

Department of Health & Human Services



2012 ACTUARIAL REPORT
ON THE FINANCIAL OUTLOOK
FOR MEDICAID



Office of the Actuary
Centers for Medicare & Medicaid Services
United States Department of Health & Human Services

Report to Congress

2012 ACTUARIAL REPORT ON THE FINANCIAL OUTLOOK FOR
MEDICAID

Kathleen Sebelius
Secretary of Health and Human Services

2012 ACTUARIAL REPORT ON THE FINANCIAL OUTLOOK FOR MEDICAID

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STATEMENT FROM ACTING CHIEF ACTUARY

From program inception, the cost of Medicaid has generally increased at a significantly faster pace than the U.S. economy. In 1970, combined Federal and State expenditures for Medicaid represented 0.5 percent of gross domestic product (GDP), but this percentage grew to 0.9 percent in 1980, 1.2 percent in 1990, 2.1 percent in 2000, and 2.8 percent in 2011. As illustrated by the actuarial projections in this report, Medicaid costs will almost certainly continue to increase as a share of GDP in the future under current law. Although much of Medicaid's expenditure growth (both past and future) is due to expansions of eligibility criteria, the per enrollee costs for Medicaid have also usually increased significantly faster than per capita GDP.

This growth pattern is not unique to Medicaid. Costs for virtually every form of health insurance, public and private, have increased rapidly, reflecting growth in the number of insured persons, wage increases and price inflation in the medical sector, provision of a greater number of medical services, and the development of new, better, more complex, and generally more expensive services. Together, these cost factors have increased at a faster rate than the number of workers, general inflation, and productivity underlying economic growth. Determining how to optimally balance our collective demand for the best possible health care with our not-unlimited ability to fund such care through private and public efforts represents one of the most challenging policy dilemmas facing the Nation.

The unusually slow rate of growth of Medicaid expenditures in 2012 does not necessarily contradict these trends. Following the expiration of temporary increases in the Federal matching rate, the States' share of Medicaid expenditures have grown rapidly over the last 2 years—nearly 40 percent—and the States have acted to reduce provider payment rates and/or optional benefits. Their actions had a substantial impact in 2012 and emphasize the difficulty in balancing Medicaid against other government programs in the context of States' budgets.

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, will substantially reduce the number of people in the U.S. without health insurance. Much of this reduction will occur as a result of expanded eligibility criteria for Medicaid, which we estimate will increase the number of Medicaid enrollees by about 18 million in 2021. Medicaid provides a relatively low-cost way to increase the number of people with health coverage, since its payment rates for health care services and health plans are low compared to other forms of health insurance. Even so, aggregate Medicaid costs will increase significantly as a result of these changes to eligibility criteria, due to the very large number of additional enrollees starting in 2014.

The Supreme Court decision in *National Federation of Independent Business v. Sebelius* (2012) provided that a state may not lose federal funding for its existing

program when it does not implement the Medicaid eligibility expansion under the Affordable Care Act. Some States may decide not to implement the Medicaid eligibility expansion, and the projections in this report reflect this possibility. This is an issue of particular uncertainty, since a number of States have not stated their intentions at this time. This report also presents projections under scenarios where all States, and, conversely, no States, expand eligibility, in an effort to provide a better understanding of the range of possible outcomes. While estimates of expenditures and enrollment for health insurance exchanges and other private insurance plans, as well as the number of uninsured persons, are beyond the scope of this report, the decisions by States of whether or not to expand eligibility will have ramifications beyond Medicaid. Given the wide-ranging impacts and the substantial uncertainty at this time regarding which States will choose to expand eligibility, this factor should merit close attention leading up to 2014.

The Office of the Actuary in the Centers for Medicare & Medicaid Services has prepared this annual report on the past financial trends and projected outlook for Medicaid in the hope that it will provide insight into the nature of Medicaid cost trends and be a useful source of information for policy makers and budget analysts. The report is somewhat limited in scope, with projections for the next 10 years only, but our intention is to gradually expand on its content in subsequent installments, including longer-range actuarial projections and more extensive analysis, as time and resources permit.

It is my opinion that (i) the techniques and methodology used herein to project the future costs of the Medicaid program are based upon sound principles of actuarial practice and are generally accepted within the actuarial profession, and (ii) the principal assumptions and resulting actuarial estimates are, individually and in the aggregate, reasonable for the purpose of projecting such costs under current law. Considering the substantial uncertainties inherent in projecting future health care costs, readers should be aware that actual future Medicaid costs could differ significantly from these estimates.

I would like to thank team leader Chris Truffer and team members John Klemm, C.J. Wolfe, Kathryn Rennie, and Jessica Shuff for their diligent efforts in preparing this report. In addition, John Shatto was instrumental in developing estimates of the additional Medicaid enrollment and expenditures under the Affordable Care Act, and Catherine A. Curtis provided invaluable editorial assistance. We welcome feedback from readers; comments may be sent to Christopher.Truffer@cms.hhs.gov.

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EXECUTIVE SUMMARY

The joint Federal-State Medicaid program provides health care assistance to certain low-income people and is one of the largest payers for health care in the United States. This report presents an analysis of past Medicaid trends and 10-year projections of expenditures and enrollment, including the impacts of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act).

HIGHLIGHTS AND FINDINGS

2011 Medicaid Information

- Total Medicaid outlays in fiscal year (FY) 2011 were \$432.4 billion; \$275.1 billion or 64 percent represented Federal spending, and \$157.3 billion or 36 percent represented State spending. The Federal government's share of Medicaid outlays decreased to 64 percent in 2011 (from 68 percent in 2010) as the temporary increases in the Federal matching rate expired in June 2011 (as prescribed by the American Recovery and Reinvestment Act of 2009 and Public Law 111-226). Total Medicaid expenditures increased by 6.4 percent between 2010 and 2011.
- Medicaid provided health care assistance for an estimated 55.7 million people on average in 2011. An estimated total of 70.4 million people, or about one of every five persons in the U.S., were enrolled in Medicaid for at least one month in 2011. Enrollment is estimated to have grown by 3.8 percent between 2010 and 2011.
- Per enrollee spending for health services was estimated to be \$6,982 in 2011. Estimated per capita spending for children (\$2,851) and adults (\$4,362) was much lower than that for aged (\$15,931) and disabled (\$17,958) beneficiaries, reflecting the differing health status of, and use of services by, the members of these groups. Per enrollee spending was estimated to have increased by 2.6 percent between 2010 and 2011.

2012 Medicaid Estimates

- Medicaid expenditures are projected to increase 1.1 percent to \$432.0 billion in 2012. The Federal government is projected to pay \$248.3 billion, or about 57 percent. Relatively slower projected growth in Medicaid expenditures is in part the result of the States' efforts to limit growth in light of their budget constraints and faster State expenditure growth after the expiration of the temporary Federal matching rate increases.

- Average Medicaid enrollment is projected to increase 1.9 percent to 56.7 million people in 2012.

10-Year Medicaid Projections

- Over the next 10 years, expenditures are projected to increase at an average annual rate of 6.4 percent and to reach \$795.0 billion by 2021.
- Average enrollment is projected to increase at an average annual rate of 3.4 percent over the next 10 years and to reach 77.9 million in 2021.
- Both averages reflect the anticipated significant increase in Medicaid enrollment that will begin in 2014 as a result of the expansion of Medicaid eligibility under the Affordable Care Act. The estimates of the eligibility expansion in this report are lower than those in prior reports due to the Supreme Court ruling that provided a state may not lose Federal funding for its existing program when it does not implement the Medicaid eligibility expansion under the Affordable Care Act.
- Projected Medicaid expenditures in 2020 (\$746.2 billion) in this report are 14 percent lower than in the 2011 report (\$871.0 billion). This difference reflects slower growth in 2012 than previously projected, the Supreme Court decision on the Medicaid eligibility expansion, and slower projected per enrollee cost growth.

Affordable Care Act Impacts

- The Affordable Care Act is projected to increase Medicaid expenditures by a total of \$514 billion for 2012 through 2021, an increase of about 9 percent over projections of Medicaid spending without the impact of the legislation. Most of this increase is projected to be paid by the Federal government (\$468 billion, or about 91 percent), which would be about 15 percent greater than projected Federal expenditures excluding the impact of the Act.
- The most significant change to Medicaid is the expansion of Medicaid eligibility beginning in January 2014. This expansion is projected to add 8.7 million people to enrollment in FY 2014 and 18.3 million people by FY 2021—15 percent and 31 percent, respectively, compared to pre-Affordable Care Act estimates. These estimates are based on the assumption that 55 percent of potentially newly eligible enrollees reside in States that would expand Medicaid eligibility in 2014 and that 65 percent reside in States that would expand eligibility in 2015 and later years.
- The expansion and the increase in enrollment of people eligible for Medicaid under current criteria are projected to increase Medicaid expenditures by a total of \$448 billion during 2014 through 2021, with the majority to be paid

by the Federal government (\$388 billion, or 87 percent) due to the higher Federal matching rate provided for expenditures on behalf of newly eligible enrollees.

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I. INTRODUCTION

Medicaid is a cooperative program between the Federal and State governments to pay for health care and medical services for certain low-income persons in the United States and its Territories. The Federal and the State governments share responsibilities in designing, administering, and funding the program. For the Federal government, the Centers for Medicare & Medicaid Services (CMS) is the agency charged with administering Medicaid.

This is the fourth annual Medicaid report from the Office of the Actuary (OACT) at CMS. The purpose of this report is to describe the past and projected trends for Medicaid expenditures and enrollment including estimates for fiscal years (FYs) 2011 and 2012 and projections over the next 10 years. In addition, this report provides a brief description of the estimated impacts on Medicaid of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (referred to collectively as the “Affordable Care Act”). It also describes the data available on Medicaid spending and enrollment, as well as the methodology and assumptions used in the projections. Finally, this report places the Medicaid program within the context of Federal and State government spending and the U.S. health care system.

II. OVERVIEW OF MEDICAID

Authorized by Title XIX of the Social Security Act, Medicaid was signed into law in 1965 and is an optional program for the States. Currently all States, the District of Columbia, and all of the Territories have Medicaid programs.¹

The Federal government establishes certain requirements for the States' Medicaid programs. The States then administer their own programs, determining the eligibility of applicants, deciding which health services to cover, setting provider reimbursement rates, paying for a portion of the total program, and processing claims.

Eligibility for enrollment in Medicaid is determined by both Federal and State law. Title XIX of the Social Security Act specifies which groups of people must be eligible, and States have the flexibility to extend coverage to additional groups. In addition to income, eligibility is typically based on several other factors, including financial resources (or assets), age, disability status, other government assistance, and other health or medical conditions such as pregnancy. Beginning in 2014, the Affordable Care Act provides the States the authority under their state plan to expand Medicaid eligibility to almost all individuals under age 65 in families with income below 138 percent of the Federal Poverty Level (FPL).²

Title XIX specifies that certain medical services must be covered under Medicaid, while also granting the States flexibility to cover many other benefits. Services usually covered include hospital care, physician services, laboratory and other diagnostic tests, prescription drugs, dental care, and many long-term care services. The States also have the options to use managed care plans to provide and coordinate benefits and to apply for waivers that allow the States more flexibility in developing specialized benefit packages for specific populations. With limited exceptions—such as the use of waivers, demonstration projects, and benchmark benefit plans, or those eligible only based on medical need, through Medicare savings plans, or special family planning or pregnant women eligibility groups—States must provide the same benefit package to all core Medicaid enrollees. Additionally, States must extend eligibility to all mandatory populations and cover

¹ For more information on Medicaid, including information on eligibility and covered services, see Klees, Wolfe, and Curtis, “Brief Summaries of Medicare & Medicaid,” December 2012: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/MedicareMedicaidSummaries2012.pdf>.

² The estimated impacts of the expansion of Medicaid eligibility on enrollment and expenditures are presented in the Actuarial Analysis section of this report. The Affordable Care Act technically specifies an upper income threshold of 133 percent of the FPL but also allows a 5-percent income disregard, making the effective threshold 138 percent. The Supreme Court ruling in *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012), provided that a state may not lose Federal funding for its existing program when it does not implement the Medicaid eligibility expansion under the Affordable Care Act.

all mandatory services defined by Title XIX in order to receive Federal matching funds for their Medicaid programs.³

The Federal government and the States share the responsibility for funding Medicaid. States pay providers or managed care organizations for Medicaid costs and then report these payments to CMS. The Federal government pays for a percentage of the costs of medical services by reimbursing each State; this percentage, known as the Federal Medical Assistance Percentage (FMAP), is calculated annually for each State based on a statutory formula that takes into account State per capita income with some adjustments prescribed by legislation.⁴ Notably, the Affordable Care Act specifies FMAPs for adult beneficiaries who are newly eligible as a result of the Medicaid expansion beginning in 2014 (in States that implement the expansion). Additionally, the Federal government pays for a portion of each State's administration costs. Beneficiary cost sharing, such as deductibles or co-payments, and beneficiary premiums are very limited in Medicaid and do not represent a significant share of the total cost of health care services for Medicaid enrollees.

In contrast to the Federal Medicare program, Medicaid's financial operations are not financed through trust funds. Other than a very small amount of premium revenue from enrollees, as noted above, and some other sources of State revenue (such as provider taxes), there are no dedicated revenue sources comparable to the Medicare Hospital Insurance payroll tax. Medicaid costs are met primarily by Federal and State general revenues, on an as-needed basis; the States may also rely on local government revenues to finance a portion of their share of Medicaid costs. The Federal financing is authorized through an annual appropriation by Congress. These funds are then spent through daily draws from the general fund of the Treasury in the amounts required to pay that day's Federal matching amounts on the State program expenditures. As a result, Medicaid outlays and revenues are

³ One notable exception to this requirement is for newly eligible adults added by the Affordable Care Act. While the new adult eligibility category is technically a mandatory population, the Supreme Court ruled that the Federal government cannot withhold Federal funding for the rest of the Medicaid program for States that do not expand eligibility to this group. See *National Federation of Independent Business v. Sebelius* (2012).

⁴ In general, Title XIX specifies that the FMAP for each State cannot be lower than 50 percent and cannot be higher than 83 percent; in FY 2011, FMAP ranged from 50 percent to 74 percent, prior to the impact of temporary increases in FMAP prescribed by legislation, as described below. Also, Title XIX provides for specific FMAP levels for certain States. The American Recovery and Reinvestment Act of 2009 (ARRA) and Public Law 111-226 (sometimes called the Education, Jobs, and Medicaid Assistance Act of 2010) provided temporary increases to the FMAP for 2009, 2010, and part of 2011. Additionally, the Affordable Care Act specifies different FMAP for certain sections of the Act. Most significantly, expenditures for newly eligible beneficiaries are covered at a greater FMAP than are those for currently eligible beneficiaries starting in 2014; States that already covered adults up to 100 percent of the FPL are eligible for some FMAP increases; and the temporary increase in primary care physician payments in calendar years 2013 and 2014 is paid for entirely by the Federal government.

automatically in financial balance, there is no need to maintain a contingency reserve, and, unlike Medicare, the “financial status” of the program is not in question from an actuarial perspective.

Medicaid coverage is extremely valuable to the low-income individuals and families who qualify for the health care services provided by the program. By extension, the program is also valuable to society at large, as it enables the least-fortunate members to obtain the health care they need in an orderly way. It is also important, of course, to consider the cost to society of providing this coverage and to anticipate likely future trends in such costs. The balance of this report is intended to help illuminate these trends.

III. DATA AND ASSUMPTIONS

Projections of Medicaid expenditures and enrollment are highly dependent on both demographic and economic assumptions. The most important such assumptions are those regarding the growth of health care prices, growth in the use of health care services, overall economic growth, individual wage growth, and population growth. In addition, there are various “programmatic” factors that have historically influenced Medicaid expenditure and enrollment trends, including decisions by the States regarding eligibility and payment rules for their Medicaid plans, the coverage of and enrollment in other health insurance programs, including Medicare and private health insurance, and changes in the participation rates of eligible persons in Medicaid. The projections also depend importantly on the nature and quality of the available data on Medicaid operations. This section describes the sources of data and assumptions that are used to generate the Medicaid projections shown in this report.

The data and assumptions on which these Medicaid projections are based are derived from four major sources. The first source is CMS data, which are submitted by the States to CMS on a regular basis.⁵ The States provide a quarterly report of spending by type of service; this report, known as the CMS-64, comprises expenditures for all Medicaid fee-for-service programs and capitation arrangements. The Medicaid Statistical Information System (MSIS) contains both service and demographic data supplied by the States, including provider payments and enrollment counts. The States also submit to CMS 2-year forecasts of spending by service, in a quarterly report known as the CMS-37. Spending data are reported at both the Federal and State levels in the CMS-64 and CMS-37; MSIS expenditure data are reported as total Medicaid (Federal and State spending combined). OACT makes several adjustments to these data to merge them together for use in preparing projections.⁶

The Boards of Trustees for Old-Age, Survivors, and Disability Insurance (OASDI, or Social Security) and Medicare constitute the second source for the data and assumptions.⁷ The projections in this Medicaid report are based on the same economic and demographic assumptions that were developed by the Trustees and used to determine the intermediate estimates presented in their statutory

⁵ More information on these sources is available on the CMS website at <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/MBES/medicaid-budget-and-expenditure-system-MBES.html>. Additional detail is provided in the Appendix.

⁶ The MSIS data used for the analysis presented in this report are derived from the Annual Person Summary (APS) files.

⁷ *The 2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* and *The 2012 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds*.

2012 annual reports to Congress on the financial status of the OASDI and Medicare programs. The Trustees' intermediate economic assumptions are also used to develop the health care service price forecasts underlying the projections in this report.⁸

The third source from which data and assumptions are derived is the Office of the Actuary Health Reform Model (OHRM), which is primarily based on the Medical Expenditure Panel Survey (MEPS) Household Component. The OHRM was developed and used by OACT to estimate the impact of proposed health care reform legislation, including the Affordable Care Act as enacted. The projections presented in this report for the increases in Medicaid expenditures and enrollment due to the expansion of Medicaid eligibility under the Affordable Care Act are derived from the OHRM estimates. As a result, this report also relies on the data and assumptions used by the OHRM.⁹

In addition, OACT developed assumptions regarding the eligibility expansion under the Affordable Care Act. In *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012) (*NFIB v. Sebelius*), the Supreme Court ruled that a State may not lose Federal funding for its existing program when it does not implement the Medicaid eligibility expansion under the Affordable Care Act. To develop an assumption about the effective national participation rate of the States for the eligibility expansion, OACT reviewed public information and statements for each State regarding its intent to implement the eligibility expansion in 2014. Based on this information, OACT assumed that 55 percent of all people who are potentially newly eligible Medicaid enrollees in 2014 would reside in States that elected to expand Medicaid eligibility. For 2015 and thereafter, OACT assumed that 65 percent of such individuals would reside in expansion States. In addition, OACT

⁸ These assumptions are different from those used for projections in the President's FY 2013 Budget. Consequently, the projections presented in this report usually differ somewhat from the President's Budget projections. In addition, due to differences in the timing of this report and the Budget, later data are generally available for use in this report. Finally, while the Trustees' economic assumptions underlie the health care service price forecasts for both the Medicare Trustees Report and the Medicaid actuarial report, the two sets of price growth forecasts are not the same. The two programs have significantly different statutory mechanisms for setting provider price updates, and these differences are reflected in the update assumptions for each program.

⁹ More information is available in the memorandum titled "Estimated Financial Effects of the Patient Protection and Affordable Care Act, as Amended" on the CMS website at http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf; however, the estimates of the Affordable Care Act's impacts on Medicaid have since been updated and are presented later in the report. A key assumption made in those estimates and relied upon in these projections is that there would be a sufficient supply of health care providers to meet the expected increases in demand for health care services, without considering any market disruptions or price increases. Given that Medicaid generally pays the lowest prices for health care services and that Medicaid enrollment is expected to increase, it is possible that meeting all additional demand would be difficult, especially in the early years of the coverage expansion.

previously assumed that the participation rate of persons eligible under current criteria would also increase starting in 2014. In States that do not expand eligibility, OACT assumed that increases in the participation rate among currently eligible persons would be equal to 80 percent of the increase in the participation rate among currently eligible persons in States that do expand.¹⁰

The actual participation by States could differ significantly from these assumptions. A greater or lesser number of States could elect to expand eligibility than has been assumed, and States' decisions may change over time (either to expand after 2014 or to end the expansion some time in the future). Recent CMS policy guidance clarified that States would be required to expand eligibility completely as prescribed by the Affordable Care Act to receive the increased Federal matching rate; the assumptions used in this report are consistent with this policy.¹¹

Given this specific source of uncertainty, the report also shows the range of projected future expenditures and enrollment based on different scenarios of States' decisions to expand eligibility. Projections for two alternative scenarios are presented in the Actuarial Analysis section of this report: (i) if all States expand Medicaid eligibility in 2014 ("full expansion") and (ii) if no States expand eligibility, and there is no increase in the participation rate of currently eligible individuals ("no expansion").

The fourth source of underlying data and assumptions—National Health Expenditure (NHE) historical data and projections—is used for comparing Medicaid expenditures and enrollment with Medicare, private health insurance, and total health care spending in the United States. The NHE data and projections are developed by OACT.¹²

It is important to note the limitations that are associated with the data described in this section. First, the most recent complete MSIS data available are from 2009, and the MSIS is the only available source of complete enrollment data. Consequently, to relate 2010 and 2011 actual expenditures to the number of enrollees, estimates of

¹⁰ More information on the assumed participation rates among currently eligible and newly eligible persons in Medicaid after the eligibility expansion in the Affordable Care Act is presented in the Actuarial Analysis section of this report.

¹¹ See "Frequently Asked Questions on Exchanges, Market Reforms and Medicaid," December 10, 2012: <http://medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/Downloads/Governor-FAQs-12-10-12.pdf>.

¹² More information on the NHE historical accounts and projections is available on the CMS website at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html>. Also, see A. Martin, *et al.*, "Growth in U.S. Health Spending Remained Slow in 2010; Health Share of Gross Domestic Product Was Unchanged from 2009," *Health Affairs*, January 2012; 31:208-219; and S. Keehan, *et al.*, "National Health Expenditure Projections: Modest Annual Growth until Coverage Expands and Economic Growth Accelerates," *Health Affairs*, July 2012; 31:1600-1612.

Medicaid enrollment must be made for both years. Another qualification is that the CMS-64 does not provide data on enrollment or spending by enrollment category, and the definitions of medical service categories are not consistent between the MSIS and the other CMS data sources. Adjustments need to be made to develop a data set that contains not only service-level expenditures that match the CMS-64 data but also expenditures by enrollment group; accordingly, the MSIS and the CMS-64 are merged together to provide a more complete understanding of Medicaid spending. Since the service definitions are different between these two sources, MSIS data are used to estimate spending by enrollment group for each Medicaid service.

Yet another limitation is the unavailability of demographic, macroeconomic, health care, and program assumptions specific to each State. Because these State-specific assumptions are not available, it is not possible to credibly project Medicaid spending or enrollment separately by State. In addition, since the NHE data and projections use somewhat different definitions of Medicaid spending and services than do the other Medicaid data sources, historical Medicaid data and projections from the NHE accounts may not match the historical data and projections presented here. A final caveat is that OACT reviewed the data sources used in these projections but relied on CMS program components and the States to ensure the quality of the data.

The Medicaid expenditure and enrollment projections shown in this report are based on current law; that is, they are consistent with current legislation and administrative policy regarding Medicaid as of December 31, 2012. This analysis does not attempt to forecast any future changes in policy or legislation that, if realized, would affect the Medicaid program—including Federal Medicaid, State Medicaid, or Medicare policy and legislation or other legislation that could affect private health insurance plans. Thus, while changes in Federal or State Medicaid policy have been a significant factor affecting the patterns of growth in expenditures and enrollment over history, no future changes in policy are assumed (beyond those already scheduled under current law).

Like any projection of future health care costs, the Medicaid projections presented here are necessarily uncertain. Actual numbers of enrollees, the number of services used, and the reimbursement levels per service will depend on all of the factors described previously—none of which can be predicted with certainty. Past increases in Medicaid and other health care costs have often been relatively volatile, adding to the difficulty of correctly anticipating future trends. Moreover, the impacts of the numerous sections of the Affordable Care Act that affect Medicaid, especially the broadening of Medicaid eligibility in 2014, introduce additional uncertainty into these projections. The States' decisions whether to implement the eligibility expansion also contribute to a wider range of potential Medicaid costs in the future. Finally, the actual number of people who will become eligible for and enroll in Medicaid in 2014 is unknown, as are their health care costs; accordingly, these

estimates should be considered more uncertain than other projections of Medicaid enrollment and expenditures under current eligibility criteria due to the lack of experience and program data to inform them and the uncertainty about which States will expand their eligibility standards in the future.

For these reasons, the projections shown in this report should be regarded only as a reasonable indication of future Medicaid costs under current law and from today's perspective. It is important to recognize that actual costs in the future could differ significantly from these projections, as a result of (i) unanticipated developments in demographic, economic, or health cost growth trends, (ii) effects of the Affordable Care Act (such as the proportion of newly eligible individuals and families who become enrolled) that differ from current estimates, (iii) regulatory and judicial interpretations of the Affordable Care Act that differ from our expectations, or (iv) any further changes in the legislation governing Medicaid.

IV. METHODOLOGY

This section briefly describes the methodology behind the projections of Medicaid spending presented in this report.

Health actuaries typically base estimates of medical expenditures on three major factors:

- C – the number of people enrolled in the program (“caseload”),
- U – the quantity of services each person uses (“utilization”), and
- P – the reimbursement (“price”) for each unit of service.

The product of these three factors yields an estimate of total expenditures for medical services:

$$E = C \times U \times P \tag{1}$$

Direct application of equation (1) requires data on utilization and reimbursement rates for Medicaid that are not currently available or practical to maintain.¹³ An alternative recursive approach is therefore used for the projections, as described below.

Instead of using equation (1), the projection algorithm begins with development of data on the current level of Medicaid expenditures, by eligibility category and by type of medical service, to serve as a projection base. *Changes* in the three determinants of expenditures in equation (1) are then projected for future years and applied sequentially to the base year expenditures. Thus, if E_y represents expenditures in year y , then

$$E_{y+1} = E_y \times (1 + c_{y+1}) \times (1 + u_{y+1}) \times (1 + p_{y+1}), \tag{2}$$

where c_{y+1} , u_{y+1} , and p_{y+1} are the assumed or projected rates of change in caseload, utilization, and prices, respectively, between years y and $y+1$. Equation (2) is applied separately to expenditures for each combination of the Medicaid eligibility categories and categories for type of service.

With a few exceptions, caseload change factors vary by eligibility category, and utilization and price factors vary by type of service. The projected caseload factors are determined by trend and regression analysis of Medicaid enrollment data.

¹³ No comprehensive sources are available that track reimbursement rates and use by service for all Medicaid programs. Because the expenditure data reported by the States in the CMS-64 are at an aggregate service level, each category likely includes various services with different numbers of claims and distinct reimbursement rates. Additionally, reimbursement rates and service use are different for each State.

Projections of future enrollment by eligibility category are based on estimates of the change in the share of the U.S. population enrolled in Medicaid. The most important factors are the unemployment rate and percentage of the U.S. population with private health insurance; these factors (while exhibiting some correlation between themselves) correlate strongly with the percentage of the U.S. population enrolled in Medicaid, as they reflect (i) how many people are without private health insurance and (ii) how many people might qualify for Medicaid based on its income requirements. Price changes are derived from economic forecasts produced for the 2012 Medicare Trustees Report, including forecasts for economy-wide inflation, inflation for prices of medical services, and wage growth. Utilization is treated as the residual between total growth and the growth due to enrollment and price changes. The estimate of utilization is determined by an analysis of the historical interrelationship of expenditure, caseload, and price factor growth.¹⁴ The residual factor, while termed “utilization,” reflects not only the change in the average number of services per enrollee but also changes in the “intensity” or average complexity of the services. In addition, any errors in the measurement of the number of enrollees and price per service are implicitly included in the residual.

The results obtained from the “Caseload, Utilization, Price” (“CUP”) recursive forecast, using equation (2), are frequently adjusted to be consistent with recent expenditure data and outlay trends.

As noted previously, estimates of the impact of the Medicaid eligibility expansion under the Affordable Care Act are derived from the results of the OHRM.¹⁵ This model is based on the MEPS, reweighted to match the spending and insurance coverage estimates of the NHE projections in 2012.¹⁶ The OHRM specifically estimates (i) the number of people who would become newly eligible for Medicaid and would enroll as a result of the eligibility expansion; (ii) the number of people who are already eligible for Medicaid, but are not enrolled, and who would now enroll in the program as a result of the publicity and new assistance with application that will result from the Affordable Care Act; and (iii) the amount of the new enrollees’ per capita Medicaid expenditures once they enroll. To estimate expenditures by service category for new Medicaid enrollees, it was assumed that such expenditures would be in the same proportion as that for current Medicaid enrollees by eligibility category. (For example, if 50 percent of Medicaid spending for currently enrolled children is attributable to acute care fee-for-service, then an

¹⁴ More details on the trend residual methodology are included in the Appendix.

¹⁵ More information is available in the memorandum titled “Estimated Financial Effects of the Patient Protection and Affordable Care Act, as Amended” on the CMS website at http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf. These estimates have been updated to reflect more recent data and more recent information on the implementation of the many sections of the Affordable Care Act.

¹⁶ Keehan, *et al.*, “National Health Expenditure Projections: Modest Annual Growth until Coverage Expands and Economic Growth Accelerates.”

equal share would be expected to be spent on acute care fee-for-service for newly eligible children.) Estimates of the other sections of the Affordable Care Act that affect Medicaid were developed separately by OACT and have been added to the Medicaid expenditure and enrollment projections. More details on the estimates of Medicaid impacts of the Affordable Care Act are available in the Actuarial Analysis section of this report.

V. ACTUARIAL ANALYSIS

A. FY 2011 MEDICAID OUTLAYS AND ENROLLMENT

The Federal government and the States collectively spent \$432.4 billion for Medicaid in 2011. Of this amount, the Federal government paid \$275.1 billion, representing about 64 percent of net program outlays, and the States paid \$157.3 billion, or about 36 percent of net outlays. Table 1 summarizes total Medicaid outlays for 2011.

Table 1—Medicaid Outlays for Fiscal Year 2011 by Type of Payment
(In billions)

Title XIX Outlays ¹	Federal Share	State Share	Total
Medical Assistance Payments:			
Acute Care Benefits ²	\$98.7	\$54.2	\$152.9
Long-Term Care Benefits ²	72.2	42.2	114.3
Capitation Payments and Premiums ²	74.7	41.2	115.9
Disproportionate Share Hospital (DSH) Payments ²	8.2	6.1	14.3
Adjustments ³	6.9	4.8	11.7
Subtotal, Medical Assistance Payments	260.7	148.5	409.2
Administration Payments	11.4	8.9	20.2
Vaccines for Children Program	4.0	—	4.0
Gross Outlays	276.0	157.4	433.3
Collections ⁴	-0.8	-0.1	-0.9
Net Outlays	275.1	157.3	432.4

¹ Federal outlays are the funds drawn from the U.S. Treasury by the States. The State and total outlays reflect spending as reported by the States for the purposes of drawing Federal funding from the U.S. Treasury. Expenditures represent the spending as it was paid by the State to health care plans or providers. While expenditures and outlays are generally similar, they are not equal mainly due to the timing differences between the States paying for services and the States receiving Federal funds. Neither outlays nor expenditures include Title XIX costs in support of the Children's Health Insurance Program.

² Benefit expenditures as reported on the CMS-64 (base expenditures).

³ Adjustments include net adjustments of benefits from prior periods and the difference between expenditures and outlays.

⁴ Collections from Medicare Part B for the Qualifying Individuals (QI) program and from other miscellaneous sources.

The great majority of Medicaid spending—95 percent of total outlays in 2011—was for medical assistance payments. In table 1, these payments are divided into four major categories: acute care, long-term care, capitation payments, and disproportionate share hospital (DSH) payments.

Acute care includes fee-for-service (FFS) spending for inpatient and outpatient hospital care, physician and other medical professional services, prescription drugs, dental care, laboratory and imaging tests, mental hospital services, and case management costs, as well as coinsurance payments for beneficiaries in managed care plans. Long-term care includes spending on nursing home services, home health care, intermediate care facility services, and home and community-based services. Capitation payments and premiums include premiums paid to Medicaid managed care plans, pre-paid health plans, other health plan premiums, and

premiums for Medicare Part A and Part B. (Most services provided by capitated plans under Medicaid are for acute care.) DSH payments are provided to certain hospitals that have furnished care for a significant number of uninsured persons and Medicaid beneficiaries and that have acquired, as a result, a substantial amount of uncompensated care costs.

Of these four categories, acute care represented the largest portion of Medicaid spending in 2011, accounting for \$152.9 billion or 37 percent of Medicaid expenditures on benefits. Medicaid spending amounted to \$114.3 billion for long-term care and \$115.9 billion for managed care and other premiums in 2011, each representing 28 percent of expenditures on benefits. DSH accounted for \$14.3 billion, or 4 percent, of Medicaid benefits in 2011.

Medicaid spending on program administration totaled \$20.2 billion in 2011—\$11.4 billion in Federal expenditures and \$8.9 billion in State expenditures—and represented 5 percent of Medicaid outlays. Included in administration outlays was \$0.5 billion in health information technology incentive payments to providers.¹⁷ Medicaid also provided \$4.0 billion of funding in 2011 for the Vaccines for Children program (all Federal funding).¹⁸

At the time this report was prepared, the latest Medicaid enrollment data available were from 2009. Accordingly, enrollment by eligibility group (children, adults, aged, and disabled) has been estimated for 2010 and 2011.¹⁹

Enrollment is measured in two ways: (i) “person-year equivalents” (PYE), or the average enrollment over the course of a year, and (ii) “ever-enrolled” persons, or the number of people covered by Medicaid for any period of time during the year. In 2011, Medicaid enrollment was estimated to be 55.7 million PYE (including enrollment in the U.S. territories). An estimated 70.4 million people, or slightly more than one person in five in the U.S., were ever-enrolled.

Table 2 shows estimated enrollment by eligibility group for 2011. Historically, children have been the largest group of Medicaid enrollees. In 2011, this group is estimated to have represented 27.2 million PYE, or about 50 percent of overall Medicaid enrollment (excluding Territory programs). Adults made up an estimated 13.2 million PYE (24 percent), while disabled enrollees and aged enrollees are

¹⁷ Health information technology incentive payments were provided for by the American Recovery and Reinvestment Act of 2009.

¹⁸ The Vaccines for Children program is administered by the Centers for Disease Control and Prevention and provides vaccines for children enrolled in Medicaid, as well as for other children who might otherwise not be able to afford vaccines.

¹⁹ In this report, child Medicaid enrollees include non-disabled children, children of unemployed parents, and foster care children; adult Medicaid enrollees include non-disabled non-aged adults, unemployed adults, and women covered under the Breast and Cervical Cancer Act expansion; and disabled Medicaid enrollees include blind or disabled persons.

estimated to have accounted for 9.4 million and 4.8 million PYE (17 percent and 9 percent, respectively). Another 1 million enrollees were estimated for the five U.S. territories (Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands).

Table 2—2011 Estimated Enrollment, Expenditures, and Estimated Per Enrollee Expenditures, by Enrollment Group¹

Eligibility Group	Enrollment ² (in millions)	Expenditures (in billions)	Per Enrollee Spending
Children	27.2	\$77.4	\$2,851
Adults	13.2	57.8	4,362
Disabled	9.4	169.3	17,958
Aged	4.8	77.2	15,931
Total	54.7	381.8	6,982

¹ Does not include DSH expenditures, territorial enrollees or payments, or adjustments.

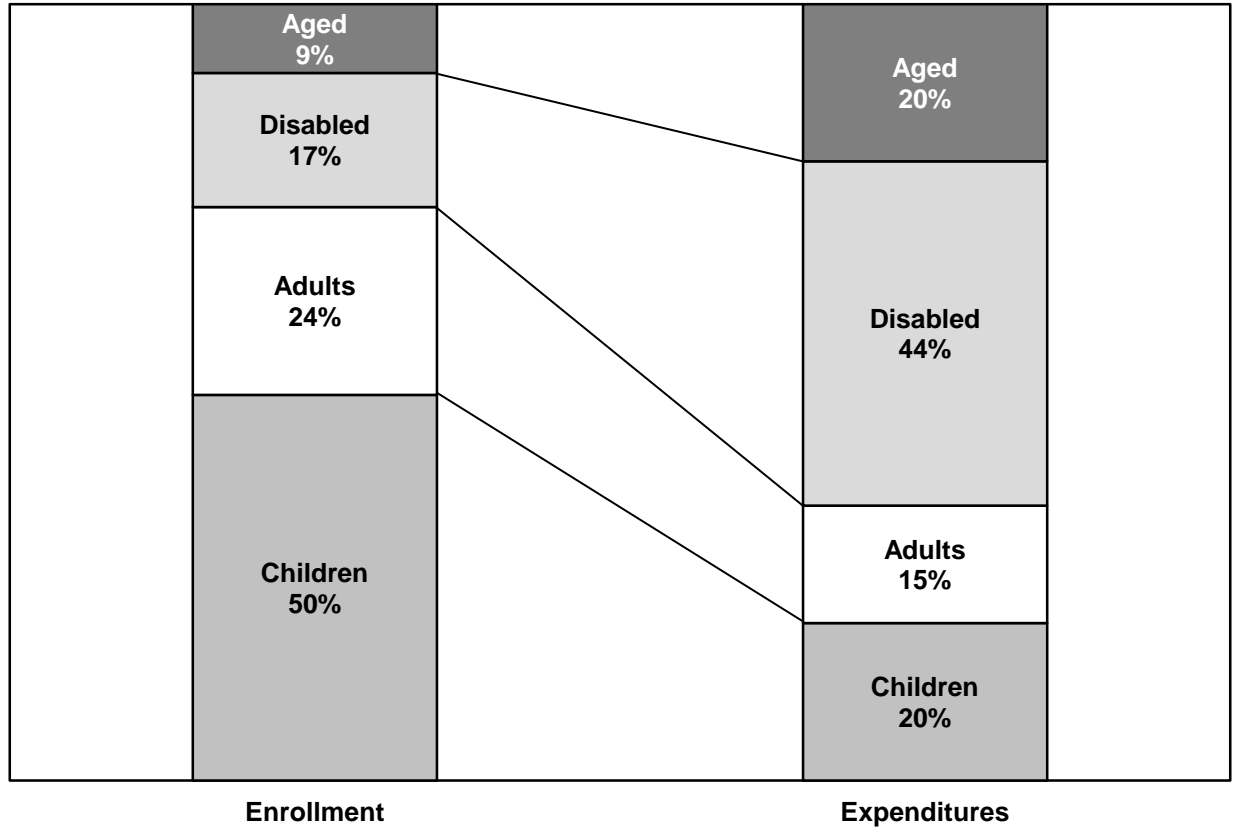
² Measured in person-year equivalents.

The average per enrollee cost for 2011 was estimated to be \$6,982 (excluding DSH outlays, territorial enrollees and costs, adjustments, and administration costs). Children in Medicaid received an estimated \$2,851 in benefits on average in 2011, and adults received an estimated average of \$4,362 in benefits (based on PYE enrollment). In both instances, these average costs reflect the relatively favorable health status of the enrollment groups, although a large portion of the adults are pregnant women. As would be expected, expenditures are substantially greater for the aged and the disabled; aged beneficiaries received an estimated \$15,931 in benefits on average, and disabled beneficiaries are estimated to have received an average of \$17,958 in benefits.

Figure 1 shows each enrollment group's relative share of enrollment and expenditures in Medicaid in 2011.²⁰ While disabled enrollees and aged enrollees are the smallest enrollment groups in Medicaid, they account for the majority of spending. Conversely, children and adults are the largest enrollment groups in Medicaid, but they receive a relatively smaller share of expenditures.

²⁰ The data points for all figures in the report can be found at <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Actuarial-Report-on-Financial-Outlook-for-Medicaid.html>.

Figure 1—Estimated Medicaid Enrollment and Expenditures by Enrollment Group, as Share of Total, Fiscal Year 2011¹



¹ Totals and components exclude DSH expenditures, territorial enrollees and expenditures, and adjustments.

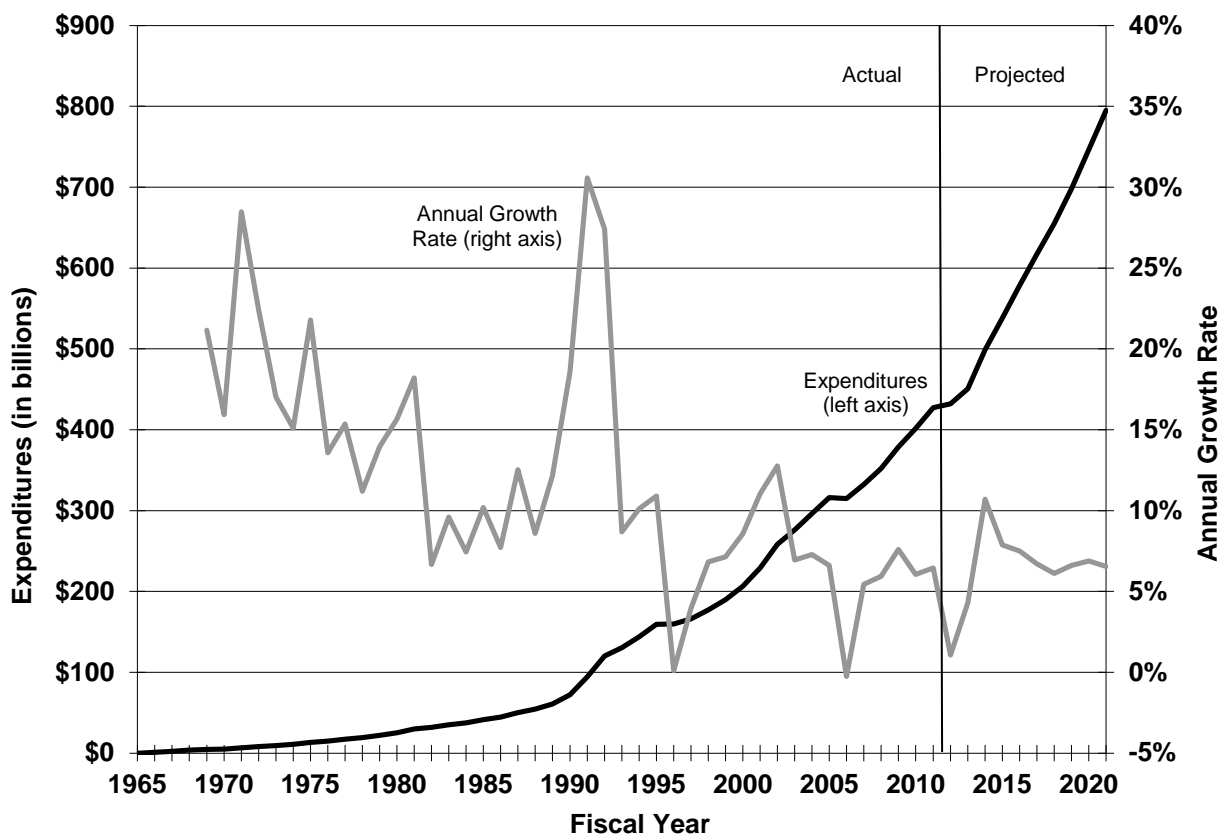
Combined, spending on aged and disabled beneficiaries constituted 65 percent of Medicaid benefit expenditures in 2011 but these groups accounted for only 26 percent of all enrollees. Children and adults represented 74 percent of all enrollees in 2011, while only 35 percent of benefit expenditures were for enrollees in these two groups.

These differences between the relative shares of enrollment and expenditures result from per enrollee costs that vary dramatically among the enrollment groups. The differences in average costs, while substantial, actually understate the impact of differences in health status for these groups. In particular, Medicaid pays almost all health care costs for enrolled children and adults. However, many aged or disabled beneficiaries are also enrolled in Medicare, which is the primary payer of benefits before Medicaid; thus, these per enrollee Medicaid estimates are less than the total cost of such beneficiaries' annual health care across all payers.

B. HISTORICAL MEDICAID TRENDS

Since the start of the program, the year-to-year growth of total Medicaid expenditures (Federal and State expenditures combined) has varied substantially, as can be seen in figure 2. The growth in expenditures over time reflects growth in the number of enrollees in the program and growth in the cost per enrollee. Enrollment growth is a result of a change in the number of people eligible and electing to participate in the program, but it is also strongly influenced by legislative changes to the eligibility criteria. Similarly, per enrollee costs vary over time due to changes in the use of medical services and the prices paid to providers of health care services and supplies, as well as legislative and other policy changes to the benefits offered by State Medicaid programs.

Figure 2—Historical and Projected Medicaid Expenditures and Annual Growth Rates, FY 1966–FY 2021



Expenditures and enrollment grew rapidly from 1966 through 1970 as the program was started and expanded significantly; expenditures were \$0.9 billion in 1966, the first year of the program, and increased to \$5.1 billion by 1970 (54.4 percent average annual growth), and enrollment increased from 4.0 million PYE to 14.0 million PYE between 1966 and 1970 (36.4 percent average annual growth). From 1971 to 2011, growth in Medicaid expenditures averaged 11.4 percent per year, and enrollment growth averaged 3.4 percent per year; the average expenditures per enrollee grew at an average annual rate of 7.7 percent. The

remainder of this section describes in more detail the trends in Medicaid expenditure, enrollment, and per enrollee cost growth from 1994 through 2011.²¹

During 1994 through 1999, Medicaid experienced a period of relatively slow expenditure growth—an average rate of 6.4 percent per year. The key driver of this slower trend was enrollment; Medicaid enrollment growth decelerated dramatically due to the combination of strong economic growth and welfare reform. Enrollment grew just 0.4 percent per year on average over the 6-year period, a rate that was lower than overall U.S. population growth. Enrollment for children and adults was actually lower in 1999 than it was in 1994. The growth in Medicaid per enrollee costs averaged 6.0 percent per year, relatively slower than in prior periods (from 1987 through 1993, per enrollee costs grew 9.8 percent per year on average). This slower growth reflected several important trends, including a deceleration in the growth of DSH expenditures and increased use of managed care plans. During this period, States expanded eligibility and benefits as strong economic growth, combined with stable enrollment, gave the States the ability to fund more generous Medicaid programs. In the absence of these expansions, the annual growth rates in expenditures and enrollment would likely have been even slower.²²

During 2000 through 2005, Medicaid growth was faster than in the previous 6 years, with spending increasing an average of 8.8 percent per year. Medicaid enrollment increased at an average rate of 6.3 percent per year during this period, in significant part due to the 2001 economic recession. Over the same time period, Medicaid per enrollee expenditures grew at an average rate of 2.4 percent per year.

One factor that likely contributed to slower growth in Medicaid per enrollee spending was States' efforts to control the costs of their Medicaid programs. As enrollment and medical prices grew faster than they had in the past and economic growth was slower, many of the States' efforts were focused on controlling program growth rather than on expanding their Medicaid programs.²³ Absent these changes, per enrollee cost growth and total expenditure growth would likely have been somewhat greater over this period. Partially offsetting this slowdown was a temporary increase in Federal funding for Medicaid. Congress increased the FMAP for parts of 2003 and 2004 in the Jobs and Growth Tax Relief Reconciliation Act of 2003, thereby temporarily increasing the Federal share of Medicaid expenditures.

²¹ For a description of Medicaid expenditure trends from the beginning of the program in 1966 through 2000, see J. Klemm, "Medicaid Spending: A Brief History," *Health Care Financing Review*, Fall 2000; 22(1): 105-112.

²² B. Bruen and J. Holahan, "Acceleration in Medicaid Spending Reflects Mounting Pressures," Kaiser Commission on Medicaid and the Uninsured, May 2002; and D. Boyd, "The Bursting State Fiscal Bubble and State Medicaid Budgets," *Health Affairs*, January 2003; 22(1): 46-61.

²³ V. Smith, *et al.*, "States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004," Kaiser Family Foundation; September 2003; and V. Smith, *et al.*, "The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005," Kaiser Family Foundation, October 2004.

While changes to the FMAP do not directly change the level of total Medicaid expenditures, these increases presumably assisted States in avoiding deeper reductions in their plans.

In 2006, aggregate Medicaid spending was 0.3 percent *lower* than in 2005, decreasing for the first time in the program's history. Medicaid enrollment grew 0.7 percent in 2006, while Medicaid per enrollee expenditures decreased 1.0 percent. The primary driver of this decrease was the shift of most prescription drug coverage for dual-eligible beneficiaries (those eligible for both Medicaid and Medicare) from Medicaid to the new Medicare Part D program, which began in January 2006. All dual-eligible beneficiaries were automatically enrolled in Part D, and Medicare now served as the primary source of their prescription drug coverage.²⁴ As a result of this shift in coverage, Medicaid drug spending (net of rebates) decreased 44 percent from 2005 to 2006. All other Medicaid benefit spending grew 4.4 percent—still a relatively low growth rate compared to historical growth trends.

Medicaid expenditures grew 5.4 percent in 2007, and enrollment decreased by 0.5 percent. Enrollment levels for children and adults declined, presumably as a result of the relatively strong economic growth in the preceding several years. Growth in Medicaid per enrollee expenditures was 6.0 percent in 2007. Due to the shift of drug coverage for dual-eligible beneficiaries to Medicare Part D, benefit spending was 1.2 percent lower in the first quarter of FY 2007 than in the first quarter of FY 2006. For the rest of FY 2007, Medicaid benefits increased 7.9 percent compared to the same period in 2006.

Medicaid expenditures increased at a rate of 5.9 percent in 2008, driven in part by a 2.7-percent increase in Medicaid enrollment. While the recent severe economic recession started in December 2007, unemployment rates increased only slightly throughout the first half of the fiscal year. Per enrollee expenditure growth slowed to 3.2 percent in 2008.

In 2009, Medicaid expenditures increased by 7.6 percent, a level that was significantly affected by the economic recession. Medicaid enrollment grew at a rate of 6.7 percent in 2009—the fastest rate since 2003. Enrollment growth was fastest among adults (12.4 percent) and children (7.1 percent). In large part because the strongest enrollment growth occurred in the categories of beneficiaries with lower average costs, per enrollee cost growth of all enrollees slowed further to 0.8 percent.

Medicaid expenditures grew at a slower rate of 6.1 percent in 2010. This deceleration in expenditure growth was a result of slower growth in Medicaid medical assistance payments (from 7.8 percent in 2009 to 6.5 percent in 2010) and a decrease in administration payments of \$0.4 billion, or 2.1 percent. Enrollment is

²⁴ Medicaid still provides some prescription drug coverage for dual-eligible beneficiaries for categories of drugs that Medicare Part D does not cover.

estimated to have increased by 5.5 percent, reflecting continuing relatively higher unemployment rates.

Total Medicaid expenditures grew slightly faster in 2011 than in 2010, at a rate of 6.4 percent. Expenditures on benefits grew somewhat more slowly (6.3 percent) than in 2010, but administration expenditures increased at the fastest rate since 2003 (8.7 percent), in part due to the incentive payments to hospitals and physicians for health information technology. Enrollment is estimated to have grown at a rate of 3.8 percent as the unemployment rate decreased and economic growth was slow but positive. Medicaid expenditures per enrollee increased at an estimated rate of 2.6 percent.

In recent years, States have continued to take actions to limit the rate of growth of Medicaid expenditures. These actions have included freezing or reducing payment rates across many types of health care providers and limiting or restricting optional benefits. It is likely that these efforts have contributed to slower spending growth rates in Medicaid expenditures per enrollee over the last several years.²⁵

It is also important to note the impact of the American Recovery and Reinvestment Act (ARRA) of 2009 on Medicaid expenditures over the past 3 years. ARRA provided for a higher temporary FMAP for all States retroactive to the beginning of FY 2009. This change resulted in an average effective Federal share for 2009 of about 65 percent (benefits and administration costs) and increased Federal expenditures by \$34.3 billion (over what the Federal government otherwise would have spent), while it decreased State expenditures by the same amount. As a result, Federal Medicaid expenditures grew by 23.0 percent in 2009, while State Medicaid expenditures declined by 12.8 percent. In 2010, the higher temporary FMAP shifted \$39.7 billion in Medicaid expenditures from the States to the Federal government, further increasing the average effective Federal share of Medicaid expenditures to 67 percent. Federal Medicaid expenditures rose by 9.6 percent in 2010, while State Medicaid expenditures declined by 0.5 percent. As the temporary FMAP increases were lowered in the second and third quarters of FY 2011 and expired altogether in the last quarter, Federal Medicaid expenditures increased only 0.3 percent, while State Medicaid expenditures grew by 19.0 percent. The average effective Federal share of Medicaid expenditures fell to 63 percent in 2011, and the higher temporary FMAP added \$26.2 billion to Federal Medicaid expenditures.²⁶

²⁵ These State actions are well documented in the annual 50-State survey of Medicaid programs conducted by the Kaiser Family Foundation; see V. Smith, *et al.*, "Medicaid Today; Preparing for Tomorrow: A Look at State Medicaid Program Spending, Enrollment and Policy Trends," Kaiser Family Foundation; October 2012.

²⁶ In general, the Federal and State annual Medicaid expenditure growth rates are similar; the largest annual differences between the two rates are the results of legislation, such as ARRA.

*C. MEDICAID EXPENDITURES AND ENROLLMENT PROJECTIONS,
FY 2012-FY 2021*

The projections presented in this report focus on Medicaid benefit expenditures and Medicaid enrollment; administration costs are also included and are based on the projections from the President's FY 2013 Budget Mid-Session Review, updated to account for the Supreme Court decision on the Affordable Care Act after the Mid-Session Review projections were completed. Other Title XIX expenditures (such as the Vaccines for Children program) are not included. Historical and projected Medicaid expenditures for medical assistance payments and administration are shown in table 3.²⁷

²⁷ In table 3, enrollment and expenditure data for the period 1966-1976 have been revised to be consistent with the current definition of the Federal Fiscal Year (October-September).

**Table 3—Historical and Projected Medicaid Enrollment and Expenditures
for Medical Assistance Payments and Administration,
and Average Federal Share of Expenditures, Selected Years**
(Enrollment in millions of person-year equivalents, expenditures in billions of dollars)

Fiscal Year	Enrollment	Total expenditures	Federal expenditures	State expenditures	Average Federal Share
Historical data:					
1966	4.0	\$0.9	\$0.5	\$0.4	50%
1970	14.0	5.1	2.8	2.3	54%
1975	20.2	13.1	7.3	5.9	55%
1980	19.6	25.2	14.0	11.2	55%
1985	19.8	41.3	22.8	18.4	57%
1990	22.9	72.2	40.9	31.3	57%
1995	33.4	159.5	90.7	68.8	57%
2000	34.5	206.2	117.0	89.2	57%
2001	36.9	229.0	129.8	99.2	57%
2002	40.5	258.2	146.6	111.6	57%
2003	43.5	276.2	161.0	115.1	58%
2004	45.2	296.3	175.0	121.3	59%
2005	46.3	315.9	180.4	135.5	57%
2006	46.7	315.1	179.3	135.8	57%
2007	46.4	332.2	189.0	143.2	57%
2008	47.7	351.9	200.2	151.7	57%
2009	50.9	378.6	246.3	132.3	65%
2010	53.7 ¹	401.5	269.8	131.7	67%
2011	55.7 ¹	427.4	270.7	156.7	63%
Projections:					
2012	56.7	432.0	248.3	183.7	57%
2013	57.0	450.5	260.0	190.6	58%
2014	65.6	498.8	296.9	201.9	60%
2015	70.8	538.0	324.3	213.8	60%
2016	73.6	578.3	351.3	227.0	61%
2017	75.1	617.2	374.1	243.1	61%
2018	76.1	654.8	396.7	258.2	61%
2019	76.8	698.1	422.7	275.3	61%
2020	77.4	746.2	449.3	296.8	60%
2021	77.9	795.0	478.1	316.8	60%

¹Enrollment is projected for 2010 and 2011.

Total Medicaid expenditures (Federal and State expenditures combined) for medical assistance payments and administration are estimated to have grown 1.1 percent in 2012 to \$432.0 billion and are projected to reach \$795.0 billion by 2021, increasing at an average rate of 6.4 percent per year over the next 10 years.²⁸ Federal government spending on Medicaid medical assistance payments and administration costs is estimated to have declined by 8.3 percent to \$248.3 billion in 2012, representing about 57 percent of total Medicaid benefit expenditures. The temporary FMAP increases under ARRA, which were extended at lower rates by Public Law 111-226, expired on June 30, 2011. The phase-down and expiration of these FMAP increases are responsible for the decrease in the average Federal share in 2011 and again in 2012. Federal spending on Medicaid is projected to reach \$478.1 billion by 2021, or about 60 percent of total spending. Total State Medicaid expenditures for benefits and administration are estimated to have increased sharply to \$183.7 billion in 2012, a growth rate of 17.2 percent following 19.0-percent growth in 2011, and are projected to reach \$316.8 billion by 2021. The rapid growth in State Medicaid expenditures is also due largely to the expiration of the temporary FMAP increases, as the States' share of Medicaid expenditures increased from 33 percent in 2010 to 43 percent in 2012.

The Affordable Care Act contains many Medicaid provisions, including a substantial increase in Medicaid eligibility beginning in 2014. These impacts are expected to have a significant influence on future Medicaid expenditure trends, and they are presented in more detail in the next section.

The Federal share of total Medicaid expenditures is projected to continue to vary over the next 10 years due to several acts of legislation. From 2005 through 2008, the average Federal share was approximately 57 percent. For 2009, 2010, and 2011, ARRA and Public Law 111-226 provided for temporary FMAP increases, in part based on changes in each State's unemployment rate. This act led to a higher Federal share of 65 percent in 2009, 67 percent in 2010, and 63 percent in 2011. The average Federal share is expected to have returned to 57 percent in 2012 and to increase slightly to 58 percent in 2013 before rising again in 2014—with the latter increase due mainly to the higher FMAP for newly eligible Medicaid beneficiaries as required in the Affordable Care Act. The projected average Federal share increases to about 60 percent in 2014 and 2015 and to about 61 percent for 2016 through 2019, and then declines to 60 percent in 2020 and 2021.

Table 4 shows historical and projected expenditures for medical assistance payments and administration costs separately.

²⁸ This increase reflects average annual growth of 2.7 percent in 2012-2013, a large increase of 10.7 percent in 2014, as the eligibility expansion under the Affordable Care Act takes effect, and average growth of 6.9 percent in 2015-2021, in part due to the continuing implementation of the Affordable Care Act.

**Table 4—Historical and Projected Medicaid Expenditures
for Medical Assistance Payments and Administration,
and Average Federal Share of Expenditures, Selected Years**
(Expenditures in billions of dollars)

Fiscal Year	Total benefit expenditures	Federal benefit expenditures	Total administration expenditures	Federal administration expenditures
Historical data:				
1966	\$0.9	\$0.4	\$0.0	\$0.0
1970	4.9	2.6	0.2	0.1
1975	12.6	6.9	0.6	0.3
1980	24.0	13.3	1.2	0.7
1985	39.3	21.7	2.0	1.2
1990	68.7	38.9	3.5	2.0
1995	151.8	86.5	7.7	4.2
2000	195.7	111.1	10.6	5.9
2001	217.1	123.3	11.9	6.6
2002	246.3	140.0	11.9	6.6
2003	262.6	153.4	13.6	7.6
2004	281.8	167.0	14.5	8.0
2005	300.7	172.1	15.1	8.3
2006	299.0	170.6	16.0	8.7
2007	315.8	180.0	16.4	9.0
2008	334.2	190.6	17.7	9.6
2009	360.3	236.3	18.3	10.0
2010	383.6	260.0	17.9	9.8
2011	407.9	259.8	19.5	10.9
Projections:				
2012	409.1	234.2	22.9	14.1
2013	428.6	247.0	21.9	12.9
2014	475.6	283.5	23.1	13.4
2015	513.5	310.1	24.5	14.1
2016	552.7	336.6	25.7	14.7
2017	590.4	358.8	26.8	15.3
2018	627.4	381.2	27.5	15.5
2019	669.8	407.0	28.2	15.8
2020	716.9	433.1	29.2	16.2
2021	764.6	461.3	30.4	16.8

Total Medicaid expenditures (Federal and State combined) for medical assistance payments are estimated to have grown 0.3 percent in 2012 to \$409.1 billion. This would be the second slowest growth rate in Medicaid expenditures for medical assistance payments in the history of the program (faster only than in 2006, when prescription drug coverage for dual-eligible beneficiaries switched from Medicaid to Medicare). Medicaid expenditures on such payments are projected to reach \$764.6 billion by 2021, increasing at an average rate of 6.5 percent per year over the next 10 years. Federal government spending on these Medicaid payments is estimated to have amounted to \$234.2 billion in 2012 and is projected to grow to \$461.3 billion by 2021.

The slow growth in 2012 appears to have been driven by several factors. The expiration of the temporary increases in the Federal matching rates led to rapid growth in State Medicaid benefit expenditures for two consecutive years—19.9 percent in 2011 and 18.1 percent in 2012—and likely prompted States to undertake program changes intended to prevent even faster growth.²⁹ Fee-for-service acute care spending is estimated to have decreased 1.9 percent. Based on current data, estimated expenditures for hospital services, physician services, and prescription drugs decreased in 2012. Included in acute care expenditures, supplemental payments are estimated to have been substantially lower in 2012 than in 2011, decreasing about \$2 billion (or about 12 percent).³⁰ Long-term care spending is estimated to have been nearly unchanged, decreasing 0.1 percent from 2011. Capitation payments and premiums are estimated to have increased 3.0 percent; these trends may also reflect some further shifts of benefits from fee-for-service plans to managed care plans within Medicaid.

Enrollment growth is also estimated to have slowed, from 3.8 percent in 2011 to 1.9 percent in 2012. Since most of this deceleration is expected to have occurred among children and adults, it is not likely that this decrease was a primary factor in the benefit expenditure slowdown.

The effects of the Affordable Care Act are expected to have contributed a small amount to the slowdown. The effects on Medicaid benefit expenditures are estimated to have added \$0.6 billion in spending in 2011 and decreased spending by \$0.5 billion in 2012, predominantly the result of a greater amount of new prescription drug rebates being collected in 2012. The savings from the additional rebates were partially offset by added costs under several other provisions of the Affordable Care Act; most notably, some States expanded Medicaid eligibility in

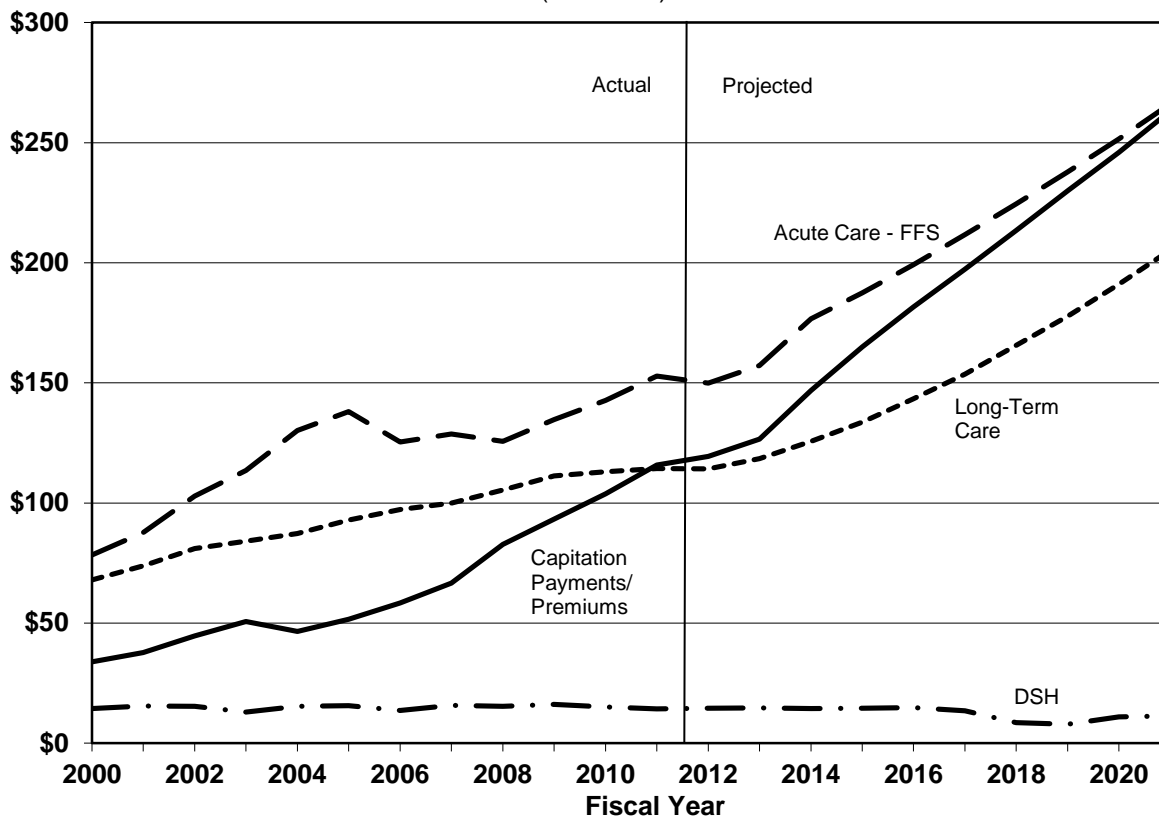
²⁹ V. Smith, *et al.*, “Medicaid Today; Preparing for Tomorrow: A Look at State Medicaid Program Spending, Enrollment and Policy Trends.”

³⁰ These supplemental payments are payments made by the States to health care providers or facilities that are above the standard program reimbursement rates, subject to the upper payment limits (UPLs). These upper payment limits are generally equal to the amount that Medicare would have paid for the same services.

2010 and 2011, which led to additional costs for new beneficiaries, and there were increased payments to territories for Medicaid. These small impacts suggest that the Affordable Care Act was not a major factor in the Medicaid trends in the past year.

Figure 3 shows historical and projected Medicaid expenditures by four major categories of services: acute care fee-for-service; long-term care; capitation payments and premiums; and DSH.

Figure 3—Past and Projected Medicaid Expenditures for Medical Assistance Payments, by Type of Payment, FY 2000–FY 2021
(In billions)



Capitation payments and premiums are expected to grow the fastest of the major Medicaid service categories over the next 10 years, as shown in figure 3. Such expenditures are projected to grow 8.6 percent per year from 2012 to 2021, which would be about 2 percentage points faster than overall Medicaid benefit growth. Relatively faster projected growth in these payments is in part the result of the Medicaid eligibility expansion in the Affordable Care Act, since most of the new enrollees are expected to be children and adults and capitation payments constitute a significant and growing share of current child and adult enrollees' benefits. Moreover, capitation payments have grown substantially faster than other service expenditures in recent history; from 2001 to 2011, these Medicaid payments grew on average 11.8 percent per year, faster than overall Medicaid benefit expenditures

(6.7 percent). The use of managed care plans within Medicaid has increased over the last 10 years, and accounts for much of the difference between the capitation payment and overall Medicaid expenditure growth rates.³¹

Acute care fee-for-service Medicaid expenditures are projected to grow at an average rate of 5.7 percent per year over the next decade. In 2012, these expenditures are estimated to have declined by 1.9 percent, but they are projected to increase in 2013 and later years. Spending for these services is projected to grow fastest in 2014, the first year of the Medicaid eligibility expansion, as the new enrollees are expected to use predominantly acute care services in both fee-for-service Medicaid and managed care plans.

Medicaid spending on long-term care is projected to grow by 6.0 percent on average for 2012 through 2021. The aging of the population is one contributing factor to growth in expenditures for long-term care: as the number of people age 65 or older increases—and especially the number of those over age 85—there is a corresponding projected increase in the amount of long-term care spending, since elderly beneficiaries tend to use more long-term care than younger beneficiaries. As the oldest members of the baby boom generation begin to reach age 65, both the number of aged enrollees in Medicaid and eventually the rate of long-term care expenditure growth are projected to increase. While the baby boom generation is not estimated to have a major effect on long-term care spending during 2012 through 2021, the increase in the number of people over age 85 in the next 10 years is expected to lead to growth in such expenditures. Additionally, while few of the newly eligible Medicaid enrollees in 2014 and later are anticipated to have significant or immediate long-term care needs, several provisions in the legislation are expected to expand access and, in turn, spending for long-term care services.

Medicaid DSH expenditures are typically expected to grow at the same rate as the Medicaid Federal DSH allotments, which are based on the Consumer Price Index (CPI). The Affordable Care Act, however, prescribes reductions in Medicaid DSH allotments beginning in 2014, with the largest adjustments starting in 2017. Thus, the average growth rate for DSH spending is projected to be -2.3 percent over the next 10 years.

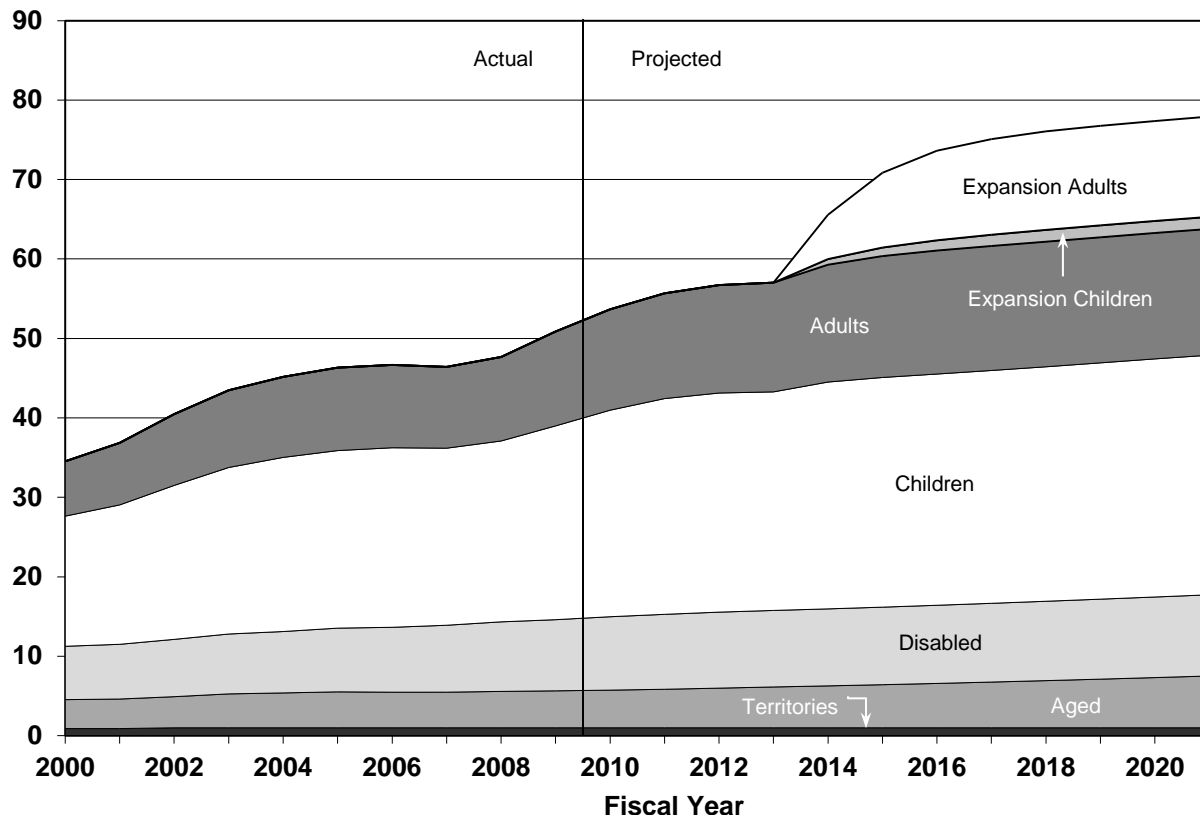
Administration costs are estimated to have been \$22.9 billion in 2012, reflecting a growth rate of 17.5 percent. This sharp increase was primarily due to health information technology incentive payments to hospitals and other providers that were added by ARRA; these payments increased from \$0.5 billion in 2011 to an estimated \$3.1 billion in 2012. Administration costs are projected to reach \$30.4 billion by 2021 and are projected to grow at an average annual rate of

³¹ Centers for Medicare & Medicaid Services, 2011 *Medicaid Managed Care Enrollment Report*.

4.5 percent. These projected costs include additional administration expenditures related to the Medicaid eligibility expansion under the Affordable Care Act.

Increasing levels of Medicaid enrollment are expected to contribute to expenditure growth over the next 10 years. Historical and projected Medicaid enrollments are shown in figure 4 by category.

Figure 4—Past and Projected Numbers of Medicaid Enrollees, by Category, FY 2000–FY 2021
(In millions of person-year equivalents)



* For purposes of this chart, “Expansion Adults” are adult enrollees who are newly eligible in 2014 and later as a result of the expanded eligibility criteria in the Affordable Care Act. “Expansion Children” are defined here as the dependent children of newly eligible adult enrollees, even if these children were eligible under current criteria. Currently eligible adults who become enrolled as a result of the publicity and outreach efforts associated with the eligibility expansion in 2014 and later are included with Adults, and their dependent children are included with Children in this figure.

Total enrollment is projected to increase from 55.7 million person-year equivalents (PYE) in 2011 (including 1.0 million enrollees in the U.S. Territories) to 56.7 million PYE in 2012 and 77.9 million PYE by 2021.

Enrollment in 2012 is estimated to have increased by 1.9 percent, based on further decreases in the unemployment rate and continuing economic growth. This increase follows 3 years of faster enrollment growth, averaging an estimated 5.3 percent per year during and immediately after the 2007–2009 recession. Job losses due to recessions result in losses of employer-sponsored health insurance and lower family

income, with an associated increase in the number of people eligible for Medicaid. Other workers may no longer be able to afford individual or employer insurance coverage and consequently seek Medicaid coverage. According to the national health expenditure (NHE) accounts and projections, private health insurance enrollment was estimated to have declined by about 11 million persons between 2007 and 2011 and is projected to increase slightly in 2012 and 2013.³²

Enrollment growth is expected to slow further in 2013, increasing only 0.5 percent, with projected continuing declines in the unemployment rate and stronger economic growth.

In 2014, when the eligibility expansion under the Affordable Care Act takes effect, total enrollment is estimated to increase by 8.6 million PYE or 15.0 percent.³³ An estimated 8.7 million new beneficiaries will enroll as a result of the legislation; absent its impact, enrollment would have been projected to grow even slower in 2014 than in 2013, reflecting the effect of projected faster economic growth and lower unemployment rates.³⁴ As noted previously, eligibility will be expanded to almost all persons under age 65 in families with income below 138 percent of the Federal poverty level (FPL) (and who are citizens or eligible legal residents) in States that choose to expand their programs. (The Affordable Care Act specifies an income threshold of 133 percent of FPL, but it also allows a 5-percentage-point income disregard, which sets the effective income limit to 138 percent of FPL.)

The increase in Medicaid enrollees attributable to the eligibility expansion is assumed to occur during 2014-2016, with most of the increase taking place in the first year. Enrollment growth in 2015 and 2016 is estimated to average 6.0 percent per year, reflecting increased enrollee participation and assumed increases in the number of States expanding eligibility.

Finally, after the coverage expansion is fully realized, the total number of Medicaid enrollees is projected to increase during 2017-2021 at about 1.1 percent per year, reflecting population growth, stable economic assumptions, and an increase in the number of aged enrollees as the baby boom generation continues to reach age 65. (Excluding the newly eligible enrollment groups, the growth of aged adults is

³² Martin, *et al.*, “Growth in U.S. Health Spending Remained Slow in 2010; Health Share of Gross Domestic Product Was Unchanged from 2009”; and Keehan, *et al.*, “National Health Expenditure Projections: Modest Annual Growth until Coverage Expands and Economic Growth Accelerates.”

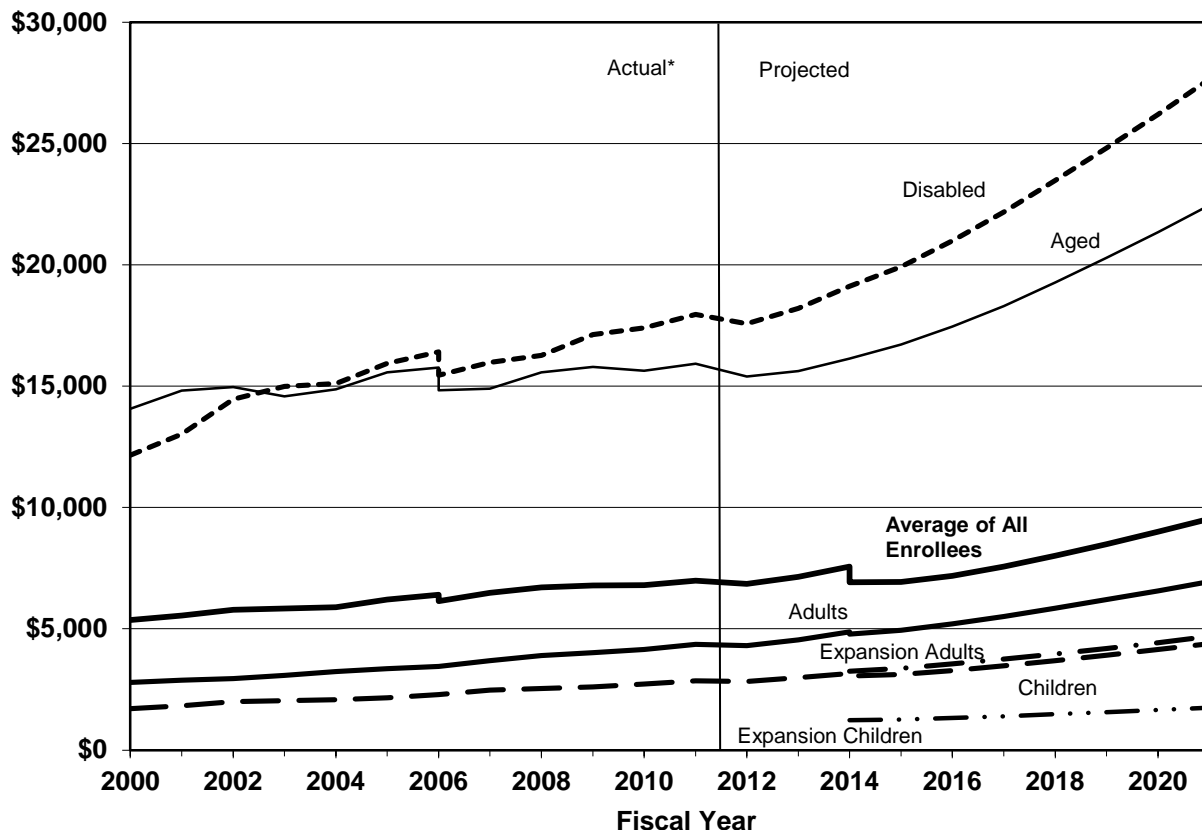
³³ Because the eligibility expansion starts in January 2014, the enrollment impact in FY 2014 only includes 9 months of enrollment for new beneficiaries. The CY 2014 impact is projected to be 11.5 million PYE, which would be a 20-percent increase in enrollment.

³⁴ The Affordable Care Act is projected to result in some other small increases in Medicaid enrollment in States that choose to expand eligibility prior to 2014. In 2013, projected enrollment related to the early eligibility expansions is 0.2 million PYE. Excluding the effects of the Affordable Care Act, Medicaid enrollment is projected to increase from 56.8 million PYE in 2013 to 56.9 million PYE in 2014.

expected to be faster than the other categories of enrollment; the average annual increase for aged adults is estimated to be 3.0 percent over the next 10 years.)

In addition to increases in Medicaid enrollment, the average costs of benefits for all enrollees are projected to increase over the next 10 years. Figure 5 displays historical and projected average Medicaid benefit expenditures per enrollee for all enrollees collectively and by eligibility group.

Figure 5—Past and Projected Medicaid Expenditures on Medical Assistance Payments Per Enrollee, by Enrollment Category, FY 2000–FY 2021



* Per enrollee amounts for 2010 and 2011 are based on actual expenditures and estimated enrollment.

The average Medicaid benefit expenditures per enrollee were estimated to have grown somewhat faster from 2010 to 2011 (2.6 percent) than in the preceding 2 years. Average Medicaid benefit expenditures per enrollee have been growing quite slowly since 2008 at an average rate of 1.4 percent per year. This trend has been significantly influenced, however, by the relatively larger number of children and adults enrolling in Medicaid (as compared to aged and disabled persons). These children and adults are expected to have health care costs that are on average significantly lower than those of the other Medicaid beneficiaries (notably aged and disabled persons), resulting in slower growth in average expenditures per enrollee when considering all enrollment categories together. If the relative share of children, adults, aged, and disabled enrollees had been held constant at 2008 levels

over the last 3 years, the estimated average growth rate of expenditures per enrollee would have been 2.9 percent.

In 2012, the estimated growth rate of Medicaid benefit expenditures per enrollee was -1.9 percent. As the growth rates of children and adult enrollment are estimated to have slowed in 2012, the relative share of enrollment by category is expected to have remained similar in 2012. Thus, if the relative share of enrollment for each category had been held constant between 2011 and 2012, the estimated growth rate of benefit expenditures per enrollee would still have been -1.9 percent.

Aged Medicaid enrollees have traditionally had the highest average benefit cost, primarily as a result of nursing facility expenses and, prior to 2006, prescription drug costs. During 2001 to 2010, however, nursing home expenditures per aged enrollee increased relatively slowly, and most costs for prescription drugs were shifted from Medicaid to the new Medicare Part D program starting January 1, 2006. As a result, the average benefit cost per aged Medicaid enrollee grew very slowly during this period (1.1 percent). The average annual increase in all other benefit costs per aged enrollee (that is, excluding nursing home and prescription drug costs) was substantially faster during 2001 to 2010.

In 2011, aged enrollees' average benefits cost was estimated to have increased 1.9 percent. Average benefits for aged enrollees are projected to continue to increase at a below-average pace (3.5 percent) for the next 10 years, in large part because of expected continuing slow growth in the use of nursing home care. The projected growth rate is significantly faster than that experienced during 2001 to 2010, since legislation had strong impacts on average growth over this historical period. The introduction of Medicare Part D led to a sharp decline in Medicaid expenditures for aged beneficiaries in 2006; in addition, provisions in the Deficit Reduction Act of 2005 tightened the eligibility criteria for nursing facility benefits. In contrast, the Affordable Care Act broadens availability of long-term care services and supports.

Per enrollee costs for the disabled have been increasing at a faster pace than for aged beneficiaries (3.7 percent on average during 2001 through 2010). Slow growth in nursing home costs has had a much smaller impact on average costs for this category of enrollees, since the proportion of disabled enrollees with nursing home placement is substantially lower than for aged enrollees. At the same time, cost increases for disabled enrollees have reflected the expanding use of home and community-based services.³⁵ Per enrollee Medicaid costs for the disabled were also reduced significantly by the shift of prescription drug coverage from Medicaid to Medicare for dual beneficiaries; however, this impact was smaller for the average

³⁵ Use of home and community-based services can substantially reduce expenditures for enrollees who would otherwise have had to enter a nursing home. Conversely, the expanding use of these services, by those who would not otherwise have had nursing home care, adds to overall program costs.

cost per disabled enrollee than for the aged, because a greater proportion of aged Medicaid enrollees are enrolled in Medicare than is the case for disabled Medicaid enrollees.

The average benefit costs for disabled enrollees are estimated to have increased by 3.2 percent in 2011. Per enrollee benefits are projected to increase in 2012 through 2021 at a rate similar to that experienced over the last decade (after adjusting for the removal of most prescription drugs). Growth in benefits for the disabled is projected to average 4.4 percent, reflecting a lower proportion of costs spent on nursing home care than for aged enrollees and a continuing rapid expansion in the use of home and community-based services.³⁶

Per enrollee Medicaid benefits for adults increased by about 4.0 percent annually during 2001 through 2010, as a result of growth in the costs of prescription drugs, clinics, laboratory tests, and capitation payments, offset by relatively flat trends in spending for inpatient and outpatient hospital care and for physician services. These patterns by type of service are strongly affected by the increasing proportion of the adult Medicaid population enrolled in managed care plans.³⁷

Average benefits for adults were estimated to increase 5.3 percent in 2011, due in part to a sharp increase in supplemental inpatient and outpatient hospital payments. This trend is expected to influence the average benefit growth among adults most strongly because, for these beneficiaries, inpatient and outpatient hospital services account for a relatively larger share of their Medicaid benefits than for other enrollment groups.³⁸ Average benefits for non-expansion adults are projected to increase during 2012 through 2021 at an average rate of 4.8 percent per year.

As shown in figure 5, the estimated average costs for adults who become enrolled as a result of the expanded eligibility criteria in the Affordable Care Act are significantly lower than those for existing beneficiaries. In part this difference arises from the fact that adults in poor health often suffer a loss in income,

³⁶ Although the availability of home and community-based services can help prevent or postpone nursing home placement—and thus substantially reduce Medicaid costs for beneficiaries—this impact appears to be outweighed by the increasing availability and use of home and community-based services by disabled enrollees who may not have used institutional long-term care in the absence of these services.

³⁷ Medicaid expenditures for nursing home care, on behalf of children and adults, are very low, and such enrollees were unaffected by the implementation of Medicare Part D in 2006. Thus, these factors, which limited expenditure per enrollee growth for aged and disabled beneficiaries, had an insignificant impact on the trends for children and adults.

³⁸ These supplemental payments are payments made by the States to health care providers or facilities that are above the standard program reimbursement rates, subject to the upper payment limits (UPLs). These upper payment limits are generally equal to the amount that Medicare would have paid for the same services.

increasing their likelihood of qualifying for Medicaid under the pre-Affordable Care Act criteria. Differences in the costs also reflect the impact of an anticipated higher participation rate in the future among persons with relatively low or no health care costs, whose inclusion would tend to lower average per enrollee costs.

For children, per enrollee Medicaid benefits increased at a 4.7-percent annual rate during 2001 through 2010. Expenditure growth was driven by capitation payments and premiums, which account for nearly half of children's Medicaid expenditures. Per enrollee expenditures are estimated to have grown 4.7 percent in 2011. Future growth in such spending is projected to be similar to the experience of the last decade, averaging about 4.4 percent per year, with the fastest growth again resulting from capitation payments and premiums, and somewhat slowed in 2014 by the addition of new children enrollees who are projected to have lower average health costs.

Over the next 10 years, the projected average annual growth rates of per enrollee benefit expenditures range from 3.5 percent for aged enrollees to 4.8 percent for adults. As suggested by the discussion above, variations in per enrollee cost growth rates among enrollment categories are mainly due to the different mix of services assumed for each group. In particular, the growth rate for aged enrollees is strongly affected by the expected continuing slow increase in the use of nursing home care, which dominates this category, while costs for other enrollees reflect a greater proportion of acute-care services and capitation payments, which are expected to increase at more normal rates.

Across all enrollment categories, by 2021 the average beneficiary is projected to receive about \$9,500 in health care benefits through Medicaid. For all categories combined, per enrollee spending on medical assistance payments during 2012 through 2021 is projected to increase at an average annual rate of 3.2 percent per year—which, somewhat counter-intuitively, is slower than the rate for any of the separate eligibility categories. The apparent anomaly is explained by expected changes in the proportions of total enrollees in each category.³⁹ In particular, most of the new enrollees becoming eligible in 2014 and later under the Affordable Care Act will be adults and children, who have a much lower average cost than do aged or disabled enrollees. Moreover, as noted above, the expansion populations are expected to have a lower average cost than existing beneficiaries in each category.

³⁹ This effect—that differences in enrollment growth rates between enrollment groups have influenced overall per enrollee spending trends—has had major impacts on historical per enrollee growth trends. These impacts have been most notable during economic recessions: as more children and adults enroll in Medicaid during a typical recession—since they tend to be the Medicaid beneficiary groups most sensitive to changes in the economy—the overall per enrollee expenditure growth rate tends to be relatively lower, reflecting the influx of less costly enrollees. In periods when enrollment growth of children and adults has been slower than that of aged and disabled beneficiaries, the overall per enrollee expenditure growth rate has tended to be relatively higher.

Without the effects of the new beneficiaries, Medicaid expenditures per enrollee would be projected to grow 5.0 percent per year on average over the next 10 years. (As indicated in figure 5, the average per enrollee cost across all beneficiaries is projected to decline 3.1 percent in 2014 with the addition of the new, comparatively less expensive enrollees, and then to increase only 0.1 percent in 2015 as additional people become enrolled under the broader eligibility criteria.)

The downward impact in average cost growth described above will be partially offset by a change in the relative number of aged enrollees in the program. With accelerating growth in the number of Medicaid enrollees age 65 or older, coinciding with the aging of the baby boom generation, there will be a greater share of aged enrollees in the program in the near future. Between 2012 and 2021, the number of such beneficiaries is expected increase by nearly one-third, or 1.7 million. Although this demographic shift is significant, it is still small compared to the expansion of coverage under the Affordable Care Act.

D. AFFORDABLE CARE ACT AND OTHER LEGISLATIVE IMPACTS

The Affordable Care Act will result in numerous changes to Medicaid and will have substantial impacts on both the expenditures and the enrollment in the program. While the eligibility expansion will likely have the largest effect and will not begin until 2014, a number of other sections of the Affordable Care Act are already having an impact. This section will describe the estimated effects on total Medicaid expenditures, Federal and State Medicaid expenditures, and Medicaid enrollment.⁴⁰

In 2010, the Affordable Care Act was estimated to have lowered Medicaid expenditures by about \$90 million. The two largest impacts in 2010 were the addition of several new drug rebates, which led to savings, and the option for States to expand eligibility to adults at higher income levels before 2014, which led to small costs that partially offset the savings from the drug rebates.

In 2011, the Affordable Care Act was estimated to have increased Medicaid expenditures by about \$600 million. The increase in costs was mainly due to increased expenditures for States that expanded Medicaid eligibility before 2014 and for Territories, while the total impact was in part offset by the new prescription drug rebates.

From 2012 through 2021, the Affordable Care Act is expected to add a total of \$514 billion to aggregate Medicaid expenditures—an increase of about 9 percent over projections of Medicaid spending without the impact of the legislation. Federal expenditures make up the great majority of this projected increase; Federal Medicaid expenditures are projected to be \$468 billion (or about 15 percent) higher over this time period, while State expenditures are projected to grow by only \$45 billion (or about 2 percent). Thus, the Federal government is projected to pay for about 91 percent of this increase.

The most significant provision, measured by its impact on expenditures and enrollment, is the expansion of Medicaid eligibility to almost all persons under age 65 living in families with incomes below 138 percent of the FPL beginning in 2014. This expansion is projected to add 8.6 million PYE to enrollment in FY 2014 during the 9 months that the new eligibility rules will be in effect for that year and is expected to add 18.3 million PYE by 2021. Of the new enrollees, about 78 percent

⁴⁰ The Office of the Actuary originally developed estimates of the impacts of the Affordable Care Act on Medicaid expenditures and enrollment that were included in the April 22, 2010 memorandum by Richard S. Foster. Subsequently, these estimates have been updated to incorporate the most recent health expenditure and coverage data, as well as to reflect the most current understanding of policy related to the implementation of the Act.

are projected to be adults, and the remaining 22 percent children.⁴¹ Furthermore, about 83 percent of new adult enrollees are projected to be newly eligible (that is, individuals who meet the definition of “newly eligible” in section 1905(y)(2) of the Social Security Act), while 17 percent are projected to be eligible under the current Medicaid rules.⁴² This latter group is expected to enroll in Medicaid as a result of the new assistance that will be available through the simplified enrollment process, the health insurance exchanges, and the publicity associated with the expansion of eligibility.

Of the total increase in Medicaid expenditures on benefits under the Affordable Care Act, the expansion, including the enrollment of newly eligible individuals and increased participation of currently eligible individuals, is projected to contribute \$448 billion from 2014 through 2021.⁴³ Of this increase, the majority is projected to be paid by the Federal government—\$388 billion, or about 87 percent—and the States are projected to spend an additional \$60 billion. The Federal government participation is relatively larger than for current Medicaid expenditures because the Affordable Care Act specifies a much higher Federal matching rate for newly eligible beneficiaries, ranging from 100 percent in 2014, 2015, and 2016 to 90 percent by 2020 and beyond.

The per enrollee costs of new beneficiaries who were formerly uninsured and are without other forms of insurance are estimated to be about 70 percent of those for current beneficiaries enrolled for the entire year, by eligibility group. That is, newly enrolled children are expected to have per enrollee benefit costs on average equal to about 70 percent of the average costs of currently enrolled children, as are newly enrolled adults relative to currently enrolled adults. This estimate includes the impact of increased utilization of health care services after individuals gain health insurance and the impact of the lower prices that Medicaid generally pays for health care services and products. Some new Medicaid enrollees are also expected to retain other forms of coverage, such as employer-sponsored insurance, and to enroll

⁴¹ In addition to the higher level of allowable income, the Affordable Care Act expands eligibility to people under age 65 who have no other qualifying factors that would have made them eligible for Medicaid under prior law, such as being under age 18, disabled, pregnant, or parents of eligible children. As noted previously, the category of adults is expected to have the greatest increase in enrollment in Medicaid under the Affordable Care Act, since the law does not require individuals to be parents of eligible children.

⁴² “Newly eligible” individuals are persons between the ages of 19 and 64 who, beginning in 2014, are enrolled in the new adult group and who would not have been eligible for full Medicaid benefits, benchmark coverage (described in subparagraph (A), (B), or (C) of section 1937(b)(1) of the Act), or benchmark-equivalent coverage (described in section 1937(b)(2) of the Act) as of December 1, 2009. An individual may also be “newly eligible” if he or she would have been eligible but could not have been enrolled for such benefits or coverage because the applicable Medicaid waiver or demonstration had limited or capped enrollment as of December 1, 2009.

⁴³ Increased administration costs associated with updating eligibility systems and overall program administration are not included in these figures and are presented in more detail below.

in Medicaid to “wrap around” the benefits of the other plans. Program costs for these enrollees are substantially lower than for beneficiaries who have only Medicaid, since the other insurance is the primary payer. These beneficiaries further lower estimates of the per enrollee Medicaid expenditures of all new enrollees.

In *NFIB v. Sebelius*, the Supreme Court ruled that a State may not lose Federal funding for its existing program if it does not implement the Medicaid eligibility expansion under the Affordable Care Act. Based on the information currently available about the States’ intentions for their Medicaid programs, it is assumed that (i) 55 percent of potentially newly eligible persons would reside in States that expand eligibility in 2014, and (ii) in 2015 and later years, 65 percent of potentially newly eligible persons would reside in States that expand eligibility as additional States implement the eligibility expansion. In the States that do not implement the eligibility expansion, the increase in the participation rate of currently eligible individuals is assumed to be about 80 percent of the increase in the participation rate in the States that do expand eligibility.

The effective participation rate of persons who would have been uninsured for a full year, but are newly eligible for Medicaid as a result of the Affordable Care Act, is assumed to be 95 percent. This assumed rate is significantly higher than actual Medicaid participation rates to date and is based on the anticipated impacts of sections of the Affordable Care Act intended to make the process of enrolling easier. Similarly, about 70 percent of persons who would be eligible under current Medicaid criteria and would otherwise be uninsured, and who reside in States that expand Medicaid eligibility are assumed to enroll in Medicaid; in States that do not expand Medicaid eligibility, about 56 percent of currently eligible and otherwise uninsured persons are assumed to enroll. In particular, simplified eligibility determinations will enable some individuals with steady income and who have applied for coverage to be enrolled through an expedited process using a prior year’s income tax return as verification of eligibility for coverage. Moreover, the legislation establishes State or Federally facilitated health insurance exchanges that, among other responsibilities, will facilitate the determination of individuals’ and families’ eligibility for Federal financial assistance for health care coverage, either through Medicaid or through the Federal premium and cost-sharing subsidies for private health insurance plans. The exchanges are assumed to perform this role effectively and, for those found to qualify for Medicaid, to assist in the enrollment process. In this role, the exchanges would also serve as a valuable new resource for health providers who seek assistance in enrolling eligible persons in Medicaid. In addition, the more widespread availability of financial assistance under the Affordable Care Act (for individuals and families with incomes up to 400 percent of FPL) is anticipated to reduce any stigma associated with receipt of such assistance through Medicaid.

Other factors underlying the assumed Medicaid participation rates for newly eligible individuals include (i) the exclusion of people ineligible for Medicaid due to citizenship status (who are not counted as newly eligible persons); (ii) different participation assumptions for eligible individuals with high versus low health care costs; (iii) lower assumed participation for persons who would have had part-year coverage from sources other than Medicaid; and (iv) separate, lower participation assumptions for people who would have had other forms of insurance, such as individually purchased insurance and employer-sponsored coverage.

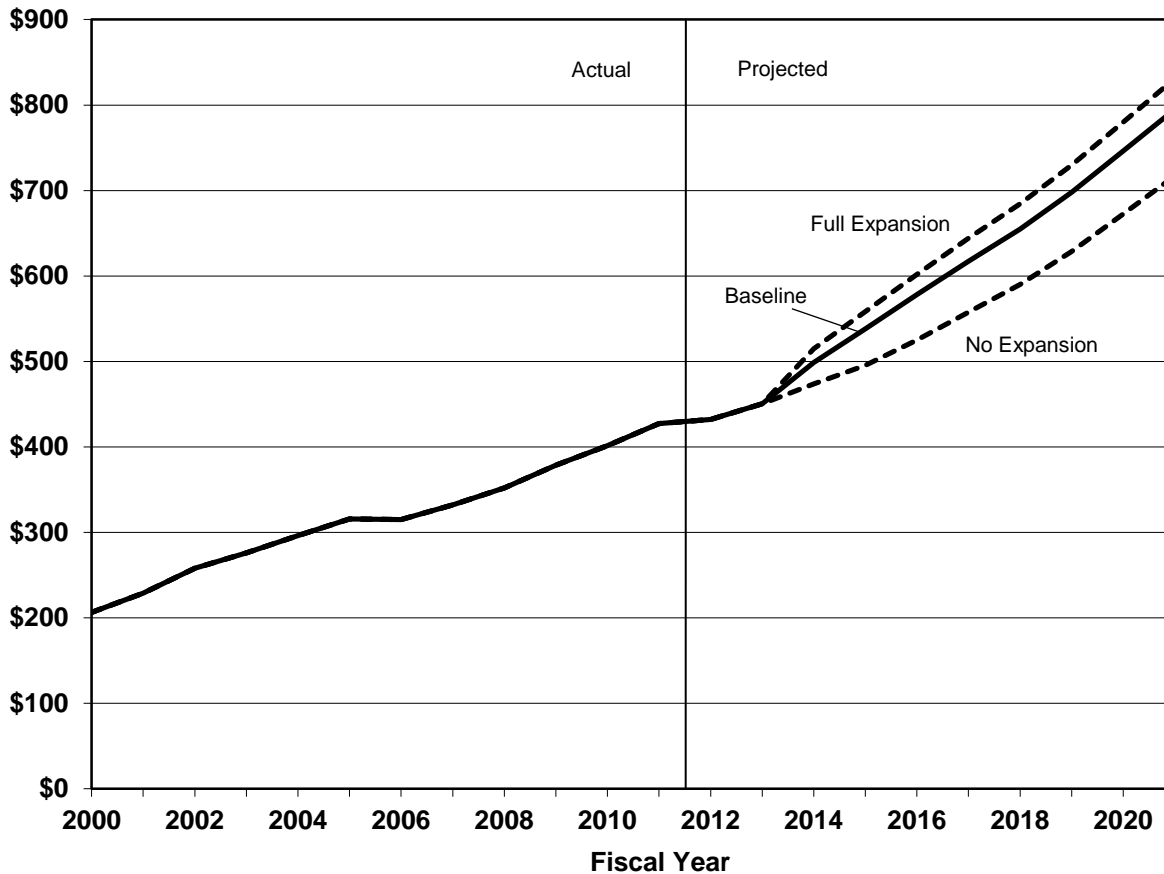
As indicated above, it is assumed that the Medicaid expansion will be implemented fully and effectively in States that choose to expand eligibility, consistent with the intent of the Affordable Care Act. Achieving these high rates of participation may be challenging, however, and will require significant improvements in the application and enrollment process, vigorous public outreach, and increased public awareness of the importance of health care coverage and the Federal subsidies available to support it. The provisions of the Affordable Care Act are designed to produce such outcomes. If actual participation in Medicaid among the newly eligible population is lower than the assumed rate, then Medicaid costs in 2014 and later would be somewhat lower than projected in this report (and likewise, higher participation rates may result in somewhat higher costs). As noted elsewhere, numerous other factors will also affect Medicaid costs in the future, and the level of such costs remains very uncertain.

Moreover, there is substantial uncertainty over which States will decide to expand Medicaid eligibility (and when they will do so). While a number of States have already taken initial steps to expand eligibility, it is unclear at this time what other States will do. Some States' political leaders have expressed interest, while others have stated that they do not plan to expand. Other States' officials have said that they are still considering their decision. Since it is possible for a State that has not begun the process to still do so, significantly more or fewer States may expand Medicaid eligibility than have been assumed, for both 2014 and later years. To the extent that the actual number of States opting for expansion differs from the assumptions used in these projections, future costs and enrollment would likely differ by a similar proportion.

The next two figures demonstrate the range of potential impacts of the Medicaid eligibility expansion on Medicaid expenditures and enrollment based on how many States choose to expand eligibility. Figure 6 shows annual projected Medicaid expenditures under three scenarios: (i) if all States choose to expand Medicaid eligibility beginning in 2014 ("full expansion"); (ii) if all States choose not to expand Medicaid eligibility (and there is no corresponding increase in the participation of currently eligible persons) ("no expansion"); and (iii) the assumption used for the

baseline projections in this report (States representing 55 percent of potential newly eligible persons expand in 2014, and 65 percent expand in 2015 and beyond).⁴⁴

Figure 6—Projected Medicaid Expenditures under “Baseline,” “Full Eligibility Expansion,” and “No Eligibility Expansion” Scenarios
(In billions)



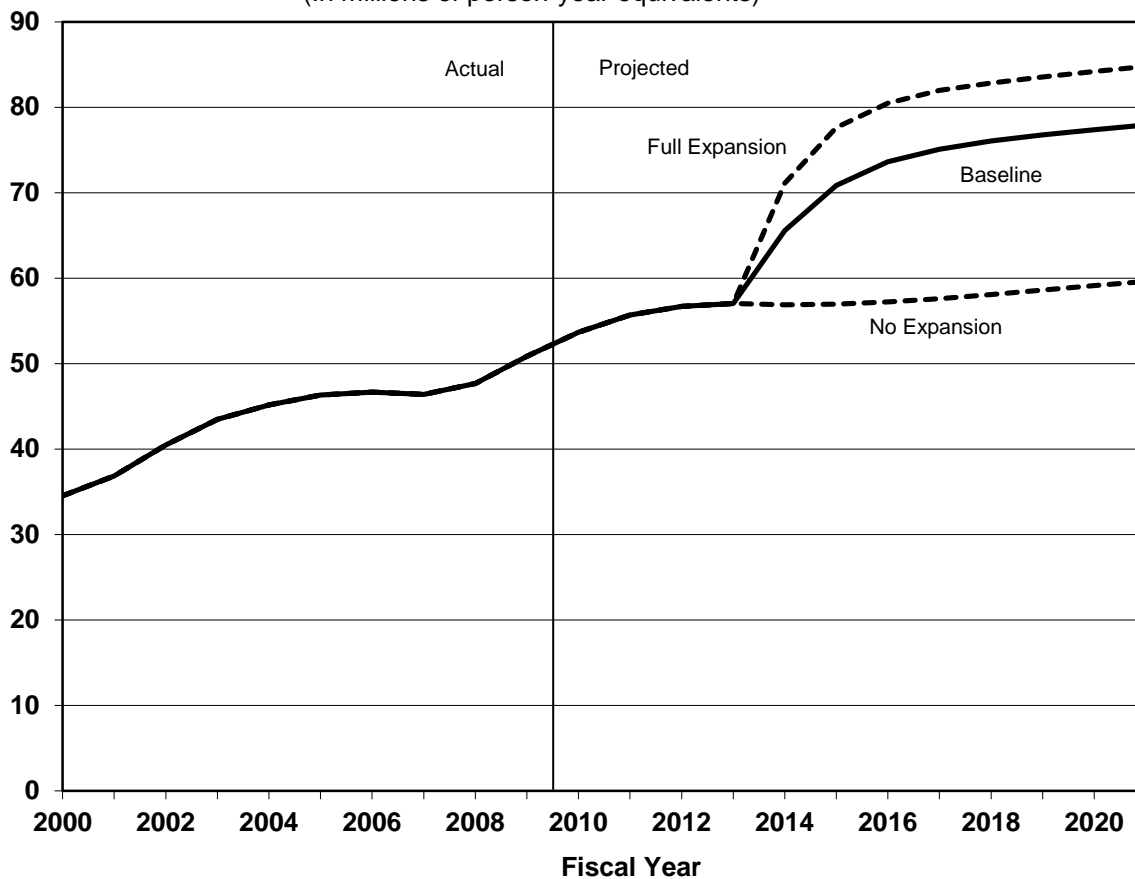
Medicaid expenditures are projected to reach \$830.9 billion in 2021 under the “full expansion” scenario (about \$35.9 billion higher than the baseline scenario) and would be \$218.6 billion greater than the expenditures under the baseline scenario from 2014 through 2021. Under the “no expansion” scenario, Medicaid expenditures are projected to reach only \$466.2 billion by 2021 (about \$77.9 billion lower than the baseline scenario) and would be \$466.2 billion lower than the expenditures under

⁴⁴ It is important to note that in the “no expansion” case there is assumed to be no increase in the participation rate of currently eligible persons. In actuality, even if no States were to implement the Medicaid eligibility expansion, there would likely still be some increase in the enrollment of currently eligible persons, but to a lesser extent than assumed in the baseline projections. This increase would be the anticipated result of enrollment simplifications, greater outreach efforts and awareness about health care coverage options, and awareness of the individual health coverage mandate (even though there would be no penalty to low-income individuals). Thus, it is likely that there would be some increases in enrollment, as well as in Federal and State Medicaid expenditures, due to increases in currently eligible enrollment even in a scenario in which no States implemented the eligibility expansion.

the baseline scenario from 2014 to 2021. While there are other reasons that actual future expenditures may differ from these projections, this range of projected costs provides a reasonable indication of how future expenditures might vary depending on how many States decide to expand Medicaid eligibility.⁴⁵

Figure 7 shows annual projected Medicaid enrollment under the three scenarios described above.

Figure 7—Projected Medicaid Enrollment under “Baseline,” “Full Eligibility Expansion,” and “No Eligibility Expansion” Scenarios
(In millions of person-year equivalents)



Under the “full expansion” scenario, by 2021 Medicaid enrollment would reach 84.8 million PYE, which is 6.8 million greater than projected under the baseline scenario. In the “no expansion” scenario, projected Medicaid enrollment in 2021 is

⁴⁵ The baseline scenario projections are closer to the “full expansion” scenario projections than the “no expansion” scenario projections, and may appear closer than the assumption that States representing 65 percent of potential newly eligible persons implement the eligibility expansion would suggest. This apparent difference is due to the assumption that there would still be a significant increase in the currently eligible enrollment in States that do not implement the expansion in the baseline scenario.

59.6 million PYE, or 18.3 million lower than under the baseline scenario. It is important to note that in the “no expansion” scenario, there is assumed to be no increase in the participation rate among currently eligible persons; in actuality, there may be some currently eligible persons who would enroll even if no States expanded eligibility, due to outreach efforts and publicity surrounding the health insurance exchanges (it is assumed in the baseline scenario that there would still be an increase in the currently eligible participation rate in States that do not expand). As is the case with the projections of expenditures under the different scenarios, although there are other factors that could lead to differences between actual future enrollment levels and these projections, this range of projected enrollment reflects a reasonable expectation of possible outcomes related to the States’ decisions to expand eligibility.

In addition to the Medicaid eligibility expansion, there are numerous other provisions of the Affordable Care Act that affect Medicaid. These provisions (excluding the effects of the eligibility expansion) are projected to add about \$41 billion in benefit expenditures over the next 10 years. While these estimates show a relatively small net increase in total Medicaid expenditures, several of the provisions are expected to result in significant costs or savings when considered separately.

There is also expected to be a difference between the net effects of the Affordable Care Act on Medicaid benefit expenditures paid for by the States and those paid for by the Federal government due to provisions other than the eligibility expansion. The States’ Medicaid benefit expenditures are projected to be lower by approximately \$25 billion, while Federal Medicaid benefit expenditures are projected to increase by about \$66 billion. This projected difference between the Federal and State impacts is attributable primarily to several provisions that rely almost entirely on Federal funding or make further changes to the Federal matching rate.

The Affordable Care Act is expected to lead to increases in Medicaid administration costs, mainly related to higher Medicaid caseloads as a result of the eligibility expansion. These costs include the expenses of updating eligibility systems to accommodate the enrollment of new Medicaid beneficiaries and determining whether persons qualify under the existing Medicaid eligibility criteria or the new criteria, as well as the increased costs of program administration associated with the number of new enrollees starting in 2014. Administration costs are projected to increase by about \$25 billion in total during 2012 through 2021 as a result of the legislation, of which about \$15 billion is expected to be paid by the Federal government and approximately \$10 billion by the States.

The additional costs related to the Affordable Care Act increase the estimated average Medicaid expenditure growth rate for 2012 through 2021, with the greatest changes starting in 2014 with the eligibility expansion:

- During 2012 through 2013, Medicaid expenditure growth is projected to average 2.7 percent per year; excluding the impact of the Affordable Care Act, growth would be projected to be slightly lower at a rate of 1.9 percent per year. The differential results from the net impact of higher expenditures associated with long-term care demonstrations, increased access to long-term care, temporarily increased payments to primary care physicians, and increased administration costs, partially offset by larger prescription drug rebates.
- Medicaid expenditures are projected to increase 10.7 percent in FY 2014 as a result of the eligibility expansion that begins on January 1, 2014. Growth in expenditures without the Affordable Care Act would be projected at 4.9 percent. As would be expected, this is the largest 1-year difference between projected growth rates with and without the impact of the legislation during 2012 through 2021.
- In the last 7 years of the period, Medicaid expenditures are projected to grow 6.9 percent per year on average, somewhat faster than without the impact of the Affordable Care Act (6.3 percent); this difference is mostly due to the additional new Medicaid enrollees in 2015 and 2016, as people continue to react to the new eligibility criteria.
- During 2012 through 2021, Medicaid expenditure growth is projected to be 6.4 percent per year on average, 1.1 percentage points higher than it would be if the Affordable Care Act impacts were excluded (5.3 percent average growth), reflecting all of the factors listed above.⁴⁶

Several legislative acts over the last year are anticipated to have relatively small impacts on Medicaid expenditures. The Temporary Payroll Tax Cut Continuation Act of 2011 (Public Law 112-78) and the Middle Class Tax Relief and Job Creation Act of 2012 (Public Law 112-96) extended the Qualifying Individual (QI) program and Transitional Medical Assistance (TMA) program through December 31, 2012. The extensions of these programs are estimated to add about \$1.3 billion in Medicaid expenditures between 2012 and 2014. The Middle Class Tax Relief and Job Creation Act of 2011 also rebased DSH allotments in 2021 on the 2020 allotments as adjusted by the Affordable Care Act; this change is estimated to decrease Medicaid expenditures by about \$6.0 billion in 2021. Finally, the Middle Class Tax Relief and Job Creation Act of 2012 and the Moving Ahead for Progress in the 21st Century Act of 2012 (Public Law 112-141) modified the special adjustment to FMAP for major disaster recovery that was added by the Affordable Care Act. Although these modifications are not expected to change total Medicaid expenditures, Federal Medicaid costs are projected to be about \$2.5 billion lower

⁴⁶ The projected growth rate excluding the Affordable Care Act impacts also excludes the impact of the Middle Class Tax Relief and Job Creation Act of 2012 on DSH allotments and expenditures.

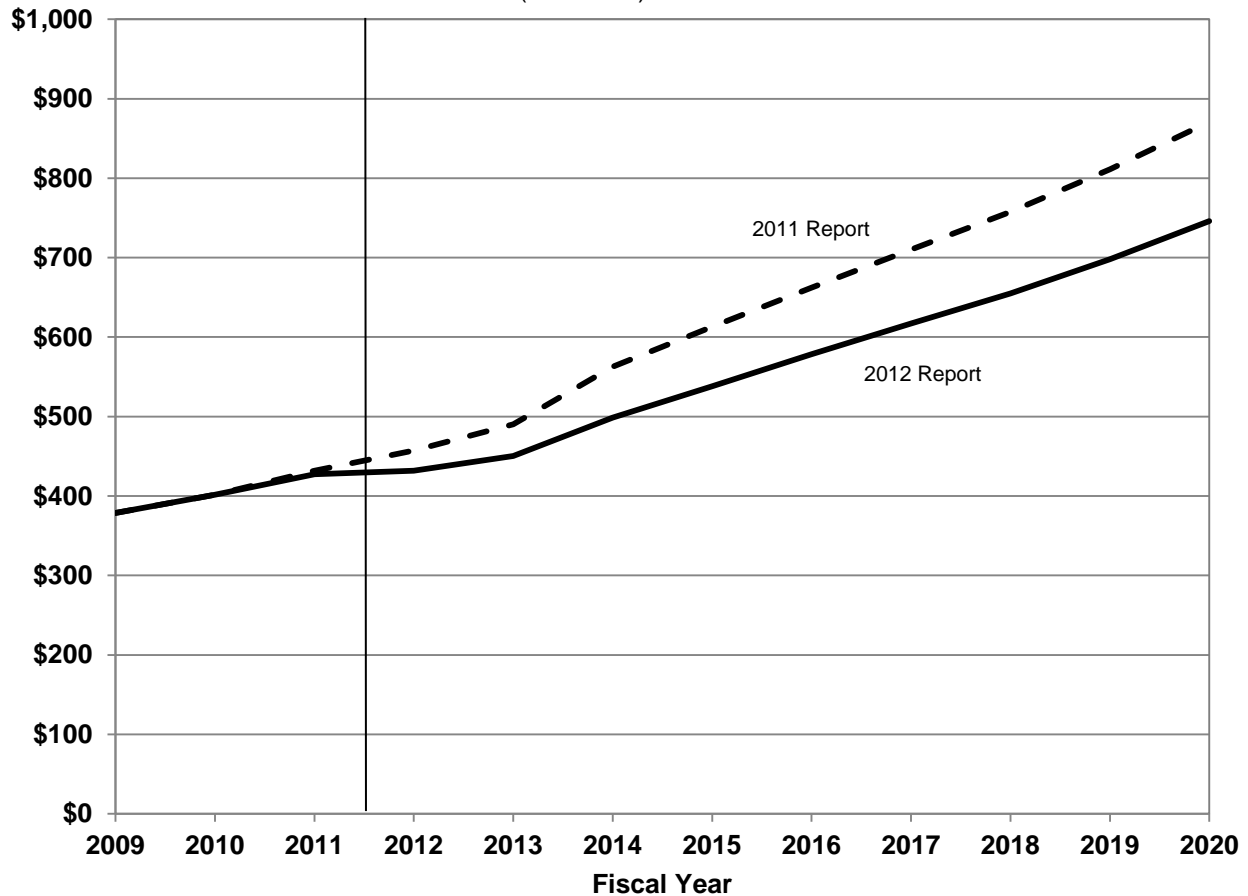
over the period 2013 to 2015, and State Medicaid expenditures are projected to be greater by the same amount.⁴⁷

⁴⁷ These estimates do not include the impacts of the American Taxpayer Relief Act of 2012 (Public Law 112-240), which was passed prior to the completion of the projections of Medicaid expenditures in this report. Notably, the American Taxpayer Relief Act of 2012 extended the QI and TMA programs through December 31, 2013.

E. COMPARISON TO 2011 REPORT PROJECTIONS

The projections of Medicaid expenditures in this report are generally much lower than in the *2011 Actuarial Report on the Financial Outlook for Medicaid*. Figure 8 compares the projections of total Medicaid expenditures (including Federal and State) to those in last year's report.

Figure 8—Projected Medicaid Expenditures: Comparison of 2011 versus 2012 Actuarial Reports on the Financial Outlook for Medicaid, FY 2008–FY 2020
(In billions)



Projected spending in 2020 of \$746.2 billion is 14 percent lower than the corresponding amount in last year's report (\$871.0 billion). There are several reasons for this unusually large difference. First, expenditures in 2012 (\$432.0 billion) were much lower than projected last year (\$457.4 billion), representing a 5.5-percent difference. As described previously in this report, the primary reason for this change appears to be the States' more extensive efforts to limit program growth in light of the relatively fast growth in the State share of Medicaid expenditures in 2011 and 2012, with lower fee-for-service acute care spending and relatively flat long-term care spending. Lower-than-projected

expenditures in 2012 represent the largest source (about 37 percent) of the difference in the projections.

Another source of the difference is the change in the projected expenditures related to the Medicaid eligibility expansion under the Affordable Care Act. The additional expenditures for 2020 associated with the expansion are substantially lower in the 2012 report than they were in 2011; in this report, projected expenditures are \$70.8 billion, compared to the 2011 projection of \$106.4 billion (or about 33 percent lower). This change is principally the result of the Supreme Court decision in *NFIB v. Sebelius*, which provided that a State may not lose Federal funding for its existing program when it does not implement the Medicaid eligibility expansion under the Affordable Care Act. The difference in the eligibility expansion estimates accounts for about 29 percent of the overall change in the projected expenditures in 2020.

The remaining difference (about 34 percent) is the result of slower projected expenditure growth. Medicaid expenditures per enrollee are projected to grow at a slower average annual rate (2.8 percent over the period 2011 to 2020) than projected in the 2011 report (3.5 percent). The projected average amount of Medicaid spending per enrollee is about \$9,000 by 2020, about 6 percent less than in last year's report. Slower projected per enrollee expenditure growth is the result of several factors, including slower 2012 spending growth and slower projected future growth in the utilization of services, which includes the changes in the volume of services, the intensity of services, and the mix of services used.

Medicaid enrollment is expected to be substantially lower by 2020 than projected in the 2011 report. Enrollment is projected to reach 77.4 million PYE by 2020, whereas in last year's report enrollment was projected to be 85.1 million by 2020 (or about 9 percent lower). Most of this difference is due to smaller projected increases in enrollment associated with the Supreme Court decision on Medicaid eligibility expansion. Medicaid enrollment from 2011 to 2020 is projected to grow at an average rate of 3.7 percent, down from last year's projection of 4.7 percent. Changes in projected enrollment excluding the impact of the eligibility expansion have a minimal contribution to the difference between the projections in the 2012 and 2011 reports.

F. MEDICAID IN CONTEXT

From the estimates and analysis of health spending in the U.S. provided by the NHE accounts, additional insight can be obtained into the role of Medicaid within the total U.S. health care system.⁴⁸ Medicaid spending in the 2010 NHE accounts represented 15.5 percent of total NHE. Private health insurance was the largest source of spending on health care in 2010, accounting for 32.7 percent of total NHE, while Medicare paid for 20.2 percent.⁴⁹

The historical NHE also presents health care spending by the original source of financing (or sponsor). In calendar year (CY) 2010, Medicaid represented 37 percent of Federal government expenditures on health services and supplies and 32 percent of such spending by State and local governments. For the Federal government, Medicaid is the largest source of general revenue-based spending on health services. Notably, Medicaid is a larger source of such Federal expenditures than Medicare. A sizeable portion of Medicare spending is funded by income from dedicated revenue sources—which include Medicare Part A payroll taxes and Part B and Part D beneficiary premiums—with the balance from Federal general revenues. In contrast, Medicaid does not have any dedicated Federal revenue source; all Federal spending on Medicaid comes from general revenue. For State governments, as with the Federal government, Medicaid is the largest source of general revenue-based spending on health services, although spending on all other health programs in 2009 and 2010 exceeded spending on Medicaid, largely because of the temporary increases to the FMAP.⁵⁰

Medicaid is also larger than Medicare in terms of the number of people covered. In FY 2011, Medicaid was estimated to have covered 55.7 million PYE, and 70.4 million people were enrolled in the program at some point during the year. In comparison, Medicare covered an average of 48.7 million people during CY 2011. Within these totals, there are substantial differences between the programs in the number and nature of people covered. For example, Medicare automatically covers nearly all people over age 65 (40.4 million beneficiaries in 2011), but only those aged

⁴⁸ The historical Medicaid spending data and projections presented in this report differ slightly from the NHE estimates and projections in several ways. Some of the differences are as follows: (i) the data and projections featured in this report are shown on a fiscal year basis, whereas the NHE amounts are on a calendar year basis; (ii) the NHE accounts make several adjustments to Medicaid, such as classifying Medicaid spending for Medicare premiums as Medicare spending; and (iii) the NHE accounts use somewhat different definitions of services than do the data presented in this report.

⁴⁹ Martin, *et al.*, “Growth in U.S. Health Spending Remained Slow in 2010; Health Share of Gross Domestic Product Was Unchanged from 2009.”

⁵⁰ *Ibid.* There are some State dedicated revenues for Medicaid. For more detail on this analysis of health care spending by sponsor, see the methodology paper at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/dsm-11.pdf>.

individuals with very low incomes—and who apply for the coverage—become Medicaid enrollees (estimated at 4.8 million PYE). Disabled enrollment was more similar between the two programs; Medicaid covered an estimated PYE average of 9.4 million blind or disabled persons in 2011, while Medicare covered 8.3 million disabled beneficiaries. Although the definition of disability is essentially the same for the two programs, the other eligibility criteria are entirely different.⁵¹ Finally, as noted earlier, a majority of Medicaid enrollees are either children or certain adults in families with low incomes. Medicare does not have comparable categories of beneficiaries. Dual-eligible individuals accounted for 9.2 million enrollees in each program in 2011.⁵²

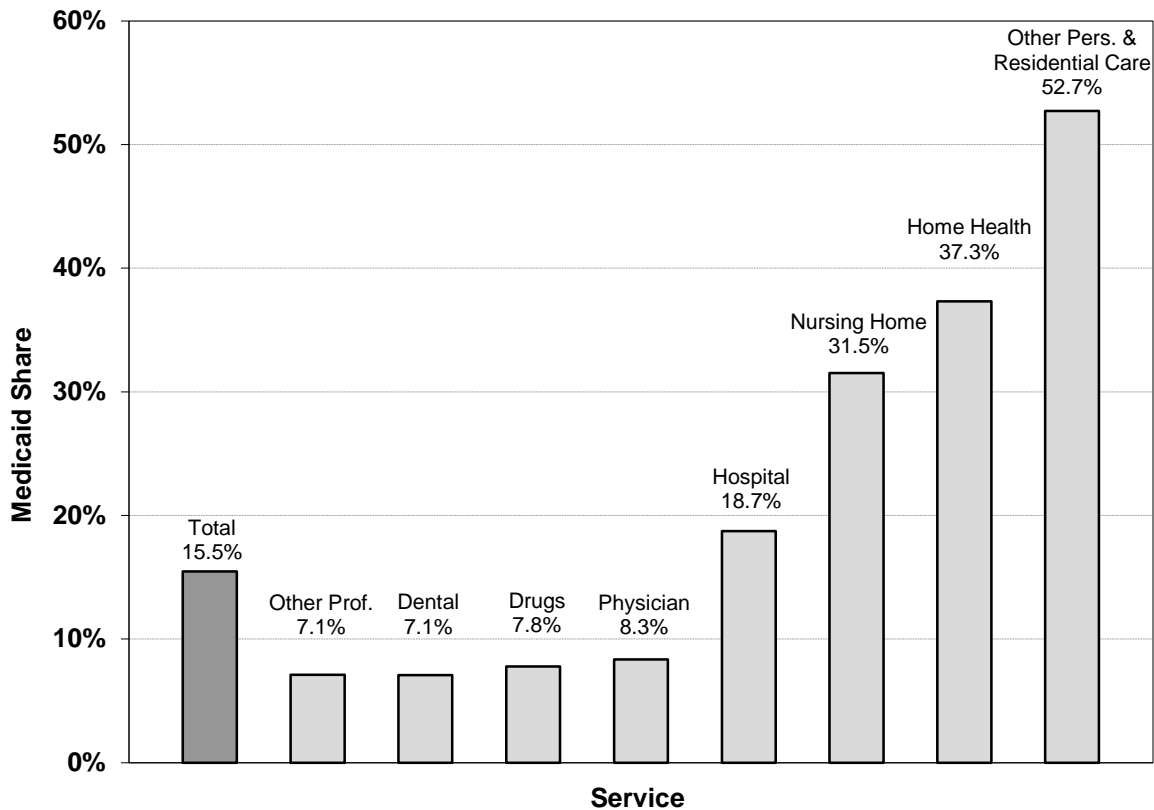
Among the different types of health care services, Medicaid plays the largest role in the funding of long-term care. According to the 2010 NHE, Medicaid is estimated to have paid for 37.3 percent of all freestanding home health care and 31.5 percent of all freestanding nursing home care in the U.S. In addition, Medicaid covered 52.7 percent of other personal and residential care in 2010, including Medicaid payments for intermediate care facilities and for home and community-based waivers.⁵³ Medicaid has a major responsibility for providing long-term care because the program covers some aged and many disabled persons, who tend to be the most frequent and most costly users of such care, and because private health insurance and Medicare often furnish only limited coverage for these benefits, particularly for nursing homes. Many people who pay for nursing home care privately become impoverished due to the expense; as a result, these people eventually become eligible for Medicaid. Figure 9 shows the percentage of total spending for the major health care services that Medicaid covers.

⁵¹ As with other enrollment categories, Medicaid eligibility for disabled individuals is based on income and asset criteria. Medicare eligibility generally depends on an individual's sufficient participation in the paid work force prior to disability. Despite these different requirements, a significant number of disabled people qualify for coverage under both Medicaid and Medicare.

⁵² Centers for Medicare & Medicaid Services, 2011 *Medicaid Managed Care Enrollment Report*. Dual-eligible beneficiaries are included in the aged or disabled enrollment groups based on their eligibility for Medicaid.

⁵³ Martin, *et al.*, "Growth in U.S. Health Spending Remained Slow in 2010; Health Share of Gross Domestic Product Was Unchanged from 2009."

Figure 9—Medicaid Expenditures as Percentage of Total U.S. Health Expenditures, by Service Category, CY 2010¹



¹ Martin, *et al.*, "Growth in U.S. Health Spending Remained Slow in 2010; Health Share of Gross Domestic Product Was Unchanged from 2009."

Historically, Medicaid expenditures per enrollee have generally grown at a slower rate than overall national health expenditures per capita. From 1971 through 2010, Medicaid expenditures per enrollee increased at an average annual rate of 7.7 percent, which is slightly less than the average growth rate of NHE per capita of 8.2 percent. This difference has become greater in more recent years; from 2001 through 2010, Medicaid expenditures per enrollee grew at an average rate of 2.5 percent, compared to 5.6 percent for NHE per capita. The difference between these two rates of growth can be significantly larger in any single year, and in many years Medicaid expenditures per enrollee grew faster than NHE per capita.

For several reasons, comparisons of per capita cost growth rates may provide only a partial explanation of how Medicaid relates to the rest of the U.S. health care system. First, NHE per capita includes both Medicaid expenditures in NHE and Medicaid enrollees in the U.S. population. As illustrated in figure 9, Medicaid pays different relative shares of health care costs by type of service; to the extent that given categories of service have grown faster or slower relative to total health spending, the differential can affect the comparison between Medicaid expenditures per enrollee and NHE per capita. In addition, the demographic composition of

Medicaid enrollees is different than the overall population; for example, Medicaid covers a significantly larger share of persons under age 18. Changes in the population covered by Medicaid—especially in the relative share of adults and children enrolled relative to disabled and aged enrollees—can have a substantial effect on the difference between Medicaid expenditures per enrollee and NHE per capita. Furthermore, changes in how people receive health care insurance—and especially in the relative number of people who are uninsured and purchasing all of their health care out-of-pocket—may affect both trends. Finally, the difference between the two growth rates may also reflect changes in legislation or policy affecting Medicaid or other parts of the health care system (for example, Medicare or the private insurance market). For these reasons, comparisons of per capita cost growth trends between Medicaid and NHE (or other payers with more homogenous enrollments, such as Medicare) are not straightforward and should be interpreted carefully.

It is also important to note that Medicaid represents a significant share of the Federal and State budgets. In FY 2011, out of a total of \$3,603 billion spent by the Federal government for all purposes, \$275 billion (or 7.6 percent) can be attributed to Medicaid. Under the President’s FY 2013 Budget, Federal outlays on Medicaid are projected to account for 10.0 percent of all Federal outlays by 2021.⁵⁴

According to the National Association of State Budget Officers (NASBO), in State fiscal year 2011, Medicaid represented an estimated 23.6 percent of all State government spending.⁵⁵ This amount, however, includes all Federal contributions to State Medicaid spending, as well as expenditures from State general revenue funds and other State funds (which for Medicaid consist of “provider taxes, fees, donations, assessments, and local funds”). According to NASBO, Medicaid was the largest program in 2011. When only State general revenues are considered, however, Medicaid spending constituted an estimated 17.4 percent of expenditures in 2011, placing it well behind elementary and secondary education. The share of State general revenues devoted to Medicaid increased from 2010 to 2011 (from 15.8 percent) as Medicaid expenditure growth outpaced overall State government expenditure growth and as the temporary FMAP increases under ARRA were phased out during 2011.

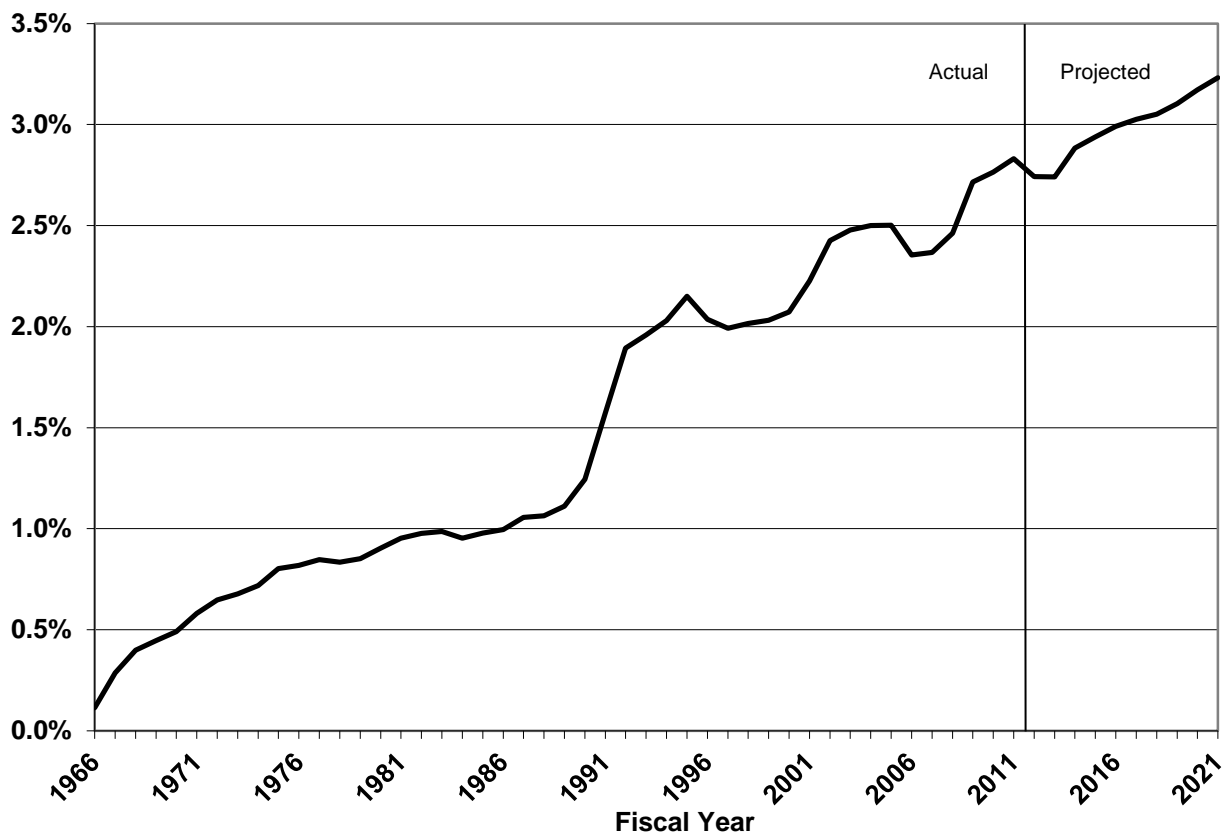
As shown in figure 10, Medicaid represented about 2.8 percent of GDP in 2011, steadily increasing from 2.4 percent in 2007. Due to the 2007-2009 economic recession—which increased enrollment in Medicaid while also suppressing GDP

⁵⁴ The projections in the President’s Budget were developed prior to the Supreme Court decision in *NFIB v. Sebelius*; thus, these projections may overstate the expected Federal Medicaid expenditures in 2021. More information on the Federal budget is available in *Analytical Perspectives, Budget of the United States Government, Fiscal Year 2013*.

⁵⁵ *FY 2010 State Expenditure Report*, National Association of State Budget Officers, December 2011.

growth—the program’s share of GDP grew significantly in every year between 2008 and 2011.

Figure 10—Past and Projected Medicaid Expenditures as Share of GDP, FY 1966–FY 2021



Medicaid is estimated to have decreased as a share of GDP in 2012, as GDP grew faster (4.4 percent) and Medicaid spending growth slowed to 1.1 percent. In 2013, Medicaid expenditures and GDP are projected to grow at the same rate (4.3 percent), and the share of GDP is expected to remain the same. Starting in 2014 through 2016, of course, as the new Affordable Care Act provisions expand eligibility to many people, Medicaid costs will increase significantly relative to GDP; Medicaid expenditures are projected to reach 3.0 percent of GDP by 2016. As seen in figure 10, the program’s expenditures are projected to continue to grow to 3.2 percent of GDP by 2021. Medicaid expenditures are projected to increase about 1.4 percentage points faster than GDP on average per year from 2012 through 2021, with much of this difference due to the eligibility expansion. The Affordable Care Act accounts for the majority of the difference between projected Medicaid expenditure and GDP growth rates over the 10 years; about 1.1 percentage points of the 1.4-percentage-point differential are attributable to the estimated impacts of the Affordable Care Act, most notably the eligibility expansion.

This projection of Medicaid expenditures as a share of GDP is substantially less than the projection included in last year's report. The share of GDP devoted to Medicaid in 2020 is projected to be 3.2 percent, about 0.6 percentage point lower than in the 2011 projection. Medicaid expenditures are projected to grow much more slowly than in last year's report, driven by lower 2012 spending, a smaller increase related to the Medicaid eligibility expansion, and slower per enrollee cost growth, while projected GDP growth in the 2012 Medicare Trustees Report is slightly faster than was projected in 2011.

VI. CONCLUSION

Medicaid expenditures are estimated to have grown relatively slowly in 2012 and to have reached \$432.0 billion. Faster growth is expected to resume after 2012, especially in 2014 with the expansion in eligibility standards, and expenditures are projected to grow to \$795.0 billion by 2021. The projected annual average growth rate of Medicaid expenditures from 2012 to 2021 is 6.4 percent—notably faster than the projection of average annual GDP growth of 5.0 percent. Should these trends continue as projected under current law, Medicaid’s share of both Federal and State budgets would continue to expand absent other changes to the program, budget expenditures, or budget revenues.

The expansion of Medicaid eligibility under the Affordable Care Act will likely broaden Medicaid’s role as part of the U.S. health care system. This growing importance, however, also increases the likelihood that health care-related issues and concerns will necessarily involve Medicaid to a greater extent than in the past.

With the eligibility expansion scheduled to begin in 2014, it is important to note the uncertainty of future Medicaid spending and enrollment levels. Significant work and decisions remain before 2014, including the conversion of the income eligibility criteria to a modified adjusted gross income (MAGI) basis, the creation of the health insurance exchanges, and the States’ decisions about whether or not to implement the Medicaid eligibility expansion. In addition, many other provisions of the Affordable Care Act that affect Medicaid—directly and indirectly—are still in the process of being implemented. Even though this legislation was enacted nearly 3 years ago, there is still a great deal that is unknown about Medicaid’s near future; accordingly, the actual expenditures, enrollment, and effects of the Act may differ significantly from the estimates and projections presented in this report.

Because Medicaid does not have any dedicated revenue source at the Federal level or a trust fund approach to financing, the solvency of the program is not an issue; the expenditures of each State (or Territory) program are covered by the State’s revenues plus Federal matching general revenues. However, even without solvency as a concern, Medicaid constitutes a significant portion of spending by both Federal and State governments and thus is important to evaluate as part of the budget.

Despite the amount of time that has passed since the end of the recession, some of its effects on Medicaid still remain. Enrollment is projected to have grown more quickly than the U.S. population in 2012, albeit at slower rates than in recent years. The expiration of the temporary Federal matching rate increases led to substantial increases in State Medicaid expenditures, but States’ budget revenues have not kept pace; these conflicting trends appear to have been a significant reason for the relatively slow rate of Medicaid expenditure growth in 2012. The extent to which States continue to undertake efforts to slow the rate of Medicaid expenditure

growth will be of major importance in the next several years. Future economic growth and employment levels also will likely have a strong influence on Medicaid; projections of expenditures and enrollment should be considered in light of the economic assumptions underlying them.

As the program's costs are projected to increase over the next 10 years, in a manner similar to the expenditure projections for private health insurance and Medicare, any efforts to slow the cost of health care spending will likely have some direct or indirect impact on Medicaid. Whether such efforts are focused on the payment or management of health care specific to certain programs, or on the delivery or practice of health care generally, it will be important to consider the potential effects not just on Medicaid but across all health-care payers. Programs and demonstrations that focus on health care provided for persons enrolled in both Medicare and Medicaid (dual-eligible beneficiaries), or that focus on Medicare but also include some dual-eligible beneficiaries, may have some effects on the costs and quality of care paid for by Medicaid.

Particular attention may need to be given to the ways in which Medicaid is different from other types of health care coverage—for example, in administration, the benefits offered, the populations covered, and the ways in which it pays for health care. Further attention may need to be given to provider participation, Medicaid payment rates, and beneficiary access to services.

VII. APPENDIX

A. MEDICAID DATA SOURCES

The primary sources for Medicaid statistical data used in the projections of Medicaid expenditures and enrollment are the Medicaid Statistical Information System (MSIS) and the CMS-64 and CMS-37 reports.

Medicaid Statistical Information System (MSIS)

MSIS is the basic source of State-submitted eligibility and claims data on the Medicaid population, its demographic characteristics, utilization of health care services, and payments. The purpose of MSIS is to collect, manage, analyze, and disseminate information on eligible individuals, beneficiaries, utilization, and payment for services that are covered. States provide CMS with quarterly computer files consisting of specified data elements for persons covered by Medicaid and adjudicated claims for medical services reimbursed with Title XIX funds. Four types of claims files representing inpatient, long-term care, prescription drugs, and non-institutional services are submitted. Claims records contain information on the types of services used, providers, service dates, costs, and types of reimbursements. Eligibility characteristics, such as basis-of-eligibility and maintenance assistance status, are the foundation of OACT's demographic projections; specifically, the primary basis-of-eligibility categories include aged persons, blind or disabled persons, non-disabled children (including foster care children), and non-aged non-disabled adults (including women eligible under the Breast and Cervical Cancer Act eligibility expansion). MSIS data are made available in several different files; generally, the analysis presented in this report has relied on the Annual Person Summary (APS) files.

CMS-64 and CMS-37 Reports

The CMS-64 and CMS-37 reports are products of the Medicaid and CHIP Budget and Expenditure Systems (MBES/CBES). These reports are submitted by the States quarterly. The CMS-64 provides current fiscal year spending, while the CMS-37 provides State budgeted amounts for the next 2 fiscal years. The expenditure amount shown on the CMS-64 report is a summary of expenditures for the various mandatory and optional services covered by the Medicaid State programs.

The mandatory services contained in the CMS-64 and CMS-37 reports include inpatient and outpatient hospital care, physician services, nursing facility care for individuals aged 21 or older, family planning services, rural health clinic services, home health care, laboratory and x-ray tests, other practitioner services, federally qualified health centers, and early and periodic screening, diagnostic, and treatment services for children under 21 (EPSDT). Among the many reported

optional services that States may provide are clinic services, prescription drugs, intermediate care facilities for the intellectually disabled, hospice care, home and community-based care to certain persons with chronic impairments, and targeted case management services. Additionally, these reports capture expenditures for disproportionate share hospital (DSH) payments, offsets to drug spending through rebates, Medicare Parts A and B premiums paid for those dually eligible for both Medicare and Medicaid, premiums paid for Medicaid-only capitated arrangements, and expenditures for home and community-based waiver programs.

Users of Medicaid data may note discrepancies between the expenditure information captured in MSIS and the CMS-64. For example, DSH payments and Medicare premiums do not appear in MSIS. Whereas actual payments are reflected in the CMS-64, in MSIS adjudicated claims data are used. Service definitions vary in these two sources, as well. Territorial data for American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands appear in the CMS-64, but not in MSIS. Each State has a different system for capturing statistical (MSIS) and financial (CMS-64/37) data.

B. DEMOGRAPHIC, ECONOMIC, AND HEALTH CARE ASSUMPTIONS

The primary demographic, economic, and health cost inflation assumptions underlying the Medicaid projections shown in this report are the same as those used by the OASDI and Medicare Boards of Trustees in their annual reports to Congress. Growth in the number of Medicaid enrollees in each eligibility category—aged, blind or disabled, children, and adults—is initially projected based on past growth trends. These growth rates are assumed to gradually transition to rates comparable to the general population by the end of the 10-year projection period. The Trustees’ population projections depend on assumed future birth rates, mortality rates, and net immigration rates.⁵⁶

The principal economic assumptions include growth in average wages and the consumer price index (CPI). These and other assumptions are used to generate health care service input price indices (or “market baskets”) for inpatient hospital and home health care services. These indices serve as indicators of increases in Medicaid payments per service. (See next section.)

Projected Medicaid costs for paying Medicare Part A premiums on behalf of enrollees who do not directly qualify for Medicare based on their work in covered employment, and for paying Part B premiums for dual beneficiaries, are available directly from the projections prepared by OACT for the Medicare Board of Trustees.

⁵⁶ Further information on the Trustees’ population projections and economic assumptions is available in the 2012 OASDI and Medicare Trustees Reports.

The proportion of enrollees in Medicaid managed care plans and the cost of capitation payments to such plans are projected based on historical growth trends.

C. ADDITIONAL PROJECTION METHODOLOGY DETAIL

This section provides additional detail concerning the “residual” cost growth assumptions for the Medicaid projections in this report. The trend residual approach to projecting Medicaid expenditures begins with an analysis of historical Medicaid expenditures per enrollee on a service-by-service basis. The annual percent change in these per capita expenditures is compared to changes in the applicable price indicator (listed below), and the differential, or residual, is calculated. This residual measures the collective impact of changes in utilization and “intensity” (average complexity) of services, case mix effects, and other factors. The price indicator may be lagged in order to obtain a residual that is as small and stable as possible. The residual is typically assumed to remain constant at its historical average value and is then combined with caseload growth and the Medicare Trustees’ forecast of change in the applicable price indicator to obtain projected expenditures, as indicated in section IV, equation (2).

The table below displays the price indicators currently used to produce Medicaid expenditure projections.

Type of Service	Price Indicator
Inpatient and outpatient	Medicare hospital input price index (market basket), before the application of productivity
Physician, clinic, and related	Average wage increase
Institutional long-term care	Maximum of CPI increase and average wage increase
Community long-term care	Medicare home health input price index, before the application of productivity adjustment
Prescription drugs	CPI increase

One exception to the trend residual methodology occurs in the case of capitated services and other premiums. Expenditures for capitation payments are projected by trend analysis of average per capita payments for Medicaid capitated services. Costs for other premiums for Medicare are based on the Trustees’ projected premium rates for Medicare Parts A and B. The proportions of aged and blind or disabled enrollees who are “bought into” Medicare by the States or the Federal government through premium payments are assumed to remain at historical levels.