



Long-Term Forecast of Medicaid Enrollment and Spending in Alaska: FY2023-FY2043



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Information presented in Section 1.3 *Recent Initiatives That May Affect Alaska's Medicaid Program in the Next Few Years* provided by Department of Health staff.

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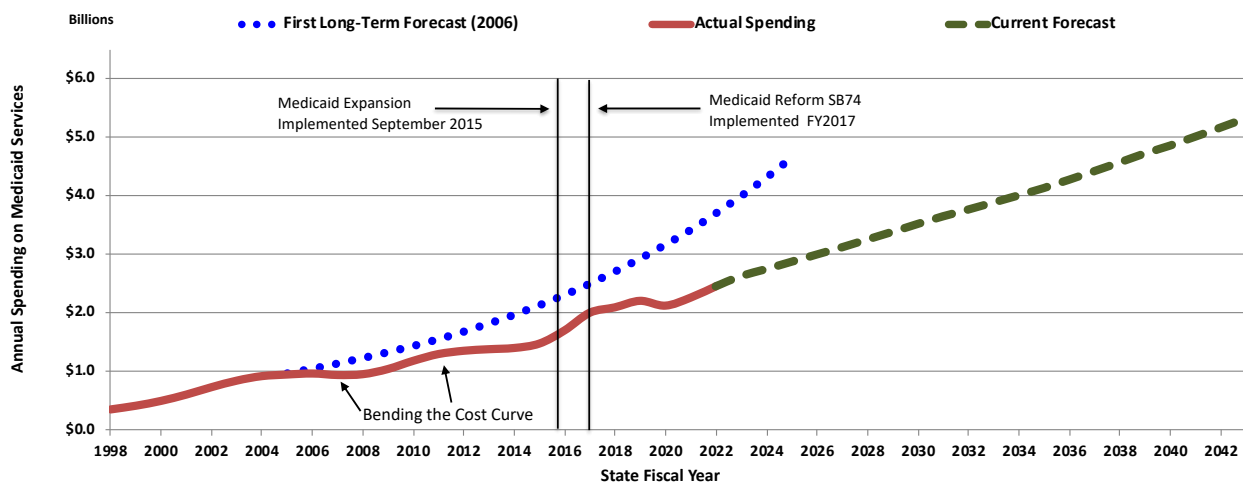
Executive Summary

This forecast 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, in February 2006. In this update, we develop long-term forecasts of enrollment in and spending on services provided by Alaska’s Medicaid program for fiscal year (FY) 2023 through FY2043. The projections presented in this report are based on the Medicaid policies, services offered, and eligibility requirements in place today. Alaska’s Medicaid program has changed considerably over the last decade, and it is likely to evolve and change over the next 20 years. Nevertheless, the long-term forecast informs decision makers about how Medicaid spending in Alaska will likely evolve given the structure of the program as it exists today. The forecast also serves as a benchmark for evaluating the impacts of initiatives introduced by the State of Alaska, including cost containment measures that have been or will be implemented by the Department of Health.

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 red line), projected spending from the first long-term Medicaid forecast (blue dotted line), and the current projection of Medicaid spending (green dashed line). Actual spending on Medicaid services in FY2022 was nearly \$1.3 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 DHSS, which helped “bend the cost curve” on Medicaid spending. We project total spending on Medicaid services will reach nearly \$5.3 billion by 2043.

Figure 1: Spending on Medicaid Services – Actual and Projected, FY1998 – FY2043

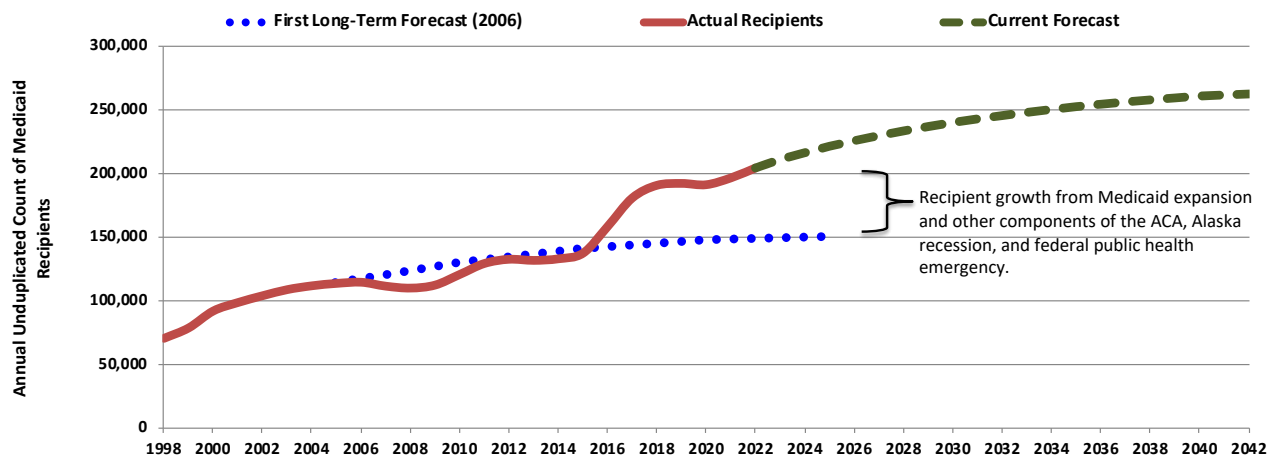


Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

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, other components of the Patient Protection and Affordable Care Act (e.g., the individual mandate), the Alaska economic recession that began in late 2014 and extended into 2019, and the ongoing federal COVID-19 public health disaster emergency that began in January 2020, enrollment in Medicaid increased considerably.

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. However, growth in utilization of Medicaid services has since rebounded and, for the current forecast, we expect the number of Medicaid recipients to continue to grow, but at a decreasing rate through the projection period.

Figure 2: Medicaid Recipients – Actual and Projected, FY1998 – FY2043



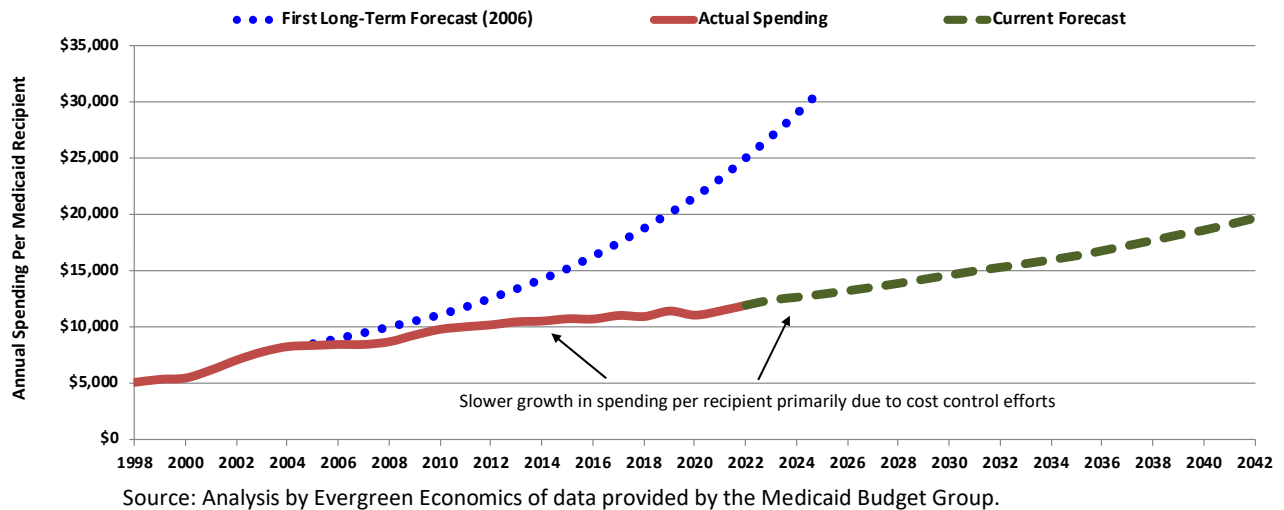
Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

As noted, spending on Alaska’s Medicaid program is considerably less today 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

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 FY2022, 74 percent of Medicaid enrollees were also recipients, which means that about one of every four (26%) Medicaid enrollees did not receive any Medicaid services in FY2022.

and a greater-than-projected number of recipients is much lower-than-projected average spending per Medicaid recipient. Figure 3 shows actual average annual spending per recipient (red line), as well as projected spending per recipient from the current and the first long-term Medicaid forecasts. The compound effect of lower-than-expected total spending and greater-than-expected enrollment in the Medicaid program is that spending per recipient is currently well below the earlier forecast and is projected to continue to grow at a relatively slow rate.

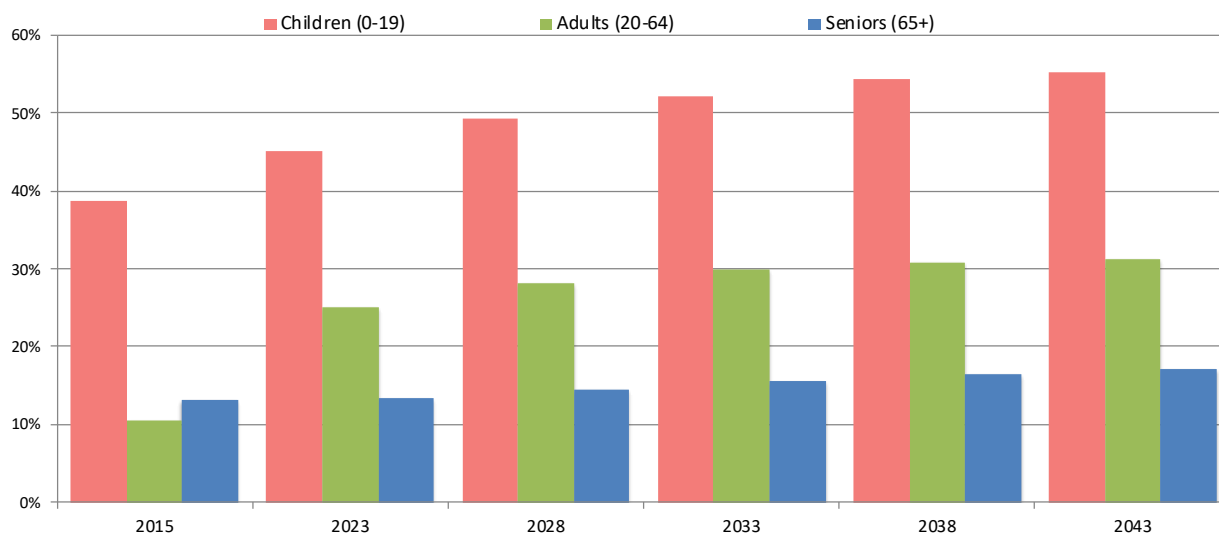
Figure 3: Medicaid Spending per Recipient – Actual and Projected, FY1998 – FY2043



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 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, about 25 percent of adults will receive services through Alaska’s Medicaid program in FY2023, up from just 10.6 percent in FY2015. We project that nearly 30 percent of Alaska adults will be Medicaid recipients by FY2033 and that about 31 percent will be recipients by FY2043.

We project that the proportion of seniors receiving Medicaid services will grow from 13.3 percent in FY2023 to 17 percent by FY2043, and that the proportion of Alaska children receiving Medicaid services (or services through the Children’s Health Insurance Program [CHIP]) will grow from 45 percent in FY2023 to 55 percent in FY2043.

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 \$2.57 billion in FY2023 to nearly \$5.3 billion in FY2043—an average of 3.6 percent per year. 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. In that forecast, spending on Medicaid services was projected to grow on an annual average basis by 7.8 percent, which was still far below the 17 percent per year rate of growth between FY1998 and FY2004.³

We project that spending on Medicaid services by the State of Alaska (state general funds) will grow on average by 4.5 percent and federal spending will grow by 3.2 percent per year through FY2043 (Table 1). The faster rate of growth in spending for state general funds is largely due to the unwinding of the federal health emergency response to COVID-19 through the end of 2023.

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

Fund Source	2015	2023	2028	2033	2038	2043	Annual Growth*
State General Funds	\$681.1	\$615.7	\$853.0	\$1,026.5	\$1,224.2	\$1,412.7	4.2%
Federal	\$901.0	\$2,011.5	\$2,410.4	\$2,846.4	\$3,359.2	\$3,871.7	3.3%
Total Spending*	\$1,582.1	\$2,627.1	\$3,263.5	\$3,872.9	\$4,583.3	\$5,284.3	3.6%

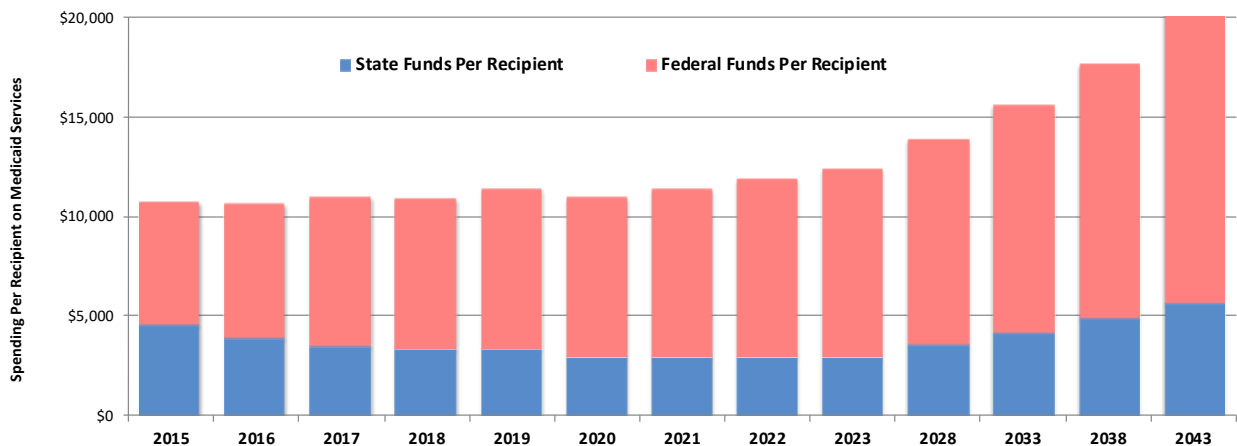
Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

* Annual growth computed from FY2023 to FY2043.

³ Note: the original long-term Medicaid forecast and each annual update through 2017 were based on calendar year. The forecast was changed to fiscal year beginning with the FY2019 – FY2039 update completed in October 2018.

Figure 5 shows recent actual and projected future spending per Medicaid recipient. Between FY2015 and FY2020, spending per Medicaid recipient was flat, and the proportion paid with state general funds decreased substantially. Between FY2020 and FY2022, average spending per recipient grew by \$640 (2.9% per year), but average general fund spending remained flat. Over the next 20 years, we project average spending per recipient to increase by about 2.4 percent per year due primarily to growth in reimbursement rates paid to providers and the aging of Alaska's population.⁴

Figure 5: Average State and Federal Spending Per Medicaid Recipient by Fiscal Year*



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

* By date of service; FY2015 – FY2021 are actuals, FY2022 is estimated, FY2023 – FY2043 are projected.

Key Findings from the Long-Term Medicaid Forecast

The following bulleted list presents important findings from our analysis, each of which is explained in greater detail in the report.

Key Findings – Medicaid Enrollment and Spending Projection

- Between 2023 and 2043, the Alaska Department of Labor and Workforce Development projects that Alaska's population will grow by only 22,500.
 - The number of Alaskans under 20 years of age will *shrink* by 12,000.
 - The number of Alaskans 20 to 64 years of age will grow by 15,600.
 - The number of Alaskans 65 years of age and older will grow by 18,900.

⁴ Reimbursement rates paid to providers by the Medicaid program are based on fee schedules for covered medical and related services. <https://manuals.medicidalaska.com/medicidalaska/providers/feeschedule.asp>

- Alaska’s Medicaid population, which has grown rapidly since 2015, will continue to grow, but at a much slower rate.
- From FY2015 through FY2020, spending per Medicaid recipient remained flat and general fund spending per recipient decreased; spending per recipient ticked up in FY2021 and FY2022 and will continue to grow through FY2043.
- After remaining well below the rate of medical price inflation for years, Medicaid reimbursement rates paid to providers grew slightly faster than medical price inflation between FY2020 and FY2021 (4.2% versus 3.8%) and grew 1.4 percentage points faster than medical price inflation between FY2021 and FY2022 (4.3% versus 2.9%).
- We project Medicaid reimbursement rates will grow on average by about 1.6 percent per year through FY2043—well below the expected rate of medical price inflation.
- Through FY2043, spending on Medicaid services will grow on an average annual basis by 3.6 percent; general fund spending will grow by 4.5 percent as the federal government unwinds the additional funding provided to states as part of the federal COVID-19 public health disaster emergency.
 - We project total spending on Medicaid services will be nearly \$5.3 billion in FY2043.
 - We project general fund spending on Medicaid services will be just under \$1.5 billion in FY2043.

Key Findings – Impact of COVID-19 on Medicaid Spending

- Through December 2022, the Alaska Medicaid program has paid \$78.5 million on claims to hospitals and other healthcare providers for services provided to Medicaid recipients hospitalized for complications associated with COVID-19 infection; general fund spending totaled \$14.6 million.
- Through December 2022, 1,512 Medicaid recipients have been diagnosed with post-COVID conditions; total spending on services to treat these conditions was \$4.5 million and general fund spending was \$814,000.
- Spending on Medicaid services has largely reverted to the pre-COVID trend, and we do not expect the pandemic to substantially impact the Medicaid program over the 20-year projection period.

Key Findings – Impact of Chronic Conditions on Medicaid Spending

- In FY2022, about one out of every four Medicaid recipients (51,474 individuals) was diagnosed with one or more chronic conditions.
- The prevalence of chronic conditions increases with age, which is the primary reason why average spending per Medicaid recipient increases with age.

- For recipients without a diagnosed chronic condition, age has little impact on Medicaid spending.
- Average Medicaid spending per recipient with a diagnosed chronic condition was \$34,496 in FY2022, compared to \$3,617 for recipients without a diagnosed chronic condition.
- We estimate that 82 percent of spending on Medicaid services in FY2043 will be for recipients with one or more diagnosed chronic conditions; currently, it is about 77 percent.
- Evergreen analyzed potential savings to the Medicaid program that align with specific goals of Alaska’s state health improvement plan, Healthy Alaskans 2030. We found that modest reductions in the prevalence of certain chronic conditions could result in substantial savings to the Medicaid program over the 20-year projection period.
- We found that a modest, ongoing reduction in the prevalence of cancer, obesity, mental health conditions, drug and alcohol abuse, and tobacco use could lead to substantial savings to the Medicaid program relative to the baseline spending forecast.
 - Reduction of \$427 million in total spending by FY2043
 - Reduction of \$130 million in general fund spending by FY2043

1 Introduction

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 federal government covers at least 50 percent of the cost of most services.⁵ In state fiscal years (FY) 2014 and FY2015, the federal government paid approximately 57 percent of the cost of services provided through Alaska’s Medicaid program.⁶ Federal participation was about 74 percent in FY2020, 75 percent in FY2021, and 76 percent in FY2022 due to additional funds made available to the states by the U.S. Department of Health and Human Services (HHS) in response to the COVID-19 pandemic and to tribal refinancing.⁷ Additional funds from HHS related to the COVID-19 pandemic were scheduled to end on various dates through 2022, but were extended. The Consolidated Appropriations Act 2023, signed into law December 29, 2022, phases out the additional funds beginning March 1, 2023 and completely expires December 31, 2023. We estimate federal participation for FY2023 will be about 76 percent and, for the remainder of the forecast, will remain between 72 percent and 74 percent.

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,⁸ blind, or disabled persons, children, and adults with dependent children. Medicaid 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 private health insurance. As we describe in greater detail below, Alaska again extended Medicaid coverage in 2015, this

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 overall rate of federal financial participation (57%) is an average of multiple Federal Medical Assistance Percentage (FMAP) rates weighted by the amount of spending associated with each rate. See the subsection titled State Spending on Medicaid Services in Section 2.5 for a discussion of the rate of federal financial participation associated with each FMAP.

Unless otherwise stated, all references to fiscal year are state fiscal year, which begins July 1 and ends June 30. For example, FY2023 for Alaska began July 1, 2022, and will end June 30, 2023. In comparison, federal fiscal years begin October 1 and end September 30.

⁷ For more information on tribal refinancing, please see <https://health.alaska.gov/dhcs/Pages/Tribal-Health/Tribal-Refinancing.aspx>

⁸ 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.

time to adults who meet certain income requirements but were not previously eligible for Medicaid.⁹

In Alaska, the Division of Health Care Services (HCS) administers CHIP, and the Division of Public Assistance manages enrollment for regular Medicaid and CHIP.¹⁰ Alaska Medicaid reimburses hospitals, physicians, and other healthcare providers for providing healthcare services to Medicaid enrollees. It 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 Impact of COVID-19 on the Alaska Medicaid Program

In March 2020, Governor Mike Dunleavy issued a declaration of public health disaster emergency in response to the anticipated breakout of COVID-19 in Alaska. The initial impact of COVID-19 on the healthcare sector in Alaska and across the U.S. was a substantial reduction in utilization and spending on healthcare services as hospitals, clinics, and other providers canceled or postponed elective procedures.¹¹ At the same time, some individuals, wary of the risk of COVID-19 transmission, avoided visiting hospitals, emergency rooms, or even their primary care physician for medical concerns or treatment not related to COVID.¹²

In Alaska, utilization and spending on Medicaid services dropped substantially after the Governor's declaration of a public health disaster emergency. In the eight months prior to the Governor's announcement (July 2019 – Feb 2020), just over 85,000 Medicaid enrollees utilized Medicaid services each month; in March 2020, utilization dropped to 78,400 and then to 63,000 in April 2020—a 26 percent drop from the first eight months of FY2020. A similar drop occurred for monthly spending, which averaged \$185.8 million between July 2019 and February 2020, but dropped to \$165.5 million in March 2020 and to \$137.3 million in April 2020.

Utilization and spending did pick back up after the initial shock, and as Figure 6 and Figure 7 show, trends in utilization and spending, respectively, have largely reverted to pre-COVID rates of growth. Consequently, despite the substantial impact that COVID-19 has had on Alaska communities, businesses, and healthcare providers, it does not appear that the pandemic will have

⁹ 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.

¹⁰ Both divisions are within the Alaska Department of Health.

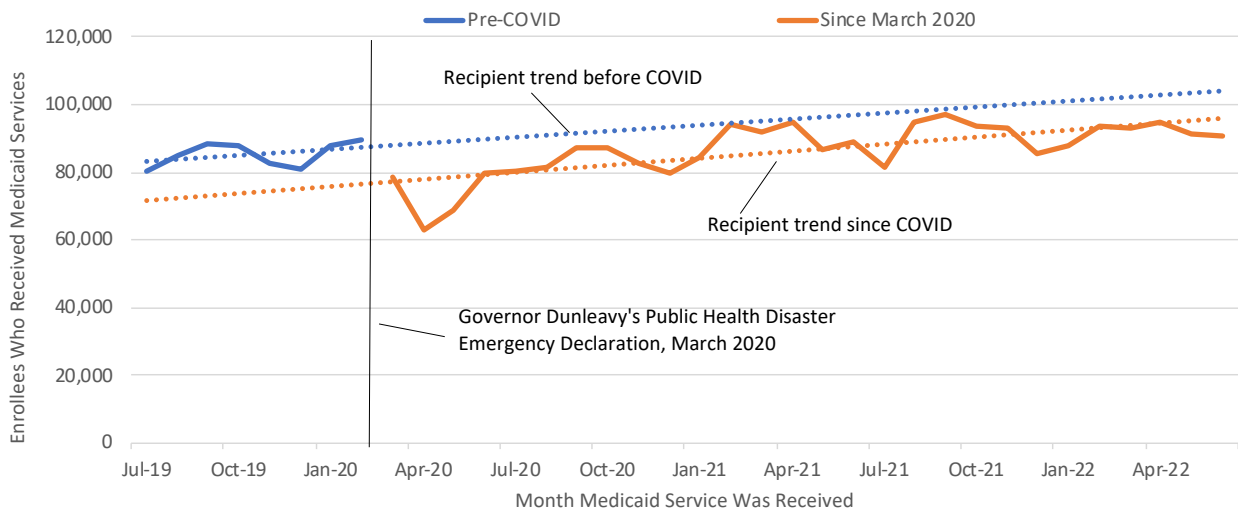
¹¹ Cynthia Cox and Krutika Amin, "How Have Health Spending and Utilization Changed During the Coronavirus Pandemic?" *Peterson-KFF Health System Tracker*, posted December 1, 2020.

<https://www.healthsystemtracker.org/chart-collection/how-have-healthcare-utilization-and-spending-changed-so-far-during-the-coronavirus-pandemic/#item-start>

¹² Kevin Loria, "Many People Avoided Hospitals During the Pandemic. The Effect Was Dire," *Consumer Reports*, July 10, 2020. <https://www.consumerreports.org/coronavirus/many-people-avoided-hospitals-during-the-pandemic-the-effect-was-dire/>

a long-term effect on the utilization of and spending on Medicaid services in Alaska. Nevertheless, as we discuss below, there is currently a relatively small but growing number of Medicaid recipients diagnosed with post-COVID conditions.

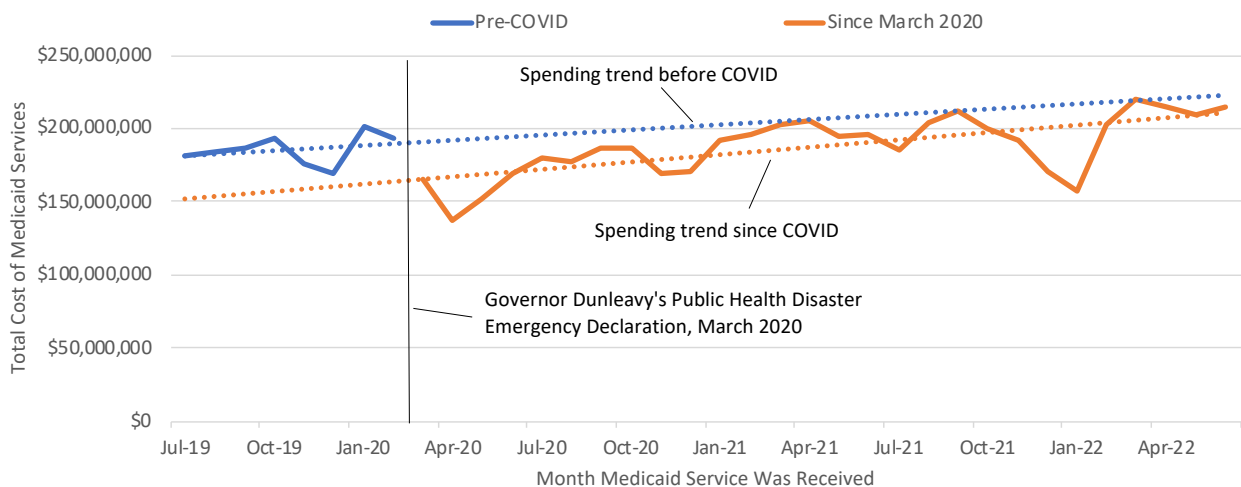
Figure 6: Monthly Count of Medicaid Recipients, FY2020 - FY2022*



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

* Based on month service was received; Total spending on Medicaid services during month had to be at least \$10 to be considered a recipient; Recipient counts were normalized to consistent number of days in month.

Figure 7: Monthly Spending on Medicaid Services, FY2020 - FY2022*



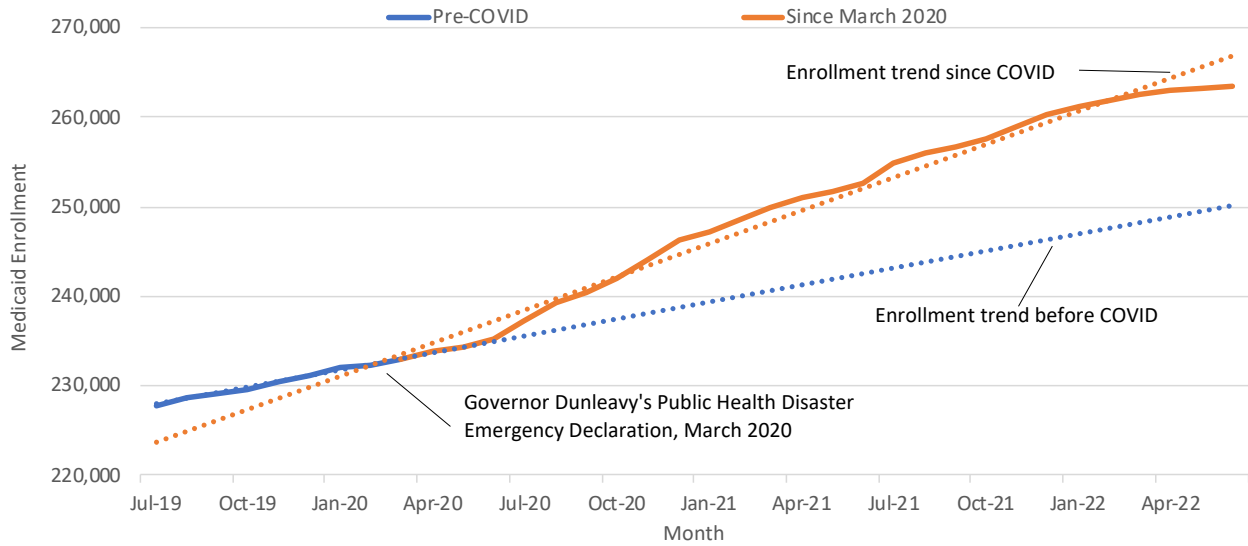
Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

* Spending aggregated based on month service was received; Monthly spending was normalized to consistent number of days; Spending in FY2022 was adjusted to account for the remaining months in which providers can invoice for services.

One aspect of the Medicaid program dramatically impacted by the COVID-19 pandemic is enrollment. As Figure 8 shows, soon after the declaration of the public health disaster emergency, enrollment began to grow rapidly from its pre-pandemic trend. The primary cause of the increase

was and is the federal COVID-19 public health emergency mandate that states maintain continuous enrollment for individuals, regardless of any change in employment, income, or other covered circumstance. Medicaid enrollment did begin to slow in the second half of FY2022, but the current trend in enrollment growth (orange dotted line) is still substantially higher than the pre-COVID growth trend (blue dotted line).

Figure 8: Monthly Enrollment in Medicaid Program, FY2020 - FY2022



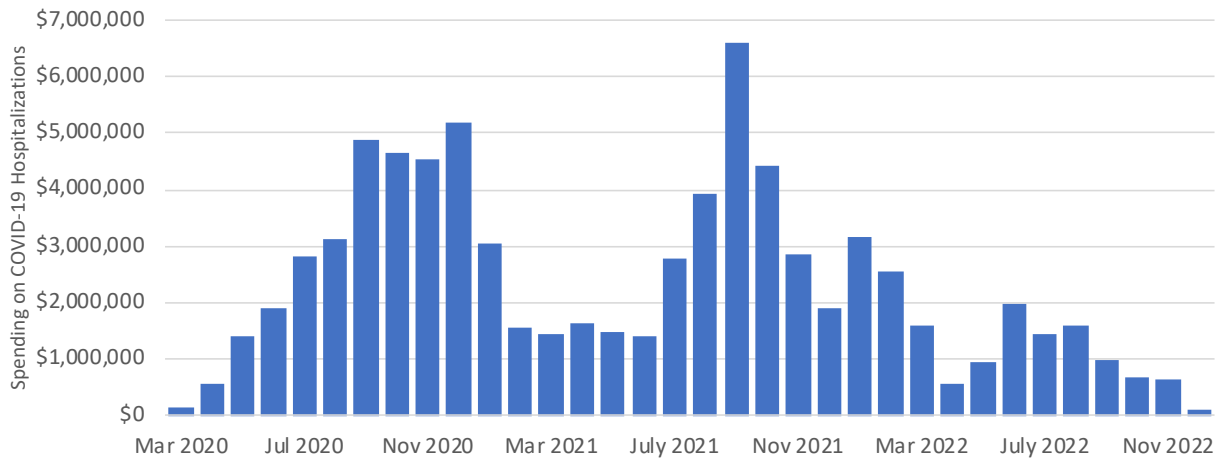
Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

1.1.1 Spending on Medicaid Services for Alaskans Hospitalized Due to COVID-19

From March 2020 through December 2022, the Alaska Medicaid program has paid \$78.5 million on claims to hospitals and other healthcare providers for services provided to Medicaid recipients hospitalized for complications associated with COVID-19 infection.¹³ Of this total, \$14.6 million in spending was from the state’s general fund (GF), and the remainder (\$63.9 million) was federally funded. As Figure 9 shows, spending on COVID-19-related hospitalizations peaked in December 2020, dropped each month through June 2021, and then rose dramatically due to the more contagious delta variant of the COVID-19 coronavirus. Monthly spending on hospitalization services for Medicaid recipients due to complications from COVID-19 has remained below \$2.0 million since March 2022.

¹³ We used the following criteria to define a Medicaid recipient as having been hospitalized with complications from COVID-19: At least \$10,000 in aggregate spending for “Inpatient Hospital Services” on claims with any of the following ICD10 diagnoses codes: U07.1, U07.2, Z20.828, J12.89.

Figure 9: Monthly Spending on Medicaid Services for Recipients Hospitalized Due to Complications from COVID-19, March 2020 – December 2022*



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

* Costs are based on month of payment; as such, spending in most recent months will likely adjust upward as additional claims submitted by providers for services delivered are processed and paid by the Medicaid program.

1.1.2 Impact of Post-COVID on Alaska’s Medicaid Population

Some people who have been infected with COVID-19 can experience long-term effects from their infection, known as post-COVID conditions or long COVID.¹⁴ In June 2021, the Centers for Disease Control and Prevention (CDC) announced the creation of a diagnosis code for tracking the costs of healthcare services provided to individuals displaying symptoms consistent with post-COVID.¹⁵ The diagnosis code (ICD10 “U09.9”) became effective October 1, 2021. Through December 2022, the Alaska Medicaid program has provided services to 1,512 individuals diagnosed with post-COVID; total and state general fund spending for these services was \$4.5 million and \$814,000, respectively.

1.2 The Affordable Care Act

The Patient Protection and Affordable Care Act (ACA) has affected many aspects of the U.S. healthcare system, including the Medicaid program.

¹⁴ Centers for Disease Control and Prevention, “Long COVID or Post-COVID Conditions,” updated September 1, 2022. <https://www.cdc.gov/coronavirus/2019-ncov/long-term-effects/index.html>

¹⁵ AAPM&R, “CDC Announces Approval of ICD-10 Code for Post-Acute Sequelae of COVID-19,” July 20, 2021. <https://www.aapmr.org/members-publications/member-news/member-news-details/2021/07/20/cdc-announces-approval-of-icd-10-code-for-post-acute-sequelae-of-covid-19>

1.2.1 Medicaid Expansion

In January 2014, the ACA extended Medicaid eligibility to adults without dependent children who are not disabled and meet certain income requirements (commonly referred to as “Medicaid expansion.”) Alaska did not expand its Medicaid program at that time. However, then-Governor Bill Walker expanded Medicaid in September 2015. In CY2016, the federal government paid 100 percent of the cost of Medicaid services provided to those enrolled through expansion. In CY2017, federal participation dropped to 95 percent and then to 94 percent in CY2018, to 93 percent in CY2019, and finally to 90 percent in CY2020, where it has remained and is scheduled to remain.¹⁶

Medicaid expansion may also have impacted the Alaska Medicaid program indirectly by allowing individuals with disabilities to enroll in Medicaid through Medicaid expansion eligibility (i.e., by being below the income threshold) rather than waiting for a disability determination. Prior to Medicaid expansion, adults without dependent children could only qualify for Medicaid based on the determination of having a qualified disability and meeting income requirements specific to the individual’s living arrangement.¹⁷

1.2.2 Modified Adjusted Gross Income (MAGI)

The ACA changed the way that financial eligibility is determined for children, parents and other caretakers, and pregnant women. For these groups, as well as for those who enroll in Medicaid through expansion, financial eligibility for Medicaid is now determined based on the MAGI standard, which is consistent across states and is tied to how people report income on their taxes. The MAGI standard simplifies the process for determining Medicaid eligibility by moving the process online for most applications, eliminating documentation requirements with applicant attestation, and eliminating the asset test for most non-senior applicants.¹⁸ The likely result for Alaska’s Medicaid program is that the MAGI standard has led to higher rates of Medicaid enrollment.

¹⁶ Many adults enrolled through Medicaid expansion are American Indian and Alaska Native (AI/AN). When these enrollees receive services from a qualifying Medicaid provider, the federal government reimburses the State of Alaska 100 percent of the cost of the services. Thus, even as the federal financial participation rate for Medicaid expansion has decreased each year through CY2020, the State of Alaska still receives 100 percent reimbursement from the federal government for many of the services provided to recipients enrolled through expansion.

¹⁷ For information on income eligibility for Medicaid, see Alaska Department of Health, Division of Public Assistance, “Medicaid.” <http://dhss.alaska.gov/dpa/Pages/medicaid/>

¹⁸ Each state is responsible for conducting third-party verification for a certain proportion of applicants. Prior to 2014, Medicaid eligibility determination also considered the value of the applicant’s assets. The MAGI standard also includes a 5 percent disregard of income.

1.2.3 No Wrong Door

The “no wrong door” provision of the ACA allows an individual to complete a single streamlined application to determine eligibility for a host of entitlement programs, including Medicaid, the Children’s Health Insurance Program (CHIP), and qualified health plans available on the federal or individual state health exchanges, as well as other assistance programs. Rather than apply individually for these programs, the single application is screened for eligibility into multiple programs, ensuring that it does not go through a “wrong door.” Thus, some low-income individuals who apply for individual insurance through the federal health exchange may learn they are eligible for Medicaid and/or other assistance programs. The likely result for Alaska’s Medicaid program is that the “no wrong door” provision has led to higher rates of Medicaid enrollment.

1.2.4 Insurance Mandate

The ACA restricts the ability of insurance companies to set insurance rates based on an individual’s preexisting medical condition or on the expected healthcare needs of the individual. Recognizing that this restriction will be a financial burden to insurance providers, the ACA included the individual mandate requiring most Americans to have a basic level of health insurance coverage. The rationale for the individual mandate was that by requiring all individuals to maintain a basic level of health insurance, the financial risks associated with providing health insurance would be spread across a wider population even though healthcare utilization and costs are heavily weighted toward seniors and those with chronic medical conditions. Without the individual mandate, many younger, healthier adults would forego health insurance coverage because of the cost, leaving those with greater medical needs in the insurance pool. Congress repealed the individual mandate in December 2017. The repeal took effect beginning in January 2019, and there is no longer a federal requirement to maintain health insurance coverage.¹⁹ We believe that the repeal of the insurance mandate is having a moderating effect on enrollment growth in the Medicaid program, which we incorporated into the enrollment forecast.

1.3 Recent Initiatives That May Affect Alaska’s Medicaid Program in the Next Few Years

The State initiated comprehensive reforms to Alaska’s Medicaid program via Senate Bill (SB) 74, passed by the Alaska Legislature in 2016. In FY2020, the Alaska Department of Health and Social Services (DHSS), now the Department of Health, adopted new requirements that became effective in November 2019 for mental health physician clinics. The new requirements included screening and brief intervention services and an integrated mental health and substance use intake

¹⁹ For information on the ACA individual mandate to purchase health insurance, please see KFF, “The Requirement to Buy Coverage Under the Affordable Care Act,” August 2, 2017. <http://kff.org/infographic/the-requirement-to-buy-coverage-under-the-affordable-care-act/>

assessment. Regulations were also adopted for Medicaid behavioral health marital & family therapy services, which became effective July 2020. The new regulations added licensed marital and family therapists (LMFTs) to the list of providers eligible to enroll with DHSS and to bill directly for Medicaid services rendered. DHSS also adopted Medicaid Coverage, Behavioral Health Services, and Revised Requirements for Behavioral Health Providers in April 2020, which added a new specialty for substance use disorder (SUD) counselors.

1.3.1 Behavioral Health System Reform

SB 74 directed DHSS to apply for an 1115 Waiver, a transformative Medicaid tool, to improve access to services, improve population health outcomes, contain costs, and increase the types of behavioral health providers serving Medicaid recipients. Implementation of Alaska's 1115 Waiver demonstration project continued in 2021, ensuring that the entire continuum of approved 1115 Waiver services was available. The department transferred claims processing for the 1115 Waiver SUD services from the HCS contractor, Conduent, to the Administrative Service Organization (ASO) contracted through the Division of Behavioral Health (DBH). The ASO began processing some claims for behavioral health services received through the 1115 Waiver in July 2019; by July 2021, all claims for behavioral health services were processed through the ASO.

In FY2022, 11,670 Medicaid beneficiaries received 1115 Waiver services. Nearly all these beneficiaries (11,253) were Medicaid recipients in FY2021 or another earlier fiscal year. More females than males received 1115 Waiver services in FY2022, but males were slightly more likely than females to receive these waiver services (Table 2).

Table 2: Demographic Characteristics of 1115 Waiver Recipients, FY2022

Demographic Characteristic	Total Recipients	1115 Waiver Recipients	
		Recipients	Percent
Gender			
Female	108,065	6,058	5.6%
Male	96,101	5,612	5.8%
Age			
Under 10	45,443	828	1.8%
10-19	41,394	2,468	6.0%
20-34	43,320	3,282	7.6%
35-44	24,966	2,443	9.8%
45-54	16,598	1,249	7.5%
55-64	19,013	1,103	5.8%
65+	13,432	297	2.2%
Eligibility			
Expansion*	47,825	4,364	9.1%
Regular Medicaid	156,341	7,306	4.7%

Demographic Characteristic	Total Recipients	1115 Waiver Recipients	
		Recipients	Percent
DOH Region			
Northern	25,552	1,166	4.6%
Western	27,466	893	3.3%
South Central	27,960	1,520	5.4%
Anchorage / Mat-Su	104,185	6,379	6.1%
Southeast	19,003	1,712	9.0%
All Recipients	204,166	11,670	5.7%

*Includes Indian Health Service (IHS) expansion.

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

Utilization of 1115 Waiver services increased with age through the 35-44 age group and then decreased with each subsequent age group. Utilization was also greater for recipients enrolled through Medicaid expansion compared to regular Medicaid. This is explained by the age criteria associated with Medicaid expansion—adults 18 to 64 years of age. The proportion of recipients that utilized 1115 Waiver services differed substantially by region of the state, with only about 3.3 percent of recipients in the Western region utilizing 1115 Waiver services in FY2022 versus 9 percent of recipients in the Southeast region.

1.3.2 Behavioral Health Pandemic Response

Over the past year, the COVID-19 pandemic has rapidly changed how Alaskans receive behavioral health treatment. The pandemic exacerbated the need for behavioral health services. In response, the Department of Health continued focused efforts on expanding access to behavioral health treatment and seeking new funding opportunities to distribute support to communities for further and continuing services. In addition, by maintaining telehealth flexibilities and utilization during Alaska's declaration of a public health disaster emergency, behavioral health providers have been able to offer telemedicine options when face-to-face encounters jeopardize the health and safety of treatment recipients and providers. As a result, the use of telehealth proliferated during the pandemic, expanding access to care while reducing exposure for staff and treatment recipients. The Alaskan response to the use of telehealth was so overwhelmingly positive, it fueled legislation that made the flexibility permanent in Alaska.

1.3.3 Healthcare and Tribal Health Services Reforms

COVID-19 Flexibilities

Section 1135 of the Social Security Act authorizes the Secretary of Health and Human Services to temporarily modify certain Medicaid requirements when there is a Presidential declaration of national emergency. Such modifications are referred to as “flexibilities.”²⁰ At the onset of the COVID-19 public health emergency and state disaster declaration, the Alaska Medicaid program implemented numerous flexibilities to increase access to and remove potential barriers to the provision of healthcare services. Flexibilities related to the now-expired state disaster declaration have been phased out, while those related to the federal public health emergency remain in place. Data from these federal and state flexibilities afford the Department of Health the opportunity to analyze the efficacies of these temporary changes and determine which, if any, should be reimplemented on a permanent basis through regulatory changes.

Telehealth Services

In FY2022, the Medicaid program paid \$33.7 million in claims for services delivered via telehealth methods, a decrease of 30.8 percent compared to the amount paid for services delivered via telehealth in FY2021. Delivering services to a recipient via telehealth has the potential for program savings through avoided non-emergent transportation costs. The savings in transportation costs have not yet been quantified and will be difficult to analyze until the COVID-19 public health emergency is no longer affecting travel for Alaskans.

Coordinated Care Demonstration Project

The Coordinated Care Demonstration Project Initiative awarded a competitively bid contract to a patient-centered medical home provider in Anchorage in 2018. With a focus on facilitating ss to mature the alignment of reimbursement with more coordinated care clinical delivery models, HCS is analyzing the clinical and financial benefits from this demonstration project, following three years of continuous operation, for a potential transition to a more sustainable and inclusive program, such as a 1915(b) Waiver program

Covered Outpatient Drug Value-Based Purchasing (VBP) Arrangements

The Centers for Medicare & Medicaid Services (CMS) delayed the effective date of final rule CMS-2482-F2 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

²⁰ Centers for Medicare & Medicaid Services, “Waivers & Flexibilities.” <https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Resources/Waivers-and-flexibilities>

VBP arrangements with pharmaceutical manufacturers, outside of a supplemental rebate agreement, when such manufacturers offer the VBP arrangement in the commercial marketplace.²¹ As of the release date of this report, the HCS Pharmacy Services Team 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 federal financial participation (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 #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, contingent upon the presence of a care coordination agreement between the providers, documentation of a referral by the tribal health provider, and an exchange of medical records of the care received. Under the direction of SB 74, DHSS (now the Department of Health) partnered with tribal health organizations to fully implement this revised federal policy. To date, more than 7,030 care coordination agreements signed between tribal and non-tribal providers have resulted in state general fund savings exceeding \$300 million.

Procurement of Fiscal Agent Services

In late FY2022, the Department of Health will issue a request for proposals (RFP) for a qualified contractor to provide Medicaid Management Information System (MMIS) support services to operate the claims processing system for the Alaska Medicaid program. This is the second phase in the initiative to separate Medicaid program fiscal agent services from technical operations and maintenance of the MMIS database, affording the department greater flexibility in responding to changing operational and administrative needs of the program.

Care Management Services

The Care Management Program (CMP) was established by the Alaska DHSS under the authority of Section 7 of the Alaska Administrative Code (AAC) 105.600 to restrict the use of Medicaid services deemed to be at a frequency or amount that is not appropriate.²² Historically, the CMP restricted a recipient to a primary care provider (PCP) and a single primary care physician and pharmacy to

²¹ 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>

²² The Alaska State Legislature. “Title 7 Health and Social Services, Chapter 105 Medicaid Provider and Recipient Participation, Section 600 Restriction of recipient’s choice of providers.” <http://www.akleg.gov/basis/aac.asp#7.105.600>

reduce overuse and misuse of services, encourage continuity of care, and promote communication between the recipient's PCP and pharmacy. Effective January 1, 2021, HCS implemented regulatory changes to the CMP to allow assignment of primary dental and behavioral health providers. The Quality Assurance unit in HCS continues to work on growing both programs. The growth in FY2022 of the Alaska Medicaid Coordinated Care Initiative (AMCCI) was 20 percent, and the CMP program grew 100 percent. The CMP currently has 107 individuals/groups acting in a primary care provider role, and 95 different pharmacies serving the 600+ CMP members; this represents an approximately 20 percent increase in unique providers participating compared with FY2021.

Dental Services

In 2019, a Legislative Single Audit identified that there was "likely over-utilization of dental services for individuals under the age of 22" in the Alaska Medicaid dental program. HCS pushed forward a regulation package to clarify and reduce overutilization of certain Alaska Medicaid dental services. The regulation change amends service authorization requirements; removes several adult requirements that were considered administrative; and adds adult and pediatric requirements for crowns, extractions, and sedation to enhance oversight. The regulations went into effect December 1, 2022.

1.3.4 Senior and Disabilities Services Reforms

The Division of Senior and Disabilities Services (SDS) updated regulations affecting Medicaid-funded services in three important areas in FY2022:

1. To make permanent some temporary flexibilities that were awarded during the COVID-19 pandemic and were found both to be popular with providers/recipients and to improve operations. These include allowing certain amounts of select waiver services to be provided using distance delivery methods, reducing the required number of in-person visits by care coordinators, accepting electronic signatures on documents, allowing required certification for first aid and cardiopulmonary resuscitation to be obtained online, and allowing a certain amount of day habilitation to be provided in residential settings.
2. To extend the timeline for provider re-certification to up to four years, depending on past performance.
3. To add Electronic Visit Verification (EVV) for Specialized Private Duty Nursing waiver services, as required under the federal 21st Century Cures Act of 2016. EVV will enable the state to improve the health and welfare of recipients of personal care services by validating delivery of those services through mobile phones and other applications. Once fully implemented, EVV is anticipated to be a valuable tool in reducing fraud, waste, and abuse in service provision.

The number of applicants for the Individualized Support Waiver (ISW) (one of the initiatives of SB 74, the 2016 Medicaid reform bill) is expected to reach its capacity of 600 recipients by the end of FY2023. The waiver draws recipients from the Developmental Disabilities Registration and Review waitlist; many of the recipients on the ISW remain on the waitlist for the Intellectual and Developmental Disabilities (IDD) waiver, as it provides more comprehensive coverage.

SDS began two initiatives to distribute federal funds from the American Rescue Plan Act intended to support long-term support services:

1. In partnership with the University of Alaska’s Center for Human Development, implementation of a new training and certification program for direct support professionals (DSPs); and
2. Reimbursements to providers for COVID-19-related expenses that were made during the first year of the pandemic.

SDS continues to be concerned about growth in Alaska’s population aged 60 and older, how to meet the needs of individuals with disabilities who also have complex behavioral or medical conditions, and how to address workforce challenges so that the number of DSPs is adequate to meet recipients’ needs. These issues collectively increase the likelihood that Medicaid spending will increase in the years ahead. Without adequate capacity and infrastructure across the spectrum of home and community-based services, seniors and individuals with disabilities will increasingly need to meet their care needs in nursing facilities and other institutional settings. Institutional care is not only more expensive than home and community-based care, but it also reduces an individual’s independence, dignity, choice, and participation in community living.

1.3.5 Public Health Pandemic Response and Initiatives

The Department of Health has provided leadership and capacity for Alaska to respond to the COVID-19 pandemic, including providing expertise and guidance to communities, healthcare systems and facilities, schools, businesses, large group gatherings, and other partners to enable their use of non-pharmaceutical interventions. This has included coordination and dissemination of information on public access to those services.²³

Compared to peer states—Idaho, Montana, North Dakota, South Dakota, New Mexico, and Wyoming—Alaska had lower rates of COVID-19 hospitalizations and deaths as of November 7,

²³ Nonpharmaceutical interventions (NPIs) are actions, apart from vaccinations or other medicines, that individuals and communities can take to slow the spread of an illness. Centers for Disease Control and Prevention (CDC). 2020. “Nonpharmaceutical Interventions (NPIs).” <https://www.cdc.gov/nonpharmaceutical-interventions/index.html>

2022.²⁴ Had Alaska experienced similar rates of hospitalizations and deaths as those peer states, Alaska Medicaid spending over that period would have been more than \$31 million higher.²⁵

The Department of Health coordinated the dissemination of testing, vaccination, and monoclonal antibody treatment services between healthcare providers and the public to increase access to those services. The Department of Health also provided community-based testing, vaccination, and monoclonal antibody treatment services statewide to supplement services offered by local and regional healthcare providers and communities. These services were directly provided by Department of Health staff or by contracted vendors. This supplemental capacity made these services more widely available to the public, especially during periods of peak demand.

Public Health Initiatives

With the Alaska Native Tribal Health Consortium (ANTHC), the Department of Health leads the development and implementation of the Healthy Alaskans 2030 (HA2030) plan, which is Alaska's state health improvement plan. 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 Alaskan 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 and when the HA2030 targets are met, Medicaid costs may be reduced, as this will be an indicator of improved health of all Alaskans.

The Department of Health is participating in a Case for Coverage project, hosted by the National Association of Chronic Disease Directors in collaboration with the CDC, Division of Diabetes Translation, and the Kem C. Gardner Policy Institute. The goal of the project is to assess the potential impact of the National Diabetes Prevention Program on diabetes prevention and overall incidence of diabetes as it relates to public health and Medicaid expenditures.

1.4 The Long-Term Medicaid Forecast

In this study, we develop long-term forecasts of enrollment in Alaska's Medicaid program, and 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

²⁴ Memorandum from Evergreen Economics to Linnea Osborne, Medicaid, Allocation, and Audit Services, Finance and Management Services, Department of Health, November 11, 2022.

²⁵ *ibid*

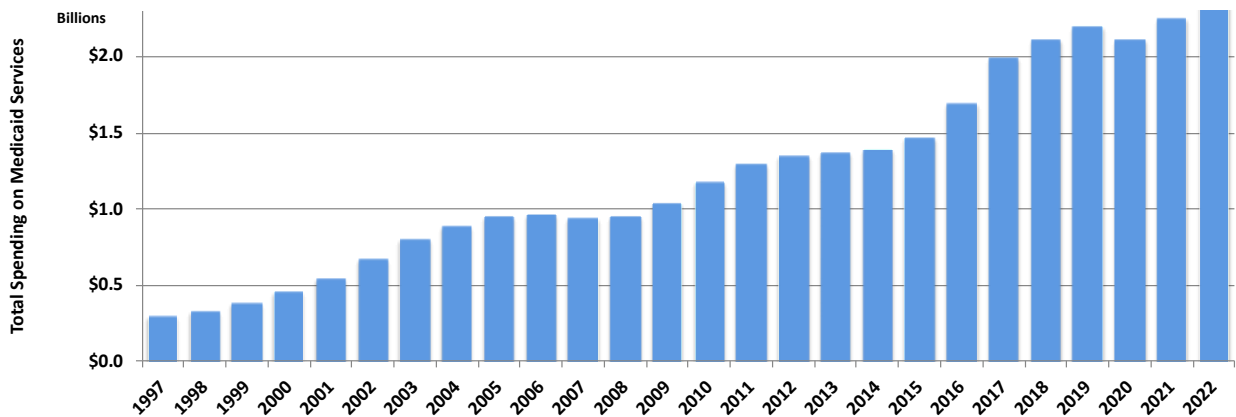
AI/AN status,²⁶ and for 12 age groups. This document presents the results of the FY2023-FY2043 projection of enrollment in and spending on the Medicaid program in Alaska. It is the sixteenth update to the original long-term Medicaid forecast, which the Lewin Group completed in January 2006.

The forecast does not assume or consider possible future changes in Medicaid policies, services offered, or eligibility requirements; rather, we develop the forecast as if the policies, services offered, and eligibility requirements in place today will remain in place throughout the forecast period. While it is likely Alaska’s Medicaid program will experience numerous 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.

1.5 Recent Historical Trends in Medicaid Spending

Spending on Alaska’s Medicaid program grew rapidly from FY1997 through FY2005, increasing an average of 15.3 percent per year (Figure 10).²⁷ Medicaid spending decreased slightly between FY2006 and FY2008 due at least in part to program changes put in place by DHSS following the release of the *Long-Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025* in January 2006. However, with the onset of the severe national economic recession that began in 2008, enrollment in and spending on Medicaid again grew rapidly beginning in FY2009 and extending into FY2011.

Figure 10: Total Cost of Medicaid Services by Fiscal Year in Which Service Occurred



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group; FY2022 estimated.

²⁶ Alaska Native, American Indian, and other race categories are based on self-identification of Medicaid enrollees. In FY2022, 88,159 Medicaid enrollees reported their race as either Alaska Native or American Indian. Of these, 2,391 (2.7%) identified as American Indian.

²⁷ FY1997 is the earliest year for which we had data on spending.

Medicaid spending then slowed again, increasing on an average annual basis by 2.6 percent between FY2011 and FY2014. Growth in Medicaid spending again increased beginning in FY2015, likely in response to aspects of the ACA, which went into effect on January 1, 2014 (e.g., the insurance mandate). Medicaid spending soared by 15.1 percent in FY2016 and 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 a public health disaster emergency in March 2020. Spending began to increase again in FY2021.

1.5.1 Recent Historical Trends in State Medicaid Spending

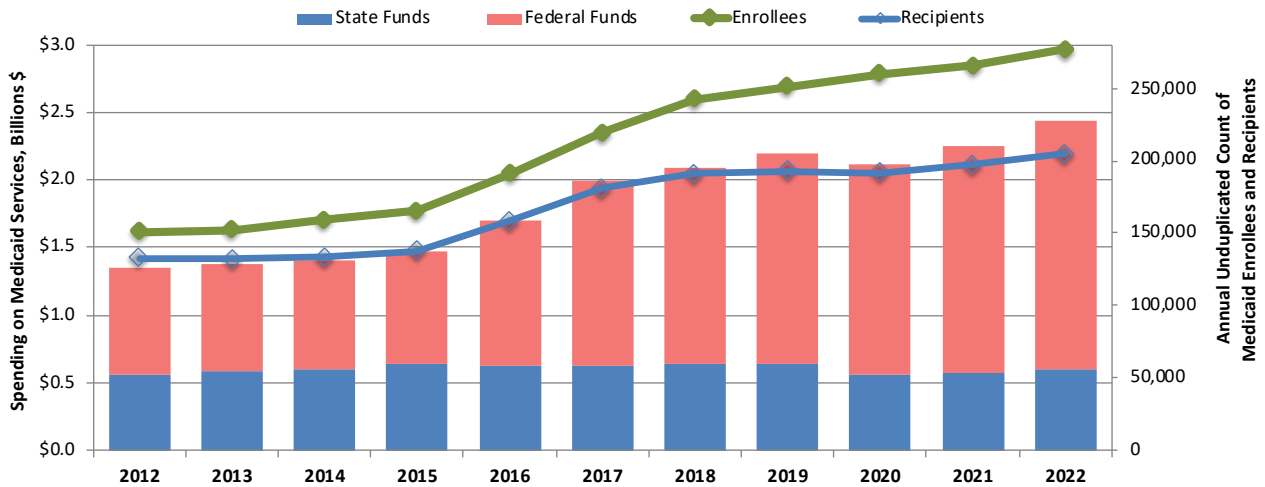
While total spending on Medicaid services has increased significantly since FY2015, general fund spending by the State of Alaska has been mostly flat and even decreased in FY2020 due to additional funding by the federal government as part of the CARES Act.²⁸ Figure 11 shows total spending on Medicaid services for FY2012 through FY2022, split by state and federal funding, and the trend in Medicaid enrollment and number of recipients over this same period.²⁹

The CARES Act requires states to maintain continuous enrollment for individuals, regardless of any change in employment, income, or other covered circumstance. As a result, whereas the Medicaid program used to experience month-to-month churn in Medicaid enrollment as individuals entered or exited the program, now enrollment only rises as eligible individuals enter the program, but no one leaves the program except those who move out of state (or die). The Consolidated Appropriations Act 2023 will end the continuous enrollment requirement on March 31, 2023.

²⁸ The Coronavirus Aid, Relief, and Economic Security (CARES) Act increased the rate of federal financial participation (FFP) for Title XIX services by 6.4 percentage points and the FFP for Title XXI and BCC (breast and cervical cancer) services by 4.34 percentage points beginning January 1, 2020 and continuing until “termination of the public health emergency.”

²⁹ State spending includes Unrestricted General Fund, Designated General Fund, and Other; enrollment is annual unduplicated count.

Figure 11: Spending on Medicaid Services, Enrollment in the Medicaid Program, and Recipients of Medicaid Services, Based on Date of Service, FY2012 – FY2022



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group; 2022 estimated.

1.5.2 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 FY2022, the proportion had grown to 38 percent. Due to Medicaid expansion and other components of the ACA, growth in the proportion of Alaskans enrolled in Medicaid was especially strong after FY2015 (Figure 12). Data from KFF and the U.S. Census indicate that the proportion of uninsured Alaskans decreased from 20.5 percent in CY2010 to 10.8 percent in CY2021.³⁰ Evergreen Economics estimates that the proportion of Alaskans without health insurance coverage further decreased slightly in FY2022 to 10.6 percent and will be about 10.4 percent in FY2023.³¹ The proportion of Alaskans receiving health insurance through an employer decreased from 51 percent in CY2010 to 43.3 percent in CY2021.³² We assume the proportion of Alaskans enrolled in employer-sponsored insurance remained at about 43.3 percent in CY2022 and will also remain at this level in CY2023.

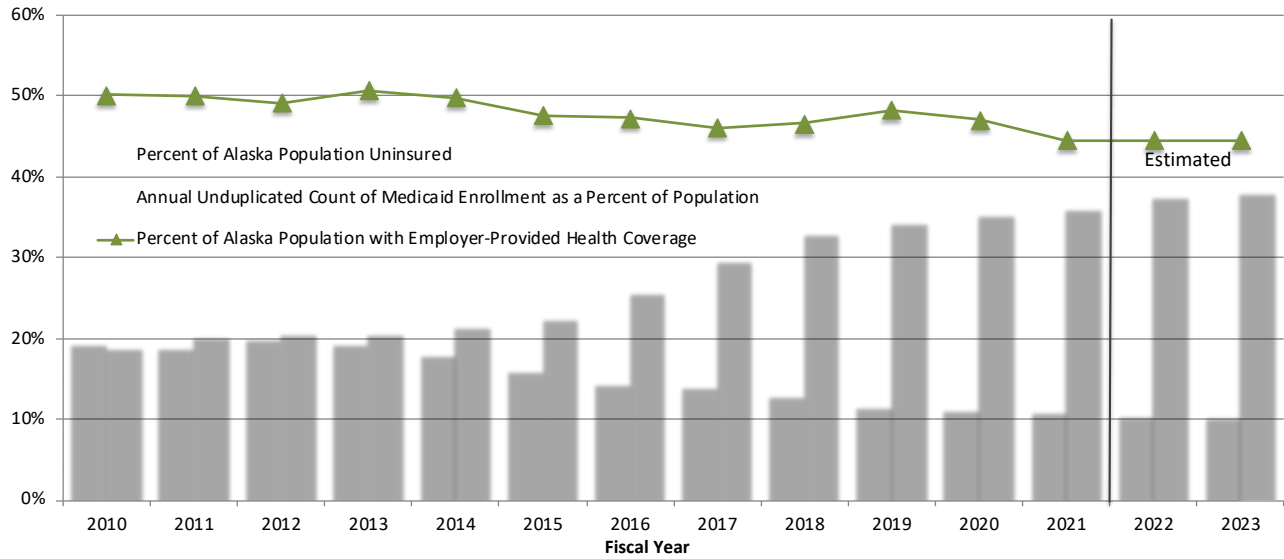
³⁰ KFF, “KFF’s State Health Facts, “Health Coverage & Uninsured.” <https://www.kff.org/state-category/health-coverage-uninsured/>

Katherine Keisler-Starkey and Lisa N. Bunch, “Health Insurance Coverage in the United States: 2019,” report number P60-271, Washington, D.C.: U.S. Census Bureau, published September 15, 2020. <https://www.census.gov/library/publications/2020/demo/p60-271.html>

³¹ On December 22, 2017, President Trump signed the Tax Cuts and Jobs Act of 2017, which eliminated the federal tax penalty for violating the individual mandate, starting in 2019.

³² Josh Bivens and Ben Zipperer, “Health insurance and the COVID-19 shock,” Economic Policy Institute, August 26, 2020. <https://www.epi.org/publication/health-insurance-and-the-covid-19-shock/>

Figure 12: Recent Trends in Health Insurance Coverage in Alaska

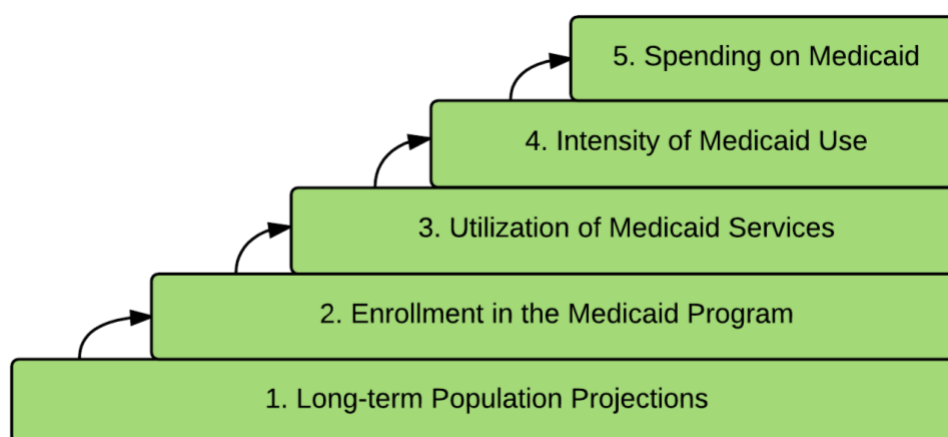


Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group and KKF (<https://www.kff.org/state-category/health-coverage-uninsured/>). Evergreen converted KKF data to fiscal year as the average of two consecutive calendar years (e.g., FY2020 is the average of CY2019 and CY2020).

2 Overview of Projections: FY2023-FY2043

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 13 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.³³ 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 13: 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 230,400,³⁴ and about one in five Alaskans (44,237) lived in Anchorage.³⁵ By the time Alaska started its Medicaid program in 1972, the population of

³³ Alaska Department of Labor and Workforce Development, Research and Analysis, *Alaska Population Projections 2021 to 2050*, June 2022. <http://live.laborstats.alaska.gov/pop/projections.cfm>

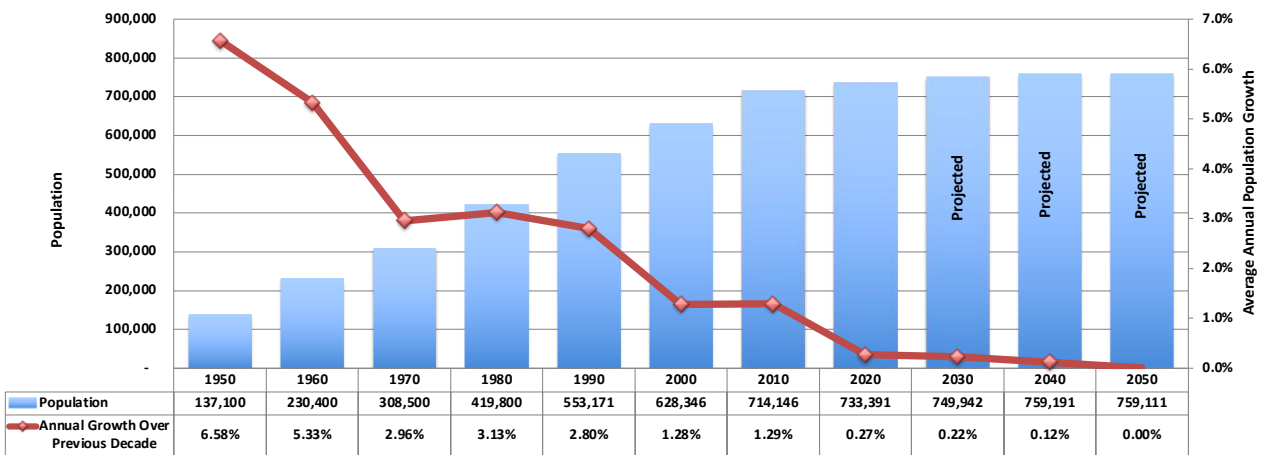
³⁴ Alaska Department of Labor and Workforce Development, *Alaska Population Overview: 2010 Census and 2011 Estimates*, October 2012. <http://live.laborstats.alaska.gov/pop/estimates/pub/1011popover.pdf>

³⁵ U.S. 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 state had increased to about 330,000.³⁶ The population continued to grow quickly through the 1970s and 1980s in part due to the construction of the Trans-Alaska Pipeline from 1975 to 1977 and other projects related to the oil industry.³⁷ By 1990, the state’s population had grown to 553,171, and two in five Alaskans (226,338) lived in Anchorage.³⁸

As Alaska’s population has grown, its rate of growth has continued to slow (Figure 14). 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 0.22 percent annually through 2030 and by 0.12 percent per year between 2030 and 2040, and will experience no population growth between 2040 and 2050.³⁹

Figure 14: Alaska's Population and Annual Growth Rates from 1950–2050



Source: U.S. 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. While the ratio of males to females has moved closer to the national average over the past decades, there were still 106 males in Alaska for every 100 females in 2021; by 2050, the Alaska DOLWD projects there will be 104 to 105 males for every 100 females.⁴⁰ We

³⁶ Alaska Department of Labor and Workforce Development’s report *Alaska Population Overview 2009 Estimates*, p. 13, available at <https://live.laborstats.alaska.gov/pop/estimates/pub/PopDigest.pdf>

³⁷ 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>

³⁸ Alaska Department of Labor and Workforce Development’s report *Alaska Population Overview 2009 Estimates*, p. 13, available at <https://live.laborstats.alaska.gov/pop/estimates/pub/PopDigest.pdf>

³⁹ 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>

⁴⁰ Alaska Department of Labor and Workforce Development. “Alaska Population Projections: 2021 to 2050,” June 2022. <https://live.laborstats.alaska.gov/pop/projections.html>; nationally, there are 103 females for every 100 males.

expect this to have a small effect on the Medicaid program, as adult females tend to incur higher average annual costs than adult males and enroll in the Medicaid program at a slightly greater rate.⁴¹

The DOLWD projects the senior population will grow at a much faster rate than the overall population (0.81% per year for seniors versus 0.15% for all Alaskans) and that the number of children in Alaska will decrease (by 0.31% per year).⁴²

Table 3: Alaska’s Projected Population by Age Cohort for Selected Calendar Years 2023–2043

Age Group	2023	2028	2033	2038	2043	Avg. Annual Change
Children (0-19)	198,785	195,042	189,480	186,858	186,809	-0.31%
Adults (20-64)	429,969	425,983	432,244	440,469	445,596	0.18%
Seniors (65+)	107,695	123,918	130,873	129,775	126,591	0.81%
Total Population	736,449	744,943	752,597	757,102	758,996	0.15%

Source: Analysis by Evergreen Economics of data from Alaska Department of Labor and Workforce Development, Research and Analysis, *Alaska Population Projections 2021 to 2050*, June 2022. <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 during a fiscal year—regardless of whether the individual receives Medicaid services during the fiscal year or not. 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.⁴³

About 57 percent of Alaska children were enrolled in the Medicaid program during all or some portion of FY2022, compared to only one in three adults and one in seven senior Alaskans. Historically, children were the primary focus of the Medicaid program. However, that changed

⁴¹ There is little difference in average annual spending on Medicaid services for male and female children. For adults, higher average annual spending on females is due primarily to pregnancy and post-pregnancy services. For seniors, higher average annual spending on females is due to a greater average lifespan of women and the high cost of senior care for Medicaid enrollees 85 years of age and older.

⁴² 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.

⁴³ This report also accounts for the end of the continuous enrollment requirement on March 31, 2023, as stated in the Consolidated Appropriations Act 2023.

substantially with the introduction of Medicaid expansion in September 2015. Today, the Alaska Medicaid program covers more adults 20-64 years of age than children, and we expect the proportion of enrollees who are children to continue to decrease through FY2043.

“Medicaid recipients” refers to individuals enrolled in Medicaid who received any Medicaid services during a fiscal year regardless of the type of services received.⁴⁴ 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.

Medicaid enrollment increased rapidly between FY2014 and FY2020, due primarily to the introduction of the ACA, which led to increases in Medicaid enrollment across the country. The ACA included changes to the Modified Adjusted Gross Income (MAGI) standard used to determine Medicaid and CHIP eligibility, which made it easier for individuals to qualify for either program. In addition, the insurance mandate in the ACA⁴⁵ and the “no wrong door” feature of the federal healthcare exchange allowed consumers to complete a single streamlined application to determine eligibility for a subsidized health plan, CHIP, or Medicaid. The congressional repeal of the insurance mandate, which took effect in January 2019, has had little-to-no discernable impact on Medicaid enrollment to date. This may be due in part to some Alaskans not being aware of the repeal, as well as to the federal COVID-19 public health emergency mandate that states maintain continuous enrollment for individuals, regardless of any change in employment, income, or other covered circumstance. We do expect that the repeal of the individual insurance mandate will result in slowing Medicaid enrollment over the 20-year forecast period, once the COVID-19 public health emergency has ended.

Medicaid expansion has had a substantial impact on Alaska’s Medicaid program. Launched in September 2015, Medicaid expansion led to a substantial increase in enrollment of adults 20-64 years of age. Alaska also experienced an economic recession that began in late 2014 or early 2015 and extended through most of 2019, which likely led to growth in Medicaid enrollment and spending.⁴⁶

⁴⁴ 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.

⁴⁵ For information on the ACA “individual mandate” to purchase health insurance, please see KFF, “The Requirement to Buy Coverage Under the Affordable Care Act,” August 2, 2017. <http://kff.org/infographic/the-requirement-to-buy-coverage-under-the-affordable-care-act/>

⁴⁶ J.A. Benitez, V. Perez, and E. Seiber, “Medicaid as a Safety Net: Does Medicaid Generosity Mitigate the Effects of Unemployment During Economic Downturns?” Proceedings from the 7th Conference of the American Society of Health Economists, June 12, 2018.

L. Snyder and R. Rudowitz, “Trends in State Medicaid Programs: Looking Back and Looking Ahead,” KFF, June 21, 2016.

We expect growth in Medicaid enrollment and in the number of recipients to slow considerably through the projection period, as the effects of Medicaid expansion and other ACA-based changes to the Medicaid program have largely already occurred, and once the COVID-19 public health emergency is ended. Table 4 shows the forecast for enrollment and recipients by age cohort through FY2043, with FY2015 as a benchmark (the year before Medicaid expansion began). We expect Medicaid enrollment to reach 314,504 by FY2043 and the number of recipients to reach nearly 264,000.

Table 4: Medicaid Enrollment and Recipients by Age Cohort for Selected Fiscal Years

Age Cohort	Measure	2015	2023	2028	2033	2038	2043	Percent Change*
Children (0-19)	Enrollees	94,799	115,192	118,496	119,890	121,608	122,902	0.32%
	Recipients	79,540	89,489	95,950	98,931	101,334	102,979	0.70%
Adults (20-64)	Enrollees	58,959	148,683	153,684	160,054	165,148	167,382	0.59%
	Recipients	48,134	107,718	120,147	129,383	135,886	139,218	1.29%
Seniors (65+)	Enrollees	11,189	16,852	20,696	23,144	24,048	24,220	1.83%
	Recipients	9,779	14,295	17,934	20,301	21,268	21,518	2.07%
All Ages**	Enrollees	164,947	280,727	292,876	303,087	310,804	314,504	0.57%
	Recipients	137,453	211,502	234,031	248,615	258,488	263,715	1.11%

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

* Average annual percent change between FY2023 and FY2043.

** Due to rounding, some totals may not precisely match the sum of components shown in the table.

In FY2015, 22.4 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 5). Adults (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. We expect that 34.6 percent of adults (20-64) will be enrolled in Medicaid in all or part of FY2023. The proportion of children enrolled in Medicaid has also grown since FY2015 due in part to components of the ACA, recessionary economic conditions in Alaska during much of this period, and the federal continuous enrollment mandate. The proportion of Alaska seniors enrolled in Medicaid has increased slightly since FY2015. Over the 20-year forecast period, we expect the proportion of Alaskans enrolled in Medicaid to grow for all three age cohorts, but at a much slower rate than was experienced between FY2015 and FY2023.

Table 5: Medicaid Enrollment and Recipients as a Proportion of Alaska’s Population, For FY2015 and Selected Future Fiscal Years

Age Cohort	Measure	2015	2023	2028	2033	2038	2043
Children (0-19)	Enrollees	46.0%	57.9%	60.8%	63.3%	65.1%	65.8%
	Recipients	38.6%	45.0%	49.2%	52.2%	54.2%	55.1%
Adults (20-64)	Enrollees	12.9%	34.6%	36.1%	37.0%	37.5%	37.6%
	Recipients	10.6%	25.1%	28.2%	29.9%	30.9%	31.2%
Seniors (65+)	Enrollees	15.0%	15.6%	16.7%	17.7%	18.5%	19.1%
	Recipients	13.1%	13.3%	14.5%	15.5%	16.4%	17.0%
All Ages	Enrollees	22.4%	38.1%	39.3%	40.3%	41.1%	41.4%
	Recipients	18.7%	28.7%	31.4%	33.0%	34.1%	34.7%

Source: Alaska Department of Labor and Workforce Development.

Table 6 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. Comparatively, we expect slower enrollment and recipient growth through Medicaid expansion and other eligibility categories.

Table 6: Medicaid Enrollees and Recipients by Broad Eligibility, FY2023 – FY2043

Eligibility Group	Measure	2023	2028	2033	2038	2043	Annual Growth
Aged or Disabled	Enrollees	32,070	34,824	37,133	38,744	39,697	1.07%
	Recipients	29,015	32,625	34,953	36,214	36,632	1.17%
Medicaid Expansion*	Enrollees	75,540	83,824	90,313	94,463	95,902	1.20%
	Recipients	51,502	60,239	66,379	70,178	71,601	1.66%
All Other Eligibilities	Enrollees	173,117	174,228	175,641	177,597	178,906	0.16%
	Recipients	133,284	142,637	148,361	152,969	156,228	0.80%
Total**	Enrollees	280,727	292,876	303,087	310,804	314,505	0.57%
	Recipients	213,801	235,501	249,692	259,361	264,460	1.07%

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 table.

2.3 Utilization of Medicaid Services

The term “utilization” has multiple meanings in healthcare. For purposes of the long-term Medicaid forecast, we define utilization as the annual unduplicated count of Medicaid enrollees who received a particular Medicaid service during a fiscal year. We refer to a Medicaid enrollee



who received a Medicaid service as a recipient, and we count an enrollee as a recipient only once per year for any given service category regardless of the number of times during the year the individual utilized the service, or the intensity of the service received.⁴⁷ 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 7—without regard for the intensity of use—during each of the 20 years of the forecast period.⁴⁸ A more detailed description of each service category is provided in the appendix of this report.

Table 7: Service Category Designations Used in the Long-Term Medicaid Forecast

Service Group	Service Category
Behavioral Health Services	Inpatient Psychiatric & Residential Psychiatric / BRC ⁴⁹ Outpatient Mental Health 1115 Waiver ⁵⁰
Long-Term Care Services	Nursing Home Home Health / Hospice Personal Care HCB State Plan Services ⁵¹ HCB 1915(c) Waivers ⁵²
Healthcare Services	Inpatient Hospital Outpatient Hospital Health Clinic Physician / Practitioner

⁴⁷ We count an enrollee as a recipient if he or she used a Medicaid service that resulted in a paid claim. In FY2010, 89 percent of Medicaid enrollees were recipients. In FY2015, the proportion of Medicaid enrollees who were also recipients had dropped to 84 percent, and in FY2022, only 74 percent of Medicaid enrollees were recipients.

⁴⁸ We consider "intensity of use" in the subsequent step of the long-term Medicaid forecast.

⁴⁹ BRC stands for Behavioral Rehabilitation Centers.

⁵⁰ 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.

⁵¹ HCB (home and community based) State Plan Services provide support for Medicaid recipients to remain in their home; services include personal care services, targeted case management services, and 1915(k) Community First Choice (CFC) services, which 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).

⁵² 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).

Service Group	Service Category
	Dental
	Lab / X-Ray
	EPSDT ⁵³
	Therapy / Rehabilitation
	Vision
	Pharmacy
	DME ⁵⁴ / Supplies
	Transportation

2.3.1 Variability in the Utilization of Medicaid Services

There is and we believe there will continue to be substantial variability among enrollees in the rate of service utilization, with upwards of 26 percent or more of enrollees not utilizing any Medicaid services during a fiscal year and a small number of recipients utilizing 10 or more different service categories during a fiscal year. Some of this variability is correlated with age as children utilize on average fewer Medicaid service categories than adults, and adults utilize on average fewer Medicaid service categories than seniors.

The primary factor that drives utilization of Medicaid services is being diagnosed with one or more chronic conditions. The likelihood of having one or more chronic conditions increases with age. In FY2022, Medicaid recipients with no diagnosed chronic conditions utilized on average three Medicaid service categories (Table 8). In comparison, Medicaid recipients with one diagnosed chronic condition utilized on average 5.2 service categories, recipients with two to four diagnosed chronic conditions utilized on average 5.7 Medicaid service categories, and recipients with five or more chronic conditions utilized on average 6.8 Medicaid service categories.

Table 8: Number of Medicaid Service Categories Utilized in FY2022

Number of Diagnosed Chronic Conditions	Number of Service Categories Utilized
No Diagnosed Chronic Conditions	3.0
One Diagnosed Chronic Condition	5.2
Two to Four Diagnosed Chronic Conditions	5.7
Five or More Diagnosed Chronic Conditions	6.8
Average of All Medicaid Recipients	3.6

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

⁵³ EPSDT stands for Early and Periodic Screening, Diagnosis, and Treatment.

⁵⁴ DME stands for Durable Medical Equipment.

We project that utilization per Medicaid recipient will grow on average by nearly 0.6 percent per year over the next 20 years as the Medicaid population continues to age and the prevalence of chronic conditions continues to grow.

2.4 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 a recipient receives. To estimate intensity of use, we analyzed spending per Medicaid enrollee for each of the 20 service categories for each fiscal year from 1997 through 2022. Over this period, Alaska and the rest of the U.S. experienced substantial healthcare price inflation, which averaged nearly 4.2 percent per year, but fluctuated year-to-year from a low of 2.3 percent in FY1999 to a high of 7.7 percent in FY2019.⁵⁵ To isolate the effects of intensity of use, we removed the price effects associated with inflation from each year of spending data, resulting in estimates of spending on Medicaid services as if there were no increases in healthcare prices. With inflation removed, year-to-year differences in average spending per Medicaid recipient represent changes in the intensity of use of services provided to recipients.⁵⁶

We used the resulting inflation-adjusted spending data to develop statistical models to explain intensity of use as a function of (1) demographic characteristics and (2) 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 FY2043. On a weighted average basis across the 20 service categories, we project intensity of use will increase on average by only about 0.4 percent per year through FY2043.⁵⁷

2.5 Total Spending on Medicaid Services

The final step (Figure 13) of the Alaska long-term forecasting model is to develop estimates of total spending for each Medicaid service category through FY2043. Beginning with the FY2022–FY2042 forecast, completed in January 2022, we made a substantive change to our approach for estimating future changes in the rates paid by the Medicaid program for services provided to Medicaid recipients, which accounts for differences between the general rate of medical price inflation in Alaska—i.e., change in prices for medical services by individuals and other private

⁵⁵ U.S. Bureau of Labor Statistics, “Consumer Price Index,” Data for medical care in urban Alaska, <https://www.bls.gov/cpi/data.htm>; converted to Alaska state fiscal year by Evergreen Economics.

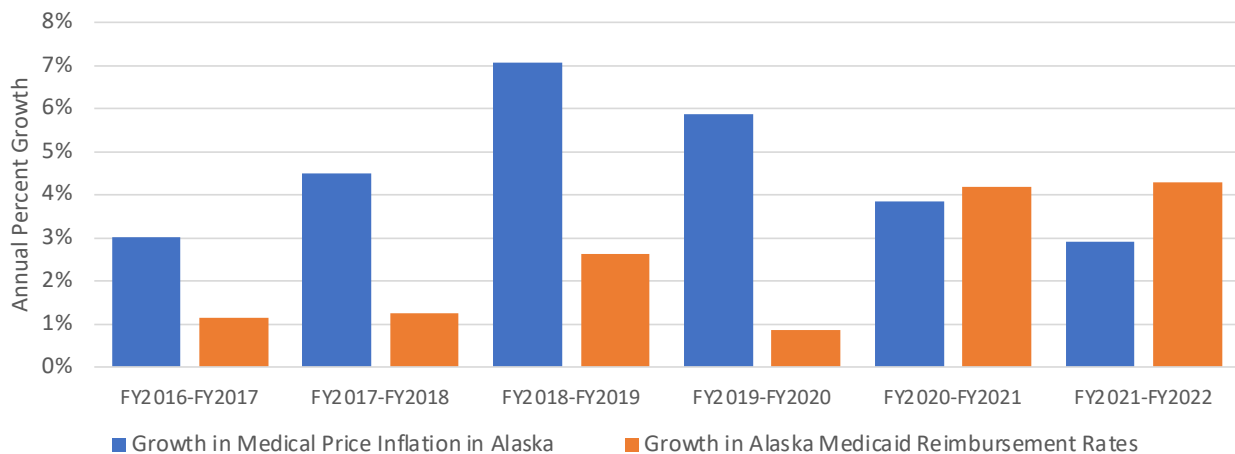
⁵⁶ We used calendar year 2000 as the base year. The choice of base year does not impact the estimates of healthcare price inflation.

⁵⁷ We relied on the *Consumer Price Index for All Urban Consumers: Medical care in Urban Alaska* index as the measure of historical healthcare price inflation, which is a measure of changes in prices paid by consumers of medical care. U.S. Bureau of Labor Statistics, “Consumer Price Index.” www.bls.gov/cpi.

payers—and the rate of growth in the schedule of fees paid by the Medicaid program to providers for services provided to Medicaid recipients.⁵⁸

Evergreen Economics analyzed the per-unit rate of growth in the costs of services over the period FY2016 to FY2022 and compared it to the rate of medical price inflation in Alaska over the same period. We found Medicaid reimbursement rates grew very slowly relative to medical price inflation each year from FY2016 through FY2020 (Figure 15), but reimbursement rates increased at a slightly faster pace than medical price inflation between FY2020 and FY2021 and increased by about 1.4 percentage points faster than medical price inflation between FY2021 and FY2022.

Figure 15: Annual Percent Change in Medicaid Reimbursement Rates and Medical Price Inflation in Alaska, FY2016 – FY2022



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

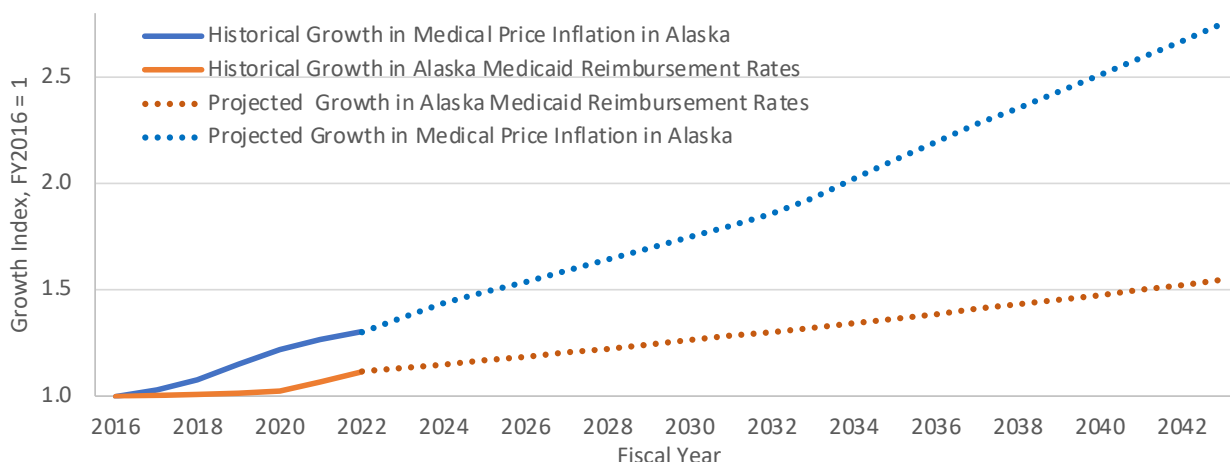
Medicaid reimbursement rates are reviewed annually, biennially, or triennially, and are periodically updated based on these reviews.⁵⁹ Figure 16 shows Evergreen Economics' indices of projected growth in Medicaid reimbursement rates and medical price inflation. We project that Medicaid reimbursement rates will increase by about 1.57 percent per year through FY2043 (slightly slower than the 1.84 annual growth rate observed between FY2016 and FY2022), while medical price inflation will increase by nearly 3.6 percent per year over this period. The slow rate of growth in Medicaid reimbursement rates—relative to medical price inflation in Alaska—will lead to substantially greater discrepancies between the prices paid by Alaska's Medicaid program for services provided to Medicaid recipients and the prices paid by Alaskans with private insurance.

⁵⁸ Alaska Medicaid fee schedules and covered codes are available at:

<http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>

⁵⁹ There are likely many factors considered when reviewing Medicaid reimbursement rates, including the costs of providing medical and related services, which are impacted by medical price inflation.

Figure 16: Projected Growth in Medical Price Inflation and Medicaid Reimbursement Rates in Alaska Through FY2043 (FY2016 = 1.0)



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

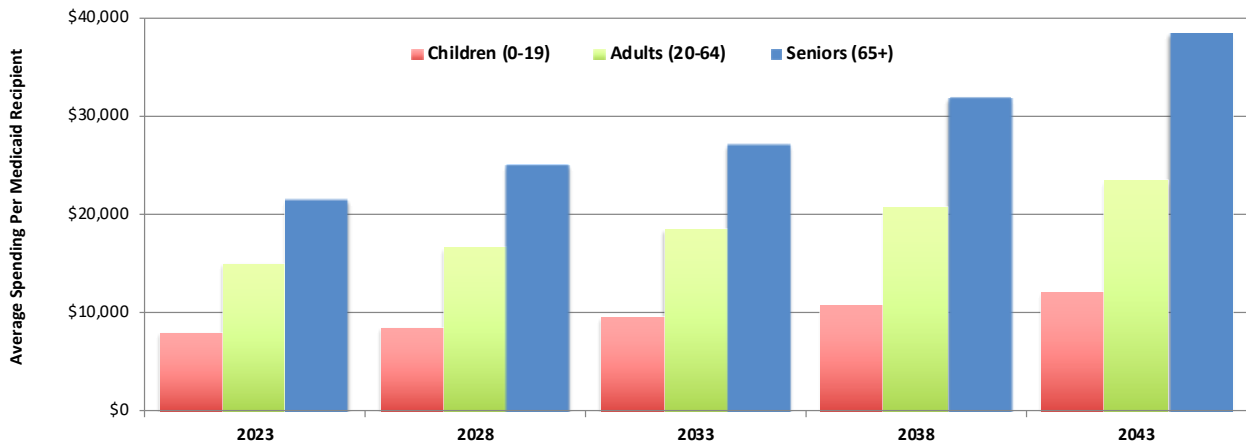
Table 9 shows projected spending by Medicaid service group. We project total Medicaid spending will increase on average by 3.6 percent per year between FY2023 and FY2043, reaching nearly \$5.3 billion. Over this period, growth in spending on long-term care services will outpace other service groups—4.9 percent for long-term care services versus 3.7 percent for behavioral health services, 3.1 percent for healthcare services that are medical in nature (e.g., inpatient hospital, provider services, dental services), and 2.7 percent for healthcare services that are non-medical in nature (e.g., transportation services).

Table 9: Medicaid Spending by Medicaid Service Group, FY2023 – FY2043 (Millions \$)

Service Group	2023	2028	2033	2038	2043	Annual Growth
Behavioral Health	\$325.4	\$393.3	\$462.4	\$560.5	\$678.1	3.7%
Long-Term Care	\$563.7	\$786.4	\$1,015.4	\$1,256.6	\$1,458.0	4.9%
Healthcare Medical	\$1,403.5	\$1,691.1	\$1,951.3	\$2,260.9	\$2,580.0	3.1%
Healthcare Non-Medical	\$334.5	\$392.7	\$443.8	\$505.3	\$568.2	2.7%
Total	\$2,627.1	\$3,263.5	\$3,872.9	\$4,583.3	\$5,284.3	3.6%

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

Figure 17 shows projected spending per recipient on Medicaid services. For FY2023, we estimate that for children, average spending per recipient will be about \$7,900, while for adults and seniors, average spending per recipient will be about \$13,600 and \$21,100, respectively. By FY2043, we project average spending per child recipient will be about \$10,600, while the average spending per adult recipient will be \$20,800 and the average spending per senior recipient will be \$35,200.

Figure 17: Average Spending Per Recipient on Medicaid Services by Age Cohort, FY2023 – FY2043


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;⁶⁰ in FY2015—the year before Medicaid expansion—the average age was 23 and the median age was 16. We project that by FY2043, the average age of a Medicaid enrollee will be 29 and the median age will be 24.

Figure 18 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 remains unchanged from FY2023 to FY2043. Figure 18 then shows how the spending forecast builds off this base. The components of spending growth are as follows:

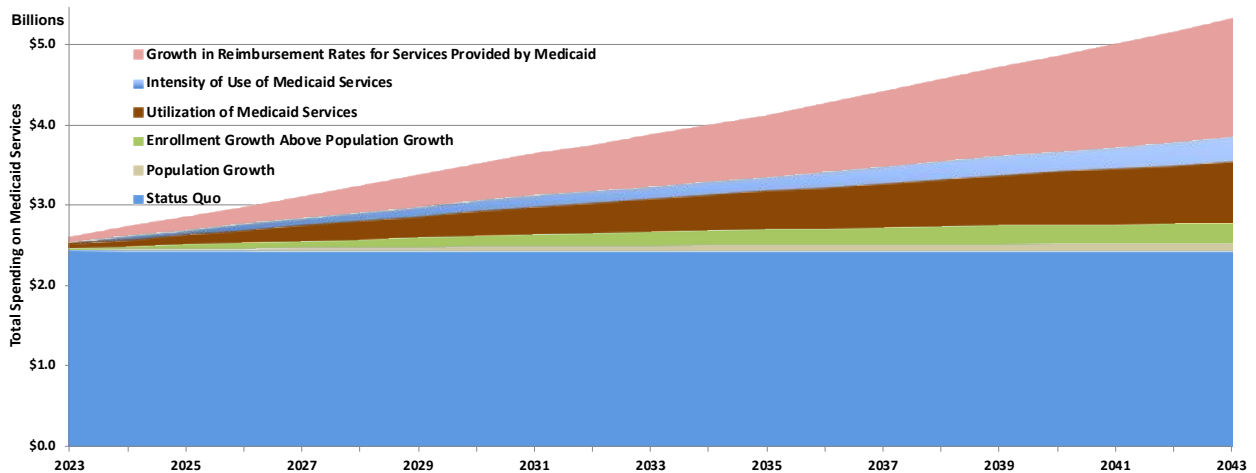
- **Population Growth** represents the additional spending due to growth in the population under the assumption that the rate of Medicaid participation will remain the same for each of the 240 sub-populations considered in the forecast.
- **Enrollment Growth Above Population Growth** is the incremental effect on Medicaid spending due to growth in the rate at which Alaskans enroll in Medicaid.
- **Utilization of Medicaid Services** represents the incremental impact on spending associated with Medicaid enrollees using, on average, a greater number of Medicaid services.
- **Intensity of Use of Medicaid Services** represents the incremental impact on spending associated with greater use of specific Medicaid services possibly, but not necessarily, due

⁶⁰ The median represents the midpoint. In FY2000, half of all Medicaid enrollees were under 14 years of age.

to changes in medical technology or practices, or increases in the scope of medical services within a Medicaid service category.

- **Growth in Reimbursement Rates for Services Provided by Medicaid** represents increases in the schedule of fees paid to Medicaid service providers.

Figure 18: Projected Spending on Medicaid Services by Component of Growth, FY2023-FY2043



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

As Figure 18 shows, we expect *growth in reimbursement rates for services provided by Medicaid* to be the primary driver of spending growth in Alaska’s Medicaid program, representing about 27 percent of total spending and 51 percent of additional spending in FY2043. Relative to healthcare price inflation, each of the other components of spending growth will have a relatively small impact on the Medicaid program over the next 20 years. Nevertheless, by FY2043, we project that growth in the population, growth in enrollment above population growth, and growth in utilization and intensity of use of Medicaid services will combine to increase spending on the Medicaid program by about \$1.4 billion.

2.5.1 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):⁶¹
 - 56.2 percent FFP from January 1, 2020 through March 31, 2023⁶²
 - 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
- 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
- Enhanced FMAP for CHIP:⁶³
 - 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
- Breast and Cervical Cancer (BCC): 65 percent FFP⁶⁴
 - 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
- Family Planning: 90 percent FFP
- Indian Health Service (IHS): 100 percent FFP
- Medicaid Expansion: 65 90 percent FFP
- Medicaid Expansion 1915 (K) CFC: 96 percent FFP
- State-Only Services: 0 percent FFP

⁶¹ CMS sets each state's FMAP rate based on a 3-year average of per capita personal income, ranked among states.

⁶² The additional 6.2 percentage points of FFP is attributable to the declaration by the U.S. Secretary of Health and Human Services related to the COVID-19 pandemic. It will begin phasing out April 1, 2023. For more information, see <https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf>

⁶³ Ibid

⁶⁴ Ibid

⁶⁵ Recipients enrolled through Medicaid expansion who are also Indian Health Service beneficiaries will always receive 100 percent FFP for qualifying services.

When a Medicaid service received by a Medicaid recipient is eligible for more than one FFP rate, the Department of Health applies the rate with the highest federal participation. The majority of Medicaid spending receives the regular FMAP rate, which is currently 56.2 percent federal participation;⁶⁶ however, most of the growth in Medicaid spending since FY2015 has received either the Medicaid expansion or IHS FFP rate. FFP rates are set at the federal level and, though they do change periodically, are largely outside of state control. We assume the FFP rates shown above will not change during the projection period. Table 10 shows our forecast of total spending on Medicaid services through FY2043, as well as our forecasts of spending by the State of Alaska and the federal government. We project that total spending on Medicaid services will grow on average by about 3.6 percent per year through FY2043, but the rate of growth in spending will be greater for the State of Alaska (4.2%) than for the federal government (3.3%).⁶⁷

Table 10: Projected State and Federal Spending on Medicaid Services (in Millions \$)

Fund Source	2023	2028	2033	2038	2043	Annual Growth
State GF and Other Matching Funds	\$615.7	\$853.0	\$1,026.5	\$1,224.2	\$1,412.7	4.2%
Federal	\$2,011.5	\$2,410.4	\$2,846.4	\$3,359.2	\$3,871.7	3.3%
Total Spending*	\$2,627.1	\$3,263.5	\$3,872.9	\$4,583.3	\$5,284.3	3.6%

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

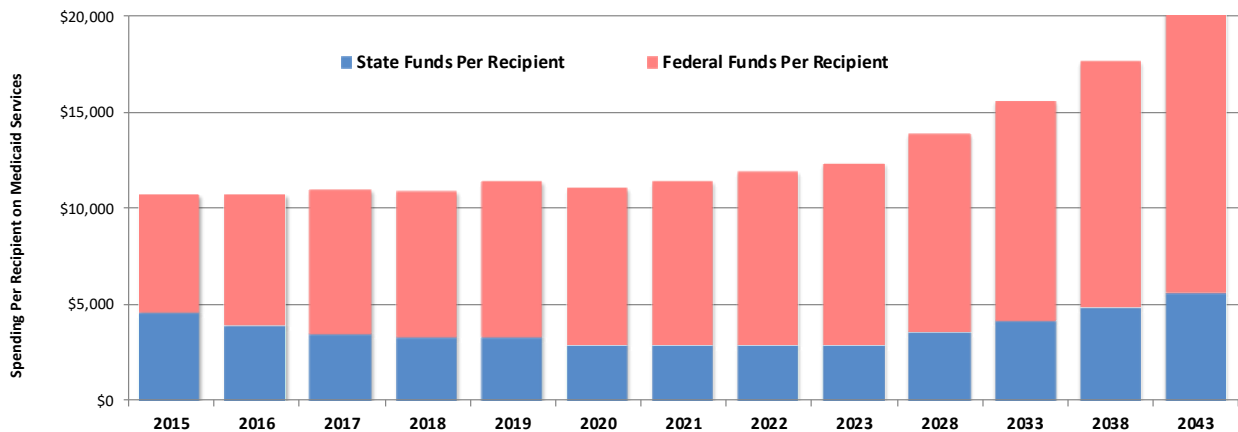
* Due to rounding, some totals may not precisely match the sum of components shown in the table.

Figure 19 shows recent actual and projected future average spending per Medicaid recipient. Between FY2015 and FY2021, spending per Medicaid recipient stayed essentially flat and the proportion paid with state general funds decreased considerably. Over the next 20 years, we project average spending per recipient will increase by about 2.3 percent per year due primarily to growth in provider reimbursement rates, which are driven by healthcare price inflation, and the aging of Alaska's population.

⁶⁶ Due to the COVID-19 pandemic emergency, regular FMAP was increased by 6.2 percentage points (to 56.2%). This enhancement will begin phasing out April 1, 2023.

⁶⁷ The greater projected rate of growth in spending for the State of Alaska is largely due to the sunseting of the additional federal participation as part of the federal COVID-19 pandemic emergency.

Figure 19: Average State and Federal Spending Per Medicaid Recipient by Fiscal Year*



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

* FY2015 – FY2021 are actual expenditures based on date of service; FY2022 is estimated based on date of payment; FY2023 – FY2043 are projected.

In FY2022, the weighted average FFP rate for Medicaid services was 75.5 percent, and we project the average FFP rate for FY2023 will be just over 76 percent. After that, we expect the weighted average FFP will begin to drop once the federal government ends the COVID-19 public health emergency. Beyond FY2024, we expect the weighted average FFP to slowly decrease over the projection period to about 72 percent by FY2043.⁶⁸

2.5.2 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;⁶⁹ and
2. Supplemental Hospital Payments including disproportionate share hospital (DSH) and upper payment limit programs paid to qualifying hospitals that serve many Medicaid or

⁶⁸ For FY2023, each percentage point of FFP equates to about \$26.3 million (1% of the projected \$2.63 billion in spending), and the importance of each percentage point of FFP will grow as total spending on Alaska’s Medicaid program grows.

⁶⁹ 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 coverage than it does to pay the claims for medical and related services.

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 15 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 11 shows the forecast of spending on Medicaid services, estimates of the cost of other Medicaid payments (net of offsetting recoveries), and total projected spending on the Medicaid program.

Table 11: Total Projected Medicaid Spending by Date of Service, FY2023–FY2043, in Millions

		2023	2028	2033	2038	2043
Spending on Medicaid Claims	Federal	\$2,011.5	\$2,410.4	\$2,846.4	\$3,359.2	\$3,871.7
	State Match	\$615.7	\$853.0	\$1,026.5	\$1,224.2	\$1,412.7
	Total	\$2,627.1	\$3,263.5	\$3,872.9	\$4,583.3	\$5,284.3
Other Medicaid Payments	Federal	\$85.4	\$106.1	\$125.9	\$149.0	\$171.7
	State Match	\$46.0	\$57.1	\$67.8	\$80.2	\$92.5
	Total	\$131.4	\$163.2	\$193.6	\$229.2	\$264.2
Total Medicaid Spending	Federal	\$2,096.8	\$2,516.5	\$2,972.3	\$3,508.1	\$4,043.4
	State Match	\$661.7	\$910.2	\$1,094.3	\$1,304.4	\$1,505.1
	Total*	\$2,758.5	\$3,426.7	\$4,066.5	\$4,812.5	\$5,548.5

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.

2.6 Spending on Medicaid Enrollees with Chronic Conditions

The U.S. National Center for Health Statistics defines chronic conditions as diseases or other medical conditions lasting three months or more.⁷⁰ 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.⁷¹ Compared to individuals without chronic conditions, adults with chronic conditions—especially those with multiple chronic

⁷⁰ National Health Council, "About Chronic Diseases." <https://nationalhealthcouncil.org/wp-content/uploads/2019/12/AboutChronicDisease.pdf>

⁷¹ Centers for Disease Control and Prevention, "About Chronic Diseases." <https://www.cdc.gov/chronicdisease/about/index.htm>

conditions—have lower health-related quality of life, greater risk of death, and significantly higher healthcare costs.

Using data from the 2018 National Health Interview Survey (NHIS), researchers from the National Center for Health Statistics found that nearly 52 percent of American adults had one or more of the following diagnosed chronic conditions: arthritis, cancer, chronic obstructive pulmonary disease, coronary heart disease, current asthma, diabetes, hepatitis, hypertension, stroke, and weak or failing kidneys, and just over 27 percent of US adults had multiple chronic conditions.⁷²

2.6.1 Identifying Medicaid Beneficiaries 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 beneficiaries who had a paid Medicaid claim that included diagnosis codes indicating the beneficiary received treatment for any of the chronic conditions listed in Table 12 during FY2022. There were about 6.8 million Medicaid claims and nearly 11 million claim lines for services provided to beneficiaries in FY2022.⁷³ 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, MMIS and ASO records also include one or more medical diagnosis codes assigned by a healthcare provider, which indicate the medical reason for the service.⁷⁴ We examined up to four diagnosis codes for each Medicaid claim line in FY2022 to identify if the service was associated with any of the chronic conditions listed in Table 12, which we arranged into 24 chronic condition groups based on the characteristics of the condition and/or the body system affected.

Table 12: 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)

⁷² Boersma P, Black LI, Ward BW. Prevalence of Multiple Chronic Conditions Among US Adults, 2018. *Prev Chronic Dis* 2020;17:200130. DOI: <http://dx.doi.org/10.5888/pcd17.200130>

⁷³ About 81 percent of Medicaid claims in FY2020 consisted of a single claim line, and 98 percent of claims were composed of 10 or fewer claim lines.

⁷⁴ In FY2022, about 2.3 million claims (21%) did not include a diagnosis code. Of these, the vast majority (98%) were either pharmacy- (74%) or dental- (24%).

	Chronic Condition Group	Chronic Conditions
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
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	Mobility Impairments
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.

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-10.⁷⁵ For each chronic condition, we relied on the CMS Chronic Conditions Data Warehouse to determine which ICD-10 codes indicated the

⁷⁵ 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.

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 a beneficiary as having a chronic condition if (a) he or she receives treatment for the condition through the Medicaid program and (b) the care facility assigns a diagnosis code indicating the beneficiary received treatment for the chronic condition.⁷⁶

Evergreen Economics used the following criteria to define a Medicaid beneficiary as having one of the chronic conditions that make up the 24 chronic condition groups shown in Table 12:⁷⁷

- The Medicaid beneficiary had at least two Medicaid claims in FY2022 with a diagnosis code specifying the chronic condition as defined in the CMS Chronic Conditions Data Warehouse; and
- The Medicaid program paid at least \$5,000 in costs for (all) services received by the Medicaid recipient during FY2022.

In FY2022, the unduplicated count of Medicaid enrollees was 276,760, of which 204,847 were recipients of Medicaid services. Applying the criteria described above, we identified 51,474 Medicaid beneficiaries as being diagnosed with one or more chronic conditions.

2.6.2 Characteristics of Beneficiaries with Chronic Conditions

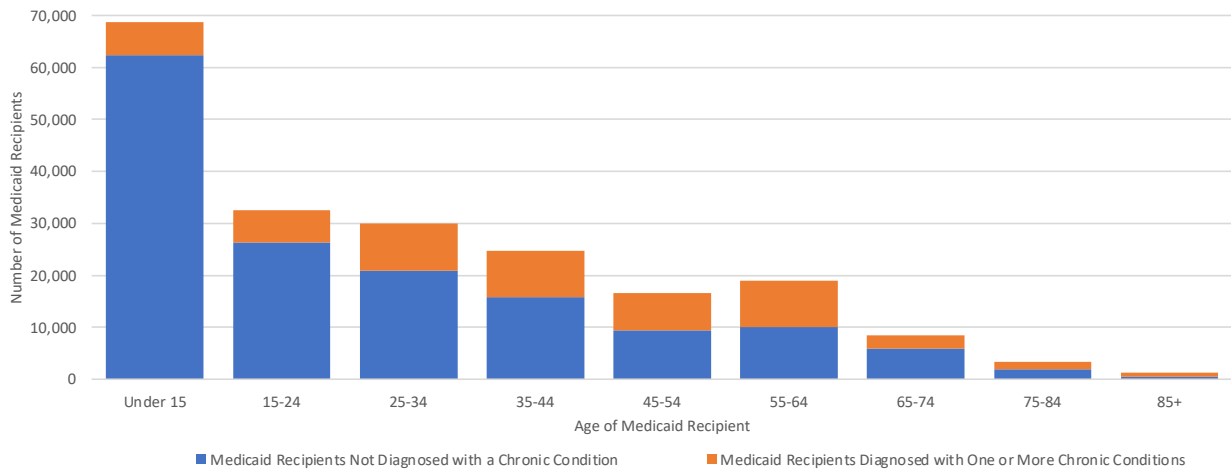
Figure 20 shows the distribution of Medicaid recipients by age and whether the recipient was diagnosed with one or more chronic conditions in FY2022. The prevalence of being diagnosed with a chronic condition increases with age and/or is linked to the aging process.⁷⁸ While the number of Medicaid recipients has generally increased each year, the distribution shown in Figure 20 has not materially changed.

⁷⁶ The likelihood of underestimating the prevalence of chronic conditions within the Medicaid population is especially pronounced for those Medicaid beneficiaries who have dual eligibility with Medicare—this would include Medicaid beneficiaries 65 years of age or older, beneficiaries younger than 65 with disabilities, and any beneficiary with end-stage renal disease.

⁷⁷ These criteria were developed by Evergreen Economics specifically for this analysis.

⁷⁸ 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." U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2012. <https://www.cdc.gov/nchs/products/databriefs/db100.htm>

Figure 20: Distribution of Medicaid Recipients by Age and Diagnosis of One or More Chronic Conditions, FY2022



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

About 9.5 percent of recipients under 15 years of age had a diagnosed chronic condition. This rate doubles (to 19.1%) for recipients 15 to 24 years of age and continues to increase through the 55 to 64 age group (47.3% have one or more diagnosed chronic conditions). However, the positive correlation between age and prevalence of chronic conditions then seemingly reverses for the 65 to 74 age group. Only 30 percent of Medicaid recipients in this age group have one or more diagnosed chronic conditions. The reason for the drop in the prevalence of chronic conditions for Medicaid recipients in the 65 to 74 age group is due to federal policies affecting the Medicaid and Medicare programs. For most Medicaid enrollees, becoming eligible for Medicare (generally at age 65) coincides with losing eligibility for Medicaid, while others gain Medicare eligibility while also maintaining full Medicaid eligibility.⁷⁹

Notably, adults who became eligible for Medicaid through expansion lose Medicaid eligibility at age 65 when they become eligible for Medicare. This explains most of the substantial drop in the number of Medicaid recipients between the 55 to 64 age group and the 65 to 74 age group. In addition, many Medicaid recipients whose eligibility is based on one or more disability determinations become dually eligible for Medicare, which assumes the role of primary payer, while Medicaid is the payer of last resort. Only the services these recipients receive through the Medicaid program are captured in Alaska’s MMIS or ASO databases (and therefore available to us

⁷⁹ MaryBeth Musumeci, Robin Rudowitz, and Tricia Neuman, “How Might Lowering the Medicare Age Affect Medicaid Enrollees?” KFF, June 10, 2021. <https://www.kff.org/medicaid/issue-brief/how-might-lowering-the-medicare-age-affect-medicaid-enrollees/>

A person must independently qualify for Medicare and Medicaid.

for analysis). It is likely that many or even most of these individuals also receive services through the Medicare program and, therefore, our analytical approach surely undercounts the number of dually-eligible Medicaid recipients with chronic conditions—as well as total spending on healthcare services.

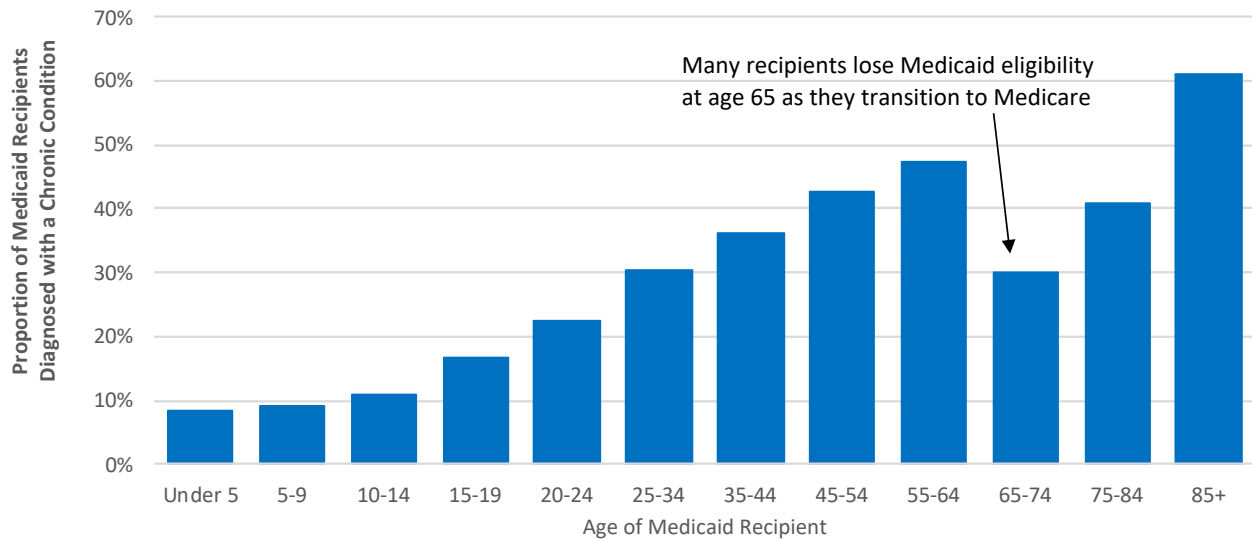
The drop in the overall prevalence of chronic conditions for Medicaid recipients 65-74 years of age (relative to the 55-64 age group) masks the substantial variation in prevalence among the 24 categories of chronic conditions. The most substantial drops were in conditions that are substantially affected by lifestyle choices, such as drug and alcohol abuse (dropping from 8% of adults 55-64 years of age to 3.6% for seniors 65-74), tobacco use (dropping from 8.6% of adults 55-64 years of age to 4% for seniors 65-74), and obesity (dropping from 3.6% of adults 55-64 years of age to 1.9% for seniors 65-74).

The prevalence of diagnosed chronic conditions generally associated with aging, such as dementia/Alzheimer's, mobility impairments, and stroke, were substantially higher for the 65-74 age group relative to the 55-64 age group, though the numbers of Medicaid recipients diagnosed with one or more of these conditions was relatively low in comparison to cardiovascular-related and other chronic conditions.

The prevalence of chronic conditions increases to 41 percent for Medicaid recipients who are seniors 75 to 84 years of age and to 61 percent for seniors 85 or older. Medicaid recipients in these age groups are also dually eligible for Medicare, which would have been the payer of many of the medical services they received in FY2020. Because of this, we surely underestimate the true prevalence of chronic conditions within these oldest age groups as the prevalence of certain chronic conditions (e.g., dementia, stroke) is highly positively correlated with age.

Figure 21 shows more clearly the relationship between the age of a Medicaid recipient and the prevalence of chronic conditions. Less than 10 percent of children under five years of age were diagnosed with a chronic condition in FY2022, while 61 percent of seniors 85 years of age or older were diagnosed with one or more chronic conditions. The strong positive correlation between age and prevalence of chronic conditions does not mean that age necessarily causes chronic conditions, but rather that age is related (and may be a contributing factor) to the increased prevalence of chronic conditions. The factors underlying many chronic conditions include family genetics, environment, and lifestyle. It often takes time for the health effects of these factors to result in diagnosis of a chronic condition.

Figure 21: Prevalence of a Diagnosed Chronic Condition by Age of Recipient, FY2022



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

Total spending on Medicaid services received in FY2022 for *all* Medicaid recipients was \$2.44 billion. Of this total, \$554.8 million was spent on services for the 153,373 Medicaid recipients with no diagnosed chronic conditions (\$3,617 per recipient), and \$1.78 billion was spent on services for the 51,474 Medicaid recipients with one or more diagnosed chronic conditions (\$34,496 per recipient).

Table 13 shows average spending per recipient on Medicaid services in FY2022 by age of the recipient for *all* Medicaid recipients (column b), per recipient without a diagnosed chronic condition (column c), and per recipient with one or more diagnosed chronic conditions (column d).

Considering the data on average spending per recipient shown in column b (without regard for a chronic condition diagnosis), the data appear to show a strong, though imperfect, 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 85+ age group). Likewise, spending per recipient for those with one or more 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 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 \$3,617 in FY2022, while average spending per recipient with *one or more chronic condition diagnoses* was nearly 10 times greater at \$34,496.

Table 13: Spending Per Recipient on Medicaid Services and Incremental Cost of Chronic Conditions, FY2022

a.	b.	c.	d.	e.
Age of Recipient	Average Spending Per Medicaid Recipient			Incremental Cost of Chronic Condition (d – c)
	All Recipients	Without a Diagnosed Chronic Condition	One or More Chronic Condition Diagnoses	
Under 5	\$8,077	\$5,063	\$41,658	\$36,595
05-09	\$4,761	\$2,941	\$23,107	\$20,166
10-14	\$6,581	\$3,065	\$35,082	\$32,017
15-19	\$9,549	\$3,816	\$38,180	\$34,364
20-24	\$9,636	\$3,671	\$30,034	\$26,362
25-34	\$12,304	\$3,919	\$31,669	\$27,750
35-44	\$13,486	\$3,527	\$31,196	\$27,669
45-54	\$15,823	\$3,231	\$32,699	\$29,468
55-64	\$17,744	\$2,870	\$34,287	\$31,417
65-74	\$14,074	\$2,378	\$41,423	\$39,045
75-84	\$25,664	\$3,798	\$57,365	\$53,566
85+	\$48,749	\$10,919	\$73,078	\$62,159
All Recipients	\$11,377	\$3,617	\$34,496	\$30,879

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

Table 14 shows the distribution of Medicaid recipients by number of diagnosed chronic conditions in FY2022, average spending per recipient, and total spending on all recipients. Almost 75 percent of Medicaid recipients have no diagnosed chronic conditions but account for less than 24 percent of total spending on Medicaid services. In comparison, 9.3 percent of recipients have one diagnosed chronic condition but account for almost 22 percent of spending, and 15.8 percent of recipients have two or more chronic conditions but account for 54 percent of total spending on Medicaid services.

Table 14: Distribution of Medicaid Recipients and the Cost of Providing Medicaid Services by the Number of Diagnosed Chronic Conditions, FY2022

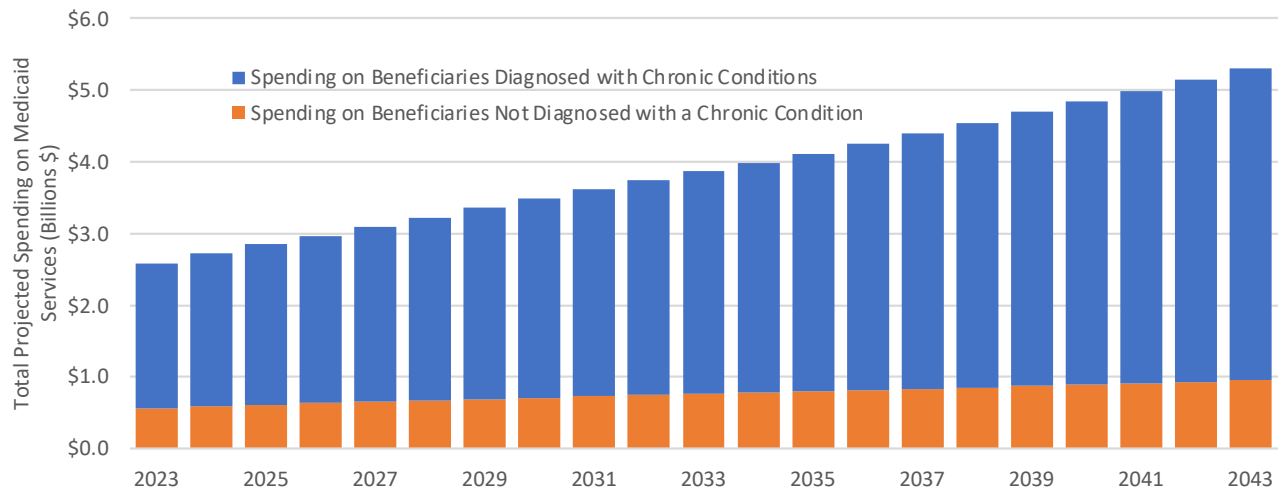
Diagnosed Chronic Conditions	Medicaid Recipients	Percent of Recipients	Average Spending Per Recipient	Total Spending	Percentage of Spending
0	153,373	74.9%	\$3,617	\$554,821,582	23.8%
1	19,138	9.3%	\$26,397	\$505,188,519	21.7%
2	12,576	6.1%	\$31,524	\$396,441,393	17.0%
3	8,442	4.1%	\$35,844	\$302,598,280	13.0%
4	5,233	2.6%	\$42,366	\$221,702,032	9.5%
5	3,023	1.5%	\$51,899	\$156,891,291	6.7%
6	1,628	0.8%	\$54,877	\$89,339,946	3.8%
7	800	0.4%	\$66,297	\$53,037,474	2.3%
8 or More	634	0.3%	\$79,562	\$50,442,078	2.2%
All Recipients	204,847	100.0%	\$11,377	\$2,330,462,596	100.0%

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

2.6.3 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 12 each year through FY2043.⁸⁰ Over this period, we project Medicaid spending on recipients diagnosed with one or more chronic conditions will grow from just over \$2 billion (77% of total Medicaid spending) in FY2023 to nearly \$4.4 billion (82% of total Medicaid spending) in FY2043. Comparatively, we project that spending on recipients *not* diagnosed with a chronic condition will increase from \$560 million to \$975 million between FY2023 and FY2043, which, though increasing by more than \$400 million over the 20-year period, will decrease as a proportion of total spending from 23 percent in FY2023 to 18 percent in FY2043.

⁸⁰ 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 22: Projected Spending on Medicaid Services, FY2023–FY2043

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

2.6.4 Post-COVID Conditions – A New Chronic Condition of Concern

Not included in the list of chronic conditions is a condition experienced by some people who have been infected with the COVID-19 virus. Known as post-COVID conditions or long COVID, an individual can experience long-term effects from their COVID-19 infection. In June 2021, the CDC announced the creation of a diagnosis code for tracking the costs of healthcare services provided to individuals displaying symptoms consistent with post-COVID.⁸¹

Table 15 shows the number and proportion of Medicaid recipients by age group diagnosed with post-COVID conditions. As has been widely reported in the media, complications from COVID-19 infection—including post-COVID conditions—are positively correlated with age. For each of the under-20 age groups, the proportion all recipients diagnosed with post-COVID conditions was less than 0.20 percent in FY2022. For adults, the prevalence of post-COVID conditions among all recipients ranged from 0.25 percent for those 20 to 24 years of age to 1.21 percent for seniors 85 years of age or older. For each age group, the prevalence of post-COVID conditions for Medicaid recipients diagnosed with one or more chronic conditions is greater than for all Medicaid recipients.⁸²

⁸¹ The diagnoses code (ICD10 “U09.9”) became effective October 1, 2021. For more information about long COVID, please see <https://www.cdc.gov/coronavirus/2019-ncov/long-term-effects/index.html>.

⁸² For seniors 85 years of age or older, however, the prevalence of post-COVID conditions is virtually the same for Medicaid recipients diagnosed with one or more chronic conditions as it is for all recipients.

Table 15: Medicaid Recipients Diagnosed with Post-COVID Conditions by Age Group, FY2022

Age Group	Recipients Diagnosed with Post-COVID	Proportion of Recipients	
		All Recipients	Diagnosed with One or More Chronic Conditions*
Under 5	29	0.12%	0.30%
5-9	24	0.10%	0.09%
10-14	25	0.11%	0.28%
15-19	30	0.16%	0.34%
20-24	33	0.25%	0.52%
25-34	143	0.48%	0.97%
35-34	184	0.74%	1.25%
45-54	143	0.86%	1.46%
55-64	172	0.90%	1.48%
65-74	92	1.08%	1.52%
75-84	31	0.92%	1.42%
85+	16	1.21%	1.23%
Total	922	0.45%	1.06%

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

* Based on the criteria described earlier in Section 2.6.

Table 16 shows the four diagnosed chronic conditions most likely to be comorbid with post-COVID conditions for Medicaid recipients 50 years of age or older. The prevalence of post-COVID conditions for older adults diagnosed with asthma, ulcers, obesity, or COPD/Bronchiectasis is more than four times greater than for older adults with no diagnosed chronic condition.

Table 16: Chronic Conditions Most Likely to be Comorbid with Post-COVID Conditions for Medicaid Recipients 50 Years of Age or Older, FY2022

Chronic Condition	Recipients	Diagnosed with Post-COVID Conditions	% Diagnosed with Post-COVID Conditions
Asthma	1,187	38	3.20%
Ulcers	695	18	2.59%
Obesity	1,600	39	2.44%
COPD / Bronchiectasis	2,660	64	2.41%
Any Diagnosed Chronic Condition	17,393	262	1.48%
No Diagnosed Chronic Conditions	22,897	118	0.51%

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

2.6.5 Potential Impacts that Public Health Programs Targeting Chronic Conditions Could Have on Medicaid Spending

Alaska’s state health improvement plan, Healthy Alaskans 2030 (HA2030), provides an approach for how the state can improve on the most significant health issues that its residents face.⁸³ With input from Alaskan residents and subject matter experts, the Department of Health in equal partnership with the Alaska Native Tribal Health Consortium (ANTHC) defined 30 health objectives along with strategies and actions that may be implemented to help achieve each respective objective by 2030. Among the 30 health objectives contained in the HA2030 plan are at least seven that are directly related to chronic conditions:

- **Objective 1** – Reduce cancer mortality rate per 100,000 population
 - **Baseline (2018):** 141.6 deaths
 - **Current (2019):** 148.8
 - **Target (2030):** 127.4 deaths
- **Objective 9** – Increase the percentage of children (students in grades K-8) who meet criteria for healthy weight
 - **Baseline (2018-2019):** 62.6 percent
 - **Current (2019-2020):** 62.5 percent
 - **Target (2030):** 66 percent
- **Objective 14** - Reduce the mean number of days in the past 30 days adults (aged 18 years and older) report being mentally unhealthy
 - **Baseline (2018):** 3.7 days
 - **Current (2019):** 3.9 days
 - **Target (2030):** 3.5 days
- **Objectives 22 & 23** – Reduce the alcohol-induced and drug-induced mortality rate per 100,000 population
 - **Baseline (2016-2018):** 26.3 alcohol deaths / 15.8 drug deaths
 - **Current (2018-2020):** 23.7 alcohol deaths / 20.1 drug deaths
 - **Target (2030):** 23.6 alcohol deaths / 14.2 drug deaths
- **Objectives 26 & 27** - Reduce the percentage of adolescents (high school students in grades 9-12) who have used electronic vapor products, cigarettes, smokeless tobacco, or other tobacco products in the last 30 days; reduce the percentage of adults (aged 18 and older)

⁸³ State Health Improvement Plan, Healthy Alaskans 2030. “Healthy Alaskans 2030 Priority Health Topics and Health Objectives.” <https://www.healthyalaskans.org/wp-content/uploads/2021/02/HA2030-Objectives.pdf>

who currently smoke cigarettes or use electronic vapor products, smokeless tobacco, or other tobacco products

- **Baseline (2019/2018):** 34.5 percent adolescents / 27.3 percent adults
- **Current (2019/2019):** 34.5 percent adolescents / 26.2 percent adults
- **Target (2030):** 32 percent adolescents / 25 percent adults

While it is beyond the scope of this analysis to conclude that achieving any of the HA2030 objectives listed above will necessarily lead to reduced spending on Medicaid services, it is possible to estimate potential impacts that reductions in the incidence of select chronic conditions might have on Medicaid spending if progress is made in achieving the HA2030 objectives. To do this, we first developed projections of the number of Medicaid recipients that will be diagnosed with each of the following five chronic conditions that are closely related to the seven HA2030 objectives described above:

1. Cancer
2. Obesity
3. Mental Health Condition
4. Drug or Alcohol Dependency
5. Tobacco Use

Next, for recipients diagnosed with each of the five chronic conditions, we projected the average cost of providing Medicaid services to treat each respective chronic condition. As shown in Table 14 of Section 2.6.2, many Medicaid recipients were diagnosed with multiple chronic conditions in FY2022. We developed the estimates of spending on Medicaid services specific to each chronic condition, while holding all other Medicaid costs static. By isolating the cost of Medicaid services specific to each of the five chronic conditions, we can estimate the impact that a reduction in the prevalence of each of the five chronic conditions (cancer, obesity, mental health condition, drug or alcohol dependency, tobacco use) has on Medicaid spending for that condition.

Finally, we estimated how much spending on Medicaid services would decrease from the baseline Medicaid forecast (as shown in Table 10 in Section 2.5.1) if the prevalence of each of the five chronic conditions decreased over the 20-year projection period at the same average annual rate represented by the seven HA2030 goals described above.⁸⁴

⁸⁴ Please note that we do not speculate or assume that achieving any of the HA2030 goals will necessarily lead to decreases in the prevalence of any of the five chronic conditions among Medicaid recipients; rather, the purpose of this exercise is to demonstrate the potential reductions in Medicaid spending associated with reductions in the prevalence of the five chronic conditions, each of which is addressed by one or more of the HA2030 goals.

Table 17 shows the potential annual reductions in Medicaid spending on recipients diagnosed with each of the five chronic conditions most closely linked to the seven HA2030 objectives described above.

Table 17: Potential Reduction in Medicaid Spending Achieved by Meeting the HA2030 Goals

HA2030 Objective	Chronic Condition	Impact FY2028	Impact FY2033	Impact FY2038	Impact FY2043
1	Cancer	\$7,927,231	\$17,406,432	\$27,790,654	\$38,273,174
9	Obesity	\$4,561,705	\$10,155,643	\$16,385,748	\$22,710,106
14	Mental Health	\$44,228,043	\$98,151,528	\$158,680,553	\$220,968,697
22 / 23	Drug & Alcohol	\$21,683,945	\$48,101,393	\$78,117,419	\$110,362,978
26 / 27	Tobacco Use	\$6,892,756	\$15,291,968	\$24,774,557	\$34,782,582
Objectives Combined	Total Savings	\$85,293,680	\$189,106,964	\$305,748,931	\$427,097,537
	General Fund	\$22,128,130	\$50,821,283	\$83,914,703	\$120,497,703

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

Reducing the prevalence of just these five chronic conditions would lead to a substantial reduction in Medicaid spending, relative to the baseline forecast. The most substantial savings would occur for services treating mental health issues and drug and alcohol abuse, both of which were areas of substantial spending in FY2022 that are also projected to continue to be high-spending service areas through FY2043.

Not captured in Table 17 are potential impacts that reductions in the prevalence of the five chronic conditions may have on spending on other co-chronic conditions and on acute care. Many Medicaid recipients were diagnosed with more than one chronic condition in FY2022 (see Table 14 in Section 2.6.2), and a reduction in the prevalence of one chronic condition will likely result in improvements in other health outcomes. For example, a reduction in the prevalence of obesity may lead to reductions in the prevalence of diabetes, heart disease, and certain types of cancer. Therefore, reductions in the prevalence of these five chronic conditions—due to improvements in the seven HA2030 objectives described above or to other factors—would likely lead to reductions in the prevalence of other chronic conditions and to additional savings to the Medicaid program.

For Objective 9 (Increase the percentage of children [students in grades K-8] who meet criteria for healthy weight), we modeled a decrease in the percentage of *all* Alaskans *not* meeting the criteria for healthy weight.

Appendix Tables

Table 18: Medicaid Service Category Descriptions for Long-Term Forecast

Service Group	Service Category	Description
Behavioral Health	Inpatient Psychiatric & Residential Psychiatric / BRC	Inpatient psychiatric hospital services; Residential psychiatric treatment centers and behavioral rehabilitation centers (BRC)
	Outpatient Mental Health	Outpatient mental health services, psychology services, and drug abuse centers
	1115 Waiver	Behavioral health waiver
Long-Term Care Services	Nursing Home	Skilled nursing and intermediate care facilities including intermediate-care facilities for the intellectually disabled, and temporary long-term care services
	Home Health/Hospice	Home health services, hospice care, nutrition services, and private duty nursing
	Personal Care	Personal care attendant services including agency-based and consumer-directed programs
	HCB State Plan Services	Skilled nursing and intermediate care facilities including intermediate-care facilities for the intellectually disabled, and temporary long-term care 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	Durable medical equipment (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
	Vision	Optometrist services and eyeglasses

Table 19: Medicaid Eligibility Classification Descriptions

Eligibility Class	Description
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
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 20: Forecast of Population by Demographic Group, FY2023-FY2043

	Fiscal Year					Annual % Change
	2023	2028	2033	2038	2043	
State	736,449	744,943	752,597	757,102	758,996	0.2%
Gender						
Female	358,288	363,400	367,818	370,463	371,488	0.2%
Male	378,161	381,543	384,779	386,639	387,508	0.1%
Native Status						
Native	151,618	156,543	161,723	167,026	171,834	0.6%
Non-Native	584,831	588,400	590,874	590,076	587,162	0.0%
Region						
Northern	122,678	124,069	125,244	125,921	126,302	0.1%
Western	43,899	44,549	45,410	46,334	47,347	0.4%
South Central	96,699	96,169	95,748	95,027	94,094	-0.1%
Anchorage/Mat-Su	401,511	409,831	417,083	422,255	425,467	0.3%
Southeast	71,662	70,325	69,112	67,565	65,786	-0.4%
Age Group						
0-4	46,521	46,295	46,382	46,858	46,974	0.0%
5-9	50,180	47,406	46,656	46,751	47,231	-0.3%
10-14	52,663	49,747	47,296	46,548	46,644	-0.6%
15-19	49,421	51,594	49,146	46,701	45,960	-0.4%
20-24	46,097	49,589	51,736	49,297	46,863	0.1%
25-34	105,599	98,181	99,143	104,791	104,522	-0.1%
35-44	107,108	111,449	106,912	100,289	101,346	-0.3%
45-54	83,009	90,178	101,811	106,861	102,530	1.1%
55-64	88,156	76,586	72,642	79,231	90,335	0.1%
65-74	71,001	73,778	67,081	57,478	54,211	-1.3%
75-84	28,942	39,902	49,245	51,908	46,735	2.4%
85+	7,752	10,238	14,547	20,389	25,645	6.2%

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

Table 21: Forecast of Enrollment by Demographic Group, FY2023-FY2043

	Fiscal Year					Annual % Change
	2023	2028	2033	2038	2043	
State	281,008	293,170	303,391	311,115	314,819	0.6%
Gender						
Female	142,169	148,768	154,385	158,559	160,369	0.6%
Male	138,840	144,401	149,005	152,556	154,450	0.5%
Native Status						
Native	89,780	95,739	101,180	106,105	109,666	1.0%
Non-Native	191,228	197,430	202,210	205,011	205,153	0.4%
Region						
Northern	36,744	38,512	39,912	40,982	41,581	0.6%
Western	32,787	34,634	36,414	38,109	39,345	0.9%
South Central	37,763	38,740	39,644	40,291	40,456	0.3%
Anchorage/Mat-Su	148,122	155,339	161,189	165,456	167,448	0.6%
Southeast	25,593	25,945	26,231	26,276	25,989	0.1%
Age Group						
0-4	28,347	29,690	31,039	32,246	32,601	0.7%
5-9	31,069	30,803	31,537	32,439	33,102	0.3%
10-14	29,236	28,922	28,623	28,964	29,344	0.0%
15-19	26,645	29,189	28,800	28,072	27,970	0.2%
20-24	21,177	23,176	24,622	24,167	23,425	0.5%
25-34	44,403	43,886	45,602	48,392	48,567	0.4%
35-44	36,360	38,911	39,111	38,333	38,988	0.3%
45-54	22,816	25,154	28,277	29,926	29,430	1.3%
55-64	24,074	22,708	22,600	24,494	27,138	0.6%
65-74	10,932	12,275	11,897	10,609	10,179	-0.4%
75-84	4,349	6,289	8,168	9,039	8,418	3.4%
85+	1,600	2,165	3,114	4,433	5,656	6.5%

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

Table 22: Forecast of Spending by Demographic Group (Millions \$), FY2023-FY2043

	Fiscal Year					Annual % Change
	2023	2028	2033	2038	2043	
State	\$2,627.1	\$3,263.5	\$3,872.9	\$4,583.3	\$5,284.3	3.6%
Gender						
Female	\$1,411.3	\$1,758.5	\$2,097.9	\$2,493.0	\$2,881.7	3.6%
Male	\$1,215.9	\$1,505.0	\$1,775.0	\$2,090.3	\$2,402.6	3.5%
Native Status						
Native	\$1,114.1	\$1,382.3	\$1,629.7	\$1,918.5	\$2,209.9	3.5%
Non-Native	\$1,513.0	\$1,881.1	\$2,243.2	\$2,664.8	\$3,074.4	3.6%
Region						
Northern	\$294.4	\$364.5	\$430.0	\$506.6	\$582.3	3.5%
Western	\$325.9	\$403.5	\$476.1	\$560.8	\$645.2	3.5%
South Central	\$379.7	\$470.1	\$554.6	\$653.3	\$751.0	3.5%
Anchorage/Mat-Su	\$1,335.4	\$1,664.3	\$1,986.1	\$2,360.8	\$2,728.9	3.6%
Southeast	\$291.7	\$361.1	\$426.1	\$501.9	\$576.9	3.5%
Age Group						
0-4	\$210.2	\$245.0	\$285.6	\$330.6	\$373.8	2.9%
5-9	\$125.3	\$137.1	\$159.8	\$185.0	\$209.2	2.6%
10-14	\$160.8	\$172.2	\$200.7	\$232.3	\$262.7	2.5%
15-19	\$208.4	\$251.2	\$292.9	\$339.0	\$383.3	3.1%
20-24	\$146.7	\$190.0	\$218.7	\$254.3	\$280.7	3.3%
25-34	\$413.7	\$500.9	\$629.2	\$764.6	\$859.5	3.7%
35-44	\$377.6	\$512.3	\$610.2	\$684.1	\$766.4	3.6%
45-54	\$295.9	\$396.2	\$476.8	\$555.2	\$601.1	3.6%
55-64	\$381.3	\$407.8	\$451.2	\$560.9	\$726.1	3.3%
65-74	\$136.6	\$178.3	\$210.2	\$250.3	\$289.3	3.8%
75-84	\$97.3	\$157.3	\$193.4	\$230.3	\$262.6	5.1%
85+	\$73.3	\$115.2	\$144.1	\$196.8	\$269.6	6.7%

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

Table 23: Forecast of Total Spending on Medicaid (Millions \$), FY2023-FY2043

Service Category	Fiscal Year					Annual % Change
	2023	2028	2033	2038	2043	
Inpatient Hospital	\$431.3	\$514.1	\$589.3	\$679.2	\$773.2	3.0%
Outpatient Hospital	\$346.1	\$410.6	\$470.0	\$542.5	\$617.2	2.9%
Family Planning	\$0.3	\$0.4	\$0.5	\$0.6	\$0.7	3.9%
Health Clinic	\$213.5	\$270.8	\$324.6	\$386.7	\$449.9	3.8%
Physician/Practitioner	\$231.4	\$268.8	\$301.5	\$341.3	\$381.2	2.5%
Dental	\$102.8	\$128.2	\$150.8	\$177.8	\$207.1	3.6%
Lab/X-ray	\$9.0	\$10.8	\$12.5	\$14.4	\$16.4	3.0%
EPSDT	\$18.8	\$24.3	\$28.5	\$32.7	\$36.4	3.4%
Therapy/Rehabilitation	\$39.5	\$50.5	\$59.7	\$70.2	\$80.7	3.6%
Vision	\$10.8	\$12.5	\$13.9	\$15.5	\$17.2	2.4%
Pharmacy	\$236.3	\$276.0	\$310.8	\$352.7	\$395.8	2.6%
DME/Supplies	\$25.3	\$31.1	\$36.5	\$42.9	\$49.1	3.4%
Transportation	\$72.9	\$85.7	\$96.5	\$109.7	\$123.3	2.7%
Inpatient-Res Psych	\$51.6	\$59.9	\$63.3	\$68.1	\$74.7	1.9%
Outpatient Mental Health	\$90.3	\$82.8	\$74.0	\$68.5	\$63.3	-1.8%
1115 Waiver	\$183.6	\$250.6	\$325.0	\$423.9	\$540.1	5.5%
Nursing Home	\$189.6	\$264.7	\$344.1	\$430.3	\$506.5	5.0%
Home Health/Hospice	\$12.8	\$17.4	\$21.7	\$26.9	\$33.1	4.9%
Personal Care	\$22.1	\$34.2	\$48.0	\$63.4	\$77.2	6.4%
HCB State Plan Services	\$317.3	\$444.6	\$573.0	\$703.4	\$804.7	4.8%
HCB 1915(c) Waivers	\$21.8	\$25.4	\$28.6	\$32.5	\$36.5	2.6%
Total Spending on Medicaid Services	\$2,627.1	\$3,263.5	\$3,872.9	\$4,583.3	\$5,284.3	3.6%
Other Medicaid Payments*	\$131.4	\$163.2	\$193.6	\$229.2	\$264.2	3.6%
Total Spending on Medicaid Program	\$2,758.5	\$3,426.7	\$4,066.5	\$4,812.5	\$5,548.5	3.6%

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

* Includes offsets received by DOH for drug rebates, third-party liability collections, or other reasons.

Table 24: Forecast of State Spending on Medicaid (Millions \$)

Service Category	Fiscal Year					Annual % Change
	2023	2028	2033	2038	2043	
Inpatient Hospital	\$95.3	\$123.5	\$141.6	\$163.2	\$185.8	3.4%
Outpatient Hospital	\$49.1	\$61.9	\$70.8	\$81.7	\$93.0	3.2%
Family Planning	\$0.3	\$0.3	\$0.4	\$0.5	\$0.5	3.8%
Health Clinic	\$10.5	\$12.6	\$15.2	\$18.0	\$21.0	3.5%
Physician/Practitioner	\$55.7	\$70.5	\$79.0	\$89.5	\$99.9	3.0%
Dental	\$23.9	\$32.7	\$38.5	\$45.4	\$52.9	4.0%
Lab/X-ray	\$2.3	\$2.9	\$3.4	\$3.9	\$4.4	3.4%
EPSDT	\$3.1	\$4.4	\$5.1	\$5.9	\$6.6	3.8%
Therapy/Rehabilitation	\$14.7	\$20.9	\$24.7	\$29.0	\$33.4	4.2%
Vision	\$3.6	\$4.6	\$5.1	\$5.7	\$6.3	2.9%
Pharmacy	\$52.8	\$66.7	\$75.1	\$85.3	\$95.7	3.0%
DME/Supplies	\$8.8	\$12.0	\$14.1	\$16.5	\$18.9	3.9%
Transportation	\$8.4	\$10.4	\$11.7	\$13.3	\$15.0	2.9%
Inpatient-Res Psych	\$20.2	\$26.2	\$27.7	\$29.8	\$32.7	2.4%
Outpatient Mental Health	\$18.7	\$18.7	\$16.7	\$15.4	\$14.3	-1.4%
1115 Waiver	\$42.8	\$63.8	\$82.7	\$107.9	\$137.5	6.0%
Nursing Home	\$59.0	\$91.6	\$119.1	\$149.0	\$175.3	5.6%
Home Health/Hospice	\$5.0	\$7.5	\$9.3	\$11.6	\$14.3	5.4%
Personal Care	\$9.5	\$16.5	\$23.2	\$30.6	\$37.3	7.1%
HCB State Plan Services	\$124.6	\$195.6	\$252.1	\$309.5	\$354.0	5.4%
HCB 1915(c) Waivers	\$7.3	\$9.7	\$10.9	\$12.3	\$13.8	3.3%
Total Spending on Medicaid Services	\$615.7	\$853.0	\$1,026.5	\$1,224.2	\$1,412.7	4.2%
Other Medicaid Payments*	\$46.0	\$57.1	\$67.8	\$80.2	\$92.5	3.6%
Total Spending on Medicaid Program	\$661.7	\$910.2	\$1,094.3	\$1,304.4	\$1,505.1	4.2%

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

* Includes offsets received by DOH for drug rebates, third-party liability collections, or other reasons.