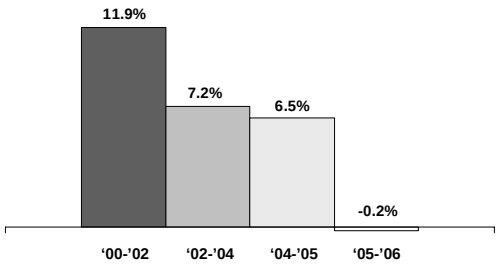
kaiser commission on MEDICAID FACTS
medicaid and the uninsured
THE HENRY J. KAISER FAMILY FOUNDATION
October 2007

MEDICAID ENROLLMENT AND SPENDING TRENDS

Medicaid spending growth declined for the first time in the program's 40-plus year history in 2006, falling by 0.2% (Figure 1). This drop followed several years of very rapid spending growth, as total Medicaid expenditures rose from $205.7 billion in 2000 to $315.0 billion in 2005 – an average annual increase of 8.9%.

Figure 1

Overall Average Annual Total Medicaid Spending Growth, 2000-2006



	'00-'02	'02-'04	'04-'05	'05-'06
Annual Spending at End of Period (billions)	$257.3	$295.9	$315.0	$314.5

SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute, 2007; estimates based on data from HCFA Financial Management Reports, 2006 (HCFA-64/CMS-64).

The slowdown in Medicaid spending in 2006 was caused by two major factors. The first was the implementation of the new Medicare Part D drug benefit in January 2006, shifting coverage of prescription drugs for dual eligibles from Medicaid to Medicare. However, even without this shift, total Medicaid spending would have increased by only 4.05 percent, considerably slower than in previous periods. The second factor was a dramatic reduction in enrollment growth. Additionally, spending growth was impacted by the more limited effect of a reduction in per enrollee spending growth for a few key services

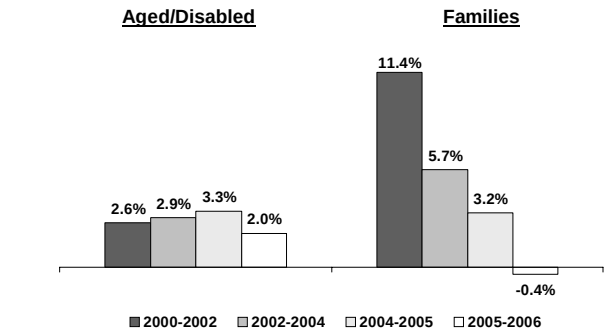
ENROLLMENT GROWTH

For the first time since the late 1990s, there was virtually no growth in Medicaid enrollment in 2006. Enrollment growth among the disabled and the elderly fell from an average of nearly 3.0 percent per year from 2000 to 2005 to less than 2.0 percent from 2005 to 2006, while the number of non-disabled adults and children enrolled in Medicaid actually declined in 2006 (Figure 2).

The slowdown in enrollment growth among families and children likely reflects both the effects of an improving economy as well as the impact of efforts in many states to control program growth. The decline in enrollment increases for the aged and the disabled occurred at the same time that the majority of this population shifted drug coverage from state Medicaid programs to the new federal Medicare Part D benefit, raising the possibility that the transition may have had some impact on enrollment.
Medicaid enrollment growth has largely tracked the continuing erosion of employer-sponsored insurance (ESI), with Medicaid

Figure 2

Medicaid Enrollment Growth Average Annual Growth Rates, 2000-2006



SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on KCMU Medicaid enrollment data collected by Health Management Associates from 44 states inflated proportionally to national totals, 2007.

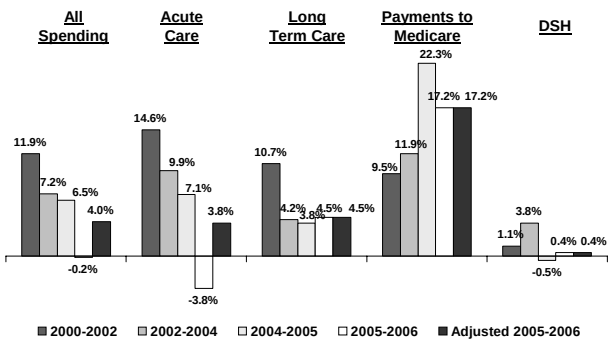
providing coverage to many low-income Americans losing ESI, particularly during the recessionary period of the early 1990s.

SPENDING GROWTH

Medicaid spending growth had averaged nearly 12 percent per year during the recessionary period of 2000-2002 as individuals lost jobs and income during the economic downturn (Figure 3). Following this period, spending growth slowed to 7.2 percent between 2002 and 2004 and 6.5 percent between 2004 and 2005 as the economy rebounded and states took steps to control program growth. Total Medicaid spending fell between 2005 and 2006, but even after adjusting for the shift in drug spending for dual eligibles to Medicare Part D, spending rose by only 4 percent, considerably slower than in previous periods. After adjusting for the shift in drug spending to Medicare, spending on a service-specific basis was slower from 2005-2006 than in previous years for most acute care services, particularly for prescribed drugs,

Figure 3

Medicaid Spending Growth Average Annual Growth Rates, 2000-2006



SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute, 2007; estimates based on data from HCFA Financial Management Reports, 2006 (HCFA-64/CMS-64).

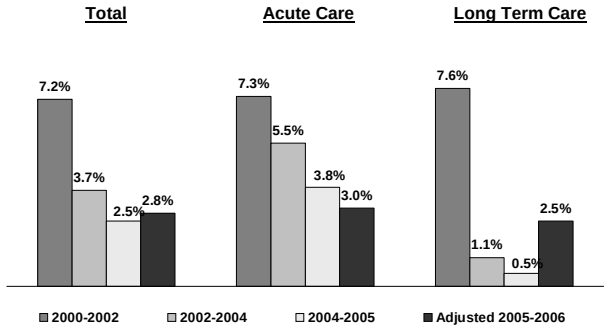
which fell by roughly 10 percent. Long-term care grew somewhat faster in 2006 than in the 2002 to 2005 period due to the increase in nursing home spending and home and community based care. The rapid growth in Medicaid payments to Medicare was primarily due to large increases in Part B Medicare premiums, which rose by 17 percent in 2005 and 13 percent in 2006.

SPENDING PER ENROLLEE

Overall Medicaid spending per enrollee has slowed considerably for both acute care and long-term care services since the 2000-2002 period. In 2006, spending per enrollee increased by 3.0 percent for acute care and 2.5 percent for long-term care, after adjusting for duals' drug spending shifting to Medicare (Figure 4).

Figure 4

Growth in Medicaid Spending Per Enrollee 2000-2006



NOTE: Adjusted expenditures exclude all prescription drug spending for dual eligibles to remove the effect of their transition to Medicare Part D in 2006.
SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute, 2007; estimates based on data the Medicaid Statistical Information System (MSIS), HCFA Financial Management Reports (HCFA-64/CMS-64), and KCMU/HMA enrollment data.

The most notable changes in per enrollee acute care spending growth in the last two years have been the increase in expenditures for managed care spending and for "other services", rising by 10 percent and 8 percent, respectively. Also noteworthy were declines in per enrollee prescription drug spending in each of the last two years – 2 percent in 2005 and 11 percent in 2006 – likely due to state cost control efforts.

Spending on long-term care services on a per enrollee basis increased slightly below the rate of growth in the previous two periods, primarily due to slow or non-existent caseload growth together with the phasing out of spending through upper payment limit programs. Spending on institutional care for the developmentally disabled and the mentally ill also declined slightly.

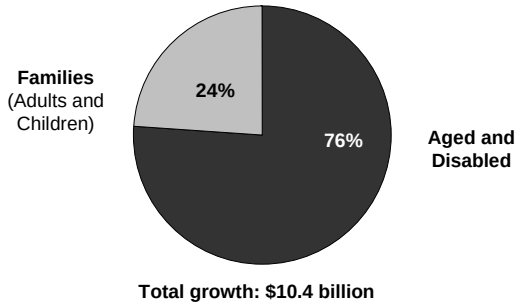
MEDICAID GROWTH BY GROUP AND IN CONTEXT

The aged and disabled make up the majority of Medicaid spending (67% in 2006) due to their higher level of need. While spending on families has increased at a faster rate, spending levels started from a level considerably below that of the aged and disabled. Thus, after adjusting for the shift of drug spending for duals, spending on the aged and disabled accounted for about three quarters of all spending growth between 2005 and 2006 (Figure 5).

It is also instructive to compare Medicaid acute care spending growth with that of the privately insured. As shown below,

Figure 5

Share of Medicaid Spending Growth Attributable to Aged/Disabled and Families between 2005 and 2006



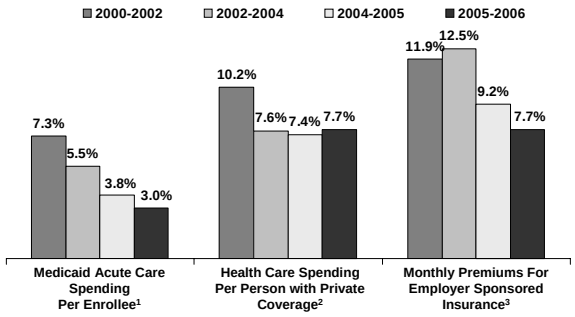
Total growth: $10.4 billion

NOTE: Expenditures exclude all prescription drug spending for dual eligibles in 2005 and 2006 to remove the effect of their transition to Medicare Part D in 2006.
SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute, 2007; estimates based on data from HCFA Financial Management Reports, 2006 (HCFA-64/CMS-64), MSIS and KCMU.

Medicaid per capita spending growth was below that of health care spending per person with private coverage or monthly premiums for employer-sponsored insurance (Figure 6).

Figure 6

Growth in Medicaid Acute Care Spending per Enrollee vs. Private Health Spending and Premium Growth, 2000-2006



[1] Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of MSIS, CMS-64, and KCMU/HMA data, 2007. 05-06 data are adjusted to remove the effect of the shift in spending for Rx drugs for dual eligibles from Medicaid to Medicare.

[2] Ginsburg, Strunk, Banker, and Cookson, "Tracking Health Care Costs: Continued Stability But At High Rates in 2005", *Health Affairs*, October 3, 2006.

[3] Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2006.

LOOKING AHEAD

This analysis indicates Medicaid spending is likely to continue to grow as long as enrollment continues to increase, particularly among the aged and disabled. Federal Medicaid outlays through August 2007 show that Medicaid spending has risen in 2007, indicating that the flattening of spending growth that occurred in 2006 was short lived. On a per enrollee basis, however, Medicaid is likely to continue to follow the overall increase in health care costs, but at levels below both private insurance spending per capita and private premium increases. Indeed, the rate of increase in Medicaid spending for acute care services has been lower than that seen in the private market. While Medicaid expenditures may have grown faster than state revenues over the last six years, they are still growing more slowly than private sector alternatives.

For additional copies of this publication (#7523-02), please visit www.kff.org/kcmu.

Source: "Why Did Medicaid Spending Decline in 2006? A Detailed Look at Program Spending and Enrollment, 2000-2006," John Holahan, Mindy Cohen, and David Rousseau. Kaiser Commission on Medicaid and the Uninsured, September, 2007.