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Why Did Medicaid Spending Decline in 2006?
A Detailed Look at Program Spending and Enrollment, 2000-2006

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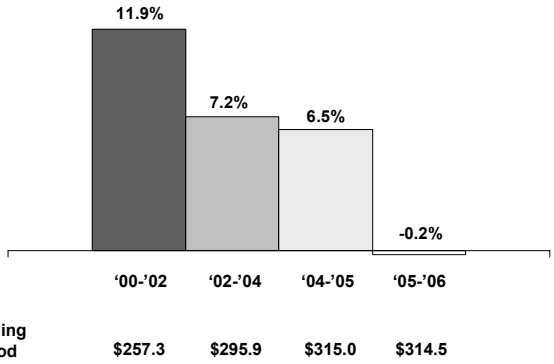
Executive Summary

Medicaid spending declined for the first time in the program's 40-plus year history in Federal Fiscal Year (FY) 2006, falling by 0.2 percent (Figure ES-1). This decline occurred after several years of very rapid spending growth, as total program spending rose from $205.7 billion in 2000 to $315.0 in 2005 – an average annual increase of 8.9 percent.

Figure ES-1

Overall Average Annual Total Medicaid Spending Growth, 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).

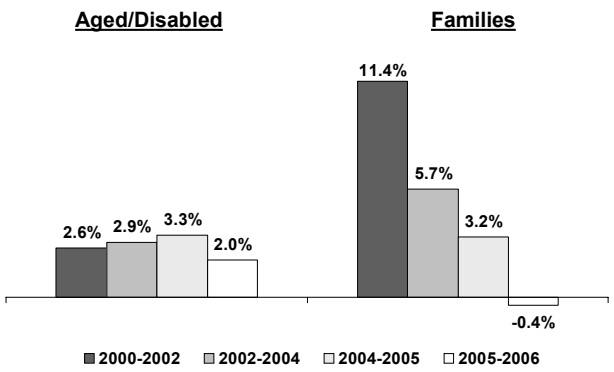
There are two major factors that underlie the 2006 decline, in addition to a more limited effect of the slowdown in per enrollee spending growth for a few key services.

- The first was the 2005 Medicare Modernization Act's creation of a new Medicare drug benefit that shifted the cost of prescription drugs for dual eligibles from Medicaid to Medicare in 2006. However, even without this shift, total Medicaid spending would have increased by 4.0 percent, and spending for medical services would have risen by 4.5 percent, considerably slower than in previous periods.[1]

- The second major factor was a dramatic reduction in enrollment growth. Enrollment growth among the disabled and the elderly fell from an average of nearly 3.0 percent per year from 2000 to 2005 to slightly 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 for the first time in nearly a decade (Figure ES-2).

Figure ES-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.

Also contributing to the slowdown in spending growth during the most recent period were declines in growth in spending per enrollee for services such as prescription drugs, nursing home care, and home and community based services.

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. 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.[2]

This period of rapid spending growth occurred during a time of large increases in program enrollment, with enrollment rising by an average of more than 5 percent per year from 2000 to 2005. As this paper documents, it was largely increases in Medicaid enrollment during these five years, particularly among the aged and disabled – rather than real increases in spending per enrollee – that drove program spending growth. On a per capita basis, Medicaid acute care spending has consistently grown more slowly than both health care spending for those with private coverage and private insurance premiums. Total Medicaid spending growth per enrollee from 2000 to 2006 averaged 4.7 percent per year for the aged and disabled and 5.2 percent per year for families, while per capita NHE and GDP grew at 5.8 percent and 5.1 percent per year, respectively.[3]

Medicaid enrollment growth has largely reflected the continuing erosion of employer-sponsored insurance (ESI). Previous research has shown that the fall in ESI has affected low-

income people in particular.[4] This was due to the much faster growth in health insurance premiums relative to workers' wages, as well as a shift of workers from larger to smaller firms and to industries less likely to offer coverage. Medicaid provided coverage to many of those losing ESI, particularly during the recession. Without the growth in Medicaid enrollment through 2005, the increase in the number of uninsured over this period would have been significantly larger.

Recent data indicate, however, that Medicaid offset less of the decline in employer-sponsored insurance, in part because recent ESI declines in 2006 occurred higher up the income scale above current Medicaid eligibility levels. Additionally, changes made to reduce Medicaid spending or enrollment in some states in response to budget pressures during the recession may have reduced the program's reach today. Despite relatively strong economic growth, the most recent data on health coverage indicate that the number of uninsured grew by 2.2 million in 2006, largely due to continued declines in ESI with no net increase in Medicaid coverage.[5]

As the availability of affordable ESI coverage continues to decline, many states have looked to expansions of Medicaid and the State Children's Health Insurance Program (SCHIP) eligibility to stem the tide of increasing uninsurance.[6] Several have also enacted broad coverage expansions that build upon Medicaid. Such state health reforms will likely result in higher Medicaid enrollment and therefore increased spending in years to come. Additionally, the reauthorization of the SCHIP program that expires on September 30, 2007 could affect future Medicaid spending. Congress has agreed to legislation that expands coverage and increases outreach to children that, if signed into law, would result in more eligible but uninsured children enrolling in Medicaid, increasing overall program enrollment and spending.[7]

This analysis suggests that Medicaid spending is likely to continue to grow as long as enrollment continues to increase, particularly among the aged and disabled. Recent U.S. Treasury data indicate that spending and enrollment may have already begun to climb in 2007. Federal Medicaid outlays through August 2007 show that Medicaid spending has risen in 2007 by roughly 5.5 percent, 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. 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.

Introduction

Growth in Medicaid spending in the early 2000s placed considerable pressure on state budgets. Since state revenues tend to grow only as fast as the underlying economy – which grew by an average of only 4.5 percent per year from 2000 to 2005 – states made considerable efforts to restrain spending growth in a program that averaged 8.9 percent growth during the same period. In 2006, however, total Medicaid spending declined for the first time in the program's history.

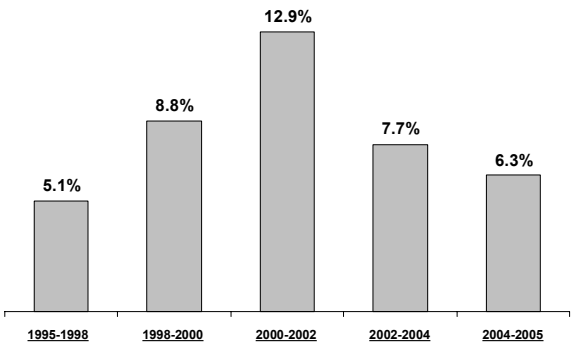
This brief explores the changes that have occurred in Medicaid spending and enrollment from 2000 to 2006, with a particular focus on changes from 2005 to 2006. Using the latest available administrative data, it presents current information on program enrollment, total spending, and spending by service, examining the factors that have contributed to the recent slowdown in program growth.

Historical Background

Medicaid spending growth on medical services was 6.3 percent in 2005 following an average increase of 7.7 percent between 2002 and 2004, bringing the rate of spending increase closer to historical levels (Figure 1). For several years, Medicaid spending growth has followed the path set by enrollment growth and health care inflation. Between 1995 and 1998, Medicaid spending on medical services grew by 5.1 percent per year. During this period, enrollment actually declined because of the early impacts of welfare reform and the strong economy. Strong economic growth increased the demand for labor, reducing Medicaid enrollment as workers' income rose, leaving fewer eligible for Medicaid at existing eligibility levels. This was

Figure 1

Average Annual Growth in Medical Services, 1998-2005



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).

also a period in which health care inflation was low throughout the entire sector, resulting in low per enrollee cost growth in Medicaid as well.

In the late 1990s (1998 to 2000), Medicaid spending increased by 8.8 percent for medical services. Medicaid enrollment began to increase as welfare reform's initial effects on enrollment were reversed, and people who had been erroneously dropped from the program were re-enrolled. State revenues expanded because of the strong economic growth, and several states used increased revenues to expand coverage, often through the Section 1931 provisions of the welfare reform legislation or Section 1115 waivers.

In addition, the implementation of SCHIP in 1998 contributed to an increase in Medicaid enrollment as many children who responded to the increased outreach efforts from SCHIP were actually eligible for Medicaid and were enrolled in that program. Health care costs also began to increase again, particularly for prescription drugs. Additionally, hospital costs for both inpatient and outpatient care increased more rapidly than in the mid 1990s. It was also during this period that states developed new financing mechanisms, such as the use of upper payment limit (UPL) programs utilizing intergovernmental transfers (IGTs) to increase Medicaid payments to certain facilities up to Medicare limits. These programs allowed some states to generate additional federal Medicaid matching funds with limited new state contributions.[8]

Between 2000 and 2002 Medicaid spending growth accelerated even more rapidly. Medicaid enrollment increased in part because of prior eligibility expansions, but also because job and income loss during the economic downturn made more people eligible for the program. Health care costs continued to increase rapidly and managed care no longer provided states (or other payers) with the same savings it had provided in 1990s.

From 2002-2004, Medicaid spending growth slowed to 7.7 percent for medical services. This resulted from slower growth in enrollment and a slowdown in the rate of increase in spending per enrollee for acute care services. There were also new limits placed on disproportionate share hospital (DSH) payments and UPL programs through changes in federal policy.

Data Sources and Methods

This brief utilizes three data sources for enrollment and expenditures between the years 2000 and 2006. First, spending by eligibility group was calculated using data from the Medicaid Statistical Information System (MSIS) for 2004. MSIS contains detailed, person-level data stratified by service type and eligibility group. These data are used to develop service-level weights to estimate spending growth by eligibility group. For certain analyses, projections of these expenditures were constructed using growth rates observed in the CMS-64 data from 2000-2006. More methodological details can be found in Appendix A.

Second, the Medicaid Financial Management Reports (Form 64) from the Center for Medicare and Medicaid Services (CMS) for 1995-2006 was used to obtain aggregate spending on services.

These CMS-64 data are available by state and by service, but are not stratified by enrollee type. Several data edits were made to correct for some inconsistencies in the reported data.[9]

Third, enrollment data from the Kaiser Commission on Medicaid and the Uninsured (KCMU) collected via survey by Health Management Associates (HMA) from all 50 states and the District of Columbia were used to measure program enrollment beyond 2004. These data provide point-in-time enrollment in June of each year. Due to the inconsistencies that occur between state reporting systems, detailed data on the number of aged/disabled and families/children is only available from 45 states. Using these data as well as total enrollment for the other seven states from KCMU, enrollment was allocated to the aged/disabled and families/children for the total population in the same proportions as reported in the 45 states.

Finally, the shift of Medicaid spending on prescription drugs for dual eligibles to the Medicare program caused a large, one-time shift in expenditures and requires certain changes to the table formats from previous Medicaid spending briefs. In this brief, we excluded spending by duals for prescription drugs in 2005 so that we could derive a spending growth number that would be comparable to the data that we observe in 2006. Tables 1-4 in this brief contain actual 2005 and 2006 spending together with adjusted 2005 and 2006 data – that is, 2005 and 2006 data are adjusted by the exclusion of prescription drug spending for dual eligibles. Tables 5-7 contain only the adjusted 2005 and 2006 data as it provides a better indication of the relative effects of enrollment vs. spending per enrollee.

Results

Enrollment Growth

For the first time since the late 1990s, there was virtually no growth in Medicaid enrollment in 2006, although Medicaid enrollment had been slowing since 2002 as the economy slowly rebounded from the recession. Enrollment growth increased by 8.7 percent between 2000 and 2002, 4.9 percent between 2002 and 2004, and by only 2.9 percent between 2004 and 2005 (Table 1). Most of the decline can be attributed to a slowdown in the rate of enrollment growth for families and children, with the number of children and families enrolled actually declining from 2005 to 2006.

Table 1
Change in Monthly US Medicaid Enrollment, 2000-2006
(in millions)

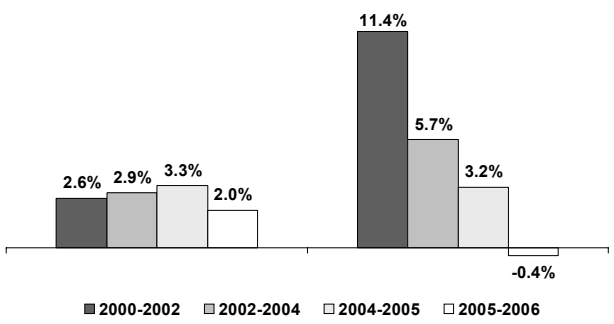
	Enrollment					Average Annual Growth Rate			
	June 2000	June 2002	June 2004	June 2005	June 2006	2000-2002	2002-2004	2004-2005	2005-2006
Total Enrollment	**31.7**	**37.5**	**41.2**	**42.6**	**42.7**	**8.7%**	**4.9%**	**3.2%**	**0.2%**
Aged and Disabled	10.0	10.5	11.2	11.5	11.7	2.6%	2.9%	3.3%	2.0%
Families	21.7	26.9	30.1	31.0	30.9	11.4%	5.7%	3.2%	-0.4%

Source: Urban Institute estimates based on KCMU and HMA data, 2007.

As shown in Figure 2, growth in the number of aged and disabled was fairly stable at 3.0 percent, increasing from 2.6 to 3.3 percent per year until 2005, followed by an increase of 2.0 percent between 2005 and 2006. In contrast, enrollment growth among families and children was 11.4 percent between 2000 and 2002, largely because of the recession, and then fell to 5.7 percent between 2002 and 2004 and 3.2 percent in 2004-2005. The absolute decline in 2006 of -0.4 percent seems to be partially due to state actions to reduce eligibility thresholds, most dramatically in Mississippi, Missouri, and Tennessee. But even excluding these three states, enrollment growth was still only 1.1 percent in 2006, well below increases seen in earlier years. The slowdown may reflect other efforts by states to make it more difficult to enroll and stay enrolled, as well as the effects of an improving economy.

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.

Analysis of the Current Population Survey indicates that Medicaid provided coverage to many losing ESI, particularly during the recession and particularly for children. Without the growth in Medicaid enrollment through 2005, the increase in the number of uninsured over this period would have been significantly larger. Medicaid's ability to absorb further declines in ESI may be limited to the extent that ESI declines are occurring higher up the income scale, above current Medicaid eligibility levels. Additionally, state efforts to reduce Medicaid spending and/or enrollment in response to budget pressures during the recession may have reduced the program's reach today. Despite relatively strong economic growth, the most recent data on health coverage indicate that the number of uninsured grew by 2.2 million in 2006, largely due to continued declines in ESI with no net increase in Medicaid coverage. More than two-thirds (69%) of the growth in uninsured children and more than half (51%) of the growth in uninsured adults occurred in families with incomes above twice the poverty level.

Growth in enrollment for the aged and the disabled fell to 2.0 percent in 2006 from an average of roughly 3.0 percent from 2000 to 2005, a significant decline in the group that accounts for the majority of Medicaid spending. This slowdown in enrollment growth occurred at the same time that the majority of this population had their drug coverage shifted 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.

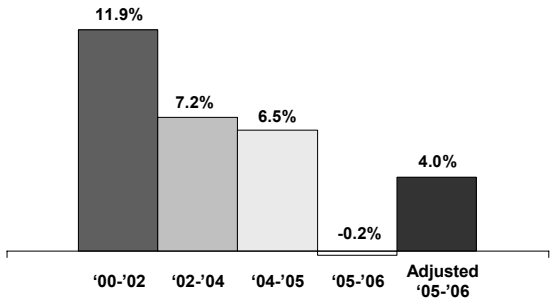
The average growth rate of 3 percent in the 2000 to 2005 period is about three times greater than the growth in the overall US population. A number of factors help explain why the aged and disabled Medicaid population is growing faster than the general population. Baby boomers who will eventually swell the size of the elderly population are now in the 55-64 age range – ages at which the likelihood of disability increases. The effects of medical technology that saves and lengthens lives for many people but leaves them with disabilities may also be a contributing factor. The improvement in drugs for HIV/AIDS patients and other conditions may have contributed to longevity, but at the same time increased disability and dependence on Medicaid. Another factor may be the increased recognition of chronic problems, particularly mental diseases as disabilities. Whether these forces will continue to cause the aged and disabled population to exceed the growth in the overall population is difficult to tell. But it will be a major factor determining the future course of Medicaid spending growth, as it has throughout the program's history.[10]

Expenditure Growth

Overall Medicaid spending fell by 0.2 percent from 2005 to 2006 (Figure 3 and Table 2). This decline largely resulted from the shift of prescription drugs for dual eligibles to Medicare. After adjusting for the shift in spending for prescription drugs for duals to Medicare, Medicaid spending overall increased between 2005 and 2006 by 4.0 percent, and spending for medical services rose by 4.5 percent. These adjusted growth rates are slower than those observed in previous years, due to slowing growth in enrollment and spending for some services.

Figure 3

Overall Average Annual Total Medicaid Spending Growth, 2000-2006



	'00-'02	'02-'04	'04-'05	'05-'06	Adjusted '05-'06
Annual Spending at End of Period (billions)	$257.3	$295.9	$315.0	$314.5	$310.8

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 from HCFA Financial Management Reports, 2006 (HCFA-64/CMS-64).

Table 2
Total US Medicaid Expenditures, Fiscal Years 2000-2006
(in billions)

Fiscal Year	Total Medicaid Expenditures	Medical Services and DSH Payments	Medical Services Only
2000	$205.7	$198.3	$182.7
2002	$257.3	$248.8	$232.8
2004	$295.9	$287.5	$270.3
2005	$315.0	$304.4	$287.3
2006	$314.5	$304.0	$286.9
Adjusted 2005*	$298.7	$288.1	$271.0
Adjusted 2006*	$310.8	$300.4	$283.2
Average Annual Percent Change			
2000-2002	11.9%	12.0%	12.9%
2002-2004	7.2%	7.5%	7.7%
2004-2005	6.5%	5.9%	6.3%
2005-2006	-0.2%	-0.1%	-0.1%
Adjusted 2005-2006*	4.0%	4.2%	4.5%

Source: Urban Institute estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64)
Note: DSH is disproportionate share hospital
* Adjusted expenditures exclude all prescription drug spending for dual eligibles.

Spending by Service

Spending on a service-specific basis was also slower from 2005 to 2006 than in previous years for most acute care services. This seems to reflect primarily declining enrollment, but spending on services also appears to have been affected by declines in non-dual eligible drug spending and the continued rise in spending through managed care arrangements, which has the effect of decreasing reported service-specific spending since spending provided under managed care can not be broken down by service using these data.

Medicaid spending for prescribed drugs fell by 45.7 percent from 2005 to 2006, largely due to the transition of drug spending for duals from Medicaid to Medicare. However, even after adjusting for this shift, prescription drug spending still fell by 9.9 percent. This decline reflects

the widespread efforts by states to control prescription drug spending through cost-control tools such as dispensing limits, preferred drug lists (PDLs), prior authorization, generic substitution, and copayments.[11] The effect of these policies can first be seen in the dramatic slowdown in prescription drug spending that began in 2005, when spending on prescribed drugs rose by only 0.8 percent after rising by 18.9 percent from 2000 to 2002 and by 14.0 percent from 2002 to 2004 (Table 3).

Spending on Medicaid managed care rose by 10.5 percent in 2006, following a significant increase of 10.6 percent in 2005. This rise in managed care spending has the effect of reducing fee-for-service spending, thereby reducing overall spending reported for specific services such as payments to hospitals and physicians. Although the rise in managed care spending also likely explains some of the steep decline in spending on prescribed drugs, state actions described above likely play a larger role. Increasing managed care spending likely does explain some of the slowdown in spending for hospital, physician, and clinic services. This increase in managed care spending likely resulted from continued growth in states' use of managed care to deliver Medicaid services (managed care enrollment as a percent of total Medicaid enrollment has risen from 56 percent in 2000 to 65 percent in 2006); state efforts to enroll more costly populations such as the aged and disabled into managed care; and some state actions to increase payments to managed care plans to help restore flat or reduced payments that states used to control program spending growth during the recession.

The increase in acute care spending for "other services" of 13.1 percent in 2005 and another 9.1 percent in 2006 may reflect some relaxation of policies affecting acute care benefits that states may offer at their option.[12] States often scale back on such "optional services" during times of fiscal stress, and the increase in recent years suggests states may be restoring spending for some services that were reduced during the recession. "Other" acute care services include dental care, other practitioners such as podiatrists, chiropractics and optometrists, emergency services for undocumented aliens and other acute care services.

Long-term care grew somewhat faster in 2006 than in previous years. The increase in nursing home spending of 3.0 percent shows a small rebound after several years of slower growth because of the phase out of UPL programs. Nonetheless, 3.0 percent is relatively slow and seems to reflect the fact that nursing home case loads are declining or growing more slowly. There was a sharp decline in spending on mental hospitals in 2006 for which there is no obvious explanation. Spending on home and community-based care increased by 10.3 percent after a slowdown in growth in 2005.

The continued increase in home and community based waiver services, which grew at faster rates than did nursing home spending and ICF/MR's throughout the period, resulted in Medicaid spending for home and community-based care programs that now approaches expenditures on institutional care. For example, by 2006, Medicaid spent $44.9 billion on home and community-based care and $47.9 billion on nursing facilities, together with another $13.0 billion on ICF/MR's.

Table 3
US Medicaid Expenditures by Type of Service and Year, 2000-2006 (in billions)

	Original Expenditures					Adjusted Expenditures*		Average Annual Growth Rate				
	FFY 2000	FFY 2002	FFY 2004	FFY 2005	FFY 2006	FFY 2005	FFY 2006	2000-2002	2002-2004	2004-2005	2005-2006	Adjusted 2005-2006
Total	**$205.7**	**$257.3**	**$295.9**	**$315.0**	**$314.5**	**$298.7**	**$310.8**	**11.9%**	**7.2%**	**6.5%**	**-0.2%**	**4.0%**
Medical Services and DSH	$198.3	$248.8	$287.5	$304.4	$304.0	$288.1	$300.4	12.0%	7.5%	5.9%	-0.1%	4.2%
Medical Services Only	$182.7	$232.8	$270.3	$287.3	$286.9	$271.0	$283.2	12.9%	7.7%	6.3%	-0.1%	4.5%
Acute Care	**$102.6**	**$134.7**	**$162.8**	**$174.4**	**$167.8**	**$158.1**	**$164.1**	**14.6%**	**9.9%**	**7.1%**	**-3.8%**	**3.8%**
Inpatient Hospital	$26.5	$32.7	$39.1	$41.8	$42.8	$41.8	$42.8	11.1%	9.4%	6.9%	2.3%	2.3%
Physician/Lab/X-Ray	$7.3	$9.3	$11.5	$11.5	$11.6	$11.5	$11.6	12.9%	11.2%	0.1%	1.3%	1.3%
Outpatient/Clinic	$13.2	$17.0	$19.6	$21.3	$20.8	$21.3	$20.8	13.5%	7.5%	8.8%	-2.4%	-2.4%
Prescribed Drugs	$16.6	$23.4	$30.4	$30.7	$16.6	$14.4	$13.0	18.9%	14.0%	0.8%	-45.7%	-9.9%
EPSDT	$0.8	$1.0	$1.0	$1.1	$1.1	$1.1	$1.1	10.2%	1.9%	2.9%	-1.8%	-1.8%
Prepaid/Managed Care	$26.5	$35.8	$44.9	$49.7	$54.9	$49.7	$54.9	16.2%	12.1%	10.6%	10.5%	10.5%
Other Services[1]	$11.7	$15.5	$16.2	$18.3	$20.0	$18.3	$20.0	15.3%	2.1%	13.1%	9.1%	9.1%
Long Term Care	**$75.4**	**$92.5**	**$100.4**	**$104.3**	**$108.9**	**$104.3**	**$108.9**	**10.7%**	**4.2%**	**3.8%**	**4.5%**	**4.5%**
Nursing Facility	$39.6	$47.5	$45.8	$46.4	$47.9	$46.4	$47.9	9.5%	-1.8%	1.3%	3.2%	3.2%
ICFMR[2]	$10.2	$11.3	$12.2	$12.5	$13.0	$12.5	$13.0	5.4%	3.8%	2.7%	3.8%	3.8%
Mental Health Institutions[3]	$3.3	$4.0	$4.8	$4.7	$3.2	$4.7	$3.2	10.8%	9.4%	-3.1%	-32.2%	-32.2%
Home/Personal Care[4]	$22.3	$29.6	$37.6	$40.7	$44.9	$40.7	$44.9	15.2%	12.7%	8.1%	10.3%	10.3%
Payments to Medicare	**$4.7**	**$5.7**	**$7.1**	**$8.7**	**$10.2**	**$8.7**	**$10.2**	**9.5%**	**11.9%**	**22.3%**	**17.2%**	**17.2%**
DSH Payments	**$15.6**	**$15.9**	**$17.2**	**$17.1**	**$17.1**	**$17.1**	**$17.1**	**1.1%**	**3.8%**	**-0.5%**	**0.4%**	**0.4%**
Inpatient	$11.6	$12.5	$14.3	$13.6	$13.5	$13.6	$13.5	4.2%	6.6%	-4.9%	-0.5%	-0.5%
Mental Health	$4.0	$3.4	$2.9	$3.5	$3.7	$3.5	$3.7	-8.2%	-7.5%	21.2%	3.7%	3.7%
Adjustments	**-$1.2**	**-$3.3**	**-$6.0**	**-$4.5**	**-$5.5**	**-$4.5**	**-$5.5**	**66.0%**	**34.8%**	**-26.0%**	**23.7%**	**23.7%**
Administration	**$8.6**	**$11.9**	**$14.4**	**$15.1**	**$15.9**	**$15.1**	**$15.9**	**17.6%**	**10.1%**	**4.6%**	**5.8%**	**5.8%**

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

* Adjusted expenditures exclude all prescription drug spending for dual eligibles.

The 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. This led to growth in payments to Medicare of more than 23 percent in 2005 and 17 percent in 2006.

DSH spending was essentially flat after an increase of 3.8 percent in 2002-2004. This increase reflected a substantial decline between 2000 and 2003, followed by a sharp increase of 20.3 percent in 2004. The increase in 2004 is attributable to the Medicare Modernization Act of 2003, which increased DSH payments in states by 16 percent in 2004. The intent of the MMA was to allow for inflation adjustments thereafter. The flattening of spending in 2005 and 2006 suggests that the states did not fully use their allotments.

Acute care vs. Long-term care

Table 4 shows that Medicaid spending growth for medical care services occurred mostly among acute care services. Acute care services accounted for at least 60 percent of the growth in services through 2005. With the actual decline in spending in 2006, it is difficult to calculate the percentage contributions, but the adjusted 2005 -2006 data shows that once again about 50 percent of the spending growth was due to acute care services.

Table 4
Spending Growth in US Medicaid Expenditures by Type of Service, Fiscal Years 2000-2006

	2000-2002		2002-2004		2004-2005		Adjusted 2005-2006*	
	Spending (in billions)	Percent	Spending (in billions)	Percent	Spending (in billions)	Percent	Spending (in billions)	Percent
Medical Services only	**$50.1**	**100.0%**	**$37.5**	**100.0%**	**$17.0**	**100.0%**	**$12.2**	**100.0%**
Acute Care	$32.1	64.1%	$28.1	74.9%	$11.6	68.1%	$6.0	49.4%
Long Term Care	$17.1	34.0%	$8.0	21.2%	$3.8	22.6%	$4.7	38.4%
Payments to Medicare	$0.9	1.9%	$1.4	3.8%	$1.6	9.3%	$1.5	12.2%

Sources: Urban Institute Estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64)
* Adjusted expenditures exclude all prescription drug spending for dual eligibles.

Growth in Spending Per Enrollee

Estimating spending per enrollee growth requires controlling for the effect of the changing composition of Medicaid enrollment. Simply dividing changes in spending by changes in enrollees would bias the estimate of growth in spending per enrollee downward because enrollment among the less expensive families group generally grows faster than growth among the aged and disabled. An overview of this approach is provided in Appendix A and has been described in more detail elsewhere.[13]

Unadjusted Medicaid spending per enrollee declined by 1.9 percent in 2006 due to the shift in spending to Medicare for prescription drugs for dual eligibles (data not shown). The adjusted 2005-2006 growth rate, excluding drug expenditures for dual eligibles, was 2.8 percent, an increase roughly equal to that from 2004 to 2005 (Table 5).

Table 5
US Expenditure Growth per Enrollee 2000-2006
(Weighted by growth in Enrollment and within Service)

	Average Annual Growth Rate			
Service	**2000-2002**	**2002-2004**	**2004-2005**	**Adjusted 2005-2006***
Total	**7.2%**	**3.7%**	**2.5%**	**2.8%**
Acute Care	**7.3%**	**5.5%**	**3.8%**	**3.0%**
Inpatient Hospital	4.1%	5.0%	3.5%	1.4%
Physician/Lab/X-Ray	4.6%	6.3%	-3.0%	0.8%
Outpatient/Clinic	6.1%	3.1%	5.4%	-3.2%
Prescribed Drugs	13.9%	10.1%	-2.3%	-11.3%
Prepaid/Managed Care	7.1%	7.0%	7.1%	10.0%
Other Services[1]	8.4%	-1.9%	9.6%	8.0%
Long Term Care	**7.6%**	**1.1%**	**0.5%**	**2.5%**
Nursing Facility	6.6%	-4.6%	-1.9%	1.2%
ICFMR[2]	2.7%	0.8%	-0.6%	1.8%
Mental Health Institutions[3]	3.3%	4.8%	-6.1%	-32.7%
Home/Personal Care[4]	12.1%	9.4%	4.7%	8.2%

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) 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.

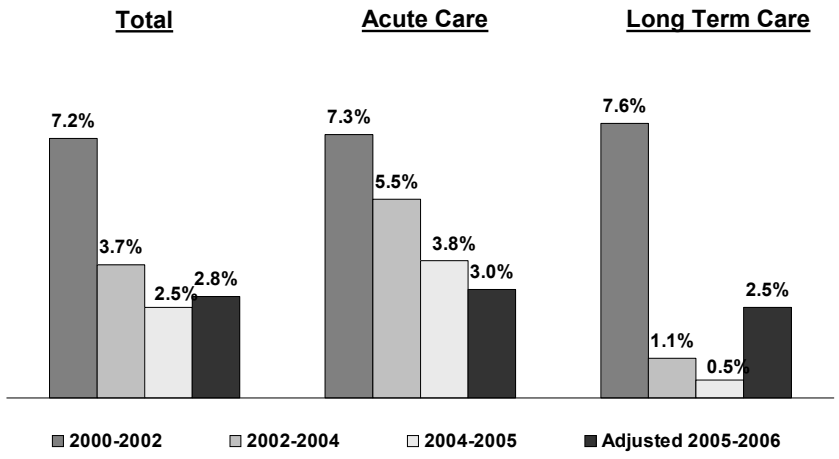
4) Includes home health services, home- and community-based waiver services, personal care, and related services

* Adjusted expenditures exclude all prescription drug spending for dual eligibles.

Growth in both of the last two years has been lower than in 2002-2004 and substantially below that for the first two years of the decade. Spending per enrollee in the last two years has been relatively slow for both acute care and long-term care services. In 2004-2005, spending per enrollee grew at 3.8 percent and long-term care at 0.5 percent. In 2006, spending per enrollee increased by 3.0 percent for acute care and 2.5 percent for long-term care, using the adjusted data (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 striking findings on per enrollee acute care growth in the last two years have been the increase in expenditures for managed care spending and spending for "other services," e.g., dental, podiatry, chiropractors, vision and hearing, etc. On a per enrollee basis, managed care spending grew by 7.1 percent in 2005 and 10.0 percent in 2006. "Other" services grew by 9.6 percent in 2005 and 8.0 percent in 2006. The increase in "other services" suggests that some states may have reversed cuts in optional acute care services that may have occurred in some states during the recession. The remaining services grew relatively slowly on a per enrollee basis. This finding is due in part to the growth in managed care which reduced the amount of care provided in fee-for-service settings. The decline in physician spending per enrollee in 2005 and a very small increase in 2006 are more difficult to explain, but may be related to the shift of some physician payments out of the fee-for-service setting and into managed care.

Per enrollee prescription drug spending declined in each of the last two years largely due to state cost control efforts. As noted previously, the decline in drug spending may be due to the widespread adoption of preferred drug programs, increased use of generics, increase use of prior authorization, and the introduction of multi-agency and multi-state purchasing coalitions may have helped some states achieve more favorable pricing.

Spending on long-term care services on a per enrollee basis in 2005 increased by 0.5 percent, slightly below the rate of growth in the previous two years. In part, this reflects the slow growth in spending on nursing homes, primarily due to slow or non-existent caseload growth together with the phasing out of spending through upper payment limit programs that often channeled funds through nursing homes. There was also a slight drop in spending on institutional care for the developmentally disabled and for the mentally ill. There was a slowdown in home and community based care and personal care growth, which increased by

only 4.7 percent following several years of much more rapid growth. From 2005-2006, long-term care spending per enrollee rebounded somewhat, rising by 2.5 percent. There was positive growth for nursing home facilities and for ICF/MR's, suggesting that the phase out of upper payment limit programs may have run its course. Home and community based care spending increased by 8.2 percent, considerably faster than in the previous year, but still below levels seen in the 2000-2004 period.

Decomposing Growth into Enrollment and Spending Per Enrollee

This section decomposes the growth in total spending into increases in enrollment and spending per enrollee for the aged and disabled and for families for the six-year period. As noted before, this analysis is based on an approach that adjusts for changes in enrollment composition. Additionally, total spending in Tables 6 and 7 differ from spending totals shown previously due to their reliance on baseline MSIS spending levels that allow spending to be associated with enrollment group rather than CMS-64 spending, which only allows for breakdowns by service. Spending data in Tables 6 and 7 and Figures 5 and 6 are also all adjusted for the shift in dual eligible drug spending to Medicare.

As noted above, Medicaid spending on medical services declined by -0.1 percent in 2006. To a large extent, this reflected the change in the coverage of prescription drugs for dual eligibles. Using the adjusted data, medical spending increased by 3.8 percent in 2006 (Table 6).[14] This was due to the combination of an increase of 0.2 percent in enrollment and 3.6 percent in spending per enrollee. The growth in enrollment was by far the slowest throughout the six-year period. The changes in spending per enrollee were roughly comparable over the entire period (they continually slowed). Except for 2000-2002, spending per enrollee grew faster for families than for the aged and disabled. This is because spending on the aged and disabled is influenced to a much greater extent by long-term care spending, which has been growing at slower rates than acute care.

Figure 5 shows the decomposition of Medicaid spending growth by group, using the adjusted data. It is noteworthy that there was a decline in spending growth for both groups. Spending on the aged and disabled fell from a growth rate of 10.9 percent between 2000 and 2002, 6.5 percent between 2002 and 2004, 5.1 percent between 2004 and 2005 and 4.4 percent between 2005 and 2006. Spending on families fell from a growth rate of 18.8 percent between 2000 and 2002, 11.2 percent from 2002 to 2004, 7.7 percent between 2004 and 2005, and 2.8 percent between 2005 and 2006.

The spending declines occurred largely for different reasons. There was far less fluctuation in enrollment growth for the aged and disabled. Enrollment rose by 2.6 percent from 2000 to 2002, 2.9 percent between 2002 and 2004, and 3.3 percent in 2005, and then by 2.0 percent in 2006. But spending per enrollee declined very sharply, falling from 8.1 percent between 2000

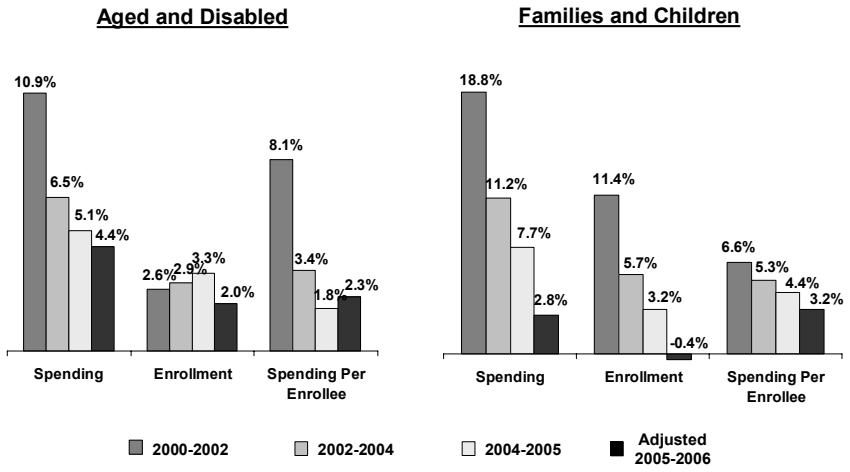
Table 6
Average Annual Changes in Enrollment and Expenditure by Group and per person, United States 2000-2006

	Enrollment (in millions)			Spending Per Enrollee			Medical Care CPI	Total Spending (in billions)		
2000-2002	**2000**	**2002**	**% Change**	**2000**	**2002**	**% Change**	**2000-2002**	**2000**	**2002**	**% Change**
Aged and Disabled	10.0	10.5	2.6%	$13,345	$15,586	8.1%		$133.3	$164.0	10.9%
Families (Adults and Children)	21.7	26.9	11.4%	$2,275	$2,587	6.6%		$49.4	$69.7	18.8%
All Enrollees	**31.7**	**37.5**	**8.7%**	**$5,763**	**$6,239**	**4.1%**	**4.9**	**$182.7**	**$233.7**	**13.1%**
2002-2004	**2002**	**2004**	**% Change**	**2002**	**2004**	**% Change**	**2002-2004**	**2002**	**2004**	**% Change**
Aged and Disabled	10.5	11.2	2.9%	$15,586	$16,671	3.4%		$164.0	$185.9	6.5%
Families (Adults and Children)	26.9	30.1	5.7%	$2,587	$2,866	5.3%		$69.7	$86.2	11.2%
All Enrollees	**37.5**	**41.2**	**4.9%**	**$6,239**	**$6,600**	**2.8%**	**4.0**	**$233.7**	**$272.1**	**7.9%**
2004-2005	**2004**	**2005**	**% Change**	**2004**	**2005**	**% Change**	**2004-2005**	**2004**	**2005**	**% Change**
Aged and Disabled	11.2	11.5	3.3%	$16,671	$16,972	1.8%		$185.9	$195.5	5.1%
Families (Adults and Children)	30.1	31.0	3.2%	$2,866	$2,992	4.4%		$86.2	$92.9	7.7%
All Enrollees	**41.2**	**42.6**	**3.2%**	**$6,600**	**$6,776**	**2.7%**	**4.3**	**$272.1**	**$288.3**	**6.0%**
Adjusted 2005-2006*	**2005***	**2006***	**% Change**	**2005***	**2006***	**% Change**	**2005-2006**	**2005***	**2006***	**% Change**
Aged and Disabled	11.5	11.7	2.0%	$15,777	$16,142	2.3%		$181.7	$189.6	4.4%
Families (Adults and Children)	31.0	30.9	-0.4%	$2,894	$2,987	3.2%		$89.8	$92.3	2.8%
All Enrollees	**42.6**	**42.7**	**0.2%**	**$6,380**	**$6,610**	**3.6%**	**3.6**	**$271.5**	**$281.9**	**3.8%**

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.
Spending totals differ from those presented in previous tables due this analysis's growing spending amounts by service-specific enrollment growth rates using 2000 MSIS spending data as the base. This method is described in more detail in Appendix A of this brief.
* Adjusted expenditures exclude all prescription drug spending for dual eligibles.

Figure 5

Decomposition of Medicaid Spending Growth by Group, 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 from HCFA Financial Management Reports, 2006 (HCFA-64/CMS-64).

and 2002 to 1.8 percent between 2004 and 2005, and 2.3 percent between 2005 and 2006. Spending per enrollee declined for the aged and disabled because they are high users of those services for which spending per enrollee fell. These include prescription drugs, nursing home care, home and community based care and personal care services.

Spending on families declined primarily because of declines in enrollment. Enrollment growth was 11.4 percent between 2000 and 2002, and then declined each year, until it fell slightly in 2006. Spending per enrollee also fell for families, but to a much lower extent. Spending per enrollee grew by 6.6 percent between 2000 and 2002 , 5.3 percent between 2002 and 2004, 4.4 percent in 2005, and 3.2 percent in 2006.

Thus, the decline in the growth rate in spending for the aged and disabled was largely driven by a drop in spending per enrollee, reflecting the services these populations used; for families the decline in spending was largely driven by the decline in enrollment, though there was some decline in spending per enrollee as well.

Table 6 also shows the increase in the medical care CPI. Between 2000 and 2002, Medicaid spending grew somewhat faster than medical care inflation. But in subsequent years, Medicaid spending per enrollee generally grew at or below the rate of inflation. Thus, most of the increase in spending per enrollee can be attributed to medical care inflation.

Aged and Disabled versus Families

Table 7 shows that a larger share of the growth in spending in all years was on behalf of the aged and disabled. While spending on families increased at a faster rate, spending levels started from a level considerably below for the aged and disabled. Thus, increased spending on families accounted for roughly 40 percent of the growth in each period, while spending on the aged and disabled accounted for roughly 60 percent of the growth between 2000 and 2006.

Table 7
Estimated Growth in US Medicaid Expenditures by Eligibility Groupings, 2000-2006

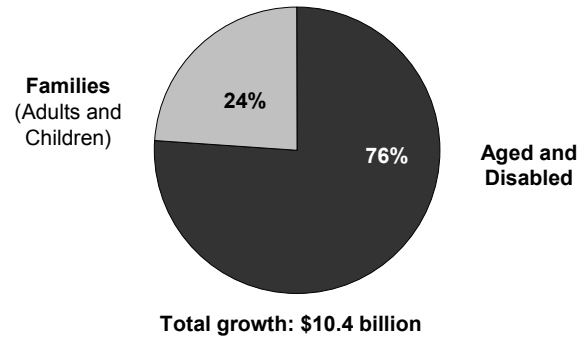
	Spending in 2000 (MSIS)	2000-2002		2002-2004		2004-2005		Adjusted 2005-2006*	
		Growth (in billions)	Share of Growth	Growth (in billions)	Share of Growth	Growth (in billions)	Share of Growth	Growth (in billions)	Share of Growth
Total Medicaid Expenditures	**$182.7**	**$51.0**	**100%**	**$38.4**	**100%**	**$16.2**	**100%**	**$10.4**	**100%**
Aged and Disabled	$133.3	$30.7	60.2%	$21.9	57.0%	$9.6	59%	$7.9	76%
Families (Adults and Children)	$49.4	$20.3	39.8%	$16.5	43.0%	$6.6	41%	$2.5	24%

Source: Urban Institute estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64), MSIS, and HMA
Spending totals differ from those presented in previous tables due this analysis's growing spending amounts by service-specific enrollment growth rates using 2000 MSIS spending data as the base. This method is described in more detail in Appendix A of this brief.
* Adjusted expenditures exclude all prescription drug spending for dual eligibles.

The adjusted 2005-2006 data, which excludes spending on prescription drugs by dual eligibles, indicate that spending on the aged and disabled accounted for about three quarters (76%) of all growth in spending between 2005 and 2006 (Figure 6).

Figure 6

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



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 Spending Growth in Context

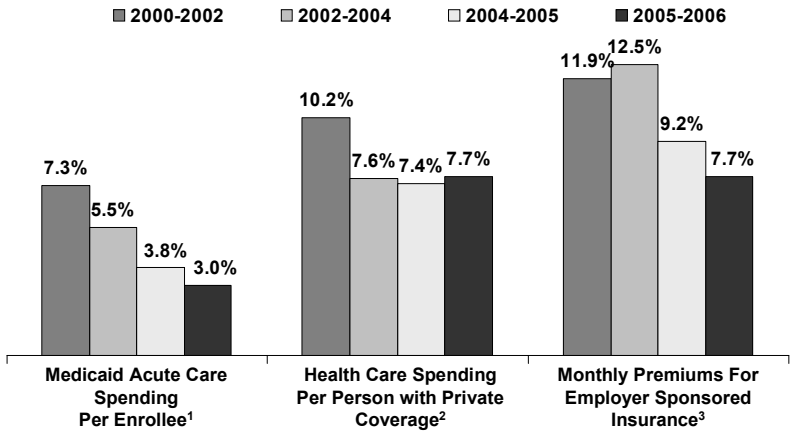
Total Medicaid spending growth averaged 8.9 percent per year from 2000 to 2005, outpacing both the average annual increase in total national health expenditures (NHE) of 8.0 percent and the annual growth in the U.S. Gross Domestic Product (GDP) of 4.8 percent. This was not true in 2006, however, even when we account for the effects of the shift of spending on prescription drugs for dual eligibles to Medicare. After adjusting for this shift, Medicaid spending grew by 4.0 percent from 2005 to 2006, compared to projected NHE growth of 6.8 percent and GDP growth of 6.1 percent.

Without the effect of enrollment growth, Medicaid spending growth would have been slower than both NHE and GDP growth. Total Medicaid spending growth per enrollee from 2000 to 2006 averaged 4.7 percent per year for the aged and disabled and 5.2 percent for families, while per capita NHE and GDP grew at 5.8 percent and 5.1 percent per year, respectively.

It is also instructive to compare Medicaid spending growth with that of the privately insured. Since private insurance typically does not include long-term care services, it is more appropriate to compare Medicaid spending growth for acute care services to that of the privately insured. In each period examined in this brief, 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 7). For example, in 2005, Medicaid acute care spending per enrollee increased by 3.8 percent, while health care spending per privately insured person increased by 7.4 percent, and monthly premiums increased by 9.2 percent. In 2006, acute care spending per enrollee (adjusted data) grew at only 3.0 percent, while both health care spending per privately insured person and health insurance premiums increased by 7.7 percent.

Figure 7

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.

Conclusion

Although the rate of Medicaid spending growth had been slowing steadily since the end of the recession in 2002, Medicaid spending fell for the first time in the program's 40-plus year history in 2006. Two primary factors were responsible for this decline.

The first was the implementation of the new Medicare Part D drug benefit. In January 2006, Medicaid and Medicare dual eligibles began receiving their drug coverage through Medicare Part D rather than through Medicaid. To recapture some of the expected savings from this transition of drug spending for duals from Medicaid to Medicare, states were required to make so-called "clawback" payments to the federal government to help fund this new benefit; however, these new payments (officially termed "phased down state contribution") are not considered Medicaid spending by the federal government.

States made clawback payments totaling $3.6 billion in FY 2006 which are not included in this analysis of program spending. To obtain a more accurate picture of recent Medicaid spending trends, data presented in this brief adjust Medicaid spending in 2005 and 2006 to eliminate the effect of this transition. Even after adjusting for this transition, however, Medicaid spending in 2006 grew at a slow rate by historical standards – 4.0 percent overall and 4.5 percent for medical services.

The low rate of growth in Medicaid spending on an adjusted basis was largely due to a second major factor: the slowdown in enrollment growth among the aged and disabled and an actual decline in the number of adults and children enrolled in the program.

After adjusting for the transition of dual eligibles' drug spending to Medicare, this brief documents that spending growth has fallen throughout the decade for a number of reasons. A slowdown in enrollment growth has played a major role, but there has also been a decline in spending per enrollee for certain services. There has been an increase in Medicaid managed care spending, which in part has substituted for fee-for-service spending. The rate of growth of spending for prescription drugs among non-dual eligibles has declined consistently throughout the decade, likely due to aggressive cost control measures implemented by the states. There has also been some growth in "other" acute care services in 2005 and 2006, e.g., dental care, podiatrists, chiropractors, etc. These optional benefits were often restricted in the early part of the decade as states dealt with severe budget shortfalls and rising Medicaid spending during the economic downturn. The impact of these reductions can be seen particularly in the 2002-2004 period, but as the economy has improved, states appear to have restored some of these cutbacks and spending growth for these "other" services seems to have rebounded in the last two years.

Long-term care spending has grown more slowly than acute care until 2006. This has resulted from a decline in nursing home spending due in part to the phase out of UPL programs. But it also appears that nursing home caseload growth has been modest. Growth in home and

community based care has also slowed since earlier in the decade, particularly in 2005 (4.7%), but rebounded somewhat in the past year to 8.2 percent.

The relative importance of the growth in enrollment and spending per person varies somewhat among the aged and disabled versus families. Among the aged and disabled, enrollment growth has been relatively stable, growing at 2.0-3.0 percent per year. Spending per enrollee for this group has declined primarily due to declines in spending for the services used heavily by these populations, primarily prescription drugs and long-term care. Growth in spending on families has declined primarily because of sharp reductions in enrollment growth over the period. Growth in spending per enrollee among families has also slowed somewhat, but to a much lesser extent than that observed for the aged and disabled.

Since 2000, Medicaid enrollment growth has reflected the continued erosion of the employer-sponsored insurance market, as premiums have continued to increase, together with changes in incomes that result in more people becoming eligible for Medicaid under existing eligibility rules. This increased enrollment was not due to widespread eligibility expansions during the 2000-2006 period.[15] It is important to note that the enrollment growth that has occurred among children and adults in Medicaid (as well as in SCHIP) has kept the uninsurance rate from increasing more than it otherwise would have. Without the growth in Medicaid enrollment through 2005, the increase in the number of uninsured over this period would have been significantly larger.

Recent data indicate, however, that Medicaid's ability to absorb further declines in ESI may be limited as recent ESI declines are occurring higher up the income scale above current Medicaid eligibility levels. Additionally, changes made to reduce Medicaid spending or enrollment in some states in response to budget pressures during the recession may have reduced the program's reach today. Despite relatively strong economic growth, the most recent data on health coverage indicate that the number of uninsured grew by 2.2 million in 2006, largely due to continued declines in ESI with no net increase in Medicaid coverage. More than two-thirds (69%) of the growth in uninsured children and more than half (51%) of the growth in uninsured adults occurred in families with incomes above twice the poverty level who are eligible for Medicaid or SCHIP coverage in most states.

As the availability of affordable ESI coverage continues to decline, many states have looked to expansions of Medicaid and SCHIP eligibility, simplified program enrollment and retention procedures, and expanded outreach efforts to stem the tide of increasing uninsurance. Several have also enacted broad coverage expansions that build upon Medicaid. Such state reforms, coupled with mounting pressure from the ongoing erosion of ESI coverage, will likely result in higher Medicaid enrollment and therefore increased spending in years to come. Additionally, the reauthorization of the SCHIP program, which expires on September 30, 2007, could affect future Medicaid spending. Congress has agreed to legislation that expands coverage and increases outreach to children that, if signed into law, would result in more eligible but uninsured children enrolling in Medicaid, increasing overall program enrollment and spending.

This analysis indicates that Medicaid spending is likely to continue to grow as long as enrollment continues to increase, particularly among the aged and disabled. Recent U.S. Treasury data suggest that spending and enrollment may have already begun to rebound in 2007. Federal Medicaid outlays through August 2007 show that Medicaid spending has risen in 2007 by roughly 5.5 percent, 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.

This brief was prepared by John Holahan and Mindy Cohen of the Urban Institute and David Rousseau of the Kaiser Commission on Medicaid and the Uninsured.

Appendix A

Medicaid spending growth through 2006 for families and children versus the aged and disabled can not be calculated directly because CMS-64 data breakdown spending by service, but do not associate spending with eligibility groups. Therefore, the analysis presented in this brief estimates spending growth for the aged and disabled versus children and adults (families) by using available data on enrollment growth by group and by estimating spending per enrollee separately for families and for the aged and disabled. Changes in spending per enrollee are calculated by using the changes in spending on each service divided by a measure of enrollment specific to each service. FY 2004 MSIS data on the distribution of spending by service for families versus aged and disabled are used to calculate a service-specific, enrollment growth rate.

In FY 2004, 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, MSIS data on the share of growth attributable to the aged/disabled (0.81) and families (0.19) are used. For hospitals, enrollment growth among the aged/disabled was given a weight of 0.55 versus 0.45 for families. 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.

Service-specific measures of spending per enrollee were used to calculate average increases in spending per enrollee for aged and disabled and for families. This was accomplished by weighting the increases in spending per enrollee by the importance of each service to the specific group. The growth of enrollment was then multiplied by 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 the calculations used to produce Table 5 began with MSIS data on spending by eligibility group in FY 2000 (totals from which differ from CMS-64 totals for FY 2000) and then apply calculated growth rates for each service through 2006.

Notes

[1] As described in more detail in the "Data Sources and Methods Section," this paper adjusts spending in FY 2005 and FY 2006 to account for the January 1, 2006, shift in dual eligible drug spending from Medicaid to Medicare by excluding Medicaid prescription drug spending on behalf of dual eligibles in both FY 2005 and FY 2006. This adjustment allows for a measure of program spending growth that is not biased by this major policy change. It is also worth noting that in 2006 states made clawback payments to the Federal Treasury totaling $3.6 billion. These payments are **not** included in this analysis. These payments, formally termed "phased down state contributions," were included in the 2005 Medicare Modernization Act to recapture from states a portion of the expected savings generated by Medicare's assumption of drug spending for dual eligibles. For more information, see "State Financing of the Medicare Drug Benefit: New Data on the 'Clawback'", Kaiser Commission on Medicaid and the Uninsured, November 2005, available at http://www.kff.org/medicaid/7438.cfm.

[2] "Low Medicaid Spending Growth Amid Rebounding State Revenues: Results From a 50-State Medicaid Budget Survey State Fiscal Years 2006 and 2007," Kaiser Commission on Medicaid and the Uninsured, October 2006, available at http://www.kff.org/medicaid/7569.cfm.

[3] Total Medicaid spending growth during the period averaged 8.9 percent per year, outpacing both the average annual increase in total national health expenditures (NHE) of 8.0 percent and the annual growth in the U.S. Gross Domestic Product (GDP) of 4.8 percent. This was not true in 2006, however, even when we account for the effects of the shift of spending on prescription drugs for dual eligibles to Medicare. After adjusting for this shift, Medicaid spending grew by 4.0 percent from 2005 to 2006, compared to projected NHE growth of 6.8 percent and GDP growth of 6.1 percent. Without the effect of enrollment growth from 2000 to 2006, however, Medicaid spending growth would have been slower than both NHE and GDP growth.

[4] Clemans-Cope et al., "Changes in Employees' Health Insurance Coverage, 2001-2005," The Kaiser Commission on Medicaid and the Uninsured, October 2006, available at http://www.kff.org/uninsured/7570.cfm.

[5] Holahan and Cook, "What Happened to the Insurance Coverage of Children and Adults in 2006?" The Kaiser Commission on Medicaid and the Uninsured, September 2007, available at http://www.kff.org/uninsured/7694.cfm.

[6] Cohen-Ross et al., "Resuming the Path to Health Coverage for Children and Parents: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2006," Kaiser Commission on Medicaid and the Uninsured, January 2007, available at http://www.kff.org/medicaid/7608a.cfm.

[7] The Congressional Budget Office has estimated that the SCHIP reauthorization bill passed by the Senate (H.R. 976), which is closest to the conference agreement soon to be adopted by both chambers of Congress, would increase federal Medicaid program spending by $4.7 billion from 2008-2012. For more detail see http://www.cbo.gov/ftpdoc.cfm?index=8584&type=1.

[8] Rousseau and Schneider, "Current Issues in Medicaid Financing – An Overview of IGTs, UPLs, and DSH," Kaiser Commission on Medicaid and the Uninsured, April 2004, available at http://www.kff.org/medicaid/7071.cfm .

[9] Delays in the data reporting mechanisms in Georgia caused unusual yearly patterns to emerge in many services, including inpatient, nursing facilities, physician/lab/x-ray and others. The amounts reported reflect actual dollar amounts paid by the federal government in that fiscal year, but not actual services delivered that year. We included the raw data in our analysis, which explains some of the trends reported in this brief.

[10] Analysis of Medicaid spending from 1975-2003 indicates that 73% of the program's growth as a share of total health spending during this period was due to growth in Medicaid spending for the disabled. See Kronick and Rousseau, "Is Medicaid Sustainable? Spending Projections for the Program's Second Forty Years," *Health Affairs*, Vol. 26, No. 2, February 2007, available at http://content.healthaffairs.org/cgi/content/abstract/26/2/w271.

[11] For more information on state efforts to control Medicaid spending growth for prescription drugs, see Crowley et al., "State Medicaid Outpatient Prescription Drug Policies: Findings from a National Survey, 2005 Update," Kaiser Commission on Medicaid and the Uninsured, October 2005, available at http://www.kff.org/medicaid/7381.cfm.

[12] For more information on mandatory vs. optional services, please see "Medicaid: An Overview of Spending on 'Mandatory' vs. 'Optional' Populations and Services," Kaiser Commission on Medicaid and the Uninsured, June 2005, available at http://www.kff.org/medicaid/7331.cfm.

[13] Holahan and Ghosh, "Understanding the Recent Growth in Medicaid Spending, 2000-2003," *Health Affairs*, W5, January 2005, available at http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.52v1.

[14] See Appendix A for more details of the methodology employed here. Total medical spending amounts for 2002-2006 differ slightly from the raw CMS 64 data presented on Tables 1 and 3 due to our method of growing spending amounts by service-specific enrollment growth rates using spending from MSIS 2000 as the base.

[15] Cohen-Ross, et al., 2006.

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