kaiser commission on medicaid and the uninsured

MEDICAID FACTS

THE HENRY J. KAISER FAMILY FOUNDATION

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MEDICAID ENROLLMENT AND SPENDING TRENDS

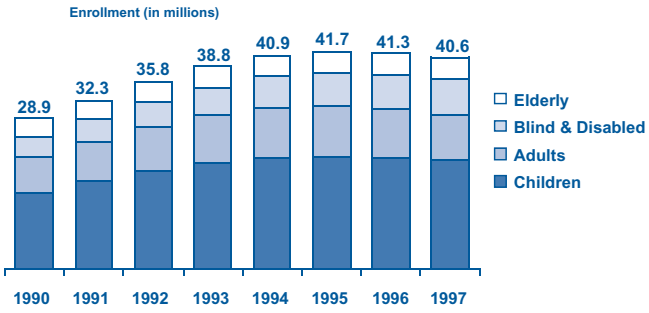
In 1997, Medicaid financed health care for 40.6 million low-income children, adults, elderly, and disabled individuals at a cost of $167.6 billion, with $161.2 billion for services and $6.4 billion for administration. After rising rapidly in the early 1990s, Medicaid spending and enrollment growth have slowed markedly. Between 1996 and 1997, Medicaid spending grew by only 4.1% and Medicaid enrollment actually declined by 1.8%, decreasing for the second year in a row.

ENROLLMENT TRENDS: 1990-1997

Medicaid enrollment grew steadily from 28.9 million people in 1990 to 41.7 million in 1995 (Figure 1), but dropped to 40.6 million by 1997.

Figure 1

Medicaid Enrollment Growth by Eligibility Group, 1990-1997



SOURCE: Urban Institute estimates based on HCFA-2082 and HCFA-64 Reports, 1999.

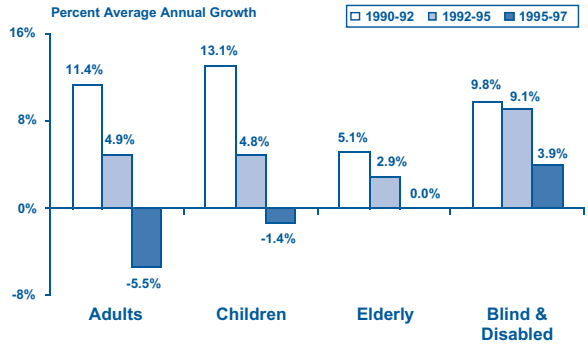
1990 to 1995: In the early 1990s, most enrollment growth resulted from expansions in coverage of low-income children and pregnant women, increases in coverage of children and adults through Supplemental Security Income (SSI), and eligibility expansions for low-income Medicare beneficiaries.

1995 to 1997: Enrollment growth declined for all eligibility groups during this period, falling by 5.5% for adults and 1.4% for children (Figure 2). Enrollment growth among disabled individuals also slowed, while the number of elderly enrollees remained stable.

The declines in enrollment of adults and children are most likely related to welfare changes. The number of Medicaid beneficiaries receiving cash assistance fell by 13% for adults and 11% for children in 1997. These drops occurred despite expansions in Medicaid coverage for adults and children.

Figure 2

Rate of Growth in Medicaid Enrollment by Eligibility Group, 1990-1997



SOURCE: Urban Institute estimates, 1999.

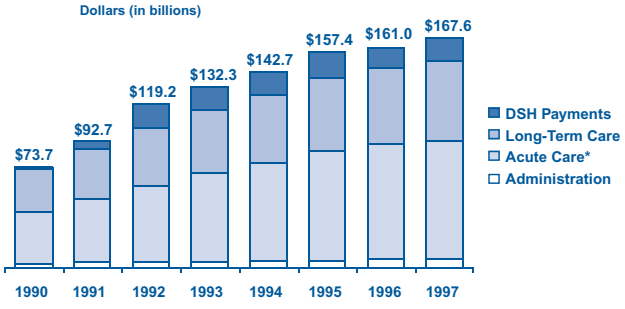
SPENDING TRENDS: 1990-1997

Medicaid spending grew from $73.7 billion in 1990 to $167.6 billion in 1997 (Figure 3). The most rapid growth occurred in the early 1990s, when spending rose at double-digit rates largely due to payments to states for disproportionate share hospitals (DSH) and enrollment increases. More recently, with low rates of inflation and federal limits in expenditures on DSH payments, spending growth has moderated.

1990 to 1995: From 1990 to 1992, Medicaid spending grew an average of 27.1% annually, largely due to unprecedented growth in DSH payments (263.4% average annual growth) as well as high rates of inflation in health care prices, significantly higher utilization, a shift in services previously

Figure 3

Medicaid Spending Growth by Service, 1990-1997



*Includes Medicare and HMO payments.
SOURCE: Urban Institute estimates based on HCFA-2082 and HCFA-64 Reports, 1999.

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financed by other programs into Medicaid, and large growth in the number of enrollees (Figure 4).

Medicaid spending growth rates fell after 1992, increasing by 9.7% per year between 1992 and 1995. This initial slowdown in growth could be attributed to smaller enrollment growth, slower growth of spending per enrollee, and a leveling of DSH payments (2.0% growth).

1995 to 1997: Overall Medicaid spending rose 3.2% annually during this period (2.3% from '95-'96 and 4.1% from '96-'97), two of the lowest rates in the history of the program. The primary reasons behind this spending slowdown are:

Figure 4

State and Federal Medicaid Expenditures by Service, 1990-1997

Type of Spending	Spending (billions)		Average Annual Growth		
	1990	1997	1990-92	1992-95	1995-97
Total	**$73.7**	**$167.6**	**27.1%**	**9.7%**	**3.2%**
Acute Care	$37.0	$85.7	22.3%	12.8%	3.9%
Long-Term Care	$32.3	$59.6	14.6%	8.2%	5.3%
DSH	$1.3	$15.9	263.4%	2.0%	-7.9%
Administration	$3.2	$6.4	9.8%	12.8%	8.0%

SOURCE: Urban Institute estimates based on HCFA-2082 and HCFA-64 Reports, 1999.

- **Lower Spending Due to Falling Enrollment.** The major reason for the slowdown in spending was the reduction in adult and children enrollees eligible because of their cash assistance status, which fell sharply in response to state welfare reforms and an improving economy. Some individuals losing cash assistance remained enrolled in Medicaid under other eligibility categories, but not enough to offset the declines in cash assistance. The rate of growth in spending for the elderly and disabled groups also declined.
- **Declines in DSH payments.** A second major reason for the low rate of Medicaid spending growth in 1996 and 1997 was a nearly 8 percent drop in DSH payments (Figure 4). In part, this decline may have been in response to full implementation of 1993 legislation limiting DSH payments. Alternatively, it may reflect an acceleration of DSH payments by some states in 1995 in the expectation of Medicaid block grant legislation. This explanation may account for the nearly 20% drop in 1996 DSH spending, which rebounded in 1997 to grow by roughly 5.5%.

As enrollment fell, the overall rate of growth in costs per enrollee remained fairly constant. However, the rate of growth in spending per adult and child enrollee has decreased appreciably in recent years (Figure 5). These data suggest, at least in the aggregate, that states are restraining spending growth. Because adults and children are the primary users of Medicaid managed care, this finding provides some early evidence that managed care may contribute to the slowing in expenditure growth.

Figure 5

Average Spending Per Enrollee by Enrollment Group, 1990-1997

Type of Enrollee	Cost per Enrollee		Average Annual Growth		
	1990	1997	1990-92	1992-95	1995-97
All	**$2,400**	**$3,581**	**6.7%**	**5.3%**	**5.9%**
Elderly	$6,904	$10,804	10.9%	5.3%	4.3%
Blind & Disabled	$6,422	$8,841	7.0%	3.7%	3.8%
Adults	$1,317	$1,874	8.9%	4.3%	2.8%
Children	$741	$1,156	9.6%	6.5%	3.7%

SOURCE: Urban Institute estimates based on HCFA-2082 and HCFA-64 Reports, 1999.

LOOKING AHEAD

Preliminary HCFA data indicate that Medicaid spending will grow by about 4.7 percent in 1998. Spending on acute care will increase by 6.5% and long-term care by 4.9%. Three central issues will determine the course of Medicaid spending growth: enrollment trends; changes in the rate of inflation underlying health care costs, as well as other factors affecting spending per enrollee such as managed care, prescription drugs, and long-term care; and the future of DSH payments. All that appears certain at this point is that DSH payments will decline according to the schedule legislated in the Balanced Budget Act of 1997.

Enrollment trends are difficult to predict; however, continued declines in welfare-related enrollment among non-disabled adults and children could result in future low rates of Medicaid spending growth. Recent studies suggest that states have not kept eligible individuals enrolled under welfare reform. However, improved outreach and administrative processes in some states may eventually counteract these forces, though not in the immediate future.

Higher health care prices and managed care premiums are also predicted to increase Medicaid costs, and the aging of the population will continue to place pressure on state Medicaid spending on long-term care.

Source: *Medicaid Spending Continues to Grow Slowly in 1997*, by Brian Bruen and John Holahan of the Urban Institute, September 1999. Prepared for the Kaiser Commission on Medicaid and the Uninsured.