

medicaid
and the uninsured

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**Medicaid Spending: What Factors Contributed to the Growth
Between 2000 and 2002?**

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Executive Summary

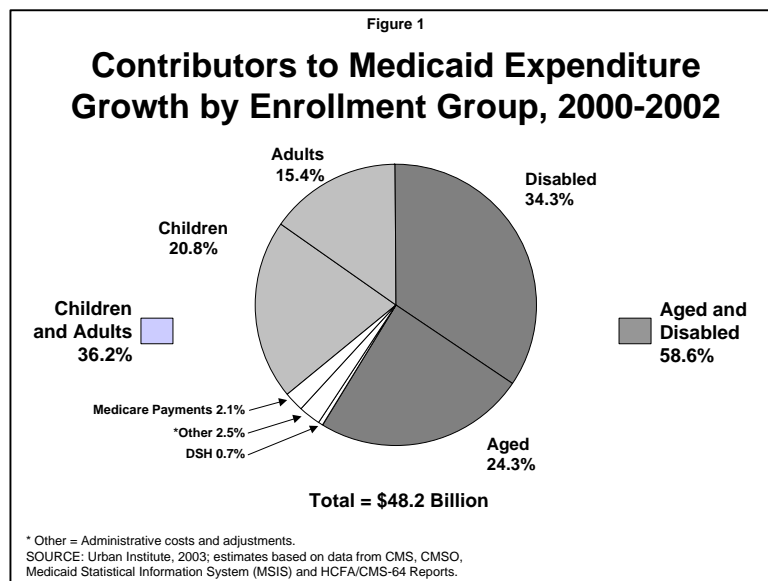
Total Medicaid spending rose by roughly 25% between federal fiscal year (FY) 2000 and FY 2002, increasing from \$205.8 billion to \$257.6 billion. At the same time, dramatic declines in state revenues have placed great pressure on state budgets, resulting in state efforts to curtail spending growth. Medicaid, the largest item in most state budgets after education, has been the target of cost-containment efforts in all 50 states and the District of Columbia.

This brief explores the factors underlying Medicaid spending growth. Rapid Medicaid spending growth has been driven, in part, by enrollment increases resulting from the loss of income and private insurance coverage during the current economic downturn, together with continued increases in hospital and prescription drug costs that have affected the entire health care sector. Despite slower enrollment growth for the aged and disabled than for children and nondisabled adults, the aged and disabled accounted for almost 60% of the spending growth. Although current growth rates may be high relative to state fiscal capacity, per enrollee spending growth is below levels seen in the private health care market.

Rapid enrollment growth among children and nondisabled adults can largely be attributed to the economic downturn, which resulted in declining incomes and lower rates of employer-sponsored insurance among low-income Americans. Medicaid enrollment grew in response. If Medicaid enrollment had not increased, the number of uninsured Americans would have increased sharply. As it was, data from the 2002 CPS (2001 data) showed that public program enrollment was sufficient to offset the decline in employer-sponsored insurance for children, but not for adults. As a result, the number of uninsured adults increased by 1.5 million, with further reported increases possible when the 2003 CPS is released (2002 data) later this month.

Medicaid spending per enrollee increased by 8.6% per year between 2000 and 2002. However, this is lower than the rates of increase in health care spending per person observed for those with private insurance and considerably lower than the rise in private health insurance premiums. Medicaid spending also increased because of rising health care costs in general. In particular, prescription drugs continue to increase at double-digit rates, with spending per enrollee increasing at about 15% per year. Medicaid is a large payer for prescription drugs because of the relatively poor health and levels of disability among its beneficiary population. Nearly half of all Medicaid drug spending went to elderly and disabled beneficiaries who were also covered by Medicare. Other acute care services such as outpatient hospitals, clinics, and prepaid managed care also had high rates of growth. In contrast, most long-term care services did not grow at particularly rapid rates. The exception was spending for home and community based services, which increased at about 12% per year.

While enrollment growth among children and nondisabled adults far exceeded the growth in the number of aged and disabled, the latter are far more expensive on a per enrollee basis. Increases in enrollment of the aged and disabled far exceeded growth in the general population, and this growth is likely to continue. Indeed, the program is affected by demographic changes that are outside of its control, such as increased rates of disability that are, in part, related to the aging of the population. Increased numbers of aged and disabled enrollees is leading to greater use of acute care and long-term care services. As a result, almost 60% of the growth in Medicaid spending over the last two years was due to increases in spending on aged and disabled individuals (Figure 1).



Interestingly, growth in acute care services among the aged and disabled was more of a contributor to growth in Medicaid spending for these populations than was growth in long-term care services (53% versus 47%), due to high use of prescription drugs and presumably technology-intensive acute care services.

Early indications are that spending growth in the program has moderated during FY 2003, with data through July 2003 suggesting an annual growth rate of 8.3%. State efforts to reduce the rate of enrollment growth through eligibility cutbacks, together with benefit reductions and provider payment freezes, have all likely contributed to this slowdown. State revenues have shown little signs of rebounding, however, and ongoing budget shortfalls will continue to place pressure on states to reduce spending growth in their Medicaid programs. While some of the factors that have driven Medicaid expenditures upward will fade as the economy improves – such as enrollment growth in response to the economic downturn – the effects of rising health care costs and demographic change on Medicaid expenditures will not. As a result, Medicaid will continue to place pressure on state budgets even with an economic recovery.

Overview

Medicaid spending growth accelerated between fiscal years 2000 and 2002, with expenditures increasing from \$205.8 billion to \$257.6 billion, or by 25% in just two years (Table 1). Overall spending increased by 11.9% per year, spending on medical services and disproportionate share payments to hospitals increased by 12.0%, and spending on medical services alone increased by 12.9%. As we will show below, this high rate of growth was driven by exceptionally large enrollment increases that occurred in response to the economic downturn and some other factors, as well as continued rapid increases in hospital and prescription drug costs that have affected the entire health care sector.

Table 1
Total Medicaid Expenditures, 1995-2002
(in billions)

	FY 1995	FY 1998	FY 2000	FY 2002	Average Annual Growth		
					1995-1998	1998-2000	2000-2002
Total Medicaid Expenditures	159.2	176.9	205.6	257.3	3.6%	7.8%	11.9%
Medical Services and DSH Payments	151.9	169.3	198.2	248.7	3.7%	8.2%	12.0%
Medical Services Only	133.1	154.4	182.6	232.8	5.1%	8.8%	12.9%

Source: Urban Institute estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64)

The increases that occurred in the last two years followed several years of slower growth. Between 1995-1998 Medicaid spending grew by 3.6% per year, and between 1998-2000, by 7.9% per year. Spending growth increased by only 3.6% per year in the mid 1990s for several reasons.¹ Because of welfare reform and the strong economy, there was an actual decline in Medicaid enrollment. At the same time, health care inflation was very low throughout the entire health care sector. Moreover, the introduction of Medicaid managed care resulted in a temporary slowdown in the Medicaid spending growth rate. Along with these factors, Medicaid disproportionate share payments to hospitals (DSH) began to decline after several years of significant increases; this reflected provisions of the Balanced Budget Act of 1997 that reduced DSH allotments.

In the late 1990s (1998-2000) Medicaid spending growth increased to 7.9% per year.² Medicaid enrollment, which had fallen unintentionally following welfare reform, began to rebound after the Centers for Medicare and Medicaid Services (CMS) directed states to increase outreach and states improved enrollment procedures.³ Consistent with significant revenue growth experienced in the late 1990s, almost all states adopted the State Children’s Health Insurance Program (SCHIP) and several used Section 1931(b) provisions of welfare reform or Section 1115 waivers to expand coverage.⁴ States also expanded home and community based waiver programs and developed prescription drug programs for the elderly. Meanwhile, health care inflation began to increase, particularly for prescription drugs, which grew at double-digit rates. Hospital costs for both inpatient and outpatient care increased more rapidly than in the mid 1990s. Growing use of upper payment limit arrangements (programs in which hospitals and nursing homes transferred funds to the states with the states increasing provider reimbursement rates and collecting federal matching payments) also contributed to rising Medicaid expenditures.

As we will discuss in detail below, Medicaid spending growth accelerated after 2000. Medicaid enrollment increased considerably, for several reasons. Health care costs increased more rapidly, led by prescription drugs and hospital costs. Medicaid managed care was no longer providing states with the same savings that it was providing in the mid 1990s. At the same time, state revenues declined dramatically and severe budget shortfalls developed in many states. Large numbers of states have subsequently made cuts in benefits and provider payment rates, and some have reduced eligibility standards.⁵

Growth in Enrollment

Medicaid enrollment increased by 7.2% per year between 2000-2002, or 14.9% over the two-year period (Table 2). Enrollment (defined as those ever on the program during the federal fiscal year) increased from 44.2 million to 50.8 million in 2002. The highest rates in enrollment growth occurred among children (8.2% per year) and adults (10.3% per year).

Enrollment of elderly and disabled individuals increased by 2.3% and 2.6%, respectively. These estimates are based on two different data sources. For 2000, we used data from the Medicaid Statistical Information System (MSIS) maintained by CMS.

Because 2002 data are not yet available from MSIS, we use estimates for 2002 provided by the Congressional Budget Office (CBO) in their March 2003

	2000	2002	Average annual percentage change	Percentage Change
Total Enrollment	44.2	50.8	7.2%	14.9%
Aged	4.3	4.5	2.3%	4.7%
Disabled	7.5	7.9	2.6%	5.3%
Children	21.8	25.5	8.2%	17.0%
Adults	10.6	12.9	10.3%	21.7%

Sources: Urban Institute estimates based on data from the Medicaid Statistical Information System (MSIS) and the Congressional Budget Office’s March 2003 Baseline.

baseline.⁶ These data on enrollment growth are consistent with data provided by surveys conducted by Health Management Associates (HMA) for the Kaiser Commission on Medicaid and the Uninsured.^{7,8}

The large enrollment growth seems to be due to a combination of the economic downturn, coupled with the increase in eligibility pathways that occurred because of SCHIP waivers, Section 1931(b) expansions, and Section 1115 waivers. These state expansions allowed more avenues for people to become eligible for Medicaid. Further, declining incomes after 2000 – i.e., increases in the number of people below the poverty level and below two times the poverty level – made more people eligible at all eligibility levels.⁹

The MSIS/CBO data are also consistent with analyses that we have presented in a previous paper.¹⁰ In that paper, we used Current Population Survey (CPS) data to calculate Medicaid, SCHIP, and state program enrollment growth between 2000 and 2001 (the most recent CPS year available). These data, shown in Table 3, indicate that Medicaid enrollment (all non-elderly beneficiaries) grew by 8.0% between 2000-2001. Enrollment increased by 9.4% for children and 6.1% for adults. Unlike the MSIS/CBO data in Table 2, enrollment growth was faster for children than for adults. However, the CPS data in Table 3 include SCHIP enrollment, and SCHIP experienced rapid rates of growth during this period because the program was in its relative infancy. Enrollment growth of adults below 100% of poverty, which is predominately Medicaid,¹¹ was actually faster for adults than for children.

Table 3
Nonelderly Covered by Medicaid or State Programs, CPS 2000-2001
by Health Insurance Unit Income
(in thousands)

	Nonelderly			Children			Adults		
	2000	2001	% Change	2000	2001	% Change	2000	2001	% Change
All Incomes	26,226	28,330	8.0%	15,627	17,089	9.4%	10,599	11,241	6.1%
Less than 100% of FPL	14,461	15,229	5.3%	8,562	8,984	4.9%	5,898	6,245	5.9%
100-199% of FPL	7,506	8,327	10.9%	4,686	5,277	12.6%	2,820	3,050	8.2%
200% of FPL and above	4,259	4,775	12.1%	2,378	2,828	18.9%	1,881	1,947	3.5%

Source: Holahan, John, and Marie Wang. 2003. "Changes in Health Care Coverage, 2000-2001." Pub. no. 4089. Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured. March.

Note: Excludes persons aged 65 and older, those in the Armed Forces and the institutionalized population.

In the same paper, we showed a sharp drop in employer sponsored insurance (ESI) between 2000 and 2001, which seemingly led to increases in Medicaid coverage. Figure 2 shows some results from that analysis, which found that there was a decline of 1.3 percentage points in the rate of employer sponsored insurance among nonelderly individuals. Medicaid coverage increased by 0.8 percentage points for this population, offsetting some but not the entire decline in ESI. As a result, the number of uninsured increased. Figure 2 also shows that there were declines in ESI of 1.7 percentage points for children and 1.2 percentage points for adults. Medicaid and SCHIP enrollment increases seemed to fully offset the decline in ESI for children. Because there are fewer

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