

Medicaid Expansion in Alaska: A Review and Analysis of Prior Forecasts ¹

by

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1. Introduction and summary³

1-A. Background

To provide estimates of the additional federal dollars that would flow into the state if Alaska expands Medicaid, this study:

- reviewed prior studies of the fiscal costs of Medicaid expansion;
- analyzed 2013 and 2008-2010 *American Community Survey* (ACS) data to obtain our own estimates of the newly eligible; and,
- compiled recent estimates from other sources of Medicaid expansion eligible and the uninsured.

We reviewed the following published reports on the effects of Medicaid expansion in Alaska:

1. *An Analysis of the Impact of Medicaid Expansion in Alaska, Final Report*, The Lewin Group, April 12, 2013;
2. *Healthier Alaskans Create a Healthier State Economy*, Alaska Native Tribal Health Consortium (ANTHC), February 1, 2013;
3. *Fiscal and Economic Impacts of Medicaid Expansion in Alaska*, Northern Economics, February 1, 2013;
4. *Medicaid in Alaska Under the ACA*, The Urban Institute, February 1, 2013; and,
5. *Memorandum Re: Projected Population, Enrollment, Service Costs and Demographics of Medicaid Expansion Beginning in FY2016*, to Valerie Davidson, Commissioner, Alaska Department of Health and Social Services, from Ted L. Helvoigt, Evergreen Economics, February 6, 2015.

On March 18, 2015, state agencies issued fiscal notes analyzing the impact on state finances of the governor's proposed Medicaid expansion and program change legislation, House Bill 148 (and companion Senate Bill 78).⁴ We reviewed the fiscal notes and the Governor's Office of Management and Budget's (OMB's) spreadsheets summarizing the direct fiscal impact of the legislation.⁵

We also reviewed draft estimates of Medicaid expansion enrollments and spending prepared by Evergreen Economics,⁶ to be included in the Alaska Department of Health and Social Services *Long-term Forecast of Medicaid Enrollment and Spending in Alaska: Supplement 2014-2034* (MESA 2015), to be published later this year.

³ This report replaces and supersedes a previous version of the same title dated April 16, 2015. Changes relate to provisions of the Affordable Care Act (ACA) governing the eligibility for subsidized marketplace insurance of adults with incomes between 100 percent and 138 percent of the Federal Poverty Guidelines who are without dependent children. This version clarifies that those individuals are not eligible for subsidized insurance. ACA requires that such applicants for Health Benefit Exchange insurance policies be enrolled in Medicaid. The changes had no material effect on the conclusions. The authors thank staff at the Dept. of Health and Social Services (DHSS) for bringing the issue to their attention.

⁴ See http://www.akleg.gov/basis/get_fiscal_notes.asp?session=29&bill=HB148 , accessed March 27, 2015.

⁵ "HB 148 / SB 78 - Medical Assistance Coverage; Reform," Alaska Office of Management and Budget (OMB), March 20, 2015.

⁶ *Personal communication*, Ted L. Helvoigt, Evergreen Economics, to Milt Barker, March 6, 2015.

In addition to the above studies, we reviewed the Kaiser Family Foundation state-by-state analyses of the numbers of uninsured persons in Alaska that would be newly eligible under Medicaid expansion.

1-B. Comparing the estimates

The authors of the ANTHC report (item 2 on our list) and the Northern Economics report (item 3) adopted enrollment and federal spending projections from the Urban Institute study (item 4). We combined the three into a single data series for display in Figure 1⁷, on the following page. Despite some issues with comparability, Figure 1 shows the range of estimated federal Alaska spending associated with expansion.⁸

OMB relies on Evergreen's estimates for the federal dollars attributable solely to Medicaid expansion. Indeed, OMB's estimates and Evergreen's published estimates (item 5 on the above list) are very close for 2016 and 2017.

However, by fiscal year (FY) 2021, OMB estimates the State would receive \$109,000,000 more in federal dollars than it would from Medicaid expansion alone. This additional \$109 million, stemming from "reforms," largely offsets existing State general fund expenditures. OMB's fiscal note summaries indicate FY 2021 general fund expenditures would decrease by \$105 million.

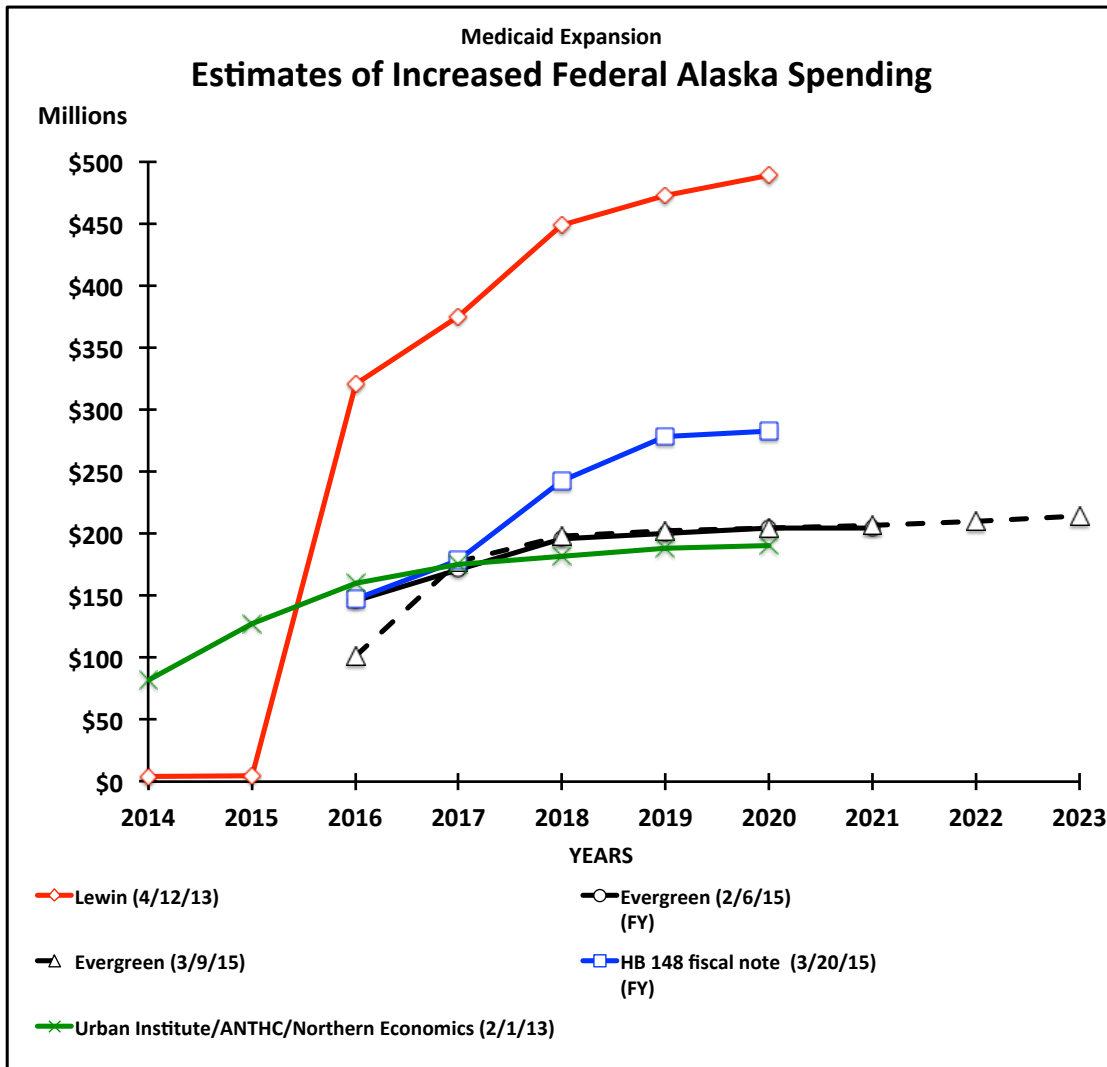
With the exception of Evergreen's estimates for 2016, Northern Economics' estimates are similar to the two Evergreen projections, but this is only happenstance. Their assumptions differ radically.

Lewin, Evergreen, and Urban Institute – all differ significantly in their assumptions.

⁷ Because administrative costs are included in the ANTHC and Northern Economic studies, they appear higher than those shown in the Urban Institute's summary table.

⁸ In FY 18 and beyond, the HB 148 fiscal note data displayed in Figure 1 includes effects of Medicaid program changes ("reform") that go beyond Medicaid expansion. In addition, two of the data series are denominated in calendar years, and three, as noted, in fiscal years.

Figure 1



1-C. Key assumptions behind the estimates

All the studies, including MESA 2015 and this study, make important assumptions about five variables:

- the number of persons that would be newly eligible under Medicaid expansion;
- the growth rate in newly eligible over time;
- enrollment rates;
- the average dollars of health care spending per enrollee; and,
- growth rates in spending per enrollee.

The estimates of enrollment rates (“take-up”), including crowd-out effects, are the same or similar, but differences in the other assumptions largely explain their varying estimates of federal dollars associated with expansion.

1-D. Conclusions

Our main conclusions are:

1. Lewin and Urban Institute overestimated the newly eligible;
2. Lewin and Urban Institute overestimated the proportion of the newly eligible that are uninsured and, as a consequence, their average enrollment rates are too high;
3. As a result of items 1 and 2, Lewin’s and the Urban Institute’s estimated increases in enrollment resulting from Medicaid expansion—40,298 and 38,580, respectively—are too high; this study’s estimated enrollment increase ranges from a low estimate of 22,826 to a high estimate of 34,135 (Tables 3 and 6);
4. The averages of estimated increases in enrollments we made in this study – 27,457 and 27,766 – is nearly the same as Evergreen’s estimated 26,393 enrollees in 2016;⁹
5. Lewin’s projected growth rates for the expansion population are aggressive; but, growth rates in the newly eligible are highly uncertain, with the state entering a major recession;
6. Evergreen’s costs per enrollee are on firmer ground; Lewin’s and Urban Institute’s costs are radically different from Evergreen’s;
7. Recent medical cost trends suggest Lewin’s somewhat dated estimates of cost growth are high; Evergreen’s rates drop sharply without explanation in 2021.

Overall, Evergreen’s projections provide the soundest basis for considering the economic impact of Medicaid expansion. Urban Institute’s total spending estimates by year are not very different from Evergreen’s, but, they appear to have arrived at similar spending figures through overestimating the newly eligible and underestimating costs per enrollee, an example of compensating errors.

2. The newly eligible

Among the published studies, the Lewin and the Urban Institute estimates of the newly eligible are almost identical (see Table 1, on the following page). The proportions without insurance are also similar.¹⁰

Evergreen’s estimates, however, are lower. Evergreen suggests the more recent vintage of their data – 2013, vs. 2008-10 for Lewin and Urban Institute – and their more reliable data source, the State of Alaska, Division of Public Health’s Behavioral Risk Factor Surveillance System (BRFSS), justifies greater confidence in their estimates.

⁹ These estimates are before applying lags in enrollment during the first two years of expansion start-up.

¹⁰ Urban Institute did not provide estimates of the newly eligible. Their estimates of the newly eligible are from *Healthier Alaskans Create a Healthier State Economy* (footnote 7, page 5), by Doneg McDonough, *et al*, Alaska Native Tribal Health Consortium, February 1, 2013.

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Kaiser Family Foundation estimates that there were 23,500 newly eligible and uninsured in Alaska in 2013.¹¹ This is just over half as many as Lewin’s and Urban Institute’s respective estimates of 42,000 and 44,470 uninsured. Interestingly, Kaiser relies on the same data source as Lewin – the U.S. Census Bureau’s *Current Population Survey* (CPS).

Study	Data Source	Year of Estimate	Uninsured	Insured	Total
Urban Institute ¹	2008-10 ACS	2014	42,000	22,000	64,000
Lewin ²	2008-10 CPS	2014	44,470	19,519	63,989
Evergreen ³	BRFSS 2012-13	2016			41,910
Evergreen ⁴		2016			41,945
this study	2013 ACS	2014	31,163	20,905	52,068
this study	2008-10 ACS	2014	28,880	18,613	47,494
this study	2013 ACS @ 100% ACA compliance	2014	19,550	32,517	52,068
this study	2008-10 ACS @ 100% ACA compliance	2014	18,274	29,220	47,494
Kaiser ⁵	2012-13 & March 2014 CPS	2014	23,500		
Notes:					
1. McDonough, D. et al, <i>Healthier Alaskans Create a Healthier State Economy</i> , Alaska Native Tribal Health Consortium, February 1, 2013. Page 5, footnote 7.					
2. Cole, M. et al, <i>An Analysis of the Impact of Medicaid Expansion in Alaska, Final Report</i> , The Lewin Group, April 12, 2013. Figure 20.					
3. Helvoigt, Ted L., Evergreen Economics, <i>Memorandum</i> to Valerie Davidson, Commissioner, Alaska Department of Health and Social Services, February 6, 2015. Table 1.					
4. Draft <i>Long-term Forecast of Medicaid Enrollment and Spending in Alaska: Supplement 2014-2034</i> , Alaska Department of Health and Social Services.					
5. Table 5.					

However, Kaiser’s data is much more recent. Lewin used data from 2008-2010. Kaiser’s latest data is from the 2014 CPS *Annual Social and Economic Supplement* (ASEC).

¹¹ The 23,500 is the total of 13,000 uninsured newly eligible that would be subject to the ACA health insurance mandate, and the 10,500 who would not. Those not subject to the mandate – the “gap” – are the uninsured below the poverty line (less than 100 percent of the Federal Poverty Guidelines). Those subject to the mandate have incomes between 100 percent and 138 percent of the poverty line. See Table 5.

As Kaiser notes in its statement of methods:

“Notably, with the 2014 ASEC, Census implemented a fundamental redesign of the health insurance coverage questions. This redesign aimed both to address longstanding issues with measurement of insurance coverage in the ASEC and to capture new coverage categories available under the ACA. The redesigned insurance questions lead to a lower estimate of the uninsured rate compared to the previous approach, addressing a longstanding issue of under-reporting of coverage in the ASEC.”

To check on these materially differing estimates of the newly eligible, we examined the Census Bureau’s *American Community Survey* (ACS) data for the most recently available year, 2013. We also checked the ACS data for 2008-10, the years used by the Urban Institute.¹²

Our analysis of ACS data produced estimates of 52,277 newly eligible using ACS’ 2013 Alaska population survey, and 45,623 using the 2008-10 survey data, a reasonable proxy for a 2009 estimate.

We estimated the newly eligible according to three eligibility categories that could be affected by Medicaid expansion:

- 19 and 20 year olds
- adults ages 21 to 64 without dependent children; and,
- adults ages 21 to 64 with dependent children.

The income ceilings for persons with a dependent child will not increase, under expansion, in families of five or fewer persons. The ceilings will increase in families of 6 or more persons. We assume there are negligibly few newly eligible persons in such families.

Our ACS estimates exclude women pregnant during the last year, disabled persons, and persons already on Medicaid.

Alaska’s population between the ages of 19 and 64 grew 4.1 percent between 2009 and 2014, but from 2013 to 2014, it *declined* 0.4 percent.¹³ Table 1, on page 7, compares the Urban Institute, Lewin, and Evergreen estimates with our estimates after adjusting for the changes in the 19 to 64 population.

After adjusting for population growth, our estimates of the newly eligible are about midway between those of Evergreen and the Urban Institute/Lewin.

This study also shows in Table 1 the change in the split of newly eligible between uninsured and insured if all newly eligible, subject to the ACA mandate to maintain minimum essential health care coverage, do so. Essentially, the 2013 and 2008-10 ACS tabulations of newly eligible in Table 1 labeled “@ 100% ACA compliance” count all newly eligible adults without dependent children, whose incomes are between 100

¹² The Urban Institute used an enhanced version of ACS’ 2008-10 PUMS data, the Integrated Public Use Microdata Sample (IPUMS) prepared by the University of Minnesota Population Center.

¹³ Alaska Department of Labor and Workforce Development at <http://labor.state.ak.us/research/pop/popest.htm>.

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percent and 138 percent of FPL (see the appendix), as insured. The remaining uninsured (those below 100 percent of FPL) are commonly referred to as the “gap”.

3. Crowd-out and take-up rates

All the studies account for the crowd-out effects of Medicaid expansion. They all assume similar crowd-out rates – i.e., the portion of persons that are already insured that nevertheless enroll in Medicaid. Lewin and Evergreen assume 39 percent of the already insured newly eligible will enroll in Medicaid. The Urban Institute assumes 36 percent.

Lewin, Evergreen, and Urban Institute have similar average enrollment rates. Their enrollment rates are weighted averages, based on the ratio of the uninsured to the already insured among the newly eligible.

Study	Data Source	Expansion Population		Enrollment Rate		
		Uninsured	Insured	Uninsured	Insured	Weighted Average
<u>Published Estimates</u>						
Urban Institute ¹	2008-10 ACS ²	65.6%	34.4%	73.0%	36.0%	60.3%
Lewin ³	2008-10 CPS ⁴	69.5%	30.5%	73.5%	39.0%	63.0%
Evergreen ⁵	(Lewin 2013)	69.5%	30.5%	73.5%	39.0%	63.0%
<u>Other Estimates</u>						
Evergreen ⁶	BRFSS 2013	44.8%	55.2%	73.5%	39.0%	54.5%
this study ⁷	2013 ACS	59.9%	40.1%	73.5%	39.0%	59.6%
this study ⁷	2008-10 ACS	60.8%	39.2%	73.5%	39.0%	60.0%
Notes:						
1. Buettgens, M. and C. Hildebrand, <i>Medicaid in Alaska Under the ACA</i> , The Urban Institute, February 1, 2013. Pages 34-35.						
2. McDonough, D. et al, <i>Healthier Alaskans Create a Healthier State Economy</i> , Alaska Native Tribal Health Consortium, February 1, 2013. Ratios derived from footnote 7, page 5.						
3. Cole, M. et al, <i>An Analysis of the Impact of Medicaid Expansion in Alaska, Final Report</i> , The Lewin Group, April 12, 2013. Figure 8.						
4. <i>Ibid.</i> Ratios of 2014 newly eligibles derived from Figure 20.						
5. Adopts Lewin's uninsured ratios and enrollment rates.						
6. Helvoigt, Ted L., Evergreen Economics, <i>Memorandum</i> to Valerie Davidson, Commissioner, Alaska Department of Health and Social Services, February 6, 2015. <i>Memorandum's</i> Table 5 uninsured percentage adjusted for 96.6% response rate. Adopts Lewin's enrollment rates.						
7. Uninsured percentages from Table 1. Adopts Lewin's enrollment rates.						

In Table 2, on the preceding page, we estimate that the ratio of uninsured to insured in 2013, before the start of the ACA's mandate, was 60 to 40, compared to Lewin's 70 to 30, and Urban Institute's 66 to 34. Our 60 to 40 estimate drops the average take-up rate to 59.6 percent.

Our estimates are based on analysis of the *American Community Survey* (ACS) Public Use Microdata Sample (PUMS) for the survey year 2013, as well as of the 2008-10 three-year sample. The 2008-10 three-year sample was the data source for Urban Institute. We found that the 60 to 40 ratio and an average take-up rate around 60 percent held true, regardless of whether we were looking at 2013 data, or 2008-10.

Lewin and Urban Institute¹⁴ directly estimated the number of insured and uninsured persons that would become newly eligible under Medicaid expansion. Refer to Table 1. Evergreen uses Lewin's weighted average enrollment rate.

All of the studies assume higher Medicaid participation ("take-up") rates among the newly eligible that have no insurance, compared with those that already have health insurance of some kind.

Lewin and Evergreen estimate 63 percent of the newly eligible will enroll in Medicaid. They assume that 73.5 percent of the newly eligible without insurance will participate in Medicaid, but that only 39 percent that already have health insurance of some kind – employer health insurance or privately purchased insurance – will enroll. Urban Institute assumes similar take-up ratios.

The 63 percent weighted average assumed by Lewin and Evergreen is based on Lewin's estimate of the ratio of the uninsured to the insured. Lewin estimated that 69.5 percent of the newly eligible would be uninsured, and 30.5 percent insured.

Urban Institute has a similar proportion – 65.6 percent uninsured and 34.4 percent insured.

Evergreen adopted Lewin's assessment of take-up rates, based on Lewin's review of the research literature on the subject, and also adopted Lewin's assumed ratio of the uninsured to the insured. Lewin does not cite the literature they reviewed.

Urban Institute cites Glied (2002)¹⁵ as summarizing the literature on take-up rates. Glied concludes that the overall take-up rate for Medicaid expansion would be 60 percent. Glied concludes that take-up rates for the privately insured should be about 30 percent as high as for the uninsured.

Urban Institute, as well as Lewin, estimated a higher take-up rate for Medicaid expansion than the literature suggests. Urban Institute cites the "no-wrong-door" effect – the automatic Medicaid referrals or eligibility determination to be built into the Health Benefit Exchange application process.

¹⁴ The Urban Institute's breakout of newly eligible into uninsured and insured is not published as part of their *Medicaid in Alaska Under the ACA*, February 1, 2013, report, but it is documented in footnote 7 of the Alaska Native Tribal Health Consortium's *Healthier Alaskans Create a Healthier State Economy*, February 1, 2013 report.

¹⁵ *Inside the Sausage Factory: Improving Estimates of the Effects of Health Insurance Expansion Proposals*, by Sherry Glied, et al, *The Milbank Quarterly*, Vol. 80, No. 4, 2002.

This effect would fall mostly on expansion population members who would otherwise purchase insurance on a Health Benefit Exchange. It may also account for Urban Institute’s insured take-up rates being 49 percent of their uninsured take-up rate (49% = 36%/73%), as well as Lewin’s 53 percent (53% = 39%/73.5%), compared to the literature’s 30 percent.

4. Enrollment

In Table 3, we estimate the increased enrollment caused by Medicaid expansion on the assumption that the average enrollment rates shown in Table 2 fully and accurately anticipate the impact of ACA and its “no-wrong-door” feature.

Study	Year of Estimate	Newly Eligibles		Enrollment Rate ²	Enrollment
		Data Source	Eligibles ¹		
<u>Published Estimates</u>					
Urban Institute	2014	2008-10 ACS	64,000	60.3%	38,580
Lewin	2014	2008-10 CPS	63,989	63.0%	40,298
Evergreen	2016	BRFSS 2012-13	41,910	63.0%	26,393
<u>Other Estimates</u>					
Evergreen	2016	BRFSS 2013 44.8% Uninsured	41,910	54.5%	22,826
this study	2014	2013 ACS	52,068	59.6%	31,058
this study	2014	2008-10 ACS	47,494	60.0%	28,486
Average of Other Estimates					27,457
Notes:					
1. Table 1.					
2. Table 2.					

The “Other Estimates” of enrollment in Table 3 differ from the “Published Estimates” only in the estimated number of newly eligibles (this study) and the proportion of newly eligibles that are uninsured (all three “Other Estimates”).

The average of the “Other Estimates” enrollment is very close to Evergreen’s published estimate.

5. Impact of the Affordable Care Act

5-A. The ACA mandate, marketplace subsidies, and Medicaid expansion

By 2014 the major provisions of the Affordable Care Act (ACA) had taken effect, including the ability of many Alaskans to purchase subsidized health insurance on a health insurance exchange. Under the ACA, U.S. citizens with incomes above 100 percent of the federal poverty guidelines (FPL) (see Appendix) are mandated to obtain health insurance; tax penalties are imposed on those not having insurance. As Lewin explains,

“By 2016 the penalty will be the greater of \$695 per person (capped at \$2,085 per family) or 2 percent of income. However, exemptions apply to people below the federal tax-filing threshold and to families where coverage is unaffordable (i.e., premiums that exceed 8 percent of family income). Most Alaska residents with incomes below 138 percent of FPL will be exempt from the penalty.”¹⁶

Alaska Natives are exempt from the penalties.

A substantial part of the newly eligible under Medicaid expansion in Alaska would fall under the ACA mandate. New Alaska Medicaid-eligible persons would consist almost entirely of persons without dependent children whose incomes are below 138 percent of FPL. The portion falling between 100 percent and 138 percent of FPL came under the ACA mandate in 2014.

The ACA denies subsidies to purchasers of health insurance on ACA marketplace exchanges if they are eligible for Medicaid or other “minimum essential coverage,” as defined by the ACA.

Expansion of Medicaid would render the adults without dependent children, with incomes between 100 percent and 138 percent of FPL ineligible for marketplace subsidies because they would become eligible for Medicaid. Moreover, ACA requires that such applicants for Health Benefit Exchange insurance policies be enrolled by the state in Medicaid.

Alaska, at this point, is an “assessment state” under the ACA. In an assessment state, the Health Benefit Exchange makes a preliminary assessment of an applicant’s Medicaid or Children’s Health Insurance Program (CHIP) eligibility, and transfers the applicant’s account to the state Medicaid or CHIP agency to make a final determination. In other states, known as “determination states,” the Exchange makes a final determination of an applicant’s eligibility.

¹⁶ *An Analysis of the Impact of Medicaid Expansion in Alaska, Final Report*, by M. Cole, et al, The Lewin Group, April 12, 2013, page 9.

5-B. Recent declines in the number of uninsured

Based on polling for the Gallup-Healthways well-being index, Gallup in February reported that Alaska’s percentage of uninsured declined from 18.9 percent in 2013, to 16.1 percent in 2014, a 14.8 percent decrease.¹⁷

In March, the U.S. Department of Health and Human Services (DHHS) reported that between the start of the first ACA enrollment period in 2013, and March 4, 2015, the percentage uninsured among those with incomes less than 138 percent of FPL in non-expansion states dropped from 61.8 percent to 54.8 percent.¹⁸ This is an 11.3 percent decline in uninsured.

Note that the 61.8 percent average rate of uninsured in 2013 in non-expansion states is very close to the 59.9 and 60.8 percent uninsured rate we found for the Alaska “non-expansion” population in the ACS data, as shown in Table 2.

Other surveys are finding similar decreases in numbers of uninsured. Across the surveys shown in Table 4, about 5 percent of the total non-elderly adult population gained coverage after ACA enrollment began in October 2013. This represented a 23–30 percent decline in the uninsured.

It would make sense that the percentage decline in uninsured among the expansion population (those below 138 percent FPL) would be less than the decline among the uninsured generally, which include those with incomes up to 400 percent of FPL. The higher income persons may be more able to take advantage of the Health Benefit Exchanges and tax credits.

Survey	Uninsured Rate		
	2013	2014	Decrease
Commonwealth Fund	20.0%	15.0%	25.0%
Gallup-Healthways	21.6%	16.2%	25.0%
RAND	20.5%	15.8%	22.9%
Urban Institute	17.7%	12.4%	29.9%
Notes:			
1. Karpman, M. et al, <i>Nonfederal Surveys Fill a Gap in Data on ACA</i> , Urban Institute, March 2015.			

¹⁷ *Arkansas, Kentucky See Most Improvement in Uninsured Rates*, by D. Witters, February 24, 2015. <http://www.gallup.com/poll/181664/arkansas-kentucky-improvement-uninsured-rates.aspx>

¹⁸ Office of the Assistant Secretary for Planning and Evaluation (ASPE) analysis of Gallup-Healthways Well-Being Index survey data through March 4, 2015, at http://aspe.hhs.gov/health/reports/2015/uninsured_change/ib_uninsured_change.pdf.

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Although it predates the ACA mandate, the Evergreen 2013 estimate of 44.8 percent of newly eligible BRFSS (Behavioral Risk Factor Surveillance System) survey respondents indicating they were uninsured is a more recent figure than Lewin and Urban Institute’s 2008-10 data. It is also lower than Lewin’s 69.5 percent, and the Urban Institute’s 65.6 percent.

5-C. Enrollments with ACA adjustment

This study estimates the effect of the ACA on Medicaid expansion enrollment by further breaking down take-up rates for the uninsured into separate take-up rates for those subject to an ACA mandate (those between 100 percent and 138 percent of FPL) and those in the “gap” (those below 100 percent of FPL).

TABLE 5				
Alaska Medicaid Expansion				
Uninsured Newly Eligible				
Study	Data Source	Incomes	Uninsured ¹	Percent
this study	2013 ACS	0%-138% FPL	31,163	100.0%
this study	2013 ACS @ 100% ACA compliance	"Gap" 0%-100% FPL	<u>19,550</u>	<u>62.7%</u>
		"Mandate" 100%-138% FPL	11,612	37.3%
this study	2008-10 ACS	0%-138% FPL	28,880	100.0%
this study	2008-10 ACS @ 100% ACA compliance	"Gap" 0%-100% FPL	<u>18,274</u>	<u>63.3%</u>
		"Mandate" 100%-138% FPL	10,607	36.7%
Kaiser ²		0%-138% FPL	23,500	100.0%
	March 2014 CPS ³	"Gap" 0%-100% FPL	<u>10,500</u>	<u>56.7%</u>
	2012-13 CPS ⁴	"Mandate" 100%-138% FPL	13,000	43.3%
Notes:				
1. From Table 1, except Kaiser.				
2. Ratios based on 2012-13 CPS (footnote 4) which reported 30,000 uninsured below 138% FPL, of which 17,000 were in the "Gap" and 13,000 were under the "Mandate".				
3. <i>The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid -- An Update, Issue Brief</i> , The Kaiser Commission on Medicaid and the Uninsured, November 2014.				
4. <i>A Closer Look at the Impact of State Decisions Not to Expand Medicaid on Coverage for Uninsured Adults, Fact Sheet</i> , The Kaiser Commission on Medicaid and the Uninsured, April 2014.				

Our analysis of ACS data, as reflected in Table 5, on the preceding page, provides a breakdown of uninsured newly eligible between those with a mandate and those in the gap. Table 5 indicates that persons subject to a mandate make up about 37 percent, and those in the gap about 63 percent, of the uninsured eligible. Kaiser’s analysis of CPS data indicates that those above the poverty line – those with a mandate – make up 43 percent of the newly eligible uninsured.

We apply DHHS’ average 11.3 percent Gallup-Healthways ACA decline in the number of uninsured in the expansion population to Evergreen’s and our low “Other Estimates with ACA Adjustment” in Table 6. It is applied to Evergreen’s 44.8 percent uninsured from the 2013 BRFSS survey and our 2013 and 2008-10 ACS percentages, unadjusted for ACA.

We assume that the decline in uninsured found by Gallup stems wholly from acquisition of health insurance on the Health Benefit Exchange. This means that with Medicaid expansion, all of the 11.3 percent of these formerly uninsured will be moved over to Medicaid.

This presumes that little or none of the Gallup decline in uninsured occurred among those below 100 percent of the FPL. Those persons have no access to the Health Benefit Exchange. Outside of the exchanges and their associated subsidies, these individuals are likely unable to buy insurance on their own.¹⁹

Our mandate take-up rate for the Evergreen “Other Estimates with ACA Adjustment” in Table 6 assumes that 100 percent of the Gallup newly insured wind up on Medicaid and that the rest of Evergreen’s mandate population experiences the Lewin 73.5 percent general take-up rate for the uninsured. We apportion Evergreen’s uninsured between mandate and gap segments in the same proportions as Lewin.

Our “Low Estimates” take-up rates in Table 6 assume that 100 percent of the Gallup newly insured wind up on Medicaid and that none of the rest of the mandate population becomes enrolled in Medicaid.

Our “High Estimates” in Table 6 assume 100 percent of the mandate population becomes enrolled in Medicaid. This would be all those between 100 percent and 138 percent of FPL. It is all the newly eligible who can purchase insurance on a Health Benefit Exchange, including the Gallup population that has already done so.

If Gallup’s 11.3 percent decline in uninsured in the expansion population is representative of what has happened in Alaska, then somewhere between a fifth to a third of the uninsured in the expansion population that have a mandate have complied with the ACA mandate.

In Table 6, we apply our enrollment rates, adjusted for ACA-induced declines in the uninsured, to the estimates of the newly eligible. The average of the “Other Estimates” is 27,766 enrollees. Of the previous studies’ “Published Estimates,” shown in Table 6, our average is close to Evergreen’s estimated enrollment – at 26,393 in 2016.

¹⁹ Legal immigrants residing in the United States less than 5 years with family incomes below 100 percent FPL are allowed access to Exchange premiums and subsidies. They are barred from enrollment in Medicaid.

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TABLE 6											
Alaska Medicaid Expansion Enrollment with ACA Adjustment											
Newly Eligibles											
Study	Year of Estimate	Data Source	Uninsured					Enrollment Rate			
			Insured ¹	Gap ²	Mandate ³	Total ⁴	Total ⁵	Insured ⁶	Gap ⁶	Mandate ⁷	Enrolled
Published Estimates											
Urban Institute	2014	2008-10 ACS	22,000			42,000	64,000	36.0%	73.0%	73.0%	38,580
Lewin	2014	2008-10 CPS	19,519	20,000	24,470	44,470	63,989	39.0%	73.5%	73.5%	40,298
Evergreen	2016	BRFSS 2012-13					41,910	63.0%	63.0%	63.0%	26,393
Other Estimates with ACA Adjustment											
Evergreen	2016	BRFSS 2013 44.8% Uninsured @ Gallup ACA compliance	23,134	8,444	10,331	18,776	41,910	39.0%	73.5%	79.0%	23,386
Low Estimates											
this study	2014	2013 ACS @ Gallup ACA compliance	20,905	19,550	11,612	31,163	52,068	39.0%	73.5%	30.4%	26,052
this study	2014	2008-10 ACS @ Gallup ACA compliance	18,613	18,274	10,607	28,880	47,494	39.0%	73.5%	30.8%	23,962
High Estimates											
this study	2014	2013 ACS @ 100% ACA compliance	20,905	19,550	11,612	31,163	52,068	39.0%	73.5%	100.0%	34,135
this study	2014	2008-10 ACS @ 100% ACA compliance	18,613	18,274	10,607	28,880	47,494	39.0%	73.5%	100.0%	31,297
Average of Other Estimates											27,766
Kaiser	2014	2012-13 & March 2014 CPS		10,500	13,000	23,500					

Notes to table 6: **1.** Table 1, with Evergreen at 44.8 percent of total eligible uninsured and the remainder insured. **2.** Table 5, except Lewin from An Analysis of the Impact of Medicaid Expansion in Alaska, Final Report, p. 29, and Evergreen, which is apportioned proportional to Lewin. **3.** Table 5, except Lewin, which is calculated, and Evergreen, which is apportioned proportional to Lewin. **4.** Lewin and Urban Institute from Table 1. **5.** Evergreen from Table 1. **6.** Table 2. **7.** Table 2, except Evergreen’s “Other Estimates with ACA Adjustment” assumes 100 percent of 2014-15 ACA Exchange insureds transfer to Medicaid. “Low Estimates” assume no additional mandate-eligible enroll beyond the 2014-15 ACA Exchange insureds. “High Estimates” assume all mandated eligible enroll.

4. The “welfare cliff”

Some observers have suggested that failure to properly account for the so-called “welfare cliff” has resulted in widespread underestimation of enrollment.²⁰ As Lewin explains:

“We do not include estimates for individuals with incomes above eligibility minimums who would take purposeful steps to become eligible. This is because these individuals would be eligible for an Exchange subsidy, which, for individuals right above the 138 FPL threshold, would cost only 3 percent of their annual income. Most individuals would have to spend-down more than it would cost to purchase the subsidized insurance.”²¹

For 2015, a single Alaskan at 138 percent FPL would pay about \$56 per month towards the premium on health insurance purchased through an exchange. Monthly income at 138 percent of FPL is \$1,692. Giving up one month’s work to qualify for Medicaid would cost far more than would be gained in foregone premium expense.

At 138 percent FPL, the actual cost would be about 3.3 percent, pursuant to Section 1401 of the ACA. The insured’s share of the premium cost for the second lowest cost silver plan in her market area would be \$56. The subsidy is calculated under ACA based on the second lowest cost silver plan.

The cost to the insured would be even less, if he selected a lower cost plan. The Alaska Department of Health and Social Services (DHSS) estimates a 30-year-old living in Anchorage at 138 percent FPL would pay about \$5 per month for the cheapest silver plan.

Individuals with chronic health conditions might find it advantageous to take a lower paying job or work less if they have large on-going out-of-pocket medical expenses that Medicaid could pick up. However, persons with incomes up to 250 percent of FPL are eligible for subsidies for their out-of-pocket costs, in addition to premiums. We know of no evidence suggesting that more than a handful of those in the expansion population – persons *not disabled*, between the ages of 19 and 64, and with no children – would find it advantageous to take a cut in income in order to qualify for Medicaid.

5. Enrollment trends

We examined Alaska Medicaid’s historical enrollment figures to see if there were trends that might apply to the expansion population. In DHSS’ statistics, the enrollment category that contains working age adults, and excludes pregnant women and the disabled, also includes some children enrolled under the same case as their parents. Most Medicaid children are enrolled under their own case, as Title XIX or Title XXI kids. Adding still more noise to the data are changes in the administrative practices regarding enrolling children in their own, vs. their parents’, cases.

²⁰ See “Medicaid Expansion: Lessons from other States,” Alaska legislative “Lunch & Learn,” presentation by Christine Herrera, Foundation for Government Accountability, Mar. 4, 2015, video at http://www.360north.org/gavel-archives/?event_id=2147483647_2015031035 accessed Mar 4, 2015.

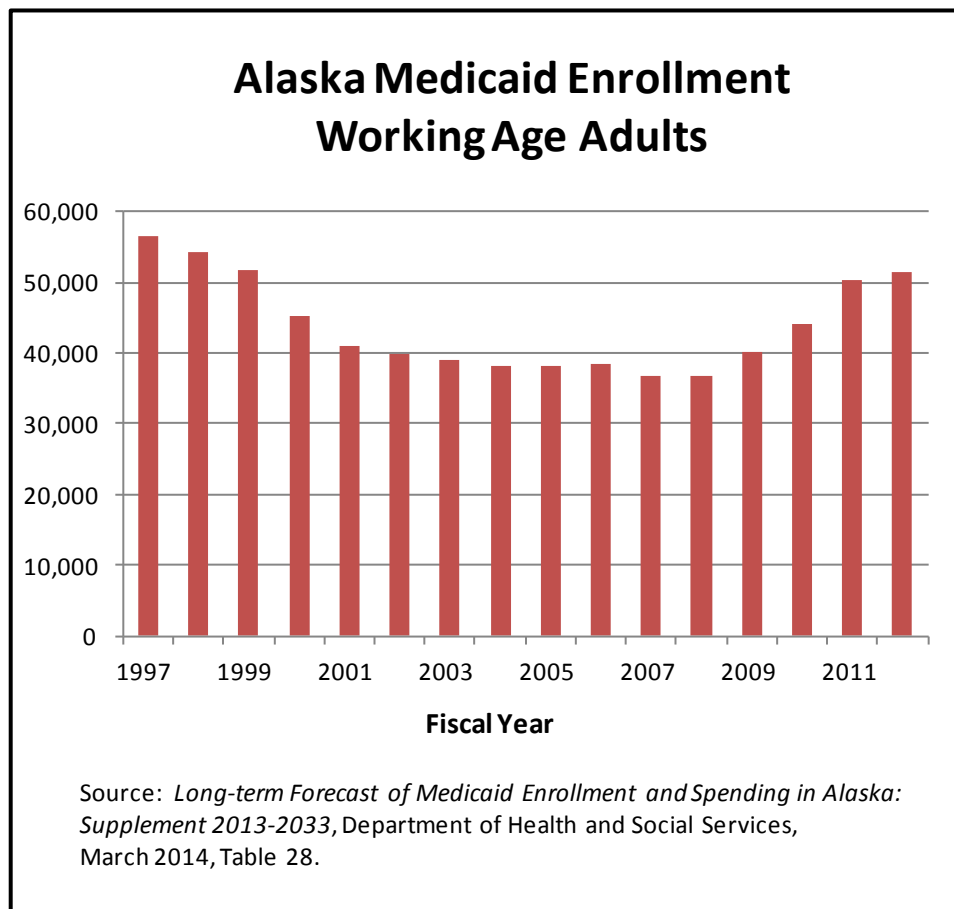
²¹ *An Analysis of the Impact of Medicaid Expansion in Alaska, Final Report*, by M. Cole, et al, The Lewin Group, April 12, 2013, page 15.

The pattern of enrollments for the category that does include working age adults is nevertheless worth noting. It demonstrates two things:

- Medicaid caseloads do not have to, nor do they always, increase; and,
- legislative and administrative measures can control caseloads.

Figure 2 shows the unduplicated counts of working age Medicaid enrollees. The data begins in 1997, the year after the enactment of the Temporary Assistance to Needy Families (TANF) program that replaced Aid to Families with Dependent Children (AFDC), commonly referred to as welfare reform. Alaska’s Medicaid enrollments in this category steadily declined from 56,673 in 1997, to 36,683 in 2008.²²

Figure 2



The steep declines following 1997 reform likely result from the legislation. Later, around 2003, Alaska rolled back the income standard for pregnant women and CHIP

²² *Long-term Forecast of Medicaid Enrollment and Spending in Alaska: Supplement 2013-2033*, Department of Health and Social Services, March 2014, Table 28.

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recipients from 200 percent FPL to 175 percent FPL, and froze income eligibility ceilings.²³ This rollback and freeze contributed to enrollments slowly creeping down for most of the 2000's.

The freeze ended in 2008, and eligibility standards for pregnant women and children, which had eroded to a level of 150 percent FPL, were restored to 175 percent. Enrollments surged, from 40,106 in 2009 to 51,567 in 2012, an average 8.4 percent growth per year. By 2012, the growth rate dropped back to 2.3 percent.

The growth period overlaps the better part of the recent U.S. recession. But, Alaska registered only one year of job decline, in 2009. Still, DHSS thinks the recession may have contributed to the recent Medicaid growth spurt. They note that caseloads in the food stamp program, now SNAP, almost doubled during the 2009 recession.

With the passing of the national recession, and the lifting of the rollback and freeze on eligibility standards having been digested, enrollment growth of the Medicaid category with working age adults may again flatten out.

Certainly, the three sets of fiscal estimates we have are based on fairly modest future annual rates of enrollment growth:

- Urban Institute: 0.5 percent;
- Lewin: 1.1 percent to 1.6 percent; and,
- Evergreen (both projections): 0.17 percent.²⁴

Evergreen bases its low growth rates on the Alaska Department of Labor and Workforce Development's *Alaska Population Projections 2012 to 2042*. They forecast a 0.2 percent decline in the age 19 to 64 population over the 2016 to 2020 period – from 471,668 to 470,845.

Lewin adds 1.0 percent to growth rates derived from the U.S. Census Bureau's *Interim State Projections of Population for Five-Year Age Groups and Selected Age Groups by Sex*. Lewin's additional 1.0 percent is to "account for an accelerated rate of growth among the population typically served by Medicaid." Lewin does not indicate why they expect higher rates, whether it's more persons without dependent children (the main expansion population component), declining incomes, or what.

Sometime last summer the Alaska economy entered a recession. Unless oil prices stage a dramatic recovery, we expect the current recession to be the worst in Alaska's history as a state.²⁵ As people lose their jobs, the recession could cause Medicaid enrollments to increase. That depends on rates of net out-migration, the levels of economic stress on those remaining, and the strength or weakness of Outside labor markets. Regardless, those with low-incomes are the least able to emigrate.

²³ "States Eye Medicaid Cuts as Cure for Fiscal Woes," by R.B. Gold, *The Guttmacher Report on Public Policy*, August 2003, Vol. 6 No. 3.

²⁴ Urban Institute, p. 36; Lewin, Figure B-6. We calculate Evergreen growth rates from Table 3 in Evergreen (2015) and their draft MESA 2015 projections.

²⁵ *The Great Alaska Recession*, by Gregg Erickson & Milt Barker, for the Alaska Mental HealthTrust Authority, April 12, 2015.

Bottom line: although it's possible the Alaska recession would trigger a decline in Medicaid enrollments, we believe an increase is more likely.

6. Costs of expansion

6-A. Historical trends

Evergreen's numbers on historical Medicaid costs per enrollee show that costs for the expansion population would run just over half the cost for the average working age adult. In Table 7, we see that they averaged 52 percent over 2009-13.

State Fiscal Year	Ages 19-64 ¹	Ages 19-64 except Pregnant or Disabled ¹	Ratio
2009	12,282	6,359	52%
2010	13,079	6,708	51%
2011	13,301	6,934	52%
2012	12,684	6,593	52%
2013	12,374	6,560	53%
Average			52%
Notes:			
1. Evergreen (2015), <i>Memorandum</i> , Table 7.			

In 2010, Alaska spent about twice the U.S. average per Medicaid enrollee. Alaska's per enrollee payments for services for parents and children was \$5,227, compared to \$2,596 nationally.²⁶ This put Alaska spending at 201 percent of the U.S. average.

If we start with the U.S. average, double it to get average Alaska costs, and then halve them to weed out the higher costs of pregnancies and disabilities, we are back to the U.S. average for parents and children as a rough indicator of where costs should fall for the expansion population.

²⁶ *State Health Care Spending on Medicaid*, The Pew Charitable Trusts and MacArthur Foundation, July 2014, Table B.6.

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Table 8 shows the Congressional Budget Office’s projected Medicaid costs (state and federal dollars) per adult enrollee, alongside the Alaska studies’ State and federal total costs.

Using the U.S. average Medicaid cost for adults as a reality check, the Evergreen numbers seem to have their feet most firmly on the ground. They also happen to be roughly in the middle of the range of estimates.

Year	Draft MESA 2014 (3/9/15) (CY) ¹	Evergreen (2/6/15) (SFY) ²	Lewin (4/12/13) (CY) ³	Urban Institute (2/1/13) (CY?) ⁴	U.S. Average Medicaid Adult (FFY) ⁵
2014	n.a.	n.a.	0	4,294	5,492
2015	n.a.	n.a.	0	4,459	6,540
2016	4,938	7,248	10,517	4,635	7,048
2017	7,636	7,495	11,055	4,816	7,190
2018	7,885	7,752	11,618	5,010	7,524
2019	8,156	8,018	12,202	5,210	7,794
2020	8,363	8,293	12,816	5,418	8,095
2021	8,493	8,433	n.a.	n.a.	8,476
2022	8,624	n.a.	n.a.	n.a.	8,905
2023	8,757	n.a.	n.a.	n.a.	9,365
Notes:					
1. Draft <i>Long-term Forecast of Medicaid Enrollment and Spending in Alaska: Supplement 2014-2034</i> , Alaska Department of Health and Social Services.					
2. Helvoigt, Ted L., Evergreen Economics, <i>Memorandum</i> to Valerie Davidson, Commissioner, Alaska Department of Health and Social Services, February 6, 2015. Table 9.					
3. Cole, M. et al, <i>An Analysis of the Impact of Medicaid Expansion in Alaska, Final Report</i> , The Lewin Group, April 12, 2013. Total costs from Figure B-6 minus total costs from B-1, divided by change in enrollment from B-6 minus change in enrollment from B-1.					
4. Buettgens, M. and C. Hildebrand, <i>Medicaid in Alaska Under the ACA</i> , The Urban Institute, February 1, 2013. Total difference due to expansion from Table 2 divided by difference in enrollment due to expansion from Table 1.					
5. U.S. average Medicaid spending per adult enrollee from <i>Detail of Spending and Enrollment for Medicaid—CBO’s March 2015 Baseline</i> at https://www.cbo.gov/sites/default/files/cbofiles/attachments/44204-2015-03-Medicaid.pdf , divided by 63% average Federal share. Federal share of total Medicaid spending varies between 64 and 62 percent, due to changing Federal share under the Affordable Care Act.					

Evergreen’s costs per enrollee are adjusted for the projected ages and gender of the expansion population, specifically recognizing the relatively older make-up of the expansion population compared to the existing enrolled Medicaid population. Evergreen based their costs per enrollee on 2009-13 costs for adults in the family Medicaid

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program. These enrollees all have dependent children and would be younger on average than the expansion population, which includes persons up to age 64 without a dependent child.

6-B. Projections

Table 9 shows rates of growth in cost per enrollee in the studies, compared to the Congressional Budget Office’s most recent projections for the U.S. adult Medicaid population.²⁷ CBO’s projected rates are reduced from previous forecasts, reflecting declines in the rate of medical cost inflation and utilization. CBO believes that the slowdown is largely a byproduct of the recent recession, and that rates of growth will pick back up over the next few years.

Evergreen is low compared to the U.S. projected rates, and has rates falling well below the CBO in years farther out. Lewin is high. Urban Institute most closely tracks the U.S. expected growth rates.

TABLE 9					
Medicaid Expansion Cost Per Member Per Year Rates of Growth					
Year	Draft MESA 2014 (3/9/15) (CY)	Evergreen (2/6/15) (SFY)	Lewin (4/12/13) (CY)	Urban Institute (2/1/13) (CY?)	U.S. Average Medicaid Adult (FFY)
2014	n.a.	n.a.		n.a.	
2015	n.a.	n.a.		3.9%	
2016	n.a.	n.a.		3.9%	
2017	54.6%	3.4%	5.1%	3.9%	2.0%
2018	3.3%	3.4%	5.1%	4.0%	4.6%
2019	3.4%	3.4%	5.0%	4.0%	3.6%
2020	2.5%	3.4%	5.0%	4.0%	3.9%
2021	1.5%	1.7%	n.a.	n.a.	4.7%
2022	1.5%	n.a.	n.a.	n.a.	5.1%
2023	1.5%	n.a.	n.a.	n.a.	5.2%
Notes:					
1. Rates of growth derived from Table 8.					

²⁷ *Detail of Spending and Enrollment for Medicaid--CBO's March 2015 Baseline*, Congressional Budget Office at <https://www.cbo.gov/sites/default/files/cbofiles/attachments/44204-2015-03-Medicaid.pdf>

APPENDIX

GLOSSARY OF ACRONYMS

<i>ACA</i>	Affordable Care Act (full title: Patient Protection and Affordable Care Act, public law 111-148)
<i>ACS</i>	American Community Survey, U.S. Census
<i>AFDC</i>	Aid to Families with Dependent Children
<i>ANTHC</i>	Alaska Native Tribal Health Consortium
<i>ASEC</i>	Annual Social and Economic Supplement [sic], U.S. Census
<i>BRFSS</i>	Behavioral Risk Factor Surveillance System, DHSS
<i>CBO</i>	Congressional Budget Office
<i>CHIP</i>	Children’s Health Insurance Program (“Denali Kid Care” in Alaska)
<i>CPS</i>	Current Population Survey, U.S. Census
<i>DHHS</i>	U.S. Department of Health and Human Services
<i>DHSS</i>	Alaska Department of Health and Social Services
<i>FPT</i>	Federal Poverty Threshold (see discussion below)
<i>FPL</i>	Federal Poverty Guideline [sic] (see discussion below)
<i>FY</i>	Fiscal Year
<i>IPUMS</i>	Integrated Public Use Microdata Sample, University of Minnesota Population Center.
<i>MESA</i>	Medicaid Enrollment and Spending in Alaska, <i>Long-term Forecast Supplement 2014-2034</i> , DHSS
<i>OMB</i>	Alaska Office of Management and Budget
<i>PUMS</i>	Public Use Microdata Sample, American Community Survey, U.S. Census
<i>SCHIP</i>	State Children’s Health Insurance Program (same as CHIP)
<i>TANF</i>	Temporary Assistance to Needy Families

FEDERAL POVERTY MEASURES

There are two slightly different versions of the federal poverty measure:

- The poverty threshold (FPT), and
- The poverty guideline (commonly, FPL with the “L” standing for “level”).

The poverty thresholds are the original version of the federal poverty measure; the Census Bureau updates them annually. The thresholds are used mainly for statistical purposes – for instance, preparing estimates of the number of Americans in poverty each year.

The poverty guidelines are the other version of the federal poverty measure. They are issued each year in the *Federal Register* by the U.S. Department of Health and Human Services (HHS). The guidelines are a simplification of the poverty thresholds for use for administrative purposes – for instance, determining financial eligibility for certain federal programs. Certain parts of Medicaid, including Medicaid expansion under the Affordable Care Act (ACA), are such programs.

The poverty guidelines are loosely referred to as the “federal poverty level” (FPL). Following common usage, this report uses the “FPL” acronym.

There are separate poverty guidelines for Alaska and Hawaii. The poverty thresholds have never had separate figures for Alaska and Hawaii.

The poverty guidelines (unlike the poverty thresholds) are designated by the year in which they are issued. For instance, the guidelines issued in January 2015 are designated the 2015 poverty guidelines. However, the 2015 HHS poverty guidelines only reflect price changes through calendar year 2014; accordingly, they are approximately equal to the Census Bureau poverty thresholds for calendar year 2014.

This summary of federal poverty measures is adapted from DHHS’ discussion of the 2015 poverty guidelines at <http://aspe.hhs.gov/poverty/15poverty.cfm>. Poverty thresholds for 2014 and prior years are available at <http://www.census.gov/hhes/www/poverty/data/threshld/index.html>.