



Medicaid in Alaska Under the ACA

Using the three years of Alaskans in the American Community Survey integrated with the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), we estimated Medicaid/CHIP enrollment and costs under the ACA with and without an expansion of eligibility to 138 percent of the FPL. Comparing the two options—

- **Medicaid enrollment.** In 2020, 172,900 nonelderly Alaskans would be enrolled in Medicaid with the expansion and 133,500 without it, a 30 percent increase.
- **State costs.** In 2020—the first year in which the state would pay 10 percent of the costs of those made eligible by the Medicaid expansion—the state would spend \$25 million more with the expansion than without it. Due to the low state contribution for the newly-eligible, this 3.7 percent increase in spending on the nonelderly is sufficient to support the 30 percent increase in enrollment.
- **Federal and state spending.** From 2014 to 2020, there would be \$1.1 billion more federal spending and \$78 million more state spending on Medicaid in Alaska with the expansion than without it. These represent increases in Medicaid spending for the nonelderly of 18.5 percent and 1.9 percent respectively.
- **The uninsured.** The ACA would reduce the uninsured rate in Alaska from 21% without the ACA to 10% under the ACA if the state participates in the Medicaid expansion, or 15% under the ACA without the expansion.
- The report also includes a sensitivity analysis of Medicaid take-up rates, detailed characteristics of ACA Medicaid enrollees and their geographic distribution among five sub-state areas.
- This report does not estimate offsetting savings to the state from sources such as reduced uncompensated care provided to the uninsured.

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Health Insurance Policy
Simulation Model

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Introduction

The Patient Protection and Affordable Care Act (ACA) became law on March 2010. One of the most important provisions in the law was an expansion of Medicaid eligibility to all Americans below a specified income threshold.¹ This is a major change from how eligibility is currently determined in Alaska. All states participating in Medicaid must offer eligibility to four groups: those eligible for the SSI program, pregnant women and children under 6 up to 133 percent of the federal poverty level (FPL), low-income children up to 100 percent of the FPL, and parents and 18-year-olds with incomes below the state's welfare standards. The Children's Health Insurance Program (CHIP) allowed states to expand eligibility for child coverage to higher incomes. In Alaska, the eligibility threshold for children and for pregnant women is 175 percent of the FPL.² The threshold is 81 percent of the FPL for working parents and 77 percent of the FPL for jobless parents. There is no income-based eligibility threshold for adults who are not parents; they can currently gain eligibility only by qualifying for special programs, such as those with disabilities. Thus, the ACA Medicaid expansion will extend eligibility to parents between 77 or 81 percent of the FPL and 138 percent and will create a new type of eligibility for nonparent adults up to 138 percent of the FPL. The eligibility of children and pregnant women would be largely unaffected.

Medicaid is funded jointly by the state and federal governments. In Alaska, the federal government and the state each pay half of Medicaid claims. There are two important exceptions to this 50/50 split. Services provided by tribal health organizations to Alaska Natives or American Indians (AN/AIs) enrolled in Medicaid are reimbursed entirely by the federal government. The federal government also pays 65 percent of the costs of children enrolled in CHIP. To reduce the burden on state budgets, the ACA substantially raised the federal share of the costs of those made newly eligible for Medicaid by the expansion. Their costs will be paid entirely by the federal government from 2014 through 2016. The federal share will gradually lower beginning in 2017 until it reaches 90 percent in 2020. It remains at 90 percent for all subsequent years.

On June 28, 2012, the Supreme Court upheld the ACA against several legal challenges.³ In doing so, however, the Court ruled that states could opt out the expansion of eligibility without losing federal funding for the populations traditionally covered.⁴

This report models Medicaid coverage and costs in Alaska under each of the Medicaid expansion alternatives now open to the state:⁵

¹ Undocumented immigrants and legal immigrants resident less than five years would not be eligible.

² Current eligibility is based on an income definition somewhat different from MAGI defined by the ACA, and includes certain disregards. Pre- and post-ACA thresholds are not exactly comparable, but this section is a general introduction.

³ *NFIB v. Sebelius*, 567 U.S. ____ (2012); No. 11–393. Argued March 26, 27, 28, 2012—Decided June 28, 2012, <http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf>.

⁴ Ricardo Alonso-Zaldivar, Supreme Court Upholds Affordable Care Act—Health Care Law: 5-4 decision finds insurance overhaul, mandate mostly legal, *The News Tribune / Tacoma, WA*, June 29, 2012, <http://www.thenewstribune.com/2012/06/29/v-printerfriendly/2198749/ruling-constitutional-supreme.html>



1. Alaska could expand Medicaid eligibility to those with family modified adjusted gross income (MAGI) up to 138 percent of the federal poverty level (FPL).
2. Alaska could choose not to expand Medicaid eligibility beyond current levels. This is the alternative explicitly allowed by the Supreme Court decision.

We estimate the effects of each option over the period from 2014 to 2020 for:

- Enrollment of nonelderly adults in Medicaid;
- Enrollment of children in Medicaid or CHIP;
- New enrollment of AN/AIs in Medicaid or CHIP;
- Total Medicaid/CHIP costs for acute care to the nonelderly;
- The state and federal shares of that total cost, taking into account the higher federal match rate for new eligibles and 100 percent federal reimbursement for services provided by tribal health organizations to AN/AIs; and
- The state share of administrative costs.

Next, we conducted a sensitivity analysis of Medicaid take-up assumptions, modeling low, medium, and high scenarios for take-up of coverage and showing how enrollment is affected. Finally, we give a detailed summary of the characteristics of those who would enroll in Medicaid under the ACA and those who would remain uninsured. These estimates are then broken out into five sub-state regions within Alaska.

The Effect of the ACA on Health Coverage in Alaska

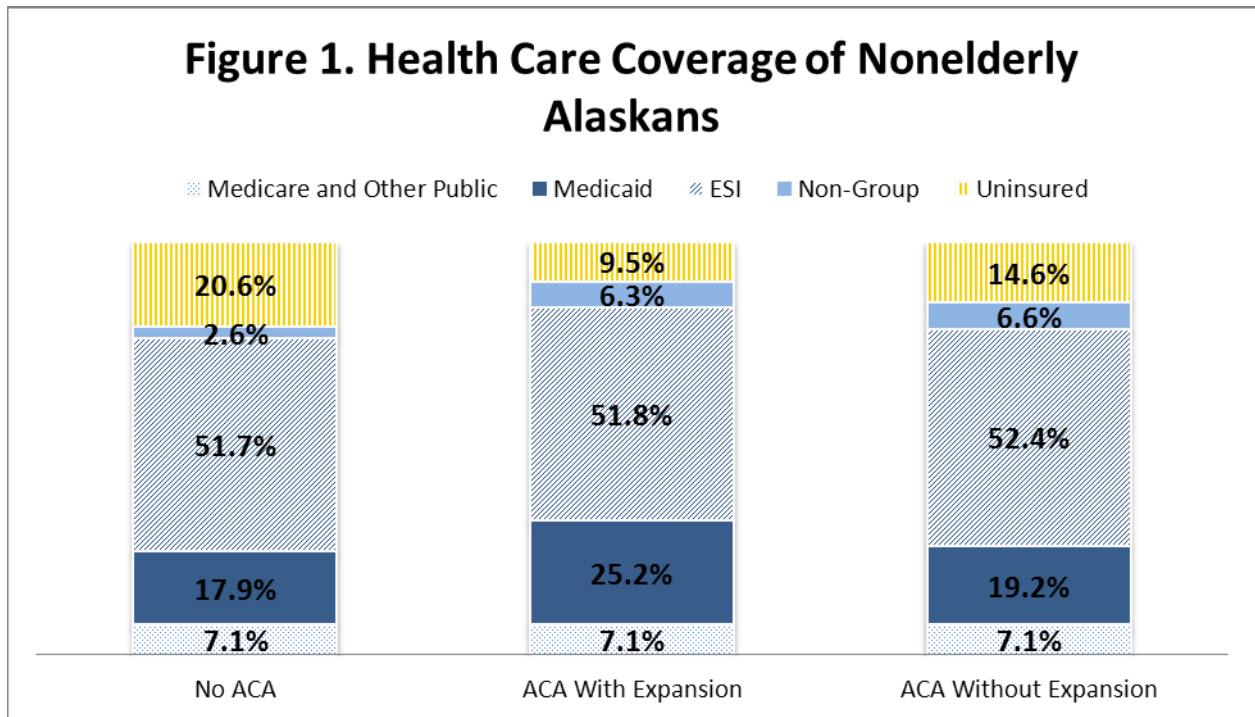
Before considering the Medicaid expansion in detail, we place it in the context of the ACA as a whole. Using the Health Insurance Policy Simulation Model (HIPSM), we forecast that the ACA will dramatically increase health insurance coverage in Alaska. Currently, about 133,000 Alaskans are uninsured, almost 21 percent of the nonelderly population (Figure 1, Column 1). About 52 percent have coverage through an employer (employer-sponsored insurance, or ESI) and about 18 percent have Medicaid. Smaller numbers have private coverage through the nongroup market or some form of public coverage other than Medicaid, such as Medicare or Tricare.

⁵ The state could apply to HHS for permission to expand to a threshold below 138 percent, but it would forgo the higher federal match rate for those made newly eligible. An expansion up to 100 percent of the FPL, for example, would result in notably lower coverage and higher state costs than the ACA expansion. We do not consider that option here. CMS, "FAQ on Exchanges, Market Reforms and Medicaid," 10 December 2012. <http://cciio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf>

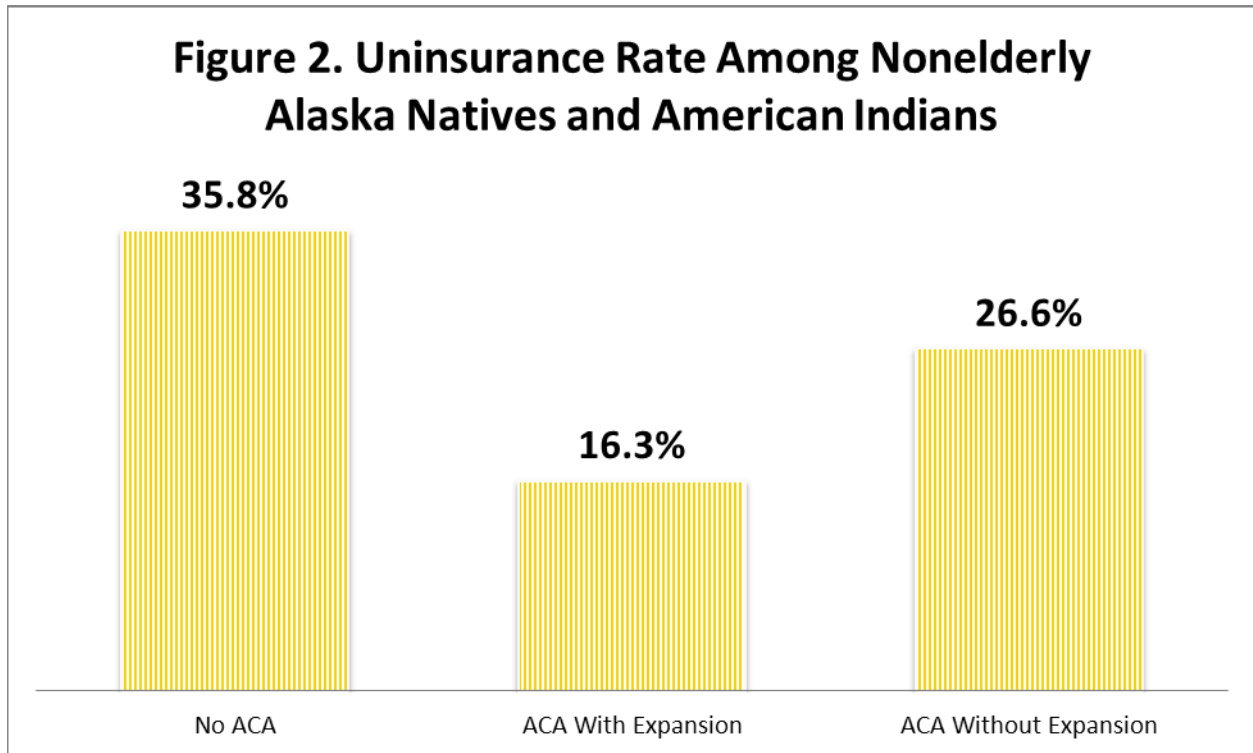


If Alaska opts for the Medicaid expansion, the ACA would cut the number of uninsured by more than half: 9.5 percent of the nonelderly would be uninsured (Figure 1, Column 2). This gain in coverage would be mostly through Medicaid (from 17.9 to 25.2 percent). Families below 400 percent of the FPL who are legally resident and do not have access to public or affordable private coverage would be able to purchase federally-subsidized private coverage through new health insurance exchanges. This is the major reason for the rise in nongroup coverage from 2.6 to 6.3 percent of the nonelderly. Another reason is that the ACA's individual coverage requirement (individual mandate) increases the demand for coverage. That is also why ESI coverage is slightly higher.

Without the Medicaid expansion, the ACA would still increase coverage, but 14.6 percent of nonelderly Alaskans would still lack coverage. The increase in Medicaid coverage would be much lower (from 17.9 to 19.2 percent). Some more people would gain subsidized nongroup coverage, since people with incomes as low as 100 percent of the FPL could qualify. There would also be a modest gain in employer-sponsored coverage (51.7 to 52.4).

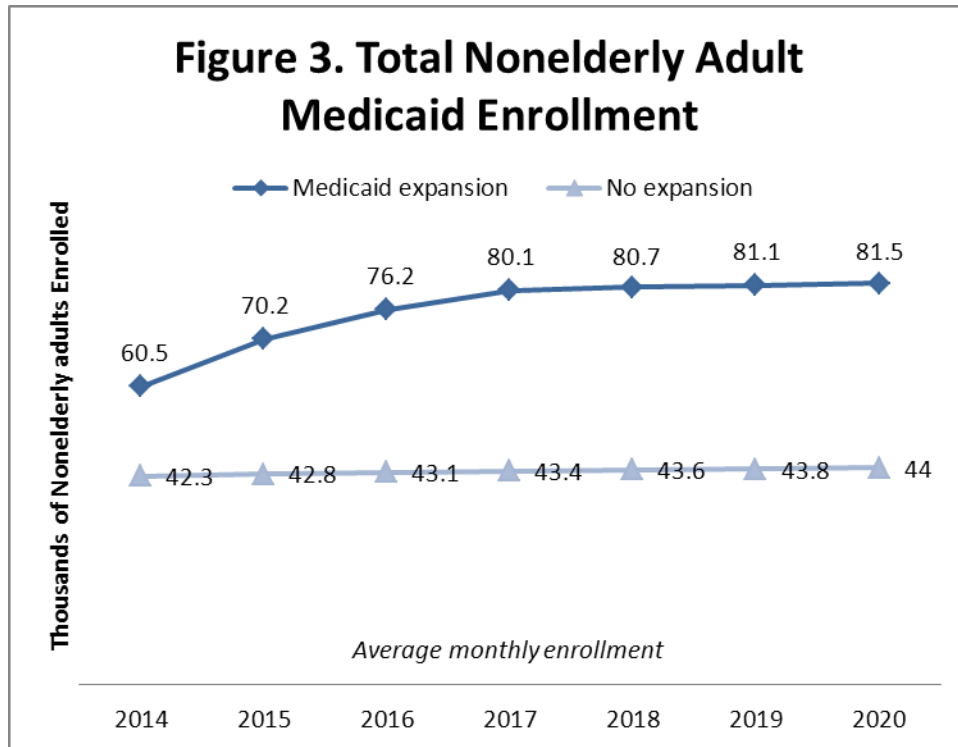


AN/AIs currently have a notably higher rate of uninsurance than the population in general, 35.8 percent versus 20.6 percent (Figure 2). The ACA combined with an expansion of Medicaid eligibility would cut this by more than half, to 16.3 percent. As with the general population, without the expansion, the ACA would have less effect on coverage; 26.6 percent of AN/AIs would remain uninsured.



Medicaid and CHIP Enrollment

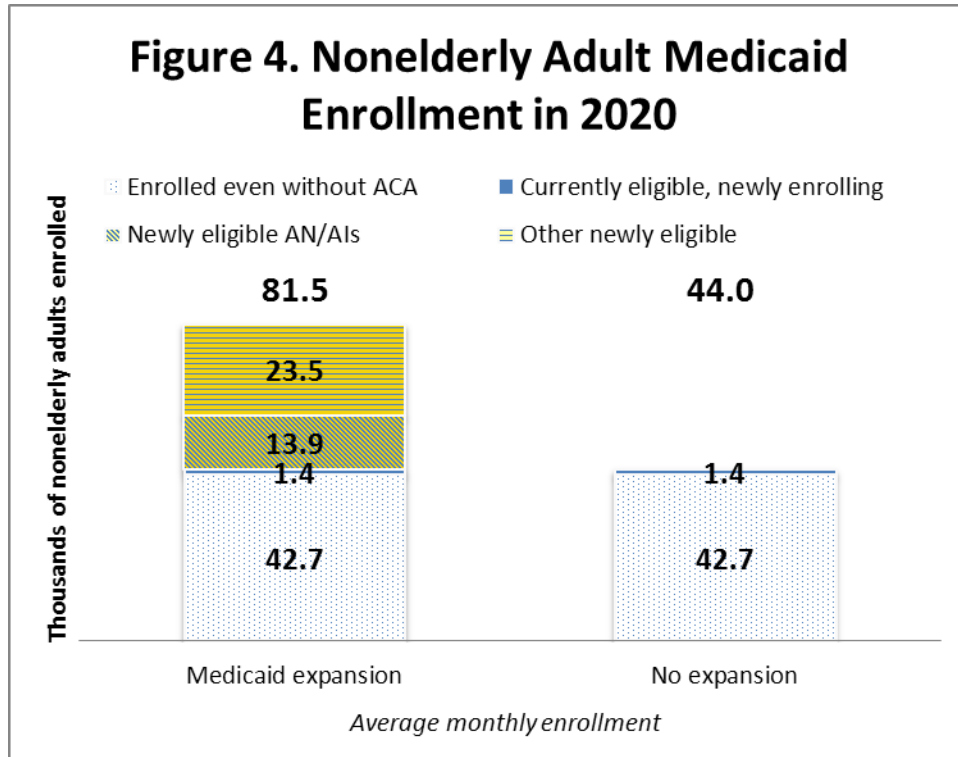
We now focus on Medicaid under the ACA, considering enrollment first and then costs. Under the ACA with a Medicaid expansion, we estimate that about 60,500 nonelderly adults would be enrolled in Medicaid in 2014 during an average month (figure 3). New enrollment due to the Medicaid expansion would not all happen in the first year; it would “ramp up” over several years as the program becomes more familiar and more people are screened for eligibility. Enrollment of nonelderly adults would rise to 81,500 in 2020. Without an expansion, enrollment of adults would follow a noticeably different trend. We estimate that without an expansion, 42,300 nonelderly adults would enroll in Medicaid in 2014, growing modestly to 44,000 in 2020. Thus, the difference in adult Medicaid enrollment due to the expansion would be 18,200 in 2014 and 37,500 in 2020.



Of the 81,500 nonelderly adults that would enroll in 2020 with an expansion, 42,700 would have enrolled with just the ACA (figure 4). In particular, the disabled are nearly all in this group. The remainder, 38,800, would not have enrolled without the ACA. A small number of the newly enrolled, 1,400, would have been eligible all along, but not enrolled. Those currently eligible would enroll at a somewhat higher rate under the ACA, sometimes called the “woodwork effect.” Several provisions of the ACA would contribute to this. Two are particularly relevant. The individual coverage requirement (individual mandate) would make people more likely to seek coverage. The no-wrong-door interface integrating eligibility and enrollment for the exchange, Medicaid, and CHIP would make people seeking coverage more likely to be screened for eligibility and would facilitate their enrollment.⁶ See the sensitivity analysis section below for a discussion on how state and federal decisions regarding this interface could impact enrollment. There would be some new enrollment of disabled adults under the “woodwork effect,” but this would be small, since their participation rates are already high.

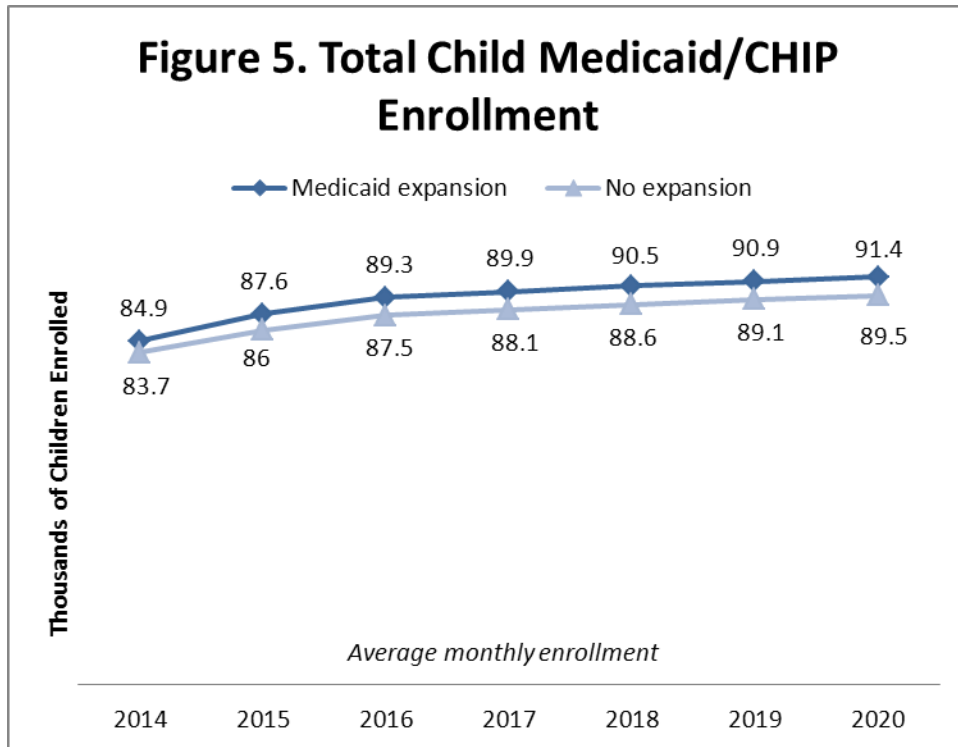
Of those newly enrolling who gained eligibility through the expansion, just under 14,000 would be AN/AIs and 23,500 would be Alaskans of other races (figure 4). Without any expansion, there would be no one gaining eligibility. However, there would still be some new enrollment of those eligible under current rules (1,400). Outreach provisions in the ACA, the individual mandate, and the “no wrong door” interface would still be in place even without the expansion of income eligibility.

⁶ Recently proposed rules from HHS would delay the requirement to implement this interface until 2015. If it is delayed in Alaska, then 2014 enrollment would be more like the low take-up scenario below. Federal Register Vol. 78 No. 14, pp. 4593-4724.

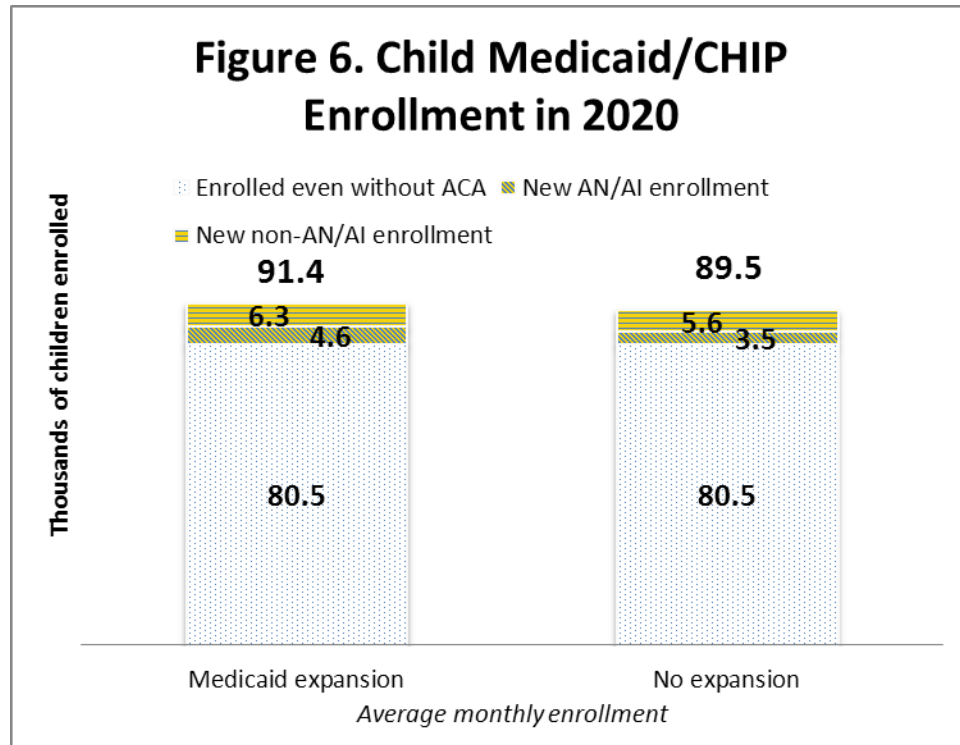


As explained above, children would not generally gain eligibility even under a full ACA Medicaid expansion.⁷ New enrollment of children would occur almost entirely among those already eligible but not enrolled. Again, such new enrollment will occur because of the individual mandate and the “no wrong door” interface. Parents are more likely to seek coverage and be screened for eligibility, so their children are more likely to be enrolled. With an expansion, just under 85,000 children would be enrolled in 2014 and 91,400 in 2020 (figure 5). Without an expansion, children’s enrollment would be somewhat lower because fewer parents of eligible children would seek coverage and hence would omit their children as well. Just under 84,000 children would be enrolled in 2014, with 89,500 enrolled in 2020. Thus, the difference in children’s enrollment due to the Medicaid expansion would be 1,200 in 2014 and 1,900 in 2020.

⁷ Under the conversion of current eligibility rules to MAGI-based criteria, a few may gain eligibility.



Among the 91,400 children who would enroll in 2020 with an expansion, the large majority (80,500) would be enrolled even without the ACA (figure 6). The remainder, just under 11,000 children, would not have enrolled without the ACA. 4,600 of these would be AN/AIs. Of the 89,500 enrolling in 2020 without an expansion, 9,100 would not have enrolled without the ACA. Of these, 3,500 would be AN/AIs.



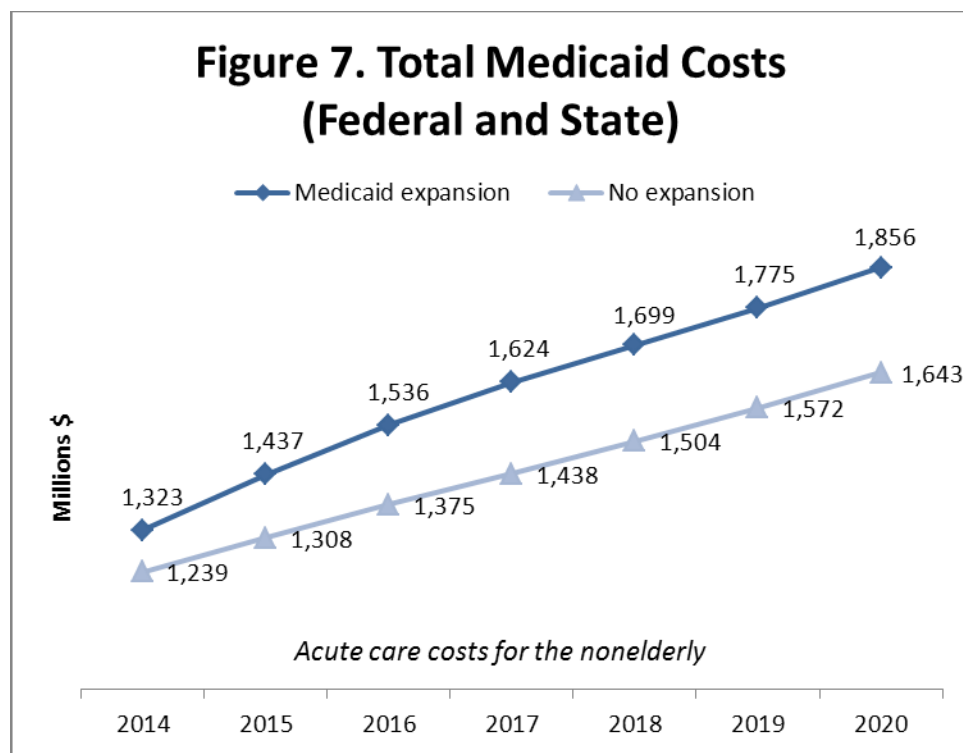
The enrollment data summarized up to this point is presented in more detail for each year of our analysis in Table 1.

Alaska State	Projected Enrollment (in thousands)						
	2014	2015	2016	2017	2018	2019	2020
ACA with Medicaid Expansion							
Enrollment without expansion	119,490	120,088	120,688	121,292	121,898	122,508	123,120
Newly eligible adult enrollment due to expansion	18,168	27,336	33,001	36,625	37,023	37,208	37,394
Currently eligible adult enrollment	909	1,207	1,372	1,400	1,418	1,426	1,433
New child enrollment due to expansion	6,819	9,123	10,411	10,672	10,826	10,880	10,935
Total Enrollment	145,386	157,754	165,472	169,989	171,166	172,022	172,882
ACA Without Medicaid Expansion							
Enrollment without expansion	119,490	120,088	120,688	121,292	121,898	122,508	123,120
Newly eligible adult enrollment due to expansion	0	0	0	0	0	0	0
Currently eligible adult enrollment	865	1,151	1,309	1,337	1,355	1,361	1,368
New child enrollment due to expansion	5,638	7,545	8,613	8,829	8,960	9,005	9,050
Total Enrollment	125,993	128,784	130,610	131,458	132,213	132,874	133,538
<i>Difference in Enrollment Due to Expansion</i>	<i>19,392</i>	<i>28,970</i>	<i>34,862</i>	<i>38,532</i>	<i>38,953</i>	<i>39,148</i>	<i>39,344</i>

Source: UI Analysis of ACS AK Records

The Cost of Acute Care for the Nonelderly

As one would expect, higher enrollment under the Medicaid expansion would mean higher total spending by both federal and state governments. Under the full expansion of eligibility, total program spending on acute care for the nonelderly would be about \$1.3 billion in 2014, rising to \$1.9 billion in 2020 (figure 7). We specify acute care to exclude long term care costs and administrative costs. The latter are estimated below. Total spending with no expansion would be \$1.2 billion in 2014 and \$1.6 billion in 2020. The costs of new Medicaid enrollees are estimated based on their characteristics, such as age, gender, and health status, which are highly correlated with health care expenses. We summarize these in Table 3 below. A full explanation of our cost estimates is in Methods below.⁸



Total spending is, of course, always split between the federal and the state shares. Those made newly eligible under the expansion will have all of their costs paid for by the federal government from 2014 to 2016 (the ACA’s initial 100 percent match for those years). The federal share will decrease gradually each year until it reaches 90 percent of total costs in 2020 and subsequent years.

⁸ On 22 January 2013, after our deadline for finalizing results, HHS released proposed rules on premiums and cost sharing for Medicaid that would potentially allow the state to reduce state and federal spending somewhat by shifting more costs onto Medicaid beneficiaries, particularly those above the poverty line. This additional cost to beneficiaries would reduce enrollment among those who would have to pay more. Note, however, that this does not affect AN/AIs—about 40 percent of new Medicaid enrollees in Alaska—since they will never pay premiums or cost sharing for Medicaid. Federal Register Vol. 78 No. 14, pp. 4593-4724.

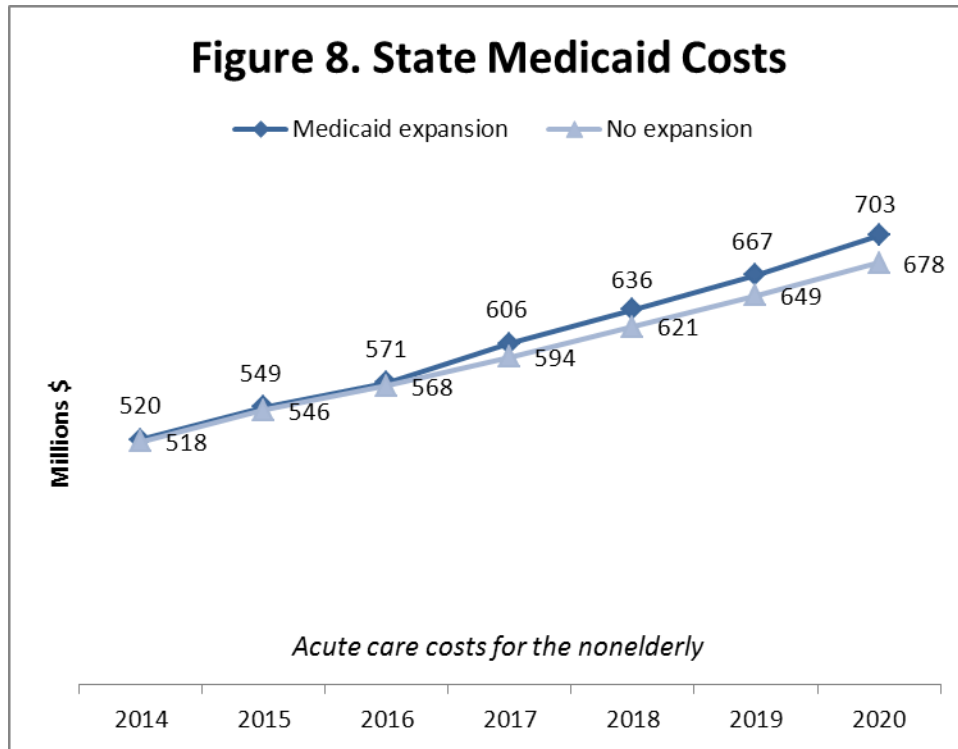


The federal government pays for 100 percent of Medicaid services provided to AN/AIs through tribal health organizations (THOs). This is true both for current and new eligibles. Based on current usage patterns reported in the FY 2011 Tribal Medicaid Activity Report, we estimate that 38 percent of Medicaid costs for AN/AI children and 42 percent for AN/AI nonelderly adults are for services provided by THOs. As we have seen, a substantial share of new Medicaid and CHIP enrollees will be AN/AIs, so this higher federal contribution rate is important for the state budget.

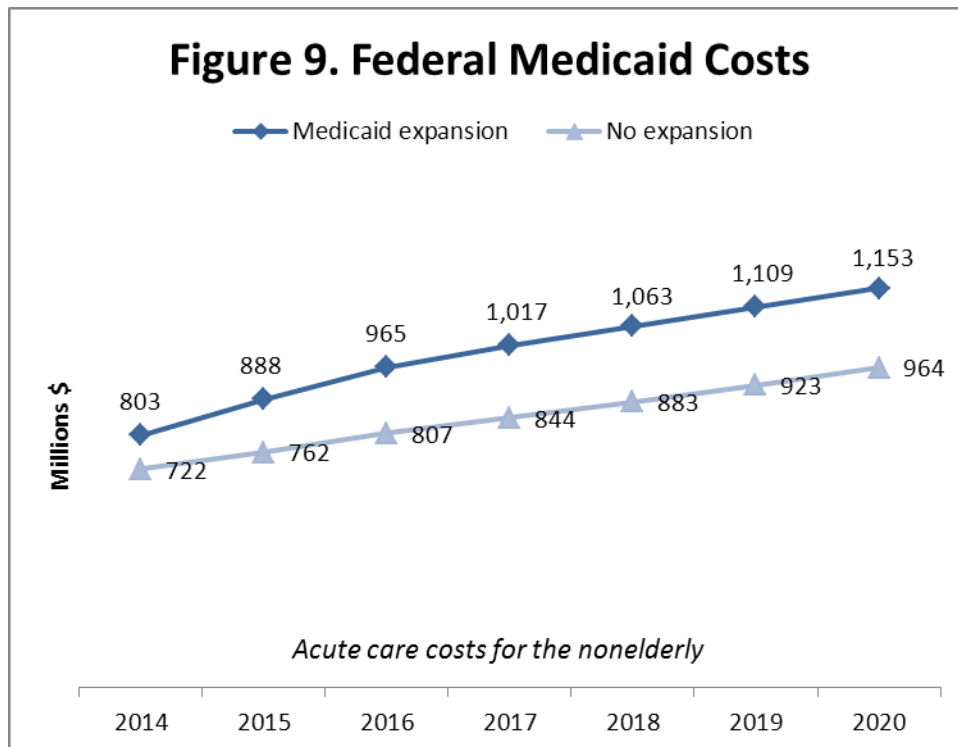
Other Medicaid enrollees would have their costs divided according to the existing FMAP. The federal share of CHIP costs is set higher by law, and will increase by 23 percentage points under the ACA beginning in 2016.⁹ These rates are the same for all three expansion options.

The net effect of these different state/federal splits of costs is shown in figures 8 and 9. Since the federal government pays 100 percent of the costs of the newly eligible from 2014 to 2016, there is very little difference in state costs with and without an expansion (Figure 8). That difference occurs because there is somewhat more new enrollment of those *currently* eligible with the expansion than without it. The difference in state costs is \$2 million in 2014, rising to \$3 million in 2016 as new enrollment due to the ACA among those currently eligible ramps up. As noted above, provisions in the ACA that impact enrollment would not see their full effect immediately in 2014. This difference widens after 2016 as the state pays a higher share of the costs of the newly eligible. 2020 is the first year in which the state pays 10 percent of the costs of the newly eligible. The state would spend \$25 million more on Medicaid and CHIP in 2020 with the expansion than without it, representing a 3.7 percent increase in spending. In total, the state would spend \$78 million more on Medicaid with the expansion from 2014 to 2020.

⁹ On the other hand, there are currently no allocations of federal funding for CHIP beyond fiscal year 2015. For this analysis, we assume that federal funding of CHIP continues. Any changes to CHIP will affect state costs with or without the expansion. If federal funding runs out, the state will be able to freeze or cut CHIP enrollment.



With an expansion, the federal government would spend \$85 million more on Medicaid and CHIP in 2014 than without it (Figure 9). In 2020, this difference is \$189 million. Altogether, the expansion would lead to \$1.1 billion more federal spending in Alaska from 2014 to 2020.





The cost data summarized above is presented in more detail for each year of our analysis in Table 2.

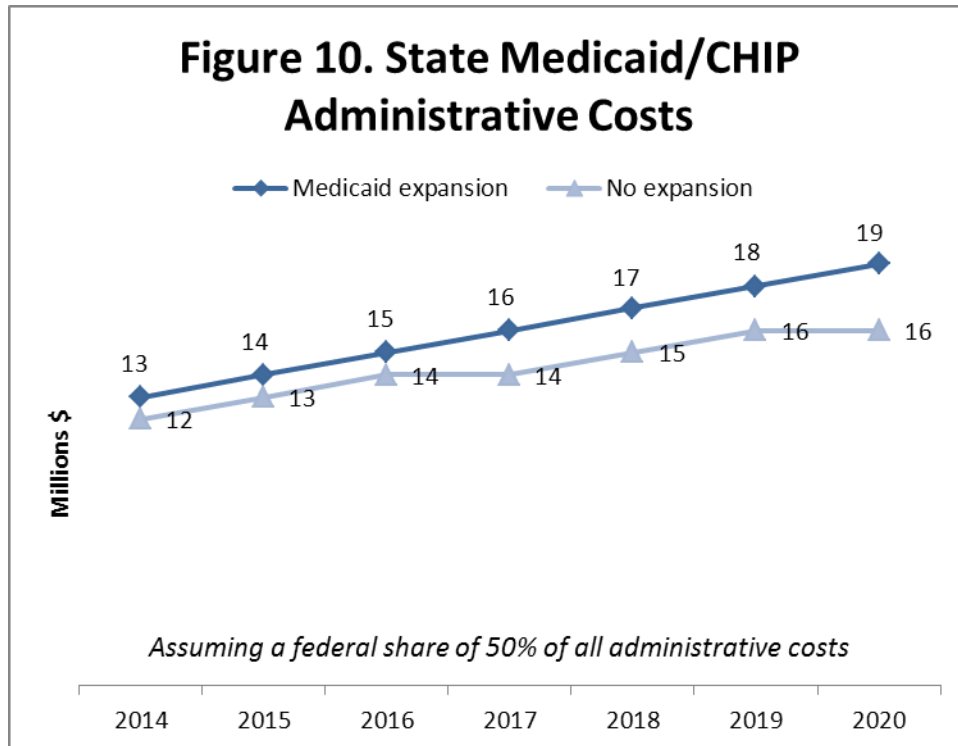
Alaska State	Projected Costs (in thousands)						
	2014	2015	2016	2017	2018	2019	2020
ACA with Medicaid Expansion							
Enrollment w/o ACA							
State	\$502,082	\$524,776	\$543,814	\$568,394	\$594,086	\$620,938	\$649,005
Federal	\$699,718	\$731,345	\$769,084	\$803,847	\$840,181	\$878,157	\$917,850
Newly Eligible Enrollment due to Expansion							
State	\$0	\$0	\$0	\$8,780	\$11,078	\$13,508	\$20,170
Federal	\$77,522	\$121,254	\$152,210	\$166,845	\$173,571	\$179,486	\$181,548
New enrollment among current eligibles due to ACA							
State	\$17,614	\$24,547	\$27,370	\$29,204	\$30,837	\$32,231	\$33,687
Federal	\$25,620	\$35,445	\$43,720	\$46,456	\$48,953	\$51,166	\$53,479
Total							
State	\$519,696	\$549,324	\$571,184	\$606,379	\$636,000	\$666,677	\$702,862
Federal	\$802,860	\$888,044	\$965,014	\$1,017,149	\$1,062,705	\$1,108,810	\$1,152,877
ACA without Medicaid Expansion							
Enrollment w/o ACA							
State	\$502,082	\$524,776	\$543,814	\$568,394	\$594,086	\$620,938	\$649,005
Federal	\$699,718	\$731,345	\$769,084	\$803,847	\$840,181	\$878,157	\$917,850
New enrollment among current eligibles due to ACA							
State	\$15,424	\$21,503	\$23,759	\$25,358	\$26,778	\$27,988	\$29,254
Federal	\$22,063	\$30,551	\$37,952	\$40,346	\$42,524	\$44,446	\$46,455
Total							
State	\$517,507	\$546,280	\$567,573	\$593,752	\$620,864	\$648,927	\$678,258
Federal	\$721,781	\$761,897	\$807,036	\$844,193	\$882,704	\$922,603	\$964,304
Difference Due to Expansion							
<i>Total</i>							
State	\$2,190	\$3,044	\$3,611	\$12,627	\$15,136	\$17,750	\$24,604
Federal	\$81,078	\$126,147	\$157,978	\$172,956	\$180,001	\$186,207	\$188,572

Source: UI Analysis of ACS AK Records

Administrative Costs

Based on available data in Alaska’s FY2011 Budget Summary, we estimate that state administrative costs represent about 2 percent of total spending. Currently, this is divided between the state and federal governments according to the standard Federal Medicaid Assistance Percentage for Alaska, 50 percent. Under the ACA, there will be opportunities for state savings on administrative costs. For example, the federal government will pay 90 percent of the development costs and 75 percent of the maintenance costs for new eligibility systems implementing the ACA. Such systems would be used for those currently eligible as well as those who gain eligibility under the expansion, so there is potential state savings for

current enrollees. Thus, a state share of 50 percent of total administrative costs is an overestimate if the state takes advantage of funding opportunities, but we will use that assumption here. As we saw above, the ACA would lead to higher Medicaid enrollment, and thus higher administrative costs, with or without the expansion. The difference in state administrative costs with and without the expansion is only about \$1 million in 2014, increasing to \$3 million in 2020 (Figure 10). Altogether, the state would spend \$12 million more from 2014 to 2020 with an expansion, excluding any state savings.



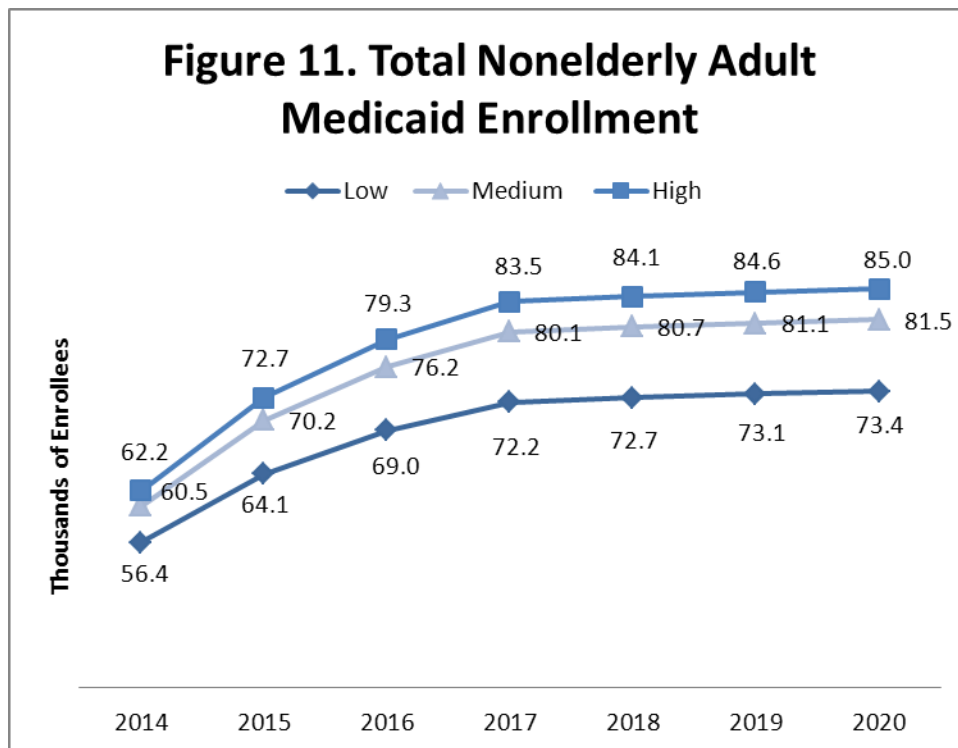
It is important to note that spending on Medicaid is only one element of the ACA’s impact on state budgets. New savings as well as new costs will occur because of expansion and the ACA’s other changes.¹⁰ For example, savings in uncompensated care provided to the uninsured could offset a significant amount of the additional state spending. Also, in-patient hospital expenses for incarcerated prisoners with MAGI below 138 percent of poverty would be covered by Medicaid under the ACA if the state were to expand eligibility, sharing the costs between the federal and state governments. The institutionalized population is not in our data, so they are not part of our estimates. Probationers and parolees, though, are included.

¹⁰ For a more complete list and discussion, see Stan Dorn, “Considerations in Assessing State-Specific Fiscal Effects of the ACA’s Medicaid Expansion,” (Washington, DC; The Urban Institute; 2012) http://www.urban.org/health_policy/url.cfm?ID=412628

A Sensitivity Analysis of Medicaid Take-Up

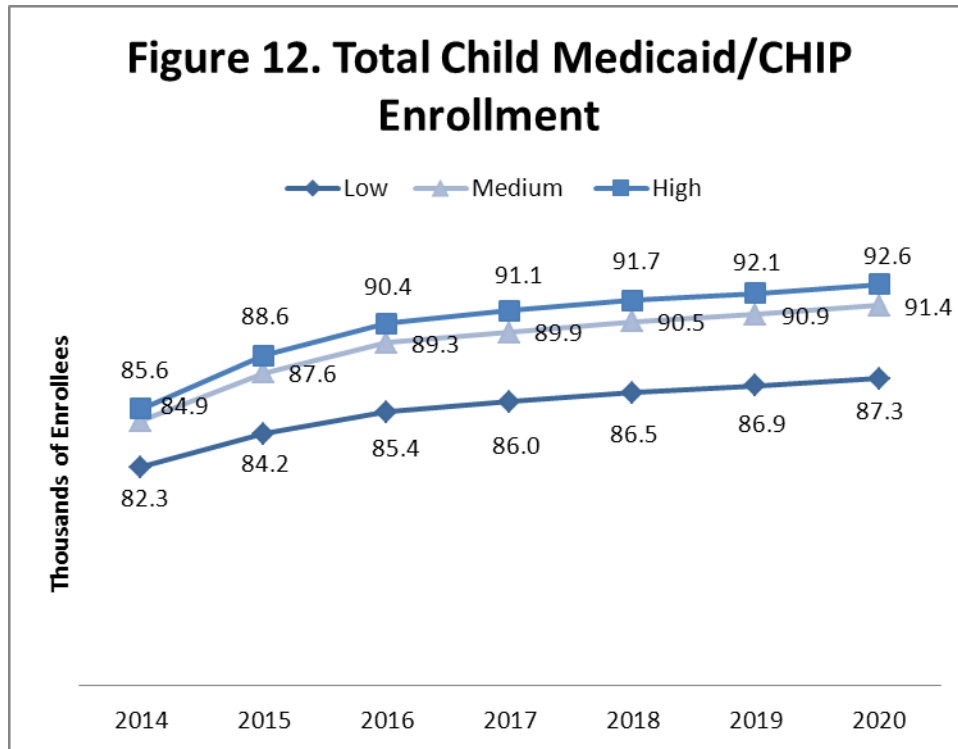
There is uncertainty about the rate at which people eligible for Medicaid would actually enroll. The results above reflect our expected overall rates of take-up. We simulated high and low take-up scenarios as well, based on the literature of public health program participation rates and programmatic features of the ACA that impact take-up behavior. Details and citations may be found in Methods below.

Under the ACA Medicaid expansion, the number of nonelderly adults enrolled would likely be between 56,400 and 62,200 in 2014 (Figure 11). The range widens by 2020, from 73,400 to 85,000. The difference between the medium and high scenarios is smaller than the difference between the medium and low scenarios because take-up rates notably higher than those currently observed are not easy to achieve. They require effective and intensive outreach efforts. Take-up rates of 100 percent have never been achieved in any public health or human services program. As we saw above, the large majority of new adult enrollment is among those newly eligible, so the effectiveness of outreach and enrollment screening for those gaining eligibility will be a crucial factor in determining enrollment.

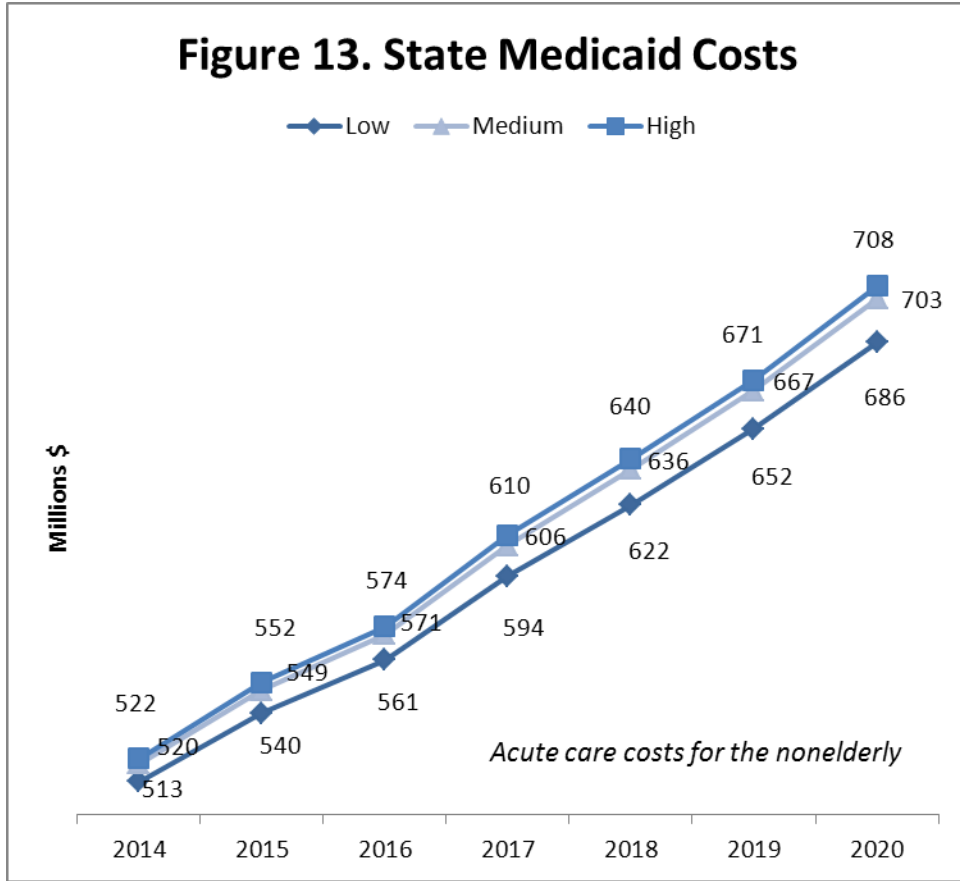


For children, the enrollment range would be from 82,300 to 85,600 in 2014 and from 87,300 to 92,600 in 2020 (Figure 12). Unlike adults, new enrollment among children is almost entirely among those who are currently eligible but not enrolled. Since these are children not responding to current outreach, raising take-up substantially above the medium scenario would be difficult. New enrollment among children under the ACA will most often be due to parents seeking coverage. The no-wrong-door

interface for the exchange, Medicaid, and CHIP will screen the families of those seeking coverage for eligibility. The medium and high scenarios represent good integration between this interface and the state Medicaid agency—actual eligibility determinations in real time and online enrollment. The low scenario represents less effective integration. For example, the interface may only make an assessment of eligibility and forward the information to the state Medicaid agency for further processing.



The range of take-up estimates has a modest effect on state costs in 2014, with the difference between low and high being \$9 million (Figure 13). This widens by 2020, when the difference between the low and high scenarios is \$22 million. The difference in state costs between the medium and high scenarios remains small over time.





Detailed Characteristics of New Medicaid Enrollees and the Remaining Uninsured

We now take a more detailed look at those who would enroll in Medicaid under the ACA and those who would remain uninsured. Note that these tables are based on the state population in 2012, with the ACA fully phased in.

Statewide

Of nearly 50,000 newly enrolling in Medicaid due to the ACA, just under 20 percent would be children (Table 3, Second Column). The adults newly enrolling in Medicaid would be younger on average than nonelderly adults currently enrolled in Medicaid (First Column). About 20 percent of the 61,000 Alaskans remaining uninsured would be children, and the adults remaining uninsured would be older on average than the adults gaining Medicaid (Third Column).

Not surprisingly, almost 90 percent of those newly enrolling in Medicaid would be below 138 percent of the FPL. Those above this level are currently eligible but not enrolled, and nearly all are children. Among those remaining uninsured, 40 percent would be below 138 percent of the FPL. Take-up rates for Medicaid are high, but 100 percent take-up has never been achieved in any state. Half of the remaining uninsured would have incomes above 200 percent of the FPL.

Just under 40 percent of those newly enrolling in Medicaid would be AN/AIs. This is similar to the percentage among current Medicaid enrollees and slightly higher than share of AN/AIs among the remaining uninsured. Just under half of those newly enrolling in Medicaid would be white, non-Hispanics.

Just over 11 percent of those newly enrolling in Medicaid would be in fair/poor health, compared with 15 percent of current enrollees. Note that most current enrollees are children, who tend to have better health status than adults. Thus, adults newly enrolling in Medicaid are younger and healthier than those currently enrolled.



Table 3. Medicaid Enrollment and Remaining Uninsured, Statewide						
	Would have enrolled in Medicaid/CHIP without the ACA		New Medicaid/CHIP enrollment due to the ACA and expansion		Remaining uninsured under the ACA	
	N	%	N	%	N	%
Total Nonelderly	114,998	100.0%	47,355	100.0%	61,325	100.0%
Age						
0 - 18	74,000	64.3%	9,207	19.4%	12,534	20.4%
19 - 24 years	6,706	5.8%	10,424	22.0%	8,073	13.2%
25 - 44 years	19,320	16.8%	17,508	37.0%	22,181	36.2%
45 - 64 years	14,973	13.0%	10,217	21.6%	18,537	30.2%
MAGI						
Under 138% FPL	86,104	74.9%	41,570	87.8%	24,390	39.8%
138% - 200% FPL	16,535	14.4%	3,875	8.2%	7,387	12.0%
200%+ FPL	12,359	10.7%	1,910	4.0%	29,548	48.2%
Race/Ethnicity						
AN/AI ¹	48,838	42.5%	18,509	39.1%	22,553	36.8%
White, Non-Hispanic	42,674	37.1%	22,676	47.9%	29,605	48.3%
Other	23,486	20.4%	6,170	13.0%	9,167	14.9%
Family Type						
Kid Only	6,854	6.0%	892	1.9%	1,535	2.5%
Single, No Dependents	15,640	13.6%	25,838	54.6%	21,951	35.8%
Single, With Dependents	36,225	31.5%	7,540	15.9%	10,285	16.8%
Married, No Dependents	3,519	3.1%	2,998	6.3%	10,540	17.2%
Married, With Dependents	52,759	45.9%	10,086	21.3%	17,014	27.7%
Health Status						
Better than Fair/Poor	98,087	85.3%	41,962	88.6%	53,616	87.4%
Fair/Poor	16,911	14.7%	5,393	11.4%	7,709	12.6%

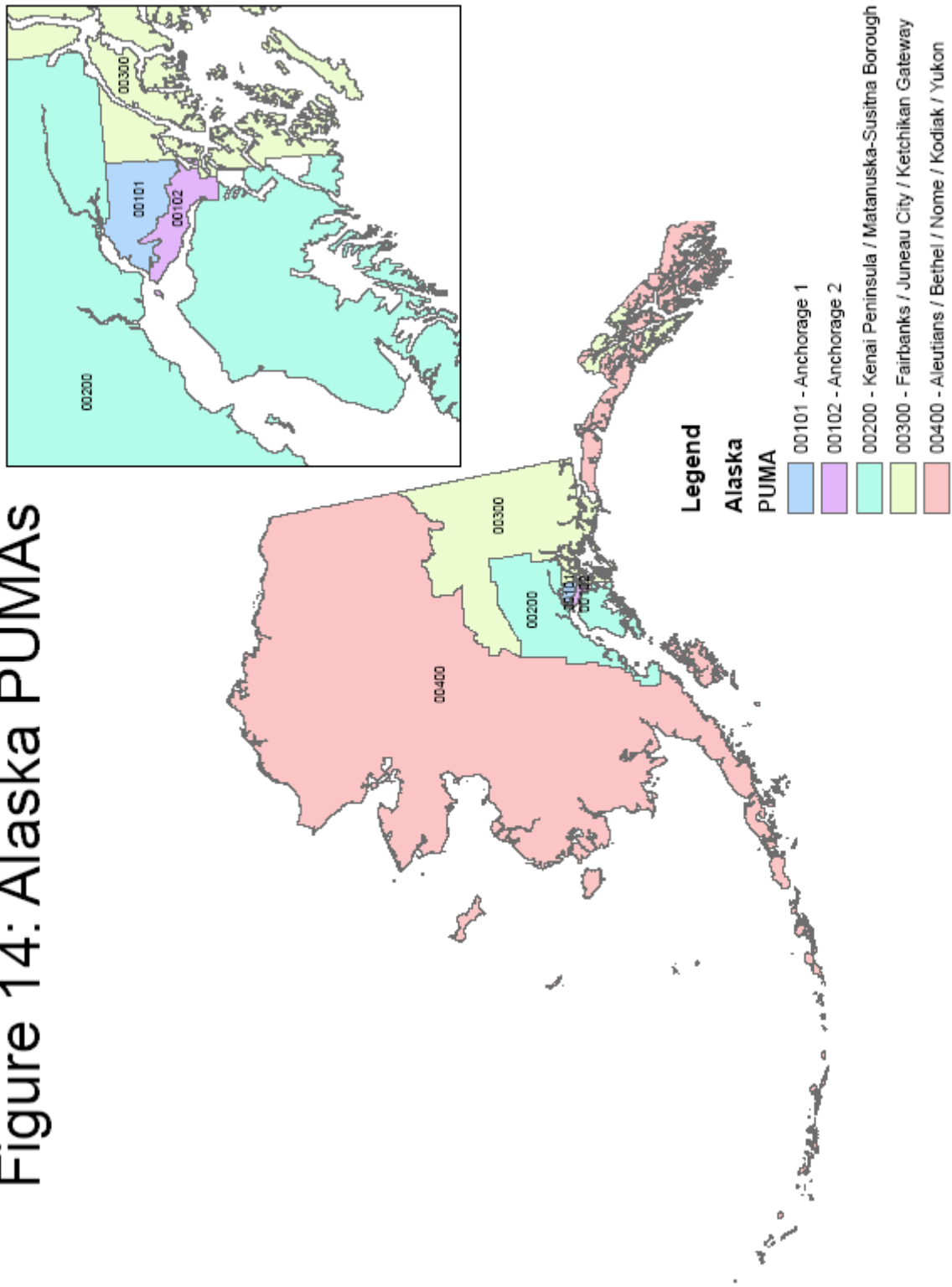
Source: UI Analysis of ACS AK Records -- ACA as if fully implemented in 2012 with Medicaid expansion

¹ Alaska Native or American Indian. Includes mixed-race.

Sub-state Geographic Areas

The large sample size of the ACS allowed us to show the number of Medicaid enrollees and their characteristics by sub-state area. The basic areas available on the survey are Public Use Microdata Areas (PUMAs) created by the Census Bureau. There are five in Alaska (Figure 14).

Figure 14: Alaska PUMAs





In Table 4, we break out the state and federal costs for 2020 by local area. In the northern Anchorage PUMA (101), for example, the Medicaid expansion would lead to the state spending \$3.4 million more in Medicaid in 2020. Also, there would be \$26.1 million in new federal Medicaid spending for that area.

Table 4: State/Federal Costs with and without Medicaid Expansion, by PUMA

Alaska State	2020	
	Projected Costs (in thousands)	
	State Costs	Federal Costs
PUMA 101 (Anchorage - 1)		
With Expansion	\$144,405	\$198,121
Without Expansion	\$141,025	\$172,070
Difference	\$3,380	\$26,051
PUMA 102 (Anchorage - 2)		
With Expansion	\$140,522	\$208,701
Without Expansion	\$137,722	\$184,514
Difference	\$2,800	\$24,187
PUMA 200 (Kenai Peninsula / Matanuska-Susitna Borough)		
With Expansion	\$183,175	\$263,627
Without Expansion	\$175,905	\$212,969
Difference	\$7,271	\$50,658
PUMA 300 (Fairbanks / Juneau City / Ketchikan Gateway)		
With Expansion	\$113,655	\$184,280
Without Expansion	\$107,934	\$141,744
Difference	\$5,721	\$42,536
PUMA 400 (Aleutians / Bethel / Nome / Kodiak / Yukon)		
With Expansion	\$121,105	\$298,149
Without Expansion	\$115,673	\$253,008
Difference	\$5,433	\$45,141

Source: UI Analysis of ACS AK Records

In Tables 5 through 9, we show the demographic and economic characteristics of Medicaid enrollees and the remaining uninsured in each PUMA. As with Table 3, which shows the same characteristics statewide, the data are as if the ACA were fully implemented in 2012.



Medicaid in Alaska Under the ACA



Table 5. Anchorage - 1						
PUMA 101	Would have enrolled in Medicaid/CHIP without the ACA		New Medicaid/CHIP enrollment due to the ACA and expansion		Remaining uninsured under the ACA	
	N	%	N	%	N	%
Total Nonelderly	19,650	100.0%	5,851	100.0%	8,844	100.0%
Age						
0 - 18	11,778	59.9%	962	16.4%	1,482	16.8%
19 - 24 years	1,351	6.9%	1,421	24.3%	1,401	15.8%
25 - 44 years	3,416	17.4%	2,485	42.5%	3,467	39.2%
45 - 64 years	3,105	15.8%	984	16.8%	2,694	30.5%
MAGI						
Under 138% FPL	15,486	78.8%	5,227	89.3%	3,486	39.4%
138% - 200% FPL	2,622	13.3%	510	8.7%	1,470	16.6%
200%+ FPL	1,542	7.8%	114	2.0%	4,090	46.2%
Race/Ethnicity						
AN/AI ¹	3,841	19.5%	1,210	20.7%	2,135	24.1%
White, Non-Hispanic	6,666	33.9%	2,376	40.6%	4,578	51.8%
Other	9,143	46.5%	2,265	38.7%	2,332	26.4%
Family Type²						
Single, No Dependents	3,777	19.8%	3,408	58.2%	3,400	38.4%
Single, With Dependents	7,199	37.7%	*	*	1,230	13.9%
Married, No Dependents	752	3.9%	*	*	1,176	13.3%
Married, With Dependents	7,390	38.7%	1,492	25.5%	3,038	34.3%
Health Status						
Better than Fair/Poor	15,741	80.1%	4,908	83.9%	7,634	86.3%
Fair/Poor	3,909	19.9%	944	16.1%	1,411	16.0%

Source: UI Analysis of ACS AK Records -- ACA as if fully implemented in 2012 with Medicaid expansion

¹ Alaska Native or American Indian. Includes mixed-race.

² Does not include a small number of child-only HIUs.

* Suppressed due to small sample size



Medicaid in Alaska Under the ACA



Table 6. Anchorage - 2						
PUMA 102	Would have enrolled in Medicaid/CHIP without the ACA		New Medicaid/CHIP enrollment due to the ACA and expansion		Remaining uninsured under the ACA	
	N	%	N	%	N	%
Total Nonelderly	20,716	100.0%	6,315	100.0%	11,554	100.0%
Age						
0 - 18	13,549	65.4%	1,488	23.6%	2,467	21.4%
19 - 24 years	1,524	7.4%	1,674	26.5%	1,654	14.3%
25 - 44 years	3,651	17.6%	2,167	34.3%	4,770	41.3%
45 - 64 years	1,991	9.6%	1,142	18.1%	2,955	25.6%
MAGI						
Under 138% FPL	13,514	65.2%	5,226	82.7%	3,918	33.9%
138% - 200% FPL	2,776	13.4%	580	9.2%	1,472	12.7%
200%+ FPL	4,426	21.4%	666	10.5%	6,456	55.9%
Race/Ethnicity						
AN/AI ¹	5,742	27.7%	1,509	23.9%	3,220	27.9%
White, Non-Hispanic	6,996	33.8%	3,612	57.2%	5,783	50.1%
Other	7,978	38.5%	1,349	21.4%	2,842	24.6%
Family Type²						
Single, No Dependents	2,282	11.5%	3,714	58.8%	4,542	39.3%
Single, With Dependents	7,737	38.8%	794	12.6%	1,584	13.7%
Married, No Dependents	342	1.7%	430	6.8%	1,816	15.7%
Married, With Dependents	9,563	48.0%	1,378	21.8%	3,613	31.3%
Health Status						
Better than Fair/Poor	17,757	85.7%	5,730	90.7%	10,427	90.2%
Fair/Poor	2,958	14.3%	741	11.7%	1,419	12.3%

Source: UI Analysis of ACS AK Records -- ACA as if fully implemented in 2012 with Medicaid expansion

¹ Alaska Native or American Indian. Includes mixed-race.

² Does not include a small number of child-only HIUs.



Medicaid in Alaska Under the ACA



Table 7. Kenai Peninsula / Matanuska-Susitna Borough						
PUMA 200	Would have enrolled in Medicaid/CHIP without the ACA		New Medicaid/CHIP enrollment due to the ACA and expansion		Remaining uninsured under the ACA	
	N	%	N	%	N	%
	Total Nonelderly	23,531	100.0%	12,345	100.0%	13,966
Age						
0 - 18	14,791	62.9%	2,368	19.2%	2,745	19.7%
19 - 24 years	1,053	4.5%	2,422	19.6%	1,766	12.6%
25 - 44 years	3,518	14.9%	4,919	39.8%	5,044	36.1%
45 - 64 years	4,169	17.7%	2,709	21.9%	4,642	33.2%
MAGI						
Under 138% FPL	18,088	76.9%	10,951	88.7%	5,312	38.0%
138% - 200% FPL	3,567	15.2%	781	6.3%	1,196	8.6%
200%+ FPL	1,877	8.0%	686	5.6%	7,690	55.1%
Race/Ethnicity						
AN/AI ¹	3,209	13.6%	2,324	18.8%	3,006	21.5%
White, Non-Hispanic	18,124	77.0%	9,550	77.4%	10,403	74.5%
Other	2,198	9.3%	544	4.4%	788	5.6%
Family Type²						
Single, No Dependents	3,684	16.6%	6,671	54.0%	5,175	37.1%
Single, With Dependents	4,763	21.5%	1,298	10.5%	1,652	11.8%
Married, No Dependents	1,162	5.2%	759	6.1%	2,431	17.4%
Married, With Dependents	12,589	56.7%	3,618	29.3%	4,708	33.7%
Health Status						
Better than Fair/Poor	19,555	83.1%	10,833	87.8%	12,161	87.1%
Fair/Poor	3,976	16.9%	1,585	12.8%	2,037	14.6%

Source: UI Analysis of ACS AK Records -- ACA as if fully implemented in 2012 with Medicaid expansion

¹ Alaska Native or American Indian. Includes mixed-race.

² Does not include a small number of child-only HIUs.



Medicaid in Alaska Under the ACA



Table 8. Fairbanks / Juneau City / Ketchikan Gateway						
PUMA 300	Would have enrolled in Medicaid/CHIP without the ACA		New Medicaid/CHIP enrollment due to the ACA and expansion		Remaining uninsured under the ACA	
	N	%	N	%	N	%
Total Nonelderly	17,636	100.0%	10,532	100.0%	11,741	100.0%
Age						
0 - 18	10,379	58.8%	2,881	27.4%	2,369	20.2%
19 - 24 years	1,037	5.9%	2,145	20.4%	1,540	13.1%
25 - 44 years	3,471	19.7%	3,729	35.4%	4,107	35.0%
45 - 64 years	2,750	15.6%	2,068	19.6%	3,843	32.7%
MAGI						
Under 138% FPL	13,388	75.9%	9,046	85.9%	4,782	40.7%
138% - 200% FPL	2,947	16.7%	1,443	13.7%	1,767	15.0%
200%+ FPL	1,302	7.4%	334	3.2%	5,311	45.2%
Race/Ethnicity						
AN/AI ¹	6,242	35.4%	3,888	36.9%	3,986	33.9%
White, Non-Hispanic	8,968	50.9%	6,005	57.0%	6,846	58.3%
Other	2,426	13.8%	930	8.8%	1,028	8.8%
Family Type²						
Single, No Dependents	3,117	18.9%	5,392	51.2%	3,772	32.1%
Single, With Dependents	5,923	36.0%	2,651	25.2%	3,351	28.5%
Married, No Dependents	645	3.9%	716	6.8%	2,847	24.3%
Married, With Dependents	6,787	41.2%	1,773	16.8%	1,771	15.1%
Health Status						
Better than Fair/Poor	14,960	84.8%	9,649	91.6%	10,342	88.1%
Fair/Poor	2,676	15.2%	1,173	11.1%	1,517	12.9%
Source: UI Analysis of ACS AK Records -- ACA as if fully implemented in 2012 with Medicaid expansion						
¹ Alaska Native or American Indian. Includes mixed-race.						
² Does not include a small number of child-only HIUs.						



Medicaid in Alaska Under the ACA



Table 9. Aleutians / Bethel / Nome / Kodiak / Yukon						
PUMA 400	Would have enrolled in Medicaid/CHIP without the ACA		New Medicaid/CHIP enrollment due to the ACA and expansion		Remaining uninsured under the ACA	
	N	%	N	%	N	%
Total Nonelderly	33,465	100.0%	11,420	100.0%	13,684	100.0%
Age						
0 - 18	23,502	70.2%	1,509	13.2%	3,470	25.4%
19 - 24 years	1,741	5.2%	2,761	24.2%	1,713	12.5%
25 - 44 years	5,264	15.7%	4,208	36.9%	4,792	35.0%
45 - 64 years	2,958	8.8%	3,314	29.0%	4,401	32.2%
MAGI						
Under 138% FPL	25,628	76.6%	11,121	97.4%	6,893	50.4%
138% - 200% FPL	4,624	13.8%	561	4.9%	1,482	10.8%
200%+ FPL	3,213	9.6%	110	1.0%	6,001	43.9%
Race/Ethnicity						
AN/AI ¹	29,804	89.1%	9,578	83.9%	10,207	74.6%
White, Non-Hispanic	1,920	5.7%	1,133	9.9%	1,994	14.6%
Other	1,741	5.2%	1,081	9.5%	2,176	15.9%
Family Type²						
Single, No Dependents	2,780	9.1%	6,654	58.3%	5,062	37.0%
Single, With Dependents	10,604	34.8%	1,847	16.2%	2,468	18.0%
Married, No Dependents	618	2.0%	1,093	9.6%	2,270	16.6%
Married, With Dependents	16,430	54.0%	1,825	16.0%	3,885	28.4%
Health Status						
Better than Fair/Poor	30,073	89.9%	10,842	94.9%	13,052	95.4%
Fair/Poor	3,392	10.1%	950	8.3%	1,325	9.7%

Source: UI Analysis of ACS AK Records -- ACA as if fully implemented in 2012 with Medicaid expansion

¹ Alaska Native or American Indian. Includes mixed-race.



Methods

Demographics and Eligibility

Our basic demographics and health care coverage data are from three years of the American Community Survey (ACS) pooled together, 2008, 2009, and 2010. The large resulting sample size of the survey (17,385 Alaskans) allows us to accurately identify AN/AIs and to accurately assess the characteristics of those affected by the Medicaid expansion, particularly those correlated with health care costs. In addition, we have augmented the survey by imputing unavailable characteristics such as Medicaid eligibility, employer offers of coverage, and immigration status which are critical to predicting insurance choices under the ACA.

The American Community Survey is an annual survey fielded by the United States Census Bureau. We use an augmented version of the ACS prepared by the University of Minnesota Population Center, known as the Integrated Public Use Microdata Sample (IPUMS), which uses the public use sample of the ACS and contains edits for family relationships and other variables.¹¹ The 2009 ACS has a reported household response rate of 98.0 percent (U.S. Census Bureau 2009). The survey uses an area frame that includes households with and without telephones (landline or cellular). It is a mixed-mode survey that starts with a mail-back questionnaire—52.7 percent of the civilian non-institutionalized sample was completed by mail—and is followed by telephone interviews for initial non-responders, and further followed by in-person interviews for a sub-sample of remaining non-responders. The estimates presented here are derived from the data collected about civilian non-institutionalized Alaskans.¹²

We simulate eligibility for Medicaid/CHIP and subsidies using the 2009 ACS, available information on the regulations for implementing the ACA, and available information on the 2010 Medicaid/CHIP eligibility guidelines.¹³ Broadly, our model initially simulates being newly Medicaid eligible or for those with disabilities, being eligible under the pre-ACA rules used in 2010. For those not initially found eligible for Medicaid our model then simulates CHIP eligibility, maintenance of effort (MOE) eligibility, and then subsidy eligibility.

New Medicaid eligibility depends on having family income less than 138 percent of the federal poverty level (FPL) and subsidy eligibility depends on having family income between 138 percent and 400 percent FPL. Under the ACA, income eligibility is based on the IRS tax definition of modified adjusted gross income (MAGI), which includes the following types of income for everyone who is not a tax-dependent child: wages, business income, retirement income, investment income, alimony, unemployment compensation, and financial and educational assistance. The ACS only indirectly asks about unemployment compensation, alimony, financial assistance and educational assistance when it

¹¹ Ruggles S., T.J. Alexander, K. Genadek, R. Goeken, M. Schroeder, and M. Sobek.. *Integrated Public Use Microdata Series: Version 5.0* [Machine-readable database]. Minneapolis, MN: University of Minnesota. 2010

¹² This includes nonelderly people living in private residences as well as students in dorms and a small number of other people living in group quarters, such as outpatient treatment facilities.

¹³ Kaiser survey 2010



asks about other income and because unemployment compensation appears to affect our results and other income includes any other sources of income, we model it, using demographic characteristics and educational attainment. MAGI also includes the income of any dependent children¹⁴ required to file taxes, which for 2009 is wage income greater than \$5,700 and investment income greater than \$950. To compute family income as a ratio of the poverty level¹⁵, we sum the person-level MAGI across the tax unit. For ACA eligibility, the tax unit includes parents and their dependent children and married people regardless of whether they file separately. Because the ACS interviews college students away at school during the school year, we put some sample college student in families.¹⁶ The ACA also stipulates that Medicaid eligibility be determined using current rules for those with disabilities and those who are Medicaid eligible under current law but not under the new rules, and for current income eligibility we use state rules for 2010. State rules include income thresholds for the appropriate family¹⁷ size, asset tests, parent/family status, and the amount and extent of disregards¹⁸ for Alaska, in place as of the middle of 2010.

Medicaid eligibility also depends on immigration status. Current and new rules require that enrollees be citizens or legal immigrants. However because the ACS does not contain sufficient information to determine whether an individual is an authorized immigrant, we impute documentation status for non-citizens based on a model used in the CPS-ASEC. Documentation status is imputed to immigrant adults in two stages using individual and family characteristics, based on an imputation methodology that was originally developed by Passel.¹⁹ Immigrant eligibility under current rules also depends on how long an immigrant has been in the country so we also determine immigration eligibility using state rules and ACS information about citizenship and date of immigration.

Once we have all the components required for eligibility simulation, we simulate eligibility for adults and children for the types of eligibility in the general order in which caseworkers or state eligibility-determination software currently check for eligibility.²⁰

¹⁴ We use the IRS definition of dependent child except that the ACS does not allow us to identify children residing in other households: people living with their parents if they are unmarried and less than age 19, or less than age 23 and in school.

¹⁵ Poverty ratio defined using Health and Human Services guidelines.

¹⁶ College students living apart from parents and remaining after we attempt to put them back with families are restricted from being eligible unless they also have Medicaid/CHIP reported.

¹⁷ Family-level characteristics used in determining eligibility, such as income, are based on the family groupings that states define during the eligibility determination process or that would apply for private coverage together, known as the health insurance unit (HIU). Indicators of family characteristics in this paper refer to this unit.

¹⁸ The model takes into account disregards for childcare expenses, work expenses, and earnings in determining eligibility, but does not take into account child support disregards because data on such amounts was not available.

¹⁹ Passel, J. and D. Cohen. *A Portrait of Unauthorized Immigrants in the United States*. Washington, DC: Pew Hispanic Center. 2009.

²⁰ The model assigns eligibility type hierarchically, and cases are classified by the first pathway for which they are eligible. For instance, if an SSI recipient gets classified as eligible through the SSI pathway, they would be classified as eligible through disability-related coverage even if they also meet the qualifications for Section 1931 coverage.



Medicaid Costs

Cost data are based on three years of the Medical Expenditure Panel Survey-Household Component (MEPS-HC) and on the latest available administrative data on Medicaid spending in Alaska. The MEPS-HC is a survey of individuals and families, employers, and medical providers across the United States that provides information about health care expenditures and health insurance coverage. There are two major components of MEPS. The Household Component collects data from individuals, families, and their health care providers, while the Insurance Component collects information on employer-based insurance from employers. To ensure an adequate sample size, we use three years of the MEPS-HC pooled together.

We reconcile MEPS-HC expenditures to be consistent with the National Health Accounts (NHA) Personal Healthcare Expenditures data, which are maintained by federal actuaries. According to Sing et al., compared to the NHA, MEPS routinely underestimates the aggregate insured costs associated with Medicaid and privately insured individuals.²¹ In adjusting expenditures, we follow the methodology developed in the cited research.

To adjust for any MEPS underreporting of the high-cost tail of the health expenditure distribution, we looked to the Society of Actuaries (SOA) High-Cost Claims Database. This comprehensive survey examined seven insurers and all of their claimants. It is designed to be representative of the national distribution of all claims to private insurers. We found that the 97th to 99th percentiles of private expenditures among the nonelderly in the MEPS data fell below the same percentiles in the SOA. The discrepancy ranged from less than 1 percent (97th percentile) to 13 percent (99th percentile). We used these discrepancies as adjustment factors for all privately insured individuals with private expenditures above the 97th percentile. In order to keep total health expenditures consistent with the NHA totals following the SOA adjustment of the tail of the distribution, we decreased the private expenditures of the privately insured individuals in the lower portion of the distribution by a fixed percentage.

The same individual will incur different levels of health expenditures when insured differently (e.g., employer coverage versus Medicaid, or Medicaid versus uninsured). This is because out-of-pocket costs and costs covered by insurance will vary depending upon plan cost-sharing requirements (e.g., deductibles, copayments, out-of-pocket maximums) and benefits covered, effectively altering the price an individual will face when consuming medical care. The higher the out-of-pocket price faced, the less the individual is apt to consume. Thus, in order to understand the value of care an individual will obtain under various coverage options pre-and post-ACA, we compute health care spending for each observation under several alternate statuses of health coverage: uninsured, insured by Medicaid/CHIP, insured under a typical comprehensive ESI package, and insured under a typical nongroup (individual)

²¹ M. Sing, J. S. Banthin, T. M. Selden, C. A. Cowan, and S. P. Keehan, "Reconciling Medical Expenditure Estimates from the MEPS and NHEA, 2002," *Health Care Financing Review* 28 (Fall 2006): 25–40. Also, T. M. Selden and M. Sing, "Aligning the Medical Expenditure Panel Survey to Aggregate U.S. Benchmarks," Agency for Healthcare Research and Quality, Working Paper No. 08006, July 2008, http://gold.ahrq.gov/projectsearch/staff_summary.jsp?project=IM05209, accessed June 28, 2010.



package. For the uninsured, we divide total spending into out-of-pocket and uncompensated care. For the other statuses, we divide spending into insured expenses and out-of-pocket costs.

Each of our observations is either insured or uninsured in the baseline. For the uninsured, expenditures in their uninsured state are obtained from the MEPS-HC, as was described above, but we need to estimate what they would spend if insured (an alternate status that may occur under reform). Conversely, we need to know what the insured would spend if they were uninsured. To simulate spending under insurance (and, conversely, under no insurance), we estimated two-part models using MEPS-HC data. For example, consider an uninsured person:

- Step 1: Estimating the probability of having any health expenditures.
 - *Probability of having any expenditures if privately insured* is computed using a sample of the privately insured and controlling for an array of socio-demographic characteristics, health status, and chronic health conditions.
 - *Probability of having any expenditures if enrolled in Medicaid* is estimated similarly, but using a sample of those reporting Medicaid coverage.
 - *Uninsured individuals are deemed to have expenditures or not in the case of being privately insured or enrolled in Medicaid* by comparing the probabilities computed to a random number from a uniform distribution.
- Step 2: For those deemed to have expenditures if insured in step 1, the change in total expenditures after gaining coverage is estimated.
 - *Expenditures if gaining private coverage* are computed using a sample of the privately insured incurring health care expenses and controlling for an array of socio-demographic characteristics, health status, and chronic health conditions.
 - *Expenditures if gaining Medicaid coverage* are computed similarly, but using a sample of those with Medicaid coverage.

We impute expenditures if uninsured and if enrolled in Medicaid for those with private coverage, and we impute expenditures if uninsured and if privately insured for Medicaid enrollees. (Similar work in the past has helped UI estimate the costs of uninsurance in many states and nationally, and what savings would occur after health coverage reform.²²) These expenditures were matched on to the 3-year ACS records using a hotdeck statistical matching procedure which took into account the demographic variables most highly correlated with cost.

²² The first of these path-breaking reports helped provide cost estimates for the debate that led to the Massachusetts health reform. John Holahan, Randall R. Bovbjerg, and Jack Hadley, *Caring for the Uninsured in Massachusetts: What Does it Cost, Who Pays and What Would Full Coverage Add to Medical Spending?* (Boston, MA: Blue Cross Blue Shield of Massachusetts Foundation, November 16, 2004), <http://bluecrossfoundation.org/Policy-and-Research/Initiatives/Roadmap-to-Coverage.aspx> and <http://www.urban.org/url.cfm?ID=1000981>.



Calibrating Medicaid Enrollment and Costs using State Data

Medicaid enrollment reported on the survey differs from state administrative data. The ACS, and nearly all other surveys, generally under-report Medicaid enrollment, particularly among the disabled. Since our model results represent a snapshot of the Alaska population, the appropriate measure was average monthly enrollment. This will be lower than annual enrollment figures, since many are only enrolled part of the year. We reweighted the Alaska ACS data to be compatible with 2011 average monthly enrollment numbers for the disabled, nondisabled nonelderly adults, and nondisabled children, while preserving important characteristics of the survey data, such as income distribution and the distribution of local geography (PUMAs). For this, we used a statistical reweighting package based on the maximum entropy principle.²³ Annual Alaska enrollment numbers are publicly available for FY 2012, but we were unable to find average monthly enrollment or counts of member-months readily available for that year. We sent a data request to the state, but did not get a response until the paper had been finalized. The data they sent were compatible with the costs we had already estimated based on other state data.

Patterns of Medicaid costs in Alaska are also notably different from national averages of Medicaid costs. The MEPS-based costs thus had to be adjusted to take into account state-specific factors such as pricing and utilization. Since we used average monthly enrollment, the corresponding cost measure would be costs per member per month (PMPM). Our data request to the state included 2012 PMPMs for basic eligibility categories. Since we did not get that data before the report deadline, we estimated PMPMs using publicly available per capita spending in FY 2012 and the difference between average monthly and annual enrollment for the disabled, nondisabled nonelderly adults, nondisabled Medicaid children, and CHIP. PMPMs were set so that the total amount spent on acute care for the nonelderly in 2012 matched the published total. The resulting PMPMs were used to calibrate the Medicaid costs of those currently enrolled. Comparable adjustments were made to the costs of those newly enrolling in Medicaid under the ACA, taking into account the differences of that population in factors such as age, gender, and health status which affect health care costs.

Modeling Coverage Changes Under the ACA

To calculate the impacts of reform options, we used the Health Insurance Policy Simulation Model (HIPSM). HIPSM is a detailed microsimulation model of the health care system. It estimates the cost and coverage effects of proposed health care policy options. HIPSM is designed for quick-turn around analysis of policy proposals. It can be rapidly adapted to analyze a wide variety of new scenarios—from novel health insurance offerings and strategies for increasing affordability to state-specific proposals—and can describe the effects of policy options at a number of points in time.²⁴

HIPSM uses a flexible new simulation approach based on the relative desirability of the health insurance options available to each individual and family under reform. The approach (known as a “utility-based

²³ Wittenberg, "An introduction to maximum entropy and minimum cross-entropy estimation using Stata," *The Stata Journal* (2010) 10, Number 3, pp. 315-330.

²⁴ For additional information and a bibliography of research using HIPSM, see *Health Microsimulation Capabilities* (Washington, DC; The Urban Institute; 2012) <http://www.urban.org/uploadedpdf/412154-Health-Microsimulation-Capabilities.pdf>



framework”) allows new coverage options to be assessed without simply extrapolating from historical data, as in previous models. Within HIPS, health insurance decisions made by individuals, families, and employers are calibrated to findings in the best empirical economics literature. A detailed description of the model and its methodology is publicly available.²⁵

The health insurance coverage decisions of individuals and families in the model take into account a number of factors such as premiums and out-of-pocket health care costs for available insurance products, health care risk, whether or not the individual mandate would apply to them, and family disposable income. Affordability of coverage is built into the decision-making, but can be greatly modified by the individual mandate for those who do not qualify for an exemption. We also use HIPS to assess eligibility for public programs such as Medicaid and CHIP and for subsidized private coverage in the exchanges. The model then predicts the insurance choices of individuals and families among available public (e.g., Medicaid/CHIP) and private options (e.g., employer-sponsored insurance, private non-group coverage inside the exchange, and private non-group coverage outside the exchange), taking into account many factors such as premiums, out of pocket healthcare costs, family income, offers of coverage from employers, and available public coverage or subsidies. The general flow of a HIPS simulation is as follows:²⁶

- The model constructs available insurance packages and computes premiums based on current enrollment;
- Simulated employers choose whether or not to offer coverage and whether to offer coverage inside or outside the exchange (if applicable);
- Individuals and families choose from among the coverage options available to them: employer-sponsored insurance, nongroup insurance, health benefit exchanges (if applicable), Medicaid/CHIP, or uninsured;
- Employer, individual, and family decisions are calibrated so that overall behavior is consistent with a number of results from the health economics literature; and
- Premiums are updated based on the new enrollment decisions. The cycle is repeated until equilibrium—in other words, until there is little change between successive iterations of the model.

We used the results of HIPS to predict changes in coverage on our enhanced ACS data. Changes in health insurance coverage under the ACA are computed in six main steps:

1. *New Medicaid and CHIP Enrollment, both among those gaining eligibility and those currently eligible but not enrolled.*
2. *Enrollment in the nongroup exchange, both subsidized and unsubsidized coverage.*
3. *Additional enrollment of the uninsured in employer-sponsored coverage due to the individual mandate, small firm tax credits, and some smaller factors.*

²⁵ Matthew Buettgens, *HIPS Methodology, 2011 National Version*, <http://www.urban.org/UploadedPDF/412471-Health-Insurance-Policy-Simulation-Model-Methodology-Documentation.pdf>

²⁶ Buettgens, *HIPS Methodology*.



4. *Additional enrollment of the uninsured in nongroup coverage outside the exchange.*
5. *Transition from single to family ESI (the individual mandate will provide incentives for families to obtain coverage for all members).*
6. *Transition from nongroup to ESI coverage.*

We simulated coverage changes under the ACA both with and without the expansion based on HIPSM simulation results. Those results showed that the number of currently eligible adults who would newly enroll in Medicaid without the expansion would be 80 percent of the number who would newly enroll with the expansion. For children, the difference was even less. New enrollment among eligible children without an expansion would be about 95% of new enrollment with the expansion.

Medicaid Take-Up Scenarios

We constructed the alternative Medicaid take-up scenarios by supplementing our existing HIPSM estimates, as applied to ACS data, with findings from the empirical literature.²⁷ We set target rates separately for cells defined by the three dimensions of baseline coverage, baseline eligibility, and age.

As we have shown, the large majority of those gaining Medicaid eligibility are adults. For newly eligible adults currently uninsured, we used a low take-up rate of 60% from Amy Davidoff et al.²⁸ That rate is also similar to assumptions made by the Congressional Budget Office.²⁹ Our best estimate of take-up rate was 73 percent, which is typical of HIPSM results elsewhere.³⁰ The high take-up rate of 78% is the highest plausible level in the literature; even with very good outreach, experience has shown that it would be difficult to achieve much higher rates for adults.³¹ For newly eligible children that are currently uninsured, we took the low take-up rate of 73% from Julie Hudson and Thomas Selden's analysis of the MEPS from 1996-2005³² and a high take-up rate of 91% from Lisa Dubay et al.³³—again, the extremes of plausible values found in the literature. There are very few newly eligible children in Alaska.

²⁷ For a useful survey, see Garrett et al., 2009, note 22 above.

²⁸ Davidoff, Amy, Alshadye Yemane, Emerald Adams. "Health Coverage for Low-Income Adults: Eligibility and Enrollment in Medicaid and State Programs, 2002." Kaiser Commission on Medicaid and the Uninsured, February 2005.

²⁹ John Holahan and Irene Headen, *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% Poverty*. The Urban Institute, 2010

³⁰ See *The Urban Institute's Health Microsimulation Capabilities*, July 19, 2010, <http://www.urban.org/url.cfm?ID=412154> and *HIPSM Methodology Documentation, 2011 National Version*, Dec. 2011, <http://www.urban.org/UploadedPDF/412471-Health-Insurance-Policy-Simulation-Model-Methodology-Documentation.pdf>.

³¹ Stan Dorn, Ian Hill, and Sara Hogan, *The Secrets of Massachusetts' Success: Why 97 Percent of State Residents Have Health Coverage*. The Urban Institute, 2009.

³² Julie L. Hudson and Thomas M. Selden. "Children's Eligibility and Coverage: Recent Trends and a Look Ahead." *Health Affairs* 26 (5): 2007. Available at <http://content.healthaffairs.org/content/26/5/w618.full>.

³³ Lisa Dubay, Jocelyn Guyer, Cindy Mann, and Michael Odeh. "Medicaid At The Ten-Year Anniversary of SCHIP: Looking Back And Moving Forward." *Health Affairs* 26 (2): 2007. Available at <http://content.healthaffairs.org/content/26/2/370.full>



Since a number of the newly eligible would currently have private coverage, estimates of crowd-out are important within the overall take-up rates.³⁴ Several papers³⁵, well-summarized by Glied et al.³⁶, provide estimates often taken as standards of crowd-out under current conditions, though care should be taken in making comparisons among them, since different authors measure crowd-out in different ways. Under the ACA, nongroup crowd-out will be substantially higher than it is currently due to the new “no wrong door” interface to the exchange and Medicaid. For the medium and high scenarios, we assume that those seeking coverage in the nongroup exchange will be automatically screened for Medicaid and CHIP eligibility, and will be automatically enrolled if found eligible. This was the most common interpretation of the law until HHS issued final regulations in March, after our work on this project was complete.³⁷ This will eventually affect the large majority of new Medicaid eligibles currently enrolled in non-group coverage. Thus, the 36 percent take-up rate in the standard scenario is the average of a high rate for those with nongroup coverage combined with the low ESI crowd-out rate from the literature. Although the law, as usually interpreted, requires automatic enrollment, it may be interpreted differently in forthcoming regulations. Also, interface limitations may cause this feature to be less effective. To show the effects of this, our low take-up scenario removes the boost that the interface would give to those with nongroup coverage.

Take-up rates for those already eligible for Medicaid but not enrolled are much lower, since these individuals have already exhibited a preference against Medicaid. Take-up rates for those currently eligible are expected to be somewhat higher under the ACA than at present due to the no wrong door process, the integration of enrollment with the tax system, the individual mandate, and concerted outreach efforts. Due to the novelty of these ACA provisions and the uncertainty about their implementation in the coming years, convincing estimates of the Medicaid take-up rates of the currently eligible in the economics literature are essentially nonexistent. Drawing on the work of Garrett, Holahan, Cook, Headen, and Lucas,³⁸ we estimated low and high take-up of 41% and 56% for currently uninsured children, 11% and 31% for uninsured adults, 5% and 25% for privately covered children, and 8% and 26% for privately covered adults by adding and subtracting a sensitivity buffer to the estimates produced by HIPSM. It is important to note that while these numbers seem low, they actually mean that Medicaid participation rates for those currently eligible are significantly higher under reform than currently.

³⁴ Crowd out here means the displacement of private coverage by Medicaid, the taking up of public coverage by someone who would otherwise be privately insured.

³⁵ Most notably, see David M. Cutler and Jonathan Gruber, “Does public insurance crowd out private insurance?” *The Quarterly Journal of Economics*, 111 (1996): 391-430.

³⁶ Glied, Sherry, Dahlia Remler, and Joshua Graff Zivin. “Inside the Sausage Factory: Improving Estimates of the Effects of Health Insurance Expansion Proposals.” *Milbank Quarterly*. Volume 80, Number 4 (2002): 603-636.

³⁷ Under these rules, the interface could simply make an assessment of potential eligibility and forward information to the state Medicaid agency for further processing. The person could receive subsidized exchange coverage in the meantime if otherwise eligible. Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, Final Rule, CMS-2349-F, Federal Register 77(57): 17143-17217, March 23, 2012?

<http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6560.pdf>

³⁸ See Garrett et al., 2009, note 19 above.



Phase-in of New Medicaid Enrollment

This section presents estimated enrollment during the “phase-in” or “ramp-up” period—that is, how Medicaid and CHIP enrollment would change during the initial years of the ACA. This break-out by year should be relevant for budgetary projections and operational planning. The 2014-2020 period covered here corresponds to the years during which the federal matching rate for newly eligible enrollees will be phased down from 100 percent to its permanent level of 90 percent for 2020 and thereafter.

Our method was to separate all of the expected new nonelderly enrollees with the ACA fully phased in into three groups based on expected variation in patterns of take-up:

1. *Those who currently have nongroup coverage and the uninsured who are currently eligible, but who are not enrolled.* The no-wrong-door interface and other provisions of the ACA would affect this group first and most strongly. We assume that their enrollment levels would be 70% of full-implementation levels in 2014, 90% in 2015, and would reach the full levels after that.
2. *The newly eligible uninsured.* Reaching this population quickly would require more outreach. Given that they are not now connected to coverage, they would not necessarily use the no-wrong-door interface immediately, and many would be exempt from the mandate because of their low incomes. For this group, we assume enrollment levels of 50% of the full-implementation level in 2014, 75% in 2015, and 90% in 2016, and full levels after that. This assumption is similar to the phase-in pattern that CBO uses in its national estimates.³⁹
3. *Medicaid eligibles who currently have ESI coverage.* It would take longer for this group to find out that they are eligible. They may never visit the no-wrong-door interface. Phase-in is expected to be slowest for this group. We assume 40% of full-implementation enrollment in 2014, 67% in 2015, 85% in 2016, and 95% in 2017. ESI-to-Medicaid crowd-out behavior would be similar for both current and new eligibles, so we did not separate them.

We then combined the phase-in rates of these groups’ new enrollees with a caseload growth of 0.5 percent per year. We assumed Medicaid cost growth of 4 percent per year.

³⁹ See, for example, CBO, Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act, March 2012, <http://cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf>.



About the Authors

Matthew Buettgens, Ph.D., is a mathematician leading the development of the Urban Institute’s Health Insurance Policy Simulation (HIPSM) model. The model has been used to provide technical assistance for health reform implementation in Massachusetts, Missouri, New York, Virginia, Utah, and Washington as well as to the federal government. His recent work includes a number of papers analyzing various aspects of national health insurance reform, both nationally and state-by-state. Topics have included the costs and savings of health reform for both federal and state governments, state-by-state analysis of changes in health insurance coverage and the remaining uninsured, the effect of reform on employers, the role of the individual mandate, the affordability of coverage under health insurance exchanges, and the implications of age rating for the affordability of coverage. Dr. Buettgens was previously a major developer of the HIRSM model—the predecessor to HIPSM—used in the design of the 2005 roadmap to universal health insurance coverage in the state of Massachusetts.

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