kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

ISSUE PAPER

September 2009

Medicaid Expenditures Increased By 5.3% in 2007, Led By Acute Care Spending Growth

by John Holahan, Alshadye Yemane, and David Rousseau

Medicaid spending in federal fiscal year 2007 increased by 5.3%, rising from $314.2 billion in 2006 to $330.8 billion in 2007 (Figure ES-1). After adjusting for the shift of prescription drugs for dual eligibles from Medicaid to Medicare, the annual rate of growth in Medicaid spending in 2007 was 6.0%. Growth in 2007 was driven in large part by an increase of 10.6% acute care spending.

Hospital inpatient spending increased by 11.6%, considerably faster than in recent years, particularly on a per enrollee basis. As discussed in more detail below, however, this growth in hospital spending was driven by growth in a relatively small number of states. Spending also increased considerably for Medicaid managed care; this seems to be attributable to both states enrolling more and more costly individuals into Medicaid managed care as well as likely increases in payment rates to managed care plans. Hospital outpatient care increased by 9.0%. These increases are all consistent with increases in provider payment rates as reported by Smith et al (2008).[1] Most of the remaining increase was in "other care" services, a "catch-all" category used by states for the funding of various unspecified services. "Other care" spending increased from $11.9 billion to $14.4 billion, an increase of 20.6%.

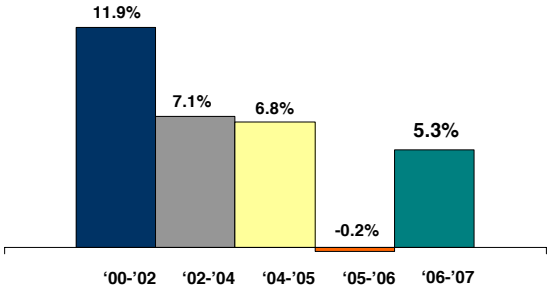
The 2007 increase follows a year that saw the first decline in expenditure growth in the program's 40 year history. The 2006 decline occurred for three main reasons:

- The 2005 Medicare Modernization Act's (MMA) creation of a new Medicare drug benefit that shifted the cost of prescription drugs for dual eligibles from Medicaid to Medicare. However, even after adjusting for the shift, total Medicaid spending would have increased by only 4.4%, and spending for medical services would have risen by 4.9%, considerably slower than in previous periods.
- Also contributing to the spending slowdown were declines in spending per enrollee for services such as outpatient services, prescription drugs, nursing home care, and mental health institutional care.
- Finally, there was a significant reduction in enrollment growth. Enrollment growth among the aged and disabled fell from an average of nearly 3.0% from 2000 to 2005 to 2.3% from 2005 to 2006 (Figure ES-2). The number of parents and children enrolled in Medicaid actually declined in 2006 for the first time in nearly a decade. The patterns we report for 2007 reflect a continuing decline in the growth in the number of aged and disabled and an absolute decline in the number of parents and children.

Historically, changes in Medicaid spending growth have been accompanied by similar changes in Medicaid enrollment. Medicaid spending growth averaged nearly 12% per year during the 2000-2002 period (Figure ES-1). This was a period of economic recession during which many individuals lost jobs and saw incomes decline. In response to the economic slowdown, Medicaid enrollment increased, leading to a significant increase in Medicaid spending.

Figure ES-1

Overall Average Annual Total Medicaid Spending Growth, 2000-2006



	'00-'02	'02-'04	'04-'05	'05-'06	'06-'07
Annual Spending at End of Period (billions)	$257.3	$295.1	$315.0	$314.4	$330.6

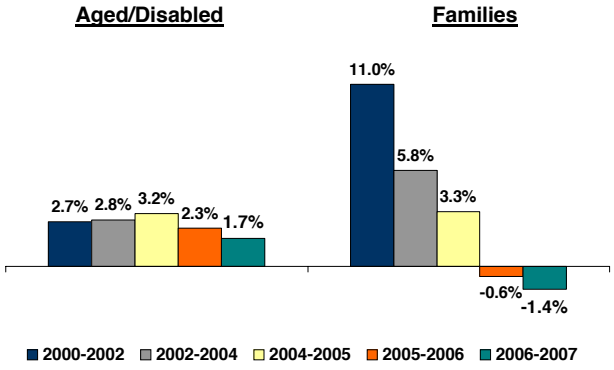
SOURCE: Urban Institute, 2008. Estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64).

Following this period, spending growth slowed to 7.1% between 2002 and 2004 and 6.8% between 2004 and 2005 as enrollment growth moderated and states took steps to control program spending growth. It was increases in Medicaid enrollment over this period, particularly among the aged and disabled, rather than real increases in spending per enrollee that drove program spending growth.

In 2007, however, this pattern seems to have changed as Medicaid spending growth was not driven by enrollment growth, but rather by increases in the growth rate of spending per enrollee, particularly for acute care services. According to data from the Kaiser Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates (HMA), enrollment fell by 1.4% for parents and children and increased by 1.7% among the aged and disabled (Figure ES-2), which resulted in a net decrease of -0.6% in total enrollment.[2]

Figure ES-2

Medicaid Enrollment Growth Average Annual Growth Rates, 2000-2007



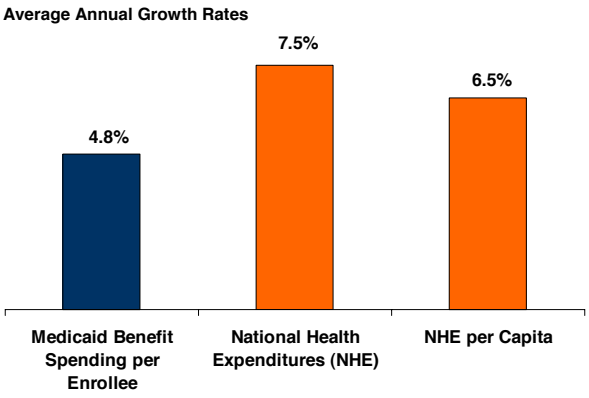
SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute, 2008. Estimates based on KCMU Medicaid enrollment data collected by Health Management Associates from 45 states inflated proportionally to national totals.

However, in 2007, Medicaid benefit spending per enrollee increased by 6.0% and acute care spending per enrollee increased by 10.5%. Long-term care spending per enrollee rose by 0.2%.

Over the entire 2000 to 2007 period, Medicaid spending grew by 8.3% (this figure excludes prescription drugs for dual eligibles in all years). On a per enrollee basis, spending grew by 4.8% per year; this consisted of 5.8% annual growth in acute care spending and 3.1% annual growth in long term care spending. The overall increase in spending per enrollee (4.8%) was slightly faster than the growth in the medical care CPI (4.4%) and about equal to GDP growth (5.0%). However, Medicaid spending on a per enrollee basis was considerably slower than national health expenditures (7.5%) as well as per capita national health expenditures (6.5%) (Figure ES-3).

Figure ES-3

Growth in Medicaid Spending per Enrollee in the Context of National Health Spending Growth, 2000-2007



SOURCE: Urban Institute, 2008. Estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64), CMS Office of the Actuary, National Health Expenditure Accounts.

In the past, Medicaid acute care spending per enrollee has consistently grown more slowly than private health care spending. From 2000 to 2006, Medicaid acute care spending growth per enrollee ranged from 3.9% to 6.6%, while growth rates for monthly ESI premiums ranged from 7.7% to 12.5% during the same period. In 2007, however, Medicaid acute care spending per enrollee grew by 10.5% whereas monthly ESI premiums only grew by 6.1%. According to Smith et al. (2008), the increase in acute care spending per enrollee in 2007 seems to reflect a one-time bump in provider payment rates as states were experiencing substantially better economic times in 2006 and 2007. There also appears to have been an increase in supplemental payments to hospitals in a small number of states, which together contributed substantially to the reported increase in hospital spending.

Medicaid enrollment growth during the first part of this decade was partly a result of the ongoing erosion of employer sponsored insurance. Without the growth in Medicaid enrollment, the increase in the number of uninsured over this period would have been significantly greater. In 2006 and 2007, there was much less of a decline in employer sponsored insurance. State economies improved and there could well have been fewer people becoming eligible for Medicaid.

In general we believe that Medicaid spending is likely to continue to follow the path of enrollment growth. The deteriorating economic conditions in 2008 and early 2009 suggest that Medicaid enrollment could be increasing sharply this year.[3] It is also likely that states will restrain provider payment rates and benefits. This suggests that Medicaid in 2008 and 2009 will revert to previous patterns and the data we report in this brief will be seen as an outlier; that is Medicaid spending growth will increase because of enrollment at the same time that growth in spending per enrollee slows considerably.

Introduction

Medicaid spending rose from $314.2 billion in fiscal year 2006 to $330.8 billion in federal fiscal year 2007, an average annual increase of 5.3%. Annual growth was 6.0% after adjusting for the shift of prescription drugs for dual eligibles to Medicare. During the previous year, total Medicaid spending had declined for the first time in the program's history, primarily due to the shift of prescription drugs to Medicare for dual eligibles as well as a slight decline in overall enrollment growth.

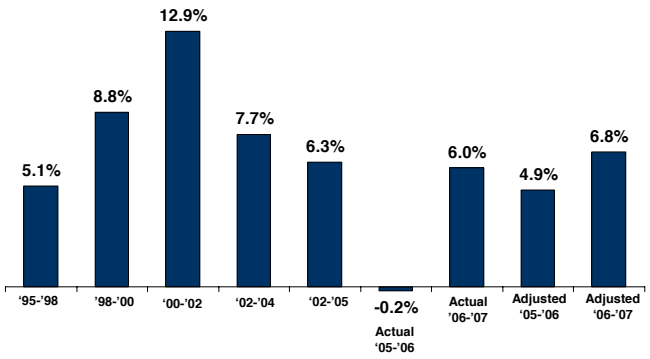
This brief presents analysis of the latest available enrollment survey and administrative spending data to provide information on Medicaid enrollment, total spending, and spending per service. Although the focus is primarily on spending changes between 2006 and 2007, an examination of the changes that occurred prior to this period provides useful context for understanding the larger forces that have historically shaped changes in program spending and enrollment.

Historical Background

Medicaid spending increases have generally followed the path of enrollment growth and health care inflation (Figure 1). As noted above and described in more detail below, this pattern changed during the 2006 to 2007 period for the first time in many years. Between 1995 and 1998, Medicaid spending on medical services grew by 5.1% per year. This period included the enactment of welfare reform and robust national economic growth, both of which contributed to overall declines in Medicaid enrollment. Medicaid enrollment fell as employment and workers' incomes increased, leaving fewer people eligible for Medicaid. This was also a period in which health care inflation was relatively low throughout the entire health sector because of growing managed care penetration which resulted in low per enrollee cost growth in Medicaid as well.

Figure 1

Average Annual Growth in Medical Services, 1998-2007



SOURCE: Urban Institute, 2008. Estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64). Adjusted expenditures exclude all prescription drug spending for dual eligibles to remove the effect of their transition to Medicare Part D in 2006.

Between 1998 and 2000, Medicaid spending for medical services increased by 8.8%. Medicaid enrollment began to increase as the early impacts of welfare reform on Medicaid enrollment were reversed and many who had been erroneously dropped from the program were reenrolled. State revenues increased because of strong economic growth and several states used these revenues to expand health coverage through Medicaid. Further, the CHIP program was implemented in 1998, and outreach and publicity associated with the new program contributed to increased enrollment in Medicaid as well as CHIP. Health care costs also began to increase, particularly for prescription drugs, and hospital costs for both inpatient and outpatient care increased more rapidly than in the mid-1990s. This was also the period in which states developed new financing mechanisms including the use of upper payment limit (UPL) programs. These programs increased payments to certain facilities up to Medicare limits, using

intergovernmental transfers to finance the state share of Medicaid. These programs allowed some states to generate additional federal matching funds with limited new state contributions.

Between 2000 and 2002, Medicaid spending growth accelerated even more rapidly. The economic recession during this period led to a sharp increase in Medicaid enrollment because declining incomes and job loss made more people eligible for the program. Health care costs continued to increase rapidly and managed care was no longer providing state Medicaid programs or other payers the same savings it had provided in the 1990s.

Medicaid spending growth for medical services slowed to 7.7% per year between 2002 and 2004 and fell to 6.3% in 2005. This resulted from a slower growth in enrollment and a slowdown in the rate of increase in Medicaid spending per enrollee for acute care services. This slower growth also reflects new federal policies designed to limit states' ability to draw down additional federal matching funds through financing mechanisms involving disproportionate share hospital payments (DSH) and UPL programs.

Data Sources and Methods

This brief uses three data sources for enrollment and expenditures between 2000 and 2007. The main source for spending data is the Medicaid Financial Management Reports (Form 64) from the Center for Medicare and Medicaid Services (CMS) for 1995-2007 which are used to obtain aggregate spending on services. These CMS-64 data are available by state and by service but are not available by type of enrollee.[4] Data from the 2004 Medicaid Statistical Information System (MSIS) are used to estimate spending and spending per enrollee growth rates by eligibility group. The MSIS contains detailed personal level data stratified by service type and eligibility group. The 2004 MSIS data are also used to create service-level weights that are used to estimate growth in total spending per enrollee in a way that accounts for differences in service use across eligibility groups. We also use MSIS data to calculate total spending and spending per enrollee levels by eligibility group by applying spending growth rates calculated from the 2004 MSIS and the CMS-64 data to the MSIS Medicaid spending levels in 2000. More methodological details can be found in appendix A.

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 provide program enrollment. These data provide point in time enrollment for June of each year. Because of inconsistencies that occur between state reporting systems, it is only possible to use detailed data on the number of aged/disabled and families/children for 45 states. Using these data as well as total enrollment for the remaining states, enrollment was allocated to the aged/disabled and families/children for the total population in the same proportions as reported in the 45 states.

During much of this decade the Current Population Survey has shown that Medicaid and SCHIP enrollment growth offset the loss of employer sponsored insurance, largely for children but also partially for adults. Without the growth in Medicaid enrollment between 2000 and 2005, the increase in the number of uninsured during this period would have been substantially larger. Medicaid enrollment growth slowed in 2006 and did not offset the decline in employer sponsored insurance. As a result, the number of uninsured increased. In 2007 the CPS showed an increase in Medicaid and SCHIP enrollment. Because employer sponsored insurance was stable in 2007, probably because of the strong economy, the uninsured fell for the first time in this decade.

The data from the CPS on Medicaid and SCHIP growth is in sharp contrast to KCMU/HMA survey data. We are unable to determine which is more accurate. We do know from the report done by Smith et al for the Kaiser Commission on Medicaid and the Uninsured that states made efforts to expand enrollment, probably because of the improving budget outlook in fiscal 2006 and 2007. Smith et al report increases in income eligibility standards and in income disregards, as well as relaxation of enrollment procedures and increases in outreach efforts to increase participation rates. But at the same time stronger economic growth could have increased employment and incomes enough to make fewer people eligible.

The CPS suggests that state efforts to expand enrollment led to increasing Medicaid/SCHIP enrollment and to a reduction in the uninsured. The administrative data suggests that the effects of the economy on employment and incomes were offsetting state efforts to expand enrollment. Preliminary data from the Medicaid Statistical Information System indicate that, in the 32 states for which FY 2007 data are available, representing nearly three-quarters (72%) of total enrollment in FY 2006, Medicaid enrollment did indeed fall between FY 2006 and FY 2007 by 1.7%. Despite these discrepancies, the administrative enrollment data from KCMU and HMA is used throughout this paper, both to be consistent with the methodology used in previous reports and because a monthly enrollment figure is still, on balance, the best data source for the analysis presented here.

Finally, the shift in Medicaid spending on prescription drugs for dual eligibles to the Medicare program caused a large one time shift in expenditures in 2006. This required certain changes to the table formats from previous Medicaid spending briefs. In this brief we attempted to exclude spending by dual eligibles for prescription drugs in 2005 and 2006 so that we could derive an estimate of spending growth that was unaffected by this shift. Several of the tables in this brief contain actual 2005 and 2006 spending together with adjusted 2005 and 2006 data. That is, the 2005 and 2006 data are adjusted by excluding the estimated amount of prescription drug spending for dual eligibles. We used the share of prescription drugs attributed to non-duals we observed from the 2003 MSIS and applied that percentage to total prescription drug spending reported in the CMS-64 data to calculate the 2005 adjusted spending values. To estimate the 2006 adjusted spending levels, we projected the 2005 adjusted spending forward using the same rate of growth we observed for 2004-2005, the last year for which we have Medicaid prescription drug spending data unaffected by the MMA. Tables 4-6 contain only the adjusted 2005 and 2006 data because it provides a better reflection of the relative effects of enrollment versus spending per enrollee.

RESULTS

Enrollment Growth

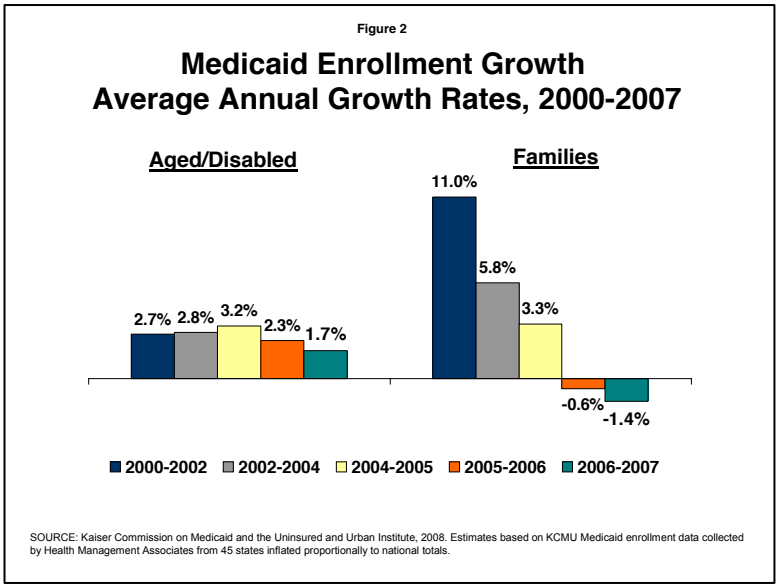
Medicaid enrollment declined by 0.6% between 2006 and 2007 (Table 1). This was the first decline in program enrollment since 1997. Medicaid enrollment declined by 1.4% for parents and children but grew by 1.7% for the aged and disabled (Figure 2). Enrollment growth has been slowing since 2002 as the economy rebounded from the 2000-2002 recession. Because of the recession, enrollment increased by 8.4% between 2000 and 2002, but this was followed by increases of 5.0% between 2002 and 2004 and 3.2% between 2004 and 2005. Most of the decline in the last two years can be attributed to children and parents whose numbers fell in both 2006 and 2007. As shown in Figure 2, the growth in the aged and disabled was relatively

Table 1. Change in Monthly Medicaid Enrollment, 2000 - 2007 (in millions)

Population	Enrollment						Average Annual Growth Rate				
	June 2000	June 2002	June 2004	June 2005	June 2006	June 2007	2000-2002	2002-2004	2004-2005	2005-2006	2006-2007
Total	**31.8**	**37.4**	**41.2**	**42.5**	**42.6**	**42.3**	**8.4%**	**5.0%**	**3.2%**	**0.2%**	**-0.6%**
Aged & Disabled	10.1	10.7	11.3	11.6	11.9	12.1	2.7%	2.8%	3.2%	2.3%	1.7%
Families	21.7	26.7	29.9	30.9	30.7	30.2	11.0%	5.8%	3.3%	-0.6%	-1.4%

SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on KCMU Medicaid enrollment data collected by Health Management Associates from 45 states inflated proportionally to national totals.

Figure 2



SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute, 2008. Estimates based on KCMU Medicaid enrollment data collected by Health Management Associates from 45 states inflated proportionally to national totals.

stable, slightly above or below 3% per year between 2000 and 2005. In 2006 enrollment increased by 2.3% and by another 1.7% in 2007. In contrast, enrollment growth among parents and children was 11.0% between 2000-2002, 5.8% between 2002-2004 and 3.3% between 2004-2005. Enrollment growth actually declined by 0.6% between 2005-2006 and then again by 1.4% between 2006-2007.

Growth in enrollment for the aged and disabled increased by only 1.7% in 2007 following the growth in 2006 of 2.3% and increases of about 3.0% between 2000 and 2005. Enrollment growth among the disabled was still growing faster than the U.S. population. The growth in the aged and disabled is important because they represent a very high needs and extremely expensive population. In past reports, we have hypothesized a number of reasons why the aged and disabled are growing faster than general population growth:

- First, the baby boomers who will eventually swell the size of the elderly population are now in the 55 to 64 age range, ages at which the likelihood of disability increases. In fact, the 55-64 year old age range is by far the fastest growing group of adults in the U.S. population.

- Second, although new medical technologies and improved prescription drugs save, improve, and lengthen lives for many, they also contribute to an increase in the number living with permanent disabilities, many of whom rely on Medicaid to finance their care.
- Finally, the increased ability to recognize and treat chronic conditions, particularly mental health problems, may also contribute enrollment growth among the disabled.

The extent to which these factors continue to cause growth in this expensive population will be a major determinant of Medicaid cost growth in the future.[5]

Expenditure Growth

Overall, Medicaid spending increased from $314.2 billion in 2006 to $330.8 billion in 2007 (Table 2). Overall spending increased by 5.3 between 2006 and 2007 and spending on benefits increased by 6.0%. After accounting for the shift of dual eligibles from Medicaid to Medicare, overall spending rose by 6.0%, and spending on benefits by 6.8%.

This increase in Medicaid spending follows a year in which Medicaid spending had declined by 0.2% from 2006 to 2007 (Figure 3). This decline was largely due to the shift in the financing of the prescription drug benefit for dual eligibles from Medicaid to Medicare. After adjusting for this shift, overall Medicaid spending increased in 2006 by 4.4% and spending on medical services by 4.9%. These adjusted growth rates are slower than those observed in previous years largely due to slower growth in enrollment.

Spending by Service. In 2007, spending increases were faster for several specific acute care services than in most other years in this decade (with the exception of 2000-2002). Spending on services such as hospital inpatient and outpatient care, Medicaid managed care, and "other care" increased dramatically. In prior periods, the growth in Medicaid managed care probably contributed to the slowing growth in hospital and physician services. But this did not appear to be true between 2006 and 2007, particularly for inpatient and outpatient services. While managed care continued to increase by 12.3% during this period, spending on hospital inpatient care increased by 11.6% and outpatient and clinic services by 9.0%.

The increase in managed care spending seems to be in part due to increased use of Medicaid managed care, particularly for aged and disabled populations. The increases in inpatient and outpatient care spending likely reflect an increase in provider payment rates as reported by Smith et al. These rates had been constrained by states for several years during difficult fiscal times earlier in the decade, but the improving revenue picture that states faced in the more recent years may have resulted in significant provider rate increases. The spending increases, particularly for inpatient care, may also reflect increased use of supplemental payment programs by a small number of states; the increases in these states were large enough to drive the national growth rates for acute care spending.[6]

Unlike inpatient and outpatient spending, physician expenditures declined in 2007 after a period of slowing growth. This would seem to suggest that there may have been relatively little real increase in fees paid to physicians[7]; this coupled with the continued movement to managed care, could explain the lack of growth. The low fees paid to private physicians could be resulting in lower participation rates and more care provided in hospital outpatient and emergency settings as well as more to hospital admissions. This overall picture is clearly different than in previous years and somewhat difficult to explain.

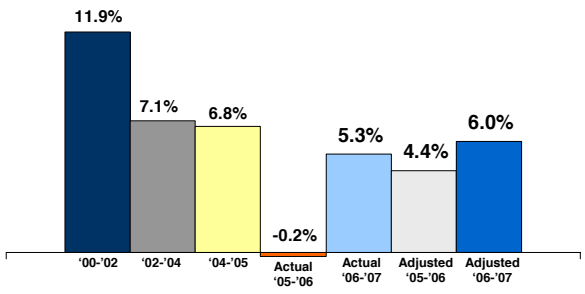
Table 2. US Medicaid Expenditures, by Type of Service and Year, FFY 2000 - FFY 2007 (in billions)

Expenditure Category	Original Expenditures						Adjusted Expenditures[5]		Average Annual Growth Rate						
	2000	2002	2004	2005	2006	2007	2005	2006	2000-2002	2002-2004	2004-2005	2005-2006	2006-2007	Adjusetd[5] 2005-2006	Adjusted[5] 2006-2007
Total Spending	**205.7**	**257.3**	**295.1**	**315.0**	**314.2**	**330.8**	**298.7**	**312.0**	**11.9%**	**7.1%**	**6.8%**	**-0.2%**	**5.3%**	**4.4%**	**6.0%**
Benefits & DSH Spending	198.3	248.8	287.2	304.9	303.8	319.7	288.7	301.6	12.0%	7.4%	6.2%	-0.4%	5.2%	4.5%	6.0%
Benefits	182.7	232.8	270.3	287.3	286.6	303.7	271.0	284.4	12.9%	7.7%	6.3%	-0.2%	6.0%	4.9%	6.8%
Acute Care	**86.0**	**111.3**	**132.4**	**143.3**	**149.6**	**165.5**	--	--	**13.8%**	**9.1%**	**8.3%**	**4.4%**	**10.6%**	--	--
Inpatient Hospital	26.5	32.7	39.1	41.8	42.8	47.8	--	--	11.1%	9.4%	6.9%	2.5%	11.6%	--	--
Physician & Lab/X-Ray	7.3	9.3	11.5	11.5	11.7	11.7	--	--	12.9%	11.2%	0.1%	2.0%	-0.1%	--	--
Outpatient	13.2	17.0	19.6	20.9	20.9	22.7	--	--	13.5%	7.5%	6.7%	-0.3%	9.0%	--	--
EPSDT Screening	0.8	1.0	1.0	1.1	1.1	0.9	--	--	10.2%	1.9%	2.9%	-1.8%	-10.4%	--	--
Medicaid Managed Care	26.5	35.8	44.9	49.6	54.1	60.7	--	--	16.2%	12.1%	10.6%	8.9%	12.3%	--	--
Other Care Services[1]	7.8	9.8	10.3	11.4	11.9	14.4	--	--	12.1%	2.4%	10.8%	4.6%	20.6%	--	--
Other Acute Care[2]	3.9	5.7	5.9	6.9	7.1	7.1	--	--	21.3%	1.6%	17.2%	2.6%	0.6%	--	--
Prescription Drugs	**16.6**	**23.4**	**30.4**	**30.7**	**16.7**	**15.0**	**14.4**	**14.5**	**18.9%**	**14.0%**	**0.8%**	**-45.4%**	**-10.2%**	**0.8%**	**3.4%**
Long-Term Care	**75.4**	**92.5**	**100.4**	**104.7**	**110.1**	**112.1**	--	--	**10.7%**	**4.2%**	**4.2%**	**5.2%**	**1.8%**	--	--
Nursing Facility Services	39.6	47.5	45.8	46.8	47.7	47.2	--	--	9.5%	-1.8%	2.2%	2.1%	-1.1%	--	--
ICFMR[3]	10.2	11.3	12.2	12.5	13.0	12.3	--	--	5.4%	3.8%	2.7%	3.8%	-5.4%	--	--
Mental Heath Institutions	3.3	4.0	4.8	4.7	4.2	4.8	--	--	10.8%	9.4%	-3.1%	-10.8%	13.9%	--	--
Home Health/Personal Care[4]	22.3	29.6	37.6	40.7	45.2	47.9	--	--	15.2%	12.7%	8.1%	11.1%	5.9%	--	--
Medicare Payments	**4.7**	**5.7**	**7.1**	**8.7**	**10.2**	**11.0**	--	--	**9.5%**	**11.9%**	**22.3%**	**17.2%**	**8.7%**	--	--
DSH	**15.6**	**15.9**	**16.9**	**17.6**	**17.1**	**16.0**	--	--	**1.1%**	**2.9%**	**4.3%**	**-2.8%**	**-6.8%**	--	--
Inpatient Hospital	11.6	12.5	14.0	14.1	13.5	13.5	--	--	4.2%	5.6%	0.8%	-4.4%	0.1%	--	--
Mental Health Institutions	4.0	3.4	2.9	3.5	3.7	2.5	--	--	-8.2%	-7.5%	21.2%	3.7%	-32.0%	--	--
Adjustments	**-3.1**	**-3.3**	**-6.5**	**-5.0**	**-5.5**	**-5.3**	--	--	**-2.6%**	**-40.6%**	**23.4%**	**-10.1%**	**4.8%**	--	--
Administration	**10.5**	**11.9**	**14.4**	**15.1**	**16.0**	**16.4**	--	--	**6.2%**	**10.2%**	**4.6%**	**5.9%**	**2.7%**	--	--

SOURCE: Urban Institute estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64). Annual expenditures reflect spending for the federal fiscal year.
1. Includes unspecified services paid for with Medicaid funds
2. Includes dental, other practitioners, abortion, sterilization, PACE programs, and emergency services for undocumented aliens
3. ICFMR stands for Intermediate Care Facilities for the Mentally Retarded
4. Includes home health services, home- and community-based waiver services, personal care, and related services.
5. Adjusted expenditures exclude all prescription drug spending for dual eligibles

Figure 3

Overall Average Annual Total Medicaid Spending Growth, 2000-2006



SOURCE: Urban Institute, 2008. Estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64). Adjusted expenditures exclude all prescription drug spending for dual eligibles to remove the effect of their transition to Medicare Part D in 2006.

Another factor contributing to overall growth in acute care spending is the increases in "other care services." This does not include "other acute care services" like dental care, vision and hearing, podiatrist, chiropractors, and so forth – these barely increased (0.6%). "Other care" appears to include rehabilitation services, residential care, psychiatric services, and adult day care. It also includes some Section 1115 waiver services.[8] "Other care" spending has increased from $7.8 billion in fiscal 2000 to $14.4 billion in fiscal year 2007.

Prescription drugs for non dual eligibles grew by only 3.4% in 2007. Prescription drug spending growth has been very slow in Medicaid since 2004. This likely reflects widespread efforts by states to control prescription drug spending through cost control tools such as dispensing limits, preferred drug lists (PDL), prior authorization, generic substitution, and co-payments. The effect of this can be seen in Table 2 which shows very slow rates of drug growth spending beginning in 2005. Data in Table 2 also shows a large reduction in drug spending in Medicaid because of the shift of dual eligibles to Medicare. This occurred largely in fiscal year 2006 but partially in fiscal year 2007 as well. Our attempt to adjust the data to reflect changes in spending on non duals suggests that prescription drug spending on non duals increased by 3.4% in 2007.

Long term care continues to grow at a very slow rate despite concerns about the effects on long term care spending of the aging of the population. These effects have not emerged at this point. Nursing home spending actually declined slightly in 2007 after several years of very slow growth. This seems to reflect a leveling off or decline in nursing home caseloads and perhaps low rates of payment increases. There was also a decline in spending on ICFMRs, perhaps reflecting a continued movement of many individuals to community-based settings. There was a sharp increase of about 14% in spending on mental health services, but this may be a data issue reflecting under-reporting in 2006 and a catch-up in 2007. There was also a significant decline in mental health DSH payments in 2007; thus the increases in mental health facility services payments may be countering that decline.

The most striking finding in long term care spending is the small increase (5.9%) in 2007 in home health care and personal care services. Smith et al reported many efforts to expand personal care and home and community based services. Because of this, we would have expected to see faster growth, but instead, spending on home and community based services and personal care grew at the slowest rate seen in this decade. Nonetheless, the rate of increase in home

health and personal care services was considerably faster than institutional spending and, as a result, Medicaid spent more on home health/personal care services ($47.9 billion) in 2007 than it did on nursing home care ($47.2 billion). There is, of course, another $12.3 billion spent on ICF-MRs and $4.8 billion on mental health facilities.

The growth in Medicaid payments for Medicare premiums increased by 8.7%, and DSH spending fell by 8.8%. The intent of the Medicare Modernization Act was to allow for inflation adjustments for DSH payments, but DSH spending has fallen in both 2006 and 2007, suggesting that states are not fully using their allotments. This could reflect efforts by the federal government to assure that the states share of DSH spending reflects real state expenditures and not financing arrangements that have resulted in federal payments with little or no real state matching funds.

Acute Care vs. Long Term Care. Table 3 shows that Medicaid spending growth for medical care services occurred mostly among acute care services. This has been true throughout this decade, but the shift toward acute care services was particularly striking in the past year. This reflects the increases in hospital inpatient and outpatient care, Medicaid managed care and "other care services" in 2007. The result was that 83% of Medicaid spending growth was due to acute care services, and only 10% was due to long term care.

Table 3. Spending Level Differences in Medicaid Expenditures by Type of Services, FFY 2000 - 2007

Service Category	2000 - 2002		2002 - 2004		2004 - 2005		Adjusted 2005 - 2006		Adjusted 2006 - 2007	
	Spending Change (in billions)	Percent of Total Change	Spending Change (in billions)	Percent of Total Change	Spending Change (in billions)	Percent of Total Change	Spending Change (in billions)	Percent of Total Change	Spending Change (in billions)	Percent of Total Change
Benefits	**50.1**	**100.0%**	**37.5**	**100.0%**	**17.0**	**100.0%**	**13.4**	**100.0%**	**19.3**	**100.0%**
Acute Care	25.3	50.4%	21.1	56.3%	10.9	64.3%	6.3	47.0%	15.9	82.5%
Prescription Drugs	6.9	13.7%	7.0	18.7%	0.3	1.5%	0.1	0.9%	0.5	2.5%
Long-Term Care	17.1	34.0%	8.0	21.2%	4.2	24.9%	5.5	40.9%	2.0	10.4%
Medicare Payments	0.9	1.9%	1.4	3.8%	1.6	9.3%	1.5	11.1%	0.9	4.6%

SOURCE: Urban Institute estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64). Annual expenditures reflect spending for the federal fiscal year.

Growth in Spending Per Enrollee

Estimating growth in spending per enrollee requires controlling for the effect of the changing composition of Medicaid enrollment. Simply dividing the total changes in spending by the total change in enrollees would bias the estimate of the growth in spending per enrollee. The bias would be downward in the early years of this decade because of the faster enrollment growth among less expensive parents and children relative to the aged and disabled. The reverse is true in the last two years when the aged and disabled have grown more rapidly than parents and children.

The approach that we take is described in appendix A. Essentially, the growth in spending per enrollee for a specific service reflects the changes in spending on that service divided by the growth of enrollees, with the growth of enrollees weighted to reflect the increases in enrollment in proportion to each group's use of that particular service. For example, the growth in enrollees for long term care services basically reflects the growth in enrollment of the aged and disabled not the growth among parents and children. To a lesser degree the reverse is true for acute care services; that is, enrollees for acute care services are weighted somewhat more towards parents and children.

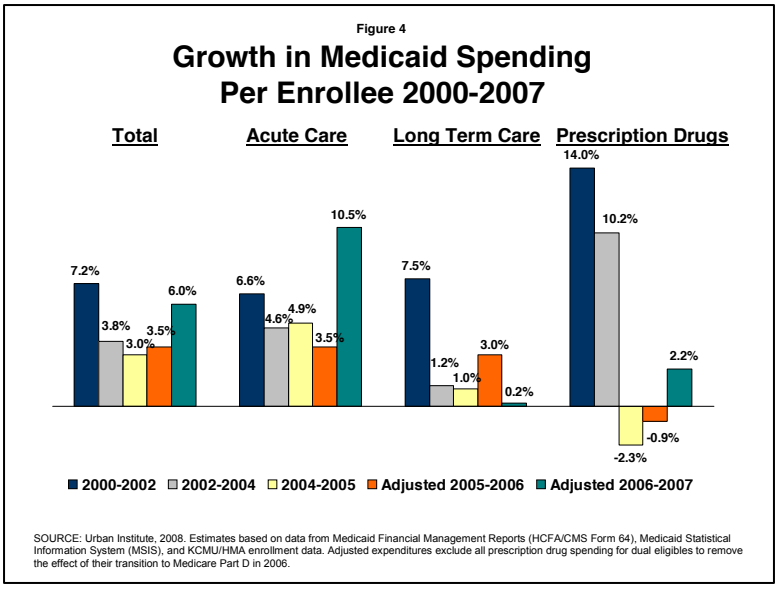
Table 4. Growth in Spending Per Enrollee by Type of Service, FFY 2000 - 2007

Service Category	2000-2002	2002-2004	2004-2005	Adjusted[4] 2005-2006	Adjusted[4] 2006-2007
Benefits	**7.2%**	**3.8%**	**3.0%**	**3.5%**	**6.0%**
Acute Care	**6.6%**	**4.6%**	**4.9%**	**3.5%**	**10.5%**
Inpatient Hospital	4.2%	5.0%	3.5%	1.5%	11.3%
Physician & Lab/X-Ray	4.8%	6.3%	-3.0%	1.4%	0.1%
Outpatient	6.3%	3.1%	3.4%	-1.2%	8.8%
Medicaid Managed Care	9.4%	7.7%	7.1%	7.7%	11.9%
Other Acute Care[1]	6.5%	-2.6%	9.6%	3.4%	13.6%
Prescription Drugs	14.0%	10.2%	-2.3%	-0.9%	2.2%
Long-Term Care	**7.5%**	**1.2%**	**1.0%**	**3.0%**	**0.2%**
Nursing Facility Services	6.6%	-4.5%	-1.0%	-0.2%	-2.8%
ICFMR[2]	2.6%	0.9%	-0.4%	1.6%	-6.9%
Mental Health Institutions	3.5%	4.8%	-6.1%	-11.5%	13.9%
Home Health/Personal Care[3]	12.0%	9.5%	4.8%	8.7%	4.2%

SOURCE: Urban Institute estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64), Medicaid Statistical Information System (MSIS), and KCMU/HMA enrollment data. Excludes payments made under SCHIP, Medicare premiums paid by Medicaid for persons eligible for both programs, Disproportionate Share Hospital (DHS) payments, administrative costs, and accounting adjustments.
1. Includes dental, other practitioners, abortion, sterilization, PACE programs, emergency services for undocumented aliens, and other care services. Other care services could not be calculated separately from other acute care services due to data limitations.
2. ICFMR stands for Intermediate Care Facilities for the Mentally Retarded
3. Includes home health services, home- and community-based waiver services, personal care, and related services.
4. Adjusted expenditures exclude all prescription drug spending for dual eligibles.

The results are provided in Table 4 and Figure 4. Spending per enrollee data between 2000 and 2005 reflects all spending for both dual eligibles and non dual eligibles. The adjusted spending per enrollee estimates for 2005-2007 excludes prescription drug spending for dual eligibles. The data shows that overall spending growth per enrollee on health care benefits increased by 6.0% in 2007 after increasing by 3.5% between 2005 and 2006.

Figure 4



SOURCE: Urban Institute, 2008. Estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64), Medicaid Statistical Information System (MSIS), and KCMU/HMA enrollment data. Adjusted expenditures exclude all prescription drug spending for dual eligibles to remove the effect of their transition to Medicare Part D in 2006.

The increase in spending per enrollee is almost wholly attributable to the increase in acute care spending. Several reasons for the increase in spending have been given above. There was a large increase in spending on hospital inpatient and outpatient (and clinic services); these may be due to higher utilization but more likely reflect increases in payment rates to hospitals, reflecting the improved revenue picture that states experienced in 2006 and 2007, as well as the increased use of supplemental payment programs discussed above. There was also a significant increase in Medicaid managed care services on a per enrollee basis. This could reflect both an increase in capitation rates and increased enrollment of aged and disabled populations. There is very little increase, on a per enrollee basis, in spending on physician and lab and x-ray services as well as other acute care services such as dentists, vision and hearing, podiatrist, chiropractors and other practitioners. There was a large increase, for "other acute care" services. Once again, this is not due to spending on services such as dental care, vision and hearing, but because of increases in spending on a difficult to decompose "other" category that reflects spending on different types of services in different states.[9] Spending per enrollee for prescription drugs increased very little since 2004. This seems to reflect the success that states have had with a large number of cost-containment policies mentioned above.

Spending on long term care services was virtually flat. This reflected a decline in nursing home spending per enrollee of 2.8%. This seems to suggest little change in payment rates along with the continued phasing out of spending through upper payment limit programs that often channeled funds through nursing homes. There was also very slow growth in home health and personal care services, slower than has been seen in any time in this decade. This seems at odds with Smith et al who reported a large number of efforts by states to expand community-based service programs. But nonetheless, community-based services continue to grow substantially faster than institutional care.

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 a seven year period. As in the previous section, this analysis is based on an approach that adjusted for changes in enrollment composition. However, because the CMS-64 does not report spending levels by eligibility group, 2000 MSIS data were used to calculate baseline spending by service by eligibility group. We calculated spending per enrollee growth for each eligibility group using service specific weights from the MSIS to derive spending per enrollee estimates for each group. Enrollment growth was taken from Table 1. Spending growth rates for each eligibility group were then estimated. This approach causes total spending figures to differ slightly from what is reported in previous tables. The data adjust for the shift in dual eligible drug spending to Medicare. That is, the data on changes between 2005-2006 and 2006-2007 reflect only spending on prescription drugs for non dual eligibles.

Table 5 and Figures 5 and 6 show the decomposition of Medicaid spending growth by group using actual expenditure data for 2000-2005 and the adjusted data for 2006 and 2007. The chart shows that spending growth for both groups increased in 2007 after very slow rates of growth in 2006. Again, this reflects an approach that eliminates the effect of the movement of prescription drugs for dual eligibles from the data. Spending growth for the aged and disabled declined from a growth rate of 11.1% between 2000 and 2002, 6.4% from 2002-2004, 5.2% between 2004 and 2005 and 4.9% between 2005 and 2006; before rebounding to increase by 5.7% in 2007. Spending growth for families fell from a growth rate of 19.1% in 2000 and 2002, 11.6% between 2002 and 2004, 7.6% between 2004 and 2005 and 3.0% between 2005 and 2006; spending increased by 8.5% in 2007.

Table 5. Average Annual Changes in Enrollment and Expenditure by Eligibility Group, FFY 2000 - 2007

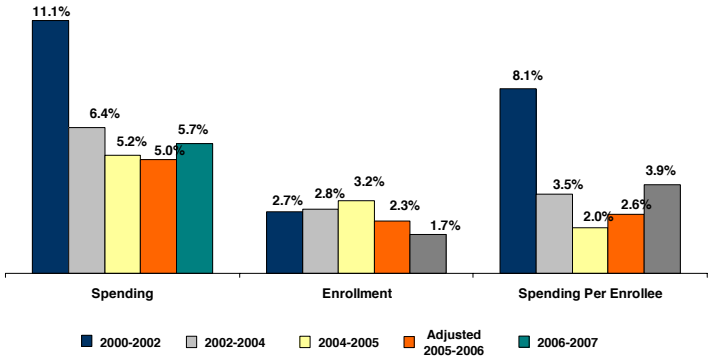
Population	Enrollment (in millions)			Spending Per Enrollee			Total Spending (in billions)			CPI-U Medical Care
2000-2002	**2000**	**2000**	**Percent Change**	**2000**	**2000**	**Percent Change**	**2000**	**2000**	**Percent Change**	**2000-2002**
Aged & Disabled	10.1	10.7	2.7%	$13,181	$15,413	8.1%	$133	$164	11.1%	
Families	21.7	26.7	11.0%	$2,279	$2,626	7.3%	$49	$70	19.1%	
All Enrollees	**31.8**	**37.4**	**8.4%**	**$5,747**	**$6,276**	**4.5%**	**$183**	**$235**	**13.3%**	**4.6%**
2002-2004	**2002**	**2002**	**Percent Change**	**2002**	**2002**	**Percent Change**	**2002**	**2002**	**Percent Change**	**2002-2004**
Aged & Disabled	10.7	11.3	2.8%	$15,413	$16,510	3.5%	$164	$186	6.4%	
Families	26.7	29.9	5.8%	$2,626	$2,919	5.4%	$70	$87	11.6%	
All Enrollees	**37.4**	**41.2**	**5.0%**	**$6,276**	**$6,643**	**2.9%**	**$235**	**$274**	**8.0%**	**4.2%**
2004 - 2005	**2004**	**2004**	**Percent Change**	**2004**	**2004**	**Percent Change**	**2004**	**2004**	**Percent Change**	**2004 - 2005**
Aged & Disabled	11.3	11.6	3.2%	$16,510	$16,836	2.0%	$186	$196	5.2%	
Families	29.9	30.9	3.3%	$2,919	$3,041	4.2%	$87	$94	7.6%	
All Enrollees	**41.2**	**42.5**	**3.2%**	**$6,643**	**$6,819**	**2.6%**	**$274**	**$290**	**6.0%**	**4.2%**
2005 - 2006[1]	**2005**	**2005**	**Percent Change**	**2005**	**2005**	**Percent Change**	**2005**	**2005**	**Percent Change**	**2005-2006**
Aged & Disabled	11.6	11.9	2.3%	$15,653	$16,067	2.6%	$182	$191	5.0%	
Families	30.9	30.7	-0.6%	$2,942	$3,038	3.2%	$91	$93	2.6%	
All Enrollees	**42.5**	**42.6**	**0.2%**	**$6,423**	**$6,679**	**4.0%**	**$273**	**$284**	**4.2%**	**4.0%**
2006 - 2007[1]	**2006**	**2006**	**Percent Change**	**2006**	**2006**	**Percent Change**	**2006**	**2006**	**Percent Change**	**2006-2007**
Aged & Disabled	11.9	12.1	1.7%	$16,067	$16,700	3.9%	$191	$202	5.7%	
Families	30.7	30.2	-1.4%	$3,038	$3,344	10.1%	$93	$101	8.5%	
All Enrollees	**42.6**	**42.3**	**-0.6%**	**$6,679**	**$7,161**	**7.2%**	**$284**	**$303**	**6.6%**	**4.4%**

SOURCE: Urban Institute estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64), Medicaid Statistical Information System (MSIS), and KCMU/HMA enrollment data. Excludes payments made under SCHIP, Medicare premums paid by Medicaid for persons eligibe for both programs, Disproportionate Share Hospital (DHS) payments, administrative costs, and accounting adjustments. Total spending levels and growth rates differ from those presented in previous tables because the data source and method used to calculate total spending are different. Total spending reflect sums of spending by eligibility group which is calculated by taking the 2000 MSIS spending level for each eligibility group and applying the corresponding growth rates. This method is described in more detail in Appendix A of this brief. Growth rates for CPI-U Medical Care come from the Bureau of Labor Statistics, Consumer Price Index Detail Report Tables, Annual Average Indexes 2000 - 2007, Table 1A. Consumer Price Index for All Urban Consumers (CPI-U): U.S. city average, by expenditure category and commodity and service group (1982-84=100, unless otherwise noted), http://www.bls.gov/cpi/cpi_dr.htm, accessed October 31, 2008

1. Spending figures reflect adjusted expenditures that exclude prescription drug spending for dual eligibles

Figure 5

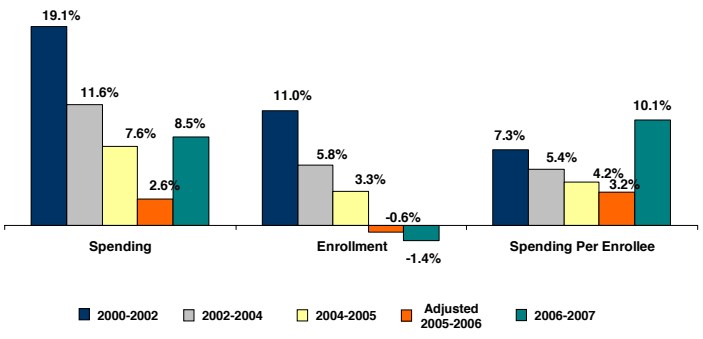
Decomposition of Medicaid Spending Growth for Aged and Disabled by Group, 2000-2007



SOURCE: Urban Institute, 2008. Estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64), Medicaid Statistical Information System (MSIS), and KCMU/HMA enrollment data. Adjusted expenditures exclude all prescription drug spending for dual eligibles to remove the effect of their transition to Medicare Part D in 2006.

Figure 6

Decomposition of Medicaid Spending Growth for Families and Children , 2000-2007



SOURCE: Urban Institute, 2008. Estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64), Medicaid Statistical Information System (MSIS), and KCMU/HMA enrollment data. Adjusted expenditures exclude all prescription drug spending for dual eligibles to remove the effect of their transition to Medicare Part D in 2006.

The decline in spending growth for the aged and disabled reflected a decline in spending per enrollee, falling from 8.1% between 2000 and 2002 to 2.6% in 2005-2006, and 3.9% between 2006-2007. On the other hand, enrollment growth was relatively stable even though the rate of growth declined slightly in the last two years. Declines in spending per enrollee for the aged and disabled reflect their high users of services for which total spending per enrollee fell or slowed considerably in 2007. These include nursing home care, prescription drugs, and home health/personal care services.

Spending on families declined until the past year primarily because of declines in enrollment. Enrollment growth was 11.0% between 2000-2002 and then declined each year until enrollment levels fell slightly in 2006, and then declined again by 1.4% in 2007. Spending per enrollee also fell for families, but to a much lesser extent. Spending per enrollee grew by 7.3% between 2000-2002, 5.4% between 2002-2004, 4.2% in 2005 and 3.2% in 2006. But then it increased by 10.1% in 2007 because of the rapid growth in acute care spending.

Thus, the decline in the growth rate of spending for the aged and disabled was largely driven by declines in spending per enrollee. In the last two years, there has been declining rate of growth in enrollment. For families the decline in spending has clearly reflected the decline in enrollment growth, but until the past year there had also been a decline in spending per enrollee. Spending on a per enrollee basis increased sharply in the past year in contrast to previous years.

Aged and Disabled vs. Families. Table 6 shows that a larger share of the growth in spending in all years has been on behalf of the aged and disabled. Spending on parents and children increased at a faster rate in each year, but spending levels started from a level considerably below that for the aged and disabled. The increased spending on families accounted for roughly 40% of the growth in each period with the remainder accounted for by the aged and disabled. Despite the faster growth in spending on families versus the aged and disabled (8.5% versus 5.7%), the aged and disabled accounted for about 58% of overall Medicaid spending growth between 2006 and 2007, and parents and children accounted for 42% (Figure 7).

Table 6. Spending Level Differences in Medicaid Expenditures by Eligibility Group, FFY 2000 - 2007

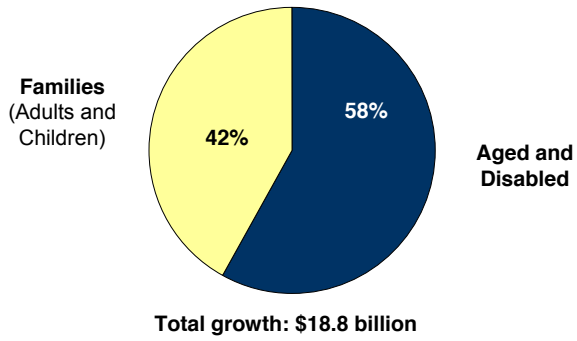
Eligibility Group	Spending in 2000 (MSIS)	2000 - 2002		2002 - 2004		2004 - 2005		Adjusted[1] 2005 - 2006		Adjusted[1] 2006 - 2007	
		Spending Change	Percent of Total Change	Spending Change	Percent of Total Change	Spending Change	Percent of Total Change	Spending Change	Percent of Total Change	Spending Change	Percent of Total Change
Total	182.7	51.9	100%	39.0	100%	16.3	100%	11.4	100%	18.8	100%
Aged & Disabled	133.3	31.2	60%	21.8	56%	9.7	60%	9.0	79%	10.9	58%
Families	49.4	20.7	40%	17.1	44%	6.6	40%	2.4	21%	7.9	42%

SOURCE: Urban Institute estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64), Medicaid Statistical Information System (MSIS), and KCMU/HMA enrollment data. Excludes payments made under SCHIP, Medicare premiums paid by Medicaid for persons eligible for both programs, Disproportionate Share Hospital (DHS) payments, administrative costs, and accounting adjustments. Total spending levels and growth rates differ from those presented in previous tables because the data source and method used to calculate total spending are different. Total spending reflect sums of spending by eligibility group which is calculated by taking the 2000 MSIS spending level for each eligibility group and applying the corresponding growth rates. This method is described in more detail in Appendix A of this brief.

1. Figures reflect adjusted expenditures that exclude prescription drug spending for dual eligibles

Figure 7

Share of Medicaid Spending Growth Attributable to Aged/Disabled and Families between 2006 and 2007



SOURCE: Urban Institute, 2008. Estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64), Medicaid Statistical Information System (MSIS), and KCMU/HMA enrollment data. Excludes payments made under SCHIP, Medicare premiums paid by Medicaid for persons eligible for both programs, Disproportionate Share Hospital (DHS) payments, administrative costs, and accounting adjustments. Figures reflect adjusted expenditures that exclude prescription drug spending for dual eligibles

Medicaid Spending Growth in Context

Overall Medicaid spending growth in this decade (2000-2007) [excluding spending on prescription drugs for dual eligibles in all years] has generally been faster (8.3%) than both the increases in total national health expenditures (NHE) of 7.5% and the annual growth in gross domestic product (GDP) of 5.0% (Table 7). But, in general, Medicaid spending has only been faster than various benchmarks because of enrollment growth. Total Medicaid spending growth averaged 9.3% per year between 2000-2005; during the same period NHE grew by 7.9% and GDP by 4.8%. Between 2005 and 2007 when prescription drugs for dual eligibles were shifted to Medicare and there was a sharp slow down in the enrollment growth, overall Medicaid spending slowed to grow by only 5.9% per year, (excluding prescription drugs for dual eligibles). This compared with NHE growth of 6.4% and GDP growth of 5.4% between 2005 and 2007.

However, on a per enrollee basis, Medicaid spending increases have been considerably slower than growth in national health expenditures and roughly in line with increases in the medical care CPI and with GDP. Between 2000 and 2005, overall Medicaid spending per enrollee increased by 4.7%; acute care spending grew by 5.3% per year, and long term care spending

Table 7. Medicaid Expenditure Growth and Selected Benchmarks

	Average Annual Growth Rates		
	2000-2005	2005-2007	2000-2007
Medicaid Expenditures for Benefits*	9.3%	5.9%	8.3%
Medicaid Expenditures per Enrollee			
Benefits*	4.7%	4.8%	4.8%
Acute Care*	5.3%	6.9%	5.8%
Long Term Care	3.7%	1.6%	3.1%
CPI- Medical Care	4.4%	4.2%	4.3%
National Health Expenditure	7.9%	6.4%	7.5%
NHE per Capita	6.9%	5.4%	6.5%
Gross Domestic Product	4.8%	5.4%	5.0%
GDP per Capita	3.8%	4.4%	4.0%

* Because of the shift of prescription drug payments for dual eligibles to Medicare in 2006, Medicaid expenditures and expenditures per enrollee exclude prescription drug spending for dual eligibles.

by 3.7%. This is in contrast to increases in the medical care CPI of 4.4% per year, GDP growth of 4.8% per year, and GDP per capita increases of 3.8% per year. National health expenditures grew more rapidly by 7.9% per year (by 6.9% on a per capita basis).

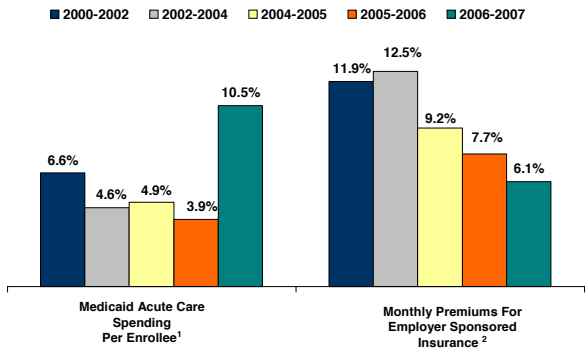
Between 2005 and 2007, with slow enrollment growth and the shift of prescription drugs to dual eligibles, Medicaid spending per enrollee grew by 4.8% (this excludes the shift of prescription drugs for dual eligibles to Medicare). Acute care spending per enrollee grew by 6.9% because of the spike in 2007, particularly in hospital spending that was discussed above. Acute care spending was somewhat faster than the medical care CPI as well as national health expenditures and GDP growth. But, on the other hand, long term care spending growth per year was considerably slower at 1.6%.

Over the entire period, Medicaid spending per enrollee compares favorably with various benchmarks. Over the entire period (2000-2007), Medicaid spending per enrollee grew by 4.8%. This was a combination of growth in acute care spending of 5.8% and long term care spending per enrollee of 3.1%. Acute care spending over the period was about 1.5 percentage points faster than the medical CPI and about 1% faster than GDP growth. In contrast, long term care spending was slower than each of the benchmarks. Acute care spending in Medicaid on a per enrollee basis was still below increases in national health expenditures and even national health expenditures per capita.

The driving factor behind the recent growth in spending per enrollee is the growth in acute care spending. In previous years, Medicaid spending growth for acute care services has consistently grown more slowly than monthly premiums for employer sponsored insurance (Figure 8). In the past year this was not true; the reverse occurred with Medicaid spending on acute year growing faster than the private spending. As we have noted before, rapid acute care spending growth in 2007 may have reflected one-time increases in payment rates that likely will not occur again given the current fiscal environment, and were also driven by very significant increases in hospital payments in a handful of states.

Figure 8

Growth in Medicaid Acute Care Spending per Enrollee vs. ESI Premium Growth, 2000-2007



[1] Urban Institute, 2008. Estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64), Medicaid Statistical Information System (MSIS), and KCMU/HMA enrollment data. Adjusted expenditures exclude all prescription drug spending for dual eligibles to remove the effect of their transition to Medicare Part D in 2006.

[2] Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2007.

CONCLUSION

Medicaid spending in 2007 increased by 5.3%, considerably faster than the virtually zero growth between 2005 and 2006. Overall unadjusted spending on benefits increased by 6.0%. After fully adjusting for the shift to dual eligibles to Medicare, Medicaid spending increased by 6.0%, with spending on benefits increasing by 6.8%. Unlike previous years, very little of the spending increase in Medicaid can be attributed to enrollment growth. Enrollment increased by 1.7% for the aged and disabled but declined by 1.4% for families.

In contrast, the explanation for the growth in spending was the increases in acute care spending. It appears that there were large increases in spending for hospital inpatient (11.6%) and outpatient care (9.0%), as well as for payments to Medicaid managed care plans, (12.3%). All of these could reflect the increases in payment rates reported by Smith et al. They also seem to reflect increased use of supplemental payment programs by a relatively small number of states, as discussed above. Medicaid managed care increases could also be due to the movement of more expensive populations into Medicaid managed care plans. The 20.6% increase in "other care" services is difficult to explain – it may reflect increases in residential care, adult day care, and psychiatric services, as well as Section 1115 waiver services, although limitations in existing data systems limit our ability to explain this growth. In contrast to these services, there was virtually no growth in spending on physician or in other acute care services, such as dental care, vision and hearing, and other practitioner services. Prescription drug spending was also relatively flat because of the continued success of various state policies aimed at controlling prescription drug spending. Long term care spending also grew at very

slow rates, reflecting a decline in nursing home spending and a slower rate of growth in home health and personal care services.

The increase of 5.3% in Medicaid spending in 2007 follows a year in which there was virtually no change in Medicaid spending. The Medicare Part D drug benefit was implemented in that year. In January 2006 Medicaid and Medicare dual eligibles began receiving their drug coverage through Medicare Part D rather than through Medicaid. Medicaid spending would naturally be expected to decline. States were required to offset some of this through "clawback" payments to the federal government to help fund the benefit. These payments are not included in this paper as Medicaid spending. In this paper we adjusted Medicaid spending to account for the shift of drug spending for dual eligibles to the federal government and present drug spending in 2006 and 2007 only for non dual eligibles. Once this adjustment is made, Medicaid spending increased by 4.9% and 6.8% for health care benefits.

In the next few years, Medicaid spending is likely to increase at a significantly faster rate than that observed in the past year. With the deterioration in economic conditions that began in 2008, it seems highly likely that Medicaid enrollment will increase both in 2008 and 2009. For example, we have projected that Medicaid enrollment would increase by 2.4 million if the unemployment rate increased from the 2007 average of 4.6% to 7.0% in 2009;[10] the unemployment rate stood at 9.4% in July 2009, suggesting an increase in Medicaid enrollment of roughly 4.5 million since 2007. The increase in enrollment places significant strain on state budgets, particularly because states have also been facing declining revenues and large budget gaps during this recession. States are likely, as they have in the past, to reduce optional benefits and to restrain, freeze or cut provider payment rates. All of these should limit the rate of growth in spending per enrollee.

The impact on Medicaid expenditures could be substantial. Data shown in this paper for the last recession, roughly 2000 to 2002, indicated that Medicaid spending growth increased by 12% per year. During this period, enrollment growth increased overall by 8.4% and 11% per year for parents and children. There is some likelihood that the recession that we will experience in 2008-2009 will be deeper and more prolonged. Thus, it is very likely that substantial expenditure increases will be seen in the next couple of years, driven largely by enrollment.

This brief was prepared by John Holahan and Alshadye Yemane of the Urban Institute and David Rousseau of the Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation.

Appendix A

Medicaid spending growth through 2007 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 2007.

Notes

[1] Vernon Smith et al., "Headed for a Crunch: An Update on Medicaid Spending, Coverage and Policy Heading into an Economic Downturn", prepared for the Kaiser Commission on Medicaid and the Uninsured, October 2008, available at http://www.kff.org/medicaid/7815.cfm.

[2] It should be noted that the enrollment declines for parents and children reported in the KCMU/HMA data are inconsistent with data recently reported in the Current Population Survey (CPS). For 2007, the CPS reported enrollment growth for non-elderly adults and children in Medicaid and SCHIP of about 2.3% and 3.8% respectively. Most of this growth was among those below 100% FPL. For those in poverty, the increases for non-elderly adults and children were 2.9% and 4.8% respectively. These numbers suggest that the growth seems to be largely in Medicaid not SCHIP. According to CPS, this increase in public coverage led to the first reduction in the number of uninsured in this decade. If in fact the CPS is closer to the underlying reality than the administrative data, this would explain some of the particularly sharp increase in acute care spending. However, preliminary data from the Medicaid Statistical Information System indicate that, in the 32 states for which FY 2007 data are available (representing nearly three-quarters of total enrollment in FY 2006), Medicaid enrollment did indeed fall between FY 2006 and FY 2007 by nearly 2%.

[3] See John Holahan and Bowen Garrett, "Rising Unemployment, Medicaid, and the Uninsured," prepared for the Kaiser Commission on Medicaid and the Uninsured, January 2009, available at http://www.kff.org/uninsured/7850.cfm.

[4] Several data edits were made to correct for some inconsistencies in the reported data.

[5] See Richard Kronick and David Rousseau, "Is Medicaid Sustainable? Spending Projections for the Program's Second Forty Years," *Health Affairs*, 26, no. 2 (2007): w271-w287 (published online 23 February 2007), available at http://content.healthaffairs.org/cgi/content/full/26/2/w271. According to this analysis, 73% of Medicaid's growth as a share of national health spending (NHE) between 1975 and 2003 was due to growth in enrollment and spending for individuals with disabilities.

[6] These states were Texas (56.2%), California (22.9%), Illinois (29.1%), Massachusetts (59.1%), Florida (20.4%), Pennsylvania (41.2%), Alabama (87.8%), Oklahoma (38.6%), and Rhode Island (58.5%). Growth in the remaining states was quite modest. With the exception of Florida, each of these states had double-digit increases in overall acute care spending.

[7] See Steve Zuckerman et al., "Trends In Medicaid Physician Fees, 2003–2008," *Health Affairs*, 28, no. 3 (2009): w510-w519 (published online 28 April 2009), available at http://content.healthaffairs.org/cgi/content/abstract/hlthaff.28.3.w510v1

[8] Communication with New York and Massachusetts officials, October 2008.

[9] As previously mentioned, calculating total spending per enrollee growth requires service-level weights by eligibility group that are calculated using the MSIS. Since the MSIS does not have a comparable service category to the CMS-64 data's "Other Care Services" category, we could not separate out other care services from other acute care services when examining spending per enrollee growth.

[10] Holahan and Garrett, January 2009.

1330 G Street NW, Washington, DC 20005
Phone: (202) 347-5270, *Fax:* (202) 347-5274
Website: www.kff.org/KCMU

This publication (#7978) is available on the Kaiser Family Foundation's website at www.kff.org.

THE HENRY J. KAISER FAMILY FOUNDATION

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.