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Medicaid's High Cost Enrollees: How Much Do They Drive Program Spending?

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Overview

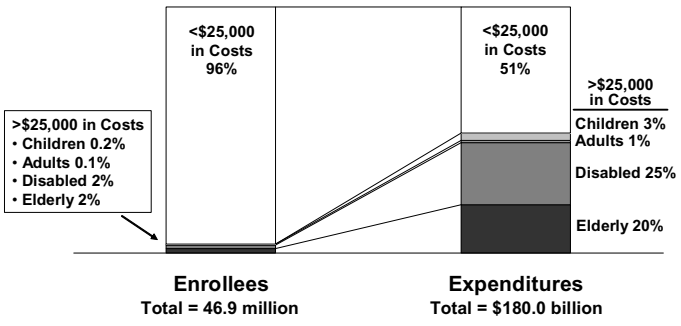
Achieving cost savings in the Medicaid program has become increasingly important to federal and state policy makers. In order to develop long-run cost saving reforms, it is helpful to understand how Medicaid spending is distributed and where the costs are concentrated.

Medicaid serves a very diverse population, including low-income children, parents and pregnant women, working disabled adults and severely disabled adults and children living in communities, and elderly and disabled living in institutions. Previous research has demonstrated that most Medicaid enrollees are low cost, with average spending well below average spending in the private market, after accounting for the poorer health status of Medicaid enrollees relative to individuals covered through the private market.[1] However, some Medicaid enrollees incur very high costs, and these individuals represent an area of possible cost reduction due to the high level of services they utilize and the large share of total Medicaid spending for which they are accountable.

This brief presents new information on the distribution of Medicaid spending for all enrollees, including those residing in institutions, with a particular focus on "high-cost" individuals, defined here as those who spend above certain dollar amounts annually. In Federal Fiscal Year (FFY) 2001, the 7.6% of enrollees with annual spending exceeding $10,000 accounted for roughly two of every three Medicaid dollars spent nationally (65.3%), and the 3.6% of Medicaid enrollees with annual spending exceeding $25,000 accounted for nearly half (48.8%) of all Medicaid spending (Figure 1).

Figure 1

Small Share of Medicaid Population Accounts for Large Share of Expenditures



SOURCE: Urban Institute estimates based on MSIS 2001 data.

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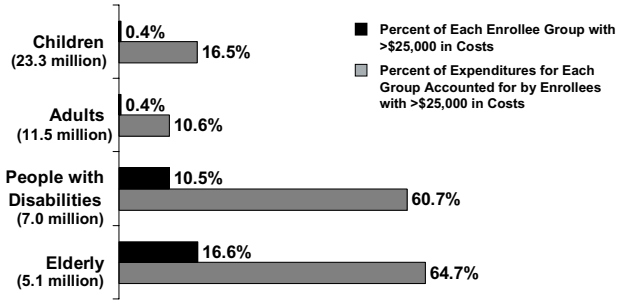
Across all major eligibility groups, a small share of enrollees account for a very large share of spending; otherwise, most Medicaid enrollees are relatively low-cost (Figure 2). More than half (53.6%) of all enrollees had spending of less than $1,000 in 2001, while 11.2% had no Medicaid spending whatsoever. This skewed distribution in spending among enrollees suggests opportunities to develop cost-containment strategies that focus on a small group of very high-cost enrollees and the services they use, while maintaining access to an appropriate level of care.

Figure 2

High Cost Enrollees Account for Large Share of Expenditures Among Groups



SOURCE: Urban Institute estimates based on MSIS 2001 data.

Background, Data Sources, and Methods

On average, Medicaid spending grew over 10% annually between 2000 and 2003.[2] Recent research has attributed growth in Medicaid expenditures primarily to higher caseloads stemming from the economic downturn beginning in 2001.[3] Average spending per enrollee has also climbed, but not as fast as per enrollee spending in the private insurance market. Growth in Medicaid spending is a critical issue for both federal and state governments because they jointly finance Medicaid. In 2004, Medicaid accounted for 7% of the federal budget and an estimated 17% of state general fund spending.[4]

Both federal and state policy makers have proposed new Medicaid cost containment strategies. Last year, the Medicaid Commission established by Department of Health and Human Services Secretary Michael Leavitt recommended reforms to achieve $10 billion in savings over a 5 year period.[5] These proposed reforms were broad in scope and included recommendations to reduce the prices Medicaid pays for pharmaceuticals, toughen eligibility standards for elderly persons transferring assets prior to becoming eligible for Medicaid, increase copayments by enrollees, and reform managed care organization provider tax requirements. The National Governors Association (NGA) has also developed a set of proposals for short-run cost containment in Medicaid, proposing many of the same strategies proposed by Leavitt's Commission.[6] The Deficit Reduction Act of 2005 (DRA), signed into law on February 8, 2006, adopted several of these policies to generate an expected $11.5 billion in savings over the next 5 years.[7] The NGA has also acknowledged the need for "broader program and health care reforms" to

achieve sustainable growth in Medicaid over the long run. The analysis presented here provides additional data to help inform the development of such long-term cost containment strategies.

The concentration of medical spending among a small group of users is typical in all health insurance markets, including Medicare[8] and the employer-sponsored health insurance market.[9] A 2005 study by Schneider, Lambrew, and Shenouda examined the distribution of spending for Medicaid enrollees in 2002 among the non-institutionalized using the Medical Expenditure Panel Survey (MEPS).[10] This study found that the top 10% of non-institutionalized enrollees accounted for 72% of Medicaid spending for this population. Medicaid spent an average of $7,770 per beneficiary in this top 10 percentile, with 40% of these costs attributable to hospital care. Several chronic conditions conducive to medical management were commonly reported among these high-cost enrollees, including high blood pressure, heart disease, and diabetes. This suggests that potentially large cost savings might be realized by managing the care of these high cost users with concentrated spending. The analysis presented here includes all Medicaid enrollees, including the institutionalized – who account for nearly a third of all Medicaid spending – together with the non-institutionalized, providing one of the first comprehensive pictures of the distribution of spending in Medicaid.

This brief is based on analysis of the 2001 Medicaid Statistical Information System (MSIS) Summary File, examining the distribution of spending in Medicaid for all Medicaid enrollees – including those in long-term care institutions – and the characteristics of "high-cost" users. The MSIS data contains aggregated expenditure data for 46.9 million enrollees in 2001. For each Medicaid enrollee, the MSIS reports aggregated expenditures for 29 service categories, including five types of institutional spending and three types of capitated managed care or prepaid services. Unlike the MEPS, which tracks only the non-institutionalized population, the 2001 MSIS Summary File includes individuals residing in institutions, but does not include information on diagnoses or conditions, so we cannot draw conclusions about the composition of chronic conditions in this population.

The analysis begins with the distribution of spending for all Medicaid enrollees, both those enrolled for the full year and part of the year. The four major categories of enrollment – elderly, disabled, children, and adults – are then analyzed separately. The elderly and disabled are also examined by those with and without institutional spending. The disabled are defined as those classified as disabled by the Medicaid program for the purposes of Medicaid eligibility, and include adults age 21-64 and some children under age 21. Non-disabled adults and children are also analyzed by those with and without managed care spending. Capitated arrangements that pay health plans or providers a monthly or prospective lump sum for most services can obscure the identification of enrollees who would be high-cost based on services utilized, so our calculations of the distribution of medical spending may underestimate some individual beneficiary's actual use of high-cost services.[11] Spending data include capitated payments to HMOs, prepaid health plans (PHP), and to providers for Primary Care Case Management (PCCM). Adults include non-disabled parents, relative caretakers, and pregnant women. The child category includes all children under the age of 21 who were not classified as disabled by the Medicaid program, but includes some children with disabilities or special health care needs who were deemed eligible for Medicaid through criteria other than disability.

This analysis excludes individuals in MSIS with unknown eligibility, individuals with a negative annual expenditure total, lump sum payments in MSIS that could not be attributed to a particular beneficiary, and any Medicaid expenditures not reported in MSIS. Expenditures not reported in MSIS include any payments made by Medicaid to states reported as administrative costs or accounting adjustments, disproportionate share (DSH) payments to providers, and all payments to Medicare (premiums or copayments) on behalf of Medicaid enrollees.

Results

Distribution of Spending for All Enrollees

Table 1 shows the distribution of Medicaid expenditures by total expenditures per person and the share of all enrollment and expenditures represented by each expenditure interval.[12] In FFY 2001, those with spending over $25,000 (referred to here as "high cost") represented only 3.6% of enrollees, but accounted for almost half of all spending, 48.8% or $87.8 billion. Only 1.1% of enrollees had spending greater than $50,000, but this top one percent accounts for over a quarter (25.7%) of all Medicaid spending, or $46.2 billion. Those with spending under $5,000 (referred to here as "low-cost"), represented 85.7% of Medicaid enrollees in FFY 2001, but accounted for only 22.8% of all spending. More than half (53.6%) of all enrollees had spending of less than $1,000 in 2001, including more than one in ten Medicaid enrollees (11.2%) who had zero spending.

Table 1

Total Medicaid Enrollment and Expenditures: Total, Full and Part-Year, MSIS 2001

	Total Expenditures Per Person	Enrollment (thousands)	% of All Enrollment	Total Expenditures (millions)	% of All Expenditures
All	**United States**	**46,908**	**100.0%**	**$180,026**	**100.0%**
	$0	5,252	11.2%	$0	0.0%
	$0-$1000	19,874	42.4%	$8,267	4.6%
	$1000-$2000	8,465	18.0%	$11,720	6.5%
	$2000-$5000	6,618	14.1%	$21,037	11.7%
	$5000-$10000	3,100	6.6%	$21,460	11.9%
	$10000-$25000	1,886	4.0%	$29,706	16.5%
	$25000-$50000	1,184	2.5%	$41,625	23.1%
	$50000+	529	1.1%	$46,210	25.7%
	Mean (in dollars)			*$3,838*	
Full-Year Enrollees	**United States**	**26,148**	**55.7%**	**$142,554**	**79.2%**
	$0	1,017	2.2%	$0	0.0%
	$0-$1000	9,100	19.4%	$4,541	2.5%
	$1000-$2000	6,143	13.1%	$8,465	4.7%
	$2000-$5000	4,688	10.0%	$14,899	8.3%
	$5000-$10000	2,321	4.9%	$16,136	9.0%
	$10000-$25000	1,400	3.0%	$22,049	12.2%
	$25000-$50000	1,010	2.2%	$35,754	19.9%
	$50000+	469	1.0%	$40,711	22.6%
	Mean (in dollars)			*$5,452*	
Part-Year Enrollees	**United States**	**20,761**	**44.3%**	**$37,471**	**20.8%**
	$0	4,235	9.0%	$0	0.0%
	$0-$1000	10,774	23.0%	$3,726	2.1%
	$1000-$2000	2,322	4.9%	$3,256	1.8%
	$2000-$5000	1,930	4.1%	$6,138	3.4%
	$5000-$10000	779	1.7%	$5,324	3.0%
	$10000-$25000	487	1.0%	$7,658	4.3%
	$25000-$50000	174	0.4%	$5,871	3.3%
	$50000+	60	0.1%	$5,498	3.1%
	Mean (in dollars)			*$1,805*	

The second and third blocks in Table 1 show the distribution of Medicaid expenditures for full-year and part-year enrollees. The 26.1 million enrollees enrolled for the full year in Medicaid accounted for 55.7% of all enrollees and nearly four of every five Medicaid dollars (79.2%) in 2001. As would be expected, most of the high-cost enrollees – about 86% – were full-year enrollees. Most of those with no spending – 80.6% – were part-year enrollees, although a few part-year enrollees were high-cost.

Table 2 on the next page shows the distribution of Medicaid expenditures by institutional care status. Although institutionalized enrollees have the highest average expenditures ($36,062), non-institutionalized enrollees constitute the vast majority (96.6%) of enrollees and more than two-thirds (68.4%) of expenditures. Although a very small percentage of enrollees had institutional care, 3.4%, they accounted for a disproportionately large percentage of total expenditures, 31.6%. The bulk of this spending was attributable to an even smaller share of enrollees with spending over $25,000 who accounted for more than a quarter (27.1%) of all Medicaid spending in 2001. Non-institutionalized enrollees show a similar but slightly less skewed distribution.

Table 3 shows the distribution of Medicaid expenditures for the elderly. A total of 5.1 million elderly accounted for expenditures in Medicaid of $54.5 billion, an average of $10,656 per elderly beneficiary. Overall, 16.6% of the elderly had spending over $25,000, which accounted for 64.7% of the spending on the elderly, or 19.6% of all Medicaid spending. Elderly high-cost enrollees (with spending over $25,000) represented 848,000 enrollees and $35.2 billion. Although the elderly are generally considered to have above average spending as a group, nearly a third (31.2%) of the elderly enrollees had spending in Medicaid of less than $1,000, including the roughly 13% of all elderly enrollees with no spending. Expenditures for many elderly Medicaid enrollees may not reflect total spending on their medical care because expenditures that are covered through Medicare cannot be counted in this analysis; some elderly with low or no spending in Medicaid might instead have high spending in Medicare.

High-cost enrollees with institutional care accounted for 14.1% of elderly enrollees, but 54.7% of expenditures for the elderly. High-cost elderly enrollees without institutional care accounted for 2.4% of elderly enrollees and only 10.0% of expenditures for the elderly.

Table 2

Total Medicaid Enrollment and Expenditures by Institutional Care, MSIS 2001

	Total Expenditures Per Person	Enrollment (thousands)	% of All Enrollment	Total Expenditures (millions)	% of All Expenditures
All	**United States**	**46,908**	**100.0%**	**$180,026**	**100.0%**
	$0	5,252	11.2%	$0	0.0%
	$0-$1000	19,874	42.4%	$8,267	4.6%
	$1000-$2000	8,465	18.0%	$11,720	6.5%
	$2000-$5000	6,618	14.1%	$21,037	11.7%
	$5000-$10000	3,100	6.6%	$21,460	11.9%
	$10000-$25000	1,886	4.0%	$29,706	16.5%
	$25000-$50000	1,184	2.5%	$41,625	23.1%
	$50000+	529	1.1%	$46,210	25.7%
	Mean (in dollars)			*$3,838*	
With Institutional Care*	**United States**	**1,577**	**3.4%**	**$56,856**	**31.6%**
	$0	0	0.0%	$0	0.0%
	$0-$1000	12	0.0%	$6	0.0%
	$1000-$2000	16	0.0%	$24	0.0%
	$2000-$5000	66	0.1%	$235	0.1%
	$5000-$10000	121	0.3%	$909	0.5%
	$10000-$25000	386	0.8%	$6,873	3.8%
	$25000-$50000	700	1.5%	$25,063	13.9%
	$50000+	277	0.6%	$23,746	13.2%
	Mean (in dollars)			*$36,062*	
Without Institutional Care	**United States**	**45,332**	**96.6%**	**$123,170**	**68.4%**
	$0	5,252	11.2%	$0	0.0%
	$0-$1000	19,862	42.3%	$8,261	4.6%
	$1000-$2000	8,449	18.0%	$11,696	6.5%
	$2000-$5000	6,552	14.0%	$20,802	11.6%
	$5000-$10000	2,979	6.4%	$20,551	11.4%
	$10000-$25000	1,501	3.2%	$22,833	12.7%
	$25000-$50000	484	1.0%	$16,563	9.2%
	$50000+	252	0.5%	$22,464	12.5%
	Mean (in dollars)			*$2,717*	

* Institutional care includes nursing home and intermediate care facility services for the mentally retarded.

Table 3

Total Medicaid Enrollment and Expenditures for the Elderly, MSIS 2001

	Total Expenditures Per Person	Enrollment (thousands)	% of Elderly Enrollment	% of All Enrollment	Total Expenditures (millions)	% of Elderly Expenditures	% of All Expenditures
All	**United States**	**5,117**	**100.0%**	**10.9%**	**$54,526**	**100.0%**	**30.3%**
	$0	651	12.7%	1.4%	$0	0.0%	0.0%
	$0-$1000	947	18.5%	2.0%	$365	0.7%	0.2%
	$1000-$2000	502	9.8%	1.1%	$740	1.4%	0.4%
	$2000-$5000	946	18.5%	2.0%	$3,122	5.7%	1.7%
	$5000-$10000	555	10.8%	1.2%	$3,927	7.2%	2.2%
	$10000-$25000	667	13.0%	1.4%	$11,090	20.3%	6.2%
	$25000-$50000	691	13.5%	1.5%	$24,303	44.6%	13.5%
	$50000+	157	3.1%	0.3%	$10,980	20.1%	6.1%
	Mean (in dollars)				*$10,656*		
With Institutional Care*	**United States**	**1,261**	**24.6%**	**2.7%**	**$37,042**	**67.9%**	**20.6%**
	$0	0	0.0%	0.0%	$0	0.0%	0.0%
	$0-$1000	10	0.2%	0.0%	$5	0.0%	0.0%
	$1000-$2000	14	0.3%	0.0%	$21	0.0%	0.0%
	$2000-$5000	59	1.2%	0.1%	$211	0.4%	0.1%
	$5000-$10000	108	2.1%	0.2%	$814	1.5%	0.5%
	$10000-$25000	345	6.7%	0.7%	$6,151	11.3%	3.4%
	$25000-$50000	596	11.7%	1.3%	$21,169	38.8%	11.8%
	$50000+	128	2.5%	0.3%	$8,670	15.9%	4.8%
	Mean (in dollars)				*$29,378*		
Without Institutional Care	**United States**	**3,856**	**75.4%**	**8.2%**	**$17,484**	**32.1%**	**9.7%**
	$0	651	12.7%	1.4%	$0	0.0%	0.0%
	$0-$1000	937	18.3%	2.0%	$359	0.7%	0.2%
	$1000-$2000	488	9.5%	1.0%	$719	1.3%	0.4%
	$2000-$5000	886	17.3%	1.9%	$2,911	5.3%	1.6%
	$5000-$10000	446	8.7%	1.0%	$3,113	5.7%	1.7%
	$10000-$25000	322	6.3%	0.7%	$4,939	9.1%	2.7%
	$25000-$50000	95	1.9%	0.2%	$3,134	5.7%	1.7%
	$50000+	29	0.6%	0.1%	$2,310	4.2%	1.3%
	Mean (in dollars)				*$4,534*		

* Institutional care includes nursing home and intermediate care facility services for the mentally retarded.

Table 4 shows the expenditure distribution for adult and child enrollees eligible based on disability. A total of almost 7.0 million disabled accounted for expenditures in Medicaid of $74.7 billion, an average of $10,710 per disabled beneficiary. Overall, 10.6% of the disabled had spending over $25,000, which accounted for 60.7% of the spending on the disabled, or 25.2% of all Medicaid spending. Disabled high-cost enrollees (with spending over $25,000) represented 734,000 enrollees and $45.4 billion. Although the

Table 4

Total Medicaid Enrollment and Expenditures for the Disabled, MSIS 2001

	Total Expenditures Per Person	Enrollment (thousands)	% of Disabled Enrollment	% of All Enrollment	Total Expenditures (millions)	% of Disabled Expenditures	% of All Expenditures
All	**United States**	**6,972**	**100.0%**	**14.9%**	**$74,674**	**100.0%**	**41.5%**
	$0	538	7.7%	1.1%	$0	0.0%	0.0%
	$0-$1000	1,323	19.0%	2.8%	$523	0.7%	0.3%
	$1000-$2000	696	10.0%	1.5%	$1,025	1.4%	0.6%
	$2000-$5000	1,505	21.6%	3.2%	$5,209	7.0%	2.9%
	$5000-$10000	1,332	19.1%	2.8%	$9,402	12.6%	5.2%
	$10000-$25000	845	12.1%	1.8%	$13,152	17.6%	7.3%
	$25000-$50000	408	5.9%	0.9%	$14,420	19.3%	8.0%
	$50000+	326	4.7%	0.7%	$30,943	41.4%	17.2%
	Mean (in dollars)				*$10,710*		
With Institutional Care*	**United States**	**310**	**4.4%**	**0.7%**	**$19,560**	**26.2%**	**10.9%**
	$0	0	0.0%	0.0%	$0	0.0%	0.0%
	$0-$1000	1	0.0%	0.0%	$1	0.0%	0.0%
	$1000-$2000	2	0.0%	0.0%	$2	0.0%	0.0%
	$2000-$5000	6	0.1%	0.0%	$21	0.0%	0.0%
	$5000-$10000	12	0.2%	0.0%	$89	0.1%	0.0%
	$10000-$25000	39	0.6%	0.1%	$701	0.9%	0.4%
	$25000-$50000	103	1.5%	0.2%	$3,858	5.2%	2.1%
	$50000+	147	2.1%	0.3%	$14,888	19.9%	8.3%
	Mean (in dollars)				*$63,118*		
Without Institutional Care	**United States**	**6,663**	**95.6%**	**14.2%**	**$55,113**	**73.8%**	**30.6%**
	$0	538	7.7%	1.1%	$0	0.0%	0.0%
	$0-$1000	1,321	18.9%	2.8%	$523	0.7%	0.3%
	$1000-$2000	694	10.0%	1.5%	$1,023	1.4%	0.6%
	$2000-$5000	1,499	21.5%	3.2%	$5,188	6.9%	2.9%
	$5000-$10000	1,321	18.9%	2.8%	$9,313	12.5%	5.2%
	$10000-$25000	806	11.6%	1.7%	$12,450	16.7%	6.9%
	$25000-$50000	306	4.4%	0.7%	$10,562	14.1%	5.9%
	$50000+	178	2.6%	0.4%	$16,054	21.5%	8.9%
	Mean (in dollars)				*$8,272*		

* Institutional care includes nursing home and intermediate care facility services for the mentally retarded.

disabled are considered to have above average spending as a group, 19% of all disabled enrollees had spending less than $1,000, including about 8% who had no spending. As with the elderly, some of the disabled with low spending in Medicaid may have high costs through Medicare, since about 34% of the disabled are dually eligible for Medicaid and Medicare. The vast majority (95.6% of disabled enrollees had no institutional long-term care spending. However, high-cost disabled enrollees with institutional care accounted for a quarter (25.1%) of all spending for the disabled.

Tables 5 and 6 show the distribution of Medicaid expenditures for non-disabled children and adults, respectively. While these children and adults do not include those eligible for Medicaid based on disability, these groups can include children and adults with disabilities or chronic conditions more broadly defined. Non-disabled individuals also may have high spending due to an accident or illness that requires acute care treatment or long-term rehabilitation. These episodes are likely to be incurred over a short term but can still yield high expenditures. We also separately classify non-disabled children

and adults based on having any managed care spending (in the HMO, PHP, or PCCM spending categories).

Non-disabled children represent the largest number of enrollees in Medicaid – about 23.3 million in 2001. These children accounted for $30.8 billion (17.1% of all Medicaid spending) for an average of $1,320 per child (Table 5). It should be noted that children in Medicaid are often enrolled in managed care plans and approximately 69.3% were enrolled in managed care in 2001, based on reported spending in one of the three managed care spending categories. Because managed care plans are paid a capitated rate for each child, the distribution of actual services provided is difficult to observe. Children in managed care may have some spending outside of capitated payments for services used prior to enrollment in managed care and for services carved out of managed care contracts, but primarily their spending consists of capitated payments. Some children may have high levels of utilization that reflect high costs to managed care plans that cannot be observed using MSIS. Similarly, the percentage of children with no spending reported here will be low compared to the percentage of children with no utilization because children receiving no services who are enrolled in managed care will still have capitated spending. Nonetheless, spending for children reported in MSIS reflects total Medicaid spending for all children, regardless of their enrollment in a managed care plan.

Only a very small share of all non-disabled children – less than one-half of one percent – had spending over $25,000 and accounted for 16.5% of all spending for non-disabled children (Table 5). Another fraction of a percent of children has spending between $10,000 and $25,000 accounting for 9.5% of spending on children. Thus, about 285,000 children (1.2%) accounted for almost $8 billion in spending.

Most children enrolled in managed care had spending of less than $2,000. Calculations based on the data shown in Table 5 demonstrate that of all children enrolled in managed care, 86.0% of enrollees had spending under $2,000. Of children with no managed care spending, 31.4% had no spending at all (data not shown). Notably, although children in managed care account for 69.4% of all children in Medicaid, they account for only half of high-cost child enrollees (data not shown).

Non-disabled adults include low-income parents, pregnant women, and adults with no children in states with Section 1115 coverage expansions. Overall, less than one-half of one percent of non-disabled adults had spending over $25,000, accounting for 10.6% of all spending on non-disabled adults (1.2% of all Medicaid spending) (Table 6). Thus, about 44,000 adults accounted for just over $2 billion in spending, or about 1% of all Medicaid spending and 11% of spending on non-disabled adults. Almost half (49.4%) of non-disabled adults were enrolled in some form of managed care. Of those with managed care spending, two-thirds (66.8%) had total spending of less than $2,000. Although adults in managed care account for half of all adults in Medicaid, they account for a smaller share (36.7%) of high-cost adult enrollees.

Table 5

Total Medicaid Enrollment and Expenditures for Non-Disabled Children, MSIS 2001

	Total Expenditures Per Person	Enrollment (thousands)	% of Non-Disabled Children Enrollment	% of All Enrollment	Total Expenditures (millions)	% of Non-Disabled Children Expenditures	% of All Expenditures
All	**United States**	**23,327**	**100.0%**	**49.7%**	**$30,786**	**100.0%**	**17.1%**
	$0	2,242	9.6%	4.8%	$0	0.0%	0.0%
	$0-$1000	12,947	55.5%	27.6%	$5,786	18.8%	3.2%
	$1000-$2000	5,116	21.9%	10.9%	$6,899	22.4%	3.8%
	$2000-$5000	2,222	9.5%	4.7%	$6,642	21.6%	3.7%
	$5000-$10000	515	2.2%	1.1%	$3,467	11.3%	1.9%
	$10000-$25000	197	0.8%	0.4%	$2,925	9.5%	1.6%
	$25000-$50000	54	0.2%	0.1%	$1,877	6.1%	1.0%
	$50000+	33	0.1%	0.1%	$3,191	10.4%	1.8%
	Mean (in dollars)				*$1,320*		
With Managed Care*	**United States**	**16,183**	**69.4%**	**34.5%**	**$22,212**	**72.2%**	**12.3%**
	$0	0	0.0%	0.0%	$0	0.0%	0.0%
	$0-$1000	9,450	40.5%	20.1%	$4,618	15.0%	2.6%
	$1000-$2000	4,469	19.2%	9.5%	$5,991	19.5%	3.3%
	$2000-$5000	1,749	7.5%	3.7%	$5,172	16.8%	2.9%
	$5000-$10000	354	1.5%	0.8%	$2,355	7.7%	1.3%
	$10000-$25000	117	0.5%	0.3%	$1,722	5.6%	1.0%
	$25000-$50000	29	0.1%	0.1%	$987	3.2%	0.5%
	$50000+	15	0.1%	0.0%	$1,366	4.4%	0.8%
	Mean (in dollars)				*$1,373*		
Without Managed Care	**United States**	**7,144**	**30.6%**	**15.2%**	**$8,574**	**27.8%**	**4.8%**
	$0	2,242	9.6%	4.8%	$0	0.0%	0.0%
	$0-$1000	3,496	15.0%	7.5%	$1,168	3.8%	0.6%
	$1000-$2000	648	2.8%	1.4%	$907	2.9%	0.5%
	$2000-$5000	473	2.0%	1.0%	$1,470	4.8%	0.8%
	$5000-$10000	162	0.7%	0.3%	$1,111	3.6%	0.6%
	$10000-$25000	80	0.3%	0.2%	$1,203	3.9%	0.7%
	$25000-$50000	26	0.1%	0.1%	$890	2.9%	0.5%
	$50000+	18	0.1%	0.0%	$1,825	5.9%	1.0%
	Mean (in dollars)				*$1,200*		

* Managed care is defined here as HMO, prepaid health plan, or primary care case management services.

Table 6

Total Medicaid Enrollment and Expenditures for Non-Disabled Adults, MSIS 2001

	Total Expenditures Per Person	Enrollment (thousands)	% of Non-Disabled Adult Enrollment	% of All Enrollment	Total Expenditures (millions)	% of Non-Disabled Adult Expenditures	% of All Expenditures
All	**United States**	**11,492**	**100.0%**	**24.5%**	**$20,039**	**100.0%**	**11.1%**
	$0	1,821	15.8%	3.9%	$0	0.0%	0.0%
	$0-$1000	4,657	40.5%	9.9%	$1,593	7.9%	0.9%
	$1000-$2000	2,151	18.7%	4.6%	$3,057	15.3%	1.7%
	$2000-$5000	1,945	16.9%	4.1%	$6,064	30.3%	3.4%
	$5000-$10000	697	6.1%	1.5%	$4,665	23.3%	2.6%
	$10000-$25000	177	1.5%	0.4%	$2,539	12.7%	1.4%
	$25000-$50000	30	0.3%	0.1%	$1,025	5.1%	0.6%
	$50000+	14	0.1%	0.0%	$1,096	5.5%	0.6%
	Mean (in dollars)				*$1,744*		
With Managed Care*	**United States**	**5,682**	**49.4%**	**12.1%**	**$12,314**	**61.4%**	**6.8%**
	$0	0	0.0%	0.0%	$0	0.0%	0.0%
	$0-$1000	1,960	17.1%	4.2%	$865	4.3%	0.5%
	$1000-$2000	1,833	16.0%	3.9%	$2,601	13.0%	1.4%
	$2000-$5000	1,375	12.0%	2.9%	$4,120	20.6%	2.3%
	$5000-$10000	407	3.5%	0.9%	$2,721	13.6%	1.5%
	$10000-$25000	90	0.8%	0.2%	$1,275	6.4%	0.7%
	$25000-$50000	12	0.1%	0.0%	$402	2.0%	0.2%
	$50000+	4	0.0%	0.0%	$328	1.6%	0.2%
	Mean (in dollars)				*$2,167*		
Without Managed Care	**United States**	**5,811**	**50.6%**	**12.4%**	**$7,725**	**38.6%**	**4.3%**
	$0	1,820	15.8%	3.9%	$0	0.0%	0.0%
	$0-$1000	2,697	23.5%	5.7%	$728	3.6%	0.4%
	$1000-$2000	318	2.8%	0.7%	$455	2.3%	0.3%
	$2000-$5000	571	5.0%	1.2%	$1,944	9.7%	1.1%
	$5000-$10000	290	2.5%	0.6%	$1,943	9.7%	1.1%
	$10000-$25000	86	0.8%	0.2%	$1,264	6.3%	0.7%
	$25000-$50000	18	0.2%	0.0%	$623	3.1%	0.3%
	$50000+	9	0.1%	0.0%	$768	3.8%	0.4%
	Mean (in dollars)				*$1,329*		

* Managed care is defined here as HMO, prepaid health plan, or primary care case management services.

In addition, we examined spending for adults and children based on their full- and part-year enrollment in Medicaid (data not shown). Among children, 55% are full-year enrollees, compared to only 35% among adults. Among these full-year enrollees, average spending is much lower per child ($1,624) than per adult ($2,535). This difference is much higher than the overall averages presented in Tables 5 and 6. Therefore, differences in the length of time enrolled between adults and children obscure a greater difference in spending between adults and children.

Characteristics of High-Cost Enrollees

High-cost enrollees differ on important characteristics when compared to low-cost enrollees. High-cost Medicaid enrollees with over $25,000 in annual spending represent about 4% of all enrollees in 2001 and 49% of all spending. Low-cost enrollees, defined as having less than $5,000 in annual spending, represent 86% of all enrollees and 23% of all spending. Virtually all high-cost enrollees are elderly or disabled – 49% elderly and 43% disabled – and only 3% are non-disabled adults and 5% are non-disabled children (Table 7). High-cost enrollees classified as disabled have the highest average spending per enrollee of $61,794, followed by non-disabled children ($58,157). The elderly high-cost cases may have the lowest average spending because Medicare would cover most hospital and other acute care expenditures for most of these elderly. In contrast, 56% of low-cost enrollees are children.

A little over one third of high-cost enrollees are eligible through cash/1931 categories, a similar proportion as the low-cost enrollees, while another third of high-cost cases are classified for eligibility as "other," compared to only 15% of low-cost cases (Table 7). The "other" high-cost eligibles are virtually all disabled and aged, and include elderly in institutions covered at state option, the working disabled, and both elderly and disabled eligible solely through home and community-based waiver programs. This group is disproportionately high-cost. Among the "other" eligibles, 7.8% are high-cost compared to 3.6% overall.

Table 7

Characteristics of High-Cost and Low-Cost Medicaid Enrollees, 2001

	High-Cost Enrollees (Over $25,000)			Low-Cost Enrollees (Under $5,000)		
	Enrollment	Enrollment Percent	Average Spending per Enrollee	Enrollment	Enrollment Percent	Average Spending per Enrollee
Elderly	848,009	49%	$41,607	3,047,081	8%	$1,387
Disabled	734,097	43%	$61,794	4,060,655	10%	$1,664
Adult	43,923	3%	$48,301	10,574,244	26%	$1,013
Child	87,138	5%	$58,157	22,527,055	56%	$858
Cash	625,113	36%	$56,743	14,091,061	35%	$1,267
Poverty	122,202	7%	$50,035	12,861,528	32%	$844
Medically Needy	342,247	20%	$53,797	2,876,241	7%	$1,027
1115	15,865	1%	$48,976	4,180,648	10%	$697
Other*	607,728	35%	$44,527	6,199,270	15%	$1,040
Less than 21	189,674	11%	$63,273	24,251,593	60%	$887
21-64	657,649	38%	$60,241	12,709,285	32%	$1,183
65+	848,009	49%	$41,607	3,047,081	8%	$1,387
Unknown	17,835	1%	$52,294	201,076	1%	$1,245
Female	1,047,432	61%	$47,444	23,893,102	59%	$1,064
Male	664,864	39%	$57,259	16,204,047	40%	$958
Unknown	871	0%	$80,653	111,886	0%	$715
Hispanic/Latino	93,247	5%	$54,288	8,958,337	22%	$851
Black/Afr. American	296,752	17%	$52,796	10,224,939	25%	$1,024
White	1,113,315	65%	$49,273	16,747,703	42%	$1,082
Other	44,686	3%	$54,175	2,045,654	5%	$1,117
Unknown	165,167	10%	$59,506	2,232,402	6%	$1,131
TOTAL	**1,713,167**	**100%**	**$51,270**	**40,209,035**	**100%**	**$1,020**

Note: Totals do not include individuals with unknown eligibility or ineligibles, or individuals with negative spending.

* There were 299 individuals with known basis of eligibility but unknown MAS that were excluded from the totals in this MAS breakdown.

The medically needy account for 20% of high-cost cases, compared to 7% of low-cost cases (Table 7). Interestingly, this group has lower average spending relative to the cash eligibility group. It is important to note that not all medically needy enrollees have high medical costs. Medically needy programs allow states to cover individuals who are categorically eligible for Medicaid, but who have incomes above traditional limits established for state Medicaid programs. To qualify as medically needy, individuals can report medical expenditures to "spend down" their income to below medically needy income thresholds, which are set above categorical eligibility thresholds. Thus, many who qualify through this category have high medical costs. However, an individual with income above categorical income thresholds but below the medically needy threshold need not have *any* medical expenses to qualify. Thus, some medically needy enrollees can be expected to have spending comparable to low-cost enrollees. Nonetheless, the medically needy are disproportionately high-cost. While 3.6% of enrollees are high-cost overall, 9.3% of the medically needy are high-cost.

The majority of high-cost enrollees are female (61%), comparable to low-cost enrollees who are 59% female. However, the racial/ethnic distribution is very different between high-cost and low-cost cases, with 65% of high-cost cases reported as non-Hispanic White, 17% as Black/African-American, and 5% as Hispanic/Latino. In contrast, 42% of low-cost cases are reported as White non-Hispanic, 25% as Black/African-American, and 22% as Hispanic/Latino. This difference is likely due to a difference in the racial/ethnic distribution within the youngest and oldest age groups: compared to all Medicaid enrollees, a disproportionate share of children, the lowest cost group on average, are Black and Hispanic, while a disproportionate share of the elderly are White/non-Hispanic.

Table 8 shows the distribution of high-cost enrollees as a share of all enrollees in the state and in the U.S. Each state's total enrollment and enrollment as a share of U.S. total enrollment are presented for comparison. Shaded states are those with a disproportionately large share of high-cost enrollees relative to the state's share of all enrollees in Medicaid. In this table, states are considered to have a disproportionately large share of high-cost enrollees when the percentage point difference between a state's share of all high cost Medicaid enrollees and its share of all Medicaid enrollees is greater than 0.2 – one standard deviation above the mean difference. Not surprisingly, all Northeastern states except Vermont have a disproportionately high share of high-cost enrollees in their state relative to the state's share of the Medicaid population. This region has the highest average costs in the private insurance market, and constitutes the region with the highest costs of living. Some of the remaining shaded states, such as North Dakota and Ohio, rely heavily on institutional care to support the long-term care population. Notably, New York accounts for 7.5% of all Medicaid enrollees but 16.4% of all high-cost cases, a disproportionately high share.

Spending by Service among High-cost Enrollees

High-cost enrollees with per beneficiary spending over $25,000 spent a total of $87.8 billion, while low-cost enrollees with per beneficiary spending under $5,000 spent a total of $41.0 billion. Table 9 shows the distribution of spending across services for high-cost and low-cost cases. Nursing home care accounted for the largest share of spending on high-cost cases ($30.9 billion), followed by hospital care ($12.9 billion) and other acute care ($12.0 billion). Overall, 48% of spending for high-cost cases was attributable to long-term institutional care, including care for the mentally retarded and individuals with mental disease; while 16% was attributable to community-based long-term care, including home and community-based waiver services (HCBS) and other home health and personal attendant services not covered by waivers. In contrast, 75% of spending for low-cost enrollees was attributable to acute care services other than hospital care, including physician, outpatient services, and managed care payments, while 16% was for prescription drugs.

The distribution of spending by service for high-cost enrollees varied for the elderly, disabled, non-disabled adults, and non-disabled children (Table 9). Among the elderly, 71% of spending was for nursing home care, and spending for other services was distributed uniformly across other services. Among the disabled, spending was distributed fairly evenly across long term and acute care services. Spending on ICF/MR and institutional care for persons with mental disease was accountable for one-fifth of all spending for the disabled. Among non-disabled adults, hospital care accounted for the majority of spending, while prescription drugs accounted for 8% and other acute care accounted for 18% of spending. Among non-disabled children, spending on ICF/MR and institutional psychiatric care was accountable for 14% of spending, while hospital care accounted for 45% and other acute care accounted for 31%.

Table 8

High Cost Medicaid Enrollees: State Distribution, 2001

State	Number of Enrollees in State	Number of High Cost Enrollees	All Enrollees in State as Share of U.S. Total	High Cost Enrollees as Share of U.S. Total	High Cost Enrollees As Share of State's Enrollment
Total	**46,908,433**	**1,713,167**	**100%**	**100%**	**3.7%**
AK	99,655	4,416	0.2%	0.3%	4.4%
AL	778,218	22,301	1.7%	1.3%	2.9%
AR	550,320	14,131	1.2%	0.8%	2.6%
AZ	808,132	27,670	1.7%	1.6%	3.4%
CA	8,526,417	147,464	18.2%	8.6%	1.7%
CO	410,306	19,544	0.9%	1.1%	4.8%
CT	443,530	32,025	0.9%	1.9%	7.2%
DC	152,406	7,885	0.3%	0.5%	5.2%
DE	133,047	4,745	0.3%	0.3%	3.6%
FL	2,432,335	74,972	5.2%	4.4%	3.1%
GA	1,327,248	31,763	2.8%	1.9%	2.4%
HI	189,529	3,983	0.4%	0.2%	2.1%
IA	330,236	17,310	0.7%	1.0%	5.2%
ID	172,243	7,427	0.4%	0.4%	4.3%
IL	1,796,315	73,333	3.8%	4.3%	4.1%
IN	824,298	39,512	1.8%	2.3%	4.8%
KS	280,125	16,766	0.6%	1.0%	6.0%
KY	760,488	26,963	1.6%	1.6%	3.5%
LA	879,065	29,048	1.9%	1.7%	3.3%
MA	1,124,100	59,162	2.4%	3.5%	5.3%
MD	702,730	36,719	1.5%	2.1%	5.2%
ME	277,058	15,053	0.6%	0.9%	5.4%
MI	1,429,640	31,225	3.0%	1.8%	2.2%
MN	657,399	40,698	1.4%	2.4%	6.2%
MO	1,030,989	37,198	2.2%	2.2%	3.6%
MS	676,842	19,828	1.4%	1.2%	2.9%
MT	101,722	5,364	0.2%	0.3%	5.3%
NC	1,375,108	53,665	2.9%	3.1%	3.9%
ND	65,219	5,256	0.1%	0.3%	8.1%
NE	248,679	10,333	0.5%	0.6%	4.2%
NH	108,418	8,885	0.2%	0.5%	8.2%
NJ	921,957	54,746	2.0%	3.2%	5.9%
NM	423,402	9,774	0.9%	0.6%	2.3%
NV	166,979	5,058	0.4%	0.3%	3.0%
NY	3,521,765	280,833	7.5%	16.4%	8.0%
OH	1,650,712	88,289	3.5%	5.2%	5.3%
OK	676,868	20,685	1.4%	1.2%	3.1%
OR	594,219	10,003	1.3%	0.6%	1.7%
PA	1,645,703	67,396	3.5%	3.9%	4.1%
RI	193,089	11,745	0.4%	0.7%	6.1%
SC	871,631	22,320	1.9%	1.3%	2.6%
SD	106,130	5,038	0.2%	0.3%	4.7%
TN	1,580,778	19,956	3.4%	1.2%	1.3%
TX	2,723,764	83,806	5.8%	4.9%	3.1%
UT	214,347	6,473	0.5%	0.4%	3.0%
VA	700,032	25,715	1.5%	1.5%	3.7%
VT	151,891	5,232	0.3%	0.3%	3.4%
WA	1,000,307	18,263	2.1%	1.1%	1.8%
WI	664,148	36,741	1.4%	2.1%	5.5%
WV	351,103	13,724	0.7%	0.8%	3.9%
WY	57,791	2,726	0.1%	0.2%	4.7%

Source: Estimates based on Urban Institute calculations on MSIS 2001 Summary File.

Note: Totals do not include individuals with unknown eligibility, or individuals with negative spending. High cost cases defined as Medicaid spending >$25,000 in FFY 2001. Shaded states denote a share of high-cost cases disproportionately high (>0.2 percentage point difference or one standard deviation) relative to the state's share of total enrollment.

Table 9

Medicaid Spending for High Cost and Low Cost Enrollees - Column Percents

	Total				Elderly				Disabled			
Service Groups	High Cost		Low Cost		High Cost		Low Cost		High Cost		Low Cost	
	Spending (in millions)	Percent	Spending (in millions)	Percent	Spending (in millions)	Percent	Spending (in millions)	Percent	Spending (in millions)	Percent	Spending (in millions)	Percent
Total Medicaid Spending	**$87,835**	**100%**	**$41,024**	**100%**	**$35,283**	**100%**	**$4,226**	**100%**	**$45,362**	**100%**	**$6,757**	**100%**
Nursing Home	$30,888	35%	$181	0%	$25,083	71%	$167	4%	$5,733	13%	$12	0%
ICFMR/Mental Health*	$11,031	13%	$18	0%	$1,091	3%	$1	0%	$9,236	20%	$5	0%
HCBS	$9,065	10%	$125	0%	$1,044	3%	$75	2%	$7,742	17%	$45	1%
Other Community Long-Term Care**	$5,322	6%	$666	2%	$2,111	6%	$127	3%	$2,930	6%	$205	3%
Hospital	$12,902	15%	$2,892	7%	$1,362	4%	$216	5%	$8,020	18%	$204	3%
Drugs	$6,649	8%	$6,574	16%	$2,436	7%	$2,108	50%	$3,833	8%	$2,202	33%
Other Acute Care***	$11,978	14%	$30,567	75%	$2,156	6%	$1,531	36%	$7,869	17%	$4,085	60%

	Non-Disabled Adults				Non-Disabled Children			
Service Groups	High Cost		Low Cost		High Cost		Low Cost	
	Spending (in millions)	Percent	Spending (in millions)	Percent	Spending (in millions)	Percent	Spending (in millions)	Percent
Total Medicaid Spending	**$2,122**	**100%**	**$10,714**	**100%**	**$5,068**	**100%**	**$19,327**	**100%**
Nursing Home	$28	1%	$1	0%	$43	1%	$1	0%
ICFMR/Mental Health*	$15	1%	$1	0%	$689	14%	$12	0%
HCBS	$216	10%	$2	0%	$65	1%	$3	0%
Other Community Long-Term Care**	$38	2%	$34	0%	$243	5%	$300	2%
Hospital	$1,265	60%	$1,284	12%	$2,255	45%	$1,188	6%
Drugs	$169	8%	$887	8%	$211	4%	$1,377	7%
Other Acute Care***	$391	18%	$8,505	79%	$1,562	31%	$16,447	85%

High cost is defined as those spending more than $25,000 and low cost is defined as those spending less than $5,000.

Note: Totals do not include individuals with unknown eligibility or ineligibles, or individuals with negative spending.

* ICFMR/Mental Health includes intermediate care facility services for the mentally retarded, services in institutions for mental disease for the elderly, and inpatient psychiatric care for children under age 21.

** Other Community Long-Term Care includes home health, personal care, hospice, targeted case management, and private duty nursing.

*** Other Acute Care services include physician, outpatient, clinic, lab and x-ray, HMO, prepaid health plan, primary care case management, nurse practitioner, dental, and other practitioners, rehabilitation. and other therapies, and transportation.

Conclusion

This analysis demonstrates that fewer than 5% of Medicaid enrollees spent more than $25,000 in 2001 but these 1.7 million enrollees accounted for nearly half of all spending in Medicaid. For all four major population groups served by Medicaid – the elderly, disabled, and non-disabled adults and children – a small share of enrollees in each group account for a very large share of spending. Otherwise, most Medicaid enrollees are low-cost. More than half of all enrollees had spending of less than $1,000, and 86% had less than $5,000. This very skewed distribution in spending among enrollees suggests an opportunity for controlling Medicaid expenditures by developing cost containment strategies focused on a small group of high-cost individuals. The challenge is to promote strategies for cost containment that continue to provide an appropriate level of care for those most in need. Although research has demonstrated that it is less expensive to provide care to the non-disabled population through Medicaid rather than through the private market,[13] caring for many high-cost users has been the primary responsibility of Medicaid, especially those who are institutionalized or have severe disability. Therefore, it is more difficult to assess what the "appropriate" level of spending is for such high-cost users.

High-cost enrollees are primarily elderly and disabled, but otherwise appear to be a heterogeneous group in terms of their eligibility categories and demographics. A number of states have a disproportionate share of high costs enrollees, including states in the Northeast where health care costs are higher and states that rely heavily on institutional care. While individuals qualifying through medically needy categories are perceived to be high-cost, and they do account for 20% of high-cost cases, not all medically needy are high-cost. Similarly, some disabled enrollees appear to have low annual costs. The corollary to these findings is that there may be some individuals with high medical expenses that cannot be identified here because the bulk of expenses are incurred in Medicare. Since the first step to developing intervention strategies for any high-cost group is identification of those at risk of incurring high costs prospectively,

capacity to track and link overall Medicaid and Medicare costs for individuals dually eligible should be developed. Special needs managed care plans established through the Medicare Modernization Act that are expected to serve the dually eligible could provide information systems for compiling such data.

Spending distributions among high-cost enrollees exhibit different service use patterns by eligibility group, suggesting that spending patterns may be a function of different cost drivers, and intervention strategies for the elderly, disabled, adults, and children would need to vary. The broad distribution of spending for the high-cost disabled suggests that interventions would require assessment of service use in integrated care settings. Some high-cost enrollees who incur costs episodically through hospital admissions may be difficult to identify prospectively, while others served in long-term care settings, such as ICF/MR and nursing homes may be more suitable for prospective identification.

The data we use do not track specific medical diagnoses, or identify specific providers. Further analysis is best conducted by states using more detailed claims data to identify potential interventions appropriate within a state based on its program and delivery structure. Because managed care capitation arrangements obscure actual costs across enrollees of managed care plans, some high-cost users can only be identified by managed care plans. Special needs plans under Medicare Part D will provide an opportunity to further understand service use patterns among high-cost users within managed care settings. However, reduced spending for high-cost users in managed care will only translate into savings to the Medicaid program if capitation rates are adjusted to reflect such savings.

Our analysis shows that fewer than 5% of enrollees account for almost half of all Medicaid spending, or about $88 billion. Achieving savings for this group may be difficult due to their complex health needs. The amount of savings that could be achieved through a combination of care coordination, reduced emphasis on institutionalization, and reductions in service duplication over the long run has not yet been enumerated. Studies on cost savings associated with state-based disease management programs in Medicaid show promise but are so far inconclusive.[14] Given that the private insurance market has also faced dramatic increases in costs, fundamental changes that reshape delivery systems, and reform or integrate financing strategies across markets may be required to achieve long-run Medicaid cost containment. Regardless, because spending in the program is so skewed, strategies that focus on providing more appropriate and efficient care to high cost cases may hold the greatest potential for reigning in long-run Medicaid cost growth without adversely affecting access to necessary and appropriate care.

Endnotes

[1] Hadley, Jack, and John Holahan. 2003. Is Health Care Spending Higher under Medicaid or Private Insurance? Inquiry 40(4): 323-342.
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[11] Enrollees are identified as recipients of managed care based on having positive expenditures for HMO, PHP, or PCCM service categories. A handful of enrollees have positive spending in these categories but zero spending across all service categories when expenditures are summed. They are included as managed care recipients nonetheless.
[12] Note that due to rounding, the percentages and amounts used in text of the report may not match those the reader may calculate using data presented in tables.
[13] Hadley and Holahan, 2004.
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