

CHAPTER 1

Trends in Medicaid Spending

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Key Points

- Medicaid is growing as a share of gross domestic product (GDP), national health care spending, and the federal budget, but it accounts for a smaller share of GDP and national health expenditures than Medicare and private insurance, and a smaller share of the federal budget than Medicare.
- Medicaid's share of state budgets depends upon how it is calculated. Medicaid accounted for 25.6 percent of state budgets in state fiscal year 2014 with all state and federal sources of funding included, but 15.3 percent of state budgets when only the state-funded portion was counted.
- Medicaid's rate of growth in spending per enrollee has been comparable to or lower than that of Medicare and private insurance since the early 1990s, and it is projected to be lower than that of Medicare and private insurance in the future.
- The majority (70.7 percent) of Medicaid benefit spending growth from fiscal year (FY) 1975 to FY 2012 (adjusted for health care price inflation) is attributable to growth in enrollment as opposed to growth in spending per enrollee (29.3 percent). When examining spending growth by eligibility group, almost half is attributable to individuals eligible on the basis of disability.
- Because Medicaid spending per enrollee varies substantially across eligibility groups, enrollment mix has a strong effect on average spending per enrollee. In FY 2012, spending per enrollee for individuals eligible on the basis of disability and those age 65 and older was more than three times that of adults eligible on a basis other than disability and more than five times that of children eligible on a basis other than disability.
- In 2014, total Medicaid spending grew 8 percent, largely due to enrollment growth, with most of the increase due to expansion to the new adult group. Because the federal government covered 100 percent of the costs of these new enrollees, federal spending grew 13 percent compared to 1 percent by states.
- In 2014, prescription drug spending increased by more than 20 percent, partly due to the introduction of high-cost treatments for hepatitis C. Even so, spending for prescription drugs accounts for about 6 percent of total Medicaid benefit spending. Growth rates are expected to decrease in the future as states negotiate higher supplemental rebates for hepatitis C treatments and other high-cost drugs.
- Spending is projected to grow about 6 percent annually over the next decade, reflecting diminishing expansion effects, expiration of the primary care payment increase, and negotiation with drug manufacturers.

CHAPTER 1: Trends in Medicaid Spending

Since its inception in 1965, the Medicaid program has grown to become a major payer in the health care system, accounting for almost \$500 billion in combined federal and state spending for fiscal year (FY) 2014. Although Medicaid accounted for about 16 percent of U.S. health care spending in calendar year (CY) 2014, it accounted for a smaller share of national health expenditures than Medicare (20 percent) and private insurance (33 percent) (MACPAC 2016a). For certain types of services, such as long-term services and supports (LTSS), Medicaid accounts for a larger portion of total U.S. spending than any other payer. In CY 2014, Medicaid financed almost one-third of nursing facility services and over half of the category of other health, residential, and personal care, a category that includes a variety of home and community-based services (MACPAC 2016a). Some policymakers have expressed concerns about the growth and sustainability of Medicaid as it becomes a larger share of both federal and state budgets.

Growth in aggregate Medicaid spending has led the program to account for an increasing share of gross domestic product (GDP), national health care spending, and federal and state budgets. Most of the historical growth in Medicaid spending has been due to increases in enrollment. Growth in Medicaid spending per enrollee has generally been moderate compared to other benchmarks. Much of the growth in Medicaid spending in FY 2014 was attributable to the increase in enrollment to adults newly eligible for Medicaid as a result of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) as well as an increase in prescription drug spending due to the introduction of new high-cost drugs.

This chapter examines Medicaid spending through a variety of lenses. It begins by comparing the

growth in Medicaid spending as a share of national health expenditures and federal and state budgets to other programs and benchmarks. The chapter then examines the components of spending growth, which include changes in enrollment and spending per enrollee. The chapter concludes by examining recent changes in Medicaid spending (in particular, the impact of the eligibility expansion to the new adult group) and projections in enrollment and spending growth by eligibility group for future years. This chapter largely focuses on national trends because much of the historical and projected Medicaid spending information is available only at the national level. The factors and components of growth contributing to national spending trends may vary from those in any particular state.¹

Medicaid Share of U.S. Health Care Spending

Health care spending is growing as a share of the nation's economy, and Medicaid spending mirrors that trend. Between 1970 and 2014, U.S. health care spending increased from 7.0 percent of GDP to 17.5 percent; over the same period, Medicaid spending increased from 0.5 percent of GDP to 2.9 percent (OACT 2015a, 2015b). Much of the historical growth in Medicaid spending as a percentage of GDP can be explained by the growth in overall health care spending as a percentage of GDP (Kronick and Rousseau 2007).

Spending for Medicaid, Medicare, and private insurance has increased as a share of U.S. health care spending over time; in contrast, the share attributable to out-of-pocket spending and other third-party payer spending (such as private philanthropy, workers' compensation, state and local subsidies to hospitals and other facilities, and government public health activities) has decreased. From 1975 to 1989, Medicaid's share of national health expenditures remained nearly constant at about 10 percent; it then grew rapidly between 1989 and 1996 to 15 percent (Kronick and Rousseau 2007). In 2014,

the most recent year for which historical data are available, combined federal and state expenditures for Medicaid accounted for about 16 percent of U.S. health care spending. In comparison, Medicare spending accounted for 20 percent of U.S. health care spending and private insurance accounted for 33 percent (MACPAC 2016a).

Although Medicaid enrollment and spending are expected to increase with the expansion to the new adult group, Medicaid is projected to remain a smaller share of U.S. health care spending than Medicare and private insurance: Medicaid's share of national health expenditures is projected to reach 17 percent in 2015 and to decrease slightly through 2024, while Medicare is projected to reach 23 percent through a steady climb over the same period, and private insurance is projected to fall to 32 percent after a brief increase (MACPAC 2015a, OACT 2015c).

For certain types of services, such as LTSS, Medicaid accounts for a larger portion of total U.S. spending than any other payer, reflecting Medicaid's unique role in providing these services. In CY 2014, Medicaid financed 32 percent of nursing facility services and 56 percent of the category of other health, residential, and personal care, which includes a variety of home and community-based services (MACPAC 2016a). An analysis of national health expenditures using slightly different service categories found that Medicaid accounted for 61 percent of all LTSS spending in CY 2012, that is, \$134 billion out of a total of \$220 billion (O'Shaughnessy 2014). Medicaid also pays for more than one-quarter (27 percent) of all spending on mental health services and about one-fifth (21 percent) of all spending on substance abuse treatment (SAMHSA 2013).

Medicaid as Share of Federal Spending

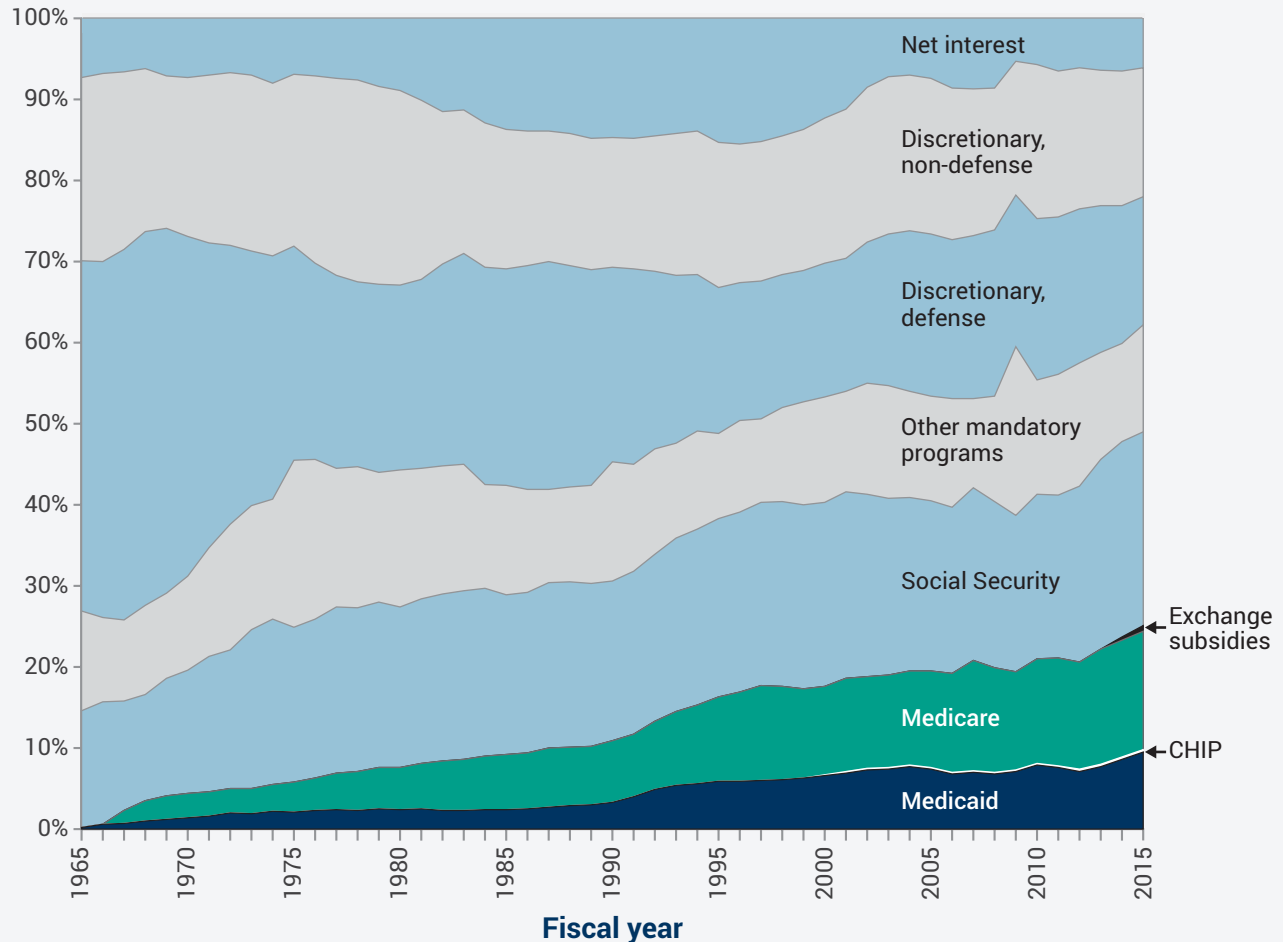
As with Medicare and Social Security, federal outlays for the Medicaid program are mandatory

spending, meaning that the amounts are generally driven by statutory criteria such as eligibility and benefits as opposed to annual appropriations. However, Medicaid is financed entirely by general revenues, while Medicare and Social Security receive substantial financing from dedicated revenue sources such as payroll taxes. Mandatory spending programs comprised less than 30 percent of the federal budget when Medicare and Medicaid were enacted in 1965; today, their share is about 60 percent. During this time period, spending for health care-related programs, including Medicaid, Medicare, the State Children's Health Insurance Program (CHIP), and exchange subsidies, has grown to one-quarter of federal outlays (Figure 1-1).

Medicaid grew from 1.4 percent of federal outlays in FY 1970 to 9.5 percent in FY 2015. Since 2000, Medicaid has grown slightly faster than Medicare, with Medicaid growing at an average rate of 7.5 percent a year compared to Medicare at 7.1 percent (Figure 1-1). Both programs expanded substantially during this period—Medicaid expanded eligibility to the new adult group in 2014 and Medicare added prescription drug coverage under Medicare Part D in 2006. But even with the recent growth in enrollment due to the new adult group, Medicaid's 9.5 percent share of the federal budget was smaller than Medicare's 14.6 percent share in FY 2015 (MACPAC 2016b).

Over the next several years, Medicaid is projected to grow at a rate that is comparable to or slower than Medicare. The Office of Management and Budget projects federal Medicaid spending to grow at an average of 4 percent a year compared to 5 percent for Medicare from FY 2015 to FY 2020 (MACPAC 2016c). The Congressional Budget Office projects both Medicaid and Medicare to grow at an average rate of 5.6 percent annually from FY 2015 to FY 2020 and projects Medicaid to grow at an average rate of 5.3 percent annually—compared to 7.1 percent for Medicare—from FY 2020 to FY 2025 (CBO 2016a, 2016b).

FIGURE 1-1. Major Health Programs and Other Components of the Federal Budget as a Share of Federal Outlays, FYs 1965–2015



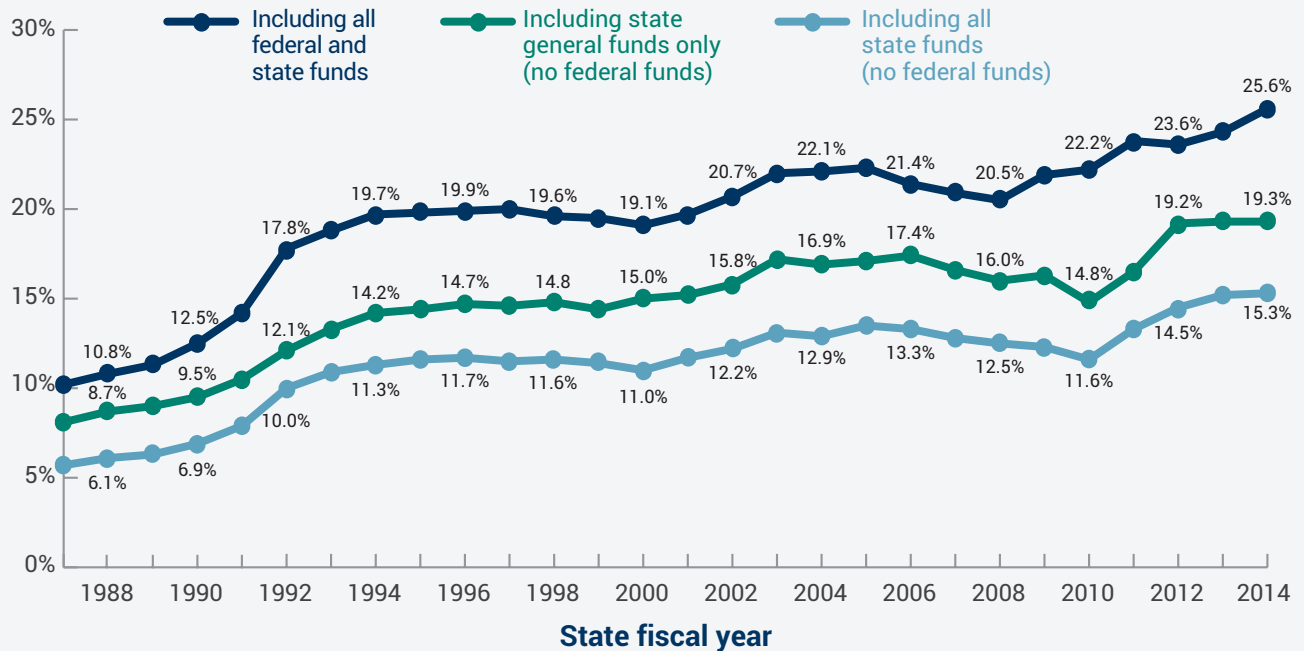
Note: FY is fiscal year.
 Source: MACPAC 2016b.

Medicaid’s Share of State Budgets

Medicaid accounts for a large share of state budgets, but that share differs substantially depending on how it is measured.² Medicaid’s share of a state’s budget also varies from state to state (MACPAC 2016d). Looking at spending across all states for state fiscal year (SFY) 2014, Medicaid accounted for over one-quarter (25.6 percent) of state budgets, including funds from all state and federal sources (Figure 1-2).

Another way to look at state spending is to consider the state-funded portion of state budgets (i.e., excluding federal funds), because this is the amount that states must finance on their own through taxes and other means. States must provide the non-federal, or state, share of Medicaid in order to draw down federal matching funds. Excluding federal matching funds, Medicaid accounted for 19.3 percent of spending from state general funds (e.g., raised through income, sales, and other broad-based state taxes) in SFY 2014 (Figure 1-2).

FIGURE 1-2. Medicaid’s Share of State Budgets Including and Excluding Federal Funds, SFYs 1987–2014



Note: SFY is state fiscal year. The all federal and state funds category reflects amounts from any source. The state general funds only category reflects amounts from revenues raised through income, sales, and other broad-based state taxes. The all state funds only category reflects amounts from any non-federal source; these include state general funds, other state funds (amounts from revenue sources that are restricted by law for particular government functions or activities, which for Medicaid includes provider taxes and local funds), and bonds (expenditures from the sale of bonds, generally for capital projects). Amounts shown here reflect the most recent information available in cases where data for a given year were published and then updated in a subsequent report.

Source: MACPAC 2016e.

Funding for the non-federal share of Medicaid can come from a variety of sources. By law, at least 40 percent of the non-federal share of total Medicaid expenditures must be financed by the state and up to 60 percent may come from local governments. States have a significant amount of flexibility in using dedicated sources of revenue including health care-related taxes on providers, intergovernmental transfers (IGTs), and certified public expenditures (CPEs), and have increasingly relied on these additional sources of revenue to finance the program. In SFY 2012, 69 percent of funds came from state general revenues, 16 percent came from local governments (including IGTs and CPEs), 10 percent came from health care-related taxes, and 5 percent came from other

sources (GAO 2014). When all available sources of non-federal funding are considered—including state general funds, bonds, and other sources such as health care-related taxes and local funds—Medicaid spending accounted for 15.3 percent of the state budget derived from these funds (Figure 1-2).

Regardless of how Medicaid’s share of state budgets is measured, a similar growth trajectory is observed over the SFY 1987 to 2008 period (Figure 1-2). In SFYs 2009 and 2010, however, the program’s share of state-funded budgets (excluding federal funds) remained stable or dropped, while its share of total state budgets (including federal funds) continued to increase. This divergence was largely due to a temporary increase in the Medicaid

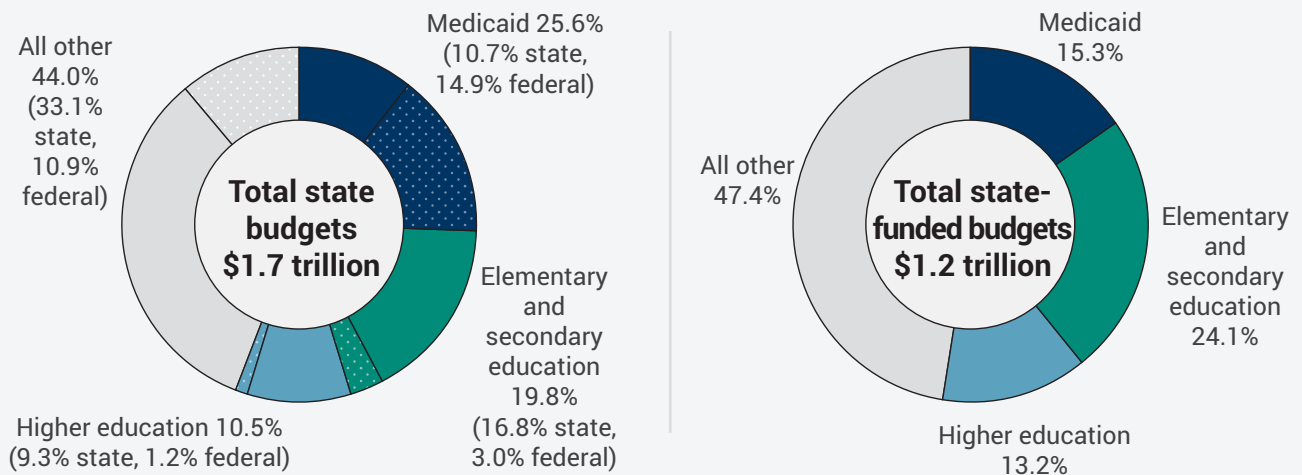
federal medical assistance percentages (FMAPs) under the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5), which was intended to provide states with fiscal relief during an economic downturn. The temporary increase ran from the first quarter of FY 2009 through the third quarter of FY 2011. By SFY 2011, Medicaid’s share of state-funded budgets had returned to previous levels. In SFY 2014, Medicaid’s share of total state budgets increased, but its share of state-funded budgets remained unchanged due to 100 percent federal funding available for the new adult group.

Many governors and state legislators have raised concerns that growth in Medicaid spending is squeezing out spending for other priorities. Although Medicaid is one of the largest budget items for states, it is important to note that Medicaid receives a greater percentage of its funding from federal sources than other programs do. When all state and federal funds are counted,

Medicaid is the largest portion of state budgets (25.6 percent), followed by elementary and secondary education (19.8 percent) and higher education (10.5 percent) (Figure 1-3). Excluding federal funds, elementary and secondary education (24.1 percent) is the largest portion of state-funded budgets, followed by Medicaid (15.3 percent) and higher education (13.2 percent) (Figure 1-3).

Relative to education, Medicaid’s share of spending is even smaller when all spending by both state and local governments is considered. This is due to variation in the level of government at which spending for various functions occurs. For example, the majority of Medicaid spending occurs at the state level: the state Medicaid agency is generally the entity that pays health care providers or managed care organizations for services rendered to Medicaid beneficiaries. By contrast, both state and local governments may make payments for elementary and secondary education. Higher education spending

FIGURE 1-3. Distribution of Medicaid, Education, and All Other Spending from Total State Budgets versus State-Funded State Budgets, SFY 2014



Note: SFY is state fiscal year. Total state budgets include all state funds (solid segments) and federal funds (dotted segments). State-funded state budgets include all non-federal funds, and consist of state general funds (expenditures from revenues raised through income, sales, and other broad-based state taxes), other state funds (expenditures from revenue sources that are restricted by law for particular government functions or activities, which for Medicaid includes provider taxes and local funds), and bonds (expenditures from the sale of bonds, generally for capital projects).

Source: MACPAC 2016 analysis of NASBO 2015.

generally occurs at the state level.³ As a result, although Medicaid’s share of spending by state governments (from all revenue sources, including federal dollars) was nearly 26 percent and education’s share was about 30 percent in SFY 2014, when amounts that include spending by both state and local governments are examined, Medicaid’s share is smaller—an estimated 17 percent or less in SFY 2012—and education’s share is about the same at 28 percent (Figure 1-3) (MACPAC 2015b).⁴

Growth in Spending per Enrollee

The annual growth rate in spending per enrollee in Medicaid has been comparable to or lower than the annual growth rate in spending per enrollee in Medicare and private insurance since the early 1990s (Table 1-1). For the past 15 years (1999 to 2014),

not only has the annual growth rate in spending per enrollee in Medicaid been lower than the annual growth rate in spending per enrollee in Medicare and private insurance, but it has also been lower than the average rate of price inflation for medical services as measured by the medical care component of the Consumer Price Index (CPI) (Table 1-1).

Changes in spending per enrollee are influenced by a number of factors, including changes in prices and payment rates, the breadth of covered benefits, the amount of beneficiary cost sharing, and the mix and composition of the beneficiary population. For example, the decrease in Medicaid spending per enrollee and the large increase in Medicare spending per enrollee between 2005 and 2006 reflects the introduction of Medicare Part D and the accompanying shift in drug spending for dually eligible beneficiaries from Medicaid to Medicare.⁵

TABLE 1-1. Average Annual Growth in Medicaid Spending per Enrollee Compared to Various Benchmarks, 1987–2023

| | 1987–1991 | 1991–1999 | 1999–2005 | 2005–2006 ¹ | 2006–2013 | 2013–2014 | 2014–2023 ² |
|--|-----------|-----------|-----------|------------------------|-----------|-----------|------------------------|
| Average annual growth in spending per enrollee by coverage type | | | | | | | |
| Medicaid | 9.2% | 5.9% | 2.8% | -0.3% | 1.9% | -2.0% | 3.6% ³ |
| Medicare | 7.8 | 5.9 | 6.6 | 16.5 | 2.6 | 2.4 | 4.2 |
| Private | 14.2 | 5.3 | 8.8 | 4.8 | 4.4 | 3.2 | 4.0–6.0 ^{3,4} |
| Average annual growth in prices and economic output | | | | | | | |
| CPI-U | 4.6 | 2.6 | 2.7 | 3.2 | 2.1 | 1.6 | 2.0 |
| CPI-U medical care | 8.0 | 4.4 | 4.3 | 4.0 | 3.4 | 2.4 | 4.0 |
| GDP | 6.1 | 5.8 | 5.2 | 5.8 | 2.7 | 4.1 | 4.0 |

Notes: CPI-U is Consumer Price Index for All Urban Consumers. GDP is gross domestic product. Growth rates reflect calendar years except in the case of Medicaid and private insurance for 2014–2023, which reflect fiscal years. Time periods displayed through 2014 were selected by grouping years with roughly similar Medicaid growth rates. Growth rates are not controlled for changes in enrollee mix or benefit design.

¹ Reflects implementation of Medicare Part D, which created a new drug benefit for Medicare enrollees and shifted drug costs for dually eligible beneficiaries from Medicaid to Medicare.

² Data are projected.

³ Projected growth is for fiscal years 2014–2023.

⁴ Private health insurance spending per enrollee is projected to grow by an average of 4.3 percent per year over the FY 2014–2018 period (CBO 2015). Private health insurance spending per enrollee is projected to increase by an average of 5.3 percent per year over the FY 2016–2025 period (CBO 2016c). CBO projects premiums for private plans will increase by an average of about 4 percent per year from FY 2014 through FY 2018 and by 5 percent to 6 percent per year from FY 2019 to FY 2025 (CBO 2016d).

Source: MACPAC 2016 analysis of BLS 2016; CBO 2016c, 2016d, 2016e, 2015; OACT 2015a, 2015b, 2015c; and Trustees 2015.

Between 2013 and 2014, the decrease in Medicaid spending per enrollee reflects a shift in the mix of enrollees—the addition of relatively lower-cost adults who enrolled through the Medicaid expansion shifted the enrollment mix to include a higher proportion of lower-cost individuals.

Between FY 2014 and FY 2023, Medicaid spending per enrollee is projected to grow at an average of about 3.6 percent annually, which is higher than the growth rate over the previous decade, but lower than the projected growth rate for Medicare and private insurance over the same time period. This higher growth rate relative to recent years reflects a number of assumptions by the Office of the Actuary at the Centers for Medicare & Medicaid Services (CMS), including assumptions that states would institute fewer provider payment rate freezes and reductions and would allow more rate increases in the future, that home and community-based services for enrollees with disabilities would continue to expand, and that there would be a modest increase in medical inflation (OACT 2015d, 2014a).⁶

Components of Spending Growth

Changes in Medicaid spending can be driven by changes in the number of people enrolled in the program, changes in average spending per enrollee, or both. Factors driving growth in Medicaid spending per person include the mix of people enrolled in the program, the volume and intensity of the services enrollees use, and the prices paid for those items and services.

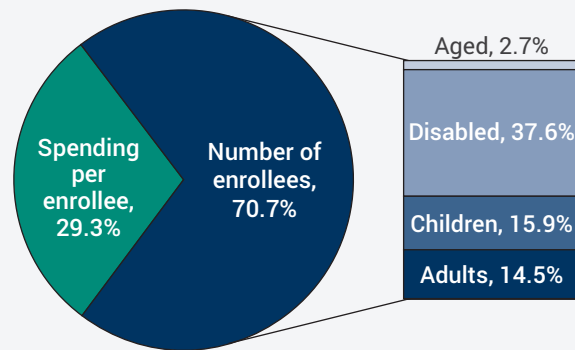
Enrollment

The majority of historical growth in real Medicaid spending (adjusted for health care price inflation) can be attributed to enrollment. From FY 1975 to FY 2012, more than two-thirds (70.7 percent) of growth in real Medicaid benefit spending was due to increases in the number of enrollees (Figure 1-4).

Enrollment growth among individuals eligible on the basis of disability accounted for over one-third of the historical growth (Figure 1-4). Given the high average spending per person for individuals who are eligible on the basis of disability, even low rates of enrollment growth for this population can have a large effect on total Medicaid spending.

Not all enrollment growth is driven by eligibility expansions. For example, population aging alone can increase Medicaid enrollment because low-income individuals can become eligible for Medicaid when they turn 65 if they qualify for Supplemental Security Income or need LTSS. Decreases in income during economic recessions also increase enrollment under existing eligibility rules, particularly among children and adults eligible on a basis other than disability. In addition, efforts to expand outreach and simplify the

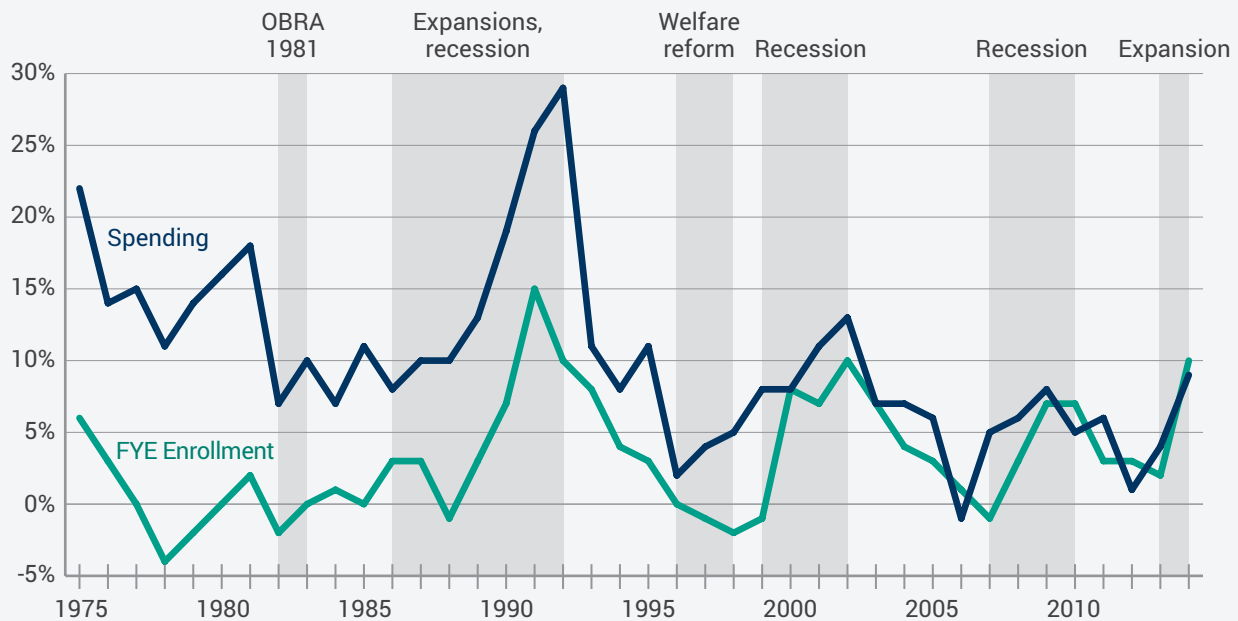
FIGURE 1-4. Growth in Real Medicaid Benefit Spending Due to Enrollment by Eligibility Group, FYs 1975–2012



Notes: FY is fiscal year. Dollar amounts were adjusted for inflation using the gross domestic product (GDP) price deflator for health care.

Source: MACPAC 2016 analysis of Centers for Medicare & Medicaid Services (CMS) 2012 Medicare & Medicaid Statistical Supplement data from Tables 13.4 and 13.10 (for FY 1975), and Medicaid Statistical Information System (MSIS) data as of December 2014 and CMS-64 Financial Management Report (FMR) net expenditure data as of June 2015 (for FY 2012).

FIGURE 1-5. Annual Growth Rates in Medicaid Enrollment and Spending, FYs 1975–2014



Note: FY is fiscal year. FYE is full-year equivalent, which also may be referred to as average monthly enrollment. OBRA is Omnibus Budget Reconciliation Act. All numbers exclude CHIP-financed coverage. Spending consists of federal and state Medicaid expenditures for benefits and administration, excluding the Vaccines for Children program. Enrollment counts are full-year equivalents and for FYs 2012–2014 are projected; FYs 1999–2014 include estimates for Puerto Rico and the Virgin Islands.

Source: Office of the Actuary (OACT), Centers for Medicare & Medicaid Services, 2015, data compilation provided to MACPAC staff, April 17, 2015. (Figure adapted from Exhibit 9 in MACStats: Medicaid and CHIP data book, December 2015, Washington, DC: MACPAC.)

enrollment process can increase take-up rates among the eligible population and increase enrollment.

Policy changes and economic conditions play an important role in Medicaid enrollment and spending and can result in sizeable changes from year to year (Figure 1-5). For example, in the late 1970s and early 1980s, high economy-wide inflation led to high Medicaid spending growth even during times of low enrollment growth. From the mid-1980s to the mid-1990s, many Medicaid-specific changes occurred, including eligibility expansions that increased both enrollment and spending as well as states’ use of disproportionate share hospital (DSH) payments and alternative financing mechanisms that increased spending. As spending growth rates spiked at over 25 percent between 1990 and 1992, Congress passed

legislation to place aggregate caps on DSH spending and restrict the use of health care-related taxes, which led to a slowdown in spending growth in the following years (Klemm 2000). In the mid-to-late 1990s, growth was affected by changes in federal Medicaid policy, including 1996 welfare reform legislation that severed the link between Medicaid eligibility and receipt of cash welfare assistance for low-income families, which had the effect of decreasing Medicaid enrollment (Klemm 2000). Growth rates accelerated in years around the recessions of 2001 and 2007 to 2009, then slowed as economic conditions improved (Young et al. 2013, Holahan et al. 2007). Medicaid spending actually decreased from FYs 2005 to 2006, primarily due to the implementation of Medicare Part D, which shifted the coverage of outpatient prescription drugs for dually eligible beneficiaries from Medicaid to Medicare (Holahan et al. 2007).⁷

In FY 2014, growth rates were primarily driven by an adult eligibility expansion; as of January 2016, 31 states and the District of Columbia had chosen to adopt the adult expansion (MACPAC 2015c).⁸

Spending per enrollee

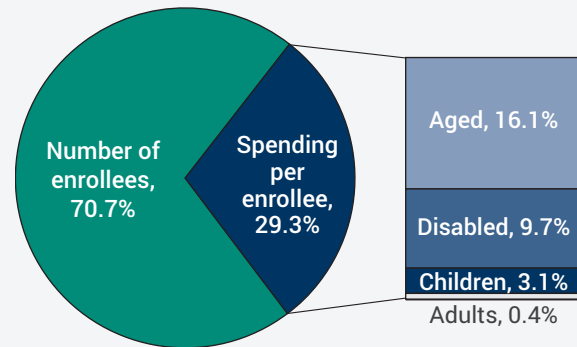
Less than one-third (29.3 percent) of growth in real Medicaid benefit spending between FY 1975 and FY 2012 was due to increases in spending per enrollee (Figure 1-6). The growth due to increases in spending per enrollee shown here reflects an increase in the volume and intensity of Medicaid services because spending has been adjusted for health care price inflation and changing enrollment mix. The majority of the increase in spending per enrollee was attributable to individuals eligible on the basis of disability and those age 65 and over (Figure 1-6).

Medicaid benefit spending per enrollee varies substantially across states. In FY 2012, the average spending per enrollee across states ranged from 70 percent to 190 percent of the national average (MACPAC 2015d). This variation reflects several factors, including the breadth of benefits that states choose to cover, the proportion of enrollees receiving the full benefit package or a more limited version, the health status and other characteristics of enrollees, the underlying costs of delivering health care services in specific geographic areas, and state policies regarding benefit limits, provider payments, care management, and other program features. Other factors affecting spending per enrollee may include efforts to re-engineer delivery systems, changes to beneficiary incentives through cost sharing or other means, and program integrity initiatives to reduce improper spending.

Enrollee mix

Per enrollee spending varies substantially across the different Medicaid eligibility groups. In FY 2012, children eligible on a basis other than disability averaged the least amount of benefit spending

FIGURE 1-6. Growth in Real Medicaid Benefit Spending Due to Spending per Enrollee by Eligibility Group, FYs 1975–2012



Notes: FY is fiscal year. Dollar amounts were adjusted for inflation using the gross domestic product (GDP) price deflator for health care.

Source: MACPAC 2016 analysis of Centers for Medicare & Medicaid Services (CMS) 2012 Medicare & Medicaid Statistical Supplement data from Tables 13.4 and 13.10 (for FY 1975), and Medicaid Statistical Information System (MSIS) data as of December 2014 and CMS-64 Financial Management Report (FMR) net expenditure data as of June 2015 (for FY 2012).

at \$2,679 per enrollee, and individuals eligible on the basis of disability had the highest average benefit spending at \$17,848 per enrollee (Figure 1-7). Individuals eligible on the basis of disability and those age 65 and older accounted for about one-quarter of Medicaid enrollees, but about two-thirds of program spending (MACPAC 2015e, 2015f). When the components of historical growth in real Medicaid benefit spending are examined by eligibility group, almost half of the growth is attributable to individuals who are eligible on the basis of disability (Figures 1-4 and 1-6).

As a result of these spending differences across enrollees, the overall average Medicaid spending per enrollee is heavily influenced by enrollment mix across the different eligibility groups. For example, the increase in relatively low-cost adults through Medicaid expansions beginning in 2014 shifted the

enrollment mix to include a higher portion of lower-cost individuals. Overall Medicaid benefit spending per enrollee is estimated to have increased by 0.3 percent in FY 2014, but when changes in enrollment mix that reflected the influx of the newly eligible adults are excluded, the estimated increase is 3.1 percent (OACT 2015d). Over the next 10 years, Medicaid benefit spending per enrollee is projected to grow at an average annual rate of 3.5 percent; when the effects of changes in the enrollment mix are excluded, benefit spending per enrollee is projected to grow at an average annual rate of 4.1 percent (OACT 2015d).

Volume, mix, and intensity of services

The differences in per enrollee spending across eligibility groups reflect the differences in health status of the enrollees, thus also reflecting the volume, mix, and intensity of services used by those enrollees. Much of the spending for individuals who qualify on the basis of disability and those age 65 and older reflects the use of LTSS. LTSS accounted for over one-third (37 percent) of spending for individuals eligible on the basis of disability and over half (64 percent) of spending for those age 65 and older (MACPAC 2015g). In fact, the average per enrollee spending for LTSS alone for individuals eligible on the basis of disability and individuals age 65 and older was greater than the total per enrollee spending for either children or adults eligible on a basis other than disability (Figure 1-7). LTSS users made up only 6 percent of enrollees but accounted for over 40 percent of spending in FY 2012 (MACPAC 2015h).

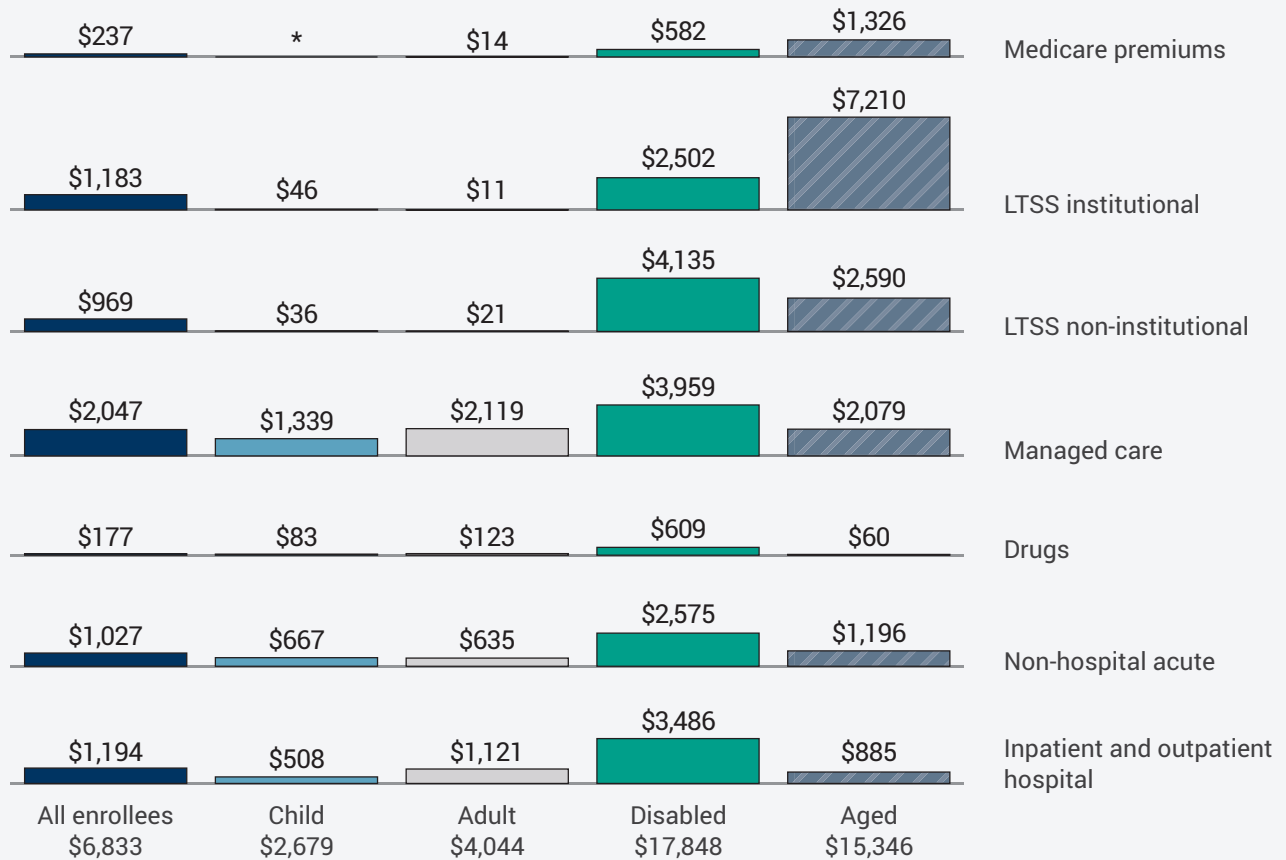
Among enrollees with similar health status, differences in the volume, mix, and intensity of services across states may reflect the flexibility states have in designing their own Medicaid programs, including the breadth of benefits a state covers, limits or restrictions on those benefits, the level and setting of care (e.g., nursing facility versus home and community-based LTSS), and the delivery systems and level of care management

provided (e.g., primary care case management, managed care). Because of the amount of spending associated with LTSS, many states have sought to reduce institutionalization and provide more services in the community. This shift can provide long-term cost savings (Kaye et al. 2009). Over the next 10 years, the growth in average benefit cost for individuals eligible on the basis of disability and those age 65 and older is expected to be slower than other eligibility groups due in large part to the relatively slower growth in the cost of LTSS as states continue using more home and community-based services to postpone enrollee need for long-term care facilities (OACT 2015d). Even disregarding LTSS, individuals eligible on the basis of disability use a considerable amount of services, with their fee-for-service spending for hospital and other acute care services being higher than total spending per enrollee for either children or adults. For children and adults, just over half of benefit spending is for capitation payments made to managed care plans because states have put more than half of these beneficiaries into comprehensive managed care (Figure 1-7). The data do not allow us to estimate what proportion of the capitation payments went toward individual services provided by the managed care plans.

Prices

The amounts that states pay for any particular service (i.e., unit prices) are developed by each state and must be approved by CMS to ensure that they are consistent with the principles set forth in statute that payments be consistent with efficiency, economy, quality, and access, and safeguard against unnecessary utilization (§ 1902(a)(30)(A) of the Social Security Act). Medicaid payments for a particular service may vary substantially across states due to the use of different payment methods. For example, states may use different payment methods to pay for inpatient hospital services, including cost reimbursement, per diem, per stay, and prospective payment based on diagnosis-related groups (MACPAC 2014a). But even when states

FIGURE 1-7. Medicaid Benefit Spending per Full-Year Equivalent Enrollee by Eligibility Group and Service Category, FY 2012



Notes: FY is fiscal year. LTSS is long-term services and supports. Includes federal and state funds. Excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. Children and adults under age 65 who qualify for Medicaid on the basis of disability are included in the disabled category. About 737,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as aged. Amounts are fee for service unless otherwise noted, and they reflect all enrollees, including those with limited benefits. Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to reflect CMS-64 totals. Due to changes in both methods and data, figures shown here are not directly comparable to earlier years. With regard to methods, spending totals now exclude disproportionate share hospital (DSH) and certain incentive and uncompensated care pool payments made under Section 1115 waiver expenditure authority, which were previously included. See <https://www.macpac.gov/macstats/data-sources-and-methods/> for additional information.

* Values less than \$1 are not shown.

Sources: MACPAC 2015 analysis of MSIS data as of December 2014 and analysis of CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of June 2015. (Figure reprinted from Exhibit 19 in *MACStats: Medicaid and CHIP data book*, December 2015, Washington, DC: MACPAC.)

use similar payment methods, payment rates can still vary substantially due to differences in state policy goals, local market conditions, and the underlying costs of delivering health care services in a specific geographic area. For example, states generally pay physicians based on a fee schedule,

but a 2012 survey of Medicaid physician fees for a selection of commonly used services found that Medicaid fees paid by different states ranged from 58 percent of the national average in Rhode Island to 242 percent of the national average in Alaska (Zuckerman and Goin 2012).

Year-to-year changes in unit price may or may not track with underlying growth in overall health care prices. The 2012 physician fee survey found that Medicaid fee-for-service payment rates for the selected services increased 4.9 percent between 2008 and 2012; over this same time period, the CPI increased 4.4 percent and the medical care component of the CPI increased 14.9 percent (Zuckerman and Goin 2012). States are not required to make inflationary adjustments; instead, they may change payment rates to support particular policy goals (e.g., to increase provider participation and access), to tie payment rates to the attainment of certain benchmarks related to quality, or to accommodate state budget constraints.

Additionally, state payments for a particular service may be influenced by mechanisms for financing the non-federal share, such as health care-related provider taxes and contributions from local governments. These non-general fund sources of financing are often used in conjunction with supplemental payments, which are typically lump-sum payments made to a provider in addition to the standard payment rate for services. These

supplemental payments play an important role in Medicaid payment to certain providers such as hospitals and nursing facilities (MACPAC 2014b, 2012). For example, supplemental payments comprised over 40 percent of total Medicaid payments to hospitals in FY 2014 (MACPAC 2015i).

Medicaid Spending in 2014 and Beyond

Total Medicaid spending increased by about 8 percent in FY 2014, rising from \$460 billion in FY 2013 to \$498 billion (MACPAC 2015j). The spending growth was much higher for some services than for others in 2014, reflecting a variety of factors, including increases in enrollment and changes in enrollment mix, payment policy, and the mix of services within a service category (Table 1-2). Because much of the spending growth was attributable to the new adult group, growth was higher in services that the new adult group was most likely to use. LTSS, including nursing and retirement facilities and other health, residential,

TABLE 1-2. Distribution and Annual Growth of Medicaid Benefit Spending by Type of Service, FYs 2006–2016

| Type of service | Share of benefit spending 2014 ¹ | Average annual growth 2006–2013 | Annual growth 2013–2014 | Projected growth | |
|--|---|---------------------------------|-------------------------|------------------|------|
| | | | | 2015 | 2016 |
| Hospital | 38% | 5% | 8% | 9% | 6% |
| Other health, residential, and personal care | 19 | 6 | 3 | 4 | 5 |
| Physician and clinical | 14 | 7 | 23 | 6 | 0 |
| Nursing and retirement facilities | 11 | 2 | 3 | 3 | 4 |
| Home health | 7 | 8 | 4 | 7 | 6 |
| Prescription drugs | 6 | 2 | 24 | 13 | 3 |
| Dental | 2 | 9 | 14 | 13 | 6 |
| Other professional | 1 | 7 | 17 | 15 | 6 |
| Durable medical equipment | 1 | 6 | 12 | 9 | 7 |

Note:

¹ Components may not sum to 100 percent due to rounding.

Source: MACPAC 2016 analysis of OACT 2015a, 2015c.

and personal care services, were less likely to be used by the new adult group, and spending for these services increased the least in 2014. Spending for physician and clinical, dental, and other professional services was partly driven by policy changes that included expanded coverage for adults and a mandated primary care payment increase under the ACA, which required states to pay primary care providers fees that were at least equal to Medicare fees. The availability of new high-cost drugs, particularly for the treatment of hepatitis C, also contributed to much higher than average growth for the prescription drug category in 2014 (Box 1-1). The managed care share of total Medicaid benefit spending increased by almost 6

percentage points, from 31.6 percent in FY 2013 to 37.5 percent in FY 2014; nearly all individuals gaining eligibility through the new adult group were enrolled in managed care plans, and many states, including non-expansion states, increased their use of managed care (MACPAC 2015k). The CMS Office of the Actuary projects that spending growth rates for 2015 and beyond will be lower going forward, at about 6 percent annually over the next decade. These projections reflect factors that include the moderation of expansion effects, expiration of the primary care payment increase, and negotiation with drug manufacturers (Keehan et al. 2015).

BOX 1-1. Prescription Drug Spending

Prescription drug spending was a key driver of the increase in national health spending from 2013 to 2014 for all payers. After many years of low to moderate growth, overall prescription drug spending for all payers increased 12 percent in 2014, and the increase for Medicaid was even higher at 24 percent (Martin et al. 2016). The increase in prescription drug spending was largely the result of increased enrollment under the expansion to the new adult group and the introduction of new, high-cost drugs to treat conditions such as hepatitis C.

In CYs 2013 to 2014, gross Medicaid drug spending (i.e., spending before rebates) increased more in states that expanded Medicaid eligibility to the new adult group than in states that did not expand Medicaid. Gross drug spending increased 24.6 percent in expansion states compared to 14.1 percent in non-expansion states. This 10 percentage point difference provides a sense of the impact of expansion in eligibility; however, the data do not tell us exactly how much of the annual increase in gross spending is due solely to the Medicaid expansion (MACPAC 2016f).

Additionally, there has been an increase in the use and price of high-cost specialty drugs. In CY 2014, drugs costing over \$1,000 per claim accounted for less than 1 percent (0.9 percent) of claims but almost one-third (32 percent) of total gross drug spending. A substantial amount of the increase in high-cost drugs in 2014 was attributable to the introduction of new treatments for hepatitis C in late 2013 (Sovaldi) and 2014 (e.g., Harvoni, Viekira Pak). The introduction of these new hepatitis C treatments led to an increase in Medicaid spending for hepatitis C treatment from \$0.4–\$0.6 billion in CYs 2011 to 2013 to \$1.8 billion in CY 2014, which was more than the prior three years combined. The \$1.4 billion spent on new hepatitis C drugs accounted for about 20 percent of the \$7.3 billion increase in gross drug spending between CY 2013 and CY 2014 (MACPAC 2016f). Prescription drug spending in 2015 and beyond is expected to increase less because states have been able to negotiate higher supplemental rebates as different manufacturers bring new hepatitis C drugs to the market (Loftus 2015).

Impact of Medicaid expansion

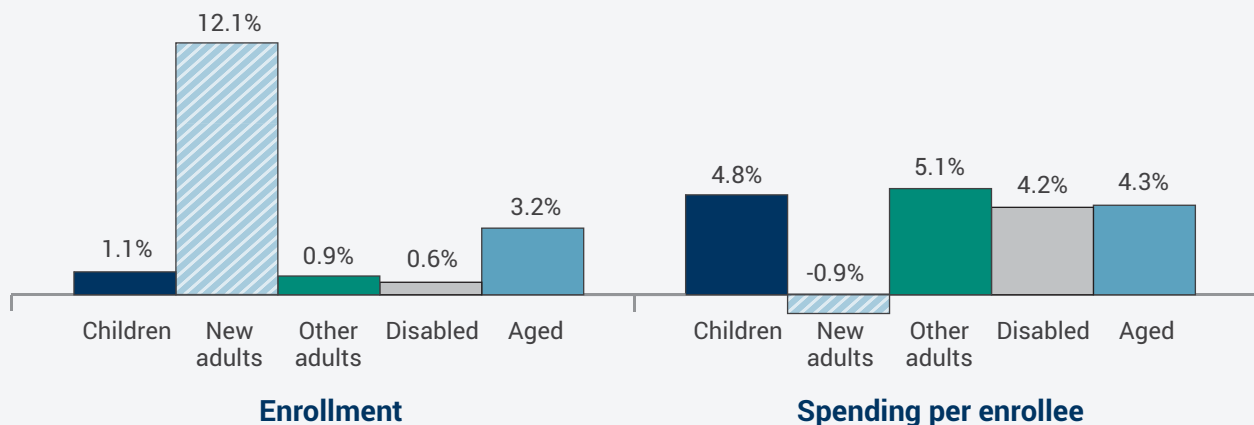
The growth in Medicaid spending in 2014 is largely attributable to enrollment growth related to the expansion of Medicaid to the newly eligible adult group. Enrollment in Medicaid is estimated to have increased by almost 10 percent, with most of the increase associated with the new adult group. Excluding the newly eligible adults, enrollment increased by about 2.3 percent (OACT 2015d). Growth in the newly eligible adult group is expected to drive overall enrollment growth over the next decade. From FY 2014 to FY 2023, the newly eligible adult group is projected to grow 12 percent on an annual basis compared to growth rates of 3 percent or less for the other eligibility groups (Figure 1-8). Most of the growth in the newly eligible adult group is front-loaded in FYs 2014–2016, with most of the enrollment assumed to occur in FY 2014. Enrollment growth in FY 2015 and FY 2016 is projected to be about 6 percent, reflecting increased enrollee take-up and increases in the number of states expanding Medicaid eligibility after 2014 (OACT 2015d).

As mentioned previously, the expansion to the new adult group has affected overall Medicaid spending

per enrollee by changing the enrollee mix to include a greater proportion of lower-cost individuals. From FYs 2014 to 2023, changes in the enrollment mix are project to decrease Medicaid benefit spending per enrollee by an average of 0.5 percentage points per year (OACT 2015d). With the exception of the new adult group, growth in Medicaid spending per enrollee for FYs 2014 to 2023 is projected to be somewhat higher than price inflation as measured by the medical care component of the CPI (4.0 percent) over the same period (Figure 1-8). The projected decrease in Medicaid spending per enrollee for new adults reflects moderation in the use of services as pent-up demand for medical care decreases and a healthier mix of individuals enroll over time; it also assumes certain changes in managed care capitation rates as states collect more data and experience to use in setting rates (OACT 2015d).

Impact of expansion on federal spending. Most of the growth in Medicaid spending in FY 2014 consisted of an increase in federal spending, which rose by about 13 percent, from \$267 billion in FY 2013 to \$303 billion in FY 2014. In comparison, overall state spending on Medicaid increased by only about 1 percent, from \$193 billion in FY 2013 to \$195 billion in FY 2014. This difference in the increase in

FIGURE 1-8. Average Annual Growth in Projected Enrollment and Spending per Enrollee, FYs 2014–2023



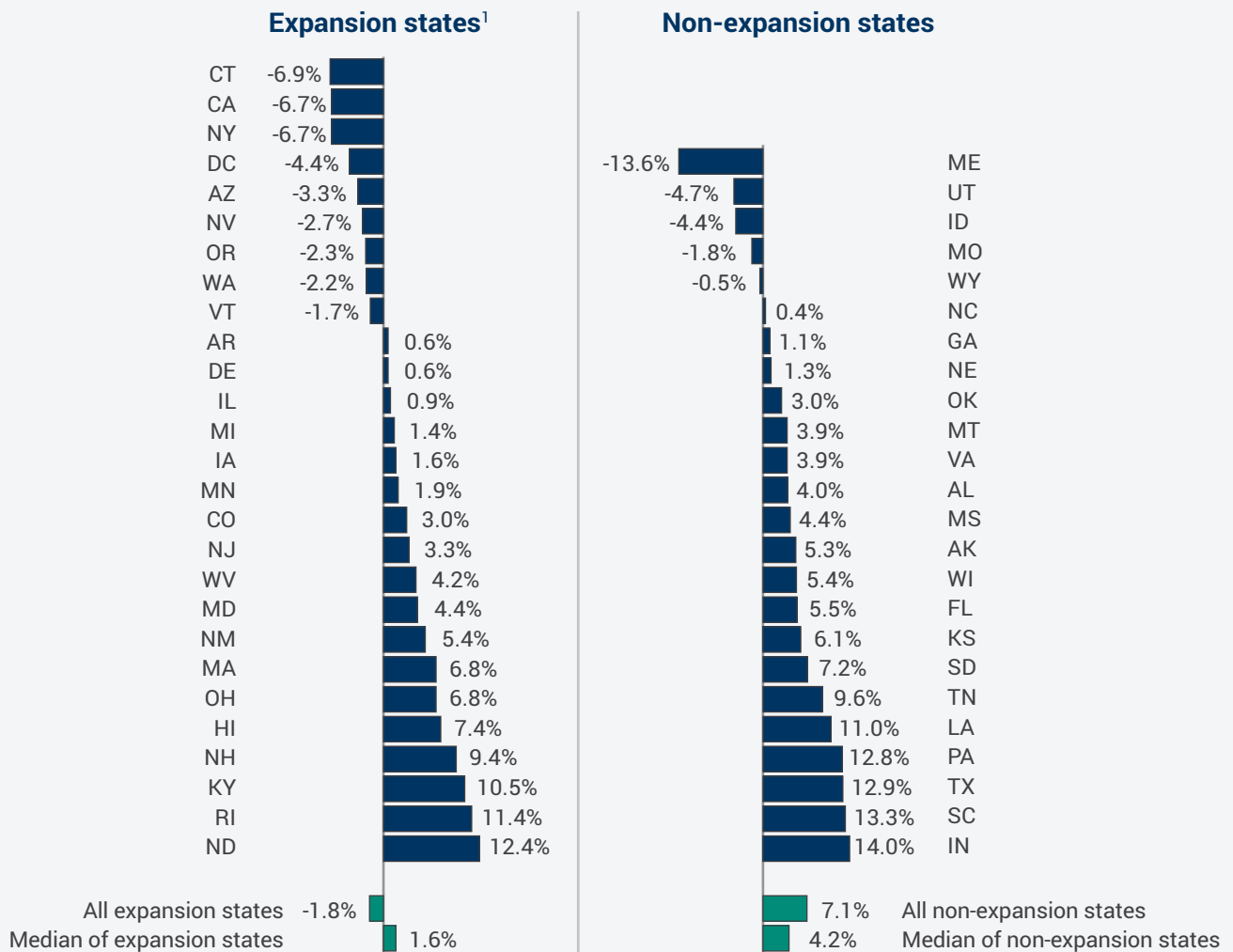
Note: FY is fiscal year.

Source: MACPAC 2015 analysis of OACT 2015d (Tables 13, 15, and 16).

federal and state spending is the result of the 100 percent federal funding available for newly eligible adult enrollees. As a result of the increased federal match for the new adult group, the federal share of Medicaid spending on benefits at the national level increased from its historical average of 57 percent to 60 percent (MACPAC 2015j).

Impact of expansion on state spending. Overall state spending on Medicaid increased by only about 1 percent in FY 2014, and expansion states had a median growth rate that was almost one-third that of non-expansion states (Figure 1-9). Among expansion states, aggregate state spending decreased by 1.8 percent, and the median change

FIGURE 1-9. Growth in State Medicaid Spending (Excluding Federal Funds) in Expansion and Non-Expansion States, FY 2014



Notes: FY is fiscal year. California had not certified its third and fourth quarter CMS-64 Financial Management Report (FMR) submissions as of April 5, 2016. Figures presented may change if states revise their expenditure data after April 5, 2016.

¹ Expansion states include only those that expanded before the end of FY 2014; coverage became effective January 1, 2014, in these states except for Michigan (effective April 1, 2014) and New Hampshire (effective August 15, 2014). Pennsylvania and Indiana expanded in FY 2015 and are shown in the non-expansion category.

Source: MACPAC 2016 analysis of CMS-64 FMR net expenditure data as of April 5, 2016.

in state spending was an increase of 1.6 percent. Among non-expansion states, aggregate state spending increased by 7.1 percent, and the median change in state spending was an increase of 4.2 percent. The differences in the change in state spending between expansion and non-expansion states may reflect a variety of factors. Expansion states that had previously expanded to cover adults up to at least 100 percent of the federal poverty level before the enactment of the ACA can receive a phased-in increase in their federal matching rate for childless adults under age 65 beginning on January 1, 2014 (Rudowitz 2014). This increase in federal match would reduce state spending for this group of beneficiaries. Additionally, many non-expansion states saw a decrease in their FMAP rate that resulted in a shift in spending from federal to state dollars. Particularly among expansion states with the largest increases in state spending, it is possible that some have not yet claimed the full amount of enhanced FMAP to which they may be entitled for new adult group enrollees; revisions to prior period reporting are common and may be reported in future data submissions, and this could result in a decrease in the change in state spending for these states. The state Medicaid spending growth in some expansion states may also reflect a shift of state dollars to Medicaid because activities and populations previously supported with state general funds alone are now eligible for federal match (Bachrach et al. 2016).

Endnotes

- ¹ Additional state-level spending information may be found in MACStats, our annual publication of Medicaid data and information. The most recent MACstats and prior publications can be found at <https://www.macpac.gov/macstats/>.
- ² The composition of health spending at the federal, state, and local levels is beyond the scope of this chapter. However, Medicaid is the largest component of state and local government spending on health care; its share was 39 percent in 2013, followed by health insurance contributions for state and local employees at 33 percent, and spending for other health programs (including maternal and child health, vocational rehabilitation, general assistance, school health, CHIP, public health activities, other state and local programs, Part D state phased-down payments, and investment in research, structures and equipment) at 29 percent (OACT 2014b).
- ³ State funding systems for education vary greatly, and some have moved toward increasing their share of funding for elementary and secondary education by substituting state funds for local funds, often to reduce local government reliance on property taxes (NASBO 2015). Nearly half of all public elementary and secondary education revenue was from state sources in SFY 2012 (Dixon 2014).
- ⁴ Medicaid's share is estimated because spending for the program cannot be precisely isolated in the data on combined state and local spending from the U.S. Census Bureau's Survey of Government Finances (SGF), for which SFY 2012 information is the most recent. The 17 percent share is a high estimate obtained by summing two SGF categories that are not limited to amounts paid by Medicaid: public welfare vendor payments (12 percent) and hospitals (5 percent). The public welfare vendor payments category reflects payments made directly to private purveyors for medical care, burials, and other commodities and services provided under welfare programs. Among other items, the hospitals category includes services provided directly by the government through its own hospitals and health agencies, which may be paid in part through disproportionate share hospital (DSH) and other Medicaid amounts.

⁵ Although Medicaid is no longer directly responsible for paying for most prescription drugs used by dually eligible beneficiaries, states still pay for part of the cost of their Part D coverage through monthly phased-down state contributions—commonly referred to as clawback payments—that offset some of Medicare’s spending for these individuals. These clawback payments are included in the data on Medicaid’s share of state budgets but are typically not included in other estimates of Medicaid spending.

⁶ Specific examples are not given, but the Office of the Actuary (OACT) noted that during and immediately after the 2007 to 2009 recession, states took stronger actions to limit expenditure growth, including freezing or reducing provider rates. In more recent years, states have made fewer provider reimbursement rate reductions and have instituted rate increases. OACT also notes that the use of home and community-based services can substantially reduce expenditures for enrollees who would otherwise have to enter a nursing home or who transition from institutional to community settings, but that the expanding use of these services by those who do not otherwise need nursing home care can add to overall program costs. When averaging over the period 2014 to 2023, growth in spending per enrollee resulting from these factors is moderated by low growth in spending per enrollee through 2016 resulting from the influx of new adults whose costs are lower than the cost of an average beneficiary.

⁷ This change in Medicaid spending does not include the clawback payments states must make to Medicare Part D.

⁸ This count includes Louisiana. The governor of Louisiana has issued an executive order to implement a Medicaid expansion effective July 1, 2016.

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