A COMMISSION REPORT

Intergovernmental Problems in MEDICAID

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ADVISORY COMMISSION ON INTERGOVERNMENTAL RELATIONS
WASHINGTON, D. C. 20575
SEPTEMBER 1968
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ADVISORY COMMISSION ON INTERGOVERNMENTAL RELATIONS

(November 1968)

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PREFACE

The Advisory Commission on Intergovernmental Relations was established by Public Law 380, passed by the first session of the 86th Congress and approved by the President September 24, 1959. Section 2 of the Act sets forth the following declaration of purpose and specific responsibilities for the Commission:

> Sec. 2. Because the complexity of modern life intensifies the need in a federal form of government for the fullest cooperation and coordination of activities between the levels of government, and because population growth and scientific developments portend an increasingly complex society in future years, it is essential that an appropriate agency be established to give continuing attention to intergovernmental problems.
>
> It is intended that the commission, in the performance of its duties, will –
>
> (1) bring together representatives of the Federal, State and local governments for the consideration of common problems;
>
> (2) provide a forum for discussing the administration and coordination of Federal grant and other programs requiring intergovernmental cooperation;
>
> (3) give critical attention to the conditions and controls involved in the administration of Federal grant programs;
>
> (4) make available technical assistance to the executive and legislative branches of the Federal Government in the review of proposed legislation to determine its overall effect on the Federal system;
>
> (5) encourage discussion and study at an early stage of emerging public problems that are likely to require intergovernmental cooperation;
>
> (6) recommend, within the framework of the Constitution, the most desirable allocation of governmental functions, responsibilities and revenues among the several levels of government; and
>
> (7) recommend methods of coordinating and simplifying tax laws and administrative practices to achieve a more orderly and less competitive fiscal relationship between the levels of government and to reduce the burden of compliance for taxpayers.

Pursuant to its statutory responsibilities, the Commission from time to time singles out for study and recommendation particular problems, the amelioration of which, in the Commission's view, would enhance cooperation among the different levels of government and thereby improve the effectiveness of the Federal system of government as established by the Constitution. One subject so identified by the Commission is the intergovernmental fiscal and other problems associated with Medicaid – the Federal grant-in-aid program of medical assistance to the needy and medically needy enacted by Congress in 1965.

In the following report, the Commission examines the events leading up to enactment of Medicaid; analyzes the first two and a half years of experience under the program; identifies the points of strain, particularly the fiscal burden imposed on State and local government; and offers proposals for change, consistent with achieving the goal of comprehensive care for the needy and medically needy and an equitable sharing of fiscal and program responsibility among the Federal, State, and local governments.

The report was approved at a meeting of the Commission on September 20, 1968.

Farris Bryant

Chairman

ACKNOWLEDGMENTS

Responsibility for the staff work on this report was shared by Albert J. Richter, James H. Pickford, Carl Stenberg and Thomas Hanna. Clerical assistance was provided chiefly by Linda Topham and Karen Haagensen.

The Commission and its staff benefited from an informal review of an early draft of the report by a number of individuals, including Mark Alger, Linda Asey, James Baden, Frank Bane, George Bell, Jo Bingham, Andrew Boesel, Jay Constantine, William Dean Fullerton, Delphis C. Goldberg, Thomas Graves, Harold Hagen, Peter Harkins, John Jones, I. M. Labovitz, Mary Logan, Selma Mushkin, Richard Shoemaker, Charles Smith, Prof. Herman N. Somers, Frank Waters, and Elsie Watters. Their participation in the review in no way implies an endorsement of the report.

The Commission found most helpful the presentations of the following persons at its public hearing on Medicaid in San Francisco on September 19, 1968: Henry A. Boney, Member, Board of Supervisors, San Diego County, Calif., Dr. Harold R. Chope, Director of Public Health and Welfare, San Mateo County, Calif., Gordon Duffy, Chairman, California Assembly Committee on Public Health, James I. Gibson, Nevada State Senator, Kenneth McCaffree, Professor of Economics, University of Washington, Carel E. H. Mulder, Director, California State Department of Health Care Services, Charles H. Shreve, Regional Director, Department of Health, Education, and Welfare, and Spencer Williams, Secretary, California State Human Relations Agency.

Valuable insights into the operation of the Medicaid program at the State level were gained from a questionnaire circulated to Governors, State legislative leaders, and legislative service agencies through the cooperation of the National Governors' Conference and the National Conference of State Legislative Leaders. Responses were received from Governors or their appointees in 43 States, and from legislative leaders or legislative service agencies of 28 States.

Excellent cooperation was received from the Department of Health, Education, and Welfare in all stages of the study. The Commission wishes to acknowledge particularly the assistance of Dr. Francis L. Land, Charles Hawkins, John Hurley, Sam Martz, and Henry Spiegelblatt.

The Commission records its appreciation for the contribution of these individuals and organizations to this report. Responsibility for content and accuracy rests, of course, with the Commission and its staff.

Wm. G. Colman
Executive Director

David B. Walker
Assistant Director
(Governmental Structure and Functions)

WORKING PROCEDURES OF THE COMMISSION

This statement of the procedures followed by the Advisory Commission on Intergovernmental Relations is intended to assist the reader's consideration of this report. The Commission, made up of busy public officials and private persons occupying positions of major responsibility, must deal with diverse and specialized subjects. It is important, therefore, in evaluating reports and recommendations of the Commission to know the processes of consultation, criticism and review to which particular reports are subjected.

The duty of the Advisory Commission, under Public Law 86-380, is to give continuing attention to intergovernmental problems in Federal-State, Federal-local, and State-local, as well as interstate and interlocal relations. The Commission's approach to this broad area of responsibility is to select specific, discrete intergovernmental problems for analysis and policy recommendation. In some cases, matters proposed for study are introduced by individual members of the Commission; in other cases, public officials, professional organizations or scholars propose projects. In still others, possible subjects are suggested by the staff. Frequently, two or more subjects compete for a single "slot" on the Commission's work program. In such instances selection is by majority vote.

Once a subject is placed on the work program, a staff member is assigned to it. In limited instances the study is contracted for with an expert in the field or a research organization. The staff's job is to assemble and analyze the facts, identify the differing points of view involved and develop a range of possible, frequently alternative, policy considerations and recommendations which the Commission might wish to consider. This is all developed and set forth in a preliminary draft report containing (a) historical and factual background, (b) analysis of the issues, and (c) alternative solutions.

The preliminary draft is reviewed within the staff of the Commission and after revision is placed before an informal group of "critics" for searching review and criticism. In assembling these reviewers, care is taken to provide (a) expert knowledge, and (b) a diversity of substantive and philosophical viewpoints. Additionally, representatives of the National League of Cities, Council of State Governments, National Association of Counties, U.S. Conference of Mayors, U.S. Bureau of the Budget and any Federal agencies directly concerned with the subject matter participate, along with the other "critics" in reviewing the draft. It should be emphasized that participation by an individual or organization in the review process does not imply in any way endorsement of the draft report. Criticisms and suggestions are presented; some may be adopted, others rejected by the Commission staff.

The draft report is then revised by the staff in light of criticisms and comments received and transmitted to the members of the Commission at least three weeks in advance of the meeting at which it is to be considered. (Before acting on the present report, the Commission also held a public hearing in San Francisco, to which it invited representatives of local, State, and Federal governments to comment on Medicaid in general and the draft report in particular.)

In its formal consideration of the draft report, the Commission registers any general opinion it may have as to further staff work or other considerations which it believes warranted. However, most of the time available is devoted to a specific and detailed examination of conclusions and possible recommendations.

Differences of opinion are aired, suggested revisions discussed, amendments considered and voted upon, and finally a recommendation adopted (or modified or diluted as the case may be) with individual dissents registered. The report is then revised in the light of Commission decisions and sent to the printer, with footnotes of dissent by individual members, if any, recorded as appropriate in the copy.

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Chapter I

INTRODUCTION

Relatively unnoticed in 1965 when Congress enacted "Medicare" was enactment of its companion measure–"Medicaid."

– **Medicare**, Title 18 of the Social Security Act, is the national insurance program for persons 65 and over and which covers (a) hospital and related institutional care, financed through employers' and employees' contributions under the Federal social security and railroad retirement systems, and (b) physicians' care and other health services through monthly insurance premiums paid voluntarily by persons 65 and over and matched by a Federal contribution.

– **Medicaid**, Title 19 of the Social Security Act, is the Federal-State program of medical assistance for the needy and medically needy financed out of Federal, State, and (at State option) local tax funds.

Not long after its launching on January 1, 1966, Medicaid came forcefully to the attention of policy-makers at all levels of government as its fiscal impact began to be felt. Federally assisted "medical vendor payments" (i.e., payments to physicians and others for medical services) in States with Title 19 programs rose from $1,061 million in 1965 to $1,567 million in 1966. The trend continued upward in 1967 and 1968 and was a major cause of Congressional imposition in 1967 of limitations on Federal financial participation in the Medicaid program. Some States have hesitated to come into the program well ahead of a 1970 statutory deadline, uncertain of the cost and waiting to profit from the experience of others. Most States under Medicaid have proceeded cautiously in expanding their basic programs to include additional persons and services.

Amidst the widespread concern in official and other circles about the fiscal and other problems involved in the operation of Medicaid, the National Conference of State Legislative Leaders in December 1967 formally requested the Advisory Commission to undertake an analysis of the program covering "the legislative background as well as the program and its implications for the States." At its February 1968 meeting the Commission voted to undertake the study.

The Commission's study focuses mainly on basic policies affecting Federal, State, and local sharing of responsibility for financing Medicaid. In addition, it directs attention to certain specific nonfiscal problems involving constitutional, legislative, and administrative changes in the operation of the program. A source of valuable insights into the operation of the program from executive and legislative vantage points at the State level was gained from a questionnaire circulated to Governors and State legislative leaders through the cooperation of the National Governors' Conference and the National Conference of State Legislative Leaders.

The Advisory Commission's study does not attempt to examine the nature and magnitude of medical need nor evaluate Medicaid's overall performance–present and potential–in meeting that need. Neither does it deal with the major problems of organization, manpower, facilities, and supply that confront the

whole health services "industry" and which are at the root of much of the recent cost escalation.

The Commission then has limited this study to an examination of the existing Medicaid program. We are concerned about related basic issues, such as income maintenance, employer-employee insurance plans and a comprehensive health care program. We determined, however, that we could only undertake at this time a study of Title 19, excluding the major alternatives to the present system. It follows that we imply no preference for the Title 19 program compared with any other system.

The Commission accepts the premises that Medicaid under Title 19 is an intergovernmental program, financed basically from public funds, providing medical care to the needy and medically needy with eligibility for services determined on the basis of a "means test," that is, through establishment of an income and resource level which recipients must fall below in order to qualify as "needy" or "medically needy."

Chapter II of this report presents a short history of governmental responsibility for medical assistance in the United States from colonial times through the Depression of the 1930's through the mounting interest in a national program assuring health care for all during the late forties and the decade of the fifties, to the Kerr-Mills program of Medical Assistance for the Aged, and finally Medicare and Medicaid along with their 1967 amendments.

In Chapter III, the principal provisions of Title 19 are summarized and the basic ways set forth in which it differs from previous Federal-State governmental programs offering assistance for medical care.

Chapter IV analyzes the major fiscal effects of the Medicaid program on the Federal Government and the States and intergovernmental problems of a nonfiscal nature are briefly summarized. The description of the fiscal impact on the States centers on the chief program decisions affecting the scope and effect of the program: when to initiate the program, who should be covered, what kind of services should be provided, and what levels of income and resources should be used for qualifying the medically needy. Chapter IV also describes the extent to which States have called on their local governments to share in financing the Medicaid program. Further, it considers the implication of Title 19's 1975 goal of comprehensive care for "substantially all" needy and medically needy in the light of current political and fiscal realities. It also analyzes the problem of rising medical costs as a contributor to increased Medicaid expenditures. Finally, the chapter identifies nonfiscal intergovernmental problems, based on questionnaire replies, a Tax Foundation survey, and reports by State legislative and administrative agencies.

Chapter V summarizes major findings and presents 15 Commission recommendations for improvements in the Medicaid program under four major headings:

A. Medicaid goals.

B. Allocation of responsibility between Federal and State governments.

C. Allocation of fiscal responsibility between State and local governments.

D. Other issues requiring Federal and State constitutional, legislative, or administrative change.

Chapter II

GOVERNMENTAL RESPONSIBILITY FOR MEDICAL CARE FOR THE NEEDY AND MEDICALLY NEEDY: A SHORT HISTORY[1]

Early in the colonial period, common law established that the care of the poor—including medical care—was fundamentally a function of local government. It held that no government should allow its citizens to die of starvation, sickness or exposure merely because they are poor, and generally assigned responsibility for "poor relief" to the smallest political unit, whether it was the village, town, city, parish or county. With the advent of national independence, this concept was incorporated in State constitutions and statutes.

In the 19th century State governments gradually began to take over some administrative responsibilities for poor relief and assumed obligation for actual care of some categories of the poor who had previously been strictly local charges. This was the beginning of "categorical relief" and was prompted by humanitarian motives as well as the prohibitive cost of providing special care to only a few persons in any one special category in a single locality. These categories generally included the sick, deaf, and insane. The major burden of financing poor relief still fell on local governments, however. This division of responsibility between local and State governments continued essentially up to the 1930's.

State and local governmental responsibility for medical care usually was carried out through public institutions for medical care of the indigent, employing salaried physicians, or by purchasing care from private physicians. In most of the larger local jurisdictions, however, such medical services were commonly provided through city or county hospitals. Some cities, many counties and some States offered at least emergency care to the indigent. In addition, a large number of physicians and voluntary hospitals gave the poor free or part-pay services.

Federal Responsibility

The Federal Government long has provided hospitalization and other medical care for armed services personnel, veterans, merchant seamen, Indians and certain other groups. Attempts were made in the 19th century to extend this responsibility to at least certain segments of the poor under the "general welfare" clause of the Constitution. Strict constructionism usually defeated these efforts, however. Witness President Franklin Pierce's 1854 veto of a bill providing Federal land grants to the States for the benefit of the insane. In his message, Pierce stated that the Federal Government did not have constitutional power to provide for the indigent insane or any other indigent person. This view prevailed until the depression of the 1930's.

From 1933 to 1935 the Federal Government through the Federal Emergency Relief Administration (FERA) for the first time made available to the States funds to pay the medical expenses of the needy unemployed. The program observed the traditional patient-physician relationship by giving patients free choice of physician. Payments were made according to State fee schedules negotiated with the medical, dental, and nursing professions. Services were limited to physician's care, emergency dental care, bedside nursing service, drugs and emergency appliances. Hospitalization was not included, and the amount of care

available was sharply restricted. One writer summed up the long range effect of this experience: [2]

> Although the FERA program was not applied uniformly throughout the country and had many serious shortcomings, the plan exercised great influence on subsequent medical care programs. It emphasized the role of governmental agencies as purchasers of medical care in contrast with previous reliance on free services of physicians and hospitals, and it set a precedent for increased participation of state and federal governments in financing medical care for the needy.

The Social Security Act of 1935

The Social Security Act of 1935, besides providing a system of social insurance for the aged, set up the "categorical" public assistance system in which the Federal Government shared with the States the cost of providing maintenance to the needy aged, blind, families with dependent children, and, subsequently, the permanently and totally disabled. The Act made no special provision for medical assistance, but included the cost of medical care in the monthly assistance payment for which Federal financial participation was available. The 1939, 1946, and 1948 legislative amendments increased Federal cost-sharing, but the medical care that could be provided within the cash payment continued to be limited, and the care varied widely in nature and scope from State to State.

Federal administrative regulations required cash payments to the recipients, rather than to the grocer, landlord, or doctor. With full independence in use of their money payments, many recipients neglected medical care, often because States set the overall money payment level so low as to be insufficient for basic food and shelter.

Public Assistance Medical Care

In the 1950 amendments to the Social Security Act, Congress broadened the definition of assistance to include money for "vendor payments"—direct payments by the State to doctors, nurses, and health care institutions, rather than to the welfare recipient himself. The change created an administrative framework for a welfare medical program. The ceiling on Federal sharing in the assistance payment for each case was not raised, however, and only a few States implemented the provision.

In 1956 Federal participation in the medical care costs for all categories was increased by provision for separate matching for medical care payments, in addition to the cash assistance grant, and still on an individual case basis. All recipients had to meet the State definition of "needy" in order to qualify for either cash payments or medical services.

Under a 1958 amendment, the basis of Federal sharing was changed to a general averaging formula which included both vendor payments for medical care and cash payments for maintenance. The Federal Government was thus enabled to share with the States in larger medical expenditures for individual cases, up to the Federal ceiling. By 1960 four-fifths of the States provided medical vendor payments in federally aided categorical assistance programs, and many also allowed some items of medical care in their cash payments to recipients. Despite this expanded Federal and State effort, however, the need was so great that most States could finance only a few services.

The Kerr-Mills Bill: Medical Assistance for the Aged

The next Congressional action improving the Federal-State system of medical assistance for the indigent came largely as an outgrowth of the long legislative struggle to provide a comprehensive program for

increased and improved medical services for the entire population, culminating in the enactment of Medicare and Medicaid in 1965. The conflict began in 1935 when the Committee on Economic Security established by President Franklin D. Roosevelt endorsed the principle of compulsory health insurance as part of the proposed new social security system. President Roosevelt never submitted the proposal to Congress in his twelve years in office, but in 1943, Senators Robert F. Wagner and James Murray and Congressman John R. Dingell introduced the first in a series of "Wagner-Murray-Dingell" medical care bills. These called for creation of a compulsory national health insurance system financed through a payroll tax. Programs of similar scope were proposed by President Harry S. Truman in 1945 and in subsequent years and were introduced as bills by Wagner, Murray, and Dingell. None was ever acted on by either House.

When President Dwight D. Eisenhower took office in 1953, the increased opposition to compulsory national health insurance led supporters of the Truman proposals to scale down their aims. They proposed as a first step that the Social Security Old Age and Survivors Insurance (OASI) system begin paying for hospitalization costs for OASI beneficiaries aged 65 and over. No action was taken on the proposal or its counterpart bills submitted during the period 1953-1957. The Eisenhower Administration from 1954 through 1957 advanced several programs designed to help private insurance companies offer improved medical cost coverage, but none was approved by either House.

In 1957, Congressman Aime Forand introduced another bill for use of the Social Security system to provide limited care for the aged, with administration through the Federal Government, but again with no legislative success. He introduced a slightly modified version of the bill in 1959. In 1960, the Eisenhower Administration proposed a new Federal-State program to protect the low-income aged against the cost of long-term illness. It would have provided Federal matching grants to the States to help them pay for specified medical, hospital, and nursing costs for elderly persons with an income of $2,500 a year or less ($3,800 for a couple). Eligible persons would be given the option of receiving cash payments instead to help purchase private health insurance. The States, the Federal Government, and enrollees would have shared the cost.

The Ways and Means Committee under Chairman Wilbur Mills rejected the Administration and Forand proposals as well as a bill submitted by Senator Patrick V. McNamara designed to overcome certain criticisms of the Forand measure. Instead it reported out an amended Social Security Act, put together by Mills, providing a medical care plan for the aged similar to the Eisenhower proposal but not quite as generous. The Senate Finance Committee reported out a liberalized version of the Mills bill, named after Senator Robert Kerr, its chief Senate sponsor. After reconciling differences in the conference, the final bill became known as the Kerr-Mills bill.

The new legislation established a new category of public assistance–Medical Assistance for the Aged (MAA)–and made available additional separate funds for vendor payments for medical care under existing old age assistance programs. Under the latter program, the Federal Government contributed to State expenditures for medical care within a maximum expenditure of $15 average per aged recipient per month. Under Medical Assistance for the Aged, the Federal Government offered to reimburse the States for 50 to 80 percent of the cost of setting up State programs to pay medical care costs for "medically needy" aged persons, with the higher percentages going to States with low per capita income. No limit was set on the benefits that could be provided or the total amount that could be spent. State participation was optional.

1961-1963: King-Anderson Proposals; Kerr-Mills in Trouble

President John F. Kennedy picked up the cudgels for health care for the aged through social security in his 1961 health message to Congress. An Administration bill was introduced in the Senate by Senator Clinton Anderson and in the House by Congressman Cecil R. King. Hearings were held in the House, but no action was taken. President Kennedy continued to push for passage in 1962 and 1963, with attention

centered on variations of the King-Anderson legislation, including coverage of persons over 65 not under social security and optional use of private insurance. Again, none of these efforts was successful.

On the public assistance front, however, two significant developments occurred in relation to medical care. The 1962 amendments to the Social Security Act increased Federal participation in the costs to the States of providing medical care for public assistance recipients. Second, a subcommittee of the Senate Special Committee on Aging after noting that it was "the intent of Congress that the MAA program would provide broad health services to the many aged needing them but unable to afford them even though the individuals were not on welfare," concluded that operations of the Kerr-Mills program "demonstrated that the Congressional intent has not and will not be realized . . . ." [3] By mid-1963 more than two-fifths of the total aged population resided in States which had no MAA program in operation. The subcommittee issued a report in which it said: [4]

> We find the Kerr-Mills Program of medical assistance for the aged still suffers from these major defects:
>
> 1. After three years it is still not a national program and there is no reason to expect that it will become one in the foreseeable future. Although all 50 state legislatures have met since this program was enacted into law three years ago, only 28 states and four other jurisdictions now have the program in operation.
>
> 2. Stringent eligibility tests, 'lien type' recovery provisions and responsible relative provisions have severely limited participation in those jurisdictions where the program is in operation. In July of 1963, only 148,000 people received MAA assistance or less than one percent of the nation's older citizens.
>
> 3. The duration, levels and types of benefits vary widely from state to state. Except for those four states having comprehensive programs (Hawaii, Massachusetts, New York and North Dakota) benefits are nominal, non-existent or inadequate.
>
> 4. Administrative costs of MAA remain too high in most jurisdictions. In Tennessee, for example, administrative costs totaled 59 percent, while in four states, they exceeded 25 percent of benefits.
>
> 5. The distribution of federal matching funds under MAA has been grossly disproportionate, with a few wealthy states best able to finance their phase of the program getting the lion's share of the funds. Five states, California, New York, Massachusetts, Michigan, and Pennsylvania, for example, received 88 percent of all federal MAA funds distributed from the start of the program through December 31, 1962, although those five states have only 32 percent of the nation's elderly people. New York alone, with 10 percent of the nation's elderly, received 42 percent of this total.
>
> 6. The Congressional intent to extend assistance to a new type of medically indigent person through MAA has been frustrated by the practice of several states in transferring nearly 100,000 persons already on other welfare programs, mainly OAA, to the Kerr-Mills program. The states have done this to take advantage of the higher matching grants provisions of Kerr-Mills, saving millions of dollars in state costs, but diverting money meant for other purposes.
>
> 7. The welfare aspect of the Kerr-Mills MAA program, including cumbersome investigations of eligibility, plus the requirement in most states that resources of an older person must be depleted to a point of near-dependency, have further reduced participation.

The Enactment of Medicare and Medicaid

In his special health message to Congress in February 1964, President Lyndon B. Johnson began his efforts in behalf of medical care for the aged under social security. A Ways and Means Committee bill approved by the House that year liberalized the benefits and coverage of the Social Security Act but did not incorporate medical care for the elderly. As amended by the Senate, the bill included such a program, but this provision was dropped in conference.

Pressure for a medical care program for the aged built up early in 1965. The report of the Advisory Council on Social Security on *The Status of the Social Security Program and Recommendations for Its Improvement* [5] pointed out that older and disabled people have a special need for protection against costs of hospital and other medical care and recommended hospital insurance protection for them. Shortly thereafter President Johnson declared in his State of the Union Message that help for "the elderly, by providing hospital care under Social Security and by raising benefit payments to those struggling to maintain the dignity of their later years," [6] was one of the priority items in his legislative program. Congressman King and Senator Anderson responded by introducing as the first bill in each House the Administration's hospital insurance proposal. They were essentially similar to the measure that died in conference the previous year.

The efforts of the House Ways and Means Committee had shifted from a study of whether an insurance program should be established to a search for opinions on the specific content of such a program. The Committee had before it, in addition to the Administration proposal, a bill supported by the Republican leadership providing for an insurance system separate from the social security system with voluntary participation and a government subsidy. The bill offered a comprehensive range of benefits including physician services in and out of hospitals, differing in this respect from the Administration's hospital-benefits-only provision. The American Medical Association, long the staunchest opponent of any proposal for hospitalization through the social security system, came out with a bill that was dubbed "Eldercare." Although only a modest extension of existing Kerr-Mills legislation, it served to break the remaining opposition against a broad program of government-supported medical care for the aged.

The Republican and "Eldercare" plans focused attention on the limited benefits of the Administration bill and caused Chairman Mills to combine elements of all three bills and report out a new three-tier bill which some labeled "Elder-Medi-Bettercare." This new proposal emerged after six weeks of hearings and called for an unprecedented package of health benefits and social security improvements. It was the first time that the House Ways and Means Committee had acted favorably on a medical insurance bill for all older citizens. The new bill was introduced in the House by Congressman Mills on March 24 as part of the "Social Security Amendments of 1965," and after running the legislative gauntlet, was signed into law by President Johnson on July 30, 1965. [7]

In its June 1965 report to accompany the bill, the Senate Finance Committee declared, regarding experience under Kerr-Mills: [8]

> It has now been 5 years since the enactment of the 1960 Social Security Amendments and there has been opportunity to evaluate the implementation of the medical assistance for the aged program, and to formulate a judgment as to the extent to which this national problem is being met. Although the committee believes that the Kerr-Mills legislation as a whole has been very beneficial to the needy aged in our country, it has now concluded that the overall national problem of adequate medical care for the aged has not been met to the extent desired under existing legislation because of the failure of some States to provide coverage and services to the extent anticipated. The committee, therefore, has concluded that a more comprehensive Federal program as to both persons who can qualify and protection afforded is required.

The legislation called for two new titles to be added to the Social Security Act. Title 18—Medicare—was

a combination of the King-Anderson and Republican bills and established an insurance program for persons 65 and over which finances hospital and related institutional care through employer-employee contributions under the social security system, and physicians' care and other health services through monthly insurance premiums paid voluntarily by persons 65 and over and matched by a Federal contribution. Title 19—Medicaid—took the AMA's "Eldercare" plan as its base and extended the benefits to the recipients of Federal-State public assistance programs other than old age assistance, as well as to "medically indigent" related to all Federal categorical programs. The result was a greatly expanded medical assistance program for the needy and medically needy which combined all the medical vendor provisions for the aged, blind, disabled, and families with dependent children under a uniform program and matching formula in a single new title.

The new legislation also provided for an interlinking of Titles 18 and 19, specifying that States under Title 19 could "buy-in" to the physicians' care part of Title 18 for their medically needy aged by paying the premium. The States could also pay the coinsurance and deductibles portions of the Title 18 inpatient hospitalization costs of the medically needy.

The 1967 Amendments

As States moved rapidly to implement Title 19, financial and administrative problems arose that caused some members of Congress to feel that Congressional intent was not being followed. The expansion of the program in early 1966 began pushing its costs upward to such an extent that a supplemental appropriation was necessary to finance the Federal share. In May 1966 and for the next six months, the Ways and Means Committee held periodic hearings regarding Title 19. These hearings were focused on two concerns: (1) that a very large and substantially unlimited Federal financial liability would arise under the law as it operated; and (2) that the program was being used in some States to assist persons in the population with near-average incomes, thereby undercutting private health insurance and other protection which they might obtain for themselves. The Committee felt that the latter result went far beyond the intent of Congress in enacting Title 19.

At the conclusion of these hearings in October 1966, the Committee reported out a bill but too late for consideration by Congress. The measure would have limited the program by eliminating from Federal participation practically all individuals between 21 and 65 other than those receiving cash assistance payments. It also would have restricted the program by establishing a relationship between the income levels used in determining eligibility for cash assistance payments and those used to determine who is medically needy.

In the report to accompany the bill the Committee stated: [9]

> Your Committee never intended that Federal matching under Title XIX would be made in the case of a considerable portion of the adult working population of moderate income. The qualification of this group of people through the application of cash assistance criteria of the aid to families with dependent children program—concepts of 'physical and mental incapacity,' 'absence from the home,' and 'unemployment'—are neither meaningful nor workable. Thus, as a first step in this direction, your committee's bill would exclude from Federal matching the medical assistance payments on behalf of these adult relatives whose income exceeds the limits set by the States for money payments under the aid to families with dependent children program.

It was expected that this amendment coupled with other provisions in the bill would result in an $80 million reduction in expenditures for the next fiscal year (1967-1968) with long-range savings of even greater significance. The idea embodied in this recommendation was picked up by the Administration and presented to the 90th Congress in the President's message on "Aid for the Aged." The House adopted the principle on a much more stringent basis than the Administration had suggested.

After the President's bill was introduced on February 20, 1967, the Ways and Means Committee held hearings on the President's proposals that lasted into mid-April. Extensive changes were made with the Committee reporting out a new bill which passed the House in August, and after a floor fight in the Senate because of restrictive welfare provisions, passed the Senate on December 15th.

As approved by the President [10] the 1967 amendments to the Medicaid program established a maximum income level for Federal financial participation in the cost of medical assistance for the medically needy. The limitation was set ultimately at 133-1/3 percent of the actual payment level under the AFDC program. Another amendment of major fiscal consequence extended the privilege of buying-in to the Title 18 supplementary medical insurance program to people who are eligible for Medicaid but do not receive cash assistance; and provides that Federal matching will not be available to States toward the cost of services which could have been covered by buying-in but were not.

Chapter III

SUMMARY OF MAJOR MEDICAID PROVISIONS

Medicaid is a grant-in-aid program in which the Federal and State (and sometimes local) governments share the costs of medical care for the needy and medically needy. Its ultimate goal is to make medical care of high quality readily available to those unable to pay for it.

Until enactment of Medicaid, the Federal Government helped finance medical assistance for the needy by sharing in the cost of the categorical assistance programs (OAA, AFDC, AB, and APTD). It also participated financially in the separate Kerr-Mills program of Medical Aid for the Aged (MAA), which States could elect to use instead of the more limited medical assistance under OAA. MAA made medical assistance available to the medically needy as well as the needy aged.

Medicaid represents a departure from this system in several major respects:

– It substitutes a single program of medical assistance for separate programs provided under the four categorical assistance programs and MAA; thus it provides uniformity in administration, eligibility standards, medical services offered [1] and Federal-State cost-sharing where formerly there was diversity among the separate categories.

– It offers most States a proportionately higher Federal reimbursement for medical expenditures than they received for medical expenditures made as part of the four basic categorical programs.

– It extends medical assistance to certain medically needy persons in all four categorical assistance programs, thereby applying across-the-board the principle introduced in the aged category by the Kerr-Mills Act. States have the option to provide medical assistance to these medically needy, and are encouraged to do so by the offer of Federal cost-sharing.

– Finally, Medicaid mandates the ultimate extension of medical assistance to all others determined to be needy and medically needy by the States' standards of eligibility. Under Section 1903 (e) of the Act, States must move toward broadening the scope of care and services and liberalizing eligibility requirements "with a view toward furnishing by July 1, 1975, comprehensive care and services to substantially all" the needy and medically needy.

The State Plan

To qualify its Medicaid program under Title 19, a State must submit an acceptable State plan to the Department of Health, Education, and Welfare. The plan is a description of the State's program and the organization and procedures for carrying it out. The required elements of the plan are set forth in Title 19 and Supplement D of the Handbook of Public Assistance Administration.

Groups Covered

With respect to the people to be covered by the State's program, the plan *must* include:

(1) Everyone receiving financial aid under the four categorical public assistance programs (the categorically needy).

(2) Everyone who in all other respects would be eligible for such public assistance except that he does not meet certain State imposed eligibility conditions (categorically related needy).

(3) Everyone under age 21 who, except for a State age or school-attendance requirement, would be eligible for AFDC (categorically related needy).

The plan *may* include the following additional groups for whom Federal cost-sharing is also available:

(1) People who would be eligible under one of the public assistance categories if the State's programs were as broad as Federal legislation permits–for example, families with an unemployed father in the home in States not making AFDC payments to such families and people considered permanently and totally disabled under the Federal definition but not under the State's more restrictive definition (categorically related needy).

(2) Everyone who would be eligible for assistance payments if he were not a patient in a medical facility (categorically related needy); one exception to this rule is the person under 65 who is a patient in a mental or tuberculosis institution.

(3) People whose income and resources are large enough to cover their daily living expenses (according to income levels set by the State) but are not adequate to pay for their medical care and who are aged, disabled, blind, or members of families with dependent children; in other words, people who would be eligible for federally aided financial assistance if they had less income and resources. A State that includes people in any of these groups (aged, blind, disabled, or families with dependent children) must include those in all four groups (categorically related **medically** needy).

(4) All medically needy people under age 21 even though they are not eligible for financial assistance under another federally aided public assistance program; they need not live with their parents to be eligible, and they can be children whose parents are employed but do not earn enough to pay the children's medical care (noncategorically related medically needy).

Finally, the plan *may* cover other people at the State's discretion, such as:

(1) People who are receiving or are eligible for general assistance under a statewide program (noncategorically related needy).

(2) Those between the ages of 21 and 65 who have enough income and resources for daily needs but not for medical expenses and are not blind, disabled, or members of families with dependent children (noncategorically related medically needy).

(3) Those with income above the federally established maximum for the medically needy (noncategorically related medically needy).

The Federal Government will share in the administrative costs of providing medical services to such groups included at the State's discretion if they receive care and services comparable to those provided other groups under the plan and under comparable eligibility conditions, but it cannot share in the costs of the care.

Under Section 1903 (e), as was noted earlier, States must move toward providing comprehensive care for substantially all the above groups by July 1, 1975.

The various groupings of eligibles are summarized in Table 1 in terms of availability of Federal matching funds and State discretion in including them in their Title 19 program.

Table 1. Title 19 Coverage Groupings

Federal Cost-Sharing Available		Federal Cost-Sharing *Not* Available
States *must* include in plan	States *may* include in plan	States *may* include in plan
Categorically needy	Certain categorically related needy	Noncategorically related needy
Certain categorically related needy	Categorically related medically needy	Most noncategorically related medically needy
	Certain noncategorically related medically needy	

Income and Resource Limits for Eligibility

Subject to federally established conditions, the States set the amount of income and resources an applicant may have and still be eligible for Medicaid with Federal financial participation. If the State provides medical assistance to the medically needy, it must establish income levels that it deems necessary for maintenance costs. For Federal sharing, these levels cannot exceed a federally specified proportion of the State's maximum AFDC payment level. For most States the proportions are 150 percent for the second half of 1968, 140 percent for 1969, and 133-1/3 percent thereafter.

The level of income defined by the State as necessary for daily living expenses must be comparable for families of various sizes. It may vary, however, to reflect differences in shelter costs for urban and rural areas.

Income and resources above the established level are considered available to meet medical costs—first, for medical insurance premiums and other medical care not covered by the State's Medicaid program, and second, for medical care that may be covered. Each State decides how much property a person can hold and not use toward costs of medical care. This usually includes, in addition to a home, a modest amount of savings and/or life insurance and a car of moderate value. As with income, the State must permit the amount of savings or insurance that can be held to vary with the size of family. Anything over the amount designated as being unavailable for medical care costs must be applied toward those costs.

Relative responsibility; lien and recovery

Only the husband or wife of an individual or the parents of a person who is under age 21 or blind or totally disabled can be held responsible for paying the costs of the medical care provided.

No liens or encombrances of any kind can be imposed before an individual's death on his real or personal property because of medical assistance correctly paid (or to be paid) on his behalf, or at any time if he was under age 65 when he received the assistance. An exception may be made if a court decides that benefits have been incorrectly paid. Adjustments or recovery for medical assistance correctly paid can be sought only from the estate of an individual who was aged 65 or older when he received such assistance, and then only (1) after the death of his surviving spouse, if any, and (2) when he has no surviving child who is under age 21 or is blind or permanently and totally disabled.

Medical Care and Services Provided

States may include the following services in their Medicaid plan:

(1) Inpatient hospital services (other than services in an institution for tuberculosis or mental disease).

(2) Outpatient hospital services.

(3) Other laboratory and X-ray services.

(4) (a) skilled nursing home services;

(b) effective July 1, 1969, early and periodic screening, diagnosis, and treatment of physical and mental defects in eligible people under 21.

(5) Physicians' services (in the office, patient's home, hospital, skilled nursing home, or elsewhere).

(6) Medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law (such as podiatrists, chiropractors, naturopaths).

(7) Home health care services.

(8) Private duty nursing services.

(9) Clinic services.

(10) Dental services.

(11) Physical therapy and related services.

(12) Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or an optometrist, whichever the patient may select.

(13) Other diagnostic, screening, preventive, and rehabilitative services.

(14) Inpatient hospital services and skilled nursing home services for individuals aged 65 or over in an institution for tuberculosis or mental diseases.

(15) Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary, such as transportation to receive services, family planning services, whole blood when not otherwise available, Christian Science practitioners' services and care in Christian Science sanitoria, skilled nursing home services for people under 21, and emergency hospital services.

For the categorically needy and categorically related needy, States must provide the first five services (known as the "basic five") except that skilled nursing home services may be limited to those 21 and older. In regard to the medically needy, the States have certain choices. They may provide the "basic five," or any seven of the first 14 services listed. If either inpatient hospital care or skilled nursing home service is included among the seven, physicians' services must be provided for individuals while they are in a hospital or nursing home.

In addition, for both of the above groups, effective July 1, 1970, home health services must be provided for any individual who, under the State plan, is entitled to skilled nursing home services.

Comparability of services offered

Medicaid recipients who are categorically needy or categorically related needy must be given the same medical care and services, and all those who are medically needy as a group must get the same medical care and services. Exceptions to the rule are:

(1) Medical care services provided through "buying-in" under Medicare Part B (see below, "Coordination with Medicare") for people aged 65 or older do not have to be provided to other recipients.

(2) Skilled nursing home care may be limited to people aged 21 or over, but there is Federal matching for those under 21.

(3) Care in institutions for tuberculosis or mental diseases may be limited to people aged 65 or older. There is no Federal matching for those under 65.

(4) Effective July 1, 1969, eligible individuals under age 21 may be provided periodic screening and diagnostic services needed to identify physical and mental defects, and measures designed to correct or ameliorate such defects and chronic conditions.

A State may not provide more in the way of services for the medically needy than for the categorically needy and categorically related needy, but it may provide less.

Free Choice of Medical Vendor

Beginning July 1, 1969, States must allow Medicaid recipients free choice among qualified practitioners, medical facilities and community pharmacies. The free choice principle includes the right to choose a qualified group of physicians organized in group practice, as well as to choose a qualified physician. Group practice covers not only a voluntary association of three or more physicians working as a team, but also a consumer-sponsored, prepaid, group practice medical care program. In the latter, an applicant could have his prepayment fees or dues paid to the group by the State Medicaid agency. There would have to be, however, an agreement between the agency and the group, making clear the care and services covered by the fees and dues.

Reimbursement for Care and Services

Hospitals are reimbursed for inpatient care on the basis of "reasonable cost." Other suppliers of medical services are reimbursed according to State policies. Federal regulations recommend reimbursement of institutions on the basis of reasonable cost and encourage the payment of reasonable fees to individual suppliers. The 1967 amendments to Title 19 authorized the Secretary of HEW to approve experiments with new ways

of reimbursement that promise more efficient methods of providing medical care and services without adversely affecting their quality.

A State may require medically needy patients to pay a "deductible" and "coinsurance" for hospital care, medical care, or other services received, including part or all of the deductibles and coinsurance under Medicare. Income in excess of the amount specified by the State must also be applied to medical care costs, but any such cost sharing must be "reasonably related" to the individual's income or his income and resources.

Medicaid care and services are available for eligible patients who have some health insurance, but States must make sure that health insurance benefits are used before payment is made under Medicaid.

Coordination with Medicare (Title 18 of the Social Security Act)

Medicare is the federally administered program of health insurance for people aged 65 and over established in 1965 by Title 18 of the Social Security Act. It offers two kinds of benefits: Hospital insurance (for hospitalization and related care—Part A) and supplementary medical insurance (for physicians' services and some other medical services—Part B). Benefits are the same throughout the Nation. The hospital insurance is a right for most of the aged and is financed by deductions from employees' wages and matching taxes paid by employers and by a tax paid by the self-employed. Medical insurance is a voluntary program, financed by monthly premiums paid by the individual and by a matching amount from the Federal Government. The Social Security Administration administers the entire Medicare program.

Medicaid complements the hospital insurance provisions of Medicare (Part A) by paying all or part of the deductible and coinsurance amounts for the medically needy aged who are insured. States are encouraged to "buy-in" to the voluntary medical insurance Medicare program (Part B) for those 65 and over under the Medicaid plan. The Federal Government shares with the State the cost of the individual's portion of the premium in the case of the needy, but for the medically needy, the full portion is borne by the State. Penalty for not "buying-in" by January 1, 1970 is forfeiture of Federal reimbursement for any such medical care costs that could be met by Medicare.

State and Local Financial Participation

Major intergovernmental fiscal aspects of the Medicaid program are: (1) greater State (as opposed to local) responsibility; (2) increased Federal reimbursement; and (3) the prohibition of reduction in assistance to the needy.

Title 19 medical costs, including health insurance premiums, are reimbursed from Federal funds at the rate of the State's Federal medical assistance percentage (except for the "buying-in" provision of Part B of Medicare for the medically needy, noted above). Federal matching varies from 50 to 83 percent—inversely in relation to a State's per capita income, with the highest Federal matching going to States with the lowest per capita income. A State receives about 55 percent Federal matching funds if its per capita income is equal to the national average. Table 2 shows the matching percentages for the periods January 1966—June 1967 and July 1967—June 1969.

An exception to the above occurs if the Federal share for any quarter between January 1, 1966 and June 30, 1969 is less than 105 percent of the Federal share of the State's medical expenditures for categorical public assistance during the year ending June 30, 1965. In that case, 105 percent of that former Federal share becomes the Federal medical assistance percentage for such quarter(s). The objective is to avoid any State's receiving reduced Federal medical assistance as a result of coming in to Medicaid, at least until June 30, 1969.

Under the categorical cash assistance programs, Federal matching applies only to a fixed average amount per recipient. The Federal matching under Medicaid applies to the total amount spent by the State, except for that portion spent for the medically needy which exceeds the income limits set by the 1967 amendments (see "Income and Resource Limits for Eligibility" above) and the portion spent for individuals not eligible for Federal financial participation. The absence of all but these limits on Federal matching is one of the most significant fiscal aspects of Title 19.

In order to receive additional Federal funds as a result of expenditures under Medicaid, States must not reduce assistance under the basic maintenance assistance programs as it existed prior to the initiation of the Medicaid program in the State. Continuation of Federal matching is contingent on the State's showing progress toward providing a system of comprehensive care for "substantially all" the needy and medically needy by July 1, 1975.

Table 2. Percentage of Federal Matching For Medicaid Expenditures, by State

1/1/66 – 6/30/67 and 7/1/67 – 6/30/69

State	Effective	
	1/1/66–6/30/67	7/1/67–6/30/69
Alabama	79.85	78.60
Alaska	50.00	50.00
Arizona	63.94	64.99
Arkansas	81.67	79.81
California	50.00	50.00
Colorado	53.08	55.31
Connecticut	50.00	50.00
Delaware	50.00	50.00
District of Columbia	50.00	50.00
Florida	65.21	65.09
Georgia	74.91	72.85
Hawaii	52.97	50.00
Idaho	70.73	67.87
Illinois	50.00	50.00
Indiana	55.77	53.39
Iowa	60.39	59.60
Kansas	61.45	57.90
Kentucky	76.70	75.25
Louisiana	76.41	74.58
Maine	69.57	69.92
Maryland	50.00	50.00
Massachusetts	50.00	50.00
Michigan	50.31	50.00
Minnesota	60.46	58.40
Mississippi	83.00	83.00
Missouri	53.90	58.40
Montana	62.86	64.01
Nebraska	60.39	60.48
Nevada	50.00	50.00

Table 2 — Contd.

State	Effective	
	1/1/66–6/30/67	7/1/67–6/30/69
New Hampshire	61.31	60.12
New Jersey	50.00	50.00
New Mexico	70.73	70.15
New York	50.00	50.00
North Carolina	75.58	75.30
North Dakota	66.67	70.74
Ohio	52.33	52.64
Oklahoma	70.32	69.61
Oregon	54.12	54.37
Pennsylvania	54.38	55.03
Rhode Island	56.13	52.61
South Carolina	81.30	80.50
South Dakota	71.05	73.26
Tennessee	76.86	76.14
Texas	67.27	67.10
Utah	66.30	65.24
Vermont	68.44	69.00
Virginia	66.96	65.85
Washington	50.31	50.00
West Virginia	74.27	75.84
Wisconsin	57.60	56.68
Wyoming	55.47	59.20
Guam	55.00	55.00
Puerto Rico	55.00	55.00
Virgin Islands	55.00	55.00

Source: U.S. Department of Health, Education, and Welfare, *Handbook of Public Assistance Administration,* Supplement D

State and local share

In previous public assistance legislation, States were free to require their local governments to pay a significant portion of the non-Federal share. Federal legislation mandated only some State participation. Title 19 as amended requires that prior to July 1969 States must pay at least 40 percent of the non-Federal share of costs and thereafter must pay either the entire non-Federal cost or must distribute State and Federal funds in such a way that inadequacy of local funds will not cause lowering of the scope or quality of the program.

Administration

At the Federal level, the Secretary of Health, Education, and Welfare is responsible for administration of Federal grants-in-aid for the State Medicaid programs. Under him, immediate responsibility is assigned to the Medical Services Administration of the Social and Rehabilitation Service.

At the State level, a single State agency administers the program or supervises its administration. It

may be the agency that administers the Federal-State program of old age assistance, or another unit, such as the State health agency. In any case, the agency administering old age assistance determines eligibility, but in States where aid to the blind is administered separately, the agency in charge of that program administers medical assistance for blind recipients.

Title 19 creates a Medical Assistance Advisory Council of 21 members to advise the Secretary of HEW on administration of the Medicaid program at the Federal level. Members are appointed by the Secretary and represent consumers of health services, State and local agencies, nongovernmental organizations, and groups concerned with health.

Similarly, each State with a Medicaid program must establish a State Medical Care Advisory Committee to advise the State agency director on the program. Members generally are appointed by the Governor or the director of the designated State agency.

Title 19 Timetable: July 1, 1968 to July 1, 1975

The following is a summary outline of dates various major provisions of Title 19 become effective after July 1, 1968.

June 30, 1969—This date ends the period during which States' medical care expenditures may be matched under the special 105 percent provision.

July 1, 1969—Commencing at this time, recipients must be given free choice of doctors, institutions, pharmacies, agencies and prepayment organizations qualified to perform the service or services required.

July 1, 1969—Non-Federal share of expenditures must either be financed entirely from State money or alternatively, if local funds are also used, the State must provide for distributing Federal and State funds on an equalization or other basis which assures that shortage of local resources will not force curtailment of the scope or quality of care.

January 1, 1970—States must initiate a Medicaid plan or forego all Federal assistance for any medical vendor payments as part of their categorical assistance programs for the needy.

January 1, 1970—This date also marks the deadline for States to "buy-in" to Part B of Medicare.

July 1, 1975—By this time States must furnish comprehensive care and services to substantially all persons meeting the eligibility standards for needy and medically needy set forth in individual State plans.

Chapter IV

MEDICAID IN OPERATION

Medicaid went into effect on January 1, 1966. Largely as a consequence of this new program, total federally assisted medical vendor payments rose from $1,358 million in calendar year 1965 to an estimated $4,184 million in FY 1969. Figure 1 pictures the trend from 1951, when medical vendor payments were first authorized for the categorical assistance programs, projected through FY 1969. The trend line shows clearly the escalating effect of the Kerr-Mills law in 1960, which authorized more generous Federal cost sharing and expanded coverage and services for the aged, and then the more pronounced upsurge with Medicaid from FY 1966 through FY 1969.

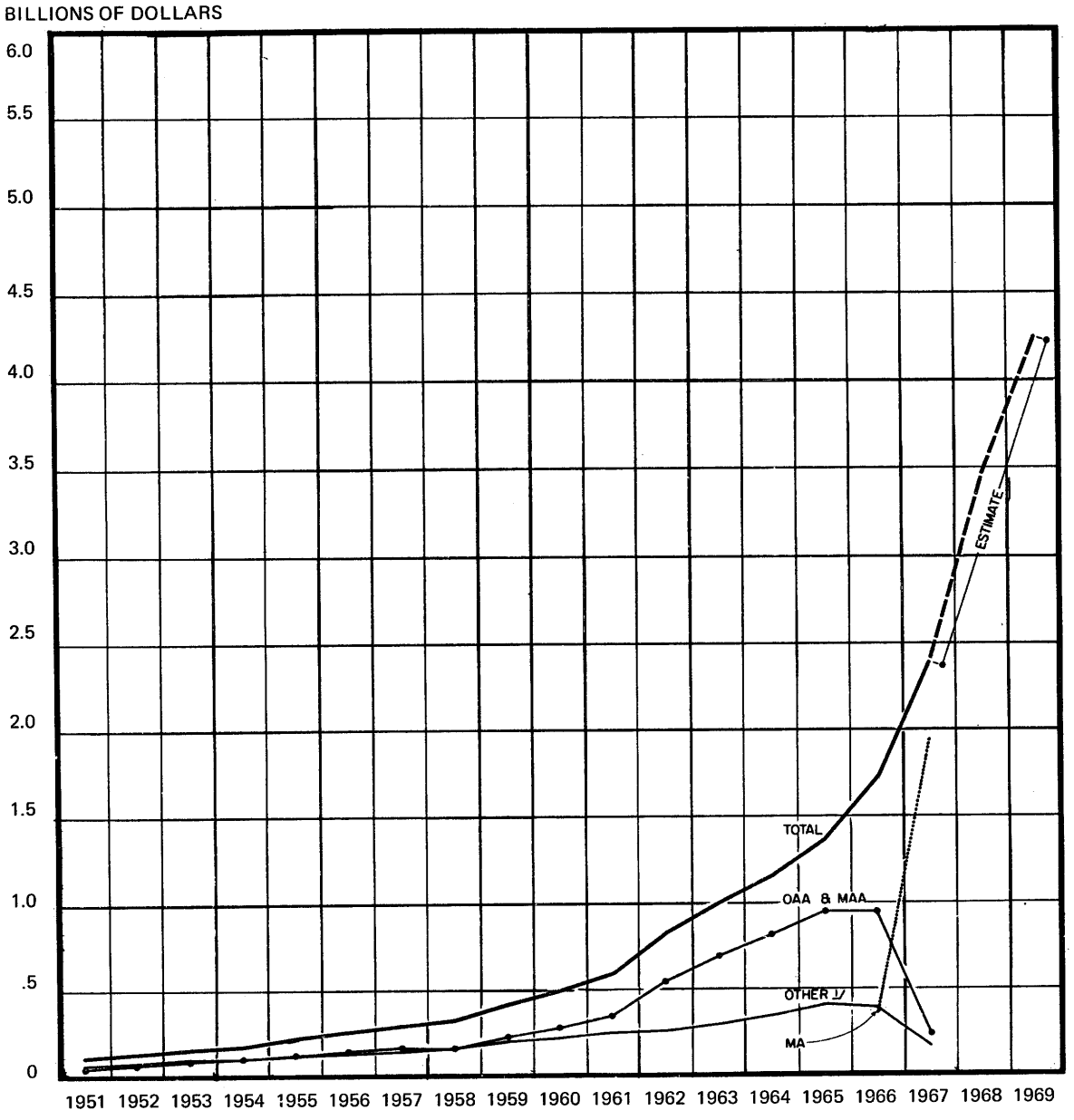
As of July 1, 1968, 38 States and three territories were operating Medicaid programs.[1] Twenty-six State programs began in calendar year 1966, 11 in 1967, and one in 1968 thus far, as indicated in Table 3.

Table 3. States Operating Medicaid Programs as of July 1, 1968 by Month of Initiation

Program Initiated	State
January 1966	Hawaii, Illinois, Minnesota, North Dakota, Oklahoma, Pennsylvania
March 1966	California
May 1966	New York
July 1966	Connecticut, Idaho, Kentucky, Louisiana, Maine, Maryland, Nebraska, Ohio, Rhode Island, Utah, Vermont, Washington, West Virginia, Wisconsin
September 1966	Massachusetts
October 1966	Delaware, Michigan
December 1966	New Mexico
June 1967	Kansas
July 1967	Iowa, Montana, Nevada, New Hampshire, Oregon, Wyoming
September 1967	Texas
October 1967	Georgia, Missouri, South Dakota
July 1968	South Carolina

Source: Department of Health, Education, and Welfare, Social and Rehabilitation Service, "Selected Characteristics of the Medical Assistance Program under Title 19 of the Social Security Act" (various dates).

Figure 1 — Federally Assisted Vendor Payments for Medical Care, Fiscal Years 1951 to 1969



[1] AB, APTD, AFDC, and GA.

Source: Department of Health, Education, and Welfare, *Budget Justification FY 1969* (processed)

In the questionnaire survey of the Advisory Commission on Intergovernmental Relations-National Governors' Conference-National Conference of State Legislative Leaders, States not yet having Medicaid programs in operation were asked to give the reasons. All of the 12 States not having Medicaid programs responded to the question.[2] Most indicated the main reasons for inaction to date were that their policy-makers felt the State could not afford the program and that there was a need to gather more information on other States' experience. Typical of the latter was the comment that since "(we have) been aware of the difficulties experienced by other States, we are hoping to avoid some of the mistakes, administratively and financially, encountered in some of these programs." Another respondent stated: "The most important single factor in the delay in implementing Medicaid has been the desire to develop the best possible cost estimates for the program, based on the experience in our sister states."

Early in 1968, HEW estimated that by the end of FY 1969 all but six States will have established Title 19 programs.[3] All States are required to have such a program by January 1, 1970 or lose Federal assistance for medical vendor payments in categorical assistance programs.

In May 1967, 2,704,000 people in 26 States received medical assistance under Title 19 at a cost of $188,669,000 for that month. By November 1967, the comparable figures had increased to 3,823,000 in 37 States and $255,878,000.[4] The number of different people on whose behalf medical payments are made during the course of a year is much larger -- probably 25 percent larger -- than the number for a single month. Table 4 shows for specified months the number of States under Medicaid, the number of recipients of medical vendor payments, and the amount of such payments. Similar data for States not under Medicaid are also shown.

Table 4. Number of Recipients and Amounts of Medical Vendor Payments: Medical Assistance Financed Under Public Assistance Titles of Social Security Act May and November 1967

	Number of States		Medical Vendor Payments Number of Recipients		Amount (000)	
	May 1967	November 1967	May 1967	November 1967	May 1967	November 1967
Title 19 States	26	37	2,704,000	3,823,000	$188,669	$255,878
Other States	24	13	1,387,000	786,000	28,346	18,392
	50	50	4,091,000	4,609,000	$217,015	$274,270

Source: U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, *Medical Assistance Financed Under the Public Assistance Titles of the Social Security Act,* May and November 1967.

The overall fiscal effect of Title 19 can be shown by contrasting the rise in total federally assisted medical vendor payments in the States that have adopted the program with those that have not. This comparison is shown in Table 5 for the period from calendar year 1965 -- the last year prior to Medicaid -- and calendar year 1967, the latest year for which expenditure data are available from HEW.

It should be noted that the increase for Title 19 States is greater than the total increase in dollar value of *service* between the two years. Apart from price rises, the expansion was also affected by the fact that some services financed through medical vendor payments in FY 1967 were provided in CY 1965 directly by

Table 5. Medical Vendor Payments under Public Assistance Titles of Social Security Act 1965 and 1967 (000)

	CY 1965	CY 1967	Increase	
			Amount	%
Title 19 States (37)	$1,186,405	$2,568,018	$1,381,613	116
Other States (13 plus District of Columbia)	170,559	204,574	34,015	20
	$1,356,964	$2,772,592	$1,415,628	104

Source: U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, *Source of Funds Expended for Public Assistance Payments,* Calendar Years Ended December 31, 1965 and December 31, 1967.

State and local public hospitals, clinics, etc., which were financed out of general tax funds without Federal assistance. In other words, the increase represents to some extent a shift in the governmental source of financing as well as an expansion of services. Nevertheless, the largest share of the increase doubtless stemmed from expansion of services under Title 19.

Another measure of the growth of medical services due to Title 19 would be a comparison of the number of recipients of medical vendor payments in each of the two years, particularly a comparison showing the growth in number of persons not covered under the categorical assistance programs, including mainly the "medically needy," since coverage of such persons is a major change wrought by Medicaid. HEW data prior to Medicaid, however, did not identify the number of recipients of medical vendor payments among those receiving money payments for categorical assistance. Nevertheless, Table 6 suggests the magnitude of the change by comparing for the month of November 1967 the proportion of money payment recipients in Title 19 and non-Title 19 States, respectively.

Table 6. Percentage of November 1967 Recipients of Medical Vendor Payments Who Did and Did Not Also Receive Money Assistance Payments

	Also received money assistance payments	Did *not* receive money assistance payments
Title 19 States (37)	61%	39%
Other States (13)	81%	19%

Source: U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, *Medical Assistance Financed Under the Public Assistance Titles of the Social Security Act,* November 1967.

Thus, only 61 percent of the medical vendor payment recipients in the Title 19 States were categorical assistance recipients, compared to 81 percent in the other States. The percentage in the right hand column for the non-Title 19 group is as high as it is because of the Kerr-Mills program in some of those States, which makes medical vendor payments available to the "medically needy" aged.[5]

In the next two sections of this chapter, attention is directed at the fiscal impact of Medicaid on the Federal and State (including local) governments. The different legal frameworks of the three levels impose different degrees of restraint on the way each can respond to that impact. Thus, the Federal Government for all practical purposes has unlimited borrowing power, no restriction on incurring current deficits, and has the use of the increasingly productive income tax. The States, on the other hand, are generally under the restraints of constitutional limits on borrowing, both as to amounts and purposes (borrowing for current expenses is usually forbidden). Moreover, a few are restrained by constitutional limits on their power to raise revenue through the income tax. Similarly, local governments participating in the non-Federal share of Medicaid expenses are checked by charter or legislative prohibitions on the amount and purposes for which they may borrow. Their tax resources are also closely limited by charter and law. In short, States and to a greater extent local governments have much less financial flexibility than the Federal Government in meeting the additional expenditure requirements of a new program like Medicaid.

THE FISCAL IMPACT ON THE FEDERAL GOVERNMENT

In its report on the Social Security Amendments of 1965, the House Ways and Means Committee stated that "if all States took full advantage of provisions of the proposed Title XIX, the additional Federal participation would amount to $238 million. However, because all States can not be expected to act immediately to establish programs under the new title, and because of provisions in the bill which permit States to receive funds only to the extent that they increase their total expenditures, the Department of Health, Education, and Welfare estimates that additional Federal costs in the first year of operation will not exceed $200 million."[6] Subsequent Congressional actions authorized programs adding $115 million to the Medicaid program, making a total expansion of $315 million in medical vendor payments that could be expected under this program.

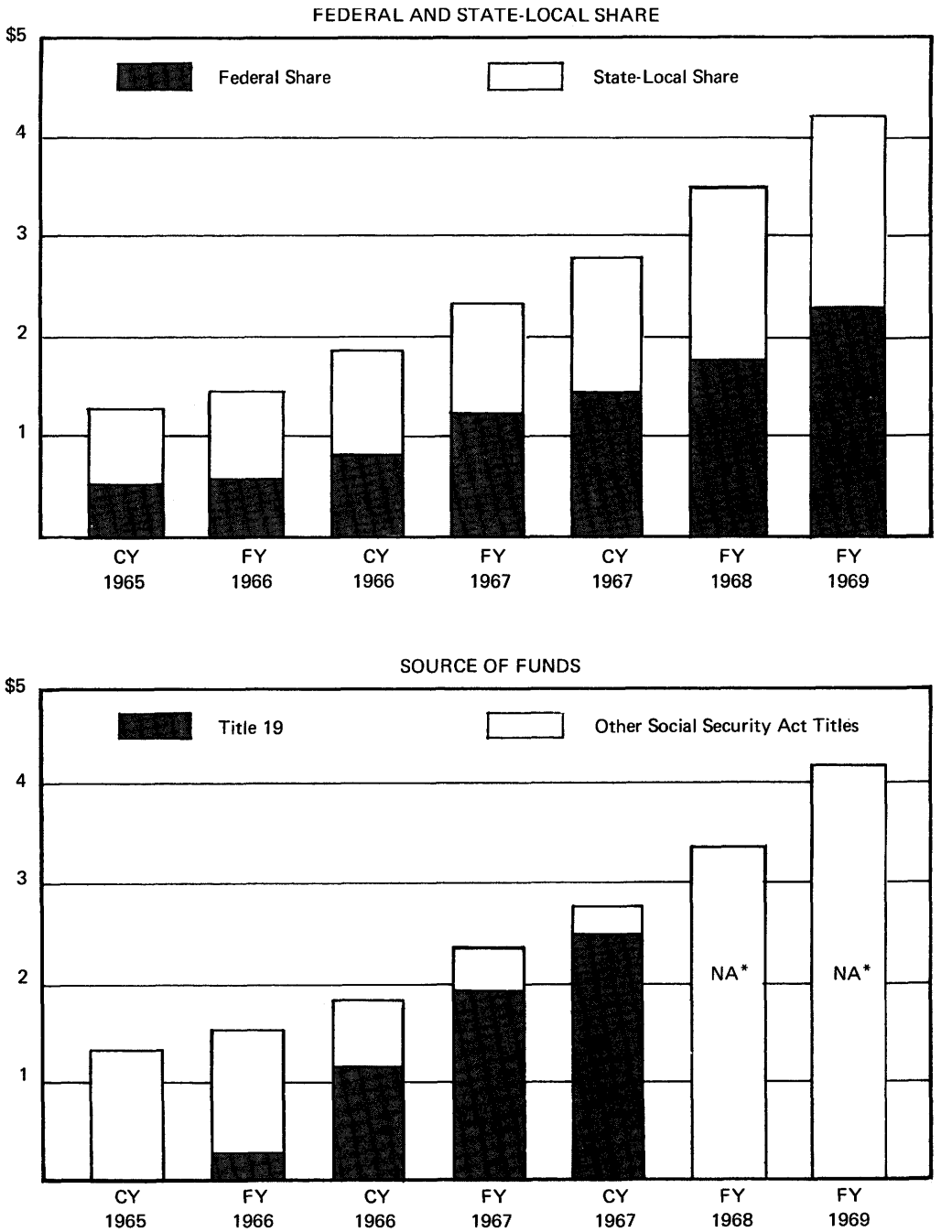
The Federal share of expenditures for all medical vendor payments actually rose in 1966 by $238 million – from $757 million for CY 1965 to $995 million for CY 1966 – as indicated in Figure 2 (also see Appendix Table A-1). An increase of $590 million for Title 19 was offset by a decline of about $350 million in the other programs. The actual and estimated figures for ensuing fiscal years indicate a continuing increase in Federal Title 19 funds accompanied by a decline in other medical vendor payments but a net overall increase. For FY 1967, there was a net rise of $265 million; for FY 1968, an increase of $621 million; and for FY 1969, an estimated increase of $367 million.

Soon after Medicaid went into effect, both Congress and the Executive Branch expressed concern over the unanticipated burgeoning of costs under the new program. The House Ways and Means Committee issued a report in the Fall of 1966 calling for amendments to Title 19 in an effort to apply a brake to the rising cost curve.[7] The five amendments included a proposal that States would be limited in setting income levels for Federal matching purposes to 133-1/3 percent of the AFDC payment level. (For the period July-December 1968, the percentage would be 150, and for calendar year 1969 it would be 140 percent.) Federal matching for medical care for all those who are receiving or eligible for cash assistance or who would be eligible for cash assistance if not institutionalized would not be affected under the amendment. Another recommendation sought to "encourage" States to "buy-in" for their aged public assistance recipients under Part B of Medicare. The amendments were eventually enacted as part of the package of 1967 amendments to the Social Security Act.[8]

- In the same 1966 report, the Ways and Means Committee stated:[9]

> The Committee on Ways and Means at this time, has been unable to develop a formula applying specific fiscal limitations as to Federal participation in title XIX which would be both effective and equitable. It has given consideration to a number of proposed methods of limiting future Federal financial liability with respect to overall limitation of State plans and of eligibility limitations on the

Figure 2 — Federally Assisted Medical Vendor Payments by Federal and State-Local Share and By Source of Funds CY 1965 — FY 1969 (billions of dollars)



*Breakdown not available.

Source: Appendix Table A-1.

income of individuals and families for whom payments might be made with Federal financial participation, particularly those with attachments to the labor force that generally afford access to health insurance protection. Your committee wishes to make its intention clear, however, that such a formula may be developed and it therefore now cautions the States to avoid unrealistic levels of income and resources for title XIX eligibility purposes. Your committee will continue to study appropriate means of achieving these goals and expects its staff and experts in the Department of Health, Education, and Welfare to continue to work on the development of appropriate, objective, and equitable formulas to accomplish the desired results.

In 1967, limitations became the subject of study and discussion in both the Ways and Means Committee and the Senate Finance Committee. These efforts resulted in the 1967 amendment to Title 19 that prohibits Federal sharing in expenditures for medically needy families whose income is more than 133-1/3 percent of the highest amount ordinarily paid under its AFDC program to a family of the same size without any income or resources.[10]

HEW officials estimated that this limitation, effective July 1, 1968, would reduce the Federal share of Medicaid payments by about $100 million. They further anticipated that the option for "buying-in" to Part B of Medicare for additional persons aged 65 years and over would reduce Title 19 Federal costs by $22 million; and that transfer to the old age assistance program of the costs of old age recipients who can be cared for in "intermediate care" facilities rather than skilled nursing homes would achieve an additional Title 19 reduction of $20 million.[11] The Department estimated that these actions, plus one other small reduction and one increase, would reduce FY 1969 costs by $125.5 million.

At the time Congress was considering these steps to hold down future Medicaid budgets, however, it was evident that FY 1968 payments would require additional funding, since they were continuing to grow beyond original appropriations. Various factors combined to produce this result, including an expanding number of cash assistance recipients (the categorically needy), increased utilization of the program by persons who became aware that they qualified as medically needy, and a continuing rise in medical prices at an average annual rate of about 5 percent and a rate of 6.4 percent in 1967 alone.[12] Consequently, early in 1968 the Administration requested a FY 1968 supplemental appropriation of $568.3 million. The unprecedented magnitude of this request led the President to make the following comment to the National Governors' Conference mid-year meeting on February 29, 1968:[13]

> The other day I sent to the Congress a supplemental estimate of $568 million for Medicaid, a 50 percent increase in the original 1968 budget estimate of $1.2 billion.
>
> There are many reasons why that supplemental was necessary. Nevertheless, I think you will all agree that it represents a pretty wide error in budget estimating. It is true that medical costs have risen sharply. But we in the Federal Government have inadequate information on which to predict what the States will do:
>
> – how many persons will be covered,
> – what kind of services they will receive, and
> – what are the cost implications?
>
> Let us try to arrive at a solution to this together. I propose that we establish a joint Federal-State task force, where a select group of State budget directors and health and welfare officials can work with HEW and our Budget Bureau to bring about improvements in reporting and estimating the cost of Medicaid.

The Task Force on Costs of Medicaid and Public Assistance was subsequently established under the chairmanship of the Assistant Secretary and Comptroller of the Department of Health, Education, and

Welfare. The other 16 members include eleven representatives of State government – four State fiscal officers, six health and/or welfare administrators, and the staff director of the National Legislative Conference – and five Federal officials, including the Commissioner of the Medical Services Administration who has charge of Medicaid.

As its title indicates, the Task Force's mission was broadened to include estimating costs of public assistance, including cash payment and supportive programs, such as social services, training, demonstration, and work incentive programs. As stated in one of its working papers, the Task Force's goal is:

> To develop a Federal-State system of data gathering, estimating, and reporting, and monitoring which will enable informed and timely decisions on Medicaid and Public Assistance Costs concerning:
>
> – Scope of programs.
> – Effects under alternative decisions.
> – Actual data at points in time compared to estimated data.

THE STATE-LOCAL FISCAL EFFECT

The Title 19 program has had varying fiscal impacts on the States that have thus far elected to implement it. As seen in Figure 3, for 26 States with programs in effect for all of 1967, the change in total expenditures for medical vendor payments in the two year period from calendar year 1965 – the last complete year prior to Medicaid – through CY 1967 varied from an increase of 371 percent in Delaware to a decline of 15 percent in West Virginia, with a median increase of 56 percent. In total dollar terms, the change ranged from an increase of $487 million in New York to a decrease of $1.7 million in West Virginia (for details, see Appendix Table A-2).

The variations in State fiscal response over this period stem from a complex of causes, among which are certain basic decisions by State legislatures and administrators in initiating and establishing Title 19 State plans. First, of course, was the decision as to when the State should begin implementing Medicaid, which is reflected in Table 3 presented earlier. Other critical decisions were:

– Whether the States chose to provide medical assistance payments to the medically needy as well as the categorically needy.

– Whether they decided to include the noncategorically related in the medically needy group.

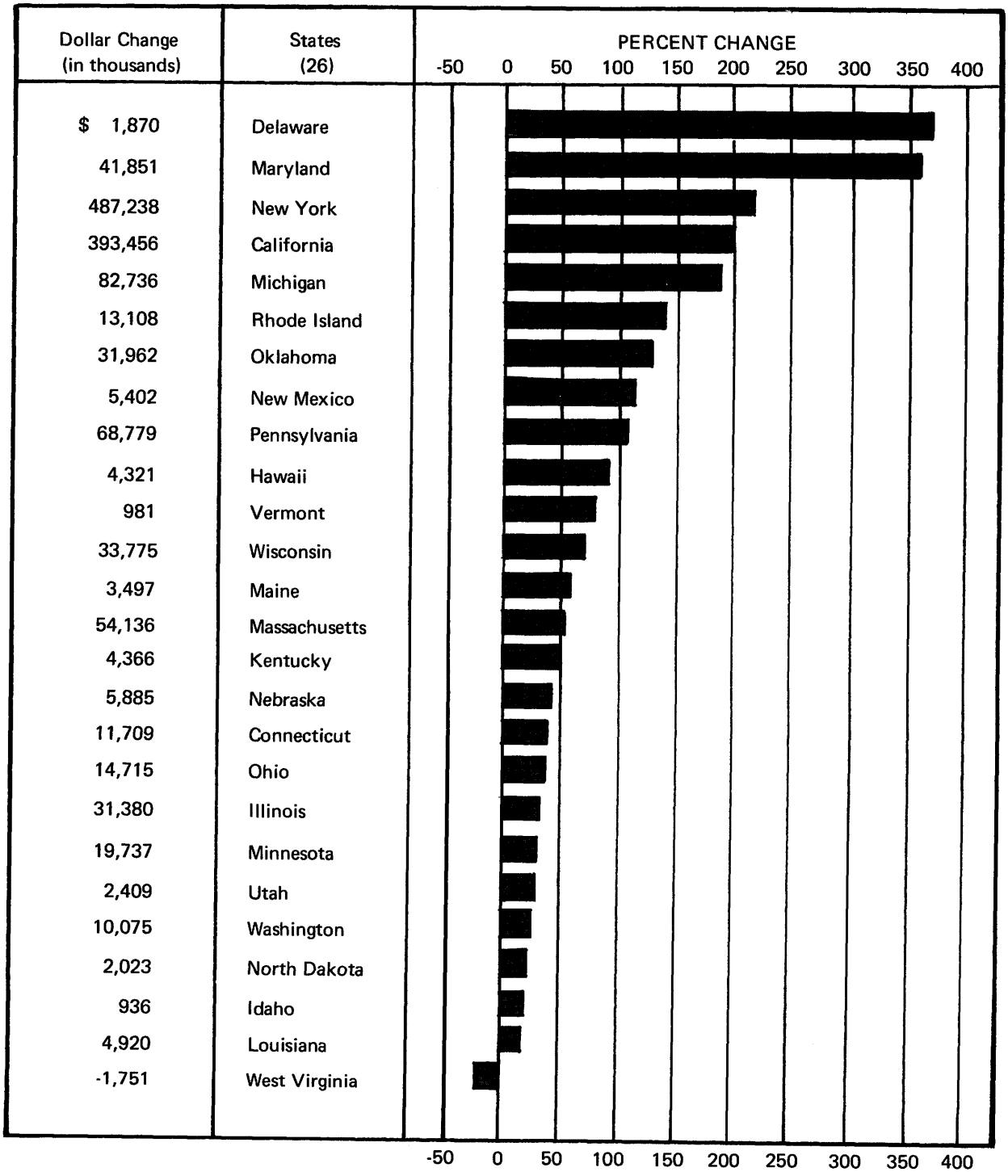
– How they defined "medically needy" from the standpoint of income and resources limitations.

– The scope and level of services provided to both the categorically and medically needy.

– The division of cost sharing between the States and their local governments.

Within the limitations of the available data and the scope of this report it is not feasible to pinpoint the effect of these decisions State by State. Even if it were feasible, however, such analysis would still fail to explain with precision and reliability the variations in fiscal impact among the States, unless there were similar analysis of such important factors as variations in medical costs and the full comparative picture of State-local arrangements for providing medical services for the needy and medically needy *before* the advent of Medicaid. The following analysis then is presented as illustrative of major features of existing Title 19 State plans that account for the widely differing fiscal impact of the program among the States. It is supplemented with pertinent findings of a recent study by the Tax Foundation, *Medicaid: State Programs After Two Years.*[14] In addition, Appendix B presents sketches of experience with medical assistance before and after Medicaid in

Figure 3 — Changes in Federally Assisted Medical Vendor Payments From CY 1965 to CY 1967: 26 States With Title 19 Programs in Effect For All of 1967



Source: Appendix Table A-2.

California and New York. While these two are by no means typical of the States as a whole, they do help to illustrate in more depth some of the reasons for the varying fiscal effects.

Groups Covered: the Various Classifications of the "Needy" and the "Medically Needy"

States under Title 19 *must* provide medical vendor payments for the "categorically needy" – those receiving money payments under the federally aided categorical programs (OAA, AB, APTD, AFDC) – and for certain other "categorically related needy" persons prescribed by law, such as those who meet all but the durational residence requirements under the categorical programs. States have the *option* of including in their Title 19 plan persons who are needy but lack one or more eligibility qualifications for categorical money payments, such as aged needy persons in nursing homes or mental institutions. These persons also fall in the "categorically related needy" group. In addition, States may include persons who have all qualifications for categorical assistance except that their income and resources are sufficient to maintain themselves, although not sufficient to afford necessary medical care. These come under the "categorically related medically needy" bracket. Federal cost sharing is available for these three groups.

A State plan may also authorize aid for a fourth group: the "non-categorically related needy or medically needy." These encompass persons who usually lack age or disability qualifications for categorical assistance money payments and are "needy" or "medically needy" and include mostly persons in the 21 to 64 age group on general assistance or with income and resources sufficient to pay living expenses but not medical costs. With one exception, no Federal matching is available to meet medical vendor payments for this fourth category.[15]

Table 7 classifies the Title 19 States according to their coverage of two or more of the four groupings: categorically needy, categorically related needy, categorically related medically needy, and noncategorically related needy or medically needy. It should be emphasized that individual State programs varied widely with regard to what they included within the last three groupings. For example, Missouri included under the third group only unemployable individuals who were receiving general relief, whereas Maryland's coverage for this group took in *all* residents of the State who were in need of medical care and could not pay for all or part of such care.[16]

HEW data on the number of recipients and amount of vendor payments in their behalf permit identification of the categorically needy but not the other groups, except for a rough identification of one group, as noted below.[17] As an approximate indication of the degree to which States have extended eligibility beyond the categorically needy, Table 8 shows, by the four classes used in Table 7, the percentage of total recipients who were not categorically needy (for detail, see Appendix Table A-3). Table 9 shows the percentage of total medical vendor payments on behalf of these recipients, by the same classification of States (for detail, see Appendix Table A-4). As would be expected, the classes of States covering the medically needy (those that include B and C) have the higher percentages.

From the standpoint of its fiscal impact, a significant decision for a State is inclusion of a broad segment of noncategorically related needy and medically needy in a Title 19 State plan (other than persons under 21 covered by the "Ribicoff amendment"), since no Federal matching is available for these people. A rough indication of its magnitude is provided by HEW data on medical vendor payments on behalf of other Title 19 recipients aged 21 to 64 for whom money payments were not authorized, shown in Appendix Table A-5. Columns (a) and (b) of the table largely, but not exclusively, represent these noncategorically related needy and medically needy. This group accounted for a substantial proportion of total recipients and medical vendor payments in New York (44 percent of recipients, 17 percent of payments) and Maryland (16 percent and 23 percent).

Table 7. Title 19 States Classified by Groups Eligible for Medical Vendor Payments

July 1, 1968

A (13 States)	AB (9 States)	AC (4 States)	ABC (12 States)
Georgia	California	Missouri	Connecticut[1]
Idaho	Delaware	Oklahoma[1]	Hawaii[1]
Louisiana	Illinois	South Carolina	Iowa
Maine	Kentucky	West Virginia	Kansas
Montana	Nebraska		Maryland
Nevada	New Hampshire		Massachusetts[1]
New Mexico	North Dakota		Michigan[1]
Ohio	Rhode Island		Minnesota[1]
Oregon	Wisconsin		New York
South Dakota			Pennsylvania[1]
Texas			Utah[1]
Vermont			Washington
Wyoming			

Key:
A = categorically needy and categorically related needy
B = categorically related medically needy
C = noncategorically related needy or medically needy

[1] Limited to persons under 21 in the noncategorically related needy or medically needy groups qualifying under the "Ribicoff Amendment." See footnote 15 of the text.

Source: Department of Health, Education, and Welfare, Assistance Payments Administration, Division of Program Operations, "Selected Characteristics of the Medical Assistance Program under Title XIX of the Social Security Act," (various dates). As of July 1, 1968 a number of States had submitted proposed changes in their plans which had not yet been approved and therefore are not reflected in the Table.

Table 8. Percentage of Total Recipients of Medical Vendor Payments Other Than the Categorically Needy: November 1967

Classification of States by Eligibles Covered	Median %	Range Among States	
		Low	High
A	24	* (Georgia)	47 (South Dakota)
AB	33	16 (Delaware)	54 (Wisconsin)
AC	N/A	N/A	N/A
ABC	41	13 (Iowa)	61 (New York)
All States	33		

*Less than 1 percent.

Source: Table 7 and Appendix Table A-3.

Table 9. Percentage of Total Medical Vendor Payments in Behalf of Recipients Other Than the Categorically Needy: November 1967

Classification of States by Eligibles Covered	Median %	Range Among States	
		Low	High
A	41	1 (Georgia)	64 (South Dakota)
AB	53	30 (Delaware)	73 (Wisconsin)
AC	N/A	N/A	N/A
ABC	67	31 (Utah)	75 (New York)
All States	52		

Source: Table 7 and Appendix Table A-4.

Number of people covered: before and after Medicaid.

The Tax Foundation's State survey in the Fall of 1967 found that in the first year of implementation, Title 19 had a wide range of effects on the number of people receiving public assistance medical care.[18] Estimates of changes in coverage ranged all the way from declines in four States (Maine, Oregon, Utah, and West Virginia) to a more than doubling in five (Connecticut, Delaware, Michigan, Montana, and Oklahoma).

Only a handful of States estimated the number that would be covered when the program is fully implemented. Tax Foundation concluded:[19]

> . . . in many instances the numbers served initially will be small in relation to the number eligible when the program is fully implemented. Those States beginning with minimum coverage might logically be expected to report significant further gains as the program is extended to other groups, as was the case in Maine and West Virginia. Even for some of the States with the broadest programs in terms of categorical coverage, however, the beginning programs are considered quite modest in relation to their potential. New York and Utah, both in the latter category, expect that their programs will eventually expand several-fold.[20]

Expansion of eligibles covered.

Section 1903 (e) requires States to show that they are making efforts toward providing by July 1, 1975 comprehensive care to "substantially all" persons who meet their eligibility standards. State plans as of July 1, 1968 indicated that 11 of the 37 whose programs were at least six months old had expanded coverage since inception of their programs (see Appendix Table A-6).[21] One of the States (Nebraska) expanded coverage to include the categorically related medically needy. The additional coverage in the other ten States was confined to bringing in other subgroups of the categorically needy, mostly persons over 65 in mental and tuberculosis institutions, and children under 21 who, except for age and school attendance, would be eligible for AFDC.

Services Provided

The original Medicaid act provided that State plans had to include some institutional and some non-institutional care, and by July 1, 1967, at least the five following basic services: inpatient hospital (other than in a TB or mental institution), outpatient hospital, other laboratory and X-ray services, skilled nursing

home services for those 21 years old and older, and physicians services. The 1967 amendments changed these requirements for the medically needy to provide that the State plan could include either the "basic five" services or any seven of the 14 total services listed in Section 1905 (a) of the Social Security Act, provided that some institutional and noninstitutional services were included.

Table 10 shows by State the number of services offered under the State Medicaid plans, distinguishing between services given only to the needy and those given to both the medically needy and needy. Differentiation is also made between the "basic five" services offered and 15 other services. The 15 correspond to the nine services specified in the Act beyond the "basic five," subclassifications of the nine, or other services provided at State option (for detail, see Appendix Table A-7). The State plans show that:

– 17 States provided to some degree at least 14 of the 20 medical services for both needy and medically needy (corresponding to 11 of the 14 services listed in the law).

– The 23 States which authorize care for the medically needy provided the basic five services to them as well as to their needy.

– Of these 23, all but five (Michigan, New Hampshire, Pennsylvania, Rhode Island, and Wisconsin) made the same list of services available to both groups; in some cases, however, limits were placed on the scope of particular services (California, Michigan, New Hampshire, Oklahoma, Pennsylvania, and Wisconsin).

– After the basic five, the most frequently provided services in descending order were prosthetic devices, home health care, dental care, prescribed drugs, eyeglasses, and transportation or ambulance.

Services before and after Medicaid.

Tax Foundation's survey found that in slightly more than half of the 26 reporting States Medicaid represented a "moderate expansion" of medical services in comparison with what was available under previous public assistance programs. The replies, in general, revealed that:[22]

> . . . the big change was not in the scope of medical services offered to those receiving most liberal aid under the pre-Title 19 program, but in the extension of comparable services to other groups, who in some instances had received only minimum medical assistance.

Subsequent expansion or addition of services.

With reference again to the Section 1903 (e) provision that States must move to expand services and coverage with a view to providing comprehensive care for substantially all the needy and medically needy – approved State plans as of July 1, 1968 indicated that ten of the 37 States that had programs at least six months old had added or expanded services since initiation of their programs (see Appendix Table A-8). Since all the States provided the "basic five" services, the extension covered a variety of the other nine services listed in the Act, plus others. The types of additions followed no special pattern, however. In general, States that already provided a wide range of services, either to the needy only or to both the needy and medically needy, seemed to be the ones that extended service coverage. Six States (Connecticut, Illinois, Kansas, Louisiana, New Mexico, and West Virginia) appear in both this list and the list of States that expanded the types of eligibles covered (Appendix Table A-6). Finally, a few States, such as Louisiana and Texas, cut back on some services.

Table 10. Services Provided under Title 19 to the Categorically Needy, the Categorically Related Needy, and the Medically Needy

July 1, 1968

	Total number of services provided	Number of basic services offered to:		Number of other services offered to:	
		Group I	Group II	Group I	Group II
California	20		5		15
Connecticut	20		5		15
Delaware	6		5		1
Georgia	8	5		3	
Hawaii	16		5		11
Idaho	7	5		2	
Illinois	17		5		12
Iowa	16		5		11
Kansas	14		5		9
Kentucky	8		5		3
Louisiana	11	5		6	
Maine	8	5		3	
Maryland	15		5		10
Massachusetts	18		5		13
Michigan	11		5	1	5
Minnesota	19		5		14
Missouri	7	5		2	
Montana	12	5		7	
Nebraska	17		5		12
Nevada	17	5		12	
New Hampshire	19		5	9	5
New Mexico	19	5		14	
New York	19		5		14
North Dakota	19		5		14
Ohio	19	5		14	
Oklahoma	12		5	2	5
Oregon	18	5		13	
Pennsylvania	10		5	4	1
Rhode Island	14		5	4	5
South Carolina	10	5		5	
South Dakota	14	5		9	
Texas	15	5		10	
Utah	15		5		10
Virginia	11		5		6
Washington	18		5		13
West Virginia	15	5		10	
Wisconsin	17		5	8	4
Wyoming	5	5			

Key: Group I – categorically needy and categorically related needy.
Group II– categorically needy, categorically related needy, and medically needy.

Source: Appendix Table A-7.

Income Eligibility Levels for Medically Needy

The most critical factor determining eligibility for the medically needy is the amount of annual income a family is presumed to need to meet normal maintenance requirements – food, clothing, and shelter. Such income levels under Medicaid regulations must be comparable as among individuals and families of varying sizes. Income in excess of that needed for maintenance will be applied first to costs required for necessary medical care recognized by State law but not encompassed within the Title 19 plan, and second, to costs of medical aid included in the plan.

It was little wonder that Congress, in attempting to contain the rising cost of the Medicaid program, decided to establish limits on annual income which it would allow States to set for the federally assisted medically needy. The limits established in the 1967 amendments to Title 19 are based on the highest amounts of money payments ordinarily paid to AFDC families of the same sizes. States are free to specify maximums above the limits, but Federal financial participation is barred for the portion above such limits. The 20 States whose Medicaid plans were approved prior to July 26, 1967 and included coverage for medically needy individuals are required to bring their income eligibility levels down to 150 percent of their top AFDC level by July 1, 1968; to 140 percent by January 1, 1969; and to 133-1/3 percent by January 1, 1970. The three States that began serving the medically needy after July 25, 1967 (Iowa, Kansas, and Vermont) must come within the 133-1/3 percent level by July 1, 1968, and other States that extend services to this group in the future must observe the 133-1/3 percent ceiling.

Table 11 indicates the number of States whose income eligibility levels for the medically needy as of June 1, 1968 fell within certain ranges.

Table 11. Number of States by Range of Income Eligibility Level for Medically Needy, June 1, 1968

One person		Family of four	
Income range	Number of States	Income range	Number of States
$1200-1399	1	$2400-2799	2
1400-1599	2	2800-3199	6
1600-1799	9	3200-3599	5
1800-1999	3	3600-3999	4
2000-2199	6	4000-4399	4
2200-2900	2	4400-4799	1
		4800-6200	1
Total	23	Total	23

Source: Appendix Table A-9

Appendix Table A-9 shows the detailed data by State for families of one to four persons and indicates, by parenthetical figures, HEW's preliminary estimates of the maximum levels permitted by the 1967 amendment that are below the levels actually in use on June 1, 1968. It indicates that the limitations would have differing effects, because States have set their income eligibility lines at varying distances from the maximum AFDC payment. For the 20 States subject to the three-stage cutbacks:

– Eight had to impose cutbacks to the 150 percent level by July 1, 1968 (California, Delaware, Kentucky, Maryland, New York, Oklahoma, Pennsylvania,[23] and Rhode Island); these States accounted for over 60 percent of Title 19 medical vendor payments for November 1967 and California and New York alone accounted for over 50 percent.

– Two additional States will have to impose cutbacks by January 1, 1969 (Connecticut and Illinois).

– Ten are already within the 133-1/3 percent range and will not have to make any cutbacks (Hawaii, Kansas, Massachusetts, Michigan, Minnesota, Nebraska, North Dakota, Utah, Washington, and Wisconsin).

– Of the three States that had to be within the 133-1/3 percent limit by July 1, 1968, only one (Iowa) had to impose a cutback to reach that level.

Governors' and legislative leaders' views.

The ACIR-NGC-NCSLL questionnaire asked Governors and State legislative leaders whether or not they considered the 1967 limitations on income desirable, and why. The responses from 34 Governors and from legislative leaders representing 18 States are summarized in Table 12 and are distributed between those from States whose existing income eligibility levels were above the new limits, and thus must be cut back, and those from "non cutback" States.

Table 12. Governors' and State Legislative Leaders' Opinions of the 1967 Amendment Imposing Limits on Medically Needy Income Eligibility Level

Limits considered –	Governors of –			Legislative leaders of –		
	Cutback[1] States	Non-cutback States	Total	Cutback[1] States	Non-cutback States	Total
Desirable	6	19-1/2[4]	25-1/2	3	9-1/2[3,4]	12-1/2
Not desirable	3	5-1/2[4]	8-1/2	2[2]	3-1/2[4]	5-1/2
	9	25	34	5	13	18

[1]States whose eligibility income levels had to be cut back to meet new Federal limits.

[2]Three legislators from one State tabulated as one.

[3]Two legislators from one State tabulated as one.

[4]Two respondents from one State expressed conflicting viewpoints.

Source: ACIR-NGC-NCSLL questionnaire survey, Summer, 1968.

Governors by a margin of almost three to one considered the limits desirable, with the Governors from the "cutback" States favoring them by two to one and the others by over three to one. Legislative leaders who responded to the question represented many fewer States than the Governors, but two-thirds of those who replied gave an affirmative response. In four States that responded, the Governors favored the limits

while the legislative leaders were opposed. In one State, the Governor opposed the limits while the legislative leader believed they were desirable. In all other cases Governors and legislative leaders were on the same side of the issue.

Governors gave various reasons for their opinions. Among those favoring the limits, 13 used general terms of endorsement, such as "realistic," "reasonable," and "equitable." Five believed that the limits would put needed pressure on States to raise their public assistance standards, particularly AFDC, expressing or implying the view that such assistance should have priority over providing medical care for the medically needy. Five others said they favored the limits, but indicated that they felt these are too low. Three Governors stated that the limits insured that Federal money would go to those most in need, and one contended that they would keep the wealthier States from using up an undue share of available Federal funds. One expressed support but reserved judgment as to whether these would prove to be the right limits; and one, while endorsing the limits, complained about the short lead time for putting them into effect.

Among the Governors opposed, three thought that the question of limits should be left to State legislatures to decide; three felt that the limits would prevent the extension of adequate medical care to the medically needy, with one citing the heavy burden placed on State and local finances to provide an adequate standard of such care; and one Governor opposed the limits as unrealistic in light of his State's high cost of living. Two Governors opposed the distorting tendencies of the limits when applied to the severity of need for medical care or to basic maintenance need.

Among the legislative leaders from the States considering the limits desirable, nine stated that there must be some limit and three suggested that the limits would help give greater priority to the need for raising inadequate maintenance assistance standards. Three legislators each advanced differing views: one stated that the limits were desirable at least for the time being; another that they would help prevent overloading the program and bankrupting the States; and the third that the curbs would keep the wealthier States from taking the bulk of Federal money. While indicating the need for limits, three legislative leaders contended that the present AFDC standard failed to meet the criterion for regional variations based upon differences in cost of living, and that there was no assurance that States would not use the level of AFDC payment to expand or contract the care provided to the numbers of medically needy.

The legislative leaders from three of the States responding negatively generally felt that the Federal Government should not shift so much of the burden to the States as long as it insists on coverage for the medically needy, while one respondent believed that the limits represented a further expansion of Federal control into matters which are primarily of State concern. One thought that the limits are not low enough and another, that they should not be related to the eligibility income level for public assistance. One legislative leader asserted that limiting the numbers of eligible medically indigent is contrary to the concept of aiding those who have suffered catastrophic illness to return to self-sufficiency.

Resource Levels for Medically Needy

While current income is the principal financial resource relied on for paying medical bills, savings, insurance, and various other kinds of real and personal property are in varying degrees available to meet medical expenses. Under Title 19, resources which may be held must at least be at the most liberal level used in any Federal categorical assistance program in the State on or after January 1, 1966. Further, the amount of liquid assets which may be held must increase with an increase in the number of persons. A State may set limits on resources that may be protected from being applied toward maintenance costs so long as such limits are reasonable. Moreover, resources in property must be reasonably evaluated; State regulations must not take into account the financial responsibility of any individual for any assistance recipient unless the recipient is the individual's spouse or child under age 21 or is blind or disabled; must provide flexibility in applying eligibility standards on income by taking into account costs incurred for medical care, including insurance

premiums; and, with certain exceptions, must provide that no lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf.

Figure 4 summarizes for the 23 States serving the medically needy on June 1, 1968, the provisions under each State plan for the amount of cash or other liquid resources that may be protected from use for medical expenses (see Appendix Table A-10 for details).

Factors Tending to Lower State-Local Costs

Expansion of the number and types of eligibles and the number and scope of services produced an upward thrust in total costs of medical assistance payments. So far as the State-local share was concerned, however, certain provisions of Medicaid and other parts of the 1965 Social Security Act amendments offered the potential of some offsetting reductions. These were (1) liberalization of Federal matching, (2) increases in the income of State and local government hospitals from Medicare and Medicaid payments for indigent and medically indigent patients formerly carried at the expense of those hospitals, (3) increases in income of State and local mental and tuberculosis hospitals resulting from the 1965 Social Security Act amendments that permitted federally assisted maintenance assistance as well as medical assistance payments for old age patients in these institutions, and (4) miscellaneous offsets to State and local costs due to changes in other Federal health service policies. The Tax Foundation questioned the States about the actual effects of these changes in the first year of their Medicaid programs.[24]

Increased Federal matching.

Title 19's "maintenance of effort" provisions was intended to result in States' passing on additional Federal funds to public assistance recipients, rather than using them to replace State-local funds. Tax Foundation found, however, that at least in the first year of their Medicaid programs, seven States reported reductions in State-local medical vendor payment costs -- Illinois, Iowa, Maryland, Minnesota, Ohio, Oklahoma, and Oregon.

Effects of initiating Medicare and terminating Kerr-Mills.

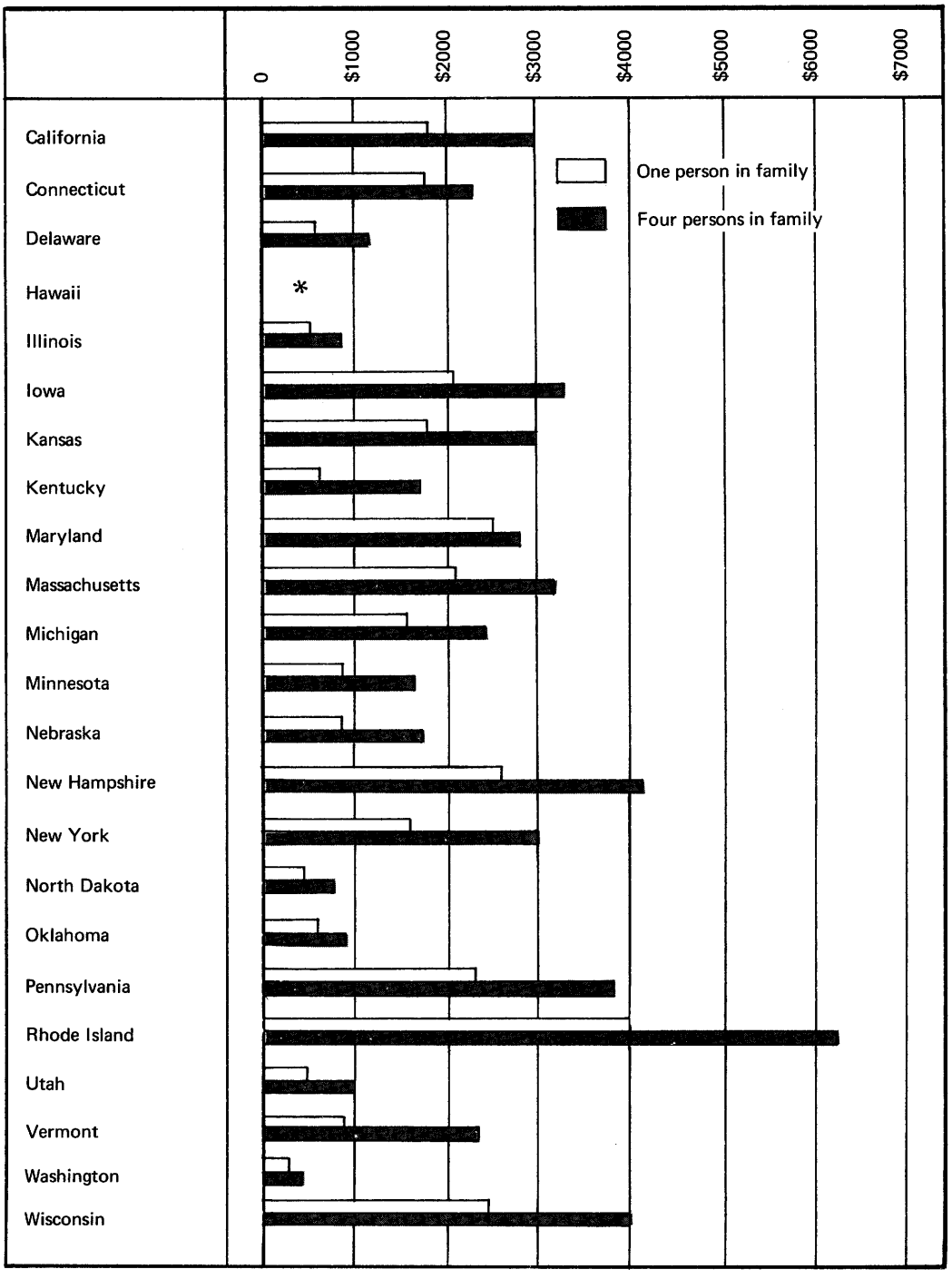
Medicaid is charged for deductible and coinsurance costs for indigents under Medicare, yet Medicare could be expected to effect a net drop in Medicaid expenses by covering many medical expenses of the poor aged. Also, replacement of a Kerr-Mills program by a Title 19 program limited to the needy would reduce costs by eliminating the medically needy eligibles covered under the former.

Tax Foundation found that two-thirds of the States responding to a question on these effects indicated some reductions were achieved. Fairly substantial dollar offsets were reported in Massachusetts, Michigan, Minnesota, Ohio, Pennsylvania, and West Virginia.

Additional income of State and local hospitals.

Tax Foundation received few responses to its inquiry on the effects of the 1967 Social Security Act amendments on State and local hospitals' income. It concluded that experience had been too limited to warrant a generalization.

Figure 4. Cash or Other Liquid Resources Levels for Medically Needy in Title 19 Plans in Operation on 6/1/68



*"At least as high as those uniform levels now in effect for the money payment programs."

Source: Appendix Table A-10.

Other cost offsets.

A few States anticipated reduced State and local outlays from increased Federal sharing in other health services. Included were such services as maternity and infant care project costs (Hawaii), afflicted children's program (Michigan), foster care (Oregon), crippled children (Illinois), and mentally retarded in State schools (Pennsylvania).

State-Local Sharing of Non-Federal Funding

One of the requirements of Title 19 is that the State bear at least 40 percent of the non-Federal share of the expenditures, and effective July 1, 1969 assume all the non-Federal share "or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan . . ."[25] Until the 1967 amendments the deadline for full State assumption or equalization of the non-Federal share had been July 1, 1970.

Of the 37 States that reported Medicaid expenditures for calendar year 1967, 15[26] shared the non-Federal cost with their local governments, as shown in Table 13. According to these figures, all 15 were well above the 40 percent minimum requirement. (For provisions of State plans establishing State-local sharing, see Appendix Table A-11).

Information obtained from the States through the ACIR-NGC-NCSLL questionnaire indicates that in one of the States for which a local contribution is shown in Table 13 (Pennsylvania) local governments were not sharing in the funding at the time of the response (April-June 1968), and that as of July 1, 1968, the State of Massachusetts would assume the full non-Federal share as part of its assumption of the financing of public assistance. HEW sources indicate further that Vermont planned to go to full State coverage on October 1, 1968.

Governors' and legislative leaders' views.

Governors and State legislative leaders were asked their opinions of the statutory provision for State assumption of the total non-Federal share or distribution of the State share on an equalized basis. Among the Governors responding whose States have full State payment of the non-Federal share, four indicated general approval of the system as being fair, equitable, or assuring more statewide uniformity. One ventured the opinion that the State should assume all welfare costs, not only those of Medicaid. One cited difficulties his State had had with an equalization system for local education aid. Another felt that States must pay the bill if they are to exercise the required control over the program. Two indicated dissatisfaction with the requirement, one feeling that the State should have an option and the other saying bluntly that the provision intrudes on the State's right to decide how it wants to finance its share.

Among the Governors whose States have local sharing, one stated that he saw no reason to alter a cost sharing pattern that had existed since 1929. Another felt there was greater county surveillance when these jurisdictions were required to participate financially. One contended that transferring the full non-Federal share to the State would not guarantee availability of funds. Another respondent contended that if the 1975 goals are to be met, States may be forced to spread some of the costs of medical assistance over local jurisdictions unless Federal sharing is provided for all medical care. Two acknowledged that State mandating of local sharing could impose hardships; two believed that full State assumption of the non-Federal share was not necessary since State laws provided for State reimbursement or subsidization in the case of localities which were unable to assume their share of costs of medical care; and one stated outright that there should be full State responsibility. Twenty-one Governors expressed no opinion on this issue.

Table 13. State and Local Sharing of Non-Federal Costs of Title 19 Medical Vendor Payments, Calendar Year 1967[1]

(amounts in thousands)

State	State funds		Local funds	
	Amount	Percent	Amount	Percent
California	$197,235	67%	$ 97,405	33%
Kansas[2]	2,320	53	2,079	47
Maryland[2]	29,105	91	3,041	19
Massachusetts	50,409	67	24,800	33
Minnesota	14,835	50	14,847	50
Montana	446	53	394	47
Nebraska	3,463	49	3,661	51
Nevada	502	47	574	53
New Hampshire	273	64	154	36
New York[2]	242,777	56	192,447	44
North Dakota	2,560	86	425	14
Oregon	2,843	85	502	15
Pennsylvania[2]	58,155	85	10,165	15
Vermont	1,582	79	420	21
Wisconsin	19,028	54	16,111	46

[1] Only the 15 States shown had State-local sharing. Twenty-two other Title 19 States had full State assumption of non-Federal cost.

[2] The figures for Kansas, Maryland, New York, and Pennsylvania are not the precise State share percentages for Medicaid expenditures for which Federal money was available, since they include payments for persons not eligible for Federal funds, e.g., the noncategorically related needy and medically needy. These are the best data available and probably approximate the State-local sharing of those portions of Title 19 programs for which Federal funds are available.

Source: U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, *Sources of Funds Expended for Public Assistance Payments, Calendar Year Ended December 31, 1967.*

Among the State legislative leaders whose States pay the full non-Federal cost, one indicated that the system raised no problems; three cited the difficulties local governments would have in contributing; and two thought an equalization system is difficult, unreliable, and illogical. One legislator believed that local governments should have some obligation to help support the program financially and police its operation.

The State legislative leaders from the four States now under local cost sharing uniformly favored this arrangement. Comments included:

– "Do not like provision (for full State assumption)."

– "Oppose Federal dictation."

– "This is unwarranted meddling by the Federal Government in a matter which is and should continue to be a purely State and local matter."

– "Transferring non-Federal share entirely to State will not guarantee funds being available."

– "The Federal Government dangles too many carrots. We in [ ] cannot match all these Federal matching fund projects."

– "Counties will exercise higher degree of surveillance if they share financially."

One legislator contended that the provision was reasonable. Since the amount of local sharing was fixed in his State, the funds available for the program did not depend upon the size of the local contribution. Three of the responding State legislative leaders expressed or implied no opinion on the issue.

State-Local Tax Changes

Tax Foundation's survey asked the States whether any new taxes had been enacted or existing tax rates raised to support the Medicaid program. None of the 27 States with programs in operation reported that new or higher State-level taxes had been imposed to date solely for Medicaid, but several indicated that recent increases were linked in part to the Medicaid programs:[27]

> In California, it was anticipated that a portion of a one-cent increase in the state general sales tax would be needed to support the medical program in future years. Recent state tax increases in Hawaii were attributable in part to a "much larger budget for increased medical care." The state takeover of welfare costs in Massachusetts was reported to be a major factor in the $94 million tax increase program enacted in that state during 1967. And in Pennsylvania, medical assistance costs were reported to be reflected in a threatened general fund deficit for fiscal 1967-68 which led to the enactment late in 1967 of a $264 million tax increase.

Some responses indicated that higher taxes were forestalled by postponing initiation of a Medicaid program or by restricting the program's scope:[28]

> In at least 6 of the 13 states not operating Medicaid programs as of January 1968, reports indicated that new revenue sources would be required if the program were adopted (Alabama, Arkansas, Colorado, Florida, New Jersey, and Tennessee). Further, seven states with Medicaid programs reported that the initial legislation had included authority to expand the program to cover additional persons, but that funds had not yet been made available by the legislature for funding more liberal programs (Idaho, Iowa, Louisiana, Maine, North Dakota, Ohio, and Oregon). For the most part, these states had established minimum programs, covering only the medical care of regular welfare cases, exclusive of medically indigent persons.

THE 1975 GOAL AND ITS IMPLICATIONS

A wide gap clearly exists between the present coverage of State Medicaid programs and the 1975 goal of comprehensive care for "substantially all" the needy and medically needy set by Section 1903 (e) of Title 19. How large is the gap in money terms? Official estimates are not available from HEW and presumably will not be at least until the recommendations of the Joint Task Force on Medicaid and Public Assistance Costs are implemented. In calendar year 1967 $2.5 billion was spent by 37 States with programs of various degrees of comprehensiveness in persons covered and services offered. The HEW budget projection for FY 1969 is a total Federal-State-local outlay of $4.1 billion, with six States still expected to be outside the program for the

entire year, six others for part of the year, and many of the remaining 38 States at various stages of achieving comprehensiveness. Thus it might well be expected that the cost of a full program for all 50 States would reach $6 or $7 billion a year or more by 1975, assuming continuation of present conditions including the recent 5 percent annual increase in the cost of medical services.

The fiscal implications of such a rising cost for the next seven years depend on how seriously the Federal and State governments regard the 1975 goal and how conscientiously they seek to implement it. Indications are that, at this point, Congress – and specifically the House Ways and Means Committee and the Senate Finance Committee – does not intend to implement the 1975 requirement. The limited documentation found in the legislative history of Section 1903 (e) indicates that Congress must have given perfunctory consideration to the implications of the provision when putting it in Title 19. The section was not included in the Administration's original proposal; the reports of the two "money" committees of Congress did little more than repeat the words of the law itself; and there is no record of comment on the section in the floor debate in either House. Moreover, the 1966 report of the Ways and Means Committee on methods of limiting costs of the program – issued even before the end of the first year of operation – and the 1967 amendments setting a ceiling on Federal financial participation in the care of the medically needy, provide clear evidence that Congress was and is interested in moving back from the existing program level, rather than gradually expanding toward broad coverage for all eligibles by 1975. In the opinion of persons familiar with the attitude of the "money" committees, Congress is not likely to be interested in encouraging, let alone requiring, the States to expand their programs until such time as more adequate controls are placed on costs incurred under such programs. Indeed, the same sources seem to expect action by Congress to repeal Section 1903 (e) long before 1975.

Section 1903 (e) assigns the Secretary of HEW responsibility for determining whether a State, from the time of initiation of its program, is "making a satisfactory showing that it is making efforts in the direction" of broadening the program toward meeting the 1975 goal. Thus far States' efforts along these lines have been relatively modest. HEW guidelines state that, "until appropriate goals are reached," State effort must be evident in strengthening administrative and supervisory staff, broadening the scope of services, liberalizing eligibility requirements to admit more low-income persons, and intensifying social services.[29] Yet there appear to be different views among Medical Services Administration personnel on how conscientiously to push implementation of Section 1903 (e). In any case, it seems likely in the light of executive-legislative relationships, that HEW will take its cue from Congress.

Even if Section 1903 (e) stands as is, and the Secretary of HEW actively pursues implementation, what the States themselves choose to do will be critical in determining the actual program and fiscal impact. They have basic discretion within statutory and HEW guidelines to set income and resource limits for eligibility for the needy and medically needy. The limits that many States establish for categorical assistance are substantially below the income required for basic maintenance under any objective standard. In 1966, for example, 29,657,000 persons were below the poverty level as defined by the Social Security Administration,[30] yet only 8,073,000 were receiving public assistance. The 21-plus million not covered included some who were within the State eligibility limit but were denied, refused, or decided not to avail themselves of, the opportunity to get assistance; others were beyond the reach of even the most positive casefinding. Clearly, a considerable number of the group were excluded from public assistance because their incomes lay somewhere between the low eligibility level set by the States and the amount deemed necessary to provide an adequate minimum standard of living. Moreover, since eligibility standards for the medically needy are tied to those for the needy, inadequate State standards for the latter would carry over to the standards for the medically needy.

In short, so long as the current Congressional attitude persists, it may be questionable policy to expect that the Federal Government will strive to achieve comprehensive care for substantially all the needy and medically needy by 1975. Moreover, even if the Federal Government conscientiously pursued implementation of 1903 (e), the fiscal and program effects would still be in doubt since so much depends on standards

of eligibility for the needy and medically needy set by the States, and past experience suggests that many might set such standards well below realistic standards of need.

THE PROBLEM OF RISING MEDICAL COSTS

A key factor contributing to the rising curve of Medicaid expenditures is the increase in medical costs. Medical prices rose 6.6 percent in 1966 – the first year of Medicaid; in 1967 they went up 6.4 percent. In those two years the general price index went up 3.3 and 3.1 percent, respectively. Since the Medicaid program constitutes only one corner of the total medical services market, it is necessary to look at the industry as a whole to comprehend the forces that are determining medical costs and are therefore contributing to the fiscal problem confronting the Federal and State governments in the operation and financing of Medicaid.

Medical Care Price Trends[31]

There is nothing new about rising medical costs. The medical care component of the Bureau of Labor Statistics consumer price index has risen continuously for 25 years. Since World War II, however, medical prices have gone up considerably faster than overall consumer prices – from 1945 to 1967 the medical price index rose by 136 percent compared to 86 percent for the overall consumer price index. The rise in the former, moreover, was particularly sharp in 1966 and 1967, as indicated in Figures 5 and 6 and Table 14.

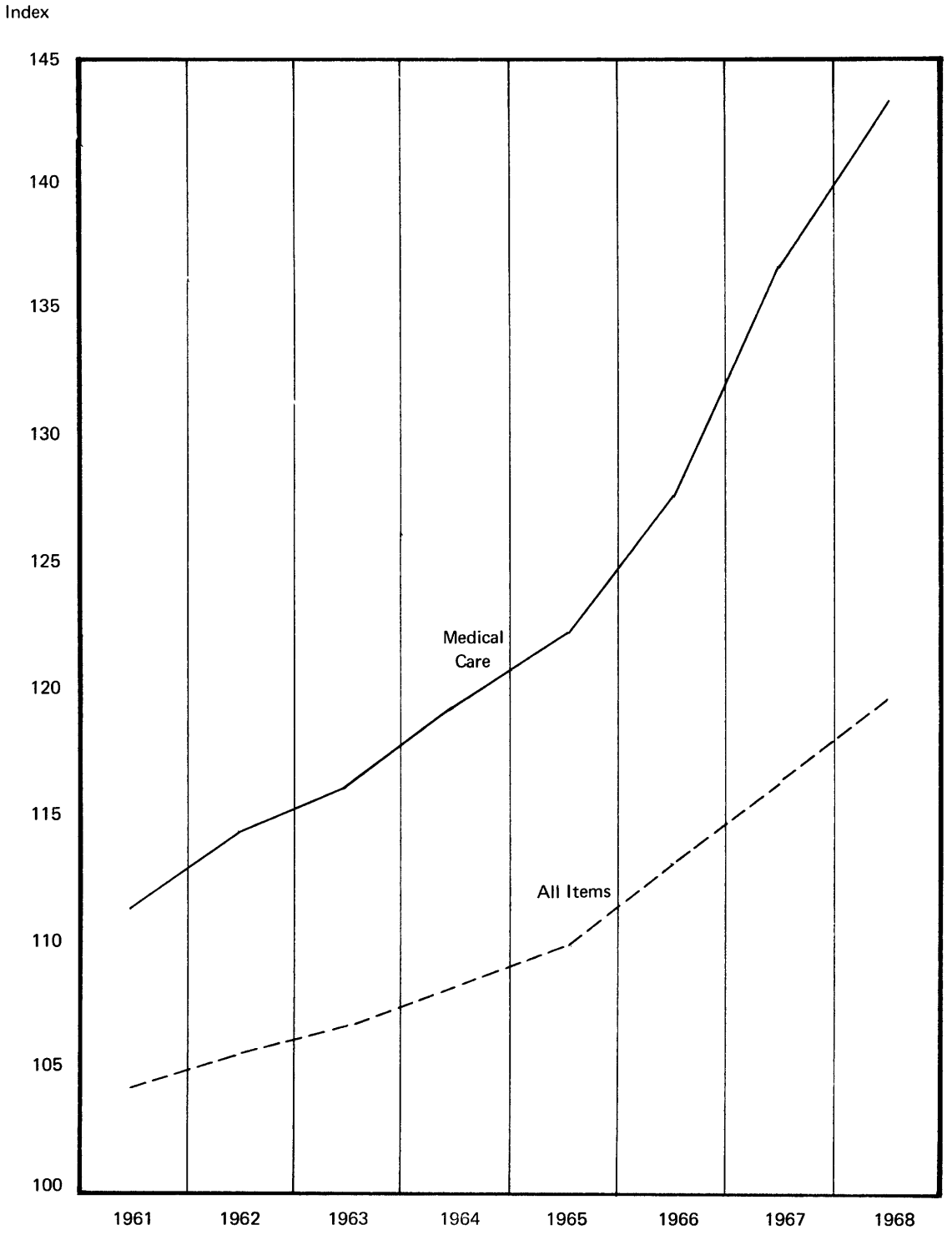
Table 14. Consumer Price Index: Percent Increases by Type of Component

	Percent increase			
	Average annual 1960-65	Dec. 1964-Dec. 1965	Dec. 1965-Dec. 1966	Dec. 1966-Dec. 1967
Consumer price index	1.3	2.0	3.3	3.1
All medical care	2.5	2.8	6.6	6.4
Hospital charges	6.3	6.6	16.5	15.5
Physicians' fees	2.8	3.8	7.8	6.1
Drugs and prescriptions	–0.8	0.0	0.2	– 0.2

Source: Department of Labor, Bureau of Labor Statistics.

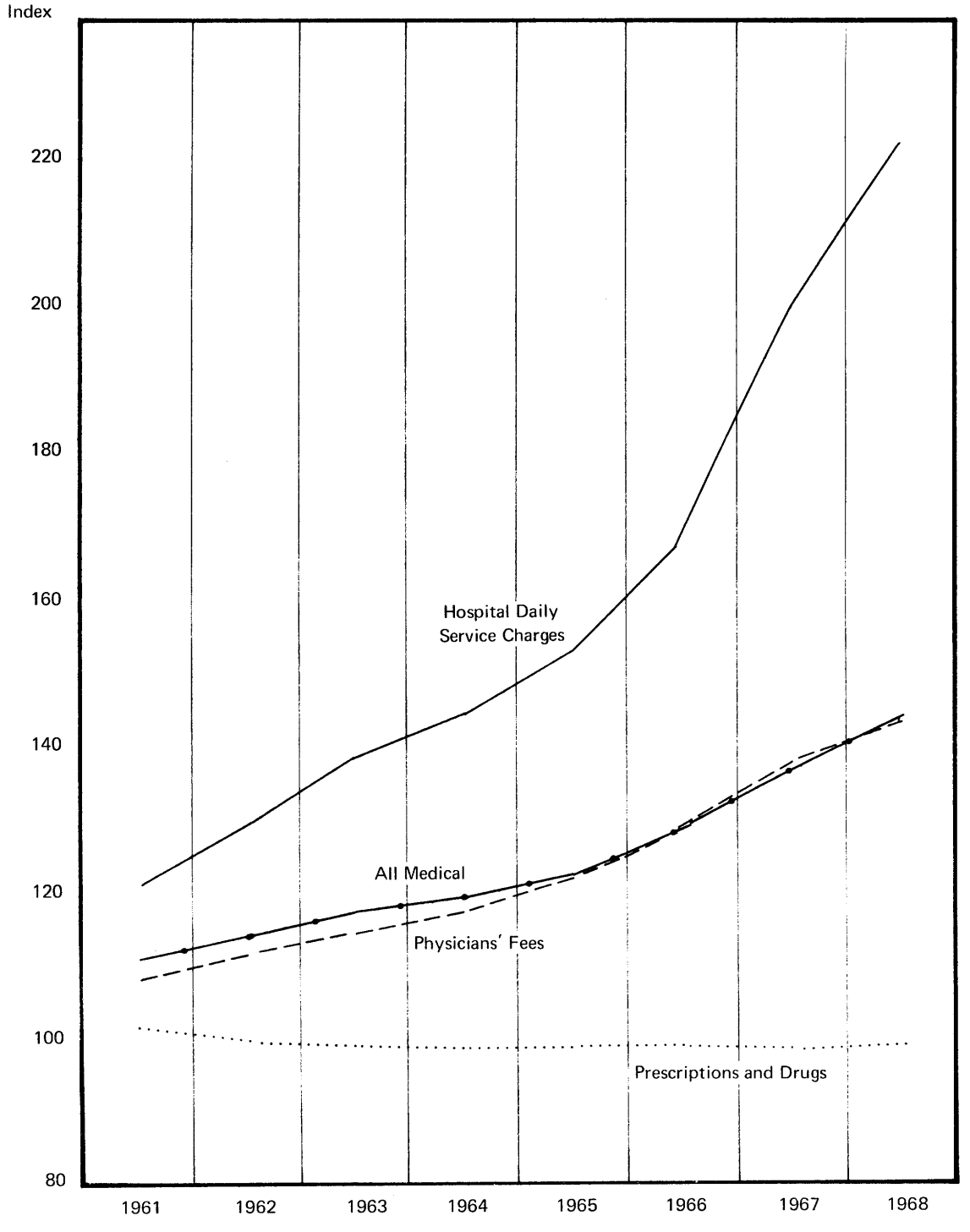
The breakdown of the medical care index into its components in Table 14 shows that hospital charges and physicians' fees were responsible for the overall increase in the index. The increase in physicians' fees was about 3 percent per year in the period 1960-65, went up to 7.8 percent in 1966, and dropped to 6.1 percent in 1967. The 1966 annual increase was the largest since 1927 – the earliest date for which these figures are available. Hospital daily charges, which had been rising about 6 percent per year between 1960 and 1965 skyrocketed to 16.5 percent in 1966 – the largest annual increase in 18 years – and dropped to 15.5 percent in 1967. In contrast, the drugs and prescription component has remained steady. There was an actual decrease of 0.8 percent between 1960-65, a 0.2 percent gain in 1966, and another decrease of 0.2 percent in 1967.

Figure 5 — Consumer Price Index, 1961-1968 (1957-1959 = 100)



Source: Department of Labor, Bureau of Labor Statistics

Figure 6 — Medical Care Price Index, 1961-1968 (1957-1959 = 100)



Source: Department of Labor, Bureau of Labor Statistics

The 1966-67 increase in medical care prices is, at least partly, a reflection of the widespread inflationary pressures in the economy. The rate of increase in the consumer price index as a whole, for example, in 1966 was 3.3 percent – the largest in 15 years. It dropped somewhat in 1967 – to 3.1 percent.

Expensive New Technology

Medical practice has been one of the leading participants in the general explosion of science and technology, and possesses cures and preventives that could not have been predicted a decade ago. Thus underlying the general rise in medical care costs is the development of costly new techniques and apparatus for detecting, diagnosing, and treating illness, such as renal dialysis, open heart surgery, organ transplants, high voltage x-ray therapy, and ultrasonic diagnostic techniques.

The products of the new technology are usually expensive to acquire, and highly trained and well-paid technicians are required to maintain and operate them. A new apparatus for x-raying the inner ear and hearing nerve, for example, costs $75,000 to import from Europe and $25,000 to install. The physician is able to diagnose tumors of the hearing nerve as small as a pea with this equipment, whereas before he could not make the diagnosis until the tumor had become as large as a small lemon and had reached the brain.

Physicians' Fees

The sustained increase in the demand for physicians' services without a corresponding expansion in the number of physicians has caused the general rise in physicians' fees since 1950. Population growth and the increase in disposable income per capita have generated a rising demand for physicians' services. This demand has been accelerated further by the public's desire for better medical care, by the changes in the characteristics in the population (the larger percentage of young children and elderly have created an additional demand), and by the greatly expanded number of persons covered by surgical expense insurance.

The supply of physicians, however, has grown more slowly since 1950. Although the number of active physicians increased by 33 percent, the total number of family physicians (pediatricians, internists, and general practitioners) actually declined. Further, the number of physicians in private practice increased only 14.3 percent.

In the years ahead, the minimum demand for physicians' services can be expected to increase at least by one-third. But as Medicaid is widely adopted and provision of medical care for the poor expands, authorities anticipate that the demand for physicians' services will increase substantially more than this amount. The number of physicians is not expected to increase more than 17 percent in the next decade. Unless the number of physicians increases more rapidly than expected, or their productivity rises, or both, it will not be possible to meet the anticipated need for physicians' services. Demand will continue to rise rapidly and services consequently will be rationed via the price mechanism.

Hospital Charges

Hospital services are the most expensive form of medical care. Admissions to non-Federal, short-term general hospitals increased from 128.9 to 139.2 per thousand population from 1960 to 1966. Changes in the characteristics of the population, rising incomes, and broader insurance coverage have all tended to increase hospital utilization. In spite of the greater use of hospitals, the average length of stay of patients has remained quite stable in recent years.

Wages and salaries are major components of hospital costs. Nevertheless, payroll costs as a proportion of total hospital costs have remained remarkably constant during the past ten years. Despite this stability, the number of employees per patient has been rising. The average earnings of hospital employees have also been rising at a rapid rate as many employees for the first time are now being phased into the new minimum wage law standards.

Non wage costs, of course, have increased along with the general consumer price index. Expenditures for food, drugs, and other commodities depend on the number of patients in the hospital and the price level of the commodities in question. Maintenance, heat, light and power, as well as depreciation charges, constitute a large share of non wage cost. These are fixed charges and their costs are predetermined by the size of capital investment rather than volume of services provided and thereby represent the particular size of the hospital's plant and equipment. Over the past few years hospitals have become much better equipped with specialized care facilities, most of which are expensive to install and operate. Hospitals have also been placing increased emphasis on non-medical facilities such as private rooms, air conditioning, and individual baths or toilets. Finally, new hospital construction has become steadily more expensive.

Prices of Drugs and Prescriptions

The drug component of the consumer price index has not been a major contributor to rising medical prices. The percentage of disposable income spent on drugs, however, has increased, reflecting a significant increase in the use of drugs by the average consumer. A large proportion of total drug expenditures is accounted for by persons who are high users of medical care. For example, in 1962, 10 percent of those persons over age 65 incurred 40 percent of the expenditures on drugs by all persons over the age of 65.

Although drug prices are not rising appreciably, studies have shown that such prices are higher than need be if there were greater price competition in the industry either at the manufacturing or retail level. The pharmaceutical industry is characterized by high concentration, high advertising cost, and intense nonprice competition.

Proposals for Moderating Price Increases

A report on medical costs, published in early 1967 by the Department of Health, Education, and Welfare, offered little hope for an early end to medical price increases.[32] The Nation's growing population and rising income, as well as the demand for adequate medical care for all citizens, the report stated, will continue to put pressure on medical prices. The authors concluded, however, that steps can be taken to moderate the rise in medical prices by using medical resources more efficiently. They recommended:

– Establishment of a National Center for Health Services Research and Development to discover and disseminate new ways of delivering health care efficiently.

– Encouragement of group practice of medicine.

– Strong Federal support of State and areawide planning for the efficient use of health resources.

– Reexamination of the reimbursement formulas in Medicare and Medicaid in an effort to design formulas which increase the incentives to health institutions to operate efficiently.

– Appointment of a Presidential commission to review Federal programs of support for health institutions with an eye to the efficient distribution of such institutions.

– Training and use of physicians' assistants, innovations in medical education, and efficient use of medical manpower.

– Initiating a study of frequently prescribed drugs to determine the relative therapeutic value of brand name products and other drugs with the same generic equivalents.

The National Conference on Medical Costs convened by President Johnson in June 1967 focused on the problem of medical costs within an industrywide context. The 300 participants representing both providers and consumers of health services were not asked to agree upon formal recommendations or to indicate specific courses of action. They were requested, however, to present ideas and proposals concerning medical care costs and the impact of these costs upon the availability of health care services.

In its "restatement of the problem," the Conference made a pointed reference to the special character of the medical industry as an important factor affecting rising medical costs:[33]

> The health care industry differs markedly in structure (as the economists use this term) from the structure of other industries in the United States. Entry into the practice of medicine is severely restricted and competition among practitioners is circumscribed. The buyer of medical service is seldom competent to assess the services that are offered or the price that will be charged. There is virtually no price competition. Nonprofit operations are the rule in the hospital field. Advertising and patent control influence the market for drugs. A large and increasing portion of all costs of medical care are paid for through insurers. These characteristics of the health care industry condition the ways in which medical care costs can be controlled.

The Conference generally supported the recommendations of the HEW report on *Medical Care Prices* and suggested further long range solutions:[34]

– Physicians have a responsibility to help reduce the cost of medical care to individual patients through limiting needless hospitalization, supporting the training and employment of physician and other health assistants, encouraging group practice systems, and reducing the prescription of unnecessary drugs.

– Pharmacists should utilize a "professional fee" rather than a "percentage fee" as a means of counteracting the incentive for dispensing high cost drugs.

– Hospitals should work closely with local health planning councils. Where appropriate, there should be more extensive use of ambulatory care, home care, and extended care facilities as substitutes for hospital care. Incentives should be utilized to encourage hospitals to increase productivity, to furnish weekend utilization comparable with weekday use, to centralize services and facilities, to employ drug formularies and generic drugs wherever possible, to maintain adequate cost records and effective cost control systems, to plan for the discharge and after-care of patients, and to provide comprehensive services to special groups.

– The need for developing adequate comprehensive health insurance protection is critical, particularly for those persons who are not members of employed groups.

– State laws which prohibit the establishment of consumer-sponsored, group practice plans or other types of group practice prepayment systems should be repealed.

Medicaid and Rising Medical Costs

Governmentally financed expenditures represented an appreciably greater share of total expenditures for personal health care in 1966 than in 1965, as seen in Table 15. The governmental share rose from 21.3 percent in 1964 and 21.4 percent in 1965 to 24.8 percent in 1966. Of the $2.2 billion increase in governmental expenditures in 1966, about $500 million was due to medical assistance under Medicaid and public assistance (see Appendix Table A-1). Medicare accounted mainly for the remainder. Although actual total figures are not available, Medicaid expenditures very likely represented even a larger share of total health expenditures in 1967, since they increased $1.3 billion in that year. It seems fair to conclude that the unusual increase in medical care costs in the past two years must have been due to a considerable extent to the sudden spurt in demand created by Medicare and, to a lesser extent, Medicaid, considering the inelasticity of the supply of physicians' services and the generally noncompetitive character of the medical market noted earlier.

Table 15. Amount and Percent of Expenditures for Personal Health Care[1] Met by Out-of-Pocket Payments and by Third Parties, 1964-66

(amounts in millions)

	1964		1965		1966	
	Amt.	%	Amt.	%	Amt.	%
Out-of-pocket expenditures	$17,005	52.5	$18,259	51.8	$19,517	49.9
Third-party payments	15,403	47.5	16,983	48.2	19,598	50.1
Private health insurance	7,832	24.2	8,729	24.8	9,142	23.4
Government[2]	6,903	21.3	7,557	21.4	9,712	24.8
Philanthropy and others	668	2.1	697	2.0	744	1.9
Total	$32,408	100.0	$35,242	100.0	$39,115	100.0

[1] All expenditures for health services and supplies other than (1) expenses for prepayment and administration, (2) government public health activities, and (3) expenditures of private voluntary agencies for other health services.

[2] Includes benefit payments under health insurance for the aged (Medicare).

Source: Dorothy P. Rice and Barbara S. Cooper, "National Health Expenditures, 1950-66", *Social Security Bulletin,* April 1968, Table 9, p. 19.

The report on *Medical Care Prices* pointed out that medical care price rises can be moderated by using resources more efficiently. Conversely, to the extent that efficient use of resources is not achieved medical price rises are given further impetus. Indications are that Medicaid by and large has some distance to go in achieving efficiency. This is suggested by the *Medical Care Prices* report's urging of reexamination of the reimbursement formulas in Medicare and Medicaid so as to increase incentives to health institutions to operate more effectively; by Congress' setting of a limit on the income level of the medically needy for which Federal cost-sharing would be available, stemming at least in part from dissatisfaction with expenditure control measures under Medicaid; by section 237 of the 1967 Social Security Act amendments requiring States to provide safeguards against overutilization and assure that payments do not exceed reasonable charges; by section 402 of the 1967 amendments authorizing experiments with various methods of reimbursement which

offer incentives for keeping program costs down; and finally by widespread complaints about States' payment of physicians on the basis of usual and customary charges rather than fee schedules.

To sum up the relationship of Medicaid to rising medical care costs, Medicaid has indeed suffered from the industrywide rise in medical costs. Yet a good case can be made for the contention that it has contributed more than proportionately to that rise in the past two and a half years, through its sudden injection – in combination with Medicare – of billions of additional dollars on the demand side. Its lag in achieving effective controls over expenditures has also added to the pressure on medical prices. On the other hand, the rapidly advancing technology of medicine, accompanied by inevitably increasing costs for more sophisticated equipment and treatment methodology, seems to dictate that savings on medical costs lie at the margin rather than the core of the medical cost problem.

OTHER INTERGOVERNMENTAL ISSUES

Governors and State legislative leaders were asked in the ACIR-NGC-NCSLL survey to comment on their States' efforts to evaluate the impact of the Medicaid program, the linkage of Medicaid with comprehensive health planning, and other problems of an intergovernmental nature that their States had experienced. Their replies provide an insight into progress under Medicaid and some of the problems encountered.

Program Evaluation Efforts

State officials were asked: What steps, if any, is your State taking (or planning to take) to evaluate the effects of the Medicaid program in such terms, for example, as average number of days in hospital per eligible recipient, death rate, infant mortality rate?

Most respondents interpreted the question as referring to data to be used in controlling the utilization of medical services, such as length of stay in hospital or nursing home, or number of physicians' visits. A few indicated their intention to evaluate the program in the broader sense, that is, its ultimate impact on people's health and life span. None of the latter, however, indicated that they had such an evaluation program underway. Some stated that their tardiness was due to having come recently under Medicaid. Many indicated recognition of the need for developing a computerized information system, whether for utilization control or broad impact evaluation, but a large number seemed to be only in the early stages of setting up such systems. According to one legislative leader:

> (State has a rudimentary reporting and statistical gathering system in the . . . program which is geared almost entirely to program management . . . The Legislature has appropriated funds to develop a more sophisticated data system for the program and an important by-product should be important information for evaluation. It should be emphasized that the Legislature is very concerned about the problem of evaluating the . . . program. However, there is a growing feeling that the traditional, basically quantitative means of evaluating health care services is not adequate. Morbidity and mortality figures are only very gross indicators of total health. Statistics on utilization of services such as average length of stay and physician visits per year only measure the present system and do not significantly answer questions of quality. There is a great requirement to define our health care goals and determine means of measuring our success in terms of meeting those goals.

Linkage to Comprehensive Health Planning

The questionnaire asked Governors and State legislative leaders what steps were being taken to relate

the Medicaid program with the State's comprehensive health planning program under the Partnership for Health Act.

State responses indicated various stages of development from the point of view of both program coordination and organizational arrangements. In a few States the comprehensive planning unit was just beginning to work on the State health plan and it was too early to evaluate Medicaid linkages. All, however, recognized the need to relate their comprehensive health planning function to Medicaid. One respondent indicated that this need was underscored by the variety of governmental agencies which provide varying degrees of medical assistance to the disadvantaged.

In nearly three-fourths of the States, the agency charged with administration of Title 19 is in a different department than that responsible for comprehensive health planning. Generally, the former is in a department of welfare or social services, the latter in the department of health. To ensure coordination of Medicaid with other health care systems, these States have established interdepartmental policy committees or councils, as in Louisiana, Michigan, and Oklahoma; Medicaid coordinators, as in New Hampshire; representation of the State Medicaid agency on the comprehensive health planning advisory council; or representation of the department of health on the Medicaid advisory committee. About one-fourth of the States reported that the comprehensive health planning and the medical assistance function are administered by the same department.

It is too early to appraise the effectiveness of the fairly diverse State efforts to coordinate the Medicaid program with the comprehensive health planning program. Whatever approach is taken, however, the basic problem probably will be to shift from the traditional emphasis on discouraging establishment of unnecessary facilities to a much more positive role of planning for and encouraging development of facilities and services where they are most needed. State comprehensive health planning then can play a vital role in the solution of problems that confront Medicaid.

Other Intergovernmental Problems

State officials participating in the questionnaire survey were asked to describe what they regarded as other major intergovernmental problems in the policy and administration of Medicaid.

Table 16 is a tabulation of the answers by Governors and legislative leaders. Governors most frequently mentioned the problems of coordinating the policies and administration of Medicare and Medicaid; the difficulty of adapting the Title 19 law and regulations to individual States; and the cost escalation effect of basing hospital reimbursement on actual costs. The legislative leaders mostly criticized the inflexibility of the program's law and regulations, Title 18 and 19 coordination difficulties, and the hospital reimbursement problem, in that order. The Titles 18-19 problem warrants further comment.

Title 18 and 19 coordination.

The complaints about the relationship between Medicare and Medicaid seem to fall into three general groups: (1) that certain standards under Title 18 are improperly applied to Title 19; (2) that there are obstacles to an information flow between Medicare and Medicaid with regard to recipients who come under both programs; and (3) that the administrative procedure for coordinating the paperwork on such recipients is overly complex.

With reference to the application of Title 18 standards to Title 19 programs, States complain that the requirement imposes unnecessary expenses on their Medicaid programs. Quoting from the questionnaire responses:

Table 16. Medicaid Problems Other than Intergovernmental Fiscal Policy as Reported by State Governors and Legislative Leaders

Summer 1968

		Number of times mentioned: by Governors	by legislative leaders
1.	Coordination of policy and administration between Medicare and Medicaid	14	6
2.	Law and guidelines unrealistic and inflexible in light of State needs and capacities	7	8
3.	Requirement to base hospital reimbursement on costs	4	4
4.	Insufficient decentralization of authority and communication to regional offices	3	1
5.	Tardiness of guidelines	3	1
6.	Guidelines unclear	–	2
7.	Inadequate advance consultation with States in developing policy changes	2	2
8.	Inadequate time to implement guidelines	–	1
9.	Duplication and overlapping in Federal health programs	3	1
10.	Guidelines not specific enough	1	–
11.	Federal-State liaison should be closer	1	1
12.	Objection to single State agency requirement	1	–
13.	Determination of eligibility too complex	–	1
14.	Social services should not be mandated for medically needy	–	1
15.	High administrative costs	–	1
16.	Federal Government should finance part of medical care for noncategorically related medically needy	–	1
17.	1975 deadline should be extended to 1980	–	1
18.	More gradual "phase-in" to program for medically needy	–	1

Source: ACIR-NGC-NCSLL questionnaire survey, Summer 1968

The federal requirement that we must pay the hospital's cost instead of charges, if lower, is costing the State approximately $3 million a year. We think this requirement should not be extended to Title XIX. (Illinois)

The Federal government has tended to require the same standards and conditions for participation in Title 19 as in Title 18. This is acceptable when the concepts and conditions are the same but should not occur when they are not. A prime example is the requirement that skilled nursing homes under Title 19 meet Title 18 extended care facilities (ECF) standards in order to participate in the program. This requirement confuses the distinction between the short term semi-acute care to be provided in ECF's (no more than 100 days after a stay in an acute hospital) and the long-term care provided in skilled nursing homes. If such long-term care is to be provided under the Title 19 program, there will be considerable waste of resources in providing such care in highly staffed ECF's. (California)

There is great need to unify policies of the Medicare and Medicaid programs. The present trend is to force the States to adopt Medicare procedures and standards even though they may not be feasible for the much larger (and different) Medicaid program. (Pennsylvania)

Major administrative problems have prevailed, and continue to prevail, in relation to the interrelationship of Titles XVIII and XIX. The impact of Title XVIII in relation to usual and customary charges and reasonable costs has had a significant impact on the administration of Title XIX with the various providers of service. (Rhode Island)

With regard to the information flow between Medicare and Medicaid:

One of the problems which we have experienced and which apparently exists in all states which have implemented Title XIX is a need for more coordination and a freer interchange of information between those administering Title XIX and Title XVIII. In Hawaii, the agency administering these two titles, and the fiscal intermediary, are willing to provide such an interchange of information but are hampered by restrictions imposed by the Social Security Administration on the release of information under Title XVIII. It is difficult to understand why two federally funded programs as closely related as these two titles of the Social Security Act and under the same federal agency, should not be able to provide each other with full and prompt information about experience, rates, utilization and future planning. (Hawaii)

We believe also that since the Title XVIII program is so closely allied to the Title XIX program, it is essential that the State Public Welfare Department be kept advised of any policy changes anticipated. It would improve the administration of Title XIX in relation to services to the persons 65 and over if the Public Welfare Department could obtain accurate information on what recipients are maintaining payments in Title XVIII. (Louisiana)

Turning to paperwork coordination:

Our relationship with the Medicare carriers has created a vast administrative problem – handling of paper – because of paying deductions and coinsurance under Title XIX. It would be wise to have a study made of this whole area as it may be less costly to have Title XVIII pay for these deductions and coinsurance than the State having the tremendous administrative job of paying for them under Title XIX since the Federal government pays 50 percent anyway. (Illinois)

There are still many problems in relating Medicaid to the provisions of Title XVIII. The amounts of money involved, especially in connection with hospitalization, probably do not justify the administrative time required. (Ohio)

Title 18 covers part of the medical care for eligibles over 65 and Title 19 covers the balance. Payment from one source would greatly reduce administrative cost. (Wyoming)

Apart from these specific criticisms, other States registered more general complaints about Medicare-Medicaid coordination:

(Other intergovernmental problems) Blending the administration of Medicaid and Medicare for those over 65 . . . More coordination is needed between OASI and State welfare departments. (Connecticut)

Other intergovernmental problems essentially relate to the unnecessary tie-in between Title XVIII and Title XIX. It is very difficult to understand why the Medicare program is so reluctant to completely cooperate with the Title XIX program. It would appear that the same tax dollar should allow for the mutual sharing of information without additional costs. (Nevada)

It is difficult, if not impossible, to coordinate the health care programs as provided under Title 18 and 19, resulting in problems around quality and appropriateness of care. Programs need to be coordinated philosophically and fiscally in order to provide greater benefit to the patients. (Washington)

In contrast with the findings of the ACIR-NGC-NCSLL questionnaire survey, HEW officials contend that coordination between Titles 18 and 19 is not a serious administrative problem for the States. They concede that some difficulties arose relatively early in the history of the programs, but point out that since then the principal problems involved in the coordination of paperwork processing in Title 18 and 19 have been resolved in a number of instances through use of a common procedure for billing under State public assistance, Medicaid, and Medicare programs. This procedure is designed to eliminate dual billing by physicians, reduce delays in the disposition of claims by the fiscal intermediary and in the payment of physicians, and clarify deductibles, coinsurance, and determination of claims for those age 65 or older. HEW officials contend that in those States which have adopted this form, many of the billing problems involved in the relationship between Medicare and Medicaid have been eliminated or reduced.

At the same time, in July 1968 HEW headquarters reported that only six States had adopted the billing procedure. One (Pennsylvania) adopted but later abandoned it. The States' lag in using the common billing was ascribed to some extent to lack of "push" by HEW regional offices, States' objection to the processing charge involved, and their belief that existing arrangements with fiscal intermediaries were better than the proposed system.

At the Advisory Commission hearing on the draft of this report in San Francisco on September 19, however, the regional director of HEW stated: "The experience in this Region is that all seven States are using the Title XVIII billing form. This includes Alaska and Arizona, which have not yet implemented their Medicaid programs, as they are paying for Title XVIII deductibles and coinsurance under their non-Title XIX medical programs. Oregon requested extensive changes which were negotiated with Social Security Administration. The other six States in this Region are using the SSA form without major revisions. I suggest that there has been considerable 'push' by HEW Regional Offices and that a recheck would find many more than six States nationally using the common form now."

In any case, the difficulties of meshing Titles 18 and 19 raise the basic question of how much coordination can be achieved between a program that is essentially unitary and one that allows the 50 States considerable discretion in adapting a program to their individual preferences and experiences. Clearly, coordination in these circumstances is not as easy as under two programs operating under centrally prescribed, uniform rules.

Tax Foundation survey.

Tax Foundation tabulated criticisms of Title 19 operations in its 1967 questionnaire survey of public and private agencies in the 50 States. These are shown in Table 17. It should be noted that respondents were not asked to focus on intergovernmental difficulties, as in the ACIR-NGC-NCSLL survey, but on operational problems generally. The result is reflected in the heavy emphasis on questions of "supply, demand, pricing, and payments."

Table 17. Some Criticisms of Title 19 Program Operations as Reported from 26 States (a)

Nature of criticism	Number of States reporting criticism
A. General conditions of supply, demand, pricing, payments:	
1. Unwillingness of physicians or other suppliers of services to participate. Reasons reported:	14
a. Fees are held inadequate	11
b. Payment is too slow	7
c. Excessive "red tape"	10
d. Other	3
2. Shortages of personnel – doctors, nurses, auxiliary medical helpers, etc.	9
3. Shortages of facilities and equipment, such as hospital beds, clinics, nursing homes, etc.	8
4. Availability of medical care has led to unwarranted use or over-use of "free" services (e.g., a visit to the doctor for a minor cold).	1
5. Fees and charges (doctors, hospitals, etc.) have risen sharply. Among causes reported are:	17
a. "Profiteering" (i.e., raising of fees to take advantage of maximum allowable)	8
b. Increase in charges for hospital care to take into account allowances for depreciation of buildings and equipment	5
c. General cost-push inflation, e.g., rising salaries	16
6. "Racketeering" on part of some medical practitioners (e.g., reported payment for doctors' visits never made).	1
7. Delays in payments of vendors (doctors, hospitals, etc., for services performed).	8

Table 17. *(Continued)*

Nature of Criticism	Number of States reporting criticism
8. Lack of coordination of rate-setting among different state agencies.	7
9. Conflicts between Federal and state allowances for fees and other costs.	4
10. Problems associated with auditing medical records	6
B. Enrollment of persons eligible	
1. Failure of "medically indigent" to enroll and establish eligibility. Reasons reported:	9
a. They are unaware of the fact that they are eligible	9
b. They wish to avoid the "welfare" stigma which they feel is associated with receiving aid	8
2. Difficulties in determining eligibility of applicants for medical assistance with resulting delays in certification.	3
a. Associated with technical provisions of Federal or state law	2
b. Shortage of state-local welfare personnel who are screening applications	6
C. Other "complaints"	8

(a) At the time of the survey, only 21 states had experienced as much as one year's operations under a Title 19 program.

Source: Tax Foundation, *Medicaid: State Programs After Two Years* (New York, N.Y., 1968) Table 20.

Chapter V

CONCLUSIONS AND RECOMMENDATIONS

In this report the Commission has examined the evolution and nature of the Medicaid program and analyzed experience to date, with special emphasis on the fiscal impact of the program upon Federal and State budgets. We now set forth our major findings and conclusions, and proposals for action designed to make most effective use of the institutional and fiscal resources of Federal, State, and local governments in achieving the objectives of the Medicaid program.

Summary of Major Findings

(1) **Medicaid evolved out of government's historic responsibility for providing for the needy.** This responsibility with respect to medical care was relatively limited from colonial days until the Depression of the 1930's, when the Federal Government became substantially involved fiscally and programmatically through the Social Security Act, particularly beginning in the 1950's. Since that time, the expansion of publicly assisted medical care for the needy has been closely linked with the broader issue of the government's role in assuring adequate medical care for all the people, poor and nonpoor alike, culminating in Congressional enactment of Medicare and Medicaid as part of an interrelated package in 1965.

(2) **Policy-makers at all governmental levels were largely unprepared for the magnitude of the fiscal impact of Medicaid that became apparent soon after the program's initiation in 1966.** Federally assisted medical vendor payments rose from $1,358 million in CY 1965 to an estimated $4,184 million in FY 1969. For the Federal Government this was an increase from $756 million to an estimated $2,040 million in three and a half years; for State and local governments, a rise from $602 million to an estimated $2,145 million during the same period. As a consequence of the impact of Medicaid, Congress in 1967 amended Title 19 to limit Federal sharing in medical assistance payments for the medically needy to those whose income does not exceed 133-1/3 percent of the maximum actually paid for cash assistance under the AFDC program. Moreover, in early 1968 President Johnson created a Federal-State Task Force on Medicaid and Public Assistance Costs to develop procedures designed to give Federal and State officials a sounder basis for estimating future costs of the program.

(3) **For the States, the story of Medicaid's first two and one-half years was one of a wide variation in scope of the program and its fiscal impact:**

– as of July 1, 1968, 38 State programs were in operation and programs in two more States and the District of Columbia were authorized but not yet implemented.

– 13 State programs authorized medical care only for the categorically needy and the categorically related needy.

– 12 authorized care for a broad range of needy and medically needy, but some of these

covered only portions of certain eligibles, and only a few covered the noncategorically related medically needy for whom Federal matching funds were not available.

– 17 States provided to some extent at least 11 of the 14 types of statutorially specified medical services for both needy and medically needy.

– for 27 Medicaid States with programs in effect for all of 1967, the change in total medical vendor payments between 1965 and 1967 varied from an increase of 371 percent in Delaware to a decline of 15 percent in West Virginia, with a median increase of 56 percent. In dollar terms, the change ranged from an increase of $487 million in New York to a decrease of $1.7 million in West Virginia.

– of the 37 States that reported Medicaid expenditures for 1967, 16 shared the non-Federal cost with their local governments, ranging from a State share of 47 percent in Nevada to 91 percent in Maryland with a median of 66 percent.

– of the 23 States providing care to the medically needy, 11 were forced to cut back or otherwise adjust their income eligibility levels due to the 1967 amendments of Title 19.

– 11 of the 37 States whose programs were at least six months old by July 1, 1968, had expanded the coverage of eligibles since initiation; these efforts were largely confined to bringing in subgroups of the categorically needy; 10 of these same 37 States had added or expanded services since initiation of their programs.

– in a few States new or higher State level taxes were linked in part to Medicaid programs; in others, higher taxes were forestalled by postponing initiation of a Medicaid program or by restricting the program's scope.

– unlike the Federal Government, State responses to mounting Medicaid expenditures were restricted by constitutional prohibitions against borrowing for current expenses ("deficit financing"); local governmental sharing in the non-Federal costs was limited by charter and legislative restrictions.

(4) **The legislative history of Section 1903(e) of Title 19 requiring all States to provide comprehensive care to "substantially all" the needy and medically needy by July 1975, and Congressional attitudes toward further cost escalation of the Medicaid program, raise doubts about the strength of the Federal Government's real commitment to this goal.** Considering the lag on the part of many States in getting into Medicaid and in providing a comprehensive program for the needy and medically needy, according to one estimate total program expenditures would rise by 1975 to $6 or $7 billion or more from the $4.2 billion estimated for FY 1969. Even if the Federal Government conscientiously pursued implementation of Section 1903(e), moreover, the program effects would still be questionable since so much depends on standards of eligibility for the needy and medically needy set by the States, and past experience suggests that many might set such standards well below realistic standards of need.

(5) **A key factor contributing to the rising curve of Medicaid expenditures is the increase in medical costs. Medical prices increased 6.6 percent in 1966 and 6.4 percent in 1967, compared to rises of 3.3 and 3.1 percent in the overall consumer price index.** While Medicaid has thus suffered from the industrywide increase in medical costs, it has contributed to that rise out of proportion to the number of persons it serves because of its sudden injection of billions of additional dollars into the demand for medical services. Its lag in achieving effective controls over expenditures has added to the pressure on medical prices.

(6) **Among the nonfiscal problems in the Medicaid program most concerning the Governors and State legislative leaders** according to a joint survey by the Advisory Commission, the National Governors' Conference, and the National Conference of State Legislative Leaders are:

– **difficulties in coordinating the administration of Medicare and Medicaid.**

– **the inflexibility of the law and guidelines, specifically, the requirement for "comparability of services" among categories covered.**

– **difficulties in imposing adequate controls over charges for service.**

* * * * *

The Commission now sets forth 15 recommendations for intergovernmental action to improve the functioning of the Medicaid program within the context of a strengthened federal system. The recommendations are grouped under four major headings:

A. Medicaid Goals

B. Allocation of Responsibility between Federal and State Governments

C. Allocation of Fiscal Responsibility between State and Local Governments

D. Other Matters Requiring Federal and State Constitutional, Legislative, or Administrative Improvement

A. MEDICAID GOALS

The uncertainty surrounding Section 1903(e) of Title 19 – which sets 1975 goals of the Medicaid program – raises a basic issue in Medicaid policy:

– Should Congress repeal the section, thereby removing the injunction to the Secretary of HEW and the States to move toward providing comprehensive care for substantially all the needy and medically needy by 1975?

– Or should Congress affirm its intention that Section 1903(e) be implemented as it now stands?

– Or should Congress modify the provision to reflect what it considers a current realistic assessment of attainable objectives for the Medicaid program?

In favor of a strong reaffirmation of the intent of Section 1903(e), it may be argued that:

1. The 1975 goal is a realistic statement of what the Nation must commit itself to if it is to satisfy the medical needs of the poor and near poor that have been projected by many studies and forcefully confirmed already by the two and a half years of program experience. Such a commitment is an essential part of a growing sense of urgency surrounding public policies for upgrading the lot of the poor and the near poor.

2. However casual the original concern of the Congress for the implications of Section 1903(e) may have been, the fact is that the 1975 goal was put into law, and read at face value it is a commitment of the Federal Government. Concerned groups, such as the 1966 Advisory Committee on Public Welfare, viewed it as a commitment. To renege now would add to frustrations built up by the failure or delayed success of other social and economic programs directed at the underprivileged and near poor.

3. The 1975 goal was considered a long-range goal when initiated on January 1, 1966 – nine and a half years in the future. Almost seven full years remain. Considering the long-range dynamism of the economy, and the likelihood that by 1975 present burdensome overseas and military commitments will diminish, the current concern over those priority needs should not precipitate abandonment of a goal that is by no means certain at this time of being beyond our fiscal capacity.

4. In any case, the injunction to the States is to be administered flexibly by the Secretary of HEW. He is required to be satisfied that progress is being made from now till 1975. Prudent administration would recognize the varying capacities of different States and the different distances they have to travel to achieve the objective. Adding flexibility is the requirement that the goal contemplates provision of comprehensive service to "substantially all", not necessarily all.

5. The States have a powerful hand on the throttle in moving their programs toward the objective. They establish the income limits for determining who is qualified as needy and medically needy. Considering the 33 year history of the public assistance programs in similarly allowing States to set eligibility standards for cash payments recipients of categorical welfare, it would require a reversal of form for the Federal Government to apply pressure on the States to raise those standards to the point where they would effectively remove that hand from the throttle.

6. By keeping policymakers' eyes on the cost implications of a full-blown program of medical assistance for the needy and medically needy, retention of the 1975 goal will have the salutary effect of forcing serious consideration of other alternatives to the same end, such as proposals for a universal system of health insurance.

In favor of repeal or modification of Section 1903(e), it may be contended that:

1. The unanticipated high costs of the Medicaid program over the first two and a half years already make it unrealistic to think that we can finance a full-blown program even by 1975. Federally assisted medical vendor payments nearly tripled in the first two years, in which 37 States had been operating for varying lengths of time with programs in different degrees of comprehensiveness as to coverage and scope of services. In two States medical vendor payments increased over 350 percent in two years; other States were reluctant to initiate the program, or initiated it only on a very limited basis, because of budgetary fears. Fiscal prudence dictates that we scale down our goals to realizable proportions.

2. Maintaining an unattainable goal is bound to add to the frustration of those who already have been disappointed by the failure of other social and economic programs to attain their promise. It is sounder policy to face the sober truth now than to let expectations continue to build up only to be ultimately let down.

3. Until such time as more adequate data become available on the true measure of medical requirements of the needy and near needy, it is folly to pretend that we can attain a goal whose dimensions we really are not in a position to gauge accurately at this time.

4. Competent studies, such as those of the National Conference on Medical Costs, indicate that

the organization, manpower, facilities, and supplies of the medical industry are, and will be for some time, inadequate to meet the goal of comprehensive care for all. To expect to provide such care for the needy and medically needy when it means denying adequate care for the majority nonneedy – as it might in view of the shortage of overall capacity – is politically unrealistic and probably questionable public policy.

5. No one is sure that the Medicaid pattern of a fully financed governmental program is the best approach to assuring comprehensive care for the needy and near needy. To dedicate the Nation to the full-blown Medicaid approach is to jeopardize the opportunity to consider and experiment with other alternatives.

6. The legislative history of Section 1903(e) is proof that its full implications were not thought through by Congress. Those implications have become clearer since 1966 with the constant rise in expenditures and it is political statesmanship to reflect them in law. This means repealing or modifying Section 1903(e).

Recommendation 1. Adherence to Existing 1975 Goal; Study of Possible Financial Involvement of Private Sector

The Commission recommends that Congress and the Administration adhere to the goal of comprehensive care for "substantially all" the needy and medically needy established in Section 1903(e) of the Social Security Act, and that they, along with the States and localities, take such steps as necessary to move toward that goal; however, the Commission further recommends that Congress and the Administration study the feasibility of broadening the financial base of the program through increased involvement of the private sector, including among other possibilities some form of employer-employee contributory health insurance.

The Commission is convinced on balance that the 1975 goal set forth in Section 1903(e) can serve a useful purpose in guiding the States toward fulfillment of a level of medical care for the needy and near needy that is widely accepted as necessary. We recognize and understand the fiscal conditions that led Congress and the Administration in 1967 to impose a cutback on Federal participation in the care of the medically needy and thus move away from the goal set by Section 1903(e). Yet we believe that this action was the result of concern over the unanticipated escalation of the Title 19 budget, a desire to put the lid on further cost increases until such time as Congress can be assured that State programs are taking effective steps to control costs, and the unrelenting fiscal pressure from other public demands, particularly military requirements.

We believe that medical care must rate high in any weighing of relative priorities between provision of medical care for the needy and near needy, as against other items on the domestic services agenda. Health care has come to be regarded by many as a matter of right; the health care provided by Medicaid goes to those at the lowest end of the economic scale, for whom the other programs competing most urgently for scarce public funds are intended; and good health is a basic necessity for these people if they are to make effective use of such other programs.

The virtue of Section 1903(e) is that, while it establishes a firm long run goal for the Medicaid program, it clearly implies that the Secretary of HEW must be flexible in seeing that States move toward that goal. A State must make "a satisfactory showing that it is making efforts in the direction of broadening the scope of the care and services. . ." Thus the Secretary will have to discharge his responsibilities in a way that is sensitive to the relative capacities and needs of the individual States. Furthermore, his control over the pace of effectuation is shared with the States, since they determine the eligibility standards for qualifying the needy and medically needy.

We have confidence that the health of the overall economy will sustain the likely cost of realizing the 1975 goal, particularly as the demands of the Vietnam war ease. Yet our study compels us to recognize that achieving this goal within the present basically governmental system of financing would place an increasing strain on already hard-pressed governmental resources. State and local tax sources are particularly vulnerable. We therefore urge Congress and the Administration to give immediate attention to various possible alternatives for broadening the financial base of the program to include increased involvement of the private sector.

One possibility that might be considered is a national universal health insurance program as proposed by Governor Nelson Rockefeller of New York, involving equal contributions by employers and employees toward the purchase of prepaid health care. Under this proposal, based on a bill for a State plan that Governor Rockefeller submitted to the New York Legislature, the health insurance premiums of the unemployed and the poor would be paid by the State or Federal government. Health insurance would be provided by existing private companies, with many existing plans qualifying. Governor Rockefeller urged that hospital reimbursement rates be tied to the hospital's efficiency and quality of care under any such compulsory insurance program.

Recommendation 2. Deferment of Deadline for Initiating State Medicaid Program

The Commission recommends that Congress amend the Social Security Act to permit States not participating in Medicaid to continue receiving Federal assistance for medical vendor payments until January 1, 1972, provided that they have submitted a proposed State plan to the Department of Health, Education, and Welfare by 1971, and provided further that such plan must be operative by 1972.*

By July 1, 1968, 38 States and three territories were operating Medicaid programs. It appeared that by July 1, 1969, six of the remaining 12 States would have initiated programs. Under Title 19, all the remaining six will have to come under Medicaid by January 1, 1970 or else lose Federal financial participation in medical vendor payments for any categorical welfare recipients.

The questionnaire survey of the States conducted jointly by the Advisory Commission, the National Governors' Conference, and the National Conference of State Legislative Leaders found that the anticipated fiscal impact was one of the main reasons States had hesitated to come under Medicaid. Five of the six States that are not expected to come under the program by July 1, 1969 are below the national average of per capita income, and four – North Carolina, Alabama, Arkansas, and Mississippi – are well below.

The Commission believes that these States should be given more time to muster the additional resources needed to initiate their Medicaid programs, and therefore the deadline should be put off two years until 1972. In return for this deferral, however, these States should be required to set in motion plans and other preparations for establishment of Medicaid programs. The law should also be changed, therefore, to

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* Professor Cline, Mayor Naftalin, and Governor Rockefeller dissent from this recommendation and state: "States have known since passage of Title 19 in July 1965 that unless they initiated a Medicaid program by January 1, 1970, they would forfeit Federal assistance for medical vendor payments for welfare cases. Thirty-eight States acted by June 30, 1968 to come under Medicaid. In many cases this required difficult decisions in raising additional State and local revenue or in making budgetary adjustments. The remaining 12 States should be able to face up to their responsibility similarly in the remaining year and a quarter. Moreover, if the date for initiating a minimum program were postponed from 1970 to 1972, States would find greater difficulty in meeting the 1975 goal of comprehensive care for all the needy and near needy, which this Commission has strongly endorsed."

require them to submit proposed State plans no later than January 1, 1971. In being compelled to make such preparations a year ahead of actually coming into the program – rather than waiting until 1972 – these States should find it possible to reach the 1975 goal of comprehensive care for substantially all the needy and medically needy.

B. ALLOCATION OF RESPONSIBILITY BETWEEN FEDERAL AND STATE GOVERNMENTS

Medicaid is an expansion of the public assistance approach to provision of medical care. The sharing of fiscal responsibility between the Federal Government and the States is therefore basically similar, and so are the issues surrounding these relationships. The new features are expansion of coverage to include – at considerable discretion of the State – the near poor as well as the poor; and the fact that medical costs among individuals are apt to vary extensively, in contrast to costs of the basic elements of public assistance – food, clothing, and shelter.

The issues considered here involve Federal vs. State establishment of eligibility standards, closed vs. open ended appropriations, the degree to which the Federal Government should share in the cost of medical care for various groups of the needy and medically needy, the establishment of lien and recovery rules, allowable variations in resource limits for the States in determining eligibility, and a study by the Federal Government of the allocation of fiscal responsibility among the levels of government.

Recommendation 3. Continuation of Present Arrangements for Setting Income Eligibility Standards and 150 Percent Income Limitation for Medically Needy

Although supporting greater interstate uniformity in eligibility requirements as a long-range goal, the Commission recommends continuation of the present policy under Title 19 whereby the States establish standards of income eligibility for the needy and the Federal Government sets income limits for the medically needy that are related to these State established standards; in this connection, however, the Commission recommends that Congress amend the Act to freeze the present 150 percent income limitation and not reduce this level of participation as is now scheduled.*, **

The needy under Title 19 are mainly persons receiving categorical assistance. Standards of eligibility for these people are those that apply to maintenance assistance under the applicable categorical welfare program: OAA, AB, APTD, and AFDC. These standards are set by the individual States to cover basic needs as each State defines them. Assignment of this discretion to the States reflects the traditional preference for decentralizing responsibility for welfare to the States and their subdivisions. It makes the

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* Professor Cline and Mayor Naftalin dissent from this recommendation and state: "The existence of widely variable and low standards of need for categorical assistance recipients is inconsistent with Title 19's expression of a national commitment to provide comprehensive medical care for the needy and medically needy. We believe that to fulfill that commitment, the Federal Government must establish a national uniform standard of income eligibility which the States would have to meet."

** Congressman Fountain dissents from this recommendation and states: "The decision of Congress to establish 133-1/3 percent of the maximum AFDC payment as the level of income at which it will continue to share financially in State coverage of the medically needy was based on a careful analysis of the budgetary implications of various alternative levels of Federal financial participation. In view of our budgetary situation, I do not believe it is sound public policy at this time for the Federal Government to share the cost of medical care for persons whose incomes are more than 33-1/3 percent above their State's maximum payments for public assistance."

welfare program responsive to State by State variations in political, economic, and social conditions and attitudes.

Many States set the levels of need far below any reasonable standard of adequacy, even when allowing for regional variations in the cost of living. Thus, in 1966 the Social Security Administration's minimum monthly standard of poverty was set at $267 for a family of four. Only three States had a needs standard this high, the median was $212, and standards of 19 were below $200. In addition, many States actually used a maximum payment which was below the established standard. Referring again to the poverty level for comparison, only one State that imposed a maximum had an authorized payment as high as $267; the median was $185; and 19 were below $150.

The Advisory Council on Public Welfare, appointed by the Secretary of HEW pursuant to a 1962 amendment to the Social Security Act, summarized the situation in its 1966 report, *Having the Power, We Have the Duty:*

> Even within the low standards the States have established for minimum health and decency, a number of States, because of inadequate appropriations, must reduce the actual amount of the public assistance payments, regardless of the amount of need determined under these standards. For example, percentage cuts are imposed across the board; policies with respect to other income or resources or relatives' responsibility may be unrealistic; or fixed maximums may discriminate against the larger family. As a result, actual needs are frequently overlooked, understated, or ignored.
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> Some States, to meet the ever present problem of inadequate State and local appropriations, set arbitrary maximums on the amount of assistance payments – 29 States limit arbitrarily the amount of assistance payment in OAA, AB, and AFDC, and 26 do so in APTD. Other States pay only an arbitrary percentage of the need computed under the State standard; 3 States pay only a percentage of need in OAA and AB, 5 States do so in APTD, and 13 States in AFDC.
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> Standards of assistance and average payments are not only low; they vary widely from State to State. . .

Congress in 1967 amended Title 19 to provide Federal matching funds for the medically needy only when their income eligibility standards did not exceed a specified percentage of the maximum AFDC payment authorized by the State. For States whose Medicaid plans were approved prior to July 29, 1967, the limit is 150 percent from July 1 to December 31, 1968, 140 percent for all of 1969, and 133-1/3 percent thereafter. For all other States the limit is 133-1/3 percent starting on July 1, 1968. The effect of linking the limit to AFDC is to make this federally sanctioned eligibility standard no more consistent among the States than the level of actual AFDC payments on which it is based.

To overcome the problem of inconsistency among the States, the Federal government might establish a national uniform or minimum standard of income eligibility, either for both public assistance and medical assistance or for medical assistance alone. Such uniformity, it is contended, would support Title 19's expression of a national commitment to provide comprehensive medical care for the poor. It would, of course, withdraw from the States the critical power they now possess to control eligibility. If limited to medical assistance, moreover, it would result in many States having one standard of need for maintenance assistance and another for medical assistance.

Another proposal concerning income eligibility standards is that Congress rescind its 1967 restrictions on the income level of the medically needy for whom Federal matching funds are available. It is contended that the limitation discourages achievement of the Congressionally mandated 1975 goal of comprehensive care for all, including the medically needy. Against this position can be cited the results of the ACIR-NGC-NCSLL survey, in which a substantial majority of both the Governors and legislative leaders approved the

limitation; and the widespread belief among Governors that the limitation is desirable because it keeps the bigger States from using up the lion's share of Medicaid funds. Contrary to the latter argument, however, it must be noted that Medicaid's "open-end" type of appropriation does not restrict the amount of funds *any* State, large or small, may draw from the Federal government.

The Advisory Commission favors moving toward greater interstate uniformity in financial eligibility standards as a long range goal, but we see difficulties in achieving such uniformity for Medicaid in the immediate future. Since the eligibility standards for medical service for the needy are established by the individual States under the public assistance programs, establishment of a Federal national standard for the needy for purposes of medical assistance would have the effect of erecting two sets of standards for essentially the same group. Even if this were justified in the interest of applying pressure for more consistency among maintenance assistance standards throughout the Nation, we question it on the grounds of administrative complexity. Welfare administrators would have to use two systems, and would find themselves declaring some people poor for maintenance assistance but not for medical assistance. The Commission therefore believes that if uniform eligibility standards are going to be established by the Federal Government for medical care they must be made basically to apply to determination of need under the cash assistance programs. The Commission in its recent report, *Urban and Rural America: Policies for Future Growth,* has already urged that the Federal Government consider seriously the setting of national minimum standards as one way of neutralizing the undesirable "migrational pull" that congested areas exert by virtue of their different (higher) public assistance standards. We reiterate our support for greater uniformity in these eligibility standards.

Under the 1967 limit on the maximum amount for the medically needy which the Federal Government will match, Congress has tied the eligibility level for the medically needy precisely to the level of actual maximum payments for the needy under AFDC. This imposes throughout the Nation at least a uniform relationship between the standard for the needy and the medically needy. It reflects the assessment by Congress of the realities of current fiscal needs and priorities and represents use of an effective tool for imposing controls on potentially the greatest source of additional cost of the medical care program, namely, the services to the medically needy.

Eight of the 20 States that were serving the medically needy before July 26, 1967 had to cut back their income eligibility levels, or make other adjustments, in order to meet the 150 percent standard set by Congress in the 1967 amendment. Under the amendment these States will have to make further adjustments to cut back to the 140 percent level by January 1, 1969, and then to 133-1/3 percent by January 1, 1970. Two additional States will have to impose cutbacks to meet the January 1, 1969 limit.

The Commission believes that imposition of a cutback to the 150 percent level imposes a serious enough adjustment on the States in terms of forcing hard decisions on Governors and administrators in denying medical care to persons who had been receiving it, or finding additional State-local money to replace withdrawn Federal funds. Eight of the 20 States were faced with such decisions. The Commission believes that the States should be spared such "Hobson's choices" in the future and therefore the Federal Government should not follow through with the additional two steps in 1969 and 1970. Abandoning these two additional cuts will not subvert the basic objective of the Congressional action, namely, a definite curb on States' income eligibility standards for the medically needy. It will, however, serve to distribute more equitably between the Federal and State governments, the burden of adjusting to meet the unanticipated high cost of providing medical care for the medically needy.

Recommendation 4. Continuation of an "Open-End" Appropriation for Medicaid

The Commission recommends that the present provisions of Title 19 of the Social Security Act be retained whereby Congress appropriates for Medicaid on an "open-end" basis, that is, without

limits on the amount of money that may go to any single State.*

Unlike most Federal grant-in-aid programs, the Medicaid program is an "open-end" program. Except for the limitation on payments for the medically needy, there is no limit to the amount of money the Federal Government will pay out to match the States from anywhere from 50 to 83 percent of the money they put up, depending on their per capita incomes.

Considering the fiscal impact that Medicaid has made on both the States and the Federal Government, it is little wonder that attention has turned to the possibility of changing the present "open-end" approach to a "closed-end" appropriation system. The "open-end" system makes it possible for: (1) States to put relatively large numbers of recipients on the medical assistance rolls and (2) Congress has little control over the annual appropriations for the program. Under the "closed-end" procedure Congress would make an annual appropriation and an allotment to each State on the basis of a formula reflecting, among other things, the State's needs and its willingness and ability to finance them. The formula would be subject to annual revision to reflect substantial changes in these items.

Major arguments for and against the "closed-end" appropriation in the public assistance program were presented in a staff report to the (Kestnbaum) Commission on Intergovernmental Relations in 1955. Key arguments **for** the "closed-end" appropriation (adapted here to the Medicaid program) were:

(1) It would place the primary fiscal and administrative responsibility for the medical assistance program on the States and local governments where it belongs.

(2) It is consistent with the general pattern of Federal aid and fiscal responsibilities assumed by the Federal Government in other fields.

(3) It would place a limit on Medicaid expenditures in each State which may be financed in part by Federal funds.

(4) By setting up an adjustable allotment to each State for medical assistance, the entire program is made more responsive to the will of the people as expressed through Congress and the State legislatures.

(5) It would make for greater simplicity in Federal-State relations and a minimization of Federal control of administration.

Arguments advanced **against** the "closed-end" appropriations are:

(1) The practical result might well be insufficient funds to permit the Federal Government fully to

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* Chairman Bryant, Governor Daniel, Congressman Fountain, and Congressman Uilman dissent from this recommendation and state: "Medicaid represents a commitment by the Federal Government to provide medical care for the needy and near needy beyond any it has made before. Realistically, however, this commitment cannot be interpreted as unlimited and certainly not as unlimited as it appears under the 'open-end' appropriation system. The government has responsibilities in many fields, most of which are subject to 'closed-end' appropriations. These responsibilities vary from time to time in relative significance as conditions change and public and official opinion shift. 'Open-end' appropriations provide no effective controls by which such shifts in priority can be made. We believe that some middle alternative between 'open-end' and 'closed-end' appropriations must be found to give Congress better control over its budgetary commitment and yet assure the States financial assistance for reasonable efforts to achieve the goals of medical service under Medicaid. Until such an alternative is developed, however, we believe Federal budgetary considerations require a shift to a 'closed-end' system for Medicaid."

meet its responsibility for providing medical care for the needy and near needy.

(2) The Federal Government would not share with the States the responsibility for making adjustments to changing economic circumstances.

(3) It would lead to constant pressure on Congress from the States for supplemental appropriations to meet changing economic conditions.

(4) Serious practical difficulties would be presented in developing an equitable formula for apportioning the Federal funds among the States.

(5) It would infringe on State autonomy for determining need of recipients.

On balance, the Commission favors continuation of the "open-end" appropriation for Medicaid. We are particularly persuaded by the fact that a switch to a "closed-end" procedure would place an undue burden on States and localities in making adjustments to meet increased need for assistance as the result of fluctuating economic conditions. The Federal Government is better able to make these adjustments and does participate in such adjustments under the "open-end" appropriation. Also, a change to an allotment formula required under the "closed-end" approach, would encroach on the States' traditional responsibility for determining need and eligibility under public assistance programs.

In favoring continuance of the "open-end" appropriation for Medicaid, however, we acknowledge the budgetary difficulties it causes for the Federal Government. These difficulties were, of course, responsible for the federally imposed cutbacks through the 1967 Amendments. It is very possible that, faced with continuing cost escalation, Congress and the Administration will impose additional cutbacks, thereby further reducing the "open-end" character of Medicaid funding. In the long run, therefore, we believe diligent search should be made for a middle alternative between an "open-end" and a "closed-end" appropriation to maximize the coverage of Medicaid and yet avoid imposition of cutbacks on the States or an uncontrolled drain on Federal financing.

One such possibility was suggested by the chairman of the California Assembly Committee on Public Health in his presentation at the Advisory Commission's public hearing on Medicaid. He proposed that Congress make funds available on the estimated number of recipient-months covered by a State program. This system, however, would require detailed information on which to base such estimates – the number of recipients in categories which are statistically relevant for determining health care costs and the costs of providing each service to each category of person – and States are a long distance from having such information.

Another possible bridge between the "closed-end" and "open-end" appropriation is suggested by the 1967 appropriation statute of the State of Washington. The legislature appropriated $10 million as a contingency fund from which the governor may request allocations to meet "any catastrophe, disaster, or unforeseen or unanticipated condition or circumstance or abnormal change of condition or circumstance." The request can be granted by a vote of 60 percent each of the Legislative Budget Committee and the Legislative Council both of which are bipartisan bodies. The gubernatorial requests must set forth the factors which give rise to the need and include workload indicators and revenue source conditions or changes or any other information which may be available and appropriate. The contingency fund has been tapped three times, including once to meet an unanticipated demand on public assistance funds.

Recommendation 5. Federal Matching for the Noncategorically Related Needy and Medically Needy

The Commission recommends that the Federal Government provide matching funds for

medical assistance for the noncategorically related needy and medically needy.*

Section 1903(e) of the Medicaid statute requires the States to move so as to provide comprehensive care for substantially all the needy and medically needy by July 1, 1975. Yet the Federal Government currently provides no matching funds for a large group of those falling into these two groups, largely the needy and medically needy between the ages of 21 and 64. Only a handful of States currently provide Medical assistance through Medicaid for this large group of persons in medical need. Experience so far indicates that progress is slow among States in moving toward such coverage.

A common complaint about the present Medicaid program received in the questionnaire addressed to the States was that Medicaid requires the States to show progress toward furnishing comprehensive care for all the needy and medically needy, yet offers no Federal financial help in providing such care for a substantial segment of the group – the noncategorically related. It was felt that such an arrangement departs from the basic *quid pro quo* nature of the grant-in-aid: Federal requirements in exchange for Federal financial assistance.

The Advisory Council on Public Welfare in its 1966 report urged extension of Federal matching to the noncategorically related. It stated:

> Another difficulty for financially hard pressed States is the requirement that by July 1, 1975, the States must provide a broad program of medical assistance for all needy people in the States. The Council concurs in this goal. The provision for Federal sharing in the cost of reaching the goal, however, is not complete. Under the law States will receive matching Federal funds for only a portion of the needy people who do not have the same eligibility characteristics as persons receiving money payments. Federal sharing is currently available for providing needed medical assistance to children under age 21, but many other low income people cannot receive federally aided medical assistance. The groups omitted are persons between age 21 and 65 who are not blind, disabled, or the parents of a child under 21.
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> The Council believes that these gaps should be closed through Federal sharing in the cost of medical assistance for the medically needy between 21 and 65 years of age.

The needy in the noncategorically related group are basically the general assistance recipients: the poor not covered by OAA, AB, APTD, and AFDC. They may receive medical care outside the Medicaid program but without the assurance of standards of care provided by that program.

With respect to these people, it may be contended that the Federal Government would be getting its priorities out of line if it provided money for medical care for them, when it does not provide funds for their basic maintenance needs. The Commission agrees, but believes that the way to meet this objection is not to deny medical assistance, but to extend Federal assistance for maintenance needs. As we noted earlier, in a recent report, *Urban and Rural America: Policies for Future Growth,* we have urged the Federal Government to give serious consideration to national assumption of the total cost of public assistance, including general assistance which is now borne fully by the States and local governments.

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* Congressmen Fountain and Ullman dissent from this recommendation and state: "Facing the budgetary implications of Medicaid, Congress in 1967 voted to limit the Federal Government's financial participation in medical assistance for the categorically related medically needy. With Federal finances insufficient to meet the needs of this group, we do not see how Congress could be expected realistically now to extend Federal matching funds to a group that has historically been the responsibility of State and local governments, that is, the noncategorically related needy and medically needy."

Again, the present condition of fiscal and program data make difficult an estimate of the cost of the recommended action. Using such data as are available, however, we would estimate that calendar year 1967 costs to the Federal Government would have been increased by about $163 million if there had been Federal matching for the noncategorically related needy and medically needy.

Recommendation 6. Study of Allocation of Fiscal Responsibility Among Levels of Government

Recognizing the fiscal problems which arise out of the Federal mandating of additional State and local responsibilities through Title 19 of the Social Security Act, the Commission recommends that Congress and the Administration study the present allocation of fiscal responsibility among the levels of government with special reference to the more circumscribed revenue capability of the States and their localities.

State and local governments have been keenly sensitive to the fiscal impact of the Medicaid program. Fiscal uncertainty induced many States to hesitate in coming into the program, or once in, to move slowly to expand services and recipient coverage. It has been a major cause of 12 States remaining outside the program two and a half years after its inception. In a few States, new or higher State and local taxes were linked in part to Medicaid programs; in others, higher taxes were forestalled by postponing initiation of a Medicaid program or by restricting the program's scope. States that had initiated Medicaid and extended their programs to encompass the medically needy found themselves mousetrapped by the 1967 amendment restricting the extent to which the Federal Government would continue to participate in financing the care of this group. With the Federal cutbacks, they were confronted with the hard political choice of raising State and local revenues to replace withdrawn Federal aid, or cutting off medical services to certain medically needy who had had as much as two and a half years to get used to them.

It appears to the Commission that when the Federal Government mandates such programs as Medicaid, involving the expenditure of substantial amounts of State and local as well as Federal funds, concern for a maximum partnership effort dictates that it be more sensitive to the weaker fiscal position of State and local governments. They have less flexibility and resources than the Federal Government in financing new expenditures. They are less able to adjust quickly to expand their total share of expenditures when the Federal Government reduces its share, as it did in imposing the 1967 amendment cutback. The Federal Government has virtually unlimited borrowing power, no restriction on running up current deficits, and can tap the increasingly productive income tax. On the other hand, the States are restrained by constitutional limits on borrowing, both as to amounts and purposes, and a few are limited by constitutional restrictions on their authority to levy an income tax. Local governments are checked by charter or legislative prohibitions on the amount and purposes for which they may borrow. Their tax resources are also closely limited by charter and law.

The seriousness of the impact of Federal decisions on State and local finances would be modified if there were greater private sector involvement in financing. We have proposed in Recommendation One that such involvement be carefully explored by the Federal Government. The State-local impact would also be alleviated by two other recommendations: stabilizing the cutback on Federal participation in the cost of the medically needy at the 150 percent level rather than reducing it to 133 percent, as is now scheduled; and extending the Federal Government's financial participation to include the noncategorically related needy and near needy.

Beyond these actions, we believe that the Medicaid experience underscores the need for Congress and the Administration to examine carefully the basic question of the allocation of fiscal responsibility among the Federal, State, and local governments, with a view to adjusting the Federal Government's financial participation in domestic programs to accord more closely with the relative revenue capabilities of the several levels. Clearly such an examination can not be effectively limited to the expenditure needs of the Medicaid program alone; it must consider the overall needs of governmental programs at all three levels.

This type of broad framework was the context of the Advisory Commission's recent report, *Fiscal Balance in the American Federal System,* in which we recommended a broadened fiscal "mix" and greater fiscal flexibility in Federal aid to States and localities. In our judgment, consideration of the factors explored and recommendations made in that report is indispensable for the most judicious allocation of fiscal responsibilities among the levels of government.

Recommendation 7. Greater State Latitude in Lien and Recovery Requirements

The Commission recommends that Congress amend Title 19 of the Social Security Act to permit the States greater latitude in determination of lien and recovery provisions.*

In the categorical assistance programs, States are permitted to determine whether there shall be statutory provisions for placing liens on the property of a recipient of public assistance or for recovery from the estate of deceased recipients. State legal requirements may also be adopted establishing the responsibility of children or other relatives for recipients. Lien, recovery, and relative responsibility requirements are much more common in old age assistance programs than in the other categorical programs.

By way of contrast, Title 19 limits the discretion of States to include such statutory provisions in their respective Medicaid programs. It prohibits States from assigning fiscal responsibility for payment of medical costs to any relative other than a recipient's spouse or the parents of a child who is under 21 years of age or who is blind or disabled. Further, States may not impose liens or encumbrances of any kind on a recipient's real or personal property prior to death for compensation of medical assistance paid on his behalf. Moreover, such claims may not be imposed at any time if the recipient was under age 65 when he received assistance. States may seek recovery for medical payments only from the estate of an individual who was age 65 or older when he received such assistance provided that his spouse is also deceased and there is no surviving child who is blind or disabled or under 21 years of age.

The Commission believes that the lien and recovery provisions of Title 19 tend unduly to restrict State control over the recipient rolls for medical assistance. Illinois officials, for example, have objected to provisions prohibiting the States from establishing a lien on the real property of a recipient of medical assistance. They have pointed out that the present provision prevents a State from protecting its claim against the estate of recipients 65 years or older who drop out of the program before their death.

Thus, inequities are generated in the financing of medical assistance. Further, permitting people who have adequate financial resources to receive public medical assistance and preventing the States from imposing liens on the property of some recipients of medical payments prior to their death, contribute to the spiraling costs of care and the increasing numbers of the medically indigent.

Governor Ronald Reagan recently recommended that the California legislature enact a bill authorizing the State to share in the estates of deceased recipients of welfare payments. Under this proposal, which some would like to apply to the State medical assistance program, aid payments to adults would be made a lien against any property owned by the recipient. However, settlements would not be executed against a house while the surviving spouse lived in it.

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* Professor Cline, Commissioner Dever, and Mayor Naftalin dissent from this recommendation and state: "We favor retention of the present lien and recovery provisions of Title 19, since they are basically consistent with the principle that an individual receiving medical care should be allowed to maintain a minimum reserve of unencumbered resources which is protected from use in the payment of medical care costs. Having available unencumbered resources is not only essential to the dignity of the individual and the security of the family; these assets may be utilized in such a manner as to enable a person eventually to be removed from the recipient rolls."

If Title 19 restrictions concerning lien and recovery were amended to permit imposition of a lien upon a recipient's real or personal property before his death, provision still could be made for not depriving him of the full use of property which he, his spouse, and children may require.

In general then, reductions in the costs incurred by States in the provision of medical assistance in the adult categories as well as a better division of personal and public responsibilities could be realized if the lien and recovery restrictions were modified.

Recommendation 8. Federal Criteria for Evaluating State Resource Limitations Requirements.

The Commission recommends that Congress amend Section 1902(a) (17) of the Social Security Act to establish systematic criteria for evaluating those portions of State plans relating to resource limitations (cash or other liquid assets) used in establishing eligibility of the medically needy.

Among the many controls over Medicaid established by Federal and State regulations are those relating to the financial eligibility of the medically needy. These controls concern two elements: (1) current income and (2) other kinds of cash or liquid assets such as savings and insurance. Title 19 requires that each State plan serving the medically needy specify the amount of cash or other liquid resources that may be protected from use for medical expenses. Resources that may be held must be at least at the most liberal level used in any Federal categorical assistance program in effect within the State and must vary with the size of family.

A very wide diversity exists among the 23 States serving the medically needy (as of June 1, 1968) regarding the amount of cash or other liquid resources that may be protected from use for medical expenses. For one person in the family the cash assets limitation ranges from $200 in Washington to $4,000 in Rhode Island; for four persons in the family from $450 in Washington to $6,200 in Rhode Island. Furthermore, there appears to be no consistency in the lower and upper range of cash assets based on the number of persons in the family among the States. The spread in allowable cash assets for one person in the family and four persons in the family within a single State amounts to $250 in Washington while in Rhode Island the difference is $2,200. Finally, limits established for the value of cash assets appear to have no correlation with those set on current income. Some States may have relatively high limits for the former and low limits for the latter; others may have established just the opposite pattern.

The essential question then is whether the Federal Government should tighten its requirements so that all the States would be either uniformly "liberal" or "conservative" in their policies toward placing limitations on the cash assets of the medically needy or whether such limitations should be prohibited and eligibility control be determined solely by current income level.

The main argument for allowing States to impose resource limitations is that the authority to control factors determining eligibility and need is what is really important to the States. They should be allowed to vary conditions of eligibility, and to restrict or broaden the availability of medical assistance in accordance with overall State goals and policies and their ability to finance such programs. Second, cash asset limitations have long been used in the public assistance programs. Finally, it seems reasonable public policy to require that recipients pay for medical expenses first from their own resources before seeking public assistance.

The variation among States in the amount of cash or liquid assets that may be retained by the medically needy is so great, however, as to jeopardize, in our opinion, the achievement of any consistency in program effect throughout the country. Variations in the cost of living, State per capita income, and social and economic conditions obviously affect the picture. Their presence, however, cannot fully explain or justify such a wide variation.

The Commission believes, therefore, that Congress should amend the Social Security Act to establish criteria to guide the Secretary of HEW in evaluating the amount of cash or liquid assets which the States may allow the medically needy to retain. The legislative limits should reflect State to State variations in specified social and economic factors. The Commission feels that this question of limits on resource limitations carries significant policy implications and thus should be established in the law rather than be left to administrative discretion.

C. ALLOCATION OF FISCAL RESPONSIBILITY BETWEEN STATE AND LOCAL GOVERNMENTS

Recommendation 9. Full Discretion Regarding Local Matching Should Be Left to States

The Commission recommends that Congress amend Title 19 of the Social Security Act with respect to State and local government responsibility for the non-Federal share of medical assistance payments after July 1, 1969 by allowing each State to determine whether it will assume the full non-Federal cost or require that there be a local portion, such portion to be determined by a State-prescribed formula.*

Title 19 provides that by July 1, 1969, States must assume the total non-Federal share of Medicaid expenditures or arrange for distribution of Federal and State funds "on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services. . ." Fifteen States with Medicaid programs had some sort of local sharing in 1967. The ACIR-NGC-NCSLL survey found that a large majority of the State officials were generally satisfied with the present law. As might be expected, there was little disposition to alter the arrangement they were working under, whether with full State responsibility or State-local sharing.

The Commission believes that the general satisfaction of State officials with their present arrangements for full State payment of the non-Federal share of Medicaid costs or State-local sharing, as the case may be in their respective States, speaks eloquently for the policy of leaving up to the States the choice of whether to assume full responsibility for the non-Federal expenses or share it with their localities. This is in accord with the spirit of a cooperative program like Medicaid.

The issue of State-local sharing must be worked out by each State, taking account of its own political history and institutions. Practice with respect to State-local sharing of the financing of public assistance and other functions, the strength of home rule, and the extent of local revenue sources are factors to be considered. States that want to assume full cost of the non-Federal share should certainly be allowed to do so. To force them to do so, however, would be an unwarranted intrusion on their prerogatives. The decision on whether to share the non-Federal cost of Medicaid with local units, therefore, should be left entirely to each State government. Where a State chooses to require a local contribution, morevoer, it should have full discretion to determine the formula for such contribution, including the degree and method of equalization to be employed, if any.

Accordingly, we believe that Congress should delete Section 1902(a) (2) of the Social Security Act

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* Mayor Blaisdell, Professor Cline, and Mayor Walsh dissent from this recommendation and state: "We believe that the States should be required to assume the full non-Federal share of medical assistance costs. Local governments have enough problems of a local nature to consume their already hard-pressed resources. In addition, alleviation of indigence has increasingly been accepted as a responsibility of the State and National Governments; its causes are increasingly found in conditions over which local governments have diminishing control – national economic conditions, educational opportunities, and attitudes toward minorities."

thereby removing any Federal requirement with respect to State-local sharing of the non-Federal cost of Medicaid.

D. OTHER MATTERS REQUIRING FEDERAL AND STATE CONSTITUTIONAL, LEGISLATIVE, OR ADMINISTRATIVE CHANGE

A number of problems in the operation of Medicaid came to the Commission's attention that concern intergovernmental issues other than those of Federal-State-local sharing of fiscal responsibility. The recommendations which follow deal with some of these issues: (1) removing State legal barriers to prepaid group practice of health care; (2) altering the reimbursement formula for inpatient hospital services; (3) methods of increasing the efficiency and economy of health services; (4) modification of the "comparability of services" provision; (5) simplification of procedures for determining financial eligibility; and (6) the special fiscal problems associated with providing Medicaid for Indians, Alaskan natives, and other indigenous groups.

Recommendation 10. Prepaid Group Practice

The Commission recommends that States eliminate constitutional and legislative barriers to the establishment of prepaid group practice of health care.

In order to broaden the health service options available to Title 19 beneficiaries and possibly to reduce the cost of this program, the States should strike the constitutional and legislative shackles that impede the organization and expansion of group practice.

Prepayment group practice plans have certain things in common: (1) comprehensive medical services are provided directly to a group of people; (2) these services are provided through the coordinated practice of a group of physicians; (3) payments for medical services are made periodically on a fixed capitation basis regulating the payments for needed medical care; and (4) regular premium payments provide compensation for doctors and cover the operating expenses so that no member of the physician group has a financial interest in any specific direct service to any individual.

In assessing the potential role of group practice as it relates to Medicaid, we are mindful of the arguments advanced by protagonists that generally it facilitates the provision of better quality medical care, that it significantly lowers the rates of hospitalization utilization, that it makes possible the integration of specialization in medicine, that it permits development of a predictable annual cost, and that it can serve therefore as a mechanism for quality control. We are also conscious of the counterclaims – that group health plans have not always assured patient satisfaction, that the services of nonplan physicians frequently have had to be relied upon, that the approach only has relevance in certain types of urban areas, that it restricts freedom of choice, and above all that it undermines the traditional patient-practitioner relationship.

The Commission takes no position with reference to the pros and cons of group practice as such, but it is convinced that arbitrary State constitutional and legislative barriers to this approach should be revised and updated, in order to provide a range of alternatives to Title 19 beneficiaries and possibly to reduce program cost since group practice health care tends to accentuate the preventive approach to medical care and reduce the incidence of hospitalization.

According to the Group Health Association of America, Inc., some 20 States have serious restrictions in their laws with reference to group practice as defined above. These include: Alabama, Colorado, Georgia, Idaho, Iowa, Kansas, Kentucky, Maine, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Mexico, Pennsylvania, South Carolina, South Dakota, Tennessee, Virginia, and West Virginia. Such

limitations generally stem from various provisions of State laws and some constitutions that regulate the practice of the health arts, public powers, insurance, protection of public health, and taxation. They exist in differing and diverse degrees among the States cited, and may be classified broadly under the following categories:

– restrictions on the right to organize group practices to provide comprehensive medical care which includes, in addition to physician services, the talents of others in the medical profession;

– restrictions on the right to establish insurance or other prepayment corporations offering comprehensive health benefits;

– restrictions on the right to establish organizations that combine group practice with prepayment to provide comprehensive health services;

– restrictions on the right of consumers or their agents to run such organizations;

– restrictions on the size of areas that might be served by group practice organizations; and

– restrictions on the functioning of group health plans that arise out of the application of insurance principles to the regulation of direct service health plans.

It is noteworthy that the "free choice of vendor" provision of the 1967 Social Security Act amendments specifically mentioned prepaid group practice as one of the choices to be made available to recipients:

> A State plan for medical assistance must provide that any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arrangements for their availability, on a prepayment basis), who undertakes to provide him such services.

To sum up, the Commission makes no choice between the group and solo medicine patterns of dispensing medical services. But it does feel that a choice between the two patterns should be offered to Title 19 beneficiaries, and to the States in their search for more effective, flexible, and diverse approaches for implementing their respective State plans.

Recommendation 11. Reimbursement Formula for Inpatient Hospital Services

The Commission recommends that the Secretary of Health, Education, and Welfare rescind regulations that require reimbursements for hospital inpatient services under Medicaid to be on the same basis as such reimbursements under Medicare.

Title 19 provides that State Medicaid programs must pay for inpatient hospital services on the basis of "the reasonable cost (as determined in accordance with standards approved by the Secretary and included in the plan). . ." HEW imp'ementing regulations provide that, for each hospital also participating in the Medicare program, the State agency must apply the same standards, principles, and method of computing payments that are provided under Medicare. The Medicare formula is a Ratio of Costs to Charges (RCC) formula. It is designed to charge a patient for all costs incurred for him, and to avoid attributing any part of his allowable cost to the cost of another patient's care or to another program. It is distinguished, for example, from a system using the average per diem rate, which involves spreading the expenses of certain high cost services to all patients, rather than to only those receiving those services.

HEW has explained the linking of Title 19 to the Title 18 reimbursement formula as follows:

> By July 1967. . .the Medicare program already had been in operation for a year and a half and payment for hospital care was being made on the basis of the reimbursement formula which had been developed by the Bureau of Health Insurance of Social Security Administration. The proposal to adopt the Social Security Administration method was supported by a desire for uniformity among programs operated within the same Department of Health, Education, and Welfare. Even those hospitals which opposed the use of the Social Security method felt that it would be burdensome for them to employ still another method for a different program within its institution. Approximately, 6,700 hospitals of the 7,000 hospitals in the United States are participating in Title 18.

As noted in Chapter 4, one of the major points of criticism of Medicaid voiced by State officials in the ACIR-NGC-NCSLL questionnaire survey was the required linkage between Titles 18 and 19. From California, for example, this comment was received: "The Federal government has tended to require the same standards and conditions for participation in Title 19 as in Title 18. This is acceptable when the concepts and conditions are the same but should not occur when they are not." From Pennsylvania: "The present trend is to force the States to adopt Medicare procedures and standards even though they may not be feasible for the much larger (and different) Medicaid program." From Rhode Island: "The impact of Title 18 in relation to usual and customary charges and reasonable costs has had a significant impact on the administration of Title 19 with the various providers of services."

Governor Rockefeller of New York and others, particularly the California Assembly Committee on Public Health, have contended that since most of the operating expenses of a hospital are covered by insurance payments, government reimbursement under the RCC method, or philanthropy, there is no direct financial incentive for the adoption of sound management practices. Rather, higher hospital operating costs are usually translated into increased health insurance and government reimbursement rates. Further, the RCC formula in effect reinforces the operation of hospitals on a "cost-plus" basis. The States cannot impose ceilings on the amounts paid for hospital services, but must reimburse the actual costs incurred by hospitals without any corresponding control over the efficiency of these institutions. According to the preliminary report on Medi-Cal operation by the Assembly Committee on Public Health of the California legislature:

> . . .Medi-Cal (California's Title 19 program) will pay the costs of an efficiently run hospital which provides high quality care and will also pay all the costs of an inefficiently operated hospital which provides lower quality care. There is no provision for differences in quality of care or efficiency of operation; it is obvious that such an approach offers little financial incentive for either.

HEW's own 1966 report to the President on *Medical Care Prices* recommended that the Department "review the reimbursement formulas used in medicare and medicaid in an effort to find practical ways of increasing the incentives for hospitals and other health facilities to operate efficiently." It continued:

> The present medicare reimbursement scheme, based on "reasonable cost," does not provide hospitals and other health facilities with adequate incentive to be efficient. The medicare and Title XIX reimbursement formulas, as well as the reimbursement formulas of some private insurance plans, tend to maintain institutions that are inefficient in size, plant layout, and equipment.

The conclusions of a discussion panel on hospital costs at the 1967 National Conference on Medical Costs were summarized as follows:

> Cost-based reimbursement to hospitals is an open-ended invitation to increase expenditures. The development of satisfactory alternate methods of reimbursement is enormously complicated by the fact that the end products of improved health and quality care have thus far defied logical

measurement. However, there was no dissent from the view that measures of quality must be found that will permit the development of cost-saving incentives and stop paying for whatever inefficiencies may exist.

The foregoing casts serious doubt on the use of the RCC reimbursement formula in either Title 18 or 19. Whether the criticisms are as applicable to Title 18 as to Title 19, we can not say, since we have not examined Title 18 per se. We are convinced, however, that the RCC formula now used in Title 18 should not be used in Title 19 and therefore Title 19 should be divorced from Title 18 for purposes of the hospital reimbursement formula.

Recommendation 12. Increased Efficiency and Economy of Health Services.

The Commission recommends that pursuant to Sections 237 and 402 of the 1967 amendments to the Social Security Act, the States move vigorously to experiment with methods of increasing the efficiency and economy of health services under the Medicaid program. Such experiments should include (a) reimbursing hospitals contingent on their operating under an acceptable standard of management efficiency, (b) expanding prior authorization for elective surgical procedures, (c) payment for physicians' services on a basis other than usual and customary charges, (d) use of copayments for the purchase of specified health care services, and (e) improved techniques of utilization review.

Efficiency in managing the Medicaid program depends heavily on States' policies and procedures in purchasing medical services, within Federal guidelines and regulations. In Sections 237 and 402 of the 1967 amendments to the Social Security Act, Congress acted to prod and encourage States to put more effort into measures for economy and efficiency.

– Section 237 requires States, as part of their Medicaid plan, to establish methods and procedures for safeguarding against unnecessary utilization of health care and services, as well as assuring that payments do not exceed reasonable charges and are consistent with efficiency, economy, and quality of care.

– Section 402 authorizes the Secretary of HEW to experiment with various methods of reimbursement to organizations, institutions, and physicians, on a voluntary basis, participating under Medicaid (as well as Medicare and child health programs) which offer incentives for keeping program costs down while maintaining quality of care.

The Commission believes that in line with these provisions, and with encouragement from HEW, States should pay particular attention to the possibility of linking hospital reimbursement to management efficiency, expansion of prior authorization for certain surgical procedures, compensation of physicians on a basis other than usual and customary fees, use of copayments for purchase of specified health care services, and improved techniques of utilization review.

Incentives for improved hospital efficiency. Hospital costs have risen faster in recent years than any other category of health services. In 1966 alone they went up 16.5 percent compared to 6.6 percent for all medical care costs. Key factors responsible for this trend are:

– marked increases in the numbers and salaries of hospital personnel;

– high costs of medicine, and particularly the purchase, installation, equipment, and maintenance of such specialized medical facilities as intensive coronary care units;

– sharp growth in the demand for medical services accompanying the enactment of Medicare and Medicaid resulting from: the backlog of people who could not afford needed medical treatment

before these programs became available; and payment by government of the medical bills of patients who prior to the passage of the Title 18 and 19 programs had received treatment on a "no-charge" basis or at reduced charges.

Another major contributor to the burgeoning cost of hospital care – and the factor most amenable to control – is inefficient hospital planning and operations. Chairman Wilbur Mills of the House Ways and Means Committee raised some pointed questions about hospital efficiency in his address to the 1967 National Conference on Medical Costs:

> Are hospitals and other providers of medical care using the most modern business methods? Are the funds being spent for acute short-term beds or maternity or pediatric beds in areas where the true need is for long-term beds? Are too many extremely expensive installations for open heart surgery being made in the same area? Is the question of whether to get new equipment in a hospital in too many cases resolved in favor of prestige rather than carefully assessed need? Has the art of local health planning developed to the point that we are sure it is the most useful device to meet the problems we are concerned with?

Divorcing Title 19 from the Title 18 inpatient hospital reimbursement formula would go a long way toward removing the "cost-plus" factor that provides little incentive for hospitals to hold costs down. Even under a different formula, however, States need to offer positive incentives to hospitals to reduce costs. One approach was suggested under Governor Rockefeller's proposed Health Security Act in New York: making reimbursement rates conditional on hospitals' operating efficiency. Rates would be related to the trend in the overall economy and to costs of services and facilities in comparable hospitals. Hospitals would receive more favorable reimbursement rates, for instance, if they agreed to centralize such facilities as laboratories, blood banks, and laundries. Such services as organ transplant and heart surgery would be excluded if they were not clearly necessary and if adequate alternative services were already available. Establishment on a statewide basis of a uniform cost-accounting and cost-finding system for all hospitals would be required.

HEW's 1966 report on *Medical Care Prices* suggested possible ways of using incentives to reduce costs:

> Two examples of reimbursement plans that might be considered are: cost-plus-incentive fee approaches in which the institutions' demonstrated efficiency would determine the amount of an allowable growth factor; or a fixed-price approach in which the institution prices its services in advance and then gains or loses depending on its ability to control costs. In either case, detailed standards of service would have to be specified.

Victor Fuchs, an economist participating in the National Conference on Medical Costs in 1967, suggested establishing target rates for each hospital, or fixed rates for groups of hospitals providing comparable service:

> These reimbursement rates would probably be related in some way to average costs. Inefficient hospitals, therefore, would be under strong pressure to bring their costs down, while efficient hospitals would find themselves with extra funds which they could spend for improving the range and quality of services offered. Such a system might well enlist the support of attending physicians. If the medical staff realized that by holding down costs the hospital would be able to buy new equipment, or make other improvements, the hospital administrator would be in a much better position to obtain their cooperation.

Related to operating efficiency is effectiveness of hospital facilities planning. Lack of such planning produces duplication of services and facilities, excessive investment in medical equipment, and construction

of hospitals without regard for their location relative to other facilities. According to the HEW Advisory Committee on Hospital Effectiveness:

> Lack of planning and control results in. . .two new hospitals, both half empty, within a few blocks of each other in one city neighborhood; half a dozen hospitals in another city equipped and staffed for open heart surgery, where the number of cases would barely keep one of the centers busy; empty beds the rule rather than the exception in obstetric and pediatric services across the nation. . .

The Senate Finance Committee in 1967 sought to encourage health facilities planning by coordinating reimbursement of capital expenditures under Title 18 and 19 with State comprehensive health facility, service, and manpower planning under the Partnership for Health Act. Basically, these provisions (which were not included in the bill as enacted) would have authorized the Secretary of HEW to utilize the services of State agencies responsible for planning under the Partnership for Health Act to determine whether "substantial capital items" (involving aggregate expenditures of $50,000 or more, or significantly changing the services or bed capacity of the facility) acquired by a provider of service were consistent with the comprehensive plan of the State agency. In addition, depreciation and interest attributable to "substantial capital items" which were determined by the State agency to be inconsistent with its overall plan would have been ineligible for inclusion as part of "reasonable costs" or "reasonable charges" for Medicare and Medicaid services.

Finally, a discussion panel of the National Conference on Medical Costs suggested other areas of hospital operations where incentives for reducing costs could be explored. It proposed rewarding hospitals that:

- provide efficient and measurably effective use of the utilization review process.
- develop weekend utilization more comparable with weekday use.
- engage in shared activities with others – laboratories, computers, laundries, etc.
- use formularies and generic drugs.
- maintain high-caliber cost records and develop use of effective cost-control systems.
- use professional advisory and consultant talent for more efficient use of hospital services.
- use social and other services to plan for the discharge and next steps for patients.
- devise working departmental incentive programs which lower supply consumption and increase productivity.

Utilization review. Widespread allegations are heard that Medicaid is unduly costly because of over-utilization of the program both by recipients and providers of service. Unnecessary visits to physicians, over-long stays in hospital and nursing homes, increased use of luxury services, and a number of other abuses have been charged. Little evidence exists, however, as to the extent of these practices; recent studies in California and New York did not support claims of widespread fraud or abuse in those States' medical assistance programs.

It is understandable, however, that overutilization is suspected, and that it might easily exist, under a "third party" relationship, whether it is Medicaid, health insurance, or a prepaid health plan. Where the patient pays the provider of service directly for the service, there is an obvious check on overutilization. With the third party paying the bill, however, the incentive for cost restraint is removed for the patient and

the provider. It is important under third party arrangements, therefore, to develop adequate utilization controls.

Developing standards for utilization controls is not easy. As the California Assembly Committee on Public Health pointed out:

> . . .the major problem in trying to control utilization by externally imposed controls is that those controls must be based on a norm, and slight deviation from the norm must be accepted while only gross misutilization can be successfully challenged. For example, if 50 patients stay in the hospital one day too long, the cost is greater than one or two patients staying a week too long. The former is much more difficult to detect and more likely to occur.

Despite these difficulties, the Commission believes that utilization review is worth exploring as a technique of cost control. Ordinarily it is used by committees in hospitals and nursing homes and by local medical societies. The review follows performance of the service and if improper utilization is flagrant, the physician involved may be barred from participation in the program. The main thrust of this procedure is educational, aiming to persuade errant practitioners to change their ways.

The Secretary of the Human Relations Agency of the State of California endorsed the use of utilization review bodies in his statement at the Commission's hearing on Medicaid:

> I also believe that we should continue, where it already exists, and institute, where it does not exist, a system of program review by peer review committees. Here, groups of professionals review the practices of their fellows for charges, utilization, and quality of care. This self-policing system can be and should be the most effective method of assuring to patients a high quality of care and the taxpayer of a good return on the tax dollar. Guidelines and standards must be established that would permit government to obtain an accurate evaluation of the performance of providers while still protecting the traditional patient-doctor relationship and the integrity of the health care practitioners.

Prior authorization. Another form of utilization control deserving exploration is prior authorization for elective medical and surgical procedures. Objections are sometimes made that prior authorization interferes with the practice of medicine. It is generally acknowledged, however, that certain procedures have been abused in private practice and are thus likely to occur in State Medicaid programs. Singled out are tonsillectomies and hysterectomies. It may also be contended that physicians' decisions are already reviewed post-operatively by hospitals' medical staffs, thus checking any tendency to undertake surgical procedures unnecessarily. In such a review, however, the staff committee is aware that a physician's professional reputation is more affected by a criticism of his decision after a surgery has been performed than by a withholding of authorization in advance, and therefore the committee is likely to be less rigorous in its interpretation of the "necessity" of a surgical procedure than a prior authorization review body.

Under a prior authorization system, the State administrator with the advice of the State program review council would determine what procedures are considered elective. Emergencies, of course, would be exempted from prior authorization requirements. Final decisions on questions of utilization might be based on peer review by local utilization review committees.

Use of copayments for purchase of specified health services. Title 19 permits States to require payment by a medically indigent recipient of a portion of the cost of a service so long as such payment is reasonably related to his income and resources. The validity and administrative implications of this arrangement, known as copayment for services, also deserve exploration by the States on a limited or pilot basis.

The purpose of the copayment is to discourage, for example, repeated unnecessary visits to a physician or physicians, or excessive purchases of drugs. First visits to physicians might be allowed even though

some may be unnecessary. Thereafter, copayment might be applied unless a prior waiver had been obtained for medically needy hardship cases.

One of the administrative limitations often cited is the amount of red tape involved in keeping a record of the recipient's cumulative copayments to make certain that they do not exceed the point of "reasonable" relationship to his income and resources.

To be meaningful, the copayment should be large enough to represent a financial sacrifice by the recipient, even though it does not overstep the point of reasonableness. On the other hand, the amount should not be so high as to discourage the use of services by persons who would benefit from early care and thereby avoid more costly care at a later time. The Secretary of the Human Relations Agency of the State of California endorsed a study of the possibilities of copayments in his presentation at the Commission's Medicaid hearing. He suggested that copayments be limited to "non-essential services," so as not to bar persons of limited means from receiving essential assistance.

Payment for physicians' services. With respect to payments for other than hospital services, HEW guidelines state:

> The requirement for fee structures permits a variety of means which may be used in determining payments to providers of services other than hospitals. . .Among the means which may be used in relation to practitioners' services are usual and customary charges; negotiated fee schedules which allow fees equivalent or similar to those paid on behalf of individuals in similar financial circumstances by organizations that pay for substantial amounts of medical and remedial care and services (supplementary medical insurance under part B of Title XVIII, Blue Shield organizations, group health associations, and other insuring and governmental agencies); and other means, including payments on a capitation basis to an organization providing medical and remedial care and services.

Many States compensate physicians under Title 19 on the basis of "usual and customary charges." "Usual charges" are what the provider usually charges his patients, whether they are private or public assistance cases. "Customary charges" are those customarily made in the community.

The escalating effect on costs of introducing the "usual and customary" basis was explained in relation to Medicare by the HEW report on *Medical Care Prices:*

> Starting July 1, 1966, (the date of initiation of Medicare) average fees of physicians, and their incomes, have increased because of the payment of customary charges under medicare for the aged, many of whom were previously paying charges lower than the customary charges of physicians. Therefore, many aged persons will now find that they are being charged more for a given service, since their physician is now charging them the same fee he charges to the majority of his patients.

At the National Conference on Medical Costs, the Commissioner of Social Security, Robert M. Ball, raised questions about the workability of the customary charges system under Medicare:

> In the area of physicians' charges the Medicare program is engaged in a very important experiment. The law provides for reimbursement of the physician on the basis of his customary charge as long as it is within the rates prevailing within his locality – that is, there is to be no negotiated fee schedule and no subsidy of low-income patients. The physician is to receive his customary charge, meaning what he generally charges the rest of his patients. Can this be made to work? Will physicians in general exercise sufficient restraint so that cost can be kept in bounds and the practice of reimbursing on a customary fee rather than a negotiated fee be continued?

The Director of the Illinois Medicaid program, Harold O. Swank, speaking at the same conference,

indicated the cost consequences in his State of switching to the "customary charges" basis for physicians' services purchased for public assistance recipients:

> Our schedule of fees and our quantity standards had to be abandoned after Title 18 and Title 19 came along, and is estimated to result in a 100 percent increase in the cost of physicians' services. We still are paying less than Title 18 for many procedures, and I am sure the pressure will continue until physicians are able to obtain the full amount of their charges. I know of several physicians, with large public assistance practices, who have been collecting in excess of $30,000 per year from the public assistance agency. Based on the average increase in physicians' fees, we expect that they will now be collecting more than $50,000 per year, and we can't help wondering if their patients are getting any better medical care as a result. I doubt that the spending of this addditional money automatically provides recipients of assistance with access to better care.

In its *1968 Preliminary Report on Medi-Cal,* the California Assembly Committee on Public Health suggested paying physicians and other medical professions on the basis of what is "usual, customary, or reasonable":

> . . .under the usual and customary approach it is still possible to have fees and charges which are unreasonably high. Therefore, it is necessary to develop a means of determining what is reasonable.
>
> The best criteria for reasonableness is the amount allowed by private health prepayment and insurance plans for the same services. These plans have much the same problems as the State in balancing payments and premiums (instead of taxes) and have developed considerable experience and expertise in determining what is reasonable. A representative sample of these plans should be surveyed to determine the range in which their fees and charges fall and if this range is within narrow limits, it should be accepted as reasonable. If not, it should be narrowed so that it still contains most of the plans in the survey. Such a survey should be updated on a yearly basis to reflect current conditions.

Walter J. McNerney, President of the Blue Cross Association, described for the National Conference on Medical Costs in June 1967 the various methods of paying physicians, including fee-for-service, a negotiated fee schedule, usual or customary charges, on a per capita basis, or on a salary basis. He added:

> Until recent months the issue of physician costs was less compelling. The rise in physician fees was measurably less than the rise in cost of institutional services. The recent inordinate rise in physician fees has served to stimulate new interest in fiscal controls. At the moment there is a widespread move among many carriers to what may be termed reasonable and customary charges. If the rise in fees in 1966 over 1965 persists, however, carriers will have to explore more energetically, carefully constructed service contracts where certain outer limits are known for any given period of time; and the potential of per capita payments to associated physicians where the outer limits of the commitment are periodically negotiated.

All of the foregoing suggests, in the judgment of the Commission, ample reason for the States to explore various methods of paying for physicians' services, to the end that this important sector of Medicaid costs is brought under more effective control.

Recommendation 13. Flexibility in Allocation of Medical Services among Eligible Groups

The Commission recommends that Congress modify Section 1902(a) (10) of the Social Security Act to permit States to depart from the "comparability of services" requirement, subject to approval of the Secretary of Health, Education, and Welfare.

The "comparability of services" requirement provides that, with a few exceptions, all Medicaid

recipients who are categorically needy must have access to comparable medical services, and all those who are medically needy must as a group get comparable medical care and services. A State may not provide more services for the medically needy than the needy, but it may provide less.

The House Ways and Means Committee report on the Medicaid bill in 1965 said that this provision "will assure comparable treatment for all of the needy aided under the federally aided categories of assistance and will eliminate some of the unevenness which has been apparent in the treatment of the medical needs of various groups of the needy." The reference was to the pre-Medicaid system in which the medical programs for each of the four welfare categories (OAA, AB, APTD, and AFDC) were under different State plans and varied in regard to type and scope of services provided.

Under the heading of "other intergovernmental problems" in the ACIR-NGC-NCSLL questionnaire, a number of Governors and State legislative leaders, or their representatives, complained about general lack of flexibility accorded the States in planning and administering Medicaid. Several specifically mentioned the difficulty in having to operate under the comparability of services provision:

– "Present regulations make phasing-in difficult. This makes it difficult to develop information on a partial basis to use in planning additional programs. . .States should be allowed to establish trial programs by categories as was the case in previous programs. The Federal government is trying to avoid discrimination by saying that all categories must be covered. While the principle is good, it is not working out well in practice." (West Virginia legislator)

– "We would be desirous of as much flexibility as possible on the part of the Federal agency in setting up ground rules which would tend to give the State more latitude in what it would like to do in connection with the Medicaid program." (Governor of Indiana)

– ". . .services desirable for children or those given priority may not be the same services which would normally be given top priority for another group of eligible individuals as the aged, over 65, or the disabled adults."* (Governor of West Virginia)

–"More flexibility should be accorded the State. . . ." (Governor of Texas)

– "Perhaps the major problem with the outgrowth of the federally aided welfare programs is the lack of flexibility given to the states in administering a program. For example, the federal government requires that certain types of medical services must be rendered; however, at the same time, a request is made to the states to collect information in order that a system of priorities for medical care can be established in each state. If priorities are not clearly defined why should states be forced to select certain basic services? Dental care for children is an area in which many legislators would like to provide financial assistance for medical services. However, under federal regulations the same type of medical care must be given to all classes of recipients. Dental hygiene and other types of preventive dental care for children could result in the saving of teeth in adult life, reducing the overall need for dental care in the years ahead. . . .The Colorado Legislative Council interim committee attempted to classify certain types of dental care for inclusion in a program in Colorado. HEW administrators pointed out that these attempts to classify dental care by age groups would not meet with federal approval."* (Governor of Colorado)

– "(Comparability) is a laudable objective, if there are sufficient resources to reach it.

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* A 1967 amendment (section 302(a)) to the comparability provision provides that, as of July 1, 1969, State plans may single out persons under 21 for special screening, diagnosis, and treatment, pursuant to regulations of the Secretary of HEW.

However, it is questionable whether there are and at the same time expand the program to other persons (sic). There are valid distinctions which can be made for allocating resources, e.g., preventive services for children generally provide a more significant pay-off than for older persons. The states should have greater flexibility in developing their programs to meet needs as they see them, and to make optimum use of available resources. The elimination or modification of the comparability requirement would be a major step in this direction."* (California legislator)

The Commission believes the arguments advanced by these State responses, particularly those from Colorado and California, make a good case for modifying the comparability of services provision. State fiscal resources are limited, so that States must constantly review and balance needs and resources. Even a program such as Medicaid which draws on a Federal open-end appropriation is not immune from possible retrenchment. When Medicaid funds must be curtailed – as they had to be in a number of States in 1968 – the State must make program adjustments skillfully to achieve most effective use of the funds available. At the present time such adjustments are rendered more difficult by the fact that a State's options are limited under the comparability of service requirement. If it wishes to cut back, it must drop or reduce a service across-the-board or cut out an entire group of eligibles. It does not have the option to drop or cut back certain services for some recipients and not others. On the positive side, when a State wishes to initiate or expand a program this limitation of options also hampers the State's flexibility in tailoring the program to its people's needs.

The possibility of departing from comparability of services makes sense from the standpoint of better overall health results, as well as easing the State's role in cutting its fiscal program cloth to fit the pattern. A case in point is special treatment for children, suggested by the above quotes from Colorado and California and now authorized by a modification of the comparability provision in the 1967 Social Security amendments. It will now be possible to get more results for the Medicaid dollar by concentrating preventive attention on children, as in dental care. Other justifiable needs for exceptions to the comparability provision may arise in the future and should not have to travel the laborious legislative amendment route to be authorized.

The wide variation in services under the pre-Medicaid programs was certainly a legitimate reason for requiring comparability under Medicaid. It seems to us, however, that the very fact that Medicaid is a single program with a single set of standards under unified administration should guard against many of the inconsistencies that may have crept in when the individual categorical programs were under separate plans and sometimes separate administrations. In urging such a modification in the law, moreover, we do not suggest that States be allowed to slip below standards of quality care, either in initiating or expanding their programs.

Finally, vesting in the Secretary of Health, Education, and Welfare the decision as to whether a departure should be allowed from the comparability provision is a way of assuring that variations are legitimate and consistent with the overall objectives of the Medicaid program, and are not allowed for reasons other than the achievement of the best medical service for the available funds.

Recommendation 14. State Experimentation with Simplification of Financial Eligibility Determination

The Commission recommends that States move vigorously to experiment with simplified procedures for establishing financial qualifications for medical assistance under Medicaid. The Commission further recommends that Congress amend the Internal Revenue Code in order to establish a specific procedure

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* See footnote, page 81.

whereby State medical assistance officials would have access – on request – to individual Federal income tax returns for program inspection purposes.*

At the present time, Title 19 requires that eligibility determination must be made by the same agency that makes determinations under cash assistance programs. This means that as Medicaid programs expand to include more of the medically needy, the administrative burden of welfare agencies will become heavier and heavier. Furthermore, some observers claim that the procedures and application forms developed and utilized by welfare agencies, in effect, do not conform to HEW regulations developed to carry out the mandate of Title 19 that "a State plan for medical assistance must. . .provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided in a manner consistent with simplicity of administration and the best interest of the recipient. . ." Mayor John V. Lindsay of New York, for example, has charged that the questionnaires now used to screen "the poor and the indigent are cumbersome, inefficient, demeaning, complicated, and expensive." Moreover, present procedures appear to provide special psychic problems for the medically needy surrounding the stigma of the means test.

The Commission believes that on administrative as well as humanitarian grounds a simpler procedure for determining eligibility under Medicaid should be developed.

HEW regulations already make it clear that it would consider a simple declaration filed by an applicant for assistance (in person, by mail, or by telephone) as adequate for fulfilling the requirements for establishing financial eligibility. The regulations indicate, for example, that the State agency should make "maximum use of declarations or other types of statements containing only essential factors of eligibility filled out and signed by the applicant or recipient or someone acting responsibly for him." In a transmittal to the States in August 1967, moreover, HEW suggested guidelines for development and use of declaration forms and included two samples. The guidelines and forms were based on experiments conducted by several State agencies "aimed at simplifying operating procedures while maintaining the validity of eligibility decisions."

We understand that the Secretary of HEW is now in the process of issuing a mandate to the States to use a simple declaration of financial status in the public assistance and Medicaid programs effective July 1, 1969. In our judgment, it is premature to impose such a mandate, despite the mounting criticism of the eligibility determination process – a major cause of growing dissatisfaction with the traditional welfare system. The fact that HEW itself has relied on State experiments with simplified declarations in preparing its guidelines and samples sent to the States, in our opinion, justifies giving them further opportunities to conduct more experiments.

Imposition of a nationwide requirement would take away a key part of the States' share of decision-making in the partnership Medicaid program, and would raise a real question as to how much partnership is left. Furthermore, continuing to encourage State-by-State experimentation is likely to nurture the development of a range of procedures which will achieve simplicity but in the framework of each State's own needs and traditions and without imposing needless conformity. Certainly it is too early to conclude that one system of simplified declaration is the best and should be used throughout the country. A system recently

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* Mayor Blaisdell, Professor Cline, Mayor Naftalin, and Mayor Walsh dissent from this recommendation and state: "The fact that the States have long had the authorization and active encouragement from HEW to establish and use a simple declaration form, and yet have not seen fit to use it, leads us to conclude that adoption of this important reform will come only as the result of a Federal mandate. Such a nationally oriented approach to simplifying Medicaid application procedure has many advantages, including establishing uniformity, barring requirements that inflict the demeaning overtones of a means test, and eliminating cumbersome, sometimes intimidating, lengthy forms and procedures."

proposed in the California legislature, for example, justifies confidence in States' interest in and ability to develop their own approaches to simplicity in eligibility determination.

Under the California proposal, called "Cal-Med," an income tax filing system is used to simplify the eligibility determination process and to relieve the State Department of Social Welfare of a mounting administrative burden. In brief, any State resident would enter the proposed Cal-Med system by filing an income tax return and a supplementary statement with the Franchise Tax Board. The supplementary statement would contain information about income which is not required to be reported on the State income tax return and the names of dependents declared in the return who are 21 years of age or older and not eligible as family members under Cal-Med. By filing an income tax return and the supplementary statement for the preceding calendar year, membership would be established in the program for the forthcoming one year basic eligibility period. Persons who are not residents of the State during the preceding calendar year could enter the program by filing a supplementary statement with the Franchise Tax Board. In general, if a person were a resident of the State during the preceding year and did not file a return prior to the final day of filing, he would not be eligible for Cal-Med benefits during the ensuing eligibility period. In any event, persons qualifying for public assistance or general assistance would automatically become members at the time they become eligible for such aid, although they still would have to file an income tax return as well as a supplementary statement.

In order to give further stimulus to States to develop a simplified procedure for determining financial eligibility, we propose that Federal income tax returns be made available for examination by State Medicaid officials. This requires amending Section 6103(b) of the Internal Revenue Code to authorize specifically the opening up, on request, of income returns "to inspection by any official lawfully charged with the administration of any medical assistance program under the Social Security Act established by State law. . ." Any such inspection would be governed by rules established by the Secretary of the Treasury or his representative and resulting information would be used only for the administration of a Medicaid program. It would be up to State officials whether they wanted to check on a 100 percent or sample basis.

To sum up, the Commission believes that States should adopt simpler techniques for determining financial eligibility for Medicaid applicants, but that they should have further opportunity to explore various alternatives to this goal with the encouragement of HEW and the Internal Revenue Service.

Recommendation 15. The Special Case of Indians, Eskimos, and Other Indigenous Groups.

The Commission recommends that the President direct the Secretaries of Interior and Health, Education, and Welfare to prepare and submit a joint report and recommendations to clarify the relationship between Medicaid and the medical services provided Indians, Eskimos, and other indigenous groups by the Department of Health, Education, and Welfare.

The primary reason that Alaska and Arizona have not initiated Medicaid programs is their apprehension over the probable cost of Medicaid for the Alaska natives and Arizona Indians. At present, full-scale medical attention, including hospital care, is furnished to these indigenous groups by the Division of Indian Health of the Public Health Service completely at Federal expense. If substantial numbers of these persons chose to use Medicaid, the State would in effect have to pay about 50 percent of the cost of their care in Alaska and 35 percent in Arizona. This would raise serious fiscal problems in both States.

Alaskan natives – Indians, Eskimos, and Aleuts – total almost 44,000, roughly 20 percent of the total State population. American Indians in Arizona reservations in 1963 totaled over 83,000, about six percent of the total population. In both States, a large proportion of these indigenous people are on welfare programs, and thus would be eligible for Medicaid.

In describing this special problem at the Commission's hearing on Medicaid, the regional director of

HEW indicated that a number of ways of implementing the Medicaid program in these states had been suggested in discussions with Governors and State health and welfare directors. These included such alternatives as:

– Being able to consider Division of Indian Health Services a prior or primary resource for medical care.

– A change in requirements which would not require States to provide medical care for reservation Indians.

– A higher medical assistance matching formula for these States.

– Reimbursement by the Federal Government for Medicaid services provided Alaskan natives and reservation Indians in Arizona.

It seems clear to the Commission that attention needs to be given to the fiscal problems created by the special status of the indigenous peoples vis-a-vis the Federal Government. Perhaps one or more concessions of the kind suggested are the answer. In any case, the Commission believes that HEW and the Department of the Interior – the latter because of its basic responsibilities for the welfare of natives of Alaska and Indians – should be directed to study the problem jointly and propose workable solutions in the interest of medical care for the people affected and the fiscal health of the States involved.

FOOTNOTES

Chapter II

1. General sources used as reference for this chapter were Josephine C. Brown, *Public Relief 1929-1939* (New York: Holt, 1940), pp. 3-38; Herman M. and Anne R. Somers, *Medicare and the Hospitals: Issues and Prospects* (Washington, D. C.: The Brookings Institution, 1967), pp. 1-24; *Congress and the Nation 1945-1964* (Washington, D. C.: Congressional Quarterly Service, 1965), pp. 1151-1155; Margaret Greenfield, *Health Insurance for the Aged: The 1965 Program for Medicare* (Berkeley: Institute of Governmental Studies, University of California, 1966); and Richard Harris, "Annals of Legislation – Medicare," *The New Yorker,* July 2, 1966, July 9, 1966, July 16, 1966, and July 23, 1966.

2. Margaret Greenfield, *op. cit.,* p. 101.

3. U. S. Congress, Senate, Subcommittee on Health of the Elderly, Special Committee on Aging, *Medical Assistance for the Aged: The Kerr-Mills Program 1960-1963,* 88th Cong., 1st Sess., Committee Print, October 1963, p. 3.

4. *Ibid.,* pp. 1-2.

5. U. S. Advisory Council on Social Security, *The Status of the Social Security Program and Recommendations for Its Improvement* (Washington, D. C.: 1965), pp. 29-52.

6. Lyndon B. Johnson, *State of the Union Message,* January 4, 1965.

7. P. L. 89-97.

8. U. S. Congress, Senate, Committee on Finance, *Social Security Amendments of 1965,* 89th Cong., 1st Sess., Report 404, Part 1, p. 23.

9. U. S. Congress, House, *Limitations on Federal Participation Under Title XIX of the Social Security Act,* 89th Cong., 2d Sess., Report No. 2224, (October 11, 1966), p. 2.

10. P. L. 90-248.

Chapter III

1. The 1967 amendments now permit different services for the aged through the "buy-in" to Medicare.

Chapter IV

1. In addition, the District of Columbia had submitted its plan to HEW for approval. Colorado and Tennessee had passed legislation for new programs to start January 1, 1969 and on or after July 1, 1969, respectively, but neither had yet submitted its plan.

2. Alabama, Alaska, Arizona, Arkansas, Colorado, Florida, Indiana, Mississippi, New Jersey, North Carolina, Tennessee, and Virginia.

3. U. S. Department of Health, Education, and Welfare, *FY 1969 Budget Justification,* (processed), p. 101. According to HEW, the six States are Alabama, Arkansas, Florida, Indiana, Mississippi, and North Carolina.

4. May and November are the middle months of the second and fourth quarters of the calendar year. State agencies report to HEW for the middle of each quarter.

5. In addition, some part of the percentage in the right hand column for both groups of States represents general assistance recipients (not federally assisted) which are not separated out in HEW statistics.

6. U. S. Congress, House, Committee on Ways and Means, *Social Security Amendments of 1965,* 89th Cong., 1st Sess., Report No. 213, (1965), p. 75.

7. U. S. Congress, House, *Limitations on Federal Participation Under Title XIX of the Social Security Act,* 89th Cong., 2d Sess., Report No. 2224, (October 11, 1966).

8. See P. L. 90-248, secs. 220, 221, 222, and 225.

9. U. S. Congress, House, *Limitations. . ., op. cit.,* pp. 2-3.

10. P. L. 90-248, Sec. 220.

11. U. S. Department of Health, Education, and Welfare, *FY 1969 Budget Justification,* (processed), p. 102.

12. For a discussion of medical price trends, see later section in this chapter, "The Problem of Rising Medical Costs."

13. *Weekly Compilation of Presidential Documents,* Monday, March 4, 1968, p. 389.

14. Tax Foundation, Inc., New York, New York, 1968.

15. The exception to the "no Federal matching provision" in this group is persons covered under the so-called "Ribicoff amendment" – individuals under 21 who qualify on the basis of financial eligibility but do not qualify as dependent children under the State's AFDC plan.

16. Table 7 is limited to medical care purchased through vendor payments, so that medical care provided directly by governmental facilities is not indicated. The latter type of care is provided usually for the general assistance cases but also sometimes, as in California, for the noncategorically related medically needy.

17. For a description of data reported to HEW on recipients and medical vendor payments, and an understanding of the problems involved in distinguishing the various kinds of recipients in the data, see U. S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, *Medical Assistance Financed Under the Public Assistance Titles of the Social Security Act August 1967* (March 1968), (processed), pp. 5-6.

18. Tax Foundation, *op. cit.,* p. 19. An unresolved question is the effect of Medicare on the number of these recipients. See section below, "Factors Tending to Lower State-Local Costs."

19. *Ibid.*

20. These predictions, however, were made before the 1967 Social Security Act amendments imposed income limitations on medically needy eligibility.

21. HEW sources indicate that some States may have effected other expansions which were not yet reflected in approved amendments to the State plans. A survey was being undertaken by HEW (July 1968) to determine coverage in actual operation.

22. Tax Foundation, *op. cit.,* p. 19.

23. Pennsylvania avoided the cutback, however, by raising its maximum AFDC payments level, thereby raising the medically needy income level.

24. Tax Foundation, *op. cit.,* pp. 26-29.

25. Social Security Act, Title 19, Sec. 1902(a) (2).

26. Excluding Michigan, whose local share was relatively negligible.

27. Tax Foundation, *op. cit.,* p. 40.

28. *Ibid.*

29. U. S. Department of Health, Education, and Welfare, *Handbook of Public Assistance Administration,* Supplement D, D-1100.

30. Mollie Orshansky, "The Shape of Poverty in 1966," *Social Security Bulletin,* March 1968.

31. This analysis draws substantially upon U. S. Department of Health, Education, and Welfare, *Medical Care Prices: A Report to the President* (Washington, D. C.: Government Printing Office, 1967).

32. U. S. Department of Health, Education, and Welfare, *Medical Care Prices. . . ., op. cit.*

33. U. S. Department of Health, Education, and Welfare, *Report of the National Conference on Medical Costs* (Washington, D. C.: Government Printing Office, 1967), p. xiii-xiv.

34. *Ibid.,* pp. 15-18.

APPENDICES

APPENDIX A

SUPPORTING TABLES FOR CHAPTER IV

Table A-1 — Federally Assisted Medical Vendor Payments, by Federal and State-Local Share

CY 1965 — FY 1969

(in thousands)

	Federal Share			State-Local Share			Total		
	Title 19	Other	Total	Title 19	Other	Total	Title 19	Other	Total
CY 1965	—	756,649	756,649	—	602,407	602,407	—	1,359,056	1,359,056
FY 1966	193,642	684,667[1]	878,309[1]	178,770	548,907[1]	727,677[1]	372,352	1,233,634	1,605,986
CY 1966	590,345	404,803[1]	995,148[1]	603,423	324,571[1]	927,994[1]	1,193,768	729,374	1,923,142
FY 1967	952,068	190,937[1]	1,143,005[1]	992,093	173,094[1]	1,165,187[1]	1,944,161	364,031	2,308,192
CY 1967	1,239,772	167,362[1]	1,407,134[1]	1,270,759	128,697[1]	1,399,456	2,510,531	296,059	2,806,590
FY 1968[2]	1,648,700	123,700	1,764,400	N/A	N/A	1,797,200	N/A	N/A	3,561,600
FY 1969[2]	2,068,000	63,300	2,131,300	N/A	N/A	2,245,700	N/A	N/A	4,376,000

[1] Estimated by ACIR.

[2] FY 1968 and 1969 figures include cost of State and local administration, between 4 and 5 percent of the total.

Source: U. S. Department of Health, Education, and Welfare, Welfare Administration, Bureau of Family Services, Division of Research, *Source of Funds Expended for Public Assistance Payments,* CY 1965, FY 1966, CY 1966; Social and Rehabilitation Service, *Source of Funds Expended for Public Assistance Payments,* FY 1967, and U. S. Department of Health, Education, and Welfare, FY 1969 *Budget Justification Document,* pp. 114-121 (processed).

Table A-2 — Federally Assisted Medical Vendor Payments, by State, CY 1965-CY 1967 (In Thousands)

State	Month and Year State Began Title 19	CY 1965	CY 1966				CY 1967				% CY 1967 Over CY 1965 Total
				Title 19				Title 19			
		Total M.V. Payments	Total M.V. Payments	Total	Federal Share	State-local Share	Total M.V. Payments	Total	Federal Share	State-local Share	
United States		$1,359,056	$1,923,142	$1,193,768	$590,345	$603,423	$2,772,624	$2,476,572	$1,221,961	$1,254,610	104
Alabama		17,275	16,523				15,334				
Alaska		548	558				679				
Arizona		888	1,266				1,709				
Arkansas		15,590	16,743				19,834				
California	March '66	195,824	454,477	419,538	209,769	209,768	589,280	589,280	294,640	294,640	200
Colorado		21,935	25,499				23,783				
Connecticut	July '66	27,618	30,708	15,588	7,760	7,828	39,327	39,327	19,664	19,664	42
Delaware	Oct. '66	516	475	37	22	14	2,431	2,431	1,481	950	371
Dist. of Col.		4,155	4,408				3,716				
Florida		19,946	22,974				23,453				
Georgia	Oct. '67	14,447	16,813				23,276	7,084[1]	5,786	1,298	
Hawaii	Jan. '66	4,552	6,832	6,532	3,149	3,383	8,873	8,873	4,133	4,740	95
Idaho	July '66	5,257	5,592	2,656	1,879	777	6,193	6,193	4,374	1,819	18
Illinois	Jan. '66	81,989	83,312	83,312	41,543	41,768	113,369	113,369	56,562	56,808	38
Indiana		18,186	22,242				25,673				
Iowa	July '67	22,116	21,450				20,091	9,513[1]	5,670	3,843	
Kansas	June '67	16,040	16,191				16,673	9,608[1]	5,209	4,399	
Kentucky	July '66	20,620	20,742	10,087	8,161	1,926	30,986	30,986	25,048	5,938	50
Louisiana	July '66	31,257	29,989	12,860	9,826	3,034	36,187	36,187	27,648	8,539	16
Maine	July '66	6,190	6,734	2,855	1,986	869	9,687	9,687	6,757	2,930	56
Maryland	July '66	11,720	19,456	10,859	5,003	5,856	53,571	53,571	21,424	32,146	357
Massachusetts	Sept. '66	96,099	106,792	34,779	17,389	17,389	150,235	150,235	75,026	75,209	56
Michigan	Oct. '66	44,250	75,982	19,530	9,826	9,705	126,986	126,986	63,942	63,044	187
Minnesota	Jan. '66	53,342	67,159	67,159	40,603	22,656	73,079	73,079	43,397	29,682	37
Mississippi		1,864	1,476				2,377				
Missouri	Oct. '67	14,815	15,702				12,679	2,544[1]	1,830	715	
Montana	July '67	1,650	3,689				3,880	2,334[1]	1,494	840	
Nebraska	July '66	12,769	16,112	7,828	4,834	2,974	18,654	18,654	11,530	7,124	46
Nevada	July '67	1,473	2,718				3,400	2,151[1]	1,075	1,076	
New Hampshire	July '67	3,089	3,248				2,340	1,072[1]	644	427	
New Jersey		26,830	29,898				39,644				
New Mexico	Dec. '66	4,746	6,707	670	474	196	10,148	10,148	7,143	3,004	113
New York	May '66	219,819	314,239	237,162	81,984	155,177	707,057	707,057	271,832	435,224	222
North Carolina		14,835	19,225				17,182				
North Dakota	Jan. '66	7,530	7,863	7,863	5,242	2,622	9,553	9,553	6,568	2,985	27
Ohio	July '66	35,807	32,635	12,900	6,751	6,150	50,522	50,522	26,409	24,114	41
Oklahoma	Jan. '66	25,855	57,802	57,802	40,646	17,156	57,817	57,817	40,440	17,377	124
Oregon	July '67	12,839	13,352				13,832	7,330[1]	3,986	3,345	
Pennsylvania	Jan. '66	61,023	96,620	96,620	44,844	51,776	129,802	129,802	61,483	68,320	113
Rhode Island	July '66	9,196	12,059	4,612	2,589	2,023	22,304	22,304	12,124	10,180	143
South Carolina		8,767	8,624				8,442				
South Dakota	Oct. '67	3,206	4,161				5,352	2,851[1]	2,090	761	
Tennessee		11,682	13,649				14,336				
Texas	Sept. '67	34,132	41,778				66,281	32,378[1]	25,831	6,547	
Utah	July '66	6,622	7,943	4,133	2,732	1,401	9,031	9,031	5,900	3,131	36
Vermont	July '66	3,412	4,060	2,066	1,414	653	6,393	6,393	4,391	2,002	87
Virginia		8,058	8,823				8,412				
Washington	July '66	36,198	38,685	20,526	9,654	10,872	46,273	46,273	22,745	23,528	28
West Virginia	July '66	11,522	10,667	4,572	3,395	1,176	9,771	9,771	6,879	2,892	15
Wisconsin	July '66	47,833	53,109	26,778	15,424	11,354	81,608	81,608	46,468	35,139	71
Wyoming	July '67	1,032	1,151				1,077	569[1]	337	233	

[1]Total includes only that portion of year that the Title XIX program was in operation.

Source: U.S. Department of Health, Education, and Welfare, *Source of Funds Expended for Public Assistance Payments, Calendar Year 1965, Calendar Year 1966, Calendar Year 1967.*

Table A-3 – Number of Persons in Title 19 States for Whom Medical Vendor Payments Were Made Directly or through Fiscal Agents:[1] by Categorically Needy and "Other", by State, November 1967[2]

	Categorically needy (1)	Other (2)	Total	"Other" as percent of total
United States	1,839,400	1,083,900	2,922,000	37
California	518,400	107,400	607,000	18
Connecticut	24,000	17,700	41,600	42
Delaware	5,000	980	6,000	16
Georgia	39,600	76	39,700	–
Hawaii	5,200	3,100	8,300	37
Idaho	3,700	1,700	5,400	31
Illinois	172,000	38,700	210,000	18
Iowa	16,730	2,670	19,300	13
Kansas[3]	25,800	6,700	32,500	21
Kentucky	59,400	29,900	89,300	33
Louisiana	58,400	12,100	70,500	17
Maine	3,600	1,800	5,400	33
Maryland	40,472	53,628	94,100	56
Massachusetts	80,000	109,000	189,000	57
Michigan	77,500	22,500	100,000	22
Minnesota	41,000	28,200	69,200	40
Missouri	[4]	[4]	[4]	
Montana	5,000	1,600	6,600	24
Nebraska	10,400	5,100	15,500	33
Nevada	[5]	[5]	[5]	
New Hampshire	4,700	2,300	6,900	33
New Mexico	20,600	910	21,500	4
New York	302,200	481,800	784,000	61
North Dakota	5,570	2,630	8,200	32
Ohio	90,300	14,100	104,000	13
Oklahoma	– [6]	4,600	4,600	100
Oregon	14,100	4,600	18,700	24
Pennsylvania	69,500	53,800	123,800	43
Rhode Island	15,800	13,900	29,700	46
South Dakota	2,400	2,200	4,600	47
Texas	13,400	6,300	19,700	32
Utah	9,060	2,340	11,400	20
Vermont	3,800	1,400	4,200	33
Washington	34,500	32,900	67,400	48
West Virginia	37,800	–	37,800	–
Wisconsin	30,000	35,800	65,700	54
Wyoming	800	160	960	16

[1] For purposes of simplification, the data are limited to care for which payments are made directly or though a fiscal agent, and thus exclude care financed by payments into an insurance fund. Dollarwise, the latter amounts to about 2 percent of the former.

[2] Figures may not add because of rounding.

[3] Estimated

[4] Program initiated in November; no payments made.

[5] Data not reported.

[6] Oklahoma data for categorically needy are included in the "other" column.

Source: U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, *Medical Assistance Financed Under the Public Assistance Titles of the Social Security Act, November 1967.*

Table A-4 — Amount of Medical Vendor Payments to Vendors Directly or through Fiscal Agents[1] in Title 19 States: by Categorically Needy and "Other", by State, November 1967[2]

	Categorically needy (1)	Other (2)	Total	"Other" as percent of total
United States	$93,079,000	$149,750,000	$242,829,000	61
California	22,433,000	14,866,000	37,298,000	40
Connecticut	777,000	2,248,000	3,025,000	74
Delaware	187,000	81,600	269,000	30
Georgia	1,984,000	11,700	1,996,000	1
Hawaii	263,000	591,000	853,000	69
Idaho	222,000	297,000	518,000	57
Illinois	6,668,000	5,910,000	12,578,000	46
Iowa	454,000	252,900	706,000	35
Kansas	888,000	796,000	1,684,000	47
Kentucky	1,317,000	941,000	2,258,000	41
Louisiana	1,617,000	1,692,000	3,309,000	51
Maine	566,000	257,000	823,000	31
Maryland	1,516,180	3,222,820	4,740,000	67
Massachusetts	4,830,000	10,441,000	15,271,000	68
Michigan	4,542,000	7,563,000	12,104,000	62
Minnesota	2,246,000	4,413,000	6,660,000	66
Missouri	[3]	[3]	[3]	
Montana	238,000	320,000	558,000	57
Nebraska	598,000	813,000	1,411,000	57
Nevada	[4]	[4]	[4]	
New Hampshire	101,000	51,200	153,000	33
New Mexico	1,111,000	157,000	1,268,000	12
New York	22,607,000	69,192,000	91,799,000	75
North Dakota	317,600	521,400	839,000	62
Ohio	4,204,000	1,660,000	5,864,000	28
Oklahoma	— [5]	1,107,000	1,107,000	100
Oregon	717,000	642,000	1,359,000	47
Pennsylvania	3,205,000	9,127,000	12,332,000	74
Rhode Island	835,000	1,338,000	2,224,000	60
South Dakota	169,000	309,000	478,000	64
Texas	3,006,000	1,391,000	4,396,000	31
Utah	683,000	291,000	944,000	31
Vermont	471,000	295,000	471,000	62
Washington	1,337,200	2,796,800	4,134,000	67
West Virginia	1,059,000	—	1,059,000	—
Wisconsin	2,147,000	6,075,000	8,221,000	73
Wyoming	58,200	32,300	90,500	35

[1] For purposes of simplification, the data are limited to care for which payments are made directly or through a fiscal agent, and thus exclude care financed by payments into an insurance fund. Dollarwise, the latter amounts to about 2 percent of the former.

[2] Figures may not add because of rounding.

[3] Includes $62,800 in Oklahoma not distributed by eligibility.

[4] Program initiated in November; no payments made.

[5] Oklahoma data for the categorically needy are included in the "other" column.

Source: U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, *Medical Assistance Financed Under the Public Assistance Titles of the Social Security Act, November 1967.*

Table A-5 — Number of Recipients of Medical Vendor Payments in Title 19 States, Aged 21-64, Who Were Not Categorically Related and Not Recipients of Maintenance Assistance; and Amount of Medical Vendor Payments on Their Behalf:[1] November 1967

	Number of recipients		Amount of payments	
	(a)	As % of total M.V. payments recipients	(b)	As % of total M.V. payments
United States	153,000	5%	$19,150,000	8%
California	2,100	*	75,700	*
Connecticut	—	—	—	—
Delaware	—	—	—	—
Georgia	—	—	—	—
Hawaii	170	*	20,800	2
Idaho	—	—	—	—
Illinois	—	—	—	—
Iowa	—	—	—	—
Kansas	29	*	1,100	*
Kentucky	—	—	—	—
Louisiana	—	—	—	—
Maine	—	—	—	—
Maryland	14,500	15	1,072,000	22
Massachusetts	—	—	—	—
Michigan	—	—	—	—
Minnesota	—	—	—	—
Missouri	[2]		[2]	
Montana	—	—	—	—
Nebraska	—	—	—	—
Nevada	[3]		[3]	
New Hampshire	—	—	—	—
New Mexico	—	—	—	—
New York	133,000	17	17,393,000	18
North Dakota	—	—	—	—
Ohio	—	—	—	—
Oklahoma	1,700	36	395,000	35
Oregon	—	—	—	—
Pennsylvania	—	—	—	—
Rhode Island	—	—	—	—
South Dakota	—	—	—	—
Texas	—	—	—	—
Utah	—	—	—	—
Vermont	—	—	—	—
Washington	1,600	2	192,000	5
West Virginia	—	—	—	—
Wisconsin	—	—	—	—
Wyoming	—	—	—	—

[1] See footnote 1, Table A-3.

*Less than 0.50 percent

[2] Program initiated in November; no payments made.

[3] Data not reported.

Source: U. S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, *Medical Assistance Financed Under the Public Assistance Titles of the Social Security Act, November, 1967,* Tables 14 and 20.

Table A-6 — Eligibles Added since Initiation of State Title 19 Plans, by State through July 1, 1968

	Effective date of plan	Effective date of addition	Nature of additional coverage
Connecticut	7/1/66	2/14/67	Persons over 65 in mental institutions.
Idaho	7/1/66	7/1/67	All persons under 21 who meet conditions of eligibility for AFDC other than age and school attendance.
Illinois	1/1/66	9/1/66	Persons over 65 in mental institutions.
		7/1/67	Persons over 65 in TB institutions.
		7/1/67	Children under 21 who, except for age, would be eligible under AFDC.
		7/1/67	Children under 21 in foster homes or private child welfare institutions for whom public agencies assume financial responsibility.
Kansas	6/1/67	3/20/68	Essential spouse of recipient of AABD.
Louisiana	7/1/66	1/1/67	Persons over 65 in mental institutions.
			Persons over 65 in TB institutions.
Maine	7/1/66	7/1/67	Children under 21 eligible for AFDC except for age.
		7/1/67	Caretaker relatives having in their care children under 21 eligible for AFDC except for age.
		9/1/67	Persons under 21 in foster homes or other homes for whom public agencies assume financial responsibility in whole or part.
Nebraska	7/1/66	4/1/67	Categorically related medically needy.
New Mexico	12/1/66	7/1/67	Children under 21 eligible for AFDC except for age and school attendance.
North Dakota	1/1/66	7/1/66	Persons over 65 in mental institutions.
		7/1/66	Persons over 65 in TB institutions.
		10/1/66	Persons under 21 in foster homes or others in other approved homes for whom public agencies assume financial responsibility.
Oregon	7/1/67	4/1/68	Essential spouse of recipient of OAA, AB, or APTD.
West Virginia	7/1/66	7/1/67	Children under 21 eligible for AFDC except for age and school attendance.
			Persons over 65 in mental institutions.
			Persons over 65 in TB institutions.

Source: Department of Health, Education, and Welfare, Assistance Payments Administration, Division of Program Operations, *Selected Characteristics of the Medical Assistance Program under Title XIX of the Social Security Act* (various dates).

Table A-7 — Services Provided Under Title 19 to the Categorically Needy, the Categorically Related Needy, and the Medically Needy, by State[1]

July 1, 1968

Key: services provided — o = categorically and categorically related needy only; x = categorically and categorically related needy and medically needy	Inpatient Hospital	Outpatient Hospital	Lab and X-ray	Skilled Nursing Home	Physicians	Podiatrists	Chiropractors	Naturopaths, Other Practitioners	Home Health Care	Private Duty Nursing	Clinic	Dental	Physical Therapy and Related	Eyeglasses	Prosthetic Devices	Prescribed Drugs	Audiology or Speech	Hearing Aids	Other Diagnostic, Screening Preventive Rehabilitation	Transportation or Ambulance	Total Services Provided x	Total Services Provided o
California	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	20	—
Connecticut	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	20	—
Delaware	x	x	x	x	x											x					6	—
Georgia	o	o	o	o	o				o						o	o				o	—	9
Hawaii	x	x	x	x	x				x	x	x	x	x	x	x	x		x	x	x	16	—
Idaho	o	o	o	o	o	o	o														—	7
Illinois	x	x	x	x	x	x			x	x	x	x	x	x	x	x	x	x	x	x	18	—
Iowa	x	x	x	x	x	x	x		x		x	x	x	x	x	x	x			x	16	—
Kansas	x	x	x	x	x				x		x	x	x	x	x	x	x			x	14	—
Kentucky	x	x	x	x	x				x			x				x					8	—
Louisiana	o	o	o	o	o							o		o	o	o		o	o		—	11
Maine	o	o	o	o	o				o						o					o	—	8
Maryland	x	x	x	x	x	x			x		x	x	x	x	x	x	x		x		15	—
Massachusetts	x	x	x	x	x	x			x	x	x	x	x	x	x	x	x	x	x	x	18	—
Michigan	x	x	x	x	x	x	x		x				x		x	o				x	11	1
Minnesota	x	x	x	x	x	x	x		x	x	x	x	x	x	x	x	x	x	x	x	19	—
Missouri	o	o	o	o	o							o				o					—	7
Montana	o	o	o	o	o				o	o		o		o	o	o				o	—	12
Nebraska	x	x	x	x	x	x	x		x	x	x	x	x	x	x	x	x		x		17	—
Nevada	o	o	o	o	o	o			o	o	o	o	o	o	o	o		o	o	o	—	17
New Hampshire	x	x	x	x	x	x	x	o	o	o	x	o	o	o	o	x		o	o	x	10	9
New Mexico	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o		o	o	o	—	19
New York	x	x	x	x	x	x	x		x	x	x	x	x	x	x	x	x	x	x	x	19	—
North Dakota	x	x	x	x	x	x	x		x	x	x	x	x	x	x	x	x	x	x	x	19	—
Ohio	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o		o	o	o	—	19
Oklahoma	x	x	x	x	x	x			x		x	x		o	x					o	10	2
Oregon	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o			o	o	—	18
Pennsylvania	x	x	x	x	x							o		x	o	o				o	6	4
Rhode Island	x	x	x	x	x	o			x			x	x	o	x	x		o		o	10	4
South Carolina	o	o	o	o	o				o			o			o	o				o	—	10
South Dakota	o	o	o	o	o	o	o		o			o	o	o	o		o			o	—	14
Texas	o	o	o	o	o	o	o		o		o	o	o	o	o				o	o	—	15
Utah	x	x	x	x	x	x		x	x			x	x	x	x	x		x		x	15	—
Vermont	x	x	x	x	x				x				x	x	x		x			x	11	—
Washington	x	x	x	x	x	x			x	x	x	x	x	x	x	x	x	x	x	x	18	—
West Virginia	o	o	o	o	o				o	o	o	o	o	o	o	o	o			o	—	15
Wisconsin	x	x	x	x	x	o			x	o		x	x	o	o	x	o	o	o	o	9	8
Wyoming	o	o	o	o	o																—	5
Summary — Number of States:																						
x	23	23	23	23	23	15	9	3	20	10	15	18	18	16	18	19	13	11	12	15		
o	15	15	15	15	15	9	6	4	12	8	6	13	8	13	15	12	3	6	7	15		
Total	38	38	38	38	38	24	15	7	32	18	21	31	26	29	33	31	16	17	19	30		

[1] As stated in State amended plans approved by HEW. For significant limitations on services provided for individual States, see source.

Source: U. S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, *Services Provided Under Title XIX of the Social Security Act, by Jurisdiction, as of April 1, 1968,* reflecting subsequent changes in State plans through July 1, 1968.

Table A-8 — Medical Services Added or Expanded since Initiation of State Title 19 Plans, by State through July 1, 1968

State	Effective date of plan	Effective date of extension	Nature of extension
Connecticut	7/1/66	2/14/67	Skilled nursing home services to patients under 21.
Illinois	1/1/66	9/1/66	Inpatient hospital and skilled nursing home services for persons 65 years or over in mental hospitals.
		7/1/67	Preventive services: school medical and dental examinations for polio, measles, small pox, tetanus, diphtheria, pertussis.
		7/1/67	Inpatient hospital and skilled nursing home services for persons 65 or over in TB hospitals.
Kansas	6/1/67	7/1/67	Home health care, including part-time nursing by a home health agency qualified under Title 18.
		9/1/67	Transportation and related travel services.
		10/1/67	Medical care by licensed practitioners.
		10/1/67	Dental services, including dentures.
Kentucky	7/1/66	7/1/67	Other lab and X-ray services.
Louisiana	7/1/66	3/1/67	Emergency room treatment and X-ray therapy.
New Hampshire	7/1/67	10/1/67	Licensed practitioners' services (including chiropractors and podiatrists) for medically needy.
		1/1/68	Clinic services for medically needy.
New Mexico	12/1/66	7/1/67	Removed limitations of 12 visits for home and office calls, and one visit per month to patients in skilled nursing home.
Utah	7/1/66	11/10/66	Psychiatric evaluations for categorically needy.
		7/1/67	Inpatient hospital services [other than in a TB or mental hospital] increased from maximum of 20 days per spell of illness to 60 days with extensions upon prior authorization. (Categorically and medically needy persons.)
Vermont	7/1/66	7/1/67	Inpatient hospital services: for as long as necessary. Includes payment for first 3 pints of whole blood, if not replaced. Limitation to 90 days per spell of illness was eliminated.
West Virginia	7/1/66	7/1/67	Physicians' services at home, office, hospital, nursing home or elsewhere: removed limitation to 30 hospital visits per fiscal year plus 24 visits of all other types.
		7/1/67	Clinic services.
		7/1/67	Skilled nursing home services for persons under 21.

Source: Department of Health, Education, and Welfare, Assistance Payments Administration, Division of Program Operations, *Selected Characteristics of the Medical Assistance Program under Title XIX of the Social Security Act (various dates).*

Table A-9 — Annual Income Levels for Medically Needy in 23 Title 19 Plans in Operation on June 1, 1968, and Estimated Reduced Levels Required to Comply with Limits Set by 1967 Amendments

Key: a = actual — June 1, 1968
b = 150 percent of AFDC
c = 140 percent of AFDC
d = 133-1/3 percent of AFDC

State	Type of limit	Income protected for maintenance, by number of persons in family[1]			
		1	2	3	4
California	a	2,028	3,372	3,636	3,900
	b		(2,700)	(3,100)	
	c	(1,960)	(2,520)	(2,894)	(3,734)
	d	(1,867)	(2,400)	(2,756)	(3,556)
Connecticut	a	2,100	3,200	3,800	4,400
	b				
	c		(3,080)		
	d		(2,933)		
Delaware	a	1,500	2,100	2,700	3,300
	b	(1,400)			
	c	(1,306)			(3,174)
	d	(1,244)	(2,044)		(3,023)
Hawaii	a	1,440	2,160	2,520	3,000
	b				
	c				
	d				
Illinois	a	1,800	2,400	3,000	3,600
	b				
	c	(1,774)			
	d	(1,689)			
Iowa	a	1,600[2]	2,400	3,000	3,600
	d	(1,300)			
Kansas	a	1,600	2,200	2,600	3,000
	d				
Kentucky	a	1,620	2,220	2,820	3,420
	b	(1,500)	(1,900)	(2,800)	(3,300)
	c	(1,400)	(1,774)	(2,614)	(3,080)
	d	(1,333)	(1,689)	(2,489)	(2,933)
Maryland	a	1,800	2,280	2,700	3,120
	b	(1,600)	(2,200)		
	c	(1,494)	(2,054)	(2,614)	
	d	(1,423)	(1,956)	(2,489)	(3,023)
Massachusetts	a	2,160	2,832	3,504	4,176
	b				
	c				
	d				
Michigan	a	1,900	2,700	3,120	3,540
	b				
	c				
	d				
Minnesota	a	1,620	2,220	2,628	3,036
	b				
	c				
	d				

Table A-9 *(Continued)*

State	Type of limit	Income protected for maintenance, by number of persons in family[1]			
		1	2	3	4
Nebraska	a	1,600	2,200	2,600	3,000
	b				
	c				
	d				
New Hampshire	a	2,088	3,336	3,696	4,056
	b				
	c				
	d				
New York	a	2,900[3]	4,000	5,200	6,000
	b	(2,400)	(3,500)	(4,400)	(5,500)
	c	(2,240)	(3,266)	(4,106)	(5,134)
	d	(2,133)	(3,111)	(3,910)	(4,889)
North Dakota	a	1,600	2,200	2,600	3,000
	b				
	c				
	d				
Oklahoma	a	1,728[4]	1,968	2,208	2,448
	b	(700)			
	c	(654)			
	d	(623)	(1,956)		
Pennsylvania[5]	a	2,000	2,500	3,250	4,000
	b	(1,800)		(3,200)	(3,900)
	c	(1,680)	(2,426)	(2,986)	(3,640)
	d	(1,600)	(2,311)	(2,844)	(3,467)
Rhode Island	a	2,500	3,500	3,900	4,300
	b	(2,300)	(3,100)		
	c	(2,146)	(2,894)	(3,640)	
	d	(2,044)	(2,756)	(3,467)	
Utah	a	1,200	1,680	2,160	2,640
	b				
	c				
	d				
Vermont	a	1,740	2,460	3,000	3,420
	d				
Washington	a	2,040	2,580	3,060	3,480
	b				
	c				
	d				
Wisconsin	a	1,800	2,700	3,200	3,700
	b				
	c				
	d				

[1]Plans also include provisions for additional sums for additional members of family.

[2]$1600 per member for first adult family member. For *child* who is not a member of a family group, $800 is provided for maintenance.

[3]Figures apply for family with one wage earner.

[4]Figures apply to persons owning own home.

[5]Pennsylvania subsequently raised maximum payments for AFDC thereby raising medically needy income level.

Source: U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, *Income and Resource Levels for Medically Needy in Title XIX Plans in Operation,* as of April 1, 1968 (processed), amended in case of Vermont.

Table A-10 -- Cash or Other Liquid Resources Levels for Medically Needy in Title 19 Plans in Operation on June 1, 1968[1]

State	Value of cash assets or other liquid resources, by number of persons in family				
	1	2	3	4	Plus $ for additional persons or other assets allowed
California	1500	3000	3000	3000	–
Connecticut	1400	1900	2100	2300	$200 each additional person.
Delaware	600	900	1000	1100	$100 each additional family member; cash value of life insurance, $500 for single person, $1000 for 2 or more persons. Health insurance premium exempt as paid up to $150 a year for 1 person, $250 a year for 2, and $350 for 3 or more.
Hawaii	--	–	–	–	"At least as high as those uniform levels now in effect for the money payment programs."
Illinois	400	600	700	800	$100 each additional family member.
Iowa	2000	3000	3200	3400	$200 each additional person.
Kansas	1600	2200	2600	3000	$100 each additional person.
Kentucky	500	1000	1500	1500	Life insurance up to $1000 value, each person.
Maryland	2500	2600	2700	2800	$100 each additional person.
Massachusetts	2000	3000	3100	3200	$100 each additional person.
Michigan	1500	2000	2200	2400	$200 additional, each person. Life insurance up to $1000 cash value per family.
Minnesota	750	1000	1150	1300	$150 each additional person. Plus life insurance with cash surrender value not in excess of $1000 per applicant; a prepaid funeral contract not in excess of $600, and a lot in a burial ground.
Nebraska	750	1500	1525	1550	$25 each additional. Plus life insurance of $1000 for each person. Personal property (including nonhome real property) up to $3000 value if used toward self-support.
New Hampshire	2500	4000	4100	4200	$100 each additional person.
New York	1450[2]	2000	2600	3000	$425 each additional person; plus burial reserve in cash resources or face value of life insurance up to $1000 per person.
North Dakota	300[3]	600	650	700	$50 additional per person up to 10; $25 additional per person over 10.

Table A-10 *(Continued)*

State	Value of cash assets or other liquid resources, by number of persons in family				Plus $ for additional persons or other assets allowed
	1	2	3	4	
Oklahoma	500	700	800	900	$100 each additional person up to 10.
Pennsylvania	2400	3840	3840	3840	Plus $500 cash surrender value insurance for each dependent.
Rhode Island	4000[4]	6000	6100	6200	$100 each additional; plus amount allowed for life insurance, face value, $4000 – each adult; $1000 – each child.
Utah	400	800	900	1000	$50 each additional; plus up to $500 cash surrender value of life insurance for 1 person, and $1000 for over 1 person.
Vermont	900	1800	2100	2400	Plus $300 each additional person.
Washington	200	400	425	450	$25 each additional; or may have combination of liquid assets, cash surrender value of life insurance and equity in car of $750 single person, $1450 for 2, plus $50 each additional.
Wisconsin	2300	3000	3500	4000	$500 each additional legal dependent.

[1]Home, household goods and personal effects are exempt in all jurisdictions. References to other real property which may be retained, unless identified in a Title 19 plan as included within the total limitation on resources, have been omitted from this table.

[2]Figures shown here apply in family with one wage earner. For a family with no wage earner, resources may be: 1-$1150; 2-$1625; 3-$2175; 4-$2575; plus $425 for each additional dependent. In addition, a recipient may have annual contribution up to $1080 from person not residing in the family household.

[3]These maximums on liquid assets are included within the overall limitation of $2500 on the equity which a family may have in personal property; the difference may be held in the value of such other property as vehicle, machinery, livestock, and the cash surrender value of life insurance.

[4]In addition, tangible personal property to the value of $5000 per household unit may be retained.

Source: U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, *Income and Resource Levels for Medically Needy in Title XIX Plans in Operation,* as of April 1, 1968 (processed), amended in case of Vermont.

Table A-11 — Local Financial Participation in Costs of Medical Assistance Provisions under Title 19 as of June 30, 1968 (adapted from State plans)

CALIFORNIA — The county share of the cost of medical assistance is based upon formulae contained in the State's medical assistance law. These formulae stabilize the cost of medical assistance to each county at the approximate level of county expenditures for medical care during fiscal 1964-65 on behalf of:

a. the total indigent population, or
b. the groups within the indigent population encompassed by the categorical programs.

In either case, the contribution required of each county for medical assistance funding is not less than the expenditure level of that county during 1964-65.

During 1964-65, the county share of medical care and administrative costs under categorical programs was approximately 40% of the non-Federal share. The State is responsible for paying all local costs for medical assistance and administration after deducting the local contribution described above. This results in a State share in medical assistance costs of not less than 40% of the non-Federal share, including both assistance and administration and training.

KANSAS — The State pays 52% of the cost of total expenditures after Federal share is computed except that for certain groups the State bears 100% of the cost after the Federal share.

MARYLAND — The following are the arrangements under which State funds are used to pay not less than 40 percentum of the non-Federal share of the total expenditures under the plan. Certain programs require local participation. The first is the General Hospital Inpatient Program and by law passed in 1966, the subdivisions must contribute to the cost of this program. The amounts to be paid by the subdivisions were established by the Legislature. The State pays 100% of the hospital charges, and the subdivisions' share is computed based on the total amount of charges incurred by residents of the subdivision. If at the end of the year the entire amount of the subdivisions' appropriation has not been offset by expenses, the remaining balance is pro-rated and returned to the subdivision.

The second program that requires local participation is the Nursing Home Program. Local financial responsibility is determined by the following payments for care:

— Persons 65 years or older	1/6 of payment
— Blind	35% of payment
— Disabled	25% of payment
— All others	50% of payment

Payments are made directly to the nursing home by the State at an established rate of $210 per month less patient resources.

The Chronic Disease Hospital Program requires that the subdivision pay $.75 per diem for each patient with residence in the subdivision. If there is any recovery from the patient, it is applied against the subdivision's contribution up to the amount of $.75 per diem.

The State Mental Hospitals require that the subdivisions pay $125 per year for each patient with residence in the subdivision. If there is any recovery from the patient, it is applied against the subdivision's contribution up to the amount of $125 per year.

MASSACHUSETTS* — In addition to the amount of Federal reimbursement paid to a city or town under this program, the city or town is also reimbursed by the State for 2/3 of the remainder of such

*In Title 19 program of the Commission for the Blind, State funds are used to pay all of the non-Federal share of expenditures. Note that as of July 1, 1968 the State assumed full cost of the non-Federal share of Title 19 expenditures.

Table A-11 — (Continued)

MASSACHUSETTS (Continued) — disbursements of assistance, and for 1/2 of the remainder of the expenses of administration. In Welfare Districts, the State reimburses 1/3 of the total expenses of administration. The Department administers the medical assistance program with respect to persons in public institutions for mental diseases and children under the care of the Division of Child Guardianship with no city or town participation.

MINNESOTA — Minnesota's plan for Medical Assistance provides that 50% of the non-Federal share of assistance payments is paid by the State. This is more than sufficient to meet the Federal requirement.

Legal basis for this division of program cost is found in Section 3, (a) of Chapter 755, Laws of 1965 (Minnesota), which reads:

"Section 3. *Division of cost.* The cost of medical assistance paid by each county of financial responsibility shall be borne as follows:

(a) Payments shall be made by the State to the county for that portion of medical assistance paid by the Federal government and the State on or before the 20th day of each month for the succeeding month upon requisition from the county as to the amount required for the succeeding month. The expense of medical assistance not paid by federal funds available for that purpose shall be shared equally by state and county, Minnesota Statutes, section 256.11 to 256.43, section 256.72 to 256.87, section 245.21 to 245.43, and section 256.49 to 256.71 to the contrary notwithstanding."

MONTANA — Each county department reimburses the State department in the amount of 1/2 of the approved medical payments paid by the State department in behalf of persons in the county each month exclusive of the Federal share. Such reimbursements are credited to the medical assistance account of the State department. The State has total responsibility for Ward Indians and pays the total non-Federal participation. Each county must levy up to 17 mills for the county poor fund budget. If, then, they have insufficient funds to meet their share of medical assistance, they are eligible for State grant-in-aid from the State equalization fund.

NEBRASKA — County Division pays 20% of their recipients' expenses for medical care and services to be paid through the Medical Assistance Program.

NEVADA — By State law, all counties are required to deposit in the State Treasury an amount of money equivalent to 11¢ of each county's ad valorem tax rate. Also deposited in the State Treasury in the Title 19 fund is a sufficient amount of money appropriated from the (State's) general fund to finance the balance of the State's share of the program.

NEW HAMPSHIRE — (a) There is no local participation in administrative expenditures;
(b) Local participation at the rate of 25% and 35% for Old Age Assistance and Aid to the Permanently and Totally Disabled respectively (money payment recipients only);
(c) Local participation at the rate of 50% of the non-Federal share for Old Age Assistance-aliens (money payment recipients only);
(d) No local participation is involved in the medically needy or non-money payment categorically needy program.

NEW YORK — State and local shares of expenditures are as follows:
(a) State funds are used to pay 50% of non-Federal share of the cost of medical assistance payments by local public welfare districts, except as hereinafter provided.
(b) State funds are used to pay 50% of the non-Federal share of the costs of administration by local public welfare districts, including social services and training.
(c) State funds are used to pay 100% of the non-Federal share of the costs of State administration.
(d) State funds are used to pay 100% of the non-Federal share of the costs of medical assistance payments and the related costs of local administration for "State charges", including Indians on reservations.

Table A-11 — (Continued)

NEW YORK (Continued)

(e) State funds are used to pay 100% of the non-Federal share of the costs of care and treatment of persons 65 years of age or older who are inpatients of State institutions for tuberculosis and mental diseases.

NORTH DAKOTA

— Effective 1/1/66, the Medical Assistance plan provides that:
(a) State funds are used to pay not less than 40% of the non-Federal share of medical assistance payments, and
(b) State and Federal funds are apportioned among the county welfare boards on a basis consistent with equitable treatment of individuals in similar circumstances throughout the State.

North Dakota State Statutes provide for a method for apportioning State and Federal funds among the political subdivisions on an equalization basis (a) consistent with equitable treatment of individuals in similar circumstances throughout the State, and (b) that will assure that lack of funds from local sources does not retard the progressive development of the Medical Assistance program in amount, duration, scope, quality of care and services or level of administration in any part of the State.

Section 50-24-23 of the North Dakota Century Code states:

"When County's Share of Funds is Furnished by State — If the financial condition of any county is such that it cannot make an appropriation or levy a tax for assistance, or cannot legally issue warrants in an amount sufficient to provide the necessary funds to comply with the provisions of this chapter, the board of county commissioners shall report such fact to the State Department. The State Department shall make, or cause to be made, a complete investigation of the financial condition of such county. If such investigation shows that the county cannot appropriate funds or legally issue warrants or levy a tax in an amount sufficient to provide the county's share of funds needed for the purpose of this chapter in that county, the State Department may provide either as a grant or as a loan that county's share of funds for the purposes of this chapter or so much thereof as may be necessary, from State funds appropriate to the State Department for the purposes of this chapter."

OREGON

— The following are the arrangements under which State (as distinguished from local) funds will be used to pay not less than 40% of the non-Federal share of the total expenditures under the plan requirement by State statute (ORS 411.160). State funds will be used in both assistance and administration.

— [ORS 411.100 *Contributions by State and counties; administrative costs; payments from Federal or State funds.* (1) Exclusive of all sums of money contributed by the Federal Government for public assistance and for the expenses of administration of such assistance and aid, and except as otherwise provided in ORS 411.200 and in section (2) of this section, the State of Oregon shall contribute 70% and the several counties of the State, from funds raised by the taxes provided in ORS 411.170 and 411.180, shall each contribute 30% of all sums required to be expended for such purposes in and for such respective counties.

(2) All costs of medical assistance for aged psychiatric or tubercular patients and of administration of the State and county departments shall be paid from Federal funds granted to the State of Oregon for such purpose and from funds of the State of Oregon. On and after July 1, 1968, the several counties shall contribute 30% of the cost of medical assistance to the categorically needy, not including aged psychiatric or tubercular patients, that is not paid from Federal funds. On and after July 1, 1969, the several counties are not required to make any contribution for medical assistance.

(3) If the total of the payments made by any county to the State commission and deposited by it in the State Treasury at any time shall prove less than sufficient to pay the proportionate contribution of such county for public assistance, payments in full of assistance to the person entitled thereto shall nevertheless be made from funds of the Federal Government and of the State of Oregon available for that purpose.]

Table A-11 — (Continued)

PENNSYLVANIA

— State and local shares of expenditures are as follows:

State: All of non-Federal share of all medical assistance service except public nursing home care (nursing home care in a County-operated nursing home).

Local: Non-Federal share of care in a County-operated nursing home.

(a) Estimated expenditures for public nursing home care are $14 million; the local share of this will be 46.7% or roughly $6.5 million.

— Total expenditures for medical assistance, including public nursing home care, are estimated at $83.1 million of which the State's share will be $40.1 million. The local share in medical assistance will thus be about 16% of the total expenditures for medical assistance.

(b) Estimated expenditures for public assistance administration and training in local units are $33,175,925. The local share in this expenditure will be approximately $75,000. (1% of the Federal share of expenditures for public nursing home care). The local share in administration and training expenditures will be well under 1%.

VERMONT

— The following are the arrangements under which State (as distinguished from local) funds are used to pay not less than 40 percentum of the non-Federal share of the total expenditures under the plan:

(a) There is no local participation in the costs of administration under the program.
(b) State statute requires local participation in nursing home and hospitalization services in the agency's Aid to the Aged, Blind, and Disabled program. Local sharing in hospitalization services is assessed at 30% of the cost of services and such sharing in the nursing home program is assessed at 30 percentum of the vendor payment and money payment minus $80 monthly.
(c) Under the Title 19 program there is no local sharing in physician services for any recipient of such services under the plan.
(d) There is no local sharing for medical assistance provided to Aid to Families with Dependent Children recipients.

WISCONSIN

— Under the variable equalizing formula for State and county participation, the State pays proportions of the non-Federal share ranging from 45% to 80%. Variations in the rate of county contribution are related to ability to pay determined by an equalized assessed valuation formula.

Source: Department of Health, Education, and Welfare, Social and Rehabilitation Service, Assistance Payments Administration, Division of Field Services.

APPENDIX B

CALIFORNIA AND NEW YORK EXPERIENCE WITH PUBLICLY ASSISTED MEDICAL CARE: BEFORE AND AFTER MEDICAID

As could be expected, the Nation's two most populous States have had a pervasive effect on Title 19 so far. In terms of number of recipients and payments, in federally assisted medical assistance programs, their impact has been disproportionate to their populations, as seen in Table B-1. Both States came into

Table B-1 — Percent of U. S. Total of Specified Types of Recipients and Payments Accounted for by California and New York, August 1967

Item	California	New York
Population (July 1967 est.)	9.7%	9.3%
Recipients of:		
Money payments: Total	15.0	10.9
Aged	14.0	3.4
AFDC	15.0	14.6
Payments to medical vendors: Total	19.5	17.8
Aged	22.5	12.5
Members of families with dependent children	16.9	19.2
Other (under 21 and 21-64)	5.2	56.1
Payments:		
Money payments: Total	19.7	13.2
Aged	20.8	4.3
AFDC	17.0	21.6
Payments to medical vendors: Total	19.9	28.6
Aged	15.5	20.9
Members of families with dependent children	26.6	35.5
Other (under 21 and 21-64)	2.4	73.4

Source: U. S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, "Medical Assistance Financed Under the Public Assistance Titles of the Social Security Act, August 1967," March 1968 (processed)

Medicaid early – California in March 1966 and New York in May 1966. Yet key aspects of their medical assistance programs were different before Medicaid and are different now – such as the State-local sharing of responsibility. In light of their major impact, early entry into Medicaid, and differences in approach, brief sketches of the experiences of California and New York before and after Medicaid are presented at this point.

CALIFORNIA[1]

Prior to Medi-Cal – the Title 19 program – publicly assisted health care services were provided in California through a variety of programs and institutions, with varying levels of service for different classes of recipients and various eligibility standards. The major programs involving Federal matching funds were the State's Public Assistance Medical Care program (PAMC) for categorical assistance recipients, and Medical Assistance for the Aged (MAA) for the medically needy aged. Health care largely without Federal assistance was provided through county hospitals and clinics, crippled children services, State mental hospitals, and the local mental health programs. The county hospitals, which were first authorized in 1855, offered a wide range of inpatient and outpatient services to all persons who met county indigency standards, whether or not they were public assistance recipients. The hospitals were financed primarily through local property taxes with minor contributions from private patients and insurance programs and, once PAMC and MAA went into effect, from vendor payments for those eligible for those programs.

Public Assistance Medical Care Program (PAMC)

The 1956 amendments to the Social Security Act made available separate Federal matching funds for medical care payments on behalf of categorical aid recipients. This prompted the California legislature to adopt a statewide medical care program in 1957 for recipients of categorical public assistance. The program, PAMC, excluded recipients of general relief and the medically indigent, who remained the responsibility of county government.

PAMC initially emphasized treatment rather than preventive care, except that full dental care was made available to needy children under 13 years of age. High cost services benefiting relatively few people were generally excluded. The program paid for practitioners' fees, diagnostic x-ray and laboratory services, and drugs.

Increased Federal funding for medical vendor payments in 1960 permitted California to broaden its PAMC services. By the end of 1961 recipients of old age assistance, aid to the blind, and aid to the disabled received physicians' services, emergency and elective office surgery, radium therapy, podiatry, chiropractic services, formulary drugs, ancillary services of laboratory, diagnostic x-ray, physical therapy and home nursing visits, complete dental care, eye refractions and appliances.

Under AFDC, adults were permitted emergency office surgery and physicians' services, but not consultation or complete physical examinations. Outpatient rehabilitation services and emergency dental care were permitted but laboratory services, physical therapy, and home nursing visits were not. Children, on the other hand, were entitled to physicians' services and emergency office surgery as well as chiropractic and

[1] Major sources relied on in this sketch were: California Assembly Committee on Public Health, *A Preliminary Report on Medi-Cal,* Sacramento, California, February 29, 1968; Margaret Greenfield, "Medi-Cal – Mainstream or State Medicine?," *Public Affairs Report,* Bulletin of the Institute of Governmental Studies, University of California, Berkeley, Vol. 8, No. 6, December 1967; California Office of Health Care Services, *Public Welfare Medical Care in California from 1957 to 1966,* Sacramento, California, September 1966; *Governor's Budget, Medical Assistance Program Expenditure Estimates,* 1966-1967, 1967-1968, 1968-1969.

limited diagnostic x-ray. Dental care for children to the age of 18 was complete, including orthodontia. Neither eye refractions nor appliances were available for adults or children.

Due to the varying amounts of State funding available, the scope of benefits changed frequently under PAMC. This was especially true in AFDC.

Medical Assistance for the Aged (MAA)

In 1962 the California legislature took advantage of the 1960 Kerr-Mills amendment to the Social Security Act by enacting the Medical Assistance for the Aged (MAA) program under which the Federal Government contributed 50 percent of the costs with no ceiling on expenditures. In carrying out this program, the State gave the highest priority to the costly and lengthy care in medical institutions. In 1962, MAA was modified to provide protection for the aged against the cost of chronic illness by assuring payment of hospital and nursing home care beyond the first 30 days. This was supplemented by the PAMC program which provided outpatient services after discharge from the hospital or nursing home.

Administration of MAA tended to channel most people into county hospitals for care. The resultant heavy demand on county funds caused the legislature to ease the local fiscal burden by authorizing payment from the first day of confinement in a county hospital or in a hospital which provided contract services to a county in 1963.

The Title 19 Program: Medi-Cal

Medi-Cal was initiated on March 1, 1966. A major concern of State officials was the Federal requirement that services could not be cut below those offered by the State before the Title 19 program went into effect. Table B-2, comparing health services offered before and after Medi-Cal, indicates that the new program effected a significant broadening of services.

The prospect of additional Federal matching funds was a major inducement for California to adopt a Title 19 program. During FY 1964-65, the State and counties spent an estimated $12 million per month on medical programs and received less than $8 million per month in Federal funds. If Title 19 had been in effect, the State would have received another $4 million per month from the Federal Government. Title 19 permitted the State to share on a 50-50 basis with the Federal Government for many services that formerly were covered entirely by State and county funds. Title 19 offered no cost sharing advantage over MAA, since this was already on a 50-50 matching basis; and PAMC had varying levels of matching, depending upon the category of recipient. State and county hospitals and the local mental health programs, however, were almost 100 percent State and county financed, and the financing of crippled children's services included only a small percentage of Federal funds.

Another new provision of the Social Security Act offered additional fiscal advantages to California. It permitted a State with an approved Title 19 program to claim Federal participation in expenditures for income maintenance on the same basis as for medical aid – for California 50 percent of such expenditures – no matter how high such expenditures were for any one individual.[2] As a result, California reduced State general fund requirements for categorical assistance by over $48 million in 1966-67, which amount was then used as one of the major inputs for State matching of Federal funds for Medi-Cal.

A report of the Assembly Committee on Public Health traces the rapid rise in costs in Medi-Cal and

[2] Public Law 89-97, Sec. 411.

undertakes to explain why it occurred. While the program was being considered in the legislature, it was claimed that the influx of new Federal money to match existing State and county funds would provide sufficient resources to greatly expand services and the number of persons covered without an abnormal increase in State and county expenditures. As it developed, for the fiscal year 1966-67 under Medi-Cal, there was an actual increase in Federal aid of almost $400 million over fiscal year 1964-65, which was the last fiscal year before passage of Medi-Cal. The legislative committee report estimated that the net increase in Federal funds above the amount which would have been available had Medi-Cal not been passed was approximately $250 million for the 1966-67 fiscal year.

The prediction concerning State costs did not come about, however, as the State share exceeded the original estimate by approximately $86 million. The legislative committee concluded that this underestimation could be attributed to several factors: first, the erroneous assumption that a Medicare windfall would accrue for county hospitals and the counties then would be required to return part of this to the State; second, overestimation of the county share of the program based on 1964-65 costs; and third, lack of an estimate of how much the "county option" guarantee would cost the State. The "county option" generally guaranteed that if a county would agree to pay an amount equal to its expenditure for its county hospital during a base year, adjusted for population changes, into the Medi-Cal fund each year, the State would pay all costs of running the hospital not met by Medicare, Medi-Cal or private reimbursements. County hospital costs were underestimated by as much as $50 million, due, the Assembly committee concluded, to the slowness of many county hospitals in submitting bills.

By early 1967 both the State administration and the legislature attempted to find a way to bring expenditures more in line with resources. Estimates of cost shifted by millions of dollars throughout the spring and summer, and the situation was worsened when the Attorney General issued an opinion that Medi-Cal accounting must be placed on an accrual basis. In other words, payment of bills for services rendered in fiscal 1966-67 but not received in that year had to be paid under the limitation upon expenditures for 1966-67. Since the same type of bills for fiscal 1965-66 had been paid under the 1966-67 limitation also, this meant that the limitation would be exceeded unless the law was changed. The law was changed and the limitation for 1966-67 was removed so that the bills could be legally paid, but this presented a cash problem for the General Fund which was the guarantor of the Medi-Cal Health Care Deposit Fund.

In order to solve this cash problem, the Administration decided that Medi-Cal expenditures for 1967-68 must be less than the amount approved by the legislature. In September 1967, action was initiated to reduce services to only the "basic five" required under Title 19 – physicians' services, hospital outpatient services, laboratory and x-ray services, inpatient hospital services, and nursing home services. Free choice was eliminated from inpatient hospital services by limiting the Medi-Cal-covered stay in a noncounty hospital to eight days per admission. Also eliminated from the program were hospital admission charges for surgical correction of a nonemergency or nonlife-threatening condition. Drugs were limited to those essential to maintain life or relieve severe pain and within this overall reduced benefit structure, additional deductions and services were made. Payments were excluded for: outpatient psychiatric services in physicians' offices; eye refractions, except following extraction of lens; hearing examinations and evaluations for purpose of determining the need for hearing aid; routine foot care; all orthoptics and pleoptics; and all dental care except emergency care.

The effect of this action would have been to remove from Medi-Cal a significant number of benefits which had long been in pre-Medi-Cal programs, especially for recipients of old age assistance, aid to the blind, and aid to the disabled. The major portion of savings was expected to accrue from the limitation of private hospital care and the diminution of elective surgery.

The Administration's actions to reduce services were prevented from going into effect, however, when an injunction was secured from the Superior Court. Then in the late fall of 1967, the State Supreme Court

Table B-2 — Comparison of Pre-Title 19 and Title 19 Medical Assistance Programs in California

Public Medical Care (Prior to March 1, 1966)	California Medical Assistance Program (After March 1, 1966)	Significant changes
AID CATEGORY: OLD AGE SECURITY (OAS) Provided: — out-of-hospital physicians' services — county hospital outpatient clinic services — out-of-hospital laboratory and X-ray services — dental care (with limitations) — eye examination and glasses (with limitations) — other remedial care, out-of-hospital only — outpatient office surgery (except cosmetic procedures) — home health services — inpatient and outpatient rehabilitation services — drugs listed in the State Drug Formulary Excluded: — inpatient short-term acute hospital care (except for sight restoration) — hearing aids — prosthetic appliances and braces (except when part of a rehabilitation program) — wheelchairs and assistive devices — ambulance services (except in sight restoration cases) — blood and blood substitutes	Provides: — in and out-of-hospital physician services — inpatient short-term acute hospital care — nursing home services — organized hospital outpatient services in approved hospitals — out-of-hospital laboratory and X-ray services — dental care (some limitations) — other remedial care, both in and out-of-hospital — outpatient office surgery (some limitations) — home health services — eye examinations and glasses — inpatient and outpatient rehabilitation services — drugs listed in the State Drug Formulary — hearing aids — prosthetic appliances and devices — wheelchairs and assistive devices — ambulance services — blood and blood substitutes — preventive medical services offered by organized outpatient clinics not affiliated with hospitals, subject to standards established by the State Department of Public Health	Comprehensive health benefits, stressing prevention of illness as well as treatment and rehabilitation, are now available. *Continuity of health care is encouraged.* Acute inpatient hospital care is covered. Nursing and convalescent home care is covered. Limited psychiatric care is covered. Physical examinations through which preventive measures can be applied, are now covered. For persons over 65, inpatient care in mental hospitals and tuberculosis sanatoria is covered. Hearing aids, prosthetic and orthotic devices, blood and blood substitutes, ambulance services — all essential for continuity and completeness of care — are now covered. Organized outpatient services, including those devoted to mental health, may be used both in recognized hospitals and other agencies. Revised drug formulary contains a less restrictive list of essential drugs. To receive health benefits *only,* residence requirements have been removed. The $400 liquid asset restriction to obtain dentures has been removed.
AID CATEGORY: AID TO THE BLIND (AB) Provided: — all the services provided to OAS recipients plus inpatient short-term acute hospital care	Provides: — all services listed above	The same significant changes stated above apply.
AID CATEGORY: AID TO THE DISABLED (ATD) Provided: — all the services provided to OAS recipients	Provides: — all services listed above	The same significant changes stated above apply.

Table B-2 (Continued)

Public Medical Care (Prior to March 1, 1966)	California Medical Assistance Program (After March 1, 1966)	Significant changes
AID CATEGORY: AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)		
Provided to *children:* – all the services provided to OAS recipients excluding nursing home care, home health services and eye glasses Provided to *adults* (Parents of AFDC children): – *only* emergency dental care and outpatient rehabilitation services.	Provides: – all services listed above, except nursing home care Provides: – *all services listed above, including maternity care*	The same significant changes stated above apply. Greatly increased health benefits to parents are provided. Birth control devices and drugs added to State Drug Formulary are included. Family planning and counseling services are available.
AID CATEGORY: MEDICAL ASSISTANCE FOR THE AGED (MAA)		
Provided to 32,000 MAA recipients: – extended care in nursing homes – limited care for selected patients in rehabilitation centers – transfer to general hospital for acute care as needed, with supportive physician and related services Provided to 1,800 MAA "outpatients": – all services provided to OAS recipients	The MAA program terminates. The new "medically needy" group is no longer restricted to MAA, but includes all persons who can be linked categorically by virtue of need.	Program to cover the medically needy population is no longer restricted to the aged. An enlarged population becomes eligible for health benefits. The 30-day waiting period for hospital and nursing home care formerly required for MAA has been removed.
AID CATEGORY: MEDICALLY NEEDY		
None provided except for the persons previously under the medical assistance to the aged program.	Provides:[1] – skilled nursing home care for all over age 21 – acute inpatient hospital care when needed – all outpatient and dental services listed above, limited to 90 days following discharge from a hospital or nursing home	Approximately 1,200,000 persons not formerly eligible for care under MAA or Public Assistance Medical Care will now be covered for medical assistance.

[1] Physicians' services were added as of July 1, 1967.

Source: *Governor's Budget, 1966-1967, California Medical Assistance Program,* pp. 38-39.

ruled that the cuts in programs were illegal. It declared that the manner in which the reductions were made violated both the 1965 and the 1967 Medi-Cal laws. The deficit, in the meantime, had been paid out of the State general fund surplus and essentially the program continued to operate as it was first initiated.

Other Effects of Medi-Cal

The Assembly Committee examined other effects of Medi-Cal. Its conclusions are summarized as follows.

Increased services. The services provided by Medi-Cal were increased in two ways. First, a comprehensive group of services was provided for public assistance recipients, some of which were not generally available under existing State or private programs. Secondly, there was a considerable difference in services not previously offered under PAMC, especially to AFDC adults. While some of these were formerly offered by a county or provided free by individuals and groups, Medi-Cal represented shifts in funding to the State and Federal Governments as well as a change in providers of service from public to private facilities with resultant increased costs.

Increased eligibles. The MAA program had already provided public health care assistance for the medically needy aged. Other medical indigents had received some services in county facilities. Medi-Cal thus absorbed these additional eligibles and shifted funding to the State and Federal Government.

Property tax relief. The shift of a substantial fiscal burden from the counties to the State made possible local property tax relief. In addition, the State paid the county share of the PAMC-MAA bills which were unpaid at the start of the program – an amount totaling $12 million. Recent estimates of the cost for county options for 1968-69 are approximately $50 million.

"Mainstream" health care. While not specifically appearing in Medi-Cal legislation, a clear, strong desire was expressed by several legislators during the debate on the program to bring recipients of medical assistance into the "mainstream" of medical care by abolishing requirements that the indigent be provided service at only one place – county hospitals and clinics. The stigma of charity care would thus be eliminated. Medi-Cal's concept, as practiced at this time, is freedom of choice and the elimination of segregated services and facilities for the poor.

"Usual and customary." The Medi-Cal legislation does not provide detailed guidance on the way providers of service are to be reimbursed. All that is required is that the physicians must be paid "usual and customary" fees. Payments in pre-Medi-Cal programs were made on the basis of a fixed fee schedule. The average fee for physician services under Medi-Cal is substantially higher than under PAMC. The legislature in the 1967 session, however, permitted the administrator to modify the usual and customary concept to keep the program within its fiscal limits. In September 1967, fees were frozen at the January 1967 level and standards were set whereby fees would have to parallel the customary community standard.

State administration. The health care program prior to Medi-Cal was an integral part of the entire social welfare program and was administered by county social welfare departments. Most of the health care administration under Medi-Cal is now shifted to the State level. Eligibility determination and prior authorizations for certain services are still the responsibility of the counties while local medical societies monitor the utilization of services and charges. The State agency administering the program is the office of Health Care Services within the Health and Welfare Agency.

Blue Cross and Blue Shield have been named by the State as fiscal agents for the program and are responsible for processing claims and determining their validity and correctness in making payment to

providers. Blue Cross handles institutional claims while Blue Shield administers claims of other providers of service, such as physicians, dentists, and pharmacists.

Summary

It appears that the greatest increase in cost due to Medi-Cal has been borne by the Federal Government. On the other hand, county governments have been substantially relieved from this increased burden by the expanded State fiscal role. Soaring costs can be attributed in large part to the fact that some services offered under earlier programs are now provided in a different more costly fashion; presumably they are of higher quality. Others still adhere to earlier servicing arrangements, which simply cost more to provide. Another cost escalation factor is the greater individual use of services and more limited reliance on county hospitals.

NEW YORK[3]

Pre-Medicaid

Provision of a broad program of medical care to the indigent and medically indigent is an even older concept in New York State than in California. In 1929 the State legislature acted to require local welfare districts to provide medical care to all persons receiving relief as well as to persons otherwise self-supporting who were unable to pay for necessary medical care. Local governments paid all medical costs for needy persons and received reimbursement from the State for all except inpatient hospital care. The latter service was eventually placed on a State matching basis in 1965.

The State government's first organized medical care program was initiated in 1931 in the form of standards and guidelines for local governments in administering programs for recipients of emergency relief. The program was extended to the federally assisted categorical welfare programs in 1937 following passage of the Social Security Act. The State program was discontinued in 1942 and supplanted by one which permitted local welfare districts two options – differing mainly in the degree of local autonomy authorized. Both, however, provided the same standards for professional medical care services for the public assistance recipient.

One option provided for State approval of local welfare districts' development and promulgation of their own State minimum requirements. The majority of the local welfare districts chose this approach as they enjoyed more autonomy under it. Under the second approach, local welfare districts did not develop a medical care plan. They were therefore subjected to closer State supervision. Most were small or rural districts and consequently the Department of Social Welfare was more directly involved in the day-to-day provision of medical care within their jurisdictions. Prior approval by the Department was required for certain types of care and fee schedules were fixed by the State.

The last major change in the State government's involvement in medical care prior to Medicaid was undertaken in 1955, when all local districts were mandated to develop medical care plans. At the same

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[3]Sources relied on for the following discussion included: *Statistical Supplement to Annual Report,* New York State, Department of Social Welfare, 1960 through 1965; *Medicaid: Year in Review, May 1966-April 1967,* New York State Department of Social Services; *Study of Medicaid,* State of New York, Peat, Marwick, Mitchell and Co., 1968; *Leadership and Practical Action,* Annual Report of the Joint Legislative Committee on the Problems of Public Health, Medicare, Medicaid and Compulsory Health and Hospital Insurance, March 31, 1968; and statistical and unpublished data provided by the New York State Department of Social Services.

time the State revised its policies and procedures to require localities to provide a comprehensive program of medical care services. Included in the program were: physician services, drugs, sickroom supplies and blood products, hospital services, prosthetic, surgical and orthopedic appliances, eye refractions, eyeglasses, other eye aids and orthoptic training, laboratory services, nursing service in the home, nursing home care, ambulance and common carrier transportation, rehabilitation therapies, podiatry, special diets, and dental care.

Local agencies were permitted complete freedom in selecting the method of providing medical care: by an individual practitioner on a free choice, fee-for-service basis; by a panel system; by a salaried plan; by clinics and dispensaries; by a capitation method; by hospital based programs; by an insurance plan; by any combination of these methods or other suitable plan. Of the 65 local welfare districts, all but three adopted the free choice, fee-for-service method. For physicians services one local agency adopted a combination salary and free choice system; another adopted a combination of the panel and free choice system. New York City used a number of different methods including the panel system, use of dispensaries and clinics, capitation plan, insurance plan, and hospital based home care program.

Local welfare districts were required to prepare and maintain their medical plans as operating documents. The plans were reviewed and approved by the Department of Social Welfare before they became effective. The State established the maximum reimbursable fee schedules applicable to most items of medical care although fee schedules in local plans could differ.

Medicaid

New York State initiated its Medicaid program in May 1966 and assigned responsibility for administering it to the State Department of Social Services.

Eligibles. Five groups are eligible under the program: (1) persons receiving all or part of their incomes from the federally aided public assistance programs; (2) persons who reside in the State and, except for having enough income for their daily needs under State assistance standards, could qualify for public assistance under the Federal eligibility requirements but are without sufficient income or resources to pay for needed medical care; (3) persons under the age of 21 without sufficient resources or income to pay for needed medical care; (4) inpatients 65 and over in tuberculosis and mental institutions; and (5) adult general assistance money payment recipients (21 and over) and other medically needy persons whose income and resources are insufficient to meet all the costs of medical care (no Federal financial participation in the cost of medical care is claimed for this group).

Based on a family of four persons, with one wage earner, the income exemption level for "hospital only" medical assistance – before the Federal enactment – was $5,200. The Department proposed and the State Board of Social Welfare recommended the following factors for computing family incomes: an income exemption up to $5,700; savings exemptions up to one-fourth of that amount; and exclusion of the annual cost of health insurance premiums as well as the amount of Federal and State income taxes paid.

Subsequently, legislative action established these standards, pegged to the four-in-a-family base:

– a net income exemption of $6,000;

– savings up to 50 percent of exempt income;

– life insurance with a face value of $1,000 per person; or, lacking insurance, establishment from existing savings of a burial reserve in the same amount for each member of the family; and

– deduction of health insurance premiums and paid State and Federal income taxes in computations of net income.

The Department estimated that about one-third or not more than 6 million of the State's 18 million residents would be potentially eligible, on the basis of income and resources, for medical assistance under the program, with maximum potential expenditures of about $1 billion on a 1965 cost basis.

Table B-3 compares total governmental expenditures for medical assistance in 1965, the last year before Medicaid, and 1967. Expenditures went up from $241 million to $607 million in the two year period.

Table B-3 – Medical Assistance Expenditures in the State of New York, 1965 and 1967 (in thousands)

		CY 1965	CY 1967
Medicaid			$606,668[1]
Medical assistance financed with aid of Federal categorical welfare programs		$220,728	
Medical assistance financed exclusively with State and local funds:			
a) Hospital costs for home relief families	$9,558		
b) Other medical costs for home relief families	3,636		
c) Hospital costs for medically indigents	5,142		
d) Hospital costs of children in foster care	2,165		
		20,501	
TOTAL		$241,229	$606,668[1]

[1] A part of this represents non-categorically related costs for which there was no Federal financial participation. Available data do not indicate this amount separately.

Source: New York State Department of Social Services.

For all medical care except inpatient services, a deductible payment is required for the medically needy with an annual income of $4500 or more. The deductible is the amount of money a person or family must pay annually toward medical expenses before the program will pay any costs. There are two methods for determing the deductible: (1) 1 percent of the gross annual income, or (2) 5 percent of that part of the applicant's net income which is in excess of 80 percent of the minimum income exemption. The lesser amount must be paid.

Services. In addition to the five basic medical services (physicians' services, inpatient hospital services, outpatient hospital services, skilled nursing home services and laboratory and x-ray services), ten other medical care services are provided in the State program. While many of these were already included in

New York's previous medical care program, the State broadened some services and established several new programs. These included home care, provision of medical care to medically indigent children, inclusion of patients over 65 years of age in institutions for tuberculosis and mentally disabled, outpatient care including clinic and emergency room care, and allowance for inclusion of the cost of deductibles – coinsurance and premium costs – required under Title 18.

Full social services are available to all applicants for medical assistance. The same broad coverage of social services available under the other titles is also available to the medically needy on a selective basis. Social services are now available to eligible patients in mental hospitals and for persons released from such institutions.

Cabinet committee's report. In January 1968, an ad hoc cabinet study committee appointed by the Governor, concluded that despite the many benefits of the State's Medicaid program, experience had made it clear that the program had encountered medical, fiscal, and administrative problems that required urgent attention. The committee consisted of the Commissioners of the departments of Social Services, Health, and Local Government. It criticized Federal cost formulas which have not placed curbs on costs and offered no incentives to economize, especially in the area of hospital management. Furthermore, it objected to the Federal action in 1967 limiting Federal sharing in the cost of the medically needy. The Committee stated that as a result of this action the State had to consider three alternative approaches to amend the original medical assistance program:

(1) cut back eligibility levels to those called for by the new Federal amendment;

(2) adopt eligibility standards by geographic regions;

(3) institute cost-sharing (coinsurance) and deductible features.

It was estimated that the New York Medicaid program, unless amended, would represent a $300 million additional cost to State, Federal, and local governments in fiscal year 1968-69. This rising cost, according to the Committee, might threaten access to medical care for everyone in the State, including those who finance their own medical expenses with health insurance. In light of this fiscal prospect, the Committee supported the proposal for adoption of a State Universal Health Insurance (UHI) plan. UHI, it contended, would prevent the large-scale cancellation of voluntary insurance by Medicaid eligibles and should become the preferred method for financing medical care. It would represent the first line of health defense while Medicaid should be viewed as the second line of defense to protect those who are medically needy and those whose insurance benefits have run out.

The committee identified three major administrative problems that were mainly a result of the lack of planning time to put the Medicaid program into effect. First, there was a critical need for fast, reliable, and uniform data to insure a sound basis for administrative decisions and management control. The committee recommended that it be empowered to take immediate steps to develop a statewide data collection and analysis system for the administration of Medicaid at the State and local levels. Secondly, the committee found a need to improve State-local Medicaid coordination and therefore proposed that measures be designed to insure prompt and effective interchange between State and local personnel. Finally, it asked for authority to review pertinent State studies and arrange for additional studies on the feasibility of utilizing fiscal intermediaries.

The committee advanced six other proposals for moderating costs and improving health care:

(1) To improve the quality of care, steps should be taken to maximize the impact of prompt and thorough care throughout the continuum of prevention, cure, and rehabilitation.

(2) To improve medical care facilities a continuing effort should be made to improve the quality and balance of medical care facilities within each region of the State.

(3) To relieve the existing critical shortages of trained manpower in the health and social service professions and occupations, a pool of trained manpower should be developed so that shortages would not act to push costs disproportionately upward.

(4) To evaluate spiraling medical vendor payments, the present reimbursement formula and fee schedules of Medicaid should be subjected to review.

(5) To administer the Medicaid program at maximum effectiveness, staffing in both the Departments of Health and Social Services should be completed as rapidly as possible.

(6) To account for the varying relative resources and responsibilities of Federal, State, and local levels of government, a continuing review of current and prospective costs of Medicaid should be undertaken.

Impact on local government. Consultants to the ad hoc cabinet committee on Medicaid reported on the impact and problems of Medicaid as seen by local government officials in late 1967. Three areas of investigation were covered – finance, administration, and medical resources.

In upstate New York, approximately one-third of the total cost of Medicaid was being borne by the counties.[4] Most counties indicated that the program could be supported at the existing level of expenditure (1967) within their current sources of income. But officials felt that a reduction in State or Federal funds would severely hamper the program and cause local governments to cut back their services. According to county officials, other resources for raising the additional funds did not exist. All of the upstate county officials agreed that the program had not reached its peak in late 1967. However, they estimated that by July 1968 maximum enrollment would likely be attained. At the time the survey was conducted only about 35 percent of the estimated number of people eligible for Medicaid were enrolled in the upstate counties. The study found that an increased enrollment from 35 to 100 percent would probably cause program costs to jump 200 to 300 percent in the upstate areas.

New York City has had a long history of extensive medical assistance programs for welfare recipients. The city also has had facilities under its direction to provide medical assistance at no cost to large numbers of people. As in the upstate counties, approximately one-third of the cost of the Medicaid program was being borne by the city. City officials indicated at the time they were interviewed that they expected the program to peak out in mid-1968 with an estimated claim payout of about $65 million a month. It was believed that nearly 70 to 80 percent of those eligible were now enrolled in the program – much higher than upstate.

The administration of Medicaid at the county level is the responsibility of the local Social Services Department. Both upstate and New York City officials felt that the dual participation of the State Department of Social Services and the Department of Health resulted in confusion between State and local authorities. All of those interviewed agreed that paperwork should be simplified and standardized and that greater use of the computer should be made to assist in quality audits of services. Most also believed that the imposition of mandatory fees and rates by the State resulted in excessive cost for the program and suggested that local government set fees and rates with the State establishing a ceiling.

In the upstate counties officials felt that the program provided an incentive for young doctors to

[4] Peat, Marwick, Mitchell, and Co., *Study of Medicaid, State of New York,* January 12, 1968, Appendix III – Survey of Local Government Offices.

practice in rural areas and underscored the need for new medical facilities and personnel. Many officials felt that because of limited facilities and personnel, the heavier demand had possibly reduced the quality of medical service. New York City officials emphasized the need for some method of redistributing medical services to geographic areas where they are most needed, especially nursing homes and hospital clinics. Upstate officials stated that the basic steps for improving the program included the development of a differential level of eligibility by area and the establishment of differential rates and fees. State established eligibility levels and fees were too high for rural upstate areas, it was claimed. New York City officials concurred that differential area rates should be established. They also urged that the program be operated on the State level under one agency. Other recommendations made by city officials included encouragement of group medical practices, simplification of enrollment and eligibility requirements, combining Medicare and Medicaid, and finally, recruitment of more qualified program administrators.

The consultants observed that while Medicaid had had a heavy impact on the financial resources of several counties, the effect on county tax structures was not as great as protest might indicate. They pointed out that in some instances $5 per $1000 on real estate or a one percent sales tax would cover the local share of Medicaid cost. The consultants concluded that the major objection to Medicaid by local officials "appeared to be the trend toward matching more and more dollars with State and Federal governments. Local executives have problems of juvenile delinquency, crime, fire protection, and others that they feel are more important than Medicaid. Medicaid is regarded as one more encroachment on home rule that is apparently resented."[5]

Health insurance proposal. In March 1968, Governor Rockefeller recommended in a special message to the New York State Legislature the adoption of a Health Security Act. The proposal would have carried out the major recommendation of the Governor's study committee for a universal health insurance plan.

The basic purpose of the proposed bill was to provide mandatory hospital protection for New York State residents – particularly the 15.7 million people under 65 years of age – through a contributory system of health insurance. Another major objective was to establish an effective system to control the spiraling cost of hospitalization resulting from inefficient hospital management practices.

Within this context, the proposed Health Security Act contained the following major provisions, for establishment of a compulsory health insurance system:

- Every insurance carrier writing health coverage in the State would be required to offer a contract providing the health service benefits mandated by the bill. Insurers would be exempted from the tax on premiums for the coverage required by the act.

- Employers of one or more persons would be required to provide employees and their dependents with basic health insurance benefits. The basic service benefit would consist of: 120 days of semi-private in-hospital care, including maternity and psychiatric care and ancillary hospital services; 100 days of home care; and hospital outpatient diagnostic services and care for accidental injury or emergency illness.

- The employee's insurance contribution would be limited to the lesser of either 2 percent of his wages or one-half of the actual cost of providing coverage mandated by the act.

- The State would contribute to the cost of required health benefits when the combined employer-employee contribution exceeded 4 percent of the employer's annual payroll. Payments would be

[5] Peat, Marwick, Mitchell and Co., *op, cit.*, p. 37

made upon application by the affected insurance carrier, and subsequent to a review of the carrier's operating practices and a survey of coverage available elsewhere at lower rates.

- A Health Benefits Commission consisting of the Commissioners of the Departments of Health, Social Services, and Mental Hygiene, the Superintendent of Insurance, and five public members appointed by the Governor would be created in the Department of Health to administer the health benefit system under the legislation.

The principal provisions relating to hospital cost controls included:

- Authority for the Commissioner of Health to certify rates for hospital services to be paid by all governmental agencies and health insurers in the State. The rates would follow a formula designed to provide an incentive to hospitals to increase operational efficiency and reduce costs – such as through centralization of laboratory facilities, blood banks, and laundries – without impairing service.

- Establishment of a uniform cost accounting and cost finding system on a statewide basis for all hospitals by the Commissioner of Health and the State Hospital Council; and

- Registration of all persons engaged in hospital administration who make decisions affecting hospital financial policies.

The Health Security bill provided that the State must obtain from carriers at rates specified by the Health Benefits Commission insurance coverage for the basic health service benefits, to be provided to each unemployed person receiving public assistance or eligible for medical assistance under the Medicaid program. The State would pay the premiums for such insurance coverage. The amount of Federal aid would be deducted by the State from the total funds allocated to each social services district.

Governor Rockefeller explained the rationale underlying his support of compulsory health insurance as the primary approach to the provision of medical care, and the relationship between this system and the Medicaid program as follows:

> As for guaranteeing people access to medical care, no state has done more for its people than New York, and it will still be the leading state even after the Federal and state cutbacks in Medicaid this year. However, it is abundantly clear that programs of publicly paid care, like Medicaid, will continue to be costly and difficult to control. The beneficiary has no direct stake as a contributor to the financing of these public programs, and therefore, they lack any self-restraining force to curb abuse or excessive expansion. I have consistently advocated health insurance as the best first line of health defense. Medicaid is a good second line of defense to aid those unable to afford medical care or those whose insurance benefits have run out. The recently enacted cutback in Medicaid highlights the compelling necessity for assuring our people the protection of universal health insurance.[6]

The health insurance proposal, however, did not receive legislative approval. To keep Medicaid costs down amendments were made that cut back benefits by reducing the income eligibility level for a family of four from $6000 to $5,300. The amendments also denied benefits to persons between 21 and 64 who do not otherwise qualify for welfare benefits except for inpatient hospital care in cases of catastrophic illness where medical costs exceed 25 percent of the patient's net income. Other changes included provision that not more than 80 percent of the cost of medical care other than inpatient care shall be provided to eligible applicants; and permission for the State Social Welfare Board, upon a local social service district's application

[6] Nelson A. Rockefeller, *News Release,* March 20, 1968, p. 2

authorized by the local legislative body, to adjust the income exemption to reflect cost of shelter variations in urban and rural areas.

Summary

The increased fiscal burden of medical care services in New York State has been shared by both the State and local governments. The New York program, one of the most liberal State programs both in terms of eligibility and scope of services, is financed on the long standing State-local matching basis. Almost all counties had to raise taxes to meet their Medicaid fiscal obligations. The fiscal impact was greatest in upstate New York as New York City had a relatively large program of health for the needy at the start of the new program.

While a number of proposals have been or are being considered to improve the present program, the most significant is the mandatory universal hospital insurance for all New York State residents. This contributory system of health insurance would provide protection to all persons under 65 years of age who are potentially medically needy and would be the "first line of health defense." Medicaid would thus be the second line of defense to assist the medically needy and persons whose insurance benefits have been exhausted. If adopted, the universal hospital insurance proposal would significantly shift a major part of medical costs for the medically needy to the private sector.

Comparative Observations

Pre-Medicaid and Medicaid programs in California and New York exhibit a number of similarities and differences. Both States have been faced with critical fiscal problems in meeting the demand for medical services, but have differed somewhat in their attempts to resolve them. Both have undertaken studies to evaluate program effectiveness and have proposed a number of similar improvements dealing with administration and services.

Differences in the programs of the two States stem primarily from practice developed in the pre-Medicaid medical assistance programs. New York State has had a much longer history of extensive governmental involvement in providing medical assistance to the needy and the local governments' share of this burden has grown at the same rate as the State's, since the Federal contribution is matched equally by both levels of government. In California, on the other hand, the State assumed the major portion of the increase in medical assistance costs with the advent of Medicaid, thereby easing the local government burden.

Problems associated with trying to provide uniform standards of service to various sized communities appear to have been more troublesome in New York State than in California. This probably is because New York City's needs bulk so large in the total medical assistance picture. Statewide application of uniform income eligibility standards for the medically needy have also caused difficulties in New York State. California may be less affected in this respect because of its more uniform statewide family income. In addition, the fact that the State assumes at least 70 percent of the non-Federal share of Medicaid costs tends to play down possible disparities stemming from differentials in local fiscal resources.

New York State's program provides much broader coverage of the medically needy both in number of recipients (60 percent of the total) and payments (75 percent of the total), especially for those from 21 to 64. California, however, has a larger portion of payments for old age assistance – nearly two and one half times that of New York.

Differences and similarities are summarized by statistics in Table B-4.

Table B-4 — Comparative Statistics of California and New York Title 19 Programs

	California	New York
Population	18,802,000	18,205,000
Total medical vendor payments, CY 1967	$589,280,000	$707,057,000
Number of persons for whom payments made, November 1967:		
a) categorically needy	518,400	302,200
b) other	107,400	481,800
Amount of payments, November 1967:		
a) categorically needy	$ 22,433,000	$ 22,607,000
b) other	$ 14,866,000	$ 69,192,000
Number of recipients not categorically related and not receiving maintenance assistance, November 1967	2,100	133,000
Amount of payments	$ 75,700	$ 17,393,000
Number of services to categorically needy, categorically related needy, and medically needy, July 1968	20	19
Income levels for medically needy, June 1968		
a) one person	$ 2,028	$ 2,900
b) four in family	$ 3,900	$ 6,000
Cash or other liquid resources levels for medically needy, June 1968:		
a) one	$ 1,500	$ 1,450
b) four in family	$ 3,000	$ 3,000

Source: Appendix A tables.

APPENDIX C

Table C-1 — States Responding to ACIR-NGC-NCSLL Questionnaire Survey Summer 1968

	Governors*	Legislative leaders**		Governors*	Legislative leaders**
Alabama	X	—	Montana	—	X
Alaska	X	X	Nebraska	X	X
Arizona	—	X	Nevada	X	X
Arkansas	X	X	New Hampshire	X	X
California	X	X	New Jersey	—	X
Colorado	X	X	New Mexico	X	X
Connecticut	X	—	New York	X	—
Delaware	X	—	North Carolina	X	—
Florida	X	X	North Dakota	X	X
Georgia	X	X	Ohio	X	X
Hawaii	X	X	Oklahoma	—	X
Idaho	X	X	Oregon	X	—
Illinois	X	X	Pennsylvania	X	—
Indiana	X	X	Rhode Island	X	—
Iowa	X	—	South Carolina	—	—
Kansas	X	X	South Dakota	X	X
Kentucky	—	X	Tennessee	X	X
Louisiana	X	—	Texas	X	—
Maine	—	-	Utah	X	X
Maryland	X	X	Vermont	X	—
Massachusetts	X	—	Virginia	X	—
Michigan	X	—	Washington	X	X
Minnesota	X	—	West Virginia	X	X
Mississippi	X	—	Wisconsin	X	—
Missouri	X	—	Wyoming	X	—
			TOTAL	43	28

* Indicates response from Governor or department head.

** Indicates response from legislative leader or legislative service agency director.

* U. S. GOVERNMENT PRINTING OFFICE : 1969 O - 342-506 (3238)

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[1] Single copies of reports may be obtained without charge from the Advisory Commission on Intergovernmental Relations, Washington, D. C. 20575.

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