

State of Alaska Health and Social Services Medicaid Study

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Project Scope

The Wilson Agency (TWA) was asked by The Department of Health and Social Services to conduct an analysis of the varying estimates of the number of Alaskans' in the Medicaid "donut hole". The donut hole population is identified as those uninsured whose incomes exceed eligibility limits for Medicaid yet do not meet the income requirements needed to qualify for for the premium tax credits and cost-sharing reductions available in Alaska's Federally Facilitated Exchange. In addition, TWA was asked to exclude those groups who have access to health care services through government sponsored programs.

Introduction

Under the Affordable Care Act (ACA), individuals with incomes between 100 percent and 400 percent of the federal poverty level (FPL) may be eligible for advanceable premium tax credits, as well as cost-sharing assistance with out-of-pocket health care expenses. Depending on the health plan chosen, premiums may be as low as \$0 for low income individuals purchasing a Bronze Plan to graduated monthly premiums for Silver, Gold or Platinum Plans. The amount of the advanceable premium tax credit is based on income and the cost of the selected insurance plan. It is available only to those without employer coverage that meets the requirements of the ACA or those not eligible for other types of coverage, such as Medicaid, Medicare.

The ACA originally envisioned low income individuals obtaining health insurance coverage through individual state expansion of Medicaid to 138 percent of the FPL. However, the Supreme Court ruled that states were not mandated to expand the Medicaid program in their state. In states where Medicaid was not expanded, low income individuals now fall in the coverage gap, earning too much to qualify for Medicaid and too little to receive the advanceable premium tax credits. Alaskans who fall into the coverage gap are ineligible for any financial assistance in the ACA.

The State of Alaska is interested in understanding how the coverage gap population will be served, and the estimated cost associated with providing health care services to this population. The Kaiser Family Foundation estimates that 17,290 uninsured Alaskans fall into the coverage gap.¹ The Kaiser Family Foundation published estimates of the coverage gap population for every state using pooled data from the 2012 and 2013 Current Population Survey Annual Social and Economic Supplement (CPS ASEC). Two years of data was used to increase the precision of their estimates. The CPS ASEC provides socioeconomic and demographic data for states and specific subpopulations. (For a detailed methodology refer to: <http://www.kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid>, Appendices A and B).

Over the course of years, individual incomes may fluctuate, impacting the individual's eligibility for Medicaid. Because the Kaiser Family Foundation estimates are based on annual income it represents only a "snapshot" of the number of people that fall in the coverage gap. In any given year, it is possible for a significant number of people to move in and out of the coverage gap as

¹ "Characteristics of Poor Uninsured Adults who Fall into the Coverage Gap," Kaiser Family Foundation, December 17, 2013.

their income circumstances change. This is especially true in Alaska where employment is highly seasonal.

Methodology

The Kaiser Family Foundation estimates that 100 percent of the 17,290 coverage gap population is comprised of adults without dependent children. In Alaska, as is the case in many states, adults without dependent children are largely ineligible for Medicaid regardless of income. In Alaska, Medicaid eligibility is limited to non-disabled parents with incomes below 123 percent of the poverty level, about \$36,300 a year for a family of four.

In an effort to separate out the Alaskan Natives eligible for medical care under Indian Health Service, a methodology was followed using data from the 2008-2012 American Community Survey 5-Year Estimates, U. S. Census Bureau.² Kaiser Family Foundation estimates that 49 percent of the coverage gap population is people of color. People of color includes Black/African American, American Indian/Alaskan Native, Asian, National Hawaiian/Other Pacific Islander, Other Races, and those claiming two or more races. Hence, based on Kaiser Family Foundation's estimate approximately 8,472 individuals fall into one of the race/ethnicity categories listed above.

The number of Alaskan Natives in the coverage gap population is then subtracted from the number of people of color (8,472).. According to the estimates, approximately 134,111 Alaskans are uninsured. Those who classify themselves as "White" account for 52 percent of the uninsured. Alaskan Natives comprise of 26 percent of the uninsured, or nearly 35,000 in number. This uninsured population includes all income categories, and is not limited to only those in the coverage gap whose incomes are below 100 percent of the federal poverty level. Using the number of uninsured Alaskan Natives (34,967 \pm 1,079) as a proportion of the total uninsured non-white population in Alaska (64,681 \pm 2,868), approximately 4,562 Alaskan Natives may fall into the coverage gap. These individuals may be eligible for health care services under Indian Health Services. This leaves a balance of 12,647 non Alaskan Natives who may not fall under any type of coverage.

Two caveats, however, apply to this estimate. First, not all Alaskan Natives fall under the 100 percent poverty threshold. Hence the number of Alaskan Natives (4,562) subtracted from the entire coverage gap population as estimated by the Kaiser Family Foundation may leave more non Alaskan Natives in the coverage gap population than estimated using this methodology, which would make the estimate higher. Second, some Alaskan Natives may have reported themselves as two races. Individuals self-reporting two or more races account for 10 percent of the total uninsured population in Alaska. Some of these individuals may still qualify for health care services as Alaskan Natives, which would make the estimate smaller. Therefore, our estimate that 12,647 non-native Alaskans may not have any access to health care services is subject to two possible biases. It is not possible, however, to accurately assess the direction of the biases.

² American FactFinder, U.S. Census Bureau, Health Insurance Coverage Status, 2008-2012 American Community Survey 5-Year Estimates.

The ethnic composition of the entire coverage gap population is estimated using the methodology of distributing the uninsured across race categories as reported in the American Community Survey and applied to the Kaiser Family Foundation estimates of the coverage gap population. This assumes that the racial composition of the coverage gap population is similar to the racial composition of all the uninsured in Alaska. The coverage gap population by racial composition is presented in Table 1.

Table 1: Racial/Ethnic Composition of the Coverage Gap Population in Alaska

| Racial/Ethnic Composition | Estimated Number in Coverage Gap |
|---|----------------------------------|
| White | 8,777 |
| Black/African American | 430 |
| American Indian/Alaska Native | 4,562 |
| Asian | 1,240 |
| Native Hawaiian/Other Pacific Islander | 202 |
| Some Other Race | 194 |
| Two or More Races | 1,804 |
| Total, All Uninsured in Coverage Gap | 17,209 |

The allocation of the expected costs of delivering health care services to the 12,000 plus non-native individuals that fall into the coverage gap depends on their age, gender, and health risk. According to the Kaiser Family Foundation, we know the following about this national demographic:

- Non-disabled adults without dependent children, regardless of their income, account for a disproportionate share (76 percent) of the coverage gap population in states not expanding Medicaid.
- The age composition of the coverage gap population is an older demographic. Over half are middle-aged (35 to 54 years old) or “near” elderly (55 to 64 years of age). This age demographic tends to have greater health care needs than younger populations, and particularly for the uninsured, they often delay needed medical care creating more expensive care when it is finally delivered.
- Twenty percent of the coverage gap population self-reports their health as “fair or poor.”
- Women are more likely to qualify for Medicaid under current eligibility rules,. Therefore, men are expected to represent a disproportionate share of the coverage gap population.³

Without additional survey-based primary data to better understand the specific demographics of the coverage gap population in Alaska, a methodology was employed using age and gender risk assessments and estimated medical costs as determined by The Lewin Group in its report “An Analysis of the Impact of Medicaid Expansion in Alaska,” updated April 12, 2013. The Lewin Group used five year historical monthly enrollment data provided by the Department of Health

³ “Characteristics of Poor Uninsured Adults who Fall into the Coverage Gap,” Kaiser Family Foundation, December 17, 2013.

and Social Services and trended age and gender growth rates derived from U.S. Census projections and the Medicaid Statistical Information System Unique Eligibles Count data to forecast program costs. (see The Lewin Group, April, 2013, “An Analysis of the Impact of Medicaid Expansion in Alaska,” Appendix A).

Using The Lewin Group cost estimates for newly eligible and previously uninsured to 138 percent of the federal poverty level as proxy costs for the coverage gap population, cost estimates are presented for the 2014 to 2020 time periods. These estimates could conceivably be biased based on possible differences in health status between individuals in the coverage gap population (upper limit is 100 percent of the federal poverty level) and the health status of individuals between 100 percent and 138 percent of the federal poverty level included in The Lewin Group study. Any differences in health status could not be determined from available data sources.

Table 2 below summarizes the estimated total monthly health care costs associated with the coverage gap population through 2020.

Table 2: Estimated Per Member Per Month (PMPM) Medical Costs for the Coverage Gap Population in Alaska

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 |
|---------|-------|-------|-------|-------|-------|-------|---------|
| PMPM \$ | \$763 | \$767 | \$810 | \$856 | \$904 | \$955 | \$1,008 |

Source: DataSmart

The per member per month costs reported in Table 2 are the blended average costs, assuming 12,647 Alaskan non-natives remain in the coverage gap. These figures are based on the distribution of costs by age and gender composition reported by The Lewin Group (April 2013). Any differences in the age and gender distribution of the coverage gap population and the data reported by The Lewin Group is unknown.

Table 3 annualizes the estimated medical costs for the coverage gap population in Alaska.

Table 3: Estimated Annual Medical Costs for the Coverage Gap Population in Alaska

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 |
|-------|---------|---------|---------|---------|---------|---------|---------|
| TOTAL | \$115.8 | \$116.4 | \$123.0 | \$129.9 | \$137.2 | \$144.9 | \$153.0 |

Source: DataSmart

Reported figures are in the millions

The cost estimates in Tables 2 and 3 assume that the coverage gap population remains the same in each year through 2020. Variations in year-to-year incomes will move people in and out of the coverage gap. Variations in income have moved individuals in and out of Medicaid programs nationally and present a well-documented challenge in estimating eligibility numbers. It is impossible to predict how many people could move in and out of the coverage gap population with any accuracy, since changes in income depend on any number of circumstances, including the health of the Alaskan economy and changes in family status.

Donut Hole Population Conclusion

According to the Kaiser Family Foundation, approximately 17,209 uninsured adults without dependent children (13 percent of Alaska's uninsured population) fall into the coverage gap.

We estimate that as many as 12,647 non-native Alaskan citizens will fall into the coverage gap. Using cost estimates prepared by The Lewin Group for the newly eligible Medicaid expansion population, and distributed by age and gender, the State of Alaska could face medical costs of over \$116 million in 2014, and eventually reaching \$153 million by 2020.

Future Challenges

At the request of the Governor's Office, the Department of Health and Social Services will be convening a Medicaid Task Force to address the growth in the Medicaid program, its impact on the State's budget, the program's structure and cost saving ideas. Estimating the potential costs and benefits of changes to the Medicaid program is fraught with challenges and Alaska's health care delivery market adds further difficulties.

In this Information Age, we have come to confuse information with understanding. But, true understanding comes with knowledge of the information and stories that make the data points come to life. A key foundation of the Task Force will be its ability to compile divergent data sets and programs into a source of meaningful information from which wise policy decisions can be made.

Some of the ideas discussed in the 2011 Medicaid Task Force Report "Options for Cost-Savings" that are worthy of a second review by the Task Force include:

- Patient-Centered Medical Home
- Care Management
- Increase Substitution to Generic Medication
- Increase Generic Medication Utilization
- Enhanced Preferred Drug List
- State Maximum Allowable Cost (SMAC)
- Psychiatric Medication Policy and Community
- First Choice (Personal Care Attendant)

In addition, the Task Force may want to:

- Conduct an intensive survey of households to help identify some of the key economic parameters that are necessary to better model the impact a policy change may have on the use of health care.
- Develop a model for the take-up rate - the number of individuals eligible for Medicaid who actually enroll, because adults with no children are typically less likely to enroll in Medicaid than others.

- Consider the bubble population - those at risk of cycling in and out of Medicaid due to changing income and family circumstances. Many studies suggest the population most likely to move in and out of Medicaid has an income between 138 percent and 150 percent of the federal poverty level.
- Assess the potential for crowd-out, which occurs when individuals are pushed as the result of a policy change from private insurance to a public alternative or in the opposite direction.
- Look deeper into the critical variables in modeling the cost of Medicaid: the cost per member per year (PMPY) and the medical services being used. The analysis should look at:
 - Individual Risk Stratification – Through the use of predictive modeling, each individual with health care data points should be assessed for a variety of risk factors in order to predict their future utilization.
 - Medical Care Episode Grouping – Episode grouping measurements to compare a healthcare provider’s charges for an episode of care across a region or a specialty.
 - Analysis of Key Care Gaps – To identify how many people are lacking care markers. The information can be used to identify potential outreach programs for utilization, care management and medication therapy management.
 - Care Management –To identify near term cost drivers, that will assist the State in developing clinical solutions that will engage individuals in the top five percent of the highest cost.
- Assess and estimate administrative costs and how they may be split between the state and the federal government.
- Assess the impact of a policy change on uncompensated care. The uninsured are more likely to delay care and to have unmet health needs. They are also more likely to be hospitalized for medical conditions that can be adequately addressed on an outpatient basis.
- Develop models to assess any policy change and its increase in the demand for services. Added demands will place stress on the health care infrastructure, particularly the medical provider workforce.