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## Estimated Financial Impact of Medicaid Expansion Coverage Options on the Alaska Medicaid Budget

Prepared for:  
**Alaska Department of Health and Social Services**

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## I. BACKGROUND

The Alaska Department of Health and Social Services (AK DHSS) is exploring various health system reform initiatives through its Medicaid Redesign and Expansion Project. In June 2015, the Alaska Department of Health and Social Services contracted with Agnew::Beck Consulting, Health Management Associates, and Milliman, Inc. to provide technical assistance for the Department's Medicaid Redesign and Expansion Project. As part of this engagement, Milliman was asked to estimate the financial impact to the state Medicaid medical expenditures, including the incremental administrative cost, of these reform initiatives. We have not included costs that require a capital investment such as an investment in Information Technology (IT) Infrastructure that may be required to administer the proposed Expansion Options. We have not analyzed the fiscal impact to the state's economy, uninsured population health care costs, or other residual economic impacts in this report. This report contains our findings related to the options for the Medicaid expansion population.

### Description of Coverage Options for Expansion Population

Agnew::Beck worked closely with AK DHSS to design the project approach and stakeholder engagement process. The HMA team completed an Environmental Assessment and shared the findings with key partners. Throughout the process, HMA shared policy expertise and national experience. Milliman attended all key partner work sessions, provided feedback on potential actuarial impact, and reviewed draft analyses throughout each round of the project. Medicaid expansion options were identified based on stakeholder feedback, other states' experiences, and an understanding of Alaska's current Medicaid system. Upon completion of this process, Milliman was asked to estimate expenditures for the following options:

**Expansion Option 1: Current Alternative Benefit Plan (ABP).** On September 1, 2015, Alaska Medicaid expanded eligibility to include adults between ages 19 to 64, who have income at or below 138 percent of the Federal Poverty Level (FPL) and who are not eligible for another type of coverage under Medicaid or Medicare. Individuals eligible for Medicaid under Alaska's expansion are covered under an ABP that is defined as the standard benefits offered to other Medicaid eligible individuals in the state. Expansion Option 1 assumes expansion enrollees continue to receive coverage under the current Alternative Benefit Plan that includes the same benefits and services provided to existing Medicaid enrollees.

**Expansion Option 2: Alternative Benefit Plan (ABP) based on a Qualified Health Plan (QHP).** Under Expansion Option 2, expansion enrollees are covered under a benefit package based on an ABP that differs from the current Medicaid benefit package.

**Expansion Option 3: Private Option based on a Qualified Health Plan (QHP).** Expansion enrollees purchase coverage through the Federally Facilitated Marketplace. Medicaid pays premiums and co-payment amounts directly to the private insurer and pays for any required Medicaid services not provided through the QHP.

## II. FISCAL IMPACT SUMMARY

Alaska Medicaid expanded eligibility on September 1, 2015. In order to avoid showing a partial year during the ramp up period of Medicaid expansion, we did not include state fiscal year 2016 in our analysis. Although any changes to the current expansion population coverage could not occur until at least state fiscal year 2018, our analysis analyzes the five-year period beginning with state fiscal year 2017. The tables below summarize the projected state and federal expenditures for the Medicaid expansion enrollees by state fiscal year for each coverage option.

**Expansion Option 1: Current Alternative Benefit Package\***

	FY2017	FY2018	FY2019	FY2020	FY2021
New ly Eligible Adults	41,980	42,050	42,120	42,190	42,260
Take-Up Rate	55.4%	63.0%	63.0%	63.0%	63.0%
New Enrollees	23,273	26,492	26,535	26,580	26,623
<b>Cost Per Enrollee</b>					
Medical	\$7,854	\$8,213	\$8,593	\$8,994	\$9,418
Admin	\$59	\$62	\$65	\$68	\$71
Total	\$7,913	\$8,275	\$8,658	\$9,062	\$9,489
<b>Total Cost</b>	<b>\$184,161,000</b>	<b>\$219,234,000</b>	<b>\$229,743,000</b>	<b>\$240,876,000</b>	<b>\$252,634,000</b>
<b>Federal Cost</b>	<b>\$179,294,000</b>	<b>\$207,471,000</b>	<b>\$215,331,000</b>	<b>\$221,394,000</b>	<b>\$228,761,000</b>
<b>State Cost</b>	<b>\$4,867,000</b>	<b>\$11,763,000</b>	<b>\$14,412,000</b>	<b>\$19,482,000</b>	<b>\$23,873,000</b>

\* Excludes impact of pharmacy rebates and third party recoveries. Excludes savings from Medicaid reform initiatives. Excludes savings from cost reductions in other state programs.

**Expansion Option 2: Alternative Benefit Plan (ABP) based on a Qualified Health Plan (QHP)\*\***

	FY2017	FY2018	FY2019	FY2020	FY2021
New ly Eligible Adults	41,980	42,050	42,120	42,190	42,260
Take-Up Rate	55.4%	63.0%	63.0%	63.0%	63.0%
New Enrollees	23,273	26,492	26,535	26,580	26,623
<b>Cost Per Enrollee</b>					
Medical	\$7,326	\$7,672	\$8,039	\$8,427	\$8,838
Admin	\$93	\$97	\$102	\$107	\$112
Total	\$7,418	\$7,770	\$8,141	\$8,534	\$8,950
<b>Total Cost</b>	<b>\$172,648,000</b>	<b>\$205,831,000</b>	<b>\$216,021,000</b>	<b>\$226,831,000</b>	<b>\$238,266,000</b>
<b>Federal Cost</b>	<b>\$167,699,000</b>	<b>\$194,394,000</b>	<b>\$202,076,000</b>	<b>\$208,115,000</b>	<b>\$215,396,000</b>
<b>State Cost</b>	<b>\$4,949,000</b>	<b>\$11,437,000</b>	<b>\$13,945,000</b>	<b>\$18,716,000</b>	<b>\$22,870,000</b>

**Comparison to Expansion Option 1**

Change in Total Cost	(\$11,513,000)	(\$13,403,000)	(\$13,722,000)	(\$14,045,000)	(\$14,368,000)
Change in Federal Cost	(\$11,595,000)	(\$13,077,000)	(\$13,255,000)	(\$13,279,000)	(\$13,365,000)
Change in State Cost	\$82,000	(\$326,000)	(\$467,000)	(\$766,000)	(\$1,003,000)

\*\* Excludes impact of pharmacy rebates and third party recoveries. Excludes savings from Medicaid reform initiatives. Excludes savings from cost reductions in other state programs.

For state fiscal years 2020 and later, we estimate that Expansion Option 2 would result in a cost reduction of approximately 4% in comparison to the Expansion Option 1 projected state and federal Medicaid expansion expenditures. This is primarily driven by the removal of dental benefits for these members. For state fiscal year 2017, we estimate an increase in state cost under Expansion Option 2. The state's share of increase in administrative cost would be greater than the state's share of decrease in medical cost, resulting in the increase of state cost in total. We assumed the same Medicaid enrollment take-up rates for all three options. Therefore, we did not measure any change in participation that may occur based on the option implemented. However, take-up rates may be lower for Expansion Option 2 due to the

removal of dental benefits. In particular, younger, healthier eligibles may find the dental coverage more valuable than the medical coverage and have less incentive to enroll under Expansion Option 2.

**Coverage Option 3: Private Option based on a Qualified Health Plan (QHP)\*\*\***

	FY2017	FY2018	FY2019	FY2020	FY2021
New ly Eligible Adults	41,980	42,050	42,120	42,190	42,260
Take-Up Rate	55.4%	63.0%	63.0%	63.0%	63.0%
New Enrollees	23,273	26,492	26,535	26,580	26,623
<b>Cost Per Enrollee</b>					
Medical	\$10,288	\$10,904	\$11,561	\$12,262	\$13,009
Admin	\$99	\$105	\$112	\$118	\$126
Total	\$10,387	\$11,010	\$11,673	\$12,380	\$13,134
<b>Total Cost</b>	<b>\$241,747,000</b>	<b>\$291,668,000</b>	<b>\$309,741,000</b>	<b>\$329,062,000</b>	<b>\$349,671,000</b>
<b>Federal Cost</b>	<b>\$179,294,000</b>	<b>\$207,471,000</b>	<b>\$215,331,000</b>	<b>\$221,394,000</b>	<b>\$228,761,000</b>
<b>State Cost</b>	<b>\$62,453,000</b>	<b>\$84,197,000</b>	<b>\$94,410,000</b>	<b>\$107,668,000</b>	<b>\$120,910,000</b>

**Comparison to Expansion Option 1**

Change in Total Cost	\$57,586,000	\$72,434,000	\$79,998,000	\$88,186,000	\$97,037,000
Change in Federal Cost	\$0	\$0	\$0	\$0	\$0
Change in State Cost	\$57,586,000	\$72,434,000	\$79,998,000	\$88,186,000	\$97,037,000

\*\*\* Excludes impact of pharmacy rebates and third party recoveries. Excludes savings from Medicaid reform initiatives. Excludes savings from cost reductions in other state programs.

We estimate that the Expansion Option 3 would result in increased state and federal expenditures of between 30% and 40%, depending on fiscal year, over Expansion Option 1 projected state and federal Medicaid expansion expenditures. However, the federal government will not fund expenditures greater than those projected in the baseline. Therefore, the cost to the state would increase substantially over the projected expenditures for the state in the Expansion Option 1. As noted above, we assumed the same take-up rates for all three options, and did not measure any change in participation that may occur based on the option implemented. However, the perception of a commercial plan having greater access, desirability, and ease of maintaining coverage with income fluctuations may lead to higher take-up rates for Expansion Option 3.

Note that we have provided point estimates for both costs and enrollment. Actual results will vary from our projections for many reasons, including differences from assumptions regarding take up rates, projected members by FPL levels, cost trends, and future FMAP rates, as well as other random and non-random factors. Experience should continue to be monitored on a regular basis, with modifications to projections as necessary.

### III. METHODOLOGY AND ASSUMPTIONS

#### Expansion Option 1: Current Alternative Benefit Package

Previously, the AK DHSS engaged Evergreen Economics to estimate the cost of the Medicaid expansion enrollees. In order not to duplicate effort, it was requested that we rely on the Evergreen report to the extent possible. We reviewed the Evergreen Economics memorandum “Projected Population, Enrollment, Service Costs and Demographics of Medicaid Expansion Beginning in FY2016” for reasonableness. Generally, we found the assumptions that Evergreen Economics used to be reasonable. We made the following modifications to the Evergreen Economics estimates to produce the expected expenditures for Expansion Option 1.

- We used calendar year 2014 eligibility and claims experience for Alaska Medicaid enrollees 19-64 years of age, excluding enrollees classified as Old Age Assistance and Aid to the Blind or Disabled. We adjusted the historical experience to reflect the expected demographics of the expansion population and removed medical expenses related to pregnancy. The data identified tribal health facilities. We assumed the Alaska Native expansion enrollees will use the same proportion of services at tribal health facilities as the enrollees in the experience data. Calendar year 2014 data was not available when Evergreen's report was produced. We believe it is appropriate to use the most up-to-date claims experience data.
- We included costs related to administrative activities in our estimate of the total cost of Medicaid expansion. There will be incremental costs associated with the administration of the additional members and we believe it is appropriate to include them in the expenditures associated with the expansion population. We assumed administrative costs would be 0.75% of expected total expenses, consistent with estimates used in the report "The Healthy Alaska Plan: A Catalyst for Reform."

We used the same take-up rate assumptions as the Evergreen report for consistency. Take-up rates observed in other states have been higher. However, the take-up rates for the expansion population in other states are below the take-up rates for the children populations in those states. Without further analysis, we believe the take-up rates assumed Alaska's expansion population have a similar relationship to the children take-up rates that are observed in Alaska.

## Expansion Option 2: ABP Based on a QHP

We adjusted baseline projections for the expected impact of the benefit changes. The benefit changes included:

- Removal of dental benefits
- Removal of hearing aid benefits
- Increased coverage for services such as chiropractic and acupuncture
- Reduction in vision benefits

Based on our interpretation of the benefits, the other benefit changes were assumed not to have a material impact on the results. The medically frail population must be provided the option of receiving traditional Medicaid benefits. We assumed that all medically frail Medicaid expansion enrollees would remain in the traditional Medicaid benefit package.

We increased emergency room utilization by 2% due to the removal of dental coverage. We assumed administrative expenses are 1.25% of total expenses due to the increased administrative effort associated with administering two benefit packages. We estimate that Expansion Option 2 would reduce state and federal Medicaid expenditures for the expansion population by approximately 4% in state fiscal years 2020 and later in comparison to Expansion Option 1. The primary driver of the difference in expenditures is the removal of the dental benefit. If all medically frail Medicaid expansion enrollees moved to the ABP based on a QHP, the reduction in state and federal Medicaid expenditures for the expansion population would be approximately 5% in state fiscal years 2020 and later.

## Expansion Option 3: Private Option Based on a QHP

The medically frail population is not required to enroll in the private option; therefore, we have assumed that all of the medically frail expansion enrollees will remain in traditional fee-for-service Medicaid. Based on observations from other states, we have estimated that approximately 10% of the expansion population will qualify as medically frail, with an average morbidity factor of 2.5 times the average expansion population morbidity, except for dental services where we assumed an average morbidity factor of 1.35. For the population who will enroll in the private option, the Medicaid program will be responsible for the following medical costs:

- Premium for coverage purchased from the individual marketplace
- Cost sharing amounts in excess of 5% of member income
- Cost of non-emergency transportation at a level similar to current Medicaid coverage

We estimated the required revenue for the expansion population as the expected members multiplied by baseline Medicaid PMPM adjusted by the following factors:

- 1.25 factor to reflect increased provider fees associated with products offered on the Exchange
- 0.90 factor to reflect a shift from Medicaid fee-for-service to a more managed environment
- 30% silver plan cost-sharing
- 15% administrative load, typical of the administrative load included for commercial premiums

We estimated the required revenue for the individuals on the Exchange by multiplying the number of enrollees by the premium for 2016 second-lowest silver plan. We then solved for the premium adjustment needed to produce the estimated required revenue for both the expansion and individual Exchange members based on the demographics of the combined membership.

We estimate that the Expansion Option 3 would result in increased expenditures of between 30% and 40%, depending on fiscal year, over Expansion Option 1 projected state and federal Medicaid expansion expenditures. However, the federal government will not fund expenditures greater than those projected in the baseline. Therefore, the cost to the State of Alaska would increase substantially over the projected expenditures for the State in the Expansion Option 1.

The Alaska Exchange market has seen high rate increases the past two years and continues to evolve. It is difficult to project the future premium increase or decrease given the volatility of the individual market in the Alaska Exchange without a robust analysis of the underlying claims data. The estimates for Expansion Option 3 are highly dependent on the future premiums for individual coverage on the Alaska Exchange. To the extent the premiums are higher or lower than projected, the federal and state expenditures projected above may vary significantly.

Expansion Option 3 assumes all non-medically frail expansion eligibles receive coverage through the Alaska exchange. However, certain states have used split enrollment models where the lower FPL eligible receive traditional Medicaid and the higher FPL eligibles receive coverage through the Private Option. The split enrollment scenario may meet budget neutrality requirements resulting in a more favorable federal matching rate.

## Assumptions

The following assumptions were used in all of the expansion option projections unless otherwise noted below.

### Expansion Population

The primary enrollees of Medicaid expansion are working-age adults 21–64 years of age who are not caring for dependent children, are not disabled or pregnant, and who are at or below 138 percent of Federal Poverty Level (FPL). The income eligibility threshold is 133% FPL with a 5% income disregard, making the threshold effectively 138% of FPL. In addition, Medicaid expansion affects a small number of other adults, 18–64 years of age, who do not meet current income limits for Medicaid eligibility. Specifically, Medicaid expansion will include Non-disabled individuals, ages 19-20, between 123% and 138% of FPL, and Disabled individuals, ages 18-64, between 102% and 138% of FPL, who do not receive Medicare.

### Rebates and Third Party Liability

Pharmacy rebates and recoveries from third party liability have not been included in the projections and will reduce the projected costs in our analysis.

### Pent-up Demand for Services

We did not include an adjustment for pent-up demand for services. Individuals who are currently uninsured may have pent-up demand for health care services; however, other sources were available to obtain financial assistance for medical care prior to Medicaid expansion in Alaska. For example, one program is the Chronic & Acute Medical Assistance (CAMA) program, a state-only program administered through the DHSS Division of Health Care Services that provides financial assistance to Alaskans who need medical care but do not qualify for the state Medicaid program. Additionally,

an analysis of new enrollees to the Alaska Medicaid program over the last several years who were previously uninsured adults did not show increased utilization of services during the first few months of enrollment into the program.

Additionally, since there is a nine month time period lapse between the expansion implementation date and the start date of our projections, most pent-up demand will have occurred prior to our projection period. Based on these factors, we believe it is reasonable to not include an explicit adjustment for pent-up demand.

### Utilization Trend

Certain utilization trends were applied to the calendar year 2014 base data by category of service to reflect the expectation of utilization differences between the base data and the baseline projection period. Trend rates were estimated based on industry experience for comparable programs and actuarial judgment. Table 1 illustrates the annual growth rates used to trend the base data to the midpoint of each fiscal year. The calendar year 2014 data has been adjusted before trending to reflect an explicit adjustment for emerging calendar year 2015 experience that primarily reflects increased utilization of recent break-through therapies such as those associated with hemophilia and Hepatitis C. Table 1a illustrates the adjustment made to the pharmacy data.

Table 1 Alaska Department of Health and Social Services Medicaid Redesign Initiatives Utilization Trend							
Category	1H15*	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021
Average Utilization – IP	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Average Utilization – OP	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%
Average Utilization – Prof	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%
Average Utilization – Rx	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%
Average Utilization – Other	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%

\* Annualized trend shown

Table 1a Alaska Department of Health and Social Services Medicaid Redesign Initiatives Pharmacy Adjustment	
	One-Time Adjustment 2015
Break-Through Therapy	5%

### Allowed Charge Trend

We made an adjustment for the following items that are expected to impact the historical allowed charge:

- Expected rate rebasing
- Expected rate schedule increases and/or decreases
- Average allowed charge trend reflecting shift to higher acuity services

The assumed trend rate by category of service for average allowed charge that is attributed to these changes is outlined in Table 2.



Table 2 Alaska Department of Health and Social Services Medicaid Redesign Initiatives Allowed Charge Trend							
Category	1H2015*	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021
Average Allowed Charge - IP	3.00%	3.00%	1.00%	1.00%	1.00%	1.00%	1.00%
Average Allowed Charge - OP	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%
Average Allowed Charge - Prof	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%
Average Allowed Charge - Rx	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%
Average Allowed Charge - Other	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%

\* Annualized trend shown

For Expansion Option 3, we assumed that average charge trends for service categories other than prescription drugs would be higher than the trends assumed for Expansion Options 1 and 2 due to the coverage being provided in the commercial market. We assumed that average charge trends for these service categories would be 2% higher on an annual basis in Expansion Option 3 than the trends assumed for Expansion Options 1 and 2.

### Medicaid Provider Reimbursement

We assumed there would be no change in Medicaid provider reimbursement rates specific to the expansion population, except as noted under the Expansion Option 3. Each state establishes the reimbursement rate that will be paid to hospitals, physicians, pharmacies and other healthcare providers. Medicaid reimbursement rates are typically lower than those paid by Medicare and commercial health insurance carriers. In order to ensure access to the expansion population, some states have chosen to increase the Medicaid reimbursement rates. Alaska has historically paid Medicaid reimbursement rates that are higher than those for Medicare. Therefore, we believe it is reasonable to assume that the Medicaid reimbursement rates for the entire Medicaid program will remain consistent with current methodology.

### Federal Medical Assistance Percentage

Table 3 below shows the Federal Medical Assistance Percentages (FMAPs) used to determine the federal share of the projected expenditures for the expansion population. Medical expenses for Alaska Natives receiving services at a tribal facility are eligible for 100% FMAP. Alaska Natives were identified based on their status in the enrollment data. We were also provided a list of Tribal Health Facilities to identify the facilities eligible for 100% FMAP. The combination of enrollment data and Tribal Health Facilities enabled us to project the FMAP separately for this population.

Table 3 Alaska Department of Health and Social Services Medicaid Redesign Initiatives Federal Medical Assistance Percentage (FMAP)						
Category	SFY2016	SFY2017	SFY2018	SFY2019	SFY2020	SFY2021
Medical	100.00%	97.50%	94.50%	93.50%	91.50%	90.00%
Medical - Alaska Native at Tribal Health Facility	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Admin	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%

## IV. OTHER IMPACTS NOT MODELED

The following outlines additional financial impacts related to Medicaid expansion. The issues highlighted below ***have not*** been included in the financial projections shown in our analysis.

- **Reductions in DSH Allotments:** Medicaid Disproportionate Share (DSH) funding will be reduced starting in 2018 depending on the characteristics of each state. Changes to DSH funding are not part of our estimates. The dollar reductions in DSH allotments would be consistent for each scenario modeled.
- **Impact on Other State Programs:** We did not consider the impact of Medicaid expansion on any other Alaska state programs. We would expect that many individuals currently receiving care in state-funded or subsidized programs will become eligible and enroll in the Medicaid expansion. This will produce savings for Alaska as the costs of these programs are reduced or eliminated. These savings are not incorporated into the scenarios above. For example, Chronic & Acute Medical Assistance (CAMA) program, a 100% state-funded program administered through the DHSS Division of Health Care Services that provides financial assistance to Alaskans who need medical care but do not qualify for the state Medicaid program, medical services paid for by the Department of Corrections, and Behavioral Health Grants may all be reduced. DHSS projects annual savings for these programs with Medicaid expansion will range from \$13 million to \$25 million from state fiscal year 2017 through 2021. Another example would be state employees who have health coverage through the State but who have incomes below 138 percent of FPL. These individuals may become eligible for the Medicaid expansion and enroll in the program.
- **Economic Ripple Effect or Multiplier:** We did not consider the multiplied impact of the additional state and federal dollars spent in the state.
- **Implementation Cost:** We did not consider the cost of implementation of the options in our analysis.

## V. DATA RELIANCE AND IMPORTANT CAVEATS

We used fee-for-service data, encounter data, and eligibility data provided by the AK DHSS. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Differences between the projected and actual experience will depend on the extent that future experience conforms to the assumptions made in the projections. It is certain that actual experience will not conform exactly to the assumptions used. Actual amounts will differ from projected amounts to the extent that actual experience is better or worse than expected.

This report has been prepared solely for the internal business use of and is only to be relied upon by the management of AK DHSS. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work. It should only be reviewed in its entirety.

The results of this report are technical in nature and are dependent upon specific assumptions and methods. No party should rely on these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The author of this report is a member of the American Academy of Actuaries, and meets the qualifications for performing the analyses in this report.

The terms of Agnew::Beck's contract with the Alaska Department of Health and Social Services effective June 1, 2015 apply to this report and its use.