

Long-term Forecast of Medicaid Enrollment and Spending in Alaska: *Supplement 2008–2028*

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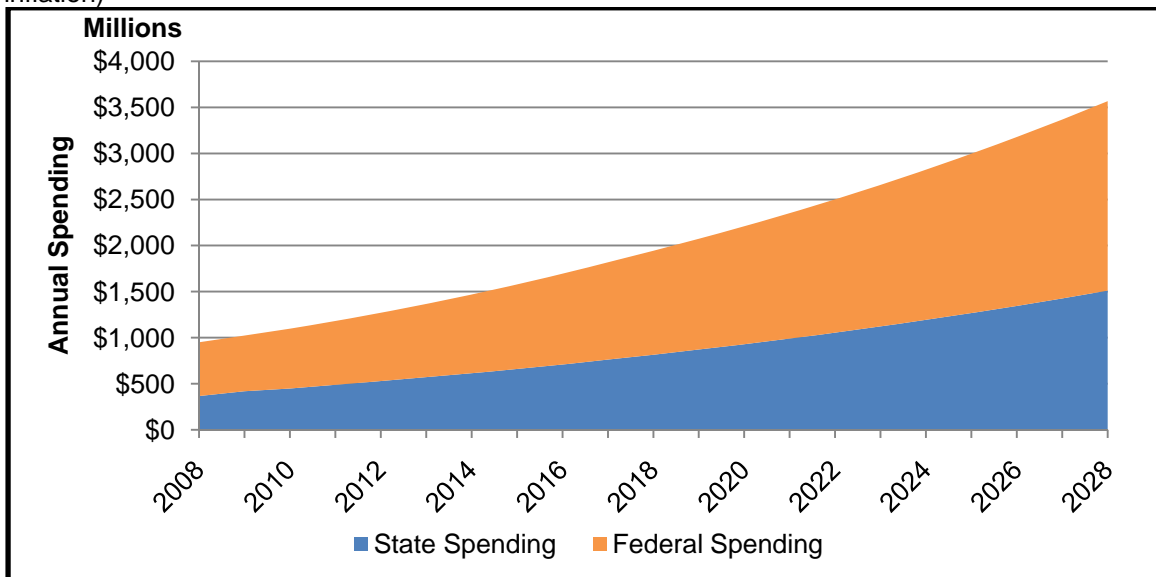
Executive Summary

This is the third update to the *Long-Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025*. In this update, we develop long-term forecasts of Medicaid program enrollment, utilization, and spending from 2008-2028.

Total Medicaid spending on the elderly (ages 65+ years) is expected to equal spending on working-age adults (ages 20-64 years) and children (ages 0-19 years) in 2028. This forecast predicts that each age group will comprise approximately 33 percent of total Medicaid spending by the end of the forecast period. This is a shift in the expected outcome from the baseline 2005-2025 forecast which predicted spending on the elderly would exceed spending in all other groups in 2018. This 10-year shift is caused by changes in policy and slower population growth than predicted in the baseline. Policy changes to control growth in personal care attendant services have begun to show up in the base data and the resultant changes are apparent in the forecast.

Total spending in 2028 is expected to reach \$3.6 billion. The average annual growth rate is 6.8 percent overall; however, state spending will grow faster at 7.3 percent.

Figure 1: Total Medicaid spending in 2028 will reach \$3.6 billion
 PROJECTED ANNUAL FEDERAL AND STATE SPENDING ON MEDICAID (not adjusted for inflation)



Source: Medicaid Budget Group, MESA Model

Spending per enrollee will increase from \$7,400 per enrollee in 2008 to \$22,100 per enrollee in 2028 (not adjusted for inflation). This growth in spending per enrollee can be attributed to two main factors: inflation in the prices of medical goods and services, and an increase in the proportion of enrollees who are elderly, and thus more costly than children or working age adults. State spending per enrollee will increase from \$2,900 in 2008 to \$9,400 in 2028. The proportion of state spending per enrollee will increase from 38.7 percent to 42.4 percent.

The rate of growth for enrollment will slow throughout the forecast period. The average annual rate of growth for enrollment is 1.1 percent -- faster than the population which is growing at 0.9 percent. The elderly (65+) are the fastest growing age group, with enrollment growing at 5.3 percent annually. The enrollment for children (0-19) and working-age adults (20-64) is growing slower than overall enrollment, 0.6 and 0.9 percent, respectively.

Utilization will see the highest average annual growth rates in Home and Community Based Waivers (6.0 percent), Personal Care (5.9 percent), and Health Clinic (5.4 percent).

Introduction

This report presents and discusses the annual update to the long-term forecast of Medicaid Enrollment and Spending in Alaska (MESA). In this update, we develop a 20-year outlook of Medicaid¹ program enrollment, utilization, and spending from 2008-2028. MESA was first prepared in 2005 by The Lewin Group and ECONorthwest on behalf of the State of Alaska Department of Health and Social Services (DHSS) and the Alaska Legislature.

The original MESA report covered the twenty-year period from 2005-2025. In each successive year, the department's Alaska Medicaid Budget Group, with consultation from ECONorthwest, updates the underlying enrollment and claims data on which the MESA forecasting model depends and re-estimates the model to project enrollment and spending over the successive 20-year period. By integrating a successive year of data into the MESA model, we update the Medicaid program's status quo with respect to eligibility, enrollment trends, and spending. Thus, as changes are made to the Medicaid program by DHSS or the Legislature, MESA provides estimates of the long-term impact of the changes.

The purpose of the MESA forecast is to provide a long-term view of future enrollment and spending in the Alaska Medicaid program under the current mix of Medicaid services and the current criteria for enrollment in the Medicaid program. MESA provides department executives and the Alaska State Legislature with information on the direction and approximate magnitude of growth in enrollment and state matching fund spending for the Medicaid program. It is particularly helpful to pay attention to growth rates as opposed to simply focusing on values.

It is important for the reader to keep in mind that the projections of spending presented in this report assume that the mix of Medicaid services remains constant and that eligibility criteria do not change in the future. These assumptions are necessary to show how Medicaid spending in Alaska would grow under the program as it exists today. Because of this, the forecast does not take into consideration the dynamic nature of Medicaid policy and changing funding mechanisms that may take place throughout the forecast period.

We realize that the value of economic analysis depends on the quality of the data and assumptions employed. We have worked carefully to ensure the quality of our work and the accuracy of our data. We have undertaken considerable effort

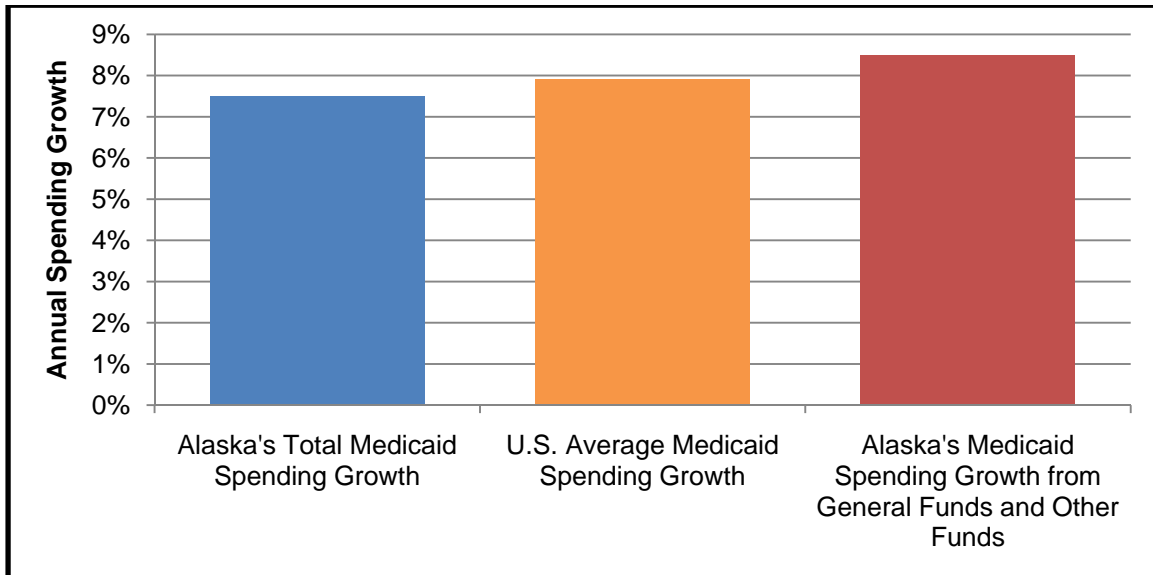
¹ In this report, the term "Medicaid" includes both Title XIX Medicaid and the Title XXI State Children's Health Insurance Program (SCHIP) Medicaid expansion.

to validate the forecast and to confirm the reasonableness of the data and assumptions on which the forecast is based. Nonetheless, we acknowledge that any forecast of the future is uncertain. The fact that we view the forecasts in this report as reasonable does not guarantee that actual enrollment in, utilization of, and spending on the Alaska Medicaid program will equal the projections in this report. Administrators and Alaska’s elected representatives must recognize the inherent uncertainty that surrounds forecasts in considering the long-term Medicaid spending projections.

Comparison to Other States

Figure 2: Alaska’s total spending growth is projected to be lower than the national average

ANNUAL GROWTH IN MEDICAID SPENDING FROM 2008 TO 2017



Source: Medicaid Budget Group, MESA Model

According to the Centers for Medicare and Medicaid Services, Medicaid spending nationally is projected to increase at an average annual rate of 7.9 percent between 2008 and 2017.² In comparison, Alaska’s total Medicaid spending is projected to increase at 7.5 percent per year over the same period and by 6.8 percent per year over the entire forecast period (through 2028). At least part of the lower expected growth rate in Alaska’s Medicaid spending can be attributed to the cost control measures implemented by the department and the legislature in recent years.

² Sean Keehan, et al. “Health Spending Projections Through 2017: The Baby Boom Generation is Coming to Medicare.” *Health Affairs*. Vol. 27 no.2, p152. Downloaded on December 10, 2008 from <http://www.amsa.org/business/Health%20Spending%20Projections.pdf>.

Since the federal government will be shifting a larger share of the cost of Alaska's Medicaid program back to the state³, Medicaid spending from general funds and other non-federal funds is projected to grow at 8.5 percent annually from 2008 to 2017.

The Economy and Medicaid

During the past several months, the current economic downturn has been a major news story. Questions have arisen about how the current economic circumstances affect Alaska's Medicaid program. One in five Alaskans is enrolled in Medicaid in any given year. In an average week, 25,500 Alaskans receive some level of medical care that costs the Medicaid program \$17 to \$25 million for benefit payments made to 2,100 health care providers. Medicaid provides jobs for health providers, but more importantly, it provides critical health services for those who, without Medicaid, wouldn't be able to afford them. People wonder how Alaska's situation compares with the national state of affairs and how this affects Medicaid.

Economic activity affects the state's Medicaid program in two ways. First of all, it provides workers and families with income, which can be used to purchase health care and health insurance in the private market, thus reducing the need for Medicaid services. It also increases the tax revenues collected by the state that can be used to finance the Medicaid program. When economic activity slows, less tax revenue is collected by the state, resulting in greater pressure on the General Fund portion of the Medicaid budget. Compounding the budget impact associated with an economic downturn is less income is generated that can be used to purchase private health insurance, thus increasing the demand on the state's Medicaid program.

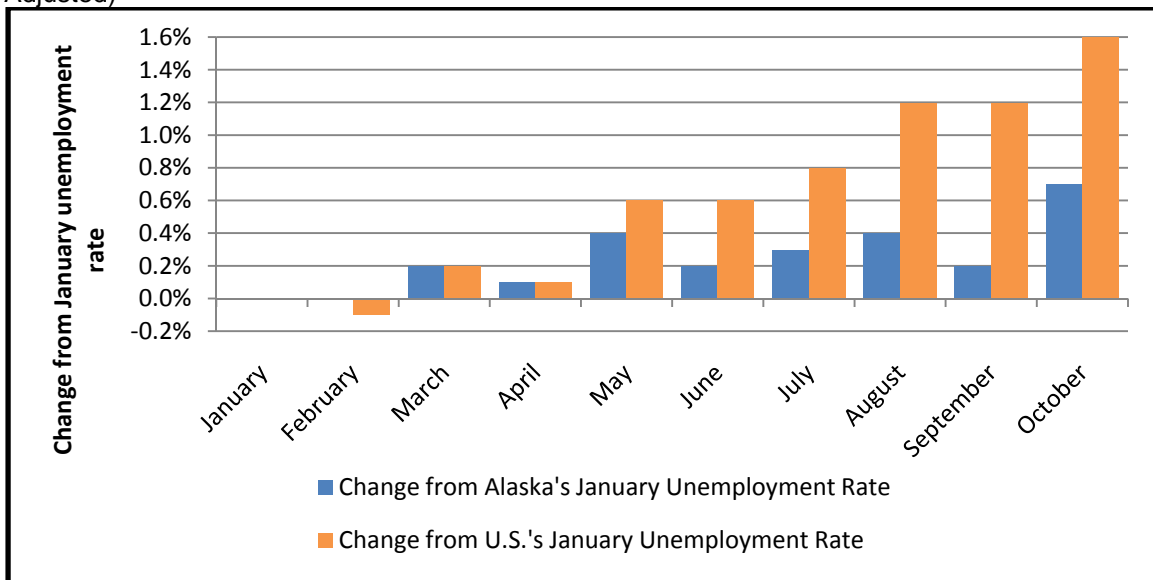
With respect to Alaska's Medicaid program, recent historical experience indicates that economic fluctuations do not affect Medicaid enrollment and spending to the degree one might expect. Statistical analysis conducted in support of the *Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025* showed that policy changes related to the Medicaid program and population and demographic changes had a far greater impact on Medicaid enrollment and spending than did changes in the state's economy. In addition, Alaska's economy may not experience as severe an economic slowdown as the nation.

³ The costs will be deferred back to the state because of a lower Federal Medical Assistance Percentage. See the State Spending section.

Alaska’s economic experience over the past two decades has differed from the nation as a whole. Alaska has experienced 21 consecutive years of slow and steady economic and employment growth. Recently, incomes have stagnated across much the country, but per capita income in Alaska continued to grow in the first two quarters of 2008.⁴ Even though the Alaska unemployment rate continues to be higher than the national average, the rate of growth in the unemployment rate has been slower in Alaska over the past year than the national average.

Figure 3: Alaska’s unemployment rate growth in 2008 is slower than that of the U.S.

CHANGE FROM CATEGORY’S JANUARY 2008 UNEMPLOYMENT RATES (Seasonally Adjusted)



Source: Alaska Economic Trends publication, Alaska Department of Labor and Workforce Development

Even though there is uncertainty about the economy and, therefore, questions about the demand for Medicaid services and tax revenue to pay for them, the consensus is that there is less cause for concern about Alaska’s situation than for other states’. Neal Fried, an economist with the Alaska Department of Labor and Workforce Development, reports that nationally, employment has been declining each month since December 2007, but increasing in Alaska.⁵ He expects Alaska’s employment growth for 2009 to be flat or even decline slightly⁶.

⁴ Tim Bradner. “Economists: Don’t worry, but be wary.” *Alaska Journal of Commerce*, November 23, 2008. Vol. 32 No. 47.

⁵ Margaret Bauman. “Economic conditions to bring more competition to Alaska.” *Alaska Journal of Commerce*, December 21, 2008. Vol. 32 No. 51.

⁶ Tim Bradner. “Oil, gas cutbacks likely to level employment growth.” *Alaska Journal of Commerce*, December 28, 2008. Vol. 32 No. 52.

In addition, data obtained from the Medicaid Budget Group doesn't suggest a dramatic change in enrollment; in fact, enrollment has dropped slightly in the past two years. The cost containment strategies implemented by the department and legislature a couple of years ago are believed to be responsible for reining in the escalating costs of the program. A few years ago, the growth in Alaska's Medicaid spending was faster than the national average, but now Alaska's spending growth is slower than the national average.

It is still possible that the downturn which the rest of the United States is experiencing just hasn't shown up in Alaska's numbers yet, since the oil prices have recently fallen from their record highs in July; however, past analysis of the economy's effect on Medicaid, Alaska's current situation, recent Medicaid enrollment figures, and cost containment measures lead us to believe that dramatic changes in Medicaid enrollment and spending are not likely.

Summary of Methodology

The MESA forecasting model is composed of multiple components, which successively build upon each other. The model begins by distributing the long-term population projections developed by the Alaska Department of Labor and Workforce Development into individual forecasts of regional and demographic subgroups. Next, enrollment is projected for each demographic group. Then the probability that a Medicaid enrollee will utilize a Medicaid service is estimated based on logistic regression model. Finally, total spending by service category and demographic group is projected and from this state general fund spending is allocated based on known and projected future federal financial participation rates.⁷

Throughout the analysis, we rely upon the best available information, including historic Medicaid claim data, the state of Alaska's official population forecast, and nationally recognized information on trends in medical prices. In addition, in no instances do we impose any speculation on future Medicaid policies or procedures. Rather, we develop the long-term forecast as if the policies and practices of today will be the status quo throughout the forecast period.

The main factors responsible for growth in state spending on Medicaid services are

- Growth in Alaska's resident population and changes in demographic composition;

⁷ For detailed information on the development of the MESA forecast, please see "*Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025*".

- Changes in the Medicaid enrollment rate;
- Changes in the utilization of Medicaid services by Medicaid enrollees;
- Personal health services specific price inflation;
- Changes in federal financial participation;

Our methodology, therefore, entails detailed analysis of each of these factors in order to formulate a series of statistical models to project total and state spending on Medicaid services. We project total and state spending for demographic characteristics (age, gender, Native/non-Native status) and for five regions of the state – a total of 220 subpopulations. In addition, we project enrollment in 11 eligibility groups plus utilization and spending for 20 categories of services provided under the Alaska Medicaid program. Although results are presented at state level for all residents, analysis is conducted on a regional basis for demographic subgroups of the population.

Population forecasts for five regions of Alaska were based on historical Census population estimates and statewide population forecasts developed by the Alaska Department of Labor and Workforce Development (ADLWD). ADLWD produced an updated population projection for years 2008 through 2030. These data were used to develop a new projection for Medicaid enrollment. The statistical models of Medicaid enrollment, and service utilization and spending used in the MESA model were developed using historical enrollment-level Medicaid data for paid claims provided by the Department of Health and Social Services for the years 1997-2007. Only complete fiscal years based on dates of service are included in the Medicaid data file. Many of the claims incurred during 2008 will not be paid until fiscal year 2009; therefore, data for 2008 are excluded. Please see *Appendix C* for historical spending data.

ALASKA MEDICAID FORECAST: 2008-2028

The 2008-2028 Alaska Medicaid forecast integrates the most recent enrollment and spending data for the Alaska Medicaid program with the Alaska Department of Labor and Workforce Development (ADLWD) population forecast, developed in 2007. The 2007 ADLWD population forecast projects a slower rate of growth in the elderly population over the next 20 years than did the 2005 ADLWD forecast. The slower anticipated growth in the elderly population leads to slightly slower expected growth in Medicaid enrollment and, more importantly, slower projected growth in Medicaid spending relative to the 2005 Medicaid forecast. The annual enrollment growth rate is projected to be 1.1 percent, which is slightly less than the increase of 1.2 percent which was previously forecast. The above factors, in combination with cost containment and programmatic changes, lead to slower projected growth in Medicaid spending.

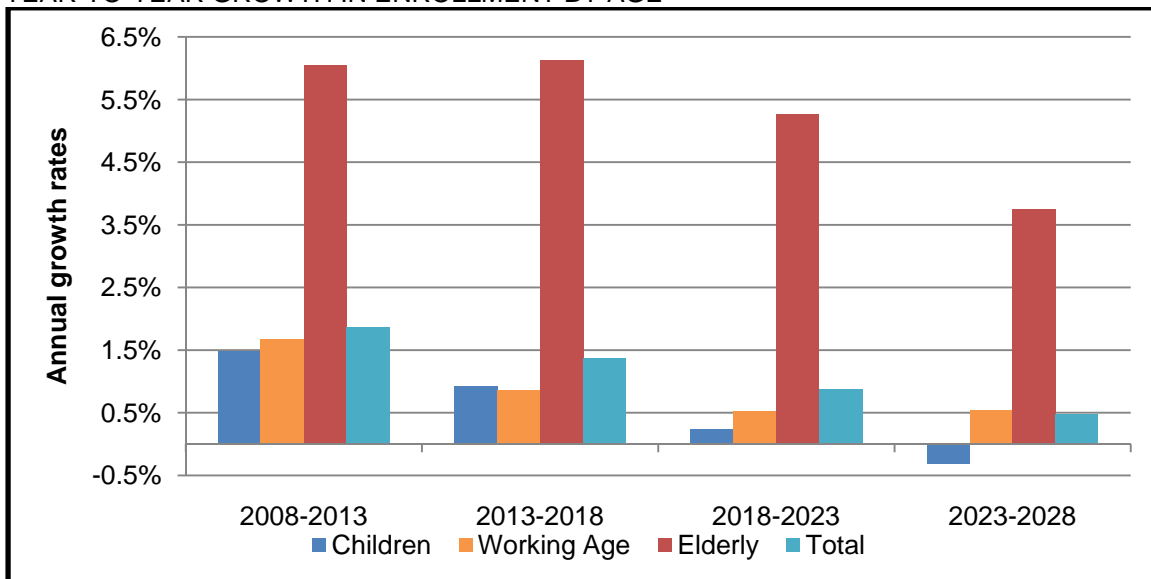
Enrollment

The elderly population will continue to have a dramatic impact on the Medicaid program through 2028. The growth in enrollment among the elderly will average 5.3 percent per year through the forecast period, causing the elderly’s share of enrollment to more than double by 2028, reaching 15 percent of total enrollment. During the same period, the growth rate in enrollment among children and working-age adults will be 0.6 percent and 0.9 percent respectively. The rate of growth in enrollment across the entire population will slow from 1.9 percent annually over the first five years of the forecast to 0.5 percent over the last five years.

Enrollment refers to the number of individuals who both meet the requirements and are registered to receive Medicaid services. The growth in enrollment is determined by two primary factors: changes in the demographics of the population and changes in eligibility requirements. For the purposes of this report, enrollment changes are primarily driven by changes in the demographics of the population, since the present eligibility requirements are already incorporated into the current enrollment figures.

Figure 4: Enrollment growth slows down over time. The elderly remain the fastest-growing group

YEAR-TO-YEAR GROWTH IN ENROLLMENT BY AGE



Source: Medicaid Budget Group, MESA Model

Figure 4 shows that enrollment growth for the entire population will slow down over time, and the elderly (age 65+) will experience the highest growth rate over the forecast period. The growth rates in enrollment for children (age 0-19) and

working-age adults (age 20-64) are roughly equal to each other through the first ten years, but then the growth rate for children drops below that of the adults. Over the last five years, the growth rate for children becomes negative.

Table 1: Elderly enrollment is projected to grow faster than other age groups

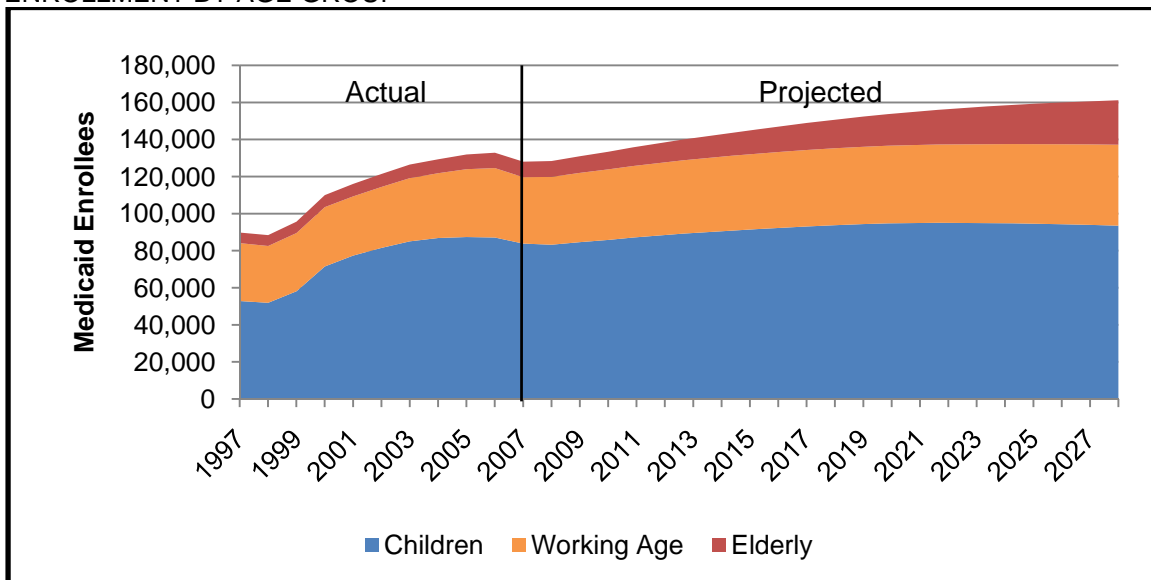
MEDICAID ENROLLMENT BY AGE GROUP FOR SELECTED YEARS, 2008-2028

Age Group	2008	2013	2018	2023	2028	Average Annual Change
Children (0-19)	86,318	89,651	93,854	94,994	93,541	0.6%
Working Age Adults (20-64)	36,568	39,719	41,452	42,540	43,684	0.9%
Elderly (65+)	8,556	11,476	15,445	19,962	23,990	5.3%

Source: Medicaid Budget Group, MESA Model.

Figure 5: Enrollment increases are projected to be modest

ENROLLMENT BY AGE GROUP



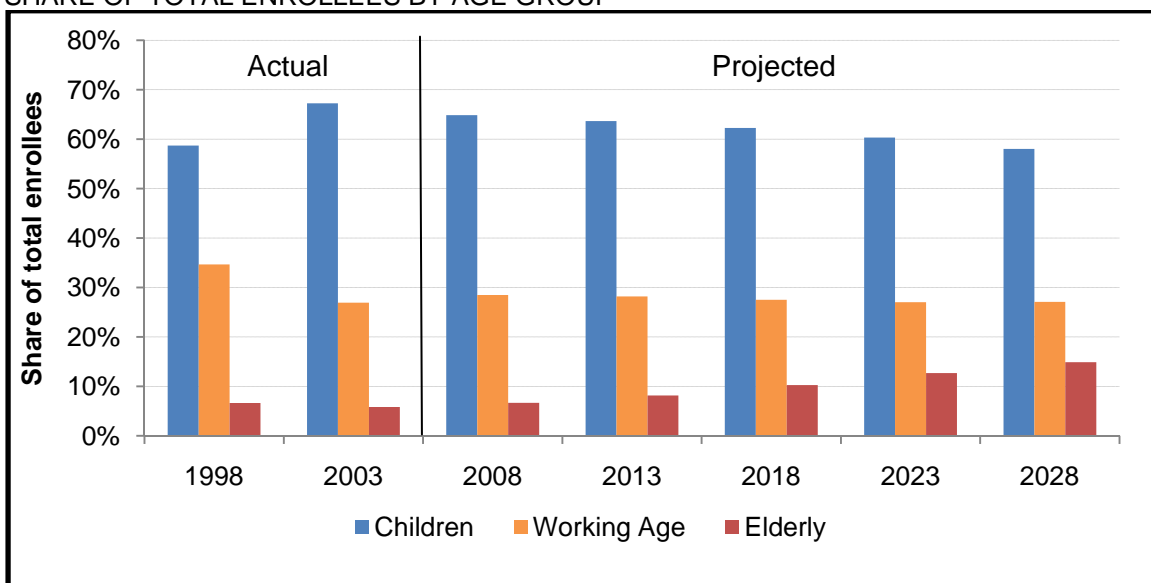
Source: Medicaid Budget Group, MESA Model

The demographic makeup of Medicaid enrollees has changed and will continue to do so in the future. Children as a proportion of total enrollment increased in the late 1990's and in the beginning of this decade until 2004, when they accounted for 67 percent of enrollees. This coincided with the introduction of Denali KidCare, which expanded Medicaid to more pregnant women and individuals. From 2004 to 2007, the household income eligibility requirements for Denali KidCare were locked into place instead of being adjusted for inflation, so some individuals fell off the rolls. The proportion of enrollees who are children has since dropped to 66 percent. With a 0.6 percent annual growth rate from 2008

to 2028, children’s share of enrollment will continue to fall; by 2028, enrollment is projected to include 93,500 children, which will account for 58 percent of enrollment.

The proportion of the enrollment for working-age adults experienced a large drop in the late 1990’s, dropping from 35 percent of enrollment in 1997 to 27 percent of enrollment in 2002. Their enrollment is projected to grow over the forecast period at 0.9 percent per year. Their share is projected to remain steady throughout the forecast period, resulting in an increase from 36,600 adults enrolled in 2008 to 43,700 in 2028.

Figure 6: Percentage of enrollees who are elderly will increase in the future
SHARE OF TOTAL ENROLLEES BY AGE GROUP



Source: Medicaid Budget Group, MESA Model

With an increasing share of the Baby Boom Generation approaching retirement age, the elderly will account for a larger share of Medicaid enrollees over the forecast period, with annual enrollment increasing by 5.3 percent. Enrollment of elderly is expected to grow from 8,600 in 2008 to 24,000 in 2028. This will increase their share of total enrollment from 7 percent to 15 percent in 2028.

Throughout the forecast period, the enrollees will continue to be 55 percent female, 45 percent male, and 66 percent non-Native, 34 percent Native; the enrollment for each of these groups is projected to grow at 1.1 percent annually.

There is a projected increase in enrollment levels for each eligibility group, but the eligibility groups that tend to have a larger share of the elderly are among those with the highest growth rates. These groups include **Long Term Care Non-Cash** and **SSI/APA/LTC Cash**, which are projected to grow annually at 3.5

percent and 2.7 percent, respectively. **SSI/APA/LTC Cash** happens to be the eligibility group that will experience the largest growth in total enrollees. It is expected to gain 14,000 enrollees by increasing from 20,000 to 34,000 enrollees in 2028.

Table 2: Enrollment levels of eligibility groups associated with the elderly tend to grow faster than the 1.1 percent average

MEDICAID ENROLLMENT FOR SELECT ELIGIBILITY GROUPS

Eligibility group	2008	2013	2018	2023	2028	Annual Change
Title XIX Kids	43,816	47,142	49,236	49,819	49,285	0.6%
Title XXI Kids	6,114	6,709	7,068	7,317	7,547	1.1%
SSI/APA/LTC Cash	19,960	23,638	27,525	31,163	33,997	2.7%
LTC Non-cash	1,828	2,192	2,620	3,129	3,651	3.5%

Source: Medicaid Budget Group, MESA Model

The **Title XIX Kids** eligibility group is currently the largest eligibility group. It is projected to maintain that distinction; even though its 0.6 percent annual growth is among the slowest. It is projected to reach its maximum number of enrollees in 2022 and then decrease thereafter.

Total Medicaid Spending⁸

Total Medicaid spending is expected to increase by 6.8% annually between 2008 and 2028. This is based on the program as it currently exists and does not consider policy changes that may occur throughout the forecast period. Service categories which serve the elderly more heavily tend to have higher per-person average costs will experience the highest growth during the forecast period.

Table 3: Spending on the elderly grows nearly twice as fast as spending on other age groups

MEDICAID SPENDING BY AGE GROUP FOR SELECTED YEARS, 2008-2028 (IN MILLIONS)

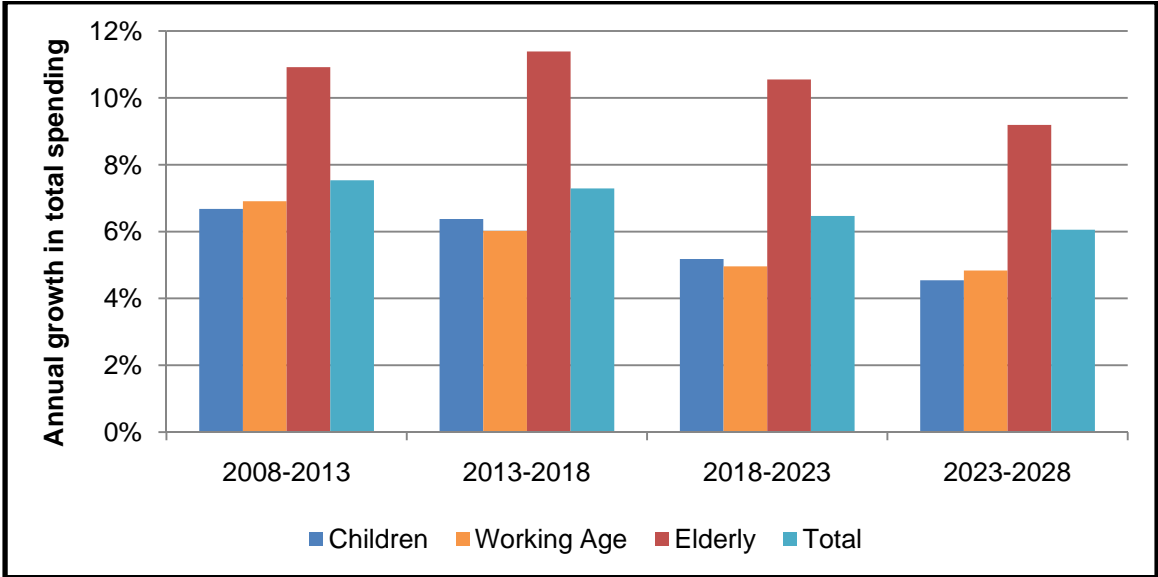
Age Group	2008	2013	2018	2023	2028	Average Annual Change
Children (0-19)	\$383.5	\$529.8	\$721.6	\$928.9	\$1,159.9	5.7%
Working Age Adults (20-64)	\$407.8	\$569.5	\$762.7	\$971.5	\$1,230.3	5.7%
Elderly (65+)	\$159.7	\$268.1	\$459.7	\$759.0	\$1,178.1	10.5%
Total	\$951.0	\$1,367.4	\$1,944.0	\$2,659.4	\$3,568.3	6.8%

Source: Medicaid Budget Group, MESA Model

⁸ All figures are nominal unless otherwise noted. Nominal, or actual spending, is the projected future value without adjusting for inflation. Please see Appendix C for real spending tables.

Figure 7: Growth in total spending will slow down with time

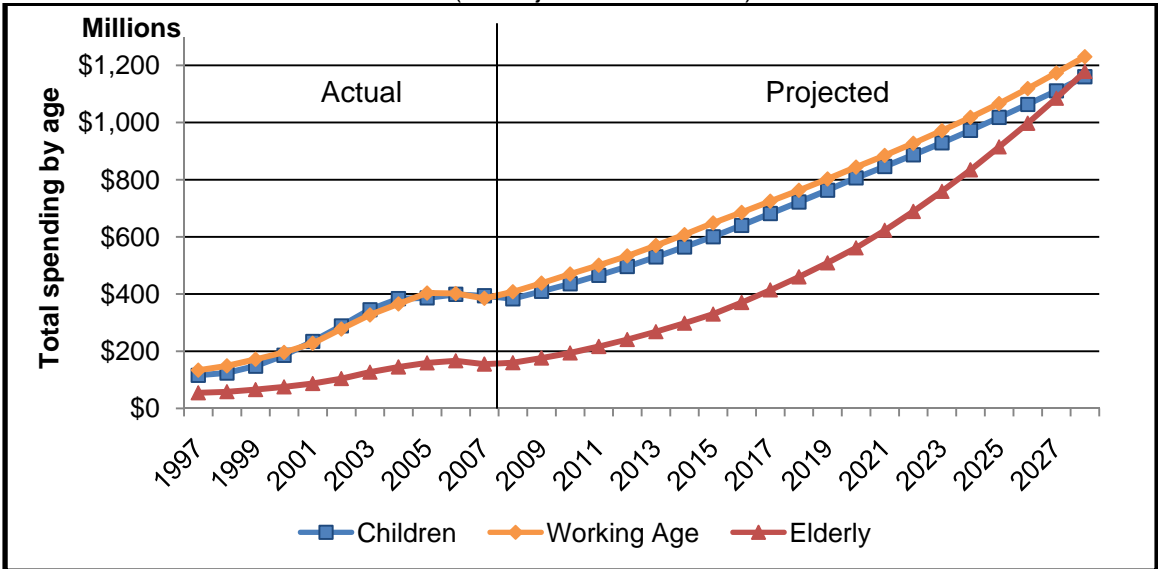
ANNUAL GROWTH IN TOTAL SPENDING BY AGE GROUP



Source: Medicaid Budget Group, MESA Model

Figure 8: By 2028, spending for each age group will converge

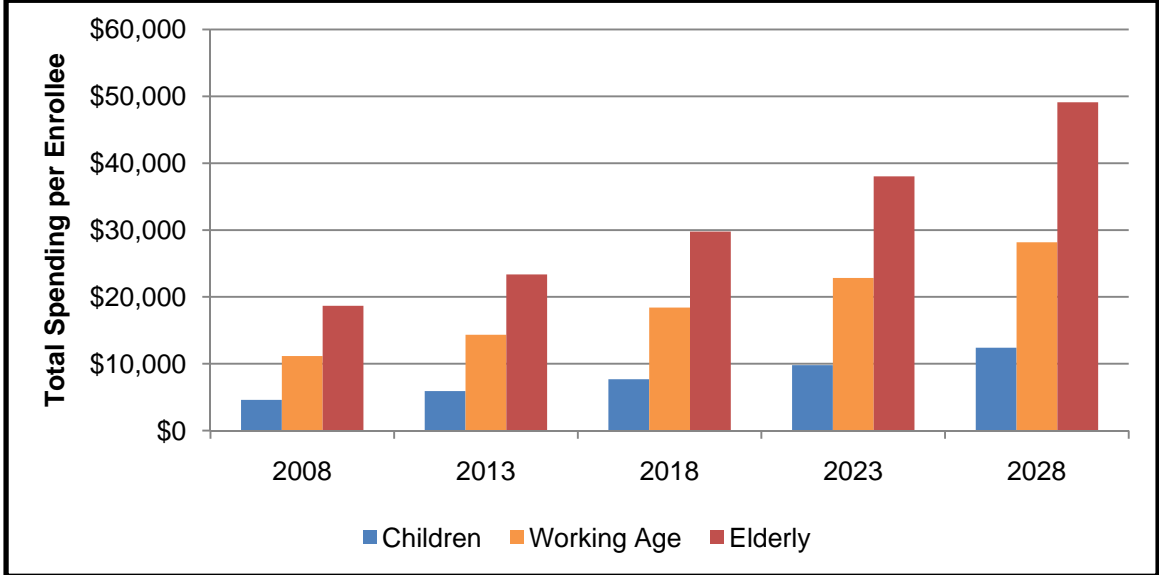
TOTAL SPENDING BY AGE GROUP (not adjusted for inflation)



Source: Medicaid Budget Group: MESA Model

Since the growth rate in enrollment for the elderly was higher than the growth rates for the other groups, it is natural to expect similar trends for spending. The growth rate in spending for the elderly is projected to be 10.5 percent, while it is projected to be only 5.7 percent for both children working-age adults. Over the forecast period, spending will grow from \$951 million in 2008 to \$3.6 billion in 2028, for an annual rate of 6.8 percent.

Figure 9: Each elderly enrollee costs about four times as much as a child
AVERAGE TOTAL SPENDING PER ENROLLEE (not adjusted for inflation)

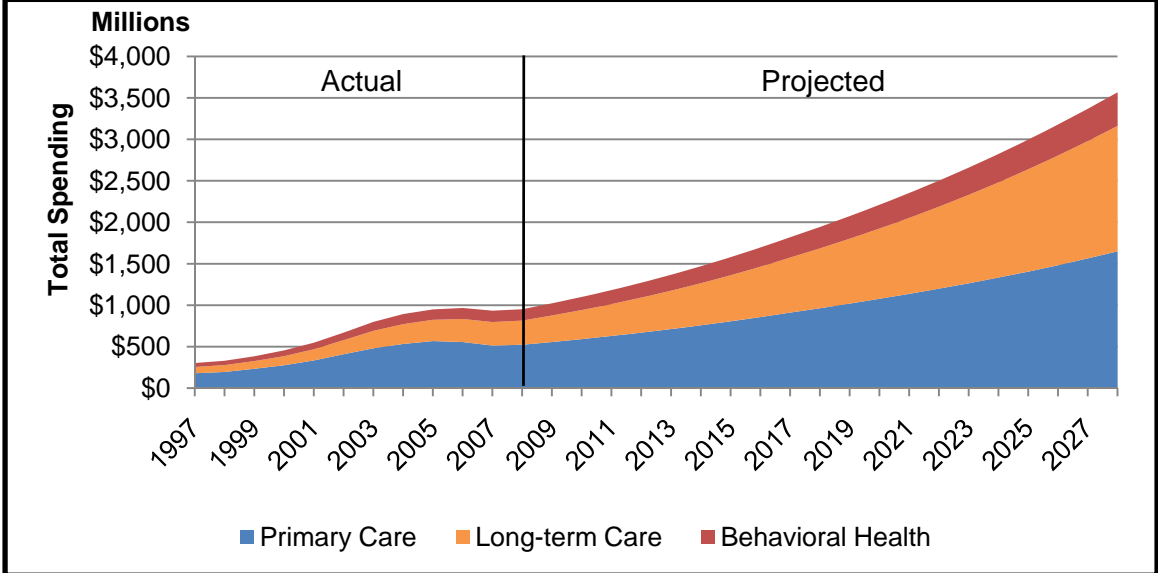


Source: Medicaid Budget Group: MESA Model

Even though the enrollment of the elderly will only account for 15 percent of total enrollment in 2028, because of the higher costs involved with caring for the elderly, their share of total spending will converge with that of children and working-age adults by the end of the forecast period; each age group will account for roughly a third of Medicaid spending.

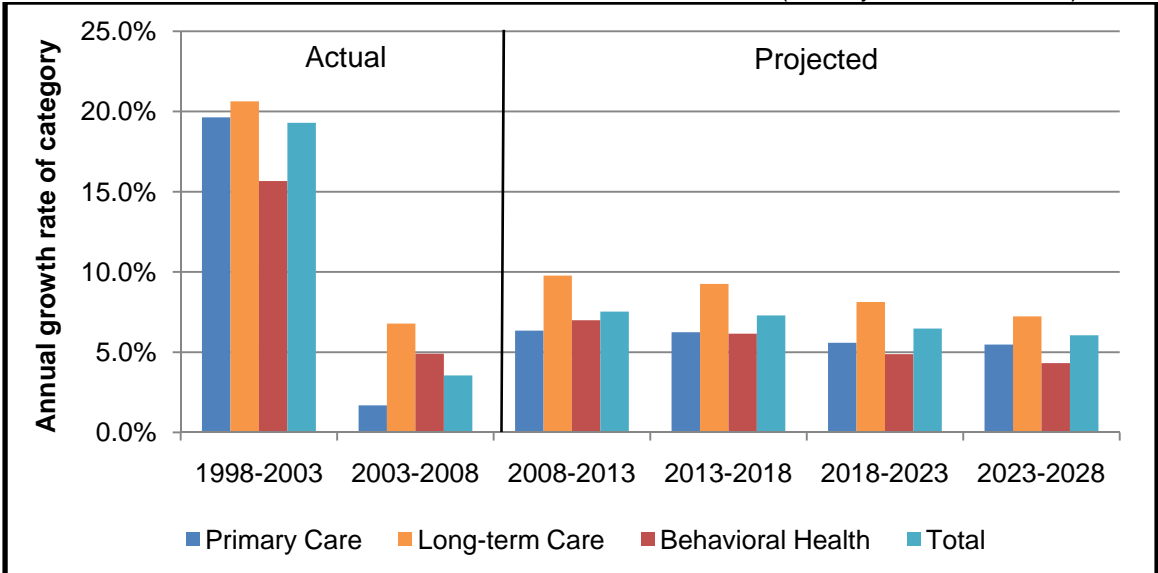
When looking at a chart of Alaska’s historical and projected Medicaid spending, the large spending increases of the late 1990’s now seem to be under control. Spending on Medicaid increased rapidly from 1998 to 2003; the growth was over 10 percent each year and averaged 18 percent annually for the period. Growth in spending has slowed in recent years and is projected to remain at the lower level throughout the forecast period, during which time growth will average 6.8 percent.

Figure 10: Total spending in 2028 will be almost four times the 2008 value
 TOTAL SPENDING BY CATEGORY GROUPING (not adjusted for inflation)



Source: Medicaid Budget Group: MESA Model

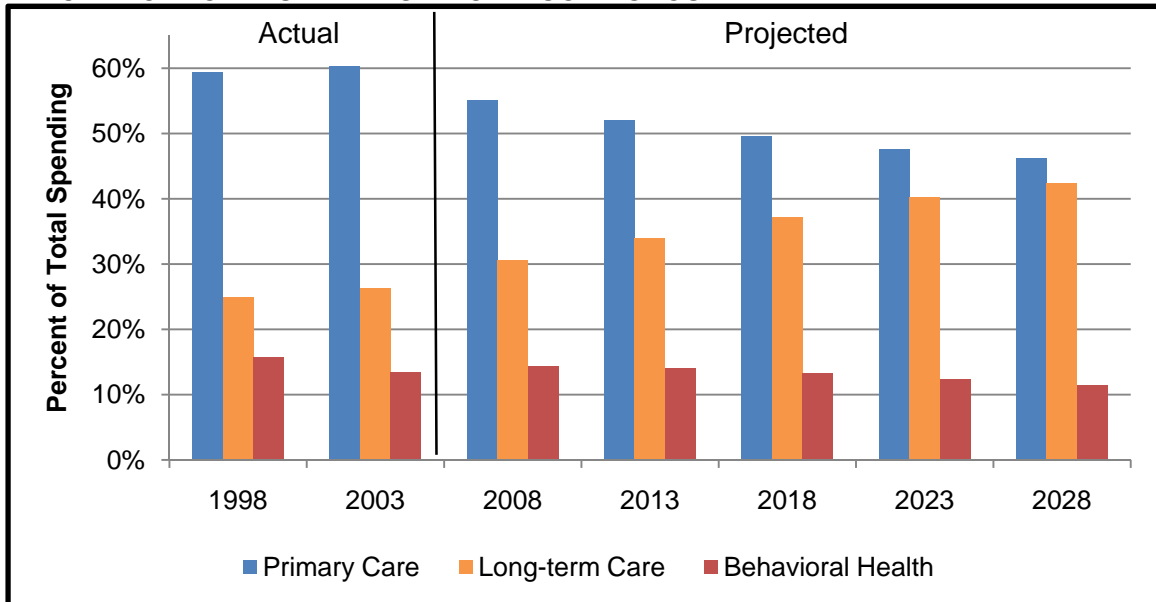
Figure 11: Growth in total spending has slowed dramatically in recent years
 ANNUAL GROWTH IN SPENDING BY CATEGORY GROUPING (not adjusted for inflation)



Source: Medicaid Budget Group: MESA Model

Figure 12: Spending on Long-term Care services will increase as a share of total spending

PERCENT OF TOTAL SPENDING BY CATEGORY GROUP



Source: Medicaid Budget Group: MESA Model

Spending on **Long-term Care** services, such as **HCB Waiver** and **Personal Care**, is projected to grow faster than spending on **Primary Care** and **Behavioral Health**. **Long-term Care**, which is expected to grow from 31 percent to 44 percent of total spending, has a larger share of recipients over the age of 65 than either **Primary Care** or **Behavioral Health**.

Table 4: Home and Community Based Waivers and Personal Care are the fastest growing service categories

MEDICAID SPENDING BY SERVICE CATEGORY FOR SELECTED YEARS (IN MILLIONS)

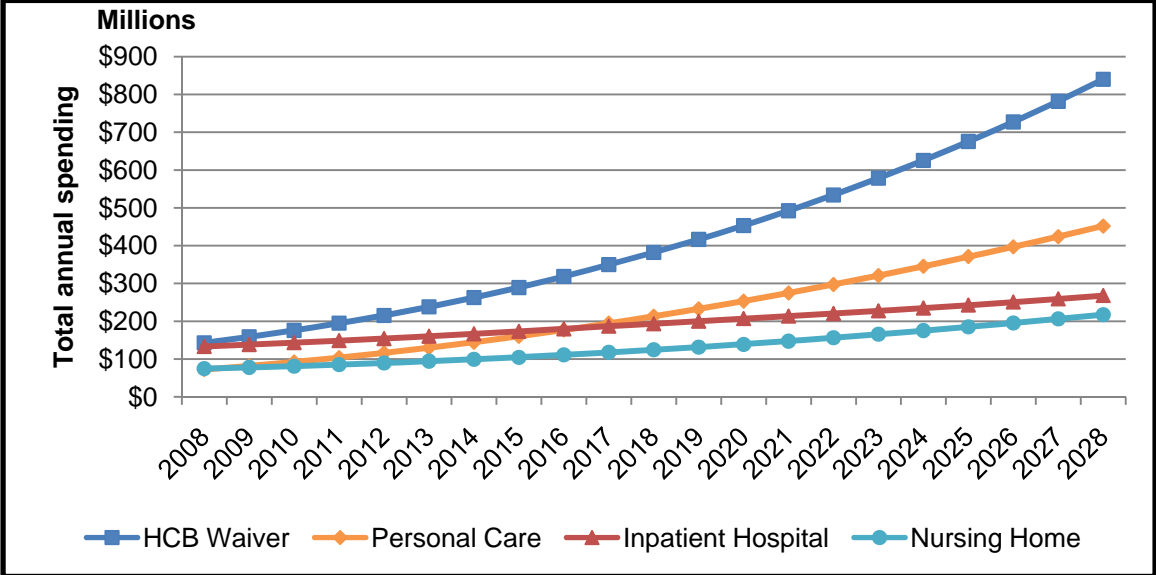
Service	2008	2013	2018	2023	2028	Annual Growth
Behavioral Health	\$136.8	\$191.8	\$258.4	\$327.9	\$405.0	5.6%
Long-Term Care	\$291.0	\$464.0	\$722.4	\$1,067.5	\$1,513.1	8.6%
Primary Care	\$523.2	\$711.7	\$963.2	\$1,239.9	\$1,650.2	5.9%
Total	\$951.0	\$1,367.4	\$1,944.0	\$2,659.4	\$3,568.3	6.8%

Source: Medicaid Budget Group, MESA model.

Total Medicaid spending will grow at an average rate of 6.8 percent through the forecast period; however, there is some variation in the growth rates of the different categories. Two categories, **Home and Community Based Waiver** and **Personal Care**, are projected to grow at over 9 percent annually. By the end of the forecast period, **HCB Waiver** will account for \$840 million or 23.5 percent of

Medicaid spending, up from the current 15.0 percent. **Personal Care** will also make large gains as its share will jump from 7.6 percent of total Medicaid spending in 2008 to \$452 million or 12.7 percent of spending in 2028. Spending in both of these programs is heavily influenced by the disabled and elderly.

Figure 13: Higher growth rates lead to dramatic changes over time
TOTAL SPENDING FOR SELECT SERVICE CATEGORIES

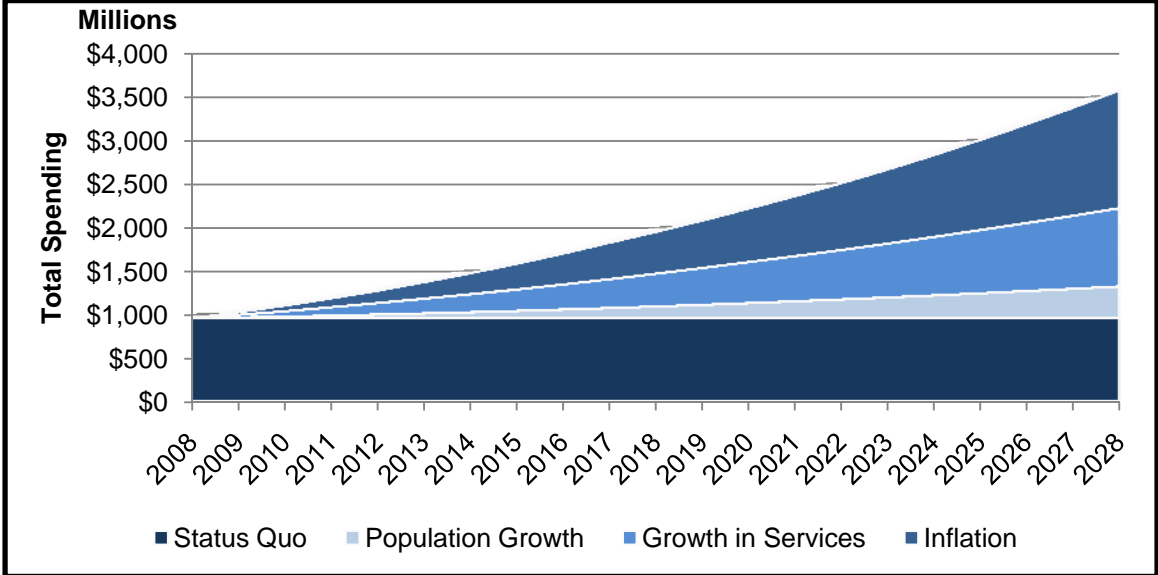


Source: Medicaid Budget Group, MESA model

Conversely, **Inpatient Hospital** is currently one of the largest categories for spending in 2008, second only to **HCB Waiver**. It is not as heavily influenced by growth in the enrollment of the elderly and will only grow by 3.6 percent during the forecast period. As a result, spending on **Inpatient Hospital** as a percent of total Medicaid spending will drop from 14.0 percent to 7.5 percent in 2028.

It is interesting to note that despite the relatively high rate of growth in the elderly population, the rate of spending growth for **Nursing Homes** will be slower than the growth in spending for Medicaid as a whole, which will cause the **Nursing Home** category to drop out of the top five spending categories (and be replaced by **Personal Care**). The data suggests that recipients may be shifting from **Nursing Homes**, where services are received in an institutional setting, to **Personal Care** and **Home and Community Based Waivers**, where care is received in one’s own home.

Figure 14: Inflation accounts for the largest part of increased spending
SPENDING DECOMPOSED INTO GROWTH COMPONENTS



Source: Medicaid Budget Group, MESA model

Figure 14 decomposes the growth in total spending into its various factors. The components of spending growth are as follows:

- *Status Quo* refers to what would happen if there were no growth in health cost inflation, no growth in population, and no growth in services provided; everything in future years remains exactly the same as in 2008.
- *Population Growth* is the additional cost on top of the status quo that we would experience because of a growth in population. Only the increase in total population is taken into account and not demographic changes such as an aging population.
- *Growth in Services* includes the additional spending from an aging population and other demographic changes, as well as the change in amount, duration, and scope of services provided from an increase of technology.
- *Inflation* is the rate at which the price of a given medical service is expected to increase over time.

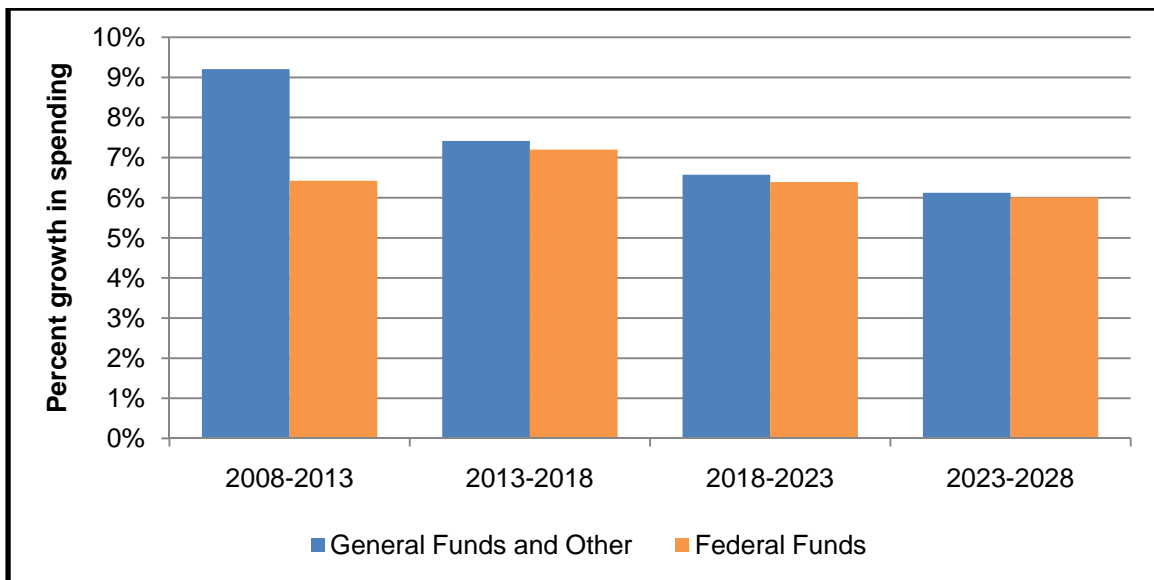
The component that will have the largest influence on total spending is inflation. Without inflation, Medicaid spending would increase from \$951 million to \$2.2 billion in 2028, for an increase of 4.3 percent annually. However, inflation increases the amount of spending in 2028 an additional \$1.4 billion for a total cost of \$3.6 billion – a combined annual increase of 6.8 percent over the forecast period.

State Spending

State spending is projected to grow at 7.3 percent annually for the forecast period, whereas federal spending will increase at 6.5 percent. The average state will experience a growth rate of 7.9 percent from 2008 to 2017, but Alaska’s total Medicaid spending is projected to grow at just 7.5 percent over the same timeframe. The federal financial participation (FFP) rates that apply to the majority of Medicaid spending level off to close to 50 percent and are expected to continue at approximately the same level throughout the forecast period. This projection is based on spending patterns of today and is not intended to consider possible changes to federal participation in the future, such as temporary changes which could occur as a result of an economic stimulus package.

Figure 15: After adjustments to FFP changes, state and federal spending growth rates are roughly equal

GROWTH RATES FOR MEDICAID BY GENERAL FUND AND OTHER AND FEDERAL FUND



Source: Medicaid Budget Group, MESA model

Table 5: State share of Medicaid funding increases throughout the forecast period

Medicaid Spending by Fund Source as a Percent of Total Spending for Selected Years, 2008-2028

Fund Source	2008	2013	2018	2023	2028
State and Other Match Funds (Percent of Total)	38.7%	41.8%	42.0%	42.2%	42.4%
Federal (Percent of Total)	61.3%	58.2%	58.0%	57.8%	57.6%

Source: Medicaid Budget Group, MESA model.

Medicaid is jointly funded by the federal and state government. Federal financial participation (FFP) rates are set at the federal level, and are largely outside of state control. The state's portion of Medicaid Service costs differs according to the recipient's Medicaid eligibility group, category of Medicaid service, provider of Medicaid-related service, and Native/Non-native status. For most Medicaid eligibility groups and services, the portion of state Medicaid benefits paid by the federal government is called the Federal Medical Assistance Percentage, or FMAP, which is 50.53 percent for Alaska in federal fiscal year 2009 and 51.43 percent for federal fiscal year 2010.

The FMAP is based on a three-year average of per capita personal income, ranked among states. While each state has its own FMAP, it can be no lower than 50 percent. Although the majority of benefits are reimbursed at the regular FMAP rate, certain subgroups have higher reimbursement rates (*e.g.*, qualified Indian Health Services claims are reimbursed 100 percent). Where possible, the state contains costs by taking advantage of higher reimbursement rates.

Alaska benefited from special legislation passed in the Deficit Reduction Act of 2005 that allowed the FMAP to remain at the FFY 2005 level of 57.58 percent for FFY 2006 and 2007. This special rate expired October 1, 2008, at which time Alaska's FMAP dropped 5.1 percentage points to 52.48 percent. At the same time the enhanced FMAP dropped from 70.31 percent to 66.74 percent. In FFY 2009 and FFY 2010 the FMAP will continue to decrease towards the minimum of 50.00% and 65.00% for enhanced FMAP. These changes contribute to the increase in state spending relative to federal and other match funds.

The tapering down of the federal financial participation rate leads to a higher growth rate in Alaska's share of Medicaid spending than the federal government's share. The state will experience growth of 7.3 percent versus 6.5 percent for the federal government. However, when we compare the year-to-year growth in spending, the growth in federal and state Medicaid spending are roughly the same except for the transition years when the FMAP is adjusting and shifting a larger share of the costs to the state.

Recently, as part of an economic stimulus package, there have been discussions about introducing temporary increases to the FMAP rates for each state. As a consequence of this, the federal government's share of Medicaid spending would increase for a couple of years, thereby giving the states more flexibility with their general fund spending. At this point, these increases to Alaska's FMAP rate are speculative and, therefore, are not a part of this report.

Summary

Total spending is forecast to reach \$3.6 billion by 2028 (see Table 10), growing at an average annual rate of 6.8 percent. State spending is expected to grow at 7.3 percent. After accounting for inflation, growth in total spending through 2028 is primarily due to the following:

- Population growth – expected to average 0.9 percent per year
- Enrollment growth – expected to average 1.1 percent per year

Embedded in the growth rate of the above components is the changing demographic profile of Alaska. The average annual growth rate of the elderly (65+ years) is expected to be 4.6 percent. This causes a shift in the overall focus of the Medicaid program from child-based to a program more evenly distributed amongst the age groups. It is important to note that despite this convergence, spending on the elderly is still growing at a rate almost double that of the Children and Working-Age Adults and it is likely to continue. The expected shift in spending towards the elderly is still likely to occur, but the timing is delayed compared to earlier forecasts.

It is important to note that services utilized more heavily by the elderly such as Personal Care and Home and Community Based Waivers will experience the highest spending growth throughout the forecast period.

The purpose of this forecast is to enable policy makers and Health and Social Services executives to see where Medicaid is headed based on key growth components. By looking farther into the future, policy can be based more on proactive rather than reactive measures.

Appendices

Appendix A: Medicaid Eligibility Classification Descriptions

Eligibility Class	Description
AFDC & Related	Eligible for AFDC-based Family Medicare or Transitional Medicaid
Alien (Foreign)	Illegal, sponsored, or amnesty alien
Exams	Disability, waiver, or pregnancy determination pending
Kids in Custody	Children in custody of DHSS
LTC Non-cash	Elderly or disabled individual not receiving SSI or cash supplement
Medicare	Eligible for Medicare cost-sharing assistance only
Other Disabled	Working disabled or eligible due to breast/cervical cancer screening
Pregnancy/Post Partum	Eligible during pregnancy and for 60 days after giving birth
SSI/APA/LTC Cash	Eligible for SSI or other state cash supplement
Title XIX Kids	Children under age 19 not eligible for coverage under M-SCHIP
Title XXI Kids	Children under age 19 eligible for coverage under M-SCHIP

Appendix B: Medicaid Service Category Descriptions

Service Group	Service Category	Description
Behavioral Health	Inpatient Psychiatric Hospital	Inpatient psychiatric hospital services
Behavioral Health	Outpatient Mental Health	Outpatient mental health services, psychology services, and drug abuse centers
Behavioral Health	Residential Psychiatric/Behavioral Rehabilitation Services	Residential psychiatric treatment centers and behavioral rehabilitation services (BRS)
Long-term Care	Home & Community Based Waiver	Home and community based long-term care services offered through Medicaid Waivers including Alaska Pioneer Homes, assisted living homes, respite care, adult day care, chore services, residential and day habilitation, nutrition, and meals.
Long-term Care	Home Health/Hospice	Home health services, hospice care, nutrition services, and private duty nursing
Long-term Care	Nursing Home	Skilled nursing and intermediate care facilities including intermediate-care facilities for the mentally retarded; and temporary long-term care services
Long-term Care	Personal Care	Personal care attendant services including agency-based and consumer-directed programs
Primary Care	Dental	Dental services for children and adults
Primary Care	Durable Medical Equipment/Supplies	Durable medical equipment (DME), medical supplies, prosthetics, and orthotics
Primary Care	Early & Periodic Screening, Diagnosis & Testing	Early, periodic screening, diagnosis and treatment (EPSDT) including preventive health checkups, health screenings and immunizations
Primary Care	Health Clinic	Health clinic services including rural health clinics, federally-qualified health clinics and tribal health clinics
Primary Care	Inpatient Hospital	Inpatient hospital services
Primary Care	Laboratory/X-Ray	Laboratory, x-ray and diagnostic services
Primary Care	Other Services	Other services not classified elsewhere
Primary Care	Outpatient Hospital	Outpatient hospital services, outpatient surgery services, and end-stage renal disease services
Primary Care	Pharmacy	Prescription drugs
Primary Care	Physician/Practitioner Services	Physician, podiatrist, advanced nurse practitioner, and midwifery services
Primary Care	Therapy/Rehabilitation	Outpatient rehabilitation, physical therapy, occupational therapy, speech therapy, audiology, and chiropractic services
Primary Care	Transportation	Emergency and non-emergency medically necessary transportation and accommodation
Primary Care	Vision	Optometrist services and eyeglasses

Appendix C: Detailed Tables of 2008-2028 MESA Forecast

Table 6: Forecast of Enrollment by Subpopulations						
	Calendar Year					Annual %
	2008	2013	2018	2023	2028	Change
State	128,441	140,846	150,750	157,495	161,215	1.1%
Gender						
Male	58,589	63,627	68,069	70,925	72,256	1.1%
Female	69,853	77,219	82,680	86,570	88,959	1.2%
Native Status						
Native	46,720	50,756	54,261	56,818	58,570	1.1%
Non-Native	81,722	90,090	96,489	100,678	102,645	1.1%
Region						
Northern	17,702	19,654	20,901	21,582	21,879	1.1%
Western	18,710	20,456	21,897	22,992	23,857	1.2%
South Central	18,114	19,527	20,451	20,843	20,622	0.7%
Anchorage/Mat-Su	61,303	68,086	74,305	79,169	82,482	1.5%
Southeast	12,612	13,123	13,195	12,910	12,374	-0.1%
Age Group						
0-4	28,501	31,338	33,047	33,112	32,248	0.6%
5-9	20,346	22,360	23,515	23,924	23,499	0.7%
10-14	17,847	19,344	20,308	20,733	20,638	0.7%
15-19	16,624	16,609	16,984	17,225	17,156	0.2%
20-24	6,858	7,454	7,277	7,559	8,030	0.8%
25-34	10,445	12,283	13,877	14,156	14,165	1.5%
35-44	7,881	7,839	8,306	9,427	10,453	1.4%
45-54	6,818	6,551	6,043	5,830	6,074	-0.6%
55-64	4,566	5,593	5,949	5,568	4,961	0.4%
65-74	4,347	6,320	8,776	10,627	11,101	4.8%
75+	4,209	5,156	6,669	9,335	12,889	5.8%

Eligibility Group	2008	2013	2018	2023	2028	Annual % Change
AFDC & Related	37,254	40,194	42,275	43,536	44,238	0.9%
Exams	849	952	1,055	1,174	1,300	2.2%
Kids in Custody	3,659	3,908	4,100	4,187	4,175	0.7%
LTC Non-cash	1,828	2,192	2,620	3,129	3,651	3.5%
Medicare	405	447	473	485	489	1.0%
Other	6	7	8	10	12	3.7%
Other Disabled	220	287	365	438	487	4.0%
Pregnancy/Post Partum	14,330	15,371	16,025	16,235	16,033	0.6%
SSI/APA/LTC Cash	19,960	23,638	27,525	31,163	33,997	2.7%
Title XIX Kids	43,816	47,142	49,236	49,819	49,285	0.6%
Title XXI Kids	6,114	6,709	7,068	7,317	7,547	1.1%
Total (Unduplicated Count)	128,441	140,846	150,750	157,495	161,215	1.1%

	Calendar Year					Annual % Change
	2008	2013	2018	2023	2028	
State	502,261	599,667	686,381	754,767	801,308	2.4%
Gender						
Male	206,706	248,247	285,432	313,980	332,226	2.4%
Female	295,555	351,420	400,949	440,786	469,082	2.3%
Native Status						
Native	157,235	186,716	213,204	234,096	249,226	2.3%
Non-Native	345,026	412,951	473,177	520,671	552,081	2.4%
Region						
Northern	62,534	75,866	86,700	94,654	99,866	2.4%
Western	68,726	82,098	94,032	103,784	111,499	2.4%
South Central	64,935	76,245	85,529	91,974	94,712	1.9%
Anchorage/Mat-Su	260,805	314,135	364,835	407,336	438,435	2.6%
Southeast	45,261	51,323	55,285	57,019	56,795	1.1%
Age Group						
0-4	93,668	110,719	123,450	130,083	133,267	1.8%
5-9	76,260	91,159	102,264	109,056	110,715	1.9%
10-14	68,553	80,708	90,407	96,833	99,638	1.9%
15-19	58,387	63,188	68,691	72,974	75,091	1.3%
20-24	26,681	31,047	31,915	34,419	37,541	1.7%
25-34	42,506	53,701	64,026	67,883	69,723	2.5%
35-44	35,061	37,484	41,929	49,430	56,182	2.4%
45-54	27,612	28,433	27,628	27,644	29,469	0.3%
55-64	26,108	34,385	38,406	37,098	33,712	1.3%
65-74	26,418	41,346	60,492	75,803	80,685	5.7%
75+	21,009	27,497	37,172	53,544	75,285	6.6%

Table 9: Forecast of **Utilization** by Service Category

Service	Calendar Year					Annual % Change
	2008	2013	2018	2023	2028	
Dental	40,516	50,325	59,775	68,550	76,743	3.2%
DME/Supplies	10,148	12,599	15,422	18,549	21,795	3.9%
EPSDT	143	103	73	50	35	-6.8%
HCB Waiver	4,009	5,858	8,054	10,468	12,841	6.0%
Health Clinic	29,956	43,132	57,288	71,488	85,216	5.4%
Home Health/Hospice	680	759	846	932	1,009	2.0%
Inpatient Hospital	15,244	16,016	16,653	17,184	17,612	0.7%
Inpatient Psychiatric	763	848	933	1,014	1,095	1.8%
Lab/X-ray	13,634	13,822	13,897	13,908	13,859	0.1%
Nursing Home	1,154	1,249	1,380	1,547	1,698	2.0%
Other Services	343	326	306	287	268	-1.2%
Outpatient Hospital	58,498	69,191	80,078	90,981	101,885	2.8%
Outpatient Mental Health	11,403	12,686	14,020	15,391	16,797	2.0%
Personal Care	3,369	5,148	7,074	8,973	10,589	5.9%
Pharmacy	65,021	75,844	86,838	97,845	108,841	2.6%
Physician/Practitioner	86,298	100,414	114,335	127,961	141,453	2.5%
Residential Psychiatric/BRC	1,026	1,359	1,593	1,709	1,730	2.6%
Therapy/Rehabilitation	8,343	11,385	14,733	18,192	21,574	4.9%
Transportation	23,658	29,087	34,849	40,846	47,002	3.5%
Vision	21,856	29,713	38,168	46,799	55,245	4.7%

Table 10: Forecast of Total Nominal Spending by Subpopulations (in millions)						
	Calendar Year					Annual % Change
	2008	2013	2018	2023	2028	
State	\$951.0	\$1,367.4	\$1,944.0	\$2,659.4	\$3,568.3	6.8%
Gender						
Male	\$416.0	\$601.6	\$858.9	\$1,175.4	\$1,572.1	6.9%
Female	\$535.0	\$765.8	\$1,085.1	\$1,484.0	\$1,996.2	6.8%
Native Status						
Native	\$334.7	\$478.7	\$679.1	\$927.7	\$1,248.0	6.8%
Non-Native	\$616.3	\$888.6	\$1,264.9	\$1,731.7	\$2,320.3	6.9%
Region						
Northern	\$107.3	\$157.2	\$223.6	\$304.4	\$406.8	6.9%
Western	\$110.2	\$158.8	\$226.4	\$311.6	\$424.1	7.0%
South Central	\$138.0	\$195.6	\$273.1	\$366.2	\$477.8	6.4%
Anchorage/Mat-Su	\$480.5	\$698.5	\$1,009.8	\$1,405.8	\$1,917.1	7.2%
Southeast	\$115.0	\$157.3	\$211.0	\$271.3	\$342.4	5.6%
Age Group						
0-4	\$126.7	\$179.5	\$245.8	\$314.0	\$391.7	5.8%
5-9	\$55.3	\$79.2	\$109.1	\$141.0	\$174.3	5.9%
10-14	\$83.5	\$117.8	\$162.1	\$210.4	\$263.6	5.9%
15-19	\$118.1	\$153.3	\$204.7	\$263.5	\$330.2	5.3%
20-24	\$57.3	\$79.9	\$100.9	\$131.9	\$175.2	5.7%
25-34	\$86.4	\$130.8	\$191.5	\$246.2	\$307.9	6.6%
35-44	\$80.7	\$103.4	\$142.1	\$203.1	\$281.1	6.4%
45-54	\$99.8	\$123.3	\$147.1	\$178.4	\$231.6	4.3%
55-64	\$83.6	\$132.0	\$181.1	\$212.0	\$234.6	5.3%
65-74	\$57.0	\$107.0	\$192.2	\$291.9	\$378.3	9.9%
75+	\$102.7	\$161.2	\$267.5	\$467.1	\$799.8	10.8%

Values not adjusted for inflation

Table 11: Forecast of Total **Nominal Spending** by Service Category (in millions)

Service	Calendar Year					Annual % Change
	2008	2013	2018	2023	2028	
Dental	\$25.9	\$37.6	\$53.2	\$71.8	\$95.4	6.7%
DME/Supplies	\$16.1	\$22.9	\$32.7	\$45.6	\$63.1	7.1%
EPSDT	\$0.013	\$0.011	\$0.009	\$0.007	\$0.006	-3.8%
HCB Waiver	\$142.9	\$238.2	\$382.1	\$578.4	\$840.1	9.3%
Health Clinic	\$35.5	\$58.0	\$89.0	\$127.2	\$176.2	8.3%
Home Health/Hospice	\$1.3	\$1.7	\$2.3	\$3.1	\$4.1	6.0%
Inpatient Hospital	\$133.2	\$160.3	\$193.3	\$227.4	\$267.9	3.6%
Inpatient Psychiatric	\$16.9	\$22.0	\$28.9	\$36.9	\$47.0	5.2%
Lab/X-ray	\$1.6	\$1.9	\$2.3	\$2.7	\$3.2	3.5%
Nursing Home	\$74.6	\$94.2	\$124.4	\$165.4	\$217.1	5.5%
Other Services	\$0.1	\$0.2	\$0.2	\$0.2	\$0.2	2.2%
Outpatient Hospital	\$84.7	\$116.4	\$158.7	\$209.3	\$275.2	6.1%
Outpatient Mental Health	\$60.5	\$77.8	\$101.2	\$129.0	\$164.0	5.1%
Personal Care	\$72.3	\$130.0	\$213.6	\$320.6	\$451.7	9.6%
Pharmacy	\$71.4	\$97.0	\$131.2	\$173.0	\$227.7	6.0%
Physician/Practitioner	\$83.4	\$112.9	\$151.7	\$198.0	\$258.3	5.8%
Residential Psychiatric/BRC	\$59.4	\$92.0	\$128.3	\$162.1	\$194.0	6.1%
Therapy/Rehabilitation	\$23.3	\$35.6	\$53.3	\$75.5	\$103.6	7.8%
Transportation	\$44.5	\$63.4	\$89.4	\$121.5	\$163.4	6.7%
Vision	\$3.3	\$5.3	\$8.1	\$11.6	\$16.1	8.2%
Total Spending	\$951.0	\$1,367.4	\$1,944.0	\$2,659.4	\$3,568.3	6.8%

Values not adjusted for inflation

Table 12: Forecast of Total Real Spending by Subpopulations (in millions of 2008 dollars)						
	Calendar Year					Annual % Change
	2008	2013	2018	2023	2028	
State	\$951.0	\$1,140.4	\$1,306.8	\$1,436.8	\$1,518.9	2.4%
Gender						
Male	\$416.0	\$501.7	\$577.4	\$635.0	\$669.2	2.4%
Female	\$535.0	\$638.7	\$729.4	\$801.7	\$849.7	2.3%
Native Status						
Native	\$334.7	\$399.3	\$456.5	\$501.2	\$531.2	2.3%
Non-Native	\$616.3	\$741.1	\$850.3	\$935.6	\$987.6	2.4%
Region						
Northern	\$107.3	\$131.1	\$150.3	\$164.4	\$173.2	2.4%
Western	\$110.2	\$132.4	\$152.2	\$168.4	\$180.5	2.5%
South Central	\$138.0	\$163.1	\$183.6	\$197.9	\$203.4	2.0%
Anchorage/Mat-Su	\$480.5	\$582.5	\$678.9	\$759.5	\$816.0	2.7%
Southeast	\$115.0	\$131.2	\$141.8	\$146.6	\$145.8	1.2%
Age Group						
0-4	\$126.7	\$149.7	\$165.2	\$169.6	\$166.7	1.4%
5-9	\$55.3	\$66.0	\$73.3	\$76.2	\$74.2	1.5%
10-14	\$83.5	\$98.2	\$108.9	\$113.7	\$112.2	1.5%
15-19	\$118.1	\$127.9	\$137.6	\$142.4	\$140.6	0.9%
20-24	\$57.3	\$66.6	\$67.8	\$71.2	\$74.6	1.3%
25-34	\$86.4	\$109.1	\$128.8	\$133.0	\$131.1	2.1%
35-44	\$80.7	\$86.3	\$95.5	\$109.7	\$119.6	2.0%
45-54	\$99.8	\$102.8	\$98.9	\$96.4	\$98.6	-0.1%
55-64	\$83.6	\$110.1	\$121.7	\$114.5	\$99.9	0.9%
65-74	\$57.0	\$89.2	\$129.2	\$157.7	\$161.0	5.3%
75+	\$102.7	\$134.4	\$179.8	\$252.4	\$340.4	6.2%

Service	Calendar Year					Annual % Change
	2008	2013	2018	2023	2028	
Dental	\$25.9	\$31.3	\$35.8	\$38.8	\$40.6	2.3%
DME/Supplies	\$16.1	\$19.1	\$22.0	\$24.6	\$26.9	2.6%
EPSDT	\$0.013	\$0.009	\$0.006	\$0.004	\$0.003	-7.8%
HCW Waiver	\$142.9	\$198.6	\$256.9	\$312.5	\$357.6	4.7%
Health Clinic	\$35.5	\$48.4	\$59.9	\$68.7	\$75.0	3.8%
Home Health/Hospice	\$1.3	\$1.4	\$1.5	\$1.7	\$1.8	1.6%
Inpatient Hospital	\$133.2	\$133.7	\$130.0	\$122.9	\$114.0	-0.8%
Inpatient Psychiatric	\$16.9	\$18.4	\$19.4	\$19.9	\$20.0	0.8%
Lab/X-ray	\$1.6	\$1.6	\$1.5	\$1.4	\$1.3	-0.9%
Nursing Home	\$74.6	\$78.5	\$83.6	\$89.4	\$92.4	1.1%
Other Services	\$0.1	\$0.1	\$0.1	\$0.1	\$0.1	-2.1%
Outpatient Hospital	\$84.7	\$97.1	\$106.7	\$113.1	\$117.1	1.6%
Outpatient Mental Health	\$60.5	\$64.9	\$68.1	\$69.7	\$69.8	0.7%
Personal Care	\$72.3	\$108.4	\$143.6	\$173.2	\$192.3	5.0%
Pharmacy	\$71.4	\$80.9	\$88.2	\$93.5	\$96.9	1.5%
Physician/Practitioner	\$83.4	\$94.1	\$102.0	\$107.0	\$109.9	1.4%
Residential Psychiatric/BRC	\$59.4	\$76.7	\$86.3	\$87.6	\$82.6	1.7%
Therapy/Rehabilitation	\$23.3	\$29.7	\$35.9	\$40.8	\$44.1	3.2%
Transportation	\$44.5	\$52.9	\$60.1	\$65.7	\$69.6	2.3%
Vision	\$3.3	\$4.4	\$5.4	\$6.2	\$6.8	3.7%
Total Spending	\$951.0	\$1,140.4	\$1,306.8	\$1,436.8	\$1,518.9	2.4%

Service	Calendar Year					Annual % Change
	2008	2013	2018	2023	2028	
Dental	\$8.9	\$13.9	\$19.6	\$26.5	\$35.2	7.1%
DME/Supplies	\$7.4	\$11.3	\$16.2	\$22.5	\$31.2	7.4%
EPSDT	\$0.006	\$0.005	\$0.004	\$0.004	\$0.003	-3.5%
HCW Waiver	\$64.1	\$114.7	\$184.1	\$278.6	\$404.6	9.7%
Health Clinic	\$3.0	\$5.2	\$8.0	\$11.4	\$15.9	8.7%
Home Health/Hospice	\$0.5	\$0.7	\$1.0	\$1.3	\$1.7	6.4%
Inpatient Hospital	\$44.3	\$57.2	\$69.0	\$81.2	\$95.6	3.9%
Inpatient Psychiatric	\$7.6	\$10.7	\$14.0	\$17.9	\$22.8	5.6%
Lab/X-ray	\$0.7	\$0.9	\$1.1	\$1.3	\$1.6	3.8%
Nursing Home	\$32.7	\$44.3	\$58.5	\$77.8	\$102.2	5.9%
Other Services	\$0.1	\$0.2	\$0.2	\$0.2	\$0.2	2.2%
Outpatient Hospital	\$24.5	\$36.2	\$49.3	\$65.1	\$85.5	6.4%
Outpatient Mental Health	\$24.7	\$34.1	\$44.4	\$56.6	\$71.9	5.5%
Personal Care	\$33.3	\$64.3	\$105.7	\$158.7	\$223.6	10.0%
Pharmacy	\$27.5	\$40.1	\$54.3	\$71.6	\$94.2	6.4%
Physician/Practitioner	\$33.3	\$48.3	\$65.0	\$84.8	\$110.6	6.2%
Residential Psychiatric/BRC	\$26.8	\$44.6	\$62.2	\$78.6	\$94.1	6.5%
Therapy/Rehabilitation	\$9.7	\$15.9	\$23.8	\$33.7	\$46.3	8.1%
Transportation	\$17.0	\$25.9	\$36.6	\$49.7	\$66.8	7.1%
Vision	\$1.5	\$2.5	\$3.9	\$5.5	\$7.7	8.6%
Total Spending	\$367.7	\$571.2	\$816.8	\$1,123.0	\$1,511.7	7.3%

Values not adjusted for inflation

Table 15: Historical Enrollment by Demographic Group

Year	Non-Native		Female	Male	Children	Working Age		Elderly	Total
	Native								
1997	59,555	30,309	51,981	37,883	52,940	31,196	5,728	89,864	
1998	57,939	30,555	50,828	37,666	51,959	30,676	5,859	88,494	
1999	62,872	32,818	54,301	41,389	58,207	31,391	6,092	95,690	
2000	72,728	37,351	61,789	48,290	71,522	32,082	6,475	110,079	
2001	76,626	39,507	64,535	51,598	77,403	31,995	6,735	116,133	
2002	80,468	41,008	67,130	54,346	81,590	32,903	6,983	121,476	
2003	83,945	42,606	69,755	56,796	85,097	34,080	7,374	126,551	
2004	84,824	44,592	71,230	58,186	86,936	34,904	7,576	129,416	
2005	85,402	46,564	72,710	59,256	87,454	36,601	7,911	131,966	
2006	85,232	47,691	73,187	59,736	87,206	37,419	8,298	132,923	
2007	81,047	47,027	70,579	57,495	83,929	35,829	8,316	128,074	

Table 16: Historical Spending by Demographic Group (in millions)

Year	Non-Native		Female	Male	Children	Working Age		Elderly	Total
	Native								
1997	\$238.9	\$65.0	\$172.0	\$131.9	\$115.8	\$133.6	\$54.4	\$303.9	
1998	\$248.7	\$81.8	\$188.4	\$142.1	\$123.8	\$148.6	\$58.1	\$330.5	
1999	\$280.5	\$104.5	\$221.9	\$163.0	\$147.8	\$171.6	\$65.6	\$384.9	
2000	\$326.9	\$129.9	260.5	\$196.2	\$186.6	\$196.1	\$75.5	\$456.7	
2001	\$383.4	\$165.6	\$310.6	\$238.6	\$234.7	\$227.5	\$86.9	\$549.1	
2002	\$455.7	\$214.4	\$384.1	\$286.1	\$288.7	\$277.5	\$103.9	\$670.2	
2003	\$533.5	\$265.0	\$458.5	\$340.2	\$345.3	\$326.8	\$126.5	\$798.6	
2004	\$589.6	\$304.1	\$506.3	\$387.4	\$383.6	\$365.4	\$144.7	\$883.7	
2005	\$654.8	\$294.5	\$539.6	\$409.6	\$386.6	\$403.5	\$159.1	\$949.2	
2006	\$647.1	\$320.0	\$550.3	\$416.8	\$398.8	\$401.9	\$166.4	\$967.1	
2007	\$618.3	\$315.0	\$526.9	\$406.5	\$393.8	\$384.8	\$154.8	\$933.4	

Values not adjusted for inflation

Table 17: Historical Spending by Service Category Group (in millions)

Year	Behavioral Health	Long-Term Care	Primary Care	Total
1997	\$48.3	\$76.3	\$179.2	\$303.9
1998	\$52.0	\$82.1	\$196.4	\$330.5
1999	\$57.6	\$93.6	\$233.8	\$384.9
2000	\$69.7	\$110.2	\$276.8	\$456.7
2001	\$80.3	\$135.4	\$333.4	\$549.1
2002	\$90.8	\$169.7	\$409.6	\$670.2
2003	\$107.7	\$209.7	\$481.3	\$798.6
2004	\$121.3	\$239.1	\$533.3	\$893.7
2005	\$124.6	\$257.3	\$567.3	\$949.2
2006	\$132.9	\$278.7	\$555.5	\$967.1
2007	\$136.6	\$283.0	\$513.7	\$933.4

Values not adjusted for inflation

**Long-term Forecast of
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and
Spending in Alaska:
*Supplement 2008–2028***

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