The Impact of Federal Welfare Reform on Texas Medical Care Costs.

A REPORT TO GOVERNOR
DOLPH BRISCOE AND THE TEXAS LEGISLATURE
BY THE
TEXAS RESEARCH LEAGUE

On October 5, 1973, the State Board of Public Welfare decided that Texas will provide Medicaid coverage to all recipients of cash grants under the new federal Supplemental Security Income program. This report discusses some of the considerations which went into that decision.

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THE IMPACT OF FEDERAL WELFARE REFORM ON TEXAS MEDICAL CARE COSTS

A Report by the

TEXAS RESEARCH LEAGUE

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December 1973

HONORABLE DOLPH BRISCOE
GOVERNOR OF TEXAS
AUSTIN, TEXAS

Dear Governor:

The Texas Research League is pleased to submit to you this report entitled The Impact of Federal Welfare Reform on Texas Medical Care Costs, in response to your request for analysis of the options provided by the recent federal "welfare reform" act (PL 92-603). The report contains discussions of the nature and cost of options for coordinating Texas' Medicaid program with the new federal Supplemental Security Income program.

The State Board of Public Welfare decided on October 5, 1973, to opt for Medicaid coverage of all aged, blind and disabled persons in Texas who will receive Supplemental Security Income benefits after inception of the program on January 1, 1974. Prior to that decision, staff members of the Texas Research League reviewed the findings of this study with officials of the Texas Department of Public Welfare. The results also were presented to the Board as background material for its consideration.

This report makes no recommendations on the Medicaid options examined. Its purpose was to provide a factual basis for evaluation of the choices facing the State of Texas.

Thank you for giving us this opportunity to be of service.

Very truly yours,

James W. McGrew
Executive Director

JWM:ch
Enclosure

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INTRODUCTION

The enactment of Public Law 92-603 (popularly known as H.R. 1) in October 1972 placed a significant burden of decision-making on State public officials concerned with welfare programs. The act made several major changes in existing welfare programs and authorized others at the discretion of each State. The short time span between enactment and the January 1974 effective date of many of the law's provisions made prompt consideration of alternatives an urgent matter.

In February of 1973, Governor Dolph Briscoe requested that the Texas Research League analyze the impact of H.R. 1 on welfare programs in Texas. The Governor pointed to two areas of concern in his letter of request:

- First, he asked for "an independent analysis of the options available to Texas under this legislation and an estimate of the State cost which these options might involve."

- Second, he wrote that "for the longer term, we also need a study of the potentials for improving our welfare system, including the prospective impact of H.R. 1 on our health care delivery systems."

This report contains details of the League research on the impact of Medicaid eligibility options allowed under H.R. 1. Because of the cost implications of these options and the general lack of good information on which to base the State's decision, this choice was considered to be of overriding importance by the League staff. The intention of the Texas Research League in presenting this analysis is not to recommend any program option; rather, this document simply presents the data upon which a decision might be based. Any judgment as to the weight to be placed on various factors differentiating the options - including social implications and other policy differences, as well as funding requirements - must be made by the State's policymakers. It is hoped that this research effort will contribute to the rational consideration of alternatives.

Chapter I of the report is a background discussion of the development of the welfare "system," welfare programs in Texas, and the provisions of H.R. 1; readers familiar with the subject may wish to skip this overview. Chapter II comprises an analysis of the nature of Medicaid eligibility options under H.R. 1 and their cost implications. Detailed appendices on methodology for estimating eligibility and costs under the options appear at the end of the text.

Future Directions of League Research

The potential effect of H.R. 1 on overall expenditures for health care in Texas has received little attention. The new law takes effect in a period of steeply rising health-care costs, and in the midst of efforts to find means of coordinating and managing medical services so that adequate care can be obtained at reasonable cost. Medicaid (as well as Medicare) dollars purchase services in the same health-care delivery system used by other consumers in the State; it is claimed by some that public-assisted care drives up medical costs in general by increasing the pressures on the delivery system. In pursuing the request of Governor Briscoe to examine "the prospective impact of H.R. 1 on our health care delivery systems," the League will turn in coming months to the question: What will "welfare reform" mean for the taxpayer and consumer of medical care in Texas?

I

THE WELFARE "SYSTEM" AND H.R. 1

THE SOCIAL SECURITY ACT OF 1935

The current public welfare system in the United States originated with the Social Security Act of 1935. That statute created two programs of social benefits:

- Social Security, a program of social insurance under which payments are made to an individual or his survivors, financed by employer-employee contributions during his income-earning years and

- Public Assistance, a program of payments made on the basis of need to persons in four categories of dependency.

The public assistance titles of the act created a joint federal-state system of welfare payments. Federal matching funds were provided for State cash payments to needy aged and blind adults and to dependent children (and, later, to permanently and totally disabled adults).[1] The authors of the Social Security Act believed that this system of public assistance would "wither away" as the social insurance program became universal and as economic prosperity returned to the country.[2]

This of course has not happened: welfare rolls have grown considerably since 1935; and as the caseloads have increased, new programs which attempt to solve welfare problems have multiplied.

THE PROLIFERATION OF WELFARE PROGRAMS

Public assistance under the Social Security Act was intended primarily to provide cash to relieve the needs of the indigent. But the act contained the seeds of medical and social-service programs, and in later amendments these elements were given independent status within the framework of the categorical public

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1 *The common titles of these programs are: Old Age Assistance (OAA), Aid to the Blind (AB), Aid to the Permanently and Totally Disabled (APTD) and Aid to Families with Dependent Children (AFDC). The first three are known generally as the adult categories.*

2 *See the discussion of the "withering away fallacy" in Gilbert Y. Steiner's Social Insecurity: The Politics of Welfare (Chicago: Rand McNally, 1966), Chapter 2.*

assistance system. Meanwhile, food, housing, manpower training and other social-service programs have been added to the welfare effort without a formal relationship to public assistance - and generally with little relationship to one another.

The Issues Involved

Underlying development of various welfare and related programs are several perceptions of the nature of welfare problems and proper solutions thereto. Some programs, particularly those providing in-kind benefits such as housing, food and medical care, complement the cash benefits of public assistance and undoubtedly stem from a desire to raise the living standards of the indigent to a livable minimum. But the more recent social-service programs have been developed against a background of rising AFDC caseloads in a period of general prosperity. The key themes in these programs have been to reduce dependency and to provide work incentives and job training for welfare recipients able to work. Whatever the emphasis, each new program has added to the cost of the social-welfare effort; and within recent years a third issue has emerged - limiting the total cost within acceptable levels.

Medical Assistance Programs

The need for medical assistance to the poor was recognized in the original Social Security Act, which provided federal matching for medical-care allowances included in cash payments to categorical recipients. Direct payments to doctors, nurses and health care institutions were authorized in 1950. Medical Assistance for the Aged was added ten years later as a new category in public assistance, providing federal matching for programs to pay the medical costs of "medically needy" aged persons not on welfare.

The Social Security Act was amended in 1965 to add two titles containing the current medical assistance programs. Title XVIII created Medicare - a medical insurance program for the aged under social security, financed by employer-employee contributions and by monthly premiums paid by the elderly. Under Title XIX, Medicaid, a single program of medical assistance to welfare recipients and the medically needy, was substituted for earlier programs operating within the cash grant framework. The Medicaid program provides federal matching funds for State medical programs which (1) cover welfare recipients and (at the state's option) other persons unable to pay for medical care, and (2) offer a minimum schedule of medical services.

Social Service Programs

Services for homeless, dependent and neglected children were authorized by the Social Security Act in 1935. After two decades of public assistance it became obvious that welfare caseloads were not "withering away," and programs were added providing services intended to reduce the welfare rolls.

In 1956 Congress authorized federal matching for state expenditures to promote self-support and strengthen family life among welfare recipients. Six years later a higher rate of federal matching was applied to these social service programs than to other public assistance expenditures. With AFDC caseloads growing rapidly, Congress in 1967 required all states to institute a family services program for AFDC recipients and created the Work Incentive Program. Family planning programs were introduced in 1967 also, in order to combat the problem of illegitimacy within the AFDC population; and in 1972 the states were required to offer family planning services.

Other Programs

Social-welfare programs have expanded outside, as well as within, the framework of the Social Security Act. Among those not related to public assistance and social security are:

- the Federal housing program, administered by the Department of Housing and Urban Development;
- the food stamp program, administered by the Department of Agriculture;
- various manpower training programs in the Departments of Health, Education, and Welfare; Housing and Urban Development; Labor; and Office of Economic Opportunity.

These and other programs in related areas provide benefits for the low-income population. But the piecemeal nature of their creation has fashioned a "nonsystem" in which a multiplicity of programs having identical or related objectives are administered by several agencies without coordination.

To the effects of this "nonsystem" on social welfare must be added the effects of programs under the Social Security Act. The overall impacts of this multi-billion dollar mixture of programs in such areas of concern as income distribution, work incentives and delivery of services to the client population are not readily understood, and efforts at comprehensive analysis have begun only recently.[1]

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[1] *See, for example, "How Welfare Benefits are Distributed in Low-Income Areas," Studies in Public Welfare, Paper No. 6, a staff study prepared for the use of the Subcommittee on Fiscal Policy of the Joint Economic Committee, Congress of the United States (U.S. Government Printing Office: 1973), March 26, 1973; and "Study of Federal Programs for Manpower Services for the Disadvantaged in the District of Columbia," a report to the Congress by the Comptroller General of the United States, January 30, 1973.*

WELFARE PROGRAMS IN TEXAS

While trends in welfare programs and issues in Texas have been similar to those nationwide, there are certain distinguishing characteristics in this State's welfare programs which should be understood as a background for future decisions. Of principal importance is the cost of the various welfare programs supported by this State.

Major Welfare Programs

The Texas Department of Public Welfare has been charged by statute with the administration of welfare programs under the Social Security Act of 1935 and certain other welfare-related programs.[1] For purposes of analysis the functions of the Department can be divided into four major areas:

1. Financial Aid, including the original public assistance programs of cash grants to the aged, blind, disabled and families with dependent children, together with the food stamp and surplus commodity programs for welfare recipients and other low-income persons;

2. Medicaid, the Texas medical assistance program for welfare recipients;

3. Social Services, adoptive and protective services for children and various services for welfare recipients; and

4. Administration of the Department.

Funds have been allocated unequally to these functional areas in the last five appropriation acts of the Texas Legislature; the differential growth rates of the various programs have produced some dramatic shifts in welfare costs (see Table 1). In terms of dollars, the most significant change has been the increase of medical program funds from a relatively small portion (16%) of 1966-1967 appropriations to almost two-thirds of 1974-1975 appropriations for welfare in Texas.[2] Eighty percent of the growth in welfare money during this period has gone to Medicaid.

Thus, one important characteristic of the welfare effort in Texas is the size of medical program costs in relation to other welfare expenditures. Other traits can be seen in the distribution of medical expenditures.

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[1] *Article 695c through 695j-1, VACS.*

[2] *The extremely low growth rate for financial aid programs is due to the Constitutional ceiling on welfare payments, currently set at $80 million per year, and (in 1974-75) to the expected federal takeover of adult cash assistance programs.*

Table 1

Biennial Appropriations for Texas Department of Public Welfare, by Major Functional Areas, 1966-1975

Major Program Area	Biennial Appropriations (in millions) 1966 1967	1968 1969	1970 1971	1972 1973	1974 1975
Financial Aid	$120.8	$121.0	$121.1	$169.4	$142.4
Medical Assistance*	25.6	55.5	117.0	270.1	392.0
Social Services	1.0	2.0	3.4	10.5	31.5
Administration	10.0	15.6	19.4	36.9	50.8
TOTAL	$157.3	$194.0	$260.9	$486.9	$616.7

Figures may not add to total because of rounding.

**Figures for 1966-1967 represent appropriations for medical assistance grants to OAA recipients. The Texas Medicaid Program began on September 1, 1967 (FY 1968).*

The Distribution of Medicaid Expenditures

All welfare recipients in Texas are eligible for Medicaid benefits. The program offers a schedule of services including:

- hospital and professional care,
- nursing home care,
- prescribed drugs,
- care in state institutions, and
- payment of Medicare Part B premiums for elderly recipients.

Adult welfare recipients (i.e., the aged, blind and disabled) account for most of Medicaid costs, with the aged category alone benefiting from a majority of medical expenditures (as shown in Table 2). However, it is important to note that AFDC costs are increasing relatively faster than those of other categories.

Table 2

Distribution of Medicaid Expenditures in Texas
By Category of Recipients, 1969-1972*

Category of Recipients	Amount of Expenditures (Millions) FY 1969	%	FY 1970	%	FY 1971	%	FY 1972	%
Aged	$123.1	(75)	$143.2	(70)	$169.7	(66)	$203.5	(63)
Blind	1.5	(1)	1.7	(1)	1.7	(1)	2.1	(1)
Disabled	21.9	(13)	28.8	(14)	31.2	(12)	35.4	(11)
AFDC	18.4	(11)	31.2	(15)	53.4	(21)	81.7	(25)
TOTAL	$164.9	(100)	$205.0	(100)	$255.9	(100)	$322.7	(100)

Figures may not add to total due to rounding.

**Actual expenditures of both State and Federal monies, including all payments to providers of services. Sources: Annual Reports of Department of Public Welfare, 1969-72; and "A Statistical Profile of the Medical Assistance Program, September 1971 through August 1972."*

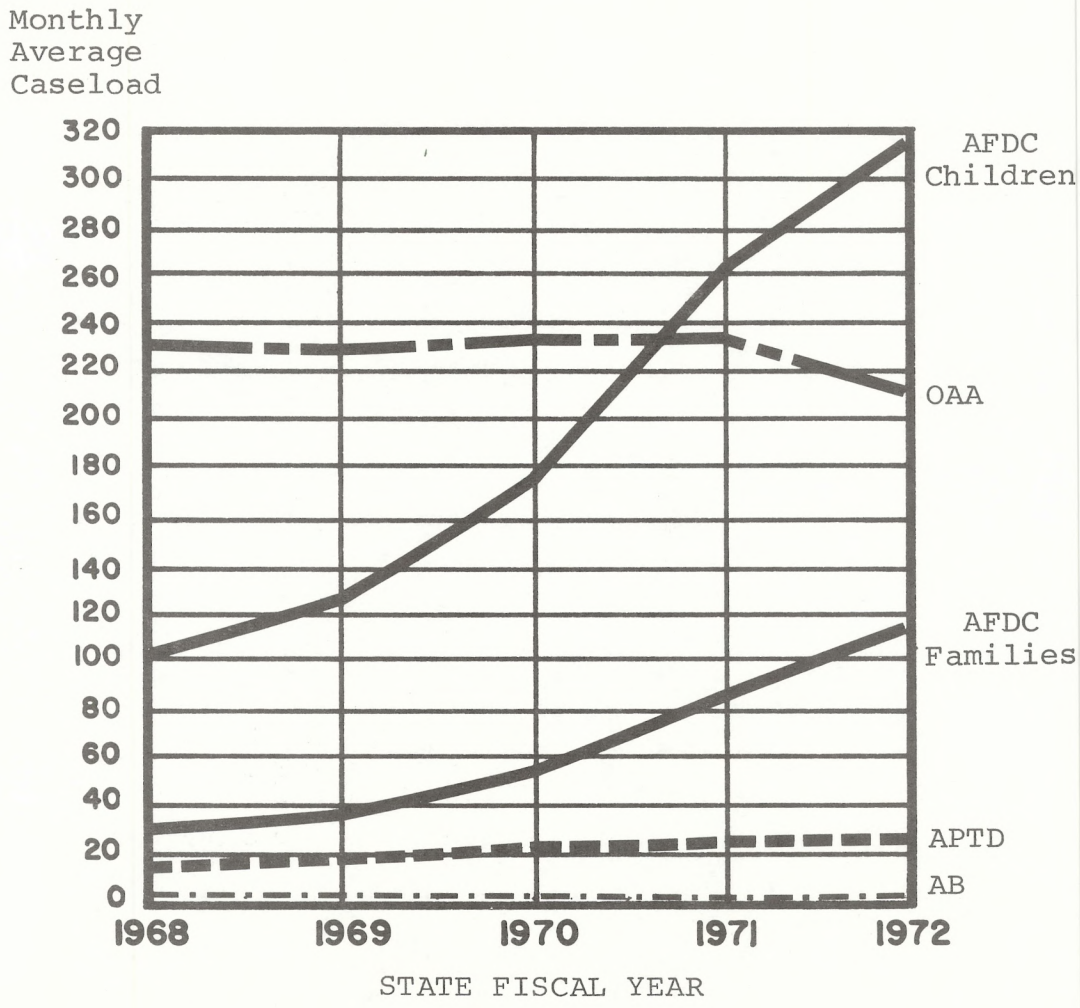
Much of this distribution of Medicaid expenditures is explained by welfare caseloads. Public assistance caseloads in Texas (shown in Figure 1 for the period FY 1968-1972), are in some respects atypical of the nation as a whole. The per capita level of APTD recipients is much lower than the national average, due at least partially to the disability definition employed by the State.[1] Caseloads for OAA are much higher, which in part may be attributed to generally low income levels among the aged and to the relatively low proportion of the aged in Texas covered by Social Security. The AFDC caseload is also somewhat lower than national figures, although the growth of AFDC cases in Texas parallels the recent experience across the country. (Table 3 contains per capita recipient levels for OAA, APTD and AB, and AFDC recipients - comparing Texas, neighboring states and national averages.)

[1] *In May of 1973, a U.S. District Court declared invalid certain portions of the Texas definition of disability for welfare purposes. Center v. Vowell, W.Dist.Tex.* *See note 1 on page 33.*

Figure 1

MONTHLY AVERAGE CASELOADS FOR PUBLIC ASSISTANCE IN TEXAS, BY CATEGORY OF RECIPIENTS, FY 1968-1972

(IN THOUSANDS)



Source: Annual Reports of Department of Public Welfare, 1968-1972.

Table 3

Public Assistance Recipients Per 1,000 Persons in the Population, December 1972

State	OAA	APTD & AB	AFDC
U.S. Average	9.2	5.9	52.6
Texas	16.0	2.7	38.2
Louisiana	29.3	6.8	68.6
Arkansas	28.8	7.3	40.3
Oklahoma	21.3	8.9	38.6
New Mexico	7.4	9.2	55.2

Source: "Public Assistance Statistics, December 1972," National Center for Social Statistics, April 10, 1973.

To these public assistance caseload figures must be added those who receive medical assistance only (MAO). The Texas Medicaid program provides coverage for persons residing in nursing homes or state institutions who are not eligible for public assistance, but would be if not in an institutional setting. The average monthly caseload for this group (10,443 in FY 1968) has more than trebled in the past five years (32,186 in FY 1972). Individuals comprising the MAO caseload are predominantly over 64, and the great majority are in nursing homes.

When both public assistance and MAO cases are considered, there is a close correspondence between Medicaid costs and average monthly welfare caseloads in Texas (as shown in Table 4). Within the Medicaid program, then, a large (though declining) majority of expenditures go for adult recipients because they constitute the largest portion of the welfare caseload.

Table 4

The Relationship Between Medicaid Costs and Average Monthly Welfare Caseloads in Texas, FY 1970-1972

	FY 1970		FY 1971		FY 1972	
Category	% Cases	% Costs	% Cases	% Costs	% Cases	% Costs
Aged	75	70	68	66	62	63
Blind	1	1	1	1	1	1
Disabled	8	14	7	12	7	11
AFDC (families)	16	15	24	21	29	25
Total	100	100	100	100	100	100

Figures may not add to total due to rounding.

H.R. 1: REFORM OF WELFARE PROGRAMS UNDER THE SOCIAL SECURITY ACT

One of the central purposes of H.R. 1 as introduced was to restructure public aid to low-income families and to correct various problems of the AFDC program. The nature of the reforms proposed for family aid was stated succinctly by the House Ways and Means Committee in its report on the legislation:

> *. . .all needy families with children will be eligible for assistance. The aim, however, will be to move every family in which there are employable adults toward employment and economic independence. These families will be enrolled by the Department of Labor in the Opportunities for Families program designed to help people move off welfare. Other families, in which there is no employable adult, will be enrolled in the Family Assistance Plan, under the Department of Health, Education, and Welfare.*[1]

These proposals were deleted in conference committee. H.R. 1 as enacted, however, does restructure *adult* welfare programs and make several changes in the Medicaid program.

The Supplemental Security Income Program

H.R. 1 provides that on January 1, 1974, a new federal program entitled "Supplemental Security Income" (SSI) will replace the joint federal-state public assistance program for adults (OAA, AB and APTD) under the Social Security Act.[2] The SSI program, in effect, creates a federal guaranteed income for aged, blind and disabled adults of $130 a month for an individual and $195 a month for a couple.[3] The Social Security Administration will administer the SSI program based on *federal* rules of financial and categorical eligibility. The program will be funded solely by federal dollars, with state supplementation of federal payments wherever the new program is less generous than its predecessors.

Federal assumption of adult public assistance will result in substantial savings to the states, in terms of both program and administrative costs. Texas will save almost $50 million in

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1 *U.S. Congress, House of Representatives, Report of the Committee on Ways and Means, Social Security Amendments of 1971, 92nd Congress, 1st Session, H. Rept. 231, p. 3.*

2 *Blind and disabled children below age 18 will be eligible in the "adult" categories for the first time under the terms of the new act.*

3 *Under a subsequent law (PL 93-66), payments will be increased to $140 and $210 as of July 1, 1974.*

1974-1975 in financial aid to welfare recipients. Only one joint cash grant program - Aid to Families with Dependent Children - will remain under State administration.

Changes in the Medicaid Program

Several changes in the Medicaid program also are built into the new law. Congressional concern over public medical assistance programs (Medicaid and Medicare) is evident in the Ways and Means Committee report on H.R. 1, which stated:

> *. . .These programs taken together accounted for $10 billion of the total of $67 billion which was expended for health care in the United States in fiscal year 1970. Clearly, the impact which these programs have on the health industry is quite substantial. Clearly, too, developments in the health care field have a substantial impact on these programs.*
>
> *Your committee is convinced that there have developed a number of serious deficiencies in the operation and administration of the present programs which need correction.*[1]

The Committee concluded that no "simple or single" solution was possible, but that several modifications in the program were desirable. The changes in Medicaid effected by H.R. 1 are summarized below.

Eligibility Rules. Under current law, all recipients of public assistance are eligible for Medicaid. States also may cover "medically needy" individuals whose income and resources are too high for public assistance but are insufficient to meet medical expenses. H.R. 1 creates an option for states in setting eligibility limits for Medicaid to complement the new SSI financial aid program for adults. After January 1, 1974, a state may choose to:

1. Make all persons who receive SSI payments eligible for Medicaid benefits; or

2. Limit Medicaid eligibility for adults to those individuals who would have been eligible under the state's January 1972 standards.

In choosing this latter option, however, a state must allow the deduction of incurred medical expenses from income - in effect allowing individuals to "spend down" into Medicaid eligibility.

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[1] *U.S. Congress, op. cit., p. 6.*

Medicaid eligibility rules also are affected by provisions of H.R. 1 which require (1) coverage of individuals for three months prior to application for public assistance, and (2) coverage of certain families for four months after they become ineligible for financial aid.

Medicaid Program Content. The new law affects the content of state Medicaid programs in three important respects.

1. The legal requirements for states to maintain the scope of Medicaid services (i.e., not eliminate any type of service offered) and to move toward comprehensive Medicaid programs are repealed, thus giving the states more control over program design.

2. Certain program requirements are strengthened; notably, (1) nursing home standards are made more stringent, and (2) child health screening and family planning services are required for AFDC recipients.

3. Two potentially significant program options are made available to the states. One provides federal matching for intermediate care in mental and tuberculosis institutions for persons over 64. The other provides matching for treatment of persons under 21 in mental hospitals.

Utilization and Cost Controls. Several provisions of H.R. 1 are intended to provide means to control costs of services and insure efficient utilization of health facilities under Medicaid. Penalties are established for states not having effective utilization review procedures. Limits are set on charges for certain types of medical services. State Medicaid programs are permitted to include fees, copayments and deductibles for services to the medically indigent; and deductibles for optional services to public assistance recipients.

Relationship with HMOs. Closely related to provisions establishing utilization and cost controls are those establishing the authority for contractual relationships between health maintenance organizations (HMOs) and the Medicare and Medicaid programs. HMOs provide an organized basis for prepaid group medical practice, as opposed to the dominant mode of individualized practice based upon a fee for service. The advantages of such a shift in the method of delivering medical services to the population are said by proponents to include:

- lower costs, due to (1) comprehensiveness of medical coverage, (2) establishment of incentives toward the most economical use of health-care resources, and (3) greater control of the utilization of medical facilities; and

- high-quality care, because of (1) better utilization of physicians, (2) greater use of peer review among physicians, and (3) greater continuity of care for the individual.[1]

However, others point out that flaws may exist in the HMO concept. In their view, some of the potential shortcomings include:[2]

- Lack of applicability to high-risk populations. Generally, private prepaid groups that have been solvent and successful have middle-class subscribers. The financial and medical effectiveness of HMOs for high-risk families and individuals - such as those receiving welfare - remains undetermined.

- A tendency to undertreat and underhospitalize. Although it is asserted that a set premium for medical services thwarts the temptation to overtreat and overhospitalize, the opposite may be true. In order to avoid a deficit, the HMO may curtail treatment and hospitalization.

- Inability to curb high medical costs. Many of the costliest sicknesses in our society are largely unpreventable through medical means - including heart disease, cancer, strokes, and accidents, which together account for 75 percent of the deaths in the United States. The preventive medicine concept of HMOs can have little effect on high medical costs due to these and other such factors.

The new law authorizes the Secretary of Health, Education, and Welfare to enter into contracts with HMOs under Medicare and to provide technical assistance to states in contracting with HMOs under Medicaid. It also permits states to enter into contracts with comprehensive-care organizations without regard to provisions of law requiring Medicaid programs to be statewide in scope and to provide comparable care for all persons covered.

Integrating HMOs into Medicaid would be hindered in many states by laws restricting the practice of group medicine. In Texas, for example, state laws prohibit consumer-controlled nonprofit corporations from contracting for the provision of medical services, and bar the corporate practice of medicine. These laws

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[1] *See "The Role of Prepaid Group Practice in Relieving the Medical Care Crisis," Harvard Law Review, Vol. 84:887 (Feb. 1971).*

[2] *John R. Kernodle, M.D., "HMOs: Can They Maintain Health?" The Wall Street Journal, August 8, 1973.*

serve to limit HMO development to physician-controlled organizations.[1]

H.R. 1 AND WELFARE PROGRAMS IN TEXAS

As discussed above, Medicaid is far and away the largest welfare program in Texas, lending significance to the effects of the new law on the medical assistance program in this State. And because the bulk of Medicaid costs in Texas are attributable to the adult categories of recipients, the relationship of the new SSI program to Medicaid is of special importance. PL 92-603 provides options for the states in this regard. Thus, perhaps the single most important issue posed for the State of Texas by H.R. 1 is which direction to take in establishing Medicaid eligibility for adults after January 1, 1974. The options are analyzed in the following chapter.

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[1] *See "Report of the [Texas] Senate Interim Committee to Study Rising Medical Costs," January 1973. The statutes cited therein include VATS Ins. Code, Art. 20.01 and 20.12, and VACS, Art. 4505 and 4506, together with Attorney General's opinions and court decisions interpreting these laws.*

II

MEDICAID ELIGIBILITY OPTIONS: "SPEND DOWN" vs. "COVER ALL"

Since 1965 federal law has required that state Medicaid programs cover all recipients of public assistance.[1] Thus, while there are options for covering other groups, basic Medicaid eligibility has been tied directly to receipt of financial aid. With the enactment of the new federal financial aid program, however, each state has been offered the option of departing from that standard. H.R. 1 provides that after January 1, 1974,

> *. . .no State shall be required to provide medical assistance to any aged, blind or disabled individual. . .for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this title and in effect on January 1, 1972, been in effect in such month. . . .*[2]

In coordinating its Medicaid program with the new SSI program for adults, then, the State of Texas has a choice of:

- covering all persons who receive SSI cash benefits, or
- returning to its 1972 public assistance standards to determine eligibility of adults.

These options generally are denominated "cover all" and "spend down," respectively. Their nature and impact are discussed in the sections below.

THE NATURE OF THE OPTIONS

Covering All SSI Recipients

Medicaid is a program intended to provide medical assistance to those whose income and resources are insufficient to meet the cost of medical care. A "cover all" eligibility criterion defines

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[1] *Title XIX of the Social Security Act, as enacted; 42 USC 1396a.*

[2] *PL 92-603, Sec. 209(b). Note that this provision applies to the adult categories and does not include AFDC recipients.*

this insufficiency in terms of the *level* of income and resources (i.e., assets) of an individual. Anyone whose income and resources are low enough to qualify him for financial aid thereby becomes eligible for medical assistance. Thus under the "cover all" option, the present basis for Medicaid eligibility - receipt of public assistance payments - would continue after January 1, 1974. The State would provide full Medicaid coverage for anyone receiving SSI payments; and no other aged, blind or disabled individual would be eligible for Medicaid. The nature of this option creates certain administrative advantages for State Medicaid programs.

A Simple Eligibility Standard. Eligibility under a "cover all" program is determined by the income and resources tests which are used to qualify categorical individuals for financial aid. Anyone who meets these tests also becomes eligible for Medicaid. Thus, the administrative burden of eligibility determination is borne by the financial aid program. After January 1, 1974, this burden will be assumed by the Federal Government in administering SSI. States with "cover all" programs then will be able to use SSI recipient lists in Medicaid administration.

A Universal Level of Benefits. Not only does a "cover all" program create a well-defined and easily determined Medicaid population, it provides all recipients with the same level of benefits. Medical assistance is delivered in an "on-off" fashion. For any financial-aid recipient, Medicaid pays all medical expenses that are covered by the State's plan. The converse is also true: anyone not receiving payments has no Medicaid coverage. Thus, the initial tests for financial aid serve to determine the level of benefits as well as eligibility for benefits. But there is a price to be paid for such administrative simplicity.

Loss of State Control Over Program Standards. Any state selecting the "cover all" option cuts itself loose from its own categorical and financial standards for Medicaid eligibility and ties itself to federally set standards. The magnitude of the change from Texas to SSI income standards is illustrated in Table 5. As the figures indicate, higher incomes are allowed under SSI regardless of whether they are earned or unearned; and earned income is treated with special favor. The increased income limits under SSI certainly will affect Medicaid caseloads and program costs, and these are important considerations. But more significant is the fact that under the "cover all" program the State loses its capacity to control the *timing* and *extent* of changes in Medicaid eligibility standards. Whenever the Federal Government alters SSI income limits - or categorical standards of eligibility - it will be altering Medicaid standards for those states electing to cover all SSI recipients. *In fact, SSI income standards already have been increased once in the few months since their enactment:* under Public Law 93-66, the income limits shown in Table 5 for SSI will increase to $1,920 (unearned) and $4,380 (earned), beginning July 1, 1974.

Table 5

Annual Income Limits for SSI and Texas Adult Welfare Programs, Under Given Conditions*

	Annual Income Limit If All Income Is:	
	Unearned	Earned
SSI	$1,800	$4,140
OAA (1972)	1,518	2,118
AB (1972)	1,392	3,804
APTD (1972)	1,392	1,392

**Figures are those for a single individual without dependents. In the case of mixed income (i.e., both earned and unearned), the general rule for all programs is that the limit falls somewhere between the figures in the Table.*

Inequities in the Distribution of Benefits. The "on-off" nature of coverage in this type of program can create an inequitable distribution of benefits. One aspect of this inequity is the "notch" established at the income threshold of Medicaid. The "cover all" program pays all medical expenses of any categorically related individual whose income is below the limit; but if his income is $1 above the limit, he receives no benefits. At the margin, then, a $1 increase in income results in the potential loss of hundreds of dollars in medical benefits.[1]

The potential for inequity inherent in this situation can be illustrated by the following example:

> Assume that the income limit for Medicaid is $2,000 for a single person. Mr. Jones and Mr. Smith, both over 65, each incur medical bills of $1,000. Mr. Smith, whose income is $1,900, receives public assistance and thus will be covered for his total expenses. Mr. Jones, earning $2,100, is not eligible for welfare; he can receive no benefits.

The effects of Medicaid in such a situation are to maintain Mr. Smith's net income (after medical expenses) at $1,900 - but to

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[1] *See Henry J. Aaron, Why is Welfare So Hard to Reform?, The Brookings Institution, Washington, D.C., 1973, pp. 13-16.*

allow Mr. Jones' net income to sink to $1,100. Obviously, Medicaid eligibility provides a medical-coverage potential for welfare recipients that cannot be matched by persons with slightly higher incomes. Thus it is possible that Medicaid under an "all or nothing" eligibility criterion enables welfare recipients to afford better medical care than is within the reach of the not-so-poor. It also is likely that a "cover all" program presents a substantial disincentive for earning any income which would push a potential welfare recipient's total above the statutory limit.

Raising the income limit does not solve the problem. Regardless of where the margin is set, a "cover all" eligibility criterion will create a Medicaid benefit notch and a consequent disadvantage to those just above the limit. In fact, a higher income standard simply adds another aspect to the equity issue. The large majority of Medicaid claims (at least in Texas) are relatively small - $300 or less annually.[1] A higher income ceiling for Medicaid simply means, in the majority of cases, that the State extends full coverage for general medical expenses to persons with greater incomes. At some point up the income scale it becomes appropriate to question expenditure of the public's medical dollar for an individual's *ordinary* medical expenses, and to pose an alternative: would it not be a preferable public policy to restrict full coverage to those who cannot afford any medical expense, and give some attention to any *extraordinary* (or "catastrophic") medical bills among those who - like Mr. Jones - are above the limit? Just when this point is reached is a matter of debate and the proper domain of public policymaking.

Coverage of catastrophic health-care costs of middle- as well as low-income families and individuals has become a key focus of national health insurance proposals. One such proposal, introduced in Congress by Senators Long, Ribicoff and others on October 2, 1973, provides for federal payment of most family medical costs exceeding $2,000 a year. It also would replace the current Medicaid program with a federal medical assistance program covering (1) all medical expenses of families and individuals with income below specified limits, and (2) any remaining medical expenses of individuals and families with somewhat higher incomes, but whose medical bills exhaust all income above the specified limits.[2]

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1 *Data provided by the Department of Public Welfare reveal that in (Federal) Fiscal Year 1972, 69% of adult-category Medicaid recipients had claims of $300 or less. In the first eleven months of Fiscal Year 1973, the figure was 65%.*

2 *S. 2513, "The Catastrophic Health Insurance and Medical Assistance Reform Act of 1973."*

For Texas, the issue of equity is further complicated by the existence of a "medical assistance only" (MAO) program under which an estimated 6,000 persons with income beyond SSI statutory limits are now receiving subsidized nursing home care.[1] Although these MAOs already receiving such care will be protected by a "grandfather clause" in PL 93-66, that protection does not extend to persons in the same category who will require nursing home care after January 1, 1974. In the future, some undetermined number of persons with income beyond SSI statutory limits may be unable to obtain nursing home care because they cannot afford such care without assistance.

Returning to 1972 Standards: The "Spend Down" Program

If the State chooses to return to its 1972 welfare standards, it would abandon the "cover all" criterion for Medicaid eligibility. *Full* coverage under the program would be provided only to those adults who meet 1972 Texas standards for age, blindness and disability and whose incomes are below 1972 Texas limits. But the terms of H.R. 1 provide for *partial* coverage of another group, based on a spend-down of "available" income:[2]

> . . .[A]*ny such* [aged, blind or disabled] *individual shall be deemed eligible for medical assistance under such State plan if. . .the income of any such individual. . .(after deducting such individual's* [SSI] *payment. . .and incurred expenses for medical care . . .) is not in excess of the standard for medical assistance established under the State plan in effect on January 1, 1972.*[3] (Emphasis added.)

The properties of a "spend down" program are different in several respects from those of a "cover all" program.

Dual Eligibility Standards. The "spend down" option would create two adult eligibility groups and two levels of medical benefits:

1. For categorical individuals whose incomes are below the 1972 State limits, Medicaid pays *all* covered medical expenses, and

2. For categorical individuals whose incomes are above 1972 State limits, but whose medical bills exhaust

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[1] *Any nursing home patient in Texas is currently eligible for Medicaid if his income is $363 per month or less, but he must apply his own income down to the last $25 per month before receiving medical assistance.*

[2] *That is, all income above the limit defined in State welfare standards.*

[3] *PL 92-603, Sec. 209(b).*

all income above the limits, Medicaid pays the *remaining* covered medical expenses.[1]

Individuals in the former group presumably have insufficient resources to pay for *any* medical care. Under the "spend down" rationale, individuals in the latter group are capable of paying ordinary medical expenses - that is, expenses that are in some sense proportional to income. But if the cost of medical care is extraordinary in this same sense, these individuals also can become incapable of paying; and a "spend down" program confers Medicaid eligibility after medical bills reduce their incomes to welfare levels.

No Threshold Notch in Benefits. Under a "spend down" eligibility criterion, medical assistance benefits are based on the *relationship* between medical expenses and income, rather than on the level of income alone. There is no single income notch separating those who are covered from those who are not. Instead, the likelihood of obtaining benefits and the potential level of benefits are reduced as income increases.

State Control of Eligibility Standards. The "spend down" option allows the State to maintain its own standards for Medicaid eligibility, which includes the capacity to change those standards. Under a "spend down" program, then, the State would be able to choose when to alter its policies on income and categorical standards for Medicaid, and free to choose the extent of these policy changes (while remaining within Federal guidelines).

State Administrative Responsibility. Since a "spend down" program is based entirely on State standards, there is no direct federal role in determination of Medicaid eligibility. This means that the State must administer the process of eligibility determination for a "spend down" program - an administrative burden not required by the "cover all" option.[2] Furthermore, the eligi-

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1 *In this respect the "spend down" program is similar to medically needy programs authorized under prior law - except that under the "spend down" option the State would not be required to cover the AFDC category.*

2 *A certain amount of eligibility determination may be required of the States under either option, by the terms of Section 255 of PL 92-603. This provision of the law requires Medicaid coverage of a welfare applicant for three months prior to application - provided he was eligible when medical expenses were incurred. It is expected that the States, rather than the Federal Government, will be given the responsibility to determine eligibility and verify incurred medical expenses under this provision. The procedure would appear to be very similar to that required for "spend down" cases.*

bility criteria include expenses as well as categorical and income standards, making the determination more complex. An example will clarify the procedures involved:

> Mr. Jones is 66 and has a monthly income of $150. In the past three months he has spent $150 on medical care. Now his doctor has informed him that he must undergo an operation which probably will cost $500. Mr. Jones comes to the welfare office seeking assistance.
>
> Luckily for Mr. Jones (who is above the State's public assistance income limits), the State has a spend-down program allowing aged, blind or disabled individuals to retain the first $100 per month for essential expenses. All income above this amount is considered available for medical expenses, and Medicaid will pay any medical bills exceeding available income during a six-month period.
>
> The caseworker handling Mr. Jones' case must:
>
> - verify his income and subtract from it the standard for essential income, to derive available income;
> - verify his incurred medical expenses and subtract these from available income, to derive the amount Mr. Jones is still obligated to pay; and
> - redetermine Mr. Jones' eligibility status at the end of the six-month period.[1]

An Incentive to Costly Care? In principle the differences between "cover all" and "spend down" Medicaid eligibility criteria are clear:

- The "cover all" criterion guarantees accesss to medical care for categorical individuals with insufficient income.

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[1] *The mathematics of eligibility determination in this case are:*

Income for 6 months	*= $150 x 6 =*	*$900*
(Less) standard for essential income	*= $100 x 6 =*	*-600*
Available income	*=*	*$300*
(Less) incurred medical expenses	*=*	*-150*
Remainder of Mr. Jones' obligation	*=*	*$150*

Medicaid pays all bills beyond $150 during the six-month period.

- The "spend down" standard provides partial reimbursement for those categorically related individuals whose medical expenses are out of all proportion to income - regardless of the level of income.

A "spend down" criterion, then, gives more emphasis to coverage of catastrophic medical expenses. It might be argued that such a program would encourage costly health care. Undoubtedly, a higher proportion of medical assistance would go for such treatment under a "spend down" program; yet it is hard to imagine that an incentive for nursing home care (to take one example) would be created by a program with eligibility requirements that include:

- spending all but the last $25 per month of income on medical bills, and

- divesting oneself of all resources above welfare limits.

More appropriate is the argument that a "spend down" program would fail to create disincentives for undergoing costly medical care among the nonwelfare population of aged, blind and disabled. A "cover all" program establishes these disincentives simply because no aid is available - regardless of the individual's situation - unless he is eligible for financial assistance.

Nevertheless, the possibility must be considered that a "spend down" program could result in an intolerable level of expenditure by the State for expensive care to individuals above welfare income limits. This and other financial impacts of the two Medicaid eligibility options are analyzed in the following section.

THE COST OF EACH OPTION

One of the foremost considerations in the choice between "spend down" and "cover all" eligibility criteria for Medicaid is simply how much each will cost the State. The cost factor occupies a pivotal position in evaluating the options because it is the key to the weight that can be assigned other variables in the decision. Given cost estimates for the two options that vary widely, the cheaper program becomes comparatively more attractive regardless of all but extremely unfavorable ratings on its nonmonetary properties. On the other hand, costs that differ only slightly give more significance to other characteristics of the two options.

The cost factor is also important in this decision because Medicaid already has been funded for the 1974-1975 biennium in

Texas. Estimates of the costs involved in the two eligibility options make it possible to project whether additional money will be required for Medicaid in these years.

Existing Projections of Caseloads and Costs

Several estimates of caseloads and costs for the adult programs after January 1, 1974 have been made. Each of these is considered briefly below.

Social Security Administration Estimate of SSI Eligibles and New Claims. The Social Security Administration has projected both the number of eligibles for SSI as of January 1, 1974, and the number of new claims for the program during 1974. These figures, representing a breakdown of national estimates on a state-by-state basis, were completed in December 1972. The Social Security projections by category (Table 6) indicate that over 110,000 persons will be added to adult caseloads during the first year of program operation.

Table 6

Social Security Administration Estimates of SSI Eligibles and New Claims for 1974

	Aged	Blind and Disabled	All Adults (Total)
Eligibles, 1/1/74	277,300	80,400	357,700
New Claims	59,000	52,200	111,200

Source: Figures supplied by Dallas regional office of SSA.

Governor Smith's Task Force Report. Soon after enactment of H.R. 1 in October 1972, then Governor Preston Smith appointed a task force to estimate the impact of the new law on welfare programs in Texas. The task force report, published in January 1973, contained estimates of Medicaid caseloads and costs for both "spend down" and "cover all" eligibility options (see Table 7).[1] The report also projected average monthly caseloads for SSI in Texas at 415,302 for FY 1974 and 529,386 for FY 1975.

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[1] *"Report to the Governor of Texas on Public Law 92-603 (H.R. 1), Social Security Amendments of 1972," prepared by the Inter-Departmental Task Force, January 12, 1973.*

Table 7

Task Force Estimates of Additional Medicaid Caseloads and Costs for 1974-75 Under H.R. 1 Eligibility Options

		"Spend Down"	"Cover All"
1974	Added Caseload	59,000 - 142,000	142,000
	Added Cost to State	$18 - 48 Million	$33 Million
1975	Added Caseload	107,000 - 256,000	256,000
	Added Cost to State	$30 - 87 Million	$54 Million

The task force study was limited in two important respects. First, the 1970 Census data for Texas were not available during the study. As a result, the task force relied heavily on data from the 1970 Texas Housing Survey[1] to project SSI caseloads for the aged, who comprise the great majority of those eligible for the program. While this survey was adequate for the purpose it was intended to serve - the analysis of housing conditions in the state, it has several shortcomings when applied to analysis of the elderly population:

- The sample size was insufficient for accurate analysis of population subgroups (such as age groups);
- Group quarters, such as nursing homes, were not included in the sample; and
- Income data were not obtained in the detail required for SSI eligibility determination.

Second, the task force had to work within an extremely short time frame which particularly limited analysis of the complexities of "spend down," including determination of the administrative costs involved in this option and projection of caseloads and program costs. Administrative costs were not considered in the report, and estimates of "spend down" caseloads were derived essentially from the analysis of the "cover all" option.

The Biennial Appropriations Act. Department of Public Welfare budget estimates for 1974-1975 were based on the "cover all" option, using the caseloads projected in the task force report. However, in the appropriation process a different set of SSI caseload projections was introduced. Drawn up by Senate staff, these

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[1] *A survey of housing conditions in Texas done for the Governor and the Texas Department of Community Affairs. See Texas Housing Report: Results of Comprehensive Survey of Texas Housing Conditions and Occupant Attitudes, Office of the Governor of Texas and Texas Department of Community Affairs (January 1972).*

projections were lower than those of the task force, totaling some 322,760 cases for the average month in FY 1974 and 467,014 in FY 1975. Final Medicaid appropriations for 1974-1975 to some extent represented a compromise between these varying projections, amounting to $392 million. While this figure was not broken down by category, past experience would indicate that approximately three-fourths ($294 million) is intended for aged, blind and disabled recipients.

The Impact of a "Cover All" Program

The basic property of the "cover all" eligibility criterion is its provision of a universal level of benefits to a population defined by income and categorical standards. Thus, conceptually, cost analysis of a "cover all" program can be relatively straightforward, following the equation:

NUMBER OF ELIGIBLES	X	RATE OF PARTICIPATION	X	COST PER PARTICIPANT	=	TOTAL COST

Answers to three questions, then, provide the key to the impact of covering all SSI recipients under Medicaid in Texas:

- How many will be made eligible for Medicaid?
- How many will participate?
- What will be the cost per participant?

Reasonable answers to all of these questions are possible. Income and other socioeconomic data are now available from the 1970 Census, making possible valid estimates of SSI eligibility. And since a "cover all" program will continue the present operating rules of Medicaid in Texas, both the rate at which eligibles participate and the average cost per participant can be estimated from experience. Methods and results of the analysis of these factors are summarized below.[1]

Eligibility for SSI. Eligibility criteria for SSI are rather complex, although generally they simplify the existing standards of adult welfare programs. In order to become eligible for SSI, an individual must satisfy requirements which take into account:

- categorical status (i.e., age, blindness or disability);
- income and resources; and
- personal and family situation, including dependency and marital status.

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[1] *For a more detailed discussion of methodology generally, see the appendices to this report.*

The most complete source of information relevant to these criteria is the 1970 Census. The strengths and weaknesses of the Census data can be summarized as follows. Individual responses to Census questions provide direct identification of the aged and disabled;[1] the blind population cannot be so identified, but may be derived statistically from the larger group of partially disabled persons.[2] Household records contain a detailed inventory of personal relationships and status, allowing the delineation of family characteristics and the derivation of dependency situations. Income data are sufficiently detailed to provide totals for earned and unearned income. Of resources, only homestead value can be obtained.

A sample containing one percent of the personal and household records from the 1970 Census for Texas (a total of 153,000 records) yields the following picture of the adult categorical population in Texas (as adjusted for 1974 conditions). Over 1.4 million persons will be categorically eligible for SSI - that is, aged, blind and disabled - in 1974 (see Table 8). The large majority of these will be in the 65-and-over category. Within the disabled and blind categories are some 17,800 children aged 14-18 who will become categorically eligible for SSI but have not been eligible under the "adult" categories in the past. Blind and disabled children younger than 14 also will be eligible for SSI, but were not identified in the Census sample.

Table 8

Estimates of the Aged, Blind and Disabled Populations of Texas, 1974

Category	Number	Percent
Aged	1,076,000	76
Blind	29,000	2
Disabled	307,000	22
TOTAL	1,412,000	100

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[1] *Disability is defined in PL 92-603 by the existence of an impairment which prevents any "substantial gainful activity." The Census isolates those who are "disabled, cannot work at all," which may be assumed functionally equivalent to the legal definition.*

[2] *This assumes that (1) blind persons identified themselves as partially disabled in the Census, and (2) blind persons are similar to other partially disabled persons in all relevant socio-economic characteristics.*

Not all of these individuals will meet the income and resource standards of the SSI program for persons with various living situations - but the income data from Census records do reveal a strikingly low level of earnings for the categorical population of Texas (shown in Figure 2, as adjusted to 1974). Over half of the aged and disabled groups have estimated 1974 incomes of $2,000 or less, with the blind population faring somewhat better. This means, of course, that much of the categorical population will be within the limits of SSI financial eligibility.

Apparently some 695,900 categorical individuals will be eligible under SSI income standards in State FY 1974, and the figure will increase to 730,700 in FY 1975 (as shown in Table 9). This is much higher than previous estimates of eligibility for the new program in Texas, and is especially impressive when compared with the current adult welfare caseload of about 262,000.[1] The option of covering all SSI recipients under Medicaid, then, potentially could add over 430,000 persons to the Medicaid rolls in this State in 1974. The important question is, *How many will participate?*

Table 9

Estimated Number of Persons Eligible Under SSI Income Standards in Texas, by Categories, 1974 and 1975

Category	Number Eligible 1974	Number Eligible 1975
Aged	549,000	579,000
Blind	8,800	8,900
Disabled	138,100	142,800
TOTALS	695,900	730,700

Participation by SSI Eligibles. Historical rates of participation under Texas' adult welfare programs are the only available index of participation to be expected by SSI eligibles in the near future. The rates of participation experienced in the past under Texas programs can be derived by comparing actual welfare caseloads at one point in time with an estimate of the number eligible by State standards at that time.

Applying 1972 Texas welfare income standards to adjusted Census sample data (see Table 10) results in estimated participation rates of less than 50 percent for all three adult categories.

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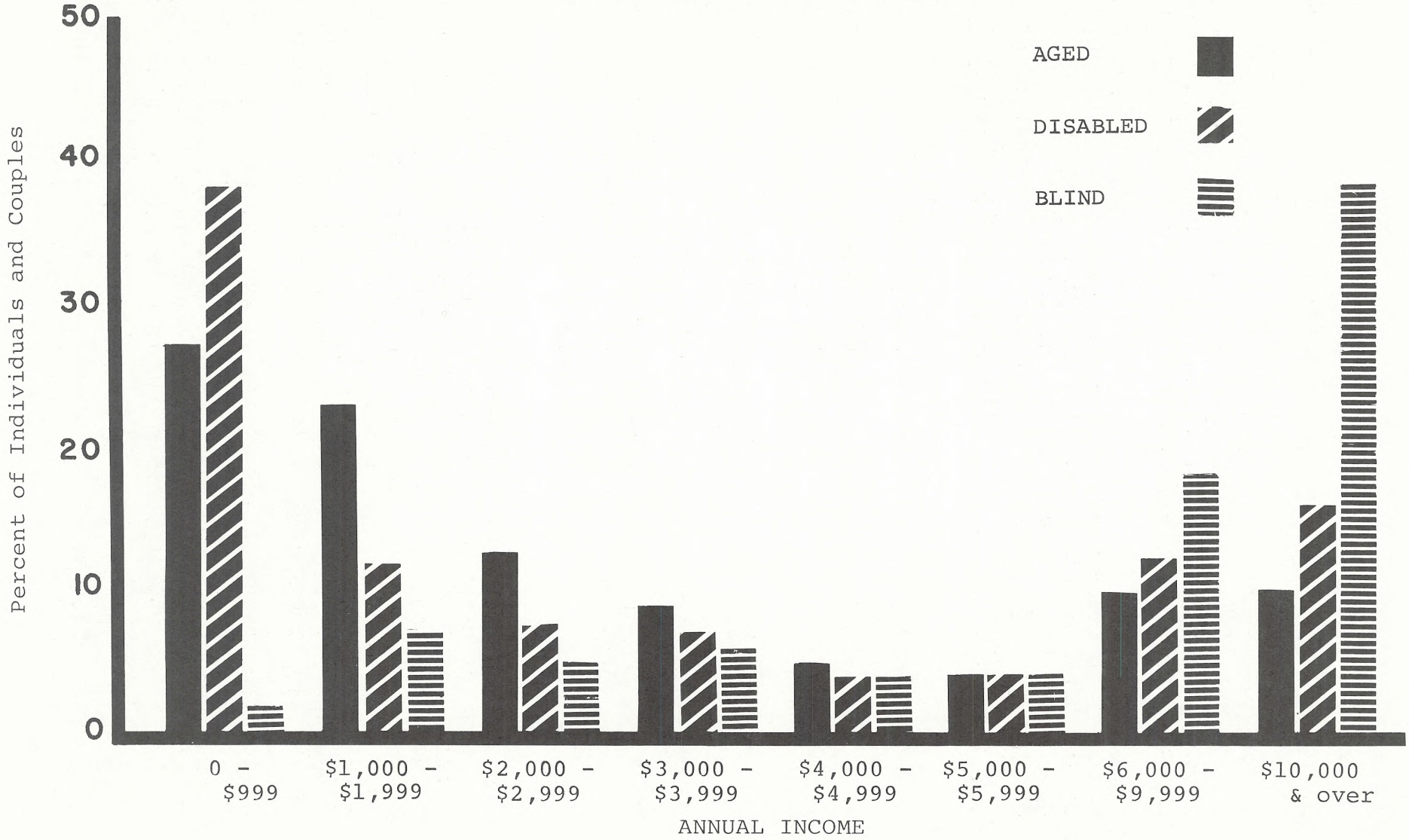
[1] *As of August 1973, including MAO cases.*

Figure 2

PROJECTED INCOME DISTRIBUTIONS FOR THE AGED, BLIND AND DISABLED IN TEXAS, 1974



Source: Estimated from Public Use Sample of 1970 Census Records for Texas.

The figures reveal a much lower level of participation than expected - for example, Governor Smith's task force estimated participation by the aged at 92 percent.[1] A partial explanation for the extremely low rate for the disabled is the restrictive 1972 Texas definition of disability, which allowed eligibility only for those disabled individuals who require the presence or services of another person in performing the usual activities of daily living.[2] Since the SSI definition of disability (which does not include such a requirement) is generally in line with the definitions of many states, the more appropriate "experience" on which to draw may be the national norm for disability cases - which is about twice the rate in Texas.[3] Even with this adjustment, however, the fact of low participation in Texas' adult welfare programs remains.

Table 10

Estimated Rates of Participation by Eligibles
Under Texas Welfare Income Standards, April 1972

Category	Number of Eligibles	Number of Recipients*	Rate of Participation
Aged	516,900	239,411	46.3%
Blind	8,060	3,830	47.5%
Disabled	94,900	28,025	29.5%
TOTALS	619,860	271,266	

**Source: Texas Department of Public Welfare, Statistical Memorandum No. 4, May 11, 1972. Figures include MAO recipients.*

Two questions are raised by these findings:

- Why have so few participated?
- Will participation rates increase under SSI?

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1 *"Report to the Governor of Texas on Public Law 92-603. . . ."*

2 *Article 695c, Section 16-B, VACS. This definition was declared invalid by a federal court in May of 1973 (Center v. Vowell, W. Dist., Texas.)*

3 *According to the 1970 Annual Report of the Department of Public Welfare, APTD recipients totaled 0.37% of the Texas population aged 18-64 in December 1969, compared with 0.72% for the U.S. as a whole.*

Although no definite answer can be given either question, some of the relevant considerations may be suggested in both cases. Participation among those qualified under welfare income standards can be affected by categorical definitions such as the disability standard mentioned above, by legal limits on assets (e.g. savings and personal property), and by family support in terms of housing and other essentials. Nonparticipation by the rural poor may reflect less dependence on money income in such areas. Finally, the stigma of welfare itself may lower participation.

Many of these factors will affect SSI as much as they have the Texas programs. SSI standards, for example, contain limits on assets as well as income, just as the programs being replaced. Yet there is one crucial difference in the new program: it will be run by the Social Security Administration. Because of this, SSI could become recognized as an extension of the social security program - unless efforts are made by administrators to distinguish the two. Identification of SSI with social security undoubtedly would lead to higher participation. Much, then, may depend on the manner in which the program is publicized and its standards administered.[1]

SSI Caseloads. Given expected participation rates (Table 10), together with projected numbers of eligible individuals (Table 9), SSI caseloads can be estimated by multiplication. Final figures for the 1974-75 period must be adjusted to account for the changeover between Texas programs and SSI after the first four months of the State's Fiscal Year 1974,[2] as well as for the higher SSI income standards that will take effect on July 1, 1974.[3]

At the assumed participation rates,[4] monthly average public assistance caseloads for the aged, blind and disabled under SSI will climb by 58,000 over State FY 1973 levels during the first

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1 *See Walter Williams, "The Supplemental Security Income Program: Potentially the Next Crucial Step Toward Social Security and Welfare Reform," Institute of Governmental Research, Univ. of Washington (January 1973), pp. 20-21.*

2 *SSI takes effect in January 1974, while the State's Fiscal Year 1974 begins in September 1973. Thus, FY 1974 will be split between the current Medicaid program and a program based on the options in PL 92-603.*

3 *See page 16 above.*

4 *With participation by the disabled at twice the derived rate of 29.5% (59.0%). See discussion above, page 29, for justification of this adjustment.*

year of the program, and the caseload total will average almost 363,000 in FY 1975 (see Table 11). Cases will increase in each category, but the increase will be especially dramatic for the disabled - who benefit under SSI from a broader definition of disability, relaxed income standards, and a lower age limit for eligibility.

Table 11

Estimated Monthly Average SSI Caseloads for Texas, 1974-1975, Compared with 1973

	----------Monthly Number of Cases----------		
Category	August 1973*	Avg. FY 1974	Avg. FY 1975
Aged	225,204	249,900	274,100
Blind	3,817	4,100	4,200
Disabled	32,740	65,900	84,500
TOTALS	261,761	319,900	362,800

**Source: Texas Department of Public Welfare, Statistical Memorandum No. 4, September 14, 1973. Figures include MAO recipients.*

The Cost of An SSI-Related Medicaid Program. Since providing medical benefits to all SSI recipients will continue the present operating procedure for Medicaid in Texas, experience appears to be the best available guide in determining overall Medicaid costs for such a program. Per capita expenditures based on actual figures for recent years can be applied to projected caseloads to produce an estimate of medical costs for a "cover all" program.

Assuming the general continuation of per captia cost trends experienced from 1970-1972, as well as the participation rates discussed earlier, a Medicaid program covering all SSI recipients in Texas would cost the State approximately $289 million in the 1974-1975 Biennium (see Table 12).[1] The bulk of this cost would be for the aged, who represent the majority of adult welfare cases; but the greatest increase in expenditures over current levels would be for the disabled.

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[1] *Actual cost of the program for "adult" recipients is estimated at $296 million, but adjustments to account for potential transfer of children from AFDC to SSI leave the net total at $289 million. See Appendix B.*

Table 12

Estimated Cost of Medicaid for Adult Categories in Texas Under a "Cover All" Eligibility Criterion, 1974-1975

1974

Category	SSI Caseload	Per Capita Cost to State	Total Cost to State
Aged	249,900	$371.84	$ 92,923,000
Blind	4,100	442.42	1,814,000
Disabled	65,900	576.71	35,249,000*
TOTALS	319,900		$129,986,000

1975

Category	SSI Caseload	Per Capita Cost to State	Total Cost to State
Aged	274,100	$402.72	$110,386,000
Blind	4,200	459.80	1,931,000
Disabled	84,500	599.07	46,374,000*
TOTALS	362,800		$158,691,000
		GRAND TOTAL, 1974-1975	$288,677,000

**Reflecting adjustments due to potential AFDC transfers.*

The Impact of a "Spend Down" Program

Estimating the total cost of a "spend down" Medicaid program is more complex than analyzing the "cover all" option, since the "spend down" criterion creates a dual eligibility standard. One categorically eligible group, defined in terms of 1972 State welfare standards, may receive full Medicaid coverage in a "spend down" program. For another categorical group - those above 1972 welfare standards - the key to eligibility for, and amount of, Medicaid benefits lies in the relationship of income to medical expenses.

The analysis of Medicaid costs for these two eligibility groups must be performed separately. Expenditures for the fully

covered group can be estimated in the same manner as costs for a "cover all" program. For the partially covered (or spend-down) group the important consideration is an individual one, and the analysis must in some way match medical expenses with pertinent socioeconomic data for each potentially eligible person. To the program costs derived in these analyses must be added the administrative costs of eligibility determination and casework. Projected "spend down" costs and the methods used to obtain them are outlined in the following pages.[1]

Medicaid Costs for the Fully Covered Group. Costs for medical assistance to the fully covered group under a "spend down" program can be estimated from answers to three questions:

- How many adults will be eligible in 1974 and 1975 under 1972 Texas welfare standards?
- How many will participate?
- What will be the cost per participant?

The basic participation rates and per capita costs for each category of eligibles can be assumed equivalent to those derived for "cover all" program eligibles, since this group is the counterpart under State standards to SSI recipients and will receive the same type of coverage. Only the first question requires new projections.

The application of Texas' 1972 welfare income standards for adult categories to adjusted Census data yields an estimate of more than 600,000 persons eligible for full medical coverage under a "spend down" program in 1974, with a slightly larger number eligible the following year. Assuming that participation remains consistent with historical rates,[2] and that recent per capita cost

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[1] *For a more detailed discussion of methodology generally, see the appendices to this report.*

[2] *In a recent decision, the U.S. District Court for the Western District of Texas has found Texas law and regulations defining permanent and total disability to be out of conformity with the Social Security Act, insofar as they provide that a person must be "restricted in his performance of usual activities of daily living to the extent that he requires services, or the presence of another person in performing these activities." Center v. Vowell. The court-modified Texas disability definition appears generally to be functionally equivalent to that of SSI; therefore, the same participation rate has been assumed for the disabled under both the "spend down" and "cover all" programs.*

trends continue,[1] Medicaid for the fully covered portion of a "spend down" caseload in Texas would require some $202 million of State money in the 1974-1975 Biennium (see Table 13).

Table 13

Estimated Numbers of Eligibles, Caseloads, and Medical Costs for the Fully Covered Portion of a "Spend Down" Caseload in Texas, 1974-1975

1974

Category	Number of Eligibles	Caseload	Per Capita Cost to State	Total Cost to State
Aged	501,200	277,900	$371.84/262.12*	$67,973,000
Blind	7,600	3,700	442.42	1,637,000
Disabled	95,800	48,800	576.71	28,143,000
TOTALS	604,600	280,400		$97,753,000

1975

Category	Number of Eligibles	Caseload	Per Capita Cost to State	Total Cost to State
Aged	512,000	237,100	$287.77	$ 68,230,000
Blind	7,600	3,200	459.80	1,471,000
Disabled	97,800	57,700	599.07	34,566,000
TOTALS	617,400	298,000		$104,267,000
			GRAND TOTAL, 1974-1975	$202,020,000

**$371.84 for September-December 1973; $262.12 for January-August 1974.*

[1] *Per capita Medicaid costs for the aged category in Texas have been heavily influenced by expenditures for Medical Assistance Only recipients. Since this group would not be included in the fully covered portion of a "spend down" program (but rather in the spend-down group itself), per capita expenditures have been reduced to remove the effects of MAO medical costs after January 1, 1974. This adjustment is reflected in figures for the aged found in Table 13.*

Medicaid Costs for the Spend-Down Group. Since the group of categorically eligible adults above 1972 welfare standards must spend down into eligibility, the key to Medicaid costs for this group is the relationship between income and medical expenses. Income data for categorical adults are revealed in Census records. Medical expense information must be obtained elsewhere.

The incidence of medical problems among the adult categorical population can be expected to exceed that of other population subgroups; thus average medical expenditure figures generally are not relevant for these individuals. The most appropriate data available for comparative purposes are Medicaid expenses for adult welfare recipients in Texas during Federal Fiscal Year 1972. These data indicate that even among adult categorical individuals a majority can be expected to have rather moderate medical expenses: in 1972 over three-fourths of all adult Medicaid recipients in Texas had medical claims of $500 or less (see Table 14).

Table 14

Percentage Distribution of Adult Medicaid Recipients in Texas by Size of Claim for Benefits, Federal FY 1972

Size of Claim	Percent of Recipients
$ 1 - 500	75.69%
501 - 1,500	7.09
1,501 - 2,500	4.50
2,501 - 3,500	5.10
3,501 - 4,500	5.84
4,501 - over	1.79
	100.00%

Figures do not add to total due to rounding.

Source: Texas Department of Public Welfare, "Texas Medicaid Frequency Distribution of Payment 07-01-71 to 06-30-72," June 21, 1973, Table 1A. These figures do not include an approximate 8 percent of welfare recipients who filed no Medicaid claims in FY 1972.

In order to become eligible for Medicaid benefits, each person in the spend-down group must have a net income after medical expenses that is less than the applicable 1972 welfare standards. The simplest method of making the comparison between income and medical expenses is to "simulate" the spend-down process by randomly assigning a medical expense from Medicaid data (adjusted to account for medical cost increases) to each individual's Census Record.

Attaching medical expenses based on Texas Medicaid data to all categorical individuals not eligible for full coverage under

1972 Texas income standards, subtracting these expenses from income, and reducing for participation rates, results in an additional Medicaid cost to the State of $92 million for the 1974-1975 Biennium (see Table 15).[1]

Table 15

Estimated Numbers of Individuals Receiving Medicaid Benefits Through a Spend-Down Process in Texas, and Cost to the State, 1974-1975

----------1974----------

Category	Number Receiving Medicaid Benefits	Total Cost to State
Aged	51,500	$29,947,000
Blind	620	222,000
Disabled	9,400	4,845,000
TOTALS	61,520	$35,014,000

----------1975----------

Category	Number Receiving Medicaid Benefits	Total Cost to State
Aged	51,100	$49,799,000
Blind	620	311,000
Disabled	8,700	6,800,000
TOTALS	60,420	$56,910,000
GRAND TOTAL, 1974-1975		$91,924,000

[1] *Because of the properties of the Census sample, nursing home recipients have been assigned a 365-day cost for their care rather than a random expense; this avoids understating medical costs for such recipients. Participation rates derived from 1972 have been utilized for non-nursing home eligibles, while 100% participation has been assumed for nursing home eligibles. See Appendix B.*

The total medical cost which would accrue to the State through a "spend down" program in 1974-1975 under the foregoing assumptions (adding the totals from Tables 13 and 15) would be $294 million - which is some $5 million above the net medical costs of a "cover all" program. But for the "spend down" option the costs of administering State eligibility standards must be added to medical costs.

The Cost of Administering State Eligibility Standards. Under the "spend down" option, the State would have to employ staff to provide Medicaid eligibility determination for adults. Expenses for the additional employees must be added to the medical costs of this type of program. Administrative costs are determined from departmental policy on staff-case ratios and from the department's per-employee average costs for salaries, insurance, travel and other items.

The Texas Department of Public Welfare employs college-level staff as caseworkers. Recent policy of the Department has been for caseworkers in the adult programs to handle 1,000 "transactions" per year, including:

- administering 600 active cases,
- reviewing 120 cases, and
- processing 280 applications.

But the spend-down cases are of a different nature than cases involving public assistance. It would be necessary to redetermine eligibility for these cases at six-month intervals, which would raise the ratio of reviews to active cases for each caseworker. Considering available information and opinions, a reasonable work load for Texas caseworkers under a "spend down" program might include 990 "transactions," divided as follows:

- 400 active cases,
- 400 case reviews, and
- 190 applications.[1]

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[1] *The State of Michigan uses high school graduates as caseworkers and assigns each one 375 active cases, (presumably) 375 reviews, and 80 applications. While this is a lighter work load than that set for Texas workers, the educational differential must be considered. Further, the Michigan policy is to give 400 cases to workers administering only spend-down cases, because they require no home visits by the worker.*

It should be noted that the number of applications per worker must bear the same relationship to cases assigned as does the level of applicants to active cases.

If college-level caseworkers were employed as under present policy, current supervisory and clerical ratios per worker can be assumed adequate.[1]

The number of employees required for administration of a "spend down" program can be determined from these staffing ratios and the projected caseloads for the 1974-1975 Biennium. Applying average salary and other support costs to the employee totals yields expected State administrative costs of over $13 million for a "spend down" program in 1974-1975 (see Table 16).

Table 16

Estimated Administrative Cost of a "Spend Down" Program in Texas, 1974-1975

1974	Number of Employees	State Administrative Costs
Caseworker	855	$ 3,100,000
Clerk	658	1,721,000
Supervisor	86	379,000
Program Dir.	11	56,000
TOTALS	1,610	$ 5,256,000

1975	Number of Employees	State Administrative Costs
Caseworker	896	$ 5,016,000
Clerk	689	2,784,000
Supervisor	90	612,000
Program Dir.	12	94,000
TOTALS	1,687	$ 8,506,000

GRAND TOTAL, 1974-1975 $13,762,000

The total State cost of a "spend down" program in Texas for 1974-1975 - the sum of medical and administrative costs - would be almost $308 million under the assumptions of this analysis:

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[1] *One supervisor per 10 caseworkers, one program director per 7.6 supervisors, clerical personnel at 35% of total professional salaries (or about one clerk per 1.3 caseworkers).*

$202,020,000 for medical coverage of those eligible under 1972 Texas standards;

$ 91,924,000 for medical coverage of those spending down into 1972 Texas standards;

$ 13,762,000 for administration;

$307,706,000 in total.

A "spend down" program for the aged, blind and disabled therefore would be about $19 million more expensive than an SSI-related program for these three categories.

There are, however, differences in the cost comparisons of the two options for each category; and it is possible for the State to select the "cover all" option for one or two of the categories, together with the "spend down" option for the other(s). A recapitulation of costs by category is necessary to reveal the magnitude of such differences.

A Recapitulation of Medicaid Costs Under the "Cover All" and "Spend Down" Options

The overall results of the foregoing analysis reveal a cost comparison favorable to an SSI-related Medicaid program if all three categories are considered jointly - the major differential being quite clearly the administrative costs of a program utilizing State eligibility standards (see Table 17).

Table 17

Comparison of State Medicaid Costs Under the "Spend Down" and "Cover All" Program Options, 1974-1975

	"Spend Down" Costs	"Cover All" Costs
Program	$293,944,000	$288,677,000
Administration	13,762,000	
TOTALS	$306,706,000	$288,677,000

But the close balance in program or medical costs of the two options for all adult categories conceals differences in program costs for two of the three categories. If administrative costs are apportioned to each category under the "spend down" option,, these differences can be put in dollar terms (as shown in Table 18). Such a category-by-category comparison reveals that, under the assumptions of this analysis:

- a "cover all" program would be almost $24 million less expensive in 1974-1975 for the aged category than a "spend down" program for that group;

- there is very little difference between the options for the blind category; and

- a "spend down" program for the disabled would require almost $5 million less than a "cover all" program for that category.

Table 18

Comparison of State Medicaid Costs for Each Category of Recipients Under the "Spend Down" and "Cover All" Program Options, 1974-1975

Category	(1) "Spend Down" Costs*	(2) "Cover All" Costs	Difference (1) - (2)
Aged	$227,063,720	$203,309,000	$23,754,720
Blind	3,778,620	3,745,000	33,620
Disabled	76,863,660	81,623,000	-4,759,340
TOTALS	$307,706,000	$288,677,000	$19,029,000

**"Spend down" costs include administrative expenses apportioned to each category according to caseloads.*

The significance of these cost differentials as compared with other factors differentiating the two options (such as the policy differences discussed on pages 15-22, above) is a matter of judgment for those who must decide the future of Texas' Medicaid program for adults. To balance all relevant considerations is not the intention of this analysis - rather it is to make explicit the cost implications and other factors so that an intelligent decision is possible.

HOW WILL H.R. 1 AFFECT OTHER HEALTH-CARE DOLLARS SPENT IN TEXAS?

The focus of this report has been on the immediate impact of H.R. 1 on welfare programs in Texas, particularly on the State's Medicaid program. Such an emphasis - while important for the short-term decisions that must be made by State policymakers - does not capture the full effects of federal "welfare reform" on medical costs in Texas. What will H.R. 1 mean for the taxpayer and consumer of medical services in Texas?

By increasing the number of Medicaid recipients in Texas, H.R. 1 will add new federal dollars to an already high demand for the services of hospitals, physicians and other providers of medical care. These Medicaid dollars, together with those spent through Medicare (the federal medical insurance program tied to Social Security), purchase services in the same "health care delivery system" used by other consumers in the State. It is claimed by some that public-assisted care provided through these programs drives up medical costs in general by increasing the pressures on the delivery system.

H.R. 1 requires "utilization review" in an attempt to curb inefficient care under Medicaid, and it provides for comprehensive and potentially cost-saving "health maintenance organizations" within Medicaid and Medicare. These aspects, too, can have a significant, but yet undetermined, impact on health care facilities and costs.

A sizable portion of publicly assisted medical care in Texas is provided by locally financed public hospitals. Some 113 of these city, county and district hospitals reported more than $73 million in uncompensated services (charity plus uncollected billings) in 1970-71.[1] The relationship of indigent care obtained through these facilities to Medicaid and Medicare, and to general medical costs in the State, remain substantially unknown.

- What types of care are provided by local public hospitals, who receives it, and who pays for it?

- Will expansion of Medicaid bring about any general substitution of state-federal dollars for the local tax monies supporting uncompensated care in these facilities?

- How does the mixture of local, state and federal health-care dollars affect the costs of medical services for the general public?

These and related questions form the basis for the second phase of the League's two-part study for Governor Dolph Briscoe covering the effects of H.R. 1 on welfare and health care delivery in Texas.

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[1] *"Report of Implementation of Local Welfare Expenditure Reporting System, Prescribed by Senate Bill 245, Sixty-Second Legislature," Arthur Young and Company (July 1972).*

APPENDIX A

METHODOLOGY FOR ESTIMATING "COVER ALL" AND "SPEND DOWN" ELIGIBILITY FROM CENSUS TAPES

Medical program costs for Texas under both the "cover all" and "spend down" options were estimated using a two-step procedure: first, an estimate of the numbers eligible for medical assistance was derived; and second, these data were adjusted to project Medicaid program users and costs. The first step is detailed in this appendix, the second in a following appendix.

The following material constitutes a general discussion of the Census data and methods used to analyze Census records, followed by a description of the estimating procedures for deriving eligibility totals under the Supplemental Security Income (SSI) program and a "spend down" program utilizing January 1972 Texas welfare standards. Census data analysis was performed with computer programs written in FORTRAN V and executed on a UNIVAC 1108 computer. A copy of UNIVAC-compatible Census data tapes and technical assistance were provided by Walter Wood, Census Coordinator, Division of Demographic Analysis, Office of Information Services.

OBTAINING RELEVANT DATA FROM THE CENSUS

The Public Use Samples of Basic Census Records

A data source was required to identify the Texas population by categorical eligibility for adult welfare programs and by income and various other characteristics which determine eligibility for public assistance. The most useful source was the 1970 Census. Estimates of eligibility were based primarily on Public Use Samples of Basic Records from the 1970 Census. Six sets of Public Use Samples (PUS) exist for the 1970 Census of Texas. The analysis described herein made use of the one-in-one hundred sample, consisting of 153,219 personal and household records drawn from questionnaires in the 5% population sample.[1] Access to the demographic and socioeconomic information in these questionnaires allowed an in-depth analysis of the relevant characteristics of the population to a much greater degree than would have been possible through the use of published Census tabulations, with a resulting increase in accuracy of estimation.

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[1] *For detailed discussion see Public Use Samples of Basic Records from the 1970 Census: Description and Technical Documentation, U.S. Bureau of the Census, Washington, D.C., 1972.*

Data Elements of the Public Use Sample

The PUS is organized by household records, which include the personal records of each household member. For group quarters (hospitals, dormitories, etc.), household records are followed by one sample personal record of an occupant. The following data elements from household and personal records were utilized in the analysis:

From Household Records:	From Personal Records:
Tenure (occupancy by renter, owner, etc.)	Sex
Value of Property	Age
Household Type (private or group quarters)	Marital Status
	Earnings from Wages and Salaries
	Earnings from Business
	Earnings from Farm
	Income from Social Security or Railroad Retirement
	Other Income
	Disability Limiting Work
	Disability Preventing Work
	Type of Group Quarters
	Relationship of Persons in Household (8 items)

The succeeding paragraphs describe the uses and limitations of these data elements.

Tenure. The tenure data item was used in SSI analysis. If a household record indicated the unit was owner occupied, ownership was attributed to the head of household.

Property Value. Welfare standards contain specific dollar and/or quantity limits on various types of personal resources. The values of owner-occupied homes are the only resource data included in Census data, and these were used in SSI analysis. Other resource limitations were not considered.

Household Type. Texas welfare standards distinguish between those who live in households and those who reside in certain types of group quarters - notably nursing homes. While SSI standards of eligibility do not differentiate between individuals in households and in group quarters, some data elements do not apply to both. Thus, a distinction was made in programming to allow for separate analyses. The "Type of Group Quarters" item lists 12 types of quarters, of which "Aged and Dependent Homes" most closely describes nursing homes. The eligible population in this group was tabulated separately.

Age. Age requirements complicate the identification of categorical individuals through Census records. Under SSI,

children who meet the categorical requirements for blindness and disability are eligible under those categories (under Texas standards, no one under 18 is eligible for these "adult" categories). The Census disability questions were asked only of individuals 14 and older. As a result, SSI estimates do not include potentially eligible children aged 13 or younger.[1] Similarly, the two disability data items were not obtained for persons 65 and older. The lack of this disability data does not affect total eligibility, since such individuals would be eligible by virtue of age - although it may tend to overstate the aged category at the expense of the blind, who can choose either category if qualified for both, under Texas and SSI standards. Another slight overstatement of the aged group (and a corresponding understatement of the other two groups) resulted from the tabulation of all married couples in which both were eligible under the husband's category. Such a procedure misclassifies, for example, the disabled wife of a man over 65.

Earnings. Income standards in both SSI and Texas programs distinguish between earned and unearned incomes. Earnings from wages and salaries, business and farm were summed to arrive at earned income. The other two income elements were considered unearned income.

Disability. The two Census data items regarding disability were used to identify categorically blind and disabled individuals. Individuals suffering from blindness are not enumerated in the Census. It was assumed, however, that they are included in the "Disability Limiting Work" (DLW) group of Census respondents. Characteristics of the DLW group were used in estimating eligibility for the blind, and the eligibility totals were adjusted to reflect the estimated blind population total. The National Society for the Prevention of Blindness estimates the incidence of blindness at 2.4 persons per 1,000 population; at this rate, the 1970 blind population for Texas was 26,873.[2] The DLW group total in the PUS is 429,100. Thus, all figures derived from the DLW group to represent the blind were reduced by a .063 factor (26,873 ÷ 429,100) to arrive at the estimated blind figure. This assumed, of course, that the blind population shares the same socioeconomic characteristics as the partially disabled population.

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[1] *Many of these children may be AFDC recipients, in which case the cost impact is minimal.*

[2] *This estimation procedure was suggested by Charles R. Raeke, State Supervisor for Technical and Consultive Services, State Commission for the Blind.*

The "Disability Preventing Work" (DPW) group of Census respondents was assumed equivalent to the set of individuals meeting the disability definition of SSI, which requires the existence of a medical impairment preventing any "substantial gainful work." Texas welfare standards until recently used a more restrictive test requiring that the presence of another person in the house be necessary. A recent court decision has disallowed that requirement,[1] and it was assumed in the analysis that the Texas definition now is functionally equivalent to that of SSI. Thus, the DPW group was used directly to estimate the categorically disabled group under Texas as well as SSI standards.

Household Relationships. The eight items on relationships of household members were used for various eligibility requirements. Both SSI and Texas welfare programs distinguish between dependents and nondependents, the former group being allowed less income because in-kind support (e.g., room and board) is furnished them. In the analysis, heads of households, their spouses and persons in group quarters were assumed to be nondependents. Questions arose in the case of other categorical individuals in households, because Census records do not indicate whether or not such individuals pay for lodging. If the absence of such information, two assumptions were made:

- if the individual was not related to the head of the household, he was assumed to be a nondependent, since such persons (roommates, lodgers, boarders, etc.) are not likely to be in residence gratis; and

- persons related to the head of household, other than spouse, were assumed to be dependents, since relatives are most likely to be living there at no charge.

Marital Status. It was necessary to identify the spouse of married persons so that their incomes could be combined for purposes of income eligibility determination. This procedure relied on a variety of data elements on family relationship, living arrangements and family structure. "Married" for SSI purposes includes only couples where both are categorically eligible. If only one partner is categorically eligible, incomes are combined, but the individual's eligibility is measured by standards applicable to single persons.

In the analysis, the spouse of a married person "head of household" was assumed to be the individual listed as "wife of head." This was validated by checking marital status and sex of both. A married couple related to the head of household constitutes a subfamily. The head of that subfamily was assumed to be married to the wife of the head of that subfamily, which was validated by checks of marital status, sex and subfamily number.

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[1] *Center v. Vowell, W. Dist., Texas, May 1973.*

Individuals "not related to head of household" were matched in a similar fashion.

Group Quarters. Individuals in group quarters were treated similarly to individuals not related to head of household, except that all were considered to be single.[1]

A marital adjustment for nursing home individuals was made in an attempt to estimate more accurately eligibility in that group. Census data indicate which nursing home patients are married; these were assigned a spouse at random from the general sample population. Because it was impossible to identify couples in nursing homes, all spouses were assumed to be outside the nursing home. Three selection parameters were utilized - a marital status of "Married, Spouse Absent," opposite sex and age within plus or minus ten years.

Persons in correctional institutions are not eligible for either program, and were excluded from the estimates. Persons in State institutions are eligible, but Census data do not separate public from private institutions. Accordingly, persons in these institutions were not included directly in the analysis (although their numbers within the caseload and their medical costs were taken into account in the analyses of caseloads and costs; see Appendix B).

Tape Search Procedure. The same basic PUS tape search procedure was used for both SSI and Texas programs. First, a household/group quarters was identified, and the personal records following it were searched to identify categorically eligible individuals. Then, for each categorical individual, appropriate parameters were defined (spouse, income, dependency, home ownership, etc.) and income measured against eligibility standards.

POPULATION AND INCOME ADJUSTMENTS

Population and personal income were adjusted to update the PUS for FY 1974 and 1975 estimates. Income was adjusted for each individual prior to eligibility determination. Summary totals of categorical individuals and eligibles were upped to reflect population growth.

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[1] *This was done because Census records do not recognize married couples in group quarters. PUS documentation does not give any specific reason for this. One possible explanation is that among residents of group quarters (mostly institutions of various types) there may be a high incidence of married persons with spouse living elsewhere, making it impossible to group together personal records of such couples.*

Population growth trends were used to ascertain the percentage of increase from 1970 to the desired year. Population estimates made by TRL staff prior to this study were utilized. Based on the 65 years and older segment of the population, 1974 and 1975 growth percentages were estimated at 8.19% and 10.50%, respectively. The total of individuals 65 and older in the PUS is higher than in the total Census count indicating an oversampling in the PUS by approximately 1.76%. To allow for this, the growth percentages were reduced by the oversampling rate, giving the final population factors of 1.06 and 1.09. A factor for 1972 was required in the participation rate estimation procedure; 1.02 was used, calculated in the same manner as the other factors.

The income factor was derived from earnings data published in Texas Manpower Trends, Official Publication of the Texas Employment Commission. For the month of April, years 1969 and 1973, a statewide average weekly earnings was calculated. These figures were the average of earnings for production workers in manufacturing industries and nonsupervisory employees in five major nonmanufacturing divisions, weighted by their shares of the Texas civilian labor force. The percent change from year to year was averaged, giving an average annual increase of 5.81%. With this annual growth rate, the income factors from mid-1969 (income data in the 1970 Census reflected calendar year 1969) to 1974 and 1975 were 1.26 and 1.32, respectively. A 1972 income factor was calculated at 1.15 using the procedures described above. The earned income factor was applied to each person's earned income. "Income from Social Security and Railroad Retirement" was adjusted by a factor of 1.3 percent to reflect increased Social Security benefits; "Income from Other Sources" (interest, pensions, etc.) was not adjusted.

ESTIMATING ELIGIBILITY UNDER SSI PROGRAM STANDARDS

Under the SSI program, categorical individuals who meet income and resource requirements are eligible. The analysis of these standards using Census data to estimate eligibility for SSI is discussed below.

SSI Resource Limits

SSI standards specify limits for several types of resources, although the PUS contains information only with respect to the value of owner-occupied homes. SSI excludes from eligibility an individual owning a home over a certain value. This value, not specified in the law, had not been established by the Secretary of Health, Education and Welfare at the time of this study, but it was expected to be $25,000. If a household record indicated it was owner occupied and valued over $25,000, the head of household was excluded if otherwise SSI eligible.

SSI Income Limits

For married's, as defined previously, the maximum annual income allowed by PL 92-603 (i.e, the "stated maximum" income) is $2,340, while singles are limited to $1,560. For dependents, the maximum is reduced by 1/3, to $1,560 and $1,040, respectively. In the income determination process, the first $240 of annual income (whether earned or unearned) is excluded, together with the first $780 of earned income and 1/2 of the remainder of earned income. As a result, the actual income allowed is greater than the stated limits, and can vary according to the mixture of earned and unearned incomes. To illustrate, the computation for a non-dependent single person is shown below; the procedure is the same for the other subgroups. In each case "X" represents earned income and "Y" represents unearned income.

Case 1: all income is unearned. The first $240 of unearned income is excluded, and the balance cannot exceed the stated maximum of $1,560. Algebraically, the maximum income allowed is:

$$\$1,560 = Y - \$240, \text{ or } Y = \$1,800.$$

Case 2: all income is earned. The $240 exclusion is applied, then the $780 exclusion, and finally 1/2 the remainder of earned income is excluded. Algebraically:

$$\$1,560 = X - \$240 - \$780 - 1/2(X - \$240 - \$780),$$

with the resulting allowed income of X = $4,140.

Case 3: income is partly earned and partly unearned.

3.1 If unearned income is less than $240, the maximum is the same as in Case 2. For example, assume unearned income is $40 (Y = $40). The $240 exclusion is reduced by $40 and the formula for allowable earned income becomes:

$$\$1,560 = X - \$200 - \$780 - 1/2(X - \$200 - \$780),$$

or X = $4,100. Maximum earned and unearned income allowed (X + Y) remains at $4,140 ($4,100 + $40).

3.2 If unearned income is greater than $240, the maximum allowable income as calculated is reduced by the amount that unearned income exceeds $240. For example, assume unearned income of $300. The $240 income exclusion is applied ($300 - $240 = $60), and the balance is counted against the stated maximum ($1,560 - $60 = $1,500), since it is not eligible for any other exclusion. Computation of maximum earned income becomes:

$$\$1,500 = X - \$780 - 1/2(X - \$780),$$

with X = $3,780. Thus, the total allowed income is $4,080 (X + Y = $3,780 + $300). Note that the maximum in Case 2, $4,140, is reduced by $60, the amount by which unearned income exceeds the $240 exclusion. Note also that if unearned income exceeds the Case 1 limit of $1,800, the individual is ineligible regardless of his earned income.

For couples and dependents the same maximum income determination procedure is used, except that the applicable statutory limits from PL 92-603 are substituted in each case (e.g., $2,340 for a couple). For couples, the incomes of both are totaled in these computations.

The Computer Algorithm for Determining Allowable Income. Because Census records list income by $100 brackets, the computer program utilized a maximum allowable $100 bracket rather than a specific dollar amount. Generally, the program accepted as eligible all incomes in the bracket where the actual limit fell. (For example, if the actual limit was $4,080, the program accepted incomes in the $4,000-4,099 bracket. The income analysis procedure was simplified as much as possible to conserve computer program execution time, with a resulting overstatement for Case 2 persons, who were allowed an income approximately $200 higher than the actual limit. This overstatement had minimal impact: for aged nondependent singles it increased eligibles by 0.32%.

The computer program algorithm contained the following operations: (1) Unearned income was checked against the maximum allowable under Case 1 circumstances ("A"). If unearned income was greater than or equal to A, the individual or couple was defined as ineligible. (2) For those not eliminated by the first operation, maximum allowable earned income ("B") was calculated according to the equation B = $780 + [(A - Y) x.2]. (It is here that the Case 2 overstatement was created. If there is no unearned income, then A - Y = A, and this is multiplied by 2. However, A includes the $240 exclusion, which is thereby counted twice.) (3) The calculated maximum allowable earned income was checked against the actual earned income to determine eligibility. If earned income was less than or equal to B, the individual or couple was defined as eligible. Briefly,

(1) IF ($Y \geq A$), INELIGIBLE. STOP.

(2) IF ($Y < A$), COMPUTE B = $780 + [(A - Y) x 2].

(3) IF ($X > B$), INELIGIBLE. STOP.

IF ($X \leq B$), ELIGIBLE. CONTINUE.

ESTIMATING ELIGIBILITY UNDER TEXAS WELFARE STANDARDS WITH A "SPEND DOWN" PROVISION

Estimates of eligibility under a "spend down" program were made utilizing Texas welfare standards in effect in January 1972. Eligibility totals for two separate groups were estimated:

- the fully covered group - persons eligible under Texas' January 1972 standards, and
- the spend-down group - persons eligible under Texas standards only when medical expenses were deducted from incomes.

1972 Texas Welfare Standards for Adults

Texas standards are different in several respects from those of the SSI program. Under Texas standards, the minimum age for eligibility in the adult programs is 18. Thus, categorical blind and disabled persons were not counted in the "spend down" analysis if less than 18 years of age. Texas standards also consider children in the eligibility determination process. Two eligibility and grant determinations are made - one considering only the categorical person and spouse (if any) and their incomes, with the second determination including any children and their incomes. Therefore, the eligibility estimation program for Texas standards considered children or grandchildren under 21 who were not in another subfamily or categorically eligible in their own right.

Income limits for welfare eligibility in Texas also vary among categories, unlike SSI standards. Because of these categorical differences, as well as the greater attention paid to individual circumstances in the "standard budgets" of Texas programs, determination of maximum allowable income under Texas standards is much more complex than under SSI limits. Shown below are the standard budgets and income exclusions used in the program for each category of non-nursing home individuals. The budgets are reduced by a percentage control factor set to reflect the amount of welfare funds available.

Individual Standard (Annual)

	OAA	ANB	APTD
Personal needs	$ 876	$ 840	$ 840
Shelter	396	396	396
Utilities	156	156	156
TOTAL	$1,428	$1,392	$1,392
For ineligible spouse add:	$468	$468	$468
For eligible spouse add:	$876	$840	$840
For each child under 18/over 18 add:	$300/$468	$300/$468	$300/$468
Percentage control factor	100%	95%	95%

Income Exclusions:

OAA - First $90, any type. Of earned, first $240 and 1/2 of next $720. Work expense allowance of $168 (if part time) or $336 (if full time).

ANB - Of earned income, first $1,020, and 1/2 the remainder.

APTD - None.

Determining Eligibility Under 1972 Texas Standards

The Fully Covered Group. The general procedure of the computer algorithm for determining eligibility under Texas standards followed that of the SSI program, although many more adjustments were necessary both in calculating the appropriate income limit and in netting income for persons being tested against the standards. Different maximum allowable incomes were utilized for individuals, couples and dependents in each category - all based on the table above. Personal incomes were netted (with adjustments for applicable exclusions) as follows:

- For aged persons, $240 and $360 ($720 x 1/2) were subtracted from earned income. If earned income was greater than $1,800, the full-time work expense allowance ($336) - or, if less than $1,800 but greater than $0, the part-time allowance ($168) - was subtracted from earned income. The $90 exclusion was subtracted from unearned

income; if there was no unearned income, it was taken from earned income. The two net income amounts then were summed to arrive at adjusted income.

- For blind persons, earned income was reduced by $1,020 and then divided in half. To this was added unearned income for the adjusted income total.

- For disabled persons, unearned and earned incomes were totaled.

In no case could a negative income be obtained. If an exclusion resulted in negative income, income was considered zero, and the remainder of the exclusion lost.

Eligibility determination procedures in the computer program were the same for all categories. To ascertain eligibility, each individual's maximum allowable income and his netted (or adjusted) income were compared. If income was less than or equal to the standard, the person was defined as eligible and tabulated in the fully covered group. If the individual was ineligible under this procedure but had children, a second comparison was made - with children's income added and maximum allowable income raised by $468 per child. Those with adjusted incomes less than or equal to this allowable income were added to the fully covered group.

The Spend-Down Group. For those individuals not eligible under either of the above procedures, a spend-down calculation was made. A medical expense was calculated for the individual (and another for the spouse if eligible) and then subtracted from adjusted income. A comparison with the appropriate maximum allowable income was made, according to which an individual became eligible if his income, less medical expenses, was less than the allowable. For each spend-down eligible, the difference between the maximum allowable income and his adjusted income was tabulated, representing the Medicaid program cost for that person.

Department of Public Welfare medical cost data were used to simulate incurred medical expenses for each person in the spend-down group.[1] A cumulative frequency distribution of medical expenses (including a cell for $0 expense, to allow for individuals who incur no medical expense) was used in the program, and a random number generator utilized to assign a medical expense to each individual. This procedure resulted in spend-down individuals receiving medical expenses in the same amounts and proportions as actually experienced in the categorically eligible populations.

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[1] *"Texas Medicaid Frequency Distribution of Payments, 07-01-71 to 06-30-72," Texas State Department of Public Welfare, June 21, 1973, Table 1A.*

The assigned expenses were inflated at a 4% annual rate (1.08 and 1.12 factors for 1974 and 1975) and then used in the eligibility determination procedure discussed previously.

The Nursing Home Group. Texas eligibility standards for nursing home patients are different from those for non-nursing home individuals and are the same for all three categories. If a nursing home patient was married and the spouse was categorically eligible, the spouse was considered a separate case, and their incomes were not totaled. However, if the spouse was not categorically eligible, incomes were summed and a $1,200 annual income exclusion was allowed the nursing home patient. Those nursing home patients ineligible by Texas welfare standards were assigned a medical expense and tested for eligibility in the spend-down group.

Because the Census sample of nursing home patients represented the typical patient group for the entire year, it was necessary to assume that all patients remained in the home for the entire year to avoid understating the caseload. Medical costs for the nursing home group of potential spend-down eligibles therefore had to reflect a full 365-day nursing home cost, as well as an average expense for other types of care. For each patient, a cost figure was obtained by summing two weighted averages:

- the average of Texas Medicaid vendor payment rates for the three levels of nursing home care, weighted by each level's share of the nursing home caseload (which produced an overall average for nursing home medical costs); and

- the average of hospital, professional care and vendor drugs claims from welfare nursing home clients in 1973, weighted by each type of claim's share of total claims.

The vendor payment averages for nursing home care were calculated directly from 1974 and 1975 figures, while the average claim for other medical costs was derived from 1973 Medicaid data inflated at a 4% annual rate.[1]

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[1] *Nursing home vendor payment rates were taken from "Budget Estimates 1974-1975," Texas Department of Public Welfare, Item 52-A-1. Weights were calculated from "A Statistical Profile of the Medical Assistance Program, September 1971 - August 1972," Texas Department of Public Welfare, November 1972. The weighted average of Medicaid claims for other types of care was derived from "Texas Medicaid Frequency Distribution of Payments, 07-01-72 to 05-31-73," Texas Department of Public Welfare, Table 1B.*

No adjustment was made to the income of nursing home patients other than the noneligible spouse allowance discussed above. The computer analysis tabulated all patients with net income below $300 per year (the Texas standard for nursing home patients) in the fully covered group. For individuals with income greater than or equal to $300, income was compared with the assigned medical expense figure. Those with less than $300 of income remaining after the subtraction of medical expenses were counted in the spend-down group, and their Medicaid costs were figured as the amount by which net income was pushed below the $300 figure.

APPENDIX B

METHODOLOGY FOR ESTIMATING MEDICAID COSTS UNDER "SPEND DOWN" AND "COVER ALL" ELIGIBILITY CRITERIA

This appendix discusses the methods used to estimate Medicaid costs based on the estimates of eligibility derived from Census data (as described in Appendix A). A number of adjustments to eligibility and cost data were made in the course of the analysis, some of which applied to both the "cover all" and the "spend down" program data. These are described in the initial section of this appendix. Separate sections are devoted to explaining the derivation of costs for Medicaid programs utilizing "cover all" and "spend down" eligibility criteria.

GENERAL DATA ADJUSTMENTS

Participation Rates

Historical experience indicates that not all those eligible for welfare programs will participate. Thus, estimates of the number of persons eligible for Medicaid benefits under both the "cover all" and "spend down" programs had to be reduced to reflect nonparticipation. For this purpose, a participation rate for Texas welfare programs in 1972 was derived and assumed to remain constant for the period of analysis. Estimates of the number of persons eligible under 1972 Texas welfare standards were derived from computer analysis of 1970 Census data adjusted to April 1972 conditions (of income and population). These eligibility figures were compared with actual welfare caseload data from April 1972 to produce the percentages of eligibles participating in welfare programs during that month.

For the aged and blind, the procedure yielded the following results:

AGED: 239,411 cases/516,900 eligibles = 46 3% participation;

BLIND: 3,830 cases/8,060 eligibles = 47.5% participation.

The Texas definition of disability for welfare purposes, until struck down by a federal court in May 1973, allowed only disabilities of such severity that the presence of another person was needed in performing the usual activities of daily living. A comparison of disabled caseloads per 1,000 population aged 18 to 64 for Texas and the U.S. as a whole (shown

below) indicates that the Texas rate has been less than half the national rate.[1] Assuming that this differential is due primarily to the restrictive Texas definition of disability, the historical participation rate would at least double under both the broader SSI definition and the court-ordered liberalization of the Texas definition. Thus, for the disabled the procedure was modified:

DISABLED: 28,025 cases/94,900 eligibles = 29.5% x 2 = 59.0% participation.

APTD Caseloads Per 1,000 Persons
Aged 18 to 64

	Texas	United States
1968	2	6
1969	3	7
1970	4	8
1971	4	9

Federal Matching

Medicaid program costs are borne in part by the Federal Government, in part by the State. The state-federal matching rate for 1974-1975 Medicaid programs in Texas is 36.47%-63.53%. Administrative costs of a "spend down" program would be matched at a 50%-50% rate. These rates were employed in the analysis to obtain State costs from total costs as calculated.

January 1, 1974 Program Change

The SSI program begins January 1, 1974 - four months into the State's Fiscal Year 1974. Adjustments to Medicaid caseloads and costs under both a "spend down" and a "cover all" criterion were made to reflect the four-month continuation of existing programs and the eight-month operation of the new Medicaid program in FY 1974.

DETERMINING THE COSTS OF A "COVER ALL" OR SSI-RELATED MEDICAID PROGRAM

To derive cost estimates for an SSI-related Medicaid program, SSI caseload and medical costs were estimated for each category of recipients (aged, blind and disabled) and then combined.

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[1] *Sources of data: (1) Texas - Caseloads from annual reports of The Texas Dept. of Public Welfare; population estimates from 1967 Governor's Committee on Public School Education. (2) United States - Calculated from Statistical Abstract of U.S., 1970, Tables 25 and 449, and 1972, Tables 34, 35 and 486.*

Caseloads were estimated from eligibility totals, adjusted for participation and other factors. Medical costs were derived from historical per capita Medicaid expenditures in Texas, and multiplied by caseload figures to obtain a total cost in each category.

Caseload Estimates for SSI

Reducing Eligibles to Participants. The basic adjustment necessary to produce caseload estimates from eligibility totals was a percentage reduction to account for nonparticipation. The population adjustments used to bring eligibility estimates based on 1970 data up to 1974 and 1975 (see Appendix A) resulted in eligibility totals for March 1 - the midpoint of the State's fiscal year; thus, the reduced totals represent a basic estimate of the average number of cases (or participants) in each category for FY 1974 and 1975.[1] Further adjustments were necessary for each year to derive a more accurate estimate of caseloads.

Adjustments for FY 1974. Three adjustments to the basic caseload estimation procedure were required for 1974. First, as mentioned earlier, welfare caseloads for the period September - December 1973 reflect current program standards rather than those of any new program. Provisions of PL 93-66 required two other adjustments: (1) effective July 1, 1974, SSI eligibility standards will be liberalized, creating larger eligibility totals; (2) current MAO ("medical assistance only") welfare recipients ineligible under SSI standards will be "grandfathered" into the SSI program. In order to produce final caseload estimates for FY 1974, then, the following operations were necessary:

- For September through December 1973 - public assistance caseload data from January and June 1973 were used to calculate an average monthly trend (increase or decrease), which was applied to June data in order to derive estimates of the September - December caseloads;

- For January through June 1974 - estimates of eligibles for FY 1974 were reduced by the participation rates to derive caseload estimates for the average month;

- For July and August 1974 - estimates of eligibles for FY 1975 under liberalized SSI standards were reduced by participation rates to derive monthly average FY 1975 caseload estimates, which then were averaged with FY 1974 caseload estimates (as derived for January - June 1974) to produce caseload estimates for these transition months in FY 1974;

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[1] *This assumes a uniform growth in cases throughout the months comprising the fiscal year.*

- For all of 1974 - monthly caseload estimates in each of the above segments of the fiscal year were added and divided by 12 to obtain an average monthly caseload, which was increased by the number of nursing home patients in the Census who were above SSI income standards but below Texas' MAO standard.

The calculations utilized in obtaining the adjusted FY 1974 monthly average SSI caseload are summarized below:

Segments of FY 1974	Sum of Recipient/Months in Each Segment*		
	Aged	Blind	Disabled
Sept. - Dec. 1973	878,402	15,264	133,006
Jan. - June 1974	1,525,200	25,080	489,000
July - August 1974	522,300	8,408	165,800
Total recipient/months*	2,925,902	48,752	787,806
Dividing by 12 to derive monthly average caseload:	243,825	4,063	65,651
Adding covered MAOs	6,042	20	212
Adjusted monthly average caseload	249,867	4,083	65,863

**That is, the number of welfare cases in September, plus those in October, plus. . ., adding to an annual sum for averaging purposes*

Adjustments for FY 1975. Estimating SSI caseloads for FY 1975 was much simpler. Eligibility totals (based on SSI income standards as modified by PL 93-66) were reduced by participation rates to obtain a monthly average caseload, to which "grandfathered" MAO cases were added. The procedures for FY 1975 are shown below:

	Aged	Blind	Disabled
SSI eligibles	579,000	8,900	142,800
Participation rates	.463	.475	.590
Monthly average caseloads	268,077	4,228	84,252
Adding covered MAO's	6,042	20	212
Adjusted monthly average caseloads	274,119	4,248	84,464

State Expenditures Under a "Cover All" Medicaid Program

Projected Medicaid expenditures for the 1974-1975 biennium under a "cover all" program were calculated by multiplying per capita costs by estimated SSI caseloads. The procedures and results are summarized below.

Deriving Per Capita Costs. Per capita Medicaid costs for SSI recipients were derived from FY 1972 Medicaid costs for welfare recipients in the adult categories. Medicaid expenditures during the State's FY 1972 for services to adult recipients - including nursing home care, Blue Cross premiums, vendor drugs and medical assistance to patients in State institutions (called the "four items" below) - were divided by the average monthly welfare caseloads to obtain a per capita Medicaid expenditure for these four items.[1] The figures obtained were reduced by the 1974-1975 federal matching ratio (to allow comparability between 1972 and 1974-1975 State per capita costs), producing 1972 State per capita costs. These costs then were adjusted to allow for the rise in medical costs; a 4% annual increase was used for the blind and disabled categories, while 10% was used for the aged, whose Medicaid costs historically have risen more quickly than those of the other categories. To the 1974 and 1975 costs thus derived were added the State's share of Medicare SMIB premiums ($27.57 and $29.76, respectively).[2] The calculations are summarized below:

	Aged	Blind	Disabled
1972 Medicaid expenditures for 4 items	$188,787,277	$4,047,629	$38,971,556
1972 monthly average caseloads	239,987	3,843	27,953
1972 per capita cost for 4 items	786.65	1,053.25	1,394.18
State share @ 36.47%	286.89	384.12	508.46
1974 State per capita cost	371.84	442.42	576.71
1975 State per capita cost	402.72	459.80	599.07

[1] *Sources: expenditure data from "A Statistical Profile of the Medical Assistance Program, September 1971 through August 1972," Texas Dept. of Public Welfare, pp. 6, 8, and 9; caseload data from Annual Report of Texas Dept. of Public Welfare for 1972, as amended by MAO caseload data obtained from the department.*

[2] *Calculated from Budget Estimates of the Texas Dept. of Public Welfare for 1974-1975.*

Total State Expenditures for 1974-1975. State outlays for Medicaid under an SSI-related program for the adult categories were calculated by multiplying the per capita costs by the adjusted SSI caseloads. The computations for each category, and for both years of the biennium, are shown below:

Category	Caseload	Per Capita Cost	Total Cost
1974			
Aged	249,900	$371.84	$ 92,923,000
Blind	4,100	442.42	1,814,000
Disabled	65,900	576.71	38,005,000
TOTALS	319,900		$132,742,000
1975			
Aged	274,100	$402.72	$110,386,000
Blind	4,200	459.80	1,931,000
Disabled	84,500	599.07	50,621,000
TOTALS	362,800		$162,938,000
		GRAND TOTAL, 1974-1975	$295,680,000

The Secondary Cost Effect of AFDC Transfers. The extension of SSI eligibility in the blind and disabled categories to children under 18 creates a secondary cost effect which will influence the total outlay of State funds under the SSI-related Medicaid program. Blind and disabled children currently in the AFDC welfare program who switch to the SSI program will represent no *new* medical expenditures, but rather a transfer of AFDC Medicaid expenditures to the adult programs. Because these children will receive federal SSI grants rather than state-federal AFDC grants, they also will bring about a savings in cash grants under the AFDC program. These savings must be considered in the overall comparison of "spend down" and "cover all" Medicaid programs.

Census records do not contain disability data for children under 14; therefore, in order to estimate the total under-18 disabled AFDC population a rough estimate procedure was employed. The ratio of disabled children 14-17 (found in the Census records) to the total population 14-17 was calculated and applied to the under-14 population, to derive an estimate of total disabled

children. Welfare department projections of AFDC children for 1974 were applied to the total under-18 population to obtain a ratio, which was multiplied by the total number of disabled children to produce an estimate of disabled AFDC children. These calculations are shown below:

1.	Children aged 14-17 (as estimated by 1967 Governor's Committee on Public School Education [GCPSE])	1,007,566
2.	Disabled children 14-17 (Census records)	16,500
3.	Ratio (#1:#2)	.0164
4.	Children aged 0-13 (as estimated by GCPSE)	3,180,638
5.	Disabled children 0-13 (#3 x #4)	52,162
6.	Total disabled children (#2 + #5)	68,662
7.	AFDC children, 1974 (derived from DPW Budget Estimates)	354,278
8.	Ratio AFDC:total children (#7:[#1 + #4])	.0846
9.	Disabled AFDC children (#6 x #8)	5,809

Savings in AFDC cash grants - assuming the transfer of *all* disabled children to SSI - were calculated from 1974-1975 average grant per child figures derived from Welfare Department Budget Estimates (the 1974 figure was reduced to account for the 8-month SSI operation in that fiscal year). The results were as follows:

		1974	1975
1.	Average AFDC grant per child, including caretaker (derived from DPW Budget estimates)	$88	$132
2.	Total disabled AFDC children (as derived above)	5,809	5,809
3.	State cost savings from transfer of all disabled children to SSI (#1 x #2)	$511,192	$766,788

The reduction in Medicaid expenditures for the disabled due to the transfer of 5,809 recipients from AFDC was calculated by multiplying State per capita Medicaid costs for the disabled (as derived earlier, but with 1974 costs reduced for the 8-month program operation) by the number of transferring children, yielding:

	1974	1975
Total disabled AFDC children	5,809	5,809
State per capita Medicaid cost	$386.40	$599.07
Reduction in Medicaid costs	$2,244,598	$3,479,998
Adding AFDC cash grant savings:	511,192	766,788
Total "cover all" cost adjustment to account for AFDC transfers	$2,755,790	$4,246,786

The grand total of approximately $7 million can be deducted from the SSI estimate to reflect the secondary cost effects of the transfer of disabled children from AFDC to the SSI program, resulting in the following modifications of the figures on Page B-6, above:

	1974	1975
Net State Medicaid expenditures for the disabled	$ 35,249,000	$ 46,374,000
Net total State Medicaid expenditures	129,986,000	158,691,000
Grand Total Medicaid Expenditures, 1974-1975	$288,677,000	

The same type of adjustment potentially could occur in the blind category; however, no estimate was made because (1) the incidence of blindness in the young is apparently lower than among older persons, allowing little basis for estimation; (2) the blind population is small, making sampling error quite large and overall cost impact rather slight.

DETERMINING THE COSTS OF A
"SPEND DOWN" MEDICAID PROGRAM

Cost estimates for a "spend down" Medicaid program were derived by projecting caseloads and costs for three groups of recipients, plus the numbers of employees and costs of administering State standards under such a program. Methods used to obtain these figures are discussed below.

Caseload and Cost Estimates for the Fully Covered Group of Recipients

Under a "spend down" Medicaid program, full medical coverage would be given to those who met January 1972 welfare standards. Computations for caseloads and medical costs for this group were essentially similar to the procedures already described for obtaining SSI caseloads and medical costs under a "cover all" program.

Caseloads. Monthly average caseloads for each category of recipients during the State's Fiscal Year 1974 were derived from two components: (1) caseloads for September through December 1973, under current program standards; and (2) caseloads for January through August 1974, under 1972 program standards. Caseloads projected for September - December 1973 were the same as utilized for those months in the analysis of an SSI-related program. Estimates of the numbers of aged, blind and disabled persons eligible under 1972 standards were reduced by participation rates to derive caseload projections for January - August 1974. These components were averaged together to produce monthly average caseloads for FY 1974. Calculations are summarized below:

Segments of FY 1974	Sum of Recipient/Months in Each Segment*		
	Aged	Blind	Disabled
Sept. - Dec. 1973	878,402	15,264	133,006
Jan. - Aug. 1974	1,856,448	28,880	452,176
Total recipient/months*	2,734,850	44,144	585,182
Dividing by 12 to derive monthly average caseload:	227,904	3,679	48,765

**That is, the number of cases in September, plus those in October, plus. . ., adding to an annual total for averaging purposes.*

To derive FY 1975 monthly average caseloads for the fully covered group, estimates of eligibles simply were reduced by the participation rate appropriate to each category.

Medical Costs. State Medicaid expenditures for the fully covered group were projected in the same manner as expenditures for SSI recipients under a "cover all" program. Per capita State Medicaid costs were those used for the SSI-related program, with one exception. Under the "spend down" program, MAO recipients from the current Texas programs would continue to be eligible for Medicaid - but eligibility would be due to the spend-down mechanism. Costs for MAOs therefore should not be mingled with those for the fully covered group. Since over 90% of these recipients are nursing home patients in the aged category, per capita costs for the fully covered group of aged recipients were reduced to remove expenditures for MAOs. Excluding MAO nursing home costs, 1972 Medicaid expenditures for the "four items" (see above, Page B-5) totaled $113,295,477.[1] This figure was divided by the 1972 monthly average public assistance caseload of 211,391,[2] producing a per capita cost of $535.95. The 1972 per capita State Medicaid cost for the aged group which would be fully covered under a "spend down" program thus was estimated at $195.46 (per capita cost reduced by 1974-1975 federal matching rate). Adjusting this cost by the inflation rate and SMIB premium cost (as for "cover all" costs), FY 1974 and FY 1975 State per capita costs of $262.12 and $287.77 (respectively) were obtained.

Thus, for the fully covered group of aged recipients in FY 1974, total State Medicaid cost was the sum of (1) the September - December 1973 average caseload at a $371.84 annual cost, and (2) the January - August 1974 average caseload at an annual cost of $262.12. The calculations were:

$$([878{,}402 \div 4] \times [\$371.84 \times .33]) + ([1{,}865{,}448 \div 8] \times [\$262.12 \times .67]) = \$67{,}973{,}095$$

For the blind and disabled, total State Medicaid costs were the product of a single per capita cost and the monthly average caseload for the entire fiscal year. State Medicaid costs for 1974-1975 in each category are shown below:

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[1] *This figure is adjusted to account for the fact that a higher proportion of nursing home patients in Census data fell below 1972 Texas welfare standards than were reflected in the actual 1972 ratio of public-assistance nursing home recipients to total nursing home recipients of Medicaid. This upward adjustment of $9,244,875 was necessary to avoid understatement of nursing home care expenditures in the projections for 1974 and 1975.*

[2] *Welfare recipients plus patients in State institutions receiving medical assistance.*

----------1974----------

Category	Caseload	Per Capita Cost	Total Cost
Aged	227,900	$371.84/262.12	$67,973,000
Blind	3,700	442.42	1,637,000
Disabled	48,800	576.71	28,143,000
TOTALS	280,400		$97,753,000

----------1975----------

Category	Caseload	Per Capita Cost	Total Cost
Aged	237,100	$287.77	$ 68,230,000
Blind	3,200	459.80	1,471,000
Disabled	57,700	599.07	34,566,000
TOTALS	298,000		$104,267,000
		GRAND TOTAL, 1974-1975	$202,020,000

Aged, blind and disabled individuals not meeting 1972 State welfare standards might nevertheless become eligible for Medicaid under a "spend down" program. Because of the particular features of the Census data, persons above 1972 standards were divided into two groups for purposes of estimating caseloads and costs.

Caseload and Cost Estimates for the Non-Nursing Home Spend-Down Group of Recipients

In the computer analysis of Census data, certain individuals became eligible for Medicaid under 1972 Texas standards only when medical expenses were deducted from income (see Appendix A). For those in this group who were not nursing home patients, eligibility totals by category were reduced by the appropriate participation rates to arrive at spend-down caseloads for each year of the biennium.

Medicaid costs for each individual in this spend-down caseload consisted of those medical expenses remaining after income had been reduced below 1972 standards. The total of all such medical expenses was accumulated for each category in both years. To obtain estimates of State Medicaid costs, it was necessary to reduce these totals (1) by participation rates for eligible persons

(which assumed that medical expenses can be apportioned in the same manner as participation); (2) by the federal matching ratio for Medicaid in 1974-1975; and (3) for 1974, by .67 to account for the 8-month period of program operation in that fiscal year. Costs per participant were calculated from the results of these procedures to give some perspective to the costs derived in the analysis. Figures are shown below:

----------1974----------

Category	Eligibles	Caseload	State Cost	Cost Per Capita
Aged	53,000	24,500	$ 7,084,000	$289.14
Blind	1,200	6,600	209,000	348.33
Disabled	14,000	8,300	3,962,000	477.34
TOTALS	68,200	33,400	$11,255,000	

----------1975----------

Category	Eligibles	Caseload	State Cost	Cost Per Capita
Aged	50,800	23,500	$12,845,000	$546.60
Blind	1,300	600	289,000	481.67
Disabled	12,800	7,600	5,373,000	706.97
TOTALS	64,900	31,700	$18,507,000	

GRAND TOTAL, 1974-1975 $29,762,000

Caseload and Cost Estimates for the Nursing Home Spend-Down Group of Recipients

Medicaid caseloads for nursing home patients becoming eligible through the spend-down procedure consisted of *all* nursing home patients in the Census data who were determined eligible by the computer analysis. This was done for two reasons: (1) a comparison of Census estimates of eligibles and actual nursing home patient data indicated that participation among eligible nursing home clients borders on 100%; and (2) a slight nursing home undercount in the Census data was evident.

State Medicaid costs were derived by reducing total medical costs produced in the computer analysis (i.e., the total of all nursing home patient costs remaining after individual incomes

were reduced below State standards) to account for federal matching and for 8 months of program operation in FY 1974. Per capita costs were derived from caseload and total cost results.

Caseload and cost figures as derived are shown below. It should be noted that the understatement of nursing home caseloads evident in these data is offset in the analysis by two factors: (1) an overstatement of nursing home patients in the fully covered group by Census data, especially in the aged category (due perhaps to understatement of income by respondents, as well as other factors which might bear on eligibility but are not included in the Census); and (2) an overstatement of per capita costs for the fully covered groups of blind and disabled recipients, due to the lack of an adjustment for loss of MAOs to the spend-down caseload.

----------1974----------

Category	Cases (Eligibles)	State Cost	Cost Per Capita
Aged	27,000	$22,863,000	$846.78
Blind	20	13,000	650.00
Disabled	1,100	883,000	802.72
TOTALS	28,120	$23,759,000	

----------1975----------

Category	Cases (Eligibles)	State Cost	Cost Per Capita
Aged	27,600	$36,954,000	$1,338.91
Blind	20	22,000	1,100.00
Disabled	1,100	1,427,000	1,297.27
TOTALS	28,720	$38,403,000	
GRAND TOTAL 1974-1975		$62,162,000	

Costs for Administration of State Eligibility Standards

Administrative costs for a "spend down" program were derived from caseload estimates and administrative policy regarding staff levels, together with cost data provided by the Budget Office of the Texas Department of Public Welfare.

Personnel. Personnel requirements for the department were estimated by applying estimated "spend down" caseloads for each year to departmental staffing ratios (adjusted as described in Chapter II above, to one caseworker per 400 cases, one clerk per 1.3 caseworkers, one supervisor per 10 caseworkers, and one program director per 7.6 supervisors). The resulting personnel requirements are shown below:

	1974	1975
"Spend Down" Caseload	341,920	358,420
Caseworkers	855	896
Clerks	658	689
Supervisors	86	90
Program Directors	11	12
Total Personnel Required	1,610	1,687

Salary Costs. Estimates of 1974 average salary for each type of employee were supplied by the Budget Office. Salaries for 1975 were interpolated from the 1975 State classified salary schedule, based on 1974 salaries. The resulting salary costs per employee were:

Type of Employee	1974 Salary	1975 Salary
Caseworker	$ 8,821	$ 9,117
Clerk	5,808	6,000
Supervisor	11,136	11,512
Program Director	13,248	13,692

Total salary costs were estimated by multiplying salaries by numbers of personnel required, with adjustments for the state-federal matching ratio of 50%-50% and for the 8-month operation of the program in State FY 1974. Net State salary costs are shown below

Type of Employee	1974	1975
Caseworker	$2,527,000	$4,084,000
Clerk	1,280,000	2,067,000
Supervisor	321,000	518,000
Program Director	49,000	82,000
TOTALS	$4,177,000	$6,751,000

Support Costs. The Budget Office estimated $2,000 per employee in overhead expenses for FY 1974, including such costs as consumable supplies, travel, equipment, office space, and

State-paid employee medical insurance. This figure was inflated by 4% to derive overhead expenses for 1975. As in calculating salary costs, the 1974 figure was adjusted to account for 8 months of program operation, and both 1974 and 1975 figures were reduced for federal matching. Adjusted per employee support costs multiplied by numbers of personnel are shown below:

Type of Employee	1974	1975
Caseworker	$ 573,000	$ 932,000
Clerk	441,000	717,000
Supervisor	58,000	94,000
Program Director	7,000	12,000
TOTALS	$1,079,000	$1,755,000

Total "spend down" administrative costs were calculated as the sum of salary and support costs:

Type of Employee	1974	1975
Caseworker	$3,100,000	$5,016,000
Clerk	1,721,000	2,784,000
Supervisor	379,000	612,000
Program Director	56,000	94,000
TOTALS	$5,256,000	$8,506,000

Total "Spend Down" Program Costs

Total expenditures for a "spend down" program would be the sum of medical and administrative costs, as shown below:

	1974	1975
Medical costs:		
fully covered group	$ 97,753,000	$104,267,000
non-nursing home spend-down group	11,255,000	18,507,000
nursing home spend-down group	23,759,000	38,403,000
Total, medical costs	$132,767,000	$161,177,000
Administrative costs	5,256,000	8,506,000
TOTALS	$138,023,000	$169,683,000
GRAND TOTAL, 1974-1975	$307,706,000	

Repaired 3/18/85

197[illegible] BOARD OF DIRECTORS

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Sears, Roebuck & Company
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TeleCom Corporation
Georgetown

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The Fort Worth National Bank
Fort Worth

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Texas Research League

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BEAUMONT

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PAUL R. HAAS, Oil, Gas & Investments

DALLAS

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EUGENE C. ZORN, JR., Senior Vice President & Economist, Republic National Bank of Dallas

EDINBURG

DO[illegible] L. BENTSEN, President, Tide [illegible]ducts, Inc.

[illegible]SO

[illegible] LANE, President, El Paso Electric [illegible]mpany

SAM D. YOUNG, JR., President, El Paso National Bank

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*BERL E. GODFREY, Attorney, McGown, Godfrey, Decker, McMackin, Shipman & McClane

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GROGAN LORD, Chairman of Board, TeleCom Corporation

GRAHAM

*E. BRUCE STREET, Independent Oil Operator

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RALPH McCULLOUGH, General Manager, J. S. Abercrombie Interests

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STEWART ORTON, President, Foley's

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LONGVIEW

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LUFKIN

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*TOM SEALY, Attorney, Stubbeman, McRae, Sealy, Laughlin & Browder

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MT. PLEASANT

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PAMPA

E. L. GREEN, JR.

POINT COMFORT

ERVIN L. WAHLSTEN, Operations Manager, Aluminum Company of America

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SAN ANTONIO

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FRED W. SHIELD, Independent Oil Operator

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SILSBEE

R. M. BUCKLEY, President, Eastex Incorporated

TYLER

WATSON W. WISE, Investments

JOSEPH ZEPPA, President, Delta Drilling Company

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P. K. STUBBLEFIELD, President, Victoria Bank & Trust Company

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HARRY PROVENCE, Editor-In-Chief, News-Tribune

WICHITA FALLS

JOE B. WOLVERTON, President, The First-Wichita National Bank

[illegible]e Life Members of the Board, having served as League Chairmen. As such, they are ex officio members of the Executive Committee. Mr. [illegible]as elected a Life Member of the Board on his retirement December 31, 1969, following 17 years as Executive Director of the Texas Research