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MEDICAID ENROLLMENT AND SPENDING TRENDS

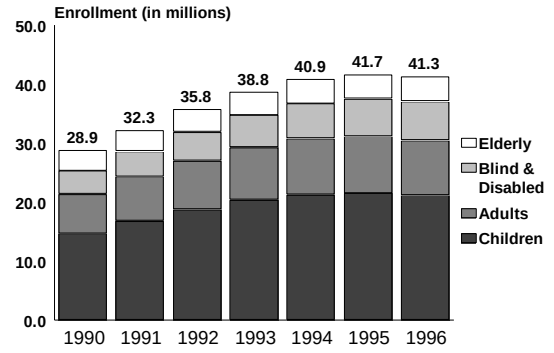
In 1996, Medicaid financed health care for 41.3 million low-income children, adults, elderly, and disabled individuals at a cost of $161.0 billion, $155.4 billion for services and $5.6 billion for administration. After rising rapidly in the early 1990s, Medicaid spending and enrollment growth have slowed markedly. Between 1995 and 1996, Medicaid spending grew by only 2.3% and Medicaid enrollment actually declined by 1.0% after a decade of growth.

ENROLLMENT TRENDS: 1990-1996

Medicaid enrollment grew steadily from 28.9 million people in 1990 to 41.7 million in 1995 (Figure 1), but dropped to 41.3 million in 1996.

Figure 1

Medicaid Enrollment Growth by Eligibility Group, 1990-1996



SOURCE: Urban Institute estimates, 1998.

1990 to 1995: In the early 1990s, most enrollment growth resulted from federal and state 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 1996: In this last year, enrollment growth declined for all eligibility groups, falling by 4% for adults and nearly 2% 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 appear to be due to welfare-related changes. The number of Medicaid beneficiaries receiving cash assistance fell by 8.5% for adults and 6.7% for children. These drops were partially offset by increases in Medicaid coverage of adults and children using other enrollment categories based on age, income, welfare transitional benefits, and other state programs.

Figure 2

Rate of Growth in Medicaid Enrollment by Eligibility Group, 1990-1996

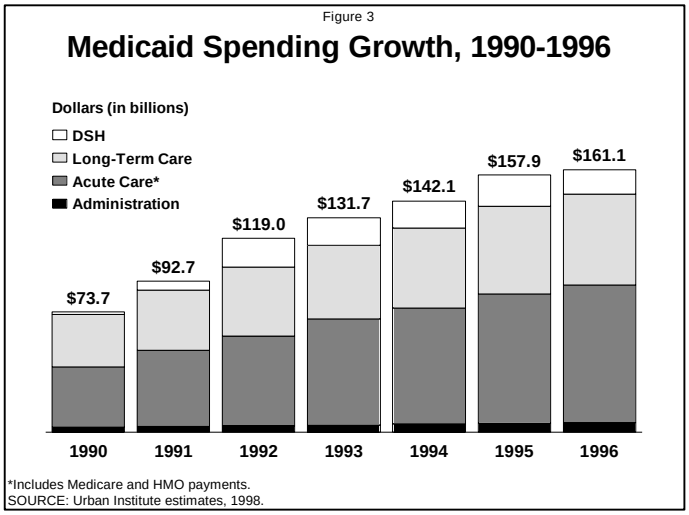
SOURCE: Urban Institute estimates, 1998.

SPENDING TRENDS: 1990-1996

Medicaid spending grew from $73.7 billion in 1990 to $161.0 billion in 1996 (Figure 3). The most rapid growth occurred in the early 1990s when spending rose at double-digit rates largely due to state use of financing mechanisms such as supplemental payments to states for disproportionate share hospitals (DSH). More recently, with low rates of inflation and federal limits in expenditures on DSH payments, spending growth has moderated.

Figure 3

Medicaid Spending Growth, 1990-1996



*Includes Medicare and HMO payments.
SOURCE: Urban Institute estimates, 1998.

1990 to 1995: In this period, Medicaid grew an average of 27.1% annually, largely due to unprecedented growth in DSH payments (263% average annual growth) as well as high rates of inflation in health care prices, significantly higher utilization, a shift in services previously 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).

Figure 4

State and Federal Medicaid Expenditures by Service, 1990-1996

Type of Spending	Spending (billions)		Average Annual Growth		
	1990	1996	1990-92	1992-95	1995-96
Total	**$ 73.7**	**$161.0**	**27.1%**	**9.7%**	**2.3%**
Acute Care	$ 37.0	$ 84.7	22.3%	12.8%	6.6%
Long-Term Care	$ 32.3	$ 55.6	14.6%	8.2%	3.5%
DSH	$ 1.3	$ 15.1	263.4%	2.0%	-19.6%
Administration	$ 3.2	$ 5.6	9.8%	12.8%	2.3%

SOURCE: Urban Institute estimates, 1998.

1995 to 1996: Medicaid spending rose 2.3%, the lowest rate in the history of the program. The primary reasons behind this spending slow down are:

- **Steep Decline in DSH payments.** The primary reason for the low rate of Medicaid spending growth in 1996 was a nearly 20 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.

- **Lower Spending Due to Falling Enrollment.** The second major reason for the slow down 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. The rate of growth in spending for the elderly and disabled groups also declined.

While enrollment fell, the rate of growth in costs per enrollees did not drop appreciably. Despite rapid increases in managed care enrollment for children and adults, average costs per enrollee for these groups increased more rapidly than for the elderly and disabled (Figure 5). These data suggest, at least in the aggregate, that Medicaid has not experienced significant savings from the expansion of managed care to low-income families.

Figure 5

Average Spending per Enrollee by Enrollment Group, 1990-1996

Type of Enrollee	Cost per Enrollee		Average Annual Growth		
	1990	1996	1990-92	1992-95	1995-96
All	**$2,400**	**$3,397**	**6.7%**	**5.3%**	**6.4%**
Elderly	$6,906	$10,336	11.0%	5.4%	3.7%
Blind & Disabled	$6,410	$8,447	7.1%	3.6%	3.2%
Adults	$1,312	$1,837	8.9%	4.0%	5.0%
Children	$747	$1,145	9.5%	6.3%	6.2%

SOURCE: Urban Institute estimates, 1998.

LOOKING AHEAD

Preliminary HCFA data suggest that Medicaid spending growth stayed low in 1997. During this period, DSH payments increased slightly (5%) compared to a drop of 20% in the previous year. An enrollment decline associated with the new welfare law appears to be reducing the number of adults and children enrolled. But reductions in spending related to enrollment apparently offset increases in long-term care spending, predominantly for home health care services.

The Urban Institute estimates that future Medicaid spending growth will be somewhat higher than growth in from 1995 to 1997, but lower than it has been historically. DSH payments could grow modestly in the short term, but will eventually decline to 1996 levels by the year 2002 reflecting the limits in the Balanced Budget Act of 1997. Furthermore, higher health care prices and managed care premiums could increase Medicaid costs. The aging of the population will continue to place pressure on state Medicaid spending on long-term care.

Medicaid expenditures will also be affected by ongoing changes in welfare caseloads. If welfare-related enrollment continues to fall and families who may be eligible for Medicaid are not enrolled, this could result in lower growth rates for Medicaid spending. This could save money in the short term but result in greater numbers of low-income uninsured adults and children.

Source: *The Decline in Medicaid Spending Growth in 1996: Why Did it Happen?* by John Holahan, Brian Bruen, and David Liska, of the Urban Institute, August 1998. Prepared for the Kaiser Commission on Medicaid and the Uninsured.