Center for American Progress

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Progressive Ideas for a Strong, Just, and Free America

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Medicaid costs are high on the health policy agenda. Medicaid, the health care program for low-income Americans, is funded jointly by the federal and state governments, with the federal government paying on average 57 percent of the cost. It is the second most costly federal health care program (after Medicare) and the most costly health program for most, if not all, states. Between 2000 and 2003, Medicaid spending grew by one-third, largely as the result of enrollment growth driven by the economic downturn.[1] The Congressional Budget Office (CBO) projects that, over the next five years, federal Medicaid spending will grow an average of 7 percent per year, from $183 billion to $260 billion.[2] At some point during this year, CBO estimates, Medicaid will provide health or long-term care coverage to over 58 million people, or about one out of every five Americans.

Given these trends, policymakers are taking great interest in controlling Medicaid spending growth without intentionally harming the tens of millions of low-income Americans that the program covers. To inform the debate over Medicaid cost containment, this paper examines the distribution of Medicaid spending among Medicaid beneficiaries in the community. Specifically, it focuses on the distribution of Medicaid spending among the non-institutionalized beneficiaries as reported in the 2002 Medicare Expenditures Panel Survey (MEPS). An explanation of this data source and its limitations is found in the Appendix. Our main findings are:

- **High-cost cases account for nearly three-fourths of Medicaid spending in the community.** Seventy-two percent of Medicaid spending was attributable to only 10 percent of Medicaid beneficiaries in the community. Medicaid spending is more concentrated among its most expensive beneficiaries than is Medicare or employer-sponsored health insurance spending. Medicaid spending on these individuals during 2002 equaled or exceeded $7,770. These high-cost beneficiaries are more likely than other Medicaid beneficiaries to be women, poor, non-Hispanic white and rural residents. Nearly one in three of the top 10 percent of high-cost Medicaid beneficiaries is also eligible for Medicare as well (i.e., dual eligible).

- **Most Medicaid spending for high-cost beneficiaries in the community is for hospital care and home health services.** Nearly two-thirds of all the costs paid by Medicaid for high-cost beneficiaries in the community were for hospital care (40 percent) and home health (24 percent). Another 18 percent of spending for this population was on prescription drugs. Over half (56 percent) of high-cost Medicaid beneficiaries were hospitalized in the last year.

- **Chronic illnesses are common among high-cost beneficiaries in the community.** A large fraction of high-cost beneficiaries in the community have chronic health problems that require medical management, including heart disease (28 percent), asthma (25 percent) and diabetes (19 percent).

[1] Holahan and Ghosh, "Understanding the Recent Growth in Medicaid Spending," *Health Affairs* W5 52-62, January 26, 2005

[2] Congressional Budget Office (CBO), Fact Sheet for CBO's March 2005 Baseline: Medicaid and the State Children's Health Insurance Program.

- **Medicaid is a major payer for high-cost people in the U.S.** Among all individuals in the community, not just Medicaid beneficiaries, Medicaid pays for about one-fourth (24 percent) of the top 10 percent most costly individuals. To put this in perspective, this is over 30 times more than the number of people served by medical high-risk pools nationwide (181,441).[3] These data understate Medicaid's role in paying for high-cost cases because they exclude nursing home residents and other institutionalized beneficiaries, for whom Medicaid is the dominant payer.

These data raise a number of important questions about Medicaid cost containment policies currently under consideration. Common among these options are two that are potentially problematic for high-cost Medicaid cases and the providers that treat them: (1) increasing copayment requirements, and (2) reducing the scope of covered benefits for certain populations. If state Medicaid programs impose higher copayments on hospital and home health services and prescription drugs, will the high-cost individuals who now use these critical services be deterred from using these services and, if so, what effects will the reduction in the use of services have on their health status? Similarly, if benefits are scaled back, what are the implications for high-cost Medicaid populations, who are heavy users of hospital services, home health care, and prescription drugs, and for the providers that now treat them? Alternatively, policymakers could explore using medical management to improve quality and possibly reduce spending on high-cost Medicaid cases.

## BACKGROUND

### Medicaid Costs and Growth

Medicaid is now the single largest source of health care coverage in the nation, providing coverage to an estimated 58 million.[4] This includes approximately 7 million Medicare beneficiaries who are also eligible to receive services such as long-term care through Medicaid (i.e., dual eligibles). Medicaid is the main source of funding for people in nursing homes. Nearly 60 percent of those in nursing homes have Medicaid as the primary source of payment.[5] Medicaid also finances one-third of all births in the United States[6] and is the largest source of federal spending for HIV/AIDS care in the country.[7]

Medicaid has become a focus of policymakers primarily due to its growth and costs. Total Medicaid spending grew by over 10 percent from 2000 to 2003 and by nearly 12 percent from 2000 to 2002.[8] In 2005, total Medicaid spending of $321 billion ($183 billion in federal and

[3] Council on Affordable Health Insurance. *High Risk Health Insurance Plans: Past, Present and Future*, November 2004.
[4] CBO March Baseline, 2005. Note that the person-year count is 44 million; Office of Management and Budget, *Budget of the United States Government, Fiscal Year 2006*. Washington, DC, January 2005.
[5] O'Brien and Elias, *Medicaid and Long-Term Care*, Kaiser Commission on Medicaid and the Uninsured, May 2004.
[6] Fact Sheet, *Women's Health Policy Facts*, Kaiser Family Foundation, November 2004.
[7] Fact Sheet, *HIV/AIDS Policy Fact Sheet*, Kaiser Family Foundation, September 2004.
[8] Holahan and Ghosh, *Health Affairs*, January 2005.

$138 billion in state spending ) is projected to exceed net Medicare spending ($290 billion) according to the Congressional Budget Office (CBO).[9]

The growth in the Medicaid program is primarily related to three factors. The first factor is that Medicaid has experienced a large increase in enrollment. Between 2000 and 2003, employers reduced health care coverage by 4.8 million people and Medicaid enrollment increased by 5.8 million.[10] These enrollment/spending trends resulted in a one-third increase in program expenditures.[11] The second factor is the impact of long-term care and of the dual eligible population (those eligible for both Medicare and Medicaid) on the Medicaid program. Forty-two percent of all Medicaid expenditures are spent on Medicare beneficiaries and the majority of Medicaid expenditures for the dual eligibles are for long-term care services (65 percent).[12] Spending growth for the aged and disabled accounted for 56 percent of all Medicaid benefit spending growth during the 2000-2003 period.[13] Finally, Medicaid is affected by health care cost drivers that affects the entire health care system, such as prescription drug costs and expanded use of expensive technologies.

A closer look at Medicaid growth reveals that its spending growth per enrollee over the last few years has actually been slower than increases in Medicare and private insurance spending. The annual rate of growth per enrollee in Medicaid between 2000 and 2003 was 6.1 percent,[14] lower than comparable Medicare spending growth per beneficiary and spending growth per privately insured person (private insurance premium growth averaged above 10 percent during this period as well).[15] The level of spending itself, relative to other health programs, is low. A study that adjusted for the different health profiles of enrollees found that Medicaid is not a high-cost program on a risk-adjusted basis.[16]

**Medicaid Costs and High-Cost Cases**

What has not received much attention in the research literature or among policymakers is the set of people in Medicaid who account for the most costs.[17] Studies of high-cost enrollees have been conducted for Medicare and private insurance spending. Recently, CBO examined the role played by high-cost Medicare beneficiaries in Medicare spending. It found that Medicare spending is highly concentrated, with the highest-cost 10 percent of Medicare beneficiaries

[9] CBO March Baseline, 2005. CBO March Baseline for Medicare, 2005.
[10] Holahan and Ghosh, *The Economic Downturn and Changes in Health Insurance Coverage, 2000-2003*, Kaiser Family Foundation, September 2004.
[11] Holahan and Ghosh, *Health Affairs*, January 2005.
[12] Policy Brief, *Dual Eligibles: Medicaid's Role for Low-income Medicare Beneficiaries*, Kaiser Commission on Medicaid and the Uninsured, January 2005.
[13] Holahan and Ghosh, *Health Affairs*, January 2005.
[14] Holahan and Ghosh, *Health Affairs*, January 2005.
[15] CBO historical data and Fact Sheets; Kaiser/HRET *Health Benefits 2004*.
[16] Hadley and Holahan, "Is Health Care Spending Higher Under Medicaid or Private Insurance?" *Inquiry* 40(4): 323–342, 2003; Policy Brief, *Medicaid: A Lower-Cost Approach to Serving a High-Cost Population*, Kaiser Commission on Medicaid and the Uninsured, March 2004.
[17] There are some state-specific studies of Medicaid high-cost cases; see for example United Hospital Fund, *Medicaid High Cost Patients: An Analysis of New York City Medicaid High Cost Patients*, Center for Health and Public Service Research, Wagner School of Public Health, March 2004; Lerch and Mayfield, *High-Cost Medicaid Clients: Targeting Diseases for Case Management*, Washington State Institute for Public Policy, December 2000.

accounting for 61.5 percent of all Medicare spending in 2001.[18] In its discussion, CBO states that the concentration of expenditures among the highest-cost beneficiaries suggests that policymakers identify the relatively small group of potentially high-cost beneficiaries and find effective intervention strategies to reduce their spending. A similar study examined the distribution of spending among non-elderly people with some private employer-sponsored insurance. It found that the top 10 percent of cases accounted for 63 percent of expenditures.[19]

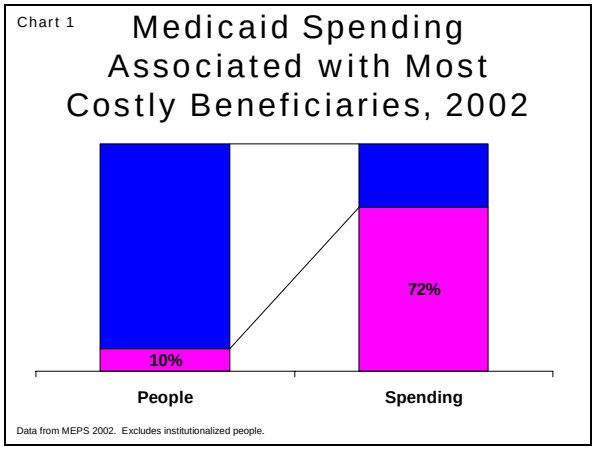
These studies raise important questions for Medicaid policymakers: Are Medicaid expenditures concentrated in a small fraction of Medicaid beneficiaries? If so, what are the characteristics of these high-cost beneficiaries? What are the implications of Medicaid cost containment policies now under discussion for these beneficiaries and the providers that treat them? Are there other cost containment strategies that might be effective at reducing spending on high-cost beneficiaries without jeopardizing their health status or well-being?

To begin to address these questions, this paper assesses high-cost Medicaid beneficiaries using national data from the 2002 Medicare Expenditures Panel Survey (MEPS) to analyze Medicaid spending by beneficiaries living in the community. "High cost" throughout this paper refers to people whose spending is in the top 10 percent of the distribution of Medicaid spending for all people enrolled in Medicaid. The sources and limitations of this data are discussed in the Appendix, which also includes tables with greater detail on the results. Because Medicaid spending is determined in large measure by eligibility, benefits, and provider payment policies, and because these policies vary significantly from state to state, these questions must ultimately be addressed at the state level using state Medicaid data. That said, the results may help inform the current policy debate.

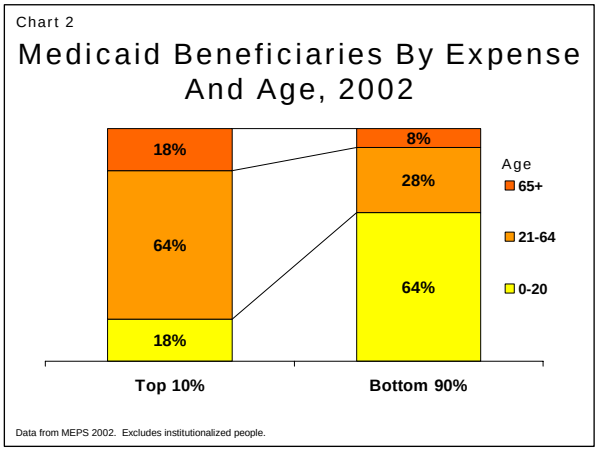
[18] Lee and Anderson, *High-Cost Medicare Beneficiaries*, Congressional Budget Office, May 2005.
[19] Blumberg and Holahan, "Government a Reinsurer: Potential Impacts on Public and Private Spending", *Inquiry*, Summer 2004.

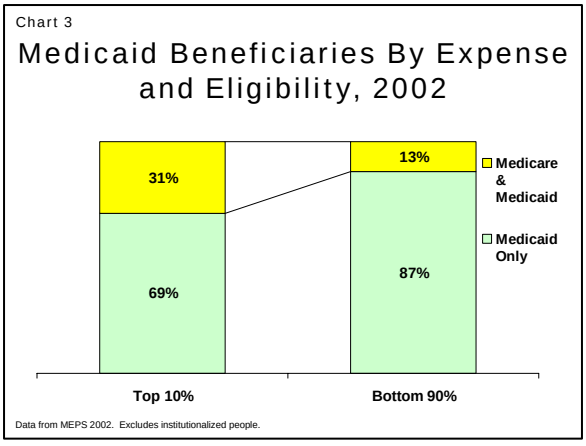
## RESULTS

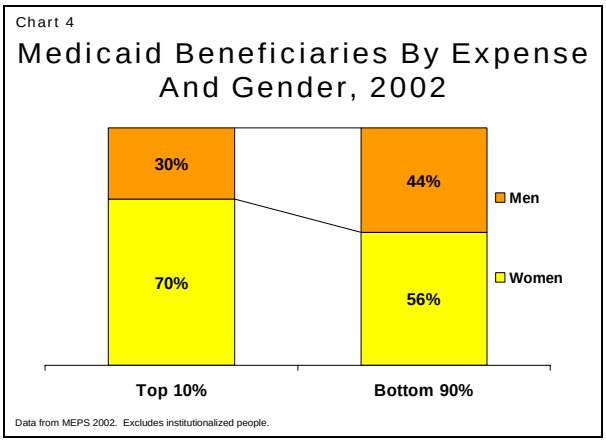
**High-Cost Cases Accounts for Nearly Three-Fourths of Medicaid Spending in the Community.** We found that the top 10 percent most expensive non-institutionalized Medicaid beneficiaries account for nearly three-fourths – 72 percent – of Medicaid spending (Chart 1). This is more skewed than the general population, in which the top 10 percent account for 64 percent of all spending (Table 1; tables located in the appendix). The top 10 percent of most expensive non-institutionalized Medicaid beneficiaries represent 4.2 million people and over $60 billion in Medicaid spending. Looking at other high-cost groups, we found that the top 5 percent of high-cost beneficiaries (2.1 million people) account for 57 percent of Medicaid spending and the top 20 percent (8.4 million people) for 88 percent of Medicaid spending (Table 1). This understates Medicaid's role since it does not consider institutionalized people's spending.

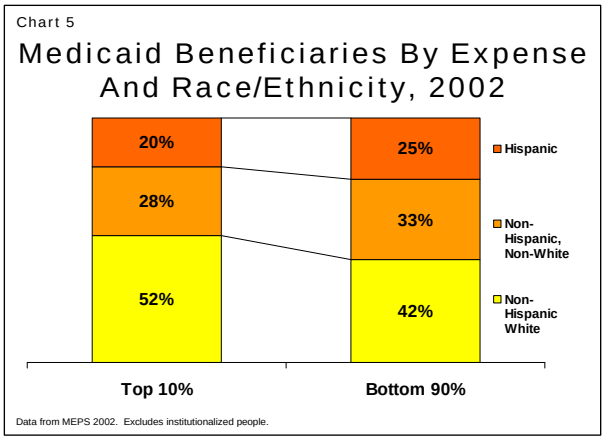



According to our findings, the top 10 percent of high-cost, non-institutionalized beneficiaries are much older than the bottom 90 percent – more than four-fifths are age 21 and older (Chart 2). Eighteen percent of these cases are age 65 and older, and 64 percent are ages 21-64. Over 30 percent of the top 10 percent of high-cost beneficiaries are eligible for both Medicare and Medicaid (i.e., dual eligible) – over twice the proportion among beneficiaries with lower spending (Chart 3). It is important to note that 70 percent of high-cost cases in Medicaid are not dual eligibles and, because of Medicare's primary coverage of dual eligibles, Medicaid's per capita spending is higher for children than for seniors (data available upon request).

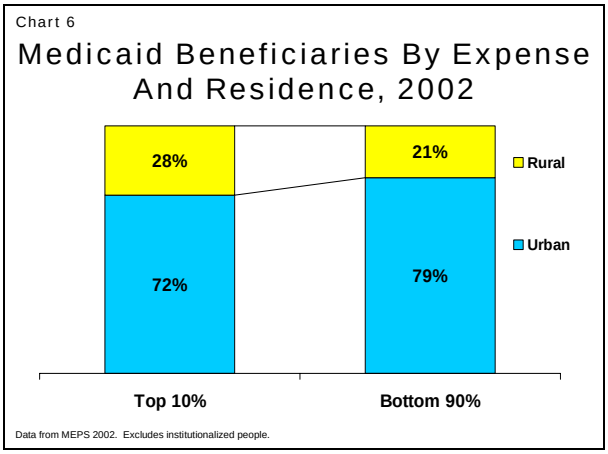


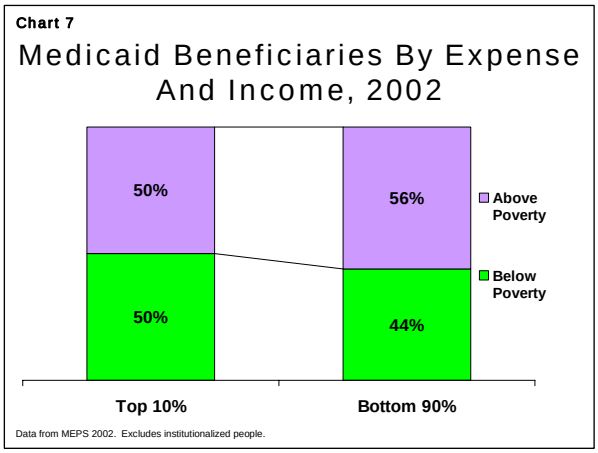






The top 10 percent of Medicaid high-cost beneficiaries are largely female – 70 percent (Chart 4). This may be related to the fact that the high-cost population is older and more likely to be dual eligibles; this group tends to be female.[20] Medicaid high-cost cases are more likely to be non-Hispanic whites (52 percent compared to 42 percent for the bottom 90 percent of cases) (Chart 5). The population is also disproportionately rural, with 28 percent (1.2 million people) living in non-Metropolitan Statistical Areas compared to 21 percent of less costly beneficiaries (Chart 6). In addition, half of the high-cost population lives below the poverty level, slightly more than the proportion among beneficiaries who are not categorized as high-cost (Chart 7). This may reflect the large number of children in families with income above the poverty level who are low-cost.



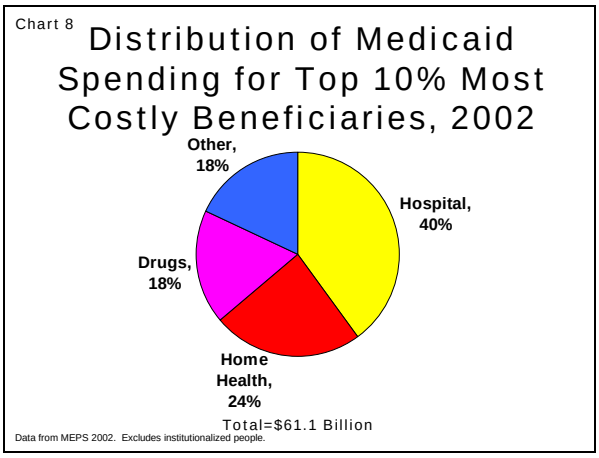



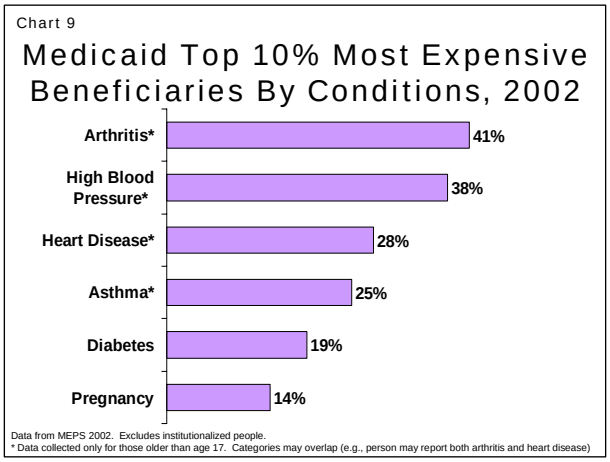

**Most Spending for High-Cost Cases for Hospital Care and Home Health Services.** The use of services by this population reflects the type and intensity of the illnesses that afflict them. The largest cost for high-cost Medicaid beneficiaries in the community is hospital care, accounting for 40 percent ($24 billion) of total Medicaid spending for this group and 84 percent of Medicaid hospital spending (Chart 8, Table 2). Fifty-six percent of the top 10 percent of high-cost beneficiaries have been hospitalized in the last year, compared to 7 percent of the bottom 90 percent (Table 3). That means that of the 4.2 million Medicaid beneficiaries who make up the

[20] Policy Brief, *Dual Eligibles*, January 2005.

top 10 percent of highest-cost beneficiaries, 2.4 million were hospitalized at some point in the year.
In addition, nearly $15 billion – or 24 percent of total spending for this group – was spent on home health care. This group's spending on home health care is one-third more than its spending on prescription drugs ($11 billion). Overall, the top 10 percent most costly Medicaid beneficiaries account for 97 percent of all Medicaid home health spending (Table 2). This suggests that Medicaid high-cost cases tend to be people with serious health and/or long-term care needs.

About 18 percent of total Medicaid spending for high-cost cases was for prescription drugs. This is lower than the percentage of spending on the bottom 90 percent of beneficiaries for prescription drugs (34 percent of their total spending, or $8 billion) (Table 2). Overall, the top 10 percent most costly Medicaid beneficiaries account for 58 percent of all Medicaid prescription drug spending. Thus, policies to change drug coverage will likely have a large impact on high-cost cases.




**Chronic Illnesses Are Common Among High-Cost Beneficiaries in the Community.** Chart 9 displays common conditions among high-cost beneficiaries; beneficiaries may have more than one of these conditions (e.g., both arthritis and heart disease). One-quarter of the top 10 percent of beneficiaries suffer from asthma (Chart 9). This accounts for over one million Medicaid beneficiaries. And, nearly one in five suffer from diabetes, far exceeding the 4 percent of the bottom 90 percent of beneficiaries who suffer from diabetes (Table 3). Around 40 percent of adults in this population suffer from high blood pressure and/or arthritis and nearly 30 percent suffer from heart disease.

**Medicaid Is A Major Payer for High-Cost People in the U.S.** In the United States, the top 10 percent of most expensive people account for nearly two-thirds – 64 percent – of all health spending (Table 1). Nearly one in four (24 percent) of the top 10 percent most costly patients are funded at least partly by Medicaid. Medicaid spending for all high-cost cases in the community accounts for 12 percent of their total cost and equals nearly $63 billion. To put this in perspective, the number of high-cost people receiving Medicaid payment for care (7 million) is

over 30 times higher than coverage in high-risk pools (181,441 in 2004).[21] These data actually understate Medicaid's role since they do include nursing home residents, who are disproportionately covered by Medicaid.

## POLICY IMPLICATIONS

These data raise a number of important questions about Medicaid cost containment policies currently under consideration. The Bush administration,[22] the Congressional Budget Office,[23] the National Governors' Association,[24] and the National Academy for State Health Policy [25] have all presented options for containing Medicaid spending. Common among these options are two that are potentially problematic for high-cost Medicaid cases and the providers that treat them: (1) increasing copayment requirements, and (2) reducing the scope of covered benefits for certain populations.

**Increasing Copayments.** Under current law, states have the option of imposing "nominal" copayments on certain services for certain populations. For example, states may impose a $3 copayment on each prescription filled for an adult disabled Medicaid beneficiary. The copayments must be "nominal" in amount and may not be applied to certain populations – e.g., children – and certain types of services – e.g., services related to pregnancy. If a beneficiary is unable to pay a required copayment at the point of service, the provider may not refuse to furnish the service.[26] The National Governors' Association, among others, has requested that states be given greater discretion to establish (where appropriate) enforceable copayment requirements in order to use "market forces and personal responsibility to improve health care delivery."[27]

The purpose of copayment requirements is to reduce the use of medical services. As demonstrated by the multi-year, multi-million-dollar Rand Experiment in the 1970s, copayments are highly effective in reducing the use of health care services by low-income individuals, whether those services are medically necessary or not.[28] If current Medicaid policy is changed to allow states to increase copayments, and if state Medicaid programs impose higher copayments on hospital and home health services and prescription drugs, the high-cost individuals who now use those services will face the highest financial burdens. Will these individuals be able to afford the copayments? If not, will their treating providers withhold services, or will their pharmacists refuse to fill their prescriptions? If so, what effects will the reduction in the use of services have on the health status of this high-cost population? If the treating providers do not withhold services, what effect will the loss of copayment revenues have on the accessibility and

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[21] Council on Affordable Health Insurance. *High Risk Health Insurance Plans:* November 2004.
[22] OMB, *Budget of the United States*, 2005.
[23] Congressional Budget Office, *Budget Options*, Washington, DC: CBO, February 2005.
[24] National Governors Association (NGA), *Policy Position EC-16: Medicaid Reform Policy*, June 1, 2005.
[25] National Academy for State Health Policy, *Making Medicaid Work for the 21st Century*, January 2005.
[26] Schneider et al., *The Medicaid Resource Book*, Kaiser Commission on Medicaid and the Uninsured, July 2002.
[27] NGA *EC-16, 16.2.3*, June 2005.
[28] Newhouse, *Free For All? Lessons from the Rand Health Insurance Experiment*, Cambridge: Harvard University Press, 1996. See also Artiga and O'Malley, *Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences*, Kaiser Commission on Medicaid and the Uninsured, May 2005 and Ku, *The Effects of Increasing Cost-Sharing in Medicaid: A Summary of Research Findings*, Center on Budget and Policy Priorities, May 31, 2005.

quality of services furnished by the providers? Can higher copayments even affect the use of non-discretionary services such as hospitalizations and home health visits?

**Reducing the Scope of Covered Benefits.** Under current Medicaid law, states that elect to participate in the program are required to cover certain medically necessary services for certain populations. For example, most adult Medicaid populations, whether disabled or elderly or parents with dependent children, are entitled to the following benefits when medically necessary: inpatient and outpatient hospital care; physician services; laboratory and x-ray services; ambulatory care furnished by a rural health clinic or a federally qualified health center; nursing facility services; family planning services and supplies; and services furnished by a nurse-midwife or nurse practitioner. (Prescription drugs, among other benefits, are commonly offered at state option.) If an individual does not need a service, the program does not pay for it. For example, if a disabled individual is able to live in the community and does not require nursing facility services, Medicaid does not pay for nursing facility care on behalf of the individual.[29]

One cost containment option under consideration is to allow states' Medicaid programs to reduce this benefit package for certain populations. For example, the 1115 demonstration waiver currently operated by Utah does not cover inpatient or outpatient hospital services for certain populations.[30] If the current minimum benefits requirements are scaled back or repealed, what are the implications for high-cost Medicaid populations? The data reviewed in this paper suggest that these individuals are heavy users of hospital services, home health care, and prescription drug services. If states are allowed to drop coverage for these services, will such reductions apply to high-cost individuals, where the savings will be the greatest? If they target the high-cost individuals, how will the treating providers whose services are no longer covered respond? Will they discontinue treatment or will they continue to furnish services on an uncompensated basis? If states choose to protect the high-cost individuals and instead target those individuals who are not frequent users, how many types of services will they have to cut in order to achieve the budgetary savings that they need?

**Medical Management.** A policy alternative to higher cost-sharing or reduced benefits is better medical management of high-cost cases. Analysts in Georgia[31] and Washington[32] have recommended that their state Medicaid programs focus case management on high-cost Medicaid beneficiaries or on beneficiaries with conditions that are associated high Medicaid expenses, such as asthma, diabetes, and heart failure. In a letter to state Medicaid directors, CMS has clarified the circumstances under which federal matching funds are available for disease management.[33] A number of states have implemented disease management programs that target high-cost Medicaid beneficiaries, such as high-cost individuals with schizophrenia and other mental health conditions.[34] While it seems plausible that medical management of high-cost

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[29] Schneider et al., *Medicaid Resource Book*, July 2002.

[30] Artiga and Mann, *New Directions for Medicaid Section 1115 Waivers: Policy Implications of Recent Waiver Activity*, Kaiser Commission on Medicaid and the Uninsured, March 2005.

[31] Minyard and Gardner, *"…1% of Medicaid Members Generate 23% of Expenditures…" An Argument for Case Management*, Georgia Health Policy Center, October 2003.

[32] Lerch and Mayfield, *High-Cost Medicaid Clients*, December 2000.

[33] Letter from D. Smith, Center for Medicaid and State Operations to State Medicaid Directors, SMDL #04-002, February 25, 2004.

[34] Gelber and Dougherty, *Disease Management for Chronic Behavioral Health and Substance Use Disorders*, Center of Health Care Strategies, Inc., February 2005, 17-23.

Medicaid beneficiaries can reduce overall Medicaid expenditures, there is no good evidence at this time on the magnitude of such savings.[35] There is little doubt, however, that medical management is far more likely to improve the quality of care and health outcomes for high-cost Medicaid beneficiaries than raising cost-sharing or reducing benefits.

## *APPENDIX*

The data used for this analysis come from the 2002 Medical Expenditure Panel Survey (MEPS).[36] This is a nationally representative, longitudinal survey that collects health, spending, socio-demographic, and other information on the non-institutionalized, civilian population in the U.S. Its Household Component collects information through several rounds of interviews. It is cosponsored by the Agency for Healthcare Research and Quality (AHRQ) and the National Center for Health Statistics. MEPS tabulations used in this analysis were produced by the Actuarial Research Corporation.

Exclusion of institutionalized individuals. The 2002 MEPS does not capture information on people residing in nursing facilities or other institutions. Thus, this analysis addresses only Medicaid spending in relation to individuals living in the community. In federal fiscal year 2002, fully one-fourth (27 percent) of Medicaid benefit spending was for nursing facilities, intermediate care facilities for the mentally retarded, and mental health institutions.[37] Because Medicaid is the largest single payer of nursing home care, the results presented here understate its role as a payer for Americans with the highest medical expenditures.

"High-cost cases." We identified high-cost cases within two groups: among the total population (all non-institutionalized people), and among people who at any point in the year reported being on Medicaid. For the analysis of the total population, we ranked individuals in descending order by their total medical spending. In MEPS, total spending includes total payments from all sources (including individuals, private insurance, Medicare, and Medicaid) to hospitals, physicians, other health providers, and pharmacies. For the analysis specific to Medicaid, we ranked individuals in descending order by Medicaid payments for such services. "High cost" throughout this paper refers to people whose spending is in the top 10 percent of the distribution of Medicaid spending for all people enrolled in Medicaid. The threshold for the top 10 percent of most costly people was $7,700 in 2002. Because we focused only on Medicaid spending, some individuals – specifically those who are also eligible for Medicare – may have total medical spending significantly higher than their Medicaid spending and thus may not be included in the top Medicaid spending brackets. Because policymakers are currently concerned only about Medicaid spending rather than Medicare or total health spending, we decided that this would be of most relevance to the debate.

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[35] A CBO review of published studies concluded that, with respect to disease management programs for congestive heart failure, coronary artery disease, and diabetes mellitus, "there is insufficient evidence to conclude that disease management programs can generally reduce the overall cost of health services." Congressional Budget Office, *An Analysis of the Literature on Disease Management Programs*, October 13, 2004.

[36] For a full description of MEPS, see http://www.meps.ahrq.gov/WhatIsMEPS/Overview.HTM

[37] J. Holahan and B. Bruen. *Medicaid Spending: What Contributed to the Growth Between 2000 and 2002?* Kaiser Commission on Medicaid and the Uninsured, September 2003.

Throughout the analysis, we define "high-cost case" as individuals whose spending is in the top 10 percent of the distribution. There is no common definition of what constitutes a high-cost case in the research literature. We chose 10 percent to ensure a sufficiently large analytic sample to describe them accurately in addition to the fact that this group generates a large share of total spending and thus is of interest to policymakers.

Characteristics. We generally used the information easily available through the survey. We chose health conditions as examples of potentially expensive but manageable chronic illnesses. The survey asked adults only about certain health conditions, such as heart disease and emphysema. These disease categories are not exclusive; a person with both arthritis and a heart condition is therefore counted twice. Income is assessed using family income. Rural/ urban residency is based on metropolitan statistical areas.

Limitations. The analysis presented here has several limitations. It is based on a relatively small number of people (730 records in the MEPS 2002 unweighted sample); it excludes a key group of high-cost beneficiaries (those in institutions); and it does not provide detail about the nature of the health problems facing high-cost beneficiaries. In addition, the analysis is done at the national level. Given the substantial variation from state to state in Medicaid eligibility, benefits, and provider payment rates, the results are not directly applicable to any specific state.

**Table 1. High-Cost People Among the Non-Institutionalized Population in the U.S., 2002**

| | People | | Spending | |
|---|---|---|---|---|
| | Millions | Percent | $ in Billions | Percent |
| **Total Population** | 288.2 | 100% | 810.7 | 100% |
| Top 5% of People in Spending | 14.4 | 5% | 394.5 | 49% |
| Top 10% of People in Spending | 28.8 | 10% | 516.1 | 64% |
| Top 20% of People in Spending | 57.5 | 20% | 646.9 | 80% |
| **Within Top 10%:** | | | | |
| Some Medicaid Payment | 7.0 | 24% | 62.9 | 12% |
| **Ever in Medicaid/Medicaid Spending** | 42.1 | 100% | 84.4 | 100% |
| Top 5% of People in Spending | 2.1 | 5% | 48.0 | 57% |
| Top 10% of People in Spending | 4.2 | 10% | 61.1 | 72% |
| Top 20% of People in Spending | 8.4 | 20% | 74.1 | 88% |

Data from 2002 Medical Expenditure Panel Survey (MEPS) as produced by Actuarial Research Corporation.
"Top x%" refers to the group of individuals whose total spending or Medicaid spending, when arrayed in order from highest to lowest, falls into that percentile.
Note: Because the top 10% of high-cost cases in the general population is 28.8 million, there are more people paid for by Medicaid in this group (7 million) than the top 10% of enrollees when considering only Medicaid (4.2 million).
Medicaid spending includes Federal and State spending; for calendar year 2002.

**Table 2. Medicaid Spending for Non-Institutionalized, Medicaid High-Cost Beneficiaries, 2002**

| | Top 10% | | Bottom 90% | |
|---|---|---|---|---|
| | $ in Billions | Percent | $ in Billions | Percent |
| **Total Medicaid Spending** | 61.1 | 100% | 23.2 | 100% |
| Hospital | 24.2 | 40% | 4.5 | 19% |
| Home Health | 14.7 | 24% | 0.5 | 2% |
| Prescription Drugs | 11.0 | 18% | 7.8 | 34% |
| Physicians | 8.5 | 14% | 6.7 | 29% |

Data from 2002 Medical Expenditure Panel Survey (MEPS) as produced by Actuarial Research Corporation.
Top 10% includes the 4.2 million people ever on Medicaid in 2002 with the highest Medicaid spending.
Medicaid spending includes Federal and State spending; for calendar year 2002.
Note: Some service categories not shown; as such, sum of services is less than the total.

**Table 3. Characteristics of Non-Institutionalized, Medicaid High-Cost Beneficiaries, 2002**

| | Top 10% | | Bottom 90% | |
|---|---|---|---|---|
| | **Millions** | **Percent** | **Millions** | **Percent** |
| **Total** | 4.2 | 100% | 37.9 | 100% |
| **Health Condition / Use** | | | | |
| Diabetes | 0.8 | 19% | 1.5 | 4% |
| Asthma | 1.1 | 25% | 4.7 | 12% |
| High Blood Pressure (adults) | 1.6 | 38% | 4.1 | 11% |
| Heart Disease (adults) | 1.2 | 28% | 2.1 | 6% |
| Emphysema (adults) | 0.3 | 7% | 0.3 | 1% |
| Arthritis (adults) | 1.7 | 41% | 3.8 | 10% |
| Pregnancy | 0.6 | 14% | 1.6 | 4% |
| Hospitalized during the year | 2.4 | 56% | 2.5 | 7% |
| **Medicare-Medicaid Dual Eligibles** | 1.3 | 31% | 4.9 | 13% |
| **Socio-Demographic Characteristics** | | | | |
| Age | | | | |
| 0-20 years | 0.7 | 18% | 24.2 | 64% |
| 21-64 years | 2.7 | 64% | 10.8 | 28% |
| 65+ years | 0.8 | 18% | 2.9 | 8% |
| Male | 1.3 | 30% | 16.7 | 44% |
| Female | 3.0 | 70% | 21.2 | 56% |
| Non-Hispanic white | 2.2 | 52% | 15.8 | 42% |
| Non-Hispanic non-white | 1.2 | 28% | 12.6 | 33% |
| Hispanic | 0.9 | 20% | 9.6 | 25% |
| Rural (non-MSA) | 1.2 | 28% | 7.8 | 21% |
| Urban (MSA) | 3.0 | 72% | 30.1 | 79% |
| Poor | 2.1 | 50% | 16.7 | 44% |
| Non-Poor | 2.1 | 50% | 21.2 | 56% |

Data from 2002 Medical Expenditure Panel Survey (MEPS) as produced by Actuarial Research Corporation.
Poverty based on family income; dual eligibles defined as having had Medicare for part of year.
Note: Compenents may not sum to total and percents may differ than calculations due to rounded numbers.

**Andy Schneider** has over 30 years of experience with the Medicaid program - as a consultant, as a congressional staffer, and as a public interest and legal services lawyer. Currently, Schneider is a Principal with Medicaid Policy, LLC, which he founded in January 2000. Based in Washington, D.C., this consulting firm specializes in Medicaid issues affecting program beneficiaries, state agencies, providers, and managed care organizations. Schneider is also an Adjunct Professor at the George Washington University School of Public Health & Health Services. From 1979 through 1994, he served as Counsel to the Subcommittee on Health and the Environment of the House Commerce Committee. Schneider's primary responsibility was Medicaid, over which the Subcommittee had exclusive legislative jurisdiction in the House. In 1995 and 1996, he served as Policy Advisor for Medicaid to the House Democratic Policy Committee within the Office of Minority Leader Richard Gephardt (D-MO). During his tenure on the Hill, Schneider staffed Medicaid issues on ten Budget Reconciliation acts, the 1988 Medicare Catastrophic legislation, and the 1991 Medicaid Provider Donations and Taxes legislation.

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