87th Congress
2d Session

COMMITTEE PRINT

PERFORMANCE OF THE STATES

EIGHTEEN MONTHS OF EXPERIENCE WITH THE MEDICAL ASSISTANCE FOR THE AGED (KERR-MILLS) PROGRAM

A REPORT

TO THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

JUNE 15, 1962

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE
84903 WASHINGTON : 1962

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LETTER OF TRANSMITTAL

To Members of the Special Committee on Aging:

Submitted herewith for the consideration of the members of the Special Committee on Aging is a staff report which evaluates the program of Medical Assistance for the Aged enacted in 1960 and generally referred to as the Kerr-Mills Act.

This evaluation is based on the first 1½ year's operation of the Kerr-Mills program. It supplements and updates a previous staff report published in June 1961 which evaluated the implementation of the Kerr-Mills program through March 31, 1961.

In preparing this report, I instructed the staff to compare and evaluate the actual accomplishments of the Kerr-Mills MAA program against two yardsticks:

(1) The hopes and expectations of the Congress when it enacted the legislation to be effective in October 1960; and

(2) The claims that have been made both before and after the Kerr-Mills program was enacted, with particular reference to recent statements on its effectiveness.

The analysis shows quite conclusively that, measured against anticipated results, Kerr-Mills has fallen considerably short of the goals set by its more optimistic proponents. In fact, after 18 months, less than one-half of the States have the Kerr-Mills program of Medical Assistance for the Aged in operation.

This situation arises not through any lack of good faith or good intentions but because of weaknesses inherent in this legislative approach which prevent it from being a significant weapon in meeting the medical requirements of America's elderly.

Indeed, a careful reading of the following report makes it obvious that Kerr-Mills—by itself—cannot be expected to meet these requirements either now or in the years to come.

A program of hospital and related insurance benefits under social security should make it financially feasible for all the States to implement the Kerr-Mills MAA program. The two programs together would provide the broad base of financial assistance that would help assure older Americans independence, dignity, and security in their retirement.

PAT MCNAMARA,
Chairman, Special Committee on Aging.

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Intent of Kerr-Mills Act

The Kerr-Mills Act has two facets—one representing a relatively minor improvement in an already existing program of aid for people on relief—and the other representing a major innovation.[1] The primary purpose and feature of Kerr-Mills was the establishment of a new category of public assistance—medical assistance for the aged. This program, Kerr-Mills MAA, offered an opportunity for the States to secure substantial Federal grants applicable toward meeting the medical expenses of older citizens who had previously been ineligible for help—the "medically indigent" aged. The "medically indigent" are those persons not on relief who, presumably, have sufficient resources to meet their ordinary living expenses but who are unable to cope with the costs of medical services.

It was the intent of Congress that the MAA program would result in providing broad medical services to the many aged needing such help but ineligible or unwilling to apply for relief.

Achievement of such a goal would require that (1) all States establish an MAA program which (2) would include a comprehensive range of medical services consistent with the needs created by the chronic health conditions faced by the aged with (3) eligibility requirements determined on the basis of their medical costs, income, and health conditions and (4) with its benefits made available without humiliating or degrading our older people.

Based upon the evidence available after 1½ years of Kerr-Mills operation, the congressional intent has not and will not be realized.

Limited Use of Act

Only 24 States and three territories, as of June 1, 1962, had operating programs under MAA.[2] All States have had an opportunity to consider Kerr-Mills. All indications are that any new MAA programs will be few and far between.

All States are not capable of financing MAA programs. At least five States—Florida, Missouri, Ohio, Rhode Island, and Wyoming—have pointed to the potential cost as the principal reason for their not establishing MAA programs. More than 2 million Americans aged 65 and over live in these five States alone. An additional 5 million older people live in the other 21 States and the District of

[1] Since 1950 the Federal Government has assisted the States with funds to be used toward payments to suppliers of medical care for people on relief. The first part of the Kerr-Mills Act simply increased the amount of Federal funds available for this purpose.

[2] It is sometimes claimed that 38 States are participating. The 24 States and 3 territories which have MAA programs in operation are: Alabama, Arkansas, California, Connecticut, Guam, Hawaii, Idaho, Illinois, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New York, North Dakota, Oklahoma, Oregon, Pennsylvania, Puerto Rico, South Carolina, Tennessee, Utah, Virgin Islands, Washington, West Virginia.

Columbia which do not have MAA programs in operation—a total of 7 million in 26 non-MAA States.

Many States cannot or do not now finance adequately what they themselves say are the basic needs (not including the health needs) of those of their citizens who are on relief. Certainly those States cannot or will not be expected to adequately finance health services for a new group neither on relief nor eligible for it.

Only 88,000 aged persons received MAA help in March 1962—one-half of 1 percent of the Nation's elderly citizens. Thousands of these people had received care or were eligible for care under relief programs existing before enactment of Kerr-Mills.

Further, as a result of the means tests in those States which have MAA programs, the number of people who can receive help is severely limited.

The Means Test

Every State with an MAA program requires an applicant to submit to a means test—an investigation of his income and assets. The means test is the basis of all relief programs. In most States, the tests, apart from any degrading qualities, exclude from help many of the aged who are desperately in need of assistance. There are at least 15 States in which the means test for MAA would serve to eliminate even those people who qualify for relief in those States.

Twelve States have "family responsibility" provisions which, in effect, also impose means tests upon the relatives of those who might be tempted to seek aid from the MAA program.

Nine States—including those with, by far, the largest number of people receiving help under Kerr-Mills MAA—have recovery provisions in their programs extending to the homes of people receiving help, and collectible after death. This committee's hearings have shown us that Americans now of retirement age equate "free and clear" ownership of one's home with self-respect. The idea of a State taking a claim on that home is completely unacceptable to them.

Freedom of Choice Restricted

Even those relatively few aged persons who are declared eligible for some help under MAA frequently find that they cannot get the care they need and in some cases that they cannot get care from the doctors of their own choice.

Many of the MAA programs, in fact, contain explicit and implicit limitations affecting the quality of care provided, the patient's freedom of choice, and the doctor's freedom to treat his patients in an individual way. All of the foregoing are affected by the relative willingness of hospitals and physicians to negotiate and accept MAA payments—which are often below the "going" rates. In one State, doctors were on the verge of refusing to care for MAA patients because the State found it necessary to reduce fees paid. In the same State, doctors were demanding the right to charge the MAA patient a fee in addition to that paid by the State. In another State, some hospitals were restricting the number of MAA patients they would admit. At least four of the jurisdictions with MAA programs require that services can only be secured from specified physicians or facilities.

As a practical matter, the failure of many jurisdictions to cover in-hospital physicians' services means that a large percentage of MAA beneficiaries must depend upon the services of hospital and clinic staff doctors.

Limitations on Benefits

The States often sharply limit their programs in terms of types of care provided, the duration or quantity of services supplied, in addition to specifying that benefits will be available only for certain kinds of illness or injury. One State provides only 6 days of hospital care and only if the applicant for MAA has an "acute, emergency, or life-endangering condition"; another State affords 10 days of hospital care per year if the person concerned is suffering from "acute illness or injury," and only after the aged individual has paid the first $25 of hospital charges.

Only 3 States—Hawaii, Massachusetts, and North Dakota—of the 24 with MAA programs in operation, have plans which meet the Department of Health, Education, and Welfare's definition of a comprehensive medical care program.

Where nursing home care is provided, the payments are often no more than enough to provide a poor quality of custodial care, and are totally insufficient to pay for any skilled nursing care. MAA funds were and are intended to purchase medical care. In these cases they are being used for an altogether different purpose.

In some States, the medically indigent person is required to make cash contributions from his meager resources toward the cost of care. Occasionally, he must make such payments before he can even qualify for MAA help. Such provisions are contradictory and self-defeating.

Uneven Distribution of Federal Funds

While the formula under which Federal grants are made to the States was intended by Congress to favor the States with low per capita incomes—where needs are greatest—in actual practice, a few wealthier States are getting the lion's share of MAA funds. Some of the States with the lowest per capita incomes in the Nation are, in effect, contributing toward the cost of MAA programs in the wealthier States—while their citizens receive in some cases, nothing, in others relatively little in return. Almost 90 percent of all MAA payments are being made in just four States—California, Massachusetts, Michigan, and New York. One hundred percent of the States must contribute to the program's support.

From the inception of MAA through March 1962 Federal and State expenditures under the MAA program totaled $167 million. Not even this thoroughly inadequate sum represents new expenditures for a new program. MAA money is being used to pay for care, previously provided under relief programs, for tens of thousands of people who were already on relief. It was not the intent of Congress when it authorized MAA that new Federal funds be used to relieve States and communities of a responsibility they had already accepted. Congress intended that this help be extended to an entirely new group of citizens—not to those already on relief. Congress offered to assume the major share of a new responsibility in the belief that the States would be eager to assume the rest.

High Administrative Costs

MAA's unavoidable administrative expenses constitute a substantial drain upon the limited resources of the States, which might otherwise be devoted to purchasing medical care. In one State, such expenses amounted to $1.24 for each dollar that was actually spent on medical care. In another State, these expenses were 64 cents for each dollar of medical benefits provided. Those States which have the highest costs for administration are the States which can least afford the expense—those with very low per capita incomes. The Federal Government pays only 50 percent of the costs of administration while it may pay as much as 80 percent of the dollars going for actual medical care. Thus, only a relatively small portion of a State's funds may go for medical care while a substantially greater amount may have to be allocated to administrative costs.

It costs a great deal of money to run a program with complex limitations on eligibility and benefits. Very careful "screening out" is required under such circumstances. In essence, simple and inexpensive administration is an impossibility in those States which cannot afford to offer comprehensive MAA programs with liberal requirements for eligibility—the very States whose older people have the lowest incomes and the greatest need for care.

A year and a half of experience indicates clearly that the strained financial resources of the States—and the competition for those funds by other pressing public needs such as education, housing, roads, and so forth—make the well-intentioned aims of the Kerr-Mills legislation incapable of realization in all the States of the Union. It proves that Kerr-Mills cannot, of itself, solve that problem which our committee has found to be the most persistent and frightening one confronting millions of older people and their children in all parts of the country—the problem of assuring economic access to medical care for all our older people on a decent, self-respecting basis.

CHAPTER I

PERSISTENT AREAS OF CONFUSION

Almost since the inception of the Kerr-Mills program, there has been confusion—some purposeful, some accidental—concerning the number of States which have implemented the program; the number of aged who receive help; where the responsibility lies for promotion; whether a means test is required and a lien permitted; the cost and where it falls. These pervasive and persistent areas of confusion are considered here.

1. Number of States implementing Kerr-Mills

Much of the confusion in relation to the number of States which have put the Kerr-Mills Act into effect stems from failure to distinguish between the two facets of Kerr-Mills: (1) The new Federal-State program of medical assistance for the aged (MAA) and (2) increased Federal support of medical care for recipients of old-age assistance (OAA) under the basic vendor payment provisions enacted by the Congress in 1950.[1]

We are, in this report, concerned only with the Kerr-Mills MAA program. The other phase of Kerr-Mills represents only one of a series of congressional acts liberalizing Federal sharing in relief programs. It does not represent a new departure and did not purport to be part of a new program to resolve a basic problem in financing the health care of the aged.

The primary purpose and new feature of Kerr-Mills was the provision by the Federal Government of an opportunity for the States to secure substantial Federal grants applicable toward meeting the medical expenses of older citizens who had previously been ineligible for such assistance—the medically indigent aged. The extent to which this purpose has been achieved is the principal measure of the accomplishments of the Kerr-Mills legislation.

Here is the outstanding example of confusion regarding the basic purpose of Kerr-Mills. An article in the March 6, 1961, AMA News (published by the American Medical Association) stated that, at the time of writing, there were Kerr-Mills programs functioning in six States and two U.S. territories. Barely one month later (April 19), the American Medical Association sponsored a full-page newspaper advertisement heralding the newly available medical care program and simultaneously shifting to a new usage of the term "the Kerr-Mills law." The advertisement contained the statement that "It [Kerr-Mills] is now being put into operation in 46 States." This shift in terminology appeared to be related to the American Medical

[1] Three methods are employed to pay medical care costs of recipients of public assistance. (1) The "vendor payment" method consists of direct payments to hospitals, doctors and other suppliers of medical care; (2) the "money payment" method is a system whereby the monthly cash grant to the recipient for his basic living expenses includes an amount to be spent on his medical requirements; (3) the third method consists of a combination of the first two. The Kerr-Mills legislation applies only to expenditures made under the "vendor payment" method.

Association's desire to create the impression that the "States are moving ahead with surprising swiftness" in adopting MAA programs.

Illustrative of the free and easy interchangeable usage of the two very distinct aspects of the Kerr-Mills Act are the situations in Texas and Florida.

In Texas, a program was instituted, effective in January 1962, which provides hospital and surgical-medical services—to a limited extent—by means of a contract between the State and Blue Cross-Blue Shield; nursing home care is provided by means of direct payments to the suppliers of such care. This program was immediately hailed as a "model" implementation of Kerr-Mills. The essential fact, however, is that the model is defective. First, Texas has no MAA program. The present plan in Texas is applicable to OAA recipients only, with all the restrictions that this implies. It makes provision only for people on relief. No provision is made for those who are only medically indigent—those persons with whom we are primarily concerned in evaluating Kerr-Mills.

Secondly, the hospital benefits in Texas—even for people on relief—are severely limited. The OAA program provides for only 15 days of care with a maximum limit of $10 daily for room, board, and routine nursing services. Additional care may be provided beyond the initial 15 days when certified as necessary by a physician but then the Texas program will allow the hospital only $5 daily for additional days. Presumably, what this "model implementation of Kerr-Mills" makes available to OAA recipients is ward care—with the hospitals absorbing room, board, and nursing costs above $5 a day after the 15 days. Such programs are unfair to hospitals. They are also unfair to the paying patients who are compelled to help make up a portion of such deficits through payment of higher charges for their care.

Granted that the Texas program is progress of a sort for people on relief, it still does absolutely nothing to make assistance with the high costs of necessary medical care a reality for the medically indigent—those persons who were to be the prime beneficiaries of Kerr-Mills. The program in Texas is not and should not be included with those Kerr-Mills MAA programs which are intended to meet the needs of older people who are not on relief.

It is often implied that Florida has implemented Kerr-Mills. Florida does not, however, have a program of medical assistance for the aged. It is true that, like Texas and other States, Florida has a program which uses Kerr-Mills funds for people who are on relief. Excerpts from the testimony of Dr. Edward R. Annis, chairman, legislative committee, Florida Medical Association, before a hearing of the Senate Special Committee on Aging held in Fort Lauderdale, Fla., on February 15, 1962, are indicative of the manner in which pretense is made that a State has implemented Kerr-Mills and that no further Federal action is necessary:

> * * * Many have been misinformed and they have stated in Florida that there has been no implementation of Kerr-Mills. As you gentlemen from Washington know, Kerr-Mills has two different provisions; one for old-age assistance, those on relief, and the second to take care of the needy sick people * * *.
>
> We have a program in Florida now operating in its seventh year, one which was set up in 1955, after several years of research by the Florida Medical Association and in cooperation with legislators, and may I point out that this program, our medical aid for the needy sick in Florida long preceded any of this political entrance into the field of care for these people.

In Florida at the present time we have totally and completely implemented the old-age assistance portion of Kerr-Mills as is noted on page 4 of my statement that I filed with you. This is presently providing complete total medical and surgical care, including hospitalization, nursing home care and drugs.

The situation in Florida has frequently been presented in a misleading and confusing fashion. Florida does provide *some* medical care to people on relief. Florida does have a special State fund from which it makes payments for *some* medical care rendered to medically indigent persons, regardless of age. The State department of public welfare receives some of the money it uses for Federal-State OAA medical care from this fund and some by direct appropriation from the State legislature. The significant point is, however, that Florida has *failed*, "totally and completely," to accept the Kerr-Mills offer of assistance for the very many medically indigent old people in that State who lack the 5 years of residence required in Florida to even qualify for relief.

The principal reason for not having a Kerr-Mills MAA program in Florida is that the State cannot afford the expenditures required to provide medical care to all of its elderly people. It therefore restricts coverage to those who meet the strictest residence requirements possible under OAA. The State does not supply even these people with comprehensive medical care—despite the claim of "complete total medical and surgical care, including hospitalization, nursing home care and drugs." Florida's program for relief recipients affords 30 days of hospitalization per 12-month period—for acute conditions only. The program provides no coverage, whatsoever, for physicians' services. Despite the absence of any provision for such care in the OAA program, reference is made to "total medical and surgical care" as an integral part of Florida's plan. The reference can only relate to those services that may be provided by the medical staff of a hospital or to the "free" care that physicians may be willing to provide.

The confusion is still being perpetrated and perpetuated by the AMA. On May 21, 1962, an AMA spokesman stated in a nationwide television broadcast that: "The Kerr-Mills law has already been accepted by 38 States." People watching this program were undoubtedly expected to receive the impression that Kerr-Mills had made it possible for older people in all 38 States to get help under the act without going on relief. However, these are the facts. An AMA representative queried by the committee staff on the day following the broadcast said that the total of 38 States was apparently based upon a computation the AMA had made as of January 1962 which indicated 27 States under MAA and 11 States making some changes under OAA. (Included in the listing of 27 States that were noted as having "accepted" Kerr-Mills were Georgia, Iowa, and New Mexico. These States have, indeed, enacted MAA programs—but neither Georgia nor Iowa has a program in operation because funds have not been made available. New Mexico has withdrawn its plan.) Of the 11 States noted under OAA, it is true that three States—Indiana, North Carolina, and Ohio—expanded their OAA programs to include medically indigent aged not in need of money payment under OAA. But in these three States it must be recognized that this means that the aged person who is medically indigent, must go onto the relief rolls in order to receive any medical help and must satisfy, where applicable, residence requirements, be subject to current liens on his property and possibly see his name on a published list of people on

relief. All of these provisions are expressly prohibited in the MAA program of the Kerr-Mills Act.

Despite such marked distinctions in type and scope and content of programs, confusion will continue so long as individuals and organizations fail or deliberately refuse to differentiate between OAA relief programs and the program of medical assistance for the aged.

TABLE I.—*Activities of the 54 jurisdictions to put into effect the new program of medical assistance for the aged, June 1, 1962*

A. Programs in effect (27): [1]

Alabama	New Hampshire
Arkansas	New York
California	North Dakota
Connecticut (April)	Oklahoma
Guam (February)	Oregon
Hawaii	Pennsylvania
Idaho	Puerto Rico
Illinois	South Carolina
Kentucky	Tennessee
Louisiana	Utah
Maine	Virgin Islands
Maryland	Washington
Massachusetts	West Virginia
Michigan	

B. Plan submitted (not in effect): None.

C. Legislation enacted; plan not yet submitted (two States):
Vermont,[2] Virginia.[3]

D. Legislation in process to give basis for program or to provide appropriation (one State):
New Jersey.

E. No legislation (21):
1961 session adjourned without action:

Alaska [4]	Montana
Arizona [4]	Nebraska
Colorado	Nevada
Delaware [4]	North Carolina
District of Columbia	Ohio
Florida	Rhode Island
Indiana	South Dakota
Kansas	Texas
Minnesota	Wisconsin
Missouri	Wyoming

1962 session: Adjourned without action.
Mississippi.

F. Have authority for MAA; not expected to implement in 1961–62 (three States):
Georgia, enacted 1961; no funds available.
Iowa, enacted 1961; no appropriation.
New Mexico, plan withdrawn; no appropriation.

[1] Plans of these States are approved except Connecticut and Guam.
[2] Effective date expected to be July 1, 1962.
[3] Enacted in 1962; appropriation effective January 1, 1964.
[4] Do not have in operation vendor payment for medical care in OAA.

Source: Bureau of Family Services, Social Security Administration, Department of Health, Education, and Welfare.

There are still other instances of confusion as to just how many States have established MAA programs:

(1) Confusion may result from inclusion with the States of the three territories which have established programs—thus the Bureau of Family Service's report of June 1, 1962, indicates 27 States as having programs in effect, but this includes Guam, Puerto Rico, and the Virgin Islands.

(2) Confusion may also result from inclusion in the number of States with programs in operation of three States—Georgia, Iowa, and New Mexico—where enabling legislation exists but where either no funds were available or no appropriation had been made and where, therefore, no program is in effect.

(3) Another area of confusion which may result in a smaller total of States than are actually implementing MAA arises from limiting the total number of programs in effect to those States which had actually reported MAA payments for a given month. Other States may have had programs in operation but might not have reported payments for a given month.

The fact is that Guam, Puerto Rico, the Virgin Islands and 24 States had MAA programs functioning as of June 1, 1962.

2. Number of recipients

Reports issued monthly by the Bureau of Family Services of the Department of Health, Education, and Welfare show the total number of MAA recipients for the latest month for which data are available. In November 1960, with 3 States reporting, there were 11,806 MAA recipients. A year later, October 1961, the total had risen to 66,049 recipients in 16 jurisdictions. By March 1962, a year and a half after the inception of the program, the total was only 88,264 in the 24 jurisdictions reporting payments during that month. Of these 61,095 were in just 3 States—California, Massachusetts, and New York.

The 88,264 people helped constitute one-half of 1 percent of the Nation's aged population.

There is no current count of the total number of individuals who have benefited from the various MAA programs. A substantial percentage of the total of beneficiaries—especially those in nursing homes—appear in the count month after month. The earlier staff report of the Senate Special Committee showed an unduplicated total count of 27,482 different individuals as recipients during the period from October 1, 1960, through March 31, 1961. The total obtained by adding the number of recipients in each of the 6 months of this period, 85,000, is 3 times the unduplicated total of 27,482. This indicates the very substantial carryover from month to month.

Despite the heavy carryover from month to month, each newly released figure on the total number of recipients in a given month is sometimes misinterpreted as an addition to previous totals.

For example, the AMA News of April 17, 1961, stated: "A mid-March report from the Department of Health, Education, and Welfare showed some 14,800 persons received financial aid through the Kerr-Mills medical assistance for the aged program in December. Another 16,800 were helped in January." By referring to the January figures as "another 16,800," the item conveyed the impression that, in the 2-month period, more than 30,000 persons received medical assistance under the new program. The fact, however, was that a very large proportion of the persons who received medical assistance in December 1960 were long-term cases who continued to receive assistance in January 1961. The MAA program in Massachusetts alone accounted for 12,930 recipients included in the December total and 13,127 of those in the January total. As almost all of the beneficiaries of MAA in Massachusetts were nursing home cases transferred from OAA, the large majority of them were included in the totals of each of the 2 months.

The number of people listed as recipients of MAA benefits has also been misinterpreted as a count of the aged to whom medical care would have been unavailable were it not for the Kerr-Mills MAA program. This misconception is quite understandable in view of the intent of Kerr-Mills to establish MAA as a program for precisely such aged persons.

Actually, however, a substantial percentage of these people had previously received medical care under OAA—but were transferred to MAA (particularly in those States with high per capita incomes) so that their States could take advantage of the more favorable matching grants offered by the Federal Government under MAA. (See also p. 14.)

3. Responsibility for promoting MAA

There is a great deal of confusion about where the responsibility lies for promoting the MAA program—and as to how much promotion is proper.

The Department of Health, Education, and Welfare clearly has responsibility to assist the States in implementing the enabling legislation. Much of the Secretary's recent report to the Ways and Means Committee of the House of Representatives [2] relates to the Department's efforts to encourage the States to avail themselves of both the medical assistance for the aged program and the improved Federal participation in vendor medical payments for recipients of old-age assistance.[3]

But there are some who do not consider such efforts sufficient, and who seem to think that the administration has a responsibility for promoting the MAA program through a public information campaign. It has been implied on the floor of the Congress as well as elsewhere that the administration has been deliberately negligent in not informing the aged of the Nation that there is a medical care program on the statute books.

Typical of such criticism is a comment contained in the Congressional Record of March 19, 1962 (p. 4084), wherein reference is made to the Kerr-Mills legislation as an enabling act which makes it possible for the States to establish programs to keep people off relief:

> * * * You come before us and we, acting under this authority, take care of your medical bills so you can stay off relief. This is the message that the Secretary of Health, Education, and Welfare, Mr. Ribicoff, could be telling the people and the States.

Just what is the message that the Federal Government could take to all the aged of the Nation? To describe the MAA program that is theoretically possible under the Kerr-Mills legislation could not but mislead virtually all of our senior citizens—even in those few States with relatively comprehensive programs—and would be construed as a cruel hoax played upon the 7 million elderly in the 26 States and the District of Columbia which do not have MAA programs functioning.

We have had an OAA program for years. Would anyone contend that the Secretary was supposed to spend Federal funds urging people throughout the Nation to go on relief? Now that we have an MAA program in some States, is it his responsibility to urge older

[2] "Medical Care Under Public Assistance: October 1960 to October 1961" submitted under date of Mar. 15, 1962, to chairman, House Committee on Ways and Means.

[3] *Ibid.* Pt. II, "Action by the Bureau of Family Services to Secure and Publish Information," and pt. III, "Action by the Bureau of Family Services to Strengthen Administrative Effectiveness and to Develop Guides and Standards for Medical Care."

people throughout the Nation to seek medical care under it? Would this not be tantamount to bringing Federal pressure to bear on State legislators and, as such, would it not be deeply and properly resented?

Those who are potentially eligible for MAA benefits can only be informed in terms of a specific program in a specific State. And here, too, States have encountered difficulties when their informational activities were misinterpreted or when attempts to determine eligibility prior to actual need were regarded as "soliciting." West Virginia, for example, followed the practice of taking applications and determining eligibility before actual need developed. Subsequently, the State's department of welfare was charged by the West Virginia State Medical Association with trying to "sabotage" MAA. And in large part, the charge was based upon a complaint that employees of the department of welfare solicit people to come in and register under the program. When urging people to anticipate needs is called "sabotage" and when not urging people to sign up is also called "sabotage," confusion is indeed compounded.

4. The means test

There is real confusion as to whether the MAA program necessitates submission to a "degrading means test" or taking of a "pauper's oath."

There is no question concerning the intention of establishing MAA as a liberalization of public assistance medical care, designed to reach beyond the group of those eligible under old-age assistance, so as to encompass those persons with sufficient resources for their usual needs but not enough for medical costs. Each State is free, under the Kerr-Mills Act, to establish its own tests of eligibility for use in identifying individuals "whose income and resources are insufficient to meet the costs of necessary medical services."

While Kerr-Mills clearly sought to distinguish between the "indigent" and the "medically indigent," the means test, nonetheless, is an element common to both and any means test for MAA should be evaluated in this context.

Passing a means test is the basic requirement for eligibility under the public assistance relief approach. After a lifetime of independence and thrift, submission to the humiliation of a test of need is a painful experience for an aged person to accept—particularly when he is under the emotion and stress that accompany serious illness.

Underlining the major problems in the usage of means tests in MAA programs are the following excerpts from a speech delivered to the American Medical Association by Dr. C. H. Peters, councilor of the Sixth District Medical Society (inserted in the Congressional Record, Apr. 11, 1962, pp. A2777–A2778):

> * * * The "means test" is a second argument our opponents repeatedly throw at us. This is a more difficult, and politically a more formidable objection. It is said that this is one of the reasons that more individuals have not availed themselves of this program. The stigma of failure, of going on relief, often creates deep-rooted emotional bias on the part of the conscientious old individual. We have attempted to counter this feeling and argument by logic of one type or another. But logic frequently fails to sway individuals as all of you know from daily application in the practice of medicine.
>
> Before the public attitude can be changed, some members of the medical profession may have to change their own attitude.
>
> If the doctor himself looks down on assistance medical care, and upon the people who receive it, the public cannot be expected to accept this as anything but last-ditch aid.

* * * The AMA survey shows that in many States MAA is being considered as "just another welfare program," an OAA medical care program for a slightly higher income level. The applicant must go through the same routines, the same type of tests, the same type of investigations, and he receives his care through the same channels as the OAA recipient.

* * * Too stringent a means test can force the applicants to pauperize themselves past the chance of recovery before they can obtain aid. Rigid administrative methods developed to deal with the long-term needy can discourage applications for help. Lack of differentiation between the totally needy and the medically needy, and the way care is provided, can be so humiliating that many will not apply, except as a course of desperation, and again be unable to regain independence once the medical crisis has passed. * * *

Notwithstanding the intent of the Kerr-Mills Act, the decision as to whether MAA requires such tests must be made in light of the various tests of eligibility actually established by the States.[4]

It should also be noted that the tests of eligibility are not finished once the applicant has satisfied the initial requirements. In continuing cases, eligibility is determined anew, and with additional administrative expense, either within 1 year of the previous determination, or each time medical care may be required.

Clearly, those States—at least 15—which utilize more inflexible tests of financial eligibility under MAA than they do under OAA (see p. 18) have not achieved the purpose of the Kerr-Mills Act. These States and others make meaningless such claims as the following:

> This act would take care of any older person who was in need because of medical expenses and the medical cost would be covered 100 percent—not just 25 percent as in the King-Anderson bill. Now was this act imposing a degrading means test on the older people? Just the opposite. (The Congressional Record, Mar. 19, 1962, p. 4086.)

This argument was effectively answered by Mr. Holland, of Pennsylvania, who introduced into the Congressional Record eight of the most lengthy, involved, and obviously embarrassing questionnaires and affidavits used in establishing eligibility for MAA in Pennsylvania.[5]

Pointing out that the "welfare clause" in the constitution of the State of Pennsylvania is a provision which previous efforts have been unsuccessful in changing, Mr. Holland summarized the financial eligibility procedure:

> Anybody who seeks aid under the Kerr-Mills bill must first of all give an accounting of his holdings, whether he has a television, whether he owns his home, and so forth. At the same time, they must call in all their family, their grandchildren. If they refuse or do not give an accounting then they are taken to our county court and there, under oath, they must make an accounting of all the holdings they have. Then if they have a little home, a lien is placed against the home. Naturally, an aged person hates to have a lien placed on his home. Then, when the home is sold or when the person dies, they close in on the loan.

[4] App. A consists of a summary of the principal characteristics of the MAA programs (as well as OAA programs) in the 27 jurisdictions.

[5] Both the MAA application, the forms for completion by relatives of the applicant, and related forms currently in use in the States of Pennsylvania, Maine, and New Hampshire, are reproduced in appendix B.

Family Responsibility Laws

One of the most criticized aspects of the means test is the "family responsibility" provision which is found in almost all OAA programs and, in one form or another, in the MAA programs of the following States:

California	Michigan
Connecticut	New Hampshire
Hawaii	New York
Illinois	North Dakota
Maine	Pennsylvania
Massachusetts	Utah

When an aged applicant files for MAA in a State utilizing family responsibility provisions, he is, in effect, often subjecting one or more of his relatives to a means test—apart from himself. (In app. B see the forms that must be completed by relatives.)

Perhaps no other condition attached to application for MAA is as distressing to so many people as the requirement that specified relatives be interviewed to determine their ability to contribute to the support of recipients. This attitude can by no means be dismissed as simply the unwillingness of families to care for their own. The adult child (or other relative) may have been providing a substantial share (if not all) of the funds necessary to aid one or both parents to live. In some cases, the applicant requests MAA help because he knows that the rest of his family is already burdened with heavy obligations. When he learns that financial aid will be demanded of other members of his family, frequently at what he knows will mean severe hardship, he may well—and very often does, as the large body of testimony taken by the Special Committee on Aging reveals—withdraw or refuse to make application and let his medical needs go unmet.

5. Is a lien permitted?

There is a great deal of confusion and misunderstanding surrounding the question of whether the Kerr-Mills Act prohibits the States from utilizing liens as a means of recovery from the assets of MAA recipients.

Statements have been made to the effect that there can be no liens taken on the property of older people seeking help under MAA. However, the Federal provision relating to liens under MAA requires that the State plan must:

> * * * provide that no lien may be imposed against the property of any individual prior to his death on account of medical assistance for the aged paid or to be paid on his behalf under the plan (except pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual), and that there shall be no adjustment or recovery (except, after the death of such individual and his surviving spouse, if any, from such individual's estate) of any medical assistance for the aged correctly paid on behalf of such individual under the plan.[6]

In plain language this means that the States can—and 10 of them do—extract from the applicant the right to collect from his estate after death. The 10 States which have such provisions are Connecticut, Illinois, Massachusetts, Michigan, New Hampshire, New York, North Dakota, Oregon, Pennsylvania, and Utah. Some 60 percent

[6] Under OAA, Federal law permits use of current liens and many States make use of such provisions.

of the total aged population in the 24 States with MAA programs are in these 10 States.

Where an MAA recipient resides in any of the 10 States mentioned, and possesses the type of property to which liens may be applied, he is in effect sharing in part—or even assuming all—of the cost of the assistance provided. His share, however, is not due until after his death (or upon the death of his surviving spouse). Obviously, inasmuch as his assets were limited initially (in order for him to qualify for MAA), the effect of the recovery provision is to virtually preclude any possibility of his leaving anything to his heirs. It may be argued that the cost of MAA care is a proper charge against the estate of a recipient and that there is no valid reason for an aged person who needs assistance with his medical costs to leave anything to his heirs. Nevertheless, the prospect of such a claim on assets can be another factor causing deferral, the foregoing or relinquishment of necessary medical care because the governing consideration may be the desire to leave "a little something" for the education of a grandchild or some similar family need.

Overriding Objection to the Use of Liens or Claims

Fourteen States have apparently recognized the basic problem in usage of recovery provisions and do not employ these devices. Ten States, however, do make use of recovery provisions.

To today's older American the technical distinction between a lien and a claim is just so much meaningless nonsense. Time and again, throughout this committee's hearings and in all parts of the country, older people made it obvious that anything which in anyway threatened their sense of free and outright ownership of the homes they had struggled to make their own was intolerable.

Those of the younger generation who proudly lay claim to "ownership" of heavily mortgaged homes in suburbia may find this idea strange and difficult to understand. Its existence is nonetheless a fact, and a most important fact for the Congress to keep in mind in evaluating programs designed to aid the elderly in a way that will not outrage their sense of decency and dignity.

These older people with whom we are concerned grew up and matured in a tradition of rugged Americanism in which home ownership was an objective of paramount importance. To them "ownership" meant—and means just that—outright ownership, free and clear. "Paying off the mortgage" was *the* goal in life for every couple. Its achievement, whether the home was valued at $5,000, $10,000 or $50,000, meant that one had proved himself, had acquired the status of a respectable, responsible, "solid" citizen.

To many of our senior citizens, the home they own represents the totality of their life savings. This is important of course. But even more important is the fact that with income low or nonexistent, with friends dead or moved away, without the satisfactions that come with employment, an older person's ownership of his home becomes to him the last remaining vestige of dignity, of security and of independence. These are all too often all that gives life meaning in old age. To rob an older person of dignity, of independence and of the feeling of security is to make of his life a mockery. The Kerr-Mills Act, itself, does not threaten to take away the home. A claim on one's home enforcible after death does not take that home away. Yet to the elderly, it seems to. To permit the State "to take a mortgage" on the home—whether it is or is not a mortgage in fact—is to admit defeat in life. The intent of Kerr-Mills was to avoid the infliction of such tragedy.

6. Cost of MAA programs

Further confusion surrounds the evaluation of actual MAA expenditures and forecast of prospective expenditures. Evaluation of the exact amount of "new" money expended under MAA is complicated by the transfer of thousands upon thousands of aged persons from OAA medical care programs to MAA, as well as by the transfer of funds from other programs to MAA in order to take advantage of more favorable matching provisions.

Forecasts of prospective expenditures are complicated by the lack of certainty with regard to the number of jurisdictions that will ultimately implement Kerr-Mills. All indications are that new MAA programs will be few and far between unless the provision of basic protection under the social security system makes it possible for additional States to finance MAA as a second line of defense. It is also impossible to predict how many States will apply further restrictions to their programs in an effort to control or reduce expenditures or how many may liberalize their MAA programs. Such changes would, of course, affect the amount of MAA expenditures.

Total MAA payments through March 1962 were $167 million of which the Federal share was $85 million—some 51 percent of the total. (See table II.)

MAA payments in March 1962—18 months after passage of Kerr-Mills—totaled $17,560,000 (see table III). This is at an annual rate of $210 million.

TABLE II.—*Cumulative payments from inception of medical assistance for the aged program through March 1962, by totals, Federal matching and percentage distribution, by jurisdiction*

Jurisdiction	Began payments	Total payments			Federal share of payments		
		Amount	Percent	Cumulative percent	Amount	Percent	Cumulative percent
Total		$166,899,530	100.0		[1] $85,313,506	100.0	
New York	April 1961	79,504,128	47.6	47.6	39,752,064	46.6	46.6
Massachusetts [2]	November 1960	52,050,342	31.2	78.8	26,025,172	30.5	77.1
Michigan	do	18,416,345	11.0	89.0	9,208,173	10.8	87.9
West Virginia	do	4,494,866	2.7	92.6	3,195,002	3.7	91.6
California	January 1962	4,052,596	2.4	95.0	2,026,298	2.4	94.0
Washington	November 1960	1,743,668	1.0	96.0	871,834	1.0	95.0
Idaho	August 1961	1,294,470	.8	96.8	858,104	1.0	96.0
Maryland	June 1961	1,013,876	.6	97.4	506,938	.6	96.6
North Dakota [2]	August 1961	921,848	.6	98.0	667,786	.8	97.4
Oklahoma	December 1960	763,638	.5	98.4	510,170	.6	98.0
South Carolina	August 1961	466,214	.3	98.7	372,972	.4	98.4
Hawaii	July 1961	405,221	.2	98.9	216,307	.3	98.7
Illinois	November 1961	351,935	.2	99.2	175,967	.2	98.9
Utah	September 1961	270,821	.2	99.3	172,622	.2	99.1
Pennsylvania	February 1962	188,320	.1	99.4	94,160	.1	99.2
Kentucky	April 1961	181,229	.1	99.5	137,005	.2	99.4
Arkansas	October 1961	172,247	.1	99.6	137,798	.2	99.5
Puerto Rico [3]	January 1961	168,658	.1	99.7	84,329	.1	99.6
Maine	January 1962	157,547	.1	99.8	104,926	.1	99.8
Louisiana	December 1961	96,343	.1	99.9	69,897	.1	99.8
Tennessee	August 1961	81,772	[4]	99.9	62,042	.1	99.9
Oregon	January 1962	45,450	[4]	99.9	23,816	[4]	99.9
Alabama	February 1962	35,761	[4]	99.9	28,265	[4]	99.9
Virgin Islands	May 1961	13,147	[4]	99.9	6,574	[4]	99.9
New Hampshire	December 1961	9,088	[4]	100.0	5,287	[4]	100.0

[1] 51.12 percent of total payments.
[2] Excludes cash payments to recipients; not subject to Federal matching. Total cash payments were: Massachusetts, $1,634,555; North Dakota, $17,031.
[3] Excludes data for January through June 1961; not available.
[4] Less than 0.05 percent.

NOTE.—Details may not add to totals due to independent rounding.

Source: Social Security Administration.

TABLE III.—*Jurisdictions*[1] *making MAA payments by amount of payments and Federal matching, March 1962*

Jurisdiction	Total payments			Federal share of payments		
	Amount	Percent	Cumulative percent	Amount	Percent	Cumulative percent
Total	$17,561,531	100.0		$9,029,784	100.0	
New York	8,207,361	46.7	46.7	4,103,680	45.4	45.4
Massachusetts	3,198,375	18.2	64.9	1,599,188	17.7	63.2
California	2,642,215	15.0	80.0	1,321,108	14.6	77.8
Michigan	1,405,945	8.0	88.0	702,972	7.8	85.6
West Virginia	377,937	2.2	90.1	265,765	2.9	88.6
Illinois	230,317	1.3	91.5	115,158	1.3	89.8
Washington	203,554	1.2	92.6	101,777	1.1	90.9
Maryland	185,130	1.1	93.7	92,565	1.0	91.9
Pennsylvania	175,799	1.0	94.7	87,900	1.0	92.9
Idaho	164,336	.9	95.6	108,938	1.2	94.1
North Dakota	147,965	.8	96.5	107,186	1.2	95.3
Utah	112,178	.6	97.1	71,502	.8	96.1
South Carolina	79,029	.5	97.5	63,223	.7	96.8
Hawaii	70,531	.4	97.9	37,649	.4	97.2
Oklahoma	63,261	.4	98.3	42,088	.5	97.7
Arkansas	54,560	.3	98.6	43,648	.5	98.2
Maine	53,901	.3	98.9	35,898	.4	98.6
Puerto Rico	46,931	.3	99.2	23,466	.3	98.8
Louisiana	41,776	.2	99.4	30,308	.3	99.2
Kentucky	36,503	.2	99.6	27,585	.3	99.5
Alabama	32,849	.2	99.8	25,964	.3	99.7
Tennessee	24,829	.1	99.9	18,838	.2	99.9
New Hampshire	3,133	(2)	99.9	1,820	(2)	99.9
Virgin Islands	3,116	(2)	100.0	1,558	(2)	100.0

[1] Guam is reported to have begun payments in February 1962, but data were not available as to any amounts expended.
[2] Less than 0.05 percent.

NOTE.—Details may not add to totals due to independent rounding. All percentages computed from unrounded figures.

Source: Social Security Administration.

How much "new money" has Kerr-Mills MAA provided?

The Department of Health, Education, and Welfare estimates total MAA expenditures at $215 million for the fiscal year ending June 30, 1962. Included in these payments are those expenditures resulting from the transfer of a very substantial number of OAA recipients to MAA. The large majority of the aged transferred to MAA were long-term nursing home cases. As nursing home care represented a significant percentage of total OAA vendor payments in those States, the transfer resulted in a reduction in average payments under OAA.

The changed matching provisions for medical care under OAA and the MAA program together have resulted in greater expenditures for medical care of the indigent and medically indigent aged. In September 1960, expenditures for vendor payments under OAA amounted to $25.3 million. In January 1962 vendor payments under OAA amounted to $29.9 million and those under MAA to $14.9 million, a total of $44.8 million. By no means all of the $19.5 million increase represents new money, however; a part represents expenditures made as vendor payments that were formerly made through inclusion in the money payments. In part because of such changes in method of payment, in part because the monthly OAA caseload dropped by 93,000 between September 1960 and January 1962 while MAA cases totaled only 65,000 in January, total expenditures for assistance under MAA and OAA combined in January 1962 were only $13.4 million larger than OAA payments in September 1960.[7]

Several additional factors—apart from Kerr-Mills—may have contributed to the overall rise in vendor payments made by the States.

[7] "The Health Care of the Aged," Department of Health, Education, and Welfare, Social Security Administration, Division of Program Research, p. 95.

Unquestionably, the costs of medical care increased during the period described. And, following the pattern of more than a decade, there were States which expanded the scope and content of medical services for persons on their relief rolls. In connection with these last two points, it should be noted that average vendor payments had been increasing yearly, prior to passage of Kerr-Mills in October 1960, due, in part, to the switch of many States from "money payments" to vendor payments. For fiscal 1960, total vendor payments increased some $65 million over fiscal 1959, and total payments in 1959 represented an increase of $56 million over fiscal 1958.

CONGRESSIONAL INTENT?

At the end of December 1961, about one-third of all persons whose eligibility for MAA had been approved (not to be confused with recipients) since the inception of the program were transferees from other public assistance programs. And many of the new cases now being listed as MAA beneficiaries would undoubtedly have received care under OAA had Kerr-Mills not been enacted.

In effect then, in a number of States—including those with by far the largest number of cases reported as coming under MAA—MAA does not, in large part, represent a new program for a new group of senior citizens.

There is nothing illegal about this procedure on the part of the States. However, it was clearly not the intent of the Congress when it authorized MAA that new Federal funds be used to the extent they have been in relieving the States and communities of payments that they were already making.[8] The Congress intended that this help be extended to an entirely new group of citizens—not those already on relief. Congress was assuming a new responsibility—not relieving the States of an existing burden.

The transfer of persons from OAA to MAA not only distorts the number of those who are receiving MAA help who would not otherwise have been aided, but results in financial "windfalls" to the wealthier States and cities that were making the same care available before enactment of Kerr-Mills.[9] A recent report prepared for the city of New York states:

> Thus, it is known that the transfer in April 1961 of 8,600 persons in institutions from OAA to MAA will yield to the city a net gain of $4 million a year.

The report continued:

> It is unlikely that there are many residents of New York City in long-term institutions who would qualify for public assistance status under MAA and were not previously recipients of OAA.[10]

[8] The staff report of last year to the Special Committee on Aging noted: "* * * 4 out of every 5 dollars which States and local governments indicate they are planning to appropriate for their MAA programs would be dollars taken from other existing medical programs, mostly old-age assistance" ("State Action to Implement Medical Programs for the Aged," a staff report to the Special Committee on Aging, U.S. Senate, Apr. 8, 1961).

[9] This relates to the fact that the Federal Government will match vendor payments under MAA without limitation as to maximum amount, while matching payments under OAA—both "Federal percentage" and "Federal medical percentage"—available only up to specified maximums. For example, a State whose "Federal percentage" and "Federal medical percentage" in the matching formulas are both at the 50-percent level, and whose average OAA assistance payment is about $80, including an average vendor payment of $15, will receive $49 per month in Federal funds for each recipient of OAA. If its nursing home payments under OAA are $200 a person a month, the Federal share of this payment is $49. But if the nursing home patient is transferred to MAA, the Federal grant then becomes $100 instead of $49. Thus, instead of spending $151 a month of its funds per nursing home recipient, the State will have to spend only $100 of its own funds with the Federal Government picking up the difference.

[10] "Health Services for the Aged in New York City," prepared for the Health Research Council, City of New York, March 1962.

TABLE IV.—*Medical assistance for the aged: Cases opened by type of previous assistance, if any, October 1960 to December 1961*

State	Total cases opened	Assistance received previously			New cases
		OAA	AB, APTD, ADC [1]	GA [2]	
Total	166,851	45,900	1,574	600	118,777
Arkansas	2,103	0	0	0	2,103
Hawaii	397	148	0	0	249
Idaho	1,663	977	51	0	635
Illinois	696	0	0	0	696
Kentucky	5,294	0	0	180	5,114
Louisiana	110	0	0	0	110
Maine	244	0	0	0	244
Maryland	7,524	0	0	0	7,524
Massachusetts	29,191	18,439	443	70	10,239
Michigan	14,557	2,743	85	258	11,471
New Hampshire	66	0	0	0	66
New York	54,910	22,768	701	82	31,359
North Dakota	1,042	786	0	0	256
Oklahoma	2,589	0	0	0	2,589
Oregon	2,852	10	92	4	2,746
South Carolina	2,645	0	0	0	2,645
Tennessee	2,441	0	0	0	2,441
Utah	582	0	198	0	384
Virgin Islands	365	0	1	0	364
Washington	3,649	29	3	6	3,611
West Virginia	33,931	0	0	0	33,931

[1] Aid to the Blind, Aid to the Permanently and Totally Disabled, Aid to Dependent Children.
[2] General Assistance.

Source: Bureau of Family Services, Social Security Administration.

CHAPTER II

ACHIEVEMENTS IN RELATION TO THE CLAIMS

After 18 months it is important that the realities of the implementation of Kerr-Mills be assessed against the advance claims, hopes, and expectations. Such an assessment is justifiably undertaken in order to determine the extent to which congressional hopes have been realized.

Following are the actualities measured against the claims and expectations:

1. "An immediate answer to the problem"

The report of the Senate Finance Committee (No. 1856, p. 2, Aug. 19, 1960) stated:

> In summary, the bill as reported by the committee represents a realistic and workable plan. States can take advantage of its provisions in part or in whole almost immediately upon enactment. The financial incentive in the plan should enable every State to improve and extend medical services to aged persons.

The statement of the committee that States could take prompt advantage of Kerr-Mills was certainly true. It was widely interpreted, however, as meaning that States would do so and that medical care for millions of the elderly would thus become available much more promptly than if a program providing health insurance under the Social Security System had been enacted.

Subsequent claims of the American Medical Association also repeated this theme of "almost immediately upon enactment" stressing this as an advantage over the Social Security proposal, which contemplated an effective date about 1 year after enactment.

More than 1½ years have passed since the enactment of the Kerr-Mills legislation, and slightly more than one-half of the States are still without functioning MAA programs. A different theme is now heard. Those who regard the inadequate implementation of the Kerr-Mills Act with a jaundiced eye are now told that it takes time for the States to act: "The State legislative mills grind slowly."

Is this explanation valid or acceptable? The legislatures of all States now have had an opportunity to consider legislation designed to establish MAA programs.

In the main, then, those States that were willing and capable of establishing MAA programs have acted. Inasmuch as most State legislatures do not meet in even-numbered years, those States that failed to take the steps necessary to establish an MAA program by December 31, 1961, are highly unlikely to act during 1962. With the exception of the General Assembly of Virginia which, earlier this year at its regular session, authorized an MAA program which will take effect January 1, 1964, no other State has enacted enabling legislation during 1962.[1]

[1] The New Jersey Legislature is presently considering an MAA program.

Indeed, "the mills grind slowly." However such a feeble explanation with its vague promise of action at an unknown future time is neither meaningful nor acceptable to those with whom we are concerned—to the elderly of today who cannot wait for many tomorrows.

Had a Federal social insurance program then been enacted, it would now be in effect throughout the United States. Were such a program enacted now, the date at which its benefits would be available to all those covered would be fixed and known.

2. "Provides help for all who need it"

Repeatedly, during the past 1½ years, it has been asserted that Kerr-Mills would effectively help all the aged who need assistance with the various costs of medical care—that, in addition to those persons on old-age assistance rolls, it would—

> protect all other senior citizens who cannot meet the costs of a serious or long-lasting illness.

This claim obviously cannot be accepted by the 7 million citizens over age 65 who reside in States that have not as yet established MAA programs.

And, with regard to those States which have established MAA programs, can it possibly be maintained that all of their citizens who are age 65 and over and in urgent need of assistance with their medical expenses, have MAA available to them? The question of whether MAA is rapidly becoming effective is not just a matter of whether States have inaugurated programs—it is also one of scope.

Income and Assets Limitations

The income and assets tests of most of the States rigidly limit the number of medically indigent who are eligible for MAA. As table V on page 19 shows, all of the States which specify dollar amounts have annual income ceilings of $1,800 or less for eligibility for individuals—with eight specifying $1,200 or less. In general the tests for couples are only half as much again. Doesn't this stretch too far the application of the adage that "two can live as cheaply as one," when the "two" are past 65 and faced with heavy medical expenses?

In at least 15 States [2] the limitations on annual income alone tend to be more rigid than those applicable to applicants for OAA. For example, an elderly individual with an income of $1,500 whose anticipated needs amount to $2,000 might be considered eligible for medical care under the relief program. In the same State, however, the individual with this same income would automatically be "cut off" from MAA assistance regardless of his needs. The reason for this is that in most instances, under OAA, needs are weighed against total resources available. Under MAA, with arbitrary "cutoff" points, they are not.

Arbitrary predetermined "cutoffs," while simplifying somewhat the task of determining eligibility, do not take into account existing debts for medical care or anticipated medical costs. Thus, in a State with an income limit of $1,200, an aged individual with an income of $1,300 a year who has a heart condition which necessitates medical and nursing home care costing $3,000 or $4,000 a year is ineligible for medical assistance under the MAA program.

[2] Alabama, Arkansas, Illinois, Kentucky, Louisiana, Maine, Maryland, Michigan, New Hampshire, Oklahoma, Oregon, South Carolina, Tennessee, Utah, and West Virginia.

Is there not a basic inequity in any "hard and fast" test which rules that an individual with income of $1,199 is "in" for full benefits while another with income of $1,201 is "out," and not entitled to any benefits whatsoever? The trend in congressional thinking is away from such "in or out" tests, as evidenced by the relatively recent introduction of a sliding-scale of pension benefits under veterans legislation and by the significant change in the retirement test under social security (to pay $1 in benefits for each $2 of earnings above the exempt amount).

In States such as Connecticut, Hawaii, Idaho, Massachusetts, New York, North Dakota, Pennsylvania, and Washington, where there is considerably more flexibility under MAA in relating the income and assets of an applicant to his needs, there is, however, another problem. This arises from the fact that the determination of the extent to which need exceeds resources (or vice versa) is heavily dependent upon the individual judgment of the investigator. Judgments of a broad nature, sometimes required, can result in lack of uniformity of treatment in the handling of relatively parallel cases.

TABLE V.—*Limitations on annual income affecting eligibility for MAA*

State	Aged individual	Aged couple
New York [1] [2]	[3] $1,800	[3] $2,600
Illinois	[4] 1,800	[4] 2,400
Connecticut	[3] 1,550	[3] 2,200
West Virginia	1,500	3,000
Michigan	1,500	2,500
Pennsylvania [1] [2]	1,500	2,400
Louisiana	[5] 1,500	[4] 2,100
Maine	1,500	2,100
Oklahoma	1,500	2,000
Oregon	1,500	2,000
Utah	1,320	2,040
Alabama	1,200	1,800
Kentucky	1,200	1,800
New Hampshire	1,200	1,800
North Dakota [1] [2]	1,200	1,800
Arkansas	1,200	1,500
Maryland	[6] 1,140	[6] 1,560
South Carolina	1,000	1,800
Tennessee	1,000	1,500

California: Estimated average monthly income over next 12 months not expected to exceed the cost of medical care plus cost of maintenance as determined by old-age standard of assistance.[7]
Hawaii: Income insufficient to meet standards of assistance established for MAA including nonmedical and medical items.[8]
Idaho: [3] Income and resources sufficient to meet the costs of basic requirements, plus $600.[9]
Massachusetts: [1] [2] Income and resources sufficient to meet the costs of necessary medical services as determined by the department of welfare.
Washington: Income sufficient to cover basic needs, as measured by the department of welfare standard of assistance.

[1] The income limits shown are applicable to persons applying for assistance in paying for medical services other than in nursing homes or chronic care hospitals.
[2] The amounts indicated are those considered necessary for living expenses and are excluded from consideration as being available to meet the costs of medical care.
[3] An additional $150 per individual and $250 per couple are allowed to cover health insurance policy premiums.
[4] After deduction of health insurance premiums.
[5] An additional $180 per individual and $300 per couple are allowed for persons with hospitalization insurance. Income in excess of these maximums disqualifies for physician's services. For hospital care, income in excess of these amounts but less than $3,000 per individual or $3,900 per couple shall be applied to the hospital bill. Income in excess of latter amounts disqualified for hospital care.
[6] These are the maximums applicable in the 6 largest counties. In 18 other counties, they are $1,080 and $1,500, respectively.
[7] Maximum standard for basic items and special need is $166 a month.
[8] Approximately $50 per month above the standards of assistance of OAA.
[9] Nonexempt assets in excess of $2,000 but less than $10,000 are considered to be available for income.

TABLE VI.—*Ceilings on assets for eligibility for MAA, in addition to home ownership*

State	Maximum value of asset holdings		Maximum excludes [1]					
	Individual	Couple	Real property: Producing	Real property: Not for income	Other income-producing assets	Surrender value of life insurance	Automobile	Household and personal effects
Utah	$10,000	$10,000			*			
Oregon	5,000	5,000			*		*	*
Arkansas	2,800	3,100						*
Maryland	2,500	2,500						
North Dakota	2,500	2,500						
Idaho	[2] 2,000	[2] 2,000				$1,000	*	*
Massachusetts	2,000	3,000	[3]	[3]		*		*
Illinois	1,800	2,400			$1,000	*	*	*
Pennsylvania	1,500	2,400			*	500 or 1,000	*	*
Michigan	1,500	2,000			1,000			*
California	[4] 1,200	[4] 2,000	$5,000				$1,500	
Alabama	1,000	1,000	*					*
Louisiana	1,000	1,500	1,000	5,000	(*)	1,500 or 2,000	(*)	
Tennessee	1,000	1,500	[5] 10,000			1,000 or 1,500		
West Virginia	1,000	1,500	[6] 4,000		(*)	(*)		(*)
Connecticut	[7] 900	[7] 1,300	(*)	(*)		500 or 1,000		(*)
New York	[7] 900	[7] 1,300				500		(*)
Kentucky	750	1,000	5,000			3,000		
Oklahoma	700	1,000			4,000	(8)		
Maine	500	800	[9] 500 or 800		1,000 or 1,500			
New Hampshire	500	800	500 or 800	4,500 or 4,800	1,500			
South Carolina	500	800	500 or 800		(*)	(8)	(*)	(*)

Hawaii: All assets are considered as available for payment of medical care except real property (value not exceeding $150), and automobile 4 years old or older or when necessary for essential transportation.
Washington: All assets are considered as available for payment of medical care, except household and personal effects, life insurance cash surrender value up to $500, and an automobile.

[1] The maximum value of the excluded resource is shown if stated in the plan; if not, an asterisk is used to show that the State excludes some or all of the asset. Where 2 amounts are given, the smaller amount is the limit for single persons, the larger for couples.
[2] Resources between $2,000 and $10,000 are considered to be available for income. In excess of $10,000, they disqualify an applicant for MAA.
[3] Owner of real property other than home disqualifies.
[4] Includes net value of idle real property.
[5] Minus value of home.
[6] Assessed value, including homestead.
[7] Assets in excess of these limits are considered available for medical expenses.
[8] Cash value of first $1,000 face value is excluded for single persons and of first $2,000 face value for married couples.
[9] Inclusive, for "income producing" and "not for income" property.

There are other uneven results when eligibility for MAA benefits depends upon tests of income and assets. Income limitations are decided deterrents to an individual who might otherwise exercise some earning power but who, if he did so, would become ineligible for MAA. Similarly, limitations on assets serve as incentives to transfer and disposal of such assets by aged persons—prior to any actual need for MAA—so as to preserve capital for either themselves or their families while at the same time achieving eligibility. For example, would it not be advisable for the aged individual who is not in immediate need of medical care to take his savings (nonexempt) and pay off the mortgage of his house (exempt)?

There is also the problem of providing MAA to eligibles in time for it to be effective. A number of States, notably West Virginia, have attempted to cope with this problem by means of "precertification"—that is, the determination of eligibility prior to actual need. As mentioned previously, the State's department of welfare was accused of trying to sabotage MAA by "soliciting" potential recipients. But, in order to provide "help to all who need it," is it not necessary to provide it in time to do the maximum good?

Precertification of eligibility is valuable in at least two regards. The aged person in need of medical assistance will seek early and timely care if he knows that he has been declared eligible for MAA benefits. On the other hand, uncertainty of eligibility and the possible incurring of major expense (almost any expense is a "major" charge on the limited resources of the aged) will frequently deter the seeking of the early care that prevents or minimizes serious illness. In addition, precertification aids in preserving the so-frequently meager assets of the aged. If application is made subsequent to the onset of illness, the individual may very well have exhausted all of his resources by the time he applies or is certified as eligible for MAA. At that point, instead of being "medically indigent" he is simply "indigent." He is on relief. MAA was supposed to keep people off relief. As table VII indicates, illness and the need for medical care have been major causal factors behind the presence of so many of our aged citizens on old-age assistance rolls.

TABLE VII.—*Old-age assistance: Distribution of cases opened by reasons for opening, by Social Security status, 25 States, January–June 1961*

Reason for opening	Total opened	Receiving Social Security benefits	Not receiving Social Security benefits
All cases	100	100	100
Total involving health problems	31	39	25
Recipient's earnings reduced because of illness, injury, or impairment	11	11	9
Assets exhausted to meet medical care	7	9	7
Increased need for medical care (with no material change in income or resources)	13	19	9
Other reasons	69	61	75

Source: Bureau of Family Services, Social Security Administration, "Reasons for Opening and Closing Public Assistance Cases," January–June 1961. (In process.)

Precertification of eligibility would, of course, be built into any social security approach to the problem.

DETERMINATION OF ELIGIBILITY

The problem of prompt and timely determination of eligibility for MAA is further compounded by the complexity of the eligibility requirements—the means test [3] and variations in definitions of medical conditions covered. These, in conjunction with the complexity of the limitations on benefits, make it virtually impossible for a person to

[3] Recognizing this problem, Senator Dirksen has proposed an amendment (S. 2811) which would provide that an applicant's statement as to his financial status, if made under oath, shall be "presumed to be factually correct for purposes of determining his eligibility." While passage of this amendment might expedite certification of eligibility, it would not, of course, eliminate investigation of the applicant's financial status to evaluate the accuracy of the statements made under oath.

understand his rights. It is very doubtful that a person would know whether he can get help or not—there is no feeling of security in a situation of this kind. Lack of understanding leads to failure to apply in many cases which could qualify and, as a result, needed care is foregone. Why should a full investigation of resources be invited by someone who isn't exactly sure as to what the rules are, and who is uncertain as to whether he qualifies for aid?

Uneven and Inequitable Distribution of Federal Funds

Assuming that a medically indigent individual resides in a State that has an MAA program, his ability to qualify for aid, and the amount of assistance available, will, nevertheless, depend upon which State he lives in rather than upon the extent of need for or cost of medical care.

The payment of Federal funds to any State depends upon whether the State has a program and how extensive its program is. With the "open ended" formula for Federal matching in the MAA program, the wealthier States most able to raise funds for their own share of a comprehensive program with liberal eligibility requirements are able to secure the greater amounts in Federal matching funds. In MAA, at present, the ability of the wealthier States to raise money means that, in fact, and despite the intended advantage offered to the lower-income States in the matching formula, the lower-income States are placed at a disadvantage. Certainly, under the MAA program, some of the States with the lowest per capita incomes are contributing to MAA programs in the wealthier States and their people are receiving nothing or relatively little in return.

Almost 90 percent of all MAA expenditures are being made in just four States—California, New York, Massachusetts, and Michigan. Together, these four States have an aged population of approximately 4,400,000—about 25 percent of the U.S. total. (Because they are relatively high-income States they can be expected to have an even smaller proportion of the needy aged population.) In this context, a recent report [4] issued by the State of New York notes:

> * * * 54 percent of the total MAA funds spent throughout the Nation in a 10-month period have been expended for services in New York State.

Only 10 percent of the Nation's aged reside in New York State. The fact that New York receives only the minimum Federal medical percentage grant—50 percent—further highlights the far greater fiscal ability of the richer States to utilize MAA grants.

The four States mentioned are utilizing large amounts of their own funds as well as Federal MAA funds in an effort to provide their medically needy with adequate medical care. Significantly, the Governors of all four States have strongly endorsed a program of health insurance financed through the Social Security System as the only long-term solution to the problem of providing adequate health care for the senior citizens of the Nation.

The disproportionate sharing of MAA payments may well continue over the long run. For example, in the half year from June to December 1961, the number of jurisdictions making MAA payments doubled (from 9 to 18), but the proportion of total MAA payments

[4] "Medical Assistance for the Aged in New York State, a Report Based Upon Experience Under 1961 State Legislation," Mar. 1962.

made by New York, Massachusetts, and Michigan remained relatively constant—93.8 percent in June and 92.4 percent in December.

The disparity, illustrated above, will become somewhat less glaring with fuller operation of MAA programs in other large States such as California, Illinois, and Pennsylvania. Nonetheless, the basic imbalance and disproportionate participation in MAA will continue to be striking as between those States with high per capita incomes and those with lower incomes. While the object of the Kerr-Mills formula was to increase the relative flow of Federal funds to the low per capita income States, the effect has been virtually the opposite. Those States which cannot afford to implement Kerr-Mills, or which can only implement nominally, are the low-income States. The real flow of funds is to the wealthier States. The Federal share comes from general revenues to which all States—including those which cannot afford Kerr-Mills—have contributed. The 12 States with the lowest per capita incomes in the Nation contribute slightly more than 10 percent of total Federal taxes [5]—in March 1962 the total Federal return in MAA matching funds to those of the 12 States that participate in MAA amounted to only some 6½ percent of total Federal MAA grants. Thus, Mississippi which contributes one-half of 1 percent of Federal taxes received no Federal MAA money in March, while New York, which pays some 13 percent of taxes received more than 45 percent of the total Federal grants.

Relatively Few Helped

In discussing "areas of confusion" with regard to MAA terminology, the importance of distinguishing between "true" MAA cases and "relief" cases was stressed. Now it is time to turn to the question of absolute numbers—the number who actually receive MAA help in relation to our more than 17 million older citizens.

In view of the restrictive eligibility characteristics and uneven distribution of resources among those States which have MAA programs, it is not surprising that relatively few aged persons are being aided. In evaluating table VIII, which shows the number of beneficiaries of MAA during March 1962, it should be borne in mind that the total is also very much affected by the scope of care available in each of the States. That is, if a State does not include nursing home care, for example, in its Kerr-Mills MAA program (as in the case in Alabama, Illinois, Kentucky, Maryland, New Hampshire, Tennessee, and Maine), or makes other such exclusions of important types of care, or has severe limitations on those types of care that are provided, the number of persons who can be aided by MAA is sharply restricted. (A discussion of the benefits provided under the various MAA programs is contained in the section which follows.)

It was the hope of the Congress that all States would, ultimately, fully implement MAA. Such complete institution of MAA programs could, it was believed, provide potential protection to as many as 10 million aged persons. As Senator Kerr expressed it, during discussion

[5] Based upon fiscal year 1960. As calculated by Tax Foundation, Inc., and published in "Facts and Figures on Government Finance."

THE NONDRAMATIC IMPACT OF MAA IN MARCH 1962

17,000,000 aged persons in Nation
88,000 elderly received MAA help
Only ½ of 1 percent of Nation's aged helped by MAA

TABLE VIII.—*Number of beneficiaries in jurisdictions making MAA payments March 1962*

Jurisdiction	Actual number of MAA beneficiaries	Aged population in State [1]	Percent of aged population receiving MAA help
Total	88,264	9,778,000	0.90
Alabama	160	269,000	.06
Arkansas	981	198,000	.50
California	11,236	1,447,000	.78
Hawaii	270	30,000	.90
Idaho	1,107	60,000	1.84
Illinois	469	1,009,000	.05
Kentucky	1,609	299,000	.54
Louisiana	219	252,000	.09
Maine	190	108,000	.18
Maryland	4,038	236,000	1.71
Massachusetts	19,461	585,000	3.33
Michigan	4,621	668,000	.69
New Hampshire	37	68,000	.05
New York	30,398	1,754,000	1.73
North Dakota	691	59,000	1.17
Oklahoma	240	256,000	.09
Oregon	[2]	191,000	[2]
Pennsylvania	947	1,163,000	.08
Puerto Rico	1,606	127,000	1.26
South Carolina	634	155,000	.41
Tennessee	343	318,000	.11
Utah	587	62,000	.95
Virgin Islands	109	2,000	4.84
Washington	740	288,000	.26
West Virginia	7,571	174,000	4.40

[1] Based upon preliminary population estimates by Social Security Administration, as of Dec. 31, 1961.
[2] Oregon reported payments in January and February 1962, but none in March 1962.

of the report of the Committee on Finance which accompanied the Kerr-Mills bill:

I understand there are 16 million people in the country over 65. On the old-age assistance rolls are 2,400,000 and under that part of the bill would be immediately eligible for this program. That leaves 13,600,000. The Finance Committee estimated that about 10 million of these might be in the position of needing medical care which they could not provide. This bill sets up a program to provide medical care for those of that group who need it.[6]

While not every one of the medically indigent requires medical services each year, a very substantial proportion do. As many as one of every six aged persons requires hospitalization each year—and an even greater proportion require the services of physicians and need prescribed drugs.

The actual number of States implementing MAA, and, in general, the quality of implementation, as reflected in the relatively few aged persons helped, sharply contrast with the hopes of the Congress.

3. "Its benefits are unlimited"

The statement above is a direct quotation from an advertisement of the American Medical Association. The clear sense of much of the testimony offered in support of the Kerr-Mills legislation prior to its passage was to the same effect. As far as MAA is concerned,

[6] The Congressional Record, August 15, 1960, p. 15242.

the benefits could, theoretically, be virtually "unlimited," because of the "open ended" matching offer of the Federal Government. The reach of the Federal offer, however, far exceeds the grasp of the States. Virtually every State excludes or restricts benefits for at least one, or in many instances several, major areas of medical expense.

Of the 24 States and 3 territories with programs in effect on June 1, 1962, only 3—Hawaii, Massachusetts, and North Dakota—have plans that can be classified as "comprehensive" in terms of the definition established by the Bureau of Family Services of the Social Security Administration.

Various standards have been established in efforts to determine whether a program is "comprehensive." The standard of measurement which is probably the most satisfactory is that applied by the Bureau of Family Services:

> The "comprehensive" programs have been defined as those which include all five kinds of services [7] with no significant limitations on illnesses needing care or the extent of care given. "Intermediate" programs can have either (*a*) five kinds of services, with important restrictions on one or more or (*b*) three or four services, with significant qualifications affecting one or more. "Minimal" programs provide two of the five kinds of care, with or without limitations.

According to these criteria, the Bureau of Family Services rates the 27 plans as follows:

Comprehensive.—Hawaii, Massachusetts, North Dakota.
Intermediate.—(*a*) Arkansas, California, Connecticut, Washington, West Virginia, and (*b*) Guam, Idaho, Michigan, Kentucky, New York, South Carolina, Louisiana, Oklahoma, Maryland, Oregon, Virgin Islands, Pennsylvania, Utah.
Minimal.—Alabama, Illinois, Maine, Puerto Rico, New Hampshire, Tennessee.

In a survey undertaken by the Tax Foundation [8] during late January, six of 24 MAA programs were classified as providing "comprehensive" services, defined as: "full medical services, no limit on length of hospital stay or readmission; nursing home care after hospitalization." The six programs thus classified were those of Hawaii, Massachusetts, Michigan, New Hampshire, North Dakota, and Oregon.

As indicative of the difference in standards of classification, it is perhaps sufficient to note that the Tax Foundation's definition of a comprehensive program does not include prescribed drugs or dental care—elements of medical expense that loom so large in the budgets of the aged.

Comprehensiveness is an essential element of a good medical program not just because it meets a broad range of medical expense, but because it is the only way of assuring "appropriateness" of care. That is, the physician caring for the aged person may select the most appropriate site and type of treatment—be it care at home, hospital, or nursing home.

Obviously any national program purporting to offer unlimited benefits would necessarily have to offer such comprehensiveness in all—not just three—States.

[7] The five services are (1) hospital care; (2) physicians' services; (3) nursing home care; (4) prescribed drugs; and (5) dental care.
[8] "The Cost of State Finances and Medical Care Programs for the Aged," prepared for the 20th annual meeting, National Taxpayers' Conference and Tax Foundation Conference on Federal Affairs.

Provisions for Hospital Care

All of the 27 jurisdictions with MAA programs in effect as of May 1 afforded some in-patient hospital care to their eligibles. Of these jurisdictions [9] 14 limited the number of days of care provided and/or the types of conditions covered:

Alabama	New Hampshire
Arkansas	Oklahoma
California	Oregon
Idaho	South Carolina
Kentucky	Tennessee
Louisiana	Utah
Maine	Washington

The limitations and restrictions can be quite severe. For example, Kentucky provides 6 days of care per admission "for acute, emergency and life endangering" conditions only; New Hampshire offers 11 days per admission, with a maximum of only $75 for necessary and often expensive ancillary services (such as cost of operating room, X-rays, and drugs); Oregon provides up to 14 days per year with the recipient paying $7.50 per day for the first 10 days; and Idaho makes available 14 days per admission for acute conditions and emergencies only.

Restricting the provision of care to cases of "acute, emergency, and life endangering" conditions may have very serious consequences. Aged persons suffering from chronic conditions such as diabetes, nephritis, arthritis, or cardiovascular disorders probably would not qualify for Kerr-Mills MAA help in States with such restrictions, until their conditions become extreme. And lack of medical care contributes to the probability that such conditions will become "acute and life endangering." Chronic conditions are especially prevalent among the aged. Persons 65 and over are twice as likely to suffer chronic conditions as those under 65.

In the context of the need for continuing care—the restorative and therapeutic treatment called for in such cases that prevents acute episodes and major after effects—the limitations of these MAA programs are unsound both in medical and human terms.

The Effect of Deductibles

The use of a flat deductible, or contributory payment as illustrated by the Oregon benefit for hospital care, limits the scope of care for which payment is made by some MAA plans. In some States the applicant is ineligible for assistance, regardless of actual need or ability to pay the deductible until the deductible conditions have been met. For example, the limited scope of care in Tennessee is further narrowed by the fact that hospital care expenses are not assumed by the State under MAA unless the applicant first incurs hospital expenses of over $25 in a fiscal year. Connecticut's program requires that an applicant obligate himself to pay $100 in medical care costs during the year. Illinois will make payments only for medical care costs which exceed 10 percent of the combined assets and annual income of the applicant and his dependents. Oregon sets a different deductible for each type of medical services, $50 a benefit year for physicians' services, etc. (the deductible applicable to hospital care has already been noted).

[9] Appendix C summarizes the scope and content of services, as of October 1961, provided by the 21 jurisdictions with MAA programs at that date.

California covers hospital care only after 30 days of hospital or nursing care in a licensed medical institution. As a practical matter, the medically indigent person in California, assuming he had little or no resources available for hospital bills, would have virtually no alternative but to spend the first 30 days in a county hospital.

In a medical care program such as MAA, where the scope should be broad in terms of the number of people covered and the medical services provided, the use of a deductible works the greatest hardship on those most in need, while those least in need might find the raising of the sum of the deductible no great barrier. It is quite logical to assume that those aged persons who are most needy are the least likely to have health insurance or relatives who are willing and able to provide for part of their medical needs. Therefore, such restrictions work to the decided disadvantage of those people for whom the program is really designed. It is recognized that some—but not all—of the proposals for hospital insurance under social security include provisions for deductibles. However, in any program necessitating the taking of a "means" test to establish inadequacy of resources, such as Kerr-Mills MAA does, the use of deductibles is contradictory, self-defeating, and indefensible.

The use of deductible provisions often functions to deter necessary care as opposed to "unnecessary" care. When limited resources are available for basic necessities such as food, clothing, and shelter, the eligible aged individual would tend to postpone necessary medical care in order to apply the $25, $50, or $100 toward those other necessities. Such effect does not encourage the early and timely care that prevents and minimizes serious illness. The problem thus becomes one not of "overutilization" of services but rather one of "underutilization."

The basic answer to controlling "unnecessary" usage of services is not the imposition of fiscal controls upon the medically indigent which force the individual to judge the necessity and urgency of care in relation to his financial situation. The answer lies in the use of medical controls whereby the aged person's physician and the physicians who comprise medical review boards are responsible for the decisions as to the necessity, appropriateness, and duration of medical care.

It is on the personal physician of the individual that we must place first reliance for seeing to it that a program of medical care is not exploited. It is the physician and only the physician who can decide whether a patient should be hospitalized and for how long. The problems of unnecessary hospitalization or overly prolonged hospitalization, of unnecessary surgery or unduly prolonged care are problems involving the whole of the population and of concern to all of our communities. Any pretense at solving such problems by introducing a financial control on the patient is patently an evasion. It means simply that the virtually penniless patient may be and is denied care regardless of his medical need whereas the patient to whom the deductible cost is not a burden may get the care, undergo the surgery, or occupy a badly needed hospital bed regardless of his medical need.

Controls over these problems must be professional, not lay; ethical, not financial. It is not sound public policy to encourage the medical profession to avoid this responsibility by pretending to have solved

the problem through placement of a financial barrier between the patient and the care he may need. In fact, the deductible serves only to bar the poorer patient. In no way does it deter a physician from authorizing the provision of unnecessary services for those who can pay the deductible charges, for whatever services the physician may be willing to let the patient believe he needs, or for services which the physician believes are not needed but which he will countenance. Such actions in effect constitute the perpetration of a fraud on the medical care fund. This behavior cannot be justified simply because he or his patient find it more convenient or because the physician is afraid of losing his patient to another more complacent, less ethical physician.

We repeat: The prevention of overutilization or exploitation of a medical care program—whether it be Kerr-Mills, Blue Cross, commercial insurance, or the Veterans' Administration program—is a responsibility first of the individual doctor and, secondly, of the medical profession. Concern is often expressed over the possibility that individual physicians will succumb to the temptation of hospitalizing people unnecessarily for the convenience of the physician or patient, or the pocketbook of the physician or patient. It is on the physician's colleagues, functioning on medical review boards, that we must rely for the imposition of proper and effective disciplinary controls over the presumably few malefactors or irresponsible people in the profession. Any suggestion that a "deductible," a financial bar to utilization of services, solves this problem of medical ethics is sheer nonsense.

Both the American Hospital Association and Blue Cross have urged hospitals to establish review boards. The desirability of such committees is virtually self-evident. Doctors—not dollars—should determine the appropriateness and availability of medical care.

Nursing Home Care

Only 18 of the 27 jurisdictions include care in nursing homes as part of their MAA programs:

Arkansas
California
Connecticut
Hawaii
Idaho
Louisiana
Massachusetts
Michigan
New York
North Dakota
Oklahoma
Oregon
Pennsylvania
Puerto Rico
South Carolina
Utah
Washington
West Virginia

Most of these States limited the provision of such care with respect to the maximum payments and Michigan, Oklahoma, Oregon, and South Carolina limit the number of days covered.

A number of States set maximum limits on payments to nursing homes—$90 monthly in Arkansas, $100 monthly in West Virginia, and $150 monthly in South Carolina, for example. Such limitations make it virtually impossible to provide nursing home care of a character beyond mere custodial care. Skilled and high-quality nursing home care is expensive—limited payments in behalf of MAA eligibles (and OAA recipients, as well) lead to toleration of marginal nursing homes and discourage the growth of nursing homes that can effectively meet the range of needs of the aged.

It might well be contended that on its face it is misrepresentation to say "nursing" care is being provided in return for payment of $100 to $150 a month. In fact, the question may be justifiably raised as to whether the Federal Government should contribute to such payments under what Congress created to be a *medical* care program. *Custodial* care is *not* medical care. To hide sick elderly people away in institutions which cannot possibly be providing the *skilled* nursing care they need and to pretend that we have thereby met their medical needs is to engage in a most hypocritical form of self-deception.

Physicians' Services

Twenty-five of the 27 jurisdictions include one or more types of physicians' services in their programs. The exceptions are Puerto Rico and Tennessee.

Where such services are provided, care rendered in the office, home or out-patient department of a hospital is generally limited in terms of visits or services in a given period. The kinds of conditions for which care will be provided are also often limited. By way of illustration, the coverage of physicians' services in Idaho combines the several elements of restriction and limitation: No provision is made for physicians' services rendered to an MAA eligible who receives care in hospital or in the outpatient department of the hospital; office and/or home calls are covered for acute conditions only—to the extent of two visits per month for both types; one call per month is covered for a recipient who is in a nursing home; and one eye examination is authorized per six-month period.

Dental Care

Thirteen of the 27 jurisdictions provide some dental services: Arkansas, California, Connecticut, Guam, Hawaii, Kentucky, Maryland, Massachusetts, North Dakota, Oklahoma, Virgin Islands, Washington, and West Virginia. Care is frequently provided only for cases of acute infection, and emergencies and the services available are usually restricted to fillings and extractions even though a major health need of the aged is for dentures to replace extracted teeth.

Prescribed Drugs

Despite the fact that aged persons spend more than twice as much, on the average, for medicines as does the entire population, and despite the fact that almost 25 percent of the per capita health expenditures of aged persons is made for drugs, only 15 of the 27 jurisdictions make any provision for such costs in their MAA programs:

Arkansas
California
Connecticut
Guam
Hawaii
Kentucky
Louisiana
Maryland
Massachusetts
New York
North Dakota
Tennessee
Virgin Islands
Washington
West Virginia

Arkansas limits the amount payable for prescribed drugs to $5 monthly; up to $5 monthly is allowed toward those items prescribed in a nursing home. Louisiana provides drug coverage only for

MAA recipients in nursing homes. Washington affords drug benefits only when the prescriptions relate to "acute and life-endangering conditions."

In summary then, the benefits available—when available—under the various MAA programs are very definitely not "unlimited." As may also be observed, the various limitations and restrictions (apart from the exclusions) are not determined by the actual needs of the aged person but, in fact, by the available financial resources of each State.

4. *"A sensible workable solution to the problem of providing full medical care to all the elderly who need such care"*

Reference to the Kerr-Mills Act as "a sensible workable solution" to the broad and complex problem of provision of care for the medically needy aged, implies that all States are capable of adopting MAA programs. Such thinking completely ignores the fact that many States are unable—even with substantial help from the Federal Government—to adequately finance the health needs or even the basic living requirements of their most indigent aged.

MAA was intended as an expansion beyond the old-age assistance program. It was intended to be a liberal measure that would aid those aged persons with incomes above the levels of eligibility of OAA. By providing assistance under MAA it was hoped that the medically indigent would not be reduced to that point of indigency where going on relief was the only solution.

However, inadequate attention has been paid to the limited fiscal resources of many States, and to the competing claims of other needs—education, roads, housing, etc.—on those limited resources.

A State that cannot *now* provide for even the most *basic* needs of its OAA recipients—with "basic" defined according to the State's own standards and disregarding special needs such as medical care—is unlikely to reach beyond its OAA rolls to encompass people who are medically indigent.

The extent to which OAA falls short of meeting even the most essential needs recognized under State-established standards is indicated by an analysis prepared by the Bureau of Family Services. During the period July–September 1960, the total monthly income requirements of the 2.3 million recipients of OAA were estimated by the States as $196 million—less than $85 per recipient per month—little more than $1,000 a year. Old-age assistance payments for the month amounted to $145 million, which, when added to the $42 million available to the assistance recipients from other sources, still left an unmet need of $9 million for the month—an annual rate of $108 million. The proportion of unmet need was highest in the Southern States—even though the level of living recognized in the standards was low, averaging just under $70 a month per recipient.

This survey, made in 1960 for the Advisory Council on Public Assistance, revealed that 36 of 49 States failed to meet their own standards of needs for the aged on their OAA rolls.

Recipients of old-age assistance, as a group, are much older than the general population 65 and over. (The median age of all persons receiving OAA in 1960 was 76.4 years as compared with 72.1 for all persons 65 and over.) They have especially heavy medical needs. This is partly due to their advanced ages—but it is also due to the

fact that many are on the OAA rolls as a result of prior illness with, however, continuing need for medical care.

Despite this greater need, 29 jurisdictions are providing less than $15 a month in vendor medical payments per OAA recipient.[10] There are some 1,600,000 OAA recipients in the 29 jurisdictions. Even after subtraction of some 125,000 OAA recipients in the States of Idaho, Massachusetts, and Michigan where average vendor payments were lowered by virtue of the transfer of high-cost nursing home cases to MAA, the remaining 1,475,000 represent approximately two-thirds of all OAA recipients.

If the levels of payment for vendor medical care were to be increased to $15 a month per recipient—the maximum amount of vendor payments subject to Federal sharing under OAA—the total vendor payments in the 29 jurisdictions would be $24 million monthly, 89 percent more than the $12,700,000 expended in January.[11]

There would appear little doubt that a State's primary obligation is to provide more adequately for its OAA recipients before moving into new areas of need. Thus, the reason why more States have not established MAA programs is clear—it is simply a question of "first things first."

It might well be asked whether any State should attempt to assume the financial burden of an MAA program while it still finds it financially impossible to provide a minimum standard of living—even by its own standards—for the people already on its relief rolls. Nevertheless, what would the States be faced with if it were decided that the health needs of all the medically indigent should be met under the public assistance programs of the States? It is estimated that there will be more than 17½ million persons age 65 and over in the United States at the beginning of 1963. If income tests of $1,500 for an individual and $2,000 for a couple were utilized by the States as a test of financial need under their MAA programs, it would result in more than one-half of the Nation's aged being eligible for vendor payments for medical care under either MAA or OAA.[12] The estimated annual per capita medical cost of the aged is $280 in 1963. At that rate, if the OAA and MAA vendor payment programs provided full payment of medical care costs for all the aged qualified on the basis of the suggested income tests, medical care payments under

[10] Source: Bureau of Family Services. Data as of Jan. 1, 1962. The 29 jurisdictions are: Alabama, Arkansas, California, District of Columbia, Florida, Georgia, Hawaii, Idaho, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, New Mexico, North Carolina, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Virginia, West Virginia, Wyoming, Puerto Rico, and the Virgin Islands. 50 jurisdictions made vendor payments in January 1962. Alaska Arizona, Delaware, and Guam made no payments at that time. (All except Delaware have started or will start to make vendor payments.) The average monthly vendor payments per recipient, among the 50 jurisdictions making such payments ranged as follows:

Average monthly vendor payments for medical care:	*Number of jurisdictions*
Total	50
Under $5	9
$5 to $9.99	9
$10 to $14.99	11
$15 to $19.99	6
$20 to $24.99	4
$25 and over	11

[11] Some States provide medical care to their beneficiaries of OAA outside of the vendor payment mechanism. Such provision may include a combination of money and vendor payments or care provided by governmental facilities. However, in the main, evaluation of State programs predicated upon average vendor payments per OAA recipient constitutes a reliable index of the extent to which medical needs are being met.

[12] The median income in 1960 of an aged individual was $1,050 and $2,530 for a 2-person family where the head of the family was 65 or over.

public assistance programs would amount to some $2½ billion in 1963.

Even with the benefit of the favorable medical assistance matching formula, the States would have to pay $1 billion to $1¼ billion from their own funds toward the $2½ billion total cost—that is, if it is assumed that all States would participate and pay for all necessary care. The State's share would represent seven to nine times the $137 million paid by the States as their share of OAA vendor payments in fiscal 1960.

The proportionate increase in expenditures necessary to fully implement the Kerr-Mills programs in any given State would depend upon two factors.

First, States with fairly broad public assistance medical care provisions and liberal means tests for OAA already in effect would need to take relatively little further action to provide adequate medical care benefits under MAA and/or OAA. Conversely, States which are doing little (and in a few cases nothing) for the medical needs of their totally indigent aged would have to take giant steps, financially, to catch up with the level of care provided elsewhere—to say nothing of the efforts that would be needed to provide fully adequate care.

The second aspect of the comparative demands on individual States relates to the per capita income of the individual States. The formulas for Federal participation in public assistance grants are predicated upon the basic assumption that the States with the lowest per capita income need the greatest Federal help in the financing of programs. The less wealthy States would, thus, if they provided the same scope of medical care under Kerr-Mills programs as do the wealthier States, receive more money per recipient from the Federal Government. The fact that, generally speaking, the poorer States spend less per capita on their public assistance recipients (including the Federal share of expenditures) than do the wealthier States strongly suggests significant limitations in ability to provide additional State funds.

Therefore, States with the poorest provisions for medical care of the totally and medically indigent would seem to be those least able to assume the costs involved if they were to attempt to provide the level of medical care available to OAA and MAA recipients in other States.

The only conclusion that can be drawn is that, in the foreseeable future, it is highly unlikely that more than a handful of States will be able to provide payments approximating the full medical care costs of their indigent senior citizens—let alone their medically indigent.

There are illustrations, too, pointing to the potential cost burden as the principal factor behind the decisions of States not to implement MAA. The Tax Foundation Study [13] reported:

> In at least two States, the matter of participating in the Kerr-Mills Act provisions is considered financially inadvisable. For Ohio, two eligibility requirements of its present old-age assistance law would have to be changed (the last legislature did not approve such alterations)—one requiring 3 years' residence, the other requiring recipients to agree to a lien on their real property to cover the extent of aid received. The current State medical care program requires an expenditure of $130,000 per month; this would increase to $1 million per month under Kerr-Mills according to State welfare department estimates.
>
> Judgment of the State welfare director of Wyoming is that the welfare staff might have to be doubled under Kerr-Mills participation to service the increased number of recipients and conduct appropriate investigations. Medical assistance

[13] See footnote 8.

is now a county program and Kerr-Mills would cost the State approximately $1 million per biennium under current estimates.

At last year's hearings, held by the Ways and Means Committee of the House of Representatives, the situation in Rhode Island was reported as follows: [14]

During the latter part of 1960, the Rhode Island Department of Social Welfare undertook to study the feasibility of implementing the provisions of the Medical Assistance Act, known as the Kerr-Mills bill, which makes possible joint Federal-State medical assistance for so-called medically indigent elderly persons. The Department concluded it was both administratively impossible as well as prohibitive costwise for the State and did not meet the basic need of all the aged for basic protection against the costs of medical care.

Florida's reason for not establishing an MAA program was the unwillingness of the legislature to embark upon a program without the safeguard of a residency requirement (according to the explanation given by Dr. Edward R. Annis, chairman, legislative committee, Florida Medical Association, before a hearing of the Special Committee on Aging, held in Fort Lauderdale on February 15, 1962).

At another hearing of the Special Committee on Aging (Kansas City, December 6, 1961), Proctor Carter, director, Missouri State Division of Welfare, submitted a statement referring to the lack of implementation of MAA by Missouri as follows:

This legislation failed of passage primarily because of the substantial cost involved and not because of indifference or lack of interest on the part of the members of the general assembly.

5. "The MAA program has the potential for simple administration"

The recent report of the Secretary of Health, Education, and Welfare to the Committee on Ways and Means of the House of Representatives said:

The MAA program has the potential for simple administration. It cannot be said with assurance that the States have employed simple methods since they have used various controls which are not required by the legislation.

Complex administration is expensive.

Administrative costs of MAA and OAA medical care programs constitute a significant drain upon the limited resources of the States. Such costs comprise a substantial part of total expenditures for almost any type of medical assistance other than long-term nursing home care.

Under the MAA program, a complete "workup" must be made for each applicant for assistance. Eligibility must be determined through examination of resources, including such difficult evaluative factors as the value of assets and—in almost half of the programs—the ability of relatives to contribute. Redeterminations of eligibility and field investigations to determine the accuracy of the applicants' statements add to administrative expense. The cost of such investigations is quite large in relation to the actual payments to physicians, or for prescribed drugs, and even for some hospital bills.

The more restricted the eligibility requirements and coverage, the greater the relative administrative expense, because extremely careful screening out of applicants is required under such circumstances. Kentucky and Arkansas are examples of States with such MAA programs. As table IX indicates, their administrative costs are very

[14] "Health Services for the Aged," p. 1723, hearings held July 24, 26, 27, 28, and 31, August 1, 2, 3, and 4, 1961, before House Committee on Ways and Means on H.R. 4222.

high. For every dollar of the taxpayer's money spent for medical care for older people in Kentucky's MAA program, $1.24 went to pay for the redtape inherent in a financially limited program involving a means test. Obviously, for the same amount of money, almost twice as much medical care, or care to almost twice as many people could have been provided had it been possible to use a social security approach.

Some other States show a misleadingly low administrative cost for their MAA programs because they had transferred to the MAA program thousands—and in New York and Massachusetts tens of thousands—of people who had already been on relief. The costs of investigating these cases do not appear in their statements of MAA administrative costs because they were charged to the OAA program.

The Federal Government pays only 50 percent of the costs of administration while it may pay as much as 80 percent of the dollars going for actual medical care. Thus only a relatively small portion of a State's funds may go for medical care while a substantially greater amount may have to be allocated to administrative costs.

TABLE IX.—*Medical assistance for the aged: Expenditures for administration as percent of assistance payments, calendar year ended Dec. 31, 1961*

State	Total administrative expenditures	Administrative cost as percent of assistance payments	State	Total administrative expenditures	Administrative cost as percent of assistance payments
Arkansas	$34,000	63.9	New York	$4,683,000	8.6
California	64,000	(1)	North Dakota	69,000	13.5
Hawaii	10,000	4.4	Oklahoma	30,000	5.3
Idaho	78,000	9.9	Oregon	66,000	(1)
Illinois	18,000	(1)	Puerto Rico	7,000	8.9
Kentucky	105,000	124.0	South Carolina	97,000	(1)
Louisiana	15,000	(1)	Tennessee	83,000	(1)
Maryland	82,000	12.3	Utah	6,000	(1)
Massachusetts	1,897,000	5.0	Virgin Islands	17,000	(1)
Michigan	345,000	2.5	Washington	51,000	3.9
New Hampshire	(2)	(1)	West Virginia	630,000	17.3

[1] Not computed; less than 1,000 case-months or program in effect 2 months or less.
[2] Less than $500.

6. "Maintains freedom of choice"

The American Medical Association, in its full-page advertisement of April 19, 1961, offered as a major reason for its support of Kerr-Mills:

> It preserves the quality of medical care—maintaining the patient's freedom of choice and the doctor's freedom to treat his patients in an individual way.

Actually, the Kerr-Mills legislation contains no provision assuring the recipients of medical care under MAA of freedom to choose a hospital or nursing home or doctor or pharmacist.

In fact, there are explicit and implicit limitations on all three of the AMA premises—"quality of medical care," "patient's freedom of choice," and the "doctor's freedom to treat his patients in an individual way."

Both the "quality of care" and the "patient's freedom of choice" can frequently be affected by the relative willingness of physicians and hospitals to negotiate and accept MAA and OAA payments—

which are often below the "going" rates. The much-publicized situation in West Virginia, while not necessarily typical, may be illustrative. It will be recalled that hospitals were rebelling over the differential between maximum daily allowances for OAA patients—$20—and the unlimited allowance for MAA patients. Physicians in that State, at one point, were on the verge of refusing to care for MAA recipients because of a reduction in fee allowances by the State.

The doctors, it would appear, sometimes apply their own means tests, which may be stricter than that of the State. In West Virginia, one of the issues between the physicians and the State concerned the desire of the doctors to have the right to charge MAA patients a *fee in addition* to that paid by the State. This approach of some physicians may further deny full "freedom of choice" to the MAA beneficiary. The aged person may be unable to pay a supplemental fee to the physician and consequently feel obliged to seek medical care elsewhere.[15]

An article in the Detroit News of March 12, 1962, also hints at the problem. The director of the Wayne County Board of Social Welfare, Walter J. Dunne, referring to the MAA payments to physicians and hospitals, which are lower than usual charges, was quoted as saying:

> Because of this discount, private hospitals would prefer patients with insurance or who can pay themselves. * * * Some hospitals are restricting intake in the Kerr-Mills and old-age assistance cases.

Several of the MAA programs sharply restrict the recipient's choice of hospital or physician. Under such circumstances, the physician's "freedom to treat his patients in an individual way" suffers when his patient must be confined in a particular hospital—in order to qualify for assistance—with which the doctor may not be affiliated. Such situations make for "fragmented" medical care—there is a lack of continuity of treatment. The physician, in such cases, takes his patient up to the door of the hospital and must then relinquish him to a staff member. Among those jurisdictions which have MAA programs restricting the individual's "freedom of choice" are:

California.—While the recipient may be confined in a hospital of his choice after the first 30 days of confinement, he is, as a practical matter, generally limited to use of a county hospital during the first 30 days.

Hawaii.—Outpatient care is provided by "government doctors," who also dispense drugs to an extent.

Pennsylvania.—Nursing home care is provided only in those homes operated by counties.

Puerto Rico.—Hospital and outpatient care available only in governmental facilities.

The failure to cover in-hospital physicians' services in many jurisdictions and the use of State, county, or teaching hospitals in others means that many of the MAA beneficiaries must depend upon the services of hospital staffs and clinics. They may well receive their treatment in charity wards. No doctor-patient relationship of an enduring nature and no choice of physician is present under these conditions.

[15] Information is not available, at the present time, concerning the proportion of physicians who have agreed to accept MAA (and OAA) fees in the various States—or the extent of compliance by physicians with such agreements. This would seem to be an area deserving of further study. (See app. D for an illustration of organized medical opposition to vendor medical care payments for OAA recipients, as recently as 4 years ago.)

APPENDIXES

Appendix A.—Implementation of Kerr-Mills Programs

ALABAMA

Aged in population (April 1, 1960): 261,000.

MAA:

Program.—Legislation enacted in 1961, effective in 1962; service began February 1, 1962.

Eligibility.—

Income: Net income in cash or readily negotiable resources may not exceed for single person, $1,200 a year; for married couple, $1,800. (Excludes from consideration, income in kind; e.g., food produced for home consumption.)

Assets: (1) Real property: House and land which is assessed as a homestead is exempt from consideration; other real property may be held if producing a net cash income. (2) Personal property: Excluded from consideration as available to meet costs of medical care are: Personal belongings; tools and livestock used to produce food for home consumption; equipment, stocks of goods, tractor, truck, and similar property if used in a business to produce net cash income; cash surrender value of life insurance. All other resources may not exceed a reserve of $1,000, single person or married couple living together. (Includes cash, bank accounts, stocks and bonds; idle tools, machinery, or livestock not used in producing food for home consumption or in a business; real property which is not producing a profit.) Benefits from health and hospital insurance policies will be taken into account in determining amount which can be paid from MAA program.

Person must be in need of hospital care to begin within 30 days of date of application.

Recovery provisions.—No provision.

Relative responsibility.—No requirement.

Deductible.—Applicant is expected to (not required to) pay first $50 of his hospital bill.

Scope of medical care provided.—Hospitalization limited to 15 days within a fiscal year for acute illness or major injury. (Not provided for 1-day admissions or illnesses or injuries which can be treated adequately on an outpatient basis; nor those for which treatment is available from the State, Federal, or local governments or private organizations under another program; e.g., eligibility for treatment for cancer through State tumor clinic program.) Physicians' services: Office calls, not to exceed three, after each period of hospitalization if made within 30 days following patient's discharge from a period of hospital care; must be directly or indirectly related to the hospitalization.

Additional provisions.—Eligibility for MAA, once determined, continues for a 12-month period unless there is some known change in eligibility status.

OAA:

Program.—During 1961 began vendor payments for nursing home care for OAA recipients (previously provided through the money payment and subject to maximums on such payments, including subsistence), initiated hospital care and limited physicians' services similar to those available under MAA.

Lien and recovery.—No provision.

Relative responsibility.—Ability of relatives to support is determined in each individual case (no State legislation prescribing such responsibility); if relative claims the applicant as a dependent for income tax purposes, he is presumed to be responsible for providing more than one-half of the support of such applicant.

Residence requirement.—One year immediately preceding application.

Scope of medical care provided.—Vendor payments are made for hospital care for acute illness and major injury up to 15 days per fiscal year; nursing home care; and physicians' services in office for a period not to exceed 30 days following patient's discharge from hospital care, limited to three office calls. (Such post-hospital services have been added since the implementation of the MAA services.) Within the money payment which includes subsistence items, an amount may be budgeted for special nursing care in the recipient's place of residence other than a medical institution.

Money payment to recipient.—Administrative maximum on money payment to recipient is $75, based on a legal maximum in terms of amount of Federal matching of State expenditures.

ARKANSAS

Aged in population (April 1, 1960): 194,400.

MAA:

Program.—Services began in September 1961, following an appropriation for the program made by the 1961 legislature.

Eligibility.—

Income: Cash income for single person not to exceed $1,200 annually; for family, $1,500.

Assets: (1) Real property: May have home or an equity in home not to exceed $7,500. Value of other real property must come under the maximum on personal property. (2) Personal property: Including value of nonhome real estate, livestock, motor vehicle, tools, equipment, and cash surrender value of life insurance. Household furnishings are excluded. Applicant may have a cash reserve up to $300 for one person and an additional $300 for dependents, with a family maximum of $600. Total value of all other property and resources may not exceed $2,500.

Recovery provisions.—No provision.

Relative responsibility.—No requirement.

Deductible.—None.

Scope of medical care provided.—Hospital care limited to 15 days per year except for specified types of cases requiring longer hospital care; nursing home care including physicians' services and prescribed drugs up to $5 per month per patient; outpatient clinic services including drugs and appliances prescribed by physicians giving the service; remedial eye care services in office or in hospital; dental care; transportation to receive medical care and domiciliary care for patients requiring such care while receiving outpatient care and treatment at an approved clinic.

Additional provisions.—Need for medical care is determined concurrently with eligibility; when additional service is needed, review or reapplication is required; not applicable to persons receiving continuing care, whose cases are reviewed annually.

OAA:

Program.—Since September 1960, added to scope of medical care for which vendor payments are made: dental care, statewide clinic services, prescribed drugs provided through clinics or to patients in nursing homes.

Lien and recovery.—No provision.

Relative responsibility.—Ability of relative to contribute to support of applicant is determined in accordance with a "combined family income" scale. However, a relative who claims an applicant (or recipient) as a dependent for income tax purposes is expected to be contributing $300 a year toward his support.

Residence requirement.—Legal: 3 years during the 5 years immediately preceding application, with last 1 year continuously. Or, by administrative interpretation: 5 years of the past 9 years immediately preceding application with 1 year immediately preceding application.

Scope of medical care provided.—Vendor payments are made for hospital care as certified by physician, up to 30 days a year; nursing home care; office or clinic visits for physicians' services or home visits for persons in nursing homes; dental care including dental surgery; prescribed drugs dispensed by an approved clinic or prescribed for patient in nursing home (prescribed drugs in other situations may be provided through the money payment to the recipient up to $10 a month within the total maximum of $65), and transportation and domiciliary care necessary to secure treatment away from home. Provided through the money payment, subject to the maximum, is nursing care in own home.

Money payment to recipient.—Maximum of $65, legal; administrative, $60.

CALIFORNIA

Aged in population (April 1, 1960): 1,376,000.

MAA:

Program.—Legislation enacted, effective January 1, 1962, provides basis for program.

Eligibility.—

Income: Average monthly income over the next 12 months is not expected to exceed the cost of his medical care plus the cost of his maintenance as determined by the standard of assistance for old-age assistance. (Maximum standard for basic items and special needs is $166 a month.) If an individual is married, income is the combined separate income of the person plus his share of the "community income" of the couple.

Assets: (1) Real property: May have home owned and occupied. Value of other real property of applicant or applicant and spouse is limited to $5,000 assessed value less encumbrances if yielding a reasonable return which is used to meet needs. (2) Personal property: Limited to $1,200 less encumbrances, if single; if spouse also recipient, total is $2,000 less encumbrances; plus automobile needed for transportation with market value up to $1,500. Term includes net value of idle real property.

Eligibility is determined after an initial period of 30 days of hospital or nursing home care in a licensed medical institution, when physician estimates that such care will continue beyond 30 days. (Days may be cumulative if person is readmitted to a certified facility within 10 days of leaving such a facility.) Certification continues for a 12-month period. Holders of a valid certificate who require noninstitutional services may be certified for such services if eligible.

Recovery provisions.—No provision.

Relative responsibility.—Ability of an adult child to contribute to support of parent is determined in relation to "relatives' contribution scale" based upon the net monthly income and the number of dependents, beginning with $400 a month. Method of computing net income of such relative makes allowances for certain taxes and expenses of employment.

Deductible.—No deductible but MAA is not applicable until after initial period of 30 days of hospital or nursing care in a licensed medical institution. This provision applies to institutional and noninstitutional care.

Scope of medical care provided.—Institutional care is available in hospital or licensed nursing home beginning after the first 30 days of care in such home, including all related services, inpatient physicians' calls and restorative and rehabilitative services; noninstitutional care is available after discharge of a period of institutional care and includes a full range of services including dental care, drugs, prosthetic appliances, physicians' services, rehabilitative services, diagnostic and therapeutic laboratory procedures and home nursing care.

Additional provisions.—Eligibility for MAA once determined continues for a 12-month period and persons who require noninstitutional services may be certified for such services on the basis of the previously established 30-day period of hospital or nursing home care.

OAA:

Program.—Added to the scope of medical care services, dental care, and home nursing; extended prescribed drugs and eye care.

Lien and recovery.—No provision.

Relative responsibility.—Ability of an adult child to contribute to support of parent is determined in relation to "relatives' contribution scale" based upon the net monthly income and number of dependents, beginning with $400 a month; allowance made for certain taxes and expenses of employment of such relative in computing his net income.

Residence requirement.—One year (immediately preceding application) and 5 of last 9 years (maximum requirement permitted by Federal law).

Scope of medical care provided.—Vendor payments are made for practitioners' services, dental care, and prescribed drugs. Other services, provided through the money payment to the recipient, are inpatient hospital care and nursing home care. Under specified circumstances, either vendor payment or money payment may be used to meet costs of sickroom supplies, home nursing care, X-rays, restorative and rehabilitative services, prosthetic applicances, equipment, and ambulance.

Money payment to recipient.—Maximum or money payment to recipient may be

as high as $166 if the person has no other income and has certain special needs as defined by the State.

CONNECTICUT

Aged in population (April 1, 1960): 242,600.

MAA:

Program.—State legislation authorizing a program of MAA was enacted in the 1961 session, to become effective April 15, 1962. The program was begun at that time and plan material has been submitted to the Bureau of Family Services for approval. (The following data is as submitted, not yet approved.)

Eligibility.—

Income: All income is considered available to meet costs of medical care except: (1) Person receiving medical care but not resident in medical facility: If single, or married and not living with spouse, $1,550 a year, plus an amount not to exceed $150 if it is applied to payment of annual premium on personal health insurance; if married and living with spouse, $2,200, plus $250 if it is applied to payment of annual premium on personal health insurance. (2) Applicant receiving care in medical facility, spouse living outside such facility: $1,800 a year may be retained for the personal or other expenses of the spouse, plus $250 for annual premium if paid on personal health insurance of both spouses, or up to $150 if only one spouse is covered by such insurance.

Assets: (1) Real property: May own home; sale value of real property not used as a home, should be determined prior to certification of eligibility for MAA with provisions for exceptions under specified circumstances. (2) Personal property: Total may not exceed $900 for single person or if married and living apart from spouse; or $1,300 if married and living with spouse. Excluded from consideration is cash surrender value of insurance up to $500 for beneficiary, and $500 for spouse.

Medical benefits, which are available to applicant from sources such as personal health insurance plans, workmen's compensation, Veterans' Administration, and private employee welfare programs, are primary resources for meeting medical needs which must be utilized before determining extent or kinds of services to be paid for through MAA.

Recovery provisions.—Provision for filing claim by the State against the estate of the deceased recipient for the amount of assistance received; no recovery until after the death of a surviving spouse, if any.

Relative responsibility.—Extent to which a legally liable relative (spouse and adult children) is a financial resource is determined in accordance with agency policy (including a cost-of-living scale); the contribution finally determined as within the ability of the relative to provide is assumed to be available to the applicant.

Deductible.—Policy proposed for calendar year 1962 is that the applicant is responsible for the first $100 of costs incurred for medical service after January 1; this will be waived for the recipient of OAA who is in a chronic or convalescent hospital, chronic disease hospital, or rest home with nursing supervision and is transferred to MAA. (Such medical service has been removed from scope of medical care provided under OAA). The applicant who meets requirements for MAA, is in need of care in a medical facility, and has no income or income less than $100 a year, may sign a promissory note payable to the Department for such amount; note will not be recovered during lifetime of the beneficiary or spouse.

Scope of medical care provided.—(1) Institutional care: Hospital care, general hospital including physicians' and surgeons' services; nursing home care as given in (*a*) chronic disease hospital, (*b*) convalescent hospital, (*c*) rest home with nurse supervision. (2) Noninstitutional care: Physicians' services, home, office, or within a medical facility; outpatient hospital and clinic services; visiting nurse services; prescribed drugs.

Recipient in medical facilities such as listed above under "nursing home care" may receive, in addition: Dental care, sick-room supplies, prosthetic, surgical, and orthopedic appliances, eye glasses, hearing aids, transportation, services of practitioners other than medical doctor, i.e., osteopath, optometrist, chiropractor, chiropodist (podiatrist), naturopath, or treatment by spiritual practitioner.

Nursing home care in the kinds of institutions specified has been withdrawn from the scope of OAA and transferred to MAA. Special provision is made to meet nonmedical budgeted needs (personal care and needs, and special needs, in-

cluding health and life insurance premiums and temporary maintenance of rental facilities or own home) through State funds without Federal financial participation.

Additional provisions.—Eligibility is established prior to or concurrently with the need for medical care. The eligible applicant is given an identification card which certifies to his eligibility for medical care under the MAA program, but does not authorize payment for medical service bills for specific services. Reviewed in relation to the applicant's income available at that time to meet medical need, including insurance resources. For persons receiving long-term care, eligibility once established is reviewed annually and reapplication is not necessary.

OAA:

Program.—Since September 1960, no significant change has been made in eligibility for or scope of the generally comprehensive medical care services available under OAA.

Lien and recovery.—State has preferred claim against estate, secured by lien against real property, to the extent that such estate is not needed for support of the surviving spouse, parent, or dependent children of the deceased recipient.

Relative responsibility.—Ability of adult children living outside the household to contribute to support and the amount of their contributions are determined in individual situations on the basis of the applicable cost of living scale and a specific responsibility factor. Needs of a self-supporting spouse residing outside the household are determined in accordance with public assistance standards plus certain additional allowances, income in excess of these needs is budgeted as income available for support of the applicant.

Residence requirement.—No provision.

Scope of medical care provided.—Vendor payments for costs of medical care are used for: Hospital care (prior to Apr. 15, 1962, for nursing home care also), practitioners' services, dental care, prescribed drugs, nursing services in own home or in medical institution, restorative services, prosthetic appliances, transportation to secure medical care, and special equipment. Allowance is made in the money payment to recipient for premium for individually held hospital insurance policy, of Blue Cross or equivalent coverage and cost.

Money payment to recipient.—No maximum on money payment to recipient to meet total needs according to State's standard of assistance.

GUAM

Aged in population (April 1, 1960): Not available.

MAA:

Program.—Legislation enacted in 1961; services under the program began February 1, 1962. The plan has been submitted but not yet approved; therefore the following data, based on the plan material as submitted, may be subject to change.

Eligibility.—

Income: Annual income not to exceed $1,500 per annum for single person and $2,500 in case of a married applicant living with spouse.

Assets: (1) Real property: Used as a home or producing income of a value not to exceed $8,000. (2) Personal property: Holdings of a cash value not to exceed $800 if single, or $1,000 if married and living with spouse, exclusive of household effects and clothing used to meet current needs.

Recovery provisions.—No provision.

Relative responsibility.—No requirement.

Deductible.—None.

Scope of medical care provided.—Hospital care, total hospital care in the civilian hospital, Guam Memorial; physicians' services, from the department of medical services when prescribed as critically necessary or for determining need of physicians' services; dental care for relief of pain; prescribed drugs; ambulance, if other transportation cannot be used without hardship; prosthetic appliances.

Additional provisions.—Nursing home care is not included because there are no such institutions on the island. Eligibility for MAA and need for medical care are determined concurrently and subject to review if circumstances change.

OAA:

Program.—In its 1961 session, the Guam legislative body made provision for vendor payment of costs of medical care for recipients of old-age assistance. Services were begun in February 1962.

Lien and recovery.—No provision.

Relative responsibility.—Ability of members of the same household as the applicant to provide support for him is determined for each individual case. (There is no legislation applicable to OAA which prescribes responsibility of relatives to support.)

Residence requirement.—No provision.

Scope of medical care provided.—Vendor payments for medical care are used for: Hospital care, physicians' services in home or at out-patient clinic when critically necessary, dental care for relief of pain, prescribed drugs, prosthetic appliances, diagnostic services, and ambulance if other means of transportation cannot be used without hardship to patient.

Money payment to recipient.—No maximum on payment to meet total needs of recipient according to agency's standards of assistance.

HAWAII

Aged in population (April 1, 1960): 29,200.

MAA:

Program.—Legislation enacted in 1961, services began July 1961.

Eligibility.—

Income: Insufficient to meet the standards of assistance establishing for MAA, including nonmedical and medical requirements (approximately $50 per month above the standards of assistance of OAA) and if the resources available to him within 12 months after date of application are insufficient to pay the cost of needed medical care.

Assets: (1) Real property: Home with tax-appraised value of less than $14,000 is exempt; also other real property with value not to exceed $150. All excess value is considered a resource for payment of medical costs. (2) Personal property: All liquid assets beyond $50 cash savings (of unemancipated minor) are considered available after allowances for payments of obligations contracted for defined essential purposes. May own automobile 4 years old or older or when necessary for essential transportation. Full loan value of life insurance is resource. Under exceptional circumstances, conservation of readily available resources allowed. Health insurance, Veterans' Administration care, workmen's compensation, and similar resources must be taken into account in determining extent to which MAA is needed.

Recovery provisions.—No provision.

Relative responsibility.—An adult child is required by law to contribute to the extent of his financial ability, unless his parents failed to support him during his minority. Amount of contribution relative is expected to make is determined by a schedule, taking into account income and number of dependents.

Deductible.—None.

Scope of medical care provided.—Hospital care, nursing home care, practitioners' services, dental care, prescribed drugs, and outpatient and allied services.

Additional provisions.—Eligibility for assistance and need for medical care are determined concurrently, taking into account resources available over the ensuing 12-month period which could be applied to costs of needed care. Annual review of persons needing continuing care, as in nursing homes; for other persons, eligibility and medical care are redetermined when additional service is needed or when circumstances of eligibility have changed.

OAA:

Program.—Since September 1960, medical care through public assistance programs has been expanded to include persons otherwise eligible for OAA but in need of assistance only to meet costs of medical care.

Lien and recovery.—Claim, secured by lien, may be filed against estate of deceased recipient for amount of assistance granted; lien not enforceable against home while occupied by beneficiary, surviving unmarried spouse, minor or physically or mentally handicapped children. Recovery is permissive and not attempted if heirs are in need.

Relative responsibility.—An adult child is required by law to contribute to the extent of his financial ability, unless his parents failed to support him during his minority. Amount of contribution relative is expected to make is determined by a schedule, taking into account ncome and number of dependents.

Residence requirement.—No durational requirement; must be resident of State at time of application.

Scope of medical care provided.—Vendor payments are made for hospital care, physicians' services, dental care, prescribed drugs, sickroom supplies, X-rays, restorative services, prosthetic appliances, transportation to secure needed medical care, equipment, and, in exceptional cases where medically necessary, private duty nursing in hospital. Nursing home care is provided through the money payment. (In rural areas, physicians' services are provided by State government physician.)

Money payment to recipient.—To meet need according to State's standard of assistance; no maximum.

IDAHO

Aged in population (April 1, 1960): 58,300.

MAA:

Program.—Legislation enacted in 1961; services began July 1, 1961.

Eligibility.—

Income: Cash income from all sources is considered available to meet costs of medical care except for amount needed to meet ordinary expenses and obligations (calculated on basic requirements in State's "standards of assistance" plus $50 a month additional allowance to cover other obligations); in addition, for any month, one-twelfth of the savings and cash resources owned above $2,000 and less than $10,000 is considered available.

Assets: (1) Real property: May own home not excessive in value in relation to community standards. Value of other real property which can be made available is considered among cash assets. Total available assets—real and personal—may not exceed $10,000. (2) Personal property: Value of real property other than home plus personal property other than exclusions listed below may be held up to $2,000. Value in excess of this amount and under the maximum is considered available to meet costs of medical care, as stated in Income above. Excluded from assets available are: household furniture and personal possessions of reasonable value, a "popular priced" car.

Recovery provisions.—No provision.

Relative responsibility.—No requirement.

Deductible.—None.

Scope of medical care provided.—Hospital care for treatment of acute conditions, emergencies, contagious diseases, and nonelective surgery; nursing home care; practitioners' services. (Dental care and prescribed drugs are not provided through this program.)

Additional provisions.—Potential eligibility is determined concurrently with a "complaint of illness or injury" for which medical care is sought; actual eligibility is determined after medical care has been provided and is directly related to the costs of medical care incurred or predicted.

OAA:

Program.—The first provision for vendor payment of medical care, beginning in January 1959, included only nursing home care. In 1960, hospitalization and physicians' services (and for a short period, prescribed drugs) were added to the program. As a result of legislation in 1961, all nursing home care was removed from OAA program and placed in scope of MAA, with due provision for meeting personal needs of patients who had no income other than assistance.

Lien and recovery.—Provision for signed agreement, to be recorded and thus constitute a lien for assistance received subsequent to July 1, 1951. Not enforced against property during life of the owner except in case of sale of property, or as long as occupied as home by surviving spouse unless estate is probated.

Relative responsibility.—Determination of ability of relatives to contribute to support of applicant is part of investigation in each individual case.

Residence requirement.—One year immediately preceding application; reciprocal agreements may be made with other States.

Scope of medical care provided.—Vendor payments for: hospital care, all usual services; physicians' services in home, hospital, office, or nursing home. (Dental care and prescribed drugs are not provided; nursing home care provided through MAA program.)

Money payment to recipient.—As needed according to State's standard of assistance; no maximum on payment.

ILLINOIS

Aged in population (April 1, 1960): 975,000.

MAA:

Program.—Services began in September 1961; enabling legislation permits comprehensive scope of services but limitations of current appropriation required limiting services to hospital care, physicians' services in hospital, and physicians' services in posthospital period of home care. (Plan as submitted needed some revision and has not yet been formally approved; however services are being given and approval will be retroactive.)

Eligibility.—

Income: After deducting amounts necessary to maintain in force a medical, surgical, hospital, or other health insurance; maximum gross income for single person, $1,800; for applicant and spouse or other dependent, $2,400; for applicant living with more than one dependent, $1,800 for applicant plus $600 for each dependent. Income includes contributions from responsible relatives.

Assets: (1) Real property: Value of property used as a home and contiguous real estate is excluded. (2) Personal property: i.e., "liquid or marketable assets," may be held with value of not more than $1,800 for single person; $2,400 for applicant living with spouse or other dependent; $1,800 for applicant and $400 for each dependent when applicant has more than one dependent. Excluded in making this determination are: clothing, personal effects, automobile, life insurance with a face value of $1,000 or less; and tangible personal property used in earning income with a fair market value of $1,000 or less.

Person is eligible for payment of costs that exceed 10 percent of his income or 10 percent of the combined income when he is living with a spouse or other dependent(s).

Recovery provisions.—Assistance received constitutes a claim against the estate of a deceased recipient.

Relative responsibility.—State plan provides for consideration of support from legally responsible relatives; i.e., spouses and adult children.

Deductible.—None required; see "Additional provisions" below.

Scope of medical care provided.—Hospital inpatient care for acute illness, accidental injury, surgery, chronic conditions requiring limited period of hospital care, or for diagnostic procedures that can be carried out only in hospital; physicians' services in hospital; during 30-day period following release from a hospital, physicians' services in patient's home or doctor's office. (Scope does not include nursing home care, dental care, or prescribed drugs.)

Additional provisions.—MAA is not available unless cost of allowable medical care exceeds 10 percent of total income of applicant or of the combined income of applicant and dependents living with him; benefits from health or hospital insurance policies covering applicant may meet or be applied to this requirement. Eligibility is determined concurrently with or prior to need for medical care and application serves for a 12-month period during which requests for new medical services require only review of financial circumstances and costs of additional service needed.

OAA:

Program.—No substantive change in eligibility requirements or comprehensive scope of services provided through vendor payment since September 1960.

Lien and recovery.—All assistance granted on and after January 1, 1962, constitutes lien on recipient's legal and equitable interests in real property, not enforceable against real property occupied as a homestead by surviving spouse or specified relatives. If person received assistance prior to January 1, 1962, and is not a recipient after that date, total of assistance paid constitutes a claim against estate; not enforceable under some conditions as affect enforcement of lien. (Formerly all assistance constituted an unsecured claim against the estate of recipient.)

Relative responsibility.—Ability of defined relatives living in separate household from recipient is determined by a relatives' contribution guide; specified expenses in addition to personal allowances are taken into account in determining contribution expected from the relative.

Residence requirement.—One year immediately preceding application, or if moved to Illinois within 5 years prior to application, must meet resident requirement of the other State. This period may not be less than 1 year nor more than 5 out of the last 9 years immediately preceding application.

Scope of medical care provided.—Vendor payments made for comprehensive scope of medical services: hospital care, practitioners' services, dental care, prescribed drugs, sickroom supplies, diagnostic and therapeutic X-ray, prosthetic appliances, special equipment, services of Visiting Nurse Association. Nursing home care is provided through a combination of the money payment to recipient and vendor payment to the home as medical care.

Money payment to recipient.—No maximum on money payment to recipient for subsistence needs as defined by State.

KENTUCKY

Aged in population (April 1, 1960): 292,300.

MAA:

Program.—Developed at the same time as first vendor payments for medical care in categorical public assistance programs; legislation enacted in a special session in 1960, effective January 1, 1961.

Eligibility.—

Income: Annual gross income for single person may not exceed $1,200; for couple, $1,800. Special provisions for determining income from self-employment or from farming operations.

Assets: (1) Real property: Homestead is not considered; the equity in nonhomestead real property may not exceed $5,000, single persons or married couple. (2) Personal property: Limited to $750 for single person, $1,000 for applicant and spouse; excluding cash surrender value of life insurance not to exceed $3,000. (Personal property is defined as "cash on hand, money in bank, stocks, bonds, and other resources that can be converted into liquid assets"; excluded from consideration is cash surrender value of insurance within the maximum stated and tangible personal property not listed in definition.) Availability of health insurance is to be determined and evaluated.

Recovery provisions.—No provision.

Relative responsibility.—No requirement.

Deductible.—None.

Scope of medical care provided.—Hospital care for acute, emergency, and life-endangering conditions up to 6 days per admission with no limit on number or frequency of admissions; physicians' services; dental care; prescribed drugs.

Additional provisions.—After eligibility for medical care is established, additional services may be secured within a 12-month period without additional application unless there has been a change in circumstances affecting eligibility.

OAA:

Program.—Legislation in 1960 regular session authorized payments in behalf of recipients of public assistance for medical care; services began in January 1961.

Lien and recovery.—No provision.

Relative responsibility.—Ability of adult children to support is determined according to an "Income Exemption Scale," based on amount of income and number of dependents of such children; in determining amount considered available for support of parent, allowances are made for unusual family medical expenses which are deductible from Federal income tax.

Residence requirement.—6 months immediately preceding application.

Scope of medical care provided.—Vendor payments for medical care are made for hospital care for acute, emergency, and life-endangering conditions up to 6 days per admission with no limit on number or frequency of admissions; physicians' services; dental care; prescribed drugs. Other services, budgeted within the money payment to the recipient and subject to the maximums on the money payment, are nursing home care, and nursing care in own home.

Money payment to recipient.—For subsistence needs, maximum of $80 per month; person in personal care home, $85; in nursing home, $110.

LOUISIANA

Aged in population (April 1, 1960): 241,600.

MAA:

Program.—Services began in November 1961, upon authorization of legislation enacted by State in regular session, 1961.

Eligibility.—

Income: Income in excess of maximum allowable monthly income of $250 for single person or $325 for couple disqualifies income less than this amount

but in excess of (1) basic income and (2) allowable increases, as defined below, must be applied to costs of needed hospital care. (1) Basic income, $125 single, $175 married couple, combined income. (2) Allowable increases, $30 per month for each dependent minor child or disabled adult declared as dependent on applicant's income tax return; $15 additional income allowable for single person with hospitalization insurance, $25 for couple with such insurance.

Assets: (1) Real property: May own home as defined for homestead tax exemption; other real property not to exceed $5,000 assessed value if income producing or $1,000 value if not income producing; excess value is considered a liquid asset. (2) Personal property: Liquid assets not to exceed $1,000 for single, $1,500 for couple; excluding insurance with cash or loan value up to $1,500 (couple $2,000), motor vehicle used for transportation, farm equipment, or business assets which are income producing. Excess value of insurance, car, or nonhome real property must come under the liquid assets maximum. Free resources for medical care, available from other than State facilities, must be used if possible without undue hardship. Medical insurance carried by applicant must be utilized fully and must be assigned to hospital before MAA is used; amounts thus paid toward hospital costs considered "participation."

Recovery provisions.—No provision.

Relative responsibility.—No requirement.

Deductible.—Hospital care only: Patients with a monthly income over $90 ($140 for couple) participate in payment of the first $50 of costs when the costs exceed $10; the amount of participation (within this $50) is based on a sliding scale applied to "available" income. Amounts received from hospital insurance are considered as "participation" in determining amount to be paid before MAA may be applied to costs of hospital care. Such medical insurance must be utilized fully.

Scope of medical care provided.—Hospital care, including surgeons and attending physicians; nursing home care in licensed homes; medical doctor, for patients with an approved medical care plan covering serious continuing illness requiring care for relief of severe suffering or for correction or prevention of permanent impairment; prescribed drugs for patients in nursing home care. (Dental care not provided.)

Additional provisions.—Need for medical care is determined concurrently with eligibility; may be for "noncontinuing care" (less than 3 months), with reapplication if other care is needed, or "continuing care," with eligibility redetermined annually unless there is a change in circumstances which affects eligibility or need for medical service.

OAA:

Program.—Since September 1960, State has added hospital care for OAA and expanded physicians' services and drugs.

Lien and recovery.—No provision.

Relative responsibility.—Determination of ability of relatives to contribute to support is part of investigation of individual case.

Residence requirement.—5 of last 9 years with 1 year immediately preceding application.

Scope of medical care provided.—Vendor payments are used for hospital care, including physicians' services in hospital; nursing home care in licensed nursing home; medical doctor for persons with an approved medical care plan covering serious continuing illness requiring care for relief of severe suffering or for correction or prevention of permanent impairment; prescribed drugs for patient in licensed nursing home. In addition, sickroom supplies, nursing care not in a medical institution, prosthetic appliances, transportation, and special equipment are provided by vendor payment or through the money payment to the recipient, according to agency's defined limitations or regulations. (Dental care not provided.)

Money payment to recipient.—Maximum of $78 for one person, $72 for each of two or more old-age-assistance recipients in same household. Maximum may be exceeded up to $95 for special medical expenses and up to $105 for nursing care in own home or in facility not subject to license. (Vendor payment for licensed nursing home.)

MAINE

Aged in population (April 1, 1960): 106,500.

MAA:

Program.—Legislation enacted in 1961 regular session; services under the program began in October 1961.

Eligibility.—

Income: Annual income for single person, not to exceed $1,500; exemption of $600 additional for each dependent.

Assets: (1) Real property: Real property used as home is exempt; other real property may be held up to a value of $500 for single person, $800 for applicant and spouse; property in excess of these amounts disqualifies. (2) Personal property: Value of personal property used to produce income (livestock, tools, farm equipment) may not exceed $1,000 for single person, $1,500 for applicant and spouse; non-income-producing personal property may not exceed $500 for single or $800 for married couple.

Medical resources such as health insurance or workmen's compensation must be applied to cost of medical care before payment for balance from MAA. Voluntary payments by the individual or by others in his behalf toward costs of medical care encompassed in MAA will be treated in the same way.

Recovery provisions.—No provision.

Relative responsibility.—Contributions made by relatives taken into account in determining amount needed from MAA.

Deductible.—None.

Scope of medical care provided.—Hospital care for essential services for chronic, emergency, and acute conditions up to a total of 45 days within a fiscal year; comprehensive clinic care for patients with cardiac diseases, arthritis, circulatory and cardiovascular diseases, tumors, diabetes, or eye diseases that may result in loss of vision if not treated, includes services of specialists; transportation to secure comprehensive clinic care; home care by aid or visiting nurse as recommended by clinic physician and provided by recognized public or private agency.

Additional provisions.—Eligibility once established entitles recipient to defined services for a 12-month period unless changes in circumstances make person ineligible.

OAA:

Program.—Medical services paid for through vendor payment included hospital care and nursing home care prior to September 1960; since that date, rates and quality standards for both types of services have been raised.

Lien and recovery.—State has unsecured claim against estate of deceased recipient for amounts paid as assistance.

Relative responsibility.—Ability of specified relatives to contribute is determined according to a standard table of income and number of dependents; allowances are made for taxes and special expenses of the relative in determining the amount he is expected to contribute. (In OAA, such relatives are spouse and adult children.)

Residence requirement.—One year immediately preceding application; reciprocal agreements made with selected States.

Scope of medical care provided.—Vendor payments are made for hospital care up to 45 days a year and for nursing home care.

Money payment to recipient.—Sixty-five dollars per month maximum may be exceeded for person receiving family care in licensed nursing home, chronic hospital, or boarding home licensed for family care. In addition, premium paid into pooled fund for medical care encompassed in plans for vendor payments to suppliers.

MARYLAND

Aged in population (April 1, 1960): 226,500.

MAA:

Program.—State agency's contract with State health department was extended to include services to persons eligible for MAA; care began June 1, 1961.

Eligibility.—

Income: Regular income not to exceed (1) in Baltimore City and 5 larger counties, $1,140 for single person; $1,560 for applicant with 1 dependent; plus allowances for additional dependents; (2) in 18 other counties, $1,080

for single person, $1,500 for applicant with 1 dependent. Income includes that of spouse or of any other person claimed as dependent. Scale of value for income in kind.

Assets: (1) Real property: Home is exempt; real property other than home is included in other resources convertible to cash. (2) Personal property: Resources in cash or convertible to cash (savings, insurance, real property other than the home) may not exceed $2,500 cash value. A person is ineligible who has any insurance or other benefit the terms of which provide for payment for the medical care items included in the plan.

Recovery provisions.—No provision.

Relative responsibility.—No requirement.

Deductible.—None.

Scope of medical care provided.—Hospital care, practitioners' services, dental care, prescribed drugs, sickroom supplies, X-ray, physical therapy, minor surgery in private office facility or accident room, special medical care clinics, eyeglasses when prescribed following cataract surgery. (Nursing home care not provided.)

Additional provisions.—Eligibility is determined concurrently with or prior to need for medical care; on the basis of the certificate from the department of public welfare, the health department issues a medical care card valid for 1 year and is responsible for identifying need for and arranging for medical care. Annual reinvestigation by welfare department, or more often if circumstances change.

OAA:

Program.—Since September 1960, added dental care to scope of medical care provided and began vendor payments for patients receiving nursing home type of care in certain chronic care hospitals.

Lien and recovery.—State has unsecured claim against estate for all assistance paid.

Relative responsibility.—Ability of children to contribute is determined with "responsibility scales" of income and number of dependents; allowances are made for extraordinary expenses in determining the amount the children are expected to contribute. (Does not apply to husband living apart from his wife; his ability to support and the amount is determined by court action.)

Residence requirement.—One year immediately preceding application; may be waived by reciprocal agreement with another State providing Federal matching is not affected.

Scope of medical care provided.—Vendor payments for medical care are used for hospital care, nursing home type of care in five chronic care hospitals, practitioners' services, dental care, prescribed drugs, sickroom supplies, X-rays, physical therapy, eyeglasses. Nursing home care other than specified above is provided through the money payment to the recipient subject to State maximums on the money payment.

Money payment to recipient.—The State is divided into three areas according to the cost of shelter as determined in the State's standards of assistance; the maximum on the money payment is $190 a month, $200, or $210 depending upon the "shelter plan" applicable to the area in which the local agency is.

MASSACHUSETTS

Aged in population (April 1, 1960): 572,000.

MAA:

Program.—Plan became operative and first payments were made in November 1960, services began in October 1960.

In the first 4 months of operations, about 89 percent of the total individual MAA recipients (roughly 14,000 out of 16,000) were transferred from other public assistance programs as recipients needing and receiving long-term nursing home care. As of January 1962 (15 months of operation) about 61 percent of the total caseload opened consisted of transfers from other public assistance programs, mainly OAA (18,826 former OAA recipients among 30,478 cases).

Eligibility.—

Income: (1) Receiving medical care in own home: If single, or if married and husband is applicant, $150 per month is excluded (if wife is applicant, $225 a month combined income), excess income considered available to apply to costs of medical care. (2) Receiving short-term medical care in a hospital, nursing home, or public medical institution: For single person or for spouse remaining at home, $150 a month is excluded; total income between $150 and $300 is considered available to be applied to medical costs for a period

of 3 or 6 months based on amount of excess; income (for couple, combined income of husband and wife) in excess of $300 a month disqualifies. (3) Receiving long-term or permanent care in a hospital, nursing home, or public medical institution: Single person or one of a couple may retain $15 for personal needs; for spouse remaining at home, $150 a month is excluded from consideration; all income (for couple, combined income of husband and wife) in excess of this amount is applied to payment of medical care. [Provision for payment of personal needs allowance from State funds, without Federal financial participation, for person with less than $15 a month income.]

Assets: (1) Real property: Ownership of home does not disqualify; ownership of any interest in other real estate disqualifies. (2) Personal property: Total may not exceed $2,000 for single person or if married and husband is the applicant; $3,000 if married and wife is applicant, including combined ownership of husband and wife.

Recovery provisions.—Action for recovery may be brought after the death of recipient and his surviving spouse, if any.

Relative responsibility: Ability of children to contribute is evaluated; allowances made for unusual circumstances involving family obligations in determining amount such children are expected to contribute.

Deductible.—None required.

Scope of medical care provided.—Comprehensive care is provided, and the program pays for all of the cost in excess of the amount of recipient's income and resources which have been determined to be available to meet such costs.

Additional provisions.—For persons in institutional care who have less than $15 a month income, allowance for personal needs of recipient is made from State funds with no Federal participation.

OAA:

Program.—No substantive change in eligibility requirements or comprehensive scope of services provided through vendor payments for medical care since October 1961, except that long-term nursing home care was removed from OAA medical services and placed within the scope of the new program of medical assistance for the aged. Special allowance is made from State funds for persons transferred thus from OAA to MAA and still in need of subsistence payments.

Lien or recovery.—Lien required on real estate, not enforcible if (1) market value at time of death and the cash surrender value of life insurance do not exceed $1,500, or (2) property is occupied by surviving spouse as a home.

Relative responsibility.—Ability of adult children to contribute is evaluated according to a scale of income and number of dependents; defined allowances are made for unusual circumstances involving family obligations in determining the amount such children are expected to contribute.

Residence requirement.—Three out of last nine years with one year immediately preceding application.

Scope of medical care provided.—Vendor payments made for comprehensive scope of medical care: Inpatient hospital care, short-term nursing home care, practitioners' services, dental care, prescribed drugs, nursing care in own home, sickroom supplies, restorative services, prosthetic appliances, transportation, and equipment.

Money payments to recipients.—No maximum on money payment to recipients for subsistence needs as defined by State.

MICHIGAN

Aged in population (April 1, 1960): 638,000.

MAA:

Program.—Services began in October 1960; first payments in November 1960. Scope of services to be provided was enlarged in 1961 by the addition of nursing home care for a posthospital period and home nursing care. The maximum on permissible income was also raised.

Eligibility.—

Income: Maximum annual income for single person (unmarried or not living with spouse) is $1,500; if married and living with spouse, not more than $2,500, including the annual income of the spouse. Income must include contributions which son, daughter, or estranged spouse should be making to applicant, according to agency standards or court determination, except that such contributions are not included in computing income during first 30 days of each separate period recipient is hospitalized.

Assets: (1) Real property: Value of property used as a home is excluded. Value of other real property must be included in limits on marketable assets specified below. (2) Personal property: i.e., liquid or marketable assets may be held with value of not more than $1,500 for single person, $2,000 for married applicant and spouse. Excluded in making this determination are: Clothing and household effects; cash surrender value (not value of matured policies) of life insurance; and not to exceed $1,000 of fair market value of personal property used in earning income. All other property, real and personal, must be evaluated in determining eligibility under the $1,500 or $2,000 limitation specified.

Recovery provisions.—Filing of claim against estate of deceased recipient is permissive, not required; held in abeyance during lifetime of surviving spouse, if any.

Relative responsibility.—Contributions from legally responsible relatives (children and spouse) or contributions which they should be making to applicant according to agency standards of court determination are included in the income of the applicant; except that such contributions are not counted as income during the first 30 days of hospitalization.

Deductible.—None required.

Scope of medical care provided.—Hospital care, including diagnostic procedures which can be carried out only on an inpatient basis; nursing home care beginning within 30 days following hospitalization for an acute illness and continuing up to a maximum of 90 days in a 12-month period; practitioners' services; nursing care in home when recommended by physician; outpatient clinic services, including first aid, physical therapy, therapeutic radium and X-ray, and specified diagnostic procedures.

Additional provisions.—Eligibility is determined concurrently with need for medical care and eligible status continues for a period of 12 months, subject to review if circumstances change.

OAA:

Program.—Scope of medical services broadened since September 1960 by addition of home nursing care services and physical examinations for each new applicant.

Lien and recovery.—Claim for reimbursement may be filed against estate for total assistance paid since October 11, 1947. Not secured.

Relative responsibility.—Ability of responsible relative is determined in accordance with detailed scales of income and number of dependents; allowances up to specified maximums are made for living costs and for unusual financial circumstances in the individual situation in determining the amount he is expected to contribute.

Residence requirement.—Five of last nine years with one year immediately preceding application; or if person is receiving assistance from another State reciprocal agreements are made on residence requirement.

Scope of medical care provided.—Vendor payments are made for hospital care, without limitation as to nature or amount of service, and for special nursing services in hospital or at home. Other services provided through the money payment (subject to the maximum reported below) are nursing home care, practitioners' services, dental care, prescribed drugs, X-rays, prosthetic appliances, and ambulance transportation.

Money payment to recipient.—Maximum on money payment to recipient for subsistence needs as defined in the State's standards is $80 a month or $90 for person receiving care in an approved convalescent home or approved county medical institution.

NEW HAMPSHIRE

Aged in population (April 1, 1960): 67,700.

MAA:

Program.—Legislation enacted in 1961 provided the basis for the program; services began September 1, 1961.

Eligibility.—

Income: Annual net income from all sources may not exceed $1,200 for single person, $1,800 for married couple living together; plus $600 allowed for support of each dependent child. If both members of a couple are in the same nursing or boarding home, they are considered as single individuals.

Assets: (1) Real property: Home owned and occupied by applicant is excluded. Also excluded is net equity in other real property up to $500 for

one person, $800 for couple. Net equity beyond $500 but less than $4,500 for single person (beyond $800 but less than $4,800 for couple) does not disqualify if real property is income producing. (2) Personal property: May hold livestock and equipment used to earn income up to a net cash value of $1,500; net cash equity of all other personal property, including cash value of life insurance, may not exceed $500 for single person, $800 for married couple. All medical resources such as health insurance or workmen's compensation are taken into account in determining extent of need for MAA.

Recovery provisions.—Provision for recovery from estate of a recipient after his death and that of the surviving spouse.

Relative responsibility.—Ability of adult children to support parents is determined according to income scale, with provision for taking into account certain extra family expenses if they exist.

Deductible.—None.

Scope of medical care provided.—Hospitalization limited to 11 days per admission, including payment to surgeon; physicians' services in home or office, limited to six calls per fiscal year. (Eye care is excluded from the scope of this program because it is available through the sight conservation division of the same State agency that administers MAA and OAA.)

Additional provisions.—Eligibility and need for medical care are determined concurrently, with the need for medical care evidenced by statement of a physician; eligibility is reviewed as new service is needed or if circumstances of case change; redetermination of total eligibility required every 12 months.

OAA:

Program.—No substantive change in eligibility or scope of services since September 1960; already provided comprehensive range of services with provisions for vendor payment of costs.

Lien and recovery.—Assistance paid constitutes by law a lien on estate of recipient and of spouse living with recipient; no recovery on real estate occupied by surviving spouse.

Relative responsibility.—Ability of relatives, whether legally liable or not, and amount of contribution available for support of applicant is determined as part of initial investigation in each individual case. (No prescribed scale of amounts expected as contributions.)

Residence requirement.—Five out of last nine years and one year immediately preceding application; reciprocal agreements may be made with other States.

Scope of medical care provided.—Vendor payments are used for hospital care; nursing home care in public nursing homes; practitioners' services in home, office, hospital, or outpatient clinic; dental care; prescribed drugs; sickroom supplies; special nursing services; X-rays, prosthetic appliances; and special equipment. Provisions are made within the money payment to the recipient for nursing home care in private nursing homes and for transportation to receive medical care.

Money payment to recipient.—Maximum of $100 per month; $105 for persons eating regularly in restaurants; plus payment into pooled fund for medical care. Maximum may be exceeded to meet costs of nursing home care (private nursing homes) or of nursing care in own home in lieu of nursing home placement; may also be exceeded for special diets, telephone required by health condition, or for premiums on individually held Blue Cross hospital insurance policy if policy has been carried for 1 year at other than agency expense.

NEW YORK

Aged in population (April 1, 1960): 1,688,000.

MAA:

Program.—Services began in April 1961. Within the first months of operation many persons classified as OAA recipients (primarily those receiving "medical care only," i.e., not in need of subsistence payments) who were receiving nursing home care were transferred to MAA. Nursing home care as a service continues to be given in both the OAA and the MAA programs without distinction as to length of time such care is needed by a recipient.

Eligibility.—

All income and resources shall be deemed available to meet costs of medical care except as follows:

Income: (1) In medical or nursing institutions for chronic care: Up to $10 a month for personal care items; annual premiums for health insurance policy up to $150 for single recipient or $250 for married recipient if policy covers

spouse; if married, up to $1,800 a year for support of spouse, including any income of spouse. (2) Not in facility for chronic care: $1,800 for single applicant; $2,600 for married applicant living with spouse; health insurance policy premiums up to $150 per year for single recipient or $250 if married and policy includes spouse. (See reserves, below.)

Assets: (1) Real property: Home is exempt; other real property not used as home must be utilized to apply to costs of care. (2) Personal property: Clothing and household effects are exempt; may have life insurance with cash surrender value of not more than $500 (single person or couple). Insurance in excess of this amount and nonessential property must be utilized.

Cash reserve permitted for person not living in a medical facility: $900 for single person or $1,300 for married couple. If value of nonhome real estate, nonessential personal property, and excess insurance together with cash or liquid assets does not exceed this reserve limit, such resources need not be utilized and applied to costs of care.

Recovery provisions.—Provision for recovery from estate of deceased recipient after death of surviving spouse.

Relative responsibility.—Spouse, parents, and children are liable for payment of medical care insofar as they are found able to assist.

Deductible.—None required; eligibility is determined concurrently with need for medical care and in relation to the known or predictable extent and cost of such care.

Scope of medical care provided.—Hospital care, nursing home care, services of medical doctor and osteopath, prescribed drugs, sickroom supplies, special nursing services, physical therapy, prosthetic appliances, and outpatient hospital or clinic services.

Additional provisions.—MAA services are part of plans for medical care developed by each local welfare district, based on State's manual and subject to approval of the State department of social welfare.

OAA:

Program.—No substantive change in eligibility or in comprehensive scope of medical care provided since September 1960 except that "medical care only" cases formerly served through OAA are generally eligible for new MAA program.

Lien and recovery.—Local public welfare official may recover amount of assistance granted from recipient or his estate. Such claim may be secured by deed, mortgage, or lien with respect to real property; by assignment of or preferred claim against insurance; by assignment of other assets.

Relative responsibility.—Ability of responsible relatives to contribute is determined through a budgeting system, taking into account circumstances of the individual situation.

Residence requirement.—No durational requirement. Must be resident of State at time of application.

Scope of medical care provided.—The welfare district elects whether to use the money payment method or vendor payment method to meet costs of medical care. Services included are hospital care, nursing home care (may use a combination of money and vendor payments), practitioners' services, dental care, prescribed drugs, sickroom supplies, special nursing services, X-rays, restorative services, prosthetic appliances, transportation, and equipment.

Money payment to recipient.—No maximum on money payment to recipient to meet subsistence needs defined by State plan.

NORTH DAKOTA

Aged in population (April 1, 1960): 58,600.

MAA:

Program.—Legislation enacted in 1961 authorizes a program comparable in scope and content to the services available to recipients of old-age assistance. Services began July 1, 1961.

Eligibility.—

Income: Annual income in excess of the following is considered available to meet costs of medical care: Single person, $1,200; married couple, $1,800. Persons living in a nursing home or hospital: Single, $96; married couple, both in nursing home or hospital, $192; married couple, one in nursing home or hospital and the other not living in an institution, $1,296.

Assets: (1) Real property: Homestead is exempt (town house and up to 2 acres of land; rural, 160 acres contiguous to house). Other real property

that is salable or in which applicant has an equity must be utilized to apply to medical care costs. (2) Personal property: Total value not to exceed $2,500, of which not more than $500 for single or $1,000 for married couple may be in cash, stocks, or bonds. Cash value of insurance comes under total value maximum but not under liquid assets maximum. Excluded from consideration as personal property are household goods, wearing apparel, or personal effects.

Recovery provisions.—Preferred claim against estate of deceased recipient; not enforcible against property needed for support or comfort of spouse.

Relative responsibility.—Applies to MAA same principles as for OAA, i.e., ability of specified relatives (those "legally liable") to contribute to support of applicant is determined for each individual case at time of initial investigation.

Deductible.—Applicant must have paid or have obligated himself to pay $50 for medical care during 12 months preceding the application; benefits from health or hospital insurance will be considered as meeting this requirement.

Scope of medical care provided.—Hospital care, nursing home care in licensed home or in hospital on monthly contract basis, practitioners' services, dental care, prescribed drugs, special nursing care, physical therapy, prosthetic appliances, outpatient hospital and clinic services, diagnostic screening and preventive services, X-ray and laboratory services, transportation, and special equipment.

Additional provisions.—Eligibility for assistance and need for medical care are determined concurrently. Redetermination of eligibility is made annually, subject to earlier review if circumstances change. Recipient is determined to be ineligible if during the 12-month period he has not received $50 or more medical health services. (Compare requirement under "Deductible" entry above.)

OAA:

Program.—No substantive change in eligibility or in scope of medical services provided since September 1960; State provides comprehensive services to recipients. (Before the beginning of the program of MAA, medical care through OAA program was available also to persons in need of medical care only, although not in need of money payment for subsistence needs.)

Lien and recovery.—Total amount of assistance granted is preferred claim against estate of deceased; not enforcible against real estate occupied by surviving spouse or dependents nor against personal property necessary for their support, maintenance, or comfort.

Relative responsibility.—Ability of specified relatives to contribute to support of applicant is determined for each individual case at time of initial investigation. (Legally liable relatives are spouse, parents, and children.)

Residence requirement.—One year immediately preceding application or if eligible in another State, same period of residence in North Dakota as would be required in other State for person moving there from North Dakota.

Scope of medical care provided.—Vendor payments are used for hospital care, all general services, limited to 60 days; short-term nursing home care, up to 30 days (long-term care is provided through the MAA program); practitioners' services; dental care; prescribed drugs; special nursing care; physical therapy; prosthetic appliances; transportation; and equipment. If applicant has health insurance and if physical condition indicates probable need for the benefits, cost of premium payments for such individually held policy may be included in the money payment.

Money payment to recipient.—No maximum; assistance granted to meet need as defined in State's standard of assistance.

OKLAHOMA

Aged in population (April 1, 1960): 248,800.

MAA:

Program.—Services began in October 1960, based on interpretation of existing State statutes.

Eligibility.—

Income: Annual income, single person, up to $1,500; for man and wife, up to $2,000. Exempts the income required by legal dependents according to ADC standards.

Assets: (1) Real property: May have equity up to $8,000 in home owned and occupied as home (urban includes necessary lots; rural includes up to 40 acres of land). Equity above this amount and value of other real property are considered among other resources. Home to which recipient or spouse

has no feasible plans to return is no longer considered eligible for exemption as home occupied by recipient. (2) Personal property: Maximum set for each of four kinds of property: (*a*) Insurance—single person, cash value of first $1,000 face value; married, cash value of first $2,000 face value; married, living together and having separate policies, cash value of first $1,000 face value for each; (*b*) equity in tools for earning a living, up to $1,500; (*c*) equity in small business which he operates, up to $2,500; (*d*) other resources limited to $700 for single person or $1,000 for married couple, including cash, stocks, bonds, etc., automobiles, excess of value of items listed in (*a*) and (*b*) preceding, excess equity of home, or property of any kind which can be made available for use of recipient or spouse.

Recovery provisions.—No provision.

Relative responsibility.—No requirement.

Deductible.—None.

Scope of medical care provided.—Care is limited to that necessary for treatment of life-endangering or sight-endangering conditions. Within that definition, program provides for hospital care, up to 6 months in any 12-month period; medical care portion of nursing home care, with recipient responsible for room-board portion and personal needs; physicians' services, including those of surgeons and specialists; dental care in a licensed general hospital for life-endangering conditions involving fractures, infections, or tumors of the mouth; nursing care in own home; for hospitalized patient, transportation. (Prescribed drugs not encompassed in the program.)

Additional provisions.—Eligibility is determined concurrently with need for medical care within the definition of the program as evidenced by statement of medical or osteopathic physician. Redetermination of eligibility is made whenever warranted by change in circumstances.

OAA:

Program.—Since September 1960, State has expanded hospitalization and physicians' services for old-age assistance recipients.

Lien and recovery.—No provision.

Relative responsibility.—No legal liability of relatives, but ability and willingness of relatives to contribute to support is evaluated in each individual case. If a relative is claiming applicant as a dependent for income tax purposes, it will be considered that he is meeting at least one-half of the applicant's needs unless it is established that the income is not available for the use of the applicant.

Residence requirement.—Five out of last nine years, with 1 year immediately preceding application.

Scope of medical care provided.—Vendor payments are used for: Hospital care; medical care portion of nursing home care costs, with the money payment to the recipient for the room-board portion and personal care items if needed; practitioners' services, home, hospital, and outpatient clinic; dental care in a general hospital for treatment of life-endangering conditions involving fractures, infections, or tumors of the mouth; special nursing services in recipient's place of residence; X-rays for treatment purposes; and transportation. (Prescribed drugs not provided for old-age assistance.)

Money payment to recipient.—Maximum of $143 a month, including nursing or attendant care; family maximum of $236.

OREGON

Aged in population (April 1, 1960): 183,700.

MAA:

Program.—Legislation enacted in 1961 authorizes the MAA program; services began November 1, 1961.

Eligibility.—

Income: Single person, less than $1,500; married, combined income of husband and wife less than $2,000. Where it is not possible to determine the income of an absent spouse, applicant is treated as a single person.

Assets: (1) Real property: Home used by applicant or legal dependents, exempt; value of other real property together with personal property may not exceed $5,000 fair market value. (2) Personal property: Excluded from consideration are: One automobile; household furnishings; personal property holdings used in earning a living (clothing, tools, machinery, and other goods and equipment). All other property must come under maximum specified above. Liquid assets (cash or equivalent) shall be less than $1,500

for single person, $2,000 for couple. Excluded from consideration is cash surrender value of life insurance held by applicant not to exceed $1,000.

Recovery provisions.—Recovery provisions of law regarding claims against estates will apply after death of recipient and spouse.

Relative responsibility.—No requirement.

Deductible.—Applicable to hospital care: Patient pays $7.50 per day for first 10 days of care up to a maximum of $75 per year. Applicable to any combination of physicians' services, X-rays, or laboratory procedures: Patient first pays $50 within a benefit year, then becomes eligible for MAA payments.

Private medical insurance policies may be utilized in the payment of such deductible amounts and must be utilized to the fullest extent possible as an offset before MAA benefits are payable. MAA and partial benefits supplement each other.

Scope of medical care provided.—Hospital care, up to 14 days per benefit year (patient pays $7.50 per day for first 10 days of care per year); nursing home care upon transfer from at least 1 day of hospital care (no deductible, but days based on 4 days of nursing home care for each of the unused days remaining from the 14 days of hospital entitlement per benefit year); practitioners' services; outpatient hospital care when the physician renders services as defined in the program.

Additional provisions.—Eligibility once established continues for a year, including additional medical services, unless circumstances of case affecting eligibility change.

OAA:

Program.—No substantive change since September 1960 in eligibility or scope of medical care; State had comprehensive services at that time.

Lien and recovery.—Assistance paid constitutes an unsecured, prior claim against property or any interest therein belonging to estate of recipient except such portion as is being occupied as a home by the spouse, minor dependent child, or parent of deceased recipient.

Relative responsibility.—Statutory income scale indicates legal liability of specified relatives; State public welfare commission has authority to review detailed circumstances of the relative and to accept a less amount as the contribution he is able to make. Voluntary contributions to meet costs of medical care may be offset against the amounts specified in the statute as support. Receipt of assistance constitutes, on the part of the recipient, consent for the State public welfare commission to take action to recover amounts granted as assistance if relatives in question refuse to support.

Residence requirement.—Five of last nine years with 1 year immediately preceding application.

Scope of medical care provided.—Vendor payments are made for: Hospital care, nursing home care, practitioners' services, dental care, prescribed drugs, sickroom supplies, special nursing services, X-rays, restorative services under exceptional circumstances, prosthetic appliances, transportation, and equipment.

Money payment to recipient.—No maximum on money payment to meet needs of recipient according to State's standard of assistance.

PENNSYLVANIA

Aged in population (April 1, 1960): 1,129,000.

MAA:

Program.—Enabling legislation was enacted in July 1961; State's plan was developed in the ensuing months and services began under the plan in January 1962.

Eligibility.—

Income: All income is considered in determining eligibility for MAA or extent to which MAA is needed, except following: Annual income up to $1,500 for single person, $2,400 combined annual income of married couple, plus $500 for each minor or incompetent child living with and dependent upon applicant. For person receiving nursing home care in a public institution: All income is considered applicable to cost of such care except $5 per month to meet personal needs.

Assets: (1) Real property: Home is exempt; value of all other real property must come under maximums cited below. (2) Personal property: Value of all other real and personal property may not exceed $1,500 for single person or $2,400 for couple, exclusive of household furnishing, neces-

sary automobile, cash surrender value of life insurance up to $500 for applicant and $500 for spouse, or tools, equipment, and stock necessary to obtain income unless the value of such possessions appears to be excessive. For persons in a public nursing home for up to 6 months of care, real and personal property may be held up to value of $1,500 (exclusions same as above); after 6 months of care, resources are reevaluated, exempting only such property up to value of $500 (exclusions same as above, except car no longer exempt). Benefits available from Blue Cross, other hospital, health, or accident insurance, or workmen's compensation are taken into account.

Recovery provisions.—Provisions for recovery from estate of recipient, as permitted under the Federal Medical Assistance for the Aged Act.

Relative responsibility.—Ability of close relatives to assist the applicant is considered in accordance with the Pennsylvania support law. (Refer to section on OAA.)

Deductible.—None required.

Scope of medical care provided.—Hospital care; posthospital care in the home, provided by the hospital under approved home-hospital plan; nursing care; nursing home care in an institution operated by a county authority.

Additional provisions.—Need for medical care must be immediate at time of determination of eligibility for MAA.

OAA:

Program.—No substantive change in eligibility requirements for this program or in scope of medical care provided since September 1960.

Lien and recovery.—Lien secures claim against property owner for all assistance paid to him or certain of his relatives; not enforcible against home or furnishings used by property owner, spouse, or dependent child.

Relative responsibility.—Ability of responsible relatives (spouse, parents, children) to support is determined in each case by a formula based on net income and number of dependents. Amount of such potential resource is considered available income of the applicant in determining extent of his need for assistance.

Residence requirement.—One year immediately prior to application, or was last a resident of State with which reciprocal agreement has been made to grant assistance without regard to period of residence. Must be residing in State at time of application.

Scope of medical care provided.—Vendor payments for medical care are used for practitioners' services in home, office, or outpatient clinic calls; dental care; prescribed drugs; sickroom supplies; nursing services in home; X-rays; certain prosthetic appliances; physical therapy; transportation; and equipment. Nursing home care is provided through the money payment to the recipient. (Hospital care is not provided through the public assistance programs but is considered to be available to recipients through the statewide system of State-owned or State-aided hospitals.)

Money payment to recipient.—There is no maximum on the money payment to the recipient to meet subsistence needs as defined by the State.

PUERTO RICO

Aged in population (April 1, 1960): 122,200.

MAA:

Program.—Services began when Federal funds were made available for this program, October 1960. Division of Public Welfare is a part of the Department of Health, which already had responsibility for providing medical care to medically indigent persons. Arrangements were made to purchase from the Health Department facilities certain medical services for persons eligible for MAA.

Eligibility.—

Income: Annual income and available liquid resources of individual may not exceed $1,500.

Assets: (1) Real property: Home where applicant resides is excluded from consideration; all other real property is taken into account in determining eligibility. (2) Personal property: Loan value of life insurance and any other available resources will be taken into account. Membership in organizations which provide medical care or payment therefor make applicant ineligible.

Recovery provisions.—No provision.

Relative responsibility.—No requirement.

Deductible.—None.

Scope of medical care provided.—Hospital care; nursing home care where available and as prescribed by physician; outpatient hospital care and dispensary services furnished through the facilities of the Department of Health and hospitals under contract, including: physicians' services, prescribed drugs and appliances, physical therapy and related services, dental care, laboratory and X-ray services, and preventive medical care. (Practitioners' services, dental care, and prescribed drugs not provided except through such clinics.)

Additional provisions.—Eligibility is determined concurrently with or prior to the need for medical care and remains in effect for additional services during 1 year, subject to review if case circumstances change. Membership of applicant in such organizations as Blue Cross, Blue Shield, State retirement or compensation systems, applicant's purchase of health insurance of any appropriate type, his rights to veterans' benefits, and similar resources to provide or meet costs of medical care shall make him ineligible for participation in MAA.

OAA:

Program.—Since September 1960, Commonwealth has begun vendor payments in behalf of OAA recipients for hospital care.

Lien and recovery.—No provision.

Relative responsibility.—Ability of specified relatives to contribute is determined through a budgeting procedure, taking into account the circumstances of the individual situation.

Residence requirement.—No durational residence requirement.

Scope of medical care provided.—Vendor payments are made for hospital care, including drugs prescribed while person is hospitalized and dental care which may be given during a period of hospital care. (Other medical services are available to recipients of OAA through the department of health program for medically indigent persons.)

Money payment to recipient.—No maximum on payment to meet needs of recipient according to agency's standards of assistance.

SOUTH CAROLINA

Aged in population (April 1, 1960): 150,600.

MAA:

Program.—Legislation was enacted in 1961 regular session authorizing the program; services were begun July 1, 1961.

Eligibility.—

Income: Maximum annual income for single person is $1,000; for married couple, combined income may not exceed $1,800. In determining income from the operation of a business, net income will be considered.

Assets: (1) Real property: Home and land upon which it stands, owned and occupied by applicant or to which he has reasonable plans to return, is exempt as a resource. Other real property may be held if income-producing; if nonincome producing, sale value of the property is considered under the income maximums. (2) Personal property: May hold (1) savings of $500 if single or $800 combined savings of married couple; (2) insurance with cash, loan, or surrender value of $1,000 for single person and of $2,000 for married couple. Savings or insurance value in excess of these amounts are considered under the maximum on income. Not considered as assets available for payment of medical care costs is value of such personal property as automobile needed for transportation, household furnishings, and farm equipment.

Recovery provisions.—No provision.

Relative responsibility.—No requirement.

Deductible.—None.

Scope of medical care provided.—Hospital care for acute illness, injury, or condition that endangers sight when the need for hospitalization is essential, not to exceed 40 days of care in a fiscal year; nursing home care following discharge from period of hospital care, generally limited to 90 days within a fiscal year but may be extended when required by such conditions as severe burns or terminal cancer; outpatient hospital or clinic services in organized clinic, including emergency room service, special diagnostic and therapeutic procedures, minor surgery such as biopsies. (Practitioners' services, dental care, and prescribed drugs not provided elsewhere.)

Additional provisions.—Eligibility is determined concurrently with need for medical care and redetermined as circumstances change or at least annually.

OAA:

Program.—No substantive change in eligibility or scope of services provided in medical care since September 1960.

Lien and recovery.—Total amount of assistance paid since July 1, 1956, allowed as unsecured claim against estate on death of recipient. No recovery on real property used by dependent relatives nor when gross market value of estate is less than $500.

Relative responsibility.—Ability of close relatives, particularly children, to contribute is determined in each individual case. If relative claims applicant as a dependent for income tax purposes, he is expected to be contributing not less than 51 percent of the budgeted need of the applicant unless the relative in question has so many dependents in his own family that he is not liable for income tax and is unable to make a contribution.

Residence requirement.—One year immediately preceding application.

Scope of medical care provided.—Vendor payments are used for hospital care for acute injuries and illnesses, up to 40 days a fiscal year; and for nursing home care for a period of 90 days following discharge from a period of hospital care, with extensions for serious conditions requiring longer care. Money payments within the maximum on total payment, including subsistence needs, are used for prescribed drugs, home nursing services, and care in facilities other than posthospital nursing home care.

Money payment to recipient.—Maximum $60 a month.

TENNESSEE

Aged in population (April 1, 1960): 308,900.

MAA:

Program.—Enabling legislation was enacted in 1961; program services began July 1, 1961.

Eligibility.—

Income: Annual income not to exceed $1,000 for single person or $1,500 for couple. May also deduct the actual cost of support of totally dependent children. Any benefit designated specifically for support of such dependent child (for example, VA or SSA) residing in the applicant's home is excluded from income of applicant; but the amount of such benefit is subtracted from cost of support of the child to determine the amount to be considered as the exemption in the income of applicant.

Assets: (1) Real property: Equity in all real property (including the home) owned by applicant cannot exceed $5,000 and the total real value of such property cannot exceed $10,000 (figured on the county assessment percentage for the county in which the real property is located). (2) Personal property: Total of cash, savings, or items readily convertible into cash may not exceed $1,000 for single person or $1,500 for a couple, excluding cash value of life insurance up to $1,000 for single person or $1,500 a couple. Excess cash value must be considered under the liquid assets maximum. Health insurance benefits and contributions for medical care must be taken into account.

Recovery provisions.—No provision.

Relative responsibility.—No requirement.

Deductible.—For hospital care, MAA payments cannot be made until the person has incurred hospital expenses amounting to $25 within a fiscal year (either at one time or as a result of more than one admission to the hospital). MAA payment can begin the day after such amount accrues. Benefits from health or hospital insurance covering the applicant may be applied to meet this $125 prior to being considered available to meet costs of days of care for which MAA would be charged.

Scope of medical care provided.—Hospital care for acute illness or injury, limited to 10 days per fiscal year; drugs prescribed for treatment of diabetes, cardiac disease, and urinary tract infection.

Additional provisions.—Eligibility for MAA may be determined at time of or immediately prior to actual need for hospital care or for the drugs for treatment of conditions specified in the program definition. Certification may be up to the predictable date when such need is expected to end or may be for a period of 1 year, subject to review and redetermination when additional need for further medical care arises.

OAA:

Program.—Since September 1960, State has extended services in hospital care and nursing home care for OAA recipients.

Lien and recovery.—No provision.

Relative responsibility.—No legislation prescribing support from relatives, but State's plan provides that the ability of specified relatives to contribute is evaluated in accordance with a scale of income and number of dependents, after allowance for taxes and special expenses. Where there is a true surplus of net income (after living and necessary work expenses, medical care, income taxes, social security taxes, retirement and union dues) above the levels shown in the scale, a portion of this surplus shall be considered income available to applicant whether actually contributed or assumed to be contributed.

Residence requirement.—One year immediately preceding date of application.

Scope of medical care provided.—Vendor payments are used for: hospital care for acute illness or injury up to a maximum of 30 days per fiscal year; nursing home care in licensed and approved homes. Provision may be made within the money payment for total needs, subject to State's maximum on such payment, for special nursing services not in a medical institution. (Practitioners' services, dental care, or prescribed drugs are not provided.)

Money payment to recipient.—Maximum on money payment, including all subsistence and special needs, $55 per month, or up to $60 for persons who require nursing care in own home or service for household tasks.

UTAH

Aged in population (April 1, 1960): 60,000.

MAA:

Program.—Legislation in 1961 amended the State public assistance act so as to authorize a program of medical assistance for the aged; services began July 1, 1961.

Eligibility.—

Income: Net monthly income available may not exceed $110 for single person, $170 for two persons or couple, $210 for three persons.

Assets: (1) Real property: Home owned and occupied is excluded; net value of other real property is included in total allowable as available to meet costs of medical care needed. (2) Personal property: Net value of all property other than the home and excluded nonliquid assets defined below may not exceed $10,000. Negotiable or liquid assets available to meet costs of medical care may not exceed $1,000 for single, $2,000 for couple or family. Amounts in excess of these maximums must be applied to cost of major medical care before MAA may be granted to cover additional costs. Excluded from consideration as liquid assets are: furniture, household equipment, livestock, implements, tools, and a necessary automobile. Health and hospital insurance will be applied on medical bills in determining amount of MAA needed or may be assigned to fulfill the "deductible" requirement.

Recovery provisions.—Medical assistance granted will constitute a preferred claim against the estate left by the recipient, after the death of recipient and surviving spouse, if any.

Relative responsibility.—Relatives are not legally responsible for the care and maintenance of a recipient but are required to contribute toward costs of medical care.

Deductible.—For hospital care, patient pays first $50 of cost for each admission; insurance benefits may be applied to fulfill this deductible requirement by assignment either to the hospital or to the county department of welfare. For physicians' services, patient pays first $20 of costs per benefit period of 90 days; when illness and treatment exceed 90 days, another benefit period is authorized and another deductible of $20 is required for each 90-day period during which service is needed.

Scope of medical care provided.—Hospital care; physicians' services in home, office, and institution. (See preceding item on "Deductible".) [In December 1961, program was expanded to encompass nursing home care in those homes which could meet the requirement of "medical institution."]

Additional provisions.—Eligibility and need for medical care are established concurrently; certification is for benefit period of 90 days, renewable upon statement of phvsician that need for medical care continues. Case which remains open is subject to annual review, or more frequent if circumstances warrant it.

OAA:

Program.—Since September 1960, State extended nursing home care and added prescribed drugs to services provided.

Lien and recovery.—All real property or interest therein must be pledged as guarantee of assistance received. Settlement of liens not operative during lifetime of spouse and may be postponed indefinitely if heirs or devisees are recipients of public assistance.

Relative responsibility.—There is no legal liability of relatives to support. State's plan requires evaluating ability of relatives to contribute to cost of needed medical care.

Residence requirement.—One year immediately preceding application.

Scope of medical care provided.—Vendor payments are used for: hospital care, up to 30 days per admission; nursing home care; physicians' services; dental care; prescribed drugs; sickroom supplies, X-rays, prosthetic appliances; transportation; and equipment. (In December 1961, the following changes were made: hospitalization cut to 15 days; nursing home care in nursing homes which could meet the requirement of "medical institution" was transferred to the scope of the MAA program; dental care was limited to treatment of pain and infection or to make it possible for an adult to accept a bona fide offer of employment.)

Money payment to recipient.—Maximum on money payment to recipient, $80 for one-person case, $128 for two-person case (additional allowances made for additional persons in case). Such maximums may be exceeded for special circumstance items specified in the State's standard of assistance.

VIRGIN ISLANDS

Aged in population (April 1, 1960): 2,200.

MAA:

Program.—Legislation enacted in 1960, services began January 1, 1961; department of social welfare contracts with Insular Department of Health for medical aspects of the program.

Eligibility.—

Income: Current continuing gross annual income of $1,200 or less for single persons, $2,400 for married couple living together.

Assets: (1) Real property: Total real property, including home owned and occupied, may not exceed $10,000. (2) Personal property: Cash assets, or those readily convertible into cash, may not exceed $1,200 for single person, $2,400 for married couple living together. Health insurance and "Government entitlement such as veterans medical services" are available assets which are taken into account in determining need for and extent of MAA.

Recovery provisions.—No provisions.

Relative responsibility.—No requirement.

Deductible.—None.

Scope of medical care provided.—Hospital care, including private duty nursing service when prescribed as "critically necessary"; physicians' services to patients under home care program; dental care and prescribed drugs as provided through facilities of health department; prosthetic and other appliances; outpatient clinic services of health department.

Additional provisions.—Eligibility may be determined prior to specific or predictable need for medical care, and such prior enrollment remains in effect as long as the person remains eligible, subject to annual or more frequent reinvestigations.

OAA:

Program.—Prior to September 1960, services for which vendor payments were made were limited to prescribed medicines and certain prosthetic appliances. Since that date, the program has been expanded to include hospitalization, physicians' services, and outpatient clinic care.

Lien and recovery.—No provision.

Relative responsibility.—Ability of specified relatives to contribute is determined on the basis of an income scale and certain percentages of the surplus income. Allowances are made for the number of dependents of the relative, certain taxes, and exceptional expenses which he has.

Residence requirement.—No durational residence requirement; must be resident of Virgin Islands at time of application.

Scope of medical care provided.—Vendor payments for medical care are used for hospital care, home visits of physicians to patients under the home care program, dental care, prescribed drugs, sickroom supplies, special nursing services, prosthetic appliances, X-rays, restorative services, transportation, and special equip-

ment. (Nursing home care is not provided because facilities are not available on the islands.)

Money payment to recipient.—No maximum on money payment to meet needs of recipient according to department of social welfare standards of assistance.

WASHINGTON

Aged in population (April 1, 1960): 279,000.

MAA:

Program.—Services began under the program in October 1960, based upon interpretation of provisions in existing State statutes.

Eligibility.—

Income: Net income (cash or kind) regularly and predictably received by the applicant, the combined dollar value of which is in excess of that needed to meet his and his legal dependents' maintenance requirements as measured by the department's OAA standards of assistance, is considered as income available which must be applied toward meeting the cost of approved medical care.

Assets: (1) Real property: Home used by applicant or his legal dependents, together with reasonable amount of contiguous land, is not considered an available asset. Value of other real estate is included in total of assets available. (2) Personal property: All other resources and liquid assets, including cash surrender value of life insurance, are considered to determine extent to which they may be utilized for payment of needed medical care, except household furnishings and personal clothing, one automobile, and personal property "used and useful or of great sentimental value." Medical insurance in force at time of application and any potential compensation for injury must be utilized to the fullest extent.

Recovery provision.—No provision.

Relative responsibility.—No requirement.

Deductible.—None.

Scope of medical care provided.—All services are limited to essential care for emergent or acute medical conditions, with exceptions being granted when supported by adequate medical justification. Within this definition, program provides hospital care, nursing home care, practitioners' services, dental care, prescribed drugs, special nursing services, X-rays, physical therapy, prosthetic appliances, transportation, equipment, and outpatient clinic care.

Additional provisions.—Need for medical care is determined on the basis of recommendations submitted by the patient's attending physician, subject to screening and approval by the State department of public assistance, and financial need is based upon current resources in relation to the estimated cost of such essential medical care. Eligibility is certified for a single ailment or condition and subject to monthly review. New certification is required if new need arises after a previous period of medical services has been terminated.

OAA:

Program.—Since September 1960, the State has extended prescribed drugs and dental care in the public assistance medical care services.

Lien and recovery.—No provision.

Relative responsibility.—Ability and willingness of relatives to contribute to support is determined for each individual case, taking into account such contributions when available.

Residence requirement.—Five out of the last nine years including one continuous year immediately preceding application.

Scope of medical care provided.—(Definition in statute includes "needed medical, dental, and allied services * * *"). Vendor payments to suppliers are made for hospital care, nursing home care in licensed homes, practitioners' services, dental care, prescribed drugs, special nursing services, X-rays, physical therapy, prosthetic appliances, transportation, and equipment. Nursing home care in home not subject to license is provided through the money payment to the recipient.

Money payment to recipient.—Maximum per month for any assistance unit is $325, unless case exemption is made because of circumstances defined in the State's plan.

WEST VIRGINIA

Aged in population (April 1, 1960): 172,500.

MAA:

Program.—Legislation enacted at a special session in October 1960; services began within the same month. [Because recent amendments to the plan for MAA have substantially changed eligibility provisions and the services provided, the following data is as reported by the State effective February 1, 1962. The information in the "Public Assistance Report 49: Characteristics of State Public Assistance Plan Provisions for Medical and Remedial Care" is the plan in effect on October 1, 1961.]

Eligibility.—

Income: For single individual, $1,500 or less per year; person married and living with spouse, combined income of both is $3,000 or less. Income includes contributions received from relatives.

Assets: (1) Real property: Assessed value of all real property, including homestead, may not exceed $4,000. (2) Personal property: Or other liquid or marketable assets, including cash surrender value of life insurance, may not exceed $1,000 for single person, $1,500 for combined assets of husband and wife. Excluded from consideration as liquid assets are clothing and personal effects, household furnishings, and an automobile.

Benefits available from commercial health insurance are taken into account in determining amount of and kind of service needed from MAA.

Financial eligibility is determined concurrently with need for medical care as evidenced by a statement from the attending physician. (Former provision for enrollment prior to need for medical care has been rescinded.)

Recovery provision.—No provision.

Relative responsibility.—No requirement.

Deductible.—None.

Scope of medical care provided.—Hospital care limited to 12 days per fiscal year, for acute illness, injury, immediate surgery, and diagnostic services under certain circumstances; nursing home care after a period of hospital care or if such care would prevent need for hospital care; acute conditions only; practitioners' services related to acute and life-endangering conditions; dental care; prescribed drugs for eight specified chronic conditions; and such other services available to OAA recipients as are related to treatment of acute conditions. (No provisions for the services classed as "remedial care.")

Additional provisions.—Eligibility is determined concurrently with need for medical care as evidenced by a statement of the attending physician. (Former provision for enrollment, if financially eligible, prior to need for medical care has been rescinded.

OAA:

Program.—Since September 1960, medical services have been expanded by extension of list of chronic conditions for which drugs are provided.

Lien and recovery.—State takes lien against real property in excess of $1,500 and against personal property in excess of $200; such lien applicable to estate after death and during lifetime; not enforced against real estate occupied by surviving spouse unless remarries or there is threatened or actual sale or transfer of the property.

Relative responsibility.—Ability of legally responsible relative to contribute to support is determined in accordance with a "Standard Income Schedule," which makes allowances for number of dependents, certain taxes, and for other specified expenses. "Surplus income" of relative living in a household separate from that of applicant is not considered available to applicant unless the relative is actually making a contribution or has expressed a willingness to contribute a specified amount regularly.

Residence requirement.—One year immediately preceding application.

Scope of medical care provided.—Vendor payments are used for hospital care for emergency medical and surgical services up to 30 days per fiscal year (for remedial care, time is extended); nursing home care; practitioners' services; dental care; prescribed drugs; sickroom supplies; special nursing services; X-rays, restorative services; prosthetic appliances; transportation; and special equipment.

Money payment to recipient.—Maximum on payment to recipient who is living in boarding or custodial care, $60; for persons living in a household, $165 for the household.

Appendix B.—Application Forms

STATE OF MAINE
DEPARTMENT OF HEALTH AND WELFARE
DIVISION OF FAMILY SERVICES

APPLICATION FOR
MEDICAL ASSISTANCE FOR THE AGED

DO NOT FILL IN
Number_____
Date Disposed of_____

Applicant's Name_____ Residence_____
(Print or Type Name in Full) (Town or City)

Post Office Address_____ Tel. No._____

Applicant's Birthdate: Mo. _____ Day _____ Year _____

Name of husband or wife _____ Mo._____ Day_____ Year_____
(Birthdate)

List all persons under 21 years of age dependent upon applicant for their support.

Name	Relationship to Applicant	Address	Yearly Income

Real and Personal Property of Applicant and Husband or Wife

Applicant		Husband or Wife	
1. Real property not occupied as home		1. Real property not occupied as home	
A. Sale Value	_____	A. Sale Value	_____
B. Mortgage	_____	B. Mortgage	_____
2. Cash on hand	_____	2. Cash on hand	_____
3. Cash in bank	_____	3. Cash in bank	_____
4. Stocks or bonds	_____	4. Stocks or bonds	_____
5. Cash surrender value of life insurance	_____	5. Cash surrender value of life insurance	_____
6. Other assets not essential to every-day living	_____	6. Other assets not essential to every-day living	_____

MAA-1 (Rev. 3-62)

(MAINE)

Cash Income of Applicant and Husband or Wife

Applicant			Husband or Wife		
Source of Income	Per Month	Per Year	Source of Income	Per Month	Per Year
1. Wages (Take home pay)			1. Wages (Take home pay)		
2. Old-Age and Survivors Insurance (Soc. Sec.)			2. Old-Age and Survivors Insurance (Soc. Sec.)		
3. Veterans Pension			3. Veterans Pension		
4. Other retirement Pension			4. Other retirement Pension		
5. Business (Net income)			5. Business (Net income)		
6. Farm (Net income)			6. Farm (Net income)		
7. Contribution from Relatives			7. Contribution from Relatives		
8. Other			8. Other		

Medical Insurance

Blue Cross ☐ Blue Shield ☐ Other ☐

Date

Signature of Applicant

Person or organization initiating application

☐ Applicant

☐ Hospital

☐ Town Official

☐ Relative

☐ Other Person

If signed by another in applicant's behalf enter name and relationship to applicant below

Name

Relationship

STATE OF MAINE
DEPARTMENT OF HEALTH AND WELFARE
RELATIVE'S FINANCIAL STATEMENT

Return completed form on or before _____ (Date)
to address checked below:

Verified Income Amount _____
Verification Returned _____

DEPARTMENT OF HEALTH AND WELFARE
DIVISION OF PUBLIC ASSISTANCE

☐ 11 Weston St., Augusta, Maine
☐ 141 N. Main St., Brewer, Maine
☐ City Building, Calais, Maine
☐ Sweden St., Caribou, Maine
☐ Franklin St. Ext., Ellsworth, Maine
☐ Market St., Fort Kent, Maine
☐ Houlton Trust Co. Bldg., Houlton, Maine
☐ 179 Lisbon Street, Lewiston, Maine
☐ Main St., Machias, Maine
☐ 178 Middle St., Portland, Maine
☐ 447 Main Street, Rockland, Maine
☐ Court House, Skowhegan, Maine

This form cannot be accepted unless each question is fully answered and the necessary verification is attached. If the answer is none enter the word "none". If each question is not answered or if the verification is not attached, the form may be returned to you for completion. Your verifications will be returned to you within a few days.

Name and address of ☐ Applicant or ☐ Recipient

_____

1. _____

A. I, _____ (Name) am the ☐ child ☐ spouse ☐ parent of the above named person. I am ☐ single ☐ married ☐ widowed ☐ divorced ☐ separated.

B. ADDRESS _____ (Street and Number) _____ (Town or City) _____ (State)

C. OCCUPATION _____

D. NAME AND ADDRESS OF EMPLOYER (If more than one, list all)

_____

_____

_____

2. Income (The income to be listed below is that received during the last calendar year)

A. INCOME FROM EMPLOYMENT (Attach copies of all W-2 forms for the past year) A. $_____

B. INCOME FROM SELF-EMPLOYMENT (Attach copy of latest income tax return) B. $_____

C. INCOME FROM ALL OTHER SOURCES (Pensions, retirement, unemployment, annuities, rentals, etc.) Attach verification C. $_____

D. TOTAL INCOME (Add items A, B and C) D. $_____

3. Dependents (List all dependents recognized by the Bureau of Internal Revenue for income tax purposes except the applicant or recipient named above)

Name	Address if different from yours	Relationship	Age	Gross income for *last* calendar year

Form PA-4 Rev. 9/61

(MAINE)

ASSETS (For assets owned jointly list only your share)		DEBTS (Include real estate mortgages)	
		To Whom Owed	Amount Owed
A. Cash on hand	$_____	_____	$_____
B. Money in bank	$_____	_____	$_____
C. Real estate (sale value)	$_____	_____	$_____
D. Stocks and bonds (sale value)	$_____	_____	$_____
E. Money owed me by others	$_____	_____	$_____
F. Automobiles and trucks (sale value)	$_____	_____	$_____
G. Life insurance (cash value)	$_____	_____	$_____
H. Other property valued at more than $100. (sale value)	$_____		
4. Total Assets	$_____	**5. Total Debts**	$_____

6. Net Assets (Subtract item 5 from item 4) $_____

7. Remarks:

_____ _____
Signature *Date*

If your relative is an applicant for public assistance (not a recipient) this section must also be completed.

STATE OF MAINE
COUNTY OF _____ } ss

I solemnly swear or affirm that this statement has been read by me or to me and that the statements made herein are true and correct to the best of my knowledge and belief.

_____ _____
Signature *Date*

Subscribed and sworn to before me this _____ day of _____ 19_____

_____
Notary Public
Justice of the Peace

1 A - 1

NEW HAMPSHIRE DEPARTMENT OF PUBLIC WELFARE
APPLICATION FOR
MEDICAL ASSISTANCE FOR THE AGED

Date Received _____ District _____

I, _____, born on month _____ day _____ year _____
wish to apply for Medical Assistance for the Aged. I reside at _____ street
_____, N.H. My spouse _____
age _____ resides at _____ street, _____, N.H.
or was deceased on _____. I / We have the following income and resources:

REAL ESTATE

Location	Assessed Value	Mortgages Amount	Mortgages Held by	Other Liens	Deed in Name of	Date Purchased

PERSONAL PROPERTY

	Applicant $ Value	Applicant Bank/Co.	Spouse $ Value	Spouse Bank/Co.
Bank or Postal Savings Acct. No.				
Stocks and Bonds No. Shares				
Life Insurance Policy No. (s)				
Other (Specify)				

CHILDREN

Name	Address	Monthly Contribution to Applicant (Cash or Kind)

No. of Dependent Children supported by Applicant _____ Monthly Cost $ _____

SUMMARY OF INCOME

	Applicant $ Monthly	Applicant $ Yearly	Spouse $ Monthly	Spouse $ Yearly	Specify Source if Applicable
Pensions and Benefits					
Net Earnings					
Relatives					

OVER

(NEW HAMPSHIRE)

SUMMARY OF INCOME, continued.

	Applicant		Spouse		
	$ Monthly	$ Yearly	$ Monthly	$ Yearly	Specify Source if Applicable
Investments					
Real Estate					
Other (Specify)					

MEDICAL RESOURCES

(List each kind - Blue Cross, Accident & Health Policy, Workmen's Comp., etc.)

Kind	No. of Cert. or Policy	Company	Coverage (Type of membership & benefits)

My physician is Dr. _____
(name) (address)

My social security number is _____ My spouse's is _____.

I understand that if I am dissatisfied with the department's decision or if action of the department with respect to this application is delayed beyond 30 days, I may appeal for a fair hearing.

I hereby authorize and request any person or organization having information concerning my financial circumstances or health to furnish such information to the Department of Public Welfare or its accredited representative.

_____ _____
Date Signature of Applicant or Person Acting on His Behalf
(if by X, 2 unrelated witnesses' signatures required)

Re-Applied _____ Residing at _____
Date Address

Re-Applied _____ Residing at _____
Date Address

(NEW HAMPSHIRE)

DW - 64

Statement of a Legally Liable Relative of

Applicant or Recipient of Public Assistance /_/

Medical Assistance for the Aged /_/

RE:_____

DATE:_____

In accordance with Chapter 167, Section 2, Revised Statutes Annotated which states children are legally liable for the support of their parents, the following information is needed to determine the eligibility of_____ whose case is now under consideration.

1. Your name -

   Your address -

   Relationship (son, etc.)

2. Marital status -

3. I am employed at_____ as a_____

   My gross wages or income from self-employment amounts to:

   weekly - $_____ monthly - $_____ yearly - $_____

   My spouse is employed at_____. Wages - $_____

   (If self-employed, report as wages the amount of gross taxable income after business deductions as reported on income tax return for previous year or as basis for estimated tax for current year.)

4. I have additional income as follows: Show source (such as rented rooms, boarder, or part-time work.) Source_____ Amount - $_____

5. I have other than myself_____ dependents on my income alone. Their names and ages are:

6. I have the following debts on which I am making weekly, monthly or quarterly payments regularly:

(NEW HAMPSHIRE)

7. The household expenses which I alone meet are as follows:

1. Rent for home (or mortgage payments) - _____
2. Electricity - _____
3. Cooking fuel - _____
4. Heating fuel - _____
5. Taxes - _____
6. Insurance (Life & Property)- _____

_____

7. Medical - _____
8. Food (average figure) - _____
9. Clothing (average figure) - _____
10. Other regular expenses - _____

_____

8. I have _____ child(ren) in college or taking other educational training beyond high school at _____. I pay part, or all, of this expense in the amount of $_____ yearly.
(No.) (Name of college or other school)

9. A. I have been helping _____ financially in the amount of $_____ each (week) (month) (year) and I am willing to continue to do so.
(Relative's name)

B. I am willing to help support _____ to the extent of $_____ each month.
(Relative's name)

C. I am ____ am not ____ claiming _____ as a dependent on my income tax return.
(Relative's name)

The above information is to the best of my knowledge a true statement of my situation.

Signed _____

Date _____

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF PUBLIC ASSISTANCE

MEDICAL ASSISTANCE FOR THE AGED
APPLICATION-DECLARATION OF RESOURCES

FOR CBA USE ONLY
CASE NUMBER
RECORD NAME
COUNTY-DISTRICT
CASEWORKER

INSTRUCTIONS

The patient or person acting for the patient should complete the application and if known the information needed for the declaration of resources.

☐ If person is receiving Old Age Assistance check this block and complete only identifying information and items A, B, I, and J under assets.

COMPLETED FORM TO BE SENT TO COUNTY BOARD OF ASSISTANCE OFFICE

APPLICATION

I hereby apply for medical assistance for the aged for myself, or on behalf of:

NAME OF PATIENT	BIRTHDATE
ADDRESS	SOCIAL SECURITY NUMBER

FAMILY

A. Marital Status (Check One)
☐ Single ☐ Married - living with spouse ☐ Divorced or Separated ☐ Married - not living with spouse ☐ Widow or Widower

B. Children - are any sons or daughters living?
☐ Yes ☐ No

TYPE OF CARE NEEDED

☐ Inpatient hospital care ☐ Post hospital care ☐ Home nursing care ☐ Public nursing home care

ASSETS

(For patient living with spouse, include spouse's assets if application is for inpatient or post hospital care or home nursing care. If application is for public nursing home care, list only patient's assets.)

	(CHECK YES OR NO FOR EACH ITEM) YES	NO		(CHECK YES OR NO FOR EACH ITEM) YES	NO
A. Blue Cross	☐	☐	F. Income	☐	☐
B. Other Medical Insurance Benefits	☐	☐	G. Own Home	☐	☐
C. Cash	☐	☐	H. Other Real Estate	☐	☐
D. Stocks, Bonds, Securities	☐	☐	I. Damage or Liability Claim Pending	☐	☐
E. Life Insurance	☐	☐	J. Other Assets Not Listed Above	☐	☐

DATE

SIGNATURE (PATIENT OR PERSON ACTING FOR PATIENT)

If patient did not sign, give reason _____

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84903 O - 62 - 6

(PENNSYLVANIA)

DECLARATION OF RESOURCES Page 2

ALL ITEMS TO BE COMPLETED--IF NOT APPLICABLE ENTER NONE

1. NAME OF SPOUSE | 2. SOCIAL SECURITY NUMBER

ADDRESS IF DIFFERENT THAN PAYIENT

3. DEPENDENT CHILDREN (minor or incompetent)

NAME	ADDRESS	AGE

4. OTHER CHILDREN

NAME	NAME
ADDRESS	ADDRESS
NAME	NAME
ADDRESS	ADDRESS
NAME	NAME
ADDRESS	ADDRESS
NAME	NAME
ADDRESS	ADDRESS
NAME	NAME
ADDRESS	ADDRESS

5. INCOME (Specify weekly, monthly, or other period of payment; give amount	PERIOD	AMOUNT
a. Social Security Payments (OASDI)		$
b. Other Benefit and Pension Payments (UMWA, R.R., etc.; source and address)		$
c. Dividends, Interest, Royalties, etc., (source and address)		$
d. Earnings (gross before deductions; name and address of employer)		$
e. Rent Income (address of property)		$
f. Other Income (contributions from children and others, etc.; source and address)		$

PA 1-M

(PENNSYLVANIA)

6. ASSETS	ENCUMBRANCES	AMOUNT
a. CASH ON HAND: at home; in safe deposit box; etc. (list where held)		
	$	$
b. BANK ACCOUNTS: check and savings		
NAME OF BANK / ADDRESS		
	$	$
c. BUILDING AND LOAN ACCOUNTS OR SHARES		
NAME OF COMPANY / ADDRESS		
	$	$
d. U.S. GOVERNMENT BONDS (current value)	$	$
e. STOCKS AND OTHER SECURITIES		
NAME OF COMPANY		MARKET VALUE
	$	$

If premium is less than $2.00 monthly or if face value is less than $500, make no entry in encumbrances or amount column.

f. LIFE INSURANCE				
NAME OF COMPANY	PREMIUM	PERIOD COVERED BY PREMIUM		CASH VALUE
	$		$	$
ADDRESS		FACE VALUE		
		$		
NAME OF COMPANY	PREMIUM	PERIOD COVERED BY PREMIUM	$	$
ADDRESS		FACE VALUE		
		$		
NAME OF COMPANY	PREMIUM	PERIOD COVERED BY PREMIUM	$	$
ADDRESS		FACE VALUE		
		$		
NAME OF COMPANY	PREMIUM	PERIOD COVERED BY PREMIUM	$	$
ADDRESS		FACE VALUE		
		$		

g. NON-RESIDENT REAL PROPERTY			
ADDRESS	OWNER		MARKET VALUE
		$	$

h. MEDICAL BENEFITS

Type of Plan

☐ Blue Cross ☐ Blue Shield ☐ Private (Name of Company)

GIVE DETAILS (AMOUNT PER DAY, DAYS OF COVERAGE, PERCENTAGE OF PAYMENT, ETC.)

(PENNSYLVANIA)

6. OTHER ASSETS

NAME OR SOURCE AND ADDRESS	ENCUMBRANCES	MARKET VALUE
	$	$

7. DAMAGE OR LIABILITY CLAIMS PENDING (give pertinent information)

8. RESIDENT PROPERTY (List Address)

9. LAST HOSPITALIZED ON (date)	NAME OF HOSPITAL

AFFIDAVIT

(To be signed in the presence of a CBA caseworker)

COMMONWEALTH OF PENNSYLVANIA

COUNTY OF _____

Before me, a person employed in the administration of Public Assistance in said County, personally appeared the undersigned who, being duly sworn or affirmed according to law, deposes and says that: the foregoing statements are true and correct and complete to the best of his knowledge and belief; that no facts which should have been contained therein have been omitted; that he agrees to give notice to the Department of Public Welfare of any changes in the facts above stated; and that the Department of Public Welfare is authorized to obtain any information that may be needed from any source including the Bureau of Old-Age and Survivors Insurance.

SWORN TO AND SUBSCRIBED BEFORE ME

This _____ day of _____ A.D. 19_____

_____ (Seal) _____ (Seal)
(Patient)

Name and address of two witnesses if patient signed by mark

SWORN TO AND SUBSCRIBED BEFORE ME

This _____ day of _____ A.D. 19_____ _____
Signature

_____ (Seal) Acting for _____
(Name of Patient)

Reason patient did not sign Relationship to Patient

PA 1-M

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF PUBLIC ASSISTANCE

MEDICAL ASSISTANCE CERTIFICATION

FOR CBA USE ONLY
CASE NUMBER
RECORD NAME
COUNTY-DISTRICT
CASEWORKER

INSTRUCTIONS: Send original to applicant; duplicate to Hospital, Institution, agency or other that will provide the care. Space below is provided for use with window envelope.

☐ ELIGIBLE

You are eligible for medical assistance. The type of care for which you are eligible is listed below:

☐ Inpatient Hospital Care; Eligible Days _____ ☐ Post-Hospital Care ☐ Public Nursing Home Care

☐ Home Nursing Care; orders:

According to information given the department about your income and assets, and your legally responsible relatives, the amount listed below is available to you to meet the cost of the care. You and your relatives are responsible for arranging to pay the TOTAL AMOUNT shown below. The department pays the difference between this amount and your bill.

TOTAL AMOUNT $_____ From Your Income and Assets $_____ From Your Relatives $_____
(see other side)

NOTE: This certification is void if the approved care is not started within 30 days of the date listed above.

☐ INELIGIBLE

You are not eligible for medical assistance. The reason you are not eligible is listed below:

☐ Age ☐ Residence ☐ No more benefit days ☐ Income ☐ Assets

☐ Others (explain): _____

Date _____ Signature _____
(County Board of Assistance)

NOTICE: If you do not understand why this action was taken, or if you feel that you have not had fair treatment, a staff member of the county board of assistance will be glad to give you further explanation. If you are not satisfied with the decision, you have a right to a hearing.

PA 5-M - 2-62 (100)

(PENNSYLVANIA)

EXPECTED CONTRIBUTIONS FROM RELATIVES

NAME AND ADDRESS OF RELATIVE	RELATIONSHIP	AMOUNT

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF PUBLIC ASSISTANCE

CASE NO. _____

RECORD NAME _____

COUNTY-DISTRICT _____

REIMBURSEMENT AGREEMENT
FOR
MEDICAL ASSISTANCE FOR THE AGED

I, of _____ County, Pennsylvania, acknowledge that my real and personal property is liable for the repayment of Medical Assistance for the Aged granted or to be granted to or for my spouse. It is understood that this liability does not apply to assistance received before my acquisition of such property. The purpose of this agreement is to give the Department of Public Welfare a lien on any real property owned wholly on in part by me while assistance was received as above.

In order to carry out the purpose of this agreement, I authorize the Prothonotary, or any Attorney, of any Court of Record of Pennsylvania, or elsewhere, to appear and to enter judgment against me for the sum of Two Thousand Dollars ($2,000.00), plus costs. This judgment shall be a lien on my real property but shall not be collected during the lifetime of myself or my spouse, and the real and personal property comprising my home and furnishings shall not be subject to execution on this judgment during the lifetime of my dependent children. It is further agreed that in the event the sum of Two Thousand Dollars ($2,000.00) exceeds the amount required for repayment of assistance as set forth above, my real property shall not be liable for any greater payment than the amount of assistance received, plus costs.

It is agreed that at any time after assistance has ceased, the Department of Public Welfare will, at my written request, furnish me with a stipulation to be filed with the Prothonotary of the court having record of this judgment, setting forth the exact amount of assistance received for which my real property is liable, if such amount is less than the sum of Two Thousand Dollars ($2,000.00).

Signed, sealed and delivered
in the presence of

_____ _____ (SEAL)
Witness

Dated _____

_____ _____ (SEAL)

Dated _____

PA 9-M - 12-61 (100)

(PENNSYLVANIA)

COMPUTATION OF RESOURCES FOR INPATIENT HOSPITAL CARE, POST HOSPITAL CARE AND HOME NURSING CARE

INSTRUCTIONS: If the client does not have income; enter NONE in item A4 and make no other entries.

If the client does not have assets; enter NONE in item B-3 and make no other entries.

If there are no legally responsible relatives, or if no contribution is expected or if the Department decides to pay the bill and take court action against the relative, enter NONE in item C-1

Date	Case No.

A. INCOME

1. TOTAL ANNUAL AMOUNT (if married and living with spouse include income of spouse; list below the source and annual income for each item that is included in the total above. The basis for the amount is obtained from PA 1-M) $_____

a. _____ b. _____

c. _____ d. _____

2. TOTAL EXEMPTIONS (if married and living with spouse $2400 is exempted; otherwise the exemption of $1500. The exemption for dependent children is $500 x number of dependents. List below the applicable exemptions.) _____

a. client _____ b. dependents _____

3. ANNUAL INCOME AVAILABLE (item 1 minus item 2) _____

4. INCOME AVAILABLE TO MEET COSTS ($\frac{1}{2}$ of item 3) _____

B. ASSETS

1. TOTAL ASSETS (if married and living with spouse include assets of spouse; list below the source and the amount for each item that is included in the total above. The basis for the amount is obtained from PA 1-M. $_____

a. _____ b. _____

c. _____ d. _____

e. _____ f. _____

2. TOTAL EXEMPTIONS (if married and living with spouse $2400 is exempted; otherwise the exemption is $1500. _____

3. ASSETS AVAILABLE TO MEET COST (item 1 minus item 2) _____

C. CONTRIBUTIONS-RELATIVES

1. TOTAL AMOUNT OF CONTRIBUTIONS FROM RELATIVES (list below the name and the amount of the contribution for each relative) $_____

a. _____ b. _____

c. _____ d. _____

D. TOTAL

1. TOTAL AMOUNT AVAILABLE TO MEET COST (item A4 plus B3 plus C1) $_____

PA 21-B - 12-61 (100)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF PUBLIC ASSISTANCE

Date _____

Name _____

Address _____

_____

Dear

Your _____ has applied for Medical Assistance for the Aged to pay for necessary medical care.

The Pennsylvania Support Law requires husbands and wives, parents, and children, to support one another if they are financially able. Before we can tell your relative whether we can pay for the medical care needed, we must have the information about your income that we are asking for on the other side of this letter.

In deciding whether you are financially able to help and to what extent, we will compare the information about your income with a reasonable standard of living for a family of your size. This standard takes into consideration the expenses people usually have for food, clothing, housing, medical bills, income tax, recreation, and the like. If your income exceeds this amount, we will notify you of the amount you will be expected to contribute towards the medical care your relative needs.

Will you please complete the other side of this letter and return it to our office within 10 days. A stamped addressed envelope is enclosed for your convenience. Please let us know whether you are giving your relative any help at this time or whether you can help your relative pay for the medical care he needs.

If you would like a personal interview, write or telephone me and I shall be glad to plan a time when we can meet.

Sincerely yours,

_____
Caseworker

PA 21-MF - 12-61 (100)

(PENNSYLVANIA)

CONFIDENTIAL INFORMATION

1. My employer's name and address is _____

_____

2. My Social Security Number is _____ Work Number is _____

3. My pay is $_____ (give full, not "take home" pay)

4. I am paid every _____
(week, 2 weeks, month, etc.)

5. I have other income of $_____ per month from _____

6. The following members of my household are employed:

Name	Relationship to me	Employer's Name and Address	Monthly Earnings before Deductions

7. I support the following persons who live with me:

Name	Relationship to me	Age	Monthly Income

8. I support the following relatives not living with me:

Name	Address	Relationship to me	Amount

9. My expenses for transportation to work are: (complete one)

_____ I drive my own car and travel _____ miles each week.

_____ I ride in a car pool. Weekly cost is $_____.

_____ I use public transportation. Weekly cost is $_____.

10. I am now assisting my relative in the following amount $_____ monthly.

11. I will give my relative $_____ monthly.

Date_____

_____
Signature

PA 21-MF

(PENNSYLVANIA)

MAA VERIFICATION SUMMARY

CASE NUMBER

ITEM NO. *	ITEM		DATE VERIFIED	HOW VERIFIED
	AGE			
	RESIDENCE: CLIENT			
	SPOUSE			
	DEPENDENT CHILDREN			
	AGE	DISABILITY		
	OTHER CHILDREN INCOME			
	INCOME			
	AMOUNT	PERIOD		
	ASSETS			
	VALUE	ENCUMBRANCES		

* ENTER ITEM NUMBER FROM PA 1-M

PA 21-MV - 12-61 (50)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF PUBLIC ASSISTANCE

CASE NO._____

RECORD NAME_____

COUNTY-DISTRICT _____

AGREEMENT TO REPAY MEDICAL ASSISTANCE FOR THE AGED CLAIM

WHEREAS, in determining eligibility for Medical Assistance for the Aged for _____, real and personal property of myself and/or my spouse have been evaluated in accordance with the requirements of the Public Assistance Law, as amended; and

WHEREAS, in addition to such property, I have a right or cause of action, to wit, _____

_____

_____

from which the ownership of property may result but the value of which cannot be determined at this time.

NOW, THEREFORE, if this right or cause of action results in the acquisition of property which, when added to that previously evaluated, exceeds the statutory limitations of value set forth in the Public Assistance Law, I, in consideration of payment of Medical Assistance for the Aged made for me or my spouse pending the receipt of such property, agree to pay to the Commonwealth of Pennsylvania, Department of Public Welfare, any amount of Medical Assistance for the Aged subsequently found to have been incorrectly paid because of the impossibility of evaluating potential resources at this time.

I direct my attorney or representative to pay to the Department of Public Welfare the money which may come into his hands as a result of the right or cause of action, after deduction of legal fees and costs incident to the recovery of these funds, or as much of the balance of the funds as shall be necessary to satisfy the claim of the Department of Public Welfare. It is understood that this authorization is irrevocable.

In order to carry out the purpose of this agreement, I do hereby authorize the prothonotary, or any attorney, of any court of record in Pennsylvania, or elsewhere, to appear for and to enter judgment against me for the sum of TWO THOUSAND DOLLARS ($2,000.00), with costs of suit, and with fifteen per cent (15%) added for collection fees.

It is further agreed that if the assistance claim, as defined above, is less than TWO THOUSAND DOLLARS ($2,000.00), I shall be liable to pay only the lesser amount plus costs and collection fees. This judgment shall be collected as other judgments. I further agree that my real estate may be sold on a writ of execution. I hereby waive and release all relief from any or all appraisement, stay or exemption laws of any state or of the United States, now in force or hereafter to be passed.

I intend to be legally bound hereby.

_____ _____(SEAL)
Witness

Date _____

_____ _____(SEAL)
Witness

Date _____

PA 176-KM - 12-61 (100)

Appendix C.—Major Types of Services and Limitations

Medical assistance for the aged: Provision of major types of services under State plans, October 1961

State	Hospital care	Nursing home care	Physicians' services				Dental care	Prescribed drugs [1]
			Office	Home or in nursing home	Hospital			
					Outpatient	Inpatient		
Arkansas	X	X	X	X	X	--	X	X
Hawaii	X	X	X	X	X	X	X	X
Idaho	X	X	X	X	--	--	--	--
Illinois	X	--	X	X	X	X	--	--
Kentucky	X	--	X	X	--	--	X	X
Louisiana	X	X	X	X	X	X	--	X
Maryland	X	--	X	X	X	--	X	X
Massachusetts	X	X	X	X	--	--	X	X
Michigan	X	X	X	--	X	X	--	--
New Hampshire	X	--	X	X	X	X	--	--
New York	X	X	X	X	X	X	--	X
North Dakota	X	X	X	X	X	X	X	X
Oklahoma	X	X	--	X	X	X	X	--
Oregon	X	X	X	X	X	X	--	--
Puerto Rico	X	X	--	--	X	--	--	--
South Carolina	X	X	--	--	X	--	--	--
Tennessee	X	--	--	--	--	--	--	X
Utah	X	--	X	X	X	X	--	--
Virgin Islands	X	--	--	X	--	--	X	X
Washington	X	X	X	X	X	X	X	X
West Virginia	X	X	X	X	X	X	X	X

[1] Other than for hospitalized patients; drugs for hospital patients are included as part of hospital care.

NOTE.—Code:
X—Service is provided.
--—Service is not provided.

Source: Bureau of Family Services, Social Security Administration.

Limitations (excluding those which can be lifted by administrative action)

Hospital care:

Arkansas: To 15 days in any 12-month period. Maximum daily rate $25.50.

Idaho: For care of acute conditions and emergencies only; 14 days per admission.

Kentucky: For care of acute, emergency, and life-endangering conditions only; 6 days per admission. No limit on number or frequency of admission.

Louisiana: Up to 30 days.

New Hampshire: Seven days per admission, plus a maximum of $75 for auxiliary services. No eye care.

Oklahoma: Care for conditions which endanger life or sight only; not to exceed 6 months' care in any 12-month period.

Oregon: Up to 14 days per year. Patient pays $7.50 per day for first 10 days up to maximum of $75 per year.

South Carolina: Care only for acute illness, injury, or condition that endangers sight; not to exceed 40 days per year.

Tennessee: Care only for acute illness or injury; up to 10 days per year. Patient pays first $100 in any year.

Utah: Up to 30 days per admission. Patient pays first $50 per admission.

Washington: Care only for acute and life-endangering conditions.

Nursing home care:

Arkansas: Up to maximum of $90 per month.

Idaho: Up to maximum of $175 per month.

Louisiana: Only for persons eligible for OAA except for durational residence requirement. Up to $165 monthly.

Michigan: Only within 30 days following hospitalization for acute illness and limited to 90 days in a 12-month period.

Oklahoma: Limited to 6 month's care in any 12-month period. Excludes room and board.

Oregon: Upon transfer from hospital. Number of days available is based on hospital entitlement—14 days per year—with allowance of 4 days of

nursing home care for each remaining day of hospital entitlement. Up to $6 per day.
South Carolina: Following hospitalization. Ordinarily up to 90 days per year. Maximum payment, $150 per month.
Virgin Islands: Facilities not available.
West Virginia: After hospitalization or to prevent hospital care. Limited to acute conditions. Maximum payment $100 per month.
Washington: Care only for acute and life-endangering conditions.

Physicians' services:
Idaho: Acute conditions; two calls per month. Nursing home: One call per month. One eye examination per 6-month period.
Illinois: Only in 30-day period immediately following release from hospital. Acute conditions: One home call daily for 1 week, six office calls per 30-day period. Chronic care: Two home calls per month, two office calls per month.
Kentucky: Two office and/or home calls per month.
Lousiana: Serious continuing illness requiring care for relief of severe suffering or for correction or prevention of permanent impairment.
Michigan: Office services limited to emergency treatment, office surgery, and procedures involving therapeutic X-ray.
New Hampshire: Six office and/or home calls per year.
North Dakota: Inpatient hospital care of more than 30 days limited to three calls per week.
Oklahoma: Patients receiving nursing care: Two calls per month. In hospital not more than 15 visits per month in certain hospitals, less in others.
Oregon: Patient pays first $50 of any combination of physicians' services, X-rays, or laboratory procedures; then eligible for maximum of $150 for physicians' care and maximum of $500 for surgery, $100 for X-rays and laboratory costs.
South Carolina: Three clinic visits per month.
Utah: Patient pays first $20 per benefit period of 90 days; if more care is needed and authorized patient pays first $20 for each additional benefit period.
Virgin Islands: Available to patients under home care program.
Washington: Only for acute and life-endangering conditions.
West Virginia: Services must be related to acute and life-endangering conditions or defined remedial care.

Dental services:
Kentucky: Services as related to relief of pain and treatment of acute infection. Up to $16 per month and $48 per year.
Maryland: Restorative dental care only, including repair and replacement of dentures.
North Dakota: Dentures and bridgework limited to when extractions occurred within previous 5 years.
Oklahoma: Only for in-hospital patients having life-endangering conditions involving fractures, infections, or tumors of the mouth.

Prescribed drugs other than for hospitalized patients:
Arkansas: Maximum of $5 per month and dispensed only by an approved clinic. Maximum of $5 per month for patient in nursing home.
Louisiana: Only for patients in nursing homes.
Washington: Only for acute and life-endangering conditions.
West Virginia: Limited to one refill for care of acute illness.

Appendix D.—Medical Opposition to Vendor Payments

The basic approach of Kerr-Mills to the provision of medical care is by means of vendor payments through the public assistance mechanism.

A 1958 full-page advertisement of the Sonoma County (Calif.) Medical Society [1] opposing vendor payment medical care is therefore of more than passing significance in the context of current claims that physicians "unanimously" support the Kerr-Mills legislation.

In contrast, and in apparent conflict with the 1958 views of the Sonoma County Medical Society, is a recent statement by the California Medical Association,

[1] Introduced as an attachment to the record (p. 428) of the hearings, before the Committee on Ways and Means of the House of Representatives, entitled "Health Services for the Aged Under the Social Security System."

which was inserted into the Congressional Record of May 8, 1962 (pp. A3372, A3373).

The statement, entitled "A Critique of the Social Security Approach to Medical Care for the Aged—Clarifying the Issue," includes the following:

"This is an effort to clarify some of the issues—an effort designed to present medicine's position as clearly as possible. This position is unreservedly one of support for the Kerr-Mills law. * * *

"The Kerr-Mills law embodies an agelong tradition and principle of providing assistance where it is needed. The American public has long been accustomed to this form of financial aid from local government. * * *

"The medical profession supports the philosophy and direction of Kerr-Mills legislation. Kerr-Mills perpetuates the dignity and freedom of the individual; it enables the medical profession to provide the highest quality of care; it acknowledges the rightful roles played by the local, State, and Federal Governments as supplements to individual and family responsibility. * * *"

MEDICINE FIGHTS FOR CONTINUING GOOD MEDICAL CARE AND MEDICAL PROGRESS

At the special meeting of the Sonoma County Medical Society, a resolution prepared by the committee on medical care for public welfare recipients was presented to the society at large. After due discussion, a vote on the resolution was taken by secret ballot and passed by a large majority. We have thereby joined with the rest of the county societies in opposing state and federal control of patient-doctor relationship.

Resolution of the Sonoma County Medical Society

The members of the Sonoma County Medical Society met in a special session. It was the studied belief of a large majority of the members that the following facts were evident:

1. That the new California Public Assistance Medical Care Program as provided by AB-679 effective October 1, 1957 is a form of "Socialized Medicine" to be paid by you from State and Federal taxes.
2. That the socialization of Medicine would be a stepping stone to the Socialization of all other professions, businesses, industries and the complete destruction of our free enterprise system.
3. That this tax-paid plan invites abuses and some have demanded unneeded prescriptions for drugs and medical care because they were free.
4. That the cost to the taxpayer for the administration, together with the cost of medical service and drugs needed will definitely greatly increase the present tax burden.
5. That the quality of medical care will decline in any large welfare plan.
6. That the need for such a welfare program does not exist in Sonoma County. In the past, physicians of this county, by services rendered in their offices, and through care given at the Sonoma County Hospital and County Clinics have provided all needy persons with medical care.
7. That the majority of American citizens desire humanitarian care of indigent patients but do not want a socialized Nation, a socialized State, or socialized Medicine.

NOW THEREFORE BE IT RESOLVED that the Sonoma County Medical Society does not approve of the Public Assistance Medical Care Program. THIS SOCIETY DOES, HOWEVER, REAFFIRM ITS PLEDGE TO CONTINUE TO PROVIDE THE BEST POSSIBLE MEDICAL AND SURGICAL CARE FOR ALL PATIENTS REGARDLESS OF THEIR ABILITY TO PAY.

CLAYTON B. TAYLOR, M.D.
Secretary-Treasurer
Sonoma County Medical Society

DISCUSS THIS WITH YOUR DOCTOR

GOOD MEDICINE NEEDS YOUR SUPPORT

The statement indicates a radical "change of heart" by the medical organizations of California. Apparently, the medical societies of California have been converted to the "agelong tradition and principle of providing assistance" sometime during the past 4 years.

It was not so many years ago either—in 1956 to be precise—that the American Medical Association itself, strongly opposed improvements in the vendor medical care provisions of the old-age assistance program. The AMA testified before the Committee on Ways and Means of the House of Representatives that they "are opposed to these changes because they are needless, wasteful, dangerous, and contrary to the established policy of gradual Federal withdrawal from local public assistance programs." [2]

It would not be inappropriate, therefore, to speculate somewhat, concerning the "wholeheartedness" of organized medicine's endorsement and acceptance of Kerr-Mills, in view of the relatively recent opposition to the principle of vendor payments—a principle central to the Kerr-Mills program.

[2] "Public Assistance Titles of the Social Security Act," hearings before the Committee on Ways and Means, 84th Cong. 2d sess., on H.R. 9120 and H.R. 9091, pp. 330–331.

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