

Department of Health & Human Services



2013 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

2013 ACTUARIAL REPORT ON THE FINANCIAL OUTLOOK FOR
MEDICAID

Kathleen Sebelius
Secretary of Health and Human Services
2013

2013 ACTUARIAL REPORT ON THE FINANCIAL OUTLOOK FOR MEDICAID

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STATEMENT FROM THE CHIEF ACTUARY

The Medicaid program is of critical importance to American society. It is the second largest health program as measured by expenditures (second only to Medicare) and the largest as measured by enrollment, and Medicaid represents one-sixth of the health economy. In 2012, its outlays of \$432 billion accounted for a sizeable portion of Federal and State budgets and were a significant source of revenue for health care providers and insurers. As importantly, Medicaid serves as a safety net for the Nation's most vulnerable populations, covering nearly 58 million beneficiaries in 2012. In this report, we analyze key historical Medicaid trends—both financial and demographic—and include projections of expenditures and enrollment to inform the public and help policy makers gain insight into the future of the program.

Projections of health care costs are inherently uncertain. For Medicaid, such projections present an even greater challenge as enrollment and costs are very sensitive to economic conditions. The economic assumptions used to generate the Medicaid projections in this report are the same as those used by the 2013 OASDI and Medicare Boards of Trustees in their annual reports to Congress.

The projections in this report also include the expected significant effects of the Affordable Care Act. This legislation 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, as well as increased participation among people eligible under the current criteria. We estimate that the Act will increase the number of Medicaid enrollees by about 18 million in 2022 and that Medicaid costs will grow significantly as a result of these changes starting in 2014. The effects of the newly eligible population and of other provisions of the Affordable Care Act are presented throughout the report.

The Medicaid program experienced its lowest underlying cost growth trend in 2012 as States acted to reduce provider payment rates and/or optional benefits. Despite this low total program growth, State spending on Medicaid increased by nearly 40 percent from 2010 to 2012 as the temporary increases in Federal matching rates expired. We anticipate that the general budgetary constraints will remain into the future and that cost growth for 2012 will be the low point of this trend. In 2013, projected growth will accelerate and will continue thereafter at rates corresponding more closely with those experienced over the last two decades.

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. 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). These projections—in particular those of the impacts of the Affordable Care Act—are subject to uncertainty.

HIGHLIGHTS AND FINDINGS

2012 Medicaid Information

- Total Medicaid outlays in Federal fiscal year (FY) 2012 were \$431.9 billion; \$250.5 billion or 58 percent represented Federal spending, and \$181.4 billion or 42 percent represented State spending. The Federal government's share of Medicaid outlays decreased to 58 percent in 2012 (from 64 percent in 2011) 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 0.8 percent in 2012, which was the second-lowest rate of growth in the program's history, as States acted to limit the rate of growth of expenditures while the States' share of costs increased.
- Medicaid provided health care assistance for an estimated 58.6 million people on average in 2012. An estimated total of 72.2 million people, or about one of every five persons in the U.S., were enrolled in Medicaid for at least one month in 2012. Enrollment is estimated to have grown by 2.2 percent.
- Per enrollee spending for health goods and services was estimated to be \$6,641 in 2012. Estimated per capita spending for children (\$2,700) and adults (\$4,101) was much lower than that for aged (\$15,688) and disabled (\$17,255) beneficiaries, reflecting the differing health statuses of, and use of goods and services by, the members of these groups. Per enrollee spending is estimated to have decreased by 1.9 percent in 2012.

2013 Medicaid Estimates

- Medicaid expenditures are projected to have increased 5.9 percent to \$456.4 billion in 2013. The Federal government is projected to have paid \$262.2 billion, or about 57 percent of that total. Faster growth is anticipated to have occurred as the result of States taking fewer actions to reduce the rate of expenditure growth than in recent years. The Affordable Care Act is expected to have contributed to a small increase in expenditures in 2013.

- Average Medicaid enrollment is projected to have increased 0.7 percent to 59.1 million people in 2013. Increases in the number of people eligible and enrolling in Medicaid are projected to have slowed as the economy continued to improve and the unemployment rate decreased. This would be the slowest rate of enrollment growth since 2007.

10-Year Medicaid Projections

- Over the next 10 years, expenditures are projected to increase at an average annual rate of 7.1 percent and to reach \$853.6 billion by 2022.
- Average enrollment is projected to increase at an average annual rate of 3.3 percent over the next 10 years and to reach 80.9 million in 2022.
- Both averages reflect the anticipated significant increase in Medicaid enrollment that began in 2014 as a result of the expansion of Medicaid eligibility under the Affordable Care Act.

Affordable Care Act Impacts

- The Affordable Care Act is projected to increase Medicaid expenditures by a total of \$500 billion for 2013 through 2022, an increase of about 8 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 (\$485 billion, or about 97 percent), which would be about 14 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 5.8 million people to enrollment in FY 2014 and 18.4 million people by FY 2022—10 percent and 29 percent, respectively, compared to current pre-Affordable Care Act estimates. These estimates are based on the assumption that 45 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.
- Of the estimated \$500-billion increase in Medicaid expenditures for 2013 through 2022 attributable to the Affordable Care Act, most is due to the eligibility expansion and the increase in enrollment of people eligible for Medicaid under current criteria. These changes are projected to increase Medicaid expenditures by a total of \$496 billion through 2022, with the majority of the costs to be paid by the Federal government (\$433 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. The Centers for Medicare & Medicaid Services (CMS) is the agency charged with administering Medicaid for the Federal government.

This is the fifth 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 Federal fiscal years (FYs) 2012 and 2013 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 January 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 who are living in families with income below 138 percent of the Federal poverty level (FPL) (and who are citizens or eligible legal residents).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, States must provide the same benefit package to all core Medicaid enrollees. Exceptions to these requirements include the use of waivers, demonstration projects, and alternative benefit plans. In addition, there may be limited benefits provided for individuals who are eligible based only on medical need, through Medicare savings programs, or through special family planning or

¹ For more information on Medicaid, including information on eligibility and covered services, see B. Klees, C. Wolfe, and C. 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.

pregnant women eligibility groups.³ Additionally, States must extend eligibility to all mandatory populations and cover all mandatory services defined by Title XIX in order to receive Federal matching funds for their Medicaid programs.⁴

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.⁵ 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 goods and 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 The Medicare Savings Programs provide assistance to low-income aged and disabled persons for their share of Medicare costs. Different programs cover a combination of the beneficiary's Part A premium, Part B premium, Part A deductible, and Part B cost-sharing requirements.

⁴ 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).

⁵ In general, Title XIX specifies that the FMAP for each State cannot be lower than 50 percent or higher than 83 percent; in FY 2012, FMAPs ranged from 50.00 percent to 74.18 percent. Also, Title XIX provides for specific FMAP levels for certain States. The Affordable Care Act specifies different FMAPs 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 of the population 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 describe these trends.⁶

⁶ This report does not cover expenditures and enrollment under the Children’s Health Insurance Program (CHIP), whether operated under Title XIX or Title XXI of the Social Security Act. CHIP provides health coverage to many children in households with income above Medicaid eligibility levels.

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 goods and 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 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.⁷ The States provide a quarterly report of spending by type of service; this report, known as the CMS-64, includes the separate Federal and State 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. MSIS expenditure data only include total Medicaid expenditures, and do not provide data separately for Federal or State expenditures. OACT makes several adjustments to these data to merge them together for use in preparing projections.⁸

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.⁹ 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

⁷ 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> and <http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/MSIS/Medicaid-Statistical-Information-System.html>. Additional detail is provided in the Appendix.

⁸ The MSIS data used for the analysis presented in this report are derived from the Annual Person Summary (APS) files.

⁹ *The 2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (<http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2013.pdf>) and *The 2013 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds* (<http://www.ssa.gov/OACT/TR/2013/tr2013.pdf>).

2013 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.¹⁰

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.¹¹ OACT developed and used the OHRM to estimate the impact of proposed health care reform legislation, including the Affordable Care Act as enacted, and subsequently used the model to estimate the anticipated effects of implementing this law. The estimates from the OHRM are used to develop 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. As a result, this report also relies on the data and assumptions used by the OHRM.¹²

In addition, OACT developed assumptions regarding States' decisions to implement the eligibility expansion. 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 Medicaid state plan amendments and public information and statements for each State regarding its intent to implement the expansion in 2014. Based on this information, OACT assumed that 45 percent of all people who are potentially newly eligible Medicaid enrollees in 2014 would

¹⁰ These assumptions are different from those used for projections in the President's Fiscal Year 2015 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.

¹¹ More information on MEPS can be found at <http://meps.ahrq.gov/mepsweb/>.

¹² More information is contained in the memorandum titled "Estimated Financial Effects of the Patient Protection and Affordable Care Act, as Amended," which is available 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.

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 assumed that the participation rate of persons eligible under current criteria would also increase starting in 2014. Even in States that do not expand eligibility, OACT assumed that there would be increases in participation among currently eligible persons but that the rate of increase would be about 20 percent less than in States that do expand eligibility.

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 sometime in the future). 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.¹³

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) excluding the impacts of the eligibility expansion under the Affordable Care Act ("without 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. OACT develops the NHE data and projections.¹⁴

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 2010, though data for some States are available from 2011, and the MSIS is the only available source of complete enrollment data. Consequently, to relate 2011 and 2012 actual expenditures to the number of enrollees, OACT has made estimates of Medicaid enrollment for both years. MSIS also does not provide data on enrollment

¹³ See "Frequently Asked Questions on Exchanges, Market Reforms and Medicaid," December 10, 2012: <http://medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/>.

¹⁴ 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.*, "National Health Spending in 2012: Rate of Health Spending Growth Remained Low for the Fourth Consecutive Year," *Health Affairs*, January 2014; 33:67-77; and G. Cuckler, *et al.*, "National Health Expenditure Projections, 2012-22: Slow Growth Until Coverage Expands and Economy Improves," *Health Affairs*, October 2013; 32:1820-1831.

in Territory programs, and thus enrollment figures for Territories are estimated from previous data.

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, although OACT reviewed the data sources used in these projections, OACT 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 25, 2013. 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. 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, or (iii) any further changes in the legislation governing Medicaid.

IV. METHODOLOGY

This section 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.¹⁵ 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. Projections of future enrollment by eligibility category are based on estimates of the

¹⁵ 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.

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 (although these factors are somewhat correlated). These factors 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 2013 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.¹⁶ 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.¹⁷ This model is based on the MEPS, reweighted to match the spending and insurance coverage estimates of the 2012-2022 NHE projections.¹⁸ 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 the application process 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

¹⁶ More details on the trend residual methodology are included in the Appendix.

¹⁷ More information is contained in the memorandum titled “Estimated Financial Effects of the Patient Protection and Affordable Care Act, as Amended,” which is available 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 information on the implementation of the many sections of the Affordable Care Act.

¹⁸ Cuckler, *et al.*, “National Health Expenditure Projections, 2012-22: Slow Growth Until Coverage Expands and Economy Improves.”

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 equal share would be expected to be spent on acute care fee-for-service for newly eligible children.) OACT separately developed estimates of the other sections of the Affordable Care Act that affect Medicaid and added these estimates 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 2012 MEDICAID OUTLAYS AND ENROLLMENT

The Federal government and the States collectively spent \$431.9 billion for Medicaid in 2012. Of this amount, the Federal government paid \$250.5 billion, representing about 58 percent of net program outlays, and the States paid \$181.4 billion, or about 42 percent of net outlays. Table 1 summarizes total Medicaid outlays for 2012.

Table 1—Medicaid Outlays for Fiscal Year 2012 by Type of Payment
(in billions)

| Title XIX Outlays ¹ | Federal Share | State Share | Total |
|---|---------------|--------------|--------------|
| Medical Assistance Payments: | | | |
| Acute Care Benefits ² | \$80.3 | \$57.2 | \$137.5 |
| Long-Term Care Benefits ² | 64.9 | 49.6 | 114.4 |
| Capitation Payments and Premiums ² | 76.6 | 55.9 | 132.5 |
| Disproportionate Share Hospital (DSH) Payments ² | 8.0 | 6.1 | 14.1 |
| Adjustments ³ | 4.0 | 4.0 | 8.0 |
| Subtotal, Medical Assistance Payments | 233.8 | 172.7 | 406.4 |
| Administration Payments | 13.9 | 8.8 | 22.6 |
| Vaccines for Children Program | 3.6 | — | 3.6 |
| Gross Outlays | 251.2 | 181.5 | 432.7 |
| Collections ⁴ | -0.7 | -0.1 | -0.7 |
| Net Outlays | 250.5 | 181.4 | 431.9 |

Totals may not add due to rounding.

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—94 percent of total outlays in 2012—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 FFS 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. 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 2012, accounting for \$137.5 billion or 34 percent of Medicaid expenditures on benefits. Capitation payments and other premiums were nearly as large, constituting \$132.5 billion or 33 percent of benefit expenditures. Medicaid spending for long-term care amounted to \$114.4 billion, representing 28 percent of expenditures on benefits. DSH payments accounted for \$14.1 billion, or 3 percent, of Medicaid benefits in 2012.

Medicaid outlays for program administration totaled \$22.6 billion in 2012—\$13.9 billion in Federal outlays and \$8.8 billion in State outlays—and represented 5 percent of Medicaid outlays. Included in administration outlays were \$4.7 billion in health information technology incentive payments to providers.¹⁹ Medicaid also provided \$3.6 billion of funding in 2012 for the Vaccines for Children program (all Federal funding).²⁰

At the time this report was prepared, the latest complete Medicaid enrollment data available were from 2010. Accordingly, enrollment by eligibility group (children, adults, aged, and disabled) has been estimated for 2011 and 2012, incorporating information from States with data available in those years.²¹

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 2012, Medicaid enrollment was estimated to be 58.6 million PYE (including enrollment in the U.S. Territories). An estimated 72.2 million people, or slightly more than one in five in the U.S. or Territory residents, were ever-enrolled.

Table 2 shows estimated enrollment by eligibility group for 2012 (excluding Territory programs). Historically, children have been the largest group of Medicaid

¹⁹ Health information technology incentive payments were provided for by the American Recovery and Reinvestment Act of 2009 and are paid entirely by the Federal government. This figure does not include payments to States to administer the health information technology incentive payment program.

²⁰ 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.

²¹ 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.

enrollees. In 2012, this group is estimated to have represented 28.3 million PYE, or 49 percent of overall Medicaid enrollment. Adults made up an estimated 14.6 million PYE (25 percent), while disabled enrollees and aged enrollees are estimated to have accounted for 9.7 million and 5.1 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—2012 Estimated Enrollment, Expenditures, and Estimated Per Enrollee Expenditures, by Enrollment Group¹

| Eligibility Group | Enrollment ² (in millions) | Expenditures (in billions) | Per enrollee spending |
|-------------------|--|-------------------------------|--------------------------|
| Children | 28.3 | \$76.3 | \$2,700 |
| Adults | 14.6 | 60.0 | 4,101 |
| Disabled | 9.7 | 166.8 | 17,255 |
| Aged | 5.1 | 79.7 | 15,688 |
| Total | 57.6 | 382.8 | 6,641 |

Totals may not add due to rounding.

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

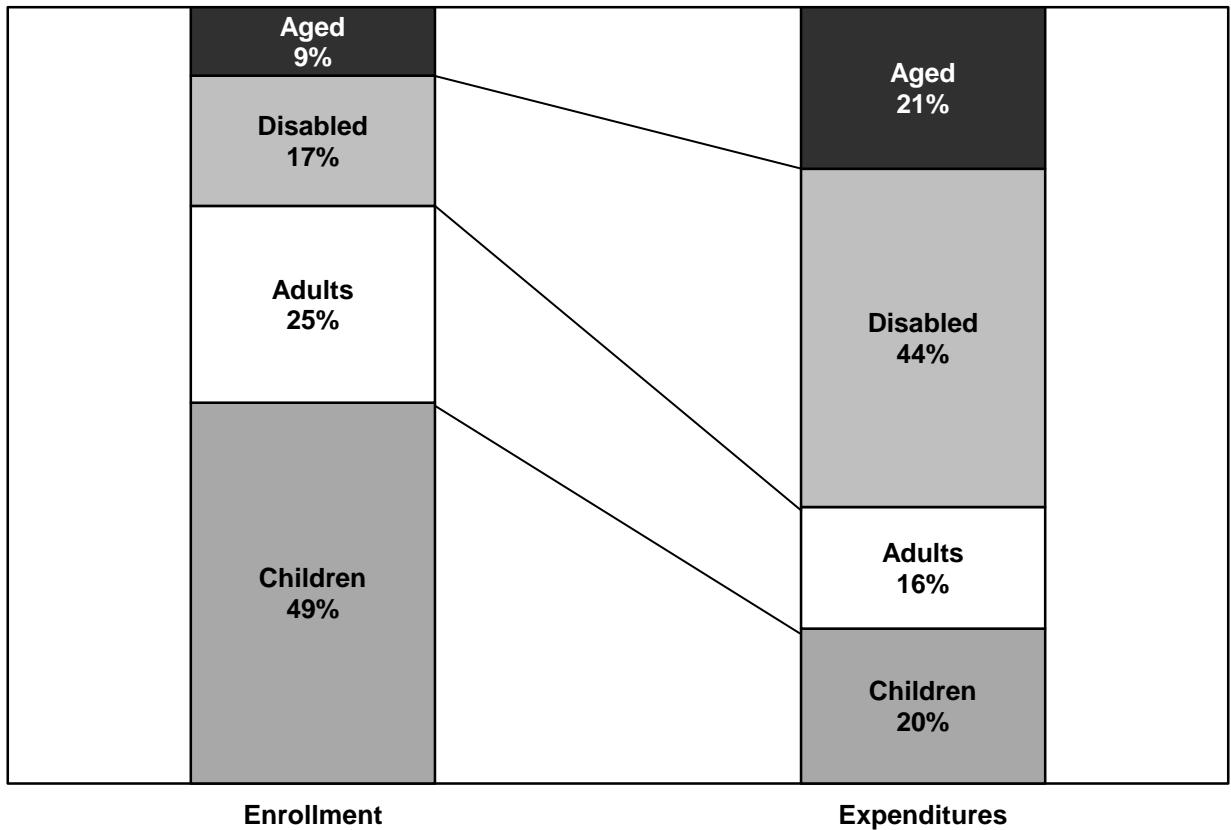
² Measured in person-year equivalents.

The average per enrollee cost for 2012 was estimated to be \$6,641 (based on PYE enrollment and excluding DSH outlays, Territorial enrollees and costs, adjustments, and administration costs). Children in Medicaid received an estimated \$2,700 in benefits on average in 2012, and adults received an estimated average of \$4,101 in benefits. In both instances, these average costs reflect the relatively favorable health status of the enrollment groups; however, among adult enrollees, a significant number of enrollees are pregnant women, whose costs are on average relatively greater. As would be expected, expenditures are substantially greater for the aged and the disabled; aged beneficiaries received an estimated \$15,688 in benefits on average, and disabled beneficiaries are estimated to have received an average of \$17,255 in benefits.²²

Figure 1 shows each enrollment group's relative share of enrollment and expenditures in Medicaid in 2012. 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.

²² The average per enrollee costs may also vary substantially among States. These variations may reflect differences in State Medicaid programs (for example, eligibility levels, benefits offered, provider reimbursement rates, or program design) and differences in the overall health care market across States.

Figure 1—Estimated Medicaid Enrollment and Expenditures by Enrollment Group, as Share of Total, Fiscal Year 2012¹



¹ Totals and components exclude DSH expenditures, Territorial enrollees and expenditures, and adjustments. Totals may not add to 100 percent due to rounding.

Combined, spending on aged and disabled beneficiaries constituted 64 percent of Medicaid benefit expenditures in 2012, but these groups accounted for only 26 percent of all enrollees. Children and adults represented 74 percent of all enrollees in 2012, while only 36 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.²³

²³ In 2009, Medicaid expenditures for persons eligible for Medicare and full Medicaid benefits (full-benefit dual-eligible beneficiaries) amounted to \$108.3 billion, and Medicare expenditures for these persons were \$130.2 billion, for a total of \$238.5 billion in expenditures between both programs. Medicaid accounted for about 45 percent of the total spending on dual-eligible beneficiaries. In addition, for persons eligible for Medicare and limited Medicaid benefits (generally payments for Medicare premiums or cost sharing), Medicaid benefits are typically an even smaller proportion of their total benefits (\$1.7 billion of \$33.5 billion, or about 5 percent, in 2009). See *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid*, Medicare Payment Advisory Commission and Medicaid and CHIP Payment and Access Commission, 2013.

B. HISTORICAL MEDICAID TRENDS

Since the start of the program, the year-to-year growth rates of total Medicaid expenditures (Federal and State expenditures combined) and enrollment have varied substantially, as can be seen in figure 2 and figure 3. 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 2022

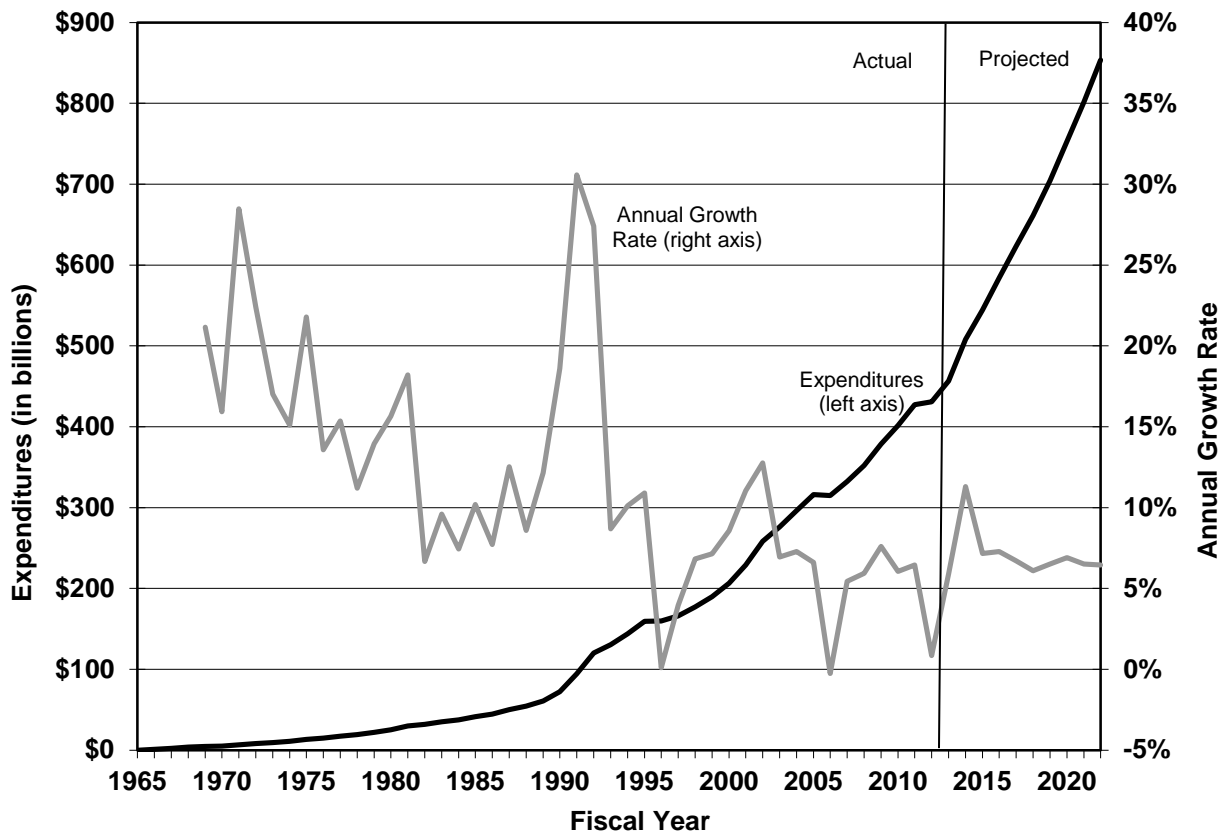
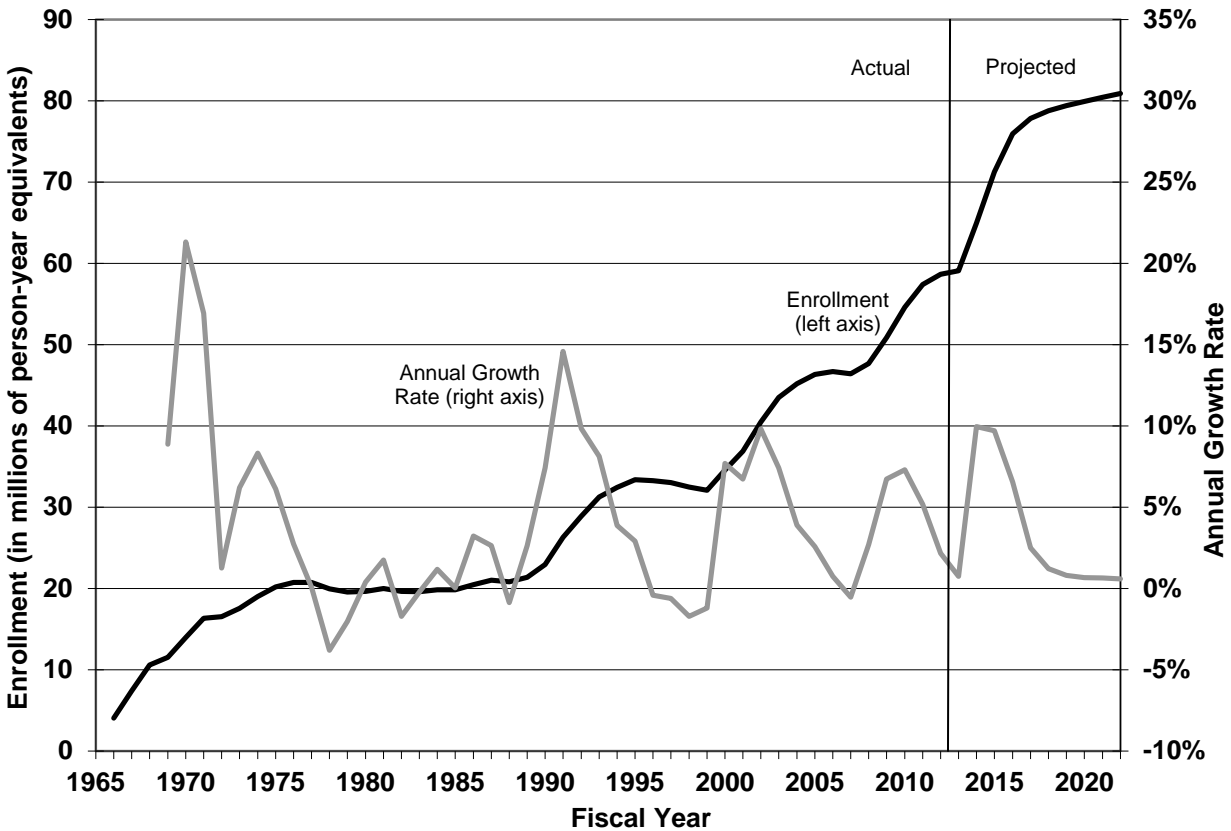


Figure 3—Historical and Projected Medicaid Enrollment and Annual Growth Rates, FY 1966–FY 2022



From 2000 to 2005, Medicaid expenditures grew at an average annual rate of 8.8 percent, which was faster than the average rate over the previous 6 years (6.4 percent). 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.²⁴

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 more rapidly than they had in the past and economic growth was slower, many of the States’ efforts were focused on controlling

²⁴ 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. Additional detail on past historical trends can also be found in the *2012 Actuarial Report on the Financial Outlook for Medicaid* (<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/medicaid-actuarial-report-2012.pdf>).

program growth rather than on expanding their Medicaid programs.²⁵ Partially offsetting this slowdown in program expenditures 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. 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 programs.

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.²⁶ 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, although 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 benefit expenditures 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

²⁵ 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.

²⁶ Medicaid still provides some prescription drug coverage for dual-eligible beneficiaries for categories of drugs that Medicare Part D does not cover.

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 increased by 7.3 percent, reflecting continuing relatively higher unemployment rates and a slowly improving economy.

Medicaid expenditures grew slightly more rapidly 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.²⁷ Enrollment is estimated to have grown at a rate of 5.2 percent as the unemployment rate decreased and economic growth was slow but positive. Medicaid expenditures per enrollee increased at an estimated rate of 1.2 percent in 2011. Slow growth in Medicaid expenditures per enrollee was driven by relatively faster enrollment growth of lower-cost populations, slower growth in medical inflation, and States' efforts to constrain program expenditure growth, such as limiting provider payment increases and restricting benefits.

In 2012, Medicaid expenditures increased by only 0.8 percent, while enrollment is estimated to have grown by 2.2 percent. The resulting decrease in per enrollee cost of 1.3 percent reflects States' continued efforts to limit the rate of growth of Medicaid expenditures. States have continued to implement reimbursement rate reductions or freezes for health care providers and optional benefit limits or reductions, and to increase the use of managed care.²⁸ In addition, supplemental payments to providers decreased by \$2.1 billion (or 10.3 percent); excluding these supplemental payments, Medicaid expenditure growth would have been about 0.5 percentage point faster.

It is also important to note the impact of the American Recovery and Reinvestment Act (ARRA) of 2009 on Medicaid expenditures over the past several years. ARRA provided for a higher temporary FMAP for all States retroactive to the beginning of

²⁷ Health information technology incentive payments were provided for by the American Recovery and Reinvestment Act of 2009 and are paid entirely by the Federal government.

²⁸ 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 in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014," Kaiser Family Foundation; October 2013.

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 \$32.9 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. As the temporary FMAP increases ended in 2011, the Federal share of expenditures fell to 58 percent in 2012, and Federal Medicaid expenditures decreased 8.1 percent from 2011 to 2012; conversely, State Medicaid expenditures increased 16.3 percent.²⁹

²⁹ 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 2013–FY 2022*

The projections presented in this report focus on Medicaid medical assistance payments (or “benefit” expenditures) and Medicaid enrollment; administration costs are also included and are based on the projections from the President’s Fiscal Year 2014 Budget Mid-Session Review. 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 3.³⁰

³⁰ 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 | 54.6 | 401.5 | 269.8 | 131.7 | 67% |
| 2011 | 57.4 ¹ | 427.4 | 270.7 | 156.7 | 63% |
| 2012 | 58.6 ¹ | 431.0 | 248.8 | 182.2 | 58% |
| Projections: | | | | | |
| 2013 | 59.1 | 456.4 | 262.2 | 194.2 | 57% |
| 2014 | 65.0 | 508.0 | 304.4 | 203.6 | 60% |
| 2015 | 71.3 | 544.4 | 328.4 | 216.0 | 60% |
| 2016 | 75.9 | 584.0 | 353.8 | 230.2 | 61% |
| 2017 | 77.8 | 623.2 | 376.5 | 246.7 | 60% |
| 2018 | 78.8 | 661.2 | 399.2 | 262.0 | 60% |
| 2019 | 79.4 | 704.2 | 425.0 | 279.3 | 60% |
| 2020 | 79.9 | 752.8 | 451.4 | 301.4 | 60% |
| 2021 | 80.4 | 801.8 | 480.2 | 321.6 | 60% |
| 2022 | 80.9 | 853.6 | 511.1 | 342.5 | 60% |

¹ Enrollment is projected for 2011 and 2012.

Expenditures

Total Medicaid expenditures (Federal and State expenditures combined) for medical assistance payments and administration are estimated to have grown 5.9 percent in 2013 to \$456.4 billion and are projected to reach \$853.6 billion by 2022, increasing at an average rate of 7.1 percent per year over the next 10 years.³¹ Federal government spending on Medicaid medical assistance payments and administration costs is estimated to have increased by 5.4 percent to \$262.2 billion in 2013, representing about 57 percent of total Medicaid benefit expenditures. Federal spending on Medicaid is projected to reach \$511.1 billion by 2022, or about 60 percent of total spending. Total State Medicaid expenditures for benefits and administration are estimated to have increased to \$194.2 billion in 2013, a growth rate of 6.6 percent following 16.3-percent growth in 2012, and are projected to reach \$342.5 billion by 2022.³²

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 Medicaid expenditures is projected to vary over the next 10 years due to several acts of legislation. In recent history, the average annual Federal share has been about 57 percent of total expenditures, with several years of greater Federal shares due to changes specified in legislation. The average Federal share is projected to be 57 percent in 2013, before rising in 2014—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 remains between 60 percent and 61 percent through 2022.

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

³¹ This increase reflects annual growth of 5.9 percent in 2013, a large increase of 11.3 percent in 2014 as the eligibility expansion under the Affordable Care Act takes effect, and average growth of 6.7 percent in 2015–2022, in part due to the continuing implementation of the Affordable Care Act.

³² The rapid growth in State Medicaid expenditures in 2012 is also due largely to the expiration of the temporary FMAP increases provided by ARRA and Public Law 111-226, as the States' share of Medicaid expenditures increased from 37 percent in 2011 to 42 percent in 2012, and is projected to reach 43 percent in 2013.

**Table 4—Historical and Projected Medicaid Expenditures
for Medical Assistance Payments and Administration**
(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 |
| 2012 | 408.8 | 235.1 | 22.2 | 13.7 |
| Projections: | | | | |
| 2013 | 434.4 | 248.9 | 22.0 | 13.4 |
| 2014 | 484.7 | 290.4 | 23.3 | 14.0 |
| 2015 | 520.6 | 314.5 | 23.8 | 13.9 |
| 2016 | 559.3 | 339.4 | 24.7 | 14.3 |
| 2017 | 597.8 | 361.8 | 25.4 | 14.7 |
| 2018 | 635.4 | 384.5 | 25.9 | 14.7 |
| 2019 | 677.7 | 410.0 | 26.6 | 14.9 |
| 2020 | 725.3 | 436.0 | 27.5 | 15.4 |
| 2021 | 773.3 | 464.3 | 28.6 | 16.0 |
| 2022 | 823.9 | 494.5 | 29.7 | 16.6 |

Total Medicaid expenditures (Federal and State combined) for medical assistance payments are estimated to have grown 6.3 percent in 2013 to \$434.4 billion. This would be a significant acceleration in expenditure growth, since Medicaid expenditures on benefits grew only 0.2 percent in 2012. Medicaid expenditures on such payments are projected to reach \$823.9 billion by 2022, increasing at an average rate of 7.3 percent per year over the next 10 years. Federal government spending on these Medicaid payments is estimated to have amounted to \$248.9 billion in 2013 and is projected to grow to \$494.5 billion by 2022.

Growth in Medicaid benefit expenditures in 2013 was likely driven by several factors. More States increased provider payment rates in 2013 than in recent years. According to a survey of State Medicaid officials, 40 States increased rates for at least one category of providers in 2013, up from 33 States in 2012. In the same survey, fewer States reported reducing provider rates in 2013 (39 States) than in 2012 (44 States). Furthermore, more States reported expanding Medicaid benefits offered in 2013 than in 2012, and fewer States reported restricting benefits in the program in the past year.³³

One reason for the acceleration in Medicaid benefit expenditures in 2013 is the impact of the change in Federal matching rates over the last several years. As the temporary increases in the Federal share of Medicaid expenditures expired in 2011, the State Medicaid expenditure growth rates increased relatively more quickly in 2011 and 2012 (19.0 percent and 16.3 percent, respectively, for medical assistance payments and administration costs). Slower State Medicaid expenditure growth in 2013 may have led States to take fewer steps to limit the rate of growth in program expenditures.

Enrollment growth is estimated to have slowed from 2.2 percent in 2012 to 0.7 percent in 2013. Decelerations in enrollment growth are projected for children, adults, and disabled enrollees, while projected growth in aged enrollment is relatively steady. These trends reflect improvements in the unemployment rate and economic growth in 2013, as well as underlying population growth. Notably, the number of persons aged 65 and older in the U.S. is projected to increase substantially.

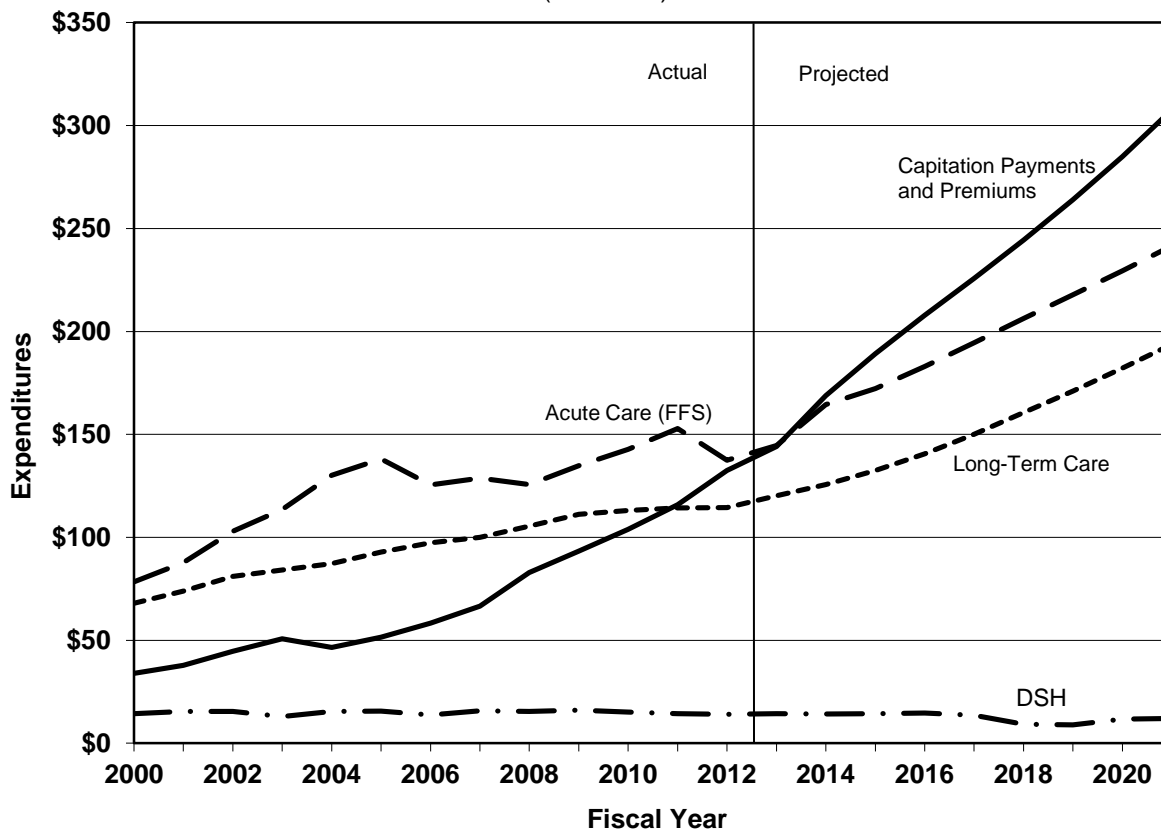
The effects of the Affordable Care Act are expected to have contributed a small amount to Medicaid expenditures in 2013, increasing total expenditures by \$1.7 billion and enrollment by about 0.2 million PYE. The increase in expenditures reflects the costs of early eligibility expansions in several States, payments to Territories, some expenditures for the increase in primary care physician payment rates, and additional administration expenditures. This increase is somewhat offset by prescription drug rebates and the estimated reductions in net expenditures from

³³ V. Smith, *et al.*, “Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014,” Kaiser Family Foundation; October 2013.

program integrity activities.³⁴ Excluding the impacts of the Affordable Care Act on expenditures in 2012 and 2013, Medicaid expenditure growth is projected to have been 5.2 percent, or 0.7 percentage point slower than the projected growth rate including the effects of the legislation.

Figure 4 shows historical and projected Medicaid benefit expenditures by four major categories of services: acute care fee-for-service; long-term care; capitation payments and premiums; and DSH.³⁵

Figure 4—Past and Projected Medicaid Expenditures for Medical Assistance Payments, by Type of Payment, FY 2000–FY 2022
(in billions)



Over the next 10 years, expenditures for capitation payments and premiums are expected to grow the fastest of the major Medicaid service categories, as shown in figure 4. These expenditures are projected to grow 9.6 percent per year on average from 2013 to 2022, which would be 2.3 percentage points faster than overall Medicaid benefit growth. Relatively faster projected growth in these payments is in

³⁴ Although the primary care physician payment increase mandated by section 1202 of the Affordable Care Act went into effect in January 2013, only a small portion of the increased payments were paid and reported in the first 9 months of 2013, as reflected in the revised estimates in this report. The projections in this report assume that the remainder of the estimated incurred payment increases would be paid and reported in 2014.

³⁵ The data points for selected figures in the report can be found in the Appendix.

part the result of the Medicaid eligibility expansion under 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, expenditures for capitation payments and premiums have grown substantially more quickly than other service expenditures in recent history. From 2001 to 2012, Medicaid payments for managed care plans and other premiums grew on average 12.0 percent per year, faster than overall Medicaid benefit expenditures (6.1 percent). The use of managed care plans within Medicaid has increased over the last 10 years, and this increase accounts for much of the difference between the capitation payment and overall Medicaid expenditure growth rates.³⁶

Acute care fee-for-service Medicaid expenditures are projected to grow at an average rate of 6.3 percent per year over the next decade. In 2013, these expenditures are estimated to have grown by 5.2 percent, and they are projected to increase 13.7 percent in 2014. This sharp increase is partly due to the increase in adult and child enrollees related to the eligibility expansion, as their costs are expected to be covered through both fee-for-service programs and managed care plans. In addition, the 2014 growth rate reflects the increased primary care physician payment rates provided by the Affordable Care Act.³⁷

Medicaid spending on long-term care is projected to grow by 6.0 percent on average for 2013 through 2022. The aging of the population is one contributing factor to growth in expenditures for long-term care. As the number of people aged 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 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 2013 through 2022, 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 are anticipated to have significant or immediate long-term care needs, several provisions in the legislation are expected to expand access to, and modestly increase 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

³⁶ Centers for Medicare & Medicaid Services, 2011 *Medicaid Managed Care Enrollment Report*.

³⁷ The projections in this report assume that most of the payments related to the primary care physician payment rate increases that were incurred in 2013 would be paid and reported in 2014; see footnote 34.

allotments, and subsequent legislation has extended those reductions through 2023. Thus, the average growth rate for DSH spending is projected to be -1.2 percent over the next 10 years.³⁸

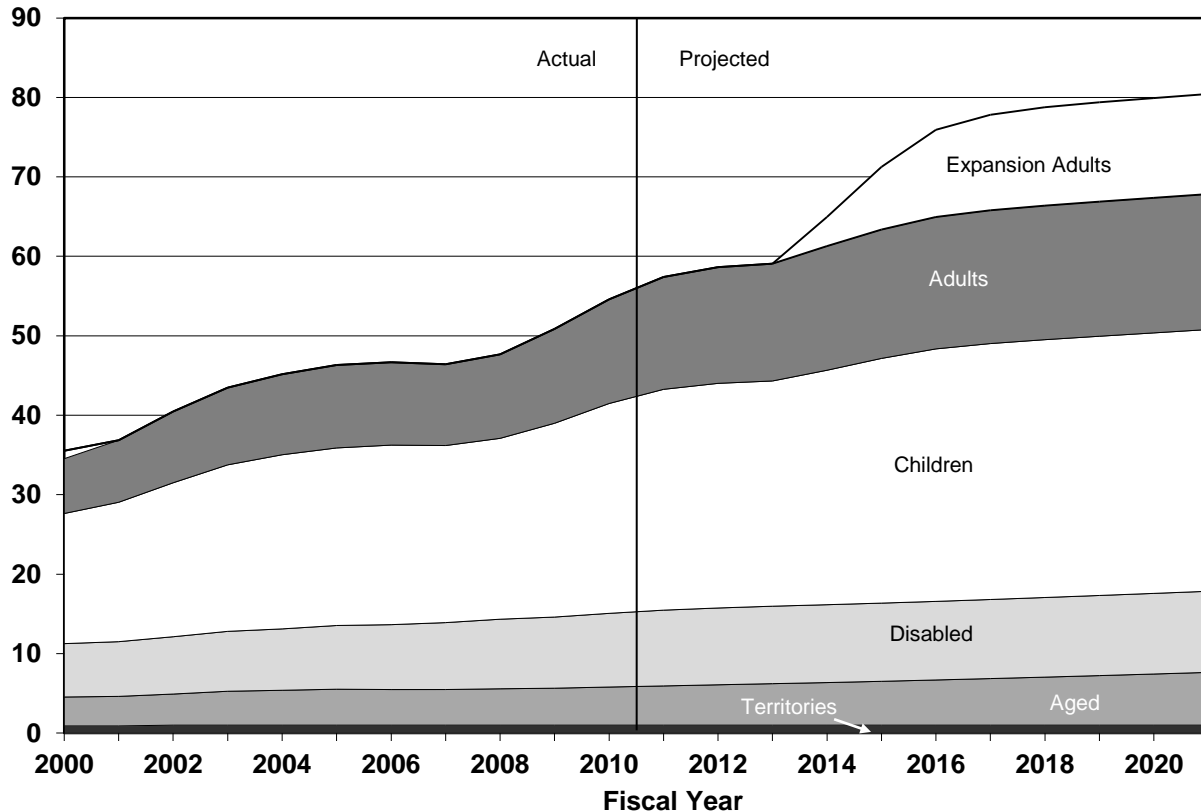
Administration costs are estimated to have been \$22.0 billion in 2013, reflecting a decrease of 0.7 percent. This decline follows a sharp increase in 2012 of 13.6 percent, which was primarily due to health information technology incentive payments to hospitals and other providers that were authorized by ARRA; these payments increased from \$0.5 billion in 2011 to an estimated \$4.7 billion in 2012. The estimated decline in 2013 is expected to occur as health information technology incentive payments decrease, while other administration costs are projected to increase. Administration costs are projected to reach \$29.7 billion by 2022, growing at an average annual rate of 3.0 percent. These projected costs include additional administration expenditures related to the Medicaid eligibility expansion under the Affordable Care Act.

Enrollment

Increasing levels of Medicaid enrollment are expected to contribute to expenditure growth over the next 10 years. Historical and projected Medicaid enrollments are shown by category in figure 5.

³⁸ These estimates do not include the impacts of the Pathway for SGR Reform Act of 2013 (Public Law 113-67). Among other impacts, the Pathway for SGR Reform Act eliminated the DSH allotment reductions in 2014 and 2015 under the Affordable Care Act, increased the DSH allotment reduction in 2016, and extended the DSH reductions through 2023. The projected average annual growth rate is not affected by these changes.

Figure 5—Past and Projected Numbers of Medicaid Enrollees, by Category, FY 2000–FY 2022
(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. 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.” In previous reports, the children of newly eligible adults have been reported as “Expansion Children.” These children are included with “Children” enrollees in this report.

Total enrollment is projected to increase from 58.6 million PYE in 2012 (including 1.0 million enrollees in the U.S. Territories) to 59.1 million PYE in 2013 and 80.9 million PYE by 2022.

Enrollment in 2013 is estimated to have increased by 0.7 percent, based on further decreases in the unemployment rate and continuing economic growth. This increase would be the third consecutive year of decelerating growth in enrollment, following the recent peak enrollment growth rate of 7.3 percent in 2010 after the recession of 2007–2009. 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, private

health insurance enrollment was estimated to have declined by about 10 million persons between 2007 and 2012.³⁹

In 2014, when the eligibility expansion under the Affordable Care Act takes effect, total enrollment is estimated to increase by 5.9 million PYE, or 9.9 percent.⁴⁰ Absent the impact of the legislation, enrollment would have been projected to grow even more slowly in 2014 than in 2013, reflecting the effect of projected faster economic growth and lower unemployment rates.⁴¹ As noted previously, in States that choose to participate, 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).⁴²

The majority of the increase in Medicaid enrollees attributable to the eligibility expansion is assumed to occur during the period 2014–2016, with most of the increase taking place in 2014. Enrollment growth in 2015 and 2016 is estimated to average 8.1 percent per year, reflecting increased enrollee participation and assumed increases in the number of States expanding Medicaid eligibility after 2014.

The total number of Medicaid enrollees is projected to increase during 2017 through 2022 at about 1.1 percent per year, reflecting population growth, stable economic assumptions, and an increase in the number of aged enrollees as baby boomers continue to reach age 65. Excluding the newly eligible enrollment groups, the growth of aged adults is expected to be faster than that for the other categories of enrollment; the average annual increase for aged adults is estimated to be 3.0 percent over the next 10 years.

Per Enrollee Costs

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 6 displays historical and projected average Medicaid benefit expenditures per enrollee for all enrollees collectively and by eligibility group.

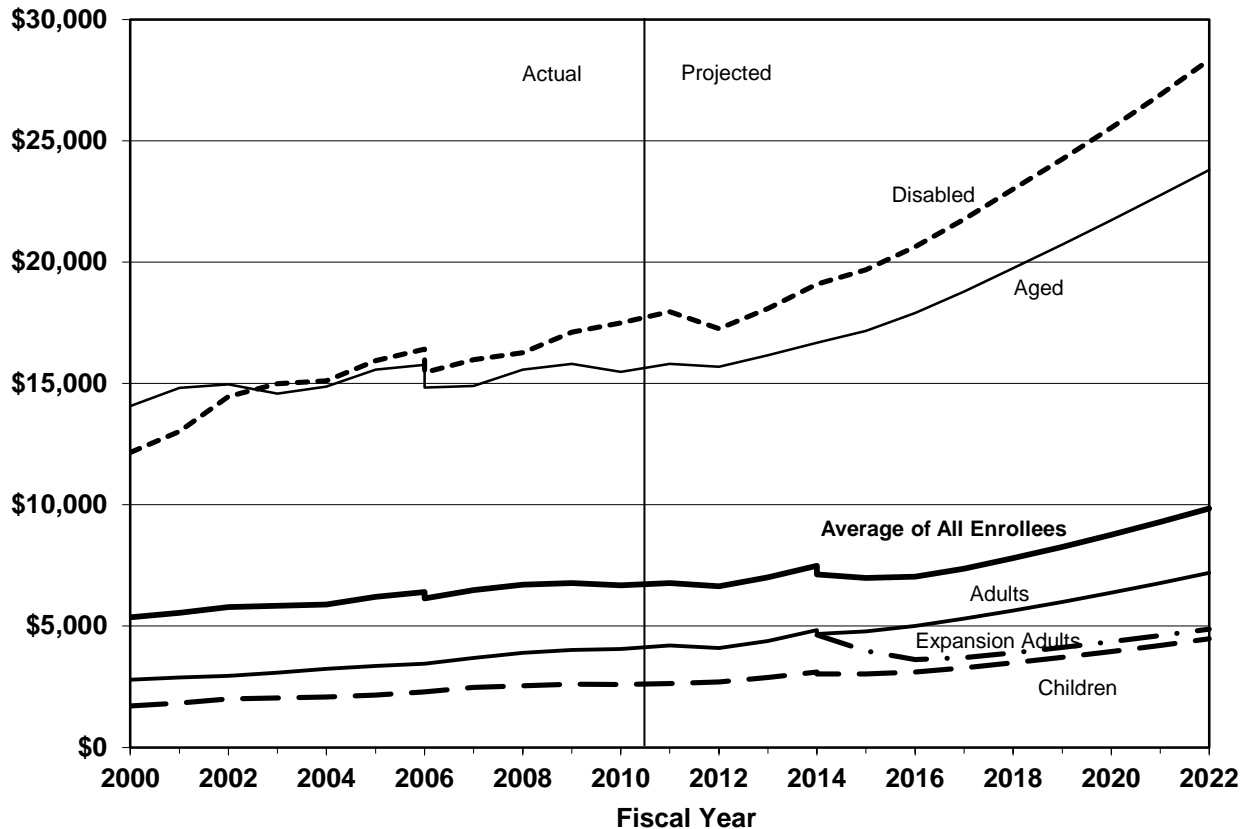
³⁹ Martin, *et al.*, “National Health Spending in 2012: Rate of Health Spending Growth Remained Low for the Fourth Consecutive Year”; and Cuckler, *et al.*, “National Health Expenditure Projections, 2012-22: Slow Growth Until Coverage Expands And Economy Improves.”

⁴⁰ Because the eligibility expansion started in January 2014, the enrollment impact in FY 2014 includes only 9 months of enrollment for new beneficiaries. The CY 2014 impact is projected to be 12.1 million PYE, which would be a 20-percent increase in enrollment.

⁴¹ The Affordable Care Act is projected to result in other small increases in Medicaid enrollment in States that chose 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 58.8 million PYE in 2013 to 59.1 million PYE in 2014.

⁴² 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.

Figure 6—Past and Projected Medicaid Expenditures on Medical Assistance Payments Per Enrollee, by Enrollment Category, FY 2000–FY 2022



Note: Per enrollee amounts for 2011 and 2012 are based on actual expenditures and estimated enrollment.

Prior to 2003, aged Medicaid enrollees had the highest average benefit cost, primarily as a result of nursing facility expenses and, prior to 2006, prescription drug costs. In recent years, disabled enrollees have experienced higher average benefit costs per enrollee. Nursing home expenditures increased relatively slowly over the last 10 years, and most costs for prescription drugs were shifted from Medicaid to the Medicare Part D program starting January 1, 2006. As a result, the average benefit cost per aged Medicaid enrollee grew very slowly over the 10-year period from 2002 through 2011 (0.6 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 over this period (an average rate of 6.0 percent per year).

In 2012, the average benefit costs for aged enrollees are estimated to have decreased 0.7 percent. For the 10-year period 2013–2022, average benefits for aged enrollees are projected to increase at an average pace of 4.3 percent per year. This rate is slower than the projected trend for other Medicaid populations, 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 2002 to 2012, since legislation enacted during this period contributed to constraining growth. Notably, the introduction of Medicare Part D in 2006 led to a sharp decline

in Medicaid benefit expenditures for aged beneficiaries, and provisions in the Deficit Reduction Act of 2005 tightened the eligibility criteria for nursing facility benefits.

Per enrollee benefit costs for the disabled grew at an average rate of 3.3 percent during 2002 through 2011, which was a faster pace than aged beneficiaries' per enrollee costs. Slow growth in nursing home costs 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 reflected the expanding use of home and community-based services.⁴³ Per enrollee Medicaid costs for the disabled were also reduced significantly by the shift of prescription drug coverage from Medicaid to Medicare for dual-eligible beneficiaries; however, this impact was relatively smaller for the average 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 decreased by 3.9 percent in 2012. This decrease is projected to be the result of reductions in spending for prescription drugs and inpatient and outpatient hospital services. Decreases in prescription drug spending were driven by increased drug rebates collected in 2012 and actions by some States to shift prescription drug benefits to managed care plans, as well as overall slow growth in prescription drug spending across all payers (0.4 percent in calendar year 2012).⁴⁴ The reductions in hospital spending in 2012 are in part a result of a sharp reduction in supplemental payments to hospitals.⁴⁵ Following the decrease in 2012, per enrollee benefits are projected to increase in 2013 through 2022. Growth in benefits for the disabled is

⁴³ Use of home and community-based services can substantially reduce expenditures for enrollees who would otherwise have had to enter a nursing home or who transition from institutional to community settings. Conversely, the expanding use of these services, by those who would not otherwise have had nursing home care, adds to overall program costs. Growth in the use of home and community long-term care reflects the increase in the number of home and community-based waivers in Medicaid. In addition, in *Olmstead v. L.C.*, 119 S. Ct. 2176 (1999), the Supreme Court ruled that under the Americans with Disabilities Act of 1990, States must provide community-based placement for persons with mental disabilities when appropriate and consistent with consumer wishes. This ruling is also expected to have led to an increase in non-institutional long-term care expenditures in Medicaid.

⁴⁴ Martin, *et al.*, "National Health Spending in 2012: Rate of Health Spending Growth Remained Low for the Fourth Consecutive Year."

⁴⁵ 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.

projected to average 5.1 percent; this projection reflects, among other factors, a continuing expansion in the use of home and community-based services.⁴⁶

Per enrollee Medicaid benefits for adults increased by about 3.9 percent annually during 2002 through 2011. The fastest growth in expenditures for adults was in capitation payments and premiums, which was driven by the increasing proportion of the adult Medicaid population enrolled in managed care plans. Expenditure growth in fee-for-service programs was much slower, with relatively flat trends in spending for inpatient and outpatient hospital care and for physician services.⁴⁷

Average benefit expenditures for adults are estimated to have decreased 2.5 percent in 2012, with growth in capitation payments offset by fewer expenditures for fee-for-service acute care services. Average benefit expenditures for non-expansion adults are projected to increase during 2013 through 2022 at an average rate of 5.8 percent per year. This increase reflects evidence that States are undertaking fewer efforts to reduce expenditure growth in the next several years and a projected modest increase in medical inflation.⁴⁸

As shown in figure 6, the estimated average benefit costs for adults who enroll as a result of the expanded eligibility criteria in the Affordable Care Act are significantly lower than those for the average beneficiary. This difference arises partly from the fact that adults in poor health often suffer a loss in income, increasing their likelihood of qualifying for Medicaid under the pre-Affordable Care Act criteria. The difference in costs also reflects 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. The estimated average costs for newly eligible adults are anticipated to be relatively higher in 2014 and 2015 than in future years, because persons with greater health care needs are expected to enroll in Medicaid more quickly than those with relatively lesser needs.

For children, per enrollee Medicaid benefits increased at an average annual rate of 3.7 percent during 2002 through 2011. Expenditure growth was driven by capitation payments and premiums, which account for nearly half of children's Medicaid

⁴⁶ Although the availability of home and community-based services can help prevent or postpone nursing home placement, or remedy inappropriate 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 long-term care in the absence of these services.

⁴⁷ Medicaid expenditures for nursing home care are very low on behalf of children and adults, and such enrollees were unaffected by the implementation of Medicare Part D in 2006. Thus, these factors, which limited per enrollee expenditure growth for aged and disabled beneficiaries, had an insignificant impact on the trends for children and adults.

⁴⁸ The average benefit expenditures for all adults—currently eligible and newly eligible—are projected to increase at an average rate of 4.2 percent during 2013 through 2022, as the newly eligible adult enrollees are projected to have relatively lower costs than current adult enrollees.

expenditures. In 2012, per enrollee expenditures for children are estimated to have increased by 2.6 percent, mostly driven by increases in expenditures for capitation payments. Such spending is projected to grow at an average annual rate of 5.2 percent per year in the future, with the fastest growth continuing in capitation payments. This difference between the past and projected growth rates in part reflects fewer efforts by States to reduce program expenditure growth in the next several years and a projected small acceleration in medical inflation. The increase in enrollment among children in 2014 (primarily due to increased participation among children eligible under Medicaid criteria prior to the Affordable Care Act) is expected to slow growth in per enrollee expenditures somewhat in that year.

Enrollment Mix

The growth in average Medicaid benefit expenditures per enrollee for all enrollment categories is significantly affected by the relative proportion of enrollment across these categories. In this report, the “enrollment mix” is defined as the contribution of the change in these relative proportions to the growth in Medicaid benefit expenditures per enrollee. This concept is similar to “age-gender mix” effects in other health care plans or programs (which measure the contribution to health care expenditures of changes in the relative proportion of enrollees by age and by gender in a plan). The enrollment mix differs in that it does not specifically consider gender and considers age in only broad ranges, but does take into account the disability status of enrollees.

The enrollment mix is an important consideration in analyzing and projecting Medicaid benefit expenditures. While the effects of age-gender mix on other programs are usually relatively small and do not change significantly from year to year, the effect of enrollment mix on Medicaid expenditures can be substantially larger or smaller and may vary greatly each year. This variation can occur because Medicaid enrollment categories experience substantially different average costs—aged and disabled enrollees’ average Medicaid costs are much greater than those of child and adult enrollees—and because the enrollment growth for these groups may vary among categories and may fluctuate annually.

For this report, the enrollment mix is measured as the difference between the increase in Medicaid benefit expenditures per enrollee and the increase in Medicaid benefit expenditures per enrollee if enrollment were held constant each year. To calculate this difference, enrollment was set at 2010 levels for each enrollment category.⁴⁹

⁴⁹ 2010 was selected as the base year for enrollment because it was the latest year for which complete Medicaid enrollment data were available. A review of the measurement of enrollment mix using other years as the base year showed no significant differences in results.

From 2002 to 2011, Medicaid benefit expenditures per enrollee grew at an average annual rate of 2.0 percent. The effects of changes in enrollment mix over this time period reduced spending by an average of 0.8 percentage point per year; that is, excluding the impacts of changes in enrollment, Medicaid benefit expenditures per enrollee would have grown 2.8 percent per year. The effects of the changes in enrollment mix on spending ranged from -2.6 percent to 1.3 percent over these 10 years. The negative effects of the changes in enrollment mix were the result of relatively faster enrollment growth for children and adults than for aged and disabled enrollees, especially from 2001 to 2003 and from 2008 to 2011.

In 2012, Medicaid benefit expenditures per enrollee decreased 1.9 percent, and the change in enrollment mix is estimated to have had only a minimal impact on growth (-0.1 percentage point). This decrease in expenditures per enrollee was driven in large part by States' efforts to limit spending growth (as the State share of Medicaid expenditures increased after the expiration of the temporary FMAP increases in 2009, 2010, and 2011). In addition, there was a small decrease in expenditures related to the Affordable Care Act, largely due to the collection of additional prescription drug rebates. After 2000, there was only one other year in which expenditures per enrollee decreased after accounting for the effect of the change in enrollment mix. In 2006, expenditures declined 1.1 percent, largely as a result of the shift of substantial prescription drug expenditures from Medicaid to Medicare for beneficiaries eligible for both programs.

Medicaid benefit expenditures per enrollee are projected to have increased 5.6 percent in 2013; this would be the fastest rate of growth since 2007. Excluding the impact of the change in the enrollment mix, Medicaid benefit expenditures per enrollee are estimated to have increased 5.2 percent, which would be faster than any single-year growth rate since 2002. As described previously in this section, this relatively faster rate of growth is expected to have been driven by States' actions to increase provider payment rates and program benefits, following years in which States took more actions to limit the rate of program expenditure growth. An estimated small increase in expenditures attributed to the Affordable Care Act also contributed to faster growth in expenditures per enrollee.

While Medicaid benefit expenditures per enrollee are projected to grow more rapidly over the next 10 years at an average annual rate of 4.0 percent, changes in enrollment mix are projected to decrease per enrollee Medicaid expenditure growth by an average of 0.8 percentage point per year over this time period; thus, excluding the effect of changes in the enrollment mix, Medicaid benefit expenditures per enrollee are projected to grow at an average annual rate of 4.8 percent. This growth is largely the result of the addition of newly eligible adult enrollees and increases in the enrollment of currently eligible adult and child enrollees through the Affordable Care Act beginning in 2014. As the benefit costs for these enrollees are projected to be less than the average benefit costs of all Medicaid enrollees (substantially less than the costs of aged and disabled enrollees and, on average, somewhat less than

the costs of current adult and child enrollees), the addition of these new enrollees is expected to slow growth in expenditures per enrollee in the next several years. The effect of the new enrollees due to the Affordable Care Act is partially offset by relatively faster growth in the number of aged Medicaid enrollees, as the oldest members of the baby boom generation reach age 65.

Excluding the effects of changes in the enrollment mix, Medicaid benefit expenditures per enrollee grew at an average annual rate of 2.4 percent per year from 2002 through 2012 (increasing at an average rate of 2.8 percent per year during the period 2002–2011 and decreasing 1.8 percent in 2012). From 2013 to 2022, Medicaid benefit expenditures per enrollee, minus the effects of estimated changes in the enrollment mix, are projected to increase 4.8 percent per year on average. This difference is driven in part by several recent legislative acts that generally provided for one-time reductions to the rate of Medicaid expenditures per enrollee (including the Deficit Reduction Act of 2005 and the Medicare Modernization Act of 2003). In addition, efforts by States to limit Medicaid expenditure growth (most notably, in 2011 and 2012) are not projected to continue with the same intensity into the future. Finally, medical price inflation is also projected to be modestly faster in the next 10 years than in recent history.

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 the program's expenditures and enrollment. While the eligibility expansion, which begins in 2014, will likely have the largest effect, a number of other provisions of the legislation are already having an impact. This section of the report describes the estimated effects on total Medicaid expenditures, Federal and State Medicaid expenditures, and Medicaid enrollment.⁵⁰

In 2010 and 2011, new drug rebates resulted in some savings that were largely offset by certain States electing to expand eligibility to higher-income adults prior to 2014. These Affordable Care Act impacts are estimated to have lowered Medicaid expenditures by about \$100 million in 2010 and to have increased expenditures by \$600 million in 2011.

In 2012, the Affordable Care Act was estimated to have decreased Medicaid expenditures by about \$1.1 billion. This impact was mainly due to the new prescription drug rebates (including rebates for prescription drug expenditures in 2010 and 2011 that were collected in 2012). The costs of the early eligibility expansions partially offset this reduction in expenditures.

This legislation is projected to increase Medicaid expenditures by about \$1.7 billion in 2013. Expenditures are expected to increase due to early eligibility expansions, payments to Territories, and increased payments to primary care physicians. These increases are offset partially by additional prescription drug rebates. Additionally, administration costs are projected to increase in 2013 in preparation for the eligibility expansion in 2014.

From 2013 through 2022, the Affordable Care Act is expected to add a total of \$500 billion to aggregate Medicaid expenditures—an increase of about 8 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 \$485 billion (or about 14 percent) higher over this time period, while State expenditures are projected to grow by only \$14 billion (or about 1 percent). Thus, the Federal government is projected to pay for about 97 percent of this increase.

The most significant provision of this legislation is the expansion of Medicaid eligibility to almost all persons under age 65 who are living in families with incomes

⁵⁰ The Office of the Actuary (OACT) originally developed estimates of the impacts of the Affordable Care Act on Medicaid expenditures and enrollment as part of the April 22, 2010 memorandum by Richard S. Foster. OACT subsequently updated these estimates to incorporate the most recent health expenditure and coverage data and to reflect the most current understanding of policy related to the implementation of the Act.

below 138 percent of the FPL beginning in 2014 (and who are citizens or eligible legal residents). This expansion is projected to add 5.8 million PYE to enrollment during the 9 months that the new eligibility rules will be in effect for FY 2014 and is expected to add 18.4 million PYE by 2022. Of the projected increase in enrollees (both newly and currently eligible) as a result of the Affordable Care Act over the period 2014 to 2022, about 80 percent are adults, and the remaining 20 percent are children.⁵¹ Furthermore, about 80 percent of new adult enrollees are projected to be newly eligible (that is, to meet the definition of “newly eligible” in section 1905(y)(2) of the Social Security Act) in 2014, while 20 percent are projected to be eligible under the current Medicaid rules.⁵² 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.⁵³ About 86 percent of new adult enrollees are projected to be newly eligible by 2022, as more States are assumed to expand Medicaid eligibility after 2014 (described in further detail below).

The expansion of eligibility criteria is anticipated to account for most of the additional Medicaid costs attributable to the Affordable Care Act. Of the total increase in Medicaid benefit expenditures under the legislation, the eligibility expansion, including the enrollment of newly eligible individuals and increased participation of currently eligible individuals, is projected to contribute \$496 billion from 2014 through 2022.⁵⁴ Of this increase, the majority is projected to be paid by the Federal government—\$433 billion, or about 87 percent—and the States are projected to spend an additional \$63 billion. 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. (For the

⁵¹ 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.

⁵² “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 Social Security Act), or benchmark-equivalent coverage (described in section 1937(b)(2) of the Social Security 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.

⁵³ The estimates of Medicaid enrollment and expenditures due to the eligibility expansion also include State programs that have received waivers to cover newly eligible enrollees in qualified health plans on the health insurance exchanges.

⁵⁴ Increased administration costs associated with updating eligibility systems and overall program administration are not included in these figures and are presented in more detail later in this section.

costs of currently eligible individuals who enroll in 2014 and thereafter, the Federal government generally pays a percentage of costs equal to the regular FMAP.)

By 2016, the per enrollee benefit 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.

In 2014 and 2015, the average benefit costs of newly eligible adult enrollees are expected to be relatively close to current enrollees. Among the newly eligible, the persons expected to enroll in Medicaid first are those who would have a greater incentive to obtain Medicaid coverage; these individuals are assumed to use relatively more health care services and goods than those expected to enroll in later years. For 2014, newly eligible adults are projected to have average per enrollee benefit costs nearly equal to those of currently eligible adults (96 percent), and, for 2015, newly eligible adults are projected to have average per enrollee benefit costs equal to about 80 percent of the costs of currently enrolled adults. For currently eligible adults who would enroll as a result of greater outreach efforts and simplified enrollment processes, the average benefit costs per enrollee are projected to be less than those of currently enrolled adults, as those with the greatest health care needs are assumed to have already enrolled.

Some new Medicaid enrollees are also expected to retain other forms of coverage, such as employer-sponsored insurance, and to enroll in Medicaid to “wrap around” the benefits of the other plans. Program benefit 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.

The ultimate 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. For persons who would be eligible under current Medicaid criteria and would otherwise be uninsured, about 70 percent of those in States that expand Medicaid eligibility are assumed to enroll in Medicaid ultimately; in States that do not expand Medicaid eligibility, about 56 percent of currently eligible and otherwise uninsured persons are assumed to enroll ultimately. In 2014 and 2015, the participation rates of those newly eligible and currently eligible are assumed to be lower than the ultimate participation rate (about 70 percent and 85 percent of the ultimate rates, respectively).

These assumed rates are significantly higher than actual Medicaid participation rates to date and are based on the anticipated impacts of sections of the Affordable Care Act that are intended to make the process of enrolling easier. In particular, simplified eligibility determinations will enable some individuals who have 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, which, among other responsibilities, will facilitate the determination of individuals' and families' eligibility for Federal financial assistance, either through Medicaid or through the Federal premium and cost-sharing subsidies for private health insurance plans. 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.

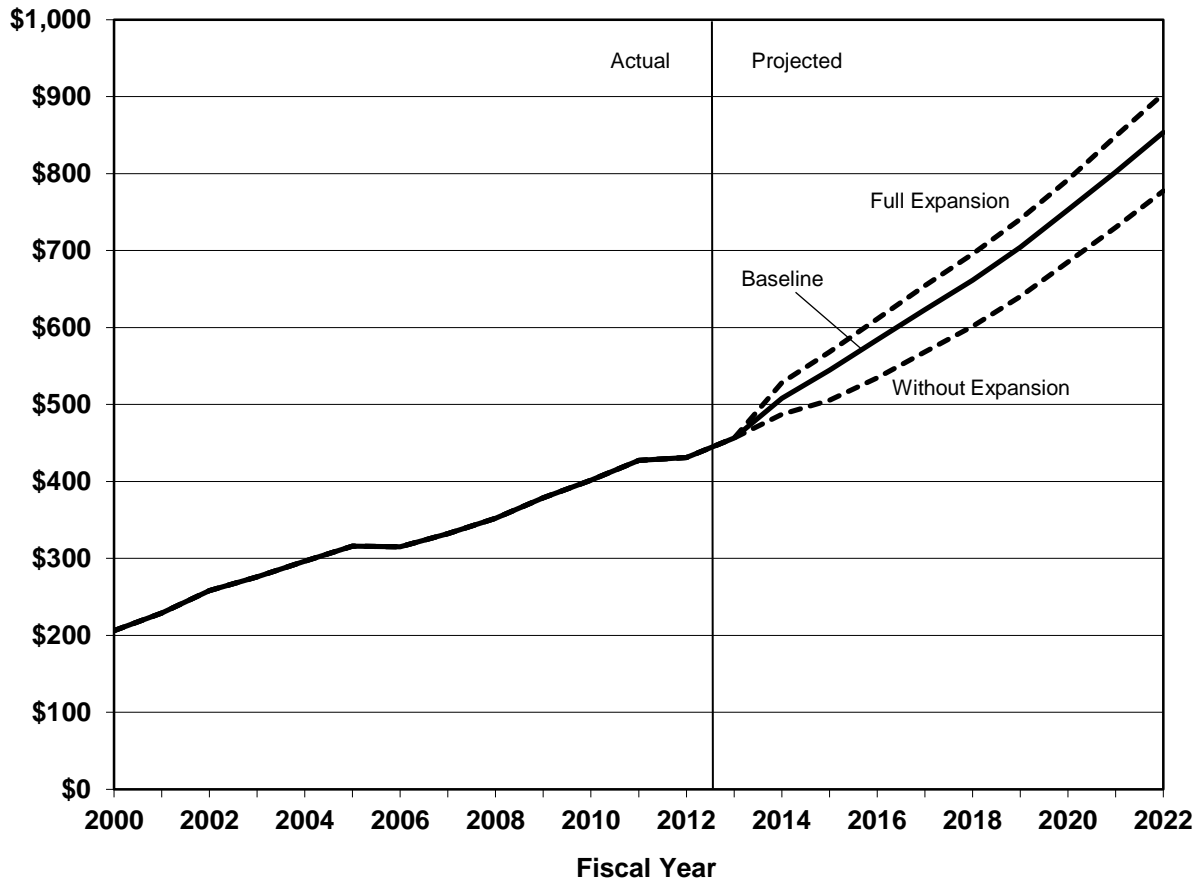
In *National Federation of Independent Business (NFIB) v. Sebelius*, the Supreme Court ruled that a State may not lose Federal funding for its existing program if it does not implement the Medicaid eligibility expansion under the Affordable Care Act. Based on the information currently available about the States' intentions for their Medicaid programs, it is estimated that (i) 45 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.

It is possible that more or fewer States may expand Medicaid eligibility than have been assumed for 2015 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, taking into account the sizes of the potential newly eligible populations in those States.

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 7 shows annual projected Medicaid expenditures under three scenarios: (i) the scenario in which all States choose to expand Medicaid eligibility beginning in 2014 ("full expansion"); (ii) the assumption used for the baseline projections in this report (States representing 45 percent of potential newly eligible persons expand in 2014, and 65 percent expand in 2015 and beyond); and (iii) the baseline projections excluding the impact of the Medicaid

eligibility expansion and the additional increase in the participation rate of currently eligible enrollees (“without expansion”).⁵⁵

Figure 7—Projected Medicaid Expenditures under “Baseline,” “Full Eligibility Expansion,” and “Without Eligibility Expansion” Scenarios
(in billions)



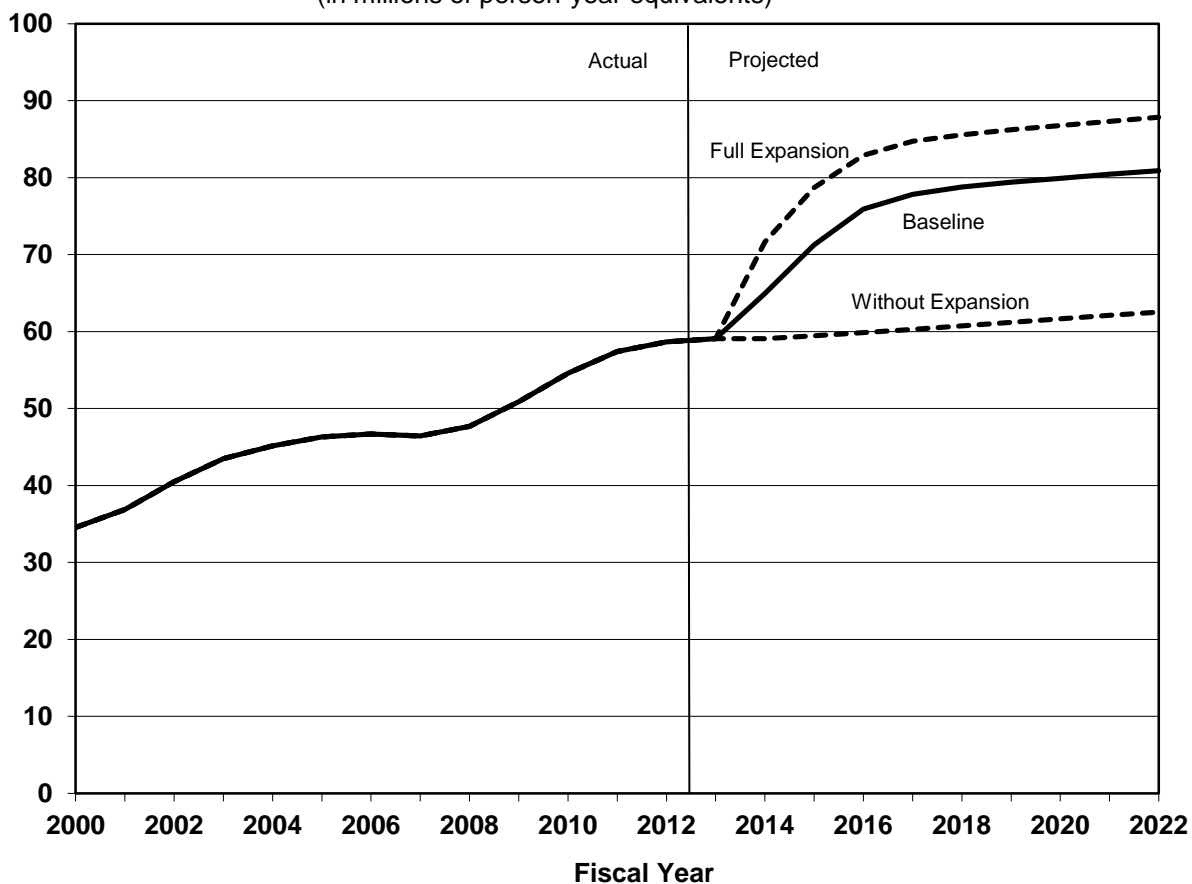
Under the “full expansion” scenario, Medicaid expenditures are projected to be 5.8 percent higher than under the baseline scenario in 2022 and 5.1 percent higher than the baseline scenario over the period 2014–2022. Excluding the impacts of the Medicaid eligibility expansion (the “without expansion” scenario), Medicaid expenditures are projected to be 8.9 percent lower in 2022 and 8.4 percent lower during 2014 through 2022. While there are other reasons that actual future expenditures may differ from these projections, the “full expansion” scenario provides a reasonable indication of future expenditures if all States were to expand

⁵⁵ The “without expansion” scenario also excludes any increase in the participation rate of currently eligible persons. In actuality, even without 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. This increase would be the anticipated result of enrollment simplifications, greater outreach efforts, knowledge of health care coverage options, and awareness of the individual health coverage mandate (even though there would be no penalty to low-income individuals).

eligibility, and the “without expansion” scenario demonstrates the projected impact of the Medicaid eligibility expansion on expenditures.⁵⁶

Figure 8 shows annual projected Medicaid enrollment under the three scenarios described above.

Figure 8—Projected Medicaid Enrollment under “Baseline,” “Full Eligibility Expansion,” and “Without Eligibility Expansion” Scenarios
(in millions of person-year equivalents)



Under the “full expansion” scenario, Medicaid enrollment would reach 87.8 million PYE by 2022, which is 6.9 million greater than projected under the baseline scenario (or 8.6 percent greater than the baseline scenario projections). Excluding the impacts of the eligibility expansion (the “without expansion” scenario), projected

⁵⁶ The baseline scenario projections are closer to the “full expansion” scenario projections than to the “without expansion” scenario projections, and they may appear closer than is suggested by the assumption that States representing 65 percent of potential newly eligible persons would implement the eligibility expansion. This apparent difference is due to the assumption in the baseline scenario that there would still be a significant increase in the currently eligible enrollment in States that do not implement the expansion. In addition, the range between the “full expansion” and “without expansion” scenarios shows possible expenditures if more or fewer States expand eligibility than assumed in these projections or if a greater or lesser percentage of all potentially newly eligible persons than estimated live in States that expand eligibility.

Medicaid enrollment in 2022 is 62.5 million PYE, or 18.4 million lower than under the baseline scenario (22.7 percent less than the baseline scenario projections). As is the case with the projections of expenditures under the different scenarios, the “full expansion” scenario shows a reasonable projection of future enrollment if all States were to expand eligibility, and the “without expansion” scenario displays the projected impact of the eligibility expansion on enrollment.⁵⁷

In addition to the Medicaid eligibility expansion, there are numerous other provisions of the Affordable Care Act that affect Medicaid. Provisions with the most significant projected impacts on Medicaid expenditures include greater payments to Territories, expanded access to long-term care, increased payments to primary care physicians, additional prescription drug rebates, and reductions to DSH allotments. These provisions (excluding the effects of the eligibility expansion) are projected to reduce Medicaid benefit expenditures over the next 10 years by about \$27 billion. While these estimates show a relatively small net decrease 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 \$60 billion, while Federal Medicaid benefit expenditures are projected to increase by about \$33 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 greater payments to Territories and the increased payments to primary care physicians are entirely paid by the Federal government. The Affordable Care Act also provides increases in the FMAP to States that had previously expanded Medicaid eligibility to adults at higher income levels and to States that increase the use of non-institutional long-term care.

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 program administration costs associated with the number of new enrollees starting in 2014. During 2013 through 2022, as a result of the legislation, administration costs are projected to increase by about \$31 billion in

⁵⁷ As with the projections of expenditures, the range between the “full expansion” and “without expansion” scenarios shows possible enrollment levels if more or fewer States expand eligibility than assumed in these projections or if a greater or lesser percentage of all potentially newly eligible persons than estimated live in States that expand eligibility.

total, of which about \$19 billion is expected to be paid by the Federal government and approximately \$12 billion by the States.

The additional costs related to the Affordable Care Act increase the estimated average Medicaid expenditure growth rate for 2013 through 2022, with the greatest changes starting in 2014 with the eligibility expansion:

- In 2013, Medicaid expenditures for medical assistance payments and administration costs are projected to grow at a rate of 5.9 percent; excluding the impact of the Affordable Care Act, projected growth would be slightly lower at 5.2 percent. The difference results from the net impact of higher expenditures associated with temporarily increased payments to primary care physicians, increases in long-term care spending, and increased administration costs. In addition, there is a projected decrease in the amount of prescription drug rebates collected in 2013 compared to 2012 (when additional rebates from 2010 and 2011 were reported and collected).
- Medicaid expenditures are projected to increase 11.3 percent in 2014 as a result of the eligibility expansion that began on January 1, 2014. Without the Affordable Care Act, growth in expenditures would be projected at 5.0 percent. As would be expected, this is the largest 1-year difference between projected growth rates with and without the impact of the legislation from 2013 through 2022.
- In the last 8 years of the period, Medicaid expenditures are projected to grow 6.7 percent per year on average, slightly faster than without the impact of the Affordable Care Act (6.4 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 and more States are assumed to expand Medicaid eligibility.
- During 2013 through 2022, Medicaid expenditure growth is projected to be 7.1 percent per year on average, which is 0.9 percentage point higher than without the Affordable Care Act impacts (or 6.1 percent average growth).⁵⁸

Legislative acts over the last year are anticipated to have relatively small impacts on Medicaid expenditures. The American Taxpayer Relief Act of 2012 (Public Law 112-240) extended the Qualifying Individual (QI) and Transitional Medical Assistance (TMA) programs through December 31, 2013, extended the Medicaid Express Lane eligibility program for 2014, and rebased DSH allotments in 2022.

⁵⁸ The projected growth rate excluding the Affordable Care Act impacts—those associated with the eligibility expansion and all other sections of the legislation—also excludes the impact of the other legislative acts that have affected Medicaid since the passage of the Act, and in particular changes to projected DSH allotments.

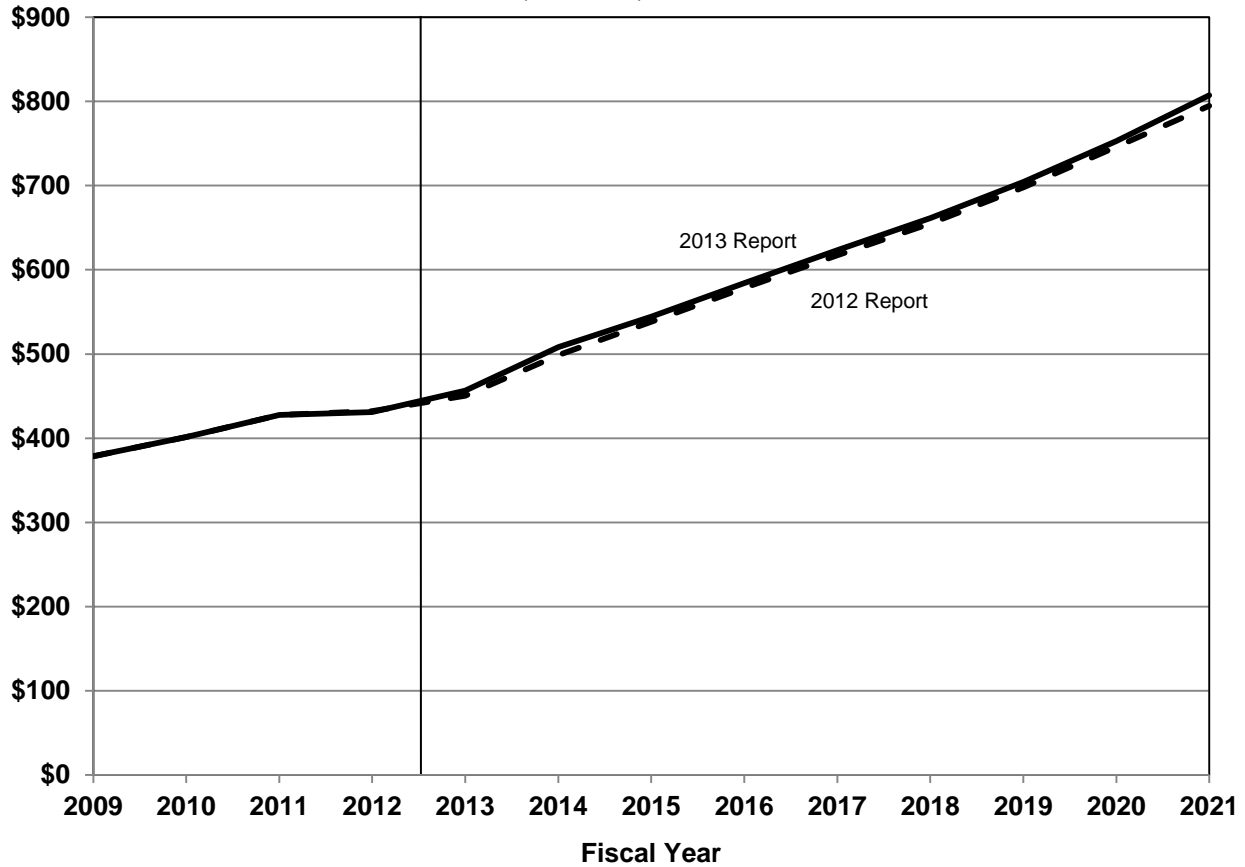
Collectively, these provisions added an estimated \$2.7 billion in Medicaid expenditures from 2013 to 2022.⁵⁹

⁵⁹ These estimates do not include the impacts of the Pathway for SGR Reform Act of 2013 (Public Law 113-67). Notably, the Pathway for SGR Reform Act extended the QI and TMA programs through December 31, 2014, eliminated the DSH allotment reductions in 2014 and 2015 under the Affordable Care Act, and increased the DSH allotment reduction in 2016; see footnote 38.

E. COMPARISON TO 2012 REPORT PROJECTIONS

The projections of Medicaid expenditures in this report are slightly higher than in the 2012 *Actuarial Report on the Financial Outlook for Medicaid*. Figure 9 compares the 2013 projections of total Medicaid expenditures (including Federal and State) to those in last year's report.

Figure 9—Projected Medicaid Expenditures: Comparison of 2012 versus 2013 Actuarial Reports on the Financial Outlook for Medicaid, FY 2008–FY 2021
(in billions)



Projected spending in 2021 of \$801.8 billion is 0.9 percent higher than the corresponding amount in last year's report (\$795.0 billion). Expenditures in 2013 (\$456.4 billion) were somewhat higher than projected last year (\$450.5 billion), representing a 1.3-percent difference. Most of this difference is attributable to faster per enrollee expenditure growth in 2013 than projected in last year's report.

Medicaid enrollment is expected to be somewhat higher by 2021 than projected in the 2012 report for the same year. Enrollment is projected to reach 80.4 million PYE by 2021, whereas enrollment was projected to be 77.9 million by 2021 (or about 3 percent higher) in last year's report. This difference is due to updated enrollment data for 2010, as well as higher-than-estimated post-recessionary unemployment

rates for 2011 and 2012. Medicaid enrollment from 2012 to 2021 is projected to grow at an average rate of 3.4 percent, which is the same as last year's projection over the same period.

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.⁶⁰ Medicaid spending in the 2012 NHE accounts represented 15.1 percent of total NHE. Private health insurance was the largest source of spending on health care in 2012, accounting for 32.8 percent of total NHE, while Medicare paid for 20.5 percent.⁶¹

The historical NHE also presents health care spending by the original source of financing (or sponsor). In calendar year (CY) 2012, Medicaid represented 33.6 percent of Federal government expenditures on health services and supplies and 38.0 percent of such spending by State and local governments. Medicaid is somewhat smaller than Medicare as a share of Federal government expenditures on health services and supplies (Medicare accounted for 37.1 of Federal expenditures in 2012). Medicaid is the largest source of Federal general revenue-based spending on health services. 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, Medicaid is the largest source of general revenue-based spending on health services, although spending on all other health programs in 2009 exceeded spending on Medicaid, largely because of the temporary increases to the FMAP.⁶²

Medicaid has a greater number of enrollees than Medicare. In FY 2012, Medicaid was estimated to have covered 58.6 million PYE (including persons residing in U.S. Territories), and 72.2 million people were enrolled in the program at some point during the year. In comparison, Medicare covered an average of 50.7 million people during CY 2012.⁶³ Within these totals, there are substantial differences between the programs in the number and nature of people covered. For example, Medicare

⁶⁰ 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.

⁶¹ Martin, *et al.*, “National Health Spending in 2012: Rate of Health Spending Growth Remained Low for the Fourth Consecutive Year.”

⁶² *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>.

⁶³ *The 2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.*

automatically covers nearly all people over age 65 (42.1 million beneficiaries in 2012), but only those aged individuals with very low incomes—and who apply for the coverage—become Medicaid enrollees (estimated at 5.0 million PYE). Disabled enrollment was more similar between the two programs; Medicaid covered an estimated PYE average of 9.7 million blind or disabled persons in 2012, while Medicare covered 8.5 million disabled beneficiaries. Although the definition of disability is essentially the same for the two programs, the other eligibility criteria are entirely different.⁶⁴ 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 2011.⁶⁵

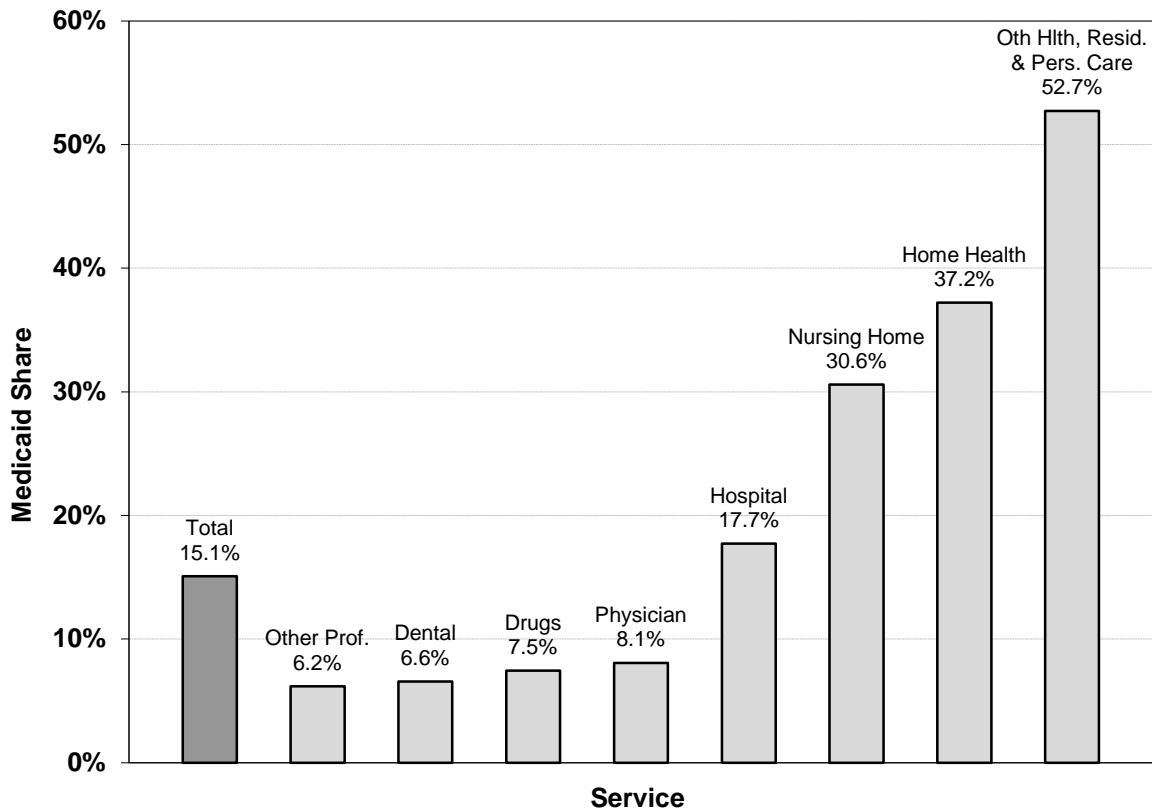
Among the different types of health care services, Medicaid plays the largest role in the funding of long-term care. According to the 2012 NHE, Medicaid is estimated to have paid for 37.2 percent of all freestanding home health care and 30.6 percent of all freestanding nursing home care in the U.S. In addition, Medicaid covered an estimated 52.7 percent of other health, personal, and residential care in 2012, including Medicaid payments for intermediate care facilities and for home and community-based waivers.⁶⁶ 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 10 shows the percentage of total spending for the major health care services that Medicaid covers.

⁶⁴ 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.

⁶⁵ 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.

⁶⁶ Martin, *et al.*, "National Health Spending in 2012: Rate of Health Spending Growth Remained Low for the Fourth Consecutive Year."

Figure 10—Medicaid Expenditures as Percentage of Total U.S. Health Expenditures, by Service Category, CY 2012



Historically, Medicaid expenditures per enrollee have generally grown at a slower rate than overall national health expenditures per capita. From 1971 through 2012, Medicaid expenditures per enrollee increased at an average annual rate of 7.4 percent, which is slightly less than the average NHE per capita growth rate of 8.0 percent. This difference has become greater in more recent years; over 2003 to 2012, Medicaid expenditures per enrollee grew at an average rate of 1.4 percent, compared to 4.6 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 more rapidly than per capita NHE.

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. One reason that such comparisons may not fully explain this relationship is that NHE per capita includes both Medicaid expenditures in NHE and Medicaid enrollees in the U.S. population. As illustrated in figure 10, Medicaid pays different relative shares of health care costs by type of service; to the extent that given categories of service have grown more quickly or more slowly 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 from 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.

Another reason that these comparisons may be of only limited use is that 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. Moreover, 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 2013, out of a total of \$3,455 billion spent by the Federal government for all purposes, \$265 billion (or 7.7 percent) can be attributed to Medicaid. Under the President’s Fiscal Year 2015 Budget, Federal outlays on Medicaid are projected to account for 9.0 percent of all Federal outlays by 2022.⁶⁷

According to the National Association of State Budget Officers (NASBO), Medicaid represented an estimated 23.7 percent of all State government spending in State fiscal year 2012.⁶⁸ 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 2012. When only State general revenues are considered, however, Medicaid spending constituted an estimated 19.3 percent of expenditures in 2012, placing it well behind elementary and secondary education. The share of State general revenues devoted to Medicaid increased from 2011 to 2012 (from 16.5 percent to 19.3 percent). While the Federal share of Medicaid expenditures decreased in 2012, State general revenue expenditures for Medicaid grew quickly (21.3 percent). The increase in State expenditures for Medicaid was in large part the result of the expiration of the temporary FMAP increases under ARRA.⁶⁹

As shown in figure 11, Medicaid represented about 2.7 percent of GDP in 2012, which was a slight decrease from the program’s 2.8-percent share in 2011. Due to

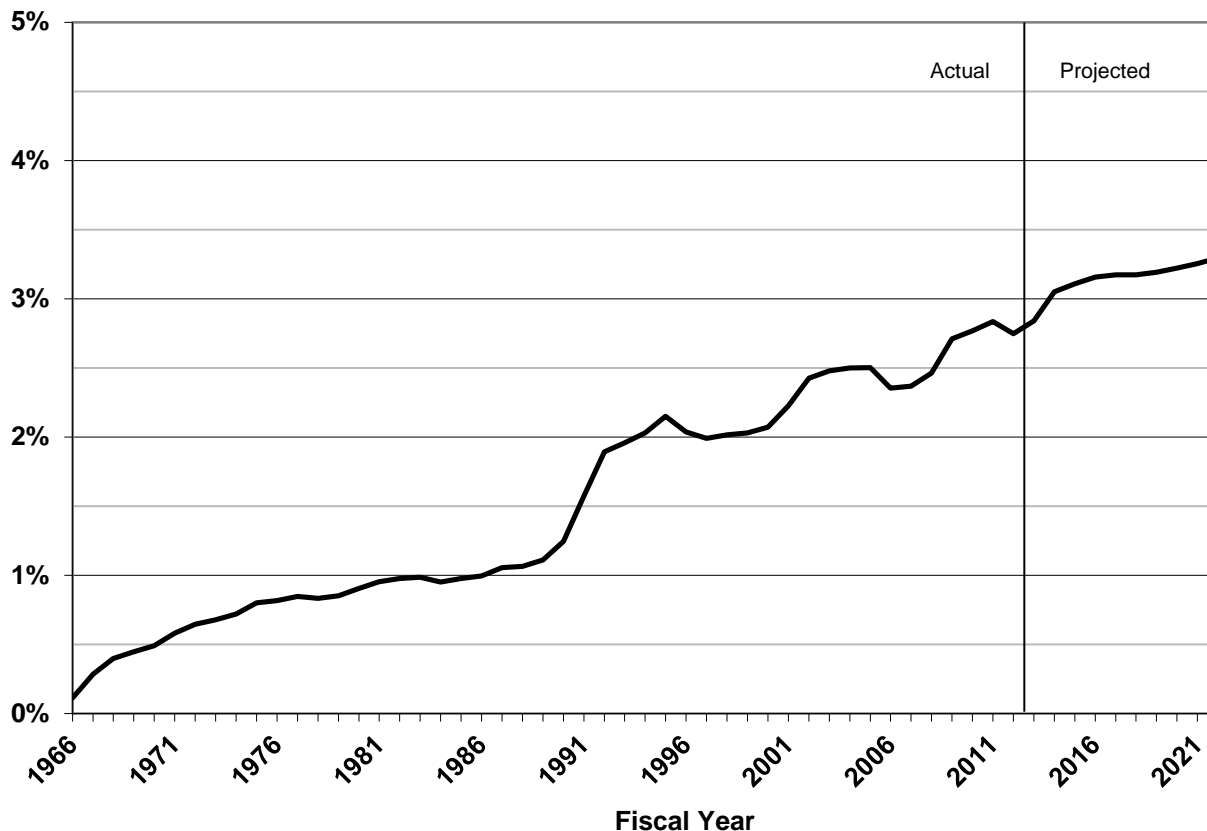
⁶⁷ More information on the Federal budget is available in *Analytical Perspectives, Budget of the United States Government, Fiscal Year 2015*.

⁶⁸ *State Expenditure Report: Examining Fiscal 2011–2013 State Spending*, National Association of State Budget Officers, 2013.

⁶⁹ See section V.B (pp. 21-22) for more information on the temporary FMAP increases.

the 2007–2009 economic recession—which increased enrollment in Medicaid while also suppressing GDP growth—the program’s share of GDP grew significantly during 2008 through 2011.

Figure 11—Past and Projected Medicaid Expenditures as Share of GDP, FY 1966–FY 2022



Medicaid is estimated to have increased as a share of GDP in 2013, as GDP grew more slowly (2.4 percent) and Medicaid spending grew more quickly at 5.9 percent. In 2014, GDP is projected to grow at a rate of 3.6 percent, while Medicaid spending is expected to increase to 11.3 percent due to the coverage expansion under the Affordable Care Act. While GDP is anticipated to grow more rapidly in 2015 and 2016, the continuing effects of the eligibility expansion are expected to contribute to faster Medicaid growth and further increases in Medicaid’s share of GDP. By 2016, Medicaid spending is projected to reach 3.2 percent of GDP.

As seen in figure 11, the program’s expenditures are projected to continue to grow to 3.3 percent of GDP by 2022. From 2013 through 2022, Medicaid expenditures are projected to increase about 1.9 percentage points faster than GDP on average per year, with much of this difference due to the eligibility expansion. The Affordable Care Act accounts for about half of the difference between projected Medicaid expenditure and GDP growth rates over the 10 years; about 0.9 percentage point of

the 1.9-percentage-point differential is 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 similar to the projection included in last year's report. The share of GDP devoted to Medicaid in 2021 is projected to be 3.3 percent, about 0.1 percentage point higher than in the 2012 projection. Medicaid expenditures are projected to grow slightly more rapidly than were projected previously, while GDP growth was also projected to be faster in the 2013 Medicare Trustees Report than in the 2012 Medicare report.

VI. CONCLUSION

Medicaid expenditures are estimated to have grown 5.9 percent in 2013, after a year of relatively slow expenditure growth, and to have reached \$456.4 billion. Faster growth is expected to continue in 2014 with the expansion in eligibility standards, and expenditures are projected to grow to \$853.6 billion by 2022. The projected annual average growth rate of Medicaid expenditures from 2013 to 2022 is 7.1 percent—notably faster than the projection of average annual GDP growth of 5.1 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 role, 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 beginning in 2014, it is important to note the uncertainty of future Medicaid spending and enrollment levels. Significant changes are occurring in 2014, including the conversion of the income eligibility criteria to a modified adjusted gross income (MAGI) basis and the start of the health insurance exchanges, at the same time that many States are implementing the Medicaid eligibility expansion. In addition, many other provisions of the Affordable Care Act that affect Medicaid, both directly and indirectly, are still in the process of being implemented. Even though this legislation was enacted in 2010, there is yet 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.

The proportion of Medicaid expenditures for capitation payments and premiums is projected to increase, as are the number of enrollees that receive all or some of their Medicaid benefits through a managed care plan. This trend is expected to accelerate as many States cover newly eligible enrollees through managed care plans beginning in 2014. In addition, States have expanded the use of managed care to cover aged and disabled enrollees and long-term care services. Thus, understanding how the use of managed care in Medicaid will affect future expenditure growth—and how fee-for-service expenditures for acute care and long-term care will also be affected—will be an important consideration for Medicaid programs in the future.

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.

Typically the cost growth rates of different payers and programs, such as Medicare, Medicaid, and private health insurance plans, are interconnected. Attempts by one payer or program to affect costs can have a direct or indirect impact on other payers and programs. 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.

This report includes projections of the current-law Medicaid program. As policy makers consider changes or reforms to the program, for Medicaid specifically or for the broader health care system, particular attention may need to be paid to the ways in which Medicaid differs from other types of health care coverage—for example, in its administration, the benefits offered, the populations covered, and the ways in which it pays for health care. Other important issues for consideration, as Medicaid’s role continues to evolve, are 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 age 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 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.⁷⁰

The principal economic assumptions include growth in average wages and the 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.

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.

⁷⁰ Further information on the Trustees’ population projections and economic assumptions is available in the 2013 OASDI and Medicare Trustees Reports.

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 hospital | Medicare hospital input price index (market basket), before the application of productivity adjustment |
| Physician, clinic, and related services | Medical CPI 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.

D. DATA POINTS FOR SELECTED FIGURES

The following tables provide the data points underlying selected figures in the report.

Table 5—Past and Projected Medicaid Expenditures for Medical Assistance Payments, by Type of Payment, FY 2000–FY 2022
(in billions)

| Fiscal Year | Acute care FFS | Long-term care | Capitation payments & premiums | Disproportionate share hospital payments |
|------------------|-------------------|-------------------|--------------------------------------|--|
| Historical data: | | | | |
| 2000 | \$78.4 | \$67.9 | \$33.9 | \$14.4 |
| 2001 | 87.7 | 73.9 | 37.8 | 15.5 |
| 2002 | 102.9 | 81.1 | 44.7 | 15.4 |
| 2003 | 113.5 | 84.1 | 50.7 | 12.9 |
| 2004 | 130.2 | 87.3 | 46.6 | 15.4 |
| 2005 | 138.1 | 92.9 | 51.6 | 15.6 |
| 2006 | 125.4 | 97.3 | 58.4 | 13.7 |
| 2007 | 128.7 | 99.9 | 66.6 | 15.8 |
| 2008 | 125.6 | 105.5 | 82.8 | 15.4 |
| 2009 | 134.7 | 111.2 | 93.3 | 16.1 |
| 2010 | 142.7 | 113.0 | 103.9 | 15.2 |
| 2011 | 152.9 | 114.3 | 115.9 | 14.3 |
| 2012 | 137.5 | 114.4 | 132.5 | 14.1 |
| Projections: | | | | |
| 2013 | 144.6 | 120.2 | 144.2 | 14.4 |
| 2014 | 164.4 | 125.6 | 168.9 | 14.2 |
| 2015 | 172.3 | 132.5 | 189.2 | 14.4 |
| 2016 | 183.1 | 140.6 | 207.9 | 14.7 |
| 2017 | 194.5 | 150.1 | 225.8 | 13.5 |
| 2018 | 206.2 | 160.6 | 244.4 | 9.3 |
| 2019 | 217.8 | 171.1 | 264.0 | 8.8 |
| 2020 | 229.5 | 182.1 | 284.9 | 11.7 |
| 2021 | 241.6 | 193.8 | 307.6 | 12.1 |
| 2022 | 254.2 | 205.7 | 332.2 | 12.4 |

**Table 6—Past and Projected Numbers of Medicaid Enrollees, by Category,
FY 2000–FY 2022**
(in millions of person-year equivalents)

| Fiscal Year | Aged | Disabled | Children | Adults | Newly eligible adults | Territories |
|------------------|------|----------|----------|--------|-----------------------|-------------|
| Historical data: | | | | | | |
| 2000 | 3.6 | 6.7 | 16.4 | 6.9 | n/a | 0.9 |
| 2001 | 3.7 | 6.9 | 17.5 | 7.8 | n/a | 0.9 |
| 2002 | 3.9 | 7.2 | 19.4 | 9.0 | n/a | 1.0 |
| 2003 | 4.3 | 7.5 | 21.0 | 9.7 | n/a | 1.0 |
| 2004 | 4.4 | 7.7 | 21.9 | 10.1 | n/a | 1.0 |
| 2005 | 4.5 | 8.0 | 22.3 | 10.4 | n/a | 1.0 |
| 2006 | 4.5 | 8.2 | 22.6 | 10.4 | n/a | 1.0 |
| 2007 | 4.5 | 8.4 | 22.3 | 10.2 | n/a | 1.0 |
| 2008 | 4.6 | 8.8 | 22.8 | 10.6 | n/a | 1.0 |
| 2009 | 4.7 | 9.0 | 24.4 | 11.9 | n/a | 1.0 |
| 2010 | 4.8 | 9.3 | 26.4 | 13.1 | n/a | 1.0 |
| Projections: | | | | | | |
| 2011 | 4.9 | 9.5 | 27.8 | 14.1 | n/a | 1.0 |
| 2012 | 5.1 | 9.7 | 28.3 | 14.6 | n/a | 1.0 |
| 2013 | 5.2 | 9.7 | 28.3 | 14.8 | n/a | 1.0 |
| 2014 | 5.4 | 9.8 | 29.5 | 15.6 | 3.7 | 1.0 |
| 2015 | 5.5 | 9.8 | 30.8 | 16.2 | 7.9 | 1.0 |
| 2016 | 5.7 | 9.9 | 31.8 | 16.6 | 11.0 | 1.0 |
| 2017 | 5.9 | 10.0 | 32.2 | 16.8 | 12.0 | 1.0 |
| 2018 | 6.0 | 10.0 | 32.4 | 16.9 | 12.4 | 1.0 |
| 2019 | 6.2 | 10.1 | 32.6 | 16.9 | 12.5 | 1.0 |
| 2020 | 6.4 | 10.1 | 32.8 | 17.0 | 12.6 | 1.0 |
| 2021 | 6.6 | 10.2 | 32.9 | 17.0 | 12.6 | 1.0 |
| 2022 | 6.9 | 10.3 | 33.1 | 17.1 | 12.6 | 1.0 |

**Table 7—Past and Projected Medicaid Expenditures on Medical Assistance Payments
Per Enrollee, by Enrollment Category, FY 2000–FY 2022**
(in dollars per person-year equivalent enrollee)

| Fiscal Year | Aged | Disabled | Children | Adults | Newly eligible adults | Average of all enrollees |
|------------------|----------|----------|----------|---------|-----------------------|--------------------------|
| Historical data: | | | | | | |
| 2000 | \$14,068 | \$12,156 | \$1,714 | \$2,797 | n/a | \$5,359 |
| 2001 | 14,817 | 13,022 | 1,831 | 2,879 | n/a | 5,545 |
| 2002 | 14,960 | 14,466 | 1,997 | 2,954 | n/a | 5,779 |
| 2003 | 14,585 | 14,982 | 2,036 | 3,081 | n/a | 5,833 |
| 2004 | 14,872 | 15,108 | 2,073 | 3,237 | n/a | 5,893 |
| 2005 | 15,564 | 15,943 | 2,154 | 3,365 | n/a | 6,210 |
| 2006 | 14,832 | 15,453 | 2,289 | 3,447 | n/a | 6,138 |
| 2007 | 14,900 | 15,981 | 2,477 | 3,693 | n/a | 6,481 |
| 2008 | 15,563 | 16,271 | 2,543 | 3,901 | n/a | 6,703 |
| 2009 | 15,810 | 17,112 | 2,609 | 4,015 | n/a | 6,779 |
| 2010 | 15,470 | 17,494 | 2,598 | 4,058 | n/a | 6,685 |
| Projections: | | | | | | |
| 2011 | 15,803 | 17,950 | 2,630 | 4,206 | n/a | 6,768 |
| 2012 | 15,688 | 17,255 | 2,700 | 4,101 | n/a | 6,641 |
| 2013 | 16,162 | 18,089 | 2,889 | 4,381 | n/a | 7,013 |
| 2014 | 16,672 | 19,091 | 3,034 | 4,682 | \$4,636 | 7,131 |
| 2015 | 17,165 | 19,679 | 3,023 | 4,781 | 3,976 | 6,980 |
| 2016 | 17,900 | 20,629 | 3,111 | 5,002 | 3,625 | 7,040 |
| 2017 | 18,781 | 21,767 | 3,283 | 5,304 | 3,703 | 7,367 |
| 2018 | 19,752 | 23,000 | 3,487 | 5,641 | 3,902 | 7,799 |
| 2019 | 20,730 | 24,241 | 3,709 | 5,997 | 4,126 | 8,265 |
| 2020 | 21,731 | 25,537 | 3,948 | 6,373 | 4,365 | 8,763 |
| 2021 | 22,753 | 26,902 | 4,201 | 6,771 | 4,612 | 9,286 |
| 2022 | 23,794 | 28,332 | 4,473 | 7,195 | 4,875 | 9,843 |

Table 8—Projected Medicaid Expenditures under “Baseline,” “Full Eligibility Expansion,” and “Without Eligibility Expansion” Scenarios
(in billions of dollars)

| Fiscal Year | Baseline scenario | Full expansion scenario | Without expansion scenario |
|------------------|-------------------|-------------------------|----------------------------|
| Historical data: | | | |
| 2000 | \$206.2 | \$206.2 | \$206.2 |
| 2001 | 229.0 | 229.0 | 229.0 |
| 2002 | 258.2 | 258.2 | 258.2 |
| 2003 | 276.2 | 276.2 | 276.2 |
| 2004 | 296.3 | 296.3 | 296.3 |
| 2005 | 315.9 | 315.9 | 315.9 |
| 2006 | 315.1 | 315.1 | 315.1 |
| 2007 | 332.2 | 332.2 | 332.2 |
| 2008 | 351.9 | 351.9 | 351.9 |
| 2009 | 378.6 | 378.6 | 378.6 |
| 2010 | 401.5 | 401.5 | 401.5 |
| 2011 | 427.4 | 427.4 | 427.4 |
| 2012 | 431.0 | 431.0 | 431.0 |
| Projections: | | | |
| 2013 | 456.4 | 456.4 | 456.4 |
| 2014 | 508.0 | 528.4 | 487.0 |
| 2015 | 544.4 | 568.4 | 505.5 |
| 2016 | 584.0 | 611.2 | 534.7 |
| 2017 | 623.2 | 654.3 | 568.1 |
| 2018 | 661.2 | 695.5 | 601.4 |
| 2019 | 704.2 | 740.9 | 640.3 |
| 2020 | 752.8 | 791.7 | 685.0 |
| 2021 | 801.8 | 848.6 | 729.9 |
| 2022 | 853.6 | 903.2 | 777.5 |

Table 9—Projected Medicaid Enrollment under “Baseline,” “Full Eligibility Expansion,” and “Without Eligibility Expansion” Scenarios
(in millions of person-year equivalents)

| Fiscal Year | Baseline scenario | Full expansion scenario | Without expansion scenario |
|------------------|-------------------|-------------------------|----------------------------|
| Historical data: | | | |
| 2000 | 34.5 | 34.5 | 34.5 |
| 2001 | 36.9 | 36.9 | 36.9 |
| 2002 | 40.5 | 40.5 | 40.5 |
| 2003 | 43.5 | 43.5 | 43.5 |
| 2004 | 45.2 | 45.2 | 45.2 |
| 2005 | 46.3 | 46.3 | 46.3 |
| 2006 | 46.7 | 46.7 | 46.7 |
| 2007 | 46.4 | 46.4 | 46.4 |
| 2008 | 47.7 | 47.7 | 47.7 |
| 2009 | 50.9 | 50.9 | 50.9 |
| 2010 | 54.6 | 54.6 | 54.6 |
| Projections: | | | |
| 2011 | 57.4 | 57.4 | 57.4 |
| 2012 | 58.6 | 58.6 | 58.6 |
| 2013 | 59.1 | 59.1 | 59.1 |
| 2014 | 65.0 | 71.6 | 59.1 |
| 2015 | 71.3 | 78.7 | 59.4 |
| 2016 | 75.9 | 82.9 | 59.8 |
| 2017 | 77.8 | 84.7 | 60.3 |
| 2018 | 78.8 | 85.6 | 60.7 |
| 2019 | 79.4 | 86.2 | 61.2 |
| 2020 | 79.9 | 86.8 | 61.6 |
| 2021 | 80.4 | 87.3 | 62.1 |
| 2022 | 80.9 | 87.8 | 62.5 |

Table 10—Projected Medicaid Expenditures: Comparison of 2012 versus 2013 Actuarial Reports on the Financial Outlook for Medicaid, FY 2008–2021
(in billions of dollars)

| Fiscal Year | 2013 Report | 2012 Report |
|--------------|-------------|-------------|
| 2000 | \$206.2 | \$206.2 |
| 2001 | 229.0 | 229.0 |
| 2002 | 258.2 | 258.2 |
| 2003 | 276.2 | 276.2 |
| 2004 | 296.3 | 296.3 |
| 2005 | 315.9 | 315.9 |
| 2006 | 315.1 | 315.1 |
| 2007 | 332.2 | 332.2 |
| 2008 | 351.9 | 351.9 |
| 2009 | 378.6 | 378.6 |
| 2010 | 401.5 | 401.5 |
| 2011 | 427.4 | 427.4 |
| 2012 | 431.0 | 432.0 |
| Projections: | | |
| 2013 | 456.4 | 450.5 |
| 2014 | 508.0 | 498.8 |
| 2015 | 544.4 | 538.0 |
| 2016 | 584.0 | 578.3 |
| 2017 | 623.2 | 617.2 |
| 2018 | 661.2 | 654.8 |
| 2019 | 704.2 | 698.1 |
| 2020 | 752.8 | 746.2 |
| 2021 | 801.8 | 795.0 |
| 2022 | 853.6 | n/a |

**Table 11—Past and Projected Medicaid Expenditures as Share of GDP, FY 1966–FY 2022,
Selected Years**
(in billions of dollars)

| Fiscal Year | Total expenditures | Expenditures as share of GDP |
|--------------|--------------------|------------------------------|
| 1966 | \$0.9 | 0.1% |
| 1970 | 5.1 | 0.5% |
| 1975 | 13.1 | 0.8% |
| 1980 | 25.2 | 0.9% |
| 1985 | 41.3 | 1.0% |
| 1990 | 72.2 | 1.2% |
| 1995 | 159.5 | 2.2% |
| 2000 | 206.2 | 2.1% |
| 2001 | 229.0 | 2.2% |
| 2002 | 258.2 | 2.4% |
| 2003 | 276.2 | 2.5% |
| 2004 | 296.3 | 2.5% |
| 2005 | 315.9 | 2.5% |
| 2006 | 315.1 | 2.4% |
| 2007 | 332.2 | 2.4% |
| 2008 | 351.9 | 2.5% |
| 2009 | 378.6 | 2.7% |
| 2010 | 401.5 | 2.8% |
| 2011 | 427.4 | 2.8% |
| 2012 | 431.0 | 2.7% |
| Projections: | | |
| 2013 | 456.4 | 2.8% |
| 2014 | 508.0 | 3.1% |
| 2015 | 544.4 | 3.1% |
| 2016 | 584.0 | 3.2% |
| 2017 | 623.2 | 3.2% |
| 2018 | 661.2 | 3.2% |
| 2019 | 704.2 | 3.2% |
| 2020 | 752.8 | 3.2% |
| 2021 | 801.8 | 3.3% |
| 2022 | 853.6 | 3.3% |