,551	\$549,970	\$586,785	\$625,555	\$667,654	\$712,882	\$3,986,143

1/ Assumes implementation January 1, 2014, current Medicaid eligible above 138 percent of FPL remain in the program and all current eligibility categories are retained.

Source: Lewin Group estimates using the Alaska version of the Health Benefits Simulation Model. Please refer to Appendix B, Figure B-4 for further detail.

2. Alternative Design Option - Delayed Program Implementation

Beginning January 1, 2014, Alaska could expand Medicaid to all adults below 138 percent of FPL and receive enhanced federal matching. However, CMS has stated that states may “decide whether and when to expand, and if a state covers the expansion group, it may later drop the coverage.”⁶ Therefore, Alaska has the option to begin the expansion at any time after January 1, 2014, and still receive the enhanced federal match. However, 100 percent federal matching is only available from 2014 through 2016. If the state decides to delay the start of the program until after January 2014, then it will lose the ability to provide coverage to residents at full federal funding during that period.

Another state concern is that the federal government may reduce the level of funding for the expansion in the future due to budget pressures or that future cost of the program will place pressure on state budgets. In any case, states could discontinue eligibility for the expansion at any time without penalty.

To illustrate the impact of this option, we estimated the cost to the state of delaying implementation of the Medicaid expansion until January 1, 2015. We assume that the state will still be required to meet eligibility simplification requirements and interface with the Exchange beginning in 2014. However, the program will still experience increased enrollment from people currently eligible who enroll to satisfy the mandate and those that become newly eligible through the enrollment simplification processes. The program will also see people leaving Medicaid for the other coverage options that become available under the ACA.

Delaying implementation of the program to 2015 would only reduce the cost to the state by \$9.9 million between 2014 and 2020 compared to the cost of implementing the program starting in 2014 (*Figure 12*). This is due to the fact that the federal government pays the full cost for the newly eligible group for the first three years of the program. The program would cover 30,000 fewer people in 2014 under a delayed implementation, while forfeiting \$387.6 million in federal

⁶ Presentation by Cindy Mann, CMS Deputy Administrator to the National Conference of State Legislators, “Medicaid and CHIP: Today and Moving Forward,” August 6, 2012.

dollars. With a one-year delay in expansion of implementation for Alaska, the federal government will save this \$387.6 million, largely due to the absence of the newly eligible enrollees for which the state would have received 100 percent FMAP funding during 2014.

Similarly, delaying implementation of the program until 2016 would only reduce the cost to the state by \$21.9 million between 2014 and 2020 compared to the cost of implementing the program in 2014 (*Figure 13*). Under these circumstances, federal contributions will be nearly \$782.7 million less over the 7 year period, when compared to implementing the program in January 2014.

Figure 12. Impact on Alaska Medicaid Spending if Medicaid is Expanded Under the ACA (2014-2020) - Program Design Option - Delayed Implementation Until January 2015^{1/}

	2014	2015	2016	2017	2018	2019	2020	2014-2020
Change in Enrollment	577	30,871	36,100	41,513	42,051	42,668	43,316	
Total Costs (\$1,000s)								
State Share	\$4,091	\$10,449	\$12,878	\$36,941	\$43,913	\$51,687	\$70,663	\$230,621
Federal Share	\$4,158	\$300,265	\$369,645	\$425,224	\$448,308	\$473,080	\$489,026	\$2,509,705
Total	\$8,249	\$310,713	\$382,523	\$462,165	\$492,221	\$524,766	\$559,688	\$2,740,326

1/ Assumes implementation January 1, 2015, current Medicaid eligible above 138 percent of FPL remain in the program and all current eligibility categories are retained.

Source: Lewin Group estimates using the Alaska version of the Health Benefits Simulation Model. Please refer to Appendix B, Figure B-5 for further detail.

Figure 13. Impact on Alaska Medicaid Spending if Medicaid is Expanded Under the ACA (2014-2020) - Program Design Option - Delayed Implementation Until January 2016^{1/}

	2014	2015	2016	2017	2018	2019	2020	2014-2020
Change in Enrollment	577	667	31,243	36,589	42,051	42,668	43,316	
Total Costs (\$1,000s)								
State Share	\$4,091	\$4,441	\$11,154	\$32,590	\$43,913	\$51,687	\$70,663	\$218,538
Federal Share	\$4,158	\$4,514	\$320,351	\$375,192	\$448,308	\$473,080	\$489,026	\$2,114,629
Total	\$8,249	\$8,955	\$331,505	\$407,782	\$492,221	\$524,766	\$559,688	\$2,333,167

1/ Assumes implementation January 1, 2016, current Medicaid eligible above 138 percent of FPL remain on the program and all current eligibility categories are retained.

Source: Lewin Group estimates using the Alaska version of the Health Benefits Simulation Model. Please refer to Appendix B, Figure B-6 for further detail.

3. Alternative Design Option - Move Current Eligibles Above 138 Percent of FPL to Exchange (Pregnant Women Eligibility Category) + Transition Enrollees Out of Breast and Cervical Cancer Program Eligibility Category

Beginning in 2014, when the Medicaid maintenance of effort requirement for adults expires, Alaska will have the option of moving currently eligible enrollees of certain subgroups, who are above 138 percent of FPL, into the Health Benefit Exchange. This will involve capping Medicaid income eligibility for these groups at 138 percent of FPL and allowing those enrollees to purchase coverage through the HBE with premium and cost-sharing subsidies, which will be paid in full by the federal government. In doing so, Alaska will no longer be responsible for funding 50 percent of the cost for these individuals. Potential eligibility groups that could be moved to the Exchange include poverty level pregnant women, who are currently eligible through 175 percent of FPL.

By reducing income eligibility for this eligibility category and moving these individuals to the Exchanges, the Medicaid program would no longer bear the cost for these individuals and the state and federal government would share the savings. However, the cost of providing premium and cost-sharing subsidies through the Exchange would be paid by the federal government. Those individuals moved to the Exchanges would be required to pay a portion of the premium, ranging from 3 percent of income for those at 138 percent of FPL to 9.5 percent of income for those at 400 percent of FPL.

This option would result in moving over 335 enrollees to the Exchanges in 2014 and an additional savings to the state of about \$28.8 million over the baseline between 2014 and 2020.

We found that the federal government would also share in the savings to Medicaid resulting from capping eligibility for this eligibility category and moving individuals into the Exchange since the federal government currently pays 50 percent of the cost for these individuals. It would save an estimated \$29.3 million between 2014 and 2020, compared to baseline expansion conditions. However, we did not show the new federal cost for providing premium and cost-sharing subsidies for these individuals. Also, this analysis does not quantify the additional cost to enrollees moved to the Exchanges who would be required to pay a portion of the premium ranging from 3 percent of income for those at 138 percent of FPL to 9.5 percent of income for those at 400 percent of FPL. Health benefit plans in the Exchange may also require these individuals to pay deductibles and copayments that well exceed cost-sharing requirements under Medicaid.

Additionally, Alaska would have the option to transition enrollees out of the Breast and Cervical Cancer Program (BCCP) eligibility category. By doing so, current enrollees as well as individuals that could become eligible for these programs in the future could enroll as newly eligible adults if their income is below 138 percent of FPL. We were unable to get income data for these enrollees, but assume that all are below 138 percent of FPL.

Due to the significantly enhanced FMAP rates under Medicaid expansion, Alaska would save most of the funds it had previously spent on covering enrollees in this eligibility category and the federal government would pay a larger share of the cost.

We estimated the cost of this option using trended Medicaid enrollment and paid claims for these groups. By evolving this current Medicaid program and allowing enrollees to take coverage under the newly eligible category or purchase subsidized health insurance through the Exchange depending on their income, the state could significantly reduce its share of the costs of the expansion. Nearly all of the costs for these individuals would become federally funded. Here, the state would save \$13.5 million, while would be incurred by the federal government.

If Alaska were to move currently eligible pregnant women above 138 percent of FPL into the Exchange, while transitioning enrollees out of the BCCP, this aggregate option would reduce the state's cost of the Medicaid expansion by \$42.3 million between 2014 and 2020 as compared to our baseline expansion estimates (*Figure 14*). Additionally, this would reduce costs for the federal government by \$15.8 million relative to our baseline expansion estimate.

Figure 14. Impact on Alaska Medicaid Spending if Medicaid is Expanded Under the ACA (2014-2020) - Program Design Option - Move Current Eligibles Above 138 Percent of FPL to Exchange (Pregnant Women Eligibility Category) + Transition Enrollees Out of Breast and Cervical Cancer Program Eligibility Category^{1/}

	2014	2015	2016	2017	2018	2019	2020	2014-2020
Change in Enrollment	30,235	35,322	40,609	41,157	41,688	42,298	42,938	
Total Costs (\$1,000s)								
State Share	\$5,266	\$6,446	\$8,703	\$30,957	\$37,673	\$45,181	\$63,977	\$198,203
Federal Share	\$294,493	\$344,596	\$416,972	\$422,949	\$445,876	\$470,480	\$486,150	\$2,881,516
Total	\$299,759	\$351,042	\$425,675	\$453,906	\$483,549	\$515,661	\$550,127	\$3,079,718

1/ Assumes implementation January 1, 2014.

Source: Lewin Group estimates using the Alaska version of the Health Benefits Simulation Model. Please refer to Appendix B, Figure B-7 for further detail.

One option not explored within this study is the option to partially expand Medicaid below 138 percent of FPL. Here, while states may elect to partially expand the program, the federal government will not provide states with the enhanced federal match unless the Medicaid program is fully expanded.⁷

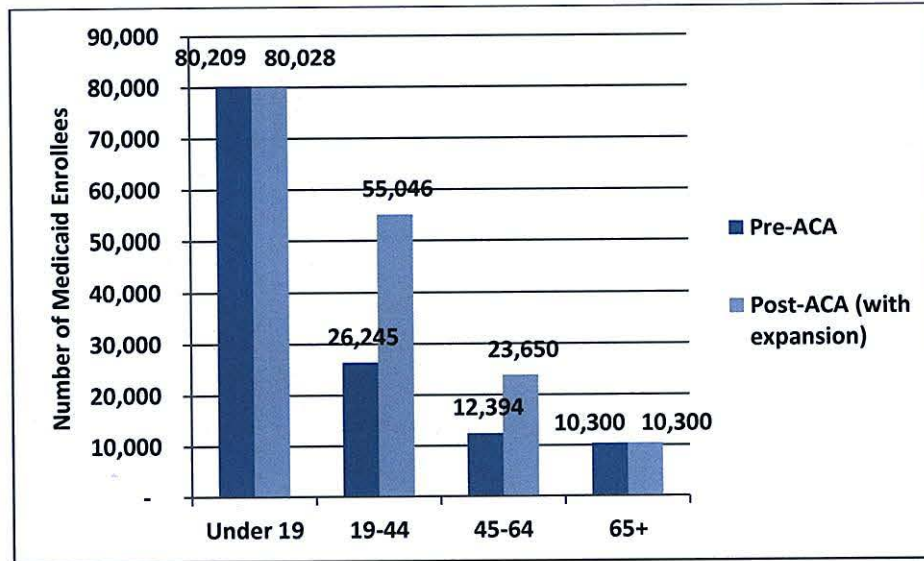
E. Impact of Medicaid Expansion on Makeup of Medicaid Population

Under the baseline Medicaid expansion option, Medicaid enrollment would increase by about 40,000 in 2014, compared to a 2014 baseline absent of ACA. The composition of this post-ACA expansion enrollment population would differ, however, in terms of age and sex, compared to current enrollees. As shown in *Figure 15* and *Figure 16*, the under 19 and over 65 enrollment would remain mostly unchanged, while the 19 to 44 and 45 to 64 age groups would experience

⁷ Centers for Medicare & Medicaid Services (2012 December 12). Memorandum - Frequently Asked Questions on Exchanges, Market Reforms and Medicaid Retrieved from <http://cciio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf>

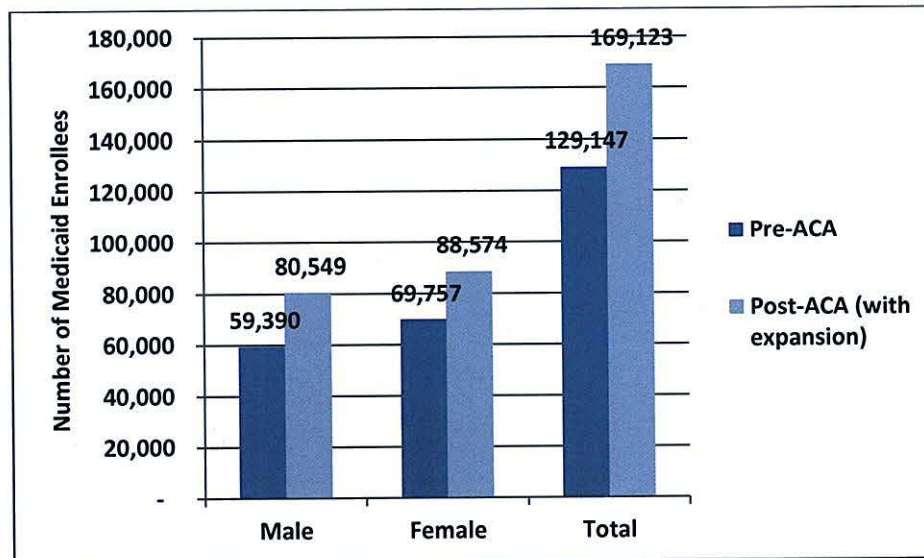
significant increases of 110 percent and 91 percent, respectively. Additionally, males would experience somewhat higher increases in enrollment than females, with respective increases of 36 and 27 percent.

Figure 15. Change in Medicaid Population by Age: Pre-ACA vs. Post-ACA, With Expansion



Source: Lewin Group estimates using the Alaska version of the Health Benefits Simulation Model

Figure 16. Change in Medicaid Population by Sex: Pre-ACA vs. Post-ACA, With Expansion



Source: Lewin Group estimates using the Alaska version of the Health Benefits Simulation Model

F. Estimated Costs for Administrative Work

Included in our scenario estimates above are estimated costs for administrative work. Total administrative costs were calculated as 8.2 percent of the annual medical cost of the Medicaid program for the fee-for-service option. This was based on our analysis of the CMS 64 data from 2006 through 2011. The state and federal shares were found by applying the estimated Federal Medical Assistance Percentage (FMAP) rate for administrative costs (55.4 percent) to the total cost.

There is some concern among states that the Medicaid expansion will require a significant increase in administrative costs. As stated above, Medicaid administrative costs in Alaska account for about 8.2 percent of total Medicaid spending. The federal government matches administrative costs at 50 percent, although some functions are matched at higher rates.⁸

Medicaid expansion may require states to adopt new administrative roles, including enhancement of current systems to interface with the Health Benefit Exchange, increased time spent on enrollment of traditional and expansion populations, outreach to newly eligible populations, and upgrading and/or modifying current systems to interface with the new Exchanges. Though associated costs may increase, the State Health Reform Assistance Network proposes that increases may be offset by enhanced federal matching (e.g., 90 percent match for building the eligibility system, 75 percent match for systems operation).

Under expansion, the state will likely experience a surge in staffing needs in order to accommodate the significant volume of new enrollment. The timely and successful provision of certain program maintenance functions (i.e., enrollee and provider appeals, case management and disease management for certain populations, program integrity, prior authorization and utilization management functions, call center operations, and claims processing) is dependent on adequate staffing. To accommodate significant new enrollment following Medicaid expansion, DHSS may need to hire new staff to maintain adequate service levels (i.e., calls are answered within a certain number of seconds, appeals are handled within a certain number of days). In the initial stages of expansion implementation, DHSS may experience a surge in staffing needs in order to handle eligibility determination and enrollment processing.

New state administrative roles may include the following:

- **Update technology systems that support eligibility:** To be eligible for enhanced federal financial participation (FFP), or enhanced match, the state's Medicaid Management Information System (MMIS) must meet a minimum set of requirements for efficient and economical operation. Before approval will be granted, the system must: align with industry standards; use open interfaces; promote sharing of Medicaid technologies and systems; support accurate and timely processing of claims; produce data and reports that contribute to program evaluation, transparency, and accountability; and coordinate seamlessly with the Exchanges.⁹

⁸ Kaiser Commission on Medicaid and the Uninsured, "Medicaid Administration," 2002.

⁹ Centers for Medicare & Medicaid Services, "Enhanced Funding Requirements: Seven Conditions and Standards," April 2011.

- **Review current eligibility categories and consider how existing and potential expanded Medicaid programs will interact with the Exchanges:** The addition of new eligibility categories may require additional administrative funds. Most existing categories can be collapsed into three groups: parents, pregnant women, and children under age 19. After January 2014, states can elect to include all non-pregnant individuals between the ages of 19 and 65 whose household incomes are at or below 133 percent of FPL. With or without Medicaid expansion, the state will need to interface with the health benefit Exchange. As previously mentioned, this will require enhancements to existing systems and possibly additional staff to facilitate operations.
- **Implement MAGI methodologies:** All state Medicaid agencies will be switching to a new standard for determining eligibility known as Modified Adjusted Gross Income (MAGI). Changing to MAGI eligibility standards will affect how income is counted and how households are defined. For example, MAGI excludes income from Veterans benefits, child-support income, and death benefits, but would include stepparent and grandparent income.¹⁰
- **Revise application processes:** The ACA requires states to use a single, streamlined application to facilitate Medicaid enrollment. In particular, the application must meet cultural competency and literacy standards to ensure access, and the online application should be tailored to the applicant based on responses to certain questions.¹¹ Most states will use the federal application, but states are permitted to develop their own application if it meets the standards set forth by the Secretary.
- **Modify and streamline renewal processes to increase retention:** Several states have already created more flexible renewal processes, including online, telephone, and administrative renewals. By reducing inefficiencies in the renewal process, states can conserve administrative funds used for closing and reopening cases and eliminate the gaps in coverage that result from individuals who “churn” on and off Medicaid over short periods of time.¹²

One promising avenue for decreasing costs is eliminating the income certification process and asset tests that many states use to prove an individual’s income. An asset test takes into consideration an individual’s resources beyond income, including savings accounts or vehicles, when considering eligibility for Medicaid. Many states have already dropped the asset test requirement, with additional states considering this possibility. For example, the state of Oklahoma reported spending \$3.5 million on administrative activities surrounding the asset test, which they reduced to \$2.5 million by removing the requirement.

Several studies suggest that introducing “self-certification” of income would reduce the burden on both applicants and enrollment officers. The Medi-Cal Policy Institute found that income

¹⁰ Kaiser Commission on Medicaid and the Uninsured, “Expanding Coverage to Adults Through Medicaid Under Health Reform,” September 2010.

¹¹ Centers for Medicare & Medicaid Services, “Supporting Statement for Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Affordable Insurance Exchanges, Medicaid and Children’s Health Insurance Program Agencies,” 2012.

¹² Kaiser Commission on Medicaid and the Uninsured, “Performing Under Pressure: Annual Findings of a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2011-2012,” January 2012.

certification was estimated to be 2.5 percent of an eligibility worker's time. Eliminating the requirement yielded a savings of approximately \$4.2 million state and federal dollars.

G. Additional Offsets to State Spending for Existing Programs if the State Expands Medicaid

Under the Medicaid expansion option, many individuals currently receiving care in state-funded or subsidized programs will become eligible and enroll in the Medicaid expansion. This will produce savings for Alaska, as the cost for these programs are reduced or eliminated. These savings are not incorporated into the scenarios above.

One program that could be transitioned entirely under Medicaid expansion is the Chronic & Acute Medical Assistance (CAMA) program, a state-only program administered through the DHSS Division of Health Care Services that provides financial assistance to Alaskans who need medical care but do not qualify for the state Medicaid program. To be eligible, an individual must be a U.S. citizen between ages 21 and 64 with a covered medical condition, have very limited income (e.g., \$300/month or less for one person), and no third party assistance or insurance. Covered medical conditions include a terminal illness; cancer requiring chemotherapy; chronic diabetes or diabetes insipidus; chronic seizure disorders; chronic mental illness; and chronic hypertension. CAMA covers prescription drugs, medical supplies, physician services related to the qualifying medical condition, chemotherapy and radiation therapy, and laboratory and X-ray services up to pre-determined limits. Under expansion, all individuals in this program would become eligible for Medicaid. We estimate savings of \$11.3 million over the 2014 to 2020 period as CAMA program enrollees are enrolled in the Medicaid expansion.

Some state employees and their dependents that have health coverage through the State and are below 138 percent of FPL may become eligible for the Medicaid expansion and enroll in the program. We estimate that 475 state employees and dependents will enroll in the Medicaid expansion, which will reduce spending for State Employee health benefits by \$22.5 million over the 2014 through 2020 period.

Additional areas where state spending may be reduced, as a result of covered individuals moving into Medicaid, include substance abuse counseling, mental health hospitals, subsidization of the cost of care for individuals in the high-risk pool, hospital inpatient services to prisoners, and public health services for the previously uninsured. However, data on these programs were not available for this study.

Thus, we estimate that about \$33.8 million in spending over the 2014 through 2020 period for other state programs could be saved as these individuals are enrolled in the Medicaid expansion (*Figure 17*).

**Figure 17. Offsets to Other State Programs if the State Decides to Expand Medicaid Under the ACA
(in \$1,000s)**

	2014	2015	2016	2017	2018	2019	2020	2014-2020
CAMA Program	\$1,376	\$1,468	\$1,565	\$1,586	\$1,674	\$1,766	\$1,823	\$11,258
State Employee Health Benefits	\$2,132	\$2,617	\$3,152	\$3,341	\$3,541	\$3,754	\$3,979	\$22,515
Total Program Offsets	\$3,508	\$4,085	\$4,717	\$4,927	\$5,215	\$5,520	\$5,802	\$33,773

Source: Lewin Projections using CMS 64 data for CHIP.

H. Secondary Effects on State Economy

In addition to impacting state Medicaid spending, the decision to expand or not expand Medicaid in Alaska could also have an impact on several secondary economic factors. For instance, payments for uncompensated care, generated by Medicaid and uninsured patients, are likely to decrease as more individuals sign up for insurance coverage through the Exchanges or are covered through an expansion of Medicaid eligibility.¹³ These savings may be offset, in part, by the planned reduction in Disproportionate Share Hospital (DSH) payments set to take effect in 2014.¹⁴ However, given that Alaska has used less than half of its DSH allotment, on average, in recent years (2008-2011), reductions in DSH are not likely to have a negative financial impact on Alaska.

Medicaid expansion will also have some more certain positive economic benefits for the state. State spending is expected to bring in significant federal matching dollars, much of which will pay for care that otherwise would have been provided at the state's expense.¹⁵ The influx of federal funds could also generate job growth within the state.¹⁶ In the health sector in particular, increased compensation resulting from an increased volume of insured patients may benefit hospitals and their providers. Finally, an increase in state revenue is likely given the impact of the rise in insurance coverage on insurance premiums taxes, medical provider taxes, and modest increases in income and sales tax receipts.^{17,18}

I. Exploration of Other Cost Control Measures

With or without Medicaid expansion, Alaska may wish to explore cost control measures that aim to bend the state cost curve for Medicaid, which in Alaska is projected to grow by 76 percent from 2013 to 2020 in the absence of Medicaid expansion. Based on experiences in other

¹³ Kaiser Family Foundation, "Health Reform Issues: Key Issues About State Financing and Medicaid," 2010.

¹⁴ National Association of Public Hospitals and Health Systems, "Need for a Sustainable Solution: Restoring the Balance in Safety Net Funding," 2012.

¹⁵ Center on Budget and Policy Priorities, "Guidance on Analyzing and Estimating the Cost of Expanding Medicaid," August 2012.

¹⁶ Ibid.

¹⁷ Bovbjerg, R.R., Ormond, B.A., & Chen, V., "State Budgets under Federal Health Reform: The Extent and Causes of Variations in Estimated Impacts," February 2011.

¹⁸ Buettgens, M., Dorn, S., & Carroll, C., "Consider Savings as Well as Costs: State Governments Would Spend at Least \$90 Billion Less With the ACA than Without It from 2014 to 2019," July 2011.

states and health systems, measures that serve to potentially control costs include promotion of patient-centered medical homes or Medicaid health homes; prevention and wellness; quality incentives to providers; drug benefit management; and telemedicine for behavioral health needs.

1. Patient Centered Medical Homes

A medical home is a health care setting that offers patients a regular source of care, enhanced access to physicians, and timely, well-organized, and integrated care. It also changes the provider reimbursement structure. Collectively, these attributes serve to improve outcomes and quality while reducing costs. Most states have adopted or are promoting the development of medical homes.¹⁹

Under Section 2703 of the ACA, a “health home” model was established as a Medicaid State Plan Option that provides comprehensive system of care coordination for Medicaid individuals with chronic conditions. The goal of health homes is to expand traditional medical home models to build linkages to other community and social supports, and to enhance coordination and integration of medical and behavioral health care. Health home services are offered to Medicaid eligibles with chronic conditions including mental health, substance abuse, asthma, diabetes, obesity, and other conditions. For states implementing Medicaid health home models, there is an enhanced match rate of 90 percent for the first eight quarters (two years) of enrollment.

Numerous states have documented savings and improved outcomes as a result of implementing medical home models. According to a December 2011 Milliman study, Medicaid medical homes in North Carolina saved \$1.0 billion in state and federal spending over four years, under the state’s Medicaid managed care program (Community Care of North Carolina). The savings were largely attributable to reductions in hospitalizations and emergency department visits for adults and children.²⁰ In Colorado, the Colorado Department of Health Care Policy and Financing has implemented a patient-centered medical home (PCMH) program that has served children enrolled in Medicaid and CHIP since 2001. An internal evaluation demonstrated both improved quality and lower costs. As of 2009, median annual costs were \$785 for PCMH children compared to about \$1,000 for non-PCMH children – a difference largely explained by reductions in hospitalizations and emergency room visits.²¹

While Medicaid health homes are in their nascent stages, experience with other medical home initiatives, coupled with the enhanced match rate for these services under the ACA, suggest that there may also be savings to states who effectively implement health home programs.

¹⁹ National Academy for State Health Policy (NASPH), “Medical Home & Patient-Centered Care,” 2012.

²⁰ Milliman, Inc., “Analysis of Community Care of South Carolina Cost Savings,” December 15, 2011.

²¹ Grumbach K, Bodenheimer T, & Grundy, P., “The Outcomes of Implementing Patient Centered Medical Home Interventions,” August 2009.

2. Prevention and Wellness

According to the U.S. Department of Health and Human Services, “nationally, Americans use preventive services at about half the recommended rate.”²² For instance, only 28 percent of adult smokers receive smoking cessation advice or assistance, 37 percent of adults age 50+ receive the recommended influenza vaccination, and 67 percent of women age 40+ have received a breast cancer screening in the past two years as recommended.²³ The reasons for this underutilization are many, with the primary reasons cited as high out of pocket costs, lack of a regular source of health care, lack of awareness about preventive services that are needed, providers’ lack or underuse of systems to increase preventive care, and limited investment in a prevention-oriented health care workforce.²⁴

Studies of preventive services indicate that they are cost-effective, or even cost-saving, depending on age and health status of the patient. Examples of cost-saving services include childhood immunizations, pneumococcal immunization (for those 65+), smoking cessation, vision screening, and screening for chlamydia, colorectal cancer and breast cancer.²⁵ However, as discussed by Cohen et al. (2004), it should be noted that while some preventive services are cost-saving, others can add to total health care costs (despite being cost-effective).²⁶

One way to promote preventive services is through the promotion of primary care. Numerous studies have echoed that primary care results in improved health outcomes and cost savings. For instance, studies have found that people who receive primary care have fewer preventable emergency department visits and hospital admissions. Here, promotion of primary care may be achieved by increasing the role and scope of physician assistants and nurse practitioners in primary care or through implementation of a medical home program. The ACA also prohibits cost-sharing on most preventive services, which may increase utilization of these services. Outreach and awareness of the benefit is an important determinant of utilization, however.

3. Quality Incentives

Quality incentives offer a variety of opportunities for additional cost containment. The most common quality incentive is known as pay-for-performance (P4P), a program intended to improve patient care by linking provider payments to the provision of efficient, high-quality care.²⁷ P4P programs can reduce costs by increasing the number of patients receiving preventive care or less expensive treatments, thus reducing the costs associated with future complications or treatments that could have been avoided.²⁸ In short, P4P is designed to avoid under- or overuse of health care. The latter is particularly relevant to fee-for-service models, in which

²² U.S. Department of Health & Human Services, “Background: The Affordable Care Act’s New Rules on Preventive Care,” 2011.

²³ Ibid.

²⁴ Sanchez, E., “Preventive Care: A National Profile on Use, Disparities, and Health Benefits – Presentation,” September 20, 2007.

²⁵ Maciosek, M.V. et al. (2007). Priorities Among Effective Clinical Preventive Services: Methods. *American Journal of Preventive Medicine*, 31(1): 90-96; National Business Group on Health, “A Purchaser’s Guide to Clinical Preventive Services: Moving Science into Coverage,” 2007.

²⁶ Cohen, J.T., Neumann, P.J., & Weinstein, M.C. (2008 February). Does Preventive Care Save Money? Health Economics and the Presidential Candidates. *New England Journal of Medicine*, 358:661-663.

²⁷ National Conference of State Legislatures, “Performance-Based Health Care Provider Payments,” 2010.

²⁸ Ibid.

providers are reimbursed for the number of services provided. P4P can circumvent this negative incentive by rewarding more efficient care.²⁹

Another promising avenue involves the use of health information technology (HIT) in P4P programs. Many Medicaid programs are offering incentives for participating in improvements to provider HIT structure, including the use of electronic health records, e-prescribing, patient monitoring, and other innovations.³⁰ HIT has the potential to contain costs by streamlining care and reducing the number of duplicate treatments or prescriptions per patient.³¹

4. Drug Benefit Management

Pharmacy costs, which constituted about 6 percent of Alaska's total Medicaid health care spending in 2012, also present an opportunity for cost containment. In a 2011 report on optimal management of Medicaid pharmacy programs, The Lewin Group found several areas for improvement.³² Medicaid fee-for-service (FFS) programs currently lag behind Medicaid managed care organizations (MCOs) in their use of generic drugs.³³ Medicaid FFS programs also have higher average dispensing fees than MCOs or commercial health plans, higher rates for reimbursing retail pharmacies for medication ingredients, and a higher number of prescriptions dispensed per person.³⁴

By aligning FFS pharmacy costs with the levels exhibited by Medicaid MCOs and Medicare Part D, Lewin estimates that Alaska's average for prescription costs could be reduced by 21.7 percent, per member per month (PMPM) costs could be reduced by \$13, and Alaska's savings would amount to \$92 million from 2011 to 2022.³⁵

5. Telemedicine for Behavioral Health

Telemedicine is the use of electronic communications (including email, web-based applications, and smart phone technology) to increase access to health services and meet patient demand.³⁶ The term encompasses a range of health services, including primary care consultations, specialist referrals, remote patient monitoring, consumer health information, peer-to-peer support, and medical education for health professionals.³⁷ Many states already cover telemedicine under Medicaid, including Alaska.

Telemedicine can reduce Medicaid care costs by reducing inefficiencies and travel times, improving management of chronic diseases (resulting in fewer visits or procedures), and decreasing the number and length of hospital stays.³⁸ Expanding the scope of telemedicine in

²⁹ Ibid.

³⁰ Kuhmerker, K. & Hartman, T., "Pay-for-Performance in State Medicaid Programs: A Survey of State Medicaid Directors and Programs," 2007.

³¹ Ibid.

³² The Lewin Group, "Potential Federal and State-by-State Savings if Medicaid Pharmacy Programs were Optimally Managed," February 2011.

³³ Ibid.

³⁴ Ibid.

³⁵ Ibid.

³⁶ American Telemedicine Association, "What is Telemedicine," 2012.

³⁷ Ibid.

³⁸ Ibid.

Alaska is particularly pertinent because of the size of the state and its potential to extend access to hard-to-reach, rural populations.

J. Summary

If the state of Alaska decides not to opt for the Medicaid expansion under the ACA, Medicaid spending will still increase by \$11.1 million to \$39.9 million, depending on the various design options that are available (*Figure 18*). The state would also see a net reduction in spending for the Denali KidCare program of about \$6.6 million over this same period. However, this would leave about 20,000 residents that are below poverty without health insurance since they would not be eligible for federal subsidies in the Health Benefit Exchanges.

If the state decides to expand Medicaid under the ACA, the state would encounter costs between \$240.5 million and \$305.7 million from 2014 to 2020 depending on the level of participation in the expansion. However, this would provide health insurance coverage to an additional 20,000 people in the state and provide between \$2.9 and \$3.7 billion in additional federal revenues to the state.

The state could reduce the cost of the expansion by delaying implementation implement. If the state delayed implementation by a year it would reduce the cost of the expansion by about \$9.9 million (\$240.5 to \$230.6 million) from 2014 to 2020. Delaying implementation by two years would reduce the cost by \$22 million. However, the federal government will be paying nearly 100 percent of the cost for the newly eligible adults during this period and implementing these options would reduce federal funding by \$388 million with a one year delay and \$783 million with a two year delay.

The state could also implement a variety eligibility design options to move certain current eligible groups above 138 percent of FPL to the Health Benefit Exchange and transitioning enrollees out of the Breast and Cervical Cancer Program eligibility category to the newly eligible category. Implementing these options would reduce the cost of the expansion by about \$42 million to \$198.2 million, while providing alternative options for covering these individuals. However, under this expansion scenario, the federal government would still provide \$2.9 billion in funding to the state that would otherwise be forfeited if the state does not expand Medicaid.

Figure 18. Summary of the State Cost of Various Options for Expanding Medicaid in Alaska (2014-2020)

Scenario	Cost to State (2014-2020) in \$1,000s	Cost to Federal Government (2014-2020) in \$1,000s
No Expansion:		
1. Baseline	\$39,885	\$40,543
2. Moving Currently Eligible Pregnant Women Above 138 Percent of FPL to HBE	\$11,078	\$11,261
Expansion:		
1. Baseline	\$240,488	\$2,897,320
2. 100% Participation Assumption	\$305,717	\$3,680,426
3. Delay Implementation by One Year	\$230,621	\$2,509,705
4. Delay Implementation by Two Years	\$218,538	\$2,114,629
5. Moving Currently Eligible Pregnant Women Above 138 Percent of FPL to HBE and Transition Breast and Cervical Cancer Program into Newly Eligible Category	\$198,203	\$2,881,516

Source: Lewin Group estimates using the Alaska version of the Health Benefits Simulation Model.

Under the Medicaid expansion option, the state would see additional spending reductions as enrollees in current state funded programs enrollee in the Medicaid expansion. This includes the CAMA program and some lower income state employees. We estimate that this would further reduce the cost of the Medicaid expansion to the state by \$40.4 million (*Figure 19*).

Figure 19. Summary of Impact on Other State Programs Due to Expanding Medicaid in Alaska (in \$1,000 for 2014-2020)

Program	Without Medicaid Expansion	With Medicaid Expansion
Denali KidCare Program	(\$6,637)	(\$6,637)
CAMA Program	--	(\$11,258)
State Employee Health Benefits Program	--	(\$22,515)
Total Offsets	(\$6,637)	(\$40,410)

Source: Lewin Group estimates using the Alaska version of the Health Benefits Simulation Model.

IV. Methodology

This section describes the methodology used to produce the enrollment and cost estimates presented in this report.

We used The Lewin Group Health Benefits Simulation Model (HBSM) to estimate the number of people who would become newly eligible for Medicaid through the expansion in Alaska. To do this, we simulated the number of people eligible for the expansion in coverage using 3 years of Current Population Survey (CPS) data compiled by the Bureau of the Census (2008-2010). We use the CPS because these data include the detailed information required to simulate eligibility for the program, including income by source, employment, family characteristics, and state of residence. We pooled 3 years of CPS data in order to increase the sample size, which improves the accuracy of the estimates for narrowly defined population groups.

The first step in developing these estimates is to correct the CPS data for under-reporting of Medicaid coverage. As in most household surveys, some individuals fail to report whether they were enrolled in Medicaid and/or the various public assistance programs. In fact, the CPS reports up to 40 percent fewer Medicaid enrollees than program data show actually participate in the program. To correct for this problem, we identified people who appear to be eligible for Medicaid in these data and assigned a portion of them to Medicaid covered status. The resulting data replicate program control totals on enrollment by class of eligibility.

Using these data, we can estimate the number of program filing units (single individuals and related families living together) who meet the income eligibility requirements under the current program in their state of residence. The model also simulates the number of people who would be eligible under proposed increases in income eligibility. In particular, the model can estimate the number of non-custodial adults who are eligible under expansions affecting these groups.

The model simulates a wide variety of Medicaid policy changes, including changes in income eligibility levels for selected population groups such as children, parents, two-parent families, and childless adults. It also models changes in certification period rules, changes in the deprivation standard (i.e., hours worked limit) for two-parent families, "deeming" of income from people outside the immediate family unit, and other refinements in eligibility. It uses the actual income eligibility levels in each state. The model is also designed to simulate the unique features of the Medicaid program including month-by-month simulations of income eligibility and the unique family unit definitions used in the program.

A. Simulate Newly Eligible Population

The first step of the modeling was to simulate the current Medicaid eligibility rules for Alaska to identify people who currently meet the income and categorical eligible criteria for Medicaid in the state. We use the CPS data to simulate eligibility on a month-by-month basis. We do this by allocating reported weeks of employment across the 52 weeks of the year according to the number of jobs reported for the year. Reported weeks of unemployment and non-participation in the labor force are also allocated over the year. We then distribute wages across the weeks employed and distribute unemployment compensation over weeks unemployed. Workers compensation income over weeks not in the labor force and other sources of income are allocated across all 12 months of the year. Using the same methodology, we simulate people

who would become newly eligible for the expansion program under the ACA to 133 percent of FPL (plus the 5 percent income disregard).

The HBSM simulates enrollment among newly eligible people based on estimates of the percentage of people who are eligible for the current program who actually enroll. Not all eligible people are expected to enroll in Medicaid when they become eligible. We estimated the number of eligible people who enroll under the Medicaid expansion based on a multivariate model of enrollment among people across the country (i.e., national data) who are currently eligible under the existing Medicaid program, which varies with age, race, income, work status, and other factors affecting enrollment.

This participation model reflects differences in the percentage of eligible people who participate in Medicaid by age, income, self-reported health status, race/ethnicity, employment status, and coverage from other sources of insurance. This approach results in an average participation rate of about 75 percent among people who are currently uninsured and about 39 percent among eligible people who have coverage from some other source. Thus, the model simulates the number of privately insured people who would shift to public coverage (i.e., "crowd-out").

B. Simulate Crowd-Out

"Crowd-out" is a major concern for policy makers in considering coverage expansions under public programs. Crowd-out is the process whereby publicly subsidized coverage is substituted for private insurance. Several studies have attempted to estimate the extent of crowd-out using data on enrollment under public and private coverage during periods where Medicaid eligibility for poverty level children was expanded.³⁹ A review of the literature today reveals a range of crowd-out estimates from 0 to 60 percent for Medicaid and CHIP expansions using various data sources and analytical techniques. Thus, up to 60 percent of those taking coverage under these coverage expansions would have had private insurance in the absence of the program.

Our Medicaid participation model simulates the crowd-out that occurs as newly eligible people discontinue their private coverage and enroll in public coverage. As discussed above, we estimate that the participation rate for people with access to employer-sponsored insurance (ESI) is about 39 percent. We developed this estimate based upon CPS data showing the availability of employer-based coverage for children who are eligible under Medicaid or SCHIP. This provided a basis for estimating separate participation rates for children with and without access to ESI, thus enabling an estimate of crowd-out for public program expansion simulation.

C. Simulate Enrollment for Currently Eligible but Not Enrolled Population

Changes in eligibility for the Medicaid expansion can lead to increased enrollment among those who are already eligible for the program. For example, we assume that currently eligible but

³⁹ Beginning in 1989, there were a series of Medicaid eligibility expansions for children and pregnant women. Children through age 5 and pregnant women are eligible through 133 percent of FPL. States also have the option of expanding eligibility for pregnant women to 185 percent of the FPL. Also, all children below the FPL who were born after September 30, 1983, are eligible for the program. Thus, all children below the FPL will be covered by 2001.

uninsured children would become enrolled in cases where a newly eligible parent becomes enrolled under a coverage expansion. This is because eligibility for parents is determined on a family unit basis. Thus, uninsured children of parents who enroll in the program are assumed to be automatically enrolled.

We also estimate an increase in enrollment among the currently eligible but not enrolled population resulting from the eligibility expansions. We modeled the behavioral impact that the mandate for health insurance would have on enrollment for this group of people. The penalty for remaining uninsured under ACA (\$695 per person per year, up to \$2,085 per family in 2016) is assumed to be an additional cost of being uninsured. We apply this assumption only to families that would face the penalty (i.e., with incomes above the federal tax filing threshold). We then estimate the increase in coverage for this group using a multivariate analysis of a broad range of factors affecting the level of insurance coverage, including the price paid for coverage, which includes the amount of the penalty.

D. Integrate Medicaid Expansion with HBSM

We integrated the Medicaid simulations developed with CPS data into MEPS data included in the HBSM. The MEPS data used in HBSM include all of the data required to simulate eligibility for the program except state of residence, which makes it difficult to use for Medicaid simulations. Our approach is to assign MEPS households to a state within the census region identified for the individual in proportion to the distribution of people by income (derived from the CPS). We then simulate eligibility and enrollment for MEPS households using exactly the same models and assumptions used to simulate Medicaid eligibility with the CPS. We then adjust participation function so that the MEPS-based enrollment estimates replicate the estimates developed with the CPS.

The MEPS data would actually be ideal for Medicaid simulations if they included a state of residence indicator. MEPS include month-by-month coverage and employment data which provide a basis for allocating reported income across months for each individual in these data. They also provide the family composition information required to identify family units.

This approach enables us to integrate the state-based Medicaid program analyses into the HBSM, where detailed health data are available to simulate costs and other aspects of health reform. It also allows us to integrate the simulation of Medicaid expansions together with other elements of health reform such as employer requirements and the effect of premium subsidies on coverage and spending.

The HBSM also simulates all the coverage options available under the ACA, including new offers of employer coverage due to the employer penalty and worker demand for coverage due to the individual mandate. Our model provides estimates of new employer coverage due to the ACA, which could lead to a new offer of employer coverage for people currently on Medicaid in Alaska. Our analysis assumes that a portion of those people will shift to employer coverage if offered.

Figure 20 shows our estimate of the number of Alaska residents that would be newly eligible and enroll in a Medicaid expansion up to 138 percent of FPL assuming participation rates are similar to that of non-aged, non-disabled adults in the current Medicaid program. The table also

shows the number of people we estimate are eligible for the current Medicaid program but are not enrolled. Finally, the table shows our estimate of the number of current enrollees that would leave Medicaid for a new offer of employer coverage under the ACA.

Figure 20. Estimate of Number Eligible and Who Will Enroll in a Medicaid Expansion to 138 Percent of FPL in Alaska in 2014 (Assuming Current Participation Rate)^{1/}

Expansion to 138 Percent FPL	Newly Eligible - Previously Uninsured		Newly Eligible - Previously Insured (Crowd-Out)		Currently Eligible but Uninsured (Woodwork)		Leave Medicaid for New Offer of Employer Coverage	Net Change in Medicaid Enrollment
	Eligible	Enroll	Eligible	Enroll	Eligible	Enroll		
Under age 1 M&F	0	0	0	0	460	109	72	37
Age 1-5 M&F	0	0	0	0	1,447	268	695	-428
Age 6-13 M&F	0	0	0	0	2,907	535	819	-285
Age 14-20 M	2,867	1,724	2,308	922	643	179	264	2,561
Age 14-20 F	2,227	1,557	2,231	862	768	158	253	2,324
Age 21-44 M	16,976	12,504	4,512	1,382	610	82	55	13,912
Age 21-44 F	11,997	8,318	4,246	1,562	2,390	712	194	10,398
Age 45-64 M	4,978	4,154	2,128	1,004	264	17	40	5,136
Age 45-64 F	5,425	4,416	4,095	1,879	382	51	26	6,320
Age 65+ M	0	0	0	0	0	0	0	0
Age 65+ F	0	0	0	0	0	0	0	0
Total	44,470	32,674	19,519	7,610	9,869	2,111	2,419	39,976

1/ Assumes that all provisions are fully implemented and ultimate enrollment is reached in 2014.

Figure 21 shows our estimate of the number of Alaska residents that would be newly eligible and enroll in a Medicaid expansion up to 138 percent of FPL assuming 100 percent participation for uninsured adults that would be newly eligible for the expansion. In this scenario, we assume that crowd-out and enrollment for currently eligible but uninsured would increase proportionally.

Figure 21. Estimate of Number Eligible and Who Will Enroll in a Medicaid Expansion to 138 Percent of FPL in Alaska in 2014 (Assuming 100 Percent Participation Rate for Newly Eligible)^{1/}

Expansion to 138 Percent FPL	Newly Eligible - Previously Uninsured		Newly Eligible - Previously Insured (Crowd-Out)		Currently Eligible but Uninsured (Woodwork)		Leave Medicaid for New Offer of Employer Coverage	Net Change in Medicaid Enrollment
	Age/Sex Category	Eligible	Enroll	Eligible	Enroll	Eligible		
Under age 1 M&F	0	0	0	0	460	182	72	109
Age 1-5 M&F	0	0	0	0	1,447	445	695	-250
Age 6-13 M&F	0	0	0	0	2,907	889	819	70
Age 14-20 M	2,867	2,867	2,308	1,533	643	297	264	4,434
Age 14-20 F	2,227	2,227	2,231	1,233	768	226	253	3,434
Age 21-44 M	16,976	16,976	4,512	1,876	610	111	55	18,907
Age 21-44 F	11,997	11,997	4,246	2,252	2,390	1,028	194	15,082
Age 45-64 M	4,978	4,978	2,128	1,204	264	21	40	6,162
Age 45-64 F	5,425	5,425	4,095	2,308	382	62	26	7,769
Age 65+ M	0	0	0	0	0	0	0	0
Age 65+ F	0	0	0	0	0	0	0	0
Total	44,470	44,470	19,519	10,405	9,869	3,261	2,419	55,718

1/ Assumes that all provisions are fully implemented and ultimate enrollment is reached in 2014.

Estimates of persons eligible and enrolling in the expansion were projected from 2014 through 2020 using age- and sex-specific population growth rates for Alaska, adjusted for potentially higher rate of growth among the demographic enrolled in Medicaid. The population growth rate for each age and sex category was derived using state-level data from the U.S. Census Bureau's *Interim State Projections of Population for Five-Year Age Groups and Selected Age Groups by Sex, 2005*. An annual adjustment factor of 1 percent was added to reflect the growth in the population in poverty.

E. Estimate Costs for the Newly Eligible Population

To understand the cost ramifications of the potential expansion to Alaska's Medicaid program under the ACA, OptumInsight compiled multiple data sources. The primary data source for the analysis was historical Medicaid claims data. The data was extracted from the Medicaid Statistical Information System (MSIS) provided by the Centers for Medicare & Medicaid Services (CMS), including claims and enrollment data by age and gender. The data reflect experience from calendar year 2010.

We also examined Alaska Medicaid enrollment and paid claims data for non-aged, non-disabled, non-pregnant adults in the program for SFY 2012. Paid amounts for enrollees under age 45 were relatively consistent with results from other data sources. However, these data showed limited experience for people over age 45 and average paid amounts were substantially less than what other data indicate for the cost for these individuals relative to those under age 45.

Given the lack of historical claims and enrollment data for the population who would be eligible for the expansion up to 138 percent of FPL under a Medicaid environment, OptumInsight relied on a blending of current enrollees' adjusted experience and other supplemental sources. The supplemental sources include the Health Benefits Simulation Model (HBSM), the Office of the Actuary's 2011 report, and the 2011 Long-Term Forecast of Medicaid Enrollment and Spending in Alaska: Supplement 2010-2030 (MESA).

To develop baseline projections for 2014 to 2020, the historical FFS experience was trended forward to the appropriate time periods. Further documentation regarding the trend factor development is discussed later in this report.

F. Medical Cost Trend Development

Medical cost trend estimates were developed under Alaska's fee-for-service delivery system. The trends were used to project the baseline costs forward to calendar years 2014 to 2020. Several data sources were used to develop the trend estimates, including:

- Historical Alaska Medicaid data from 1997-2009
- 2011 MESA report projections for 2010-2030
- The 2011 Actuarial Report on the Financial Outlook for Medicaid prepared by the Office of the Actuary

The data was grouped into the following categories based on the member's age:

- Children (ages 0-19)
- Adults (ages 20-64)
- Aged (ages 65+)

Once the data was grouped, we performed a trend analysis based on the historical per member per month (PMPM) paid claims data.

Our final trend source was the 2011 Actuarial Report on the Financial Outlook for Medicaid. This report was prepared by the Office of the Actuary and is a national look at Medicaid trend levels extending to calendar year 2020. Recent historical Alaska FFS trends have been higher than national Medicaid trend levels; however, future Alaska trends may migrate toward the national level.

The three trend estimates were blended at the following levels to develop the trends used for this analysis:

- Historical Alaska Medicaid data - 40%
- 2011 MESA report projections - 40%
- 2011 Actuarial Report - 20%

The following table provides the results of the blending and presents the annual trend assumptions:

Population	FFS Annual Trend Rate
Adults	5.6%
Children	4.2%
Aged	4.5%

In addition, we assumed a 5 percent selection factor for enrollees in the initial year of the program. Our final estimate of PMPM medical cost for an expansion population under is presented in *Figure 22*.

Figure 22: Estimated Monthly Medical Cost for the Expansion Population in Alaska

Age / Gender	2014	2015	2016	2017	2018	2019	2020
Under age 1 M&F	\$1,745	\$1,733	\$1,806	\$1,883	\$1,962	\$2,045	\$2,132
Age 1-5 M&F	\$482	\$478	\$498	\$519	\$541	\$564	\$588
Age 6-13 M&F	\$467	\$464	\$483	\$504	\$525	\$547	\$570
Age 14-20 M	\$566	\$562	\$586	\$610	\$636	\$663	\$691
Age 14-20 F	\$609	\$613	\$647	\$683	\$722	\$762	\$805
Age 21-44 M	\$582	\$585	\$618	\$653	\$690	\$728	\$769
Age 21-44 F	\$676	\$680	\$718	\$758	\$801	\$846	\$894
Age 45-64 M	\$1,171	\$1,178	\$1,244	\$1,314	\$1,388	\$1,465	\$1,548
Age 45-64 F	\$1,126	\$1,132	\$1,196	\$1,263	\$1,334	\$1,409	\$1,488

G. Children's Health Insurance Program (CHIP)

Under the ACA, states will receive a 23 percent increase in federal funding matching rate (from 65 percent to 88 percent) for the state's Denali KidCare (DKC) Program, between federal fiscal year 2016 and 2019. However, Alaska will be required to provide Medicaid coverage to children between 100 and 133 percent of the FPL, which will receive Alaska's current federal Medicaid match rate of 50 percent.

State savings were calculated by comparing baseline annual state expenses without this ACA provision to projected state expenses under the proposed changes in the federal matching rates. *Figure 23* shows our estimated DKC enrollment and spending without the ACA along with the state and federal share of costs. State and federal costs were then calculated based on the requirements under the ACA for children above and below 133 percent of FPL. Although the state was unable to provide DKC enrollment and costs separately for children by FPL level, we estimated the portion below 133 percent FPL using data reported in the Alaska subsample of the Current Population Survey. This analysis shows that the state would save about \$6.6 million between 2014 and 2020 under these provisions.

Figure 23. Calculation of Impact on Alaska Denali KidCare Funding Under the ACA (in \$1,000s)

	2014	2015	2016	2017	2018	2019	2020	2014-2020
DKC Enrollment	12,155	12,474	12,807	13,159	13,525	13,888	14,252	
Baseline Costs Without ACA								
FMAP	0.66	0.66	0.66	0.66	0.66	0.66	0.66	
Total	\$33,332	\$35,605	\$38,092	\$40,908	\$44,005	\$47,473	\$51,262	\$290,677
State Share	\$11,333	\$12,106	\$12,951	\$13,909	\$14,962	\$16,141	\$17,429	\$98,830
Federal Share	\$21,999	\$23,499	\$25,141	\$26,999	\$29,043	\$31,332	\$33,833	\$191,847
Children Below 133% Moved to Medicaid								
FMAP	0.5	0.5	0.5	0.5	0.5	0.5	0.5	
Total	\$12,666	\$13,530	\$14,475	\$15,545	\$16,722	\$18,040	\$19,480	\$110,457
State Share	\$6,333	\$6,765	\$7,238	\$7,772	\$8,361	\$9,020	\$9,740	\$55,229
Federal Share	\$6,333	\$6,765	\$7,238	\$7,772	\$8,361	\$9,020	\$9,740	\$55,229
Children Above 133% Receive Enhanced Federal Match								
FMAP	0.66	0.66	0.89	0.89	0.89	0.89	0.66	
Total	\$20,666	\$22,075	\$23,617	\$25,363	\$27,283	\$29,433	\$31,782	\$180,220
State Share	\$7,026	\$7,506	\$2,598	\$2,790	\$3,001	\$3,238	\$10,806	\$36,965
Federal Share	\$13,640	\$14,570	\$21,019	\$22,573	\$24,282	\$26,195	\$20,976	\$143,255
Difference from Baseline Without ACA								
State Share	\$2,027	\$2,165	-\$3,116	-\$3,346	-\$3,600	-\$3,883	\$3,117	-\$6,637
Federal Share	-\$2,027	-\$2,165	\$3,116	\$3,346	\$3,600	\$3,883	-\$3,117	\$6,637

Source: Lewin Projections using CMS 64 data for CHIP.

H. Move Current Eligibles Above 138 Percent of FPL to the Health Benefit Exchange

Beginning January 2014, Alaska would have the option to reduce Medicaid eligibility for adults to 138 percent of the FPL. We identified adults in the pregnant women eligibility category as those that could potentially be moved to the Exchange. Since the state would no longer be responsible for expenses incurred by enrollees, it would save all of the funds it had previously devoted to covering this subgroup. By the same token, the federal government would save an equal amount as the state because it too would cease to be responsible for the remaining 50 percent of expenses. We also assume that the cost of administering the program for these adults would decline as well. *Figure 24* shows the estimated savings under this option from 2014 through 2020.

Figure 24. Impact of Moving Enrollees above 138 Percent of FPL to the Health Benefit Exchange (in \$1,000s)

	2014	2015	2016	2017	2018	2019	2020	2014-2020
Enrollees	335	342	349	356	363	370	377	
Total Provider Payments	\$6,593.8	\$6,923.5	\$7,269.7	\$7,633.2	\$8,014.9	\$8,415.6	\$8,836.4	\$53,687.1
FMAP	50%	50%	50%	50%	50%	50%	50%	
Savings from Provider Payments								
State Savings	-\$3,296.9	-\$3,461.8	-\$3,634.9	-\$3,816.6	-\$4,007.4	-\$4,207.8	-\$4,418.2	-\$26,843.5
Federal Savings	-\$3,296.9	-\$3,461.8	-\$3,634.9	-\$3,816.6	-\$4,007.4	-\$4,207.8	-\$4,418.2	-\$26,843.5
Administrative Cost Savings								
State Savings	-\$241.1	-\$253.2	-\$265.9	-\$279.2	-\$293.1	-\$307.8	-\$323.2	-\$1,963.4
Federal Savings	-\$299.5	-\$314.5	-\$330.2	-\$346.8	-\$364.1	-\$382.3	-\$401.4	-\$2,438.9
Total Savings								
State Savings	-\$3,538.1	-\$3,715.0	-\$3,900.7	-\$4,095.8	-\$4,300.5	-\$4,515.6	-\$4,741.3	-\$28,807.0
Federal Savings	-\$3,596.5	-\$3,776.3	-\$3,965.1	-\$4,163.4	-\$4,371.5	-\$4,590.1	-\$4,819.6	-\$29,282.4

I. Transition Enrollees Out of Breast and Cervical Cancer Program Eligibility Category

One option available to Alaska is to move adults who are currently enrolled in the Breast and Cervical Cancer Program (BCCP) eligibility category out of the current Medicaid program and into the newly eligible category, which would receive the enhanced Medicaid matching rate. This option could be done after the maintenance of effort requirement for adults expires in January 2014. Enrollees below 138 percent of FPL would enroll in the expanded Medicaid program as "new eligibles." *Figure 25* shows the estimated savings to the state under this option.

Figure 25. Impact on State and Federal Spending of Moving BCCP Enrollees to Newly Eligible Group Under the ACA (in \$1,000s)

	2014	2015	2016	2017	2018	2019	2020	2014-2020
Baseline Spending as Currently Eligible Group								
Total Payments	\$3,626.3	\$3,807.6	\$3,998.0	\$4,197.9	\$4,407.8	\$4,628.2	\$4,859.6	\$29,525.2
FMAP	50%	50%	50%	50%	50%	50%	50%	
State Share	\$1,813.1	\$1,903.8	\$1,999.0	\$2,098.9	\$2,203.9	\$2,314.1	\$2,429.8	\$14,762.6
Federal Share	\$1,813.1	\$1,903.8	\$1,999.0	\$2,098.9	\$2,203.9	\$2,314.1	\$2,429.8	\$14,762.6
Spending as Newly Eligible Group								
Total Payments	\$3,626.3	\$3,807.6	\$3,998.0	\$4,197.9	\$4,407.8	\$4,628.2	\$4,859.6	\$29,525.2
FMAP	100%	100%	100%	95%	94%	93%	90%	
State Share	\$0.0	\$0.0	\$0.0	\$209.9	\$264.5	\$324.0	\$486.0	\$1,284.3
Federal Share	\$3,626.3	\$3,807.6	\$3,998.0	\$3,988.0	\$4,143.3	\$4,304.2	\$4,373.6	\$28,241.0
Change in Spending								
State Share	-\$1,813.1	-\$1,903.8	-\$1,999.0	-\$1,889.0	-\$1,939.4	-\$1,990.1	-\$1,943.8	-\$13,478.3
Federal Share	\$1,813.1	\$1,903.8	\$1,999.0	\$1,889.0	\$1,939.4	\$1,990.1	\$1,943.8	\$13,478.3

Appendix A. Detailed Tables

Trending of Medicaid Enrollment and Costs

Enrollment growth estimates through SFY 2020 are modeled using five years of historical monthly enrollment data provided by the Department of Health and Social Services (DHSS) and trended using age- and sex- adjusted growth rates derived from U.S. Census projections and the Medicaid Statistical Information System (MSIS) Unique Eligibles Count data.

Annual population growth factors, derived from the Census Bureau's Interim State Projections of Population for Five-Year Age Groups and Selected Age Groups by Sex, are adjusted by an additional one percent across all age and sex categories to account for an accelerated rate of growth among the population typically served by Medicaid. These annual population growth rates are then applied to 2010 Medicaid Statistical Information System Unique Eligibles Count data, which are concurrently delineated by eligibility category, as well as by a variety of demographic groupings.

These weighted distributions are then used to generate growth rates through SFY 2020 based on the state's historical enrollment, accounting for age, sex, and health status. We apply the age- and sex- adjusted growth rates for each health status category to the enrollment data supplied by the DHSS in order to find the age- and sex-adjusted projection rate for the program's eligible counts. Eligible counts are then trended through SFY 2020.

To forecast program costs, we use five years (2008-2012) of eligibility and cost data supplied by DHSS to compute per-enrollee costs for each service category and demographic group. The MESA model, adjusted using The CMS' National Health Projections, is used to estimate a year-by-year trending factor for costs associated with each type of service. We then project per member per year (PMPY) costs to 2020 using the trending factors developed for each type of service.

Projected annual PMPY amounts for each service category are then multiplied by projected enrollment for each demographic and health status category to arrive at final total cost estimates. The state and federal proportions of total cost for each service category are computed for each of the five historical years. The calculated proportions for 2012 are applied to all forecasted years to estimate the respective state and federal costs to treat Medicaid patients in each health status category.

Figure A-1. Historic and Projected Eligibles Count, Before Adjusting for ACA

Eligibles Count													
Total Annual Costs	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
AGE													
<1	5,617	5,829	6,090	6,637	6,450	6,618	6,790	6,946	7,088	7,219	7,342	7,459	7,571
1-5	18,105	18,537	21,252	22,404	23,312	23,917	24,538	25,102	25,616	26,089	26,532	26,956	27,359
6-14	27,098	27,488	30,608	32,292	33,588	34,798	36,052	37,404	38,712	40,105	41,669	43,128	44,529
15-18	11,264	11,224	12,233	12,633	12,906	12,867	12,829	12,861	13,093	13,421	13,703	14,101	14,587
19-20	1,821	2,000	2,448	2,894	3,046	3,009	2,972	2,917	2,864	2,822	2,807	2,813	2,833
21-44	15,772	16,596	18,245	20,504	21,980	22,617	23,273	23,935	24,612	25,325	26,034	26,737	27,444
45-64	9,372	9,715	10,407	11,754	12,362	12,378	12,394	12,410	12,409	12,338	12,230	12,106	11,974
65-74	3,847	3,864	3,999	4,556	5,005	5,393	5,810	6,244	6,636	7,041	7,444	7,847	8,286
75-84	2,623	2,619	2,671	2,748	2,883	3,021	3,165	3,336	3,550	3,818	4,130	4,441	4,735
85 and over	1,014	1,060	1,089	1,093	1,156	1,238	1,325	1,421	1,510	1,590	1,680	1,779	1,893
Unknown	0	0	0	1	0	0	0	0	0	0	0	0	0
Total	96,534	98,931	109,040	117,515	122,688	125,855	129,148	132,575	136,089	139,769	143,572	147,367	151,213
SEX													
Male	44,082	45,246	50,184	54,083	56,455	57,894	59,390	60,939	62,527	64,183	65,904	67,613	69,323
Female	52,451	53,685	58,857	63,432	66,233	67,961	69,757	71,636	73,563	75,586	77,669	79,754	81,890
Unknown	1	0	0	0	0	0	0	0	0	0	0	0	0
Total	96,534	98,931	109,040	117,515	122,688	125,855	129,148	132,575	136,089	139,769	143,572	147,367	151,213
RACE/ETHNICITY													
Alaska Native or American Indian	38,348	38,977	42,849	46,543	48,805	50,057	51,357	52,709	54,098	55,555	57,062	58,565	60,086
Asian	6,282	7,173	8,193	8,639	9,086	9,353	9,632	9,926	10,229	10,550	10,886	11,222	11,564
Black or African-American	5,420	5,594	6,321	6,861	7,100	7,275	7,456	7,645	7,837	8,038	8,245	8,451	8,658
Hispanic or Latino	3,605	3,693	4,103	4,328	4,546	4,666	4,790	4,919	5,052	5,190	5,335	5,478	5,623
Pacific Islander	2,954	3,159	3,674	4,200	4,628	4,751	4,879	5,012	5,149	5,292	5,441	5,589	5,737
Unknown	1,710	1,719	2,032	2,294	2,544	2,615	2,689	2,766	2,844	2,925	3,010	3,094	3,179
White	38,215	38,617	41,870	44,651	45,979	47,138	48,344	49,598	50,882	52,218	53,594	54,968	56,366
Total	96,534	98,931	109,040	117,515	122,688	125,855	129,148	132,575	136,089	139,769	143,572	147,367	151,213
HEALTH STATUS													
Aged	6,495	6,488	6,628	7,269	7,399	7,877	8,388	8,945	9,507	10,118	10,779	11,448	12,144
Disabled/Blind Child	2,127	2,276	2,443	3,111	3,033	3,108	3,186	3,270	3,362	3,461	3,567	3,672	3,778
Disabled/Blind Adult	12,740	13,062	13,681	14,805	15,589	15,852	16,127	16,405	16,669	16,898	17,104	17,300	17,499
Child	61,778	62,801	70,188	73,747	76,267	78,212	80,220	82,309	84,464	86,737	89,103	91,447	93,791
Adult	13,373	14,304	16,101	18,581	20,400	20,806	21,226	21,645	22,087	22,554	23,020	23,500	24,001
Unknown	21	0	0	0	0	0	0	0	0	0	0	0	0
Total	96,534	98,931	109,040	117,514	122,687	125,855	129,148	132,575	136,089	139,769	143,572	147,367	151,213

Figure A-2. Historic and Projected Costs for Inpatient/Outpatient Facilities, Before Adjusting for ACA

Inpatient/Outpatient Facilities (in millions)													
Total Annual Costs	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
AGE													
<1	\$68.2	\$68.7	\$72.8	\$63.2	\$74.0	\$78.1	\$82.4	\$86.6	\$90.9	\$95.2	\$99.8	\$104.6	\$109.8
1-5	\$23.9	\$20.4	\$22.8	\$21.5	\$24.9	\$26.2	\$27.7	\$29.1	\$30.5	\$32.0	\$33.5	\$35.2	\$36.9
6-14	\$53.6	\$48.9	\$46.6	\$45.3	\$51.7	\$55.0	\$58.6	\$62.5	\$66.5	\$70.9	\$75.9	\$81.0	\$86.5
15-18	\$54.7	\$49.8	\$47.1	\$43.3	\$43.8	\$44.9	\$46.0	\$47.4	\$49.6	\$52.4	\$55.1	\$58.5	\$62.5
19-20	\$10.7	\$10.6	\$12.3	\$11.2	\$11.5	\$11.7	\$11.9	\$12.0	\$12.1	\$12.3	\$12.6	\$13.0	\$13.5
21-44	\$72.2	\$77.0	\$78.0	\$84.6	\$86.2	\$91.2	\$96.5	\$102.0	\$107.8	\$114.2	\$120.9	\$128.1	\$136.0
45-64	\$47.1	\$46.9	\$50.8	\$57.5	\$62.1	\$63.9	\$65.8	\$67.7	\$69.6	\$71.2	\$72.7	\$74.3	\$75.9
65-74	\$4.0	\$2.6	\$3.4	\$4.8	\$5.6	\$6.2	\$6.9	\$7.6	\$8.3	\$9.1	\$9.9	\$10.7	\$11.7
75-84	\$1.2	\$1.5	\$1.2	\$1.4	\$2.5	\$2.7	\$2.9	\$3.1	\$3.4	\$3.8	\$4.2	\$4.7	\$5.1
85 and over	\$0.2	\$0.2	\$0.2	\$0.3	\$0.4	\$0.4	\$0.5	\$0.5	\$0.6	\$0.6	\$0.7	\$0.7	\$0.8
Unknown	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total	\$335.8	\$326.4	\$335.3	\$333.2	\$362.6	\$380.3	\$398.9	\$418.6	\$439.3	\$461.6	\$485.1	\$510.8	\$538.7
SEX													
Male	\$143.6	\$139.0	\$145.7	\$144.7	\$152.9	\$160.3	\$168.1	\$176.3	\$184.9	\$194.2	\$204.0	\$214.7	\$226.2
Female	\$192.2	\$187.4	\$189.6	\$188.6	\$209.7	\$220.0	\$230.8	\$242.3	\$254.4	\$267.4	\$281.1	\$296.1	\$312.5
Unknown	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total	\$335.8	\$326.4	\$335.3	\$333.2	\$362.6	\$380.3	\$398.9	\$418.6	\$439.3	\$461.6	\$485.1	\$510.8	\$538.7
RACE/ETHNICITY													
Alaska Native or American Indian	\$159.7	\$135.3	\$152.3	\$142.1	\$169.7	\$178.0	\$186.7	\$195.8	\$205.5	\$215.9	\$226.9	\$238.9	\$252.0
Asian	\$11.6	\$15.1	\$14.6	\$19.2	\$18.9	\$19.9	\$21.0	\$22.1	\$23.3	\$24.6	\$25.9	\$27.4	\$29.1
Black or African-American	\$17.2	\$19.1	\$16.1	\$17.7	\$18.7	\$19.6	\$20.5	\$21.5	\$22.6	\$23.7	\$24.9	\$26.1	\$27.5
Hispanic or Latino	\$7.9	\$9.1	\$8.8	\$9.0	\$9.3	\$9.8	\$10.3	\$10.8	\$11.3	\$11.9	\$12.5	\$13.2	\$13.9
Pacific Islander	\$7.3	\$8.8	\$7.6	\$9.6	\$10.3	\$10.9	\$11.4	\$12.0	\$12.6	\$13.2	\$13.9	\$14.7	\$15.5
Unknown	\$12.5	\$11.1	\$9.9	\$9.3	\$8.3	\$8.7	\$9.2	\$9.6	\$10.1	\$10.7	\$11.2	\$11.8	\$12.5
White	\$119.6	\$128.0	\$126.0	\$126.4	\$127.3	\$133.4	\$139.9	\$146.7	\$153.9	\$161.6	\$169.7	\$178.6	\$188.3
Total	\$335.8	\$326.4	\$335.3	\$333.2	\$362.6	\$380.3	\$398.9	\$418.6	\$439.3	\$461.6	\$485.1	\$510.8	\$538.7
HEALTH STATUS													
Aged	\$4.1	\$3.5	\$4.0	\$5.3	\$7.4	\$8.1	\$8.8	\$9.6	\$10.5	\$11.4	\$12.5	\$13.6	\$14.9
Disabled/Blind Child	\$26.3	\$20.9	\$22.5	\$18.7	\$24.2	\$25.4	\$26.7	\$28.1	\$29.6	\$31.2	\$33.0	\$35.0	\$37.1
Disabled/Blind Adult	\$59.9	\$60.0	\$63.9	\$71.9	\$72.5	\$75.6	\$78.8	\$82.1	\$85.5	\$88.9	\$92.4	\$96.1	\$100.2
Child	\$184.8	\$177.4	\$179.2	\$165.8	\$181.7	\$190.9	\$200.7	\$211.0	\$222.0	\$233.8	\$246.5	\$260.2	\$275.1
Adult	\$60.6	\$64.6	\$65.7	\$71.6	\$76.9	\$80.3	\$84.0	\$87.8	\$91.8	\$96.2	\$100.7	\$105.8	\$111.4
Unknown	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total	\$335.8	\$326.4	\$335.3	\$333.2	\$362.6	\$380.3	\$398.9	\$418.6	\$439.3	\$461.6	\$485.1	\$510.8	\$538.7
FUNDING SOURCE													
Federal Share	\$221.1	\$225.2	\$238.2	\$200.9	\$227.7	\$238.8	\$250.5	\$262.9	\$275.9	\$289.9	\$304.7	\$320.8	\$338.3
State Share	\$114.6	\$100.9	\$97.1	\$132.3	\$134.9	\$141.5	\$148.4	\$155.7	\$163.4	\$171.7	\$180.4	\$190.0	\$200.4

Figure A-3. Historic and Projected Costs for Nursing Facilities, Before Adjusting for ACA

Nursing Facilities (in millions)													
Total Annual Costs	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
AGE													
<1	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
1-5	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
6-14	\$0.0	\$0.1	\$0.2	\$0.1	\$0.4	\$0.4	\$0.4	\$0.5	\$0.5	\$0.5	\$0.5	\$0.6	\$0.6
15-18	\$0.2	\$0.3	\$0.4	\$0.7	\$0.6	\$0.6	\$0.6	\$0.6	\$0.7	\$0.7	\$0.7	\$0.8	\$0.8
19-20	\$0.5	\$0.4	\$0.1	\$0.3	\$0.4	\$0.4	\$0.4	\$0.4	\$0.4	\$0.4	\$0.4	\$0.4	\$0.4
21-44	\$3.7	\$3.1	\$3.8	\$4.7	\$5.5	\$5.8	\$6.1	\$6.4	\$6.7	\$7.1	\$7.5	\$7.9	\$8.4
45-64	\$17.9	\$16.8	\$16.4	\$17.9	\$19.2	\$19.7	\$20.2	\$20.7	\$21.2	\$21.7	\$22.1	\$22.5	\$22.8
65-74	\$14.8	\$13.6	\$13.5	\$19.9	\$19.2	\$21.2	\$23.4	\$25.8	\$28.1	\$30.6	\$33.3	\$36.0	\$39.1
75-84	\$24.3	\$20.3	\$20.3	\$28.0	\$28.8	\$30.9	\$33.2	\$35.8	\$39.1	\$43.2	\$48.0	\$53.0	\$58.2
85 and over	\$21.4	\$20.9	\$21.1	\$25.4	\$27.5	\$30.1	\$33.0	\$36.3	\$39.5	\$42.7	\$46.4	\$50.5	\$55.3
Unknown	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total	\$82.7	\$75.4	\$75.8	\$97.1	\$101.5	\$109.0	\$117.3	\$126.4	\$136.2	\$146.8	\$158.9	\$171.7	\$185.6
SEX													
Male	\$32.4	\$28.2	\$27.8	\$34.9	\$40.2	\$43.2	\$46.5	\$50.1	\$53.9	\$58.1	\$62.8	\$67.8	\$73.3
Female	\$50.3	\$47.2	\$48.0	\$62.2	\$61.3	\$65.8	\$70.8	\$76.4	\$82.3	\$88.8	\$96.1	\$103.8	\$112.4
Unknown	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total	\$82.7	\$75.4	\$75.8	\$97.1	\$101.5	\$109.0	\$117.3	\$126.4	\$136.2	\$146.8	\$158.9	\$171.7	\$185.6
RACE/ETHNICITY													
Alaska Native or American Indian	\$22.7	\$20.3	\$18.9	\$31.0	\$28.3	\$30.4	\$32.7	\$35.3	\$38.0	\$41.0	\$44.4	\$47.9	\$51.9
Asian	\$2.8	\$2.7	\$2.5	\$2.7	\$3.2	\$3.4	\$3.7	\$4.0	\$4.3	\$4.7	\$5.1	\$5.5	\$6.0
Black or African-American	\$2.2	\$2.2	\$2.3	\$2.4	\$2.2	\$2.4	\$2.6	\$2.7	\$3.0	\$3.2	\$3.4	\$3.7	\$4.0
Hispanic or Latino	\$0.6	\$0.8	\$0.5	\$0.7	\$0.7	\$0.7	\$0.8	\$0.8	\$0.9	\$1.0	\$1.0	\$1.1	\$1.2
Pacific Islander	\$0.4	\$0.7	\$0.7	\$0.7	\$0.6	\$0.6	\$0.7	\$0.7	\$0.8	\$0.8	\$0.9	\$1.0	\$1.1
Unknown	\$2.7	\$2.5	\$3.8	\$4.7	\$4.9	\$5.2	\$5.6	\$6.1	\$6.6	\$7.1	\$7.7	\$8.3	\$9.0
White	\$51.3	\$46.2	\$47.0	\$54.9	\$61.7	\$66.2	\$71.2	\$76.8	\$82.7	\$89.1	\$96.3	\$104.0	\$112.5
Total	\$82.7	\$75.4	\$75.8	\$97.1	\$101.5	\$109.0	\$117.3	\$126.4	\$136.2	\$146.8	\$158.9	\$171.7	\$185.6
HEALTH STATUS													
Aged	\$57.8	\$51.4	\$51.8	\$68.5	\$71.4	\$77.7	\$84.7	\$92.5	\$100.8	\$110.0	\$120.5	\$131.7	\$143.9
Disabled/Blind Child	\$0.7	\$0.7	\$0.7	\$1.1	\$1.2	\$1.2	\$1.3	\$1.4	\$1.4	\$1.5	\$1.6	\$1.7	\$1.8
Disabled/Blind Adult	\$24.1	\$23.1	\$23.2	\$27.3	\$28.7	\$29.8	\$31.1	\$32.4	\$33.7	\$35.0	\$36.5	\$38.0	\$39.6
Child	\$0.0	\$0.1	\$0.0	\$0.1	\$0.1	\$0.1	\$0.2	\$0.2	\$0.2	\$0.2	\$0.2	\$0.2	\$0.2
Adult	\$0.1	\$0.2	\$0.1	\$0.1	\$0.1	\$0.1	\$0.1	\$0.1	\$0.1	\$0.1	\$0.1	\$0.1	\$0.1
Unknown	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total	\$82.7	\$75.4	\$75.8	\$97.1	\$101.5	\$109.0	\$117.3	\$126.4	\$136.2	\$146.8	\$158.9	\$171.7	\$185.6
FUNDING SOURCE													
Federal Share	\$45.2	\$47.1	\$47.3	\$53.7	\$52.7	\$56.6	\$60.9	\$65.7	\$70.8	\$76.3	\$82.5	\$89.2	\$96.4
State Share	\$37.5	\$28.3	\$28.5	\$43.4	\$48.8	\$52.4	\$56.4	\$60.8	\$65.5	\$70.6	\$76.3	\$82.5	\$89.2

Figure A-4. Historic and Projected Costs of Physician/Other Practitioner/Clinic Services, Before Adjusting for ACA

Physician/Other Practitioner/Clinic Services (in millions)													
Total Annual Costs	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
AGE													
<1	\$15.8	\$17.5	\$20.1	\$18.7	\$20.4	\$21.9	\$23.4	\$25.1	\$26.7	\$28.5	\$30.4	\$32.5	\$34.7
1-5	\$17.7	\$19.8	\$25.0	\$24.0	\$27.9	\$30.0	\$32.1	\$34.4	\$36.6	\$39.1	\$41.7	\$44.6	\$47.6
6-14	\$16.3	\$19.4	\$23.6	\$23.3	\$27.9	\$30.2	\$32.7	\$35.5	\$38.3	\$41.6	\$45.4	\$49.4	\$53.6
15-18	\$10.0	\$11.5	\$13.1	\$12.1	\$13.5	\$14.1	\$14.7	\$15.4	\$16.4	\$17.6	\$18.8	\$20.4	\$22.2
19-20	\$4.3	\$4.9	\$6.0	\$6.0	\$6.0	\$6.2	\$6.4	\$6.6	\$6.8	\$7.0	\$7.3	\$7.7	\$8.1
21-44	\$35.3	\$40.2	\$47.0	\$48.4	\$52.8	\$56.8	\$61.1	\$65.6	\$70.5	\$76.0	\$82.0	\$88.5	\$95.6
45-64	\$19.3	\$21.4	\$26.0	\$27.5	\$30.2	\$31.6	\$33.0	\$34.6	\$36.1	\$37.6	\$39.1	\$40.7	\$42.4
65-74	\$1.6	\$1.5	\$1.8	\$1.6	\$1.9	\$2.1	\$2.4	\$2.7	\$2.9	\$3.3	\$3.6	\$4.0	\$4.5
75-84	\$0.7	\$0.8	\$0.9	\$0.7	\$0.9	\$0.9	\$1.0	\$1.1	\$1.3	\$1.4	\$1.6	\$1.8	\$2.1
85 and over	\$0.1	\$0.2	\$0.2	\$0.2	\$0.2	\$0.2	\$0.2	\$0.2	\$0.3	\$0.3	\$0.3	\$0.4	\$0.4
Unknown	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total	\$121.2	\$137.2	\$163.6	\$162.4	\$181.6	\$193.9	\$207.1	\$221.1	\$236.0	\$252.6	\$270.3	\$290.1	\$311.2
SEX													
Male	\$44.9	\$51.5	\$63.4	\$61.9	\$69.7	\$74.4	\$79.4	\$84.7	\$90.4	\$96.7	\$103.4	\$110.9	\$118.9
Female	\$76.4	\$85.7	\$100.2	\$100.5	\$111.9	\$119.6	\$127.7	\$136.4	\$145.6	\$155.9	\$166.9	\$179.1	\$192.3
Unknown	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total	\$121.2	\$137.2	\$163.6	\$162.4	\$181.6	\$193.9	\$207.1	\$221.1	\$236.0	\$252.6	\$270.3	\$290.1	\$311.2
RACE/ETHNICITY													
Alaska Native or American Indian	\$52.2	\$62.0	\$74.8	\$67.7	\$85.3	\$91.0	\$97.2	\$103.8	\$110.7	\$118.5	\$126.8	\$136.1	\$146.0
Asian	\$5.1	\$5.4	\$6.4	\$7.4	\$8.0	\$8.5	\$9.1	\$9.8	\$10.5	\$11.3	\$12.1	\$13.1	\$14.1
Black or African-American	\$5.4	\$6.0	\$7.5	\$8.1	\$8.7	\$9.3	\$10.0	\$10.6	\$11.3	\$12.1	\$12.9	\$13.9	\$14.8
Hispanic or Latino	\$3.8	\$3.9	\$4.8	\$5.1	\$5.4	\$5.8	\$6.1	\$6.6	\$7.0	\$7.5	\$8.0	\$8.6	\$9.3
Pacific Islander	\$3.0	\$3.1	\$3.8	\$4.3	\$4.8	\$5.1	\$5.5	\$5.8	\$6.2	\$6.7	\$7.1	\$7.7	\$8.2
Unknown	\$3.7	\$3.8	\$4.0	\$4.0	\$4.1	\$4.4	\$4.7	\$5.0	\$5.4	\$5.8	\$6.2	\$6.7	\$7.2
White	\$48.0	\$52.9	\$62.3	\$65.9	\$65.4	\$69.8	\$74.5	\$79.5	\$84.8	\$90.7	\$97.0	\$104.0	\$111.5
Total	\$121.2	\$137.2	\$163.6	\$162.4	\$181.6	\$193.9	\$207.1	\$221.1	\$236.0	\$252.6	\$270.3	\$290.1	\$311.2
HEALTH STATUS													
Aged	\$2.0	\$2.0	\$2.3	\$2.1	\$2.3	\$2.6	\$2.9	\$3.2	\$3.6	\$4.0	\$4.4	\$4.9	\$5.5
Disabled/Blind Child	\$7.7	\$8.8	\$10.7	\$11.4	\$12.2	\$13.0	\$13.9	\$14.9	\$16.0	\$17.2	\$18.5	\$20.0	\$21.6
Disabled/Blind Adult	\$22.4	\$24.7	\$29.0	\$29.7	\$32.1	\$34.0	\$36.1	\$38.4	\$40.6	\$43.1	\$45.6	\$48.4	\$51.3
Child	\$56.5	\$64.3	\$77.1	\$72.6	\$83.6	\$89.5	\$95.9	\$102.6	\$109.8	\$117.9	\$126.6	\$136.3	\$146.6
Adult	\$32.7	\$37.4	\$44.5	\$46.6	\$51.4	\$54.8	\$58.3	\$62.1	\$66.0	\$70.5	\$75.2	\$80.5	\$86.2
Unknown	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total	\$121.2	\$137.2	\$163.6	\$162.4	\$181.6	\$193.9	\$207.1	\$221.1	\$236.0	\$252.6	\$270.3	\$290.1	\$311.2
FUNDING SOURCE													
Federal Share	\$81.7	\$85.3	\$103.0	\$104.6	\$122.8	\$131.2	\$140.1	\$149.5	\$159.6	\$170.8	\$182.8	\$196.2	\$210.4
State Share	\$39.5	\$51.9	\$60.6	\$57.8	\$58.8	\$62.8	\$67.0	\$71.6	\$76.4	\$81.8	\$87.5	\$93.9	\$100.7

Figure A-5. Historic and Projected Costs for Pharmacy Services, Before Adjusting for ACA

Pharmacy (in millions)													
Total Annual Costs	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
AGE													
<1	\$3.3	\$3.2	\$2.1	\$1.7	\$1.6	\$1.7	\$1.8	\$1.9	\$2.0	\$2.1	\$2.2	\$2.3	\$2.4
1-5	\$4.2	\$4.1	\$4.7	\$4.2	\$3.6	\$3.8	\$4.0	\$4.2	\$4.5	\$4.7	\$5.0	\$5.2	\$5.5
6-14	\$10.0	\$9.5	\$10.1	\$11.1	\$11.1	\$11.9	\$12.8	\$13.7	\$14.6	\$15.7	\$16.9	\$18.2	\$19.5
15-18	\$7.2	\$6.9	\$6.5	\$6.6	\$5.7	\$5.9	\$6.1	\$6.3	\$6.7	\$7.1	\$7.5	\$8.0	\$8.6
19-20	\$2.1	\$1.4	\$2.4	\$2.8	\$1.4	\$1.4	\$1.4	\$1.5	\$1.5	\$1.5	\$1.6	\$1.6	\$1.7
21-44	\$23.1	\$23.2	\$24.6	\$27.5	\$23.7	\$25.2	\$26.8	\$28.5	\$30.3	\$32.3	\$34.4	\$36.7	\$39.2
45-64	\$26.5	\$26.1	\$28.1	\$31.0	\$27.0	\$27.9	\$28.9	\$29.9	\$30.9	\$31.9	\$32.8	\$33.6	\$34.6
65-74	\$1.9	\$1.8	\$1.8	\$1.8	\$1.3	\$1.5	\$1.7	\$1.8	\$2.0	\$2.2	\$2.5	\$2.7	\$2.9
75-84	\$0.9	\$0.9	\$1.0	\$1.0	\$0.8	\$0.8	\$0.9	\$1.0	\$1.1	\$1.2	\$1.4	\$1.5	\$1.7
85 and over	\$0.2	\$0.2	\$0.2	\$0.3	\$0.2	\$0.2	\$0.2	\$0.2	\$0.3	\$0.3	\$0.3	\$0.3	\$0.4
Unknown	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total	\$79.4	\$77.3	\$81.6	\$87.9	\$76.3	\$80.3	\$84.5	\$88.9	\$93.8	\$99.1	\$104.5	\$110.2	\$116.6
SEX													
Male	\$33.9	\$33.3	\$35.6	\$38.7	\$33.0	\$34.7	\$36.5	\$38.4	\$40.5	\$42.8	\$45.1	\$47.5	\$50.2
Female	\$45.4	\$44.0	\$46.0	\$49.2	\$43.3	\$45.6	\$48.0	\$50.5	\$53.3	\$56.4	\$59.4	\$62.7	\$66.4
Unknown	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total	\$79.4	\$77.3	\$81.6	\$87.9	\$76.3	\$80.3	\$84.5	\$88.9	\$93.8	\$99.1	\$104.5	\$110.2	\$116.6
RACE/ETHNICITY													
Alaska Native or American Indian	\$23.9	\$23.4	\$23.8	\$25.9	\$21.9	\$23.1	\$24.3	\$25.5	\$26.9	\$28.5	\$30.0	\$31.7	\$33.5
Asian	\$3.6	\$3.9	\$4.0	\$4.6	\$4.1	\$4.3	\$4.5	\$4.8	\$5.1	\$5.4	\$5.7	\$6.1	\$6.4
Black or African-American	\$4.5	\$4.4	\$4.5	\$5.2	\$4.7	\$5.0	\$5.2	\$5.5	\$5.8	\$6.1	\$6.4	\$6.8	\$7.2
Hispanic or Latino	\$2.1	\$2.0	\$2.2	\$2.3	\$2.1	\$2.2	\$2.3	\$2.4	\$2.5	\$2.7	\$2.8	\$3.0	\$3.2
Pacific Islander	\$1.3	\$1.1	\$1.2	\$1.4	\$1.3	\$1.3	\$1.4	\$1.5	\$1.6	\$1.6	\$1.7	\$1.8	\$1.9
Unknown	\$1.6	\$1.4	\$1.5	\$1.6	\$1.6	\$1.7	\$1.8	\$1.9	\$2.0	\$2.1	\$2.3	\$2.4	\$2.5
White	\$42.4	\$41.1	\$44.4	\$46.8	\$40.6	\$42.7	\$44.9	\$47.3	\$49.8	\$52.6	\$55.5	\$58.5	\$61.8
Total	\$79.4	\$77.3	\$81.6	\$87.9	\$76.3	\$80.3	\$84.5	\$88.9	\$93.8	\$99.1	\$104.5	\$110.2	\$116.6
HEALTH STATUS													
Aged	\$2.3	\$2.2	\$6.5	\$2.3	\$1.8	\$2.0	\$2.2	\$2.4	\$2.6	\$2.9	\$3.1	\$3.5	\$3.8
Disabled/Blind Child	\$7.6	\$6.5	\$37.8	\$6.8	\$5.4	\$5.7	\$6.0	\$6.3	\$6.7	\$7.1	\$7.6	\$8.1	\$8.6
Disabled/Blind Adult	\$36.2	\$36.5	\$19.3	\$41.5	\$35.1	\$36.8	\$38.5	\$40.4	\$42.3	\$44.4	\$46.5	\$48.6	\$51.0
Child	\$19.2	\$18.7	\$15.6	\$19.5	\$18.0	\$19.1	\$20.1	\$21.3	\$22.5	\$24.0	\$25.4	\$27.0	\$28.7
Adult	\$14.1	\$13.5	\$2.4	\$17.7	\$16.1	\$16.9	\$17.7	\$18.6	\$19.6	\$20.7	\$21.9	\$23.1	\$24.4
Unknown	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total	\$79.4	\$77.3	\$81.6	\$87.9	\$76.3	\$80.3	\$84.5	\$88.9	\$93.8	\$99.1	\$104.5	\$110.2	\$116.6
FUNDING SOURCE													
Federal Share	\$47.8	\$52.2	\$55.6	\$51.3	\$44.5	\$46.8	\$49.3	\$51.9	\$54.7	\$57.8	\$61.0	\$64.3	\$68.0
State Share	\$31.6	\$25.2	\$26.0	\$36.6	\$31.8	\$33.5	\$35.2	\$37.1	\$39.1	\$41.3	\$43.5	\$45.9	\$48.6

Figure A-6. Historic and Projected Costs of Dental Services, Before Adjusting for ACA

Dental Services (in millions)													
Total Annual Costs	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
AGE													
<1	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.1	\$0.1
1-5	\$3.9	\$5.3	\$7.0	\$8.4	\$8.5	\$9.0	\$9.7	\$10.5	\$11.3	\$12.3	\$13.3	\$14.5	\$15.8
6-14	\$7.0	\$10.2	\$13.3	\$15.6	\$16.0	\$17.1	\$18.5	\$20.3	\$22.3	\$24.5	\$27.2	\$30.2	\$33.4
15-18	\$4.0	\$5.9	\$7.5	\$8.8	\$8.4	\$8.7	\$9.0	\$9.6	\$10.3	\$11.2	\$12.3	\$13.5	\$15.0
19-20	\$0.5	\$1.0	\$1.6	\$2.4	\$2.1	\$2.2	\$2.2	\$2.3	\$2.4	\$2.5	\$2.7	\$2.9	\$3.1
21-44	\$4.0	\$6.1	\$7.8	\$10.7	\$11.8	\$12.5	\$13.4	\$14.6	\$15.9	\$17.4	\$19.1	\$21.0	\$23.2
45-64	\$2.5	\$3.5	\$4.1	\$5.5	\$6.3	\$6.5	\$6.8	\$7.2	\$7.6	\$8.1	\$8.5	\$9.1	\$9.6
65-74	\$0.7	\$0.9	\$1.0	\$1.4	\$1.5	\$1.7	\$1.9	\$2.2	\$2.5	\$2.8	\$3.1	\$3.6	\$4.0
75-84	\$0.4	\$0.4	\$0.5	\$0.6	\$0.7	\$0.7	\$0.8	\$0.9	\$1.0	\$1.1	\$1.3	\$1.5	\$1.7
85 and over	\$0.1	\$0.1	\$0.1	\$0.2	\$0.2	\$0.2	\$0.2	\$0.3	\$0.3	\$0.4	\$0.4	\$0.5	\$0.5
Unknown	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total	\$23.0	\$33.5	\$43.1	\$53.5	\$55.6	\$58.7	\$62.7	\$68.0	\$73.7	\$80.3	\$87.9	\$96.8	\$106.4
SEX													
Male	\$10.1	\$14.5	\$19.1	\$23.2	\$24.2	\$25.5	\$27.3	\$29.6	\$32.0	\$34.8	\$38.1	\$42.0	\$46.1
Female	\$12.9	\$19.0	\$24.0	\$30.3	\$31.4	\$33.2	\$35.5	\$38.5	\$41.7	\$45.4	\$49.7	\$54.8	\$60.3
Unknown	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total	\$23.0	\$33.5	\$43.1	\$53.5	\$55.6	\$58.7	\$62.7	\$68.0	\$73.7	\$80.3	\$87.9	\$96.8	\$106.4
RACE/ETHNICITY													
Alaska Native or American Indian	\$7.4	\$11.5	\$14.8	\$17.1	\$17.6	\$18.6	\$19.9	\$21.6	\$23.4	\$25.4	\$27.8	\$30.7	\$33.7
Asian	\$1.4	\$2.0	\$3.1	\$4.1	\$4.4	\$4.6	\$5.0	\$5.4	\$5.9	\$6.4	\$7.1	\$7.8	\$8.6
Black or African-American	\$1.2	\$1.7	\$2.4	\$3.5	\$3.7	\$3.9	\$4.2	\$4.5	\$4.9	\$5.3	\$5.8	\$6.4	\$7.0
Hispanic or Latino	\$0.8	\$1.2	\$1.6	\$2.2	\$2.2	\$2.4	\$2.5	\$2.7	\$3.0	\$3.2	\$3.6	\$3.9	\$4.3
Pacific Islander	\$0.8	\$1.1	\$1.7	\$2.6	\$3.0	\$3.1	\$3.4	\$3.7	\$4.0	\$4.3	\$4.7	\$5.2	\$5.7
Unknown	\$0.5	\$0.7	\$0.9	\$1.2	\$1.2	\$1.3	\$1.4	\$1.5	\$1.6	\$1.7	\$1.9	\$2.1	\$2.3
White	\$10.9	\$15.4	\$18.6	\$22.9	\$23.5	\$24.8	\$26.5	\$28.7	\$31.1	\$33.8	\$37.0	\$40.7	\$44.7
Total	\$23.0	\$33.5	\$43.1	\$53.5	\$55.6	\$58.7	\$62.7	\$68.0	\$73.7	\$80.3	\$87.9	\$96.8	\$106.4
HEALTH STATUS													
Aged	\$0.9	\$1.2	\$1.4	\$1.8	\$2.0	\$2.1	\$2.4	\$2.7	\$3.0	\$3.4	\$3.9	\$4.4	\$5.0
Disabled/Blind Child	\$0.4	\$0.6	\$0.8	\$1.0	\$1.1	\$1.1	\$1.2	\$1.3	\$1.4	\$1.6	\$1.7	\$1.9	\$2.1
Disabled/Blind Adult	\$3.4	\$4.7	\$5.3	\$6.8	\$7.8	\$8.2	\$8.7	\$9.3	\$10.0	\$10.8	\$11.7	\$12.7	\$13.8
Child	\$15.0	\$21.9	\$28.7	\$34.2	\$34.0	\$36.0	\$38.5	\$41.8	\$45.3	\$49.4	\$54.2	\$59.7	\$65.7
Adult	\$3.2	\$5.2	\$6.9	\$9.8	\$10.7	\$11.3	\$12.0	\$12.9	\$13.9	\$15.1	\$16.4	\$18.0	\$19.8
Unknown	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total	\$23.0	\$33.5	\$43.1	\$53.5	\$55.6	\$58.7	\$62.7	\$68.0	\$73.7	\$80.3	\$87.9	\$96.8	\$106.4
FUNDING SOURCE													
Federal Share	\$14.6	\$25.4	\$32.4	\$32.8	\$33.7	\$35.6	\$38.1	\$41.3	\$44.7	\$48.7	\$53.3	\$58.7	\$64.5
State Share	\$8.5	\$8.1	\$10.7	\$20.8	\$21.9	\$23.1	\$24.7	\$26.8	\$29.0	\$31.6	\$34.6	\$38.1	\$41.9

Figure A-7. Historic and Projected Costs for Mental and Behavioral Health Services, Before Adjusting for ACA

Mental and Behavioral Health Services (in millions)													
Total Annual Costs	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
AGE													
<1	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.1	\$0.1	\$0.1	\$0.1	\$0.1	\$0.1
1-5	\$2.8	\$3.9	\$5.3	\$4.9	\$4.3	\$4.6	\$5.0	\$5.3	\$5.7	\$6.0	\$6.4	\$6.9	\$7.3
6-14	\$25.4	\$29.1	\$37.0	\$40.0	\$38.2	\$41.3	\$44.7	\$48.4	\$52.4	\$56.8	\$61.9	\$67.3	\$73.1
15-18	\$16.8	\$18.9	\$24.8	\$26.3	\$25.1	\$26.1	\$27.2	\$28.5	\$30.3	\$32.5	\$34.8	\$37.7	\$41.0
19-20	\$0.8	\$1.2	\$1.7	\$2.4	\$2.3	\$2.4	\$2.5	\$2.5	\$2.6	\$2.7	\$2.8	\$3.0	\$3.1
21-44	\$9.4	\$10.0	\$12.7	\$13.2	\$12.7	\$13.6	\$14.7	\$15.8	\$16.9	\$18.3	\$19.7	\$21.2	\$22.9
45-64	\$7.3	\$7.6	\$10.0	\$11.6	\$10.7	\$11.2	\$11.8	\$12.3	\$12.8	\$13.4	\$13.9	\$14.5	\$15.0
65-74	\$0.7	\$0.7	\$0.9	\$1.1	\$1.3	\$1.5	\$1.7	\$1.9	\$2.1	\$2.3	\$2.6	\$2.8	\$3.2
75-84	\$0.0	\$0.1	\$0.1	\$0.1	\$0.1	\$0.1	\$0.2	\$0.2	\$0.2	\$0.2	\$0.2	\$0.3	\$0.3
85 and over	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Unknown	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total	\$63.3	\$71.5	\$92.7	\$99.6	\$94.8	\$101.0	\$107.7	\$115.0	\$123.1	\$132.4	\$142.4	\$153.8	\$166.0
SEX													
Male	\$38.4	\$43.6	\$55.5	\$60.1	\$57.7	\$61.5	\$65.5	\$70.0	\$74.8	\$80.5	\$86.6	\$93.4	\$100.8
Female	\$24.8	\$27.9	\$37.2	\$39.5	\$37.1	\$39.5	\$42.1	\$45.0	\$48.2	\$51.9	\$55.9	\$60.3	\$65.2
Unknown	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total	\$63.3	\$71.5	\$92.7	\$99.6	\$94.8	\$101.0	\$107.7	\$115.0	\$123.1	\$132.4	\$142.4	\$153.8	\$166.0
RACE/ETHNICITY													
Alaska Native or American Indian	\$28.6	\$33.2	\$41.5	\$43.7	\$41.7	\$44.4	\$47.3	\$50.5	\$54.1	\$58.2	\$62.6	\$67.7	\$73.1
Asian	\$0.6	\$0.7	\$1.0	\$1.2	\$1.2	\$1.2	\$1.3	\$1.4	\$1.5	\$1.6	\$1.8	\$1.9	\$2.1
Black or African-American	\$2.8	\$3.3	\$4.5	\$4.5	\$4.2	\$4.5	\$4.8	\$5.1	\$5.4	\$5.8	\$6.3	\$6.8	\$7.3
Hispanic or Latino	\$0.8	\$1.0	\$1.7	\$1.8	\$1.9	\$2.0	\$2.1	\$2.3	\$2.4	\$2.6	\$2.8	\$3.1	\$3.3
Pacific Islander	\$0.5	\$0.5	\$0.5	\$0.6	\$0.8	\$0.8	\$0.9	\$0.9	\$1.0	\$1.1	\$1.2	\$1.2	\$1.3
Unknown	\$1.7	\$1.3	\$1.4	\$2.3	\$1.9	\$2.1	\$2.2	\$2.4	\$2.6	\$2.7	\$3.0	\$3.2	\$3.5
White	\$28.2	\$31.5	\$42.0	\$45.6	\$43.2	\$46.0	\$49.0	\$52.4	\$56.0	\$60.2	\$64.8	\$69.9	\$75.5
Total	\$63.3	\$71.5	\$92.7	\$99.6	\$94.8	\$101.0	\$107.7	\$115.0	\$123.1	\$132.4	\$142.4	\$153.8	\$166.0
HEALTH STATUS													
Aged	\$0.3	\$0.6	\$0.9	\$1.0	\$1.2	\$1.3	\$1.4	\$1.6	\$1.8	\$2.0	\$2.2	\$2.5	\$2.7
Disabled/Blind Child	\$6.8	\$7.9	\$10.1	\$10.7	\$10.4	\$11.1	\$11.9	\$12.7	\$13.6	\$14.7	\$15.9	\$17.3	\$18.8
Disabled/Blind Adult	\$15.0	\$15.5	\$19.6	\$21.0	\$19.6	\$20.7	\$22.0	\$23.3	\$24.7	\$26.3	\$27.9	\$29.8	\$31.8
Child	\$39.1	\$45.2	\$58.8	\$63.0	\$59.5	\$63.5	\$67.8	\$72.5	\$77.7	\$83.7	\$90.3	\$97.7	\$105.7
Adult	\$2.0	\$2.4	\$3.4	\$4.1	\$4.1	\$4.4	\$4.7	\$5.0	\$5.3	\$5.7	\$6.1	\$6.5	\$7.0
Unknown	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total	\$63.3	\$71.5	\$92.7	\$99.6	\$94.8	\$101.0	\$107.7	\$115.0	\$123.1	\$132.4	\$142.4	\$153.8	\$166.0
FUNDING SOURCE													
Federal Share	\$36.2	\$46.5	\$61.0	\$50.5	\$50.9	\$54.2	\$57.8	\$61.7	\$66.1	\$71.1	\$76.5	\$82.6	\$89.1
State Share	\$27.1	\$24.9	\$31.7	\$49.1	\$43.9	\$46.8	\$49.9	\$53.2	\$57.0	\$61.3	\$65.9	\$71.2	\$76.9

Figure A-8. Historic and Projected Costs for All Other Services, Before Adjusting for ACA

All Other Services (in millions)													
Total Annual Costs	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
AGE													
<1	\$5.2	\$6.6	\$6.7	\$6.6	\$7.2	\$7.9	\$8.8	\$9.6	\$10.5	\$11.6	\$12.7	\$14.0	\$15.4
1-5	\$12.3	\$13.8	\$15.3	\$15.3	\$16.9	\$18.6	\$20.5	\$22.6	\$24.7	\$27.1	\$29.8	\$32.8	\$36.1
6-14	\$18.4	\$22.8	\$25.2	\$25.3	\$29.0	\$32.2	\$35.8	\$40.0	\$44.4	\$49.5	\$55.6	\$62.4	\$69.8
15-18	\$14.4	\$20.7	\$22.2	\$16.1	\$18.5	\$19.8	\$21.2	\$22.8	\$24.9	\$27.5	\$30.4	\$33.8	\$38.0
19-20	\$7.7	\$7.5	\$9.0	\$10.7	\$11.9	\$12.7	\$13.4	\$14.2	\$14.9	\$15.8	\$17.0	\$18.5	\$20.2
21-44	\$81.6	\$89.9	\$105.0	\$115.1	\$129.5	\$143.1	\$158.2	\$174.8	\$192.9	\$213.6	\$237.6	\$264.3	\$294.1
45-64	\$72.7	\$79.0	\$92.6	\$102.1	\$114.0	\$122.6	\$131.8	\$141.8	\$152.2	\$162.9	\$174.7	\$187.3	\$200.8
65-74	\$35.2	\$36.9	\$41.7	\$47.8	\$54.9	\$63.5	\$73.5	\$84.9	\$96.8	\$110.5	\$126.4	\$144.3	\$165.2
75-84	\$38.6	\$41.0	\$48.0	\$52.2	\$55.0	\$61.9	\$69.7	\$78.9	\$90.1	\$104.3	\$122.1	\$142.2	\$164.4
85 and over	\$21.5	\$23.9	\$27.9	\$29.3	\$33.9	\$38.9	\$44.8	\$51.6	\$58.9	\$66.7	\$76.2	\$87.4	\$100.9
Unknown	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total	\$307.6	\$341.9	\$393.5	\$420.6	\$470.8	\$521.3	\$577.7	\$641.0	\$710.4	\$789.6	\$882.6	\$987.0	\$1,104.8
SEX													
Male	\$133.1	\$149.6	\$174.3	\$184.3	\$209.3	\$231.7	\$256.6	\$284.6	\$315.3	\$350.2	\$391.3	\$437.4	\$489.2
Female	\$174.4	\$192.3	\$219.2	\$236.2	\$261.5	\$289.7	\$321.1	\$356.4	\$395.1	\$439.3	\$491.3	\$549.6	\$615.6
Unknown	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total	\$307.6	\$341.9	\$393.5	\$420.6	\$470.8	\$521.3	\$577.7	\$641.0	\$710.4	\$789.6	\$882.6	\$987.0	\$1,104.8
RACE/ETHNICITY													
Alaska Native or American Indian	\$103.5	\$116.3	\$127.6	\$131.2	\$137.9	\$152.6	\$169.1	\$187.6	\$207.8	\$230.9	\$258.1	\$288.6	\$322.9
Asian	\$23.5	\$27.6	\$34.9	\$41.9	\$47.6	\$52.8	\$58.8	\$65.4	\$72.8	\$81.2	\$91.2	\$102.4	\$115.1
Black or African-American	\$11.6	\$13.2	\$15.4	\$16.5	\$25.8	\$28.6	\$31.6	\$35.0	\$38.7	\$43.0	\$48.0	\$53.6	\$59.9
Hispanic or Latino	\$6.4	\$7.6	\$9.3	\$10.4	\$11.8	\$13.1	\$14.5	\$16.1	\$17.8	\$19.8	\$22.2	\$24.8	\$27.8
Pacific Islander	\$7.9	\$9.4	\$12.4	\$14.9	\$17.0	\$18.8	\$20.9	\$23.2	\$25.7	\$28.6	\$31.9	\$35.7	\$40.0
Unknown	\$9.3	\$10.3	\$12.2	\$13.5	\$15.1	\$16.8	\$18.6	\$20.7	\$23.0	\$25.6	\$28.7	\$32.1	\$36.0
White	\$145.4	\$157.5	\$181.7	\$192.0	\$215.7	\$238.6	\$264.3	\$293.0	\$324.5	\$360.4	\$402.5	\$449.7	\$503.0
Total	\$307.6	\$341.9	\$393.5	\$420.6	\$470.8	\$521.3	\$577.7	\$641.0	\$710.4	\$789.6	\$882.6	\$987.0	\$1,104.8
HEALTH STATUS													
Aged	\$84.3	\$88.8	\$94.2	\$110.6	\$121.7	\$139.2	\$159.3	\$182.5	\$208.4	\$239.1	\$276.0	\$318.1	\$366.6
Disabled/Blind Child	\$26.6	\$28.1	\$44.4	\$34.9	\$40.4	\$44.4	\$48.9	\$54.0	\$59.6	\$66.2	\$73.9	\$82.5	\$92.2
Disabled/Blind Adult	\$153.4	\$168.7	\$186.4	\$217.8	\$247.1	\$270.0	\$295.0	\$322.5	\$352.1	\$384.7	\$421.9	\$463.1	\$508.9
Child	\$31.4	\$43.2	\$45.5	\$39.1	\$43.1	\$47.4	\$52.3	\$57.6	\$63.5	\$70.3	\$78.3	\$87.2	\$97.2
Adult	\$11.9	\$13.2	\$23.0	\$18.1	\$18.5	\$20.3	\$22.2	\$24.3	\$26.7	\$29.4	\$32.5	\$36.0	\$39.9
Unknown	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total	\$307.6	\$341.9	\$393.5	\$420.6	\$470.8	\$521.3	\$577.7	\$641.0	\$710.4	\$789.6	\$882.6	\$987.0	\$1,104.8
FUNDING SOURCE													
Federal Share	\$169.2	\$217.0	\$250.8	\$221.8	\$241.2	\$267.1	\$296.0	\$328.5	\$364.0	\$404.6	\$452.2	\$505.7	\$566.1
State Share	\$138.4	\$125.0	\$142.7	\$198.7	\$229.6	\$254.2	\$281.7	\$312.6	\$346.4	\$385.0	\$430.3	\$481.2	\$538.7

Figure A-9. Historic and Projected Costs for Total of All Services, Before Adjusting for ACA

Total All Services (in millions)													
Total Annual Costs	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
AGE													
<1	\$92.5	\$96.0	\$101.7	\$90.1	\$103.3	\$109.6	\$116.4	\$123.3	\$130.2	\$137.5	\$145.2	\$153.5	\$162.4
1-5	\$64.9	\$67.2	\$80.3	\$78.3	\$86.2	\$92.3	\$99.0	\$106.1	\$113.4	\$121.2	\$129.7	\$139.1	\$149.2
6-14	\$130.8	\$140.0	\$156.0	\$160.7	\$174.1	\$188.1	\$203.5	\$220.8	\$239.0	\$259.6	\$283.4	\$309.1	\$336.6
15-18	\$107.3	\$114.0	\$121.6	\$113.8	\$115.7	\$120.1	\$124.9	\$130.7	\$138.9	\$149.0	\$159.6	\$172.7	\$188.1
19-20	\$26.6	\$27.0	\$33.2	\$35.8	\$35.7	\$36.9	\$38.3	\$39.5	\$40.7	\$42.2	\$44.3	\$47.1	\$50.2
21-44	\$229.3	\$249.6	\$278.9	\$304.4	\$322.1	\$348.2	\$376.7	\$407.7	\$441.1	\$479.0	\$521.1	\$567.8	\$619.2
45-64	\$193.2	\$201.4	\$228.1	\$253.0	\$269.4	\$283.4	\$298.2	\$314.2	\$330.5	\$346.7	\$363.7	\$381.9	\$401.2
65-74	\$58.8	\$57.8	\$64.1	\$78.4	\$85.8	\$97.7	\$111.4	\$126.8	\$142.7	\$160.8	\$181.3	\$204.2	\$230.7
75-84	\$66.1	\$64.9	\$71.9	\$84.0	\$88.8	\$98.1	\$108.6	\$121.0	\$136.2	\$155.2	\$178.8	\$205.0	\$233.4
85 and over	\$43.5	\$45.5	\$49.8	\$55.7	\$62.3	\$70.1	\$78.9	\$89.1	\$99.8	\$111.0	\$124.4	\$139.8	\$158.3
Unknown	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total	\$1,012.9	\$1,063.3	\$1,185.6	\$1,254.3	\$1,343.4	\$1,444.6	\$1,555.9	\$1,679.2	\$1,812.5	\$1,962.3	\$2,131.6	\$2,320.2	\$2,529.4
SEX													
Male	\$436.4	\$459.7	\$521.5	\$547.8	\$587.0	\$631.3	\$679.9	\$733.6	\$791.8	\$857.2	\$931.3	\$1,013.7	\$1,104.8
Female	\$576.5	\$603.6	\$664.1	\$706.5	\$756.3	\$813.4	\$876.0	\$945.5	\$1,020.6	\$1,105.1	\$1,200.3	\$1,306.5	\$1,424.6
Unknown	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total	\$1,012.9	\$1,063.3	\$1,185.6	\$1,254.3	\$1,343.4	\$1,444.6	\$1,555.9	\$1,679.2	\$1,812.5	\$1,962.3	\$2,131.6	\$2,320.2	\$2,529.4
RACE/ETHNICITY													
Alaska Native or American Indian	\$398.0	\$401.9	\$453.7	\$458.8	\$502.4	\$538.1	\$577.2	\$620.1	\$666.5	\$718.5	\$776.7	\$841.6	\$913.1
Asian	\$48.6	\$57.3	\$66.6	\$81.1	\$87.2	\$94.9	\$103.4	\$113.0	\$123.4	\$135.2	\$148.9	\$164.3	\$181.5
Black or African-American	\$44.9	\$49.9	\$52.8	\$57.9	\$68.1	\$73.2	\$78.8	\$85.0	\$91.7	\$99.2	\$107.7	\$117.2	\$127.7
Hispanic or Latino	\$22.4	\$25.6	\$28.9	\$31.4	\$33.4	\$35.9	\$38.6	\$41.7	\$45.0	\$48.8	\$53.0	\$57.7	\$63.0
Pacific Islander	\$21.3	\$24.8	\$27.9	\$34.1	\$37.7	\$40.7	\$44.0	\$47.7	\$51.8	\$56.3	\$61.5	\$67.4	\$73.8
Unknown	\$32.1	\$31.2	\$33.7	\$36.5	\$37.2	\$40.2	\$43.5	\$47.3	\$51.3	\$55.8	\$60.9	\$66.6	\$73.0
White	\$445.7	\$472.7	\$522.0	\$554.5	\$577.4	\$621.7	\$670.4	\$724.4	\$782.9	\$848.5	\$922.7	\$1,005.4	\$1,097.3
Total	\$1,012.9	\$1,063.3	\$1,185.6	\$1,254.3	\$1,343.4	\$1,444.6	\$1,555.9	\$1,679.2	\$1,812.5	\$1,962.3	\$2,131.6	\$2,320.2	\$2,529.4
HEALTH STATUS													
Aged	\$151.8	\$149.6	\$161.0	\$191.7	\$207.8	\$233.0	\$261.6	\$294.5	\$330.6	\$372.7	\$422.6	\$478.7	\$542.5
Disabled/Blind Child	\$76.2	\$73.5	\$127.0	\$84.6	\$94.8	\$102.0	\$109.9	\$118.7	\$128.4	\$139.6	\$152.3	\$166.5	\$182.3
Disabled/Blind Adult	\$314.4	\$333.1	\$346.7	\$415.8	\$442.9	\$475.1	\$510.1	\$548.3	\$589.0	\$633.2	\$682.4	\$736.6	\$796.5
Child	\$346.0	\$370.7	\$404.9	\$394.2	\$420.1	\$446.6	\$475.4	\$507.0	\$541.0	\$579.3	\$621.4	\$668.4	\$719.2
Adult	\$124.6	\$136.4	\$146.0	\$168.0	\$177.8	\$188.0	\$199.0	\$210.7	\$223.4	\$237.6	\$252.9	\$270.0	\$288.9
Unknown	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total	\$1,012.9	\$1,063.3	\$1,185.6	\$1,254.3	\$1,343.4	\$1,444.6	\$1,555.9	\$1,679.2	\$1,812.5	\$1,962.3	\$2,131.6	\$2,320.2	\$2,529.4
FUNDING SOURCE													
Federal Share	\$615.8	\$699.1	\$788.4	\$715.6	\$773.7	\$830.5	\$892.7	\$961.5	\$1,035.8	\$1,119.1	\$1,212.9	\$1,317.4	\$1,433.0
State Share	\$397.1	\$364.2	\$397.2	\$538.8	\$569.6	\$614.2	\$663.2	\$717.7	\$776.7	\$843.2	\$918.7	\$1,002.8	\$1,096.3

Appendix B. Post-ACA Expansion and No Expansion Impact Analyses

Figure B-1. Impact on Alaska Medicaid Spending if Medicaid is Not Expanded under the ACA (2014-2020)

	2014	2015	2016	2017	2018	2019	2020	Cumulative
1. Cost of Currently Eligible but Not Enrolled								
Population growth rate		2.0%	2.2%	2.3%	2.3%	2.4%	2.4%	
Currently Eligible but Uninsured - Eligible	11,231	11,461	11,711	11,979	12,257	12,545	12,841	
Currently Eligible but Uninsured - Enrolled	3,172	3,228	3,290	3,358	3,428	3,502	3,580	
Take Up Rate	28%	28%	28%	28%	28%	28%	28%	
Lag Rate	76%	88%	100%	100%	100%	100%	100%	
Lag Rate * Enrollment	2,426	2,848	3,290	3,358	3,428	3,502	3,580	
PMPY Cost	\$8,136	\$8,146	\$8,560	\$8,991	\$9,441	\$9,913	\$10,409	
Total Cost	\$19,738,239	\$23,202,207	\$28,166,227	\$30,190,003	\$32,362,277	\$34,719,589	\$37,262,053	\$205,640,595
FMAP	50%	50%	50%	50%	50%	50%	50%	
Subtotal - State Cost	\$9,869,119	\$11,601,104	\$14,083,113	\$15,095,001	\$16,181,139	\$17,359,794	\$18,631,027	\$102,820,298
Subtotal - Federal Cost	\$9,869,119	\$11,601,104	\$14,083,113	\$15,095,001	\$16,181,139	\$17,359,794	\$18,631,027	\$102,820,298
2. Leave Medicaid for New Offer of Employer Coverage								
Population Growth Rate		2.2%	2.4%	2.5%	2.5%	2.6%	2.6%	
Disenrollment	2,419	2,473	2,533	2,597	2,663	2,731	2,801	
Lag Rate	76%	88%	100%	100%	100%	100%	100%	
Lag Rate * Disenrollment	1,849	2,182	2,533	2,597	2,663	2,731	2,801	
PMPY Cost	\$6,550	\$6,841	\$7,146	\$7,464	\$7,793	\$8,139	\$8,503	
Total Savings	\$12,114,354	\$14,926,110	\$18,098,042	\$19,383,122	\$20,749,329	\$22,223,993	\$23,812,934	\$131,307,885
FMAP	50%	50%	50%	50%	50%	50%	50%	
Subtotal - State Savings	\$6,057,177	\$7,463,055	\$9,049,021	\$9,691,561	\$10,374,665	\$11,111,996	\$11,906,467	\$65,653,942
Subtotal - Federal Savings	\$6,057,177	\$7,463,055	\$9,049,021	\$9,691,561	\$10,374,665	\$11,111,996	\$11,906,467	\$65,653,942
3. Total Net Impact								
Change in Enrollment	577	667	758	761	765	772	779	
Health Care Costs								
State Cost	\$3,811,942	\$4,138,049	\$5,034,092	\$5,403,440	\$5,806,474	\$6,247,798	\$6,724,559	\$37,166,355
Federal Cost	\$3,811,942	\$4,138,049	\$5,034,092	\$5,403,440	\$5,806,474	\$6,247,798	\$6,724,559	\$37,166,355
Subtotal	\$7,623,885	\$8,276,097	\$10,068,184	\$10,806,881	\$11,612,948	\$12,495,596	\$13,449,119	\$74,332,710
Administrative Costs								
State Share	\$278,821	\$302,673	\$368,214	\$395,229	\$424,709	\$456,989	\$491,861	\$2,718,496
Federal Share	\$346,338	\$375,967	\$457,377	\$490,935	\$527,553	\$567,650	\$610,967	\$3,376,786
Subtotal	\$625,159	\$678,640	\$825,591	\$886,164	\$952,262	\$1,024,639	\$1,102,828	\$6,095,282
Total								
State Share	\$4,090,763	\$4,440,722	\$5,402,306	\$5,798,670	\$6,231,183	\$6,704,787	\$7,216,421	\$39,884,851
Federal Share	\$4,158,280	\$4,514,015	\$5,491,470	\$5,894,375	\$6,334,027	\$6,815,448	\$7,335,526	\$40,543,142
Total	\$8,249,043	\$8,954,737	\$10,893,775	\$11,693,045	\$12,565,210	\$13,520,235	\$14,551,947	\$80,427,993

Figure B-2. Impact on Alaska Medicaid Spending if Medicaid is Not Expanded Under the ACA (2014-2020) and Capping Eligibility for Pregnant Women at 138 Percent of FPL

	2014	2015	2016	2017	2018	2019	2020	Cumulative
1. Cost of Currently Eligible but Not Enrolled								
Population growth rate		2.0%	2.2%	2.3%	2.3%	2.4%	2.4%	
Currently Eligible but Uninsured - Eligible	11,231	11,461	11,711	11,979	12,257	12,545	12,841	
Currently Eligible but Uninsured - Enrolled	3,172	3,228	3,290	3,358	3,428	3,502	3,580	
Take Up Rate	28%	28%	28%	28%	28%	28%	28%	
Lag Rate	76%	88%	100%	100%	100%	100%	100%	
Lag Rate * Enrollment	2,426	2,848	3,290	3,358	3,428	3,502	3,580	
PMPY Cost	\$8,136	\$8,146	\$8,560	\$8,991	\$9,441	\$9,913	\$10,409	
Total Cost	\$19,738,239	\$23,202,207	\$28,166,227	\$30,190,003	\$32,362,277	\$34,719,589	\$37,262,053	\$205,640,595
FMAP	50%	50%	50%	50%	50%	50%	50%	
Subtotal - State Cost	\$9,869,119	\$11,601,104	\$14,083,113	\$15,095,001	\$16,181,139	\$17,359,794	\$18,631,027	\$102,820,298
Subtotal - Federal Cost	\$9,869,119	\$11,601,104	\$14,083,113	\$15,095,001	\$16,181,139	\$17,359,794	\$18,631,027	\$102,820,298
2. Leave Medicaid for New Offer of Employer Coverage								
Population Growth Rate		2.2%	2.4%	2.5%	2.5%	2.6%	2.6%	
Disenrollment	2,419	2,473	2,533	2,597	2,663	2,731	2,801	
Lag Rate	76%	88%	100%	100%	100%	100%	100%	
Lag Rate * Disenrollment	1,849	2,182	2,533	2,597	2,663	2,731	2,801	
PMPY Cost	\$6,550	\$6,841	\$7,146	\$7,464	\$7,793	\$8,139	\$8,503	
Total Savings	\$12,114,354	\$14,926,110	\$18,098,042	\$19,383,122	\$20,749,329	\$22,223,993	\$23,812,934	\$131,307,885
FMAP	50%	50%	50%	50%	50%	50%	50%	
Subtotal - State Savings	\$6,057,177	\$7,463,055	\$9,049,021	\$9,691,561	\$10,374,665	\$11,111,996	\$11,906,467	\$65,653,942
Subtotal - Federal Savings	\$6,057,177	\$7,463,055	\$9,049,021	\$9,691,561	\$10,374,665	\$11,111,996	\$11,906,467	\$65,653,942
Other Cost Offsets								
3. Moving Current Eligibles above 138% to HIX								
Pregnant Women								
Enrollees	335	342	349	356	363	370	377	
State costs	-\$3,296,919	-\$3,461,764	-\$3,634,853	-\$3,816,595	-\$4,007,425	-\$4,207,796	-\$4,418,186	-\$26,843,538
Federal costs	-\$3,296,919	-\$3,461,764	-\$3,634,853	-\$3,816,595	-\$4,007,425	-\$4,207,796	-\$4,418,186	-\$26,843,538
Administrative Costs								
State costs	-\$241,150	-\$253,207	-\$265,868	-\$279,161	-\$293,119	-\$307,775	-\$323,164	-\$1,963,444
Federal costs	-\$299,545	-\$314,522	-\$330,248	-\$346,761	-\$364,099	-\$382,304	-\$401,419	-\$2,438,897
4. Total Net Impact								
Change in Enrollment	242	325	409	405	403	402	402	
Health Care Costs								
State Cost	\$515,024	\$676,284	\$1,399,240	\$1,586,845	\$1,799,049	\$2,040,002	\$2,306,373	\$10,322,817
Federal Cost	\$515,024	\$676,284	\$1,399,240	\$1,586,845	\$1,799,049	\$2,040,002	\$2,306,373	\$10,322,817
Subtotal	\$1,030,048	\$1,352,569	\$2,798,479	\$3,173,690	\$3,598,098	\$4,080,004	\$4,612,747	\$20,645,634
Administrative Costs								
State Share	\$37,671	\$49,466	\$102,346	\$116,068	\$131,590	\$149,214	\$168,697	\$755,052
Federal Share	\$46,793	\$61,444	\$127,129	\$144,174	\$163,454	\$185,346	\$209,548	\$937,890
Subtotal	\$84,464	\$110,911	\$229,475	\$260,243	\$295,044	\$334,560	\$378,245	\$1,692,942
Total								
State Share	\$552,695	\$725,750	\$1,501,586	\$1,702,913	\$1,930,639	\$2,189,216	\$2,475,071	\$11,077,869
Federal Share	\$561,817	\$737,729	\$1,526,369	\$1,731,020	\$1,962,503	\$2,225,348	\$2,515,921	\$11,260,707
Total	\$1,114,512	\$1,463,479	\$3,027,954	\$3,433,933	\$3,893,142	\$4,414,564	\$4,990,992	\$22,338,576

Figure B-3. Impact on Alaska Medicaid Spending if Medicaid is Expanded under the ACA (2014-2020) - Baseline ACA Analysis

	2014	2015	2016	2017	2018	2019	2020	Cumulative
1. Cost of Newly Eligibles								
Population growth rate		1.1%	1.4%	1.5%	1.4%	1.6%	1.6%	
Projected Total Number of Newly Eligibles	63,989	64,713	65,619	66,571	67,496	68,560	69,684	
Projected Newly Eligibles Who Enroll	40,284	40,736	41,286	41,853	42,401	43,029	43,687	
Take Up Rate	63%	63%	63%	63%	63%	63%	63%	
Lag Rate	76%	88%	100%	100%	100%	100%	100%	
Lag Rate * Enrollment	30,806	35,944	41,286	41,853	42,401	43,029	43,687	
PMPY Cost	\$9,191	\$9,222	\$9,708	\$10,208	\$10,730	\$11,272	\$11,839	
Total Cost	\$283,147,943	\$331,468,851	\$400,787,147	\$427,221,539	\$454,961,724	\$484,997,562	\$517,227,696	\$2,899,812,463
FMAP	100%	100%	100%	95%	94%	93%	90%	
Subtotal - State Cost	\$0	\$0	\$0	\$21,361,077	\$27,297,703	\$33,949,829	\$51,722,770	\$134,331,379
Subtotal - Federal Cost	\$283,147,943	\$331,468,851	\$400,787,147	\$405,860,462	\$427,664,020	\$451,047,733	\$465,504,926	\$2,765,481,084
2. Cost of Currently Eligible but Not Enrolled								
Population growth rate		2.1%	2.3%	2.4%	2.4%	2.4%	2.4%	
Currently Eligible but Uninsured - Eligible	9,869	10,081	10,309	10,554	10,807	11,069	11,337	
Currently Eligible but Uninsured - Enrolled	2,111	2,155	2,204	2,257	2,312	2,370	2,429	
Take Up Rate	21%	21%	21%	21%	21%	21%	21%	
Lag Rate	76%	88%	100%	100%	100%	100%	100%	
Lag Rate * Enrollment	1,614	1,902	2,204	2,257	2,312	2,370	2,429	
PMPY Cost	\$7,807	\$7,793	\$8,166	\$8,553	\$8,956	\$9,379	\$9,822	
Total Cost	\$12,601,611	\$14,818,704	\$17,995,571	\$19,301,241	\$20,705,193	\$22,223,171	\$23,857,148	\$131,502,639
FMAP	50%	50%	50%	50%	50%	50%	50%	
Subtotal - State Cost	\$6,300,806	\$7,409,352	\$8,997,785	\$9,650,620	\$10,352,596	\$11,111,586	\$11,928,574	\$65,751,320
Subtotal - Federal Cost	\$6,300,806	\$7,409,352	\$8,997,785	\$9,650,620	\$10,352,596	\$11,111,586	\$11,928,574	\$65,751,320
3. Leave Medicaid for New Offer of Employer Coverage								
Population Growth Rate		2.2%	2.4%	2.5%	2.5%	2.6%	2.6%	
Disenrollment	2,419	2,473	2,533	2,597	2,663	2,731	2,801	
Lag Rate	76%	88%	100%	100%	100%	100%	100%	
Lag Rate * Disenrollment	1,849	2,182	2,533	2,597	2,663	2,731	2,801	
PMPY Cost	\$6,550	\$6,841	\$7,146	\$7,464	\$7,793	\$8,139	\$8,503	
Total Savings	\$12,114,354	\$14,926,110	\$18,098,042	\$19,383,122	\$20,749,329	\$22,223,993	\$23,812,934	\$131,307,885
FMAP	50%	50%	50%	50%	50%	50%	50%	
Subtotal - State Savings	\$6,057,177	\$7,463,055	\$9,049,021	\$9,691,561	\$10,374,665	\$11,111,996	\$11,906,467	\$65,653,942
Subtotal - Federal Savings	\$6,057,177	\$7,463,055	\$9,049,021	\$9,691,561	\$10,374,665	\$11,111,996	\$11,906,467	\$65,653,942
4. Total Net Impact								
Change in Enrollment	30,570	35,664	40,957	41,513	42,051	42,668	43,316	
Health Care Costs								
State Cost	\$243,629	-\$53,703	-\$51,236	\$21,320,136	\$27,275,635	\$33,949,419	\$51,744,876	\$134,428,757
Federal Cost	\$283,391,572	\$331,415,149	\$400,735,911	\$405,819,522	\$427,641,952	\$451,047,322	\$465,527,033	\$2,765,578,461
Subtotal	\$283,635,201	\$331,361,446	\$400,684,675	\$427,139,658	\$454,917,587	\$484,996,741	\$517,271,909	\$2,900,007,218
Administrative Costs								
State Share	\$10,373,107	\$12,118,551	\$14,653,840	\$15,621,352	\$16,637,246	\$17,737,301	\$18,917,668	\$106,059,064
Federal Share	\$12,884,980	\$15,053,088	\$18,202,303	\$19,404,100	\$20,665,996	\$22,032,432	\$23,498,628	\$131,741,528
Subtotal	\$23,258,086	\$27,171,639	\$32,856,143	\$35,025,452	\$37,303,242	\$39,769,733	\$42,416,297	\$237,800,592
Total								
State Share	\$10,616,735	\$12,064,848	\$14,602,604	\$36,941,488	\$43,912,881	\$51,686,719	\$70,662,545	\$240,487,821
Federal Share	\$296,276,552	\$346,468,236	\$418,938,215	\$425,223,622	\$448,307,948	\$473,079,754	\$489,025,661	\$2,897,319,989
Total	\$306,893,287	\$358,533,084	\$433,540,819	\$462,165,110	\$492,220,829	\$524,766,474	\$559,688,206	\$3,137,807,809

Figure B-4. Impact on Alaska Medicaid Spending if Medicaid is Expanded Under the ACA (2014-2020) - Sensitivity Analysis - 100 Percent Participation Assumption

	2014	2015	2016	2017	2018	2019	2020	Cumulative
1. Cost of Newly Eligibles								
Population growth rate		1.1%	1.4%	1.5%	1.4%	1.6%	1.6%	
Projected Total Number of Newly Eligibles	63,989	64,713	65,619	66,571	67,496	68,560	69,684	
Projected Newly Eligibles Who Enroll	52,080	52,686	53,427	54,202	54,960	55,827	56,736	
Take Up Rate	81%	81%	81%	81%	81%	81%	81%	
Lag Rate	76%	88%	100%	100%	100%	100%	100%	
Lag Rate * Enrollment	39,826	46,488	53,427	54,202	54,960	55,827	56,736	
PMPY Cost	\$9,009	\$9,039	\$9,516	\$10,007	\$10,520	\$11,053	\$11,612	
Total Cost	\$358,796,660	\$420,209,937	\$508,392,524	\$542,396,839	\$578,191,440	\$617,056,228	\$658,812,037	\$3,683,855,666
FMAP	100%	100%	100%	95%	94%	93%	90%	
Subtotal - State Cost	\$0	\$0	\$0	\$27,119,842	\$34,691,486	\$43,193,936	\$65,881,204	\$170,886,468
Subtotal - Federal Cost	\$358,796,660	\$420,209,937	\$508,392,524	\$515,276,997	\$543,499,953	\$573,862,292	\$592,930,833	\$3,512,969,198
2. Cost of Currently Eligible but Not Enrolled								
Population growth rate		2.1%	2.3%	2.4%	2.4%	2.4%	2.4%	
Currently Eligible but Uninsured - Eligible	9,869	10,081	10,309	10,554	10,807	11,069	11,337	
Currently Eligible but Uninsured - Enrolled	2,111	2,155	2,204	2,257	2,312	2,370	2,429	
Take Up Rate	21%	21%	21%	21%	21%	21%	21%	
Lag Rate	76%	88%	100%	100%	100%	100%	100%	
Lag Rate * Enrollment	1,614	1,902	2,204	2,257	2,312	2,370	2,429	
PMPY Cost	\$7,807	\$7,793	\$8,166	\$8,553	\$8,956	\$9,379	\$9,822	
Total Cost	\$12,601,611	\$14,818,704	\$17,995,571	\$19,301,241	\$20,705,193	\$22,223,171	\$23,857,148	\$131,502,639
FMAP	50%	50%	50%	50%	50%	50%	50%	
Subtotal - State Cost	\$6,300,806	\$7,409,352	\$8,997,785	\$9,650,620	\$10,352,596	\$11,111,586	\$11,928,574	\$65,751,320
Subtotal - Federal Cost	\$6,300,806	\$7,409,352	\$8,997,785	\$9,650,620	\$10,352,596	\$11,111,586	\$11,928,574	\$65,751,320
3. Leave Medicaid for New Offer of Employer Coverage								
Population Growth Rate		2.2%	2.4%	2.5%	2.5%	2.6%	2.6%	
Disenrollment	2,419	2,473	2,533	2,597	2,663	2,731	2,801	
Lag Rate	76%	88%	100%	100%	100%	100%	100%	
Lag Rate * Disenrollment	1,849	2,182	2,533	2,597	2,663	2,731	2,801	
PMPY Cost	\$6,550	\$6,841	\$7,146	\$7,464	\$7,793	\$8,139	\$8,503	
Total Savings	\$12,114,354	\$14,926,110	\$18,098,042	\$19,383,122	\$20,749,329	\$22,223,993	\$23,812,934	\$131,307,885
FMAP	50%	50%	50%	50%	50%	50%	50%	
Subtotal - State Savings	\$6,057,177	\$7,463,055	\$9,049,021	\$9,691,561	\$10,374,665	\$11,111,996	\$11,906,467	\$65,653,942
Subtotal - Federal Savings	\$6,057,177	\$7,463,055	\$9,049,021	\$9,691,561	\$10,374,665	\$11,111,996	\$11,906,467	\$65,653,942
4. Total Net Impact								
Change in Enrollment	39,590	46,207	53,098	53,862	54,609	55,466	56,364	
Health Care Costs								
State Cost	\$243,629	-\$53,703	-\$51,236	\$27,078,901	\$34,669,418	\$43,193,525	\$65,903,310	\$170,983,845
Federal Cost	\$359,040,289	\$420,156,235	\$508,341,288	\$515,236,056	\$543,477,885	\$573,861,882	\$592,952,940	\$3,513,066,575
Subtotal	\$359,283,918	\$420,102,532	\$508,290,052	\$542,314,958	\$578,147,303	\$617,055,407	\$658,856,251	\$3,684,050,420
Administrative Costs								
State Share	\$13,139,731	\$15,363,990	\$18,589,184	\$19,833,543	\$21,144,003	\$22,566,950	\$24,095,691	\$134,733,092
Federal Share	\$16,321,550	\$19,084,418	\$23,090,601	\$24,636,284	\$26,264,076	\$28,031,593	\$29,930,522	\$167,359,042
Subtotal	\$29,461,281	\$34,448,408	\$41,679,784	\$44,469,827	\$47,408,079	\$50,598,543	\$54,026,213	\$302,092,134
Total								
State Share	\$13,383,360	\$15,310,287	\$18,537,948	\$46,912,444	\$55,813,421	\$65,760,476	\$89,999,001	\$305,716,937
Federal Share	\$375,361,839	\$439,240,652	\$531,431,889	\$539,872,340	\$569,741,960	\$601,893,475	\$622,883,462	\$3,680,425,617
Total	\$388,745,199	\$454,550,939	\$549,969,837	\$586,784,784	\$625,555,382	\$667,653,950	\$712,882,463	\$3,986,142,555

Figure B-5. Impact on Alaska Medicaid Spending if Medicaid is Expanded under the ACA (2014-2020) - Program Design Option - Delayed Implementation Until January 2015

	2014	2015	2016	2017	2018	2019	2020	Cumulative
1. Cost of Newly Eligibles								
Population growth rate		1.1%	1.4%	1.5%	1.4%	1.6%	1.6%	
Projected Total Number of Newly Eligibles	63,989	64,713	65,619	66,571	67,496	68,560	69,684	
Projected Newly Eligibles Who Enroll	40,284	40,736	41,286	41,853	42,401	43,029	43,687	
Take Up Rate	63%	63%	63%	63%	63%	63%	63%	
Lag Rate	0%	76%	88%	100%	100%	100%	100%	
Lag Rate * Enrollment	-	31,151	36,429	41,853	42,401	43,029	43,687	
PMPY Cost	-	\$9,222	\$9,708	\$10,208	\$10,730	\$11,272	\$11,839	
Total Cost	\$0	\$287,273,005	\$353,635,718	\$427,221,539	\$454,961,724	\$484,997,562	\$517,227,696	\$2,525,317,244
FMAP	-	100%	100%	95%	94%	93%	90%	
Subtotal - State Cost	\$0	\$0	\$0	\$21,361,077	\$27,297,703	\$33,949,829	\$51,722,770	\$134,331,379
Subtotal - Federal Cost	\$0	\$287,273,005	\$353,635,718	\$405,860,462	\$427,664,020	\$451,047,733	\$465,504,926	\$2,390,985,865
2. Cost of Currently Eligible but Not Enrolled								
Population growth rate		-10.2%	2.3%	2.4%	2.4%	2.4%	2.4%	
Currently Eligible but Uninsured - Eligible	11,231	10,081	10,309	10,554	10,807	11,069	11,337	
Currently Eligible but Uninsured - Enrolled	3,172	2,155	2,204	2,257	2,312	2,370	2,429	
Take Up Rate	28%	21%	21%	21%	21%	21%	21%	
Lag Rate	76%	88%	100%	100%	100%	100%	100%	
Lag Rate * Enrollment	2,426	1,902	2,204	2,257	2,312	2,370	2,429	
PMPY Cost	\$8,136	\$7,793	\$8,166	\$8,553	\$8,956	\$9,379	\$9,822	
Total Cost	\$19,738,239	\$14,818,704	\$17,995,571	\$19,301,241	\$20,705,193	\$22,223,171	\$23,857,148	\$138,639,266
FMAP	50%	50%	50%	50%	50%	50%	50%	
Subtotal - State Cost	\$9,869,119	\$7,409,352	\$8,997,785	\$9,650,620	\$10,352,596	\$11,111,586	\$11,928,574	\$69,319,633
Subtotal - Federal Cost	\$9,869,119	\$7,409,352	\$8,997,785	\$9,650,620	\$10,352,596	\$11,111,586	\$11,928,574	\$69,319,633
3. Leave Medicaid for New Offer of Employer Coverage								
Population Growth Rate		2.2%	2.4%	2.5%	2.5%	2.6%	2.6%	
Disenrollment	2,419	2,473	2,533	2,597	2,663	2,731	2,801	
Lag Rate	76%	88%	100%	100%	100%	100%	100%	
Lag Rate * Disenrollment	1,849	2,182	2,533	2,597	2,663	2,731	2,801	
PMPY Cost	\$6,550	\$6,841	\$7,146	\$7,464	\$7,793	\$8,139	\$8,503	
Total Savings	\$12,114,354	\$14,926,110	\$18,098,042	\$19,383,122	\$20,749,329	\$22,223,993	\$23,812,934	\$131,307,885
FMAP	50%	50%	50%	50%	50%	50%	50%	
Subtotal - State Savings	\$6,057,177	\$7,463,055	\$9,049,021	\$9,691,561	\$10,374,665	\$11,111,996	\$11,906,467	\$65,653,942
Subtotal - Federal Savings	\$6,057,177	\$7,463,055	\$9,049,021	\$9,691,561	\$10,374,665	\$11,111,996	\$11,906,467	\$65,653,942
4. Total Net Impact								
Change in Enrollment	577	30,871	36,100	41,513	42,051	42,668	43,316	
Health Care Costs								
State Cost	\$3,811,942	-\$53,703	-\$51,236	\$21,320,136	\$27,275,635	\$33,949,419	\$51,744,876	\$137,997,070
Federal Cost	\$3,811,942	\$287,219,302	\$353,584,482	\$405,819,522	\$427,641,952	\$451,047,322	\$465,527,033	\$2,394,651,556
Subtotal	\$7,623,885	\$287,165,599	\$353,533,246	\$427,139,658	\$454,917,587	\$484,996,741	\$517,271,909	\$2,532,648,626
Administrative Costs								
State Share	\$278,821	\$10,502,220	\$12,929,418	\$15,621,352	\$16,637,246	\$17,737,301	\$18,917,668	\$92,624,026
Federal Share	\$346,338	\$13,045,359	\$16,060,308	\$19,404,100	\$20,665,996	\$22,032,432	\$23,498,628	\$115,053,162
Subtotal	\$625,159	\$23,547,579	\$28,989,726	\$35,025,452	\$37,303,242	\$39,769,733	\$42,416,297	\$207,677,187
Total								
State Share	\$4,090,763	\$10,448,517	\$12,878,182	\$36,941,488	\$43,912,881	\$51,686,719	\$70,662,545	\$230,621,096
Federal Share	\$4,158,280	\$300,264,661	\$369,644,791	\$425,223,622	\$448,307,948	\$473,079,754	\$489,025,661	\$2,509,704,717
Total	\$8,249,043	\$310,713,178	\$382,522,972	\$462,165,110	\$492,220,829	\$524,766,474	\$559,688,206	\$2,740,325,813

Figure B-6. Impact on Alaska Medicaid Spending if Medicaid is Expanded under the ACA (2014-2020) - Program Design Option - Delayed Implementation Until January 2016

	2014	2015	2016	2017	2018	2019	2020	Cumulative
1. Cost of Newly Eligibles								
Population growth rate		1.1%	1.4%	1.5%	1.4%	1.6%	1.6%	
Projected Total Number of Newly Eligibles	63,989	64,713	65,619	66,571	67,496	68,560	69,684	
Projected Newly Eligibles Who Enroll	40,284	40,736	41,286	41,853	42,401	43,029	43,687	
Take Up Rate	63%	63%	63%	63%	63%	63%	63%	
Lag Rate	0%	0%	76%	88%	100%	100%	100%	
Lag Rate * Enrollment	-	-	31,572	36,929	42,401	43,029	43,687	
PMPY Cost	-	-	\$9,708	\$10,208	\$10,730	\$11,272	\$11,839	
Total Cost	\$0	\$0	\$306,484,289	\$376,960,182	\$454,961,724	\$484,997,562	\$517,227,696	\$2,140,631,453
FMAP	-	-	100%	95%	94%	93%	90%	
Subtotal - State Cost	\$0	\$0	\$0	\$18,848,009	\$27,297,703	\$33,949,829	\$51,722,770	\$131,818,311
Subtotal - Federal Cost	\$0	\$0	\$306,484,289	\$358,112,173	\$427,664,020	\$451,047,733	\$465,504,926	\$2,008,813,142
2. Cost of Currently Eligible but Not Enrolled								
Population growth rate		2.0%	-10.1%	2.4%	2.4%	2.4%	2.4%	
Currently Eligible but Uninsured - Eligible	11,231	11,461	10,309	10,554	10,807	11,069	11,337	
Currently Eligible but Uninsured - Enrolled	3,172	3,228	2,204	2,257	2,312	2,370	2,429	
Take Up Rate	28%	28%	21%	21%	21%	21%	21%	
Lag Rate	76%	88%	100%	100%	100%	100%	100%	
Lag Rate * Enrollment	2,426	2,848	2,204	2,257	2,312	2,370	2,429	
PMPY Cost	\$8,136	\$8,146	\$8,166	\$8,553	\$8,956	\$9,379	\$9,822	
Total Cost	\$19,738,239	\$23,202,207	\$17,995,571	\$19,301,241	\$20,705,193	\$22,223,171	\$23,857,148	\$147,022,769
FMAP	50%	50%	50%	50%	50%	50%	50%	
Subtotal - State Cost	\$9,869,119	\$11,601,104	\$8,997,785	\$9,650,620	\$10,352,596	\$11,111,586	\$11,928,574	\$73,511,385
Subtotal - Federal Cost	\$9,869,119	\$11,601,104	\$8,997,785	\$9,650,620	\$10,352,596	\$11,111,586	\$11,928,574	\$73,511,385
3. Leave Medicaid for New Offer of Employer Coverage								
Population Growth Rate		2.2%	2.4%	2.5%	2.5%	2.6%	2.6%	
Disenrollment	2,419	2,473	2,533	2,597	2,663	2,731	2,801	
Lag Rate	76%	88%	100%	100%	100%	100%	100%	
Lag Rate * Disenrollment	1,849	2,182	2,533	2,597	2,663	2,731	2,801	
PMPY Cost	\$6,550	\$6,841	\$7,146	\$7,464	\$7,793	\$8,139	\$8,503	
Total Savings	\$12,114,354	\$14,926,110	\$18,098,042	\$19,383,122	\$20,749,329	\$22,223,993	\$23,812,934	\$131,307,885
FMAP	50%	50%	50%	50%	50%	50%	50%	
Subtotal - State Savings	\$6,057,177	\$7,463,055	\$9,049,021	\$9,691,561	\$10,374,665	\$11,111,996	\$11,906,467	\$65,653,942
Subtotal - Federal Savings	\$6,057,177	\$7,463,055	\$9,049,021	\$9,691,561	\$10,374,665	\$11,111,996	\$11,906,467	\$65,653,942
4. Total Net Impact								
Change in Enrollment	577	667	31,243	36,589	42,051	42,668	43,316	
Health Care Costs								
State Cost	\$3,811,942	\$4,138,049	-\$51,236	\$18,807,069	\$27,275,635	\$33,949,419	\$51,744,876	\$139,675,754
Federal Cost	\$3,811,942	\$4,138,049	\$306,433,053	\$358,071,232	\$427,641,952	\$451,047,322	\$465,527,033	\$2,016,670,584
Subtotal	\$7,623,885	\$8,276,097	\$306,381,817	\$376,878,301	\$454,917,587	\$484,996,741	\$517,271,909	\$2,156,346,338
Administrative Costs								
State Share	\$278,821	\$302,673	\$11,204,996	\$13,783,193	\$16,637,246	\$17,737,301	\$18,917,668	\$78,861,898
Federal Share	\$346,338	\$375,967	\$13,918,313	\$17,120,827	\$20,665,996	\$22,032,432	\$23,498,628	\$97,958,501
Subtotal	\$625,159	\$678,640	\$25,123,309	\$30,904,021	\$37,303,242	\$39,769,733	\$42,416,297	\$176,820,400
Total								
State Share	\$4,090,763	\$4,440,722	\$11,153,760	\$32,590,262	\$43,912,881	\$51,686,719	\$70,662,545	\$218,537,652
Federal Share	\$4,158,280	\$4,514,015	\$320,351,366	\$375,192,060	\$448,307,948	\$473,079,754	\$489,025,661	\$2,114,629,085
Total	\$8,249,043	\$8,954,737	\$331,505,126	\$407,782,321	\$492,220,829	\$524,766,474	\$559,688,206	\$2,333,166,737

Figure B-7. Impact on Alaska Medicaid Spending if Medicaid is Expanded Under the ACA (2014-2020) - Program Design Option - Move current Eligibles Above 138 Percent of FPL to Exchange (Pregnant Women Eligibility Category) + Transition Enrollees Out of Breast and Cervical Cancer Program Eligibility Category

	2014	2015	2016	2017	2018	2019	2020	Cumulative
1. Cost of Newly Eligibles								
Population growth rate		1.1%	1.4%	1.5%	1.4%	1.6%	1.6%	
Projected Total Number of Newly Eligibles	63,989	64,713	65,619	66,571	67,496	68,560	69,684	
Projected Newly Eligibles Who Enroll	40,284	40,736	41,286	41,853	42,401	43,029	43,687	
Take Up Rate	63%	63%	63%	63%	63%	63%	63%	
Lag Rate	76%	88%	100%	100%	100%	100%	100%	
Lag Rate * Enrollment	30,806	35,944	41,286	41,853	42,401	43,029	43,687	
PMPY Cost	\$9,191	\$9,222	\$9,78	\$10,208	\$10,730	\$11,272	\$11,839	
Total Cost	\$283,147,943	\$331,468,851	\$400,787,147	\$427,221,539	\$454,961,724	\$484,997,562	\$517,227,696	\$2,899,812,463
FMAP	100%	100%	100%	95%	94%	93%	90%	
Subtotal - State Cost	\$0	\$0	\$0	\$21,361,077	\$27,297,703	\$33,949,829	\$51,722,770	\$134,331,379
Subtotal - Federal Cost	\$283,147,943	\$331,468,851	\$400,787,147	\$405,860,462	\$427,664,020	\$451,047,733	\$465,504,926	\$2,765,481,084
2. Cost of Currently Eligible but Not Enrolled								
Population growth rate		2.1%	2.3%	2.4%	2.4%	2.4%	2.4%	
Currently Eligible but Uninsured - Eligible	9,869	10,081	10,309	10,554	10,807	11,069	11,337	
Currently Eligible but Uninsured - Enrolled	2,111	2,155	2,204	2,257	2,312	2,370	2,429	
Take Up Rate	21%	21%	21%	21%	21%	21%	21%	
Lag Rate	76%	88%	100%	100%	100%	100%	100%	
Lag Rate * Enrollment	1,614	1,902	2,204	2,257	2,312	2,370	2,429	
PMPY Cost	\$7,807	\$7,793	\$8,166	\$8,553	\$8,956	\$9,379	\$9,822	
Total Cost	\$12,601,611	\$14,818,704	\$17,995,571	\$19,301,241	\$20,705,193	\$22,223,171	\$23,857,148	\$131,502,639
FMAP	50%	50%	50%	50%	50%	50%	50%	
Subtotal - State Cost	\$6,300,806	\$7,409,352	\$8,997,785	\$9,650,620	\$10,352,596	\$11,111,586	\$11,928,574	\$65,751,320
Subtotal - Federal Cost	\$6,300,806	\$7,409,352	\$8,997,785	\$9,650,620	\$10,352,596	\$11,111,586	\$11,928,574	\$65,751,320
3. Leave Medicaid for New Offer of Employer Coverage								
Population Growth Rate		2.2%	2.4%	2.5%	2.5%	2.6%	2.6%	
Disenrollment	2,419	2,473	2,533	2,597	2,663	2,731	2,801	
Lag Rate	76%	88%	100%	100%	100%	100%	100%	
Lag Rate * Disenrollment	1,849	2,182	2,533	2,597	2,663	2,731	2,801	
PMPY Cost	\$6,550	\$6,841	\$7,146	\$7,464	\$7,793	\$8,139	\$8,503	
Total Savings	\$12,114,354	\$14,926,110	\$18,098,042	\$19,383,122	\$20,749,329	\$22,223,993	\$23,812,934	\$131,307,885
FMAP	50%	50%	50%	50%	50%	50%	50%	
Subtotal - State Savings	\$6,057,177	\$7,463,055	\$9,049,021	\$9,691,561	\$10,374,665	\$11,111,996	\$11,906,467	\$65,653,942
Subtotal - Federal Savings	\$6,057,177	\$7,463,055	\$9,049,021	\$9,691,561	\$10,374,665	\$11,111,996	\$11,906,467	\$65,653,942
Other Cost Offsets								
4. Moving Current Eligibles above 138% to HIX								
Pregnant Women								
Enrollees	335	342	349	356	363	370	377	
State costs	-\$3,296,919	-\$3,461,764	-\$3,634,853	-\$3,816,595	-\$4,007,425	-\$4,207,796	-\$4,418,186	-\$26,843,538
Federal costs	-\$3,296,919	-\$3,461,764	-\$3,634,853	-\$3,816,595	-\$4,007,425	-\$4,207,796	-\$4,418,186	-\$26,843,538
Administrative Costs								
State costs	-\$241,150	-\$253,207	-\$265,868	-\$279,161	-\$293,119	-\$307,775	-\$323,164	-\$1,963,444
Federal costs	-\$299,545	-\$314,522	-\$330,248	-\$346,761	-\$364,099	-\$382,304	-\$401,419	-\$2,438,897

	2014	2015	2016	2017	2018	2019	2020	Cumulative
5. Move Current Eligibles to Newly Eligible								
BCCA								
State costs	-\$1,813,143	-\$1,903,800	-\$1,998,990	-\$1,889,045	-\$1,939,420	-\$1,990,109	-\$1,943,827	-\$13,478,333
Federal costs	\$1,813,143	\$1,903,800	\$1,998,990	\$1,889,045	\$1,939,420	\$1,990,109	\$1,943,827	\$13,478,333
6. Total Net Impact								
Change in Enrollment	30,235	35,322	40,609	41,157	41,688	42,298	42,938	
Health Care Costs								
State Cost	-\$4,866,432	-\$5,419,267	-\$5,685,078	\$15,614,496	\$21,328,790	\$27,751,513	\$45,382,863	\$94,106,885
Federal Cost	\$281,907,796	\$329,857,184	\$399,100,048	\$403,891,972	\$425,573,947	\$448,829,635	\$463,052,675	\$2,752,213,256
Subtotal	\$277,041,364	\$324,437,917	\$393,414,970	\$419,506,468	\$446,902,737	\$476,581,148	\$508,435,537	\$2,846,320,141
Administrative Costs								
State Share	\$10,131,957	\$11,865,343	\$14,387,972	\$15,342,191	\$16,344,127	\$17,429,526	\$18,594,504	\$104,095,620
Federal Share	\$12,585,435	\$14,738,566	\$17,872,055	\$19,057,340	\$20,301,898	\$21,650,128	\$23,097,210	\$129,302,631
Subtotal	\$22,717,392	\$26,603,909	\$32,260,028	\$34,399,530	\$36,646,024	\$39,079,654	\$41,691,714	\$233,398,252
Total								
State Share	\$5,265,525	\$6,446,077	\$8,702,894	\$30,956,687	\$37,672,917	\$45,181,039	\$63,977,367	\$198,202,505
Federal Share	\$294,493,231	\$344,595,749	\$416,972,103	\$422,949,312	\$445,875,844	\$470,479,764	\$486,149,884	\$2,881,515,887
Total	\$299,758,756	\$351,041,826	\$425,674,998	\$453,905,998	\$483,548,761	\$515,660,803	\$550,127,251	\$3,079,718,393



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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

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.



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.

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

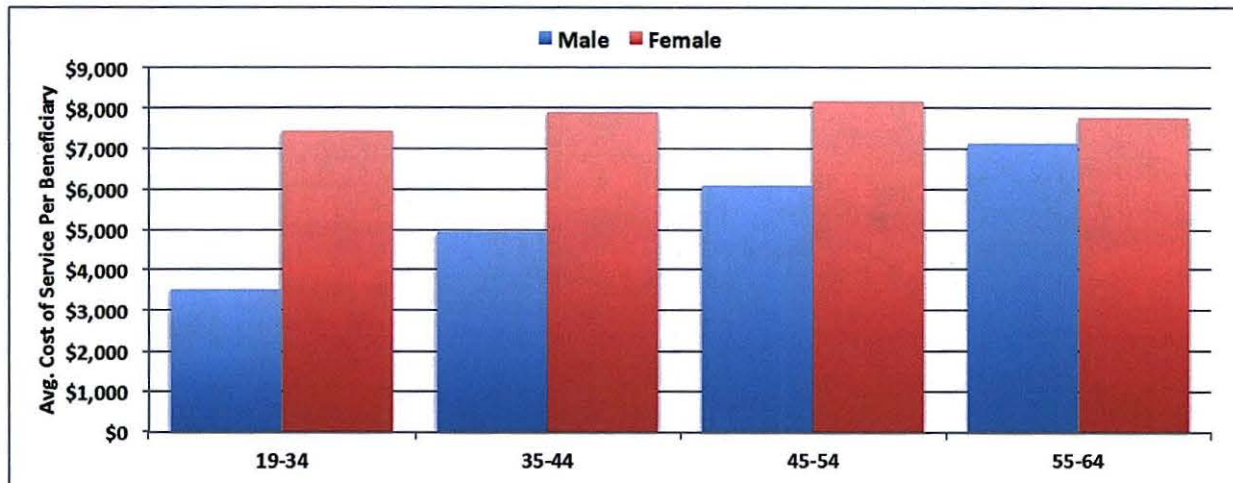
⁸ ADLWD uses a cohort component technique to "age" over time sub-populations based on gender and age. The demographers then add in projected births and in-migrants and subtract out projected deaths and out-migrants. ADLWD expects the working-age population to grow by 14 percent between 2012 and 2042, 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. Row 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 $41,910 \times 47.9\% = 20,066$ 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.

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 <u>Physical</u> 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 <u>Mental</u> 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



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House Health & Social Services Committee

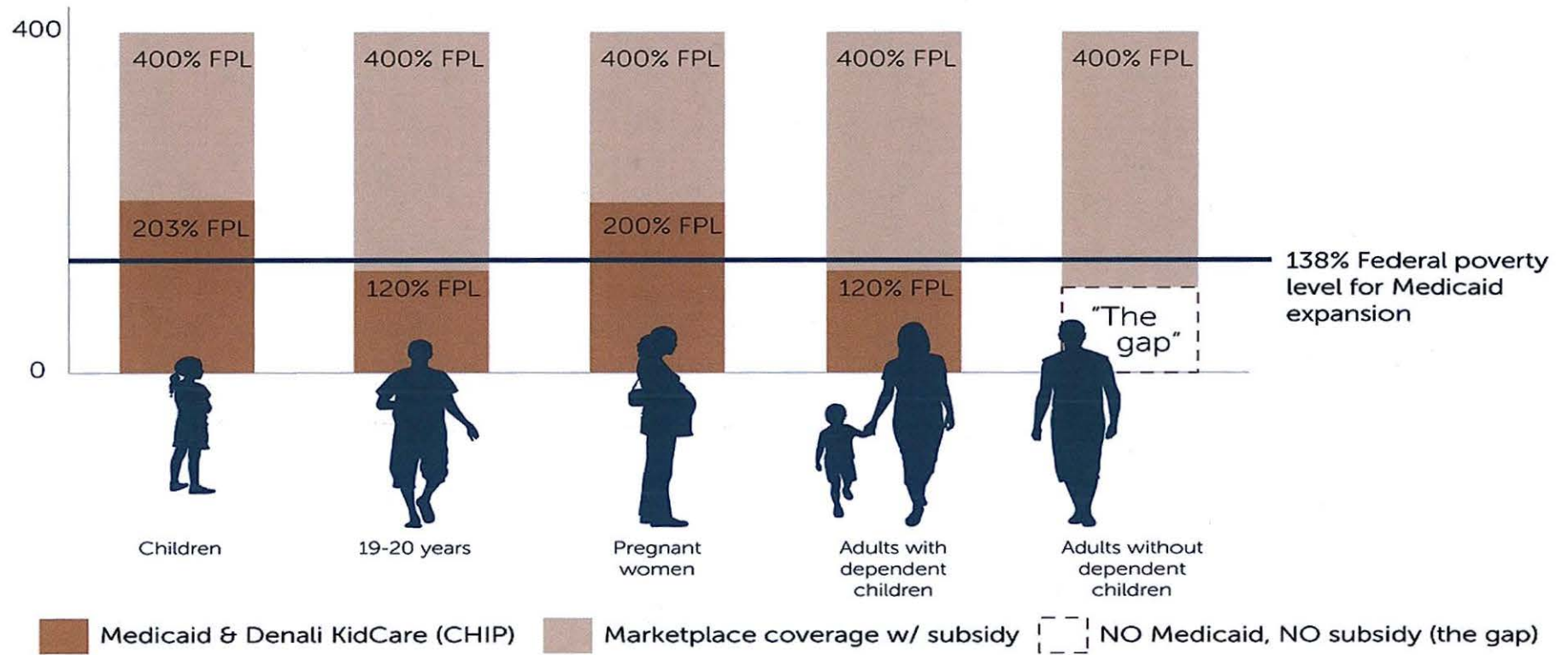
Healthy Alaska Plan

Valerie Davidson, Commissioner

March 5, 2015

Healthy Alaskans

Who is covered now?



Medicaid Expansion

- Higher Federal Match

	2014	2015	2016	2017	2018	2019	2020 & Beyond
Federal match under expansion	100%	100%	100%	95%	94%	93%	90%

- Reducing Uncompensated Care
 - Reducing the number of uninsured
 - More than \$90 Million in 2013
- Saves the State money



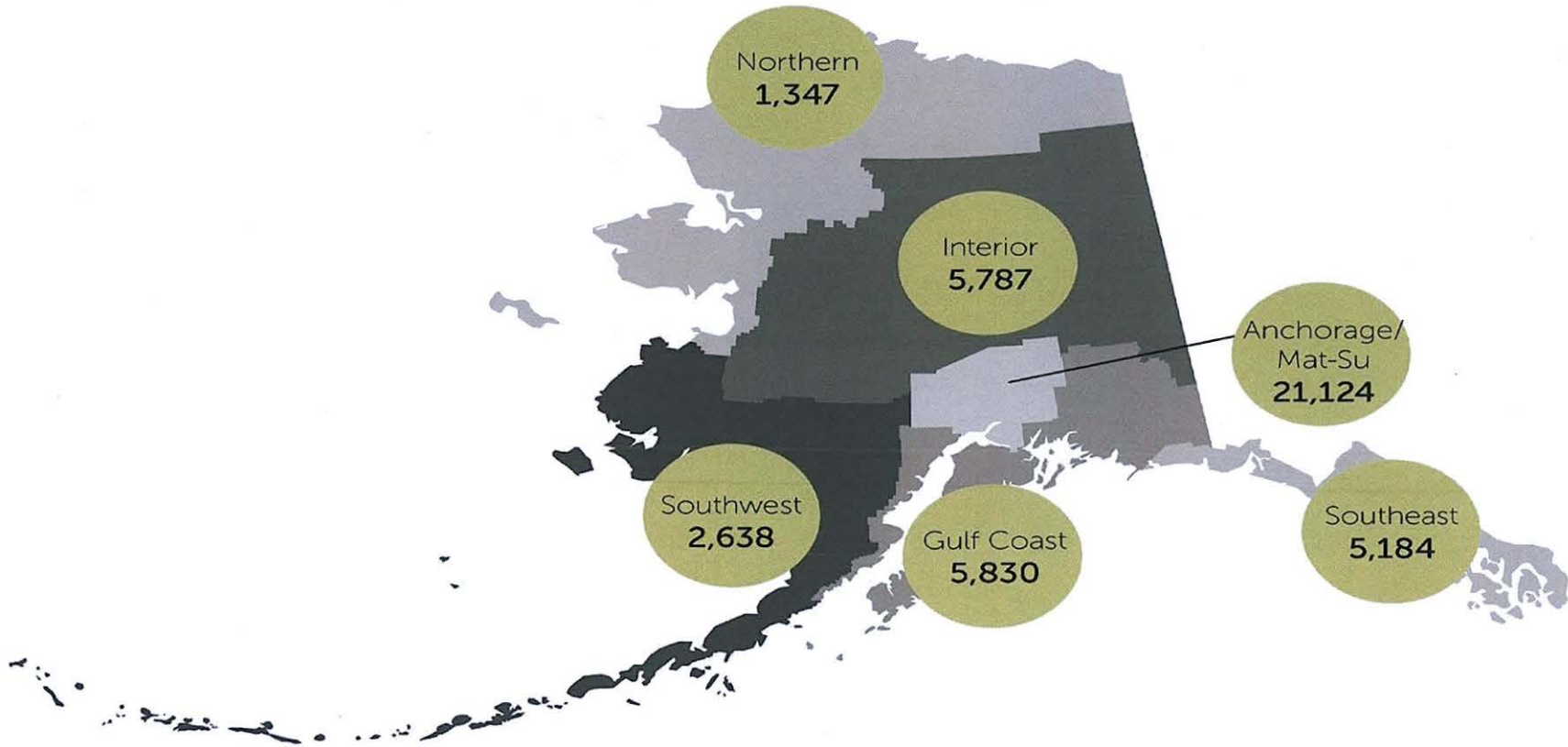
Healthy Alaskans

Who would be covered by Expansion?

- Adults without dependent children
- Ages 19 – 64
 - Not otherwise eligible for Medicaid or Medicare
- Earning up to 138% of the Federal Poverty Level (FPL)
 - Single adults earning up to \$20,314 per year
 - Married couples earning up to \$27,490 per year



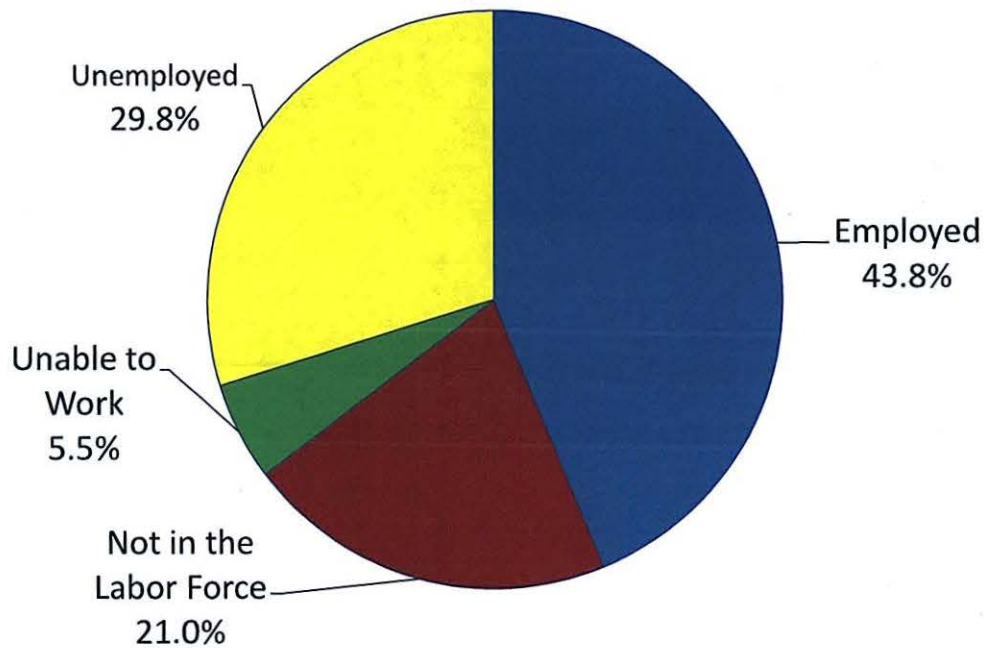
Healthy Alaskans Where are they?



Healthy Alaskans

The Expansion Population

**Employment Status of Alaska's
Medicaid Expansion Population**



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 healthcare services provided by tribal health facilities and possibly other sources.



Healthy Alaskans

How many will sign up?

	2016	2017	2018	2019	2020	2021
Newly Eligible Adults	41,910	41,980	42,050	42,120	42,190	42,260
Take-up Rate	47.90%	55.40%	63%	63%	63%	63%
New Enrollees	20,066	23,273	26,492	26,535	26,580	26,623



Healthy Alaskans Cost Per Enrollee

- Projected Cost of Service Per Newly Eligible Medicaid Enrollee

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

- Weighted by Expected Gender and Age Distribution of the Expansion Population

Gender	Ages 19-34	Ages 35-44	Ages 45-54	Ages 55-64	All Ages
Male	20.10%	5.20%	13.60%	14.40%	54%
Female	12.60%	5.80%	13.80%	14.50%	46%
Total	32.70%	11.00%	27.40%	28.90%	100%



Healthy Alaskans

Reducing Recidivism

2015 Recidivism Reduction Plan

http://www.legis.state.ak.us/basis/get_documents.asp?session=29&docid=1372

- Convicted felons who completed a DOC substance program:
 - 12% recidivated compared to the control group in which 20% recidivated within 12 months of being released
- Institute of Social and Economic Research (ISER) report:
 - With no change in policies, the number of Alaska inmates is likely to double by 2030
 - From 5,300 to 10,500
 - With an additional \$4 million a year to expand the education and substance abuse programs, the prison population in 2030 would be 10% smaller than projected
 - About 1,050 fewer inmates
- Continued access to substance abuse programs following release is key



Healthy Alaskans
Improving Health

Access to health care means improved health outcomes and increased productivity and independence

- The number of uninsured Alaskans would be reduced by half
- More Alaskans would receive preventative and primary care, including behavioral health services and help in managing costly chronic diseases
- Alaska's statewide mortality rate would drop
- Health care access for survivors of domestic violence and sexual assault
- Access to health care is already showing a positive difference for the homeless population in other states
 - Improving capability to gain employment



Healthy Economy
New Federal Dollars

- Higher Federal Contribution under Expansion

	2014	2015	2016	2017	2018	2019	2020 & Beyond
Federal match under expansion	100%	100%	100%	95%	94%	93%	90%

- \$1.12B in new federal revenue

	2016	2017	2018	2019	2020	2021
Federal Match*	\$145,435.0	\$170,633.0	\$195,514.0	\$200,683.0	\$204,087.0	\$204,928.0

* Costs in Thousands of Dollars



Healthy Budgets Saves Money

- Costs to the State

	2016	2017	2018	2019	2020	2021
State Match for Health Care Costs	\$0	\$3,804.0	\$9,854.0	\$12,064.0	\$16,346.0	\$19,587.0
Administrative Costs for Expansion <small>(State General Fund)</small>	\$0*	\$1,392.0	\$1,478.0	\$1,499.0	\$1,600.0	\$1,625.0
State Costs:	\$0	\$5,196.0	\$11,332.0	\$13,563.0	\$17,946.0	\$21,212.0

* FY16 Administrative Cost is being funded by the Alaska Mental Health Trust Authority

Costs in thousands



Healthy Budgets Saves Money

- Offsets to the State Budget

	2016	2017	2018	2019	2020	2021
Chronic & Acute Medical Assistance (CAMA)	\$1,000.0	\$1,300.0	\$1,400.0	\$1,500.0	\$1,500.0	\$1,500.0
Corrections	\$4,100.0	\$7,000.0	\$7,000.0	\$7,000.0	\$7,000.0	\$7,000.0
Behavioral Health Grants	\$1,500.0	\$5,000.0	\$9,000.0	\$13,000.0	\$16,000.0	\$16,000.0
State Offsets:	\$6,600.0	\$13,300.0	\$17,400.0	\$21,500.0	\$24,500.0	\$24,500.0

Costs in thousands



Healthy Budgets Saves Money

		2016	2017	2018	2019	2020	2021
C O S T S	State Match for Health Care Costs	\$0	\$3,804.0	\$9,854.0	\$12,064.0	\$16,346.0	\$19,587.0
	Administrative Costs for Expansion (State General Fund)	\$0*	\$1,392.0	\$1,478.0	\$1,499.0	\$1,600.0	\$1,625.0
State Costs:		\$0	\$5,196.0	\$11,332.0	\$13,563.0	\$17,946.0	\$21,212.0
O F F S E T S	Chronic & Acute Medical Assistance (CAMA)	\$1,000.0	\$1,300.0	\$1,400.0	\$1,500.0	\$1,500.0	\$1,500.0
	Corrections	\$4,100.0	\$7,000.0	\$7,000.0	\$7,000.0	\$7,000.0	\$7,000.0
	Behavioral Health Grants	\$1,500.0	\$5,000.0	\$9,000.0	\$13,000.0	\$16,000.0	\$16,000.0
State Offsets		\$6,600.0	\$13,300.0	\$17,400.0	\$21,500.0	\$24,500.0	\$24,500.0
Net Savings to State GF		(\$6,600.0)	(\$8,104.0)	(\$6,068.0)	(\$7,937.0)	(\$6,554.0)	(\$3,288.0)
Federal Match		\$145,435.0	\$170,633.0	\$195,514.0	\$200,683.0	\$204,087.0	\$204,928.0

* FY16 Administrative Cost is being funded by the Alaska Mental Health Trust Authority



Reform is Necessary

Reform is necessary

- State of the Budget Address
 - Identify 25% cuts over the next several years
- Minimize the impact to those we serve
- Efficiencies, Improvements and Innovations are critical to bend the cost curve

DHSS Budget = \$2.7B

- Medicaid = \$1.7B

The current Medicaid program is not sustainable



Catalyst for Reform

Building on Reforms Underway

- Control overutilization of hospital emergency room services
- Increased fraud and abuse prevention and control efforts
- Activities to reduce waste
- Home and community-based service improvements
- Coordination with Patient-Centered Medical Home initiatives
- Coordination with the Alaska tribal health system
- Investigating waiver options



Catalyst for Reform
Additional Reforms

Recently identified reforms:

- Continued partnership with Tribal Health
- Change eligibility for Personal Care Assistance (PCA) services
- Possible savings in Durable Medical Equipment, Vision, and Hearing
- Increase number in the Super Utilizer contract for management of care
- Dental
- Implement utilization control for Behavioral Health services
- Transportation



Catalyst for Reform

Designing Reform

- Funding from the Alaska Mental Health Trust Authority
 - March 18, 2015: Deadline for Proposal Submission
 - <https://aws.state.ak.us/OnlinePublicNotices/Notices/View.aspx?id=175783>
- Technical Assistance for Reform
 - Building an Alaskan Model
 - Current Program
 - Expansion
 - Reform efforts/Best practices in other states
 - Stakeholder process
 - Identifying the approval process
 - Regulation, Statutory, Budgetary, State Plan Amendments, waivers



Catalyst for Reform

Additional Reform Options

Building blocks to achieving meaningful reform

- Payment Reform
- Strengthened Primary Care
- Care Management
- Workforce Innovation
- Maximizing federal matching fund opportunities
- Improved Telehealth Capability



Catalyst for Reform


Additional Reform Options

Reform strategies for increasing prevention and shared responsibility

- Cost-sharing options
- Health Savings Accounts (HSAs)
- Services to direct patients to the appropriate level of care
- Incentives for healthy behaviors
- Increased access to preventative services
- Work assistance benefits for the expansion group



Healthy Economy Impact to the Economy



nearly 42,000
uninsured
ALASKANS
eligible for basic health
care coverage*



\$1.1
BILLION
in new federal
revenue for Alaska*



4,000
new
JOBS**



\$1.2
BILLION
more in wages
and salaries
paid to Alaskans**



Questions?

Thank You





VISION
ALASKA INDIVIDUALS, FAMILIES AND COMMUNITIES ARE SAFE AND HEALTHY
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TO PROMOTE AND PROTECT THE HEALTH AND WELL-BEING OF ALASKANS

House Finance Budget Subcommittee | FY2016 Division Overview

Margaret Brodie | Director
Jon Sherwood | Deputy Commissioner

Medicaid 101

March 19, 2015

Medicaid Services Overview

- **Medicaid Goals:**
 - Integrate and coordinate services
 - Strategically leverage technology
 - Implement sound policy
 - Practice fiscal responsibility
 - Measure and improve performance

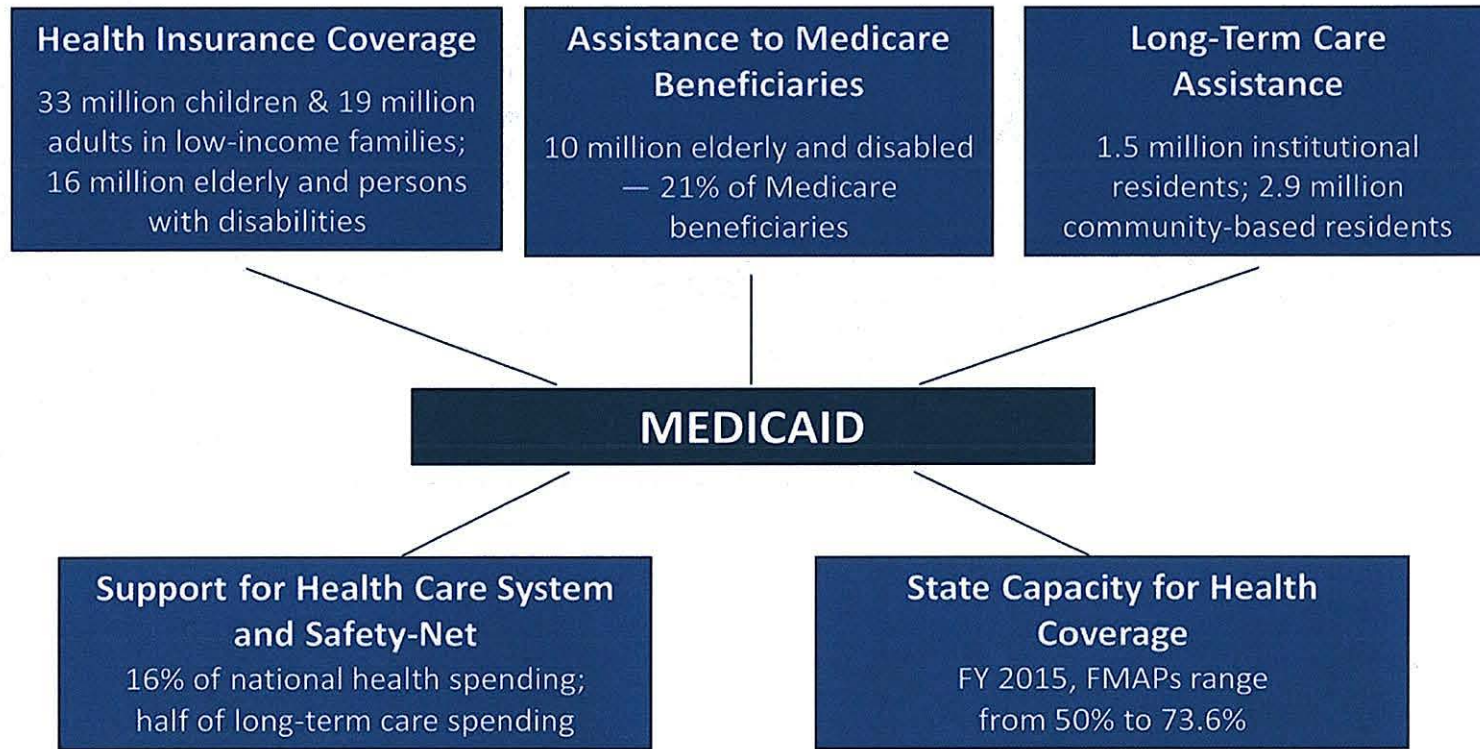


Medicaid Services Overview

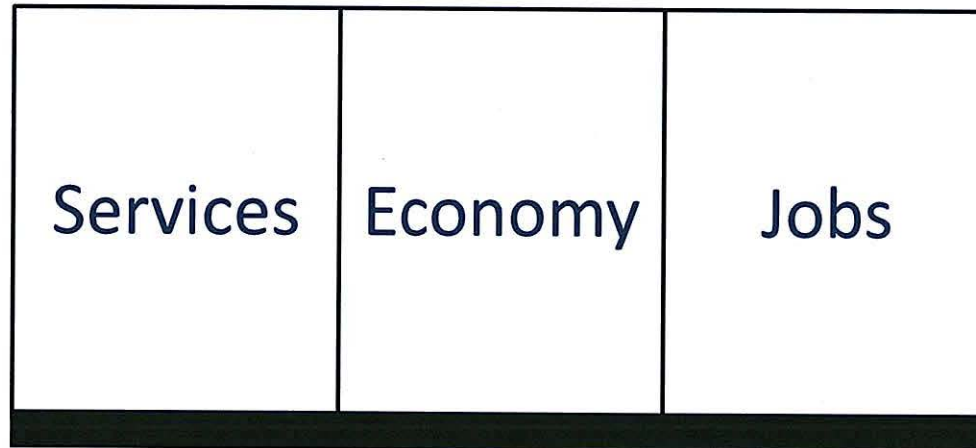
- Medicaid started in 1965
- Each State runs their program differently
- Medicaid provides insurance to more than 80 million people
- Alaska had 158,853 enrolled in 2014
 - 138,300 utilized services



The Role of Medicaid



Medicaid is an Integral Health Care Component



Services

- The Medicaid program supports providers
 - Is one of many payers in the system
- Serves as a safety net for individuals, children and elders who would otherwise be uninsured



Economy

- Medicaid is the primary payer for:
 - Long term care services
 - Behavioral Health Services
 - Anti-psychotic Medications
- Health Care Expenditures in Alaska were \$7.5 billion in the last census.
 - Medicaid was about 18%

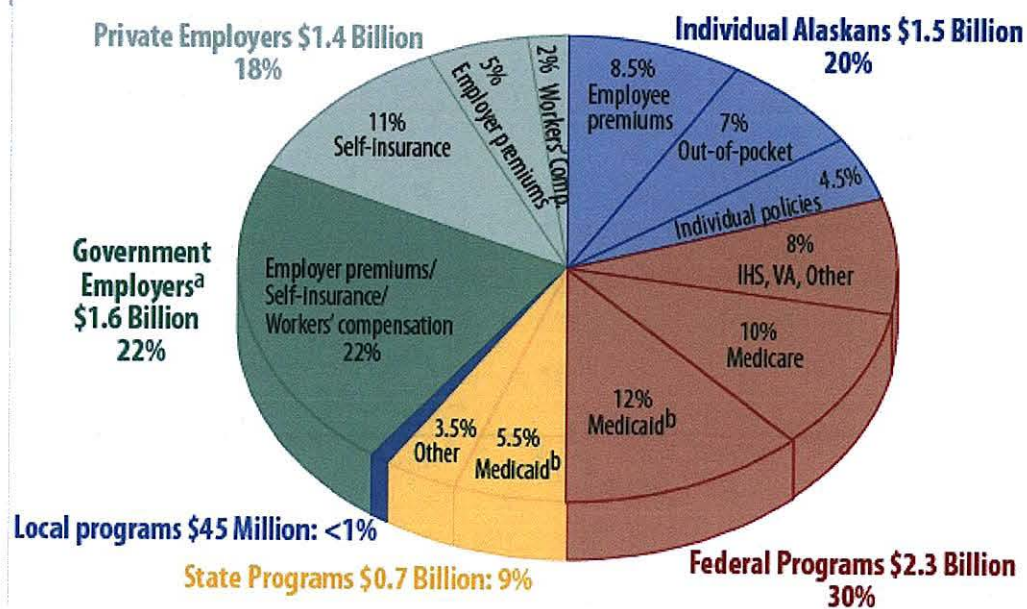


Jobs

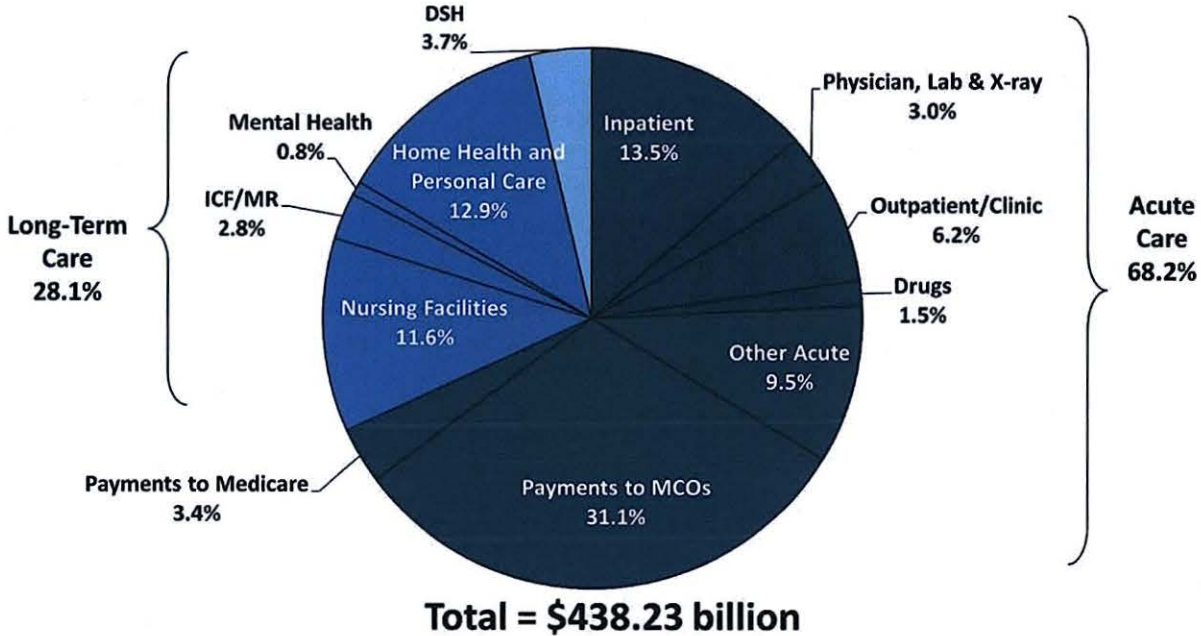
- 34,100 Health care jobs in Alaska in 2014



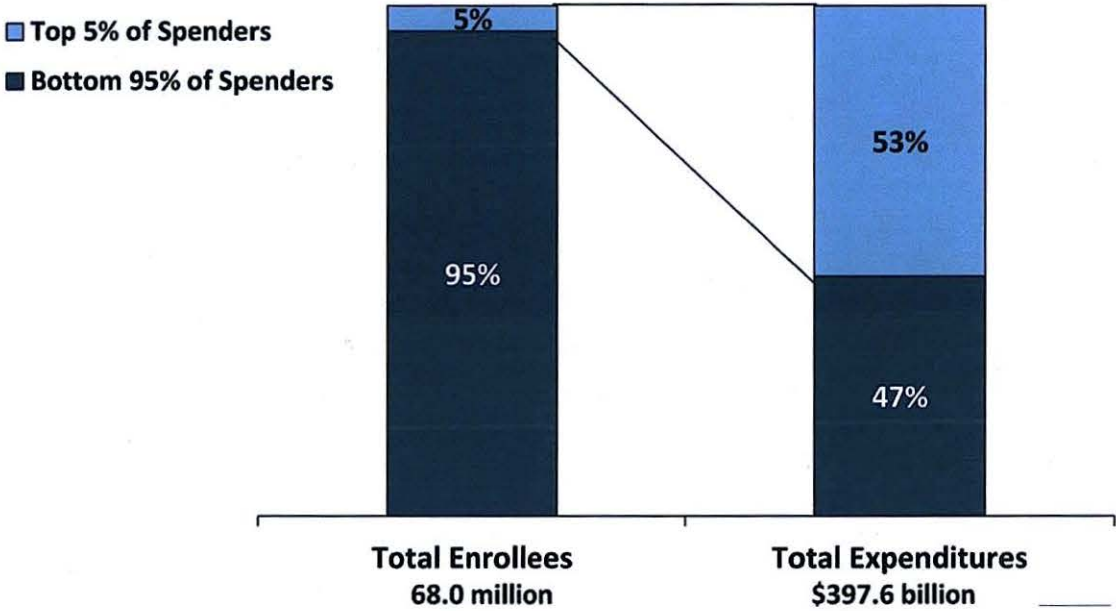
Who Pays for Health Care in Alaska?



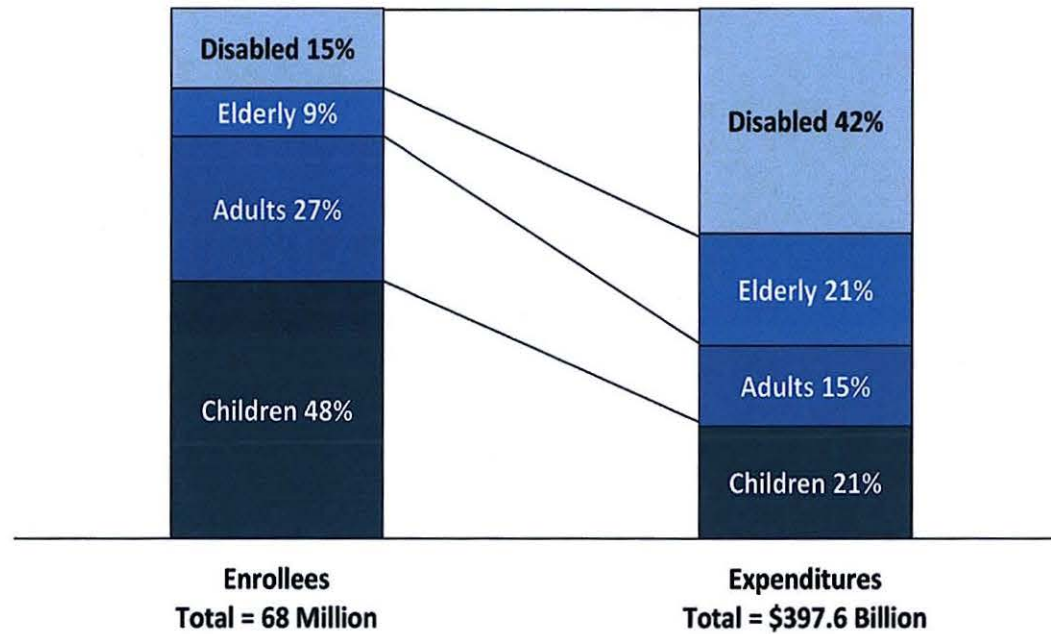
Medicaid Expenditures by Service FY 2013



Top 5% of Enrollees Account for More than Half of Medicaid Spending



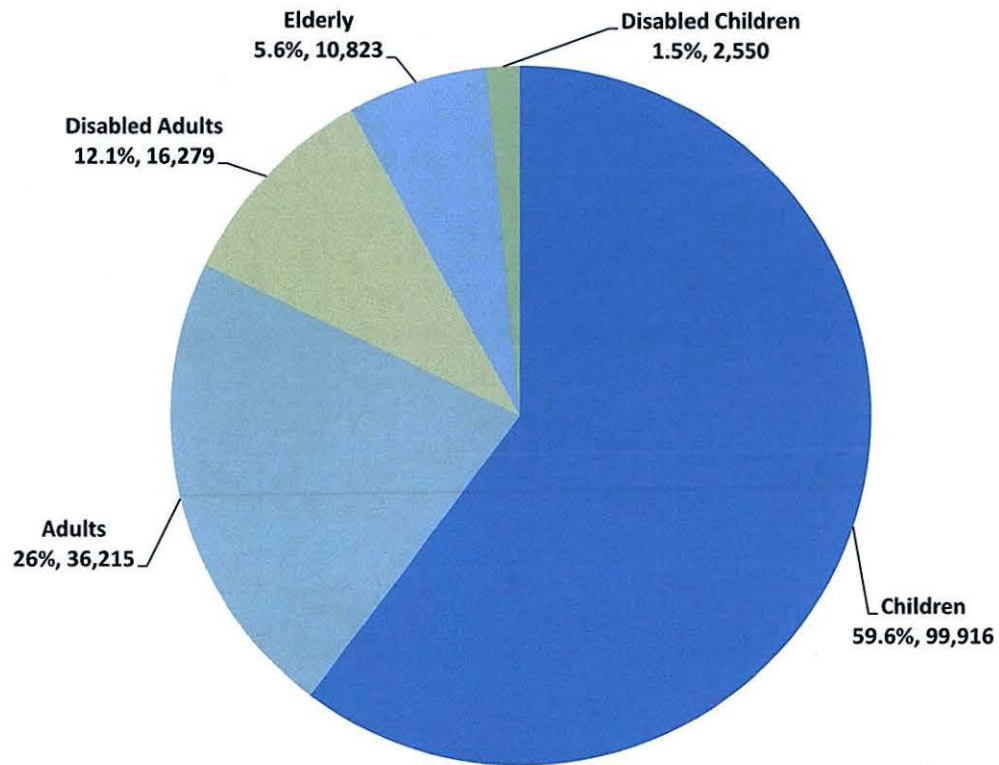
Medicaid Enrollees and Expenditures



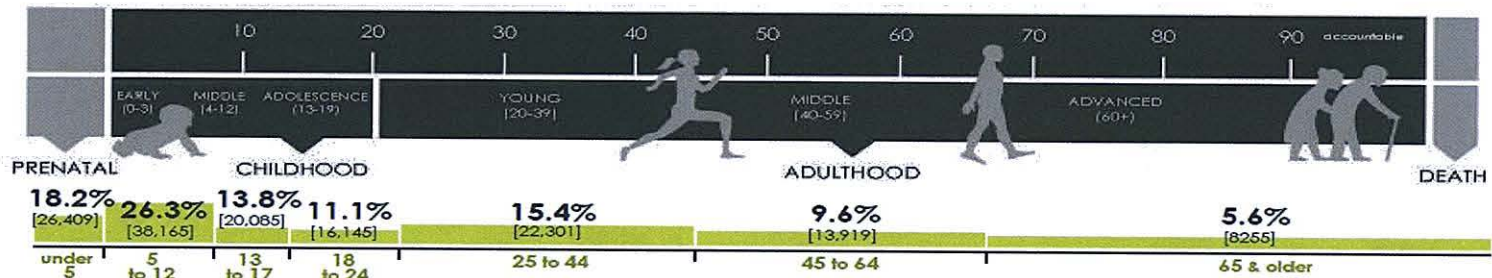
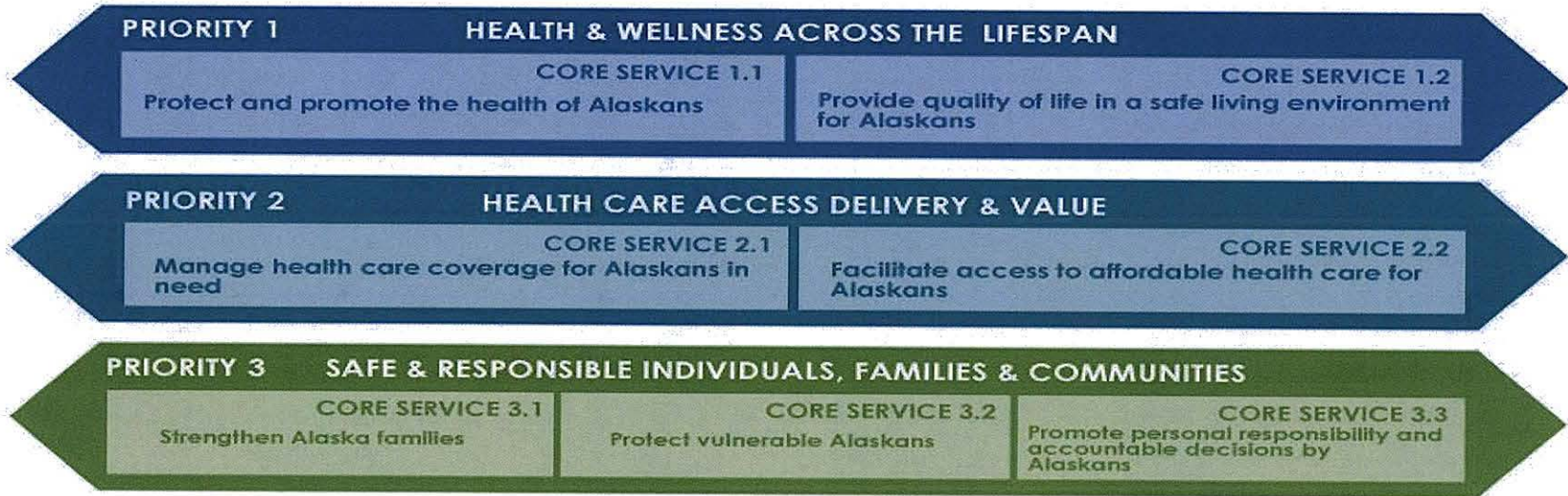
SOURCE: KCMU/Urban Institute estimates based on data from FY 2011 MSIS and CMS-64. MSIS FY 2010 data were used for FL, KS, ME, MD, MT, NM, NJ, TX, UT, OK but adjusted to 2011 spending levels.



FY2014 Total Medicaid Recipients

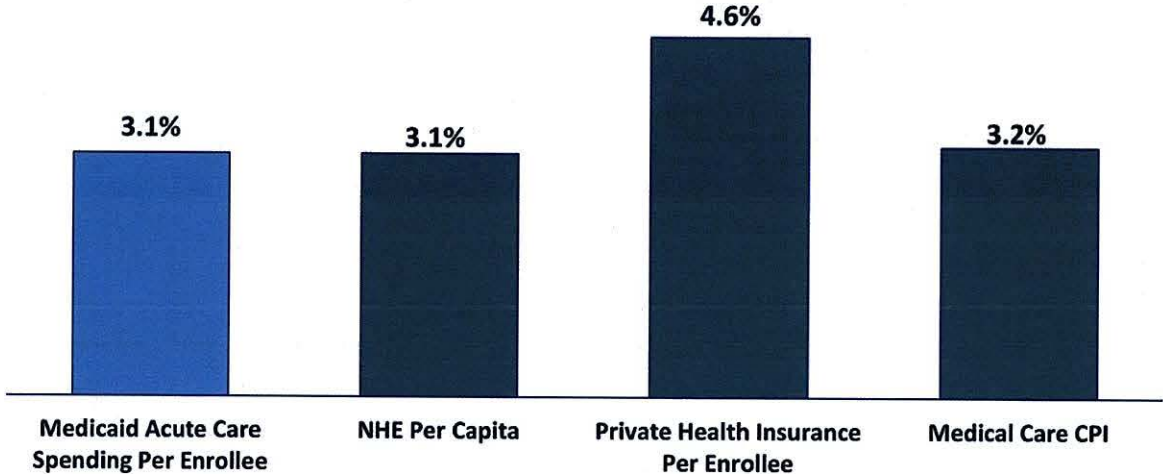


Medicaid Service Population



Growth in Per-Enrollee Medicaid Spending vs. Other Health Spending

Average Annual Growth Rate, FY 2007-2012:

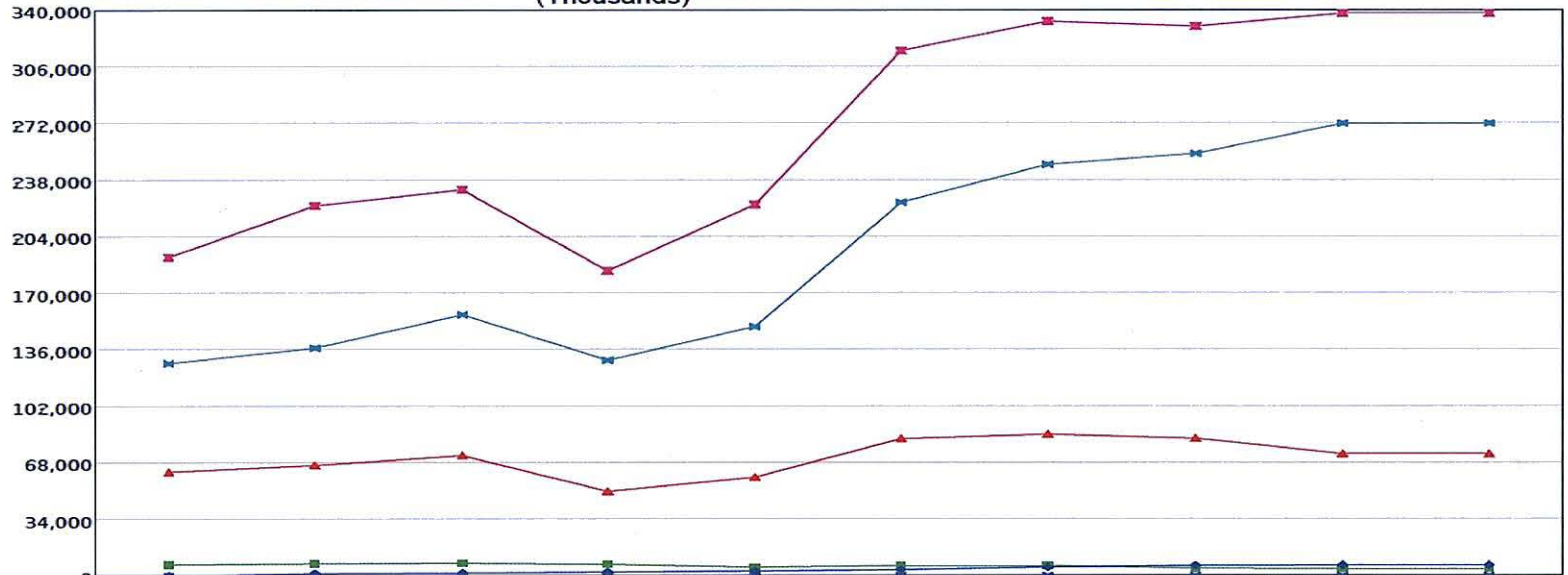


Allocation Summary 2007-2016

Multi-year Allocation Summary - Operating Budget - FY 2016 Governor Structure
 Department of Health and Social Services
 Medicaid Services Appropriation
 (Thousands)

Numbers and Language
 Fund Groups: General Funds

Provided by:
 Legislative
 Finance
 Division



	07MgtPln	08MgtPln	09MgtPln	10MgtPln	11MgtPln	12MgtPln	13MgtPln	14MgtPln	15MgtPln	16Gov
Behavioral Health Medicaid Svc	62,654.3	66,679.5	72,575.8	51,040.9	59,444.0	82,579.6	85,141.7	82,765.0	73,525.1	73,525.1
Children's Medicaid Services	7,080.6	7,570.6	7,926.2	7,139.0	5,396.5	6,308.1	6,308.1	4,659.4	4,410.7	4,410.7
Adult Prev Dental Medicaid Svc	219.7	1,543.1	1,877.0	2,416.8	2,981.7	3,804.1	5,390.2	6,377.1	6,547.2	6,547.2
Health Care Medicaid Services	191,830.7	222,805.0	232,494.1	183,688.4	223,385.2	315,890.8	333,513.3	330,549.4	338,265.2	338,265.2
Senior/Disabilities Medicaid	127,991.6	137,245.9	157,271.7	129,770.1	149,998.9	224,679.2	247,470.5	253,955.4	272,081.5	272,081.5
Unallocated Reduction	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	389,776.9	435,844.1	472,144.8	374,055.2	441,206.3	633,261.8	677,823.8	678,306.3	694,829.7	694,829.7



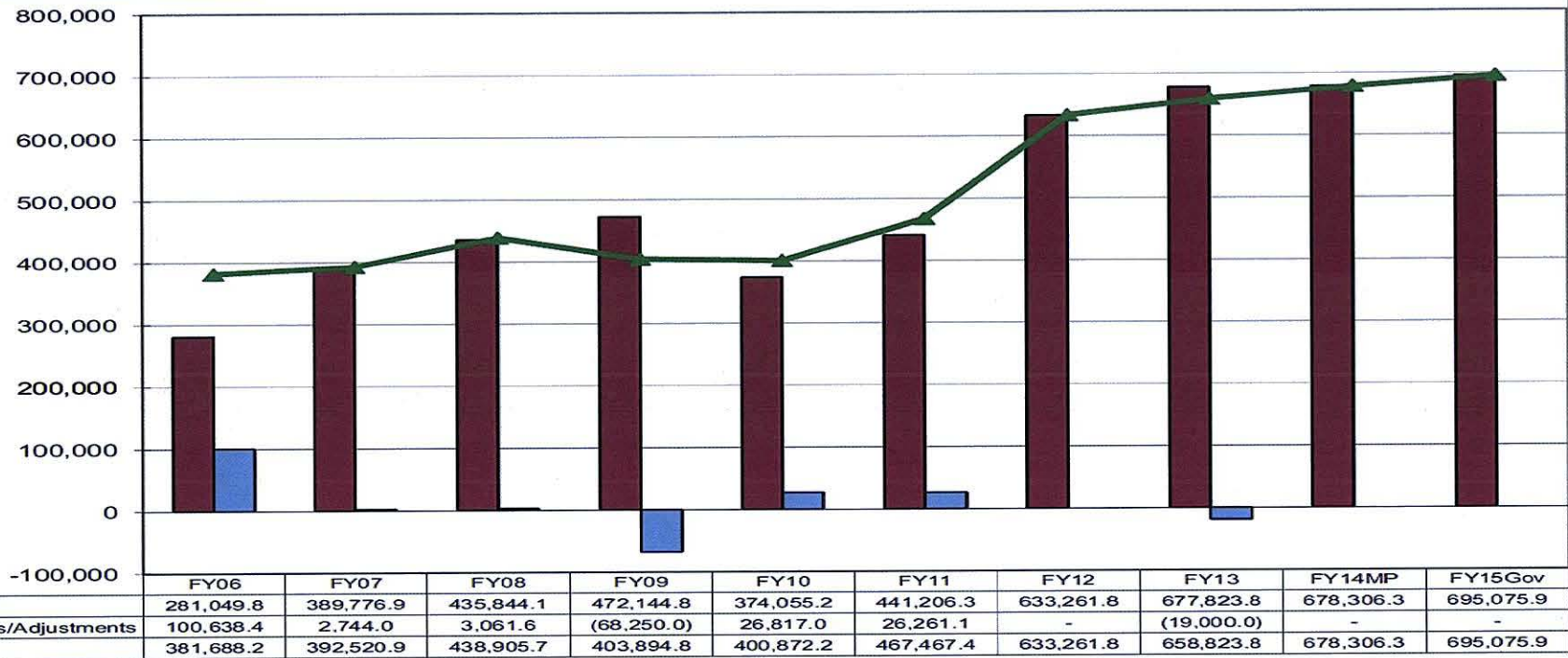
General Fund 2006-2015

Medicaid GF has grown by \$313.4 million (82%) between the FY06 Final Budget and the FY15 Budget. Of this increase:

- \$134.8 million is attributable to FairShare/ProShare
- \$75.2 million is attributable to FMAP changes
- \$32.5 million is attributable to Rate Rebasing

TOTAL MEDICAID FORMULA APPROPRIATIONS (GF ONLY) (\$ Thousands)

Provided by:
Legislative
Finance
Division



Controlling Growth in Medicaid

The Options are Limited

•Eligibility	•Compliance/Anti-Fraud
•Covered Services	•Innovations in Service Delivery
•Rates	•Technology
•Utilization Controls	•Maximize Revenue



Covered Services

- Optional Benefits, *but not really*
- Limits on benefits?
- Considerations
 - Shifting bulge
 - Medicaid rules, Olmstead and other implications
 - CMS approval process
 - Access and quality impacts



Mandatory VS Optional Services

Mandatory

- Inpatient hospital
- Outpatient hospital
- Physicians
- Nurse midwives
- Lab and X-ray
- Advanced Nurse Practitioners
- Early Periodic Screening, Diagnosis, and Treatment
- Family planning services
- Pregnancy-related services
- Nursing facility (NF) services
- Home Health (NF qualified)
- Medical/surgical dental services

Optional

- MH Rehab/Stabilization
- Diagnostic/Screening/Preventive
- Therapies (OP, PT, SLP)
- Inpatient psychiatry <21 years
- Drugs
- Intermediate Care Facility/ Intellectual Disability
- Personal care
- Dental
- Other home health
- Other licensed practitioners
- Transportation
- Targeted Case Management



Rates

- Most common reduction by states
- Considerations
 - Reducing rates in one area may cause cost increases in another
 - Potential litigation
 - CMS approval of State Plan Amendment (SPA)
 - Impact on access and quality of care

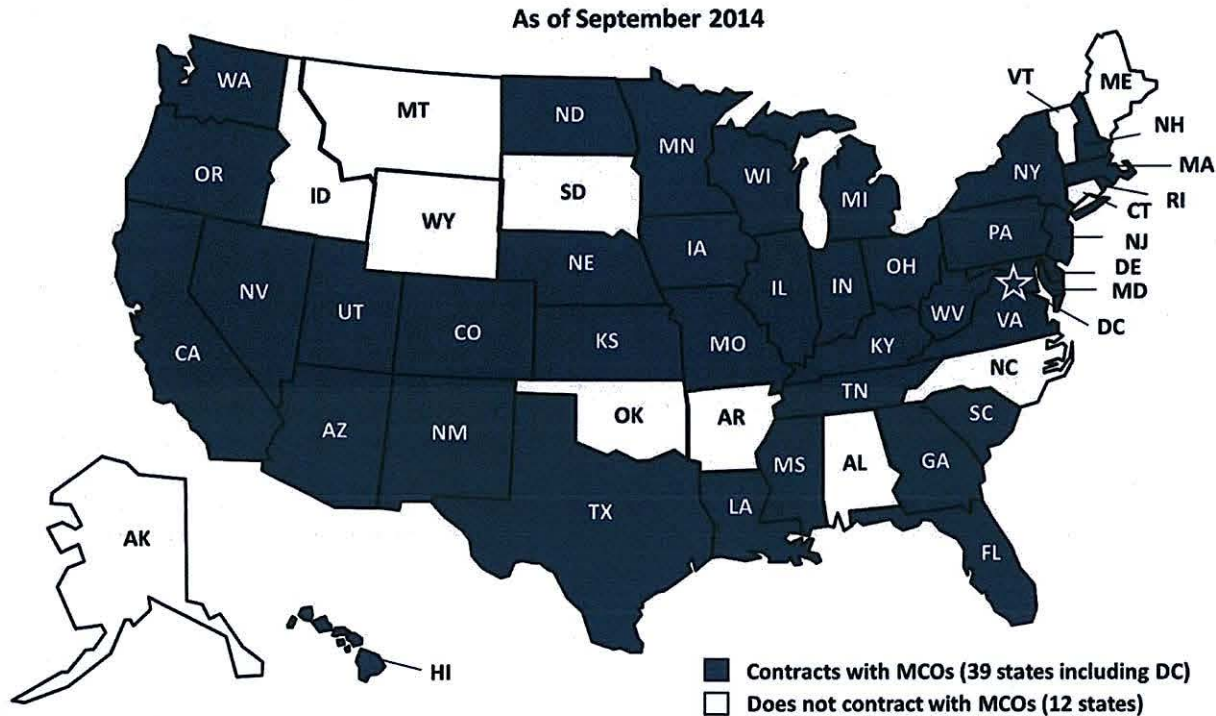


Utilization Controls

- States may impose utilization controls to ensure appropriateness of treatment being funded
- Wide range of controls and screens
 - Prior Authorization
 - Post payment reviews
 - Hard or soft edits
 - Bundling, unbundling, and order of billing
 - New edits and audits for FFS (fee-for-service)



States that Contract with Managed Care Organizations (MCOs)



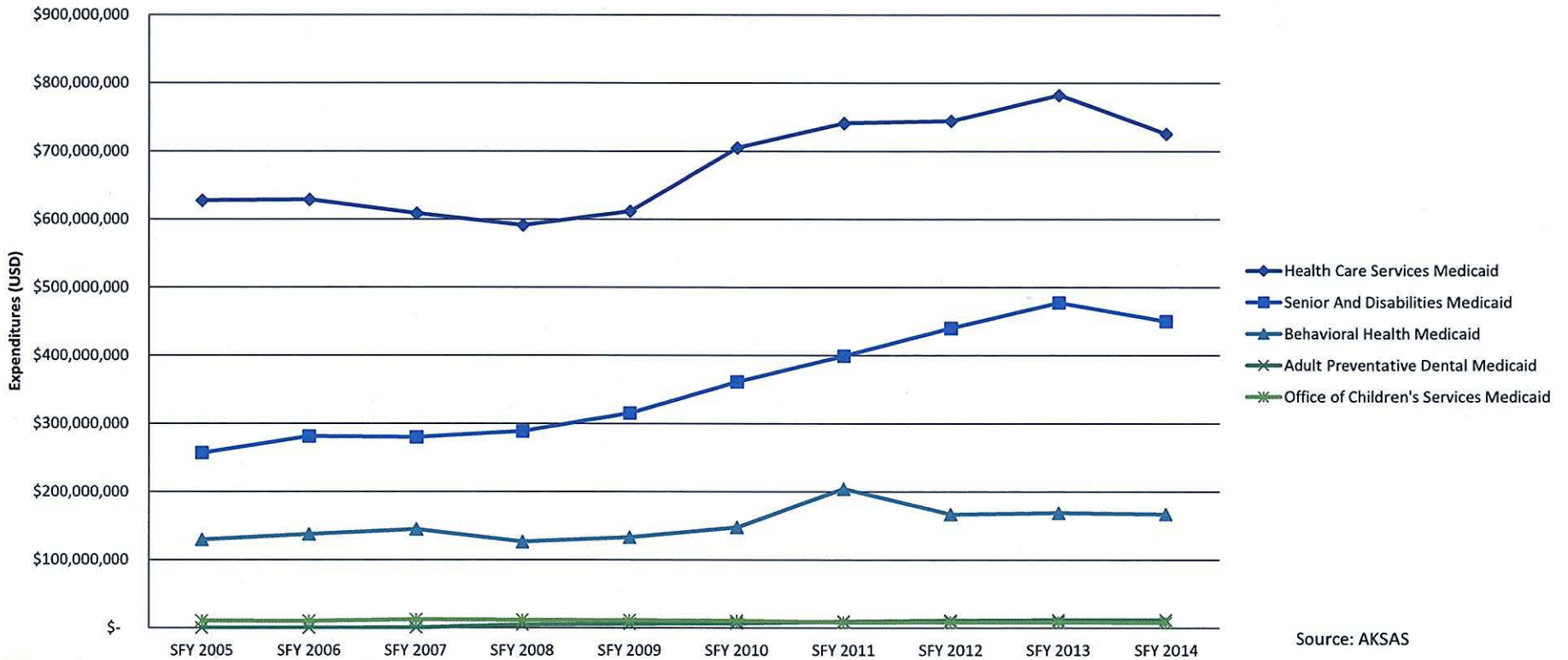
Compliance/Anti-Fraud

- In some states may be an untapped area for savings
- Fraud in Medicaid is a reality
- Numerous methods and vendors
- Fraud undermines the entire program
- Politically popular reduction



FY 2005-2014 Medicaid Expenditures by Division

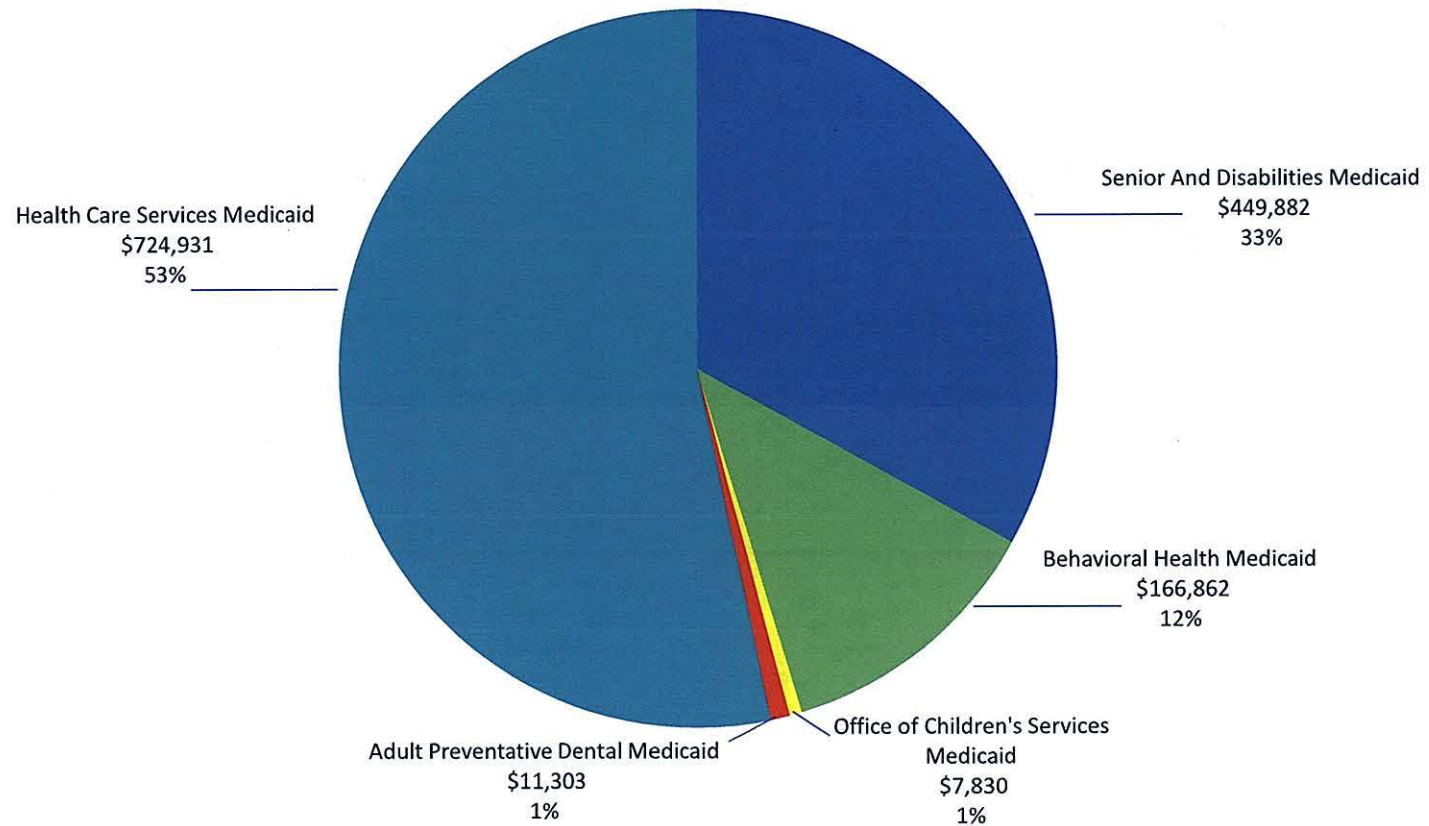
FY 2005-2014 Medicaid Direct Services Expenditures by Division



Source: AKSAS



FY 2014 Medicaid Expenditures by Division



Source: AKSAS



Services Requiring Prior Authorization to Contain Costs

- Travel
- Hospital
- High Cost Imaging
- Adult Dental
- Waiver Services
- Behavioral Health



Other Savings

- Including Rendering Providers on Claims
- Listing Referring, Ordering, and Prescribing Providers on Claims
- Meeting National Correct Coding Initiative Standards
- Auditing Providers
- Partnering with Tribes



Additional Savings

- Commercial Insurance Recoupment
- Substitution to Generic Medication
- Using ClaimCheck
- Collecting Negative Balances
- Surveillance and Utilization Reviews
- Quality Assurance sections



Independent Review

- Pain Management Contract
- Psychotropic Medication Review for Children in OCS/DJJ Custody and those on Medicaid

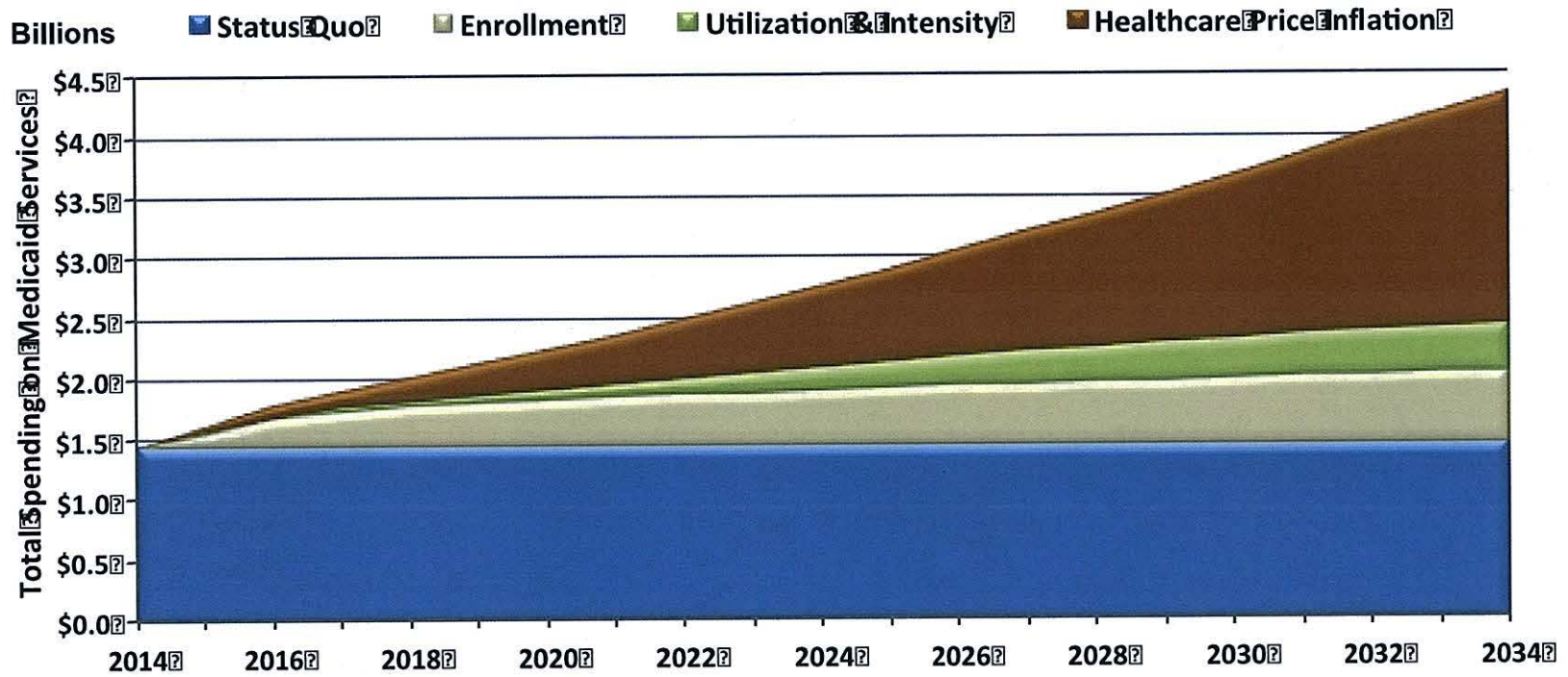


Future Cost Containment Strategies

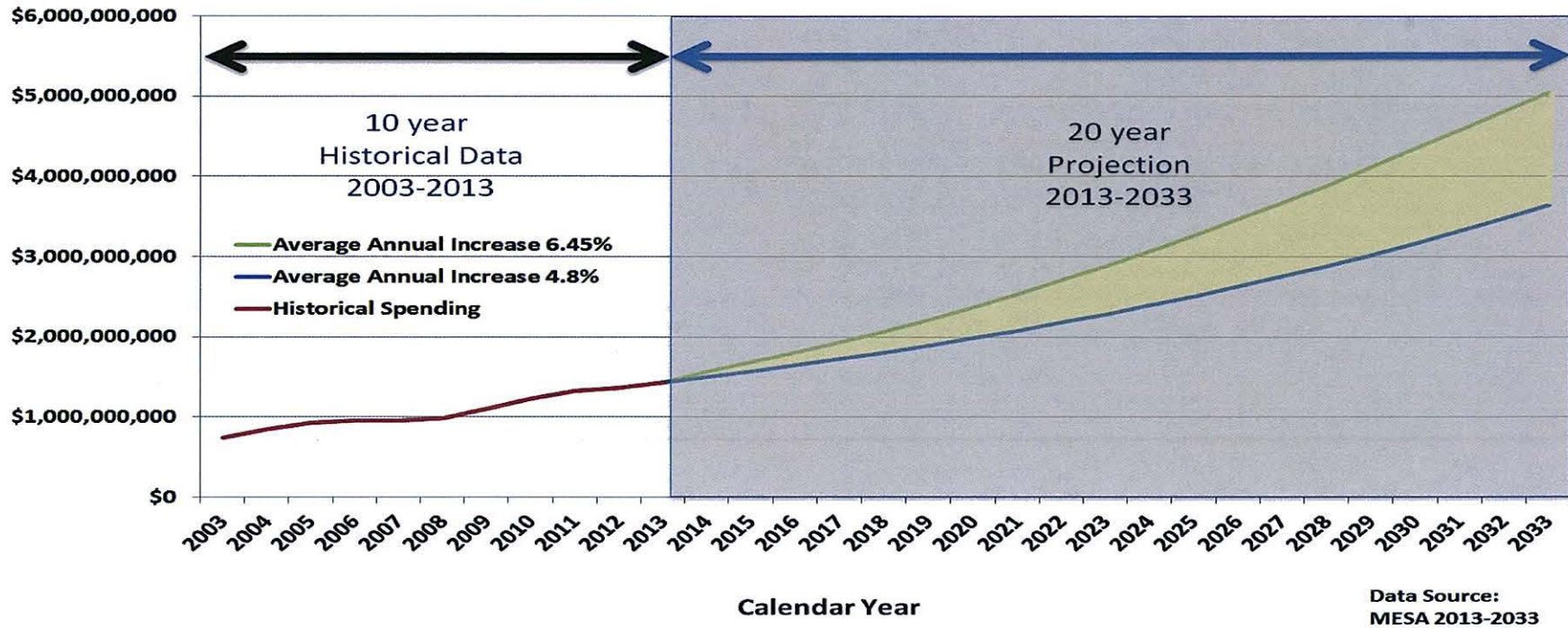
- Durable Medical Equipment payment regulation updates
- Collecting Patient Share of Cost - regulation changes
- Acuity Rate Project
- Automated Service Plan



Expenditures Avoided



Expenditures Avoided



QUESTIONS?

Thank You



Taneeka Hansen

From: David D'Amato <DavidD@alaskapca.org>
Sent: Thursday, March 26, 2015 11:08 AM
To: Taneeka Hansen
Subject: RE: Following up on Saturday's meeting
Attachments: Map.docx

Taneeka,

Thank you for the opportunity to comment. Attached please find the map which outlines the location of the Community Health Centers (CHC's) in Alaska. The 28 CHC's operate more than 170 clinic sites across the state. Together CHC's see more than 100,000 individual patients for medical, dental, mental health, vision and enabling services. CHC's are responsible for over 500 jobs, and Alaska Health Center funding generates more than 61 million dollars in enhanced economic impact to the State of Alaska.

Community Health Centers are federally mandated to provide these services to anyone who walk through our doors ***regardless of their ability to pay***; which means that uncompensated care is a major issue for us.

From: Taneeka Hansen [Taneeka.Hansen@akleg.gov]
Sent: Monday, March 23, 2015 6:30 PM
To: David D'Amato
Subject: Following up on Saturday's meeting

David,

Thank you so much for participating in Saturday's Medicaid round table. Uncompensated care outside of hospitals is something the committee had not yet held discussion on, and your input really helped inform our discussion.

Representative Seaton asked that I reach out to the stakeholders and provider groups who participated to make sure all your comments and suggestions are heard. We had hoped to get suggestions from all stakeholders during the meeting but, as I am sure you know, it is a big topic and we did not get to all our points of discussion.

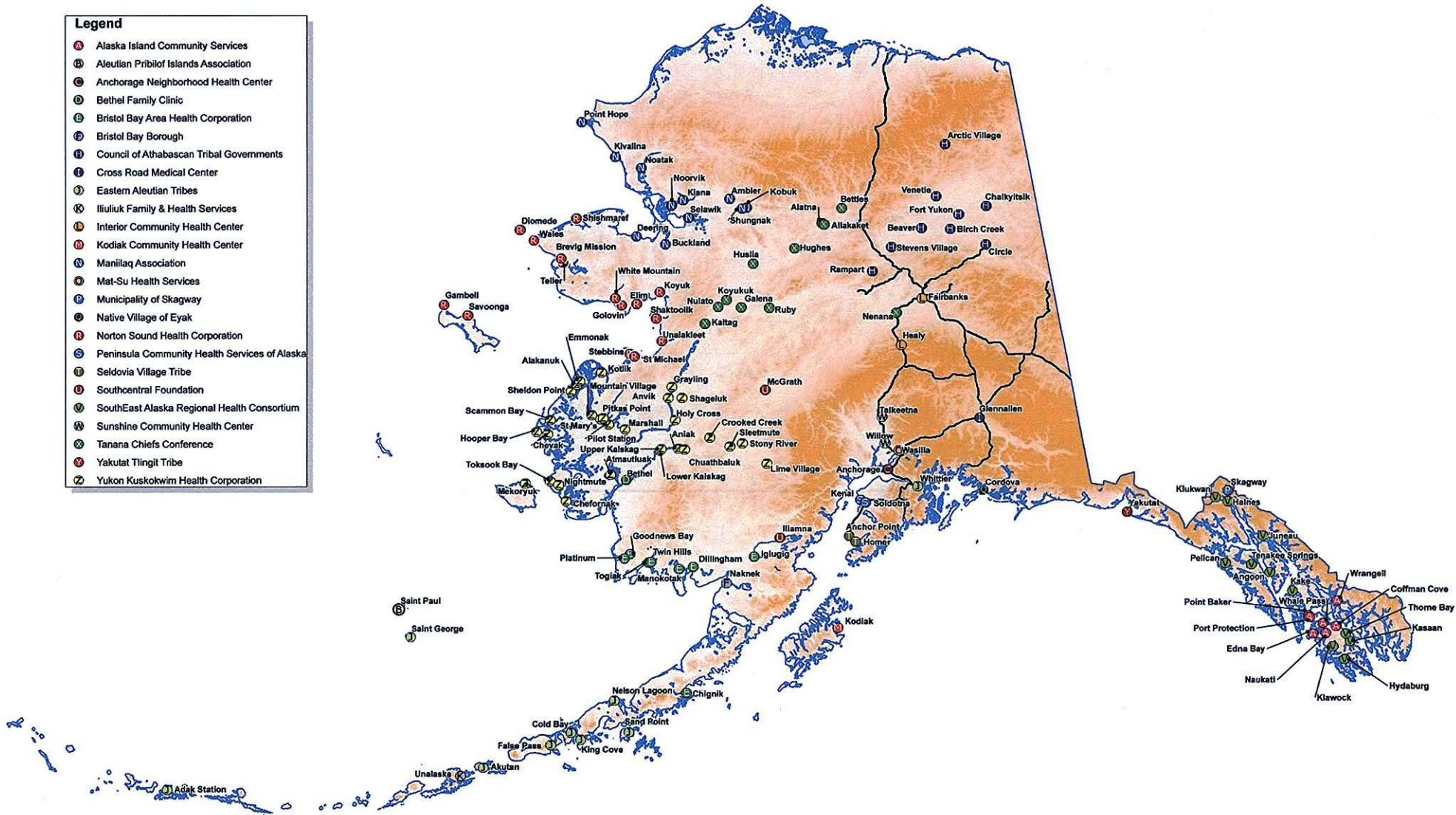
If there were additional comments or suggestions, please send them in writing to me. Again, we really appreciated your input on Saturday.

Sincerely,

Taneeka Hansen
Legislative Aide
Representative Paul Seaton
Committee Aide, Health and Social Services
(907) 465-3923

Legend

- Ⓐ Alaska Island Community Services
- Ⓑ Aleutian Pribilof Islands Association
- Ⓒ Anchorage Neighborhood Health Center
- Ⓓ Bethel Family Clinic
- Ⓔ Bristol Bay Area Health Corporation
- Ⓕ Bristol Bay Borough
- Ⓖ Council of Athabascan Tribal Governments
- Ⓗ Cross Road Medical Center
- Ⓙ Eastern Aleutian Tribes
- Ⓚ Iliuliuk Family & Health Services
- Ⓛ Interior Community Health Center
- Ⓜ Kodiak Community Health Center
- Ⓝ Manillaq Association
- Ⓟ Mat-Su Health Services
- Ⓠ Municipality of Skagway
- Ⓡ Native Village of Eyak
- Ⓢ Norton Sound Health Corporation
- Ⓣ Peninsula Community Health Services of Alaska
- Ⓤ Seldovia Village Tribe
- Ⓡ Southcentral Foundation
- Ⓥ SouthEast Alaska Regional Health Consortium
- Ⓦ Sunshine Community Health Center
- Ⓧ Tanana Chiefs Conference
- Ⓨ Yakutat Tlingit Tribe
- Ⓩ Yukon Kuskokwim Health Corporation



******The following is draft language for possible reform benchmarks and timelines prepared by the office of Representative Seaton. Any dates or percentages are suggestions only and are subject to change pending guidance from providers and the department on what is feasible.******

Sec. 3. AS 47.07.030(d) is amended to read:

(d) The department shall [MAY] establish [AS OPTIONAL SERVICES] a primary care case management system or a managed care organization contract in which certain eligible individuals are required to enroll and seek approval from a case manager or the managed care organization before receiving certain services. The department shall establish enrollment criteria and determine eligibility for services consistent with federal and state law.

Sec. 5. AS 47.07.036 is amended by adding a new subsection to read:

(d) The department shall implement cost containment measures under this section to reduce overall state costs for recipient travel. The measures implemented under this subsection must include regulations providing mechanisms to expand the use of telemedicine.

* Sec. 6. AS 47.07.050 is amended by adding a new subsection to read:

(b) The regulations adopted under this section must include a requirement that a medical services provider receiving payments under AS 47.07 use a code system established by the department to track and report to the department payments received by the provider for services provided to recipients described under AS 47.07.020(b)(16).[Expansion population]

* Sec. 7. The uncodified law of the State of Alaska is amended by adding a new section to read: MEDICAID REDESIGN; REPORTS TO LEGISLATURE; COST-SHARING AND MANAGED CARE PLANS.

(a) The Department of Health and Social Services shall present to the legislature on or before the 10th day of the Second Regular Session of the Twenty- Ninth Alaska State Legislature, the results of the Medicaid Redesign and Expansion Technical Assistance study, advertised under request for proposal number 2015-0600-2986, issued February 25, 2015. The department shall include in the presentation a description of a program for reforming the medical assistance program.

(b) On or before March 1, 2016, the department shall present to the legislature a plan for reducing the cost of the medical assistance program by implementing cost-sharing requirements authorized under AS 47.07.042, including cost-sharing requirements applicable to recipients of medical assistance who use hospital emergency departments for nonemergency medical services. If approved by the United States Department of Health and Human Services, the department shall implement the plan under this subsection on or before December 31, 2016.

(c) The department shall develop a plan for reducing the total cost of travel under the medical assistance program in accordance with AS 47.07.036(d), added by sec. 5 of this Act. The plan developed under this subsection must include an increase in the use of telemedicine services and must be designed to result in a reduction of 10 percent in the annual travel costs for the medical assistance program by January 1, 2018, as compared to the travel costs of fiscal year 2015 for the medical assistance program.

(d) On or before January 1, 2017, the department shall present to the legislature a plan for converting the medical assistance program into a health maintenance organization.

(e) On or before January 1, 2017, the department shall establish a program of designated providers to manage care under AS 47.07.030(d), as amended by sec. 3 of this Act,

for super-utilizers, as identified by the department, and shall present a report on the program to the legislature.

(f) The department shall deliver a copy of the reports and plans required under this section to the senate secretary and chief clerk of the house of representatives and notify the legislature that the reports and plans are available.

(g) In this section,

- (1) 'department' means the Department of Health and Social Services;
- (2) "medical assistance program" means the program described under AS 47.07.

* Sec. 8. The uncodified law of the State of Alaska is amended by adding a new section to read:

MEDICAID STATE PLAN; INSTRUCTIONS. The Department of Health and Social Services shall immediately amend and submit to the United States Department of Health and Human Services for approval the state plan for medical assistance coverage as necessary to implement this Act.

Sec. 47.07.042. Recipient cost-sharing. (a) Except as provided in (b) - (d) of this section, the state plan developed under AS 47.07.040 shall impose deductible, coinsurance, and copayment requirements on persons eligible for assistance under this chapter to the maximum extent allowed under federal law and regulations. The plan must provide that health care providers shall collect the allowable charge. The department shall reduce payments to each provider by the amount of the allowable charge. A provider may not deny services because a recipient is unable to share costs, but an inability to share costs imposed under this section does not relieve the recipient of liability for the costs.

(b) The state plan developed under AS 47.07.040 shall impose a copayment requirement for inpatient hospital services in an amount that is the lesser of

- (1) \$50 a day, up to a maximum of \$200 per discharge; or
- (2) the maximum allowed under federal law and

regulations.

(c) If the department has clear and compelling reason to believe that application of the maximum allowable charges under (a) of this section to a specific service would not reduce state expenditures or would generate savings to the state that are insignificant in relation to the total cost containment possible, then the department may waive the charges otherwise required under (a) of this section as to that specific service.

(d) In addition to the requirements established under (a) and

From the office of Representative Seaton

(b) of this section, the department may require premiums or cost-sharing contributions from recipients who are eligible for benefits under AS 47.07.020(b)(13) and whose household income is between 150 and 175 percent of the federal poverty line. If the department requires premiums or cost-sharing contributions under this subsection, the department

(1) shall adopt in regulation a sliding scale for those premiums or contributions based on household income;

(2) may not exceed the maximums allowed under federal law; and

(3) shall implement a system by which the department or its designee collects those premiums or contributions.

(e) Except as provided in (c) of this section and notwithstanding (b) of this section, the department may require premiums and other cost-sharing contributions from recipients who are eligible for assistance under AS 47.07.020(b)(15) to the maximum extent allowed by federal law. If the department requires premiums or other cost-sharing contributions under this subsection, the department shall

(1) adopt in regulation a sliding scale for those premiums or contributions based on household income; and

(2) implement a system by which the department or its designee collects the premiums or other cost-sharing contributions.

ALASKA STATE LEGISLATURE

Session:
State Capitol, Room 428
Juneau, AK 99801

Phone: (907) 465-3892
Toll-free: 1 (866) 465-3892
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Email: Rep.Liz.Vazquez@akleg.gov

Interim:
716 West Fourth Avenue
Anchorage, AK 99501

Phone: (907) 269-0234
Toll-free: 1 (866) 465-3892
Fax: (907) 269-0238

REPRESENTATIVE LIZ VAZQUEZ

District 22 - Jewel Lake, Sand Lake, Dimond & Kincaid

MEMORANDUM

Date: Tuesday, March 17, 2015
To: Members of the 29th Legislature
From: Representative Liz Vazquez
Re: Medicaid expansion savings eclipsed by dramatic cost discrepancies

Attached please find a table developed by my staff based on estimates of costs and savings for the proposed Medicaid expansion. The table draws on forecasts from the Lewin Group and Evergreen Economics, two studies commissioned and paid for by the Alaska Department of Health & Social Services (DHSS).

As the attached table demonstrates, there are dramatic differences in projected costs for Medicaid expansion. For example, the Lewin Group report predicts that the cumulative cost of Medicaid expansion from 2016 through 2020 will be approximately \$210 million, while Evergreen Economics predicts it will be approximately \$48 million.

DHSS claims that the proposed Medicaid expansion will result in net savings to the state.¹ Accordingly, the attached table also includes a forecast of net savings forecasted by DHSS.

As the attached table shows, when the Evergreen/DHSS cost figures are compared to the Lewin Group's cost estimations, the differences are large and far exceed any cost savings suggested by DHSS.

These materials are provided for your information. Please contact me or my staff Anita Halterman with any questions at 465-3892.

Attachments:

1. "The Bottom Line: Discrepancies in Projections for Medicaid Expansion". Table prepared by the Office of Representative Liz Vazquez.

¹ These forecasts of savings were presented by DHSS Commissioner Valerie Davidson before the House Health & Social Services Committee on March 5, 2015.

THE BOTTOM LINE: DISCREPANCIES IN PROJECTIONS FOR MEDICAID EXPANSION

Comparisons of Projected Total Costs (State Share) and Savings

<u>State Share of Costs</u>	<u>2016</u>	<u>2017</u>	<u>2018</u>	<u>2019</u>	<u>2020</u>	<u>Cumulative through 2020</u>
Lewin Group ¹	\$ 11,153,760	\$ 32,590,262	\$ 43,912,881	\$ 51,686,719	\$ 70,662,545	\$ 210,006,167
Evergreen Economics/DHSS ²	\$ -	\$ 5,196,000	\$ 11,332,000	\$ 13,563,000	\$ 17,946,000	\$ 48,037,000
DHSS Projected State Savings ³	\$ 6,600,000	\$ 8,104,000	\$ 6,068,000	\$ 7,937,000	\$ 6,554,000	\$ 35,263,000

¹ Lewin Group forecasts provided in Lewin Group report, Figure B-6, page 56.

² DHSS provides their own calculations of the state's share of administrative costs (see Table 3). DHSS then adds these to Evergreen Economics' forecasts of state health care costs (see Table 2) to calculate the figures given here. Refer to DHSS March 5th presentation before House Health & Social Service, slide 14.

³ DHSS forecasts presented before House Health & Social Services Committee, March 5th 2015. Forecasts made by DHSS based on DHSS forecasts of cost offsets net of Evergreen Economics' cost share forecasts and DHSS forecasts of administrative costs. Refer to DHSS presentation, slide 14.

Hi Taneeka,

To get into writing what some of Rep. Tarr's discussion points would be:

- Providing healthcare to those who do not have coverage and over utilize emergency room services
 - Anchorage Faith and Action, Congregations Together (AFACT) distributed a statement of support (see attached) that hits on a very good point related to this. That is "the Alaska State Constitution prohibits the creation of a debtor's prison (Article 1.17). Failure to provide a community safety net for emergencies, regular checkups, mental health services, or treatment programs means that many Alaskans are but an accident or diagnosis away from serious debt or bankruptcy. Allowing this to happen creates a de facto debtor's prison, which violates the spirit, if not the letter, of our constitution."

- Impacts to the corrections budget
 - We could save millions of dollars when it comes to corrections. Most Alaskans with substance abuse or mental health problems see a judge before a doctor, and the cost to the state to keep one person on a prison bed per night is \$150. If we would get people to see a doctor before a judge, we would reduce our recidivism rates and corrections budget overall.

- The King-Burwell ruling
 - If the Supreme Court rules against subsidies, any exchange not operated by the state itself would lose the ability to help people pay for their health insurance. In 2014, 88% of the people who enrolled on the exchange received subsidies. If Medicaid expansion is not a reality for Alaska, what will happen to these Alaskans when the Supreme Court rules against subsidies and Alaskans can no longer afford that coverage?

- Alaska is an "old" state
 - Despite its age, Alaska is one of the "oldest states"- Medicaid expansion would provide preventative treatments to seniors that then would reduce cost to the Medicare program and allow the state to subsidize another marginalized group like the non-elderly working poor and the lower middle class.

Let me know if I can be of further assistance.

Best,
Ray

Ray Friedlander

Legislative Staff for Representative Tarr
State Capitol, Room 409
Juneau, AK 99801
907.465.3424

Prepared by the Department of Health and Social Services

HB 148, "An Act relating to medical assistance reform measures; relating to eligibility for medical assistance coverage; relating to medical assistance cost containment measures by the Department of Health and Social Services; and providing for an effective date."

Sectional Analysis:

- Section 1 Adopts intent language and legislative findings related to Medicaid expansion and the need to reform the existing Medicaid program, including instructing the Department of Health and Social Services (DHSS) to propose legislation to implement a provider tax in January 2016, to help offset the cost of the Medicaid program .
- Section 2 Amends AS 44.23.075 to exclude the expansion population from the current Permanent Fund Hold Harmless program.
- Section 3 Amends AS 47.05.200(a) to clarify the minimum number of audits that DHSS should conduct each year, along with instructions that DHSS, should to the extent possible, minimize duplicative state and federal audits for Medicaid providers.
- Section 4 Amends AS 47.05.200(b) to allow DHSS to impose interest penalties on identified overpayments using the post judgment statutory rate.
- Section 5 Adopts AS 47.05.250 that authorizes DHSS to develop provider fines though regulation for violations of AS 47.05, AS 47.07 or regulations adopted under those chapters.
- Section 6 Amends AS 47.07.020(b) including technical corrections related to eligibility for Medicaid authorized under the Affordable Care Act. This section also provides the authority for DHSS to expand Medicaid to adults aged 19-64 who are not caring for dependent children, are not disabled or pregnant, and who earn at or below 138 percent of the federal poverty guidelines for Alaska including the 5 percent income disregard.
- Section 7 and 8 Amends AS 47.07.020(g) and (m) to clarify when DHSS may impose transfer of asset penalties when determining eligibility for Medicaid.
- Section 9 and 10 Amends AS 47.07.036(b) and adds AS 47.07.036(d) to outline cost containment and reform measures that DHSS must undertake, including seeking demonstration waivers, applying for other options under the Medicaid Act and improving telemedicine for Medicaid recipients.
- Section 11 and 12 Amends AS 47.07.900(4) and (17) to remove the requirement that behavioral health providers be a grantee of the state of Alaska in order to bill Medicaid.
- Section 13 Instructs DHSS to amend any state plan it has with the federal government to be consistent with this Act.
- Section 14 Authorizes DHSS to engage in emergency rule making under the Alaska Administrative Code to implement Medicaid reform measures and the provisions of this Act.

Section 15

Instruct the Revisor of Statutes to make technical amendments to the title of AS 47.07.036 to conform to amendments in this Act.

Section 16

Provides that Section 13 and 14 are effective immediately

Section 17

Provides that Section 1- 12 and 15 of the Act are effective on July 1, 2015.

Response to H-HSS Committee Question on March 5, 2015:

“Please provide the incomes of the hospitals that reported the \$90 million in uncompensated care.”

The following is a list of the total reported net income for each hospital that reported uncompensated care costs in 2013. The net income is reflected in both dollars and as a percentage of total revenue.

While these numbers reflect total net income for each hospital, they do not in any way represent “profit.” The calculation for total net income simply looks at the remaining dollar amount after considering total revenue sources and total expenses. The reason this is not indicative of profit is because total revenue includes artificial payment streams (artificial in the sense that they are not operationally driven and are irregular).

For example, Central Peninsula Hospital shows a total net income of \$14.2 million in 2013. Naturally, one may want to conclude that since this is the dollar amount remaining after total expenses were paid, it must represent the hospital’s profit. However, this conclusion would be incorrect because, in this case, Central Peninsula Hospital’s total revenue includes a \$2 million capital budget appropriation from the State of Alaska so that the hospital could build a radiology oncology facility. Again, that \$2 million in revenue is a one-time payment that was not in any way driven by the hospital’s patient care or operations.

Similarly, Bartlett Regional Hospital shows a total net income of \$5.3 million in 2013. The total revenue in that net income calculation includes a statutorily-required contribution from the State of Alaska of \$4.2 million for PERS expenses. Again, \$5.3 million in total net income cannot represent profit or financial health when it includes contributions from the State of Alaska that have no relation to patient care or operations.

TOTAL NET INCOME		
Facility	FYE 2013	% OF REVENUE
ALASKA REGIONAL	\$34,036,233	15%
BARTLETT	\$5,285,508	6%
CENTRAL PENINSULA	\$14,210,763	11%
CORDOVA	\$1,193,381	12%
FAIRBANKS MEMORIAL	\$4,856,459	2%
KETCHIKAN	\$4,003,578	6%
MAT-SU	\$39,282,807	26%
NORTON SOUND	\$15,043,584	13%
PROVIDENCE ALASKA MED CENTER	\$88,699,318	13%
PETERSBURG	\$921,688	6%
PROV. KODIAK	\$3,135,525	8%
PROV. SEWARD	\$4,851,415	22%
PROV. VALDEZ	\$1,531,254	11%
SITKA	\$252,550	1%
SOUTH PENINSULA	\$1,385,380	3%
WRANGELL	\$1,496,879	13%

Medicaid Reforms included in the Governor's Bill

- The bill calls for the Department of Health and Social Services to look at all options available to improve the Medicaid program and limit its costs.
- The reforms we are actively pursuing can be found in Section 10 and describe “waivers” and “options” – opportunities to craft the Medicaid program to meet Alaska’s specific needs. They are named after the section of the Social Security Act in which they’re found:
 - The **1115 (Eleven-fifteen) waiver** will enable Alaska to increase the number of Indian Health Services beneficiaries seen by tribal health providers.
 - Results in services for HIS beneficiaries being 100% reimbursed by the federal government instead of the current 50% federal/50% state funding rate.
 - Potential savings of \$100–150 million annually in General Fund.
 - The **1915(i) option** will realize savings for Alaskans who do not meet nursing level of care, but meet other criteria (such as Alzheimer’s, traumatic brain injury, severe mental illness, or individuals with developmental or intellectual disabilities)
 - Increases the 50% federal match (from 0% to 50%) for those currently eligible for Medicaid.
 - Individuals in the new Medicaid expansion population will be eligible at the enhanced federal match rate.
 - The **1915(k) option** will improve savings on home and community-based attendant services to Medicaid-eligible individuals.
 - Increases the federal contribution for these services from 50% to 56%.
 - Potential for \$24M annual in combined GF savings for 1915(i) and (k) waivers upon full implementation, which could be 2 – 3 years.
- The bill directs the Department to develop further reforms by:
 - Pursuing demonstration projects for other, new models for payment reform and innovative service delivery. Broad authority here allows us to be able to pursue opportunities as they arise.
 - Enhancing telehealth capability and reimbursement to incentivize telehealth delivery
 - Streamlining audit requirements to better coordinate required federal and state audits and reduce the burdens that audits create for providers.
 - Providing emergency regulation authority to be able to implement savings opportunities quickly

Alaska Dispatch News

Published on *Alaska Dispatch News* (<http://www.adn.com>)

[Home](#) > Alaska Medicaid patients strain system with repeated emergency room visits

Dermot Cole ⁽¹⁾

January 27, 2014

Main Image:

Hospital bed 2 ⁽²⁾

Main Image Caption:

More than 6,500 people in Alaska on Medicaid, including about 1,000 in Anchorage's Mountain View neighborhood, are running up needless medical bills with repeat visits to hospital emergency rooms for minor problems.

From the office of Rep. Tara

FAIRBANKS -- The government has a term to describe about 6,500 Medicaid patients in Alaska who make a habit of going to hospital emergency rooms with minor problems -- "super utilizers."

Margaret Brodie, state Medicaid director, told an Alaska House hearing Monday that those patients are a super problem for the program, which provides \$1 billion in state and federal funds for medical care to low-income Alaskans. A state review found that one patient used the emergency room 79 times between Jan. 1, 2012 and Sept. 17, 2013, though the average was 12 visits per person.

She said the state has found that one Anchorage neighborhood is a hotspot for many of the more than 3,000 super utilizers in the state's largest city. More than a third of the city's total, 1,069 super utilizers, were in Mountain View, the northeast neighborhood. But why?

"There's not a health clinic there," Brodie said. "The closest thing to them is Alaska Regional Hospital, and it happens to be right on the bus route. So that's where they get their primary care."

About 1,800 of the Medicaid patients in Alaska who make regular repeat visits are children 12 and under who are brought to emergency rooms by parents or guardians.

Alaska is one of five states working with the National Governors Association to come up with ways to prevent the excessive use of emergency room services. The state Division of Health Care Services (DHCS) said it "has identified a group of super utilizer patients who will have their care guided throughout a 12-consecutive-month process. By following these patients, DHCS will develop an informed sense of the challenges of providing appropriate, medically necessary health care to super utilizer patients."

"We're looking at ways that we can stop them from using the emergency room inappropriately," Brodie told the health and social services finance subcommittee. "They'll get the care that they need, but not through an emergency room setting. We'd rather pay an office visit than an emergency room visit."

The state is working with the hospital and others to see what can be done to "get some sort of health care" in Mountain View.

Rep. Les Gara, an Anchorage Democrat, said the problem could be directly addressed at the emergency room by referring patients directly to clinics for minor problems.

"There should be something at the emergency room that Medicaid works with the hospitals on that says, 'Here's a cab voucher. We've called. There's availability there. They can deal with your minor conditions. If you decide not to do that, we will garnish your Permanent Fund Dividend. It's harsh, but it's cheaper,'" he said, asking for state officials to tell him why that wouldn't be the right approach.

He said that the reason people go to the emergency room is that they know Medicaid covers the cost.

A national study said that 5 percent of Medicaid beneficiaries are responsible for 54 percent of the program's cost.

Contact Dermot Cole at [dermot\(at\)alaskadispatch.com](mailto:dermot(at)alaskadispatch.com) [3]. Follow him on Twitter [@dermotmcole](https://twitter.com/dermotmcole) [4]

Source URL: <http://www.adn.com/article/20140127/alaska-medicaid-patients-strain-system-repeated-emergency-room-visits>

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From the office of Rep. Tanr

Alaska Medicaid Looking to Rein in ER "Super Utilizers"

By Amy Snow Landa , January 28, 2014

Share this:



Alaska is taking a closer look at its Medicaid beneficiaries who regularly visit hospital emergency departments seeking primary care services.

The state's Medicaid director, Margaret Brodie, told legislators at a House hearing on Jan. 27 that reining in these ER "super utilizers" is a primary cost-control strategy that the Department of Health and Social Services is pursuing.



"Super utilizers" are defined as people who use hospital ERs for non-emergent care at least four times per year.

A recent study found that about 25 percent of ER utilization by Medicaid beneficiaries is in one "hotspot"—the neighborhood of Mountain View in Anchorage, Brodie told the health and social services finance subcommittee. Mountain View is in northeast Anchorage and borders a military base.

There is no health clinic in that area, Brodie noted. "The closest provider is Alaska Regional Hospital, and it happens to be right on the bus route. So that is where they get their primary care."

Brodie said the Department is looking for ways to redirect super utilizers to appropriate settings for primary care. The plan includes working with Alaska Regional Hospital and the state's public health system to see if there is a way to provide "some sort of health care in that area," she said.

The Department is under pressure to contain growth in Medicaid expenditures, with Gov. Sean Parnell calling for the state to restrain spending across the board in FY 2015.

Total Medicaid expenditures are about \$1.65 billion in FY 2014.

The Governor's budget proposal calls for an increase of about \$8.2 million in FY 2015, Brodie said.

The increase was initially going to be about \$16 million, noted the subcommittee's chairman, Rep. Mark Neumann, R-Wasilla.

He asked Brodie how that increase was reduced. She responded that each of the divisions had made cuts, largely by eliminating certain staff positions.



"The Department will still be providing the same level services we do now." Brodie said.

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Legislators urged her and Craig Christenson, deputy commissioner for Medicaid and health care policy, to continue to find efficiencies in the budget to reduce cost growth.

Brodie's presentation slides noted (on slide 11) that the average cost per Medicaid recipient in Alaska has been declining over the past few years, from more than \$5,400 in FY 2011 to less than \$5,100 in FY 2013.

The average cost per Medicaid recipient under age 17 using psychotropic medication has also dropped during the same period, from nearly \$1,600 to less than \$1,300 per year. (slide 8).

Share this:



From the office of Rep. Tan

Amended Request for Proposals: Alaska Medicaid Coordinated Care Initiative (AMCCI - ER Superutilizers)

****Amendment #1 issued 10/22/14 serves to change the deadline for receipt of proposals to October 31, 2014 @ 1:00 pm, Alaska Prevailing Time. All other sections of the RFP remain the same. Refer to the attached amendment.****

The Department of Health and Social Services (DHSS), Division of Health Care Services (DHCS), is soliciting proposals to award one or more contracts at DHSS sole discretion, if budget permits, to provide case management and utilization review (CM/UR) services in support of Alaska Medicaid Coordinated Care Initiative (AMCCI).

DHCS has identified high utilizers of emergency room services (superutilizers) whose care would be the initial focus of this contract and the AMCCI (see section 4.02.3). However, at the sole discretion of DHCS, AMCCI participants may include any or all AK Medicaid member.

Initially, the AMCCI aims to reduce the number of emergency room (ER) visits, specifically those that are not emergent. Other goals include increased use of preventive care, comprehensive care coordination, and enhanced integration of primary medical care and behavioral health services. The intended outcome of the AMCCI is to improve access to services and healthcare outcomes, as well as promoting more efficient use of services thereby reducing unnecessary and wasteful health care expenditures.

Issue Date: October 10, 2014

Deadline for receipt of proposals: October 31, 2014 @ 4:00 pm, Alaska Prevailing Time. Faxed or oral proposals are not acceptable. An offeror's failure to submit a proposal prior to the deadline will cause the proposal to be disqualified. Late proposals or amendments will not be opened or accepted for evaluation.

Important Notice: If you received this solicitation from the State of Alaska's "Online Public Notice" web site, you must register with the Procurement Officer listed in this document to receive subsequent amendments. Failure to contact the procurement officer may result in the rejection of your offer.

Procurement Officer: Lois Lemus
907-269-3002p, 907-269-7829f, 907-465-3196tdd
Email: lois.lemus@alaska.gov

Attachments:
RFP 2015-0600-2824

Attachments Separate from RFP:

1. Standard Agreement Form - EXAMPLE
2. Notice of Intent to Award - EXAMPLE
3. Vendor Report Template
4. Medication Screening
5. Satisfaction Survey

Attachments, History, Details

Attachments

2015-0600-2824 - RFP Amendment #1.pdf
 EXAMPLE -Notice of Intent to Award.pdf
 EXAMPLE -Standard Agreement.pdf
 FROM Vendor Report Template 2014-10-09.pdf
 Init Hlth Screen (AMCCI) 2014-10-09.pdf
 Monthly Medication Compliance Form.pdf
 Patient Satisfaction Survey 2014-10-09.pdf

Details

Department: Health and Social Services
 Category: Procurement
 Sub-Category:
 Location(s): Statewide
 Project/Regulation #:
 Publish Date: 10/22/2014
 Archive Date: 11/3/2014

**House Health & Social Services Committee
March 5, 2015 Meeting – Follow-up Questions**

This is a consolidated list of the reforms discussed at the March 5th committee meeting. The reform efforts listed below correspond with the associated slide number in the PowerPoint presentation.

- Building on Reform Underway (Slide 16)
- Recently Identified Reform (Slide 17)
- Building Blocks to Achieve Reform (Slide 19)
- Reform Strategies (Slide 20)

Care Management:

Building on Reform Underway: Control overutilization of emergency room services

- Target: \$7M savings (reduce by 25%)

Recently Identified Reform: Expanding program to reduce overutilization of emergency room services

- Target: \$2.5M savings

Building Blocks to Achieve Reform: Certain recipients that over-utilize services are assigned a designated provider who coordinates services.

Reform Strategies: Choice restrictions and services to direct patients to the appropriate level of care

Reform Strategies: Increased access to preventive services

Reform Strategies: Incentives for healthy behaviors

Building Blocks to Achieve Reform: Strengthened Primary Care. Work with providers to find more efficiencies and more effective ways of delivering services

Increased fraud, waste and abuse prevention and control efforts:

Building on Reform Underway: Cost avoidance is result of providers not submitting future claims based on another provider being found fraudulent

- Target: \$15 million in annual avoided costs

Home and community-based service improvements:

Building on Reform Underway: 1915(i) Option will replace services currently provided with 100% state general funds with federally matched Medicaid services.

Building on Reform Underway: 1915(k) Option would allow DHSS to replace existing Medicaid home and community-based waiver services matched at 50% federal with 1915k services matched at 56% federal

- Target: \$24M annual savings upon full implementation

Patient-centered Medicaid Home initiatives:

Building on Reform Underway: Provide coordinated primary care services that help people with chronic health issues to receive appropriate care that will reduce hospitalizations and emergency department use

- Target: \$78,000 - \$165,000 annual savings per 1,000 enrollees

Coordination with the Alaska tribal health system:

Building on Reform Underway: Work with tribal health partners to increase the number of IHS beneficiaries who received services from tribal providers for 100% federal match

- Target: \$15M savings

Recently Identified Reform: Savings from new Tribal health system new facilities, expanded dental services, 36 new long term care beds, increased utilization of telehealth services in the tribal system, increased utilization of community health aides/practitioners and dental health aide therapists.

- Target: \$10M savings

Investigating waiver options:

Building on Reform Underway: Behavioral Health and Senior & Disability Services are investigating potential opportunities to redesign the way we provide and pay for a number of services

- Both for the expansion and general Medicaid populations

Building on Reform Underway: Opportunities for various tribal waivers

Building Blocks to Achieve Reform: Maximizing federal matching fund opportunities. Partnerships with the tribal health system to identify additional opportunities to receive 100% federal reimbursement for Medicaid services

- Longer term target of \$100M Savings

Change eligibility for Personal Care Assistance (PCA) services:

Recently Identified Reform: Change threshold to qualify for Personal Care Attendant services from one to two activities of daily living (ADL) or more and possibly other eligibility changes

- Target: \$2.5M savings

Durable Medical Equipment, Vision, and Audiology:

Recently Identified Reform: Provide more comparable supplies to other states, re-solicit vision contract, audiology fee schedule adjustments

- Target: \$1M savings

Dental:

Recently Identified Reform: Adopt new fee scale for all services, implement the recommendations on use of panoramic films and full mouth films, denture guidelines, implement guidelines for oral hygiene requirements before beginning orthodontia (except for the cleft palate cases where timing is important for satisfactory treatment).

- Target: \$1M savings

Transportation:

Recently Identified Reform: Review current travel policies, adopt a fee schedule instead of paying billed prices for ground transportation, consolidation of family travel needs

- Target: \$1M savings

Implement Utilization Control for Behavioral Health Services:

Recently Identified Reform: Development of clearer program standards and stronger admission criteria and thorough review for residential psychiatric treatment centers, behavioral rehabilitation services, and acute psychiatric service settings. Revise requirements for Recipient Support Services.

- Target: \$2M savings

Payment Reform:

Building Blocks to Achieve Reform: Reimbursement methodologies from fee-for-service payment structures to alternative payment mechanisms that can drive improved value

Workforce Innovation:

Building Blocks to Achieve Reform: Design of new provider types that can work as members of health care teams and allow clinicians to work at the top of their licenses and function more efficiently

Maximizing federal matching fund opportunities:

Building Blocks to Achieve Reform: Working with other state agencies and with systems such as the statewide community health centers to leverage federal financing

Expansion of Telehealth Services:

Building Blocks to Achieve Reform: Improve access, address health care system capacity, and reduce travel requirements

Cost-sharing Options:

Reform Strategies: Cost sharing requirements, charging premiums and higher cost sharing requirements for non-emergency use of hospital emergency rooms.

Health Savings Accounts (HSAs):

Reform Strategies: Explore the idea of higher income recipients being encouraged to establish a health savings account that can be used to pay co-pays and deductibles.

Work assistance:

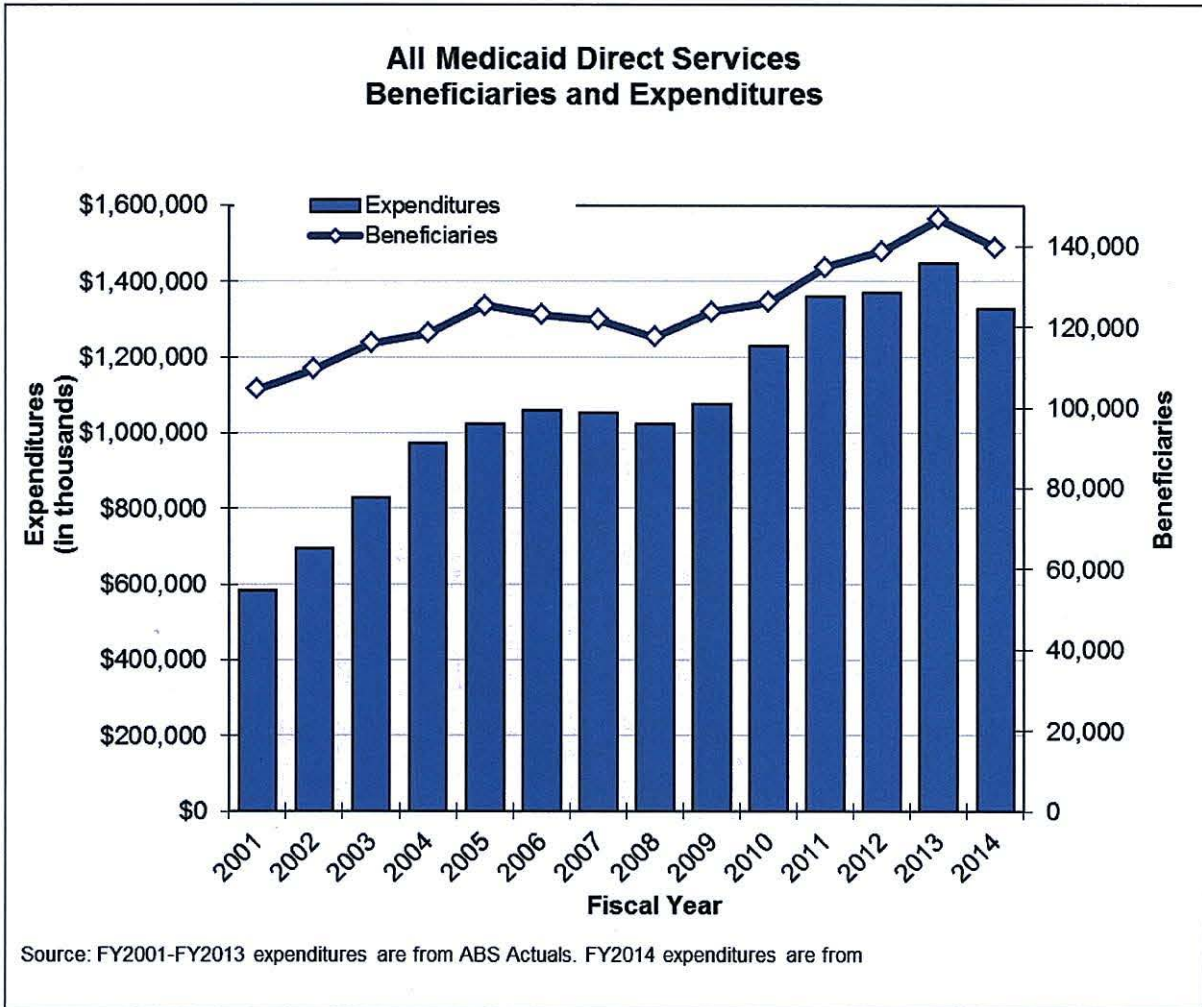
Reform Strategies: Access to job search websites, resume assistance, job training, vocational rehabilitation and other work supports

Note: Reforms without reference to a targeted savings are being examined further to determine approval process and potential savings.

Questions and Responses for House-HSS Committee Hearing

Follow-up from Thursday March 5, 2015

1. Please provide a graph of the past 10 years of Medicaid enrollees and Medicaid expenditures.



**Medicaid Expenditures by Fund Source
(dollars in thousands)**

Fiscal Year	Beneficiaries*	Unrestricted General Funds	Designated General Funds	Federal Funds	Other Funds	Total Funds
2001	104,717	\$152,427	\$364	\$387,432	\$43,671	\$583,894
2002	109,541	\$192,558	\$364	\$461,847	\$38,911	\$693,680
2003	115,987	\$211,075	\$1,427	\$558,581	\$57,034	\$828,117
2004	118,453	\$230,119	\$4,512	\$658,741	\$78,119	\$971,491
2005	125,309	\$276,089	\$1,533	\$685,474	\$61,822	\$1,024,918
2006	122,975	\$348,648	\$1,500	\$664,722	\$45,007	\$1,059,877
2007	121,865	\$374,492	\$52	\$651,908	\$26,924	\$1,053,376
2008	117,472	\$408,250	\$1,558	\$604,348	\$9,632	\$1,023,788
2009	123,791	\$389,170	\$74	\$682,270	\$6,774	\$1,078,288
2010	126,127	\$400,284	\$87	\$822,907	\$6,982	\$1,230,260
2011	134,768	\$466,585	\$192	\$888,944	\$4,527	\$1,360,248
2012	138,755	\$566,267	\$195	\$798,346	\$4,825	\$1,369,633
2013	146,613	\$613,951	\$455	\$827,695	\$6,692	\$1,448,793
2014	139,755	\$562,553	\$205	\$758,061	\$5,684	\$1,326,503

Source: Medicaid Budget Group using Alaska Budget System data. AKSAS for FY2014.

2. Please provide the numbers for Medicaid expansion at full enrollment.

If, on July 1, 2015, all Alaskans newly eligible for Medicaid expansion services enroll, we would expect the following in FY2016:

Newly Eligible Adults	41,910
Spending Per Enrollee	\$7,248
Federal Participation Rate	100%
Federal Spending	\$303,763,680
State Spending*	\$1,460,650
Offsets to State Spending from CAMA, Department of Corrections, and Behavioral Health Grants	(\$6,100,000)
Savings to State	(\$4,639,350)

*State spending for full Medicaid expansion enrollment is initially estimated at \$6,041,300 (\$5,008,800 from the Division of Public Assistance, \$1,032,500 from the Division of Health Care Services). 50% of these costs will be

covered through federal participation and the AK Mental Health Trust has pledged \$1,560,000 for administrative cost support in this first year, leaving \$1,460,650 to be picked up by the state.

3. Please provide the incomes of the hospitals that reported the \$90 million in uncompensated care.

Please see attachment, "Hospital Reported Total Net Incomes."

4. Please provide a written list of the expected savings for various reforms.

See attachment, "H-HSS Reply to Question on Reforms."

5. In response to Rep. Tarr's question, please provide information on how Medicaid and Medicaid expansion might help with behavioral health medicine compliance issues.

- Medicaid expansion allows access to primary and behavioral health care, prescription medication, and case management services. Individuals who currently do not seek care or fill prescriptions for financial or accessibility reasons will now be able to do so.
- Continuity of behavioral health medication prescriptions would be enhanced through Medicaid expansion, particularly for individuals transitioning from hospital care or releases from correctional facilities, because individuals leaving these facilities will not only have prescriptions in hand for their medications but also the coverage to pay for them as long as they are medically necessary.

6. To clarify Chair Seaton's question earlier: Rep. Seaton would like to hear our opinion on whether expansion legislation could include reform requirements with a delayed implementation timeline to provide a level of accountability and assurance to the legislature.

Yes. The Department will readily work with the legislature on potential timelines for reform implementation. We don't believe any further delay on Medicaid expansion is warranted.

House HSS Committee Questions for 3/5/15 Medicaid Expansion Presentation

Questions from Committee:

1. Commissioner's presentation on 'What is Medicaid Expansion and its implications?'

We hope the presentation answers most of the questions related to Medicaid expansion and its implications.

2. What is Medicaid Reform?

Medicaid reform means reducing Medicaid's cost curve, improving program efficiencies, reducing waste. It is not any one thing but many different approaches to improvement. We have several ideas to present and are eager to hear yours.

3. What are some appropriate examples of Reform from other states and how would they work in Alaska?

Many of the reforms in this presentation (slides 19 & 20) come from other states—we will note which states have worked on these reforms. We want to emphasize, however, that to be successful Medicaid reform must be tailored to Alaska's unique needs and circumstances.

4. While examining super-utilizers for reform, has the Department considered the Medicaid Health Home Model, which provides 90% operational funding federal match for homes which target specific high-cost Medicaid patients during the first two operating years? (See attached research report)

Yes. The Health Home Model, also called the Patient-Centered Home model, is just one of the reforms we are exploring. Our intention is for our contracted consultant examining Medicaid reform to conduct a thorough analysis and recommendations regarding this model.

5. Is Medicaid Reform best accomplished through statute or regulation?

Both, depending on the type of reform.

6. Can Reform and Expansion be accomplished at the same time?

Yes. Reform is an ongoing effort that has begun already and will continue during and after expansion efforts.

7. If they are accomplished in different timeframes, can Expansion legislation integrate a delayed implementation timeline?

It would be difficult to develop a plan that delays expansion based on reform, and the department wouldn't recommend it. Moreover, every day that we delay expansion results in a loss of an estimated \$398,000 in federal funding for health care services for the estimated 20,000 Alaskans who would sign up for Medicaid under expansion in FY2016.

8. Do Reform and Expansion need to be combined so the conversion of charity care cases into participants at a higher federal reimbursement rate means providers receive enough income to accomplish Reform?

Combining reform and expansion will more quickly reduce the burden on providers to provide uncompensated care.

9. Do we worry that some types of reform would lower provider participation?

Reform must proceed with the full participation of everyone with a stake in the outcome—providers, patients, and policymakers—to ensure that all views are represented and potential impacts are understood. A goal of any reforms we embark upon would be to maximize rather than minimize provider participation.

10. If Medicaid Expansion requires parity between mental health and physical health services, how does the state propose addressing behavioral or mental health services given our current limited services?

Alaskans should have available an array of mental health and substance abuse services. Medicaid expansion is expected to spur the development of these services because newly enrolled individuals will have coverage for these services, possibly for the first time. The state intends to reduce the general fund grants needed for these services gradually as payment for these services shifts to Medicaid. This transition needs to occur gradually to ensure that providers of these services are able to make this shift and meet these demands.

11. Is the Department looking into additional funding, such as a provider tax or a copay from major providers on Medicaid expansion revenues?

All potential approaches to reform will be considered; nothing is off the table. Again, we invite participation of everyone with a stake in the outcome.

IMPACT OF MEDICAID EXPANSION ON HOSPITAL UNCOMPENSATED CARE

Uncompensated care is an overall measure of hospital care provided for which no payment was received from the patient or insurer. It is the sum of a hospital's "bad debt" and the charity care it provides. Charity care is care for which hospitals never expected to be reimbursed. A hospital incurs bad debt when it cannot obtain reimbursement for care provided.¹

ASHNHA has data representing 17 acute care hospitals for cost reporting period Oct 1, 2012 – Sept 30, 2013. **For 2013, 17 Alaska hospitals provided over \$100 million in uncompensated care.**

To ensure accuracy, uncompensated care numbers are taken from hospital's cost reports that are required to be submitted annually to Medicare and Medicaid.² Many tribal hospitals are not included in this data because of differences in cost reporting requirements.³ Tribal hospitals do have uncompensated care, but because of the difference in reporting requirements it is difficult to compare their data to the non-tribal facilities. Tribal facilities report data from patient accounting and general ledger systems and the uncompensated care represents the total amount of gross charges written off for care provided to patients who have no payer source.

This summary seeks to quantify the potential impact of Medicaid expansion on hospital uncompensated care.

- Early evidence shows a dramatic drop in uncompensated care for hospitals in states that have expanded Medicaid, due to an increase in Medicaid patient volume. At the same time, the proportion of self-pay and overall charity care has declined in expansion-state hospitals.⁴
- A Colorado study analyzed data from 465 hospitals in 30 states in the first four months of Medicaid expansion. It found that unpaid care decreased by 30 percent in expansion states and remained essentially unchanged in non-expansion states. The report links an enrollment surge in expansion states to not only the reduction in uncompensated care but also the 25-percent decrease in people paying out of pocket.⁵
- In Alaska, if Medicaid is expanded a decrease in uncompensated care is anticipated. Based on the experience in other states a 20%-30% reduction of uncompensated care could be achieved. This could amount to decrease of between \$20 and \$30 million in uncompensated care at Alaska hospitals.
- A decrease in uncompensated care could result in improved financial sustainability for Alaska's small/rural hospitals that are currently operating at a deficit. Additional resources will allow Alaska hospitals to better respond to community health needs and provide community benefits.
- Hospitals face looming uncertainty as federal cuts authorized by the ACA increase. These cuts amount to more than \$591 million over fifteen years for Alaska hospitals.⁶ Hospitals agreed to payment reductions based on the assumption that expanding Medicaid would be mandatory for all states and would make up for losses.



What would a reduction in uncompensated care mean for Alaska's health care system?

Small and large hospitals are under increasing regulatory and financial pressure to adapt to a rapidly changing business model and declining reimbursement. For small, rural hospitals, a reduction in uncompensated care could have a huge impact on future sustainability. Across the country, Critical Access Hospitals (CAH) with under 25 beds are shutting their doors. Across the country, 43 CAHs have closed since 2010.⁷ In Iowa, if a CAH closes it means you might have to drive 20 miles more down the road. In Alaska, if a CAH closes it means an expensive Medevac and delayed treatment.

The health care industry is faced with significant financial pressure and at the same time being asked to transform health care, from a system that rewards volume to one that rewards value. Incentives within the current system are not aligned. Hospitals get paid when people are sick – not for keeping them well or for delivering high-quality, cost-effective care. Health care is undergoing radical transformation, away from a system that pays for volume to a system that pays for value. The reduction in uncompensated care can give hospitals the capital needed to support transformation.

¹ American Hospital Association, Uncompensated Hospital Care Cost Fact Sheet

² Hospital cost report data, schedule S-10 includes the uncompensated care cost numbers - non-Medicare bad debt on line 23 and charity care to uninsured patients line 29.

³ Hospitals operated by Native health organizations are required to file a Schedule E cost report. The Schedule E cost report is an abbreviated form of cost reporting. As a result they are not obligated by CMS to report charity care or bad debt, simply because this is not a component of Schedule E cost report. Schedule S-10 is not a part of their cost report.

⁴ Colorado Hospital Association, Center for Health Information and Data Analytics, June 2014

⁵ Ibid.

⁶ Medicare Payments Cuts in Alaska, February 2015, DataGen Medicare Cut Analysis report

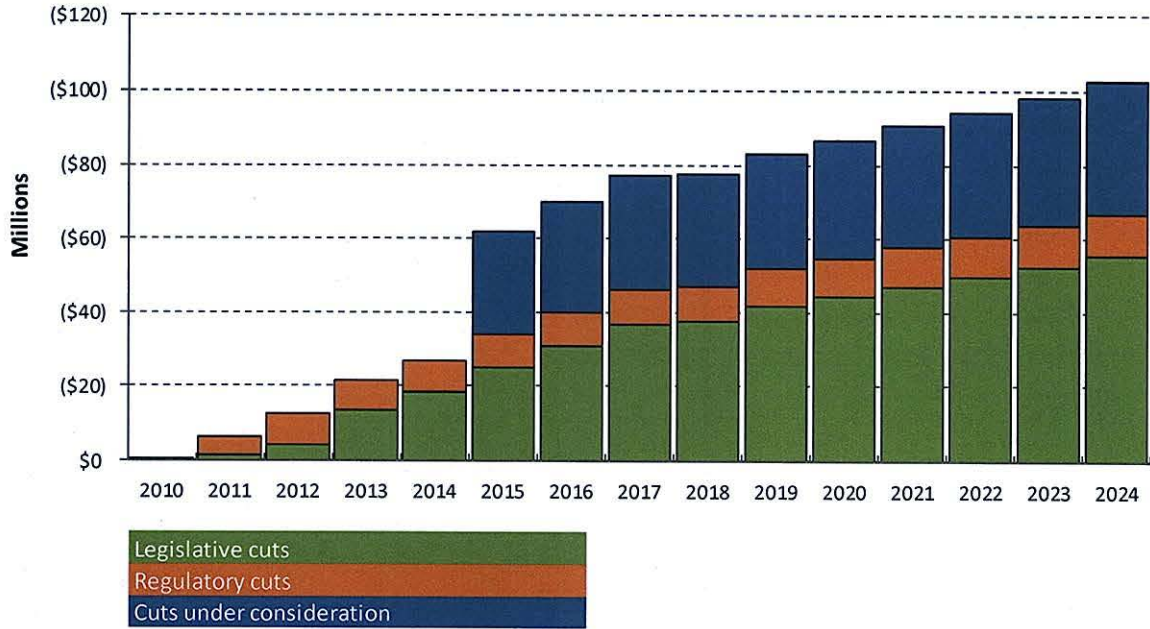
⁷ USA Today, Nov. 11, 2014 <http://www.usatoday.com/story/news/nation/2014/11/12/rural-hospital-closings-federal-reimbursement-medicare-aca/18532471/>

15-Year Medicare Cut Analysis

Estimated Value of Enacted Cuts & Cuts Under Consideration Since the Affordable Care Act (ACA)

Alaska

This report provides additional detail to the estimates on the first report by separating the estimates into two windows: 2010-2014 and 2015-2024. Estimates shown for 2010-2014 include all existing legislative and regulatory cuts that have already been implemented. Estimates shown for 2015-2024 include the compounded effects of permanent/prospective cuts put into effect prior to 2015, as well as cuts that will/may be implemented in the future.



EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

Source: American College of Emergency Physicians
<http://www.acep.org/News-Media-top-banner/EMTALA/>

What is EMTALA?

EMTALA is a federal law that requires anyone coming to a hospital emergency department to be assessed, stabilized and treated, whether or not they can pay for that care. EMTALA was enacted by Congress in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (42 U.S.C. §1395dd). Any hospital that takes Medicare is required to comply with EMTALA.

What does EMTALA require?

Hospitals have three main requirements under EMTALA:

1. Any individual presenting at the emergency department and requesting care must receive a medical screening examination to determine whether an emergency medical condition exists. Examination and treatment cannot be delayed to inquire about methods of payment or insurance coverage. Emergency departments also must post signs that notify patients and visitors of their rights to a medical screening examination and treatment.
2. If an emergency medical condition exists, treatment must be provided until the emergency medical condition is resolved or stabilized. If the hospital does not have the capability to treat the emergency medical condition, an "appropriate" transfer of the patient to another hospital must be done in accordance with the EMTALA provisions.
3. Hospitals with specialized capabilities are obligated to accept transfers from hospitals who lack the capability to treat unstable emergency medical conditions.

Scope of EMTALA:

EMTALA applies to hospital emergency departments. It does not apply to other outpatient settings, like primary care or specialty clinics. It also does not apply to inpatient care. The hospital's EMTALA obligation ends when the patient is stabilized or admitted as an inpatient.



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



MEDICARE PAYMENT CUTS IN ALASKA

Since 2010, Congress and the Centers for Medicare and Medicaid Services (CMS) have enacted a series of Medicare payment cuts for hospital services in their effort to address the federal deficit and offset other program costs, including the cost of expanding insurance coverage under the ACA.

This summary is intended to support an understanding of existing Medicare provider cuts that Alaska hospitals are facing now and in the future. This analysis includes estimated Medicare fee-for-service payments and payment changes from 2010-2024 based on legislative payment changes adopted by Congress and regulatory payment changes adopted CMS and additional cuts under consideration.

***These cuts will cost Alaska hospitals \$591 million over 15 years.¹
Cuts under consideration could reduce revenue by an additional \$320 million if enacted.***

Enacted Cuts as a Percent of Total FFS Medicare Revenue ² 15 year summary value	-10.0%
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Cuts Enacted (2010-2024): Legislative

ACA Marketbasket Cuts	(\$266,013,300)
Sequestration	(93,961,800)
Medicare DSH Cuts	(79,844,200)
Quality	(6,743,300)
ATRA Coding	(9,932,500)
Bad Debt at 65%	(2,180,700)
Total Legislative Cuts	(\$458,675,800)

Cuts Enacted (2010-2024): Regulatory

Coding Cuts	(\$127,744,400)
2-Midnight Offset	(4,769,600)
Total Regulatory Cuts	(\$132,514,000)
Total Cuts Enacted	(\$591,189,800)

Cuts Under Consideration (2015-2024)

Rural Cuts	(\$228,923,000)
OPD Cuts	(46,733,800)
IME/DGME Cuts	(14,218,200)
Bad Debt Elimination	(10,567,500)
CMS Coding Cut	(9,821,600)
Post Acute Cuts	(9,500,700)
Total Cuts Under Consideration	(\$319,764,800)



Over the past few years, law makers have repeatedly turned to cutting Medicare payments to providers to address federal budget shortfalls and/or offset the costs associated with implementing new programs including the expansion of insurance coverage provided by the Affordable Care Act (ACA). As Congress looks for ways to further reduce federal spending, address the debt ceiling, and offset costs associated with fixing the sustainable growth rate, Medicare payments to hospitals remain vulnerable. This prospect is particularly troubling in light of uncertainty surrounding implementation of the ACA, including the lack of Medicaid expansion in Alaska and the uncertainty of the subsidies received through the federal marketplace.

ASHNHA opposes additional Medicare payment cuts without full implementation of the expanded coverage promised through the ACA. ASHNHA also opposes poorly designed approaches to achieving Medicare savings through arbitrary provider cuts. Instead we support the development of more rational long-term payment methodologies that reward quality and promote better health outcomes, such as value-based purchasing and accountable care models.

Cuts enacted - Summary of 15 year impact

- **ACA Marketbasket Cuts: \$266,013,300**
The impact shown reflects the Affordable Care Act (ACA) of 2010 authorized hospital/health system payment cuts,
- **Sequestration Cuts: \$93,961,800**
The impact reflects the 2% sequester reduction on total Medicare payments currently in effect for years 2013-2024.
- **Medicare DSH Cuts: \$79,884,200**
Impacts reflect the estimated reductions to the national uncompensated care payment pool amount based on projected changes to the national uninsured rate provided by the CBO.
- **Quality Cuts: \$6,743,300**
Reflect payment adjustments related to ACA-mandated Quality Based Payment Reform including value based purchasing, readmissions, and hospital acquired conditions.
- **Bad Debt Payment Cuts: \$2,180,700**
The impact shown reflects the Middle Class Tax Relief and Job Creation Act of 2012-authorized reduction to Medicare payments for reimbursable bad debts for all provider settings to 65%.
- **ATRA Coding: \$9,932,500**
The impact reflects the American Taxpayer Relief (ATRA) of 2012-authorized retrospective (one-time) coding adjustment cuts totaling at least -9.3% that CMS must implement over a 4 year period.

Total Legislative Cuts = \$458,675,800

- **Regulatory Coding Adjustments \$ 127,744,400**
The impact shown reflect annual adjustments made to the standard amount/federal rate in order to recoup for increases in gross payments due solely to the transition to new DRGs and/or DRG weights.
- **2-Midnight Rule Offset: \$4,769,600**
The impact reflects the -0.2% adjustment to the IPPS federal rate established by CMS in order to offset grown in IPPS expenditures as a result of increased inpatient admissions associated with the "2-Midnight Rule".

Total Regulatory Cuts =\$132,514,000

¹ 15-Year Medicare Cut Analysis, DataGen, February 2015.

² This value is calculated by first estimating and aggregating Medicare Fee-for-Service (FFS) revenue overall a 15 year period (2010-2024) without the effect of existing legislative or regulatory payment cuts. Then the estimated impact of the existing cuts over the same 15 year period are aggregated and divided by the aggregated revenue calculated in the first step. The result is a 15 year summary value of cuts as a percent of total Medicare FFS revenue. This does not include any of the cuts under consideration.