

M A F A

# **ESTIMATED ECONOMIC EFFECTS IN ALASKA OF THE “PATIENT PROTECTION AND AFFORDABLE CARE ACT”, AS AMENDED (PPACA)**

---

JUNE 30, 2011 (UPDATE)

Prepared by: Mark A. Foster, MAFA

Prepared for: University of Alaska Anchorage, Institute of Social & Economic Research  
State of Alaska, Department of Health & Social Services  
State of Alaska Health Care Commission

ANCHORAGE, ALASKA

# ESTIMATED ECONOMIC EFFECTS IN ALASKA OF THE “PATIENT PROTECTION AND AFFORDABLE CARE ACT”, AS AMENDED (PPACA)

---

## INTRODUCTION

---

MAFA has prepared this memorandum in our capacity as an independent technical advisor to University of Alaska Anchorage, Institute of Social and Economic Research under a Reimbursable Services Agreement with the State of Alaska Department of Health and Social Services to examine the economic effects of the PPACA in Alaska. The costs, savings, and coverage impacts shown herein represent our best estimates for the Patient Protection and Affordable Care Act. We offer this analysis in the hope that it will be of interest and value to policy makers and administrators as they monitor these far-reaching national health care reforms. The statements, estimates, and other information provided in this memorandum are those of MAFA and do not represent an official position of the University of Alaska Anchorage, the UAA Institute of Social and Economic Research (UAA ISER), or the State of Alaska Department of Health & Human Services or the Administration.

This memorandum summarizes MAFA’s estimates of the Alaska economic and coverage effects through fiscal year 2019 of selected provisions of the “Patient Protection and Affordable Care Act” (P.L. 111-148) as enacted on March 23, 2010 and amended by the “Health Care and Education Reconciliation Act of 2010” (P.L. 111-152) as enacted on March 30, 2010. For convenience, the health reform legislation, including amendments, will be referred to in this memorandum as the Patient Protection and Affordable Care Act, or PPACA.

Our estimates rely upon the CMS Office of the Chief Actuary (hereinafter “CMS OCA”) “Estimated Financial Effects of the ‘Patient Protection and Affordable Care Act’ as Amended (April 22, 2010)” as a national estimate that we use as the basis for a top down analysis to estimate the effects of the PPACA on Alaska, with adjustments to take into account:

- 1) differences in demographic profile, e.g., Alaska has a smaller proportion, but faster growing, senior population relative to the national average
- 2) differences in the addressable health insurance market with respect to coverage, e.g., Alaska has a significantly higher proportion of Indian Health Service and Military Coverage relative to national averages, Alaska has a higher proportion of part time and seasonal employment relative to national averages

- 3) differences in household incomes and expenditures relative to national averages
- 4) differences in employer sponsored health insurance (ESI) coverage, employer/employee cost sharing and cost of health coverage relative to national averages
- 5) other differences in consumer behavior and responses to changes in markets based on our knowledge of differences between Alaska and U.S. markets

Included are the estimated net Federal expenditures in Alaska support of expanded health insurance coverage, the associated numbers of people by insured status, the changes in Medicare and Medicaid expenditures and revenues, and the overall impact on total Alaska health expenditures. We have developed preliminary estimates of the various tax and fee provisions on income and payroll taxes based on the Joint Committee on Taxation, March 20, 2010, JCX-17-10 Memoranda using a top down methodology with adjustments to take into account Alaska market differences compared to U.S. aggregate averages.

Estimates of the impact on Federal administrative expenses are excluded.

In addition, we have reviewed the CBO Letter to Honorable Jerry Lewis, May 11, 2010, Regarding PPACA as amended, PL 111-148 on Discretionary Spending, and have applied those estimates on a top down basis to Alaska, making direct cost assignments and other market adjustments as applicable.

We have not made any independent assessment of legal or constitutional issues as they might pertain to the PPACA.

For convenience, we have included a very condensed and abridged one page summary of some of the relevant provisions of the PPACA as an Appendix. For a more complete summary of the PPACA, please see <http://www.kff.org/healthreform/upload/8061.pdf>

---

**TABLE OF CONTENTS**

---

SUMMARY – PPACA IN ALASKA

ESTIMATED CHANGES IN FEDERAL SUPPORT

CHANGES IN INSURANCE COVERAGE

CHANGE IN TOTAL HEALTH CARE EXPENDITURES

EFFECTS OF PROVISIONS ON HEALTH CARE EXPENDITURES BY SPONSOR

FEDERAL EXPENDITURES

STATE OF ALASKA EXPENDITURES

EMPLOYER EXPENDITURES

HOUSEHOLD EXPENDITURES

EMPLOYER/EMPLOYEE LABOR MARKET INTERACTIONS

CAVEATS AND LIMITATIONS

APPENDICES

**SUMMARY – ESTIMATED CHANGES IN FEDERAL SUPPORT**

Table 1 below presents estimated impacts of the selected PPACA provisions on federal support for health care in Alaska for 2011-2019. For the purpose of this preliminary estimate, we assume that the net federal support is equivalent to the net transfer to the Alaska economy associated with the PPACA, i.e., the PPACA does not, in and of itself, create a health care service sector that attracts customers from outside Alaska to spend money in Alaska.

We have grouped the provisions of the legislation into four major categories:

- (i) Coverage provisions, which include a substantial expansion of Medicaid eligibility, and the additional funding for the Children’s Health Insurance Program (CHIP), substantial federal subsidies for household incomes up to 400% of the Federal Poverty Level (FPL) and mandated coverage for individuals and businesses (and associated penalties);
- (ii) Medicare provisions;
- (iii) Provisions aimed in part at changing the trend in health spending growth; and
- (iv) New federal taxes and fees on health insurance and health products.

The estimated costs and savings shown in the table are based on the effective dates specified in the law as enacted. Additionally, we assume that employers and individuals would take roughly 3 to 5 years to fully adapt to the new insurance coverage options and that the enrollment of additional individuals under the Medicaid coverage expansion would be substantially completed within the first two years of implementation.

**TABLE 1: Estimated Federal Spending (+), Savings (-), and Taxes (-) under the PPACA in Alaska, millions**

Provisions	2011	2012	2013	2014	2015	2016	2017	2018	2019
<b>TOTAL</b>	<b>-11</b>	<b>-19</b>	<b>-84</b>	<b>262</b>	<b>303</b>	<b>314</b>	<b>320</b>	<b>217</b>	<b>123</b>
<b>Coverage Provisions:</b>									
Medicaid Expansion & CHIP Funding				237	255	274	280	294	312
Exchange Subsidies				155	241	265	293	355	381
Small Employer Credits	3	4	5	7	5	2	0	0	0
Penalties (Individual+ Employer)				-17	-32	-46	-52	-57	-61
Medicare	-6	-8	-12	-30	-36	-42	-48	-54	-60
<b>Cost Trend Proposals:</b>									
Comparative Effectiveness							0	-1	-1
Prevention & Wellness							0	0	0
Fraud and Abuse							0	0	0
Administrative Simplification							0	0	0
<b>Subtotal</b>	<b>-3</b>	<b>-4</b>	<b>-7</b>	<b>353</b>	<b>433</b>	<b>453</b>	<b>473</b>	<b>537</b>	<b>571</b>
<b>Federal Taxes/Fees (PPACA)</b>	<b>-8</b>	<b>-15</b>	<b>-77</b>	<b>-91</b>	<b>-130</b>	<b>-139</b>	<b>-153</b>	<b>-320</b>	<b>-448</b>
<b>NET</b>	<b>-11</b>	<b>-19</b>	<b>-84</b>	<b>262</b>	<b>303</b>	<b>314</b>	<b>320</b>	<b>217</b>	<b>123</b>

*Source: MAFA Estimates based on CMS, Office of the Actuary (April 22, 2010, Table 1), JCK-17-10 (March 20, 2010) with Alaska Market Adjustments*

As the PPACA nears full implementation in 2019, the provisions in support of expanding health insurance coverage (including the Medicaid eligibility changes and CHIP funding (\$312M), and Exchange subsidies (\$381M)) are estimated to generate \$693 million in federal funding in support of Alaska health care expenditures. The Medicare and cost trend provisions are estimated to result in a net reduction in federal funding of around \$61 million, and new federal taxes, fees and penalties on the order of \$509 million are expected to be collected from Alaska, leaving a net overall contribution for in 2019 of \$124 million before consideration of additional State, Federal and private *administrative expenses*. This amounts to a net federal contribution of roughly \$160 per capita in 2019.

Please note that \$124 million is the estimate of the *net federal contribution* of the PPACA in Alaska in 2019. We estimate net overall health care expenditures in Alaska will increase roughly \$289 million in 2019. The difference of \$165 million represents the amount of spending that will be reallocated from previous investment and consumption preferences within the Alaska economy toward health care expenditures. The initial reallocation of the \$165 million in spending will roughly be borne by:

- State of Alaska increased contribution toward Medicaid expansion - \$41 million
- Alaska Household increased contribution toward health care expenditures - \$124 million

Alaska's relatively high price of health care and high health care cost growth associated with continued "catch up to the Lower 48" investments in new health care technology appear to magnify and accelerate the basic financial implications of the PPACA for many States and their residents:

1. Reductions in Medicare payment levels and updates that began in 2011 and continue<sup>1</sup>
2. Business and individual taxes and fees on health care that begin in 2011 and continue
3. Federally supported expansion of Medicaid for *newly eligible persons* in 2014-2016, followed by a reduction in federal support from 100% to 90% from 2017 to 2020 and an corresponding increase in the the State share

---

<sup>1</sup> Rural providers and providers adjacent to rural areas have exemptions and transitions that insulate them from the Medicare "market basket revisions and productivity adjustments" reductions which reduce payments levels to metropolitan providers (skilled nursing facilities, long-term care hospitals, inpatient rehab facilities, hospitals paid under the inpatient prospective payment system, inpatient psychiatric facilities, hospice, hospital outpatient services, and home health) starting with 0.3% a year and growing to 1.8% by 2019. The automatic sequestration provisions in the Budget Control Act of 2011 appear to be limited to across the board reductions in Medicare on the order of 2% *each year* from 2012-2021.

4. State administrative fees and increased costs (approximately 50% of total costs) for *previously Medicaid eligible persons* that enroll in response to new outreach efforts beginning in 2014<sup>2</sup>
5. Business and individual mandates, minimum coverage requirements, and penalties beginning in 2014
6. Forty percent excise tax on high cost health insurance coverage beginning in 2018 which are likely to result in rebalancing of compensation toward wages and away from health benefits, an associated reduction in health benefit cost growth and an increase in overall federal taxes on both the wage rebound and incremental health benefits

In summary, the U.S. aggregate federal financing of the health care expansion in 2014 is projected to be supported by taxes, fees, mandates/penalties and Medicare reductions that begin in 2011 and increase over time and reach a cumulative break-even in the U.S. sometime in the early 2020s as the 40% excise tax on high cost health plans begins to effect the majority of health plans in the U.S. and additional taxes are collected on the wage rebound.

In Alaska, the relatively generous (individual subsidies up to 400% of federal poverty level tied to Alaska's federal poverty level calculation of 125% of the U.S.) federal financing of the health care expansion in 2014 is projected to be supported by taxes, fees, mandate/penalties and Medicare reductions that are concentrated in Alaska's metropolitan areas, and a 40% excise tax on high cost health plans which appears likely to effect the majority of health plans in Alaska by 2019 due to high cost/high cost growth, which lead to a relatively rapid *net* decline in federal support [\$320 million in 2017 dropping to \$123 million in 2019] and concurrent cost containment pressure as incremental health benefits are taxed at 40%.

---

#### SUMMARY – ESTIMATED CHANGES IN INSURANCE COVERAGE

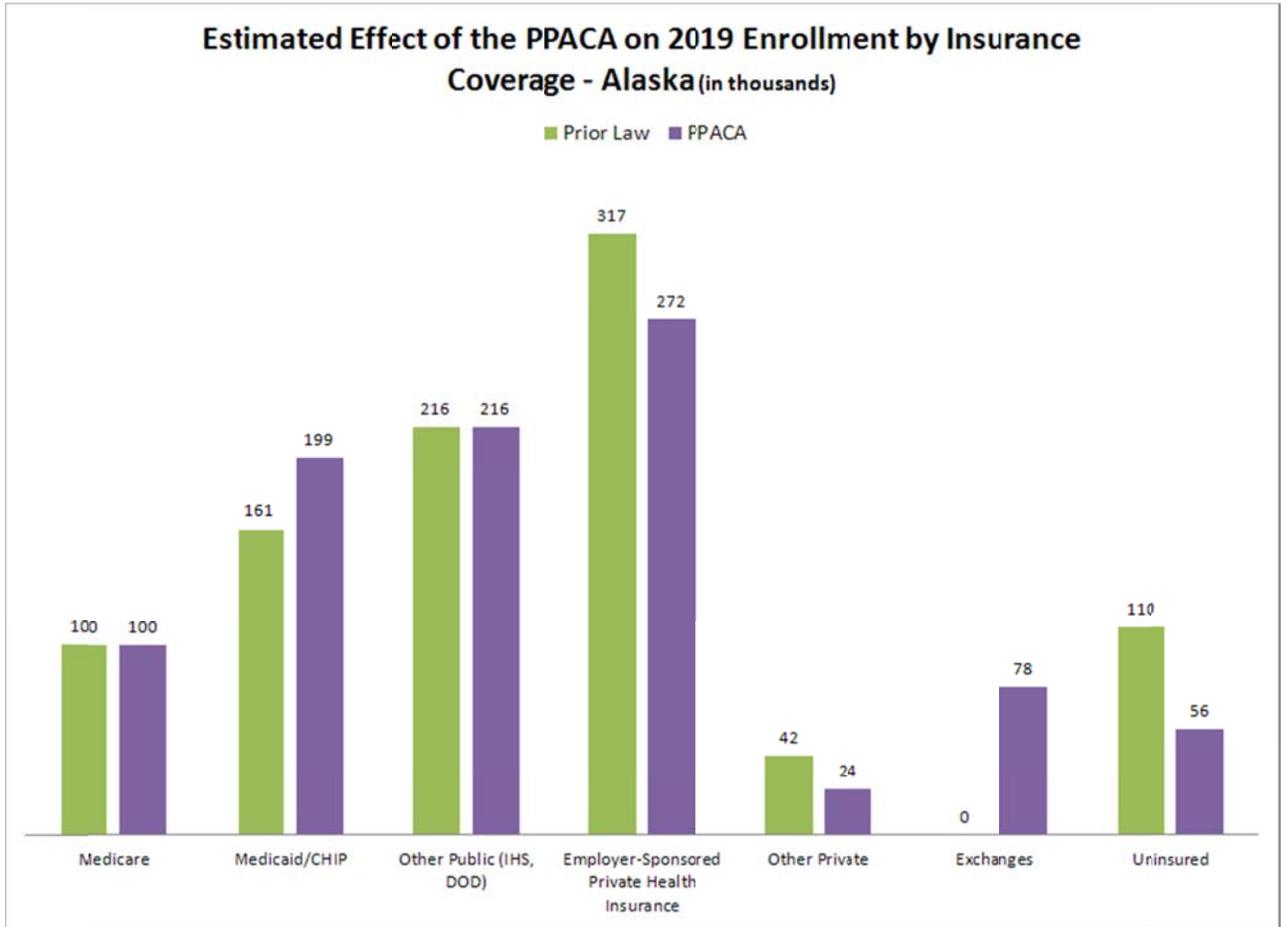
---

The following chart summarizes the estimate impacts of the PPACA on insurance coverage in Alaska. The mandated coverage provisions, which include new responsibilities for both individuals

---

<sup>2</sup> Please note that while 44 states are expected to increase spending to support the new Medicaid expansion, six states are expected to reduce Medicaid spending under PPACA due to having already expanded Medicaid coverage and are being rewarded with increases in their federal match. For example, the State of New York is expected to *reduce* its spending on Medicaid by \$11.2 billion (-5.3%) from 2014-2019 while the State of Alaska is expected to *increase* its spending on Medicaid by \$73 million (+1.6%) over the same time period (Sheils, et al, "The Impact of the Medicaid Expansions and Other Provisions of Health Reform on State Medicaid Spending", Staff Working Paper #12, December 9, 2010, Figure 6.

and employers, and the creation of the American Health Benefit Exchanges (hereafter referred to as the “Exchanges”), would lead to shifts between coverage types and a substantial overall reduction in the number of uninsured, as many of these individuals become covered through Medicaid or Exchanges.



*Note: Totals across categories are not meaningful due to overlaps among categories*

By calendar year 2019, the subsidies and mandates, coupled with the Medicaid expansion, would reduce the number of uninsured from 110 thousand, as projected under prior law, to an estimated 56 thousand under the PPACA. The additional 54,000 people who could become insured by 2019 reflect the net effect of several shifts. First, an estimated 32,000 would gain primary Medicaid coverage as a result of the expansion of eligibility to all legal resident adults under 138 percent<sup>3</sup> of the

<sup>3</sup> The health reform legislation specifies an income threshold of 133 percent of the Federal Poverty Level but also requires States to apply an “income disregard” of 5 percent of the FPL in meeting the income test. Consequently, the effective income threshold is actually 138 percent of the FPL. For convenience, we refer to effective income threshold of 138 percent in this memorandum.

Federal Poverty Level (FPL).<sup>4</sup> In addition, roughly 5 thousand people with employer-sponsored coverage would enroll in Medicaid for supplemental coverage. Another 78,000 persons; many of whom are currently uninsured, would receive individual insurance coverage through the newly created Exchanges, with roughly 60 percent of these qualifying for Federal premium and cost-sharing subsidies. Finally, we estimate that the number of individuals with employer-sponsored health insurance would decrease by about 45,000 reflecting the net of both gains and losses in employer sponsored coverage under the PPACA.<sup>5</sup> We expect the shift from employer-sponsored coverage to the Exchange to accelerate as the 40% excise tax on high cost plans (which may affect roughly half of private health insurance plans in Alaska) takes effect in 2018.<sup>6</sup>

---

**SUMMARY – ESTIMATED CHANGES IN TOTAL HEALTH CARE SPENDING IN ALASKA**

---

We estimate that the overall Alaska health expenditures under the PPACA would increase by a total of \$289 million (+2.3%) by 2019<sup>7</sup>, principally reflecting the net impact of:

- Greater utilization of health care services by individuals becoming newly covered or having more comprehensive coverage, e.g., reductions in deductibles and co-pays (with offsetting increases in the cost of insurance with much of the increase covered by federal subsidies)
- A reduction in the rate of growth in pre-tax health benefits as the 40% excise tax on high cost health plans takes effect in 2018 and impacts roughly half of the health plans in Alaska
- Lower amounts paid to health providers for the subset of those individuals who become covered by Medicaid or enroll in insurance offered on the Exchange, reflecting

---

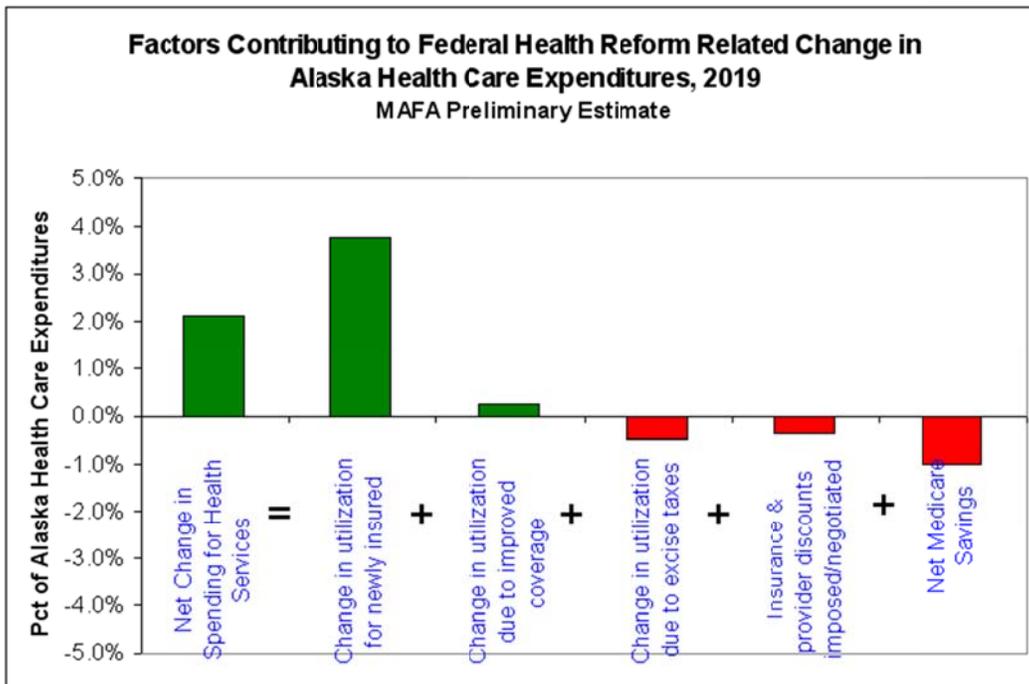
<sup>4</sup> The provision would extend eligibility to two significant groups: 1) individuals who would meet *current* Medicaid eligibility requirements, for example as disabled adults, but who have incomes in excess of the existing State thresholds but less than 138 percent of the FPL; and 2) people who live in households with incomes below 138 percent of the FPL but who have no other qualifying factors that make them eligible for Medicaid under prior law, such as being under age 18, age 65 or older, disabled, pregnant, or parents of eligible children.

<sup>5</sup> Please note that this figure is subject to *considerable uncertainty*. See especially the estimates developed by RAND, CMS and CBO on Health Insurance Exchange enrollment. When we apply their three estimates to our estimate of the addressable health insurance market in Alaska in 2019, the estimates range from 5,000 to 80,000 individuals *who will switch from employer sponsored health insurance to enroll in coverage offered through the Exchange* with smaller numbers enrolling in expanded Medicaid coverage.

<sup>6</sup> See Table 2 in the Appendix for Estimated changes in coverage over the period 2011-2019

<sup>7</sup> See Table 3 in the Appendix for Estimated changes in Alaska health care expenditures over the period 2011-2019

- Cost containment efforts by Medicaid, especially in light of incremental cost pressure associated with increased enrollment by those previously eligible who require a 50% match by the State of Alaska
- Potential competition between independent health plans offered in the exchange and at least two multi-state plans developed under contract to the Office of Personnel Management
- Lower payments and payment updates for Medicare services



The actual future impacts of the PPACA on health expenditures, insured status, individual decisions and employer behavior are *very uncertain*. The legislation will result in numerous changes in the way that health care insurance is provided and paid for in the U.S., and the scope and the magnitude of these changes are such that few precedents exist for use in estimation. Consequently, the estimated presented here are subject to a substantially greater degree of uncertainty than is usually the case with many economic projections.

The balance of this memorandum discusses these economic and coverage estimates and their limitations in more detail.

---

## EFFECTS OF PPACA ON HEALTH CARE EXPENDITURES BY SPONSOR

---

### FEDERAL EXPENDITURES

We estimate that Federal health care expenditures would increase by a total of \$693 million in 2019 as a result of the Medicaid expansion (\$312M) and premium and cost support subsidies available through the Exchange (\$381M). This increase is offset by Medicare payment reductions (\$60M), penalties (\$61M), and taxes and fees (\$448M), for a net increase in federal support of \$124 million in 2019.

\$312 million in federal support can be attributed to expanding Medicaid coverage for all adults who live in households with incomes below 138 percent of the FPL plus increased enrollment from the population of previously eligible but not enrolled. This estimate reflects the fact that newly eligible persons would be covered with a Federal Medical Assistance Percentage (FMAP) of 100 percent for the first three years, declining to 93 percent by the sixth year. The Federal government would bear a significantly greater proportion of the cost of the newly eligible enrollees than is the case for current Medicaid beneficiaries.<sup>8</sup> Also included in this cost is a reduction in the Federal share for the CHIP program for 2019, which would shift expenditures from federal support to state support by an estimated \$4 million.

\$381 million in federal support can be attributed to the coverage provisions that provide for refundable tax credits and reduced cost-sharing requirements for low-to-middle income enrollees purchasing health insurance through the Exchanges. The increases in Federal expenditures would be partially offset by the penalties paid by affected individuals who choose to remain uninsured and employers who opt not to offer coverage; such penalties total \$61 million in 2019, reflecting the relatively low per-person penalty amounts specified in the legislation.<sup>9</sup>

---

<sup>8</sup> For the newly eligible enrollees, the FMAP for fiscal year 2020 and later will be 90 percent, compared to an average of 57 percent for the previously eligible enrolled population (Medicaid + CHIP). In addition, the estimated cost includes new Medicaid enrollments by previously eligible individuals as a result of the publicity and enrollment assistance through the Exchanges, and potentially reduced stigma associated with Federal assistance for health care coverage. Also included here are the Medicaid costs for the provision to extend Medicaid coverage to individuals up to age 26 who were previously in foster care.

<sup>9</sup> The PPACA requires most people to show proof of health insurance coverage when they file tax returns or pay an excise tax penalty that is phased in over 2014 and 2015 and in 2016 and thereafter is equal to the greater of \$695 per uninsured individual or 2.5% of income up to a maximum of \$2,085 for families. These penalty amounts will be indexed annually to the Consumer Price Index beginning in 2017. The penalty does not apply to undocumented immigrants, people living below  
*(footnote continued)*

The refundable tax credits in section 1401 of the PPACA (as amended by section 1001 of the Reconciliation Act) would limit the premiums paid by individuals with incomes up to 400 percent of the FPL to a range of 2.0 to 9.5 percent of their income. An estimated 50,000 Exchange enrollees (64%) would receive these Federal premium subsidies. The cost-sharing credits would reimburse individuals and families with incomes up to 400% of the FPL for a portion of the amounts they pay out-of-pocket for health services, as specified in section 1402, as amended. These premium subsidies and cost sharing credits are estimated to total roughly \$381 million in 2019.

Please note that the refundable premium tax credit schedule may create notable changes in Alaska labor markets by introducing a large effective marginal tax rate increase for households whose income exceed the step thresholds, especially as *household incomes* increase from 399% of FPL to 401% of FPL; moving from eligibility for roughly \$5,000(single)/\$10,000(family) in refundable tax credits to no tax credit. Economic research suggests that this would be likely to reduce the labor supply of those who are not the principal income support of the household.<sup>10</sup> For example, it would not be surprising to find that many householders who would otherwise have returned to the formal workforce after their children enter elementary school, may remain outside the formal workforce in order to retain substantial federal subsidies. The net effect of these provisions could be an increase in the number of people who find informal cash and barter economy work as their children enter K-12 and again as their children enter college or the workforce. Conversely, this large “notch” in the effective marginal tax rate could reduce the availability of a number of highly skilled local workers who were previously employed in jobs at the “notches”, resulting in labor shortages in the formal employment sector and an associated increase in wages and compensation required to attract and retain employees in the affected sectors.

The PPACA establishes the Exchange premium subsidies during 2014-2018 in such a way that the reduced premiums payable by those with incomes below 400 percent of FPL would maintain the same share of total premiums over time. As a result, the Federal premium subsidies for a qualifying individual would grow at the same pace as per capita health care costs during this period. Because the cost-sharing assistance is based on a percentage of health care costs incurred by qualifying individuals and families, average Federal expenditures for this association would also increase at the

---

the tax filing threshold, Indian Health Service eligible American Indians and Alaska Natives, and individuals who have been uninsured for three months or less. People are also exempt from the penalty if the lowest cost option available to them exceeds 8 percent of income – an exemption that may become increasingly important if Alaska health insurance cost trends continue to grow more rapidly than income.

<sup>10</sup> See Joseph P. Newhouse “Assessing Health Reform’s Impact on Four Key Groups of Americans”, Health Affairs, Vol. 29, No. 9 (2010); 1714-1724, at page 1717.

same rate as per capita health care costs. After 2018, if the federal cost of the premium and cost-sharing subsidies exceeded 0.504 percent of GDP, then the share of Exchange health insurance premiums paid by enrollees below 400 percent of the FPL would increase such that the Federal cost would stay at approximately 0.504 percent of GDP. CMS estimates that the subsidy costs in 2018 would represent about 0.518 percent of GDP, with the result that the individual/household share of the total premium would generally increase in 2019 and later which in turn could lead to erosion in the percentage of health care costs covered by federal subsidies for price sensitive households. So it would appear that the most advantageous window of opportunity for Alaska businesses to encourage their employees to switch to the federally subsidized exchange is when the 40% excise tax is imminent and the proportion of costs covered by the federal subsidies are at their highest, the 2018-2019 time frame.

As noted previously, the Federal costs for the coverage expansion provisions are somewhat offset by the individual and employer penalties stipulated by the PPACA. We estimate that individual penalties would cost Alaskan households \$25 million that would be due to the Federal government in 2019. Additionally, for firms that do not offer health insurance and are subject to the “play or pay” penalties, we estimate that the penalties would total \$36 million in 2019.

The penalty amounts for noncovered individuals will be indexed over time by the CPI (or, in certain instances, by growth in income) and *would normally increase more slowly* than health care costs. As a result, penalty expenditures for nonparticipating individuals in Alaska are estimated to grow *more slowly* than the Federal expenditures for the premium assistance credits [unless real GDP growth falls, i.e., the economy goes into a recession]. Penalties for employer who do not offer health insurance will be indexed by premium levels and will thus keep pace with health care cost growth.

For future years, the limits are indexed to the growth in the average health insurance premium in the U.S. Under this approach, the proportion of health care costs above the out-of-pocket maximum would be relatively stable over time.

For the basic “silver” benefit plan for *individuals*, with an actuarial value of 70%, we estimate that the cost sharing percentage applicable before the out-of-pocket maximum is reached would average about 45 percent in 2019. The corresponding cost-sharing rate for *family coverage* is 38 percent. For more comprehensive “gold” and “platinum” benefit packages authorized through the Exchanges, these initial cost-sharing levels would be significantly higher. For the less comprehensive “bronze” benefit plan, the cost-sharing levels would be lower.

Given the continued expectation of rapid growth in medical care and health plan costs and limitations on Federal premium support tied to a percentage of GDP, it may not be surprising to find increasing interest in relaxing deductible/cost sharing and actuarial value rules in the Exchange in order to create more affordable benefit plans.

#### STATE OF ALASKA EXPENDITURES

We did not independently estimate the cost of the new insurance requirements, e.g., dependent coverage, lifting of lifetime caps, etc., on the State of Alaska as an employer.

In order to provide estimates of Medicaid enrollment and expenditures associated with the PPACA that are roughly comparable to those developed by CMS OCA, we have developed a preliminary estimate of Medicaid enrollment and expenditures that includes not only new enrollment of the newly eligible, but also new enrollment of previously eligible, a.k.a, “the woodwork effect.” The new enrollment of previously eligible is likely to include a mix of potential beneficiaries who are eligible for 100% federal funding, e.g., Alaska Natives who receive services at tribal facilities, and the balance of beneficiaries who are eligible for approximately 50% federal funding. Our estimate is that roughly another 2 thousand previously eligible children and 3 thousand previously eligible adults will become newly enrolled in addition to the 34 thousand newly eligible that will enroll in 2019. The net cost to the State of new Medicaid expenditures associated with the newly eligible plus the previously eligible is estimated to be roughly \$41 million in 2019. These estimates are highly dependent upon outreach, eligibility and enrollment coordination across the State and among providers which will depend in part on the development and implementation of the new health insurance Exchange(s). We note that our estimate of 39 thousand new Medicaid enrollees is between the State of Alaska Medicaid Enrollment and Spending in Alaska: Supplement 2010-2030 (January 2011) estimate which does not include an estimate of previously eligible new enrollment and prominent national estimates (LEWIN, URBAN INSTITUTE) which include estimates of previously eligible who are newly enrolled and project a net change in enrollment on the order of 46 – 50 thousand.<sup>11</sup>

---

<sup>11</sup> See for example, “The Impact of the Medicaid Expansions and Other Provisions of Health Reform on State Medicaid Spending,” Staff Working Paper #12, Lewin Group, December 9, 2010, Figure 4, page 8, and “Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid”, Timely Analysis of Immediate Health Policy Issues, Buettgens, Holahan and Carroll, Urban Institute, March 2011, Table 6, adjusted from 2011 Urban Institute baseline to reflect a 2019 baseline as used in this report and comparisons with MESA and CMS OCA.

In addition, we have made top down order of magnitude estimates of other Medicaid provisions not directly related to the enrollment expansion for low income populations, e.g., Community First Choice Option (§2401) which may generate on the order of \$30 million in new expenditures, Disproportionate Share Hospital Payments (§2551) may be reduced on the order of \$15 million; for a net increase of \$15 million, of which 7% is expected to be covered by the State in 2019, or about \$1 million.

## ALASKA EMPLOYER EXPENDITURES

### HEALTH INSURANCE

Initially, the Medicaid Expansion and federal subsidies for individuals who purchase insurance in the new Exchange will enable employers to consider dropping insurance coverage and reducing expenditures *on health insurance*.

In the short term Alaska employers may adjust their wage and benefit packages in response to:

- “Pay or play” mandate on employers with more than 50 employees is estimated to be a net zero as those that choose to offer new insurance coverage (either by the employer, Medicaid or through the Exchange) or pay penalties are likely to make offsetting adjustments in total employee compensation [see section below on “total compensation”]<sup>12</sup>
- The opportunity to shift from paying employee health benefits to an increase in wages while their prospective employees have opportunities to obtain health insurance from Medicaid or in the new Exchanges with federal subsidies for individuals making up to 400% of FPL [individual \$54,400; family of four \$111,760 (2011 Alaska 400% FPL)]

In the development of our estimates for the number of employees who will shift from employer sponsored insurance to Medicaid and the new Exchange, we looked at the CBO, CMS, and RAND

---

<sup>12</sup> The “pay or play” mandate assesses employers with 50 or more full-time employees that do not offer coverage a fee of \$2000 per full-time employee, excluding the first 30 employees from the assessment. We estimate that the firms with more than 50 employees that do *not* offer coverage in Alaska, approximately 6.6%±2% of private firms in 2010 representing approximately 10,000 employees or 4% of Alaska private employment) [Medical Expenditure Panel Survey, 2010], will adjust *total employee compensation* to compensate for whether they offer coverage or pay a penalty. In addition, employers with particularly health benefit sensitive employees (typically 50-64 years of age) with substantial numbers of employees in wage classifications around 400% of FPL may consider holding wages below the threshold to enable employees to take advantage of the combined effects of federal subsidies in the Exchange plus PPACA mandated insurance rate band compression [which shifts health insurance premiums from age 50-64 to those under age 50 relative to current market practice].

estimates of the shift in market share and applied those to the “addressable market” in Alaska, i.e., employer sponsored insurance, and did not expect significant shifts between ESI and Medicare, TRICARE and the Tribal health systems in Alaska, and took into account the potential shift associated with the relatively large impact of the 40% excise tax on high cost plans. The large difference between these three prominent estimates also highlights the high level of uncertainty concerning estimates of the changes that may occur as a result of the PPACA.

PPACA - Estimated Change in Employer Sponsored Insurance (ESI) in Alaska (2019)		
	Percentage Change in ESI Coverage in National Addressable Market	MAFA Estimated Percentage Change in ESI Coverage in Alaska Addressable Market
CBO (March, 2010)	-1.1%	-5%
CMS (April 22, 2010)	-0.5%	
RAND: “Establishing State Health Insurance Exchanges (2010)	-12.8%	

Source: MAFA Analysis (2011)

#### TOTAL EMPLOYEE COMPENSATION

It is also useful to note that employers frequently adjust their *total compensation* expenditures in response to changes in benefits. For the purpose of this initial reconnaissance level estimate, we assume that the net impact of the PPACA on *employer expenditures on total employee compensation (wages and benefits, including health insurance and pensions)* in Alaska may approach zero in the long run, reflecting the assumption that ***a net reduction in spending on health care benefits is likely to be roughly offset by increased spending on wages and other benefits over time*** – a common finding in the economic literature<sup>13</sup>.

<sup>13</sup> See for example Jonathan Gruber and Alan B. Krueger, “The Incidence of Mandated Employer-Provided Insurance: Lessons from Workers Compensation Insurance,” in *Tax Policy and Economy* (1991); Lawrence H. Summers, “Some Simple Economics of Mandated Benefits,” *American Economic Review* (1989); Jonathan Gruber, “The Incidence of Mandated Maternity Benefits,” *American Economic Review* (1994); James Heckman, “What Has Been Learned About Labor Supply in the Past Twenty Years?”, *American Economic Review* (1993).

## ALASKA HOUSEHOLD EXPENDITURES

In aggregate, Alaska households are expected to gain roughly \$124 million in *net federal contribution* of the PPACA in 2019. We estimate net overall health care expenditures in Alaska will increase roughly \$289 million in 2019. The difference of \$165 million represents the amount of spending that will be reallocated from previous investment and consumption preferences within the Alaska economy toward health care expenditures. The initial reallocation of the \$165 million in spending will roughly be borne by:

- State of Alaska increased contribution toward Medicaid expansion - \$41 million
- Alaska Household increased contribution toward health care expenditures - \$124 million

Aggregate Alaska household consumer expenditures in 2019 may be in the range of \$30 billion, so the aggregate federal support may be roughly 0.5% and the aggregate internal reallocation toward health care expenditures for Alaska households may be roughly 0.5%.

Within those overall changes in expenditures, there are a number of cost shifts among households. In general health insurance costs are shifted from older, less healthy households toward younger healthier households. In additional health insurance costs are shifted from those who currently pay for more comprehensive health insurance toward those who are self-insured or who have high deductibles.

While many households who currently obtain health coverage or services from their employer, TRICARE, VA or Tribal health providers are not expected to see material changes in premiums, out of pocket and *after tax wage effects* through 2019 as a result of the PPACA, Alaska's combination of high insurance/health care costs and high federal poverty level thresholds appear likely to lead to more than half of Alaska households experiencing a material change in one or more of those considerations.

### AFTER TAX WAGE EFFECTS

First, the continued trend in the combination of high costs, high incomes and relatively generous health coverage benefits in Alaska appear likely to result in roughly 50 percent of individuals with health insurance policies in Alaska subject to the 40% excise tax on their high cost plans [\$10,200 for individuals and \$27,500 for families in 2018, indexed to CPI thereafter; with higher thresholds for workers in high risk occupations and retirees age 55 to 64], leading to employer adjustments in benefits and wages and associated changes in employee after-tax wages and compensation. In

comparison, Lewin Group estimates suggest on the order of 10% and CMS estimates that on the order of 12% of individuals in the U.S. will have health insurance policies subject to the 40% excise tax on their high cost plans. In 2019, we estimate the excise tax will capture roughly \$280 million in household income [either directly on health benefits or indirectly on wage increases as compensation shifts from benefits to wages].

#### PREMIUMS

Second, premiums in the non-group market, representing roughly 5% of the population<sup>14</sup> are estimated to increase on the order of 15-25%, consisting of mandated increases in the amount of coverage, reductions in price from competition in the Exchange, and changes in the overall risk of the new pool of non-group enrollees. In aggregate, premiums in the small group and large group market, representing roughly 56% of the population, may change on the order of -2 to +3% due to mandated increases in the amount of coverage, e.g., “free” preventative services and associated increase in follow-on services, erosion of grandfathering of existing plans, mandated expansion of coverage to children up to age 26, and potential reductions in insurance and provider margins if productivity gains associated with PPACA incentive realignment outpace PPACA associated reductions in margins from Medicare, Medicaid and Exchange.

While premiums in the non-group market are expected to increase on the order of \$15 million in aggregate, around 60% of the people who purchase policies in the Exchange (the newly reconstituted non-group market plus shifts from uninsured and employer sponsored insurance) will be eligible for federal cost support – amounting to roughly \$381 million in new federal subsidies into the Alaska economy to support household expenditures on health coverage.

#### PENALTIES PAYMENTS FOR NONCOMPLIANCE WITH HEALTH INSURANCE MANDATE

Third, we estimate that roughly 7% of the population will gain coverage and another 7% of the population will remain uninsured. Of the 7% who remain uninsured, we estimate that roughly one third will be subject to the individual mandate penalties of 2.5% of income; amounting to roughly \$25 million in aggregate (2019). The balance of the uninsured will roughly consist of undocumented

---

<sup>14</sup> Please note that the “direct purchase” health coverage market share reported in the Current Population Survey for Alaska is on the order of 7% while the number of individuals reported covered by direct comprehensive major medical policies in the State of Alaska’s Division of Insurance Annual Report is on the order of 2-3%.

immigrants (1/4), households below income tax filing threshold (1/6th), and households with an exemption due to insurance premiums over 8% of income (1/4).<sup>15</sup>

#### OUT-OF-POCKET SPENDING ON HEALTH CARE

Fourth, we estimate that out-of-pocket expenses (deductibles and co-pays for covered services, spending for services not covered, spending for services by uninsured) associated with health care will, in aggregate, decrease by roughly \$120 million. This estimate reflects the combined effects of expanded coverage, mandated reductions in copays and deductibles, and a decrease in out of pocket among those who are newly insured or who shift coverage from the individual market to the offerings in the new Exchange.

#### CHANGES IN HOUSEHOLD SPENDING BY INCOME

##### *Household Incomes Under 400% of Federal Poverty Level*

For the roughly 2/3rds of households with incomes under 400% of the federal poverty level, the threshold below which individuals and households become eligible for federally subsidized coverage in the Exchange, the aggregate combined effect of subsidies, changes in premiums and out of pocket spending, penalty payments, after tax wage adjustments [reflecting net impact of 40% excise tax on high cost plans] and Medicaid coverage for incomes up to 138% of the federal poverty level may result in a net reduction in household spending of \$1000 per year for 100% of poverty up to an aggregate average of no net change for 350-400% of poverty.

If you dig down through those high level averages and split the 2/3rds of households with incomes at or below 400% of FPL into those who currently have insurance (roughly 80% of the population) and those who are self-insured (roughly 20% of the population), the average of those with insurance may see a reduction in spending on health care of around \$800 to \$1200 a year and the average of those who are self-insured and above 138% of FPL may see an increase in spending (after taking into account exchange subsidies) on the order of \$700 to \$5000 a year [up to 8% of income at 400% of FPL in 2019].

---

<sup>15</sup> We note that if health insurance premium costs rise faster than we project, a higher percentage will be exempt from the mandate and associated penalties because their after subsidy cost of insurance will exceed 8% of income. Conversely if health insurance premium costs rise slower than we project, a smaller percentage will be exempt from the mandate and penalty assessments will be higher.

### *Household Incomes at or above 400% of Federal Poverty Level*

For the roughly 1/3rd of households with incomes at or above 400% of FPL, the excise tax on high cost plans, penalty payments, and reductions in deductibles will lead to an aggregate average net increase in spending ranging from \$500 to \$1200 a year.

If you dig down through the high level averages and split the 1/3rd of households with incomes at or above 400% of FPL into those who currently have health insurance (roughly 7/8ths of the population) and those who are self-insured (roughly 1/8th of the population), the average of those with insurance may see an increase in spending on health care of around \$120 to \$480 a year and the average of those who are self-insured may see an increase on the order of \$4000 to \$8000 a year.

Over time, as an increasing proportion of compensation is subject to the combination of income taxes and excise taxes on high cost plans, the household spending on health insurance and PPACA related taxes are expected to increase faster than income.

### CHANGES IN HOUSEHOLD SPENDING BY AGE

The changes in household spending will vary with age due to a variety of insurance market regulations, most prominently the reduction in allowable age bands (maximum difference between lowest and highest premium associated with age) from roughly 5:1 in the prior market to 3:1 under the PPACA rules for individual and small group (anticipated to include up to 100 employees by 2019) markets.

As a result of the compression in rate bands, all other things being equal, rates for a 30 year old male might be expected to increase by roughly \$1260/year (+45%) while rates for a 62 year old male might be expected to decrease by roughly \$1260/year (-10%).

The relatively large increase in rates for young males in the individual and small group market raises a concern that the younger healthier population will have an incentive to avoid the higher cost plans, leaving prospective insurance pools populated by a higher proportion of older, less healthy individuals, a.k.a., “adverse selection.” In theory, the adverse selection pressure may be mitigated by the penalties for failure to comply with the insurance mandate.

The 3:1 rate banding rules do not apply in the large group and employer self-insured markets. As a result, employers with a healthier, younger workforce may have an incentive to keep their health insurance costs low relative to the plans available in the Exchange by remaining or becoming self-insured.

## **ALASKA EMPLOYER & EMPLOYEE LABOR MARKET INTERACTIONS**

### EMPLOYMENT EFFECTS [JOB LOSS ASSOCIATED WITH MINIMUM WAGE CONSTRAINTS]

We assume that employers who have increased health costs associated with minimum coverage requirements and mandated maximum deductibles and co-pays will pass those costs through to employees in the form of slower wage growth. However, firms with more than 50 employees who pay minimum wage for a substantial number of their employees may limit the number of new hires in response to the increased health insurance costs. National estimates of this effect suggest this may result in something on the order of a job loss of 0.1% to 0.2%. All other things being equal, this might amount to a prospective reduction in low wage employment in Alaska on the order of roughly 320 to 640 people in 2019.

---

## CAVEATS AND LIMITATIONS

---

The costs, savings and changes in health insurance coverage presented in this report represent MAFA's best estimates for PPACA based on distillation of CMS, CBO, and other health provider and health insurance industry analysis. Although we believe that these estimates are reasonable and fairly portray the likely future effects of this comprehensive package of health insurance reforms, they are subject to a *high level of uncertainty*. The following caveats should be noted, and the estimates should be interpreted cautiously in view of their limitations.

1. The financial and coverage impacts are based on a reconnaissance level review of the CMS analysis of PPACA, with adjustments to reflect the Alaska market where applicable.
2. Many of the provisions, particularly the coverage proposals, are unprecedented or have been implemented only in other States with substantial differences with Alaska with respect to population demographics, referral and travel patterns, and insurance coverage. It is useful to consider that a large proportion of the population in Alaska is covered by the Indian Health Service, Department of Defense and Veterans Administration and direct application of national proportions to the Alaska market require adjustment to take into account these differences.
3. The behavioral responses to changes introduced by the PPACA are assumed to be rational economic responses *based on prior small incremental market responses* to changes in insurance coverage. The number and magnitude of the changes contemplated under the PPACA are unprecedented and the interaction of several provisions may create behavioral responses outside what we have modeled.
4. The existing number of uninsured in Alaska is difficult to measure and the number of uninsured persons who are undocumented aliens is considerably more uncertain in Alaska due to its highly transient and seasonal employment.
5. We did not estimate whether Exchange enrollees would choose an enhanced benefit plan versus the basic "essential benefits package" due to a paucity of data upon which to estimate potential attractiveness of each to the eligible population.
6. In estimating the financial impacts of PPACA, we assumed that the increased demand for health care expenditures could be met without market disruptions. In practice, supply constraints are highly likely to interfere with providing the services desired by the additional 50 thousand insured persons.

7. Price reactions, i.e., providers successfully negotiating higher fees in response to greater demand, are likely to result in higher total expenditures or in some of the demand being unsatisfied or migrating to other markets, especially in light of the historic challenges of attracting and retaining a health care workforce to the remote island economy of Alaska.
8. As a result of the increase in newly insured by 50 thousand over the course of a few years, providers may be inclined to accept patients who have private insurance, with relatively attractive payments rates, and fewer Medicaid patients and even fewer Medicare patients due to their least attractive payment rates, exacerbating access problems that have been recently documented for Medicare beneficiaries [See UAA ISER “How Hard Is It for Medicare Patients to Find Family Doctors”, Understanding Alaska Research Summary #14, 2009]
9. Both higher fees and exacerbated access problems are likely in Alaska due to its relatively small, less competitive markets.
10. We have not attempted to estimate plausible supply and price effects, such as supplier entry and exit or cost-shifting towards private payers. An estimate of these potential outcomes is quite challenging at this time, given the uncertainty associated with both the magnitude of these effects and the interrelationships among Alaska and Pacific Northwest market dynamics.
11. Reductions in Medicare payment updates to institutional providers, based on economy-wide productivity gains, may not be sustainable on a permanent annual basis, especially in the Alaska market where the growing problems of Senior access to health care associated with inadequate Medicare reimbursement levels appear likely to continue.

---

**APPENDICES**

---

Summary of PPACA Provisions – U.S. & Alaska

Table 2: Changes in Coverage U.S. & Alaska

Table 3: Estimated Increases & Decreases in Alaska Health Expenditures

PPACA – Key Provisions	Considerations: U.S. & Alaska
Individual mandate to obtain minimum health insurance coverage; those without coverage pay a tax penalty up to \$695 per year or up to a max of three times that per family or 2.5% of income	Exemptions from individual mandate, including financial hardship, religious objections, American Indian/Alaska Native, undocumented immigrants, low income households who do not have to file income tax returns, and households where the cost of insurance exceeds 8 percent of income, may be higher in Alaska
Business (>50 employees) mandate to provide minimum health insurance coverage; \$2000 fee per full time employee not covered by business, but receiving federal premium support	Relatively higher proportion of smaller businesses in Alaska means larger number of businesses will be exempt from business mandate
Creation of health insurance “Exchange”; federal subsidies available for individuals up to 400% of Federal Poverty Level (FPL)	Alaska FPL is 125% of continental U.S. – Federal premium subsidy eligibility extends to higher incomes in Alaska and yields more federal subsidy per income bracket; provides marginal benefit to Alaska compared to other states <i>as Alaska incomes trend toward U.S.</i>
Medicaid Expansion to cover up to 138% of Federal Poverty Level (FPL)	Alaska FPL is 125% of continental U.S. – Federal Medicaid support subsidy eligibility extends to higher incomes in Alaska and yields more federal subsidy per income bracket; provides marginal benefit to Alaska compared to other states <i>as Alaska incomes trend toward U.S.</i>
<u>Tax Changes:</u> <ol style="list-style-type: none"> <li>40% Excise tax on high cost insurance above thresholds (\$10,200/\$27,500 in 2018)</li> <li>Medicare hospital insurance tax increase of 0.9% on incomes above \$200/\$250K and 3.8% tax on unearned income for \$200/\$250K</li> <li>Annual excise taxes and fees on pharma, health insurance, medical devices, indoor tanning services,</li> </ol>	<ol style="list-style-type: none"> <li>40% excise tax on high cost plans likely to touch around half of Alaskan health plans vs. 10-15% of U.S. in first year resulting in relatively high federal tax burden vs. other states</li> <li>Medicare tax increases on incomes above \$200/\$250K appear to touch roughly 4% of Alaskans vs. 2-3% of U.S.</li> <li>Taxes and fees assessed on a percentage basis; higher costs in Alaska may result in higher taxes and fees</li> </ol>
<u>Cost Containment:</u> <ol style="list-style-type: none"> <li>Restructure payments to Medicare Advantage plans</li> <li>Reduce annual market basket updates for inpatient hospital, home health, skilled nursing facility, hospice, and other Medicare providers, and adjust for productivity</li> <li>Reduce Medicare &amp; Medicaid disproportionate share hospital (DSH) payments</li> <li>Establish Independent Payment Advisory Board</li> </ol>	<ol style="list-style-type: none"> <li>Medicare advantage plans are de minimus in Alaska; smaller payments to MA will reduce federal spending in other States more than AK</li> <li>Reduced updates and productivity adjustments roughly comparable in Anchorage MSA; rural and near rural markets have some insulation</li> <li>DSH payment reductions roughly comparable in Anchorage MSA; API Medicaid DSH payment reductions are material</li> <li>Potential IPAB reductions in Medicare Part A &amp; B may reduce access in Anchorage MSA more acutely than other MSA's due to already low rates</li> </ol>



TABLE 2: Estimated Effects of the PPACA on Enrollment by Insurance Coverage, Thousands

PRIOR LAW BASELINE	2011	2012	2013	2014	2015	2016	2017	2018	2019
Medicare	68	71	75	79	83	87	91	96	100
Medicaid/CHIP	138	141	144	147	150	152	155	158	161
Other Public (IHS, DOD)	230	235	239	244	249	254	259	264	269
Employer-Sponsored									
Private Health Insurance	305	307	308	310	311	313	314	316	317
Other Private	36	37	37	38	38	39	39	40	42
Exchanges	0	0	0	0	0	0	0	0	0
Uninsured	94	96	98	100	102	104	106	108	110
Insured Share of AK Population	87%	87%	87%	86%	86%	86%	86%	86%	86%
PPACA	2011	2012	2013	2014	2015	2016	2017	2018	2019
Medicare	68	71	75	79	83	87	91	96	100
Medicaid/CHIP	138	141	144	184	188	190	193	196	199
Other Public (IHS, DOD)	230	235	239	244	249	254	259	264	269
Employer-Sponsored									
Private Health Insurance	306	308	309	306	290	288	285	275	272
Other Private	36	37	37	20	20	21	21	22	24
Exchange	0	0	0	30	47	52	58	72	78
Uninsured	94	96	98	56	57	58	57	57	56
Insured Share of AK Population	87%	87%	87%	92%	92%	92%	93%	93%	93%
Impact of the PPACA	2011	2012	2013	2014	2015	2016	2017	2018	2019
Medicare									
Medicaid/CHIP	0	0	0	37	38	38	38	38	38
Other Public (IHS, DOD)									
Employer-Sponsored									
Private Health Insurance	1	1	1	-4	-21	-25	-29	-41	-45
Other Private				-18	-18	-18	-18	-18	-18
Exchange				30	47	52	58	72	78
Uninsured				-44	-45	-46	-49	-51	-54
Insured Share of AK Population				6%	6%	6%	6%	7%	7%
<i>Source: MAFA Estimates based on CMS, Office of the Actuary (April 22, 2010, Table 1) with Alaska Market Adjustments</i>									
Change in Uninsured as Pct of Uninsured Baseline				-44%	-44%	-44%	-46%	-47%	-49%



