kaiser commission on MEDICAID FACTS
medicaid and the uninsured
THE HENRY J. KAISER FAMILY FOUNDATION
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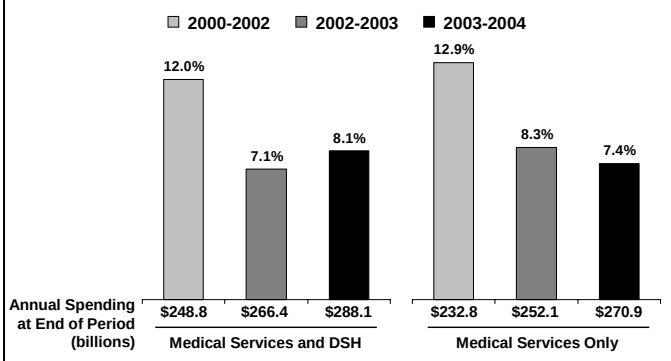
MEDICAID ENROLLMENT AND SPENDING TRENDS

From 2000 to 2004, Medicaid spending growth adjusted to changes in the overall economy and rose by 12% annually between 2000 and 2002, and then slowed to 7.6% from 2002 to 2004 as the economy improved following the 2001 recession. The rate of Medicaid spending growth slowed because of both moderating enrollment growth and state efforts to control Medicaid per enrollee spending through benefit reductions and cost sharing.

Figure 1

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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During this period of Medicaid enrollment growth, states were able to keep increases in health spending per Medicaid enrollee to levels below private insurance. Annual spending growth on medical services fell from 12.9% between 2000 and 2002 to 7.4% in the latest year (Figure 1). Nevertheless, this rise in spending from $182.7 billion in 2000 to $270.9 billion in 2004 during limited state and federal revenue growth made Medicaid a target of budget reduction discussions.

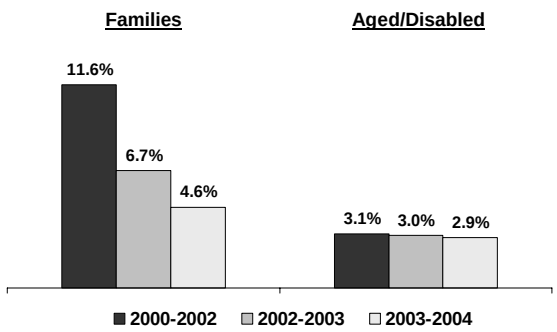
ENROLLMENT GROWTH

Enrollment for families (nondisabled adults and children) rose by an average of 11.6% per year from 2000 to 2002, but that pace slowed to 6.7% between 2002 and 2003 and 4.6% between 2003 and 2004 (Figure 2). Medicaid enrollment among the aged and disabled was stable from 2000 to 2004 – averaging 3.0% per year.

The 2001 recession and the slow economic recovery fueled much of the growth in Medicaid enrollment among families. As families experienced job losses and declines in income, the number of low-income Americans rose and more people became eligible for Medicaid under existing criteria. At the same time, the number of individuals covered by employer-sponsored insurance (ESI) fell. As the economy improved in 2003 and 2004 and some states tightened eligibility requirements, the rate of enrollment growth for families has slowed.

Figure 2

Medicaid Enrollment Growth Average Annual Growth Rates, 2000-2004



SOURCE: Urban Institute estimates based on KCMU Medicaid enrollment data collected by Health Management Associates from 44 states inflated proportionally to national totals, 2005.

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Without the increase in Medicaid enrollment between 2000 and 2004, the recent growth in the number of uninsured Americans would have been greater. The large increase in children in Medicaid and SCHIP offset the decline in ESI coverage, which prevented an increase in uninsured children. Medicaid enrollment among adults rose more slowly and was not sufficient to counter the decrease in ESI, and the number of uninsured adults grew by six million between 2000 and 2004.

The reason behind the steady enrollment growth in the aged and disabled is less clear, but may be attributable to aging baby boomers reaching the 55-64 age range, ages at which the likelihood of disabilities increases. The effects of medical technologies that lengthen lives for many people with disabilities may also be a contributing factor. Increases in the cost of prescription drugs may have also increased the need for Medicaid in this population.

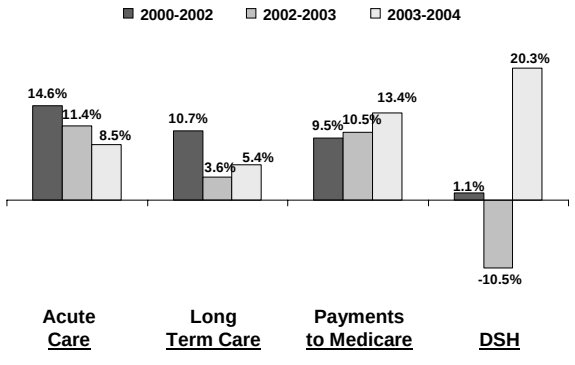
SPENDING GROWTH

Spending on acute care services accounted for more than two-thirds (68.3%) of Medicaid's spending growth from 2000 to 2004. Medicaid acute care spending increased at an average annual rate of 14.6% from 2000 to 2002, but that rate dropped to 8.5% by 2004 (Figure 3). The rate of long-term care spending growth also slowed, with the average annual growth rate dropping to 5.4% in 2004 after reaching 10.7% from 2000 to 2002. The largest component of long-term care costs is nursing home care, which grew at an average annual rate of 4.1% from 2000 to 2004. Home and personal care services comprise a growing share of long-term care costs, rising from 30% of long-term care spending in 2000 to over 37% by 2004.

Prescription drugs remained the fastest growing component of acute care spending over the whole period, averaging 16.4% growth per year. Spending for "other services," which includes vision and hearing services, hospice and prosthetic devices, fell by 3.9% between 2003 and 2004. These services have been a target of state cost containment policies.

Figure 3

Medicaid Spending Growth Average Annual Growth Rates, 2000-2004



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

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Notably, Disproportionate Share Hospital (DSH) spending increased by 20.3% in 2004 from $14.3 billion to $17.2 billion; most of this increase was in inpatient DSH payments. This change is largely attributable to the Medicare Modernization Act of 2003, which increased DSH payments. Without the rise in DSH spending, total Medicaid spending would have grown by 6.5% from 2003 to 2004, less than the level seen from 2002 to 2003.

Although the aged and disabled made up only 27% of all Medicaid enrollees, they accounted for about two-thirds (68%) of overall Medicaid spending in 2004 and 57% of the overall growth in Medicaid spending between 2000 and 2004 due to their greater need for both acute and long-term care services.

SPENDING PER PERSON ENROLLED

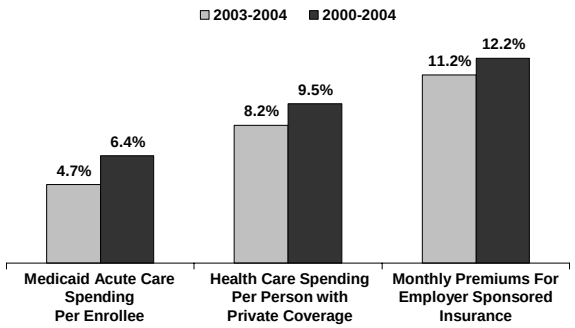
Tracking the average amount it costs Medicaid to cover an enrollee reveals spending changes that are not related to increases in enrollment. Spending per enrollee increased at an average annual rate of 5.2% for the aged and disabled and 5.9% for families from 2000 to 2004.

Spending per enrollee grew at an average annual rate of 6.4% for acute care and 4.2% for long-term care from 2000 to 2004. Notably, the per-enrollee acute care Medicaid spending growth rate was well below both the estimated 9.5% average annual increase in health spending for those with private coverage. During the same period, private insurance premiums rose by an average of 12.2% (Figure 4).

Further analysis of Medicaid spending growth measuring the relative contributions of enrollment growth, inflation and other factors (including changing patterns of service use and case mix) found that the causes of growth differ for the aged and disabled when compared to families. Increased enrollment was responsible for 33.3% of spending growth for the aged and disabled while increased health care prices were responsible for 42.6%. For families, 52.0% of spending growth was due to enrollment and 21.4% was due to higher prices for care. In both cases, the bulk of spending increases were due to those two factors, neither of which can be easily influenced by Medicaid without increasing the number of uninsured or decreasing access to care.

Figure 4

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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LOOKING AHEAD

Increased enrollment was responsible for much of the growth in Medicaid spending from 2000 to 2004. During that period there were no major expansions in eligibility; Medicaid enrollment grew primarily due to economic conditions that left more people eligible for the program as their incomes declined and many lost ESI coverage.

It is difficult to imagine how Medicaid could have better controlled per capita spending, especially given that Medicaid purchased services in the same market as private insurance plans and kept per enrollee spending growth to levels below those seen in the private market. Recent Medicaid growth trends do not point to any easy answers for controlling costs. Approaches to contain costs that impose reductions on eligibility and enrollment or further limit provider payments are likely to lead to both greater increases in the number of uninsured and access to care barriers for Medicaid's low-income population. As federal and state policy makers explore options to better manage Medicaid spending, the impact future reforms may have on the health of Medicaid enrollees, their access to providers, and the number of uninsured Americans needs to be assessed.

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Source: "Understanding the Recent Changes in Medicaid Spending and Enrollment Growth between 2000-2004," by John Holahan and Mindy Cohen. Kaiser Commission on Medicaid and the Uninsured, May, 2006.