# Overview of Medicaid in United States of America

***By***

*Sweta Kannepalli*

*Dissertation submitted for the partial fulfillment of the*

*MBA Hospital and Health Management*

*Academic year, 2016-2018*


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INSTITUTE OF HEALTH
MANAGEMENT RESEARCH
(WHO Collaborating Centre for District Health System Based on Primary Health Care)

IIHMR UNIVERSITY

**TO WHOMSOEVER MAY CONCERN**

This is to certify that **Dr. SWETA KANNEPALLI** of MBA Hospital and Health Management from The IIHMR University, Jaipur has undergone internship training at **Decision Resource Group, Bengaluru** from **5th Feb 2018 to 4th May 2018.**

The Candidate has successfully carried out the study designated to her during internship training and her approach to the study has been sincere, scientific and analytical.

The Internship is in fulfillment of the course requirements.

I wish her all success in all her future endeavors.

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May 4, 2018

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This is to certify that Sweta Kannepalli a student of IIHMR University, Jaipur has worked with DRG Analytics & Insights Private Limited from 5th February, 2018 to 4th May, 2018 and done a project on "Overview on Medicaid" and her designation at the time of leaving the organization was Intern.

We wish her all the best for her future endeavours.

Yours Sincerely,

DRG Analytics & Insights Private Limited ★ Bengaluru

Aswini Konda
Senior Associate HR

# THE IIHMR UNIVERSITY

## CERTIFICATE BY SCHOLAR

This is to certify that the dissertation **on An Overview of Medicaid in United States of America**, submitted by **Dr. Sweta Kannepalli** with Enrollment No- **IIHMR-U/01/2016-18/0511** under the supervision of **DR. P.R.Sodani** for award of MBA in Hospital and Health of the University carried out during the period from **5th FEBRUARY 2018** to **4th MAY 2018** embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other institute or other similar institution of higher learning.

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## CERTIFICATE BY SCHOLAR

**This is to certify that all ethical issues have been considered while collecting data for my dissertation titled "An Overview of Medicaid".**

Signature

# ACKNOWLEDGEMENT

I feel privileged in expressing my deep sense of gratitude to **Vikram Shanbhag (Director – Market Access) Decision Resource Group**, Bengaluru for his expert guidance and encouragement which immensely helped in the process of making this report. Without his support, exploring such a vast organization could not have been possible.

I would like to express my deep sense of gratitude to **Sonali Prusty (Manager)** Who guided and gave this project. I would not have been able to get so much knowledge and experience about the work, analyzing the data preparing the report without her kind support and guidance

I would also like to thanks to my university mentor **Dr.P.R.Sodani (President)** who guided throughout my academics and dissertation.

**Dr.Sweta Kannepalli**

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## ABBRIVATIONS

| | |
|---|---|
| CMS | Centers for Medicare & Medicaid Services |
| U.S. | United States |
| ACA | Affordable Care Act, |
| MCO | Managed Care Organization |
| OECD | Organization for Economic Co-operation and Development |
| UHC | Universal Health Coverage |
| FPL | Federal Poverty Level |
| CHIP | Children's Health Insurance Program |
| LTSS | long-term services and supports |
| MAT | medication-assisted treatment |
| IMD | institutions for mental disease |
| DC | District of Columbia |
| AR | Arkansas |
| AZ | Arizona |
| IA | Iowa |
| IN | Indiana |
| KY | Kentucky |
| MI, | Maine |
| NH | New Hampshire |
| MT | Montana |

# ABSTRACT

## An Overview of Medicaid in United States of America


### INTRODUCTION

The U.S. health care system is unique among advanced industrialized countries. The U.S. does not have a uniform health system, has no universal health care coverage, and only recently enacted legislation mandating healthcare coverage for almost everyone. The US healthcare system before the introduction of the ACA was inefficient and was focused on treating chronic diseases while not being proactive or helping people take care of their overall health and most of the uninsured were low-income and either couldn't afford coverage or didn't have access to it.

In 2016, 34 percent of U.S. health care spending came from private funds, with 28.1 percent coming from households and 19.9 percent coming from private businesses. The federal government accounted for 28.3 percent of spending while state and local governments accounted for 16.9 percent. Most health care, even if publicly financed, is delivered privately. National health spending is projected to increase at an average rate of 5.6% per year between 2016 and 2025 and 4.7% per year on a per-capita basis.

### OBJECTIVES

I. To obtain a comprehensive understanding of Medicaid in terms of structure and functioning.

II. To understand the trends and changes in Medicaid for the year 2017.

### METHODOLOGY

The study undertaken has following design characteristics:

1) Type of study – A Descriptive, Desk-based Secondary research was under taken.
2) Geographical Setting – United States of America
3) Time-frame of the study – Cross-sectional study was undertaken with emphasis on recent credible data.
4) Type of data – Publicly available secondary research data sources were deployed to obtain the following information

- Economic indicators
- National Insurance Statistics
- Information about Medicaid
- Various process, flowcharts, press releases, interviews and analyst reports etc.

## RESULTS

The U.S. Health Care System has moved close to the Universal Health Care Coverage with the enactment of ACA. Medicaid expansion under the ACA suggests that expansion has had largely positive impacts on coverage; access to care, utilization, and affordability.

Medicaid accounts for more than one-fifth of the U.S. population (Covers 77 million / 23% Americans). Private MCOs administer care to more than 70 percent of Medicaid enrollees. The Department of Health and Human Services estimates that at least 14 million people have enrolled in Medicaid through the ACA expansion.

## CONCLUSION

The study observations suggest potential for gains in coverage and access to consumers.

Medicaid enrollment has increased following implementation of the ACA, while the rate of individuals without insurance has declined but still 28 million people in U.S. are uninsured.

Currently providers in the remaining non-expansion states are considering adopting the expansion in the future which will further increase the enrollment of people falling under coverage gap.

# An Overview of Medicaid in United States of America

## 1) Introduction

The U.S. health care system is unique among advanced industrialized countries. The U.S. does not have a uniform health system, has no universal health care coverage, and only recently enacted legislation mandating healthcare coverage for almost everyone. The United States spends more on health care services than does any other nation on average, more than twice as much per person as the other Organization for Economic Co-operation and Development (OECD) countries. Rather than operating a national health service, a single-payer national health insurance system, or a multi-payer universal health insurance fund, the U.S. health care system can best be described as a hybrid system. In the mid-1960s, the United States implemented insurance programs called Medicare and Medicaid for segments of the population including low income and elderly adults. The US healthcare system before the introduction of the ACA was inefficient and was focused on treating chronic diseases while not being proactive or helping people take care of their overall health. In 2010, Obamacare became the closest the US has come to a system of UHC. A legal mandate now requires all Americans to have insurance or pay a penalty. About 28 million people remain without health insurance despite these advances. Costs are currently the major concern in the US healthcare system.

The health expenditures are financed by a complex mixture of public payers (Federal, State, and local government), as well as private insurance and individual payments. Private insurance and social insurance programs such as Medicare, which pools resources and spreads the financial risk associated with major medical expenses across the entire population to protect everyone, as well as social welfare programs such as Medicaid and the Children's Health Insurance Program, which provide assistance to people who cannot afford health coverage. The United States primarily relies on employers to voluntarily provide health insurance coverage to their employees and dependents; government programs are confined to the elderly, the disabled, and some of the poor. These private and public health insurance programs all differ with respect to benefits covered, sources of financing, and payments to medical care providers. There is little coordination between private and public programs.

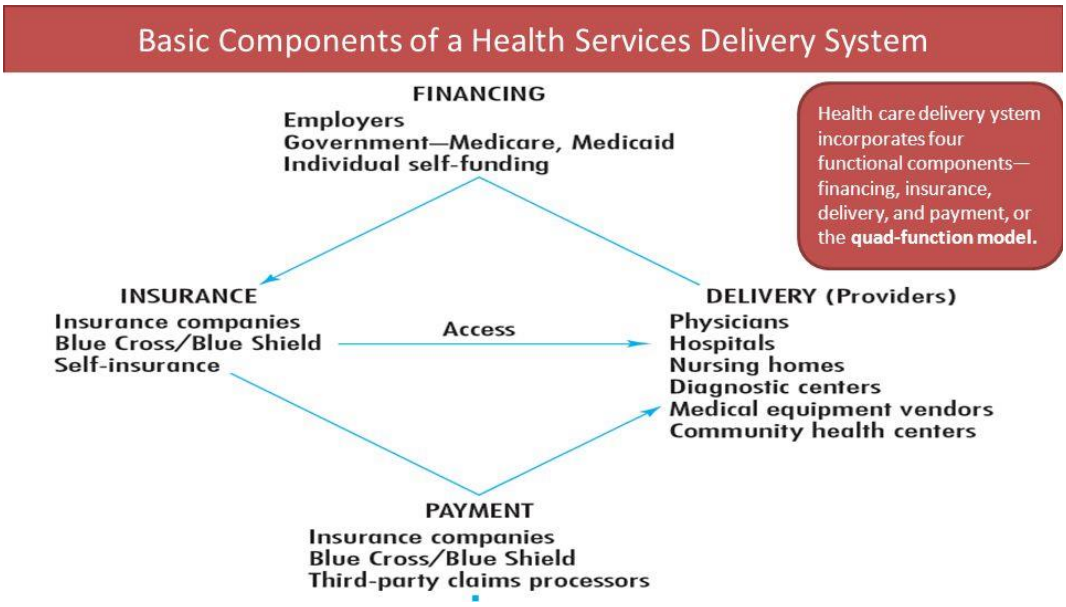


**Figure 1**: **Health Services Delivery System**

In 2016, 34 percent of U.S. health care spending came from private funds, with 28.1 percent coming from households and 19.9 percent coming from private businesses. The federal government accounted for 28.3 percent of spending while state and local governments accounted for 16.9 percent. Most health care, even if publicly financed, is delivered privately. National health spending is projected to increase at an average rate of 5.6% per year between 2016 and 2025 and 4.7% per year on a per-capita basis.

This study mainly focuses on in-depth understanding of Medicaid and its major changes and reforms that occurred from its start till 2018.

## 2) Objectives

I. To obtain a comprehensive understanding of Medicaid in terms of structure and functioning.

II. To understand the trends and changes in Medicaid for the year 2018.

## 3) Methodology

The study undertaken has following design characteristics:

1. Type of study – Descriptive, Retrospective study, Secondary Desk research was under taken.
2. Geographical Setting – United States of America
3. Time-frame of the study – Cross-sectional. Most recent credible source have been used.
4. Type of data – Publicly available secondary research data sources were deployed to obtain the following information
    - Economic indicators.
    - National Insurance Statistics
    - Information about Medicaid
    - Various process, flowcharts, press releases, interviews and analyst reports etc.

# 5) Observations

### 4.1. Introduction to Medicaid

Medicaid in the United States is a joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid also offers benefits not normally covered by Medicare, like nursing home care and personal care services. Medicaid is the largest source of funding for medical and health-related services for people with low income, providing free health insurance to 77 million (23% Americans) low-income and disabled people (as of 2017). It is a means-tested program that is jointly funded by the state and federal governments (the amount of funding varies based on average income in the state) and managed by the states, with each state currently having broad leeway to determine who is eligible for its implementation of the program. Medicaid is the 2nd-largest budget item in most of the states. Medicaid is administered by state (Fee-for-service) / MCO / Primary-care case management. It is the largest payer for many complex health conditions.

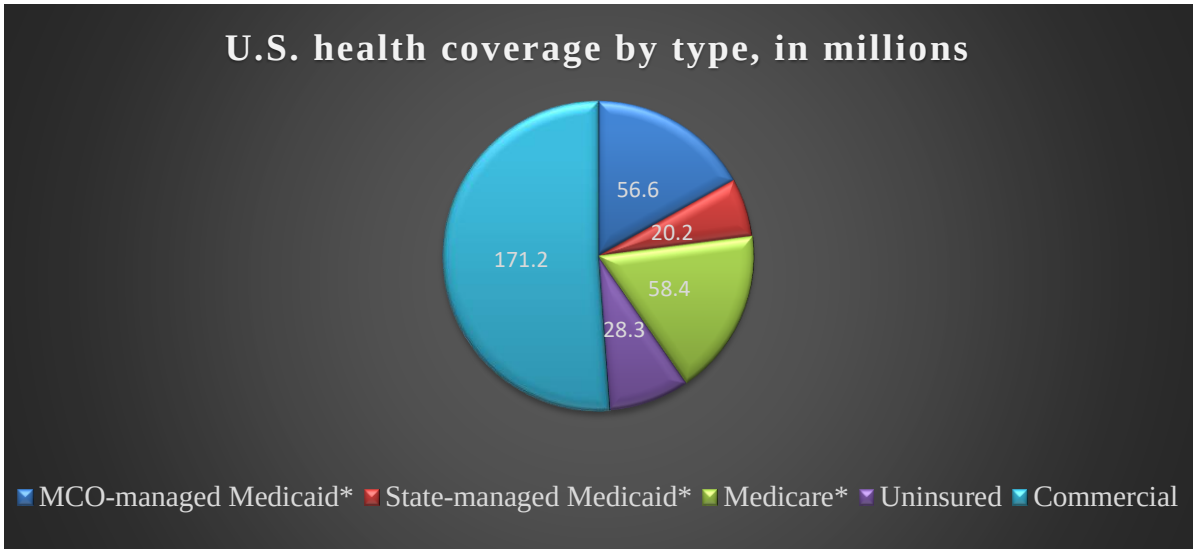


**Figure 2: U.S. Health Insurance Coverage by various insurance as of 2017**

- Medicaid accounts for more than one-fifth of the U.S. population
- Private MCOs administer care to more than 70 percent of Medicaid enrollees.
- The Department of Health and Human Services estimates that at least 14 million people have enrolled in Medicaid through the ACA expansion.

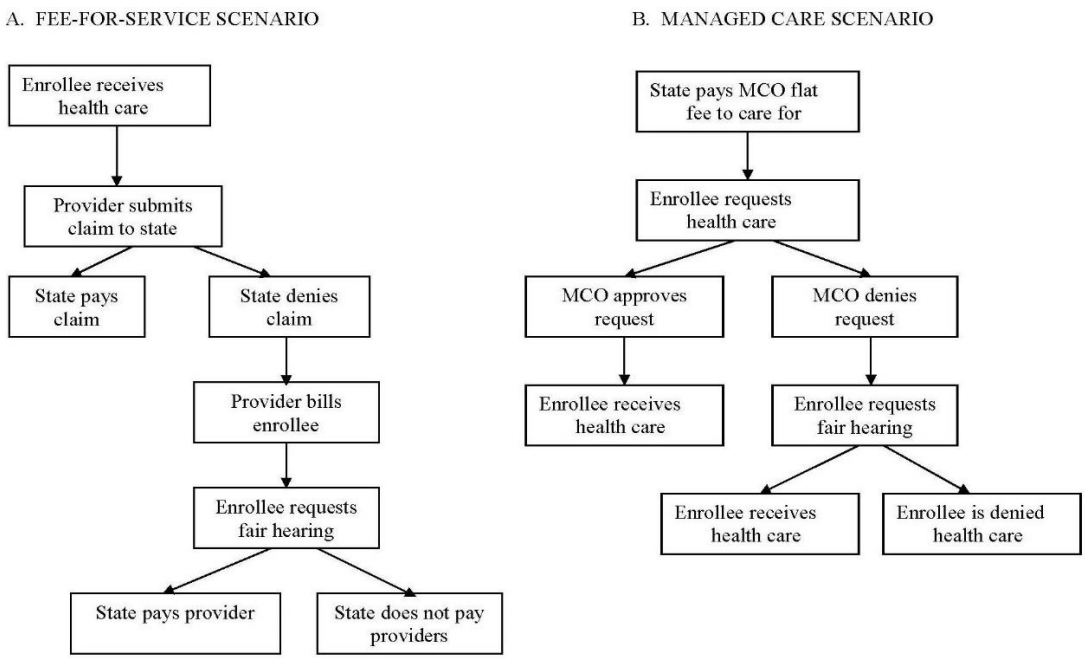


**Figure 3: Types of administration of Medicaid**

### 4.2.Eligibility and benefits for Medicaid as of January 2018

#### 4.2.1. Eligibility

Medicaid recipients must be U.S. citizens or legal permanent residents, and may include low-income adults, their children, and people with certain disabilities. Poverty alone does not necessarily qualify someone for Medicaid.

- 49 states cover children with incomes up to at least 200% of the federal poverty level (FPL, $41,560 per year for a family of three in 2018) through Medicaid and CHIP.

- Most states extend coverage to pregnant women beyond the federal minimum of 138% FPL through Medicaid and CHIP.

- 32 states cover parents and other adults with incomes up to 138% FPL ($28,676 per year for a family of three and $16,753 per year for an individual in 2018) under the ACA Medicaid expansion to low-income adults.

#### 4.2.2. Benefits

- States establish and administer their own Medicaid programs and determine the type, amount, duration, and scope of services within broad federal guidelines.
- Federal law requires states to provide certain "mandatory" benefits and allows states the choice of covering other "optional" benefits.
- Mandatory benefits include services like inpatient and outpatient hospital services, physician services, laboratory and x-ray services, and home health services, among others.
- Optional benefits include services like prescription drugs, case management, physical therapy, and occupational therapy.

### 4.3.Evolution of Medicaid

- Medicaid started out in 1965 primarily covering people receiving welfare. It didn't have its own eligibility rules or application process. If you qualified for cash assistance, you received a Medicaid card. Its reach was limited; the nation's welfare system and therefore Medicaid confined its support to the so-called deserving poor: children and their parents and the elderly, blind, and disabled.

- In the late 1980s, concerns about infant mortality and children's health prompted Congress to extend Medicaid coverage to children and pregnant women whose earnings put them above welfare eligibility levels
- The year 1996 was the year of welfare reform. The Aid to Families with Dependent Children program was replaced by the Temporary Assistance for Needy Families block grant to states, with the goal of reducing reliance on welfare by ending the entitlement to cash aid and imposing work requirements and time limits.

- The enactment of the Children's Health Insurance Program, or CHIP, in 1997 prompted the next round of changes. CHIP triggered further expansions in eligibility for children in Medicaid and CHIP and brought about a wholesale overhaul of the way children enrolled in coverage.

- In 2010, Affordable Care Act, completes Medicaid's transformation by making Medicaid coverage available to all adults in all states based on income.

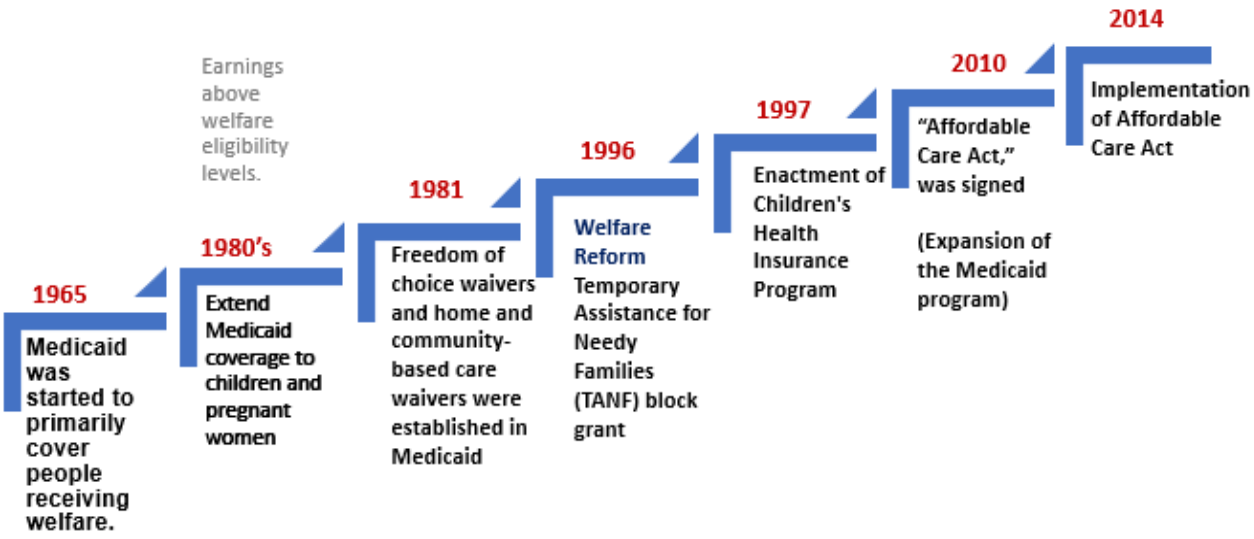


**Figure 4: Milestones of Medicaid**

### 4.4. Medicaid Expansion

The Affordable Care Act (2010) provides Americans with better health security by putting in place comprehensive health insurance reforms that will

- Expand coverage,
- Hold insurance companies accountable,
- Lower health care costs,
- Guarantee more choice, and
- Enhance the quality of care for all Americans.

Since the new law was enacted in March 2010, CMS has worked together with state partners to identify key implementation priorities and provide the guidance needed to prepare for the significant changes to Medicaid and CHIP took effect on January 1, 2014. Medicaid was expanded, to non-disabled adults, low income childless adults and raised Medicaid's mandatory income eligibility from 100% to 138% of the FPL, under ACA.

Not all states expanded Medicaid. As a result, adults in non-expansion states fall into a coverage gap and are ineligible for Medicaid but they also make too little income to qualify for subsidies to purchase private insurance on the marketplaces.

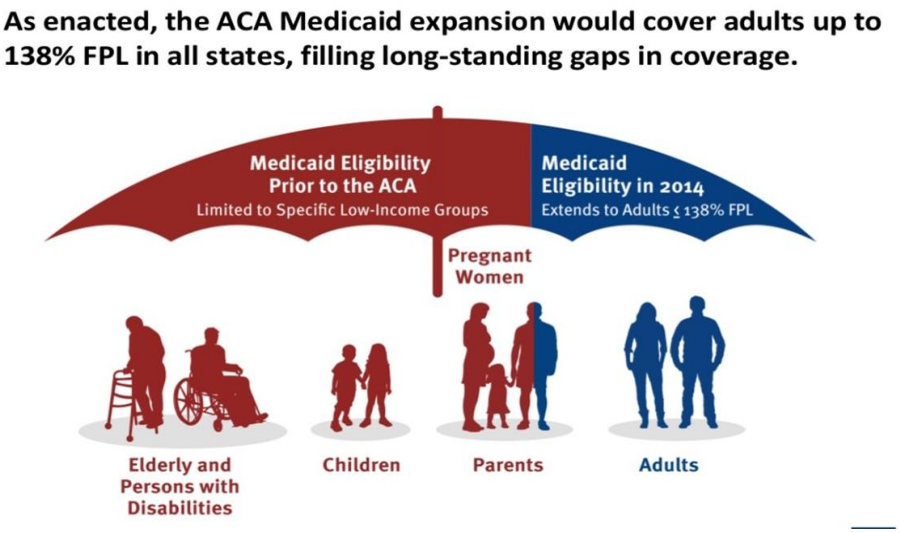


**Figure 5: ACA Medicaid Expansion**

### 4.4.1. ACA and Medicaid enrollment

Medicaid enrollment has increased following implementation of the ACA, while the rate of individuals without insurance has declined. As of November 2017, 77 million individuals are enrolled in Medicaid and overall enrollment increased by 16.3 million among the 49 states.

**Medicaid enrollment increases in expansion states**

States that expanded Medicaid to cover the new adult group showed the largest growth in enrollment. Between July 2013 and November 2017:

- Enrollment in Medicaid expansion states increased by 13.8 million or 37.4 percent;
- 22 of these states saw increases in enrollment of at least 25 percent; and
- increases ranged from 0.8 percent in Vermont to 107.9.2 percent in Kentucky (CMS 2018).

The recent growth in Medicaid enrollment was primarily driven by adults qualifying under the adult group (MACPAC 2016). As of December 2016:

- Enrollment in the new adult group made up 20.4 percent of Medicaid enrollment across all reporting states (CMS 2017).
- The 31 expansion states and the District of Columbia reported a total of 14.9 million enrollees in the new group. Of these, 80.2 percent were newly eligible individuals and entitled to the 100 percent federal matching rate (CMS 2017).

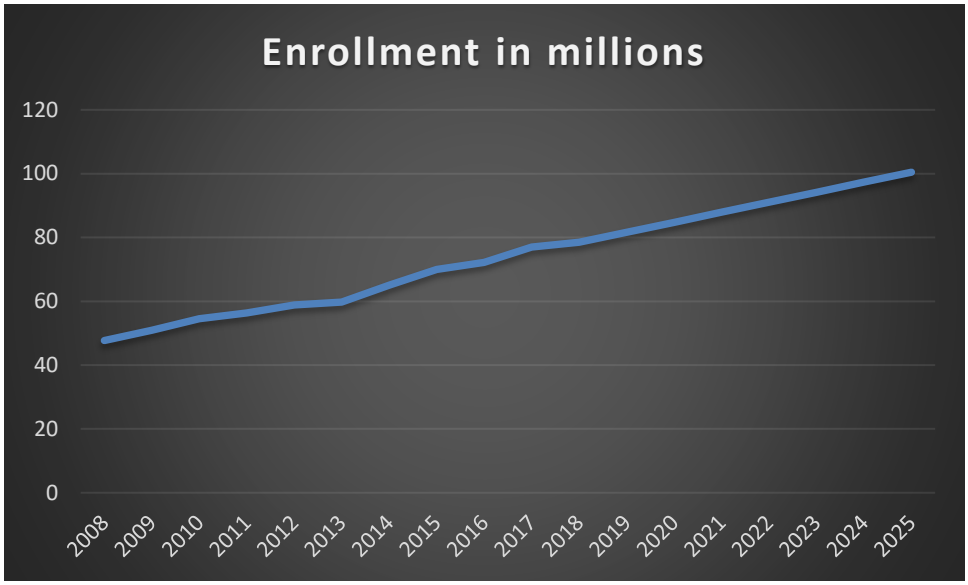


**Figure 6: Medicaid enrollment, Forecast till 2025**

- Graph shows that Medicaid enrollment has been increase from 59.8 Million to 77 million after enactment of ACA.
- Forecasting of data from 2018 shows that the enrollment may reach up to 100 million population in 2025.

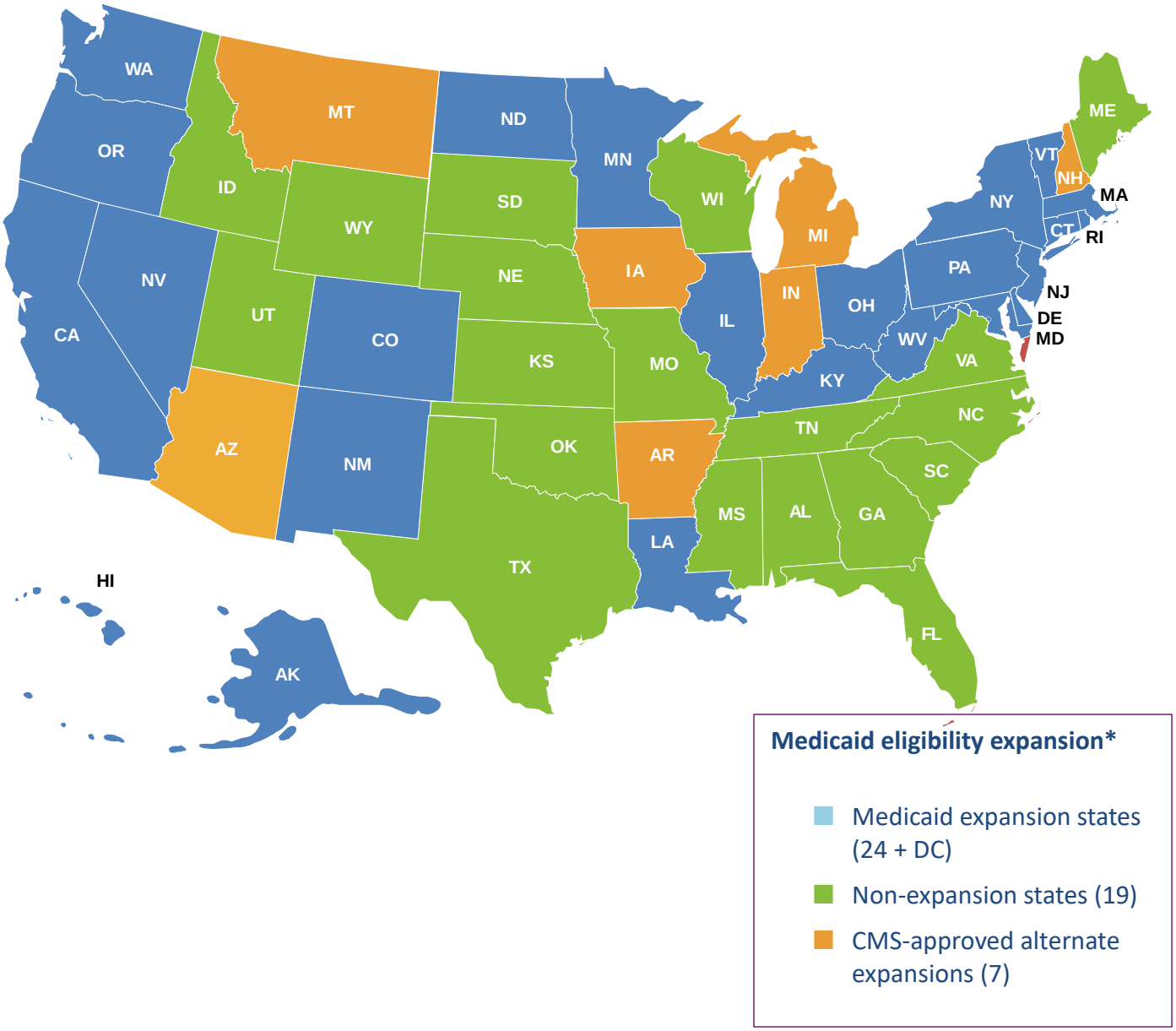


**Figure 7: Medicaid expansion by different states of U.S.**

- 24 states along with Districts of Columbia adopted Medicaid expansion as of 2018.
- 7 states got CMS – approval for alternate expansion path.
- 19 states didn't adopt any kind of expansion.

### 4.4.1. Alternate Expansion Paths

Several states have considered alternatives to the expansion of Medicaid coverage for adults included as part of the Affordable Care Act (ACA). States pursuing alternatives indicated that the expansion included in the ACA does not fit well with their goals and political culture. Notable alternatives focus on personal responsibility and connections to work or protecting state taxpayers from paying for the unanticipated costs of the expansion. The challenges associated with such approaches include internal debate within states as to whether a Medicaid expansion plan should be adopted under any circumstances, as well as negotiating approval for various approaches from CMS.

In expanding coverage to poor, underserved adults, states have grappled with the question of whether to make Medicaid services entirely free for beneficiaries or to require some cost-sharing, in the form of copayments or monthly premiums. This debate over cost-sharing has unfolded in the aftermath of the 2012 United States Supreme Court decision holding that states could not be required to expand Medicaid to maintain their existing federal Medicaid funding. To encourage states that might not otherwise expand Medicaid to participate, the Centers for Medicare and Medicaid Services (CMS) has indicated a greater willingness to consider alternative proposals from states to modify their expansion programs on a waiver basis. These waivers allow states to place beneficiaries into health insurance plans that may deviate from traditional Medicaid in their benefit design and use of incentives. Plan costs per beneficiary must not exceed those of traditional Medicaid.

As of March 5, 2018, eight states (AR, AZ, IA, IN, KY, MI, MT, and NH) have approved waivers to implement the ACA Medicaid expansion in ways that extend beyond the flexibility provided by the law. With the exception of Kentucky, which recently obtained approval to transition its Medicaid expansion from a traditional state plan amendment to a waiver, other Medicaid expansion waivers were originally approved during the previous Administration, in part because states could not otherwise secure political support to expand coverage under existing ACA rules.

States under Section 1115 waiver, has enhanced flexibility to design, improve and adopt changes to their Medicaid program, such as delivery system reforms or use of managed care capitation. Section 1115 waivers include the implementation of alternative ACA Medicaid expansion models; eligibility and enrollment restrictions; work requirements; benefit restrictions, copays and healthy behaviors; delivery system reform initiatives, especially efforts that tie provider incentive payments to performance goals; integrating physical and behavioral health or providing enhanced behavioral health services to targeted populations; authorizing the delivery of Medicaid long-term services and supports (LTSS) through capitated managed care; and responding to public health emergencies and providing coverage for other targeted groups.

### 4.4.2. Work Requirement

The Centers for Medicare and Medicaid Services (CMS) proposed new guidance for Section 1115 waiver proposals that would impose work requirements (referred to as community engagement) to “able-bodied” adults in Medicaid as a condition of eligibility on January 11, 2018.

As of April 2018, Trump administration approved Medicaid work requirements in three states: Kentucky, Arkansas, and Indiana and Kentucky is the first state to receive approval.

### 4.5. Managed Care Organization

Managed Care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services. By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care. Some states are implementing a range of initiatives to coordinate and integrate care beyond traditional managed care. These initiatives are focused on improving care for populations with chronic and complex conditions, aligning payment incentives with performance goals, and building in accountability for high quality care.

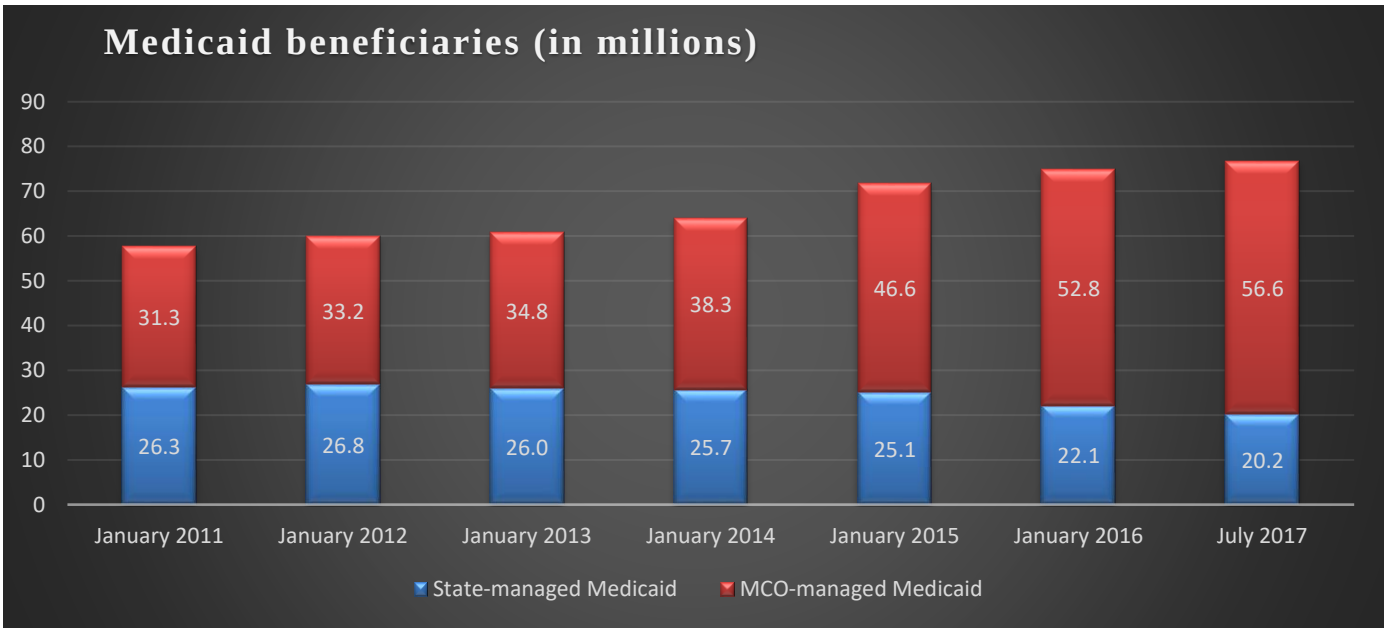


**Figure 8: Medicaid Enrollment under MCO**

- MCO-managed Medicaid enrollment has grown more than 80 percent since January 2011.
- States hurried to expand their contracts with Medicaid MCOs ahead of Medicaid expansion in 2014, adding population subgroups and expanding MCO service areas.
- Three of the largest MCO expansions occurred in Florida, Ohio, and Texas; Iowa made the move in 2016.
- Meanwhile, a few states have pulled back from MCO management; among those, Connecticut and Vermont utilize provider-led models.

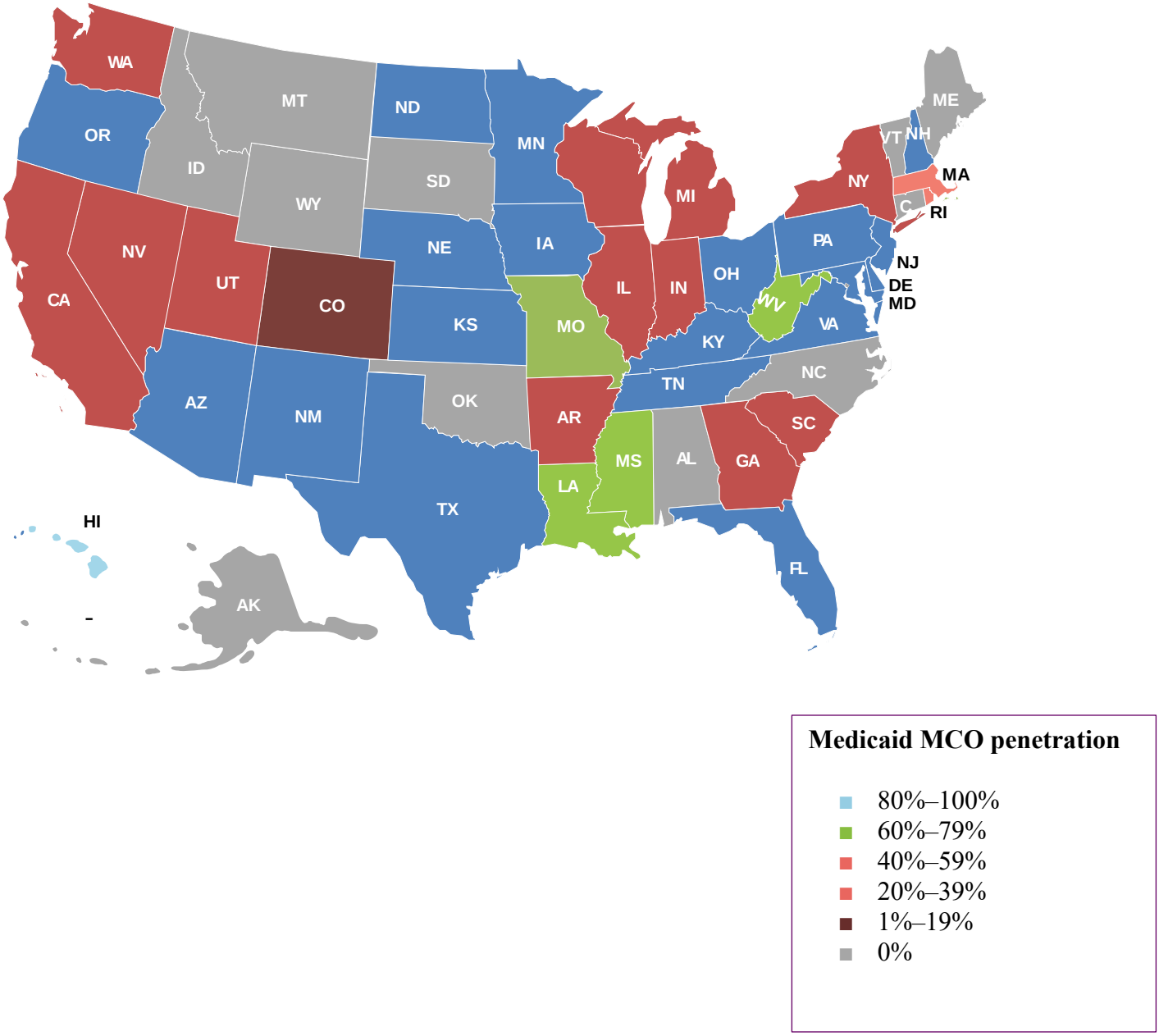


**Figure 9: % of Medicaid MCO Penetration in various states**

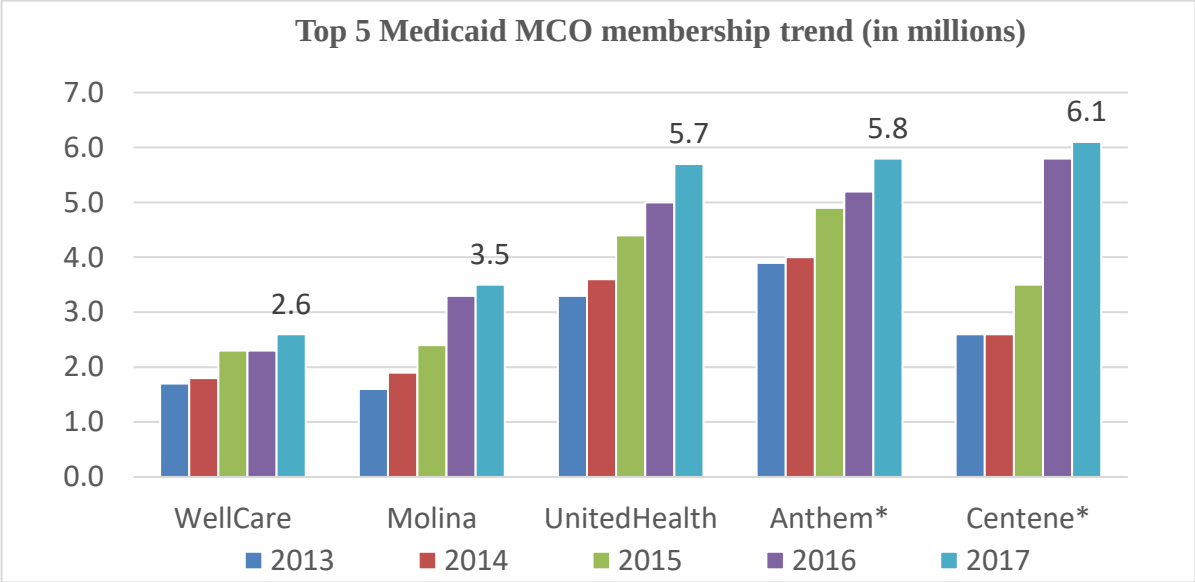


**Figure 10: Medicaid membership growth since 2013, top MCOs**

Medicaid expansion under the ACA has boosted enrollment for the five largest Medicaid MCOs, which together serve about 42 percent of MCO-based membership. As congressional leaders consider transformative changes designed to cut Medicaid spending, health plans and hospitals have a vested interest in the program's future design and funding. But despite the risk of cuts, executives of Aetna, WellCare, and Centene have declared they are in the hunt to acquire more Medicaid plans.

### 4.6. Cost sharing

States have the option to charge premiums and to establish out of pocket spending (cost sharing) requirements for Medicaid enrollees. Out of pocket costs may include copayments, coinsurance, deductibles, and other similar charges. States have flexibility to impose premiums and cost-sharing in Medicaid, with the maximum allowable amounts varying by income and group. Medicaid enrollees, including children, pregnant women, parents and the adult expansion group, with incomes below 150 percent of the FPL may not be charged premiums. Cost-sharing generally is not allowed for children with incomes below 133 percent of the FPL. Adults enrolled in Medicaid may be charged cost-sharing, but charges for those below 100 percent of the FPL are limited to nominal amounts.

Medicaid enrollees (both children and adults) with incomes above 150 percent of the FPL can be charged premiums and relatively higher cost-sharing compared to those at lower incomes.

### 4.7. Prescription Drugs

Medicaid rules give states the ability to use out of pocket charges to promote the most cost-effective use of prescription drugs. To encourage the use of lower-cost drugs, states may establish different copayments for generic versus brand-name drugs or for drugs included on a preferred drug list. For people with incomes above 150% FPL, copayments for non-preferred drugs may be as high as 20 percent of the cost of the drug. For people with income at or below 150% FPL, copayments are limited to nominal amounts. States must specify which drugs are considered either "preferred" or "non-preferred." States also have the option to establish different copayments for mail order drugs and for drugs sold in a pharmacy.

Prescription drug spending has been a key driver of the increase in Medicaid spending. After many years of low to moderate growth, Medicaid prescription drug spending increased 24.6 percent in 2014 and 13.6 percent in 2015 according to the Centers for Medicare & Medicaid Services, primarily due to increased spending for hepatitis C drugs.

These drugs, which can effectively cure many types of hepatitis C, also come with high list prices. The initial list price for Sovaldi—which has been one of the two most popular hepatitis C treatments along with Harvoni—was about $84,000 for a standard 12-week regimen when it launched in 2013. Before accounting for rebates, Medicaid programs nationwide spent more than $2.8 billion in 2015 on Sovaldi and Harvoni, almost five percent of total drug spending.

Medicaid patients suffering from hepatitis C, now gets coverage for potentially life-saving medications before they suffer serious liver damage. New Jersey officials have proposed a rule change, in April 2018, that would enable those individuals to access drugs that can potentially cure them of hep-C, a viral liver infection earlier in the course of their disease; currently, these drugs are only covered after a certain level of liver damage is detected in the patient. A growing number of states have abandoned similar requirements in recent years as the price of these costly treatments has started to decline.

### 4.8. Opioid Crisis and Management

The opioid epidemic or opioid crisis is the rapid increase in the use of prescription and non-prescription opioid drugs in the United. According to the U.S. Drug Enforcement Administration, "overdose deaths, particularly from prescription drugs and heroin, have reached epidemic levels. Nearly half of all opioid overdose deaths in 2016 involved prescription opioids. In 2016, over 64,000 Americans died from overdoses, 21 percent more than the almost 53,000 in 2015.

In 2016, 1.9 million nonelderly adults in the United States had an opioid addiction. Medicaid covers 4 in 10 nonelderly adults with opioid addiction. Medicaid helps to address the opioid epidemic by providing access to coverage and necessary health care. The program covers a disproportionate share of individuals with opioid

addiction and facilitates access to numerous treatment services. Additionally, as of February 2018, 33 states have adopted the Medicaid expansion, with enhanced federal funding, to cover adults up to 138% of the federal poverty level ($16,753/year for an individual in 2018). All Medicaid expansion benefit packages must include

behavioral health services, including mental health and substance use disorder services, which has increased access to care for many people with opioid addiction.

### 4.8.1. Medicaid's Role in Covering Opioid Addiction Treatment Services

- State Medicaid programs cover numerous addiction treatment services that fit into several state plan categories, including outpatient treatment, inpatient treatment, prescription drugs, and rehabilitation.
    - The standard of care for opioid addiction is medication-assisted treatment (MAT), which combines one of three medications (methadone, buprenorphine, or naltrexone) with counseling and other support services. All state Medicaid programs cover at least one medication used as part of MAT,11 and most cover all three of these medications.
- Several policy changes have allowed states to obtain waivers to allow Medicaid funding of substance use treatment services at institutions for mental disease (IMDs).
- Many states have also applied for other Medicaid Section 1115 behavioral health waivers focused on treating individuals with addiction, including opioid addiction.

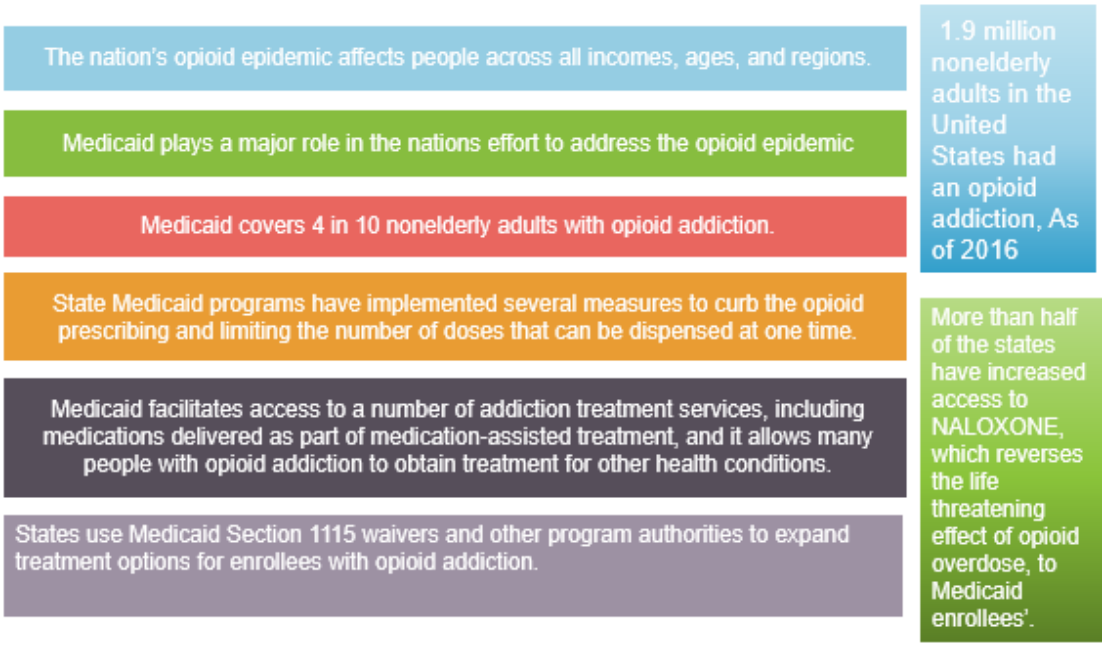


**Figure 11: Opioid Crisis and Management**

## 5) Conclusion

The US healthcare system before the introduction of the ACA was inefficient and was focused on treating chronic diseases while not being proactive or helping people take care of their overall health. In 2010, Obamacare became the closest the US has come to a system of UHC. Medicaid expansion under the ACA suggests that expansion has had largely positive impacts on coverage; access to care, utilization, and affordability. The study observations suggest potential for gains in coverage and access as well as economic benefits to states and providers in the remaining non-expansion states that may be considering adopting the expansion in the future. Medicaid enrollment has increased following implementation of the ACA, while the rate of individuals without insurance has declined. As of November 2017, 77 million individuals are enrolled in Medicaid and overall enrollment increased by 16.3 million among the 49 states. The 31 expansion states and the District of Columbia reported a total of 14.9 million enrollees in the new group Adults. Currently providers in the remaining non-expansion states are considering adopting the expansion in the future. As of March 5, 2018, eight states (AR, AZ, IA, IN, KY, MI, MT, and NH) have approved waivers to implement the ACA Medicaid expansion in ways that extend beyond the flexibility provided by the law. If the present guidelines and rule for Medicaid is followed than the enrollment may reach up to 100 million population in 2025.

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