mechanisms to contain costs, which may include establishing a maximum amount of benefits for each eligible recipient in a fiscal year for the services and specifying the scope of the services.

* **Sec. 2.** AS 47.07 is amended by adding a new section to read:

Sec. 47.07.067. Payment for adult dental services. (a) The department shall pay for adult dental services provided under AS 47.07.030(b) and under regulations adopted by the commissioner in conformity with applicable federal requirements and this chapter. Regulations adopted under this section may include the following:

(1) a maximum amount of benefits for adult dental services for each eligible recipient in a fiscal year; this paragraph does not apply to minimum treatment for the immediate relief of pain and acute infection provided by a licensed dentist; and

(2) specification of the scope of adult dental services.

(b) As used in this section, "minimum treatment" means the application or prescription of a medication or material deemed necessary by the dentist for the palliative treatment of pain or for the reduction of the spread of infection.

* **Sec. 3.** AS 47.07.900(1) is repealed.

* **Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Health and Social Services may proceed to adopt regulations necessary to implement the changes made by this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the statutory changes.

* **Sec. 5.** Section 4 of this Act takes effect immediately under AS 01.10.070(c).

* **Sec. 6.** Except as provided in sec. 5 of this Act, this Act takes effect July 1, 2005.

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB079CS(HES)-DHSS-DHCS-01-25-06
( ) Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: ADULT DENTAL COVERAGE UNDER MEDICAID
RDU: Health Care Services
Component: Medicaid Services

Sponsor: (RLS) BY REQUEST OF THE GOVERNOR

Requester: SENATE (FIN)
Component No.: 2077

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims	3,469.4	11,548.1	11,912.5	11,081.4	10,814.9	11,166.7
Miscellaneous						
TOTAL OPERATING	**3,469.4**	**11,548.1**	**11,912.5**	**11,081.4**	**10,814.9**	**11,166.7**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)						
1002 Federal Receipts	2,285.1	7,608.7	7,790.9	7,2[illegible]	7,058.8	7,356.6
1003 GF Match	759.3	2,514.4	2,696.6	2,818.9	3,056.1	3,460.1
1004 GF						
1037 GF/Mental Health						
1092 MHTAAR	425.0	1,425.0	1,425.0	1,050.0	700.0	350.0
Other(Specify Type-do not abbreviate)						
TOTAL	**3,469.4**	**11,548.1**	**11,912.5**	**11,081.4**	**10,814.9**	**11,166.7**

Estimate of any current year (FY2006) cost:
Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS						
Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

Historically Medicaid Dental Benefits for recipients 21 years or older, have been limited to immediate relief of pain and acute infection. Routine preventive or restorative services have not been covered.

Under this bill, Dental Benefits for Adults would be expanded to include preventive and resorative care up to a cap of $1,150 per person annually. Examples of services that could be provided at that level are: one exam, 4 bitewing radiographs, cleaning and about 8 restorations or extractions, or; one exam and an upper or lower full denture.

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Prepared by: Janet Clarke, Assistant Commissioner — Phone: 465-1630
Division: Finance and Management Services — Date/Time: 01/24/2006
Approved by: Karleen Jackson, Commissioner — Date: 01/25/2006
Agency: Department of Health and Social Services

STATE OF ALASKA
2006 LEGISLATIVE SESSION

BILL NO. SB079CS(HES)-DHSS-DHCS-01-25-06

ANALYSIS CONTINUATION
Analysis Con't

It is estimated that approximately 41,000 individuals would be eligible for the expanded Medicaid Dental Benefits, including adults with disabilities and seniors. Not all eligible individuals will seek dental benefits, and those that do will utilize services at varying rates. Of the 41,000 eligible persons, 50% of Alaska Native adults and 35% of non-Native adults are expected to access dental care - about 15,800 individuals.

Based on the assumptions below on utilization of dental benefits, the weighted average benefit for a full fiscal year is about $730 per recipient.

- Of adult recipients that access dental care it is estimated that:
  - 15% will receive up to $250 in benefits
  - 25% will receive up to $500 in benefits
  - 25% will receive up to $750 in benefits
  - 20% will receive up to $1,000 in benefits
  - 15% will receive the maximum $1,150 in benefits.

The SFY08 estimated expenditure for a full year ($11,548.1) represents the costs for the 15,800 individuals projected to receive the additional benefit at an estimated weighted average cost of $730.

These utilization rates are based on provider capacity (the extent of dental access through tribal and community health center dental programs, and the extent of private dental participation in the Medicaid program) and treatment needs (not all eligible individuals will seek dental benefits, and those that do will utilize services at varying rates.)

Factoring in those individuals who are eligible for 100% federal reimbursement, the federal contribution (through FY 2012) will cover approximately 66% of the costs. State GF will constitute about 25% and Mental Health Trust about 9% of the matching funds.

It is anticipated that the program will be operational the last quarter of FY07 so costs in that year are calculated at approximately 25% of FY08 costs and adjusted higher to allow for pent up demand.

A 3% growth in utilization is included to reflect possible increases in eligible adults and/or an increased percentage of adults accessing the dental services. This utilization is partially offset by projected lower expenses in FY10, FY11 & FY12 under the assumption that adults on the program for several years would eventually have their major treatment needs met and move to a "maintenance" level of care (e.g., routine exam and cleanings but less restorative needs and less dental emergencies).

It is anticipated that this service expansion will reduce dental emergencies, however there will always be adults who avoid the dentist until there is an acute need. Because the service would not be implemented until the 4th quarter of FY07, claims for emergency dental services will likely remain the same in FY07.

Bring the Kids Home (BTKH) Initiative

Expansion of Services & Facilities

System Level	Proposed Enhancements	Activities/Discussion/Status	Resources	Proposed Implementation Schedule & Timelines by Fiscal Year												
				2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
I. Community Based																
	CMHC Capacity for Individualized Services beyond Medicaid **Grant increases for care management** **Note: This includes "In-Home Su ports"**	1. Increase capacity for lower level of care 2. Evaluate barriers of policy or reimbursement 2. Develop a reimbursement system beyond Medicaid that provide flexibility and inventive for lower levels of care.	Proposed **Individ Services** **Resources:** **MH Trust:** ***reference the $ at the Resource Committees** **Resources:** **GF/MH (Trust proposed)** **- $1,250,000 (FY07)**			2 community wraparound programs 5 kids per program *Measurement connotes number of community based wraparound programs	15 (+5)	30 (+15)	45 (+15)	60 (+15)	75 (+15)	90 (+15)		Future expansion will be driven by capacity of community behavioral health programs		
	School-Based Services	Current Status 1. Department planning committee worked with school officials to define services, and develop work process 2. Regulations for "School-Based Behavioral Health Service" has been completed, approved, and implemented				13 communities with school based programs 5 students *Measurement connotes number of communities with school based services	70 (+5)	85 (+15)	100 (+15)	Future expansion will be driven by capacity of community behavioral health programs and individual school districts. Economy of scale must be addressed.						
	Therapeutic Foster Homes	Current Status 1. Through the Community Based 1915(B) P, an additional 9 homes, each serving 1-5 children, was awarded, and will be implemented in '06	Resources *reference the $ at Regional Services				40 beds (+10)	20 beds (+10)	30 beds (+10)	Future expansion will be driven by community need, resources and capacity						

Expansion of Services & Facilities

System Level	Proposed Enhancements	Activities/Discussion/Status	Resources	Proposed Implementation Schedule & Timelines by Fiscal Year											
				2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
	Respite		Resources: *reference the $ at Regional Services							Future expansion will be driven by community need, resources and capacity						
	Crisis Respite	Current Status: 1. Through the Community Based '06RFP, an additional 3 homes (each able to serve 1-2 children) have been awarded, and will be implemented in '06.	Resources: *reference the $ at Regional Services							Future expansion will be driven by community need, resources and capacity						
	Crisis Nursery	Current Status: 1. Through the Community Based '06RFP, an additional program to serve approximately 21 children, will be implemented in '06	Resources: *reference the $ at Regional Services				5 beds (+5)	10 beds (+5)	15 beds (+5)	Future expansion will be driven by community need, resources and capacity						
II. Regional Level																
	Group Homes	1. Expand beds to increase capacity for placement into lower level of care. 2. Schedule of expansion acknowledges the challenges in start up efforts Current Status: 1. Through the Community Based '06RFP, an additional 5 homes (serving 8 children each) will be implemented in '06	Resources: - For variety of Home/Community based services *Start up operating:* MH Trust: - $1,110,000 (FY06) - $1,110,000 (FY07) GF/MH(Trust proposed) - $500,000 - *Capital* MH Trust: - $350,000 (FY06) - $350,000 (FY07) Denali Comm (FY05) - $110,000 (existing) - $1,250,000 (new)		10 beds	10 beds	20 beds (+10)	30 beds (+10)	40 beds (+10)	Future expansion will be driven by ongoing assessment of need, resources and capacity						

Expansion of Services & Facilities

System Level	Proposed Enhancements	Activities/Discussion/Status	Resources	Proposed Implementation Schedule & Timelines by Fiscal Year											
				2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
	OCS: BRS * facilities **Behavioral Rehab. Services**	Strategies: 1. Expand beds to increase capacity for kids in the custody of the Office of Children Services (OCS) through the various facilities of Behavioral Rehab. Services. 2. Expand beds to increase capacity for kids who are not in state's custody. 3. Increase capacity for services that allow for services at a lower level of care. Current Status: 1. Behavioral Health Regulations have completed public notice, and are in final legal review: this will allow 55 currently unused beds to be accessible to non-custody children. 2. A Rate Review is currently underway to insure that the economic sustainability of residential facilities is maintained.	Resources: GF/MH (Trust proposed) - $1,500,000 Federal '06 request of $5.5 million			350 beds[1] TOTAL current state capacity	397 beds (+47)	442 beds (+45)	487 beds (+45)	Future expansion will be driven by ongoing assessment of need, resources and capacity					
	Level I: Day Treatment		Resources: -none designated			2 programs 33 custody slots 0 non-custody										
	Level II: Emergency Stabilization & Assessment		Resources: -See Above			14 programs 99 custody beds 50 non custody	159 beds (+10)	169 beds (+10)	179 beds (+10)	Future expansion will be driven by ongoing assessment of need, resources and capacity						
	Level III: Residential Treatment		Resources: -See Above			12 programs 108 custody beds 34 non custody	162 beds (+20)	182 beds (+20)	202 beds (+20)	Future expansion will be driven by ongoing assessment of need, resources and capacity						
	Level IV: Residential	Current Status: 1. A joint venture between a nonprofit and native	Resources:			4 programs 18 custody beds	51									

[1] Child and Youth Needs Assessment (CAYNA) Report

Expansion of Services & Facilities

System Level	Proposed Enhancements	Activities/Discussion/Status	Resources	Proposed Implementation Schedule & Timelines by Fiscal Year											
				2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
	Diagnostic Services	health providers has received funding for a 15 bed facility. This will be operational in '06.	-See Above			8 non custody Total: 36 bed	beds (+15)			Future expansion will be driven by ongoing assessment of need, resources and capacity						
	Regional & Out of State Resource Committees	1. Finalize MOA between OCS, DJJ, and DBH 2. Define policy & procedure for custody and non-custody children	1. MOA is finalized. 2. In process Resources for Committees and Individualized Services: -MH Trust: -$$1,193,000 FY '06 -$700,000 * FY 07 GF/MH(Trust proposed): -$700,000 (FY07) - $150,000 (FY07)			*Measurement is a decline of recidivism by 12% per year										
III. State Level																
	Instate RPTC's	Current Status: 1. Certificat of Need process has been completed, adopted, and implemented. 2. A CON for a Level V facility has been approved for 60 beds (20 secure), and will be operational in '06.	Resources: GF/MH start up oper (Trust proposed): - $500,000 (FY07) Federal '06 request of $4.6 million			101 beds 4 programs 36 custody beds 65 non custody	161 (+60)		200 beds	Future expansion will be driven by ongoing assessment of need, resources and capacity						
	Care Coordination	Current Status: 1. Contract adjustments with 1st Health Corporation completed, resulting in hiring of 2 additional care coordinators	1. Finalized 1/1/05 Resources: -MH Trust: - $85,000 (FY05) -DBH: 1st Health Contract			*Measurement is a the decline in average LOS for OOS placement, by 8% per year										
IV Out-of-State Level																

Expansion of Services & Facilities

System Level	Proposed Enhancements	Activities/Discussion/Status	Resources	Proposed Implementation Schedule & Timelines by Fiscal Year											
				2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
	Gate keeping	1. State utilization surveyors have been hired. 2. State RPTC placement criteria has been re-written and implemented. 3. Level of Care Assessment has been adopted, and applied to the Acute Care facilities in Anchorage.				*Measurement is the decline in the number of OOS placement										
Average RPTC Placements (Placement, & Targeted Reduction*) by Fiscal Year & Unduplicated Count																
				2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
	Instate RPTC Placements	Assumptions: 1. projection is based on a rate of 10% growth per year		215	114	150	165 (+15)	182 (+17)	200 (+18)	220 (+20)	242 (+22)	266 (+24)	292 (+26)	321 (+29)	353 (+32)	388 (+35)
	Out-Of-State RPTC Placements	Assumptions: 1. projection is based on a rate of 15% reduction per year 2. Assumes that community based services will increase capacity to absorb 10% of these placements a year		399	446	500	450 (-50)	400 (-50)	350 (-50)	300 (-50)	250 (-50)	200 (-50)	150 (-50)	100 (-50)	50 (-50)	0
	Total RPTC Placements	Assumptions: 1. rate of total RPTC placements will decline 2. LOS will decline 3. Community –based services will increase 4. Diversions are at a higher level at the beginning and taper down. The assumption is that later diversions will require higher levels of care.		492	560	650	610	582	550	520	492	466	442	421	403	388

Tom Hawkins

Chair, Resource Management Committee

Tom is Chief Operating Officer for Bristol Bay Native Corporation, an ANCSA regional corporation in western Alaska with 7,500 shareholders, $80 million in assets and 3 million acres of land. He is the former Deputy Commissioner of the State Department of Natural Resources, Director of State Division of Lands, and General Manager for Choggiung Limited in Dillingham. Tom is a member of the Alaska Wilderness Recreation and Tourism Association board, the Alaska Land Managers Forum and the Bureau of Land Management's statewide Resource Advisory Council.

Term expires April 2009

Laraine Derr

Laraine is a Juneau resident who has spent much of her career in public service. She most recently served as Director of the Governor's Boards and Commissions Office. Prior to that, Laraine spent seven years as President and CEO for the Alaska State Hospital and Nursing Home Association. That position gave her direct insight into Alaska's healthcare industry. She also served as Commissioner of Revenue, whose duties include service on the Permanent Fund Board, the Alaska Housing Finance Board, and the advisory board for the Alaska State Retirement System. Her experience also includes serving as head of the School of Business and Public Administration for the University of Alaska Southeast. Laraine serves on a number of boards and commissions and is Chair of the University of Alas College of Fellows, University of Alaska Southeast; she is also a member of the University of Alaska Foundation Board.

Term expires March 2010

Beneficiary Groups

Beneficiaries of The Trust include people with mental illness, people with developmental disabilities, people with chronic alcoholism and people with Alzheimer's disease or related disorders.

Advisors

The commissioners of Health and Social Services, Natural Resources, Revenue, and Corrections by statute are important advisors to the Trustees. Trustees also work closely with four advocacy boards that represent Trust beneficiaries. They are the Advisory Board on Alcoholism and Drug Abuse, Alaska Commission on Aging, Alaska Mental Health Board, and Governor's Council on Disabilities and Special Education.

Jeff Jessee
Chief Executive Officer

Delisa Culpepper
Chief Operating Officer

Marie Trueblood
Chief Financial Officer

Marilyn McMillan
Budget Coordinator

Bill Herman
Grant Program Officer

Nancy Burke
Grant Program Officer

Steve Williams
Grant Program Officer

Erika Wolter
Grant Program Specialist
Trainee

Jody Thomas
Administrative Manager

Lucas Lind
Grants Administrator

Yvette Miller
Administrative Support
Specialist

The Trust
The Alaska Mental Health
Trust Authority

550 West 7th Avenue, Suite 1820
Anchorage, AK 99501

907-269-7960

www.mhtrust.org

ABOUT THE TRUSTEES

A DECADE OF TRUST

A seven-member Board of Trustees oversees the Alaska Mental Health Trust. Trustees have a fiduciary responsibility to Trust beneficiaries to enhance and protect the Trust's financial assets. Trustees also oversee the planning, implementation and funding of a comprehensive integrated mental health program to improve the lives of Trust beneficiaries.

Trustees are appointed by the governor and confirmed by the legislature for five-year terms.

John Pugh
Chair, Board of Trustees
Chair, Comprehensive Integrated Mental Health Plan

John is Chancellor of the University of Alaska Southeast in Juneau. He is the former Commissioner of the State Department of Health and Social Services and Director of the Division of Family and Youth Services. John serves on various boards and commissions related to higher education in Alaska and the Northwest. The past two years he has chaired the Northwest Regional Education Laboratory.

Term expires March 2006

William Doolittle, MD
Vice Chair, Board of Trustees

Bill is a retired physician who serves as a medical consultant to the Social Security Administration and the Alaska Division of Vocational Rehabilitation. He retired from the day-to-day practice of medicine in 1997, but maintains his medical certification and is licensed in Alaska. His 43-year career included serving five terms as chief of staff at Fairbanks Memorial Hospital, medical director of the North Pole Fire Department EMS Service, director of the Arctic Medical Research Laboratory and chief of medicine for Bassett Army Hospital at Fort Wainwright. He began his medical training and career in the Army and retired with the rank of lieutenant colonel. He graduated from the University of Vermont with degrees in science and medicine. Currently he serves on the Fairbanks Memorial Hospital Foundation Board of Trustees and the Fairbanks Chronic Inebriate Program Task Group. The task group is a community partnership with representatives from healthcare, law enforcement and the judicial system who are attempting to improve the lives of people dealing with chronic alcoholism.

Term expires July 2004

Margaret Lowe
Secretary, Treasurer, Board of Trustees
Chair, Rural Outreach Committee

A longtime advocate for children and adults with developmental disabilities, Margaret began her career as a teacher and retired in 1986 from the Anchorage School District after 20 years in the classroom, as a principal and as a program administrator, primarily working in special education. She went on to serve as director of the State Division of Mental Health and Developmental Disabilities and became Commissioner of Health and Social Services in 1993, a post she held at the time of the Trust Settlement. She is active on many boards and commissions throughout the state, including the Association for Retarded Citizens of which she was a charter member in 1967. She is also a past member of the Council for Exceptional Children and the Governor's Council on Mental Retardation, which she helped transition into the Alaska Developmental Disabilities Council. Margaret earned a bachelor of science in education at the University of Minnesota, a master of arts in education at the University of Alaska Fairbanks, and an education specialist certificate in public school administration from the University of Alaska Anchorage.

Term expires April 2010

Nelson G. Page
Chair, Finance Committee

Nelson is a shareholder in the Anchorage law firm of Burr, Pease and Kurtz, where he has practiced law for 22 years. He is a member of the Alaska Bar Association Ethics Committee, and past member of the Bar Association's Board of Bar Examiners Area Discipline Committee and the Alaska Supreme Court's Standing Committee on Civil Rules. His past community service includes four years on the Alaska Mental Health Board, membership on the Anchorage Transportation Commission, and membership on the Board of Directors of the Suicide Prevention and Crisis Intervention Center. Nelson is a graduate of Portland State University and the Georgetown University Law Center.

Term expires March 2007

John E. Malone
Chair, Program & Planning Committee

John is the Land Use and Planning Administrator for the City of Bethel. He has had extensive experience in the mental health community in Alaska, having served as a member of the Alaska Mental Health Board for five years and as State President of the Alaska Alliance for the Mentally Ill for four years. John was chair of the Federal Region X State Presidents Council of the National Alliance for the Mentally Ill and co-chaired the Mental Health Quality Improvement Task Force. He is a former Executive Director of Bethel Community Services, Inc.

Term expires March 2005

Photo courtesy of Alaska Rainforest Sanctuary Ketchikan, Alaska

Commercial Tourism Opportunities

Information

Maps and answers to general Mental Health Trust Land questions can be found at the Department of Natural Resources Public Information Offices.

DNR Public Information Offices
Northern Region, Fairbanks, (907) 451-2705
Southcentral Region, Anchorage, (907) 269-8400
Southeast Region, Juneau, (907) 465-3400

More specific questions should be directed to the Trust Land Office at (907) 269-8658, or email at **MHTLO@dnr.state.ak.us.**

Questions about the use of revenues should be directed to the Alaska Mental Health Trust Authority Office at (907) 269-7960.

Trust Land Office
718 L Street, Suite 202
Anchorage, AK 99501
Tel: (907) 269-8658; Fax: (907) 269-8905
www.mhtrustland.org

Alaska Mental Health Trust Land Office
718 L Street, Suite 202
Anchorage, AK 99501

The Alaska Mental Health Trust

Trust Land Office

The Trust

The *Alaska Mental Health Trust* was established by Congress in 1956. The 1956 law included a grant of one million acres of land to be used to generate revenues to meet the expenses of mental health programs in Alaska. In the mid-1980s a citizen lawsuit was filed claiming mismanagement of these lands. In 1994 the Alaska Superior Court and Alaska Legislature took actions, which effectively settled the litigation. The settlement created the Alaska Mental Health Trust Authority whose responsibility is to ensure the creation of a comprehensive integrated mental health program for Alaska.

Trust Beneficiaries

Alaska Mental Health Trust beneficiaries include people with mental illness, people with developmental disabilities, people with chronic alcoholism, and people with Alzheimer's disease or related dementia.

Trust Land Office

The 1994 settlement reconstituted the Alaska Mental Health Trust and the related legislation transferred nearly one million acres of land to the Alaska Mental Health Trust Authority. It also required the creation of a separate unit within the Department of Natural Resources, the Trust Land Office. This office was established to manage the lands under contract to the Alaska Mental Health Trust Authority. Trust Land Office activities are funded from Alaska Mental Health Trust income, not the General Fund.

Oil & Gas Exploration

Trust Land Office Mission

The Trust Land Office manages Mental Health Trust Land to generate income that is used by the Alaska Mental Health Trust Authority to improve the lives and circumstances of Trust beneficiaries.

Trust Land Opportunities

- Real estate opportunities uniquely situated for residential and commercial activities, including opportunities for development related to recreation and tourism.
- A wealth of natural resources including: commercial timber, hard rock minerals, coal, oil and natural gas.
- An enthusiastic Trust Land Office staff, dedicated to generating revenues from Mental Health Trust Land.
- A flexible business-oriented decision making process that encourages creative and sensible projects.
- The knowledge that revenues generated from Mental Health Trust Lands go to improving the lives and circumstances of trust beneficiaries.

Real Estate Development

Timber Opportunities

Trust Land Office Management Guiding Principals

- Be loyal and accountable to the Alaska Mental Heath Trust and its beneficiaries.
- Maximize revenues from Trust Land and resource assets over time.
- Protect and enhance the value and productivity of Trust Land.
- Manage Trust Land prudently, efficiently and with accountability to The Trust and its beneficiaries.
- Encourage a diversity of revenue-producing uses of Trust Land.
- Emphasize innovative solutions.

2/14/06 OVERVIEW: GOV.'S BUDGET PROPOSAL

Senate Finance Snapshot
of
The Governor's
Budget Proposal

2/14/06

	Available to Spend - 24th Legislature - 2nd Session	
A	FY 06 Surplus (1/10/05 estimate)	$1,200
B	FY 07 Unrestricted General Fund Revenue (Fall Revenue Forecast)	$3,139
C	**Total General Fund Revenue Available to Spend (our checkbook)**	***$4,339***

Minus

	Governor Proposed Spending Bills			Legislature
D	Operating Budget FY07 (SB 228 + K-12)	*$*	*3,103.60*	$ -

Minus

E	Energy Supplemental FY06 (SB 232)	$	52.00	
F	Capital Supplemental FY06 (SB 233)	$	129.40	
G	Regular Supplemental FY06 (SB 263)	$	99.90	
H	Fast Track Supplemental FY06 (SB 264)	$	13.50	
	Total Supplementals	*$*	*294.80*	$ -

Minus

I	Capital Budget (SB 231)	*$*	*432.10*	$ -

Minus

J	"Other" - Gas Pipeline Equity FY07	$	400.00	
K	"Other" ~ Legislation (12/15 OMB handout) FY07	$	28.00	
L	"Other" ~ Budget amendments FY07	$	-	
	Total "Other"	*$*	*428.00*	$ -

Minus

M	FY 07 Supplemental (estimate)	*$*	*75.00*	$ -

Leaves

O	Savings	*$*	*5.50*	$ -

Income	
FY 06 Surplus (1/10/06 estimate)	$1,200
FY 07 Unrestricted General Fund Revenue	$3,139
Total Revenue (millions)	**$4,339**

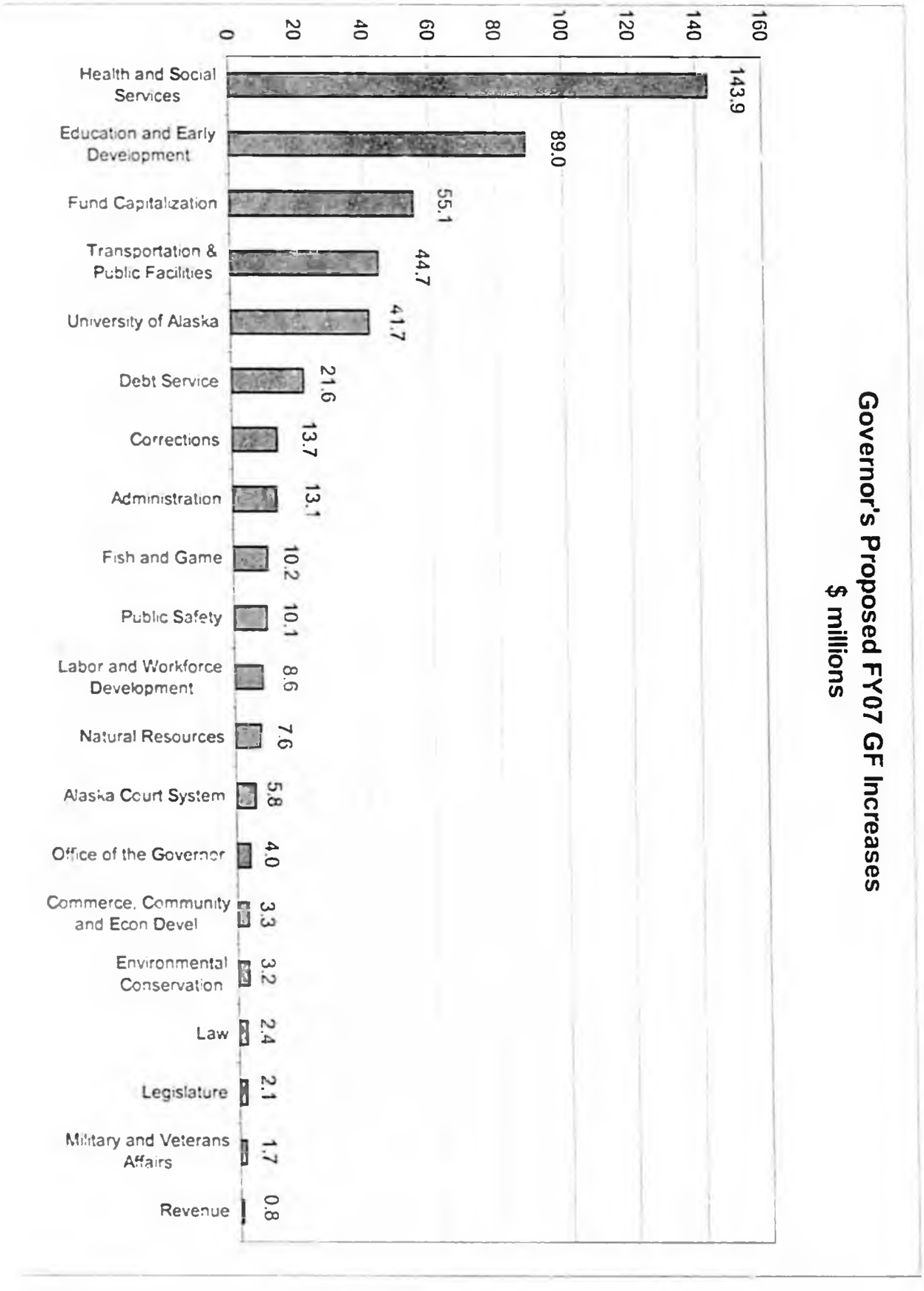
FY 2006	
Gas Pipeline Equity	$400
FY06 Energy Supplemental (SB 232)	52
FY06 Capital/Deferred Maintenace (SB 233)	129.4
FY 06 Regular Supplemental (SB 263)	99.9
FY 06 Fast Track Supplemental (SB 264)	13.5
FY 07 Legislation	28
Subtotal	**$722.8**

FY 2007	
FY06 Base Operating	$2,620
FY07 Fixed Operating Increases	210
FY07 Variable Operating Increases	273
FY07 Operating Total	$3,103.6
FY07 Supplemental (estimate)	75
FY07 Capital (12/15/05)	432
Subtotal	**$3,611**

FY 2008	
Education Fund	$0
Debt Retirement Fund	$0
Subtotal	**$0**

Out Years	
Permanent Fund Earnings Reserve	
Constitutional Budget Reserve	
Permanent Fund Principal	
Subtotal	**$0**

Total Proposed Spending	**$4,333.5**
Savings	**$5.5**
Surplus	**$0.0**


Governor's Proposed FY07 GF Increases
$ millions
0
20
40
60
80
100
120
140
160
Health and Social Services 143.9
Education and Early Development 89.0
Fund Capitalization 55.1
Transportation & Public Facilities 44.7
University of Alaska 41.7
Debt Service 21.6
Corrections 13.7
Administration 13.1
Fish and Game 10.2
Public Safety 10.1
Labor and Workforce Development 8.6
Natural Resources 7.6
Alaska Court System 5.8
Office of the Governor 4.0
Commerce, Community and Econ Devel 3.3
Environmental Conservation 3.2
Law 2.4
Legislature 2.1
Military and Veterans Affairs 1.7
Revenue 0.8

Alaska North Slope Production Forecast				
Fiscal Year	**Currently Producing**	**Under Development**	**Under Evaluation**	**Total ANS**
2000				1.040
2001				0.991
2002				1.004
2003				0.991
2004				0.980
2005	0.917			0.917
2006	0.815	0.051		0.866
2007	0.724	0.114	0.005	0.843
2008	0.658	0.138	0.035	0.831
2009	0.602	0.146	0.086	0.834
2010	0.555	0.149	0.128	0.832
2011	0.514	0.145	0.194	0.853
2012	0.479	0.136	0.231	0.846
2013	0.449	0.127	0.242	0.818
2014	0.423	0.121	0.244	0.788
2015	0.400	0.118	0.244	0.762
2016	0.380	0.114	0.306	0.800

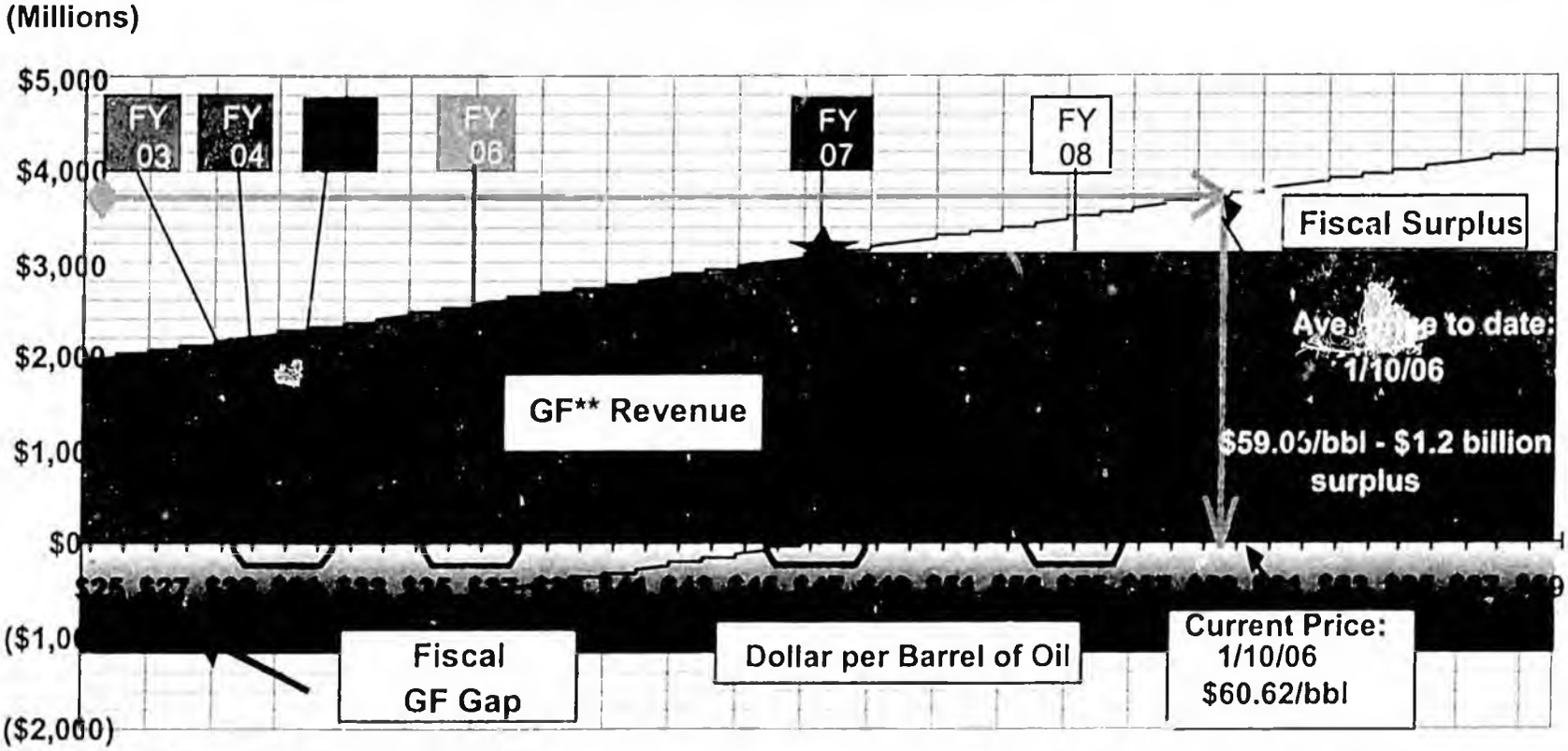
Some of the oil forecasted in the Under Development and Under Evaluation categories are from new projects in fields currently producing.

Trouble Ahead...???

Fiscal Year 2008 (Estimated Fiscal Summary)		
FY07 Base Operating	$3,103	Assumes Governor's FY07 proposed operating budget is adopted
FY08 Fixed Operating Increases	220	Assumes 7% fixed cost increase. (PERS/TRS, Health Insurance, Debt Service & Fund Capitalization, Contracts)
Estimated Major FY08 Variable Operating Increases	150	Medicaid ~ $50 million K-12 formula ~ $50 million Agencies/U of A increments ~ $50 million
FY08 Operating Total	$3,473	
FY07 Supplemental (estimate)	75	Estimated Placeholder (this year FY06 = $294 million)
FY08 Capital	133	Minimum [illegible] F Match for Federal road funds
Total FY 08 Spending	$3,681	

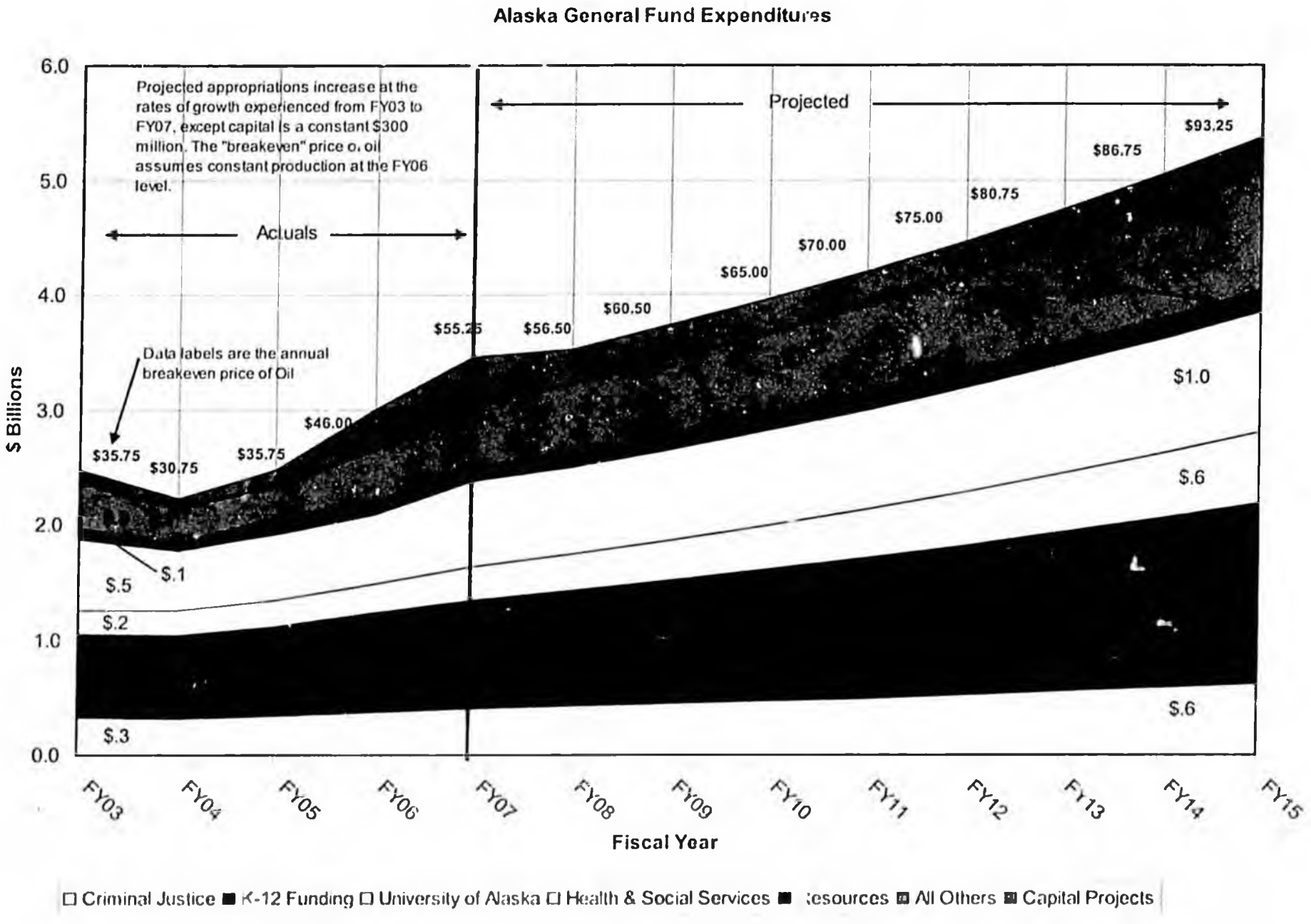
FY 08 Revenues	$3,000	Estimated at $49 dollars per barrel @.831 barrels/day (Dept. of Revenue Fall Forecast)
Surplus ?	$0	Assumes no carryforward (surplus) from FY07
Surplus/Deficit	($681)	

Projected Fiscal Gap/Surplus at Various Year-End Average ANS Crude Prices
$3.1 Billion FY07 General Fund Operating Budget with
FY 03 - 08 Breakeven Points added



* Assumes $60 million placeholder for supplemental appropriations

**Unrestricted GF Revenue required for government operations, includes revenues not directly affected by fluctuations in oil prices Assumes DOR Fall 2005 Revenue Forecast


Alaska General Fund Expenditures
Projected appropriations increase at the rates of growth experienced from FY03 to FY07, except capital is a constant $300 million. The "breakeven" price of oil assumes constant production at the FY06 level.
Actuals
Projected
Data labels are the annual breakeven price of Oil
$35.75
$30.75
$35.75
$46.00
$55.25
$56.50
$60.50
$65.00
$70.00
$75.00
$80.75
$86.75
$93.25
$1.0
$.6
$.6
$.5
$.1
$.2
$.3
$ Billions
6.0
5.0
4.0
3.0
2.0
1.0
0.0
FY03
FY04
FY05
FY06
FY07
FY08
FY09
FY10
FY11
FY12
FY13
FY14
FY15
Fiscal Year
Criminal Justice
K-12 Funding
University of Alaska
Health & Social Services
Resources
All Others
Capital Projects

	A	B	C	D
1	**Governor's 12/15/05 Proposed Fiscal Year 2007 Operating Budget - Preliminary Analysis #2**			
2	**Fiscal Year 2006 Operating Budget Totals**		***Change - FY 05 to FY 06***	
3	FY05 Management Plan	$2,321,477,000		
10	**FY 06 Budget with Fixed Costs Increases**	**$2,495,200,800**	**7.48%**	
11	*FY 06 Program Increments (Variable cost)*	$133,062,600	5.73%	
12	**FY 06 Operating Budget**	**$2,628,263,400**	**13.22%**	
13	FY 06 New Legislation (Fiscal Notes)	$11,429,100		
14	FY 06 Operating Budget (Conference Committee)	$2,639,692,500		
15	Management Plan Adjustments	-$18,861,000	Back out Local Government PERS Relief	
16	FY 06 Base Budget	$2,620,831,500		
17	**Fiscal Year 2007 Operating Budget Increments**		***Change FY 06 to FY 07***	
18		**Fixed Cost Increases**		
19	*Executive Agencies & UA Contracts*	$20,200,000		
20	*Executive Agencies & UA Health Insurance Costs*	$8,900,000		
21	*Executive Agencies Risk Management Insurance Costs*	$9,400,000	Self-insurance cost increases	
22	*Executive Agencies & UA PERS Relief*	$33,900,000	Figures 5% higher than FY06	
23	*K-12 TRS Relief*	$40,000,000		
24	*Medicaid - Fair Share*	$45,000,000	Lost appeal in 9th Circuit Court	
25	*Debt Service & Fund Capitalization*	$22,000,000		
26	*Major Maintenance Grant Fund*	$25,100,000	FY07 Capital Spending adopted in FY06 Capital budget	
27	*Arizona Prison Contracts*	$2,900,000		
28	*2006 Elections*	$2,800,000	Biennial cost	
29	**FY 07 Fixed Cost Increases**	**$210,200,000**		
30	**FY 07 Budget with Fixed Costs Increases**	**$2,831,031,500**	**8.02%**	Fixed % increase above FY06 operating budget
31		**Variable Cost Increases**		
32	*Medicaid Formula*	$53,300,000		
33	*Other H&SS increments*	$29,300,000	Total less Medicaid increases and Fairshare replacement funding	
34	*K-12 Formula Increase*	$50,000,000	Does not include PRS Costs	
35	*PCE Funding*	$16,000,000		
36	*Executive Agencies & UA Fuel Costs*	$14,700,000		
37	*Marine Highway System Expanded Services*	$9,700,000	Expanded service	
38	*DOT Increased Maintenance*	$6,300,000	Statewide or Targeted?	
39	*Teacher & Principal Mentoring*	$5,000,000	Program expansion	
40	*Youth First Initiative*	$4,000,000	New Program	
41	*Bring the Kids Home*	$3,800,000	Program expansion	
42	*Disaster Relief upfront funding*	$3,000,000		
43	*Senior Care*	$11,000,000		
44	*Epidemiology public health labs*	$3,000,000	Expansion of program	
45	*Public Advocacy & Public Defender*	$2,900,000		
46	*Wildlife Conservation - Game Management*	$2,900,000	Program expansion	
47	*"Top 15% in Class" Tuition Program*	$5,000,000	Expansion from 10% to 15%	
48	*UA Program Increment Requests*	$17,800,000		
49	*Executive Agencies Program Increments*	$34,850,000	Contains all other increments less that $2.5 million	
50	**FY 07 Variable Cost Increases**	**$272,550,000**		Variable % increase above FY06 operating budget
51	**FY 07 Budget with Fixed & Variable Costs Increases**	**$3,103,581,500**	**10.40%**	
52	*New Legislation*	$28,000,000	Gov's request of $118 million less $90 million for K-12 education	
53	*Community Dividend - Revenue Sharing*	$0	Proposes use of $27.5 of AM Hess Funds that was used for FY06 Capital Budget	
54	**FY 07 New Legislation Increases**	**$28,000,000**	**1.07%**	
55	**FY 07 Budget w/Fixed, Variable & New Legislation Increases**	**$3,131,581,500**	**19.49%**	
56	**Potential Increase over FY06 Operating Budget**	**$510,750,000**		Total increase over FY06 operating budget
57				
58				
59	Other potential increments:			
60	*Federal Medicaid Assistance Program - $75,000,000*		$0 Congress debating 2 year extension	

2/16/06 PRESENTATION: LONG-TERM FORECAST OF MEDICAID ENROLLMENT

Alaska State Senate

Senate Finance Committee

Official Business

Mail Stop 3100
State Capitol
Juneau, Alaska 99801-1182

AGENDA

Thursday, February 16, 2006
9:00 a.m.

Presentation by Lewin Group:
Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025

Bills previously heard/scheduled

The LEWIN GROUP

ECONorthwest

Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025

Prepared for:
Alaska Department of Health and Social Services

February 15, 2006

1

Who, What, and Why…

In March 2005, DHSS contracted with the Lewin Group and ECONorthwest to build a model that would allow DHSS staff to project long-term trends in Medicaid spending.

2

Who, What, and Why (cont.)...

This model will allow DHSS staff to update long-term spending projections as additional data become available.

3

Who, What, and Why (cont.)...

In addition, we were asked to prepare a report that describes the forecasting model and presents the finding of the "baseline" analysis.

4

Who, What, and Why (cont.)…

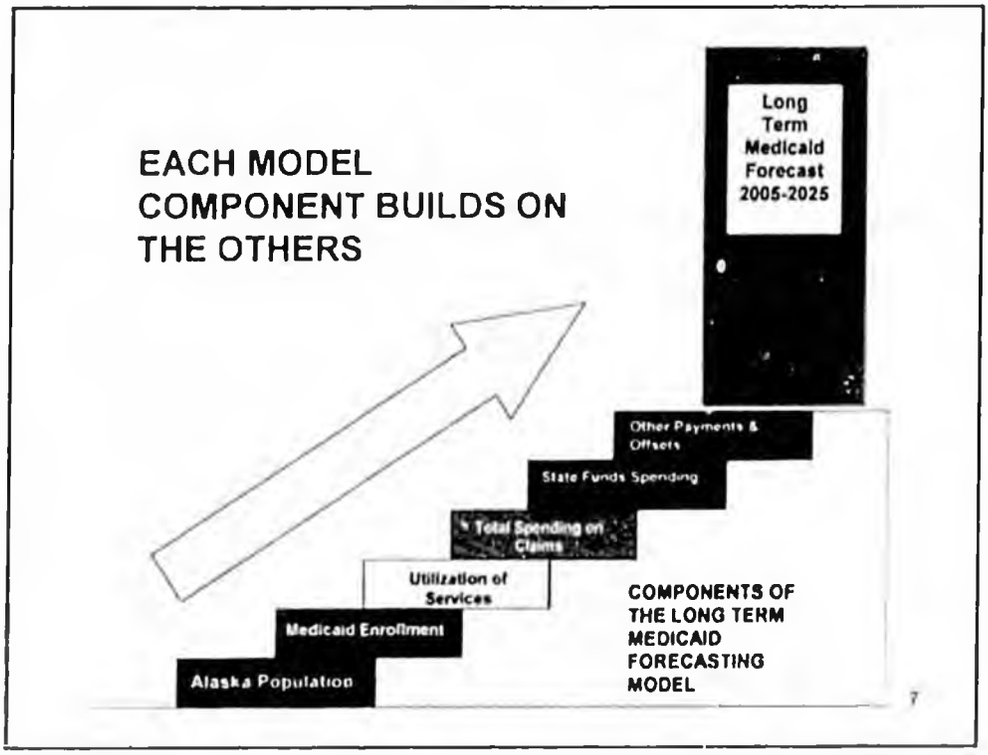
This presentation presents key findings from that analysis.

5

Presentation Outline

- "Steps" of the analysis
- Findings
  - Population
  - Enrollment
  - Utilization
  - Total spending
  - State matching fund spending
- Going Forward

6



Some factors are within your control…

- Eligibility requirements
- Reimbursement rates
- Services provided

And some factors are outside of your control…

- Population growth
- Demographic changes
- Changes in medical technology

9

Assumptions Regarding Baseline Analysis

- Assumes status quo as of FY2004
- Does not anticipate policy changes, such as these 2005 & 2006 measures
  - Cost containment
  - Bring the Kids Home initiative
  - Personal Care Attendant regulation changes
  - Medicare Part D drug benefit

10

Alaska Population

Alaska Population

The 65 and older population is projected to grow rapidly, almost tripling from 43,000 to 124,000 between 2005 and 2025.

12

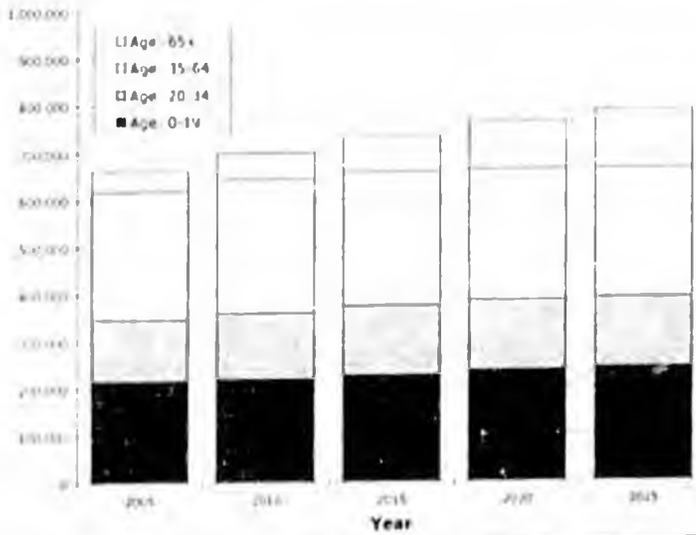
Alaska Population

- The rate of growth in the state's population will slow over the next 20 years from just over 1.0% currently to less than 0.6% by 2025
- Population growth will be concentrated in the Anchorage/Mat-Su Region
- We project the Southeast will lose population through 2025
- The Native population will grow faster than the Non-Native population (1.7% vs. 0.7%)

13

Alaska Population

Alaska's population growth will be driven by the elderly



14

Medicaid Enrollment

Medicaid Enrollment

- We Project Medicaid Enrollment will grow faster than the state's population (1.4% vs. 0.85%).
- Enrollment will grow from 132,000 in 2005 to 175,000 by 2025

16

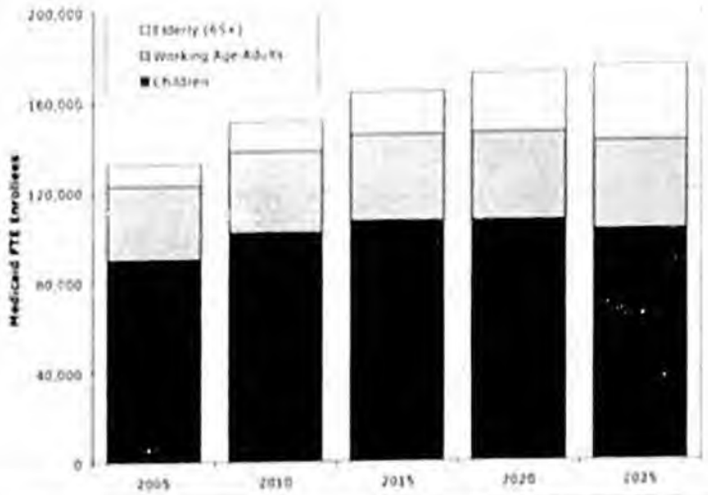
Medicaid Enrollment

- Medicaid enrollment will grow much faster for the elderly than for the entire population (6.0% vs. 1.4%)
- Elderly enrollment will grow from approximately 10,000 in 2005 to 33,000 by 2025

17

Medicaid Enrollment

Most of the projected growth in Medicaid enrollment will be in the elderly age cohort



18

Utilization of Services

Utilization of Services

A quick note…

- We define Service Utilization as the annual unduplicated count of persons who used a particular Medicaid Service during the fiscal year.

20

Utilization of Services

Growth in utilization will differ greatly among Service categories

- Some will grow very rapidly
  - Personal Care: 9.7%
  - HCB Waiver: 9.0%
  - Residential Psychiatric:7.3%
- Some will grow slowly or even decline
  - Inpatient Hospital: 0.6%
  - Lab/X-ray: -0.1%
  - Inpatient Psychiatric: -0.3%

21

Utilization of Services

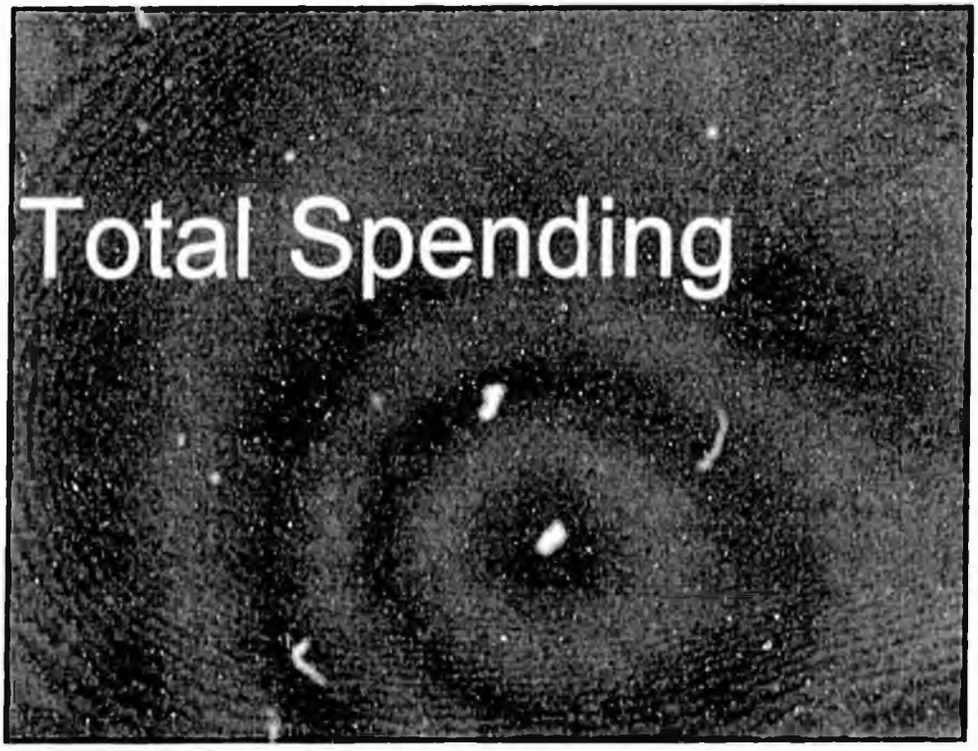
Across all Medicaid Service categories, we rely upon the CMS' national forecast of growth in utilization of 2.2% to guide growth in Alaska's Medicaid utilization.

22

Utilization of Services

Partially offsetting the projected growth in HCB Waiver is relatively slow projected growth in the Nursing Home Service category (4.2% through 2025).

23



Total Spending

Of primary importance are our findings related to the direction and approximate magnitude of changes in spending on the Medicaid Program

25

Total Spending

- Total spending on Medicaid Services is forecasted to be $1.0 billion in CY2005.
- By CY2025
  - In *actual* terms, we project total spending to grow by 7.6% per year to $4.8 billion.
  - In *inflation adjusted* terms, we project total spending to grow by 3.8% per year to $2.2 billion.

26

Total Spending

Currently (i.e., in 2005)…

- Inpatient Hospital Services is the largest Medicaid Service category, responsible for 15% of total spending.
- Comparatively,
  - HCB Waivers constitutes approximately 11% of spending
  - Personal Care constitutes approximately 10% of spending

27

Total Spending

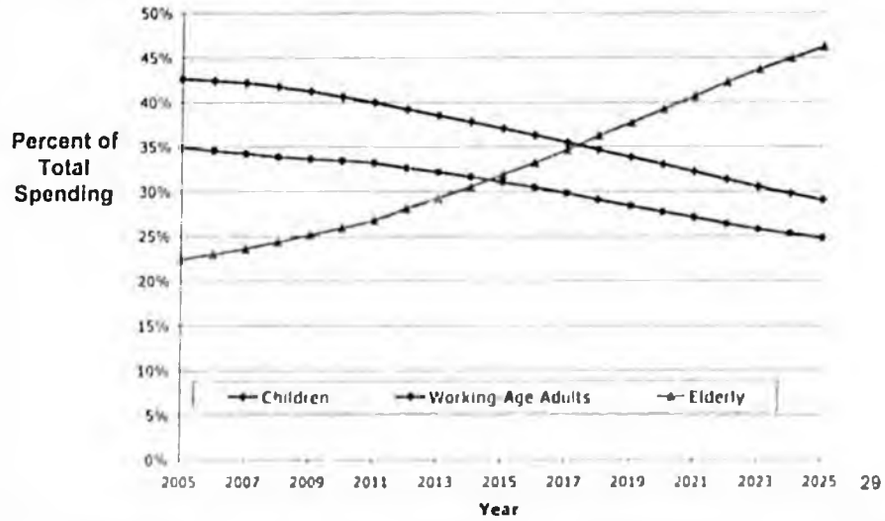
We project that in 2025…

- Inpatient Hospital Services will be only about 5% of total Medicaid Service spending.
- HCB Waivers will be about 22% of total Medicaid Service spending.
- Personal Care will be about 27% of total Medicaid Service spending.

28

Total Spending

Spending on Elderly will Surpass Spending on Working-Age Adults by 2015 and Spending on Children by 2018



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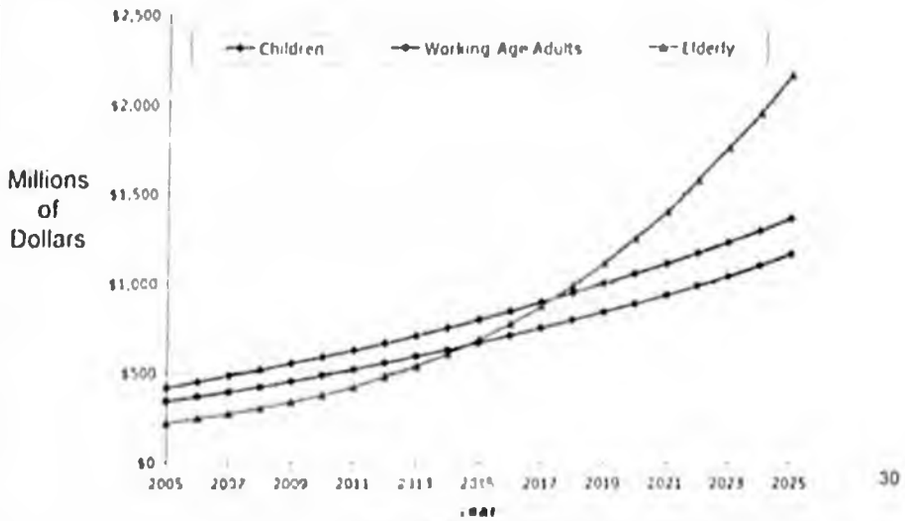
Total Spending

Forecasted Spending by Age Cohort, Calendar Years 2005-2025



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Total Spending

DHSS staff can conduct *long-term* policy scenarios using the long-term Medicaid forecasting model.

31

Total Spending

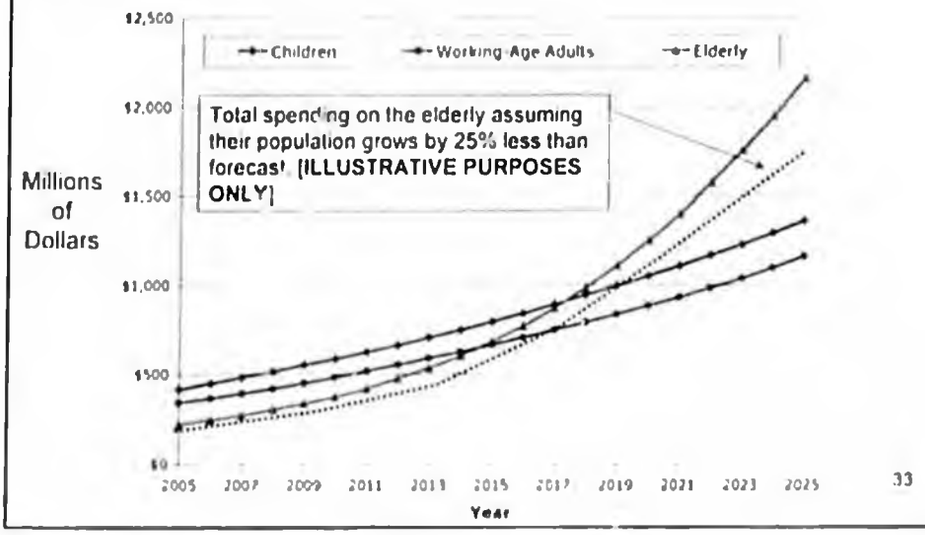
For example…

What is the effect on total Medicaid spending if the elderly population grows slower than is forecasted by the Alaska Department of Labor?

32

Total Spending

Forecasted Spending by Age Cohort, Calendar Years 2005-2025



33

Total Spending

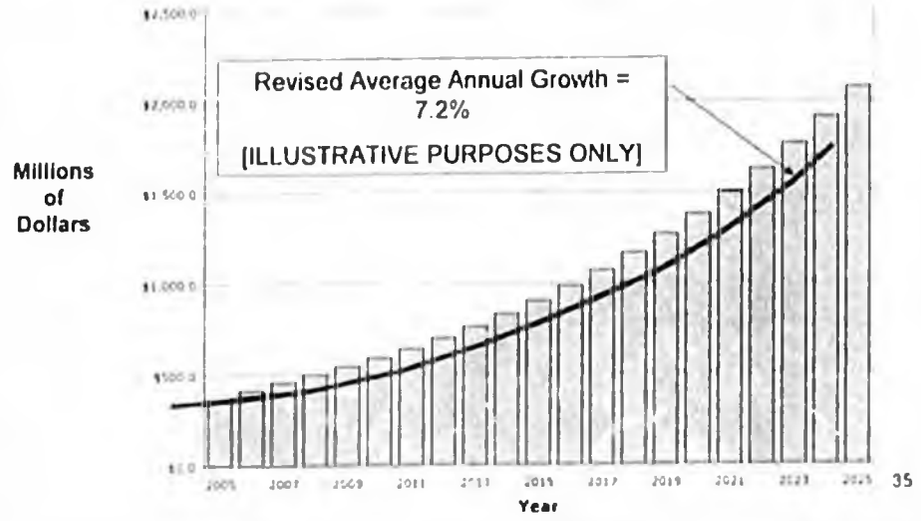
Or…

What is the effect on total Medicaid spending if utilization of Medicaid Services grows slower than is forecasted in the baseline projections?

34

Total Spending

Forecasted total spending assuming slow utilization growth



Total Spending

Comparison to national trends…

- Nationally, CMS projects Medicaid spending will grow by 7.5% per year through 2014
- Over this same period, we project Total Medicaid spending in Alaska will increase by 7.7%

36

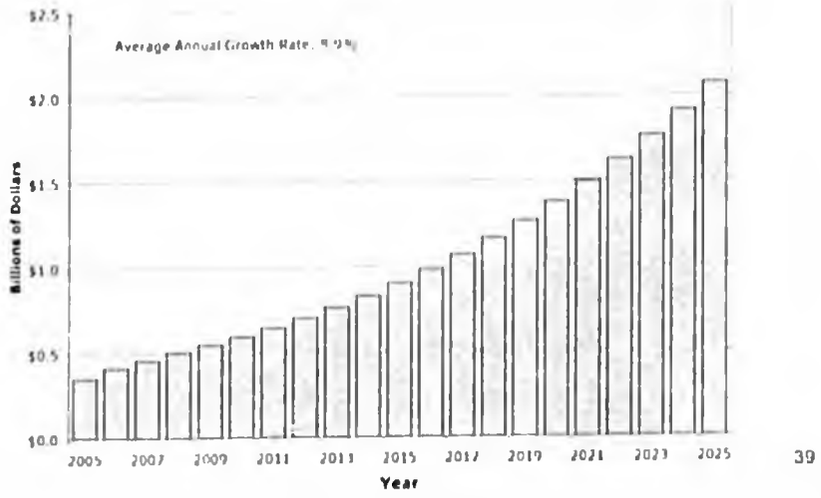
State Funds Spending

- State matching fund spending on Medicaid Services was approximately $380 million in CY2005.
- By CY2025…
  - *Actual* spending will grow to approximately $2.1 billion.
  - *Inflation adjusted* spending will grow to approximately $1.0 billion.

38

State Funds Spending

State Matching Fund Spending on Medicaid Claims to Grow 8.9% Annually



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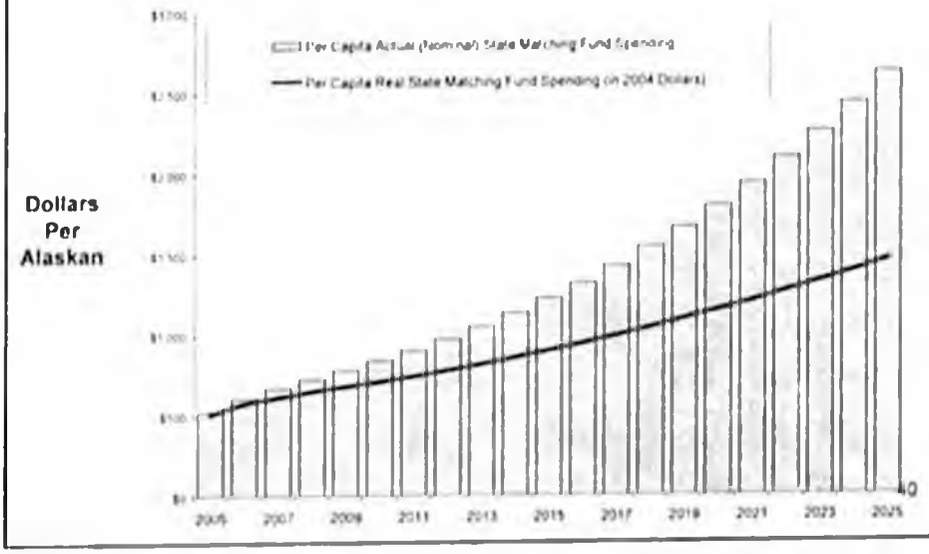
State Funds Spending

Projected per capita state matching fund spending on Medicaid Services will grow substantially .



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Going Forward

Going Forward

"The Alaska Medicaid program will fundamentally change over the next 20 years from a program that centers on children to one that is dominated by seniors."

Janet Clarke
Assistant Commissioner, DHSS

42

Going Forward

Some factors are within your control…

- Eligibility requirements
- Reimbursement rates
- Services provided

43

The complete report is available on the Internet at:

www.hss.state.ak.us/das

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The LEWIN GROUP

and

ECONorthwest

Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025

Prepared for:

State of Alaska
Department of Health and Social Services

Prepared by:

The Lewin Group and ECONorthwest

Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025

Ted L. Helvoigt
John F. Sheils
The Lewin Group and ECONorthwest

Frank H. Murkowski, Governor
State of Alaska

Karleen K. Jackson, Commissioner
Department of Health and Social Services

Janet Clarke, Assistant Commissioner
Finance and Management Services

February 15, 2006

This report is available on the Internet at:

www.hss.state.ak.us/das

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Acknowledgements

This analysis was developed under the auspices of the Alaska Department of Health and Social Services. The Department's Steering Committee provided valuable insight and comment at all stages of this project. First and foremost we would like to thank Jill Lewis, the Project Director, for her invaluable support with all aspects of this project. We would also like to thank the other members of the Steering Committee, which includes Janet Clarke, Laura Baker, Jon Sherwood, Doug Jones, Patrick Sidmore, Teri Keklak, Kate Bowns, Patricia Noel, and Judy Skagerberg. In addition, we would like to thank Ingrid Zaruba and Greg Williams of the Alaska Department of Labor and Workforce Development for providing us with historic and forecast population data for the State of Alaska. The contents of this document do not necessarily reflect views or policies of the State of Alaska.

Table of Contents

Executive Summary

In April 2005 the Alaska Department of Health and Social Services (ADHSS) contracted with the Lewin Group and ECONorthwest to develop a long-term forecasting model of Medicaid spending for the State of Alaska. This document describes the steps undertaken in the development of the forecasting model and provides details on the projected growth in enrollment, utilization, and spending on Alaska's Medicaid program through 2025.

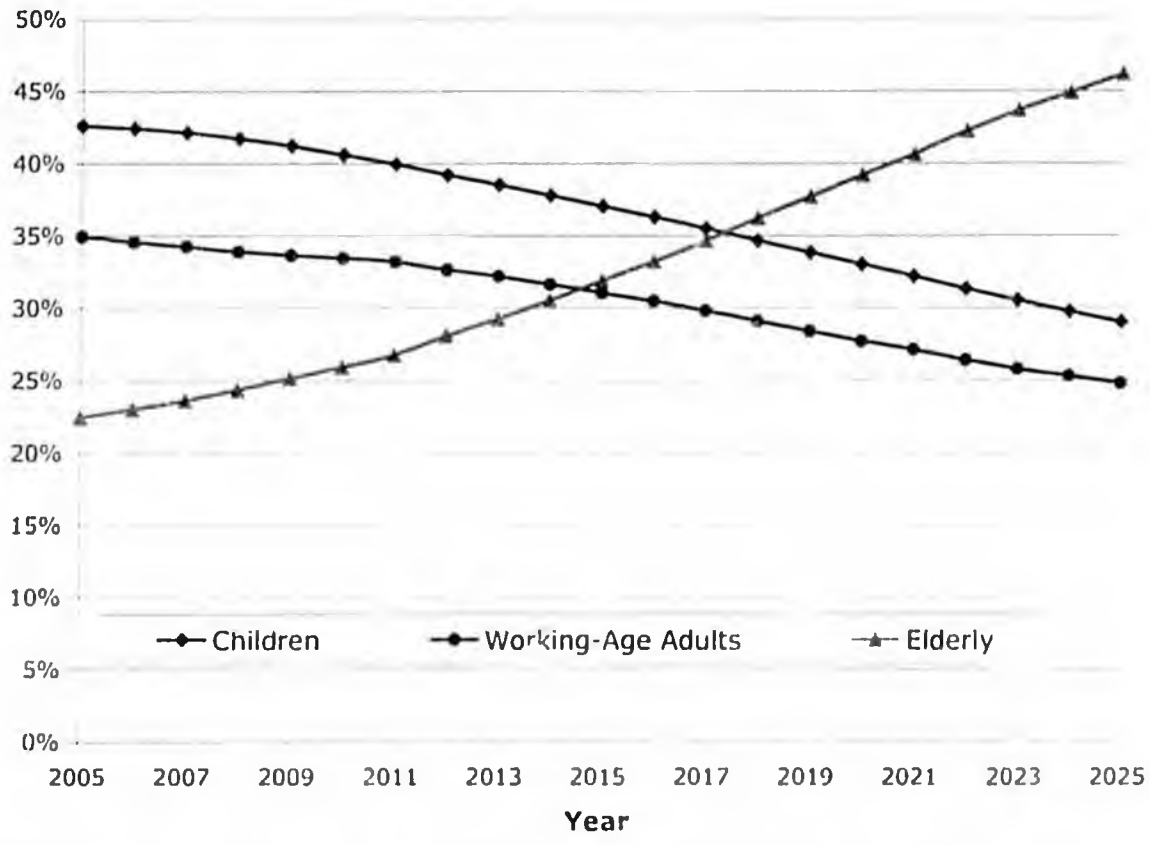
This report is intended to inform ADHSS executives and the Alaska State Legislature of the substantial projected growth in total spending on Alaska's Medicaid program and the projected growth in state matching fund spending on the Medicaid program. The projections of total and state matching fund spending presented in this report assume that the mix of Medicaid services remains constant and that eligibility criteria do not change in the future. These assumptions were necessary to show how Medicaid spending in Alaska would grow under the program's status quo. The statistical models developed for this analysis will be provided to ADHSS staff providing them the ability to update the Medicaid forecast as more timely data become available.

KEY FINDINGS

The Alaska Medicaid program will fundamentally change over the next 20 years from a program that centers on children to one that is dominated by seniors (age 65 and older). This is a result of changes in Alaska's demographic profile, which will include many more seniors. On a per-recipient basis, spending on Medicaid services for seniors is substantially higher than spending for children. As this portion of the population grows rapidly over the next 20 years, Medicaid spending will also grow rapidly. In calendar year 2005, approximately 42% of spending on Medicaid claims was devoted to children and 22% was devoted to seniors. By 2025, we expect that approximately 45% of Medicaid spending will be devoted to seniors and approximately 30% will be devoted to children. As Figure 1 shows, we expect spending on Medicaid claims for the elderly to surpass spending on the working-age population by 2015 and to surpass spending on children by 2018.

Figure 1: Spending on Elderly will Surpass Spending on Other Age Groups by 2018

Forecasted Proportion of Total Spending on Medicaid Claims by Age Group, 2005-2025



Source: Lewin Group & ECONorthwest analysis of Alaska Department of Health and Social Services data.
Note: Spending projections are on an incurred service basis.

Among the key findings of this report are the following:

- More important than any of the other factors in our projection of the Alaska population, the 65 and older population is projected to grow rapidly, almost tripling from 43,000 to 124,000 between 2005 and 2025.

- Alaska's Medicaid program has been a program dominated by spending on services for children but it will change to one much more focused on the elderly. This change will affect the mix of benefits that Medicaid provides and, more importantly, the cost. Average per-recipient costs of Medicaid services are much higher for the elderly than for children.

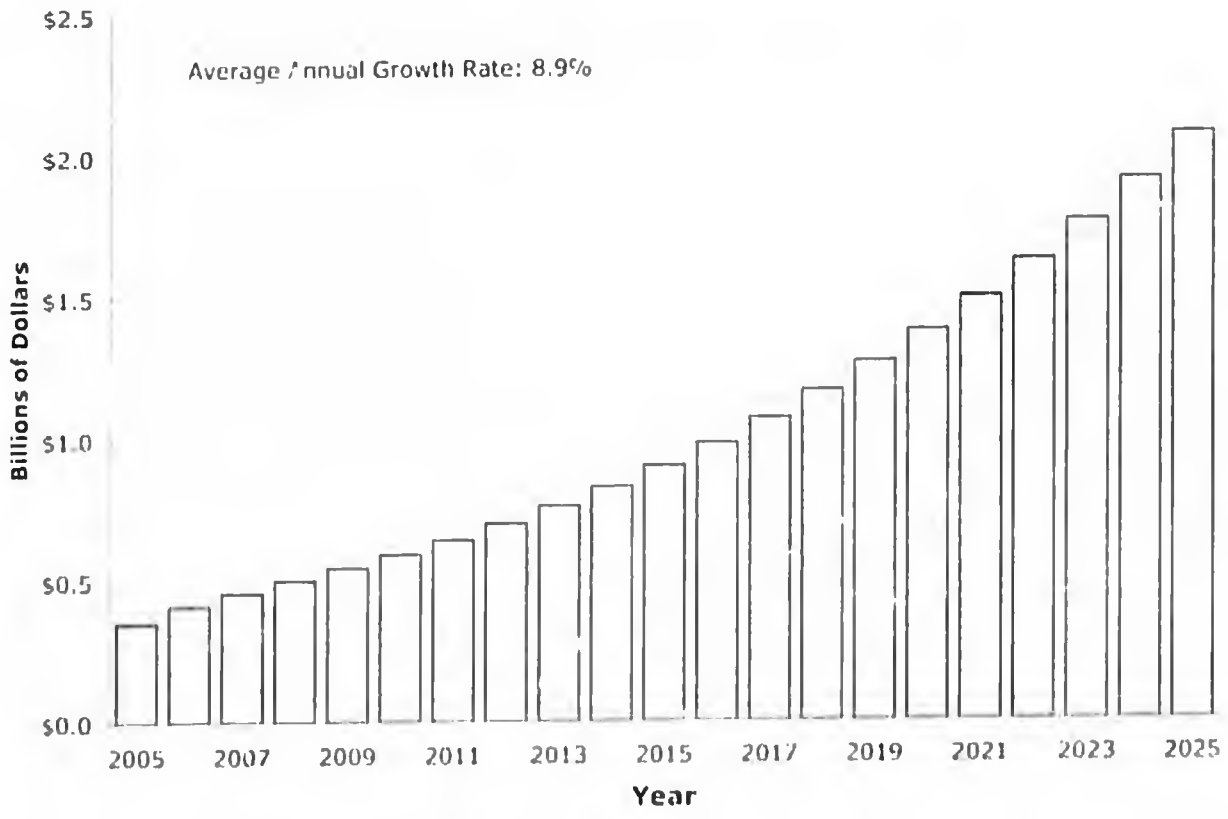
- Projected to grow a little faster than the state's population, we expect Medicaid enrollment—on a full time equivalent basis—to reach 131,000 by 2025 (compared to 95,000 in 2004).

- Total spending on Medicaid claims will increase from approximately $975 million in CY 2005 to approximately $4.7 billion in CY 2025.

- An increasing share of the Medicaid burden will be shifted away from the federal government to the state. State matching funds for Medicaid claims are projected to increase at a faster rate than the total Medicaid program—8.9% versus 7.6% for total funds (see Figure 2).

Figure 2: State Matching Fund Spending on Medicaid to Grow 8.9% Annually

Total Forecasted State Matching Funds for Medicaid Claims (in Millions of Dollars), 2005-2025



Source: Lewin Group & ECONorthwest analysis of Alaska Department of Health and Social Services data
Note: Spending projections are on an incurred service basis. Not adjusted for inflation.

Table 1 and Table 2 show projected utilization and spending for the five fastest growing Medicaid service categories. With the exception of Vision Services, these categories are also expected to be among the most expensive Medicaid services provided in 2025. In fact, As Table 2 shows, over half of state matching funds will be spent on just two service categories—Personal Care and HCB Waiver. These are two of the most important Medicaid service categories for Alaska's seniors.

Table 1: Forecast of the 5 Fastest Growing Service Categories by Utilization, 2005-2025

Medicaid Service	Calendar Year					Average Annual % Change (2005-2025)	Rank by Avg. Annual % Change
	2005	2010	2015	2020	2025		
Personal Care	5,029	8,626	14,587	23,617	35,311	9.7%	1
HCB Waiver	4,167	7,004	11,428	17,686	25,263	9.0%	2
Residential Psych./BRS	1,227	1,898	2,766	3,889	5,319	7.3%	3
Therapy/Rehabilitation	9,949	15,240	22,242	31,135	41,529	7.1%	4
Vision	24,288	35,006	47,669	61,614	75,190	5.7%	5
Unduplicated Count of Medicaid Recipients	113,953	130,047	141,184	148,117	150,743	1.4%	NA
Unduplicated Count of Medicaid Enrollees	132,344	151,036	163,971	172,022	175,073	1.4%	NA

Source: Lewin Group & ECONorthwest analysis of Alaska Department of Health and Social Services data.
Note: In this analysis we define service utilization as the annual unduplicated count of persons who used a particular Medicaid service during the fiscal year

Table 2: Forecast of the 5 Fastest Growing Service Categories by State Matching Funds (In Millions of Dollars), 2005-2025

Medicaid Service	Calendar Year					Avg. Annual % Change (2005-2025)	Rank by Avg. Annual % Change
	2005	2010	2015	2020	2025		
Personal Care	$48.7	$105.0	$200.6	$367.3	$629.1	12.8%	1
HCB Waiver	$49.0	$100.6	$181.8	$316.1	$520.4	11.8%	2
Residential Psych/BRS	$27.1	$52.9	$88.0	$141.1	$221.5	10.5%	3
Therapy/Rehabilitation	$11.5	$21.7	$35.4	$56.3	$85.9	10.0%	4
Vision	$0.4	$0.8	$1.2	$1.7	$2.4	8.6%	5
All Medicaid Services	$350	$591	$902	$1,377	$2,070	8.9%	NA

Source: Lewin Group & ECONorthwest analysis of Alaska Department of Health and Social Services data.
Note: Dollars are not adjusted for inflation.

- State matching fund spending on claims provided by the Alaska Medicaid program will grow from approximately $350 million in calendar year 2005 to just over $2 billion in calendar year 2025.

- The main factors responsible for growth in spending on Medicaid services are population growth, aging of the population, increasing utilization of Medicaid services by enrollees, and growth in the prices of medical services.

- Growth in total (federal and state funds) spending on claims will slow from the pace of the last decade. On an average annual basis, total spending on Medicaid claims is projected to increase by 7.8%. Comparatively, between 1998 and 2004, spending on Medicaid claims increased by 16.6%.

- In calendar year 2005, state-matching fund spending on Medicaid claims was approximately $500 per Alaskan citizen. We project this will grow to approximately $2,600 by 2025--an 8.0% average annual growth rate. Comparatively, per-capita personal income in Alaska is projected to grow by less than 3.0% per year over this same period.

- By 2025, more than half of state matching fund spending on Medicaid claims is expected to be for Personal Care and HCB Waiver. In CY 2005 these two service categories account for less than 30% of the state's spending on Medicaid claims.

- Medicaid enrollment will grow at almost twice the annual rate of Alaska's population (1.4% vs. 0.86%).

- For the elderly, Medicaid enrollment is also projected to grow at a greater annual rate than the population (6.3% vs. 5.3%).

- Medicaid utilization will grow by approximately 4.3% per year between 2005 and 2010, but this rate of growth will decline to approximately 2.1% between 2020 and 2025.

- We project relatively slow growth in the enrollment rates of eligibility categories specific to children (e.g. Title XIX Kids), but high rates of growth in eligibility

categories geared more heavily toward the elderly (e.g. Long Term Care Non-Cash).

- The elderly population in Alaska will almost triple between 2005 and 2025 from 43,000 to 124,000; while the child population will remain relatively stable growing only from 205,000 to 245,000 in 20 years.

- The Native population will increase on average by 1.71% per year, while the Non-Native population is expected to increase by only 0.67%. The difference between the two growth rates is expected to result in the Native proportion of the population increasing from approximately 17% in 2005 to approximately 21% by 2025.

- Currently, Natives are almost three times as likely to be enrolled in Medicaid as are non-Natives.

- The enrollment of males into the Medicaid program is projected to grow slightly faster than females. Still, due to greater life expectancies, higher rates of poverty, and pregnancy and related needs, we expect the proportion of females in the Medicaid program to remain higher than males.

- The Anchorage/Mat-Su region, with almost half of all Medicaid enrollees in 2005, is expected to increase its Medicaid population by 2.0% per year—the fastest growth of any of the regions.

Introduction—Alaska Medicaid Spending Projection

In this study, we develop long-term forecasts of Medicaid program spending from 2005 through 2025. We project spending for 20 categories of services provided under the Alaska Medicaid program. Although results are presented at state level for all residents, analysis is conducted on a regional basis for demographic subgroups of the population.

In addition to this report, the models constructed for and used in the analysis will be installed on Alaska Department of Health and Social Services (ADHSS) computers. This will provide ADHSS staff the ability to update the forecast as more timely data become available. The models were developed in the Statistical Package for the Social Sciences (SPSS) at the request of agency staff. The SPSS modeling syntax serves as documentation of the analysis, allowing ADHSS staff to operate and, if necessary, modify the models. Indeed, the primary contributions of this project are the development of a methodology and set of statistical models that will allow ADHSS staff to prepare long-term forecasts of Medicaid spending into the future. Neither the demographic profile of Alaska's population, nor the administrative aspects of the Medicaid program are static. It is important, therefore, that ADHSS staff has the ability to inform Medicaid administrators and policy makers about fiscal issues related to the Medicaid program. ADHSS now has a tool that they can use to project the impact of proposed changes to the Medicaid program.

This report presents the findings from our analysis of long-term Medicaid spending in Alaska. It is based on the most currently available data and represents a benchmark for future forecasts, but does not reflect changes in Alaska's Medicaid program made since the last year of historical data (fiscal year 2004). We recognize that changes to the Medicaid program ADHSS has implemented since FY 2004 already have had—and will continue to have—an impact on enrollment, utilization, and spending.[1] With the new long-term forecasting model in hand, these changes will be reflected in ADHSS' future updates of the forecast. Revised projections will have the same validity as the benchmarking projection because they will be based on the same model.

[1] Examples of changes made to the Medicaid program since FY 2004 include numerous changes implemented to contain costs, the Bring the Kids Home initiative to return children in out-of-state residential psychiatric treatment centers to Alaska, changes to the Personal Care Attendant program, and the launch of Medicare's prescription drug benefits.

SUMMARY OF METHODOLOGY

The main factors responsible for growth in spending on Medicaid services are population growth, aging of the population, increasing utilization of Medicaid services by enrollees, and growth in the prices of medical services. Our methodology, therefore, entailed detailed analysis of each of these factors in order to formulate a series of statistical models to project total spending on Medicaid services. The statistical models of Medicaid enrollment, and service utilization and spending were developed using historical enrollment-level data provided by ADHSS. Population forecasts for five regions of Alaska were based on historical Census population estimates and statewide population forecasts developed by the Alaska Department of Labor and Workforce Development.

The forecast of total spending on Medicaid services depends on the following key demographic, economic, and program-related factors:

- Growth in Alaska's resident population and changes in demographic composition
- Changes in the Medicaid enrollment rate
- Changes in the utilization of Medicaid services by Medicaid enrollees
- Personal health services specific price inflation

The creation of the long-term Medicaid forecasting model for Alaska required the development of five separate modeling tasks. These include:

- **Task 1: Project population of Alaska by regional-demographic grouping:** The first step in determining the demand for Medicaid services in future years is to understand the size of the Medicaid eligible population, its demographic characteristics, and its regional distribution. We do this by projecting Alaska's population through 2025 by the following four characteristics:
    - Region (5)
    - Age Cohort (11)
    - Gender (2)
    - Native/non-Native (2)

This results in 220 subpopulations (5 * 11 * 2 * 2 = 220) that we project for each year from 2005 to 2025. The purpose of projecting Alaska's population at such detail is that eligibility for and consumption of Medicaid services differs greatly by age and gender; the federal match rate varies between Medicaid service categories and by Native/non-Native status; there may be regional differences in the eligibility and participation rates for Medicaid, as well as in the costs of service.

Task 2: Project Medicaid enrollment rate for each of the 220 subpopulations: Using Medicaid enrollment data provided by the Alaska Medicaid program for fiscal years 1997-2004, we estimated regression equations of Medicaid enrollment rates for children (0-19 years of age), working-age adults (20-64 years of age), and the elderly (65+ years of age). These equations included a range of demographic variables designed to measure differences in enrollment for these groups, including age, gender, Native/non-Native status, and region of residence.[2] Coefficient estimates from the regression equations were used to project the proportion of each of the 220 subpopulations enrolled in Medicaid through 2025. Medicaid enrollment is then allocated across the 11 eligibility classes based on historic trends. Medicaid eligibility classifications were determined by ADHSS staff.

Task 3: Project utilization by Medicaid service class for each of the 220 subpopulations: Using historic Medicaid data on utilization of Medicaid services for each of the 20 service classes, we project Medicaid utilization for each of the 20 service classes within each of the 11 eligibility groups and the 220 subpopulations. Service utilization is modeled using logistic regression, a statistical modeling technique used for estimating the probability of an event occurring. For our purposes, the event is the utilization of a particular service within a given year.

Task 4: Forecast the average and total cost per year of Medicaid services by subpopulation: Using linear regression analysis, average spending per recipient of each Medicaid service category was regressed on demographic and other explanatory

[2] In addition, we examined statewide economic data, including total personal income, per capita personal income, and employment. The statewide data provided no explanatory power in the enrollment rate models and was, therefore, dropped from the models. Regional economic data were not examined because we know of no available long-term forecasts of such data. Statewide economic data from the University of Alaska's Institute for Social and Economic Research (ISER) were also considered in the regression models. The economic data, however, did not provide additional explanatory power and were, therefore, dropped from the models.

variables.[3] One regression model was developed and estimated for each of the 20 service categories. The results obtained from the 20 models were used to project total *real* spending *per Medicaid recipient* through 2025. Using national-level forecasts of medical inflation, we then project total annual *nominal* spending per recipient through 2025.

Task 5: Forecast total state matching fund spending on Alaska's Medicaid program: The State's obligation to cover the cost of an individual's Medicaid costs differs according to the individual's Medicaid eligibility group, category of Medicaid service, provider of Medicaid-related service, and Native/non-Native status. Based on cost share information from ADHSS and our projections of total Medicaid spending by service category, we forecast total state matching fund spending through 2025 by the State of Alaska.

Task 6: Forecast the cost of other payments and offsetting recoveries: This final component of Medicaid spending is not directly tied to individual claims and, therefore, cannot be forecasted by the same methods described above. Rather, for projections of Offsetting Recoveries, future credits are assumed to grow at approximately the same rate as in the past. For the forecasts of Medicare Part A & Part B Premiums, the historical relationship between spending on this program and growth in the elderly population (65 and older) was statistically measured and used as a basis for projecting future spending by ADHSS on Medicare Part A & Part B Premiums. Finally, for the Supplemental Hospital Payments program, the relationship between spending on this program and spending on the Inpatient and Outpatient Hospital services categories was statistically measured and used as a basis for projecting future spending on the Supplemental Hospital Payments program.

MODEL ASSUMPTIONS AND LIMITATIONS

The Lewin Group and ECONorthwest realize that the value of economic analysis depends on the quality of the data and assumptions employed. We have worked carefully to ensure the quality of our work and the accuracy of our data. Throughout this report we identify our sources of information and the assumptions used in the analysis. We have undertaken considerable effort to validate the forecast and to confirm the reasonableness of the data and assumptions on which the forecast is based.

[3] Note: Annual Medicaid spending for each of the historical years of data is inflation adjusted into 2004 dollars.

Nonetheless, we acknowledge that any forecast of the future is uncertain. The fact that we view the forecasts in this report as reasonable does not guarantee that actual enrollment in, utilization of, and spending on the Alaska Medicaid program will equal the projections in this report. ADHSS administrators and the Alaska's elected representatives must recognize the inherent uncertainty that surrounds forecasts in considering the long-term Medicaid spending projections. The primary benefit of this report to Medicaid administrators and Alaska's policy makers is information on the direction and approximate magnitude of changes in the Medicaid program.

There are many assumptions underlying the forecast, which the Lewin Group and ECONorthwest have deemed to be reasonable. ADHSS established a steering committee of program and financial managers experienced in Medicaid policy to provide guidance throughout the process of developing the forecast models. The steering committee provided valuable feedback on the suitability of our assumptions and the reasonableness of our results. Throughout the analysis, we relied upon the best available information, including historic Medicaid claim data, the State of Alaska's official population forecast, and nationally recognized information on trends in medical prices. In addition, in no instances do we impose any speculation on future Medicaid policies or procedures. Rather, we develop the long-term forecast as if the policies and practices of today will be the status quo throughout the forecast period. Assumptions of particular importance, include, but are not limited to, the following:

- The mix of currently available Medicaid services is assumed to be constant throughout the forecast period. The State of Alaska currently provides Medicaid services not mandated by the federal government. We assume the State will continue to provide these services throughout the forecast period.

- Medicaid eligibility requirements will not change throughout the length of the forecast period.

- With respect to gender and age cohort, Alaska's population will grow at approximately the rate forecasted by the Alaska Department of Labor and Workforce Development in their February 2005 report. Relative population growth by region of the state and by Native/non-Native status will be similar to that experienced between 1990 and 2000.

- The growth rate in the prices of Alaska's Medicaid services will be the same as the projected growth rate in the prices of personal health care services, embodied

in the Center for Medicare and Medicaid services' national personal health care deflator.

- Neither the historical data nor the spending forecast will directly correspond to the ADHSS accounting or budget systems. Additionally, the claims data is based on date of service while the accounting and budget systems are based on dates of payment. There are three reasons for this:

  1. The data used in the forecast of total spending are based on date of service and not on date of payment;

  2. The payment amounts include only claim payments processed through the Medicaid Management Information System (MMIS) and do not included any payments or accounting adjustments not made through MMIS (i.e., the data do not directly correspond to accounting records);

  3. The historical data are based on the State's fiscal year, but the forecasts are on a calendar year basis. This was done to remain aligned with the population forecast.

- Claim data for Fiscal Year 2005 are used as a benchmark for the long-term forecast. These data were not, however, used in the development of the forecast. The reason for this is that the statistical models used in this analysis were developed in Q2 and Q3 2005, and the earliest the FY 2005 claim data became available was a month or more into Q3 2005. Further, because this analysis is on an incurred basis and many claims are not paid for several months or more after the service is incurred, there is currently and will continue to be for several months much missing cost data in the FY 2005 claim data.

- Data for years 1997, 1999, 2001, and 2003 are not shown in historical tables of utilization and spending because of limited space. Average annual growth rates are slightly lower when considering the period 1997-2004.

- Forecast data are only shown for 2005, 2010, 2015, 2020, and 2025. The model, however, forecasts each year from 2005 through 2025.

- The enrollment and claims data provided by ADHSS were from their Juneau Claims and Enrollment (JUCE) database. JUCE contains Medicaid enrollment records and claim-level data on paid claims, adjustments, and voids. JUCE does not include denied claims, claims pending adjudication, payments not processed through MMIS, or administrative costs. For the long-term forecasting model, ADHSS summarized enrollment and paid claims data into one record for each individual enrolled in the Medicaid program for each complete fiscal year available (1997-2004) using the following 10 criteria.

1. Claim date is based on the date the service was provided (incurred), not the date the claim was paid.

2. Only complete fiscal years are included in the data file. Data for fiscal year 2005 are excluded because there is a lag between providing the service and paying the claim. Many of the claims incurred during fiscal year 2005 will not be paid until fiscal year 2006.

3. There is one record per individual for each fiscal year he/she is enrolled in Alaska's Medicaid program, regardless of whether he/she is enrolled for one month during the fiscal year or for the entire fiscal year.

4. Data were grouped so that classifications are consistent with those typically used by ADHSS in budgeting analyses and financial reporting. The list of variables include ID year, region, gender, race (Native/non-Native), age, months in program, eligibility classification, and service classification.

5. To protect the privacy of clients, no personally identifying information (i.e., name, birth date, social security number) was included in the data file. The Medicaid client identification numbers were recoded by ADHSS to create the ID variable and cannot in any way be used to identify individuals.

6. The race variable is one of two values: Native or non-Native. The Native category includes anyone identified as Alaska Native or American Indian. Race is a self-identified optional field on the enrollment application. Natives who left this item blank would be counted as non-Native.

7. The Months-in-Program variable is the number of months during the fiscal year in which the individual was enrolled in Medicaid. Eligibility is determined on a monthly basis. If a person is eligible for one day in the month, they are eligible for the whole month.

8. When summarizing enrollment data, if multiple values were encountered in the region, gender, race, or age variables, one of the values was chosen randomly by assigning an integer between 1 and 12 (inclusive). The integer represented the month of the fiscal year in which to determine the individual's value for the entire fiscal year.

9. The 11 eligibility classifications are based on groupings of eligibility subtype codes (See Appendix A). If a client's situation changes over time, he/she is reassigned to the eligibility code that best fits. Consequently, there is a great deal of movement between classifications and it is common

for individuals to have more than one eligibility code during the year. If multiple eligibility codes were encountered during a fiscal year, the last value was chosen.

10. Claim data were aggregated into 20 service classifications based on ADHSS categories of service (See Table 9). The net amount of claims paid, including debits, credits, and voids, was summarized for each individual enrolled for each fiscal year. Not all enrollees had claims in all service classifications. In fact, some enrollees did not have any claims at all for a fiscal year.

Chapter 1—Alaska Population Trends

Approximately 23% of growth in national health spending is due to population increases and changes in the demographic mix of the population.[4] Consequently, we began our forecast of Medicaid spending by developing projections of the number of people in the state by demographic characteristic (age, gender, Native/non-Native status) for five regions of the state through 2025. These data provide key underlying trends that will drive enrollment and utilization of health services. It is important to note that we undertook the task of developing long-term population projections for Alaska because we believe such information is critical to developing a long-term cost forecast for Medicaid.

STEPS IN DEVELOPING THE POPULATION FORECAST

In this section we describe in detail the steps we undertook to produce the Alaska population forecast through 2025. Prior to developing the population projection, we researched the availability of official state or federal population forecasts that we could rely on for this analysis. We identified and relied on two sources of data to develop the population projections needed in this analysis.

Decennial U.S. Census data, 1990 and 2000: Our baseline forecast was developed by calculating the average annual growth rate of each of 220 subpopulations for Alaska between 1990 and 2000. The growth rate for each of the subpopulations was then applied to its respective 2000 population and projected through 2025.

Projections for Alaska population 2005-2029, developed by the Alaska Department of Labor and Workforce Development: The Alaska Department of Labor and Workforce Development (ADLWD) provide population projections by age and gender for the state of Alaska through 2029.[5] The ADLWD is in the process of developing sub-state population forecasts by demographic characteristic, but these estimates will not be available until after this report is completed. The currently available state population forecast is nevertheless valuable in the development of our population projection. As the official population forecast for State of Alaska, it provides a control for state-level population growth by age and gender.

[4] Lewin Group analysis of the Centers for Medicare and Medicaid Services, National Health Expenditures Data.
[5] See *Alaska Economic Trends*, February 2005, Vol. 25:2

As mentioned above, the ADLWD published its long-term (through 2029) statewide forecast by age and gender. This is a valuable source of information for developing the population projections required for this analysis, as age and gender are the two key demographic characteristics related to Medicaid utilization. The ADLWD has not at this time, however, published a population forecast that includes Native/non-Native status or extended its forecast to the sub-state level. Such a forecast is expected within the near future and we recommend updating the long-term Alaska Medicaid forecast based on this official population forecast for the State of Alaska. The lack of official sub-state population forecasts compelled us to develop our own.

Step 1. Determination of Population Characteristics to Include in Forecast

Prior to developing the long-term population forecasts needed for this analysis, we worked with ADHSS staff to determine the factors of importance for developing the population projections. We found that there are three major factors to consider.

Differences in utilization: Many Medicaid services are specific to a particular gender and age cohort. Because of this, we determined that the population forecast must provide information on these two important demographic characteristics.

Maintaining consistency with Medicaid forecasts performed by the Lewin Group for other states, we determined that 11 age cohorts would provide the necessary level of detail for the analysis.[6] These are:

- Ages 0-4
- Ages 5-9
- Ages 10-14
- Ages 15-19
- Ages 20-24
- Ages 25-34
- Ages 35-44
- Ages 45-54
- Ages 55-64

[6] We also considered segmenting the 75 and older age category into two age categories: 75-84 and 85 and older. There were not enough historical data, however, to warrant a separate age category for the 85 and older age group. We recommend revisiting this issue at a future date as this portion of the population grows and more data become available.

- Ages 65-74
- Ages 75 and older

Differences in availability of Medicaid services and costs of travel to obtain services: Because the availability of Medicaid services varies across Alaska, as well as the costs incurred by Medicaid in providing travel services to obtain services, we believed it important to consider regional variation in Alaska's population growth.

We initially considered performing the analysis at the census area/borough level. Doing so, however, would have required much more information on future conditions at the regional level than is currently available. It is also doubtful that such detailed regional information would be more beneficial to the Medicaid cost forecast than more aggregate regional information.[7] Working with ADHSS staff, it was determined that it was sufficient to base the analysis on the following five regions.

Anchorage/Mat-Su:
- Matanuska-Susitna Borough
- Municipality of Anchorage

Western:
- Bethel Census Area
- Nome Census Area
- Northwest Arctic Borough
- Wade Hampton Census Area

South Central:
- Aleutians East Borough
- Aleutians West Borough
- Bristol Bay Borough
- Dillingham Census Area
- Kenai Peninsula Borough
- Lake and Peninsula Borough
- Valdez-Cordova Census Area

Northern:
- Denali Borough
- Fairbanks North Star Borough
- North Slope Borough
- Southeast Fairbanks Census Area
- Yukon-Koyukuk Census Area

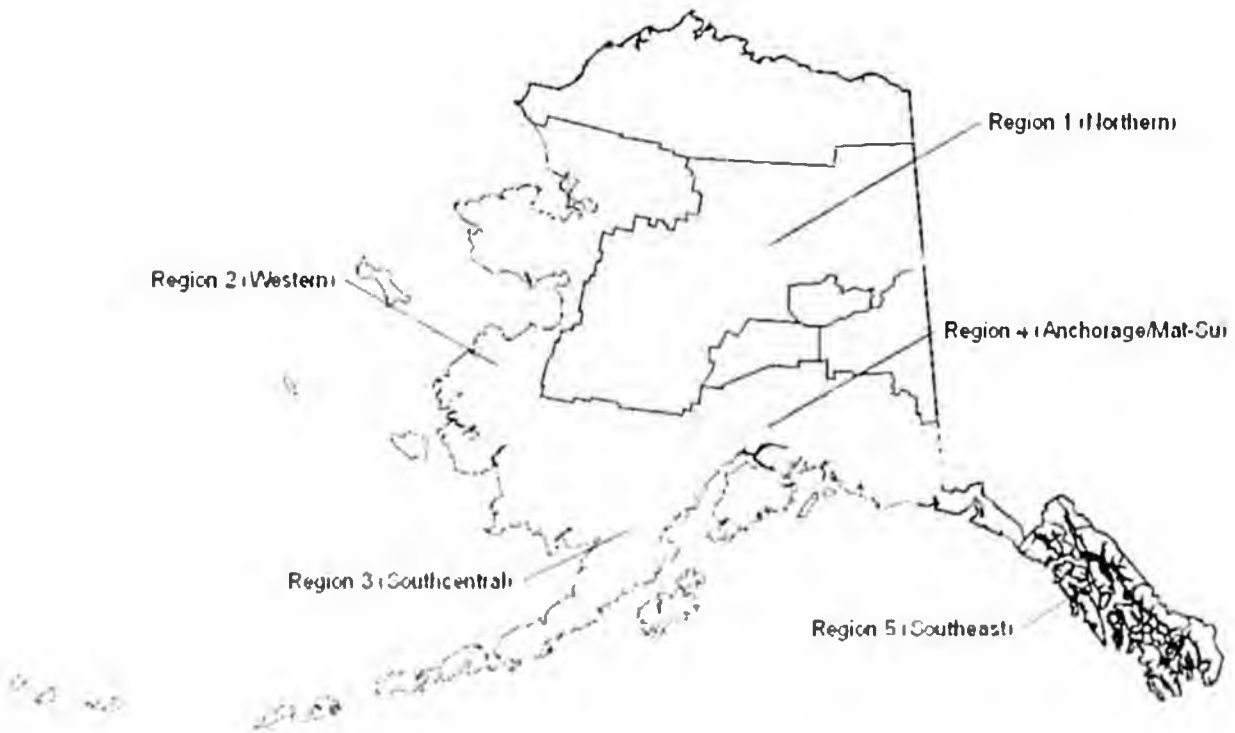
Southeast:
- Haines Borough
- Juneau Borough
- Ketchikan Gateway Borough
- Prince of Wales-Outer Ketchikan Census Area
- Sitka Borough
- Skagway-Hoonah-Angoon Census Area
- Wrangell-Petersburg Census Area
- Yakutat Borough

Figure 3 shows the regional designations used for the population and Medicaid enrollment and utilization forecasts. The five regions are consistent with U.S. Census Area boundaries and are nearly identical to what ADHSS uses as Direct Service Staff

[7] It is also likely that projecting individual socio-demographic populations within small regions of Alaska could result in inaccurate and misleading population forecasts due to the very small populations within many census areas and boroughs.

Regions. The only difference being that for the Medicaid forecast, Matanuska-Susitna Borough (Mat-Su) is combined with Anchorage instead of including it with the South Central region.[8]

Figure 3: Alaska Long-Term Medicaid Forecast Regions



Source: Lewin Group & ECONorthwest based on regional designations determined by ADHSS. Regions are consistent with Census Area boundaries.

Differences in Federal reimbursement rate for Medicaid services: There are differences in the Federal reimbursement rates for Medicaid expenses based on Native/non-Native status. In particular, the Federal government reimburses the State of Alaska for 100% of the cost associated with providing Medicaid services to the Native

[8] ADHSS Medicaid claims data are geo-coded by Census Area.

population if the provider is a tribal health facility. Because of this, we believe it important to consider population growth within each of these populations.

Considering each of these population characteristics requires forecasting 220 sub-groups of the Alaska population.[9]

Step 2. Baseline Population Forecast

The baseline population forecast for each of the 220 sub-groups is based on the growth rate of each of the sub-groups between 1990 and 2000. Using decennial U.S. Census data we calculated the average annual growth rate for each subgroup during the 1990s and applied it to the respective 2000 population for each year through 2025.

Step 3. Controlling for Statewide Population Forecast

In developing the baseline population projections, we understood that at best we would produce a rough approximation of population growth by demographic characteristic through 2025. In this third and final step of the population projection exercise, we adjusted our projections of the 220 subpopulations by Alaska's official state-level population forecast. As stated above, this forecast, produced by the ADLWD, is a projection of the State's population by gender and age through 2029. It provides us with the State's official population forecast for 22 subpopulations (2 genders * 11 age cohorts = 22 subpopulations). Excluded from the official population forecast is information at the sub-state level (i.e., at the level of the five regions considered in this analysis) and information on the Native/non-Native populations. Nevertheless, it was an invaluable source of information in which to improve the accuracy and consistency of our population projection. The ADLWD population projection was integrated into our population projection in the following way:

For each year of the baseline projection (2005-2025), we aggregated the 220 subpopulations by gender and age. Because there are 2 genders and 11 age cohorts, we aggregated the data into 22 groupings. This was done for each year of the projection, thus matching the level of aggregation of the ADLWD statewide population forecast

[9] The 220 sub-populations are created by multiplying 2 (gender) * 11 (age groups) * 2 (Native/non-Native) * 5 (regions) = 220.

We calculated the "control" factor to be applied to the baseline forecast so as to make it consistent with the ADLWD forecast. The control factor was computed using the following formula:

$$Baseline\ Population_{Gender,\ Age} \div ADLWD\ Population_{Gender,\ Age} = Correction\ Factor$$

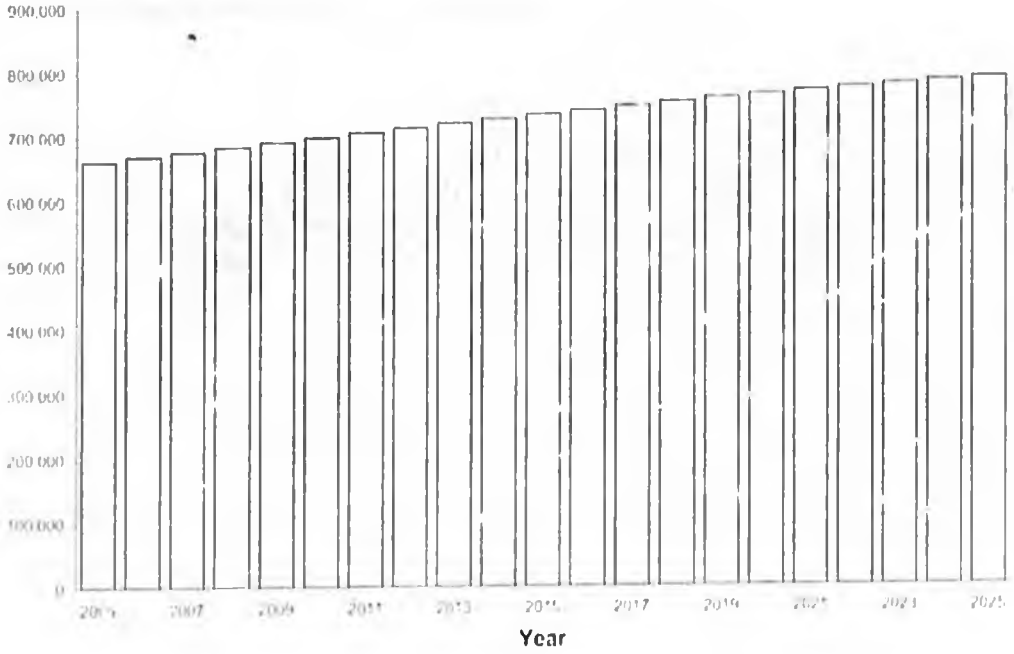
We applied the correction factor to each of the respective 220 subpopulations for each year of the projection. For example, the control factor for males age 0-4 was applied to Native males age 0-4 for each of the five regions and to Non-native males age 0-4 for each of the five regions. By doing this, we forced our projection of 220 subpopulations to be consistent with the State's official population forecast by age and gender. Throughout this report we refer to the forecast of the 220 subpopulations as the *Alaska Long Term Population Projection* (ALTPP).

PROJECTION OF ALASKA POPULATION

In this section we review the implications of the ALTPP with respect to changes in population by region, Native/non-Native status, gender, and age cohort. It is through reviewing the population forecast by the regional/demographic grouping that we are able to determine if the projection is indeed reasonable.

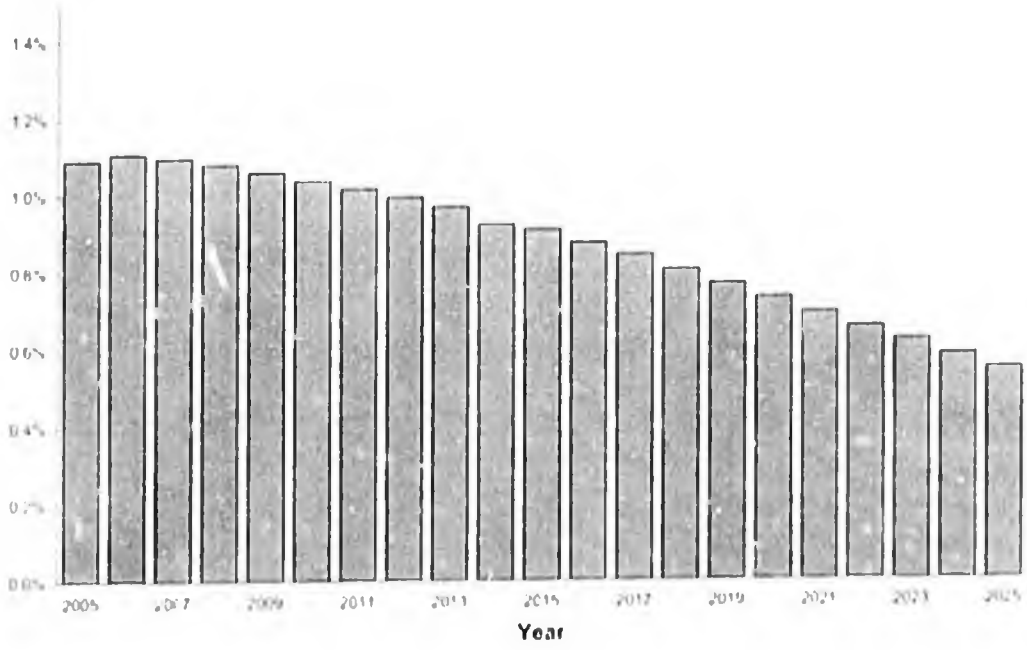
Figure 4 and Figure 5 show the projected population and population growth rates, respectively, for Alaska for each year through 2025. Although we project positive population growth through 2025, as Figure 5 shows, the rate of population growth is expected to decrease over time. This is consistent with the ADLWD population forecast.

Figure 4: Alaska Statewide Population Forecast, 2005-2025



Source: Alaska Department of Labor and Workforce Development data.

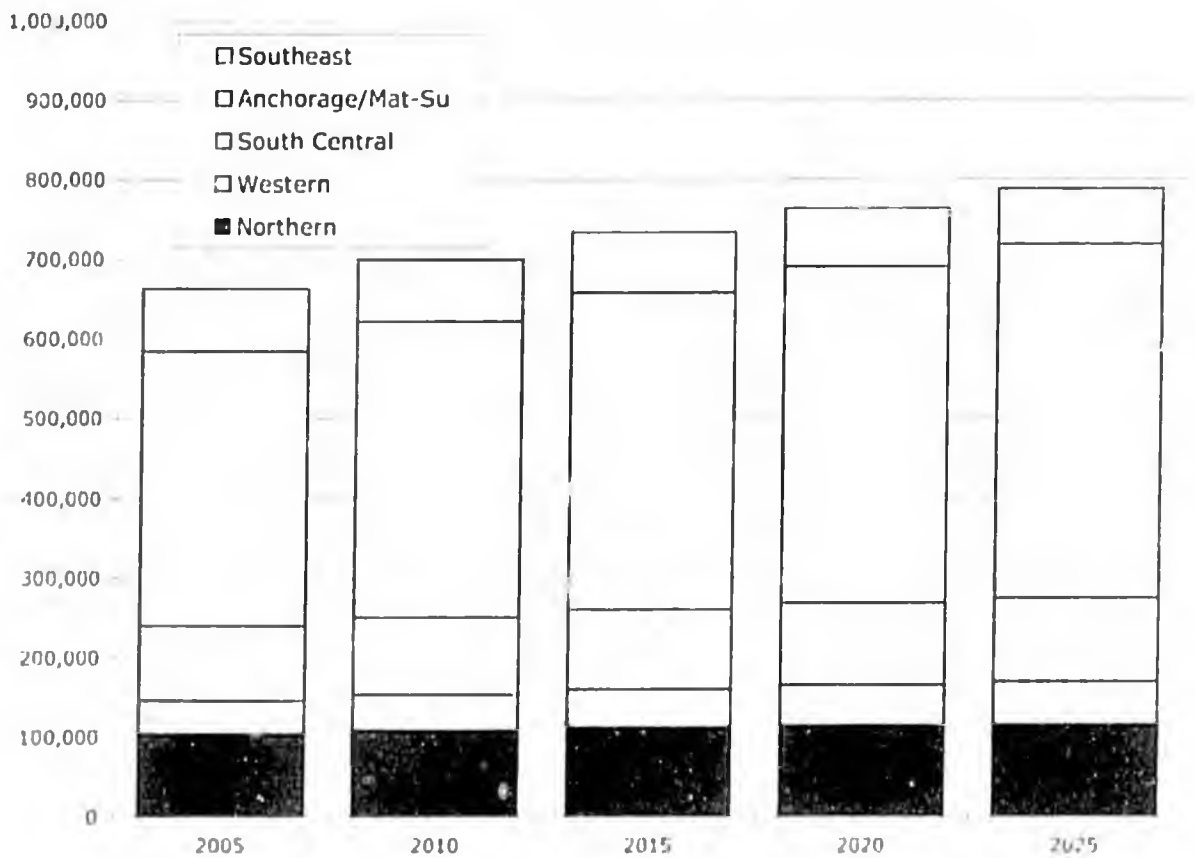
Figure 5: Projected Annual Growth Rates in Alaska Statewide Population Forecast, 2005-2025



Source: Alaska Department of Labor and Workforce Development data.

Figure 6 through Figure 9 show the ALTPP by demographic characteristic. As Figure 6 shows, we project positive population growth for the Northern, Western, South Central, and Anchorage/Mat-Su regions, but a slight population decline for the Southeast region. The Southeast region experienced the slowest rate of population growth between 1990 and 2000 of any of the five regions, based on U.S. Census Bureau data. In fact, the Southeast region grew at less than one-fourth the rate of the next slowest region (South Central) and added fewer than 1,400 persons during the decade.[10]

Figure 6: Alaska Population Forecast by Region, Selected Years



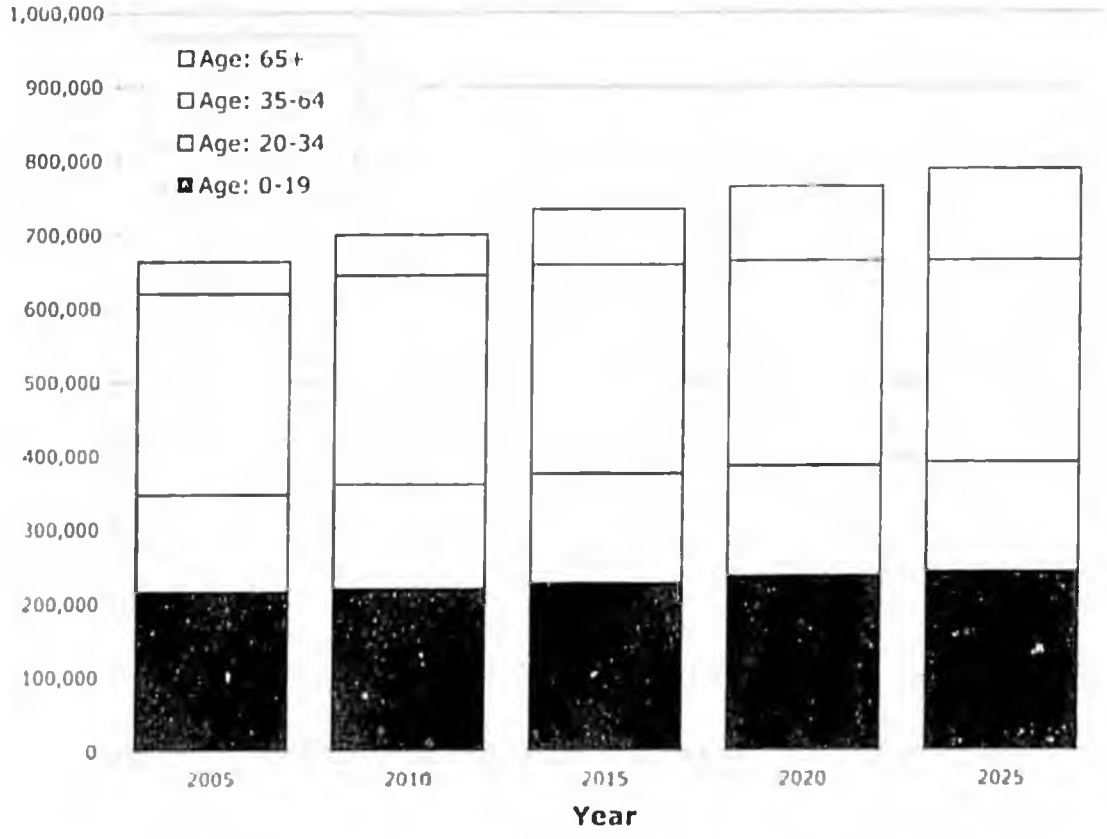
Source: Lewin Group & ECONorthwest analysis of U.S. Census and Alaska Department of Labor and Workforce Development data.

Following national trends, Figure 7 shows that while population growth in the younger age cohorts is expected be low through the forecast period, the 65 and older population is projected to grow rapidly, almost tripling from 43,000 to 124,000 between 2005 and 2025. The projected growth rate by age cohort in the ALTPP is directly tied to the 2005

[10] We again wish to note that the regional-level forecast is not directly tied to the ADLWD population forecast.

ADLWD population forecast. More important than any of the other factors by which we projected the Alaska population, the extremely large expected growth in the 65 and over population will have an accompanying large impact on the utilization of Medicaid services.

Figure 7: Alaska Population Forecast by Age Cohort, Selective Years



Source: Leavin Group & ECONorthwest analysis of U.S. Census and Alaska Department of Labor and Workforce Development data.

Despite its historic reputation as a predominantly male state, the 2005 ADLWD forecast projects the female proportion of the population to increase from 48.7% in 2005 to just over 50% in 2025 (see Figure 8). This continues a long-term trend in Alaska and puts it more closely in line with the gender ratio of the U.S. as a whole.