kaiser commission on MEDICAID FACTS

medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

June 2005

MEDICAID ENROLLMENT AND SPENDING TRENDS

In 2003, Medicaid financed health care for over 50 million low-income children, adults, and elderly and disabled individuals at a total cost of $276 billion – an increase of about $70 billion, or roughly one-third, since 2000. Recent increases in Medicaid spending were largely driven by enrollment growth, much of which resulted from declines in income and access to employer-sponsored insurance during the economic downturn. However, Medicaid spending growth slowed between 2002 and 2003 due to moderating enrollment growth and state efforts to control Medicaid per enrollee spending growth through benefit reductions, cost sharing, and provider reimbursement cuts or freezes. Declines in spending through disproportionate share hospital (DSH) and upper payment limit (UPL) financing arrangements also contributed to the recent slowdown.

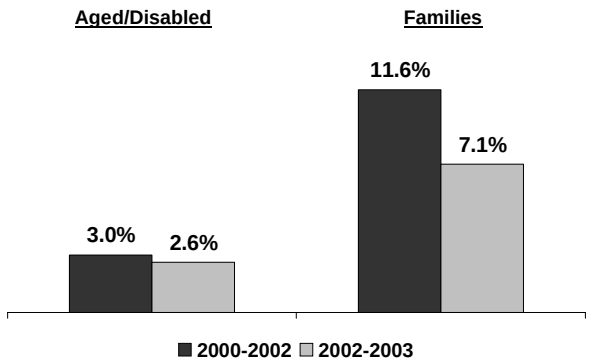
Without the increase in Medicaid enrollment between 2000 and 2003, recent growth in the number of uninsured Americans would have been greater. During this period of enrollment growth, states were able to keep increases in health spending per Medicaid enrollee to levels below both Medicare and private insurance. Nevertheless, this rise in spending occurred during a period of limited state and federal revenue growth, making Medicaid a target of budget reduction discussions at both the federal and state level.

ENROLLMENT GROWTH

While Medicaid enrollment among the aged and disabled rose by an average of 2.9 percent per year between 2000 and 2003, enrollment for families (nondisabled adults and children) rose by 11.6 percent per year between 2000 and 2002 and by another 7.1 percent between 2002 and 2003 (Figure 1).

Figure 1

Medicaid Enrollment Growth
Average Annual Growth Rates, 2000-2003



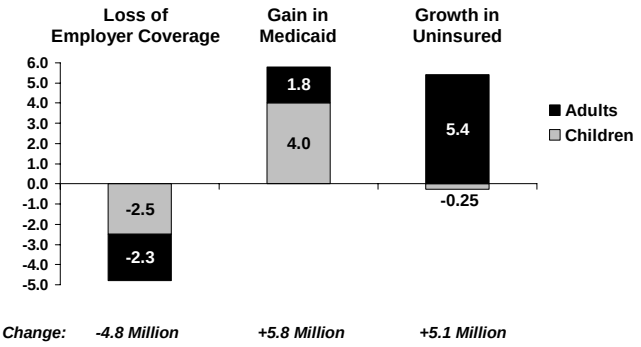
SOURCE: Urban Institute estimates based on KCMU Medicaid enrollment data collected by Health Management Associates from 44 states inflated proportionally to national totals, 2004.

The recession and slow economic recovery caused much of the growth in Medicaid enrollment among families. As families experienced job losses and income declines, the number of low-income Americans rose, and more people became eligible for Medicaid under existing criteria. At the same time, the number of individuals covered by employer-sponsored insurance (ESI) declined due, in part, to reductions in employment in large firms and in industries with high rates of ESI coverage, together with rapid increases in private insurance premiums.

Medicaid enrollment growth among families prevented greater increases in the number of uninsured. The large increase in children enrolling in Medicaid and SCHIP more than offset the decline in ESI coverage, resulting in a net decline in the number of uninsured children. Medicaid enrollment among adults also rose, but the increase was not sufficient to counter the decrease in ESI, and the number of uninsured adults grew by 5.4 million between 2000 and 2003 (Figure 2).

Figure 2

Changes in Health Insurance Coverage, 2000-2003
(in Millions)



Note: Figure excludes changes in Champus/Medicare and private non group insurance.
SOURCE: Urban Institute estimates, 2004.

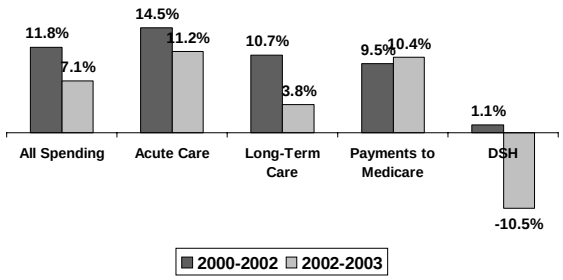
Not surprisingly, shifts in the composition of Medicaid beneficiaries affect the types of services Medicaid purchases on their behalf. An examination of 2000 data shows that changes in the number of families enrolled primarily affect spending on acute care. Changes in the number of elderly enrollees have repercussions for spending on both acute and long-term care.

SPENDING GROWTH

Medicaid acute care spending increased at an average annual rate of 13.4 percent from 2000 to 2003, outpacing spending on long-term care, which grew at an average annual rate of 8.4 percent (Figure 3). Within long-term care, there was a 6 percent decline in spending on nursing homes from 2002 to 2003. That decline was due in part to a decrease in the use of Upper Payment Limits, a mechanism that allows states to receive additional federal funds for Medicaid payments to certain providers in excess of their actual

Figure 3

Medicaid Spending Growth by Type of Service, 2000-2003



SOURCE: Urban Institute estimates based on data from CMS (Form 64), prepared for the Kaiser Commission on Medicaid and the Uninsured.

cost of providing care. An increase in the use of home and community-based long-term care may have also contributed to a decline in nursing home use. Annual spending on home and community-based care increased an average of 15.9 percent from 2000 to 2003.

Within acute care, spending on prescription drugs grew at the fastest pace, with an average annual increase of 18.9 percent from 2000 to 2002. Spending increased at a lower rate, 13.6 percent, from 2002 to 2003. In 2006, Medicaid spending on prescription drugs will decline as dual-eligibles shift to Medicare Part D. States will then make payments to the federal government to fund a portion of Medicare Part D coverage for dual eligibles.

Medicaid spending on prepaid/managed care plans grew by an average annual rate of 16.1 percent from 2000 to 2003. Increases in Medicaid enrollment among groups likely to be enrolled in managed care, such as children and parents, contributed to that growth, but state efforts to shift existing beneficiaries into managed care plans may also have been a factor.

Another category with notable spending changes was payments to disproportionate share hospitals (DSH) serving a large number of Medicaid and uninsured patients. Federal limits on those DSH payments led to an average annual decline of 2.9 percent from 2000 to 2003 in Medicaid spending on DSH. However, in 2004 the federal government allowed those payments to increase.

While aged and disabled enrollment growth only accounted for 10 percent of overall Medicaid enrollment growth between 2000 and 2003, spending on their behalf made up 56 percent of the total growth in Medicaid spending due to their more intensive use of acute and long-term care services. The families who made up 90 percent of Medicaid enrollment growth only accounted for 44 percent of the spending growth between 2000 and 2003.

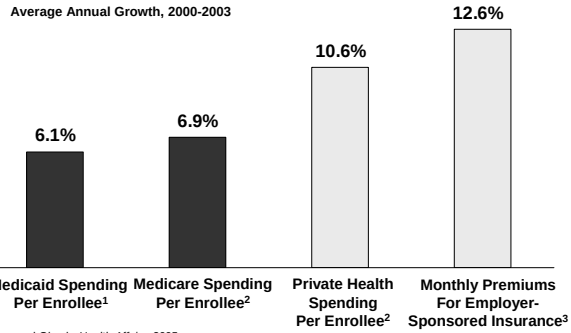
SPENDING PER PERSON ENROLLED

Tracking the average amount it costs Medicaid to cover an enrollee reveals spending changes that are not related to increases in enrollment. These figures control for the larger increase in enrollment among children and nondisabled adults – two groups that are less expensive to cover.

Spending per enrollee grew at an average annual rate of 6.1 percent from 2000 to 2003, after controlling for changes in the demographics of the covered population. Notably, this per-enrollee Medicaid spending growth rate was well below both the estimated 10.6 percent average annual increase in spending for those with private insurance and the 6.9 percent increase in Medicare per-enrollee spending. During that same period, private insurance premiums rose by an average of 12.6 percent (Figure 4).

Figure 4

Medicaid Spending Per Person Grew More Slowly than Spending Under Medicare and Private Insurance, 2000 - 2003



[1] Holahan and Ghosh, *Health Affairs*, 2005.
[2] CMS Office of the Actuary, National Health Accounts, 2005.
[3] Kaiser/HRET Survey, 2003.

LOOKING AHEAD

Increased enrollment was responsible for much of the growth in Medicaid spending from 2000 to 2003. During that period there were no major expansions in eligibility; Medicaid enrollment grew primarily due to economic conditions that left more people eligible for the program as their incomes declined and many lost ESI coverage.

State policy choices that limited benefits and provider reimbursements kept the growth of spending per Medicaid enrollee below the increases in the private market. Thus, it would have been difficult to prevent Medicaid spending increases during the economic downturn without imposing reductions on eligibility and enrollment that would likely have led to even greater increases in the number of uninsured. As federal and state policy makers explore options to better manage Medicaid spending, care should be taken to asses the impact future reforms may have on the health of Medicaid enrollees, their access providers, and the number of uninsured Americans.

Additional copies of this fact sheet (#2113-02) are available at www.kff.org.

Source: "Understanding the Recent Growth in Medicaid Spending, 2000-2003," by John Holahan and Arunabh Ghosh. *Health Affairs Web Exclusive* (WS 5, pp. 52-62), January 26, 2005.