

# Long-term Forecast of Medicaid Enrollment and Spending in Alaska: *Supplement 2009–2029*

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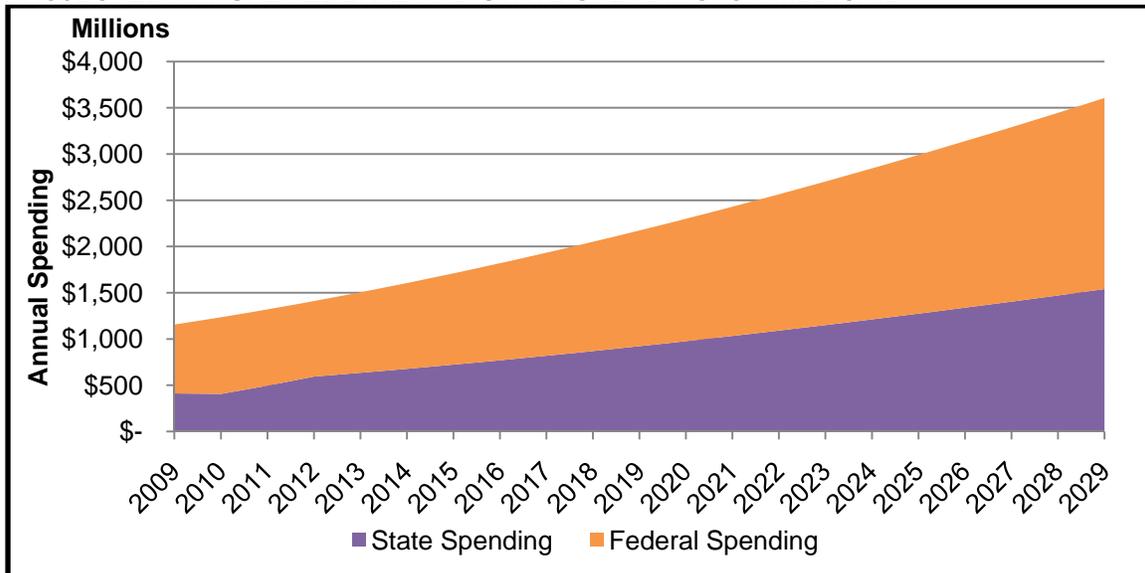
## Executive Summary

This is the fourth update to the *Long-Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025*. In this update, we develop long-term forecasts of Medicaid program enrollment, utilization, and spending from 2009 to 2029.

Today Medicaid spending for the elderly (ages 65 years and older) accounts for 17 percent of total Medicaid claims spending, while spending for children (ages 0-19 years) and working-age adults (ages 20-64 years) each account for about 42 percent. This distribution of spending will change substantially over the next 20 years; by 2029 spending for the three age groups will be approximately equal at 33 percent of total Medicaid claims spending each. This is a shift in the expected outcome from the baseline 2005-2025 forecast which projected spending on the elderly would exceed spending for either children or working-age adults in 2018. The shift is caused by changes in policy and slower population growth subsequent to the development of the baseline forecast.

**Figure 1: Total Medicaid spending in 2029 will reach \$3.6 billion**

PROJECTED ANNUAL FEDERAL AND STATE SPENDING<sup>1</sup> ON MEDICAID



Source: Medicaid Budget Group, MESA Model

Total Medicaid spending in 2029 is expected to reach \$3.6 billion. The average annual growth rate is 5.8 percent overall; however, state spending for Medicaid will grow at a faster 6.8 percent rate due to anticipated reductions in federal participation.

<sup>1</sup> All spending figures are nominal unless otherwise noted. Nominal or actual spending is the projected future value without adjusting for inflation. Please see Appendix C for real spending tables.

Spending per enrollee will increase from \$9,000 in 2009 to \$22,700 in 2029. The growth in spending per enrollee can be attributed to two main factors: (1) inflation in the prices of medical goods and services, and (2) an increase in the proportion of enrollees who are elderly, and thus more costly than children or working-age adults. State spending per enrollee will increase from \$3,200 in 2009 to \$9,700 in 2029. The proportion of state spending per enrollee will increase from 35.7 percent to 42.7 percent.

The rate of growth for enrollment will slow throughout the forecast period due to slower population growth in later years<sup>2</sup>. The average annual rate of growth for enrollment is 1.1 percent -- faster than the projected population growth rate of 0.9 percent. The elderly (65 and older) are the fastest growing age group, with enrollment growing at 5.1 percent annually. The enrollment for children (0-19) and working-age adults (20-64) is growing slower than overall enrollment, 0.6 and 0.8 percent, respectively.

Utilization will see the highest average annual growth rates in Home and Community Based Waivers (4.7 percent), Personal Care (4.5 percent), and Health Clinic (4.1 percent).

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<sup>2</sup> According to estimates provided by the Alaska Department of Labor and Workforce Development, the population is projected to grow by 1.0 percent annually from 2009 to 2014 and slow down to 0.8 percent from 2024 to 2029.

## Introduction

This report presents and discusses the annual update to the long-term forecast of Medicaid Enrollment and Spending in Alaska (MESA). In this update, we develop a 20-year outlook of Medicaid<sup>3</sup> program enrollment, utilization, and spending from 2009-2029. MESA was first prepared in 2005 by The Lewin Group and ECONorthwest on behalf of the State of Alaska Department of Health and Social Services (DHSS) and the Alaska Legislature.

The original MESA report covered the twenty-year period from 2005-2025. In each successive year, the department's Alaska Medicaid Budget Group, with consultation from ECONorthwest, updates the underlying enrollment and claims data on which the MESA forecasting model depends and re-estimates the model to project enrollment and spending over the successive 20-year period. By integrating a successive year of data into the MESA model, we update the Medicaid program's status quo with respect to eligibility, enrollment trends, and spending. Thus, as changes are made to the Medicaid program by DHSS or the Legislature, MESA provides estimates of the long-term impact of the changes.

The purpose of the MESA forecast is to provide a long-term view of future enrollment and spending in the Alaska Medicaid program under the current mix of Medicaid services and the current criteria for enrollment in the Medicaid program. MESA provides department executives and the Alaska State Legislature with information on the direction and approximate magnitude of growth in enrollment and state matching fund spending for the Medicaid program. It is particularly helpful to pay attention to growth rates as opposed to simply focusing on values because growth rates allow for the comparison of expected changes across regions (e.g. comparing Alaska with the nation).

It is important to keep in mind that the projections of 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 are necessary to show how Medicaid spending in Alaska would grow under the program as it exists today. As a result of these assumptions, the forecast does not take into consideration the dynamic nature of Medicaid policy and changing funding mechanisms that may take place throughout the forecast period.

We 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

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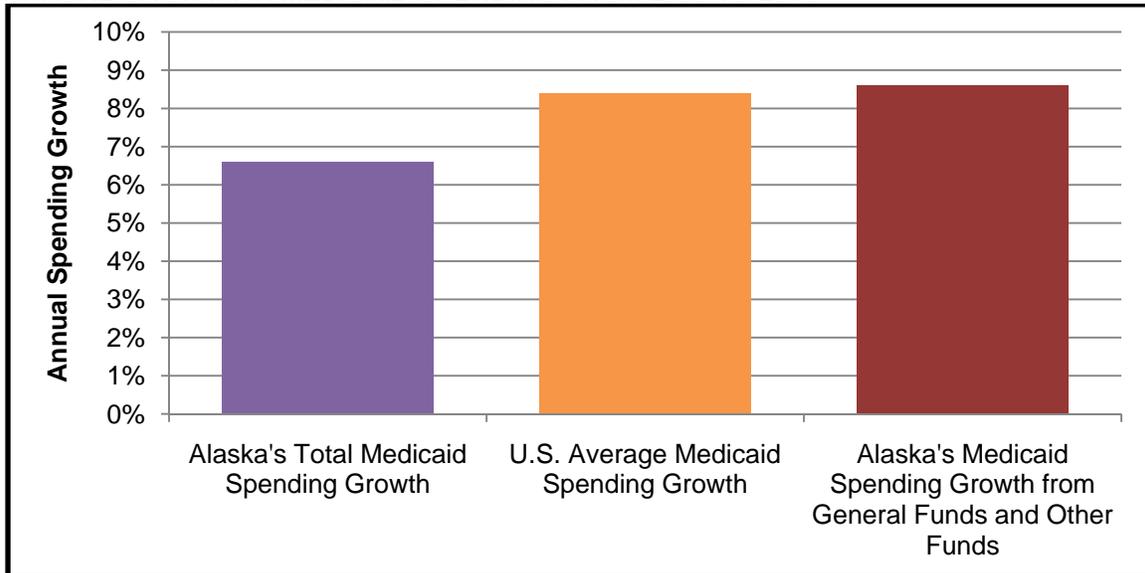
<sup>3</sup> In this report, the term "Medicaid" includes both Title XIX Medicaid and the Title XXI Children's Health Insurance Program (CHIP) Medicaid expansion.

our work and the accuracy of our data. 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. 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. Administrators and Alaska’s elected representatives must recognize the inherent uncertainty that surrounds forecasts in considering the long-term Medicaid spending projections.

## Comparison to Other States

**Figure 2: Alaska’s total spending growth is projected to be lower than the national average**

ANNUAL GROWTH IN MEDICAID SPENDING FROM 2009 TO 2018



Source: Medicaid Budget Group, MESA Model

According to the Centers for Medicare and Medicaid Services, national Medicaid spending is projected to increase at an average annual growth rate of 8.4 percent between 2009 and 2018.<sup>4</sup> In comparison, Alaska’s total Medicaid spending is projected to increase at 6.6 percent per year over the same period and by 5.8 percent per year over the entire forecast period (through 2029). At least part of the lower expected growth rate in Alaska’s Medicaid spending can be attributed to the cost control measures implemented by the department and the legislature in recent years.

<sup>4</sup> Andrea Sisko, et al. “Health Spending Projections Through 2018: Recession Effects Add Uncertainty To The Outlook.” *Health Affairs*. Vol. 28, no.2 (2009), p w350.

Since the federal government will be shifting a larger share of the cost of Alaska's Medicaid program back to the state<sup>5</sup>, Medicaid spending from general funds and other non-federal funds is projected to grow at 8.6 percent annually from 2009 to 2018.

## Summary of Methodology

The MESA forecasting model has multiple, linked components, which successively build upon each other. The first step in developing the model is the distribution of the long-term population projections developed by the Alaska Department of Labor and Workforce Development into individual forecasts for regional and demographic subgroups. The next step is projecting enrollment for each demographic group based on historical trends. Logistic regression models of historic enrollee-level claim data are then developed to estimate the probability that a Medicaid enrollee will use a Medicaid service. Finally, total spending by service category and demographic group is projected, from which state general fund spending is allocated based on known and projected future federal financial participation rates.<sup>6</sup>

Throughout the analysis, we rely 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 no instance 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.

The main factors responsible for growth in state spending on Medicaid services are

- Growth in Alaska's resident population and changes in demographic composition;
- Changes in the Medicaid enrollment rate;
- Changes in the use of Medicaid services by Medicaid enrollees;
- Personal health services specific price inflation; and
- Changes in federal financial participation.

Our methodology entails detailed analysis of each of these factors to formulate a series of statistical models to project total and state spending on Medicaid

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<sup>5</sup> The costs will be shifted back to the state because of a lower Federal Medical Assistance Percentage. Stimulus funds from the American Recovery and Reinvestment Act of 2009 are currently set to expire in December 2010. See the State Spending section.

<sup>6</sup> For detailed information on the development of the MESA forecast, please see "Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025".

services. We project total and state spending based on demographic characteristics (age, gender, Native/non-Native status) and for five regions of the state – a total of 220 subpopulations. In addition, we project enrollment in 11 eligibility groups plus use and 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.

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 (ADLWD). ADLWD produced an updated population projection in 2007 for years 2008 through 2030. The statistical models of Medicaid enrollment, service utilization, and spending used in the MESA model were developed using the new population projections from ADLWD along with historical enrollment and Medicaid claims data provided by the Department of Health and Social Services for the years 1997-2008. Only complete fiscal years based on dates of service are included in the Medicaid data file. Many of the claims incurred during 2009 will not be paid until fiscal year 2010; therefore, data for 2009 are excluded. Please see *Appendix C* for historical spending data.

## **ALASKA MEDICAID FORECAST: 2009-2029**

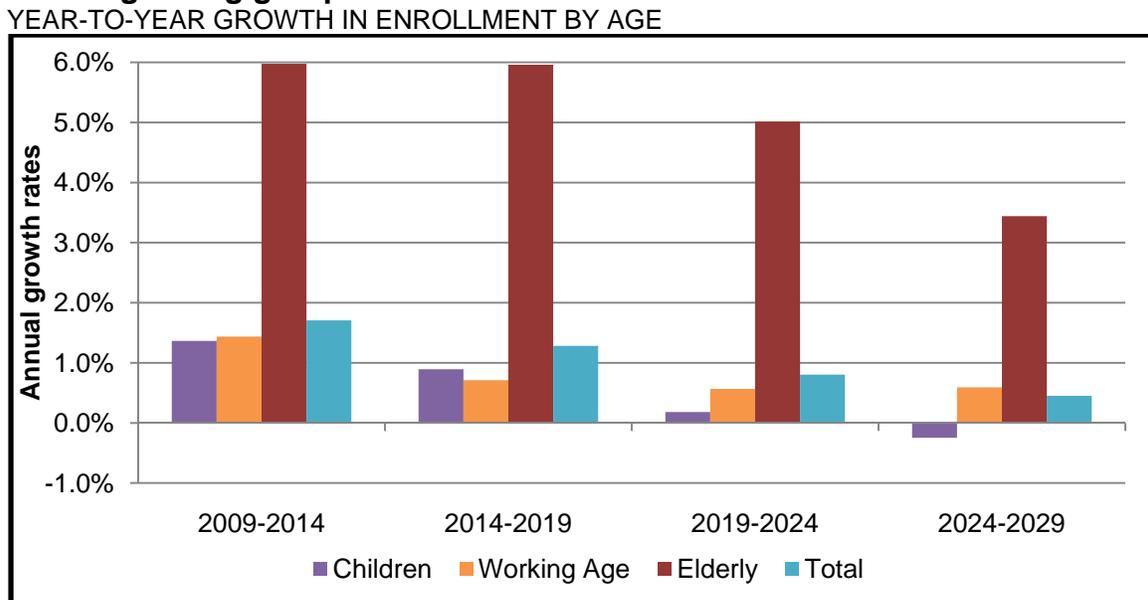
The 2009-2029 Alaska Medicaid forecast integrates the most recent enrollment and spending data for the Alaska Medicaid program with the Alaska Department of Labor and Workforce Development (ADLWD) population forecast, developed in 2007. The 2007 ADLWD population forecast projects a slower rate of growth in the elderly population over the next 20 years than did the 2005 ADLWD forecast. The slower anticipated growth in the elderly population results in slightly slower projected growth in Medicaid enrollment and, more importantly, slower projected growth in Medicaid spending relative to the 2005 Medicaid forecast. The annual enrollment growth rate is projected to be 1.1 percent, less than the increase of 1.2 percent which was previously forecast. The above factors, in combination with cost containment and programmatic changes, lead to slower projected growth in Medicaid spending.

## Enrollment

The elderly population will continue to have a dramatic impact on the Medicaid program through 2029. The growth in enrollment among the elderly will average 5.1 percent per year through the forecast period, causing the elderly’s share of enrollment to more than double by 2029, reaching 14 percent of total enrollment. During the same period, the annual growth rate in enrollment among children and working-age adults will be 0.6 percent and 0.8 percent respectively. The rate of growth in enrollment across the entire population will slow from 1.7 percent annually between 2009 and 2014 to 0.5 percent annually between 2024 and 2029.

Enrollment refers to the number of individuals who both meet the requirements and are registered to receive Medicaid services. The growth in enrollment is determined by two primary factors: (1) changes in the demographics of the population and (2) changes in eligibility requirements. For the purposes of this report, enrollment changes are primarily driven by changes in the demographics of the population, since the present eligibility requirements are already incorporated into the current enrollment figures.

**Figure 3: Enrollment growth slows down over time. The elderly remain the fastest-growing group**



Source: Medicaid Budget Group, MESA Model

Figure 3 shows that enrollment growth for the entire population will slow over time, and the elderly (age 65 and older) will experience the highest growth rate over the forecast period. The growth rates in enrollment for children (age 0-19) and working-age adults (age 20-64) are roughly equal over the first ten years, but

after 2019, the growth rate for children drops below that of the adults. Over the last five years, the growth rate for children becomes negative.

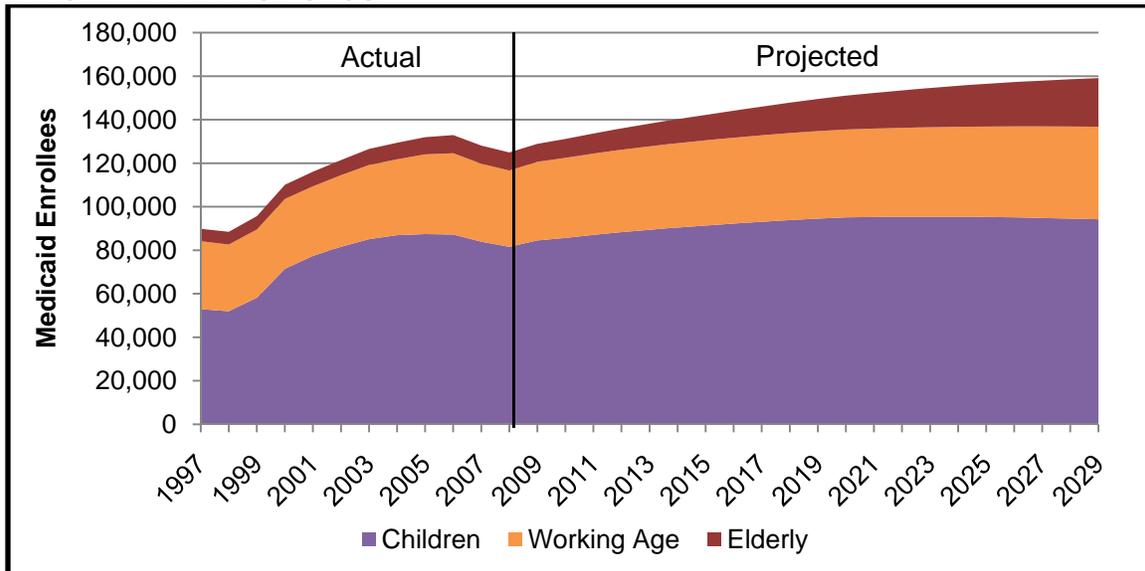
**Table 1: Elderly enrollment is projected to grow faster than other age groups**

MEDICAID ENROLLMENT BY AGE GROUP FOR SELECTED YEARS, 2009-2029

Age Group	2009	2014	2019	2024	2029	Average Annual Change
<b>Children (0-19)</b>	84,512	90,440	94,552	95,408	94,233	0.6%
<b>Working Age Adults (20-64)</b>	36,114	38,782	40,183	41,329	42,569	0.8%
<b>Elderly (65+)</b>	8,270	11,054	14,766	18,860	22,336	5.1%

Source: Medicaid Budget Group, MESA Model.

**Figure 4: Enrollment increases are projected to be modest**  
ENROLLMENT BY AGE GROUP



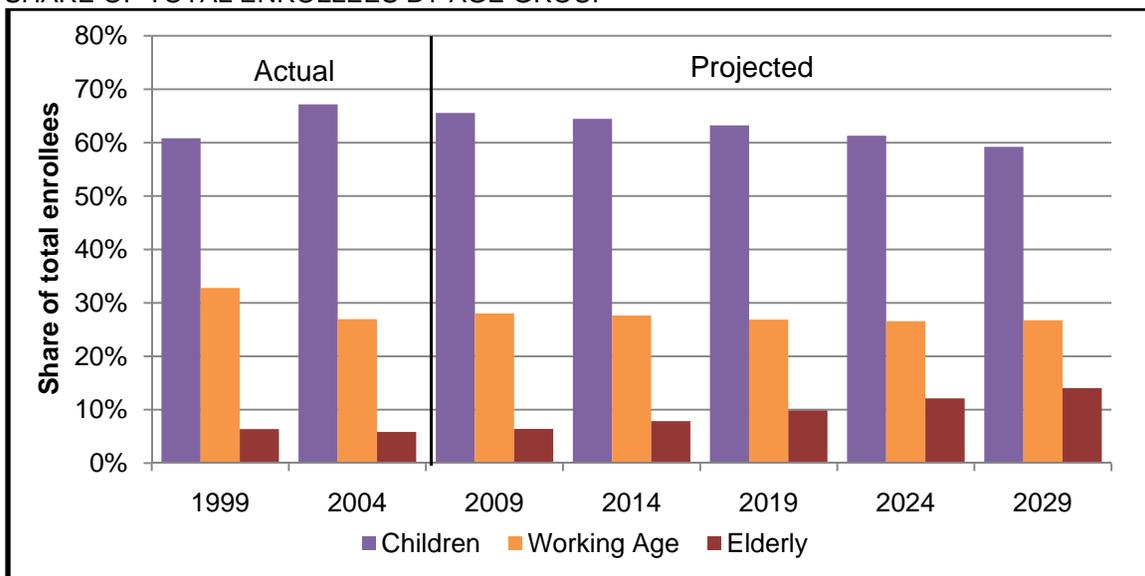
Source: Medicaid Budget Group, MESA Model

The demographic characteristics of Medicaid enrollees have changed and will continue to do so in the future. The share of children as a percent of all participants enrolled in Medicaid increased in the late 1990s and continued to increase in the beginning of this decade until 2004, when they accounted for 67 percent of enrollees. This coincided with the introduction of Denali KidCare, which expanded Medicaid to more pregnant women and individuals. From 2004 to 2007, the household income eligibility requirements for Denali KidCare were locked into place instead of being adjusted for inflation, so some individuals fell off the rolls. The proportion of enrollees who are children has since dropped to 66 percent. With a 0.6 percent annual growth rate from 2009 to 2029, children’s

share of enrollment will continue to fall; by 2029, enrollment is projected to include 94,200 children, accounting for 59 percent of enrollment.

The proportion of Medicaid enrollees who are working-age adults decreased from 35 percent of enrollment in 1997 to 27 percent of enrollment in 2002. Enrollment of working-age adults is projected to grow over the forecast period at 0.8 percent per year. The share of working-aged adults is projected to remain steady throughout the forecast period, at 27 percent, resulting in an increase from 36,000 adults enrolled in 2009 to 42,600 in 2029.

**Figure 5: Percentage of enrollees who are elderly will increase in the future**  
SHARE OF TOTAL ENROLLEES BY AGE GROUP



Source: Medicaid Budget Group, MESA Model

With more people in the Baby Boom Generation approaching retirement age, the elderly will account for a larger share of Medicaid enrollees over the forecast period, increasing from 6 percent of enrollment to 14 percent in 2029. Enrollment of elderly is expected to grow at an annual rate of 5.1 percent over the 20 year period, from 8,300 in 2009 to 22,300 in 2029.

The gender balance is projected to remain stable throughout the forecast period, with 55 percent female enrollees and 45 percent male enrollees. The racial makeup of enrollees is projected to remain at 66 percent non-Native and 34 percent Native. The enrollment for each of these groups is projected to grow at 1.1 percent annually.

The forecast projects an increase in enrollment levels for each eligibility group, with the largest growth in eligibility groups that have a larger share of the elderly. These groups include **Long Term Care Non-Cash** and **SSI/APA/LTC**

**Cash**, which are projected to grow annually at 3.3 percent and 2.5 percent, respectively. **SSI/APA/LTC Cash** is the eligibility group that is projected to have the largest growth in total enrollees and is projected to grow from 20,900 to 34,300 enrolled in 2029, an increase of 13,400 enrollees.

**Table 2: Enrollment levels of eligibility groups associated with the elderly tend to grow faster than the 1.1 percent average**

MEDICAID ENROLLMENT FOR SELECT ELIGIBILITY GROUPS

Eligibility group	2009	2014	2019	2024	2029	Annual Change
<b>Title XIX Kids</b>	43,999	46,969	48,878	49,262	48,802	0.5%
<b>Title XXI Kids</b>	6,367	6,908	7,232	7,482	7,726	1.0%
<b>SSI/APA/LTC Cash</b>	20,892	24,503	28,253	31,687	34,279	2.5%
<b>LTC Non-cash</b>	1,838	2,170	2,568	3,038	3,501	3.3%

Source: Medicaid Budget Group, MESA Model

The **Title XIX Kids** eligibility group is currently the largest eligibility group. It is projected to maintain that distinction even though its 0.5 percent annual growth is among the slowest. It is projected to reach its enrollment peak in 2023 and then decrease thereafter.

### Total Medicaid Claims Spending<sup>7</sup>

Total Medicaid spending is expected to increase by 5.8 percent annually between 2009 and 2029. This projection is based on the program as it currently exists and does not consider policy changes that may occur throughout the forecast period. Service categories that primarily serve the elderly are projected to have the highest growth during the forecast period. These services also tend to have the highest average per capita costs.

**Table 3: Spending on the elderly grows nearly twice as fast as spending on other age groups**

MEDICAID SPENDING BY AGE GROUP FOR SELECTED YEARS, 2009-2029 (IN MILLIONS)

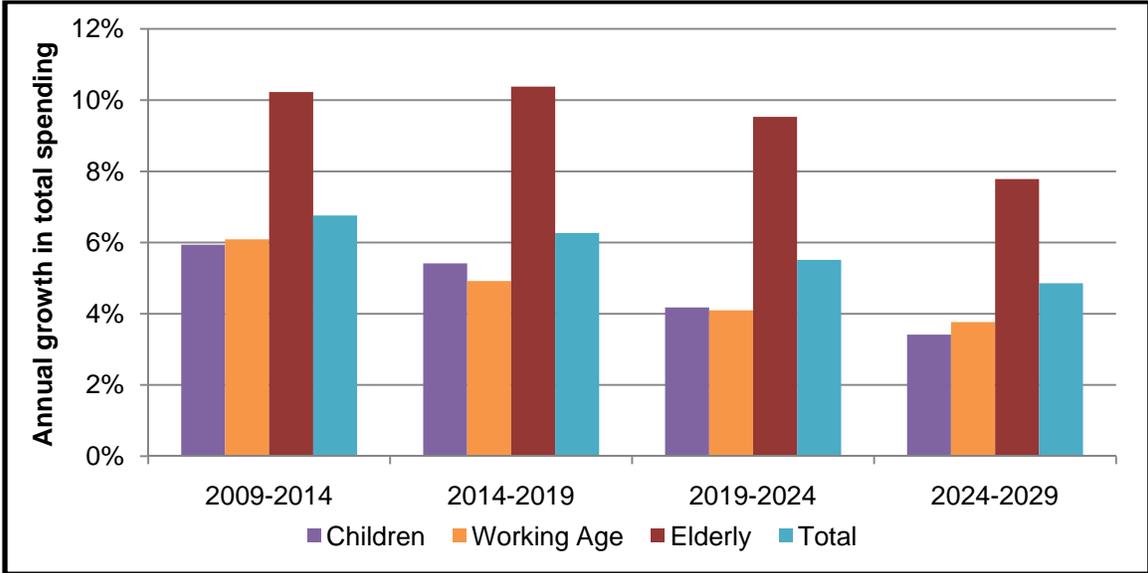
Age Group	2009	2014	2019	2024	2029	Annual Growth
<b>Children (0-19)</b>	\$446.7	\$595.9	\$775.7	\$951.9	\$1,125.9	4.7%
<b>Working Age Adults (20-64)</b>	\$454.8	\$611.2	\$777.1	\$950.0	\$1,143.0	4.8%
<b>Elderly (65+)</b>	\$180.3	\$293.3	\$480.6	\$757.6	\$1,102.0	9.5%
<b>Total</b>	\$1,081.8	\$1,500.5	\$2,033.4	\$2,659.4	\$3,370.8	5.8%

Source: Medicaid Budget Group; MESA Model

<sup>7</sup> All tables and figures are nominal unless otherwise noted. Nominal, or actual spending, is the projected future value without adjusting for inflation. Please see Appendix C for real spending tables.

**Figure 6: Growth in total spending will slow down with time**

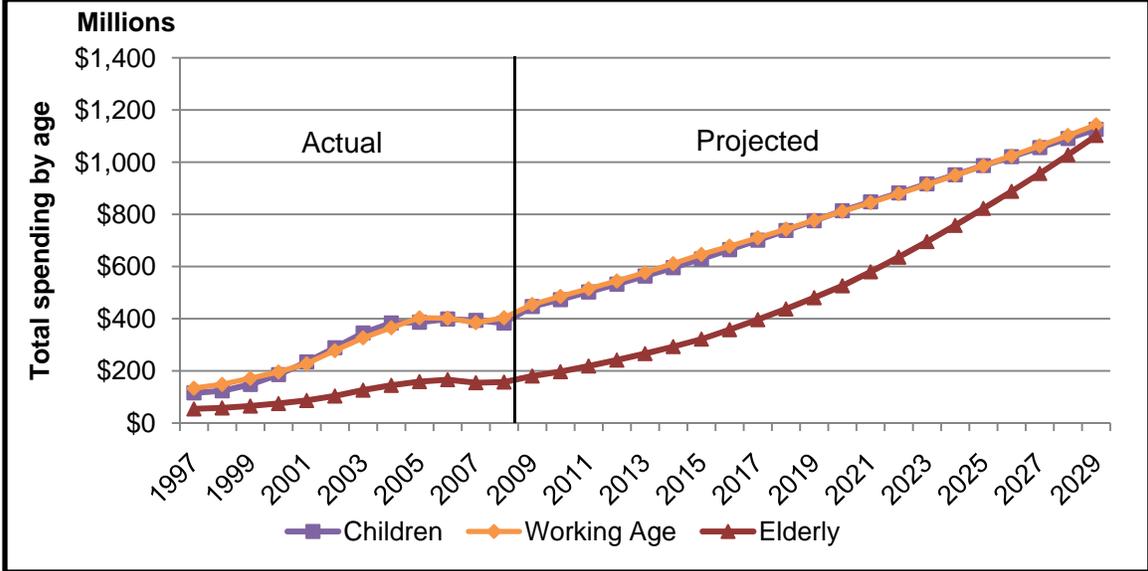
ANNUAL GROWTH IN TOTAL SPENDING BY AGE GROUP



Source: Medicaid Budget Group, MESA Model

**Figure 7: By 2029, claims spending for each age group will converge**

TOTAL SPENDING BY AGE GROUP

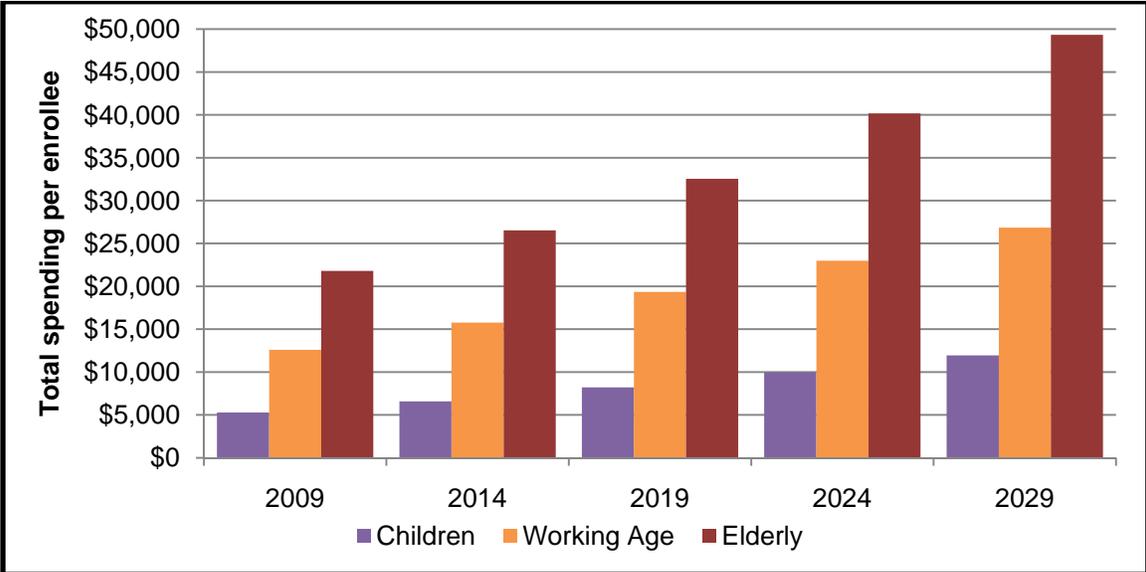


Source: Medicaid Budget Group, MESA Model

The higher projected growth rates in enrollment for the elderly will result in higher growth rates in spending for the elderly, in comparison to spending on other groups. The growth rate in spending for the elderly is projected to be 9.5 percent, in comparison to a projected annual growth of 4.8 percent for both children and working-age adults. Claims spending for all groups will grow from

\$1.1 billion in 2009 to \$3.4 billion in 2029, for an annual growth rate of 5.8 percent.

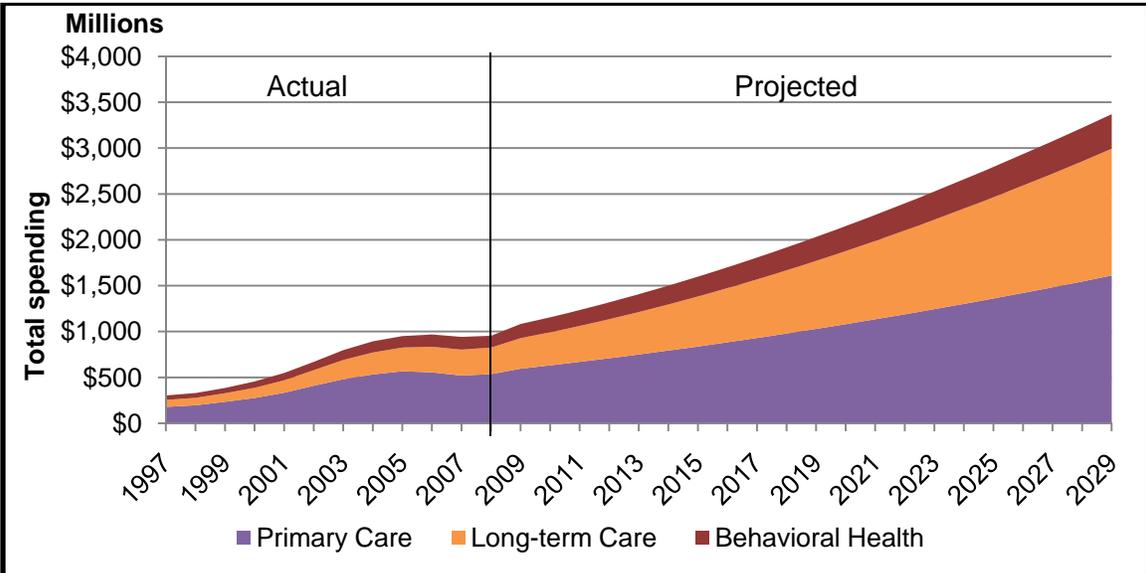
**Figure 8: Each elderly enrollee costs about four times as much as a child**  
 AVERAGE TOTAL CLAIMS SPENDING PER ENROLLEE



Source: Medicaid Budget Group: MESA Model

The higher costs of caring for the elderly will increase the total share of spending on elderly care. As a result, each of the three age groups will account for about one-third of Medicaid spending, despite the fact that the elderly are projected to account for only 14 percent of total enrollment in 2029.

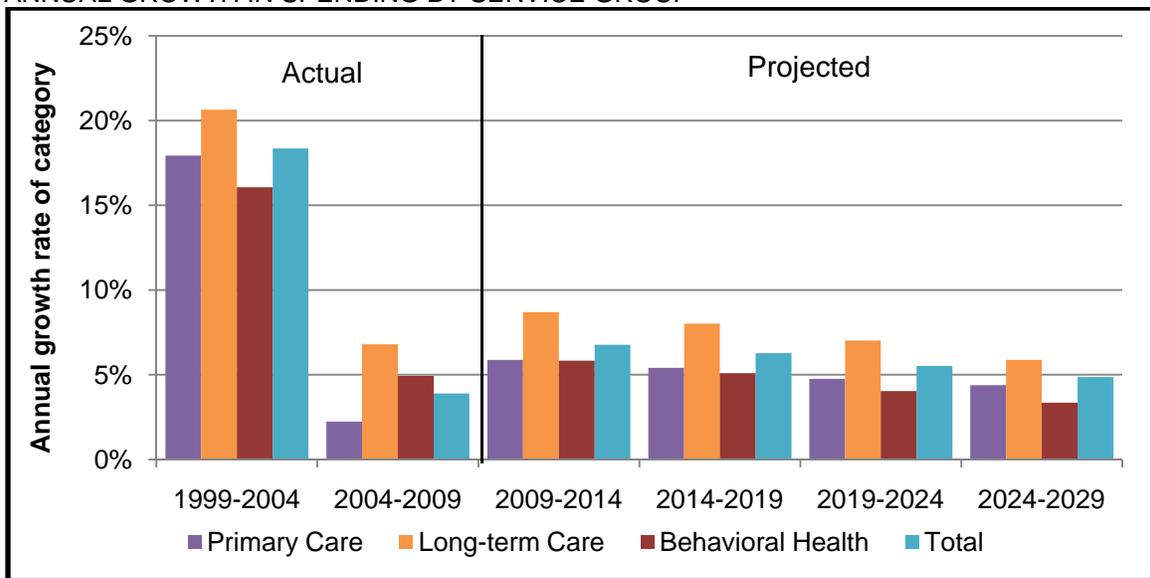
**Figure 9: Total spending in 2029 will be almost four times the 2009 value**  
 TOTAL SPENDING BY SERVICE GROUP



Source: Medicaid Budget Group: MESA Model

Figure 10 shows the growth rate in Alaska’s historical and projected Medicaid spending. Spending on Medicaid increased rapidly from 1999 to 2004; annual growth rates never dropped below 10 percent in any year and averaged 18 percent annually for the period. The large spending increases of the late 1990s seem to be under control. Growth in spending has slowed in recent years due at least in part to program changes put in place by the Legislature and Department following the release of the *Long-Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025* in January 2006. Growth in Medicaid spending is projected to remain at historically low levels throughout the forecast period.

**Figure 10: Growth in total spending has slowed dramatically in recent years**  
ANNUAL GROWTH IN SPENDING BY SERVICE GROUP

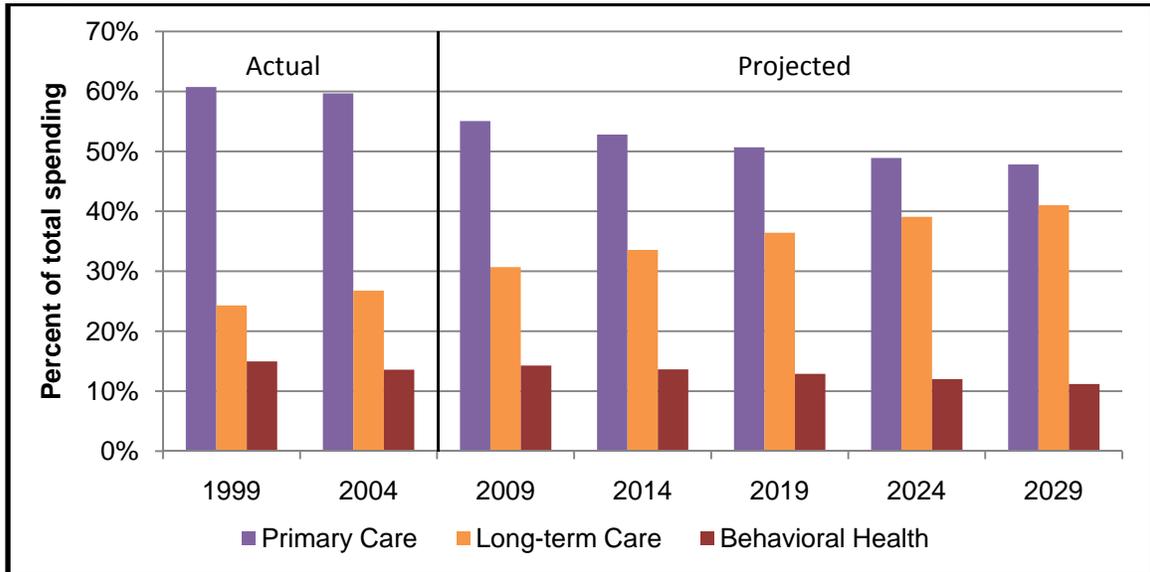


Source: Medicaid Budget Group: MESA Model

Spending on **Long-term Care** services, such as **Home and Community Based (HCB) Waiver** and **Personal Care**, is projected to grow faster than spending on **Primary Care** and **Behavioral Health**. **Long-term Care**, which is expected to grow from 31 percent to 41 percent of total spending, has a larger share of recipients over the age of 65 than either **Primary Care** or **Behavioral Health**.

**Figure 11: Spending on Long-term Care services will increase as a share of total spending**

PERCENT OF TOTAL SPENDING BY SERVICE GROUP



Source: Medicaid Budget Group: MESA Model

**Table 4: Long-Term Care is projected to be the fastest-growing service group**

MEDICAID SPENDING BY SERVICE GROUP FOR SELECTED YEARS (IN MILLIONS)

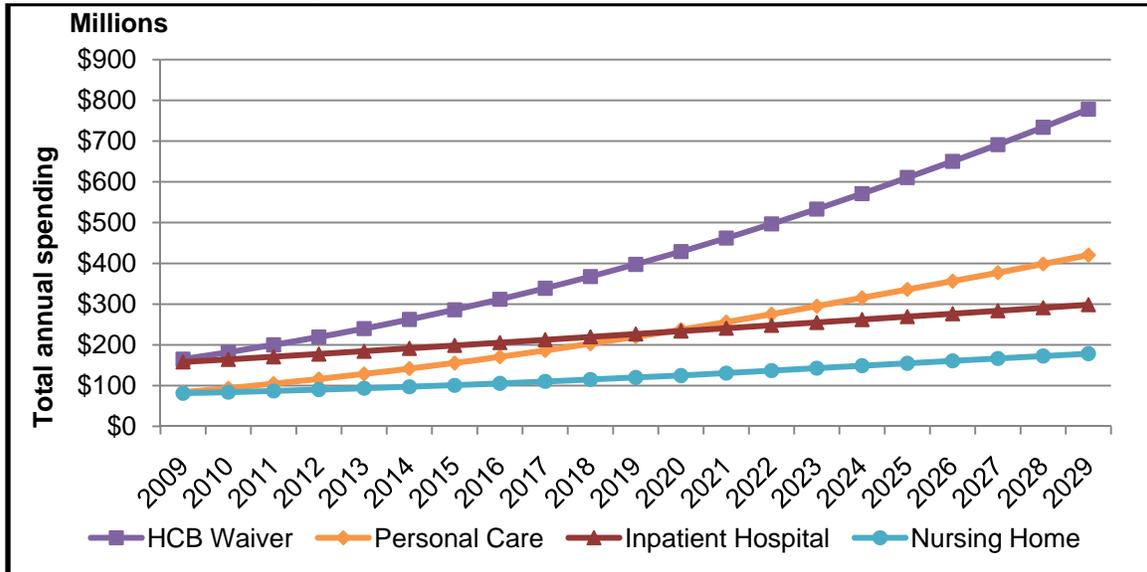
Service	2009	2014	2019	2024	2029	Annual Growth
Behavioral Health	\$154.2	\$204.7	\$262.2	\$319.5	\$376.8	4.6%
Long-Term Care	\$332.1	\$503.7	\$740.5	\$1,039.4	\$1,382.5	7.4%
Primary Care	\$595.5	\$792.1	\$1,030.7	\$1,300.5	\$1,611.5	5.1%
<b>Total</b>	<b>\$1,081.8</b>	<b>\$1,500.5</b>	<b>\$2,033.4</b>	<b>\$2,659.5</b>	<b>\$3,370.8</b>	<b>5.8%</b>

Source: Medicaid Budget Group, MESA model.

Total Medicaid spending will grow at an average rate of 5.8 percent through the forecast period. There is, however, some variation in the growth rates of the categories of spending. **HCB Waiver** and **Personal Care** are projected to grow at over 8 percent annually. By 2029 **HCB Waiver** will account for \$780 million or 23 percent of Medicaid spending, up from the current 15 percent. **Personal Care** will also make large gains, with an increase from 8 percent of total claims spending (\$84 million) in 2009 to 12 percent of spending (\$420 million) in 2029. Spending in both of these programs is driven largely by growth in enrollment of the elderly.

**Figure 12: Home and Community Based Waivers and Personal Care are the fastest growing service categories**

TOTAL SPENDING FOR SELECT SERVICE CATEGORIES



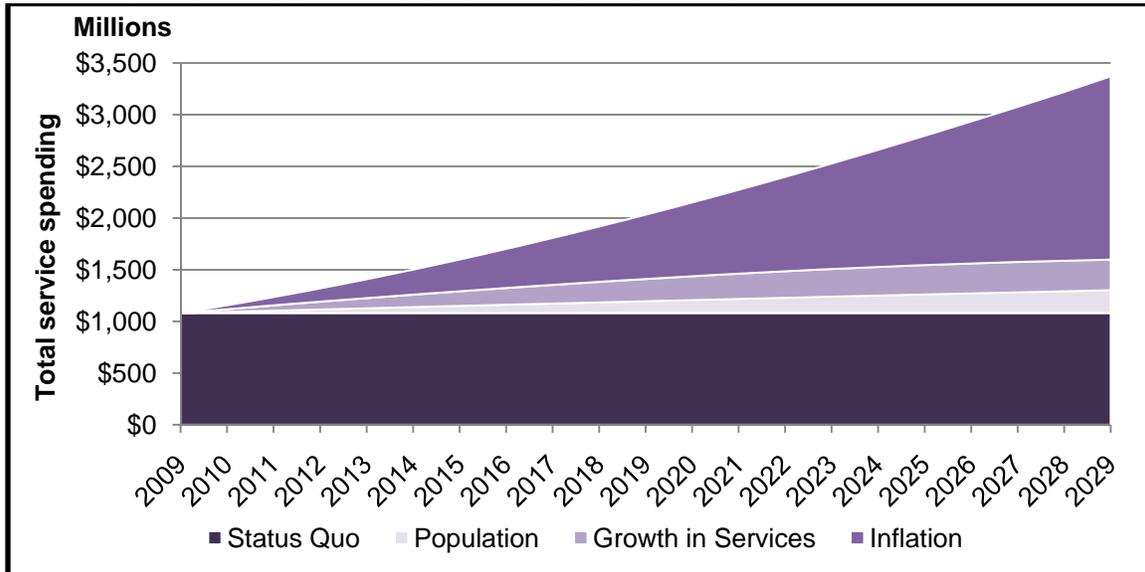
Source: Medicaid Budget Group, MESA model

Conversely, **Inpatient Hospital** is currently one of the largest categories for spending in 2009, second only to **HCB Waiver** and is not as heavily influenced by growth in the enrollment of the elderly. Inpatient Hospital spending is projected to grow by 3.2 percent annually, resulting in a decrease in share of Medicaid spending from 15 percent in 2009 to 9 percent in 2029.

Despite the relatively high rate of growth in the elderly population, the rate of spending growth for **Nursing Homes** is projected to be slower than the growth in spending for Medicaid as a whole. As a result, the **Nursing Home** category will drop out of the top five spending categories (and be replaced by **Personal Care**). The data suggests that recipients may be shifting from **Nursing Homes**, where services are received in an institutional setting, to **Personal Care** and **Home and Community Based Waivers**, where care is received in one’s own home.

**Figure 13: Inflation accounts for the largest part of increased claims spending**

SPENDING DECOMPOSED INTO GROWTH COMPONENTS



Source: Medicaid Budget Group, MESA model

Figure 13 shows the growth in total spending by components that affect spending growth. The components of spending growth are as follows:

- *Status Quo* refers to what would happen if there were no growth in health cost inflation, no growth in population, and no growth in the use and intensity of services provided. The status quo assumes that everything in future years remains exactly the same as in 2009.
- *Population Growth* is the additional cost on top of the status quo resulting from population growth. Only the increase in total population is taken into account and not demographic changes such as an aging population.
- *Growth in Services* includes the additional spending associated with a greater use and intensity of services provided. Growth in services is the result of an aging population and other demographic changes, as well as the change in amount, duration, and scope of services provided from an increase of technology.
- *Inflation* is the rate at which the price of a given medical service is expected to increase over time.

The component that will have the largest influence on total spending is inflation. Without inflation, Medicaid claims spending would increase from \$1.1 billion to \$1.6 billion in 2029, an average annual growth rate of 2.0 percent. Inflation, however, increases the amount of spending in 2029 by an additional \$1.8 billion for a total cost of \$3.4 billion – a combined annual increase of 5.8 percent over the forecast period.

## State Claims Spending

State spending is projected to grow at 6.8 percent annually for the forecast period, compared to a 5.2 percent projected annual growth in federal spending. Across the U.S., Medicaid spending is expected to grow at an annual rate of 8.4 percent from 2009 to 2018<sup>8,9</sup>, but Alaska's total Medicaid spending is projected to grow at just 6.6 percent over the same timeframe. The federal financial participation (FFP) rates that apply to the majority of Medicaid spending level off at close to 50 percent and are expected to continue at approximately the same level throughout the forecast period. This projection is based on spending patterns of today and is not intended to consider possible changes to federal participation in the future.

Medicaid is jointly funded by the federal and state government. Federal financial participation (FFP) rates are set at the federal level, and are largely outside of state control. The state's portion of Medicaid Service costs differs according to the recipient's Medicaid eligibility group, category of Medicaid service, provider of Medicaid-related service, and Native/Non-native status. For most Medicaid eligibility groups and services, the portion of state Medicaid benefits paid by the federal government is called the Federal Medical Assistance Percentage (FMAP).

**Table 5: State share of Medicaid funding increases throughout the forecast period**

Medicaid Spending by Fund Source as a Percent of Total Spending for Selected Years, 2009-2029

Fund Source	2009	2014	2019	2024	2029
<b>State and Other Match Funds (Percent of Total)</b>	35.7%	42.3%	42.5%	42.6%	42.7%
<b>Federal (Percent of Total)</b>	64.3%	57.7%	57.5%	57.4%	57.3%

Source: Medicaid Budget Group, MESA model.

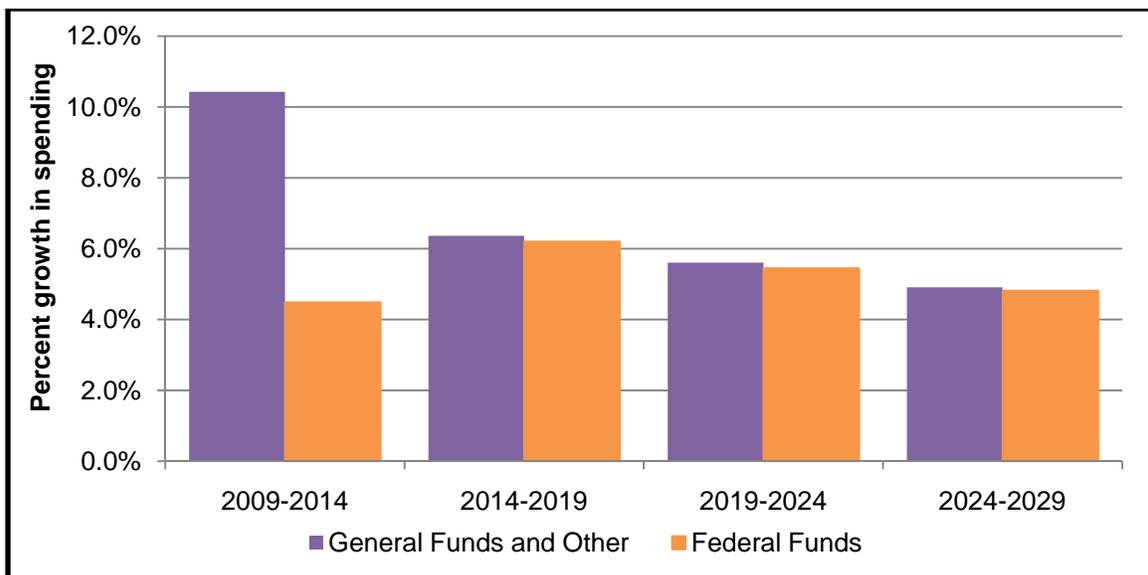
The FMAP is based on a three-year average of per capita personal income, ranked among states. While each state has its own FMAP, it can be no lower than 50 percent. Although the majority of benefits are reimbursed at the regular FMAP rate, certain subgroups have higher reimbursement rates (*e.g.*, qualified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

<sup>8</sup>Andrea Sisko, et al. "Health Spending Projections Through 2018: Recession Effects Add Uncertainty To The Outlook." Health Affairs. Vol. 28, no.2 (2009), p w350.

<sup>9</sup> The authors only conduct a 10-year forecast. Thus we are only able to compare MESA to the 10 years provided in their forecast.

Alaska benefited from special legislation passed in the Deficit Reduction Act of 2005, which allowed the FMAP to remain at the FFY 2005 level of 57.58 percent for FFY 2006 and 2007. This special rate expired October 1, 2008. More recently, Alaska has benefitted from the American Recovery and Reinvestment Act of 2009 (commonly known as the stimulus bill), which was passed in the spring of 2009. This bill increased Alaska’s FMAP rate to 58.68 percent, retroactive to October 1, 2008. Starting on April 1, 2009, Alaska’s FMAP rate was increased to 61.12 percent since a provision in the stimulus bill enables states to receive additional federal funds if the unemployment rate within the state reaches certain thresholds. After the stimulus funds expire at the end of December 2010, the Alaska FMAP rate will drop to 50.00 percent. The enhanced FMAP rate, which is used for the reimbursement rate for Title XXI and some other services, was not affected by the stimulus bill. It will drop from 66.00 percent in federal fiscal year 2010 to 65.00 percent in federal fiscal year 2011. These changes contribute to the increase in state spending relative to federal funds.

**Figure 14: After stimulus funds end in December 2010 and the FFP changes, state and federal spending growth rates are roughly equal**  
 GROWTH RATES FOR MEDICAID BY GENERAL FUND AND OTHER AND FEDERAL FUND



Source: Medicaid Budget Group, MESA model

The decrease of the federal financial participation rate leads to a higher growth rate in Alaska’s share of Medicaid spending than the federal government’s share. The state will have average spending growth of 6.8 percent, compared to 5.2 percent for the federal government. When we compare the year-to-year growth in spending, however, the growth in federal and state Medicaid spending are nearly equal with the exception of the transition years when the FMAP is adjusting and a larger share of the costs is shifted to the state.

## Other Medicaid Payments

In previous sections we projected Medicaid enrollment, utilization, and spending for the next twenty years based on historical claims payments from the Alaska Medicaid program and population projections from the Alaska Department of Labor and Workforce Development. The forecast showed that payments for services provided to individuals account for most of the Medicaid spending. There are other Medicaid payments and offsets which are not tied to services provided for any single individual. The share of total spending attributed to the special payments and offsets vary from year to year. For example, in 2005 the special payments accounted for 13 percent of total Medicaid spending, compared to 7 percent during 2008.

These additional payments and offsets include: Medicare Part A and Part B premium payments for seniors who are enrolled in both Medicare and Medicaid, drug rebates, and judgments from the Centers for Medicare and Medicaid Services (CMS). Supplemental payments are made to hospitals that serve a large number of the poor (Disproportionate Share Hospital payments or DSH payments) and to health clinics for Alaska Native tribes (continuing care agreement payments and tribal dental encounter payments). Supplemental payments to hospitals and health clinics usually make up the majority of the payments that don't go through the claims payment system.

**Table 6: Other Medicaid payments will increase total Medicaid spending in 2029 to \$3.6 billion**

Medicaid Spending by Fund Source as a Percent of Total Spending for Selected Years, 2009-2029

		2009	2014	2019	2024	2029
<b>Claims payments</b>	<b>Federal</b>	\$695.7	\$866.4	\$1,170.2	\$1,525.7	\$1,930.0
	<b>State Match</b>	\$386.1	\$634.1	\$863.2	\$1,133.8	\$1,440.8
	<b>Total</b>	\$1,081.8	\$1,500.5	\$2,033.4	\$2,659.5	\$3,370.8
<b>Other Payments</b>	<b>Federal</b>	\$48.7	\$60.6	\$81.9	\$106.8	\$135.1
	<b>State Match</b>	\$27.0	\$44.4	\$60.4	\$79.4	\$100.9
	<b>Total</b>	\$75.7	\$105.0	\$142.3	\$186.2	\$236.0
<b>Total Payments</b>	<b>Federal</b>	\$744.4	\$927.0	\$1,252.1	\$1,632.5	\$2,065.1
	<b>State Match</b>	\$413.1	\$678.5	\$923.6	\$1,213.2	\$1,541.7
	<b>Total</b>	\$1,157.5	\$1,605.5	\$2,175.7	\$2,845.7	\$3,606.8

Source: Medicaid Budget Group: MESA Model

There is uncertainty about the magnitude of the affect that special payments will have on Medicaid spending in the future. The Medicaid program is always changing, and payments that are acceptable one year may be disallowed by CMS

in later years<sup>10</sup>. The special payments are represented in this forecast by adding an additional 7 percent onto the forecast, based on claims data. In any given year, the forecast assumes that the share of total spending paid by the federal government will be the same for these special payments as it was for the claims payments.

## Summary

Total spending is forecast to reach \$3.6 billion by 2029 (see Table 6), growing at an average annual rate of 5.8 percent. State spending is expected to grow at 6.8 percent. Aside from inflation, growth in total spending through 2029 is primarily the result of the following factors:

- Population growth – expected to average 0.9 percent per year
- Enrollment growth – expected to average 1.1 percent per year

The population forecast includes assumptions about the changing demographic profile of Alaska. The average annual growth rate in enrollment of the elderly (65 and older) is expected to be 5.1 percent, which is higher than the growth rate for other age groups. As a result, the overall focus of the Medicaid program will shift from a child-based program to a program more evenly distributed between children, working-age adults, and the elderly. This demographic change affects spending because spending on the elderly is growing at a rate almost double that of children and working-age adults, and this growth is likely to continue. The expected shift in spending towards the elderly is still likely to occur, but the timing is delayed compared to earlier forecasts.

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

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

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<sup>10</sup> FairShare and ProShare are two examples of supplemental payment programs that have been discontinued in recent years.

## Appendices

### Appendix A: Medicaid Eligibility Classification Descriptions

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

## Appendix B: Medicaid Service Category Descriptions

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

## Appendix C: Detailed Tables of 2009-2029 MESA Forecast

Table 7: Forecast of <b>Population</b> by Subpopulations						
	Calendar Year					Percent Change
	2009	2014	2019	2024	2029	
<b>State</b>	691,443	727,714	764,172	799,183	832,163	0.9%
<b>Gender</b>						
<b>Male</b>	353,892	371,456	389,127	405,745	421,233	0.9%
<b>Female</b>	337,551	356,249	375,045	393,439	410,931	1.0%
<b>Native Status</b>						
<b>Native</b>	116,780	124,634	132,205	139,002	145,820	1.1%
<b>Non-Native</b>	574,663	603,080	631,967	660,181	686,343	0.9%
<b>Region</b>						
<b>Northern</b>	106,131	111,503	116,126	120,438	124,596	0.8%
<b>Western</b>	50,006	52,793	55,575	58,343	61,502	1.0%
<b>South Central</b>	91,822	94,354	96,065	97,085	97,432	0.3%
<b>Anchorage/Mat-Su</b>	373,235	399,326	427,819	456,322	483,243	1.3%
<b>Southeast</b>	70,250	69,737	68,587	66,996	65,391	-0.4%
<b>Age Group</b>						
<b>0-4</b>	54,616	57,876	60,560	62,233	64,046	0.8%
<b>5-9</b>	54,823	57,229	60,680	63,398	65,205	0.9%
<b>10-14</b>	53,642	56,864	59,382	62,924	65,704	0.9%
<b>15-19</b>	54,133	51,954	54,941	57,360	60,774	0.6%
<b>20-24</b>	50,029	50,383	48,326	51,134	53,348	0.3%
<b>25-34</b>	91,451	103,196	111,617	110,722	112,046	1.0%
<b>35-44</b>	96,123	94,632	99,027	110,857	119,586	1.1%
<b>45-54</b>	105,160	95,006	86,333	84,576	88,577	-0.9%
<b>55-64</b>	78,601	89,526	89,190	79,763	71,256	-0.5%
<b>65-74</b>	33,255	47,789	64,054	73,846	73,749	4.1%
<b>75+</b>	19,611	23,259	30,064	42,372	57,873	5.6%

	Calendar Year					Percent Change
	2009	2014	2019	2024	2029	
<b>State</b>	128,896	140,276	149,501	155,597	159,138	1.1%
<b>Gender</b>						
<b>Male</b>	57,938	63,223	67,351	69,881	71,136	1.0%
<b>Female</b>	70,959	77,054	82,149	85,717	88,003	1.1%
<b>Native Status</b>						
<b>Native</b>	46,294	50,055	53,324	55,590	57,264	1.1%
<b>Non-Native</b>	82,603	90,221	96,176	100,007	101,874	1.1%
<b>Region</b>						
<b>Northern</b>	17,368	19,015	20,086	20,675	20,957	0.9%
<b>Western</b>	18,670	20,284	21,635	22,628	23,475	1.2%
<b>South Central</b>	17,747	18,919	19,721	19,977	19,696	0.5%
<b>Anchorage/Mat-Su</b>	62,691	69,289	75,285	79,883	83,079	1.4%
<b>Southeast</b>	12,420	12,768	12,773	12,434	11,914	-0.2%
<b>Age Group</b>						
<b>0-4</b>	28,461	31,430	32,960	32,947	32,302	0.6%
<b>5-9</b>	20,556	22,118	23,271	23,501	23,058	0.6%
<b>10-14</b>	18,621	20,310	21,046	21,578	21,400	0.7%
<b>15-19</b>	16,873	16,582	17,276	17,382	17,474	0.2%
<b>20-24</b>	6,955	7,232	7,003	7,460	7,855	0.6%
<b>25-34</b>	10,413	12,328	13,688	13,645	13,773	1.4%
<b>35-44</b>	8,007	8,057	8,641	9,938	10,851	1.5%
<b>45-54</b>	6,528	6,147	5,665	5,552	5,870	-0.5%
<b>55-64</b>	4,212	5,017	5,186	4,734	4,221	0.0%
<b>65-74</b>	4,209	6,132	8,332	9,771	9,915	4.3%
<b>75+</b>	4,061	4,923	6,434	9,089	12,421	5.7%

Eligibility Group	2009	2014	2019	2024	2029	Percent Change
<b>AFDC &amp; Related</b>	37,277	39,940	41,837	42,986	43,711	0.8%
<b>Exams</b>	828	914	1,003	1,112	1,225	2.0%
<b>Kids in Custody</b>	3,817	4,048	4,237	4,308	4,297	0.6%
<b>LTC Non-cash</b>	1,838	2,170	2,568	3,038	3,501	3.3%
<b>Medicare</b>	444	485	509	519	522	0.8%
<b>Other</b>	4	5	6	8	9	4.1%
<b>Other Disabled</b>	255	329	415	490	538	3.8%
<b>Pregnancy/Post Partum</b>	13,176	14,003	14,563	14,705	14,528	0.5%
<b>SSI/APA/LTC Cash</b>	20,892	24,503	28,253	31,687	34,279	2.5%
<b>Title XIX Kids</b>	43,999	46,969	48,878	49,262	48,802	0.5%
<b>Title XXI Kids</b>	6,367	6,908	7,232	7,482	7,726	1.0%
<b>Total (Unduplicated Count)</b>	128,896	140,276	149,501	155,597	159,138	1.1%

<b>Table 10: Forecast of Utilization by Subpopulations</b>						
	<b>Calendar Year</b>					<b>Percent Change</b>
	<b>2009</b>	<b>2014</b>	<b>2019</b>	<b>2024</b>	<b>2029</b>	
<b>State</b>	394,421	461,870	521,592	567,562	598,947	2.1%
<b>Gender</b>						
<b>Male</b>	161,873	190,493	215,889	234,702	246,697	2.1%
<b>Female</b>	232,548	271,378	305,703	332,860	352,250	2.1%
<b>Native Status</b>						
<b>Native</b>	126,271	147,270	165,966	180,208	190,802	2.1%
<b>Non-Native</b>	268,150	314,601	355,625	387,354	408,146	2.1%
<b>Region</b>						
<b>Northern</b>	49,249	58,235	65,506	70,781	74,308	2.1%
<b>Western</b>	54,773	64,177	72,501	79,125	84,533	2.2%
<b>South Central</b>	51,122	58,698	64,947	68,977	70,429	1.6%
<b>Anchorage/Mat-Su</b>	203,652	241,312	276,781	306,025	327,430	2.4%
<b>Southeast</b>	35,624	39,447	41,857	42,654	42,247	0.9%
<b>Age Group</b>						
<b>0-4</b>	72,353	84,154	92,085	95,906	97,980	1.5%
<b>5-9</b>	58,900	68,115	75,730	79,592	80,301	1.6%
<b>10-14</b>	52,017	60,896	66,723	71,267	72,680	1.7%
<b>15-19</b>	44,685	46,971	51,576	54,014	55,830	1.1%
<b>20-24</b>	22,529	24,818	25,080	27,570	29,667	1.4%
<b>25-34</b>	34,632	43,601	50,674	52,186	53,827	2.2%
<b>35-44</b>	27,552	29,481	33,114	39,330	43,842	2.3%
<b>45-54</b>	22,520	22,497	21,676	21,908	23,606	0.2%
<b>55-64</b>	21,305	26,984	29,057	27,240	24,703	0.7%
<b>65-74</b>	21,325	33,073	47,004	56,754	58,472	5.2%
<b>75+</b>	16,602	21,280	28,873	41,797	58,040	6.5%

<b>Service</b>	<b>Calendar Year</b>					<b>Annual % Change</b>
	<b>2009</b>	<b>2014</b>	<b>2019</b>	<b>2024</b>	<b>2029</b>	
<b>Dental</b>	40,884	49,239	56,174	61,008	64,022	2.3%
<b>DME/Supplies</b>	10,328	12,411	14,532	16,481	18,030	2.8%
<b>EPSDT</b>	104	63	37	21	11	-10.6%
<b>Family Planning</b>	453	479	496	504	505	0.5%
<b>HCB Waiver</b>	4,841	6,709	8,704	10,572	11,996	4.6%
<b>Health Clinic</b>	29,963	40,936	51,421	60,153	66,723	4.1%
<b>Home Health/Hospice</b>	738	856	975	1,080	1,159	2.3%
<b>Inpatient Hospital</b>	14,917	15,534	15,810	15,734	15,357	0.1%
<b>Inpatient Psychiatric</b>	796	880	947	988	1,009	1.2%
<b>Lab/X-ray</b>	13,269	13,342	13,133	12,687	12,041	-0.5%
<b>Nursing Home</b>	1,081	1,108	1,143	1,173	1,154	0.3%
<b>Outpatient Hospital</b>	57,146	65,422	72,565	77,947	81,645	1.8%
<b>Outpatient Mental Health</b>	11,247	12,123	12,824	13,278	13,501	0.9%
<b>Personal Care</b>	3,734	5,336	6,905	8,216	9,022	4.5%
<b>Pharmacy</b>	66,739	74,830	81,718	86,769	90,081	1.5%
<b>Physician/Practitioner</b>	85,106	96,269	105,441	111,882	115,941	1.6%
<b>Residential Psychiatric/BRC</b>	967	1,189	1,310	1,322	1,260	1.3%
<b>Therapy/Rehabilitation</b>	7,991	10,209	12,336	14,116	15,420	3.3%
<b>Transportation</b>	22,169	26,378	30,252	33,456	35,925	2.4%
<b>Vision</b>	21,947	28,558	34,870	40,177	44,145	3.6%

<b>Table 12: Forecast of Nominal Spending by Subpopulations (in millions)</b>						
	<b>Calendar Year</b>					<b>Percent Change</b>
	<b>2009</b>	<b>2014</b>	<b>2019</b>	<b>2024</b>	<b>2029</b>	
<b>State</b>	\$1,081.8	\$1,500.5	\$2,033.4	\$2,659.4	\$3,370.8	5.8%
<b>Gender</b>						
<b>Male</b>	\$469.3	\$654.1	\$889.4	\$1,162.2	\$1,467.5	5.9%
<b>Female</b>	\$612.4	\$846.4	\$1,144.0	\$1,497.2	\$1,903.3	5.8%
<b>Native Status</b>						
<b>Native</b>	\$364.6	\$503.7	\$681.3	\$889.1	\$1,130.6	5.8%
<b>Non-Native</b>	\$717.2	\$996.8	\$1,352.2	\$1,770.3	\$2,240.2	5.9%
<b>Region</b>						
<b>Northern</b>	\$122.8	\$172.3	\$233.0	\$303.1	\$383.0	5.9%
<b>Western</b>	\$123.0	\$171.0	\$232.2	\$305.2	\$392.5	6.0%
<b>South Central</b>	\$157.8	\$215.0	\$286.0	\$365.7	\$449.5	5.4%
<b>Anchorage/Mat-Su</b>	\$553.5	\$778.3	\$1,073.2	\$1,428.9	\$1,840.1	6.2%
<b>Southeast</b>	\$124.7	\$163.9	\$209.1	\$256.5	\$305.8	4.6%
<b>Age Group</b>						
<b>0-4</b>	\$146.1	\$200.8	\$260.5	\$316.9	\$374.3	4.8%
<b>5-9</b>	\$63.7	\$87.0	\$114.7	\$140.8	\$164.3	4.9%
<b>10-14</b>	\$97.0	\$134.2	\$174.2	\$217.4	\$256.4	5.0%
<b>15-19</b>	\$140.0	\$173.9	\$226.3	\$276.8	\$330.9	4.4%
<b>20-24</b>	\$66.4	\$86.5	\$103.6	\$133.0	\$165.5	4.7%
<b>25-34</b>	\$97.9	\$145.7	\$200.7	\$241.4	\$287.9	5.5%
<b>35-44</b>	\$91.9	\$116.2	\$154.7	\$214.6	\$276.7	5.7%
<b>45-54</b>	\$109.2	\$129.0	\$147.3	\$173.9	\$216.7	3.5%
<b>55-64</b>	\$89.4	\$133.8	\$170.8	\$187.0	\$196.1	4.0%
<b>65-74</b>	\$63.5	\$116.4	\$196.1	\$276.6	\$329.5	8.6%
<b>75+</b>	\$116.8	\$176.9	\$284.5	\$481.0	\$772.5	9.9%

Note: Spending is for claims payments only.

Table 13: Forecast of **Nominal Spending** by Service Category (in millions)

Service	Calendar Year					Annual % Change
	2009	2014	2019	2024	2029	
Dental	\$32.6	\$46.6	\$64.0	\$83.9	\$106.6	6.1%
DME/Supplies	\$16.2	\$22.4	\$30.7	\$41.1	\$53.8	6.2%
EPSDT	\$0.029	\$0.020	\$0.014	\$0.010	\$0.006	-7.3%
Family Planning	\$0.29	\$0.36	\$0.44	\$0.53	\$0.65	4.1%
HCB Waiver	\$165.2	\$262.5	\$397.5	\$571.1	\$778.3	8.1%
Health Clinic	\$36.2	\$56.7	\$82.7	\$112.8	\$147.5	7.2%
Home Health/Hospice	\$1.6	\$2.3	\$3.1	\$4.2	\$5.5	6.5%
Inpatient Hospital	\$158.1	\$191.4	\$226.7	\$262.0	\$298.4	3.2%
Inpatient Psychiatric	\$16.5	\$21.6	\$27.8	\$34.7	\$42.4	4.8%
Lab/X-ray	\$1.7	\$2.0	\$2.4	\$2.8	\$3.2	3.1%
Nursing Home	\$81.4	\$97.2	\$120.0	\$148.8	\$178.5	4.0%
Outpatient Hospital	\$97.0	\$129.9	\$170.0	\$215.8	\$269.9	5.2%
Outpatient Mental Health	\$84.2	\$105.5	\$132.0	\$160.8	\$192.6	4.2%
Personal Care	\$83.9	\$141.8	\$219.8	\$315.2	\$420.2	8.4%
Pharmacy	\$77.2	\$102.0	\$132.1	\$167.3	\$208.5	5.1%
Physician/Practitioner	\$97.2	\$128.9	\$167.2	\$210.5	\$261.5	5.1%
Residential Psychiatric/BRC	\$53.5	\$77.6	\$102.5	\$124.0	\$141.7	5.0%
Therapy/Rehabilitation	\$22.2	\$32.2	\$45.6	\$61.4	\$79.3	6.6%
Transportation	\$52.4	\$72.9	\$98.9	\$128.9	\$164.2	5.9%
Vision	\$4.4	\$6.8	\$9.9	\$13.6	\$17.8	7.2%
<b>Total Spending</b>	\$1,081.8	\$1,500.5	\$2,033.4	\$2,659.4	\$3,370.8	5.8%

Note: Spending is for claims payments only.

<b>Table 14: Forecast of Real Spending by Subpopulations (in millions of 2009 dollars)</b>						
	<b>Calendar Year</b>					<b>Percent Change</b>
	<b>2009</b>	<b>2014</b>	<b>2019</b>	<b>2024</b>	<b>2029</b>	
<b>State</b>	\$1,081.8	\$1,259.1	\$1,411.3	\$1,527.1	\$1,598.3	2.0%
<b>Gender</b>						
<b>Male</b>	\$469.3	\$548.8	\$617.3	\$667.3	\$695.8	2.0%
<b>Female</b>	\$612.4	\$710.2	\$794.0	\$859.7	\$902.5	2.0%
<b>Native Status</b>						
<b>Native</b>	\$364.6	\$422.7	\$472.8	\$510.5	\$536.1	1.9%
<b>Non-Native</b>	\$717.2	\$836.4	\$938.5	\$1,016.5	\$1,062.2	2.0%
<b>Region</b>						
<b>Northern</b>	\$122.8	\$144.6	\$161.7	\$174.0	\$181.6	2.0%
<b>Western</b>	\$123.0	\$143.5	\$161.2	\$175.2	\$186.1	2.1%
<b>South Central</b>	\$157.8	\$180.4	\$198.5	\$210.0	\$213.1	1.5%
<b>Anchorage/Mat-Su</b>	\$553.5	\$653.1	\$744.9	\$820.5	\$872.5	2.3%
<b>Southeast</b>	\$124.7	\$137.5	\$145.1	\$147.3	\$145.0	0.8%
<b>Age Group</b>						
<b>0-4</b>	\$146.1	\$168.5	\$180.8	\$181.9	\$177.5	1.0%
<b>5-9</b>	\$63.7	\$73.0	\$79.6	\$80.9	\$77.9	1.0%
<b>10-14</b>	\$97.0	\$112.6	\$120.9	\$124.8	\$121.6	1.1%
<b>15-19</b>	\$140.0	\$145.6	\$157.1	\$159.0	\$156.9	0.6%
<b>20-24</b>	\$66.4	\$72.6	\$71.9	\$76.4	\$78.5	0.8%
<b>25-34</b>	\$97.9	\$122.2	\$139.3	\$138.6	\$136.5	1.7%
<b>35-44</b>	\$91.9	\$97.5	\$107.4	\$123.3	\$131.2	1.8%
<b>45-54</b>	\$109.2	\$108.2	\$102.2	\$99.9	\$102.8	-0.3%
<b>55-64</b>	\$89.4	\$112.3	\$118.5	\$107.4	\$93.0	2.0%
<b>65-74</b>	\$63.5	\$97.7	\$136.1	\$158.8	\$156.2	4.6%
<b>75+</b>	\$116.8	\$148.4	\$197.5	\$276.2	\$366.3	5.9%

Note: Spending is for claims payments only.

Table 15: Forecast of **Real Spending** by Service Category (in millions of 2009 dollars)

Service	Calendar Year					Annual % Change
	2009	2014	2019	2024	2029	
Dental	\$32.6	\$39.1	\$44.4	\$48.2	\$50.5	2.2%
DME/Supplies	\$16.2	\$18.8	\$21.3	\$23.6	\$25.5	2.3%
EPSDT	\$0.029	\$0.017	\$0.010	\$0.006	\$0.003	-10.7%
Family Planning	\$0.29	\$0.30	\$0.30	\$0.30	\$0.31	0.3%
HCB Waiver	\$165.2	\$220.2	\$275.9	\$327.9	\$369.0	4.1%
Health Clinic	\$36.2	\$47.6	\$57.4	\$64.8	\$70.0	3.4%
Home Health/Hospice	\$1.6	\$1.9	\$2.2	\$2.4	\$2.6	2.6%
Inpatient Hospital	\$158.1	\$160.6	\$157.4	\$150.4	\$141.5	-0.6%
Inpatient Psychiatric	\$16.5	\$18.1	\$19.3	\$19.9	\$20.1	1.0%
Lab/X-ray	\$1.7	\$1.7	\$1.7	\$1.6	\$1.5	-0.6%
Nursing Home	\$81.4	\$81.6	\$83.3	\$85.5	\$84.6	0.2%
Outpatient Hospital	\$97.0	\$109.0	\$118.0	\$123.9	\$128.0	1.4%
Outpatient Mental Health	\$84.2	\$88.5	\$91.6	\$92.4	\$91.3	0.4%
Personal Care	\$83.9	\$118.9	\$152.6	\$181.0	\$199.3	4.4%
Pharmacy	\$77.2	\$85.5	\$91.7	\$96.0	\$98.8	1.2%
Physician/Practitioner	\$97.2	\$108.2	\$116.0	\$120.9	\$124.0	1.2%
Residential Psychiatric/BRC	\$53.5	\$65.1	\$71.1	\$71.2	\$67.2	1.1%
Therapy/Rehabilitation	\$22.2	\$27.0	\$31.7	\$35.2	\$37.6	2.7%
Transportation	\$52.4	\$61.2	\$68.6	\$74.0	\$77.9	2.0%
Vision	\$4.4	\$5.7	\$6.9	\$7.8	\$8.4	3.3%
<b>Total Spending</b>	<b>\$1,081.8</b>	<b>\$1,259.1</b>	<b>\$1,411.3</b>	<b>\$1,527.1</b>	<b>\$1,598.3</b>	<b>2.0%</b>

Note: Spending is for claims payments only.

Table 16: Forecast of **State Spending** by Service Category (in millions)

Service	Calendar Year					Annual % Change
	2009	2014	2019	2024	2029	
Dental	\$10.5	\$17.5	\$24.1	\$31.5	\$40.1	6.9%
DME/Supplies	\$6.8	\$11.1	\$15.3	\$20.4	\$26.7	7.1%
EPSDT	\$0.012	\$0.010	\$0.007	\$0.005	\$0.003	-6.5%
Family Planning	\$0.26	\$0.33	\$0.40	\$0.49	\$0.59	4.2%
HCB Waiver	\$67.6	\$127.2	\$192.6	\$276.7	\$377.1	4.4%
Health Clinic	\$2.7	\$5.0	\$7.4	\$10.0	\$13.1	8.2%
Home Health/Hospice	\$0.6	\$1.0	\$1.3	\$1.8	\$2.4	7.3%
Inpatient Hospital	\$49.6	\$70.9	\$84.0	\$97.0	\$110.5	4.1%
Inpatient Psychiatric	\$6.9	\$10.6	\$13.6	\$17.0	\$20.8	5.7%
Lab/X-ray	\$0.7	\$1.0	\$1.2	\$1.4	\$1.6	4.0%
Nursing Home	\$32.6	\$46.1	\$56.9	\$70.5	\$84.6	4.9%
Outpatient Hospital	\$26.1	\$41.0	\$53.7	\$68.1	\$85.2	6.1%
Outpatient Mental Health	\$32.2	\$47.5	\$59.4	\$72.4	\$86.7	5.1%
Personal Care	\$35.4	\$70.8	\$109.7	\$157.3	\$209.7	9.3%
Pharmacy	\$27.4	\$42.6	\$55.2	\$69.8	\$87.0	6.0%
Physician/Practitioner	\$35.9	\$56.0	\$72.6	\$91.4	\$113.5	5.9%
Residential Psychiatric/BRC	\$22.1	\$37.6	\$49.7	\$60.2	\$68.7	5.8%
Therapy/Rehabilitation	\$8.5	\$14.6	\$20.7	\$27.9	\$36.0	7.5%
Transportation	\$18.3	\$30.1	\$40.8	\$53.2	\$67.8	6.8%
Vision	\$1.8	\$3.3	\$4.8	\$6.5	\$8.6	8.0%
<b>Total Spending</b>	<b>\$386.1</b>	<b>\$634.1</b>	<b>\$863.2</b>	<b>\$1,133.8</b>	<b>\$1,440.8</b>	<b>6.8%</b>

Note: Spending is for claims payments only.

**Table 17: Historical Enrollment by Demographic Group**

Year	Non-Native		Native		Female	Male	Working Age			Total
	Non-Native	Native	Children	Age			Elderly			
1997	59,555	30,309	51,981	37,883	52,940	31,196	5,728	89,864		
1998	57,939	30,555	50,828	37,666	51,959	30,676	5,859	88,494		
1999	62,872	32,818	54,301	41,389	58,207	31,391	6,092	95,690		
2000	72,728	37,351	61,789	48,290	71,522	32,082	6,475	110,079		
2001	76,626	39,507	64,535	51,598	77,403	31,995	6,735	116,133		
2002	80,468	41,008	67,130	54,346	81,590	32,903	6,983	121,476		
2003	83,945	42,606	69,755	56,796	85,097	34,080	7,374	126,551		
2004	84,824	44,592	71,230	58,186	86,936	34,904	7,576	129,416		
2005	87,452	44,514	72,710	59,256	87,454	36,601	7,911	131,966		
2006	86,705	45,588	73,187	59,736	87,206	37,419	8,298	132,923		
2007	81,047	47,027	70,579	57,495	83,929	35,829	8,316	128,074		
2008	78,647	46,311	68,638	56,320	81,575	35,072	8,311	124,958		

**Table 18: Historical Spending by Demographic Group (in millions)**

Year	Non-Native		Native		Female	Male	Working Age			Total
	Non-Native	Native	Children	Age			Elderly			
1997	\$238.9	\$65.0	\$172.0	\$131.9	\$115.8	\$133.6	\$54.4	\$303.9		
1998	\$248.7	\$81.8	\$188.4	\$142.1	\$123.8	\$148.6	\$58.1	\$330.5		
1999	\$280.5	\$104.5	\$221.9	\$163.0	\$147.8	\$171.6	\$65.6	\$384.9		
2000	\$326.9	\$129.9	\$260.5	\$196.2	\$186.6	\$196.1	\$75.5	\$456.7		
2001	\$383.4	\$165.6	\$310.6	\$238.6	\$234.7	\$227.5	\$86.9	\$549.1		
2002	\$455.7	\$214.4	\$384.1	\$286.1	\$288.7	\$277.5	\$103.9	\$670.2		
2003	\$533.5	\$265.0	\$458.5	\$340.2	\$345.3	\$326.8	\$126.5	\$798.6		
2004	\$589.6	\$304.1	\$506.3	\$387.4	\$383.6	\$365.4	\$144.7	\$893.7		
2005	\$654.8	\$294.5	\$539.6	\$409.6	\$386.6	\$403.5	\$159.1	\$949.2		
2006	\$647.1	\$320.0	\$550.3	\$416.8	\$398.8	\$401.9	\$166.4	\$967.1		
2007	\$618.3	\$315.0	\$526.9	\$406.5	\$393.8	\$384.8	\$154.8	\$933.4		
2008	\$626.8	\$317.9	\$536.4	\$408.3	\$383.4	\$404.0	\$157.3	\$944.7		

Note: Spending is for claims payments only.

**Table 19: Historical Spending by Service Category Group (in millions)**

Year	Behavioral Health	Long-Term Care	Primary Care	Total
1997	\$48.3	\$76.3	\$179.2	\$303.9
1998	\$52.0	\$82.1	\$196.4	\$330.5
1999	\$57.6	\$93.6	\$233.8	\$384.9
2000	\$69.7	\$110.2	\$276.8	\$456.7
2001	\$80.3	\$135.4	\$333.4	\$549.1
2002	\$90.8	\$169.7	\$409.6	\$670.2
2003	\$107.7	\$209.7	\$481.3	\$798.6
2004	\$121.3	\$239.1	\$533.3	\$893.7
2005	\$124.6	\$257.3	\$567.3	\$949.2
2006	\$132.9	\$278.7	\$555.5	\$967.1
2007	\$136.6	\$283.0	\$513.7	\$933.4
2008	\$126.7	\$286.0	\$532.1	\$944.7

Note: Spending is for claims payments only.

**Long-term Forecast of  
Medicaid Enrollment  
and  
Spending in Alaska:  
*Supplement 2009–2029***

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