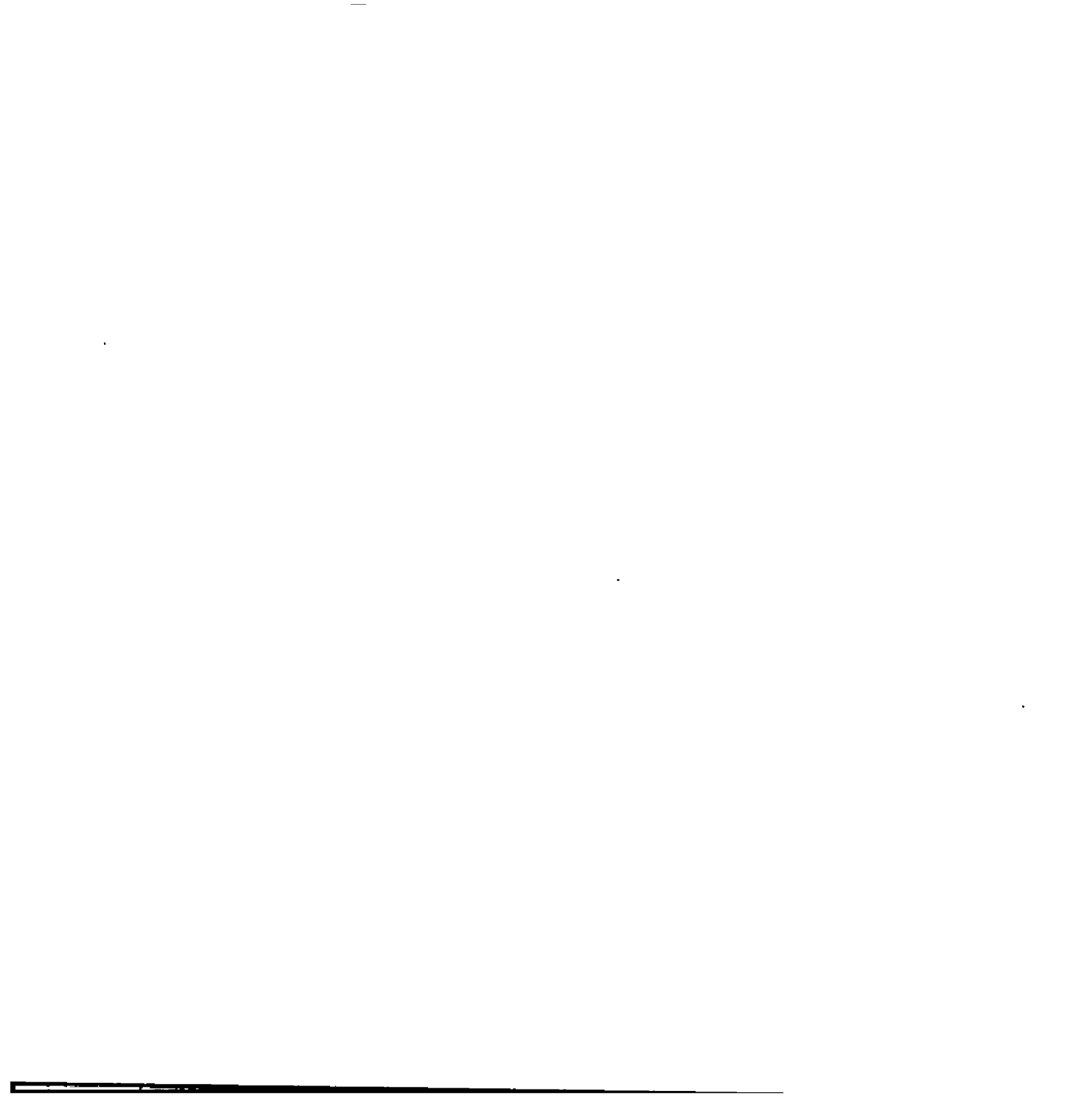


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# PROVIDER TAXES – A COMPREHENSIVE OVERVIEW

Provider taxes are a strategy that almost every state employs to help fund Medicaid programs while leveraging additional federal dollars. To control federal costs of the Medicaid program, there are certain limitations, restrictions, and other requirements that policy makers and health care providers must be aware of and take into consideration when contemplating the use of provider taxes to support Medicaid programs. Additionally, the type, amount, and use of provider taxes vary dramatically among states. This briefing will provide case studies of tax models used in different states as well as an overview of how provider taxes are being used to leverage Medicaid expansion in various states.

## Key Points

### General

- Provider taxes are defined as any fee, assessment, or mandatory payment where 85% of the burden falls upon health care providers.<sup>1</sup>
- There are 19 classes of providers that may be taxed as identified by CMS.<sup>2</sup>

### Requirements

- Provider taxes must meet three general requirements in order for the funds to be eligible to count as part of the state's Medicaid match. These three requirements are:<sup>3</sup>
  - 1) The tax must be broad based, meaning it must apply to all non-federal, non-public providers or services within that class;
  - 2) The tax must be uniform, meaning the same fee (amount, rate, percentage, etc.) must be applied to all providers or services within that class; and
  - 3) The tax cannot hold providers harmless, meaning it cannot guarantee that providers will be made financially whole through direct or indirectly means. However states can provide an indirect guarantee if the tax is 6% or less of net patient revenues within the class of providers or services being taxed.
- Eligible provider taxes may not make up more than 25% of the state's share of Medicaid expenditures within a state fiscal year.<sup>4</sup>

### Waivers

- States may apply to the Secretary of the Department of Health and Human Services (DHHS) for a waiver from the broad based and uniform requirements, but not the hold harmless requirement.
- In general, waivers must show that the proposed tax is generally distributive, that the tax is not directly correlated to Medicaid payments, and that it does not hold providers harmless. This is tested with specific formulas outlined in regulations.
- Establishing different thresholds or excluding rural access hospitals and sole community hospitals are specifically identified in statute as examples for which a waiver would be viewed favorably.<sup>5</sup>

**Provider taxes are complex and require in depth analysis and modeling to avoid unintended negative consequences on the health care infrastructure.**

**FMAP). The FMAP is calculated using a variety of different factors, but is largely based on a state's per capita income. The actual amount of federal assistance received by states is based on the FMAP and on reported Medicaid expenditures for both medical costs and administrative costs.**

**In order to receive federal funding for Medicaid, each state must provide matching funds to help pay for their portion of the program cost. In the late 1980s, states realized that they could leverage provider taxes to increase the federal funding they received for the program and to decrease state general funds as a portion of the state required match. They did this by taxing health care providers, collecting the taxes and putting them towards the state required match. The increased income from provider taxes resulted in an increase in state funding for the program, which in turn drew down additional federal funds. These funds were then passed back to providers through increased rates and supplemental payments above and beyond what providers had paid in taxes.**

**States were so successful in using provider taxes to leverage federal funds that, in an effort to contain Medicaid costs in the early 1990s, the federal government began regulating provider taxes in effect limiting a state's ability to use these funds in a way that qualifies for federal matching dollars. In order for funds generated by provider taxes to count as part of the state's match, the provider taxes must meet several requirements outlined and determined by the Center for Medicaid and Medicare Services (CMS). If CMS determines that a provider tax does not meet the requirements outlined in statute and regulation, then CMS will subtract the amount of ineligible provider tax dollars from the total state Medical assistance expenditures before calculating the federal match.<sup>6</sup>**

**In general, requirements for state matching funds include:**

- At least 40% of matching funds must be state funds.<sup>7</sup>**
- No more than 25% of a state's match can come from provider tax funds.<sup>8</sup>**
- Up to 60% of a state's match can come from local government funds or Certified Public Expenditures (CPE).<sup>9</sup> CPEs are the reported expenditures for Medicaid services performed by a hospital or provider that is owned by a local government entity. CPEs are reported to the state Medicaid program and added to the Medicaid expenditure total when calculating federal assistance. States can choose to pass all or a portion of the federal funds received for CPEs back to the local government entity.<sup>10</sup>**

### **Provider Tax Definition & Requirements-**

**Provider taxes are defined as any "fee, assessment, or mandatory payment" for which 85% or more of the burden of the payment is shouldered by health care providers.<sup>11</sup> Although often thought of as primarily a "hospital tax," there are 19 classes of health care providers that fall under this definition as outlined in federal regulations:<sup>12</sup>**

- 1) Inpatient hospital services;**
- 2) Outpatient hospital services;**
- 3) Nursing facility services (other than services of intermediate care facilities for individuals with intellectual disabilities);**
- 4) Intermediate care facility services for individuals with intellectual disabilities, and similar services furnished by community-based residences for individuals with intellectual disabilities;**
- 5) Physician services.**

- 10) Dental services;
- 11) Podiatric services;
- 12) Chiropractic services;
- 13) Optometric/optician services;
- 14) Psychological services;
- 15) Therapist services (including PT, SLP, OT, respiratory therapy, audiological services, and rehabilitative specialist services);
- 16) Nursing services (including nurse midwives, nurse practitioners, and private duty nurses);
- 17) Laboratory and x-ray services in a licensed, free-standing laboratory or x-ray facility (excludes those provided in a physician's office, hospital inpatient outpatient department);
- 18) Emergency ambulance services; and
- 19) Other health care items or services not listed above on when the state has enacted a licensing or certification fee, subject to the broad based, uniformity, and hold harmless requirements.

CMS has established three thresholds that a provider tax must pass in order to be eligible for federal matching funds. These include: 1) the tax must be broad based; 2) the tax must be uniform; and 3) the tax must not hold providers harmless. In general, these three requirements are evaluated based on how a tax is applied to a class of providers or services and are calculated in aggregate. States may apply to the DHHS Secretary for waiver of the broad based and uniform requirements, however there is no allowable waiver for the hold harmless provision. The details and process associated with each requirement (where applicable) are described below. From 2008 through 2012, CMS approved broad based and/or uniform waivers in 29 states.<sup>14</sup>

### **1. Broad based requirement**

This requirement states that a tax must be applied to "all services or items within a class including all non-federal or non-public providers within the class."<sup>15</sup> States can apply for a waiver from this requirement if they are seeking to impose a tax that excludes certain providers within a class as long as they can show that the tax is "generally redistributive in nature."<sup>16</sup>

States are automatically granted a broad based waiver if the proposed tax is no more than \$1,000 annually per provider, or if the total amount of the tax is used to cover the cost of a licensing and certification program.<sup>17</sup> To evaluate other proposed taxes for a broad based waiver, CMS applies a formula that divides the estimated amount of the tax if it were applied to all providers within that class by the estimated amount of the tax as applied to providers under the proposed waiver. If the result is 1 or higher, the waiver is automatically approved. If the result is between 0.90 and 1, CMS will review the waiver and will approve if the proposed tax only excludes or treats differently providers in the classes listed below:<sup>18</sup>

- Providers that provide no services or who do not charge for services in the state
- Rural hospitals
- Sole community hospitals
- Physicians practicing in medically underserved areas as defined by section 1302(7) of the Public Health Service Act
- Financially distressed hospitals only if:
  - 1) Such hospitals are defined by state law that is applied uniformly to hospitals around

## **2. Uniform requirement**

An additional requirement for any provider tax is that it be uniformly imposed, meaning it is applied to all providers or services within that class and that it is applied to the same degree.<sup>19</sup> Examples identified in regulation are listed below:

Example 1: If the tax is a bed tax, the same amount per bed must be applied to all providers within that class.

Example 2: If the tax is a certification fee, the fee must be the same for all providers within that class.

Example 3: If the tax is based on gross revenue receipts or net operating revenue, the tax rate must be the same for all providers within that class.

Specifically, in order to be uniform the tax must be "generally redistributive in nature," just as with the broad based requirement, but the tax must also prove that provider revenues are not correlated with Medicaid payments at any point in time. Also, there is repeated and significant emphasis that any taxes providing credits, exclusions, or direct or indirect payment to providers would violate the uniformity clause and the hold harmless clause. Some states have developed methods to work around this clause that are discussed further in this paper.

States applying for a waiver to the uniform requirement must also pass a test used to evaluate if there is any correlation between the receipt of Medicaid payments and the amount of provider taxes paid.<sup>20</sup> To determine if this relationship exists, and to what extent it does exist if at all, CMS divides the slope of the linear regression if the state's tax were broad based and uniform to the slope of the linear regression of the tax as proposed in the waiver. If the result is 1 or more, the waiver is automatically approved. If the result is between 0.90 and 1, the waiver may be approved only if it applies the tax in a non-uniform manner to the following providers (note this list is slightly different than the list of providers allowed under the broad based exclusion):<sup>21</sup>

- Providers that provide no services or who do not charge for services in the state
- Rural hospitals
- Sole community hospitals
- Physicians practicing in medically underserved areas as defined by section 1302(7) of the Public Health Service Act.
- Financially distressed hospitals only if:
  - Such hospitals are defined by state law that is applied uniformly to hospitals around the state; and
  - No more than 10% of hospitals are excluded from the tax
- Psychiatric hospitals
- Providers or payers with varying tax rates based exclusively on region subject to certain requirements

## **2. Hold harmless requirement**

This requirement essentially acts as a way to prohibit states from taxing providers, using those funds to pull down enhanced federal funding, and passing those dollars back to providers through direct or indirect means. There are no waivers to this requirement which CMS evaluates two ways:<sup>22</sup>

- 1) Does the tax use direct or indirect means to ensure the providers paying the tax are made

not constant over time.

Despite the lack of waiver for this requirement, there is an established "safe harbor" threshold that allows for a certain amount of flexibility. States can provide an indirect guarantee if the tax produces revenues less than 6% or more of the net patient revenue attributed to the class of health care providers or services being taxed.<sup>23</sup> This safe harbor provision is currently set at 6%, but it is important to note that this has changed within the past decade falling to 5.5% from 2008 to 2011 before returning to 6%. There are ongoing discussions in Congress debating the impact and financial benefit to the federal government of lowering this threshold and at one point in the past few years President Obama's budget proposed lowering the threshold to 3.5% as part of his administration's effort to reduce the federal deficit.<sup>24</sup>

To determine if there is a positive correlation or if the tax holds providers harmless, CMS applies a "two prong test:"

- Prong 1: Does the tax create more revenue than 6% of the net patient revenue attributed to the class of health care providers or services being taxed?<sup>25</sup>
- Prong 2: If so, do 75% of the providers taxed recover 75% or more of their total costs back through enhanced Medicaid or other state payments?

According to a 2014 report by the GAO, all of the 63 taxes implemented between 2008 and 2012 as a percentage of net patient revenues were below the safe harbor threshold and would have passed the hold harmless test.<sup>26</sup> This is significant in understanding how some states are able to leverage provider taxes to fund expanded Medicaid programs, and in effect be "held harmless" despite the regulatory and statute provisions.

### **Provider Donations**

Similar to provider taxes, provider donations have also come under scrutiny and both statute and regulations outline requirements that provider donations must meet in order for states to avoid reductions in federal matching funds. These requirements are:

- Provider donations can be cash, in-kind, direct or indirect services or payments to the state from a health care provider offering services under the state plan.<sup>27</sup>
- Donations from individuals of \$5,000 or less annually are allowed.<sup>28</sup>
- Donations from a health care provider/entity of \$50,000 annually or less are allowed.<sup>29</sup>

Bona fide donations are donations for which providers are not held harmless. Specifically this means that there is no positive correlation at any time between provider donations and the amount of Medicaid payments the provider receives.

Bona fide donations from hospitals, FQHC, clinics, or similar provider classes are specifically allowed if they cover the costs of staff providing Medicaid eligibility determinations or redeterminations for the state at that facility.<sup>30</sup> These types of donations are limited to no more than 10% annually of the state's Medicaid assistance administrative cost.<sup>31</sup> The donation must be a direct donation defined as costs for salaries, training, or fringe benefits for on-site or local agency support staff. Eligibility outreach costs may also be considered an allowable donation if those costs are prorated and calculated as a

the requirements are rather vague. States are required to report provider taxes and donations on a quarterly basis in summary form.<sup>33</sup> This information should include the source of tax or donation revenue and how the state is using these funds. Additionally the state is required to provide a legal basis for the donation or tax program.

The United States Government Accountability Office (GAO) has raised concerns that the current reporting system is not adequate and that CMS is not enforcing the existing reporting requirements.<sup>34</sup> CMS has indicated that they do not agree with the GAO assessment but will consider improving the reporting system at some point in the near future.

### **Process for Implementing Provider Taxes**

Generally provider taxes are enacted by a state legislature through statute. The state then adds the proposed tax to their Medicaid state plan through a State Plan Amendment (SPA). During the SPA process CMS evaluates the taxes based on the requirements outlined above. Typically the fees are collected by provider association groups and are then passed along to the Medicaid program through an intergovernmental transfer.<sup>35</sup> In some states however, a state agency is responsible for collecting the taxes from each provider.

### **Provider Taxes that are not Regulated by CMS**

Several states have implemented provider taxes that do not meet the definition in federal statute or regulation for provider taxes and thus are not subject to the requirements laid out by CMS. They have achieved this by making the taxable entities a mix of health care and non-health care providers so the total tax burden for health care providers is under the 85% threshold identified in statute. Specific examples are listed below:<sup>36</sup>

- Washington enacted a business and occupation gross receipts tax. Health care providers, specifically hospitals are taxed based on their profit or non-profit status at 1.8% of gross revenue from health care activities.<sup>37</sup> Preferential tax rates are applied to other types of health care services such as room and domiciliary care to patients in an assisted living facility which is taxed at 0.27%.<sup>38</sup>
- Maine taxed 5% of the value of mental health, intellectually disabled, and autistic home-support and institutional services along with cable and satellite television, fabrication services, video equipment and media rental, and telecommunication services.
- West Virginia enacted a 5% severance and business privilege tax on behavioral health services (inpatient, outpatient, residential) and the severing, extraction, and sale of commercial coal, limestone, or sandstone.

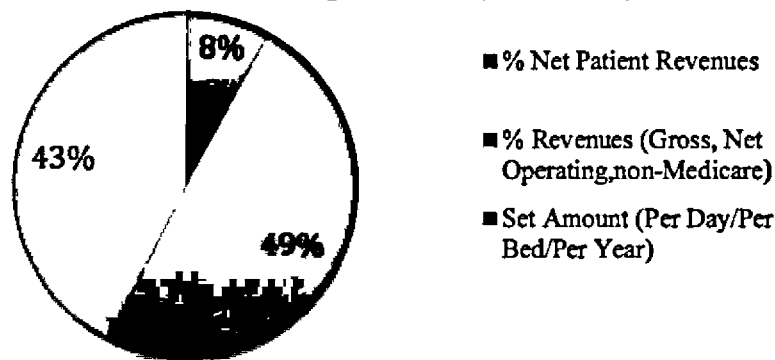
### **State Trends**

According to the Kaiser Family Foundation in their annual state survey, 49 states reported assessing at least one provider tax with most states reporting multiple taxes. Alaska was the only state that had not implemented a provider tax, but Delaware, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Virginia, and Wyoming all reported assessing only one type of provider tax in 2015.<sup>39</sup> The other 41 states reported assessing two or more taxes on health care providers in 2015.

The most popular type of tax was a tax on nursing facilities (44 states), followed by hospital services

States have been creative with the way that they implement taxes. Some examples of provider taxes include licensing fees, bed taxes, a tax per hospital admission, a tax per hospital discharge, a tax on gross revenue, a tax on net revenue, prescription taxes, etc.<sup>41</sup>

**Type of Provider Taxes Among All States (2008 - 2012)**



A recent report from the GAO highlights the increasing reliance of state Medicaid funding through provider taxes. According to their report, the amount of provider taxes funding Medicaid programs across the US increased from \$10 billion in 2008 to around \$19 billion by 2012 and increases were largely seen in provider taxes on inpatient hospitals and nursing homes.<sup>42</sup> Specifically, in 2008 there were 117 provider taxes implemented in 42 states, and by 2012 that increased to 159 provider taxes implemented across 47 states. This represents a 36% increase over the 5-year period and a net increase of 42 taxes.<sup>43</sup>

Increasingly, states have turned to provider and local government funds in order to finance the non-federal portion of supplemental payments. In 2012, seven states reported relying exclusively on provider taxes and local government funds for the non-federal portion of their Disproportionate Share Hospital (DSH) match.<sup>44</sup> Seven other states used a mix of provider taxes and local funding to provide their portion of matching funds for supplemental non-DSH payments.<sup>45</sup> Notably, Idaho and Nevada made both lists and reported funding all of their supplemental payments, DSH and non-DSH, with 100% provider taxes and local government funds. From 2009 through 2010, Idaho eliminated the use of state general funds for supplemental payments by increasing or establishing new taxes for inpatient and outpatient hospital services and nursing homes.<sup>46</sup> This increase in provider taxes and local government funding made Idaho the state with the largest increase in provider taxes in the U.S. during that time period. While Idaho is at one end of the spectrum of choices states have made in funding their Medicaid programs, the overall 5-year trend has been an increase in taxes on provider and services.

Just as every Medicaid program is unique to each state, so is their provider tax structure. Summarized below are some notable models/elements of provider taxes in a variety of states.

### **Kansas**

Assesses a 1.83% tax on hospital net inpatient operating revenue and a flat rate of \$1,950 per nursing home bed. State statute dictates that at least 90% of the revenue from the hospital tax must be

## **Minnesota**

This state has enacted some of the widest variety of provider taxes among all of the states with a focus on using provider taxes to fund public health programs for those who were uninsured and previously ineligible for Medicaid under a health plan called MinnesotaCare. MinnesotaCare was funded through the creation of the Health Care Access fund. This fund was made up of state taxes totaling 2% of hospital, surgical centers, health care providers, and wholesale drug distributor's gross revenues.<sup>48</sup> While the fund was created with the intention of funding MinnesotaCare, during challenging budget times provider tax funds were actually used to balance the state budget and were not fully put towards supporting health care programs. As a result of a combination of advocacy by provider associations and the expansion of Medicaid to uninsured, childless adults, the state decided to slowly phase out the provider taxes with the intention of eliminating them by 2019.<sup>49</sup>

## **Washington**

Aside from the Business and Occupation Tax described on page 8, the State of Washington implemented a hospital assessment to support safety net services in 2010 when the state was facing a budget shortfall.<sup>50</sup> The assessment was intended to pull down matching federal funds which would then be passed onto hospitals through increased rates with a small portion (\$50 million) being put towards the general fund. A year later, the legislature reversed course reducing Medicaid rates and directing \$110 million in Safety Net Assessment funds to the general fund. This in turn reduced the state's federal match for Medicaid and resulted in an estimated \$260 million impact. This disproportionately impacted Prospective Payment System (PPS) hospitals in the state as they ended up paying more in taxes than they were receiving. Critical access hospitals, public hospitals, and psychiatric hospitals were not impacted as deeply by the changes.

The Washington State Hospital Association filed a lawsuit in 2011 and, in an effort to avoid a contentious legal battle, the hospital association and the legislature crafted a provider tax structure that is currently in place.<sup>51</sup> Under this structure the state established a dedicated fund within the treasury called the Safety Net Assessment Fund.<sup>52</sup> The stated legislative intent is that as Medicaid expansion brings additional federal dollars to the state health care system to cover individuals in the safety net, the need for this assessment will decrease. Beginning in state fiscal year 2016, the assessment program will be phased out ending entirely in 2019.<sup>53</sup> Additionally, the legislation contains stipulations that protect hospitals from having the fund be misused or diverted as they were in the past.<sup>54</sup>

- The state cannot pull more than \$100 million per year from the assessment fund to put towards general fund spending in the Medicaid program.
- The bulk of the funds must be used to help hospitals support vulnerable patients.
- Any dollars remaining in the fund in 2019 must be distributed back to the hospitals.
- Hospitals engage in a contract with the state Health Care Authority each biennium to ensure there are no additional legislative changes to the supplemental payments, rates, assessments, DSH payments, capitation payments, or other financial arrangements outline in statute.<sup>55</sup>

Hospitals agreed to accept 2009 Medicaid rate levels for inpatient and outpatient services for both Fee for Service (FFS) and Managed Care (MC).<sup>56</sup> For PPS hospitals, the assessment is based on a flat rate

In turn, hospitals receive direct quarterly supplemental payments from the state for inpatient and outpatient FFS Medicaid services. The quarterly payments are based on a set amount fixed in statute for fiscal years 2014 and 2015 per hospital class. Should the combination of Medicaid revenues and additional supplemental payments exceed the Upper Limit (UL), the supplemental payments must be reduced until they are within the UL threshold. The remaining funds will be paid to Medicaid Managed Care organizations.<sup>58</sup>

Notably, the statute also includes a provision requiring hospitals to treat the assessment as part of their operating overhead and restricts them from passing on these costs to consumers and third-party payers through increased charges.<sup>59</sup>

### **Arizona**

In 2013 Arizona established a hospital assessment intended to cover the state's portion of the cost to expand Medicaid coverage to non-disabled, childless adults with incomes between 100% and 133% of the Federal Poverty Level (FPL) along with restoring funding for a program called Prop 204 which provided coverage for childless adults with incomes 100% FPL or less.<sup>60</sup> Rather than the Legislature developing the assessment, Governor Brewer directed the Director of the Arizona Health Care Cost Containment System (AHCCS) to develop an assessment model not codified in statute in order to retain flexibility.<sup>61</sup>

Ultimately the assessment model was supported by the Arizona Hospital and Healthcare Association (AHHA) because of a shared understanding that the assessment would be designed in such a way that no hospital would experience financial harm.<sup>62</sup> In order to achieve this, the assessment model uses a variety of exemptions and variable rates to ensure the assessment does not harm different hospital models. In a move similar to that of Washington state, legislation was crafted that specifically prohibits hospitals from passing on the cost of the assessment to consumers.

The assessment itself is at the heart of a legal challenge to Arizona's decision to expand Medicaid. Arizona requires that state taxes be approved by a two-thirds majority rather than a simple majority. Governor Brewer's administration determined the assessment was not a tax, and the enabling legislation for the hospital assessment was passed with a simple majority, however that is now being challenged in the court system.<sup>63</sup>

### **Indiana**

In order to maintain his commitment to not use taxpayer funds to support Medicaid expansion, Governor Pence worked with the hospital association to develop a funding mechanism that uses tobacco tax revenues and increases an existing provider tax to cover the state's portion of the cost to expand Medicaid.<sup>64</sup> Specifically, Indiana's expansion model uses a tax on acute and private psychiatric hospitals that was established in 2011 with proposed increases taking effect as the federal funding match for the expansion population begins to drop in 2017. The hospital tax will provide \$959 million of the estimated \$1.6 billion state required match while revenue from a tobacco tax increase will cover the additional \$640 million.

In return for the assessment, the hospitals will benefit by avoiding rate reductions and increased

## **Considerations for Provider Taxes in Alaska**

Should Alaska providers and policy makers engage in the discussion of enacting a provider tax or assessment, some considerations are listed below:

- 1) Ensure that the tax is not misappropriated by future legislatures as much as possible. With Alaska's constitutional prohibition against dedicated funds, it may be appropriate to consider taking Washington's approach and having a state agency contract with hospitals and using the contract terms to protect against misappropriation.
- 2) Can tribal health providers be included in a provider tax structure? This is an important issue that would need to be resolved early in the process. A discussion on what providers are included in a tax structure is a critical question.
- 3) Ensure that supplemental payments to hospitals or other provider classes are not in excess of the upper payment limit and develop a plan to manage any excess payments in advance.
- 4) Consider establishing a board made up of state agency representatives and hospital association or provider representatives to manage the assessment process on an annual or biennial basis.
- 5) Consider the staff time necessary to manage the tasks associated with an assessment. Specifically staff would be needed to manage the quarterly reporting requirements, the collection of the assessment, and the development of any waivers.
- 6) Ensure providers are not financially harmed by an assessment. This would require a balance of the following:
  - Staying under the 6% safe harbor threshold;
  - Ensuring that supplemental payments to make hospitals whole do not exceed Medicaid upper payment limit; and
  - Providing variable tax rates or exemptions for critical access hospitals and/or sole community hospitals.
- 7) States typically require outside expertise to assist in the development of a provider tax through modeling the impact of rates and types of taxes (e.g. bed, revenue, discharge, etc.) on different providers. Arriving at a methodology that will meet the needs of diverse providers and fulfill complex CMS requirements makes consultant support critical.

<sup>2</sup> 42 C.F.R. § 433.56

<sup>3</sup> 42 C.F.R. § 433.68

<sup>4</sup> Social Security Act § 1903(w)(5), 42 U.S.C. § 1396b

<sup>5</sup> Social Security Act § 1903 (w)(3), 42 U.S.C. § 1396b

<sup>6</sup> 42 C.F.R. § 433.57

<sup>7</sup> 42 C.F.R. § 433.53

<sup>8</sup> Social Security Act § 1903(w)(5), 42 U.S.C. § 1396b

<sup>9</sup> United States Government Accountability Office. (2014). *Medicaid Financing: States Increased Reliance on Funds From Health Care Providers and Local Governments Warrants Improved CMS Data Collection*.

<http://www.gao.gov/assets/670/665077.pdf>

<sup>10</sup> Ibid.

<sup>11</sup> 42 C.F.R. § 433.55

<sup>12</sup> 42 C.F.R. § 433.56

<sup>13</sup> Health insurance and HMO premiums are not considered a provider tax and are specifically excluded per 42 CFR § 433.55.

<sup>14</sup> United States Government Accountability Office. (2014). *Medicaid Financing: States Increased Reliance on Funds From Health Care Providers and Local Governments Warrants Improved CMS Data Collection*. Retrieved from

<http://www.gao.gov/assets/670/665077.pdf>

<sup>15</sup> 42 C.F.R. § 433.68

<sup>16</sup> Ibid.

<sup>17</sup> Ibid.

<sup>18</sup> Ibid.

<sup>19</sup> Ibid.

<sup>20</sup> 42 CFR § 433.68

<sup>21</sup> Ibid.

<sup>22</sup> Ibid.

<sup>23</sup> 42 CFR § 433.68

<sup>24</sup> Kaiser Commission on Medicaid and the Uninsured. (2013). *Quick Take: Medicaid Provider Taxes and Federal Deficit Reduction Efforts*. Retrieved from <http://kff.org/medicaid/fact-sheet/medicaid-provider-taxes-and-federal-deficit-reduction-efforts-2/>

<sup>25</sup> 42 CFR § 433.68

<sup>26</sup> United States Government Accountability Office. (2014). *Medicaid Financing: States Increased Reliance on Funds From Health Care Providers and Local Governments Warrants Improved CMS Data Collection*. Retrieved from

<http://www.gao.gov/assets/670/665077.pdf>

<sup>27</sup> Social Security Act § 1903 (w)(2), 42 U.S.C. § 1396b

<sup>28</sup> 42 CFR § 433.55

<sup>29</sup> 42 CFR § 433.55

<sup>30</sup> 42 CFR § 433.66

<sup>31</sup> 42 CFR § 433.67

<sup>32</sup> 42 CFR § 433.66

<sup>33</sup> 42 CFR § 433.74

<sup>34</sup> United States Government Accountability Office. (2014). *Medicaid Financing: States Increased Reliance on Funds From Health Care Providers and Local Governments Warrants Improved CMS Data Collection*. Retrieved from

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<sup>35</sup> Boothe, A. & Kim, S. (2014). *Medicaid Provider Fees Explained*. American Action Forum. Retrieved from

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<sup>36</sup> Pacific Health Policy Group. (2012). *Health Care-Related Tax Study Report [Prepared for the Department of Vermont Health Access]*. Retrieved from <http://dvha.vermont.gov/budget-legislative/2health-care-related-tax-study-report-01-12-12.pdf>

<sup>37</sup> State of Washington Department of Revenue. (n.d.). *Business and Occupation (B&O) Tax Classification Definitions*.

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<sup>38</sup> WAC § 458-20-168

<sup>39</sup> --

United States Government Accountability Office. (2014). *Medicaid financing: States increased reliance on federal funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection*. Retrieved from <http://www.gao.gov/assets/670/665077.pdf>

<sup>43</sup> Ibid.

<sup>44</sup> Ibid. The seven states are Colorado, Florida, Idaho, Mississippi, Nevada, South Carolina, and Tennessee.

<sup>45</sup> Ibid. The seven states are Alabama, Idaho, Illinois, Nebraska, Nevada, North Carolina, and Wyoming.

<sup>46</sup> Ibid.

<sup>47</sup> Kansas Health Institute. (2014). *Kansas Medicaid: Beyond the Basics*. Retrieved from <http://media.khi.org/news/documents/2014/06/04/MedicaidSupplementREVISED.pdf>

<sup>48</sup> Minn. Stat. § 295.52

<sup>49</sup> Minnesota Medical Association. (n.d.). *Provider/Sick Tax*. Retrieved from <http://www.mnmed.org/Advocacy/Key-Issues/Sick-Tax>

<sup>50</sup> Washington State Hospital Association. (2014). *Questions and Answers About the Safety Net Assessment Lawsuit*. Retrieved from <http://www.wsha.org/LawsuitFAQ.cfm>

<sup>51</sup> Ibid.

<sup>52</sup> Wash. Rev. Code § 74.60

<sup>53</sup> Wash. Rev. Code § 74.60

<sup>54</sup> Wash. Rev. Code § 74.60

<sup>55</sup> Wash. Rev. Code § 74.60.160

<sup>56</sup> Wash. Rev. Code § 74.60.020

<sup>57</sup> Wash. Rev. Code § 74.60.030

<sup>58</sup> Wash. Rev. Code § 74.60.120

<sup>59</sup> Wash. Rev. Code § 74.60.070

<sup>60</sup> Hospital Assessment. (n.d.)

<sup>61</sup> Arizona Hospital and Healthcare Association. (2014). *Implementing the Hospital Assessment: Ensuring Fairness and No Financial Harm [Issue Paper]*.

<sup>62</sup> Arizona Hospital and Healthcare Association. (2014). *Implementing the Hospital Assessment: Ensuring Fairness and No Financial Harm [Issue Paper]*.

<sup>63</sup> Williams, T. & Rojas, R. (31 Dec. 2014). *Arizona Supreme Court Allows Challenges to State's Medicaid Expansion*. *New York Times*. Retrieved from [http://www.nytimes.com/2015/01/01/us/politics/arizona-supreme-court-allows-challenge-to-states-medicaid-expansion.html?\\_r=0](http://www.nytimes.com/2015/01/01/us/politics/arizona-supreme-court-allows-challenge-to-states-medicaid-expansion.html?_r=0)

<sup>64</sup> Daly, R. (2015). *Indiana Hospitals Help Fund Medicaid Expansion*. Healthcare Financial Management Association. Retrieved from <https://www.hfma.org/Content.aspx?id=27903>

<sup>65</sup> Ibid.

<sup>66</sup> Indiana Family and Social Services Administration. (n.d.). *Healthy Indiana Plan 2.0*. Retrieved from [http://www.in.gov/fssa/hip/files/HIP\\_2\\_0\\_Roadshow\\_DM\\_FINAL.pdf](http://www.in.gov/fssa/hip/files/HIP_2_0_Roadshow_DM_FINAL.pdf)

March 2015 | Issue Brief

## The Effects of the Medicaid Expansion on State Budgets: An Early Look in Select States

As enacted, the Affordable Care Act (ACA) broadened Medicaid's role, making it the foundation of coverage for nearly all low-income Americans with incomes up to 138 percent of the federal poverty level (FPL) (\$16,242 per year for an individual in 2015). However, the Supreme Court ruling on the ACA effectively made the decision to implement the Medicaid expansion an option for states. For those that expand, the federal government will pay 100 percent of Medicaid costs of those newly eligible for Medicaid from 2014 to 2016. The federal share gradually phases down to 90 percent in 2020, where it remains well above traditional federal medical assistance percentage (FMAP) rates. As of March 2015, 29 states (including the District of Columbia) adopted the Medicaid expansion, though debate continues in other states. In deciding whether to implement the Medicaid expansion, the effect on state budgets has been a key issue for policy makers. However, isolating the full effects of the Medicaid expansion across all parts of the state budget has proven challenging. State-specific estimates of the Medicaid expansion were created with varying degrees of completeness; those that were complete found net fiscal gains, with state savings and revenues exceeding increased state costs.<sup>1</sup>

This brief looks beyond the estimates and examines the early budget effects of expansion in three states: Connecticut, New Mexico, and Washington State. The study was conducted during the Fall of 2014; budgets had been enacted for state fiscal year 2015, the first full state fiscal year with the Medicaid expansion in effect. Budget officials were also in the process of closing the books on SFY 2014, the latter half of which included the first 6 months of the Medicaid expansion in each of these states. These findings are based on interviews conducted with budget officials and staff in each of the three states; the interviews focused on their state's experiences in this early period, when the costs of those newly eligible are fully financed with federal dollars. Specifically, budget officials were asked about assumptions and early experiences with state savings and costs from the expansion across state budgets (within and outside of Medicaid) as well as the expansion's impact on state revenue. (See the [Methodology section](#) for more details on how the study was conducted.) Findings from a separate report commissioned by Kentucky are also included. Key findings include:

- **Overall Finding.** Early evidence from interviews with budget officials in these case study states shows state savings and revenue gains with limited costs resulting from expansion, even as some potential fiscal gains have not yet been tracked.
- **Medicaid Enrollment and State Costs.** Enrollment of those newly eligible exceeded expectations; however, these individuals are fully financed with federal dollars through December 31, 2016, presenting no costs to states during this period. While enrollment among those previously eligible but not enrolled (which



rate (and therefore reduced state costs.)

- **Savings outside of Medicaid budgets.** All study states experienced savings in other areas of the state budget beyond Medicaid, such as state-funded behavioral health services and corrections. Some savings were captured for state general funds and others were reinvested, often to compensate for earlier cutbacks.
- **Revenue effects.** The impact on state revenue, as monitored by budget officials, was primarily reflected in increased provider and premium taxes. Only one study state (New Mexico) accounted for the increased economic activity resulting from expansion in general revenue forecasts. A separate study found the Medicaid expansion in Kentucky led to increases in jobs and tax revenues for the state and localities.
- **Long-term estimates of full effects.** Disentangling the revenue and budgetary impact of the Medicaid expansion from other ACA effects as well as other factors shaping health care costs, state economies and state budgets is a tremendous challenge that is generally not part of state budget processes. The one study state that produced net estimates, Washington, projected that state savings from expansion would exceed costs, resulting in net fiscal gains. During the current fiscal year (2015), net gains of expansion are estimated to equal 1.7 percent of total General Fund spending.<sup>2</sup> Net savings through 2021 due to the expansion were also found in a separate report examining the impact of the Medicaid expansion in the Kentucky. Both states projected net state savings in future years when the federal share of spending on newly eligible adults will fall to 90 percent.



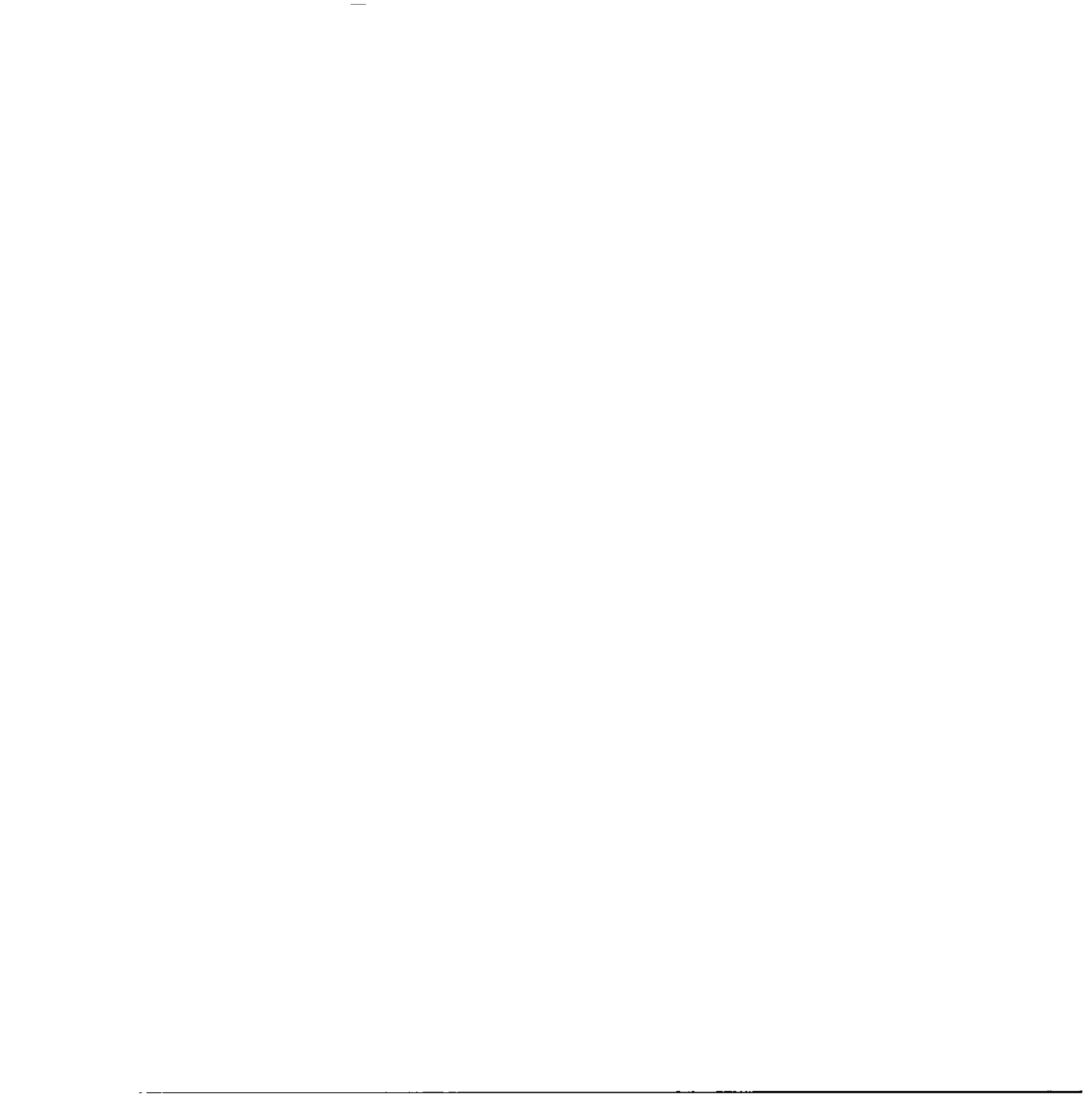
	Connecticut	New Mexico	Washington
<b>Enrollment</b>			
Newly Eligible Enrollment	Higher than projected; no state costs.	Higher than projected; no state costs.	Higher than projected; no state costs.
Previously Eligible but not Enrolled	Higher than projected; mostly children.	Higher than expected; mostly adults but also some children. <sup>3</sup>	Lower than expected; mostly children.

<b>Savings within Medicaid</b>			
Limited Medicaid programs for low-income adults	Savings from conversion of early expansion state plan group.	Substantial source of one-time savings from conversion of SCI waiver.	Substantial source of one-time savings from conversion of Bridge to Reform waiver.
Medically Needy Spend-Down	Enrollment decline noted; not included in budget.	N/A	Moderate savings noted.
Breast and Cervical Cancer Treatment	No change in enrollment.	Not noted or tracked (limited program to begin with.)	Limited savings noted from enrollment declines.
Family Planning	Limited savings noted from declining enrollment.	Not noted or tracked (limited program to begin with.)	Limited savings noted from declining enrollment.
Pregnancy Related Enrollment	Not noted or tracked.	Not noted or tracked.	Not included in budget, but enrollment decline noted (due mostly to the expansion.) Planning to take limited savings.

<b>Savings outside of Medicaid</b>			
Mental Health and Substance Abuse	Substantial savings included in budget.	Moderate savings noted, most funds reprogrammed within agency.	Moderate savings included in budget.
Uncompensated Care	Significant savings included in budget.	N/A - mostly county responsibility.	N/A - programs had mostly been eliminated by the state in earlier years.
State Funded Indigent Care**	N/A	N/A	N/A
High Risk Pools	N/A	Moderate savings included in budget; savings are slower than expected.	N/A
Inpatient Care for Prisoners	Not explicitly accounted for in budget. Many of those eligible under the expansion enrolled in the state's early expansion.	Not included in budget; anticipated to be small savings for counties and state.	Limited savings included in budget.
Public Health Services	Limited savings included in budget.	Exploring potential savings.	Limited savings included in budget.
Other Health Care Programs for Vulnerable Populations			Limited savings included in budget.

<b>Revenues</b>			
Taxes or Fees on Providers	No additional revenue included in budget.	Additional revenue included in budget.	Additional revenue included in budget.
General Revenue due to increased economic activity	Did not include in economic and revenue estimates at this time.	Included in economic and revenue estimates.	Did not include in economic and revenue estimates at this time.

\*\* Connecticut and Washington State had state-funded indigent care programs before the ACA; both states transitioned these programs to Medicaid financing before the Medicaid expansion went into effect. Connecticut's program was...

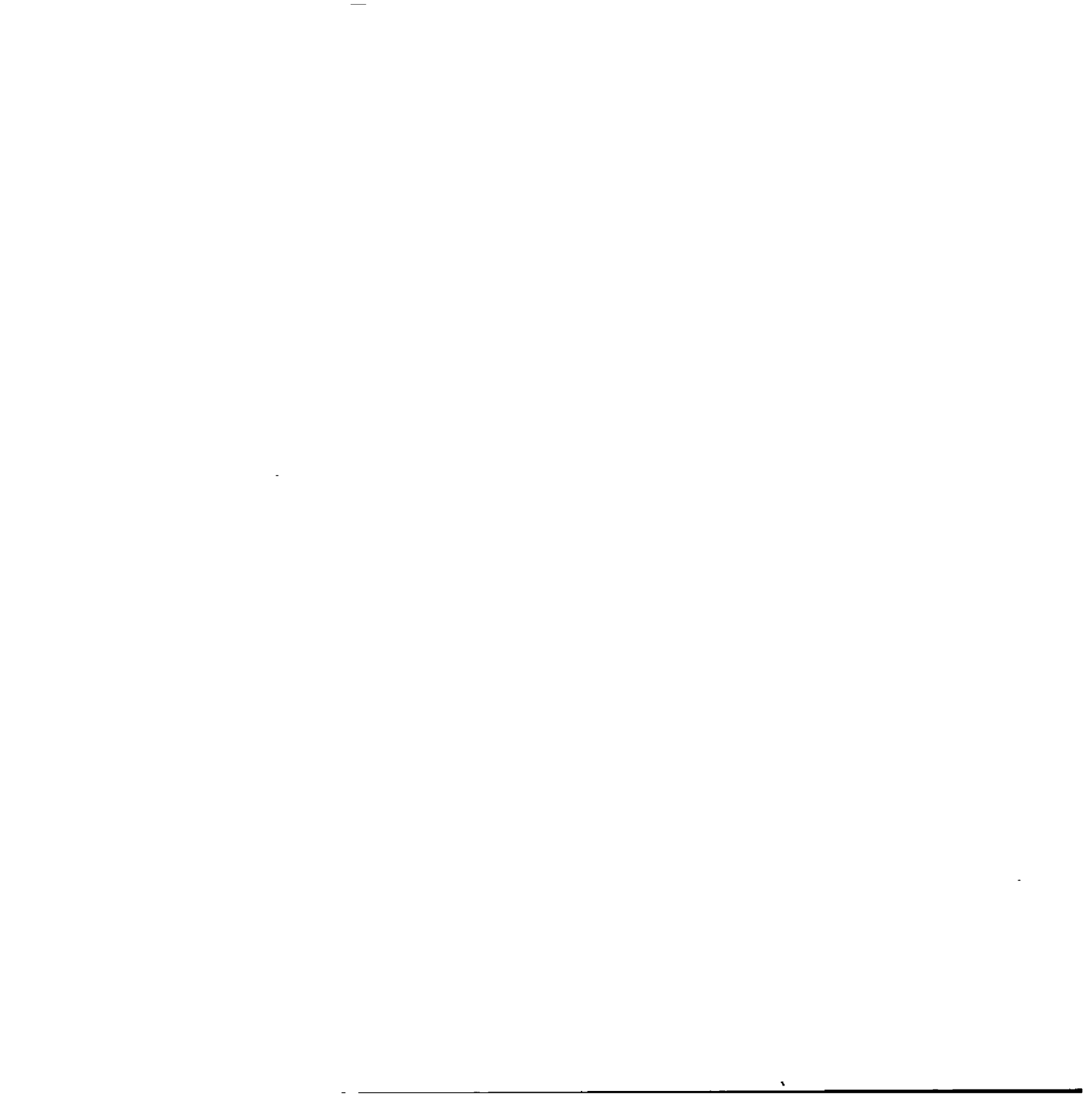


year for an individual in 2015). However, the Supreme Court ruling on the ACA effectively made the decision to implement the Medicaid expansion an option for states. For states that expand Medicaid, the federal government will pay 100 percent of Medicaid costs of those newly eligible for Medicaid for up to three calendar years from 2014 to 2016. The federal share gradually phases down to 90 percent in 2020, where it remains well above traditional federal medical assistance percentage (FMAP) rates in every state. As of March 2015, 29 states (including the District of Columbia) have adopted the Medicaid expansion though debate continues in other states. A key issue for policy makers at the state level has been the state budget effects of the Medicaid expansion on states' budgets.

This brief presents findings from a study of the early budget effects of the Medicaid expansion in three states: Connecticut, New Mexico, and Washington State. These interviews took place in the Fall of 2014, as executive-branch officials had begun preparing executive budget proposals for the 2015 legislative sessions. (See the [Methodology section](#) for more details on how the study was conducted.) Also included are findings from a separate study commissioned by Kentucky officials that examined the impact of that state's decision to expand. The findings provide a limited and early insight into the effect of the Medicaid expansion on state budgets, both within and outside of the Medicaid programs. Key findings are summarized below, first looking at effects within the Medicaid budget, then turning to the effects on other parts of the state budget as well as revenues. A summary of the findings is also presented in the [Summary Table](#). This study focused primarily on budget factors that may apply elsewhere, but one should be careful in generalizing, as each state's budget situation is unique.

## MEDICAID ENROLLMENT AND STATE COSTS

**While enrollment among those previously eligible but not enrolled (which is financed at the state's regular match rate) increased in each of the study states, the majority of this enrollment growth was driven by other changes in the ACA rather than just the Medicaid expansion. All states anticipated increased enrollment resulting from the Medicaid expansion, both for newly eligible adults and among those who were previously eligible but not enrolled. In each state, newly eligible enrollment exceeded expectations. Under the ACA, these costs are fully funded with federal dollars through December 31, 2016, so this did not increase state costs in SFYs 2014 or 2015. The extent to which states saw increased enrollment among those previously eligible but not enrolled varied across the study states. In Connecticut and New Mexico, the enrollment increase was above projections, but it was below projections in Washington State. A separate study commissioned by the Kentucky officials also found enrollment of those previously eligible but not enrolled was well above projections.<sup>4</sup> However, the enrollment growth among those previously eligible but not enrolled in each of these states was primarily driven by other ACA changes, such as the streamlining and simplifying of Medicaid enrollment processes that occurred in all states regardless of expansion decisions as well as broader outreach efforts. Washington State officials, for example, estimated that nearly three-quarters of such enrollment growth resulted from features of the ACA that would have been present with or without expanded eligibility.**



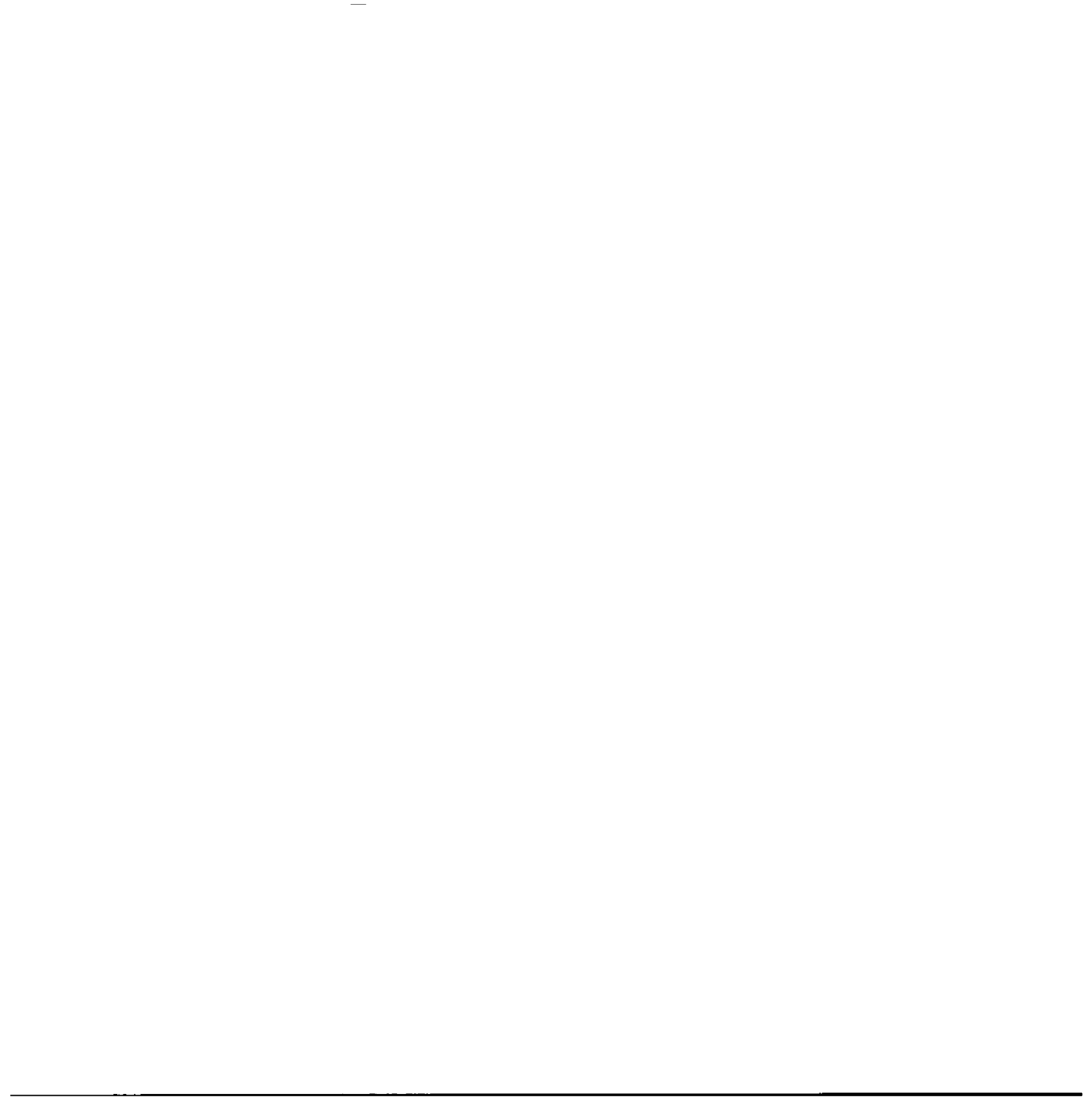
expansion due to other aspects of the ACA. Officials expect these effects to be ameliorated by the ACA's shift to a more data-driven and less labor-intensive approach to eligibility determination. The transition to this new approach is supported by 90 percent federal funding for necessary investments in information technology, along with 75 percent federal funding for operating expenses.<sup>6</sup>

## SAVINGS WITHIN MEDICAID BUDGETS

**All study states reported savings within their Medicaid programs as some beneficiaries for whom states would have received standard FMAP instead qualified as low-income adults eligible for the ACA's enhanced match rate.<sup>7</sup>** Conversion of limited Medicaid programs for low-income adults in each of the study states provided a source of immediate, significant savings within Medicaid programs. For two of these states, Connecticut and Washington, these limited Medicaid programs for low-income adults had started as state-funded indigent care programs that were converted to Medicaid financed programs (at the state's regular matching rate) ahead of the ACA expansion. (More details on these programs are provided in [Appendix A](#).)

In addition, some of the study states observed enrollment declines in optional Medicaid eligibility categories without reducing eligibility. For example, some study states saw declines in the enrollment of lower cost programs such as family planning (Connecticut and Washington) and breast and cervical cancer treatment programs (Washington). These two states also saw declining enrollment in higher-cost eligibility categories, such as medically needy spend-down programs for adults; Washington State also saw declining enrollment in an optional eligibility pathway that provides coverage for those awaiting an SSI disability determination. Adults who would have enrolled under these optional eligibility pathways were instead enrolling under the new Medicaid expansion group, qualifying for a higher matching rate.<sup>8</sup> (See [Appendix B](#) for more on these pathways.) Similar declines in enrollment among optional groups were also seen in Kentucky; according to this separate report, the Commonwealth saw savings of over \$38 million in SFYs 2014 and 2015 from beneficiaries qualifying under the newly eligible group instead of other optional pathways such as breast and cervical cancer treatment program and spend-down groups among others.<sup>9</sup>

Officials in Washington state also observed unexpected declines among pregnant women that had not been included in enacted budgets. Officials in Washington noted that much of the decline was due to more women qualifying under the Medicaid expansion group. Medicaid programs have long been required to cover pregnant women at levels at or above the Medicaid expansion. This requirement continues under the ACA; their coverage is reimbursed at the state's regular match rate. However, women enrolled in the new adult expansion group who become pregnant are not required to move to the pregnancy-related eligibility group outside of their regular renewal period. Budget officials also noted that the availability or coverage in the Marketplace as well as improving economic conditions could also have caused some of this decline.

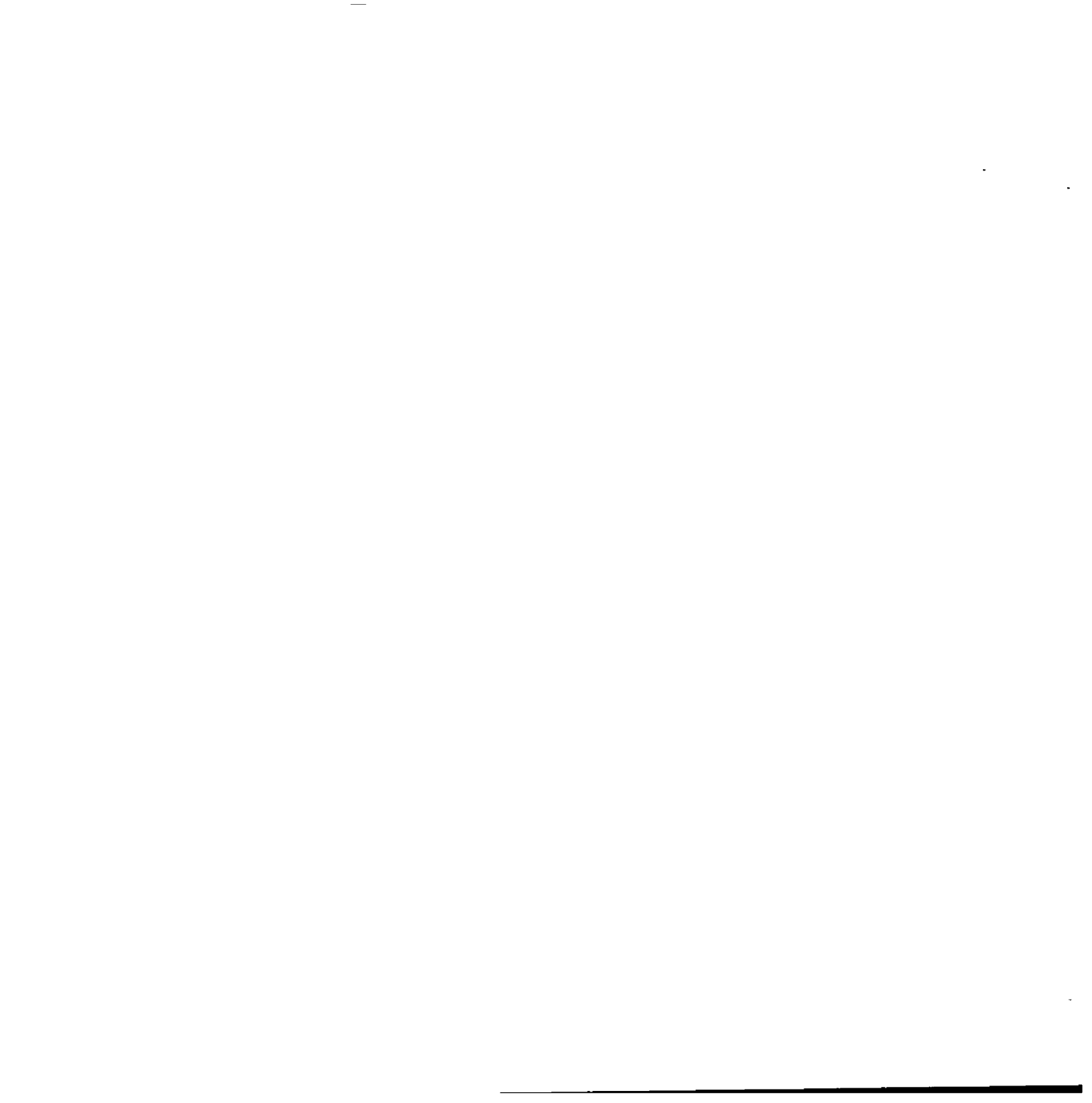


population, such as behavioral health and corrections. Savings either benefited the state general fund or were reinvested within the program area, often restoring cuts made during the economic downturn.

**All three study states experienced savings in behavioral health programs.** Behavioral health programs across the country saw substantial state funding cuts during the economic downturn; many remain underfunded.<sup>11</sup> States that have implemented the Medicaid expansion may use the federal dollars from the Medicaid expansion either to substitute for state funds spent on mental health services, help restore funding cuts implemented during the economic downturn, or reduce general fund spending (e.g. “book” savings.) Connecticut and Washington State “booked” these savings for their general funds, while New Mexico reprogrammed the majority of savings within the behavioral health agency’s budget.

While the study states noted savings and efficiencies in their behavioral health programs due to the expansion, there were some challenges and delays in transitioning behavioral health care providers to billing for their clients’ claims (rather than relying on grant funding) and enrolling beneficiaries of behavioral health programs (a generally hard-to-reach population) into Medicaid. These challenges necessitated adjustments to original budget assumptions, but state officials were confident both that expansion was already yielding savings and that the magnitude of savings would likely grow as these transitions progressed.<sup>12</sup> General Fund savings were also found for Kentucky as Medicaid beneficiaries – those newly eligible as well as those previously enrolled – received mental health treatment and substance use disorder services through community mental health centers reimbursed with Medicaid funds instead of general fund dollars.<sup>13</sup> Coinciding with the Medicaid expansion, the Commonwealth of Kentucky had expanded the types of behavioral health providers that were eligible for Medicaid reimbursement, both for the traditional Medicaid program as well as for the Medicaid expansion, increasing access to such services.<sup>14</sup>

**Two of the study states also experienced budget savings or offsets for corrections. Many inmates historically could not qualify for Medicaid since they did not fit into one of the traditional eligibility categories.** Even for inmates who did meet the income and categorical eligibility requirements to qualify for Medicaid, federal law prohibits Medicaid payment for services provided in jails or prisons under a policy known as the “inmate exclusion.”<sup>15</sup> However, Medicaid reimbursement is available for care provided to eligible individuals who are admitted to an inpatient facility off jail or prison grounds, such as a hospital, for at least 24 hours. Prior to the ACA, few states had pursued Medicaid reimbursement for these services given the limited share of the incarcerated population that could qualify for Medicaid.<sup>16</sup> However, the Medicaid expansion offers greater potential savings to states from reimbursement for inpatient services provided to incarcerated individuals, since a larger share of the incarcerated population may qualify for Medicaid under the Medicaid expansion and the federal government is providing states an enhanced federal matching rate for newly eligible adults.<sup>17</sup>



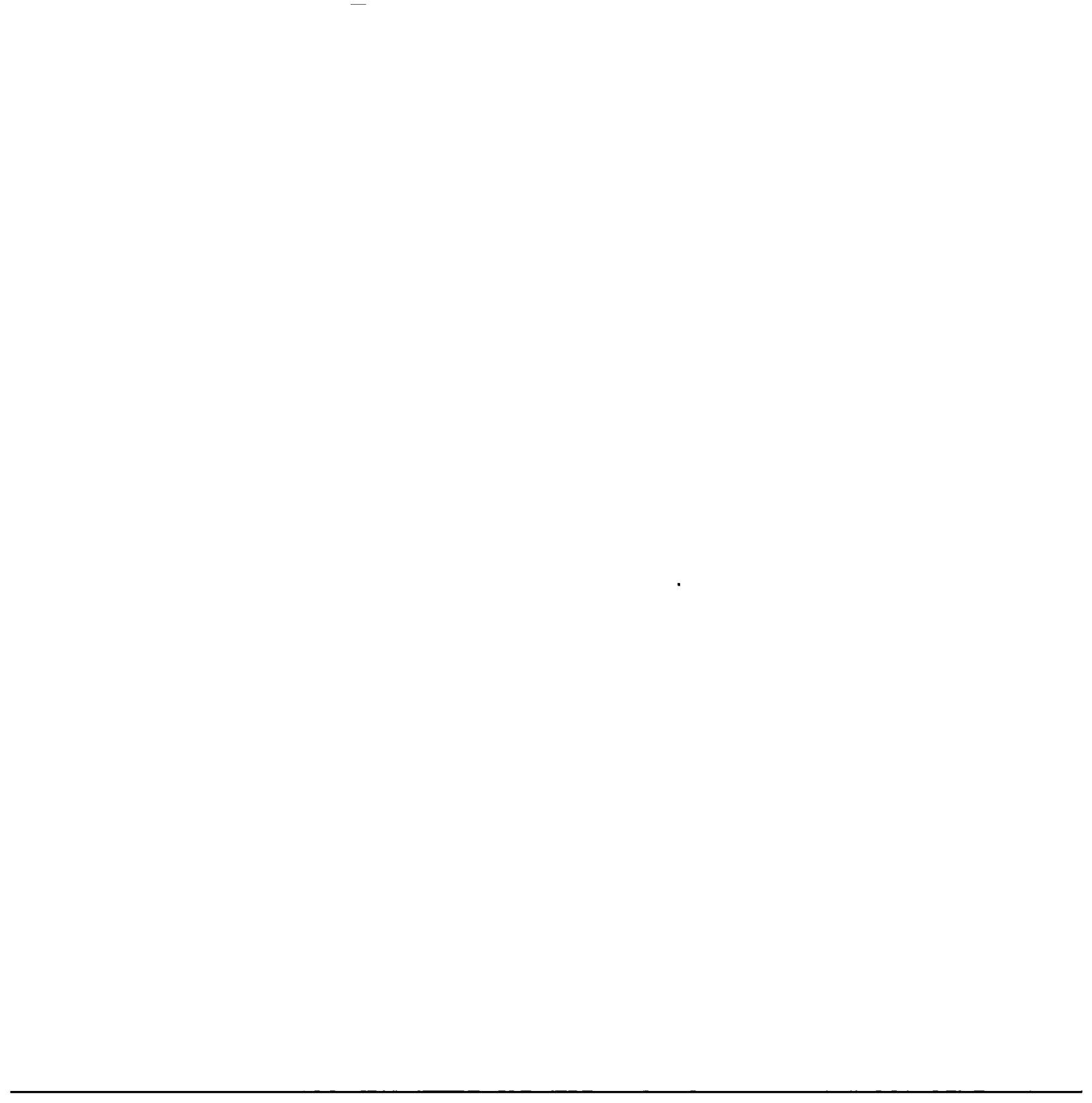
account since the state implemented the early expansion in 2010. New Mexico's Medicaid program was working to realize savings in this area, but officials also noted that many corrections responsibilities are vested locally.<sup>18</sup> General Fund savings from the Medicaid expansion in the state's corrections department were also noted in a separate report commissioned by Kentucky.<sup>19</sup>

**Some study states also reported savings in other areas, including uncompensated care payments and high risk pools.** In addition to federal funding for uncompensated care costs through Medicare and Medicaid Disproportionate Share Hospital (DSH) programs, states and localities generally fund roughly 40 percent of uncompensated care costs.<sup>20</sup> When the previously uninsured gain coverage that pays for their care, previously uncompensated costs decline. Among our three study states, only Connecticut had a state-level uncompensated care program in place before the ACA; Washington state did not have an uncompensated care pool and counties bear much of the responsibility for financing hospital uncompensated care in New Mexico. When it converted its pre-ACA state indigent care program into an early Medicaid expansion, Connecticut was able to significantly reduce their uncompensated care payments to hospitals as well as make some reductions in uncompensated care for community health and mental health centers. Reductions in state and local expenditures for uncompensated care were also noted through SFY 2016 in a separate report examining the expansion's impacts on Kentucky; this same report also noted general fund savings in later years from the scheduled reductions in DSH funds.<sup>21</sup> Early evidence from that state's expansion also saw declines in uncompensated care charges as well as increased revenues for providers.<sup>22</sup>

Case study states noted additional areas of moderate or limited budget savings outside of Medicaid. For example, New Mexico, which was the only study state that operated a state-funded high-risk pool, saw moderate savings as enrollees transitioned to other coverage options. Like the movement of behavioral health program beneficiaries into Medicaid, this transition moved more slowly than expected, resulting in fewer short-term savings than originally projected. Connecticut and Washington also reported savings from state-funded public health programs; similar savings were also found in Kentucky as services provided through local health departments to Medicaid enrollees were now reimbursed by Medicaid.<sup>23</sup> Washington reported savings from a state-funded program that provided long-term services for adults with developmental disabilities.

## REVENUE EFFECTS

**The impact on state revenue, as monitored by budget officials, was primarily reflected in increased provider and premium taxes and fees.** Washington and New Mexico projected increased revenue from provider taxes and fees as a result of expansion in their budgets. Both states have premium taxes on insurers; revenues collected from these taxes and fees increased as more Medicaid members joined managed care plans and more Medicaid patients saw providers. Connecticut experienced no increase in revenues as a result of expansion. The state's Medicaid enrollment has grown substantially as a result of the expansion and hospital revenues increased as care shifted from uncompensated to Medicaid-reimbursed. While Connecticut has Medicaid provider taxes and fees, they have not been rebased since 2009 and therefore



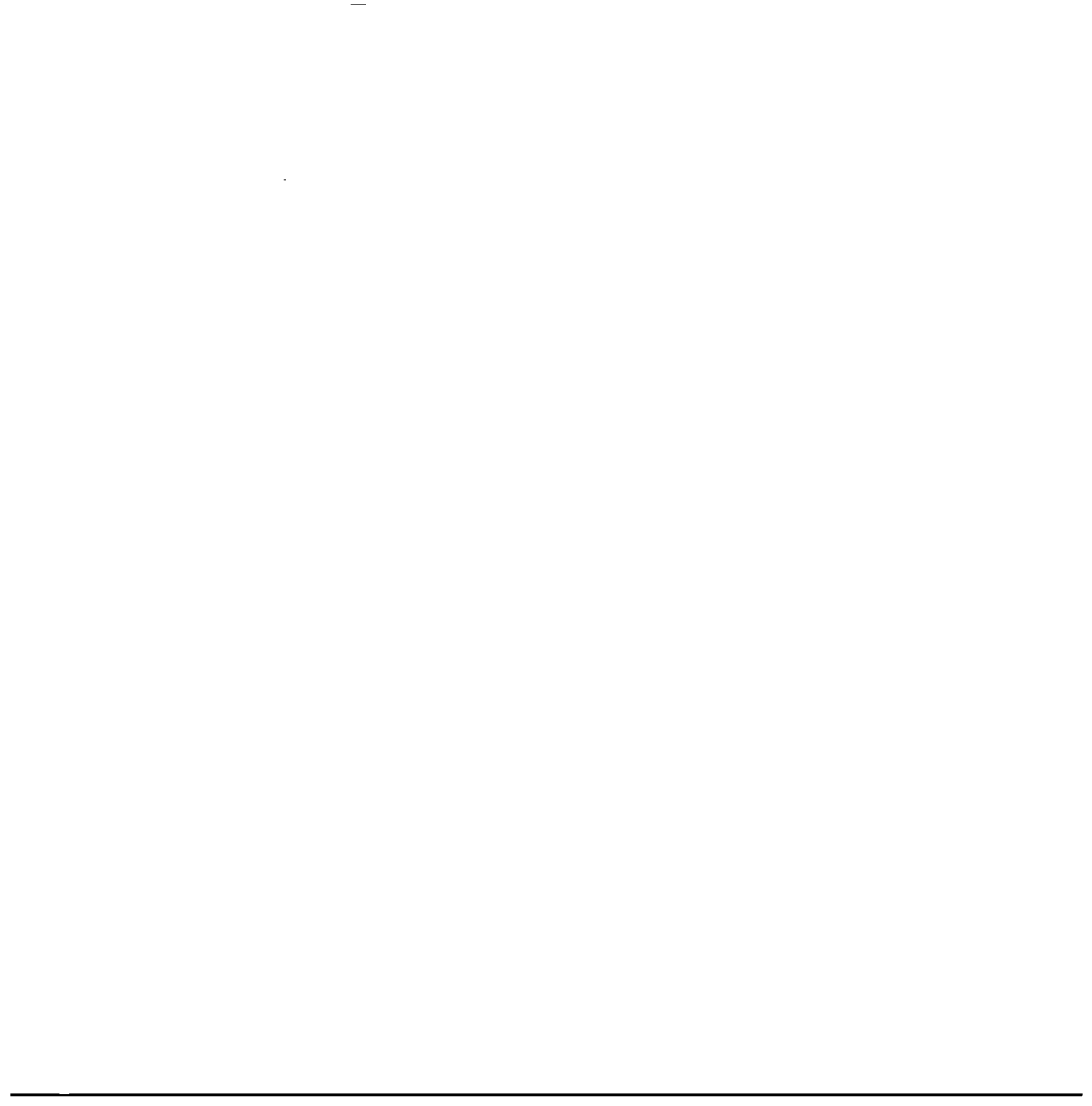
reduction in revenue from this source.

Expansion is expected to increase overall economic activity,<sup>24</sup> and thus state general revenue, due to the significant influx of federal Medicaid dollars used to purchase health care within such states. However, only one study state (New Mexico) specifically noted this effect in its overall economic and revenue projections for the first years of implementation. The other states' economic forecasts did not include such detail in their underlying assumptions at this point. It will be difficult to isolate the expansion's effects on work force and economic growth until more detailed data become available. However, a separate analysis conducted by the Urban Studies Institute at the University of Louisville estimated that the Medicaid expansion in Kentucky led to an increase of 12,000 jobs in SFY 2014 alone and over 40,000 additional jobs through 2021. The analysis estimates that this increase in jobs will result in additional tax revenue for the state and localities through SFY 2021.<sup>25</sup>

## CONCLUSION

**Disentangling the fiscal impact of expanded Medicaid eligibility from other ACA effects as well as other factors shaping health care costs can be a tremendous challenge.** Policy and budget decisions are not made in a vacuum; isolating the budgetary effects of one policy decision from other policy decisions as well as from larger demographic and economic trends is inherently difficult. In this particular case, other changes resulting from the ACA, such as requirements that all states implement new policies to streamline and simplify Medicaid enrollment, the individual coverage requirement, and new coverage options available through the Marketplace make isolating the effects of the Medicaid expansion particularly difficult.

**State budget offices are not set up to estimate the net budget impact of a single policy, such as the Medicaid expansion.** Such offices, unlike the Congressional Budget Office, do not typically maintain alternative budget scenarios that estimate costs and revenues in the absence of a particular policy (such as the Medicaid expansion.) They rarely have good reason to spend resources analyzing the effects of past decisions, like expansion. Moreover, the fiscal effects of the Medicaid expansion are hard to analyze comprehensively because they are experienced across budget categories; cost implications fall within and outside Medicaid, and both general and special revenue sources can be affected. Among the three states examined, only Washington was in a position to assess the overall budgetary impact of expansion; at the time of our interviews, the state was in the final months of maintaining an alternative budget scenario that estimated state costs in the absence of Medicaid expansion. Based on that scenario, state savings from higher federal matching rates for newly eligible enrollees and from reduced spending on some (but not all) pre-ACA, state-funded programs could be analyzed. Without taking into account any revenue gains resulting from expansion, those savings exceeded increased state costs attributable to expansion in both SFY 2014 and 2015 ([Appendix C](#)); in fact, the state noted net Medicaid budget savings for each budget period throughout the 2013-2021, including the period during which the FMAP for low-income adults reaches its final 90 percent level. During SFY 2015, the net savings from expansion was projected to equal 1.7 percent of the state's entire General Fund for SFY 2013.<sup>26</sup> Kentucky

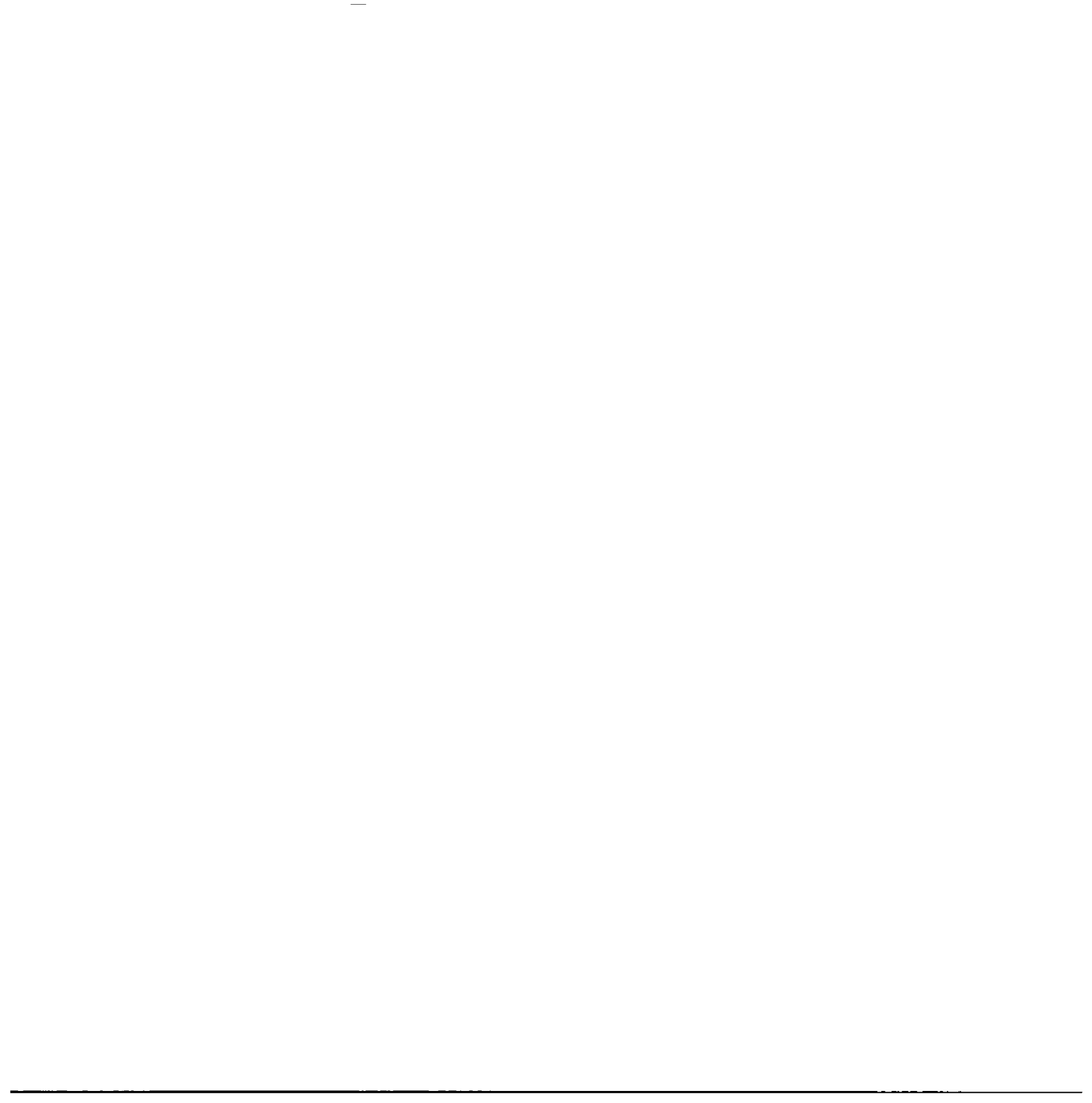


**Early evidence from these case study states shows that expansion yields state savings and state revenues while causing limited increases in state costs.** Both newly eligible consumers and those who qualified under pre-ACA categories can be expected to enroll in large numbers, although much of the latter enrollment will occur with or without expansion. States can experience notable savings both within Medicaid and outside Medicaid budgets, though savings in parts of the budget outside of Medicaid may be slower to materialize than anticipated, and policymakers may choose to reinvest savings to increase the provision of non-Medicaid services rather than reduce General Fund commitments. Two of the study states projected increased revenue from provider taxes and fees; states are expected to also realize revenue gains from increased economic activity as evidenced by the findings of the expansion's impact on Kentucky. In sum, our analysis of early experiences in three states suggests that expansion creates both state budget savings and some limited initial costs for states in these early years of the expansion, when the cost of the newly eligible is fully financed with federal dollars.

This brief provides insight into the early experiences in only three states along with findings from a separate study commissioned by Kentucky. Each state and its budget are unique. The findings of this brief are likely to illustrate important general trends, but ultimately the effect of Medicaid expansion on state budgets must be assessed in terms of the particular circumstances of each state. In states that have already chosen to expand eligibility, the implications of that decision on state budgets and revenues will continue to be monitored as implementation continues and more data become available.

This brief was prepared by Stan Dorn and Norton Francis of the Urban Institute and Robin Rudowitz and Laura Snyder from the Kaiser Family Foundation.

The authors also wish to thank the state budget officials and staff in Connecticut, New Mexico and Washington State who participated in this study. Especially in this time of limited resources and challenging workloads, we truly appreciate the time and effort provided by these public servants to participate in structured interviews and respond to our follow-up questions. Without their generous assistance, this brief would not have been possible.



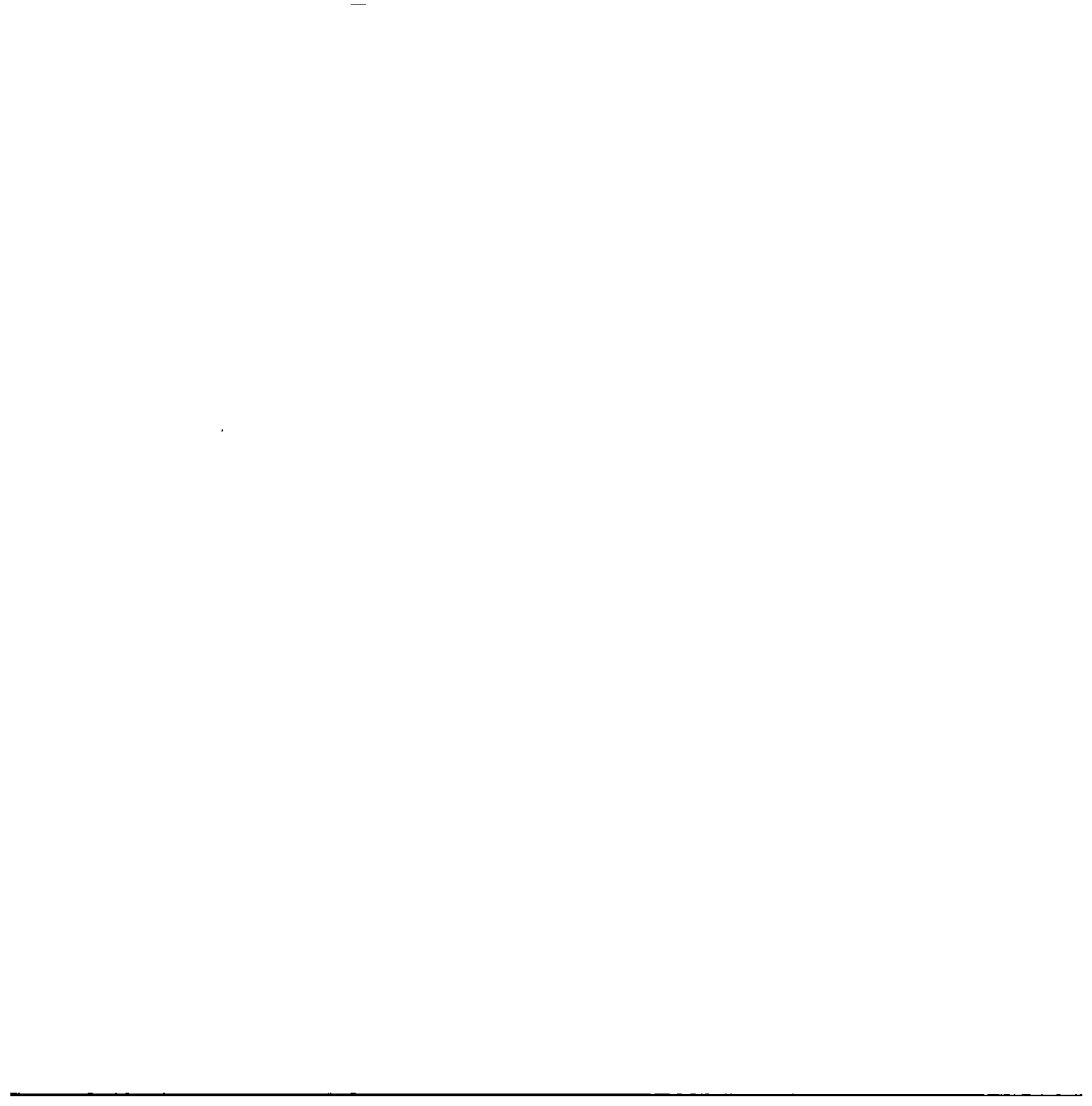
that estimates the state costs in the absence of the Medicaid expansion maintained by state officials. States often do not maintain alternative budget scenarios of what would have happened had the state not implemented a specific policy over time; Washington state officials noted that they do not plan to continue this process going forward.

Washington State Budget Effects of Medicaid Expansion, SFYs 2014 and 2015

Budget Areas	SFY 2014	SFY 2015
Increased Enrollment among those previously eligible but not enrolled*	\$22.8 million	\$59.9 million
State Administrative Costs*	\$4.0 million	\$3.5 million
State Administrative Savings*	-\$0.3 million	-\$1.6 million
<b>Savings within Medicaid from pre-ACA eligibility transitions:</b>		
1115 Waiver Transition	-\$34.0 million	-\$69.1 million
Medically Needy Spend-Down Adults	-\$11.5 million	-\$35.0 million
Breast and Cervical Cancer Program	-\$0.7 million	-\$3.6 million
Family Planning	-\$0.5 million	-\$1.0 million
Presumptive SSI***	-\$38.1 million	-\$109.8 million
<b>Savings outside of Medicaid:</b>		
Mental Health and Substance Abuse	-\$13.4 million	-\$51.2 million
Inpatient Care for Prisoners	-\$0.7 million	-\$1.4 million
Public Health Services	-\$2.6 million	-\$5.8 million
Other health care programs for vulnerable populations**	-\$4.0 million	-\$9.7 million
<b>Increased Revenues:</b>		
Premium tax revenue *		\$33.9 million
<b>Fiscal Benefit (Net Savings and New Revenues):</b>	<b>\$79.0 million</b>	<b>\$258.7 million</b>
<b>Total State General Fund Spending In SFY 2013</b>	<b>\$15.5 billion</b>	<b>\$15.5 billion</b>
<b>Fiscal Benefit from Medicaid Expansion as a Share of Total State General Fund Spending In SFY 2013</b>	<b>0.5%</b>	<b>1.7%</b>

NOTES: \*The cost and savings figures included here reflect the total impact of the ACA and are not isolated to the Medicaid expansion. \*\*This included savings for programs related to long term care, developmental disability and labor and industries programs outside of Medicaid. \*\*\*Washington State also noted savings from the transition of adults who were previously eligible for their presumptive SSI category. This is an optional Medicaid eligibility category that provides Medicaid coverage while adults await a disability determination for SSI coverage. It is unclear how many states offer Medicaid coverage for such individuals. While expenses for those that qualified under this pre-ACA eligibility pathway were not reimbursed at the 100 percent federal match rate, the state did receive a higher matching rate for these individuals (equivalent to the early adopter matching rates.)

SOURCE: Based on estimates from the state's Forecast Model as well as from the 2013-2015 budget as originally enacted by the legislature in Washington State and discussions with Washington state budget officials. Figures may differ from more recent updates to budget analyses. The calculations of savings compared to SFY General Fund Spending are those of the authors based on savings figures provided by state officials compared to the state general fund spending across all budget categories for SFY 2013 as reported by the National Association of State Budget Officers in their State Expenditure Report: Examining Fiscal 2012-2014.



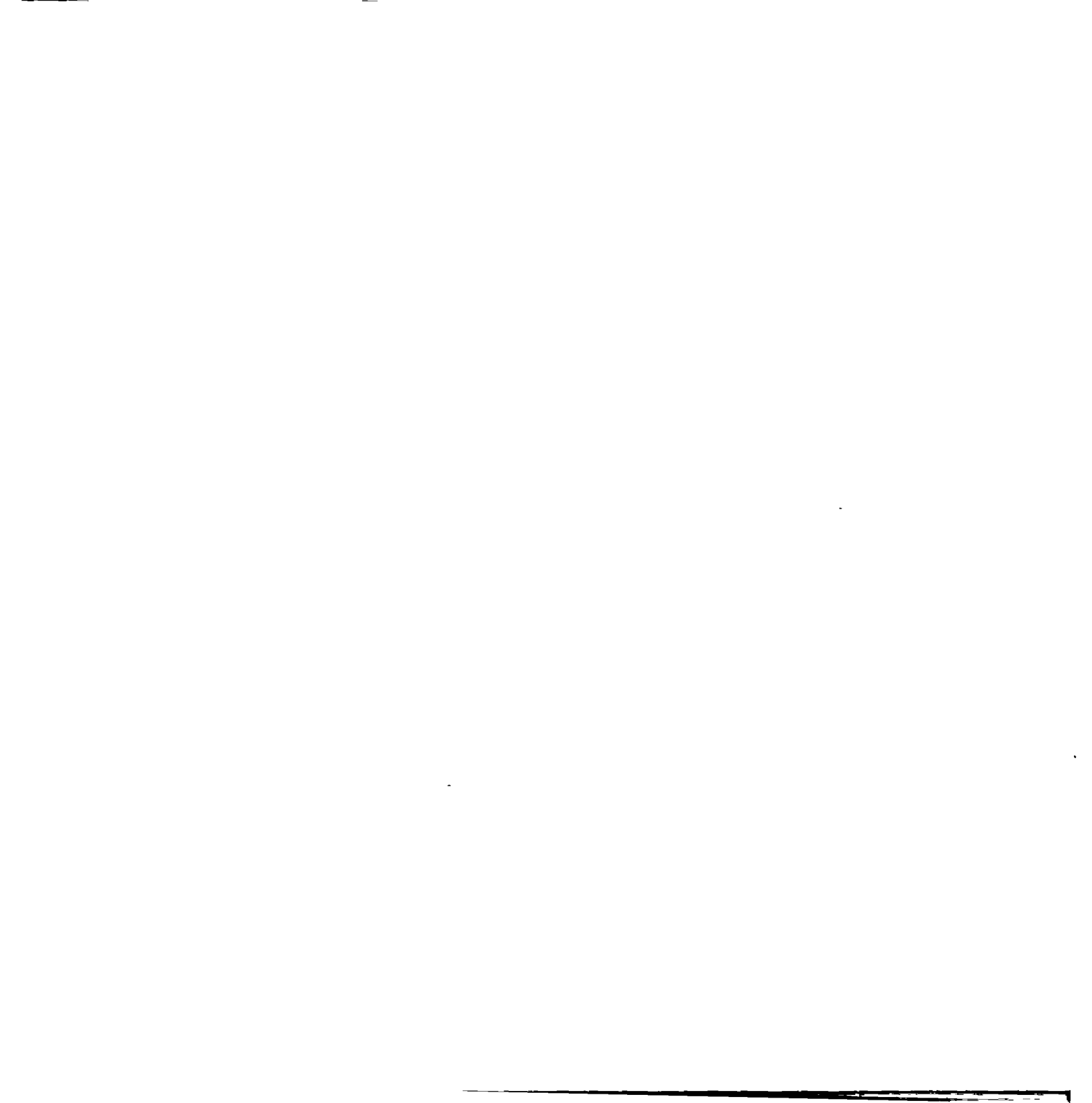
## The Effects of the Medicaid Expansion on State Budgets: An Early Look in Select States

Mar 11, 2015 | Stan Dorn and Norton Francis, Urban Institute, [Laura Snyder](http://kff.org/person/laura-snyder/) (<http://kff.org/person/laura-snyder/>), and [Robin Rudowitz](http://kff.org/person/robin-rudowitz/) (<http://kff.org/person/robin-rudowitz/>)

### Executive Summary

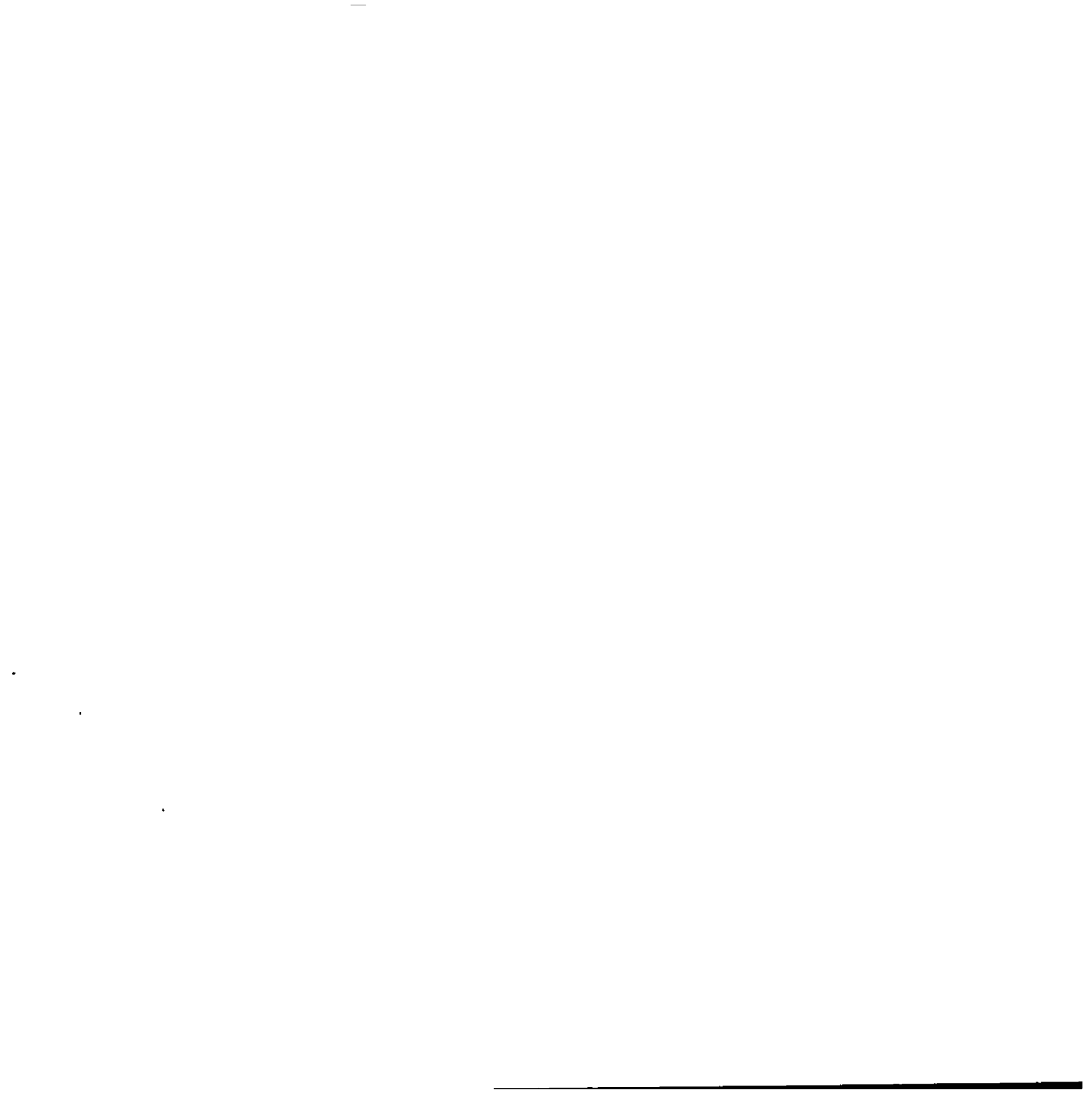
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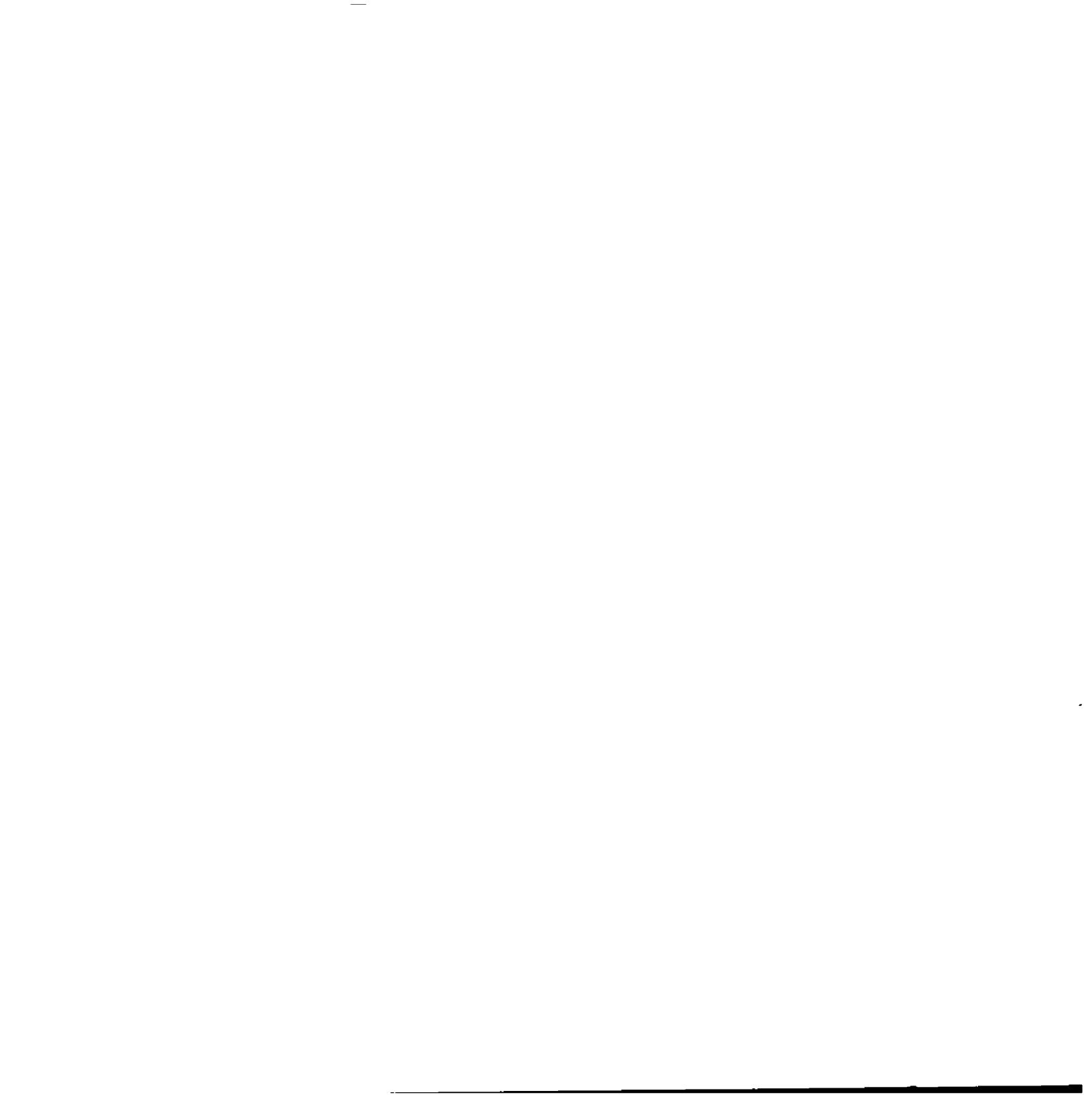


experiences with state savings and costs from the expansion across state budgets (within and outside of Medicaid) as well as the expansion's impact on state revenue. (See the Methodology section for more details on how the study was conducted.) Findings from a separate report commissioned by Kentucky are also included. Key findings include:

- **Overall Finding.** Early evidence from interviews with budget officials in these case study states shows state savings and revenue gains with limited costs resulting from expansion, even as some potential fiscal gains have not yet been tracked.
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- **Savings within Medicaid Budgets.** Savings were reported within Medicaid programs in all study states as beneficiaries who otherwise would have qualified for pre-ACA Medicaid categories at the state's regular match instead enrolled in the new expansion group and were eligible for the higher ACA enhanced match rate (and therefore reduced state costs.)
- **Savings outside of Medicaid Budgets.** All study states experienced savings in other areas of the state budget beyond Medicaid, such as state-funded behavioral health services and corrections. Some savings were captured for state general funds and others were reinvested, often to compensate for earlier cutbacks.
- **Revenue Effects.** The impact on state revenue, as monitored by budget officials, was primarily reflected in increased provider and premium taxes. Only one study state (New Mexico) accounted for the increased economic activity resulting from expansion in general revenue forecasts. A separate study found the Medicaid expansion in Kentucky led to increases in jobs and tax revenues for the state and localities.
- **Long-Term Estimates of Full Effects.** Disentangling the revenue and budgetary impact of the Medicaid expansion from other ACA effects as well as other factors shaping health care costs, state economies and state budgets is a tremendous challenge that is generally not part of state budget processes. The one study state that produced net estimates, Washington, projected that state savings from expansion would exceed costs, resulting in net fiscal gains. During the current fiscal year (2015), net gains of expansion are estimated to equal 1.7 percent of total General Fund spending.<sup>2</sup> Net savings through 2021 due to the expansion were also found in a separate report examining the impact of the Medicaid expansion in



	Connecticut	New Mexico	Washington
<b>Enrollment</b>			
Newly Eligible Enrollment	Higher than projected; no state costs.	Higher than projected; no state costs.	Higher than projected; no state costs.
Previously Eligible but not Enrolled	Higher than projected; mostly children.	Higher than expected; mostly adults but also some children.	Lower than expected; mostly children.
<b>Savings within Medicaid</b>			
Limited Medicaid programs for low-income adults	Savings from conversion of early expansion state plan group.	Substantial source of one-time savings from conversion of SCI waiver.	Substantial source of one-time savings from conversion of Bridge to Reform waiver.
Medically Needy Spend-Down	Enrollment decline noted; not included in budget.	N/A	Moderate savings noted.
Breast and Cervical Cancer Treatment	No change in enrollment.	Not noted or tracked (limited program to begin with.)	Limited savings noted from enrollment declines.
Family Planning	Limited savings noted from declining enrollment.	Not noted or tracked (limited program to begin with )	Limited savings noted from declining enrollment.
Pregnancy Related Enrollment	Not noted or tracked.	Not noted or tracked.	Not included in budget, but enrollment decline noted (due mostly to the expansion.) Planning to take limited savings.
<b>Savings outside of Medicaid</b>			
Mental Health and Substance Abuse	Substantial savings included in budget.	Moderate savings noted, most funds reprogrammed within agency.	Moderate savings included in budget.
Uncompensated Care	Significant savings included in budget.	N/A – mostly county responsibility.	N/A – programs had mostly been eliminated by the state in earlier years.
State Funded Indigent Care**	N/A	N/A	N/A
High Risk Pools	N/A	Moderate savings included in budget; savings are slower than expected.	N/A
Inpatient Care for Prisoners	Not explicitly accounted for in budget. Many of those eligible under the expansion enrolled in the state's early expansion.	Not included in budget; anticipated to be small savings for counties and state.	Limited savings included in budget.
Public Health Services	Limited savings included in budget.	Exploring potential savings.	Limited savings included in budget.



providers	Included in budget.	budget.	in budget.
General Revenue due to increased economic activity	Did not include in economic and revenue estimates at this time.	Included in economic and revenue estimates.	Did not include in economic and revenue estimates at this time.

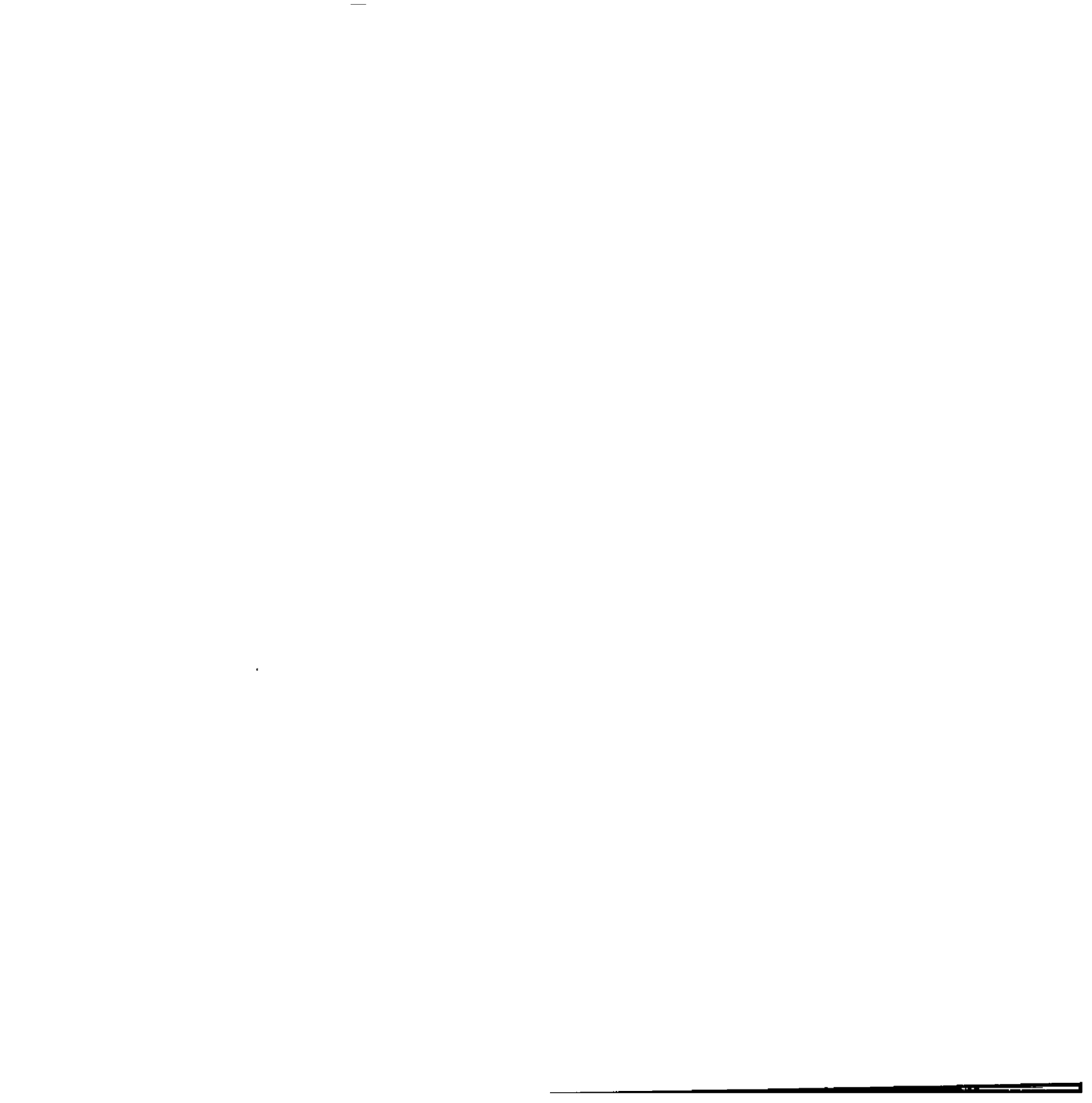
\*\* Connecticut and Washington State had state-funded indigent care programs before the ACA; both states transitioned these programs to Medicaid financing before the Medicaid expansion went into effect. See Appendix A for more details.

## Issue Brief

### Introduction

As enacted, the Affordable Care Act (ACA) broadened Medicaid's role, making it the foundation of coverage for nearly all low-income Americans with incomes up to 138 percent of the federal poverty level (FPL) (\$16,242 per year for an individual in 2015). However, the Supreme Court ruling on the ACA effectively made the decision to implement the Medicaid expansion an option for states. For states that expand Medicaid, the federal government will pay 100 percent of Medicaid costs of those newly eligible for Medicaid for up to three calendar years from 2014 to 2016. The federal share gradually phases down to 90 percent in 2020, where it remains well above traditional federal medical assistance percentage (FMAP) rates in every state. As of March 2015, 29 states (including the District of Columbia) have adopted the Medicaid expansion though debate continues in other states. A key issue for policy makers at the state level has been the state budget effects of the Medicaid expansion on states' budgets.

This brief presents findings from a study of the early budget effects of the Medicaid expansion in three states: Connecticut, New Mexico, and Washington State. These interviews took place in the Fall of 2014, as executive-branch officials had begun preparing executive budget proposals for the 2015 legislative sessions. (See the Methodology section for more details on how the study was conducted.) Also included are findings from a separate study commissioned by Kentucky officials that examined the impact of that state's decision to expand. The findings provide a limited and early insight into the effect of the Medicaid expansion on state budgets, both within and outside of the Medicaid programs. Key findings are summarized below, first looking at effects within the Medicaid budget, then turning to the effects on other parts of the state budget as well as revenues. A summary of the findings is also

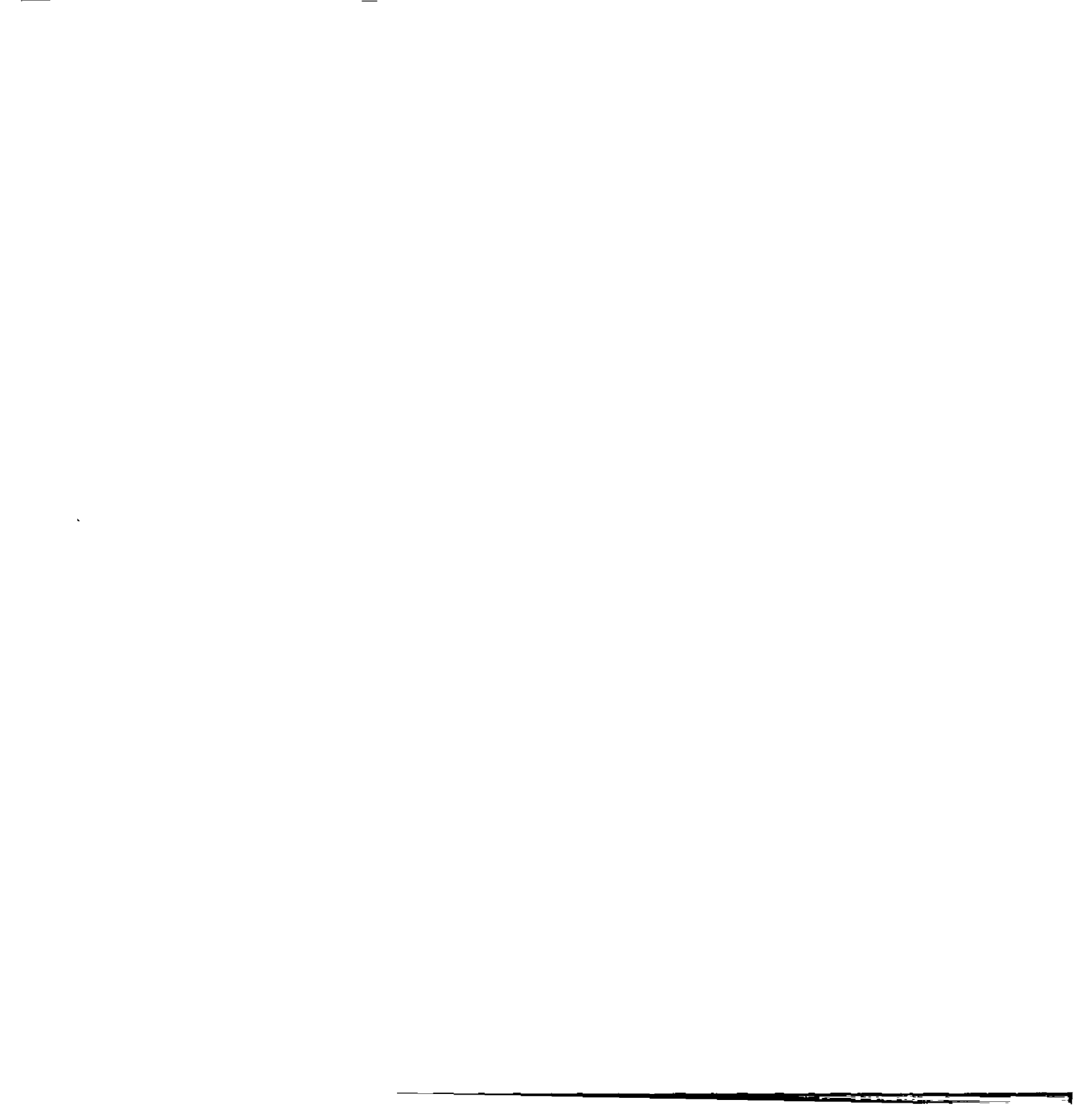


**While enrollment among those previously eligible but not enrolled (which is financed at the state's regular match rate) increased in each of the study states, the majority of this enrollment growth was driven by other changes in the ACA rather than just the Medicaid expansion.** All states anticipated increased enrollment resulting from the Medicaid expansion, both for newly eligible adults and among those who were previously eligible but not enrolled. In each state, newly eligible enrollment exceeded expectations. Under the ACA, these costs are fully funded with federal dollars through December 31, 2016, so this did not increase state costs in SFYs 2014 or 2015. The extent to which states saw increased enrollment among those previously eligible but not enrolled varied across the study states. In Connecticut and New Mexico, the enrollment increase was above projections, but it was below projections in Washington State. A separate study commissioned by the Kentucky officials also found enrollment of those previously eligible but not enrolled was well above projections.<sup>1</sup> However, the enrollment growth among those previously eligible but not enrolled in each of these states was primarily driven by other ACA changes, such as the streamlining and simplifying of Medicaid enrollment processes that occurred in all states regardless of expansion decisions as well as broader outreach efforts. Washington State officials, for example, estimated that nearly three-quarters of such enrollment growth resulted from features of the ACA that would have been present with or without expanded eligibility.

While study states saw some increased Medicaid administrative costs, these costs were relatively small. Medicaid administrative costs in general represent only five percent of total Medicaid spending nationally.<sup>2</sup> Additionally, most of these administrative costs would have been incurred with or without the Medicaid expansion due to other aspects of the ACA. Officials expect these effects to be ameliorated by the ACA's shift to a more data-driven and less labor-intensive approach to eligibility determination. The transition to this new approach is supported by 90 percent federal funding for necessary investments in information technology, along with 75 percent federal funding for operating expenses.<sup>3</sup>

### **Savings within Medicaid budgets**

**All study states reported savings within their Medicaid programs as some beneficiaries for whom states would have received standard FMAP instead qualified as low-income adults eligible for the ACA's enhanced match rate.**<sup>4</sup> Conversion of limited Medicaid programs for low-income adults in each of the study states provided a source of savings. In Connecticut, the



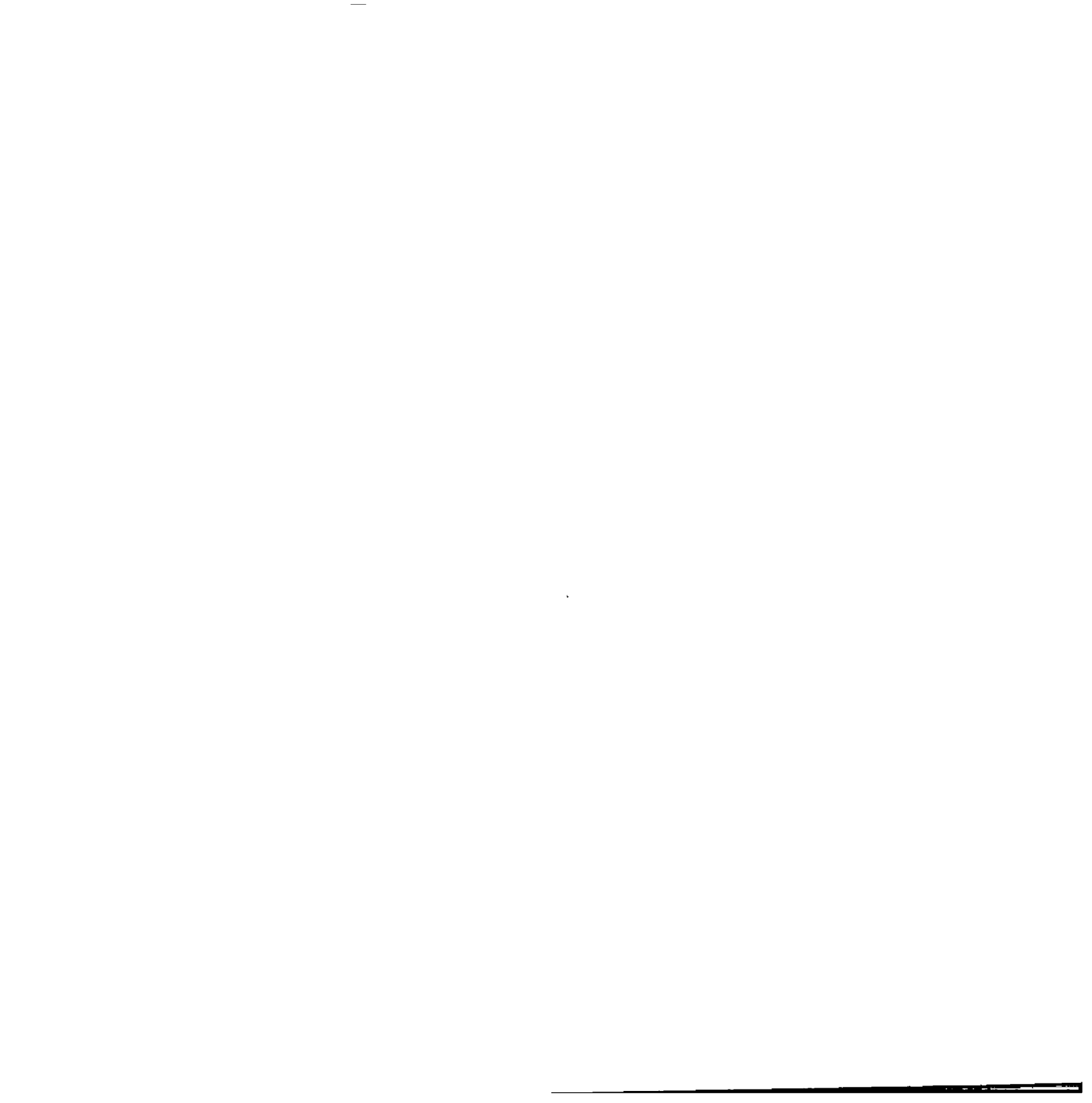
In addition, some of the study states observed enrollment declines in optional Medicaid eligibility categories without reducing eligibility. For example, some study states saw declines in the enrollment of lower cost programs such as family planning (Connecticut and Washington) and breast and cervical cancer treatment programs (Washington). These two states also saw declining enrollment in higher-cost eligibility categories, such as medically needy spend-down programs for adults; Washington State also saw declining enrollment in an optional eligibility pathway that provides coverage for those awaiting an SSI disability determination. Adults who would have enrolled under these optional eligibility pathways were instead enrolling under the new Medicaid expansion group, qualifying for a higher matching rate.<sup>5</sup> (See Appendix B for more on these pathways.) Similar declines in enrollment among optional groups were also seen in Kentucky; according to this separate report, the Commonwealth saw savings of over \$38 million in SFYs 2014 and 2015 from beneficiaries qualifying under the newly eligible group instead of other optional pathways such as breast and cervical cancer treatment program and spend-down groups among others.<sup>6</sup>

Officials in Washington state also observed unexpected declines among pregnant women that had not been included in enacted budgets. Officials in Washington noted that much of the decline was due to more women qualifying under the Medicaid expansion group. Medicaid programs have long been required to cover pregnant women at levels at or above the Medicaid expansion. This requirement continues under the ACA; their coverage is reimbursed at the state's regular match rate. However, women enrolled in the new adult expansion group who become pregnant are not required to move to the pregnancy-related eligibility group outside of their regular renewal period. Budget officials also noted that the availability or coverage in the Marketplace as well as improving economic conditions could also have caused some of this decline.

### **Savings Outside of Medicaid Budgets**

**All study states experienced savings in other areas of the state budget beyond Medicaid.<sup>7</sup>** Expanded Medicaid coverage helped to reduce some of the need for state-funded programs to serve this population, such as behavioral health and corrections. Savings either benefited the state general fund or were reinvested within the program area, often restoring cuts made during the economic downturn.

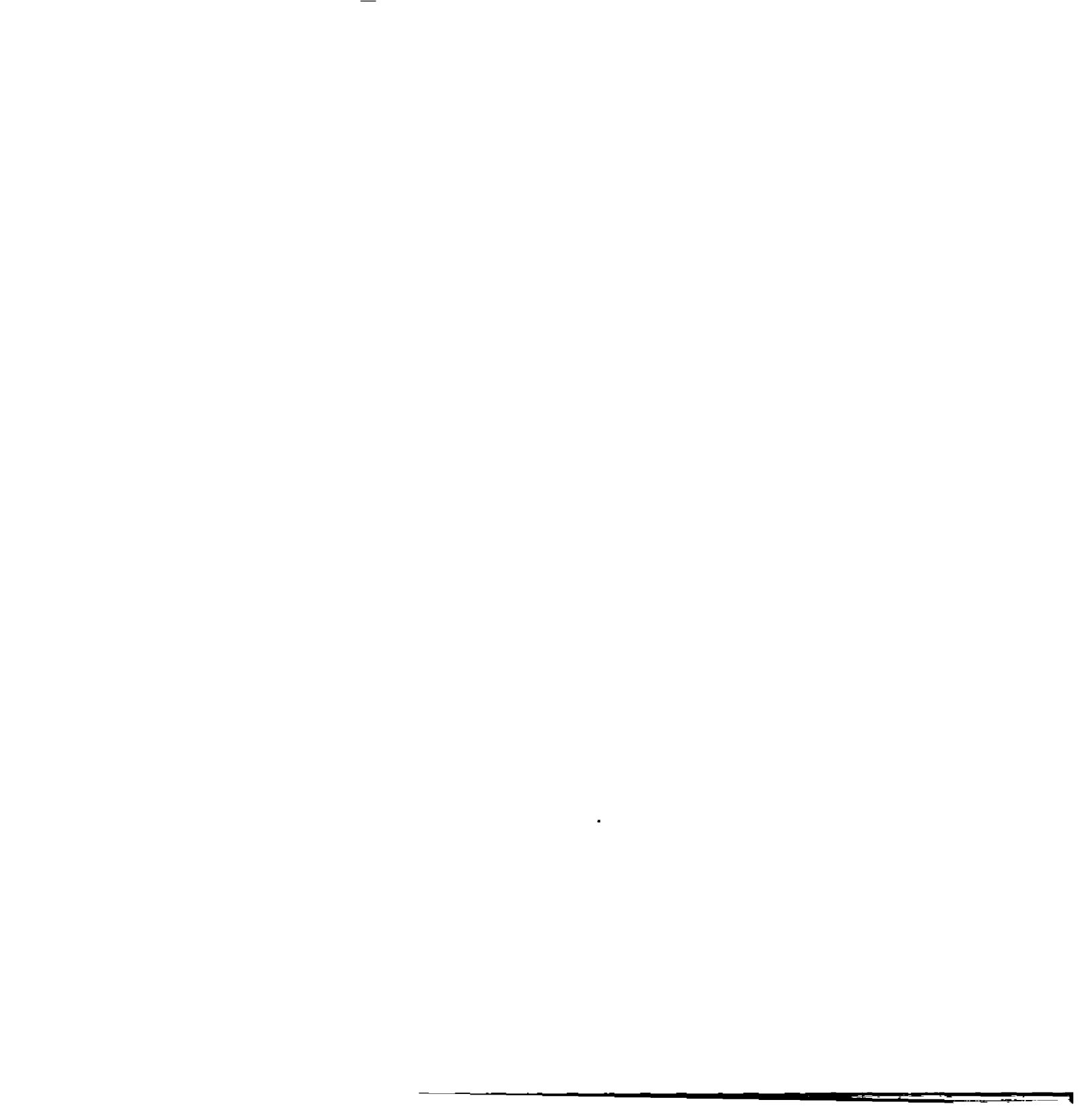
All these states...



...reducing cuts implemented during the economic downturn, or reduce general fund spending (e.g. “book” savings.) Connecticut and Washington State “booked” these savings for their general funds, while New Mexico reprogrammed the majority of savings within the behavioral health agency’s budget.

While the study states noted savings and efficiencies in their behavioral health programs due to the expansion, there were some challenges and delays in transitioning behavioral health care providers to billing for their clients’ claims (rather than relying on grant funding) and enrolling beneficiaries of behavioral health programs (a generally hard-to-reach population) into Medicaid. These challenges necessitated adjustments to original budget assumptions, but state officials were confident both that expansion was already yielding savings and that the magnitude of savings would likely grow as these transitions progressed.<sup>9</sup> General Fund savings were also found for Kentucky as Medicaid beneficiaries – those newly eligible as well as those previously enrolled – received mental health treatment and substance use disorder services through community mental health centers reimbursed with Medicaid funds instead of general fund dollars.<sup>10</sup> Coinciding with the Medicaid expansion, the Commonwealth of Kentucky had expanded the types of behavioral health providers that were eligible for Medicaid reimbursement, both for the traditional Medicaid program as well as for the Medicaid expansion, increasing access to such services.<sup>11</sup>

**Two of the study states also experienced budget savings or offsets for corrections. Many inmates historically could not qualify for Medicaid since they did not fit into one of the traditional eligibility categories.** Even for inmates who did meet the income and categorical eligibility requirements to qualify for Medicaid, federal law prohibits Medicaid payment for services provided in jails or prisons under a policy known as the “inmate exclusion.”<sup>12</sup> However, Medicaid reimbursement is available for care provided to eligible individuals who are admitted to an inpatient facility off jail or prison grounds, such as a hospital, for at least 24 hours. Prior to the ACA, few states had pursued Medicaid reimbursement for these services given the limited share of the incarcerated population that could qualify for Medicaid.<sup>13</sup> However, the Medicaid expansion offers greater potential savings to states from reimbursement for inpatient services provided to incarcerated individuals, since a larger share of the incarcerated population may qualify for Medicaid under the Medicaid expansion and the federal government is providing states an enhanced federal matching rate for newly eligible adults.<sup>14</sup>

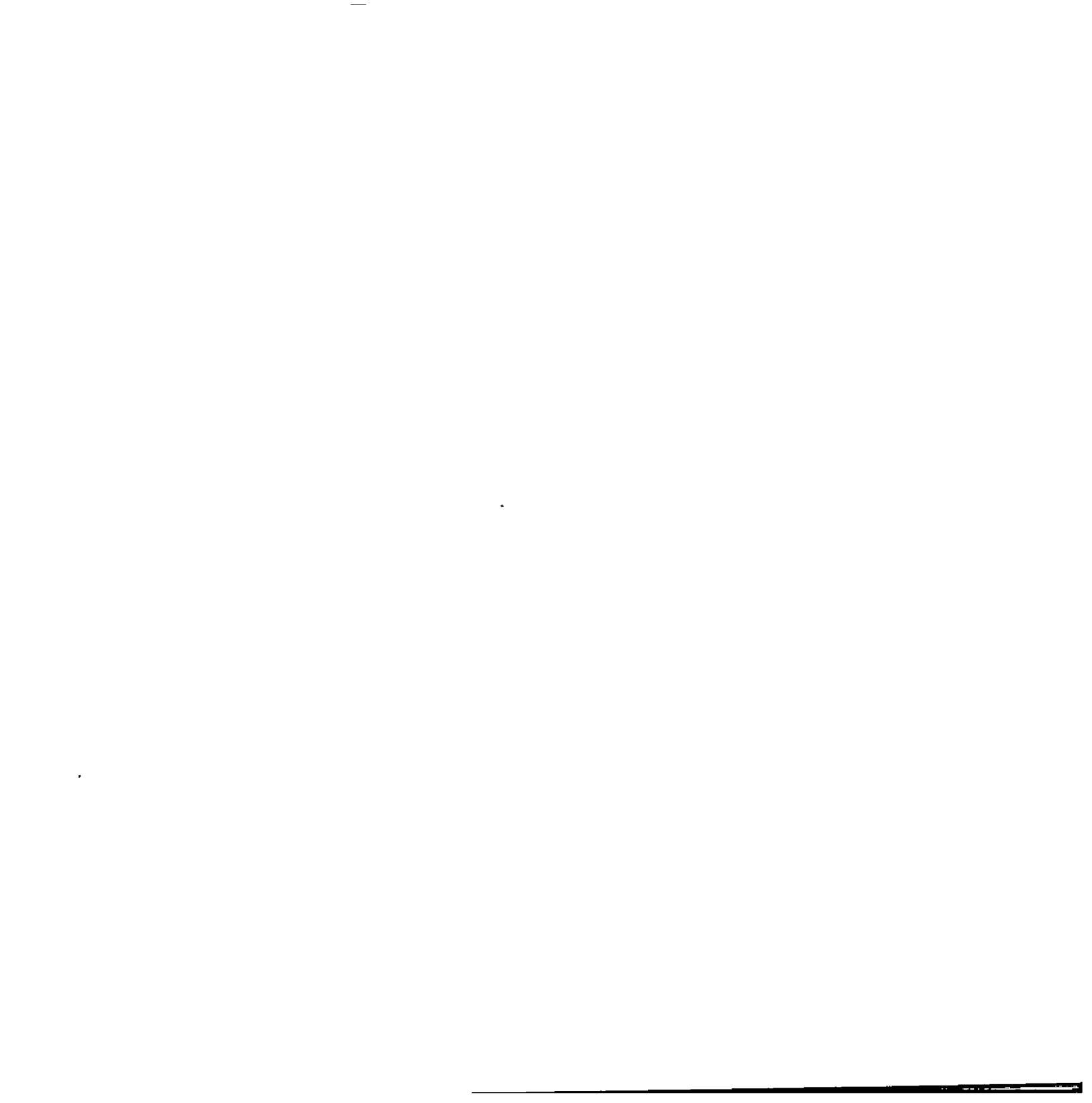


program was working to realize savings in this area, but officials also noted that many corrections responsibilities are vested locally.<sup>15</sup> General Fund savings from the Medicaid expansion in the state's corrections department were also noted in a separate report commissioned by Kentucky.<sup>16</sup>

**Some study states also reported savings in other areas, including uncompensated care payments and high risk pools.** In addition to federal funding for uncompensated care costs through Medicare and Medicaid Disproportionate Share Hospital (DSH) programs, states and localities generally fund roughly 40 percent of uncompensated care costs.<sup>17</sup> When the previously uninsured gain coverage that pays for their care, previously uncompensated costs decline. Among our three study states, only Connecticut had a state-level uncompensated care program in place before the ACA; Washington state did not have an uncompensated care pool and counties bear much of the responsibility for financing hospital uncompensated care in New Mexico. When it converted its pre-ACA state indigent care program into an early Medicaid expansion, Connecticut was able to significantly reduce their uncompensated care payments to hospitals as well as make some reductions in uncompensated care for community health and mental health centers. Reductions in state and local expenditures for uncompensated care were also noted through SFY 2016 in a separate report examining the expansion's impacts on Kentucky; this same report also noted general fund savings in later years from the scheduled reductions in DSH funds.<sup>18</sup> Early evidence from that state's expansion also saw declines in uncompensated care charges as well as increased revenues for providers.<sup>19</sup>

Case study states noted additional areas of moderate or limited budget savings outside of Medicaid. For example, New Mexico, which was the only study state that operated a state-funded high-risk pool, saw moderate savings as enrollees transitioned to other coverage options. Like the movement of behavioral health program beneficiaries into Medicaid, this transition moved more slowly than expected, resulting in fewer short-term savings than originally projected. Connecticut and Washington also reported savings from state-funded public health programs; similar savings were also found in Kentucky as services provided through local health departments to Medicaid enrollees were now reimbursed by Medicaid.<sup>20</sup> Washington reported savings from a state-funded program that provided long-term services for adults with developmental disabilities.

## **Revenue Effects**



insurers, revenues collected from these taxes and fees increased as more Medicaid members joined managed care plans and more Medicaid patients saw providers. Connecticut experienced no increase in revenues as a result of expansion. The state's Medicaid enrollment has grown substantially as a result of the expansion and hospital revenues increased as care shifted from uncompensated to Medicaid-reimbursed. While Connecticut has Medicaid provider taxes and fees, they have not been rebased since 2009 and therefore have not increased due to Medicaid expansion. Further, as a state with very high rates of health insurance coverage prior to the expansion, insurance company premium taxes have not appreciably increased following expansion. As a final complicating factor, a state program that allows for the purchase of tax credits to reduce tax liability has been utilized by some providers subject to the Medicaid provider tax, and this has resulted in a reduction in revenue from this source.

Expansion is expected to increase overall economic activity,<sup>21</sup> and thus state general revenue, due to the significant influx of federal Medicaid dollars used to purchase health care within such states. However, only one study state (New Mexico) specifically noted this effect in its overall economic and revenue projections for the first years of implementation. The other states' economic forecasts did not include such detail in their underlying assumptions at this point. It will be difficult to isolate the expansion's effects on work force and economic growth until more detailed data become available. However, a separate analysis conducted by the Urban Studies Institute at the University of Louisville estimated that the Medicaid expansion in Kentucky led to an increase of 12,000 jobs in SFY 2014 alone and over 40,000 additional jobs through 2021. The analysis estimates that this increase in jobs will result in additional tax revenue for the state in localities through SFY 2021.<sup>22</sup>

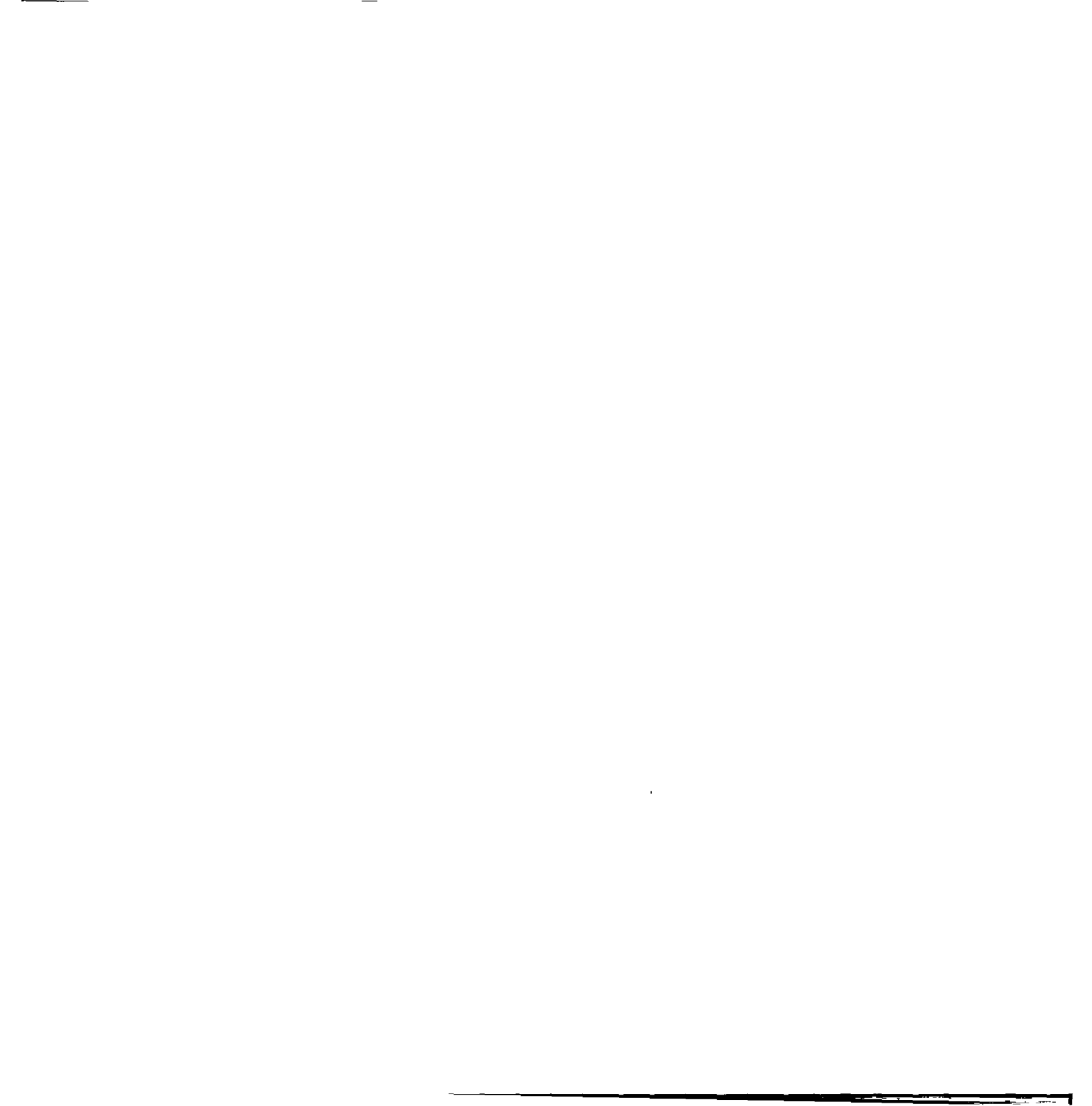
## Conclusion

**Disentangling the fiscal impact of expanded Medicaid eligibility from other ACA effects as well as other factors shaping health care costs can be a tremendous challenge.** Policy and budget decisions are not made in a vacuum; isolating the budgetary effects of one policy decision from other policy decisions as well as from larger demographic and economic trends is inherently difficult. In this particular case, other changes resulting from the ACA, such as requirements that all states implement new policies to streamline and simplify Medicaid enrollment, the individual coverage requirement, and new coverage options available through the Marketplace make isolating the effects of the Medicaid expansion particularly



Medicaid expansion.) They rarely have good reason to spend resources analyzing the effects of past decisions, like expansion. Moreover, the fiscal effects of the Medicaid expansion are hard to analyze comprehensively because they are experienced across budget categories; cost implications fall within and outside Medicaid, and both general and special revenue sources can be affected. Among the three states examined, only Washington was in a position to assess the overall budgetary impact of expansion; at the time of our interviews, the state was in the final months of maintaining an alternative budget scenario that estimated state costs in the absence of Medicaid expansion. Based on that scenario, state savings from higher federal matching rates for newly eligible enrollees and from reduced spending on some (but not all) pre-ACA, state-funded programs could be analyzed. Without taking into account any revenue gains resulting from expansion, those savings exceeded increased state costs attributable to expansion in both SFY 2014 and 2015 (Appendix C); in fact, the state noted net Medicaid budget savings for each budget period throughout the 2013-2021, including the period during which the FMAP for low-income adults reaches its final 90 percent level. During SFY 2015, the net savings from expansion was projected to equal 1.7 percent of the state's entire General Fund for SFY 2013.<sup>23</sup> Kentucky commissioned Deloitte to examine the fiscal and economic impact of the Medicaid expansion decision on Kentucky; this independent analysis, which examined the impact of the expansion across the state's budget and at the broader economic effects among other factors, estimates Kentucky will see a net positive fiscal impact of \$919.1 million over the SFY 2014 through 2021 period compared to what the state would have spent in the absence of the Medicaid expansion.<sup>24</sup>

**Early evidence from these case study states shows that expansion yields state savings and state revenues while causing limited increases in state costs.** Both newly eligible consumers and those who qualified under pre-ACA categories can be expected to enroll in large numbers, although much of the latter enrollment will occur with or without expansion. States can experience notable savings both within Medicaid and outside Medicaid budgets, though savings in parts of the budget outside of Medicaid may be slower to materialize than anticipated, and policymakers may choose to reinvest savings to increase the provision of non-Medicaid services rather than reduce General Fund commitments. Two of the study states projected increased revenue from provider taxes and fees; states are expected to also realize revenue gains from increased economic activity as evidenced by the findings of the expansion's impact on Kentucky. In sum, our analysis of early



...from a separate study commissioned by Kentucky. Each state and its budget are unique. The findings of this brief are likely to illustrate important general trends, but ultimately the effect of Medicaid expansion on state budgets must be assessed in terms of the particular circumstances of each state. In states that have already chosen to expand eligibility, the implications of that decision on state budgets and revenues will continue to be monitored as implementation continues and more data become available.

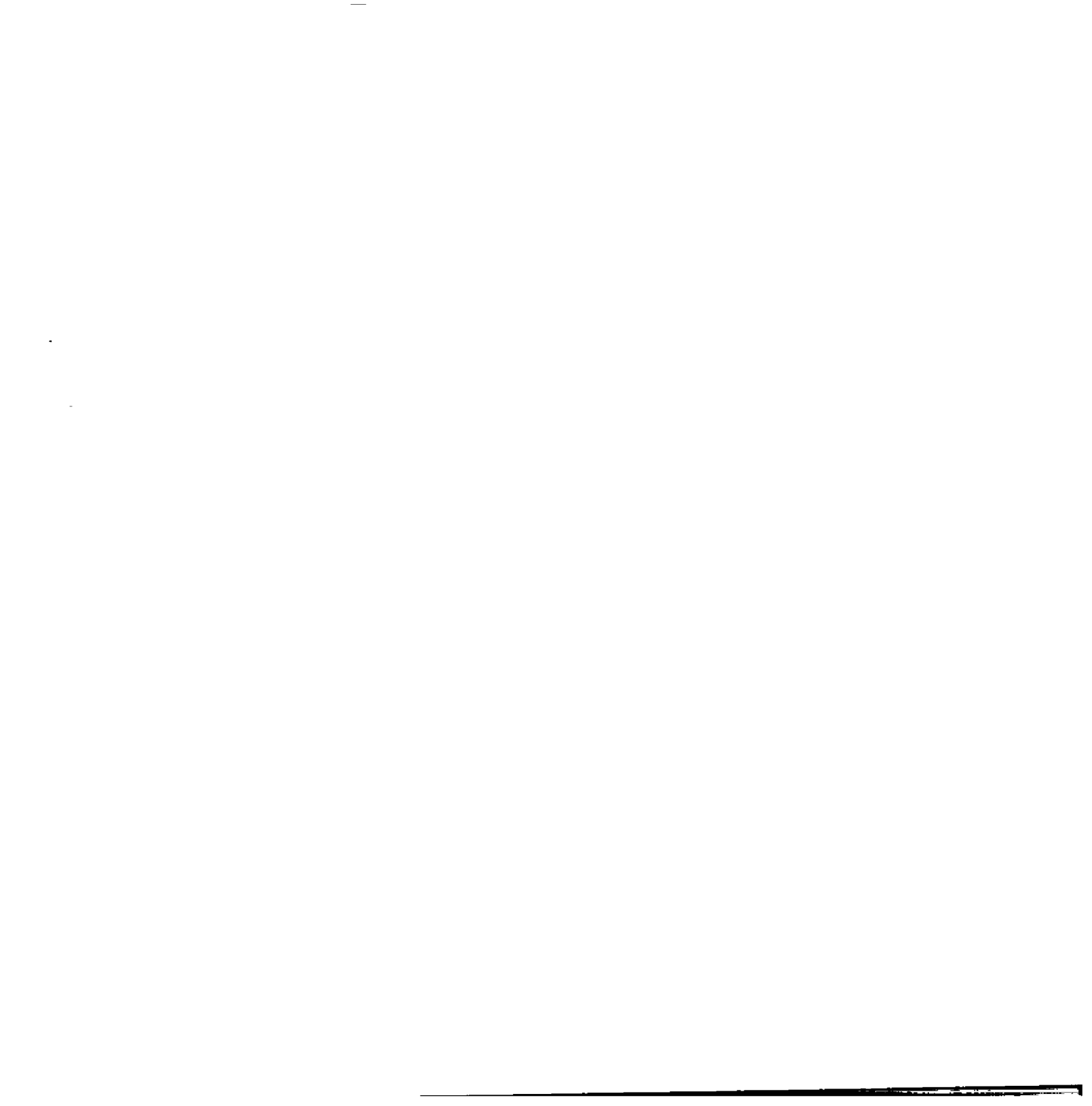
This brief was prepared by Stan Dorn and Norton Francis of the Urban Institute and Robin Rudowitz and Laura Snyder from the Kaiser Family Foundation.

The authors also wish to thank the state budget officials and staff in Connecticut, New Mexico and Washington State who participated in this study. Especially in this time of limited resources and challenging workloads, we truly appreciate the time and effort provided by these public servants to participate in structured interviews and respond to our follow-up questions. Without their generous assistance, this brief would not have been possible.

## Methods

This study analyzes the state budgetary effects that have been identified thus far in three geographically diverse states that began implementing the full expansion on January 1, 2014: Connecticut, New Mexico, and Washington State. Researchers from the Kaiser Commission on Medicaid and the Uninsured and the Urban Institute interviewed state budget staff and officials and reviewed state budget documents during August through November, 2014, before the start of the 2015 open enrollment period. These interviews were based on semi-structured protocols, and key topic areas were shared in advance with state officials.

The interviews took place as executive-branch officials had begun preparing executive budget proposals for forthcoming legislative sessions. Of the three states included in this study, two (Connecticut and Washington state) operate on a biennial budget cycle



2014 and SFY 2015. While SFY 2014 had ended, states were still finalizing actual figures for SFY 2014. Therefore, state officials were basing responses off of what was included in SFY 2014 and SFY 2015 budgets as enacted; for SFY 2014, officials commented where they could on what had been observed (e.g. if savings originally included in budgets were in line with original assumptions.)

Washington State was able to provide cost and savings estimates for a number areas affected by the state's decision to implement the Medicaid expansion due to the fact the state has maintained an alternative budget scenario that estimated state costs in the absence of Medicaid expansion, a process the state is expected to stop in the near future. Budget officials in Connecticut and New Mexico reported cost and savings estimates where possible, but all states reported more broadly about the scope of changes that had been considered to date. Each of these states reviewed the findings; their feedback has been incorporated.

Additional findings of the expansion's impact on Kentucky published in a separate report commissioned by that state have also been included.

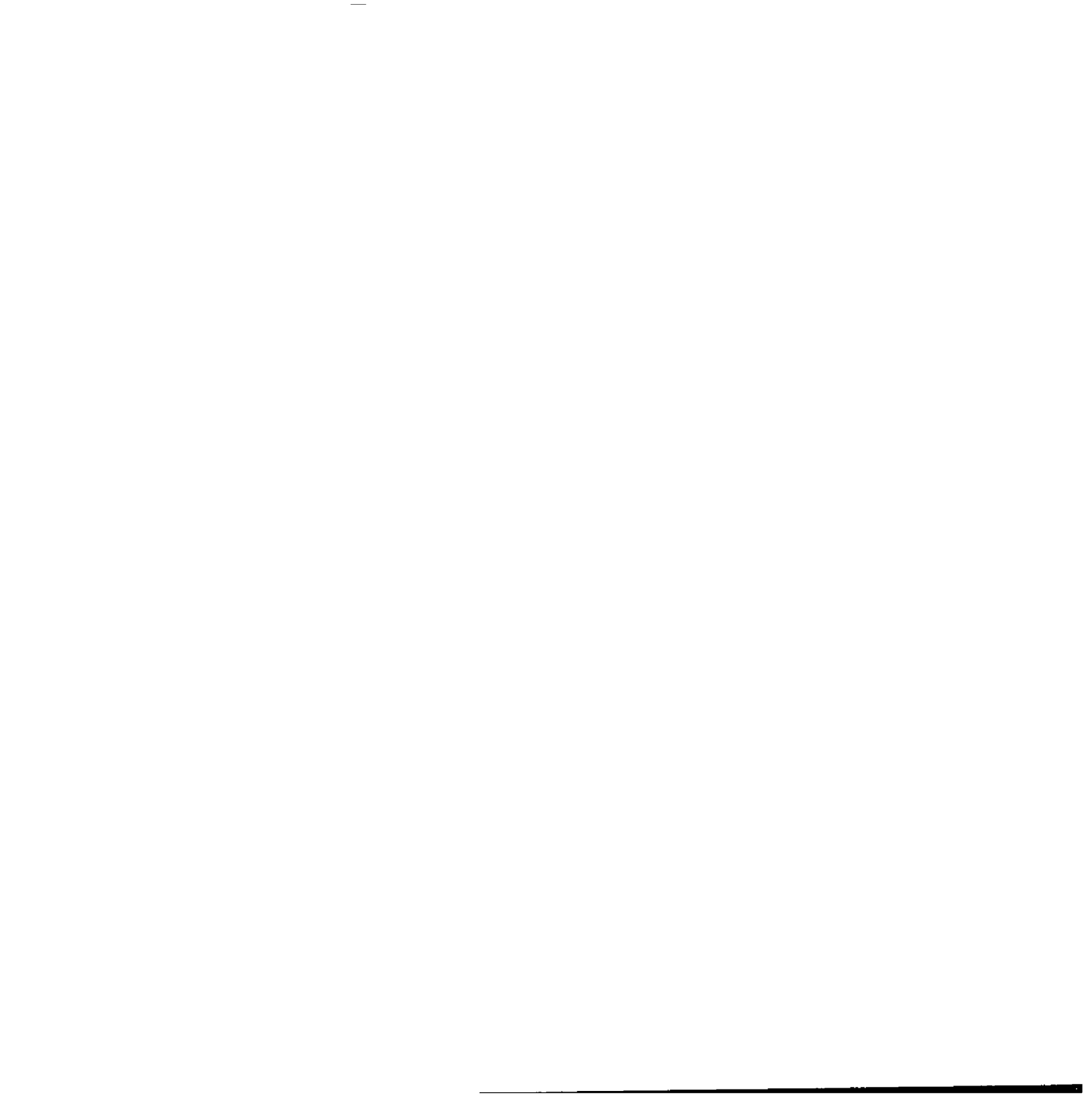
This study focused primarily on budget factors that may apply elsewhere, but one should be careful in generalizing, as each state's budget situation is unique.

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## Appendices

### Appendix A: Coverage Initiatives prior to the ACA

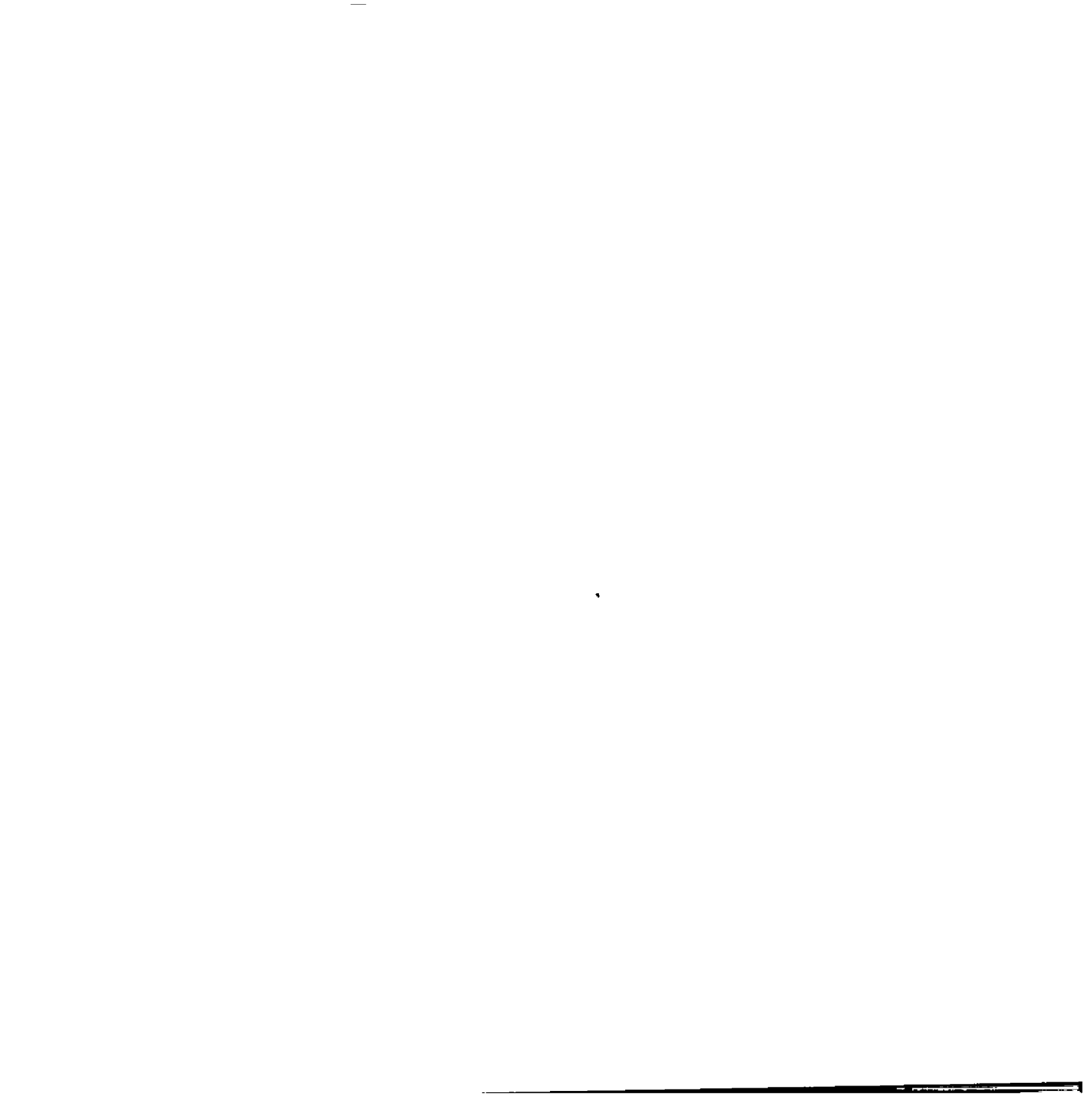
Prior to the ACA, coverage for adults was limited. Parent eligibility in many states was below the poverty level. Adults without dependent children were ineligible for Medicaid regardless of their income; states could only cover adults without dependent children through waivers. As of January 2013, nine states provided coverage for low-income adults comparable to full Medicaid benefits; an additional 16 states provided such adults with limited benefit coverage under Medicaid.<sup>1</sup> Provided below is a summary of coverage initiatives the case study states had in place prior to the Medicaid expansion; individuals in each of these programs were transitioned to the new coverage group and eligible for full federal financing under the Medicaid expansion.



the state to take up this option, implementing a state plan amendment to cover non-elderly, non-disabled adults up to 56 percent FPL without an asset test (there was a \$1000 asset test under the SAGA program.) The state experienced significantly higher enrollment than expected. Even though the federal government was paying half of the cost, the state's 50 percent share of expenditures for the new, low-income adult program exceeded the cost for medical assistance under the original SAGA program as enrollment grew substantially above projections. In January 2014, the state implemented the full Medicaid expansion, increasing income eligibility up to 138 percent FPL; the federal share for these expenditures increased to 100 percent.<sup>3</sup>

**New Mexico:** New Mexico implemented its 1115 waiver to cover uninsured adults up to 200 percent FPL in 2002 under the State Coverage Initiative. The coverage provided was more limited than Medicaid, cost-sharing and premiums were above Medicaid-allowable levels, and enrollment into the program was closed in 2008 due to budget constraints. The waiver program, originally approved as a HIFA waiver, was first financed with CHIP funding and then converted to Medicaid funding. In January 2014, the state ended the SCI program, transitioning two-thirds of those served by the program to the new Medicaid expansion group, under which the federal match increased from approximately 75 percent to 100 percent. The other one-third of SCI enrollees had incomes above 138 percent FPL and qualified for subsidies to purchase coverage in the Marketplace.

**Washington:** Washington had for decades provided coverage for low-income uninsured adults through its Basic Health Program, which was funded with state-only dollars. During the economic downturn, the state faced notable budget shortfalls. After the ACA was passed, Washington was able to obtain federal matching funds under a Section 1115 waiver program to act as a bridge to the Medicaid expansion. This conversion to a Medicaid waiver allowed the state to collect federal dollars at the state's regular matching rate for the program (as well as the Disability Lifeline program and the Alcohol and Drug Abuse Treatment and Support Act or ADATSA program, both of which were also previously state-funded.) In January 2014, the state transitioned these adults to the Medicaid expansion group, where the federal match increased from 50 to 100 percent.



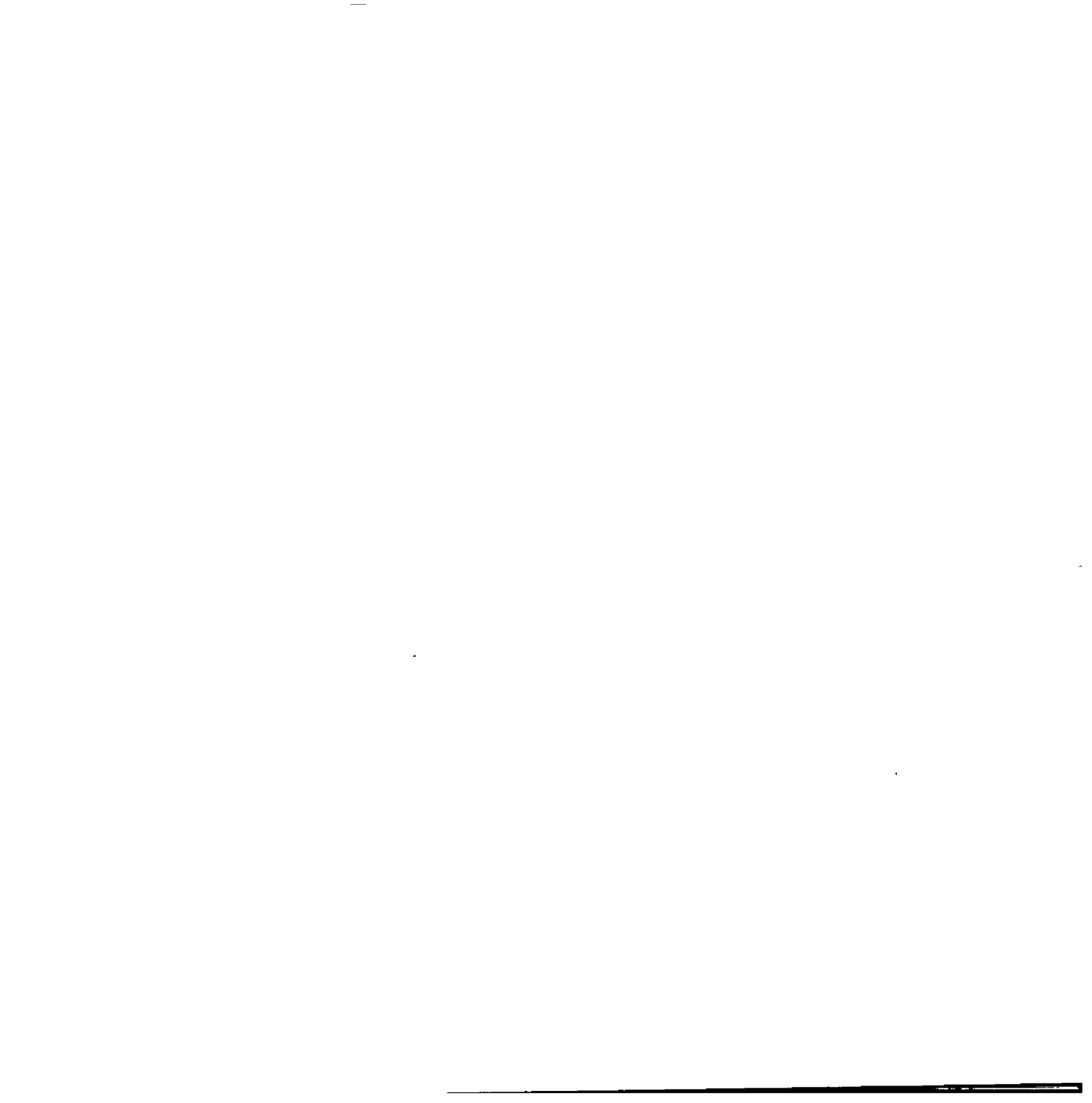
or subsidized marketplace coverage and expanded Medicaid coverage (in 28 states) provides new options for states to reconsider some of these coverage options, such as:

- **Family Planning.** Family planning waivers and state plan amendments allow for states to provide limited Medicaid coverage to US citizens otherwise ineligible for Medicaid (largely adults.) Coverage is limited to family planning services only and is reimbursed at 90 percent federal match. Washington State had an existing family planning waivers; Connecticut and New Mexico had previously adopted the family planning state plan option. None of the case study states had elected to eliminate this coverage, though across the country, eight states reported plans to end family-planning only coverage.<sup>1</sup>
- **Breast and Cervical Cancer Treatment (BCCT).** In 2000, Congress gave states the option to extend Medicaid coverage to low-income uninsured or underinsured women under age 65 that had been screened and diagnosed with breast and cervical cancer through state screening programs funded by the CDC. All states had adopted this option; coverage for these individuals is reimbursed at the state's CHIP matching rate. None of the case study states had elected to eliminate this coverage, though across the country, three states reported plans to end BCCT coverage.<sup>2</sup>
- **Medically Needy Spend-Down.** Another optional Medicaid eligibility pathway that some states considered eliminating in light of new coverage options was medically-needy spend-down programs for adults. Under this coverage group, people can qualify for Medicaid by incurring medical bills that "spend down" their income to lower levels. None of the case study states had elected to eliminate this coverage, though across the country, five states reported plans to reduce or end medically needy spend-down coverage for adults.<sup>3</sup>

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## Appendix C: Washington State Budget Impacts of the Medicaid Expansion

The figures included below were provided by Washington State budget officials and reflect estimates used when the state enacted its FY 2013-2015 state budget. These figures were derived from an alternative budget scenario that estimates the state costs in the absence of the Medicaid expansion maintained by state officials. States often do not maintain alternative budget scenarios of what would have happened had the state not implemented a specific policy over time; Washington state officials noted that they do not plan to continue this process going forward.



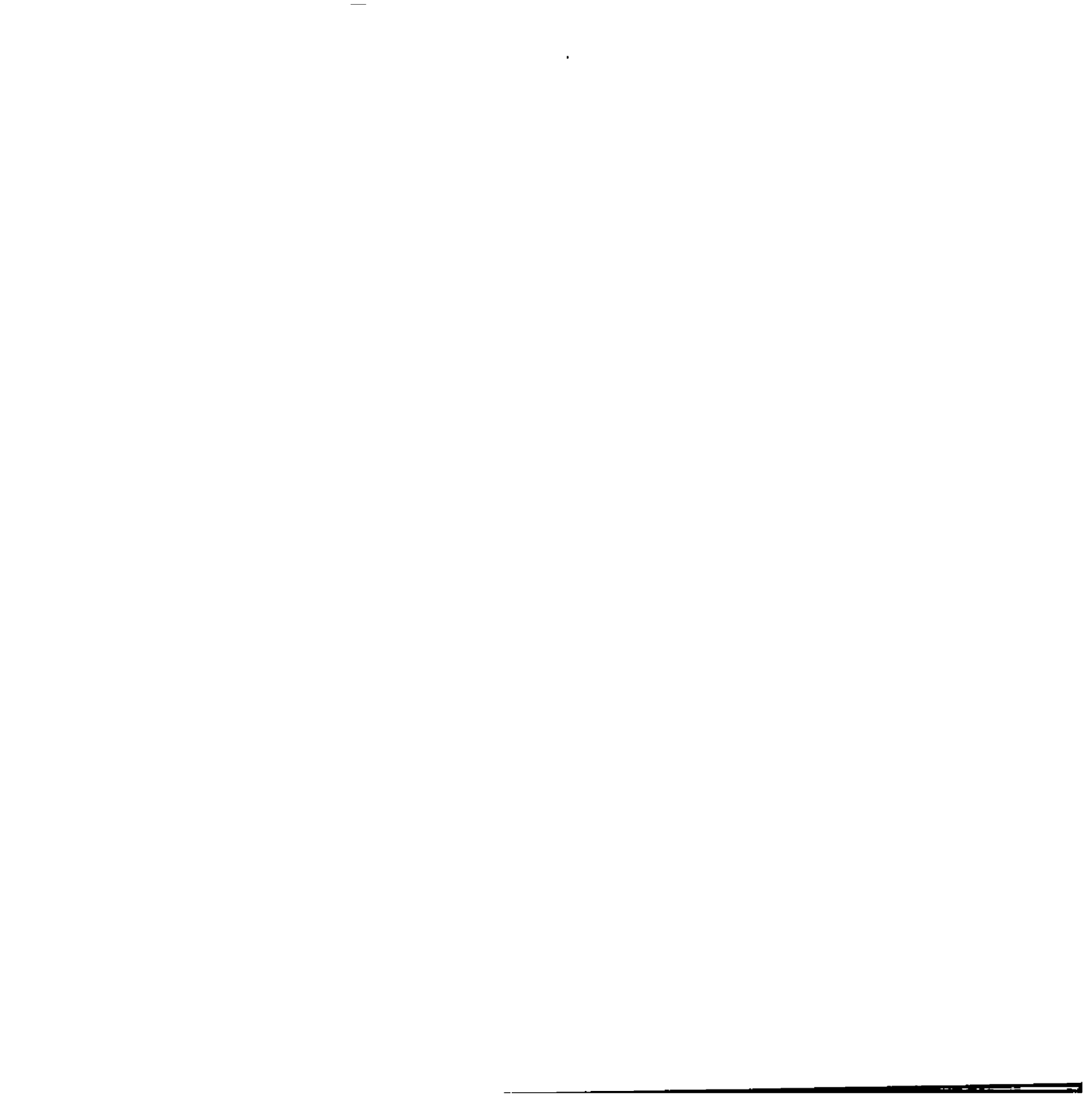
	2012	2013
State Administrative Savings*	-\$0.3 million	-\$1.6 million
Savings within Medicaid from pre-ACA eligibility transitions:		
1115 Waiver Transition	-\$34.0 million	-\$69.1 million
Medically Needy Spend-Down Adults	-\$11.5 million	-\$35.0 million
Breast and Cervical Cancer Program	-\$0.7 million	-\$3.6 million
Family Planning	-\$0.5 million	-\$1.0 million
Presumptive SSI***	-\$38.1 million	-\$109.8 million
Savings outside of Medicaid:		
Mental Health and Substance Abuse	-\$13.4 million	-\$51.2 million
Inpatient Care for Prisoners	-\$0.7 million	-\$1.4 million
Public Health Services	-\$2.6 million	-\$5.8 million
Other health care programs for vulnerable populations**	-\$4.0 million	-\$9.7 million
Increased Revenues:		
Premium tax revenue *		\$33.9 million
<b>Fiscal Benefit (Net Savings and New Revenues):</b>	<b>\$79.0 million</b>	<b>\$258.7 million</b>
<b>Total State General Fund Spending in SFY 2013</b>	<b>\$15.5 billion</b>	<b>\$15.5 billion</b>
<b>Fiscal Benefit from Medicaid Expansion as a Share of Total State General Fund Spending in SFY 2013</b>	<b>0.5%</b>	<b>1.7%</b>

**NOTES:** \*The cost and savings figures included here reflect the total impact of the ACA and are not isolated to the Medicaid expansion.\*\*This included savings for programs related to long term care, developmental disability and labor and industries programs outside of Medicaid. \*\*\*Washington State also noted savings from the transition of adults who were previously eligible for their presumptive SSI category. This is an optional Medicaid eligibility category that provides Medicaid coverage while adults await a disability determination for SSI coverage. It is unclear how many states offer Medicaid coverage for such individuals. While expenses for those that qualified under this pre-ACA eligibility pathway were not reimbursed at the 100 percent federal match rate, the state did receive a higher matching rate for these individuals (equivalent to the early adopter matching rates.)

**SOURCE:** Based on estimates from the state's Forecast Model as well as from the 2013-2015 budget as originally enacted by the legislature in Washington State and discussions with Washington state budget officials. Figures may differ from more recent updates to budget analyses. The calculations of savings compared to SFY General Fund Spending are those of the authors based on savings figures provided by state officials compared to the state general fund spending across all budget categories for SFY 2013 as reported by the National Association of State Budget Officers in their State Expenditure Report: Examining Fiscal 2012-2014.

## Appendix D: Estimates from Separate Report Commissioned by

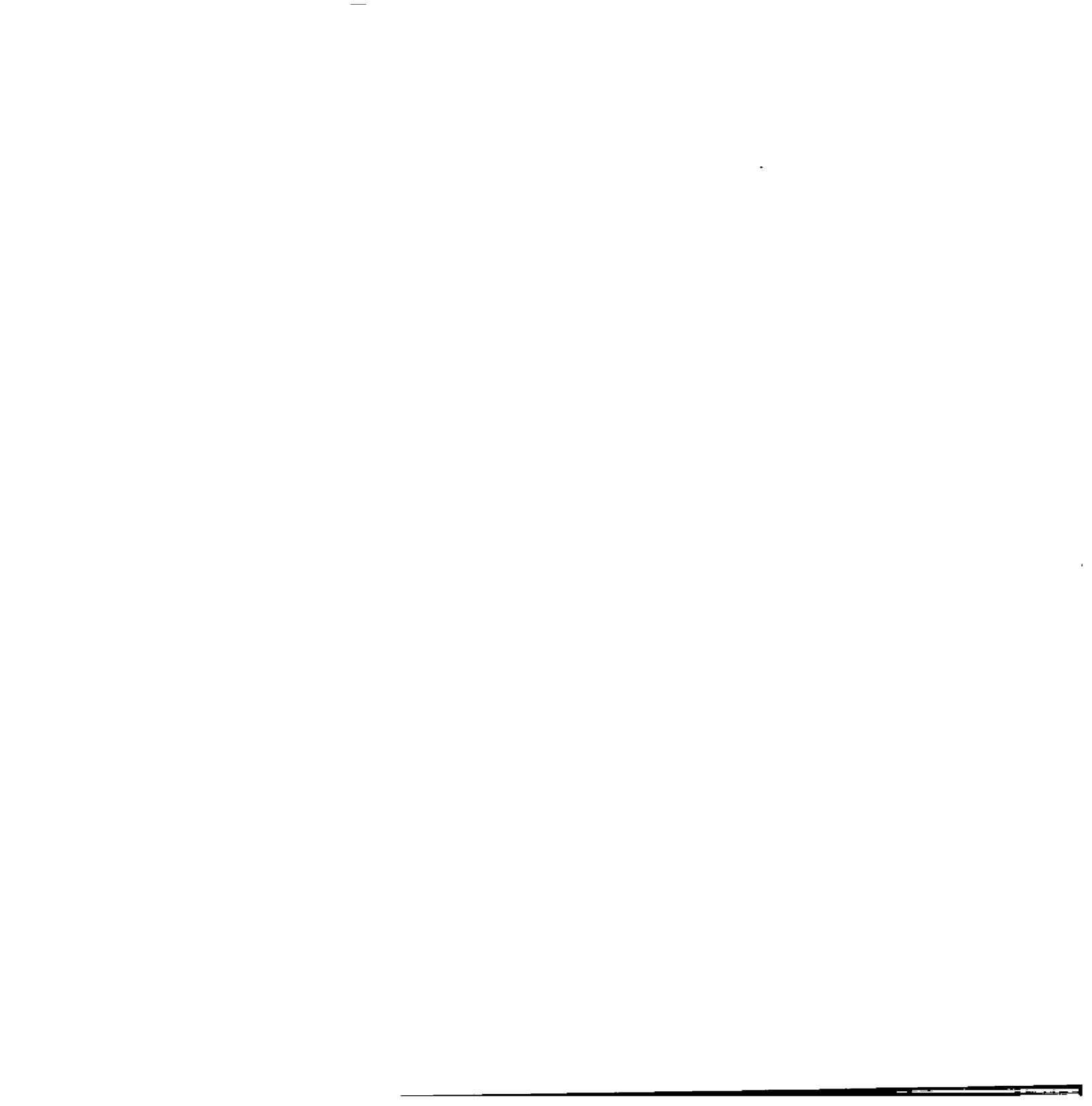
Kentucky:



... Kentucky Department for Health and Family Services (the state Medicaid agency), Aon Consulting (the state's Medicaid actuary), and the Urban Studies Institute at the University of Louisville, the study provided point-in-time analysis of the impact across multiple areas – including the impact on Medicaid enrollment, the state's uninsured rate, the state's economy, it's budget, the overall health care system and providers, and access to care for state residents. In terms of the effect on the state's budget and economy, the study estimated that the Medicaid expansion will have a significant positive cumulative impact of \$30.1 billion on Kentucky's economy through SFY 2021; the net difference between expanding and not expanding Medicaid is estimated to be a positive \$919.1 million from SFY 2014 through SFY 2021. The data below reflect the estimates for SFY 2014 and SFY 2015 and puts the fiscal effect in context of total state general fund spending.

**Kentucky State Budget Effects of Medicaid Expansion, SFYs 2014 and 2015**

<b>Budget Areas</b>	<b>SFY 2014</b>	<b>SFY 2015</b>
Increased Enrollment among those previously eligible but not enrolled*	\$15.7 million	\$41.4 million
Additional benefits provided to those not in the expansion group**	\$4.2 million	\$9.6 million
State Administrative Costs*	-	-
<b>Savings within Medicaid from pre-ACA eligibility transitions:</b>		
Medically Needy Spend-Down Adults	-\$2.4 million	-\$14.0 million
Breast and Cervical Cancer Program	-\$0.4 million	-\$1.3 million
Kentucky Transitional Medical Assistance Program (K-TAP)	-\$1.9 million	-\$9.0 million
Nursing Facility (Adult Medicaid)***	-\$1.7 million	-\$7.9 million
<b>Savings outside of Medicaid:</b>		
Department of Behavioral Health, Developmental and Intellectual Disabilities	-\$9.0 million	-\$21.0 million
Department of Corrections	-\$5.4 million	-\$11.0 million
Department of Public Health	-\$4.0 million	-\$6.0 million
Uncompensated Care Contributions (QCCT Contributions)	-	-\$13.8 million
Private Insurance for Foster Care Children****	-\$1.0 million	-\$1.1 million
<b>Increased Revenues:</b>		
State Income Taxes	\$19.3 million	\$56.3 million
State Sales Taxes	\$18.1 million	\$52.9 million
<b>Fiscal Benefit (Net Savings and New Revenues):</b>	<b>\$43.3 million</b>	<b>\$143.3 million</b>
<b>Total State General Fund Spending in SFY 2013</b>	<b>\$6.4 billion</b>	<b>\$6.4 billion</b>



... The study also noted savings from the transition of adults with disabilities from their Nursing Facility Medicaid group; according to the study, these are disabled adults that meet an administrative disability with assets below \$2000. \*\*\*\*Kentucky previously provided health care coverage with state-only dollars to former foster care children up through age 25; this is a group now covered under Medicaid. In addition to the effects listed in the above table, the study also notes increased tax revenue for local occupational and payroll taxes.

**SOURCE:** *Report on Medicaid Expansion in 2014.* (Deloitte commissioned by Kentucky, February 2015.)

[http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky\\_Medicaid\\_Expansion\\_One-Year\\_Study\\_FINAL.pdf](http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf)

([http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky\\_Medicaid\\_Expansion\\_One-Year\\_Study\\_FINAL.pdf](http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf)). The calculations of savings compared to SFY General Fund Spending are those of the authors based on savings figures provided by state officials compared to the state general fund spending across all budget categories for SFY 2013 as reported by the National Association of State Budget Officers in their State Expenditure Report: Examining Fiscal 2012-2014.

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## Endnotes

### Executive Summary

1. Researchers found fiscal estimates of the Medicaid expansion in 16 states that were deemed “comprehensive” because they estimated increased state costs resulting from higher enrollment, state budget savings both inside and outside Medicaid programs, and state revenue effects. Stan Dorn, Megan McGrath, John Holahan. What Is the Result of States Not Expanding Medicaid? Urban Institute, August 2014. <http://www.urban.org/UploadedPDF/413192-What-is-the-Result-of-States-Not-Expanding-Medicaid.pdf> (<http://www.urban.org/UploadedPDF/413192-What-is-the-Result-of-States-Not-Expanding-Medicaid.pdf>).

[← Return to text](#)

2. The calculations are those of the authors based on (1) savings figures provided by state officials (2) compared to state general fund spending across all budget categories for SFY 2013 as reported by the National Association of State Budget Officers in its State Expenditure Report: Examining Fiscal 2012-2014.

[← Return to text](#)

3. New Mexico noted that the state costs for enrollment among those previously eligible but not enrolled were significant. However, as noted earlier, the enrollment growth among those previously eligible but not enrolled was primarily driven by other ACA changes, such as the streamlining and simplifying of Medicaid enrollment processes that occurred in all states, regardless of expansion decisions, as well as broader outreach efforts.



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2. Urban Institute estimates based on data from CMS (Form 64) (as of 9/16/13).

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3. The 90 percent FMAP for initial eligibility-related IT investments was initially set to expire at the end of 2015, but in October 2014, CMS announced plans to extend the higher federal match permanently.

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4. In addition to the areas of savings within Medicaid budgets mentioned in this section, states were asked about savings-related declines in applications for disability-based cash assistance and well as savings from health care services provided to adults with disabilities under 138 percent FPL during the months while they are waiting for their disability determinations. No states in this study tracked such savings.

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5. Washington State also noted savings from the transition of adults who were previously eligible for their presumptive SSI category. This is an optional Medicaid eligibility category that provides Medicaid coverage while adults await a disability determination for SSI coverage. It is unclear how many states offer Medicaid coverage for such individuals, although once a disability determination is obtained that qualifies an applicant for Medicaid, all states are legally required to retroactively pay all Medicaid-covered claims that were incurred up to 90 days before the date of application. While expenses for those who qualified under this pre-ACA eligibility pathway in Washington state were not reimbursed at the 100 percent federal match rate, the state did receive a higher matching rate for these individuals (equivalent to the early adopter matching rates.) As a general matter, CMS has ruled that, in a state that implements the Medicaid expansion, adults who qualify based on income generate federal matching rates at the level paid for newly eligible adults for claims incurred until the point of disability determination, after which normal FMAP applies. CMS. "Medicaid Program; Increased Federal Medical Assistance Percentage Changes Under the Affordable Care Act of 2010," *Federal Register*, April 2, 2013, Vol. 78, No. 63, 19918-19947.

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Commissioned by the Commonwealth of Kentucky, February 2015.)

[http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky Medicaid Expansion One-Year Study FINAL.pdf](http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf) ([http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky Medicaid Expansion One-Year Study FINAL.pdf](http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf)).

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7. In addition to the areas of savings outside of Medicaid budgets listed in the text, states were asked about savings from reduced health insurance costs for public employees and retirees. While no state included in this study tracked such savings, some state-level projections estimated that, along with other employers, states would see premium increases decline slightly when reductions in hospital uncompensated care, caused by lower levels of uninsurance resulting from Medicaid expansion, reduce hospital cost-shifting to private insurers. *The Oregon Health Authority, Estimated Financial Effects of Expanding Oregon's Medicaid Program Under the Affordable Care Act (2014–2020)*, February 2013, [http://www.manatt.com/uploadedFiles/Content/5\\_Insights/White\\_Papers/OR EffectofACAMedicaidExpansion\\_Feb2013\\_Final.pdf](http://www.manatt.com/uploadedFiles/Content/5_Insights/White_Papers/OR_EffectofACAMedicaidExpansion_Feb2013_Final.pdf) ([http://www.manatt.com/uploadedFiles/Content/5\\_Insights/White\\_Papers/OR Effect%20of%20ACA%20Medicaid%20Expansion\\_Feb2013\\_Final.pdf](http://www.manatt.com/uploadedFiles/Content/5_Insights/White_Papers/OR_Effect%20of%20ACA%20Medicaid%20Expansion_Feb2013_Final.pdf)).

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8. *State Mental Health Legislation 2014 - Trends, Themes & Effective Practices*. National Alliance on Mental Illness, December 2014. [http://www.nami.org/Template.cfm?Section=Policy\\_Reports&Template=/ContentManagement/ContentDisplay.cfm&ContentID=172851](http://www.nami.org/Template.cfm?Section=Policy_Reports&Template=/ContentManagement/ContentDisplay.cfm&ContentID=172851) ([http://www.nami.org/Template.cfm?Section=Policy\\_Reports&Template=/ContentManagement/ContentDisplay.cfm&ContentID=172851](http://www.nami.org/Template.cfm?Section=Policy_Reports&Template=/ContentManagement/ContentDisplay.cfm&ContentID=172851))

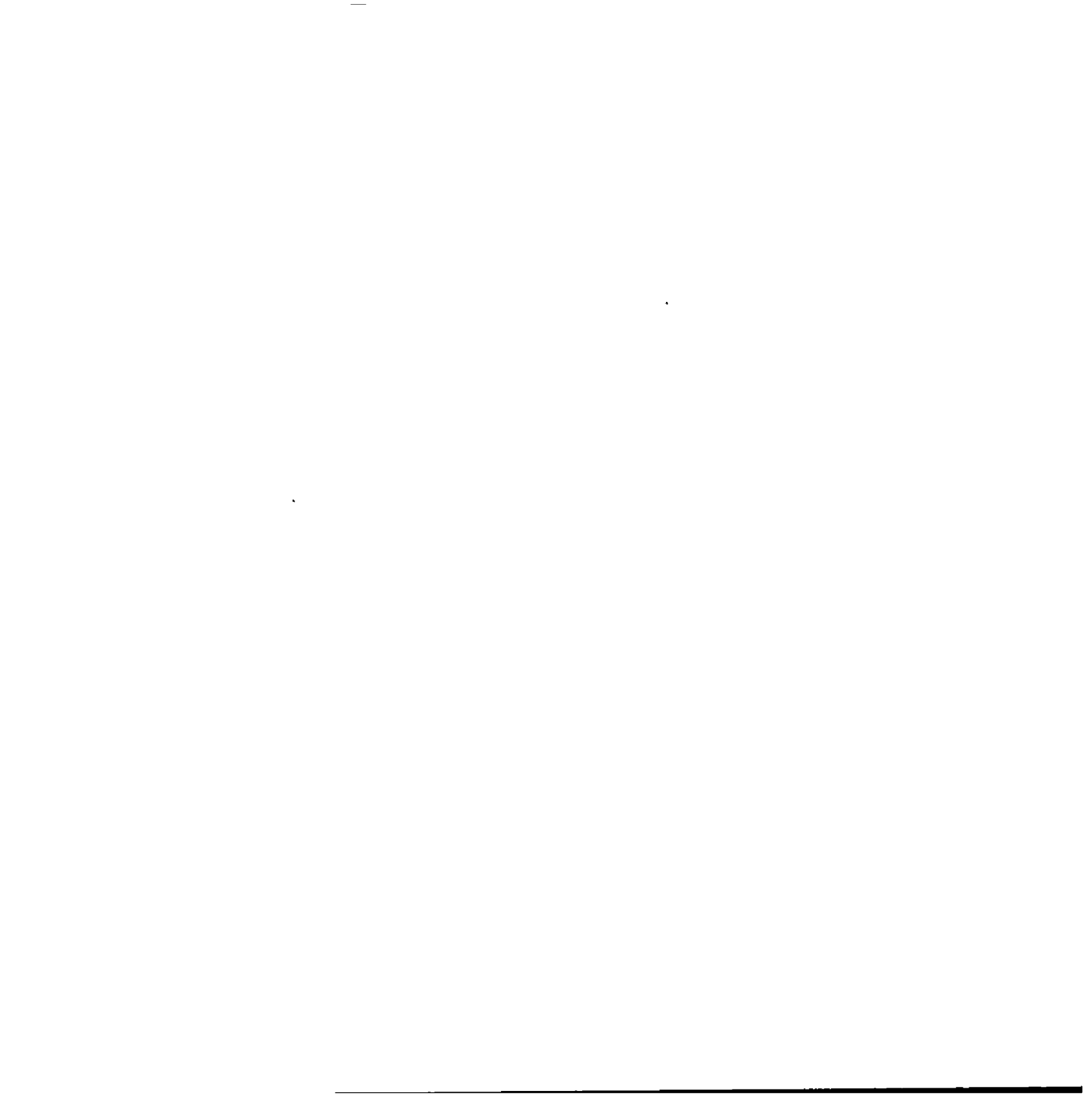
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9. Additionally, officials in Connecticut believed that the majority of the chronically mentally ill were picked up under the state's early expansion in April 2010, which included adults with income up to 56% FPL; the increase to 138% FPL in January 2014 therefore did not have a dramatic impact.

[← Return to text](#)

10. *Report on Medicaid Expansion in 2014*. (Deloitte commissioned by the Commonwealth of Kentucky, February 2015.) [http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky Medicaid Expansion One-Year Study FINAL.pdf](http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf) ([http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky Medicaid Expansion One-Year Study FINAL.pdf](http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf)).

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Kentucky elected to expand access to these substance use services to all of their Medicaid population, not just the newly eligible. The study commissioned by the Commonwealth of Kentucky noted that there would be increased general fund requirements for providing these additional substance abuse benefits to those previously eligible as well as those already enrolled in Medicaid.

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12. Federal Medicaid law (Subparagraph (A) in the matter after section 1905(a)(29) of the Social Security Act) prohibits the payment of federal Medicaid matching funds for the cost of any services provided to an “inmate of a public institution,” except when the individual is a “patient in a medical institution.” This policy applies to both adults in jails or prisons as well as to youths involuntarily detained in a state or local juvenile facility. This policy does not prohibit individuals from being enrolled in Medicaid while incarcerated; however, even if they are enrolled, Medicaid will not cover the cost of their care, except for care received as an inpatient in a hospital or other medical institution. Because individuals may remain enrolled, states can suspend, rather than terminate, Medicaid coverage for inmates to accommodate the inmate exclusion. However, suspension and termination policies vary across states.

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13. *Managing Prison Health Care Spending*, (Washington DC: Pew Charitable Trusts and John D. and Catherine T. MacArthur Foundation, October 2013),  
[http://www.pewtrusts.org/~media/legacy/uploadedfiles/pcs\\_assets/2014/PCTCorrectionsHealthcareBrief050814pdf.pdf](http://www.pewtrusts.org/~media/legacy/uploadedfiles/pcs_assets/2014/PCTCorrectionsHealthcareBrief050814pdf.pdf) ([http://www.pewtrusts.org/~media/legacy/uploadedfiles/pcs\\_assets/2014/PCTCorrectionsHealthcareBrief050814pdf.pdf](http://www.pewtrusts.org/~media/legacy/uploadedfiles/pcs_assets/2014/PCTCorrectionsHealthcareBrief050814pdf.pdf)).

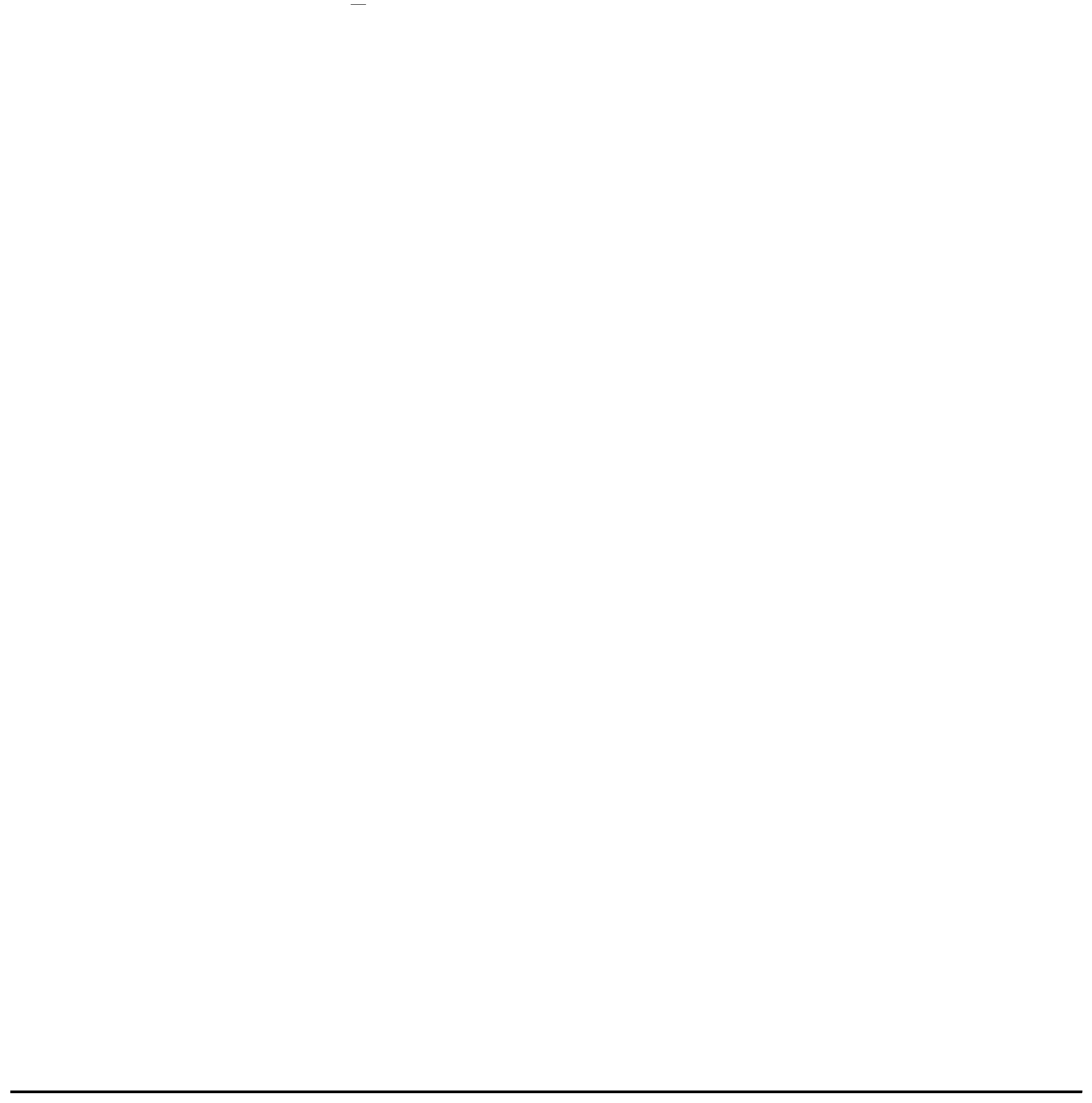
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14. *Managing Prison Health Care Spending*, (Washington DC: Pew Charitable Trusts and John D. and Catherine T. MacArthur Foundation, October 2013),  
[http://www.pewtrusts.org/~media/legacy/uploadedfiles/pcs\\_assets/2014/PCTCorrectionsHealthcareBrief050814pdf.pdf](http://www.pewtrusts.org/~media/legacy/uploadedfiles/pcs_assets/2014/PCTCorrectionsHealthcareBrief050814pdf.pdf) ([http://www.pewtrusts.org/~media/legacy/uploadedfiles/pcs\\_assets/2014/PCTCorrectionsHealthcareBrief050814pdf.pdf](http://www.pewtrusts.org/~media/legacy/uploadedfiles/pcs_assets/2014/PCTCorrectionsHealthcareBrief050814pdf.pdf)).

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15. Some state officials also noted that tracking state savings in this area can require costly reprogramming of Medicaid eligibility systems.

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17. Teresa A. Coughlin, John Holahan, Kyle Caswell, and Megan McGrath. *Uncompensated Care for the Uninsured in 2013: A Detailed Examination*. (Washington, DC: Urban Institute, May 2014.) <http://kff.org/uninsured/report/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination/> (<http://kff.org/uninsured/report/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination/>).

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18. *Report on Medicaid Expansion in 2014*. (Deloitte commissioned by the Commonwealth of Kentucky, February 2015.) [http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky Medicaid Expansion One-Year Study FINAL.pdf](http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf) ([http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky Medicaid Expansion One-Year Study FINAL.pdf](http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf)).

[← Return to text](#)

19. Ibid.

[← Return to text](#)

20. Ibid.

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21. Council of Economic Advisers. *Missed Opportunities: The Consequences of State Decisions Not to Expand Medicaid*. July 2014, [http://www.whitehouse.gov/sites/default/files/docs/missed\\_opportunities\\_medicaid.pdf](http://www.whitehouse.gov/sites/default/files/docs/missed_opportunities_medicaid.pdf) ([http://www.whitehouse.gov/sites/default/files/docs/missed\\_opportunities\\_medicaid.pdf](http://www.whitehouse.gov/sites/default/files/docs/missed_opportunities_medicaid.pdf)).

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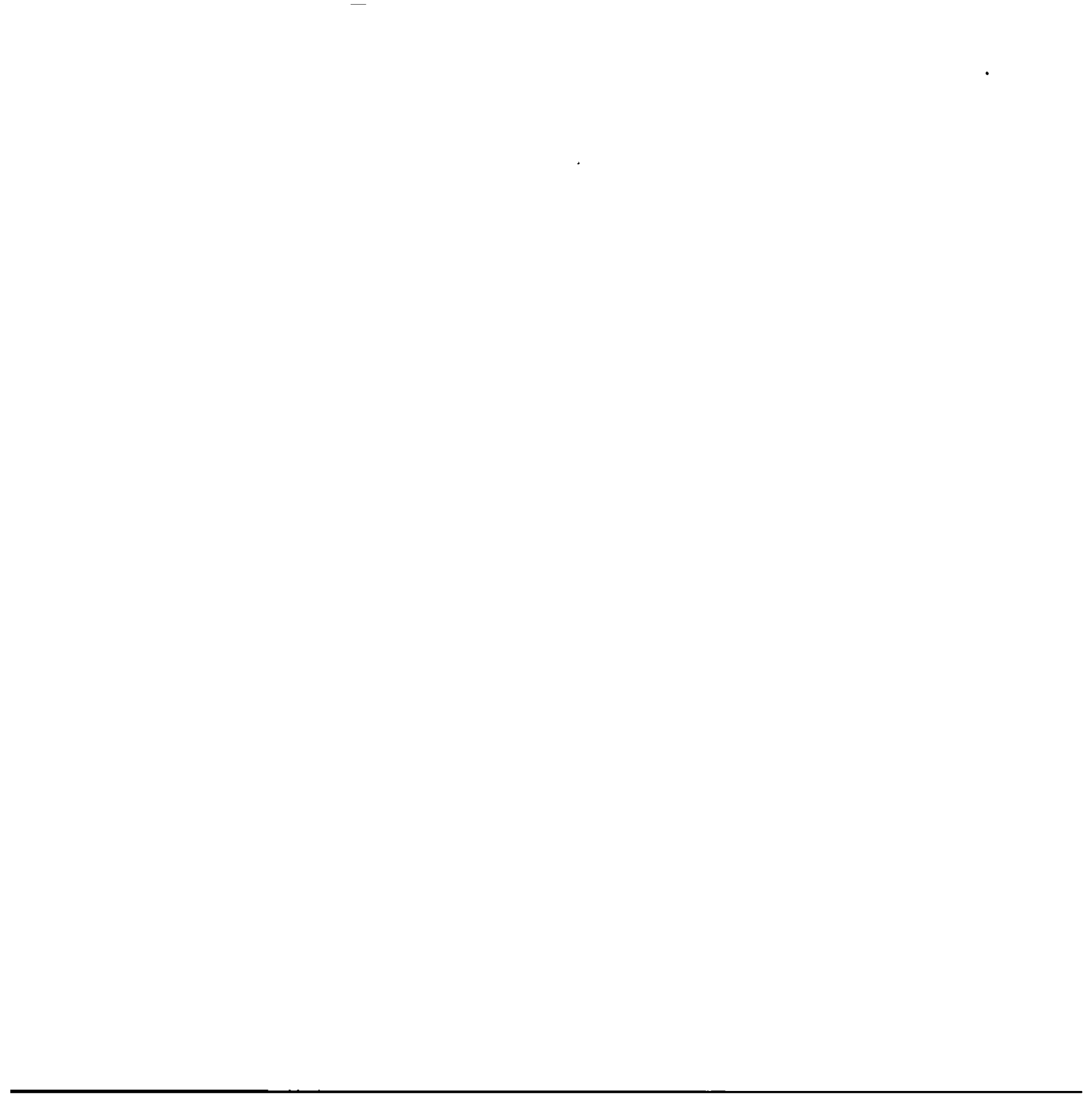
22. *Report on Medicaid Expansion in 2014*. (Deloitte commissioned by the Commonwealth of Kentucky, February 2015.) [http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky Medicaid Expansion One-Year Study FINAL.pdf](http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf) ([http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky Medicaid Expansion One-Year Study FINAL.pdf](http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf)).

[← Return to text](#)

23. The calculations are those of the authors based on (1) savings figures provided by state officials as (2) compared to state general fund spending across all budget categories for SFY 2013 as reported by the National Association of State Budget Officers in its *State Expenditure Report: Examining Fiscal 2012-2014*.

[← Return to text](#)

24. *Report on Medicaid Expansion in 2014*. (Deloitte commissioned by the



## Appendices

### Appendix A: Coverage Initiatives prior to the ACA

1. Martha Heberlein, Tricia Brooks, Joan Alker, Samantha Artiga and Jessica Stephens. *Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2012-2013*. (Kaiser Commission on Medicaid and the Uninsured, January 2013.) <http://kff.org/medicaid/report/getting-into-gear-for-2014-findings-from-a-50-state-survey-of-eligibility-enrollment-renewal-and-cost-sharing-policies-in-medicaid-and-chip-2012-2013/> (<http://kff.org/medicaid/report/getting-into-gear-for-2014-findings-from-a-50-state-survey-of-eligibility-enrollment-renewal-and-cost-sharing-policies-in-medicaid-and-chip-2012-2013/>).

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2. Connecticut's SAGA program included both cash and medical assistance; the cash assistance component remains.

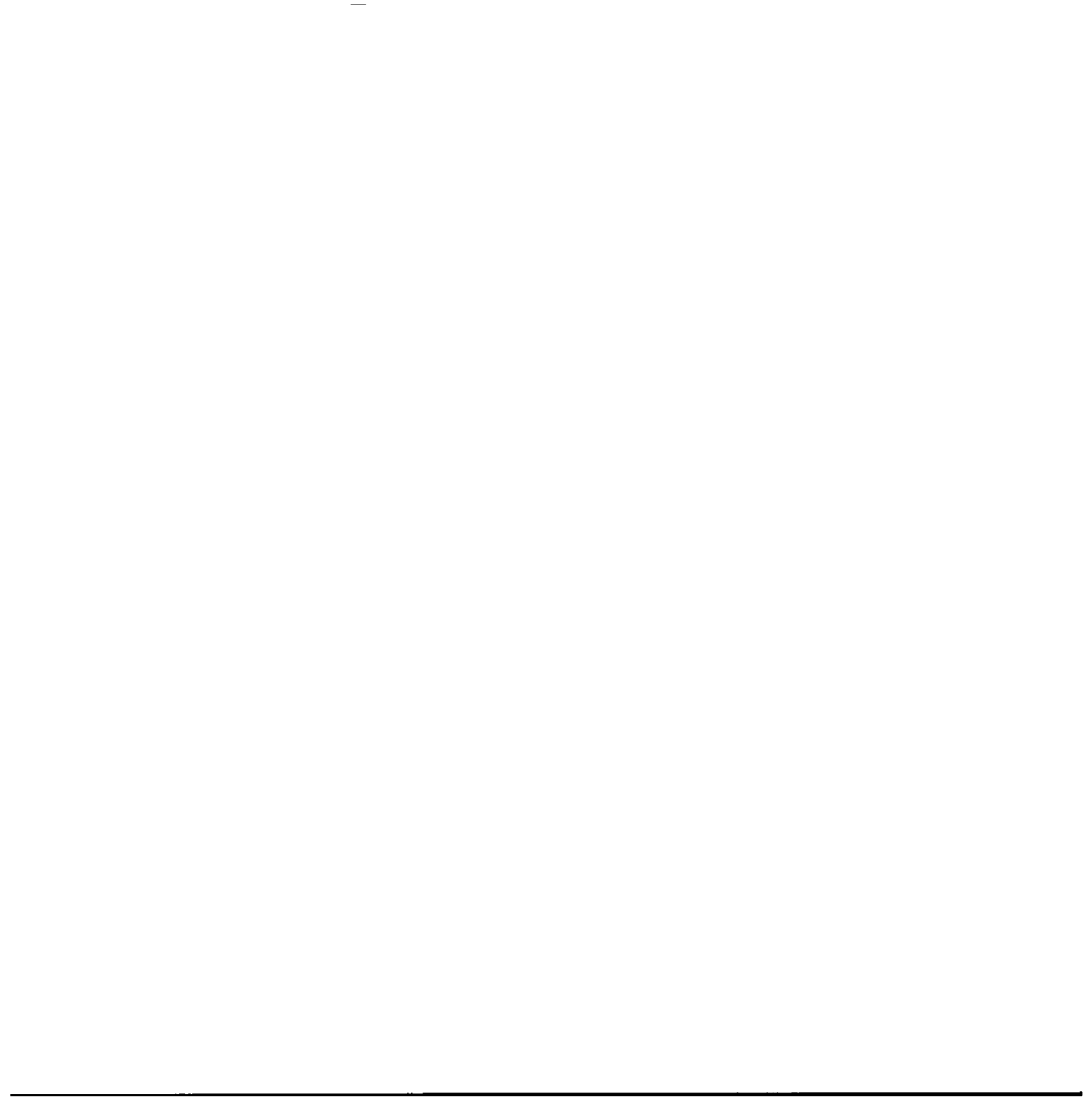
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3. After projecting a \$300 million surplus for FY 2015 twice, the state's Comptroller projected a \$31 million deficit due in part to a shortfall in the Medicaid program resulting from federal reimbursement issues and hospital settlement payments that were above projections. <http://www.osc.ct.gov/public/news/releases/20150102.html> (<http://www.osc.ct.gov/public/news/releases/20150102.html>). The state has been working with CMS to finalize the methodology for obtaining the enhanced match.

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### Appendix B: Optional Medicaid Eligibility Pathways

1. New Mexico had originally reported plans to eliminate its family planning program, but did not ultimately do so. Virginia also reduced eligibility for this group to 100 percent FPL in 2014 but plans to restore coverage to 200 percent FPL in 2015. Vern Smith, Kathleen Gifford, Eileen Ellis, Robin Rudowitz and Laura Snyder. *Medicaid in an Era of Health and Delivery System Reform: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and 2015*. (Washington, DC: Kaiser Commission on Medicaid and the Uninsured,) October 2014. <http://kff.org/medicaid/report/medicaid-in-an-era-of-health-delivery-system-reform-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2014-and-2015/> (<http://kff.org/medicaid/report/medicaid-in-an-era-of-health-delivery-system-reform-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2014-and-2015/>).



2014. <http://kff.org/medicaid/report/medicaid-in-an-era-of-health-delivery-system-reform-results-from-a-50-state-medicad-budget-survey-for-state-fiscal-years-2014-and-2015/> (<http://kff.org/medicaid/report/medicaid-in-an-era-of-health-delivery-system-reform-results-from-a-50-state-medicad-budget-survey-for-state-fiscal-years-2014-and-2015/>).

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### 3. Ibid.

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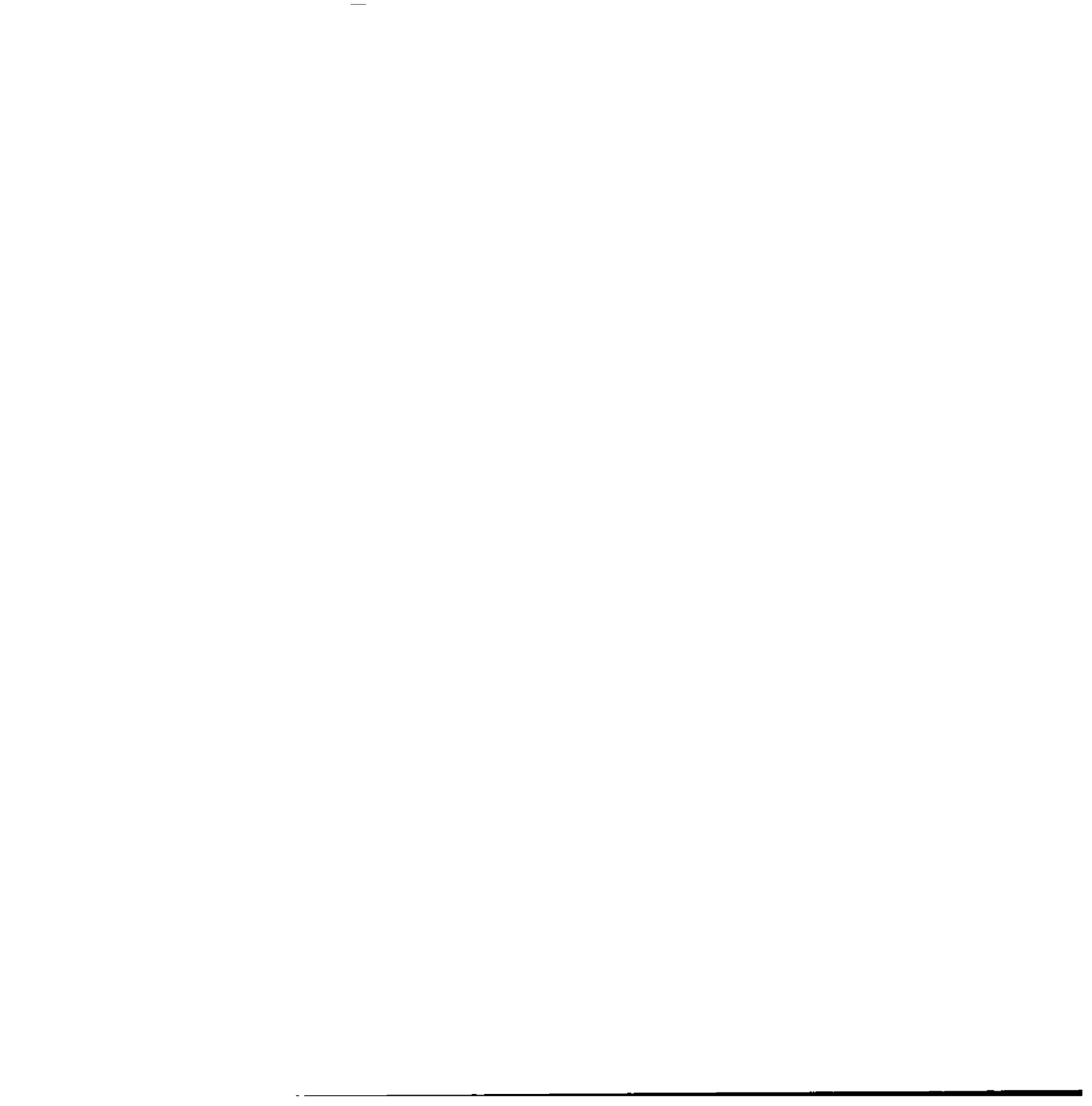
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The Henry J. Kaiser Family Foundation Headquarters: 2400 Sand Hill Road, Menlo Park, CA 94025 | Phone 650-854-9400

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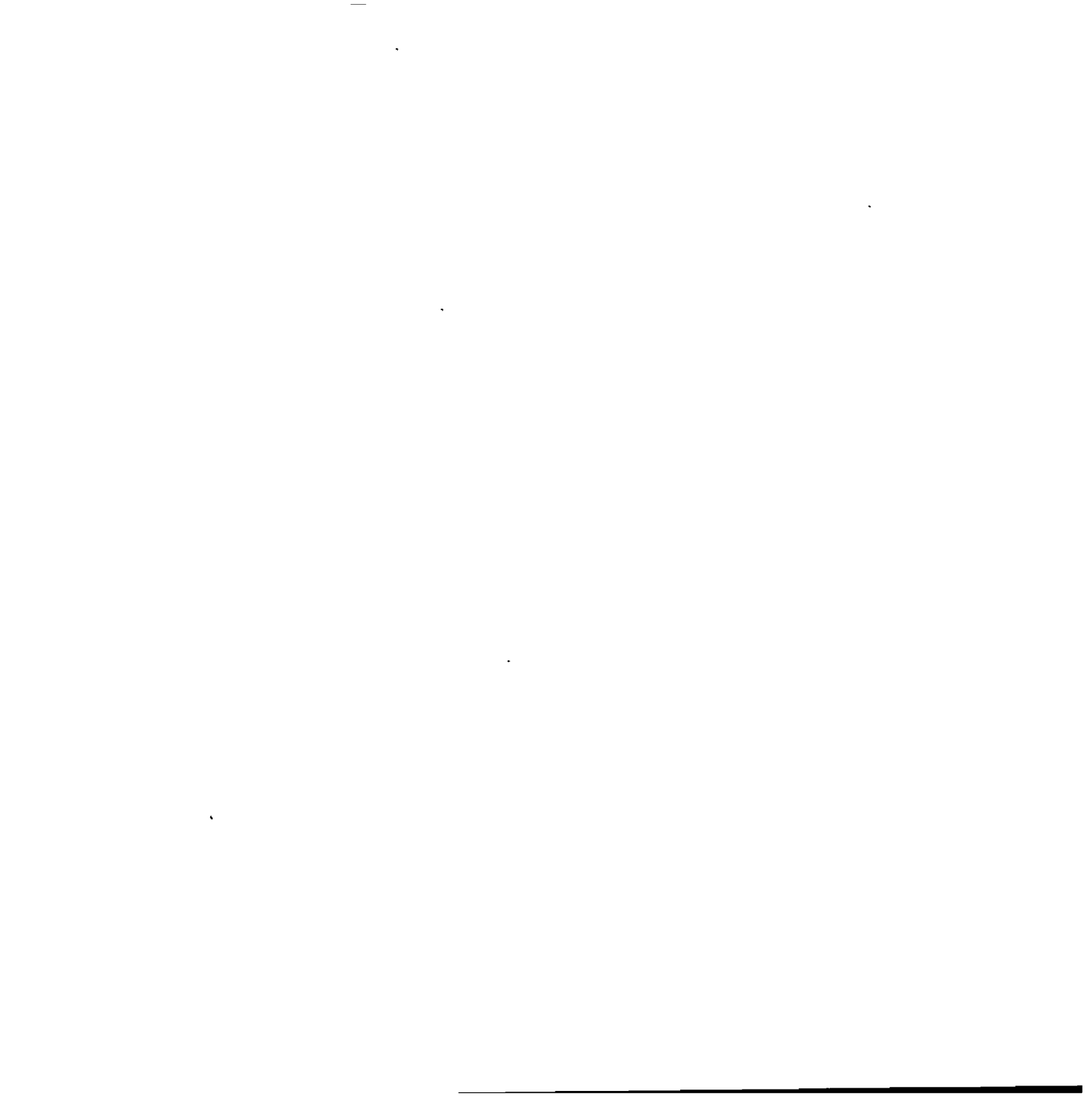
*Filling the need for trusted information on national health issues, the Kaiser Family Foundation is a nonprofit organization based in Menlo Park, California.*



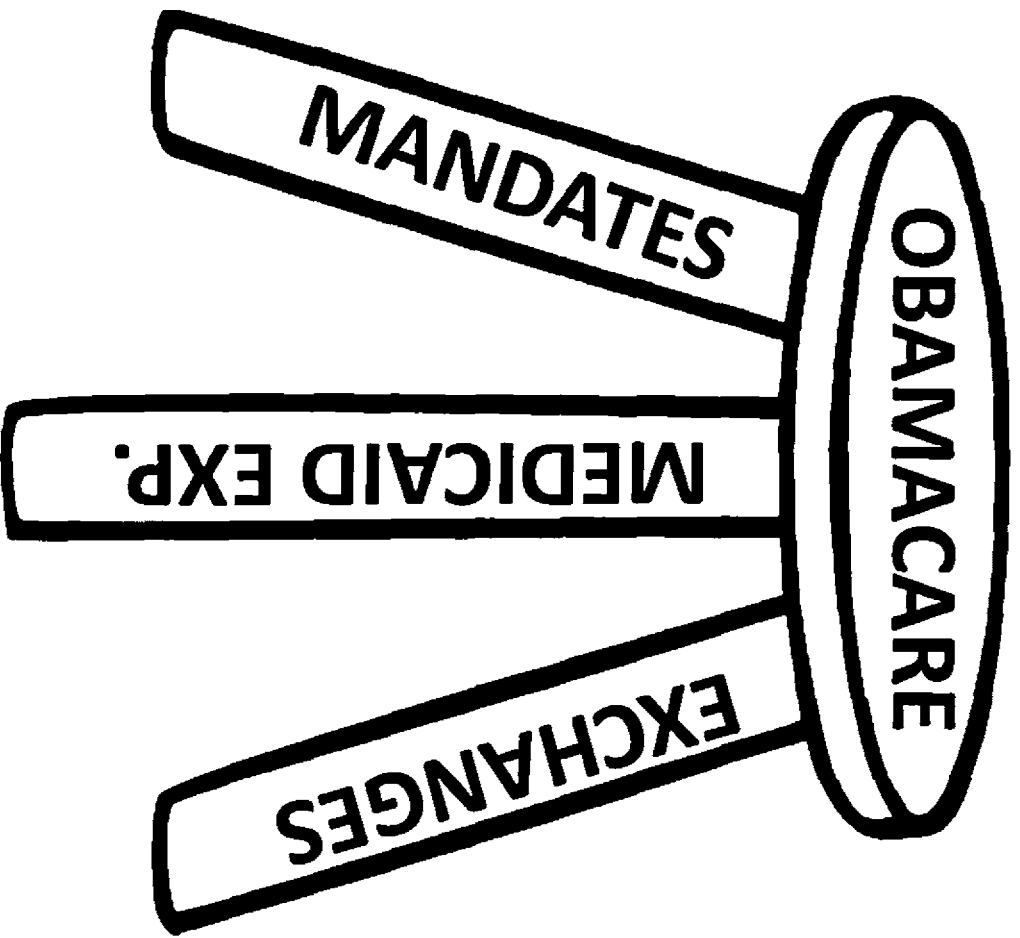


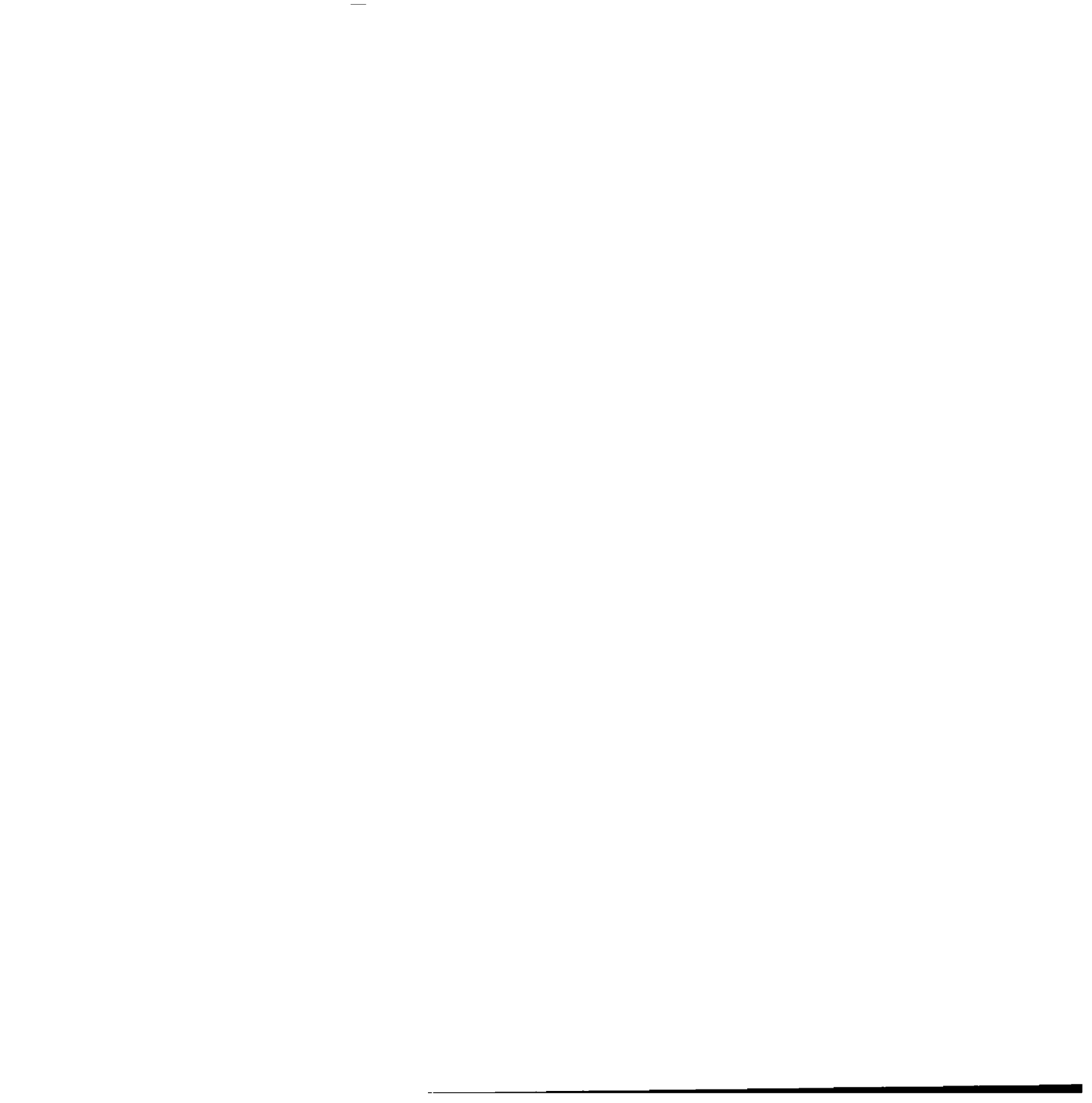
# **Medicaid Expansion: Lessons from Other States**

**Christie Herrera, Senior Fellow  
Foundation for Government Accountability  
Alaska Legislative Briefing  
March 4, 2015**

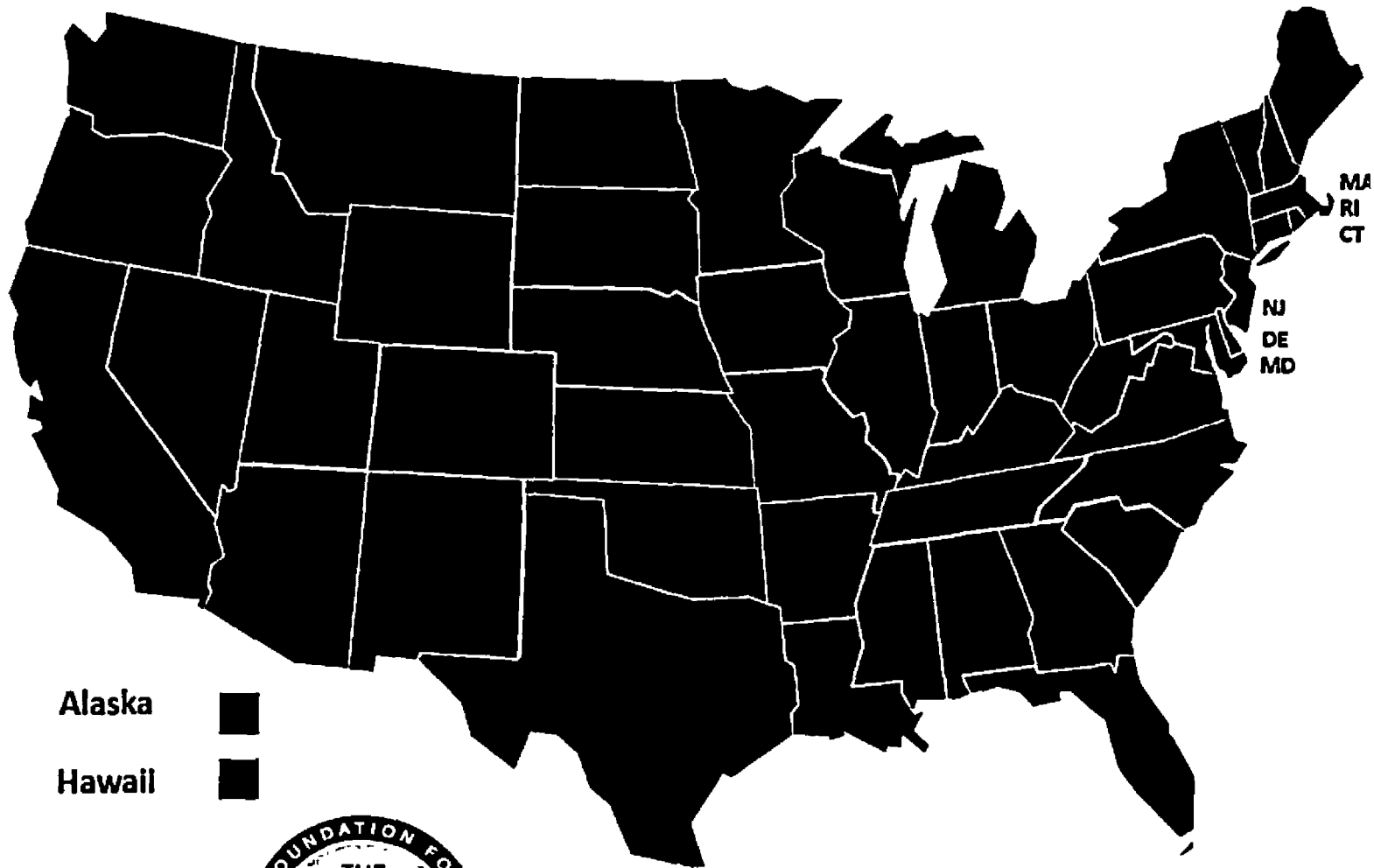


# Expansion Is Part of ObamaCare





# What States Have Expanded Medicaid

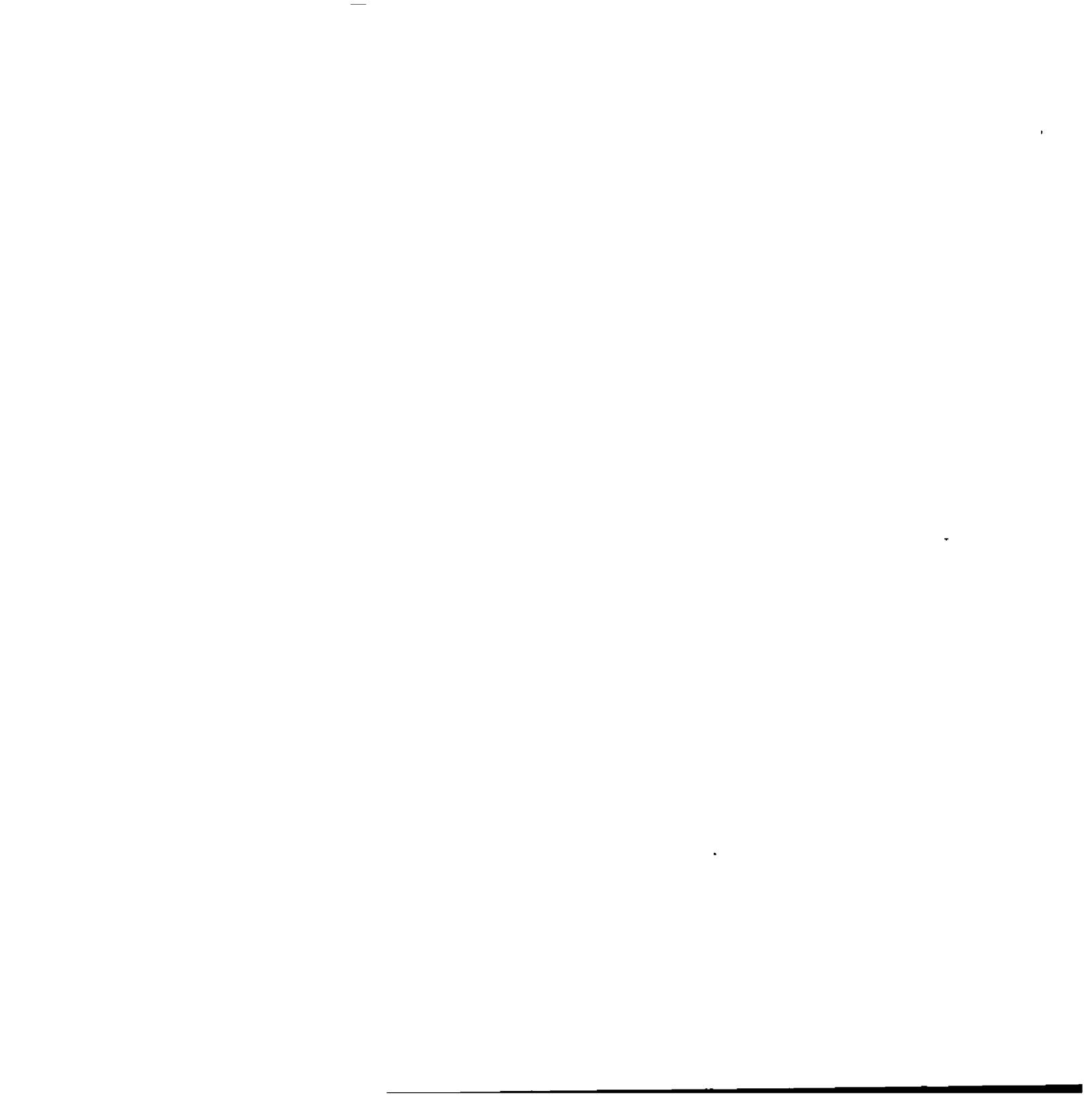


Alaska  
Hawaii



Not Implementing PPACA's Medicaid Expansion (23)

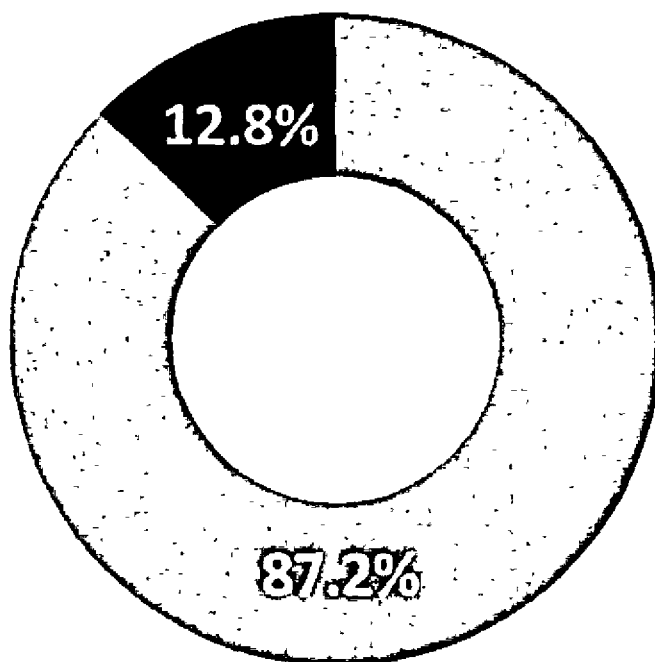
Implementing PPACA's Medicaid Expansion (27)



# Alaska's Expansion Population

**Early 9 in 10 Potential Enrollees Are Able-Bodied, Childless Adults**

*Alaska's Medicaid Expansion Population by Parental Status*

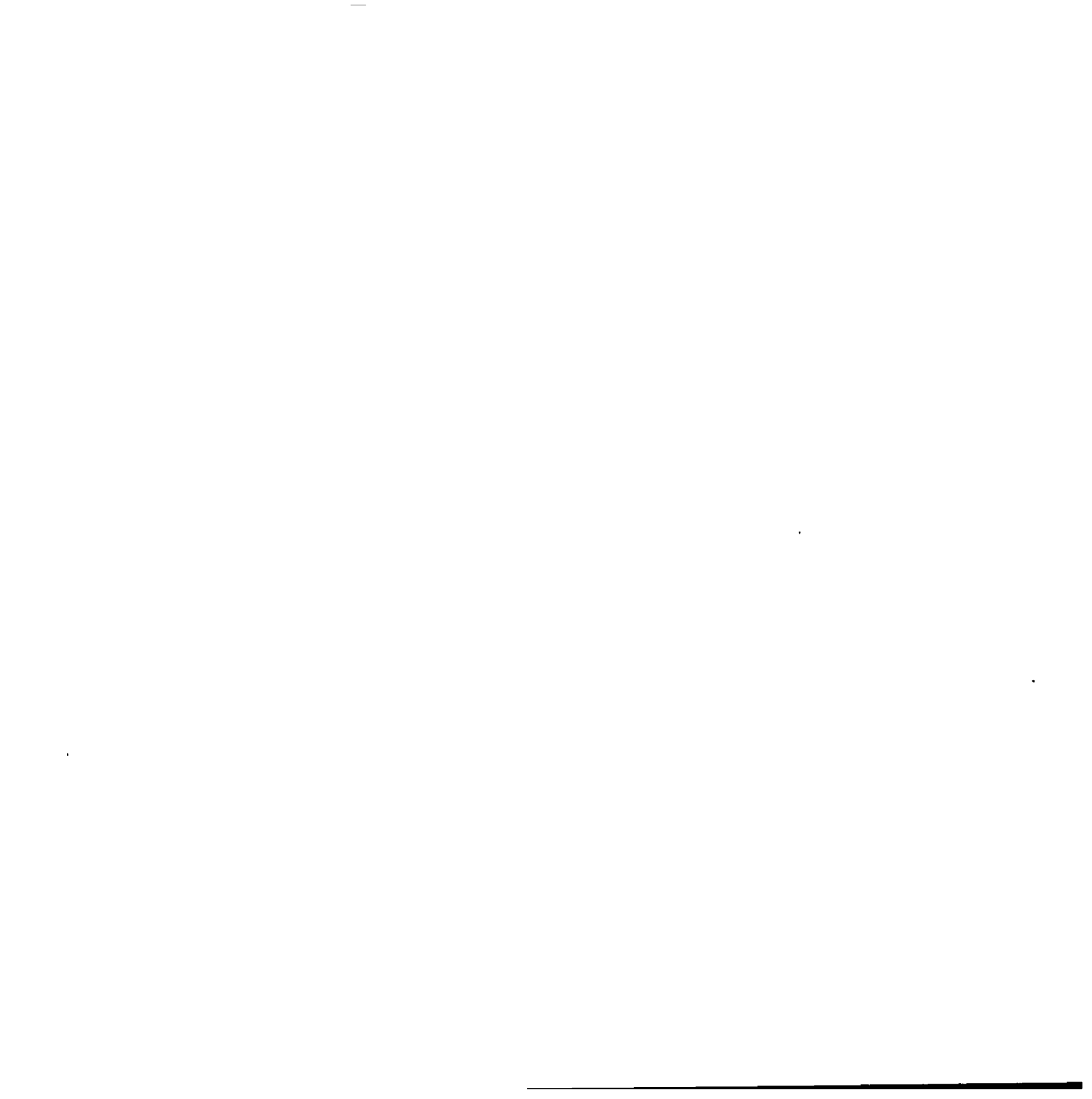


□ Childless Adults

■ Low-Income Parents



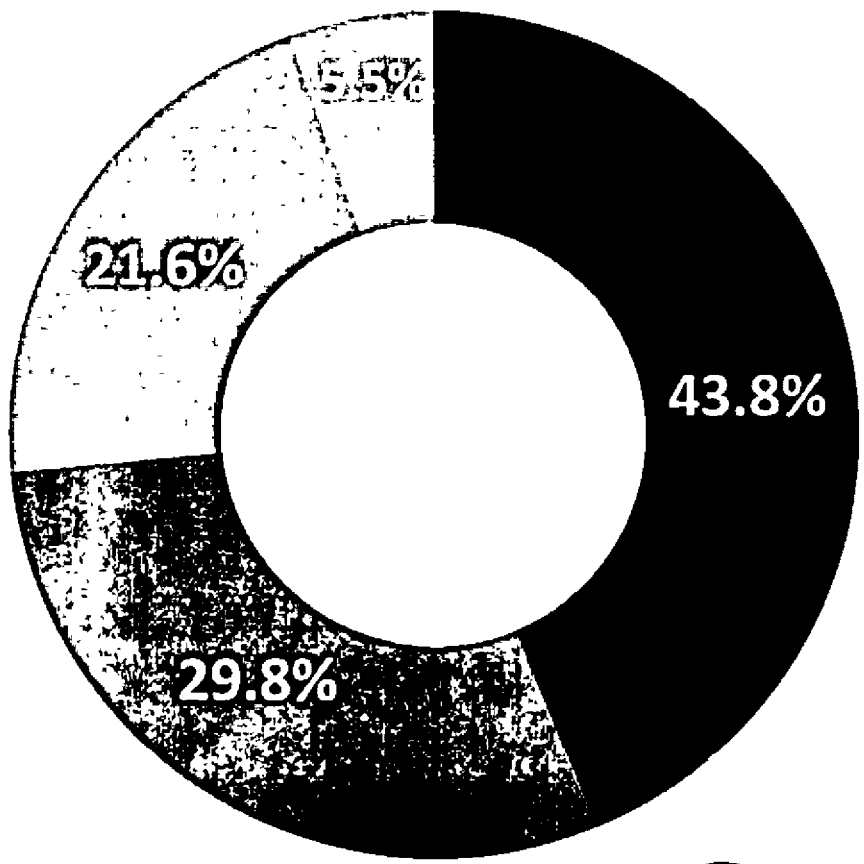
Source: Urban Institute



# Alaska's Expansion Population

## More Than Half of Potential Enrollees Don't Work At All

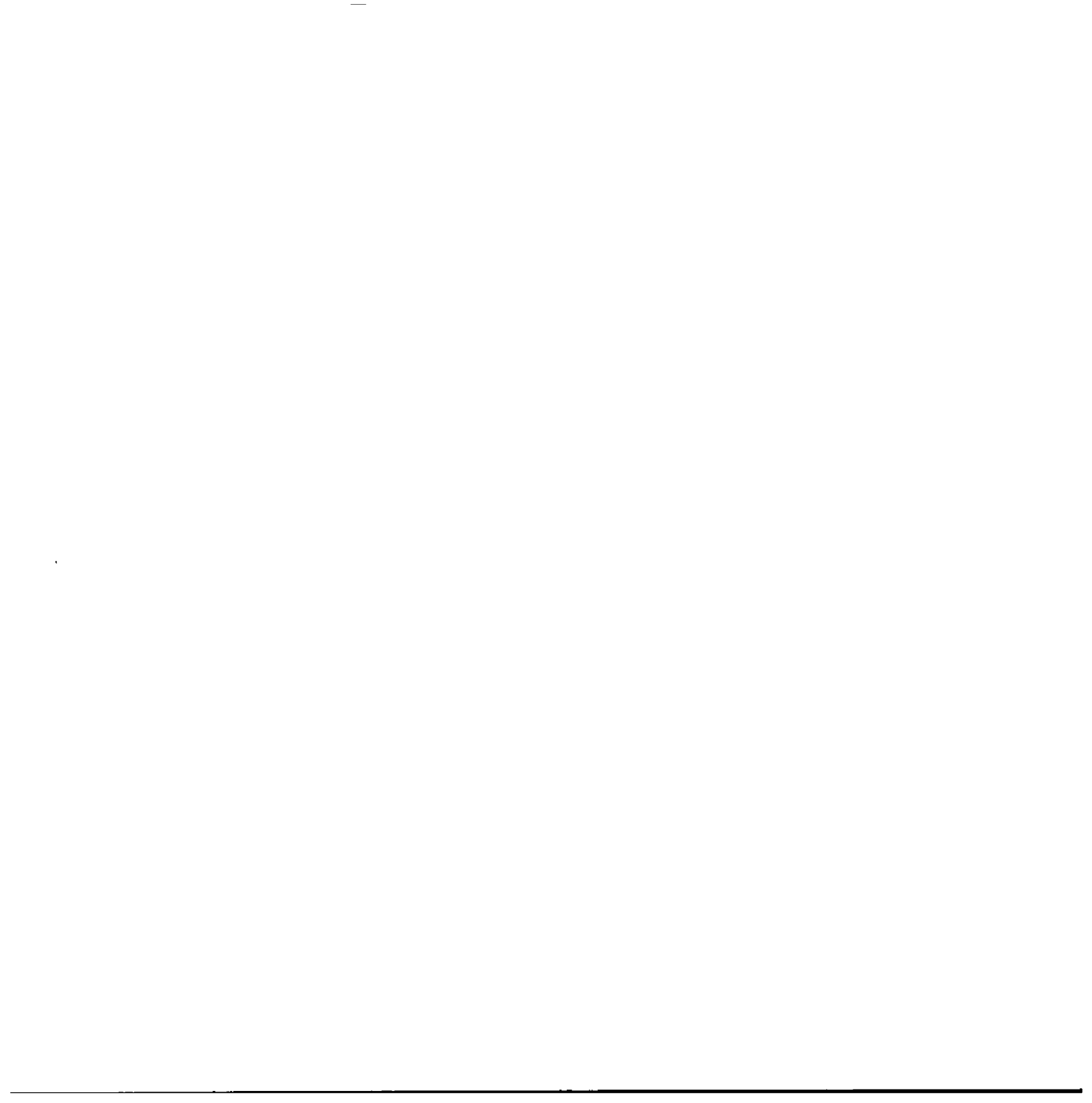
*Alaska's Medicaid Expansion Population by Employment Status*



- Employed
- ▣ Unemployed
- ▣ "Not in Labor Force"
- ▣ "Unable to Work"



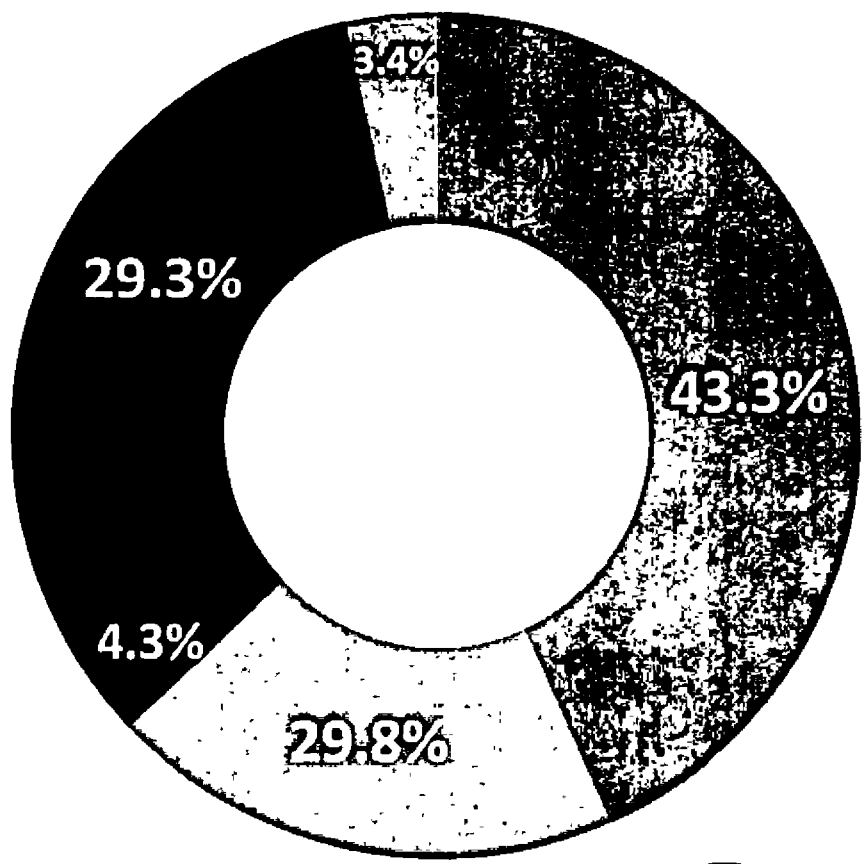
Source: Evergreen Economics



# Alaska's Expansion Population

**More Than Half of Potential Enrollees Already Have Coverage**

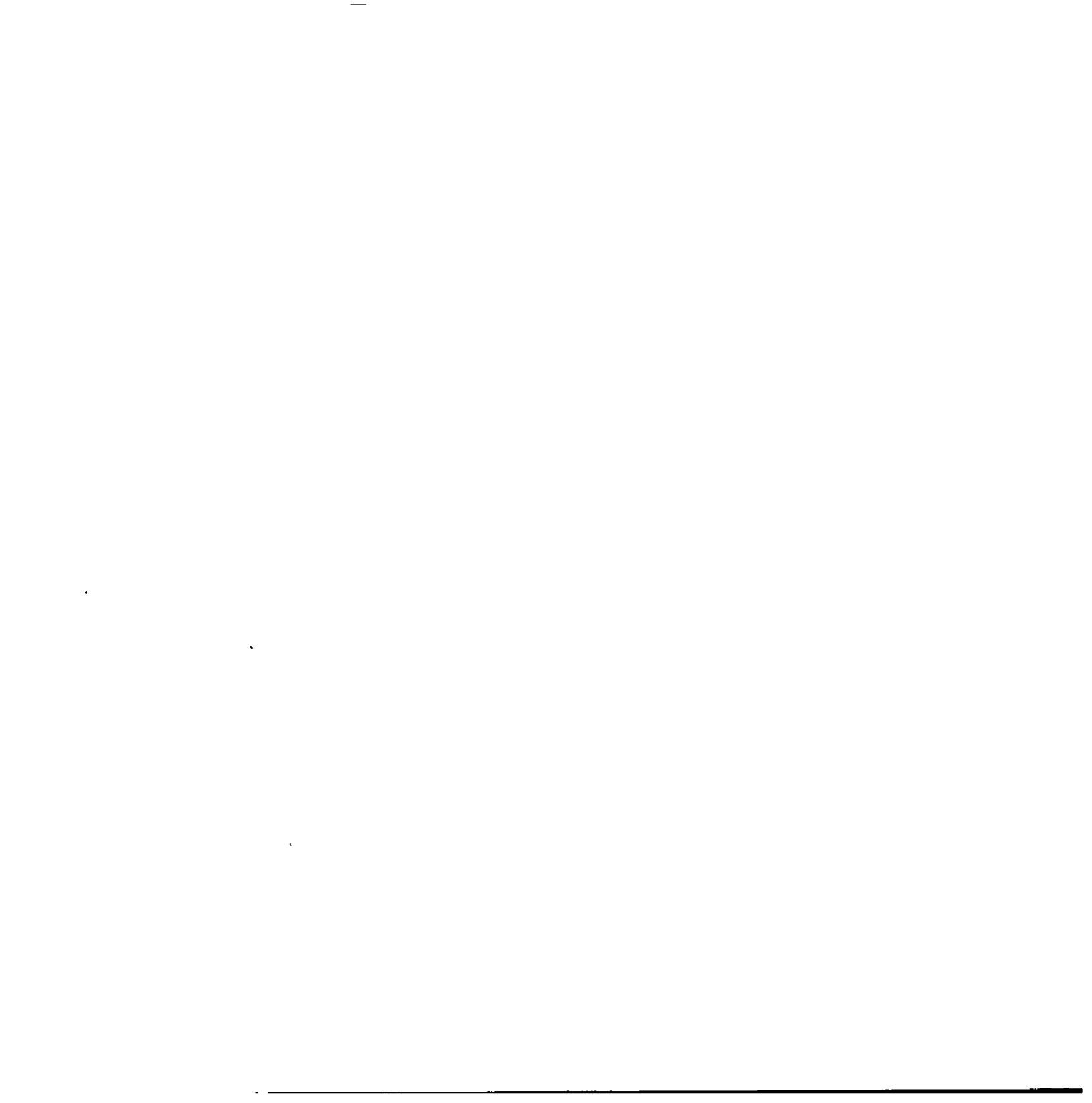
*Alaska's Medicaid Expansion Population by Insurance Status*



- Uninsured
- Employer Coverage
- Individual Coverage
- Other Coverage (Military, TriCare, IHS)
- Don't Know/Refused



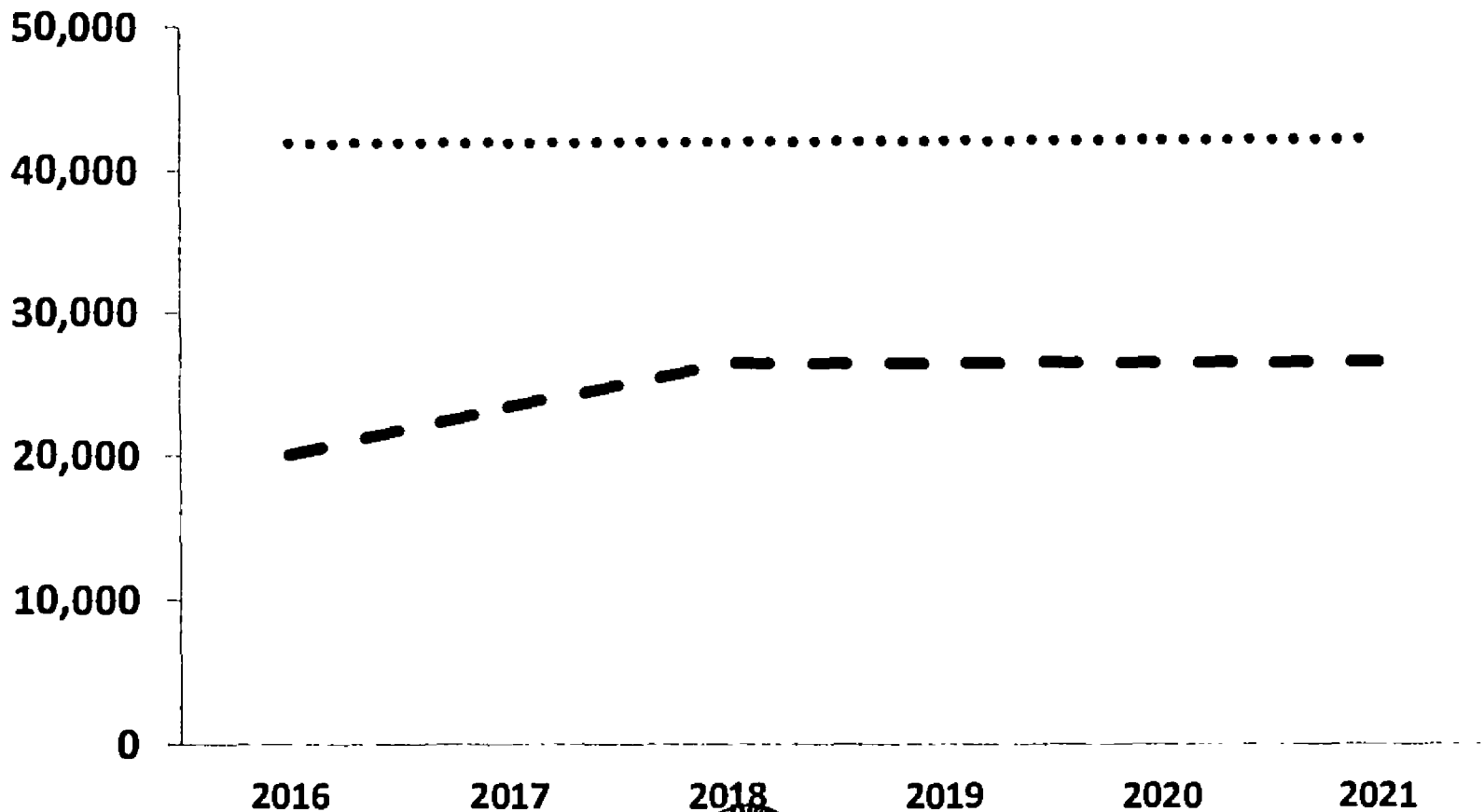
Source: Evergreen Economics



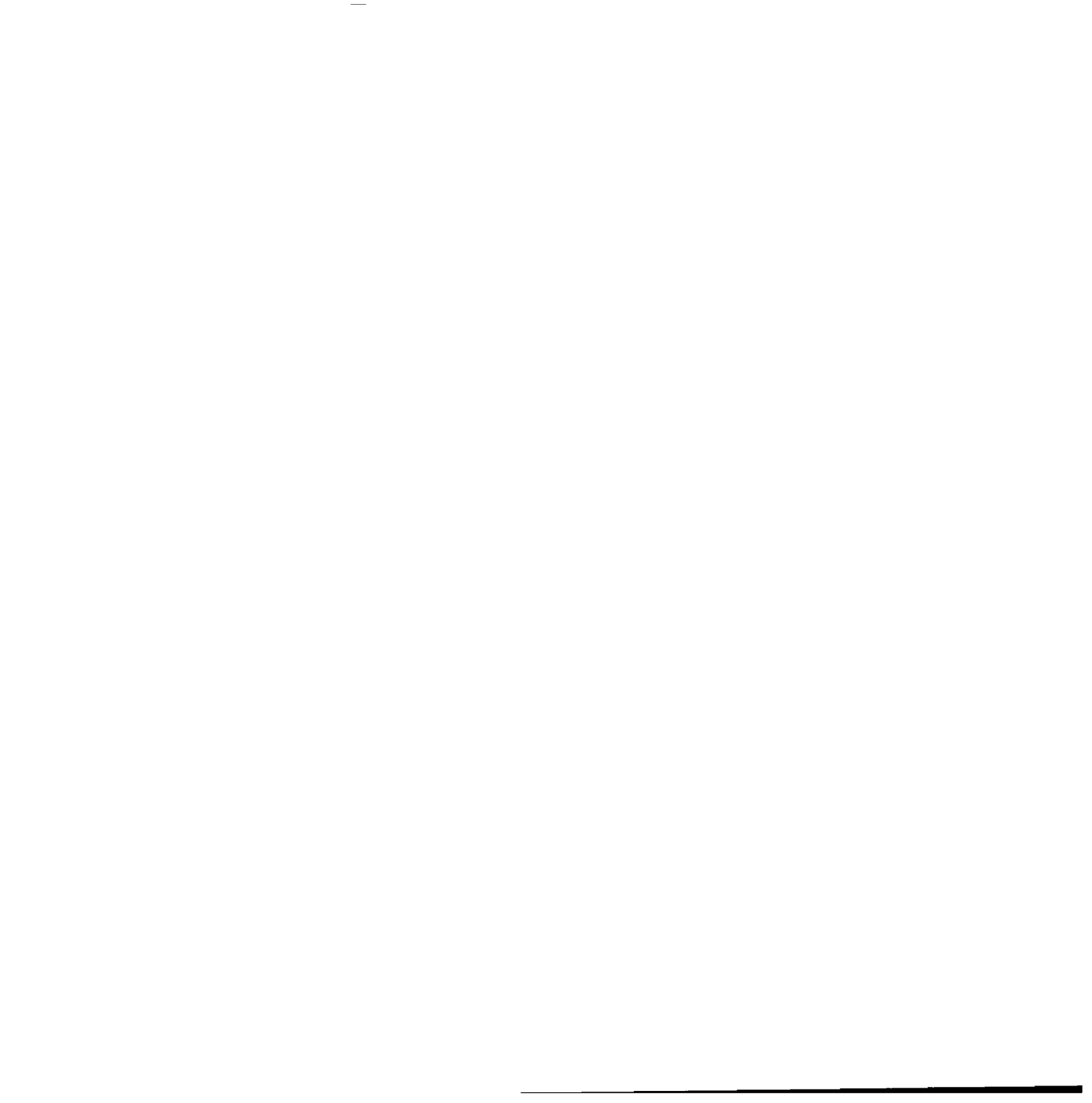
# Alaska Expansion Prediction

## No More Than 63% of Eligible Alaskans Expected to Enroll

*Alaska's Projected Medicaid Enrollment: 2016-2021*



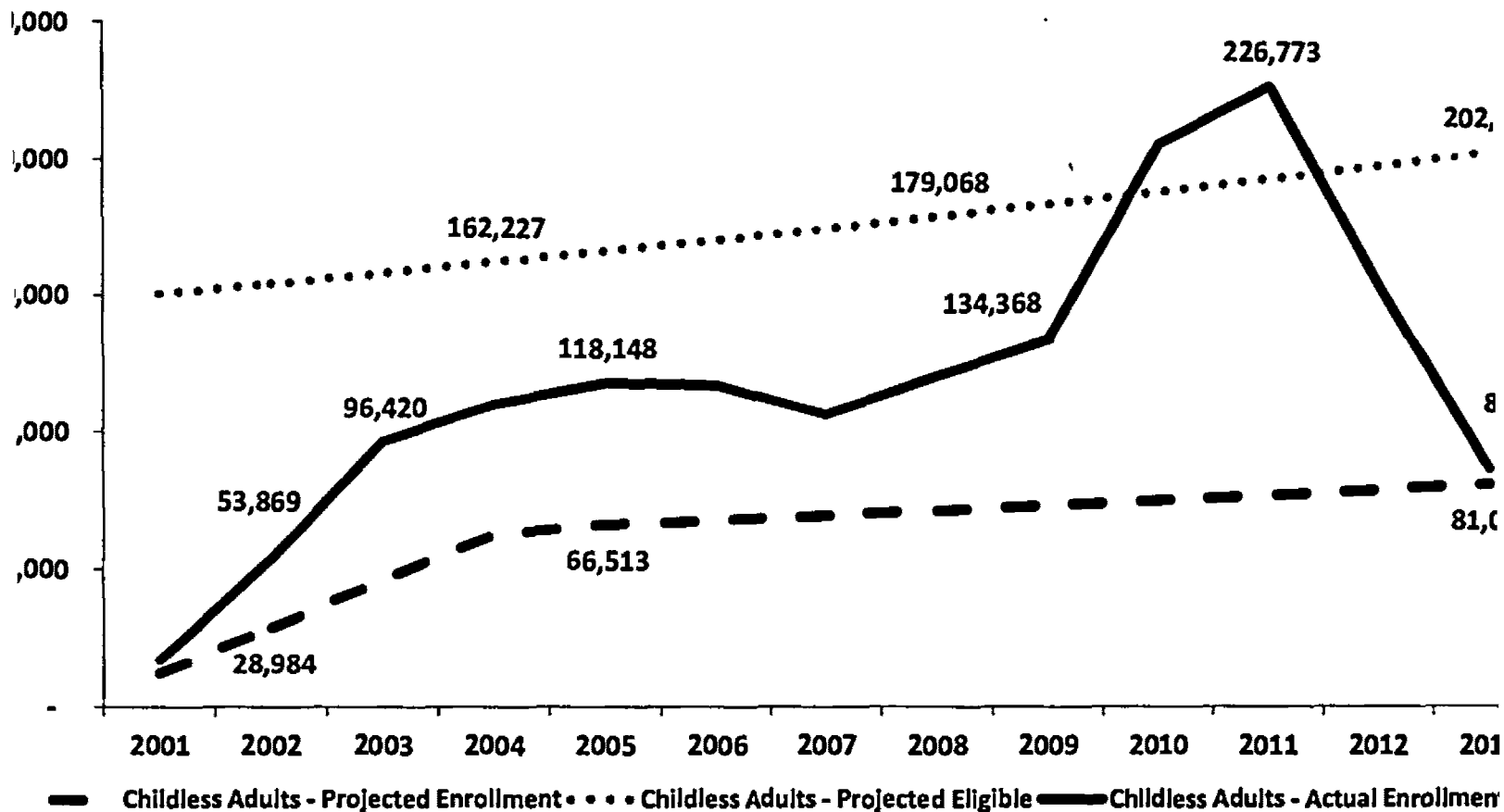
Source: Evergreen Econom



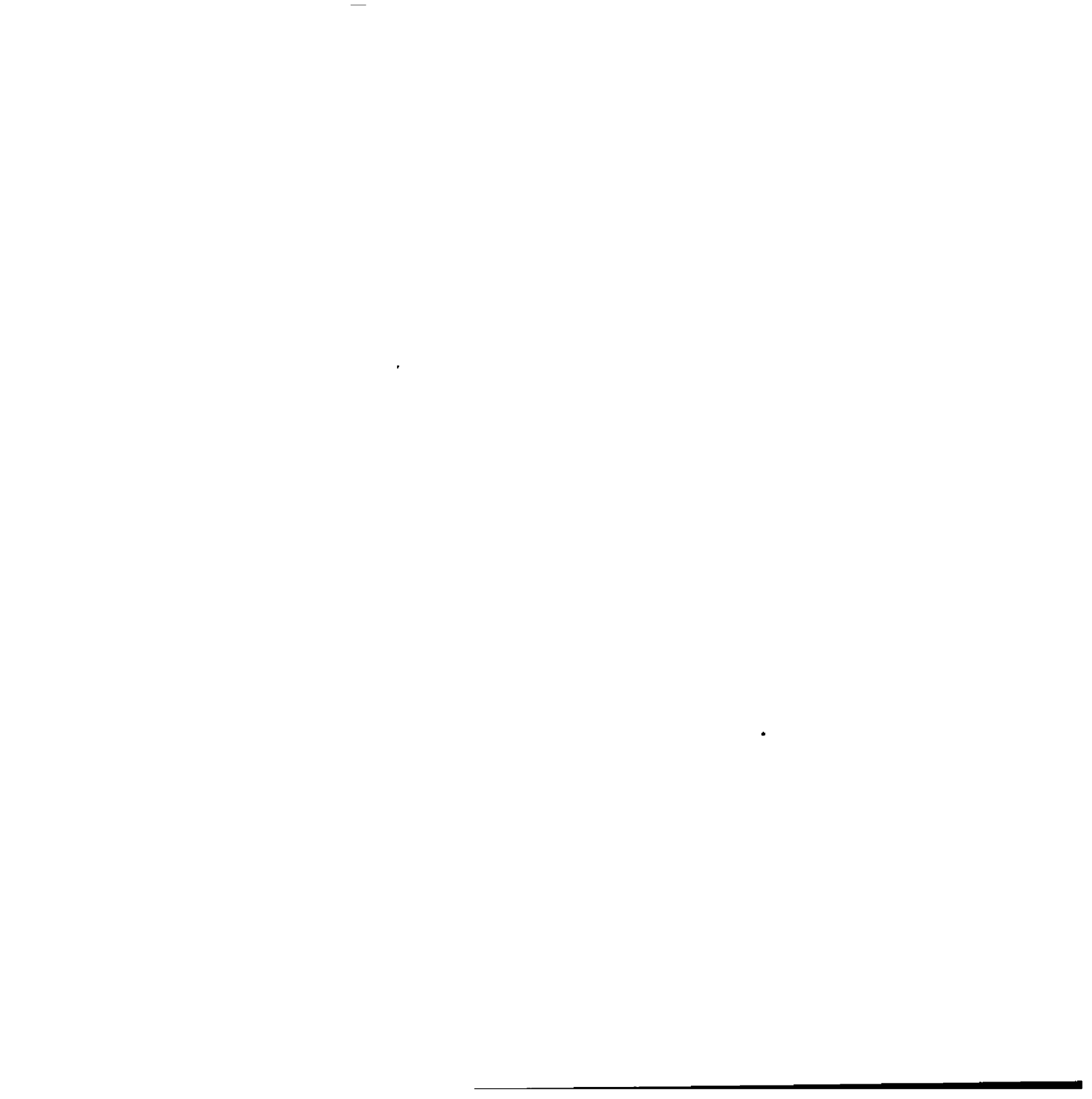
# The Arizona Experience

Arizona Enrolled Three Times As Many Childless Adults Than Pro

*Arizona's Optional 2000 Medicaid Expansion Enrollment: Projected vs. Actual*



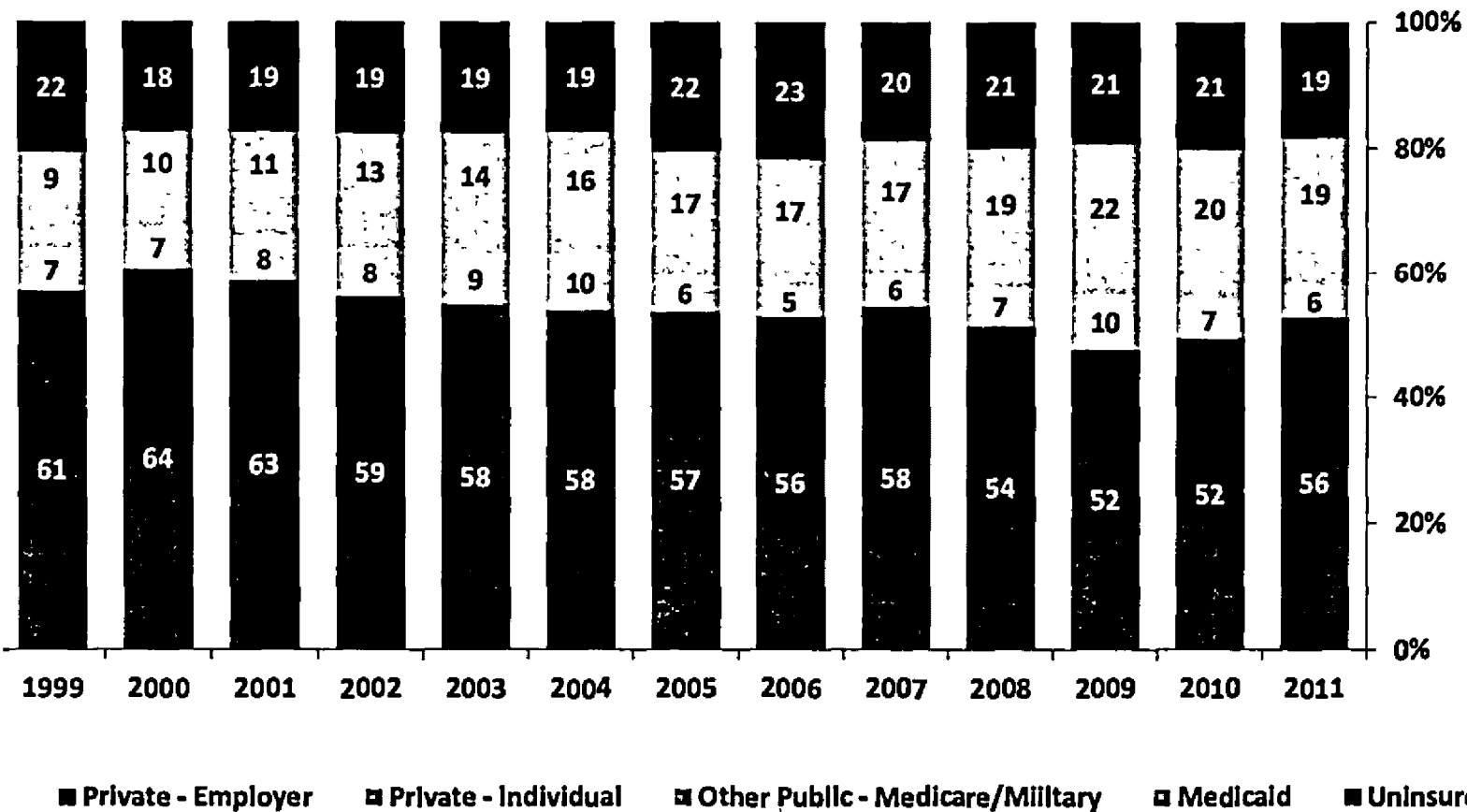
Source: Arizona Legislature's Joint Legislative Committee (2001 actual and 2001-2010 Arizona Health Care Cost Containment Council 2013 actual, based on January enrollment)



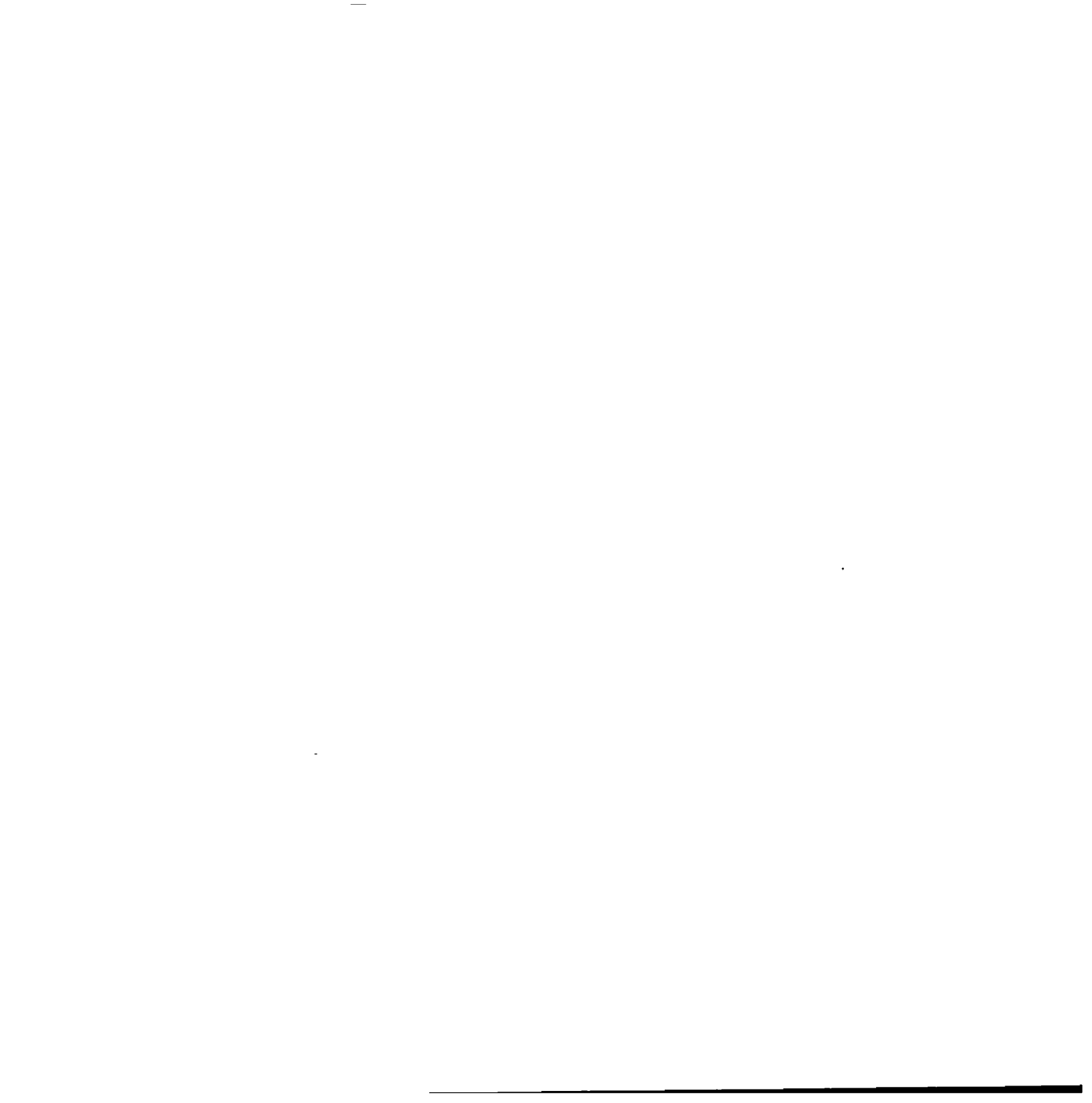
# Let the Uninsured ... Stay the Same

## No Change in Uninsured; More Medicaid; Less Private Coverage

*Non-Elderly Arizonans' Insurance Coverage, 1999-2011*



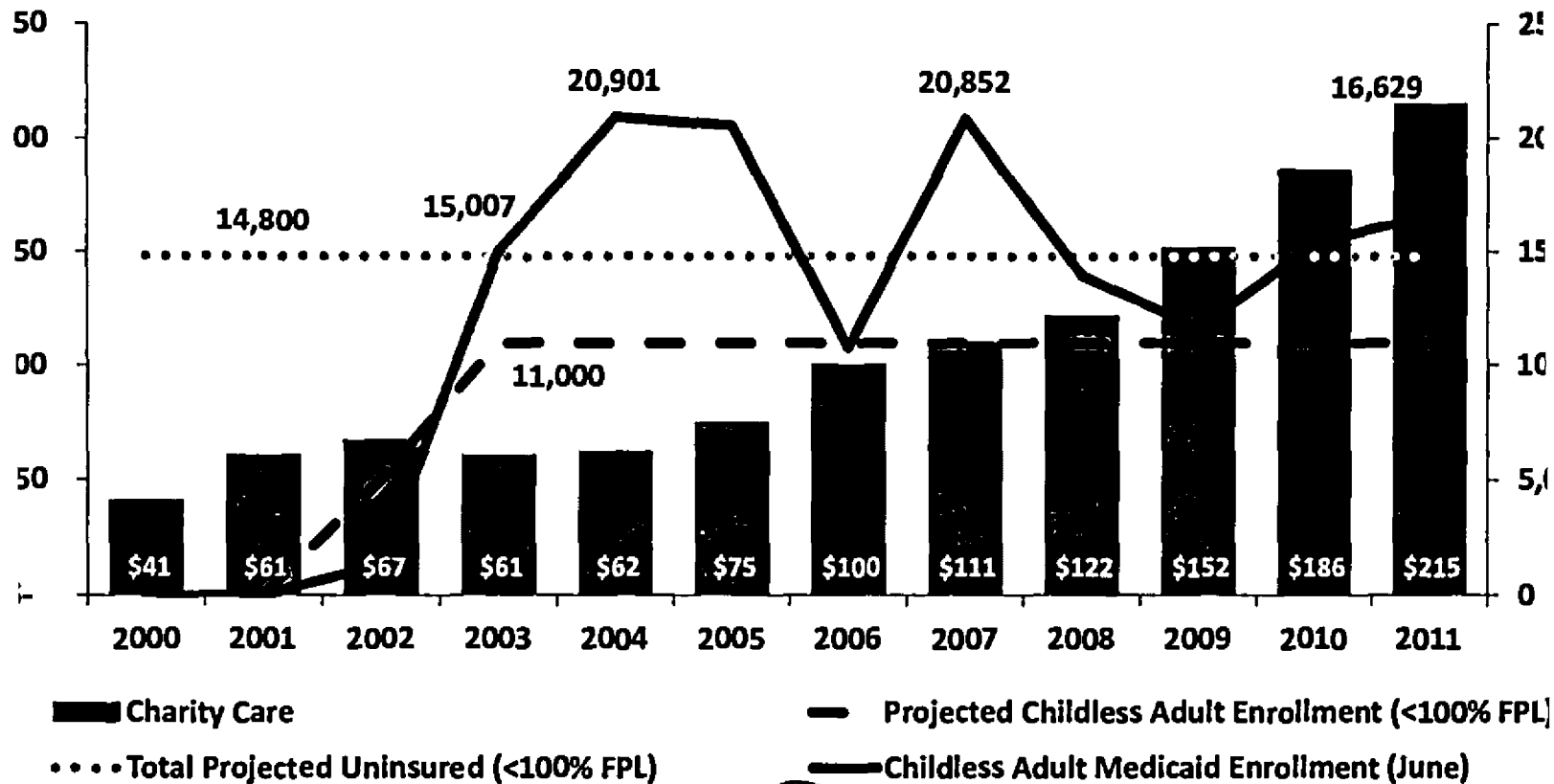
Source: U.S. Census Bu



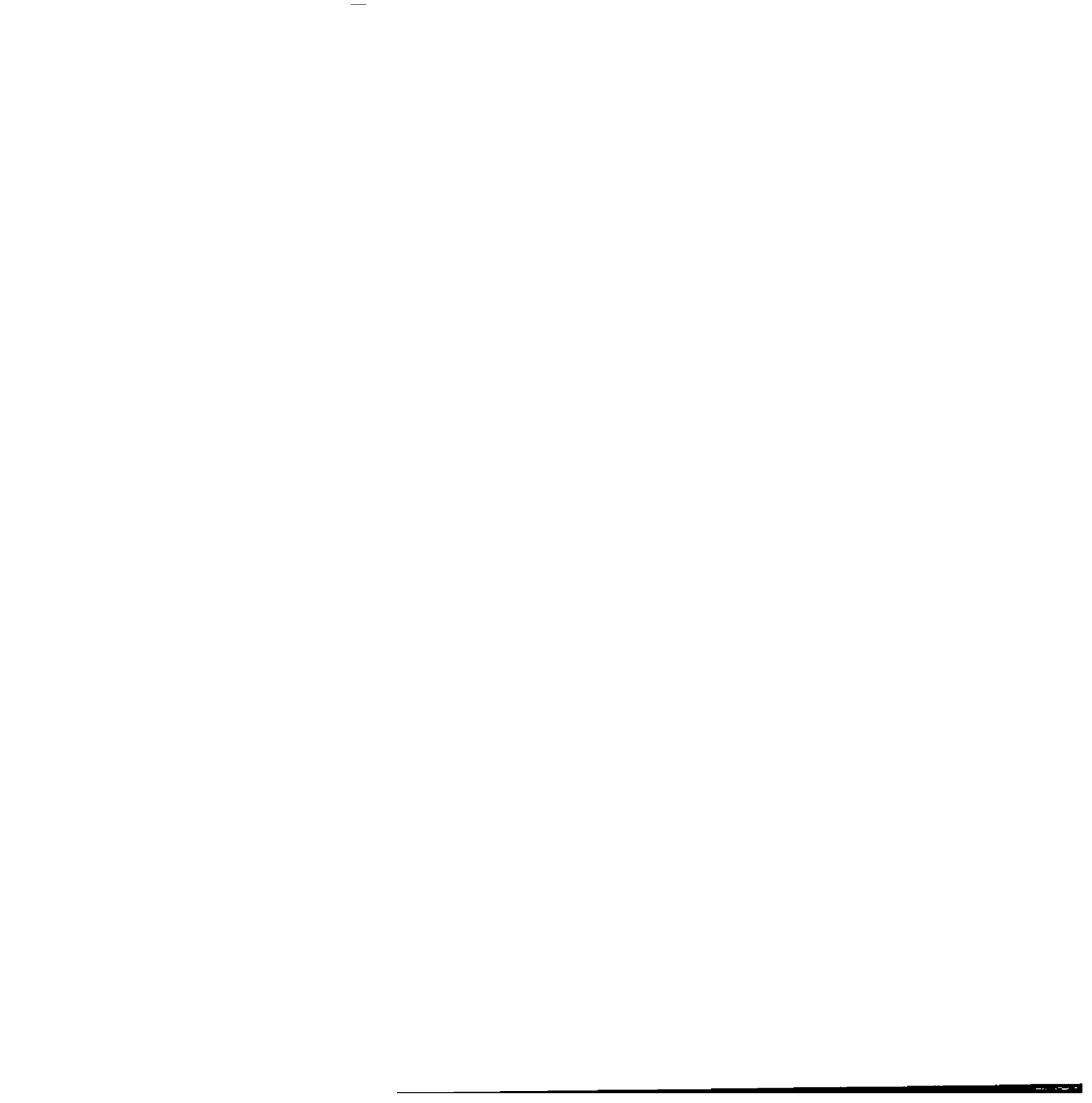
# The Maine Experience

## Skyrocketing Enrollment and Charity Care

### *Maine's Optional 2002 Medicaid Expansion*



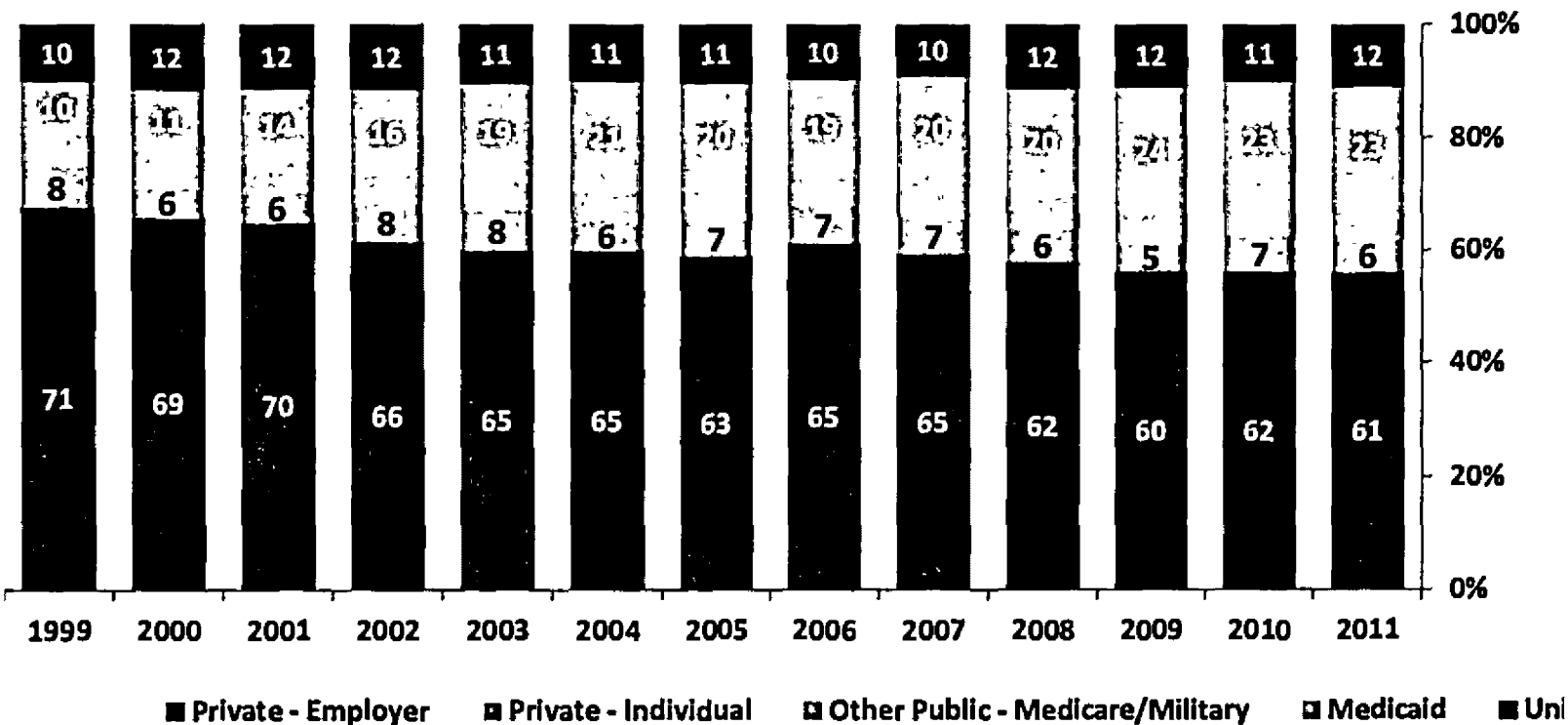
Source: Maine Legislature's Fiscal Office (projections, en  
Maine Hospital Association (charity care)



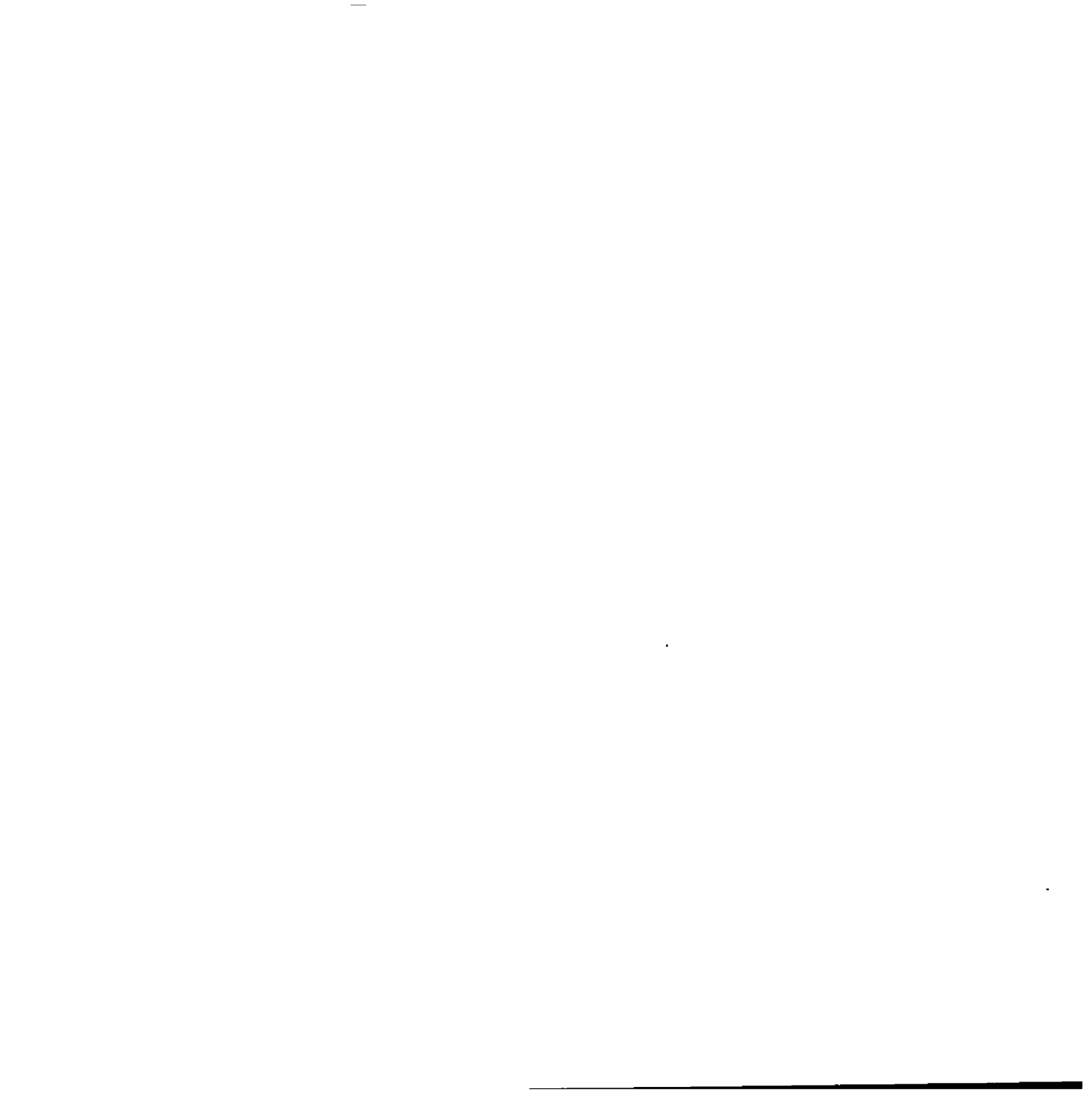
# Let the Uninsured ... Stay the Same

## No Change in Uninsured; More Medicaid; Less Private Coverage

### Non-Elderly Mainers' Insurance Coverage, 1999-2011



Source: U.S. Census Bureau

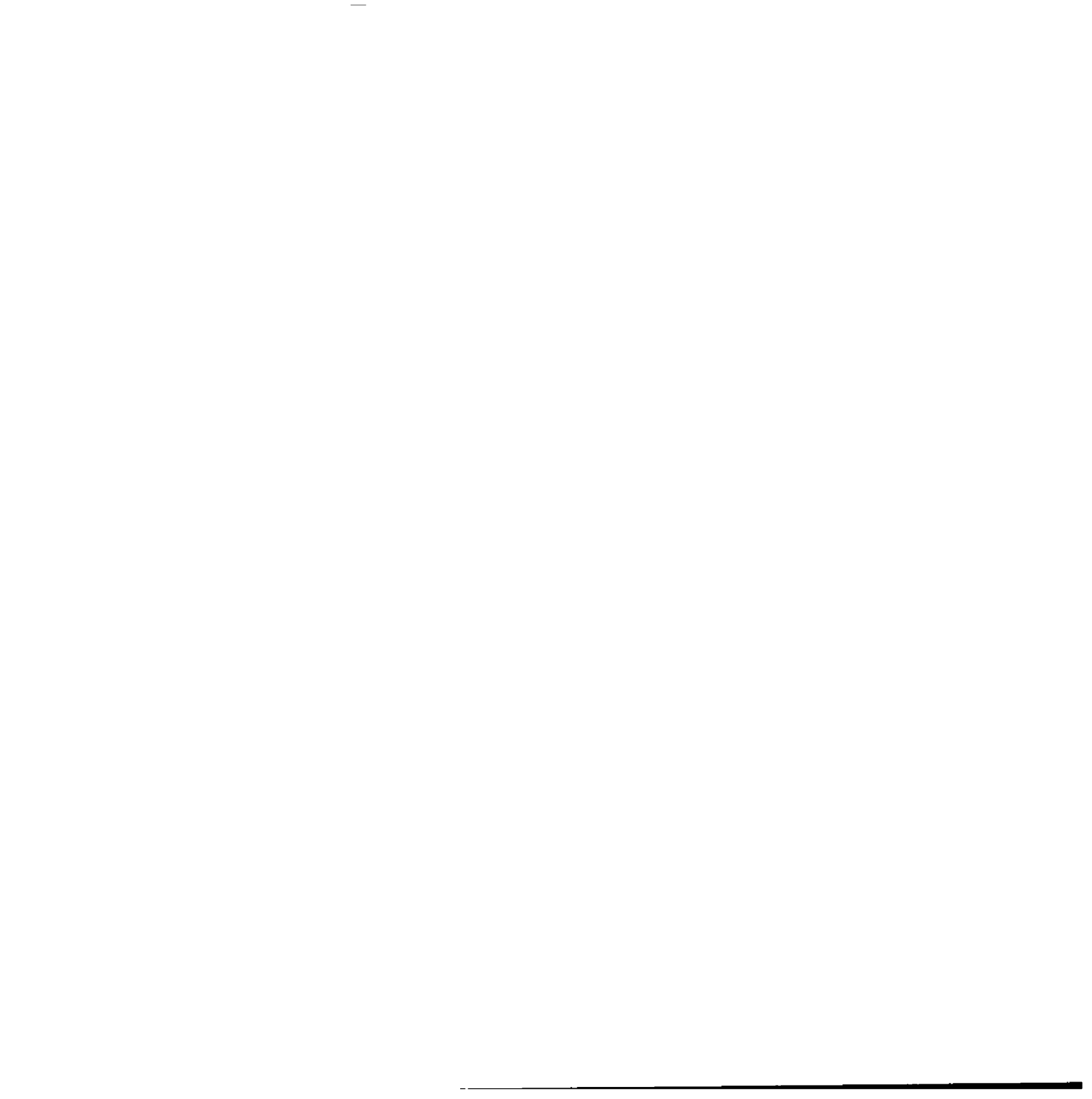


# Enrollment Always Exceeds Projection

STATE	# OF EXPANSION ENROLLEES PROJECTED	# OF PEOPLE ACTUALLY ENROLLED
Nevada	78,000	182,000
Michigan	323,000	481,863
N. Virginia	91,000	145,000
Arkansas	161,000	224,000
Ohio	366,000	450,000
Kentucky	137,634	317,000
Illinois	199,000	561,000



Source: Foundation for Government Accountability



# The New Medicaid Math

STATE	CUTS NEEDED TO SAVE \$1: ELDERLY, DISABLED, KIDS (2015)	CUTS NEEDED TO SAVE \$1: EXPANSION POPULATION (2017)
Alaska	\$2.00	\$20.00
Louisiana	\$2.64	\$20.00
Missouri	\$2.74	\$20.00
Montana	\$2.93	\$20.00
So. Dakota	\$2.07	\$20.00
Tennessee	\$2.86	\$20.00
Texas	\$2.38	\$20.00
Wyoming	\$2.00	\$20.00



Source: Foundation for Government Accounts

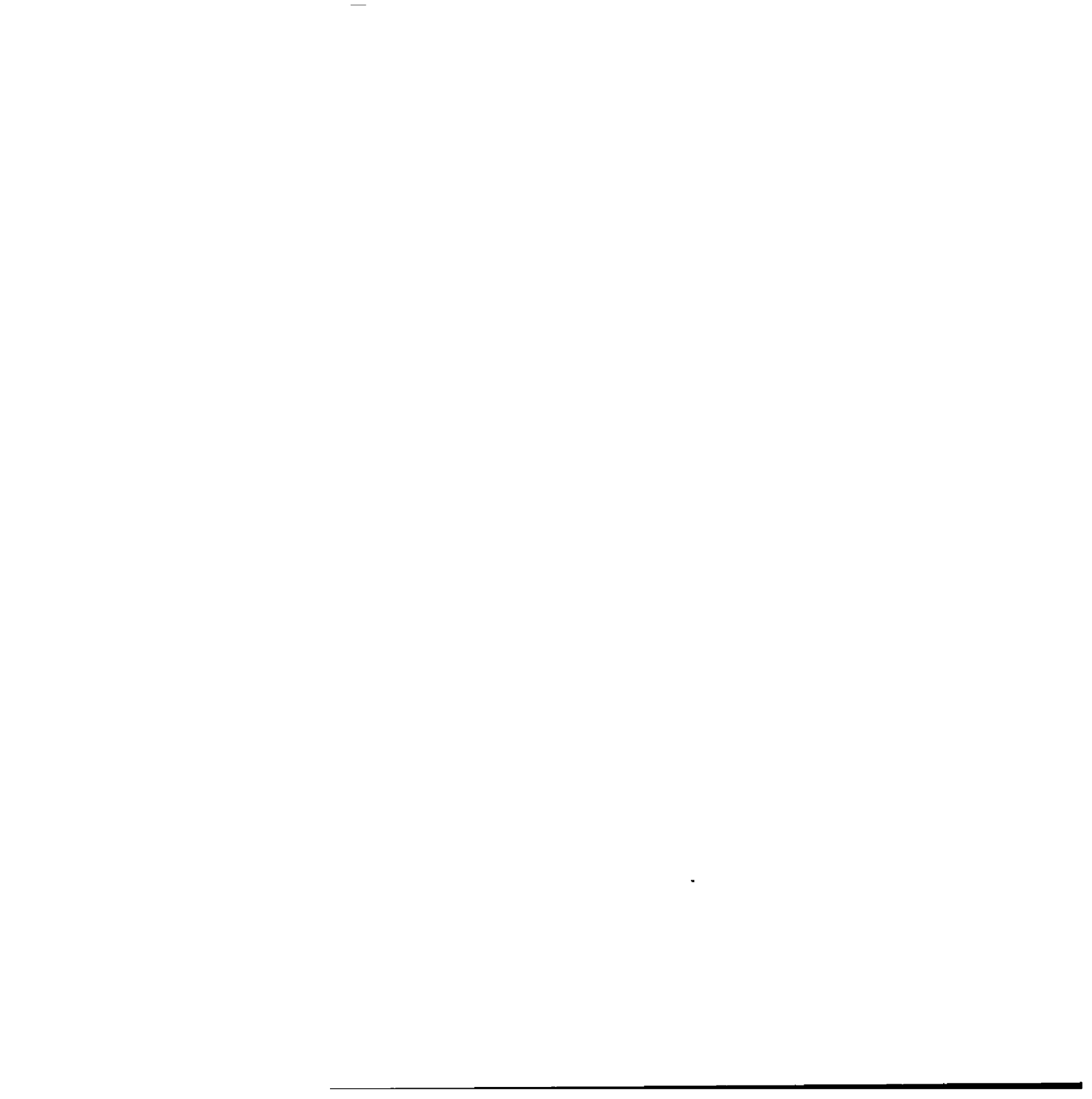


# Cuts Have Happened in Some States



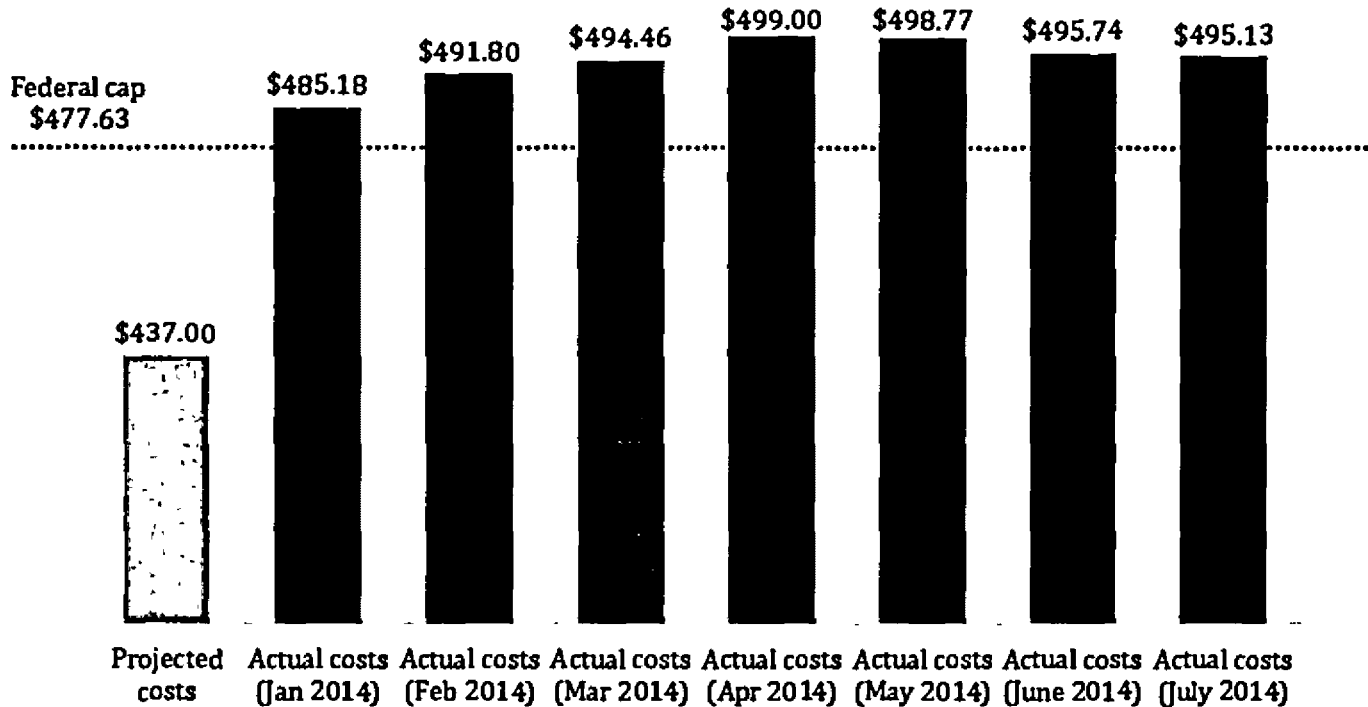
- **Arizona:** Stopped Medicaid coverage for heart, lung, liver, pancreas, and bone marrow transplants
- **Arkansas:** Denied life-saving drugs for cystic fibrosis patients
- **Oregon:** Stopped Medicaid coverage for advanced-stage cancer treatments
- **Maine:** Stopped treating brain injury patients
- **Rhode Island:** Implemented \$3,000 premium for disabled kids on Medicaid





# Arkansas Is Already Over Budget

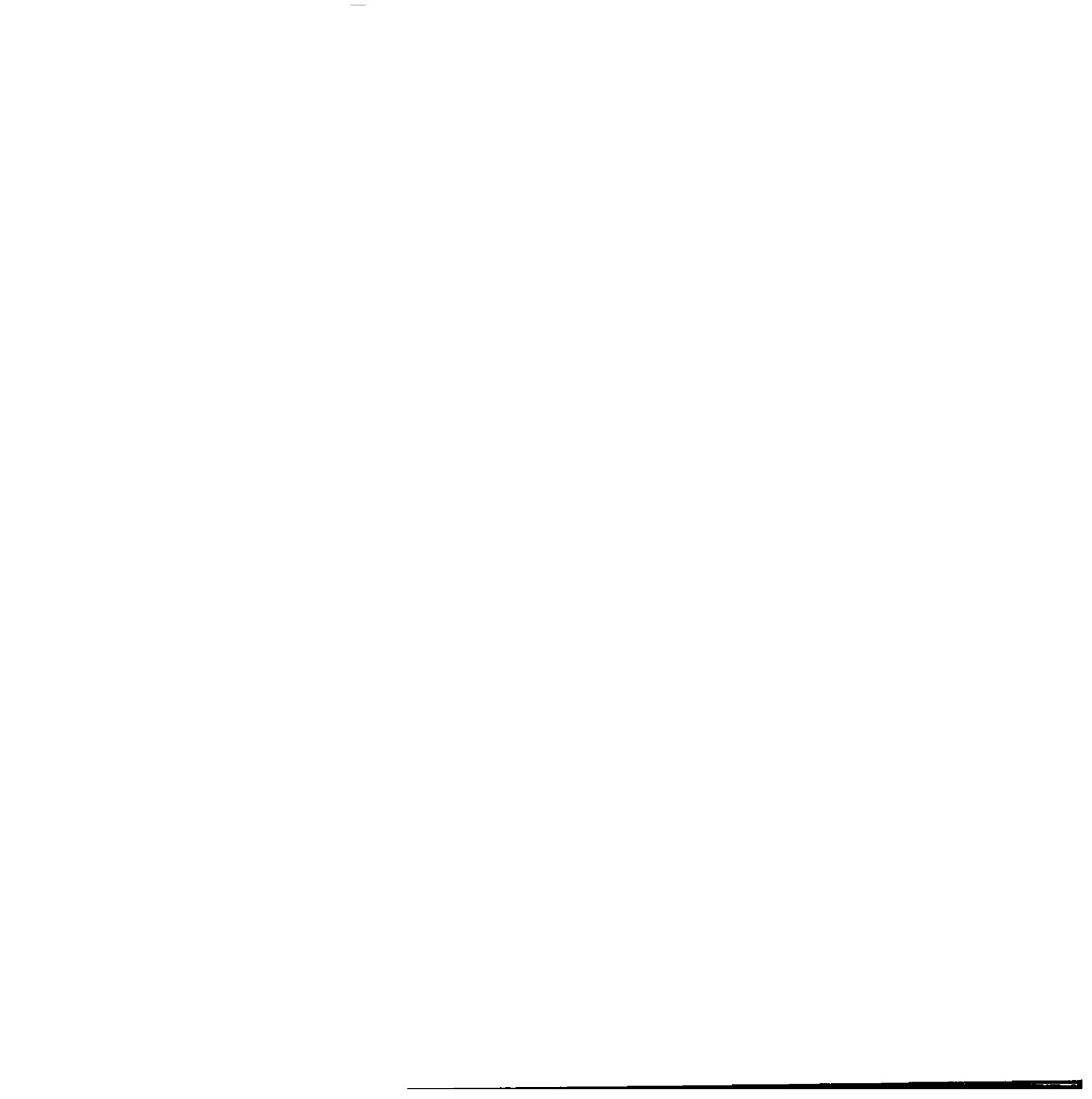
## THE PRIVATE OPTION MEDICAID EXPANSION ALREADY COSTS MORE THAN INITIAL PROJECTIONS Average monthly per-person costs for the Private Option in 2014



*Source: Arkansas Department of Human Services*

**Note:** These totals include projected costs of wraparound benefits as provided by the Arkansas Department of Human Services. Actual wraparound costs have not yet been validated.





# Iowa: Requested vs. Received

**What Iowa Wanted**

**CMS Decision**

**What Iowa Got**

**“No skin in the game” for everyone**

**DENIED**

- No cost-sharing under 50%
- All cost-sharing waived Year

**Premiums up to 3% of income**

**DENIED**

- Premiums up to 1% of income

**Enforce personal responsibility**

**DENIED**

- 50-100% FPL can't be disen
- 100-138% FPL can self-atte
- “hardship”

**Exclude NEMT services**

**DENIED**

- NEMT exclusion only in Year

**Exclude EPSDT services**

**DENIED**

- EPSDT exclusion rejected by

**\$10 ER copay for non-ER care**

**DENIED**

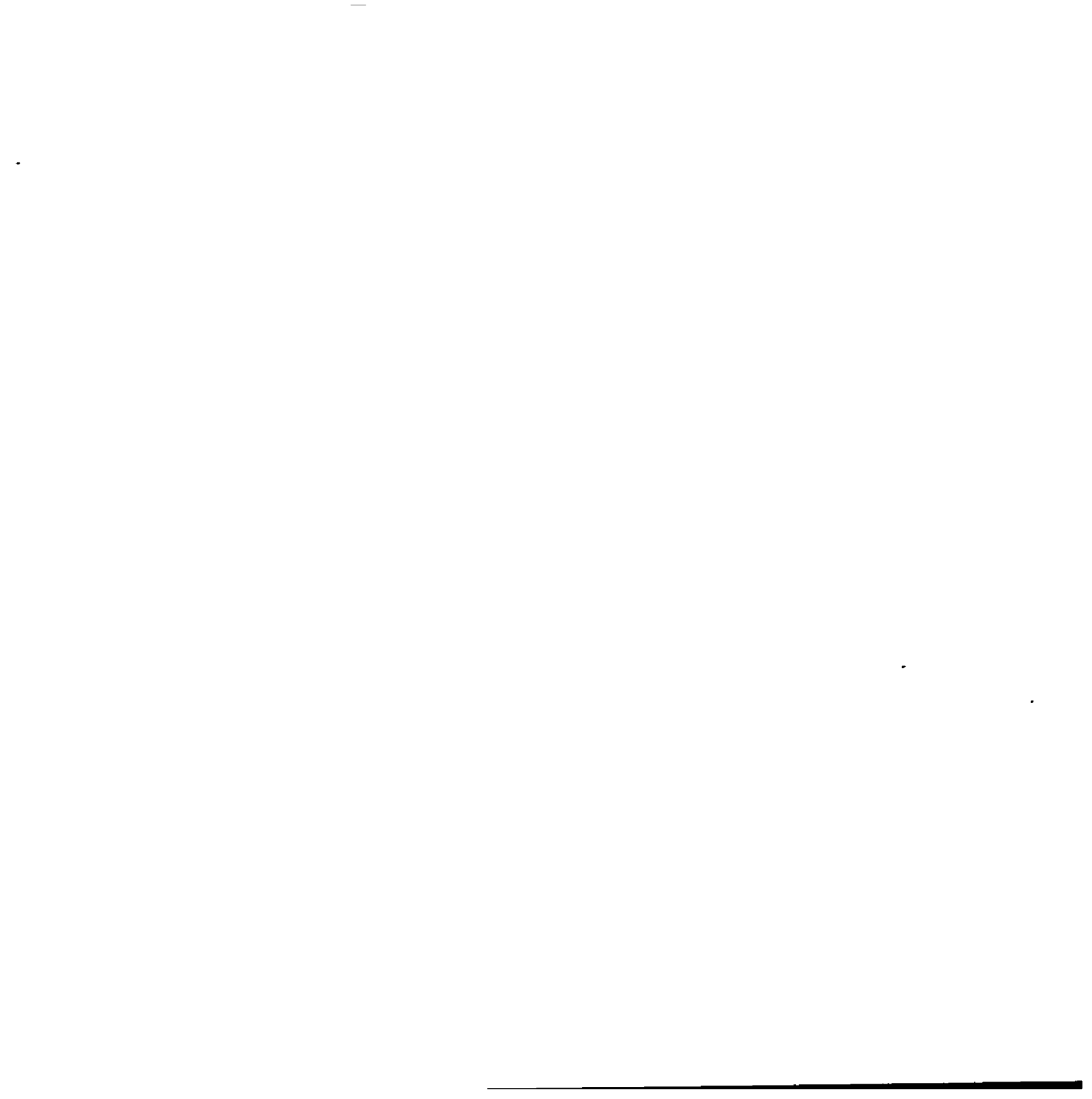
- \$8 ER copay allowed by CM

**Exclude retroactive eligibility**

**DENIED**

- Iowa Medicaid pays for retroactive bills up to 30 da





# Indiana's Medicaid Expansion

## The Washington Times

### EDITORIAL: Pence's sellout on Medicaid expansion in Indiana

There's nothing conservative about Hoosier's scheme

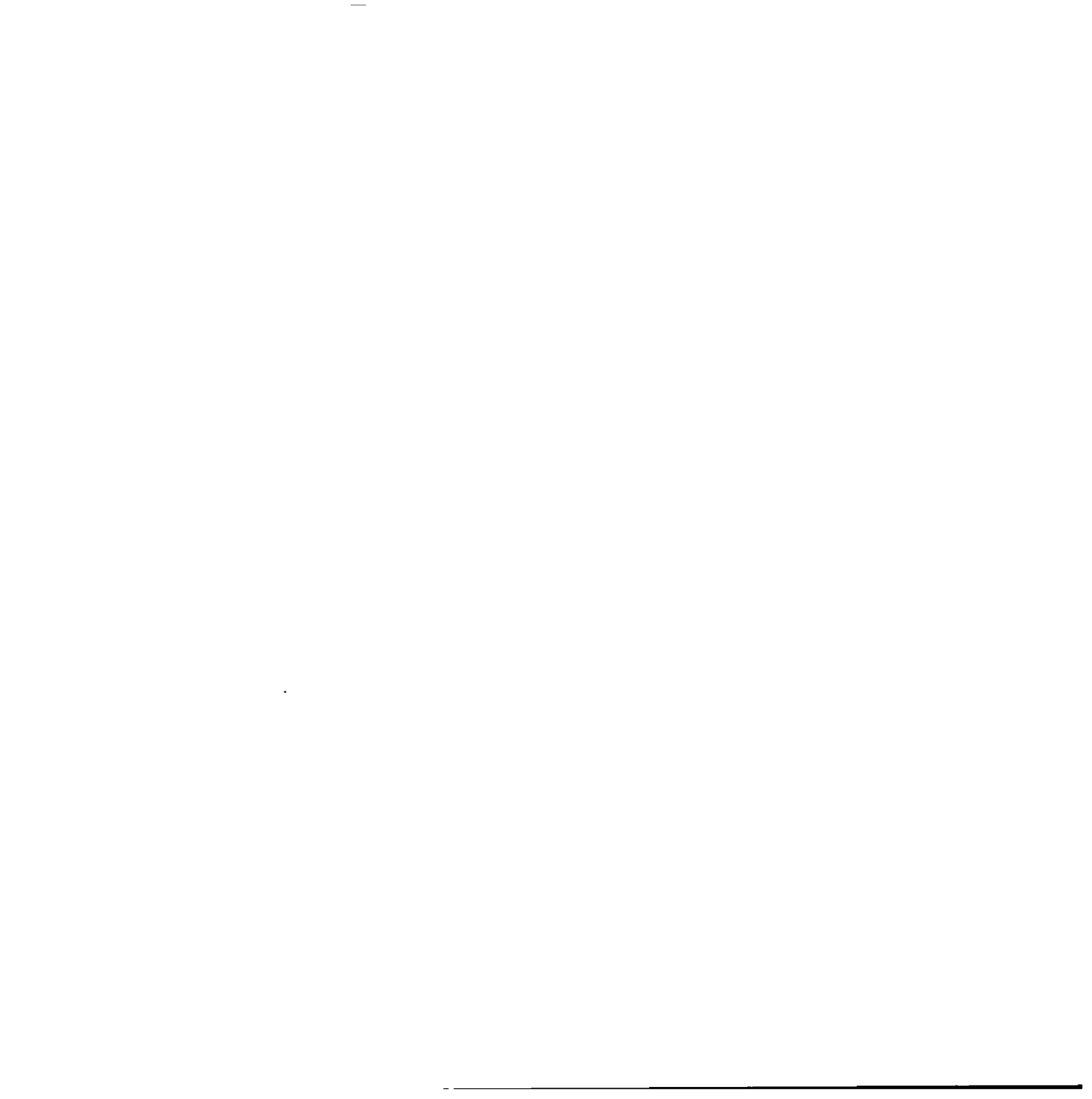
by THE WASHINGTON TIMES - - *Tuesday, June 3, 2014*

Mike Pence is a rising star of Republicans, and has been for years. During his 10-year membership in Congress, he held the No. 4 leadership position in the House and topped the 2010 Values Voter Summit presidential preference poll. He became governor of Indiana last year with his conservative bona fides in order.

That's why it's puzzling that Mr. Pence last month announced a scheme to expand Medicaid in Indiana, inflicting a new burden of Obamacare on patients and taxpayers. Called "HIP 2.0," the Pence plan co-opts the existing Healthy Indiana plan — a Medicaid program devised by his predecessor, Mitch Daniels — to make Medicaid larger to satisfy Obama requirements.

Mr. Pence wants conservatives to embrace Medicaid expansion as a responsible, limited-government alternative to Obamacare, writing in an editorial essay in *The Wall Street Journal* and in a speech to the American Enterprise Institute. We include us out.





# Indiana: Reading Between the Lines

## What Indiana Says

**We're charging premiums**

**\$25 ER co-pay for non-ER care**

**forceable copays and premiums,  
or "lockout" for nonpayment**

**No retroactive eligibility**

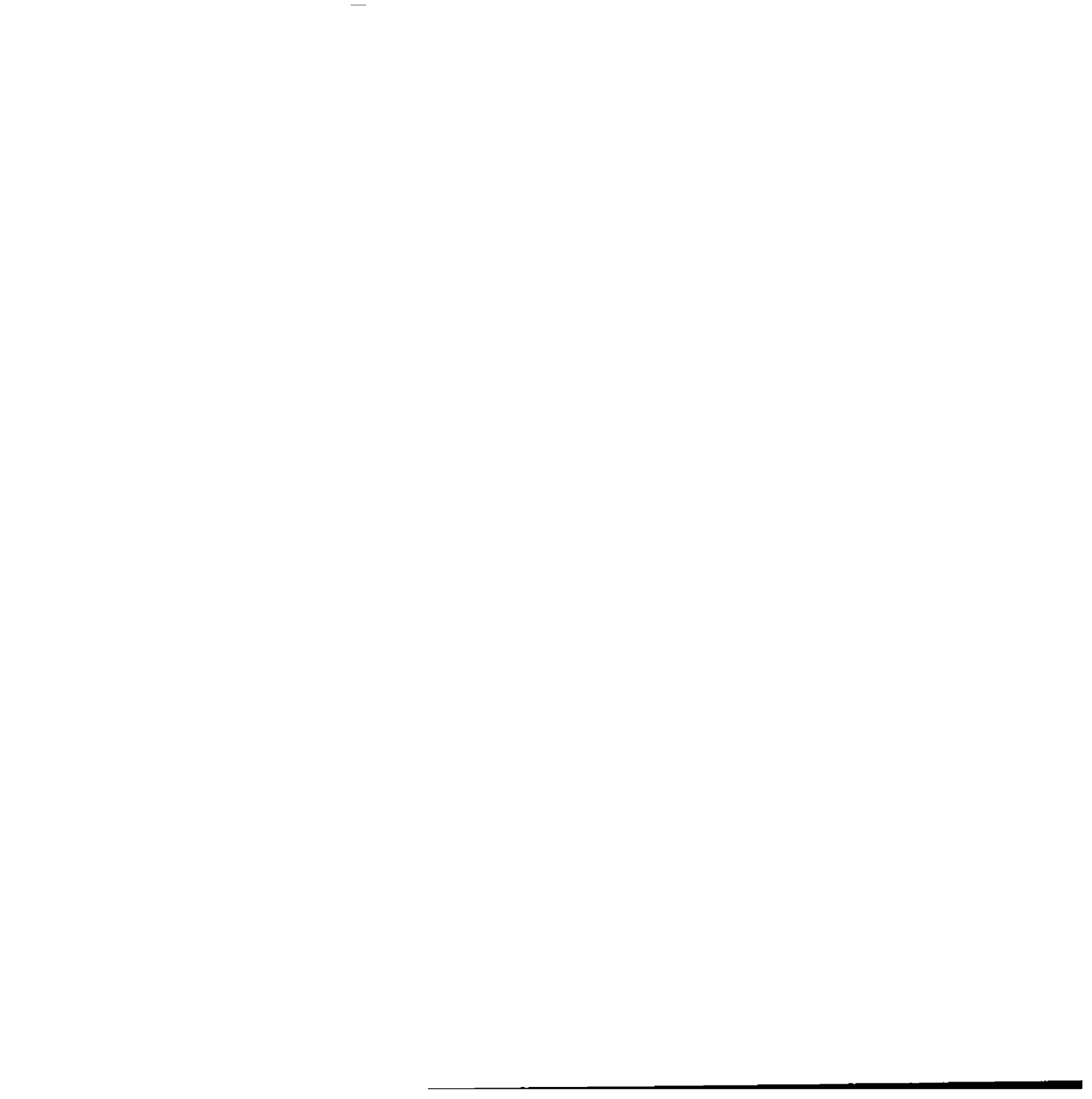
**No NEMT**

**We can exit at any time**

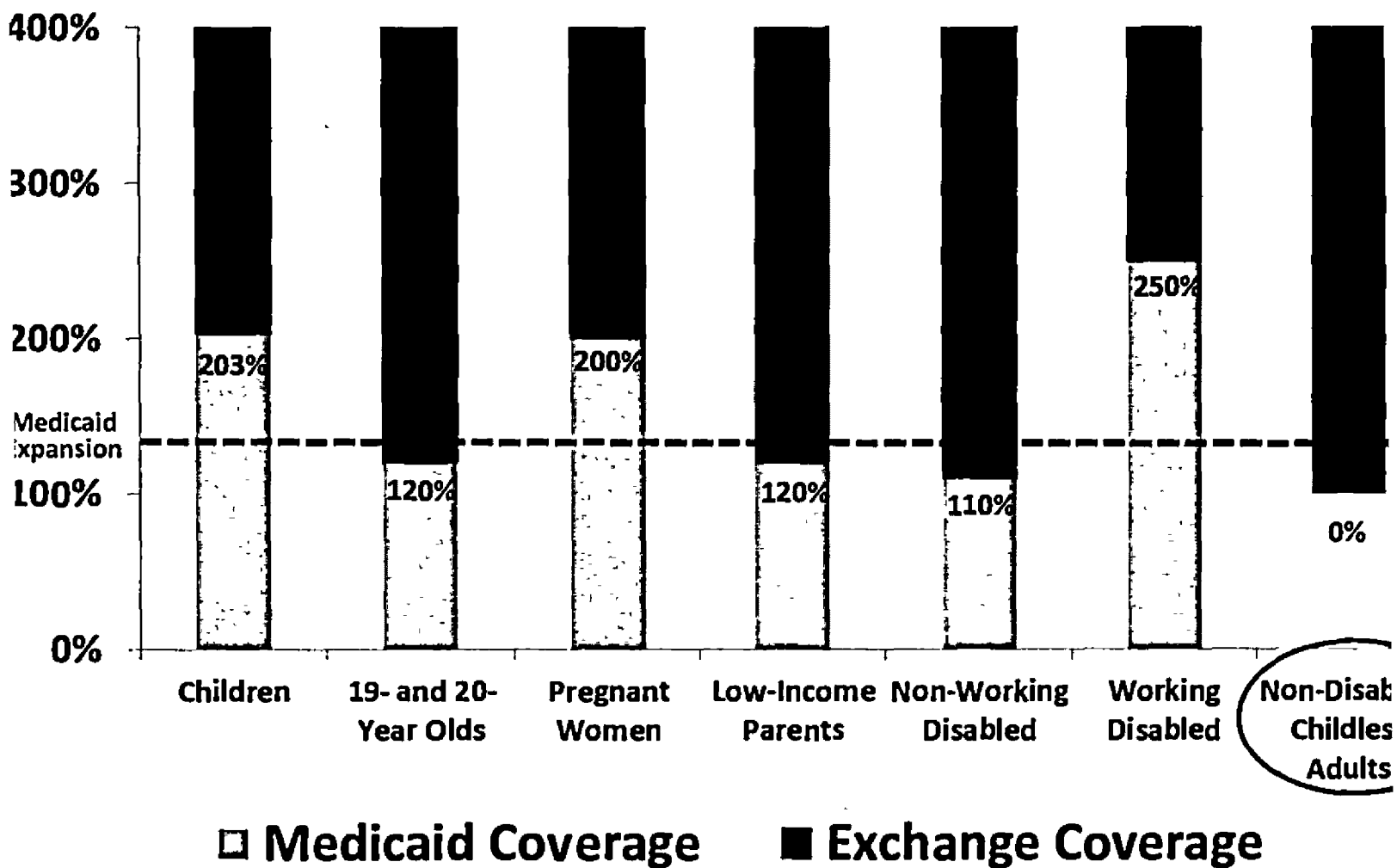
## What Indiana Means

- Premiums are less than ½ of what Medicaid all
- 100% of premiums can be paid by someone else
- Only for Year #1 and Year #2 of the waiver
- Thousands are exempt from paying it
- You can escape the copay by calling an ER nurse
- 77% of enrollees are exempt from lockout entirely
- Everyone else can claim one of many exemptions
- Indiana can add further exemptions at any time
- Only for Year #1 of the waiver
- In exchange, IN grows Medicaid rolls faster with "expanded presumptive eligibility"
- Only for Year #1 of the waiver
- If Indiana terminates the waiver, it must "ensure ongoing coverage for eligible individuals"

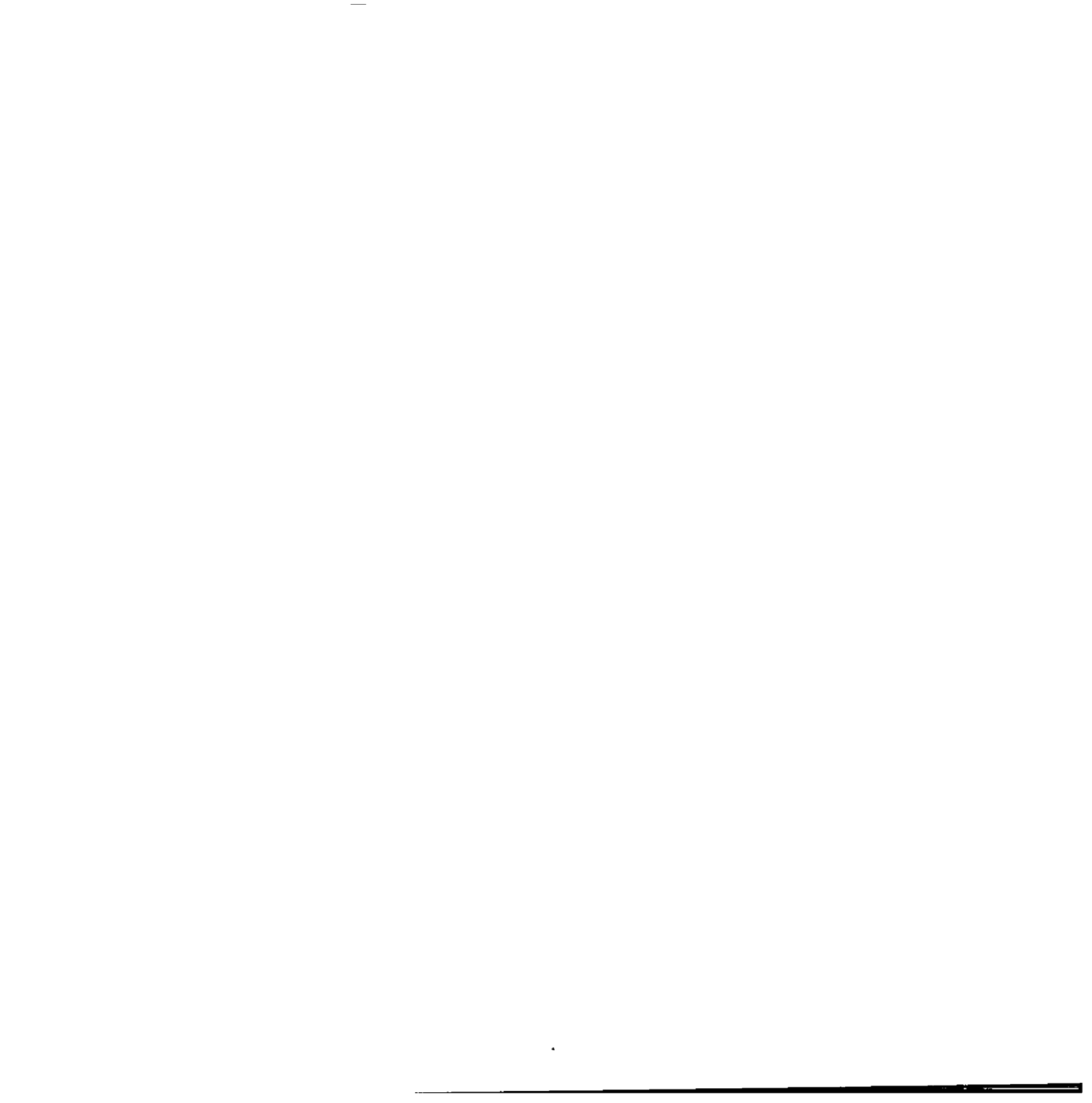




# How Medicaid & Exchanges Work



Source: U.S. Department of Health and Human Services



**Thank You!**

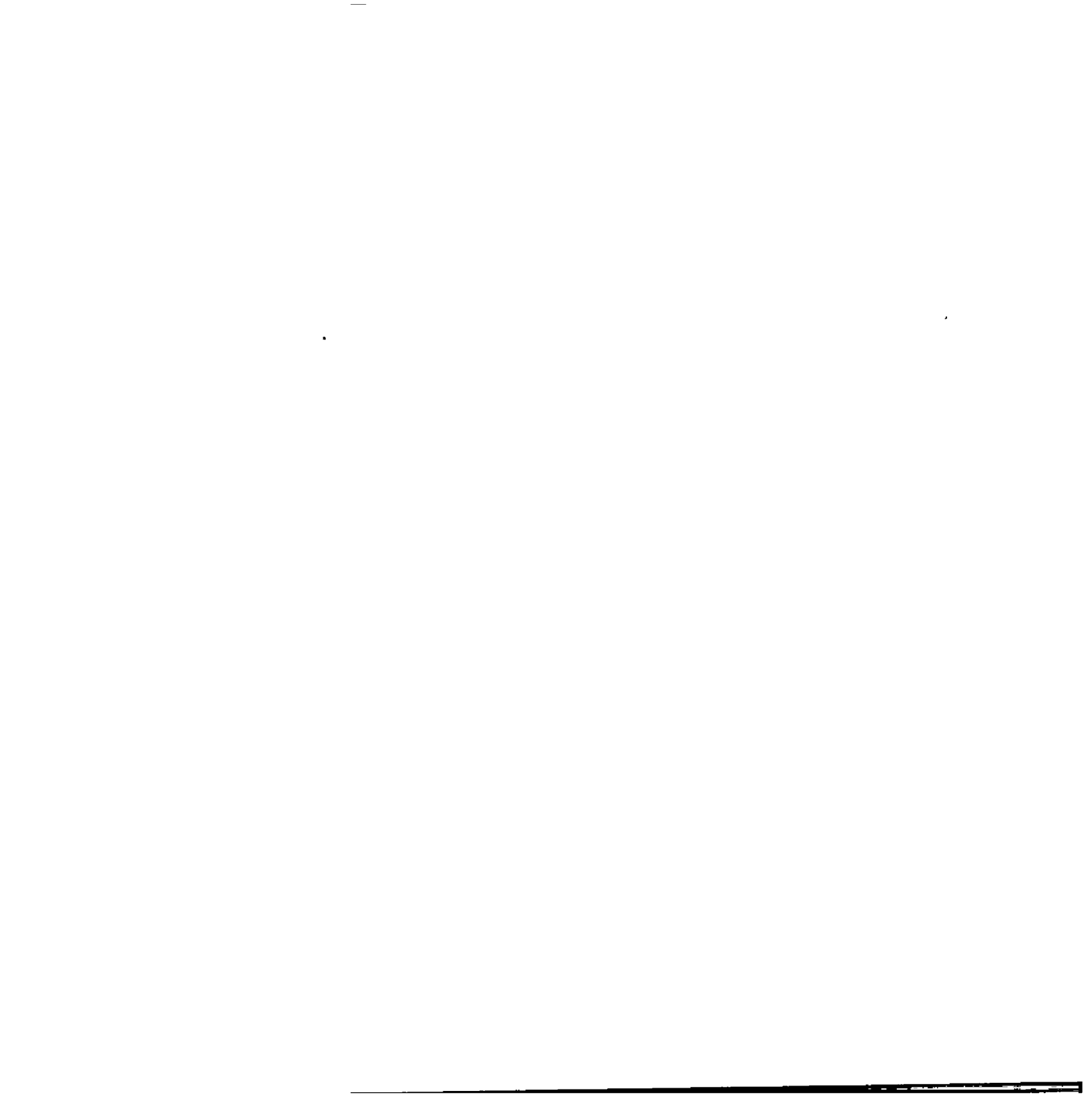
**Christie Herrera**

**Senior Fellow**

**[christie@thefga.org](mailto:christie@thefga.org)**

**Follow us on Twitter: @thefga**





## Mission

To promote and protect the health and well-being of Alaskans. AS 47.05.101

Priority 1. Health & Wellness Across the Lifespan

Priority 2. Health Care Access, Delivery & Value

Priority 3. Safe & Responsible Individuals, Families & Communities

## Key Performance Indicators

FY15 Management Plan as of 12/09/2014 (in thousands)

Department of Health and Social Services Totals	Funding					Positions		
	UGF Funds	DGF Funds	Other Funds	Federal Funds	Total Funds	Full Time	Part Time	Non Perm
	\$1,253,650.2	\$96,278.1	\$89,091.5	\$1,253,304.7	\$2,692,324.5	3,495	60	106

### 1. Protect and promote the health of Alaskans.

Funding	Funding					Positions		
	UGF Funds	DGF Funds	Other Funds	Federal Funds	Total Funds	Full Time	Part Time	Non Perm
	\$461,737.3	\$50,691.5	\$44,922.9	\$563,176.2	\$1,120,527.9	1,094	22	45

- Target: Percentage of children 19 - 35 months of age who are fully immunized
- Target: Cost to fully immunize a child 19 - 35 months of age
- Target: Number of Alaskans experiencing unintentional injuries
- Target: Cost of injury prevention program per capita

### 2. Provide quality of life in a safe living environment for Alaskans.

Funding	Funding					Positions		
	UGF Funds	DGF Funds	Other Funds	Federal Funds	Total Funds	Full Time	Part Time	Non Perm
	\$385,937.8	\$11,543.8	\$14,304.7	\$356,911.3	\$768,697.6	661	20	26

- Target: Percent of child abuse/neglect assessments (investigations) that are initiated within required timeframes
- Target: Percent of assessments (investigations) completed timely
- Target: Number of months Long Term Services and Supports recipients are able to remain in their home before institutional placement
- Target: Average cost of Long Term Services and Supports per recipient

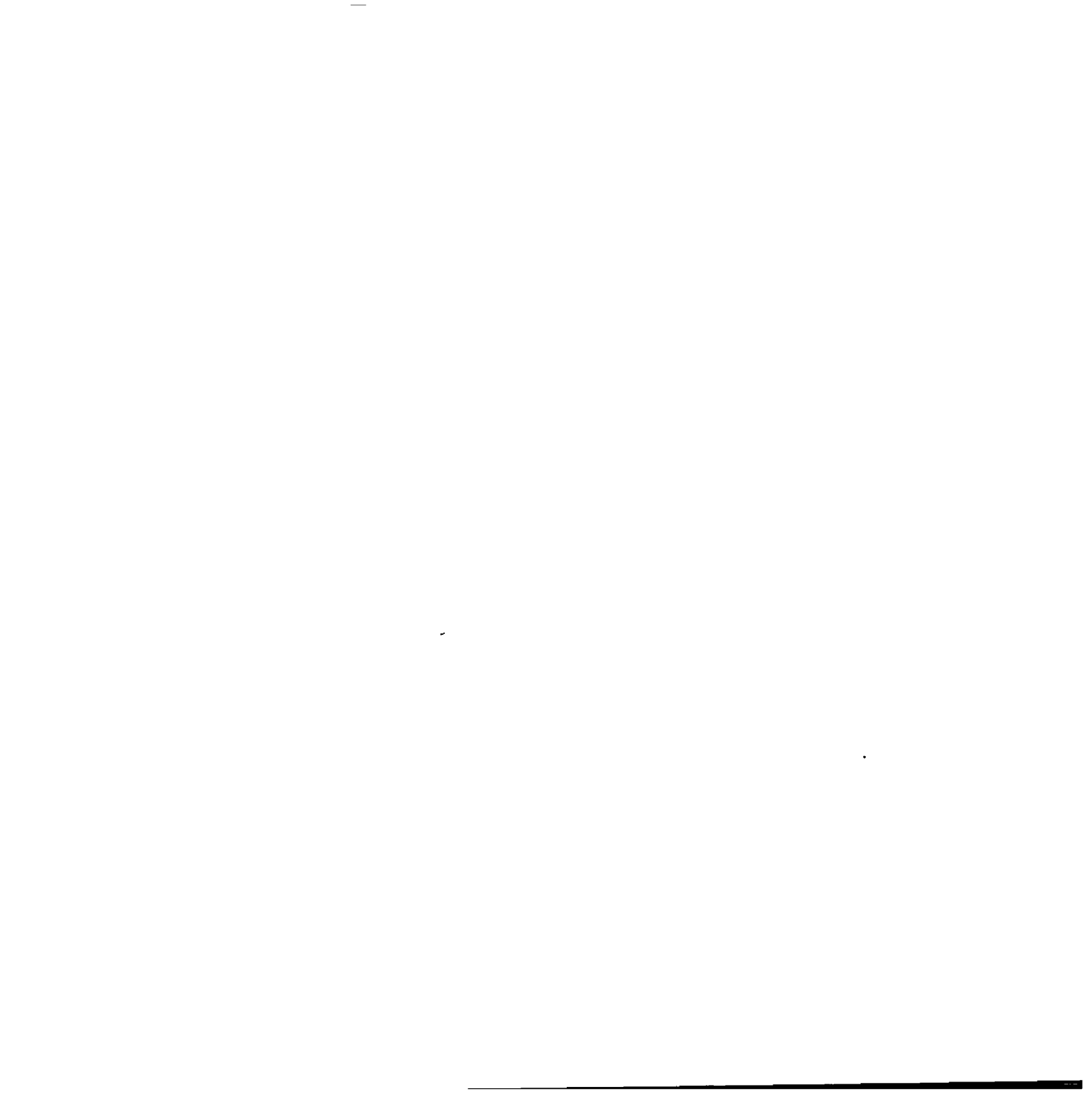
### 3. Manage health care coverage for Alaskans in need.

Funding	Funding					Positions		
	UGF Funds	DGF Funds	Other Funds	Federal Funds	Total Funds	Full Time	Part Time	Non Perm
	\$47,096.1	\$649.6	\$2,034.6	\$71,454.3	\$121,234.6	36	0	2

- Target: Percent of individuals served by the department with access to a regular primary care provider
- Target: Cost to provide health care services per client

### 4. Facilitate access to affordable health

Funding



<b>5. Strengthen Alaska families.</b>	Funding					Positions		
	UGF Funds	DGF Funds	Other Funds	Federal Funds	Total Funds	Full Time	Part Time	Non Perm
	\$108,445.0	\$14,367.1	\$10,330.6	\$72,160.3	\$205,303.0	577	12	7

- Target: Percent of individuals receiving employment related services from the department who achieve employment
- Target: Cost of supported employment services per successful participant in Job Start or on-the-job training
- Target: Percent of low-income Alaskans receiving supplemental nutrition benefits through the Food Stamp program
- Target: Accuracy rate for open Food Stamp cases
- Target: Average time from receipt of initial application to eligibility determination

<b>6. Protect vulnerable Alaskans.</b>	Funding					Positions		
	UGF Funds	DGF Funds	Other Funds	Federal Funds	Total Funds	Full Time	Part Time	Non Perm
	\$149,503.0	\$11,031.0	\$11,927.4	\$102,426.0	\$274,887.4	692	4	13

- Target: Percent of children discharged from out-of-home care who are reunified with their parents
- Target: Percent of children who re-enter out-of-home care within twelve months
- Target: Percent of Alaska adults with substantiated reports of abuse or neglect
- Target: Average time to initiate an investigation
- Target: Percent of background checks completed within established timeframes
- Target: Cost of administering background check program
- Target: Average time to complete final determination

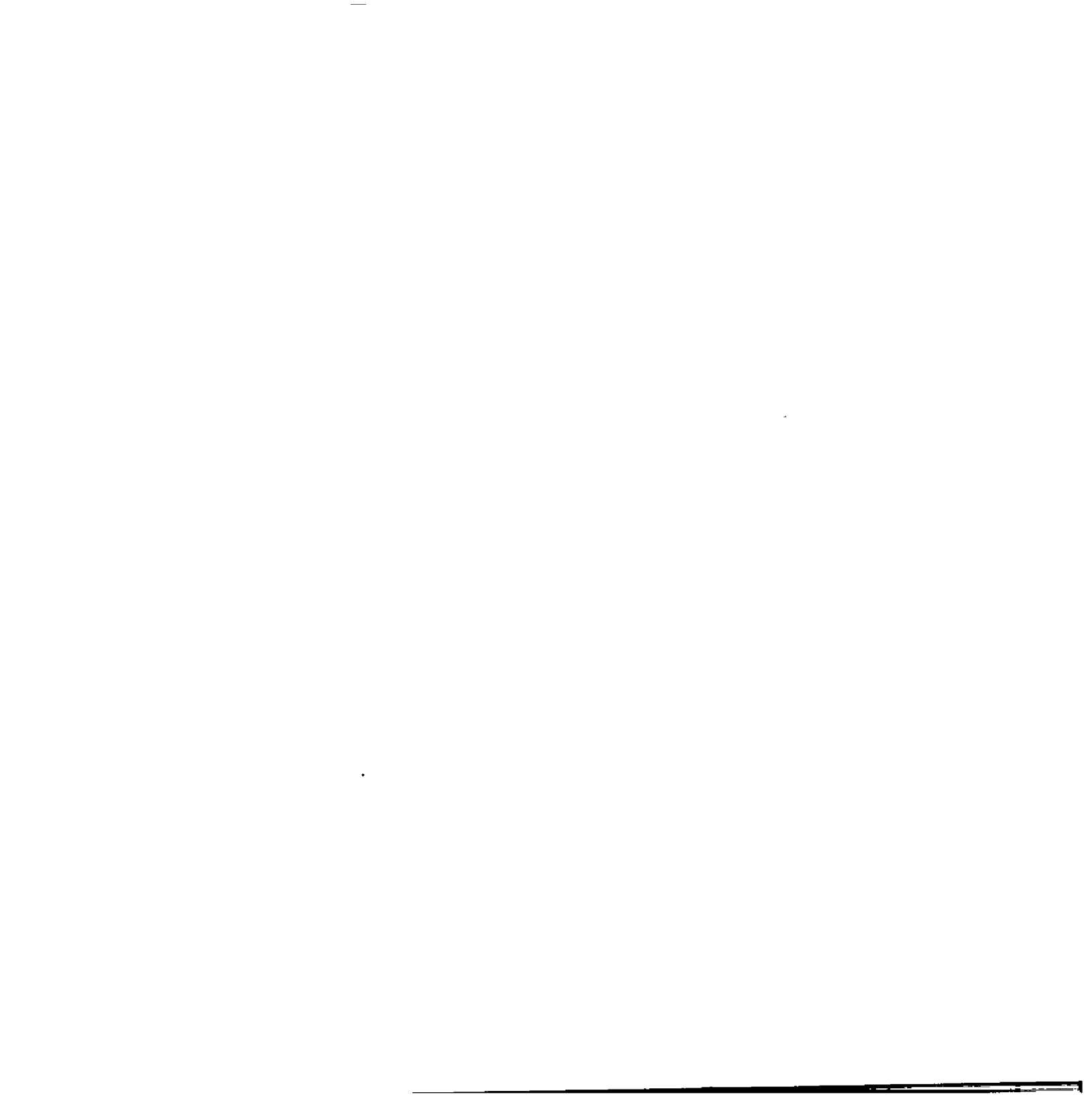
<b>7. Promote personal responsibility and accountable decisions by Alaskans.</b>	Funding					Positions		
	UGF Funds	DGF Funds	Other Funds	Federal Funds	Total Funds	Full Time	Part Time	Non Perm
	\$51,570.3	\$1,771.0	\$2,679.4	\$20,231.4	\$76,252.1	324	0	10

- Target: Reduce the rate of recidivism for juveniles released from Division of Juvenile Justice Probation
- Target: Cost per day for probation services based on average daily population
- Target: Percentage of investigations that result in fraud determinations
- Target: Program savings per fraud investigator

## Performance Detail

### 1: Protect and promote the health of Alaskans.

Target #1: Cost of injury prevention program per capita



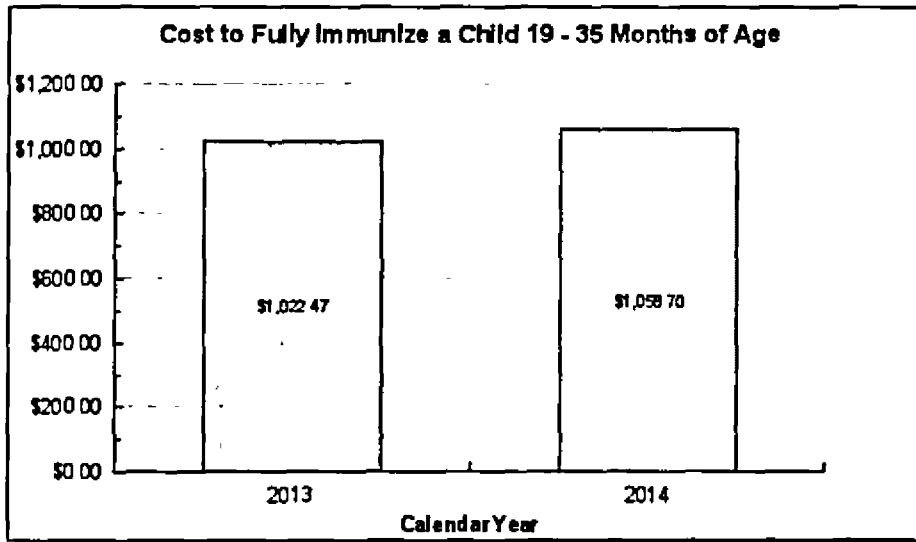


Methodology: Budget numbers are tracked on an ongoing basis, however July 15th of each year is the soonest we are able to capture the previous fiscal year's expenditures in their entirety.

### Total Per Capita Cost of Public Health Injury Prevention Programs (in 000s)

Fiscal Year	Quarter 1
FY 2013	\$0.7
FY 2012	\$0.7
FY 2011	\$0.8

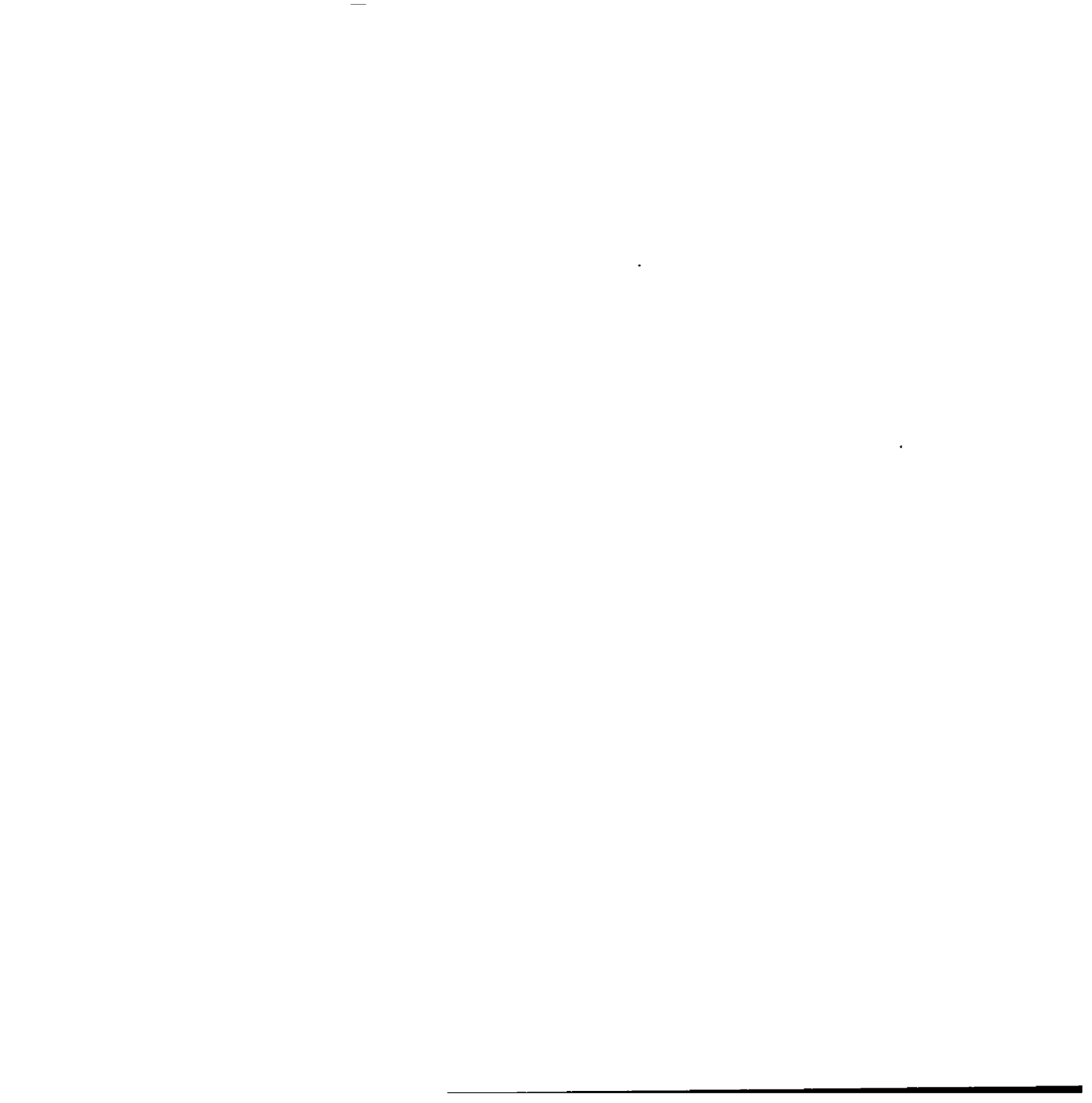
### Target #2: Cost to fully immunize a child 19 - 35 months of age

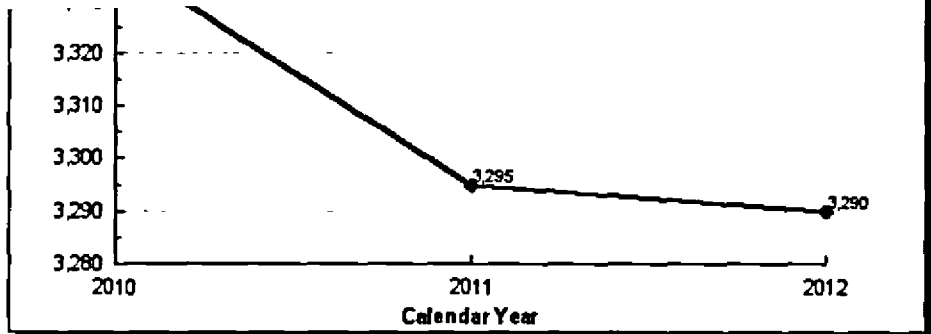


Methodology: CDC federal pediatric vaccine contract price list and the state Immunization Program vaccine formulary

### Cost to Fully Immunize a Child 19 - 35 Months of Age

Year	Quarter 1
2014	\$1,058.70
2013	\$1,022.47



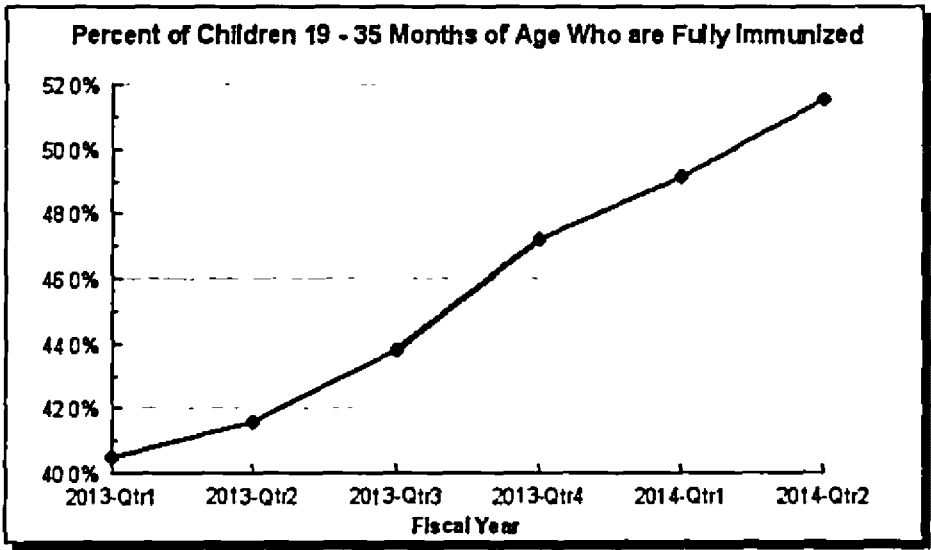


Methodology: Number of Unintentional Injury and Poisoning Hospitalizations/Transfers from Alaska Trauma Registry

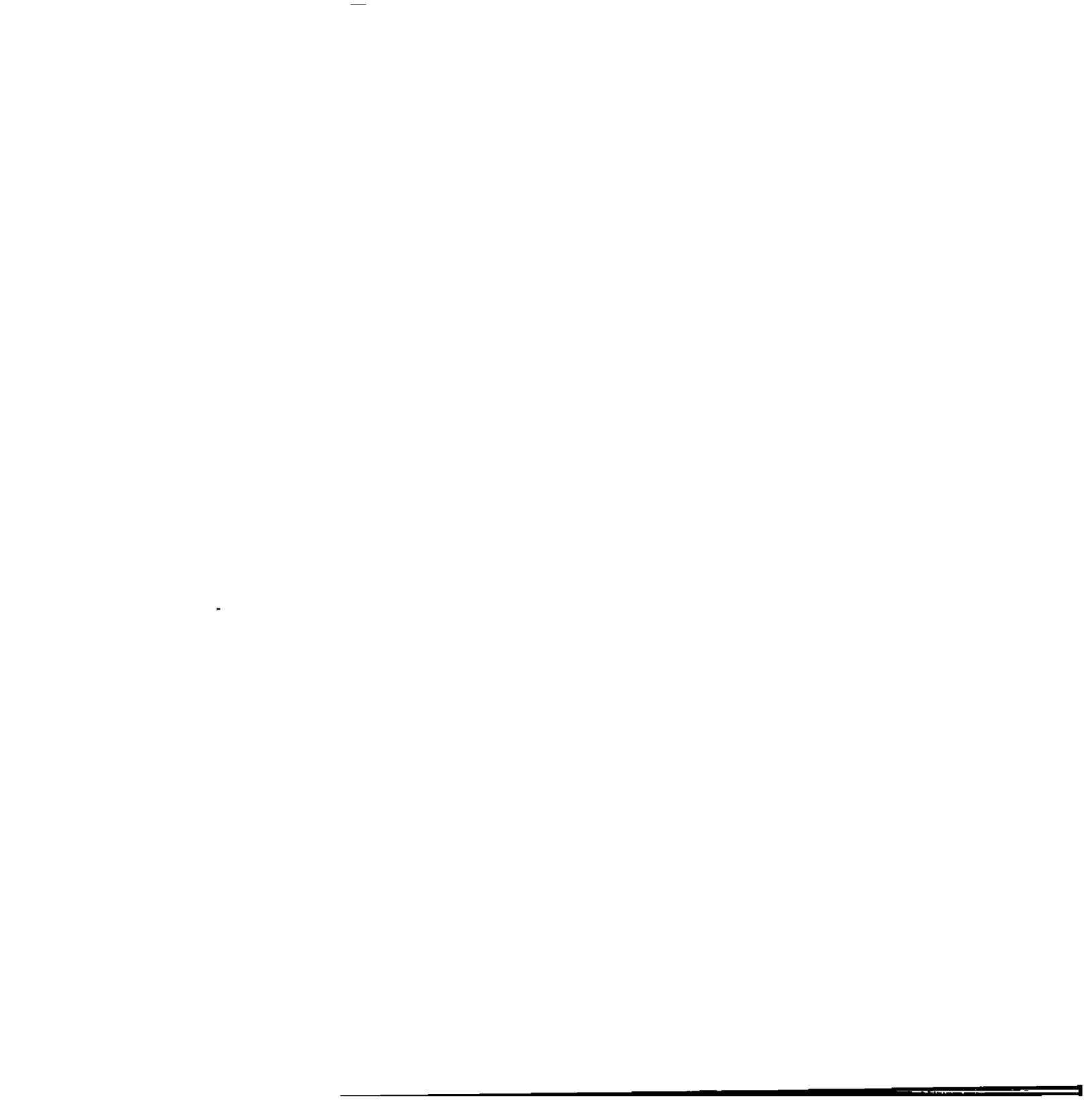
**Overall Crude Unintentional Injury Rate of All In Need (per 100,000 persons)**

Year	Quarter 1
2012	3,290 -0.15%
2011	3,295 -1.29%
2010	3,338

**Target #4: Percentage of children 19 - 35 months of age who are fully immunized**



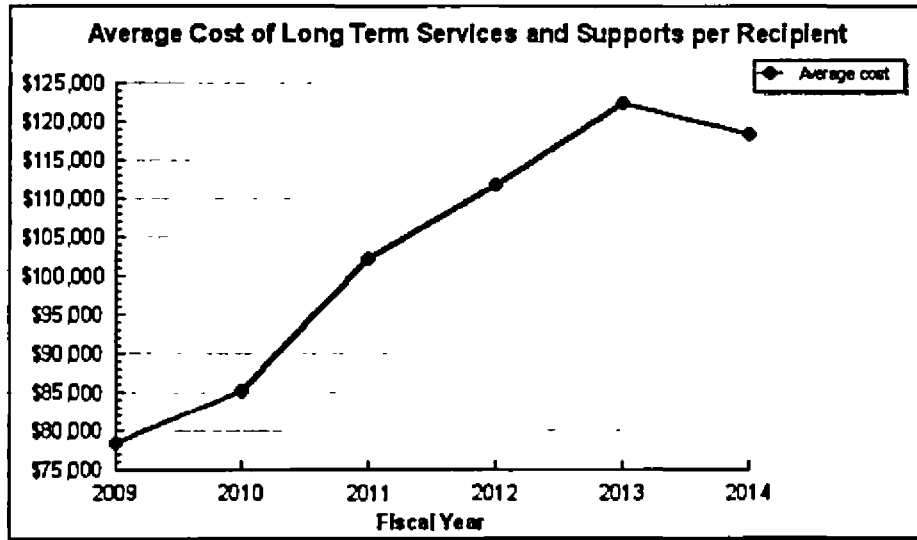
Methodology: VacTrAK (Alaska's Immunization Information System)



FY 2014-Qtr1	45.1%
FY 2013-Qtr4	47.2%
FY 2013-Qtr3	43.8%
FY 2013-Qtr2	41.6%
FY 2013-Qtr1	40.5%

**2: Provide quality of life in a safe living environment for Alaskans.**

**Target #1: Average cost of Long Term Services and Supports per recipient**

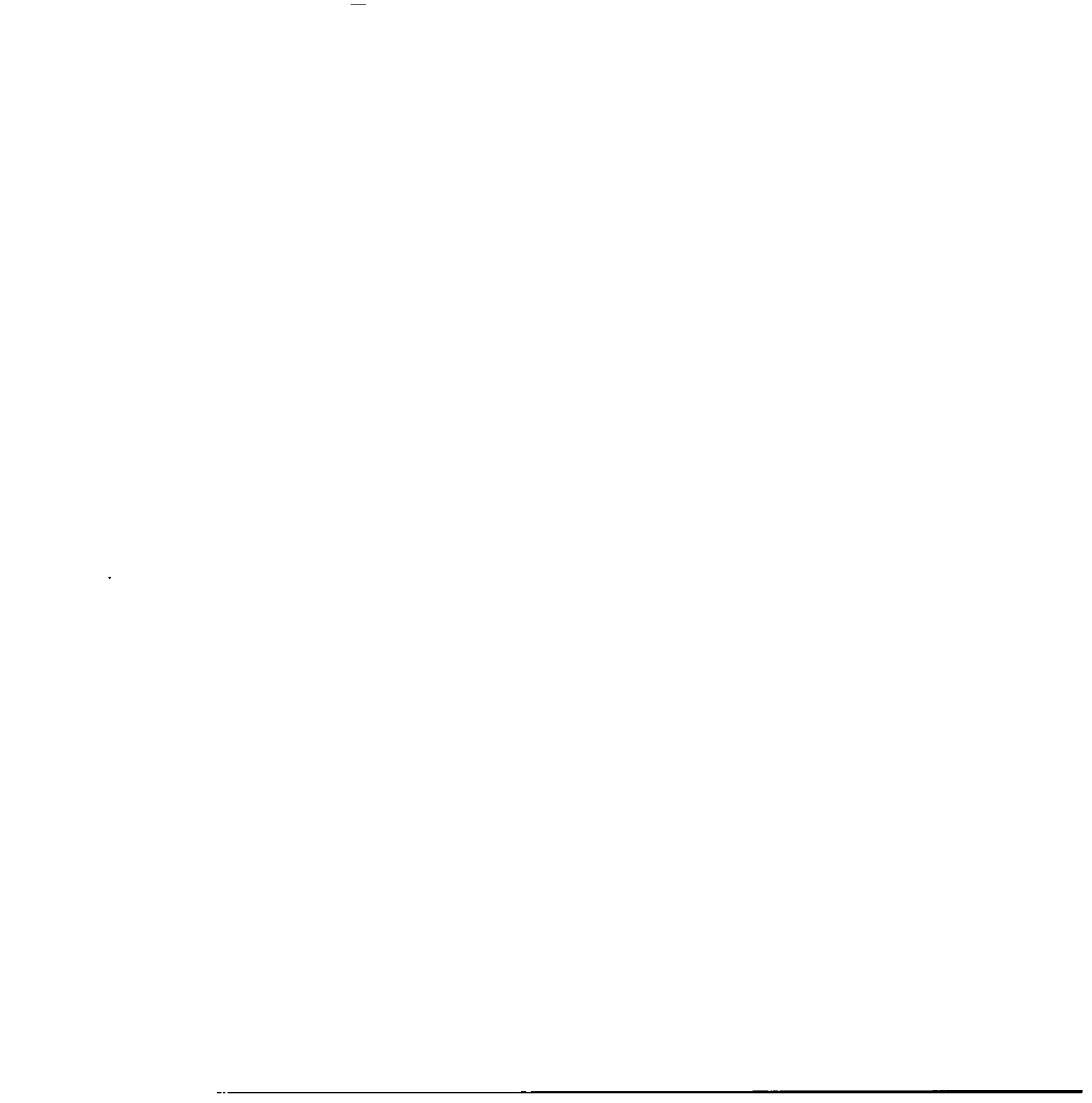


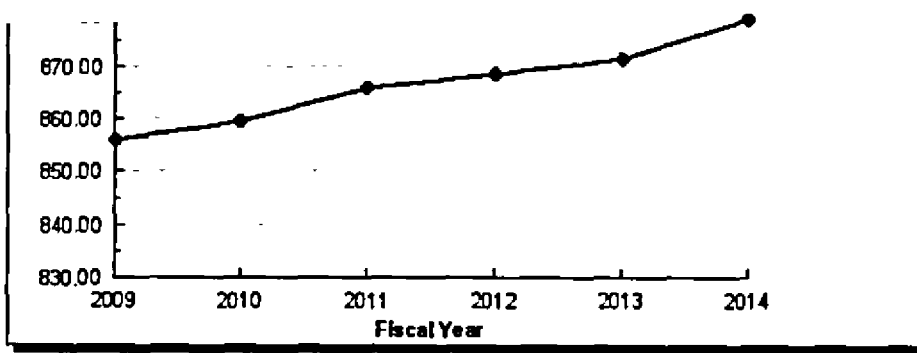
*Methodology: This performance measure is calculated by taking the average cost of long term care services rendered during the fiscal year per Medicaid recipient. There are four categories of service that indicate the use of long term care services (010 – Short Term LTC Services; 011 – SNF Nursing Home; 012 – ICF Nursing Home; 013 – ICF/MR Service). This Division utilizes MMIS Enterprise and Cognos to query long term care billing claims. It is important to note that providers have a year to bill from the date of service, which may bias the overall average.*

**Average Cost of Long Term Services and Supports per Recipient**

Fiscal Year	Average cost
FY 2014	\$118,406
FY 2013	\$122,330
FY 2012	\$111,788
FY 2011	\$102,251
FY 2010	\$85,284
FY 2009	\$78,421

**Target #2: Number of months Long Term Services and Supports recipients are able to remain in their home before institutional placement**



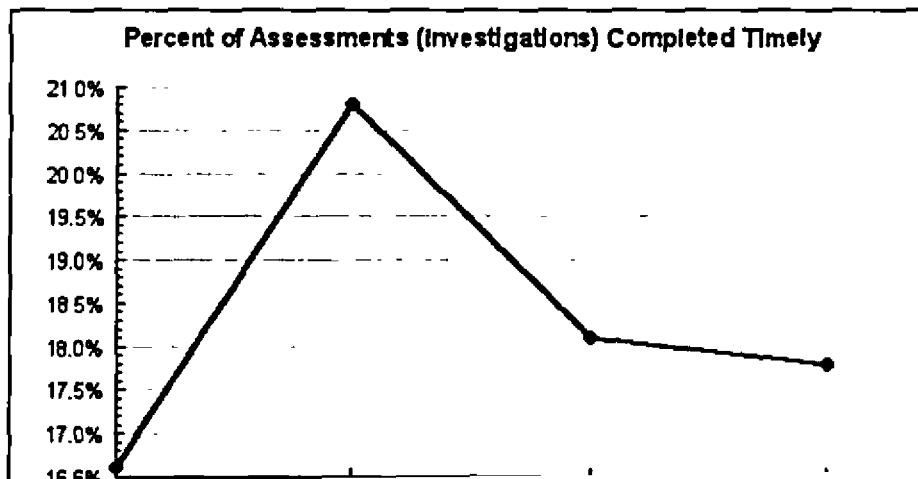


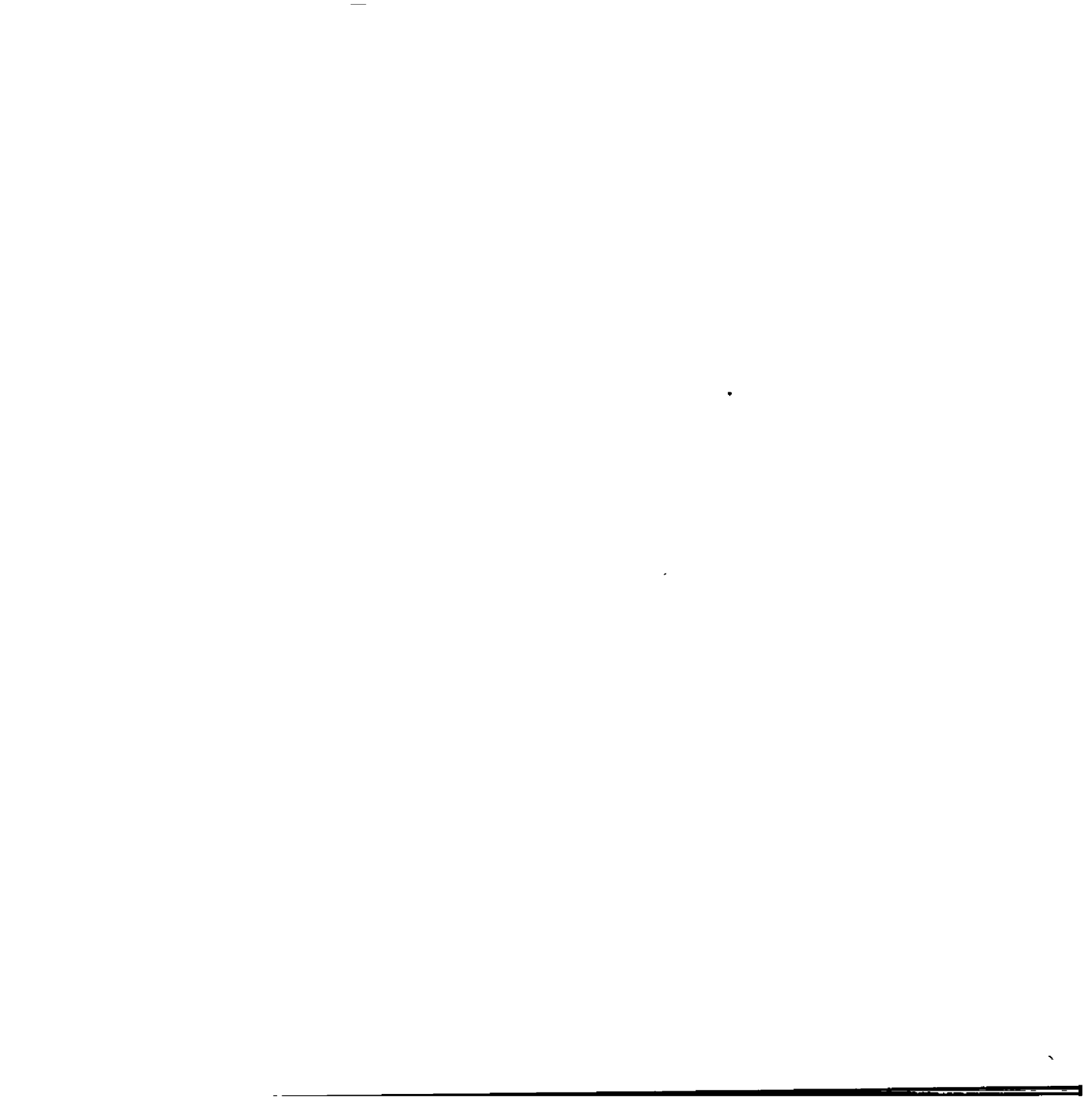
*Methodology: This performance measure is calculated by averaging the age of all the Medicaid long term services and supports recipients who were placed in an institution during a fiscal year and then converting the age into months. Recipients' age is calculated by the computing the difference between their date of birth and the initial date of institutional placement (i.e., first date of service at the long term care facility). There are four categories of service that indicate institutional placement (010 - Short Term LTC Services; 011 - SNF Nursing Home; 012 - ICF Nursing Home; 013 - ICF/MR Service). This Division utilizes MMIS Enterprise and Cognos to query long term care billing claims. It is important to note that providers have a year to bill from the date of service, which may bias the overall number of months.*

### Number of Months Long Term Services and Supports Recipients are able to Remain in their Home before Institutional Placement

Fiscal Year	Number of Months
FY 2014	879.12 +0.88%
FY 2013	871.44 +0.35%
FY 2012	868.36 +0.28%
FY 2011	865.92 +0.77%
FY 2010	859.32 +0.41%
FY 2009	855.84

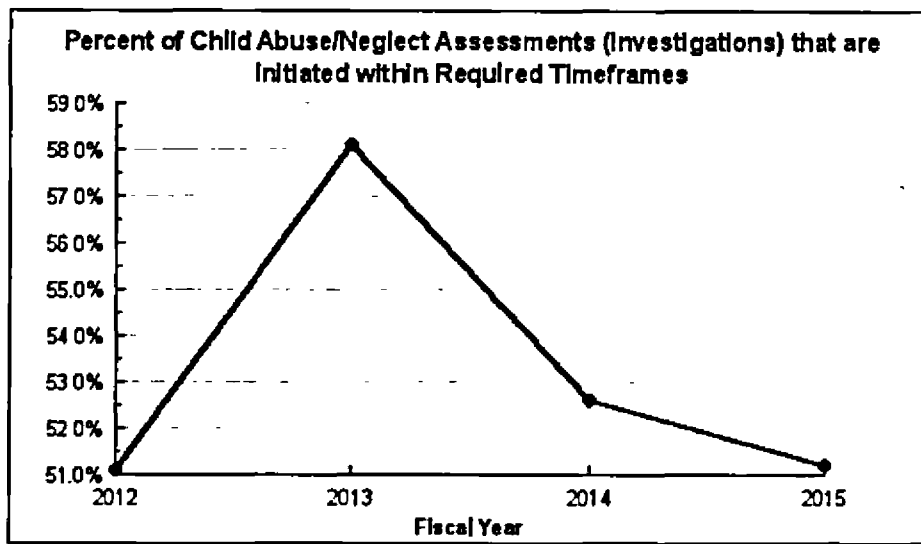
### Target #3: Percent of assessments (investigations) completed timely





FY 2014	20.2%	20.2%	14.4%	18.1%	18.1%
FY 2013	20.5%	23.4%	19.1%	24.2%	20.8%
FY 2012	20.2%	23.1%	14.4%	12.5%	16.6%

**Target #4: Percent of child abuse/neglect assessments (investigations) that are initiated within required timeframes**



*Methodology: Of all initial assessments completed in the report period, the percent that were initiated within the following timeframes: (one combined rate is reported)*

*< = 1 day for Priority 1 reports*

*< = 3 days for Priority 2 reports*

*< = 7 days for Priority 3 reports*

*Numerator: Number of assessments in the denominator that were initiated timely*

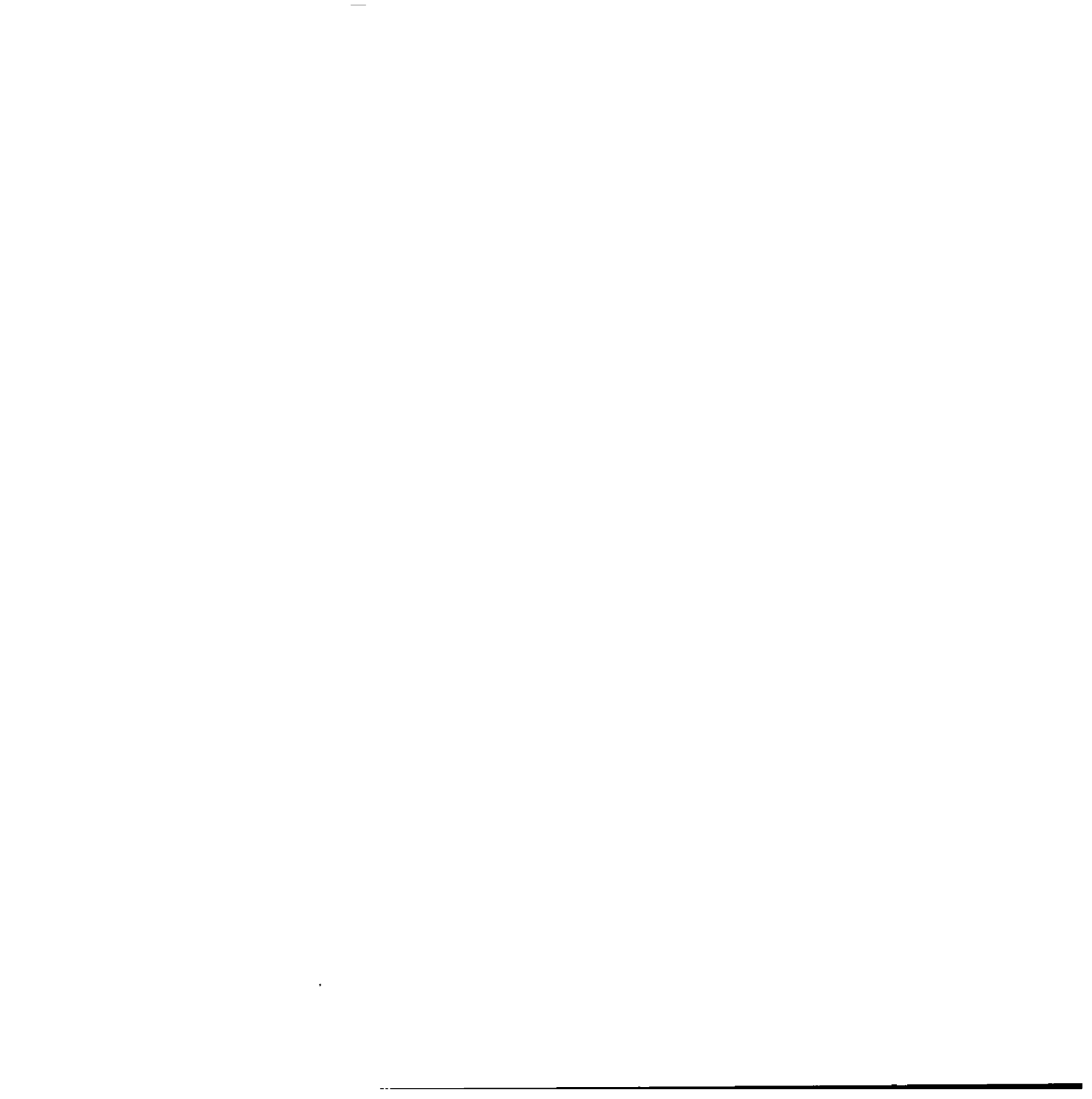
*Denominator: Total number of initial assessments completed in the report period that were not closed without finding.*

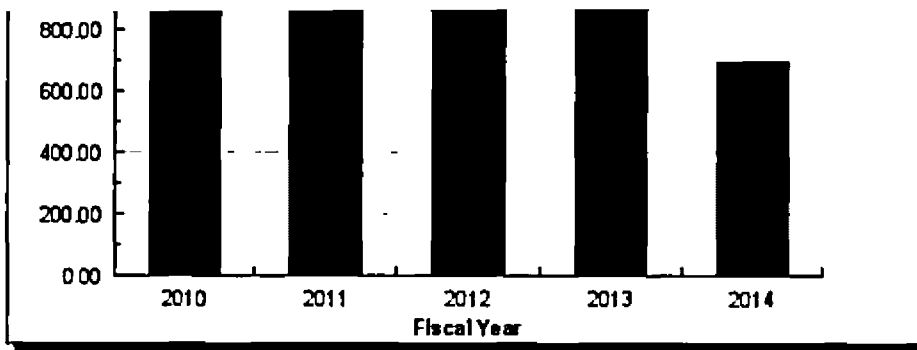
**Percent of Child Abuse/Neglect Assessments (Investigations) that are Initiated within Required Timeframes**

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2015	51.2%	0	0	0	51.2%
FY 2014	55.5%	54.7%	49.5%	50.9%	52.6%
FY 2013	53.6%	60.1%	58.6%	61.2%	58.1%
FY 2012	54.8%	54.5%	50.4%	48.9%	51.1%

**3: Manage health care coverage for Alaskans in need.**

**Target #1: Cost to provide health care services per client**





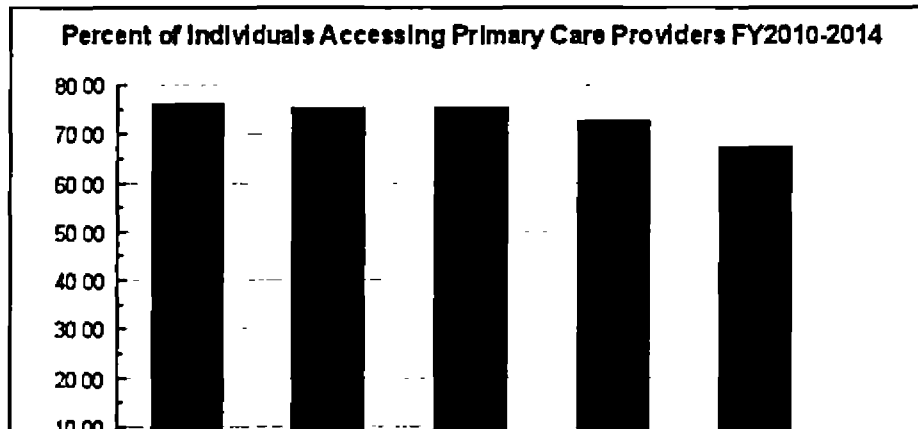
*Methodology: Cognos decision support system (starting 7/1/2014); STARS decision support system (7/1/2013) Note: The Division of Health Care Services makes every effort to ensure that reported numbers are as accurate as possible. However, due to possible defects in the new Health Enterprise Medicaid Management Information System, claims processing system (including converted historical records), the data provided in this report is to be considered a draft and may be updated in future iterations.*

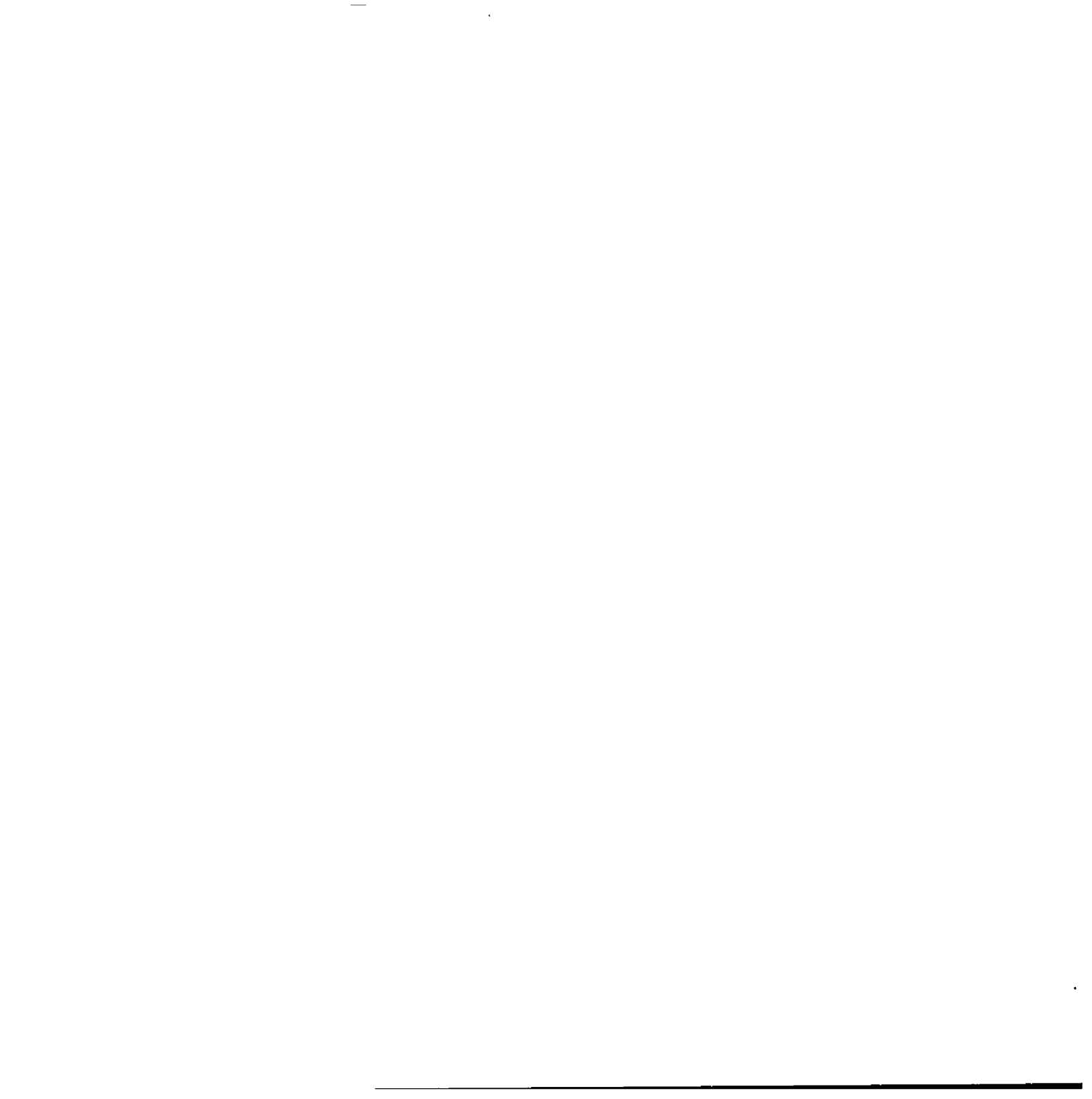
#### Cost to Provide Health Care Services per Client FY2010-2014 (In Dollars)

Fiscal Year	Cost per Client
FY 2014	695.59 -30.02%
FY 2013	994.02 -0.07%
FY 2012	994.71 -1.92%
FY 2011	1,014.14 +2.62%
FY 2010	988.20

**Analysis of results and challenges:** The cost to provide health care services per client was at its highest in FY2011, \$1,014.14. For fiscal years 2012 and 2013, the cost remained steady at around \$994.00. For FY2014 the cost declined to \$695.59. This is a difference of \$318.55 compared to FY2011.

#### Target #2: Percent of individuals served by the department with access to a regular primary care provider



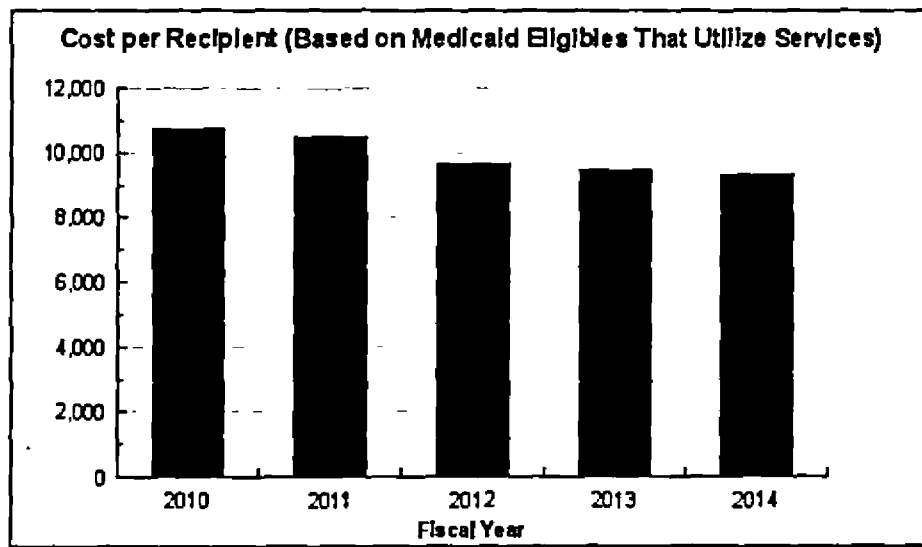


Fiscal Year	Percent
FY 2014	67.06 -7.63%
FY 2013	72.8 -3.46%
FY 2012	75.2 -0.13%
FY 2011	75.3 -1.31%
FY 2010	78.3

**Analysis of results and challenges:** There has been a steady decline in the percent of individuals accessing primary care providers from FY2010 to FY2014. In FY2010 76.8% of Medicaid eligible individuals accessed primary care providers. By FY14 that number had declined to 67.06%.

**4: Facilitate access to affordable health care for Alaskans.**

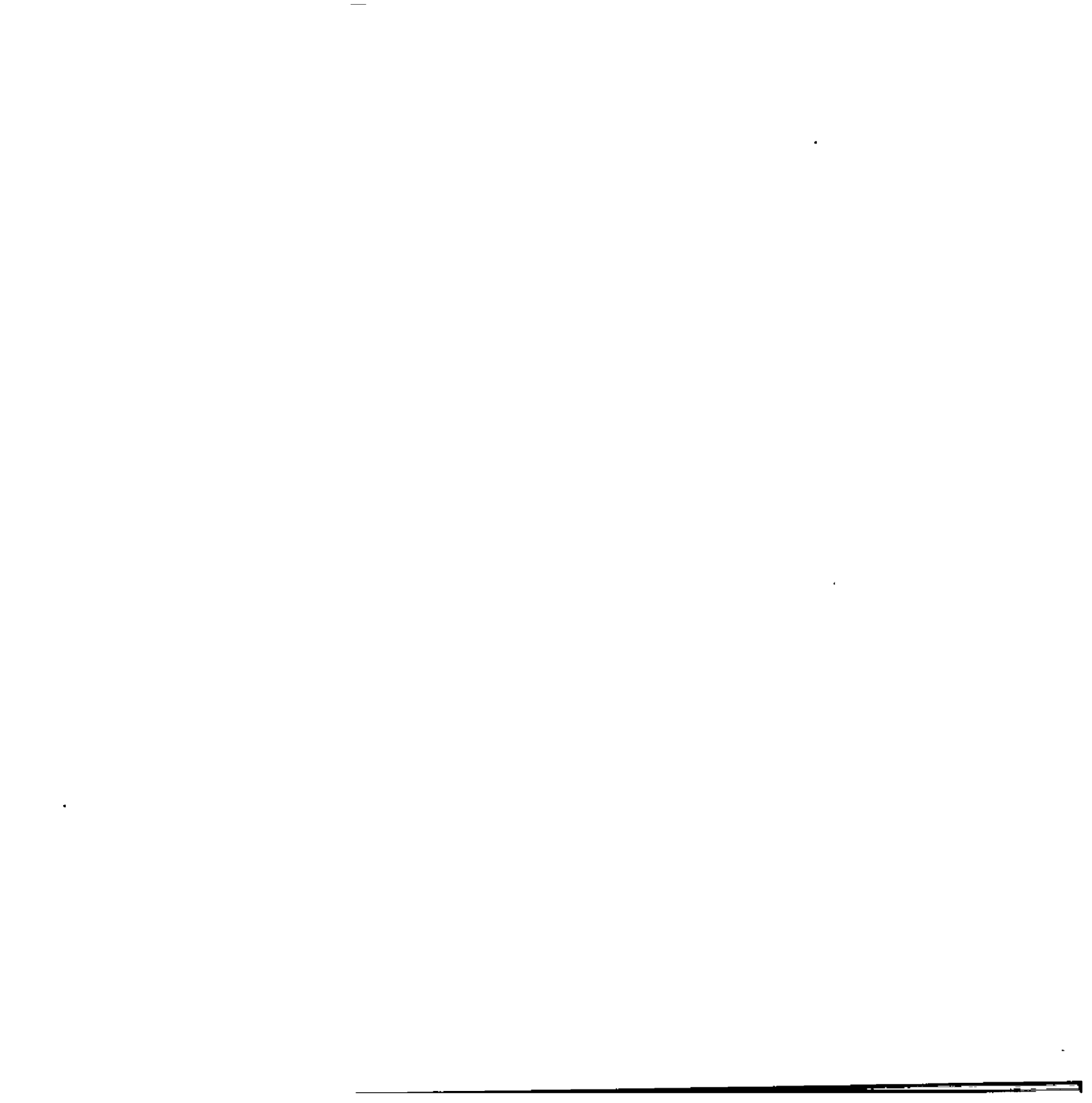
**Target #1: Cost per recipient**



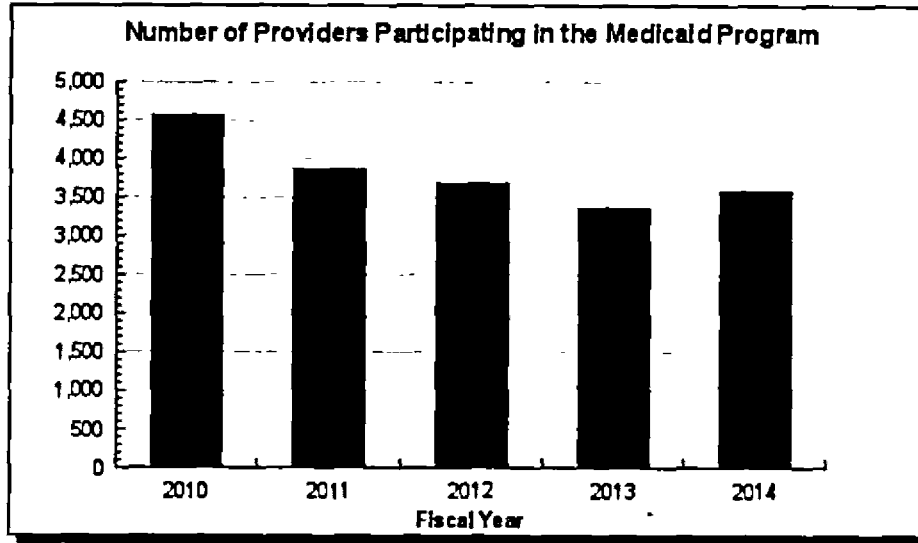
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**Cost per Recipient (Based on Medicaid Eligibles That Utilize Services)**

Fiscal Year	Cost per Recipient
FY 2014	9,310 -1.43%



**Target #2: Number of providers participating in the Medicaid program**



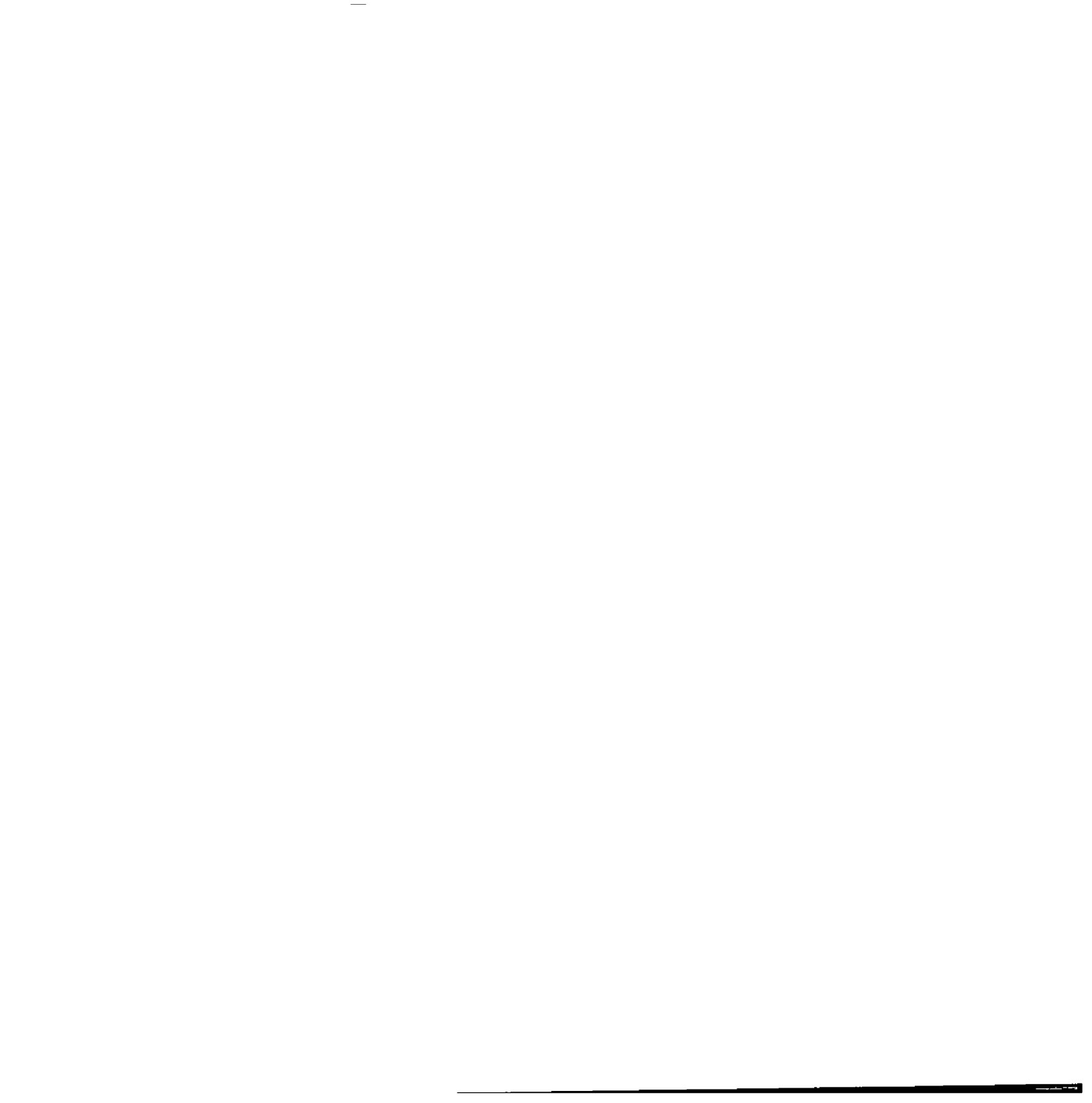
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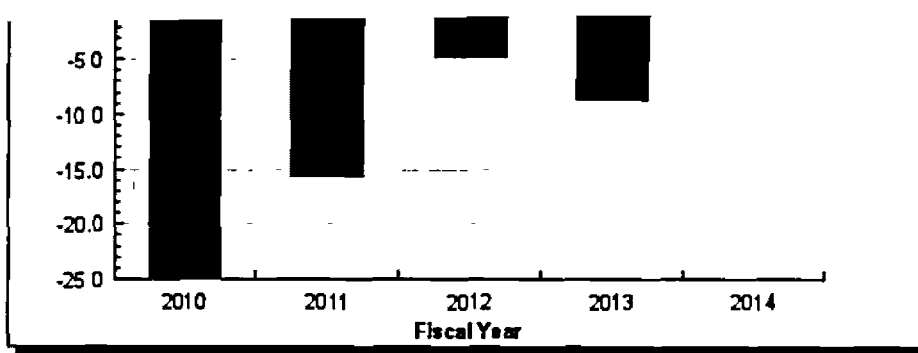
**Number of Providers Participating in the Medicaid Program**

Fiscal Year	Number of Providers
FY 2014	3,572 +6.44%
FY 2013	3,358 -8.63%
FY 2012	3,673 -4.72%
FY 2011	3,855 -15.61%
FY 2010	4,568

**Analysis of results and challenges:** The number of participating Medicaid providers steadily declined from fiscal years 2010 to 2013. There was a slight increase from FY2013 to FY2014. But, overall there has been a decline in the number of participating Medicaid providers from FY2010 to FY2014 by about 1,000 providers.

**Target #3: Percent change in number of providers participating**





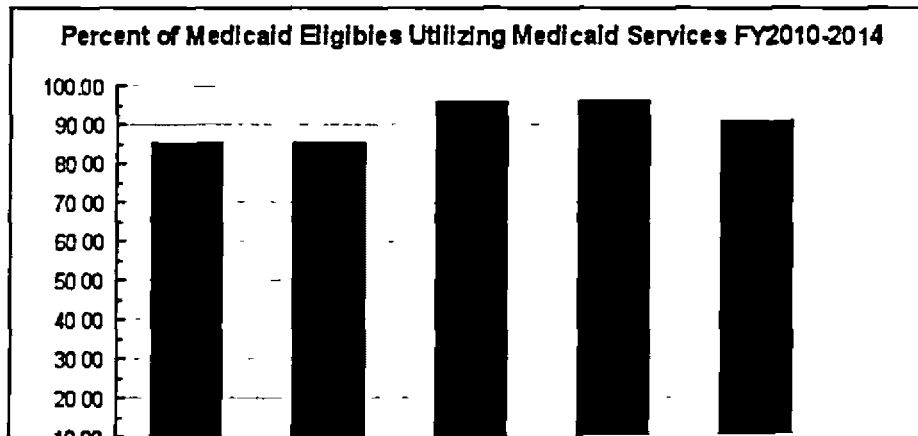
*Methodology: Cognos, Note: The Division of Health Care Services makes every effort to ensure that reported numbers are as accurate as possible. However, due to possible defects in the new Health Enterprise Medicaid Management Information System, claims processing system (including converted historical records), the data provided in this report is to be considered a draft and may be updated in future iterations.*

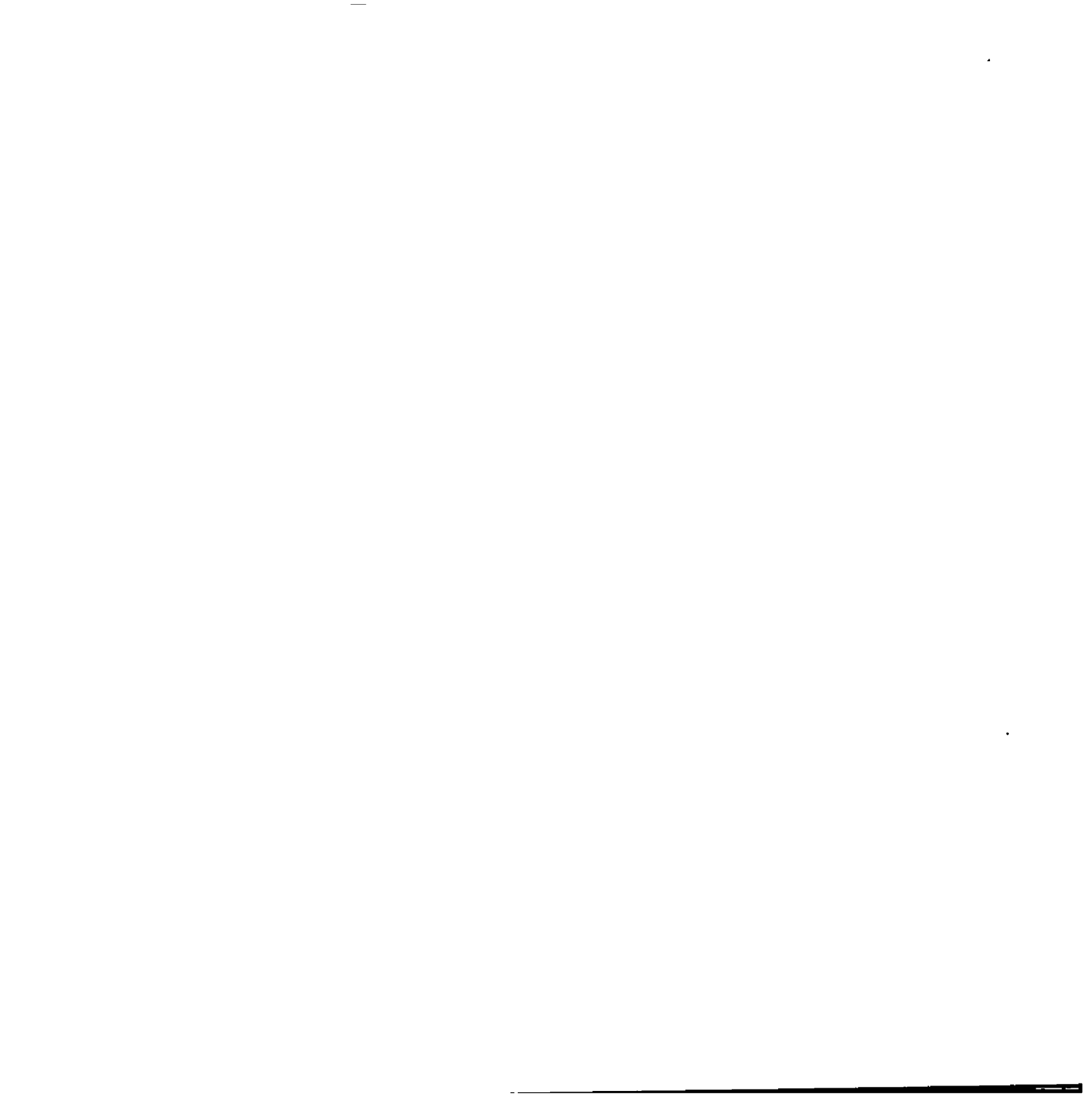
#### Percentage Change in Participating Medicaid Providers FY2010-2014

Fiscal Year	Percent Change
FY 2014	6.4 -174.42%
FY 2013	-8.6 +82.98%
FY 2012	-4.7 -69.87%
FY 2011	-15.6 -37.1%
FY 2010	-24.8

**Analysis of results and challenges:** The Medicaid program had fewer participating providers from FY2010 to FY2013. From FY2013 to FY2014 the Medicaid program had an increase of about 200 providers. Therefore, the percentage change from FY2013 went from negative to positive to reflect this increase.

#### Target #4: Percent of Medicaid eligibles who utilize Medicaid Services



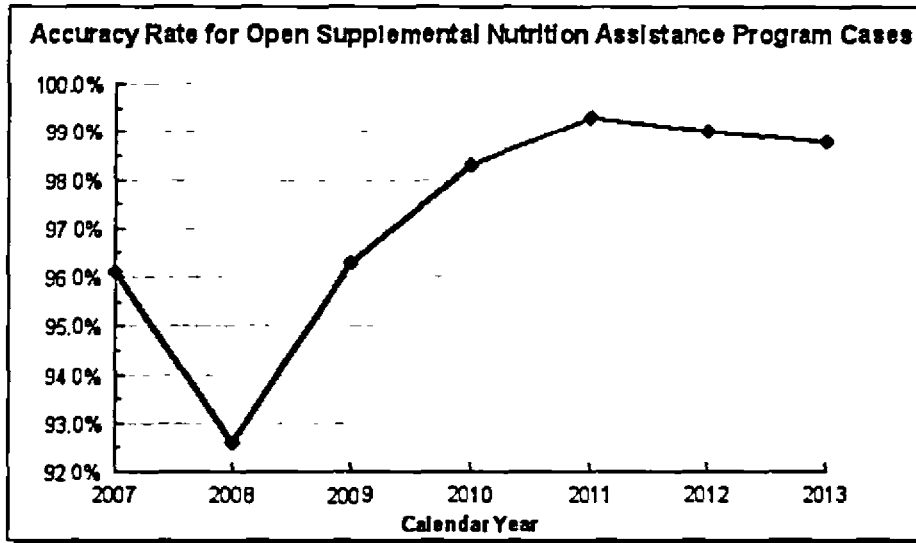


Fiscal Year	Percent
FY 2014	90.66 -5.52%
FY 2013	95.96 +0.87%
FY 2012	95.13 +11.83%
FY 2011	85.07 +0.05%
FY 2010	85.03

**Analysis of results and challenges:** The percent of Medicaid eligibles utilizing Medicaid services increased from FY2010 to FY2014 by about 5%. Fiscal years 2012 and 2013 had peak utilization of 95% before the percentage decreased to 90% in FY14.

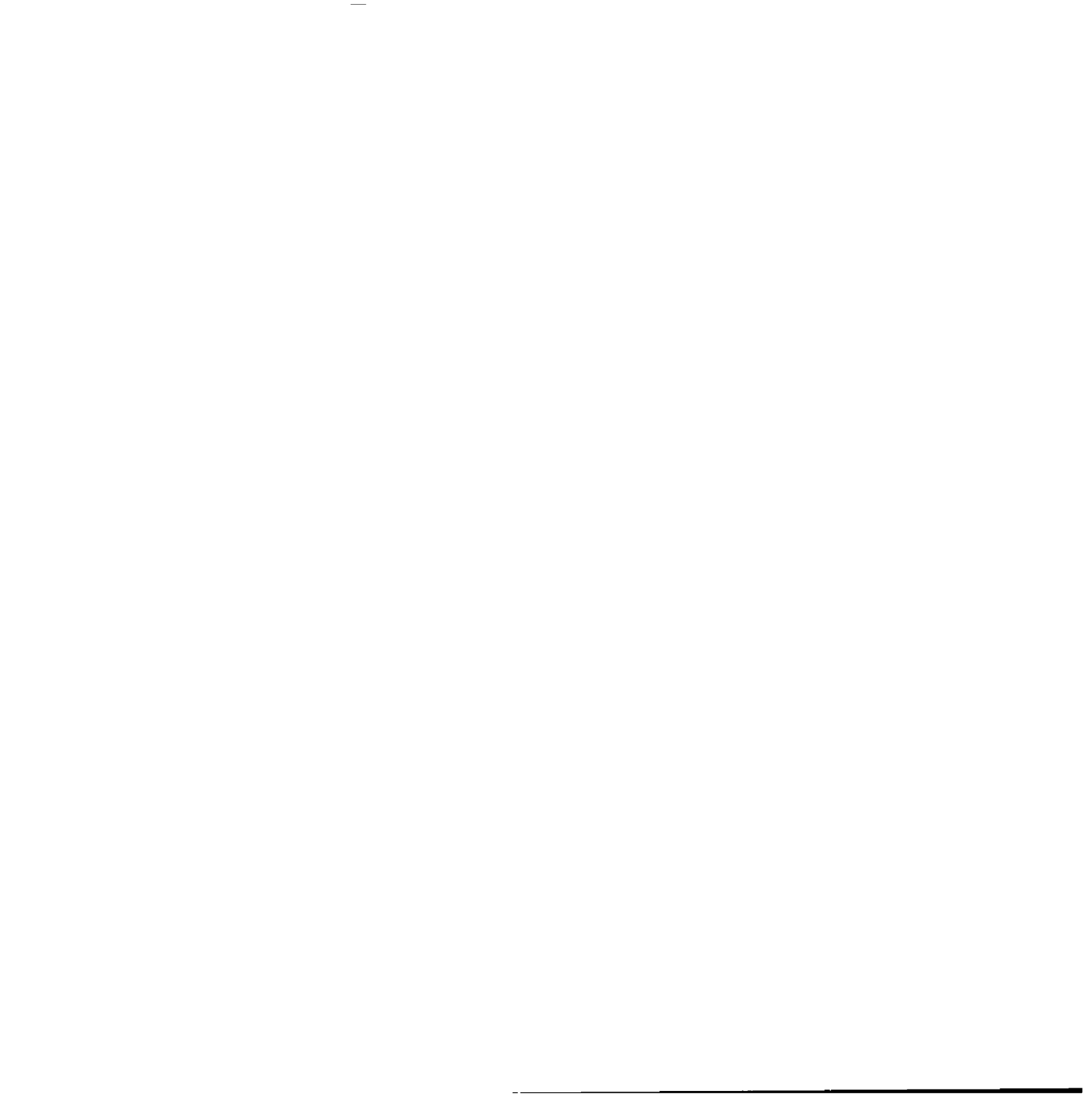
**5: Strengthen Alaska families.**

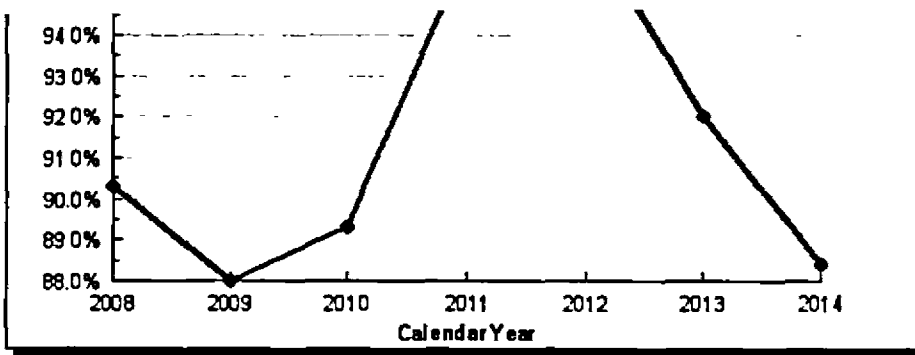
**Target #1: Accuracy rate for open Food Stamp cases**



**Accuracy Rate for Open Supplemental Nutrition Assistance Program Cases**

Year	YTD Total
2013	98.8%
2012	99%
2011	99.3%
2010	98.3%
2009	96.3%
2008	92.6%

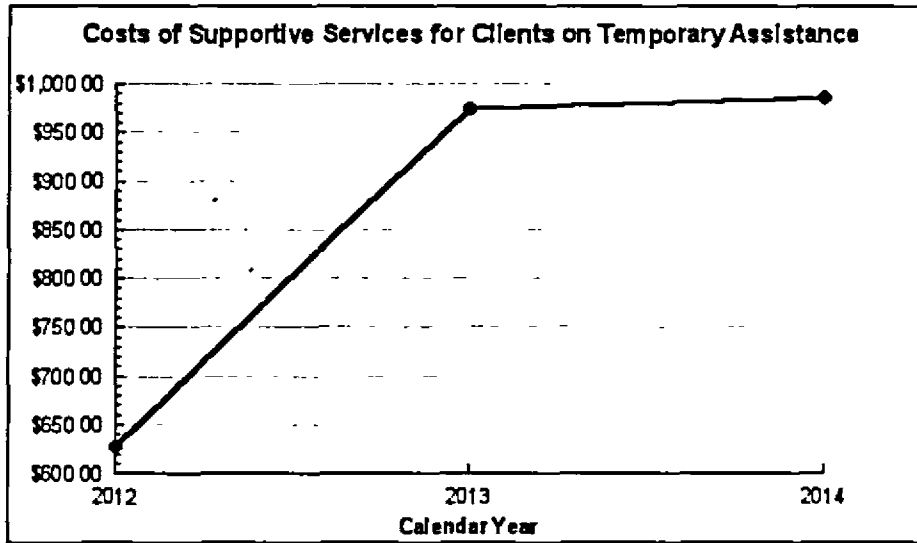




**Percent of Supplemental Nutrition Assistance Program Applications Processed Timely**

Year	YTD Total
2014	88.4%
2013	92%
2012	96.7%
2011	96.1%
2010	89.3%
2009	88%
2008	90.3%

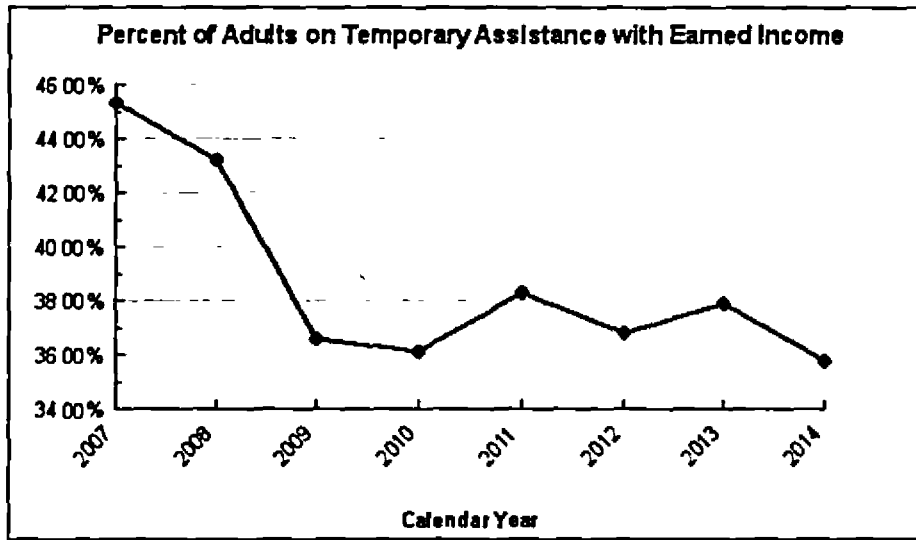
**Target #3: Cost of supported employment services per successful participant in Job Start or on-the-job training**



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Target #4: Percent of individuals receiving employment related services from the department who achieve employment



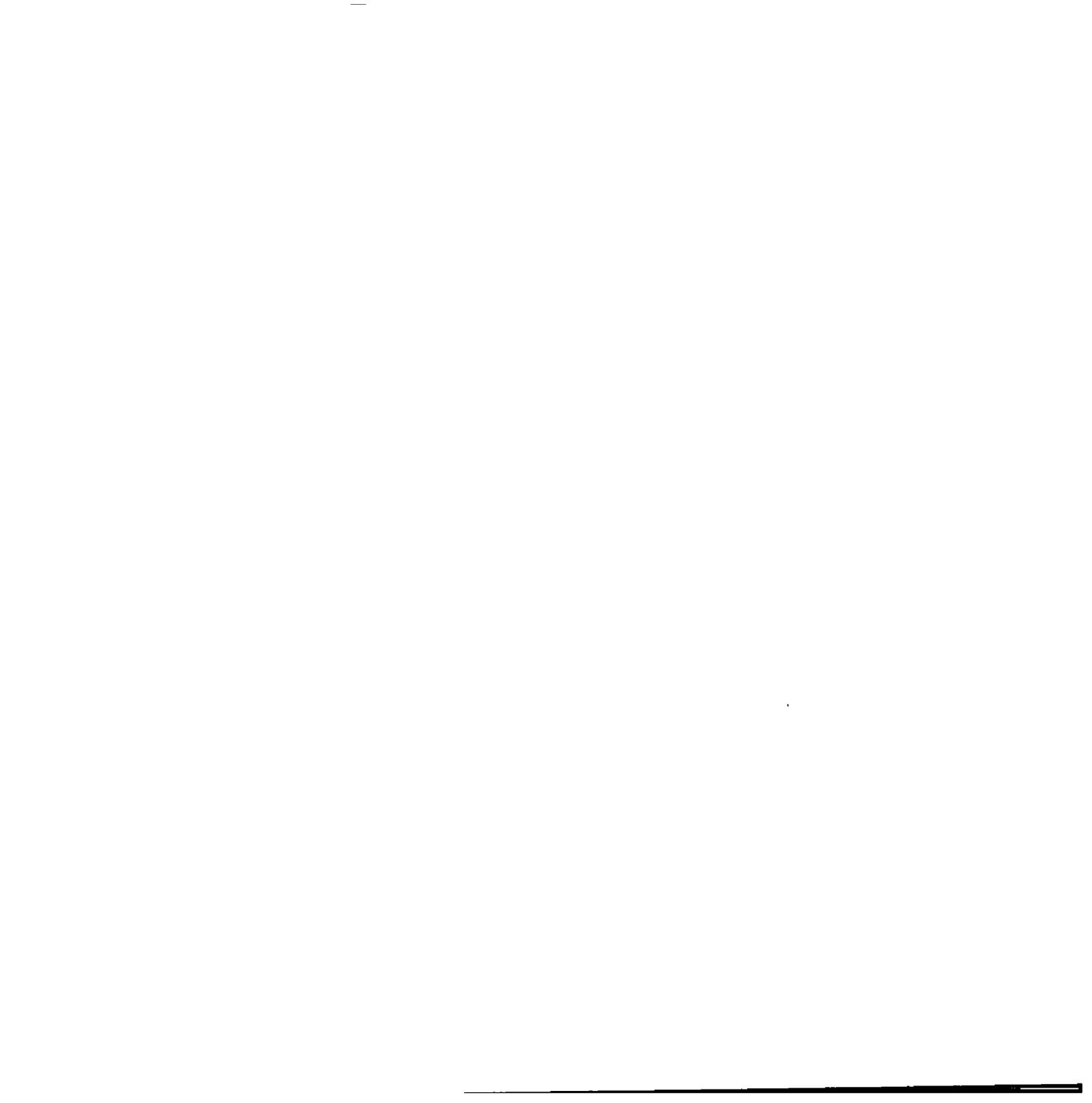
Methodology: Numerator: Number of adults in the Temporary Assistance Program who have earned income; Denominator: Number of adults in the Temporary Assistance Program who are work eligible.

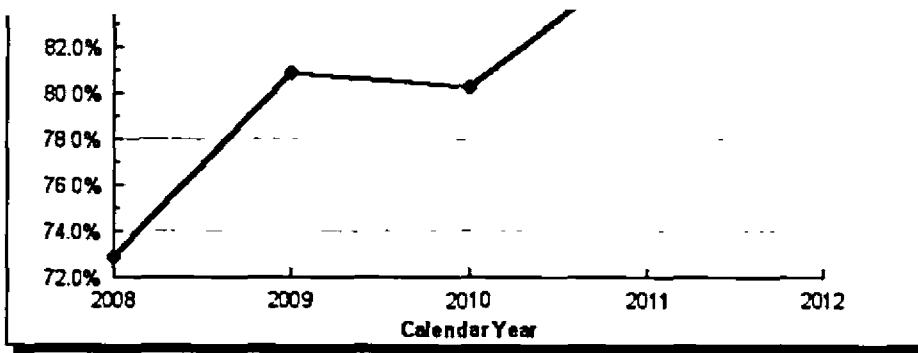
Source:

**Percent of Adults on Temporary Assistance with Earned Income**

Year	YTD Total
2014	35.75%
2013	37.9%
2012	36.8%
2011	38.3%
2010	36.1%
2009	36.6%
2008	43.2%
2007	45.3%

Target #5: Percent of low-income Alaskans receiving supplemental nutrition benefits through the Food Stamp program



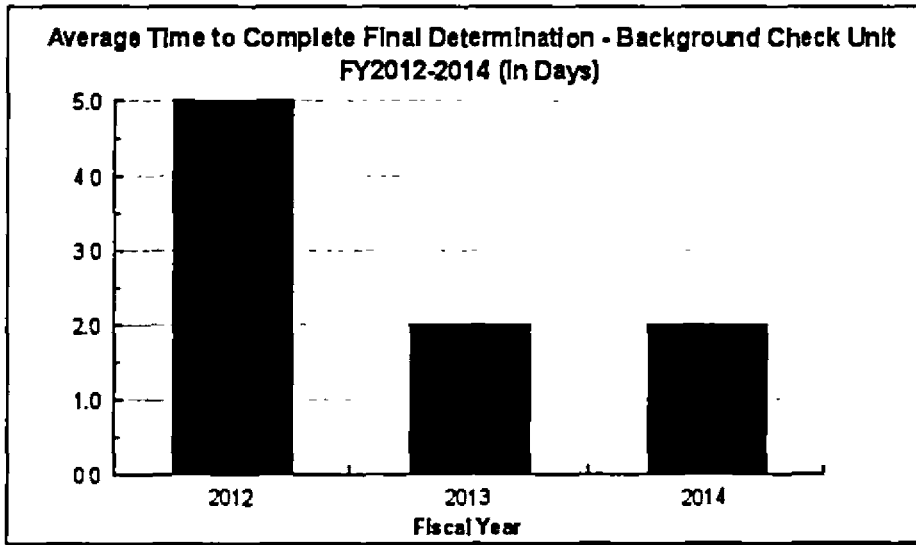


**Percent of Low-income Alaskans Receiving Supplemental Nutrition Assistance Program Benefits**

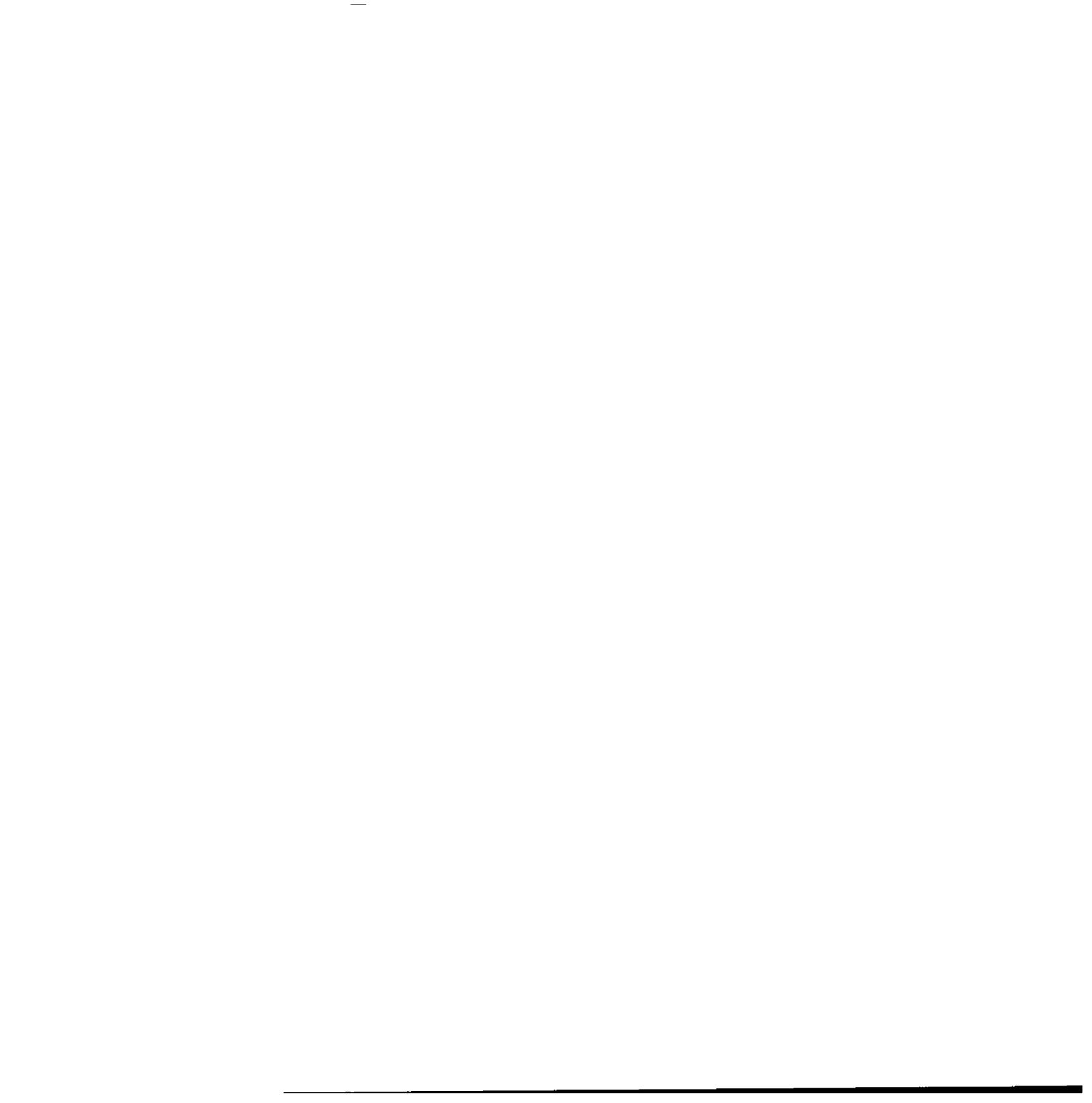
Year	YTD Total
2012	87.0%
2011	86.2%
2010	80.3%
2009	80.9%
2008	72.9%

**6: Protect vulnerable Alaskans.**

**Target #1: Average time to complete final determination**



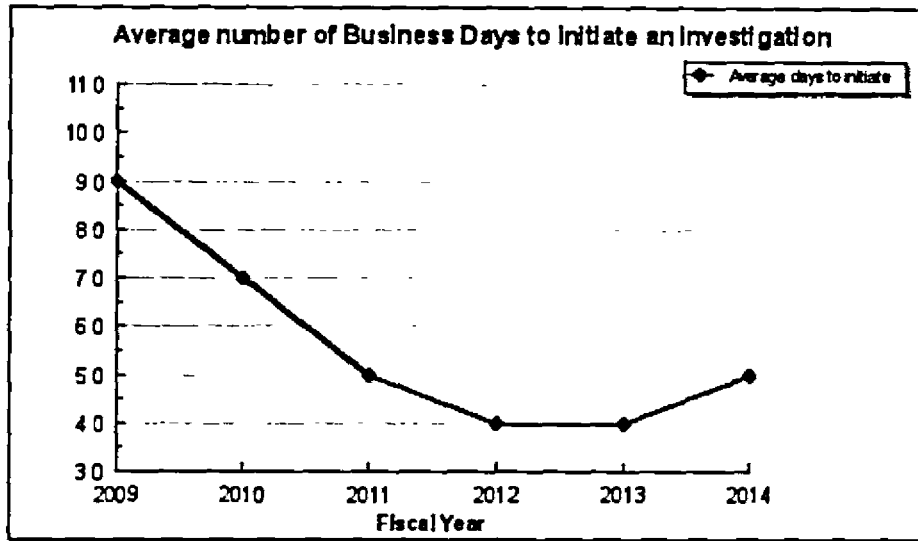
*Methodology: Background Check Program*



FY 2013	2.0 -60%
FY 2012	5.0

**Analysis of results and challenges:** The average time it takes to complete a final background check determination once all information has been received has decreased from 5 days in FY2012 to just 2 days in fiscal years 2013 and 2014.

**Target #2: Average time to initiate an investigation**

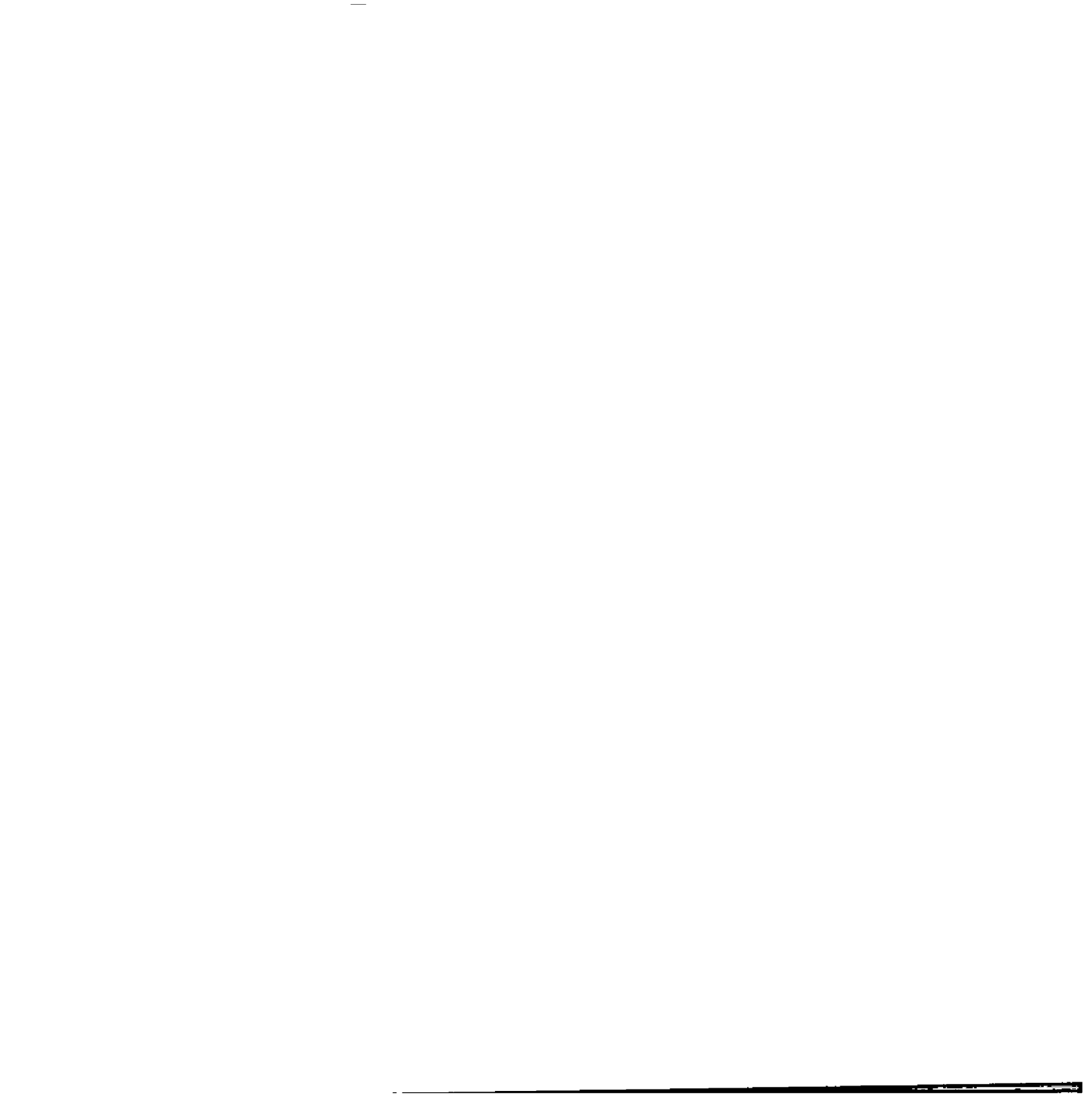


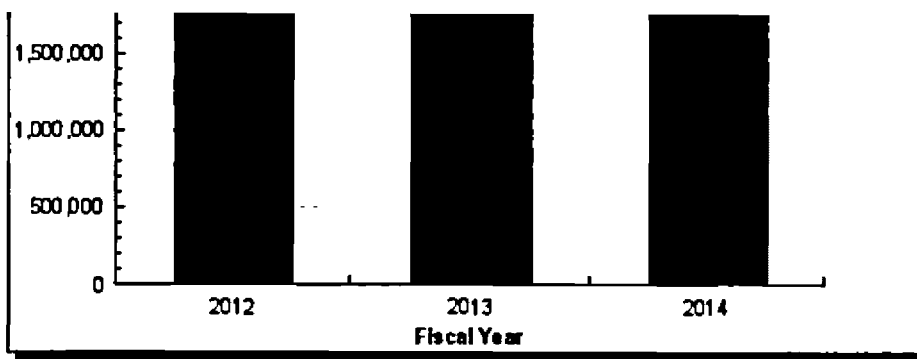
*Methodology: This performance measure is calculated by averaging the number of business days it takes Adult Protective Service investigations to conduct the initial face-to-face contact with the alleged victim of abuse, neglect, or exploitation once the report of harm is received by the Division of Senior and Disabilities Services. The Division strives to conduct the initial face-to-face visit within 10 business days of receiving the report of harm. The Division utilizes its database system, DS3 (Division of Senior and Disabilities Services Database System), to store and monitor all data pertaining to Adult Protective Services.*

**Average number of Business Days to Initiate an Investigation**

Fiscal Year	Average days to initiate
FY 2014	5 +25%
FY 2013	4 0%
FY 2012	4 -20%
FY 2011	5 -28.57%
FY 2010	7 -22.22%
FY 2009	9

**Target #3: Cost of administering background check program**





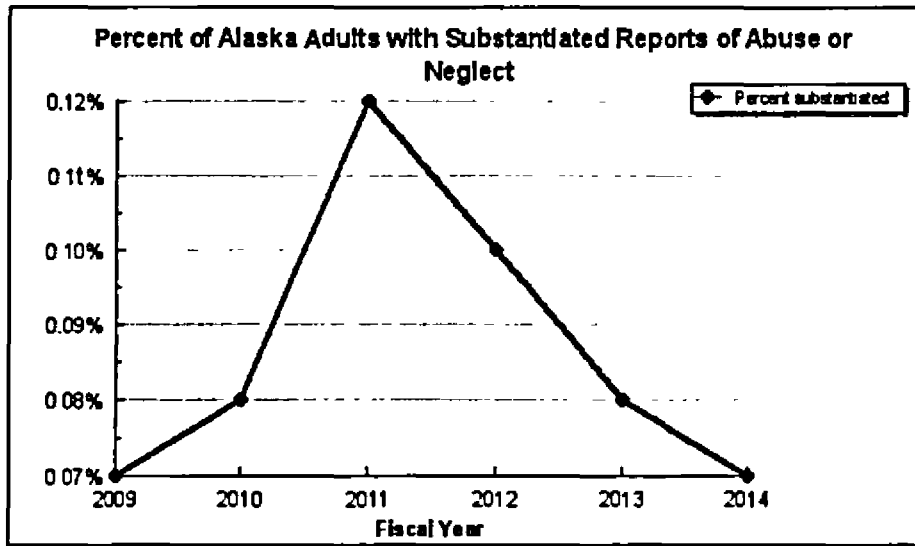
Methodology: Background Check Program, Health Care Services Administration

#### Cost of Administering Background Check Program FY2012-2014

Fiscal Year	Cost of Program
FY 2014	2,169,761 -5.74%
FY 2013	2,301,959 +3.43%
FY 2012	2,225,667

**Analysis of results and challenges:** The cost of administering the background check program from FY2012 to FY2014 has been just over \$2,000,000 for each year, with a peak cost in FY2013 of \$2,301,959.

#### Target #4: Percent of Alaska adults with substantiated reports of abuse or neglect

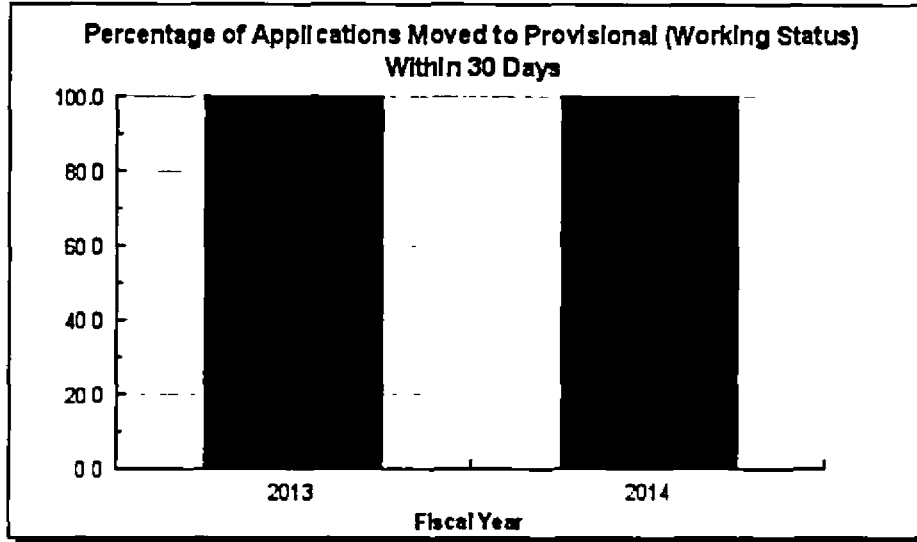


Methodology: This performance measure is calculated by taking the percentage of Alaskan adults with at least one report of harm having at least one substantiated allegation. The percentage is calculated by taking the unduplicated count of adults who had at least one report of harm filed for them with at least one allegation determined to be substantiated at the conclusion of the Adult Protective Service investigation over the estimated population of Alaska for the year being targeted. There are two important caveats to the methodology used to calculate this performance measure: first, The population estimates are taken from the U.S. Census, and it encompasses the entire population of Alaska, not just adults. Secondly, the number of adults with substantiated reports of harm is subject to change at any given point in time, based on investigations that take a week or months to close. Both of these caveats can potentially bias the overall percentage. The



FY 2010	.08%
FY 2009	.07%

**Target #5: Percent of background checks completed within established timeframes**



*Methodology: Background Check Program*

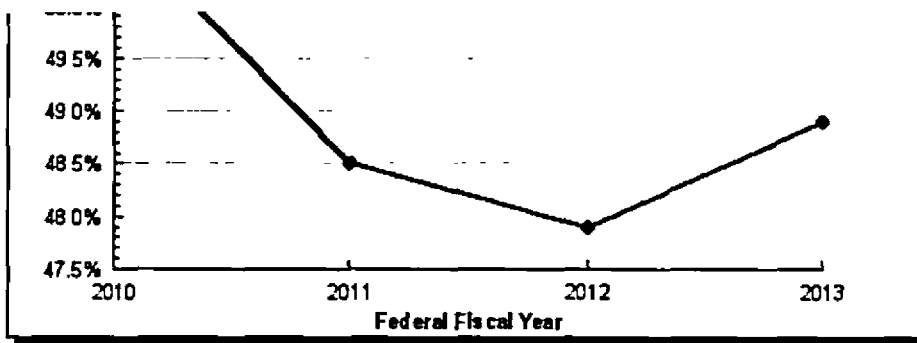
**Percentage of Applications Moved to Provisional (Working Status) Within 30 Days**

Fiscal Year	Percent
FY 2014	100.0 0%
FY 2013	100.0

**Analysis of results and challenges:** The percent of background checks completed within established timeframes is 100% for fiscal years 2013 and 2014. Completed within established timeframes refers to applications moved to provisional working status within 30 days.

**Target #6: Percent of children discharged from out-of-home care who are reunified with their parents**





*Methodology: Of all children discharged during the year who had been in out-of-home care for at least eight days, the percent that were discharged to reunification*

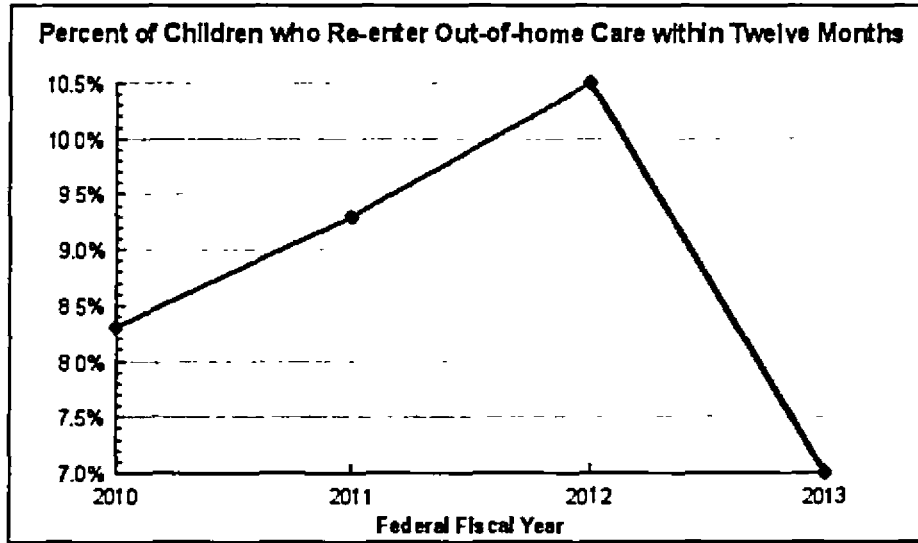
*Numerator: Of the children in the denominator, the number whose last discharge of the year had a discharge reason of reunification*

*Denominator: The unique number of children placed out-of-home for at least eight days who were discharged during the year*

### Percent of Children Discharged from Out-of-Home Care who are Reunified with their Parents

Fiscal Year	YTD Total
FFY 2013	48.9%
FFY 2012	47.9%
FFY 2011	48.5%
FFY 2010	50.8%

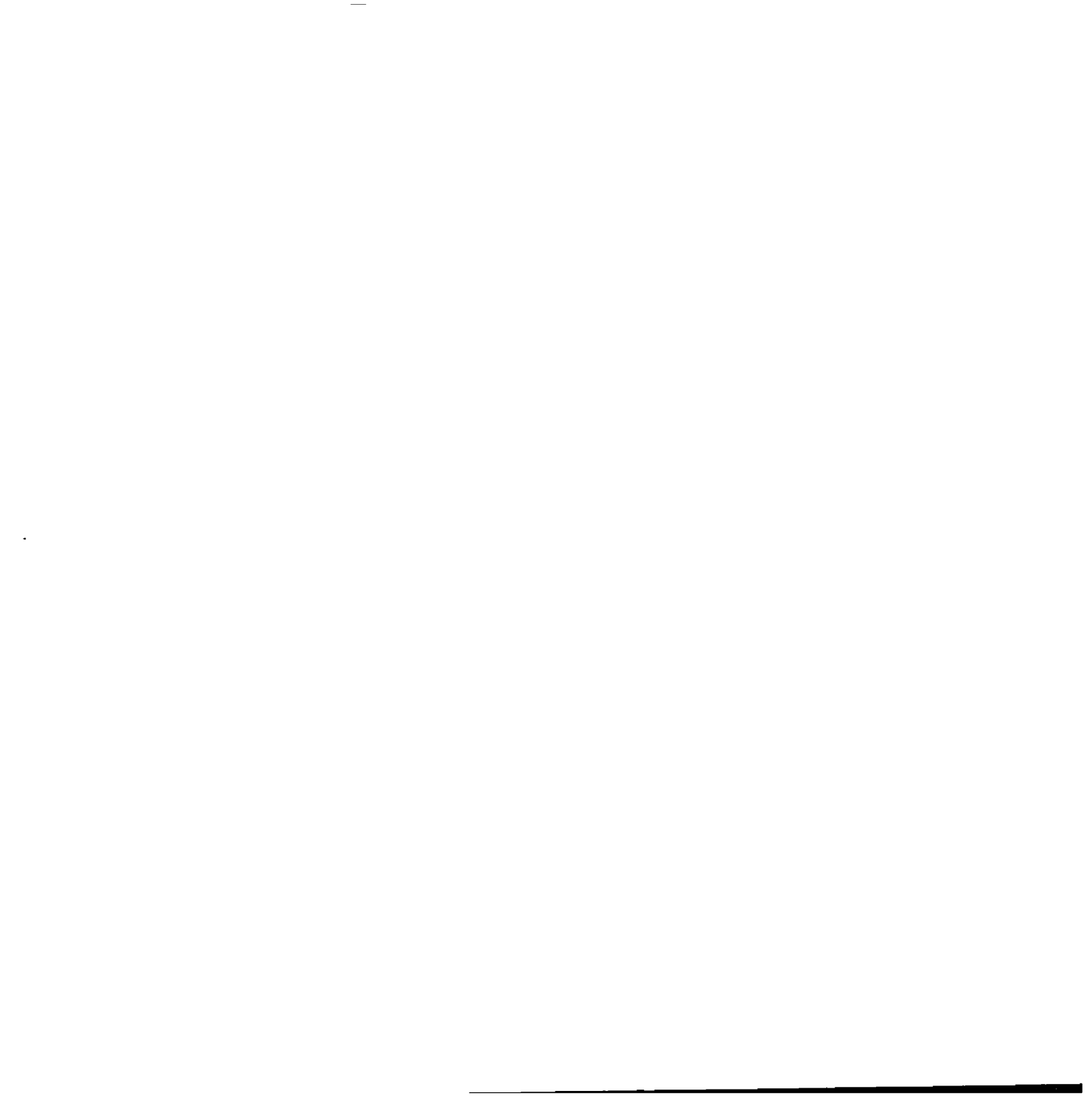
### Target #7: Percent of children who re-enter out-of-home care within twelve months



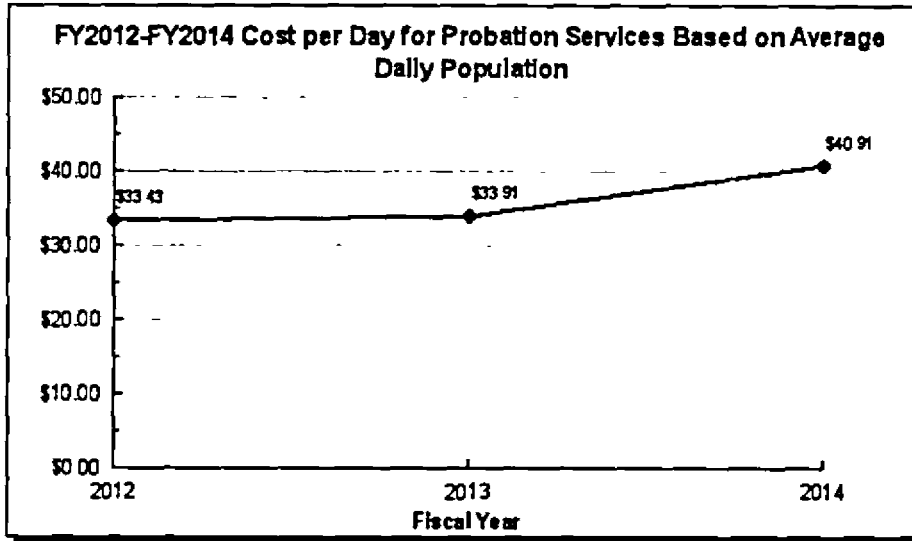
*Methodology: Of all children discharged from foster care to reunification in the 12-month period prior to the year shown, the percent that re-entered foster care in less than 12 months from the date of discharge.*

*Numerator: The number of children in the denominator who re-entered out of home care in less than 12 months from the date of discharge*

*Denominator: The unique number of children discharged to reunification in the preceding year*



**Target #1: Cost per day for probation services based on average daily population**



*Methodology: The cost per day for the Probation core service is calculated by taking the cost for each probation region and then allocating to each region portions of Director's Office and Delinquency Prevention components, and Youth Court expenditures. The population of youth receiving probation services is based on the number of juveniles with open supervision or intake records in the fiscal year. The total number of youth receiving probation services for the year is divided by 365 to come up with an average daily population.*

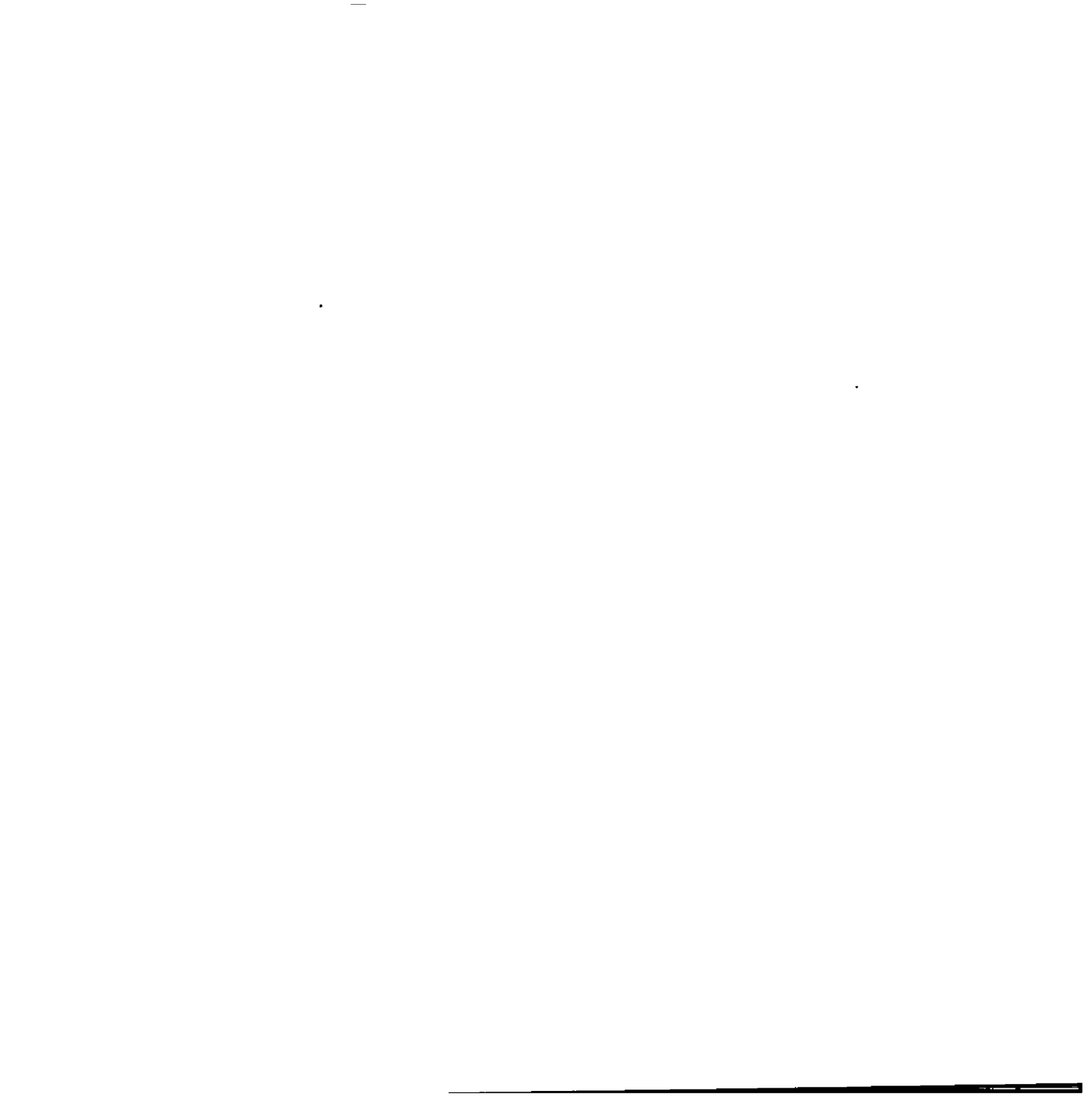
**FY2012-FY2014 Cost per Day for Probation Services Based on Average Daily Population**

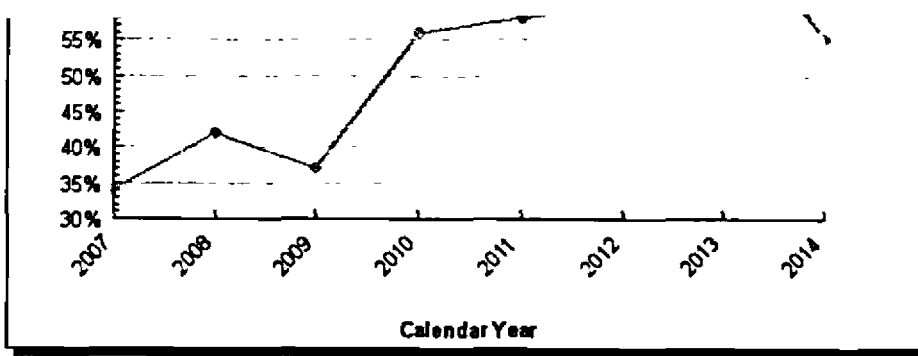
Fiscal Year	Cost Per Day
FY 2014	\$40.91
FY 2013	\$33.91
FY 2012	\$33.43

**Analysis of results and challenges:** The cost to provide probation services to a youth in Alaska has remained fairly stable over the past three years. Changes in the number of youth referred to the division from year to year is the largest factor in creating fluctuations in the cost per day for probation services. Declines in referrals over the past three years result in the division being able to allocate more attention and services to individual youth, which increases the cost of probation services per youth.

Costs to provide probation services vary slightly depending on the regions in which these services are provided. For example, probation services in regions with many rural communities generally are more expensive than those in urban regions because of increased costs for travel, supplies, and other resources.

**Target #2: Percentage of investigations that result in fraud determinations**

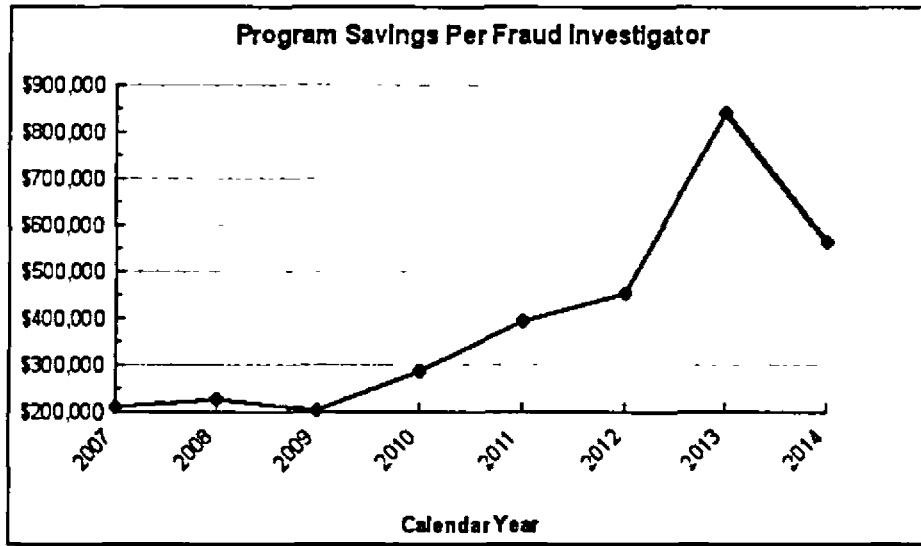


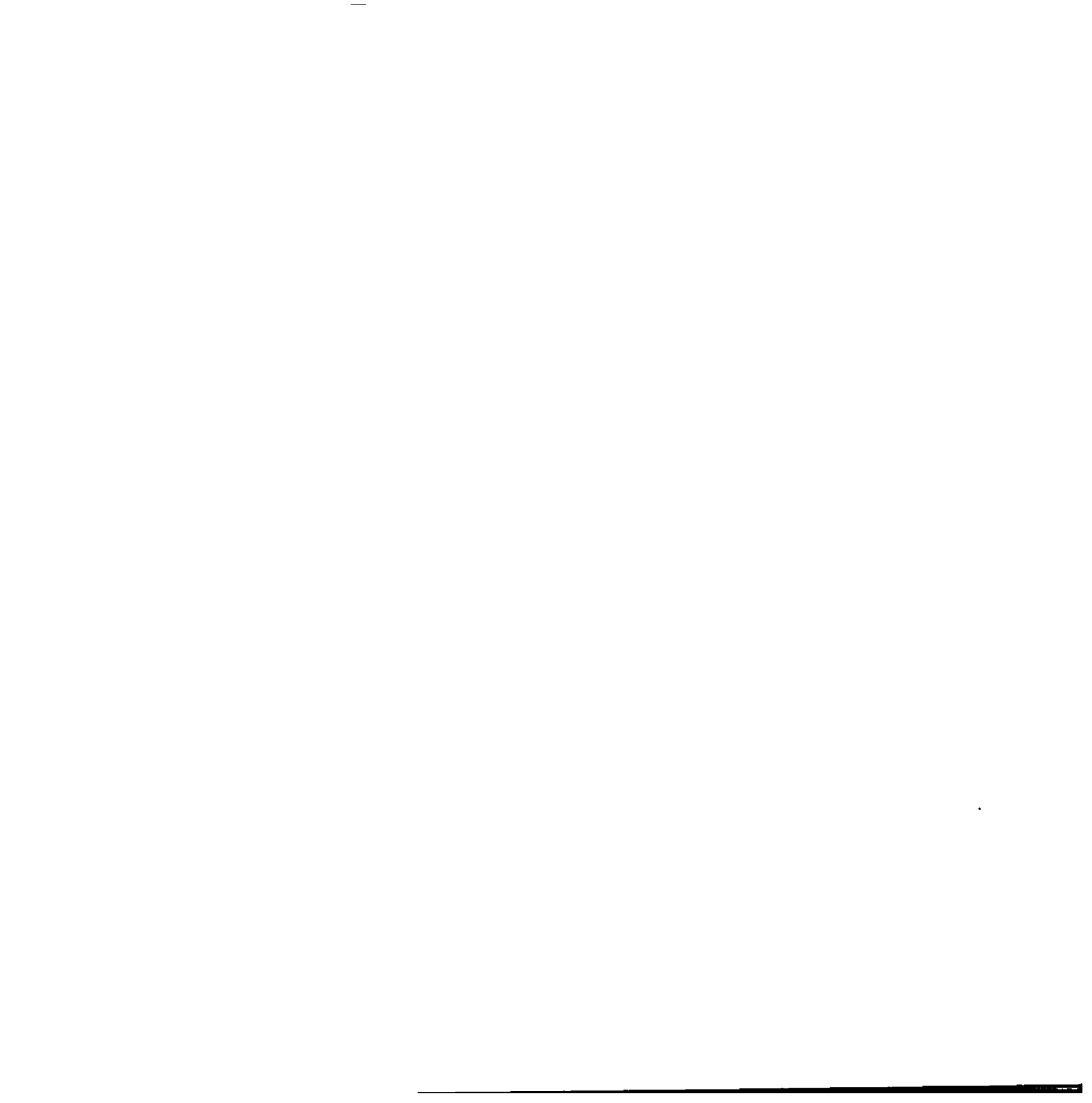


**Percent of Investigations that Result in Fraud Determinations**

Year	YTD Total
2014	55%
2013	74%
2012	60%
2011	58%
2010	56%
2009	37%
2008	42%
2007	34%

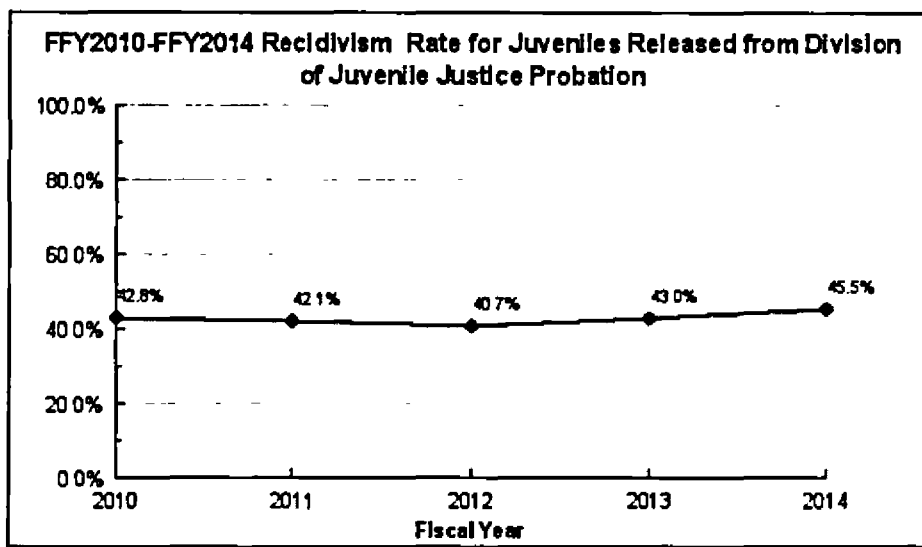
**Target #3: Program savings per fraud investigator**





2012	\$452,304
2011	\$394,905
2010	\$287,738
2009	\$204,041
2008	\$226,404
2007	\$209,087

**Target #4: Reduce the rate of recidivism for juveniles released from Division of Juvenile Justice Probation**

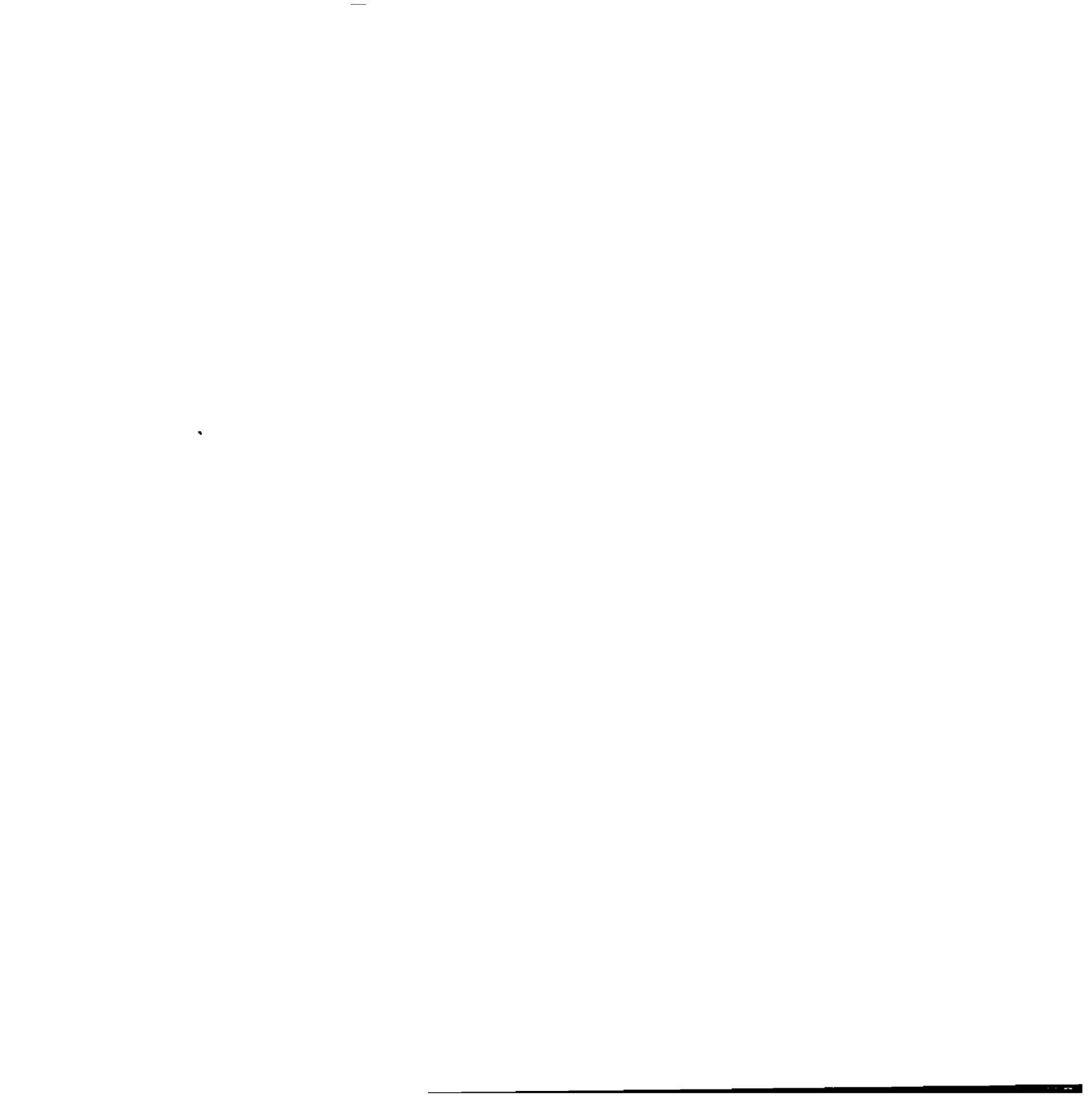


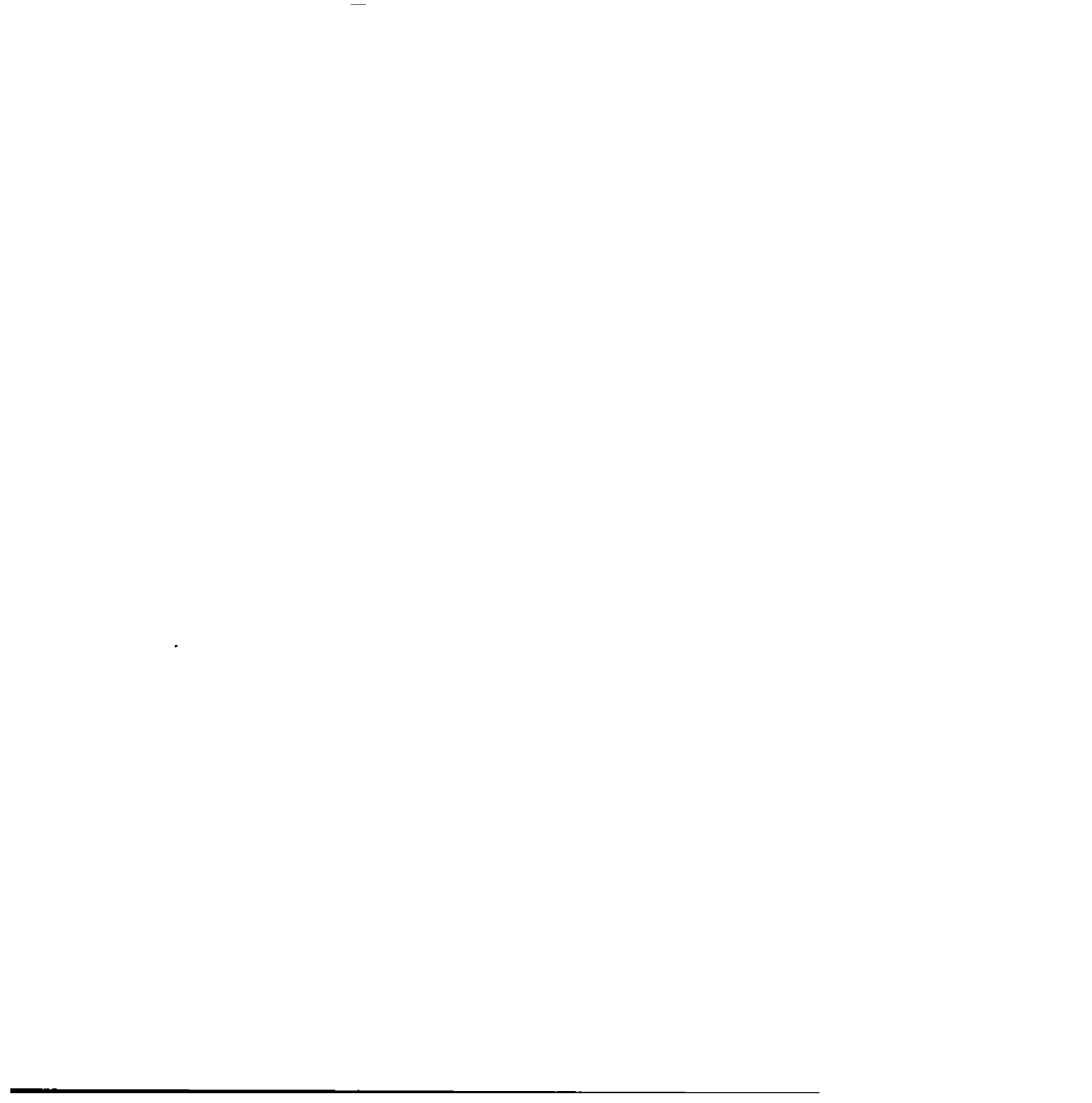
*Methodology: For juveniles to be counted as recidivists in the data above, adjudication and conviction information on offenses that were committed 24 months after release from probation supervision must have been entered in the division's Juvenile Offender Management Information System or the Alaska Public Safety Information Network by July 3, 2014. The analysis also excludes youth who were ordered to an Alaskan juvenile treatment facility any time prior to their supervision end date, as these youth are included in the analysis for our juvenile treatment facilities, below. Non-criminal motor vehicle, Fish & Game, tobacco, and alcohol violations are not counted as re-offenses. Adjudications and convictions received outside Alaska also are excluded from this analysis.*

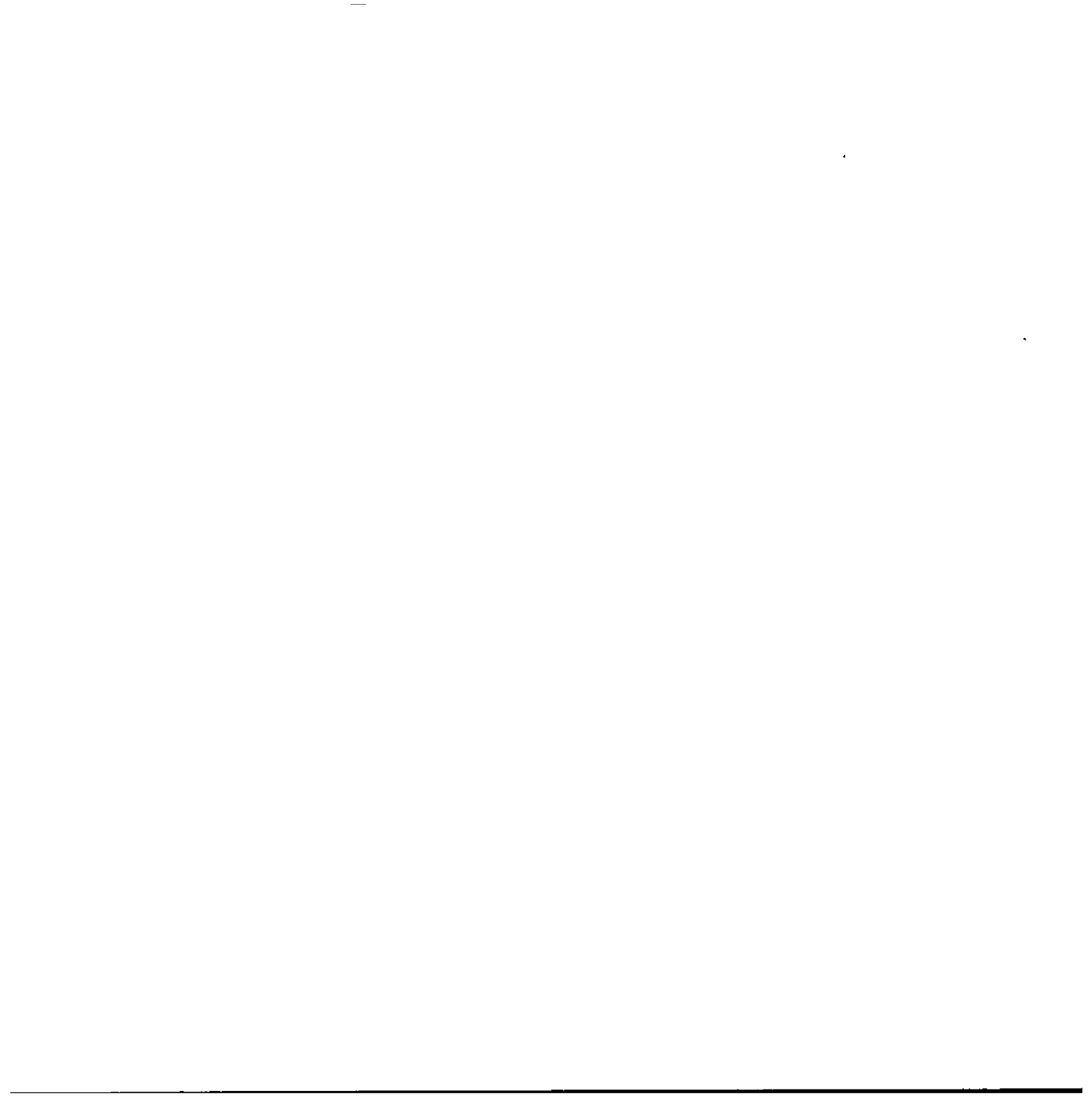
**FFY2010-FFY2014 Recidivism Rate for Juveniles Released from Division of Juvenile Justice Probation**

Fiscal Year	Recidivism Rate
FY 2014	45.5%
FY 2013	43.0%
FY 2012	40.7%
FY 2011	42.1%
FY 2010	42.8%

**Analysis of results and challenges:** This measure examines reoffense rates for juveniles who received probation supervision while either remaining at home or in a nonsecure custodial placement. These youths typically have committed less serious offenses and have demonstrated less chronic criminal behavior than youth who have been committed to a juvenile treatment facility.









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# Medicaid Provider Taxes

**Alison Mitchell**

Analyst in Health Care Financing

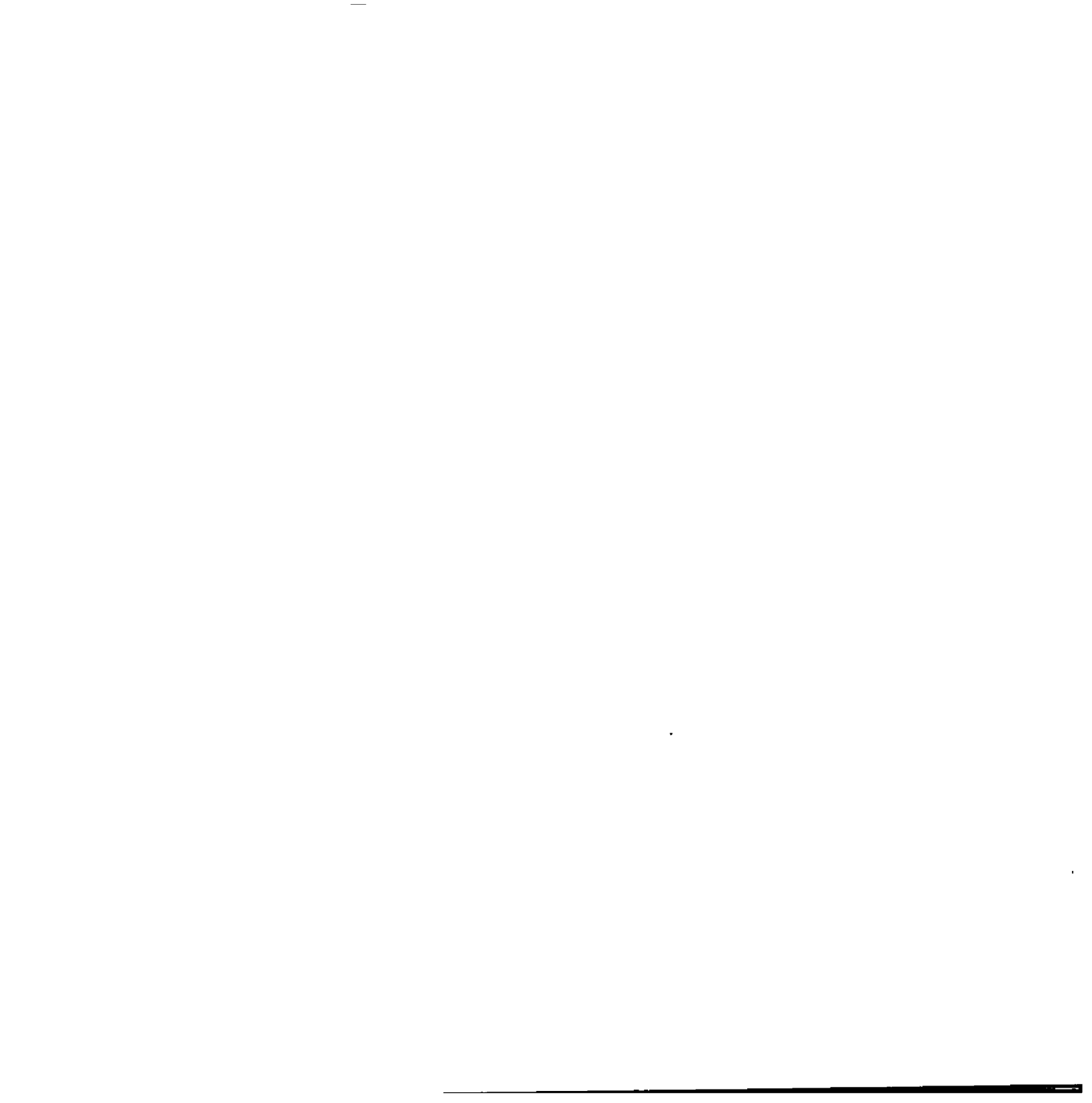
March 15, 2012

**Congressional Research Service**

7-5700

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RS77842



## Summary

States are able to use revenues from health care provider taxes to help finance the state share of Medicaid expenditures. Federal statute and regulations define a provider tax as a health care-related fee, assessment, or other mandatory payment for which at least 85% of the burden of the tax revenue falls on health care providers. In order for states to be able to draw down federal Medicaid matching funds, the provider tax must be both broad-based (i.e., imposed on all providers within a specified class of providers) and uniform (i.e., the same tax for all providers within a specified class of providers). Also, states are not allowed to hold the providers harmless for the cost of the provider tax (i.e., they can not guarantee that providers receive their money back).

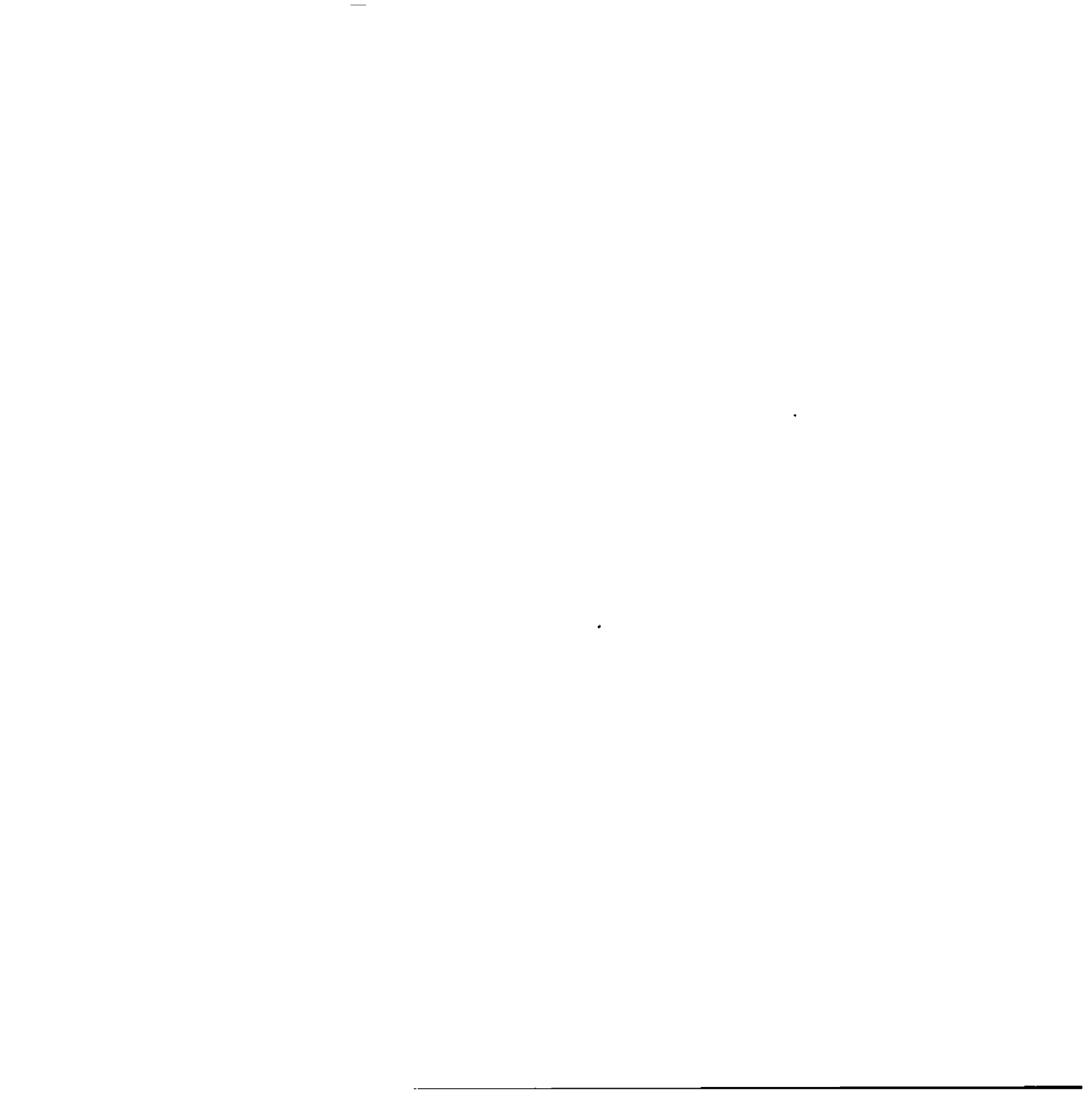
A vast majority of states use at least one provider tax to help finance Medicaid. Many of these states use the provider tax revenue to increase Medicaid payment rates for the class of providers, such as hospitals, responsible for paying the provider tax. This financing strategy allows states to fund increases to Medicaid payment rates without the use of state funds because the increased Medicaid payment rates are funded with provider tax revenue and federal Medicaid matching funds. States also use provider tax revenues to fund other Medicaid or non-Medicaid purposes.

States first began using health care provider taxes to help finance the state's share of Medicaid expenditures in the mid-1980s. Some states were particularly aggressive in their use of provider taxes. As a result, in the early 1990s, the federal government imposed statutory and regulatory limitations on states' use of health care provider tax revenue to finance Medicaid.

While federal requirements allow states to impose provider taxes on 19 classes of health care providers, the classes of providers that are most often taxed include nursing facilities, hospitals, intermediate care facilities for individuals with mental retardation or developmental disabilities (ICF-MR/DD), and managed care organizations. During the most recent recession, a number of states took action to generate additional provider tax revenue, and these actions mainly involved hospital and nursing facility taxes.

Even with the statutory and regulatory limitations, provider taxes continue to cause tension between the federal government and the states. As a result, some deficit reduction proposals include a recommendation to limit states' ability to use provider taxes to finance the state share of Medicaid expenditures. This limitation would decrease federal Medicaid payments to states.

This report provides background regarding states' use of provider taxes in the 1980s and describes the relevant federal statutes and regulations, which were mostly established in the early 1990s. The report explains how states use provider taxes to help finance Medicaid and provides information regarding the extent to which states currently use such taxes. The report ends with a discussion of the provider tax provisions in various deficit reduction proposals.



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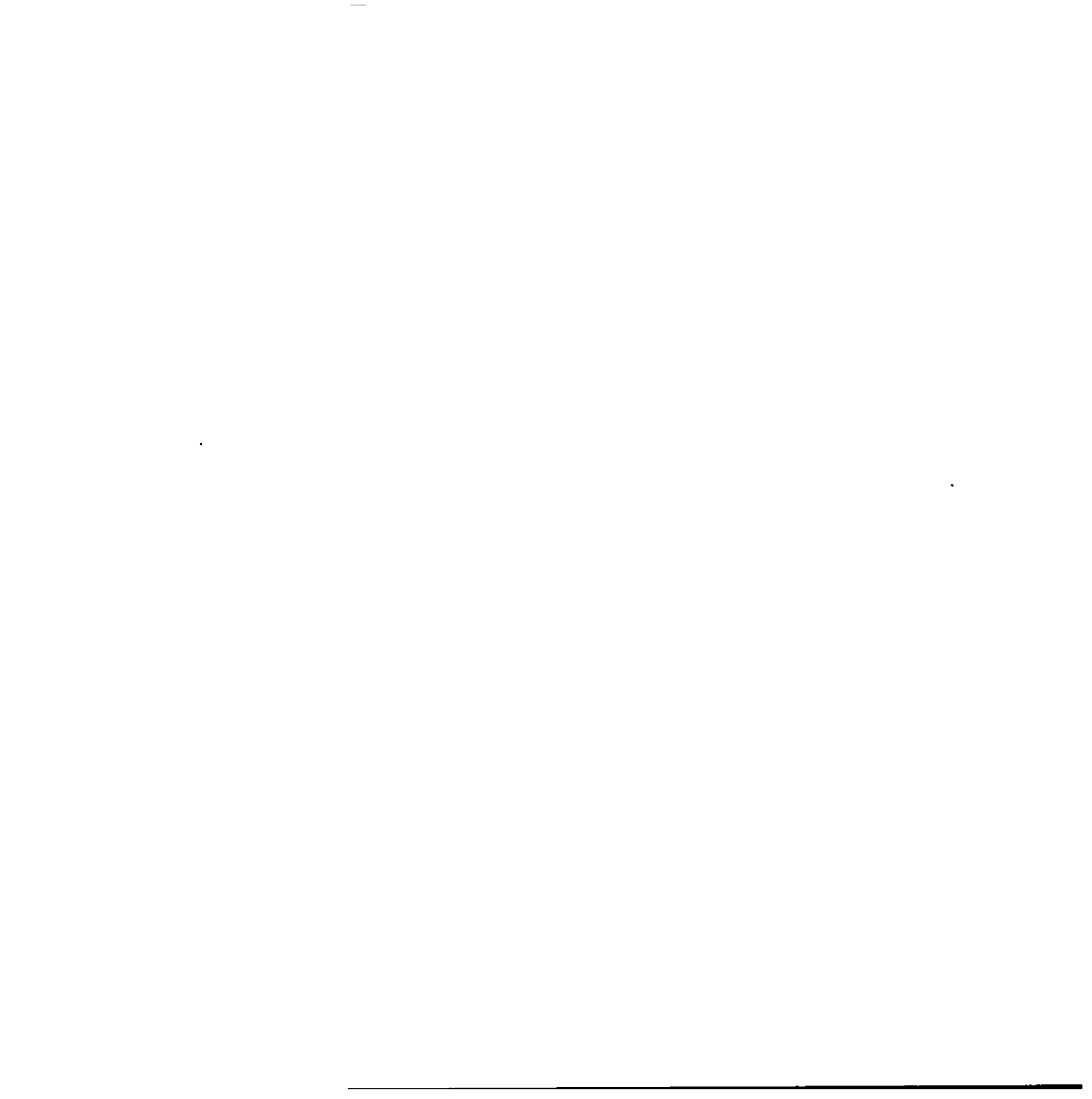
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# Introduction

Medicaid is a means-tested entitlement program that finances the delivery of primary and acute medical services as well as long-term care.<sup>1</sup> Participation in Medicaid is voluntary for states, though all states, the District of Columbia, and five territories choose to participate. Each state designs and administers its own version of Medicaid under broad federal rules, and Medicaid is jointly financed by the federal government and the states.

States incur Medicaid costs by making payments to service providers (e.g., for beneficiaries' doctor visits) and performing administrative activities (e.g., making eligibility determinations), and the federal government reimburses states for a share of these costs.<sup>2</sup> The federal government's share of a state's expenditures for most Medicaid services is called the federal medical assistance percentage (FMAP).<sup>3</sup> The FMAP varies by state according to each state's per capita income. For FY2012, FMAPs range from 50% to 74%, with the federal contribution covering about 57% of the total cost of Medicaid in a typical year.

The state share of Medicaid expenditures is funded through a variety of sources. At least 40% of each state's share of Medicaid expenditures must be financed by the state, and up to 60% of the state's share may come from local governments.<sup>4</sup> In state fiscal year (SFY) 2009, states reported that about 78% of the state share of Medicaid costs was financed by state general funds (most of which are raised from personal income, sales, and corporate income taxes). The remaining 22% was financed by other funds (including local government funds, provider taxes, fees, donations, assessments, and tobacco settlement funds).<sup>5</sup>

Currently, many states use provider taxes to finance a portion of their state share of Medicaid expenditures. Federal statute and regulations define a provider tax as a health care-related fee, assessment, or other mandatory payment for which at least 85% of the burden of the tax revenue falls on health care providers.<sup>6</sup> In order for states to be able to draw down federal Medicaid matching funds, the provider tax must be both broad-based (i.e., imposed on all providers within a specified class of providers) and uniform (i.e., the same tax for all providers within a specified class of providers). States are not allowed to hold the providers harmless for the cost of the provider tax (i.e., they cannot guarantee that providers receive their money back).<sup>7</sup> In addition, provider tax revenue is prohibited from exceeding 25% of the state share of Medicaid expenditures.<sup>8</sup>

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<sup>1</sup> For more information about the Medicaid program, see CRS Report RL33202, *Medicaid. A Primer*, by Elicia J. Herz.

<sup>2</sup> For a broader overview of financing issues, see out-of-print CRS Report RS22849, *Medicaid Financing*, by April Grady.

<sup>3</sup> For more information about the FMAP, see CRS Report RL32950, *Medicaid: The Federal Medical Assistance Percentage (FMAP)*, by Alison Mitchell and Evelyne P. Baumrucker.

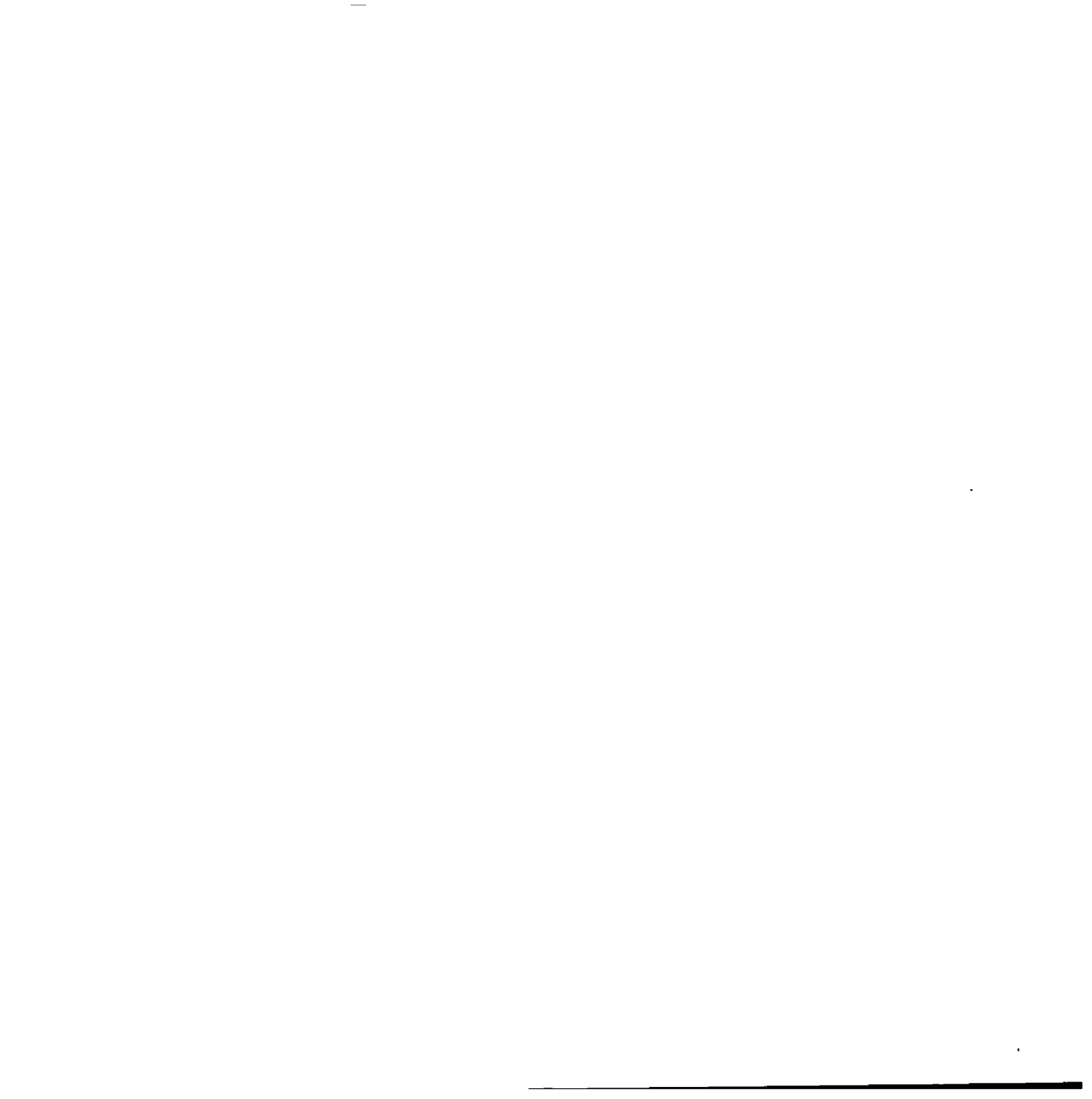
<sup>4</sup> Section 1902(a)(2) of the Social Security Act.

<sup>5</sup> National Association of State Budget Officers, *2009 State Expenditure Report*, December 2010.

<sup>6</sup> Section 1903(w)(3)(A) of the Social Security Act. 42 C.F.R. 433.55.

<sup>7</sup> Section 1903(w)(3) of the Social Security Act. 42 C.F.R. 433.68. These requirements are explained in more detail in the "Federal Statutes and Regulations" section below.

<sup>8</sup> Section 1903(w)(5)(A).



States are able to use revenues from provider taxes to help finance the state share of Medicaid expenditures when certain conditions are met. In FY2012, a vast majority of states and the District of Columbia are using at least one provider tax to finance Medicaid. Many of these states use the provider tax revenue to increase Medicaid payment rates for the class of providers, such as hospitals, responsible for paying the provider tax. This financing strategy allows states to fund increases to Medicaid payment rates without the use of state funds because the increased Medicaid payment rates are funded with provider tax revenue and federal Medicaid matching funds. States also use provider tax revenue to fund other Medicaid or non-Medicaid purposes.

This report provides background regarding states' use of provider taxes in the 1980s and describes the relevant federal statutes and regulations, which were mostly established in the early 1990s. The report explains how states use provider taxes to help finance Medicaid and provides information regarding the extent to which state's currently use such taxes. The report ends with a discussion of the provider tax provisions in various deficit reduction proposals.

## States' Initial Use of Provider Taxes in the 1980s

In the mid-1980s, states began using provider taxes along with provider donations<sup>9</sup> to help finance Medicaid. Essentially, Medicaid providers would donate funds or agree to be taxed, and the revenue from these taxes and donations would be used to finance a portion of the state's share of Medicaid expenditures. In some cases, Medicaid providers initiated these provider tax and donation arrangements because states would often use the provider tax and donation revenue to raise Medicaid payment rates. Plus, these arrangements were often designed in such a way as to hold the Medicaid providers harmless for the cost of their taxes or donations.<sup>10</sup>

Here is an example of how the provider tax arrangements operated in the 1980s. In a state, hospitals with high Medicaid utilization could agree to pay \$10 million in provider taxes, and the state would increase Medicaid reimbursement rates for hospitals with high Medicaid utilization by \$20 million. Assuming the state had a 60% FMAP, the state would then receive \$12 million in federal Medicaid matching funds (60% of \$20 million). In the end, hospitals with high Medicaid utilization would have gained \$10 million (\$20 million in increased Medicaid rates minus \$10 million in tax payments), the state would have gained \$2 million (\$22 million from the hospitals and the federal government minus the \$20 million paid to the hospitals), and the federal government would have paid \$12 million.<sup>11</sup>

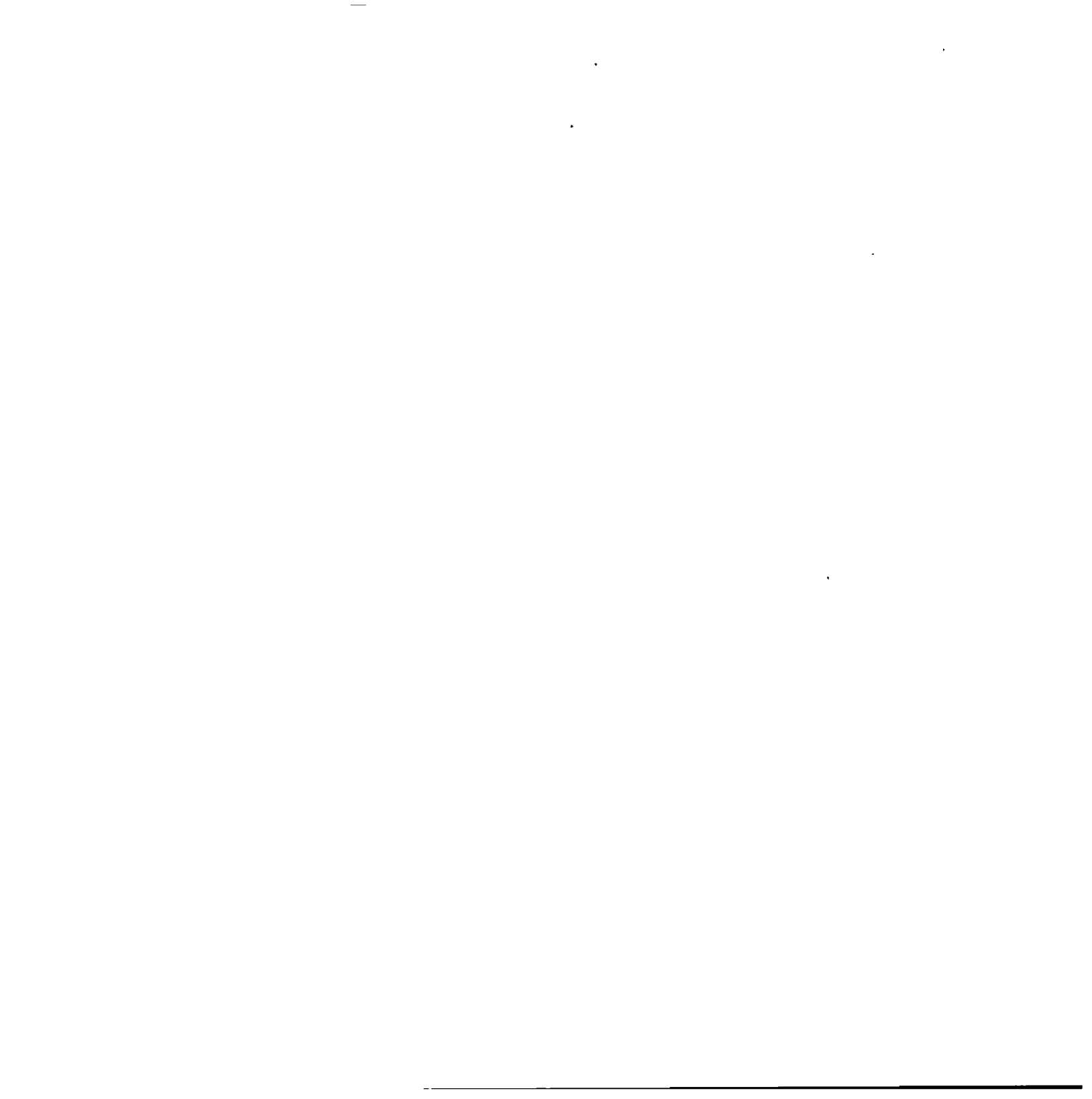
Essentially, states were borrowing funds from Medicaid providers in order to draw down federal funds and increase Medicaid payment rates to the providers that had paid taxes or donated funds. The providers were often fully reimbursed for the cost of their tax payment or donation. For this reason, provider tax mechanisms were politically viable for states.

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<sup>9</sup> Provider donations are any donation or other voluntary payment made to a state or unit of local government by a health care provider. Section 1903(w)(2) of the Social Security Act.

<sup>10</sup> Andy Schneider, Risa Elias, Rachel Garfield, David Rousseau, and Victoria Wachino, *The Medicaid Resource Book*, Kaiser Commission on Medicaid and the Uninsured, July 2002.

<sup>11</sup> In this example, the provider tax arrangement allowed for hospitals with high Medicaid utilization to receive increased Medicaid payment rates. Without the provider tax arrangement, the Medicaid payment rates to hospitals with high Medicaid utilization would have been less.



These financing arrangements became a point of contention between the federal government and the states. While not all states were using these Medicaid financing strategies, some states were particularly aggressive in their use of provider taxes and donations in financing Medicaid. This aggressive use of these Medicaid financing strategies motivated congressional action to curb states' use of the provider tax and donation arrangements.

## Federal Statutes and Regulations

In 1991, Congress passed the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments (P.L. 102-234) to restrict the use of provider donations in financing Medicaid to extremely limited situations<sup>12</sup> and to limit states' ability to draw down federal Medicaid matching funds with provider tax revenue.<sup>13</sup>

The 1991 law defines a provider tax as any licensing fee, assessment, or other mandatory payment in which 85% or more of the burden falls upon health care providers. In order for states to claim federal matching payments for provider tax revenues, the 1991 law

- requires provider taxes to be broad-based (i.e., imposed on all providers within a specified class of providers) and uniform (i.e., the same tax for all providers within a specified class of providers)—in other words, states cannot limit the provider taxes to only Medicaid providers;
- prohibits taxes that exceed 25% of the state (or non-federal) share of Medicaid expenditures; and
- prohibits states from a direct or indirect guarantee that providers receive their money back (or be “held harmless”).

The Secretary of Health and Human Services (HHS) is authorized to waive the broad-based and uniform requirements of provider taxes. In order to waive either the broad-based or uniform requirement, a state needs to prove that the net impact of the tax is “generally redistributive” and the amount of the tax is not directly correlated to Medicaid payments.<sup>14</sup>

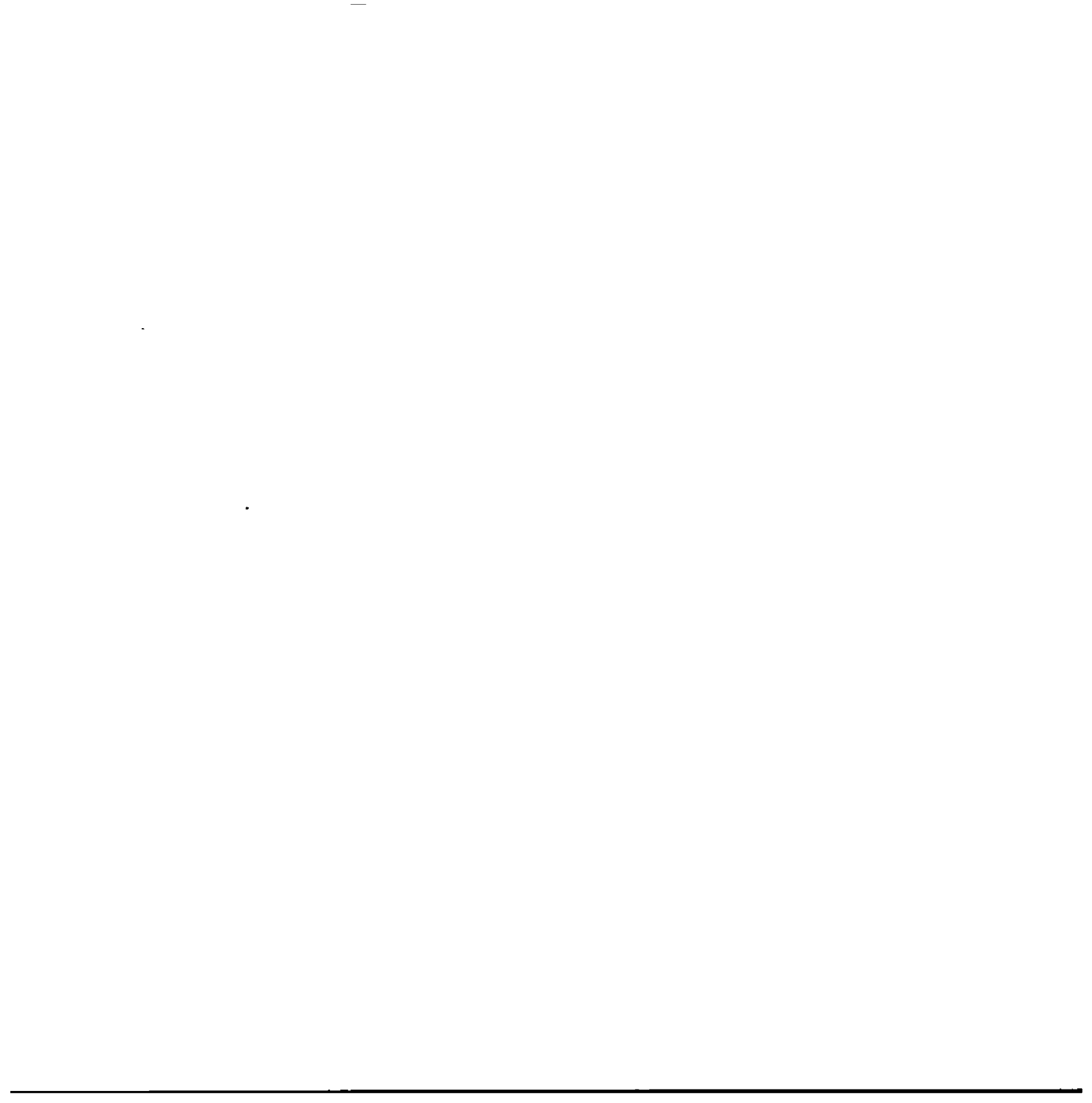
“Generally redistributive” is defined as the tendency of a state’s provider tax to derive revenues from non-Medicaid services in a class and to use these revenues as the state’s share of Medicaid expenditures. According to the quantitative tests set forth in regulation, a provider tax is perfectly redistributive if the tax burden for Medicaid providers is the same under a tax without the waiver

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<sup>12</sup> Provider donations are permissible if they do not exceed \$5,000 per year in the case of an individual provider or \$50,000 per year in the case of a “health care organization entity” (42 C.F.R. 433.66(a)(1)). Also, provider donations are allowed if the donations are made by a hospital, clinic, or similar entity (such as federally qualified health centers) for the direct costs of state or local agency personnel who are stationed at the facility to determine the eligibility of individuals for Medicaid or to provide outreach services to eligible (or potentially eligible) Medicaid individuals (i.e., outstationed eligibility workers) (42 C.F.R. 433.66(a)(2)). Provider donations for outstationed eligibility workers may not exceed 10% of a state’s administrative costs for the Medicaid program (42 C.F.R. 433.67).

<sup>13</sup> The statute regarding provider taxes can be found in Section 1903(w) of the Social Security Act, and the accompanying regulations can be found at 42 C.F.R. Part 433.

<sup>14</sup> Rural and sole community providers are expressly cited as allowable exemptions to both the broad-based and uniform requirements with Secretary approval.



as under the tax with the waiver. The redistributive nature of a provider tax increases as the tax burden falls more heavily on providers with relatively fewer Medicaid patients.<sup>15</sup>

## Classes of Providers

The specified 19 classes of providers used to ensure that tax programs are “broad-based” are those that provide the following:<sup>16</sup>

- inpatient hospital services,
- outpatient hospital services,
- nursing facility services,
- services of intermediate care facilities for the mentally retarded,
- physicians' services,
- home health care services,
- outpatient prescription drugs,
- services of Medicaid managed care organizations (including health maintenance organizations, preferred provider organizations, and such other similar organizations as the Secretary may specify by regulation),<sup>17</sup>
- ambulatory surgical centers,
- dental services,
- podiatric services,
- chiropractic services,
- optometric/optician services,
- psychological services,
- therapist services,<sup>18</sup>
- nursing services,<sup>19</sup>
- laboratory and X-ray services,<sup>20</sup>

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<sup>15</sup> Health Care Financing Administration, “Medicaid Program; Limitations on Provider-Related Donations and Health-Care Related Taxes; Limitations on Payments to Disproportionate Share Hospitals,” *57 Federal Register* 55118, November 24, 1992.

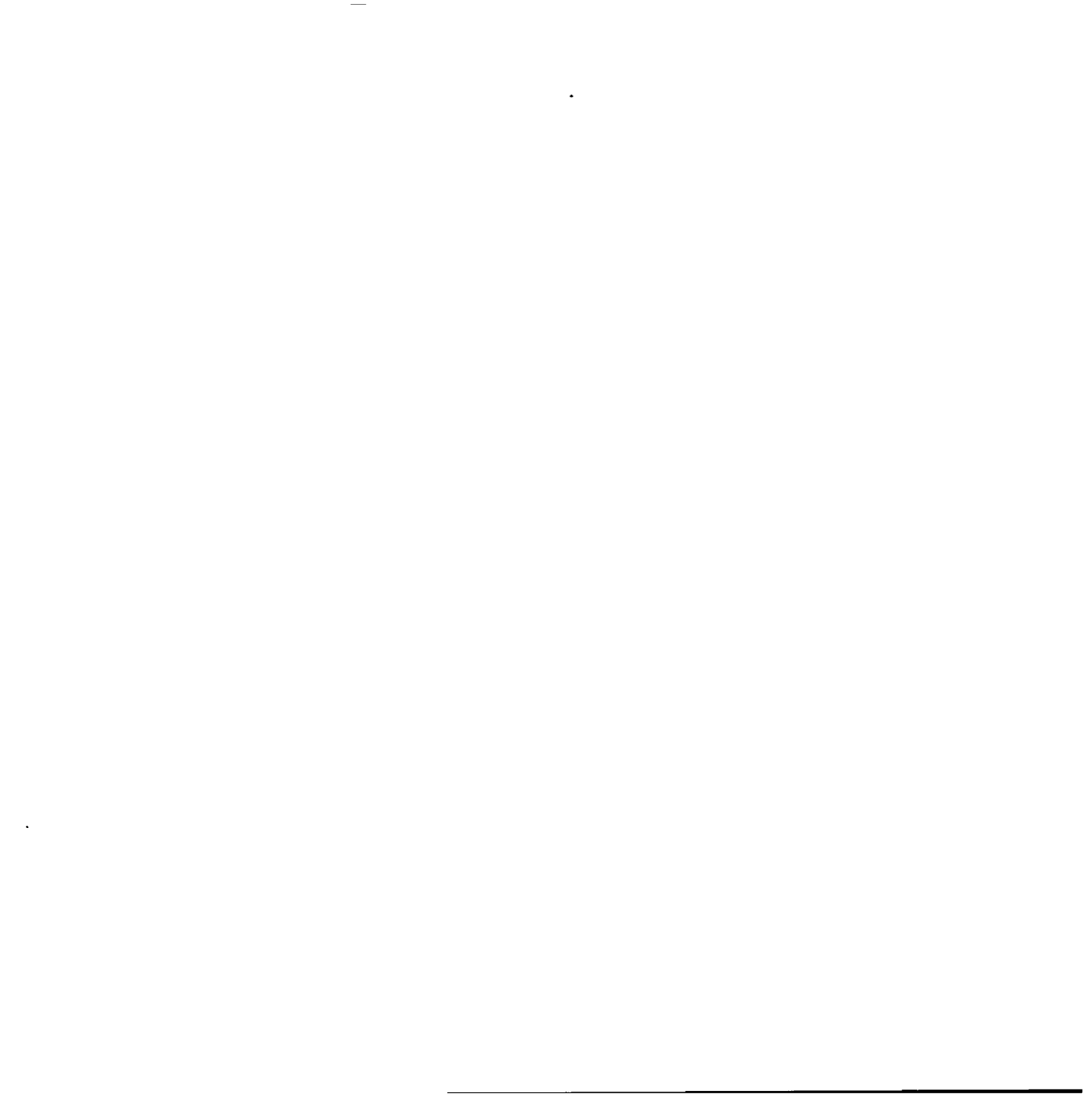
<sup>16</sup> 42 C.F.R. 433.56.

<sup>17</sup> The Deficit Reduction Act of 2005 (DRA, P.L. 109-171) modified this class of providers by changing “Medicaid managed care organizations” to all “managed care organizations.” This change further broadened the group upon which a tax could be imposed, thereby reducing the potential for abusive tax programs.

<sup>18</sup> Therapist services include physical therapy, speech therapy, occupational therapy, respiratory therapy, audiological therapy, and rehabilitative specialist services.

<sup>19</sup> Nursing services include nurse midwives, nurse practitioners, and private duty nurses.

<sup>20</sup> Laboratory and X-ray services are defined as services provided in a licensed, free-standing laboratory or X-ray facility. The definition does not include laboratory or X-ray services provided in a physician's office, hospital inpatient department, or hospital outpatient department.



- other health care items or services for which the state has enacted a licensing or certification fee.<sup>21</sup>

Requiring that all providers within a class be taxed, as opposed to only Medicaid providers, dampened the appeal of provider taxes. Prior to the 1991 law, provider taxes were often imposed only on Medicaid providers. These provider tax arrangements were agreed to (and sometimes initiated) by the Medicaid providers because the Medicaid providers could be held harmless from the cost of the tax through increased Medicaid payment rates. However, because non-Medicaid providers cannot be as easily held harmless from the cost of the tax, the broad-based requirement restricted the use of provider taxes because the non-Medicaid providers are more likely to oppose the imposition of provider taxes.

## Hold Harmless

Regulations describe three tests that are applied to provider taxes in order to determine whether taxpayers are held harmless. Taxes that fail any of these tests are determined to have a hold harmless provision in violation of the law. The three tests are as follows:

- A *positive correlation test* is used to determine whether a state or other unit of government imposing the tax provides directly or indirectly for a non-Medicaid payment to the taxpayers in an amount that is positively correlated to either the tax amount or the difference between their Medicaid payment and the tax amount.<sup>22</sup>
- The *Medicaid payment test* is violated if all or any portion of the Medicaid payment to the taxpayer varies based *only* on the amount of the total tax payments.
- The *guarantee test* is violated if the state or other unit of government imposing the tax provides directly or indirectly for any payment, offset, or waiver that guarantees to hold taxpayers harmless for all or a portion of the tax.

Under the guarantee test, the existence of an indirect guarantee is determined through a two-prong test. The first prong of the guarantee test relates to the rate at which taxpayers are taxed. That is, if the provider tax is applied at a rate less than 6%<sup>23</sup> of the net patient service revenues received by the taxpayer, the tax is permissible under the guarantee test.<sup>24</sup>

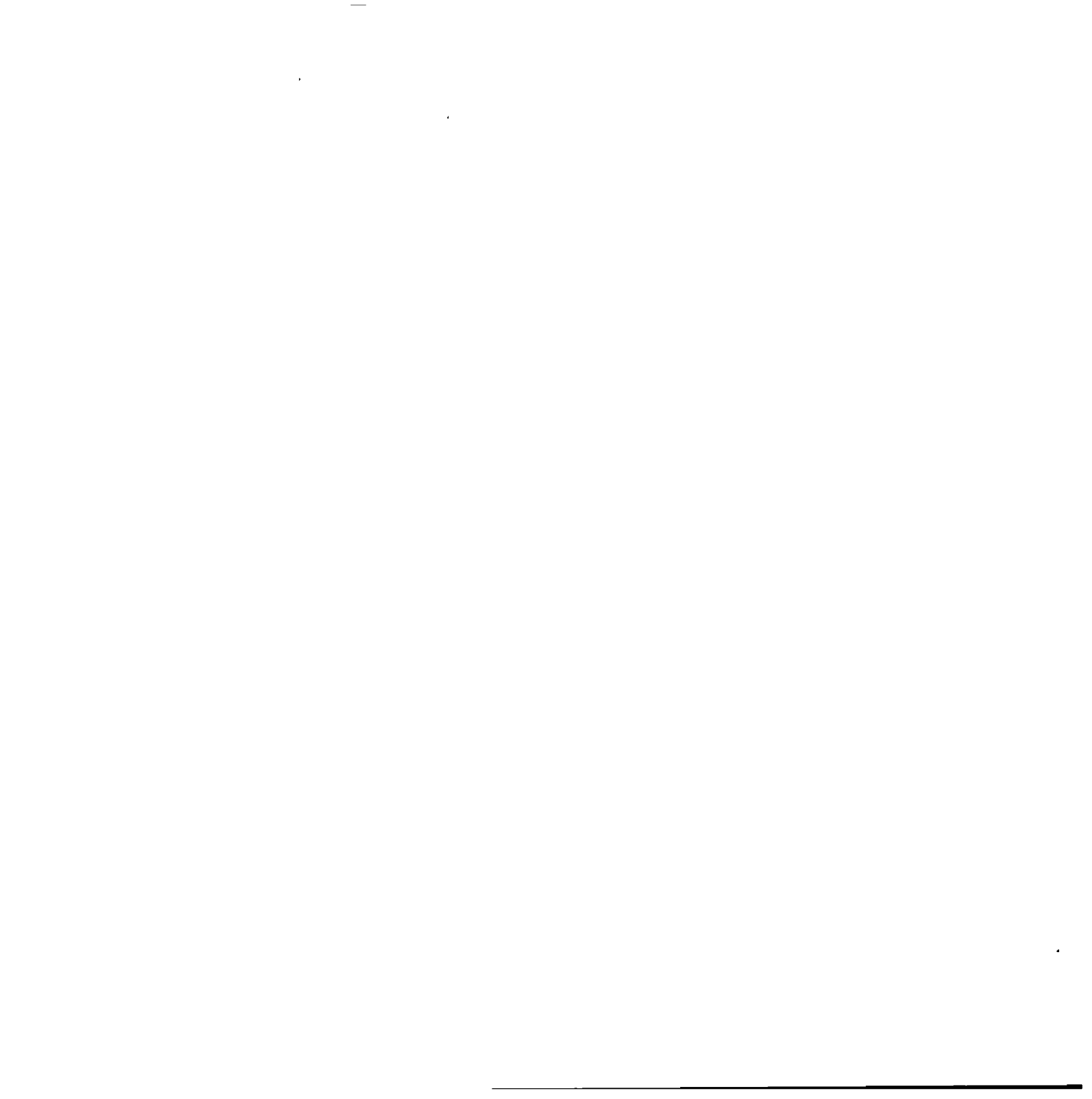
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<sup>21</sup> The licensing or certification fee must be broad-based and uniform. In addition, the payer of the fee cannot be held harmless for the cost of the fee. Also, the aggregate amount of the fee cannot exceed the state's estimated cost of operating the licensing or certification program

<sup>22</sup> An example of a violation of the positive correlation would be if a state gave a portion of the tax revenue to private pay patients in the form of grants in order to compensate the patients for the tax added to their bill from the provider.

<sup>23</sup> For the period of January 1, 2008, through September 30, 2011, the Tax Relief and Health Care Act of 2006 (P.L. 109-432) changed the threshold to 5.5% of net patient service revenues. On October 1, 2011, the threshold reverted to 6% of net patient service revenues

<sup>24</sup> 42 C.F.R. 433.68(f)(3)(i)(A). Some interpret this provision as a waiver of the hold harmless tests when the tax is applied at a rate below the 6% threshold. For this reason, the threshold has been referred to as a "safe harbor."



imposed at a rate greater than the threshold amount specified in the first prong of the guarantee test (currently 6%). When the provider tax produces revenue in excess of the threshold amount, the tax is considered to hold the taxpayers harmless (i.e., violate the hold harmless test) if more than 75% of the taxpayers in the provider class receive 75% or more of the cost of the tax back through enhanced Medicaid payments or other state payments.<sup>25</sup>

In other words, a state can impose a provider tax above the threshold amount (currently 6%) and draw down federal matching funds on the tax revenue, as long as the state can prove that the "75/75 rule" has not been violated (i.e., more than 75% of the taxpaying providers do *not* receive more than 75% of the cost of the tax back through enhanced Medicaid rates).

If a state imposes a provider tax above the threshold amount and violates the "75/75 rule" (i.e., more than 75% of the taxpaying providers receive more than 75% of the cost of the tax back through enhanced Medicaid rates), then the full amount of the tax revenue would be offset from the state's Medicaid expenditures. This means the provider tax revenue could still be used to fund Medicaid, but the state would not be able to draw down federal Medicaid matching funds on the provider tax revenue. Specifically, the revenue from provider taxes that do not meet federal requirements would be deducted from the state's Medicaid expenditures prior to the calculation of the federal financial participation.<sup>26</sup>

To date, no state has imposed a provider tax at a rate above the threshold amount specified in the first prong of the guarantee test.

## States' Current Use of Provider Taxes

States' use of provider tax revenue varies from state to state, but states often use provider tax revenue to draw down federal Medicaid matching funds in order to increase Medicaid payment rates for the same providers that are responsible for paying the tax.<sup>27</sup> A simple example of this is illustrated in Figure 1. In this example, a state with a 60% FMAP imposes a provider tax on all nursing homes in the state, and the state collects \$10 million in tax revenue through this provider tax. The state then increases Medicaid reimbursement rates to nursing homes, which means nursing homes with Medicaid enrollees receive an additional \$8 million. With these Medicaid expenditures, the state draws down \$4.8 million (60% of \$8 million) in federal Medicaid matching funds. In this example, the state was able to increase Medicaid payment rates to nursing homes without the use of any state general funds, and the state is left with \$6.8 million to use for other Medicaid or non-Medicaid purposes.<sup>28</sup>

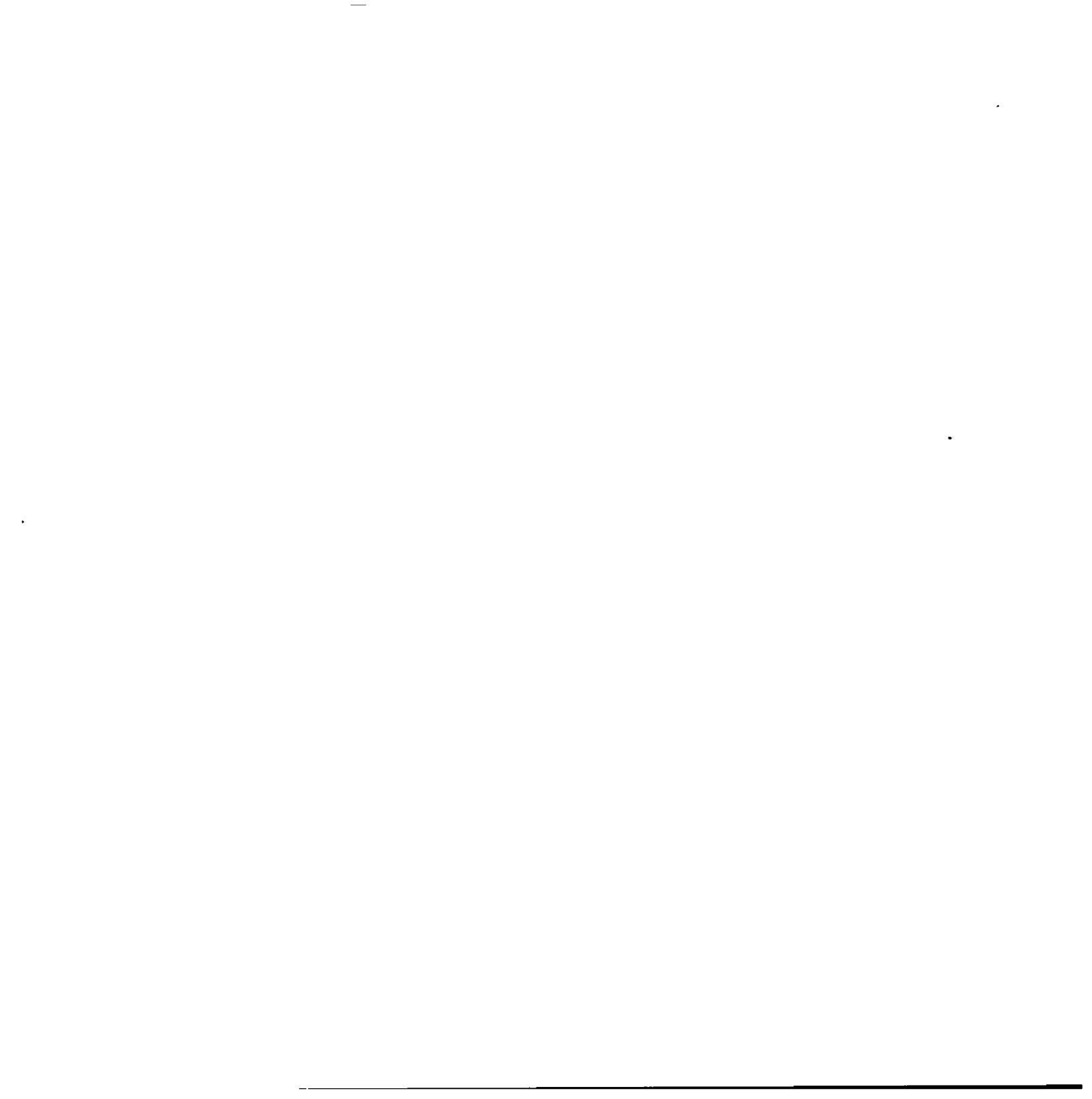
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<sup>25</sup> 42 C.F.R. 433.68(f)(3)(i)(B)

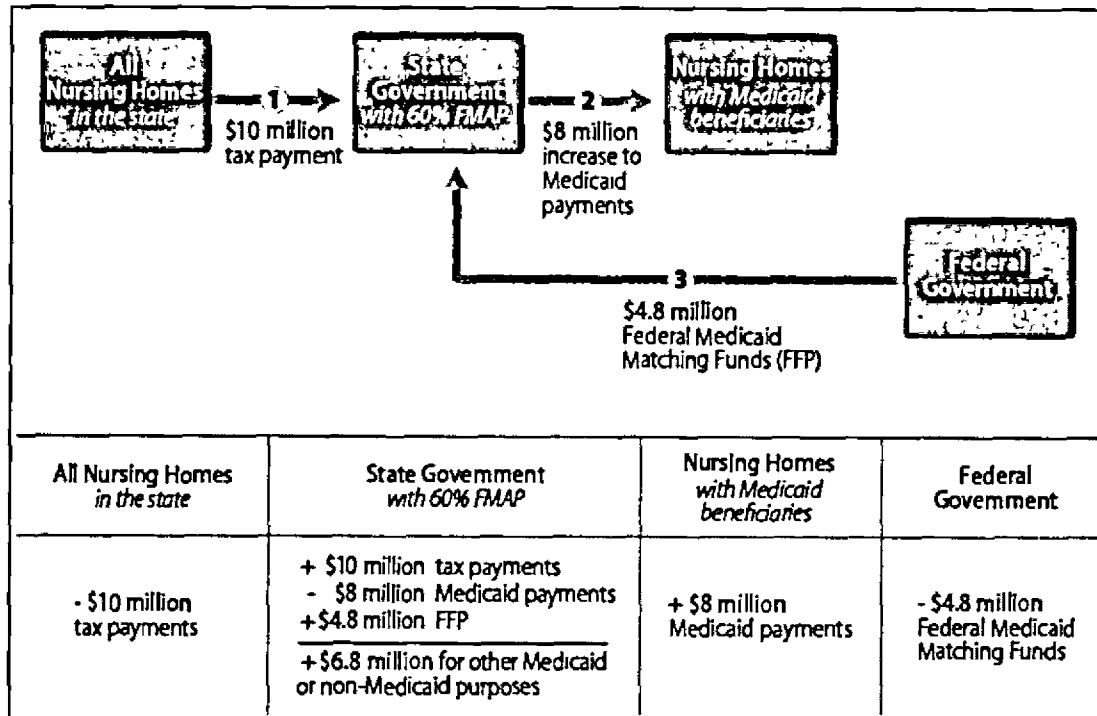
<sup>26</sup> 42 C.F.R. 433.70.

<sup>27</sup> Congressional Budget Office, *Budget Options Volume I: Health Care*, December 2008.

<sup>28</sup> In this example, the provider tax arrangement allowed for nursing homes to receive increased Medicaid payment rates. Without the provider tax arrangement, the Medicaid payment rates to nursing homes would have been less



## Using Nursing Home Provider Tax Revenue to Increase Medicaid Reimbursement Rates to Nursing Homes



Source: Teresa A. Coughlin and Stephen Zuckerman, *States' Use of Medicaid Maximization Strategies to Top Federal Revenues: Program Implications and*, Urban Institute, June 2002. Based on Figure 1.

A vast majority of states use at least one provider tax to help finance Medicaid. While federal requirements allow states to impose taxes on 19 classes of providers, the classes of providers that are most often taxed include nursing facilities, hospitals, intermediate care facilities for individuals with mental retardation or developmental disabilities (ICF-MR/DD), and managed care organizations. Details regarding the types of provider taxes used by each state is provided in **Table A-1** of the Appendix.

### Provider Tax Revenue

The full amount of provider tax revenues used by states to help finance the state share of Medicaid expenditures is unknown. The Center for Medicare & Medicaid Services (CMS) collects some information from states regarding the amount of provider tax revenue through data included on the CMS-64 form,<sup>29</sup> but this information is underreported. The National Association of State Budget Officers (NASBO) augments the information collected by CMS, but the NASBO information is also incomplete.

<sup>29</sup> States submit the CMS-64 form to CMS on a quarterly basis, and the CMS-64 form is a statement of expenditures for which states are entitled to federal Medicaid matching funds. States are required to provide supporting documentation for total Medicaid expenditures. The provider tax information is reported in section CMS-64.11A of the form, and the provider tax information is provided to CMS for informational rather than reimbursement purposes.



Information on the CMS-64 form collects information regarding the provider donations, taxes, fees, and assessments collected by states. While states are required to provide this information to CMS for informational purposes, states report this information inconsistently, and the provider tax information is likely underreported. For example, in FY2010, 13 states did not report any provider tax revenue on the CMS-64 form, even though 45 states and the District of Columbia reported having at least one provider tax during that period of time.<sup>30</sup>

NASBO publishes an annual state expenditures report<sup>31</sup> that provides information regarding the state and federal shares of Medicaid expenditures. The report specifies the sources of the states' share of Medicaid expenditures as either state general funds or "other state funds," which are revenues collected by the state that are restricted by law for particular governmental functions or activities. Provider taxes comprise a significant portion of "other state funds," while tobacco tax revenue, donations, and local funds are also common sources of "other state funds."

The primary source for NASBO's "other state funds" information is the CMS-64 expenditure data, but NASBO augments this data. Specifically, NASBO collects detailed information from some states regarding the amount of provider taxes, fees, donations, assessments, and local funds used to finance the state share of Medicaid expenditures. However, NASBO acknowledges that its State Expenditure Report does not capture 100% of the provider taxes, fees, assessments, and local funds used to finance the state share of Medicaid expenditures.

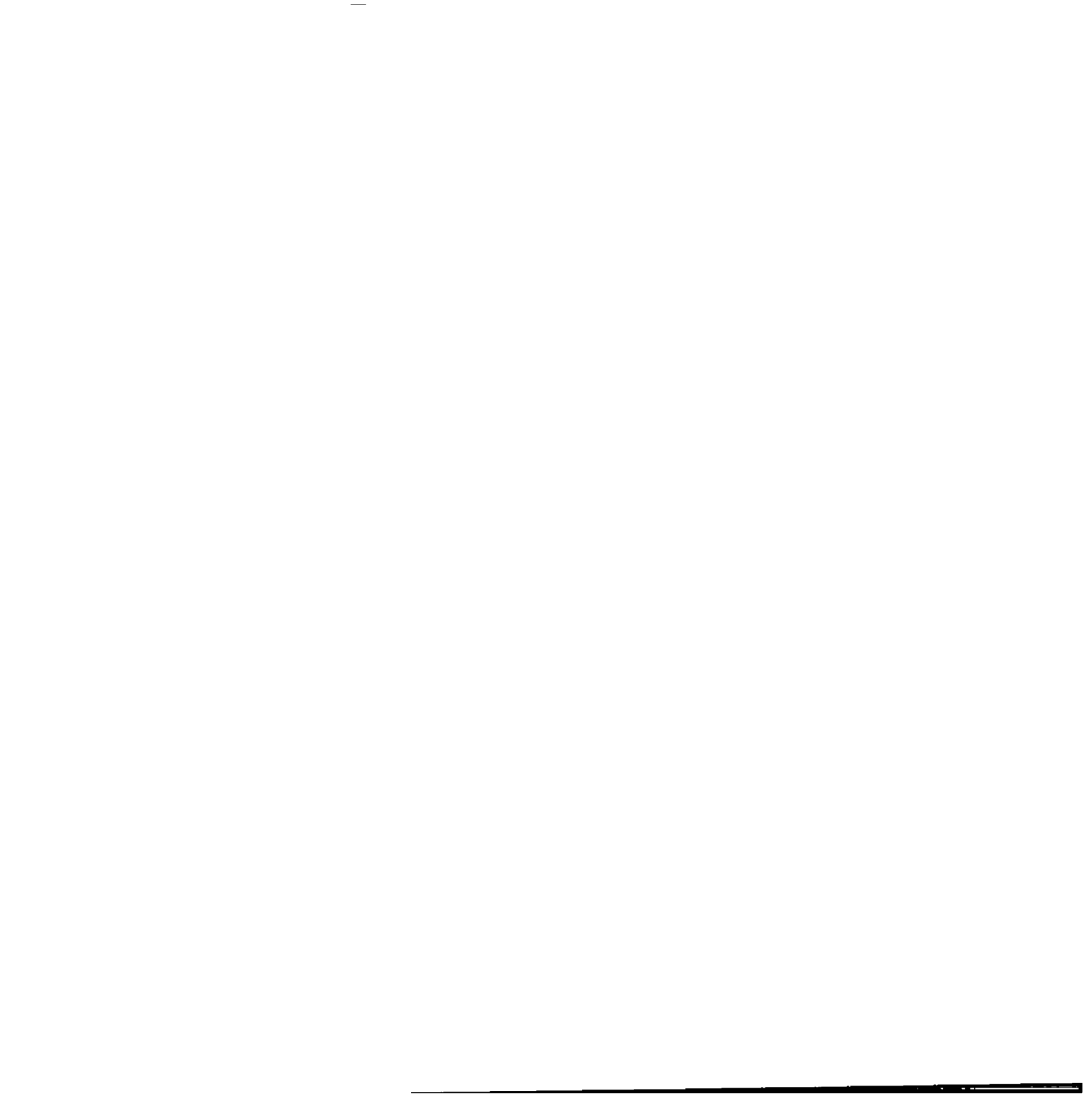
The available data (shown in Figure 2), while limited, indicate a trend showing that states' use of "other state funds" has increased significantly as a percent of the state share of Medicaid expenditures since SFY 1990. Also, during the most recent recession, the data indicate that states' use of "other state funds" increased from 20% to almost 26% of the state share.<sup>32</sup>

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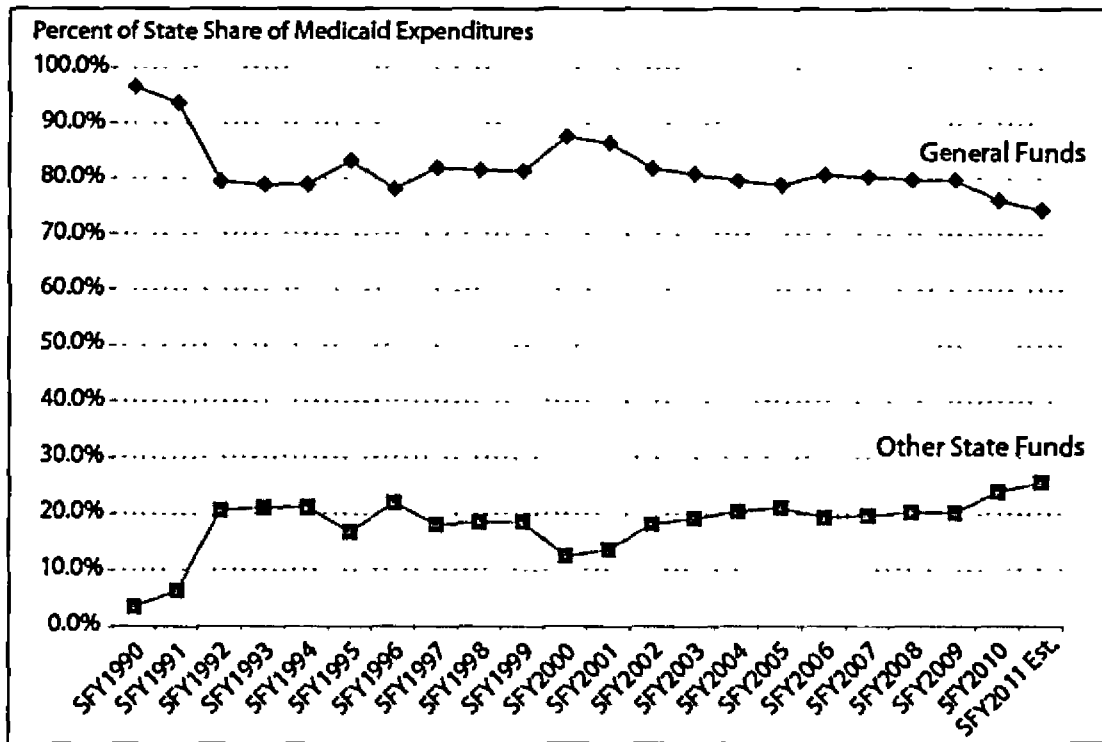
<sup>30</sup> Vernon K. Smith, Kathleen Gifford, Eileen Ellis, et al., *Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2010 and 2011*, Kaiser Commission on Medicaid and the Uninsured, September 2010.

<sup>31</sup> National Association of State Budget Officers, *State Expenditure Report: Examining Fiscal Year 2009-2011*, December 2011.

<sup>32</sup> *Ibid.*



**Figure 3: General Funds and Other State Funds  
as a Percentage of the State Share of Medicaid Expenditures  
(SFY1990 to SFY2011 estimate)**



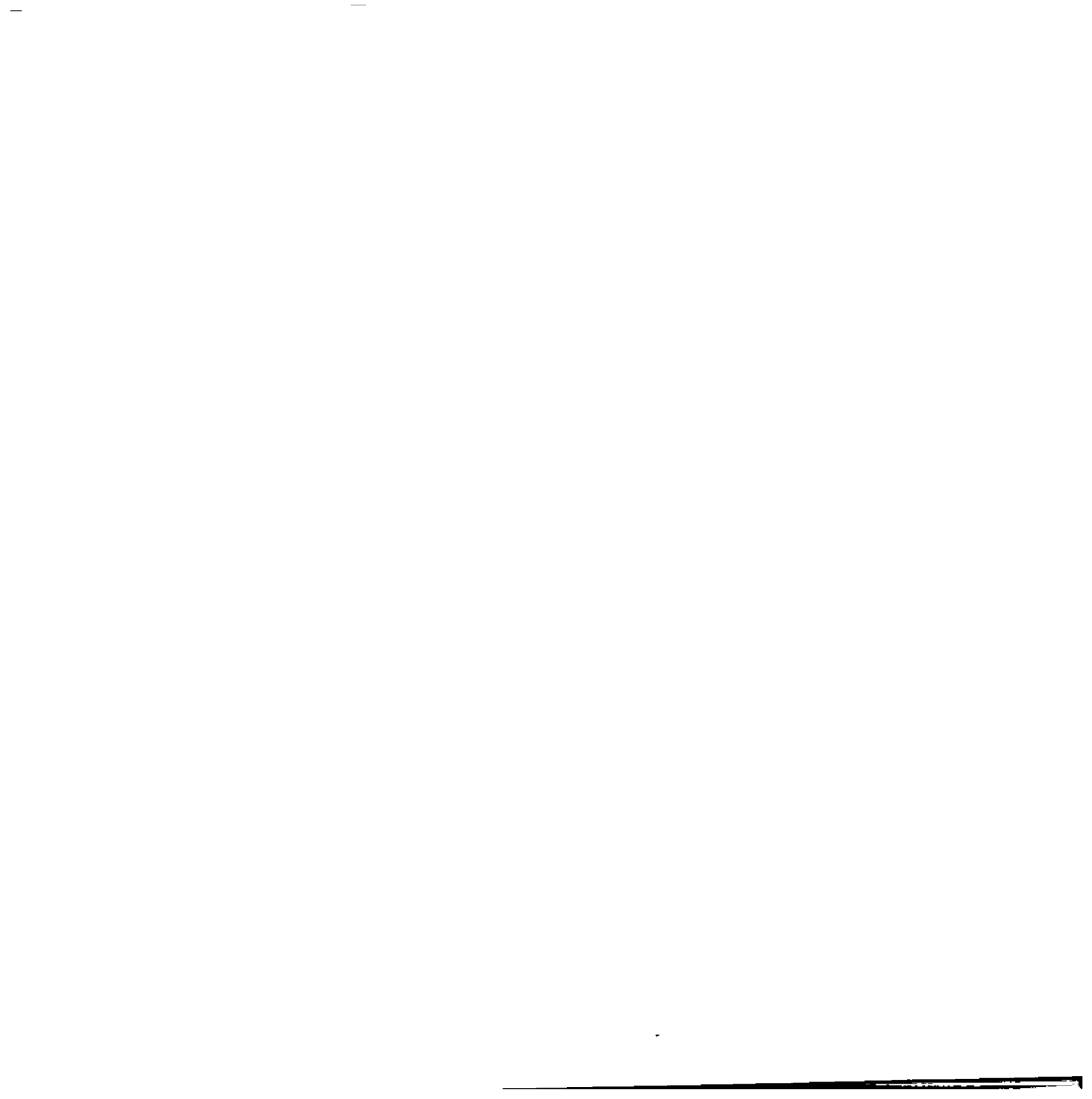
Source: National Association of State Budget Officers, *State Expenditure Report*.

Note: SFY = state fiscal year.

## During Economic Downturns

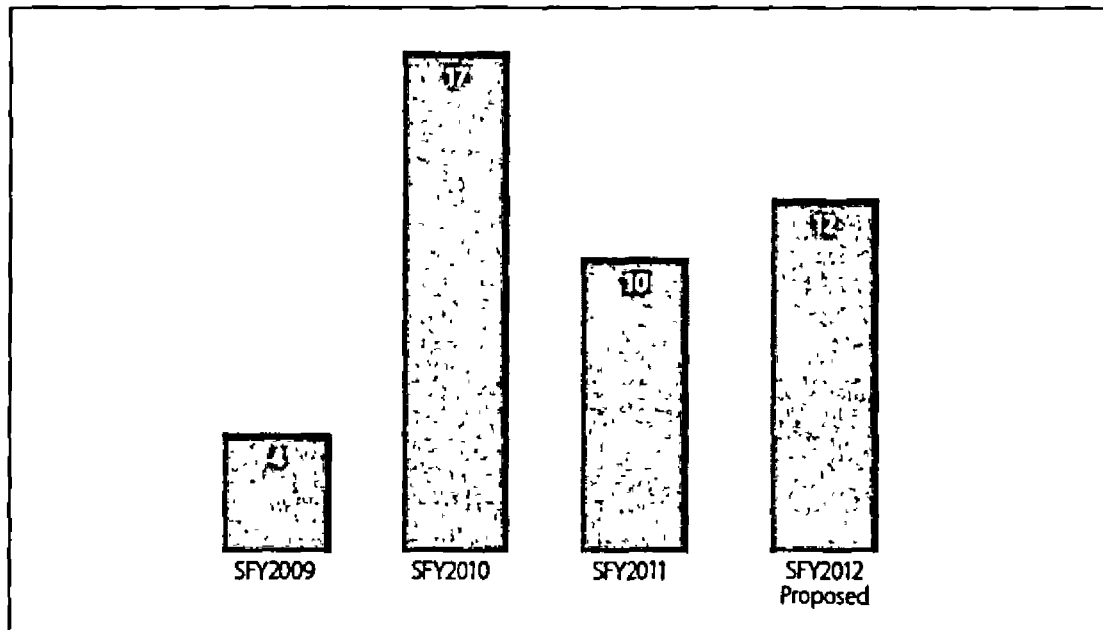
Because all states (except Vermont) have balanced budget requirements, funding Medicaid expenditure growth during economic downturns can be challenging. Medicaid spending is countercyclical, which means Medicaid enrollment expands and expenditures grow when the economy is weak. At the same time, states' tax collection ability can be strained, making it more difficult for states to maintain funding for all state programs. For these reasons, states are more likely to impose or increase provider taxes during economic downturns in order to generate additional revenue to finance Medicaid.

For example, during the most recent recession (December 2007 to June 2009), a number of states took action to generate additional provider tax revenue. Figure 3 shows the number of states that took at least one action to generate additional provider tax revenue in each year, since SFY2009.



## Additional Provider Tax Revenue

(SFY2009 to SFY2012 proposed)



Source: National Association of State Budget Officers, *The Fiscal Survey of States*.

Note: SFY = state fiscal year.

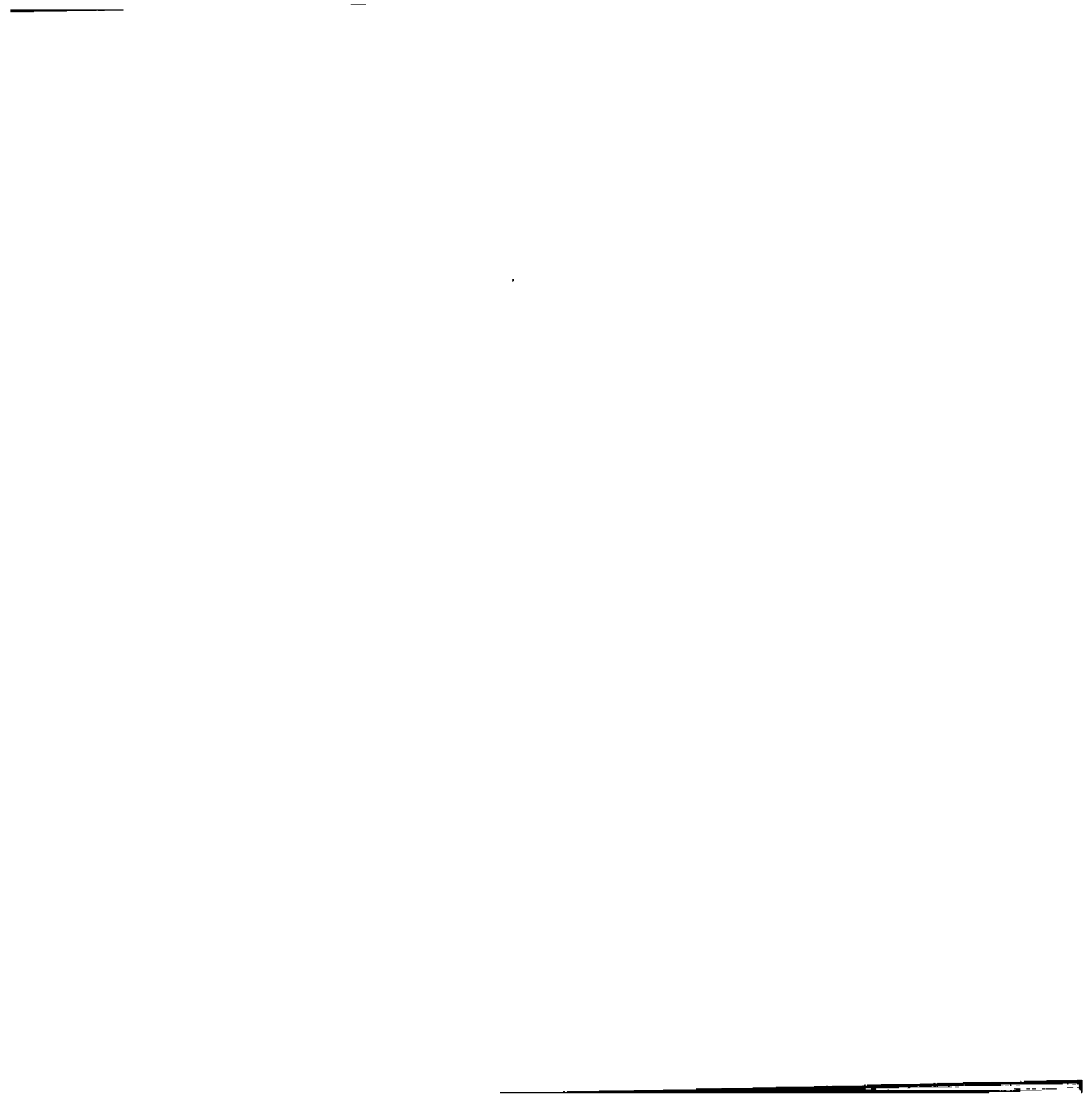
A Government Accountability Office (GAO) analysis<sup>33</sup> found that, during the period of February 2009 through July 2010, 10 states and the District of Columbia reported implementing 28 different provider tax actions to generate additional revenue. These actions consisted of 15 new provider taxes and 13 increases to existing provider taxes. States concentrated their actions on a few classes of providers, with hospitals and nursing facilities accounting for 21 of the 28 tax actions.

Traditionally, states have used provider tax revenue to maintain or increase Medicaid provider payment rates. For example, during the recession in the early 2000s, many states were able to avoid reducing Medicaid reimbursement rates to nursing homes by increasing nursing home provider tax revenue along with other funding sources, such as tobacco settlement funds, budget stabilization funds, and cigarette taxes.<sup>34</sup> However, during the most recent recession, the revenue from provider taxes was not always used to preserve or increase the reimbursement rates of the providers being taxed. In GAO's 2010 analysis, it found that states reduced or froze Medicaid payment rates for at least half of the providers that experienced new or increased provider taxes, which means states used the additional provider tax revenue to fund other Medicaid or non-Medicaid purposes.<sup>35</sup>

<sup>33</sup> Government Accountability Office, *Recovery Act: Opportunities to Improve Management and Strengthen Accountability over States' and Localities' Uses of Funds*, September 2010, GAO-10-999.

<sup>34</sup> Government Accountability Office, *Medicaid Nursing Home Payments: States' Payment Rates Largely Unaffected by Recent Fiscal Pressures*, October 2003, GAO-04-143.

<sup>35</sup> Government Accountability Office, *Recovery Act: Opportunities to Improve Management and Strengthen Accountability over States' and Localities' Uses of Funds*, September 2010, GAO-10-999.



CMS is responsible for determining whether states abide by the statutory and regulatory requirements pertaining to provider taxes. States are not required to receive CMS approval for provider taxes that adhere to the federal requirements. However, states seeking waivers from the broad-based and uniform requirements do need CMS approval.

## Current Issues

### Federal Deficit Reduction

In a typical year, the federal government funds roughly 57% of the total cost for Medicaid,<sup>36</sup> and these federal Medicaid expenditures account for almost 8% of all federal spending.<sup>37</sup> In FY2011, federal Medicaid payments to states are estimated to amount to \$275 billion.<sup>38</sup> Federal Medicaid payments are anticipated to grow significantly beginning in FY2014 due to the expansion of Medicaid eligibility provided in the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).<sup>39</sup> As a percentage of gross domestic product (GDP), federal Medicaid expenditures are expected to increase from about 1.9% of GDP in FY2011 to 2.5% of GDP in FY2021.<sup>40</sup> As a result, controlling federal Medicaid spending has been a focus of federal deficit reduction proposals, and further limiting states' use of provider taxes in financing Medicaid is often identified as a way to reduce federal Medicaid spending.

The President's FY2013 budget proposal includes a provision to phase down the Medicaid provider tax threshold from the current level of 6% to 3.5% from FY2015 to FY2017. The President's budget estimates that this proposal would reduce federal Medicaid expenditures by \$21.8 billion from FY2015 through FY2022.<sup>41</sup>

The National Commission on Fiscal Responsibility and Reform recommended restricting and eventually eliminating states' use of provider taxes. The commission estimated this provision would reduce federal Medicaid expenditures by \$44 billion from FY2012 through FY2020.<sup>42</sup>

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(.. continued)

*Accountability over States' and Localities' Uses of Funds*, September 2010, GAO-10-999.

<sup>36</sup> Office of the Actuary, *2010 Actuarial Report on the Financial Outlook for Medicaid*, Centers for Medicare and Medicaid Services, December 2010.

<sup>37</sup> Office of Management and Budget, *Historical Tables: Budget of the U.S. Government, Fiscal Year 2012*.

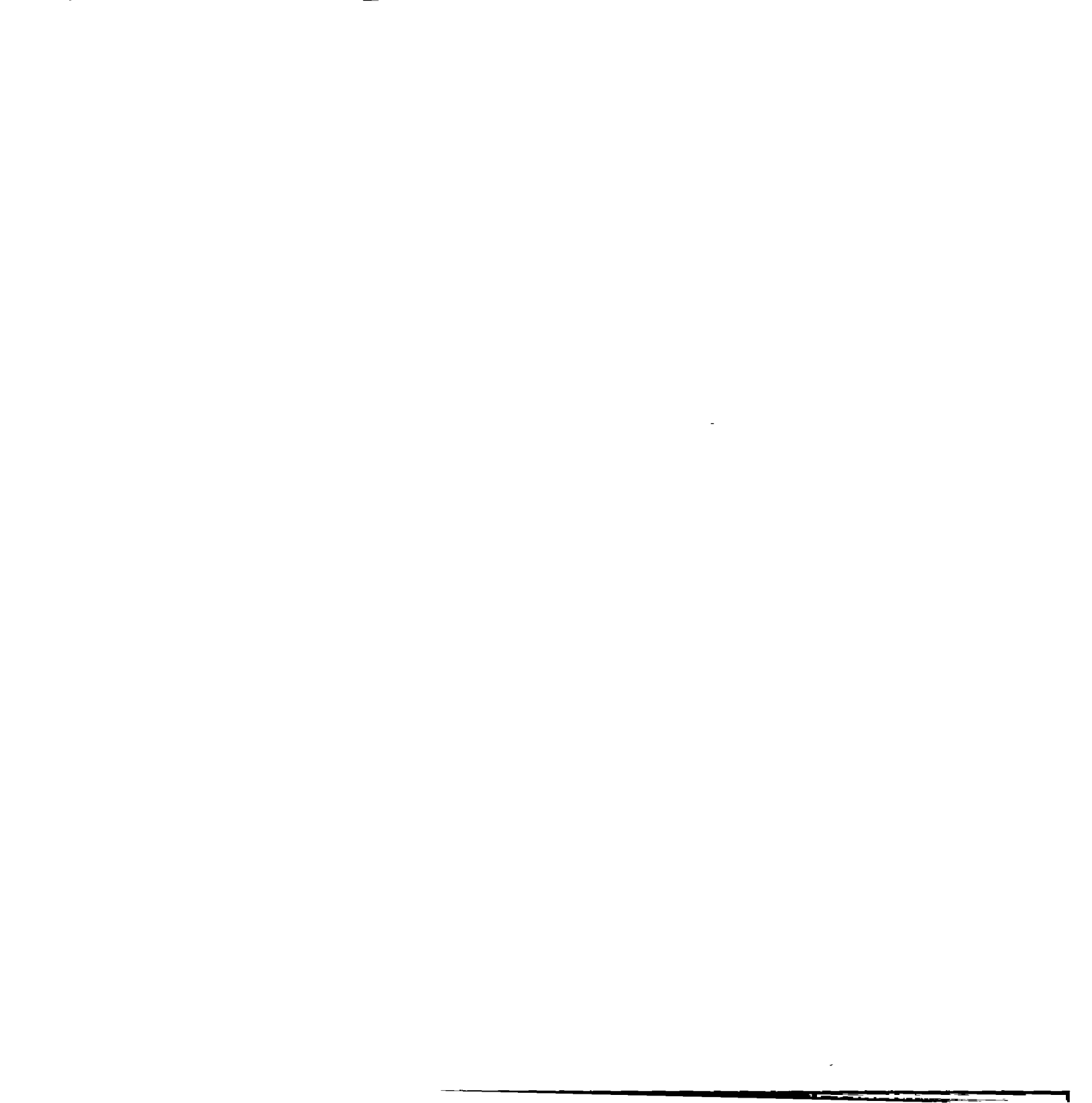
<sup>38</sup> Congressional Budget Office, *Spending and Enrollment Detail for CBO's March 2011 Baseline: Medicaid*, March 18, 2011.

<sup>39</sup> Historically, Medicaid eligibility was generally limited to low-income children, pregnant women, parents of dependent children, the elderly, and people with disabilities; however, ACA requires Medicaid coverage for individuals under the age of 65 with income up to 133% of the federal poverty level. For more information about the ACA changes to Medicaid, see CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline*, by Evelyne P. Baumrucker et al.

<sup>40</sup> Congressional Budget Office, *The Budget and Economic Outlook, FY2011 to FY2021*, January 2011.

<sup>41</sup> Department of Health and Human Services, *Fiscal Year 2013 Budget in Brief: Strengthening Health and Opportunity for All Americans*, <http://www.hhs.gov/budget/budget-brief-fy2013.pdf>.

<sup>42</sup> The National Commission on Fiscal Responsibility and Reform, *The Moment of Truth*, December 2010.



provider tax threshold to 3% over a period of three years. CBO estimated this budget option would reduce federal Medicaid expenditures by \$48 billion from FY2010 through FY2019.<sup>43</sup>

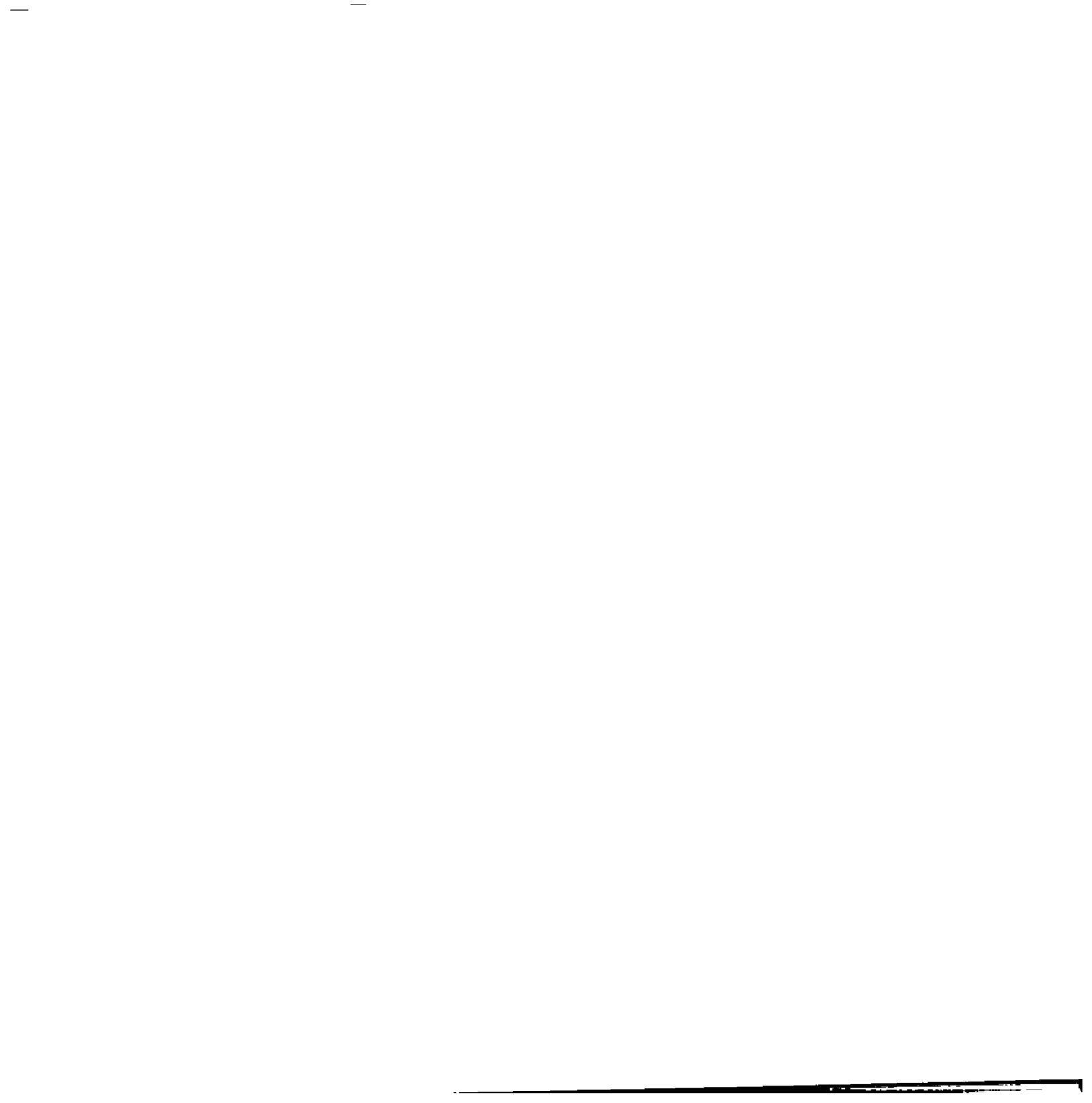
Lowering the threshold for provider taxes would limit states' ability to use provider taxes in financing the state share of Medicaid expenditures, which would decrease federal Medicaid payments to states.<sup>44</sup> This would effectively shift more of the Medicaid program's growing costs to the states.<sup>45</sup> As a result, states would have to weigh the impact of maintaining current Medicaid reimbursement and/or service levels against other state priorities for spending. They could choose to constrain Medicaid expenditures by reducing provider payment rates, limiting benefit packages, or restricting eligibility. These types of programmatic changes could also affect access to and the quality of medical care for Medicaid enrollees. For example, if states reduced the Medicaid reimbursement rates to providers, such as hospitals, physician, and nursing homes, these providers may be less willing to accept Medicaid patients.

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<sup>43</sup> Congressional Budget Office, *Budget Options Volume I: Health Care*, December 2008

<sup>44</sup> *Ibid.*

<sup>45</sup> *Ibid.*



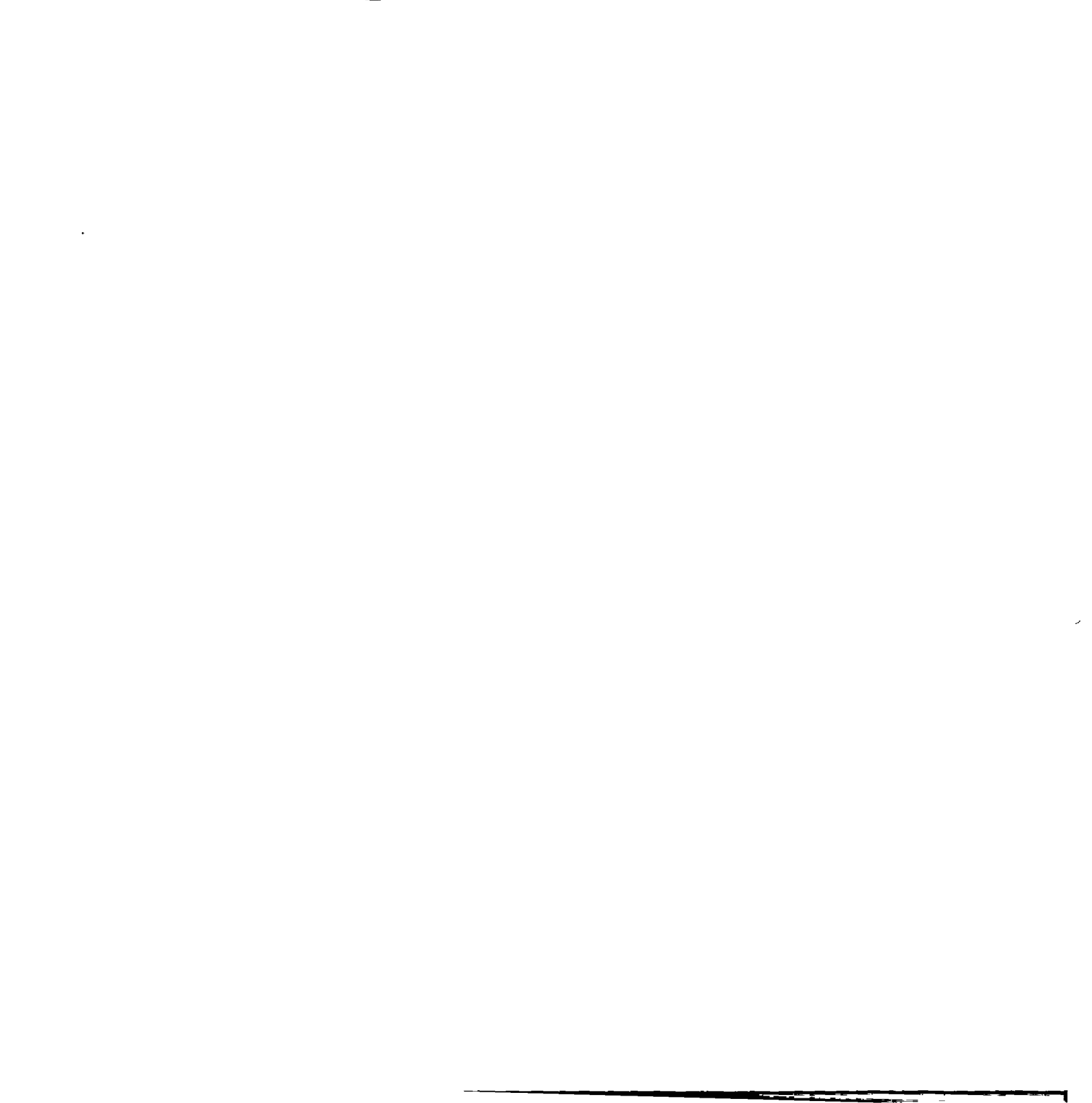
# Appendix. Types of Provider Taxes Used by States

A vast majority of states use provider taxes to finance Medicaid. As shown in Table A-1, 47 states and the District of Columbia used at least one provider tax in SFY2012. The three states without any provider taxes in SFY2012 were Alaska, Delaware, and Hawaii.

Nursing home taxes were the most popular type of provider tax, with 41 states using a nursing home tax. Hospital and ICF-MR/DD provider taxes were used by a majority of states, with hospital taxes in 39 states and ICF-MR/DD taxes in 34 states. In addition, 9 states had managed care taxes, and 12 states had other types of provider taxes.

**Table A-1. State-by-State Provider Taxes, by Type, SFY2012**

State	No Provider Tax	Type of Provider Tax				
		Hospital	ICF/MR- DD	Nursing Home	Managed Care	Other
Alabama		X		X		X
Alaska	X					
Arizona					X	
Arkansas		X	X	X		
California		X	X	X		
Colorado		X		X		
Connecticut		X	X	X		
Delaware	X					
District of Columbia		X	X	X	X	
Florida		X	X	X		
Georgia		X		X		
Hawaii	X					
Idaho		X	X	X		
Illinois		X	X	X		
Indiana		X	X	X		
Iowa		X	X	X		
Kansas		X		X		
Kentucky		X	X	X		X
Louisiana			X	X		X
Maine		X	X	X		X
Maryland		X	X	X	X	
Massachusetts		X		X		
Michigan		X		X		
Minnesota		X	X	X	X	X
Mississippi		X	X	X		
Missouri		X	X	X		X
Montana		X	X	X		
Nebraska			X	X		



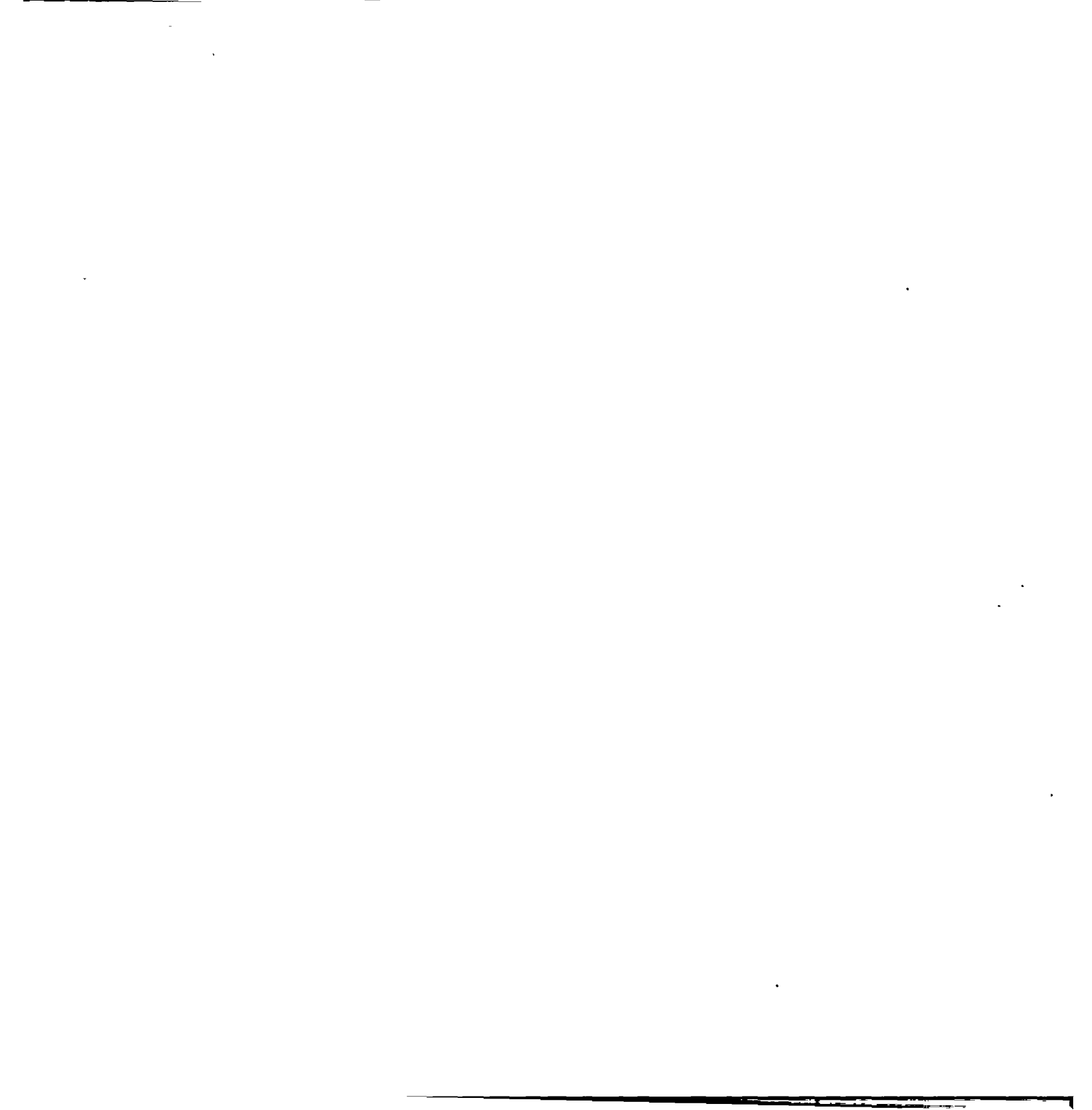
State	No Provider Tax	Type of Provider Tax				
		Hospital	ICF/MR- DD	Nursing Home	Managed Care	Other
Nevada				X		
New Hampshire		X		X		
New Jersey		X	X	X	X	X
New Mexico					X	
New York		X	X	X		X
North Carolina		X	X	X		X
North Dakota			X			
Ohio		X	X	X		
Oklahoma		X		X		
Oregon		X		X		
Pennsylvania		X	X	X		
Rhode Island		X		X	X	
South Carolina		X	X			
South Dakota			X			
Tennessee		X	X	X	X	
Texas			X		X	
Utah		X	X	X		
Vermont		X	X	X		X
Virginia			X			
Washington		X	X	X		
West Virginia		X	X	X		X
Wisconsin		X	X	X		X
Wyoming		X		X		
<b>Number of States</b>	<b>3</b>	<b>39</b>	<b>34</b>	<b>41</b>	<b>9</b>	<b>12</b>

Source: Vernon K. Smith, Kathleen Gifford, Eileen Ellis, et al., *Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012*, Kaiser Commission on Medicaid and the Uninsured, October 2011.

Notes: SFY = state fiscal year; ICF-MR/DD = Intermediate care facilities for Individuals with mental retardation or developmental disabilities.

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**Long-term Forecast of  
Medicaid Enrollment  
and  
Spending in Alaska:  
*Supplement 2012–2032***

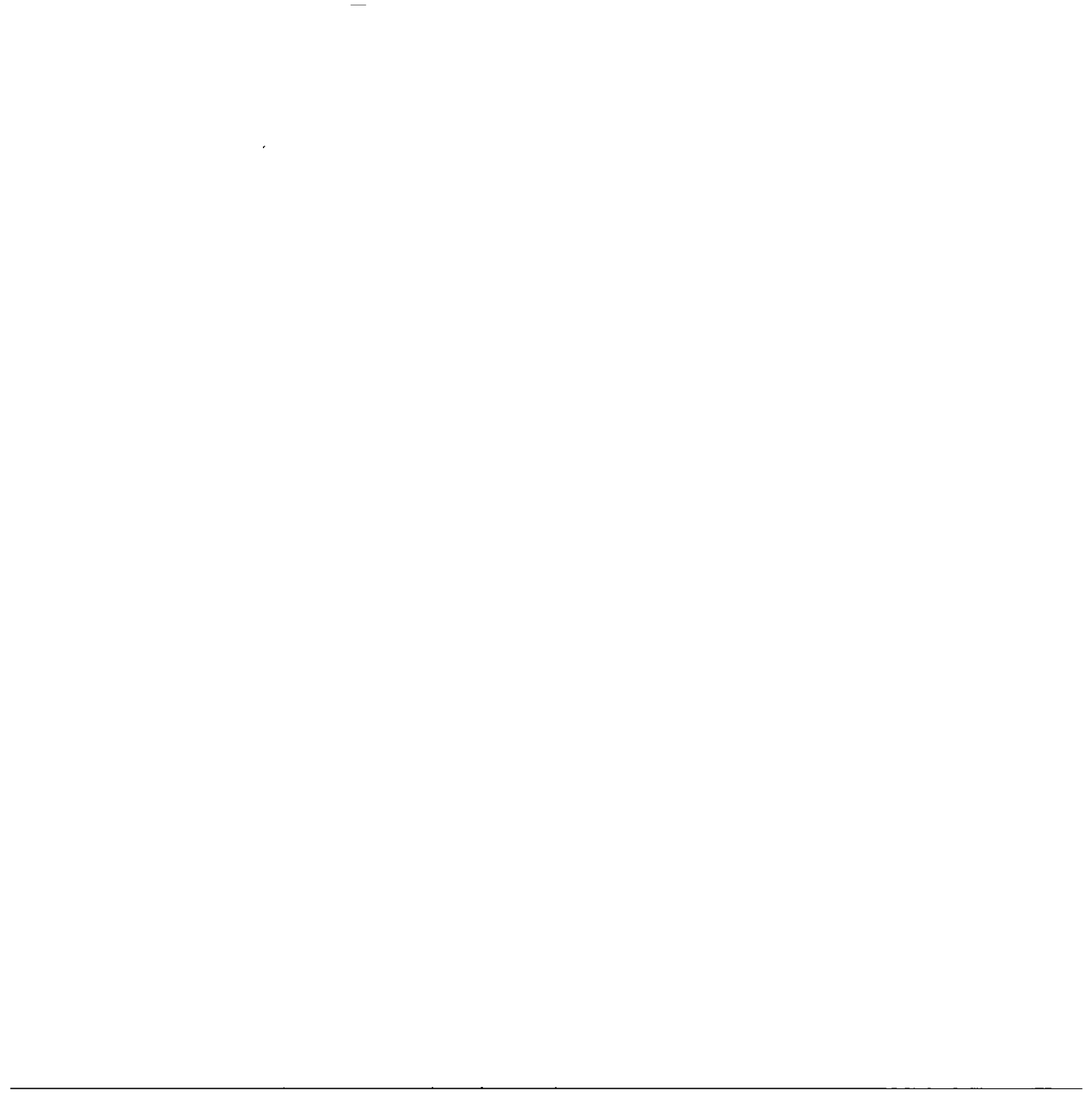
**Sean Parnell, Governor  
State of Alaska**

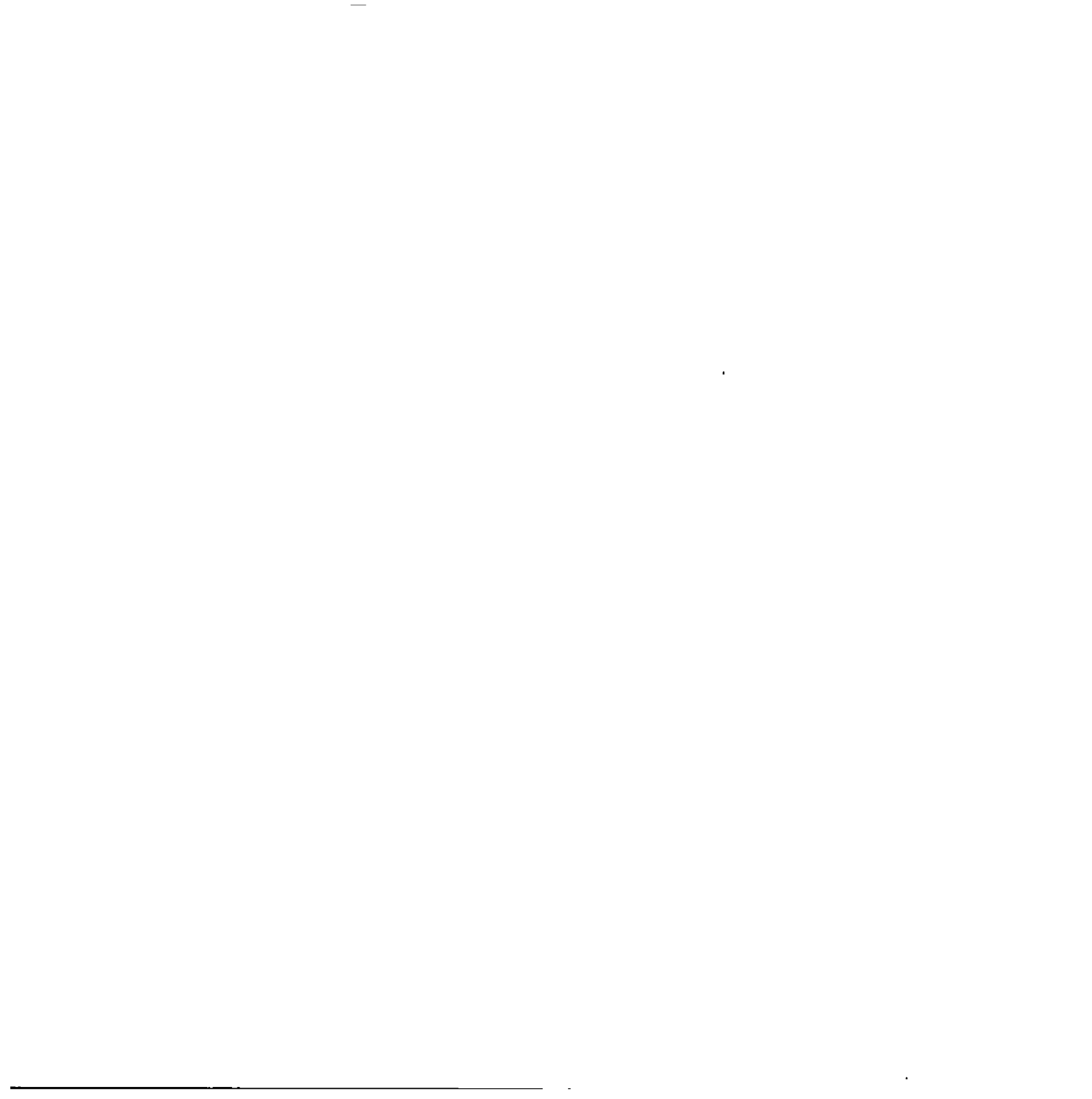
**William J. Streur, Commissioner  
Department of Health and Social Services**

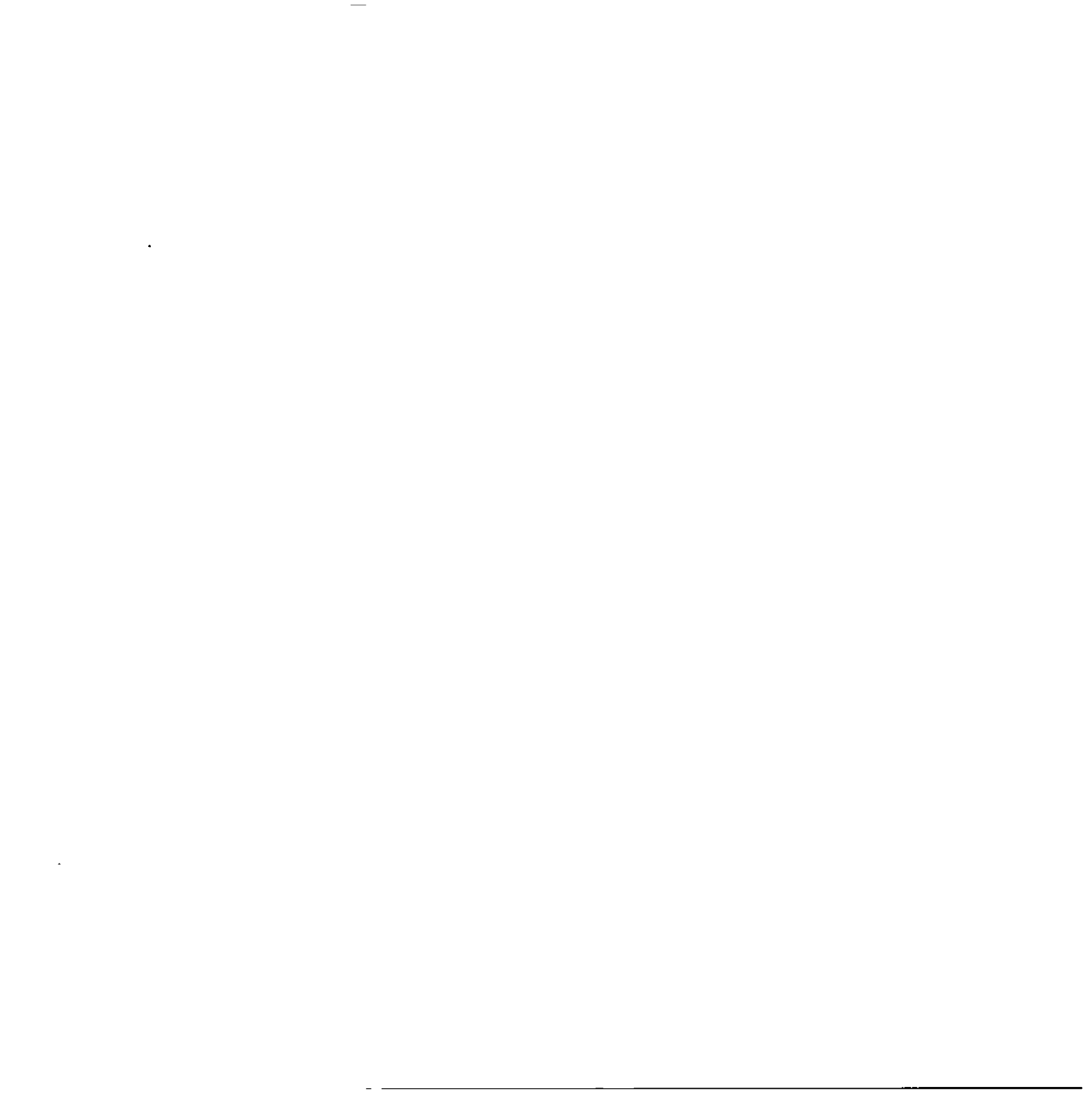
**Prepared by: Medicaid Budget Group  
Finance and Management Services  
Department of Health and Social Services**

**July 2013**



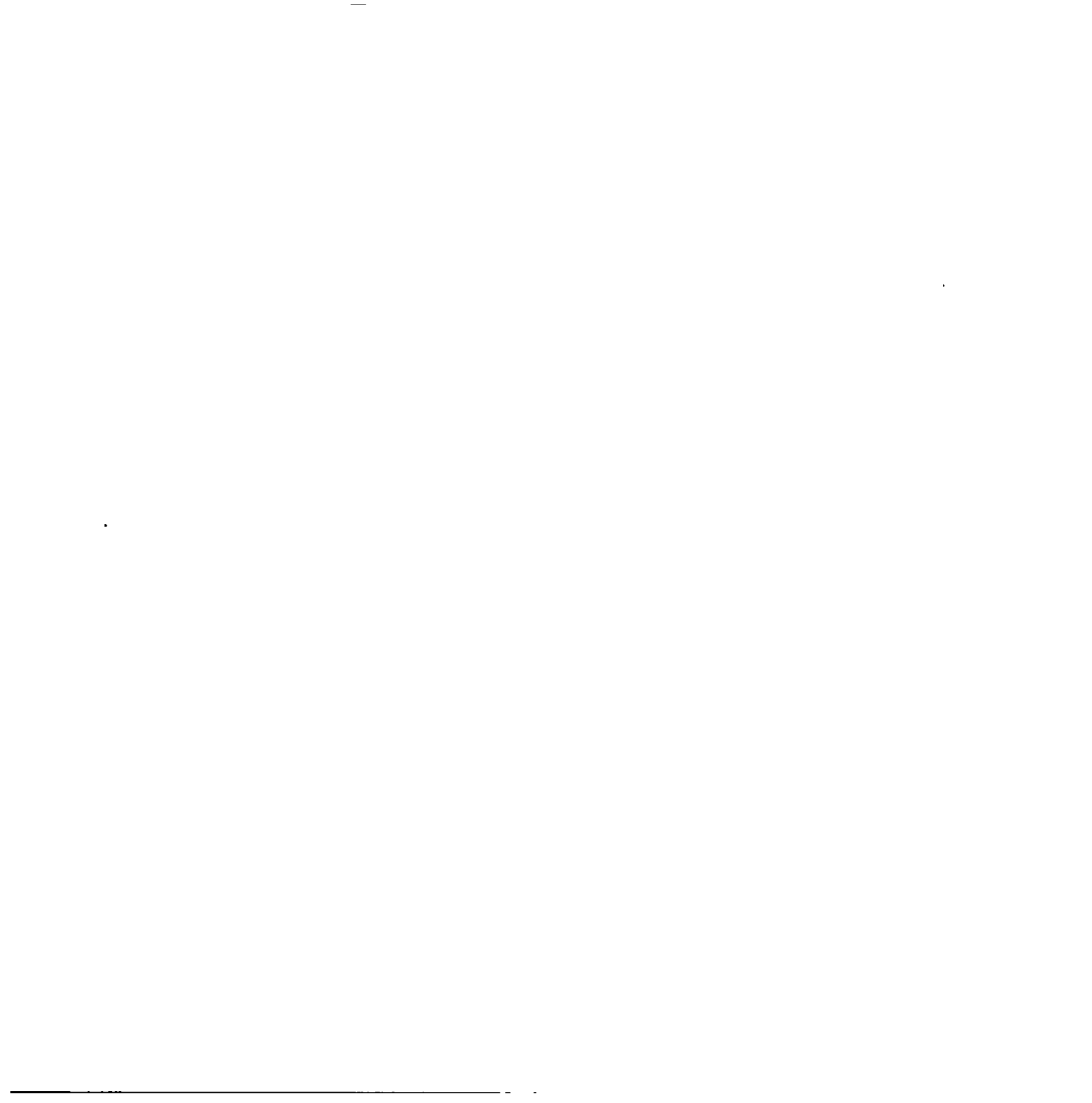






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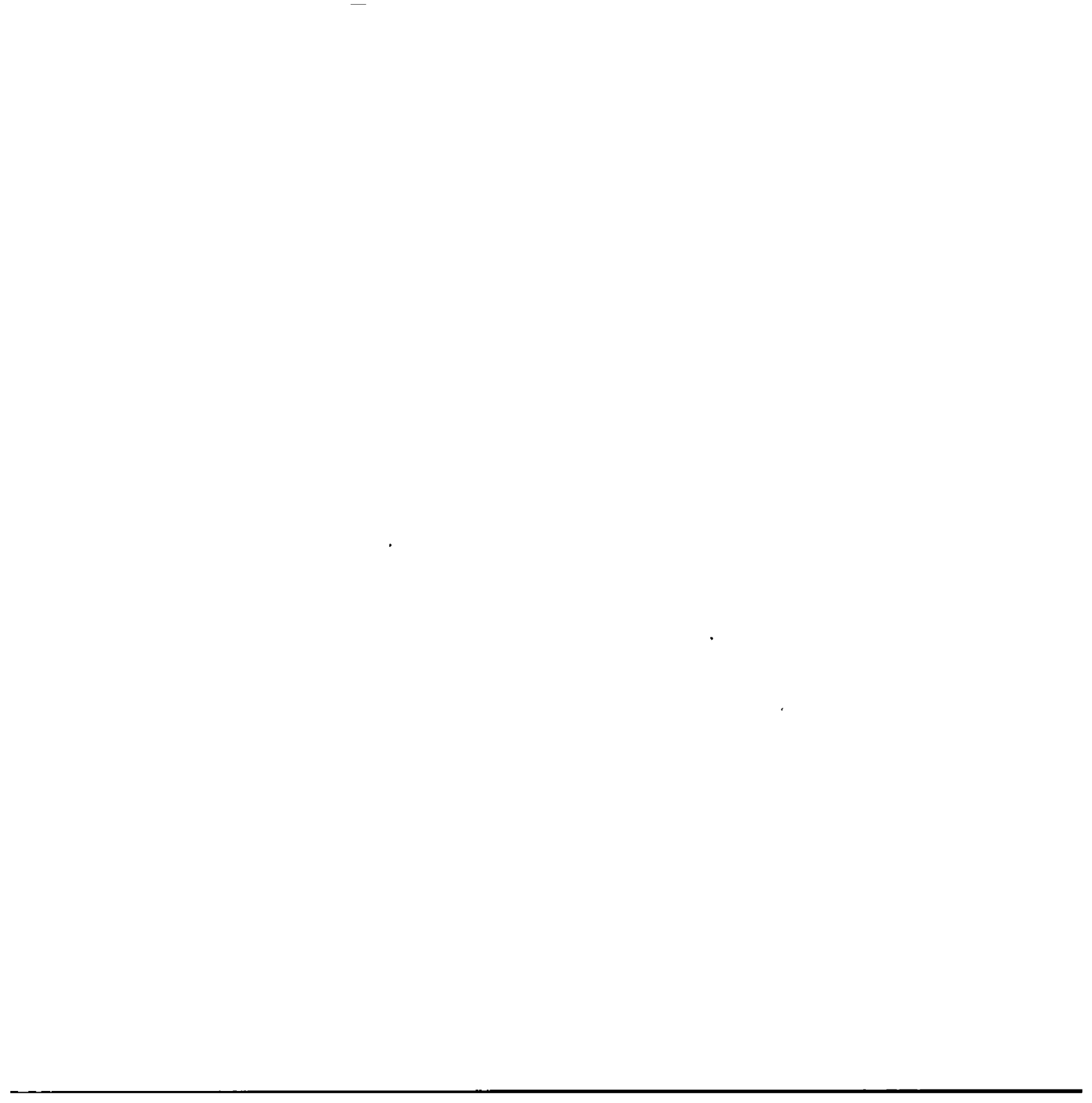
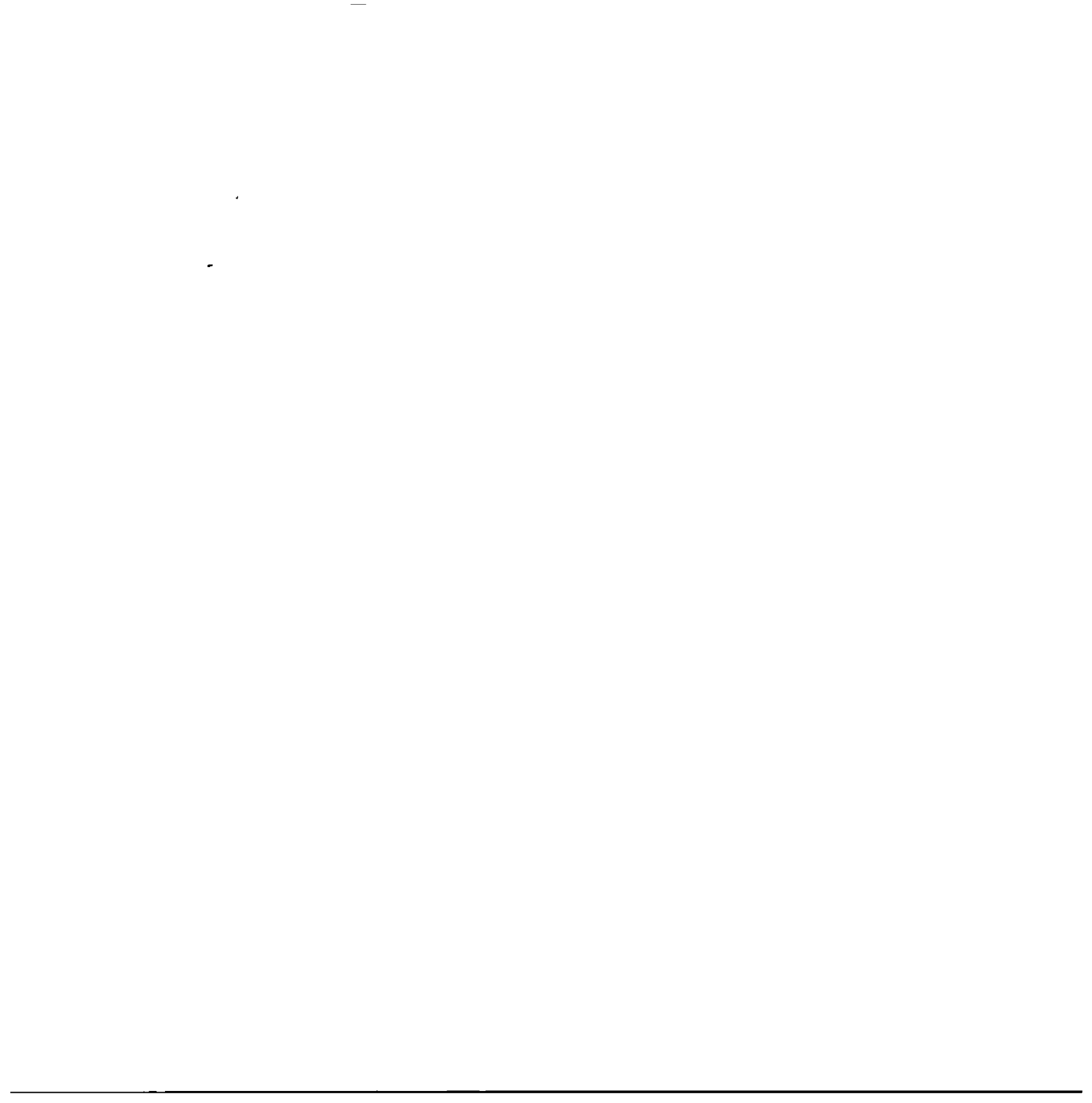


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Medicaid is an entitlement program created in 1965 by the federal government, but administered by the states, to provide payment for healthcare services for low-income citizens. People qualify for Medicaid by meeting federal income and asset standards and meeting specified eligibility requirements. Medicaid covers the aged, blind, or disabled persons and single parent families. In addition, Medicaid expanded coverage in 1998 through the Children's Health Insurance Program (CHIP) to children whose family income is too high to qualify for regular Medicaid, but too low to afford private health insurance. In Alaska, the CHIP program is administered through the Division of Health Care Services. The Division of Public Assistance manages enrollment for regular Medicaid and CHIP.

## Alaska Medicaid History

Medicaid is jointly funded by the federal government and by the individual states, with each state managing its own program. Participation in the Medicaid program is optional, but all states choosing to participate in the program must follow certain federal guidelines pertaining to eligibility and services to be provided. An individual state is permitted to make a Medicaid state plan amendment (SPA) in order to modify how Medicaid is operated within the state. However, the Center for Medicare and Medicaid Services (CMS) must review and approve the SPA for consistency with federal laws and regulations before the state is allowed to implement a Medicaid program modification.

The website for the Alaska Division of Public Assistance contains the following information about Alaska's Medicaid program:<sup>1</sup>

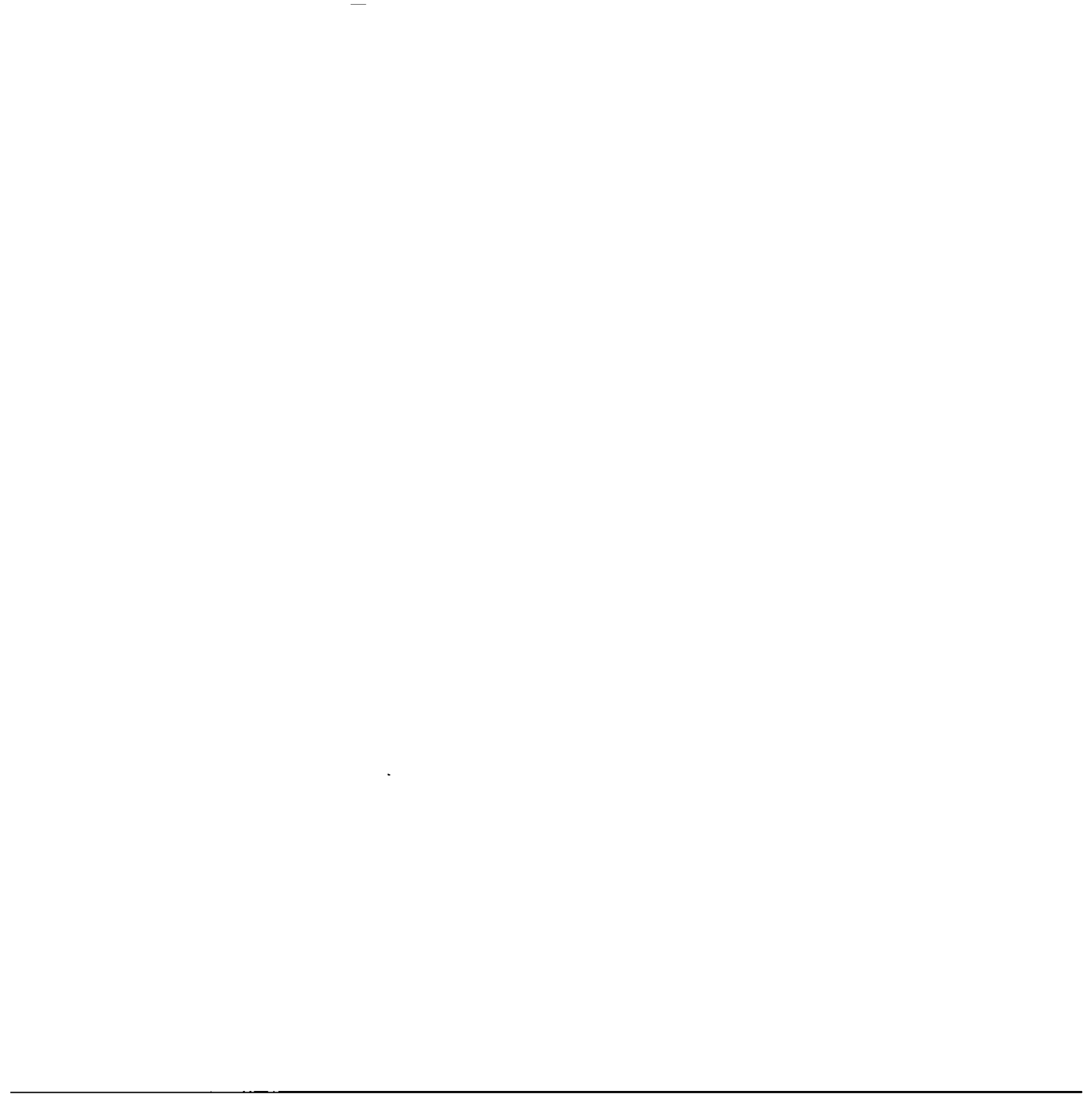
"Medicaid was established by Title XIX of the Social Security Act in 1965 to provide medical assistance to certain low-income needy individuals and families. Medicaid is basically intended to provide coverage for needy children, pregnant women, and aged, blind and disabled persons.

The Alaska Department of Health and Social Services administers the Medicaid program in accordance with federal and state laws and regulations. The Medicaid program is authorized under Title XIX and Title XXI of the Social Security Act and the Code of Federal Regulations, Title 42 Part 435 and Title 45 Part 233.

Alaska joined the Medicaid program in September 1972. New services and eligible groups have been added to the program since that time by the Legislature. The Medicaid

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<sup>1</sup> [http://dpaweb.hss.state.ak.us/manuals/fam-med/5000/5000-1\\_introduction\\_to\\_medicaid.htm](http://dpaweb.hss.state.ak.us/manuals/fam-med/5000/5000-1_introduction_to_medicaid.htm)  
[http://dpaweb.hss.state.ak.us/manuals/fam-med/5300/5300\\_denalidikcare.htm](http://dpaweb.hss.state.ak.us/manuals/fam-med/5300/5300_denalidikcare.htm)



Persons receiving Adult Public Assistance (APA) and Supplemental Security Income (SSI) are automatically eligible for Medicaid. There are eligibility categories for pregnant women and children based on having income below a percentage of the federal poverty level for Alaska. There are number of narrow eligibility categories that follow SSI or APA eligibility policy, but are for the elderly or disabled who are not recipients of those cash programs. Alaska also purchases Part B Medicare for Medicaid-eligible recipients, and provides payment for long term care services for persons whose income is within 300% of the SSI Supplemental Security Income payment level.

Before July 1, 1997, individuals and families who were eligible for and/or received Aid to Families with Dependent Children [AFDC] were automatically eligible for Medicaid. This entitlement was removed by the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. As a result of this major welfare reform legislation, families who are receiving cash assistance through the Alaska Temporary Assistance Program (ATAP), generally referred to as "Temporary Assistance" (TA), are not automatically eligible for Medicaid. This legislation eliminated the program, but required that Medicaid continue to be available to those who would have qualified for AFDC. This category of Medicaid is now called Family Medicaid.

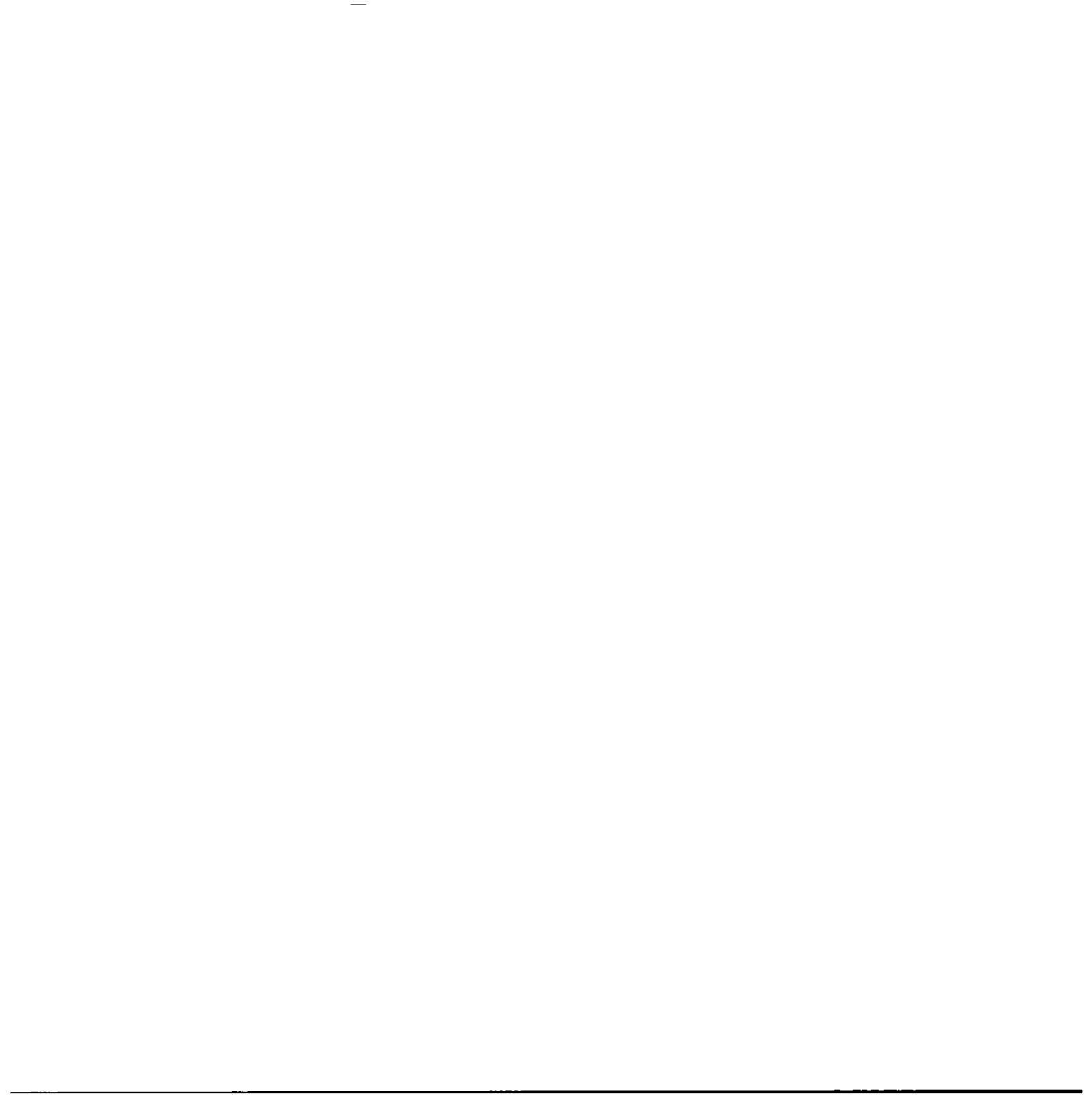
The Balanced Budget Act of 1997 established the Child Health Insurance Program (CHIP) in Title 21 of the Social Security Act. This program provides Alaska with enhanced federal matching money to expand Medicaid eligibility to more children. At the same time, eligibility was also expanded for pregnant women.

Beginning March 1, 1999, children under age 19 and pregnant women qualified for health care coverage if their household income was at or below 200 percent of the federal poverty guideline (FPG) for Alaska."

On September 1, 2003, the eligibility standard for children without insurance and pregnant women was reduced from 200 percent to 175 percent of the 2003 federal poverty guideline (FPG) for Alaska. This 175 percent FPG standard was frozen at the 2003 level and did not increase each year as it had historically.

Effective July 1, 2007, the eligibility standard for children without insurance and pregnant women was increased to 175 percent of the 2007 federal poverty guideline for Alaska due to a change in law. This standard will increase each year along with the annual increases in the FPG.

Denali KidCare is an expansion of Medicaid, using the same basic infrastructure and benefit package. The Denali KidCare name encompasses the Medicaid eligibility subtypes of pregnant and postpartum women (PB, PC, PR, and PX), CHIP children (CP, H2, and S2), as well as other



## Alaska Medicaid Is a Fee for Service Program

Alaska Medicaid reimburses hospitals, physicians, and other healthcare providers for providing healthcare services to Medicaid enrollees. Alaska runs its program as fee-for-service program, meaning that it reimburses providers as payments per unit of service rendered according to an established payment rate. This is in contrast to managed care, where a healthcare organization receives a monthly payment for each Medicaid recipient enrolled in the plan. In a managed care arrangement, the health care organization is responsible for ensuring that the enrollees have access to a comprehensive range of medical services.

## Origins of the Long-term Medicaid Forecast

In April 2005 the Alaska Department of Health and Social Services (HSS) contracted with the Lewin Group and ECONorthwest to develop a long-term forecasting model of Medicaid spending for the State of Alaska. In February 2006 a report, based on the results of the forecasting model, was submitted to the Alaska Legislature to inform policy makers of the projected growth in total spending on Alaska's Medicaid program over the 20-year period ending in 2025.

The purpose of the Long-term Medicaid forecast (assigned the acronym MESA—Medicaid Enrollment and Spending in Alaska—by HSS in 2007) is to provide a long-term view of future enrollment and spending in the Alaska Medicaid program under the current mix of Medicaid services and the current eligibility criteria for enrollment in the Medicaid program. MESA provides department executives and the Alaska State Legislature with information on the direction and approximate magnitude of growth in enrollment and state matching fund spending for the Medicaid program.

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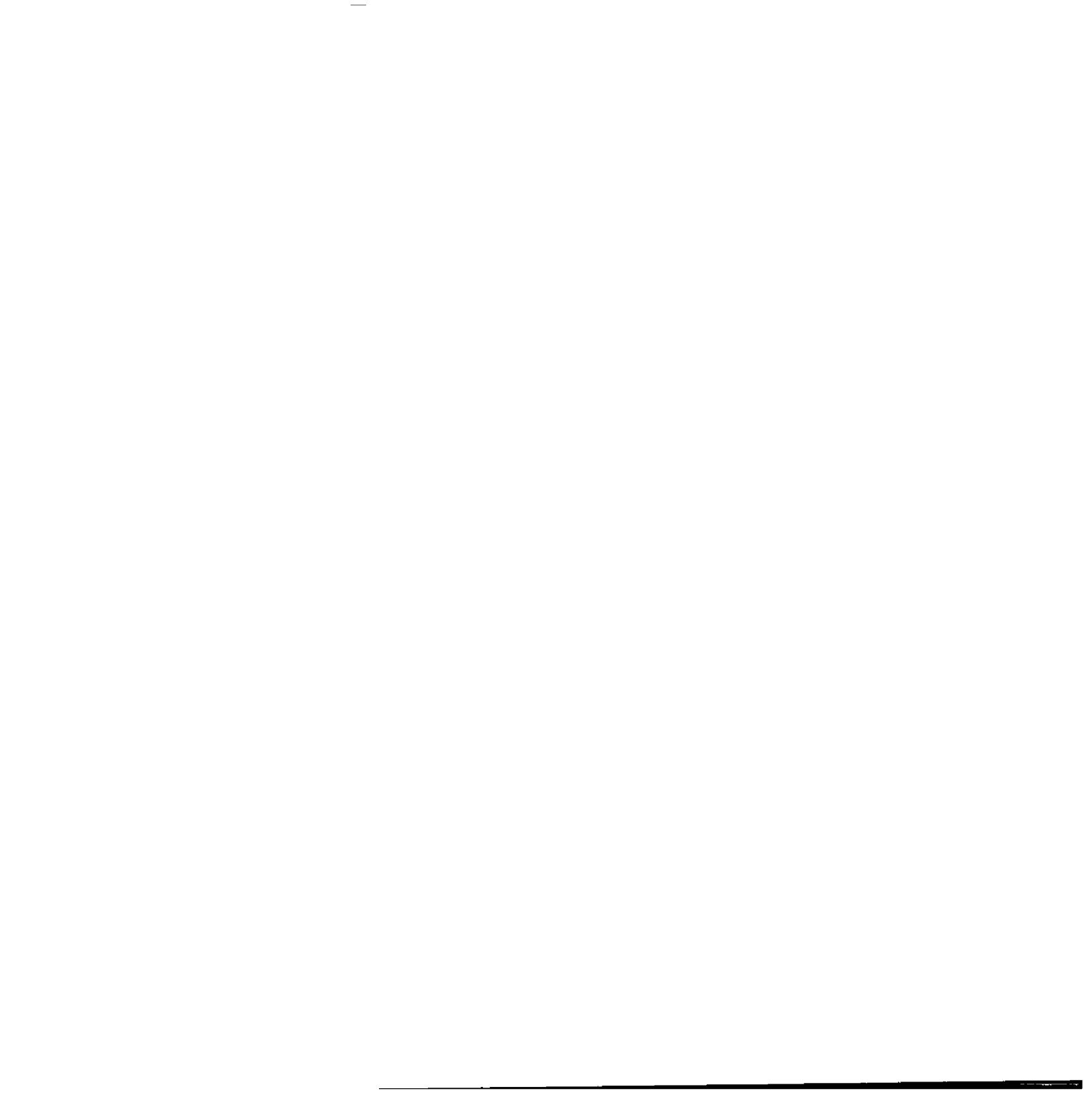
<sup>2</sup> Pregnant and Postpartum Women: PR = Pregnant with income < 133% FPG; PX = Pregnant with income > 133% FPG <= 175% FPG; PB = Postpartum income < 133% FPG; PC = Postpartum income > 133% FPG <= 175% FPG

CHIP Children: CP = > 150% & <= 175% (age 0-8); H2 = > 133% & <= 150% (age 0-8); S2 = > 100% & <= 133% (age 6-18);

Other Children: H1 = > 133% & <= 150% (age 0-8); S1 = > 100% & <= 133% (age 6-18); HC = > 100% & <= 133% (age 0-5); SU <= 100% FPG (age 6-18)

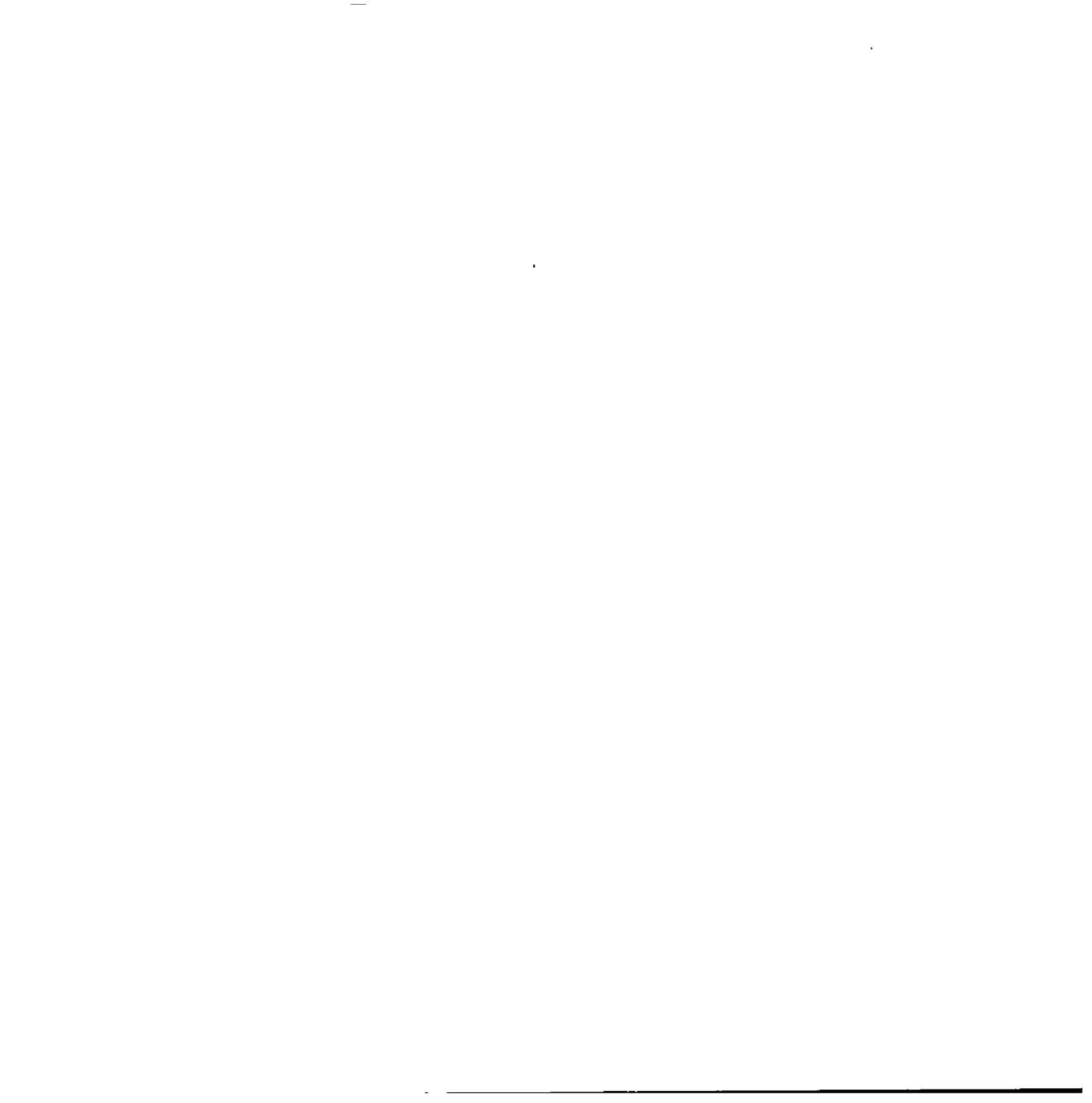
<sup>3</sup> Appendix B contains a list of descriptions for Denali KidCare eligibility subtypes, as well as the other eligibility subtypes.

The Medicaid expenses for children who are eligible for the Medicaid program because of the Children's Health Insurance Program (CHIP) are eligible to be reimbursed by the federal government at the Enhanced Federal Medical Assistance Percentage (Enhanced FMAP). The Enhanced FMAP reduces the state's share of spending by 30 percent. If the regular FMAP for a state is 50 percent, the Enhanced FMAP is 65 percent.



consultation from ECONorthwest and now with Evergreen Economics, has updated the underlying enrollment and claims data on which the MESA forecasting model depends, and has re-estimated the model to project enrollment and spending over the successive 20-year period. By integrating a successive year of data into the MESA model, we update the Medicaid program's status quo with respect to eligibility, enrollment trends, and spending. Thus, as changes are made to the Medicaid program by HSS or the Legislature, MESA provides estimates of the long-term impact of the changes.

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This chapter covers projections for claims on services provided to individual.<sup>4</sup> The analysis combines historical Alaska Medicaid enrollment and claims data, based on date of service, for fiscal years 1997 through 2011,<sup>5</sup> with U.S. Census data and population projections from the Alaska Department of Labor and Workforce Development (ADLWD) to develop forecasts of enrollment in the Medicaid program and utilization of and spending on Medicaid services. The projections are based on the Medicaid program as it currently exists.

## Population

The population of Alaska has changed substantially in the years since statehood. In 1960, one year after Alaska became a state, the population was 226,167 and about one-fifth (44,237) of all Alaskans lived in Anchorage.<sup>6</sup> By the time Alaska started its Medicaid program in 1972, the population of the state had increased to 329,800, for an average annual growth of 3.2 percent.<sup>7</sup> Population continued to grow quickly through the 1970s and 1980s, partly influenced by the construction of the Trans-Alaska Pipeline from 1975 to 1977 and other jobs related to the oil industry.<sup>8</sup> By 1990, the State's population had risen to 550,043 and the population of Anchorage had grown to 226,338 residents, or just over two-fifths of the state population.<sup>9</sup>

Alaska's population growth has slowed in recent years. From 1990 to 2012, the population increased on average by 1.3 percent per year, reaching 732,298 in 2012. Of these residents, 298,842 lived in Anchorage (41 percent).<sup>10</sup> While the ratio of males to females has moved toward the national average over the past decades, in 2012, there were still about 108 males in Alaska for every 100 females.<sup>11</sup>

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<sup>4</sup> Chapter 2 deals with other Medicaid payments and offsetting recoveries, which are not directly tied to a particular claim.

<sup>5</sup> Since the forecast is based on date of service and providers have up to a year to submit claims, many of the medical claims for services that were provided during fiscal year 2012 have not yet entered the claims system.

<sup>6</sup> <http://www2.census.gov/prod2/decennial/documents/15611103.pdf>

<sup>7</sup> See the Alaska Department of Labor and Workforce Development's report *Alaska Population Overview 2009 Estimates*, page 13, available at <http://labor.alaska.gov/research/pop/estimates/pub/popover.pdf>

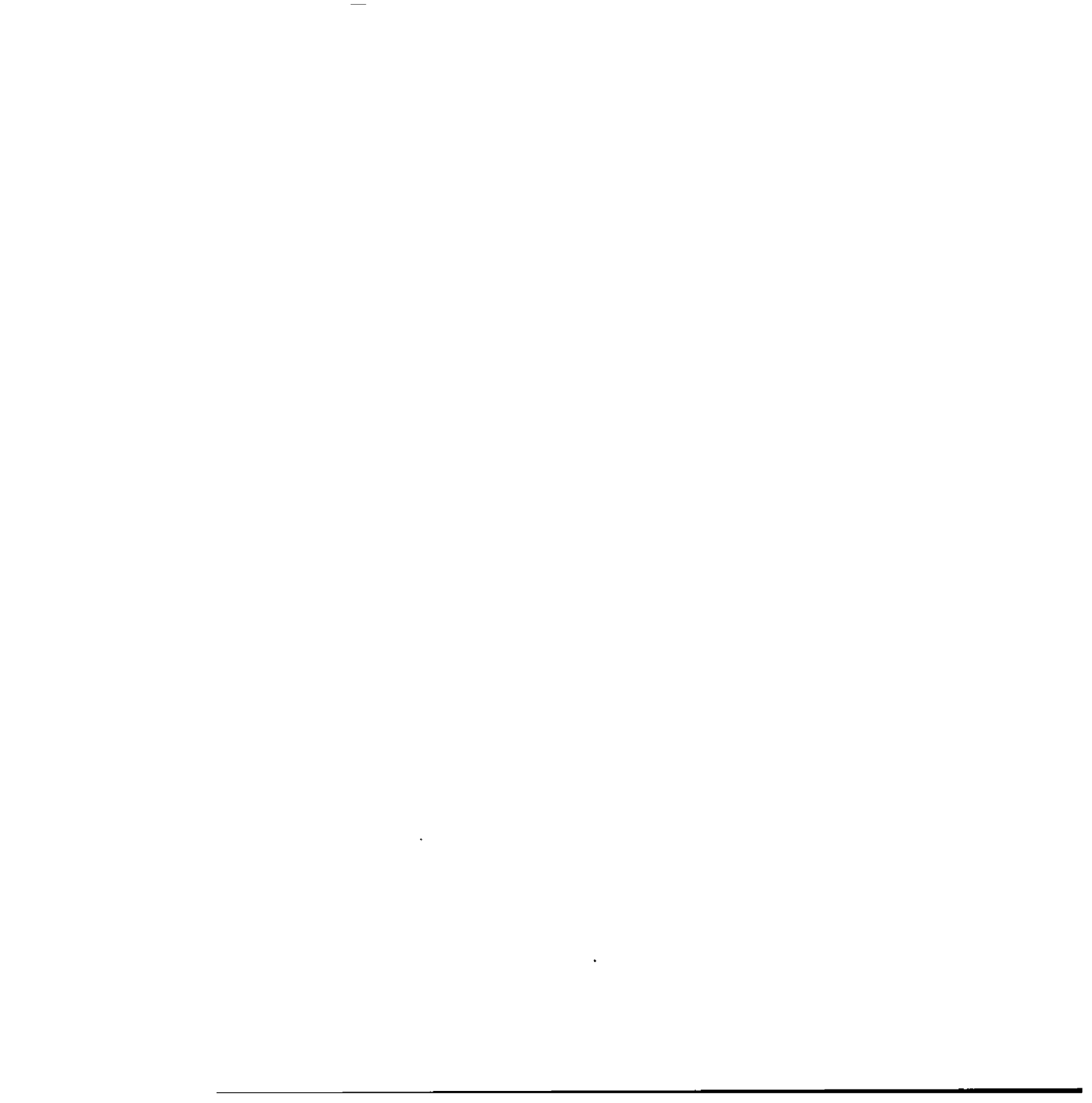
<sup>8</sup> Population grew at an average annual rate of 2.9 percent over this period.

For more information on the impact of the Trans-Alaska Pipeline see <http://www.alaska-pipe.com/pipelinefacts.html>

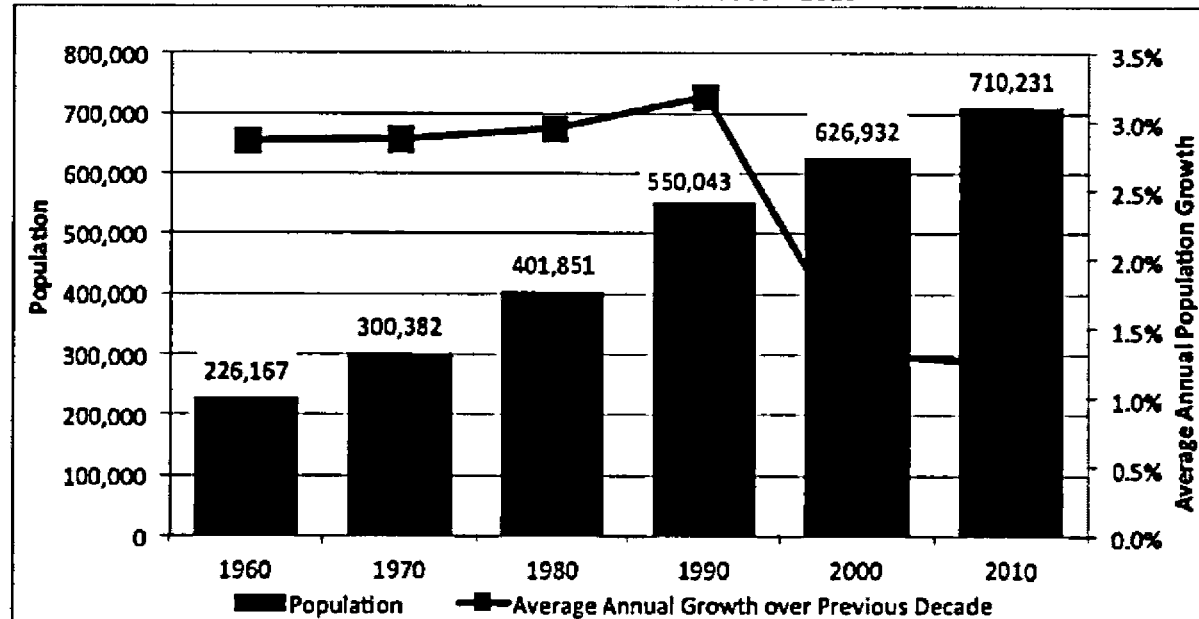
<sup>9</sup> See <http://www.census.gov/prod/cen1990/cph2/cph:2-3.pdf>

<sup>10</sup> See <http://laborstats.alaska.gov/pop/popest.htm>

<sup>11</sup> See <http://www.census.gov/prod/cen2010/briefs/c2010br-03.pdf>



## ALASKA'S POPULATION AND ANNUAL GROWTH RATES FROM 1960 – 2010



Source: U.S. Census Bureau

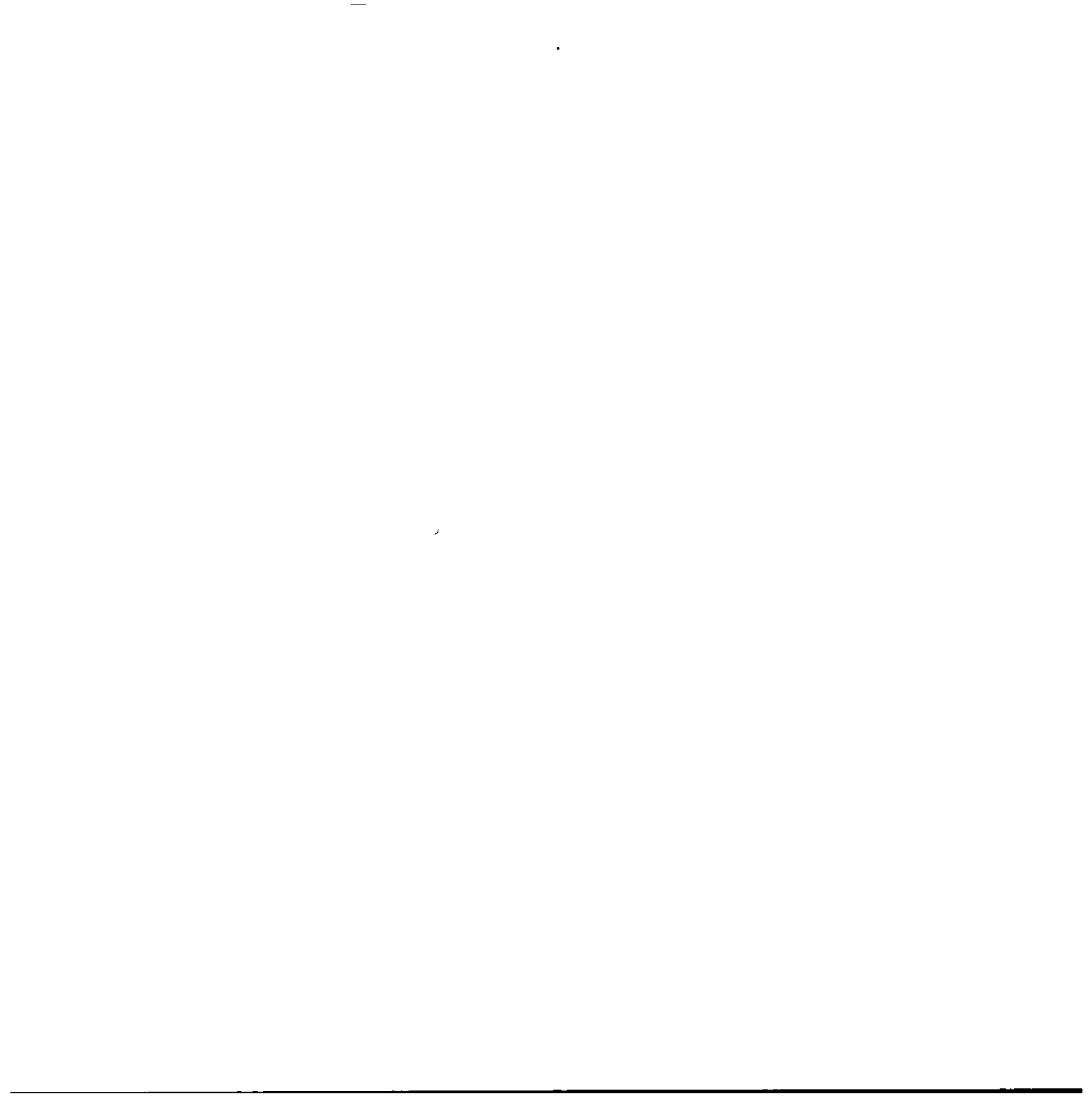
Even though Alaska's population has grown substantially over the past 50 years, it is important to keep in mind that there have been significant fluctuations in the year-to-year growth rates, and there have been some years when the population has decreased.<sup>12</sup> An extremely strong or extremely weak economic climate—relative to the rest of the nation—could lead to similar swings in growth in future years.

Based on analysis by the ADLWD, the population of Alaska is projected to grow at an average rate of 1.02 percent per year over the next 20 years, reaching 893,978 residents in 2032.<sup>13</sup> Population growth is expected to lead to growth in Medicaid enrollment and in turn more spending by the state on Medicaid services.

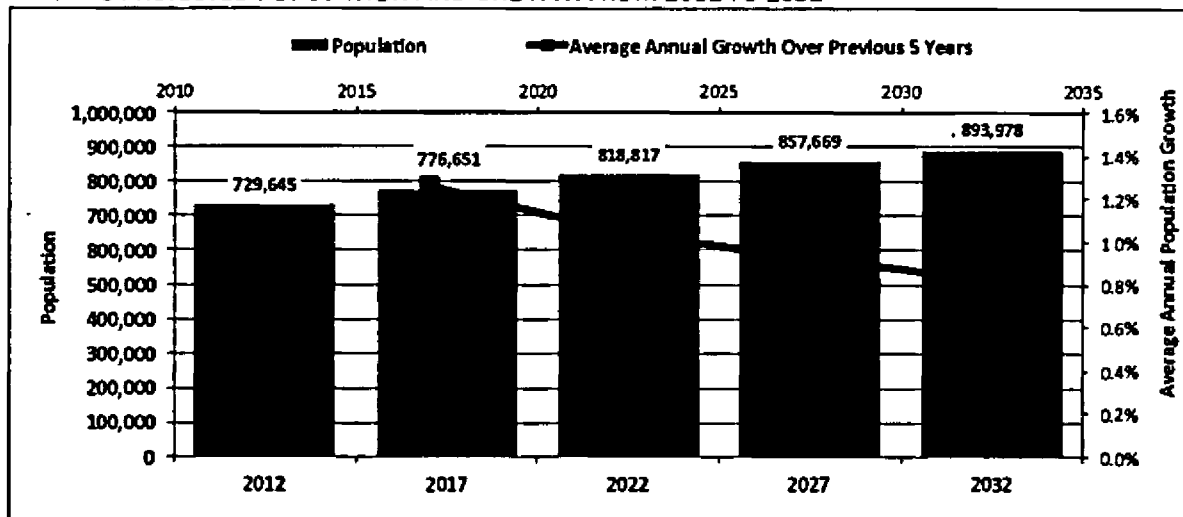
<sup>12</sup> See the Alaska Department of Labor and Workforce Development's report *Alaska Population Overview 2009 Estimates*, page 13, available at <http://labor.alaska.gov/research/pop/estimates/pub/popover.pdf> for details about the Alaska population estimates from 1945 to 2009.

<sup>13</sup> See Table 12 in Appendix D.

Population projections are derived from the growth rates within the ADLWD's report *Alaska Population Projections 2010 to 2034*, available at <http://labor.alaska.gov/research/pop/projected/pub/popproj.pdf>.



## ALASKA'S PROJECTED POPULATION AND GROWTH FROM 2012 TO 2032



Source: MESA model, December 2012, using data from the Alaska Department of Labor and Workforce Development and adjusting for 2010 Census data.

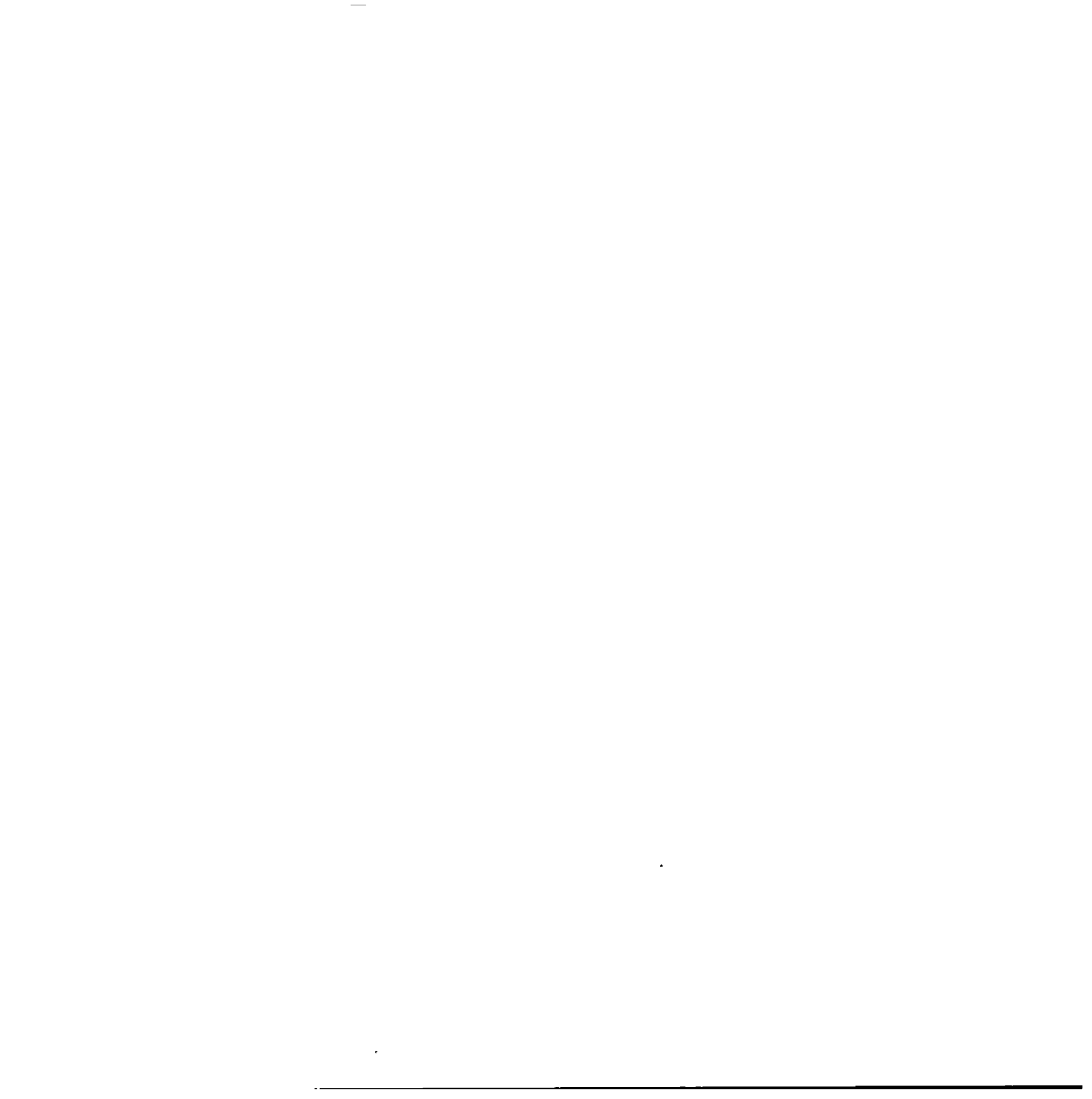
The ADLWD projects the distribution of residents by gender and age will change over the next two decades as the state adds more females than males and the overall population ages. We expect this to have an impact on the Medicaid program as females enroll in the Medicaid program at a greater rate and tend to incur higher costs on average than men.<sup>14</sup> The population will also grow older, with the highest percent growth in the state being those above age 75. The elderly population not only tends to enroll in Medicaid at a higher rate than working-age adults, but the costs associated with caring for the elderly are also significantly higher than they are for children or working-age adults.

**Table 1: The elderly population is projected to grow faster than other age groups**  
**ALASKA'S PROJECTED POPULATION BY AGE GROUP FOR SELECTED YEARS, 2012—2032**

Age Group	2012	2017	2022	2027	2032	Average Annual Change
Children (0-19)	210,758	224,857	238,216	249,453	257,541	1.01%
Working Age Adults (20-64)	455,938	464,050	465,282	469,461	484,400	0.30%
Elderly (65+)	62,950	87,744	115,319	138,755	152,038	4.51%
<b>Total Population</b>	<b>729,645</b>	<b>776,651</b>	<b>818,817</b>	<b>857,669</b>	<b>893,978</b>	<b>1.02%</b>

Source: MESA model, using data from the Alaska Department of Labor and Workforce Development.

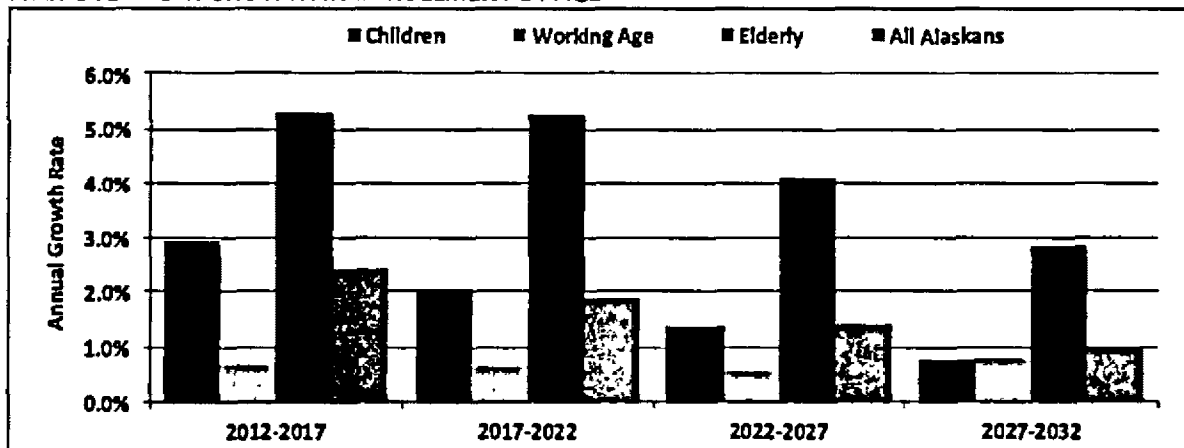
<sup>14</sup> More specifically, working-age females incur greater costs on average than working age males and elderly females incur greater costs on average than elderly males. Average Medicaid costs for male and female children are approximately equal.



The elderly population will continue to have a dramatic impact on the Medicaid program through 2032. The growth in enrollment among the elderly will average 4.37 percent per year through the forecast period, causing the elderly's share of enrollment to more than double by 2032, reaching 10 percent of total enrollment. During the same period, the annual growth rate in enrollment among children and working-age adults will be 1.76 percent and 0.68 percent, respectively.<sup>15</sup> The rate of growth in enrollment across the entire population will slow from .6 percent annually between 2012 and 2017 to 0.24 percent annually between 2027 and 2032.

Enrollment refers to the number of individuals who both meet the requirements and are registered to receive Medicaid services. Growth in enrollment is determined by two primary factors: (1) population growth and changes in the demographics of the population and (2) changes in eligibility requirements. For the purposes of this report, eligibility requirements are assumed to remain constant over the next two decades.<sup>16</sup>

**Figure 3: Enrollment growth slows down over time. The elderly remain the fastest growing group.**  
**YEAR-OVER-YEAR GROWTH IN ENROLLMENT BY AGE**



Source: Medicaid Budget Group, MESA Model.

Figure 4 shows that, while the growth in Medicaid enrollment for the entire population will slow over time, the Medicaid program will experience substantial growth in the elderly (age 65 and older) population. The growth rate in enrollment for children (age 0-19) will be faster than that of working-age adults (age 20-64) for the first fifteen years of the forecast. After 2027 the growth rate in enrollment for working-age adults will exceed, albeit slightly, the growth rate for children.

<sup>15</sup> See Table 3, page 11.

<sup>16</sup> We assume that the Modified Adjusted Gross Income (MAGI) methodology, which will take affect in January 2014, will not influence Medicaid enrollment in a materially significant way. We will revisit this assumption for the 2013-2033 MESA forecast.

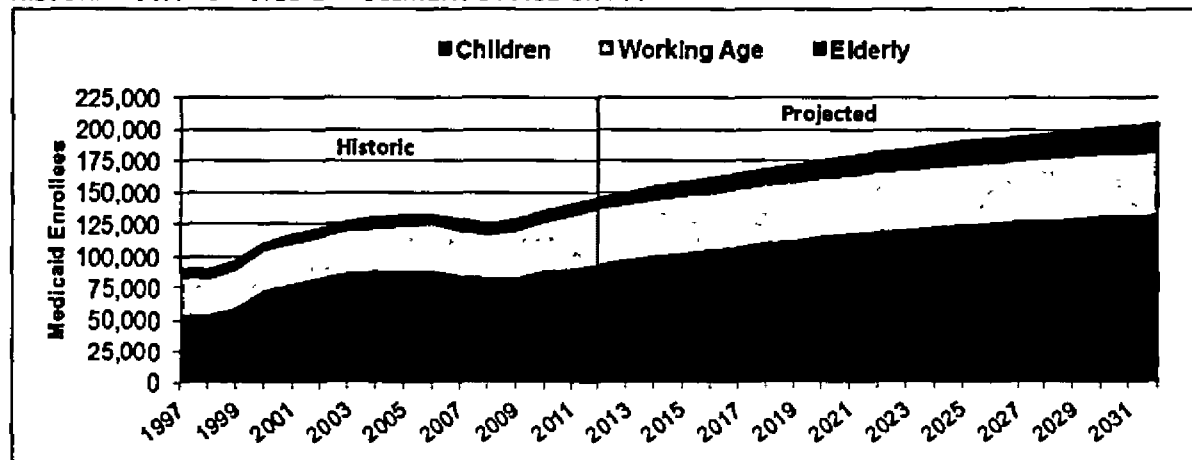


**MEDICAID ENROLLMENT BY AGE GROUP FOR SELECTED YEARS, 2012 – 2032**

Age Group	2012	2016	2021	2026	2032	Average Annual Change
Children (0-19)	92,683	106,993	118,356	126,571	131,398	1.76%
Working Age Adults (20-64)	44,531	46,052	47,590	48,991	50,977	0.68%
Elderly (65+)	9,263	11,988	15,491	18,941	21,801	4.37%
<b>Total Enrollment</b>	<b>146,476</b>	<b>165,033</b>	<b>181,436</b>	<b>194,504</b>	<b>204,176</b>	<b>1.67%</b>

Source: Medicaid Budget Group, MESA Model.

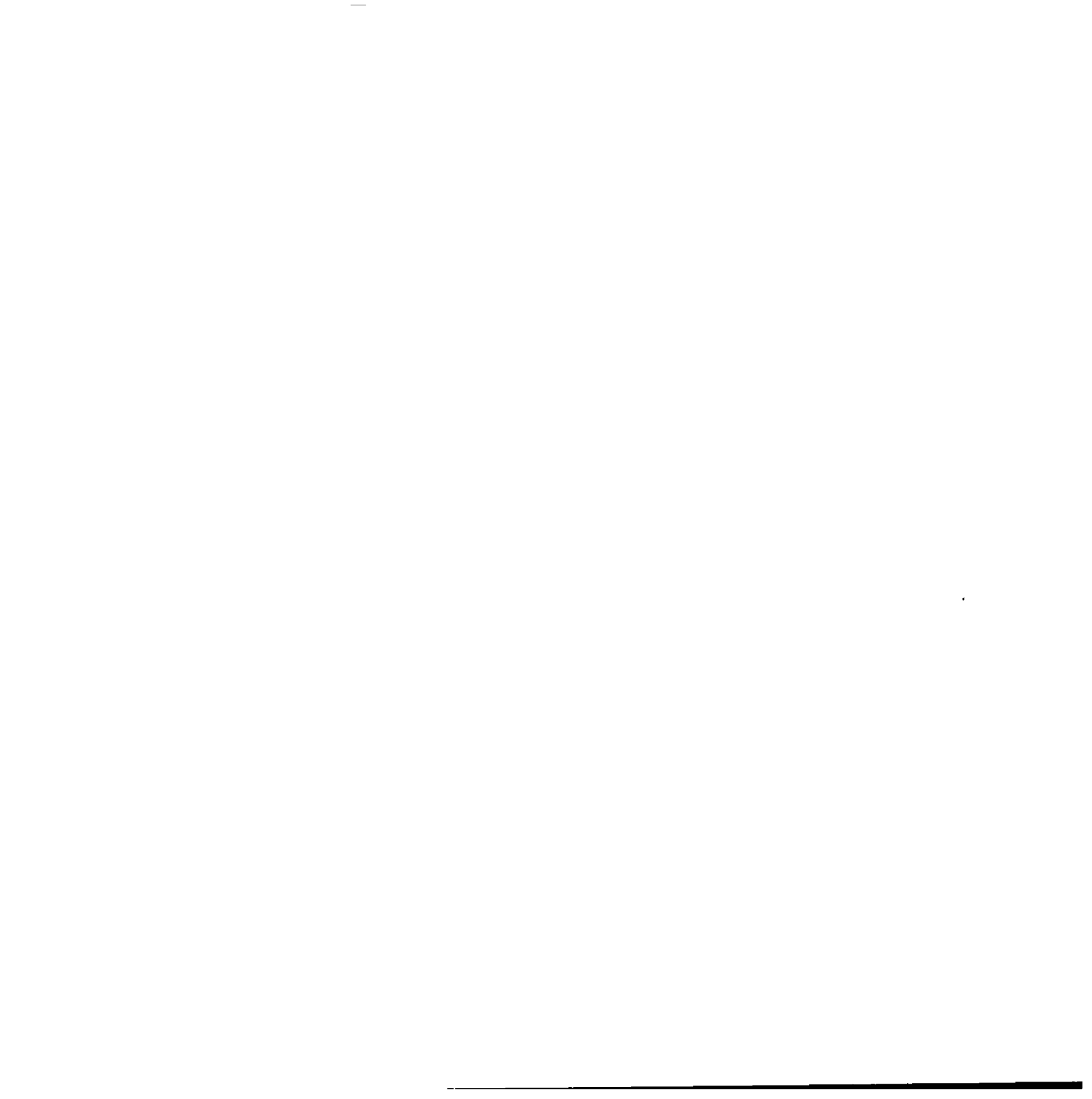
**Figure 4: Enrollment will continue to increase throughout the projection period**  
**HISTORICAL & PROJECTED ENROLLMENT BY AGE GROUP**



Source: Medicaid Budget Group, MESA Model

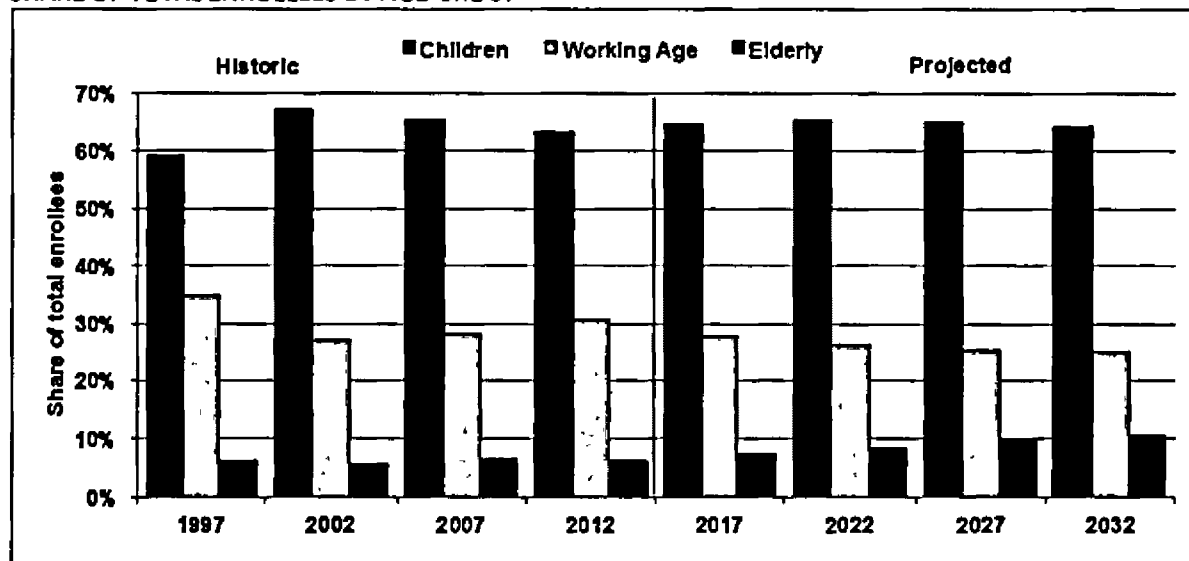
The demographic characteristics of Medicaid enrollees have changed and will continue to do so in the future. The share of children as a percent of all participants enrolled in Medicaid increased in the late 1990s and continued to increase until 2004, when they accounted for 67 percent of enrollees. This coincided with the introduction of Denali KidCare, which expanded Medicaid to more pregnant women and individuals. From 2004 to 2007, the household income eligibility requirements for Denali KidCare were locked into place instead of being adjusted for inflation, so some individuals fell off the rolls. The proportion of enrollees who are children has since dropped to 63 percent. With a projected 1.76 percent annual growth rate from 2012 to 2032, children’s share of enrollment will remain largely unchanged; by 2032, enrollment is projected to include 131,398 children, accounting for 64 percent of enrollment.

The proportion of Medicaid enrollees who are working-age adults decreased from 35 percent of enrollment in 1997 to 27 percent of enrollment in 2002. Enrollment of working-age adults is projected to grow over the forecast period at 0.68 percent per year—slower than the projected rate for children and much slower than the projected rate for the elderly. The share of enrollees



percent in 2012 to 25 percent in 2032.

**Figure 5: The percentage of enrollees who are elderly will increase over the next 20 years**  
**SHARE OF TOTAL ENROLLEES BY AGE GROUP**



Source: Medicaid Budget Group, MESA Model

With ever more people in the Baby Boom Generation reaching retirement age, the elderly will account for a larger share of Medicaid enrollees over the forecast period, increasing from 6 percent of enrollment to 11 percent in 2032. Enrollment of elderly is expected to grow at an annual rate of 4.37 percent over the next 20 years, from 9,200 in 2012 to 22,000 in 2032.

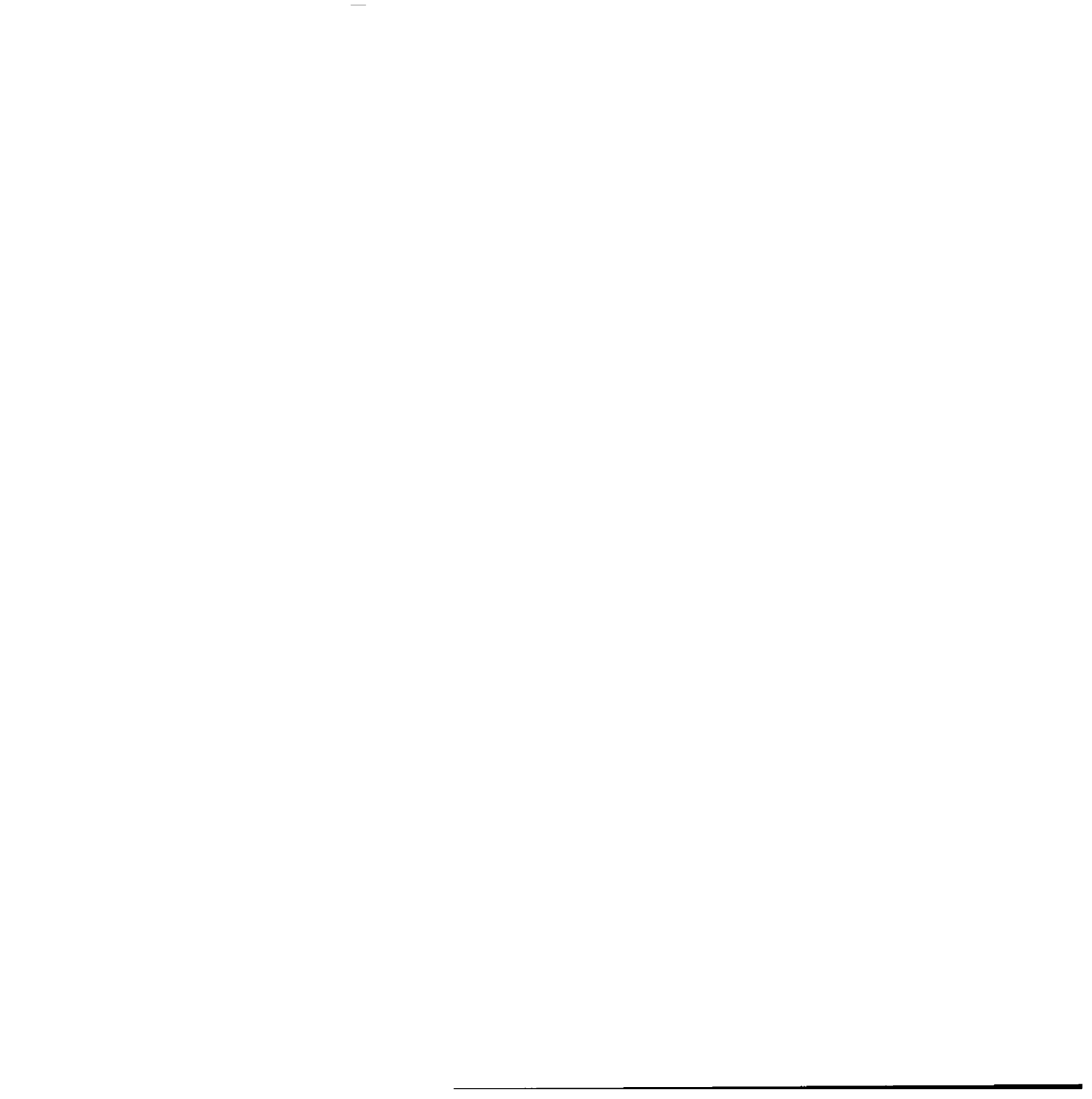
The proportion of enrollees by gender is projected to remain stable throughout the forecast period at approximately 55 percent female and 45 percent male.<sup>17</sup> The Native/Non-Native ratio of enrollees will also remain stable throughout the forecast period; Alaska Natives currently make up a little more than 36 percent of Medicaid enrollees, and that figure will remain roughly the same in 2032.

The forecast projects an increase in enrollment levels for each eligibility group,<sup>18</sup> with the greatest growth tending to be in eligibility categories that have a larger share of the disabled and the elderly. These groups include Other Disabled, Long Term Care Non-Cash, and SSI/APA/LTC Cash,<sup>19</sup> which we project will experience average annual enrollment growth of 1.3 percent, 4.2 percent, and 2.9 percent, respectively. SSI/APA/LTC Cash is the eligibility group that we project will experience the greatest increase in enrollment between 2012 and 2032 (19,400 additional enrollees).

<sup>17</sup> See Table 12 in Appendix D

<sup>18</sup> See Table 13 in Appendix D

<sup>19</sup> SSI = Social Security income; APA = Adult Public Assistance; LTC Cash = long-term care cash assistance



Eligibility Categories  
**MEDICAID ENROLLMENT FOR SELECTED ELIGIBILITY GROUPS**

Eligibility group	2012	2017	2022	2027	2032	Annual Change
LTC Non-cash	2,596	3,227	4,049	5,011	5,953	4.2%
Medicare	552	601	634	651	664	0.9%
SSI/APA/LTC Cash	25,651	30,609	36,054	41,123	45,096	2.9%
All Other Eligibility Categories	117,677	130,596	140,699	147,719	152,462	1.3%

Source: Medicaid Budget Group, MESA Model

## Utilization

In the above sections of this report we presented information pertaining to projected population growth in Alaska and projected Medicaid enrollment growth. In this section, we present information pertaining to the utilization of Medicaid services.

The term “utilization” has multiple meanings in healthcare economics. For our purposes, we define utilization as the annual unduplicated count of Medicaid enrollees who received a particular Medicaid service during a fiscal year. These enrollees are referred to as “recipients” or “beneficiaries.” Recipients are counted as utilizing a Medicaid service category if they used a Medicaid service during the fiscal year that resulted in a paid claim greater than zero dollars. Recipients are counted only once per fiscal year for any given service category, whether they used a service category once or used it multiple times during the fiscal year. To summarize, for the purposes of the MESA analysis, “utilization” measures the number of individuals who used a Medicaid service during a fiscal year, but it does not measure the quantity (or “intensity”) of the service that an individual used. The quantity of use of a Medicaid service is considered in the forecast of spending on Medicaid services.

**Table 4: Service category designations in the MESA forecast**

Dental	Inpatient Hospital	Pharmacy
DME <sup>20</sup> / Supplies	Inpatient Psychiatric	Physician / Practitioner
EPSDT <sup>21</sup>	Lab / X-Ray	Residential Psychiatric / BRC <sup>22</sup>
Family Planning	Nursing Home	Therapy / Rehabilitation
HCB <sup>23</sup> Waiver	Outpatient Hospital	Transportation
Health Clinic	Outpatient Mental Health	Vision
Home Health / Hospice	Personal Care	

Currently, the service category with the highest utilization is Physician / Practitioner services, which had an estimated 108,800 users during 2012. We project that it will remain the service category with the highest utilization throughout the forecast period. This does not mean,

<sup>20</sup> Durable Medical Equipment

<sup>21</sup> Early and Periodic Screening, Diagnosis, and Treatment

<sup>22</sup> Behavioral Rehabilitation Centers

<sup>23</sup> Home and Community Based Waiver

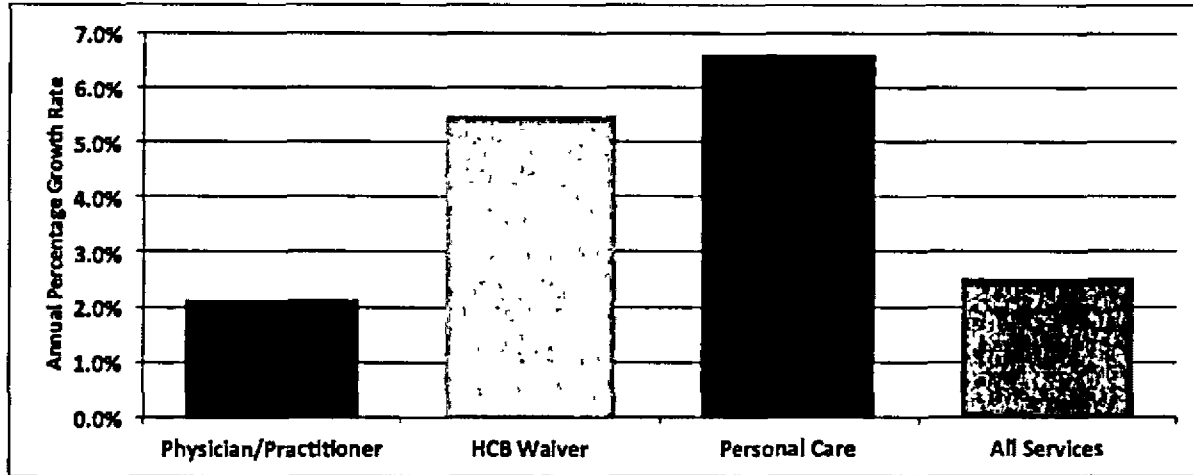


averaging 2.1 percent per year, the Physician / Practitioner service category is one of the slower growing Medicaid service categories. It is projected that in 2032, approximately 165,000 Alaskans will receive Physician / Practitioner services through the Medicaid program.

The two service categories that are expected to see the highest percentage growth in utilization over the next twenty years are Personal Care, with an average annual growth of 6.6 percent, and Home and Community Based (HCB) Waiver (5.5 percent). The increasing number of the elderly in the Medicaid program will drive the increased utilization of these services. In spite of the high growth rates in utilization for services related to the elderly, Personal Care and HCB Waiver will continue to have low utilization relative to many other service categories.

**Figure 6: HCB Walver and Personal Care are projected to experience growth in utilization in excess of 5 percent per year**

**AVERAGE ANNUAL PERCENT GROWTH IN UTILIZATION FOR SELECTEO SERVICE CATEGORIES**

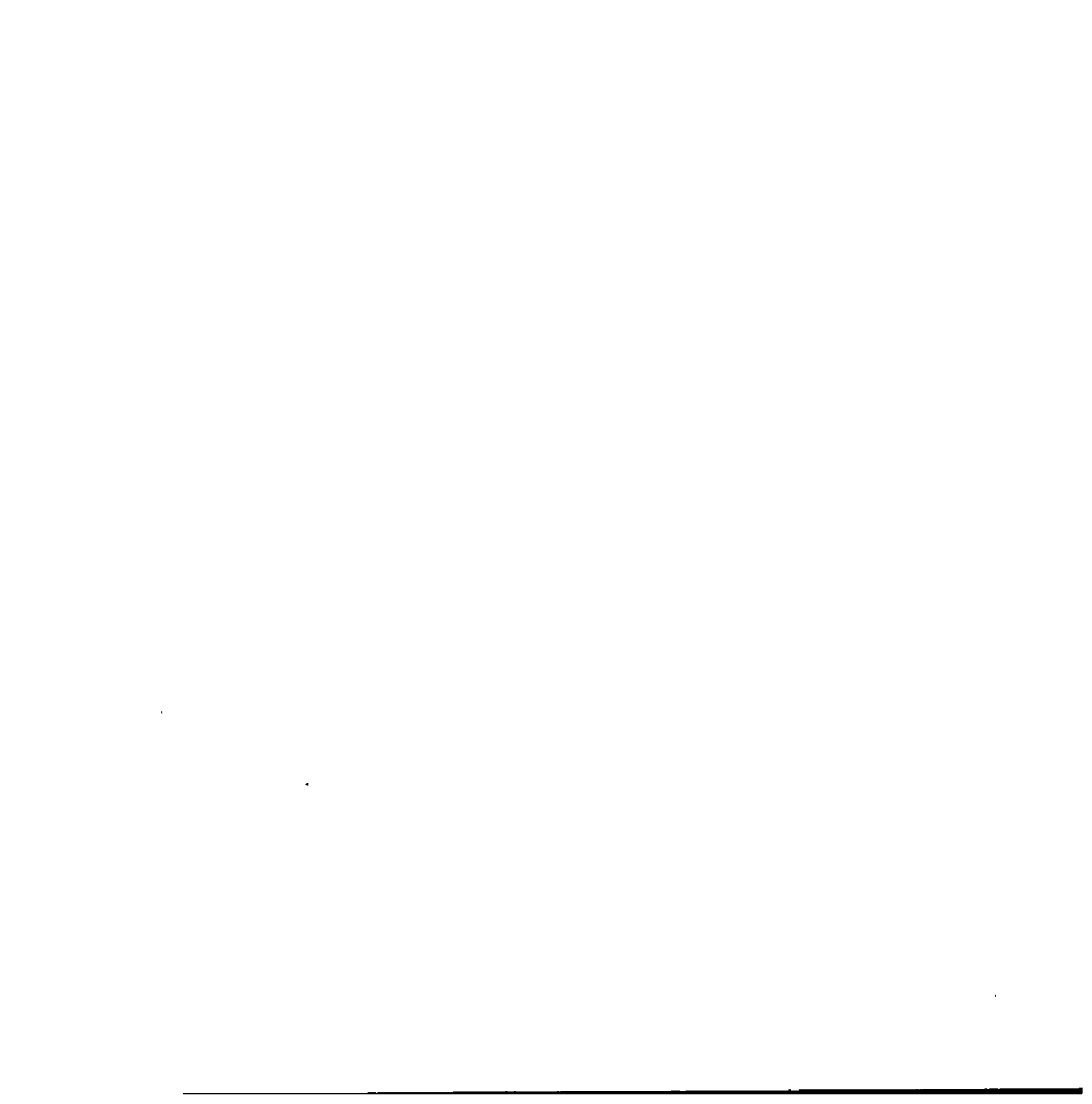


Source: Medicaid Budget Group, MESA model

## Spending

We project that total Medicaid spending will increase by 7.6 percent annually between 2012 and 2032. This projection is based on the Medicaid program as it currently exists and does not consider policy changes that may occur during the forecast period. Service categories that primarily serve the elderly are projected to experience the highest growth in spending during the forecast period.<sup>24</sup> These services also tend to have the highest average per capita costs.

<sup>24</sup> See Appendix Table 14

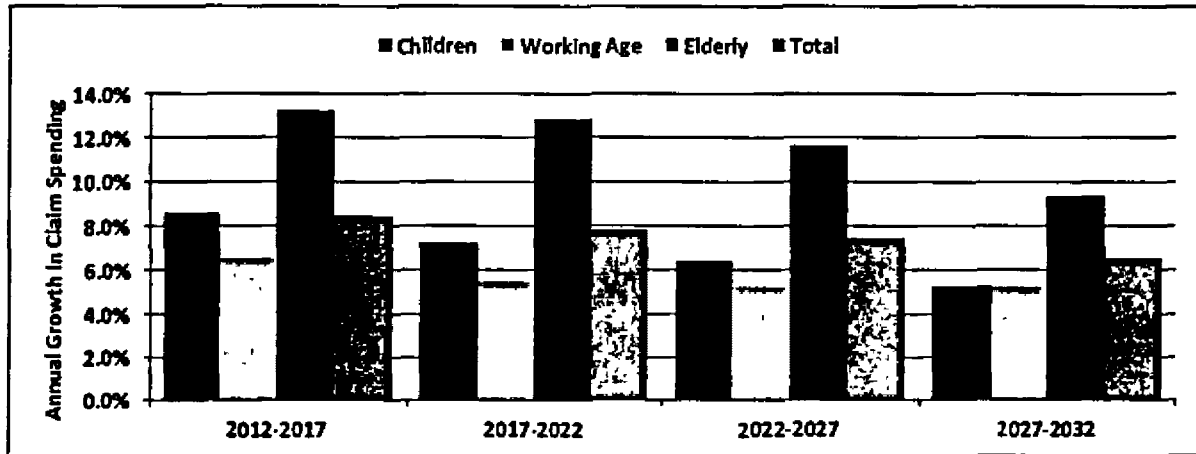


MEDICAID SPENDING BY AGE GROUP FOR SELECTED YEARS, 2012 – 2032 (IN MILLIONS)						
Age Group	2012	2017	2022	2027	2032	Annual Growth
Children (0-19)	\$524.3	\$789.9	\$1,121.0	\$1,529.0	\$1,977.4	6.9%
Working Age Adults (20-64)	\$631.5	\$868.3	\$1,137.7	\$1,470.9	\$1,895.5	5.7%
Elderly (65+)	\$228.5	\$425.9	\$779.7	\$1,352.2	\$2,112.4	11.8%
Total	\$1,384.3	\$2,084.0	\$3,038.4	\$4,352.0	\$5,985.3	7.6%

Source: Medicaid Budget Group: MESA Model

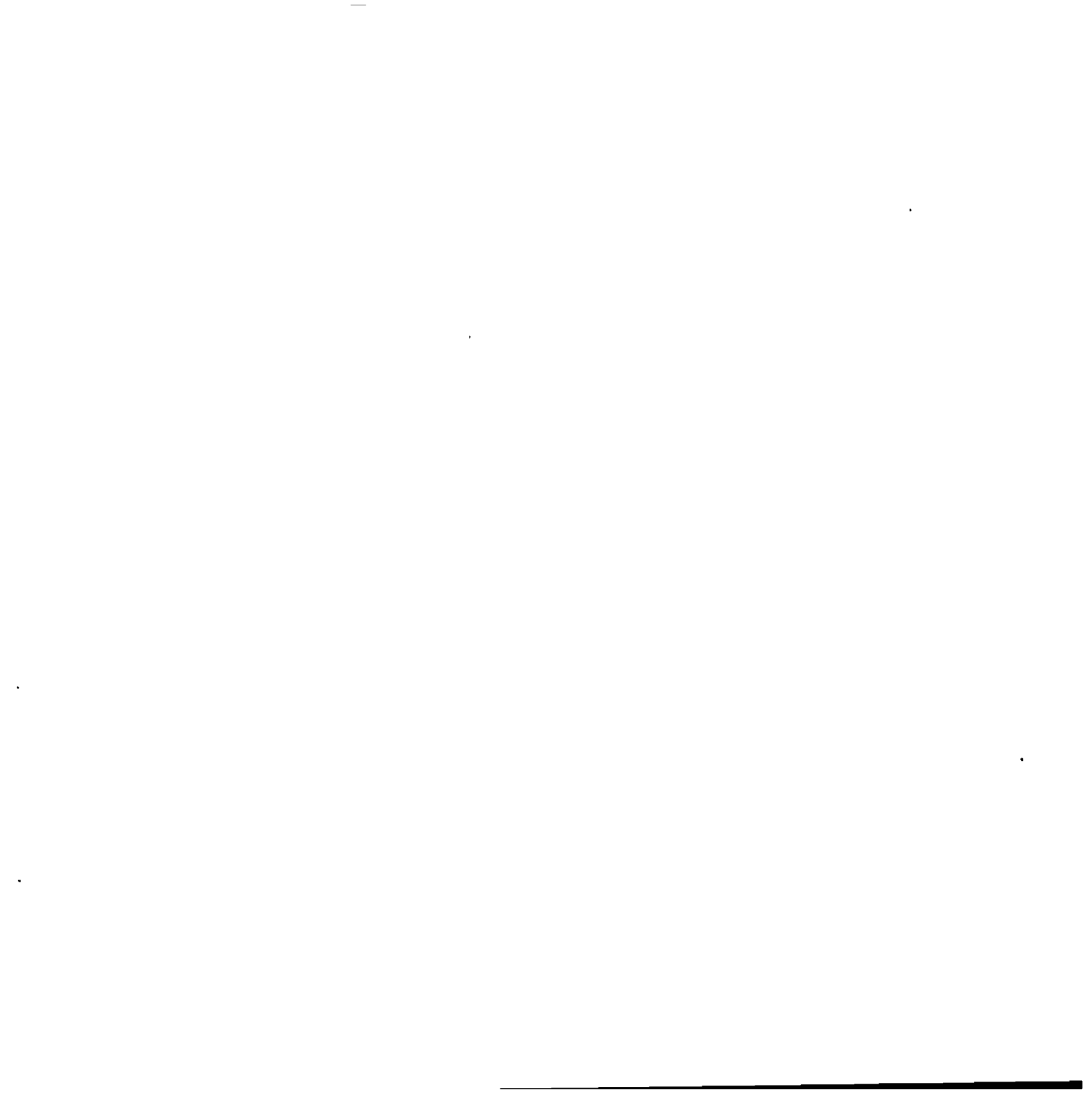
Figure 7: Growth In Medicaid spending on the elderly will accelerate between 2012 & 2017 and then slow throughout the forecast period

ANNUAL GROWTH IN TOTAL CLAIMS SPENDING BY AGE GROUP

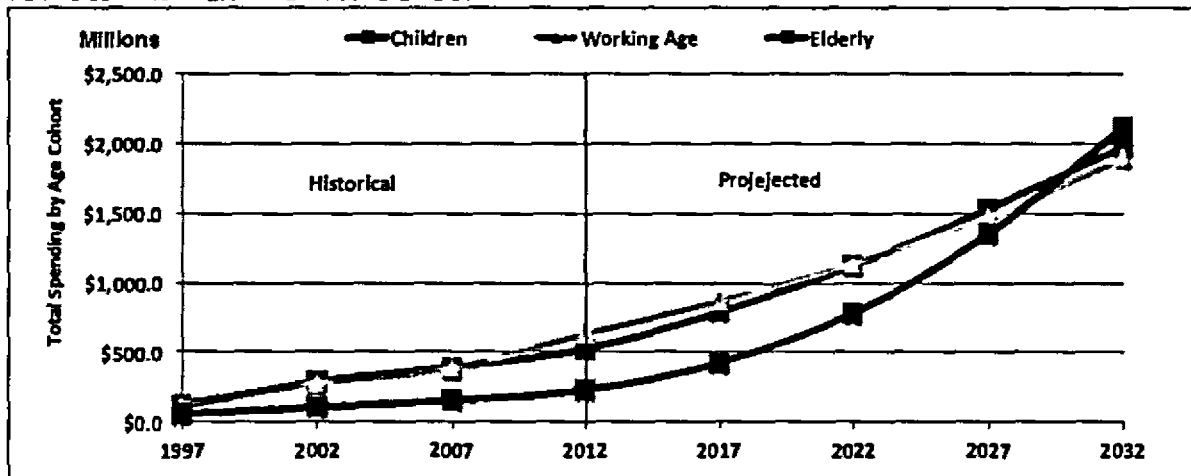


Source: Medicaid Budget Group, MESA Model

We project the average annual growth rate in spending for the elderly will be 11.76 percent through 2032. In comparison, we project average annual growth rates of 6.9 percent for children and 5.7 percent for working-age adults. Claims spending for all groups will grow from \$1.4 billion in 2012 to \$6.0 billion in 2032, for an annual growth rate of 7.6 percent. The higher projected growth rates in spending on the elderly, relative to children and working-age adults, is due in large part to the higher projected growth rate in enrollment of the elderly, relative to the younger age groups.



### TOTAL CLAIMS SPENDING BY AGE GROUP

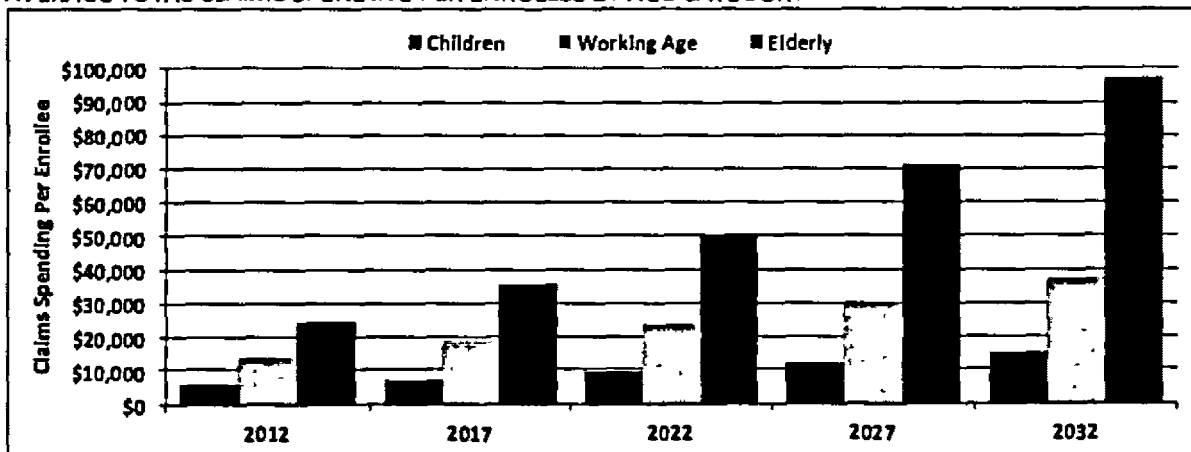


Source: Medicaid Budget Group: MESA Model

The higher costs of caring for the elderly will increase the total share of spending on elderly care. By 2032, we project spending for the elderly will account for 35 percent of total spending, even though the elderly will account for only 11 percent of Medicaid enrollees.

Figure 9: Spending on each elderly enrollee will continue to outpace spending per enrollee on children and working-age adults

### AVERAGE TOTAL CLAIMS SPENDING PER ENROLLEE BY AGE CATEGORY<sup>25</sup>

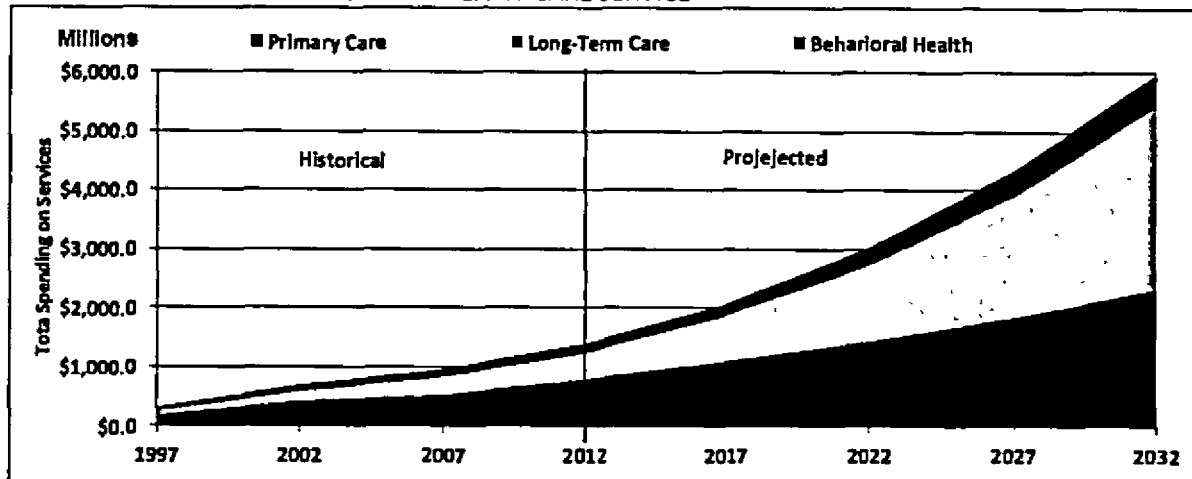


Source: Medicaid Budget Group: MESA Model

<sup>25</sup> For more in-depth information about average spending per enrollee by demographic group, see Table 15 in Appendix.



Medicaid will quadruple between 2012 and 2032  
**TOTAL CLAIMS SPENDING BY TYPE OF HEALTHCARE SERVICE**

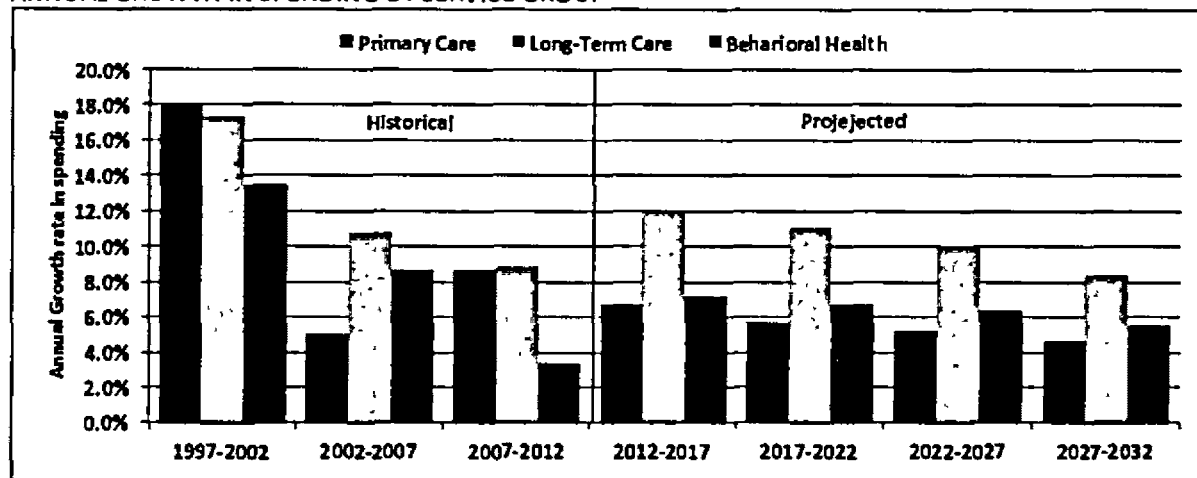


Source: Medicaid Budget Group: MESA Model

Note: All spending on Medicaid services is categorized into one and only one of these three types of healthcare services

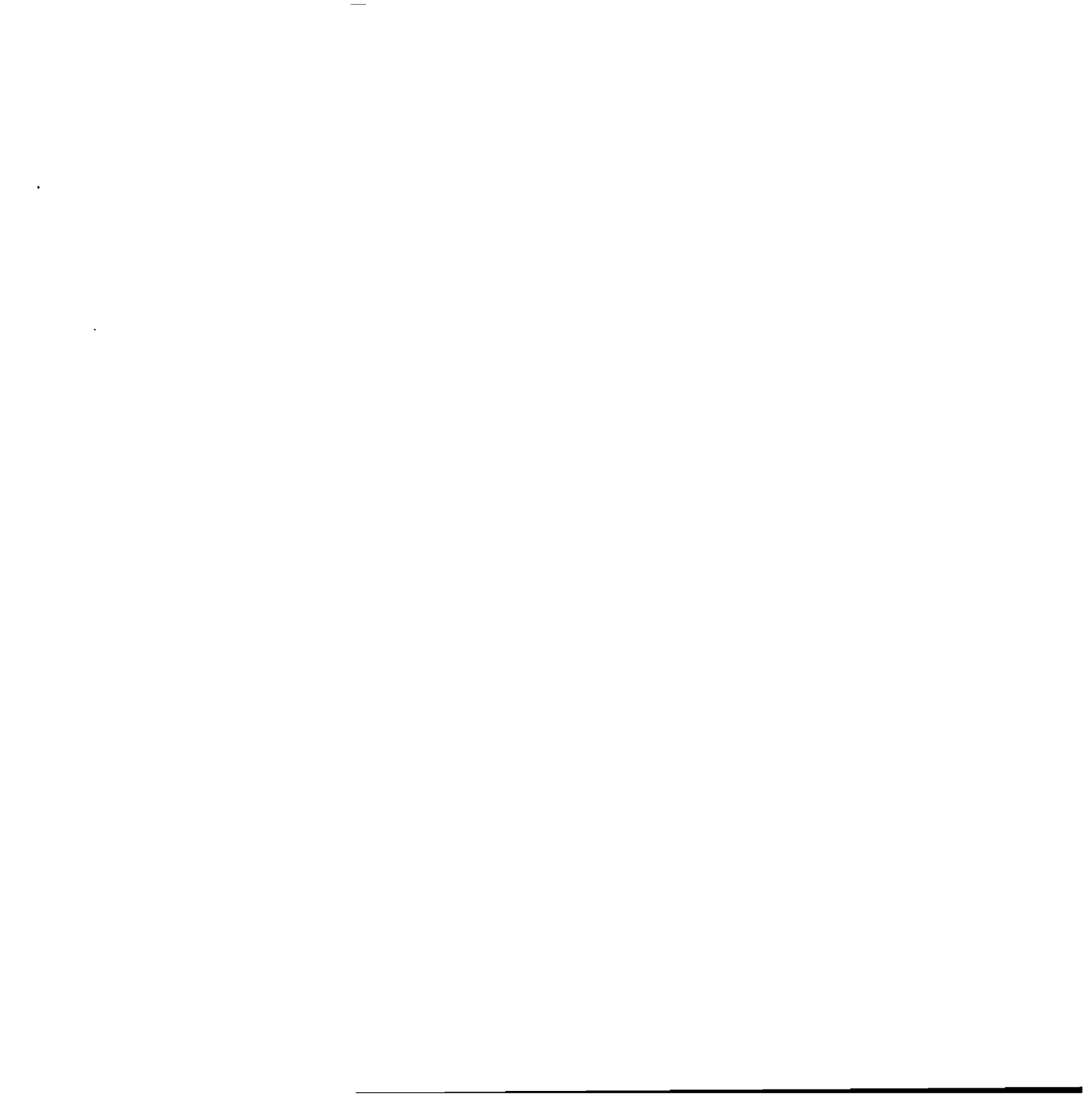
**Figure 11: Growth in total spending has slowed dramatically in recent years**

**ANNUAL GROWTH IN SPENDING BY SERVICE GROUP**



Source: Medicaid Budget Group: MESA Model

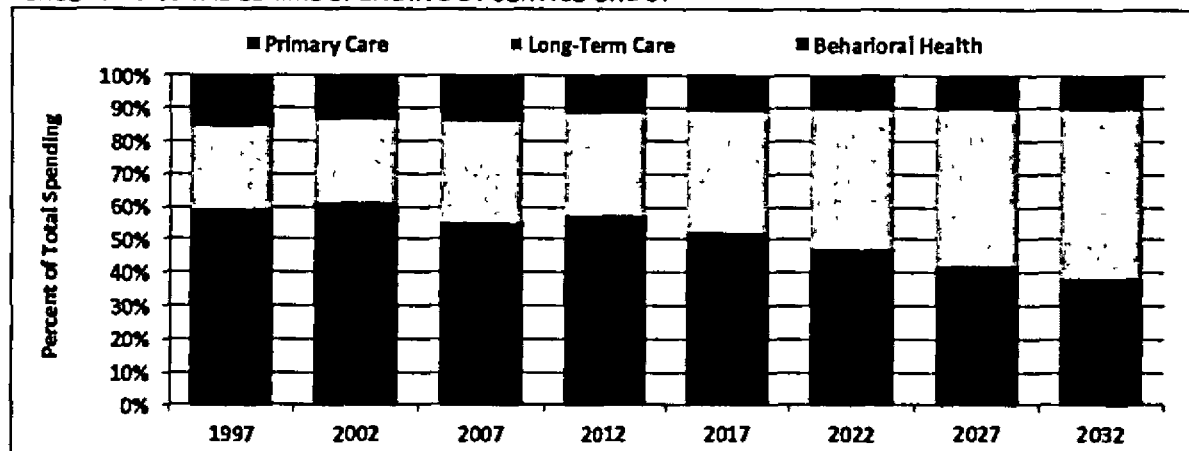
Figure 11 shows the growth rate in Alaska's historical and projected Medicaid spending. Spending on Medicaid increased rapidly from 1997 to 2002; annual growth rates never dropped below 10 percent in any year and averaged 16 percent annually for the period. The large spending increases of the late 1990s and early 2000s were brought under control from 2006 through 2008. The slowing down of the growth in spending from 2006 to 2008 was due at least in part to program changes put in place by the Legislature and Department following the release of the *Long-Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025* in January 2006. However, with the severe economic recession that hit the country in 2008, enrollment in and spending on Medicaid increased in 2009 and 2010. Medicaid claims spending



percent annual growth over the forecast period.

Spending on long-term care services, such as Home and Community Based (HCB) Waiver and Personal Care,<sup>26</sup> is projected to grow faster than spending on Primary Care and Behavioral Health. Long-term Care, which is expected to grow from 31 percent to 51 percent of total spending, has a larger share of recipients over the age of 65 than either Primary Care or Behavioral Health.

**Figure 12: Spending on long-term care services will increase as a share of total Medicaid spending**  
**PERCENT OF TOTAL CLAIMS SPENDING BY SERVICE GROUP**



Source: Medicaid Budget Group: MESA Model

**Table 6: Long-term care is projected to be the fastest growing service category**

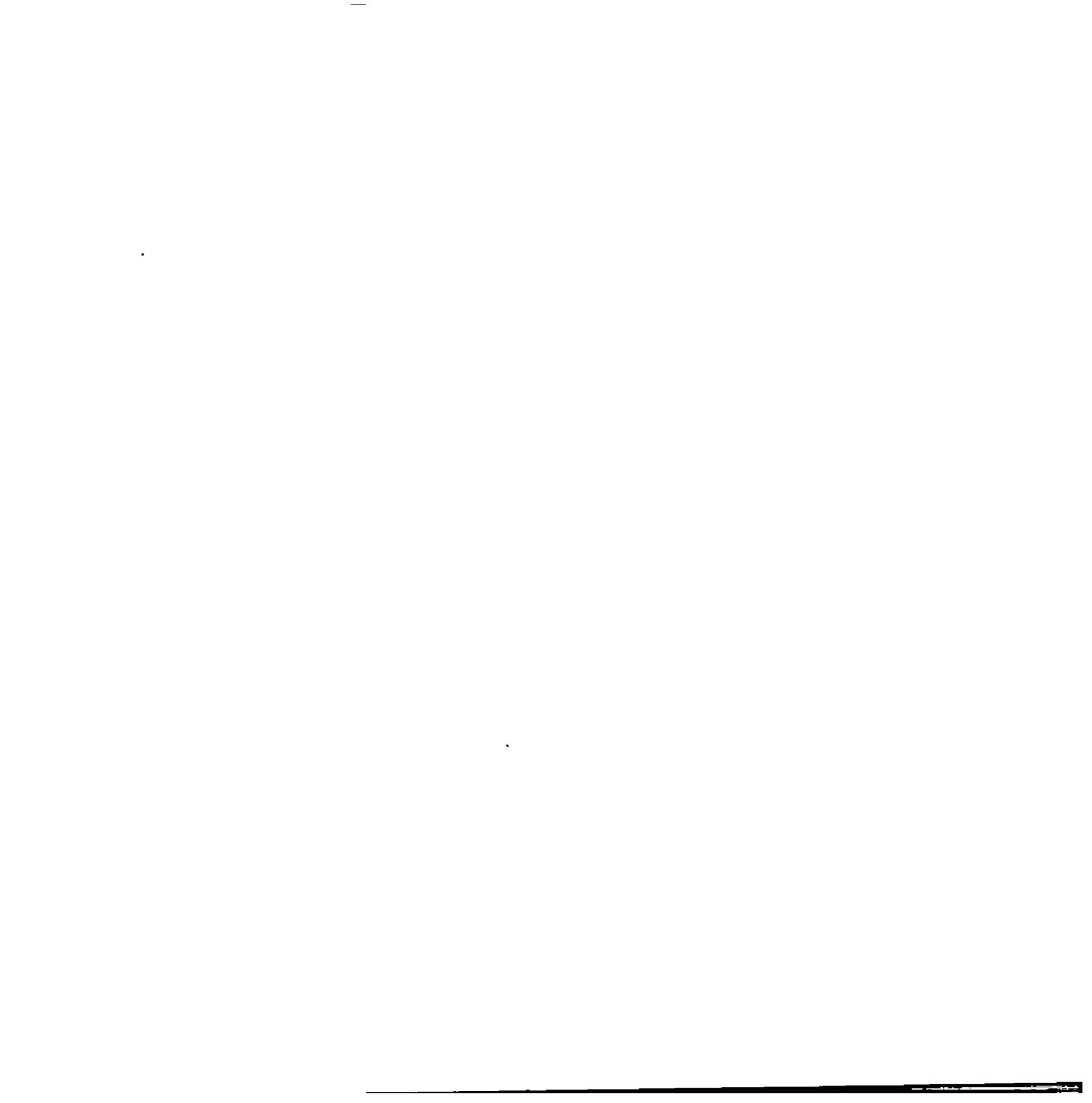
**MEDICAID SPENDING AND CLAIM PAYMENTS BY SERVICE GROUP FOR SELECTED YEARS (IN MILLIONS)**

Service	2012	2017	2022	2027	2032	Annual Growth
Behavioral Health	\$162.41	\$230.67	\$325.23	\$456.36	\$626.59	6.98%
Long-Term Care	\$432.66	\$761.77	\$1,282.49	\$2,064.75	\$3,075.07	10.30%
Primary Care	\$789.27	\$1,091.61	\$1,430.65	\$1,830.85	\$2,283.65	5.46%
<b>Total</b>	<b>\$1,384.33</b>	<b>\$2,084.04</b>	<b>\$3,038.37</b>	<b>\$4,351.97</b>	<b>\$5,985.31</b>	<b>7.60%</b>

Source: Medicaid Budget Group, MESA model.

While total Medicaid spending is projected to grow at an average annual rate of 7.6 percent through the forecast period, there is significant variation in the growth rates of the individual services. Spending on HCB Waiver is projected to grow by an average of 9.5 percent per year. Personal Care is projected to grow by 13.1 percent per year. By 2032, HCB Waiver will account

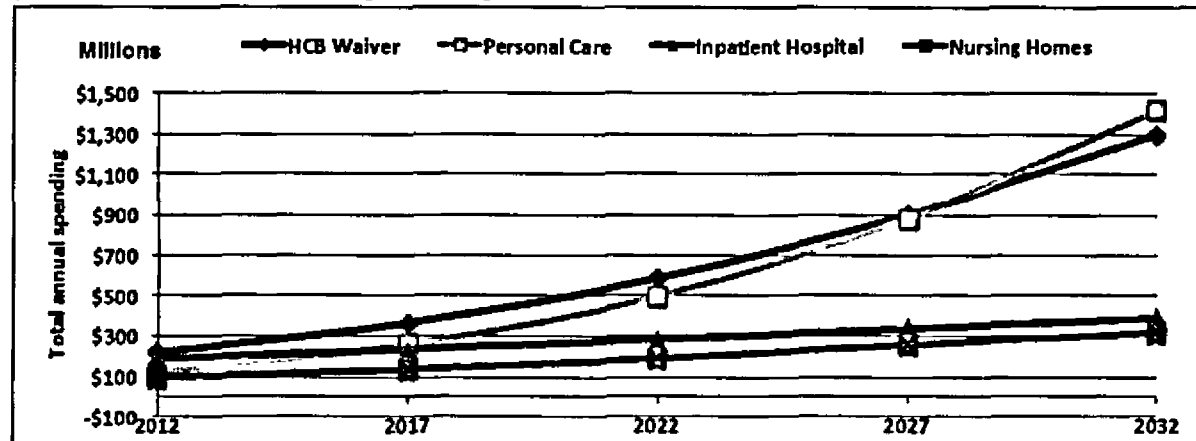
<sup>26</sup> The HCB Waiver program allows people who would otherwise need an institutional level of care to live in their home or community and receive the care they need. These "waivers" are approved by the federal government and allow Alaska Medicaid to provide expanded services to people who meet the eligibility criteria for the specific waiver. Home and Community Based Waiver programs help the elderly and disabled, mentally retarded, developmentally disabled, and certain other disabled adults.



Personal Care will also make large gains, with an increase from 20 percent of total claims spending (\$120 million) in 2012 to 41 percent of spending (\$1.4 billion) in 2032. Spending in both of these programs is driven largely by growth in enrollment of the elderly.

**Figure 13: Home and Community Based Waivers and Personal Care are the fastest growing service categories**

**TOTAL CLAIMS SPENDING FOR SELECTED SERVICE CATEGORIES**



Source: Medicaid Budget Group, MESA model

Conversely, Inpatient Hospital is currently one of the largest categories of spending in 2012, second only to HCB Waiver, and is not as heavily influenced by growth in the enrollment of the elderly. Inpatient Hospital spending is projected to grow by 3.8 percent annually, resulting in a decrease in share of Medicaid spending from 30 percent in 2012 to 11 percent in 2032.<sup>28</sup>

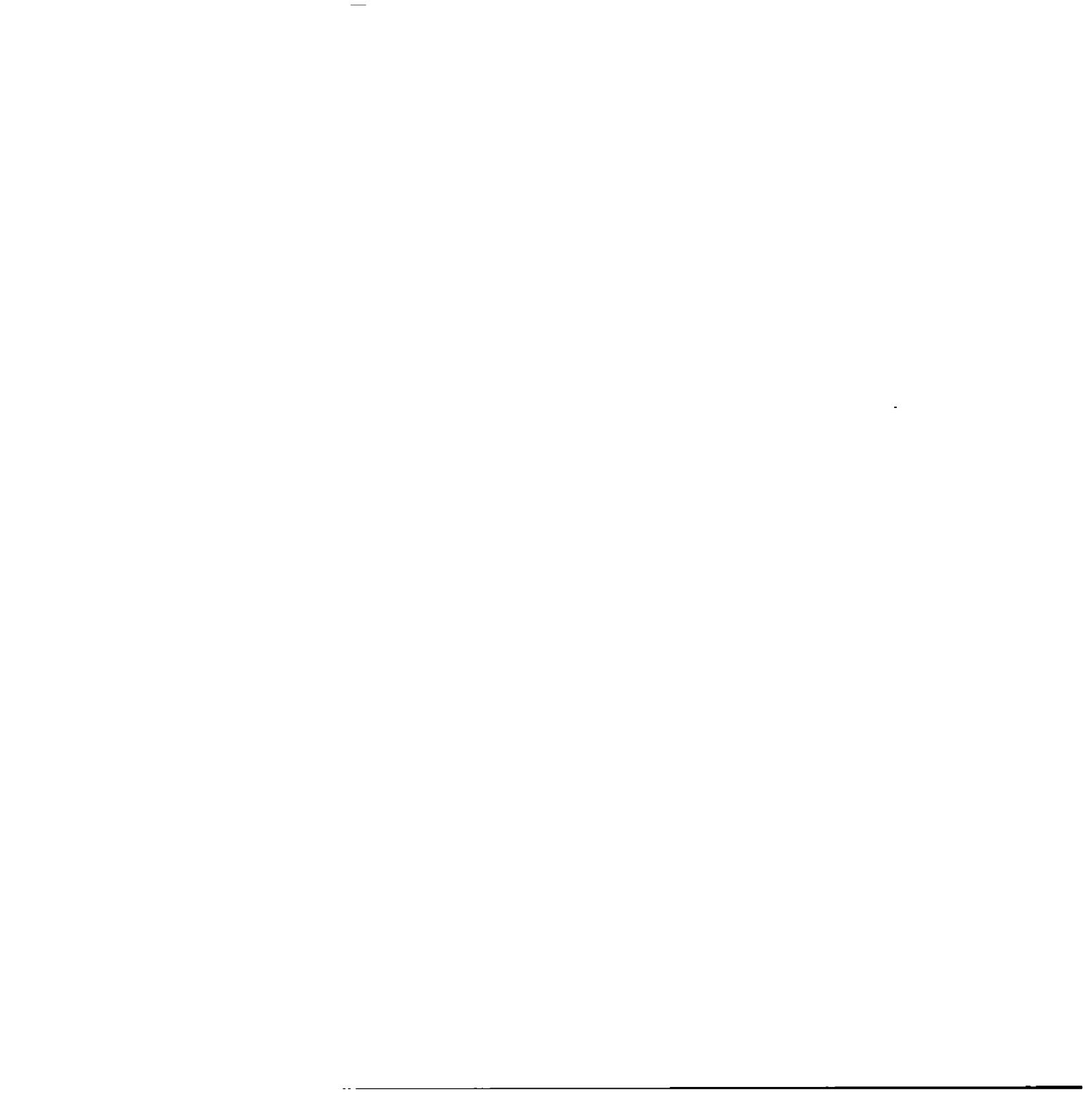
Despite the relatively high rate of growth in the elderly population, the rate of spending growth for Nursing Homes is projected to be slower than the growth in spending for Medicaid as a whole. As a result, the Nursing Home category will drop from 16 percent of total Medicaid spending in 2012 to 9 percent by 2032. The data suggests that recipients may be shifting from Nursing Homes, where services are received in an institutional setting, to Personal Care and Home and Community Based Waivers, where care is received in one's own home.

Figure 14 shows the growth in total spending by components that affect spending growth. The components of spending growth are as follows:

*Status Quo* refers to what would happen if there were no health cost inflation, no growth in population, and no growth in the use and intensity of services provided. The status quo assumes that everything in future years remains exactly the same as in 2012.

<sup>27</sup> See Table 16 in Appendix

<sup>28</sup> IBID



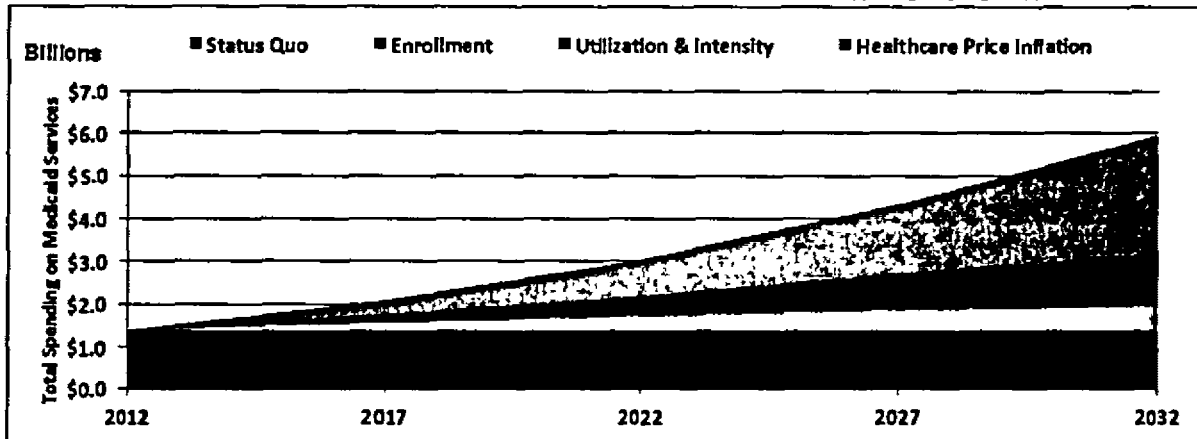
enrollment. Only the increase in total enrollment is taken into account and not demographic changes such as an aging population.

*Growth in Services* includes the additional spending associated with a greater use and intensity of services provided. Growth in services is the result of an aging population and other demographic changes, as well as the change in amount, duration, and scope of services provided from an increase of technology.

*Inflation* is the rate at which the price of a given medical service is expected to increase over time.

The component that will have the largest influence on growth in total spending is healthcare price inflation. Without inflation, Medicaid claims spending would increase from \$1.3 billion to \$3.2 billion in 2032, an average annual growth rate of 4.3 percent. Healthcare price inflation, however, increases the amount of spending in 2032 by an additional \$2.8 billion for a total cost of \$6.0 billion – a combined annual increase of 7.6 percent over the forecast period.

**Figure 14: Healthcare price Inflation accounts for the largest part of Increased claims spending**  
**PROJECTED SPENDING ON MEDICAID SERVICES BY INDIVIDUAL COMPONENTS OF GROWTH**



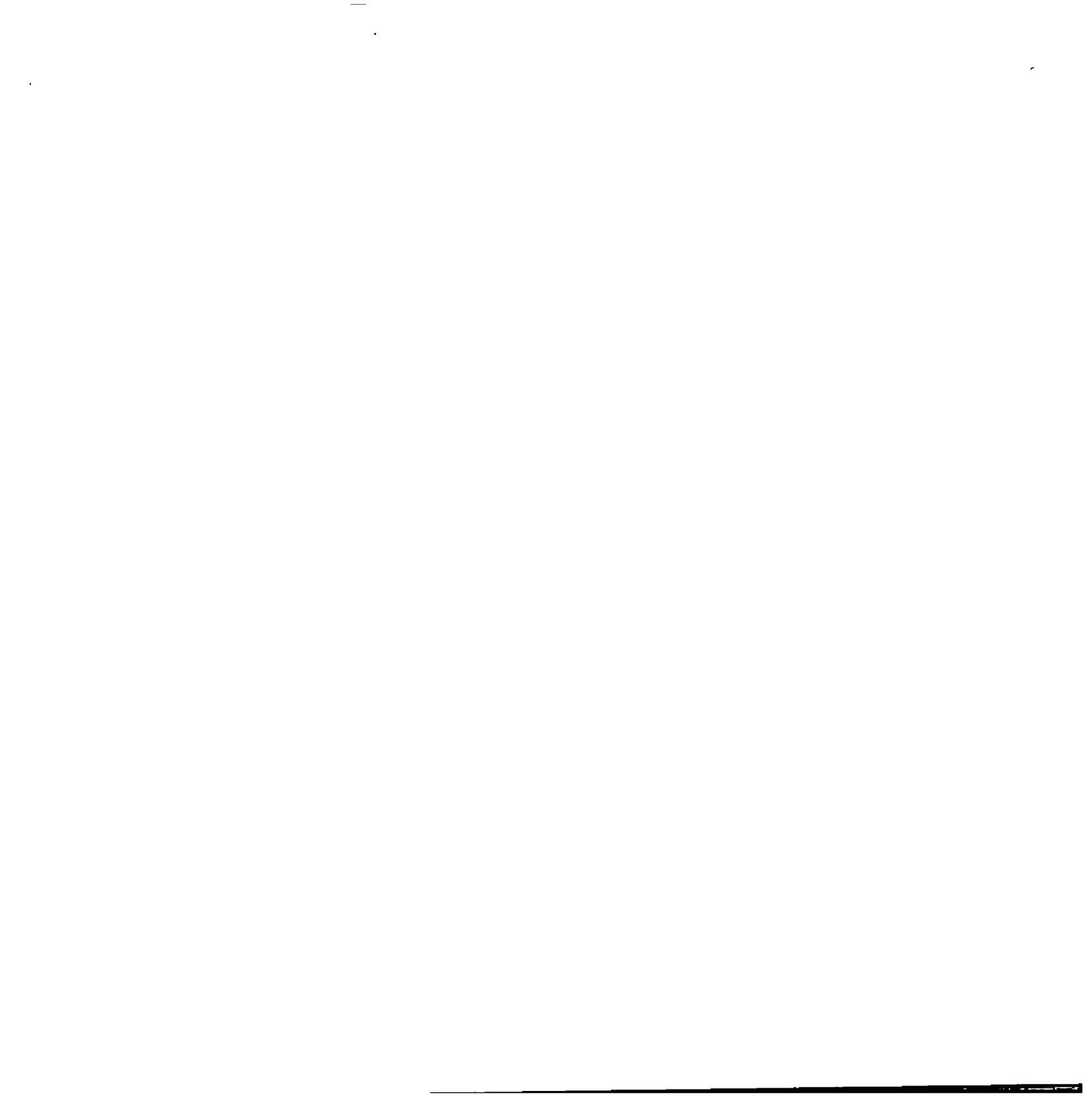
Source: Medicaid Budget Group, MESA model

## State Spending

State spending is projected to grow at 7.9 percent annually for the forecast period, compared to a projected 7.3 percent annual growth in federal spending.<sup>29</sup> The Federal Financial Participation (FFP) rate that applies to the majority of Medicaid spending is known as the Federal Medical Assistance Percentage (FMAP).<sup>30</sup> During the second half of calendar year 2011, the FMAP

<sup>29</sup> See Table 18 in Appendix

<sup>30</sup> Historically approximately 80 percent of Alaska Medicaid spending is reimbursed at the Regular FMAP rate. Alaska also has a substantial amount of Indian Health Services (IHS) spending, which is reimbursed at 100 percent. Family planning services are



the forecast period. This projection, therefore, does not incorporate possible changes to the rate of federal financial participation in the future.

Federal financial participation rates are set at the federal level, and are largely outside of state control. The state's portion of Medicaid Service costs differs according to the recipient's Medicaid eligibility group, category of Medicaid service, provider of Medicaid-related service, and Native/Non-native status.

**Table 7: State share of Medicaid funding increases throughout the forecast period**  
**MEDICAID SPENDING BY FUND SOURCE AS A PERCENT OF TOTAL SPENDING, 2012 – 2032**

<b>Fund Source</b>	<b>2012</b>	<b>2017</b>	<b>2022</b>	<b>2027</b>	<b>2032</b>
<b>State and Other Match Funds (Percent of Total)</b>	42.2%	42.8%	43.6%	44.4%	45.0%
<b>Federal (Percent of Total)</b>	57.8%	57.2%	56.4%	55.6%	55.0%

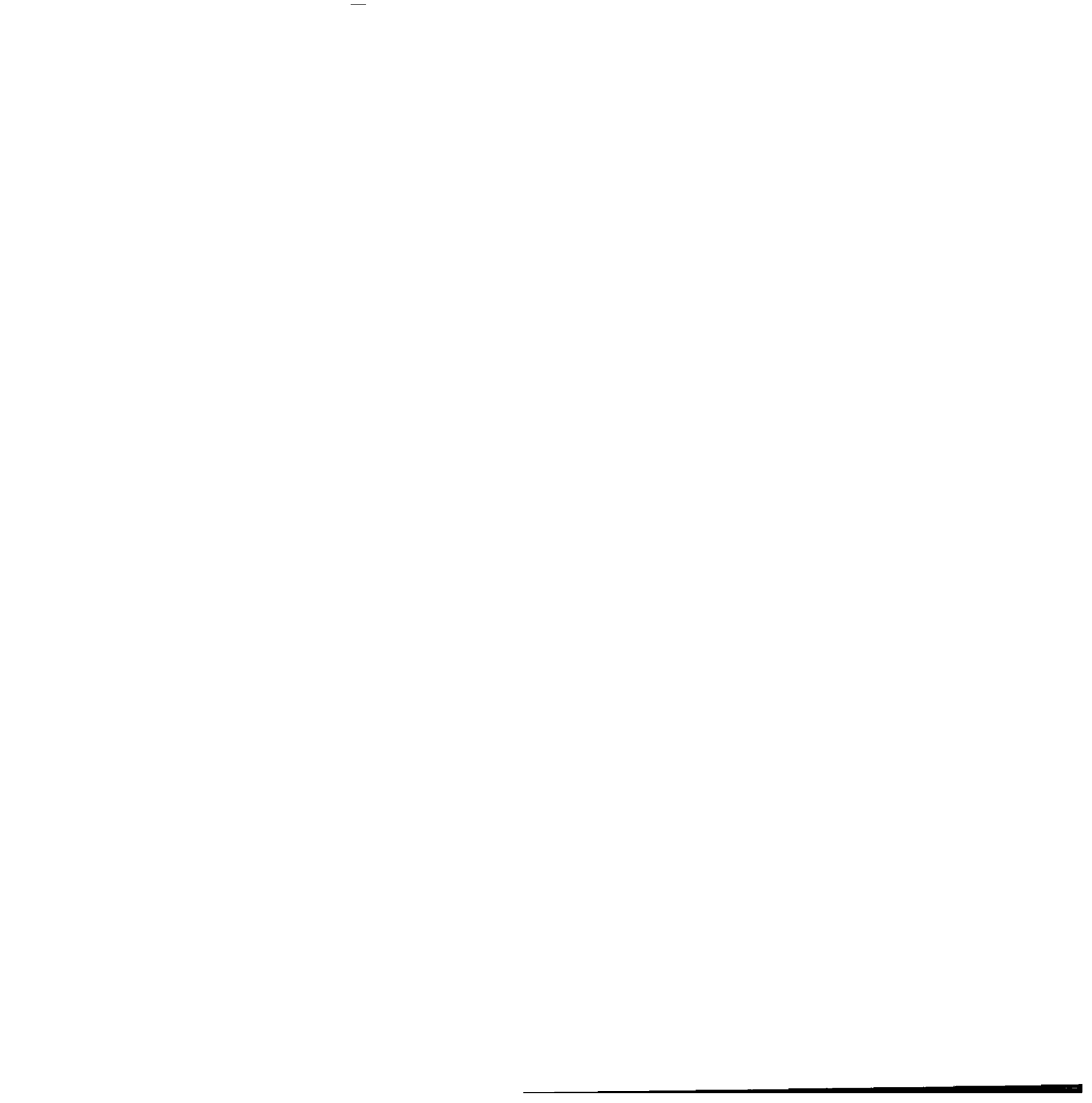
Source: Medicaid Budget Group, MESA model.

The FMAP is based on a three-year average of per capita personal income, ranked among states. While each state has its own FMAP, it can be no lower than 50 percent. Although the majority of Medicaid benefits are reimbursed at the regular FMAP rate, certain subgroups have higher reimbursement rates (e.g., qualified Indian Health Services claims are reimbursed 100 percent). Where possible, the state contains costs by taking advantage of higher reimbursement rates.

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reimbursed at 90 percent. Breast and Cervical Cancer services and Title XXI (CHIP) services are both reimbursed at what is called the "Enhanced FMAP", which is expected to be about 65 percent throughout the forecast period.

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Chapter 2 deals with other (“special”) Medicaid payments and offsetting recoveries, which are not tied to services provided to any individual Medicaid enrollee. The share of total spending attributed to the special payments and offsets varies from year to year. For example, in 2005 the special payments accounted for 13 percent of total Medicaid spending, compared to 5 percent during 2009.

These additional payments and offsets include Medicare premium payments, Medicare “clawback” payments, Disproportionate Share Hospital (DSH) payments, Continuing Care Agreement payments, and Tribal Encounter payments.<sup>31</sup>

**Medicare Part A premium payments:** Medicare Part A, or Hospital Insurance (HI), is a Medicaid program that helps pay for the costs of hospital stays, including meals, supplies, testing, and a semi-private room. The Medicaid Part A program also pays for home health care such as physical, occupational, and speech therapy that is provided on a part-time basis and deemed medically necessary. Care in a skilled nursing facility as well as certain medical equipment for the aged and disabled such as walkers and wheelchairs are also covered by Part A. Part A is generally available without having to pay a monthly premium, since payroll taxes are used to cover these costs.

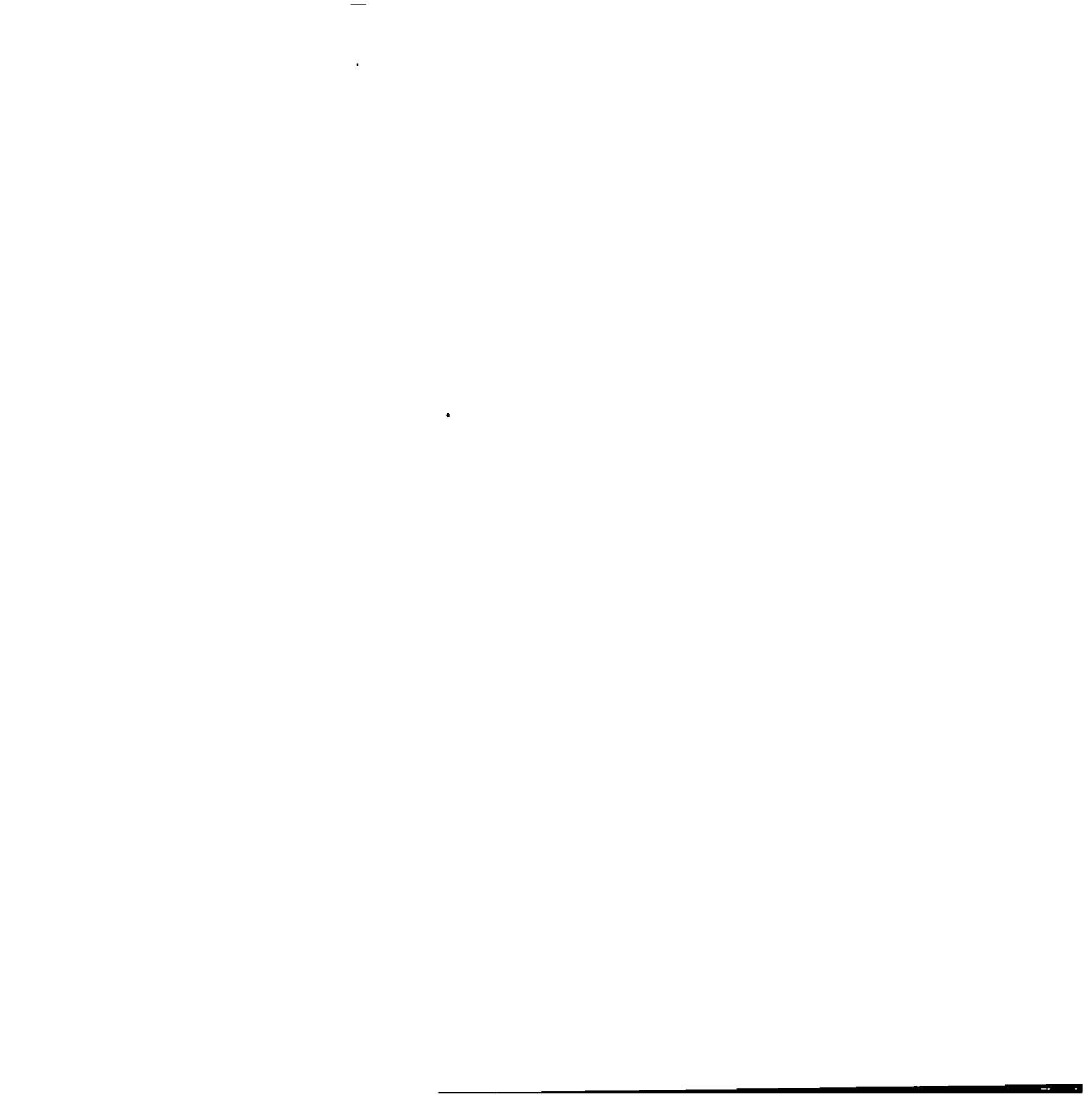
**Medicare Part B premium payments:** Medicare Part B is also called Supplementary Medical Insurance (SMI). It helps pay for medically necessary physician visits, outpatient hospital visits, home health care costs, and other services for the aged and disabled.

**Medicare Part D clawback:** Medicare Part D is a federal program to subsidize the costs of prescription drugs for Medicare beneficiaries in the United States. It was enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and went into effect on January 1, 2006. Prior to Medicare Part D going into effect, the state’s Medicaid program paid the drug costs for seniors in the Medicaid program. The federal government now pays the drug benefits for these individuals, but also requires that the state contribute payments on behalf of these individuals. These payments are called the Medicare Part D clawback.

**Disproportionate Share Hospital (DSH) payments:** DSH payments are designed to help hospitals that serve large numbers of Medicaid and uninsured patients. The Medicaid DSH

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<sup>31</sup> Medicare is a federal program that provides health insurance to people age 65 or older, people under age 65 with certain disabilities, and people of all ages with End Stage Renal Disease. The program is voluntary and beneficiaries must pay monthly premiums. If Medicare beneficiaries have low-income, they may also be eligible for benefits under Medicaid. Because Medicaid is the payer of last resort, Medicare pays for ‘dual-eligible’ beneficiaries’ claims before Medicaid does. Medicaid pays the premium for low-income Medicare Part A and Part B beneficiaries who cannot afford the insurance because it costs substantially less to pay the premium than to pay the claim.



**Continuing Care Agreement payments:** These payments are paid to Tribal health care providers, which must provide particular services and perform certain administrative functions for children in the Medicaid program. Some of the medical services include the screening, diagnosis, treatment, and referral for follow-up services and physician's services needed by the recipient for acute, episodic, or chronic illnesses or conditions. Administrative functions include maintaining the recipient's consolidated health history and submitting any reports that the state Medicaid agency may reasonably require. Reimbursing Tribal continuing care providers for the cost of actually delivering the comprehensive range of health services offered at Tribal facilities helps ensure financial stability for the Tribal health care delivery system. It also avoids the costs (partially state funded) of transporting Medicaid clients elsewhere in the state to receive the health care services they need.

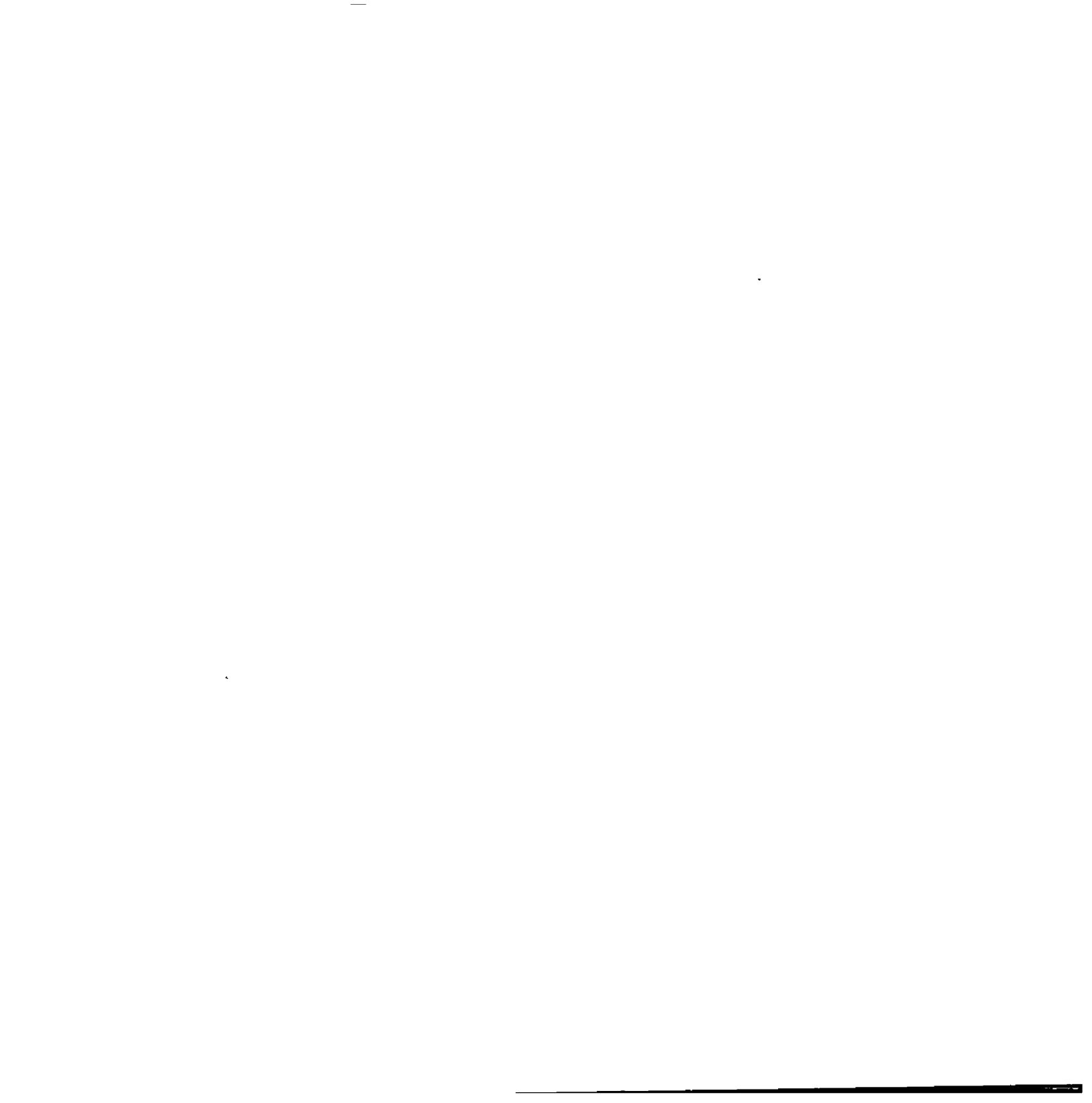
**Encounter payments:** These payments have been used for a quarter-century to pay Indian Health Services (IHS) and tribally operated facilities for services provided to Medicare and Medicaid enrollees. The encounter rate is a flat daily rate per visit that is published annually in the federal register. There are different inpatient and outpatient rates calculated for Alaska and the lower 48 states for Medicaid and Medicare Services.

**Offsetting recoveries:** "Offsetting recoveries" refers to credits used to reduce expenses and they include collections for third-party liability on claims and drug rebates. One of the tenants of Medicaid is that Medicaid is the payer of last resort; therefore, the department does not pay medical claims that are payable by a third party. The department contracts for the collection of medical expenses paid by Medicaid from potential third parties and does not pay medical claims that are payable by a third party.

There is uncertainty about the magnitude of the effect that special payments will have on Medicaid spending in the future. The Medicaid program is always changing, and payments that are acceptable one year may be disallowed by Centers for Medicare and Medicaid Services (CMS) in later years.<sup>32</sup> Because of this, we are unable to develop reasonable estimates of spending on special Medicaid payments and offsetting recoveries by type. However, on average total spending on these payments historically has been approximately 5 percent of total spending on Medicaid claims. Therefore, special payments are represented in this forecast by adding an additional 5 percent onto the forecast, based on claims data. In any given year, the forecast assumes that the share of total spending paid by the federal government will be the same for these special payments as it was for the claims payments.

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<sup>32</sup> FairShare and ProShare are two examples of supplemental payment programs that have been discontinued in recent years.



**MEDICAID SPENDING BY FUND SOURCE FOR SELECTED YEARS, 2012 – 2032 (IN MILLIONS)**

		<b>2012</b>	<b>2017</b>	<b>2022</b>	<b>2027</b>	<b>2032</b>
<b>Claims payments</b>	<b>Federal</b>	\$800.5	\$1,192.2	\$1,715.0	\$2,421.8	\$3,291.3
	<b>State Match</b>	\$583.9	\$891.9	\$1,323.4	\$1,930.1	\$2,694.0
	<b>Total</b>	\$1,384.3	\$2,084.0	\$3,038.4	\$4,352.0	\$5,985.3
<b>Other Payments</b>	<b>Federal</b>	\$40.0	\$59.6	\$85.8	\$121.1	\$164.6
	<b>State Match</b>	\$29.2	\$44.6	\$66.2	\$96.5	\$134.7
	<b>Total</b>	\$69.2	\$104.2	\$151.9	\$217.6	\$299.3
<b>Total Payments</b>	<b>Federal</b>	\$840.5	\$1,251.8	\$1,800.8	\$2,542.9	\$3,455.9
	<b>State Match</b>	\$613.1	\$936.5	\$1,389.5	\$2,026.6	\$2,828.7
	<b>Total</b>	\$1,453.6	\$2,188.3	\$3,190.3	\$4,569.6	\$6,284.6

Source: Medicaid Budget Group: MESA Model. Estimates include only the costs for Medicaid services.

\*

We project total spending on Alaska's Medicaid program to grow at an average annual rate of 7.6 percent over the next 20 years and to reach \$6.3 billion by 2032 (see Table 8, page 22). Over this same period, State spending is expected to grow at 8.0 percent and reach \$2.8 billion. In addition to healthcare price inflation, which is expected to average 3.3 percent per year, growth in spending on the Medicaid program through 2032 is the result of the following factors:

Growth in Alaska's Population – expected to average 1.0 percent per year

Growth in Medicaid Enrollment – expected to average 0.7 percent per year

Growth in the Utilization of Medicaid Services – expected to average 0.9 percent per year

Growth in Intensity of Service Provided – expected to average 1.7 percent per year

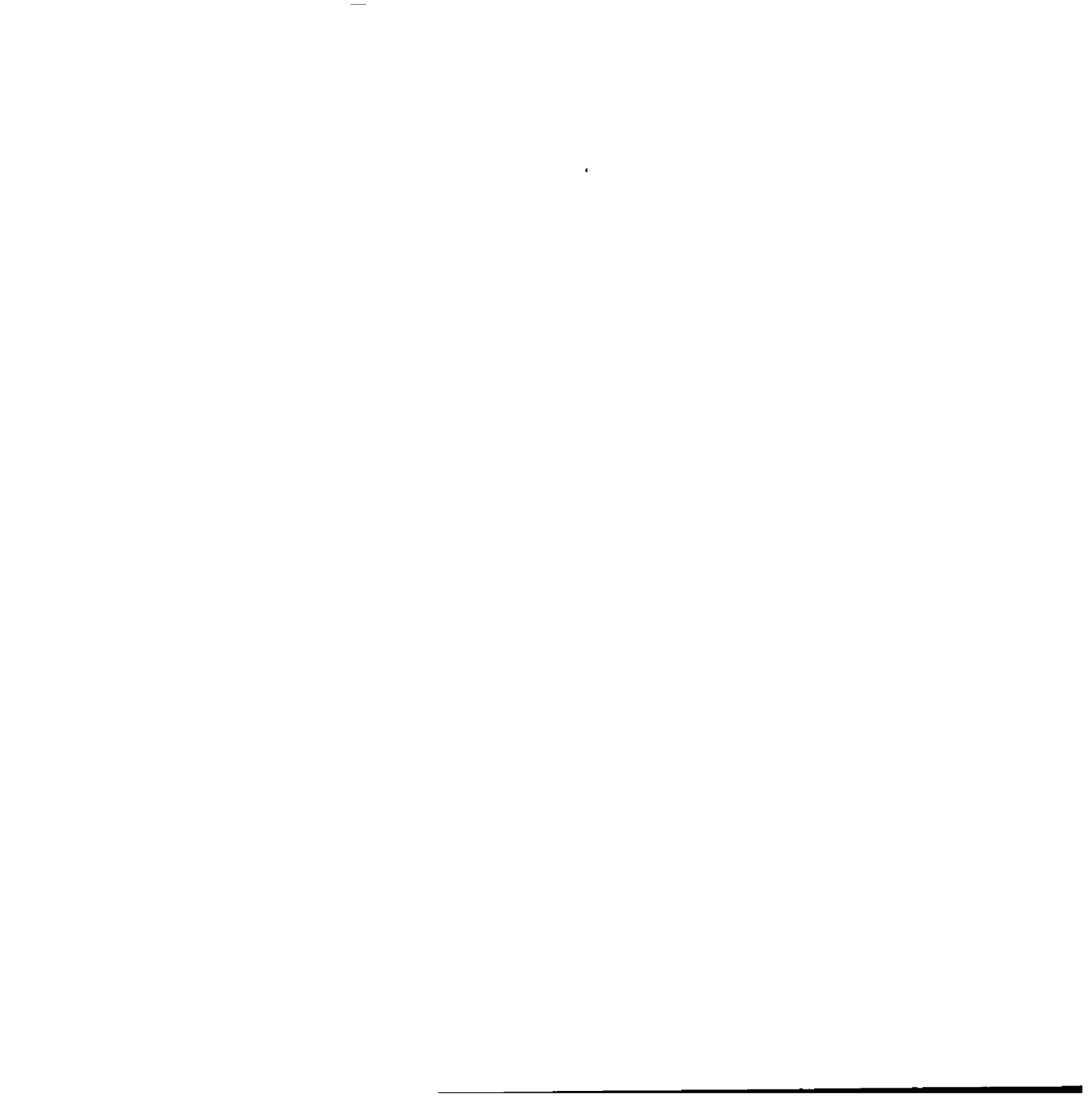
The population forecast includes assumptions about the changing demographic profile of Alaska. The average annual growth rate in enrollment of the elderly (65 and older) is expected to be 4.5 percent, which is higher than the growth rate for other age groups. As a result, the overall focus of the Medicaid program will shift from a child-based program to programs more evenly distributed between the elderly, working-age adults, and children. This demographic change affects spending, because spending on the elderly is growing at a rate over double that of children and working-age adults; this growth is likely to continue. A shift in spending towards the elderly is still expected to occur, but the timing will be delayed compared to earlier forecasts.

Services used more heavily by the elderly, such as Personal Care and Home and Community Based Waivers, will experience the highest spending growth throughout the forecast period.

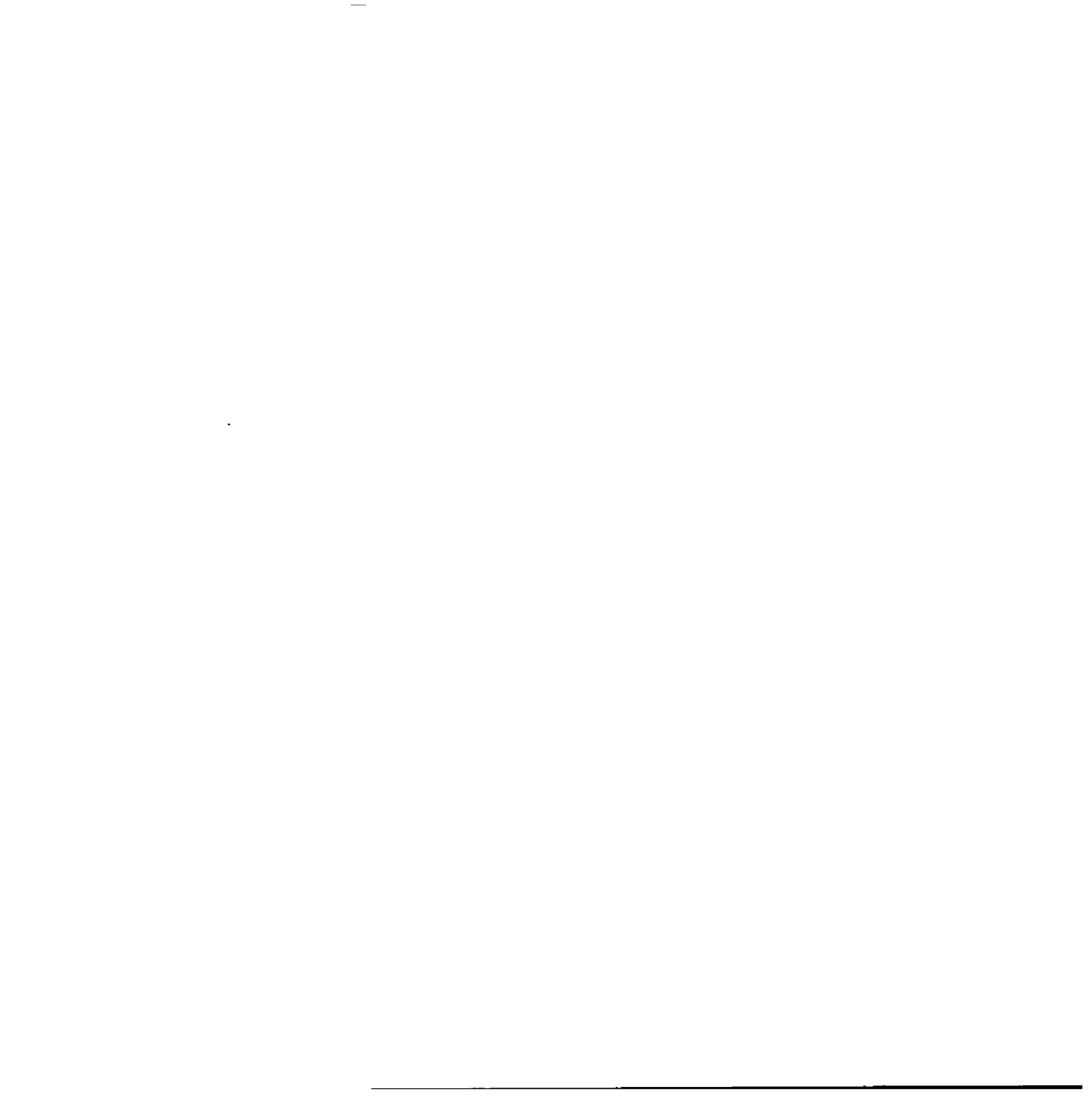
The purpose of this forecast is to enable policy makers and the Department of Health and Social Services to see where Medicaid is headed, based on key growth components. By looking farther into the future, policy can be based more on proactive rather than reactive measures.



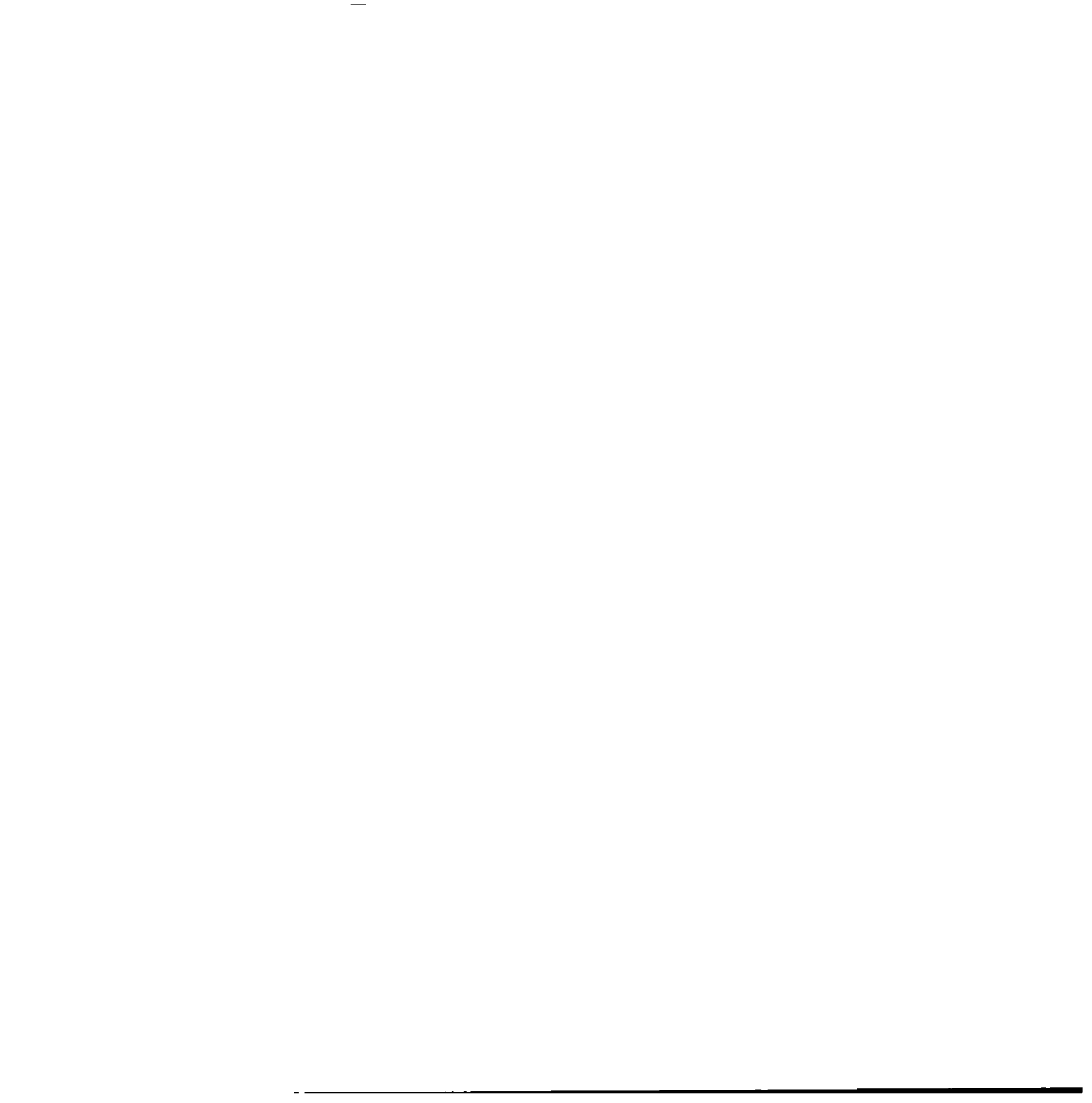
<b>Eligibility Class</b>	<b>Description</b>
<b>AFDC &amp; Related</b>	Eligible for AFDC-based Family Medicare or Transitional Medicaid
<b>Alien (Foreign)</b>	Illegal, sponsored, or amnesty alien
<b>Exams</b>	Disability, waiver, or pregnancy determination pending
<b>Kids in Custody</b>	Children in custody of DHSS
<b>LTC Non-cash</b>	Elderly or disabled individual not receiving SSI or cash supplement
<b>Medicare</b>	Eligible for Medicare cost-sharing assistance only
<b>Other Disabled</b>	Working disabled or eligible due to breast/cervical cancer screening
<b>Pregnancy/Post Partum</b>	Eligible during pregnancy and for 60 days after giving birth
<b>SSI/APA/LTC Cash</b>	Eligible for SSI or other state cash supplement
<b>Title XIX Kids</b>	Children under age 19 not eligible for coverage under CHIP
<b>Title XXI Kids</b>	Children under age 19 eligible for coverage under CHIP



<b>FFP Type</b>	<b>Rate of Federal Financial Participation</b>
Regular Medicaid "FMAP"	Not Less than 50 Percent
CHIP "Enhanced FMAP"	Regular FMAP + $\approx$ 15 percentage points $\approx$ 65 Percent
Breast and Cervical Cancer "Enhanced FMAP"	Regular FMAP + $\approx$ 15 percentage points $\approx$ 65 Percent
Indian Health Services	100 Percent
Family Planning (always 90% federal)	90 Percent
State Only	0 Percent

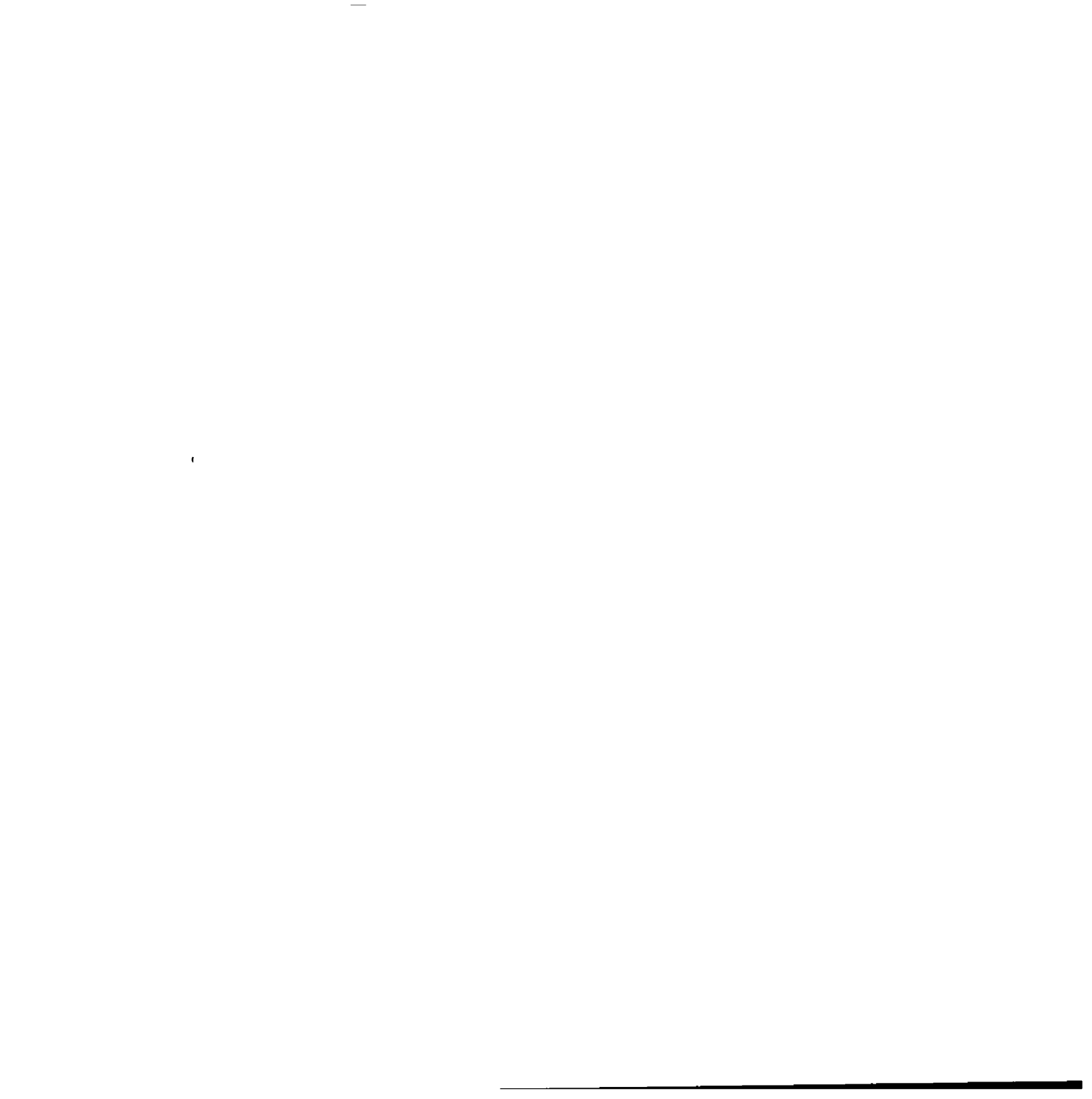


<b>Service Group</b>	<b>Service Category</b>	<b>Description</b>
<b>Behavioral Health</b>	<b>Inpatient Psychiatric Hospital</b>	Inpatient psychiatric hospital services
<b>Behavioral Health</b>	<b>Outpatient Mental Health</b>	Outpatient mental health services, psychology services, and drug abuse centers
<b>Behavioral Health</b>	<b>Residential Psychiatric/Behavioral Rehabilitation Services</b>	Residential psychiatric treatment centers and behavioral rehabilitation services (BRS)
<b>Long-term Care</b>	<b>Home &amp; Community Based Walver</b>	Home and community based long-term care services offered through Medicaid Waivers including Alaska Pioneer Homes, assisted living homes, respite care, adult day care, chore services, residential and day habilitation, nutrition, and meals.
<b>Long-term Care</b>	<b>Home Health/Hospice</b>	Home health services, hospice care, nutrition services, and private duty nursing
<b>Long-term Care</b>	<b>Nursing Home</b>	Skilled nursing and intermediate care facilities including intermediate-care facilities for the mentally retarded; and temporary long-term care services
<b>Long-term Care</b>	<b>Personal Care</b>	Personal care attendant services including agency-based and consumer-directed programs
<b>Primary Care</b>	<b>Dental</b>	Dental services for children and adults
<b>Primary Care</b>	<b>Durable Medical Equipment/Supplies</b>	Durable medical equipment (DME), medical supplies, prosthetics, and orthotics
<b>Primary Care</b>	<b>Early &amp; Periodic Screening, Diagnosis &amp; Testing</b>	Early, periodic screening, diagnosis and treatment (EPSDT) including preventive health checkups, health screenings and immunizations
<b>Primary Care</b>	<b>Health Clinic</b>	Health clinic services including rural health clinics, federally-qualified health clinics and tribal health clinics
<b>Primary Care</b>	<b>Inpatient Hospital</b>	Inpatient hospital services
<b>Primary Care</b>	<b>Laboratory/X-Ray</b>	Laboratory, x-ray and diagnostic services
<b>Primary Care</b>	<b>Other Services</b>	Other services not classified elsewhere
<b>Primary Care</b>	<b>Outpatient Hospital</b>	Outpatient hospital services, outpatient surgery services, and end-stage renal disease services
<b>Primary Care</b>	<b>Pharmacy</b>	Prescription drugs
<b>Primary Care</b>	<b>Physician/Practitioner Services</b>	Physician, podiatrist, advanced nurse practitioner, and midwifery services
<b>Primary Care</b>	<b>Therapy/Rehabilitation</b>	Outpatient rehabilitation, physical therapy, occupational therapy, speech therapy, audiology, and chiropractic services
<b>Primary Care</b>	<b>Transportation</b>	Emergency and non-emergency medically necessary transportation and accommodation
<b>Primary Care</b>	<b>Vision</b>	Optometrist services and eyeglasses



**Table 9: Forecast of Population by Subpopulations**

	Calendar Year					Annual % Change
	2012	2017	2022	2027	2032	
<b>State</b>	729,645	776,651	818,817	857,669	893,978	1.02%
<b>Gender</b>						
<b>Male</b>	378,978	402,145	422,509	441,057	458,239	0.95%
<b>Female</b>	350,667	374,506	396,308	416,611	435,739	1.09%
<b>Native Status</b>						
<b>Native</b>	122,873	130,154	136,682	142,780	148,289	0.94%
<b>Non-Native</b>	606,772	646,498	682,135	714,888	745,689	1.04%
<b>Region</b>						
<b>Northern</b>	123,415	131,341	138,465	145,253	152,160	1.05%
<b>Western</b>	43,156	45,883	48,489	50,903	53,108	1.04%
<b>South Central</b>	97,093	100,273	102,847	104,670	105,732	0.43%
<b>Anchorage / Mat-Su</b>	394,286	425,896	456,413	485,379	513,070	1.33%
<b>Southeast</b>	71,695	73,258	72,603	71,464	69,908	-0.13%
<b>Age Group</b>						
<b>0-4</b>	56,137	60,613	61,575	62,202	64,230	0.68%
<b>5-9</b>	52,573	58,400	62,530	63,606	64,337	1.01%
<b>10-14</b>	51,584	54,683	60,052	64,270	65,427	1.20%
<b>15-19</b>	50,463	51,161	54,059	59,375	63,547	1.16%
<b>20-24</b>	54,025	50,330	49,614	52,307	57,427	0.31%
<b>25-34</b>	109,517	114,971	112,101	109,280	112,009	0.11%
<b>35-44</b>	92,854	101,922	115,429	122,455	120,218	1.30%
<b>45-54</b>	106,361	96,545	92,400	99,738	113,069	0.31%
<b>55-64</b>	93,181	100,282	95,738	85,681	81,676	-0.66%
<b>65-74</b>	41,532	60,378	77,074	84,340	80,234	3.35%
<b>75+</b>	21,417	27,367	38,245	54,415	71,803	6.24%



**Table 10: Forecast of Enrollment by Subpopulations**

	Calendar Year					Annual % Change
	2012	2017	2022	2027	2032	
<b>State</b>	146,476	165,033	181,436	194,504	204,176	1.7%
<b>Gender</b>						
<b>Male</b>	66,582	74,791	82,491	88,443	92,563	1.7%
<b>Female</b>	79,894	90,242	98,945	105,061	111,612	1.7%
<b>Native Status</b>						
<b>Native</b>	53,719	59,945	64,851	68,760	71,615	1.4%
<b>Non-Native</b>	92,757	105,088	116,585	125,744	132,560	1.8%
<b>Region</b>						
<b>Northern</b>	18,366	20,988	23,174	24,910	26,222	1.8%
<b>Western</b>	20,947	23,647	25,943	27,831	29,304	1.7%
<b>South Central</b>	19,320	21,374	23,004	24,153	24,770	1.3%
<b>Anchorage / Mat-Su</b>	74,023	84,023	93,844	102,005	108,443	1.9%
<b>Southeast</b>	13,820	15,001	15,471	15,606	15,437	0.6%
<b>Age Group</b>						
<b>0-4</b>	32,152	37,104	39,229	40,606	42,272	1.4%
<b>5-9</b>	22,661	28,677	32,202	33,663	34,310	2.1%
<b>10-14</b>	19,835	22,978	26,560	29,249	29,974	2.1%
<b>15-19</b>	18,035	18,234	20,365	23,054	24,842	1.6%
<b>20-24</b>	8,704	7,383	7,496	8,079	8,978	0.2%
<b>25-34</b>	13,645	15,501	15,576	15,510	16,031	0.8%
<b>35-44</b>	8,574	9,759	11,372	12,334	12,254	1.8%
<b>45-54</b>	7,794	6,113	5,990	6,574	7,497	-0.2%
<b>55-64</b>	5,814	7,296	7,154	6,494	6,216	0.3%
<b>65-74</b>	4,874	6,370	8,147	9,344	9,277	3.3%
<b>75+</b>	4,389	5,619	7,343	9,598	12,524	5.4%



**Table 11: Enrollment Rates by Subpopulations**

	Calendar Year					Annual % Change
	2012	2017	2022	2027	2032	
<b>State</b>	20.1%	21.2%	22.2%	22.7%	22.8%	0.6%
<b>Gender</b>						
<b>Male</b>	17.6%	18.6%	19.5%	20.1%	20.2%	0.7%
<b>Female</b>	22.8%	24.1%	25.0%	25.5%	25.6%	0.6%
<b>Native Status</b>						
<b>Native</b>	43.7%	46.1%	47.4%	48.2%	48.3%	0.5%
<b>Non-Native</b>	15.3%	16.3%	17.1%	17.6%	17.8%	0.8%
<b>Region</b>						
<b>Northern</b>	14.9%	16.0%	16.7%	17.1%	17.2%	0.7%
<b>Western</b>	48.5%	51.5%	53.5%	54.7%	55.2%	0.6%
<b>South Central</b>	19.9%	21.3%	22.4%	23.1%	23.4%	0.8%
<b>Anchorage / Mat-Su</b>	18.8%	19.7%	20.6%	21.0%	21.1%	0.6%
<b>Southeast</b>	19.3%	20.5%	21.3%	21.8%	22.1%	0.7%
<b>Age Group</b>						
<b>0-4</b>	57.3%	61.2%	63.7%	65.3%	65.8%	0.7%
<b>5-9</b>	43.1%	49.1%	51.5%	52.9%	53.3%	1.1%
<b>10-14</b>	38.5%	42.0%	44.2%	45.5%	45.8%	0.9%
<b>15-19</b>	35.7%	35.6%	37.7%	38.8%	39.1%	0.4%
<b>20-24</b>	16.1%	14.7%	15.1%	15.4%	15.6%	-0.1%
<b>25-34</b>	12.5%	13.5%	13.9%	14.2%	14.3%	0.7%
<b>35-44</b>	9.2%	9.6%	9.9%	10.1%	10.2%	0.5%
<b>45-54</b>	7.3%	6.3%	6.5%	6.6%	6.6%	-0.5%
<b>55-64</b>	6.2%	7.3%	7.5%	7.6%	7.6%	1.0%
<b>65-74</b>	11.7%	10.5%	10.6%	11.1%	11.6%	-0.1%
<b>75+</b>	20.5%	20.5%	19.2%	17.6%	17.4%	-0.8%

**Table 12: Enrollment Levels by Eligibility Groups**

	Calendar Year					Annual % Change
	2012	2017	2022	2027	2032	
<b>AFDC &amp; Related</b>	47,387	51,621	55,015	57,469	59,280	1.13%
<b>Title XIX Kids</b>	6,741	7,012	7,211	7,488	7,886	0.79%
<b>Title XXI Kids</b>	44,410	50,207	54,393	57,064	58,729	1.41%
<b>Pregnancy/Post Partum</b>	13,229	15,018	16,552	17,536	17,986	1.55%
<b>Kids in Custody</b>	4,585	5,146	5,624	5,942	6,096	1.43%
<b>Ailen (Foreign)</b>	4	5	5	6	7	2.83%
<b>SSI/APA/LTC Cash</b>	25,651	30,609	36,054	41,123	45,096	2.86%
<b>LTC Non-cash</b>	2,596	3,227	4,049	5,011	5,953	4.24%
<b>Other Disabled</b>	476	635	809	961	1,058	4.08%
<b>Medicare</b>	552	601	634	651	664	0.93%
<b>Exams</b>	846	952	1,089	1,253	1,421	2.63%
<b>Total (Undup. Count)</b>	146,476	165,033	181,436	194,504	204,176	1.67%

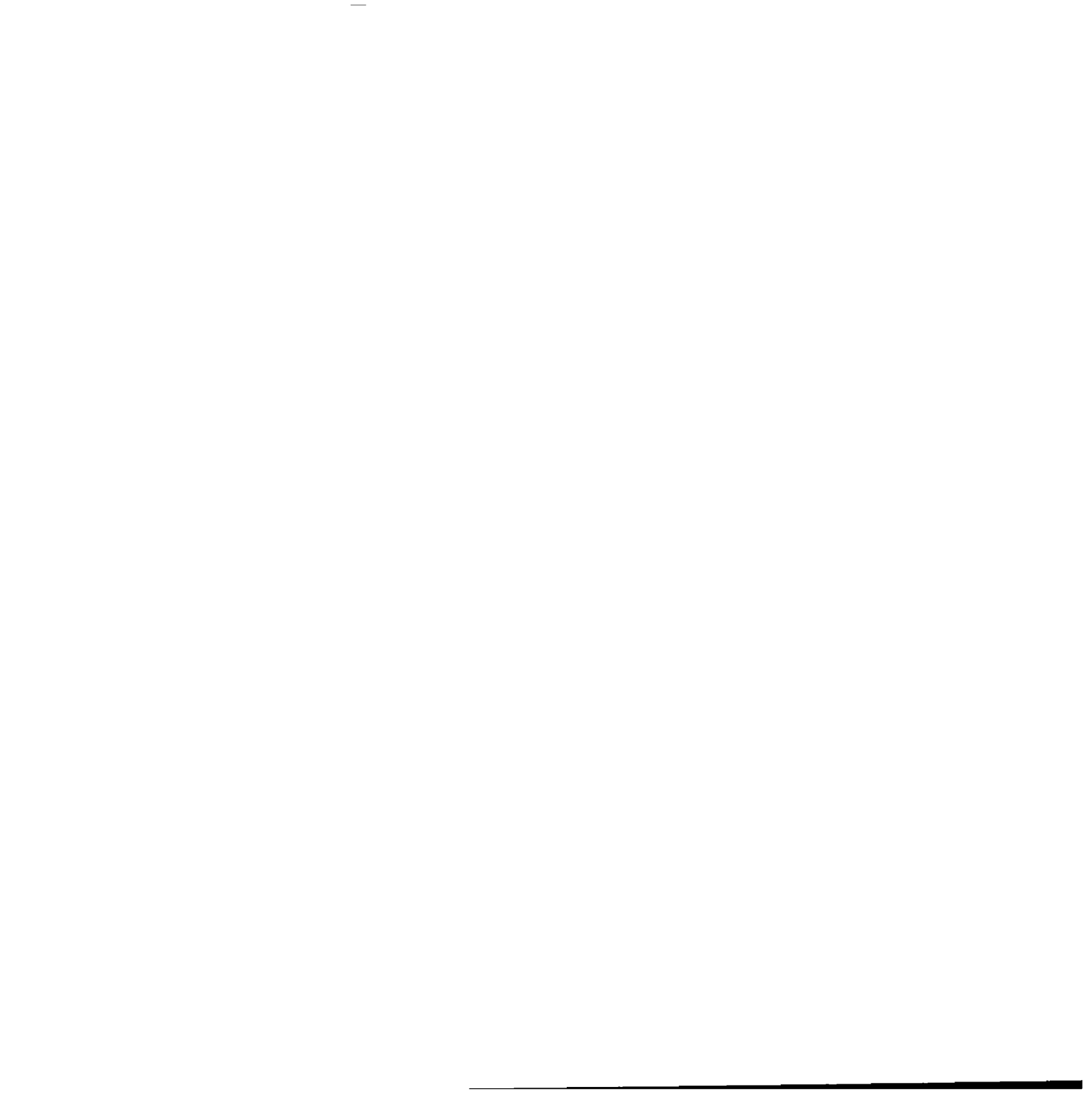
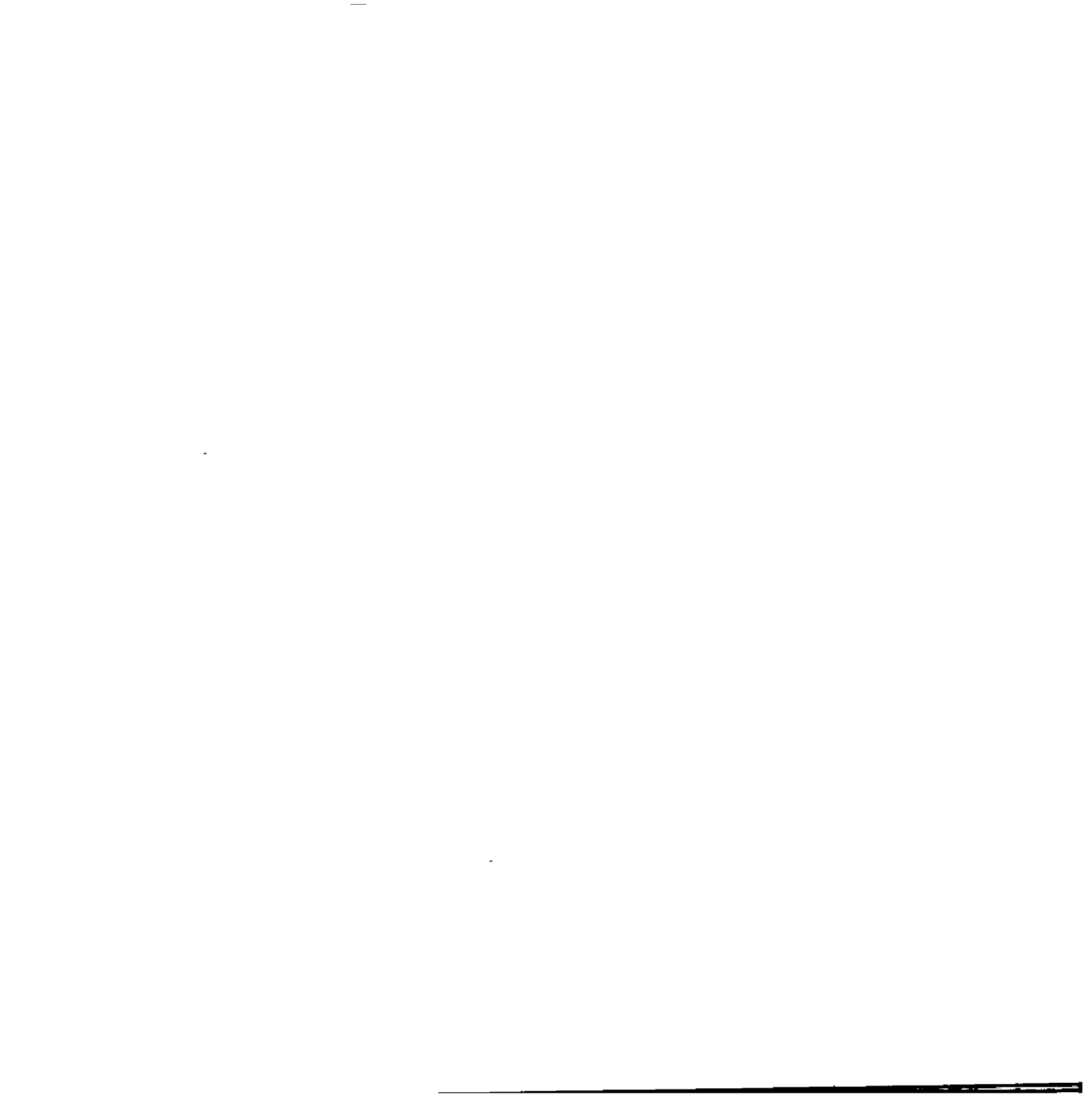
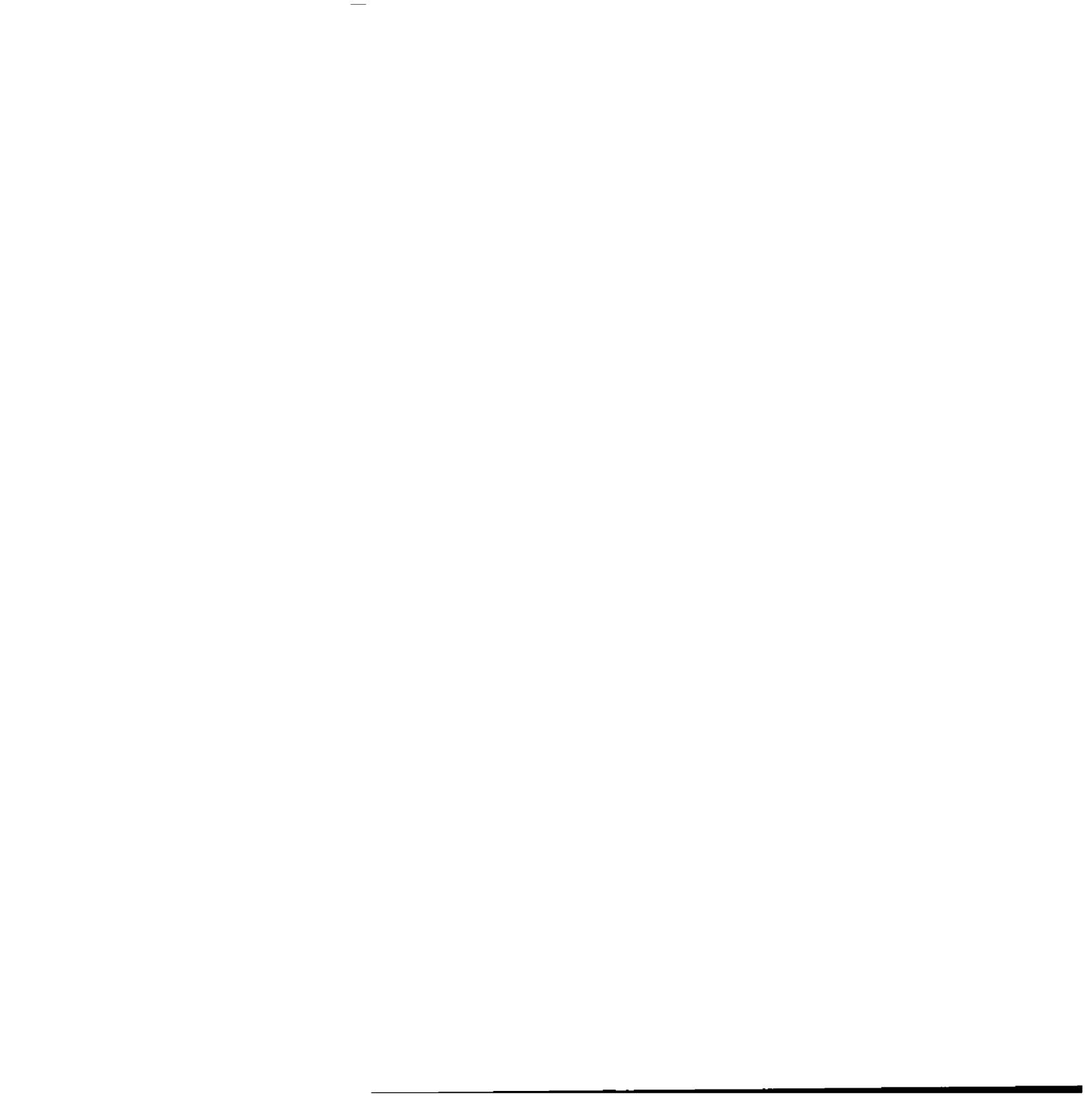


Table 22. Total spending on Medicaid services by subpopulations (in millions)

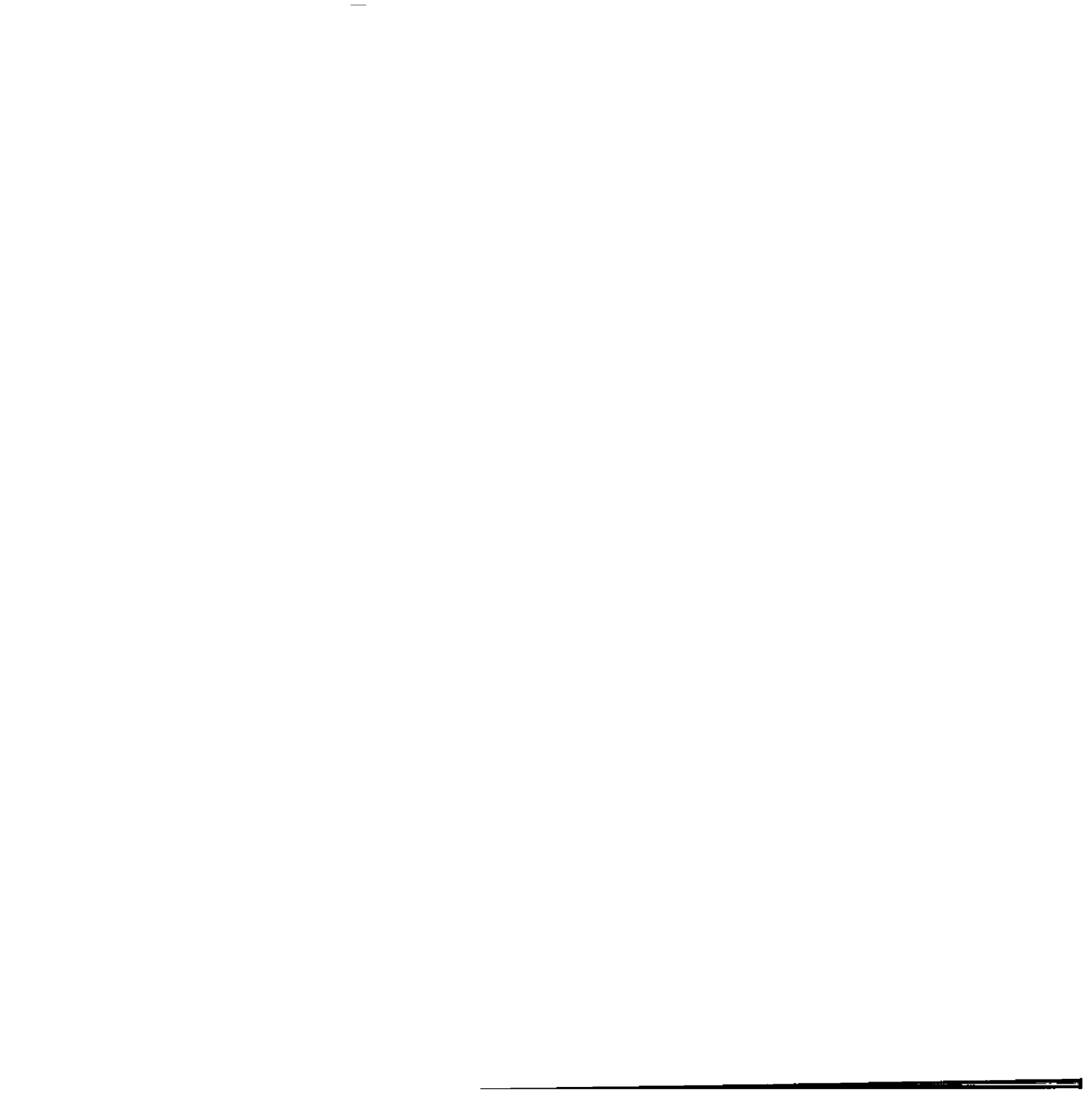
	Calendar Year					Annual % Change
	2012	2017	2022	2027	2032	
<b>State</b>	\$1,384.3	\$2,084.0	\$3,038.4	\$4,352.0	\$5,985.3	7.6%
<b>Gender</b>						
<b>Male</b>	\$605.7	\$920.5	\$1,348.8	\$1,932.9	\$2,649.6	7.7%
<b>Female</b>	\$778.6	\$1,163.6	\$1,689.6	\$2,419.1	\$3,335.7	7.5%
<b>Native Status</b>						
<b>Native</b>	\$464.0	\$687.6	\$984.1	\$1,387.3	\$1,883.5	7.3%
<b>Non-Native</b>	\$920.3	\$1,396.4	\$2,054.3	\$2,964.6	\$4,101.8	7.8%
<b>Region</b>						
<b>Northern</b>	\$146.1	\$222.0	\$326.4	\$470.6	\$651.4	7.8%
<b>Western</b>	\$151.8	\$228.3	\$332.1	\$474.7	\$652.3	7.6%
<b>South Central</b>	\$214.0	\$314.9	\$451.2	\$635.5	\$857.4	7.2%
<b>Anchorage / Mat-Su</b>	\$716.5	\$1,093.7	\$1,619.8	\$2,353.7	\$3,281.1	7.9%
<b>Southeast</b>	\$156.0	\$225.2	\$308.8	\$417.5	\$543.2	6.4%
<b>Age Group</b>						
<b>0-4</b>	\$176.1	\$266.1	\$360.9	\$472.4	\$609.3	6.4%
<b>5-9</b>	\$83.8	\$131.9	\$190.0	\$251.2	\$317.1	6.9%
<b>10-14</b>	\$115.6	\$175.0	\$259.5	\$361.3	\$458.5	7.1%
<b>15-19</b>	\$148.8	\$216.9	\$310.6	\$444.1	\$592.6	7.2%
<b>20-24</b>	\$97.5	\$123.5	\$160.0	\$216.9	\$297.5	5.7%
<b>25-34</b>	\$152.8	\$217.7	\$279.5	\$350.5	\$447.3	5.5%
<b>35-44</b>	\$106.3	\$158.4	\$235.8	\$322.3	\$395.4	6.8%
<b>45-54</b>	\$141.6	\$173.0	\$216.6	\$299.7	\$422.3	5.6%
<b>55-64</b>	\$133.2	\$195.8	\$245.8	\$281.4	\$333.0	4.7%
<b>65-74</b>	\$82.3	\$167.8	\$293.7	\$432.5	\$536.2	9.8%
<b>75+</b>	\$146.2	\$258.0	\$485.9	\$919.6	\$1,576.1	12.6%



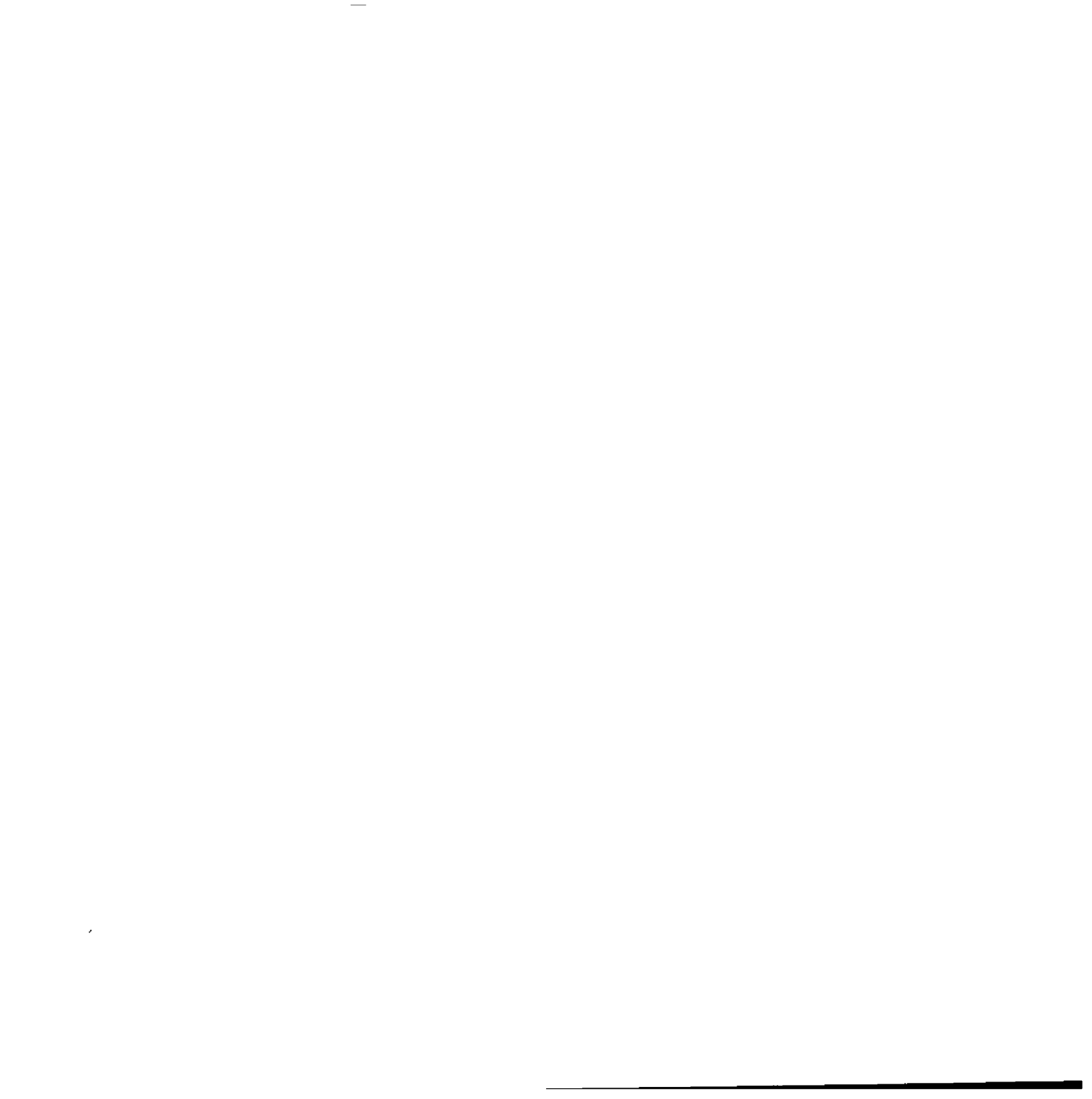
	Calendar Year					Annual %
	2012	2017	2022	2027	2032	Change
<b>State</b>	\$9,451	\$12,628	\$16,746	\$22,375	\$29,315	5.8%
<b>Gender</b>						
<b>Male</b>	\$9,097	\$12,307	\$16,350	\$21,855	\$28,625	5.9%
<b>Female</b>	\$9,746	\$12,894	\$17,076	\$22,808	\$29,886	5.8%
<b>Native Status</b>						
<b>Native</b>	\$8,638	\$11,471	\$15,175	\$20,177	\$26,300	5.7%
<b>Non-Native</b>	\$9,922	\$13,288	\$17,620	\$23,577	\$30,943	5.9%
<b>Region</b>						
<b>Northern</b>	\$7,954	\$10,579	\$14,084	\$18,891	\$24,841	5.9%
<b>Western</b>	\$7,246	\$9,653	\$12,802	\$17,055	\$22,260	5.8%
<b>South Central</b>	\$11,076	\$14,731	\$19,614	\$26,312	\$34,613	5.9%
<b>Anchorage / Mat-Su</b>	\$9,679	\$13,017	\$17,261	\$23,075	\$30,256	5.9%
<b>Southeast</b>	\$11,287	\$15,010	\$19,961	\$26,754	\$35,187	5.8%
<b>Age Group</b>						
<b>0-4</b>	\$5,476	\$7,172	\$9,201	\$11,634	\$14,413	5.0%
<b>5-9</b>	\$3,697	\$4,599	\$5,901	\$7,461	\$9,242	4.7%
<b>10-14</b>	\$5,828	\$7,614	\$9,768	\$12,352	\$15,297	4.9%
<b>15-19</b>	\$8,253	\$11,897	\$15,250	\$19,265	\$23,854	5.5%
<b>20-24</b>	\$11,207	\$16,724	\$21,338	\$26,854	\$33,139	5.6%
<b>25-34</b>	\$11,199	\$14,044	\$17,942	\$22,601	\$27,900	4.7%
<b>35-44</b>	\$12,401	\$16,232	\$20,736	\$26,126	\$32,266	4.9%
<b>45-54</b>	\$18,170	\$28,297	\$36,166	\$45,588	\$56,327	5.8%
<b>55-64</b>	\$22,915	\$26,832	\$34,363	\$43,335	\$53,573	4.3%
<b>65-74</b>	\$16,890	\$26,348	\$36,055	\$46,291	\$57,800	6.3%
<b>75+</b>	\$33,313	\$45,924	\$66,172	\$95,817	\$125,854	6.9%



Service	Calendar Year					Annual % Change
	2012	2017	2022	2027	2032	
Dental	\$61.4	\$93.3	\$132.0	\$180.1	\$236.2	7.0%
DME/Supplies	\$19.4	\$28.3	\$39.8	\$55.1	\$73.7	6.9%
EPSDT	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	0.2%
HCW Waiver	\$212.5	\$363.9	\$586.8	\$907.2	\$1,318.5	9.6%
Health Clinic	\$57.8	\$89.3	\$125.8	\$169.4	\$219.3	6.9%
Home Health/Hospice	\$6.0	\$8.7	\$12.5	\$17.9	\$25.2	7.5%
Inpatient Hospital	\$183.4	\$233.8	\$283.6	\$337.1	\$393.3	3.9%
Inpatient Psychiatric	\$19.2	\$31.4	\$51.5	\$78.6	\$110.4	9.1%
Lab/X-ray	\$2.4	\$3.0	\$3.7	\$4.4	\$5.2	4.0%
Nursing Home	\$94.7	\$133.3	\$188.1	\$258.1	\$320.1	6.3%
Other Services	\$0.1	\$0.1	\$0.1	\$0.1	\$0.1	0.9%
Outpatient Hospital	\$144.2	\$199.0	\$260.6	\$334.2	\$418.9	5.5%
Outpatient Mental Health	\$111.0	\$148.0	\$191.2	\$244.4	\$305.9	5.2%
Personal Care	\$119.5	\$256.4	\$498.2	\$890.9	\$1,439.6	13.3%
Pharmacy	\$89.7	\$119.8	\$154.3	\$196.2	\$244.3	5.1%
Physician/Practitioner	\$133.2	\$184.0	\$241.9	\$313.8	\$399.4	5.6%
Residential Psych/BRC	\$32.2	\$50.3	\$75.5	\$109.4	\$149.7	8.0%
Therapy/Rehabilitation	\$24.2	\$35.3	\$48.5	\$64.4	\$81.9	6.3%
Transportation	\$67.5	\$96.8	\$131.0	\$172.4	\$219.5	6.1%
Vision	\$5.9	\$9.3	\$13.4	\$18.4	\$24.1	7.3%
<b>Total Service Spending</b>	<b>\$1,384.3</b>	<b>\$2,084.0</b>	<b>\$3,038.4</b>	<b>\$4,352.0</b>	<b>\$5,985.3</b>	<b>7.6%</b>



Service	Calendar Year					Annual % Change
	2012	2017	2022	2027	2032	
Dental	\$1,049	\$1,275	\$1,539	\$1,883	\$2,296	4.0%
DME/Supplies	\$1,454	\$1,714	\$2,009	\$2,394	\$2,869	3.5%
EPSDT	\$162	\$163	\$165	\$168	\$170	0.2%
HCB Waiver	\$34,560	\$41,704	\$49,794	\$60,450	\$73,723	3.9%
Health Clinic	\$1,477	\$1,711	\$1,949	\$2,249	\$2,615	2.9%
Home Health/Hospice	\$9,180	\$11,220	\$13,844	\$17,588	\$22,647	4.6%
Inpatient Hospital	\$11,206	\$13,110	\$15,044	\$17,321	\$19,981	2.9%
Inpatient Psychiatric	\$19,296	\$26,818	\$39,138	\$55,096	\$73,303	6.9%
Lab/X-ray	\$150	\$178	\$208	\$245	\$290	3.4%
Nursing Home	\$95,631	\$123,337	\$157,896	\$200,284	\$243,417	4.8%
Other Services	\$446	\$535	\$637	\$769	\$923	3.7%
Outpatient Hospital	\$2,009	\$2,360	\$2,732	\$3,195	\$3,750	3.2%
Outpatient Mental Health	\$8,890	\$11,080	\$13,714	\$17,189	\$21,564	4.5%
Personal Care	\$25,682	\$35,830	\$48,450	\$65,112	\$85,907	6.2%
Pharmacy	\$1,143	\$1,347	\$1,577	\$1,865	\$2,209	3.3%
Physician/Practitioner	\$1,273	\$1,503	\$1,759	\$2,096	\$2,514	3.5%
Residential Psychiatric/BRC	\$49,289	\$63,485	\$82,983	\$109,421	\$141,011	5.4%
Therapy/Rehabilitation	\$2,697	\$3,204	\$3,753	\$4,426	\$5,188	3.3%
Transportation	\$2,588	\$3,084	\$3,603	\$4,230	\$4,961	3.3%
Vision	\$199	\$239	\$281	\$333	\$394	3.5%
<b>Total Service Spending</b>	<b>\$2,826</b>	<b>\$3,552</b>	<b>\$4,504</b>	<b>\$5,809</b>	<b>\$7,422</b>	<b>4.9%</b>

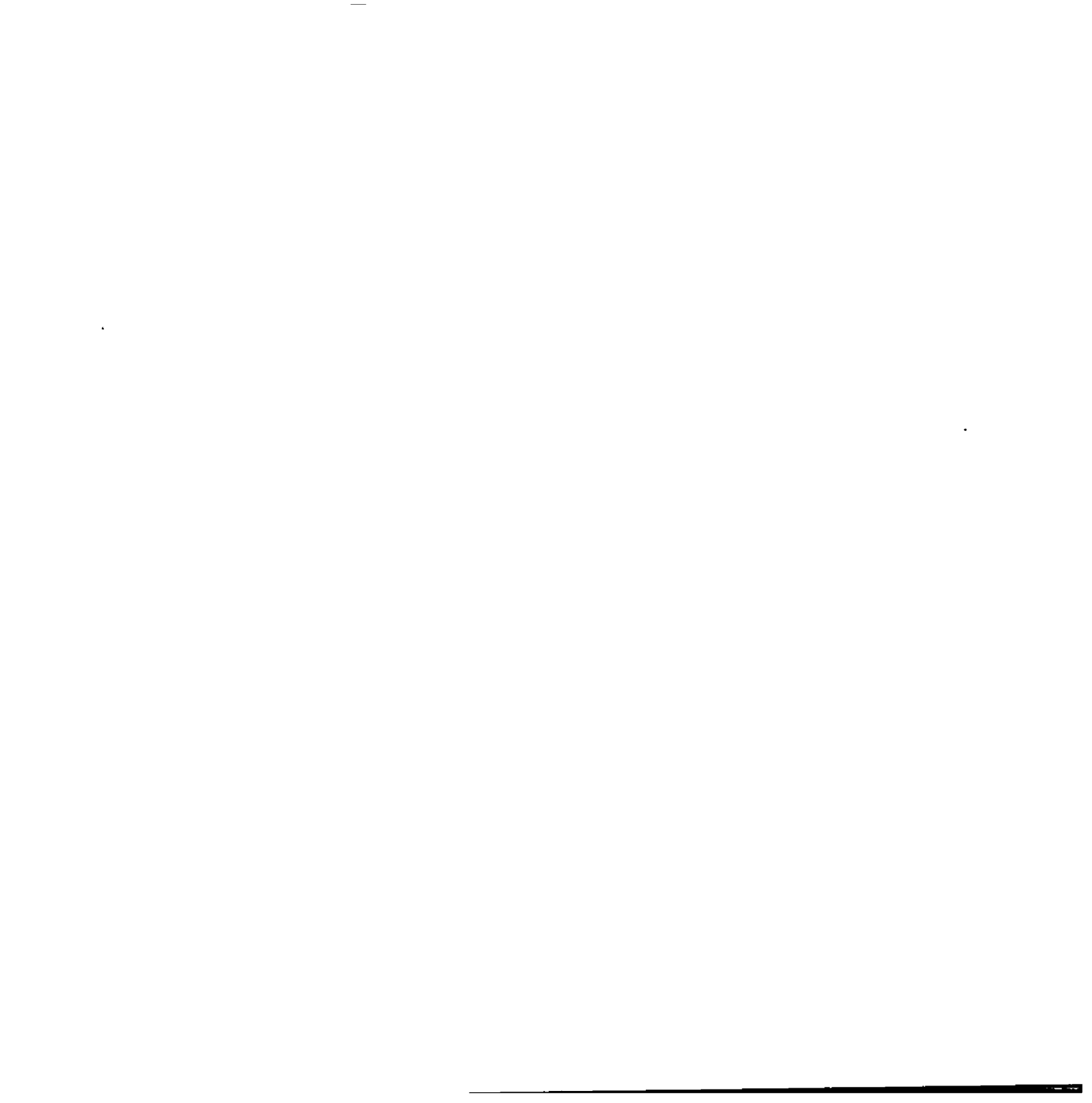


**Table 17: Forecast of State Claims Spending by Service Category (in millions)**

Service	Calendar Year					Annual % Change
	2012	2017	2022	2027	2032	
Dental	\$23.6	\$36.0	\$51.0	\$69.5	\$90.9	7.0%
DME/Supplies	\$9.7	\$14.1	\$19.9	\$27.5	\$36.7	6.9%
EPSDT	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	0.0%
HCB Waiver	\$104.2	\$179.1	\$289.4	\$448.5	\$651.5	9.6%
Health Clinic	\$4.5	\$7.0	\$9.9	\$13.4	\$17.3	6.9%
Home Health/Hospice	\$2.7	\$3.9	\$5.6	\$8.0	\$11.3	7.5%
Inpatient Hospital	\$70.5	\$90.2	\$109.4	\$130.0	\$151.3	3.9%
Inpatient Psychiatric	\$9.4	\$14.7	\$24.8	\$39.5	\$58.7	9.6%
Lab/X-ray	\$1.2	\$1.5	\$1.8	\$2.2	\$2.6	4.0%
Nursing Home	\$45.4	\$65.6	\$92.8	\$127.6	\$158.2	6.4%
Other Services	\$0.1	\$0.1	\$0.1	\$0.1	\$0.1	0.9%
Outpatient Hospital	\$48.2	\$66.8	\$87.5	\$112.2	\$140.3	5.5%
Outpatient Mental Health	\$50.5	\$69.6	\$92.3	\$122.9	\$162.7	6.0%
Personal Care	\$59.6	\$126.2	\$245.7	\$440.5	\$711.3	13.2%
Pharmacy	\$37.4	\$50.1	\$64.6	\$82.1	\$102.0	5.1%
Physician/Practitioner	\$55.7	\$77.2	\$101.6	\$131.6	\$167.1	5.6%
Residential Psych/BRC	\$15.6	\$23.6	\$36.4	\$55.0	\$79.6	8.5%
Therapy/Rehabilitation	\$11.3	\$16.5	\$22.7	\$30.2	\$38.3	6.3%
Transportation	\$31.4	\$45.2	\$61.2	\$80.5	\$102.2	6.1%
Vision	\$2.9	\$4.5	\$6.5	\$8.9	\$11.6	7.3%
<b>Total Service Spending</b>	<b>\$583.9</b>	<b>\$891.9</b>	<b>\$1,323.4</b>	<b>\$1,930.1</b>	<b>\$2,694.0</b>	<b>7.9%</b>

**Table 18: Historical Enrollment by Demographic Group**

Year	Non-Native	Native	Female	Male	Children	Working Age	Elderly	Total
1997	59,803	30,327	52,149	37,981	53,098	31,290	5,742	90,130
1998	58,154	30,572	50,967	37,759	52,103	30,754	5,869	88,726
1999	62,994	32,840	54,381	41,453	58,296	31,444	6,094	95,834
2000	72,898	37,368	61,889	48,377	71,649	32,133	6,484	110,266
2001	76,732	39,524	64,603	51,653	77,477	32,038	6,741	116,256
2002	80,588	41,021	67,201	54,408	81,677	32,943	6,989	121,609
2003	84,045	42,621	69,828	56,838	85,171	34,116	7,379	126,666
2004	84,943	44,611	71,305	58,249	87,027	34,946	7,581	129,554
2005	85,450	46,569	72,742	59,277	87,485	36,619	7,915	132,019
2006	85,269	47,695	73,215	59,749	87,232	37,433	8,299	132,964
2007	81,048	47,027	70,580	57,495	83,930	35,829	8,316	128,075
2008	78,813	46,325	68,745	56,393	81,694	35,126	8,318	125,138
2009	80,670	47,274	70,193	57,751	82,930	36,578	8,436	127,944
2010	85,733	49,353	74,014	61,072	86,502	39,849	8,735	135,086



ADLWD:	Alaska Department of Labor and Workforce Development
AFDC:	Aid to Families with Dependent Children
APA:	Adult Public Assistance
BCC:	Breast and Cervical Cancer
BEA:	Bureau of Economic Analysis
BRS:	Behavioral Rehabilitation Services
CHIP:	Children's Health Insurance Program
CMS:	Center for Medicare and Medicaid Services
CPI:	Consumer Price Index
CY:	Calendar Year
DME:	Durable Medical Equipment
DSH:	Disproportionate Share Hospital
EPSDT:	Early & Periodic Screening, Diagnosis and Treatment
FFP:	Federal Financial Participation
FFY:	Federal Fiscal Year
FMAP:	Federal Medical Assistance Percentage
FY:	Fiscal Year
GDP:	Gross Domestic Product
HCB:	Home and Community Based
IHS:	Indian Health Services
HSS:	Alaska Department of Health and Social Services
ISER:	Institute for Social and Economic Research
JUCE:	Juneau Claims and Eligibility System
LTC:	Long Term Care
MMIS:	Medicaid Management Information System
PCPI:	Per Capital Personal Income
PDL:	Preferred Drug List
SCHIP:	State Children's Health Insurance Program/Denali KidCare
SFY:	State Fiscal Year
SHP:	Supplemental Hospital Payments
SSI:	Supplemental Security Income
SURS	Surveillance and Utilization Review System
Title XIX:	Medicaid
Title XXI:	CHIP, which is an expansion to Alaska's Medicaid program that receives an enhanced FMAP
TPL:	Total Personal Income
TPL:	Third Party Liability



**SPONSORED ALIEN:** A sponsored alien is an alien admitted into the United States for permanent residence as defined in the immigration and Nationality Act and, as a condition of entry, was sponsored by a person who executed an affidavit of support for the alien. Sponsored Alien is ineligible for Supplemental Security Income/Adult Public assistance.

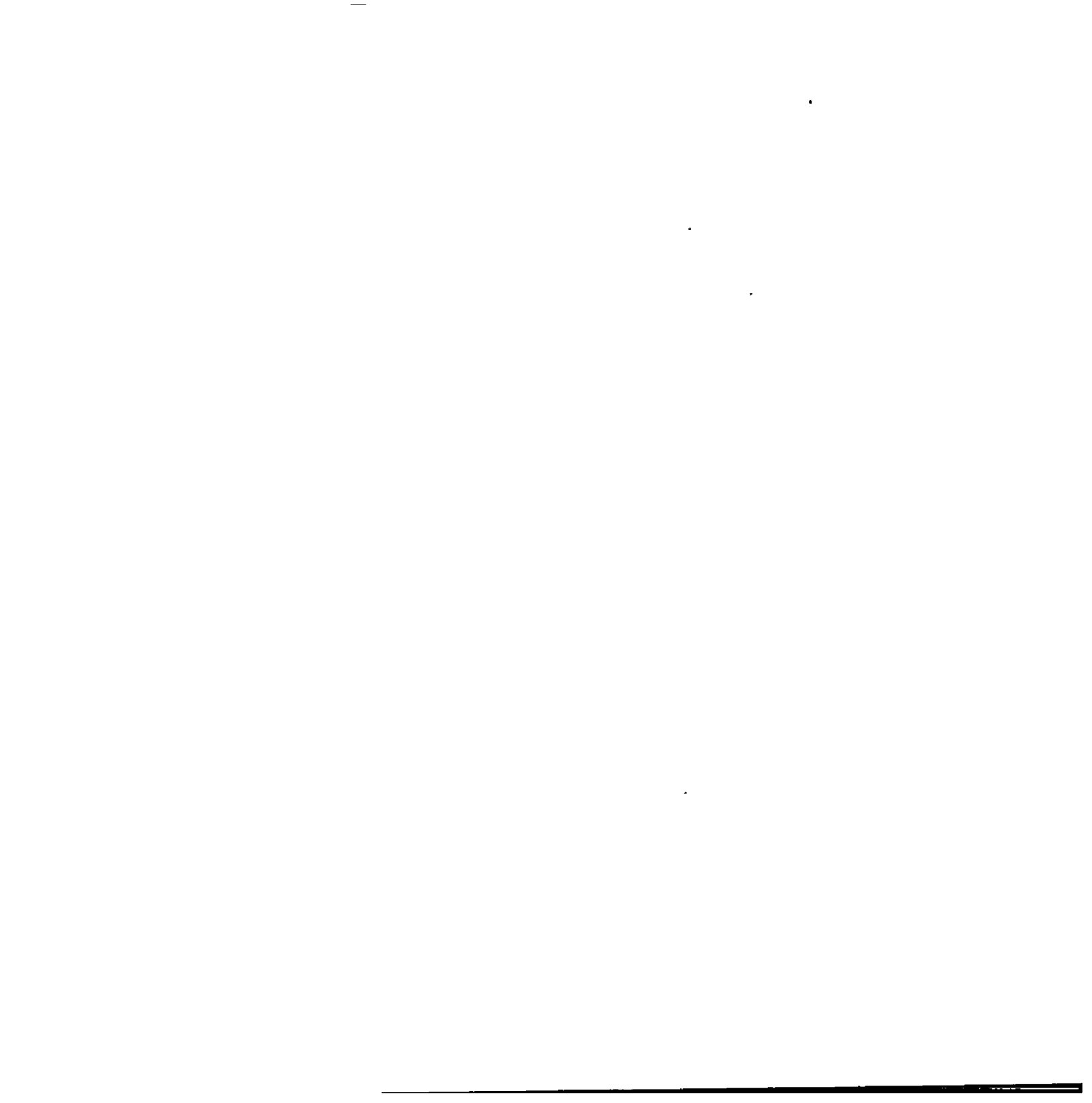
**SSI "1619" ELIGIBLE:** Section 1619(b) Blind or disabled individuals who have had their SSI eligibility maintained for Medicaid purposes by section 1619(b) of the Social Security Act.

**SSI ELIGIBLE WHO HAVE NOT APPLIED FOR SSI:** This phrase refers to those applicants who are ineligible for Supplemental Security Income/Adult Public assistance because of requirements that do not apply to Medicaid.

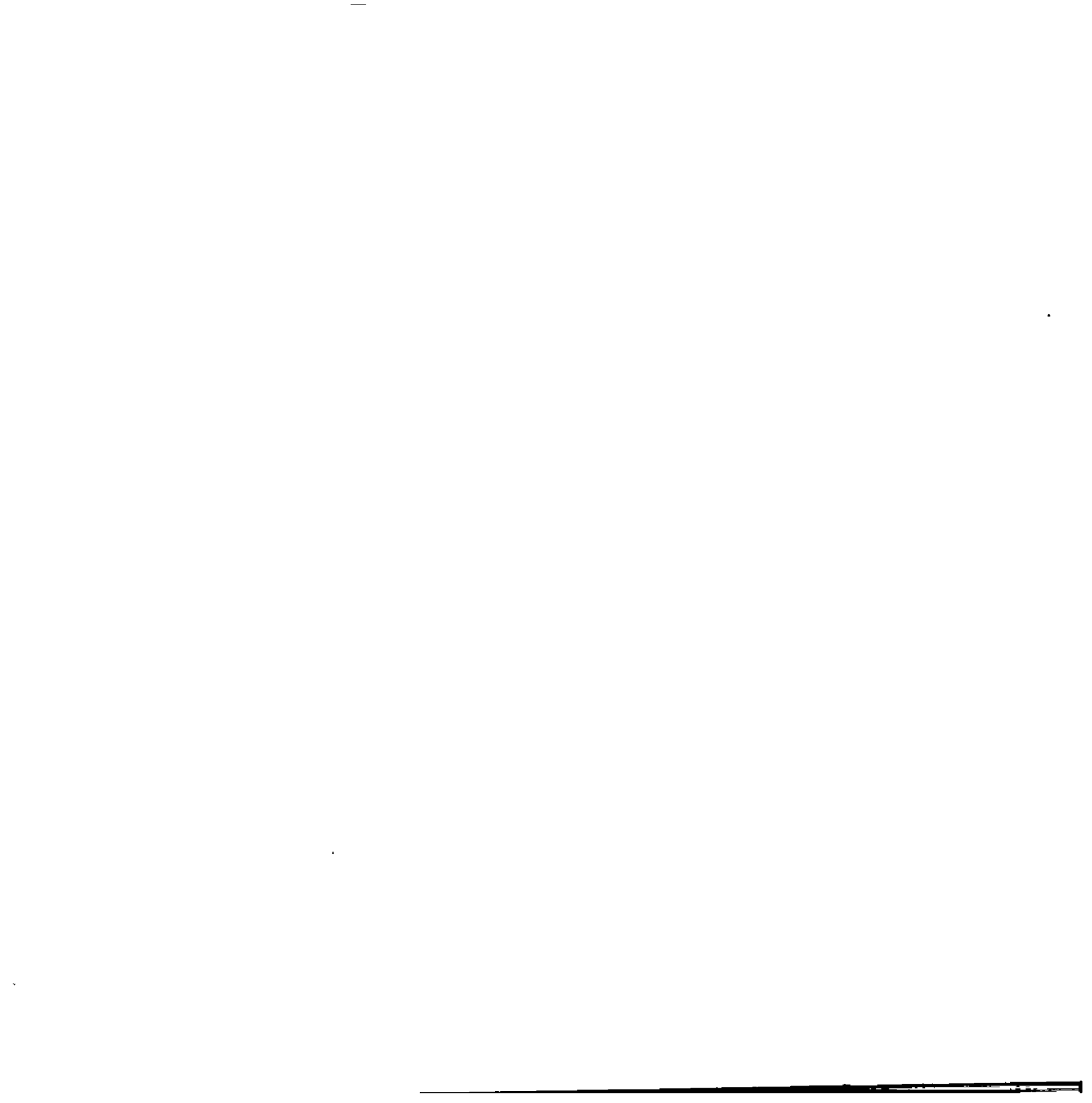
**TITLE IV-E SUBSIDIZED ADOPTION:** Title IV-E is created to prevent unnecessary placement of children from low-income families by offering state fiscal incentives for providing preventive services. Title IV-E subsidized adoption program is to ensure that "special needs" children who are difficult to place in adoptive homes do not remain in foster care solely for financial reasons.

**TITLE XIX:** Title XIX of the Social Security Act is the federal legislation that established Medicaid, a joint federal state program that provides Medical Assistance to low-income consumers of all ages who need care but cannot afford it.

**TITLE XXI:** Title XXI of the Social Security Act provides funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.



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**Long-term Forecast of  
Medicaid Enrollment  
and  
Spending in Alaska:  
*Supplement 2012-2032***

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**This report is available on the Internet at:**

**<http://dhss.alaska.gov/fms>**





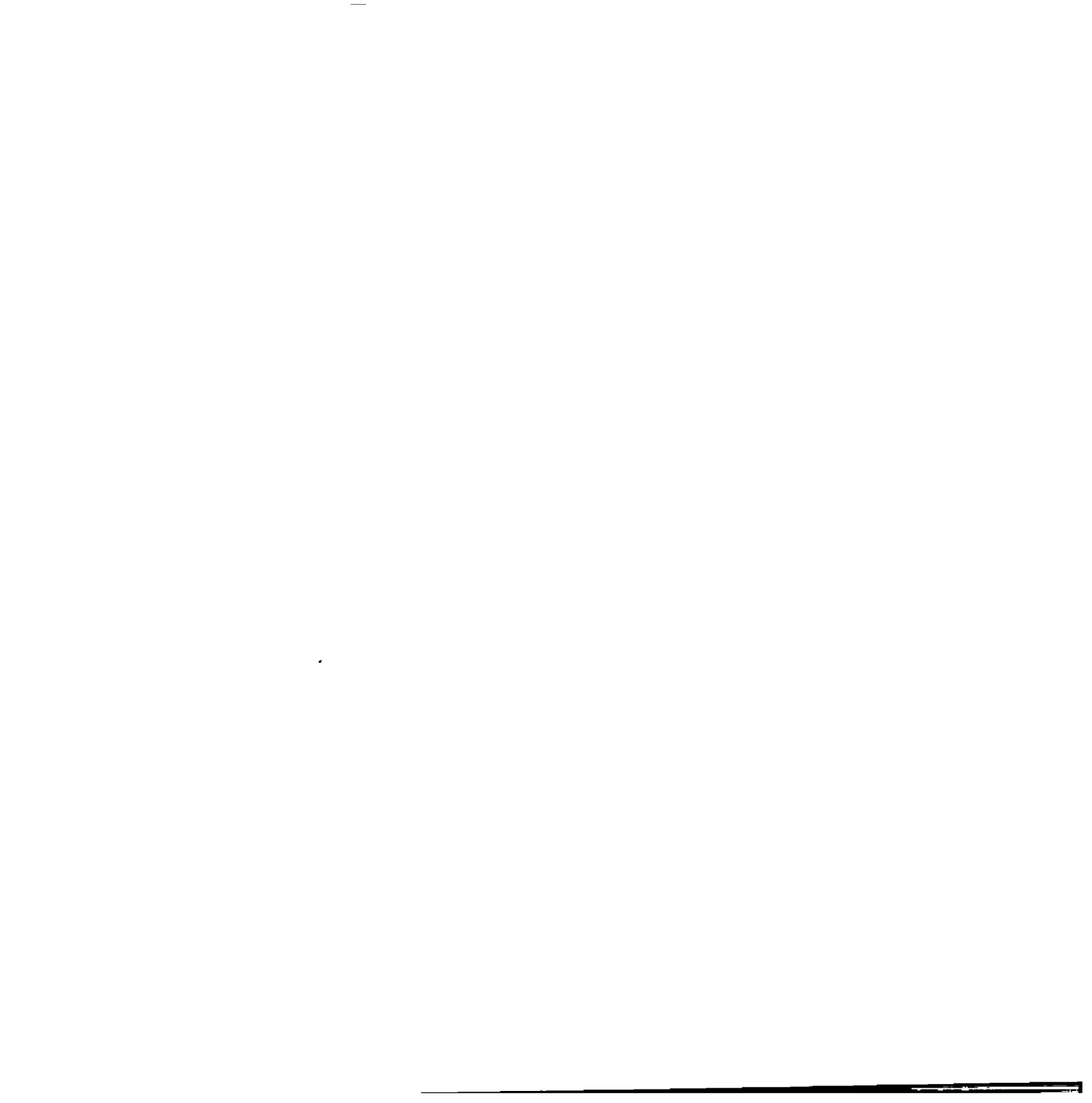
HEALTH CARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING—WITH REAL-WORLD PERSPECTIVE.

## **An Analysis of the Impact of Medicaid Expansion in Alaska**

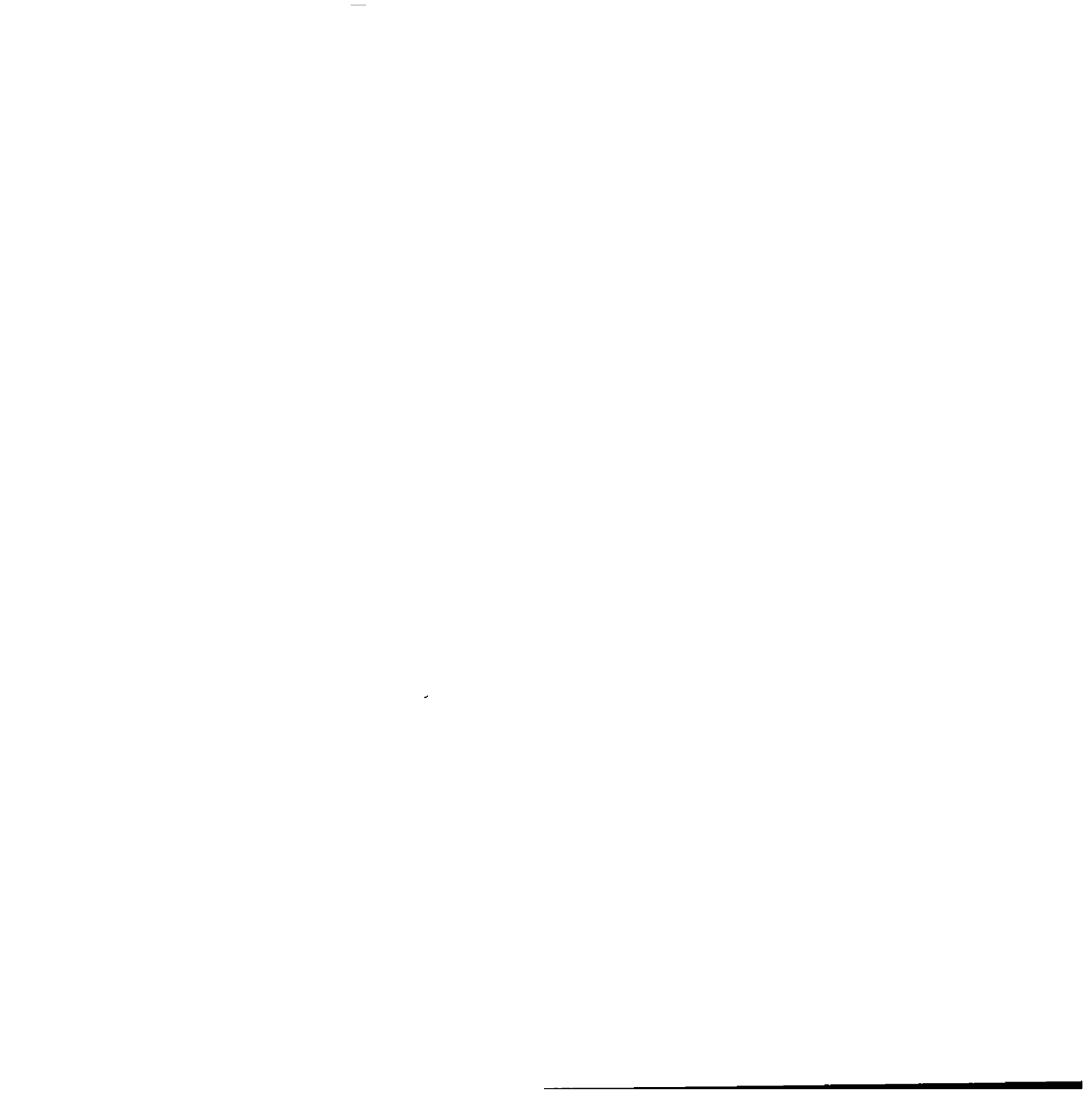
*Final Report*

*Prepared by:*

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



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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.

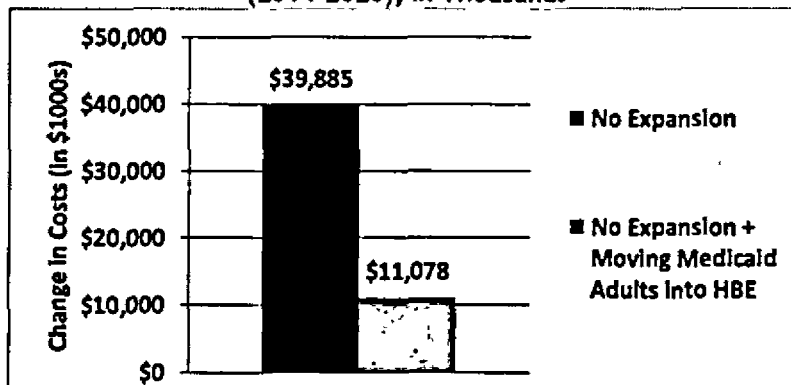
This report provides estimates on Medicaid costs and enrollment under the option of not expanding Medicaid compared to the option of expanding Medicaid under various program design options. We also include a discussion of impact on administrative costs, on additional offsets due to elimination or changes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

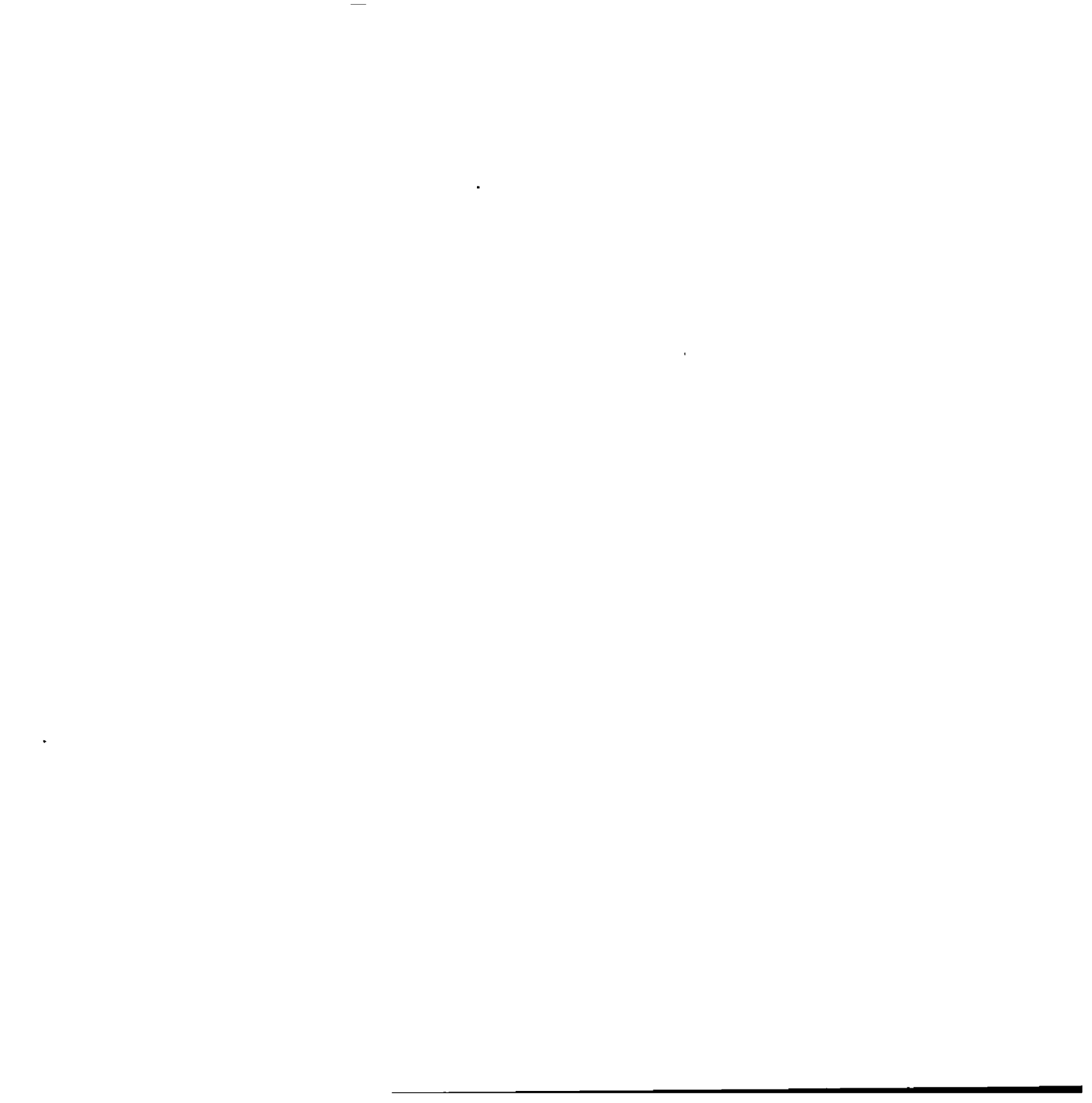
### Option to Not Expand Medicaid

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.

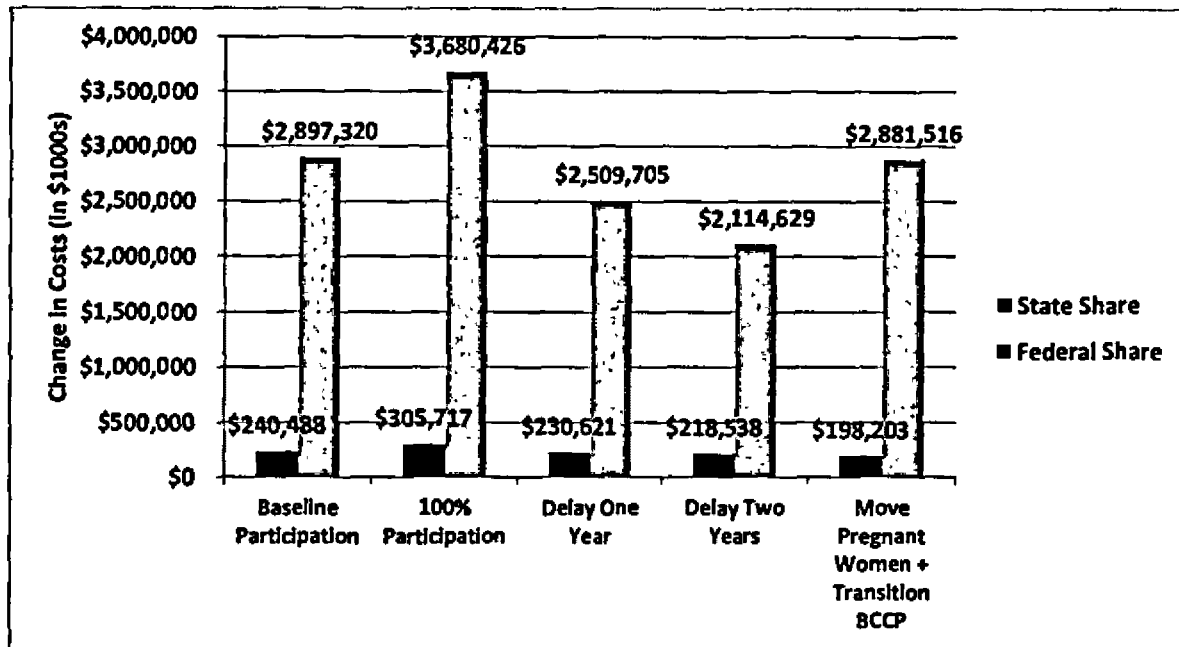
Figure E-1. Comparison of No Expansion Scenarios: Cumulative Change in Alaska Medicaid Costs (2014-2020), in Thousands





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.<sup>1</sup> 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<sup>1/2/</sup>**

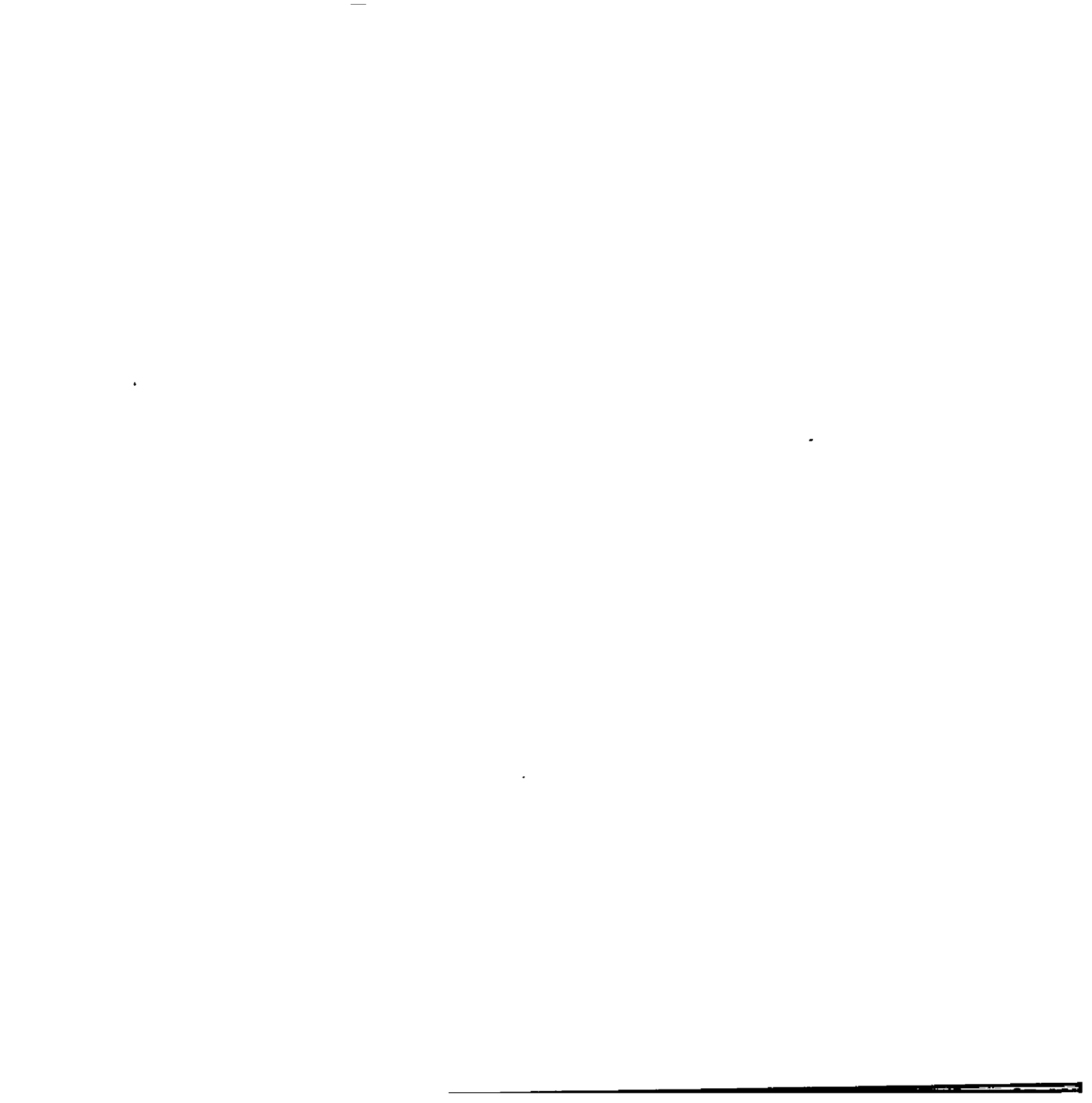


1/Baseline participation scenario includes participation rates of 73.5 percent for newly eligible previously uninsured, 39.0 percent for newly eligible previously insured, and 21.4 percent for currently eligible but not enrolled.

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

<sup>1</sup> 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 potential costs.



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.

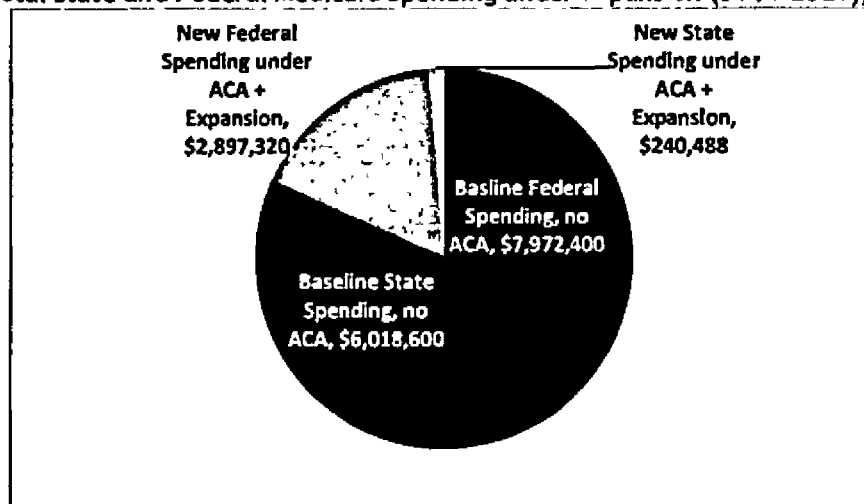
**Figure E-3. Summary of Impact on Other State Programs Due to Expanding Medicaid In Alaska (in \$1,000s for 2014-2020)**

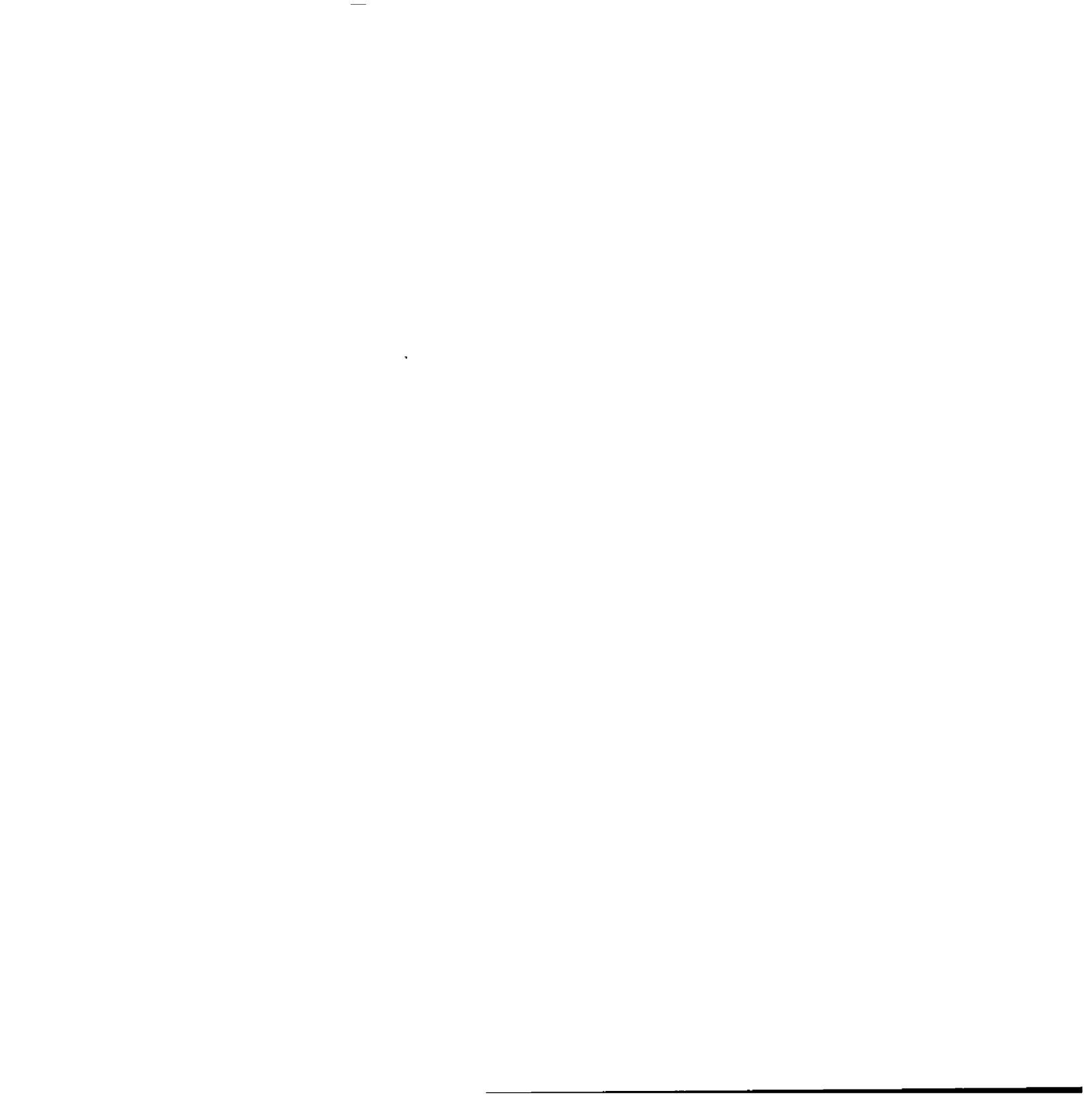
Program	Without Medicaid Expansion	With Medicaid Expansion
Denali KidCare Program	(\$6,637)	(\$6,637)
CAMA Program	--	(\$11,258)
State Employee Health Benefits Program	--	(\$22,515)
Total Offsets	(\$6,637)	(\$40,410)

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<sup>1/</sup>**





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:
  - o Consideration of factors that account for historical experience with Medicaid



currently enrolled

- o Estimates assuming all newly eligible previously uninsured individuals enroll in the Medicaid program
- o Estimates assuming 74 percent of newly eligible previously uninsured and 39 percent of the newly eligible previously insured enroll in the Medicaid program
- o Consideration of whether individuals with incomes above eligibility minimums may take purposeful steps to become eligible

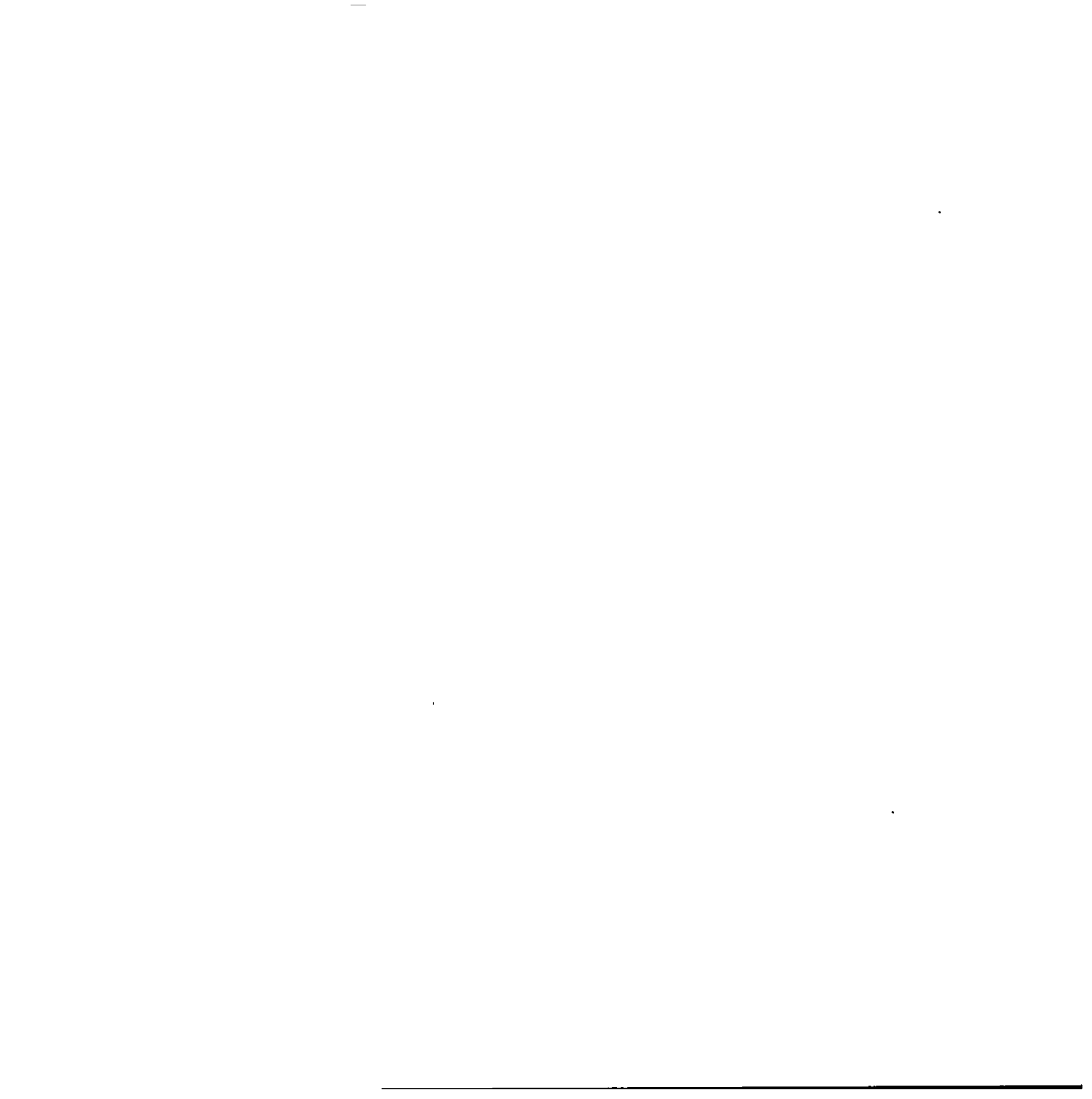
This report first provides background on historical Medicaid costs and eligibility counts in Alaska, and using this historical data, projects costs and eligibility through 2020 in absence of the ACA. We next provide estimates on Medicaid enrollment and state and federal costs under the option of not 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.



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).

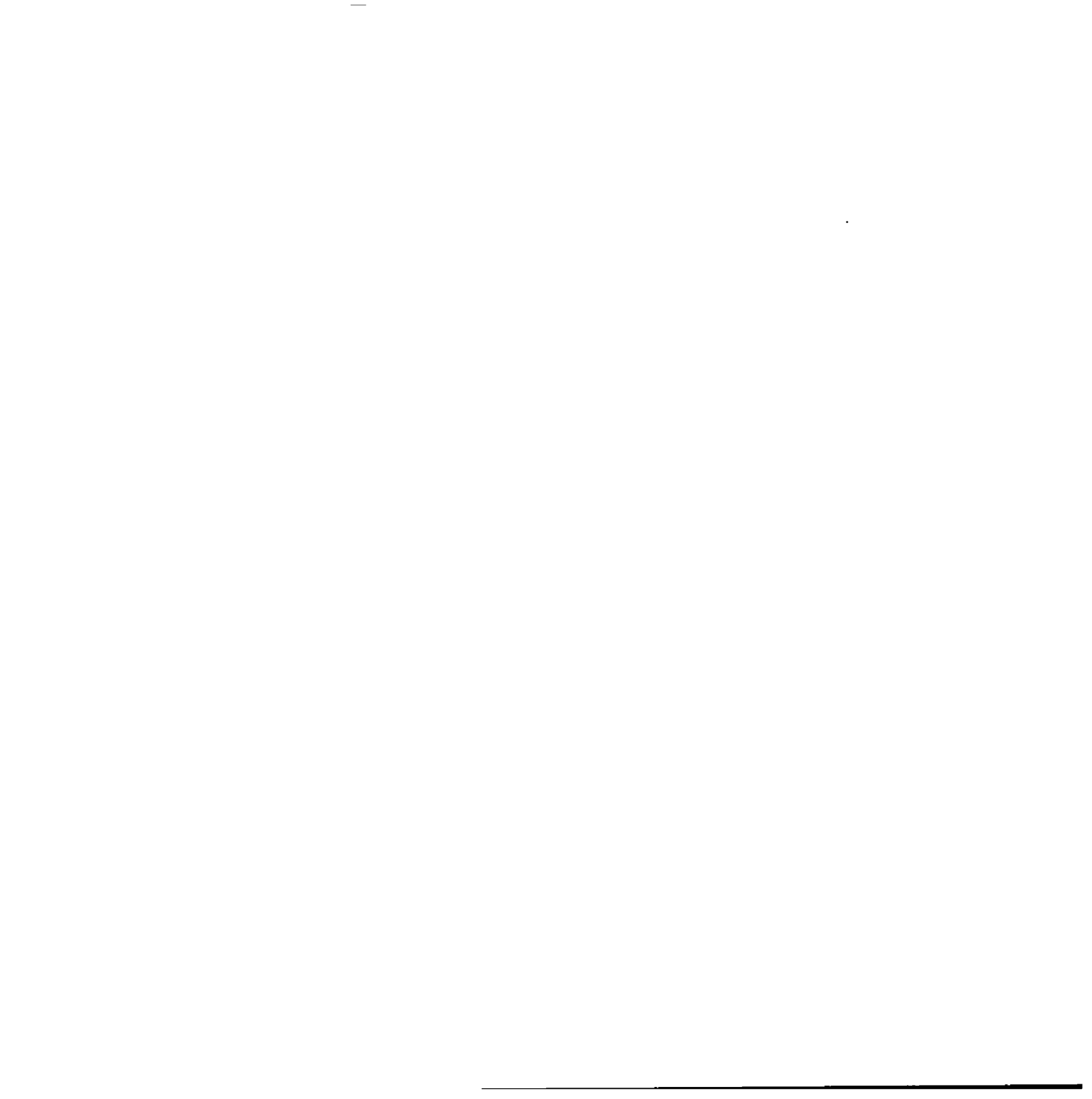
**Figure 1. Historical Costs Eligibility Counts for Alaska Medicaid (2008-2012)**

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
<b>Total</b>	<b>\$1,012,943</b>	<b>\$1,063,284</b>	<b>\$1,185,608</b>	<b>\$1,254,334</b>	<b>\$1,343,363</b>

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.

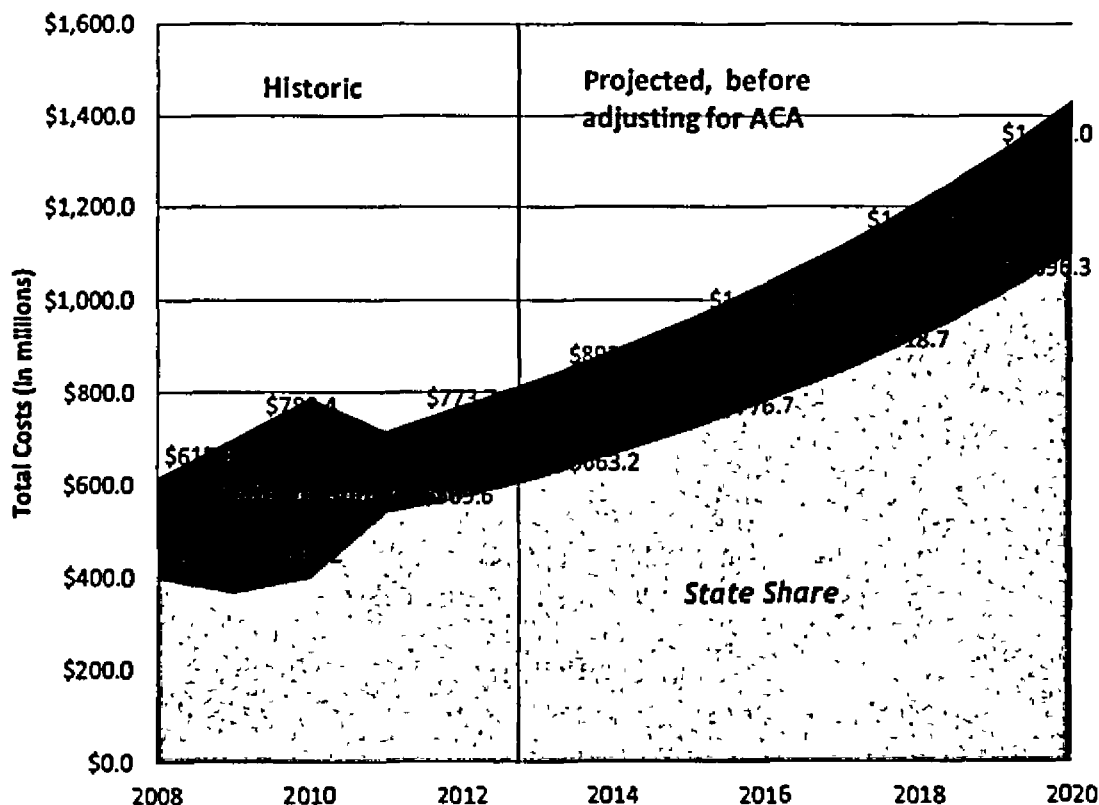


Projected, Before Adjusting for ACA								
	2013	2014	2015	2016	2017	2018	2019	2020
Eligibility Counts	125,855	129,148	132,575	136,089	139,769	143,572	147,367	151,213
Total Costs (\$1,000s)								
State Share	\$614,160	\$663,226	\$717,677	\$776,701	\$843,168	\$918,667	\$1,002,820	\$1,096,335
Federal 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

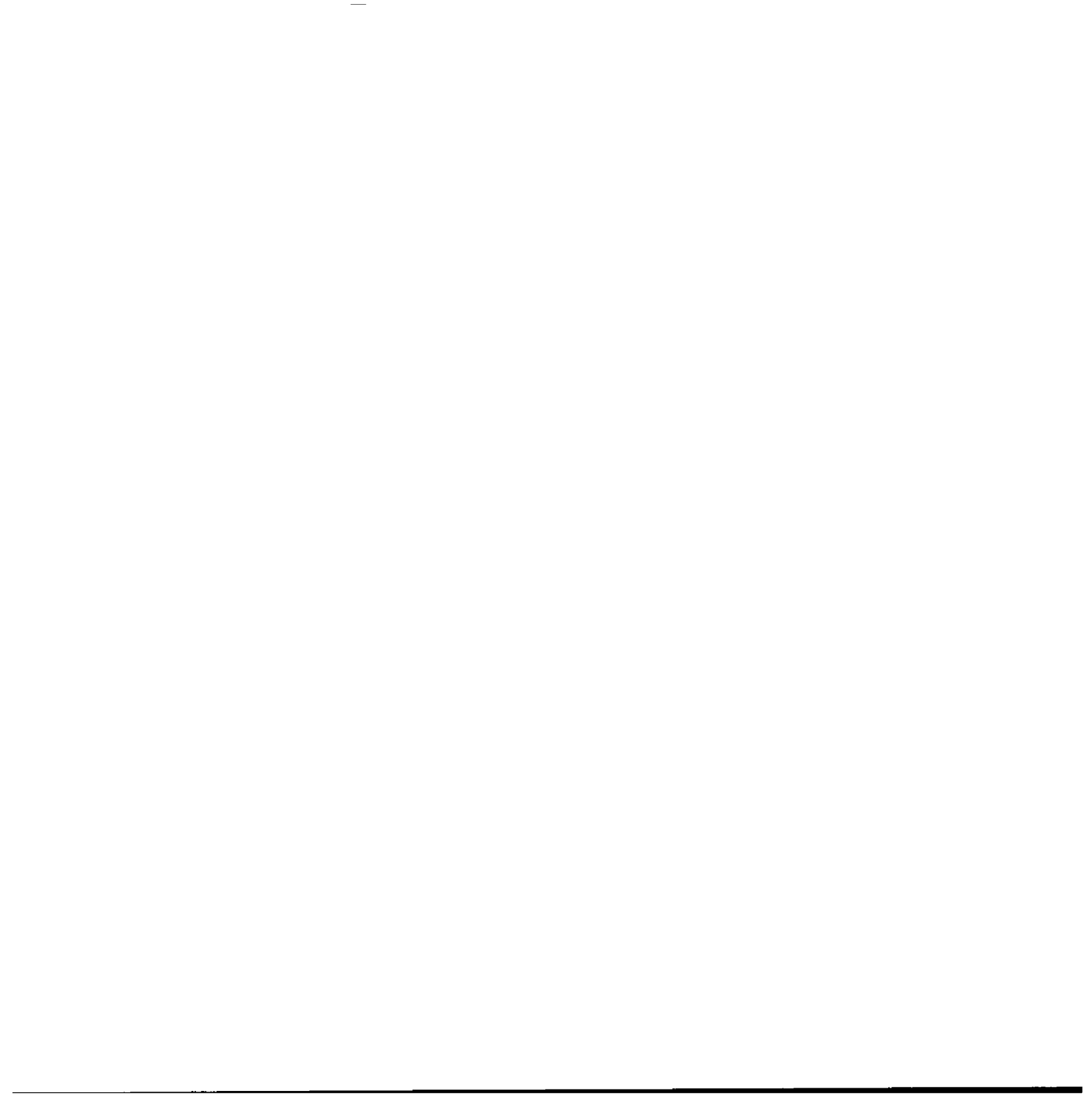
Source: Alaska DHSS historical Medicaid cost and eligibility count data. Excludes administrative costs.

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)

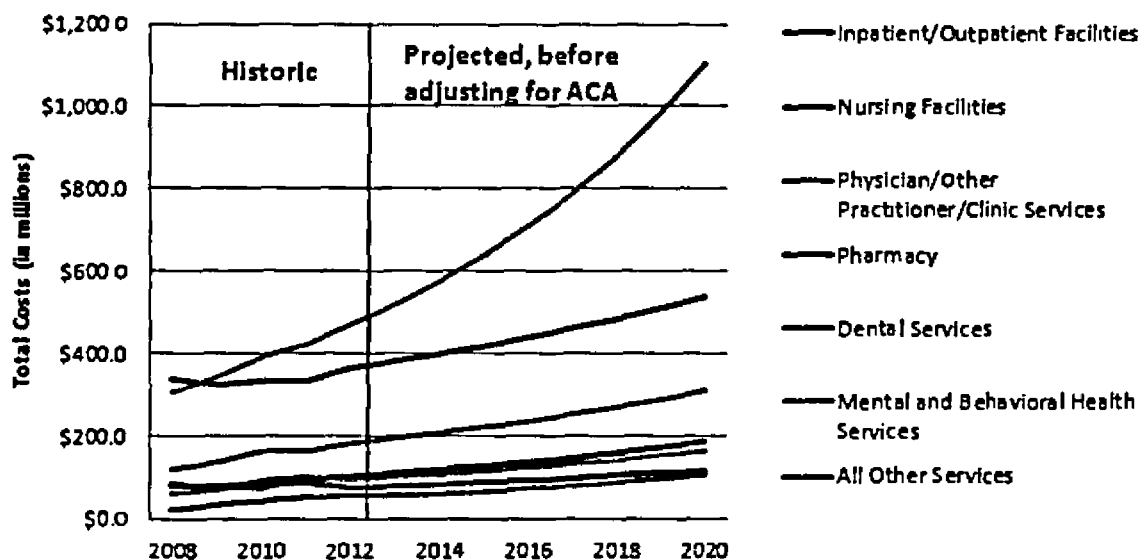


As the state considers options for improving upon its current Medicaid program in light of ACA provisions, it may be beneficial to consider the trajectory of projected costs of the current program by benefit type, demographic characteristics, and the state's share of total expenses. From 2008 to 2012,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

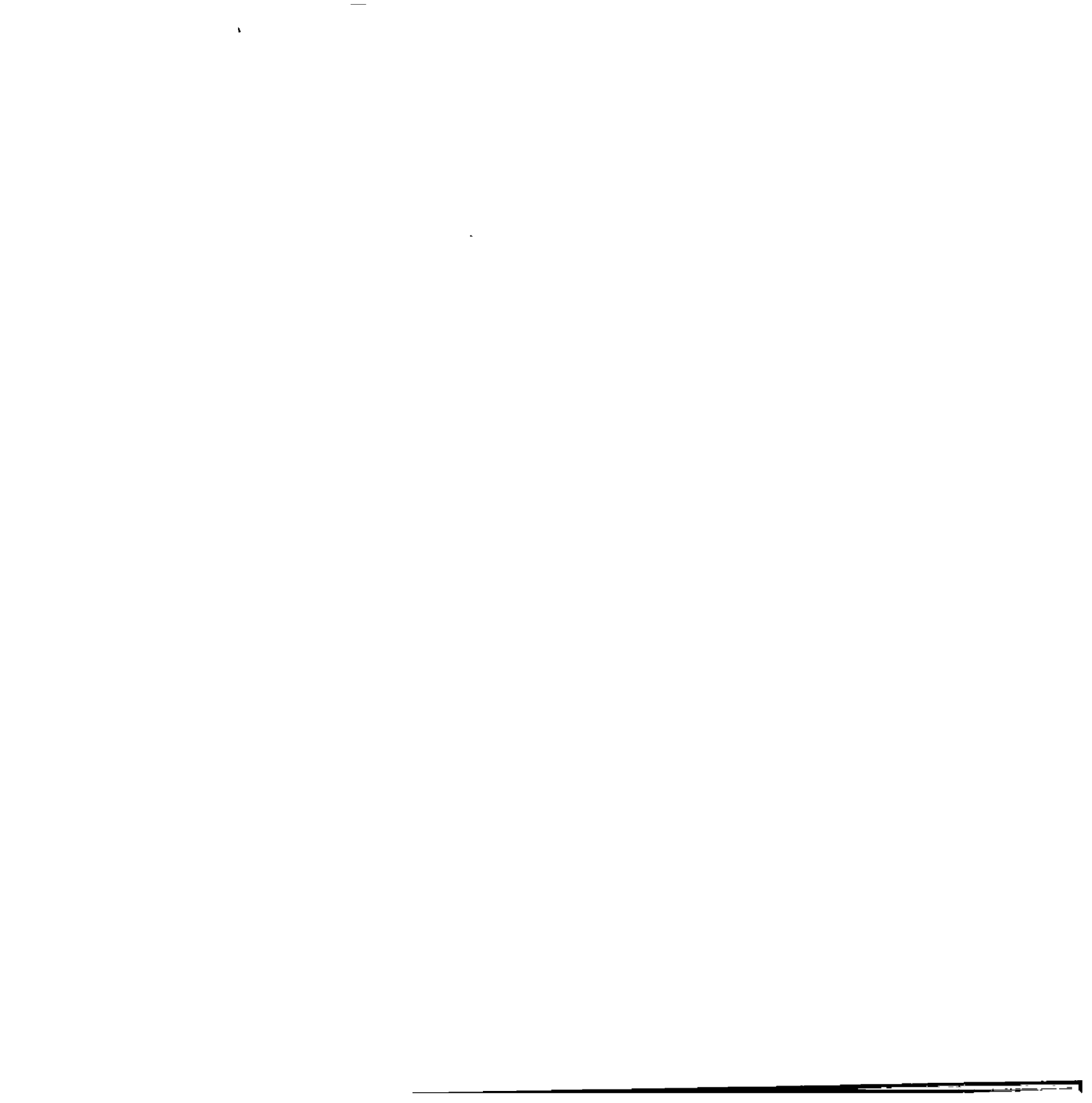


...benefit type categories. This particular benefit type ("All Other Services") is projected to increase at a rate substantially higher than that of other benefit types, indicative of a rapid rise in certain non-ambulatory services. By SFY 2020, total costs for this "All Other Services" category, which 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.



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

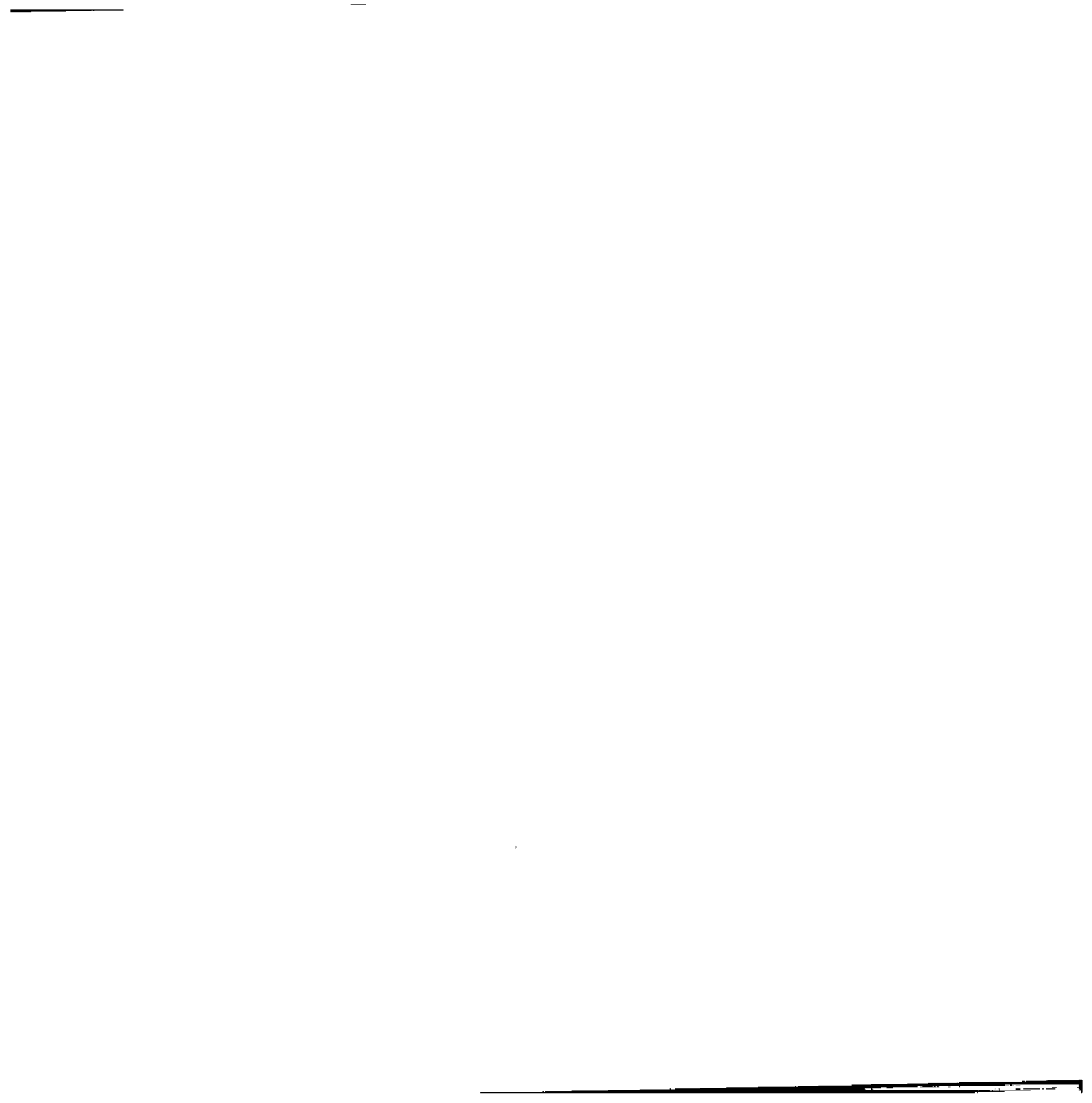
As noted, the state has the option of not expanding Medicaid as originally required under the ACA without facing a financial penalty. However, other aspects of the ACA will affect Alaska's Medicaid program regardless of any changes made to the current program. These other provisions include the following:

- **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.<sup>2,3</sup> 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.

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<sup>2</sup> Utah Department of Health, "Medicaid Asset Limit Study," October 2005.

<sup>3</sup> National Academies of Sciences, "Medicaid Asset Limit Study," October 2005.



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.

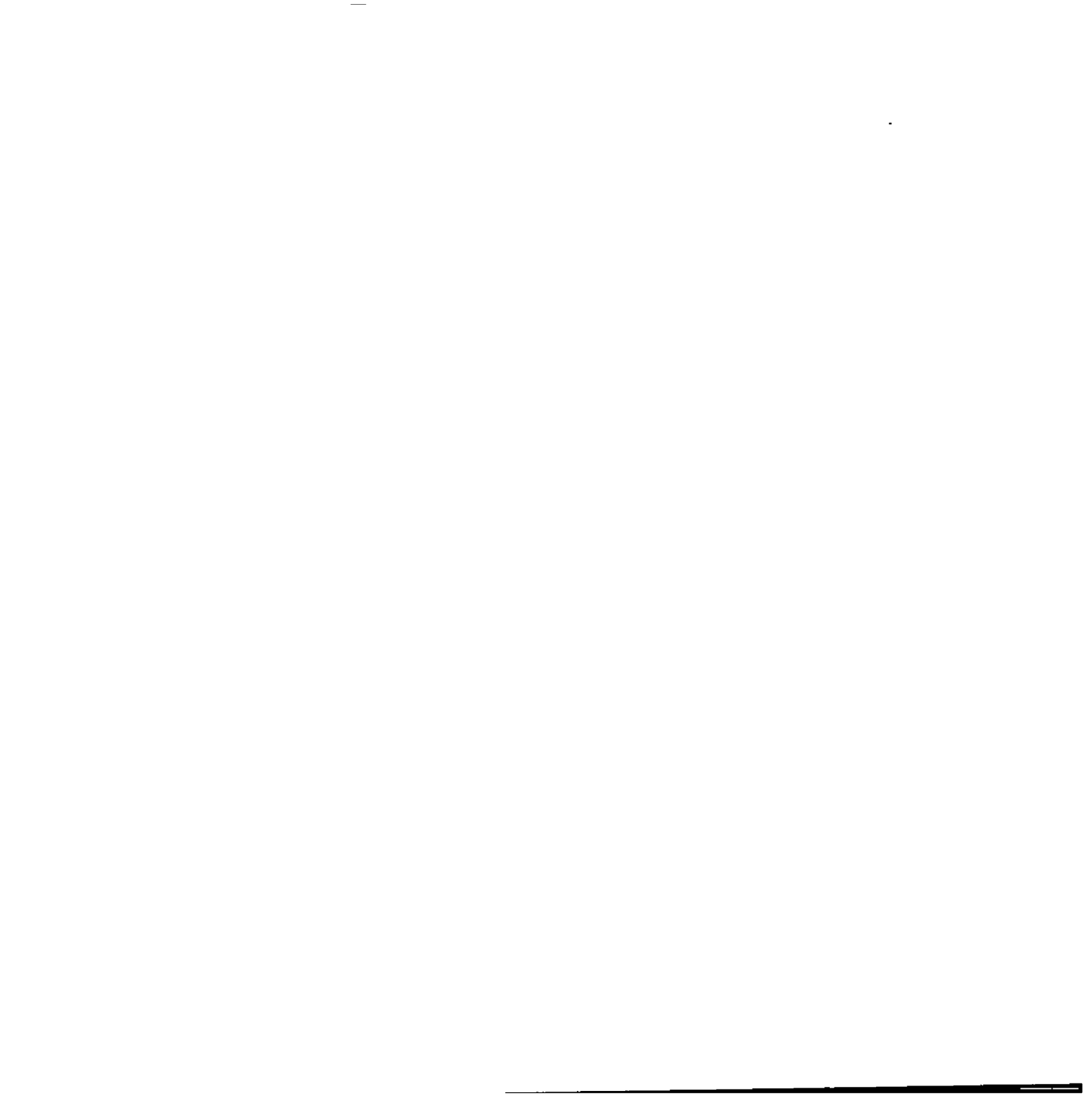
**Figure 5. Impact on Alaska Medicaid Spending if Medicaid is Not Expanded Under the ACA (2014-2020)**

	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.



	2014	2015	2016	2017	2018	2019	2020	2014-2020
Change in Enrollment	242	325	409	405	403	402	402	
<b>Total Costs (\$1,000s)</b>								
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.<sup>4</sup> 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.

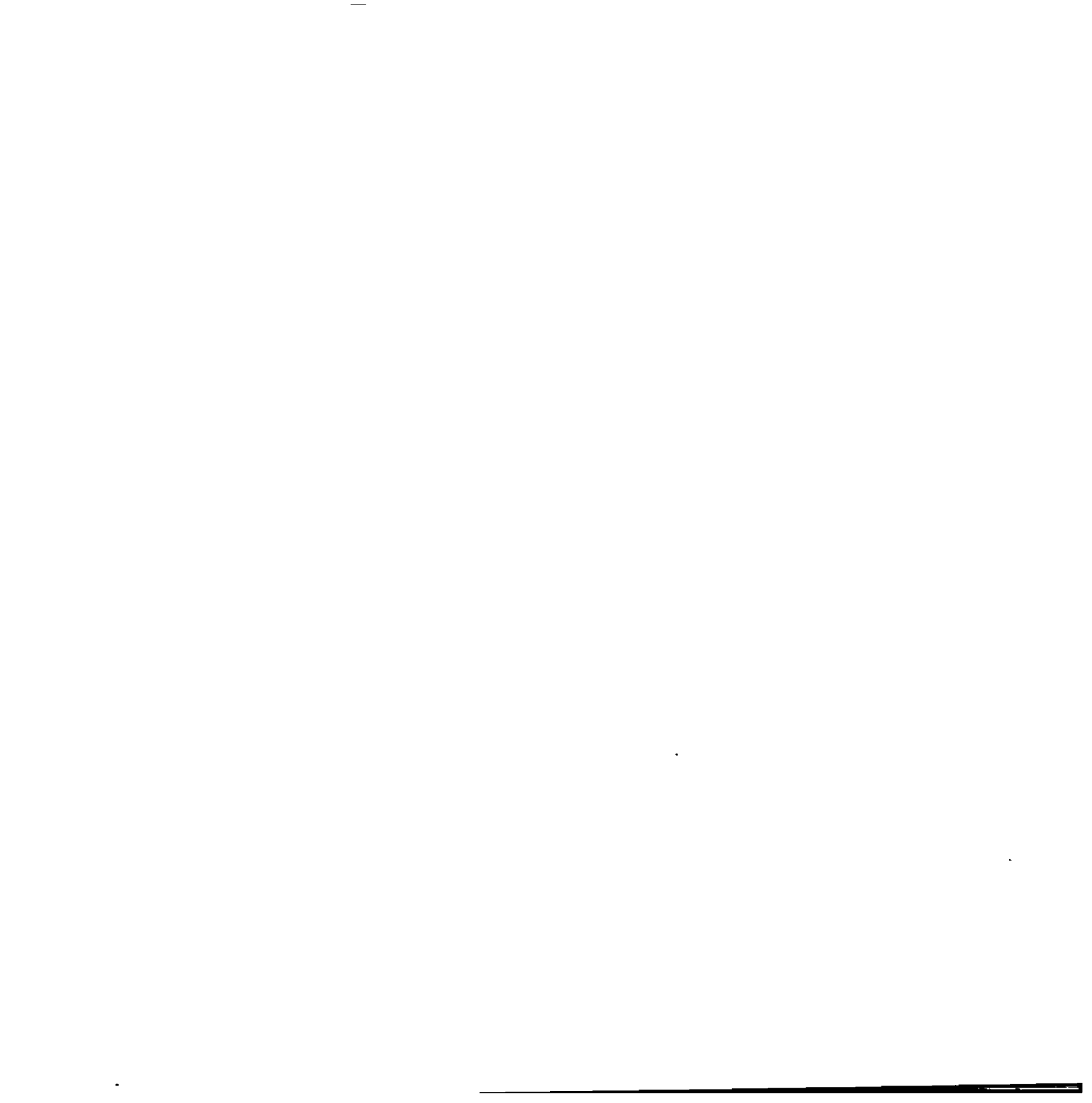
## B. ACA Provisions that Affect the Medicaid Program Regardless of Expansion

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

<sup>4</sup> 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.



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.

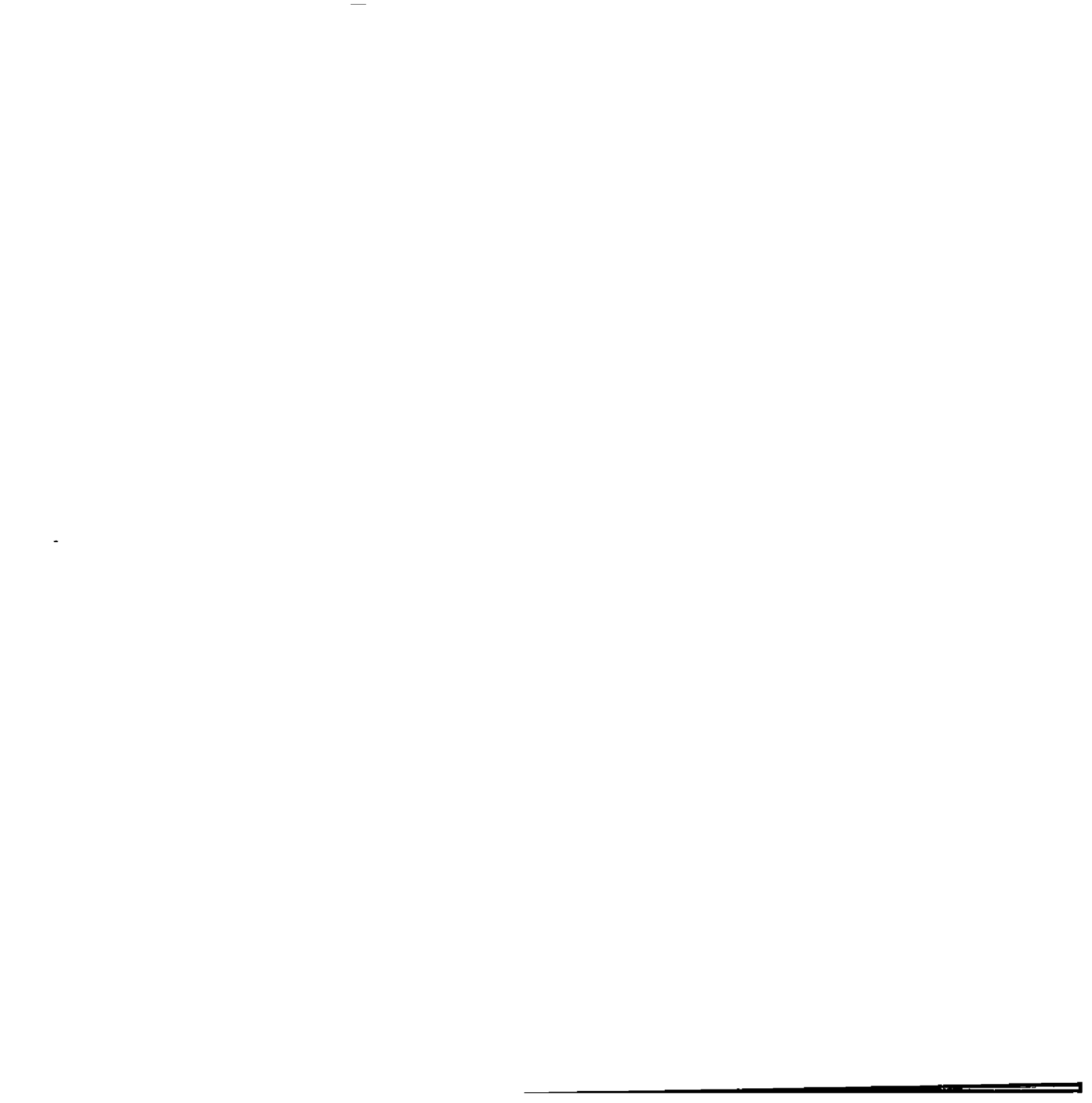
## ***2. Changes in Payment Levels to Primary Care Physicians***

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.



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.<sup>5</sup>

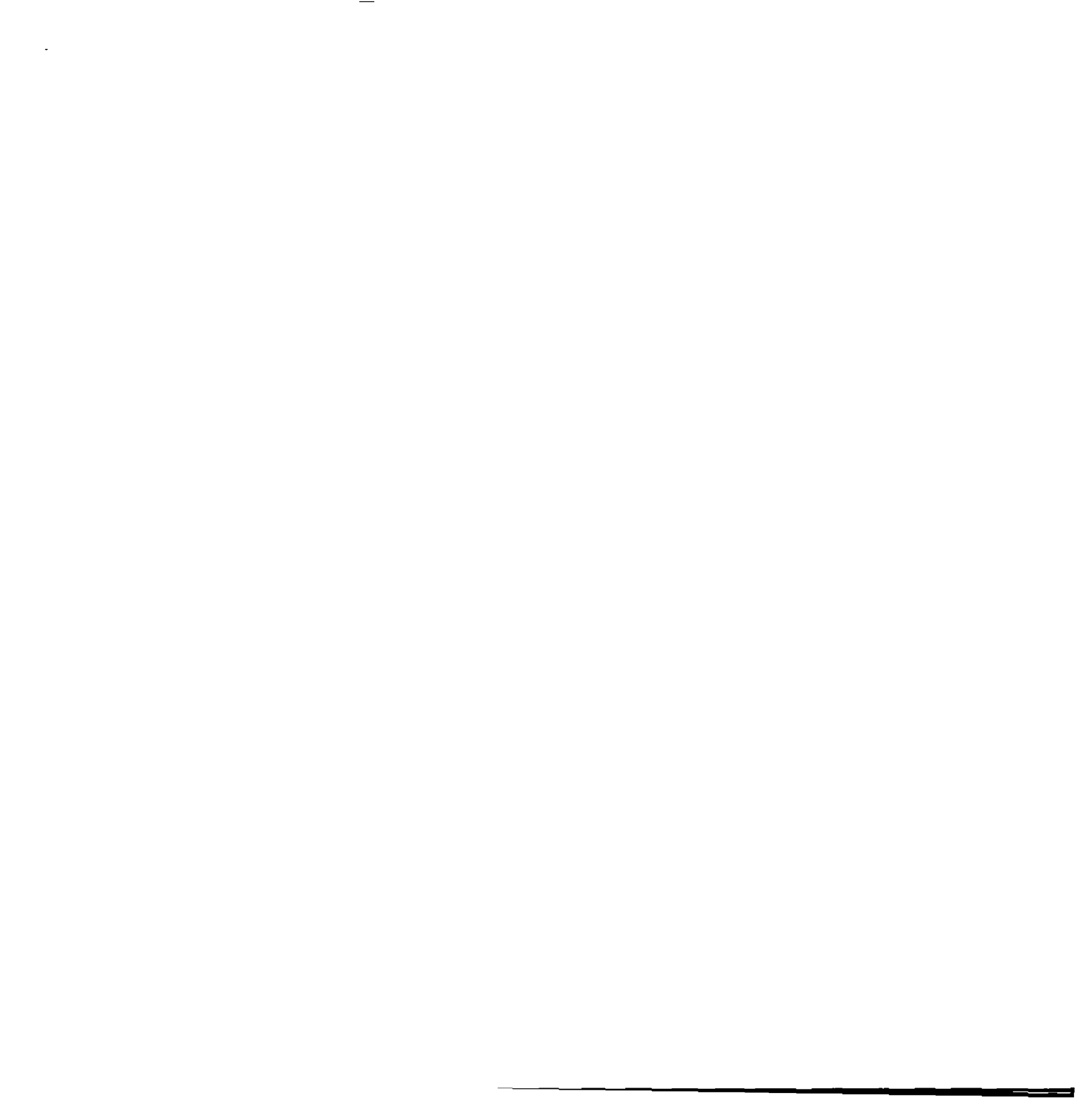
Additionally, if the state decides to expand Medicaid coverage as originally designed under the ACA, then all state residents below 400 percent of FPL will have access to subsidized coverage. However, if the state does not expand Medicaid, many of the lowest income adults (below 100 percent of FPL) will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

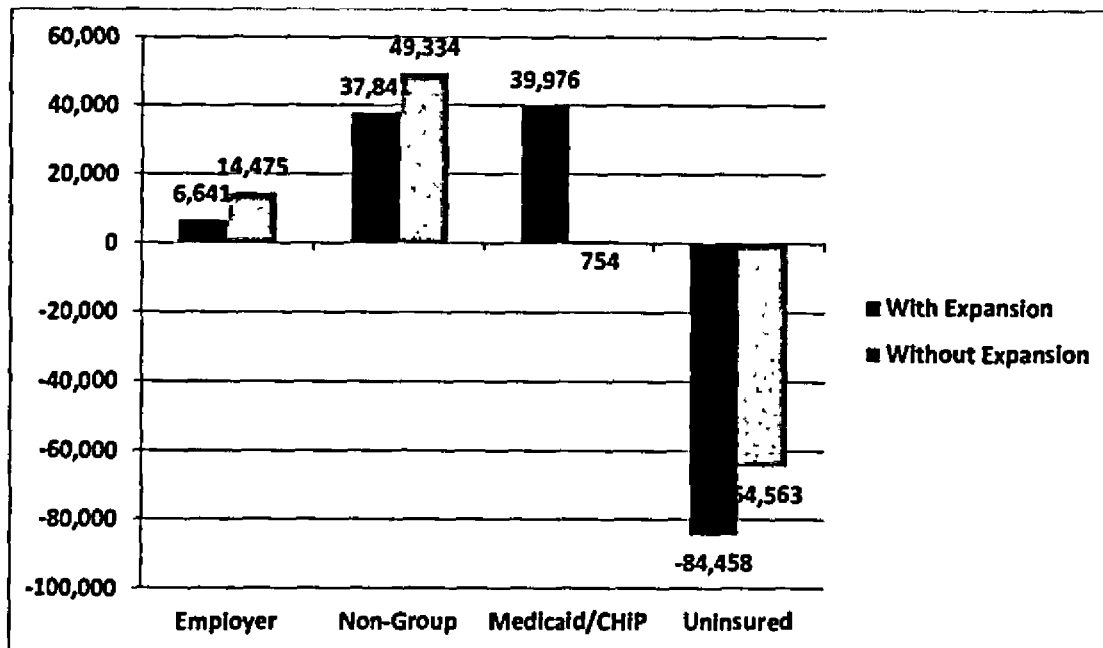
We estimate that there will be about 144,983 uninsured in Alaska in 2014 in the absence of the ACA. Taking into account all other provisions of the ACA, our estimates show that if the state expands Medicaid, the number of uninsured would be reduced to 60,435—an 84,548 total decrease, or a 58.3 percent 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.

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<sup>5</sup> 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.





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 <sup>1/</sup>

	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

<sup>1/</sup>Assumes full implementation and ultimate enrollment in 2014

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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.

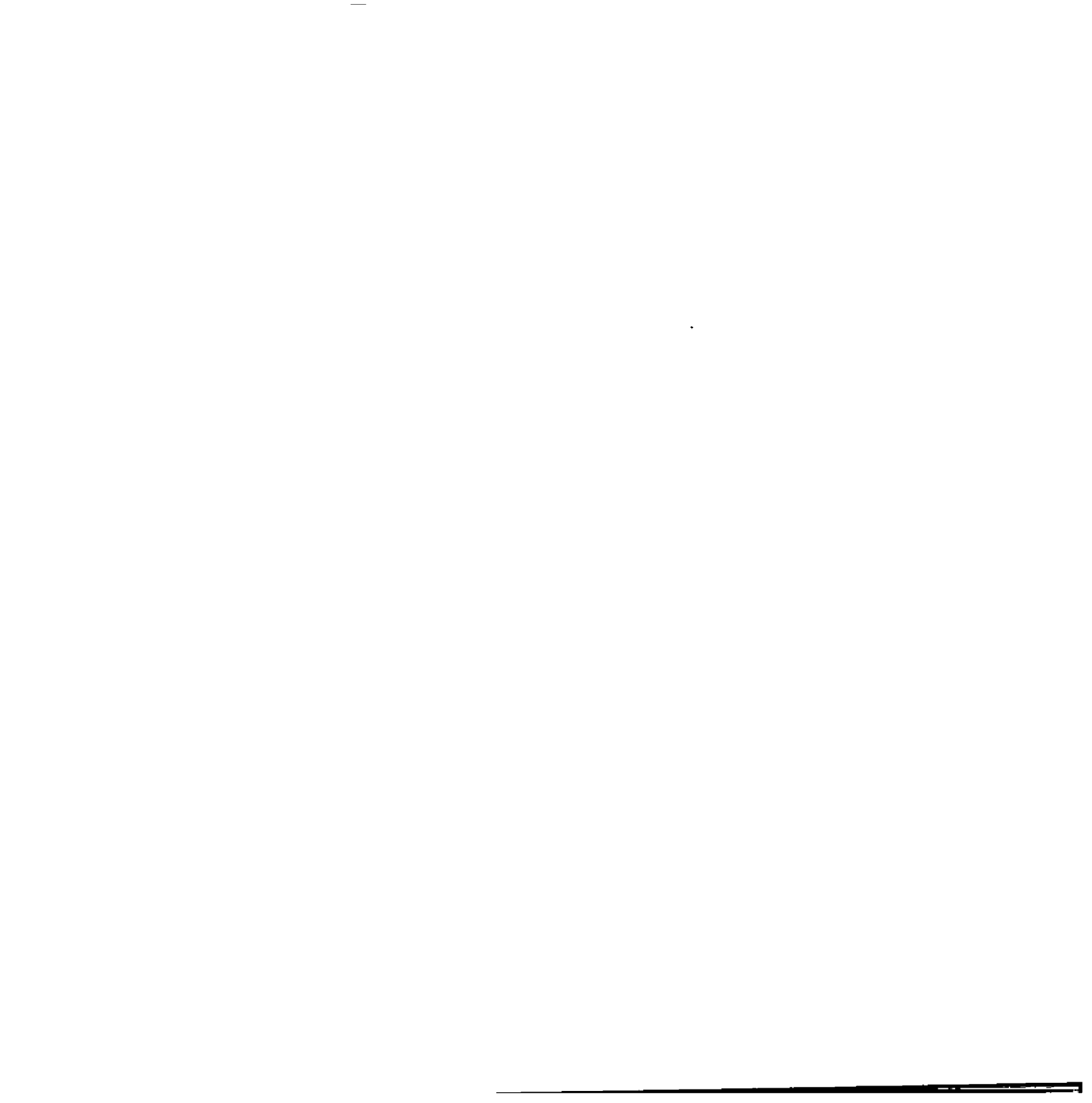
**Figure 9. Impact on Alaska Medicaid Spending if Medicaid is Expanded Under the ACA (2014-2020) - Baseline ACA Analysis <sup>1/</sup>**

	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	
<b>Total Costs (\$1,000s)</b>								
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

<sup>1/</sup> 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



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.

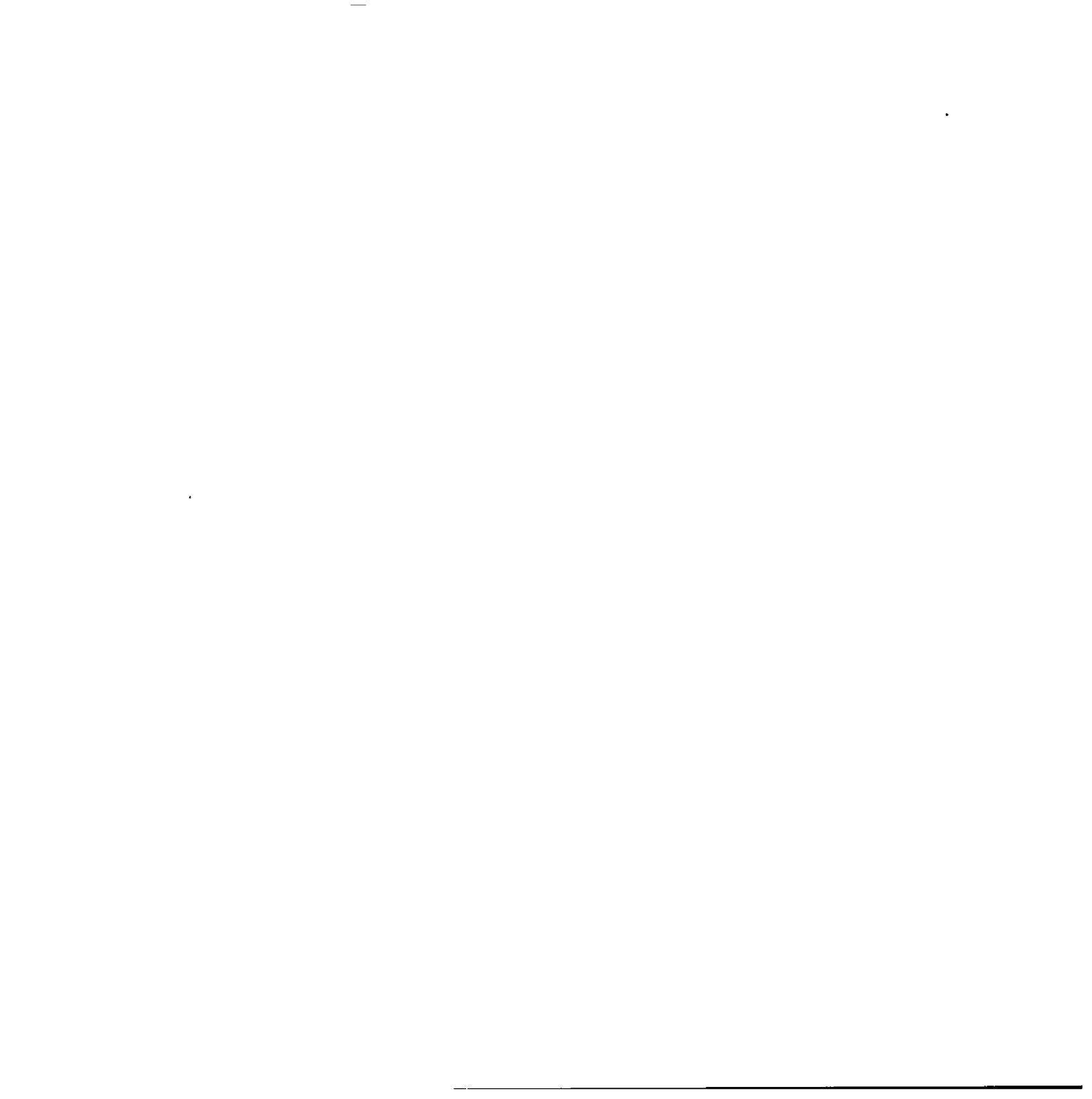
### 1. *Alternative Take-Up Rate for Newly Eligible Group*

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)<sup>1/</sup>

	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

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



	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	
<b>Total Costs (\$1,000s)</b>								
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
<b>Total</b>	<b>\$388,745</b>	<b>\$454,551</b>	<b>\$549,970</b>	<b>\$586,785</b>	<b>\$625,555</b>	<b>\$667,654</b>	<b>\$712,882</b>	<b>\$3,986,143</b>

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

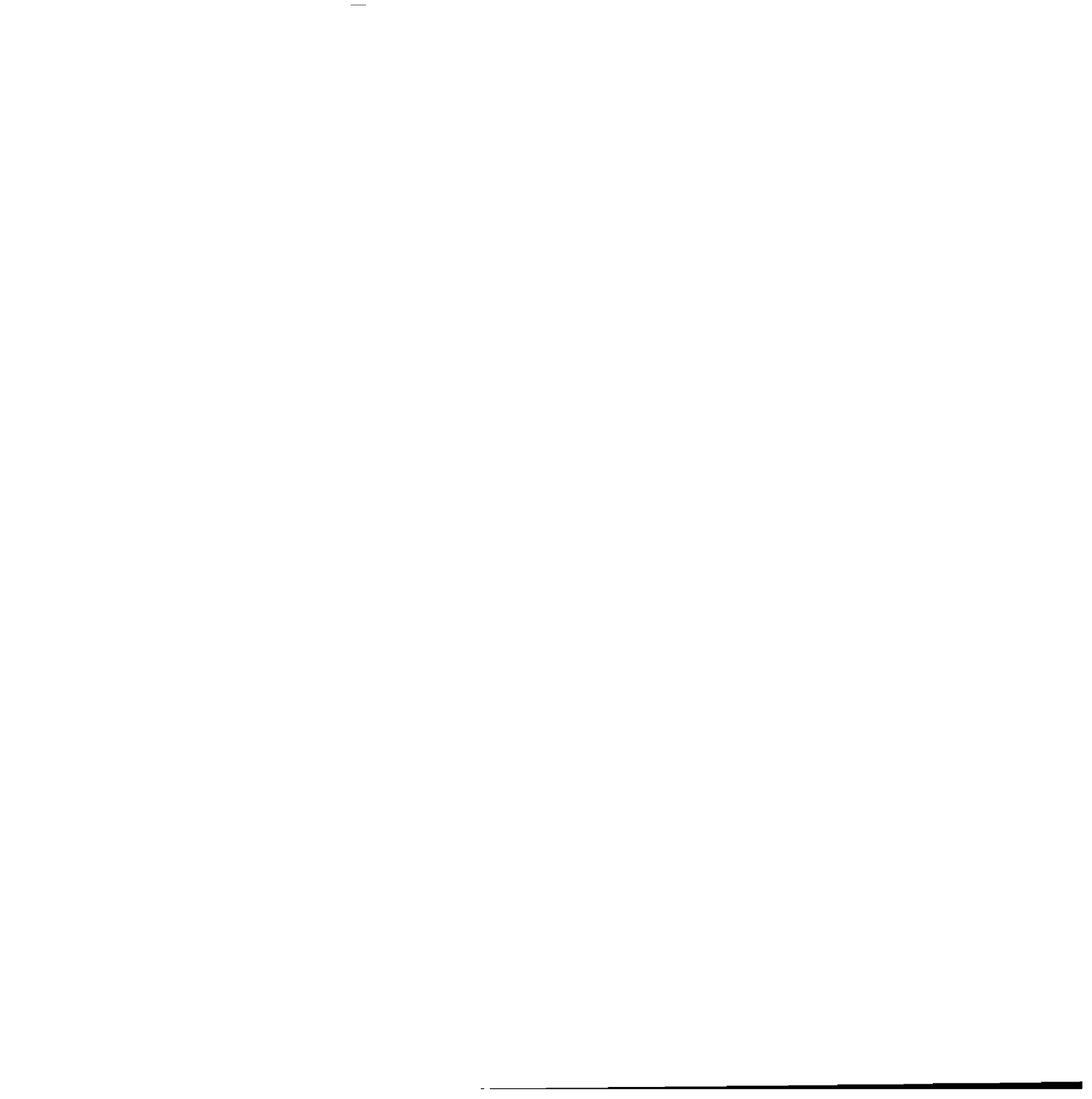
Beginning January 1, 2014, Alaska could expand Medicaid to all adults below 138 percent of FPL and receive enhanced federal matching. However, CMS has stated that states may “decide whether and when to expand, and if a state covers the expansion group, it may later drop the coverage.”<sup>6</sup> Therefore, 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

<sup>6</sup> Presentation by Cindy Mann, CMS Deputy Administrator to the National Conference of State Legislators, “Medicaid and



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<sup>1/</sup>**

	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	
<b>Total Costs (\$1,000s)</b>								
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.

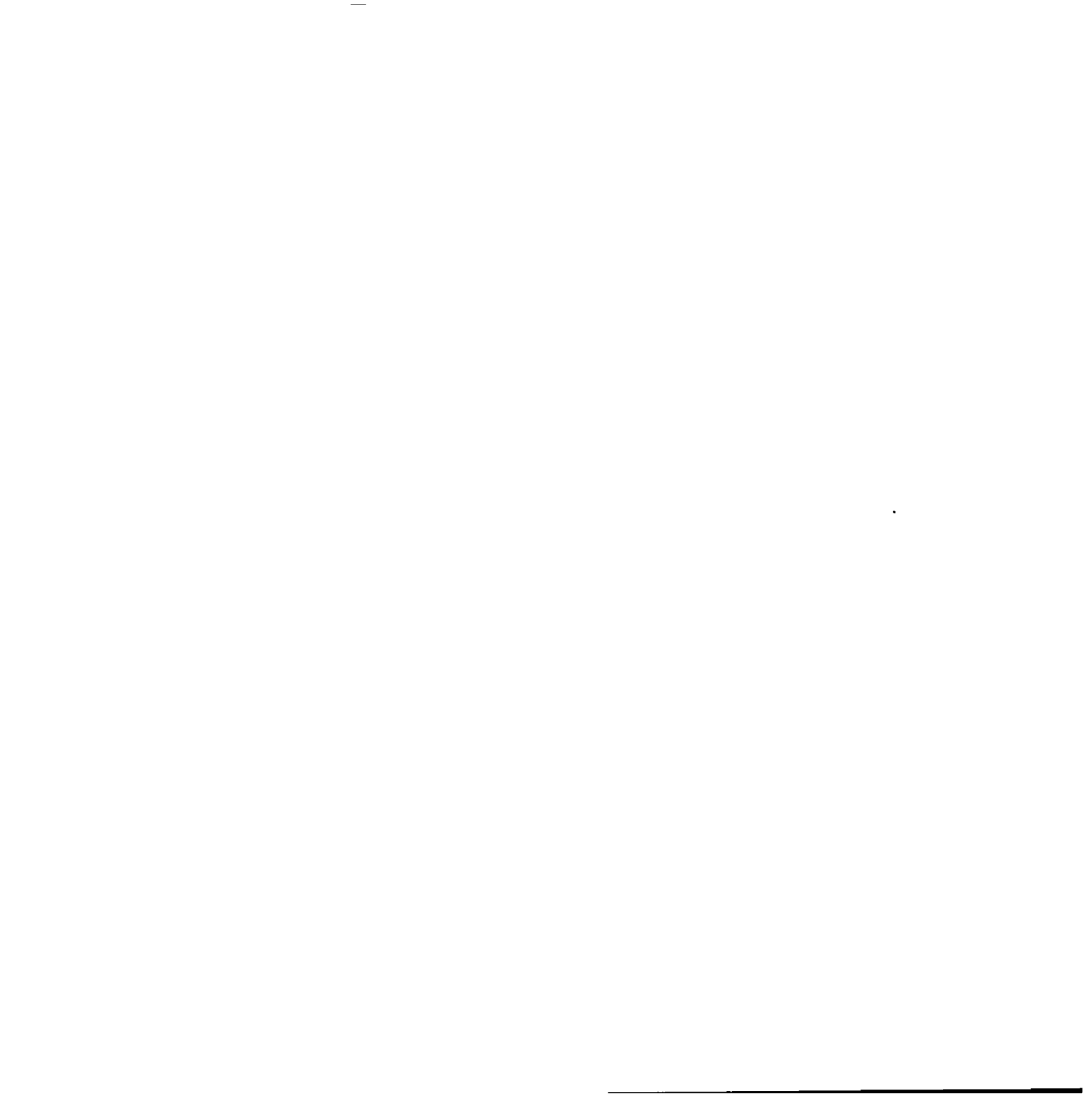
Source: Lewin Group estimates using the Alaska version of the Health Benefits Simulation Model. Please refer to Appendix B, Figure B-5 for further detail.

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

	2014	2015	2016	2017	2018	2019	2020	2014-2020
Change In Enrollment	577	667	31,243	36,589	42,051	42,668	43,316	
<b>Total Costs (\$1,000s)</b>								
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.



***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.

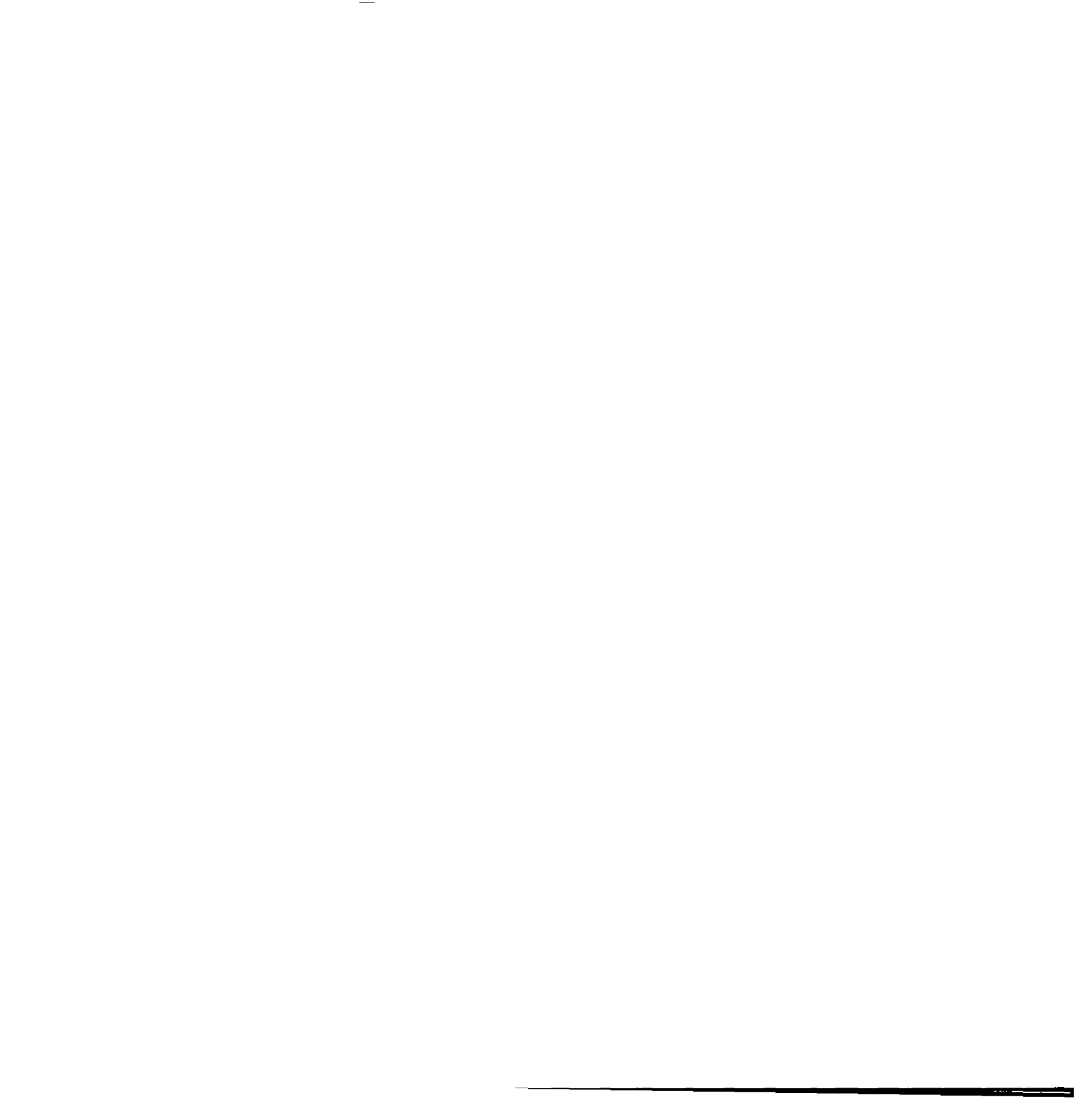
By reducing income eligibility for this eligibility category and moving these individuals to the Exchanges, the Medicaid program would no longer bear the cost for these individuals and the state and federal government would share the savings. However, the cost of providing premium and cost-sharing subsidies 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.

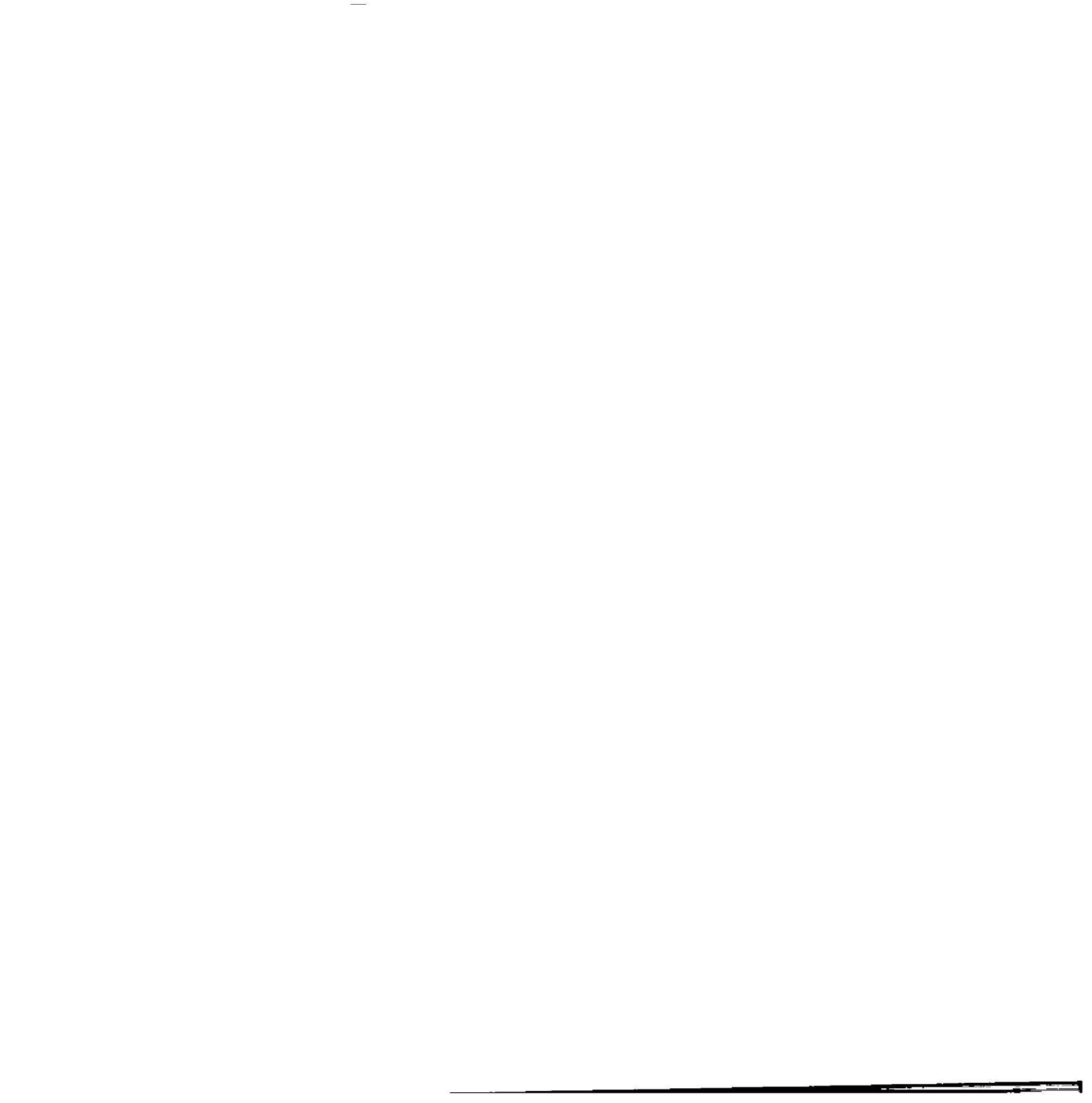
We found that the federal government would also share in the savings to Medicaid resulting from capping eligibility for this eligibility category and moving individuals into the Exchange since the federal government currently pays 50 percent of the cost for these individuals. It would save an estimated \$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.

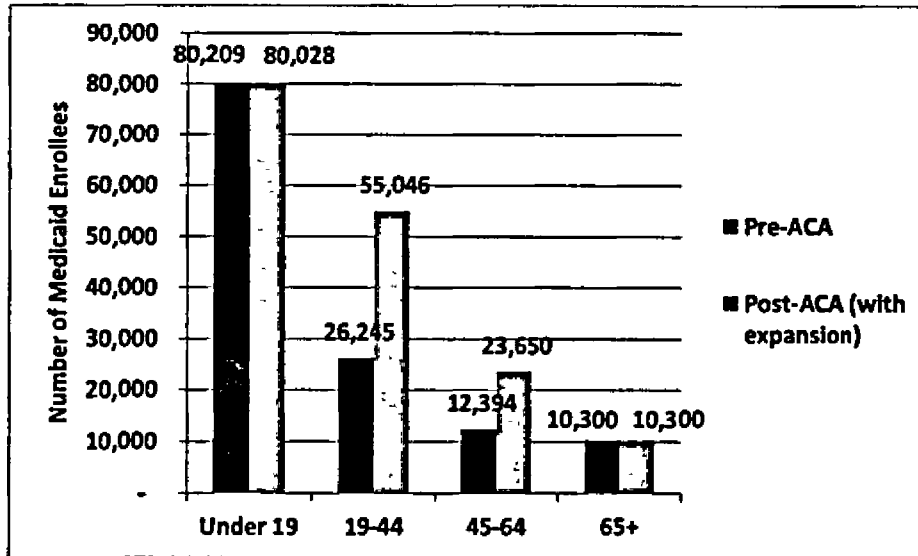






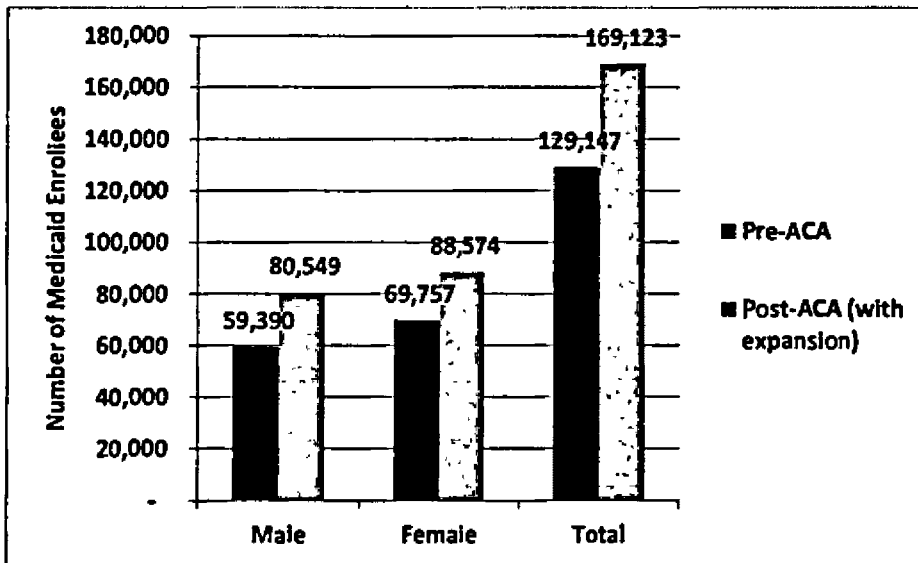
experience somewhat higher increases in enrollment than females, with respective increases of 36 and 27 percent.

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



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.<sup>8</sup>

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).

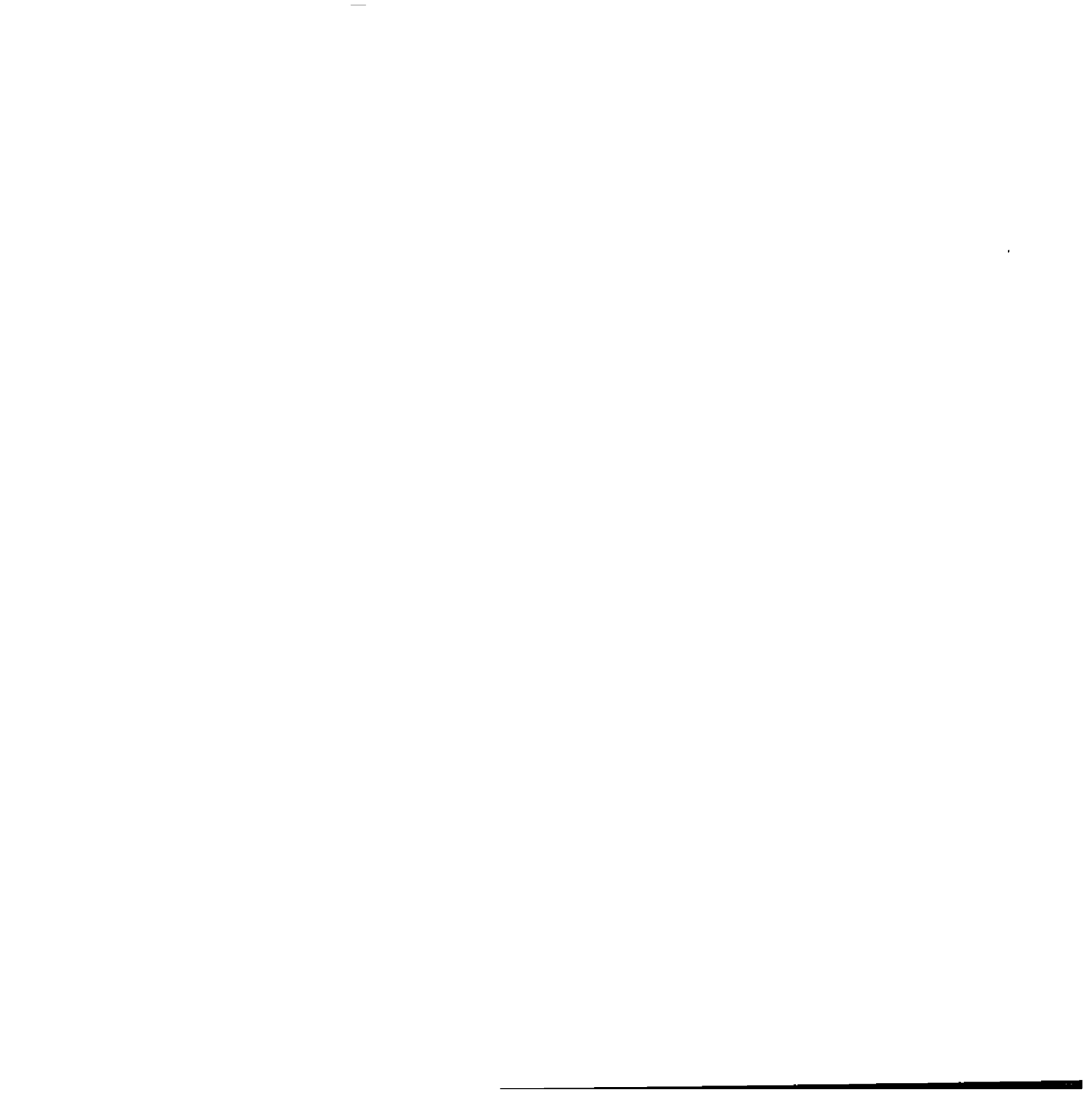
Under expansion, the state will likely experience a surge in staffing needs in order to accommodate the significant volume of new enrollment. The timely and successful provision of certain program maintenance functions (i.e., enrollee and provider appeals, case management and disease management for certain 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.<sup>9</sup>

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<sup>8</sup> Kaiser Commission on Medicaid and the Uninsured, "Medicaid Administration," 2002.



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.<sup>10</sup>
- **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.<sup>11</sup> 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.<sup>12</sup>

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.

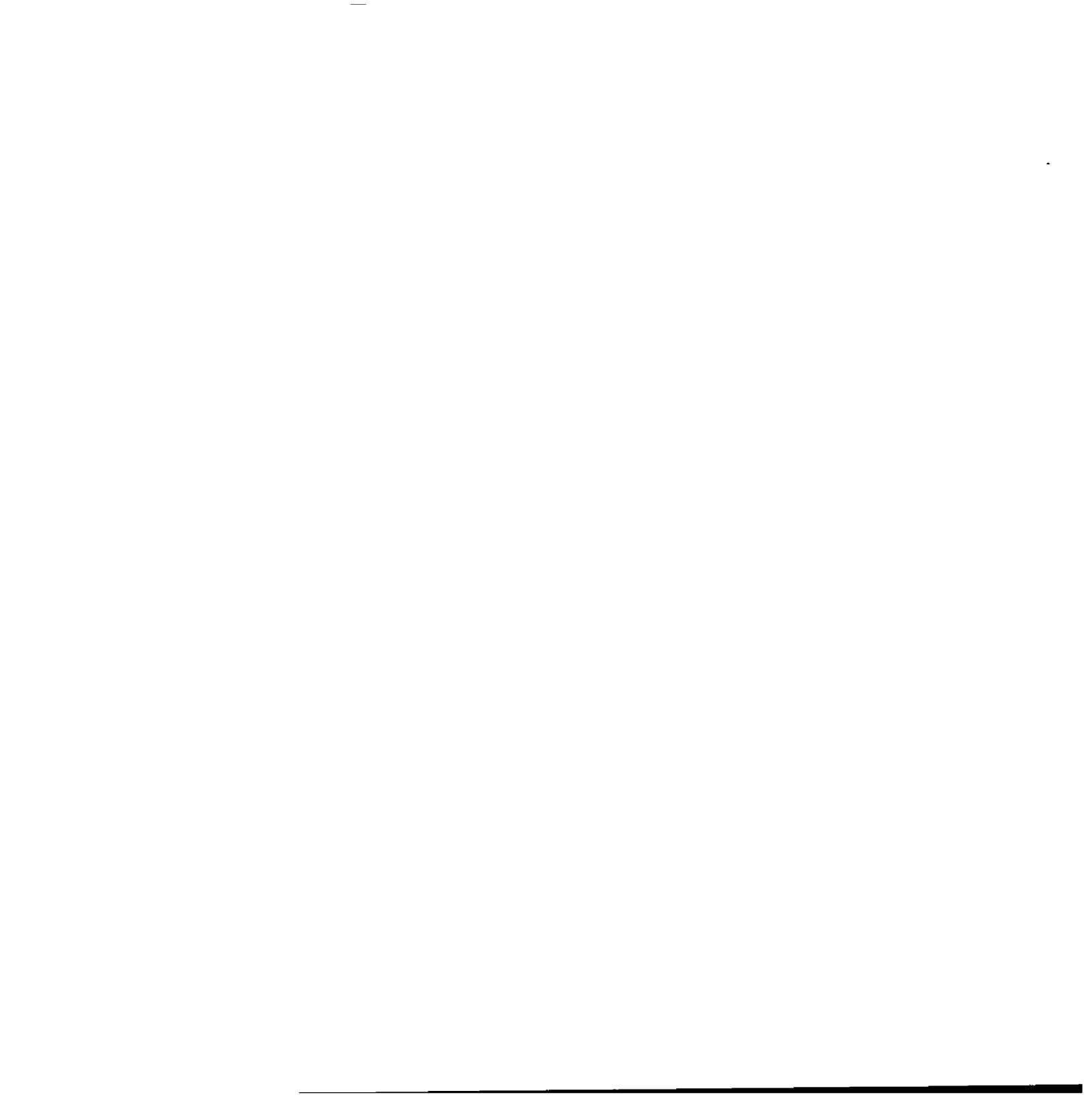
Several studies suggest that introducing “self-certification” of income would reduce the burden on both applicants and enrollment officers. The Medi-Cal Policy Institute found that income

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

<sup>11</sup> 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.

<sup>12</sup> Kaiser Commission on Medicaid and the Uninsured, “Performing Under Pressure: Annual Findings of a 50-State Survey of



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**

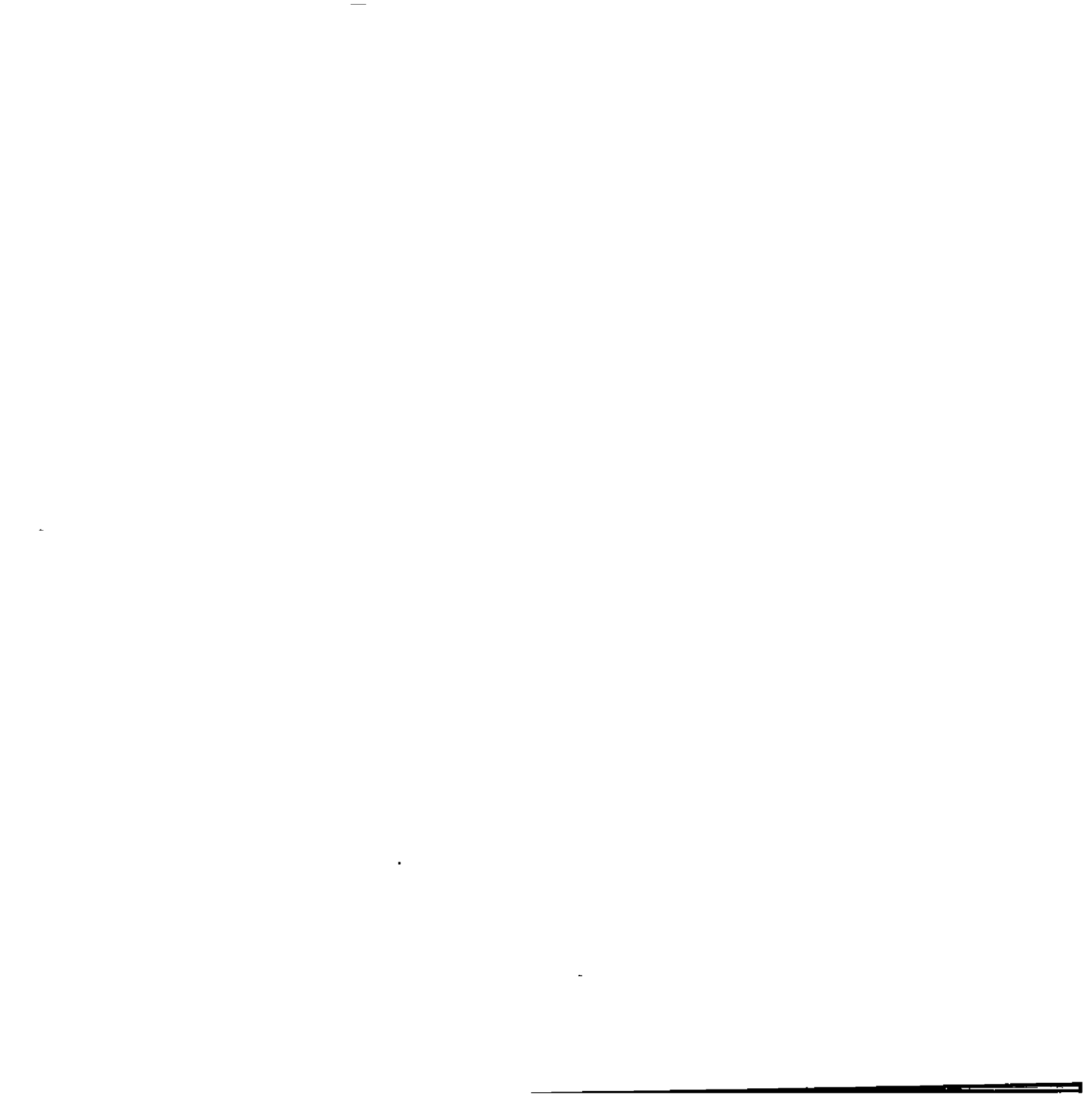
Under the Medicaid expansion option, many individuals currently receiving care in state-funded or subsidized programs will become eligible and enroll in the Medicaid expansion. This will produce savings for Alaska, as the cost for these programs are reduced or eliminated. These savings are not incorporated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



	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.<sup>13</sup> These savings may be offset, in part, by the planned reduction in Disproportionate Share Hospital (DSH) payments set to take effect in 2014.<sup>14</sup> 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.<sup>15</sup> The influx of federal funds could also generate job growth within the state.<sup>16</sup> 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.<sup>17,18</sup>

## 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

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

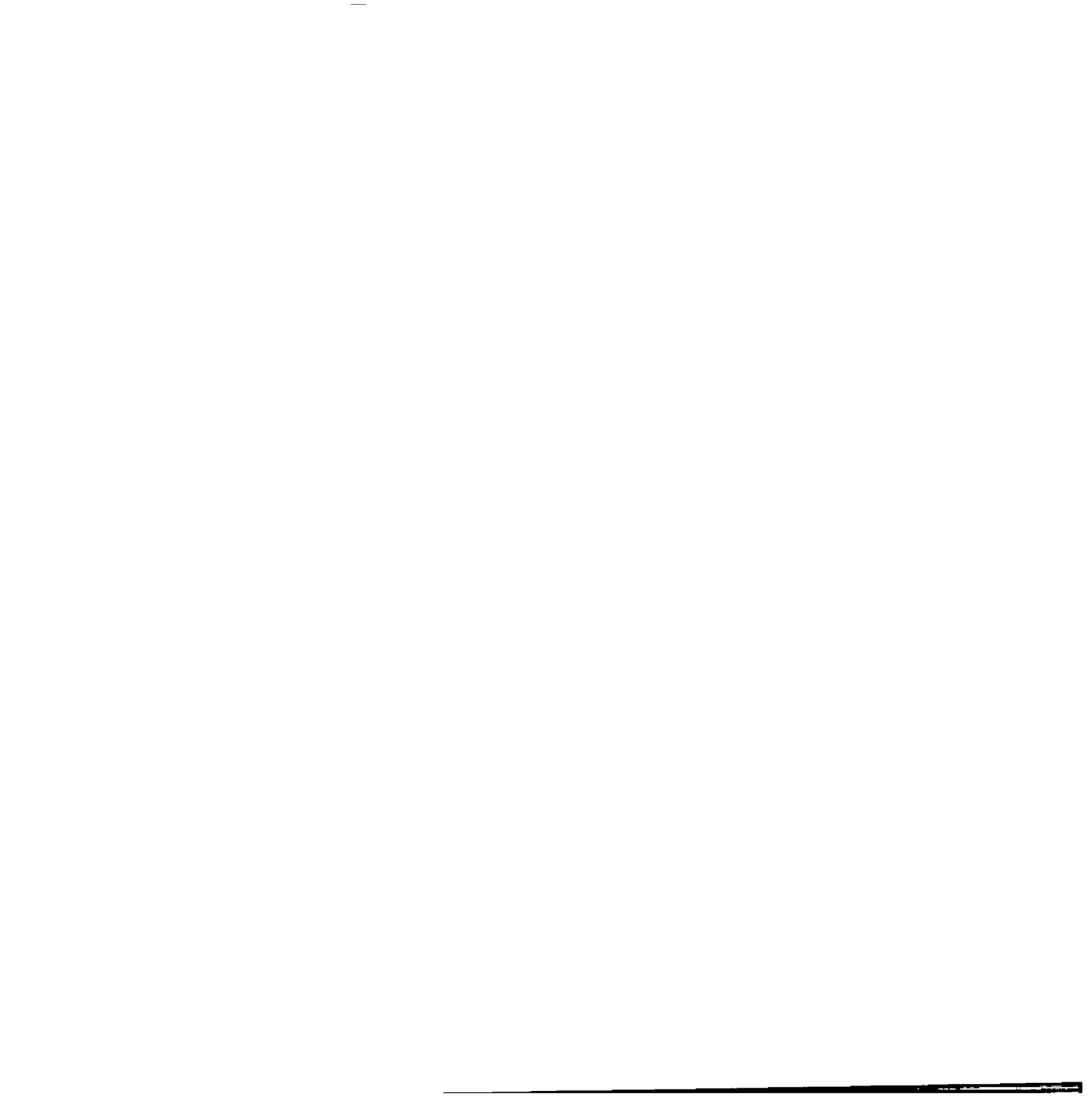
<sup>14</sup> National Association of Public Hospitals and Health Systems, "Need for a Sustainable Solution: Restoring the Balance in Safety Net Funding," 2012.

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

<sup>16</sup> Ibid.

<sup>17</sup> 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.

<sup>18</sup> 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," 2012.



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.<sup>19</sup>

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.<sup>20</sup> 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.<sup>21</sup>

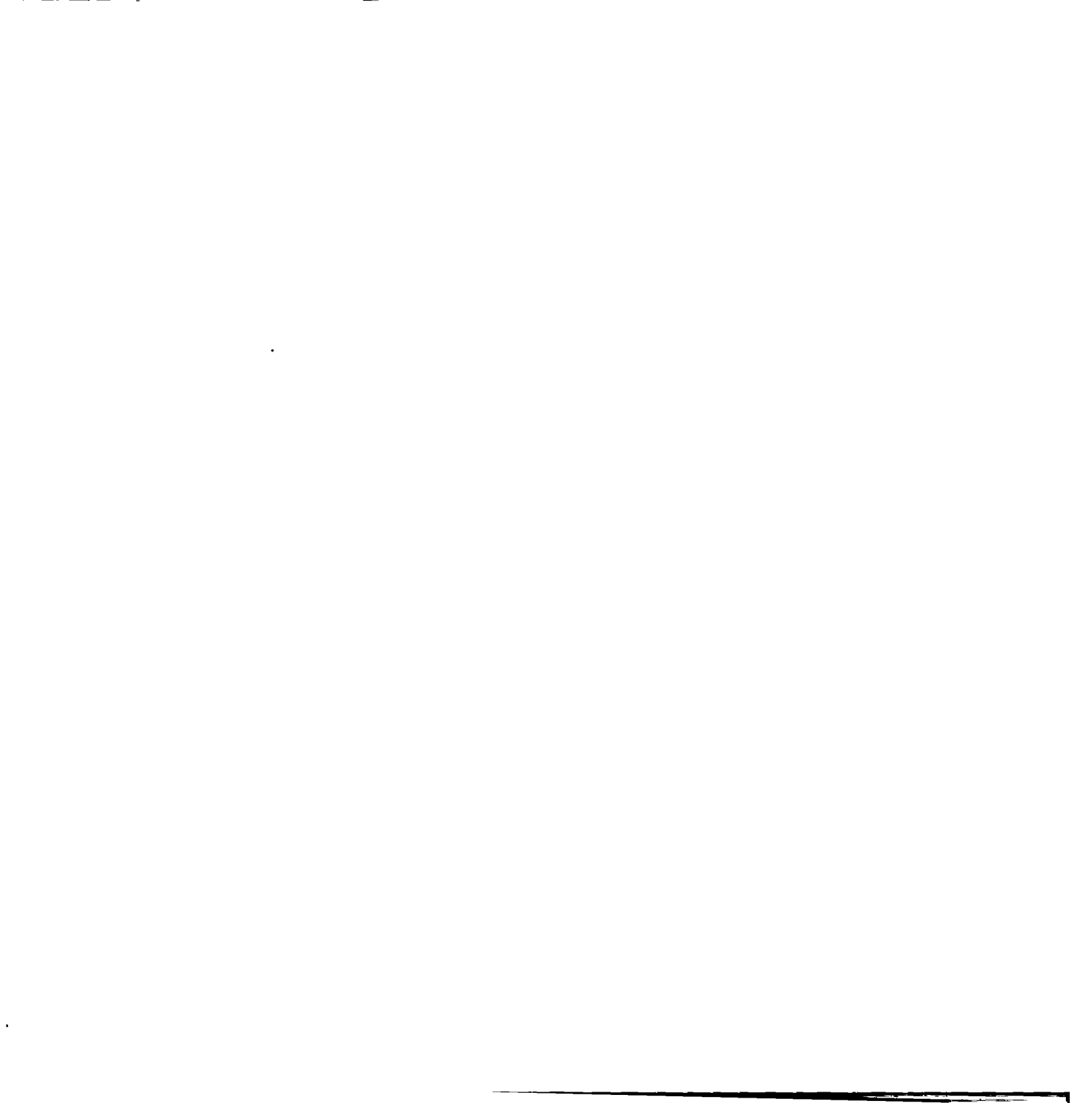
While Medicaid health homes are in their nascent stages, experience with other medical home initiatives, coupled with the enhanced match rate for these services under the ACA, suggest that there may also be savings to states who effectively implement health home programs.

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<sup>19</sup> National Academy for State Health Policy (NASPH), "Medical Home & Patient-Centered Care," 2012.

<sup>20</sup> Milliman, Inc., "Analysis of Community Care of South Carolina Cost Savings," December 15, 2011.

<sup>21</sup> Grumbach K, Bodenheimer T, & Grundy, P., "The Outcomes of Implementing Patient Centered Medical Home Interventions." August 2009



According to the U.S. Department of Health and Human Services, "nationally, Americans use preventive services at about half the recommended rate."<sup>22</sup> 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.<sup>23</sup> 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.<sup>24</sup>

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.<sup>25</sup> 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).<sup>26</sup>

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.<sup>27</sup> 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.<sup>28</sup> 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

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<sup>22</sup> U.S. Department of Health & Human Services, "Background: The Affordable Care Act's New Rules on Preventive Care," 2011.

<sup>23</sup> Ibid.

<sup>24</sup> Sanchez, E., "Preventive Care: A National Profile on Use, Disparities, and Health Benefits – Presentation," September 20, 2007.

<sup>25</sup> 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.

<sup>26</sup> 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.

<sup>27</sup> National Conference of State Legislatures, "Performance-Based Health Care Provider Payments," 2010.



negative incentive by rewarding more efficient care.<sup>29</sup>

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.<sup>30</sup> HIT has the potential to contain costs by streamlining care and reducing the number of duplicate treatments or prescriptions per patient.<sup>31</sup>

#### **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.<sup>32</sup> Medicaid fee-for-service (FFS) programs currently lag behind Medicaid managed care organizations (MCOs) in their use of generic drugs.<sup>33</sup> 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.<sup>34</sup>

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.<sup>35</sup>

#### **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.<sup>36</sup> 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.<sup>37</sup> 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.<sup>38</sup> Expanding the scope of telemedicine in

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<sup>29</sup> Ibid.

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

<sup>31</sup> Ibid.

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

<sup>33</sup> Ibid.

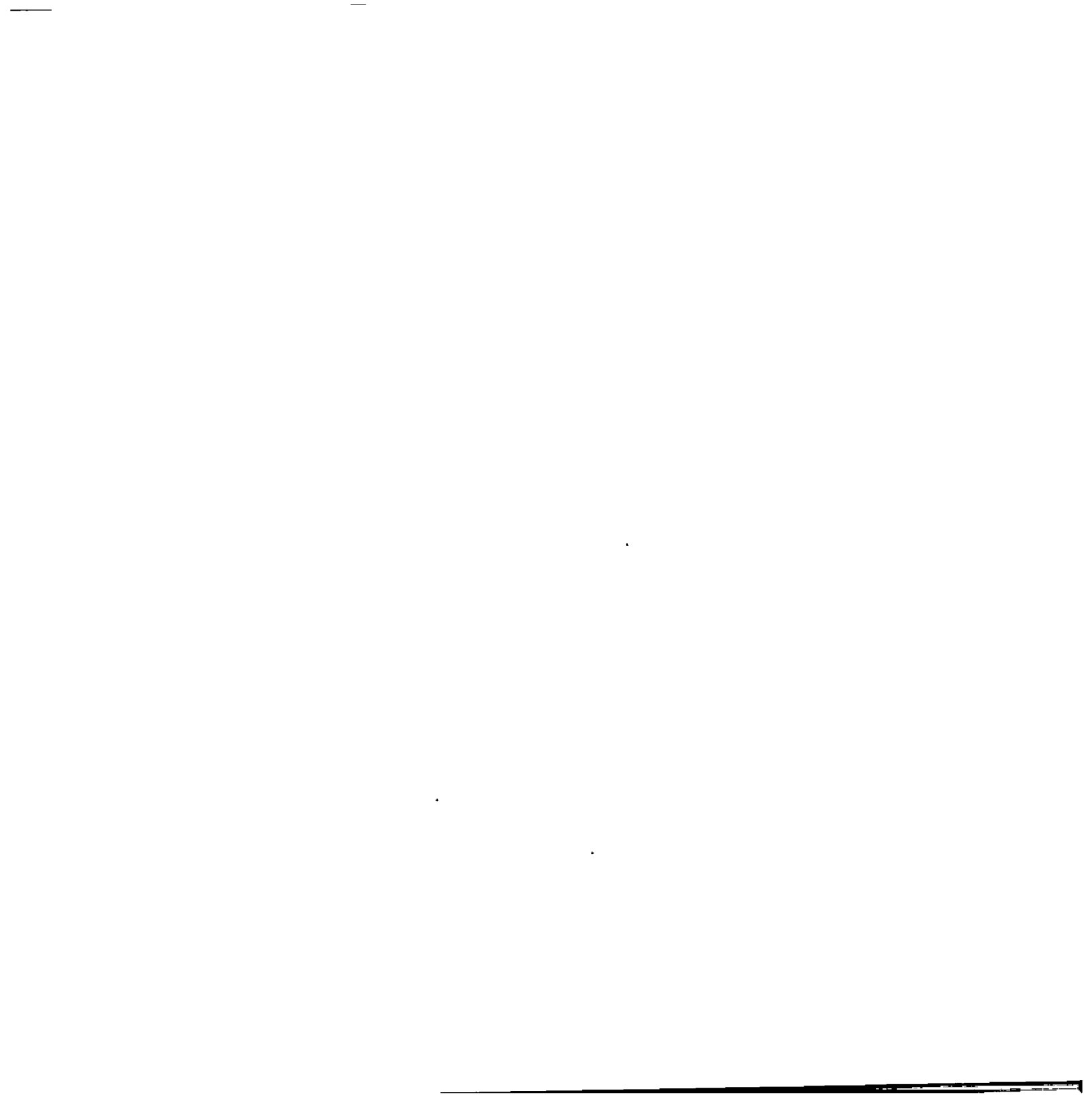
<sup>34</sup> Ibid.

<sup>35</sup> Ibid.

<sup>36</sup> American Telemedicine Association, "What is Telemedicine," 2012.

<sup>37</sup> Ibid.

<sup>38</sup> . . .



to near-to-reach, rural populations.

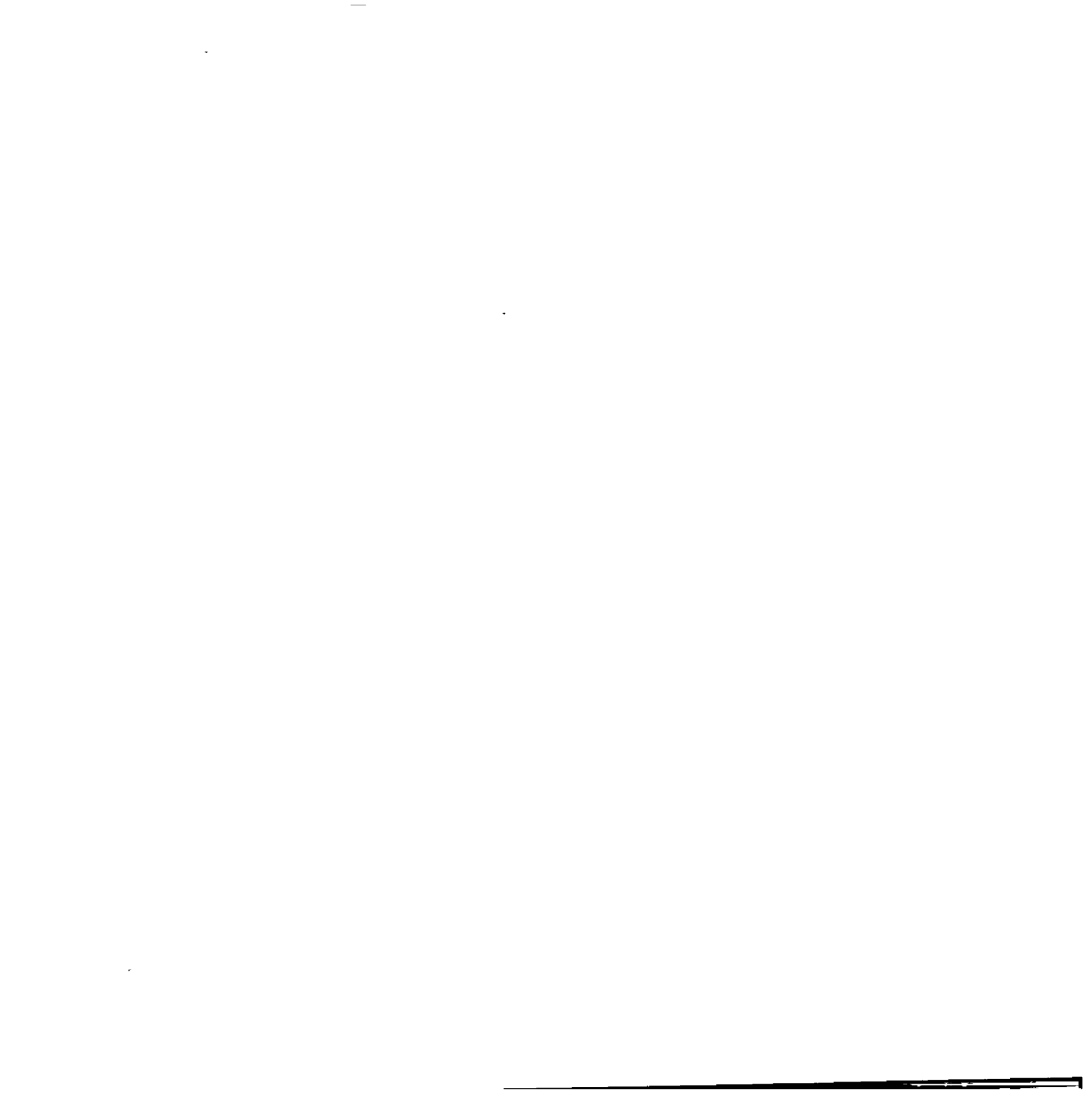
## J. Summary

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.



Scenario	Cost to State (2014-2020) in \$1,000s	Cost to Federal Government (2014- 2020) in \$1,000s
<b>No Expansion:</b>		
1. Baseline	\$39,885	\$40,543
2. Moving Currently Eligible Pregnant Women Above 138 Percent of FPL to HBE	\$11,078	\$11,261
<b>Expansion:</b>		
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

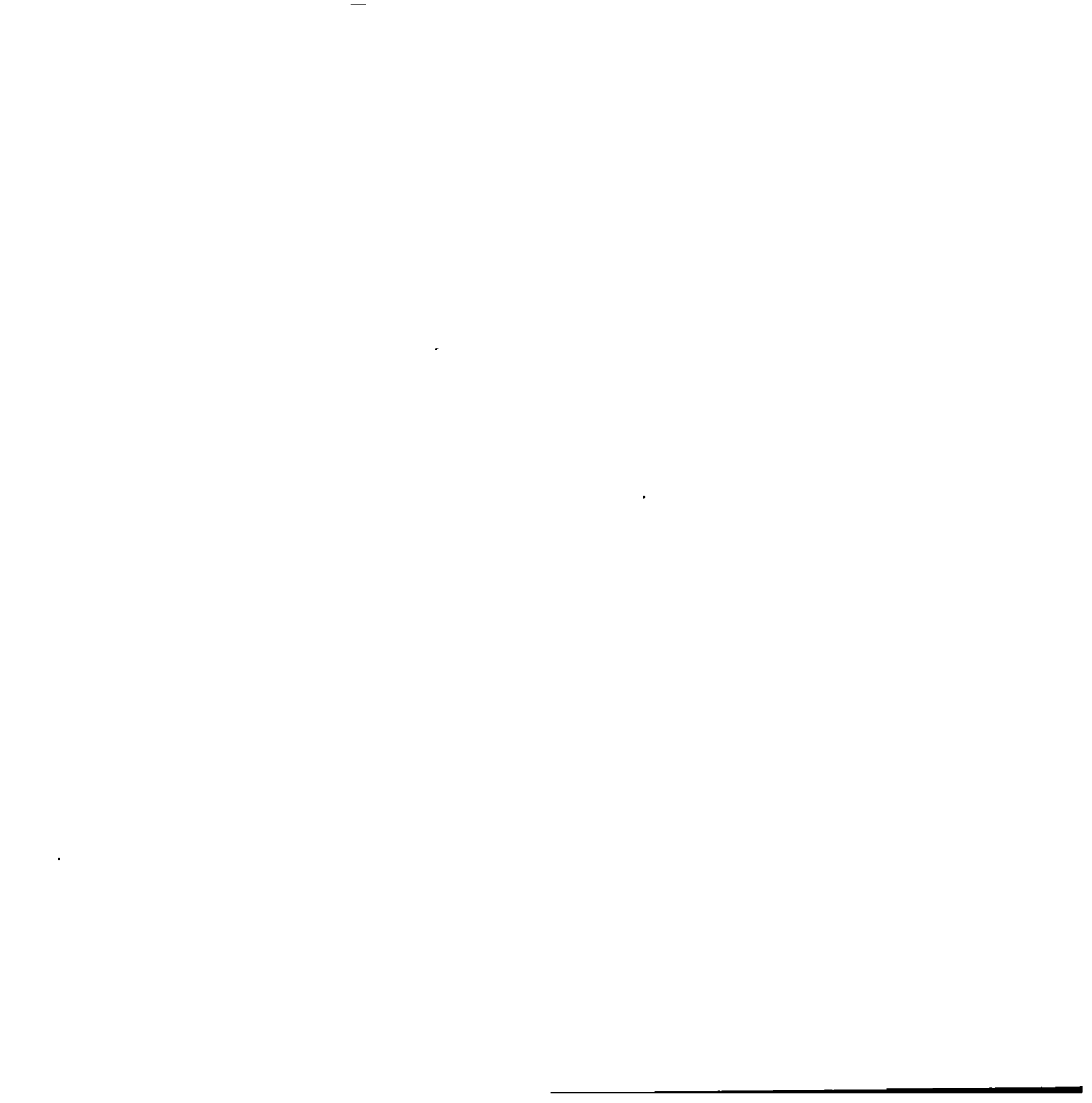
Source: Lewin Group estimates using the Alaska version of the Health Benefits Simulation Model.

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.



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.

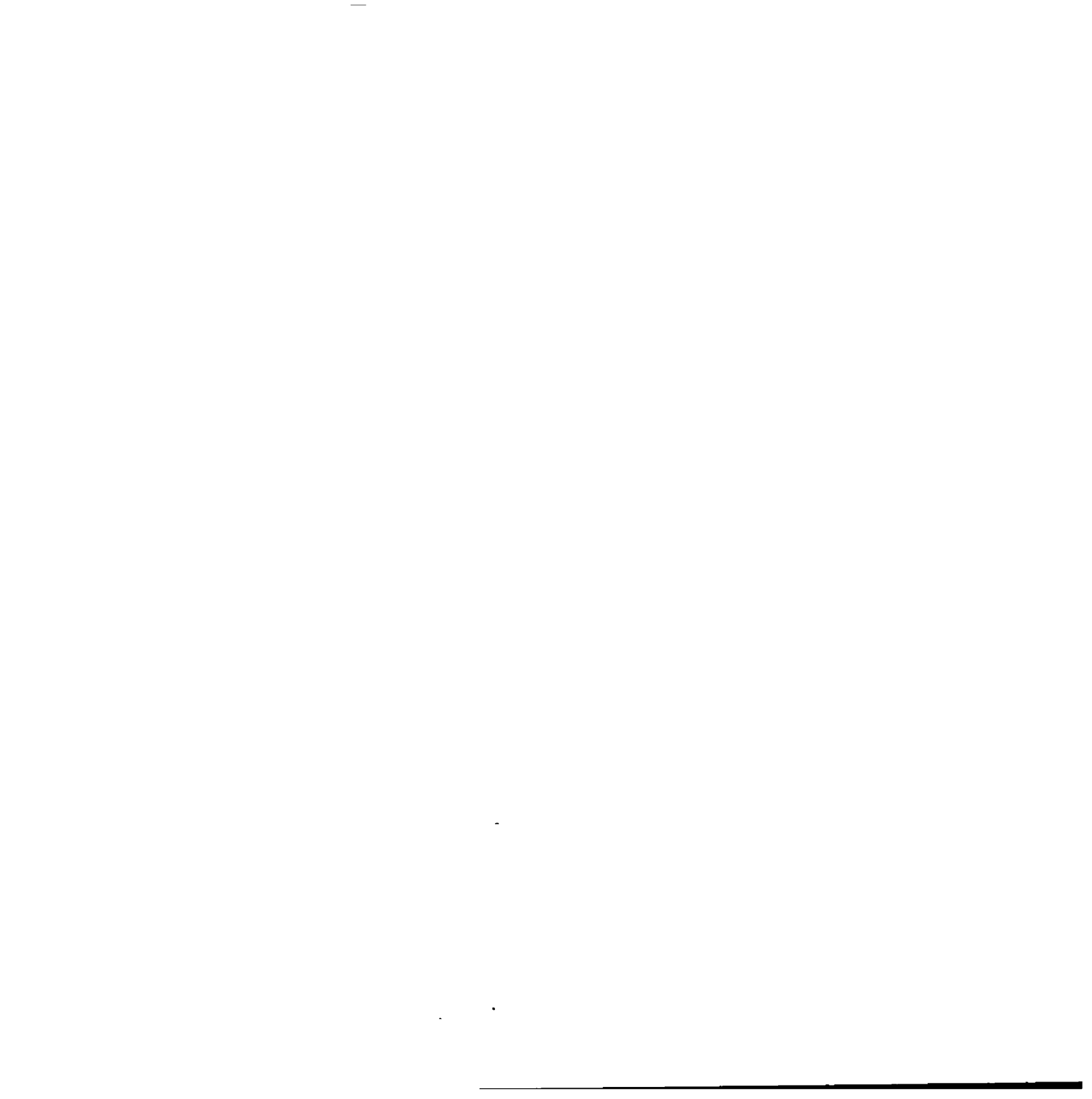
The first step in developing these estimates is to correct the CPS data for under-reporting of Medicaid coverage. As in most household surveys, some individuals fail to report whether they were enrolled in Medicaid and/or the various public assistance programs. In fact, the CPS reports up to 40 percent 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



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.<sup>39</sup> 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.

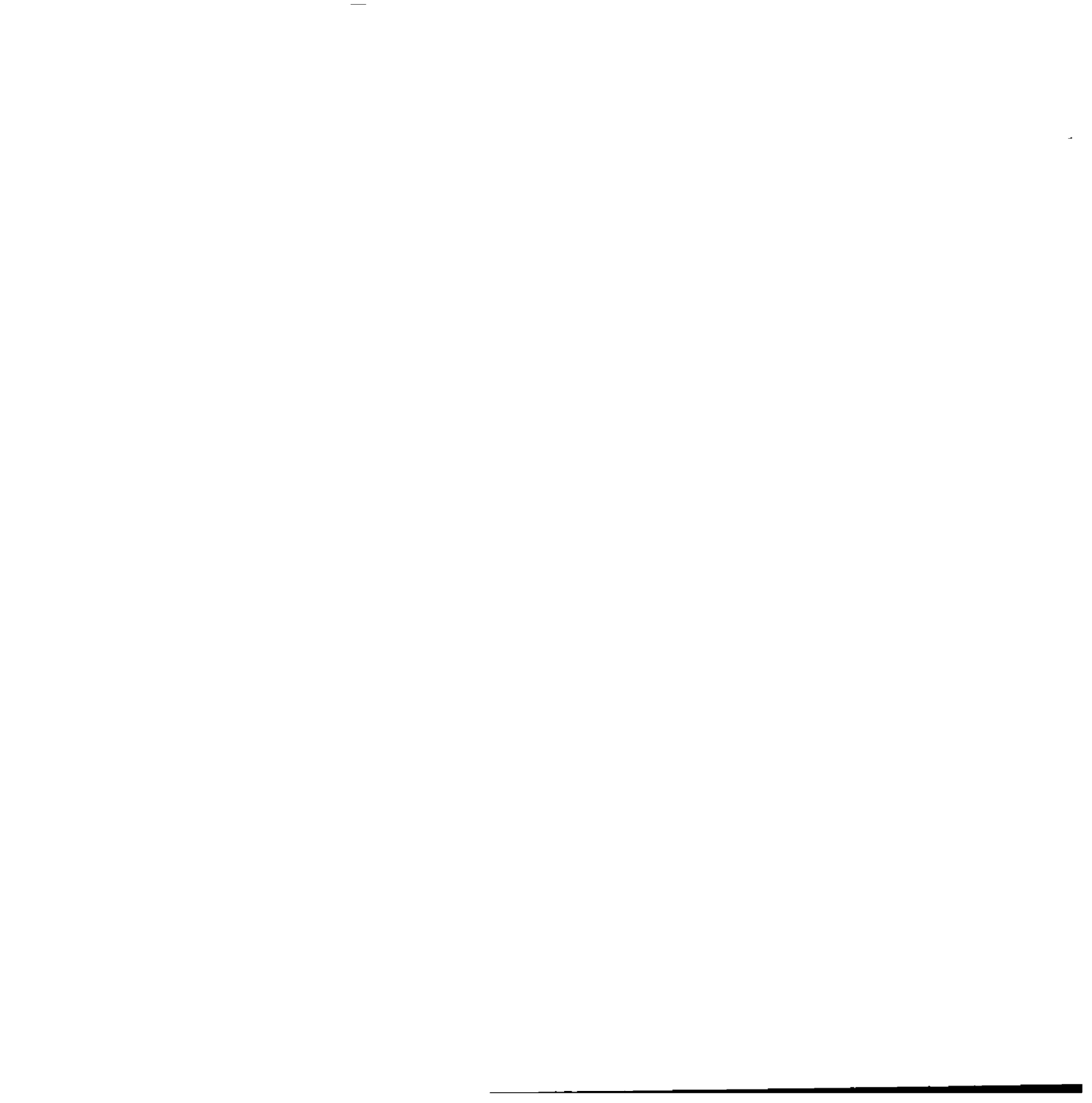
Our Medicaid participation model simulates the crowd-out that occurs as newly eligible people discontinue their private coverage and enroll in public coverage. As discussed above, we estimate that the participation rate for people with access to employer-sponsored insurance (ESI) is about 39 percent. 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

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<sup>39</sup> 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



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**

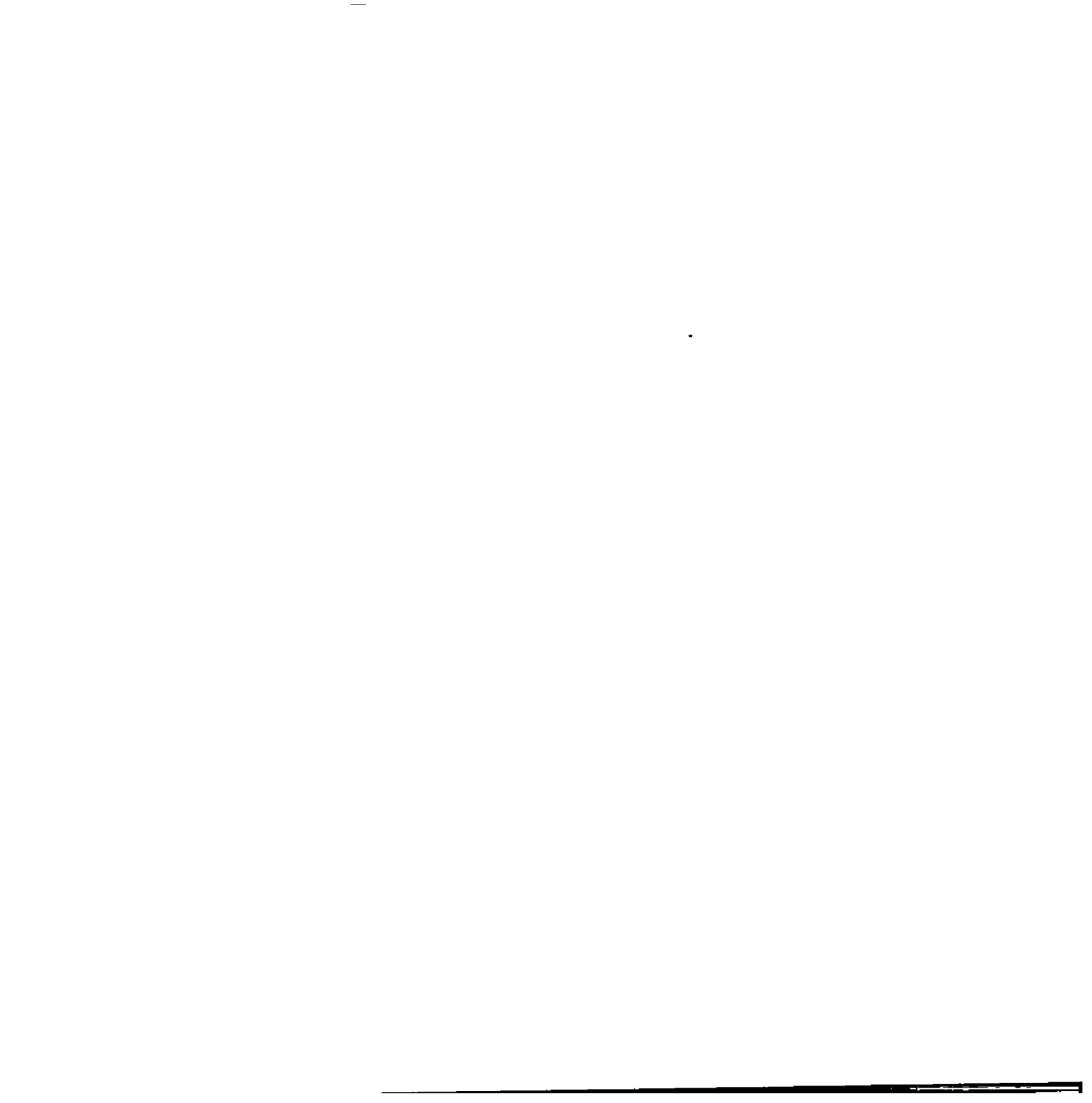
We integrated the Medicaid simulations developed with CPS data into MEPS data included in the HBSM. The MEPS data used in HBSM include all of the data required to simulate eligibility for the program except state of residence, which makes it difficult to use for Medicaid simulations. Our approach is 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



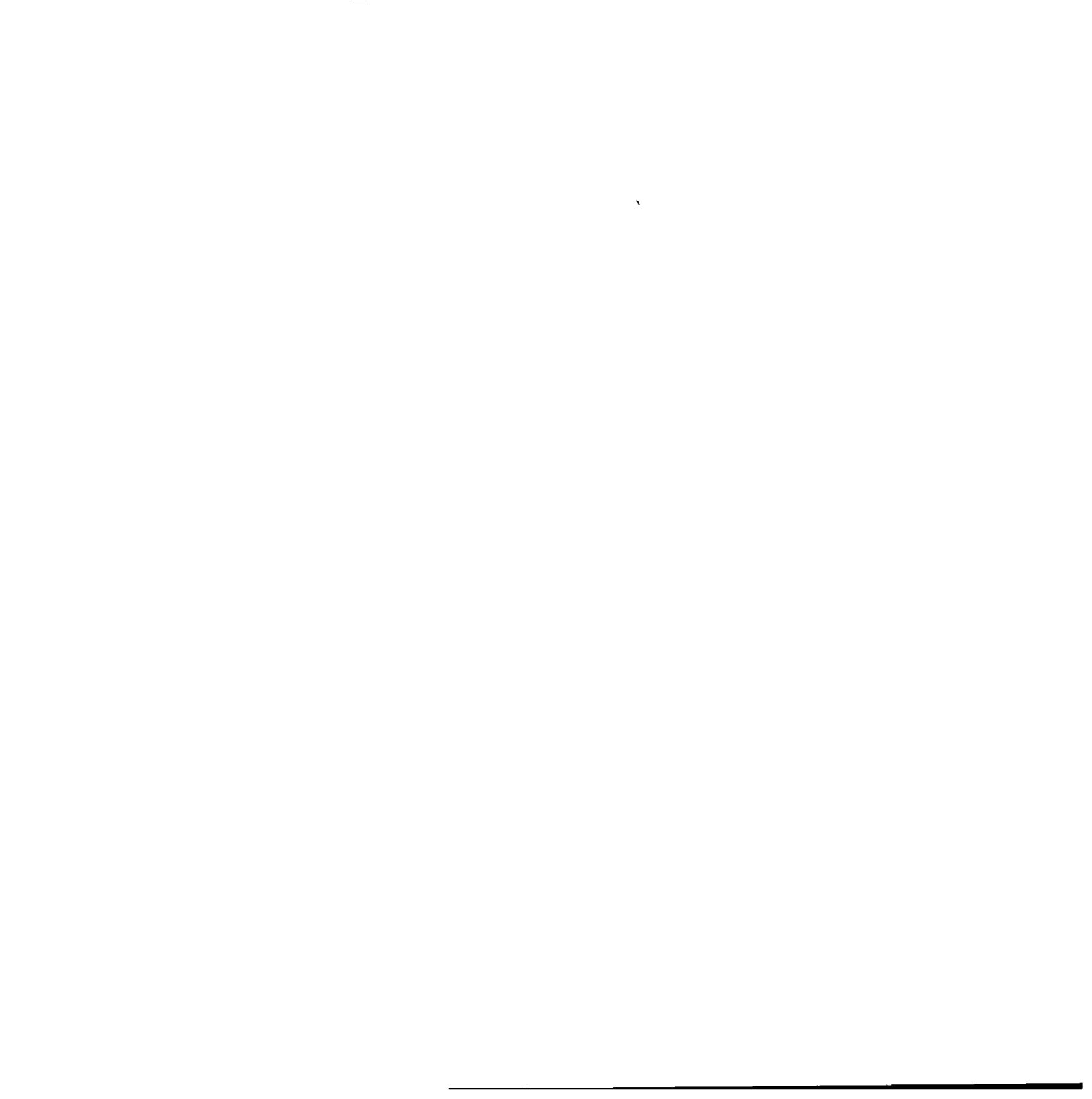
not enrolled. Finally, the table shows our estimate of the number of current enrollees that would leave Medicaid for a new offer of employer coverage under the ACA.

**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)<sup>1/</sup>**

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
<b>Total</b>	<b>44,470</b>	<b>32,674</b>	<b>19,519</b>	<b>7,610</b>	<b>9,869</b>	<b>2,111</b>	<b>2,419</b>	<b>39,976</b>

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.



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	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
<b>Total</b>	<b>44,470</b>	<b>44,470</b>	<b>19,519</b>	<b>10,405</b>	<b>9,869</b>	<b>3,261</b>	<b>2,419</b>	<b>55,718</b>

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.



eligible for the expansion up to 150 percent of FFL 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+)

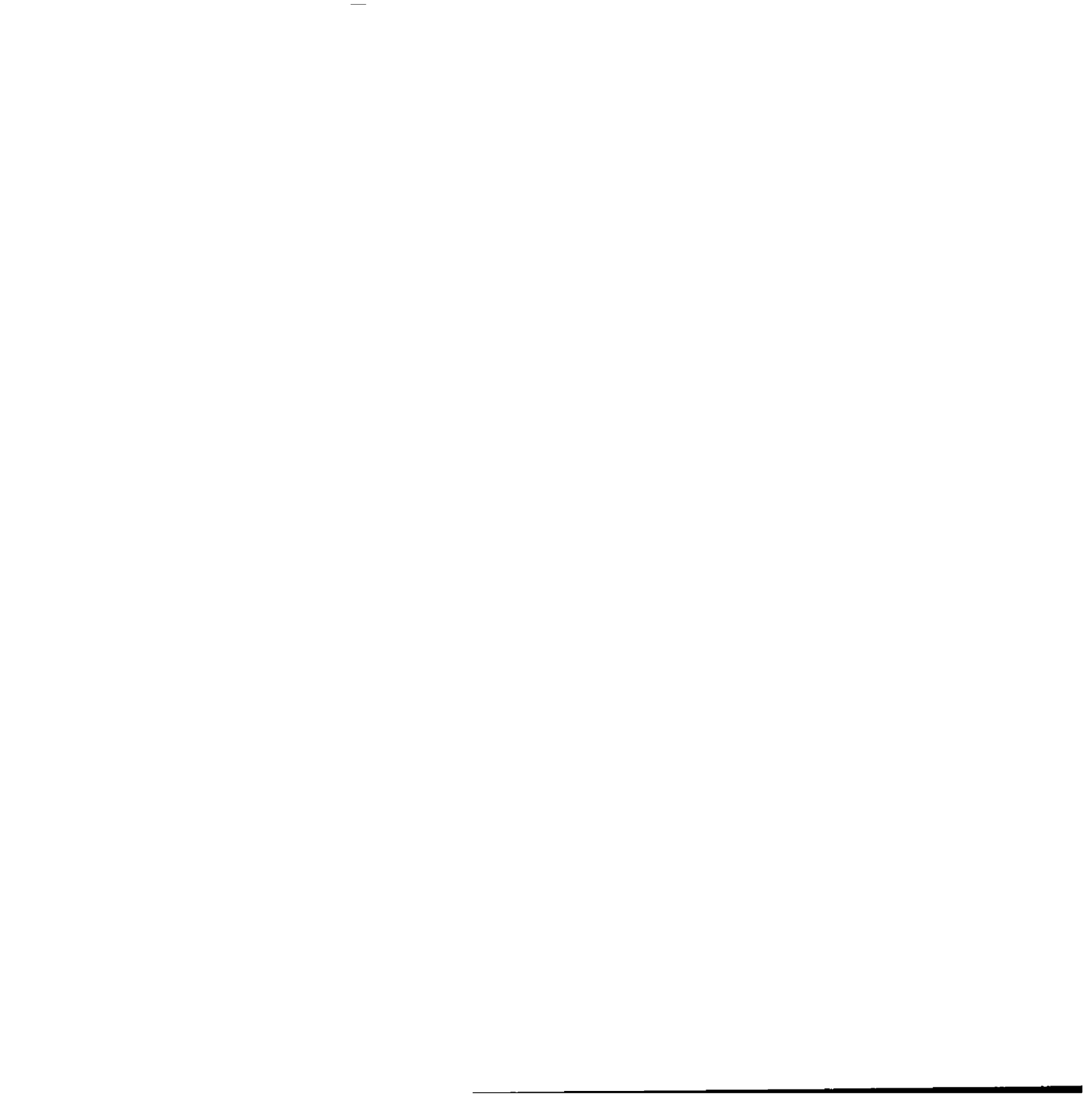
Once the data was grouped, we performed a trend analysis based on the historical per member per month (PMPM) paid claims data.

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	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*.

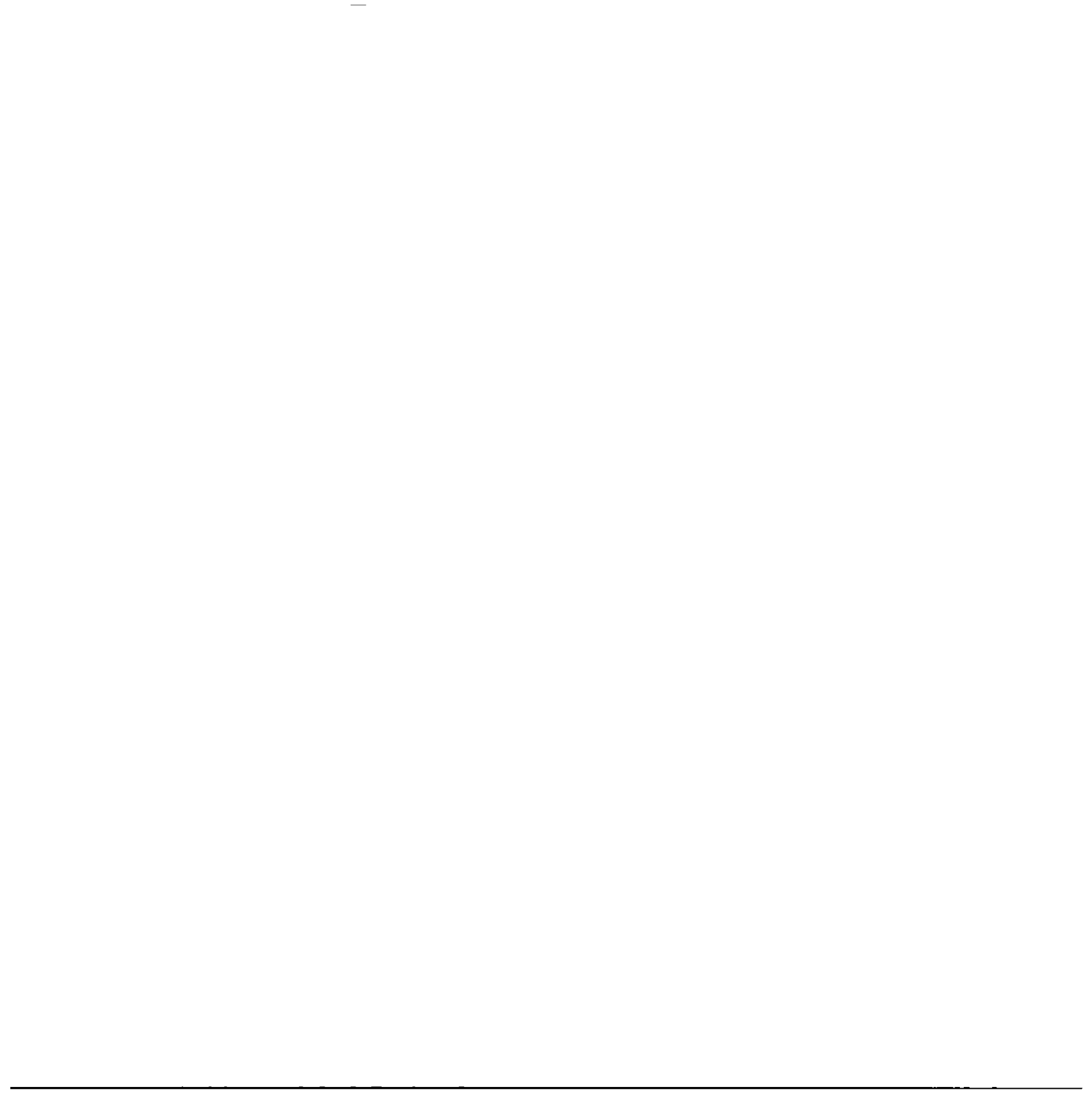
**Figure 22: Estimated Monthly Medical Cost for the Expansion Population in Alaska**

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.



	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	
<b>Baseline Costs Without ACA</b>								
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
<b>Children Below 133% Moved to Medicaid</b>								
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
<b>Children Above 133% Receive Enhanced Federal Match</b>								
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
<b>Difference from Baseline Without ACA</b>								
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

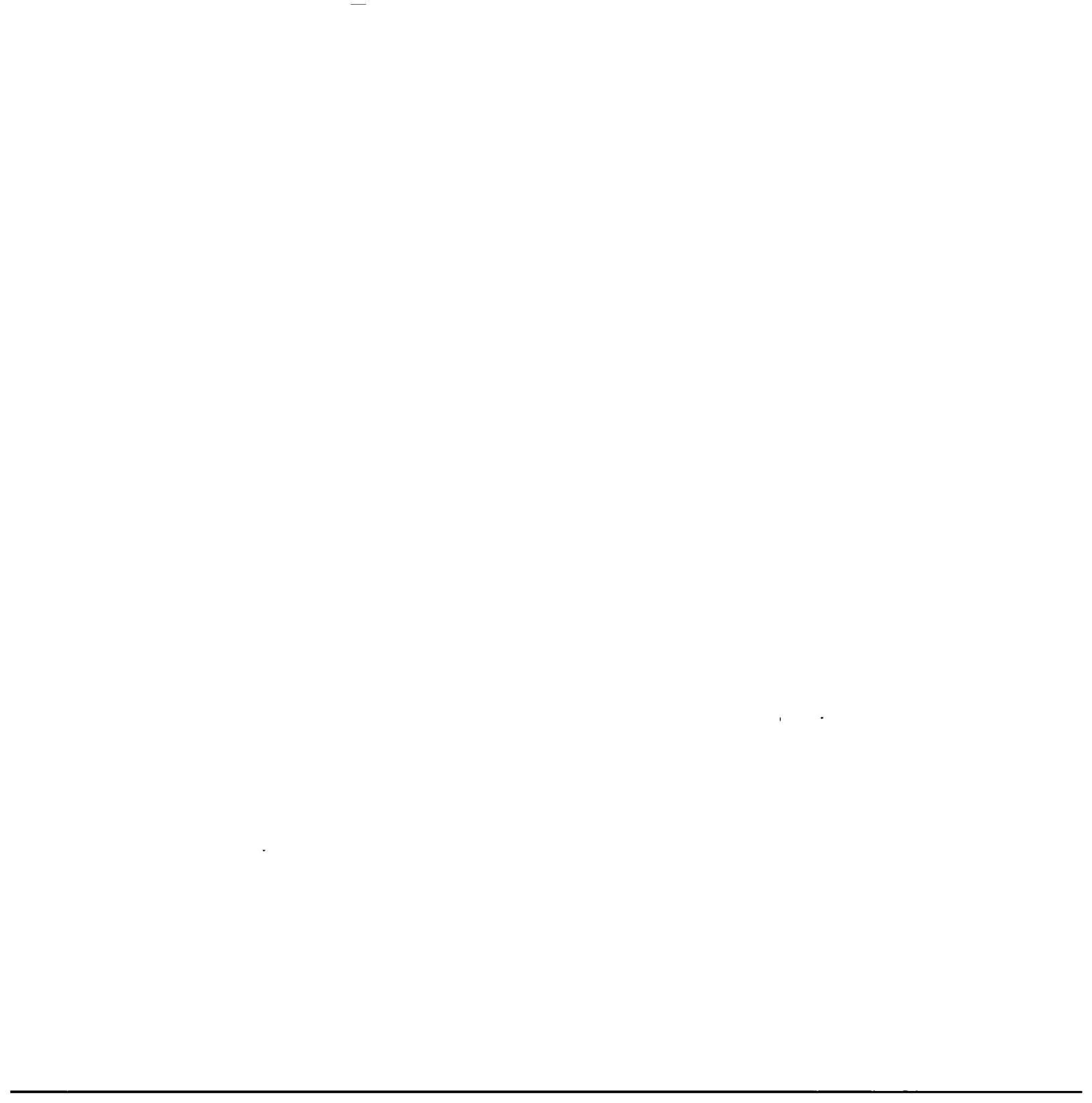
Beginning January 2014, Alaska would have the option to reduce Medicaid eligibility for adults to 138 percent of the FPL. We identified adults in the pregnant women eligibility category as those that could potentially be moved to the Exchange. Since the state would no longer be responsible for expenses 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.



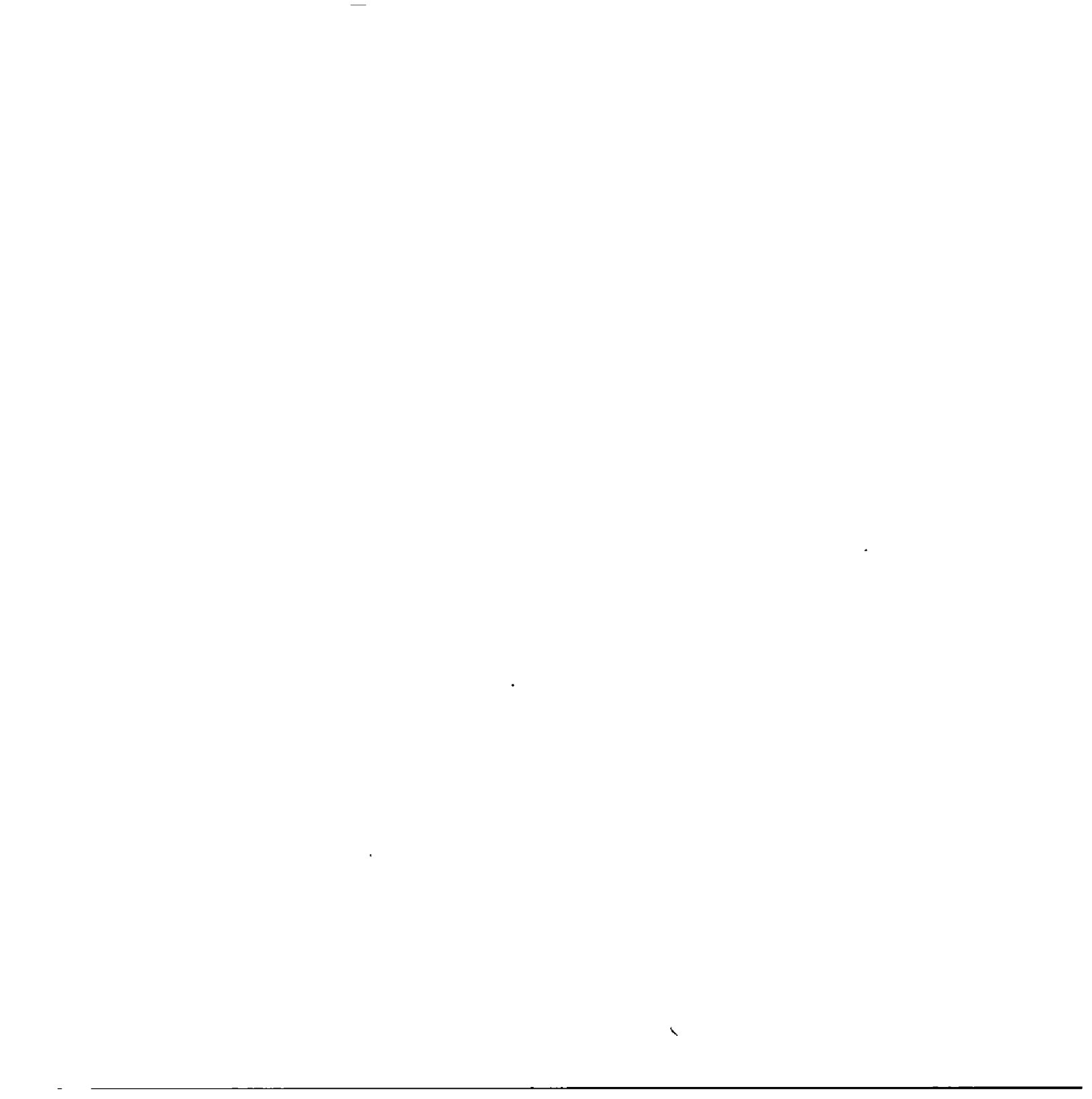
	2014	2015	2016	2017	2018	2019	2020	2014-2020
Enrollees	335	342	349	356	363	370	377	
Total Provider Payments	\$6,593.8	\$6,923.5	\$7,269.7	\$7,633.2	\$8,014.9	\$8,415.6	\$8,836.4	\$53,687.1
FMAP	50%	50%	50%	50%	50%	50%	50%	
<b>Savings from Provider Payments</b>								
State Savings	-\$3,296.9	-\$3,461.8	-\$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
<b>Administrative Cost Savings</b>								
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
<b>Total Savings</b>								
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.



	2014	2015	2016	2017	2018	2019	2020	2014-2020
<b>Baseline Spending as Currently Eligible Group</b>								
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
<b>Spending as Newly Eligible Group</b>								
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
<b>Change in Spending</b>								
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



## **Trending of Medicaid Enrollment and Costs**

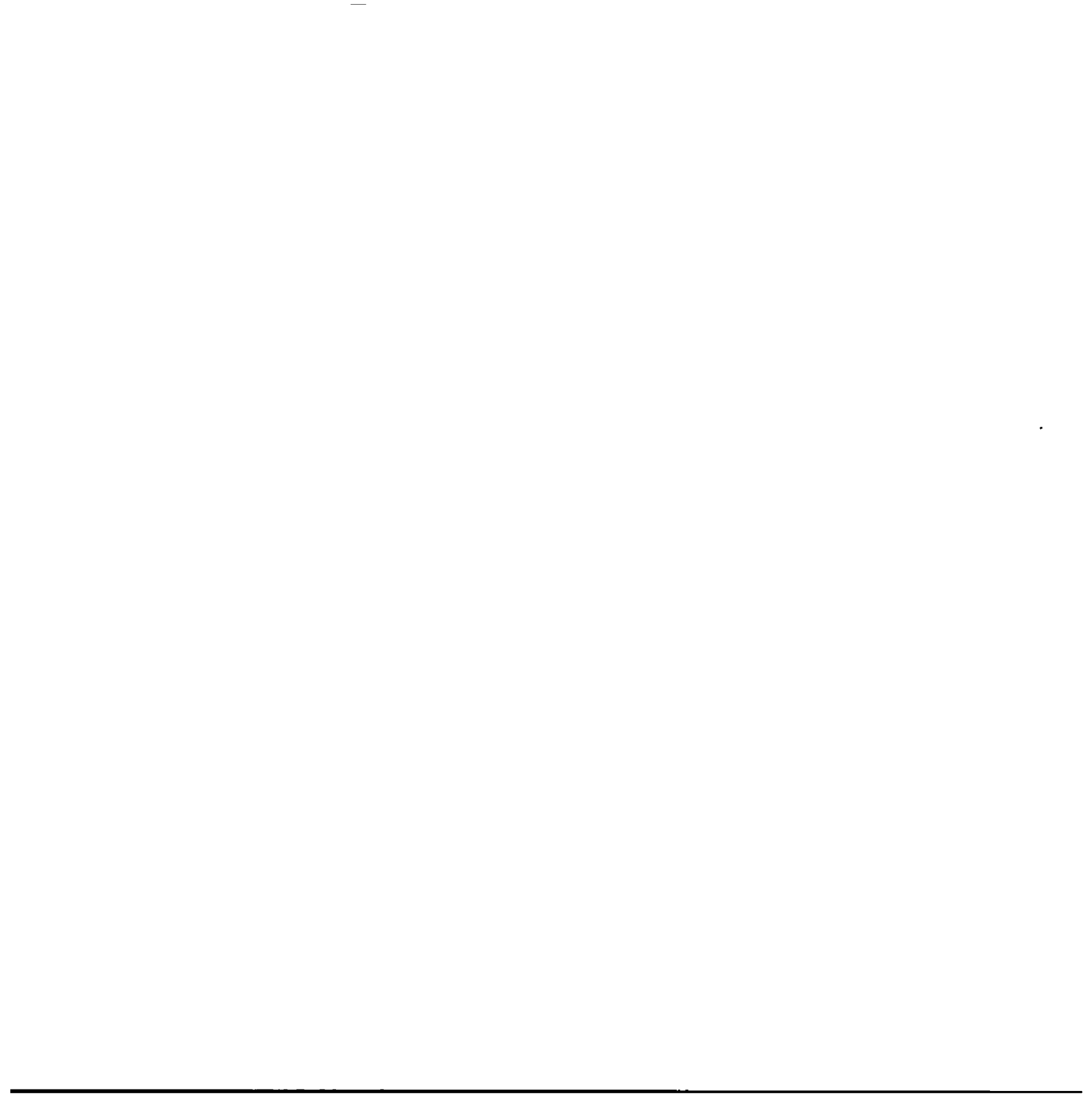
Enrollment growth estimates through SFY 2020 are modeled using five years of historical monthly enrollment data provided by the Department of Health and Social Services (DHSS) and trended using age- and sex- adjusted growth rates derived from U.S. Census projections and the Medicaid Statistical Information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

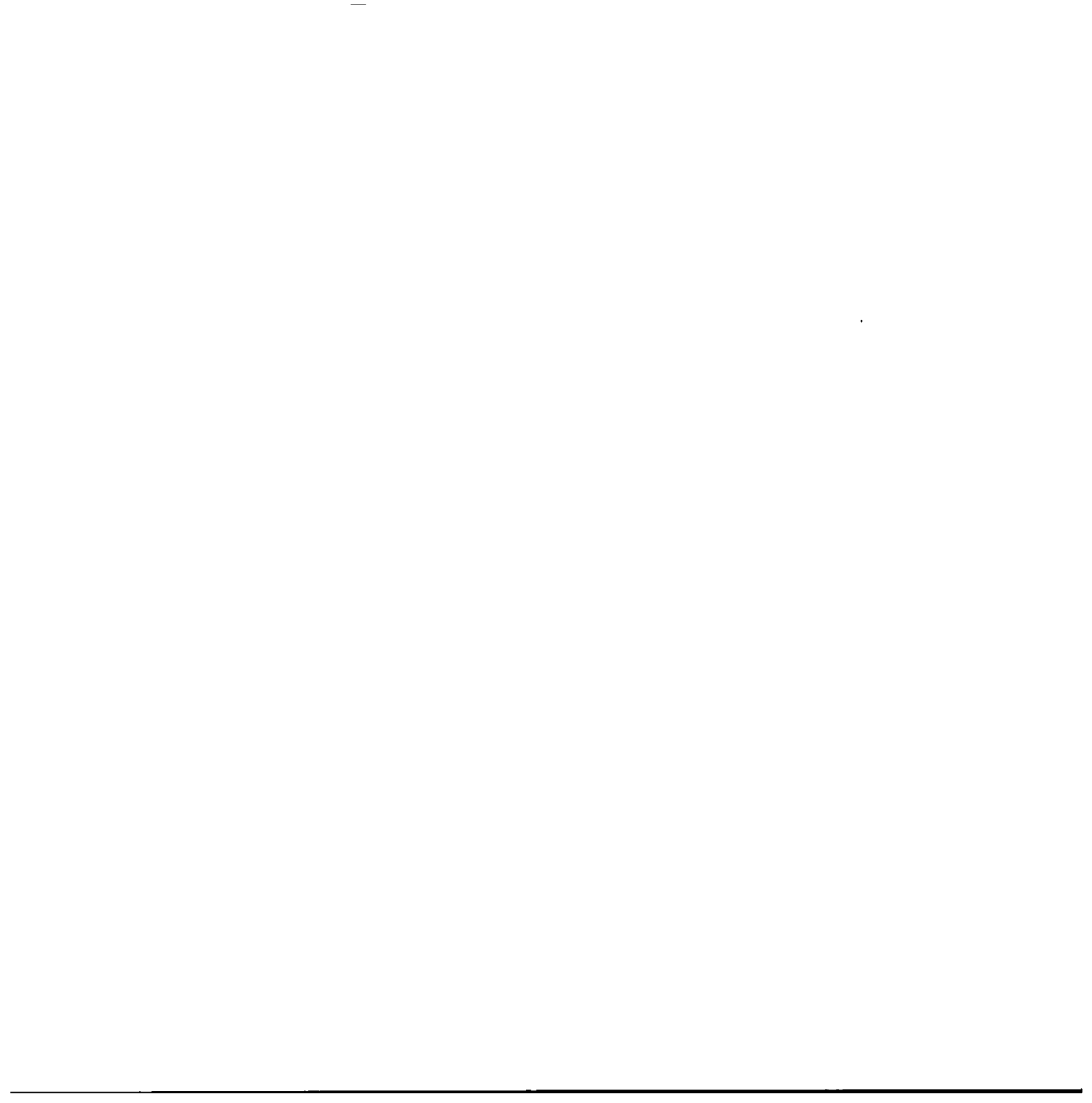
To forecast program costs, we use five years (2008-2012) of eligibility and cost data supplied by DHSS to compute per-enrollee costs for each service category and demographic group. The MESA model, adjusted using The CMS' National Health Projections, is used to estimate a year-by-year trending factor 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 and state and federal costs to treat Medicaid patients in each health status category.



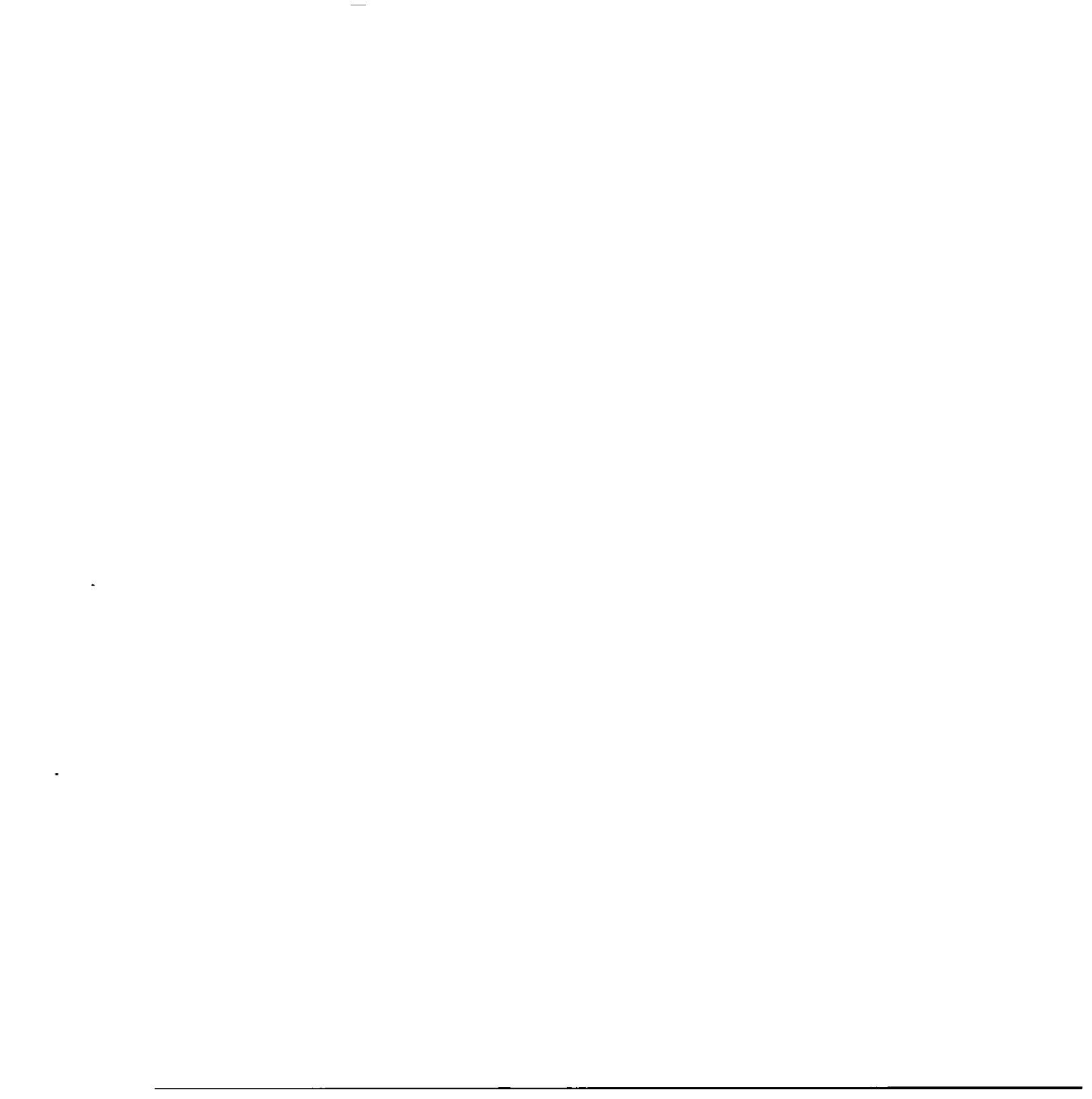
## Eligibles Count

Total Annual Costs	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
<b>AGE</b>													
<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
<b>Total</b>	<b>96,534</b>	<b>98,931</b>	<b>109,040</b>	<b>117,515</b>	<b>122,688</b>	<b>125,855</b>	<b>129,148</b>	<b>132,575</b>	<b>136,089</b>	<b>139,769</b>	<b>143,572</b>	<b>147,367</b>	<b>151,213</b>
<b>SEX</b>													
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
<b>Total</b>	<b>96,534</b>	<b>98,931</b>	<b>109,040</b>	<b>117,515</b>	<b>122,688</b>	<b>125,855</b>	<b>129,148</b>	<b>132,575</b>	<b>136,089</b>	<b>139,769</b>	<b>143,572</b>	<b>147,367</b>	<b>151,213</b>
<b>RACE/ETHNICITY</b>													
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
<b>Total</b>	<b>96,534</b>	<b>98,931</b>	<b>109,040</b>	<b>117,515</b>	<b>122,688</b>	<b>125,855</b>	<b>129,148</b>	<b>132,575</b>	<b>136,089</b>	<b>139,769</b>	<b>143,572</b>	<b>147,367</b>	<b>151,213</b>
<b>HEALTH STATUS</b>													
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
<b>Total</b>	<b>96,534</b>	<b>98,931</b>	<b>109,040</b>	<b>117,514</b>	<b>122,687</b>	<b>125,855</b>	<b>129,148</b>	<b>132,575</b>	<b>136,089</b>	<b>139,769</b>	<b>143,572</b>	<b>147,367</b>	<b>151,213</b>



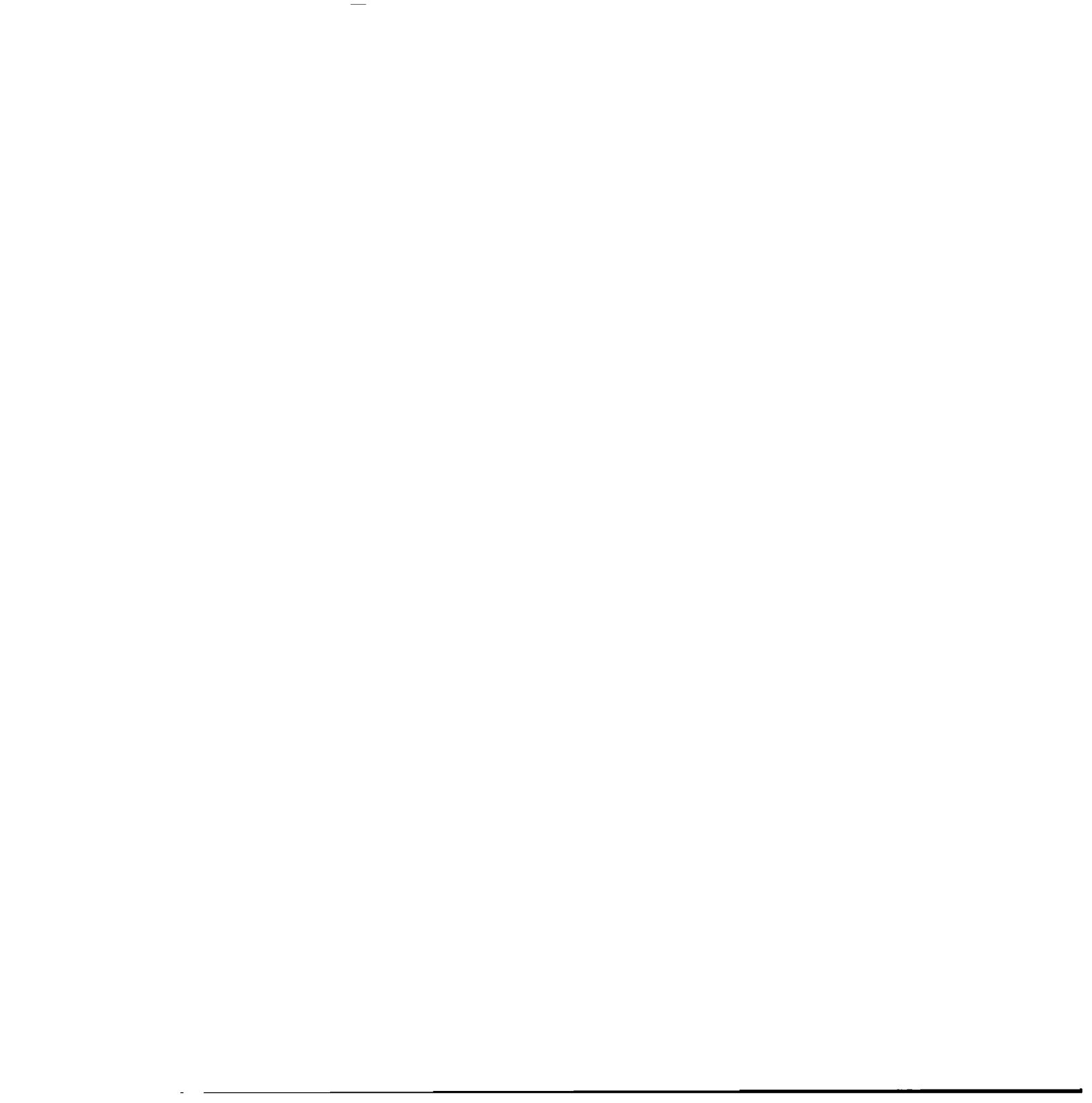
**Inpatient/Outpatient Facilities (in millions)**

<b>Total Annual Costs</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
<b>AGE</b>													
<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
<b>Total</b>	<b>\$335.8</b>	<b>\$326.4</b>	<b>\$335.3</b>	<b>\$333.2</b>	<b>\$362.6</b>	<b>\$380.3</b>	<b>\$398.9</b>	<b>\$418.6</b>	<b>\$439.3</b>	<b>\$461.6</b>	<b>\$485.1</b>	<b>\$510.8</b>	<b>\$538.7</b>
<b>SEX</b>													
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
<b>Total</b>	<b>\$335.8</b>	<b>\$326.4</b>	<b>\$335.3</b>	<b>\$333.2</b>	<b>\$362.6</b>	<b>\$380.3</b>	<b>\$398.9</b>	<b>\$418.6</b>	<b>\$439.3</b>	<b>\$461.6</b>	<b>\$485.1</b>	<b>\$510.8</b>	<b>\$538.7</b>
<b>RACE/ETHNICITY</b>													
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
<b>Total</b>	<b>\$335.8</b>	<b>\$326.4</b>	<b>\$335.3</b>	<b>\$333.2</b>	<b>\$362.6</b>	<b>\$380.3</b>	<b>\$398.9</b>	<b>\$418.6</b>	<b>\$439.3</b>	<b>\$461.6</b>	<b>\$485.1</b>	<b>\$510.8</b>	<b>\$538.7</b>
<b>HEALTH STATUS</b>													
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
<b>Total</b>	<b>\$335.8</b>	<b>\$326.4</b>	<b>\$335.3</b>	<b>\$333.2</b>	<b>\$362.6</b>	<b>\$380.3</b>	<b>\$398.9</b>	<b>\$418.6</b>	<b>\$439.3</b>	<b>\$461.6</b>	<b>\$485.1</b>	<b>\$510.8</b>	<b>\$538.7</b>
<b>FUNDING SOURCE</b>													
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



**Nursing Facilities (in millions)**

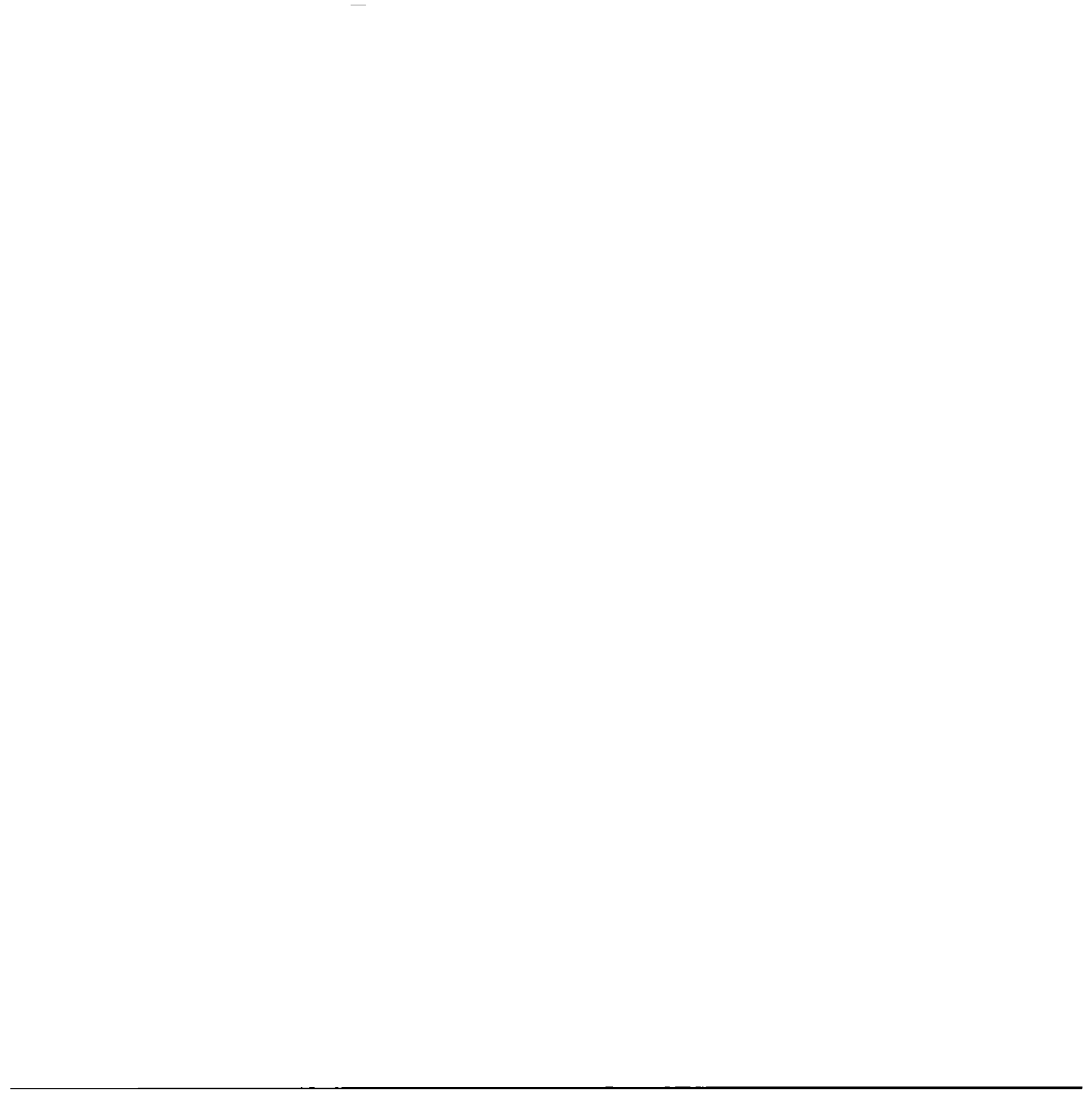
<b>Total Annual Costs</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
<b>AGE</b>													
<1	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
1-5	\$0.0	\$0.0	\$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
<b>Total</b>	<b>\$82.7</b>	<b>\$75.4</b>	<b>\$75.8</b>	<b>\$97.1</b>	<b>\$101.5</b>	<b>\$109.0</b>	<b>\$117.3</b>	<b>\$126.4</b>	<b>\$136.2</b>	<b>\$146.8</b>	<b>\$158.9</b>	<b>\$171.7</b>	<b>\$185.6</b>
<b>SEX</b>													
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
<b>Total</b>	<b>\$82.7</b>	<b>\$75.4</b>	<b>\$75.8</b>	<b>\$97.1</b>	<b>\$101.5</b>	<b>\$109.0</b>	<b>\$117.3</b>	<b>\$126.4</b>	<b>\$136.2</b>	<b>\$146.8</b>	<b>\$158.9</b>	<b>\$171.7</b>	<b>\$185.6</b>
<b>RACE/ETHNICITY</b>													
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
<b>Total</b>	<b>\$82.7</b>	<b>\$75.4</b>	<b>\$75.8</b>	<b>\$97.1</b>	<b>\$101.5</b>	<b>\$109.0</b>	<b>\$117.3</b>	<b>\$126.4</b>	<b>\$136.2</b>	<b>\$146.8</b>	<b>\$158.9</b>	<b>\$171.7</b>	<b>\$185.6</b>
<b>HEALTH STATUS</b>													
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
<b>Total</b>	<b>\$82.7</b>	<b>\$75.4</b>	<b>\$75.8</b>	<b>\$97.1</b>	<b>\$101.5</b>	<b>\$109.0</b>	<b>\$117.3</b>	<b>\$126.4</b>	<b>\$136.2</b>	<b>\$146.8</b>	<b>\$158.9</b>	<b>\$171.7</b>	<b>\$185.6</b>
<b>FUNDING SOURCE</b>													
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



**ADJUSTING FOR ACA**

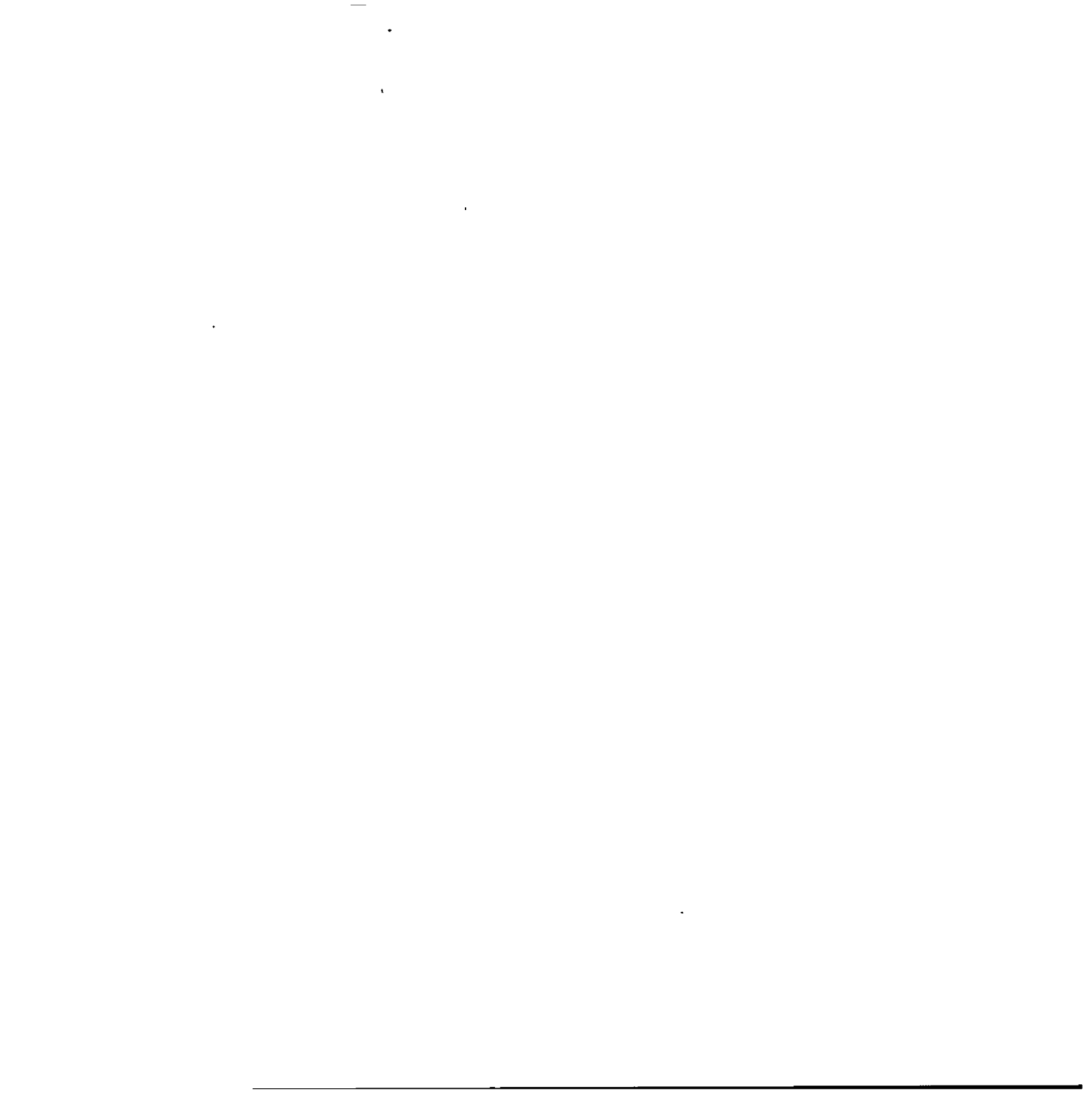
**Physician/Other Practitioner/Clinic Services (in millions)**

Total Annual Costs	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
<b>AGE</b>													
<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
<b>Total</b>	<b>\$121.2</b>	<b>\$137.2</b>	<b>\$163.6</b>	<b>\$162.4</b>	<b>\$181.6</b>	<b>\$193.9</b>	<b>\$207.1</b>	<b>\$221.1</b>	<b>\$236.0</b>	<b>\$252.6</b>	<b>\$270.3</b>	<b>\$290.1</b>	<b>\$311.2</b>
<b>SEX</b>													
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
<b>Total</b>	<b>\$121.2</b>	<b>\$137.2</b>	<b>\$163.6</b>	<b>\$162.4</b>	<b>\$181.6</b>	<b>\$193.9</b>	<b>\$207.1</b>	<b>\$221.1</b>	<b>\$236.0</b>	<b>\$252.6</b>	<b>\$270.3</b>	<b>\$290.1</b>	<b>\$311.2</b>
<b>RACE/ETHNICITY</b>													
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
<b>Total</b>	<b>\$121.2</b>	<b>\$137.2</b>	<b>\$163.6</b>	<b>\$162.4</b>	<b>\$181.6</b>	<b>\$193.9</b>	<b>\$207.1</b>	<b>\$221.1</b>	<b>\$236.0</b>	<b>\$252.6</b>	<b>\$270.3</b>	<b>\$290.1</b>	<b>\$311.2</b>
<b>HEALTH STATUS</b>													
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
<b>Total</b>	<b>\$121.2</b>	<b>\$137.2</b>	<b>\$163.6</b>	<b>\$162.4</b>	<b>\$181.6</b>	<b>\$193.9</b>	<b>\$207.1</b>	<b>\$221.1</b>	<b>\$236.0</b>	<b>\$252.6</b>	<b>\$270.3</b>	<b>\$290.1</b>	<b>\$311.2</b>
<b>FUNDING SOURCE</b>													
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



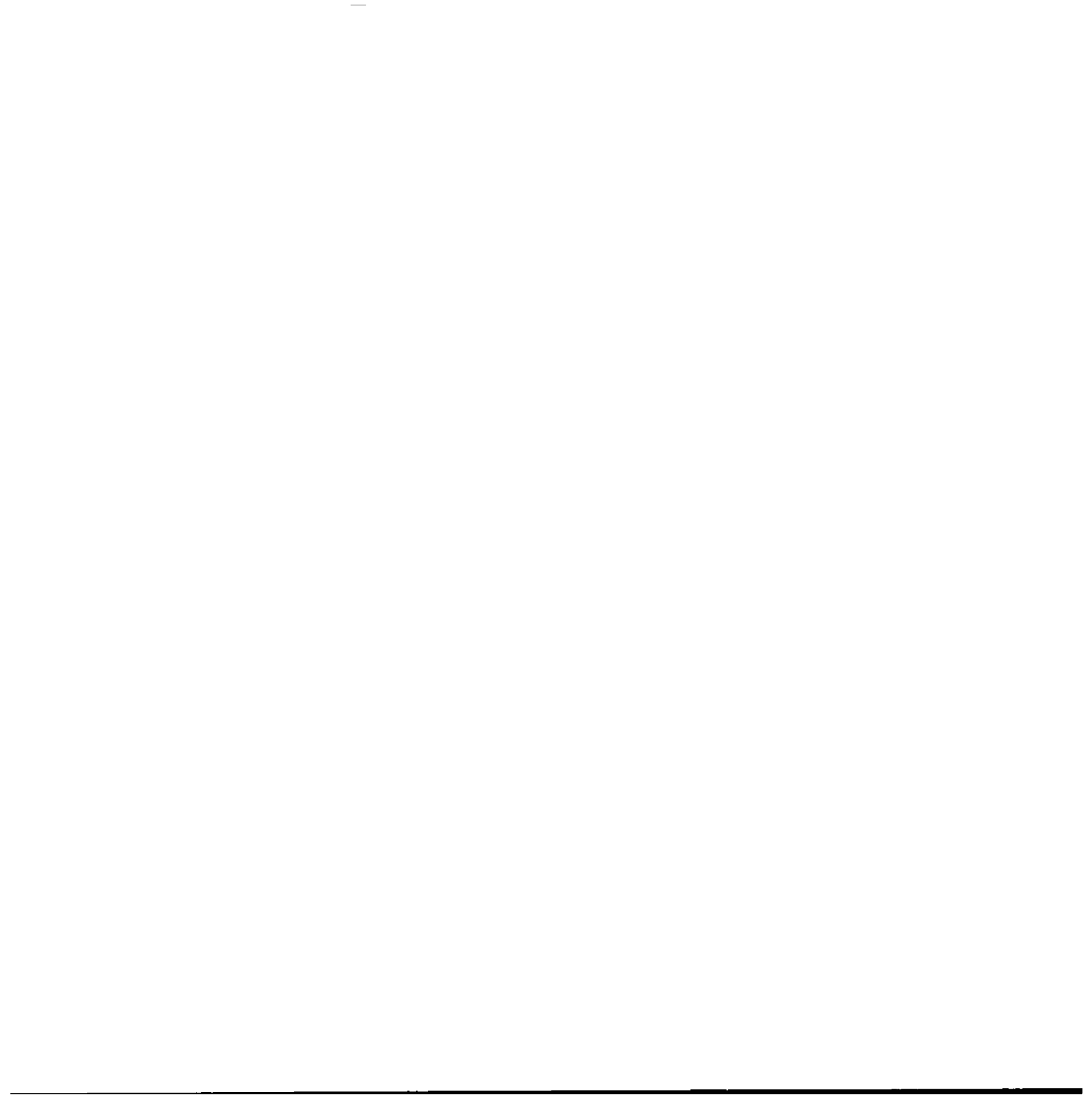
## Pharmacy (In millions)

Total Annual Costs	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
<b>AGE</b>													
<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
<b>Total</b>	<b>\$79.4</b>	<b>\$77.3</b>	<b>\$81.6</b>	<b>\$87.9</b>	<b>\$76.3</b>	<b>\$80.3</b>	<b>\$84.5</b>	<b>\$88.9</b>	<b>\$93.8</b>	<b>\$99.1</b>	<b>\$104.5</b>	<b>\$110.2</b>	<b>\$116.6</b>
<b>SEX</b>													
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
<b>Total</b>	<b>\$79.4</b>	<b>\$77.3</b>	<b>\$81.6</b>	<b>\$87.9</b>	<b>\$76.3</b>	<b>\$80.3</b>	<b>\$84.5</b>	<b>\$88.9</b>	<b>\$93.8</b>	<b>\$99.1</b>	<b>\$104.5</b>	<b>\$110.2</b>	<b>\$116.6</b>
<b>RACE/ETHNICITY</b>													
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
<b>Total</b>	<b>\$79.4</b>	<b>\$77.3</b>	<b>\$81.6</b>	<b>\$87.9</b>	<b>\$76.3</b>	<b>\$80.3</b>	<b>\$84.5</b>	<b>\$88.9</b>	<b>\$93.8</b>	<b>\$99.1</b>	<b>\$104.5</b>	<b>\$110.2</b>	<b>\$116.6</b>
<b>HEALTH STATUS</b>													
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
<b>Total</b>	<b>\$79.4</b>	<b>\$77.3</b>	<b>\$81.6</b>	<b>\$87.9</b>	<b>\$76.3</b>	<b>\$80.3</b>	<b>\$84.5</b>	<b>\$88.9</b>	<b>\$93.8</b>	<b>\$99.1</b>	<b>\$104.5</b>	<b>\$110.2</b>	<b>\$116.6</b>
<b>FUNDING SOURCE</b>													
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



**Dental Services (in millions)**

<b>Total Annual Costs</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
<b>AGE</b>													
<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
<b>Total</b>	<b>\$23.0</b>	<b>\$33.5</b>	<b>\$43.1</b>	<b>\$53.5</b>	<b>\$55.6</b>	<b>\$58.7</b>	<b>\$62.7</b>	<b>\$68.0</b>	<b>\$73.7</b>	<b>\$80.3</b>	<b>\$87.9</b>	<b>\$96.8</b>	<b>\$106.4</b>
<b>SEX</b>													
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
<b>Total</b>	<b>\$23.0</b>	<b>\$33.5</b>	<b>\$43.1</b>	<b>\$53.5</b>	<b>\$55.6</b>	<b>\$58.7</b>	<b>\$62.7</b>	<b>\$68.0</b>	<b>\$73.7</b>	<b>\$80.3</b>	<b>\$87.9</b>	<b>\$96.8</b>	<b>\$106.4</b>
<b>RACE/ETHNICITY</b>													
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
<b>Total</b>	<b>\$23.0</b>	<b>\$33.5</b>	<b>\$43.1</b>	<b>\$53.5</b>	<b>\$55.6</b>	<b>\$58.7</b>	<b>\$62.7</b>	<b>\$68.0</b>	<b>\$73.7</b>	<b>\$80.3</b>	<b>\$87.9</b>	<b>\$96.8</b>	<b>\$106.4</b>
<b>HEALTH STATUS</b>													
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
<b>Total</b>	<b>\$23.0</b>	<b>\$33.5</b>	<b>\$43.1</b>	<b>\$53.5</b>	<b>\$55.6</b>	<b>\$58.7</b>	<b>\$62.7</b>	<b>\$68.0</b>	<b>\$73.7</b>	<b>\$80.3</b>	<b>\$87.9</b>	<b>\$96.8</b>	<b>\$106.4</b>
<b>FUNDING SOURCE</b>													
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



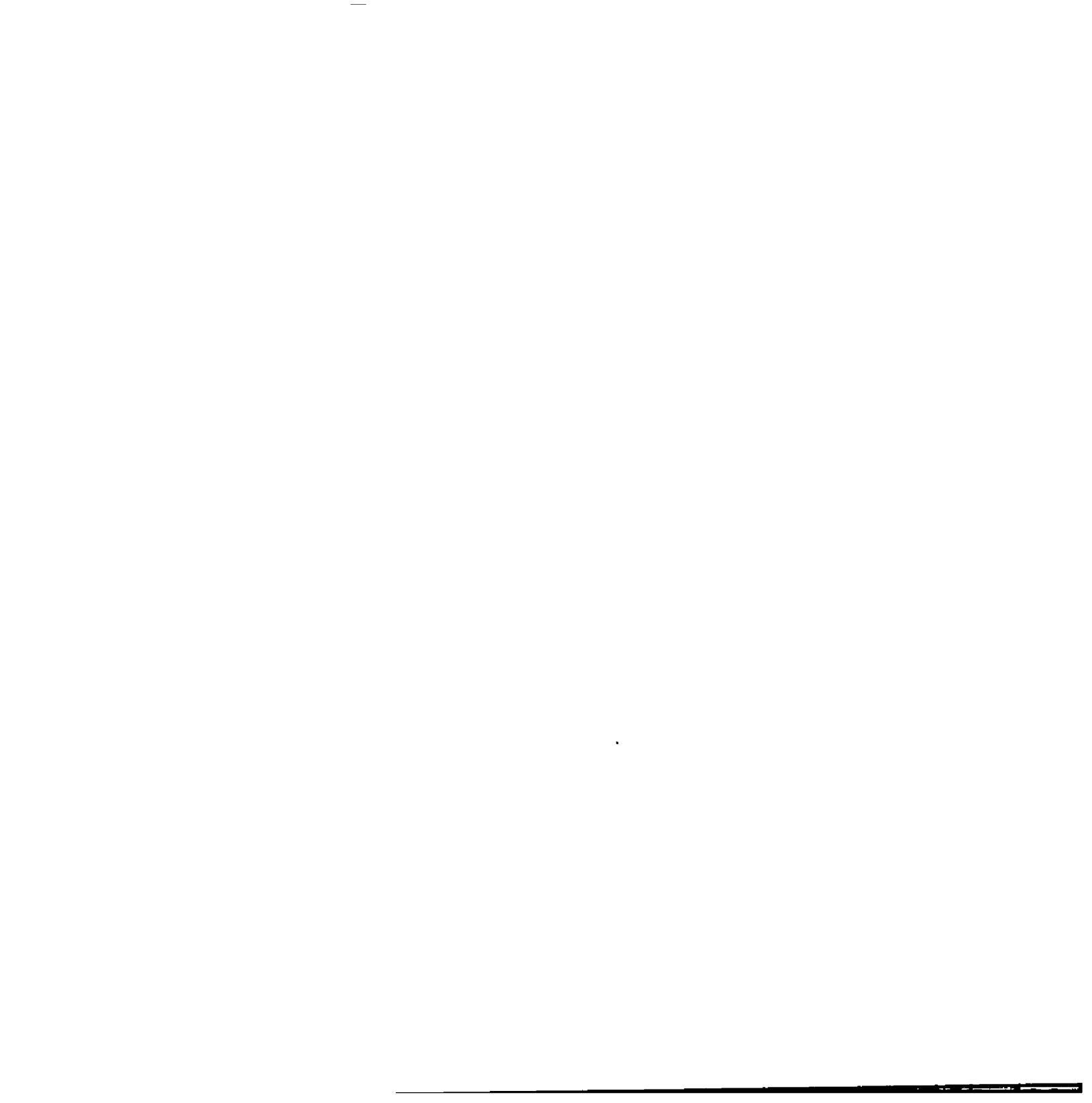
**Mental and Behavioral Health Services (in millions)**

Total Annual Costs	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
<b>AGE</b>													
<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
<b>Total</b>	<b>\$63.3</b>	<b>\$71.5</b>	<b>\$92.7</b>	<b>\$99.6</b>	<b>\$94.8</b>	<b>\$101.0</b>	<b>\$107.7</b>	<b>\$115.0</b>	<b>\$123.1</b>	<b>\$132.4</b>	<b>\$142.4</b>	<b>\$153.8</b>	<b>\$166.0</b>
<b>SEX</b>													
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
<b>Total</b>	<b>\$63.3</b>	<b>\$71.5</b>	<b>\$92.7</b>	<b>\$99.6</b>	<b>\$94.8</b>	<b>\$101.0</b>	<b>\$107.7</b>	<b>\$115.0</b>	<b>\$123.1</b>	<b>\$132.4</b>	<b>\$142.4</b>	<b>\$153.8</b>	<b>\$166.0</b>
<b>RACE/ETHNICITY</b>													
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
<b>Total</b>	<b>\$63.3</b>	<b>\$71.5</b>	<b>\$92.7</b>	<b>\$99.6</b>	<b>\$94.8</b>	<b>\$101.0</b>	<b>\$107.7</b>	<b>\$115.0</b>	<b>\$123.1</b>	<b>\$132.4</b>	<b>\$142.4</b>	<b>\$153.8</b>	<b>\$166.0</b>
<b>HEALTH STATUS</b>													
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
<b>Total</b>	<b>\$63.3</b>	<b>\$71.5</b>	<b>\$92.7</b>	<b>\$99.6</b>	<b>\$94.8</b>	<b>\$101.0</b>	<b>\$107.7</b>	<b>\$115.0</b>	<b>\$123.1</b>	<b>\$132.4</b>	<b>\$142.4</b>	<b>\$153.8</b>	<b>\$166.0</b>
<b>FUNDING SOURCE</b>													
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



## All Other Services (In millions)

Total Annual Costs	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
<b>AGE</b>													
<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
<b>Total</b>	<b>\$307.6</b>	<b>\$341.9</b>	<b>\$393.5</b>	<b>\$420.6</b>	<b>\$470.8</b>	<b>\$521.3</b>	<b>\$577.7</b>	<b>\$641.0</b>	<b>\$710.4</b>	<b>\$789.6</b>	<b>\$882.6</b>	<b>\$987.0</b>	<b>\$1,104.8</b>
<b>SEX</b>													
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
<b>Total</b>	<b>\$307.6</b>	<b>\$341.9</b>	<b>\$393.5</b>	<b>\$420.6</b>	<b>\$470.8</b>	<b>\$521.3</b>	<b>\$577.7</b>	<b>\$641.0</b>	<b>\$710.4</b>	<b>\$789.6</b>	<b>\$882.6</b>	<b>\$987.0</b>	<b>\$1,104.8</b>
<b>RACE/ETHNICITY</b>													
Alaska Native or American Indian	\$103.5	\$116.3	\$127.6	\$131.2	\$137.9	\$152.6	\$169.2	\$187.6	\$207.8	\$230.9	\$258.2	\$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	\$16.2	\$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
<b>Total</b>	<b>\$307.6</b>	<b>\$341.9</b>	<b>\$393.5</b>	<b>\$420.6</b>	<b>\$470.8</b>	<b>\$521.3</b>	<b>\$577.7</b>	<b>\$641.0</b>	<b>\$710.4</b>	<b>\$789.6</b>	<b>\$882.6</b>	<b>\$987.0</b>	<b>\$1,104.8</b>
<b>HEALTH STATUS</b>													
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
<b>Total</b>	<b>\$307.6</b>	<b>\$341.9</b>	<b>\$393.5</b>	<b>\$420.6</b>	<b>\$470.8</b>	<b>\$521.3</b>	<b>\$577.7</b>	<b>\$641.0</b>	<b>\$710.4</b>	<b>\$789.6</b>	<b>\$882.6</b>	<b>\$987.0</b>	<b>\$1,104.8</b>
<b>FUNDING SOURCE</b>													
Federal Share	\$169.2	\$217.0	\$250.8	\$221.8	\$241.2	\$257.2	\$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



Total Annual Costs	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
<b>AGE</b>													
<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	\$65.1	\$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	\$99.6	\$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
<b>Total</b>	<b>\$1,012.9</b>	<b>\$1,063.3</b>	<b>\$1,185.6</b>	<b>\$1,254.3</b>	<b>\$1,343.4</b>	<b>\$1,444.6</b>	<b>\$1,555.9</b>	<b>\$1,679.2</b>	<b>\$1,812.5</b>	<b>\$1,962.3</b>	<b>\$2,131.6</b>	<b>\$2,320.2</b>	<b>\$2,529.4</b>

<b>SEX</b>													
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
<b>Total</b>	<b>\$1,012.9</b>	<b>\$1,063.3</b>	<b>\$1,185.6</b>	<b>\$1,254.3</b>	<b>\$1,343.4</b>	<b>\$1,444.6</b>	<b>\$1,555.9</b>	<b>\$1,679.2</b>	<b>\$1,812.5</b>	<b>\$1,962.3</b>	<b>\$2,131.6</b>	<b>\$2,320.2</b>	<b>\$2,529.4</b>

<b>RACE/ETHNICITY</b>													
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
<b>Total</b>	<b>\$1,012.9</b>	<b>\$1,063.3</b>	<b>\$1,185.6</b>	<b>\$1,254.3</b>	<b>\$1,343.4</b>	<b>\$1,444.6</b>	<b>\$1,555.9</b>	<b>\$1,679.2</b>	<b>\$1,812.5</b>	<b>\$1,962.3</b>	<b>\$2,131.6</b>	<b>\$2,320.2</b>	<b>\$2,529.4</b>

<b>HEALTH STATUS</b>													
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
<b>Total</b>	<b>\$1,012.9</b>	<b>\$1,063.3</b>	<b>\$1,185.6</b>	<b>\$1,254.3</b>	<b>\$1,343.4</b>	<b>\$1,444.6</b>	<b>\$1,555.9</b>	<b>\$1,679.2</b>	<b>\$1,812.5</b>	<b>\$1,962.3</b>	<b>\$2,131.6</b>	<b>\$2,320.2</b>	<b>\$2,529.4</b>

<b>FUNDING SOURCE</b>													
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

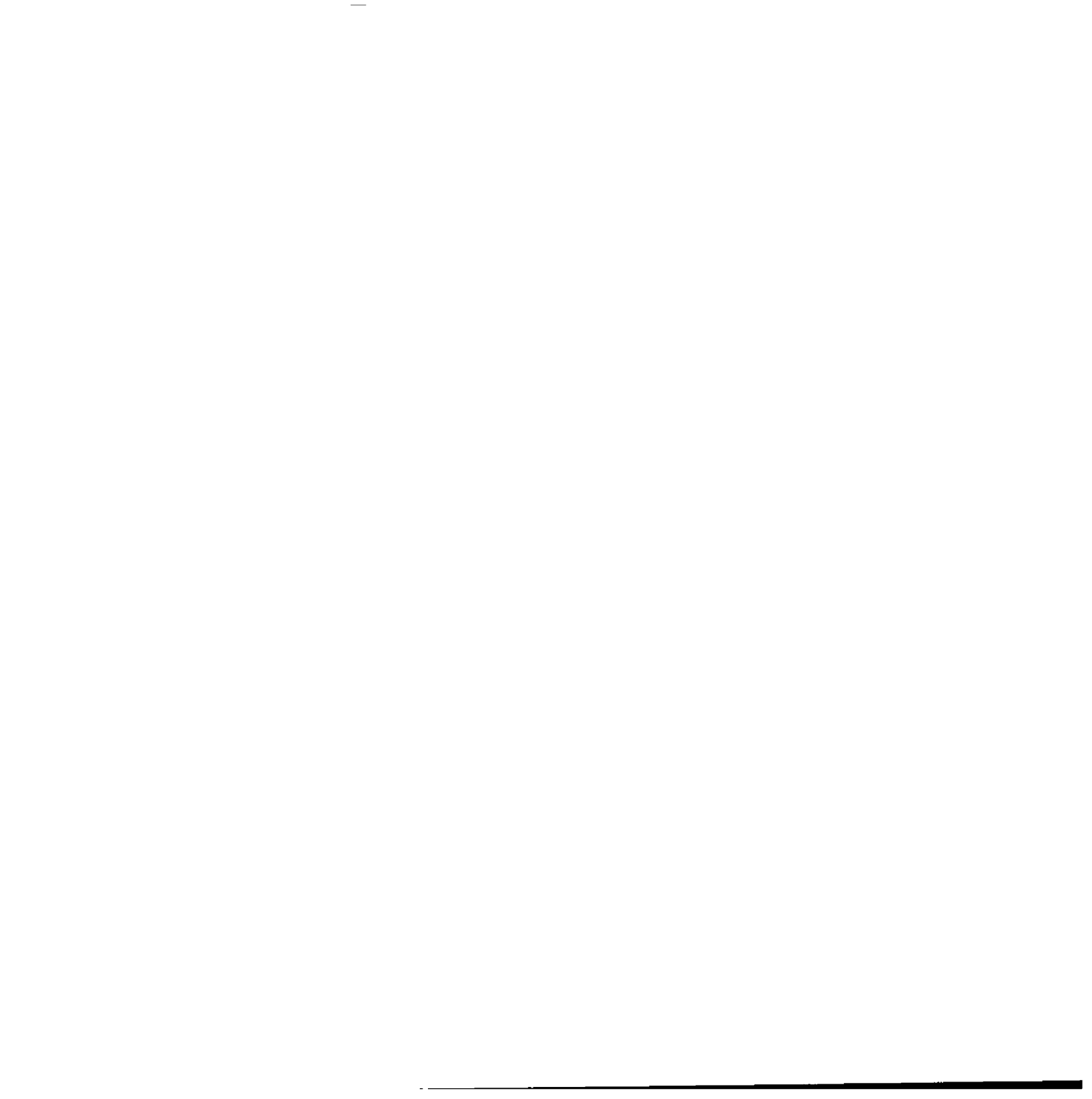
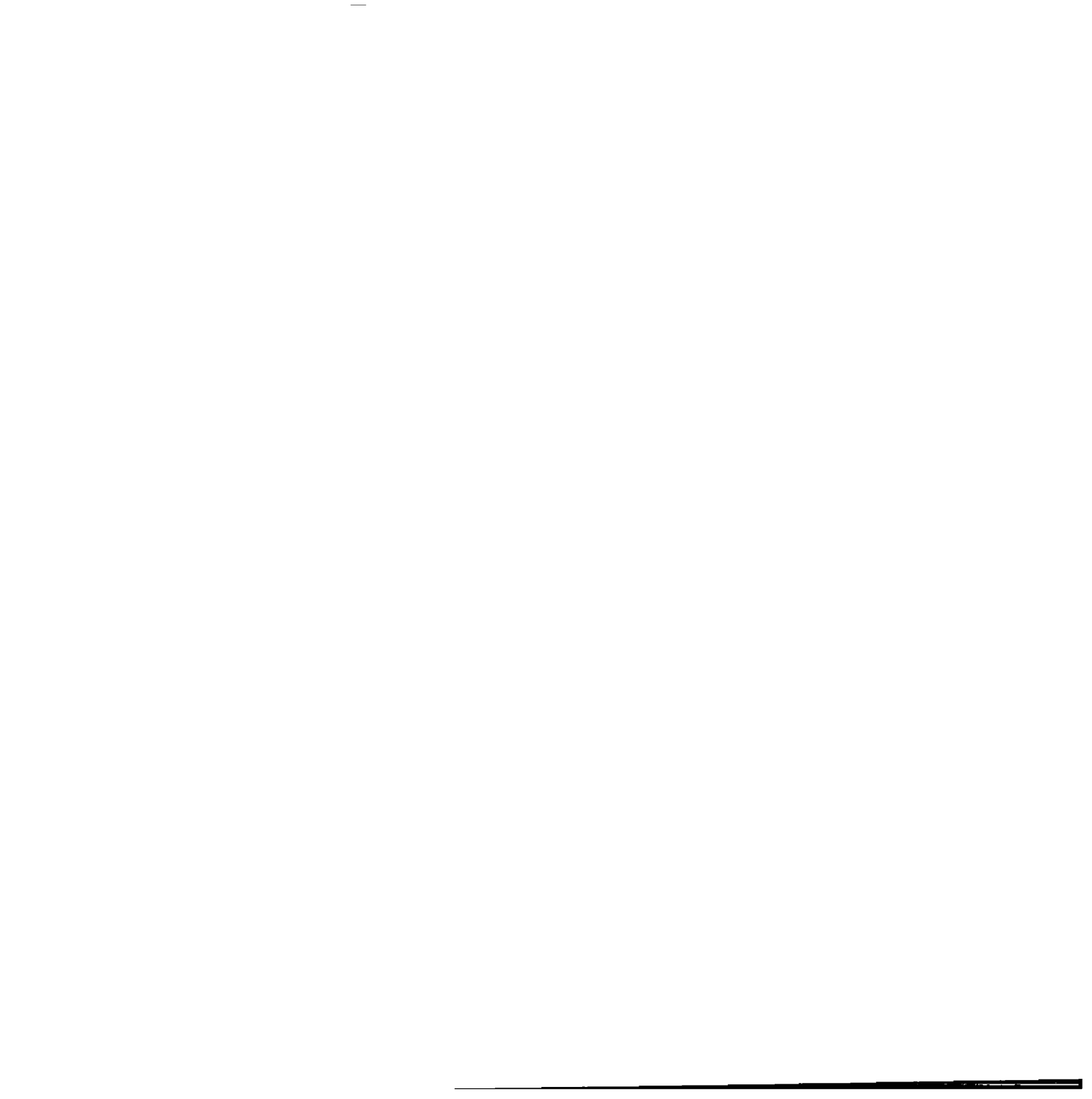


Figure B-1. Impact on Alaska Medicaid Spending if Medicaid is Not Expanded under the ACA (2014-2020)

	2014	2015	2016	2017	2018	2019	2020	Cumulative
<b>1. Cost of Currently Eligible but Not Enrolled</b>								
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
<b>2. Leave Medicaid for New Offer of Employer Coverage</b>								
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
<b>3. Total Net Impact</b>								
Change in Enrollment	577	667	758	761	765	772	779	
<b>Health Care Costs</b>								
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
<b>Administrative Costs</b>								
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
<b>Total</b>								
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



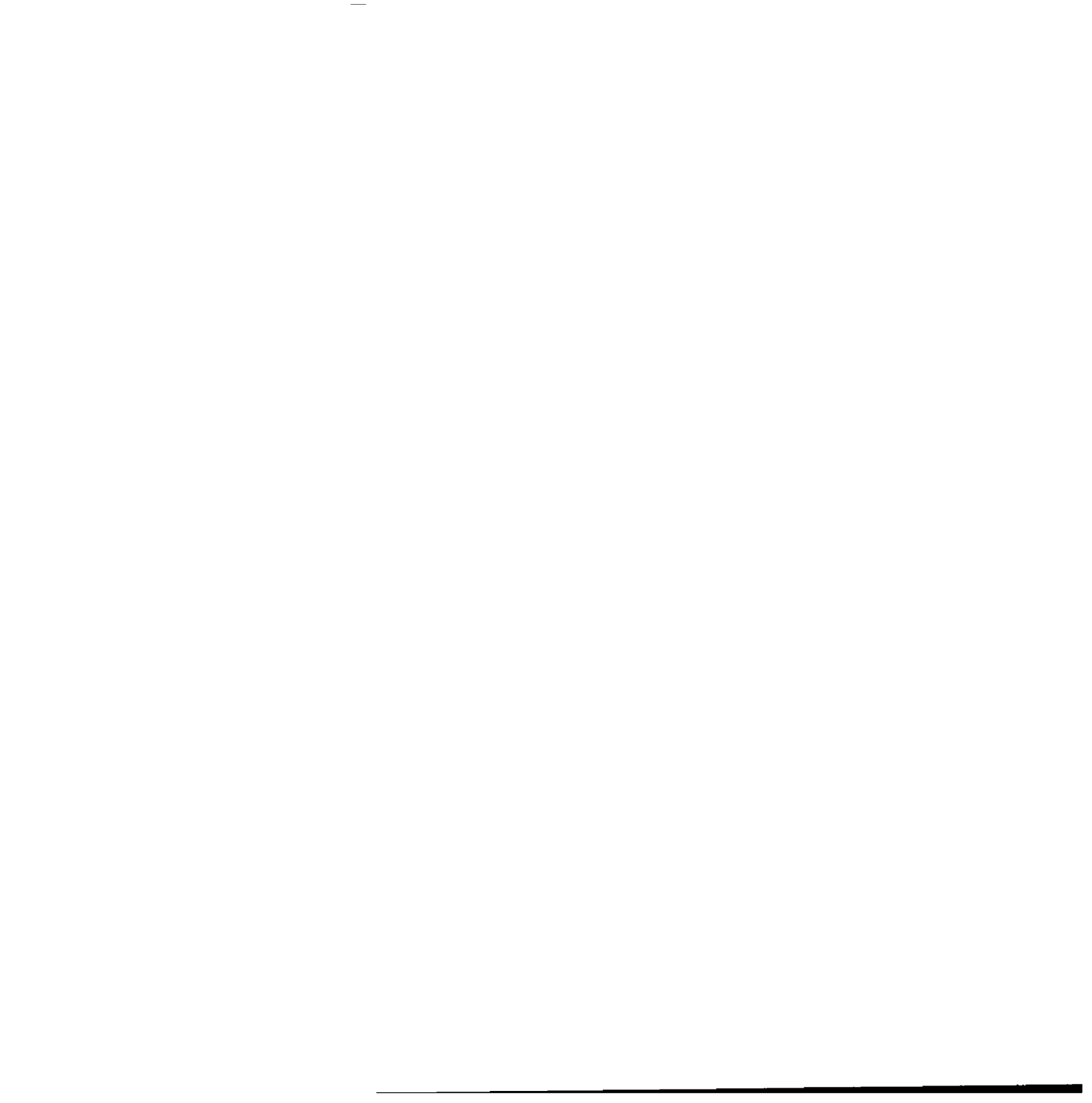
	2014	2015	2016	2017	2018	2019	2020	Cumulative
<b>1. Cost of Currently Eligible but Not Enrolled</b>								
Population growth rate		2.0%	2.2%	2.3%	2.3%	2.4%	2.4%	
Currently Eligible but Uninsured - Eligible	11,231	11,461	11,711	11,979	12,257	12,545	12,841	
Currently Eligible but Uninsured - Enrolled	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

<b>2. Leave Medicaid for New Offer of Employer Coverage</b>								
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**

<b>3. Moving Current Eligibles above 138% to HIX</b>								
<b>Pregnant Women</b>								
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

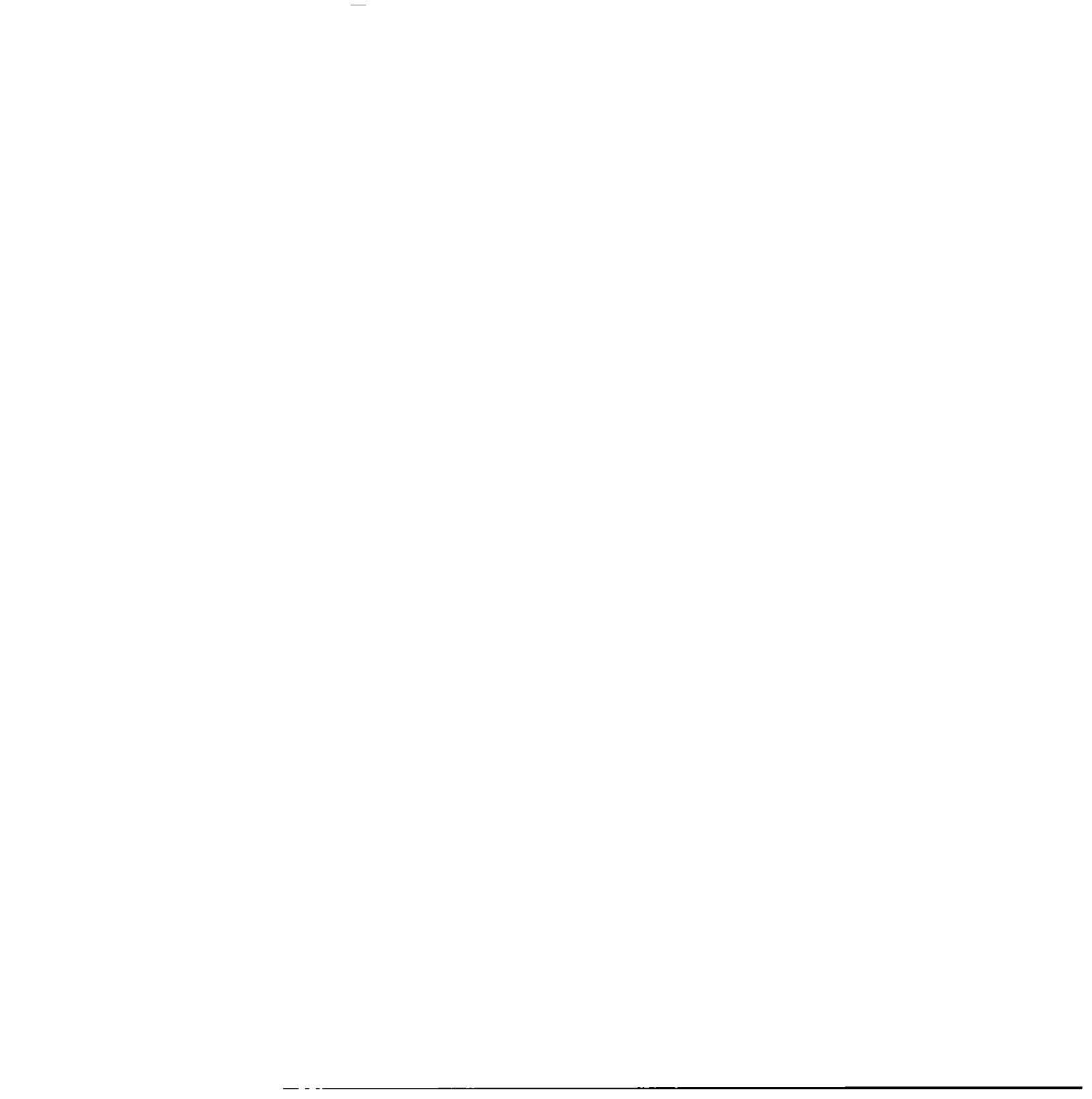
<b>4. Total Net Impact</b>								
Change in Enrollment	242	325	409	405	403	402	402	
<b>Health Care Costs</b>								
State Cost	\$515,024	\$676,284	\$1,399,240	\$1,586,845	\$1,799,049	\$2,040,002	\$2,306,373	\$10,322,817
Federal Cost	\$515,024	\$676,284	\$1,399,240	\$1,586,845	\$1,799,049	\$2,040,002	\$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
<b>Administrative Costs</b>								
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
<b>Total</b>								
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



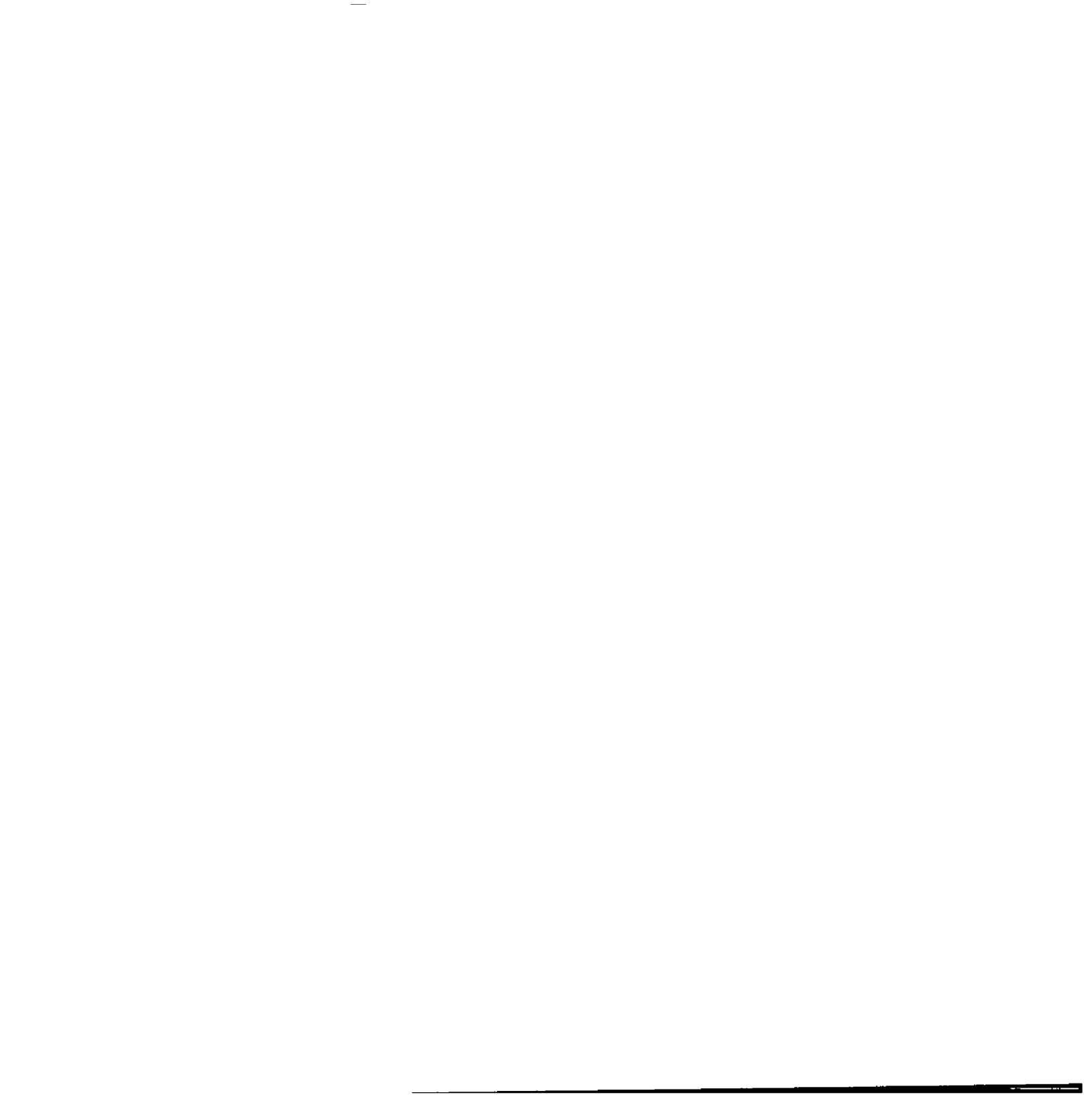
	2014	2015	2016	2017	2018	2019	2020	Cumulative
<b>1. Cost of Newly Eligibles</b>								
Population growth rate		1.1%	1.4%	1.5%	1.4%	1.6%	1.6%	
Projected Total Number of Newly Eligibles	63,989	64,713	65,619	66,571	67,496	68,560	69,684	
Projected Newly Eligibles Who Enroll	40,284	40,736	41,286	41,853	42,401	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
	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
<b>2. Cost of Currently Eligible but Not Enrolled</b>								
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
<b>3. Leave Medicaid for New Offer of Employer Coverage</b>								
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
<b>4. Total Net Impact</b>								
Change In Enrollment	30,570	35,664	40,957	41,513	42,051	42,668	43,316	
<b>Health Care Costs</b>								
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
<b>Administrative Costs</b>								
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
<b>Total</b>								
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	\$418,938,219	\$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



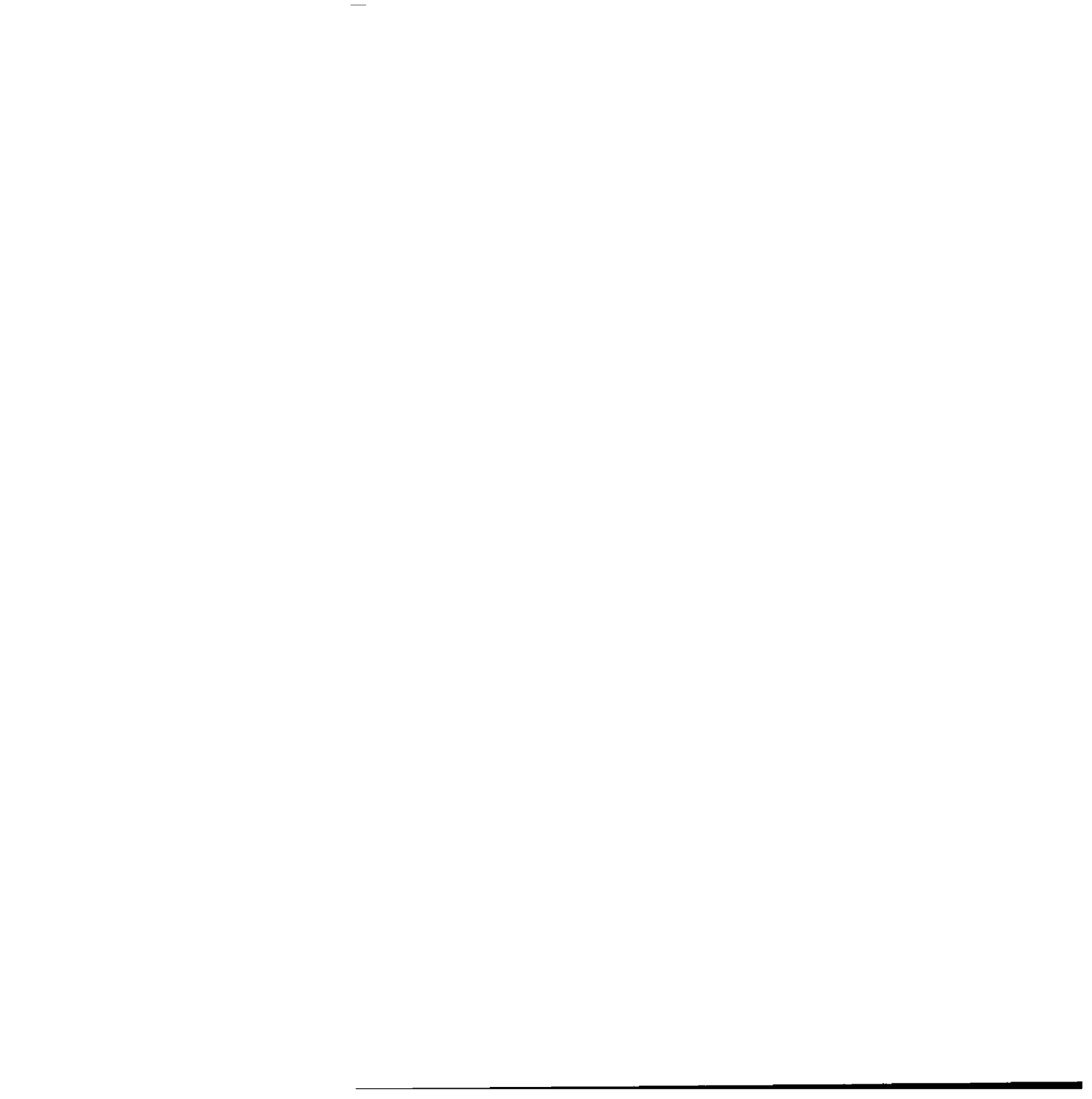
	2014	2015	2016	2017	2018	2019	2020	Cumulative
<b>1. Cost of Newly Eligibles</b>								
Population growth rate		1.1%	1.4%	1.5%	1.4%	1.6%	1.6%	
Projected Total Number of Newly Eligibles	63,989	64,713	65,619	66,571	67,496	68,560	69,684	
Projected Newly Eligibles Who Enroll	52,080	52,686	53,427	54,202	54,960	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
<b>2. Cost of Currently Eligible but Not Enrolled</b>								
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
<b>3. Leave Medicaid for New Offer of Employer Coverage</b>								
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
<b>4. Total Net Impact</b>								
Change in Enrollment	39,590	46,207	53,098	53,862	54,609	55,466	56,364	
<b>Health Care Costs</b>								
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
<b>Administrative Costs</b>								
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
<b>Total</b>								
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



	2014	2015	2016	2017	2018	2019	2020	Cumulative
<b>1. Cost of Newly Eligibles</b>								
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
<b>2. Cost of Currently Eligible but Not Enrolled</b>								
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
<b>3. Leave Medicaid for New Offer of Employer Coverage</b>								
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	\$10,374,663	\$11,111,996	\$11,906,467	\$65,653,942
<b>4. Total Net Impact</b>								
Change in Enrollment	577	30,871	36,100	41,513	42,051	42,668	43,316	
<b>Health Care Costs</b>								
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
<b>Administrative Costs</b>								
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	\$13,045,355	\$16,060,308	\$19,404,100	\$20,665,996	\$22,032,432	\$23,498,628	\$115,053,162
Subtotal	\$625,159	\$23,547,575	\$28,989,726	\$35,025,452	\$37,303,242	\$39,769,733	\$42,416,297	\$207,677,187
<b>Total</b>								
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



	2014	2015	2016	2017	2018	2019	2020	Cumulative
<b>1. Cost of Newly Eligibles</b>								
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
<b>2. Cost of Currently Eligible but Not Enrolled</b>								
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
<b>3. Leave Medicaid for New Offer of Employer Coverage</b>								
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
<b>4. Total Net Impact</b>								
Change in Enrollment	577	667	31,243	36,589	42,051	42,668	43,316	
<b>Health Care Costs</b>								
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
<b>Administrative Costs</b>								
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
<b>Total</b>								
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



**(Pregnant Women Eligibility Category) + Transition Enrollees Out of Breast and Cervical Cancer Program Eligibility Category**

	2014	2015	2016	2017	2018	2019	2020	Cumulative
<b>1. Cost of Newly Eligibles</b>								
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
<b>2. Cost of Currently Eligible but Not Enrolled</b>								
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
<b>3. Leave Medicaid for New Offer of Employer Coverage</b>								
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
<b>Other Cost Offsets</b>								
<b>4. Moving Current Eligibles above 138% to HIX</b>								
<b>Pregnant Women</b>								
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



<i>State costs</i>	-\$1,813,143	-\$1,903,800	-\$1,998,990	-\$1,889,045	-\$1,939,420	-\$1,990,109	-\$1,943,827	-\$13,478,333
<i>Federal costs</i>	\$1,813,143	\$1,903,800	\$1,998,990	\$1,889,045	\$1,939,420	\$1,990,109	\$1,943,827	\$13,478,333
<b>6. Total Net Impact</b>								
<b>Change in Enrollment</b>	30,235	35,322	40,609	41,157	41,688	42,298	42,938	
<b>Health Care Costs</b>								
<i>State Cost</i>	-\$4,866,432	-\$5,419,267	-\$5,685,078	\$15,614,496	\$21,328,790	\$27,751,513	\$45,382,863	\$94,106,885
<i>Federal Cost</i>	\$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
<i>Subtotal</i>	\$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
<b>Administrative Costs</b>								
<i>State Share</i>	\$10,131,957	\$11,865,343	\$14,387,972	\$15,342,191	\$16,344,127	\$17,429,526	\$18,594,504	\$104,095,620
<i>Federal Share</i>	\$12,585,435	\$14,738,566	\$17,872,055	\$19,057,340	\$20,301,898	\$21,650,128	\$23,097,210	\$129,302,631
<i>Subtotal</i>	\$22,717,392	\$26,603,909	\$32,260,028	\$34,399,530	\$36,646,024	\$39,079,654	\$41,691,714	\$233,398,252
<b>Total</b>								
<i>State Share</i>	\$5,265,525	\$6,446,077	\$8,702,894	\$30,956,687	\$37,672,917	\$45,181,039	\$63,977,367	\$198,202,505
<i>Federal Share</i>	\$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
<i>Total</i>	\$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

