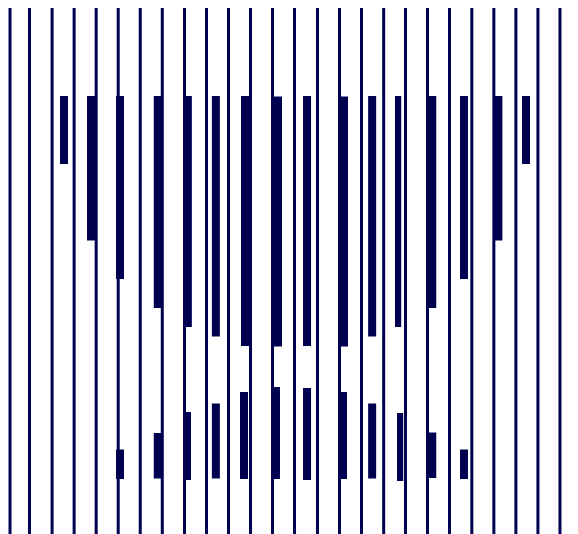
**BEHIND THE NUMBERS:
AN EXPLANATION
OF CBO'S JANUARY 1997
MEDICAID BASELINE**

April 1997



CBO MEMORANDUM

BEHIND THE NUMBERS:
AN EXPLANATION
OF CBO'S JANUARY 1997
MEDICAID BASELINE

April 1997

CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

Prepared in response to numerous Congressional requests, this memorandum describes the assumptions underlying the projections of Medicaid spending issued by the Congressional Budget Office (CBO) in January 1997. The memorandum was written by Robin J. Rudowitz of the Health Cost Estimates Unit in CBO's Budget Analysis Division under the supervision of Paul N. Van de Water and Murray N. Ross. Linda Bilheimer of CBO's Health and Human Resources Division provided helpful comments.

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SUMMARY AND INTRODUCTION

In its current baseline, the Congressional Budget Office (CBO) has lowered its projections of growth in Medicaid spending by about 2 percentage points below its May 1996 projections. CBO had previously projected that Medicaid spending would increase at an average annual rate of 9.6 percent through 2002. The baseline adjustment has significant implications: even though projections of spending for Medicaid have been reduced, the program is still one of the largest and most rapidly growing entitlement programs, and it continues to be a major source of upward pressure on the deficit. Legislation will undoubtedly be introduced to curb the growth of the Medicaid program, and the baseline projections will serve as a benchmark against which to measure the effects of such proposals.

CBO now projects that federal outlays for Medicaid will grow from $92 billion in 1996 to $216 billion in 2007—an average annual growth rate of 8 percent (see Table 1 at the end of this memorandum). The largest component—spending for medical assistance payments—is projected to rise from about $80 billion in 1996 to $186 billion in 2007, and spending for payments to disproportionate share hospitals (so-called DSH payments) is estimated to climb from about $9 billion in 1996 to almost $20 billion in 2007. Administrative expenses account for the rest of the program's spending. About 50 percent of Medicaid's growth over the 1996-2007 period stems from higher payment rates, 15 percent from rising enrollment, and 35 percent from other factors such as increases in DSH payments, administrative costs, and use of health care services.

CBO's current projections of federal Medicaid spending over the 1996-2002 period are a sizable $90 billion less than its May 1996 projections. About one-third of that reduction is attributable to 1996 outlays that were almost $4 billion lower than CBO had previously anticipated. But other factors were at play. CBO also lowered its projection of the average annual rate of growth in spending over the 1996-2002 period from 9.6 percent to 7.7 percent as a result of revised projections of growth in enrollment, smaller expected increases in inflation, and lower projected use of services. Moreover, included in that reduction is $4 billion in cumulative savings resulting from provisions of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. Most of those savings stem from the provisions to limit Medicaid coverage for certain legal immigrants.

The growth in Medicaid has descended from the sky-high rates of the early 1990s. Spending for the Medicaid program jumped by between 20 percent and 30 percent a year from 1990 through 1992. Yet its growth wound down to an average of about 10 percent a year from 1993 through 1995 and to just 3.3 percent in 1996.

Two factors largely fueled the surge in spending in the early 1990s. First, the states used provider-specific taxes and voluntary donations plus intergovernmental

transfers that generated additional federal matching funds to disproportionate share hospitals (see Box 1). Second, the states shifted services to the Medicaid program that they had previously funded without federal assistance—an activity that is commonly referred to as Medicaid maximization. As a result, states could obtain additional federal matching funds without committing any new resources of their own.

Other factors also contributed to the spiraling growth of Medicaid. They include the 1990-1991 recession, increased payment rates to providers, and federally legislated as well as state-initiated enrollment expansions (especially for coverage of poor pregnant women, children, and low-income Medicare beneficiaries).

Last year's unusually low growth rate—indeed, one of the smallest annual increases since Medicaid started in 1965—may be partly the result of general uncertainty about the outcome of proposals to reform the program as well as efforts by the states to make the most of any new system. (For example, anticipating passage of a proposal for a Medicaid block grant in 1996, a state could have increased the 1995 base on which its future federal funding would have been computed by shifting some spending from 1996 to 1995.) In any case, that uncertainty helped to precipitate an erratic spending pattern; federal expenditures did not increase at all above the 1995 level during the first half of 1996, but they then grew at an annual rate of more than 6 percent during the second half of the year.

BOX 1.
PROVIDER TAXES AND VOLUNTARY DONATIONS

By 1991, many states had instituted provider tax and voluntary donation programs to finance their share of Medicaid expenditures. States imposed taxes or required hospitals to make donations and returned the funds to the same providers through disproportionate share hospital (DSH) payments or higher reimbursement rates. The state would receive a federal match on those payments even though no real state contributions were made. Intergovernmental transfers worked in a similar way. Public hospitals transferred money to the state through the county government in most cases. The state used those funds in turn to make DSH payments (paid mainly to those same hospitals), and the state drew down federal matching dollars for those payments.

Legislation passed in 1991 and 1993 limited the ability of the states to draw down federal funds for DSH payments. In 1991, states were barred from receiving federal matching funds for most provider donations, restricted in their ability to use provider taxes, and limited to spending no more than 12 percent of total medical assistance payments on DSH. In 1993, DSH payments were also made subject to a hospital-specific cap. However, states still retain their ability to use intergovernmental transfers to finance their share of the Medicaid program.

CBO's current Medicaid projections reflect its forecast that rates of growth will be relatively low in the near term and somewhat higher thereafter, as pressures for higher spending reemerge. Those pressures are likely to come from several sources. First, CBO believes that savings from expanding enrollment in managed care are not likely to be large in the long run. Current fee-for-service reimbursement rates are already low, and the beneficiaries moving into managed care account for a relatively small share of Medicaid spending. Developing appropriate and cost-saving models of managed care for elderly and disabled beneficiaries (particularly those in long-term care), who account for the bulk of Medicaid expenditures, will be difficult. Second, states still have the ability to secure additional federal funds at no expense to themselves by simply using Medicaid maximization techniques or inter-governmental transfers. Finally, pressures for greater use of health care services continue to exist in a number of areas, including noninstitutional long-term care (such as home health services), prescription drugs, and other acute care services.

A growth rate of 8 percent a year in Medicaid falls within a wide range of plausible outcomes. In the light of experience, the rate of growth of Medicaid spending could easily exceed 10 percent a year, whereas growth below 6 percent in the long run is far less likely.

PROJECTING CASELOADS

In making its new, lower projections, CBO has also revised its projections of caseloads and of spending for benefits, DSH payments, and administration. The Medicaid program covers pregnant women; people who are aged, blind, or disabled; and members of certain families with children. To be eligible, those people must meet certain standards for income and resources. Such standards vary among both eligibility groups and states.

Medicaid beneficiaries are usually classified into four basic eligibility categories: aged, blind and disabled, children, and adults. Furthermore, beneficiaries can be counted in three ways: as recipients, enrollees, and full-year equivalents. A recipient is someone who receives a medical service paid for by Medicaid. An enrollee has a Medicaid card but does not necessarily receive any services during the year. The total number of full-year equivalents is the sum of the number of beneficiaries enrolled in the program for the full year plus the total number of months covered by all of the beneficiaries enrolled in the program for less than the full year divided by 12 months.

CBO's current baseline reflects Medicaid enrollment, whereas previous baselines were calculated using the number of Medicaid recipients. With increasing numbers of Medicaid beneficiaries participating in managed care arrangements,

states and the Health Care Financing Administration (HCFA) have informed CBO that the counts of enrollees are more accurate than the counts of recipients. Counts of both recipients and enrollees tally all individuals who participated throughout the year regardless of how long they were in the program. Counts of full-year equivalents represent the average number of program participants at any given time during the year.

Using recipients, enrollees, or full-year equivalents will not affect comparisons of growth rates from previous projections. However, estimates of average spending per beneficiary will vary depending on what type of beneficiary count is used in the denominator: using full-year equivalents will yield the highest per capita estimates; using enrollee counts will show lower average spending results.

Medicaid enrollment increased at an average annual rate of over 9 percent during the 1990-1994 period. That rapid growth in the number of enrollees was the result of several factors, including legislative expansions for children, pregnant women, and low-income Medicare beneficiaries; state-initiated expansions under section 1902(r)(2) and section 1115 waivers; and the *Sullivan v. Zebley* decision, which increased the number of disabled children eligible for Supplemental Security Income (SSI) and Medicaid by liberalizing the definition of disability.[1]

Growth in Medicaid enrollment dipped to 2.3 percent in 1995, although the growth rate for disabled beneficiaries was well above that average at about 9 percent. In 1995, the latest year for which Medicaid enrollment data are available, Medicaid enrollees numbered 42 million. Approximately 55 percent of all enrollees also received Aid to Families with Dependent Children (AFDC) or SSI cash benefits, about 25 percent were aged and disabled, and the rest were children and adults. Over the past five years, the share of cash recipients has been shrinking, but the overall distribution of beneficiaries by eligibility group (aged, blind and disabled, children, and adults) has remained fairly constant.

CBO projects total enrollment to increase at an average annual rate of 1.4 percent from 1996 through 2002, down from the average annual rate of 2.7 percent projected in May 1996. Thus, the number of Medicaid enrollees is projected to

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1. Section 1902(r)(2) of the Social Security Act allows states to expand Medicaid eligibility to groups not traditionally eligible for the program by disregarding certain income and resources.

   Section 1115 of the Social Security Act allows the Secretary of Health and Human Services to waive certain Medicaid requirements and grant states the flexibility to establish statewide demonstration projects. Section 1115 waivers have been used to expand eligibility and increase managed care enrollment. Ten states are currently implementing 1115 waivers. In the order of the dates on which the waivers may become effective, those states are Arizona, Tennessee, Oregon, Hawaii, Rhode Island, Minnesota, Delaware, Vermont, Oklahoma, and Ohio. Six other states have waivers approved by the Secretary but are not implementing them, and at least nine waivers are under review by the Health Care Financing Administration.

expand from 42 million in 1995 to 47 million in 2002. CBO's lower projections of enrollment take into account recent program experience, demographics, welfare reform, and a better accounting of the phase-in of certain legislative expansions. Overall caseload projections are more uncertain than usual for two reasons: the link between AFDC and Medicaid has been severed, and the link between SSI and Medicaid is weaker because many legal aliens will no longer be eligible for SSI but will continue to be eligible for Medicaid.

The Aged and Disabled

CBO lowered its projected growth in enrollment for the aged and disabled from an average annual rate of 3.4 percent over the 1996-2002 period to 2.3 percent. Previous baseline projections had been based on a rate of growth for the aged and disabled that reflected the mandatory phase-in of coverage for premiums and cost sharing for certain low-income Medicare beneficiaries. The new, lower projections better reflect the end of that phase-in, and they also incorporate new projections of caseloads for the SSI program, to which Medicaid eligibility is tied in most states. CBO also added a demographic factor to take account of the rates of growth for the population over 85, who are more likely to be poor and participate in the Medicaid program.

Children and Adults

CBO has also reduced its projected growth in enrollment for children and adults for the 1996-2002 period, from an average annual rate of 2.4 percent to 1.0 percent. That reduction is based on recent program experience and a revised estimate of the number of children entering the Medicaid program through federal requirements or expansions initiated by the states. Medicaid program data are not yet available, but evidence shows that AFDC rolls dropped precipitously in 1996, even though many of those children and pregnant women would have continued to qualify for Medicaid on the basis of their income. CBO estimates that the large reductions in AFDC caseloads generated lower net growth in Medicaid enrollment in 1996 than had previously been anticipated.

CBO assumes that Medicaid enrollment for children and adults after 1996 will increase at the same rate as the overall population, with one notable exception—through 2002, an additional cohort of children (about 125,000) will participate in the Medicaid program each year in keeping with the continued phase-in of expansions enacted in the Omnibus Budget Reconciliation Act of 1990 (OBRA-90). That act requires states to phase in coverage of children up to age 18 whose family income falls below the poverty level. CBO's reestimate takes into account the

decision of many states to adopt the mandatory coverage for all of those children at one time instead of phasing in coverage for an additional cohort each year.

The Impact of Welfare Reform on Medicaid Enrollment

CBO estimates that enacting welfare reform will bring down the number of legal immigrants eligible for Medicaid. The law forbids states to provide regular Medicaid coverage to future immigrants (except refugees) for their first five years in the United States. New requirements for all means-tested programs will bar most future immigrants with financial sponsors from Medicaid until they have worked for 40 quarters or are naturalized. States will have the option of providing Medicaid coverage for aliens currently residing in the United States.

CBO assumes that most states will continue to cover many immigrants who are current residents. Some current residents will lose Medicaid coverage, however, because they are no longer eligible to receive SSI cash benefits and cannot qualify for Medicaid under any other eligibility category. For example, a current resident who loses SSI may qualify for Medicaid under the state's medically needy program, which covers individuals who do not qualify for cash programs but who meet certain standards for income and resources that the states have established. If a state does not have a medically needy program, then current residents will probably lose Medicaid benefits.

CBO estimates that nearly 300,000 aliens will lose eligibility by 1998 and that that number will more than double by 2002. About 60 percent of those losing eligibility for Medicaid in 2002 will be children and adults; the aged and disabled represent the remainder. Approximately 15 percent of the total losing coverage are estimated to be current residents who will lose SSI benefits and have no alternative route to the Medicaid program.

Other provisions of welfare reform eliminated SSI coverage for certain disabled children. However, CBO assumed that most of those children would qualify for Medicaid on the basis of their family's income, although they would move from the category of eligibility for the disabled to the category for low-income children.

PROJECTING BENEFITS

CBO projects Medicaid fee-for-service benefits and payments to other insurers, including fee-for-service arrangements, managed care plans, and Medicare.

Fee-for-Service Payments

Traditional fee-for-service payments account for about 75 percent of all spending in the Medicaid program. More than half of those payments are for acute care and just under half for long-term care (of which 80 percent are payments to institutions). The aged and disabled account for 75 percent of the spending, and children and adults account for the remaining 25 percent.

States have a great deal of flexibility in operating the Medicaid program. In addition to providing mandatory acute care and long-term care services, states have chosen to cover a wide array of optional services. They set reimbursement rates to providers and have broad discretion over the amount, duration, and scope of the services provided. That flexibility fosters a great deal of variation among state programs.

Medicaid fee-for-service payments have increased rapidly since 1990. During that time, many states expanded their Medicaid programs by moving services that had previously been paid with only state funds into the Medicaid program so that the state funds for those services could qualify for additional federal matching funds. Spending for acute care may have increased in part because of the secondary effects of DSH schemes. Many states used provider-specific taxes and voluntary donations to draw down federal matching funds and in turn used those payments to provide more health services, thereby increasing acute care spending.

Recently, spending for institutional long-term care services has been growing more slowly than that for acute care services. Nevertheless, during the 1990-1992 period, spending for long-term care grew rapidly because of the costs of complying with nursing home regulations passed in the Omnibus Budget Reconciliation Act of 1987. The currently lower growth of spending on Medicaid long-term care may also be related to burgeoning Medicare expenditures for skilled nursing facilities and home health services.

CBO's current fee-for-service projections are based on 1996 spending as determined from the HCFA-64 report. Spending on each service is distributed among eligibility groups using the proportions from the 1995 HCFA-2082 report.[2] CBO groups services into broad categories and projects future spending on those categories using changes in enrollment, payment rates, and utilization.

2. The HCFA-2082 is an annual report designed to collect state-reported data on Medicaid beneficiaries and expenditures for the fiscal year. The latest available HCFA-2082 report has data from fiscal year 1995. The HCFA-64 is a quarterly statement of each state's Medicaid expenditures for which states are entitled to federal reimbursement. The HCFA-64 report contains data on expenditures for managed care plans, Medicare premiums, disproportionate share payments, and administration payments that are not included in the HCFA-2082 report.

Changes resulting from payment rates are estimated using Medicare's market basket for hospital services, the consumer price index (CPI) for physician services, the medical component of the CPI for other acute care services, and the employment cost index for long-term care expenditures. Because states set reimbursement levels, those price factors serve as proxies for how states set reimbursement rates. For the 1996-2002 period, CBO is projecting general inflation to be lower than it projected in May 1996.

In addition to prices and caseloads, changes in the use of services partly account for the climb in fee-for-service spending. That component includes the increased number and complexity of services per enrollee. The utilization factor also implicitly accounts for other important effects such as changes in state programs and expansions or contractions in services provided. CBO assigns utilization factors to different categories after analyzing historical trends and expected program changes. That update of CBO's baseline includes significant adjustments in use of noninstitutional long-term care services and nonhospital/nonphysician acute care services. Spending for both of those categories has been increasing rapidly in the past few years.

Finally, CBO adjusts projections of fee-for-service outlays to account for the increasing number of beneficiaries moving out of the fee-for-service sector and into fully capitated managed care arrangements. Because some states exclude (or "carve out") certain types of benefits that are paid on a capitated basis, some beneficiaries may be enrolled in the managed care and fee-for-service sectors simultaneously. Therefore, higher enrollment in managed care does not imply a corresponding decrease in fee-for-service enrollment. Nevertheless, CBO estimates that overall enrollment and outlays for managed care are increasing at a faster rate than they are for the fee-for-service programs.

Managed Care

Managed care enrollment in Medicaid has exploded in recent years. Forty-four states now operate some type of managed care program, and in 1995 those programs covered about 25 percent of Medicaid enrollees. CBO's discussions with state Medicaid directors strongly suggest that concerns about proposals to cap total Medicaid spending or limit the growth of payments on a per-person basis have contributed to the recent rapid growth in managed care. Paying for services on a per capita basis is especially appealing to states if federal funds are constrained, because it provides them with greater certainty about the level of payments by shifting some of the financing risk onto providers.

The Health Care Financing Administration does not collect data on the distribution of managed care enrollees among eligibility categories, but CBO has assumed in the past that only between 10 percent and 15 percent of managed care enrollees are aged or disabled. CBO anticipates that the fraction will remain fairly constant throughout the projection period.

Financial arrangements for Medicaid managed care range from payments to fully capitated and full-risk plans to plans with benefits paid primarily on a fee-for-service basis. A fully capitated plan is one that contracts to provide health services to enrollees for one prepaid, negotiated rate. About half of all Medicaid recipients enrolled in managed care plans are in that type of plan. Many Medicaid enrollees are in partially capitated organizations in which inpatient hospital services—and sometimes other services—are left out of the capitation rate. Still others are in primary care case management (PCCM) entities. In PCCMs, benefits are usually not paid under capitation of any kind; instead, a primary care gatekeeper manages care for beneficiaries. Finally, many health insuring organizations, which counties administer, operate like traditional indemnity plans, paying providers set rates.

CBO separately projects outlays for fully capitated managed care plans. Outlays for other types of managed care plans are paid to providers and therefore are included in the fee-for-service projections. Although CBO did not make any explicit assumptions about the approval of new statewide section 1115 waivers, CBO expects managed care enrollment to keep rising rapidly as HCFA continues to approve new section 1915(b) and section 1115 waivers, and as states continue to carry out existing managed care programs.[3] HCFA has already approved 16 of the section 1115 waivers and is reviewing nine more. Approving those waivers under review could significantly expand enrollment in managed care plans.

CBO used total payments reported as "payments to other group plans" on the HCFA-64 form as the starting point for determining total expenditures paid for enrollees in fully capitated managed care plans. That total was increased over the projection period to reflect the rising number of beneficiaries enrolling in managed care plans and the projected rate of growth in premiums for private health insurance. Total outlays were adjusted to account for increases in the number of more expensive aged and disabled enrollees participating in managed care.

Overall, CBO projects that outlays for fully capitated managed care plans will rise from $7 billion to $17 billion between 1996 and 2002—an average annual rate of over 15 percent. CBO does not anticipate that the shift from fee-for-service to

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3. Section 1915(b) waivers give states greater flexibility to enroll Medicaid beneficiaries in managed care programs.

managed care will dramatically reduce overall Medicaid spending, for several reasons.

First, children and adults constitute the majority of the enrollees participating in managed care. Expenditures for those groups account for less than one-third of total spending on benefits. Consequently, any small savings gained by moving some of those enrollees to managed care will have a negligible impact on overall spending. Moreover, if rates do not properly account for nonusers, states may not even achieve small savings if they make capitation payments on behalf of some healthy beneficiaries who would not otherwise have used health care services.

Second, the savings from a move to managed care occur only once. States may be able to negotiate capitation rates below what beneficiaries would have cost had they remained in fee-for-service. Whatever the outcome of such negotiations, however, increases in the capitation rates are likely to be similar to those for fee-for-service rates.

Third, as managed care plans receive more scrutiny, they may realize that they cannot provide quality care for such low rates and may try to renegotiate for higher capitation payments.

Finally, beneficiaries in managed care may still make extensive use of hospital emergency rooms for care. If so, Medicaid may end up paying for the cost of the emergency care in addition to the capitation payment.

Payments of Medicare Premiums

Since the beginning of the Medicaid program, states have been able to pay the Part B Medicare premiums for certain Medicaid beneficiaries. The Medicare Catastrophic Coverage Act of 1988 required all states to phase in coverage of premiums and cost sharing for qualified Medicare beneficiaries (QMBs) with income up to 100 percent of the federal poverty level and with resources within 200 percent of the SSI limits. The requirement to cover QMBs supplements rather than supersedes Medicaid rules for the aged and disabled. OBRA-90 accelerated the phase-in and also required states to pay Medicare Part B premiums for specified low-income Medicare beneficiaries (SLMBs) with income between 100 percent and 120 percent of the federal poverty line. States are also required to pay Medicare Part A premiums for a limited number of aged individuals and for qualified disabled working individuals (QDWIs) who have income below 200 percent of poverty. QDWIs are people who were previously entitled to Medicare Part A on the basis of a disability, then lost their entitlement based on earnings from work, but who continue to have a disabling condition.

In summary, three groups of people are eligible for both Medicaid and Medicare, but the extent of their Medicaid coverage differs: dual eligibles, for whom Medicaid pays Medicare premiums and cost sharing in addition to traditional Medicaid-only services; QMBs, for whom Medicaid pays for Medicare premiums and cost sharing but no other Medicaid services; and SLMBs, for whom Medicaid pays only Part B Medicare premiums.

According to the July 1996 HCFA Third-Party Premium Billing File, Medicare had 4.9 million buy-ins (people for whom Medicaid paid for at least Medicare premiums and in most cases cost sharing). Of that total, the states identified 2.5 million as QMBs only. There were 0.3 million Part A QMBs. The total number of buy-ins represents about 12 percent of all Medicare beneficiaries. CBO estimates that by 2002, the total number of buy-ins will increase to 6.0 million people—or about 15 percent of all Medicare beneficiaries. That percentage is expected to increase because the number of aged and disabled beneficiaries receiving Medicaid is projected to rise faster than Medicare enrollment.

In 1996, the federal share of Medicaid payments for Medicare premiums was about $2 billion. To arrive at an estimate for premium payments, CBO uses estimates of Medicare premiums multiplied by the number of expected buy-ins. Such payments are projected to grow to $3.1 billion by 2002. CBO does not separately project payments for Medicare cost sharing. Medicaid makes those payments directly to providers, and states do not report the portion of total service payments made for Medicare cost sharing.

PROJECTING DISPROPORTIONATE SHARE PAYMENTS

Federal law requires states to make disproportionate share payments to hospitals that serve a large number of Medicaid beneficiaries and other low-income individuals. DSH spending was a major contributor to high Medicaid growth rates in the early 1990s. In 1991 and again in 1993, legislation was passed to rein in disproportionate share spending. States are no longer able to use provider-specific taxes and donations to generate the state share for DSH payments. In fact, they are now subject to statewide and hospital-specific DSH caps. Each year, HCFA publishes preliminary and final state DSH allotments. DSH payments above the allotments are not eligible for federal matching payments.

States are classified as high-DSH or low-DSH. High-DSH states are those receiving DSH payments in excess of 12 percent of total medical assistance payments. The allotment amount for those states is frozen at the previous year's level until that level is equal to or below 12 percent of medical assistance payments by the states. In 1996, 14 states were high-DSH states and accounted for about half of all

DSH payments. The allotment amount for a low-DSH state is raised by the percentage increase that is projected for that state's total medical assistance payments, subject to the 12 percent cap. CBO projects that not all states will spend as much on DSH as their allotment would permit. In addition to the overall 12 percent cap, a hospital-specific cap prohibits states from reimbursing individual hospitals for more than 100 percent of their costs for uncompensated care.

CBO's May 1996 Medicaid baseline projected that DSH payments would grow by 5 percent a year and fall as a share of overall Medicaid payments. That estimate assumed that the hospital-specific caps would bind more tightly than the 12 percent cap. However, some states have used their ability to redistribute payments to avoid that constraint. The new baseline assumes that DSH payments will increase at rates slightly below overall medical assistance payments and remain roughly constant as a share of those payments. The federal share of DSH payments is projected to increase from $9 billion in 1996 to $13.6 billion in 2002.

PROJECTING ADMINISTRATIVE COSTS

State agencies administer the Medicaid program under the general oversight of the Health Care Financing Administration. States must designate a single administrative agency to determine eligibility, certify providers, and process claims. Most administrative activities—including those three—are reimbursed at 50 percent. Some functions of program operations are reimbursed at a 75 percent rate, and a small number of administrative functions have even higher matching rates.

CBO has increased its projections of Medicaid's administrative payments by $1 billion. That increase includes $500 million in budget authority provided for 1997 in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. Under that legislation, Medicaid agencies are required to enroll individuals who would have been eligible under the state AFDC programs that existed before the bill was enacted. Because enrollment in Medicaid had been tied to AFDC, those determinations of eligibility were previously left to the state agencies that administered AFDC. The state Medicaid agencies will now need to conduct "shadow" determinations of eligibility for AFDC, and the $500 million funds the additional administrative expenses related to those determinations. The other $500 million is for additional administrative payments in 1997 and 1998 to reflect the incentives that states have to increase federal payments by shifting some of the costs of administering their welfare programs to Medicaid. Medicaid's administrative expenses are eligible for federal matching payments, whereas costs to administer the new welfare program must come out of a state's welfare block grant.

TABLE 1. CBO'S JANUARY 1997 BASELINE FOR MEDICAID (By fiscal year)

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Average Annual Rate of Growth 1996-2002	1996-2007
Medicaid Outlays (Billions of dollars)														
Federal														
Acute care benefits	49.6	52.8	56.5	61.4	66.5	72.1	77.9	84.3	91.0	98.4	106.5	115.4	7.8	8.0
Long-term care benefits	29.9	31.6	33.4	35.6	38.4	41.4	45.1	49.1	53.5	58.5	64.0	70.1	7.1	8.1
Subtotal	79.5	84.4	89.9	97.0	104.9	113.5	123.0	133.4	144.4	156.9	170.6	185.5	7.5	8.0
Disproportionate share payments	8.6	9.8	10.3	11.1	11.8	12.7	13.6	14.6	15.7	16.9	18.2	19.6	7.9	7.7
Administration	3.9	4.4	5.1	5.5	6.1	6.6	7.2	7.8	8.5	9.3	10.2	11.1	10.8	10.0
Total Federal Outlays	92.0	98.6	105.3	113.6	122.9	132.8	143.8	155.9	168.7	183.1	198.9	216.2	7.7	8.1
State Share of Medicaid Payments	69.4	74.4	79.4	85.7	92.7	100.2	108.5	117.6	127.3	138.1	150.1	163.1	7.7	8.1
Total Medicaid Outlays	161.4	173.0	184.8	199.3	215.5	233.0	252.3	273.4	295.9	321.3	349.0	379.4	7.7	8.1
Annual Percentage Change in Total	3.3	7.2	6.8	7.9	8.1	8.1	8.3	8.4	8.2	8.6	8.6	8.7	n.a	n.a.

(Continued)

TABLE 1. CONTINUED

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Average Annual Rate of Growth 1996-2002	1996-2007
Federal Outlays for Benefits by Eligibility Category (Billions of dollars)														
Aged	24.5	26.1	27.3	29.0	31.1	33.5	36.1	39.2	42.2	45.7	49.6	53.8	6.7	7.4
Blind and Disabled	31.7	33.7	36.5	39.9	43.8	47.9	52.6	57.8	63.4	69.7	76.6	84.2	8.8	9.3
Children	13.7	14.6	15.8	17.1	18.4	19.8	21.2	22.6	24.1	25.8	27.5	29.5	7.5	7.2
Adults	9.6	9.9	10.3	11.0	11.6	12.3	13.0	13.9	14.8	15.8	16.8	18.0	5.3	5.9
Total	79.5	84.4	89.9	97.0	104.9	113.5	123.0	133.4	144.4	156.9	170.6	185.5	7.5	8.0
Enrollees by Eligibility Category (Millions of people)[a]														
Aged	4.5	4.6	4.6	4.7	4.8	4.8	4.9	5.0	5.1	5.2	5.3	5.4	1.6	1.8
Blind and Disabled	6.8	7.0	7.1	7.3	7.5	7.8	8.0	8.2	8.5	8.7	9.0	9.2	2.7	2.8
Children	21.7	22.1	22.4	22.8	23.1	23.4	23.6	23.8	24.0	24.1	24.3	24.4	1.4	1.1
Adults	9.9	10.0	10.0	10.1	10.1	10.1	10.2	10.2	10.3	10.3	10.4	10.4	0.5	0.4
Total	42.9	43.6	44.1	44.8	45.5	46.1	46.7	47.3	47.8	48.4	48.9	49.4	1.4	1.3
Federal Share of Payments per Enrollee (Dollars)														
Aged	5,500	5,680	5,930	6,200	6,550	6,920	7,350	7,800	8,240	8,750	9,300	9,890	5.0	5.5
Blind and Disabled	4,660	4,840	5,140	5,480	5,820	6,170	6,580	7,020	7,480	7,990	8,550	9,160	5.9	6.3
Children	630	660	710	750	800	850	900	950	1,010	1,070	1,130	1,210	6.1	6.1
Adults	970	1,000	1,030	1,090	1,150	1,210	1,280	1,350	1,430	1,530	1,630	1,730	4.7	5.4
Average	1,850	1,940	2,040	2,160	2,310	2,460	2,630	2,820	3,020	3,240	3,490	3,750	6.0	6.6

(Continued)

TABLE 1. CONTINUED

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Average Annual Rate of Growth 1996-2002	1996-2007
Full-Year Equivalents by Eligibility Category (Millions of people)[b]														
Aged	3.8	3.9	3.9	4.0	4.1	4.1	4.2	4.3	4.4	4.5	4.6	4.6	1.6	1.8
Blind and Disabled	6.1	6.2	6.4	6.5	6.7	6.9	7.2	7.4	7.6	7.8	8.0	8.2	2.7	2.8
Children	16.8	17.0	17.3	17.6	17.8	18.0	18.2	18.4	18.5	18.6	18.7	18.8	1.4	1.1
Adults	7.1	7.1	7.1	7.2	7.2	7.2	7.3	7.3	7.3	7.4	7.4	7.4	0.5	0.4
Total	33.7	34.3	34.7	35.3	35.8	36.4	36.9	37.3	37.8	38.2	38.7	39.1	1.5	1.4
Federal Share of Payments per Full-Year Equivalent (Dollars)														
Aged	6,440	6,650	6,950	7,260	7,670	8,100	8,600	9,140	9,650	10,250	10,880	11,570	4.9	5.5
Blind and Disabled	5,200	5,410	5,740	6,130	6,500	6,900	7,350	7,840	8,360	8,930	9,550	10,230	5.9	6.3
Children	820	860	910	970	1,030	1,100	1,160	1,230	1,300	1,380	1,470	1,560	6.0	6.0
Adults	1,360	1,400	1,450	1,530	1,610	1,700	1,790	1,900	2,010	2,140	2,280	2,430	4.7	5.4
Average	2,360	2,460	2,590	2,750	2,930	3,120	3,340	3,570	3,820	4,100	4,410	4,740	6.0	6.5
Federal Outlays to Other Insurance Plans (Billions of dollars)														
Premium Payments to Medicare	2.1	2.2	2.4	2.6	2.8	2.9	3.1	3.3	3.5	3.7	3.9	4.1	7.2	6.6
Payments to Other Group Plans	7.2	9.2	10.7	12.4	14.1	15.7	17.3	18.7	20.0	21.3	22.7	24.3	15.7	11.6
Other Benefits	70.2	73.0	76.8	82.1	88.1	94.8	102.5	111.4	121.0	131.9	143.9	157.1	6.5	7.6
Total	79.5	84.4	89.9	97.0	104.9	113.5	123.0	133.4	144.4	156.9	170.6	185.5	7.5	8.0

(Continued)

TABLE 1. CONTINUED

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
	Medicare Buy-ins (Millions of people)											
Dual Eligibles[c]	2.2	2.3	2.5	2.5	2.6	2.7	2.7	2.8	2.8	2.9	2.9	3.0
QMBs[d]	2.5	2.6	2.7	2.8	2.9	2.9	3.0	3.1	3.1	3.2	3.2	3.3
SLMBs[e]	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3
Total	4.9	5.2	5.4	5.6	5.7	5.9	6.0	6.2	6.3	6.3	6.4	6.5

SOURCE: Congressional Budget Office.

NOTES: With the exception of total outlays, all values for 1996 are estimated. As a result, projections of the components of spending and enrollment may change when more complete information becomes available.

n.a. = not applicable.

a. Note that CBO now projects enrollees and not recipients, as in its previous Medicaid baseline fact sheets. Enrollees are beneficiaries who are enrolled in the Medicaid program but may or may not receive a medical service paid for by Medicaid during the year. Recipients are beneficiaries who receive a medical service paid for by Medicaid during the year.

b. Full-year equivalents are estimates of the average number of beneficiaries at any point during the year.

c. Dual eligibles are people eligible for Medicare and the full range of Medicaid benefits. Medicaid pays for their Medicare premiums and cost sharing.

d. QMBs (qualified Medicare beneficiaries) are not eligible for other Medicaid-only benefits. Medicaid pays for their Medicare premiums and cost sharing.

e. SLMBs are specified low-income Medicare beneficiaries. Medicaid pays for their Medicare premiums only.