HJR

20

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REPRESENTATIVE JUSTIN PARISH

Alaska State Legislature / Juneau, Alaska District 34

Sponsor Statement HJR 20

This resolution urges our United States Congress and the President of the United States to maintain the Medicaid Expansion to cover individual health insurance coverage.

Health care is an essential service for our residents. Health care coverage also benefits employers as healthy employees are more productive. Alaska has the second highest rate of residents without health care in the nation. This expansion has provided coverage to more than 31,000 Alaskans who would otherwise not be covered. As of March 31st, 2017, Alaska has received $413 million total payments made under the expanded program reducing the number of uninsured people visiting emergency rooms and providing necessary funding for behavioral health treatment and treatment for substance abuse.

I would appreciate your support for this resolution to maintain the federal funding for Medicaid Expansion.

Alaska State Capitol, Juneau, Alaska 99801 Phone: 907-247-4672 Toll Free: 1-800-686-3824907-465-5269 Fax: 907-465-3175

MEDICAID IN ALASKA

March 31, 2017 Report Month

31,894

Lives covered by Medicaid expansion

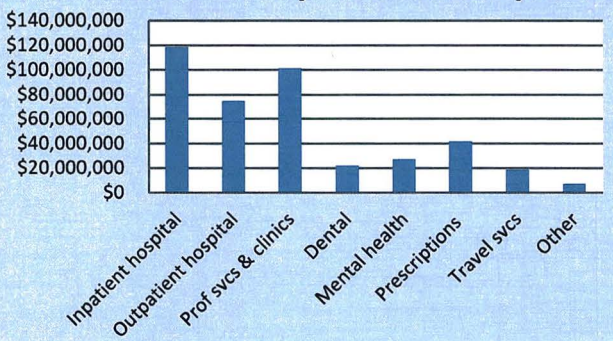
Demographics of Medicaid expansion enrollees

	19-34	35-44	45-54	55-64
Enrollee count	12,581	5,092	6,986	7,235

Male 18,231 Female 13,663

Medicaid expansion began on Sept. 1, 2015 in Alaska.

Medicaid expansion claims paid to date

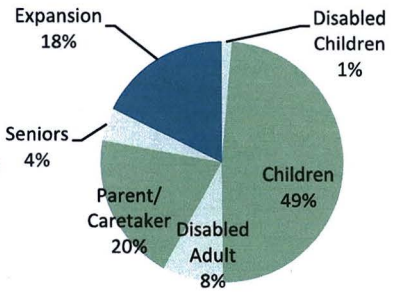


Total
$413,994,273

100% federally funded through CY16 and will transition to 90% in 2020 and beyond.

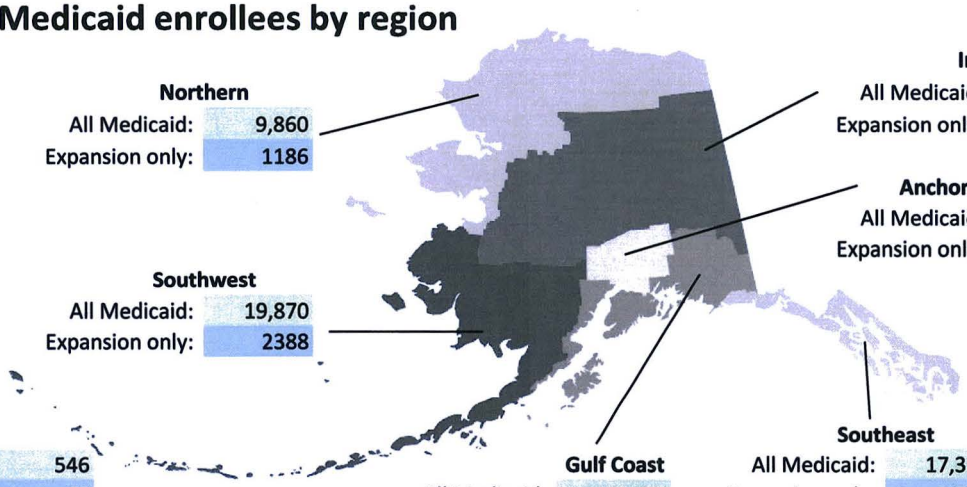
Medicaid provides health benefits to many Alaskans.

All Medicaid enrollees by category



Alaskans across the state benefit from Medicaid.

Medicaid enrollees by region



Northern
All Medicaid: 9,860
Expansion only: 1186

Interior
All Medicaid: 20,069
Expansion only: 3547

Anchorage/Mat-Su:
All Medicaid: 92,275
Expansion only: 16,966

Southwest
All Medicaid: 19,870
Expansion only: 2388

Out of state*
All Medicaid: 546
Expansion only: 69
*Temporarily absent or in an out of state medical institution.

Gulf Coast
All Medicaid: 20,189
Expansion only: 3,988

Southeast
All Medicaid: 17,370
Expansion only: 3,750

180,179

Lives covered by all Medicaid

Demographics of all Medicaid enrollees

	18 or less	19-34	35-44	45-54	55-64	65+
Enrollee count	84,612	39,363	17,219	15,001	14,155	9,829

Male 85,164 Female 90,954

MAT-SU HEALTH FOUNDATION

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Phone: (907) 352-2863 • Fax (907) 352-2865
www.matsuhealthfoundation.org

May 4, 2017

Representative Justin Parish
120 4th Street, State Capitol Room 432
Juneau, AK. 99807-1182

Dear Representative Parish,

The Mat-Su Health Foundation shares ownership in Mat-Su Regional Medical Center and invests its profits from that partnership back into the community to improve the health and wellness of Alaskans living in the Mat-Su.

I am writing today to express support for House Joint Resolution 20, Urging the United States Congress and the President of the United States to maintain health coverage for individuals currently covered by Medicaid expansion.

We supported Medicaid expansion in order to increase access to behavioral health and primary care for more Alaskans, and it has worked. Medicaid expansion has improved access to healthcare and preventive services to help people stay healthy, manage chronic diseases, and prevent unnecessary hospitalizations. Access to healthcare services in a timely way translates to healthier individuals, a stronger workforce and improved economic prospects for families. And, it saves lives! Mortality rates in expansion states have declined compared to non-expansion states. Medicaid expansion even helps low income older adults have access to affordable healthcare as they wait for Medicare benefits—so they will be healthier going onto Medicare when they turn 65.

Thanks to Medicaid expansion, more people now have access to care upstream for behavioral and other health issues and this helps prevent costly emergency department visits. Access to health care and mental health care in a timely way and in the appropriate setting improves health outcomes for people and helps control costs for all populations, not just those who will gain access to Medicaid. Here in the Mat-Su, a clear example of how expansion benefits us can be drawn from the Emergency Department at Mat-Su Regional Medical Center, which sees five times the number of people with behavioral health issues than our community mental health center. The Mat-Su population nearly doubled from 50,000 people to 98,000 people since 2000 but Mat-Su's community mental health center grants from the Department of Behavioral Health stayed flat. State funding mechanisms for this safety net population literally drove people to seek care in the ED instead of in lower cost settings. These folks delayed care until it was a crisis and presented to the ED. With Medicaid coverage, a portion of these individuals could get care sooner, before a crisis occurs, and in a lower-cost setting.

Medicaid expansion has brought needed care to more than 2,000 Mat-Su residents and almost 30,000 Alaskans. It has also directly and positively impacted the availability of treatment for alcohol and substance abuse, which were ranked by Mat-Su residents as the most pressing health issues in the Borough. Medicaid expansion provides critical behavioral health treatment that addresses root causes rather than allowing problems to escalate to more expensive treatment settings. At the same time, it has brought more than $352 million in federal funding into Alaska. Further, 82,000 Alaska children rely on Medicaid and Denali KidCare to get the care they need to be healthy. We feel it is absolutely critical that coverage be maintained for all who are currently covered by Medicaid.

Sincerely,

Elizabeth Ripley

Chief Executive Officer

ASHNHA

ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

HOSPITAL UNCOMPENSATED CARE

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

Uncompensated care at Alaska acute care hospitals declined by 23% from 2013 to 2015.

ASHNHA has data representing 15 acute care non-tribal hospitals 2011-2015. To ensure accuracy, uncompensated care numbers are taken from hospital's cost reports that are required to be submitted annually to Medicare and Medicaid.[2] Hospitals have different cost reporting periods based on their fiscal year (calendar, state FY, federal FY) so the data doesn't represent the same time period for each facility. However this does provide a snapshot of uncompensated care.

Uncompensated Care at Alaska Hospitals				
2011	2012	2013	2014	2015
$ 85,047,723	$ 90,025,771	$ 94,475,540	$ 89,001,149	$ 72,594,126

Medicaid expansion was implemented in September 2015. For some facilities, the 2015 data represents only three months of Medicaid expansion (those reporting on a calendar year) and for others the data represents nine months of Medicaid expansion (those reporting on a state fiscal year). Until 2016 cost report data is released, it will be difficult to fully assess the impact of Medicaid expansion on uncompensated care in Alaska.

Tribal hospitals are not included in this data because of differences in cost reporting requirements.[3] Tribal hospitals do have uncompensated care, but because of the difference in reporting requirements it is difficult to compare their data to the non-tribal facilities. Tribal facilities report data from patient accounting and general ledger systems and the uncompensated care represents the total amount of gross charges written off for care provided to patients who have no payer source.

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

- A decrease in uncompensated care can result in improved financial sustainability for Alaska's small/rural hospitals that have been operating at a deficit. Additional resources allow Alaska hospitals to better respond to community health needs and provide community benefits.

- Hospitals face looming uncertainty due to federal cuts authorized by the ACA. These cuts amount to more than $857 million (-11%) over sixteen years for Alaska hospitals.[4] Hospitals agreed to payment reductions based on the assumption that Medicaid expansion and insurance subsidies would result in fewer uninsured patients. If the ACA Medicare cuts are maintained and Medicaid expansion and insurance subsidies go away, the pressure on hospitals will be significant.

- Small and large hospitals are under increasing regulatory and financial pressure to adapt to a rapidly changing business model and declining reimbursement.

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

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[1] American Hospital Association, Uncompensated Hospital Care Cost Fact Sheet

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

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

[4] Medicare Payments Cuts in Alaska, February 2017, DataGen Enacted Medicare Cut Analysis report

Medicaid Cost Savings by Year		Savings
FY2016	Reform Efforts	(57,885.0)
	Expansion Savings	(3,462.5)
	Total FY2016 Savings	**(61,347.5)**
FY2017	Reform Efforts	(53,303.5)
	Expansion Savings	(12,108.6)
	Total FY2017 Savings	**(65,412.1)**
FY2018	Reform Efforts	(6,927.3)
	Expansion Savings	(3,017.1)
	Total FY2018 Savings	**(9,944.4)**

Total Reform Efforts	(118,115.8)
Total Expansion Savings	(18,588.2)
Grand Total Medicaid Cost Savings	**(136,704.0)**

Detail By Year		
FY2016		
Reform Efforts	Reduce by Value of Average Lapsing Balance, Non-Mandatory Abortion Services, and Prescription Database Funding	(31,860.8)
	Implement Medicaid Cost-Saving Measures - Including plans to not implement customary 1-2% rate adjustments.	(26,024.2)
Expansion Savings	BH Treatment and Recovery - Shift clients to Medicaid Expansion	(1,000.0)
	HCS CAMA - Shift clients to Medicaid Expansion	(971.0)
	Dept. of Corrections Inmate Health Care Savings due to inmates now eligible under Medicaid Expansion.	(1,491.5)
	Total FY2016	**(61,347.5)**
FY2017		
Reform Efforts	Dept. of Admin - Study to determine feasibility of creating a health care authority.	834.6
	DHSS Pioneer Homes - Shift clients to Medicaid.	(1,066.7)
	DHSS Commissioners Office - Tribal federal liaison section for new CMS policy.	824.7
	DHSS Medical Assistance Admin - Reform and fraud reduction.	57.7
	DHSS Rate Review - Demonstration projects for innovative payment models.	250.0
	DHSS Adult Preventative Dental Medicaid Services - Reduction to preventative dental services.	(3,479.8)
	DHSS Behavioral Health Medicaid Services - Super utilizer management, pharmacy services, and fraud and abuse reform.	(3,370.7)
	DHSS Health Care Medicaid Services - Reform and efficiency savings and replacement of UGF for tribal travel.	(35,101.9)
	DHSS Health Care Medicaid Services - SB74 Efforts	228.9
	DHSS Senior and Disabilities Services Medicaid - Reform and efficiencies	(13,261.5)
	DHSS Fraud Investigation - Fraud and waste control	618.8
	DHSS SDS Admin	71.1
	Dept of Law - SB74 Efforts	91.3
Expansion Savings	BH Treatment and Recovery - Shift clients to Medicaid Expansion	(5,779.6)
	HCS CAMA - Shift clients to Medicaid Expansion	(329.0)
	Dept of Corrections Inmate Health Care Savings due to inmates now eligible under Medicaid Expansion.	(6,000.0)
	Total FY2017	**(65,412.1)**
FY2018		
Reform Efforts	DHSS Medical Assistance Admin - Reform and fraud reduction.	(8.8)
	DHSS Rate Review - Demonstration projects for innovative payment models.	(150.0)
	DHSS Fraud Investigation - Fraud and waste control	(641.8)
	DHSS SDS Admin	226.2
	DHSS Commissioners Office - Reverse one time costs	(535.0)
	Medicaid Services Reform Savings	(17,523.1)
	Medicaid Services projections	17,523.1
	DHSS SDS CDD Grants - Transition to Medicaid	(5,817.9)
Expansion Savings	HCS CAMA - Shift clients to Medicaid Expansion	(17.1)
	BH Treatment and Recovery - Shift clients to Medicaid Expansion	(3,000.0)
	Total FY2018	**(9,944.4)**

Medicaid Expansion: Just the Facts

1. **MEDICAID EXPANSION HAS A POSITIVE IMPACT ON STATE AND LOCAL BUDGETS.** The evidence from states that have expanded consistently shows that it generates savings and revenue which can be used to finance other priorities or offset much, if not all, of the state costs of expansion.

    - States cite three sources of expansion-related budgets savings and revenue: (1) as low-income residents gain Medicaid coverage, federal Medicaid funding can replace some or all state-funded services for the uninsured; (2) as individuals move from specialized Medicaid eligibility categories into the new adult category, states are able to claim enhanced federal match rather than regular federal match; (3) revenues from pre-expansion provider taxes and assessments increase because the base upon which they are calculated grows when more people are covered. These direct budget savings are *in addition to* any economic boost flowing from more federal revenues and growth in jobs.[i]

    - Thirty states, plus Washington DC, that expanded in 2014 are reporting general fund savings and new revenue. Examples include:
        - *Arkansas*: A recent analysis projected that Arkansas's expansion will have a net positive impact of $637 million on the state budget between 2017 and 2021, up from an early projection of $438 million.[ii]
        - *Kentucky*: Kentucky estimates saving $820 million, net of costs, between 2014 and 2021 due to expanding Medicaid.[iii]
        - *New Jersey*: The State expects a $75 million decrease in State funding for charity care in 2017 as a result of Medicaid expansion.[iv]
        - *New Mexico:* Medicaid expansion is expected to create a $300 million surplus for the State's General Fund between 2014 and 2021.[v]
        - *Colorado:* Medicaid expansion is expected to generate net revenue for the State's General Fund of $102 million in FY 2015-2016. Annual net revenue is expected to grow to $250 million in FY 2034-35. [vi]

    - In FY 2015, the growth in state general fund spending on Medicaid in expansion states was half as much as it was in non-expansion states (3.4% compared to 6.9%). The differential is primarily due to the enhanced federal match for expansion adults.[vii]

    - Expansion states continue to report state savings in behavioral health, uncompensated care, and criminal justice, and increased revenues, as a result of expansion.[viii, ix]

- States' shares of Medicaid spending grew more slowly in states that expanded. In FY 2015, states' shares of general fund spending on Medicaid in expansion states declined relative to the previous year, and it was half as much as it was in non-expansion states (3.4% compared to 6.9%).[x]

2. **MEDICAID EXPANSION BOLSTERS STATE ECONOMIES.** Medicaid expansion brings in hundreds of millions of federal dollars annually, which ripples through the state economies, creates jobs, and allows savings in other areas.

    - Medicaid expansion states see more jobs in the health sector. On average, the states that expanded Medicaid in January 2014 saw jobs grow by 2.4% during 2014, while jobs in states that did not expand grew by only 1.8% in the same year.[xi]

    - The Bureau of Labor Statistics projects health care and social assistance jobs will grow to nearly 22 million by 2022 due to Medicaid expansion.[xii]

    - In 2014, Kentucky's expanded Medicaid created 12,000 new jobs and it is estimated by 2021 that expansion will be responsible for the employment of 40,000 Kentuckians annually.[xiii]

    - In New Mexico, almost 4,000 new jobs in the healthcare and social assistance industry were created in 2014; these jobs are primarily in the private sector.[xiv]

    - In Colorado, the state economy has already grown by $3.82 billion, or 1.14 percent, as a result of Medicaid expansion and is expected to grow by $8.53 billion, or 1.38 percent, by FY 2034-35. In addition, Colorado's economy now supports over 31,000 additional jobs due to Medicaid expansion and average annual earnings per household have increased by $643. By FY 2034-35, the number of additional jobs is expected to grow to over 43,000 and annual earnings are expected to increase by $1,033.[xv]

3. **STATES CAN COUNT ON CONTINUED FEDERAL FINANCIAL SUPPORT FOR EXPANSION.** The Federal "enhanced" match covers the vast majority of expansion costs and is in federal law. It cannot be changed without Congressional and Presidential approval.

    - Federal law requires the federal government to pick up 100% of the expansion's costs through 2016; it drops to 95% in 2017 but never goes below 90%. This means that when the 10% state share is in effect (in 2020), the federal government will pay $90 for every $100 in health care costs for the newly eligible people.[xvi, xvii]

    - The federal share of the expansion will average roughly 95% from 2016 to 2025, according to the Congressional Budget Office (CBO). The CBO estimates total state spending on Medicaid and CHIP will increase by only 1.6% over the same time period.[xviii]

    - New federal law would be required to change federal funding commitment, and history shows no evidence that this is likely. Congress has only modified Medicaid's overall matching rate three times over the last three and a half decades. President

Reagan and Congress enacted a temporary cut in 1981, but the most recent changes involved temporary *increases* to aid states during the last two economic downturns.[xix]

- In the event that the match rate changes — or for any other reason — states can drop their Medicaid expansion. Several states have included sunset provisions in their authorizing legislation.[xx]

4. **MEDICAID EXPANSION PROTECTS AND STRENGTHENS STRUGGLING AND RURAL HOSPITALS.** Medicaid expansion significantly reduces hospitals' uncompensated care costs and helps stabilize rural hospitals.

    - Hospital financial reporting suggests that coverage expansions are contributing to a national reduction in hospital uncompensated care costs. Hospitals' uncompensated care costs are estimated to have been $7.4 billion (21%) less in 2014 than they would have been in the absence of coverage expansions.[xxi]

    - Ascension Health, which has hospitals in expansion and non-expansion states, found that, in 2014, hospitals in expansion states saw a 63.2% reduction in uncompensated care compared to a 2.6% increase in non-expansion states.[xxii, xxiii]

    - In New Mexico, uncompensated care reimbursements for the state's Safety Net Care Pool (SNCP) have dropped by 30% as a result of Medicaid expansion. Additionally, for all hospitals within the state, uncompensated care as a share of hospital expenses dropped by 12.5%, and net revenue increased by more than 40% in 2014 compared to 2013.[xxiv]

    - As of September 2015, the percentage of rural hospitals at risk of closure has nearly doubled in non-expansion states in comparison to expansion states (based on measures of financial strength, quality and outcomes, inpatient/outpatient share, and population risk). For FY 2013, vulnerable hospitals reported operating profit margins were 131% lower than the national median, and cash flow margins were 76% lower than the national median.[xxv]

    - In states that have chosen not to expand the program, rural hospitals are struggling with the fallout. In many rural counties, these hospitals are the largest employers, but many say they're now facing layoffs, even closure.[xxvi]

    - According to the National Rural Health Association, 300 rural hospitals across the U.S. are on the verge of closing due to financial issues. The major cause for these issues is the states opting out of Medicaid expansion. In addition to compromising the health of rural people, a hospital closure causes lost jobs, lost economic activity, and lost community vibrancy in rural communities. A small-town hospital closure costs about $1,000 in per capita income.[xxvii]

5. **MEDICAID EXPANSION IS AFFORDABLE INSURANCE FOR LOW-INCOME, WORKING ADULTS.** Most people eligible for Medicaid expansion are in working families, many caring for children.

    - Between 2013 and 2014, the average rate of uninsured workers decreased significantly more in Medicaid expansion states (25%) than non-expansion states (13%).[xxviii]

    - Nationally, 61% of those eligible for Medicaid expansion are in working families. More than half (55%) work in either the service industry or agriculture, and most work in firms with less than 100 employees, the types of firms that are less likely to offer affordable insurance. One out of four are caring for children, some have medical issues that limit their ability to work (one out of five report poor health), and 17% are over age 55.[xxix]

    - Among the uninsured non-elderly adults (19-64) with incomes below 138% FPL — people eligible under the expansion and those already eligible but unenrolled — 72% report working full time.[xxx]

    - Medicaid expansion encourages work and job advancement among low-income parents. In the median states that have not expanded, a parent is "over income" for Medicaid if she earns $8,840 for a family of three. If she gets a better job, a raise, or more hours, she is likely to fall within the coverage gap — her income is too high for Medicaid and too low for the Marketplace subsidies. By contrast, in states that expand, low-income parents can earn more without losing their health insurance.

    - Expanded Medicaid coverage enables occupational and industry mobility in low-income, working adults.[xxxi]

6. **STATE SPECIFIC SOLUTIONS ARE WORKING.** States have crafted programs that address their unique health care and cultural landscapes, giving them control.

    - Medicaid gives states flexibility to design their own programs. States can design their benefit packages for the new adult group based on a commercial benchmark that they select, and states have the flexibility to impose copayments at nominal levels for those under poverty and a higher level for those with incomes at or above the poverty level.[xxxii]

    - States can make additional changes through Section 1115 waivers. Six states that have expanded Medicaid have done so using an alternative to traditional expansion: Arkansas, Iowa, Indiana, Michigan, Montana, and New Hampshire.[xxxiii] These waiver-based expansions include policies such as premiums, health savings accounts, incentives for healthy behaviors, referrals to work programs, and initiatives to use Medicaid funds to purchase private insurance policies offered by employers or through the Marketplace.

7. **ENROLLMENT GROWTH IN EXPANSION STATES IS STRONG, DRIVING DOWN THE UNINSURED RATE TO RECORD LOWS.**

- Overall, the nation's current uninsured rate is the lowest it's been in the last 60 years. In one year, Arkansas and Kentucky cut their uninsured rate in half.[xxxiv]

- Nine of the ten states with the largest reductions in uninsured rates expanded Medicaid.[xxxv]

- In 17 of the 29 states that expanded in 2015, enrollment grew faster than the state projected. At the same time, the costs per enrollee were as or lower than expected. States project the rate of growth leveling off over the next year.[xxxvi]

- Despite higher than expected expansion enrollment, Ohio's actual FY 2014 Medicaid spending was $2 billion below estimates because of a number of program reforms.[xxxvii]

8. **MEDICAID EXPANSION IS GOOD FOR PATIENTS AND PUBLIC HEALTH.** Expansion increases access to primary and preventive care and increases continuity of coverage, which improves health and ultimately reduces costs.

- In non-expansion states, 28.4 percent of the uninsured population that would be eligible under expansion had a mental illness or substance use disorder between 2010 and 2014 and 11.5 percent of the uninsured population received treatment for a mental illness or substance use disorder.[xxxviii] Medicaid expansion enables states to offer new adult services for mental health and substance abuse with an enhanced match[xxxix, xl] — particularly critical service needs in light of the alarming growth in opioid abuse.[xli]

- In Medicaid expansion states, rates of primary and preventative care visits increased between 2013 and 2014. The rates remained unchanged in non-expansion states over the same time period.[xlii, xliii]

- Consumers in Medicaid expansion states (Kentucky and Arkansas) experienced improved access to care when compared to a non-expansion state (Texas): the rate of insurance was higher, individuals with chronic conditions were more likely to receive regular care, consumers were less likely to have trouble paying their medical bills, and there was a lower prevalence of skipping medications because of cost.[xliv]

- Women in Medicaid expansion states are far more likely to get screened for breast cancer. In 2008 — before states could expand Medicaid — low-income women in states that would go on to expand Medicaid were equally likely to be screened for breast cancer as low-income women in states that would remain un-expanded. In 2012, however, low-income women in expansion states were 25% more likely to get screened for breast cancer than those in non-expansion states.[xlv]

- Expansion enables states to connect ex-inmates to health coverage, address their mental health or substance use disorder needs, and reduce recidivism rates.[xlvi]

- Expansion increases coverage of homeless individuals as well as revenue of providers serving the homeless population.[xlvii]

- *Kentucky*: Low-income Kentuckians had fewer unmet medical needs because of cost and were more likely to have a regular source of care following Medicaid expansion.[xlviii]

- *Kentucky*: More Kentuckians are receiving substance abuse treatment due to Medicaid expansion.[xlix]

- *Michigan:* Expansion is increasing access to primary care — as of February 2015, more than half of expansion enrollees had visited a primary care physician, and enrollees were participating in the expansion program's voluntary health risk assessment program at more than twice the rate of enrollees in private health insurance plans.[l]

- *Oregon:* A landmark study of Oregon's Medicaid program found that, compared with similar people without coverage, people with Medicaid were 40% less likely to have suffered a decline in their health in the previous six months. They were also more likely to use preventive care (such as cholesterol screenings), to have a regular office or clinic where they could receive primary care, and to receive a diagnosis of and treatment for depression and diabetes. People with Medicaid in Oregon were also 40% less likely than those without insurance to go into medical debt or to leave other bills unpaid in order to cover medical expenses. In fact, the latest research from Oregon found that Medicaid coverage "nearly eliminated catastrophic out-of-pocket medical expenditures."[li]

- *Arizona, Maine, and New York:* Research published in the *New England Journal of Medicine* reported that expansions of Medicaid coverage for low-income adults in Arizona, Maine, and New York reduced mortality by 6.1%.[lii]

9. MEDICAID IS COST EFFICIENT AND IS MOVING FORWARD WITH CARE AND PAYMENT IMPROVEMENTS.

- Medicaid's costs per beneficiary are lower than those for private insurance and national health expenditure per capita costs between fiscal years 2000 and 2011.[liii]

- Access to care for Medicaid enrollees is generally as good as it is in the private sector.[liv]

- Medicaid programs across the country are implementing innovative delivery system and payment reforms:[lv]
    - 27 states have PCMHs in place in their Medicaid program;
    - 25 states have implemented or plan to implement the Medicaid Health Home program;
    - 10 states have Medicaid-focused ACOs or plan to implement in 2016; and
    - Nine states are participating or plan to participate in the Delivery System Reform Incentive Payment program.

April 2016

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[ii] The Stephen Group. (17 February 2016). *Arkansas Health Care Reform Task Force: TSG Update Report.*

[iii] Commonwealth of Kentucky Office of the Governor. (12 February 2015). *KY's Medicaid Expansion: 40,000 Jobs, $30 B Economic Impact.* Retrieved from https://dss.mo.gov/mhd/oversight/pdf/150217-kentucky-medicaid-extension-press-release.pdf.

[iv] New Jersey Office of Management and Budget (16 February 2016). *The Governor's FY 2017 Budget: Budget Summary*. Retrieved from http://www.nj.gov/treasury/omb/publications/17bib/BIB.pdf.

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[xi] Willard, P. (24 March 2015). *Medicaid Expansion States See Financial Savings and Health Care Jobs Growth.* Retrieved from http://familiesusa.org/blog/2015/03/medicaid-expansion-states-see-financial-savings-and-health-care-jobs-growth.

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ASHNHA

ALASKA STATE **HOSPITAL &**
NURSING HOME ASSOCIATION

Resolution 2012 #2

A resolution of support by the Executive Committee of the Alaska State Hospital and Nursing Home Association on behalf of its membership concerning the expansion of the Medicaid Program in Alaska.

WHEREAS: Affordability and accessibility of health care is an important issue for all Alaskans;

WHEREAS: On June 28, 2012 the Supreme Court of the United States ruled on certain aspects of the Affordable Care Act and its constitutionality;

WHEREAS: As part of this ruling the Supreme Court allows, without penalty, states to either expand their Medicaid program to serve certain recipients up to 138% of FPL or decline to expand their Medicaid program to serve these recipients;

WHEREAS: Governor Parnell must now determine if Alaska will expand their Medicaid coverage in accordance with these provisions;

WHEREAS: Approximately 35,000-55,000 uninsured or underinsured Alaskans will be eligible for Medicaid under this expansion;

WHEREAS: Expanding this coverage will lessen the financial impact to the state's employers, increase access for needy and uninsured Alaskans and alleviate the uncompensated care burden with Alaska hospitals and providers;

WHEREAS: The federal government will fund the first three years of the expansion at 100% federal funding for programmatic services and then stepping down funding to 90% in 2019 and beyond resulting in approximately $2 billion in new health care funding over the next five years;

WHEREAS: The ACA and other Congressional actions will reduce or *likely* will reduce Medicare payments to hospitals over a similar period;

THEREFORE BE IT RESOLVED, THAT:
The Executive Committee of the Association, on behalf of its members, formally supports the expansion of Medicaid recipients to 138% FPL,

FURTHER BE IT RESOLVED, THAT:
The Association pledges to support Governor Parnell and his Administration in any way feasible to provide information, resources and support to gain the information necessary to fully evaluate the benefits and the costs of such an expansion.

Passed by the majority of the Executive Committee this 16th day of August, 2012

ATTEST:
Bruce Lamoureux
Signature to follow
Bruce Lamoureux
Chair