CBO TESTIMONY

Statement of
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Director
Congressional Budget Office

on
Growth in Medicaid Spending

before the
Committee on the Budget
U.S. House of Representatives

April 4, 1995

NOTICE

This statement is not available for public release until it is delivered at 10:00 a.m. (EDT), Tuesday, April 4, 1995.

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

Mr. Chairman and Members of the Committee, it is my pleasure to be here today to share with you the analysis that the Congressional Budget Office (CBO) has conducted concerning the recent growth in Medicaid expenditures and the program's projected growth under current policy. The rapid increases in Medicaid spending and the growing prominence of the program in the federal budget surely present a serious challenge to the Congress.

Between 1988 and 1993, Medicaid spending on average increased at the rapid rate of 16 percent a year. Yet over the same period national health expenditures were rising at an average annual rate of only 9 percent. Medicaid expenditures are expected to continue to rise faster than other health expenditures through 2002. Medicaid now accounts for about 6 percent of the federal budget, but that percentage is projected to climb to 8 percent by 2002. Modifying those trends will clearly require policy changes by both the Congress and the states.

OVERVIEW

Medicaid is the nation's major program providing medical and long-term care services to low-income populations. The federal and state governments jointly fund the program. The states administer it, however, and though they are subject to federal guidelines, they retain considerable discretion over all aspects of program operation. The federal share of total Medicaid spending in a state varies inversely

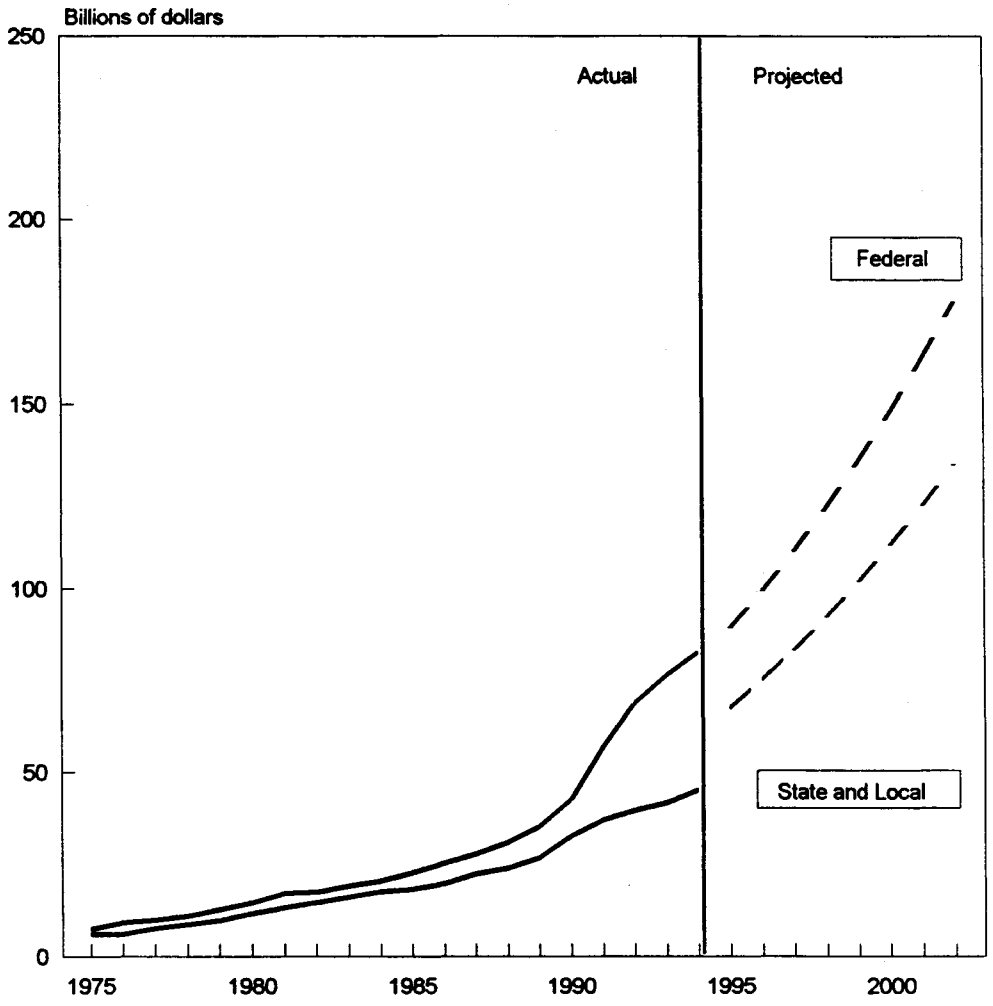
with the per capita income of the state, subject to a lower limit of 50 percent and an upper limit of 83 percent. Total Medicaid expenditures are expected to reach $157 billion in 1995, of which $89 billion (57 percent) represents the federal share (see Figure 1).

Medicaid Beneficiaries

The Medicaid program has always covered recipients and potential recipients of cash welfare benefits provided through the Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) programs. In addition, coverage has been extended to large numbers of poor and near-poor children and pregnant women, as well as to certain low-income Medicare beneficiaries. In 1993, over 33 million people received Medicaid benefits (see Table 1). Children under the age of 21 are by far the largest group of Medicaid beneficiaries, accounting for almost half of the total in 1993 (see Figure 2). About 12 percent of beneficiaries were elderly and 15 percent disabled. Most of the remainder were nondisabled adults.

The vast majority of Medicaid recipients are poor or near-poor. In 1992, according to the Census Bureau's Current Population Survey, 61 percent of the noninstitutionalized Medicaid population had income below the poverty level; 74

FIGURE 1. MEDICAID EXPENDITURES, 1975-2002



SOURCES: Health Care Financing Administration, Office of National Health Statistics, and the Congressional Budget Office.

NOTE: Historical Medicaid data are presented by calendar year. Projections of Medicaid expenditures are estimated using a federal matching percentage of 57 percent and are on a fiscal year basis.

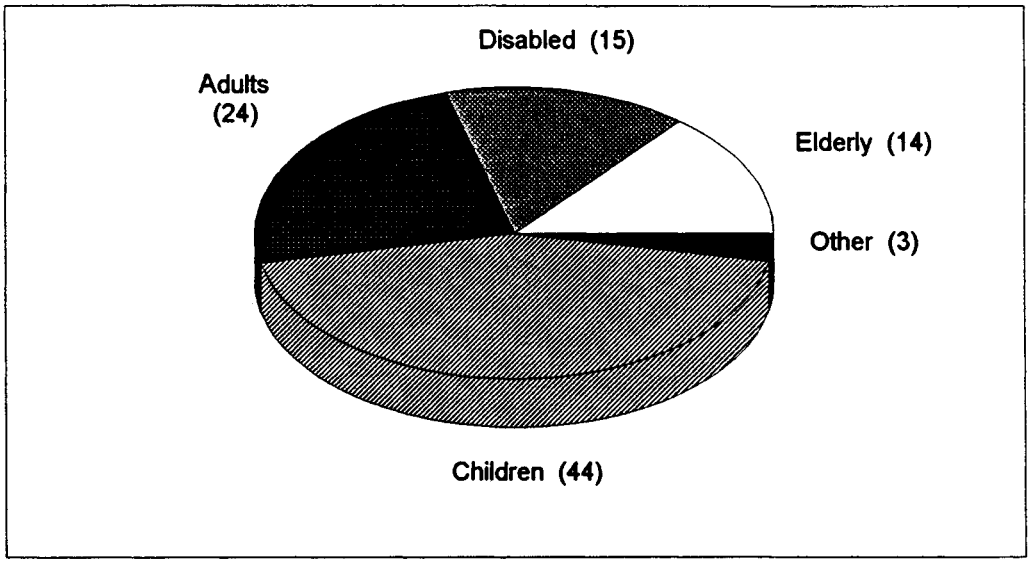
TABLE 1. MEDICAID BENEFICIARIES, 1988-1993 (By fiscal year, in millions)

Type of Beneficiary	1988	1989	1990	1991	1992	1993	Average Annual Rate of Growth (In percent)
Elderly	3.2	3.1	3.2	3.4	3.7	3.9	4.1
Cash recipients	1.7	1.6	1.5	1.5	1.5	1.5	-1.5
Other beneficiaries	1.5	1.6	1.7	1.9	2.2	2.3	9.2
Disabled	3.5	3.6	3.7	4.1	4.5	5.0	7.5
Cash recipients	2.8	2.8	2.8	3.1	3.3	3.8	6.2
Other beneficiaries	0.7	0.8	0.9	1.0	1.1	1.3	12.2
Adults	5.5	5.7	6.0	6.8	7.0	7.5	6.4
Cash recipients	4.1	4.1	4.0	4.2	4.4	4.6	2.6
Other beneficiaries	1.4	1.6	2.0	2.6	2.6	2.9	15.0
Children	10.0	10.3	11.2	13.4	15.2	16.3	10.2
Cash recipients	8.1	7.9	8.1	8.6	9.5	9.6	3.6
Other beneficiaries	2.0	2.4	3.1	4.9	5.7	6.6	27.6
Other/Unknown	0.7	0.8	1.1	0.7	0.7	0.8	1.1
Total	22.9	23.5	25.3	28.3	31.2	33.4	7.9

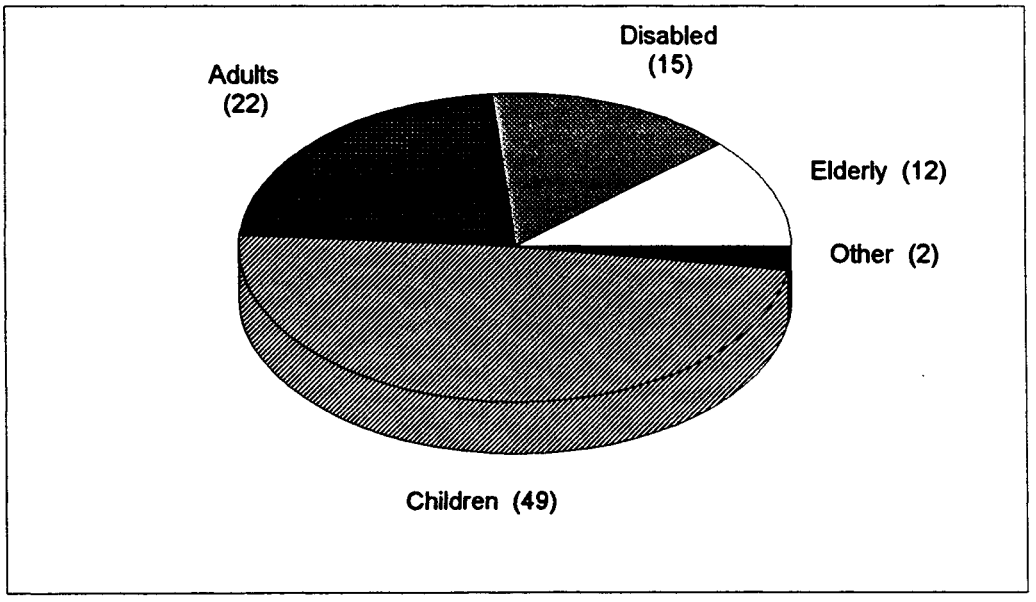
SOURCE: Congressional Budget Office estimates based on data from the Health Care Financing Administration, HCFA Form-2082.

FIGURE 2. DISTRIBUTION OF MEDICAID BENEFICIARIES BY ELIGIBILITY GROUP, FISCAL YEARS 1988 AND 1993 (In percent)

Fiscal Year 1988



Fiscal Year 1993



SOURCE: Congressional Budget Office estimates based on data from the Health Care Financing Administration, HCFA Form-2082.

percent were below 133 percent of the poverty level. However, 16 percent had income greater than 185 percent of the poverty level.

Provision of Services

Medicaid covers both acute medical services and long-term care. The federal government requires all states to provide a core group of services, including hospital, physician, and general nursing facility services. States have the option, however, to cover an extensive range of services in addition to the mandated ones, and all of the states do so. Optional services include drugs, dental services, eyeglasses, and personal care services. For the typical Medicaid beneficiary, acute care services are provided free of charge or for a nominal copayment. However, beneficiaries often face limited access to providers, many of whom are unwilling to see Medicaid patients.

Concern about access to providers was an important factor in the decision of some states to develop managed care arrangements for providing acute care services to some of their Medicaid beneficiaries--generally nondisabled adults and children. By June 1994, about 8 million Medicaid beneficiaries--almost a quarter of the total--were enrolled in managed care plans in 42 states and the District of Columbia.

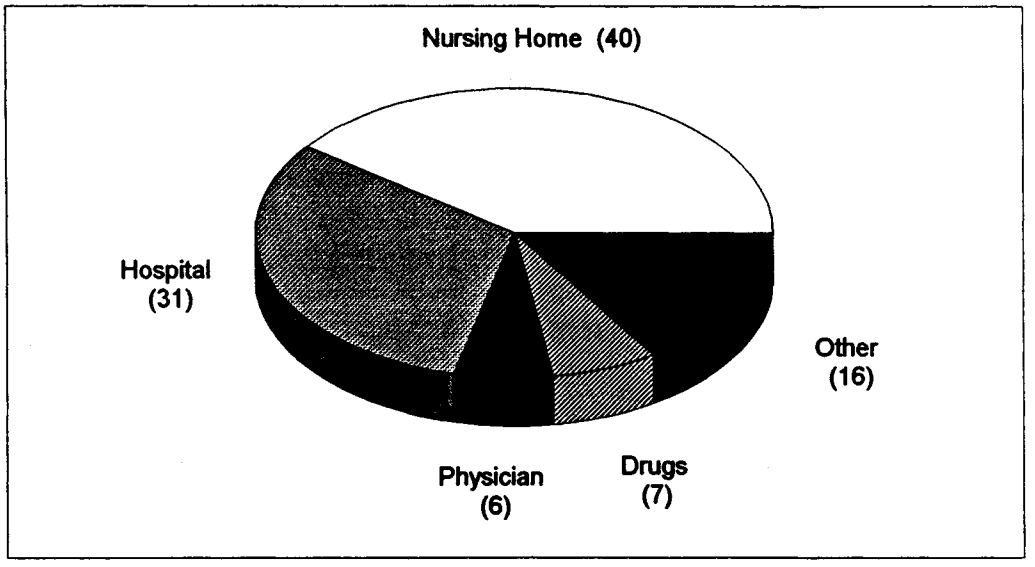
Expenditures by Type of Service

The largest share of Medicaid expenditures is for hospital and nursing home services, which accounted for two-thirds of the total in 1993 (see Figure 3). Hospital expenditures include payments to hospitals for inpatient and outpatient services received by Medicaid beneficiaries, as well as so-called "disproportionate share" (DSH) payments to hospitals that serve disproportionately large numbers of Medicaid and uninsured patients. Nursing homes include general nursing facilities as well as intermediate care facilities for the mentally retarded.

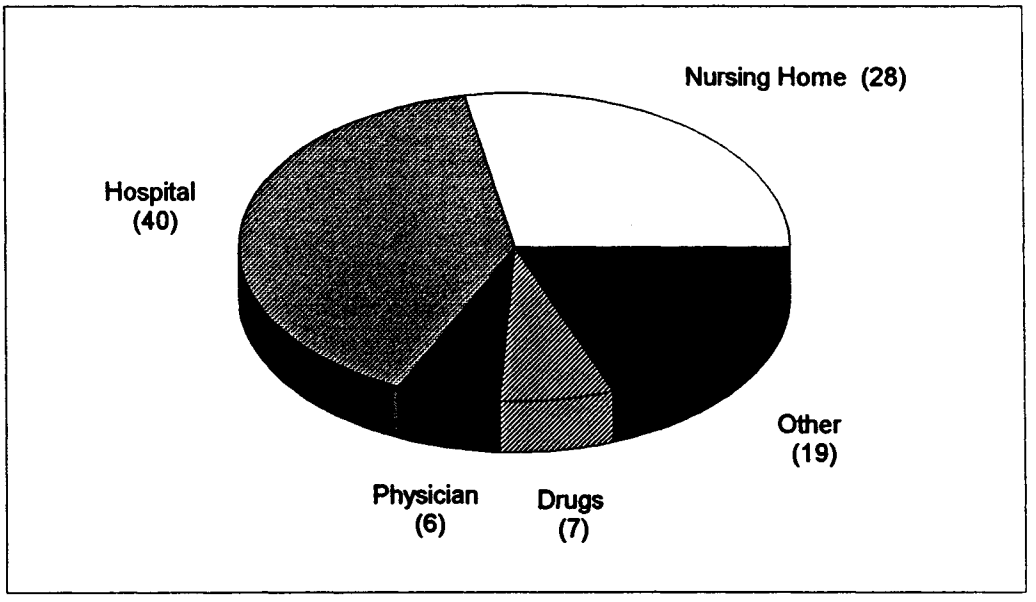
Disproportionate share payments, as reported by the states, have grown from a negligible fraction of total spending in 1988 to 13 percent of total spending in 1993. In that year, all payments to hospitals--inpatient, outpatient, and DSH--nominally accounted for 40 percent of total spending compared with 31 percent in 1988. By contrast, spending for institutional long-term care services dropped from 40 percent in 1988 to 28 percent in 1993. As discussed later, however, part of the total reported DSH payments probably represented illusory expenditures by the states. Consequently, 40 percent is likely to be an overestimate of the actual share of spending for hospitals.

FIGURE 3. DISTRIBUTION OF MEDICAID EXPENDITURES BY CATEGORY OF SERVICE, FISCAL YEARS 1988 AND 1993 (In percent)

Fiscal Year 1988



Fiscal Year 1993



SOURCE: Congressional Budget Office estimates based on data from the Health Care Financing Administration, HCFA Form-64.

NOTES: Nursing home expenditures include spending for nursing home facilities and intermediate care facilities for the mentally retarded.

Hospital expenditures include spending for inpatient and outpatient care and disproportionate share payments.

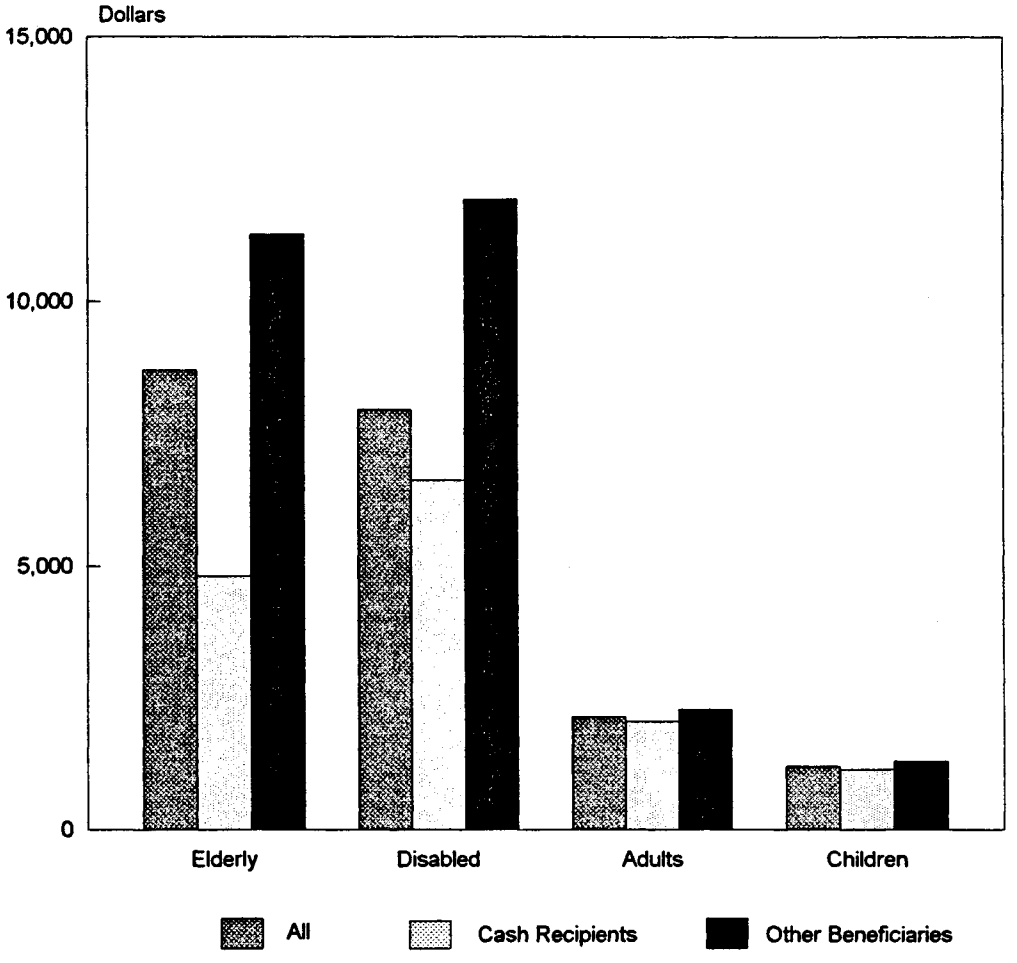
Expenditures by Eligibility Status

Because of their use of nursing home services and their extensive acute care needs, elderly and disabled Medicaid beneficiaries generate much higher medical expenditures than do children and other adults (see Figure 4). Some elderly and disabled beneficiaries become eligible for Medicaid because of their need for costly nursing home services, even though they have not been recipients of cash welfare benefits. As a result, although the elderly and disabled represented less than 30 percent of Medicaid beneficiaries in 1993, they accounted for about two-thirds of all Medicaid expenditures, excluding DSH payments (see Figure 5).

State Variation in Expenditures

Medicaid expenditures vary considerably from state to state for a number of reasons: the size and makeup of the beneficiary population, the coverage of optional services, the use of services by beneficiaries, and provider payment levels. In addition, some states have raised DSH payments substantially by taking advantage of certain financing schemes, whereas others have not. Because of those factors, total Medicaid expenditures vary much more widely among the states than might be expected, given the relative size of their low-income populations (see Table A-1 in the appendix).

FIGURE 4. MEDICAID EXPENDITURES PER BENEFICIARY, FISCAL YEAR 1993

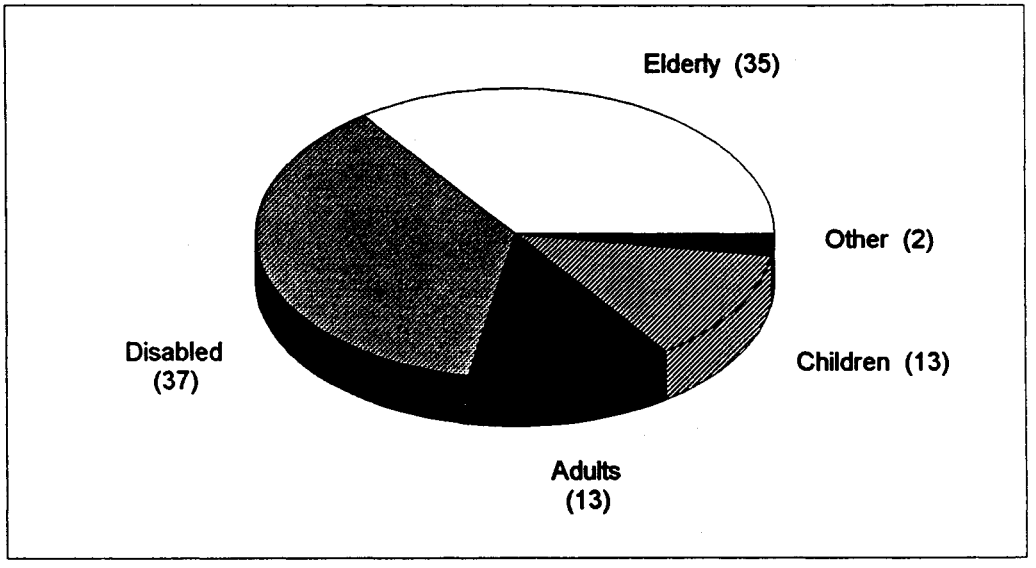


SOURCE: Congressional Budget Office estimates based on data from the Health Care Financing Administration, HCFA Form-2082 and HCFA Form-64.

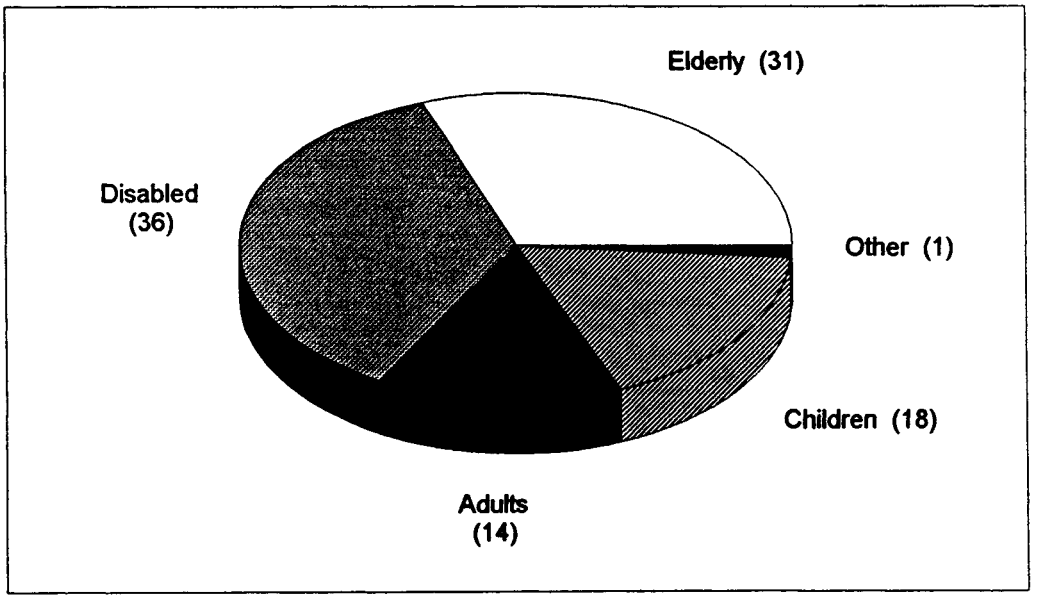
NOTE: Excludes administrative costs and disproportionate share payments.

FIGURE 5. DISTRIBUTION OF MEDICAID EXPENDITURES BY ELIGIBILITY GROUP, FISCAL YEARS 1988 AND 1993 (In percent)

Fiscal Year 1988



Fiscal Year 1993



SOURCE: Congressional Budget Office estimates based on data from the Health Care Financing Administration, HCFA Form-2082 and HCFA Form-64.

NOTE: Excludes administrative costs and disproportionate share payments.

In California, for example, about 5.5 million people on average were in families with income below the poverty level over the 1990-1992 period compared with about 3 million in New York.[1] But in 1993, New York spent $18 billion on Medicaid (excluding administrative costs), whereas California spent only $14 billion.

In addition to the other factors contributing to program variation, differential use of DSH payments helps to account for the varying growth rates in Medicaid spending among the states (see Table A-2). For example, over the 1988-1993 period, the average annual growth rate of Medicaid spending was 14 percent in Massachusetts and 33 percent in Louisiana. In 1993, DSH payments were $484 million (about 12 percent of Medicaid expenditures) in Massachusetts compared with $1.2 billion (about one-third of Medicaid expenditures) in Louisiana.

For some of the reasons already cited, Medicaid expenditures per enrollee also vary widely among the states, ranging from less than $2,000 in Alabama, California, and Mississippi in 1993 to more than $5,000 in New York (excluding DSH payments). The extent to which the quality of services varies, however, is not easy to discern.

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1. Colin Winterbottom, David W. Liska, and Karen M. Obermaier, *State-Level Databook on Health Care Access and Financing* (Washington, D.C.: Urban Institute, 1995).

Since 1975, the growth of Medicaid expenditures has been uneven, and recent patterns of growth have not reflected those of Medicare, private health insurance, or national health expenditures (see Table 2).[2] The trend in Medicaid expenditures for the 1975-1993 period can actually be divided into three distinct periods for analytic purposes: 1975 to 1981, when Medicaid spending grew rapidly but still remained at virtually the same rate as national health expenditures; 1981 to 1988, when Medicaid spending grew relatively slowly and less rapidly than national health expenditures; and 1988 to 1993, when Medicaid spending grew extremely rapidly and much faster than national health expenditures.

Between 1975 and 1981, Medicaid spending grew at about 14 percent a year, the same as national health expenditures. Private health insurance and Medicare expenditures both grew at about 18 percent a year during that period. Since the number of beneficiaries remained virtually unchanged at around 22 million, the growth in Medicaid spending was attributable to increases in prices and utilization per beneficiary.

2. CBO's analysis of spending trends is based on data from the national health accounts. In developing those estimates, the Health Care Financing Administration reduced the amount of disproportionate share payments to hospitals when such payments were offset by taxes and donations paid by the same facilities. The effect is to reduce the estimates of state Medicaid spending in the 1990s below the levels actually reported by the states. See Katherine R. Levit and others, "National Health Spending Trends, 1960-1993," *Health Affairs*, vol. 13 (Winter 1994), pp. 14-31.

TABLE 2. NATIONAL HEALTH EXPENDITURES BY SOURCE OF PAYMENT, 1975-1993 (By calendar year)

Source of Payment	1975	1980	1985	1990	1993
Billions of Dollars					
National Health Expenditures	132.6	251.1	434.5	696.6	884.2
Private health insurance	32.0	72.1	139.8	236.9	296.1
Medicare	16.4	37.5	72.2	112.1	154.2
Medicaid	13.5	26.1	41.3	75.4	117.9
Federal	7.4	14.5	22.8	42.7	76.1
State and local	6.1	11.6	18.4	32.7	41.8
Other	70.7	115.3	181.2	272.1	316.0
Average Annual Growth Rate from Previous Year Shown (Percent)					
National Health Expenditures	n.a.	13.6	11.6	9.9	8.3
Private health insurance	n.a.	17.6	14.2	11.1	7.7
Medicare	n.a.	18.0	14.0	9.2	11.2
Medicaid	n.a.	14.1	9.6	12.8	16.0
Federal	n.a.	14.3	9.5	13.3	21.2
State and local	n.a.	13.9	9.7	12.2	8.5
Other	n.a.	10.3	9.5	8.5	5.1

Average Annual Growth Rate Over Indicated Periods (Percent)	1975-1981	1981-1988	1988-1993
National Health Expenditures	14.0	9.8	9.5
Private health insurance	17.7	11.7	9.9
Medicare	18.3	10.3	11.5
Medicaid	14.5	8.9	16.4
Federal	15.0	8.8	19.6
State and local	13.8	9.0	11.7
Other	10.8	8.6	6.3

SOURCE: Congressional Budget Office based on data from the Health Care Financing Administration, Office of National Health Statistics.

NOTE: n.a. = not applicable.

Medicaid expenditures grew relatively slowly during the 1981-1988 period, at an annual rate of about 9 percent. Medicare and private health insurance spending grew at 10 percent and 12 percent, respectively, and national health expenditures grew at about 10 percent. As in the previous period, the growth in Medicaid expenditures primarily reflected price increases and increases in utilization per beneficiary; the number of beneficiaries grew only slightly during the period, reaching about 23 million in 1988. Indeed, in spite of the effects of the 1981-1982 recession, the number of Medicaid beneficiaries actually fell slightly between 1981 and 1983. Factors contributing to that decline probably included cutbacks in the AFDC program enacted in the Omnibus Budget Reconciliation Act of 1981 combined with new Medicaid options that granted states greater flexibility in determining which groups of children to cover. Although the Congress authorized expansions in eligibility for children and pregnant women beginning in 1984, the early expansions were tied to categorical eligibility for welfare and did not have a major impact on the number of beneficiaries.

The 1988-1993 trends represented a break with the historical precedent of growth in Medicaid spending, trailing behind that of private health insurance and Medicare. In fact, Medicaid expenditures soared, rising at an average annual rate of more than 16 percent, although national health expenditures grew at less than 10 percent. By contrast, private health insurance expenditures grew at about 10 percent during the period, and Medicare spending grew at less than 12 percent. The most

striking increases occurred between 1990 and 1992, when Medicaid spending jumped by over 40 percent. Several factors contributed to Medicaid's dramatic growth: sharp rises in Medicaid enrollment, payment increases for providers, and financing schemes and disproportionate share payments. But isolating their separate and interactive effects is difficult.

Rapid Increases in Medicaid Enrollment

In contrast to earlier periods, 1988 to 1993 was marked by swift growth in the number of Medicaid beneficiaries. Not only were there large increases in the number of children covered by the program, but there was also rapid growth in the enrollment of population groups that are more costly to serve.

Expansions in Eligibility. Beginning in 1984 and continuing through 1990, the Congress authorized a series of mandatory and optional expansions in Medicaid eligibility. Low-income children and pregnant women were the primary focus of those expansions, but the target populations also included the elderly and the disabled.

Of particular importance were the options granted to the states in the Omnibus Budget Reconciliation Act of 1986, which severed the required link between Medicaid and welfare eligibility. A rapid succession of mandates and options for covering low-income children and pregnant women followed, as well as requirements for covering low-income Medicare beneficiaries. The most recent mandatory expansion of the program, authorized in the Omnibus Budget Reconciliation Act of 1990, requires states to provide coverage to all poor children under 19 who were born after September 30, 1983. That requirement means that mandatory expansions in Medicaid eligibility will continue under current law through 2002.

Such expansions in eligibility, along with efforts to streamline the eligibility process, have brought about large increases in the number of Medicaid beneficiaries who do not receive cash welfare benefits. The number of those beneficiaries rose at an average annual rate of about 17 percent between 1988 and 1993, having risen at an average rate of about 3 percent between 1981 and 1988. By 1993, over 40 percent of Medicaid beneficiaries did not receive cash welfare benefits, compared with less than 30 percent in 1988. Much of that increase, however, was among children, who are the least expensive beneficiaries to cover, and the proportion of total expenditures attributable to beneficiaries who do not receive cash benefits increased only slightly over the period.

Effects of the Recession. The 1990-1991 recession sparked greater enrollment in the Medicaid program because more families received cash welfare benefits and fewer families had access to employer-sponsored health insurance. Determining the magnitude of the effects of the recession, however, is extremely hard to do.

The number of Medicaid beneficiaries who received cash welfare payments remained virtually constant at about 16.5 million throughout the 1980s. Consistent with the effects of a recession, that number increased to 17.2 million in 1991 and 18.8 million in 1992. But the number continued to rise to 19.6 million in 1993, even when the economy was expanding. Moreover, to some extent, the growth in the enrollment of Medicaid beneficiaries who were eligible for cash welfare benefits itself spurred growth in welfare caseloads. Some states began conducting aggressive outreach efforts to enroll children and pregnant women in Medicaid in the early 1990s and, in so doing, identified families who were eligible for cash welfare benefits but were not receiving them.

The recession also contributed to the enrollment of other low-income individuals and families in the Medicaid program, as they lost their jobs or faced reduced hours of work. It would be a formidable task, however, to disentangle the effects of the recession from the effects of the expansions in eligibility that were occurring at the same time.

Increases in High-Cost Beneficiaries. Medicaid expenditures depend not only on the total number of beneficiaries but also on their distribution among the different categories of eligibility. For a given number of beneficiaries, the higher the proportion of elderly and disabled beneficiaries, the greater spending will be. The proportion of pregnant women among the nondisabled adult population also has an important impact on spending.

The number of disabled Medicaid beneficiaries expanded rapidly in the early 1990s, rising from 3.5 million in 1988 to 5 million in 1993--an increase of 44 percent, or about 7.5 percent per year (see Table 3). Over that period, Medicaid expenditures for the disabled grew from about $19 billion to about $40 billion--an increase of over 100 percent. Thus, in spite of the large increases in the number of children covered by the program, the disabled population still represented 15 percent of total Medicaid beneficiaries in 1993, as it had in 1988, and accounted for almost the same proportion of total spending (excluding DSH payments). Several factors contributed to the growth in the disabled population, including expansions of the Supplemental Security Income program for children and increasing numbers of beneficiaries with AIDS and mental illness. The number of disabled beneficiaries is expected to expand more rapidly than total beneficiaries for the remainder of the decade.

TABLE 3. GROWTH IN MEDICAID BENEFICIARIES AND EXPENDITURES, 1988-1993 (By fiscal year)

	Average Annual Rate of Growth, 1988-1993 (In percent)	
	Beneficiaries	Expenditures
Elderly	4.1	13.3
Cash recipients	-1.5	9.6
Other beneficiaries	9.2	14.5
Disabled	7.5	15.7
Cash recipients	6.2	16.0
Other beneficiaries	12.2	15.2
Adults	6.4	19.3
Cash recipients	2.6	13.2
Other beneficiaries	15.0	33.7
Children	10.2	24.1
Cash recipients	3.6	16.5
Other beneficiaries	27.6	41.4

SOURCE: Congressional Budget Office estimates based on data from the Health Care Financing Administration, HCFA Form-2082 and HCFA Form-64.

NOTE: Expenditures exclude administrative costs and disproportionate share payments.

The expansions in eligibility for pregnant women during the 1988-1993 period also brought into the Medicaid program a beneficiary group that, by definition, had extensive acute medical care needs. The number of nondisabled adult beneficiaries who did not receive cash welfare payments more than doubled over the period, from 1.4 million to 2.9 million--and payments for that group rose from $1.5 billion to $6.5 billion.

Increases in Payments to Providers

During the 1980s, providers in several states filed lawsuits challenging the reasonableness and adequacy of reimbursement rates for hospitals and nursing homes. Those lawsuits were filed under the Boren Amendment (originally enacted as part of the Omnibus Reconciliation Act of 1980 and expanded in the Omnibus Budget Reconciliation Act of 1981), which required states to pay rates that were "reasonable and adequate" to meet those costs that would be incurred by "efficiently and economically operated" facilities. A decision by the U.S. Supreme Court in 1990 established that providers have an enforceable right to such rates and that they may sue state officials for declaratory and injunctive relief.

Following the Supreme Court's ruling, decisions favoring providers were handed down in several states. Moreover, the mere threat of suit under the Boren Amendment may have been sufficient to make some states increase payments. Consequently, in the early 1990s, payments to hospitals and nursing homes rose substantially in some states. Despite recent court decisions favoring the states in suits brought under the Boren Amendment, the National Governors' Association is trying to have the amendment repealed, believing that it significantly limits the ability of the states to control Medicaid expenditures.

Financing Schemes and Disproportionate Share Payments

In the late 1980s and early 1990s, faced with burgeoning Medicaid costs and pressures to increase their reimbursement rates for providers, many states developed financing schemes to generate part of their share of Medicaid expenditures. Those schemes, which involved voluntary donations from providers, taxes on providers, and intergovernmental transfers, drew down federal matching dollars for what were often illusory Medicaid expenditures.[3] Such financing mechanisms were closely associated with the rapid growth in DSH payments that occurred during the period (sometimes as a response to actual or potential litigation under the Boren

3. General Accounting Office, *Medicaid: States Use Illusory Methods to Shift Program Costs to the Federal Government* (August 1994).

Amendment). According to researchers at the Urban Institute, DSH payments rose from less than $1 billion in 1990 to more than $17 billion in 1992.[4] But some of those amounts were almost certainly offset by taxes or donations from providers.

The Congress took action in 1991 to limit the use of provider taxes and donations and also to place a cap on the growth of DSH payments. Further restrictions on DSH payments were enacted in the Omnibus Budget Reconciliation Act of 1993. It is still too early to assess the full impact of those provisions, but DSH payments fell in 1993 and 1994 and rapid growth in the future is unlikely.

FACTORS CONTRIBUTING TO FUTURE GROWTH IN EXPENDITURES

The future growth of Medicaid expenditures under current law will be critically affected by expansions in eligibility, changes in the mix of Medicaid beneficiaries, and the success of efforts by the states to control Medicaid spending through expanding enrollment in managed care plans. Considerable uncertainty surrounds all of those issues.

4. John Holahan, David Liska, and Karen Obermaier, *Medicaid Expenditures and Beneficiary Trends, 1988-1993* (Washington, D.C.: Urban Institute, September 1994).

Expansions in Eligibility

Some expansions in eligibility will occur because of the current-law mandate to phase in coverage of poor children. Since children are the least costly group of Medicaid beneficiaries and only one age cohort is being added each year, the mandate is not expected to prompt rapid growth in expenditures.

Expansions in eligibility that are undertaken at the option of the states are much more difficult to predict. Several states have recently taken advantage of a provision in section 1902(r)(2) of the Social Security Act that enables them to expand coverage to children and pregnant women in families whose income is considerably higher than the levels nominally permitted by legislation. Moreover, several states have obtained--or are seeking--waivers from Medicaid regulations in order to expand insurance coverage to poor and near-poor population groups. Although such expansions are supposed to be budget neutral, the Health Care Financing Administration (HCFA) is allowing states to incorporate hypothetical expansions of eligibility under section 1902(r)(2) into their Medicaid baselines for purposes of establishing budget neutrality.

To date, eight states have had waivers approved, a further 11 states have applications pending, and others are considering applying. (The eight approved states include Arizona, which has always operated its Medicaid program under a

statewide demonstration waiver.) At least four of the recently approved statewide waivers incorporated expansions of eligibility into the state's baseline expenditures.

Note, however, that not all waivers that are approved will actually be implemented. Kentucky, for example, had a waiver approved by HCFA to enable the state to expand coverage to other low-income groups. But the state legislature stipulated that the Medicaid program had to prove that it could generate sufficient savings to cover the expanded eligibility before such expansions could occur. To date, therefore, no expansion in eligibility has occurred. Nor will all the states that are considering applying in order to expand coverage actually do so, especially given the current uncertainty about the future course of the Medicaid program. Indeed, some states, such as New York, may actually be trying to cut their Medicaid budgets.

Changing Mix of Beneficiaries

As mentioned previously, the number of disabled Medicaid beneficiaries is expected to continue to increase quite rapidly--from about 6 million in 1995 to 8.3 million in 2002, or at an average annual rate of 4.9 percent. Total beneficiaries are expected to grow at an annual rate of only 3.2 percent during that period. The rapid growth in the number of disabled beneficiaries reflects the continuing effects of outreach to the affected populations by the Social Security Administration, a broader definition of

disability than in earlier years, and the growing number of individuals reaching ages at which there is a high incidence of disability. Those factors are resulting in increasing numbers of both cash welfare recipients and others who do not receive cash welfare benefits.

Growth of Managed Care

Many states are moving quickly to enroll Medicaid beneficiaries in managed care plans, both to improve access and to control costs. The evidence to date, however, on the effectiveness of managed care in containing Medicaid costs is limited.[5] Moreover, most states have concentrated thus far on developing managed care options for children and nondisabled adults, and those groups account for only about one-third of Medicaid spending. It will be much tougher to develop appropriate and cost-saving models of managed care for elderly and disabled beneficiaries, who account for the bulk of Medicaid expenditures.[6] Arizona enrolls both AFDC and SSI beneficiaries in prepaid health plans, and Tennessee is attempting to cover all noninstitutionalized Medicaid beneficiaries under its statewide section 1115 waiver. In addition, a few other states are developing managed care options for the elderly

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5. Robert E. Hurley, Deborah A. Freund, and John E. Paul, *Managed Care in Medicaid: Lessons for Policy and Program Design* (Ann Arbor, Mich.: Health Administration Press, 1993).

6. Deborah A. Freund and Robert E. Hurley, "Medicaid Managed Care: Contribution to Issues of Health Reform," *Annual Reviews of Public Health*, vol. 16 (1995), pp. 473-495.

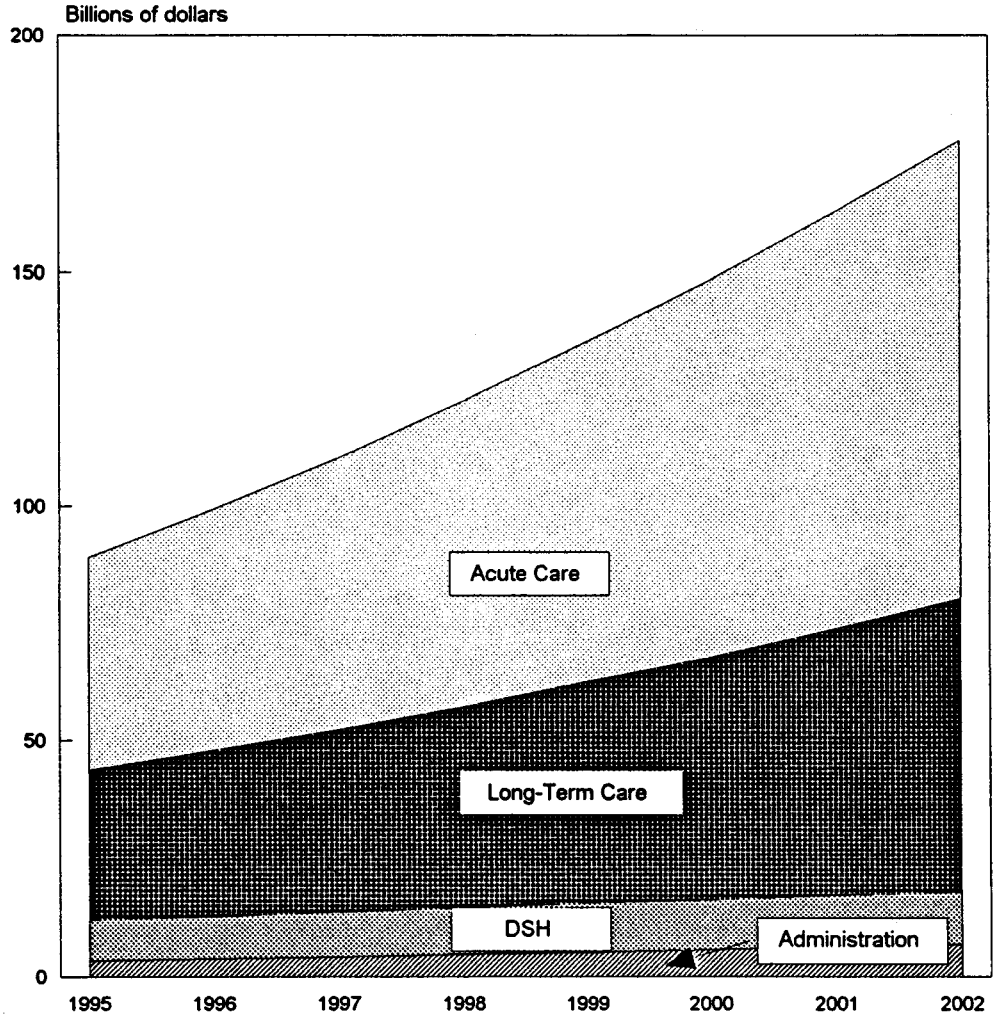
and disabled, in some cases incorporating both acute and long-term care services. But the widespread enrollment of elderly and disabled Medicaid beneficiaries in managed care plans seems unlikely in the immediate future.

CBO'S SPENDING PROJECTIONS

Under current law, CBO projects that the federal share of Medicaid payments will rise from $89 billion in 1995 to $178 billion in 2002, which represents an average annual rate of growth of 10.4 percent (see Figure 6). Most of that increase stems from the growth in payments for acute and long-term care benefits, with DSH payments rising only slowly during the period.

Three primary factors drive CBO's projections of Medicaid expenditures for the next several years: growth in the number of beneficiaries, price increases, and residual growth. The total number of beneficiaries is expected to increase by 4 percent in 1995, slowing to about 2.5 percent by 2002. But the number of aged and disabled beneficiaries is expected to grow faster than the total. Accounting for that change in composition, about 40 percent of projected overall Medicaid growth can be attributed to increases in caseload.

FIGURE 6. PROJECTIONS OF FEDERAL MEDICAID SPENDING, FISCAL YEARS 1995-2002



SOURCE: Congressional Budget Office.

NOTE: DSH = disproportionate share hospital payments.

CBO uses different inflation factors for different categories of Medicaid expenditures. On average, those factors are expected to increase at about 4 percent a year. Over the 1995-2002 period, changes in prices account for approximately 30 percent of the projected increase in Medicaid outlays.

Finally, the projections assume that all other factors combined (excluding DSH payments) will increase Medicaid spending by about 2 percent in 1995 and 3 percent a year for the remainder of the period. That residual growth factor, which accounts for about 25 percent of overall Medicaid growth, encompasses changes in utilization, the use of more complex technologies, changes in the benefit packages that states offer, and increases in payment rates above general inflation.

CBO's current Medicaid projections are somewhat lower than those it made last summer. The current estimate of 1994 federal Medicaid spending is about $82 billion, or about $2 billion lower than CBO's summer projection. Similarly, the current projection for 1995 is $89 billion, or about $7 billion lower than the summer projection. Because 1994 Medicaid spending was lower than CBO had projected, CBO has lowered the starting level of Medicaid expenditures on which the projections are based. Change in that level accounts for much of the change in expected outlays. CBO has also lowered the assumed rate of growth of spending by about 1 percentage point beginning in 1996.

The Medicaid projections developed by the Office of Management and Budget (OMB) are lower than CBO's (see Table 4). OMB assumed that lower-than-anticipated spending in 1994 represented a change in the program that will be sustained throughout the projection period. By contrast, CBO projects that growth will return to more historical levels.

CONCLUSION

Many of the nation's governors are now seeking less federal control of the Medicaid program to enable the states to meet the needs of their particular low-income populations more effectively. The states' desire for greater flexibility plus the ongoing rapid growth of spending make the Medicaid program potentially ripe for change. How to limit program growth without adverse effects on the intended beneficiaries is the challenge facing the Congress and the states.

TABLE 4. COMPARISON OF CONGRESSIONAL BUDGET OFFICE AND OFFICE OF MANAGEMENT AND BUDGET MEDICAID PROJECTIONS (By fiscal year)

	1994	1995	1996	1997	1998	1999	2000
Projected Outlays for Medicaid (In billions of dollars)							
Congressional Budget Office	82.0	89.2	99.3	110.0	122.1	134.8	148.1
Office of Management and Budget	82.0	88.4	96.0	104.6	114.5	124.5	136.3
Difference in Outlays	0	0.8	3.3	5.4	7.6	10.3	11.8
Projected Rate of Growth of Outlays (In percent)							
Congressional Budget Office	n.a.	8.8	11.3	10.8	10.9	10.5	9.9
Office of Management and Budget	n.a.	7.8	8.6	9.0	9.5	8.7	9.5

SOURCES: Congressional Budget Office February 1995 baseline and Office of Management and Budget, *Budget of the United States Government, Fiscal Year 1996.*

NOTE: n.a. = not applicable.

APPENDIX

STATE MEDICAID AND POVERTY DATA

TABLE A-1. STATE STATISTICS ON MEDICAID EXPENDITURES AND POVERTY

State	Total Medicaid Expenditures, 1993 (In millions of dollars)	Federal Medicaid Expenditures, 1993 (In millions of dollars)	Percentage of All Federal Medicaid Expenditures, 1993	Federal Matching Percentage, 1993	Poverty Population, 1990-1992 (In thousands)	Percentage of U.S. Poverty Population, 1990-1992
Alaska	301.1	160.6	0.2	50.0	80	0.2
Alabama	1,635.9	1,170.9	1.6	71.5	788	2.0
Arkansas	1,017.8	758.0	1.0	74.4	426	1.1
Arizona	1,375.4	918.3	1.3	65.9	535	1.4
California	14,060.9	7,043.4	9.8	50.0	5,487	13.9
Colorado	1,281.1	700.5	1.0	54.4	401	1.0
Connecticut	1,992.9	999.8	1.4	50.0	259	0.7
District of Columbia	654.6	327.7	0.5	50.0	130	0.3
Delaware	251.0	126.2	0.2	50.0	73	0.2
Florida	4,861.8	2,680.7	3.7	55.0	2,243	5.7
Georgia	2,766.1	1,723.8	2.4	62.1	1,184	3.0
Hawaii	385.7	193.6	0.3	50.0	141	0.4
Iowa	959.0	603.8	0.8	62.7	322	0.8
Idaho	291.0	207.7	0.3	71.2	158	0.4
Illinois	4,908.1	2,461.9	3.4	50.0	1,948	4.9
Indiana	2,785.7	1,763.4	2.4	63.2	734	1.9
Kansas	1,073.4	624.5	0.9	58.2	302	0.8
Kentucky	1,823.7	1,309.3	1.8	71.7	680	1.7
Louisiana	3,906.3	2,888.3	4.0	73.7	975	2.5
Massachusetts	3,976.1	1,996.8	2.8	50.0	724	1.8
Maryland	1,972.2	989.8	1.4	50.0	621	1.6
Maine	827.9	511.9	0.7	61.8	179	0.5
Michigan	4,403.5	2,465.8	3.4	55.8	1,585	4.0
Minnesota	2,138.8	1,184.5	1.6	54.9	542	1.4
Missouri	2,244.6	1,356.5	1.9	60.6	786	2.0
Mississippi	1,175.2	928.9	1.3	79.0	658	1.7
Montana	328.0	235.6	0.3	70.9	134	0.3
North Carolina	2,839.0	1,875.3	2.6	65.9	1,004	2.5
North Dakota	258.2	188.6	0.3	72.2	82	0.2
Nebraska	560.0	344.2	0.5	61.3	171	0.4
New Hampshire	412.3	207.3	0.3	50.0	108	0.3
New Jersey	4,883.0	2,447.0	3.4	50.0	898	2.3
New Mexico	582.2	434.0	0.6	73.9	334	0.8
Nevada	389.6	205.2	0.3	52.3	175	0.4
New York	18,015.0	9,033.3	12.5	50.0	2,972	7.5
Ohio	5,161.5	3,114.7	4.3	60.3	1,502	3.8
Oklahoma	1,075.8	753.4	1.0	69.7	519	1.3
Oregon	946.8	592.3	0.8	62.4	354	0.9
Pennsylvania	6,468.0	3,599.2	5.0	55.5	1,561	4.0
Rhode Island	820.4	440.7	0.6	53.6	116	0.3
South Carolina	1,639.4	1,170.8	1.6	71.3	671	1.7
South Dakota	264.0	188.0	0.3	70.3	102	0.3
Tennessee	2,645.3	1,787.7	2.5	67.6	921	2.3
Texas	7,030.3	4,544.2	6.3	64.4	3,260	8.3
Utah	475.5	358.2	0.5	75.3	204	0.5
Virginia	1,788.5	898.0	1.2	50.0	841	2.1
Vermont	259.2	155.9	0.2	59.9	63	0.2
Washington	2,263.1	1,249.8	1.7	55.0	578	1.5
Wisconsin	2,094.0	1,269.7	1.8	60.4	543	1.4
West Virginia	1,199.7	915.6	1.3	76.3	366	0.9
Wyoming	133.1	90.0	0.1	67.1	52	0.1

SOURCE: Health Care Financing Administration, HCFA Form-64; and Colin Winterbottom, David W. Liska, and Karen M. Obermaier, *State-Level Databook on Health Care Access and Financing* (Washington, D.C.: Urban Institute, 1995).

NOTE: Expenditures do not include administrative costs. Totals do not include U.S. territories. Expenditure data are for fiscal years. Poverty data are based on calendar years.

TABLE A-2. MEDICAID EXPENDITURES BY STATE, 1988 AND 1993 (By fiscal year)

State	Total Medicaid Expenditures, 1988 (In millions of dollars)	Total Medicaid Expenditures, 1993 (In millions of dollars)	Average Annual Rate of Growth, 1988-1993	Percentage of Total Medicaid Expenditures, 1988	Percentage of Total Medicaid Expenditures, 1993
Alaska	102.8	301.1	24.0	0.2	0.2
Alabama	466.8	1,635.9	28.5	0.9	1.3
Arkansas	428.4	1,017.8	18.9	0.8	0.8
Arizona	183.1	1,375.4	49.7	0.4	1.1
California	5,592.7	14,060.9	20.0	10.9	11.2
Colorado	480.9	1,281.1	26.1	0.9	1.0
Connecticut	834.7	1,992.9	19.0	1.6	1.6
District of Columbia	379.2	654.6	11.5	0.7	0.5
Delaware	100.9	251.0	20.2	0.2	0.2
Florida	1,524.7	4,861.8	26.1	3.0	3.9
Georgia	1,136.0	2,766.1	19.5	2.2	2.2
Hawaii	159.8	385.7	19.3	0.3	0.3
Iowa	477.1	959.0	15.0	0.9	0.8
Idaho	118.5	291.0	19.7	0.2	0.2
Illinois	1,915.0	4,908.1	20.7	3.7	3.9
Indiana	1,024.0	2,785.7	22.2	2.0	2.2
Kansas	328.9	1,073.4	26.7	0.6	0.9
Kentucky	714.2	1,823.7	20.6	1.4	1.5
Louisiana	939.4	3,906.3	33.0	1.8	3.1
Massachusetts	2,078.4	3,976.1	13.9	4.0	3.2
Maryland	931.2	1,972.2	16.2	1.8	1.6
Maine	325.4	827.9	20.5	0.6	0.7
Michigan	2,047.5	4,403.5	16.6	4.0	3.5
Minnesota	1,183.2	2,138.8	12.6	2.3	1.7
Missouri	714.7	2,244.6	25.7	1.4	1.8
Mississippi	443.9	1,175.2	21.5	0.9	0.9
Montana	152.1	328.0	16.6	0.3	0.3
North Carolina	965.7	2,839.0	24.1	1.9	2.3
North Dakota	159.6	258.2	10.1	0.3	0.2
Nebraska	240.8	560.0	18.4	0.5	0.4
New Hampshire	172.0	412.3	19.1	0.3	0.3
New Jersey	1,748.2	4,883.0	22.8	3.4	3.9
New Mexico	229.0	582.2	20.5	0.4	0.5
Nevada	96.5	389.6	32.2	0.2	0.3
New York	9,717.2	18,015.0	13.1	18.9	14.3
Ohio	2,363.5	5,161.5	16.9	4.6	4.1
Oklahoma	593.1	1,075.8	12.6	1.2	0.9
Oregon	364.6	946.8	21.0	0.7	0.8
Pennsylvania	2,544.0	6,468.0	20.5	4.9	5.1
Rhode Island	334.0	820.4	19.7	0.6	0.7
South Carolina	472.3	1,639.4	28.3	0.9	1.3
South Dakota	125.9	264.0	16.0	0.2	0.2
Tennessee	1,009.5	2,645.3	21.2	2.0	2.1
Texas	2,017.2	7,030.3	28.4	3.9	5.6
Utah	196.6	475.5	19.3	0.4	0.4
Virginia	776.3	1,788.5	18.2	1.5	1.4
Vermont	113.4	259.2	18.0	0.2	0.2
Washington	932.1	2,263.1	19.4	1.8	1.8
Wisconsin	1,139.0	2,094.0	13.0	2.2	1.7
West Virginia	315.0	1,199.7	30.7	0.6	1.0
Wyoming	46.7	133.1	23.3	0.1	0.1

SOURCE: Health Care Financing Administration, HCFA Form-64.

NOTE: Expenditures do not include administrative costs. Totals do not include U.S. territories.