Urban Institute a nonpartisan economic and social policy research organization

The Decline In Medicaid Spending Growth In 1996

Why Did It Happen?

(*Policy Briefs*)

Author(s): John Holahan, Brian K. Bruen, David Liska

Other Availability: Order Online

Published: September 01, 1998

This policy brief was prepared for the Kaiser Commission on Medicaid and the Uninsured.

Medicaid spending grew by only 2.3 percent in 1996, the lowest rate of growth in the history of the program. After a period of explosive growth between 1988 and 1992, averaging over 20 percent per year, Medicaid spending slowed to 9-10 percent per year between 1992 and 1995.[1] In 1996, Medicaid financed acute and long-term care services for 41.3 million people at a cost of $155.4 billion. Spending growth in 1996 was extremely low, and slow growth seems to have continued in 1997. The primary reason for the low rate of growth in 1996 was a nearly 20 percent drop in disproportionate share hospital (DSH) payments. A reduction in adult and children enrolled through cash assistance in response to state welfare reforms and an improving economy as well as moderation in enrollment growth of elderly and disabled beneficiaries also contributed to the slowdown.

Medicaid spending growth has slowed to unprecedented levels and, for the first time in the program's history, enrollment has fallen. This policy brief updates earlier analyses conducted for the Kaiser Commission on Medicaid and the Uninsured by researchers at the Urban Institute. It critically examines Medicaid enrollment and spending trends from 1990 to 1996, highlighting periods of extensive growth between 1990 and 1992, moderate growth between 1992 and 1995, and limited growth between 1995 and 1996. It then reviews the primary factors contributing to the dramatic slowdown in both spending and enrollment growth between 1995 and 1996. The final section presents preliminary estimates of spending for 1997 and projects Medicaid spending growth over the next five years.

Medicaid Spending: 1990 to 1992

Between 1990 and 1992, Medicaid grew at an extraordinary 27.1 percent annual growth rate, with expenditures increasing from $73.7 billion to $119.9 billion in just two years. During the same period, Medicaid spending on the elderly and disabled increased by 16.7 and 17.6 percent per year, respectively, while expenditures on adults and children increased by 21.4 and 23.8 percent per year, respectively (Table 1). Disproportionate share payments increased by over 250 percent per year. There were several reasons for these high growth rates.

Table 1

Medicaid Expenditures by Group and Type of Service, 1990-1996

	Year					Average Annual Growth			
	1990	1992	1995	1996		1990-96	1990-92	1992-95	1995-96
Total Expenditures (billions)	$73.7	$119.2	$157.4	$161.0		13.9%	27.1%	9.7%	2.3%
Benefits Only									
By Service	$69.2	$97.7	$133.1	$140.3		12.5%	18.8%	10.9%	5.4%
Acute Care	37.0	55.3	79.4	84.7		14.8	22.3	12.8	6.6
Long-Term Care	32.3	42.4	53.7	55.6		9.5	14.6	8.2	3.5
By Group	$69.2	$97.7	$133.1	$140.3		12.5%	18.8%	10.9%	5.4%
Elderly	23.6	32.1	40.9	42.4		10.3	16.7	8.4	3.7
Blind and Disabled	25.9	35.8	52.1	56.6		13.9	17.6	13.3	8.6
Adults	8.8	13.0	16.8	16.9		11.5	21.4	9.1	0.6

Children	11.0	16.8	21.4	23.3		14.2	23.8	11.4	4.5
DSH	$1.3	$17.7	$18.8	$15.1		49.7%	263.4%	2.0%	-19.6%
Administration	$3.2	$3.8	$5.4	$5.6		10.0%	9.8%	12.8%	2.3%

Source: Urban Institute estimates based on data from HCFA-2082 and HCFA-64 reports.
Note: Does not include the U.S. Territories or accounting adjustments. Acute care services include inpatient, physician, lab and x-ray, outpatient, clinic, EPSDT, dental, vision, other practicioners, payments to managed care organizations, payments to Medicare, and all other unspecified care services. Long-term care includes nursing facilities, intermediate care facilities for the mentally retarded, mental health services, and home health services. DSH refers to disproportionate share hospital payments. Payments to Medicare are distributed among aged, blind, and disabled enrollees. Payments to managed care are primarily distributed.

The major reason is the aggressive use of DSH payments often financed by provider taxes and donations. The DSH payments grew at an average annual rate of 263 percent, accounting for about $1.3 billion in 1988 and growing to more than $17 billion by 1992. A second reason was the high rate of inflation in health care prices (8.3 percent per year between 1990 and 1992), which affects Medicaid provider payment rates. States became increasingly adept at shifting services previously financed by other programs into Medicaid. This allowed states to use federal matching funds to replace programs previously funded entirely by the state.

Expenditures also seem to have grown during this period because of significant increases in health care utilization. Medicaid began covering a population with greater needs, including pregnant women, AIDS patients, and people with problems with drugs and alcohol. In addition, states increased the provision of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services to children. The final reason is a large increase in the number of beneficiaries. In the late 1980s, Congress enacted a series of expansions of coverage for pregnant women, infants and children. By 1990, Medicaid programs were required to cover all pregnant women, infants, and children under age 6 with family incomes up to 133 percent of the Federal Poverty Level (FPL), and they were given the option to expand coverage to pregnant women and infants up to 185 percent of the FPL. States were also required to cover children below the FPL born after September 30, 1983; in effect, older children were scheduled to be phased in one year at a time until all children through age 18 are covered by the year 2002.[2] In addition, states were required to cover Medicare premiums and cost sharing for all Medicare-eligible persons with incomes below the FPL and to cover premiums for Medicare-eligibles with incomes between 100 and 120 percent of poverty. Finally, the SSI program grew for a number of reasons, particularly as a result of court decisions and Congressional mandates that extended coverage to learning-disabled children. Medicaid Spending: 1992 to 1995

Medicaid spending growth fell after 1992, increasing by only 9.7 percent per year on average between 1992 and 1995 (Table 1). There were three principal reasons for the reduction in the rate of growth: slower enrollment growth, slower growth of spending per enrollee, and a leveling off of DSH payments. First, enrollment growth among adults and children declined because of improving state economies and tougher AFDC work requirements imposed by states. In addition, the Medicaid expansions to pregnant women and children were more fully phased in and began to experience lower rates of growth. Growth rates among the blind and disabled also declined, because the court decisions and coverage changes responsible for the increases in enrollment of disabled children in the 1988 to 1992 period were fully phased in. Finally, enrollment growth among the elderly also declined because of a slowdown in enrollment of Qualified Medicare Beneficiaries (QMBs) as well as a decline in the number of elderly receiving cash assistance through SSI.

Table 2

Medicaid Expenditures, Enrollment, and Expenditures per Enrollee, 1990-1996

	Year					**Average Annual Growth**			
	1990	**1992**	**1995**	**1996**		**1990-96**	**1990-92**	**1992-95**	**1995-96**
Total Expenditures									
Benefits Only (billions)	**$69.2**	**$97.7**	**$133.1**	**$140.3**		**12.5%**	**18.8%**	**10.9%**	**5.4%**
Total Enrollment (millions)	**28.9**	**35.8**	**41.7**	**41.3**		**6.2%**	**11.3%**	**5.3%**	**-1.0%**
Elderly	3.4	3.8	4.1	4.1		3.1	5.1	2.9	0.0
Blind and Disabled	4.0	4.9	6.4	6.7		8.8	9.8	9.3	5.2
Adults	6.7	8.3	9.6	9.2		5.5	11.4	5.0	-4.1
Children	14.7	18.8	21.6	21.3		6.4	13.1	4.8	-1.6
Expenditures per Enrollee	**$2,400**	**$2,732**	**$3,192**	**$3,397**		**6.0%**	**6.7%**	**5.3%**	**6.4%**
Elderly	6,906	8,504	9,965	10,336		7.0	11.0	5.4	3.7
Blind and Disabled	6,410	7,348	8,182	8,447		4.7	7.1	3.6	3.2
Adults	1,312	1,557	1,750	1,837		5.8	8.9	4.0	5.0
Children	747	897	1,078	1,145		7.4	9.5	6.3	6.2

Source: Urban Institute estimates based on data from HCFA-2082 and HCFA-64 reports.
Note: Does not include the U.S. Territories. Expenditures shown do not include disproportionate share hospital payments, administrative costs, or accounting adjustments. States are not consistent in the way they report payments to Medicare or to managed care organizations (MCOs). For states where reported data are either missing or appear unreliable, formulas were used to distribute these payments to appropriate enrollee groups. Payments to Medicare are distributed among aged, blind, and disabled enrollees. Payments to MCOs are primarily distributed to adults and children. Enrollees are people who sign up for the Medicaid program for any length of time in a given fiscal year.

Second, spending per enrollee also declined from 6.7 percent to 5.3 percent per year (Table 2). There are a number of possible explanations, including the reduction in health care inflation (5.1 percent between 1992 and 1995). Another factor explaining the lower growth in spending per enrollee could be rapid growth in Medicaid managed care which may have achieved at least short-term savings in several states in these years. Finally, DSH payments began to level off due to 1991 and 1993 legislation restricting the use of these payments. The 1991 legislation banned the use of private donations, and severely restricted the kind of provider taxes the state could employ. The 1991 legislation also limited the growth of DSH payments to that of overall program expenditures and also capped DSH payments at 12 percent of program expenditures. The 1993 legislation made it illegal for states to pay a hospital more than what the hospital was losing through uncompensated care or through low Medicaid reimbursement rates. This severely restricted states' ability to pay large amounts of money to specific hospitals, which in turn reduced Medicaid expenditures in some states.

The Projected Slowdown

In 1997, both the Urban Institute (UI) and the Congressional Budget Office (CBO) projected that Medicaid spending growth would continue to slow down. They projected that Medicaid spending would increase by 7.5 percent (UI) and 7.7 percent (CBO), through the year 2002. However, the most recent experience for 1993 was 2.3 percent and recent evidence suggests that future spending will continue to slow. There were three principal reasons for these lower projected rates of expenditure growth. First, enrollment growth was likely to slow down for a number of reasons. One is that the majority of mandated expansions of coverage for pregnant women and children had already been implemented and had achieved relatively high participation. In addition, cash assistance AFDC rolls were expected to decline due to the rapidly growing economy, state efforts to reduce welfare program participation, and the recent enactment of the Temporary Assistance to Needy Families (TANF) program, which promised to cut welfare enrollment even further. Finally, the number of disabled beneficiaries was expected to grow, but at a slower rate, reflecting the lower rate of increase in SSI enrollment. Since the disabled are a high-cost population, slower growth in enrollment could have a significant effect on expenditures.

Second, spending per enrollee was expected to moderate due to the increased use of managed care and low health care inflation. Long-term care spending was likely to remain low because of limits on the rate of growth in nursing home beds and the use of community-based alternatives to nursing home care, particularly for the disabled. Third, the 1991 and 1993 DSH legislation seemed to have successfully restricted states' ability to expand DSH payments. For these reasons, both the Urban Institute and the CBO projected Medicaid spending to grow by about 7.5 percent through 2002.

Spending Slows: 1995 to 1996

Medicaid spending grew by only 2.3 percent between 1995 and 1996. While CBO and the Urban Institute were correct in projecting a slower rate of growth, they were quite inaccurate in forecasting the actual 1996 experience. The question is why program growth virtually stopped. The primary reason for the drop in Medicaid spending is the 19.6 percent decline in DSH payments (Table 1). This drop may have been due to a one-time acceleration of payments in 1995, possibly because states attempted to increase expenditures in 1995, believing they would be the basis for the distribution of Medicaid block grant funds.[3] Alternatively, it could reflect the full phase-in of the 1993 DSH legislation, which limited states' ability to make payments to any specific hospital to cover losses on Medicaid patients and the costs of uncompensated care.[4] It is reported that the 1993 legislation has affected many states' ability to continue historic levels of DSH payments. The 19.6 percent decline in 1996 is equal to the entire decline, at the national level, that was called for in the 1997 Balanced Budget Act (BBA) when fully implemented in 2002. The BBA reduced DSH allotments in all states, though by varying amounts, and phased in the reductions between 1998 and 2002. Thus, because states can spend more in the interim it is likely that DSH payments will rebound somewhat in the near future.

In 1996, Medicaid spending growth fell for each enrollment group relative to previous years. Spending growth also fell for both acute and long-term care services. Acute care spending increased by 6.6 percent in 1996, while long-term care expenditures grew by only 3.5 percent. The decline in Medicaid enrollment among adults and children is an important factor explaining the slower rate of growth for acute care (Table 2). Enrollment declined by 4.1 percent for adults and 1.6 percent for children. These declines were caused by reductions in cash assistance enrollees, 8.5 percent for adults and 6.7 percent for children (Tables 3 and 4). These drops were partially offset by increases in other enrollment groups as adults and children turned to poverty-related expansions, transition benefits, and medically-needy provisions to maintain enrollment. The increases in non-cash enrollment tended to be greatest in states with the largest decreases in cash enrollment. In addition, the offsetting increases in non-cash enrollment were greater for children than for adults; thus the reductions in overall Medicaid enrollment were greater for adults than for children, but fell overall for both groups. Enrollment of the blind and disabled population grew by 5.2 percent between 1995 and 1996, an increase in the number of enrollees but a lower rate of increase than seen in earlier years. The number of elderly Medicaid enrollees stayed roughly the same in 1996. Because the aged, blind, and disabled are high-cost groups, a slowdown in enrollment, even a modest one, can have a significant effect on spending growth.

Expenditures per enrollee rose by 6.4 percent between 1995 and 1996. The rate of growth varied by enrollment group; spending per enrollee grew by less than 4 percent for the elderly and blind and disabled, while it increased 5.0 percent for adults, and 6.2 percent for

children (Table 5). Some of this variation reflects a change in the composition of Medicaid enrollees, with more disabled enrollees and fewer adults and children. Differing rates of growth by service type also contribute to this variation.

Acute care spending per enrollee grew substantially faster than long-term care spending per enrollee (8.6 percent vs. 2.1 percent for the elderly and 5.2 percent vs. 0.4 percent for the blind and disabled). Spending per enrollee for adults and children, which is almost entirely for acute care, grew by 5.0 percent and 6.2 percent, respectively. Further examination of long-term care spending revealed that the growth of spending per enrollee for nursing homes was extremely slow (1.6 percent for the elderly and 2.1 percent for the blind and disabled; see Table 6). In nearly every case, spending per enrollee growth in 1996 is slower than in previous years, consistent with lower health care inflation (3.7 percent between 1995 and 1996). However, these data seem to rule out dramatic savings from the expansion of Medicaid managed care.

Table 3

Medicaid Adult Enrollees and Annual Growth, 1995-1996

	1995 Adult Enrollees (in thousands)			1996 Adult Enrollees (in thousands)			1995-1996 Annual Growth		
State	**Cash**	**Other**	**Total**	**Cash**	**Other**	**Total**	**Cash**	**Other**	**Total**
United States*	**5,411.1**	**4,211.3**	**9,622.3**	**4,952.1**	**4,272.9**	**9,225.0**	**-8.5%**	**1.5%**	**-4.1%**
Alabama	48.5	48.0	96.6	43.5	48.0	91.6	-10.3	0.0	-5.2
Alaska	16.8	6.7	23.5	16.3	7.0	23.4	-2.8	5.7	-0.4
Arizona	87.5	64.7	152.2	76.4	87.8	164.2	-12.7	35.6	7.8
Arkansas	23.2	36.8	60.0	21.5	35.2	56.7	-7.6	-4.2	-5.5
California	1,042.2	917.9	1,960.1	1,006.1	904.7	1,910.8	-3.5	-1.4	-2.5
Colorado	47.6	45.0	92.6	42.7	39.9	82.6	-10.3	-11.3	-10.8
Connecticut	66.0	25.6	91.6	62.7	28.7	91.4	-5.1	12.2	-0.2
Delaware	10.3	7.4	17.8	9.4	15.4	24.8	-9.1	106.5	39.3
District of Columbia	27.1	4.4	31.5	26.2	4.6	30.8	-3.3	4.3	-2.2
Florida	278.3	126.2	404.6	253.4	126.1	379.5	-8.9	-0.1	-6.2
Georgia	136.4	122.4	258.7	120.3	130.7	250.9	-11.8	6.8	-3.0
Hawaii*	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Idaho	10.5	17.8	28.3	10.3	17.2	27.4	-2.5	-3.5	-3.1
Illinois	245.5	187.5	432.9	225.3	193.9	419.2	-8.2	3.4	-3.2
Indiana*	n/a	n/a	118.1	n/a	n/a	109.8	n/a	n/a	-7.1
Iowa	46.5	35.9	82.4	40.2	38.2	78.3	-13.5	6.3	-4.9
Kansas	37.3	23.0	60.3	31.9	23.8	55.7	-14.4	3.5	-7.6
Kentucky	73.1	64.2	137.3	60.8	61.6	122.5	-16.8	-4.0	-10.8
Louisiana	79.1	67.0	146.0	65.3	71.1	136.3	-17.5	6.1	-6.6
Maine	28.0	16.2	44.2	26.1	14.7	40.9	-6.7	-9.2	-7.6
Maryland*	n/a	n/a	117.0	n/a	n/a	110.3	n/a	n/a	-5.8
Massachusetts	114.7	57.2	171.9	93.6	69.5	163.1	-18.4	21.4	-5.1
Michigan	230.5	126.6	357.0	204.7	145.7	350.3	-11.2	15.1	-1.9
Minnesota	75.2	53.1	128.3	69.7	52.6	122.3	-7.3	-0.9	-4.7
Mississippi*	n/a	n/a	78.9	n/a	n/a	73.6	n/a	n/a	-6.7
Missouri	103.6	71.5	175.1	91.6	72.1	163.7	-11.6	0.8	-6.5
Montana	13.6	10.5	24.1	11.7	10.4	22.1	-13.8	-0.7	-8.1
Nebraska	16.0	13.1	29.1	16.4	13.7	30.2	2.6	4.5	3.5
Nevada	19.9	11.7	31.6	16.1	14.0	30.1	-18.8	19.5	-4.6
New Jersey	128.3	70.7	199.0	117.3	76.4	193.6	-8.6	8.0	-2.7
New York	464.1	187.0	651.0	442.5	197.1	639.6	-4.6	5.4	-1.8
New Hampshire	12.6	11.9	24.5	10.9	12.3	23.2	-14.0	3.4	-5.6
New Mexico	43.8	18.3	62.2	41.5	17.9	59.4	-5.4	-2.2	-4.5

North Carolina	154.2	96.1	250.3	140.0	98.5	238.5	-9.2	2.5	-4.7
North Dakota	8.7	5.7	14.3	7.6	5.6	13.2	-12.3	-1.9	-8.2
Ohio	249.0	98.9	347.9	211.0	109.9	320.9	-15.3	11.2	-7.8
Oklahoma	54.6	44.3	98.9	47.5	46.0	93.6	-12.8	3.8	-5.4
Oregon*	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Pennsylvania	220.3	148.1	368.4	195.7	162.9	358.7	-11.1	10.0	-2.6
Rhode Island	25.1	8.8	33.9	22.7	9.5	32.2	-9.5	8.1	-5.0
South Carolina	44.8	51.8	96.6	39.2	67.8	107.0	-12.4	30.7	10.8
South Dakota	7.5	6.7	14.2	7.1	6.6	13.7	-5.3	-1.3	-3.4
Tennessee	111.7	440.9	552.6	106.7	389.3	496.0	-4.5	-11.7	-10.2
Texas	317.5	283.4	600.9	289.7	279.3	569.1	-8.7	-1.4	-5.3
Utah	21.0	30.2	51.2	18.8	30.7	49.5	-10.6	1.7	-3.4
Vermont	12.5	10.6	23.1	9.2	17.9	27.1	-26.6	69.4	17.3
Virginia	77.5	50.6	128.1	69.5	50.7	120.2	-10.4	0.2	-6.2
Washington	122.2	89.1	211.3	117.6	86.7	204.3	-3.8	-2.6	-3.3
West Virginia	70.3	50.1	120.4	69.5	37.3	106.9	-1.1	-25.5	-11.3
Wisconsin	73.3	47.1	120.4	52.0	54.2	106.2	-29.0	15.2	-11.7
Wyoming	7.1	4.8	11.9	6.1	4.8	10.9	-13.5	0.7	-7.8

Source: Urban Institute estimates based on HCFA-2082 reports.
Does not include the U.S. Territories. Cash and other groups may not sum to totals due to rounding. Enrollees are people enrolled in the Medicaid program at any time during the year. "Cash" refers to enrollees who receive AFDC or SSI payments. "Other" enrollees include the medically needy, poverty-related expansion groups, and people eligible under Medicaid 1115 waivers. * Indicates states with missing/invalid data. Estimates for missing/invalid data are included in national totals.

Table 4

Medicaid Child Enrollees and Annual Growth, 1995-1996

	1995 Child Enrollees (in thousands)			1996 Child Enrollees (in thousands)			1995-1996 Annual Growth		
State	**Cash**	**Other**	**Total**	**Cash**	**Other**	**Total**	**Cash**	**Other**	**Total**
United States*	**11,208.4**	**10,408.6**	**21,616.9**	**10,457.3**	**10,813.2**	**21,270.5**	**-6.7%**	**3.9%**	**-1.6%**
Alabama	114.3	185.8	300.0	105.4	198.3	303.7	-7.8	6.7	1.2
Alaska	33.2	16.1	49.3	32.8	16.9	49.8	-1.0	5.0	1.0
Arizona	189.1	231.4	420.5	176.4	235.6	412.0	-6.7	1.8	-2.0
Arkansas	67.8	95.7	163.5	65.4	104.7	170.0	-3.6	9.4	4.0
California	1,841.9	1,560.7	3,402.6	1,785.9	1,487.0	3,272.9	-3.0	-4.7	-3.8
Colorado	95.6	80.9	176.5	88.0	87.7	175.6	-8.0	8.4	-0.5
Connecticut	132.7	66.4	199.0	126.9	74.6	201.5	-4.4	12.4	1.2
Delaware	22.6	25.8	48.4	21.8	27.5	49.2	-3.9	6.5	1.7
District of Columbia	63.6	12.8	76.3	61.2	13.0	74.2	-3.7	1.8	-2.8
Florida	641.9	556.7	1,198.6	598.5	557.3	1,155.8	-6.8	0.1	-3.6
Georgia	296.1	374.9	670.9	268.8	422.4	691.2	-9.2	12.7	3.0
Hawaii*	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Idaho	21.6	51.4	73.0	21.9	51.3	73.2	1.1	-0.1	0.3
Illinois	593.5	469.1	1,062.6	563.1	484.4	1,047.5	-5.1	3.3	-1.4
Indiana*	n/a	n/a	381.6	n/a	n/a	354.7	n/a	n/a	-7.1
Iowa	80.5	79.2	159.7	72.4	81.3	153.7	-10.0	2.7	-3.7
Kansas	71.1	76.0	147.1	62.3	81.0	143.3	-12.3	6.5	-2.6
Kentucky	154.0	168.1	322.0	140.7	164.3	304.9	-8.6	-2.3	-5.3
Louisiana	201.4	197.2	398.5	179.2	208.7	387.8	-11.0	5.8	-2.7

Maine	39.9	50.9	90.8	39.0	51.1	90.1	-2.2	0.3	-0.8
Maryland*	n/a	n/a	334.8	n/a	n/a	315.5	n/a	n/a	-5.8
Massachusetts	212.0	152.1	364.1	180.4	175.6	356.0	-14.9	15.5	-2.2
Michigan	462.1	257.8	719.9	421.8	284.4	706.3	-8.7	10.3	-1.9
Minnesota	152.8	193.2	346.0	146.1	204.8	350.9	-4.4	6.0	1.4
Mississippi	130.3	152.9	283.2	119.5	161.1	280.6	-8.4	5.4	-0.9
Missouri	203.6	215.0	418.6	187.7	232.3	420.1	-7.8	8.1	0.3
Montana	28.3	26.0	54.3	26.8	27.7	54.5	-5.2	6.7	0.5
Nebraska	33.1	71.0	104.1	34.0	72.3	106.3	2.7	1.8	2.1
Nevada	40.8	37.4	78.2	37.3	45.5	82.9	-8.5	21.6	5.9
New Jersey	260.5	173.4	433.9	236.6	195.4	432.0	-9.2	12.7	-0.4
New York	1,087.5	644.5	1,732.0	1,041.5	662.8	1,704.3	-4.2	2.8	-1.6
New Hampshire	21.4	35.0	56.4	18.9	37.9	56.8	-11.4	8.3	0.8
New Mexico	98.8	107.9	206.7	91.9	123.5	215.4	-7.0	14.5	4.2
North Carolina	296.8	272.2	569.0	272.9	296.3	569.2	-8.1	8.9	0.0
North Dakota	14.2	19.9	34.1	12.5	20.4	32.8	-12.2	2.2	-3.8
Ohio	527.4	338.9	866.3	463.3	351.7	815.0	-12.2	3.8	-5.9
Oklahoma	139.6	106.9	246.5	125.6	109.5	235.1	-10.0	2.4	-4.6
Oregon*	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Pennsylvania	470.5	415.2	885.7	432.7	438.4	871.1	-8.0	5.6	-1.6
Rhode Island	50.3	19.9	70.2	46.7	21.7	68.4	-7.1	9.1	-2.5
South Carolina	122.0	144.7	266.7	111.8	158.3	270.0	-8.4	9.4	1.2
South Dakota	16.7	28.6	45.3	16.0	31.7	47.7	-3.8	10.6	5.3
Tennessee	224.2	326.6	550.8	214.1	341.0	555.1	-4.5	4.4	0.8
Texas	655.5	1,016.9	1,672.4	606.1	1,059.0	1,665.1	-7.5	4.1	-0.4
Utah	39.9	81.9	121.8	36.3	83.9	120.1	-9.1	2.4	-1.4
Vermont	19.6	36.9	56.6	17.0	41.0	58.0	-13.2	10.9	2.6
Virginia	163.9	230.4	394.3	149.5	244.7	394.2	-8.8	6.2	0.0
Washington	241.8	222.0	463.8	244.1	271.3	515.5	1.0	22.2	11.1
West Virginia	109.3	103.4	212.8	106.8	114.4	221.2	-2.3	10.6	4.0
Wisconsin	177.7	164.3	341.9	132.2	191.2	323.5	-25.6	16.4	-5.4
Wyoming	16.9	15.2	32.1	15.9	16.2	32.0	-5.9	6.2	-0.2

Source: Urban Institute estimates based on HCFA-2082 reports.
Does not include the U.S. Territories. Cash and other groups may not sum to totals due to rounding. Enrollees are people enrolled in the Medicaid program at any time during the year. "Cash" refers to enrollees who receive AFDC or SSI payments. "Other" enrollees include the medically needy, poverty-related expansion groups, and people eligible under Medicaid 1115 waivers. * Indicates states with missing/invalid data. Estimates for missing/invalid data are included in the national totals.

Table 5

Medicaid Expenditures per Enrollee, by Group, 1990-1996

	Expenditures per Enrollee				Average Annual Growth			
Enrollment Group	**1990**	**1992**	**1995**	**1996**	**1990-96**	**1990-92**	**1992-95**	**1995-96**
All Enrollees	**$2,400**	**$2,732**	**$3,192**	**$3,397**	**6.0%**	**6.7%**	**5.3%**	**6.4%**
Acute Care	1,281	1,547	1,903	2,050	8.2	9.9	7.2	7.7
Long-Term Care	1,119	1,186	1,288	1,347	3.1	2.9	2.8	4.5
Elderly	**$6,906**	**$8,504**	**$9,965**	**$10,336**	**7.0%**	**11.0%**	**5.4%**	**3.7%**
Acute Care	1,497	1,914	2,519	2,735	10.6	13.1	9.6	8.6
Long-Term Care	5,409	6,590	7,446	7,601	5.8	10.4	4.2	2.1

Blind and Disabled	**$6,410**	**$7,348**	**$8,182**	**$8,447**	**4.7%**	**7.1%**	**3.6%**	**3.2%**
Acute Care	3,229	4,046	4,804	5,055	7.8	11.9	5.9	5.2
Long-Term Care	3,181	3,302	3,377	3,392	1.1	1.9	0.8	0.4
Adults	**$1,312**	**$1,557**	**$1,750**	**$1,837**	**5.8%**	**8.9%**	**4.0%**	**5.0%**
Children	**$747**	**$897**	**$1,078**	**$1,145**	**7.4%**	**9.5%**	**6.3%**	**6.2%**

Source: Urban Institute estimates based on data from HCFA-2082 and HCFA-64 reports.
Does not include disproportionate share hospital payments, administrative costs, accounting adjustments, or the U.S. Territories. Acute care services include inpatient, physician, lab, x-ray, outpatient, clinic, EPSDT, dental, vision, other practitioners, payments to Medicare, payments to managed care organizations, and all other unspecified care services. Long-term care services include nursing facilities, intermediate care facilities for the mentally retarded, mental health, and home health. States are not consistent in the way they report payments to Medicare or to managed care organizations (MCOs). For states where reported data are either missing or appear unreliable, formulas were used to distribute these payments to appropriate enrollee groups. Payments to Medicare are distributed among aged, blind, and disabled enrollees. Payments to MCOs are primarily distributed to adults and children. Enrollees are people who sign up for the Medicaid program for any length of time in a given fiscal year.

Table 6

Medicaid Long-Term Care Expenditures per Elderly, Blind, and Disabled Enrollee, 1990-1996

	Expenditures per Enrollee				Average Annual Growth			
Enrollment Group	**1990**	**1992**	**1995**	**1996**	**1990-96**	**1990-92**	**1992-95**	**1995-96**
Elderly	**$5,409**	**$6,590**	**$7,446**	**$7,601**	**5.8%**	**10.4%**	**4.2%**	**2.1%**
Nursing Facilities	4,427	5,432	6,145	6,244	5.9	10.8	4.2	1.6
ICF-MR	92	104	139	139	7.1	6.5	10.0	-0.1
Mental Health	305	357	297	296	-0.5	8.1	-5.9	-0.4
Home Health	584	697	865	922	7.9	9.2	7.5	6.6
Blind and Disabled	**3,181**	**3,302**	**3,377**	**3,392**	**1.1%**	**1.9%**	**0.8%**	**0.4%**
Nursing Facilities	792	812	775	792	0.0	1.2	-1.5	2.1
ICF-MR	1,802	1,724	1,464	1,384	-4.3	-2.2	-5.3	-5.5
Mental Health	94	123	117	124	4.7	14.3	-1.7	6.1
Home Health	492	643	1,021	1,092	14.2	14.3	16.7	7.0

Source: Urban Institute estimates based on data from HCFA-2082 and HCFA-64 reports.
Does not include disproportionate share hospital payments, administrative costs, accounting adjustments, or the U.S. Territories. "ICF-MR" refers to intermediate care facilities for the mentally-retarded.

Looking Ahead

Finally, Table 7 shows data on spending growth from unedited HCFA 64 data for 1995-1996 and preliminary HCFA 64 data for 1996-1997.[5] The data suggest that Medicaid spending grew by about 4.0 percent in 1997. DSH payments increased by about 5.8 percent in 1997, again suggesting that 1996 DSH spending levels may have been a one-year aberration. The low rate of growth in acute care spending is probably due to declining AFDC/TANF-related enrollment. Other data has shown that welfare rolls declined by about 13.5 percent in 1997.[6] This drop will undoubtedly be partially offset by increases in non-cash enrollment, particularly for children. However, we expect to see an overall drop in enrollment of adults and children in 1997, which would explain the very low growth in spending on acute care services. Long-term care spending actually increased fairly substantially, about 8.1 percent. This appears to be due to a large jump in home health care (27.7 percent, data not shown), which amounted for over half the increase in long-term care spending in 1996. Nursing home spending continued to grow fairly slowly (4.8 percent, data not shown).

Thus, it appears that Medicaid spending growth stayed low in 1997, but that the reasons were somewhat different than in 1996. DSH payments increased by 5 percent rather than falling by 20 percent, and a decline in enrollment of AFDC/TANF populations reduced the number of adults and children on the Medicaid rolls and, in turn, reduced expenditures. These reductions apparently offset increases in long-term care spending.

Table 7

Annual Growth of Medicaid Expenditures by Type of Service, 1995-1997

Type of Service	**1995-96**	**1996-97**
Total (Benefits and DSH)	1.79%	3.96%
Acute Care	5.98	0.95
Long-term Care	3.53	8.15

DSH	-20.71	5.84

Source: Health Care Financing Administration, 1998.
Note: The 1996-97 growth rates reported in this table are based on unedited preliminary data from HCFA. The 1995-96 growth rates are also based on unedited expenditures and may differ from other tables presented in this text.

Medicaid spending growth after 1997 will probably be somewhat higher than growth in 1996 and 1997 but nonetheless lower than it has been historically. Medicaid expenditures will be very much affected by ongoing changes in enrollment of adults and children. If cash assistance rolls continue to fall and if families are not enrolled in Medicaid after they leave cash assistance rolls, Medicaid enrollment will continue to decline, with the result being a low rate of growth in Medicaid expenditures. Disproportionate share payments could grow modestly in the short term, but will eventually decline to approximately 1996 levels by the year 2002. There is no evidence of inflation-adjusted declines in acute care spending per enrollee. Furthermore, increases in health care prices and managed care premiums could ultimately place upward pressure on Medicaid costs. The growth in long-term care spending that occurred in 1997 may not be repeated, but there is likely to be continued pressure on state Medicaid spending for long-term care because of the increased aging of the population.

Notes

1. John Holahan, Diane Rowland, Judith Feder, and David Heslam, "Explaining the Recent Growth in Medicaid Expenditures," Health Affairs 12 (Fall 1993): 177-193; 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.

2. John Holahan and David Liska, "The Slowdown in Medicaid Spending Growth," Health Affairs, 16 (March/April 1997): 157-163.

3. "Medicaid: Sustainability of Low 1996 Spending Growth is Uncertain," General Accounting Office, June 1997.

4. Teresa A. Coughlin and David Liska, "Changing State and Federal Payment Policies for Medicaid Disproportionate Share Hospitals," Health Affairs 17 (May/June 1998): 118-136.
Teresa A. Coughlin and David Liska, "The Medicaid Disproportionate Share Hospital Payment Program: Background and Issues," Urban Institute Policy Brief (October 1997).

5. These data are taken directly from expenditure files compiled by HCFA. Other tables in this text use data that have been edited by the Urban Insitute to account for reporting errors, accounting adjustments, and missing data. Consequently, the data in Table 7 may differ from other information presented in this report.

6. Ellwood, Marilyn R., and Leighton Ku, "Welfare and Immigration Reforms: Unintended Side Effects for Medicaid," Health Affairs 17 (May/June 1998): 137-151.

Email this Article