Long-Term Forecast of Medicaid Enrollment and Spending in Alaska: FY2026-2046

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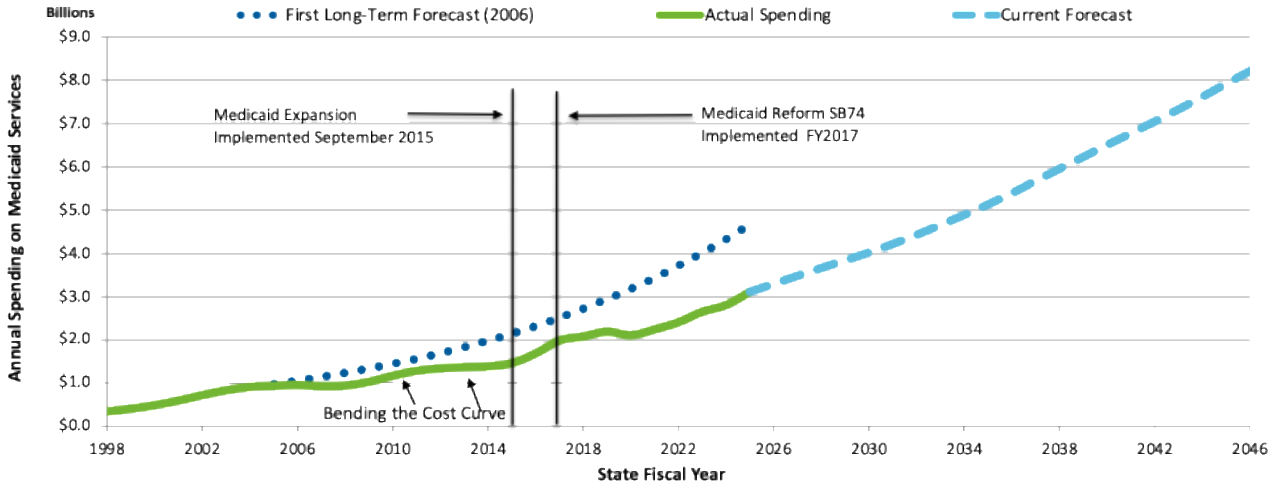
Executive Summary

The forecast presented in this report is an update to the *Long-Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025*, which was released by the Alaska Department of Health and Social Services (DHSS), now the Department of Health (DOH), in February 2006. In this report, we develop long-term forecasts of enrollment in and spending on services provided by Alaska's Medicaid program for fiscal year (FY) 2026 through FY2046. These projections are based on the Medicaid policies, services offered, and eligibility requirements in place today. Alaska's Medicaid program has changed considerably since 2006 and will likely continue to change over the next 20 years. Nevertheless, the purpose of the long-term forecast is to inform decision makers about how Medicaid spending in Alaska will likely evolve given the structure of the program as it exists today.

Summary of the Long-Term Forecast of Medicaid Enrollment and Spending in Alaska

Figure 1 shows actual spending on Medicaid services beginning in FY1998 (solid green line), projected spending from the first long-term Medicaid forecast (dark blue dotted line), and the current projection of Medicaid spending (light blue dashed line). Actual spending on Medicaid services in FY2025 was nearly $1.56 billion less than was projected in the first long-term Medicaid forecast. Much of this difference is attributable to cost saving efforts by the Alaska Legislature and the DOH, which helped "bend the cost curve" on Medicaid spending. We project total spending on Medicaid services will reach $8.2 billion by FY2046.

Figure 1: Spending on Medicaid Services – Actual and Projected, FY1998 – FY2046

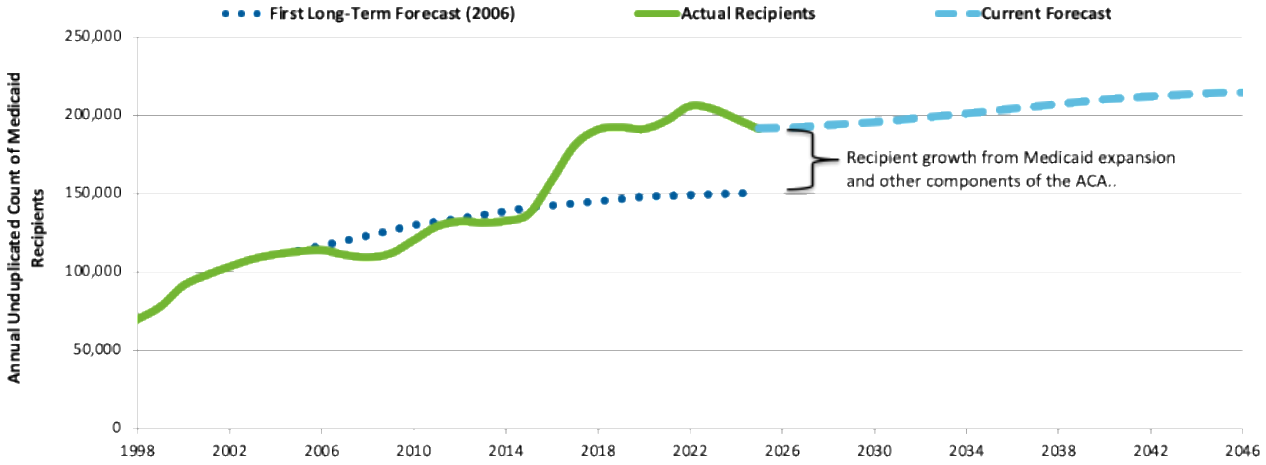


Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Figure 2 shows the number of Medicaid enrollees who received Medicaid services (referred to as "recipients") each year beginning in FY1998 and the projected number of Medicaid recipients from the first long-term Medicaid forecast and for the current forecast.[1] Between FY2006 and FY2015, the actual number of Medicaid recipients tracked closely to the number of recipients projected in the 2006 forecast. However, with the initiation of Medicaid expansion in September 2015, enrollment in Medicaid increased considerably, which in turn led to substantial growth in the number of recipients of Medicaid services.

The number of recipients decreased slightly in FY2020 as some elective procedures were canceled by providers and many Medicaid enrollees chose to postpone visits to healthcare providers due to concerns related to COVID-19. Utilization of Medicaid services grew again in FY2021, peaked in FY2022, and declined each year between FY2023 and FY2025. For the current forecast, we expect the number of Medicaid recipients to grow at a relatively slow rate through the projection period.

Figure 2: Medicaid Recipients – Actual and Projected, FY1998 – FY2046



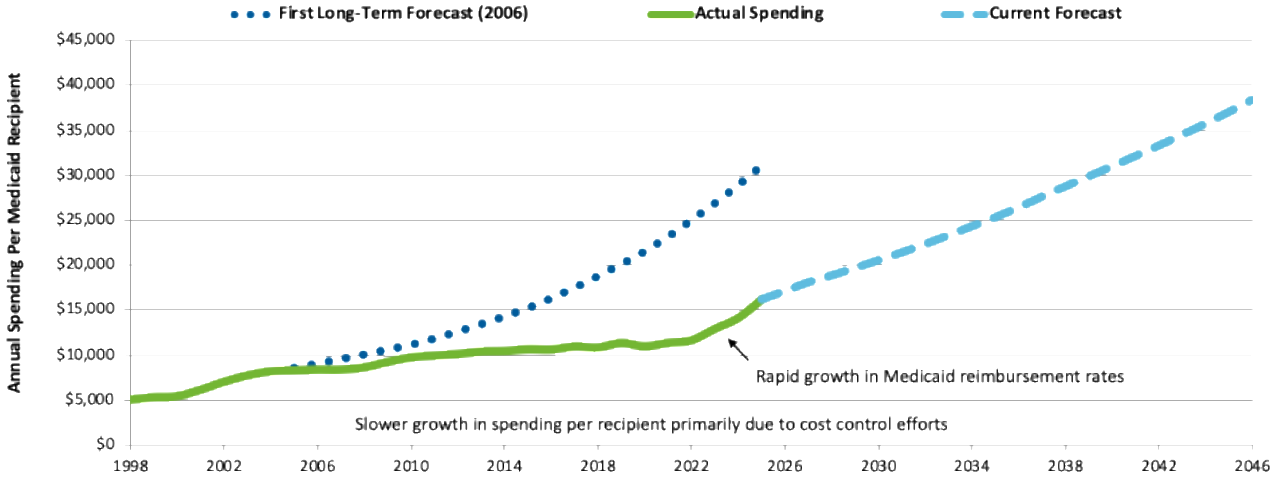
Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

As noted, spending on Alaska's Medicaid program today is considerably less than was projected in the first long-term Medicaid forecast. At the same time, the number of Medicaid recipients is much greater today than was projected in 2006. The net effect of lower-than-projected spending and greater-than-projected numbers of recipients is much lower-than-projected average spending per Medicaid recipient. Figure 3 shows actual average annual spending per recipient (solid green line), as well as projected spending per recipient from the current and the first long-term Medicaid

[1] The term "Medicaid enrollee" refers to an individual enrolled in the Medicaid program at any time during a fiscal year regardless of whether the individual utilized any services provided by the Medicaid program.
The term "Medicaid recipient" refers to a Medicaid enrollee who utilized Medicaid services at least one time during a fiscal year. In FY2025, 68 percent of Medicaid enrollees were also recipients, which means that nearly one of every three (32%) Medicaid enrollees did not receive any Medicaid services in FY2025.

forecasts. Between FY2005 and FY2022, spending per recipient grew on an average annual basis by just 2 percent per year—far less than the 9 percent annual rate the program experienced during the first half of the 2000s. Since FY2022, spending per recipient has grown rapidly, increasing on average by 11.6 percent per year in FY2023, FY2024, and FY2025.

Figure 3: Medicaid Spending per Recipient – Actual and Projected, FY1998 – FY2046



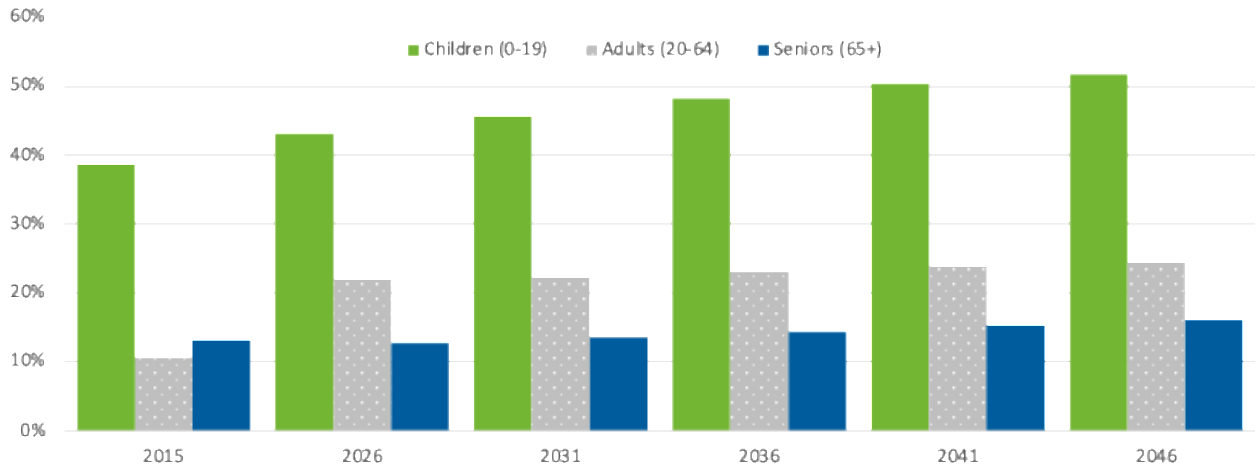
Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Across all age cohorts, the proportion of Alaskans receiving services through the Medicaid program has grown, and we expect it to continue to grow—though at a much slower rate. Figure 4 shows the proportion of Alaska children,[2] adults, and seniors who received Medicaid services in FY2015—the fiscal year prior to the initiation of Medicaid expansion—and are projected to receive Medicaid services over the next 20 years.

Due primarily to Medicaid expansion, approximately 22 percent of adults 20 to 64 years of age will receive services through Alaska's Medicaid program in FY2026, up from just 10.6 percent in FY2015. We project that 23 percent of Alaska adults will be Medicaid recipients by FY2036 and nearly 25 percent will be recipients by FY2046. We project that the proportion of seniors receiving Medicaid services will grow from 12.7 percent in FY2026 to 16 percent by FY2046, and that the proportion of Alaska children receiving Medicaid services (or services through the Children's Health Insurance Program [CHIP]) will grow from 43 percent in FY2026 to 52 percent in FY2046.

[2] Throughout this report, we use three general age categories: children to refer to anyone under 20 years of age, adults to refer to those 20 to 64 years of age, and seniors to refer to anyone 65 years of age or older.

Figure 4: Medicaid Recipients as a Proportion of Alaska's Population for Selected Fiscal Years



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

We project that total spending on Medicaid services will increase from $3.3 billion in FY2026 to $8.2 billion in FY2046—an average annual growth rate of nearly 4.7 percent. This projected rate of growth in Medicaid spending is substantially lower than the projected growth rate from the first long-term forecast completed in 2006, but greater than the rate projected in recent forecasts due to higher inflation expectations over the next two decades. We project that spending on Medicaid services by the State of Alaska (from state general funds) will grow on average by 4.8 percent and that federal spending will grow by 4.6 percent per year through FY2046 (Table 1).

Table 1: Projected State and Federal Spending on Medicaid Services (in Millions $)

Fund Source	2015	2026	2031	2036	2041	2046	Annual Growth*
State General Funds	$681.1	$761.7	$968.2	$1,243.7	$1,572.9	$1,941.8	4.8%
Federal	$900.7	$2,540.2	$3,253.0	$4,152.0	$5,203.5	$6,276.3	4.6%
Total Spending*	**$1,581.8**	**$3,301.9**	**$4,221.2**	**$5,395.7**	**$6,776.4**	**$8,218.2**	**4.7%**

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.
* Annual growth computed from FY2025 to FY2045.

Key Findings – Alaska Population Trends

- Between 2026 and 2046, the Alaska Department of Labor and Workforce Development projects that Alaska's population will *decrease* by 8,750.[3]
    - The number of Alaskans under 20 years of age will *decrease* by 20,050.

[3] Alaska Department of Labor and Workforce Development, Research and Analysis. 2024. *Alaska Population Projections 2023 to 2050*. http://live.laborstats.alaska.gov/pop/projections.cfm

- The number of Alaskans 20 to 64 years of age will grow by 4,100.
- The number of Alaskans 65 years of age or older will grow by 7,200.

Key Findings—Medicaid Enrollment and Recipients

- Between FY2010 through FY2025, enrollment in Medicaid grew 5 percent per year on average—from 135,086 to 281,937. Most of this growth was due to Medicaid expansion in FY2016.
- Over this same period (FY2010 to FY2025), the number of Medicaid recipients (Medicaid enrollees that received Medicaid services) grew by 3.1 percent per year on average—from 120,621 to 191,517.

Key Findings—Medicaid Reimbursement Rates

- After growing well below Alaska's rate of medical price inflation for years, beginning in FY2021, Medicaid reimbursement rates have grown at a similar pace as medical price inflation.
- We project Medicaid reimbursement rates will grow on average by about 3.0 percent per year through FY2046, which is below the expected rate of medical price inflation (3.7%), but well above the pace of growth in Medicaid reimbursement rates prior to FY2021.

Key Findings—Medicaid Spending

- Through FY2046, we project total spending on Medicaid services will grow on an average annual basis by 4.7 percent; general fund spending will grow by 4.8 percent.
    - We project total spending on Medicaid services will reach $8.2 billion in FY2046 and that total spending on the Medicaid program, including non-claim-related spending, will be nearly $8.6 billion.[4]
    - We project general fund spending on Medicaid services in FY2046 will be $1.9 billion ($2.1 billion including non-claim-related spending).

Key Findings—Medicaid Recipients with Chronic Conditions

- In FY2025, 45 percent of Medicaid recipients (86,652 individuals) were diagnosed with one or more chronic conditions.

[4] Non-claim-related spending includes Medicare Part A and Part B premiums, supplemental hospital payments, and offsetting recoveries, which are credits. For each year of the forecast, we assume non-claim-related spending will be equal to 5 percent of total spending on Medicaid services; we further assume that 65 percent of non-claim-related spending will be paid with federal funds and that 35 percent will be paid with state general funds.

- Average Medicaid spending per recipient with a diagnosed chronic condition was $29,600 in FY2025, compared to $4,900 for recipients without a diagnosed chronic condition.
- We estimate that 84.5 percent of spending on Medicaid services by FY2046 will be for recipients with one or more diagnosed chronic conditions; currently, it is 81 percent.

Key Findings—High and Low Utilizers of Medicaid Services

- In FY2025, the 1 percent of Medicaid recipients with the highest costs accounted for 21 percent of spending on Medicaid services, and the 10 percent of Medicaid recipients with the highest costs accounted for two-thirds of spending on Medicaid services.
- Over this same period, the half of recipients with the lowest costs accounted for less than 5 percent of spending on Medicaid services—unchanged from FY2024.
- High utilizers of Medicaid services are much more likely to have been diagnosed with one or more chronic conditions and to have utilized services from an emergency department on multiple occasions during FY2025.

1 Introduction

This document presents the results of the fiscal year (FY) 2026-FY2046 projection of enrollment in and spending on the Medicaid program in Alaska. It is the twentieth update to the original long-term Medicaid forecast, which the Lewin Group completed in January 2006.

Medicaid is a federal entitlement program established by Title XIX of the Social Security Act in 1965 to provide payment for healthcare services for low-income families and individuals. Medicaid is jointly funded by the federal government and individual states, with each state managing its own program. State participation in the Medicaid program is optional, but all states do participate in the program and in doing so must follow certain federal guidelines pertaining to eligibility and services provided.

The rate of federal financial participation (FFP) for services received through the Medicaid program is known as the FMAP (Federal Medical Assistance Percentage). A state's FMAP is redetermined each federal fiscal year based on its per-capita personal income relative to the national average, but with a floor of 50 percent—meaning that the federal government covers at least 50 percent of the cost of most Medicaid services.[5] In addition to "regular" FMAP, which for federal FY2026 is 52.42 percent, there are other "enhanced" FMAP rates that are applicable based on one or more defined factors, including a recipient's eligibility category, service received, and service provider. For (federal) FY2026, enhanced FMAP rates for Alaska's Medicaid program range from 58.42 percent to 90 percent, and we project the overall rate of FFP will be 77 percent.[6]

People qualify for Medicaid by meeting income standards and specified eligibility requirements related to age, family status, and disability status. Traditionally, Medicaid covered only aged,[7] blind, or disabled persons, children, and adults with dependent children. Alaska's Medicaid program extended coverage in 1998 through the Children's Health Insurance Program (CHIP) to children whose family income is too high to qualify for regular Medicaid but too low to afford

[5] The few services for which the federal government does not cover at least 50 percent of the cost are referred to as "state-only" services.

[6] The federal fiscal year begin October 1 and end September 30. The overall rate of federal financial participation is an average of multiple FMAP rates weighted by the amount of spending associated with each rate. See the subsection titled State Spending on Medicaid Services (Section 2.6.1) for a discussion of the rate of federal financial participation associated with each FMAP rate.
Unless otherwise stated, all references to fiscal year are state fiscal year, which begins July 1 and ends June 30. For example, FY2025 for Alaska began July 1, 2024, and ended June 30, 2025.

[7] Under Medicaid descriptions of eligibility, "aged" refers to persons 65 years of age or older. Throughout this report, we refer to this population as "seniors" except when referring to Medicaid eligibility.

private health insurance. Alaska again extended Medicaid coverage in September 2015, this time for adults who met certain income requirements but were not previously eligible for Medicaid.[8]

In Alaska, the Division of Health Care Services (HCS) administers Medicaid and CHIP, while the Division of Public Assistance (DPA) determines eligibility for the two programs.[9] Alaska Medicaid reimburses hospitals, physicians, and others for healthcare and associated services provided to Medicaid recipients. In Alaska, Medicaid operates as a fee-for-service program, meaning that it reimburses (pays) providers per unit of service rendered according to established rates of payment.

1.1 Unwinding of Medicaid Continuous Enrollment

The Families First Coronavirus Response Act (FFCRA), passed by Congress in March 2020, required states to ensure that individuals enrolled in Medicaid would not lose their coverage during the COVID-19 public health emergency. Under this policy, states received a temporary increase in FMAP, with the condition that states would not disenroll members during the public health emergency, regardless of any change in employment, income, or other covered circumstance. Beginning in April 2023, Alaska and other states were permitted to begin conducting redeterminations of Medicaid eligibility (commonly referred to as "Medicaid unwinding").[10]

Impact of Unwinding on Medicaid Spending and Recipients

While unwinding has impacted the number of individuals enrolled in Medicaid and the number receiving services, it has not, to date, appeared to have impacted spending on Medicaid services. Figure 5 shows monthly spending on Medicaid claims from July 2019 to December 2025 based on the month the payment to the provider occurred (as opposed to the month the Medicaid enrollee received the service).[11] The solid blue line shows actual spending on claims each month, and the dotted green line shows the 12-month moving average of monthly spending. The moving average "smooths" monthly variation in spending, thereby revealing the longer-term trend in spending. Medicaid spending varies month-to-month due to seasonal factors, random variation in the healthcare needs of Medicaid beneficiaries, the timing of invoices submitted to the Department of Health (DOH), and (most importantly) in the number of "check-writes" made by the DOH during a

[8] Specifically, Alaska initiated Medicaid expansion in September 2015, which extended coverage to individuals 19 to 64 years of age with incomes up to 138 percent of the federal poverty level, are not disabled, and do not have dependent children.
Throughout this report, we use three general age categories: children to refer to anyone under 20 years of age, adults to refer to those 20 to 64 years of age, and seniors to refer to anyone 65 years of age or older.

[9] Both divisions are within the Alaska Department of Health.

[10] In Alaska, the Division of Public Assistance is responsible for conducting Medicaid eligibility "redeterminations."

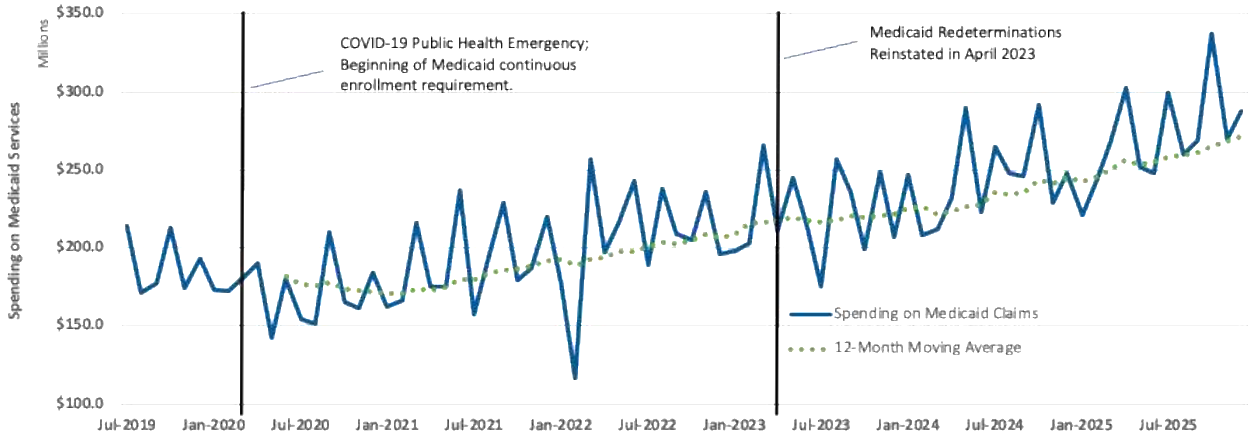
[11] On average, 70 to 75 percent of Medicaid services are paid in the month the service was received or in the subsequent month.

given month.[12] Regardless, both the blue and dotted green lines show a strong positive trend in Medicaid spending beginning in early 2021 and continuing through December 2025. This roughly five-year period includes much of the COVID-19 public health emergency, as well as the end of the public health emergency and the reinstatement of Medicaid redeterminations.

From July 2019 through February 2021, monthly spending on Medicaid services trended slightly downward. This 20-month period includes the eight months just prior to Governor Dunleavy's declaration of a public health disaster emergency in response to the outbreak of COVID-19 and the first 12 months of the pandemic. Over these 20 months, average monthly spending on Medicaid services was $177 million, but during the first four months (July 2019 – October 2019), spending averaged $194 million per month. During the last four months (November 2020 – February 2021), spending averaged $169 million per month.

Monthly spending on Medicaid services began trending upward in March 2021 and, despite the end of the COVID-19 public health emergency and the resumption of Medicaid redeterminations, that upward trend continued through December 2025. In the first four months of Medicaid redeterminations, monthly Medicaid spending averaged $223 million per month; during the most recent four months (September 2025 – December 2025), Medicaid spending averaged $291 million per month.

Figure 5: Monthly Spending on Medicaid Claims, July 2019 - December 2025*

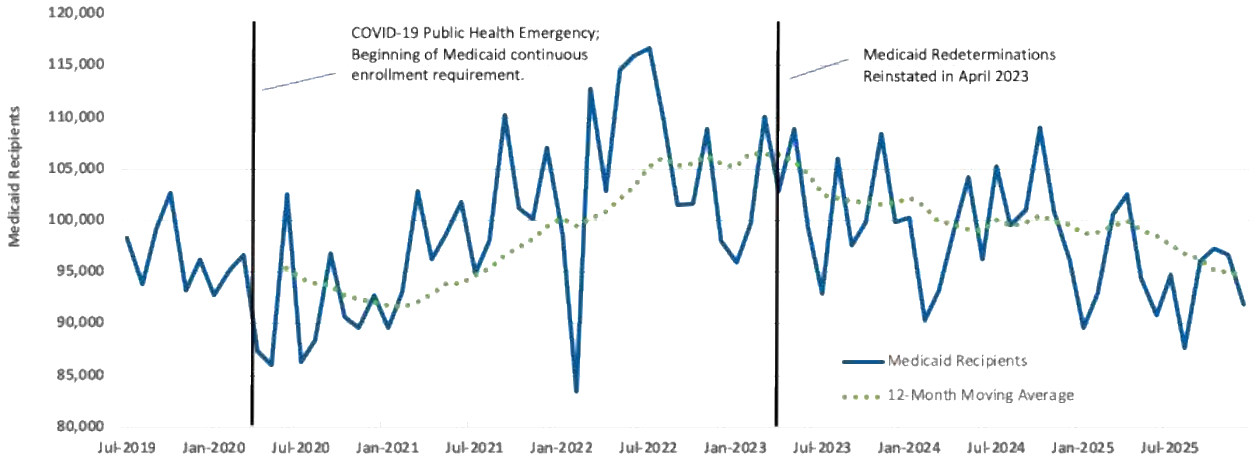


Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.
* Based on date of payment. Medicaid providers submit claims for services provided to Medicaid recipients.

[12] Check-writes (remittances to providers) typically occur each Wednesday. Each month contains either four or five Wednesdays. On average, total spending on Medicaid services in months containing five Wednesdays is 25 percent greater than in months containing only four Wednesdays.

Figure 6 shows the number of Medicaid recipients each month from July 2019 through December 2025, which varies substantially month-to-month.[13] As with monthly spending on Medicaid claims, recipient counts trended downward from July 2019 through February 2021 and then began to rise. However, unlike Medicaid spending, recipient counts peaked in July 2022, and the trend in recipient counts—as measured by the 12-month moving average (green dotted line)—remained flat until May 2023. Since then, recipient counts have slowly trended downward such that recipient counts for the most recent four months (September 2025 – December 2025) averaged 95,500, which is well below the monthly average of 114,300 recipients between May 2022 and August 2022. It is also slightly below the monthly average during the eight months prior to the COVID-19 public health emergency (96,500).

Figure 6: Number of Recipients with Paid Medicaid Claims, July 2019 – December 2025*

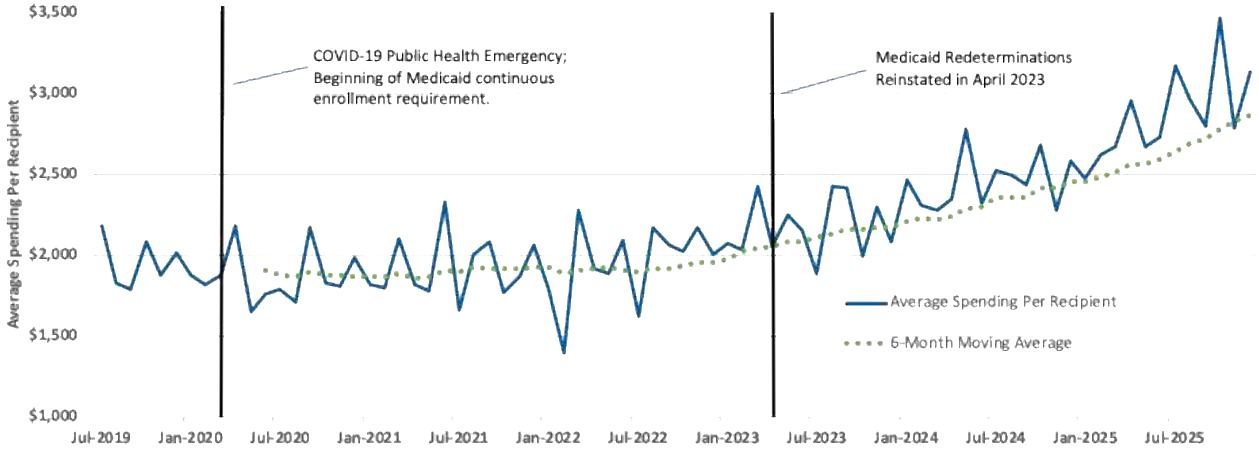


Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.
* Based on date of payment. Medicaid providers submit claims for services provided to Medicaid recipients.

Bringing together the information shown in the previous two figures, Figure 7 shows monthly spending per recipient between July 2019 and December 2025. Through the first three years, per-recipient spending remained basically flat. Since then, per-recipient spending has experienced strong growth, rising from an average of $2,006 per month during the first half of FY2023 (July 2022 – December 2022) to an average of $3,050 during the first half of FY2026 (July 2025 – December 2025), which equates to an increase in spending per recipient of 15 percent per year.

[13] The reasons for monthly variation in recipient counts are the same as for Medicaid spending: seasonal factors, random variation in the healthcare needs of Medicaid beneficiaries, the timing of invoices submitted to the DOH, and (most importantly) in the number of "check-writes" made by the DOH during a given month.

Figure 7: Average Spending Per Recipient by Month, July 2019 – December 2025*



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.
* Based on date of payment. Medicaid providers submit claims for services provided to Medicaid recipients.

1.2 Recent Initiatives That May Affect Alaska's Medicaid Program in the Next Few Years

The information in this section was provided by leaders of operational divisions within the DOH as a summary of initiatives that were recently enacted or are in the process of being enacted and that may impact future utilization and spending on Medicaid services.

1.2.1 Behavioral Health System Reform

Substance Use Disorder and Behavioral Health Program – 1115 Behavioral Health Reform

On March 26, 2024, the Centers for Medicare & Medicaid Services (CMS) approved the renewal of Alaska's 1115 Behavioral Health Reform demonstration waiver through December 31, 2028. The renewal provides the DOH with continued flexibility to test and implement strategies to strengthen the state's behavioral health system, including the ability to expand service options through future amendments.

To inform waiver priorities, the Division of Behavioral Health (DBH) conducted discovery sessions with community stakeholders and providers. These discussions identified three primary focus areas: (1) expanding and increasing flexibility for community-based crisis services; (2) strengthening in-home and community-based support systems to help youth remain safely connected to their families and communities; and (3) improving administrative efficiency across Medicaid behavioral health programs, including enhanced provider technical assistance, clearer program guidance, and streamlined processes.

In FY2025, the 1115 waiver supported 11,220 unique individuals through an expanded array of substance use disorder and behavioral health services.

Behavioral Health Medicaid Claims Transition

On November 1, 2024, DBH reintegrated outpatient behavioral health claims processing into the Medicaid Management Information System (MMIS), stabilizing payments for community-based providers. Throughout the transition, the DOH prioritized clear and consistent communication with the behavioral health provider community, reviewed opportunities to reduce administrative burden, and improved process transparency and efficiency to support a sustainable claims management framework.

Behavioral Health Provider Support Organization

DBH issued a Request for Proposals (RFP) to secure a partner that will support full implementation of services authorized under the 1115 Behavioral Health Reform demonstration waiver. The selected vendor will provide targeted provider network support and technical assistance to strengthen participation in the Alaska Medicaid program, including outreach and engagement with currently non-participating providers—particularly in rural and underserved areas that lack access to the full range of behavioral health services.

Key deliverables include building regional provider capacity, developing tailored provider communication and support tools, and facilitating provider quality improvement and outcomes-focused efforts to strengthen service delivery and access. DBH anticipates issuing a notice of award in the near term.

Behavioral Health Medicaid Rates

Behavioral health services were included in Phase 1 of the DOH's Medicaid Payment Methodology Evaluation, a statewide initiative to assess current payment methodologies, compare reimbursement rates to provider costs, and identify opportunities to improve clarity, consistency, and alignment with Alaska's service delivery environment. The evaluation is intended to produce recommendations to inform future Medicaid rate updates.

The DOH conducted multiple rounds of outreach with behavioral health providers through large-group meetings, online surveys, and optional one-on-one discussions. The contractor supporting the evaluation synthesized this input into draft recommendations. The Behavioral Health Rate Study Report was published on October 8, 2025, and outlines nine recommendations, which the DOH anticipates implementing on a staggered timeline as part of future rate-setting and policy planning efforts.

Crisis Continuum of Care

In FY2025, DBH continued its contracted work with Milliman to host a series of stakeholder engagement sessions to inform the design of a tiered and expanded Crisis Services Continuum. This framework is intended to provide scalability and flexibility for community-based behavioral health providers to deliver crisis services that are responsive to local needs.

Building on the input gathered through these sessions, DBH developed a set of policy and programmatic recommendations that will guide the next phase of implementation activities, including the establishment of rate-setting methodologies for new and expanded crisis services. The goal of the rate-setting process will be to rebalance reimbursement to more accurately reflect the cost of care and in doing so, support the financial sustainability of providers.

In addition, DBH will pursue updates to existing service regulations and, as needed, Medicaid State Plan or waiver amendments to strengthen the state's authority to cover critical crisis services. This expansion effort also serves DBH's broader Certified Community Behavioral Health Clinic (CCBHC) initiative, which requires the capacity to deliver comprehensive, coordinated, and integrated crisis response services statewide. This work will be ongoing in the next fiscal year.

Certified Community Behavioral Health Center Grant

In FY2025, DBH advanced planning for CCBHCs by awarding pilot grants to Alaska Behavioral Health–Fairbanks and Central Peninsula Behavioral Health and convening a statewide CCBHC Steering Committee with broad stakeholder representation, including providers, consumer advocates, Tribal Health Organizations (THOs), and Medicaid administrators. This engagement has been critical in shaping Alaska's CCBHC strategy, ensuring alignment with federal requirements while accounting for Alaska-specific factors such as geography, workforce capacity, and service infrastructure.

Building on these efforts, DBH is developing comprehensive policy recommendations to guide full CCBHC implementation. Key areas include establishing a state certification process for CCBHC designation, designing a prospective payment system (PPS) rate methodology to support financial sustainability, and updating service regulations and Medicaid authorities, including potential State Plan or waiver amendments, to expand coverage of essential behavioral health and crisis services. Rate-setting activities will focus on aligning reimbursement with the true cost of care and promoting equitable access.

CCBHC planning is closely coordinated with DBH's tiered Crisis Services Continuum initiative, with both efforts aimed at strengthening system capacity, improving care coordination, and ensuring timely, appropriate care.

In FY2026, DBH will focus on finalizing and publishing the CCBHC planning report and policy recommendations, developing draft PPS rate methodology for review, drafting regulatory and waiver updates, and preparing Alaska's application to participate in the federal CCBHC Demonstration Project.

1.2.2 Healthcare and Tribal Health Services Reforms

The Alaska Medicaid program allows for the provision of healthcare services remotely throughout the state by means of telehealth services provided through three modes: live video, audio-only, and store-and-forward.[14]

Telehealth Services

Telehealth Cost Trends: Medicaid paid $76.1 million in reimbursements to providers of medical and behavioral health services in FY2025, up from $71.8 million in FY2024. There was a substantial drop in reimbursements in FY2021 and FY2022. This decrease began to flatten between FY2022 and FY2024, signaling a stabilization in service utilization after the COVID-19 pandemic. FY2025 marks the first increase in reimbursements in several years, likely reflecting the impacts of service rate increases.

Telehealth Growth: The continued use of telehealth for behavioral and mental health services accounted for 72 percent of all telehealth services, indicating sustained demand for remote care options. Telehealth remains a key strategy for improving healthcare access, especially in rural areas.

Covered Outpatient Drug Value-Based Purchasing (VBP) Arrangements

CMS delayed the effective date of final rule CMS-2482-F entitled "Medicaid Program; Establishing Minimum Standards in Medicaid State Drug Utilization Review (DUR) and Supporting Value-Based Purchasing (VBP) for Drugs Covered in Medicaid, Revising Medicaid Drug Rebate and Third-Party Liability (TPL) Requirements" to July 1, 2022. Once the rule went into effect, state Medicaid programs had the opportunity to enter into VBP arrangements with pharmaceutical manufacturers, outside of a supplemental rebate agreement, when such manufacturers offered the VBP arrangement in the commercial marketspace.[15] The HCS Pharmacy Services Team has submitted a State Plan Amendment to CMS to allow for VBP participation and continues to evaluate current VBP opportunities, but has not entered into any value-based arrangements.

Federal Financial Participation for Services to American Indians and Alaska Natives

Historically, Alaska's Medicaid program has received 100 percent FFP for Medicaid services provided to American Indians/Alaska Natives (AI/AN) only when those services were received through federal or Tribal healthcare facilities. CMS's February 2016 State Health Official Letter

[14] Store-and-forward refers to the secure transfer of patient medical data (e.g., images or lab results) for a medical provider to review at a later time.

[15] *Federal Register*, "Medicaid Program; Establishing Minimum Standards in Medicaid State Drug Utilization Review (DUR) and Supporting Value-Based Purchasing (VBP) for Drugs Covered in Medicaid, Revising Medicaid Drug Rebate and Third-Party Liability (TP) Requirements," December 31, 2020, p. 87028. https://www.federalregister.gov/documents/2020/12/31/2020-28567/medicaid-program-establishing-minimum-standards-in-medicaid-state-drug-utilization-review-dur-and

#16-002 updated the "received through" policy to allow state Medicaid programs to claim 100 percent FFP for services provided to an AI/AN Medicaid recipient by a non-federal or non-Tribal healthcare facility, if a care coordination agreement (CCA) between the providers, documentation of a referral by the Tribal health provider, and an exchange of medical records of the care received are in place.

During FY2025, HCS continued to strengthen partnerships with THOs and non-Tribal providers through CCAs, driving statewide engagement and significant general fund savings. In FY2025, there were 8,476 CCAs between 18 THOs and 652 providers—an increase from 8,159 CCAs and 623 providers in FY2024. This reflects a 4 percent increase in CCAs and 5 percent more providers, demonstrating sustained statewide participation.

These agreements generated $126.5 million in general fund savings in FY2025, slightly below the savings of $138.4 million in FY2024. A total of $764.9 million in savings were generated since the February 2016 State Health Official (SHO) letter.[16] The year-to-year variation reflects a decrease in the percentage and number of referrals verified. Additionally, as the network of CCAs matures, Alaska may see slower savings growth as many high-volume relationships are already established, and newer CCAs add providers with fewer AI/AN beneficiaries.

Procurement of Provider Enrollment Module

In May of 2021, the DOH initiated steps to separate the technical operations and maintenance of MMIS from the fiscal management and support of the Medicaid program. These steps were completed in April of 2023, affording the department flexibility in responding to the changing operational and administrative needs of the program. The DOH plans to procure a Provider Enrollment Module and a Service Authorization Module in FY2026 to modernize system components and create greater efficiencies in how providers are enrolled and services are delivered. Funding to support these modernization efforts will be made possible through an approved capital allocation.

Care Management Services

The DOH established the Care Management Program (CMP) to restrict the use of Medicaid services deemed to be at a frequency or amount that is not appropriate.[17] Historically, the CMP restricted a recipient to a primary care provider (PCP) and a pharmacy to reduce overuse and misuse of services, encourage continuity of care, and promote communication between the recipient's PCP and pharmacy. The CMP currently (as of January 2026) has 107 individuals/groups

[16] CMS issues SHO letters to provide formal guidance, policy clarifications, and instructions to state Medicaid directors regarding the administration of Medicaid or CHIP.

[17] The CMP was established under the authority granted in Section 7 of the Alaska Administrative Code (AAC) 105.600.

acting in a PCP role and 87 different pharmacies serving CMP members, representing a minimal decrease in the number of participating providers compared with FY2025.

The Alaska Medicaid Coordinated Care Initiative (AMCCI), which provides one-on-one case management services to Medicaid recipients, experienced a 21.7 percent decrease in utilization from FY2024 to FY2025.

Of note, FY2025 results show a 26 percent decrease in emergency room costs and a 28 percent decrease in emergency room visits. Case management efforts also resulted in a 77 percent drop in inpatient costs and a 77 percent decrease in inpatient visits compared with members' pre-enrollment levels.

1.2.3 Senior and Disabilities Services Reforms

The Division of Senior and Disabilities Services (SDS) saw the following changes to Medicaid-funded services in FY2025:

- SDS worked closely with an outside consultant to conduct an analysis of the rates and methodologies used to calculate Medicaid payments for long-term services and supports, which include home and community-based waivers and personal care services. The work included significant outreach to providers, self-advocates, and other stakeholders interested in these services, as well as comparisons with other states. The report from the consulting firm was finalized early FY2026.
- SDS devoted considerable time and energy planning for the implementation of a new assessment tool for its home and community-based waiver and personal care services. SDS's documentation of its planning efforts received approval for 90 percent federal match. The state also used federal American Rescue Plan Act funding and Alaska Mental Health Trust Authority funding to assist with planning efforts and receive technical assistance in making this system change.
- SDS launched a new software system that compares claims information from MMIS with reports made to the SDS's Central Intake reporting platform. This platform allows SDS to identify critical incidents that have not been reported by providers, helping identify areas of concern and need for more education and quality assurance.
- SDS continued to support projects through the American Rescue Plan Act (ARPA) Section 9817 funding opportunity. Under Section 9817, states are permitted to save 10 percent of their home and community-based services spending to fund projects that "enhance, expand, or strengthen" these services. Projects must be approved by CMS. In FY2025, the funding supported initiatives to aid individuals with complex care needs. These included support to DBH to expand its Complex Behavioral Collaborative set of services to individuals on the Intellectual and Developmental Disabilities waiver. SDS also established a fund for assisted living homes to use for modifications to better serve individuals with

complex care needs, such as electronic security systems, plexiglass windows, steel toilets, and other environmental modifications. In addition, in collaboration with the Alaska Training Cooperative, SDS established a statewide dementia training initiative for caregivers, first responders, and others to better enable them to serve family members and clients with dementia.

- SDS established a work plan for adoption of the new Medicaid Ensuring Access Rule, a sweeping rule impacting many facets of home and community-based services administration. The Access Rule requirements have a time frame for implementation staged over the next 8 to 10 years.

In the coming year, SDS will be applying for renewal of four of its Medicaid home and community-based waivers—the Alaskans Living Independently, Intellectual and Developmental Disabilities, Adults with Physical and Developmental Disabilities, and Children with Complex Medical Conditions waivers. This is a significant effort that requires review and revision of data, policies, and other details by multiple division units and department partners. Public comment and Tribal consultation occur in the lead-up to renewal of the waivers, which must occur by July 1, 2026. SDS intends to begin assessing individuals seeking waiver services and personal care in the fall of 2026.

1.2.4 Public Health Initiatives

In partnership with the Alaska Native Tribal Health Consortium (ANTHC), the DOH co-leads the development and implementation of Alaska's state health improvement plan, Healthy Alaskans 2030 (HA2030). HA2030 is a roadmap for how the state can improve on the most significant health issues faced by its residents. The HA2030 plan includes 15 health priority topics containing 30 health objectives, each with a target to reach by 2030. These priorities were selected based on health mortality and morbidity data along with input from Alaska residents and subject matter experts. Each health objective contains strategies and actions that may be implemented to help move the state toward established targets. If the HA2030 targets are met, Medicaid costs may be reduced, as this will be an indicator of the improved health of all Alaskans.

In FY2025, the DOH launched a three-year pilot project to implement the Community Care Hub (CCH) model in Alaska. This model recognizes the role of community-based organizations (CBOs) in improving access to care, particularly for chronic disease prevention and treatment and addressing health-related needs. In recent years, several CBO initiatives in Alaska have flourished, partly due to increased grant funding during the COVID-19 public health emergency. The DOH's CCH pilot project seeks to build on this momentum by establishing more sustainable funding for CBOs through reimbursement mechanisms under Medicare, Medicaid, and private payers. Initially focusing on the Anchorage area, the CCH will serve as a central administrative and operational hub and will enter into contractual relationships with multiple CBOs. The CCH will enable CBOs to seek reimbursement for services such as screenings, referrals, and navigating and aligning clinical and community services. The CCH will support all types of providers including but not limited to community health workers, who will be employed directly by CBOs to deliver services. The CCH

will work with DPH and other partners to develop referral processes that connect priority populations with resources to improve health outcomes.

The Fresh Start campaign, led by DPH, is transforming chronic disease prevention by providing Alaskans with tools to manage their health. Programs such as the Diabetes Prevention Program, Diabetes Self-Management Education and Support, and Self-Measured Blood Pressure monitoring are at the forefront of this effort. These programs offer health education combined with counseling to empower Alaskans with the tools needed to adopt healthier lifestyles, reduce complications, and mitigate risks associated with chronic conditions such as diabetes and cardiovascular disease.

Fresh Start's partnerships with healthcare providers, community organizations, and culturally specific stakeholders ensure the delivery of locally led and culturally tailored interventions that resonate with Alaska's diverse populations. DPH works to increase the resources available for the Fresh Start campaign to address identified barriers and fosters community-driven support that reflects the unique traditions and needs of Alaska Native communities and other priority groups.

Since the inception of Fresh Start, Alaskans have lost a combined 35,000+ pounds. Since 2023, more than 70 percent of Alaskans participating in an online diabetes management program met their goal of reducing their A1C levels. In addition, over 70 percent of Alaskans whose blood pressure met the criteria for Stage 1 hypertension at the time of enrollment in an online blood pressure management program and almost 50 percent of Alaskans whose blood pressure met the criteria for Stage 2 hypertension were able to control their blood pressure using the program.

1.3 The Long-Term Medicaid Forecast

For the Alaska Long-Term Medicaid Forecast, we developed a bottom-up modeling approach that begins with Alaska population forecasts subdivided into 288 subpopulations based on age (12 categories), gender (2 categories), American Indian/Alaska Native (AI/AN) status (2 categories), and region of the state (6 categories).[18] We then develop estimates of future Medicaid enrollment for each subpopulation demographic group based on historical enrollment trends and projected population estimates. For each of these subpopulations, we project future utilization of 20 different Medicaid service categories and the intensity of use of each service category. Finally, we project growth in Medicaid reimbursement rates to providers based on the historical relationship between reimbursement rates and medical price inflation in Alaska.[19]

[18] 12 age categories × 2 gender categories × 2 AI/AN status categories × 6 state region categories = 288 subpopulations.

[19] To project medical price inflation in Alaska, we first use regression analysis to estimate the historical relationship between the *Consumer Price Index for All Urban Consumers: Medical Care in Urban Alaska* index (our measure of

The following factors are explicitly incorporated into the Alaska long-term forecast.

- **Alaska Population and Demographic Forecast**: On a biennial basis, the Alaska Department of Labor and Workforce Development (DOLWD) publishes population projections for the State of Alaska and for individual communities by gender, age, and race.[20] Population-demographic data are critical for developing the long-term Medicaid forecast as potential changes in the number and demographic mix of Medicaid enrollees will have a substantial impact on Medicaid spending.
- **Trends in Medicaid Enrollment**: Medicaid enrollment is a function of Alaska's population—divided into each of the 288 subpopulations described above—and trends in the rate of Medicaid enrollment for each of the subpopulations. For each subpopulation, we calculate the percentage (the "rate") of individuals enrolled in Medicaid for each historical year (FY2016 – FY2025).[21] While the overall rate of Medicaid enrollment has increased over the past decade, the rate of growth has differed substantially across the 288 subpopulations and year-to-year has not always increased.[22]
- **Trends in Utilization and Intensity of Use of Medicaid Services**: Utilization represents the number of different Medicaid service categories a recipient uses during a fiscal year, whereas intensity of use of a Medicaid service represents how much of a respective service category a recipient uses. Changes in Medicaid utilization and intensity of use are a function of numerous factors—including aging of the population; increases in the prevalence of chronic conditions, which lead to greater morbidity; and changes in medical technology and practices.
- **Trends in Medicaid Reimbursement Rates and Medical Price Inflation**: Medical price inflation, which includes the costs of medical services, prescription drugs, and medical devices paid for out-of-pocket by consumers of medical care, has outpaced general price inflation and is the primary long-term driver of healthcare spending in the US.[23] Medical price inflation does not directly impact reimbursement rates paid to providers of Medicaid services, but growth in the costs of medical services, which medical price inflation represents, does impact Medicaid reimbursement rates. Each Medicaid service receives

medical price inflation in Alaska) and the US All Urban Consumer Price Index (CPI). We then use a national forecast of the CPI from Standard and Poor's to project Alaska's rate of medical price inflation through 2046.

[20] Alaska Department of Labor and Workforce Development, Research and Analysis. 2024. *Alaska Population Projections 2023 to 2050*. http://live.laborstats.alaska.gov/pop/projections.cfm

[21] Medicaid enrollment ÷ population = rate of Medicaid enrollment.

[22] In fact, enrollment rates have decreased for all subpopulations in response to reinstatement of redetermination.

[23] Out-of-pocket spending refers to payments made directly by individuals from their own funds for medical services. This is in contrast to Medicaid or other government program spending, which represents payments made by the government on behalf of beneficiaries using public funds.

periodic rate reviews, and Medicaid reimbursement rates are routinely changed—generally upward—based on these reviews.

- **Epidemiological Trends**: Changes in disease prevalence and the emergence of new health concerns, such as growth in the prevalence of (illegal) synthetic opioid abuse, can have both short- and long-term impacts on Medicaid spending.
- **Known Forthcoming Changes in Policy or the Regulatory Environment**: Forthcoming changes in Medicaid policies at the federal and state levels can substantially impact Medicaid enrollment and spending. For example, Medicaid expansion in FY2016 led to an immediate and rapid increase in the number of individuals aged 18 to 64 enrolled in the Medicaid program.

While not *explicitly* considered in the long-term Medicaid forecast, long-term trends in socioeconomic factors such as poverty rates, changes in personal income, and workforce participation are *implicitly* represented in the forecast based on enduring historical trends in Medicaid enrollment for each of the 288 subpopulations.

Finally, as the purpose of the long-term Medicaid forecast is to provide DOH leaders and Alaska policy makers with a projection of enrollment in and spending on Medicaid as the program exists today, the forecast does not incorporate the following:

- Speculative future changes in Medicaid eligibility criteria, services, or administrative processes.
- Speculative future changes to the federal or state regulatory environments affecting the Medicaid program.
- Speculative impacts of public health initiatives aimed at improving health outcomes and reducing healthcare costs.

In this study, we develop long-term forecasts of enrollment in Alaska's Medicaid program, as well as utilization of and spending on services provided through the Medicaid program. We aggregate the thousands of services provided by the Medicaid program into 20 categories of services, each of which we project over a 20-year period. We also develop forecasts of spending by gender, by AI/AN status,[24] by region of the state, and for 12 age groups.

While it is likely that Alaska's Medicaid program will experience changes during the projection period, the assumption of no change is necessary to show how Medicaid spending in Alaska will likely evolve given the structure of the program as it exists today. The no-change assumption also provides a baseline, which is necessary to understand how future unanticipated changes, such as

[24] Alaska Native, American Indian, and other race categories are based on self-identification by Medicaid enrollees. In FY2025, 87,814 Medicaid enrollees (31%) reported their race as either Alaska Native or American Indian.

in policy or FMAPs, impact Medicaid enrollment, utilization, and spending.

1.4 Recent Historical Trends in Medicaid Spending

Total spending on Medicaid services grew slowly between FY2012 and FY2015, increasing on an average annual basis by 2.9 percent (see Figure 8). Spending jumped by 15.1 percent in FY2016 and by 17.8 percent in FY2017 due primarily to Medicaid expansion, which went into effect in Alaska in September 2015. The rate of growth in Medicaid spending began to slow in FY2018 and decreased in FY2020 with the Governor's declaration of the COVID-19 public health emergency in March 2020. Spending began to increase again in FY2021, and through FY2025, it grew by 7.1 percent per year.

1.4.1 Recent Historical Trends in State Medicaid Spending

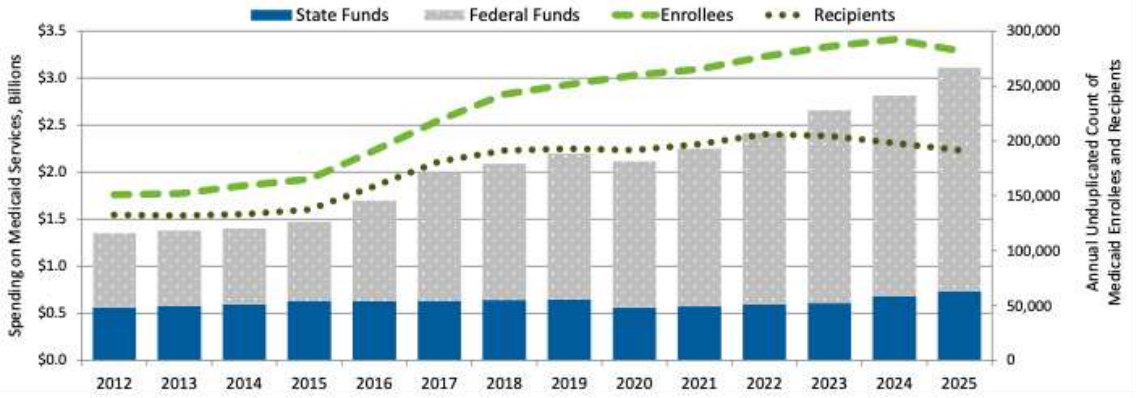
Figure 8 shows total spending on Medicaid services for FY2012 through FY2025, split by state general fund (blue bars) and federal funding (gray bars), and Medicaid enrollment (green dashed line) and count of recipients (dark blue dotted line) over this same period.[25] Over this entire period, Medicaid spending grew by 6.6 percent per year—with essentially all of this growth occurring after FY2015.

While total spending on Medicaid services has increased significantly since FY2012, general fund spending by the State of Alaska grew by less than 2 percent per year through FY2019 and by only 0.5 percent per year between FY2019 and FY2023 (after first decreasing in FY2020 due to additional funding by the federal government as part of the Families First Coronavirus Response Act [FFCRA]).[26] In FY2024, general fund spending grew by 12.4 percent due in part to overall growth in spending, but also due to the phasing out of the additional COVID-19-related funding provided by the federal government. General fund spending growth slowed in FY2025 but still measured 7.1 percent.

[25] State spending includes Unrestricted General Fund, Designated General Fund, and other funds.

[26] The FFCRA required state Medicaid programs to keep people continuously enrolled in Medicaid through the end of the COVID-19 public health emergency in exchange for enhanced federal funding (6.4 percentage points for Title XIX services, 4.34 percentage points for Title XXI and BCC [breast and cervical cancer] services) beginning January 1, 2020, and continuing until "termination of the public health emergency."

Figure 8: Spending on Medicaid Services, Enrollment in the Medicaid Program, and the Number of Recipients of Medicaid Services, Based on Date of Service, FY2012 – FY2025



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group; FY2025 estimated.

Between FY2012 and FY2024, enrollment increased by 93 percent, while the number of recipients grew by only 48 percent. In FY2025, enrollment and the number of recipients decreased by 3.6 percent and 3.3 percent, respectively. In FY2012, 88 percent of Medicaid enrollees were recipients (i.e., received Medicaid services). The proportion of Medicaid enrollees that are recipients has declined since FY2012, dropping below 77 percent in FY2019 and to 67.7 percent in FY2024 and 67.9 percent in FY2025. Our expectation is that this proportion will increase over the duration of the 20-year projection but will remain well below the rates in FY2012 and earlier fiscal years.

1.4.2 The Role of Medicaid in Providing Health Insurance to Alaskans

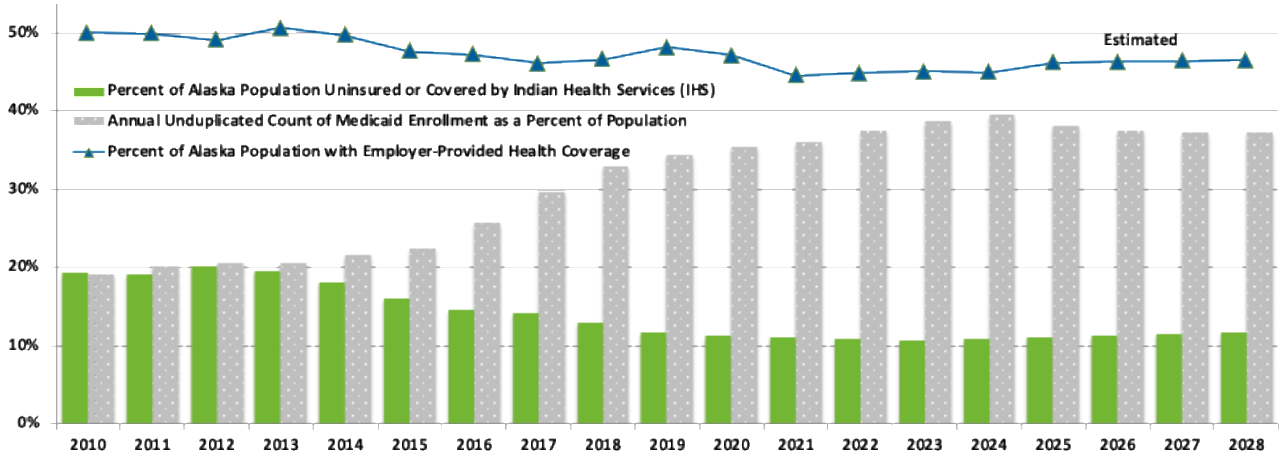
Medicaid's role as a provider of healthcare insurance in Alaska has grown significantly. In FY1998, 14 percent of Alaskans were enrolled in Medicaid all or part of the year, and by FY2024, the proportion had grown to 40 percent. Due to Medicaid expansion and other components of the Affordable Care Act, growth in the proportion of Alaskans enrolled in Medicaid was especially strong after FY2015 (Figure 9). Data reported by KFF indicate that the proportion of Alaskans uninsured or covered only by Indian Health Services (IHS) decreased from 19.3 percent in FY2010 to 10.8 percent in FY2024.[27] While this represents a substantial decrease in the proportion of Alaskans who were uninsured (or covered only by IHS), it may still overstate the actual proportion of Alaskans who were uninsured (or covered only by IHS) during that period. The same KFF source reported that only 23 percent and 22.5 percent of Alaskans were covered by Medicaid, respectively, in calendar years 2023 and 2024. Based on actual enrollment data for the Alaska

[27] KFF, "KFF's State Health Facts, "Health Coverage & Uninsured." https://www.kff.org/state-category/health-coverage-uninsured/. Evergreen converted KKF data to fiscal year as the average of two consecutive calendar years (e.g., FY2020 is the average of CY2019 and CY2020).
Katherine Keisler-Starkey and Lisa N. Bunch, "Health Insurance Coverage in the United States: 2019," report number P60-271, Washington, D.C.: US Census Bureau, published September 15, 2020. https://www.census.gov/library/publications/2020/demo/p60-271.html

Medicaid program, more than 38 percent of Alaskans were covered by Medicaid during all or some portion of each of these two calendar years. Further, during FY2023, FY2024, and FY2025, Medicaid beneficiaries were enrolled on average for 10.6 to 11.8 months, indicating that the Medicaid-eligible population remained enrolled in Medicaid the vast majority of each year.

The proportion of Alaskans receiving health insurance through an employer decreased from 50.1 percent in FY2010 to 45 percent in FY2024.[28] We estimate the proportion of Alaskans enrolled in an employer-sponsored insurance plan will increase very slightly over the next few years, reaching approximately 46.5 percent in FY2028.

Figure 9: Recent Trends in Health Insurance Coverage in Alaska



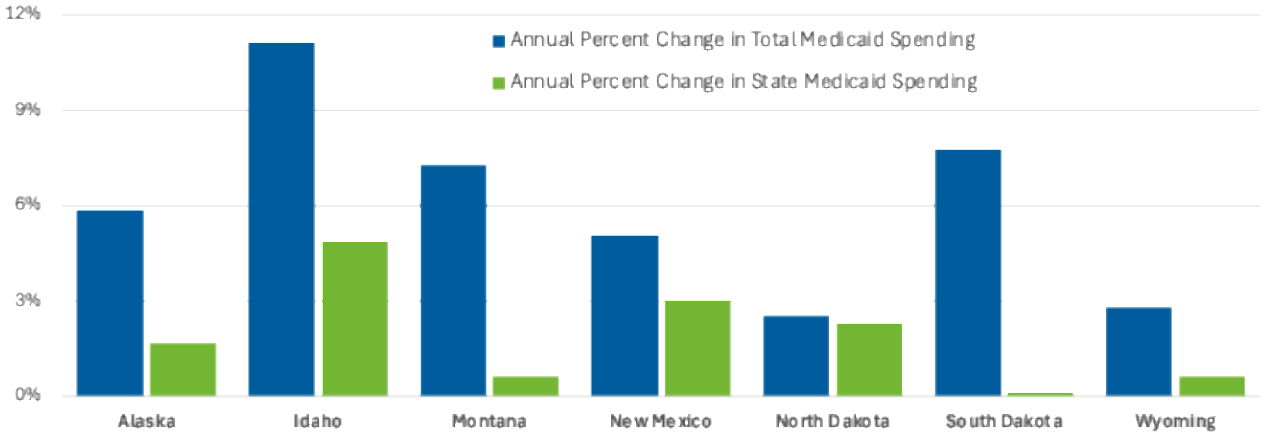
Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group and KKF. (https://www.kff.org/state-category/health-coverage-uninsured/).

1.4.3 Comparison to the Medicaid Programs of Other States

Figure 10 shows average annual growth in Medicaid spending and enrollment data from FY2016 through FY2024 for Alaska and six comparison states (Idaho, Montana, New Mexico, North Dakota, South Dakota, and Wyoming). There was substantial variation among the states with respect to rates of growth in both total and state Medicaid spending. Idaho led all states in annual growth in Medicaid spending (11.1 % in total spending and 4.9% in state spending), while total Medicaid spending in North Dakota and Wyoming grew by only 2.5 percent and 2.8 percent, respectively, and growth in state spending for all states (other than Idaho) did not exceed 3 percent. Wyoming is the only state among these seven that has not undergone Medicaid expansion.

[28] KFF, "KFF's State Health Facts, "Health Coverage & Uninsured." https://www.kff.org/state-category/health-coverage-uninsured/.

Figure 10: Average Annual Growth in Medicaid Spending in Alaska and Comparison States Between FY2016 and FY2024

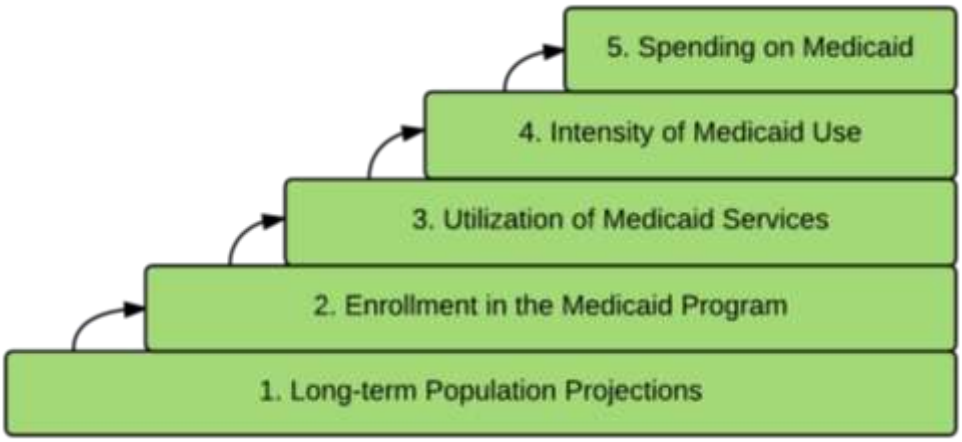


Source: Analysis by Evergreen Economics of data from *The Medicaid and CHIP Payment and Access Commission (MACPAC)*. https://www.macpac.gov/publication/macstats-archive/. Data were not available for FY2025.

2 Overview of Projections: FY2026-FY2046

The long-term Medicaid forecast follows a structured modeling approach in which we develop annual estimates of spending on Medicaid services in five steps, with each successive step building on the results of the previous step. As Figure 11 shows, the foundation of the Medicaid spending forecast is the long-term projection of Alaska's population, which, for this update, is based on the Alaska Department of Labor and Workforce Development's (DOLWD's) most recent population forecast.[29] In subsequent steps, we project enrollment in the Medicaid program, utilization of Medicaid services, intensity of use of Medicaid services, and finally, total spending on Medicaid. We summarize the results of each step of the long-term Medicaid forecasting in the same systematic fashion.

Figure 11: The Five Steps to Develop the Alaska Long-Term Medicaid Forecast



2.1 Long-Term Population Projections

The population of Alaska has changed substantially in the years since statehood. In 1960, one year after Alaska became a state, the population was 230,400,[30] and about one in five Alaskans (44,237) lived in Anchorage.[31] The population grew quickly through the 1960s, 1970s, and 1980s in part due to the construction of the Trans-Alaska Pipeline from 1975 to 1977 and other projects related to

[29] Alaska Department of Labor and Workforce Development, Research and Analysis. 2024. *Alaska Population Projections 2023 to 2050.* http://live.laborstats.alaska.gov/pop/projections.cfm

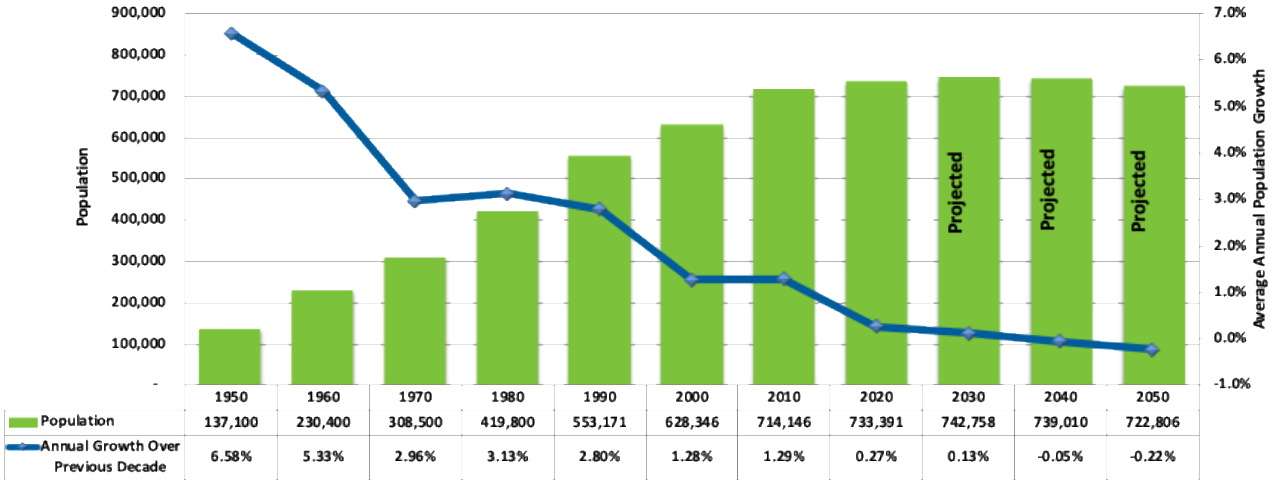
[30] Alaska Department of Labor and Workforce Development, *Alaska Population Overview: 2010 Census and 2011 Estimates*, October 2012. http://live.laborstats.alaska.gov/pop/estimates/pub/1011popover.pdf

[31] US Department of Commerce Bureau of the Census, *1960 Census of Population, Advance Reports: General Social and Economic Characteristics*, April 27, 1962. http://www2.census.gov/prod2/decennial/documents/15611103.pdf

the oil industry.[32] By 1990, the state's population had grown to 553,171, and two in five Alaskans (226,338) lived in Anchorage.[33]

As Alaska's population has grown, its rate of growth has continued to slow (Figure 12). Between 1990 and 2010, population growth averaged just less than 1.3 percent per year and further slowed to 0.27 percent per year between 2010 and 2020. The Alaska DOLWD projects that the population will grow by 0.13 percent annually through 2030 but then will decline by 0.05 percent per year between 2030 and 2040 and by 0.22 percent per year between 2040 and 2050.[34]

Figure 12: Alaska's Population and Annual Growth Rates from 1950–2050



	1950	1960	1970	1980	1990	2000	2010	2020	2030	2040	2050
Population	137,100	230,400	308,500	419,800	553,171	628,346	714,146	733,391	742,758	739,010	722,806
Annual Growth Over Previous Decade	6.58%	5.33%	2.96%	3.13%	2.80%	1.28%	1.29%	0.27%	0.13%	-0.05%	-0.22%

Source: US Census Bureau; Alaska Department of Labor and Workforce Development.

The Alaska DOLWD projects the distribution of residents by gender and age to change over the next two decades as the female population grows slightly faster than the male population and the overall population ages. The ratio of males to females has moved closer to the national average over the past decades and by 2050, the Alaska DOLWD projects there will be 104 to 105 males for every 100 females, down from 108 males per 100 females in FY2020.[35] We expect this relative increase in females will have a modest effect on the Medicaid program, as women have a longer average life expectancy than men and Medicaid costs are higher for the oldest seniors (85+) than

[32] For more information on the impact of the Trans-Alaska Pipeline, see Alyeska Pipeline Service Company, "Trans Alaska Pipeline System - The Facts." http://alyeska-pipeline.com/TAPS/PipelineFacts

[33] Alaska Department of Labor and Workforce Development, Alaska Population Estimates, Historical Data: Places, https://live.laborstats.alaska.gov/data-pages/alaska-population-estimates

[34] Alaska Department of Labor and Workforce Development. *Alaska Population Overview: 2010 Census and 2011 Estimates*. October 2012. http://live.laborstats.alaska.gov/pop/estimates/pub/1011popover.pdf

[35] Alaska Department of Labor and Workforce Development. 2024. *Alaska Population Projections 2023 to 2050*. https://live.laborstats.alaska.gov/pop/projections.html; nationally, there are 103 females for every 100 males.

for younger seniors, working-age adults, or children.[36]

The DOLWD projects the senior population will grow at a much faster rate than the overall population (0.29% per year for seniors versus a decrease of 0.06% for the total population) and that the number of children in Alaska will decrease by 0.55% per year (Table 2).

Table 2: Alaska's Projected Population by Age Cohort for Selected Calendar Years 2026–2046

Age Group	2026	2031	2036	2041	2046	Avg. Annual Change
Children (0-19)	192,446	185,156	178,884	175,033	172,402	-0.55%
Adults (20-64)	424,942	424,402	428,719	431,470	429,035	0.05%
Seniors (65+)	121,012	132,499	133,835	130,608	128,208	0.29%
Total Population	**738,400**	**742,057**	**741,438**	**737,111**	**729,645**	-0.06%

Source: Analysis by Evergreen Economics of data from Alaska Department of Labor and Workforce Development, 2024. Research and Analysis, *Alaska Population Projections 2023 to 2050*. http://live.laborstats.alaska.gov/pop/projections.cfm.

2.2 Enrollment in the Medicaid Program

"Enrollment" refers to the number of individuals who both meet the eligibility requirements for Medicaid at the time of enrollment and register to receive Medicaid services at any time during a fiscal year—regardless of whether the individual receives Medicaid services during the fiscal year. There are three primary factors that determine growth in Medicaid enrollment: (1) population growth, (2) changes in the demographic characteristics of the population, and (3) changes in Medicaid eligibility requirements. For this report, we assume that eligibility requirements as they exist today will remain constant over the 20-year projection period.[37]

Approximately 57 percent of Alaska children were enrolled in the Medicaid program during all or some portion of FY2025, compared to 36 percent of adults aged 20 to 64 and 15 percent of Alaska seniors. Historically, children were the primary focus of the Medicaid program. However, that changed substantially with the introduction of Medicaid expansion in September 2015. Today, the Alaska Medicaid program covers more adults 20 to 64 years of age than children. Between FY2026

[36] There is little difference in average annual spending on Medicaid services for male and female children. For adults, higher average annual spending for women is due primarily to pregnancy and post-pregnancy services. For seniors, higher average annual spending on women is due to a greater average lifespan of women and the high cost of senior care for Medicaid enrollees 85 years of age or older.

[37] This report accounts for the end of the continuous enrollment requirement on March 31, 2023, as stated in the Consolidated Appropriations Act 2023, and the reinstatement of Medicaid redeterminations, which began in April 2023.
Changes in economic activity (either positive or negative) that impact employment also influence Medicaid enrollment. This is implicitly captured in the forecast through our analysis of trends in Medicaid enrollment rates.

and FY2046, we expect the proportion of children enrolled in Medicaid to increase from 58 percent to 64 percent and the proportion of adults 20 to 64 years of age and seniors to remain fairly constant at approximately 35 percent and 14 percent, respectively.

"Medicaid recipients" refers to individuals enrolled in Medicaid who received any Medicaid services during a fiscal year regardless of the type of services received.[38] In developing the forecast, we project both enrollment in Medicaid and the number of recipients of Medicaid services. In this report, we primarily focus on recipients because these are the Medicaid enrollees who are utilizing Medicaid services.

The reinstatement of Medicaid redeterminations led to a drop in Medicaid enrollment in FY2025 of nearly 10,500 individuals.[39] We anticipate that enrollment will continue to decrease—albeit at a slower rate—in FY2026 and in FY2027. We then project slow growth in enrollment through the remainder of the projection period. In FY2046, we project that Medicaid enrollment will be just over 285,000 (see Table 3), and that Medicaid will provide medical coverage to 39 percent of Alaska's projected 2045 population. This would represent an increase in the proportion of Alaskans covered by Medicaid of nearly two percentage point over FY2026 and five percentage points over FY2019—the year prior to the COVID-19 public health emergency.

Given the uncertainty associated with any long-term population forecast, actual Medicaid enrollment could be substantially different. Nevertheless, barring any substantive changes in Medicaid eligibility requirements (such as a continuous enrollment mandate), we believe it is unlikely that the proportion of Alaskans covered by Medicaid will substantially exceed 40 percent of the state's population.

Even while we expect enrollment to decrease over the next two years before slowly growing again, we project the number of recipients—Medicaid enrollees that utilize services—to continue to grow throughout the forecast (see Table 3), reaching nearly 215,000 in FY2046 (77% of projected enrollees that year).

[38] To be considered a recipient, the total cost of Medicaid services received by the Medicaid enrollee during the fiscal year must be at least $10.

[39] For the purpose of the long-term forecast, we measure enrollment based on annual unduplicated count, which means that an individual that begins a fiscal year enrolled in Medicaid is counted as being enrolled during that fiscal year even if they are disenrolled before the end of the fiscal year.

Table 3: Medicaid Enrollment and Recipients by Age Cohort, For FY2015 and Select Fiscal Years

Age Cohort	Measure	2015	2026	2031	2036	2041	2046	*Percent Change**
Children (0-19)	Enrollees	94,532	110,751	110,593	110,376	110,866	109,965	-0.04%
	Recipients	79,540	82,875	84,558	86,090	88,167	89,083	0.36%
Adults (20-64)	Enrollees	58,884	147,206	145,534	149,462	152,265	151,842	0.16%
	Recipients	48,134	93,720	94,376	98,903	102,949	104,905	0.57%
Seniors (65+)	Enrollees	11,209	18,829	21,506	22,743	23,150	23,419	1.10%
	Recipients	9,779	15,338	17,848	19,255	19,998	20,601	1.49%
All Ages**	**Enrollees**	**164,625**	**276,786**	**277,633**	**282,581**	**286,282**	**285,226**	0.15%
	Recipients	**137,453**	**191,933**	**196,782**	**204,248**	**211,114**	**214,589**	0.56%

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.
* Average annual percent change between FY2026 and FY2046.
** Due to rounding, some totals may not precisely match the sum of components shown in the table.

In FY2015, 22.3 percent of Alaskans were enrolled in Medicaid during all or part of the fiscal year, and 18.7 percent of Alaskans received Medicaid services (Table 4). At 12.9 percent, adults (ages 20-64) were the least likely of the three age cohorts to be enrolled in Medicaid. This changed dramatically after Alaska expanded Medicaid in September 2015, and we expect that 34.6 percent of adults will be enrolled in Medicaid in all or part of FY2026. The proportion of children enrolled in Medicaid has also grown since FY2015 due in part to components of the Affordable Care Act and, decreasingly, to the federal continuous enrollment mandate. The proportion of Alaska seniors enrolled in Medicaid has increased only slightly since FY2015. Over the 20-year forecast period, we expect the proportion of Alaska children and seniors enrolled in Medicaid to increase and the proportion of adults 20 to 64 years of age to change only slightly.

Table 4: Medicaid Enrollment and Recipients as a Proportion of Alaska's Population, for FY2015 and Select Future Fiscal Years

Age Cohort	Measure	2015	2026	2031	2036	2041	2046
Children (0-19)	Enrollees	45.9%	57.5%	59.7%	61.7%	63.3%	63.8%
	Recipients	38.6%	43.1%	45.7%	48.1%	50.4%	51.7%
Adults (20-64)	Enrollees	12.9%	34.6%	34.3%	34.9%	35.3%	35.4%
	Recipients	10.6%	22.1%	22.2%	23.1%	23.9%	24.5%
Seniors (65+)	Enrollees	15.0%	15.6%	16.2%	17.0%	17.7%	18.3%
	Recipients	13.1%	12.7%	13.5%	14.4%	15.3%	16.1%
All Ages	**Enrollees**	**22.3%**	**37.5%**	**37.4%**	**38.1%**	**38.8%**	**39.1%**
	Recipients	**18.7%**	**26.0%**	**26.5%**	**27.5%**	**28.6%**	**29.4%**

Source: Alaska Department of Labor and Workforce Development.

Table 5 shows the forecast of Medicaid enrollment and recipients by broad eligibility category. On a percentage basis, growth will be greatest for the Aged or Disabled eligibility group. We project that enrollment and recipient counts for all other eligibility categories will also increase, though at a substantially slower rate, while enrollment and recipient counts will decline for the Medicaid Expansion eligibility group.[40]

Table 5: Medicaid Enrollees and Recipients by Broad Eligibility, FY2026 – FY2046

Eligibility Group	Measure	2026	2031	2036	2041	2046	Annual Growth
Aged or Disabled	Enrollees	30,926	36,905	39,754	41,804	42,622	1.62%
	Recipients	25,267	29,913	32,155	33,778	34,417	1.56%
Medicaid Expansion*	Enrollees	83,309	69,808	70,518	70,971	70,570	-0.83%
	Recipients	51,841	43,868	45,016	46,068	46,600	-0.53%
All Other Eligibilities	Enrollees	162,551	170,920	172,309	173,507	172,034	0.28%
	Recipients	114,825	123,002	127,077	131,267	133,572	0.76%
Total**	**Enrollees**	**276,786**	**277,633**	**282,581**	**286,282**	**285,226**	**0.15%**
	Recipients	**191,933**	**196,782**	**204,248**	**211,114**	**214,589**	**0.56%**

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.
* An individual's Medicaid eligibility can change during a fiscal year. Enrollment through Medicaid expansion is comprised of persons projected to be (a) enrolled in Medicaid through expansion at the end of the fiscal year or (b) enrolled in Medicaid through expansion during an earlier month of the fiscal year and not enrolled through traditional Medicaid during any month.
** Due to rounding, some totals may not precisely match the sum of components shown in the table.

2.3 Growth in the Utilization of Medicaid Services

The term "utilization" has multiple meanings in healthcare. For the purpose of the long-term Medicaid forecast, we define utilization of a Medicaid service category as the annual unduplicated count of Medicaid recipients who used a particular Medicaid service during a fiscal year regardless of the number of times during the year the individual used the service or the intensity of use of the service received.[41] For the long-term Medicaid forecast, we project the number of Medicaid enrollees who will use each of the 20 service categories listed in Table 6—without regard for the intensity of use—during each of the 20 years of the forecast period.[42] A more detailed description of each service category is provided in the appendix of this report.

[40] Note: We project that all of the decline in enrollment and recipient counts for Medicaid expansion will occur between FY2026 and FY2031.
[41] Analogously, we also consider utilization in terms of the Medicaid recipient. From this perspective, we track historical trends in the number of Medicaid service categories that individual recipients used and project the average number of Medicaid service categories that individuals within each of the 288 subpopulations will receive.
[42] We consider "intensity of use" in the subsequent step of the long-term Medicaid forecast.

Table 6: Service Category Designations Used in the Long-Term Medicaid Forecast

Service Group	Service Category
Behavioral Health Services	Inpatient Psychiatric & Residential Psychiatric / BRC[43]
	Outpatient Mental Health
	1115 Waiver[44]
Long-Term Care Services	Nursing Home
Long Term Services & Supports	State Plan Personal Care Services
	Community First Choice (1915(k)) Services[45]
	Home and Community-based 1915(c) Waivers[46]
Healthcare, Direct Medical Services	Inpatient Hospital
	Outpatient Hospital
	Health Clinic
	Physician / Practitioner
	Dental
	Lab / X-Ray
	EPSDT[47]
	Therapy / Rehabilitation
	Vision
	Home Health / Hospice
Healthcare, Other Services	Pharmacy

[43] BRC stands for Behavioral Rehabilitation Centers.
[44] Medicaid Section 1115 Demonstration Waivers provide states with flexibility to test new approaches within Medicaid to aid in redesigning and improving their health system without increasing costs. Alaska's 1115 waiver is an integrated behavioral health system of care for Alaskans experiencing serious mental illness, severe emotional disturbance, substance use disorder (SUD), co-occurring substance use and mental illness, and at-risk families and children.
[45] Community First Choice (CFC), or 1915(k) services, include CFC personal care services, personal emergency response systems, and chore services. To be eligible for CFC, an enrollee must require a level of care that would otherwise be provided in an institution such as a nursing home or intermediate care facility for individuals with intellectual disabilities (ICF/IID).
[46] Alaska has five different home- and community-based 1915(c) waivers. Eligibility for 1915(c) waiver services depends on participants requiring a level of care that would otherwise be provided in an institution, such as a nursing home or intermediate care facility for individuals with intellectual disabilities (ICF/IID).
[47] EPSDT stands for Early and Periodic Screening, Diagnosis, and Treatment.

Service Group	Service Category
	DME[48] / Supplies
	Transportation

2.3.1 Variability in the Utilization of Medicaid Services

There is and will likely continue to be substantial variability among enrollees in the rate of service utilization. In recent fiscal years, including FY2025, fewer than three in four enrollees utilized any Medicaid services, while a small number of recipients utilized 10 or more different service categories during the fiscal year. Some of this variability is correlated with age as children utilize on average fewer Medicaid service categories than adults, and adults (those 20 to 64 years of age) utilize on average fewer Medicaid service categories than seniors.

A primary factor driving utilization of Medicaid services is being diagnosed with one or more chronic conditions, the probability of which increases with age.[49] In FY2025, Medicaid recipients with no diagnosed chronic conditions utilized on average 2.8 Medicaid service categories (Table 7). In comparison, Medicaid recipients with one diagnosed chronic condition utilized on average 4.3 service categories, recipients with two to four diagnosed chronic conditions utilized on average 5.2 Medicaid service categories, and recipients with five or more chronic conditions utilized on average 6.5 Medicaid service categories.

Table 7: Number of Medicaid Service Categories Utilized in FY2025

Number of Diagnosed Chronic Conditions	Number of Service Categories Utilized
No Diagnosed Chronic Conditions	2.8
One Diagnosed Chronic Condition	4.3
Two to Four Diagnosed Chronic Conditions	5.2
Five or More Diagnosed Chronic Conditions	6.5
Average of All Medicaid Recipients	3.8

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

The average number of service categories utilized per Medicaid recipient has increased slowly over the past two decades, and we project it will continue to grow slowly over the next two decades, reaching an average of 4.0 service categories per recipient by FY2046 as the Medicaid population continues to age and the prevalence of chronic conditions continues to grow.

[48] DME stands for Durable Medical Equipment.
[49] We present findings from our analysis of chronic conditions within the Medicaid population in Section 2.7.

2.4 Growth in the Intensity of Use of Medicaid Services

While utilization refers to the number of different Medicaid service categories a recipient uses, intensity of use refers to the *amount* of a particular service category a typical recipient receives. To estimate intensity of use, it is first necessary to recognize that the primary driver of increased spending on Medicaid services over time is growth in Medicaid reimbursement rates.[50] As we will describe in Section 2.5, we estimated the annual rate of growth in the Medicaid reimbursement rate for each year between FY2016 and FY2025.[51] We used these annual estimates of growth in Medicaid reimbursement rates to "net out" the impact of growth in reimbursement rates for all Medicaid claims for each year between FY2016 and FY2025. This had the effect of estimating what Medicaid spending would have been for each and every claim from FY2017 through FY2025 as if Medicaid reimbursement rates from FY2016 had remained constant through FY2025.[52]

We used the resulting reimbursement rate-adjusted estimates of spending on each claim to estimate regression models to explain intensity of use of each Medicaid service category as a function of demographic characteristics and a time-trend. We then used the coefficients estimated in these models to predict intensity of use for each of the 20 service categories through FY2046. On a weighted average basis across the 20 service categories, we project that intensity of use will increase on average by only about 0.3 percent per year through FY2046.

[50] Of course, in any given year, the primary driver of growth in Medicaid spending may be enrollment (e.g., from Medicaid expansion in FY2016 – FY2018) or another factor, but over the long term, most of the growth in Medicaid spending is attributable to growth in Medicaid reimbursement rates, which are themselves driven by increases in the cost of providing Medicaid services.

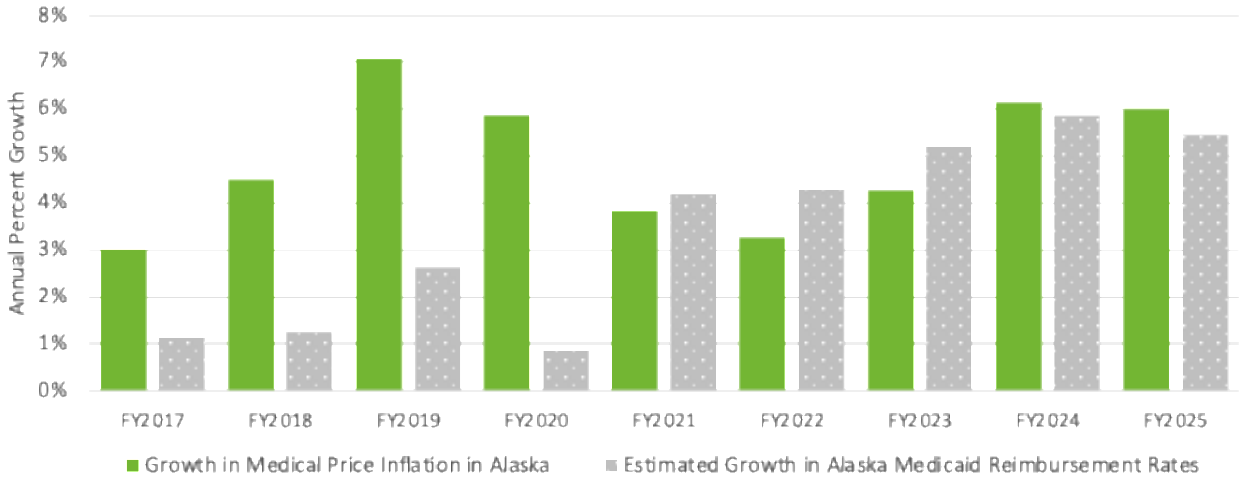
[51] There are thousands of reimbursement rates for Medicaid services that are periodically reviewed and updated. For the purpose of the long-term Medicaid forecast, we develop a single ("overall") annual estimate of the change in Medicaid reimbursement rates based on a weighted average of all Medicaid reimbursement rates.

[52] It is important to recognize that our goal in netting out the effect of Medicaid reimbursement rates from claims data was to estimate the average rate of growth in the intensity of use of Medicaid services overall and for each of the 20 Medicaid service categories; it was not to estimate the rate of growth in the intensity of use of each or any of the thousands of individual Medicaid services.

2.5 Growth in Medicaid Reimbursement Rates Paid to Providers

We analyzed the per-unit rates of growth in reimbursement rates paid to Medicaid service providers from FY2016 to FY2025 and compared them to the rates of medical price inflation in Alaska over the same period.[53] We found that Medicaid reimbursement rates grew at a much slower rate than medical price inflation each year from FY2016 through FY2020 (Figure 13), but reimbursement rates increased at a faster pace than medical price inflation in FY2021, FY2022, and FY2023. There was strong growth in Medicaid reimbursement rates in FY2024 and FY2025 but based on our analysis, they still grew slightly slower than medical price inflation.

Figure 13: Annual Percent Change in Medicaid Reimbursement Rates and Medical Price Inflation in Alaska, FY2016 – FY2025



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group and the US Bureau of Labor Statistics.

We project that Medicaid reimbursement rates will continue to increase over the projection period but at a slower rate than we estimated for fiscal years 2021 through 2025. While there will likely be years in which the rate of growth of the Medicaid reimbursement rate will outpace medical price inflation in Alaska (as we estimated for FY2022 through FY2024), we expect the long-term growth in reimbursement rates to average 3.05 percent per year, while we expect the annual rate of medical price inflation to average 3.68 percent per year.

[53] Each Medicaid reimbursement rate is reviewed either annually, biennially, or triennially, and periodically updated based on these reviews. Alaska Medicaid fee schedules and covered codes are available at https://extranet-sp.dhss.alaska.gov/hcs/medicaidalaska/Provider/Sites/ArchivedFeeSchedule.html
Medical price inflation is a measure of the change in "out of pocket" prices paid by consumers for medical services and health insurance premiums. We relied on the *Consumer Price Index for All Urban Consumers: Medical Care in Urban Alaska* index as the measure of historical medical price inflation by consumers for medical care and health insurance premiums. US Bureau of Labor Statistics, https://www.bls.gov/cpi/data.htm

2.6 Total Spending on Medicaid Services

The final step of the long-term forecast is to project spending on Medicaid services, which incorporates the forecasts of Medicaid enrollment, utilization and intensity of use of Medicaid services, and reimbursement rates as described above.

Table 8 shows projected spending by Medicaid service group. We project that total spending on Medicaid services will increase on average by 4.7 percent per year between FY2026 and FY2046, reaching more than $8.2 billion. Over this period, growth in spending on Long-Term Care services (primarily nursing homes) and Long-Term Care Services and Supports, which include Personal Care, Community First Choice 1915(k), and HCB 1915(c) waivers, will outpace spending on the other service groups. For both of the long-term care service groups, we project spending will exceed 6 percent per year, while for the Behavioral Health service group and the Healthcare Services group, we project growth will average 4.8 percent and 3.8 percent, respectively.[54]

Table 8: Medicaid Spending by Medicaid Service Group, FY2026 – FY2046 (Millions $)

Service Group*	2026	2031	2036	2041	2046	Annual Growth
Behavioral Health	$571.7	$753.9	$979.7	$1,225.4	$1,470.1	4.8%
Long-Term Care	$207.5	$312.0	$432.5	$574.5	$710.5	6.3%
Long Term Care Services & Supports	$493.5	$764.3	$1,065.0	$1,404.6	$1,731.6	6.5%
Healthcare Services	$2,029.2	$2,391.0	$2,918.6	$3,571.9	$4,306.0	3.8%
Total	**$3,301.9**	**$4,221.2**	**$5,395.7**	**$6,776.4**	**$8,218.2**	**4.7%**

* See Table 14 for listing and descriptions of Medicaid service categories included in each service group.
Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

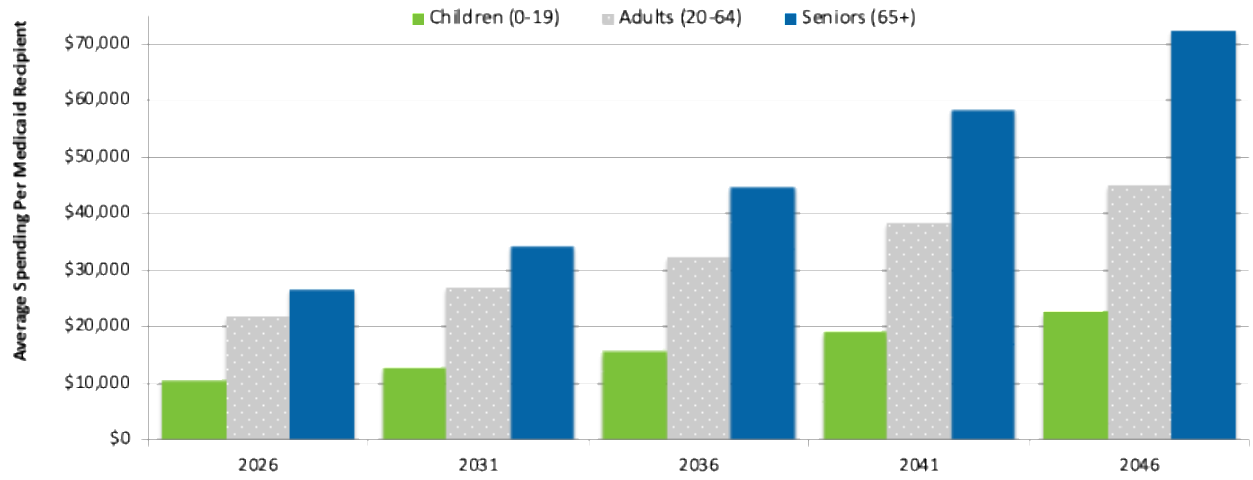
Figure 14 shows projected spending per recipient on Medicaid services. For FY2026, we estimate that for children, average spending per recipient will be approximately $10,300, while for adults and seniors, average spending per recipient will be approximately $21,800 and $26,600, respectively. By FY2046, we project that average spending per child recipient will be $22,600, while average spending per adult recipient will be $45,000 and the average spending per senior recipient will be $72,200. The higher average spending on seniors is due almost entirely to the greater incidence of chronic conditions among this subpopulation. The greater rate of growth in average spending is due to growth in the number (and proportion) of seniors 85 years of age or

[54] See Table 14 for descriptions of the service categories contained in each service group.

older who tend to have more diagnosed chronic conditions than younger seniors and chronic conditions that are especially costly to treat.[55]

Over the next 20 years, average spending per Medicaid recipient will grow the fastest for seniors (4.5% per year), while for children and adults 20 to 64 years of age, per-recipient spending growth will average 4 percent and 3.7 percent, respectively. This greater rate of growth for seniors is due to the aging of the Medicaid population. For children and adults (20 to 64 years of age), we project no meaningful change in average age between FY2026 and FY2046. For FY2026, we estimate there are approximately 1,600 Medicaid recipients that are 85 years of age or older, representing 10 percent of all seniors. By FY2046, we project the number of Medicaid recipients 85 years of age or older will triple to 4,800 and will represent 23 percent of the senior population. Over this period, we estimate that the average age of a Medicaid recipient who is a senior will increase by at least three years from 75 in FY2026 to at least 78.[56]

Figure 14: Average Spending Per Recipient on Medicaid Services by Age Cohort, FY2026 – FY2046



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

As Alaska's population ages, its Medicaid population also ages. Even without any increase in the number of persons enrolled in Medicaid, the cost of providing Medicaid services will rise due to the positive relationship between age and spending on healthcare services. In FY2000, the average age of a Medicaid enrollee in Alaska was 21 and the median age was 14;[57] in FY2015—the year

[55] Such chronic conditions include stroke, Demetia/Alzheimer's, and complications from falls.

[56] We do not estimate the exact age of each Medicaid enrollee or recipient. Rather, we project enrollees and recipients by 12 age groups. For the 85+ age group, we assume an average age of 92.5. For each of the younger age groups, we assume an average age based on the midpoint of the respective age group (e.g., for the 25-34 age group, we assume an average age of 29.5).

[57] The median represents the midpoint. In FY2000, half of all Medicaid enrollees were under 14 years of age.

before Medicaid expansion—the average age was 23 and the median age was 16. We project that by FY2046, the average age of a Medicaid enrollee will be 31 and the median age will be 26.

Figure 15 shows our forecast of total spending on Medicaid services by factor affecting spending growth. The figure begins with the *status quo*, which is simply the unchanging level of spending if there were no external or internal factors affecting spending over the next 20 years. The status quo assumes that everything about the Medicaid program will remain unchanged (i.e., number of recipients, age distribution, health conditions, etc.) from FY2026 to FY2046. Figure 15 then shows how the spending forecast builds off this base.

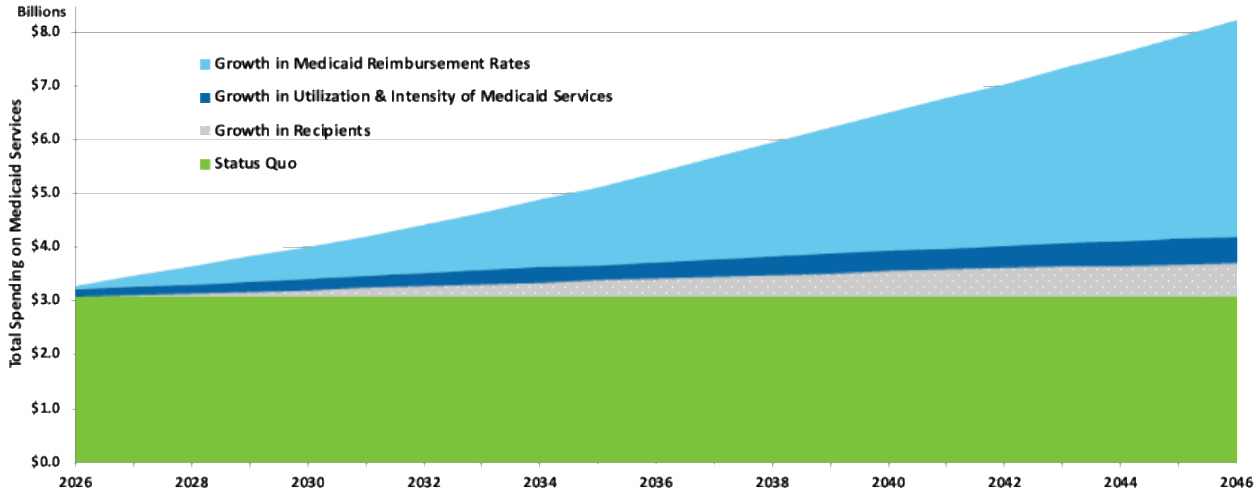
The components of spending growth are as follows:

- ***Growth in Medicaid Reimbursement Rates*** represents increases in the schedule of fees paid to Medicaid service providers.
- ***Growth in Utilization & Intensity of Medicaid Services*** represents the incremental impact of growth in the number of Medicaid service categories used by a recipient and the greater use of a service category.[58]
- ***Growth in Recipients*** represents the impact of growth in either the number of Medicaid enrollees utilizing Medicaid services due to increases in the number of Medicaid enrollees, the rate at which enrollees utilize Medicaid services, or both.

As Figure 15 shows, we expect *growth in reimbursement rates* to be the primary driver of spending growth for Alaska's Medicaid program, representing 46 percent of total spending in FY2046 and 76 percent of the growth in spending between FY2026 and FY2046. Relative to growth in Medicaid reimbursement rates, the combined impact of all other factors that affect growth in Medicaid spending will be relatively modest.

[58] Increases in the intensity of use of a Medicaid service category may be due to changes in medical technology or practices, an increase in the scope of services within a Medicaid service category, or another reason.

Figure 15: Projected Spending on Medicaid Services by Component of Growth, FY2026-FY2046

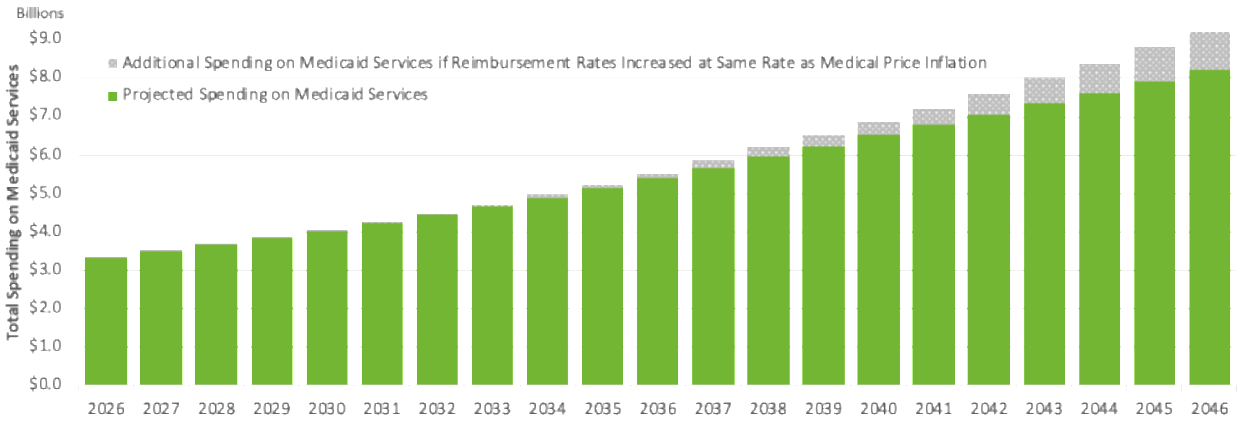


* All other factors include population growth, growth in enrollment rates, growth in utilization of Medicaid services, and growth in the intensity of use of Medicaid services.
Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Even with the substantial impact that growth in Medicaid reimbursement rates will have on Medicaid spending over the next two decades, it is worth reiterating that we expect Medicaid reimbursement rates to increase slower than medical price inflation in Alaska.[59] Figure 16 shows the projected forecast for total Medicaid spending through FY2046 (in green) and how much greater the forecast would be if Medicaid reimbursement rates grew at the projected rate of medical price inflation (in grey). We estimate that if Medicaid reimbursement rates increase at the same rate as we project medical price inflation to increase, Medicaid spending in FY2046 would be $1 billion greater than our forecast and that over the 20-year projection period, total spending would be $6.2 billion greater.

[59] Recall that medical price inflation is a measure of the change in "out-of-pocket" prices paid by private consumers for medical goods and services, as well as health insurance premiums.

Figure 16: Impact of Reimbursement Rates Growing at the Same Rate as Medical Price Inflation



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

2.6.1 State Spending on Medicaid Services

The state and federal governments share the funding of the Medicaid program. The proportion of the cost of a Medicaid service that the state and federal governments are responsible for is a function of the eligibility status of each Medicaid recipient, the rate of federal financial participation (FFP) associated with each eligibility category, and, in certain cases, the facility in which the recipient receives care.

Each Medicaid service received by an enrollee is eligible for one or more of the following FFP rates:

- Regular Federal Medical Assistance Percentage (FMAP):[60]
  - 56.2 percent FFP from January 1, 2020 through March 31, 2023[61]
  - 55 percent FFP from April 1, 2023 through June 30, 2023
  - 52.5 percent FFP from July 1, 2023 through September 30, 2023
  - 51.51 percent FFP from October 1, 2023 through December 31, 2023
  - 50.01 percent FFP beginning January 1, 2024 through September 30, 2024
  - 51.54 percent FFP beginning October 1, 2024 through September 30, 2025
  - 52.42 percent FFP beginning October 1, 2025 through September 30, 2026
  - 51.37 percent FFP beginning October 1, 2026

[60] CMS sets each state's FMAP rate based on a three-year average of per capita personal income, ranked among states.

[61] The additional 6.2 percentage points of FFP is attributable to the declaration by the US Secretary of Health and Human Services related to the COVID-19 pandemic. It was phased out by December 31, 2023. For more information, see "COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies." https://www.medicaid.gov/sites/default/files/2021-01/covid-19-faqs.pdf

- 1915 (K) Community First Choice (CFC):
    - 62.2 percent FFP from January 1, 2020 through March 31, 2023
    - 61 percent FFP from April 1, 2023 through June 30, 2023
    - 58.5 percent FFP from July 1, 2023 through September 30, 2023
    - 57.51 percent FFP from October 1, 2023 through December 31, 2023
    - 56.01 percent FFP beginning January 1, 2024 through September 30, 2024
    - 57.54 percent FFP beginning October 1, 2024 through September 30, 2025
    - 58.42 percent FFP beginning October 1, 2025 through September 30, 2026
    - 57.37 percent FFP beginning October 1, 2026
- Enhanced FMAP for Children's Health Insurance Program (CHIP):[62]
    - 80.84 percent FFP From January 1, 2020 through September 30, 2020
    - 69.34 percent FFP from October 1, 2020 through March 31, 2023
    - 68.5 percent FFP from April 1, 2023 through June 30, 2023
    - 66.75 percent FFP from July 1, 2023 through September 30, 2023
    - 66.06 percent FFP from October 1, 2023 through December 31, 2023
    - 65.01 percent FFP beginning January 1, 2024 through September 30, 2024
    - 66.08 percent FFP beginning October 1, 2024 through September 30, 2025
    - 66.69 percent FFP beginning October 1, 2025 through September 30, 2026
    - 65.96 percent FFP beginning October 1, 2026
- Breast and Cervical Cancer (BCC):[63]
    - 69.34 percent FFP from January 1, 2020 through March 31, 2023
    - 68.5 percent FFP from April 1, 2023 through June 30, 2023
    - 66.75 percent FFP from July 1, 2023 through September 30, 2023
    - 66.06 percent FFP from October 1, 2023 through December 31, 2023
    - 65.01 percent FFP beginning January 1, 2024 through September 30, 2024
    - 66.08 percent FFP beginning October 1, 2024 through September 30, 2025
    - 66.69 percent FFP beginning October 1, 2025 through September 30, 2026
    - 65.96 percent FFP beginning October 1, 2026
- Family Planning: 90 percent FFP
- Indian Health Service (IHS): 100 percent FFP
- Medicaid Expansion: 90 percent FFP [64]

[62] Ibid
[63] Ibid
[64] Recipients enrolled through Medicaid expansion who are also Indian Health Service beneficiaries will always receive 100 percent FFP for qualifying services.

- Medicaid Expansion 1915 (K) CFC: 96 percent FFP
- State-Only Services: 0 percent FFP

When a Medicaid service received by a Medicaid recipient is eligible for more than one FFP rate, the DOH applies the rate with the highest federal participation. The majority of Medicaid spending receives the regular FMAP rate, which is currently 52.42 percent; however, most of the growth in Medicaid spending since FY2015 has been for services that received either the Medicaid expansion or IHS FFP rates—90 percent and 100 percent, respectively. FFP rates are set at the federal level and, though they do change periodically, are largely outside of state control. We do not know in what future years FFP rates will change or what the new rates will be. For this reason, we assume the current FFP rates will remain constant throughout the projection period. Table 9 shows our forecast of total spending on Medicaid services through FY2046 and our assumptions of the portions of spending that will be paid by the State of Alaska and by the federal government. We project that total spending on Medicaid services will grow on average by nearly 4.7 percent per year through FY2046, but the rate of growth in spending will be slightly greater for the State of Alaska (4.79%) than for the federal government (4.63%).[65]

Table 9: Projected State and Federal Spending on Medicaid Services (in Millions $)

Fund Source	2026	2031	2036	2041	2046	Annual Growth
State GF and Other Matching Funds	$761.7	$968.2	$1,243.7	$1,572.9	$1,941.8	4.79%
Federal	$2,540.2	$3,253.0	$4,152.0	$5,203.5	$6,276.3	4.63%
Total Spending*	**$3,301.9**	**$4,221.2**	**$5,395.7**	**$6,776.4**	**$8,218.2**	**4.66%**

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.
* Due to rounding, some totals may not precisely match the sum of components shown in the table.

[65] The greater projected rate of growth in spending for the State of Alaska is due to projected growth in the number of seniors in the Medicaid program over the next 20 years and declines in the number of adults enrolled through Medicaid expansion through FY2030. A greater share of spending on Medicaid services for seniors is paid with state general funds than is spending on individuals enrolled through Medicaid expansion.

2.6.2 Other Medicaid Payments and Offsets

There are other costs associated with the Medicaid program that are not directly tied to services provided to individual recipients. These other costs can be broadly classified into two categories:

1. Premium payments for Medicare Part A and Part B;[66] and
2. Supplemental Hospital Payments including disproportionate share hospital (DSH) and upper payment limit programs paid to qualifying hospitals that serve many Medicaid or uninsured individuals, continuing care agreement payments, and Tribal dental encounter payments made to IHS and Tribal clinics.

The share of total Medicaid spending attributed to these other payments varies from year to year but has trended downward over the past 20 years. In addition, there are offsetting recoveries such as third-party liability collections and drug rebates, which are credited to the Medicaid program and are roughly equal to 2 percent to 3 percent of annual spending on Medicaid services. Table 10 shows the forecast of spending on Medicaid services, estimates of the cost of other Medicaid payments, and total projected spending on the Medicaid program.

Table 10: Total Projected Medicaid Spending by Date of Service, FY2026–FY2046, in Millions

Spending Type		2026	2031	2036	2041	2046
Medicaid Services	Federal	$2,540.2	$3,253.0	$4,152.0	$5,203.5	$6,276.3
	State Match	$761.7	$968.2	$1,243.7	$1,572.9	$1,941.8
	Total*	$3,301.9	$4,221.2	$5,395.7	$6,776.4	$8,218.2
Other Payments**	Federal	$107.3	$137.2	$175.4	$220.2	$267.1
	State Match	$57.8	$73.9	$94.4	$118.6	$143.8
	Total*	$165.1	$211.1	$269.8	$338.8	$410.9
Total Spending	**Federal**	$2,647.5	$3,390.2	$4,327.3	$5,423.7	$6,543.4
	State Match	$819.5	$1,042.1	$1,338.1	$1,691.5	$2,085.6
	Total*	$3,467.0	$4,432.3	$5,665.4	$7,115.3	$8,629.1

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.
* Due to rounding, some totals may not precisely match the sum of components shown in the table.
**Costs of other Medicaid payments includes savings from offsetting recoveries.

[66] Medicare is a federal program that provides health insurance to people aged 65 or older, people under the age of 65 with certain disabilities, and people of all ages with end-stage renal disease. The program is voluntary, and beneficiaries must pay monthly premiums. Medicare beneficiaries with low incomes may be eligible for benefits under Medicaid (referred to as being "dual-eligible"). If an individual is dual-eligible, Medicaid pays the premiums for Medicare Part A and Part B because Medicaid is the payer of last resort, and it costs the Medicaid program substantially less to pay the premiums for Medicare than it does to pay the claims for medical and related services.

2.7 Spending on Medicaid Enrollees with Chronic Conditions

The US National Center for Health Statistics defines chronic conditions as diseases or other medical conditions lasting three months or more.[67] The Centers for Disease Control and Prevention (CDC) defines chronic conditions as those that last one or more years and require ongoing medical attention or limit activities of daily living or both.[68] Unlike acute illnesses, which typically resolve within days or weeks, chronic conditions are long-term health problems that progress or extend over months or years and often require ongoing management without the possibility of a cure. Chronic conditions often have complex origins including genetics, lifestyle behaviors, and environmental influences, and having a chronic condition significantly increases the risk of developing additional chronic conditions, a phenomenon known as multimorbidity, which is especially prevalent among the senior population. These additional chronic conditions may develop as a result of the original chronic condition, while others may arise from shared risk factors such as lifestyle behaviors or genetic predisposition, creating complex health challenges.

Compared to individuals without chronic conditions, adults with chronic conditions—especially those with multiple chronic conditions—have lower health-related quality of life, greater risk of death, and significantly higher healthcare costs. Chronic conditions also have a substantial impact on healthcare spending in Alaska, the US, and globally. Chronic conditions affect healthcare costs in many ways, including:

Increased Utilization of Healthcare Services: Relative to individuals without diagnosed chronic conditions, those with chronic conditions typically require more frequent visits to healthcare providers, including specialists, which leads to higher costs. For many chronic conditions, individuals often require frequent and ongoing medical care, monitoring, and management of their conditions.

Long-Term Medications and Treatments: Certain chronic conditions require long-term medication regimens, which are often expensive, especially if the drugs are not available through a generic producer or are specialized for a specific condition. Some chronic conditions also require costly treatments or medical equipment.

Hospitalizations and Emergency Department Care: Chronic conditions can lead to various medical complications that require hospitalization. Alaska Medicaid recipients with diagnosed chronic conditions are also more likely to be *readmitted* for inpatient hospital care and are more likely to

[67] National Health Council, "About Chronic Diseases." https://nationalhealthcouncil.org/wp-content/uploads/2019/12/AboutChronicDisease.pdf

[68] Centers for Disease Control and Prevention, "About Chronic Diseases." https://www.cdc.gov/chronic-disease/about/?CDC_AAref_Val=https://www.cdc.gov/chronicdisease/about/index.htm

seek medical care through an emergency department. Inpatient hospital care and emergency department care are costly and contribute significantly to healthcare spending.

Increased Demand for Long-Term Care Services: Certain chronic conditions such as Alzheimer's disease and severe injuries such as fractures of the hip, pelvis, or vertebrae often require long-term care solutions such as in-home care or residential care facilities, both of which are expensive.

2.7.1 Identifying Medicaid Recipients with a Chronic Condition

We analyzed claims data from the Alaska Medicaid Management Information System (MMIS) and the Administrative Service Organization (ASO) to identify Medicaid recipients who had a paid Medicaid claim that included one or more diagnosis codes indicating the individual received treatment for any of the chronic conditions listed in Table 11 during FY2025. There were nearly 6.8 million Medicaid claims and approximately 10.2 million claim lines for services provided to recipients in FY2025. Each Medicaid claim line corresponds to an individual billable service provided by a hospital, health clinic, or other provider of services associated with the Medicaid claim.

Most, but not all, claim records also include one or more medical diagnosis codes assigned by a healthcare provider, which indicate the medical reason for the service.[69] We examined up to four diagnosis codes for each Medicaid claim line in FY2025 to identify if the service provided to the Medicaid recipient was associated with any of the chronic conditions listed in Table 11, which we arranged into 24 chronic condition groups based on the characteristics of the condition and/or the body system affected.

Table 11: Chronic Conditions Considered in Long-Term Forecast

	Chronic Condition Group	Chronic Conditions*
1	Blood	Anemia
2	Cancer	Breast, Colorectal, Endometrial, Lung, Prostate Cancers, Leukemias/Lymphomas
3	Cardiovascular	Atrial Fibrillation, Heart Attack or Ischemic Heart Disease, Heart Failure, Hypertension, Peripheral Vascular Disease (PVD)
4	Congenital Disorders	Cystic Fibrosis
5	Diabetes	Type I and Type II Diabetes
6	Drug & Alcohol Abuse	Alcohol Use Disorders, Drug Use Disorders including Opioid Use Disorder
7	Ear Condition	SDHI - Sensory - disabling hearing impairment

[69] In FY2025, 2.3 million claim lines (20.5%) did not include a diagnosis code. Of these, nearly all (96%) were either for pharmacy or dental services.

	Chronic Condition Group	Chronic Conditions*
8	Eye Condition	Cataract, Glaucoma, SBVI - Sensory - blindness and visual impairment
9	Injuries and Accidents	Hip or Pelvic Fracture, Spinal Cord Injury, Traumatic Brain Injury
10	Liver Disease	Cirrhosis/Liver Disease, Viral Hepatitis
11	Lung Disease	COPD, Bronchiectasis
12	Mental Health	ADHD/Hyperkinetic Syndrome, Anxiety Disorders including PTSD, Autism Spectrum Disorders, Depression or Depressive Disorder, Developmental Delays, Intellectual Disabilities, Learning Disabilities, Personality Disorders
13	Mobility Impairments	Encephalitis, Myelitis, Hereditary Ataxia, Hemiplegia, Hemiparesis, Sequelae of Cerebrovascular Disease, Other Paralytic Syndromes
14	Musculoskeletal	Fibromyalgia, Chronic Fatigue Syndrome, Muscular Dystrophy, Osteoporosis, Rheumatoid Arthritis/Osteoarthritis
15	Neurological	Dementia, Alzheimer's
16	Other Neurological	Cerebral Palsy, Epilepsy, Migraine/Chronic Headache, MS or Transverse Myelitis, Spina Bifida
17	Obesity	Obesity
18	Other Metabolic and Endocrine	Acquired Hypothyroidism, Hyperlipidemia
19	Renal and Urogenital	Benign Prostatic Hyperplasia, Chronic Kidney Disease
20	Respiratory	Asthma
21	Skin	Ulcers
22	Sexually Transmitted Infection	HIV AIDS
23	Stroke	Stroke, Transient Ischemic Attack
24	Tobacco	Smoking, Vaping, or Chewing Tobacco Use

Source: Analysis by Evergreen Economics of data from the CDC.
*The list of chronic conditions is not exhaustive.

Each chronic condition is identified by one or more International Classification of Diseases (ICD) diagnosis codes. The ICD codes are updated periodically, with the most recent update occurring on October 1, 2015 with the conversion from ICD-9 to ICD-10.[70] For each chronic condition, we relied on the Centers for Medicare and Medicaid Services (CMS) Chronic Conditions Data Warehouse to determine which ICD-10 codes indicated the respective chronic condition. This approach to identifying the presence of a chronic condition represents a limitation in the study in that we may *underestimate* the prevalence of each chronic condition within the Medicaid population because we only observe an individual as having a chronic condition if (a) they receive treatment for the

[70] Note: The full acronyms are ICD-9-CM and ICD-10-CM, where "CM" stands for Clinical Modification. It is a common practice to drop the "-CM." ICD-10 codes provide greater specificity about the medical encounter; there are approximately 68,000 ICD-10 codes.

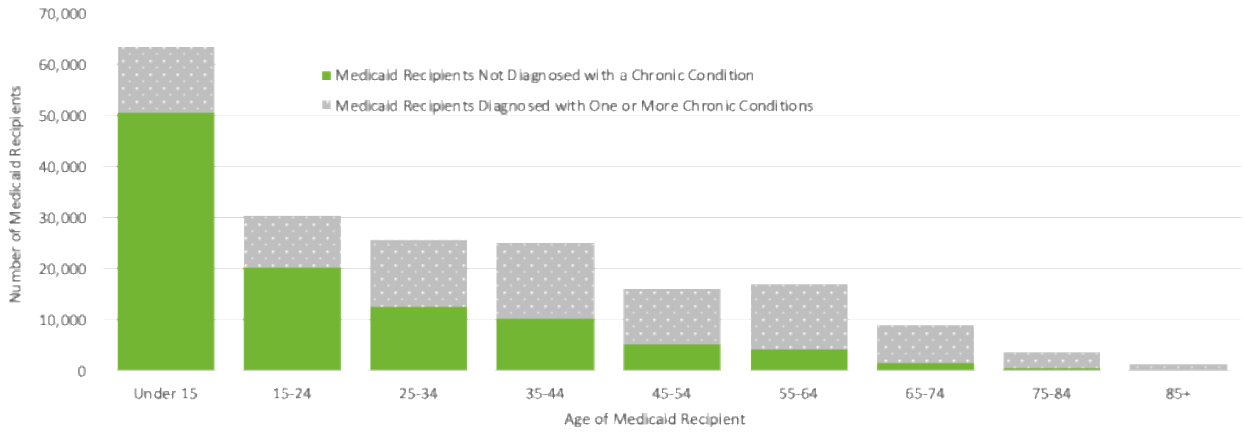
condition through the Medicaid program and (b) the care facility assigns a diagnosis code indicating the recipient received treatment for the chronic condition.[71]

We used a single criterion to define a Medicaid recipient as having one of the chronic conditions shown in Table 11: the Medicaid recipient had at least two Medicaid claims in FY2025 with a diagnosis code specifying the chronic condition as defined in the CMS Chronic Conditions Data Warehouse.[72] In FY2025, the unduplicated count of Medicaid enrollees was 281,937, of which 191,933 were recipients of Medicaid services. Applying the criterion described above, we identified 86,841 Medicaid recipients as being diagnosed with one or more chronic conditions.

2.7.2 Characteristics of Recipients with Chronic Conditions

Figure 17 shows the distribution of Medicaid recipients by age and whether the recipient was diagnosed with one or more chronic conditions in FY2025. The prevalence of being diagnosed with a chronic condition increases with age and/or is linked to the aging process.[73] While the distribution shown in Figure 17 has not materially changed since we began analyzing chronic condition diagnoses in 2018, the prevalence of chronic conditions within Alaska's Medicaid population has trended upward.

Figure 17: Medicaid Recipients by Age and Diagnosis of One or More Chronic Conditions, FY2025



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

[71] The likelihood of underestimating the prevalence of chronic conditions within the Medicaid population is especially pronounced for those Medicaid recipients who have dual eligibility with Medicare. This would include Medicaid recipients 65 years of age or older, recipients younger than 65 with disabilities, and any recipient with end-stage renal disease.

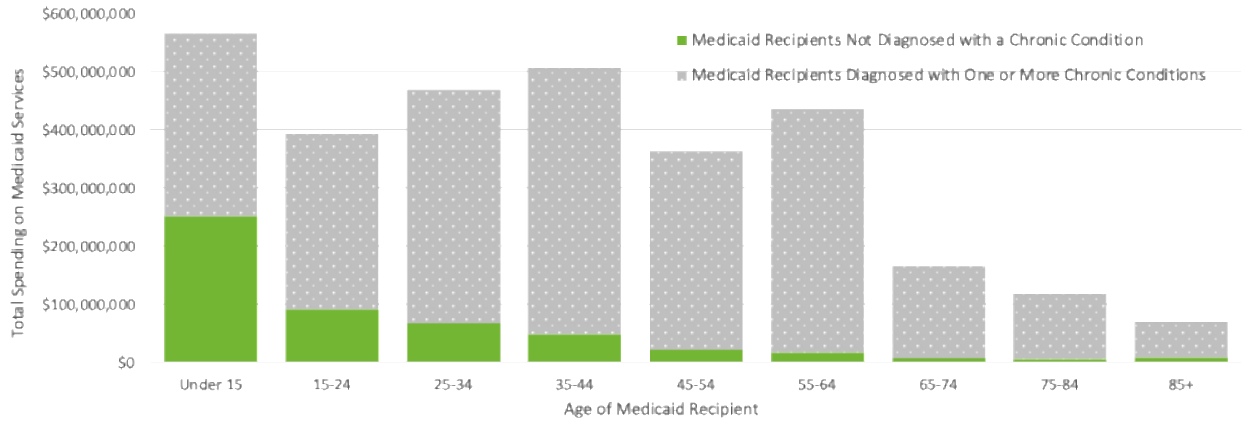
[72] These criteria were developed by Evergreen Economics specifically for this analysis.

[73] See, for example, Virginia M. Fried, Amy B. Bernstein, and Mary Ann Bush, "Multiple Chronic Conditions Among Adults Aged 45 and Over: Trends Over the Past 10 Years." US Department of Health and Human Services, Centers for Disease Control and Prevention, 2012. https://www.cdc.gov/nchs/products/databriefs/db100.htm

Approximately 20 percent of recipients under 15 years of age had a diagnosed chronic condition. The rate increases to 34 percent for recipients 15 to 24 years of age and continues to increase with each age group, reaching 84 percent for seniors 75 years of age or older. Medicaid recipients 65 years of age or older are dually eligible for Medicare, which is the primary payer for medical services—meaning Medicare would have been the payer of many of the medical services received by the dually eligible population in FY2025. Medical claims paid by Medicare are not captured in the MMIS or ASO systems, which only contain Medicaid claims. For this reason, we likely underestimate the true prevalence of chronic conditions within these oldest age groups.

Figure 18 shows total spending on Medicaid services by age and whether the recipient was diagnosed with a chronic condition. Comparing the distribution of spending by age in Figure 18 to the distribution of recipients by age in Figure 17 shows the substantial impact that chronic conditions have on Medicaid spending regardless of age.

Figure 18: Total Spending by Age and Diagnosis of a Chronic Condition, FY2025



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Table 12 shows average spending per recipient on Medicaid services in FY2025 by age of the recipient for *all* Medicaid recipients (column b), recipients without a diagnosed chronic condition (column c), and recipients with one or more diagnosed chronic conditions (column d).

Considering the data on average spending per recipient for all recipients shown in column b, the data appear to show a positive relationship between age and spending on Medicaid services. In comparison, spending per recipient for those without a chronic condition (column c) does not appear to be related to age (apart from the 75-84 and 85+ age groups). Likewise, spending per recipient for those with one or more diagnosed chronic conditions (column d) does not increase with age (apart from the 75-84 and 85+ age groups). Collectively, columns b, c, and d show that age, in and of itself, has relatively little impact on Medicaid spending. Instead, Medicaid spending is primarily driven by the cost of services directly or indirectly related to chronic conditions. Average spending per recipient *without a diagnosis of a chronic condition* was $4,943 in FY2025,

while average spending per recipient with *one or more chronic condition diagnoses* was six times greater at $29,597.

Table 12: Spending Per Medicaid Recipient and Incremental Cost of Chronic Conditions, FY2025

a.	b.	c.	d.	e.
Age of Recipient	Avg. Spending per Recipient - All Recipients	Avg. Spending per Recipient - Without a Diagnosed Chronic Condition	Avg. Spending per Recipient - One or More Chronic Condition Diagnoses	Incremental Cost of Chronic Condition (d – c)
Under 5	$11,143	$7,024	$33,297	$26,273
05-09	$6,771	$3,670	$17,925	$14,254
10-14	$8,910	$4,089	$24,233	$20,144
15-19	$12,175	$4,324	$30,015	$25,692
20-24	$14,063	$4,925	$28,147	$23,223
25-34	$18,287	$5,356	$30,627	$25,271
35-44	$20,163	$4,809	$30,663	$25,854
45-54	$22,503	$4,152	$31,223	$27,072
55-64	$25,526	$4,281	$32,290	$28,009
65-74	$18,619	$4,918	$21,536	$16,618
75-84	$32,443	$10,454	$36,398	$25,945
85+	$53,820	$33,854	$58,315	$24,461
All Recipients	**$16,098**	**$4,943**	**$29,597**	**$24,655**

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Table 13 shows the distribution of Medicaid recipients by number of diagnosed chronic conditions in FY2025, average spending per recipient, and total spending on all recipients. Most Medicaid recipients (54.9%) had no diagnosed chronic conditions.[74] These recipients accounted for 16.7 percent of total spending on Medicaid services. In comparison, 20.9 percent of recipients had one diagnosed chronic condition and accounted for 25.3 percent of spending, and 24.2 percent of recipients had two or more chronic conditions and accounted for 58 percent of total spending on Medicaid services.

[74] Based on the criterion that the Medicaid recipient did not receive at least two diagnoses (based on ICD-10 codes) for any of the chronic conditions listed in Table 11 on Medicaid claims incurred during FY2025. If a Medicaid recipient had a chronic condition in FY2025, but the diagnosis of that condition went unreported in the MMIS or ASO systems in FY2025, we would categorize that recipient as not having a chronic condition in FY2025.

Table 13: Distribution of Medicaid Recipients and the Cost of Providing Medicaid Services by the Number of Diagnosed Chronic Conditions, FY2025

Diagnosed Chronic Conditions	Medicaid Recipients	Percent of Recipients	Average Spending Per Recipient	Total Spending	Percentage of Spending
0	105,448	54.9%	$4,943	$521,183,267	16.71%
1	40,113	20.9%	$18,770	$790,088,014	25.34%
2	19,362	10.1%	$28,899	$559,550,376	17.95%
3	11,819	6.2%	$36,844	$435,461,870	13.97%
4	6,997	3.6%	$43,705	$305,805,427	9.81%
5	4,111	2.1%	$53,364	$219,378,907	7.04%
6	2,148	1.1%	$59,277	$127,328,007	4.08%
7	1,082	0.6%	$72,360	$78,293,166	2.51%
8 or More	853	0.4%	$94,954	$80,995,542	2.60%
All Recipients	**191,933**	**100.0%**	**$16,052**	**$3,118,084,578**	**100.0%**

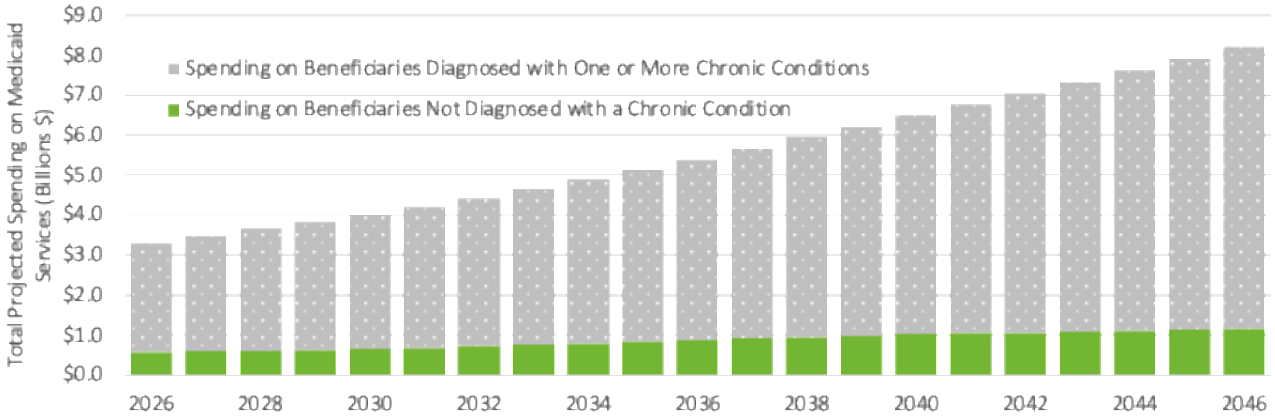
Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

2.7.3 Projected Spending on Medicaid Services for Recipients with Chronic Conditions

We used recipient-level data from the MMIS and ASO databases and the Medicaid enrollment forecast presented earlier in this report to project spending on services for Medicaid recipients diagnosed with one or more of the chronic conditions shown in Table 11 each year through FY2046 (Figure 19).[75] Over this period, we project that Medicaid spending on recipients diagnosed with one or more chronic conditions will grow from $2.7 billion (82.7% of total Medicaid spending) in FY2026 to $7.1 billion (85.9% of total Medicaid spending) in FY2046. Comparatively, we project that spending on recipients *not* diagnosed with a chronic condition will increase from $570 million in FY2026 to nearly $1.2 billion in FY2046, which, though increasing by $630 million over the 20-year period, will decrease as a proportion of total spending from 17.3 percent in FY2026 to 14.1 percent in FY2046.

[75] The spending forecast accounts for projected changes in the demographic makeup of the Medicaid population but does not attempt to project changes in the prevalence of each chronic condition within each demographic subgroup.

Figure 19: Projected Spending on Medicaid Services, FY2026–FY2046



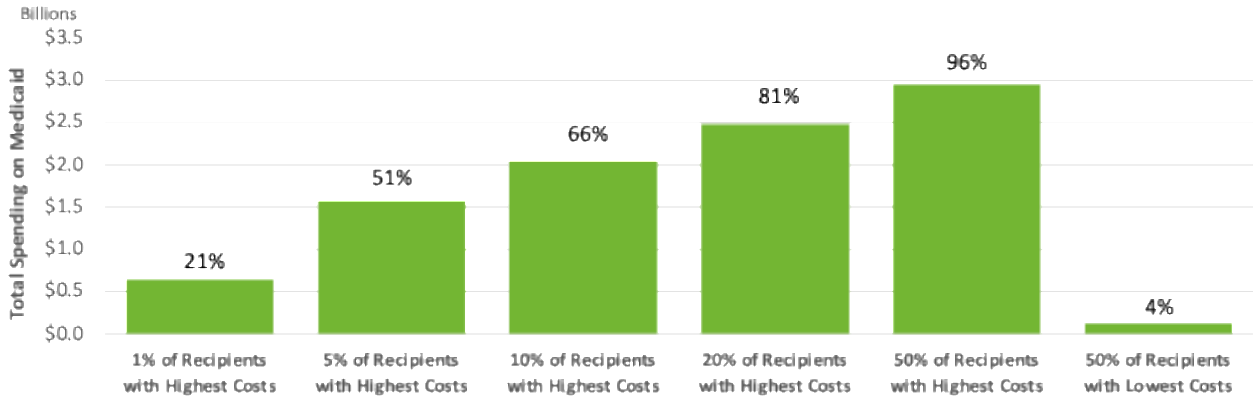
Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

2.7.4 High Utilizers in Alaska's Medicaid Population

We also examined the distribution of spending on Medicaid services for FY2025 and found that spending is highly concentrated among a relatively small proportion of recipients. For example, we found that the 1 percent of recipients with the highest costs accounted for 21 percent of total spending on Medicaid services, and that the 5 percent and 10 percent of recipients with the highest costs accounted for 51 percent and 66 percent of spending, respectively (Figure 20). In comparison, the half of Medicaid recipients with the lowest costs accounted for only 4 percent of spending on Medicaid services.

The average spending per recipient on Medicaid services for the 1 percent of recipients with the highest costs was $336,000 in FY2025, while it was $160,000 and $104,000, respectively, for the 5 percent and 10 percent of recipients with the highest costs. For the half of recipients with the highest Medicaid costs, spending per recipient was $29,960, and for the half with the lowest Medicaid costs, spending per recipient was $1,326.

Figure 20: Distribution of Medicaid Spending by Recipient Cost of Services

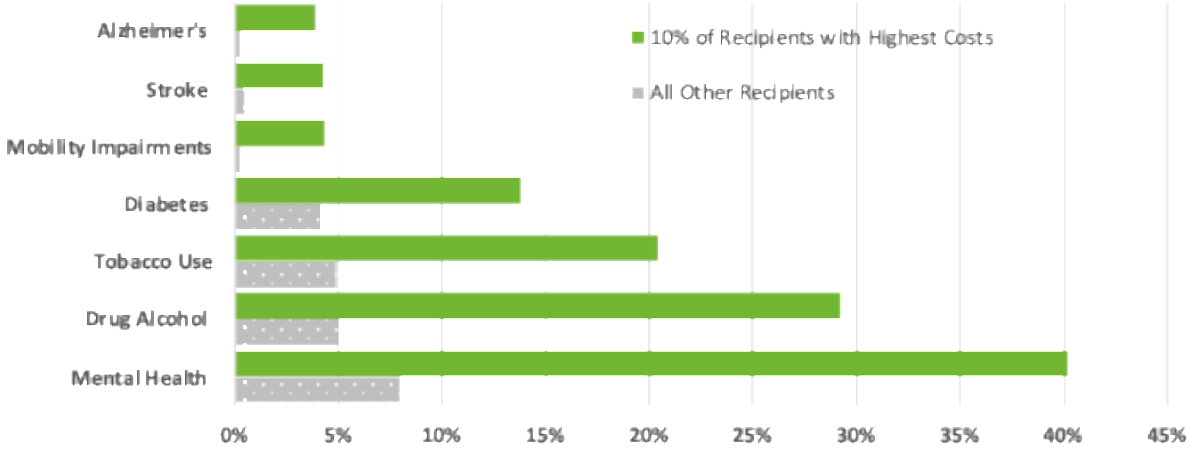


Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

The distribution of Medicaid spending shown in Figure 20 is nearly identical to the distribution in FY2025 and very similar to findings reported by researchers at KFF in a January 2024 study of the entire US population.[76]

Unsurprisingly, the prevalence of chronic conditions is much greater among Medicaid recipients with the highest spending. For example, Figure 21 shows the proportion of Medicaid recipients with each of seven different chronic conditions in FY2025. The green bars represent the 10 percent of recipients with the highest Medicaid costs, and the gray bars represent all other Medicaid recipients.[77] Perhaps most striking is the prevalence of diagnosed mental health conditions among the 10 percent of recipients with the highest costs (40%) versus among all other Medicaid recipients (8%). The prevalence ratio (PR) between these two groups is 5, indicating that the prevalence of a diagnosis of a mental health condition is five times greater among the 10 percent of recipients with the highest costs.[78] The prevalence of diagnosis is lower for the other chronic conditions shown in Figure 21; however, the PRs between the two groups (*the 10 percent of recipients with the highest costs* and *all other Medicaid recipients*) are still substantial—ranging from 3.3 for diabetes to 19.6 for mobility impairments.[79]

Figure 21: Proportion of Medicaid Recipients with Select Chronic Conditions



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

[76] Ortaliza, Jared, Matthew McGough, Emma Wager Twitter, Gary Claxton, and Krutika Amin. "How do health expenditures vary across the population?" Peterson Center on Healthcare and KFF, January 4, 2024. https://www.healthsystemtracker.org/chart-collection/health-expenditures-vary-across-population/

[77] Many Medicaid recipients with a diagnosed chronic condition have multimorbidity (more than one chronic condition). For this reason, recipients with multimorbidity may be represented in multiple bars in Figure 21.

[78] A prevalence ratio compares the prevalence of a condition between two groups by dividing the prevalence in one group (e.g., the 10% of recipients with the highest Medicaid costs) by the prevalence in another group (e.g., all other Medicaid recipients), indicating how much more or less common the condition is in one group relative to the other.

[79] Mobility impairment conditions include but are not limited to the following: encephalitis, myelitis, hereditary ataxia, hemiplegia, hemiparesis, sequelae of cerebrovascular disease, and other paralytic syndromes.

Table 14: Medicaid Service Category Descriptions for Long-Term Forecast

Service Group	Service Category	Description
Behavioral Health	Inpatient Psychiatric & Residential Psychiatric/Behavioral Rehabilitation Centers (BRC)	Inpatient psychiatric hospital services; Residential psychiatric treatment centers and BRC
	Outpatient Mental Health	Outpatient mental health services, psychology services, and drug abuse centers
	1115 Waiver	Behavioral health waiver
Long-Term Care	Nursing Home	Skilled nursing and intermediate care facilities including intermediate-care facilities for the intellectually disabled, and temporary long-term care services
Long-Term Services and Supports	Personal Care	Personal care attendant services including agency-based and consumer-directed programs
	Community First Choice 1915(k)	Community First Choice (CFC), or 1915(k) services, include CFC personal care services, personal emergency response systems, and chore services.
	HCB 1915(c) Waivers	Alaska has five different home- and community-based 1915(c) waivers. Eligibility for 1915(c) waiver services depends on participants requiring a level of care that would otherwise be provided in an institution.
Healthcare Services	Dental	Dental services for children and adults
	Durable Medical Equipment (DME)/Supplies	DME, medical supplies, prosthetics, and orthotics
	Early & Periodic Screening, Diagnosis & Treatment (EPSDT)	EPSDT including preventive health checkups, immunizations, and medically necessary treatment
	Health Clinic	Health clinic services including rural health clinics, federally qualified health clinics, and Tribal health clinics
	Inpatient Hospital	Inpatient hospital services
	Laboratory/X-Ray	Laboratory, x-ray, and diagnostic services
	Other Services	Other services not classified elsewhere

Service Group	Service Category	Description
	Outpatient Hospital	Outpatient hospital services, outpatient surgery services, and end-stage renal disease services
	Pharmacy	Prescription drugs
	Physician/Practitioner Services	Physician, podiatrist, advanced nurse practitioner, and midwifery services
	Therapy/Rehabilitation	Outpatient rehabilitation, physical therapy, occupational therapy, speech therapy, audiology, and chiropractic services
	Transportation	Emergency and non-emergency medically necessary transportation and accommodation
	Home Health/Hospice	Home health services, hospice care, nutrition services, and private duty nursing
	Vision	Optometrist services and eyeglasses

Table 15: Medicaid Eligibility Classification Descriptions

Eligibility Class	Description
Aid to Families with Dependent Children (AFDC) & Related	Eligible for AFDC-based Family Medicare or Transitional Medicaid
Alien (Foreign)	Illegal, sponsored, or amnesty alien
Exams	Disability, waiver, or pregnancy determination pending
Kids in Custody	Children in custody of the Department of Health
Long-Term Care (LTC) Non-Cash	Aged or disabled individual not receiving SSI or cash supplement
Medicare	Eligible for Medicare cost-sharing assistance only
Other Disabled	Working disabled or eligible due to breast/cervical cancer screening
Pregnancy/Post-Partum	Eligible during pregnancy and for 60 days after giving birth
SSI/APA/LTC Cash	Eligible for SSI or other state cash supplement
Title XIX Kids	Children under age 19 not eligible for coverage under CHIP
Title XXI Kids	Children under age 19 eligible for coverage under CHIP
Expansion	Non-disabled adults 18 – 64 without dependent children

Table 16: Forecast of Population by Demographic Group, FY2026-FY2046

	FY2026	FY2031	FY2036	FY2041	FY2046	Annual % Change
State	738,400	742,057	741,438	737,111	729,645	738,400
Gender						
Female	354,926	356,816	356,519	354,208	350,079	354,926
Male	383,474	385,241	384,919	382,903	379,566	383,474
AI/AN Status						
AI/AN	166,869	171,406	175,232	178,455	180,721	166,869
Not AI/AN	571,531	570,651	566,206	558,656	548,924	571,531
Region						
Northern	27,790	28,007	28,281	28,516	28,738	0.2%
Interior	109,260	108,499	107,056	105,354	103,562	-0.3%
Gulf Coast	84,015	84,182	83,720	82,631	81,129	-0.2%
Anchorage/Mat-Su	404,911	409,724	412,098	411,953	409,450	0.1%
Southeast	70,416	68,642	66,444	63,993	61,293	-0.7%
Southwest	42,008	43,003	43,839	44,664	45,473	0.4%
Age Group						
0-4	44,673	44,801	44,034	43,315	41,998	-0.3%
5-9	47,384	44,858	44,990	44,230	43,513	-0.4%
10-14	49,950	46,821	44,300	44,432	43,679	-0.7%
15-19	50,439	48,676	45,560	43,056	43,212	-0.8%
20-24	48,471	49,259	47,508	44,428	41,978	-0.7%
25-34	103,382	100,175	99,789	98,863	94,059	-0.5%
35-44	108,371	108,749	105,629	102,620	102,342	-0.3%
45-54	84,318	93,850	102,074	102,585	99,703	0.8%
55-64	80,400	72,369	73,719	82,974	90,953	0.6%
65-74	75,641	71,687	61,377	54,617	56,198	-1.5%
75-84	36,524	48,084	53,836	50,802	43,097	0.8%
85+	8,847	12,728	18,622	25,189	28,913	6.1%

Source: Analysis by Evergreen Economics of data from the Alaska Department of Labor and Workforce Development.

Table 17: Forecast of Enrollment by Demographic Group, FY2026-FY2046

	FY2026	FY2031	FY2036	FY2041	FY2046	Annual % Change
State	276,786	277,633	282,581	286,282	285,226	0.2%
Gender						
Female	140,020	140,885	143,509	145,408	144,705	0.2%
Male	136,766	136,748	139,072	140,874	140,522	0.1%
AI/AN Status						
AI/AN	94,670	100,774	104,273	107,621	109,248	0.7%
Not AI/AN	182,116	176,859	178,309	178,661	175,978	-0.2%
Region						
Northern	14,754	15,227	15,762	16,243	16,467	0.6%
Interior	32,552	32,410	32,654	32,833	32,601	0.0%
Gulf Coast	32,502	32,441	32,828	33,014	32,642	0.0%
Anchorage/Mat-Su	144,944	144,813	147,626	149,591	148,956	0.1%
Southeast	24,554	23,727	23,370	22,971	22,145	-0.5%
Southwest	27,480	29,015	30,340	31,631	32,414	0.8%
Age Group						
0-4	27,203	29,816	30,318	30,602	29,883	0.5%
5-9	28,631	27,460	28,400	28,668	28,434	0.0%
10-14	28,028	26,551	25,964	26,677	26,481	-0.3%
15-19	26,888	26,767	25,694	24,920	25,167	-0.3%
20-24	20,536	21,039	20,965	20,160	19,451	-0.3%
25-34	42,372	41,081	42,273	43,068	41,643	-0.1%
35-44	38,251	37,476	37,174	37,050	37,583	-0.1%
45-54	23,802	25,401	27,691	28,294	27,623	0.7%
55-64	22,244	20,538	21,359	23,694	25,542	0.7%
65-74	11,602	11,923	10,957	10,210	10,661	-0.4%
75-84	5,454	7,150	8,496	8,577	7,606	1.7%
85+	1,774	2,433	3,290	4,364	5,152	5.5%

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Table 18: Forecast of Spending by Demographic Group (Millions $), FY2026-FY2046

	FY2026	FY2031	FY2036	FY2041	FY2046	Annual % Change
State	$3,301.9	$4,221.2	$5,395.7	$6,776.4	$8,218.2	4.7%
Gender						
Female	$1,719.2	$2,198.6	$2,810.3	$3,527.0	$4,275.0	4.7%
Male	$1,582.7	$2,022.6	$2,585.4	$3,249.4	$3,943.3	4.7%
AI/AN Status						
AI/AN	$1,502.9	$1,917.5	$2,439.9	$3,050.7	$3,688.6	4.6%
Not AI/AN	$1,799.0	$2,303.7	$2,955.8	$3,725.7	$4,529.7	4.7%
Region						
Northern	$216.5	$283.5	$369.0	$467.9	$569.6	5.0%
Interior	$329.4	$433.4	$568.9	$727.2	$891.2	5.1%
Gulf Coast	$387.3	$510.0	$669.4	$855.6	$1,047.4	5.1%
Anchorage/Mat-Su	$1,657.5	$2,181.1	$2,862.6	$3,659.2	$4,484.8	5.1%
Southeast	$398.2	$520.9	$678.0	$859.7	$1,046.6	5.0%
Southwest	$313.1	$292.3	$247.9	$206.9	$178.6	-2.8%
Age Group						
0-4	$251.1	$318.7	$394.2	$480.9	$568.9	4.2%
5-9	$153.5	$176.5	$209.0	$244.0	$279.7	3.0%
10-14	$198.9	$254.6	$328.2	$422.8	$522.5	4.9%
15-19	$247.5	$321.2	$411.3	$519.1	$640.4	4.9%
20-24	$174.0	$205.8	$230.2	$248.3	$267.5	2.2%
25-34	$495.7	$628.5	$817.5	$1,043.3	$1,263.3	4.8%
35-44	$535.5	$681.7	$873.0	$1,103.1	$1,360.8	4.8%
45-54	$380.1	$461.6	$549.8	$618.3	$671.9	2.9%
55-64	$457.5	$563.6	$719.9	$928.8	$1,155.0	4.7%
65-74	$184.6	$250.4	$328.8	$426.0	$548.7	5.6%
75-84	$140.8	$223.1	$320.9	$425.5	$517.0	6.7%
85+	$82.9	$135.4	$212.9	$316.3	$422.5	8.5%

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Table 19: Forecast of Total Spending on Medicaid (Millions $), FY2026-FY2046

Service Category	FY2026	FY2031	FY2036	FY2041	FY2046	Annual % Change
Inpatient Hospital	$494.8	$588.3	$722.7	$889.5	$1,075.7	4.0%
Outpatient Hospital	$361.4	$419.2	$505.5	$610.8	$728.2	3.6%
Family Planning	$0.4	$0.4	$0.5	$0.6	$0.8	3.9%
Health Clinic	$312.1	$384.6	$481.6	$602.2	$738.8	4.4%
Physician/Practitioner	$247.9	$282.6	$339.2	$408.7	$485.5	3.4%
Dental	$118.4	$140.0	$169.4	$206.5	$250.4	3.8%
Lab/X-ray	$8.5	$9.7	$12.0	$14.7	$17.7	3.8%
EPSDT	$25.8	$33.3	$42.1	$53.5	$66.7	4.9%
Therapy/Rehabilitation	$45.4	$51.6	$60.9	$72.2	$84.5	3.2%
Home Health/Hospice	$14.0	$18.9	$25.0	$33.2	$43.8	5.9%
Vision	$8.7	$9.8	$11.6	$13.9	$16.4	3.2%
Pharmacy	$238.8	$267.5	$322.0	$389.8	$465.4	3.4%
DME/Supplies	$30.0	$36.6	$45.7	$56.9	$69.1	4.3%
Transportation	$123.2	$148.6	$180.4	$219.3	$262.9	3.9%
Inpatient-Res Psych	$49.0	$55.7	$62.9	$73.0	$86.8	2.9%
Outpatient Mental Health	$182.2	$246.8	$336.1	$449.1	$584.1	6.0%
1115 Waver	$340.5	$451.4	$580.6	$703.3	$799.2	4.4%
Nursing Home	$207.5	$312.0	$432.5	$574.5	$710.5	6.3%
State Plan Personal Care Services	$26.1	$43.3	$63.2	$85.8	$106.2	7.3%
Community First Choice 1915(k) Services	$434.6	$667.2	$926.1	$1,222.0	$1,515.6	6.4%
HCB 1915(c) Waivers	$32.7	$53.8	$75.7	$96.8	$109.8	6.2%
Total Spending on Medicaid Services	$3,301.9	$4,221.2	$5,395.7	$6,776.4	$8,218.2	4.7%
Other Medicaid Payments*	$165.1	$211.1	$269.8	$338.8	$410.9	4.7%
Total Spending on Medicaid Program	**$3,467.0**	**$4,432.2**	**$5,665.5**	**$7,115.2**	**$8,629.1**	**4.7%**

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.
* Includes offsets received by the DOH for drug rebates, third-party liability collections, or other reasons.

Table 20: Forecast of State GF Spending on Medicaid (Millions $), FY2026-FY2046

Service Category	FY2026	FY2031	FY2036	FY2041	FY2046	Annual % Change
Inpatient Hospital	$102.0	$116.4	$141.6	$174.0	$213.8	3.8%
Outpatient Hospital	$58.8	$64.7	$77.3	$93.2	$112.9	3.3%
Family Planning	$0.3	$0.4	$0.5	$0.6	$0.7	3.8%
Health Clinic	$17.1	$17.9	$22.1	$27.6	$34.4	3.6%
Physician/Practitioner	$62.5	$69.0	$81.9	$98.5	$119.0	3.3%
Dental	$26.6	$30.4	$36.4	$44.3	$54.5	3.6%
Lab/X-ray	$2.2	$2.5	$3.0	$3.7	$4.5	3.6%
EPSDT	$4.5	$5.5	$6.9	$8.8	$11.1	4.6%
Therapy/Rehabilitation	$19.0	$21.1	$24.7	$29.2	$34.7	3.1%
Home Health/Hospice	$5.5	$7.3	$9.6	$12.7	$17.0	5.8%
Vision	$3.1	$3.5	$4.1	$4.9	$5.8	3.1%
Pharmacy	$57.4	$62.1	$74.0	$89.4	$108.5	3.2%
DME/Supplies	$10.9	$13.0	$16.1	$20.1	$24.8	4.2%
Transportation	$11.6	$12.8	$15.3	$18.6	$22.7	3.4%
Inpatient-Res Psych	$14.4	$16.0	$17.8	$20.7	$25.0	2.8%
Outpatient Mental Health	$33.3	$43.0	$58.0	$77.4	$102.3	5.8%
1115 Waver	$74.9	$95.5	$121.5	$146.9	$169.6	4.2%
Nursing Home	$66.5	$97.5	$133.8	$177.4	$222.9	6.2%
Personal Care	$12.3	$20.2	$29.1	$39.4	$49.6	7.2%
Community First Choice 1915(k) Services	$166.3	$249.5	$342.3	$450.3	$567.0	6.3%
HCB 1915(c) Waivers	$12.4	$19.9	$27.8	$35.4	$40.9	6.2%
Total Spending on Medicaid Services	$761.7	$968.2	$1,243.7	$1,572.9	$1,941.8	4.8%
Other Medicaid Payments*	$57.8	$73.9	$94.4	$118.6	$143.8	4.7%
Total Spending on Medicaid Program	**$819.5**	**$1,042.1**	**$1,338.1**	**$1,691.5**	**$2,085.6**	**4.8%**

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.
* Includes offsets received by the DOH for drug rebates, third-party liability collections, or other reasons.