March 6, 2026

Highlights from the February 2026 Edition of MACStats

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Medicaid and CHIP Payment and Access Commission

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Overview

- Compiles data on Medicaid and State Children's Health Insurance Program (CHIP) from multiple sources, including:
  - Key statistics on Medicaid and CHIP
  - Trends in Medicaid and CHIP enrollment and spending
  - State-level Medicaid and CHIP enrollment and spending by eligibility group, type of service, and other factors
  - State-level Medicaid and CHIP eligibility thresholds
  - Measure of beneficiary health, use of services, and access to care
  - Technical guide

Key Statistics

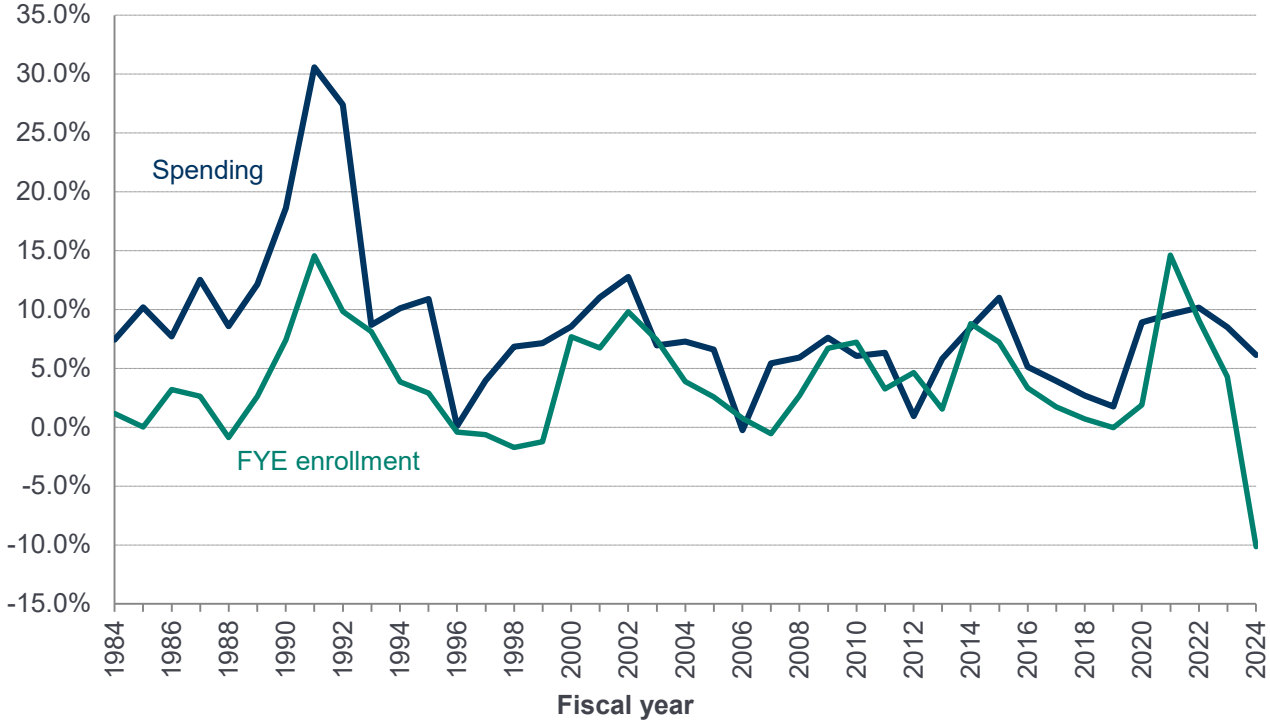
- In fiscal year (FY) 2024, more than 31 percent of the U.S. population was enrolled in Medicaid or CHIP for at least part of the year
  - 98.7 million in Medicaid
  - 9.2 million in CHIP
- Excluding federal funds, Medicaid made up 15.1 percent of state budgets in state fiscal year 2023; elementary and secondary education made up 23.0 percent
- Medicaid and CHIP were 18.4 percent of national health expenditures compared to 21.2 percent for Medicare in calendar year 2023

Full-Benefit Medicaid and CHIP Enrollment, Selected Months in 2013–2025 (millions)

Year	Number of Enrollees	Annual growth
July–September 2013 average	56.5	–
July 2022	90.3	–
July 2023	92.2	2.1%
July 2024	80.2	-13.0%
July 2025	78.0	-2.8%

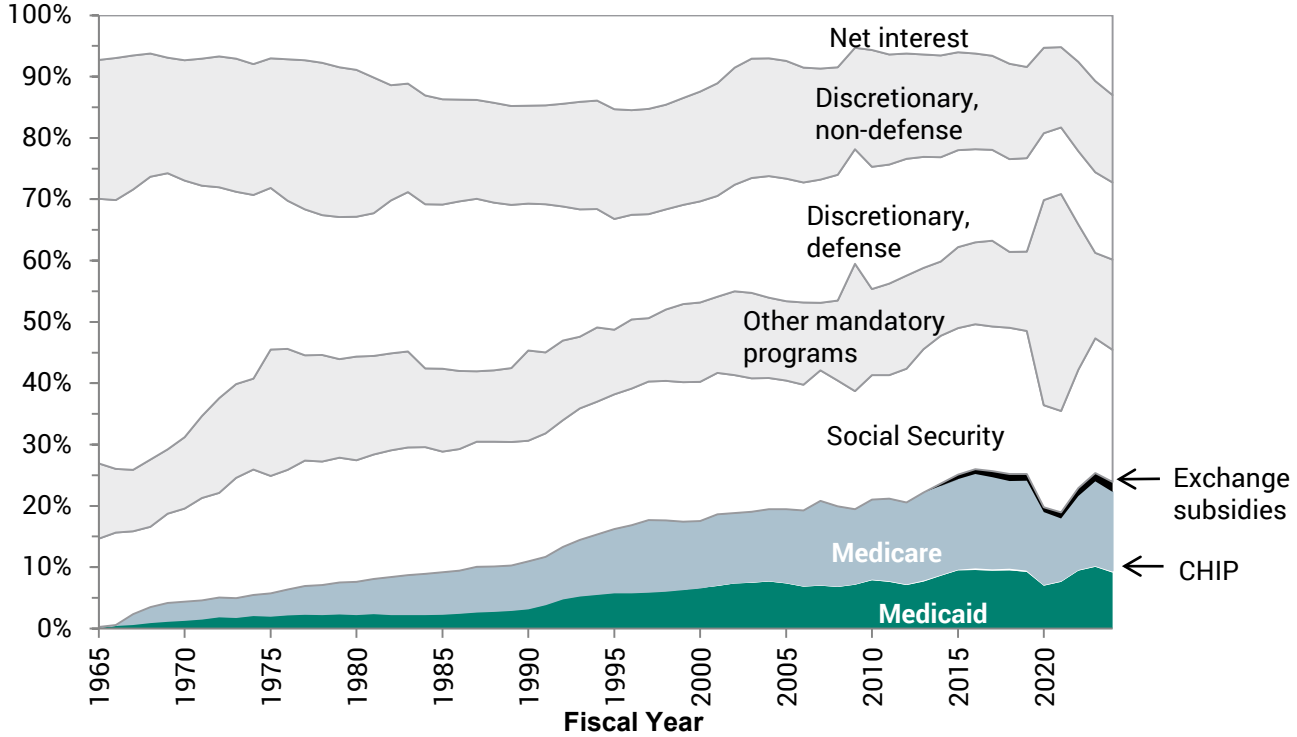
Source: MACPAC, 2026, *MACStats*, Exhibit 11, February 2026.

Annual Growth in Medicaid Enrollment and Spending, FY 1984–FY 2024



Notes: FY is fiscal year. FYE is full-year equivalent, which also may be referred to as average monthly enrollment. All numbers exclude CHIP-financed coverage. Spending consists of federal and state Medicaid expenditures for benefits and administration, excluding the Vaccines for Children program. Enrollment data for FYs 2013–2020 are projected; those for FYs 1999–2024 include estimates for the territories.
Source: MACPAC, 2026, *MACStats*, Exhibit 9, February 2026.

Major Components of Federal Budget as a Share of Total Federal Outlays, FY 1965–2024

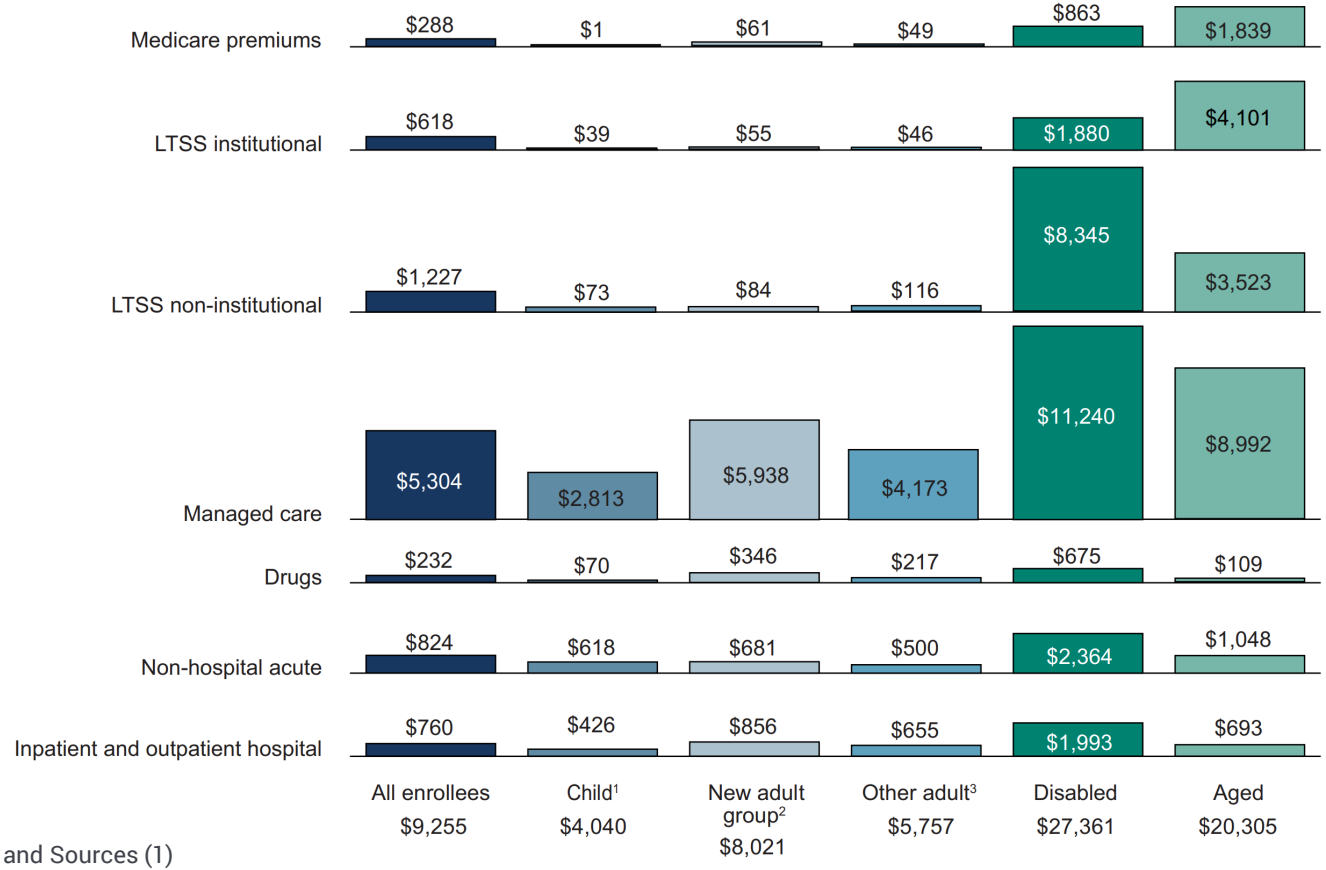


Note: FY is fiscal year.
Source: MACPAC, 2026, *MACStats*, Exhibit 4, February 2026.

Program Enrollment and Spending

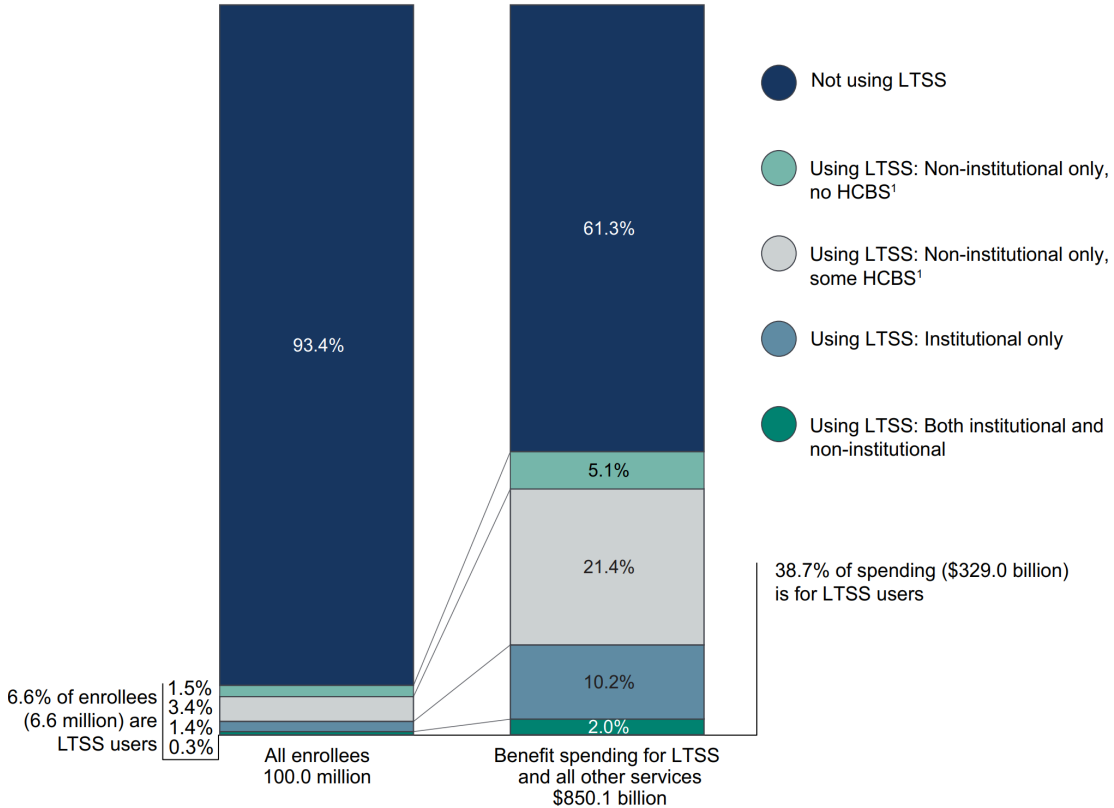
- Nearly three-quarters of enrollees were enrolled in comprehensive managed care and capitation payments to managed care plans accounted for over 50 percent of Medicaid benefit spending in FY 2023
- The new adult group accounted for 26 percent of enrollees and 23 percent of spending in FY 2023
- Drug rebates reduced gross drug spending by 54.9 percent in FY 2024
- Disproportionate share hospital (DSH), upper payment limit, and other types of supplemental payments accounted for over half (52.1 percent) of fee-for-service payments to hospitals in FY 2024

Medicaid Benefit Spending per Full-Year Equivalent (FYE) Enrollees, FY 2023



Notes and Sources (1)

Distribution of Medicaid Enrollment and Benefit Spending by Users and Non-Users of Long-Term Services and Supports, FY 2023



Notes and Sources (2)

Medicaid and CHIP Eligibility

- In 2024, about 36 percent of all individuals enrolled in Medicaid had family incomes below 100 percent of the federal poverty level (FPL) and 52 percent had incomes below 138 percent FPL
- As of July 2025, 40 states and the District of Columbia are now covering non-disabled low-income adults up to 138 percent FPL ($21,597 for a single individual)

Beneficiary Health, Service Use, and Access to Care

- In 2024, children and adults with Medicaid or CHIP coverage were less likely to be in excellent or very good health than those who have private coverage
- Children with Medicaid or CHIP coverage were as likely to report seeing a doctor or having a wellness visit within the past year as those with private coverage, and more likely than those who were uninsured
- While most children with Medicaid or CHIP coverage had a usual source of care, they were less likely to have one compared to children with private insurance
- Children and adults with Medicaid or CHIP coverage are as likely to report no difficulty reaching their usual medical provider by phone during business hours as those covered by private insurance

Figure Notes and Sources (1)

Notes: FY is fiscal year. LTSS is long-term services and supports. Full-year equivalent (FYE) may also be referred to as average monthly enrollment. Includes federal and state funds. Excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. Children and adults under age 65 who qualify for Medicaid on the basis of disability are included in the disabled category. Individuals age 65 and older eligible through an aged, blind, or disabled pathway are included in the aged category. Amounts are fee for service unless otherwise noted, and they reflect all enrollees, including those with limited benefits. Benefit spending from Transformed Medicaid Statistical Information System (T-MSIS) data has been adjusted to reflect CMS-64 totals. With regard to methods, spending totals exclude disproportionate share hospital (DSH) and certain incentive and uncompensated care pool payments made under waiver expenditure authority of Section 1115 of the Social Security Act (the Act), which were previously included before the December 2015 data book. Additionally, figures shown here may not be directly comparable to data books prior to 2025 due to a change in the method used to identify non-institutional LTSS. See https://www.macpac.gov/macstats/data-sources-and-methods/ for additional information.

[1] California, North Dakota, and Utah have a state plan amendment (SPA) that allows the state to receive the CHIP enhanced federal medical assistance percentage (FMAP) for Medicaid children who would have, before January 1, 2014, been enrolled in CHIP if not for the elimination of the Medicaid asset test. These children cannot be separately identified in the T-MSIS data. Because the state claims the spending for these children as Medicaid-expansion CHIP, we reduced child enrollment and spending in these states based on the proportion reported in their SPA. Correspondingly, we reduced child FYE enrollment by 259,000 and spending by $833.3 million.

[2] Includes both newly eligible and not newly eligible adults who are eligible under Section 1902(a)(10)(A)(i)(VIII) of the Act. Newly eligible adults include those who are not eligible for Medicaid under the rules that a state had in place on December 1, 2009. Not newly eligible adults include those who would have previously been eligible for Medicaid under the rules that a state had in place on December 1, 2009; this includes states that had already expanded to adults with incomes greater than 100 percent of the federal poverty level as of March 23, 2010, and receive the expansion state transitional matching rate.

[3] Includes adults under age 65 who qualify through a pathway other than disability or Section 1902(a)(10)(A)(i)(VIII) of the Act (e.g., parents and caretakers, pregnancy).

Source: MACPAC, 2026, *MACStats*, Exhibit 19, February 2026.

Figure Notes and Sources (2)

Notes: FY is fiscal year. LTSS is long-term services and supports. HCBS is home- and community-based services. Includes federal and state funds. Excludes spending on administration, the territories, and Medicaid-expansion CHIP enrollees. Benefit spending from Transformed Medicaid Statistical Information System (T-MSIS) data has been adjusted to reflect CMS-64 totals, and enrollment counts are unduplicated using unique national identification numbers. With regard to methods, spending totals exclude disproportionate share hospital (DSH) and certain incentive and uncompensated care pool payments made under waiver expenditure authority of Section 1115 of the Social Security Act (the Act), which were previously included prior to the December 2015 data book. Additionally, figures shown here may not be directly comparable to data books prior to 2025 due to a change in the method used to identify non-institutional LTSS. See https://www.macpac.gov/macstats/data-sources-and-methods/ for additional information.

LTSS users are defined here as enrollees using at least one LTSS service during the year. For example, an enrollee with a short stay in a nursing facility for rehabilitation following a hospital discharge and an enrollee with permanent residence in a nursing facility would both be counted as LTSS users. Beginning in 2025, this figure includes enrollees who received LTSS through a managed care plan as a user; this is a change from prior years that only identified users receiving services through a fee-for-service arrangement. As such, this figure may not be directly comparable to data books prior to 2025 due to this change.

California, North Dakota, and Utah have a state plan amendment (SPA) that allows the state to receive the enhanced FMAP for Medicaid children who would have, before January 1, 2014, been enrolled in CHIP if not for the elimination of the Medicaid asset test. These children cannot be separately identified in the T-MSIS data. Because the state claims the spending for these children as Medicaid-expansion CHIP, we reduced child enrollment and spending in these states based on the proportion reported in their SPA. Correspondingly, we reduced child FYE enrollment by 259,000 and spending by $833.3 million.

[1] All states have HCBS waiver programs that provide a range of LTSS for targeted populations of non-institutionalized enrollees who require institutional levels of care. The number of HCBS waiver enrollees and associated spending may be different from other sources such as the CMS-372 report (a state-reported source containing aggregate spending and enrollment for HCBS waivers).

Source: MACPAC, 2026, *MACStats*, Exhibit 19, February 2026.

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MARCH MEETING

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