



Long-Term Forecast of Medicaid Enrollment and Spending in Alaska: FY2021–FY2041 FINAL REPORT

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Table of Contents

EXECUTIVE SUMMARY	1
Impacts of COVID-19 on Healthcare in Alaska	1
Summary of the Long-Term Forecast of Medicaid Enrollment and Spending in Alaska	1
1 INTRODUCTION.....	7
1.1 IMPACT OF COVID-19 ON EMPLOYMENT IN ALASKA	8
1.2 THE AFFORDABLE CARE ACT	10
Medicaid Expansion	10
Modified Adjusted Gross Income (MAGI).....	11
No Wrong Door.....	11
Insurance Mandate	11
1.3 RECENT INITIATIVES THAT MAY AFFECT ALASKA’S MEDICAID PROGRAM IN THE NEXT FEW YEARS.....	12
Behavioral Health System Reform.....	12
Behavioral Health Pandemic Response	13
Health Care and Tribal Health Services Reforms.....	14
Senior and Disability Services Reforms	14
1.4 THE LONG-TERM MEDICAID FORECAST	15
1.5 RECENT HISTORICAL TRENDS IN MEDICAID SPENDING	15
Recent Historical Trends in State Medicaid Spending	16
The Role of Medicaid in Providing Health Insurance to Alaskans	17
1.6 VARIATION IN ENROLLMENT AND SPENDING ON MEDICAID SERVICES BY RURAL / URBAN STATUS.....	18
2 OVERVIEW OF PROJECTIONS: FY2021-FY2041	21
2.1 LONG-TERM POPULATION PROJECTIONS.....	21
2.2 ENROLLMENT IN THE MEDICAID PROGRAM	23
2.3 UTILIZATION OF MEDICAID SERVICES.....	27
2.4 INTENSITY OF USE OF MEDICAID SERVICES.....	29
2.5 TOTAL SPENDING ON MEDICAID SERVICES.....	30
Enrollment in and Spending on Medicaid Services by Rural/Urban	34
State Spending on Medicaid Services	35
Other Medicaid Payments and Offsets	38
2.6 SPENDING ON MEDICAID ENROLLEES WITH CHRONIC CONDITIONS.....	40
Identifying Medicaid Beneficiaries with a Chronic Condition.....	40
Characteristics of Beneficiaries with Chronic Conditions.....	43
Projected Spending on Medicaid Services for Recipients with Chronic Conditions	49
3 APPENDIX TABLES	51

List of Tables

Table 1: Projected State and Federal Spending on Medicaid Services (in Millions \$)	6
Table 2: Distribution of Alaska Population by Rural / Urban Status, FY2020	19
Table 3: Expected and Actual Spending on the 10 Medicaid Services in FY2019 With the Highest Spending, Segmented in Millions \$.....	20
Table 4: Alaska’s Projected Population by Age Cohort for Selected Years 2021–2041	23
Table 5: Medicaid Enrollment and Recipients by Age Cohort for Selected Fiscal Years	25
Table 6: Medicaid Enrollment and Recipients as a Proportion of Alaska’s Population, For FY2015 and Selected Future Fiscal Years.....	26
Table 7: Medicaid Enrollees and Recipients for Selected Eligibility Groups, FY2021 – FY2041.....	26
Table 8: Service Category Designations Used in the Long-Term Medicaid Forecast	27
Table 9: Number of Medicaid Service Categories Utilized in FY2019	28
Table 10: Most Frequently Utilized Medicaid Service Categories, FY2021 – FY2041	29
Table 11: Medicaid Spending by Age Cohort, FY2021 – FY2041 (Millions \$).....	30
Table 12: Projected Spending on Medicaid Services by Broad Category (Millions \$)	32
Table 13: Projected Population, Medicaid Enrollment, and Medicaid Spending by Rural/Urban, FY2021 – FY2041	34
Table 14: Projected State and Federal Spending on Medicaid Services (in Millions \$)	37
Table 15: Total Projected Medicaid Spending, FY2021 – FY2041.....	39
Table 16: Chronic Conditions Considered in Long-Term Forecast	41
Table 17: Spending Per Recipient on Medicaid Services and Incremental Cost of Chronic Conditions, FY2019	46
Table 18: Total Incremental Cost of Chronic Conditions on Medicaid Spending, FY2019 ..	47
Table 19: Distribution of Medicaid Recipients and the Cost of Providing Medicaid Services by the Number of Diagnosed Chronic Conditions, FY2019	49
Table 20: Medicaid Service Category Descriptions for Long-Term Forecast	51
Table 21: Medicaid Eligibility Classification Descriptions.....	52
Table 22: Population Proportion by Rural & Urban, Alaska Boroughs and Census Areas .	53
Table 23: Forecast of Population by Demographic Group.....	54
Table 24: Forecast of Enrollment by Demographic Group	55
Table 25: Forecast of Spending by Demographic Group (Millions \$)	56
Table 26: Forecast of Total Spending on Medicaid (Millions \$)	57
Table 27: Forecast of State Spending on Medicaid (Millions \$).....	58

List of Figures

Figure 1: Spending on Medicaid Services – Actual and Projected	2
Figure 2: Medicaid Recipients – Actual and Projected	3
Figure 3: Medicaid Spending per Recipient – Actual and Projected	3
Figure 4: Medicaid Recipients as a Proportion of Alaska’s Population for Selected Fiscal Years 2015–2041	4
Figure 5: Spending on Medicaid Services by Component of Growth.....	5
Figure 6: Average State and Federal Spending Per Medicaid Recipient by Fiscal Year*	6
Figure 7: Weekly Unemployment Data for Alaska: Long-Term (pre-Pandemic) Average and Weekly Claims Since Mid-March 2020	8
Figure 8: Year-Over-Year Percent Change in Medicaid Enrollment, Jul 2019 - Dec 2020	10
Figure 9: Average Annual Spending on Medicaid Services for 146 Recipients Who Received 1115 Waiver Services in FY2020 and Received Medicaid Services in the Previous Five Fiscal Years	13
Figure 10: Total Cost of Medicaid Services by Fiscal Year in Which Service Occurred	16
Figure 11: Spending on Medicaid Services, Enrollment in the Medicaid Program, and Recipients of Medicaid Services, Based on Date of Service, FY2012 – FY2020	17
Figure 12: Recent Trends in Health Insurance Coverage in Alaska	18
Figure 13: The Five Steps to Develop the Alaska Long-Term Medicaid Forecast.....	21
Figure 14: Alaska's Population and Annual Growth Rates from 1950–2040.....	22
Figure 15: Total Spending on Medicaid Claims by Age Cohort, FY2021 – FY2041	31
Figure 16: Average Spending Per Recipient on Medicaid Services by Age Cohort, FY2021 – FY2041.....	32
Figure 17: Projected Spending on Medicaid Services by Component of Growth	33
Figure 18: Average State and Federal Spending Per Medicaid Recipient by Fiscal Year* ...	38
Figure 19: Distribution of Medicaid Recipients by Age and Diagnosis of One or More Chronic Conditions, FY2019.....	43
Figure 20: Proportion of Recipients with One or More Diagnosed Chronic Conditions	45
Figure 21: Average Number of Diagnosed Chronic Conditions by Age for Medicaid Recipients Diagnosed with at Least One Chronic Condition, FY2019.....	48
Figure 22: Projected Spending on Medicaid Services, FY2021 – FY2041	50

Executive Summary

This forecast is an update to the *Long-Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025*, which was released 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) 2021 through FY2041. The projections presented in this report are based on the Medicaid policies, services offered, and eligibility requirements in place today. While it is likely that Alaska's Medicaid program will experience changes during the projection period, the 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 implemented during the forecast period.

Impacts of COVID-19 on Healthcare in Alaska

The initial response to the COVID-19 pandemic was a substantial reduction in utilization and spending on healthcare services in Alaska and across the U.S. as hospitals, clinics, and other providers canceled or postponed elective procedures.¹ 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.² Utilization and spending on healthcare services did partially rebound in the third quarter of calendar year (CY) 2020, but data are not yet available to determine if that rebound continued in the final months of 2020.³ Nevertheless, despite the substantial impact that COVID-19 has had and continues to have on Alaska communities, businesses, and health care systems, we do not anticipate that the pandemic will have long-term impacts on Alaska's Medicaid program.

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

Figure 1 shows actual spending on Medicaid services from FY1998 through FY2020 (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

¹ 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.

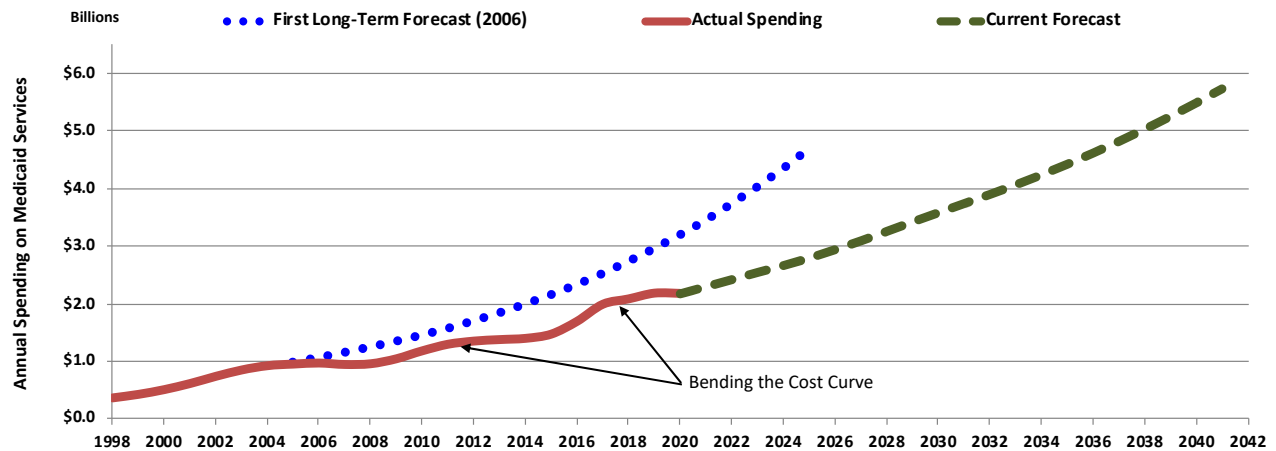
<https://www.healthsystemtracker.org/chart-collection/how-have-healthcare-utilization-and-spending-changed-so-far-during-the-coronavirus-pandemic/#item-start>

² 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/>

³ Ibid.

Medicaid services provided in FY2020 was nearly \$1.0 billion less than was projected in the first long-term Medicaid forecast. Much of this difference is attributable to cost saving efforts by the Alaska Legislature and the Alaska Department of Health and Social Services (DHSS), which helped “bend the cost curve” on Medicaid spending.

Figure 1: Spending on Medicaid Services – Actual and Projected

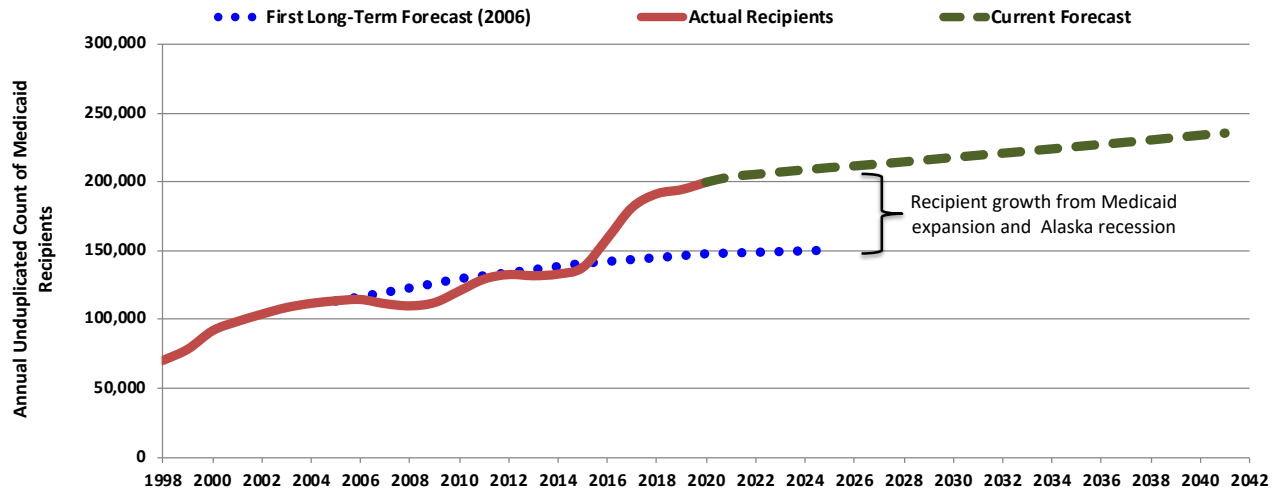


Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Figure 2 shows the number of Medicaid enrollees who received Medicaid services (referred to as “recipients”) each year from FY1998 through FY2020 and the projected number of Medicaid recipients based on the first long-term Medicaid forecast and this current forecast.⁴ 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, or the ACA (e.g., the individual mandate), and the Alaska economic recession that began in late 2014 and extended into 2019, enrollment in Medicaid increased considerably. For the current forecast, we expect the number of Medicaid recipients to continue to grow, but at a decreasing rate through the projection period.

⁴ 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 FY2020, about 77 percent of Medicaid enrollees were also recipients. Stated another way, about 23 percent of Medicaid enrollees did not receive any Medicaid services in FY2020.

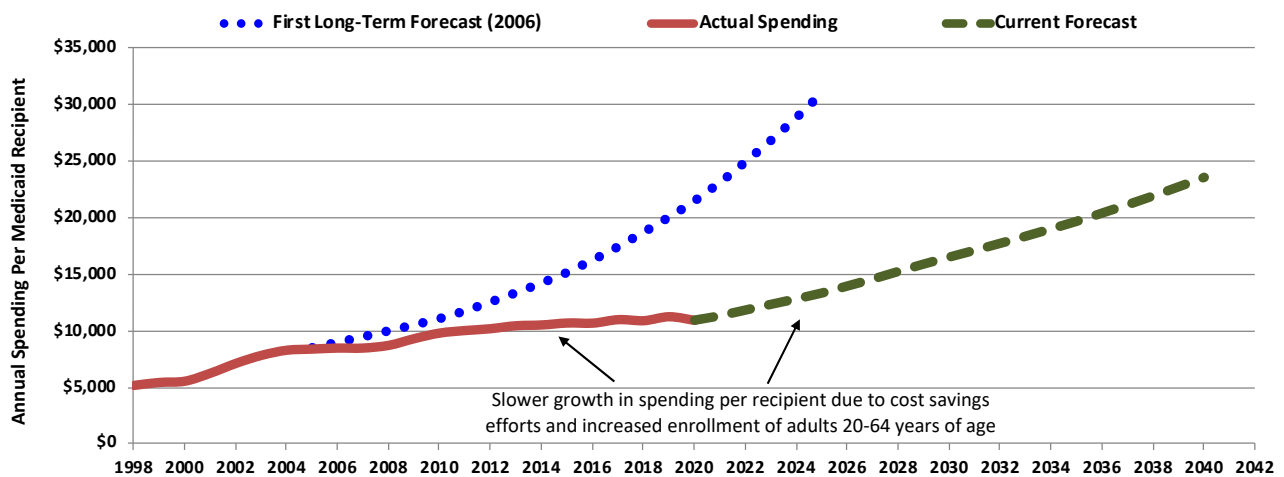
Figure 2: Medicaid Recipients - Actual and Projected



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

Spending on Alaska’s Medicaid program is considerably less today than was projected in the first long-term Medicaid forecast. At the same time, Medicaid enrollment and the number of recipients are much greater today than was predicted. The net effect of lower-than-projected spending and greater-than-projected enrollment 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 much slower rate.

Figure 3: Medicaid Spending per Recipient - Actual and Projected



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

Across all age cohorts, the proportion of Alaskans receiving services through the Medicaid program has grown, and we expect it to continue to grow – though at a slower rate – throughout the projection period. Figure 4 shows the proportion of Alaska children,⁵ adults, and seniors who received Medicaid services in FY2015 and are projected to receive Medicaid services over the next 20 years. Due primarily to Medicaid expansion, about 23 percent of adults will receive services through Alaska’s Medicaid program in FY2021, up from just 11 percent in FY2015. We project that 25 percent of Alaska adults will be Medicaid recipients by FY2031 and that this proportion will remain roughly constant through FY2041.

We project that the proportion of seniors receiving Medicaid services will grow from 12.8 percent today to 15.4 percent by FY2041, and that the proportion of Alaska children receiving Medicaid services (or services through the Children’s Health Insurance Program [CHIP]) will grow from 44 percent today to 50 percent in FY2041.

Figure 4: Medicaid Recipients as a Proportion of Alaska’s Population for Selected Fiscal Years 2015–2041



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

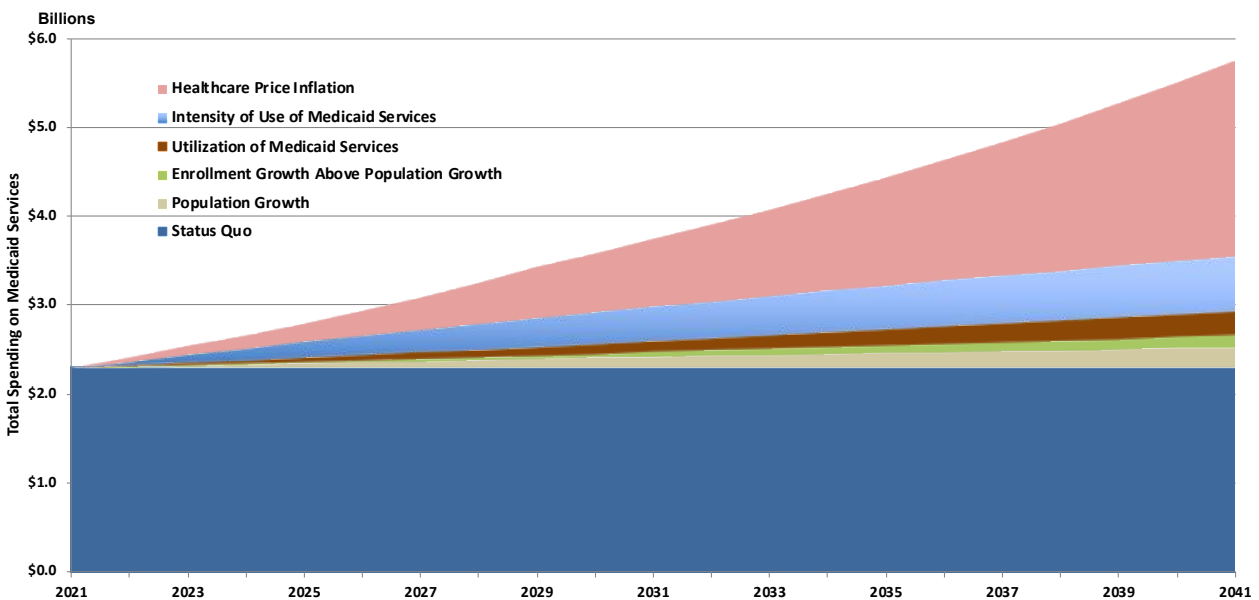
We project that total Medicaid spending will increase on average by 4.7 percent per year between FY2021 and FY2041, reaching \$2.95 billion in FY2026 and \$5.74 billion by FY2041. This projected rate of growth in Medicaid spending is substantially lower than the projected growth rate from the first long-term forecast completed in 2006. In that forecast,

⁵ 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.

spending on Medicaid services was projected to grow on an annual average basis by 7.8 percent, reaching \$4.7 billion by CY2025.⁶

We expect healthcare price inflation to be the primary driver of spending growth in Alaska’s Medicaid program, accounting for about 64 percent of the growth in spending between FY2021 and FY2041 (see Figure 5). Healthcare price inflation may not directly impact what DHSS pays providers for services in any given year. Nevertheless, DHSS has processes in place to work with providers to periodically update the schedule of rates paid for Medicaid services, and rates typically adjust upward every one to four years, roughly in line with the rate of healthcare price inflation affecting providers.

Figure 5: Spending on Medicaid Services by Component of Growth



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

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 FY2041, we project that growth in the population, growth in the proportion of Alaskans enrolling in Medicaid, and growth in utilization and intensity of

⁶ Note: the original long-term Medicaid forecast and each annual update through 2017 was based on calendar year. The forecast was changed to fiscal year beginning with the FY2019 – FY2039 update completed in October 2018.

Medicaid services will combine to increase spending on the Medicaid program by about \$1.25 billion.

The proportion of the cost of a Medicaid service that the state and federal governments are each responsible for is a function of the eligibility status of the Medicaid recipient and, in certain cases, the facility in which the recipient receives care. We project that spending on Medicaid services will grow on average by just under 4.7 percent per year through FY2041, with slightly faster growth in spending by the State of Alaska (see Table 1).

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

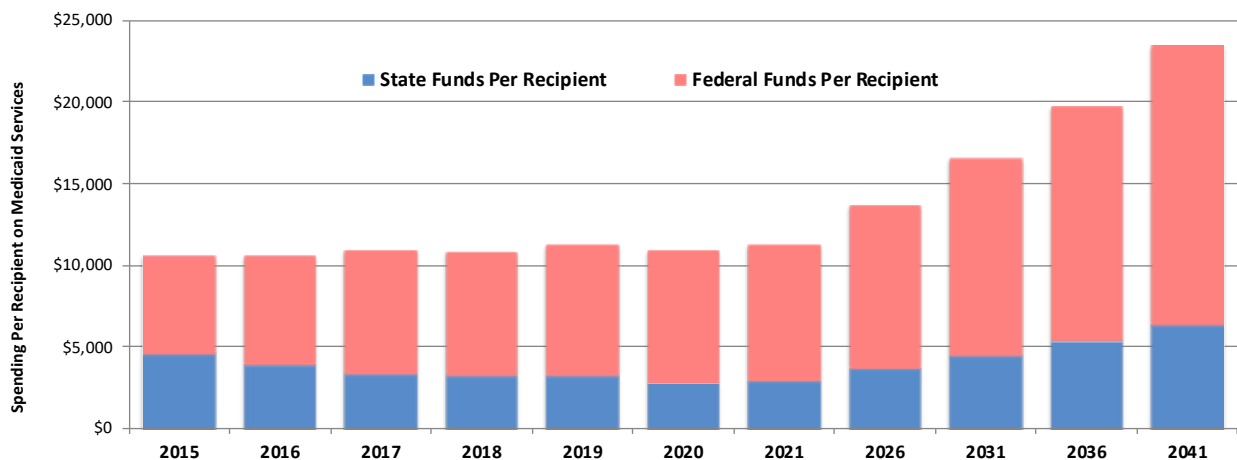
Fund Source	2015	2021	2026	2031	2036	2041	Annual Growth
State and Other Match Funds	\$681	\$588	\$783	\$987	\$1,207	\$1,481	4.7%
Federal	\$901	\$1,719	\$2,168	\$2,763	\$3,420	\$4,262	4.6%
Total Spending*	\$1,582	\$2,308	\$2,951	\$3,750	\$4,628	\$5,743	4.66%

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

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

Figure 6 shows recent actual and projected future average spending per Medicaid recipient. Between FY2015 and FY2020, spending per Medicaid recipient was flat, and the proportion paid with state general funds actually decreased. Over the next 20 years, we project average spending per recipient will increase by about 3.8 percent per year due primarily to growth in healthcare price inflation and the aging of Alaska's population.

Figure 6: 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 - FY2019 are actuals, FY2020 is estimated, FY2021 - FY2041 are projected.

I Introduction

Medicaid is an entitlement program established by Title XIX of the Social Security Act in 1965 to provide payment for healthcare services for low-income citizens. Medicaid is jointly funded by the federal government and individual states, with each state managing its own program. Participation in the Medicaid program is optional, but all states choosing to participate in the program 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.⁷ In state fiscal year (FY) 2014 and FY2015, the federal government paid approximately 57 percent of the cost of Alaska's Medicaid program.⁸ Federal participation was nearly 74 percent in FY2020, and we expect it to be at least 75 percent in FY2021 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. Federal participation will drop slightly in FY2022 and remain between 73 percent and 74.5 percent through the end of the forecast period (FY2041).

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,⁹ 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 time to adults who meet certain income requirements, but were not previously eligible for Medicaid.¹⁰

In Alaska, the Division of Health Care Services administers CHIP, and the Division of Public Assistance manages enrollment for regular Medicaid and CHIP.¹¹ Alaska Medicaid reimburses hospitals, physicians, and other healthcare providers for providing healthcare

⁷ 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.

⁸ 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 on page 33 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. In comparison, federal fiscal years begin October 1 and end September 30. For example, FY2020 began July 1, 2019 and ended June 30, 2020.

⁹ 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.

¹⁰ 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.

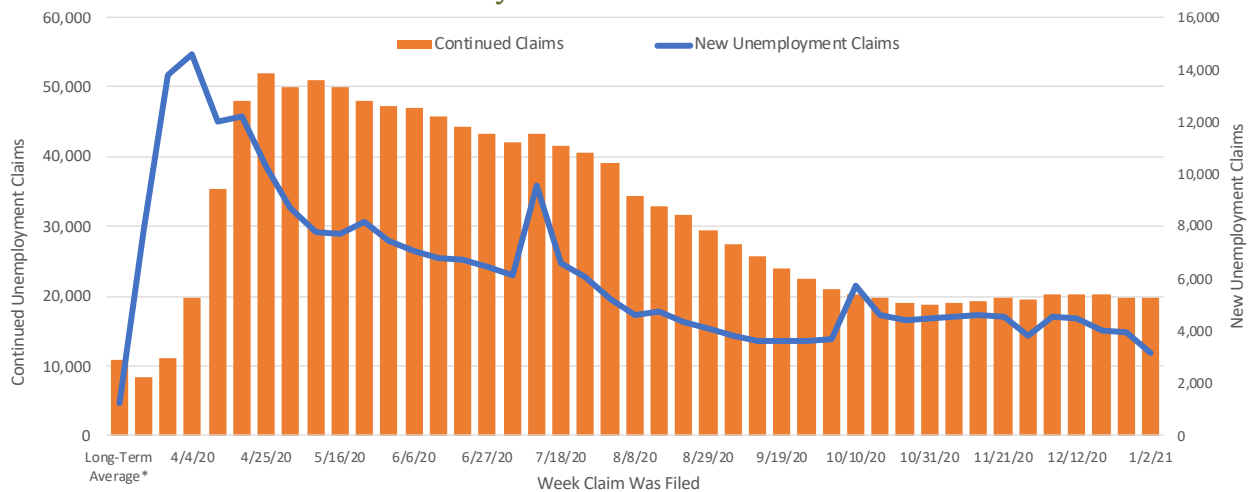
¹¹ Both divisions are within the Department of Health and Social Services (DHSS).

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 Employment in Alaska

The economic shutdowns instituted by governors across the U.S. in an attempt to stem the rapid growth of the COVID-19 pandemic resulted in an unprecedented spike in unemployment. In the U.S. and in Alaska, first-time unemployment claims peaked in the first week of April 2020, and continued unemployment claims peaked in the last week of April 2020 (see Figure 7).¹² Since then, both have slowly declined, but remain well above pre-pandemic levels. Continued unemployment claims have hovered around 20,000 since early October 2020 and will likely stay at or near this level through at least the first quarter of CY2021.

Figure 7: Weekly Unemployment Data for Alaska: Long-Term (pre-Pandemic) Average and Weekly Claims Since Mid-March 2020



Source: Analysis by Evergreen Economics of data from U.S. Bureau of Labor Statistics (BLS).

* Average weekly new and continued claims, January 1, 2013 – March 14, 2020.

During the seven years prior to the COVID-19 outbreak – represented by the point on the horizontal axis labeled “Long-Term Average” in Figure 7 – new unemployment claims averaged about 1,300 per week, and total continued claims averaged fewer than 11,000. This seven-year period provides an appropriate baseline for considering the severity of COVID-19’s impact on Alaska. These seven years were a time of relative economic

¹² Continued claims represent the number of people who have already filed an initial claim for unemployment insurance, have experienced a subsequent week of unemployment, and have then filed a continued claim in order to receive benefits for that week of unemployment.

difficulty in Alaska set off by a steep drop in worldwide prices for oil and natural gas beginning in late 2014. The state endured its longest recession (2015–2019) and has experienced a net loss in population over the past four years (from 740,637 in July 2016 to 728,903 in July 2020).¹³

Nationally, the large number of Americans who have lost their jobs due to the pandemic has led to increased enrollment in Medicaid.¹⁴ At the same time, restrictions enacted by state and local governments on businesses to combat the spread of COVID-19, as well as higher unemployment rates, have resulted in falling state tax revenues. Before the COVID-19 pandemic, the federal government paid at least half the cost of Medicaid services for regular (non-expansion) Medicaid recipients and 90 percent of the cost of services for recipients enrolled through Medicaid expansion. In March 2020 the federal government temporarily increased the medical assistance percentage (retroactive to January 2020) to assist states with funding during the pandemic. The additional funding from the federal government has been extended twice and is currently scheduled to continue through June 2021. Figure 8 shows the year-over-year percent change in Medicaid enrollment from July 2019 (first month of FY2020) through December 2020.¹⁵ Medicaid enrollment grew each month from March 2020, when Governor Michael Dunleavy declared a state of emergency, through November 2020,¹⁶ but the rates of growth are only marginally higher than the program experienced in the previous eight months.

¹³ Alaska Department of Labor and Workforce Development, Research and Analysis, “Population Estimates,” Population and Components of Change, 1945 to 2020 Excel file.

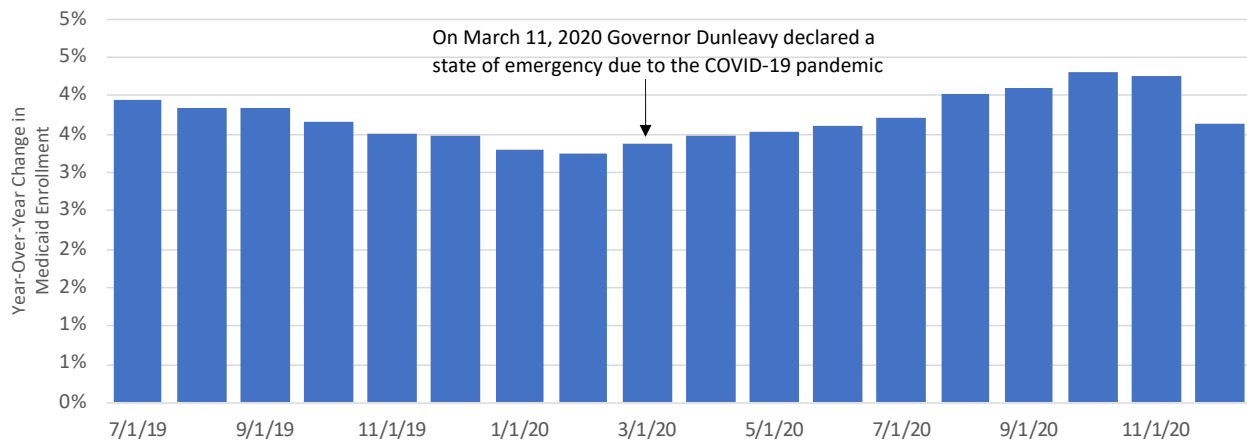
<https://live.laborstats.alaska.gov/pop/index.cfm>

¹⁴ Stephanie Armour, “Medicaid Enrollment Surge During Pandemic Leaves States Looking for Cost Cuts,” *Wall Street Journal*, November 27, 2020. <https://www.wsj.com/articles/medicaid-enrollment-surge-during-pandemic-leaves-states-looking-for-cost-cuts-11606489203>

¹⁵ Year-over-year percent change measures the rate of growth in one month relative to the same month in the prior year. For example, for July 2019, the year-over-year percent change in Medicaid enrollment is the percent change in enrollment between July 2018 and July 2019.

¹⁶ Medicaid enrolment for December is preliminary and may be adjusted higher or lower.

Figure 8: Year-Over-Year Percent Change in Medicaid Enrollment, Jul 2019 - Dec 2020



Source: Analysis by Evergreen Economics of data from U.S. Bureau of Labor Statistics (BLS).

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.

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 is scheduled to remain.¹⁷

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

¹⁷ 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.

only qualify for Medicaid based on the determination of having a qualified disability and meeting income requirements specific to the individual's living arrangement.¹⁸

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.¹⁹ The likely result for Alaska's Medicaid program is that the MAGI standard has led to higher rates of Medicaid enrollment.

No Wrong Door

The "no wrong door" provision of the ACA allows an individual to complete a single streamlined application in order to determine eligibility for a host of entitlement programs, including Medicaid, CHIP, and qualified health plans (QHP) 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.

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

¹⁸ For information on income eligibility for Medicaid, see Alaska Department of Health and Social Services Division of Public Assistance, "Medicaid." <http://dhss.alaska.gov/dpa/Pages/medicaid/>

¹⁹ 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.

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.²⁰ 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, DHSS adopted new requirements that became effective 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 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 definition for substance use disorder counselors.

Behavioral Health System Reform

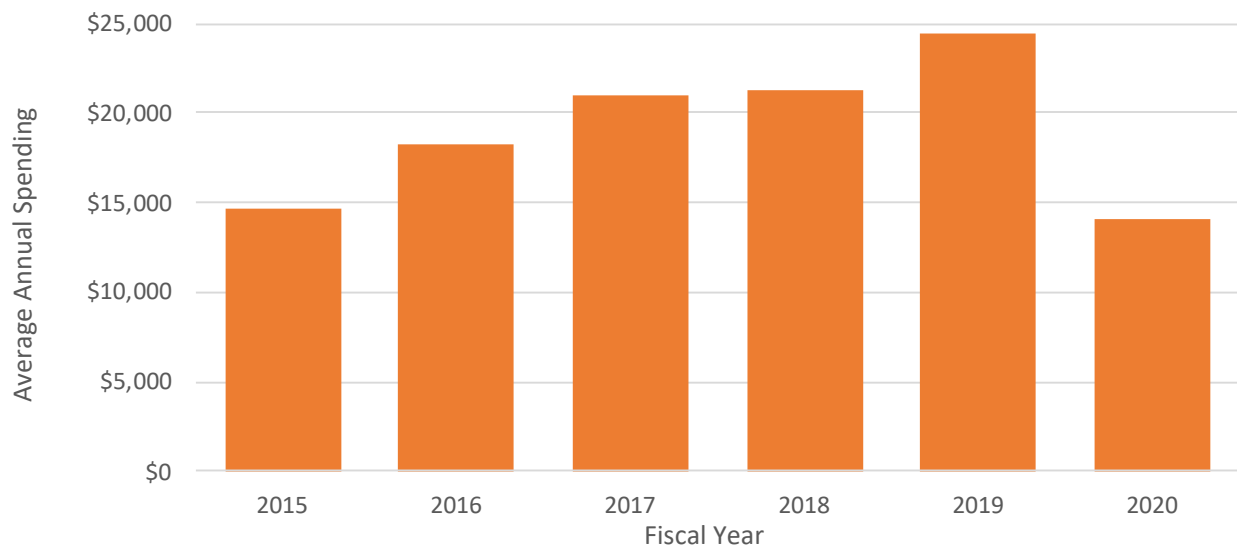
SB 74 directed DHSS to apply for an 1115 Waiver to improve access to services, improve population health outcomes, contain costs, and increase the types of behavioral health providers serving Medicaid recipients. Implementation of Alaska's 1115 Waiver demonstration project continued in 2020. The department transferred claims processing for the 1115 Waiver substance use disorder (SUD) services from the Division of Health Care Services (HCS) contractor, Conduent, to the Administrative Service Organization (ASO) contracted through the Division of Behavioral Health (DBH). The ASO assumed claims processing for the 1115 Waiver behavioral health services in May 2020 and a portion of the Alaska Medicaid state plan services in July 2020. The remaining state plan services are scheduled to transition to the ASO in July 2021.

In FY2020, 571 Medicaid enrollees received 1115 Waiver services, and total spending on these recipients in FY2020 was \$9.7 million (about \$17,000 per recipient). Of these, 146

²⁰ For information on the ACA individual mandate to purchase health insurance, please see "The Requirement to Buy Coverage Under the Affordable Care Act," KFF, August 2, 2017. <http://kff.org/infographic/the-requirement-to-buy-coverage-under-the-affordable-care-act/>

received Medicaid services in each of the previous five fiscal years (FY2015 – FY2019).²¹ As Figure 9 shows, the average spending per Medicaid recipient for these 146 individuals increased each year from FY2015 through FY2019. Over this period, average annual spending per recipient increased by \$9,800 (67%), but then dropped between FY2019 and FY2020 by \$10,335. While the data do not indicate why average annual spending dropped by so much in just the one year, this was the first year in which the 1115 Waiver became available to Alaska Medicaid recipients.²²

Figure 9: Average Annual Spending on Medicaid Services for 146 Recipients Who Received 1115 Waiver Services in FY2020 and Received Medicaid Services in the Previous Five Fiscal Years



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

Behavioral Health Pandemic Response

Over the past year, the COVID-19 pandemic has rapidly changed how Alaskans receive behavioral health treatment. DHSS’s response has been focused on expanding access to behavioral health treatment and seeking out new funding opportunities to distribute support to communities for both new and continuing services. By increasing telehealth flexibilities and utilization during Alaska’s Public Health Disaster Emergency Declaration,

²¹ Note: The 1115 Waiver was not available to Alaska Medicaid recipients prior to FY2020 and so these Medicaid services were provided without the 1115 Waiver.

²² Access to healthcare services in Alaska and across the U.S. and the world have been impacted since mid-March 2020 due to disruption caused by COVID-19, which resulted in lower-than-expected Medicaid spending during the last quarter of FY2020 (April – June 2020).

behavioral health providers are able to offer telemedicine options when face-to-face encounters jeopardize the health and safety of treatment recipients and providers.

Health Care and Tribal Health Services Reforms

Alaska's Medicaid program currently operates primarily on a fee-for-service provider reimbursement basis. The Coordinated Care Demonstration Project Initiative is intended to test new healthcare delivery and payment models to determine the most cost-effective and highest-quality approach for Alaska. The Medicaid program awarded a contract to a provider to test the Patient-Centered Medical Home model in Anchorage. The Division of Health Care Services will analyze and report on the efficacy of the demonstration project.

Medicaid services provided to American Indians and Alaska Natives (AI/ ANs) through a federal or tribal health facility are reimbursed to the state at 100 percent federal financial participation (FFP). In February 2016, the Centers for Medicare and Medicaid Services (CMS) issued State Health Official Letter #16-002, which updated its policy regarding federal funding for services "received through" a federal/tribal facility and provided to Medicaid-eligible individuals who are AI/ AN. This change in federal policy authorizes 100 percent federal funding for services provided to AI/ AN Medicaid recipients in a non-federal/tribal facility if the recipient's tribal health organization has a care coordination agreement established with the non-tribal facility and there is documentation of a referral and an exchange of records for the care received. SB 74 directed DHSS to fully implement this policy. With the department's continued partnership with tribal health organizations and more than 4,600 care coordination agreements signed between tribal and non-tribal providers, the department to-date has been able to save over \$240 million in state general funds through implementation of this policy.

Senior and Disability Services Reforms

SB 74 authorized the Alaska Medicaid program to implement two new State Plan options for long term services and support: 1915(k) Community First Choice and the 1915(i) Home and Community-Based Services benefit. After a thorough analysis and with community stakeholder involvement, the department moved forward with the 1915(k) option, but decided not to implement 1915(i) due to budgetary concerns. In lieu of the 1915(i) option, the department has implemented a new 1915(c) waiver. Both initiatives became operational October 1, 2018 (FY2019). The Community First Choice option provides enhanced personal care services, including skills training to foster independence and self-care, for recipients who meet institutional level of care criteria. The new 1915(c) waiver – the Individualized Supports Waiver – provides services under a per-individual annual dollar cap to recipients with intellectual and developmental disabilities who meet institutional level of care criteria. In FY2021, the Department expects to transfer Chore Services out of Home and Community Based (HCB) Waiver Services and into the

Community First Choice program, in order to receive an additional 6 percentage points in federal financial participation.

I.4 The Long-Term Medicaid Forecast

In this study, we develop long-term forecasts of spending for 20 categories of services provided through Alaska’s Medicaid program. We also develop forecasts of spending by gender, by AI/ AN status,²³ and for twelve age groups. This document presents the results of the FY2021-FY2041 projection of enrollment in and spending on the Medicaid program in Alaska. It is the fourteenth update to the original long-term Medicaid forecast, which DHSS engaged the Lewin Group to conduct in April 2005.

The purpose of this forecast is to serve as a benchmark and inform the Alaska Legislature and DHSS of the projected long-term trends in Medicaid enrollment and spending under the assumption that the current mix of Medicaid services remains constant and that eligibility criteria do not change. 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 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.

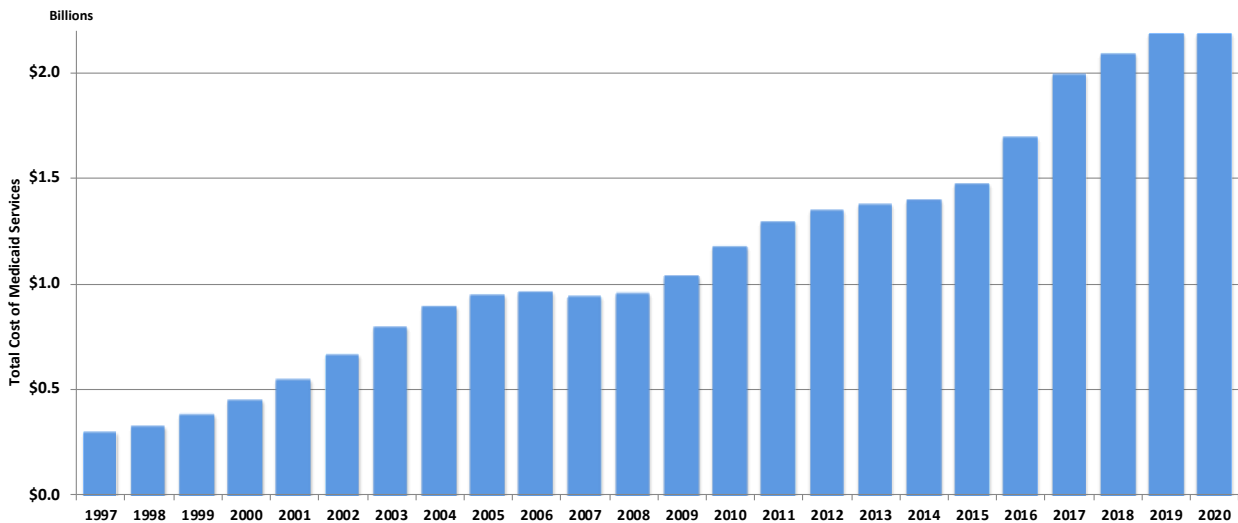
I.5 Recent Historical Trends in Medicaid Spending

Spending on Alaska’s Medicaid program grew rapidly from FY1997 through FY2005, increasing an average of 16 percent per year (see Figure 10).²⁴ Medicaid spending actually decreased 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.

²³ Alaska Native, American Indian, and other race categories are based on self-identification of Medicaid enrollees. In FY2020, 93,793 Medicaid enrollees reported their race as either Alaska Native or American Indian. Of these, 3,751 (4.0%) identified as American Indian.

²⁴ FY1997 is the earliest year for which we had data on spending.

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; FY2020 estimated.

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., 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 slowed in FY2018 and FY2019 and was flat in FY2020.

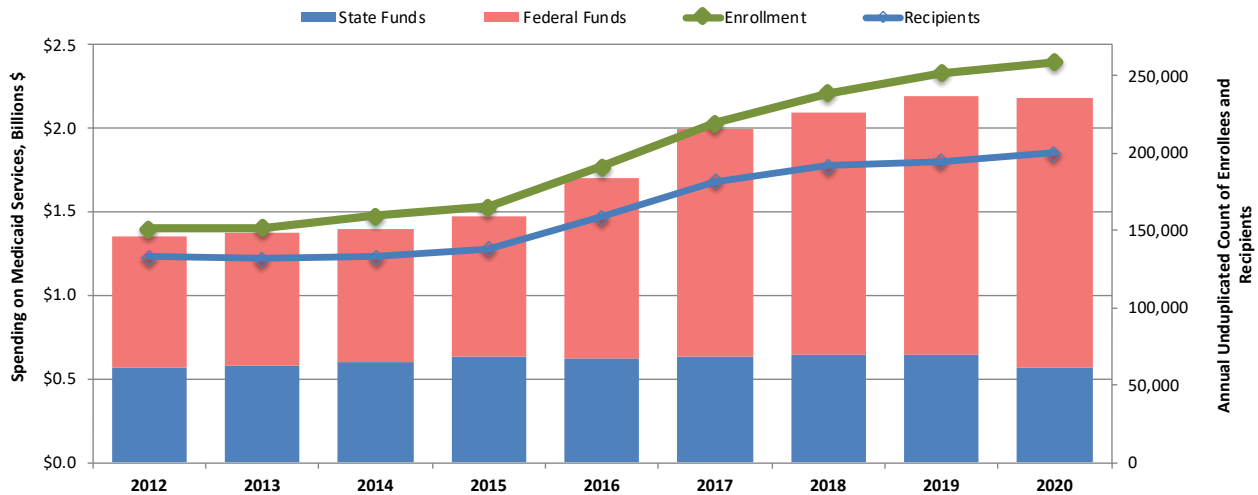
Recent Historical Trends in State Medicaid Spending

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.²⁵ Figure 11 shows total spending on Medicaid services for FY2012 through FY2020, split by state and federal funding, and the trend in Medicaid enrollment and number of recipients over this same period.²⁶

²⁵ 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.” On October 7, 2020, the Secretary of Health and Human Services (HHS) extended the public health emergency through March 2021.

²⁶ 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 – FY2020



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group; 2020 estimated.

The Role of Medicaid in Providing Health Insurance to Alaskans

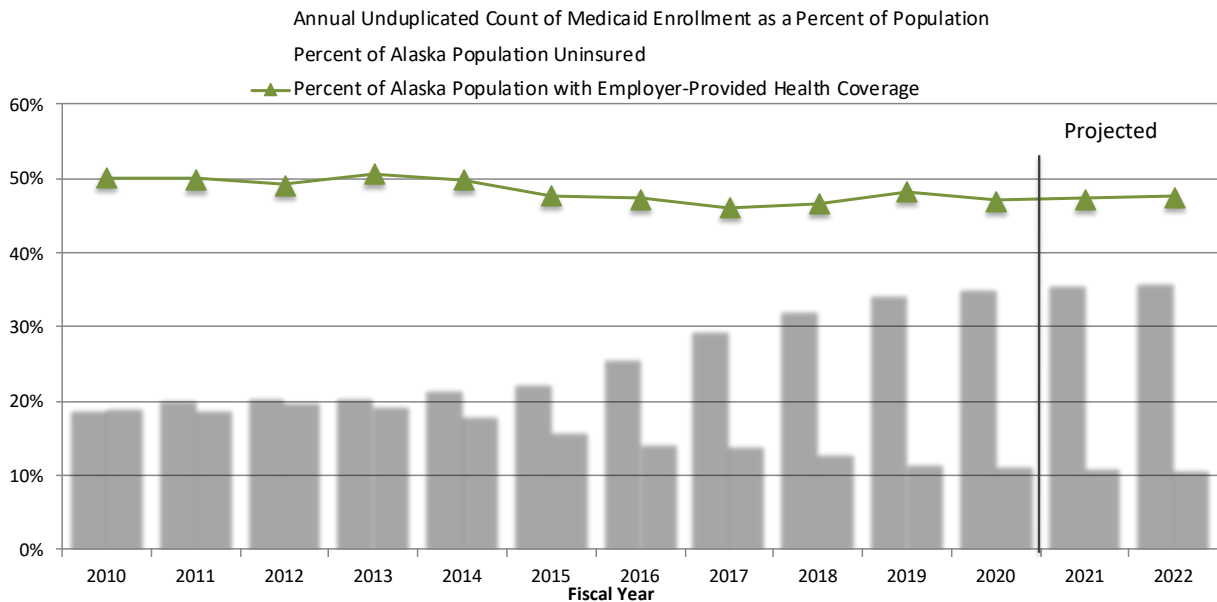
Medicaid’s role as a provider of healthcare insurance in Alaska has grown significantly. In FY1998, 14 percent of Alaskans were enrolled in Medicaid all or part of the year, and by FY2020, the proportion of Alaskans enrolled in Medicaid had grown to about 35 percent. Due to Medicaid expansion and other components of the ACA, growth in the proportion of Alaskans enrolled in Medicaid was especially strong after FY2015 (see 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 11.5 percent in CY2019.²⁷ Evergreen Economics projects that the proportion of Alaskans without health insurance coverage will continue to decline slightly to about 10.3 percent in FY2022. The proportion of Alaskans receiving health insurance through an employer decreased from 51 percent in CY2010 to 48.4 percent in CY2019, where we expect it to remain.²⁸ Potential reasons for the decline in employer-provided health insurance coverage include the recent economic recession in Alaska and the ongoing impacts of COVID-19 nationally, as well as shifting by employees to the federal health insurance exchange or to the Medicaid program.

²⁷ “KFF’s State Health Facts, “Health Coverage & Uninsured,” KFF. <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>

²⁸ Ibid.

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., FY2019 is the average of CY2018 and CY2019).

1.6 Variation in Enrollment and Spending on Medicaid Services by Rural / Urban Status

In this update of the long-term Medicaid forecast, we include projections of enrollment in and spending on Medicaid services based on rural/urban status. To define what is rural and what is urban in Alaska, we used U.S. Census designations, which define rural as any population, housing, or territory *not* in an urban area.²⁹ This of course begs the question *what is urban?* U.S. Census defines urban as either “urbanized areas,” which have a population of 50,000 or more, or “urban clusters,” which have a population of at least 2,500 (and less than 50,000).³⁰ Based on these definitions, only 34 percent of Alaskans currently live in a rural area, which places Alaska fourteenth among the states with respect to the proportion of the population living in rural areas.³¹ Table 22 in the appendix of this report shows the proportion of rural and urban population for each borough and Census area in Alaska. Perhaps ironically, the two most rural states with respect to where residents live—

²⁹ U.S. Census Bureau, “2010 Census Urban and Rural Classification and Urban Area Criteria.” <https://www.census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural/2010-urban-rural.html>

³⁰ Ibid

³¹ Ibid

Maine and Vermont – are located in the Northeast, which is the most densely populated region of the U.S.

Table 2 shows the distribution of Alaska’s population and Medicaid enrollment by rural/urban status. Nearly 250,000 Alaskans (about one in three) live in a Census-defined rural area, while the majority of Alaskans live in urbanized areas or urban clusters (again, as defined by the Census). While most Medicaid enrollees live in urban areas, a greater proportion of Alaska’s rural population is enrolled in Medicaid (41%) than is the population living in urban areas (32%).

Table 2: Distribution of Alaska Population by Rural / Urban Status, FY2020

Metric	Count	Percent of Alaska Population	Percent of Rural or Urban Population
Alaska Population	731,564		
Alaska Rural Population	247,037	34%	
Alaska Urban Population	484,527	66%	
Alaska Medicaid Enrollment*	258,627	35%	
Rural Population on Medicaid	102,222	14%	41% of Rural Population
Urban Population on Medicaid	156,405	21%	32% of Urban Population

* Annual unduplicated count

Table 3 shows expected and actual spending on the 10 Medicaid services in FY2019 for rural and urban recipients with the greatest total spending. Expected spending was computed by multiplying total spending on each Medicaid service by the proportion of Medicaid enrollees who live in rural areas (39.5%) or live in urban areas (60.5%). The difference between actual and expected spending was computed, and the 10 services were ranked based on the magnitude of the differences (from largest negative to largest positive differences for rural recipients).

For several services (e.g., Inpatient Hospital), there was little difference between actual and expected spending. For the others, actual spending on Medicaid services for recipients living in rural areas tends to be greater than expected (and lower than expected in urban areas). The exceptions to this are the Home and Community Based (HCB) Waiver and Pharmacy Medicaid service categories.

Table 3: Expected and Actual Spending on the 10 Medicaid Services in FY2019 With the Highest Spending, Segmented in Millions \$

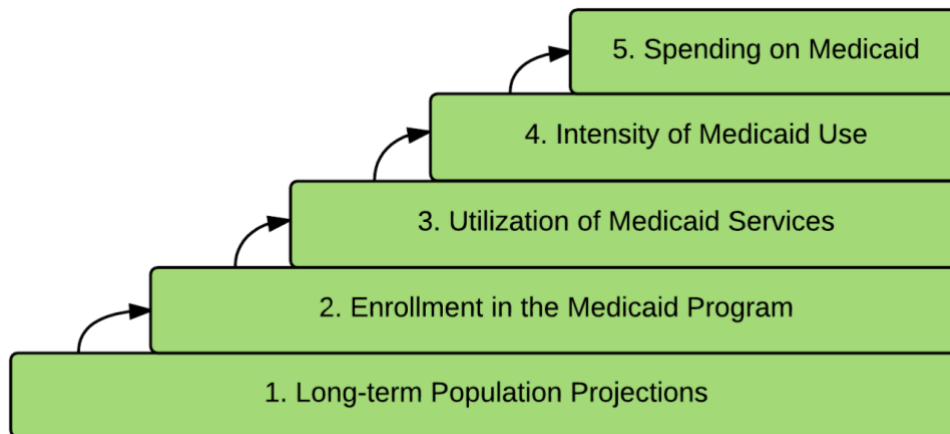
Medicaid Service	Rural (39.5% of Medicaid Enrollees)			Urban (60.5% of Medicaid Enrollees)		
	Total <i>Expected</i> Spending*	Total <i>Actual</i> Spending	Difference (Act - Exp)	Total <i>Expected</i> Spending*	Total <i>Actual</i> Spending	Difference (Actual - Expected)
HCB Waiver	\$107.9	\$76.0	(\$31.8)	\$165.0	\$196.9	\$31.8
Pharmacy	\$61.1	\$57.5	(\$3.6)	\$93.5	\$97.1	\$3.6
Inpatient Hospital	\$133.7	\$134.4	\$0.8	\$204.5	\$203.8	(\$0.8)
Outpatient Mental Health	\$82.8	\$83.6	\$0.8	\$126.7	\$126.0	(\$0.8)
Physician/Practitioner	\$84.7	\$88.5	\$3.9	\$129.5	\$125.7	(\$3.9)
Nursing Home	\$60.3	\$65.4	\$5.1	\$92.3	\$87.1	(\$5.1)
Dental	\$41.8	\$47.4	\$5.6	\$63.9	\$58.3	(\$5.6)
Health Clinic	\$50.0	\$61.5	\$11.5	\$76.5	\$65.0	(\$11.5)
Outpatient Hospital	\$111.6	\$126.8	\$15.2	\$170.7	\$155.6	(\$15.2)
Transportation	\$44.7	\$77.0	\$32.3	\$68.4	\$36.0	(\$32.3)
All Medicaid Services	\$865.3	\$894.5	\$29.2	\$1,323.9	\$1,294.7	(\$29.2)

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

2 Overview of Projections: FY2021-FY2041

The long-term Medicaid forecast follows a highly 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.³² 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) 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

³² A detailed discussion of the analytical methods used to develop the forecast is contained in *Long-Term Forecast of Medicaid Enrollment and Spending in Alaska: Appendix of Methods*.

³³ Alaska Department of Labor and Workforce Development, Research and Analysis, *Alaska Population Projections 2019 to 2045*, April 2020. <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>

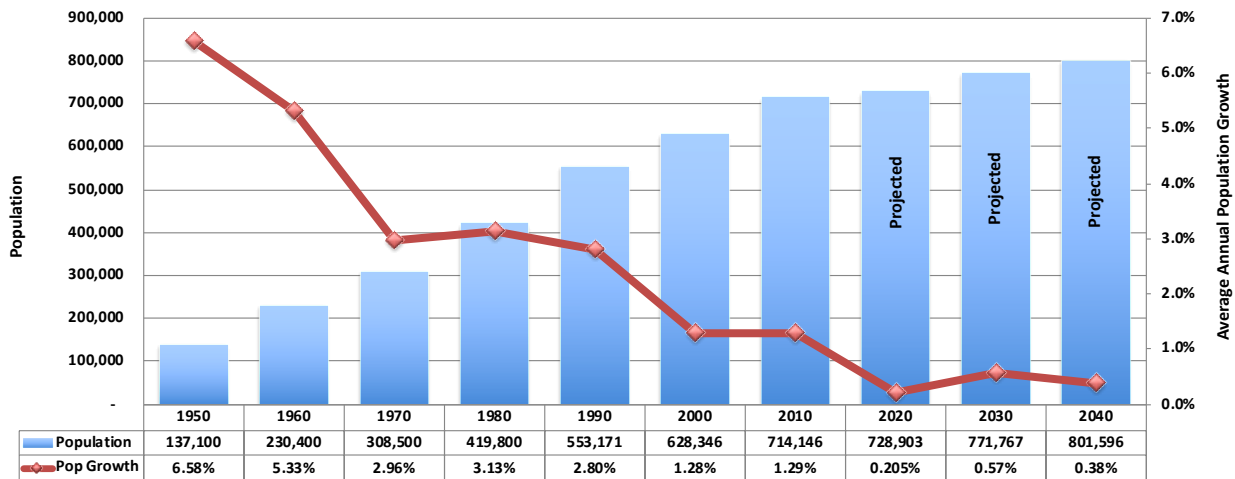
³⁵ U.S. Department of Commerce Bureau of the Census, *1960 Census of Population, Advance Reports: General Social and Economic Characteristics*, April 27, 1962.

<http://www2.census.gov/prod2/decennial/documents/15611103.pdf>

in 1972, the population of 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 (see Figure 14). Between 1990 and 2010, population growth averaged just less than 1.3 percent per year and further slowed to 0.2 percent per year between 2010 and 2020. The Alaska DOLWD projects that the population will grow by about 0.57 percent annually through 2030 and by 0.38 percent per year between 2030 and 2040.³⁹

Figure 14: Alaska's Population and Annual Growth Rates from 1950–2040



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 2019; by 2040, the Alaska DOLWD projects there will be 104 males

³⁶ See the 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, “Pipeline Facts.” <http://alyeska-pipeline.com/TAPS/PipelineFacts>

³⁸ U.S. Department of Commerce Bureau of the Census. *1990 Census of Population and Housing: Population and Housing Unit Counts, Alaska*. 1992. <http://www.census.gov/prod/cen1990/cph2/cph-2-3.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>

for every 100 females.⁴⁰ We expect this to have a small effect on the Medicaid program as adult females, who tend to incur higher average annual costs than adult males, enroll in the Medicaid program at a greater rate.⁴¹ In addition, the senior population is growing at a faster rate than the population as a whole and, though seniors enroll in Medicaid at a much lower rate than children and at a slightly lower rate than adults, the average cost per recipient of providing Medicaid services for seniors is higher than for children or adults.⁴²

Table 4: Alaska’s Projected Population by Age Cohort for Selected Years 2021–2041

Age Group	2021	2026	2031	2036	2041	Avg. Annual Change
Children (0-19)	203,513	206,153	205,436	207,131	211,846	0.20%
Adults (20-64)	431,354	428,782	434,948	447,309	459,515	0.32%
Seniors (65+)	100,140	121,367	133,848	135,530	132,188	1.40%
Total Population	735,007	756,302	774,232	789,970	803,549	0.45%

Source: Analysis by Evergreen Economics of data from Alaska Department of Labor and Workforce Development, Research and Analysis, *Alaska Population Projections 2019 to 2045*, April 2020.
<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 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 the purposes of this report, we assume that eligibility requirements as they exist today will remain constant over the 20-year projection period.

More than half of Alaska children were enrolled in the Medicaid program during all or some portion of FY2020, compared to only one in four adults and one in seven senior Alaskans. Nevertheless, with components of the Patient Protection and Affordable Care Act (ACA) having gone into effect in January 2014—including Medicaid expansion in

⁴⁰ Ibid; nationally, there are 103 females for every 100 males.

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.

September 2015 – the focus of the Medicaid program has expanded to cover a much wider swath of the population. Since FY2017, the Alaska Medicaid program has covered more adults than children, and we expect this to continue through FY2041.

“Medicaid recipients” refers to individuals enrolled in Medicaid who received any Medicaid services during a fiscal year regardless of the type or “amount” of services received. In developing the forecast, we project both enrollment and number of recipients. In presenting the results of the forecast, we consider both enrollees and recipients, but focus greater attention on recipients because – by definition – 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 ACA⁴³ 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. In September 2015, the State of Alaska launched Medicaid expansion, which led to a substantial increase in enrollment of adults. 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.⁴⁴

While many expected that the COVID-19 pandemic would lead to a jump in Medicaid enrollment, that has not happened so far. Between March and October 2020, average monthly enrollment in Medicaid increased by 2.1 percent, which is nearly identical to the rate (2.0%) experienced during the same period in 2019.

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. Table 5 shows the forecast for enrollment and recipients by age cohort through FY2041, with FY2015 as a benchmark (the year before Medicaid expansion began). We expect Medicaid

⁴³ 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/>

⁴⁴ 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.

enrollment to reach nearly 305,000 by FY2041 and the number of recipients to reach almost 244,000.

Table 5: Medicaid Enrollment and Recipients by Age Cohort for Selected Fiscal Years

Age Cohort	Measure	2015	2021	2026	2031	2036	2041	Percent Change*
Children (0-19)	Enrollees	94,799	113,035	117,194	119,882	123,492	128,690	0.65%
	Recipients	79,725	90,067	94,252	97,883	101,197	105,782	0.81%
Adults (20-64)	Enrollees	58,959	135,992	138,542	143,212	148,567	153,502	0.61%
	Recipients	48,254	101,193	103,938	108,957	113,454	117,760	0.76%
Seniors (65+)	Enrollees	11,189	14,773	18,227	20,884	22,033	22,440	2.11%
	Recipients	9,790	12,839	16,062	18,733	19,911	20,421	2.35%
All Ages**	Enrollees	164,947	263,800	273,964	283,978	294,091	304,632	0.72%
	Recipients	137,769	204,099	214,252	225,573	234,562	243,963	0.90%

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

* Average annual percent change between FY2021 and FY2041.

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

In FY2015, about 22 percent of Alaskans were enrolled in Medicaid during all or part of the fiscal year, and 18.5 percent of Alaskans received Medicaid services (see Table 6). Adults 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 more than 30 percent of adults will be enrolled in Medicaid all or part of FY2021. The proportion of children enrolled in Medicaid has also grown since FY2015 due in part to components of the ACA, but likely also due to recessionary economic conditions in Alaska over the past five years. The proportion of Alaska seniors enrolled in Medicaid has been flat 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 FY2020.

Table 6: Medicaid Enrollment and Recipients as a Proportion of Alaska's Population, For FY2015 and Selected Future Fiscal Years

Age Cohort	Measure	2015	2021	2026	2031	2036	2041
Children (0-19)	Enrollees	44.0%	55.5%	56.8%	58.4%	59.6%	60.7%
	Recipients	37.0%	44.3%	45.7%	47.6%	48.9%	49.9%
Adults (20-64)	Enrollees	12.9%	31.5%	32.3%	32.9%	33.2%	33.4%
	Recipients	10.6%	23.5%	24.2%	25.1%	25.4%	25.6%
Seniors (65+)	Enrollees	15.0%	14.8%	15.0%	15.6%	16.3%	17.0%
	Recipients	13.1%	12.8%	13.2%	14.0%	14.7%	15.4%
Total Ages*	Enrollees	22.1%	35.9%	36.2%	36.7%	37.2%	37.9%
	Recipients	18.5%	27.8%	28.3%	29.1%	29.7%	30.4%

Source: Alaska Department of Labor and Workforce Development.

Table 7 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 7: Medicaid Enrollees and Recipients for Selected Eligibility Groups, FY2021 – FY2041

Eligibility Group	Measure	2021	2026	2031	2036	2041	Annual Growth
Aged or Disabled	Enrollees	33,257	35,688	38,308	40,462	42,429	1.23%
	Recipients	29,667	32,474	34,858	36,818	38,608	1.33%
Medicaid Expansion*	Enrollees	62,333	68,049	72,411	75,172	76,120	1.00%
	Recipients	42,874	47,606	51,014	53,224	53,895	1.15%
All Other Eligibilities	Enrollees	168,210	170,227	173,258	178,459	186,082	0.51%
	Recipients	131,558	134,172	139,702	144,520	151,460	0.71%
Total**	Enrollees	263,800	273,964	283,977	294,093	304,631	0.72%
	Recipients	204,099	214,252	225,573	234,562	243,963	0.90%

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

* The Medicaid eligibility of an individual can change during a fiscal year. The forecast of 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.⁴⁵ For the long-term Medicaid forecast, we project the number of Medicaid enrollees who will use each Medicaid service category – without regard for the intensity of use – during each of the 20 years of the forecast period.⁴⁶

In the first long-term Medicaid forecast completed in February 2006 and in each subsequent forecast, Medicaid services were organized into the same 20 Medicaid service categories. These categories are listed in Table 8 and are described in the appendix of this report.

Table 8: Service Category Designations Used in the Long-Term Medicaid Forecast

Service Categories		
Dental	Inpatient Hospital	Pharmacy
DME ⁴⁷ / Supplies	Inpatient Psychiatric	Physician / Practitioner
EPSDT ⁴⁸	Lab / X-Ray	Residential Psychiatric / BRC ⁴⁹
Family Planning	Nursing Home	Therapy / Rehabilitation
HCB ⁵⁰ Waiver	Outpatient Hospital	Transportation
Health Clinic	Outpatient Mental Health	Vision
Home Health / Hospice	Personal Care	

There is and we believe there will continue to be substantial variability among enrollees in the rate of service utilization, with approximately 15 percent to 25 percent of enrollees not utilizing any Medicaid services during a fiscal year and a small number of recipients

⁴⁵ 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; that is, they received Medicaid services. In FY2015, the proportion of Medicaid enrollees who were also recipients had dropped to 84 percent, and in FY2019, only 77 percent of Medicaid enrollees were recipients.

⁴⁶ We consider “intensity of use” in the subsequent step of the long-term Medicaid forecast.

⁴⁷ Durable Medical Equipment

⁴⁸ Early and Periodic Screening, Diagnosis, and Treatment

⁴⁹ Behavioral Rehabilitation Centers

⁵⁰ Home and Community Based Waiver

utilizing 10 or more different service categories. 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 underlying factor driving utilization of Medicaid services, which is correlated with age, is being diagnosed with one or more chronic conditions. In FY2019, Medicaid recipients with no diagnosed chronic conditions utilized on average 3.2 Medicaid service categories (see Table 9). In comparison, Medicaid recipients with one diagnosed chronic condition utilized on average 5.3 service categories, recipients with two to four diagnosed chronic conditions utilized on average 6.0 Medicaid service categories, and recipients with five or more chronic conditions utilized on average 7.0 Medicaid service categories.

Table 9: Number of Medicaid Service Categories Utilized in FY2019

Number of Diagnosed Chronic Conditions	Number of Service Categories Utilized
No Diagnosed Chronic Conditions	3.2
One Diagnosed Chronic Condition	5.3
Two to Four Diagnosed Chronic Conditions	6.0
Five or More Diagnosed Chronic Conditions	7.0
Average All Medicaid Recipients	3.9

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

We project utilization of Medicaid services will grow on average by 1.2 percent per year over the next 20 years due to growth in Medicaid enrollment and particularly to growth in the number of seniors, who tend to have greater healthcare needs. Table 10 shows the five service categories that currently experience the greatest rate of utilization and are projected to continue to experience the greatest rate of utilization through the projection period. Of these, we expect utilization of the Pharmacy service category to outpace overall growth in utilization, while utilization of the Physician/Practitioner, Dental, and Health Clinic service categories will grow at a slower rate.

Table 10: Most Frequently Utilized Medicaid Service Categories, FY2021 – FY2041

Service Category	2021	2026	2031	2036	2041	Annual Growth
Physician/Practitioner	150,338	156,646	165,070	175,082	185,991	1.07%
Pharmacy	112,179	119,281	128,419	139,186	151,183	1.50%
Outpatient Hospital	111,829	118,960	125,055	129,991	133,788	0.90%
Dental	81,541	84,207	86,923	90,851	94,176	0.72%
Health Clinic	61,646	64,243	67,573	72,111	75,321	1.01%
All Medicaid Services	759,089	808,091	858,630	911,502	963,862	1.20%

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group; counts shown in the table represent the number of Medicaid recipients who received services within the respective service category at least once during the fiscal year.

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 2019. Over this period, Alaska and the rest of the U.S. experienced substantial healthcare price inflation, which averaged nearly 4.1 percent per year, but fluctuated year-to-year with a low of 2.3 percent in FY1999 to a high of 6.8 percent in FY2019.⁵¹ 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.⁵²

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 FY2041. On a weighted average basis across the 20 service categories, we project intensity of use will increase on average by only about 0.15 percent per year through FY2041. It is worth noting that, while these estimates of average growth in the intensity of use of Medicaid services are very small relative to historical (and expected future) growth in Medicaid price inflation, separating the inflation

⁵¹ U.S. Bureau of Labor Statistics, “Consumer Price Index,” Data for medical care in urban Alaska, <https://www.bls.gov/cpi/data.htm>

⁵² We used calendar year 2000 as the base year. The choice of base year does not impact the estimates of healthcare price inflation.

component from the intensity of use component is challenging given the aggregate level at which healthcare price inflation is measured.⁵³

2.5 Total Spending on Medicaid Services

The final step (see Figure 13) of the Alaska long-term forecasting model is to develop estimates of total spending for each Medicaid service category through FY2041. To do this, we first project the annual rate of healthcare price inflation for Alaska through FY2041. We then integrate these estimates of healthcare price growth into our annual estimates of growth in population (Step 1 of Figure 13), enrollment (Step 2), utilization (Step 3), and intensity of use (Step 4) to obtain a projection of total spending on Medicaid services for each year through FY2041. We project that total Medicaid spending will increase on average by 4.7 percent per year between FY2021 and FY2041 (see Table 11 and Figure 15), reaching \$5.7 billion by FY2041.

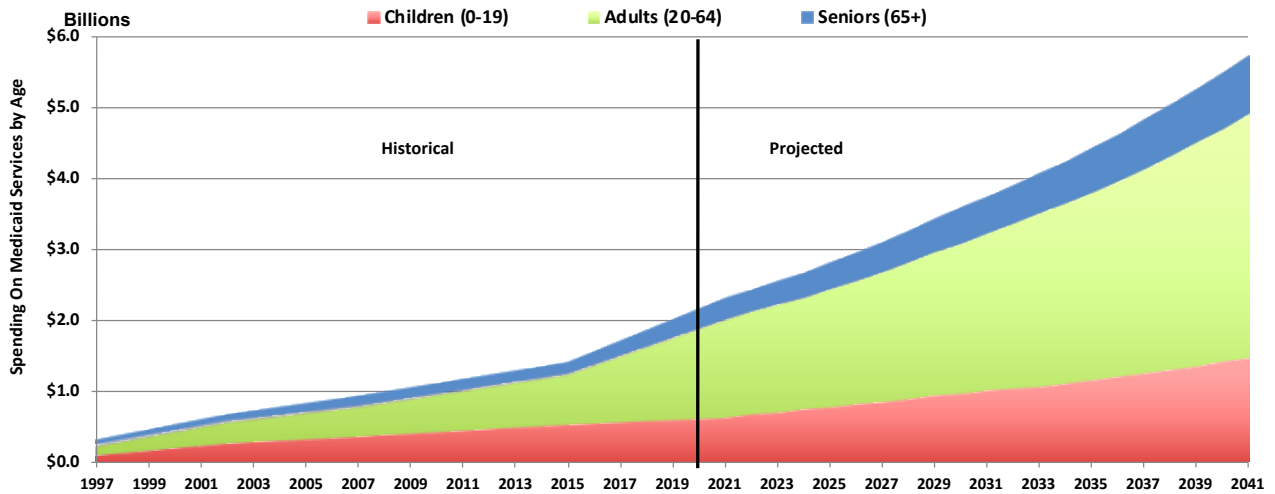
Table 11: Medicaid Spending by Age Cohort, FY2021 - FY2041 (Millions \$)

Age Group	2021	2026	2031	2036	2041	Annual Growth
Children (0-19)	\$651.6	\$832.7	\$1,015.9	\$1,208.3	\$1,488.1	4.2%
Adults (20-64)	\$1,359.6	\$1,719.6	\$2,196.9	\$2,745.7	\$3,423.2	4.7%
Seniors (65+)	\$296.3	\$398.5	\$537.3	\$673.7	\$831.7	5.3%
Total	\$2,307.6	\$2,950.8	\$3,750.2	\$4,627.7	\$5,743.0	4.7%

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

⁵³ We relied on the Medical Care component of the All Urban Consumer Price Index for Anchorage as the measure of historical healthcare price inflation. U.S. Bureau of Labor Statistics, "Consumer Price Index." www.bls.gov/cpi

Figure 15: Total Spending on Medicaid Claims by Age Cohort, FY2021 - FY2041

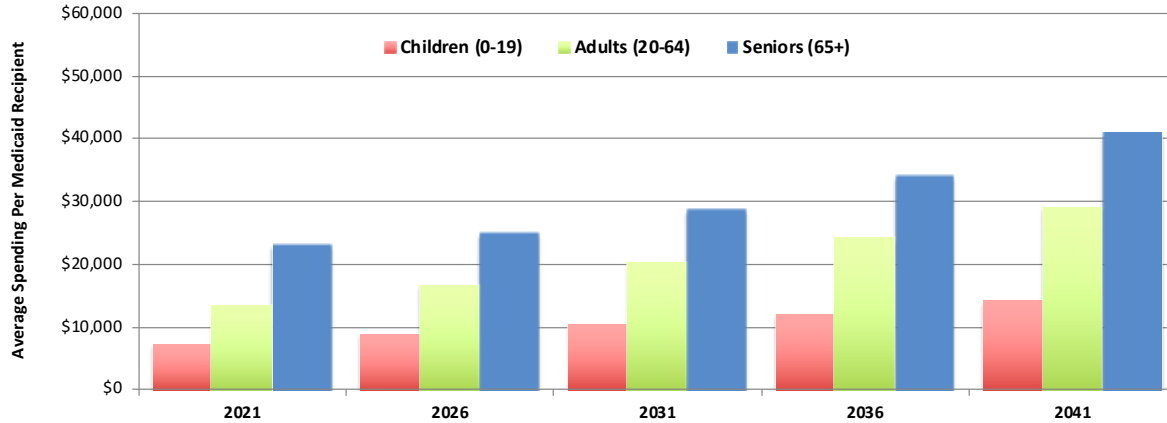


Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

We expect the annual rates of growth in Medicaid spending to differ for children, adults, and seniors, and to generally decrease over the forecast period. Through much of the historical period, total annual spending on children and adults was about the same. However, around FY2010, spending on Medicaid services for adults began to grow faster than spending on children. With Medicaid expansion in September 2015, the gap widened significantly. We expect the gap in spending to continue to widen, though more slowly, through the projection period as spending on services for those with chronic conditions – the prevalence of which increases with age – continues to outpace spending on Medicaid recipients not diagnosed with one or more chronic conditions. We also expect the rate of growth in spending on seniors to outpace spending on children.

Figure 16 shows projected spending per Medicaid recipient by age group for selected years. This figure shows the critical role age plays in the cost of healthcare services. For FY2021, we estimate the average per-recipient cost of Medicaid services for children and adults will be about \$7,200 and \$13,400, respectively. Comparatively, the average cost per senior recipient will be about \$23,000 – three times the average cost per child. By FY2041, we project average spending per child recipient will be about \$14,000, the average cost per adult recipient under the age of 65 will be \$29,000, and the average cost per senior recipient will be \$41,000.

Figure 16: Average Spending Per Recipient on Medicaid Services by Age Cohort, FY2021 – FY2041



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 increases 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; in FY2015, the average age was 23 and the median age was 16. We project that by FY2041, the average age of a Medicaid enrollee will be 29 and the median age will be 24.

Table 12 shows project spending by broad category of Medicaid services.⁵⁴ We project that spending on Medical/Other and Long-Term Care services will outpace spending on Behavioral Health services and that Medical/Other services will slightly increase its share of overall spending on Medicaid services.

Table 12: Projected Spending on Medicaid Services by Broad Category (Millions \$)

Service	2015	2021	2026	2031	2036	2041	Annual Growth*
Medical/Other	\$842	\$1,500	\$1,940	\$2,485	\$3,094	\$3,889	4.9%
Long-Term Care	\$461	\$506	\$642	\$819	\$1,007	\$1,219	4.5%
Behavioral Health	\$171	\$302	\$369	\$446	\$526	\$636	3.8%
Total**	\$1,474	\$2,308	\$2,951	\$3,750	\$4,628	\$5,743	4.7%

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

* Average annual growth rate between FY2021 and FY2041.

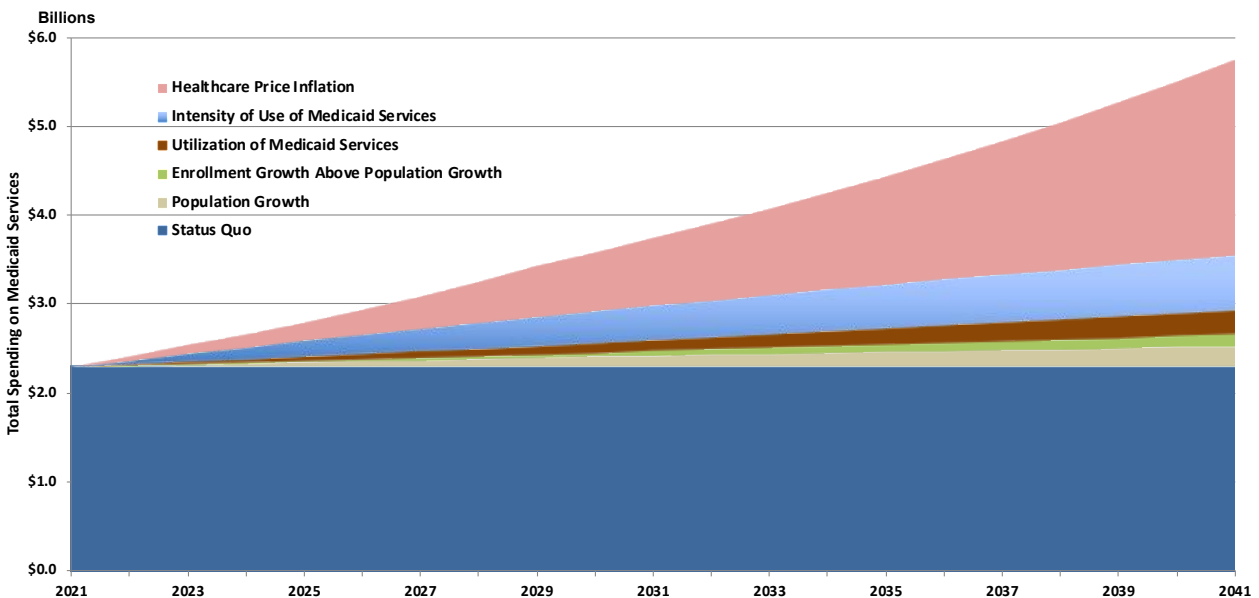
** Due to rounding, some totals may not precisely match the sum of components shown in the table.

⁵⁴ See Table 20 in the appendix for a description of the services contained within each broad service category.

Figure 17 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 FY2021 to FY2041. Figure 17 then shows how the spending forecast builds off of 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 to changes in medical technology or practices, or increases in the scope of medical services within a Medicaid service category.
- **Healthcare Price Inflation** is the rate at which prices for medical services increase over time, not related to changes in the scope or scale of the service provided.

Figure 17: Projected Spending on Medicaid Services by Component of Growth



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

As Figure 17 shows, we expect healthcare price inflation to be the primary driver of spending growth in Alaska’s Medicaid program, representing about 38 percent of total spending and 64 percent of additional spending in FY2041. Healthcare price inflation may not directly impact what DHSS pays providers for services provided to Medicaid recipients in any given year. Rather, DHSS has processes in place to work with providers to periodically update the schedule of rates paid for Medicaid services. Rates typically adjust (generally upward) every one-to-four years, roughly in line with the rate of healthcare price inflation affecting providers.

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 FY2041, we project that growth in the population, growth in enrollment above population growth, and growth in utilization and intensity of Medicaid services will combine to increase spending on the Medicaid program by more than \$1.25 billion.

Enrollment in and Spending on Medicaid Services by Rural/Urban

Table 13 shows the population projection for Alaska and the projections for Medicaid enrollment and spending based on rural and urban status.⁵⁵ For FY2021, about 34 percent of Alaska’s population lives in a rural area (as designated as rural by the U.S. Census Bureau), but 40 percent of Medicaid enrollees are from rural areas and 41 percent of Medicaid spending is on services for rural recipients. These proportions change only slightly through the projection period, with the rural population decreasing slightly, the proportion of Medicaid enrollees that live in rural areas holding steady, and the proportion of spending on services for rural recipients increasing slightly (to 42%) by FY2041.

Table 13: Projected Population, Medicaid Enrollment, and Medicaid Spending by Rural/Urban, FY2021 – FY2041

Metric	Area	FY2021	FY2026	FY2031	FY2036	FY2041
Population	Rural	247,904	253,642	258,450	262,753	266,628
	% Rural	34%	34%	33%	33%	33%
	Urban	487,103	502,660	515,782	527,217	536,921
	% Urban	66%	66%	67%	67%	67%
Medicaid Enrollment	Rural	104,266	108,139	112,060	116,111	120,615
	% Rural	40%	39%	39%	39%	40%

⁵⁵ The population forecast for Alaska was developed by the Alaska Department of Labor and Workforce Development; Evergreen Economics used information published by the U.S. Census Bureau (and shown in Table 22) to allocate by rural/urban status the forecasts of Alaska’s population, enrollment in the Medicaid program, and spending on Medicaid services.

Metric	Area	FY2021	FY2026	FY2031	FY2036	FY2041
	Urban	159,533	165,825	171,918	177,980	184,016
	% Urban	60%	61%	61%	61%	60%
	Rural	\$947.7	\$1,215.6	\$1,550.0	\$1,920.0	\$2,399.0
	% Rural	41%	41%	41%	41%	42%
Medicaid Spending (Millions \$)	Urban	\$1,359.8	\$1,735.2	\$2,200.2	\$2,707.7	\$3,344.0
	% Urban	59%	59%	59%	59%	58%

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group and Alaska Department of Labor and Workforce Development.

State Spending on Medicaid Services

So far, the focus of our spending analysis has been on Alaska’s Medicaid program as a whole. However, 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 and, in certain cases, the facility in which the recipient receives care. For example, if a Medicaid recipient who is also American Indian or Alaska Native and receives services through a facility of the Indian Health Service (IHS), including tribal health organizations, the federal government will pay 100 percent of the cost of the services. However, if that same Medicaid recipient received services from a non-IHS facility, then the federal government will likely pay a smaller portion of the cost of the service.⁵⁶

Each Medicaid service received by an enrollee is eligible for one or more of the following Federal Financial Participation (FFP) rates:

⁵⁶ In State Health Official letter #16-002 dated February 26, 2016, CMS updated its policy regarding federal funding for services “received through” an IHS/tribal facility and furnished to Medicaid-eligible American Indians and Alaska Natives. This change in federal policy on tribal Medicaid reimbursement authorizes 100 percent federal funding for services provided to Medicaid recipients who are AI/AN. The new federal policy allows the state to claim 100 percent federal reimbursement for Medicaid services provided to AI/AN Medicaid recipients in non-tribal facilities if the recipient’s tribal health organization has a care coordination agreement established with the non-tribal facility and there is documentation of a referral and an exchange of records for the care received. Projected spending by the State of Alaska in this forecast accounts for this change in policy by CMS.

- Regular Federal Medical Assistance Percentage (FMAP):⁵⁷
 - 56.2 percent FFP from January 1, 2020 through June 30, 2021⁵⁸
 - 50 percent FFP beginning July 1, 2021
- 1915 (K) Community Choice
 - 62.2 percent FFP from January 1, 2020 through June 30, 2021
 - 56 percent FFP beginning July 1, 2021
- Enhanced FMAP for CHIP:⁵⁹
 - 80.84 percent FFP From January 1, 2020 through September 30, 2020
 - 69.34 percent FFP from October 1, 2020 through June 30, 2021
 - 65 percent FFP beginning July 1, 2021
- Breast and Cervical Cancer (BCC): 65 percent FFP⁶⁰
 - 69.34 percent FFP from January 1, 2020 through June 30, 2021
 - 65 percent FFP beginning July 1, 2021
- Family Planning: 90 percent FFP
- Indian Health Service (IHS): 100 percent FFP
- Medicaid Expansion:⁶¹
 - CY2016: 100 percent FFP
 - CY2017: 95 percent FFP
 - CY2018: 94 percent FFP
 - CY2019: 93 percent FFP
 - CY2020 and beyond: 90 percent FFP
- State-Only Services: 0 percent FFP

When a Medicaid service received by a Medicaid recipient is eligible for more than one FFP rate, DHSS receives the rate with the highest federal participation. The majority of Medicaid spending receives the Regular FMAP rate of 50 percent federal reimbursement; however, most of the growth in Medicaid spending has received either the Medicaid

⁵⁷ CMS sets each state's FMAP rate based on a three-year average of state-level per capita personal income, ranked among states.

⁵⁸ The additional 6.2 percentage points of FFP is attributable to the declaration by the U.S. Secretary of Health and Human Services to extend the public health emergency related to the COVID-19 pandemic. The additional FFP is currently set to expire June 30, 2021. For more information on the Families First Coronavirus Response Act, see <https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf>

⁵⁹ Ibid

⁶⁰ Ibid

⁶¹ Recipients enrolled through Medicaid expansion who are also Indian Health Service beneficiaries will always receive 100 percent FFP for qualifying services.

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. We project that spending on Medicaid services will grow on average by about 4.7 percent per year through FY2041, and that the rate of growth in spending will be roughly equal for the State of Alaska and the federal government (see Table 14).⁶²

Table 14: Projected State and Federal Spending on Medicaid Services (in Millions \$)

Fund Source	2021	2026	2031	2036	2041	Annual Growth
State and Other Match Funds	\$588.2	\$782.7	\$986.9	\$1,207.4	\$1,481.2	4.7%
Federal	\$1,719	\$2,168	\$2,763	\$3,420	\$4,262	4.6%
Total Spending*	\$2,308	\$2,951	\$3,750	\$4,628	\$5,743	4.7%

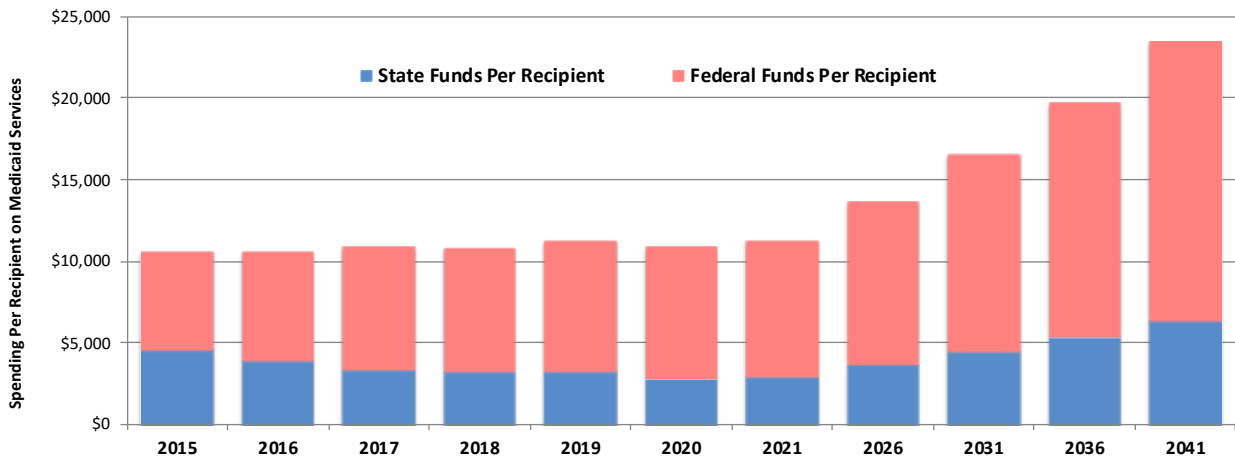
Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

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

Figure 18 shows recent actual and projected future average spending per Medicaid recipient. Between FY2015 and FY2020, spending per Medicaid recipient was basically flat, and the proportion paid with state general funds actually decreased considerably. Over the next 20 years, we project average spending per recipient will increase by about 3.6 percent per year due primarily to healthcare price inflation and the aging of Alaska's population.

⁶² This is despite expected ongoing savings to the State of Alaska associated with (a) the shifting of some services received by AI/AN adults enrolled through Medicaid expansion to the 100 percent federal IHS match rate, and (b) a change in CMS policy regarding care coordination agreements established between tribal health organizations and non-tribal facilities.

Figure 18: 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 - FY2019 are actual expenditures based on date of service; FY2020 is estimated based on date of payment; FY2021 - FY2041 are projected.

In FY2020, the weighted average FFP rate for Medicaid services was nearly 74 percent, and we project the average FFP rate for FY2021 will be at least 75 percent due to the additional funding provided by the federal government related to the COVID-19 pandemic. After that, we project the average annual FFP will drop to 73 percent for FY2022 and then slowly rise over the projection period to 74.5 percent by FY2041.⁶³ The primary driver of this gradual trend toward greater federal funding is growth in spending on services that receive the 100 percent IHS FFP rate.

Other Medicaid Payments and Offsets

Throughout this report, we have focused on enrollment in the Medicaid program, utilization and intensity of use of Medicaid services, and spending on services provided to Medicaid recipients. There are, however, 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;⁶⁴ and

⁶³ For FY2021, each percentage point of FFP equates to \$23 million (1% of \$2.3 billion), and the importance of each percentage point of FFP will grow as total spending on Alaska's Medicaid program grows.

⁶⁴ Medicare is a federal program that provides health insurance to people age 65 or older, people under age 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

2. Supplemental Hospital Payments including disproportionate share hospital (DSH) and upper payment limit programs paid to qualifying hospitals that serve a large number of Medicaid or uninsured individuals, continuing care agreement payments, and tribal dental encounter payments made to IHS and tribal clinics.

The share of total Medicaid spending attributed to these other payments varies from year to year, but has trended downward over the past 15 years. For example, in FY2005, other costs and payments accounted for 13 percent of total Medicaid spending. In more recent years, these other payments have accounted for around 7 percent to 8 percent of total Medicaid spending. 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 about 2 percent of annual spending on Medicaid services.

It is likely that the Medicaid program will experience more changes in the future, and payments allowed by the Centers for Medicare and Medicaid Services (CMS) today may be disallowed in later years.⁶⁵ DSH payments were supposed to have been phased out with implementation of the ACA, but this has not happened and likely will not happen in the near future. As an estimate of the combined impact of other Medicaid payments and offsetting recoveries in the future, we increase the annual forecast of spending on Medicaid services by 5 percent (see Table 15).

Table 15: Total Projected Medicaid Spending, FY2021 – FY2041

		2021	2026	2031	2036	2041
Spending on Medicaid Claims	Federal	\$1,719	\$2,168	\$2,763	\$3,420	\$4,262
	State Match	\$588	\$783	\$987	\$1,207	\$1,481
	Total	\$2,308	\$2,951	\$3,750	\$4,628	\$5,743
Other Medicaid Payments	Federal	\$58	\$74	\$94	\$116	\$144
	State Match	\$58	\$74	\$94	\$116	\$144
	Total	\$115	\$148	\$188	\$231	\$287
Total Spending on Medicaid	Federal	\$1,777	\$2,242	\$2,857	\$3,536	\$4,405
	State Match	\$646	\$857	\$1,081	\$1,323	\$1,625
	Total*	\$2,423	\$3,098	\$3,938	\$4,859	\$6,030

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 table.

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.

⁶⁵ FairShare and ProShare are two examples of supplemental payment programs that have been discontinued in recent years.

2.6 Spending on Medicaid Enrollees with Chronic Conditions

Throughout the U.S., increasing numbers of people suffer from one or more chronic diseases or conditions that require ongoing medical care along with educational programs and training to assist them in managing their chronic condition(s).⁶⁶ The U.S. National Center for Health Statistics defines chronic conditions as diseases or other medical conditions lasting three months or more.⁶⁷ The Centers for Disease Control (CDC) defines chronic conditions as those that last one or more years and require ongoing medical attention or limit activities of daily living or both.⁶⁸

Using data from a national survey on health care expenditures, researchers at the RAND Corporation estimate that 59 percent of U.S. adults have one or more chronic conditions and that the healthcare services they utilize constitute up to 90 percent of healthcare spending in the U.S.⁶⁹ DHSS directed Evergreen Economics to integrate into the long-term Medicaid forecast spending on chronic conditions. This update to the long-term forecast is the second projection of spending on Medicaid services for enrollees diagnosed as having one or more chronic conditions.

Identifying Medicaid Beneficiaries with a Chronic Condition

We analyzed claims data from the Alaska Medicaid Management Information System (MMIS) to identify Medicaid beneficiaries who had a paid claim that included a diagnosis code indicating the beneficiary received treatment for one of the chronic conditions listed in Table 16 during FY2019. There were just over about 6.7 million Medicaid claims and 11.5 million claim lines for services provided to beneficiaries in FY2019.⁷⁰ 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.

⁶⁶ (a) Suzanne A. Boren, Karen A. Fitzner, Pallavi S. Panhalkar, and James E. Specker, "Costs and Benefits Associated with Diabetes Education: A Review of the Literature," *The Diabetes Educator*, 2009, 35: 72-96.

(b) Simone R. de Bruin, Richard Heijink, Lidwien C. Lemmens, Jeronen N. Struijs, and Caroline A. Baan, "Impact of disease management programs on healthcare expenditures for patients with diabetes, depression, heart failure or chronic obstructive pulmonary disease: A systematic review of the literature." *Health Policy*, 2011, 101: 105-121. (c) Robert Freeman, Kristina Lybecker, and D. Wayne Taylor, "The Effectiveness of Disease Management Programs in the Medicaid Population." Hamilton, Ontario: The Cameron Institute, 2011.

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

⁶⁸ Centers for Disease Control and Prevention, "About Chronic Diseases." <https://www.cdc.gov/chronicdisease/about/index.htm>

⁶⁹ Doug Irving, "Chronic Conditions in America: Price and Prevalence," *RAND Review*. Santa Monica, CA: RAND Corporation, July 12, 2017. <https://www.rand.org/blog/rand-review/2017/07/chronic-conditions-in-america-price-and-prevalence.html>

⁷⁰ About 58 percent of Medicaid claims in FY2019 consisted of a single claim line, and 93 percent of claims were composed of 10 or fewer claim lines.

Most, but not all, MMIS records also include one or more medical diagnosis codes assigned by a healthcare provider, which indicate the medical reason for the service.⁷¹ We examined up to three diagnosis codes for each Medicaid claim in FY2019 to identify if the service was associated with any of the chronic conditions listed in Table 16, which we arranged into 23 chronic condition groups based on the characteristics of the condition and/or the body system affected.⁷²

Table 16: 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, PVD
4	Congenital disorders	Cystic Fibrosis
5	Diabetes	Type I and Type II Diabetes
6	Drug & Alcohol Abuse	Alcohol Use Disorders, Drug Use Disorders including Opioid Use Disorder, Tobacco Use,
7	Ear	SDHI - Sensory - disabling hearing impairment
8	Eye	Cataract, Glaucoma, SBVI - Sensory - blindness and visual impairment,
9	Injuries and accidents	Hip or Pelvic Fracture
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, Spinal Cord Injury
14	Musculoskeletal	Fibromyalgia Chronic Fatigue Syndrome, Muscular Dystrophy, Osteoporosis,
15	Neurological	Dementia, Alzheimer's
16	Other Neurological	Cerebral Palsy, Epilepsy, Migraine / Chronic Headache, MS or Transverse Myelitis, Spina Bifida, Traumatic Brain Injury,
17	Obesity	Obesity
18	Other Metabolic and Endocrine	Acquired Hypothyroidism, Hyperlipidemia

⁷¹ In FY2019, about 2.6 million claims (23%) did not include a diagnosis code. Of these, the vast majority (97%) were either pharmacy (59%), dental (24%), or transportation and accommodations (14%).

⁷² The MMIS database has the capacity to store more than three diagnosis codes per claim, but the vast majority of Medicaid claims (85% in FY2019) had three or fewer diagnosis codes.

Chronic Condition Group		Chronic Conditions
19	Renal and urogenital	Benign Prostatic Hyperplasia, Chronic Kidney Disease
20	Respiratory	Asthma, RAOA
21	Skin	Ulcers
22	Sexually Transmitted Infection	HIV AIDS
23	Stroke	Stroke, Transient Ischemic Attack

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-10.⁷³ For each chronic condition, we relied on the CMS Chronic Conditions Data Warehouse to determine which ICD-10 codes indicated the respective chronic condition. This approach to identifying the presence of a chronic condition represents a limitation in the study in that we may *underestimate* the prevalence of each chronic condition within the Medicaid population because we only observe 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.⁷⁴

Evergreen Economics used the following criteria to define a Medicaid beneficiary as having one of the chronic conditions that make up the 23 chronic condition groups shown in Table 16:⁷⁵

- The Medicaid beneficiary had at least two Medicaid claims in FY2019 with a diagnosis code specifying the chronic condition as defined in the CMS Chronic Conditions Data Warehouse; and

⁷³ 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.

⁷⁴ 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.

⁷⁵ These criteria, which were developed by Evergreen Economics specifically for this analysis, differ from and are more selective than the criteria used in the *Long-Term Forecast of Medicaid Enrollment and Spending in Alaska: FY2020 – FY2040*, completed last year. For that analysis, only one diagnosis code per Medicaid claim was made available to Evergreen Economics, and the criteria we chose to identify a Medicaid beneficiary as having a chronic condition were as follows: (a) one or more diagnoses for the respective chronic condition during the fiscal year and (b) at least \$2,000 in total spending on Medicaid services during the fiscal year.

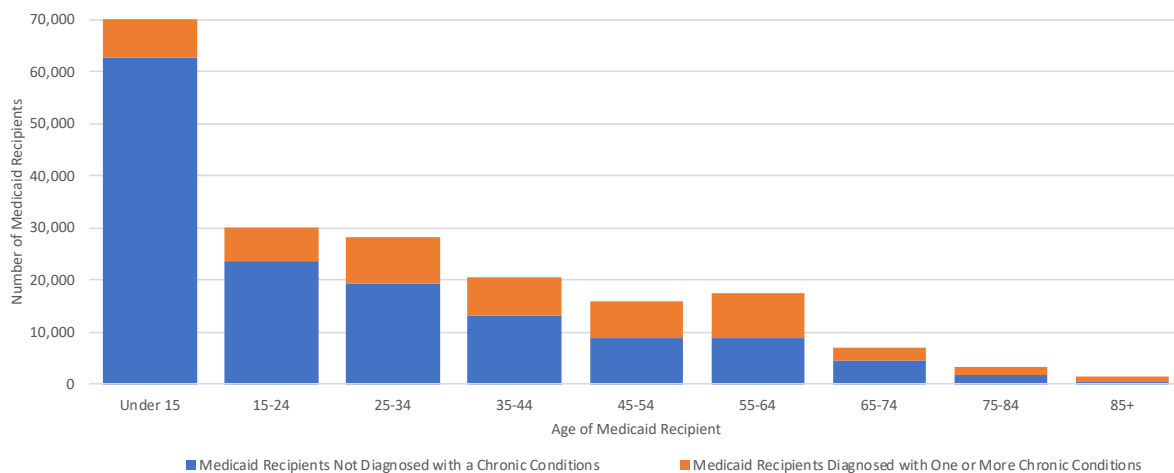
- The Medicaid program paid at least \$5,000 in costs for (all) services received by the Medicaid recipient during FY2019.

In FY2019, the unduplicated count of Medicaid enrollees was 251,661. Applying the criteria listed above, we identified 50,748 Medicaid beneficiaries as being diagnosed with one or more chronic conditions in FY2019.⁷⁶

Characteristics of Beneficiaries with Chronic Conditions

Figure 19 shows the distribution of Medicaid recipients by age and whether the recipient was diagnosed with one or more chronic conditions. The prevalence of being diagnosed with a chronic condition increases with age and/or is linked to the aging process.⁷⁷ Only about 11 percent of recipients under 15 years of age had a diagnosed chronic condition. This rate nearly doubles (to 21%) for recipients 15 to 24 years of age, but is still well below the average for all Medicaid recipients in FY2019. At the upper end of age distribution, for Medicaid recipients 75 years of age or older, the prevalence of a chronic condition increases to 53 percent.

Figure 19: Distribution of Medicaid Recipients by Age and Diagnosis of One or More Chronic Conditions, FY2019



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

⁷⁶ In the FY2020–FY2040 update to the long-term forecast completed in January 2020, we applied less selective criteria to MMIS data for FY2018 to define a Medicaid beneficiary as having a chronic condition. Based on those less selective criteria, we identified 61,672 Medicaid beneficiaries as having a chronic condition in FY2018. As a result of the differences in criteria used in the two analyses, the numbers of beneficiaries identified as having one or more chronic conditions in FY2018 and FY2019 are not comparable.

⁷⁷ 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>

The one exception to the positive correlation between age and the prevalence of chronic conditions is the 65 to 74 age group. For this age group, prevalence actually decreases, but the decrease is likely due to Medicaid beneficiaries becoming dually eligible for Medicaid and Medicare services at age 65. As the payer of last resort, only those medical and related services not covered by Medicare will be billed to the Medicaid program. It is likely that many of the healthcare costs of Medicaid beneficiaries 65 years of age and older are paid by Medicare and, therefore, are not reported as Medicaid claims in the MMIS. Nevertheless, per-recipient spending on Medicaid services is greater for seniors 75 years of age and older than for younger adults and children. This is largely due to the Medicare program not covering most types of long-term care services.

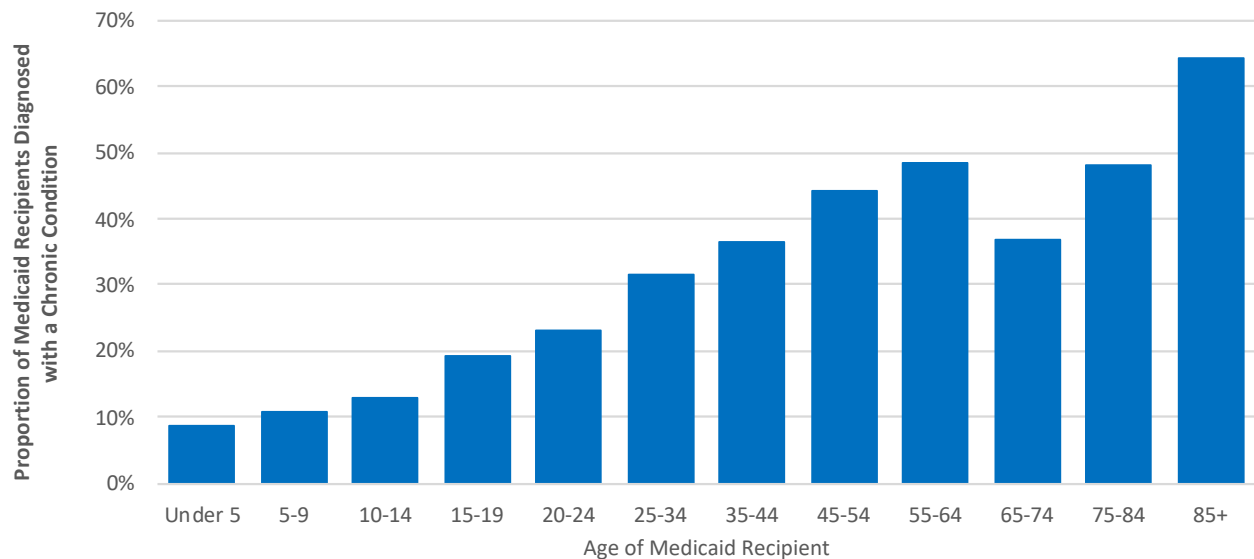
Figure 20 shows more clearly the relationship between the age of a Medicaid recipient and the prevalence of chronic conditions. Less than 10 percent of children under five years of age were diagnosed with a chronic condition in FY2019, while 64 percent of seniors 85 years of age or older were diagnosed 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 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, environmental factors, and lifestyle.

Figure 20 also shows that, after continually increasing with age, the prevalence of chronic conditions among Medicaid recipients drops precipitously for recipients 65 to 74 years of age before continuing to rise for recipients 75 years of age or older. The decrease in the proportion of Medicaid recipients 65 to 74 years of age with one or more diagnosed chronic conditions is likely not due to a drop in the prevalence of chronic conditions for this age group, but rather to (a) differences in the eligibility criteria for Medicaid enrollment for adults under 65 years of age and those 65 years of age or older and (b) to some portion of the cost of medical and related services for adults 65 year of age or older being paid by the Medicare program through dual enrollment.

The ACA expanded Medicaid eligibility to adults under 65 years of age who were not previously eligible for Medicaid, but meet certain criteria (see Section 1.2 for more details about Medicaid expansion). When some of these newly eligible older adults reach 65, they may lose their Medicaid eligibility or voluntarily leave the Medicaid program and transition to Medicare (without dual enrollment with Medicaid). For the Medicaid program, this results in a substantial drop in the number of recipients from the 55-64 age group to the 65-74 age group (see Figure 19) and, as Figure 20 shows, a sizeable drop in the proportion of Medicaid recipients with one or more diagnosed chronic conditions.

The decrease in prevalence is largely concentrated in two chronic conditions: Drug and Alcohol Abuse and Mental Health. The prevalence of Drug and Alcohol Abuse for Medicaid recipients 55-64 years of age was 19 percent, whereas for recipients 65-74 years of age, it was only 8.3 percent and only 4.6 percent for recipients 75-84 years of age. The prevalence of Mental Health chronic conditions was 15.2 percent for the 55-64 age group, while it was only 10.3 percent for the 65-74 age group and 7 percent for recipients 75 to 84 years of age.

Figure 20: Proportion of Recipients with One or More Diagnosed Chronic Conditions



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

Table 17 shows average spending per recipient on Medicaid services in FY2019 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 clearly show a strong, though imperfect, positive relationship between age and spending on Medicaid services. This relationship does not extend to average spending by age for those without a diagnosed chronic condition (column c) or for those with one or more diagnosed chronic conditions (column d). When segmenting Medicaid recipients by diagnosis of a chronic condition, average spending by age of recipient is relatively flat – with the exception of the very young (under five years of age) and seniors 75 years of age or older.

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. On average, spending on Medicaid

services for a recipient with *one or more chronic condition diagnoses* is about 10 times greater than average spending on services for a Medicaid recipient *without a diagnosis of a chronic condition* (\$33,553 versus \$3,389).

Column e of Table 17 shows the incremental cost of chronic conditions per Medicaid recipient by age. These incremental costs represent how much additional Medicaid services are required by recipient with one or more chronic conditions relative to recipients *without a diagnosis of a chronic condition*. On average, spending on a Medicaid recipient with one or more chronic conditions was about \$30,000 greater in FY2019 than a recipient without a diagnosed chronic condition.

Table 17: Spending Per Recipient on Medicaid Services and Incremental Cost of Chronic Conditions, FY2019

a.	b.	c.	d.	e.
Age of Recipient	Average Spending Per Medicaid Recipient			Incremental Cost of Chronic Condition (d – c)
	All Recipients	Without a Diagnosis for a Chronic Condition	One or More Chronic Condition Diagnoses	
Under 5	\$7,879	\$5,259	\$35,366	\$30,107
05-09	\$4,974	\$2,728	\$23,732	\$21,004
10-14	\$6,980	\$2,596	\$36,643	\$34,047
15-19	\$10,085	\$3,087	\$39,429	\$36,343
20-24	\$9,341	\$3,426	\$28,942	\$25,516
25-34	\$11,844	\$3,621	\$29,572	\$25,951
35-44	\$12,770	\$2,972	\$29,924	\$26,952
45-54	\$15,689	\$2,737	\$32,124	\$29,388
55-64	\$18,039	\$2,684	\$34,429	\$31,745
65-74	\$15,460	\$2,682	\$37,313	\$34,631
75-84	\$26,466	\$4,329	\$50,204	\$45,874
85+	\$49,879	\$11,429	\$71,182	\$59,753
All Recipients	\$11,273	\$3,389	\$33,553	\$30,271

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

Table 18 shows the total incremental cost of chronic conditions by age cohort, which is computed by multiplying the per-recipient incremental costs by the number of recipients within each age cohort diagnosed with one or more chronic conditions. Total spending on Medicaid services received in FY2019 for *all* Medicaid recipients was \$2.19 billion. Of this,

we estimate that \$1.54 billion represents the total *incremental cost* of providing Medicaid services to recipients diagnosed with one or more chronic conditions.

Table 18: Total Incremental Cost of Chronic Conditions on Medicaid Spending, FY2019

a.	e.	f.	g.
Age of Recipient	Incremental Cost of Chronic Conditions Per Recipient	Recipients with One or More Diagnosed Chronic Conditions	Total Incremental Cost of Chronic Conditions (e * f)
Under 5	\$30,107	2,208	\$66,476,155
05-09	\$21,004	2,495	\$52,404,946
10-14	\$34,047	2,743	\$93,389,960
15-19	\$36,343	3,477	\$126,363,548
20-24	\$25,516	2,758	\$70,374,434
25-34	\$25,951	8,990	\$233,296,459
35-44	\$26,952	7,491	\$201,895,621
45-54	\$29,388	7,063	\$207,564,594
55-64	\$31,745	8,396	\$266,530,162
65-74	\$34,631	2,632	\$91,149,567
75-84	\$45,874	1,605	\$73,628,518
85+	\$59,753	888	\$53,060,866
All Recipients	\$30,271	50,746	\$1,536,134,830

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

Figure 21 shows the average number of chronic conditions per Medicaid recipient diagnosed with at least one chronic condition.⁷⁸ The average number of diagnosed chronic conditions consistently increases with age, reaching a maximum of 3.7 chronic conditions on average for recipients 65-74 years of age or older, before declining. Referred to as co-chronic or multiple-chronic conditions, the prevalence of co-chronic conditions increases with age.⁷⁹ While only speculation, the decline in the average number of chronic

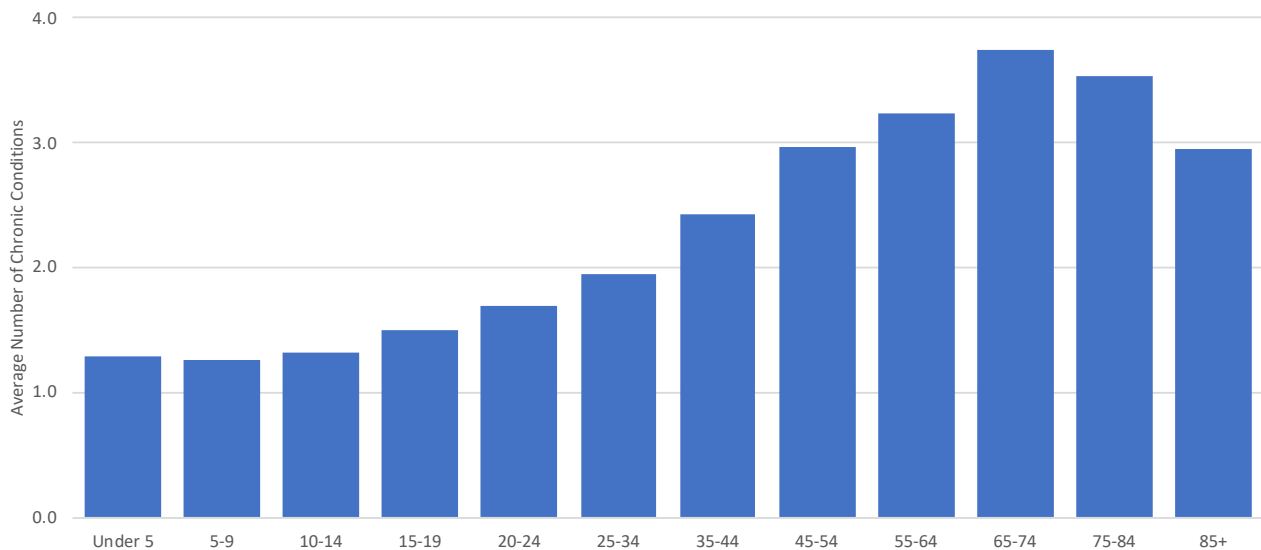
⁷⁸ In other words, the figure is based only on those recipients diagnosed with at least one chronic condition.

⁷⁹ See, for example, Mary L. Adams, "Differences Between Younger and Older US Adults with Multiple Chronic Conditions," *Preventing Chronic Disease*, 2017, Vol. 14. DOI:

https://www.cdc.gov/pcd/issues/2017/16_0613.htm

conditions for recipients in the 75-84 age cohort and the 85+ age group may be due to increased mortality associated with many chronic conditions.

Figure 21: Average Number of Diagnosed Chronic Conditions by Age for Medicaid Recipients Diagnosed with at Least One Chronic Condition, FY2019



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

Table 19 shows the distribution of Medicaid recipients by number of diagnosed chronic conditions, average spending per recipient, and total spending on all recipients. Nearly 74 percent of Medicaid recipients have no diagnosed chronic conditions and account for only 22 percent of total spending on Medicaid services. In comparison, about 10 percent of recipients have one diagnosed chronic condition but account for 23.5 percent of spending, and 16 percent of recipients have two or more chronic conditions but account for 54 percent of total spending on Medicaid services.

Average spending per recipient with one diagnosed chronic condition is nearly eight times greater than the average spending per recipient with no diagnosed chronic conditions. For Medicaid recipients with two or more diagnosed chronic conditions, average spending per recipient is 11 times greater than the average spending on a recipient with no chronic conditions.

Table 19: Distribution of Medicaid Recipients and the Cost of Providing Medicaid Services by the Number of Diagnosed Chronic Conditions, FY2019

Diagnosed Chronic Conditions	Medicaid Recipients	Percent of Recipients	Average Spending Per Recipient	Total Spending	Percentage of Spending
0	143,147	73.8%	\$3,396	\$486,056,726	22.2%
1	19,624	10.1%	\$26,226	\$514,660,802	23.5%
2	12,750	6.6%	\$32,517	\$414,594,379	18.9%
3	7,849	4.0%	\$36,203	\$284,159,502	13.0%
4	4,840	2.5%	\$41,137	\$199,101,358	9.1%
5	2,743	1.4%	\$46,774	\$128,302,217	5.9%
6	1,607	0.8%	\$48,940	\$78,646,150	3.6%
7	764	0.4%	\$60,984	\$46,592,042	2.1%
8 or More	569	0.3%	\$64,387	\$36,636,485	1.7%
All Recipients	193,893	100.0%	\$11,288	\$2,188,749,661	

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

Projected Spending on Medicaid Services for Recipients with Chronic Conditions

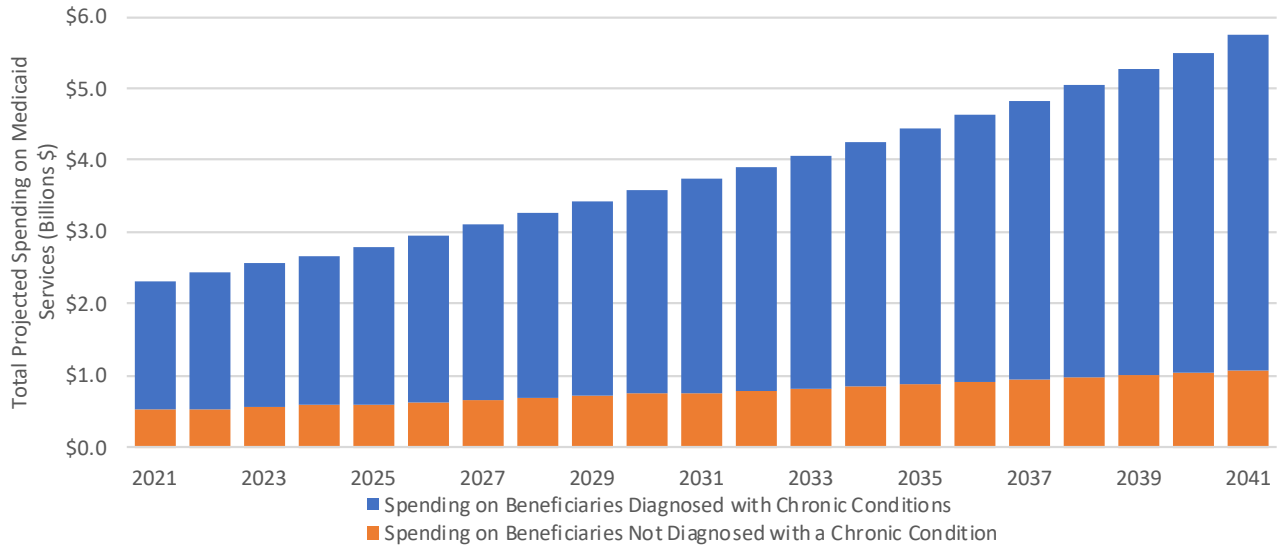
We used recipient-level data from the MMIS and the Medicaid enrollment forecast presented earlier in this report to project the prevalence of each of the chronic conditions shown in Table 16 each year through FY2041 for each of the 240 enrollment subgroups.⁸⁰ We projected the cost to the Medicaid program of providing services to each recipient with each respective chronic condition, accounting for the impacts of co-chronic conditions (so as to not double count Medicaid spending). As a conservative assumption, we fixed the rate of growth in spending on chronic conditions to be equal to the overall projected rate of growth in Medicaid spending (4.7%, see Table 12) plus the impact of changes in the demographic distribution of Medicaid enrollment – e.g., faster growth among seniors, who tend to have a greater number of chronic conditions.

Figure 22 shows our projection of total spending on Medicaid services from FY2021 through FY2041. Over this period, we project Medicaid spending on recipients diagnosed with one or more chronic conditions will grow from nearly \$1.8 billion (78% of total Medicaid spending) in FY2021 to \$4.7 billion (82% of total Medicaid spending) in FY2041.

⁸⁰ The forecasts of prevalence of chronic conditions, therefore, account for projected changes in the demographic makeup of the Medicaid population, but do not attempt to project changes in prevalence by demographic characteristic.

Comparatively, we project spending on recipients *not* diagnosed with a chronic condition will increase from \$512 million to \$1.23 billion between FY2021 and FY2041, which, though increasing on an average annual basis by 4.4 percent per year, will decrease as a proportion of total spending from 22 percent in FY2021 to 18 percent in FY2041.

Figure 22: Projected Spending on Medicaid Services, FY2021 - FY2041



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

3 Appendix Tables

Table 20: Medicaid Service Category Descriptions for Long-Term Forecast

Broad Category	Service Category	Description
Behavioral Health	Inpatient Psychiatric Hospital	Inpatient psychiatric hospital services
	Outpatient Mental Health	Outpatient mental health services, psychology services, and drug abuse centers
	Residential Psychiatric/Behavioral Rehabilitation Services	Residential psychiatric treatment centers and behavioral rehabilitation services (BRS)
Long-Term Care	Home & Community Based Waiver	Home and community based long-term care services offered through Medicaid Waivers including Alaska Pioneer Homes, assisted living homes, respite care, adult day care, chore services, residential and day habilitation, nutrition, and meals.
	Home Health/Hospice	Home health services, hospice care, nutrition services, and private duty nursing
	Nursing Home	Skilled nursing and intermediate care facilities including intermediate-care facilities for the intellectually disabled; and temporary long-term care services
	Personal Care	Personal care attendant services including agency-based and consumer-directed programs
Medical/Other	Dental	Dental services for children and adults
	Durable Medical Equipment/Supplies	Durable medical equipment (DME), medical supplies, prosthetics, and orthotics
	Early & Periodic Screening, Diagnosis & Treatment	Early, periodic screening, diagnosis and treatment (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
	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 21: 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 DHSS
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 22: Population Proportion by Rural & Urban, Alaska Boroughs and Census Areas

Borough	Rural	Urban
Aleutians East Borough	100%	0%
Aleutians West Census Area	100%	0%
Anchorage Municipality	4%	96%
Bethel Census Area	74%	26%
Bristol Bay Borough	100%	0%
Denali Borough	100%	0%
Dillingham Census Area	100%	0%
Fairbanks North Star Borough	31%	69%
Haines Borough	100%	0%
Hoonah-Angoon Census Area	100%	0%
Juneau City and Borough	22%	79%
Kenai Peninsula Borough	79%	21%
Ketchikan Gateway Borough	23%	77%
Kodiak Island Borough	31%	69%
Kusilvak Census Area	100%	0%
Lake and Peninsula Borough	100%	0%
Matanuska-Susitna Borough	50%	50%
Nome Census Area	66%	34%
North Slope Borough	59%	41%
Northwest Arctic Borough	58%	43%
Petersburg Borough	100%	0%
Prince of Wales-Hyder Census Area	100%	0%
Sitka City and Borough	21%	79%
Skagway Borough, Municipality of	100%	0%
Southeast Fairbanks Census Area	100%	0%
Valdez-Cordova Census Area	100%	0%
Wrangell City and Borough	100%	0%
Yakutat City and Borough	100%	0%
Yukon-Koyukuk Census Area	100%	0%

Source: U.S. Census Bureau, *2010 Census of Population and Housing, Population and Housing Unit Counts, CPH-2-3, Alaska*, Washington D.C.: U.S. Government Printing Office, 2012.
<https://live.laborstats.alaska.gov/cen/histpdfs/2010AlaskaPopulationHousing.pdf>

Table 23: Forecast of Population by Demographic Group

	Fiscal Year					Annual % Change
	2021	2026	2031	2036	2041	
State	735,007	756,302	774,232	789,970	803,549	0.4%
Gender						
Female	357,285	368,777	378,594	387,240	394,514	0.5%
Male	377,722	387,525	395,638	402,730	409,035	0.4%
Native Status						
Native	149,775	154,615	158,868	163,049	167,314	0.6%
Non-Native	585,232	601,687	615,364	626,921	636,235	0.4%
Region						
Northern	121,331	124,915	127,119	129,094	130,903	0.4%
Western	44,031	45,518	47,132	48,973	51,178	0.8%
South Central	96,861	98,294	99,375	100,144	100,568	0.2%
Anchorage/Mat-Su	400,773	415,641	429,076	440,952	451,210	0.6%
Southeast	72,011	71,934	71,530	70,807	69,690	-0.2%
Age Group						
0-4	49,616	51,164	51,466	52,861	54,273	0.4%
5-9	51,600	49,985	51,553	51,864	53,271	0.2%
10-14	52,923	51,940	50,341	51,919	52,242	-0.1%
15-19	49,374	53,064	52,076	50,487	52,060	0.3%
20-24	45,819	50,861	54,524	53,541	51,950	0.6%
25-34	107,830	100,409	101,633	110,552	113,459	0.3%
35-44	101,470	110,720	108,721	101,661	103,057	0.1%
45-54	83,579	86,031	97,874	106,952	105,118	1.2%
55-64	92,656	80,761	72,196	74,603	85,931	-0.4%
65-74	66,985	75,274	72,331	61,685	54,184	-1.1%
75-84	25,880	36,800	48,427	54,809	52,535	3.6%
85+	7,275	9,293	13,090	19,036	25,469	6.5%

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

Table 24: Forecast of Enrollment by Demographic Group

	Fiscal Year					Annual % Change
	2021	2026	2031	2036	2041	
State	263,800	273,964	283,978	294,091	304,632	0.7%
Gender						
Female	133,571	139,306	144,904	150,418	155,943	0.8%
Male	130,229	134,658	139,074	143,674	148,689	0.7%
Native Status						
Native	95,668	100,383	104,595	108,757	113,332	0.9%
Non-Native	168,132	173,581	179,383	185,334	191,300	0.6%
Region						
Northern	34,712	36,108	37,121	38,218	39,396	0.6%
Western	32,787	34,435	36,262	38,204	40,547	1.1%
South Central	34,959	35,873	36,845	37,815	38,861	0.5%
Anchorage/Mat-Su	136,512	142,471	148,360	154,180	159,848	0.8%
Southeast	24,830	25,078	25,390	25,674	25,981	0.2%
Age Group						
0-4	30,576	32,695	33,583	35,033	36,492	0.9%
5-9	30,070	29,747	31,739	32,471	33,863	0.6%
10-14	28,104	28,160	27,856	29,716	30,329	0.4%
15-19	24,286	26,593	26,703	26,272	28,006	0.7%
20-24	19,087	20,673	22,220	22,304	22,142	0.7%
25-34	42,195	41,123	42,294	45,469	47,055	0.5%
35-44	30,823	33,441	33,883	32,924	33,653	0.4%
45-54	21,347	22,196	24,860	27,099	27,330	1.2%
55-64	22,539	21,109	19,956	20,771	23,322	0.2%
65-74	9,371	10,819	10,875	9,596	8,629	-0.4%
75-84	3,854	5,460	7,279	8,474	8,450	4.0%
85+	1,548	1,948	2,730	3,963	5,360	6.4%

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

Table 25: Forecast of Spending by Demographic Group (Millions \$)

	Fiscal Year					Annual % Change
	2021	2026	2031	2036	2041	
State	\$2,307.6	\$2,950.8	\$3,750.2	\$4,627.7	\$5,743.0	4.7%
Gender						
Female	\$1,225.1	\$1,560.9	\$1,977.6	\$2,441.2	\$3,023.5	4.6%
Male	\$1,082.5	\$1,389.8	\$1,772.6	\$2,186.5	\$2,719.5	4.7%
Native Status						
Native	\$995.7	\$1,279.9	\$1,618.9	\$1,997.4	\$2,498.7	4.7%
Non-Native	\$1,311.8	\$1,670.8	\$2,131.3	\$2,630.4	\$3,244.4	4.6%
Region						
Northern	\$262.8	\$336.0	\$420.8	\$509.3	\$623.9	4.4%
Western	\$335.4	\$414.5	\$513.5	\$627.5	\$778.4	4.3%
South Central	\$325.5	\$411.6	\$521.2	\$637.2	\$786.8	4.5%
Anchorage/Mat-Su	\$1,137.1	\$1,488.9	\$1,930.2	\$2,421.0	\$3,031.3	5.0%
Southeast	\$246.7	\$299.7	\$364.4	\$432.7	\$522.6	3.8%
Age Group						
0-4	\$192.8	\$248.8	\$306.3	\$371.7	\$453.3	4.4%
5-9	\$116.9	\$141.7	\$176.6	\$213.2	\$261.5	4.1%
10-14	\$143.5	\$183.5	\$217.6	\$279.4	\$335.2	4.3%
15-19	\$198.4	\$258.7	\$315.4	\$344.1	\$438.1	4.0%
20-24	\$118.6	\$154.7	\$198.7	\$247.3	\$302.6	4.8%
25-34	\$349.1	\$437.7	\$555.8	\$691.9	\$849.5	4.5%
35-44	\$298.9	\$383.7	\$487.2	\$606.5	\$742.2	4.7%
45-54	\$255.4	\$320.2	\$417.6	\$530.7	\$649.4	4.8%
55-64	\$337.7	\$423.4	\$537.6	\$669.2	\$879.4	4.9%
65-74	\$134.4	\$173.9	\$209.5	\$213.2	\$219.2	2.5%
75-84	\$86.4	\$125.7	\$183.6	\$248.0	\$296.1	6.4%
85+	\$75.6	\$98.8	\$144.3	\$212.5	\$316.5	7.4%

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

Table 26: Forecast of Total Spending on Medicaid (Millions \$)

Service Category	Fiscal Year					Annual % Change
	2021	2026	2031	2036	2041	
Dental	\$81.7	\$119.5	\$152.4	\$181.4	\$213.5	4.9%
DME/Supplies	\$23.4	\$29.2	\$35.5	\$41.8	\$48.6	3.7%
EPSDT	\$16.8	\$24.0	\$29.4	\$35.2	\$42.9	4.8%
HCB Waiver	\$278.9	\$337.8	\$413.5	\$488.7	\$567.0	3.6%
Health Clinic	\$149.3	\$222.7	\$311.5	\$408.3	\$526.7	6.5%
Home Health/Hospice	\$12.5	\$19.8	\$27.7	\$36.1	\$44.4	6.5%
Inpatient Hospital	\$408.7	\$504.7	\$628.0	\$773.5	\$971.9	4.4%
Inpatient Psychiatric	\$18.6	\$22.9	\$27.1	\$31.9	\$39.1	3.8%
Lab/X-ray	\$8.1	\$9.8	\$12.3	\$15.2	\$19.0	4.4%
Nursing Home	\$169.8	\$228.3	\$309.3	\$401.4	\$513.1	5.7%
Other Services	\$1.3	\$1.6	\$1.9	\$2.2	\$2.6	3.3%
Outpatient Hospital	\$283.8	\$371.8	\$486.4	\$615.6	\$785.8	5.2%
Outpatient Mental Health	\$256.6	\$306.0	\$364.1	\$425.3	\$508.7	3.5%
Personal Care	\$45.2	\$56.2	\$68.8	\$81.2	\$94.1	3.7%
Pharmacy	\$179.3	\$219.2	\$274.5	\$337.4	\$422.8	4.4%
Physician/Practitioner	\$185.4	\$228.0	\$286.2	\$353.7	\$445.0	4.5%
Resident Psychiatric/BRC	\$26.4	\$40.0	\$54.4	\$68.8	\$87.9	6.2%
Therapy/Rehabilitation	\$34.1	\$46.2	\$57.1	\$66.4	\$75.1	4.0%
Transportation	\$119.8	\$149.7	\$189.7	\$235.3	\$297.0	4.6%
Vision	\$7.8	\$13.2	\$20.4	\$28.3	\$38.0	8.3%
Total Spending on Medicaid Services	\$2,307.6	\$2,950.8	\$3,750.2	\$4,627.7	\$5,743.0	4.7%
Other Medicaid Payments*	\$115.4	\$147.5	\$187.5	\$231.4	\$287.2	4.7%
Total Spending on Medicaid Program	\$2,422.9	\$3,098.3	\$3,937.7	\$4,859.1	\$6,030.2	4.7%

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

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

Table 27: Forecast of State Spending on Medicaid (Millions \$)

Service Category	Fiscal Year					Annual % Change
	2021	2026	2031	2036	2041	
Dental	\$19.7	\$30.0	\$38.2	\$45.5	\$53.6	5.1%
DME/Supplies	\$9.1	\$12.0	\$14.6	\$17.2	\$20.0	4.0%
EPSDT	\$3.1	\$4.6	\$5.6	\$6.7	\$8.1	4.9%
HCB Waiver	\$117.6	\$151.7	\$185.7	\$219.4	\$254.6	3.9%
Health Clinic	\$9.5	\$11.9	\$16.6	\$21.8	\$28.1	5.6%
Home Health/Hospice	\$5.3	\$9.0	\$12.5	\$16.3	\$20.1	6.9%
Inpatient Hospital	\$86.8	\$108.9	\$135.6	\$167.0	\$209.8	4.5%
Inpatient Psychiatric	\$6.4	\$8.5	\$10.0	\$11.8	\$14.5	4.1%
Lab/X-ray	\$2.2	\$2.7	\$3.4	\$4.2	\$5.2	4.5%
Nursing Home	\$58.6	\$83.1	\$112.7	\$146.2	\$186.8	6.0%
Other Services	\$0.3	\$0.3	\$0.4	\$0.5	\$0.5	2.9%
Outpatient Hospital	\$49.1	\$64.2	\$83.9	\$106.2	\$135.6	5.2%
Outpatient Mental Health	\$71.1	\$87.7	\$104.3	\$121.8	\$145.7	3.7%
Personal Care	\$18.7	\$36.4	\$44.6	\$52.7	\$61.0	6.1%
Pharmacy	\$44.6	\$56.1	\$70.2	\$86.3	\$108.1	4.5%
Physician/Practitioner	\$45.3	\$57.3	\$71.9	\$88.9	\$111.8	4.6%
Residential Psychiatric/BRC	\$12.1	\$19.6	\$26.7	\$33.7	\$43.0	6.5%
Therapy/Rehabilitation	\$13.3	\$19.1	\$23.6	\$27.5	\$31.1	4.3%
Transportation	\$12.5	\$14.8	\$18.7	\$23.2	\$29.3	4.3%
Vision	\$2.7	\$4.9	\$7.6	\$10.5	\$14.1	8.6%
Total Spending on Medicaid Services	\$588.2	\$782.7	\$986.9	\$1,207.4	\$1,481.2	4.7%
Other Medicaid Payments*	\$57.7	\$73.8	\$93.8	\$115.7	\$143.6	4.7%
Total Spending on Medicaid Program	\$645.8	\$856.5	\$1,080.6	\$1,323.1	\$1,624.8	4.7%

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

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