Effect of SSI on Medicaid Caseloads and Expenditures

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The 1972 Social Security Amendments replaced the Federal-State public assistance programs for the needy aged, blind, and disabled with the Federal supplemental security income (SSI) program. They also changed the automatic Medicaid eligibility provision under title XIX of the Social Security Act for the cash assistance population. This article provides information about recent changes in State Medicaid caseloads and payments following implementation of SSI and the possible effects of SSI on such changes. It does not appear that SSI was a significant factor in the Medicaid changes. The growth in Medicaid payments resulted primarily from expansion of medical services to include care in intermediate-care facilities, inflation, and higher utilization of medical services.

Congress and the various State government agencies (particularly those concerned with welfare and health) anticipated that implementation of the supplemental security income (SSI) program would greatly increase the number of persons eligible for medical assistance under title XIX (Medicaid) of the Social Security Act and the amount of expenditures for that program. Although both Medicaid expenditures and the number of cash assistance recipients have increased since the SSI program began, SSI has not had the impact on Medicaid costs originally anticipated.

Many factors have contributed to the continued increase in Medicaid expenditures during the 2 years following SSI. Factors other than increases in the number of cash assistance recipients may have significantly influenced the rising Medicaid costs.

Inflation contributed substantially to the growth in Medicaid expenditures. From 1973 to 1975, the medical care component of the Consumer Price Index (CPI) increased by 22.4 percent, compared with only 7.3 percent from 1971 to 1973: medical care prices were rising three times faster after SSI began. Changes in the Medicare program—raising the supplementary medical insurance (SMI) deductible to $60 in 1973—and expansion of health service coverage by some States after SSI began also resulted in higher Medicaid costs.

Conversely, while these factors were operating to increase the costs under Medicaid, other factors were operating or being implemented to reduce costs. First, the anticipated growth in the cash assistance caseload (6 million) did not develop during the first 2 years of SSI. The lower actual number (4 million) in December 1975 reduced the number of potential cash assistance Medicaid eligibles by 1.6 million persons. Second, many of the new SSI eligibles had been eligible for health care services under Medicaid before SSI. In a number of States, health care was furnished to the "medically needy"—individuals with enough income to pay for their basic living expenses but not enough to pay for their health care needs. Some States that applied eligibility factors based on their January 1972 medical assistance standards were using more restrictive Medicaid eligibility criteria for the SSI population.

The purpose of this article is twofold: (1) to analyze the available Medicaid data in conjunction with the maintenance-assistance income data both before and after implementation of SSI and (2) to provide some information regarding the effects of SSI on Medicaid for the Nation as well as the individual State programs. Whenever possible the data presented here cover the 5-year period January 1971–December 1975. In some instances, however, the data do not cover the entire period either because data were not available on a fiscal-year or calendar-year basis and/or because the data base was changed during the period. The findings of this article may, therefore, not be entirely con-

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clusive with respect to the effects of SSI on some State Medicaid programs. This article will, however, provide information on the impact of other factors for reviewing or analyzing the growth in Medicaid since the beginning of SSI.

Background

The establishment of the SSI program resulted in significant changes in the eligibility criteria under Medicaid. Before January 1, 1974, each State was required to provide medical assistance to all persons receiving money payments under the Federal grants-in-aid programs. The State agency that determined eligibility for these programs also determined the eligibility for Medicaid. In addition, States had the option of providing medical assistance to: (1) Persons eligible for cash assistance who were not actually receiving a payment, or persons who would receive a payment except that they were residents in a medical institution and (2) persons who would be eligible for cash assistance except that the level of their income and resources exceeded the State payment standards. States still have these options.

Before implementation of SSI, it was believed that many States would incur a financial burden in their Medicaid program if they were required to cover automatically all persons eligible for cash assistance under SSI. Consequently, on the assumption that the numbers of aged, blind, and disabled recipients would nearly double following implementation of SSI, the Social Security Amendments of 1972 included a provision that gave States the option of restricting Medicaid coverage. Under this provision not all recipients of cash assistance under SSI are automatically eligible for medical assistance. A State may limit coverage by applying any eligibility factor from its January 1972 medical assistance standard that was more restrictive than the eligibility conditions established for SSI. A State that limits coverage for aged, blind, and disabled persons with incomes above the 1972 standards deducts medical expenses from income in determining eligibility. More specifically, States may limit eligibility by applying: (1) A lower income standard, (2) a less generous income disregard, (3) a lower resource standard, (4) a more restrictive definition of disability, (5) any other limiting factor in their January 1972 medical assistance standards, or (6) any combination of the above factors.

Although the scope of coverage for Medicaid may be limited, certain services must be covered under a State Medicaid program: (1) inpatient hospital care, (2) outpatient hospital care, (3) other laboratory and X-ray services, (4) skilled-nursing facilities, (5) early and periodic screening, (6) physicians' services, and (7) home health care services.

Within limits, where State options are permitted, alterations can be made in Medicaid programs without Federal approval. Such alterations can reflect shifting administrative and/or legislative policy—the desire to expand or reduce the State program, for example, or to provide temporary fiscal relief.

Thirty-five of the 50 States with Medicaid programs [1] use the criteria in title XVI of the Social Security Act (supplemental security income for the aged, blind, and disabled) for determining eligibility for Medicaid. Of this total, 27 States elected to have the Social Security Administration make their Medicaid determinations and eight States make these determinations themselves.[2]

If the Social Security Administration makes the determination, it is done in conjunction with any determination that affects eligibility under SSI. Medicaid eligibility is dependent upon SSI eligibility status for either the Federal SSI payment or the federally administered State supplement. If the Social Security Administration determines that a person is ineligible for an SSI payment or a federally administered State supplement, however, it does not make a determination on Medicaid eligibility because some persons may qualify on an alternative basis under a State Medicaid program. In these cases, the State is notified that an individual is ineligible for an SSI payment or State supplementation —along with the reasons for ineligibility—and the State makes the Medicaid determination.

In 15 States [3] the criteria used in determining eligibility for Medicaid are somewhat more restrictive than those under title XVI. States that do not use title XVI criteria for Medicaid eligibility make the determinations themselves.

Newly eligible SSI recipients are not automatically eligible for medical assistance in these States as they were under the former public assistance programs. If a State elects to limit Medicaid eligibility by using any factor that is more restrictive than the comparable SSI factor, it must provide Medicaid coverage to individuals for whom the more restrictive criteria apply. These individuals must meet the more restrictive cri-

[1] Arizona has no Medicaid program.

[2] The Social Security Administration makes the determination in Alabama, Arkansas, California, Delaware, the District of Columbia, Florida, Georgia, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Montana, New Jersey, New Mexico, New York, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, West Virginia, Wisconsin, and Wyoming. The State makes the determination in Alaska, Idaho, Kansas, Michigan, Nevada, North Dakota, Oregon, and Washington.

[3] Colorado, Connecticut, Hawaii, Illinois, Indiana, Minnesota, Mississippi, Missouri, Nebraska, New Hampshire, North Carolina, Ohio, Oklahoma, Utah, and Virginia.

Table 1.— Average monthly number and percentage change in number of cash assistance and Medicaid recipients, by reason for eligibility, calendar years 1971–75

Year	Total		Aged		Blind		Disabled	
	Cash assistance	Medicaid	Cash assistance	Medicaid	Cash assistance	Medicaid	Cash assistance	Medicaid
	Average monthly number (in thousands)							
1971	3,139	2,467	2,055	1,690	80	47	1,004	731
1972	3,216	2,809	2,033	1,893	81	49	1,133	867
1973	3,147	2,820	1,852	1,861	78	48	1,217	912
1974	3,649	3,097	2,113	1,969	76	52	1,460	1,076
1975	4,258	3,277	2,360	2,030	75	47	1,823	1,200
	Percentage change from preceding year							
1972	2.4	13.8	−2.5	12.0	0.1	3.9	12.8	18.6
1973	−2.2	.4	−7.5	−1.7	−3.0	−2.3	7.4	5.2
1974	16.0	9.8	14.1	5.8	−2.3	9.5	20.0	18.0
1975	16.7	5.8	11.7	3.1	−1.6	−9.6	24.9	11.5

teria after incurred medical expenses are deducted from income (the "spend-down" provision [4]). Some SSI recipients may never become eligible for Medicaid through the spend-down process if the State uses certain other restrictions—a stricter definition of disability, for example.

Recipient Caseloads

Because of the general association of Medicaid eligibility to cash assistance status, increases in the number of cash assistance recipients would be expected to result in larger numbers of persons for whom medical bills are made. In addition, the need for medical care is greater since aging is directly related to the prevalence of chronic conditions and disabilities and most of the adult cash assistance population are aged 65 or older.[5] Consequently, the size of this cash assistance population has a direct relationship to utilization and costs of the Medicaid program.

Cash assistance. Before implementation of SSI, the caseloads for both the aged and the blind were declining, and the caseload for the disabled was continuing its steady growth, as table 1 shows. After SSI began, the caseloads for both the aged and disabled had relatively high growth rates: the former reversed its decreasing trend while the latter grew more rapidly. The caseload for the disabled was growing at such a rapid rate that, by 1975, it represented 43 percent of the total caseload for all categories, compared with 32 percent in 1971. On the other hand, the caseload for the blind continued its decline.

Medicaid. From 1971 to 1973 (excluding the disabled), the Medicaid caseload [6] continued to grow despite the limited growth in this cash assistance population. This growth was a result of greater utilization of services by all three eligibility categories—principally the aged. In addition, care in intermediate-care facilities (transferred from the cash assistance programs to Medicaid in January 1972), incurred the greatest increase in utilization. After SSI was implemented, the growth rate in the Medicaid population was greater than the earlier rate. The disabled category which had the fastest growing cash assistance caseload also had the fastest growing category for medical assistance.

When the annual unduplicated number of persons for whom one or more medical bills were paid under Medicaid is examined, a more dramatic change in growth is shown. The number receiving Medicaid rose from 18.0 million in 1971 to 22.1 million in 1975—a 23-percent increase. As table 2 shows, the rates of growth for these recipients were relatively small in 1973 and 1975. The Medicaid population experienced its largest gain in the 5-year period during 1974, the first year of SSI operations.

Although all categories of Medicaid recipients increased during that year, most of the rise was attributable to children under age 21 and adults in families receiving aid to families with dependent children (AFDC). From 1971 to 1973, the proportion of recipients represented by the adult categories dropped

[4] The "spend-down" is a process through which an individual not automatically eligible for Medicaid because his income is too high can nevertheless become eligible. The individual must first incur countable medical expenses in a total amount that, subtracted from income minus any SSI payment and any exclusions allowed under SSI, brings his remaining income below the State medical assistance standard.

[5] In December 1975, 60 percent of the adults receiving SSI were aged 65 or over and almost one-half of these were aged 75 or over.

[6] Number of recipients for whom one or more bills were paid under the Medicaid program.

Table 2.—Number of Medicaid recipients [1] and percentage change in number, by reason for eligibility, fiscal years 1971–75

Fiscal year	Total	Adults				Other [2]
		Total	Aged	Blind	Disabled	
	Number (in thousands)					
1971 [3]	17,965	5,981	4,076	135	1,770	11,984
1972	17,990	5,606	3,690	117	1,779	12,384
1973	18,818	5,484	3,549	102	1,843	13,324
1974	20,842	6,221	3,805	136	2,280	14,621
1975	22,104	6,505	3,878	120	2,507	15,599
	Percentage change from preceding year					
1972	0.1	−6.3	−9.5	−13.3	1.6	3.3
1973	4.6	−2.2	−3.5	−12.8	2.4	7.6
1974	10.7	13.4	7.2	33.3	23.7	9.7
1975	6.1	4.6	1.9	−13.3	10.0	6.7

[1] Refers to number of different persons who had at least some of their medical bills paid by Medicaid.
[2] Children under age 21 and adults receiving payments under aid to families with dependent children, here and in other tables.
[3] Includes some recipients who received aid under nonfederally matched medical assistance programs.

Table 3.—Amount and percentage distribution of Medicaid payments and percentage increase in payments, by reason for eligibility, fiscal years 1971–75

Year	Total	Adults				Other
		Total	Aged	Blind	Disabled	
	Amount (in millions)					
1971	$5,939	$2,945	$1,752	$41	$1,152	$2,995
1972	7,375	4,165	2,513	55	1,597	3,211
1973	8,810	5,380	3,273	66	2,041	3,430
1974	10,149	6,260	3,752	81	2,427	3,889
1975	12,318	7,588	4,632	86	2,870	4,730
	Percentage distribution					
1971	100.0	49.6	29.5	0.7	19.4	50.4
1972	100.0	56.5	34.1	.7	21.7	43.5
1973	100.0	61.1	37.2	.7	23.2	38.9
1974	100.0	61.7	37.0	.8	23.9	38.3
1975	100.0	61.6	37.6	.7	23.3	38.4
	Percentage increase from preceding year					
1972	24.2	41.4	43.4	34.1	38.6	7.2
1973	19.5	29.2	30.2	20.0	27.8	6.8
1974	15.2	16.4	14.6	22.7	18.9	13.4
1975	21.4	21.2	23.5	6.2	18.0	21.6

from 33 percent to 29 percent, while the percentage of children under age 21 and adults in AFDC families rose from 67 percent to 71 percent. Although the relative proportion represented by adult cash assistance recipients remained fairly constant from 1973 to 1975, within this population the percentage of aged declined slightly. That decline was offset by the increase in the disabled category.

Total Medicaid Expenditures

From 1971 to 1975, expenditures for Medicaid more than doubled, increasing from $5.9 billion to $12.3 billion (table 3). In 1971, Medicaid payments averaged $331 per recipient or $544.5 million per month; by 1975, these payments averaged $557 and $1,122.1 million, respectively (table 4). The rate of growth was greatest for 1971–72 (24 percent) primarily because of the shift of care in intermediate-care facilities to the Medicaid program. The growth rates from 1972 to 1973 and from 1973 to 1974 slowed down, possibly reflecting the effects of the price controls implemented in August 1971 under the economic stabilization program. With the removal of these controls in April 1974, the rate of growth began to accelerate, reaching a level for 1974–75 that was close to the growth rate at the beginning of the 5-year period. The cost increases in 1974–75 reflected a "catching up" after the removal of price controls.

Categories of eligibility. From 1971 to 1975, total Medicaid expenditures experienced increases for all eligibility categories. Although total payments made under each of the three SSI eligibility categories more than doubled during this period, the largest increase was for payments on behalf of persons aged 65 and over. The higher growth rates for the aged may be attributable to the costs of institutional services, which consumed the major share of health care expenditures for the aged.

Aged persons are more than four times as likely to have their activity limited by chronic health conditions than those under age 65.[7] The aged are thus more likely to require settings of the institutional type that are more costly than other services generally provided under State Medicaid programs.

The proportion of Medicaid payments on behalf of the aged contrasted sharply with cash assistance trends from 1972 to 1975 (table 5). Payments on behalf of the aged and disabled accounted for most of the rise in Medicaid expenditures although most of the growth in the number of cash assistance recipients was attributable primarily to children under age 21 and to adults in AFDC families. This fact suggests that the larger Medicaid expenditures for the aged and the disabled resulted from higher costs rather than growth in the numbers using services.

In addition, the proportion of these expenditures

[7] National Center for Health Statistics, **Limitation of Activity and Mobility Due to Chronic Conditions, United States, 1972** (Series 10, No. 96, Vital and Health Statistics), 1974, tables 25 and 26.

Table 4.—Average monthly amount of Medicaid payments and percentage change in payments, by money-payment status and reason for eligibility, calendar years 1971–75

Reason for eligibility	Amount (in thousands)					Percentage change from preceding year			
	1971	1972	1973	1974	1975	1972	1973	1974	1975
	All payments								
Total	$544,500	$676,667	$784,182	$912,919	$1,122,084	24.3	15.9	16.4	22.9
Adults	317,807	414,753	472,034	560,516	687,954	30.5	13.8	18.7	22.7
Aged	197,317	256,264	285,798	343,565	415,047	29.9	11.5	20.2	20.8
Blind	4,134	4,921	5,819	6,855	7,249	19.0	18.3	17.8	5.7
Disabled	116,356	153,568	180,417	210,096	265,658	32.0	17.5	16.5	26.4
Other	226,691	261,915	310,952	352,402	434,130	15.5	18.7	13.3	23.2
	Authorized								
Total	$308,938	$362,039	$413,072	$483,585	$591,969	17.2	14.1	17.1	22.4
Adults	138,686	179,424	201,377	230,070	289,334	29.4	12.2	14.3	25.8
Aged	59,302	76,018	79,750	93,711	117,813	28.2	4.9	17.5	25.7
Blind	3,179	3,668	4,115	4,566	4,652	15.4	12.2	11.0	1.9
Disabled	76,205	99,738	117,512	131,793	166,869	30.9	17.8	12.2	26.6
Other	170,253	182,614	211,694	253,515	302,635	7.3	15.9	19.8	20.7
	Not authorized								
Total	$235,065	$313,372	$369,914	$429,334	$518,242	33.3	18.0	16.1	20.7
Adults	178,700	234,072	270,656	330,447	398,417	31.0	15.6	22.1	20.6
Aged	137,634	179,223	206,048	249,854	297,234	30.2	15.0	21.3	19.0
Blind	952	1,252	1,704	2,290	2,394	47.0	36.1	34.4	4.5
Disabled	40,114	53,597	52,904	78,303	98,789	33.6	−1.3	48.0	26.2
Other	56,366	79,301	99,258	98,887	119,825	40.7	25.2	−.4	21.2

that went for the aged and the disabled was more than twice as large as the proportion they represent in the recipient population. This difference may reflect the fact that the aged and disabled required care at exceptionally higher cost and for much longer durations than did other recipients. It is interesting to note that the largest share of Medicaid payments was made on behalf of the aged despite Medicare's coverage of health care costs for this segment of the population. Medicaid, unlike Medicare, does provide extensive long term care.

More than two-fifths of these Medicaid payments were made on behalf of persons not receiving cash assistance—the majority of them aged 65 or over. Yet those not receiving cash payments represented only about one-fourth of Medicaid recipients.

Medicaid recipients who did not receive cash assistance during the period studied included two major groups: the medically needy and institutionalized persons. The first group consisted of those individuals who did not need assistance to meet their normal daily living expenses but were unable to pay high medical bills. Among the second group were persons residing in skilled-nursing homes, intermediate-care facilities, or general or mental hospitals where costs of care were expensive and lengths of stay generally were long. Some of these institutionalized persons were eligible for a nominal (maximum Federal SSI) cash payment of only $25 to cover the costs of personal care items. Since Medicaid eligibility depended on the fact that medical expenses are larger than the individual's income, these persons accounted for higher proportions of medical expenditures than their number in the recipient population would indicate.

Throughout the years 1972–75, institutional services [8] continued to be the primary service for which Medicaid payments were made. These services accounted for 70 cents of each Medicaid dollar spent.

Type of service. In 1972, payments for short term care in general hospitals represented nearly 40 percent of Medicaid expenditures and payments for long term institutional care—mental hospitals, skilled-nursing homes, and intermediate-care facilities—accounted for 30 percent (table 6). Beginning in 1973 the proportion for short term care rose. By 1975, the percentages for such care had reversed, that is, short term care comprised 30 percent of Medicaid payments while long term care represented 40 percent. This shift in the distribution of Medicaid expenditures reflected primarily a change in the scope of coverage. As noted previously, payments to intermediate-care facilities were defined as medical assistance (Medicaid) under title XIX, effective January 1, 1972. If payments to intermediate-care fa-

[8] Includes care in general and mental hospitals, skilled-nursing homes, and intermediate-care facilities.

Table 5.—Percentage distribution of average monthly amount of Medicaid payments, by money-payment status and reason for eligibility, calendar years 1971–75

Reason for eligibility	1971	1972	1973	1974	1975
	All payments				
Total	100.0	100.0	100.0	100.0	100.0
Adults	58.4	61.3	60.2	61.4	61.3
Aged	36.2	37.9	36.4	37.6	37.0
Blind	.8	.7	.7	.8	.6
Disabled	21.4	22.7	23.0	23.0	23.7
Other	41.6	38.7	39.7	38.6	38.7
	Authorized				
Total	56.7	53.5	52.7	53.0	52.3
Adults	25.5	26.5	25.7	25.2	25.8
Aged	10.9	11.2	10.2	10.3	10.5
Blind	.5	.5	.5	.5	.4
Disabled	14.0	14.7	15.0	14.4	14.9
Other	31.3	27.0	27.0	27.8	27.0
	Not authorized				
Total	43.2	46.3	47.2	47.0	46.2
Adults	32.8	34.6	34.5	36.2	35.5
Aged	25.3	26.5	26.3	27.4	26.5
Blind	.2	.2	.2	.2	.2
Disabled	7.3	7.9	8.0	8.6	8.8
Other	10.4	11.7	12.7	10.8	10.7

cilities were excluded, the rate of growth of Medicaid expenditures would appear somewhat slower, as the tabulation below illustrates.

Year	Total			
	Includes payments to intermediate-care facilities		Excludes payments to intermediate-care facilities	
	Amount (in millions)	Percentage increase from preceding year	Amount (in millions)	Percentage increase from preceding year
1971	$5,939	....	$5,939	....
1972	7,375	24.2	6,970	17.4
1973	8,810	19.5	7,648	9.7
1974	10,149	15.2	8,548	11.8
1975	12,318	21.4	10,139	18.6

For the remainder of the services, the distribution of Medicaid payments did not appear to change significantly from 1972 to 1975. Physicians' services accounted for 10 percent of all payments; prescribed drugs, 7 percent; dental services, 3 percent; and all other services, 10 percent.

Factors Influencing Medicaid Costs

The rising costs of Medicaid payments are attributable to a variety of factors. These factors include (1) changes in prices of medical services and goods, (2) changes in the size and age distribution of recipient caseloads, (3) changes in the composition of the services and goods provided, and (4) changes in utilization of services.

Recipient changes in the period can be partially documented and measured through data collected by

Table 6.—Amount and percentage distribution of Medicaid payments, by type of service and reason for eligibility, fiscal years 1972–75 [1]

Type of service	Total	Adults			Other
		Aged	Blind	Disabled	
	1972				
Total amount (in millions)	$7,375	$2,513	$55	$1,597	$3,211
Total percent	100.0	34.1	0.9	21.6	43.4
Inpatient hospital	39.9	4.7	.2	10.6	24.2
General	38.2	3.2	.2	10.5	24.2
Mental	1.7	1.5	(2)	.1	.1
Skilled-nursing facilities	24.1	19.1	.2	4.1	.7
Intermediate-care facilities [3]	5.5	3.9	.1	1.4	.1
Physicians'	10.9	1.5	.1	1.9	7.4
Prescribed drugs	7.4	3.1	.1	1.5	2.8
Dental	2.5	.3	(2)	.3	2.0
Outpatient hospital	5.2	.4	(2)	1.0	3.7
Laboratory	1.1	.1	(2)	.2	.8
Clinic	.6	(2)	(2)	.1	.4
Other	2.8	1.0	(2)	.5	1.2
	1973				
Total amount (in millions)	$8,810	$3,273	$66	$2,401	$3,430
Total percent	100.0	37.2	0.7	23.2	38.9
Inpatient hospital	35.3	4.4	.2	9.5	21.2
General	33.3	2.9	.2	9.0	21.2
Mental	2.0	1.5	(2)	.5	(2)
Skilled-nursing facilities	21.0	16.6	.2	3.9	.3
Intermediate-care facilities	13.2	9.5	.1	3.3	.3
Physicians'	10.8	1.8	.1	2.4	6.6
Prescribed drugs	7.0	3.7	.1	1.8	1.4
Dental	2.4	.3	(2)	.3	1.8
Outpatient hospital	2.8	.2	(2)	1.0	1.6
Laboratory	1.3	.2	(2)	.2	.9
Clinic	2.8	(2)	(2)	.1	2.6
Other	3.4	.5	(2)	.6	2.3
	1974				
Total amount (in millions)	$10,149	$3,752	$81	$2,427	$3,889
Total percent	100.0	37.0	0.8	23.9	38.3
Inpatient hospital	33.5	3.3	.2	9.4	20.7
General	31.5	1.9	.2	8.9	20.6
Mental	2.0	1.4	(2)	.5	.1
Skilled-nursing facilities	20.0	14.9	.2	4.5	.3
Intermediate-care facilities	15.8	12.2	.1	3.0	.4
Physicians'	10.7	1.6	.1	2.4	6.6
Prescribed drugs	7.0	3.5	.1	1.9	1.5
Dental	2.6	.2	(2)	.3	2.0
Outpatient	2.9	.4	(2)	1.2	1.3
Laboratory	1.3	.2	(2)	.3	.9
Clinic	2.9	(2)	(2)	.2	2.6
Other	3.5	.6	(2)	.8	2.0

Table 6.—Amount and percentage distribution of Medicaid payments, by type of service and reason for eligibility, fiscal years 1972–75—**Continued**

Type of service	Total	Adults			Other
		Aged	Blind	Disabled	
	1975				
Total amount (in millions)	$12,318	$4,632	$86	$2,870	$4,730
Total percent	100.0	37.6	0.7	23.3	38.4
Inpatient hospital	31.8	3.1	.2	8.5	20.0
General	29.9	1.9	.2	7.9	19.9
Mental	1.9	1.2	(2)	.6	.1
Skilled-nursing facilities	20.1	14.8	.2	4.5	.6
Intermediate-care facilities	17.7	13.7	.1	3.3	.6
Physicians'	10.0	1.5	.1	2.2	6.2
Prescribed drugs	6.6	3.0	.1	1.9	1.7
Dental	2.8	.2	(2)	.4	2.2
Outpatient hospital	2.8	.2	(2)	1.3	1.2
Laboratory	1.7	.2	(2)	.3	1.2
Clinic	3.2	(2)	(2)	.2	3.0
Other	3.3	.6	(2)	.8	2.0

[1] Partly estimated.
[2] Less than 0.05 percent.
[3] Beginning Jan. 1, 1972, intermediate-care facility payments were defined as medical assistance payments under title XIX (Medicaid) of the Social Security Act.

the Social and Rehabilitation Service until March 1977. The Consumer Price Index (CPI) of the Bureau of Labor Statistics provides a suitable measure of price changes. The other factors responsible for increases in expenditures for Medicaid, however, are somewhat difficult to measure and to conceptualize.

Alterations in medical technology and treatment facilities affect utilization as well as access to medical care and services. Greater utilization of various medical services with a potential for an increased number of malpractice suits may lead to further increases in prices. Since all these factors affect price increases and cannot be easily isolated, they are combined and designated "changes in the health care system."

As table 7 indicates, the influence of the above factors on increases in Medicaid expenditures has changed significantly during the period 1971–75. The percentage increase in expenditures attributable to growth in the number of recipients was negligible from 1971 to 1972. Prices accounted for 19 percent of the $1.4 billion rise in these expenditures, and changes in the health care system accounted for most (81 percent) of the increase.

The percentage increases from 1972 to 1973 resulting from these factors were: the health care system, 79 percent; prices, 16 percent; and size of recipient caseload, 5 percent. The sizable growth in Medicaid expenditures—both from 1971 to 1972 and from 1972 to 1973—was attributable to changes in the health care system, including the shift of the intermediate-care facilities program to Medicaid.

Significantly larger proportions of the increases in Medicaid expenditures were attributable to price changes from 1973 to 1974 and from 1974 to 1975. Such changes accounted for almost two-fifths of the $1.3 billion increase for 1973–74 and nearly three-fifths of the $2.2 billion for 1974–75. These increases reflected primarily removal of the price controls for medical care instituted under the economic stabilization program that were effective from August 1971–April 1974.

Changes in Medicare Program

Legislative changes in the Medicare program generally influence or contribute to fluctuations within the program. Expansion of covered services usually reduces the Medicaid costs but other changes tend to raise them. Most of the elderly received major portions of their health care under Medicare. Nearly one-fifth of them have had Medicaid payments made on their behalf to supplement their Medicare benefits.

Factors reducing Medicaid costs. The Social Security Amendments of 1972 eliminated the 20-percent coinsurance for SMI coverage of home health services furnished on or after January 1, 1973. That law also extended, beginning July 1973, Medicare protection to certain persons receiving social security benefits based on disability or end-stage renal disease.

In addition, the level-of-care requirement under Medicare for skilled-nursing homes was amended to broaden the criteria relating to skilled-nursing services so that certain persons who formerly had such services covered under Medicaid now had them covered under Medicare.

Factors raising Medicaid costs. In 1973, the SMI deductible under Medicare was raised from $50 to $60

Table 7.—Amount of increase and percentage distribution of Medicaid payments, by reason for increase, fiscal years 1971–75

Reason for increase	1971–72	1972–73	1973–74	1974–75
	Amount of increase (in millions)			
Total	$1,436	$1,435	$1,339	$2,169
Increase in—				
Prices	279	229	502	1,269
Number of recipients	2	66	144	131
Change in health care system	1,155	1,140	693	769
	Percentage distribution			
Total	100.0	100.0	100.0	100.0
Increase in—				
Prices	19.4	16.0	37.5	58.5
Number of recipients	.1	4.6	10.8	6.0
Change in health care system	80.5	79.4	51.7	35.5

with consequently larger expenditures for the Medicaid aged and disabled population. An even more important influence has been the decline in the proportion of claims for which physicians have accepted assignment under Medicare. Physicians who do not accept assignment may bill the patient or the Medicaid agency for Medicaid recipients for more than Medicare's "reasonable charges." In fiscal year 1969 the net assignment rate (excluding hospital-based physicians) was 61 percent. In 1974, it had declined to 52 percent. As a result, a greater portion of total charges for Medicaid recipients was met through Medicaid and a smaller proportion by Medicare.

During the past several years, only about 3 percent of all nursing-home expenditures have been paid by Medicare.[9] By contrast, in 1968—toward the beginning of the program and before controls on the use of skilled-nursing facilities were tightened—that program covered 16 percent of total outlays for care of the aged in nursing homes. Medicare does not pay for dental care, out-of-hospital prescribed drugs, or eyeglasses. Because of these program limitations, its share in the financing of total health care for the aged has not kept pace with the advance of its share of financing hospital and medical services.

Changes in State Medicaid Programs

Under the 1972 amendments, States may impose certain cost sharing requirements under their Medicaid program. The law specifies that no cost sharing can be imposed on the mandatory services for cash assistance recipients. The States are allowed, however, to impose "nominal" cost sharing requirements on optional services for cash assistance and on all services for the medically needy. Eight States [10] imposed cost sharing under their programs. Most of these States required a copayment of 50 cents per prescription.

These cost sharing requirements are intended to curtail costs and to discourage overutilization of medical services. To what extent these requirements function as a deterrent to the use of unnecessary services or result in underutilization of needed services is unknown. Some Medicare studies have shown that deductible and coinsurance provisions affect the demand for medical services: (1) utilization of physicians' services is higher among enrollees for whom deductible and coinsurance requirements involve little or no out-of-pocket cost and (2) utilization is reduced after some form of cost sharing has been introduced.

[9] Marjorie Smith Mueller and Robert Gibson, "Age Differences in Health Care Spending, Fiscal Year 1975," **Social Security Bulletin,** June 1976.

[10] Alabama, Arkansas, Georgia, Maryland, Montana, New Jersey, North Carolina, and Virginia.

Other Legislative Changes

Enactment of P.L. 94–48, on July 1, 1975, protects the Medicaid eligibility of persons who qualified both for cash assistance and for Medicaid in August 1972 but who lost their eligibility because their income went up when the 20-percent increase in social security became effective in 1972. Earlier legislation had provided for disregarding the social security increase in determining Medicaid eligibility until October 1974 (later extended to July 1975). The new law extends the "disregard" provision for SSI recipients indefinitely.

State Variations

To facilitate data analyses of the impact of SSI on individual State Medicaid programs, the States were divided, by type of Medicaid coverage provision, into three major groups:

Providing coverage to all SSI recipients and to medically needy

Arkansas
California
District of Columbia
Kansas
Kentucky
Maine
Maryland
Massachusetts
Michigan
Montana
New York
North Dakota
Pennsylvania
Rhode Island
Tennessee
Vermont
Washington
West Virginia
Wisconsin

Providing coverage to SSI recipients only

Alabama
Alaska
Delaware
Florida
Georgia
Idaho
Iowa
Louisiana
Nevada
New Jersey
New Mexico
Oregon
South Carolina
South Dakota
Texas
Wyoming

Restricting coverage

Colorado
Connecticut
Hawaii
Illinois
Indiana
Minnesota
Mississippi
Missouri
Nebraska
New Hampshire
North Carolina
Ohio
Oklahoma
Utah
Virginia

States Aiding All SSI Recipients and Medically Needy

Because this group of States did not have homogeneous payment standards, it was further divided into two subgroups: (1) States with a relatively high as-

sistance payment standard[11] and (2) States with relatively low assistance payment standard.[12]

Recipients. For the 11 States with relatively high standards, it was assumed that the introduction of the SSI program would have a limited effect on the cash assistance caseload, as well as on the State Medicaid program.

Assistance payment standards for these States were higher than those for SSI payments. Most or nearly all of the persons eligible for SSI therefore had already been receiving aid under the former grants-in-aid programs and were also eligible for Medicaid. Consequently, any substantial increase in the Medicaid caseloads would result from greater utilization of medical services by persons already eligible for such services before implementation of SSI. Except for Wisconsin and Maine, changes in the Medicaid caseloads were modest for the States in this group although some significant increases occurred in the cash assistance caseloads (table 8).

For Wisconsin, the growth in the Medicaid caseload appeared to be greatly influenced by the tremendous increase in the numbers of persons receiving cash assistance under SSI. In that State after SSI began, large numbers of persons in institutions for the mentally retarded not previously eligible for income-support payments were subsequently determined eligible for SSI payments. Part of the growth in the cash assistance population, moreover, may have resulted from eliminating lien provisions that had been imposed by the State under the former public assistance programs. For Maine, however, the growth in the Medicaid caseload appeared to be affected more by greater utilization of services than by significant increases in the cash assistance caseload.

In contrast, for the eight States that had relatively low payment standards, it was assumed that implementation of SSI would result in increases in the numbers of both cash assistance and Medicaid recipients. This assumption was made because the SSI payment standards were higher than those for the former grants-in-aid programs in these States. Consequently, the number of persons eligible for assistance under SSI would be expected to be larger. The data seem to support this assumption.

For Arkansas, much of the increase in the Medicaid population resulted from changes in the State Medicaid program itself. In 1974, that State expanded the services covered by Medicaid to include prescribed drugs. This expansion probably accounted for the substantial rises in the number of Medicaid recipients as well as in expenditures during that year.

Table 8.—States that aid all SSI and the medically needy: Percentage change in number of recipients and payments, by type of payment standard and State[1]

State (ranked by percentage change in Medicaid caseload)	Percentage change, 1975 from 1973		
	Number of recipients		Medicaid payments
	Medicaid	Cash assistance	
	With high-payment standards		
Wisconsin	49.6	140.0	133.0
Maine	44.4	29.6	33.9
Washington	13.3	17.7	21.1
New York	9.0	41.2	31.3
Massachusetts	7.6	53.8	15.1
Rhode Island	7.5	71.6	30.1
California	6.7	24.3	26.6
Pennsylvania	6.7	65.9	131.7
Michigan	1.4	26.4	36.4
Vermont	−5.4	33.7	21.8
Kansas	−9.2	50.9	25.0
	With low-payment standards		
Arkansas	165.6	22.6	101.8
Tennessee	70.1	72.9	83.6
Montana	50.6	48.9	81.7
West Virginia	37.6	70.2	40.8
District of Columbia	26.7	7.8	42.7
North Dakota	18.6	40.7	69.9
Kentucky	13.3	33.6	46.1
Maryland	6.8	50.6	14.1

[1] Recipient figures based on calendar-year data; payment figures based on fiscal year data.

Expenditures. Along with the growth in the numbers of aged, blind, and disabled persons for whom medical payments were made, all the States that aided SSI recipients and the medically needy had gains in the amounts expended for Medicaid from 1973–75. For the States with relatively high payment levels (except Pennsylvania and Wisconsin), most of the increase in Medicaid expenditures from 1973 to 1975 was caused by inflation rather than growth in SSI. With the medical care component of the CPI rising by 22.4 percent from 1973 to 1975, the rate of growth in Medicaid expenditures for nine of the States in this group reached 28 percent. If medical prices were held constant for this period, the growth rate would have been 6 percent.

From 1973 to 1975, Pennsylvania and Wisconsin had the most dramatic changes in expenditures, as the following tabulation shows. These changes resulted from substantial increases in the amounts of medical payments made on behalf of aged persons in skilled-nursing homes and intermediate-care facilities.

For the States with relatively low payment stan-

[11] Above the Federal SSI payment standard for persons living independently (California, Kansas, Maine, Massachusetts, Michigan, New York, Pennsylvania, Rhode Island, Vermont, Washington, and Wisconsin).

[12] Below the Federal SSI payment standard for persons living independently (Arkansas, District of Columbia, Kentucky, Maryland, Montana, North Dakota, Tennessee, and West Virginia).

[Amounts in millions]

State and type of service	Amount		Increase, 1975 from 1973	
	1973	1975	Amount	Percentage distribution
Pennsylvania				
Total	$187.0	$433.2	$246.2	100.0
Intermediate-care and skilled-nursing facilities	158.0	370.7	212.7	86.4
All other	29.0	62.5	33.5	13.6
Wisconsin				
Total	115.7	269.7	153.9	100.0
Intermediate-care and skilled-nursing facilities	76.6	210.4	133.7	86.9
All other	39.1	59.3	20.2	13.1

dards, expenditures for Medicaid were greater in 1975 than in 1973. Generally the rates of growth were larger than the corresponding rates in States with high payment levels, except in Pennsylvania and Wisconsin. Although inflation accounted for part of the increase, most of the growth in Medicaid expenditures for States with low payment levels was attributable to concurrent increases in their Medicaid caseloads. In Arkansas the expansion of medical services for which payments were made probably had a substantial impact on the growth in its Medicaid expenditures. In the District of Columbia the increase appears to have resulted from greater utilization of services, since growth in the cash assistance caseload was negligible.

States Aiding SSI Recipients Only

Recipients. In States not providing assistance to the "medically needy," it was expected that any substantial increase in the Medicaid caseload would result primarily from growth in the numbers of aged, blind, and disabled persons receiving cash payments under SSI. Otherwise, the State would have to expand its covered services under Medicaid or experience greater utilization of services by the existing caseload. From 1973 to 1975, most of these States showed increases in both the cash assistance and the Medicaid caseloads. The growth proceeded, however, at differing rates. For three States—Delaware, Oregon, and Wyoming—the average monthly number of aged, blind, and disabled persons for whom medical payments were made declined, but the numbers of such persons receiving money payments rose (table 9).

In two States—Alabama and Louisiana—the relative change in the Medicaid caseload was greater than in the cash assistance caseload. In Alabama, the increase appears to have resulted from greater utilization of services, since no coverage increase was noted. In Louisiana, expansion of coverage to include payments for intermediate-care facilities and prescribed drugs resulted in greater utilization of services and subsequent increase in the Medicaid caseload.

South Carolina, which had the largest relative increase in its Medicaid program of any of these States, also had the largest increase in the numbers of persons receiving cash assistance under SSI. The average monthly number of cash assistance recipients more than doubled from 1973 to 1975, while the Medicaid population showed an 84-percent increase.

Expenditures. From 1973 to 1975, Medicaid expenditures rose by 59 percent. If medical prices had remained constant during this period, the increase would have been 36 percent. Even that rate still would have been significant and considerably larger than the rates for the other two groups of States.

Three States—Alaska, Iowa, and Oregon—had substantial increases in their Medicaid expenditures on behalf of aged, blind, and disabled persons. These increases appear to have resulted from rising costs of the intermediate-care facilities service and greater lengths of stay for the aged and disabled in such facilities.

South Carolina, which had the largest increase in its assistance caseload (137 percent) among these States, also had a large rise in its Medicaid caseload (84 percent). This State also showed substantial growth in its Medicaid expenditures for the aged, blind, and disabled (61 percent). Although the dollar amounts expended for their medical care were greater, their share of the total Medicaid bill declined. This decline indicates that

Table 9.—States that aid SSI recipients only: Percentage change in number of recipients and payments, by State [1]

State (ranked by percentage change in Medicaid caseload)	Percentage change, 1975 from 1973		
	Number of recipients		Medicaid payments
	Medicaid	Cash assistance	
South Carolina	83.9	136.8	61.1
Louisiana	62.5	14.3	87.5
Florida	61.0	59.0	78.9
South Dakota	48.8	73.4	45.5
New Jersey	35.1	89.9	44.5
New Mexico	29.8	43.5	45.7
Nevada	29.4	106.1	40.2
Alabama	25.5	15.1	67.2
Idaho	24.1	40.9	68.6
Texas	17.9	30.9	44.1
Iowa	14.2	79.6	189.7
Oregon	−2.9	58.3	151.7
Wyoming	−3.0	18.4	10.3
Delaware	−9.3	27.4	37.1
Alaska	(2)	7.1	139.8

[1] See table 8, footnote 1.
[2] Data not available.

Table 10.—States that have restrictive eligibility provisions for Medicaid: Percentage change in number of recipients and payments, by State [1]

State (ranked by percentage change in Medicaid caseload)	Percentage change, 1975 from 1973		
	Number of recipients		Medicaid payments
	Medicaid	Cash assistance	
Hawaii	28.4	59.3	26.5
Minnesota	23.5	42.8	47.3
Indiana	18.2	71.6	40.1
Mississippi	15.1	12.0	68.6
Virginia	11.3	161.4	56.1
Connecticut	9.8	39.1	40.3
New Hampshire	7.8	17.5	242.3
Illinois	5.7	19.2	26.3
Nebraska	.4	32.6	35.8
Ohio	−1.7	35.5	60.4
Colorado	−2.6	5.7	32.4
Missouri	−7.7	−.9	33.3
North Carolina	−10.0	113.2	52.0
Oklahoma	−13.0	14.9	23.6
Utah	−16.9	14.7	24.2

[1] See table 8, footnote 1.

the State was spending a much larger percentage on its AFDC recipients and other Medicaid eligibles than on the aged, blind, and disabled.

Most of the other States in this group showed large increases in Medicaid expenditures on behalf of their aged, blind, and disabled. This rise appeared to reflect chiefly larger payments for medical care in institutional settings—that is, in intermediate-care facilities. Similarly, those States that experienced limited growth in their Medicaid expenditures appeared to have had much smaller increases in their payments for intermediate-care facilities and relatively small rises in their Medicaid and cash assistance caseloads.

States Restricting Medicaid Coverage

Recipients. It was expected that in the 15 States in this group, many of the newly eligible SSI recipients would not be automatically eligible for Medicaid. Because the eligibility criteria for SSI were less restrictive than the Medicaid eligibility standards in these States, numerous persons qualifying for Federal SSI payments after January 1, 1974, did not automatically qualify for Medicaid. Some specific restrictive criteria maintained by these States were: (1) A minimum age for disabled individuals—18 years and over; (2) market value of home below Federal standard; (3) market value of personal property below Federal standard ($1,500); (4) considering equity value of home rather than market value; and (5) considering a car with a value less than Federal standard ($1,200).

The most dramatic evidence of the application of the restrictive provisions was noted for North Carolina and Virginia. In both these States, the average monthly number of aged, blind, and disabled recipients receiving cash assistance more than doubled from 1973 to 1975, but the Medicaid caseload declined in North Carolina and rose only 11 percent in Virginia (table 10).

In contrast, in Mississippi during this period, the relative growth in the Medicaid caseload was greater than the growth in the cash assistance caseload. The growth in Medicaid appeared to be attributable more to greater utilization of medical services than to larger numbers of recipients. Little growth occurred in the cash assistance caseload because Mississippi's "need" standard ($150) was higher than the SSI payment standard.[13] Individuals with incomes of less than $150 were eligible for some assistance before SSI. Consequently, larger numbers of newly eligibles were not expected.

In Missouri, which had a payment standard similar to Mississippi, both the cash assistance and Medicaid caseloads declined. For all other States in this group, the Medicaid program grew at a slower rate than did the cash assistance caseload and appeared overall to increase much more slowly in these States than the States in the other two groups.

Expenditures. From fiscal years 1973 to 1975, expenditures for medical assistance payments for the aged, blind, and disabled rose 40.2 percent for the 15 States. Each of these States showed increases in their Medicaid expenditures.

The largest rise (242 percent) occurred in New Hampshire, although no substantial increase was reported in the average monthly number of recipients receiving cash assistance (table 11). In New Hampshire, the inclusion of Medicaid coverage for treatment in intermediate-care facilities more than offset the restrictive provisions employed to control Medicaid expenditures. Since aged persons are the primary users of this type of medical care, inclusion of care in these facilities greatly influenced the overall growth in the proportion of all Medicaid payments expended for aged, blind, and disabled.

In North Carolina, the only State in this group in which the cash assistance caseload doubled while the Medicaid caseload declined, the proportion of payments for the aged, blind, and disabled was the same in fiscal years 1973 and 1975. Thus it appears that (1) most of the increase was due to general price increases for medical services and (2) the 1972 eligibility provisions maintained by the State to control Medicaid expenditures were effective.

Of the remaining five States (Oklahoma, Utah, Colorado, Missouri, and Ohio) that showed declines in

[13] On July 1, 1975, the SSI payments standard was increased to $157.

Table 11.—Total amount of Medicaid payments and percentage increase in payments for aged, blind, and disabled recipients, by State, fiscal years 1973 and 1975

State	Total payments (in millions)		Percentage increase, 1975 from 1973
	1973	1975	
Alabama	$67.4	$100.7	67.2
Alaska	2.6	6.2	139.8
Arizona [1]	...	...	...
Arkansas	37.8	76.3	101.8
California	672.8	851.9	26.6
Colorado	56.4	74.7	32.4
Connecticut	83.9	117.7	40.3
Delaware	5.6	7.7	37.1
District of Columbia	24.7	35.2	42.7
Florida	67.4	120.5	78.9
Georgia	117.8	166.3	41.1
Hawaii	14.1	17.9	26.5
Idaho	10.7	18.1	68.6
Illinois	292.1	369.0	26.3
Indiana	86.7	121.4	40.1
Iowa	19.2	55.8	189.7
Kansas	42.2	52.7	25.0
Kentucky	42.5	62.2	46.1
Louisiana	61.0	114.4	87.5
Maine	30.1	40.3	33.9
Maryland	73.3	83.6	14.1
Massachusetts	279.6	321.8	15.1
Michigan	251.5	343.0	36.4
Minnesota	134.8	198.5	47.3
Mississippi	40.7	68.7	68.6
Missouri	37.8	50.4	33.3
Montana	11.3	20.5	81.7
Nebraska	32.0	43.4	35.8
Nevada	7.1	9.9	40.2
New Hampshire	5.6	19.1	242.3
New Jersey	138.1	199.6	44.5
New Mexico	11.4	16.5	45.7
New York	1,355.0	1,778.6	31.3
North Carolina	77.7	118.2	52.0
North Dakota	10.8	17.7	69.9
Ohio	128.2	205.7	60.4
Oklahoma	82.0	101.4	23.6
Oregon	19.1	48.1	151.7
Pennsylvania	187.0	433.2	131.7
Rhode Island	42.4	55.2	30.1
South Carolina	31.5	50.7	61.1
South Dakota	11.4	16.6	45.5
Tennessee	50.0	91.7	83.6
Texas	247.5	356.5	44.1
Utah	16.2	20.1	24.2
Vermont	17.1	20.8	21.8
Virginia	65.0	101.5	56.1
Washington	91.4	110.7	21.1
West Virginia	10.7	15.0	40.8
Wisconsin	115.7	269.7	133.0
Wyoming	3.2	3.5	10.3

[1] State has no Medicaid program.

the Medicaid population from fiscal years 1973 to 1975, only Missouri had a drop in the proportion of all Medicaid dollars expended for the aged, blind, and disabled. Although the dollar amount expended rose for all of these States, the proportion of total expenditures for the cash assistance population remained relatively constant for these 2 years.

Summary

Changes in the cash assistance caseload did not seem to have a uniform effect on the State Medicaid programs. For States that aided only SSI recipients and those with low-payment standards aiding all SSI recipients and the medically needy, the growth in the cash assistance caseload appeared to have had a greater influence on the Medicaid population. In contrast, for the other States—those with restrictive Medicaid eligibility criteria and those with high payment standards that aided all groups including the medically needy—growth in Medicaid caseloads was very limited.

Implementation of the SSI program seemed to have had the greatest influence on the caseload for the disabled. From 1973 to 1975, the cash assistance and Medicaid caseloads for the disabled became the fastest growing adult category.

It would appear, however, that the high rate of inflation from 1973 to 1975 had a much greater influence on Medicaid expenditures than did the larger numbers of aged, blind, and disabled individuals receiving medical assistance. Changes in the State Medicaid programs also had an impact on Medicaid expenditures. Several States expanded Medicaid coverage to include services not previously covered. The extension of health service coverage to include intermediate-care facilities, however, probably had a greater impact on Medicaid expenditures than the expansion of any other health service. The cost of care in intermediate-care facilities escalated following removal of price controls and the rate of inflation increased.