

Reassessing the Outlook for Medicaid Spending Growth

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This brief draws heavily from previous and ongoing work sponsored by the Kaiser Commission on the Future of Medicaid. A similar piece will appear in *Health Affairs* 16 (March-April 1997).

The Medicaid program is the primary source of health care for low-income families with children, as well as for low-income elderly and disabled persons. It is currently financed jointly by the states and the federal government, with the federal government matching whatever a state spends on its Medicaid program—dollar for dollar in the richest states and more generously in the poorer states. Between 1988 and 1992, total Medicaid spending grew at over 22 percent a year, leading to charges that Medicaid spending was “out of control”—that it was not only becoming an intolerable financial burden to the states but was also a major contributor to the growing federal deficit.

In 1995, leaders of the 104th Congress proposed that the Medicaid program be repealed and replaced with fixed block grants to states accompanied by broad state discretion on spending. The Administration proposed to keep Medicaid as an entitlement but to place a ceiling on federal spending per enrollee—again with considerable increases in state flexibility. Neither proposal became law, but at least the latter will be seriously discussed in the upcoming year.

This brief shows that Medicaid spending growth has slowed substantially since 1992 and argues that this growth slowdown is likely to continue—reducing, though not eliminating, the fiscal pressures that led to the 1995 reform proposals.

Reasons for Explosive Medicaid Growth (1988–1992)

The 22 percent annual growth rate between 1988 and 1992 increased Medicaid expenditures from \$53.5 billion to \$119.9 billion in just four years (table 1). Annual spending on the elderly

and disabled averaged annual growth rates of just under 15 percent and 17 percent, respectively. Spending on families grew by almost 24 percent a year. These growth rates compare with average annual growth in the

general inflation rate for urban consumers of 4.4 percent over the period.

Enrollment Growth. The most prominent reason for this rapid program growth was growth in beneficiaries, which increased from about 22 million to almost 30 million Americans over the period (table 2). This growth in beneficiaries was fueled by both legislative mandates and court decisions.

First, in the late 1980s, Congress ended the exclusive link between participation in the Aid to Families with Dependent Children (AFDC) program and access to Medicaid coverage for families with children. By 1990, federal law required coverage of all pregnant women, infants, and children under age 6 with family incomes up to 133 percent of the federal poverty line regardless of

Table 1
Federal and State Medicaid Expenditures, 1988–1995

Expenditures	Spending (\$ billions)			Average Annual Growth	
	1988	1992	1995	1988–1992	1992–1995
Total	\$53.5	\$119.9	\$157.3	22.4%	9.5%
Benefits	50.6	98.5	132.8	18.1	10.5
By Service					
Acute Care	25.4	55.5	80.4	21.6	13.1
Long-term Care	25.1	42.9	52.3	14.3	6.8
By Group					
Elderly	18.1	31.4	39.4	14.7	7.9
Blind and Disabled	19.3	36.2	49.9	17.0	11.3
Families	13.1	30.9	43.5	23.9	12.1
DSH Payments	0.4	17.5	19.0	149.9	2.7
Administration	2.4	3.9	5.5	12.2	12.6

Source: Urban Institute 1997.

AFDC reciprocity. States were also given the option to extend Medicaid coverage to pregnant women and infants up to 185 percent of the poverty line with federal matching payments, and many did so. States are now required to cover all children ages 6 through 13 up to the federal poverty line. Poor children ages 14 to 18 are scheduled to be phased in by the year 2002.

Between 1988 and 1992, an estimated 4.5 million pregnant women and children were covered through these mandates,¹ constituting about half the total increase in enrollment, although a substantially lower share of total spending growth.²

Second, the Medicare Catastrophic Coverage Act of 1988 and the Omnibus Budget Reconciliation Act of 1990 required Medicaid programs to cover Medicare costs for low-income elderly and disabled persons not eligible for cash assistance, called qualified Medicare beneficiaries (QMBs). States became responsible for covering Medicare premiums and cost sharing for all Medicare-eligible persons with incomes below the federal poverty line. By 1995, this was extended to premium assistance for Medicare eligibles with incomes between 100 percent and 120 percent of poverty. According to one estimate, 1.3 million low-income elderly and disabled received Medicare coverage through the QMB legislation in 1995.³

Third, Supplemental Security Income (SSI) program enrollment grew for a variety of reasons. Court decisions—principally the Zebley decision—increased SSI coverage for learning-disabled children. At the same time, a congressionally mandated broadening of the list of qualifying medical conditions affecting disabled children also expanded SSI enrollment and Medicaid eligibility. And many states and localities intensified efforts to enroll individuals into the SSI program who would have otherwise been covered by state or local general assistance programs, to obtain the federal cash contributions as well as Medicaid coverage. This period

also saw SSI coverage expanded to include many individuals with acquired immunodeficiency syndrome (AIDS), substance abuse problems, and other social and medical problems.

Finally, Medicaid also expanded during these years because of the recession and in concert with related means-tested programs. Between 1988 and 1991, AFDC enrollment increased by over 15 percent and food stamp enrollment by about 20 percent.

Utilization Growth. Another factor explaining Medicaid expenditure increases during the 1988–1992 period was growth in health care utilization,

require provider contributions or impose taxes on providers. Medicaid programs would then increase payments to the same providers through DSH payments. These DSH payments would return much, if not all, of the donations or tax payments to the providers; the state could then claim federal matching funds for the DSH payments. In many cases, these funds were used to assist hospitals in supporting indigent care. In others, federal funds substituted for expenditures states would have otherwise made, leaving total health expenditures more or less the same. Regardless of how

these funds were used, DSH payments had a major impact on Medicaid expenditure growth during this period. DSH payments accounted for about \$400 million in 1988 and grew to more than \$17 billion by 1992.

Other Factors. Several other factors also contributed to the cost explosion. Inflation in health care prices more generally, for example, affects Medicaid provider payment rates, because per-

sistent wide divergence between private and Medicare rates erodes access by reducing provider participation in Medicaid. In addition, Medicaid's financial role in nursing home care increased. New protections against spousal impoverishment increased what nursing homes received from Medicaid for the care of residents whose spouses remained in the community. Medicaid's mandate to pay for "efficiently and economically run" facilities under the Boren Amendment also exposed the program to increased facility costs, particularly wage costs.

Further financial pressure reportedly also may have come in many states because of greater availability of Medicaid-financed long-term care in the community and at home. And an unknown number of people may have divested assets to become eligible for Medicaid nursing home benefits. Finally, states became increasingly aggressive in shifting services previously financed through other programs (such as institutional services for the

Table 2
Medicaid Beneficiaries and Expenditures per Beneficiary, 1988–1995

	1988	1992	1995	1988–1992	1992–1995
	<u>Persons (millions)</u>			<u>Average Growth (%)</u>	
Beneficiaries (Total)	22.0	29.8	34.8	7.9%	5.3%
Elderly	3.1	3.5	3.9	3.2	3.0
Blind and Disabled	3.4	4.5	5.7	6.7	8.7
Families	15.5	21.8	25.1	9.0	4.9
	<u>Dollars</u>			<u>Average Growth (%)</u>	
Expenditures per Beneficiary (federal and state)	\$2,298	\$3,303	\$3,816	9.5	4.9%
Elderly	5,794	8,848	10,166	11.2	4.7
Blind and Disabled	5,619	8,099	8,685	9.6	2.4
Families	848	1,416	1,728	13.7	6.8

Source: Urban Institute 1997.

due in part to changes in the population gaining coverage. For example, expansions to cover pregnant women and increased coverage of AIDS patients and substance abusers automatically brought in groups with higher-than-average health care expenditures. The 1989 amendments to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for children, which required additional screening services—plus Medicaid coverage of all needed services irrespective of their coverage under a particular state benefit package—reportedly also have increased Medicaid spending.

Disproportionate Share Hospital (DSH) Payments. The aggressive use of DSH payments, often financed by provider taxes and donations, was a further factor pushing up Medicaid costs.⁴ These arrangements brought federal dollars to states, with the funds largely distributed to hospitals providing care to a disproportionately high share of low-income individuals. The typical practice was for states to

developmentally disabled) to Medicaid.⁵ Known as “Medicaid maximization,” this practice allowed state-only dollars to be replaced by federally matched dollars.

Slowdown in Medicaid Growth (1992–1995)

Medicaid program growth slowed substantially after 1992, growing by only 9.5 percent per year, on average, between 1992 and 1995 (table 1). Preliminary data suggest that Medicaid expenditures grew by about 3.3 percent in 1996. The low 1996 growth may reflect an acceleration of state spending in 1995 in response to proposed legislation to restructure Medicaid that would have used 1995 data as the basis for distribution of block grants. Average annual spending growth over the 1994–1996 period as a whole was about 6 percent, still lower than earlier levels.⁶

The reasons for the slowdown in growth pretty well parallel the major factors accounting for the earlier growth explosion.

Enrollment. Medicaid enrollment increases slowed from almost 8 percent annually between 1988 and 1992 to a little over 5 percent

between 1992 and 1995 (table 2), with a steadily downward trend in growth over those years. In 1995, enrollment growth increased by under 2 percent. This reduced growth was shared by each of the major eligible groups (table 3).

Among families, Medicaid enrollment increased by almost 12 percent in 1992, 9 percent in 1993, and less than 1 percent in 1995. AFDC rolls have actually declined, through a combination of improving state economies, tougher AFDC work requirements, and other factors. In addition, Medicaid enrollment growth has slowed among pregnant women and children because the new coverage mandates had produced high participation rates among these populations by the mid-1990s.

Among the blind and disabled population, Medicaid growth fell from nearly 11 percent in 1992 to under 7 percent in 1995. The major reason here is that

the court decisions responsible for dramatic increases in enrollment of disabled children in the 1988–1992 period had pretty well played out by 1994. Program data reveal that the growth in the SSI disabled population fell from more than 10 percent a year in the early 1990s to under 6 percent in 1995.⁷

Among the elderly, Medicaid enrollment growth fell from just over 7 percent in 1992 to a little over 1 percent in 1995. The reason, here again, is that the factor underlying enrollment escalation in the earlier period—QMB enrollment for this group—had already stimulated most of the potential increase in participation. In addition, the number of elderly receiving cash assistance through SSI declined.

Spending per Enrollee. Growth in spending per enrollee also slowed between 1992 and 1995, from over 9 percent to 5 percent per year. Although

implemented these programs, all but one statewide.¹⁰ Managed care enrollment has risen dramatically, from 3.6 million beneficiaries in 1992 to 11.6 million—one-third of Medicaid enrollment—in 1995.

DSH Payments. Another reason the growth in Medicaid expenditures has declined is because of 1991 and 1993 legislation affecting the use of disproportionate share payments.¹¹ Disproportionate share payments increased by only 2.7 percent per year between 1992 and 1995, after several years of explosive growth, because of the 1991 and 1993 legislation banning the use of provider donations and severely restricting the kinds of provider taxes states could employ. In effect, states could no longer guarantee that a hospital could be “made whole” for a donation or tax payment through reciprocal DSH payments. The 1991 legislation also capped DSH payments at 12 percent of program expenditures. Any state whose DSH payments exceeded 12 percent would be frozen at 1993 levels until DSH payments had fallen to 12 percent of Medicaid expenditures. Because program spending has slowed, the allowed rate of growth in DSH payments has further slowed.

The 1993 legislation also made it illegal for states to pay a hospital more than what the facility was losing through low Medicaid reimbursement rates or through the provision of uncompensated care. This severely restricted states’ ability to pay large amounts of money to specific hospitals, significantly reducing Medicaid expenditures in some of these states.

Other Factors. The enrollment slowdown, the growth of managed care, and the changes in federal DSH policy are not enough to explain all the slowdown in Medicaid spending growth. An additional explanation is the drop in average annual medical price inflation from 8.2 percent in the 1988–1992 period to 5.1 percent between 1992 and 1995. States also appear to have successfully adopted other policies to limit expenditure growth, particularly for long-term care. The growth in spending per enrollee, for example, fell *more* for the elderly

Table 3
Medicaid Beneficiaries, 1991–1995

	1991	1992	1993	1994	1995
Total (millions)	26.9	29.8	32.4	34.2	34.8
Elderly	3.3	3.5	3.7	3.8	3.9
Blind and Disabled	4.0	4.5	5.0	5.4	5.7
Families	19.5	21.8	23.8	25.0	25.2
Annual Growth		11.0%	8.8%	5.4%	1.8%
Elderly		7.2	3.7	4.0	1.2
Blind and Disabled		10.7	11.6	7.8	6.8
Families		11.7	9.1	5.1	0.8

Source: Urban Institute 1997, based on unedited HCFA 2082 form data.

it is too soon to know why, one possible reason is that rapid growth in managed care is achieving at least short-term savings in several states.⁸

In addition, there has been a rapid expansion of mandatory managed care enrollments through two waiver programs. The 1915 (b) “Freedom of Choice” waivers are typically limited to a geographic area within a state. Thirty-three states now have 1915 (b) waivers for managed care. Enrollment in managed care can be mandatory under these waivers, but health maintenance organizations (HMOs) must still have no more than 75 percent Medicaid or Medicare enrollment.

Section 1115 “Research and Demonstration” waivers permit states to move substantially further in enrolling Medicaid beneficiaries in managed care.⁹ Today, 15 states have received federal approval for Section 1115 waiver programs, and 11 have

and the blind and disabled than for families, even though families were the population most affected by the growth in managed care.

Finally, many states have slowed down efforts to expand their use of Medicaid as the vehicle through which to funnel state spending for a wide range of social service programs. While the basic financial incentives in Medicaid have not changed, and new Medicaid maximization efforts could reappear, for the moment such efforts appear to have stalled.

Why Medicaid Spending Growth Will Remain Slow through the Turn of the Century

There are many reasons to believe that Medicaid spending growth will not return to the rates seen in the early 1990s, even though the 3.3 percent growth seen in 1996 is likely a one-time phenomenon.

First, the growth in enrollment of persons living in low-income families is likely to be below the rates of the early 1990s. Between 1992 and 1995, there have been sharp declines in the growth in the numbers of adults and children receiving Medicaid.¹² The mandated coverage expansions of pregnant women and children have resulted in relatively high participation; continued rapid growth in this group should not be expected under current law except for the incremental inclusion of poor children under age 18. In addition, AFDC rolls have declined in recent years, due in part to the improved economy and in part to widespread efforts to reduce welfare program participation. Recent welfare reform legislation is also expected to depress Medicaid enrollment. While current rules for Medicaid eligibility largely remain, the work requirements and the establishment of separate enrollment procedures for the Temporary Assistance to Needy Families (TANF) program and for Medicaid, as well as limits on coverage of legal immigrants and reductions in SSI eligibility, are likely to result in lower participation rates.

There is also likely to be slower growth in enrollment of the elderly than experienced in the early 1990s.

Table 4
Federal Medicaid Expenditure and Enrollee Projections, 1996–2002
By Eligibility Group and Type of Service
Urban Institute and CBO Forecasts

	1996	2002		Average Annual Growth, 1996–2002	
		UI	CBO	UI	CBO
Expenditures (\$ billions)	\$92.0	\$142.0	\$143.8	7.5%	7.7%
Benefits					
By Service	79.5	124.1	123.0	7.7	7.5
Acute Care	49.6	77.1	77.9	7.6	7.8
Long-term Care	29.9	47.1	45.1	7.9	7.1
By Group	79.5	124.1	123.0	7.7	7.5
Elderly	24.5	38.9	36.1	8.0	6.7
Blind and Disabled	31.7	52.3	52.6	8.7	8.8
Adults	9.6	13.3	13.0	5.6	5.3
Children	13.7	19.6	21.2	6.2	7.5
DSH Payments	8.6	11.7	13.6	5.2	7.9
Administration	3.9	6.2	7.2	8.0	10.8
Enrollees (millions)^a	42.9	47.0	46.7	1.5%	1.4%
Elderly	4.5	5.2	4.9	2.3	1.6
Blind and Disabled	6.8	8.3	8.0	3.3	2.7
Adults	9.9	10.3	10.2	0.6	0.5
Children	21.7	23.3	23.6	1.2	1.4
Benefits per Enrollee (Federal)	\$1,850	\$2,640	\$2,630	6.1%	6.0%
Elderly	5,440	7,540	7,350	5.6	5.0
Blind and Disabled	4,660	6,330	6,580	5.2	5.9
Adults	970	1,300	1,280	5.0	4.7
Children	630	840	900	4.9	6.1

Source: Urban Institute 1997.

a. These projections represent numbers of enrollees. This contrasts with tables 2 and 3, which use beneficiaries, i.e., those enrollees who used at least one Medicaid service. Enrollment data were not considered reliable for earlier years and were therefore not used to explain past trends.

Enrollment growth of the elderly declined in 1993 and 1994 and increased by only 1.2 percent in 1995. The QMB program experienced rapid growth initially, but increases in participation have slowed. Moreover, the number of elderly receiving cash assistance through SSI and, thus, Medicaid coverage continues to decline.

Growth in enrollment among the blind and disabled is likely to slow as well. There has been a slowdown in enrollment of the disabled in Medicaid in the last three years following dramatic increases due to court decisions in the early 1990s. Program data reveal that enrollment growth among SSI disabled beneficiaries fell to about 5.8 percent between 1994 and 1995 and to only 2.1 percent in the first half of 1996.

Lower growth in spending per enrollee is likely to accompany slower enrollment growth. There will continue to be greater growth in enrollment in regions of the country with below-average spending per enrollee (i.e., the South and West). In addition, growth

within each eligibility group will be higher among individuals with below-average expenditures per enrollee (e.g., QMBs and older children). Further, states will continue to extend their use of managed care, including to the disabled population. Health care inflation is likely to remain low because of the growth in managed care in the private health care market. Long-term-care spending seems likely to remain low as states limit the growth in nursing home beds and increasingly employ community-based alternatives to nursing home care, particularly for the disabled. Finally, 1991 and 1993 legislation has successfully restricted states' ability to expand DSH spending.

The Urban Institute and the Congressional Budget Office (CBO) have recently made independent forecasts of federal Medicaid spending based on these considerations. State spending growth rates will differ somewhat, depending on their federal match, but they will be relatively similar to the federal rates embodied in the forecasts.

Both projections forecast similarly modest growth rates in Medicaid spending over the next five years (table 4). The Urban Institute projects average annual growth of 7.5 percent between now and 2002. The CBO projects annual growth of 7.7 percent.

While the overall annual projections are virtually identical, details differ somewhat. The two most important differences are enrollment growth and DSH spending projections. The CBO forecasts enrollment growth of 1.4 percent per year and the Urban Institute, 1.5 percent. The primary difference lies in CBO's lower enrollment forecasts for growth in numbers of the elderly and the blind and disabled. For DSH spending, the Urban Institute forecasts growth of 5.2 percent per year; the CBO, 7.9 percent.

These differences in underlying assumptions, while relatively small, reflect the difficulty in making such forecasts. Policymakers need to be aware that these predictions of Medicaid growth are necessarily based on educated guesses about future changes in a number of program components: enrollment and the composition of enrollment, the rate of medical care inflation, states' ability to control expenditures relative to the underlying rate of inflation, and the states' use of DSH and other efforts to maximize the amounts of state funds going through the Medicaid program.

The Implications of Lower Medicaid Spending Growth

Lower growth implies less need for major changes in the program in order to meet budget targets, because Medicaid's potential contribution to the federal budget deficit will be smaller than previously anticipated. Lower growth also suggests that states should be able to contain spending growth without the additional flexibility the 1995 proposals of Congress or the Administration would have provided. Lower growth also means that the changes in policies required to live within a block grant or per capita cap could be much less than has previously been believed. Of course, if Medicaid spending growth has fallen because

states have already adopted policies that would allow them to reduce expenditures, then further cuts would still prove quite difficult. Furthermore, achieving the savings envisioned by the 1995 proposals in absolute dollar terms would be quite difficult, given the lower projections in the absence of policy change. For all these reasons, consideration of increased state flexibility and some limits on Medicaid spending may still be advisable, but these can be achieved in a variety of ways, including less significant changes in policy than a block grant would represent.

Yet many of the policy suggestions still under consideration were

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developed in response to the earlier projections. The reality now appears to be that fewer people will be added to the Medicaid rolls over the next six years than previously anticipated.

There is strong evidence that the Medicaid enrollment expansions since 1988 have had a major impact in reducing the growth in the number of persons without health insurance.¹³ Now that the growth in Medicaid enrollment has slowed, growth in the number of uninsured could again increase. Particularly if employer-sponsored insurance coverage continues its steady drop, this increase could be substantial by 2002. In light of the new forecasts, there is extra reason for caution as the nation debates the current Medicaid reform proposals.

Notes

1. Urban Institute tabulations based on HCFA 2082 form data.

2. John Holahan, Diane Rowland, Judith Feder, and David Heslam, "Explaining the Recent Growth in Medicaid Expenditures," *Health Affairs* 12 (Fall 1993): 177-93; Diane Rowland, Judith Feder, John Holahan, Alina Salganicoff, and David Heslam, *The Medicaid Cost Explosion: Causes and Consequences*. The Kaiser Commission on the Future of

Medicaid. Washington, D.C.: The Henry J. Kaiser Family Foundation, 1993.

3. Urban Institute calculations from Health Care Financing Administration's 1995 Buy-In File.

4. Teresa A. Coughlin, Leighton Ku, and John Holahan, *Medicaid since 1980: Cost, Coverage, and the Shifting Alliance between the Federal Government and the States*. Washington, D.C.: The Urban Institute Press, 1994.

5. Leighton Ku and Teresa A. Coughlin, "Medicaid Disproportionate Share and Other Special Financing Programs," *Health Care Financing Review* 16(3).

6. Preliminary data suggest that Medicaid expenditures grew by less than 3 percent in 1996. The low 1996 growth probably reflects, at least partially, an acceleration of state spending in 1995 because of proposed legislation to restructure Medicaid that would have used 1995 data as the basis for distribution of block grants.

7. "Children Receiving SSI," Social Security Administration, Office of Research, Evaluation and Statistics, June 1996.

8. Robert E. Hurlley, D.A. Freund, and J.E. Paul, *Managed Care in Medicaid: Lessons for Policy and Program Design*. Ann Arbor, Michigan: Health Administration Press, 1993.

9. Judith Wooldridge, Leighton Ku, Teresa A. Coughlin, Lisa Dubay, Marilyn Ellwood, and Shruti Rajan, "Implementing State Health Care Reform: What Have We Learned from the First Year?" The First Annual Report of the Evaluation of Health Reform in Five States: Report to the Health Care Financing Administration, from Mathematica Policy Research, Inc., and the Urban Institute, forthcoming; Suzanne Rotwein, Maria Boulmetis, Paul J. Boben, Helaine I. Fingold, James P. Hadley, Kathy L. Rama, and Debbie Van Hoven, "Medicaid and State Health Care Reform: Process, Programs, and Policy Options," *Health Care Financing Review* 13(3).

10. "The Status of 1115 Waiver Health Reform Demonstrations," Health Care Financing Administration, September 1996.

11. John Holahan, Teresa A. Coughlin, Korbin Liu, Leighton Ku, Crystal Kuntz, Martcia Wade, and Susan Wall, *Cutting Medicaid Spending in Response to Budget Caps*. The Kaiser Commission on the Future of Medicaid. Washington, D.C.: The Henry J. Kaiser Family Foundation, September 1995.

12. "Children Receiving SSI," Social Security Administration, Office of Research, Evaluation and Statistics, June 1996.

13. John Holahan, Colin Winterbottom, and Shruti Rajan, "A Shifting Picture of Health Insurance Coverage," *Health Affairs* 14 (Winter 1995).

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