



Long-Term Forecast of Medicaid Enrollment and Spending in Alaska: FY2022–FY2042

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Executive Summary

This forecast is an update to the *Long-Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025*, which was released by the Alaska Department of Health and Social Services (DHSS) 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) 2022 through FY2042. The projections presented in this report are based on the Medicaid policies, services offered, and eligibility requirements in place today. Alaska’s Medicaid program has changed considerably since the first long-term forecast was released in 2006, and it is likely to evolve and change over the next 20 years. Nevertheless, the long-term forecast informs decision makers about how Medicaid spending in Alaska will likely evolve given the structure of the program as it exists today. The forecast also serves as a benchmark for evaluating the impacts of initiatives introduced by the State of Alaska, including cost containment measures that have been or will be implemented by DHSS.

Impacts of COVID-19 on Healthcare in Alaska

Governor Mike Dunleavy issued a declaration of public health disaster emergency in response to the anticipated breakout of COVID-19 in Alaska. The initial impact of COVID-19 on the healthcare sector in Alaska and across the U.S. was a substantial reduction in utilization and spending on healthcare services as hospitals, clinics, and other providers canceled or postponed elective procedures.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

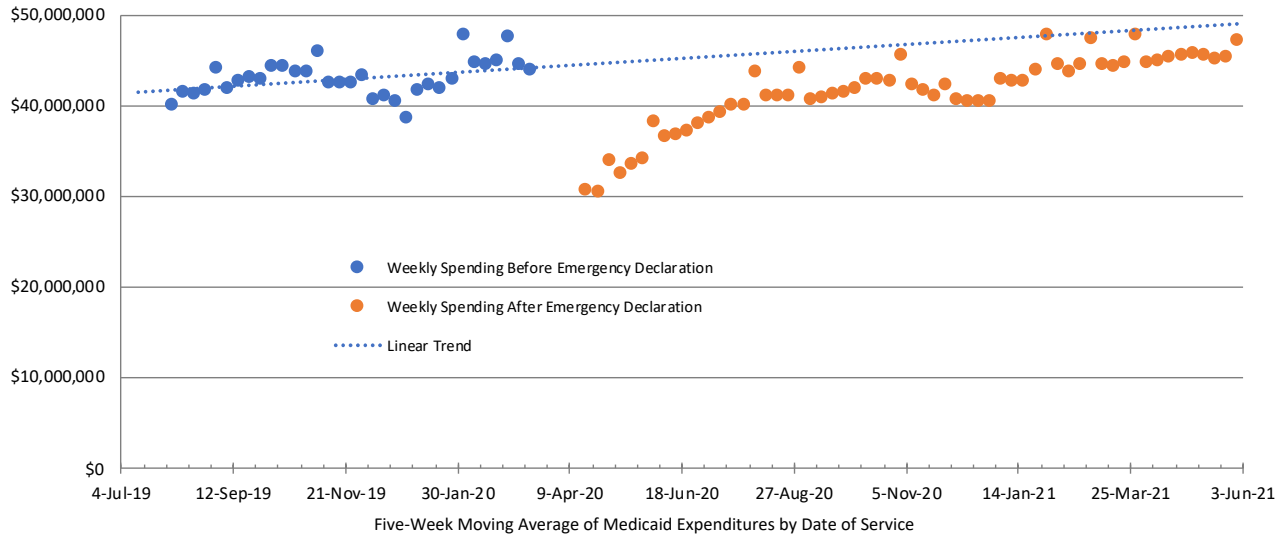
As Figure 1 shows, weekly spending on Medicaid services dropped substantially after the Governor’s declaration of a public health disaster emergency. Utilization and spending on healthcare services did pick back up after the initial shock but have not yet fully reverted to the pre-COVID trend in average weekly spending. 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.

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/>

Figure 1: Average Weekly Spending on Medicaid Services*

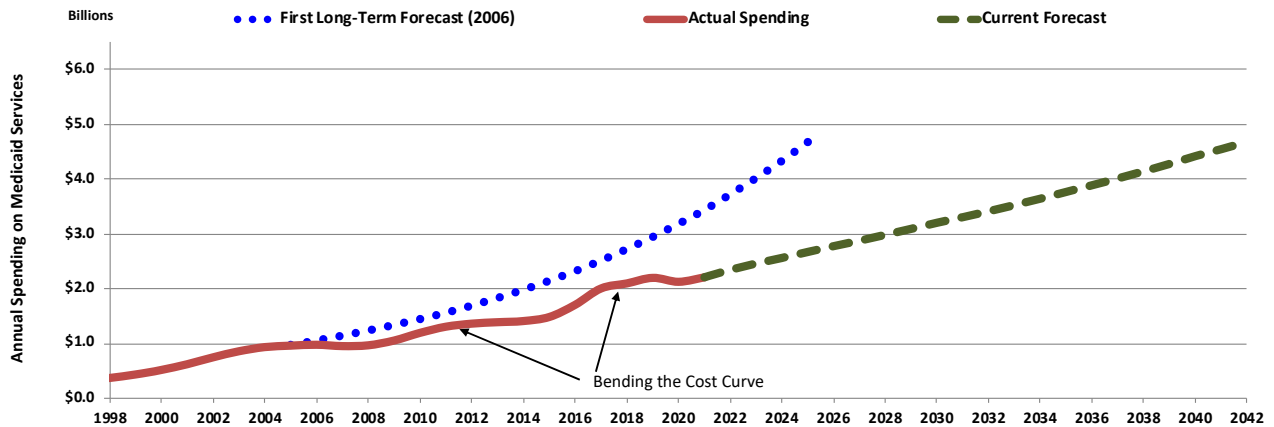


Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.
* Computed as five-week trailing moving average.

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

Figure 2 shows actual spending on Medicaid services beginning in FY1998 (solid red line), projected spending from the first long-term Medicaid forecast (blue dotted line), and the current projection of Medicaid spending (green dashed line). Actual spending on Medicaid services in FY2020 was about \$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 DHSS, which helped “bend the cost curve” on Medicaid spending.

Figure 2: Spending on Medicaid Services – Actual and Projected

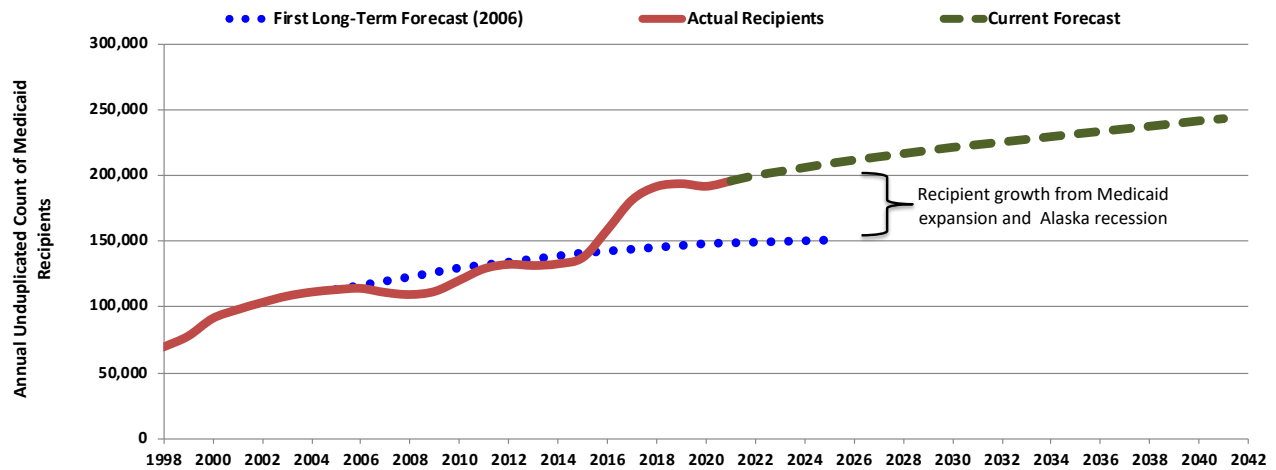


Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Figure 3 shows the number of Medicaid enrollees who received Medicaid services (referred to as “recipients”) each year beginning in FY1998 and the projected number of Medicaid recipients from the first long-term Medicaid forecast and for the current forecast.³ Between FY2006 and FY2015, the actual number of Medicaid recipients tracked closely to the number of recipients projected in the 2006 forecast. However, with the initiation of Medicaid expansion in September 2015, other components of the Patient Protection and Affordable Care Act (e.g., the individual mandate), and the Alaska economic recession that began in late 2014 and extended into 2019, enrollment in Medicaid increased considerably. The number of recipients decreased in FY2020 as some elective procedures were canceled by providers and many Medicaid enrollees chose to postpone visits to healthcare providers due to concerns related to COVID-19.

Growth in utilization of Medicaid services partially rebounded in FY2021 and, for the current forecast, we expect the number of Medicaid recipients to continue to grow, but at a decreasing rate through the projection period.

Figure 3: Medicaid Recipients – Actual and Projected

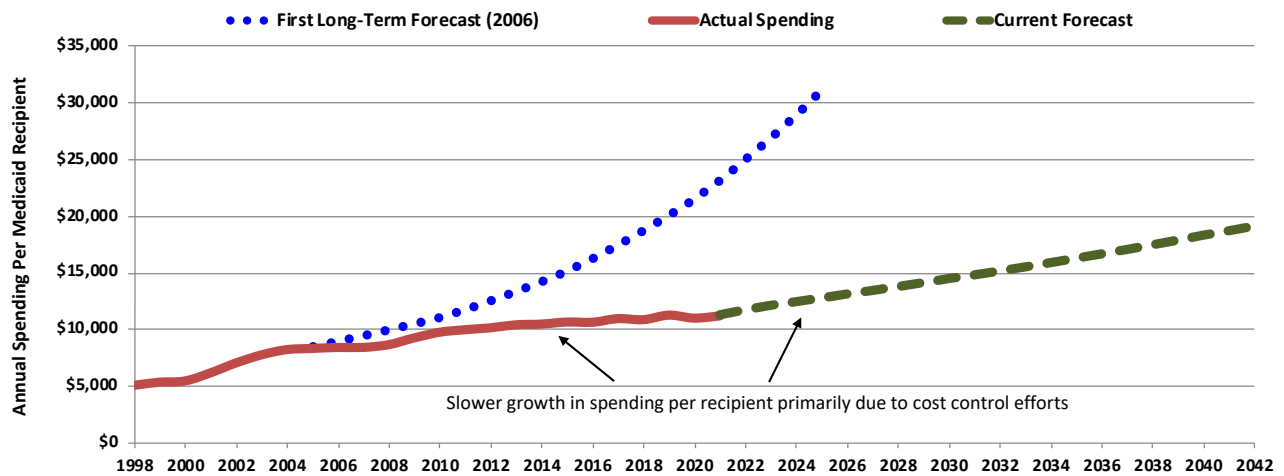


Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

³ 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.

As noted, spending on Alaska’s Medicaid program is considerably less today than was projected in the first long-term Medicaid forecast. At the same time, the number of Medicaid recipients is much greater today than was projected in 2005. The net effect of lower-than-projected spending and a greater-than-projected number of recipients is much lower-than-projected average spending per Medicaid recipient. Figure 4 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 4: Medicaid Spending per Recipient – Actual and Projected



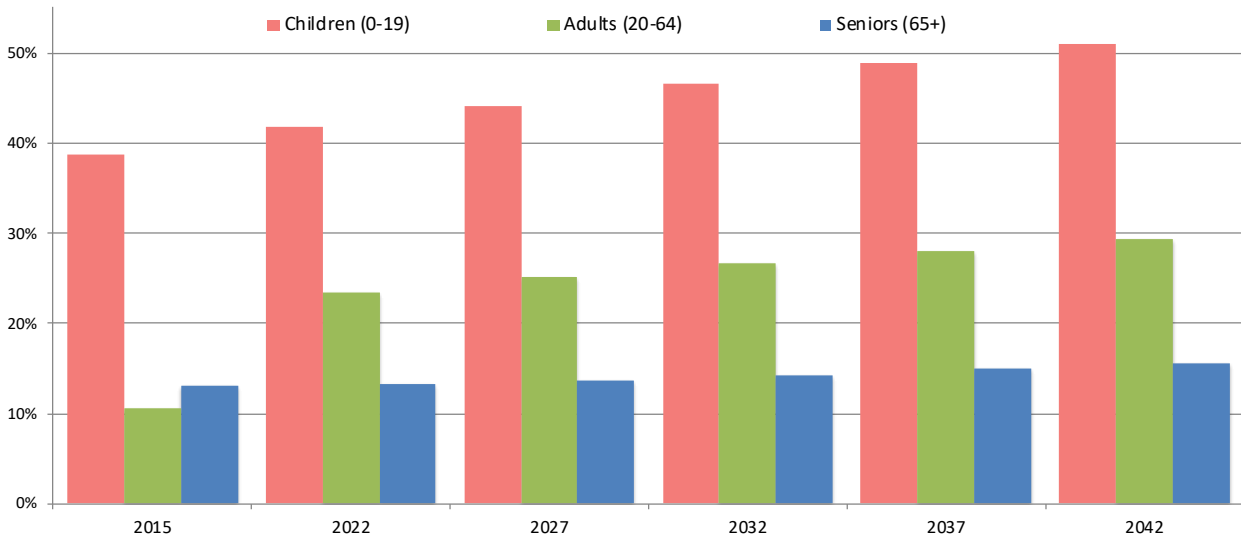
Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

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. Figure 5 shows the proportion of Alaska children,⁴ 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, nearly 24 percent of adults will receive services through Alaska’s Medicaid program in FY2022, up from just 11 percent in FY2015. We project that nearly 27 percent of Alaska adults will be Medicaid recipients by FY2032 and that about 29 percent will be recipients by FY2042.

⁴ 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.

We project that the proportion of seniors receiving Medicaid services will grow from 13.4 percent in FY2022 to nearly 17 percent by FY2042, and that the proportion of Alaska children receiving Medicaid services (or services through the Children’s Health Insurance Program [CHIP]) will grow from 42 percent today to 51 percent in FY2042.

Figure 5: Medicaid Recipients as a Proportion of Alaska’s Population for Selected Fiscal Years 2015–2042



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

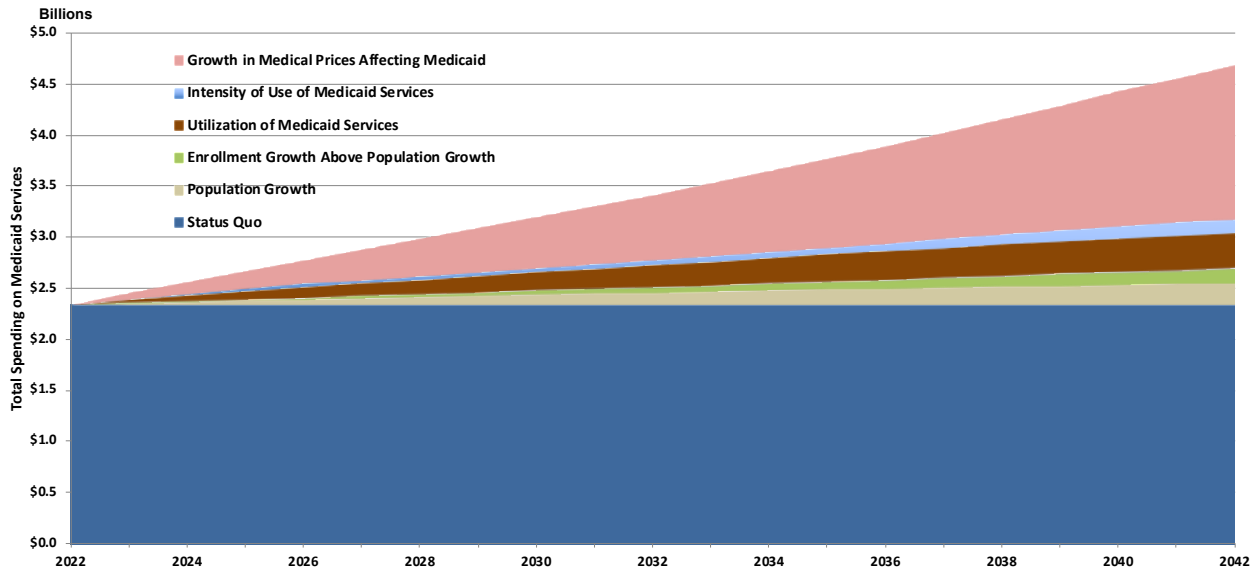
We project that total spending on Medicaid services will increase from \$2.3 billion in FY2022 to nearly \$4.7 billion in FY2042 – an average of 3.5 percent per year. This projected rate of growth in Medicaid spending is substantially lower than the projected growth rate from the first long-term forecast completed in 2006. In that forecast, spending on Medicaid services was projected to grow on an annual average basis by 7.8 percent, which was still far below the 17 percent per year rate of growth between FY1998 and FY2004.⁵

We expect healthcare price inflation to be the primary driver of spending growth in Alaska’s Medicaid program, accounting for more than 60 percent of the growth in spending between FY2022 and FY2042 (Figure 6). Healthcare price inflation may not directly impact what DHSS pays providers for services in any given year. However, DHSS has processes in place to periodically review the schedule of rates paid to providers for Medicaid services. Since 2006, provider reimbursement rates have increased at a much

⁵ 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.

slower rate than overall medical price inflation. For this forecast, we expect growth in reimbursement rates to continue to lag medical price inflation.

Figure 6: 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 FY2042, we project that growth in the population, growth in the proportion of Alaskans enrolling in Medicaid, and growth in utilization and intensity of Medicaid services will combine to increase spending on the Medicaid program by about \$834 million.

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 3.5 percent per year through FY2042, with slightly faster growth in spending by the State of Alaska (Table 1).

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

Fund Source	2015	2022	2027	2032	2037	2042	Annual Growth*
State and Other Match Funds	\$681	\$595.3	\$802.3	\$972.5	\$1,156.7	\$1,351.7	4.2%
Federal	\$901	\$1,742	\$2,067	\$2,437	\$2,854	\$3,327	3.3%
Total Spending**	\$1,582	\$2,337	\$2,870	\$3,409	\$4,010	\$4,679	3.5%

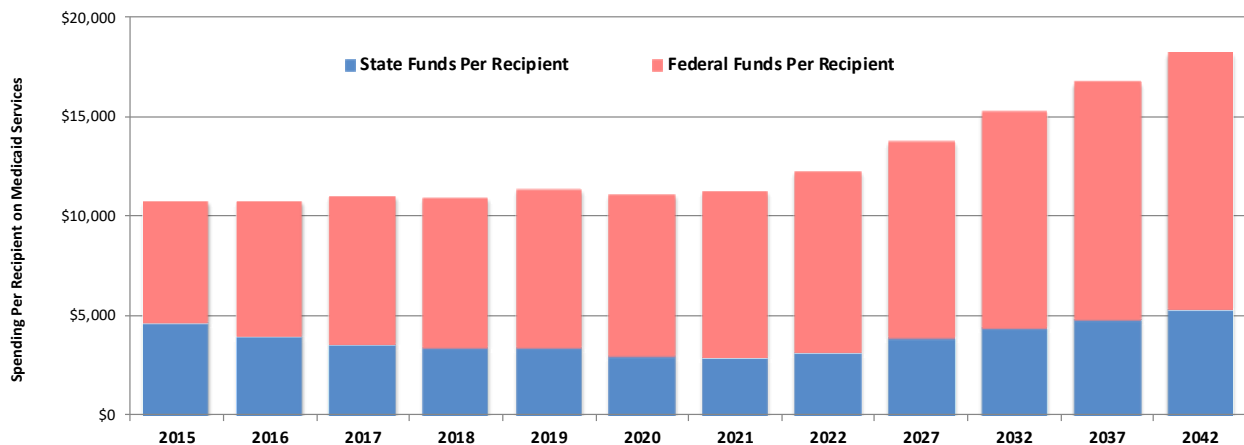
Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

* Annual growth computed from FY2022 to FY2042

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

Figure 7 shows recent actual and projected future average spending per Medicaid recipient. Between FY2015 and FY2021, spending per Medicaid recipient was flat, and the proportion paid with state general funds decreased substantially. Over the next 20 years, we project average spending per recipient will increase by about 2 percent per year due primarily to growth in healthcare price inflation and the aging of Alaska’s population. With the federal health emergency response to COVID-19 currently set to expire at the end of March 2022, we expect growth in general fund spending to average 2.7 percent through FY2042, while federal spending will grow by only 1.8 percent per year.

Figure 7: 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 – FY2020 are actuals, FY2021 is estimated, FY2022 – FY2042 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.⁶ In state fiscal year (FY) 2014 and FY2015, the federal government paid approximately 57 percent of the cost of services provided through Alaska's Medicaid program.⁷ Federal participation was about 73.6 percent in FY2020 and 74.5 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. These additional funds from HHS are scheduled to end March 31, 2022. We estimate federal participation for FY2022 will be 73.2 percent and, for the remainder of the forecast, will remain between 70 percent and 73 percent.

People qualify for Medicaid by meeting income standards and specified eligibility requirements related to age, family status, and disability status. Traditionally, Medicaid covered only aged,⁸ blind, or disabled persons, children, and adults with dependent children. Medicaid extended coverage in 1998 through the Children's Health Insurance Program (CHIP) to children whose family income is too high to qualify for regular Medicaid, but too low to afford private health insurance. As we describe in greater detail below, Alaska again extended Medicaid coverage in 2015, this time to adults who meet certain income requirements, but were not previously eligible for Medicaid.⁹

In Alaska, the Division of Health Care Services administers CHIP, and the Division of Public Assistance manages enrollment for regular Medicaid and CHIP.¹⁰ Alaska Medicaid

⁶ 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.

⁷ The overall rate of federal financial participation (57%) is an average of multiple Federal Medical Assistance Percentage (FMAP) rates weighted by the amount of spending associated with each rate. See the subsection titled State Spending on Medicaid Services in Section 2.5 for a discussion of the rate of federal financial participation associated with each FMAP.

Unless otherwise stated, all references to fiscal year are state fiscal year, which begins July 1 and ends June 30. For example, FY2020 for Alaska began July 1, 2019, and ended June 30, 2020. In comparison, federal fiscal years begin October 1 and end September 30.

⁸ Under Medicaid descriptions of eligibility, "aged" refers to persons 65 years of age or older. Throughout this report, we refer to this population as "seniors" except when referring to Medicaid eligibility.

⁹ Throughout this report, we use three general age categories: children to refer to anyone under 20 years of age, adults to refer to those 20 to 64 years of age, and seniors to refer to anyone 65 years of age or older.

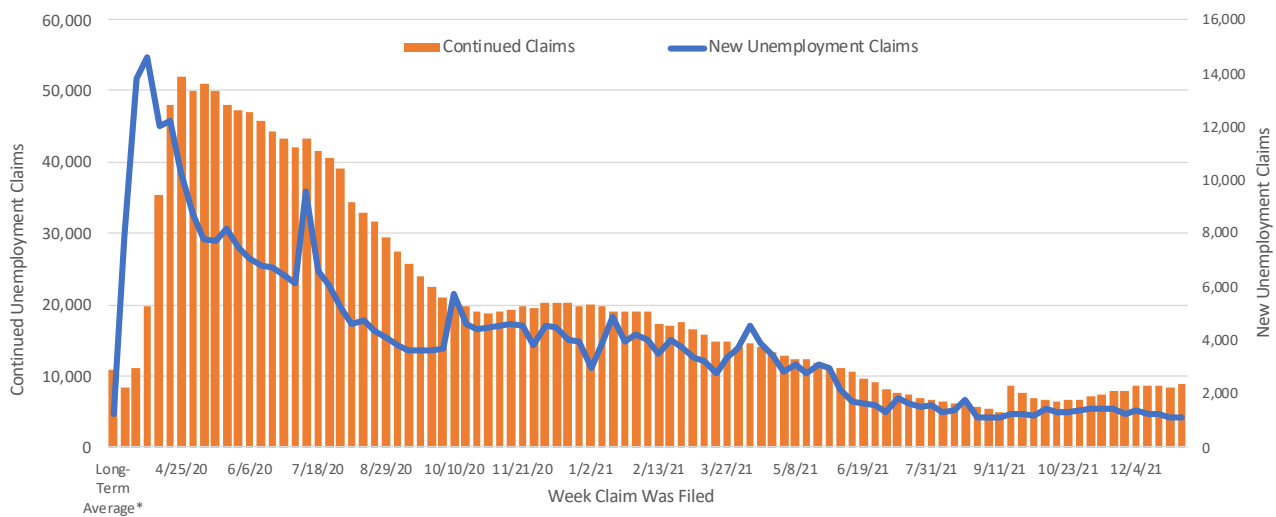
¹⁰ Both divisions are within the Alaska Department of Health and Social Services (DHSS).

reimburses hospitals, physicians, and other healthcare providers for providing healthcare services to Medicaid enrollees. It operates as a fee-for-service program, meaning that it reimburses (pays) providers per unit of service rendered according to established rates of payment.

1.1 Impact of COVID-19 on 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 (Figure 8).¹¹ Since then, both have declined and are now below the pre-pandemic, seven-year average levels, which are represented by the point on the horizontal axis labeled “Long-Term Average” in Figure 8. During that period, new unemployment claims averaged about 1,300 per week, and total continued claims averaged fewer than 11,000.¹²

Figure 8: 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 the U.S. Bureau of Labor Statistics (BLS).

* Average weekly new and continued claims, January 1, 2013 – December 4, 2021.

¹¹ 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.

¹² 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 difficulty in Alaska set off by a steep drop in worldwide prices for oil and natural gas beginning in late 2014.

I.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.¹³

Medicaid expansion may also have impacted the Alaska Medicaid program indirectly by allowing individuals with disabilities to enroll in Medicaid through Medicaid expansion eligibility (i.e., by being below the income threshold) rather than waiting for a disability determination. Prior to Medicaid expansion, adults without dependent children could only qualify for Medicaid based on the determination of having a qualified disability and meeting income requirements specific to the individual’s living arrangement.¹⁴

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

¹³ 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.

¹⁴ 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/>

most non-senior applicants.¹⁵ 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 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 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.¹⁶ 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.

¹⁵ 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.

¹⁶ For information on the ACA individual mandate to purchase health insurance, please see <http://kff.org/infographic/the-requirement-to-buy-coverage-under-the-affordable-care-act/>

I.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 in November 2019 for mental health physician clinics. The new requirements included screening and brief intervention services and an integrated mental health and substance use intake assessment. Regulations were also adopted for Medicaid Behavioral Health Marital & Family Therapy Services, which became effective July 2020. The new regulations added licensed marital and family therapists (LMFTs) to the list of providers eligible to enroll with DHSS and to bill directly for Medicaid services rendered. DHSS also adopted Medicaid Coverage, Behavioral Health Services, and Revised Requirements for Behavioral Health Providers in April 2020, which added a new specialty for substance use disorder (SUD) counselors.

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 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 transitioned to the ASO in July 2021.

In FY2021, 5,770 Medicaid beneficiaries received 1115 Waiver services. Most of these beneficiaries (5,498) were Medicaid recipients in FY2020 or another earlier fiscal year. Recipients of 1115 Waiver services were nearly evenly split by gender in FY2021 (Table 2). In comparison, for other Medicaid recipients, 53 percent were female and 47 percent were male. The distribution of recipients of 1115 Waivers differed from other Medicaid recipients with respect to age, Medicaid eligibility, and region of the state. Just over half of 1115 Waiver recipients were 20 to 44 years of age, while only about one-third of other Medicaid recipients were in this age group. Very few recipients of 1115 Waivers were in the youngest or oldest age groups; 7.4 percent were below 10 years of age and 2 percent were 65 years of age or older. In comparison, nearly 24 percent of other Medicaid recipients were under 10 years of age and 6.4 percent were 65 or older.

Recipients of 1115 Waiver services were more likely to be enrolled in Medicaid through expansion than other recipients (41% versus 23%) and less likely to be Indian Health

Service (IHS) eligible (11.6% versus 25.6%). Just under half of recipients of 1115 Waiver services were enrolled through a “regular” (not expansion) eligibility category, while just over half of other recipients were enrolled through a regular Medicaid eligibility category. Nearly 60 percent of Medicaid recipients on the 1115 Waiver live in the Anchorage/Mat-Su region, compared to half of recipients not on the 1115 Waiver. In comparison, only 6.2 percent of 1115 Waiver recipients live in the Western region, compared to nearly 14 percent of all other recipients.

Table 2: Demographic Characteristics of 1115 Waiver Recipients, FY2021

Demographic Characteristic	1115 Waiver Recipients		All Other Recipients	
	Recipients	Percent	Recipients	Percent
Gender				
Female	2,888	50.1%	101,450	53.1%
Male	2,882	49.9%	89,669	46.9%
Age				
Under 10	425	7.4%	45,085	23.6%
10-19	986	17.1%	37,954	19.9%
20-34	1,713	29.7%	40,353	21.1%
35-44	1,262	21.9%	22,026	11.5%
45-54	689	11.9%	15,510	8.1%
55-64	578	10.0%	17,877	9.4%
65+	117	2.0%	12,314	6.4%
Eligibility				
Expansion*	2,367	41.0%	44,014	23.0%
IHS	669	11.6%	48,854	25.6%
Regular Medicaid	2,734	47.4%	98,251	51.4%
DHSS Region				
Anchorage / Mat-Su	3,376	58.5%	95,722	50.1%
Northern	598	10.4%	24,369	12.8%
South Central	718	12.4%	26,000	13.6%
Southeast	681	11.8%	17,625	9.2%
Western	360	6.2%	26,276	13.7%
Unknown/Out of State	37	0.6%	1,127	0.6%
All Recipients	5,770		191,119	

*Includes IHS expansion.

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 Declaration of Public Health Disaster Emergency, behavioral health providers have been able to offer telemedicine options when face-to-face encounters jeopardize the health and safety of treatment recipients and providers.

Health Care and Tribal Health Services Reforms

COVID-19 Flexibilities

Section 1135 of the Social Security Act authorizes the Secretary of Health and Human Services to temporarily modify certain Medicaid requirements when there is a Presidential declaration of national emergency. Such modifications are referred to as "flexibilities."¹⁷ At the onset of the COVID-19 public health emergency and state disaster declaration, the Alaska Medicaid program implemented numerous flexibilities to increase access to and remove potential barriers to the provision of health care services. Flexibilities related to the now-expired state disaster declaration have been phased out, while those related to the federal public health emergency remain in place. Data from these federal and state flexibilities afford DHSS the opportunity to analyze the efficacies of these temporary changes and determine which, if any, should be reimplemented on a permanent basis through regulatory changes.

Telehealth Services

In FY2021, the Medicaid program paid \$50.6 million in claims for services delivered via telehealth methods, an increase of 134 percent over the amount paid for services delivered through telehealth in FY2020. Delivering services to a recipient via telehealth has the potential for program savings through avoided transportation costs. The savings in transportation costs have not yet been quantified and will be difficult to analyze until the COVID-19 public health emergency is no longer affecting travel for Alaskans.

Coordinated Care Demonstration Project

The Coordinated Care Demonstration Project Initiative awarded a competitively bid contract to a patient-centered medical home provider in Anchorage in 2018. With a focus on facilitating steps to mature the alignment of reimbursement with more coordinated care

¹⁷ <https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Resources/Waivers-and-flexibilities>

clinical delivery models, the Division of Health Care Services is analyzing the clinical and financial benefits from this demonstration project, following three years of continuous operation, for potential transition to a more sustainable and inclusive program, such as a 1915(b) Waiver program.

Covered Outpatient Drug Value-Based Purchasing (VBP) Arrangements

The Centers for Medicare and Medicaid Services (CMS) delayed the effective date of final rule CMS-2482-F2 entitled “Medicaid Program; Establishing Minimum Standards in Medicaid State Drug Utilization Review (DUR) and Supporting Value-Based Purchasing (VBP) for Drugs Covered in Medicaid, Revising Medicaid Drug Rebate and Third-Party Liability (TPL) Requirements” to July 1, 2022. Once the rule is in effect, state Medicaid programs will have the opportunity to enter into VBP arrangements with pharmaceutical manufacturers, outside of a supplemental rebate agreement, when such manufacturers offer the VBP arrangement in the commercial marketplace.¹⁸

Federal Financial Participation for Services to American Indians and Alaska Natives

Historically, Alaska’s Medicaid program has received 100 percent federal financial participation (FFP) for Medicaid services provided to American Indians/Alaska Natives (AI/AN) only when those services were received through federal or tribal health care facilities. CMS’s February 2016 State Health Official Letter #16-002 updated the “received through” policy to allow state Medicaid programs to claim 100 percent FFP for services provided to an AI/AN Medicaid recipient by a non-federal or non-tribal health care facility, contingent upon the presence of a care coordination agreement between the providers, documentation of a referral by the tribal health provider, and an exchange of medical records of the care received. Under the direction of SB 74, DHSS partnered with tribal health organizations to fully implement this revised federal policy. To date, more than 6,200 care coordination agreements signed between tribal and non-tribal providers have resulted in state general fund savings exceeding \$305 million.

Procurement of Fiscal Agent Services

In 2021, DHSS issued a request for proposals (RFP) to solicit proposals for a qualified contractor to provide fiscal agent services and related operational expertise to take over and operate certain administrative and clinical aspects of the Alaska Medicaid program, including fiscal agent services and related operations. This initiative will separate Medicaid program fiscal agent services from technical operations and maintenance of the Medicaid Management Information System (MMIS), affording the department greater

¹⁸ Medicaid Program, 2020, p. 87028, <https://www.federalregister.gov/documents/2020/12/31/2020-28567/medicaid-program-establishing-minimum-standards-in-medicaid-state-drug-utilization-review-dur-and>

flexibility in responding to changing operational and administrative needs of the program. The budget for the services is estimated to be \$90,000,000 to \$135,000,000 over the three initial years and five optional one-year periods of the contract.

Care Management Services

The Care Management Program (CMP) was established by the Alaska DHSS under the authority of Section 7 of the Alaska Administrative Code (AAC) 105.600 to restrict the use of Medicaid services deemed to be at a frequency or amount that is not appropriate.¹⁹ Historically, the CMP restricted a recipient to a primary care provider (PCP) and a single primary care physician and pharmacy to reduce overuse and misuse of services, encourage continuity of care, and promote communication between the recipient's PCP and pharmacy. Effective January 1, 2021, HCS implemented regulatory changes to the CMP to allow assignment of primary dental and behavioral health providers.

Outpatient Hospital Observation Services

Effective January 28, 2021, HCS implemented Medicaid coverage and payment regulatory changes related to outpatient hospital observation services, allowing providers to bill and Alaska Medicaid to seek FFP for up to 48 hours of observation services. Prior to changes, observation services were limited to 24 hours. These changes align with Medicare observation limits and allow additional time for providers to receive results of diagnostic tests and assess recipient healthcare needs when the recipient cannot be safely discharged to their home, but when the need for admission to inpatient status has not been substantiated.

Senior and Disability Services Reforms

The Division of Senior and Disabilities Services (SDS) transferred Chore Services out of Home and Community-based Waiver Services and into the Community First Choice program on January 1, 2021. This administrative change will enable the state to receive an additional 6 percentage points in FFP going forward, reducing the state's portion for funding for this Medicaid service.

The Individualized Support Waiver (ISW) is a new waiver that is expected to reach its capacity of 600 recipients by the end of FY2022. The waiver served 441 individuals in FY2021, drawing recipients from the Developmental Disabilities Registration and Review waitlist. The ISW was developed as one of the initiatives of Senate Bill 74, the 2016 Medicaid reform bill.

¹⁹ The Alaska State Legislature. "Title 7 Health and Social Services, Chapter 105 Medicaid Provider and Recipient Participation, Section 600 Restriction of recipient's choice of providers." <http://www.akleg.gov/basis/aac.asp#7.105.600>

SDS successfully implemented Electronic Visit Verification (EVV) on January 1, 2021, as required under the federal 21st Century Cures Act of 2016. EVV will enable the state to improve the health and welfare of recipients of personal care services by validating delivery of those services through mobile phones and other applications. Considerable work remains on a variety of fronts for this initiative, including development of the interface between the state’s electronic visit verification system and MMIS to validate that personal care visits documented by EVV are accurately matched to Medicaid claims for these services. Once fully implemented, EVV is anticipated to be a valuable tool in reducing fraud, waste, and abuse in personal care services.

Growth in Alaska’s population aged 60 and older, the needs of individuals with disabilities who also have complex behavioral or medical conditions, and challenges in meeting the workforce needs for all those eligible for SDS services increase the likelihood that Medicaid spending will increase in the years ahead. Without adequate capacity and infrastructure across the spectrum of home and community-based services, seniors and individuals with disabilities will increasingly need to meet their care needs in nursing facilities and other institutional settings. Institutional care is not only more expensive than home and community-based care, but it also reduces an individual’s independence, dignity, choice, and participation in community living.

Public Health Pandemic Response and Initiatives

DHSS has provided leadership and capacity for Alaska to respond to the COVID-19 pandemic, including providing expertise and guidance to communities, health care systems and facilities, schools, businesses, large group gatherings, and other partners to enable their use of non-pharmaceutical interventions. This has included coordination and dissemination of information on public access to those services.²⁰

Compared to peer states – Idaho, Montana, North Dakota, South Dakota, New Mexico, and Wyoming – Alaska had lower rates of COVID-19 hospitalizations and deaths through December 2021.²¹ Had Alaska experienced similar rates of hospitalizations and deaths as those peer states, Alaska Medicaid spending over that period would have been more than \$60 million higher.²²

²⁰ Nonpharmaceutical interventions (NPIs) are actions, apart from vaccinations or other medicines, that individuals and communities can take to slow the spread of on an illness. Centers for Disease Control and Prevention (CDC). 2020. “Nonpharmaceutical Interventions (NPIs).”

<https://www.cdc.gov/nonpharmaceutical-interventions/index.html>

²¹ Memorandum from Evergreen Economics to Linnea Osborne, Medicaid, Allocation, and Audit Services, Finance and Management Services, Department of Health and Social Services, January 12, 2022.

²² Ibid

DHSS supported five communities (Juneau, Anchorage, Kenai, Fairbanks, and Mat-Su) to start Mobile Integrated Health (MIH) programs using emergency medical services. MIH programs reduce stress on hospital systems by working with them to enable early discharge through home monitoring and care and by reducing admissions through providing appropriate triage and on-scene care to reduce the need for transport to the emergency department or allowing transport to an appropriate alternate destination or facility.

DHSS coordinated dissemination of testing, vaccination, and monoclonal antibody treatment services between health care providers and the public to increase access to those services. DHSS additionally provided community-based testing, vaccination, and monoclonal antibody treatment services statewide to supplement services offered by local and regional health care providers and communities. These services were, in some cases, directly provided by DHSS staff, and in others by contracted vendors. This supplemental capacity made these services more widely available to the public, especially during periods of peak demand.

Public Health Initiatives

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

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 FY2022-FY2042 projection of enrollment in and spending on the Medicaid program in Alaska. It is the fifteenth update to the original long-term Medicaid forecast, which DHSS engaged the Lewin Group to conduct in April 2005.

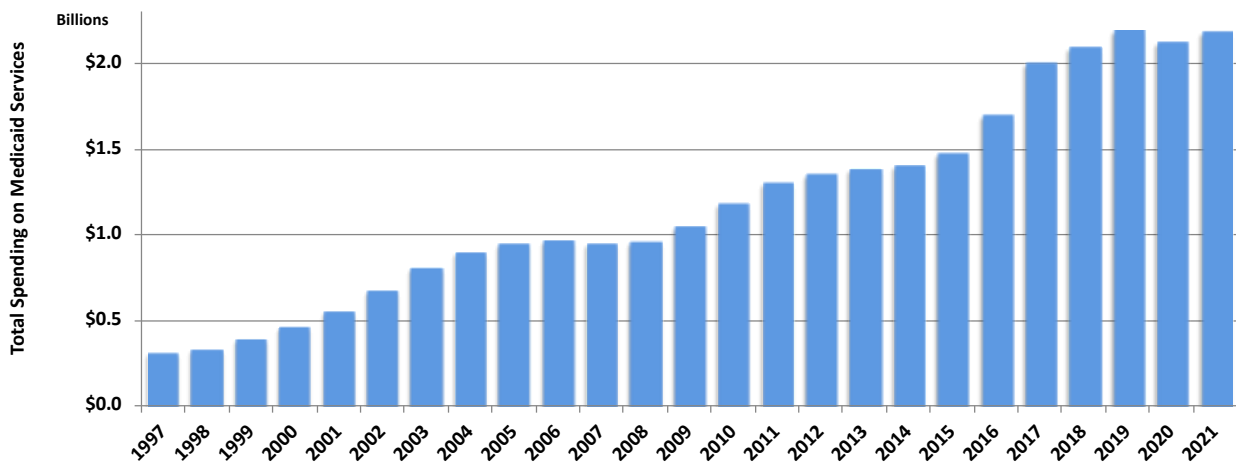
²³ Alaska Native, American Indian, and other race categories are based on self-identification of Medicaid enrollees. In FY2020, 93,793 Medicaid enrollees reported their race as either Alaska Native or American Indian. Of these, 3,751 (4.0%) identified as American Indian.

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 numerous changes during the projection period, the assumption of no change is necessary to show how Medicaid spending in Alaska will likely evolve given the structure of the program as it exists today.

1.5 Recent Historical Trends in Medicaid Spending

Spending on Alaska’s Medicaid program grew rapidly from FY1997 through FY2005, increasing an average of 16 percent per year (Figure 9).²⁴ Medicaid spending decreased slightly between FY2006 and FY2008 due at least in part to program changes put in place by DHSS following the release of the *Long-Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025* in January 2006. However, with the onset of the severe national economic recession that began in 2008, enrollment in and spending on Medicaid again grew rapidly beginning in FY2009 and extending into FY2011.

Figure 9: 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; FY2021 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

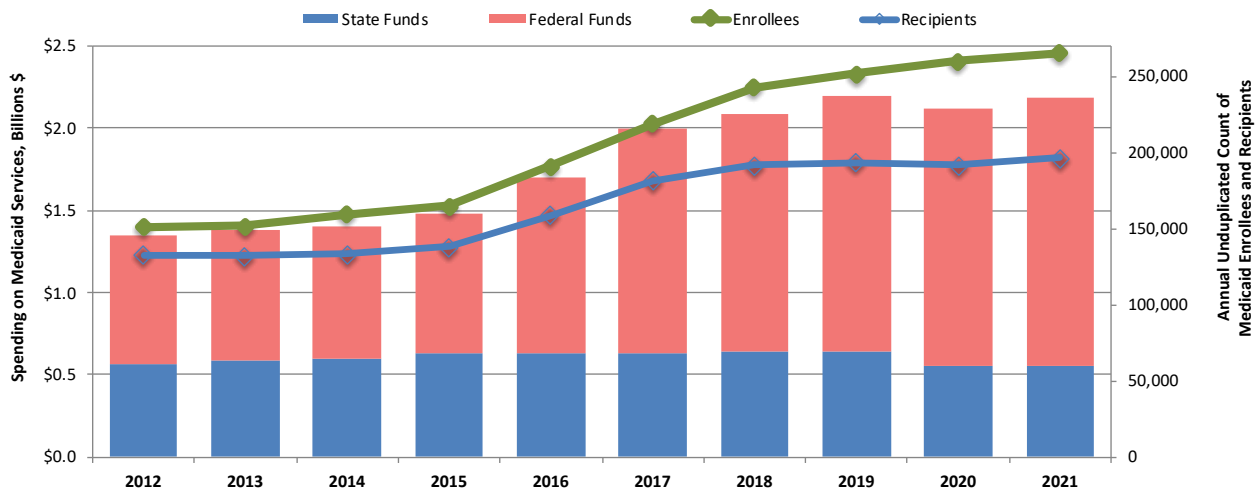
²⁴ FY1997 is the earliest year for which we had data on spending.

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 began to slow in FY2018 and decreased in FY2020 with the Governor’s declaration of a Public Health Disaster Emergency in March 2020.

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 10 shows total spending on Medicaid services for FY2012 through FY2021, split by state and federal funding, and the trend in Medicaid enrollment and number of recipients over this same period.²⁶

Figure 10: Spending on Medicaid Services, Enrollment in the Medicaid Program, and Recipients of Medicaid Services, Based on Date of Service, FY2012 - FY2021



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group; 2021 estimated.

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.” Effective October 18, 2021, the Secretary of Health and Human Services (HHS) extended the public health emergency through March 2022.

²⁶ State spending includes Unrestricted General Fund, Designated General Fund, and Other; enrollment is annual unduplicated count.

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 FY2021, the proportion of Alaskans enrolled in Medicaid at any time during the year had grown to about 36 percent. Due to Medicaid expansion and other components of the ACA, growth in the proportion of Alaskans enrolled in Medicaid was especially strong after FY2015 (Figure 11). 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, but then increased slightly in CY2020 to 12.6 percent.²⁷ Evergreen Economics projects that the proportion of Alaskans without health insurance coverage will increase slightly to about 13 percent in FY2022.²⁸ The proportion of Alaskans receiving health insurance through an employer decreased from 51 percent in CY2010 to 48.4 percent in CY2019, but then dropped precipitously to 39.9 percent in CY2020 due to employment losses associated with COVID.²⁹ We expect the proportion of Alaskans enrolled in employer-sponsored insurance has increased from the CY2020 low and will continue to increase; however, health insurance data from the U.S. Census for CY2021 will not be available until mid-2022).

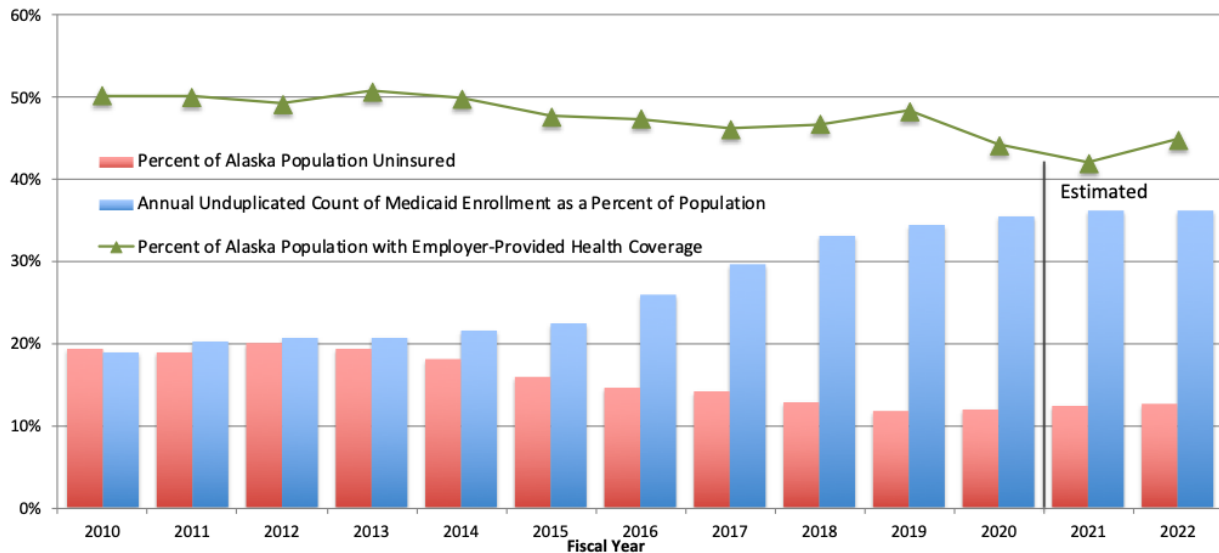
²⁷ "KFF's State Health Facts, "Health Coverage & Uninsured," KFF. <https://www.kff.org/state-category/health-coverage-uninsured/>

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

²⁹ Josh Bivens and Ben Zipperer, "Health insurance and the COVID-19 shock," Economic Policy Institute, August 26, 2020. <https://www.epi.org/publication/health-insurance-and-the-covid-19-shock/>

Figure 11: Recent Trends in Health Insurance Coverage in Alaska



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

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

The 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) and *rural* as any population, housing, or territory *not* in an urban area.³⁰ Based on these definitions, only 34 percent of Alaskans currently live in a rural area.³¹ Table 3 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 most Alaskans live in urbanized areas or urban clusters (again, as defined by the Census). A greater proportion of Alaska’s rural population is enrolled in Medicaid (41%) than is the population living in urban areas (32%).³²

³⁰ 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>

³¹ Ibid

³² Table 21 in the appendix of this report shows the proportion of the rural and urban populations for each borough and Census area in Alaska.

In FY2020, total spending on Medicaid services for Alaskans living in rural areas was \$836 million, and for Alaskans living in urban areas, total spending was \$1.28 billion. On a percentage basis, rural Alaskans accounted for 40 percent of spending on Medicaid services, and urban Alaskans accounted for 60 percent, which was virtually unchanged from FY2019.

Table 3: Distribution of Alaska Population and Medicaid Enrollment and Spending by Rural/Urban Status, FY2020

Metric	Count	Percent of Alaska Population	Percent of Rural or Urban Population
Alaska Population*	735,007		
Alaska Rural Population*	247,904	34%	
Alaska Urban Population*	487,103	66%	
Alaska Medicaid Enrollment**	265,391	36%	
Rural Population on Medicaid**	101,664	14%	41% of Rural Population
Urban Population on Medicaid**	163,727	22%	32% of Urban Population
Alaska Medicaid Spending	\$2.12 Billion		
Spending on Rural Alaskans	\$836 Million	40% of Spending on Medicaid Services	
Spending on Urban Alaskans*	\$1.28 Billion	60% of Spending on Medicaid Services	

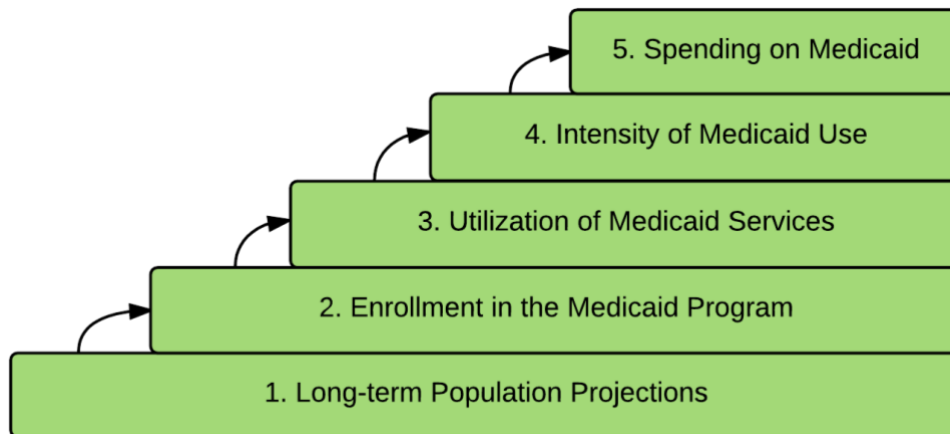
*Rural and urban population estimated by Evergreen Economics based on data from projection by the Alaska Department of Labor and Workforce Development (DOLWD); projections represent estimated population as of July 1, 2021.

**Annual unduplicated count

2 Overview of Projections: FY2022-FY2042

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.³³ As Figure 12 shows, the foundation of the Medicaid spending forecast is the long-term projection of Alaska’s population, which, for this update, is based on the Alaska Department of Labor and Workforce Development’s (DOLWD’s) most recent population forecast.³⁴ 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 12: 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 230,400,³⁵ and about one in five Alaskans (44,237) lived in Anchorage.³⁶ By the time Alaska started its Medicaid program

³³ 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*.

³⁴ 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>

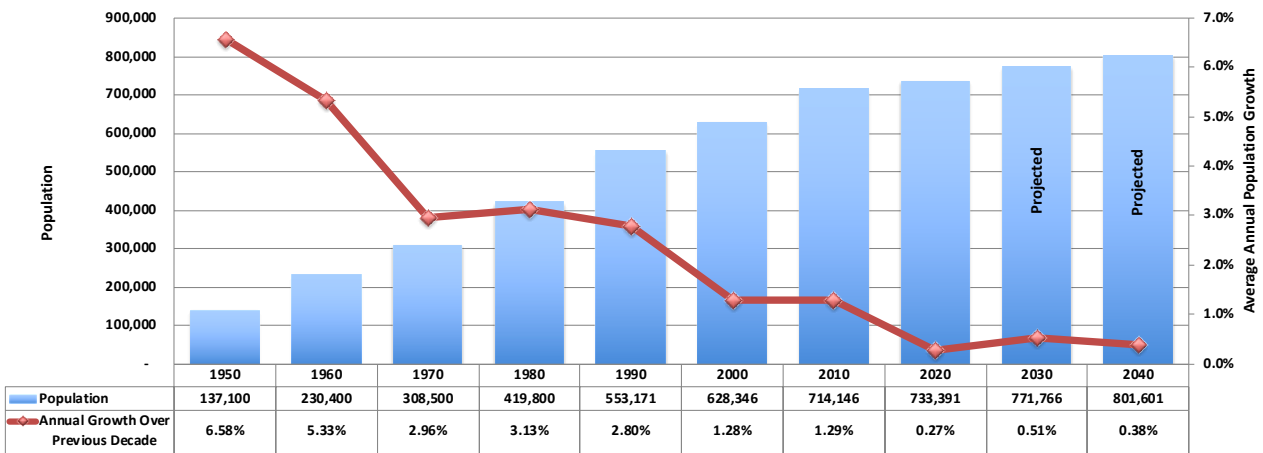
³⁵ Alaska Department of Labor and Workforce Development, *Alaska Population Overview: 2010 Census and 2011 Estimates*, October 2012. <http://live.laborstats.alaska.gov/pop/estimates/pub/1011popover.pdf>

³⁶ 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 330,000.³⁷ 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.³⁸ By 1990, the state’s population had grown to 553,171, and two in five Alaskans (226,338) lived in Anchorage.³⁹

As Alaska’s population has grown, its rate of growth has continued to slow (Figure 13). 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 2040.⁴⁰

Figure 13: 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 2020; by 2040, the Alaska DOLWD projects there will be 104 males

³⁷ 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>

³⁸ For more information on the impact of the Trans-Alaska Pipeline, see Alyeska Pipeline Service Company, “Trans Alaska Pipeline System - The Facts.” <http://alyeska-pipeline.com/TAPS/PipelineFacts>

³⁹ 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>

⁴⁰ 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.⁴¹ We expect this to have a small effect on the Medicaid program, as adult females tend to incur higher average annual costs than adult males and enroll in the Medicaid program at a slightly greater rate.⁴²

The DOLWD projects the senior population will grow at a faster rate than the overall population (Table 4) and, though seniors enroll in Medicaid at a much lower rate than children and at a slightly lower rate than adults 20-64, the average cost per recipient of providing Medicaid services for seniors is higher than for children or adults.⁴³

Table 4: Alaska’s Projected Population by Age Cohort for Selected Years 2022–2042

Age Group	2022	2027	2032	2037	2042	Avg. Annual Change
Children (0-19)	204,179	205,905	205,580	208,083	212,620	0.20%
Adults (20-64)	430,285	429,553	437,270	449,727	461,669	0.35%
Seniors (65+)	104,442	124,143	134,203	134,667	131,467	1.16%
Total Population	738,906	759,601	777,053	792,477	805,756	0.43%

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 at the time of enrollment and register to receive Medicaid services during a fiscal year – regardless of whether the individual receives Medicaid services during the fiscal year or not. There are three primary factors that determine growth in Medicaid enrollment: (1) population growth, (2) changes in the demographic characteristics of the population, and (3) changes in Medicaid eligibility requirements. For the purposes of this report, we assume that eligibility requirements as they exist today will remain constant over the 20-year projection period.

Nearly 55 percent of Alaska children were enrolled in the Medicaid program during all or some portion of FY2021, compared to only one in four adults and one in seven senior

⁴¹ Ibid; nationally, there are 103 females for every 100 males.

⁴² 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.

⁴³ 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.

Alaskans. Historically, children were the primary focus of the Medicaid program. However, that changed substantially with the introduction of Medicaid expansion in September 2015. Today, the Alaska Medicaid program covers more adults than children, and we expect the proportion of enrollees who are adults (20 years of age or older) will increase through FY2042.

“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 in Medicaid and the number of recipients of Medicaid services. In this report, we present our projections for both enrollees and recipients, but focus greater attention on recipients because these are the Medicaid enrollees who are utilizing Medicaid services.

Medicaid enrollment increased rapidly between FY2014 and FY2020, due primarily to the introduction of the ACA, which led to increases in Medicaid enrollment across the country. The ACA included changes to the Modified Adjusted Gross Income (MAGI) standard used to determine Medicaid and CHIP eligibility, which made it easier for individuals to qualify for either program. In addition, the insurance mandate in the ACA⁴⁴ and the “no wrong door” feature of the federal healthcare exchange allowed consumers to complete a single streamlined application to determine eligibility for a subsidized health plan, CHIP, or Medicaid. The congressional repeal of the insurance mandate, which took effect in January 2019, has had little-to-no discernable impact on Medicaid enrollment to date. This may be due in part to some Alaskans not being aware of the repeal, as well as to the federal COVID-19 public health emergency mandate that states maintain continuous enrollment for individuals, regardless of any change in employment, income, or other covered circumstance. We do expect that the repeal of the individual insurance mandate will result in slowing Medicaid enrollment over the 20-year forecast period, once the COVID-19 public health emergency has ended.

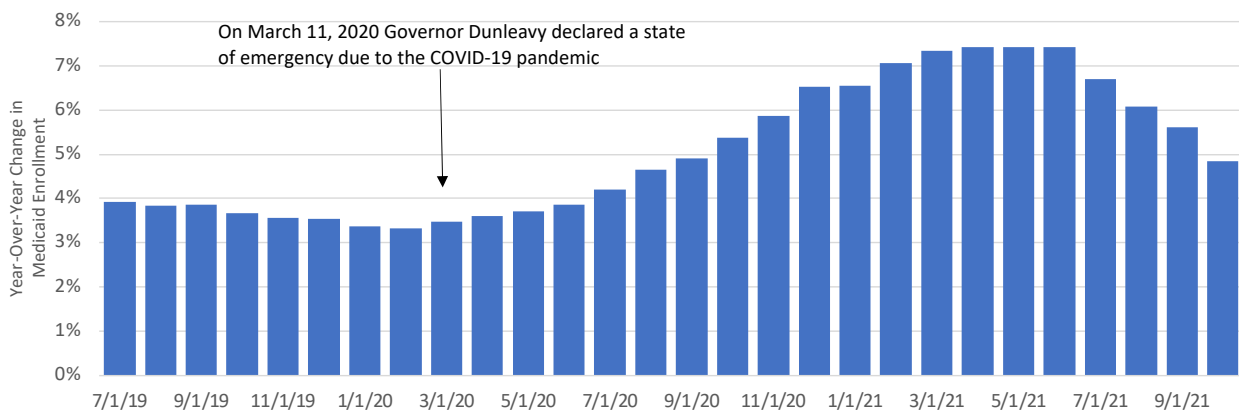
Medicaid expansion had the greatest impact on Alaska’s Medicaid program of any component of the ACA. Medicaid expansion launched in September 2015, resulting in a substantial increase in enrollment of adults. Alaska also experienced an economic

⁴⁴ 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/>

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.⁴⁵

The COVID-19 pandemic resulted in faster growth in Medicaid enrollment. Most of this growth is likely due to the continuous enrollment mandate, which requires that an individual enrolled in Medicaid remain enrolled even if the individual becomes ineligible. As Figure 14 shows, growth in Medicaid enrollment was slowing through February 2020, but then began to increase in March, when Governor Dunleavy declared a state of emergency due to the COVID-19 pandemic. The annualized rate of growth in monthly Medicaid enrollment continued to grow through June 2021 (7.4% annualized growth). The rate of growth has continued to decrease each month since July 2021 (first month of FY2022) but remains above the pre-pandemic growth rate.

Figure 14: Year-Over-Year Change in Monthly Medicaid Enrollment, July 2019 – November 2021



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

We expect growth in Medicaid enrollment and in the number of recipients to slow considerably through the projection period, as the effects of Medicaid expansion and other ACA-based changes to the Medicaid program have largely already occurred, and once the COVID-19 public health emergency is ended. Table 5 shows the forecast for enrollment and recipients by age cohort through FY2042, with FY2015 as a benchmark (the year before Medicaid expansion began). We expect Medicaid enrollment to reach 307,000 by FY2042 and the number of recipients to reach nearly 270,000.

⁴⁵ 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.

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

Age Cohort	Measure	2015	2022	2027	2032	2037	2042	Percent Change*
Children (0-19)	Enrollees	94,799	112,217	115,576	118,293	122,393	127,399	0.64%
	Recipients	79,725	85,408	90,889	96,033	102,488	109,914	0.89%
Adults (20-64)	Enrollees	58,959	139,301	142,141	146,955	152,275	157,489	0.62%
	Recipients	48,254	100,481	107,838	117,048	127,209	137,690	1.01%
Seniors (65+)	Enrollees	11,189	15,915	19,255	21,498	22,352	22,681	1.79%
	Recipients	9,790	13,946	17,000	19,163	20,140	20,633	1.91%
All Ages**	Enrollees	164,947	267,433	276,971	286,746	297,021	307,569	0.70%
	Recipients	137,769	199,835	215,727	232,244	249,837	268,237	1.03%

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

* Average annual percent change between FY2022 and FY2042.

** 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 18.7 percent of Alaskans received Medicaid services (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 32 percent of adults (20-64) will be enrolled in Medicaid in all or part of FY2022. The proportion of children enrolled in Medicaid has also grown since FY2015 due in part to components of the ACA, recessionary economic conditions in Alaska during much of this period, and the federal continuous enrollment mandate. The proportion of Alaska seniors enrolled in Medicaid has 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	2022	2027	2032	2037	2042
Children (0-19)	Enrollees	46.0%	55.0%	56.1%	57.5%	58.8%	59.9%
	Recipients	38.7%	41.8%	44.1%	46.7%	49.3%	51.7%
Adults (20-64)	Enrollees	12.9%	32.4%	33.1%	33.6%	33.9%	34.1%
	Recipients	10.6%	23.4%	25.1%	26.8%	28.3%	29.8%
Seniors (65+)	Enrollees	15.0%	15.2%	15.5%	16.0%	16.6%	17.3%
	Recipients	13.1%	13.4%	13.7%	14.3%	15.0%	15.7%
Total Ages*	Enrollees	22.4%	36.2%	36.5%	36.9%	37.5%	38.2%
	Recipients	18.7%	27.0%	28.4%	29.9%	31.5%	33.3%

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, FY2022 – FY2042

Eligibility Group	Measure	2022	2027	2032	2037	2042	Annual Growth
Aged or Disabled	Enrollees	33,047	35,789	38,430	40,636	42,596	1.28%
	Recipients	28,298	31,356	34,449	37,270	39,972	1.74%
Medicaid Expansion*	Enrollees	70,627	73,573	75,809	77,148	77,537	0.47%
	Recipients	46,688	50,498	54,025	57,084	59,569	1.23%
All Other Eligibilities	Enrollees	163,758	167,611	172,507	179,237	187,436	0.45%
	Recipients	124,848	133,873	143,770	155,483	168,696	1.23%
Total**	Enrollees	267,432	276,973	286,746	297,021	307,569	0.70%
	Recipients	199,835	215,727	232,244	249,837	268,237	1.03%

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.⁴⁶

⁴⁶ 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.

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.⁴⁷

In the first long-term Medicaid forecast completed in February 2006 and in each subsequent forecast through the FY2021-FY2041 update, Medicaid services were organized into the same 20 Medicaid service categories. For this forecast, we have made the following changes and additions to the service categories:

1. Combined Inpatient Psychiatric services and Residential Psychiatric/Behavioral Rehabilitation Centers (RBC) into a single service category.
2. Added Other services, which has average annual spending of less than \$500,000, to the Outpatient Hospital services category.
3. Added 1115 Waivers as a new service category, which was instituted in FY2020 to improve access to services, improve population health outcomes, contain costs, and increase the types of behavioral health providers serving Medicaid recipients.
4. Added 1915 Waivers as a new service category, which consists of two new State Plan options for long-term services and support: (1) the 1915(k) Community First Choice waiver, which provides enhanced personal care services including skills training to foster independence and self-care for recipients who meet institutional level of care criteria, and (2) the 1915(c) Individualized Supports waiver, which provides services under a per-individual annual dollar cap to recipients with intellectual and developmental disabilities who meet institutional level of care criteria. Both initiatives became operational October 1, 2018 (FY2019).

The 20 service categories are listed in Table 8, segmented into three service groups. A more detailed description of each service category is provided in the appendix of this report.

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

Service Group	Service Category
Behavioral Health Services	Inpatient Psychiatric & Residential Psychiatric / BRC ⁴⁸ Outpatient Mental Health

⁴⁷ We consider "intensity of use" in the subsequent step of the long-term Medicaid forecast.

⁴⁸ BRC stands for Behavioral Rehabilitation Centers.

Service Group	Service Category
	1115 Waiver ⁴⁹
Long-Term Care Services	Nursing Home
	Home Health / Hospice
	Personal Care
	HCB State Plan Services ⁵⁰
	HCB 1915(c) Waivers ⁵¹
Healthcare Services	Inpatient Hospital
	Outpatient Hospital
	Health Clinic
	Physician / Practitioner
	Dental
	Lab / X-Ray
	EPSDT ⁵²
	Therapy / Rehabilitation
	Vision
	Pharmacy
	DME ⁵³ / Supplies
Transportation	

Variability in the Utilization of Medicaid Services

There is and we believe there will continue to be substantial variability among enrollees in the rate of service utilization, with approximately 15 percent to 25 percent of enrollees not

⁴⁹ Medicaid Section 1115 Demonstration Waivers provide states with flexibility to test new approaches within Medicaid to aid in redesigning and improving their health system without increasing costs. Alaska's 1115 Waiver is an integrated behavioral health system of care for Alaskans experiencing serious mental illness, severe emotional disturbance, substance use disorder (SUD), co-occurring substance use and mental illness, and at-risk families and children.

⁵⁰ HCB (home and community based) State Plan Services provide support for Medicaid recipients to remain in their home; services include personal care services, targeted case management services, and 1915(k) Community First Choice (CFC) services, which include CFC personal care services, personal emergency response systems, and chore services. To be eligible for CFC, an enrollee must require a level of care that would otherwise be provided in an institution such as a nursing home or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

⁵¹ Alaska has five different home- and community-based 1915(c) waivers. Eligibility for 1915(c) waiver services depends on participants requiring a level of care that would otherwise be provided in an institution, such as a nursing home or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

⁵² EPSDT stands for Early and Periodic Screening, Diagnosis, and Treatment.

⁵³ DME stands for Durable Medical Equipment.

utilizing any Medicaid services during a fiscal year⁵⁴ and a small number of recipients utilizing 10 or more different service categories in the year. Some of this variability is correlated with age as children utilize on average fewer Medicaid service categories than adults, and adults utilize on average fewer Medicaid service categories than seniors.

The underlying factor driving utilization of Medicaid services is being diagnosed with one or more chronic conditions. The likelihood of having one or more chronic conditions increases with age. In FY2020, Medicaid recipients with no diagnosed chronic conditions utilized on average three Medicaid service categories (Table 9). In comparison, Medicaid recipients with one diagnosed chronic condition utilized on average 5.2 service categories, recipients with two to four diagnosed chronic conditions utilized on average 5.6 Medicaid service categories, and recipients with five or more chronic conditions utilized on average 6.4 Medicaid service categories.

Table 9: Number of Medicaid Service Categories Utilized in FY2020

Number of Diagnosed Chronic Conditions	Number of Service Categories Utilized
No Diagnosed Chronic Conditions	3.0
One Diagnosed Chronic Condition	5.2
Two to Four Diagnosed Chronic Conditions	5.6
Five or More Diagnosed Chronic Conditions	6.4
Average of All Medicaid Recipients	3.6

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

We project utilization of Medicaid services will grow on average by about 1.3 percent per year over the next 20 years, with faster growth in the next two years as the U.S. transitions out of the pandemic, and then slowing through the remainder of the forecast period.

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 2020. Over this period, Alaska

⁵⁴ In FY2020 and FY2021, nearly 27 percent of Medicaid enrollees did not utilize any Medicaid services. Under the federal COVID-19 public health emergency rules, states are required to maintain continuous Medicaid enrollment for individuals, regardless of any change in employment, income, or other circumstance (except for moving out of state). There are likely individuals enrolled in Alaska’s Medicaid program that have health insurance through an employer or another source, but because of the federal mandate, remain enrolled – but not using services – in the Medicaid program

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 FY2019.⁵⁵ To isolate the effects of intensity of use, we removed the price effects associated with inflation from each year of spending data, resulting in estimates of spending on Medicaid services as if there were no increases in healthcare prices. With inflation removed, year-to-year differences in average spending per Medicaid recipient represent changes in the intensity of use of services provided to recipients.⁵⁶

We used the resulting inflation-adjusted spending data to develop statistical models to explain intensity of use as a function of (1) demographic characteristics and (2) a time-trend. We then used the coefficients estimated in these models to predict intensity of use for each of the 20 service categories through FY2042. 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 FY2042.⁵⁷

2.5 Total Spending on Medicaid Services

The final step (Figure 12) of the Alaska long-term forecasting model is to develop estimates of total spending for each Medicaid service category through FY2042. In each previous forecast, we projected the annual rate of medical price inflation for Alaska for each year of the 20-year projection period and then applied these estimates of medical price inflation to the Medicaid spending forecast – step 5 of the 5-step process shown in Figure 12 – to complete the forecast of spending on Medicaid services. For the FY2022 – FY2042 forecast, we made a substantive change to this approach to account for differences between the rate of medical price inflation in Alaska – e.g., change in prices for all medical services regardless of payer – and the rate of growth in the schedule of fees paid by the Medicaid program to providers for services provided to Medicaid recipients.

Comparing Medical Price Inflation to Changes in the Rates Paid for Medicaid Services

Evergreen Economics analyzed Medicaid fee schedule data for a sample of procedure codes for FY2021 and earlier fiscal years.⁵⁸ We found that the rate of growth in the

⁵⁵ U.S. Bureau of Labor Statistics, “Consumer Price Index,” Data for medical care in urban Alaska, <https://www.bls.gov/cpi/data.htm>

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

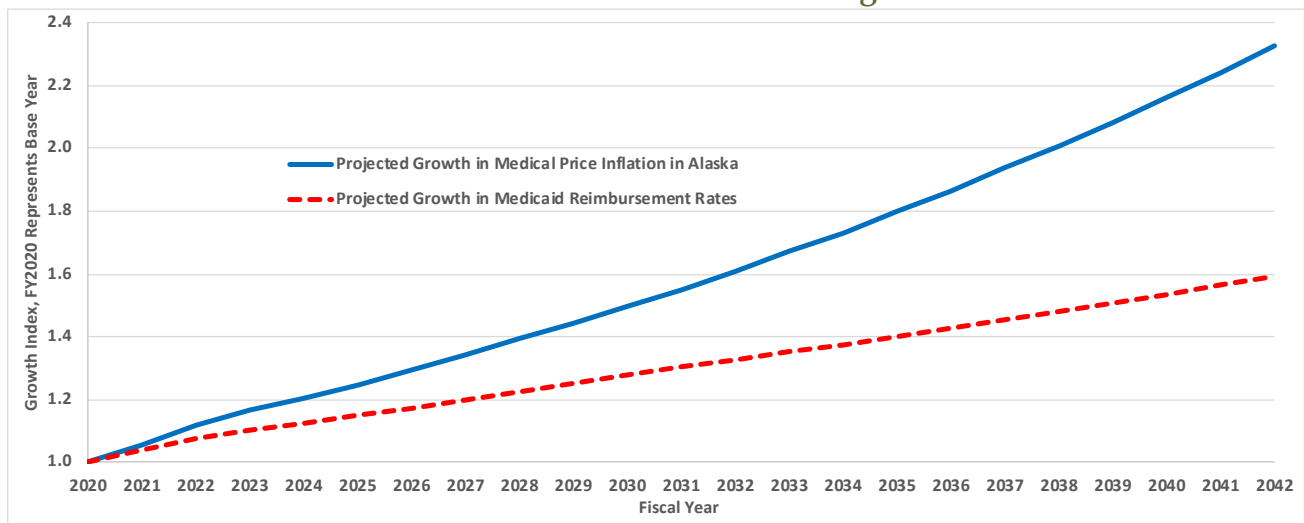
⁵⁷ We relied on the Medical Care component of the All Urban Consumer Price Index for Anchorage as the measure of historical healthcare price inflation. U.S. Bureau of Labor Statistics, “Consumer Price Index.” www.bls.gov/cpi

⁵⁸ Procedure codes are defined by the Healthcare Common Procedure Coding System (HCPCS), <https://www.cms.gov/medicare/coding/medhcpcsgeninfo>

Medicaid program’s published schedule of reimbursement rates over the past decade was substantially lower than the overall rate of medical price inflation in Alaska over the same period.⁵⁹ Based on these findings and our expectation that the rate of growth in Medicaid reimbursement rates will continue to lag overall medical price inflation, we adjusted our projection of medical price inflation to represent our expectation of future growth in reimbursement rates for Medicaid services.

Our projected rate of growth in medical price inflation is nearly twice our projected growth in Medicaid reimbursement rates (Figure 15). As we discuss below, the impact that this change has on the forecast of Medicaid spending is substantial. Reimbursement rates are reviewed annually, biennially, or triennially, and based on these reviews, are periodically updated.⁶⁰

Figure 15: Projected Rates of Growth in Medical Price Inflation and Medicaid Reimbursement Rates in Alaska Through FY2042



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

We project that while medical price inflation will increase by about 3.7 percent per year over the next 20 years, growth in Medicaid reimbursement rates will grow by only about 2.1 percent per year.

⁵⁹ Alaska Medicaid fee schedules and covered codes are available at:

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

⁶⁰ There are likely many factors considered when reviewing Medicaid reimbursement rates, including the costs of providing medical and related services, which are impacted by medical price inflation.

Table 10 shows project spending by Medicaid service group. We project total Medicaid spending will increase on average by 3.5 percent per year between FY2022 and FY2042, reaching nearly \$4.7 billion. Over this period, growth in spending on long-term care services will outpace other service groups – 4.9 percent for long-term care services versus 2.7 percent for behavioral health services, 3.2 percent for healthcare services that are medical in nature (e.g., inpatient hospital, provider services, dental services), and 2.7 percent for healthcare services that are non-medical in nature (e.g., transportation services).

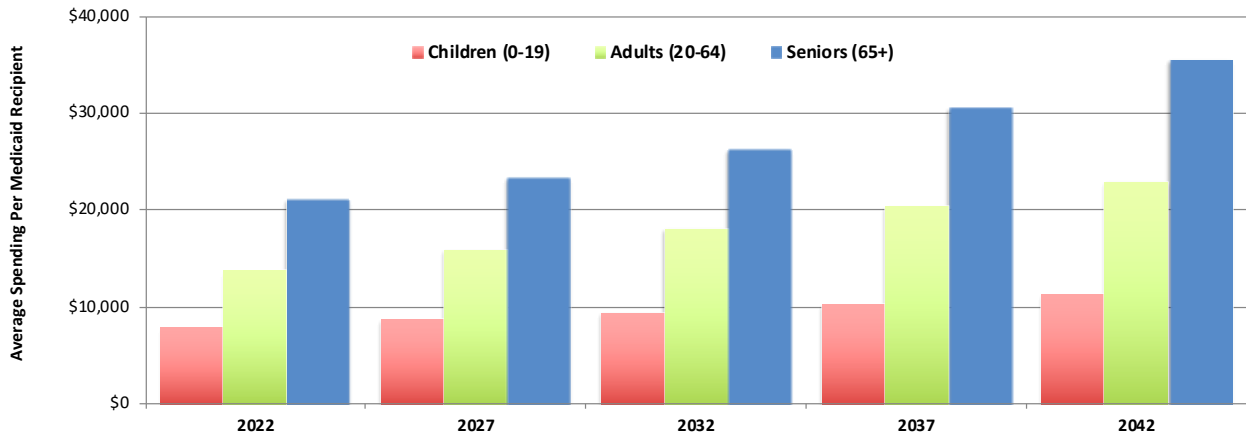
Table 10: Medicaid Spending by Medicaid Service Group, FY2022 – FY2042 (Millions \$)

Service Group	2022	2027	2032	2037	2042	Annual Growth
Behavioral Health	\$290.1	\$347.5	\$396.7	\$447.6	\$497.7	2.7%
Long-Term Care	\$530.0	\$722.3	\$935.7	\$1,160.1	\$1,382.7	4.9%
Healthcare Medical	\$1,226.9	\$1,464.9	\$1,697.7	\$1,971.5	\$2,303.2	3.2%
Healthcare Non-Medical	\$290.2	\$334.9	\$378.9	\$431.2	\$495.0	2.7%
Total	\$2,337.2	\$2,869.6	\$3,409.1	\$4,010.4	\$4,678.6	3.5%

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

Figure 16 shows projected spending per recipient on Medicaid services. For FY2022, we estimate that for children, average spending per recipient will be about \$7,900, while for adults and seniors, average spending per recipient will be about \$13,600 and \$21,100, respectively. By FY2042, we project average spending per child recipient will be about \$10,600, while the average spending per adult recipient will be \$20,800 and the average spending per senior recipient will be \$35,200.

Figure 16: Average Spending Per Recipient on Medicaid Services by Age Cohort, FY2022 – FY2042



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

As Alaska’s population ages, its Medicaid population also ages. Even without any increase in the number of persons enrolled in Medicaid, the cost of providing Medicaid services will rise due to the positive relationship between age and spending on healthcare services. In FY2000, the average age of a Medicaid enrollee in Alaska was 21 and the median age was 14;⁶¹ in FY2015 – the year before Medicaid expansion – the average age was 23 and the median age was 16. We project that by FY2042, the average age of a Medicaid enrollee will be 29 and the median age will be 24.

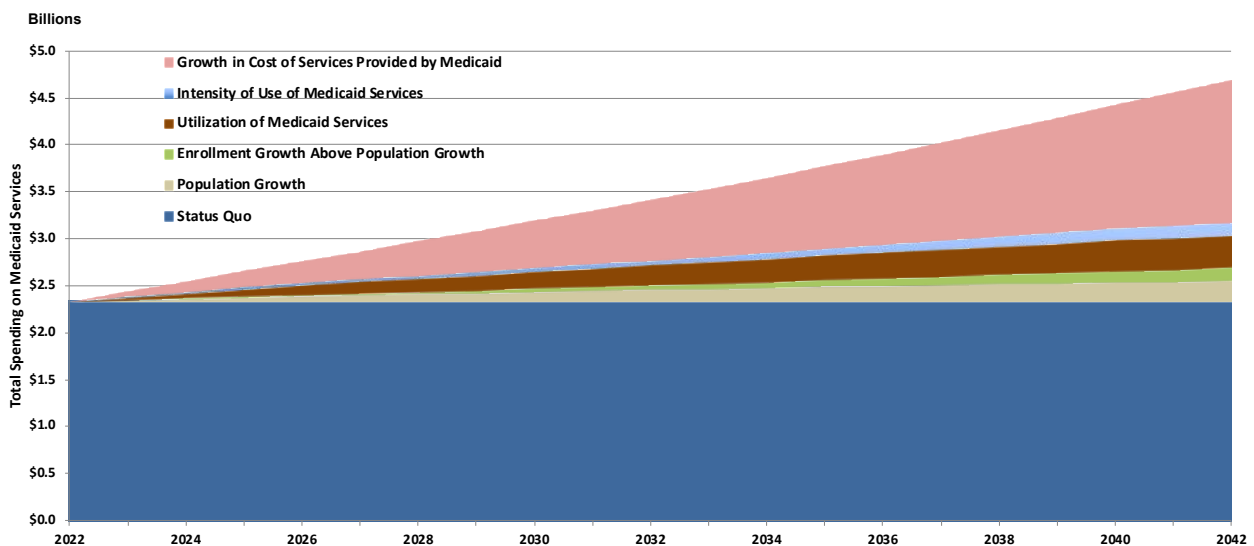
Figure 17 shows our forecast of total spending on Medicaid services by factor affecting spending growth. The figure begins with the *status quo*, which is simply the unchanging level of spending if there were no external or internal factors affecting spending over the next 20 years. The status quo assumes that everything about the Medicaid program remains unchanged from FY2022 to FY2042. Figure 17 then shows how the spending forecast builds off this base. The components of spending growth are as follows:

- **Population Growth** represents the additional spending due to growth in the population under the assumption that the rate of Medicaid participation will remain the same for each of the 240 sub-populations considered in the forecast.
- **Enrollment Growth Above Population Growth** is the incremental effect on Medicaid spending due to growth in the rate at which Alaskans enroll in Medicaid.
- **Utilization of Medicaid Services** represents the incremental impact on spending associated with Medicaid enrollees using, on average, a greater number of Medicaid services.

⁶¹ The median represents the midpoint. In FY2000, half of all Medicaid enrollees were under 14 years of age.

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

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 *growth in cost of services provided by Medicaid* to be the primary driver of spending growth in Alaska’s Medicaid program, representing about 32 percent of total spending and 64 percent of additional spending in FY2042. 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 are typically reviewed every one-to-four years and may be adjusted upward, left unchanged, or adjusted downward.

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 FY2042, 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 about \$830 million.

Enrollment in and Spending on Medicaid Services by Rural/Urban

Table 11 shows the population projection for Alaska and the projections for Medicaid

enrollment and spending based on rural and urban status. For FY2022, about 34 percent of Alaska’s population live in a rural area (as designated as rural by the U.S. Census Bureau), but 38 percent of Medicaid enrollees are from rural areas. These proportions change only slightly through the projection period, with the rural population growing slightly slower than the urban population (0.36% versus 0.47%).

While the urban population is projected to grow faster than the rural population, we project virtually no difference in the growth in Medicaid enrollment between rural and urban Alaskans (0.71% versus 0.70%), but slightly slower growth in spending on services for Medicaid enrollees living in rural areas (3.50% versus 3.55%).

Table 11: Projected Population, Medicaid Enrollment, and Medicaid Spending by Rural/Urban, FY2022 – FY2042

Metric	Area	FY2022	FY2027	FY2032	FY2037	FY2042	Annual % Change
Population	Rural	248,920	254,495	259,190	263,438	267,301	0.36%
	% Rural	34%	34%	33%	33%	33%	
	Urban	489,986	505,106	517,863	529,039	538,455	0.47%
	% Urban	66%	66%	67%	67%	67%	
Medicaid Enrollment	Rural	102,406	105,930	109,644	113,613	117,935	0.71%
	% Rural	38%	38%	38%	38%	38%	
	Urban	165,027	171,041	177,103	183,407	189,634	0.70%
	% Urban	62%	62%	62%	62%	62%	
Medicaid Spending (Millions \$)	Rural	\$941.0	\$1,149.1	\$1,361.3	\$1,601.6	\$1,872.8	3.50%
	% Rural	40%	40%	40%	40%	40%	
	Urban	\$1,396.2	\$1,720.5	\$2,047.8	\$2,408.8	\$2,805.8	3.55%
	% Urban	60%	60%	60%	60%	60%	

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

The state and federal governments share the funding of the Medicaid program. The proportion of the cost of a Medicaid service that the state and federal governments are responsible for is a function of the eligibility status of each Medicaid recipient, the rate of federal financial participation (FFP) associated with each eligibility category, and, in certain cases, the facility in which the recipient receives care. For example, if a Medicaid recipient who is 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 may pay a smaller portion of the cost of the service.⁶²

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

- Regular Federal Medical Assistance Percentage (FMAP):⁶³
 - 56.2 percent FFP from January 1, 2020 through March 31, 2022⁶⁴
 - 50 percent FFP beginning April 1, 2022
- 1915 (K) Community Choice
 - 62.2 percent FFP from January 1, 2020 through March 31, 2022
 - 56 percent FFP beginning April 1, 2022
- Enhanced FMAP for CHIP:⁶⁵
 - 80.84 percent FFP From January 1, 2020 through September 30, 2020
 - 69.34 percent FFP from October 1, 2020 through March 31, 2022
 - 65 percent FFP beginning April 1, 2022
- Breast and Cervical Cancer (BCC): 65 percent FFP⁶⁶
 - 69.34 percent FFP from January 1, 2020 through March 31, 2022
 - 65 percent FFP beginning April 1, 2022
- Family Planning: 90 percent FFP
- Indian Health Service (IHS): 100 percent FFP

⁶² 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.

⁶³ CMS sets each state’s FMAP rate based on a three-year average of state-level per capita personal income, ranked among states.

⁶⁴ 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 March 31, 2022. 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>

⁶⁵ Ibid

⁶⁶ Ibid

- Medicaid Expansion:⁶⁷
 - 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 applies the rate with the highest federal participation. The majority of Medicaid spending receives the regular FMAP rate of 50 percent federal participation;⁶⁸ however, most of the growth in Medicaid spending has received either the Medicaid expansion or IHS FFP rate. FFP rates are set at the federal level and, though they do change periodically, are largely outside of state control. We assume the FFP rates shown above will not change during the projection period. Table 12 shows our forecast of total spending on Medicaid services through FY2042, as well as our forecasts of spending by the State of Alaska and the federal government. We project that total spending on Medicaid services will grow on average by about 3.5 percent per year through FY2042, but the rate of growth in spending will be greater for the State of Alaska (4.2%) than for the federal government (3.3%).⁶⁹

Table 12: Projected State and Federal Spending on Medicaid Services (in Millions \$)

Fund Source	2022	2027	2032	2037	2042	Annual Growth
State GF and Other Matching Funds	\$595.3	\$802.3	\$972.5	\$1,156.7	\$1,351.7	4.2%
Federal	\$1,742	\$2,067	\$2,437	\$2,854	\$3,327	3.3%
Total Spending*	\$2,337	\$2,870	\$3,409	\$4,010	\$4,679	3.5%

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

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

Figure 18 shows recent actual and projected future average spending per Medicaid recipient. Between FY2015 and FY2021, spending per Medicaid recipient was basically flat,

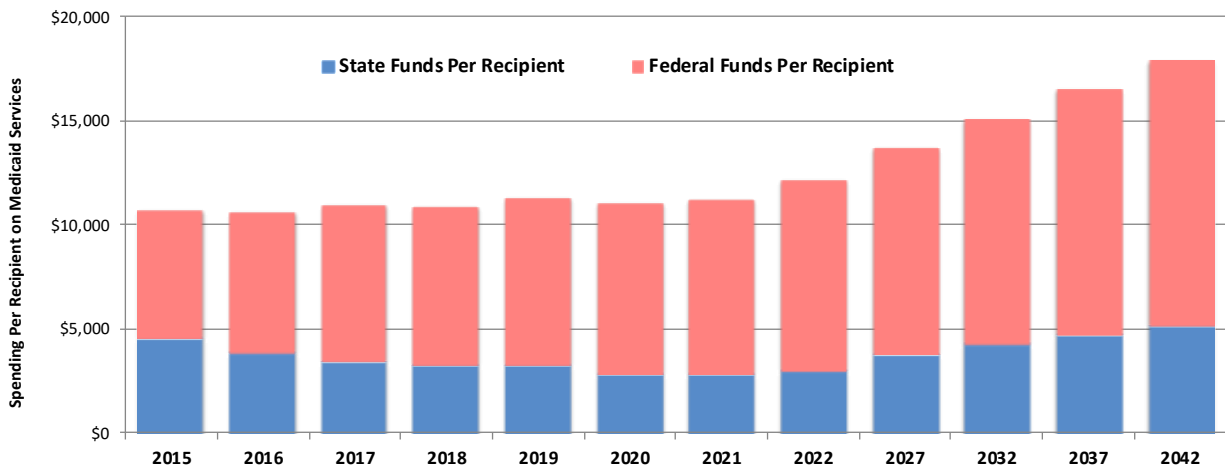
⁶⁷ Recipients enrolled through Medicaid expansion who are also Indian Health Service beneficiaries will always receive 100 percent FFP for qualifying services.

⁶⁸ Due to the COVID-19 pandemic emergency, regular FMAP was increased by 6.2 percentage points (to 56.2%). This enhancement is scheduled to end March 31, 2022.

⁶⁹ The greater projected rate of growth in spending for the State of Alaska is largely due to the sunsetting of the additional federal participation as part of the federal COVID-19 pandemic emergency.

and the proportion paid with state general funds actually decreased considerably. Over the next 20 years, we project that average spending per recipient will increase by about 3.5 percent per year due primarily to growth in provider reimbursement rates, which are driven by healthcare price inflation, and the aging of Alaska’s population.

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 – FY2020 are actual expenditures based on date of service; FY2021 is estimated based on date of payment; FY2022 – FY2042 are projected.

In FY2021, the weighted average FFP rate for Medicaid services was 74.5 percent, and we project the average FFP rate for FY2022 will be about the same. After that, we project the weighted average FFP will drop to 72.5 percent for FY2023 after the federal government ends the COVID-19 public health emergency. Beyond FY2023, we expect the weighted average FFP to slowly decrease over the projection period to about 71 percent by FY2042.⁷⁰

Other Medicaid Payments and Offsets

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

1. Premium payments for Medicare Part A and Part B;⁷¹ and

⁷⁰ For FY2021, each percentage point of FFP equates to \$21.7 million (1% of \$2.17 billion), and the importance of each percentage point of FFP will grow as total spending on Alaska’s Medicaid program grows.

⁷¹ Medicare is a federal program that provides health insurance to people aged 65 or older, people under the age of 65 with certain disabilities, and people of all ages with end-stage renal disease. The program is

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

The share of total Medicaid spending attributed to these other payments varies from year to year but has trended downward over the past 15 years. In addition, there are offsetting recoveries such as third-party liability collections and drug rebates, which are credited to the Medicaid program and are roughly equal to 2 percent to 3 percent of annual spending on Medicaid services. 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 3 percent (see Table 13).

Table 13: Total Projected Medicaid Spending by Date of Service, FY2022 - FY2042, in Millions

		2022	2027	2032	2037	2042
Spending on Medicaid Claims	Federal	\$1,742	\$2,067	\$2,437	\$2,854	\$3,327
	State Match	\$595	\$802	\$973	\$1,157	\$1,352
	Total	\$2,337	\$2,870	\$3,409	\$4,010	\$4,679
Other Medicaid Payments	Federal	\$46	\$93	\$111	\$130	\$152
	State Match	\$25	\$50	\$60	\$70	\$82
	Total	\$70	\$143	\$170	\$201	\$234
Total Spending on Medicaid	Federal	\$1,787	\$2,161	\$2,547	\$2,984	\$3,479
	State Match	\$620	\$852	\$1,032	\$1,227	\$1,434
	Total*	\$2,407	\$3,013	\$3,580	\$4,211	\$4,913

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.

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

voluntary, and beneficiaries must pay monthly premiums. Medicare beneficiaries with low incomes may be eligible for benefits under Medicaid (referred to as being “dual-eligible”). If an individual is dual-eligible, Medicaid pays the premiums for Medicare Part A and Part B because Medicaid is the payer of last resort, and it costs the Medicaid program substantially less to pay the premiums for Medicare coverage than it does to pay the claims for medical and related services.

and training to assist them in managing their chronic condition(s).⁷² The U.S. National Center for Health Statistics defines chronic conditions as diseases or other medical conditions lasting three months or more.⁷³ 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.⁷⁴

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.⁷⁵ This update to the long-term forecast is the third projection of spending on Medicaid services for recipients 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) and the State of Alaska's Administrative Services Organization (ASO), which processes claims for behavioral health services, to identify Medicaid beneficiaries who had a paid claim that included diagnosis codes indicating the beneficiary received treatment for any of the chronic conditions listed in Table 14 during FY2020. There were about 6.5 million Medicaid claims and nearly 10.7 million claim lines for services provided to beneficiaries in FY2020.⁷⁶ 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.

⁷² (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.

⁷³ National Health Council, "About Chronic Diseases." <https://nationalhealthcouncil.org/wp-content/uploads/2019/12/AboutChronicDisease.pdf>

⁷⁴ Centers for Disease Control and Prevention, "About Chronic Diseases." <https://www.cdc.gov/chronicdisease/about/index.htm>

⁷⁵ 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>

⁷⁶ About 81 percent of Medicaid claims in FY2020 consisted of a single claim line, and 98 percent of claims were composed of 10 or fewer claim lines.

Most, but not all, MMIS and ASO records also include one or more medical diagnosis codes assigned by a healthcare provider, which indicate the medical reason for the service.⁷⁷ We examined up to four diagnosis codes for each Medicaid claim in FY2020 to identify if the service was associated with any of the chronic conditions listed in Table 14, which we arranged into 24 chronic condition groups based on the characteristics of the condition and/or the body system affected.

Table 14: Chronic Conditions Considered in Long-Term Forecast

Chronic Condition Group		Chronic Conditions
1	Blood	Anemia
2	Cancer	Breast, Colorectal, Endometrial, Lung, Prostate Cancers, Leukemias / Lymphomas
3	Cardiovascular	Atrial Fibrillation, Heart Attack or Ischemic Heart Disease, Heart Failure, Hypertension, Peripheral Vascular Disease (PVD)
4	Congenital disorders	Cystic Fibrosis
5	Diabetes	Type I and Type II Diabetes
6	Drug & Alcohol Abuse	Alcohol Use Disorders, Drug Use Disorders including Opioid Use Disorder
7	Ear	SDHI - Sensory - disabling hearing impairment
8	Eye	Cataract, Glaucoma, SBVI - Sensory - blindness and visual impairment,
9	Injuries and accidents	Hip or Pelvic Fracture, Spinal Cord Injury, Traumatic Brain Injury
10	Liver Disease	Cirrhosis / Liver Disease, Viral Hepatitis
11	Lung Disease	COPD, Bronchiectasis
12	Mental Health	ADHD / Hyperkinetic Syndrome, Anxiety Disorders including PTSD, Autism Spectrum Disorders, Depression or Depressive Disorder, Developmental Delays, Intellectual Disabilities, Learning Disabilities, Personality Disorders
13	Mobility Impairments	Mobility Impairments
14	Musculoskeletal	Fibromyalgia, Chronic Fatigue Syndrome, Muscular Dystrophy, Osteoporosis, Rheumatoid Arthritis / Osteoarthritis
15	Neurological	Dementia, Alzheimer's
16	Other Neurological	Cerebral Palsy, Epilepsy, Migraine / Chronic Headache, MS or Transverse Myelitis, Spina Bifida
17	Obesity	Obesity
18	Other Metabolic and Endocrine	Acquired Hypothyroidism, Hyperlipidemia

⁷⁷ In FY2020, about 2.4 million claims (22%) did not include a diagnosis code. Of these, the vast majority (97%) were either pharmacy- (67%), dental- (20%), or transportation and accommodations-related (10%).

	Chronic Condition Group	Chronic Conditions
19	Renal and urogenital	Benign Prostatic Hyperplasia, Chronic Kidney Disease
20	Respiratory	Asthma
21	Skin	Ulcers
22	Sexually Transmitted Infection	HIV AIDS
23	Stroke	Stroke, Transient Ischemic Attack
24	Tobacco	Smoking, Vaping, or Chewing Tobacco Use

Source: Analysis by Evergreen Economics of data from the CDC.

Each chronic condition is identified by one or more International Classification of Diseases (ICD) diagnosis codes. The ICD codes are updated periodically, with the most recent update occurring on October 1, 2015, with the conversion from ICD-9 to ICD-10.⁷⁸ 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.⁷⁹

Evergreen Economics used the following criteria to define a Medicaid beneficiary as having one of the chronic conditions that make up the 24 chronic condition groups shown in Table 14:⁸⁰

- The Medicaid beneficiary had at least two Medicaid claims in FY2020 with a diagnosis code specifying the chronic condition as defined in the CMS Chronic Conditions Data Warehouse; and

⁷⁸ 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.

⁷⁹ 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.

⁸⁰ These criteria were developed by Evergreen Economics specifically for this analysis.

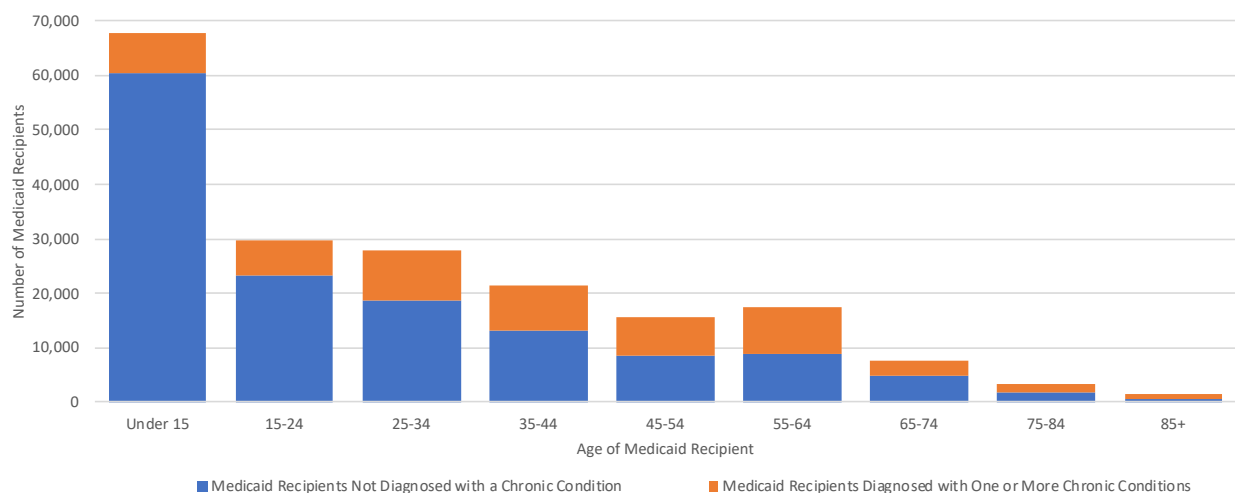
- The Medicaid program paid at least \$4,500 in costs for (all) services received by the Medicaid recipient during FY2019.⁸¹

In FY2020, the unduplicated count of Medicaid enrollees was 265,391. Applying the criteria listed above, we identified 51,234 Medicaid beneficiaries as being diagnosed with one or more chronic conditions in FY2020.

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.⁸²

Figure 19: Distribution of Medicaid Recipients by Age and Diagnosis of One or More Chronic Conditions, FY2020



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

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 and continues to increase through the 55 to 64 age group (48% have one or more diagnosed chronic conditions). However, the positive correlation between age and prevalence of chronic

⁸¹ In the most recent previous update, which relied on claim level data for FY2019, we set the minimum spending level at \$5,000. For this update, we reduced this to \$4,500 to account for the substantial drop in Medicaid utilization and spending following Governor Dunleavy's declaration of a COVID-19 public health emergency.

⁸² 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>

conditions then seemingly reverses for the 65 to 74 age group. Only 35 percent of Medicaid recipients in this age group have one or more diagnosed chronic conditions. The reason for the drop in the prevalence of chronic conditions for Medicaid recipients in the 65 to 74 age group is attributable to federal policies affecting the Medicaid and Medicare programs. For most Medicaid enrollees, becoming eligible for Medicare (generally at age 65) coincides with losing eligibility for Medicaid, while others gain Medicare eligibility while also maintaining full Medicaid eligibility.⁸³

Notably, adults who became eligible for Medicaid through expansion lose Medicaid eligibility at age 65 when they become eligible for Medicare. This explains most of the substantial drop in the number of Medicaid recipients between the 55 to 64 age group and the 65 to 74 age group. In addition, many Medicaid recipients whose eligibility is based on one or more disability determinations become dually eligible for Medicare, which assumes the role as primary payer, while Medicaid is the payer of last resort. Only the services these recipients receive through the Medicaid program are captured in Alaska’s MMIS or ASO databases. It is likely that most of these individuals also receive services through the Medicare program and that some of these services include diagnosis codes indicating one or more chronic conditions. However, since the diagnosis is associated with a service provided through Medicare, it is not captured in the MMIS or ASO databases and, therefore, our analytical approach surely undercounts chronic conditions – as well as total spending on healthcare – for dually-eligible Medicaid recipients.

Prevalence of chronic conditions increases to 45 percent for Medicaid recipients who are seniors 75 to 84 years of age and to 63 percent for seniors 85 or older. Medicaid recipients in these age groups are also dually eligible for Medicare, which would have been the payer of many of the medical services they received in FY2020. Because of this, we surely underestimate the true prevalence of chronic conditions within these oldest age groups as the prevalence of certain chronic conditions (e.g., dementia, stroke) is highly positively correlated with age.

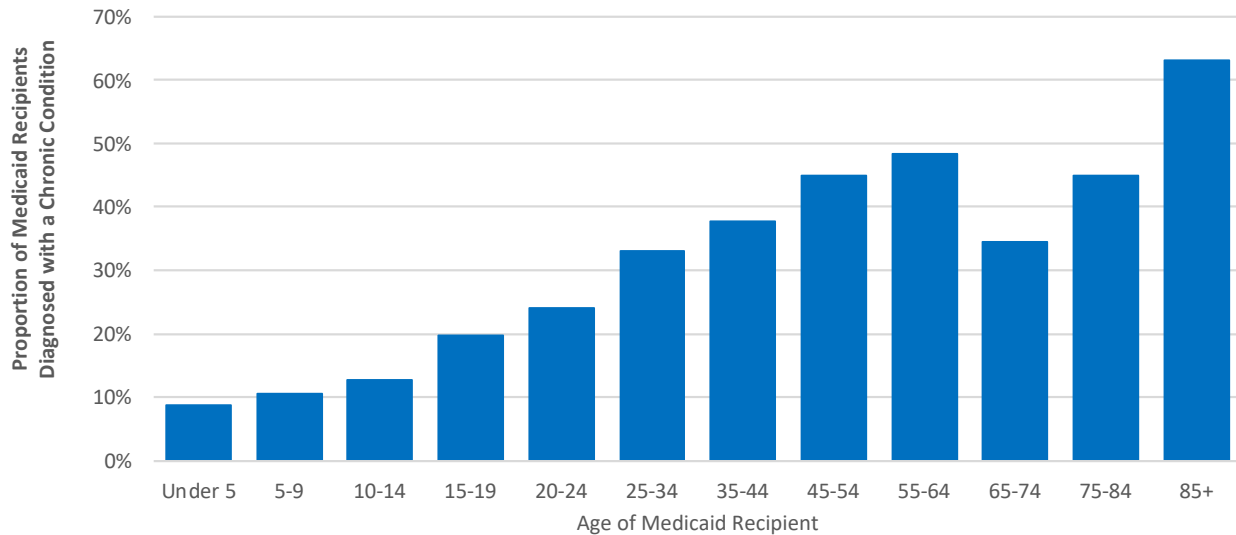
Figure 20 shows more clearly the relationship between the age of a Medicaid recipient and the prevalence of chronic conditions. Less than 10 percent of children under five years of age were diagnosed with a chronic condition in FY2020, while 63 percent of seniors 85 years of age or older were diagnosed 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

⁸³ MaryBeth Musumeci, Robin Rudowitz, and Tricia Neuman, “How Might Lowering the Medicare Age Affect Medicaid Enrollees?” KFF, June 10, 2021. <https://www.kff.org/medicaid/issue-brief/how-might-lowering-the-medicare-age-affect-medicaid-enrollees/>

A person must independently qualify for Medicare and Medicaid.

contributing factor) to the increased prevalence of chronic conditions. The factors underlying many chronic conditions include family genetics, environment, and lifestyle. It often takes time for the health effects of these factors to result in diagnosis of a chronic condition.⁸⁴

Figure 20: Prevalence of Diagnosed Chronic Conditions by Age of Medicaid Recipient



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

Total spending on Medicaid services received in FY2020 for *all* Medicaid recipients was \$2.12 billion. Of this total, \$442.7 million was spent on services for the 140,728 Medicaid recipients with no diagnosed chronic conditions (\$3,146 per recipient), and \$1.67 billion was spent on services for the 51,234 Medicaid recipients with one or more diagnosed chronic conditions (\$32,643 per recipient).

Table 15 shows average spending per recipient on Medicaid services in FY2020 by age of the recipient for *all* Medicaid recipients (column b), per recipient without a diagnosed chronic condition (column c), and per recipient with one or more diagnosed chronic conditions (column d).

Considering the data on average spending per recipient shown in column b (without regard for a chronic condition diagnosis), the data appear to show a strong, though imperfect, positive relationship between age and spending on Medicaid services. In comparison, spending per recipient for those without a chronic condition (column c) does

⁸⁴ Figure 20 also shows how becoming dually eligible for Medicare at age 65 results in a drop in the prevalence of chronic conditions among seniors enrolled in the Medicaid program due to some losing Medicaid eligibility and others becoming dually eligible for Medicare.

not appear to be related to age (apart from the 85+ age group). Likewise, spending per recipient for those with one or more chronic conditions (column d) does not increase with age (apart from the 75-84 and 85+ age groups). Collectively, columns b, c, and d show that age, in and of itself, has little impact on Medicaid spending. Instead, Medicaid spending is primarily driven by the cost of services directly or indirectly related to chronic conditions. Average spending per recipient *without a diagnosis of a chronic condition* was \$3,146 in FY2020, while average spending per recipient with *one or more chronic condition diagnoses* was 10 times greater at \$32,643.

Table 15: Spending Per Recipient on Medicaid Services and Incremental Cost of Chronic Conditions, FY2020

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	\$7,491	\$5,115	\$32,182	\$27,067
05-09	\$4,820	\$2,468	\$24,857	\$22,390
10-14	\$6,467	\$2,417	\$34,064	\$31,647
15-19	\$9,810	\$2,844	\$38,277	\$35,433
20-24	\$9,329	\$3,177	\$28,681	\$25,504
25-34	\$11,701	\$3,272	\$28,747	\$25,475
35-44	\$12,899	\$2,739	\$29,667	\$26,928
45-54	\$15,271	\$2,561	\$30,866	\$28,305
55-64	\$17,502	\$2,622	\$33,425	\$30,803
65-74	\$14,770	\$2,257	\$38,505	\$36,248
75-84	\$24,697	\$3,948	\$50,183	\$46,235
85+	\$47,500	\$9,989	\$69,335	\$59,346
All Recipients*	\$11,018	\$3,146	\$32,643	\$29,498

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

Column e of Table 15 shows the incremental cost of chronic conditions per Medicaid recipient by age. These incremental costs represent how much additional Medicaid services are required by recipients 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 \$29,618 greater in FY2020 than a recipient without a diagnosed chronic condition.

Table 16 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. We estimate that the total *incremental cost* of providing Medicaid services to recipients diagnosed with one or more chronic conditions was a little more than \$1.51 billion in FY2020.

Table 16: Total Incremental Cost of Chronic Conditions on Medicaid Spending, FY2020

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	\$27,067	2,119	\$57,354,973
05-09	\$22,390	2,367	\$52,996,474
10-14	\$31,647	2,691	\$85,161,546
15-19	\$35,433	3,497	\$123,910,186
20-24	\$25,504	2,884	\$73,553,625
25-34	\$25,475	9,243	\$235,467,166
35-44	\$26,928	8,037	\$216,418,930
45-54	\$28,305	7,036	\$199,154,077
55-64	\$30,803	8,397	\$258,654,753
65-74	\$36,248	2,616	\$94,825,164
75-84	\$46,235	1,476	\$68,243,090
85+	\$59,346	871	\$51,690,254
All Recipients	\$29,498	51,234	\$1,511,276,334

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

Table 17 shows the distribution of Medicaid recipients by number of diagnosed chronic conditions, average spending per recipient, and total spending on all recipients. About 73 percent of Medicaid recipients have no diagnosed chronic conditions but account for less than 21 percent of total spending on Medicaid services. In comparison, about 10 percent of recipients have one diagnosed chronic condition but account for 23 percent of spending, and 16.5 percent of recipients have two or more chronic conditions but account for 55 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 more than one diagnosed chronic condition, average spending per recipient is 11 times greater than the average spending on a recipient with no chronic conditions.

Table 17: Distribution of Medicaid Recipients and the Cost of Providing Medicaid Services by the Number of Diagnosed Chronic Conditions, FY2020

Diagnosed Chronic Conditions	Medicaid Recipients	Percent of Recipients	Average Spending Per Recipient	Total Spending	Percentage of Spending
0	140,728	73.3%	\$3,146	\$442,688,084	20.9%
1	19,611	10.2%	\$24,837	\$487,074,416	23.0%
2	12,861	6.7%	\$30,899	\$397,397,803	18.8%
3	7,652	4.0%	\$35,155	\$269,007,361	12.7%
4	4,914	2.6%	\$40,109	\$197,094,241	9.3%
5	3,038	1.6%	\$45,632	\$138,630,279	6.6%
6	1,661	0.9%	\$52,510	\$87,219,303	4.1%
7	818	0.4%	\$64,570	\$52,818,292	2.5%
8 or More	679	0.4%	\$63,625	\$43,201,439	2.0%
All Recipients	191,962	100.0%	\$11,018	\$2,115,131,218	100%

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

Projected Spending on Medicaid Services for Recipients with Chronic Conditions

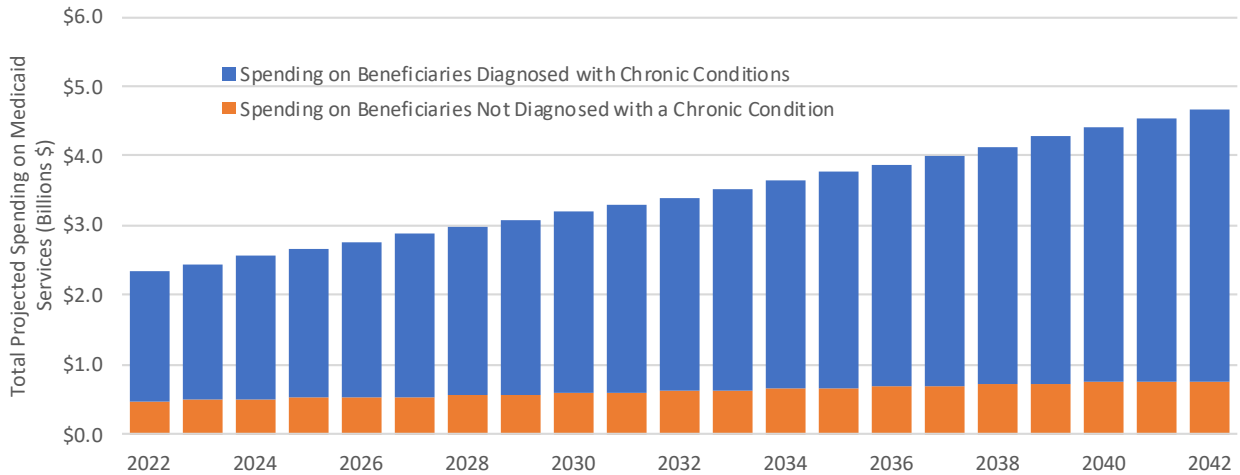
We used recipient-level data from the MMIS and ASO databases and the Medicaid enrollment forecast presented earlier in this report to project the prevalence of each of the chronic conditions shown in Table 14 each year through FY2042 for each of the 240 enrollment subgroups.⁸⁵ We projected the cost to 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 (3.5%, 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 21 shows projected total spending on Medicaid services from FY2022 through FY2042. Over this period, we project Medicaid spending on recipients diagnosed with one or more chronic conditions will grow from nearly \$1.9 billion (80% of total Medicaid spending) in FY2022 to \$3.9 billion (84% of total Medicaid spending) in FY2042. Comparatively, we project that spending on recipients *not* diagnosed with a chronic

⁸⁵ 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.

condition will increase from \$462 million to \$764 million between FY2022 and FY2042, which, though increasing on an average annual basis by 2.5 percent per year, will decrease as a proportion of total spending from 20 percent in FY2022 to 16 percent in FY2042.

Figure 21: Projected Spending on Medicaid Services, FY2022 – FY2042



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

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

Alaska’s state health improvement plan, Healthy Alaskans 2030 (HA2030), provides an approach for how the state can improve on the most significant health issues that its residents face.⁸⁶ From these health issues, which were selected with input from Alaskan residents and subject matter experts, DHSS in equal partnership with the Alaska Native Tribal Health Consortium (ANTHC) defined 30 health objectives along with strategies and actions that may be implemented to help achieve each respective objective by 2030. Among the 30 health objectives contained in the HA2030 plan are at least seven that are directly related to chronic conditions:

- **Objective 1** – Reduce cancer mortality rate per 100,000 population
 - **Baseline (2018):** 141.6 deaths
 - **Target:** 127.4 deaths

⁸⁶ State Health Improvement Plan, Healthy Alaskans 2030. “Healthy Alaskans 2030 Priority Health Topics and Health Objectives.” <https://www.healthyalaskans.org/wp-content/uploads/2021/02/HA2030-Objectives.pdf>

- **Objective 9** – Increase the percentage of children (students in grades K-8) who meet criteria for healthy weight
 - **Baseline (2018-2019):** 62.6 percent
 - **Target:** 66 percent
- **Objective 14** - Reduce the mean number of days in the past 30 days adults (aged 18 years and older) report being mentally unhealthy
 - **Baseline (2018):** 3.7 days
 - **Target:** 3.5 days
- **Objectives 22 & 23** – Reduce the alcohol-induced and drug-induced mortality rate per 100,000 population
 - **Baseline (2018):** 26.3 alcohol deaths / 15.8 drug deaths
 - **Target:** 23.6 alcohol deaths / 14.2 drug deaths
- **Objectives 26 & 27** - Reduce the percentage of adolescents (high school students in grades 9-12) who have used electronic vapor products, cigarettes, smokeless tobacco, or other tobacco products in the last 30 days; Reduce the percentage of adults (aged 18 and older) who currently smoke cigarettes or use electronic vapor products, smokeless tobacco, or other tobacco products
 - **Baseline (2019 / 2018):** 34.5 percent adolescents / 27.3 percent adults
 - **Target:** 32 percent adolescents / 25 percent adults

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

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

Next, we projected how much the Medicaid program will spend on Medicaid services provided to recipients diagnosed with each respective chronic condition (five spending

forecasts in total).⁸⁷ Finally, we estimated how much spending would decrease if the incidence of the respective chronic condition declined over the 20-year projection period. The purpose of this exercise is not to project how achieving the HA2030 goals will necessarily impact spending on chronic conditions within the Medicaid program. Rather, it is to demonstrate how relatively modest improvements in the incidence of these select chronic conditions can impact spending on the Medicaid program.

Table 18 shows potential annual reductions in Medicaid spending on recipients diagnosed with each of the five chronic conditions most closely linked to the seven HA2020 objectives described above. These estimates of reduced spending assume annual incremental improvements in each HA2030 objective beginning with 0.25 percent in FY2023 and growing to 5.0 percent by FY2042.

Table 18: Estimated Potential Reduction in Medicaid Spending Associated with a 5% Reduction by FY2042 in Prevalence of Five Chronic Conditions

HA2030 Objective	Chronic Condition	Impact FY2027	Impact FY2032	Impact FY2037	Impact FY2042
1	Cancer	\$1,290,184	\$3,101,026	\$5,525,243	\$8,678,119
9	Obesity	\$2,524,650	\$6,068,131	\$10,811,872	\$16,981,461
14	Mental Health	\$16,141,884	\$38,797,875	\$69,127,982	\$108,574,554
22 / 23	Drug & Alcohol	\$8,654,697	\$20,802,023	\$37,063,934	\$58,213,765
26 / 27	Tobacco Use	\$6,713,542	\$16,136,355	\$28,750,896	\$45,157,049
Objectives Combined*	Total Savings	\$27,906,717	\$67,075,274	\$119,511,142	\$187,707,909
	General Fund	\$7,801,893	\$19,135,002	\$34,470,356	\$54,231,438

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

*Estimated cumulative impact of incrementally achieving all seven HA2030 objectives are not strictly additive due to correlations in the incidence of the respective chronic conditions.

The HA2030 objective with the greatest potential to lead to cost savings for the Medicaid program is Objective 14 (*Reduce the mean number of days in the past 30 days adults (aged 18 years and older) report being mentally unhealthy*). This is because Medicaid recipients diagnosed with a mental health chronic condition tend to have high spending across a wide range of Medicaid services. Due to many Medicaid recipients having multiple chronic conditions, the estimated reductions in Medicaid spending are not strictly

⁸⁷ Note: it is likely that some Medicaid recipients will be diagnosed with more than one of the five chronic conditions (cancer, obesity, mental health condition, drug or alcohol dependency, tobacco use). For recipients diagnosed with two or more of these chronic conditions, we do not attempt to attribute spending to the respective chronic conditions.

additive. Improvements in one aspect of an individual’s health – e.g., reduces or eliminates tobacco use – will often positively impact other aspects of health. Therefore, while improvements in all seven of the HA2030 objectives described above would likely lead to substantial savings to the Medicaid program, those savings would be less than the sum of the estimated savings associated with each individual HA2030 objective.⁸⁸

⁸⁸ We estimate total savings associated with achieving all seven of the HA2030 objectives would be 79 percent of the sum of the individual savings.

3 Appendix Tables

Table 19: Medicaid Service Category Descriptions for Long-Term Forecast

Broad Category	Service Category	Description
Behavioral Health	Inpatient / Residential Psychiatric Hospital	Inpatient psychiatric hospital services; Residential psychiatric treatment centers and behavioral rehabilitation services (BRS)
	Outpatient Mental Health	Outpatient mental health services, psychology services, and drug abuse centers
	1115 Waiver	Behavioral health waiver
Long-Term Care	Nursing Home	Skilled nursing and intermediate care facilities including intermediate-care facilities for the intellectually disabled; and temporary long-term care services
	Home Health/Hospice	Home health services, hospice care, nutrition services, and private duty nursing
	Personal Care	Personal care attendant services including agency-based and consumer-directed programs
	HCB State Plan Services	Skilled nursing and intermediate care facilities including intermediate-care facilities for the intellectually disabled; and temporary long-term care services
	HCB 1915(c) Waivers	Alaska has five different home- and community-based 1915(c) waivers. Eligibility for 1915(c) waiver services depends on participants requiring a level of care that would otherwise be provided in an institution.
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	

Broad Category	Service Category	Description
	Transportation	Emergency and non-emergency medically necessary transportation and accommodation
	Vision	Optometrist services and eyeglasses

Table 20: 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 21: 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%	78%
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	57%	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 22: Forecast of Population by Demographic Group

	Fiscal Year					Annual % Change
	2022	2027	2032	2037	2042	
State	738,906	759,601	777,053	792,477	805,756	0.4%
Gender						
Female	359,392	370,606	380,153	388,600	395,643	0.5%
Male	379,514	388,995	396,900	403,877	410,113	0.4%
Native Status						
Native	150,696	155,403	159,635	163,852	168,108	0.5%
Non-Native	588,210	604,198	617,418	628,625	637,648	0.4%
Region						
Northern	122,022	125,304	127,442	129,405	131,238	0.4%
Western	44,295	45,817	47,458	49,369	51,754	0.8%
South Central	97,096	98,468	99,492	100,212	100,537	0.2%
Anchorage/Mat-Su	403,540	418,194	431,307	442,915	452,920	0.6%
Southeast	71,953	71,818	71,354	70,576	69,307	-0.2%
Age Group						
0-4	49,979	51,170	51,735	53,167	54,453	0.4%
5-9	51,096	50,349	51,564	52,138	53,580	0.2%
10-14	52,805	51,442	50,703	51,929	52,515	0.0%
15-19	50,299	52,944	51,578	50,849	52,072	0.2%
20-24	46,809	51,779	54,403	53,044	52,312	0.6%
25-34	105,970	100,233	103,589	111,404	112,908	0.3%
35-44	103,719	110,668	106,946	101,527	105,013	0.1%
45-54	83,626	88,361	100,074	106,927	103,412	1.1%
55-64	90,161	78,512	72,258	76,825	88,024	-0.1%
65-74	69,003	75,115	70,078	59,692	54,273	-1.2%
75-84	27,835	39,102	49,980	54,683	50,815	3.1%
85+	7,604	9,926	14,145	20,292	26,379	6.4%

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

Table 23: Forecast of Enrollment by Demographic Group

	Fiscal Year					Annual % Change
	2022	2027	2032	2037	2042	
State	267,433	276,971	286,746	297,021	307,569	0.7%
Gender						
Female	135,547	140,972	146,430	151,990	157,469	0.8%
Male	131,886	135,999	140,317	145,031	150,099	0.6%
Native Status						
Native	86,076	89,998	93,686	97,530	101,684	0.8%
Non-Native	181,357	186,973	193,060	199,490	205,885	0.6%
Region						
Northern	34,842	36,005	36,997	38,113	39,320	0.6%
Western	31,648	33,234	34,941	36,862	39,256	1.1%
South Central	35,366	36,233	37,204	38,202	39,203	0.5%
Anchorage/Mat-Su	141,088	146,787	152,606	158,551	164,285	0.8%
Southeast	24,490	24,712	24,999	25,292	25,504	0.2%
Age Group						
0-4	29,116	30,711	31,672	33,094	34,445	0.8%
5-9	29,894	30,129	31,791	32,693	34,131	0.7%
10-14	28,390	28,141	28,422	29,996	30,794	0.4%
15-19	24,818	26,594	26,408	26,611	28,029	0.6%
20-24	19,661	21,317	22,558	22,485	22,680	0.7%
25-34	42,215	41,375	43,071	46,013	47,184	0.6%
35-44	33,242	35,630	35,632	34,971	36,260	0.4%
45-54	21,454	22,700	25,346	27,194	27,124	1.2%
55-64	22,729	21,119	20,347	21,613	24,241	0.3%
65-74	10,256	11,507	11,200	9,856	9,170	-0.6%
75-84	4,093	5,742	7,461	8,429	8,151	3.5%
85+	1,566	2,006	2,837	4,066	5,361	6.3%

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

Table 24: Forecast of Spending by Demographic Group (Millions \$)

	Fiscal Year					Annual % Change
	2022	2027	2032	2037	2042	
State	\$2,337.2	\$2,869.6	\$3,409.1	\$4,010.4	\$4,678.6	3.5%
Gender						
Female	\$1,246.6	\$1,543.7	\$1,850.7	\$2,193.8	\$2,570.4	3.7%
Male	\$1,090.6	\$1,325.9	\$1,558.4	\$1,816.6	\$2,108.2	3.4%
Native Status						
Native	\$962.1	\$1,181.9	\$1,393.8	\$1,634.2	\$1,914.7	3.5%
Non-Native	\$1,375.0	\$1,687.7	\$2,015.2	\$2,376.2	\$2,763.9	3.6%
Region						
Northern	\$263.9	\$322.6	\$381.0	\$446.4	\$518.3	3.4%
Western	\$336.2	\$412.8	\$491.3	\$582.2	\$692.7	3.7%
South Central	\$330.2	\$401.9	\$475.5	\$555.5	\$642.6	3.4%
Anchorage/Mat-Su	\$1,160.4	\$1,436.7	\$1,716.4	\$2,025.6	\$2,365.6	3.6%
Southeast	\$246.3	\$295.6	\$344.9	\$400.7	\$459.3	3.2%
Age Group						
0-4	\$206.1	\$245.1	\$277.0	\$319.6	\$366.0	2.9%
5-9	\$117.1	\$134.5	\$154.1	\$176.6	\$204.2	2.8%
10-14	\$150.0	\$168.6	\$182.8	\$216.7	\$244.0	2.5%
15-19	\$198.5	\$234.9	\$255.2	\$283.3	\$331.4	2.6%
20-24	\$125.3	\$154.4	\$186.2	\$212.5	\$244.8	3.4%
25-34	\$348.4	\$423.7	\$505.7	\$600.0	\$677.3	3.4%
35-44	\$313.4	\$393.4	\$468.7	\$534.9	\$617.6	3.5%
45-54	\$259.7	\$323.0	\$406.5	\$492.3	\$549.3	3.8%
55-64	\$324.3	\$394.3	\$469.8	\$562.1	\$718.5	4.1%
65-74	\$127.4	\$164.8	\$184.3	\$187.8	\$201.6	2.3%
75-84	\$92.4	\$129.2	\$177.0	\$229.5	\$255.2	5.2%
85+	\$74.5	\$103.6	\$141.9	\$195.2	\$268.6	6.6%

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

Table 25: Forecast of Total Spending on Medicaid (Millions \$)

Service Category	Fiscal Year					Annual % Change
	2022	2027	2032	2037	2042	
Inpatient Hospital	\$363.7	\$424.0	\$480.8	\$550.6	\$638.8	2.9%
Outpatient Hospital	\$304.9	\$358.2	\$413.0	\$479.6	\$562.2	3.1%
Family Planning	\$0.4	\$0.5	\$0.6	\$0.8	\$0.9	3.6%
Health Clinic	\$171.3	\$204.4	\$236.1	\$272.6	\$315.9	3.1%
Physician/Practitioner	\$211.1	\$240.9	\$270.1	\$305.5	\$348.8	2.5%
Dental	\$95.6	\$128.3	\$161.9	\$200.2	\$245.8	4.8%
Lab/X-ray	\$8.5	\$9.8	\$11.2	\$12.8	\$14.8	2.8%
EPSDT	\$17.8	\$26.7	\$33.9	\$40.4	\$46.8	4.9%
Therapy/Rehabilitation	\$43.7	\$60.8	\$77.3	\$94.6	\$112.8	4.8%
Vision	\$9.8	\$11.3	\$12.8	\$14.5	\$16.5	2.6%
Pharmacy	\$199.9	\$229.1	\$258.3	\$293.2	\$336.2	2.6%
DME/Supplies	\$23.8	\$29.4	\$35.3	\$41.8	\$49.1	3.7%
Transportation	\$66.5	\$76.3	\$85.4	\$96.2	\$109.7	3.7%
Inpatient-Res Psych	\$49.9	\$71.5	\$90.1	\$101.8	\$102.1	2.5%
Outpatient Mental Health	\$196.6	\$227.1	\$254.4	\$289.1	\$333.2	3.6%
1115 Waiver	\$43.7	\$48.9	\$52.2	\$56.7	\$62.4	2.7%
Nursing Home	\$171.3	\$236.0	\$309.6	\$389.9	\$473.4	1.8%
Home Health/Hospice	\$13.1	\$17.3	\$21.6	\$26.6	\$33.1	5.2%
Personal Care	\$27.1	\$40.3	\$56.0	\$73.4	\$91.0	6.2%
HCB State Plan Services	\$294.7	\$401.4	\$517.6	\$635.2	\$745.1	4.7%
HCB 1915(c) Waivers	\$23.9	\$27.3	\$30.8	\$35.0	\$40.1	2.6%
Total Spending on Medicaid Services	\$2,337.2	\$2,869.6	\$3,409.1	\$4,010.4	\$4,678.6	3.5%
Other Medicaid Payments*	\$116.9	\$143.5	\$170.5	\$200.5	\$233.9	3.5%
Total Spending on Medicaid Program	\$2,454.0	\$3,013.1	\$3,579.5	\$4,210.9	\$4,912.5	3.5%

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

Service Category	Fiscal Year					Annual % Change
	2022	2027	2032	2037	2042	
Inpatient Hospital	\$80.4	\$99.4	\$112.8	\$129.1	\$149.8	3.2%
Outpatient Hospital	\$46.5	\$57.1	\$65.8	\$76.4	\$89.6	3.3%
Family Planning	\$0.3	\$0.4	\$0.5	\$0.6	\$0.7	3.6%
Health Clinic	\$9.2	\$10.6	\$12.2	\$14.1	\$16.3	2.9%
Physician/Practitioner	\$51.4	\$62.4	\$70.0	\$79.2	\$90.4	2.9%
Dental	\$24.6	\$35.4	\$44.7	\$55.3	\$67.8	5.2%
Lab/X-ray	\$2.2	\$2.7	\$3.0	\$3.5	\$4.0	3.1%
EPSDT	\$3.3	\$5.2	\$6.6	\$7.9	\$9.1	5.3%
Therapy/Rehabilitation	\$16.5	\$24.8	\$31.5	\$38.6	\$46.0	5.3%
Vision	\$3.4	\$4.2	\$4.7	\$5.3	\$6.1	3.0%
Pharmacy	\$47.2	\$57.4	\$64.7	\$73.5	\$84.3	2.9%
DME/Supplies	\$9.1	\$12.2	\$14.6	\$17.3	\$20.4	4.1%
Transportation	\$8.4	\$10.1	\$11.3	\$12.7	\$14.5	2.7%
Inpatient-Res Psych	\$21.4	\$33.4	\$42.2	\$47.6	\$47.7	4.1%
Outpatient Mental Health	\$51.3	\$63.5	\$71.2	\$80.9	\$93.2	3.0%
1115 Waiver	\$8.7	\$10.1	\$10.8	\$11.8	\$12.9	2.0%
Nursing Home	\$58.4	\$87.0	\$114.1	\$143.8	\$174.5	2.0%
Home Health/Hospice	\$5.4	\$7.7	\$9.6	\$11.9	\$14.8	5.6%
Personal Care	\$12.1	\$19.6	\$27.2	\$35.6	\$44.1	6.7%
HCB State Plan Services	\$127.4	\$188.7	\$243.3	\$298.6	\$350.2	5.2%
HCB 1915(c) Waivers	\$8.2	\$10.4	\$11.7	\$13.2	\$15.2	3.1%
Total Spending on Medicaid Services	\$595.3	\$802.3	\$972.5	\$1,156.7	\$1,351.7	4.2%
Other Medicaid Payments*	\$40.9	\$50.2	\$59.7	\$70.2	\$81.9	3.5%
Total Spending on Medicaid Program	\$636.2	\$852.5	\$1,032.2	\$1,226.9	\$1,433.6	4.1%

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.