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THE HENRY J. KAISER FAMILY FOUNDATION

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Understanding the Recent Changes in Medicaid Spending and Enrollment Growth Between 2000-2004

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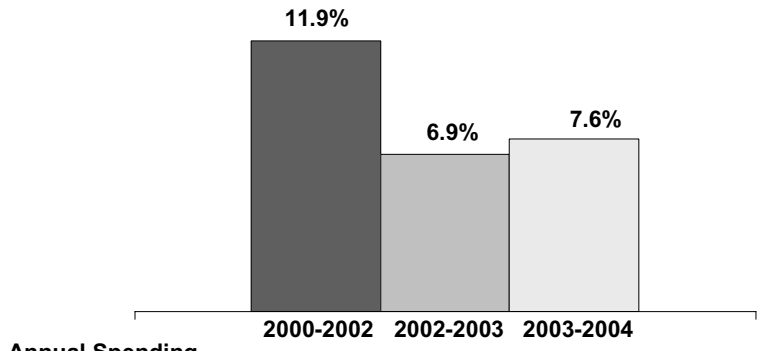
Executive Summary

Medicaid spending increased between 2000 and 2004 from $205.7 billion to $295.9 billion, an average annual increase of 9.5%. Growth over the period reflected changes in the overall economy, increasing from 2000 to 2002 during the recession and then slowing from 2002 to 2004 as the economy improved. During the entire four-year period, spending per enrollee increased by only slightly more than the rate of inflation. Rising enrollment and health care inflation produced most of Medicaid's overall spending increases. Even with a stronger economy, however, enrollment pressures on Medicaid remain due to demographic trends and continued declines in employer sponsored insurance.

In 2003 Medicaid spending grew 6.9% and that rate increased slightly in 2004 to 7.6%, but spending in both those years increased more slowly than the average annual rate of 11.9% from 2000 to 2002 (Figure 1). During the entire four-year period Medicaid spending growth, like overall national health care spending, outpaced US gross domestic product (GDP) growth, putting additional resource demands on both federal and state budgets and prompting efforts to restrain program spending.[1] On a per capita basis, Medicaid acute care spending grew more slowly than health care spending for those with private coverage (Figure 2). Increases in the number of people served by Medicaid, not higher spending per enrollee, drove the program's spending increases.

Figure 1

Overall Average Annual Medicaid Spending Growth, 2000-2004



SOURCE: Urban Institute, 2005; estimates based on data from HCFA Financial Management Reports, 2004 (HCFA-64/CMS-64).

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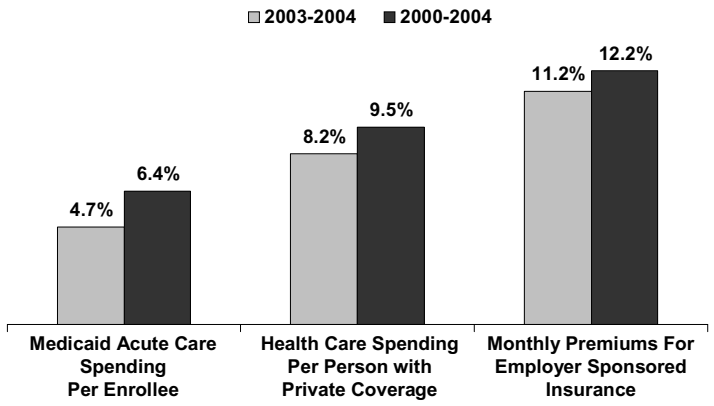
Much of Medicaid spending growth between 2000 and 2004 reflects a shift from private to public spending and not additional dollars being spent on health care. That shift occurred because of the decline in employer-sponsored coverage due to loss of jobs, declines in incomes, the shift of workers to small firms and industries less likely to offer coverage, and rising health care costs.[2] Had these low-income families who lost employer-sponsored insurance not gained coverage through Medicaid, the number of Americans who joined the ranks of the uninsured between 2000 and 2004 (six million) would likely have been even larger. While these trends have contributed to increased Medicaid enrollment, they actually reflect a shift in how low-income individuals are insured and where the cost of their care is borne. Thus, a significant share of the growing costs of Medicaid, while impacting federal and state budgets, is not contributing to the overall increase in health care as a share of our nation's GDP.

Figure 2

Medicaid Spending Growth For Acute Care Services Versus Private Insurance, 2000-2004



*Kaiser/HRET Survey of Employer Sponsored Health Benefits, 1999-2005; Bradley C. Strunk, Paul B. Ginsburg and John P. Cookson," Tracking Health Care Costs: Declining Growth Trend Pauses in 2004" Health Affairs, June 21, 2005

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Developing appropriate policies to address Medicaid spending growth requires understanding how and where this growth occurred. As with all government programs, changes in enrollment and in the amount spent on services per enrollee are the two key drivers of changes in overall spending. We show that the slowdown in spending growth between 2003 and 2004, as well as in 2002 to 2003, was the result of slower growth in enrollment for families and children, as well as a decrease in total long-term care spending. Those seeking a lower and more predictable rate of Medicaid growth need to recognize that enrollment has been the principal driver of changing rates of the program's spending growth.

Background

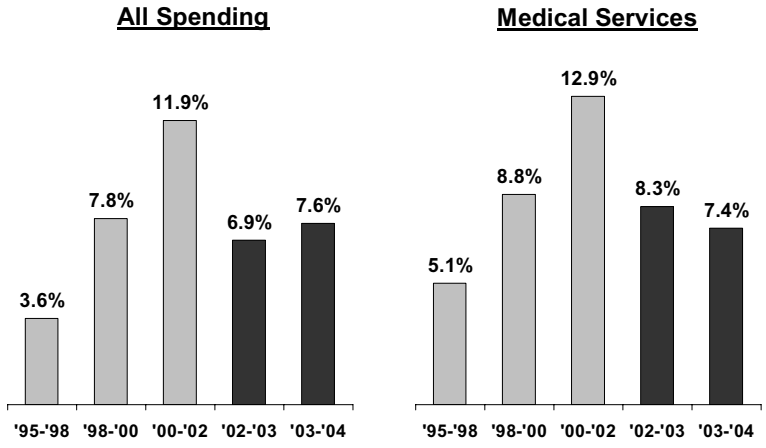
The growth in Medicaid spending of 7.6% in 2004, following the increase of 6.9% in 2003, returns the rate of spending increases to levels seen in the late 1990's (Figure 3). Medicaid spending growth has fluctuated over the last decade. Between 1995 and 1998, Medicaid spending grew by 3.6% per year. This low rate of growth occurred because of the decline in Medicaid enrollment resulting from both the loss of coverage as a result of welfare reform and the strong economy. Demand for labor grew because of strong economic growth, reducing Medicaid rolls as workers gained coverage. Health care cost growth was low because during that period health care inflation was low throughout the entire health sector.

In the late 1990's (1998-2000), Medicaid spending increased 7.8% per year.[3] This was largely due to increased Medicaid enrollment as the initial effects of welfare reform on enrollment were reversed, and people who had mistakenly been dropped from the program

were reenrolled. As state revenues improved post-economic downturn, several states used the Section 1931 provisions of the welfare reform legislation or Section 1115 waivers to expand coverage. Additionally, the implementation of the State Children's Health Insurance Program (SCHIP) in 1998 contributed to a rise in Medicaid enrollment as some of those who responded to the increased outreach efforts surrounding implementation and applied for SCHIP were actually eligible for Medicaid and enrolled in the program. In addition, health care costs 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-1990's. States also began to use upper payment limit programs more aggressively to generate additional federal matching funds, which contributed to Medicaid spending increases. These programs allow states to draw down additional federal funds through increased payment rates to selected providers, with the state share coming from inter-governmental transfers that do not always represent real state spending on health care.[4] As a result, while these strategies raise overall costs, they are used by states to reduce their share of spending.

Figure 3

Average Annual Growth in Medicaid Expenditures, 1998-2004



SOURCE: Urban Institute, 2005; estimates based on data from HCFA Financial Management Reports, 2004 (HCFA-64/CMS-64).

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Between 2000 and 2002, Medicaid spending growth again accelerated. Medicaid enrollment increased in part due to the previous expansions, but more importantly because job and income loss during the economic downturn made more people eligible for the program. Overall health care costs also began to increase more rapidly during this period, led by prescription drugs and hospital costs. Finally Medicaid managed care was no longer providing states with the same savings it had provided in the 1990's when states switched from fee-for-service to managed care. In 2003, Medicaid spending growth slowed somewhat, at 6.9% (8.3% for medical services), due to slower growth in enrollment and in spending per enrollee for acute care services. In addition, there were declines in disproportionate share hospital (DSH) payments and upper payment limit programs resulting from changes in federal policy. Medicaid spending growth in 2004 continued to be lower than the rates seen during the 2001 recession. Overall spending in 2004 grew 7.6% and enrollment grew 4.1%, which was less than half the average annual rate from 2000 to 2002.

Data Sources

This paper utilizes three data sources for enrollment and expenditures between the years 2000 and 2004. First, we used enrollment data from the Kaiser Commission on Medicaid and the Uninsured (KCMU) collected via survey by Health Management Associates (HMA) for all 50 states and the District of Columbia. These data provide enrollment as of June of each year. Due to the inconsistencies that occur between state reporting systems, HMA was only able to collect detailed data on the number of aged/disabled and families/children in 44 states. Using these data as well as total enrollment for the other seven states from KCMU, we allocated enrollment to the aged/disabled and families/children for the total population in the same proportions as was reported in the 44 states.

Second, we used the Medicaid Financial Management Reports (Form 64) from the Center for Medicare and Medicaid Services (CMS) for 1995-2004 to obtain aggregate spending on services. These data are available by state and by service, but are not stratified by enrollee type. We have made edits to correct for some inconsistencies in the reported data.

Third, we used data from the Medicaid Statistical Information System (MSIS) for 2000 for spending by eligibility group. MSIS contains detailed person-level data stratified by service type and eligibility group. These data are used to develop service level weights so that we can estimate spending growth by eligibility group. For certain analyses we projected these expenditures to increase by the growth rates that we observed in the CMS 64 data from 2000-2004. More details on our methodology can be found in Appendix A.

Results

Enrollment growth slows after rapid gains in 2001 and 2002

Overall enrollment growth slowed substantially between 2003 and 2004, growing at a rate of 4.1%, down from 5.7% in 2003 and an average of 9.0% per year between 2000 and 2002 (Table 1).[5] Much of this slowdown may be attributed to slower growth in families and children, which grew at a rate of 4.6% between 2003 and 2004, considerably slower than in the previous three years. The slowdown in growth for families and children is primarily the

Table 1
Change in Monthly US Medicaid Enrollment, 2000-2004
(in millions)

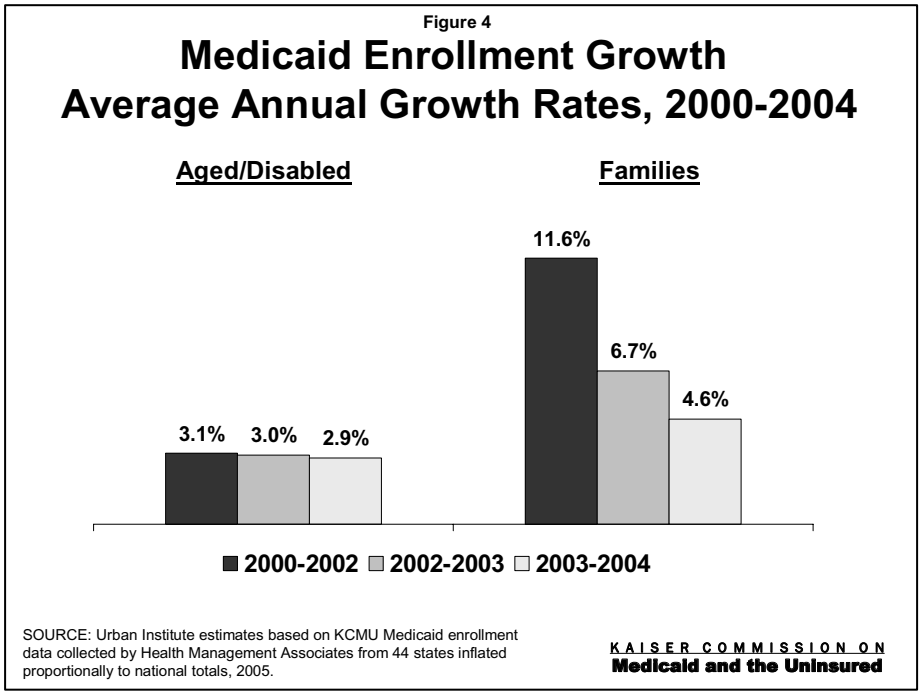
	Enrollment				Average Annual Growth Rate			
	June 2000	June 2002	June 2003	June 2004	2000-2002	2002-2003	2003-2004	2000-2004
Total Enrollment	**31.6**	**37.5**	**39.6**	**41.3**	**9.0%**	**5.7%**	**4.1%**	**6.9%**
Aged and Disabled	10.0	10.6	10.9	11.3	3.1%	3.0%	2.9%	3.0%
Families	21.6	26.9	28.7	30.0	11.6%	6.7%	4.6%	8.6%

Source: Urban Institute estimates based on Health Management Associates data

effect of the improved economy. The Current Population Survey (CPS) also showed that Medicaid enrollment growth in 2004 was considerably slower than in previous years in this decade.[6] This reflected the improving job market. Although the reduction in the rate of employer-sponsored insurance slowed, the continued declines in employer-sponsored insurance for low-income Americans contributed to some of the increase in Medicaid enrollment. State actions to reduce eligibility thresholds and outreach efforts may also have contributed to the slowdown in enrollment growth for families and children.

Growth in enrollment for the aged and disabled remained fairly consistent at roughly 3.0% over the entire period (Figure 4). However, while slower than the growth in families and children, this rate is still higher than growth in the overall US population. The continued enrollment growth in the aged and disabled at rates above general population growth is not well understood, but may be attributable to higher participation in Medicaid, as the rapid rise in the cost of

Figure 4



prescription drugs made Medicaid more attractive to this population. The baby boomers that will eventually affect the size of the elderly population are now in the 55-64 age range, ages at which as the likelihood of disabilities increases, the number of disabled beneficiaries could grow. The effects of life-saving medical technology that lengthens lives for many people with disabilities may also be a contributing factor. Improvements in drugs for HIV/AIDS patients have contributed to the longevity of people with this disease, increasing dependence on Medicaid. Another factor may be the increased recognition of chronic problems, particularly mental disease, as disabilities. For these reasons, Medicaid continues to face the cost pressures associated with increased enrollment of high cost beneficiaries.

Spending on acute care continues to grow more quickly than long-term care

Medicaid spending increased by only 7.6% in 2004, well below the average annual growth of 11.9% from 2000-2002 (Table 2), but an increase over 2003 (6.9%) due to adjustments in DSH spending. However, the growth in spending on medical services was slower in 2004 than 2003 (7.4% vs. 8.3%). Spending on acute care services increased by 8.5% in 2004 while long-term care spending increased by 5.4%. DSH spending increased by 20.3% in

Table 2
US Medicaid Expenditures by Type of Service and Year, 2000-2004

	Expenditures (in billions)				Average Annual Growth Rate			
	FFY 2000	FFY 2002	FFY 2003	FFY 2004	2000-2002	2002-2003	2003-2004	2000-2004
Total	**$205.7**	**$257.3**	**$275.1**	**$295.9**	**11.9%**	**6.9%**	**7.6%**	**9.5%**
Medical Services and DSH	$198.3	$248.8	$266.4	$288.1	12.0%	7.1%	8.1%	9.8%
Medical Services Only	$182.7	$232.8	$252.1	$270.9	12.9%	8.3%	7.4%	10.4%
Acute Care	**$102.6**	**$134.7**	**$150.1**	**$162.8**	**14.6%**	**11.4%**	**8.5%**	**12.2%**
Inpatient Hospital	$26.5	$32.7	$36.4	$39.1	11.1%	11.2%	7.6%	10.2%
Physician/Lab/X-Ray	$7.3	$9.3	$9.9	$11.5	12.9%	6.9%	15.6%	12.0%
Outpatient/Clinic	$13.2	$17.0	$17.6	$19.6	13.5%	3.6%	11.5%	10.5%
Prescribed Drugs	$16.6	$23.4	$26.6	$30.4	18.9%	13.6%	14.3%	16.4%
EPSDT	$0.8	$1.0	$1.1	$1.0	10.2%	7.5%	-3.5%	6.0%
Prepaid/Managed Care	$26.5	$35.8	$41.7	$44.9	16.2%	16.5%	7.9%	14.1%
Other Services[1]	$11.7	$15.5	$16.9	$16.2	15.3%	8.4%	-3.9%	8.5%
Long Term Care	**$75.4**	**$92.5**	**$95.8**	**$101.0**	**10.7%**	**3.6%**	**5.4%**	**7.6%**
Nursing Facility	$39.6	$47.5	$44.6	$46.5	9.5%	-6.0%	4.2%	4.1%
ICFMR[2]	$10.2	$11.3	$11.8	$12.1	5.4%	4.0%	3.0%	4.5%
Mental Health Institutions[3]	$3.3	$4.0	$4.9	$4.7	10.8%	20.2%	-2.3%	9.6%
Home/Personal Care[4]	$22.3	$29.6	$34.6	$37.6	15.2%	16.7%	8.8%	13.9%
Payments to Medicare	**$4.7**	**$5.7**	**$6.3**	**$7.1**	**9.5%**	**10.5%**	**13.4%**	**10.7%**
DSH Payments	**$15.6**	**$15.9**	**$14.3**	**$17.2**	**1.1%**	**-10.5%**	**20.3%**	**2.4%**
Inpatient	$11.6	$12.5	$11.5	$14.3	4.2%	-8.3%	24.0%	5.4%
Mental Health	$4.0	$3.4	$2.8	$2.9	-8.2%	-18.7%	5.2%	-7.8%
Adjustments	**-$1.2**	**-$3.3**	**-$4.8**	**-$6.5**	**66.0%**	**45.2%**	**36.1%**	**52.8%**
Administration	**$8.6**	**$11.9**	**$13.5**	**$14.4**	**17.6%**	**13.6%**	**6.7%**	**13.8%**

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

1) Includes dental, other practitioners, abortion, sterilization, PACE programs, emergency services for undocumented aliens, and other acute care services.

2) ICFMR = intermediate care facilities for the mentally retarded

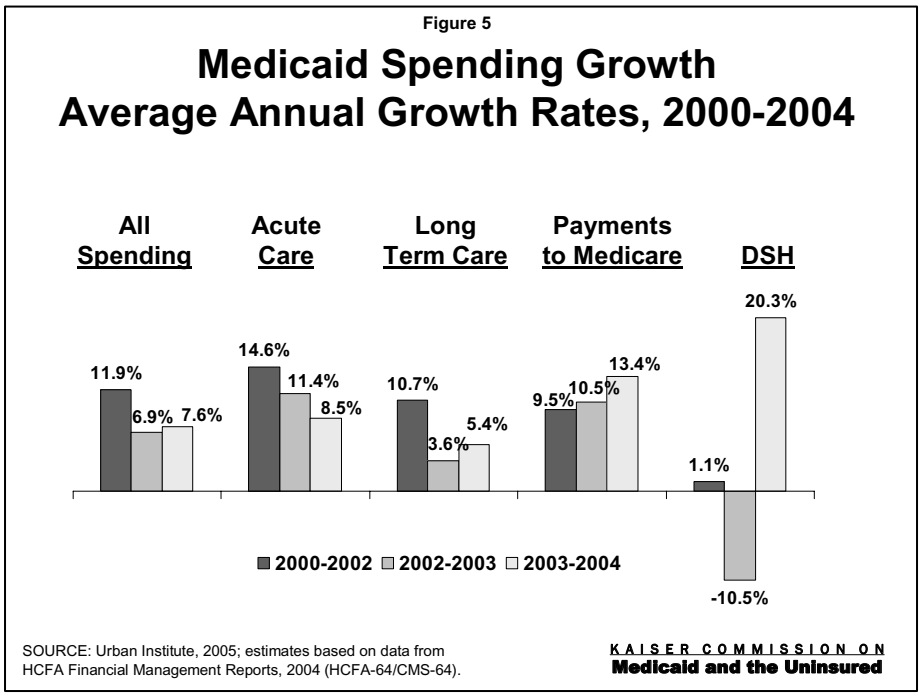
3) Includes inpatient psychiatric services for individuals under age 21 and other mental health facility services for individuals age 65 and older.

4) Includes home health services, home- and community-based waiver services, personal care, and related services

2004 from $14.3 billion to $17.2 billion; the majority of this increase was in inpatient DSH payments. This increase is attributable to the Medicare Modernization Act of 2003 that increased DSH payments in states by 16% beginning in 2004, followed by inflation adjustments thereafter.[7] Some states may have also increased the share of their DSH allotments that they were using by increasing their state payments. Without the increase in DSH spending, Medicaid would have grown by 6.5% from 2003 to 2004, less than the rate that was seen from 2002 to 2003.

Almost all acute care services experienced a slowdown in growth, resulting in total acute care spending rising by 8.5% in 2004, slower than the 11.4% in 2003 and the 14.6% average annual growth experienced in 2000-2002 (Figure 5). Some of the slower growth in acute care services reflects the slower growth in enrollment. Physician, lab and x-ray services are the only acute care services that experienced a noticeable increase in their growth rate, growing at 15.6% from 2003 to 2004, up from 6.9% in 2002-2003. Prepaid managed care and other services experienced notable reductions in their growth rates. Prepaid managed care grew at only half its previous rate, 7.9% from 2003-2004, following growth of about 16% from 2002-2003.[8] These reductions in growth rates likely reflect the aggressive cost containment policies that have been adopted by states in recent years, particularly reductions in optional acute care benefits and provider reimbursement rates.[9]

Figure 5



While still increasing rapidly, prescription drug spending growth also slowed between 2003 and 2004 (14.3%), consistent with growth in 2003 but slower than between 2000 and 2002. This again reflects not only the slowing of enrollment increases but also widespread efforts by states to control prescription drug costs including the adoption of preferred drug programs, increased use of prior authorization and the introduction of multi-state purchasing coalitions.[10]

The period also saw a continued slowdown in long-term care spending. Mental health institutions experienced a decline in spending, falling by 2.3% in 2004, following an increase of 20.2% in 2003. This sizable increase could be related to payments made to offset reductions in mental health DSH spending required in many states under the Balanced Budget Act of 1997.[11] Home and personal care growth slowed to 8.8% in 2004, following increases of 15.2% in 2000-2002 and 16.7% in 2003. Home- and community-based care and personal care services had been among the fastest growing Medicaid services. The slowdown may reflect state efforts to reduce the expansion of these programs due to fiscal constraints despite a continued commitment to these types of care. By 2004, home- and community-based care and personal care services amounted to 37.2% of long-term care spending.

The decline in nursing home spending from 2002 to 2004 ($47.5 billion in 2002 to $46.5 billion in 2004) is also a major contributor to the slower growth in long-term care services. Part of the reason for this decline may be the Medicare Modernization Act's requirement that states phase out upper payment limit programs. Nursing home caseloads were either falling or increasingly slowly in most states, which also contributes to the slow rate of growth in nursing home spending.[12]

Medicaid payments to Medicare grew by 13.4% between 2003 and 2004, compared to about 11% annually from 2000 to 2004.[13]

Acute care continues to account for the majority of spending growth

Table 3 shows how growth in spending was distributed across acute care, long-term care and payments to Medicare. Acute care accounted for more than two-thirds of all spending growth between 2003-2004 (67.9%), about equal to the average for the entire period.

Table 3
Spending Growth in US Medicaid Expenditures by Type of Service, Fiscal Years 2000-2004

	2000-2002		2002-2003		2003-2004		2000-2004	
	Spending (in billions)	Percent	Spending (in billions)	Percent	Spending (in billions)	Percent	Spending (in billions)	Percent
Medical Services only	**$50.1**	**100.0%**	**$19.3**	**100.0%**	**$18.7**	**100.0%**	**$88.2**	**100.0%**
Acute Care	$32.1	64.1%	$15.4	79.5%	$12.7	67.9%	$60.2	68.3%
Long Term Care	$17.1	34.0%	$3.4	17.4%	$5.2	27.6%	$25.6	29.0%
Payments to Medicare	$0.9	1.9%	$0.6	3.1%	$0.8	4.5%	$2.4	2.7%

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

Per enrollee rates of spending growth differ by type of care, eligibility group

Growth in spending per enrollee for all Medicaid services continued to be modest. Per enrollee spending grew at a rate of 3.8% between 2003-2004, following the 4.1% observed in 2002-2003 and the 7.1% average annual growth in 2000-2002 (Figure 6 and Table 4). (An explanation of the method of estimating spending per enrollee growth is provided in Appendix A). Some of this slowdown in growth can be attributed to low growth of long-term care spending per enrollee, which grew only 2.3% between 2003 and 2004 and 4.2% over the entire 2000-2004 period.

Figure 6

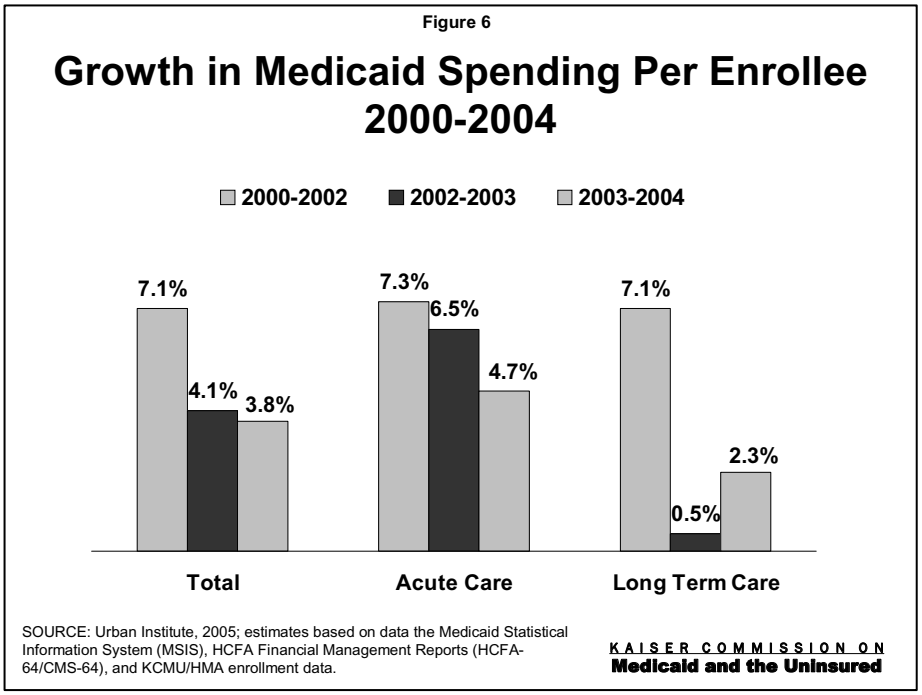


Table 4
US Expenditure Growth per Enrollee 2000-2004
(Weighted by growth in Enrollment and within Service)

	Average Annual Growth Rate				Cumulative Growth
Service	**2000-2002**	**2002-2003**	**2003-2004**	**2000-2004**	**2000-2004**
Total	**7.1%**	**4.1%**	**3.8%**	**5.5%**	**23.8%**
Acute Care	**7.3%**	**6.5%**	**4.7%**	**6.4%**	**28.1%**
Inpatient Hospital	3.8%	6.2%	3.8%	4.4%	18.7%
Physician/Lab/X-Ray	4.7%	1.8%	11.3%	5.5%	24.0%
Outpatient/Clinic	6.3%	-0.9%	7.6%	4.7%	20.1%
Prescribed Drugs	13.9%	9.7%	10.8%	12.0%	57.5%
Other Services	8.2%	3.8%	-7.2%	3.0%	12.6%
Prepaid/Managed Care	6.9%	10.5%	3.7%	6.9%	30.8%
Long Term Care	**7.1%**	**0.5%**	**2.3%**	**4.2%**	**18.0%**
Nursing Facility	6.2%	-8.7%	1.3%	1.0%	4.2%
ICFMR[1]	2.3%	1.0%	0.1%	1.4%	5.7%
Mental Health Institutions[2]	3.3%	14.7%	-5.8%	3.6%	15.0%
Home/Personal Care[3]	11.2%	13.1%	5.6%	10.2%	47.4%

Source: Urban Institute estimates based on data from the Medicaid Statistical Information System (MSIS), HCFA 64, and HMA enrollment data
General note: Excludes payments made under Title XXI (SCHIP), Medicare premiums paid by Medicaid (for persons eligible for both programs), disproportionate share hospital payments, administrative costs, accounting adjustments, and the U.S. territories.
1) ICFMR = intermediate care facilities for the mentally retarded
2) Includes inpatient psychiatric services for individuals under age 21 and other mental health facility services for individuals age 65 and older.
3) Includes home health services, home- and community-based waiver services, personal care, and related services

Specifically, per Medicaid enrollee spending on mental health institutions fell for the first time since 1997, decreasing 5.8% between 2003 and 2004. Home and personal care spending per Medicaid enrollee also grew slowly in 2003-2004 in comparison with earlier years, increasing by only 5.6%.

Overall acute care services spending per enrollee increased by 4.7% between 2003 and 2004, after increasing 7.3% annually between 2000 and 2002 (and 6.5% between 2002 and 2003). However, there was considerable variation in the growth rate among various acute care services. Growth in spending per enrollee for "other services," which includes vision and hearing services, hospice care, durable medical equipment and prosthetic devices, fell by 7.2% between 2003 and 2004. Spending per enrollee for these services increased 8.2% between 2000 and 2002, falling to 3.8% between 2002 and 2003. This decline is not surprising – "other" services have been a major target of state cost containment policies.[14] On the other hand, physician/lab/x-ray services grew tremendously during 2003-2004, at a rate of 11.3%. This follows three years of much slower growth. Physicians are often the last group to see payment increases, and the increased spending in 2004 may represent overdue rate adjustments that states enacted once the economic downturn had ended.

The increase in spending per Medicaid enrollee for acute care services was slower than was observed in the private market. Spending on health care services for those with private insurance increased by 8.2% and private insurance premiums grew by 11.2% from 2003 to 2004.[15] Medicaid per enrollee spending on acute care grew only 4.7% over that period. Figure 2 also shows that increases in Medicaid spending per enrollee for acute care services were slower than increases in private spending over the entire 2000-2004 period. The comparatively smaller increases in Medicaid acute care spending per enrollee and the recent decreases in the growth of per enrollee long-term care spending both imply that it will be difficult for policy makers to constrain program spending by further cutting per enrollee costs.

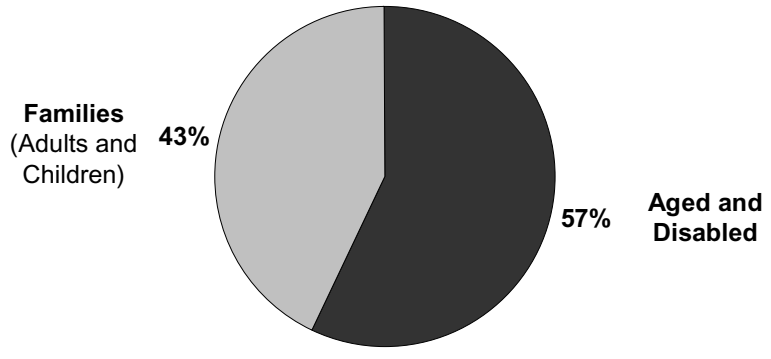
Enrollment of lower cost groups outpaced that of more expensive elderly and disabled enrollees. Table 5 shows the growth in spending per enrollee for different time periods. The results for 2000-2002 show that overall enrollment grew by 9.0%, spending per enrollee grew by 3.7%, and overall spending by 13.1%. In 2003, enrollment growth fell to 5.7%, spending per enrollee to 2.4%, and overall spending to 8.2%. The growth rate in spending per enrollee is less for all enrollees than it is for either of the two groups. This is due to rapid increases in enrollment of lower cost adults and children, which caused a shift in the overall Medicaid enrollment towards the lower cost group. This had the effect of lowering average spending per enrollee.

In 2004, enrollment growth slowed relative to the previous three years, particularly for adults and children. As a result, overall enrollment grew by 4.1%. Spending per enrollee grew by 3.2%, again slightly lower than growth in spending per enrollee for each of the two eligibility groups, due to a shift to lower-cost beneficiaries. Taken together, overall spending increased by 7.4% and spending on aged/disabled and families/children increased by 6.7% and 8.9%, respectively. Relative to the aged/disabled, the faster growth for families was largely due to faster growth in enrollment, and to a lesser extent a slightly faster growth rate in spending per enrollee.

Aged/disabled accounted for the majority of Medicaid spending growth. Although aged and disabled beneficiaries make up a smaller percentage of all Medicaid beneficiaries and their overall growth in spending is slower than that of families and children, they account for a larger portion of the increase in total spending. Between 2000 and 2004, aged and disabled accounted for 57.0% of growth in total spending while families and children accounted for 43.0% of growth (Table 6 and Figure 7). Due to the fact that aged and disabled beneficiaries spend much more per person than families and children do, they account for a much larger percentage of total spending, relative to their group size.

Figure 7

Share of Medicaid Spending Growth Attributable to Aged/Disabled and Families between 2000 and 2004



Total growth: $77.8 billion

SOURCE: Urban Institute, 2005; estimates based on data from HCFA Financial Management Reports, 2004 (HCFA-64/CMS-64), MSIS and KCMU.

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Table 5
Average Annual Changes in Enrollment and Expenditure by Group and per person, United States

	Enrollment (in millions)			Spending Per Enrollee			Total Spending (in billions)		
2000-2002	**2000**	**2002**	**% Change**	**2000**	**2002**	**% Change**	**2000**	**2002**	**% Change**
Aged and Disabled	10.0	10.6	3.1%	$11,731	$13,540	7.4%	$117.3	$143.8	10.7%
Families (Adults and Children)	21.6	26.9	11.6%	$2,057	$2,339	6.6%	$44.4	$62.9	19.0%
All Enrollees	**31.6**	**37.5**	**9.0%**	**$5,121**	**$5,511**	**3.7%**	**$161.7**	**$206.7**	**13.1%**
2002-2003	**2002**	**2003**	**% Change**	**2002**	**2003**	**% Change**	**2002**	**2003**	**% Change**
Aged and Disabled	10.6	10.9	3.0%	$13,540	$13,896	2.6%	$143.8	$152.0	5.7%
Families (Adults and Children)	26.9	28.7	6.7%	$2,339	$2,498	6.8%	$62.9	$71.7	14.0%
All Enrollees	**37.5**	**39.6**	**5.7%**	**$5,511**	**$5,643**	**2.4%**	**$206.7**	**$223.7**	**8.2%**
2003-2004	**2003**	**2004**	**% Change**	**2003**	**2004**	**% Change**	**2003**	**2004**	**% Change**
Aged and Disabled	10.9	11.3	2.9%	$13,896	$14,410	3.7%	$152.0	$162.3	6.7%
Families (Adults and Children)	28.7	30.0	4.6%	$2,498	$2,601	4.1%	$71.7	$78.1	8.9%
All Enrollees	**39.6**	**41.3**	**4.1%**	**$5,643**	**$5,822**	**3.2%**	**$223.7**	**$240.4**	**7.4%**
2000-2004	**2000**	**2004**	**% Change**	**2000**	**2004**	**% Change**	**2000**	**2004**	**% Change**
Aged and Disabled	10.0	11.3	3.0%	$11,731	$14,358	5.2%	$117.3	$161.7	8.3%
Families (Adults and Children)	21.6	30.0	8.6%	$2,057	$2,591	5.9%	$44.4	$77.8	15.1%
All Enrollees	**31.6**	**41.3**	**6.9%**	**$5,121**	**$5,801**	**3.2%**	**$161.7**	**$239.5**	**10.3%**

Source: Urban Institute estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64), MSIS, and HMA
General note: Excludes payments made under Title XXI (SCHIP), Medicare premiums paid by Medicaid (for persons eligible for both programs), disproportionate share hospital payments, administrative costs, accounting adjustments, and the U.S. territories.

Table 6
Estimated Growth in US Medicaid Expenditures by Eligibility Groupings, 2000-2004

	Spending in 2000 (MSIS)	2000-2002		2002-2003		2003-2004		2000-2004	
		Growth (in billions)	Share of Growth	Growth (in billions)	Share of Growth	Growth (in billions)	Share of Growth	Growth (in billions)	Share of Growth
Total Medicaid Expenditures	**$161.7**	**$45.0**	**100.0%**	**$17.0**	**100.0%**	**$16.6**	**100.0%**	**$77.8**	**100.0%**
Aged and Disabled	$117.3	$26.5	58.9%	$8.2	48.2%	$10.3	61.6%	$44.3	57.0%
Families (Adults and Children)	$44.4	$18.5	41.1%	$8.8	51.8%	$6.4	38.4%	$33.4	43.0%

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

Enrollment growth and inflation were responsible for most Medicaid spending growth. To further understand the role of enrollment growth, inflation and other factors in explaining Medicaid spending growth over 2000 –2004 period, we conducted an algebraic decomposition of expenditure growth for the aged and disabled and for families (Table 7). This decomposition essentially measures the impact of enrollment growth, holding constant inflation and other spending at their 2000 levels.[16] It then assumes that only inflation increased holding enrollment and other factors constant, and finally that only other factors increased holding enrollment and inflation constant. An algebraic decomposition of this kind also has an interaction term that could be positive or negative, essentially the effect of all factors moving together.

For the aged and the disabled, enrollment growth contributed about one-third, inflation about 43%, and spending growth above the inflation rate, 16.7%. The latter could be due to changes in case load within the aged and disabled group, or due to increased utilization. The remaining 7.5% is unexplained. For families, 52% of the growth was due to enrollment increases, 21% to inflation, and 13% was due to either increased utilization or changes in case mix. The interaction or unexplained term account for 13.5%. The conclusion is that the overwhelming share of the growth over the 2000-2004 period was due to either enrollment increases or inflation with a relatively small amount explained by other factors.

Table 7
Decomposition of Expenditure Growth, 2000-2004

	Share of Expenditure Growth Due To			
2000-2004	**Enrollment**	**Inflation**	**Other Factors**	**Interaction**
Aged and Disabled	33.3%	42.6%	16.7%	7.5%
Families (Adults and Children)	52.0%	21.4%	13.1%	13.5%

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

Conclusions and Policy Implications

The pace of Medicaid spending growth slowed from 2002 to 2004, after reaching an 11.9% average annual growth rate from 2000 to 2002 that coincided with rapid enrollment growth during the 2001 recession. Despite the recent decrease in the growth rate, the overall increase in Medicaid spending from $205.7 billion in 2000 to $295.9 billion in 2004 has generated debate over Medicaid at federal and state levels. Many states are using Section 1115 waivers to enact enrollment caps, increase premiums, impose cost sharing, and reduce benefits. At the federal level, the Bush administration's Medicaid Commission is developing recommendations that may call for a major restructuring of the program.

Efforts to contain Medicaid costs must acknowledge the fact that most of the growth in the Medicaid program was due to the increases in enrollment, instead of spending increases on a per capita basis. In 2000-2004, enrollment increased by about one-third; the enrollment growth in Medicaid, as well as SCHIP, undoubtedly reflects the recession and slow economic growth seen in the beginning of this decade. There was a decline in employer-sponsored insurance, and many low-income people enrolled in Medicaid. In addition, the economic downturn led to declines in incomes and made many more people eligible under existing eligibility standards. There were some states that reduced eligibility standards during this period, but enrollment increased despite these reductions.

Enrollment growth among children and adults in Medicaid as well as SCHIP undoubtedly kept the uninsurance rate from increasing more than it otherwise would have. The large increase in Medicaid and SCHIP enrollment for children offset the decline in employer-sponsored insurance, which kept the number of uninsured children from increasing. The increase in Medicaid enrollment among adults, where eligibility is more limited, was substantially smaller and was not enough to offset declines in employer-sponsored insurance. As a result there was a large rise in the number of uninsured adults over this time period.[17] Medicaid spends much less per enrollee on adults and children than the program spends on aged and disabled beneficiaries. Those beneficiaries have more health needs and account for a disproportionately high percent of the program's overall spending and spending growth.

Spending per Medicaid enrollee grew relatively slowly, slightly above or below the rate of health care inflation, for both acute care and long-term care. This was largely the result of policy choices made at the state level to reduce benefits and to control provider reimbursement rates. Most of the discussions about Medicaid reform center around policies that would affect spending per enrollee, e.g. cost sharing, benefit flexibility, defined contributions. Medicaid spending growth on a per enrollee basis, as we have shown, averaged 4.7% for acute care services between 2003 and 2004, and 6.4% for the full period. Those growth rates are lower than the increases in per person spending in the private insurance market, where spending increased 8.2% from 2003-2004 and 9.5% over the full period. The growth of per enrollee spending on long-term care remained slower than the growth rate for acute care. Long-term care spending increased only 2.3% per enrollee from 2003 to 2004. Nursing home spending comprised almost half of all Medicaid long-term care spending in 2004, but per enrollee spending on nursing homes grew only about 1% per year during the 4-year period we studied.

It is difficult to envision how Medicaid could have better controlled per capita spending, especially given that Medicaid purchases services in the same market as private insurance plans. Unfortunately, the growth trends presented in this article do not point to any easy answers for controlling Medicaid costs. Evidence on the amount of Medicaid spending that is attributable to a relatively small share of enrollees suggests that better management of high cost cases will be central to Medicaid cost containment.[18]

Methodological Appendix

Spending growth for families and children versus the aged and disabled can not be calculated directly because CMS 64 data do not provide spending by eligibility group. Instead, we estimate spending growth for the two eligibility groups by using available data on enrollment growth and by estimating spending per enrollee for families and for the aged and disabled. We calculate changes in spending per enrollee by using the changes in spending on each service divided by a measure of enrollment specific to each service. To calculate a service-specific enrollment growth rate, we use FY 2000 MSIS data on the distribution of spending by service for families versus aged and disabled.

In FY 2000, for example, families and children accounted for more than 40% of spending on inpatient hospital, physician, lab and x-ray, and outpatient hospital services, and more than 60% of the spending on prepaid managed care. But families and children accounted for only a small share of spending on long-term care. Thus enrollment growth among non-disabled adults and children is particularly likely to affect acute care services while enrollment growth among the aged/disabled is likely to affect all services. To calculate the measure of enrollment that is specific to prescription drugs, we use MSIS data on the share of growth attributable to the aged/disabled (0.85) and families (0.15). For hospitals, enrollment growth among the aged/disabled was given a weight of 0.55 and families 0.445. The service specific weights for these groups were then multiplied by the enrollment growth observed for each of the two groups to obtain a service-specific enrollment growth. Enrollment growth for each service was then divided into the growth in spending for the service to calculate the increase in spending per enrollee.

To calculate average increases in spending per enrollee for aged and disabled and for families, we use the service specific measures of spending per enrollee. To do this, we weight the increases in spending per enrollee by the importance of each service to the specific group. We then multiply the growth of enrollment times the growth of spending per enrollee to calculate the increase in total spending for each of the two eligibility groups. The spending totals and rates of growth calculated using this method are shown in Table 5 and differ from the spending growth in Figure 1 and Table 2 because for the calculations used to produce Table 5 we begin with MSIS data on spending by eligibility group in 2000 (which differ from CMS totals) and apply growth rates for each service from CMS 64 data.

Endnotes

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[7] Section 1001(a) of the Medicare Modernization Act determined state DSH allotments for 2004 by increasing their 2003 DSH spending by 16%. This was a one-time temporary increase.
[8] Part of the growth from 2000-2003 may have been due to the actuarial sound rates requirement of the Balanced Budget Act of 1997, which went into effect in 2002.
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