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STATE ACTION TO IMPLEMENT MEDICAL PROGRAMS FOR THE AGED

A STAFF REPORT

TO THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

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LETTER OF TRANSMITTAL

Hon. PAT MCNAMARA,
Chairman, Special Committee on Aging,
U.S. Senate, Washington, D.C.

DEAR SENATOR MCNAMARA: Transmitted herewith is the report on current and expected experience by the States with the program enacted in 1960 (Public Law 86–778) providing for medical assistance for the aged and changes in the existing program of medical care for recipients of old-age assistance.

The report was prepared by the staff of the Special Committee on Aging, with the technical cooperation of the Bureau of Public Assistance, on the basis of replies by the States to a questionnaire dealing with specific details of medical care programs made possible by the 1960 legislation. It is presented for consideration and comment by the committee and for general use by the Members of the Senate.

HAROLD L. SHEPPARD,
Staff Director, Special Committee on Aging.

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INTRODUCTION

In September 1960 the Congress passed legislation providing grants-in-aid to those States establishing programs of medical assistance for the medically indigent aged. The same legislation increased Federal grants to those States expanding the medical services provided through vendor payment old-age assistance.

In the 6 months following the passage of the Federal legislation, some States put into effect a program of medical assistance for the aged (MAA), a number expanded the medical services they provided under old age assistance (OAA), and still others developed plans affecting one or the other or both programs.

The staff of the Senate Special Committee on Aging and its predecessor, the Subcommittee on Problems of the Aged and Aging, remained in constant communication with the States since the passage of the Federal legislation collecting information on activity to implement the medical programs.

In February 1961 the quantity of information collected indicated that despite the short duration since passage of the Federal legislation the data available were of sufficient importance to be compiled in a systematic manner.

The staff, then, with the assistance of the Bureau of Public Assistance of the Department of Health, Education, and Welfare devised a questionnaire which was submitted to the 50 States and 4 territories.[1] Only Guam, which has a small aged population, did not reply.

This report is based on these questionnaires. The information is an accounting by the States themselves of their own present activity and future plans, as of March 31, 1961. The 6-month period since passage of the Federal legislation might be considered a short period of evaluation in terms of the actual experience of the six States which have had an operating program. However, the planning outlook extends to January 1962, covering a period of 16 months. Therefore, the present report can be viewed as containing sufficient information as a basis for certain types of evaluation.

The Bureau of Public Assistance provided invaluable technical assistance in gathering and compiling the report. However, the Bureau is not responsible for the final presentation. The staff wishes particularly to acknowledge the assistance of Mr. Paul Vernier, Chief, Operating Methods and Analyses Branch of Division of Program Operations in BPA; and Mr. Robert Mugge, survey statistician of Program Statistics and Analysis in the Bureau. Valuable assistance in preparing the report also was provided by Dr. Samuel Halperin, a congressional fellow of the American Political Science Association.

[1] See app. C for copy of questionnaire filled out by each State.

SUMMARY

It was the intent of Congress that a medical assistance for the aged (MAA) program would result in providing broad medical services to the aged needing such help.

Such a goal would require that (1) all States establish an MAA program which (2) would include hospitalization and physicians services consistent with the needs created by the chronic health conditions faced by the aged, and (3) with eligibility requirements determined on the basis of their medical costs, income, and health conditions.

An estimated 10 million persons 65 years of age or older were expected to be eligible for assistance under MAA programs if all States were to adopt the program.

However, only seven States, as of March 31, 1961, had operating programs under MAA. This includes New York, whose program began on April 1.

The total aged population of these seven States in 1960 was approximately 3.9 million. According to the reports from these States, 1.6 million of these would be potentially eligible for medical care under MAA.

In the 6 months ending March 31, 1961, 27,000 different individuals received assistance from the operating MAA programs.

Two of these seven States, Massachusetts and New York, have a progam that at best can be considered as providing comprehensive medical services.

The outlook for future developments, based on present activity and State estimates, is as follows:

1. Eighteen States, in addition to the 7 now with programs, might have an MAA program in operation by January 1962, if the 13 of these States needing enabling legislation as of March 31, 1962, obtain such legislation and appropriations; and if the 5 States yet to develop program content do so.

2. Four States of the twenty which have devised program content will provide all needed inpatient hospital care and enough other medical services to be classified as having a comprehensive medical care program in the future.

Twenty-five other States will have no program before January 1962, and probably not even during the next year. The aged population of these States is approximately 8 million.

Twenty States—of which 13 have yet to inaugurate a working program—reporting such information have a total of 3,304,963 eligible for MAA.

These same 20 States had a total aged population of 8,204,000, as of 1960.

If the average of the 20 States were to remain the average for the Nation, and if all 50 States established an MAA program, only 8 million of the Nation's 17 million individuals 65 or older would be eligible for MAA.

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And in nearly all States they would be eligible for only limited services as measured against the needs associated with chronic illnesses characterizing an aged population.

It was expected that cost of a nationwide MAA program would be approximately $600 million with about half of the funds provided by the Federal Government and half from State and local governments.

On the basis of the annual cost estimates provided by States reporting such information—and if the average for these States remains the average for all States—the annual cost of a nationwide MAA program would be more than $800 million.

But four out every five dollars which States and local governments indicate they are planning appropriate for their MAA programs would be dollars taken from other existing medical programs, mostly old-age assistance.

And of 27,000 individuals who received MAA in 5 States operating a program during the 6 months ending March 31, 1961, about 17,000 represent individuals who had already been receiving medical assistance through OAA. Only 10,000 are newly eligible individuals.

The administrative costs of MAA programs apparently will be between 7 and 10 percent but some States indicate as much as 20 percent. Some States have indicated difficulty in finding qualified personnel to administer the MAA program.

If all States and territories were to participate in an MAA program of medical care for the aged, approximately 10 million aged persons (including OAA recipients) would be eligible for varying degrees of medical assistance. If all of these jurisdictions were to participate in such programs, there would still remain about 7 million aged persons who would not receive medical care under any public program.

However, in actual fact, on the basis of replies of the States to the Special Committee on Aging, a total of about 12 million aged persons will not be protected under OAA or MAA medical care programs as of January 1962.

Finally there is the possibility that the economic burden of the MAA program will tend to restrain the scope of benefits and size of population, and thus fail to meet the legislative purpose of the program.

STATE ACTION TO IMPLEMENT MEDICAL PROGRAMS FOR THE AGED

CHAPTER I

THE HEALTH AND INCOME STATUS OF THE AGED IN THE UNITED STATES

THE INCREASE IN NUMBER OF THE AGED

In assessing the magnitude of the special health and income status of the country's aged, some basic population facts are in order. The aged population increased nearly 35 percent in the 10 years between 1950 and 1960; the total population increase was only 18.5 percent. The aged, persons 65 years and over, numbered only 4 million persons in 1920, and were 4.7 percent of the total population. Today the number is 17 million, making up 9.2 percent of the total population.

In the next 40 years the number of aged will climb to at least 30 million. There is even a further change of great import to the health problems and income problems of the aged—the older population is getting "older."

Since 1950 there has been a 60.8 percent increase in the number of persons who are 85 years and older. The rate of increase for each of the 5-year age groups over 65 shows a greater growth than the preceding age group.

TABLE 1.—*Percent increase in population 65 and over by sex, 1950–60*

Age	Percent increase, 1950–60		
	Total	Men	Women
65 and over	34.7	29.1	39.7
65 to 69 years	24.8	20.6	28.8
70 to 74 years	38.6	33.8	43.0
75 to 84 years	41.1	34.0	47.1
85 and over	60.8	52.6	66.5

The above table also reveals that the growth in the number of women is considerably greater within each 5-year group than is the rate for men. There are now 121 aged women for every 100 aged men. For the 65-to-69-year-old group the proportion is 114 women for every 100 aged men, with the proportion increasing to 157 women 85 years and older for every 100 men in that age bracket.

Significantly, the aged population increase in many of the States was much larger in the last 10 years than the national average of 34.7 percent. In Florida, for example, the increase was 132.9 percent, and 103.9 percent in Arizona. Table 2 provides the data for each State.

TABLE 2.—*Population 65 years old and over, by States, 1960 and 1950*

State	1960	1950	Increase	
			Number	Percent
United States	16,559,580	12,294,698	4,264,882	34.7
Alabama	261,147	198,648	62,499	31.5
Alaska	5,386	4,742	644	13.6
Arizona	90,225	44,241	45,984	103.9
Arkansas	194,372	148,995	45,377	30.5
California	1,376,204	895,005	481,199	53.8
Colorado	158,160	115,592	42,568	36.8
Connecticut	242,615	176,824	65,791	37.2
Delaware	35,745	26,320	9,425	35.8
District of Columbia	69,143	56,687	12,456	22.0
Florida	553,129	237,474	315,655	132.9
Georgia	290,661	219,655	71,006	32.3
Hawaii	29,162	20,419	8,743	42.8
Idaho	58,258	43,537	14,721	33.8
Illinois	974,923	754,301	220,622	29.2
Indiana	445,519	361,026	84,493	23.4
Iowa	327,685	272,998	54,687	20.0
Kansas	240,269	194,218	46,051	23.7
Kentucky	292,323	235,243	57,080	24.3
Louisiana	241,591	176,849	64,742	36.6
Maine	106,544	93,562	12,982	13.9
Maryland	226,539	163,514	63,025	38.5
Massachusetts	571,609	468,436	103,173	22.0
Michigan	638,184	461,650	176,534	38.2
Minnesota	354,351	269,130	85,221	31.7
Mississippi	190,029	152,964	37,065	24.2
Missouri	503,411	407,388	96,023	23.6
Montana	65,420	50,864	14,556	28.6
Nebraska	164,156	130,379	33,777	25.9
Nevada	18,173	10,986	7,187	65.4
New Hampshire	67,705	57,793	9,912	17.2
New Jersey	560,414	393,989	166,425	42.2
New Mexico	51,270	33,064	18,206	55.1
New York	1,687,590	1,258,457	429,133	34.1
North Carolina	312,167	225,297	86,870	38.6
North Dakota	58,591	48,196	10,395	21.6
Ohio	897,124	708,975	188,149	26.5
Oklahoma	248,831	193,922	54,909	28.3
Oregon	183,653	133,021	50,632	38.1
Pennsylvania	1,128,525	886,825	241,700	27.3
Rhode Island	89,540	70,418	19,122	27.2
South Carolina	150,599	115,005	35,594	30.9
South Dakota	71,513	55,296	16,217	29.3
Tennessee	308,861	234,884	73,977	31.5
Texas	745,391	513,420	231,971	45.2
Utah	59,957	42,418	17,539	41.3
Vermont	43,741	39,534	4,207	10.6
Virginia	288,970	214,524	74,446	34.7
Washington	279,045	211,405	67,640	32.0
West Virginia	172,516	138,526	33,990	24.5
Wisconsin	402,736	309,917	92,819	29.9
Wyoming	25,908	18,165	7,743	42.6

SPECIAL HEALTH PROBLEMS OF THE AGED

No study of the current and proposed programs of medical assistance under OAA or MAA is possible without review of the health problems of the aged.

The Subcommittee on Problems of the Aged and Aging (predecessor of the special committee) said in its report, "Action for the Aged and Aging," that "despite various attempts to obscure the basic facts, we are still impressed by the demonstrated data concerning the health problems of the aged."

To adequately understand the value of public or private medical care programs for the aged, it is necessary to consider the following:

1. The rate of chronic illness (such as heart disease, cancer, diabetes, arthritis) among the aged is more than double that for under 45 years of age—77 percent versus 34 percent.

2. Although they constitute less than 9 percent of the total population the aged make up more than 55 percent of all persons with limitations due to chronic illness.

3. The average number of physician visits among the aged is 36 percent greater than for the general population.

4. The aged spend approximately twice as many days per year (15 days per person discharged) in general hospitals as does the rest of the population.

5. The proportion of aged hospitalized in general hospitals for more than 2 weeks per year is more than three times greater than the proportion prevailing in the rest of the population, 28.5 percent as against 9.4 percent.

Chronic illness

Chronic conditions have a particular impact on the aged. Of those 65 to 74 years of age, 74 percent have one or more chronic conditions.

As age increases, so do chronic conditions. Also increasing with age is the limitation of activity resulting from chronic conditions. The percentages of different age groups suffering from a partial or major limitation of activity as a result of chronic conditions are as follows:

Age	Percent with limitation of activity	
	Partial	Major
45 to 54	11.1	1.6
55 to 64	17.1	4.3
65 to 74	26.2	9.4
75 and older	31.3	23.9

Source: National health survey, U.S. Public Health Service.

Types of chronic illness

The major specific chronic conditions suffered by older persons are detailed in table 3, along with the prevalence of these conditions in terms of the rate per 1,000 population of the various age groups.

TABLE 3.—*Rate per 1,000 population of chronic conditions among persons 45 years and older, by age, July 1957–June 1959*

Chronic conditions	45 to 54 years	55 to 64 years	65 to 74 years	75 years and older
Heart conditions	36.6	76.2	128.8	188.2
High blood pressure	50.5	88.1	128.5	130.6
Diabetes	12.4	28.4	42.9	35.6
Peptic ulcer	28.7	26.1	26.4	14.1
Arthritis and rheumatism	113.6	185.5	255.4	286.0
Hernia	19.0	32.2	49.5	64.6
Asthma-hay fever	59.0	61.9	56.6	47.7
Chronic bronchitis	12.7	16.7	19.7	17.3
Visual impairments	19.0	31.0	70.8	166.4
Deafness and other hearing impairments	38.1	66.6	126.9	259.4
Paralysis of major extremities and/or trunk	5.6	11.7	16.6	33.6

Large numbers of the aged with such conditions are not receiving medical care, as table 4 indicates.

TABLE 4.—*Number and percent distribution of selected chronic conditions not under medical care, among persons 45 years and older, July 1957 to June 1959*

[In thousands]

Chronic conditions	45 to 64 years		65 years and over	
	Number [1]	Percent	Number [1]	Percent
Heart conditions	433	23.2	341	15.6
High blood pressure	633	27.3	433	22.9
Diabetes	55	8.2	45	7.6
Peptic ulcer	180	18.8	78	23.9
Arthritis and rheumatism	2,146	42.7	1,493	38.3
Hernia	458	53.4	344	42.9
Asthma-hay fever	693	33.1	258	32.8
Chronic bronchitis	277	55.1	142	51.3
Visual impairments	408	48.6	786	51.9
Deafness and other hearing impairments	954	54.5	1,115	44.2
Paralysis of major extremities and/or trunk	129	45.3	143	43.6

[1] Number of conditions.

Source: National health survey.

The national health survey shows a negative correlation between family income and chronic illness, by age. The lowest income aged have the highest proportions of chronic conditions. For example, for those 75 years and older the proportion with no chronic conditions is 13 percent for those with a family income of less than $2,000 compared with 20 percent for those with a family income of more than $7,000.

Physician and dentist visits

Not only are chronic conditions a special problem but, according to the national health survey data, there is a correlation between the age of individuals and the number of physicians visits per person per year. The rate is 5 visits per year for the 45–54-year-old group, and the rate increases to 7.3 visits for the 75-year-and-over group. Visits to a hospital clinic are at the same rate for all age groups, and the rate for office visits declines for the 75-year-and-older group; however, home visits increase indicating increased limitation on mobility.

TABLE 5.—*Number of physician visits per person per year, by age, July 1957–June 1959*

Age	Place of visit [1]				Telephone
	Total	Office	Home	Hospital clinic	
45 to 54 years	5.0	3.6	0.4	0.5	0.3
55 to 64 years	5.8	4.1	.6	.5	.3
65 to 74 years	6.5	4.3	1.1	.5	.5
75 years and over	7.3	3.6	2.4	.5	.5

[1] Omitted here are the categories of "company or industry health unit" and "other and unknown."

The annual number of dental visits for older persons are considerably fewer—only 1.5 visits for the 45-to-64-year-old age group, and an average of 0.8 visits for each person 65 years and over.

MEDICAL EXPENSES AND INSURANCE COVERAGE

1. As of 1957–58, the average private medical expenses of the aged are 88 percent greater than for the general population. On a per capita basis the figures were $177 annually for those 65 years and older compared with $86 for the rest of the population. These data, from a 1957–58 National Opinion Research Center study for the Health Information Foundation, exclude payments for health insurance premiums (but do include benefits paid by insurance policies), payments for all institutionalized persons, expenditures by persons not surviving to be interviewed, and the value of free services.

The Division of Program Research of the Social Security Administration has estimated, on the basis of the NORC–HIF report of 1957–58, that the average per capita public and private medical expense of the aged in 1960 was $265—82 percent of which comes from private sources. The total medical bill for aged persons in the United States (exclusive of mental and tuberculosis hospital expenditures), was $4.4 billion, based on such estimates.

2. A National Health Survey report for January 1960 reported less than one-half (46 percent) of the aged are covered by private hospital insurance programs. The percentage of coverage among the retired aged (those not working year around full time) was even less (42 percent).

The percent of all aged persons and of only retired aged persons with health insurance, July–December 1959, was reported as follows:

Age	Insurance for all aged persons			Insurance for all retired aged		
	Hospital	Surgical	Doctor visit	Hospital	Surgical	Doctor visit
65 and older	46.1	37.1	10.2	42.3	32.8	8.3
65 to 74	53.2	44.2	(1)	49.1	39.6	(1)
75 and older	32.5	23.6	(1)	31.2	21.9	(1)

[1] Not reported.

In contrast to this coverage, health insurance coverage for all ages of the population is 67.1 percent with hospital insurance, 62 percent with surgical insurance, and 19.3 percent with doctor visit insurance.

In numbers of aged, approximately 7.5 million retired aged as of 1960 were without any hospital insurance; 8.7 million had no surgical insurance, and nearly 12 million were without doctor visit insurance.

For all the 17 million aged persons, at least 8.9 million have no hospital insurance, 10.4 million have no surgical insurance, and 14.9 million have no insurance to cover the costs of visits to the doctor.

As one measure of adequacy of coverage, it has been found that the retired person usually pays more in premiums for the same benefits he had when he was employed—higher costs at a time when his income suffers a sharp drop and when there is a greater risk of illness. Or in other cases, there can be not only an increase in premium costs, but there is also a decrease in benefits.

A typical health insurance policy for the retired aged is usually designed for an episode of acute illness, and not for the dominant health problems of the aged, namely, chronic illnesses. Many policies will provide, for example, only $10 per day maximum for hospital

costs, for a limited number of days, for a premium of $6.50 to $9 per month. The 1959 average charge for hospitalization was $32 per day.

The National Health Survey of 1958–60 found that only 28 percent of aged persons discharged from hospitals had as much as three-fourths of their hospital bill paid for by insurance, compared to 51 percent of persons under 65. Furthermore, the average hospital bill for aged patients is substantially higher than for younger patients.

In the vast majority of cases, health insurance policies do not contain assurances of lifetime protection or convertibility. It is not an infrequent practice of insurance companies to cancel policies of chronically ill aged or simply to refuse to renew the policy.

A comparison of proportions of the aged having hospital insurance with proportions having one or more chronic conditions—by regions—is shown in table 6. While the percentage with one or more chronic conditions is about the same for the four major regions of the United States, the proportion with hospital insurance varies widely among the regions. In all instances, however, the percent with hospitalization coverage is lower for the 75-year-and-over group than for the 65 to 74 group, while the percent with one or more chronic conditions is higher for the older age group.

TABLE 6.—*Regional comparison of hospital insurance coverage and prevalence of chronic conditions among persons age 65 and over, July 1957–June 1959*

Age	U.S. total		Northeast		North Central		South		West	
	Hospital insurance	1 or more chronic conditions	Hospital insurance	1 or more chronic conditions	Hospital insurance	1 or more chronic conditions	Hospital insurance	1 or more chronic conditions	Hospital insurance	1 or more chronic conditions
65 to 74	53.2	74.2	58.4	72.0	60.9	73.4	43.8	77.5	44.0	74.3
75 and over	32.5	83.3	32.3	79.9	36.9	82.3	29.6	86.9	30.1	83.1

Source: National health survey.

INCOME OF THE AGED

As health conditions become more severe and health insurance becomes less available (or less adequate), the aging person finds his productive years have passed and that his income becomes substantially less than it was when his health was good and when he was more likely to be protected against the costs of illness.

The income situation of the aged is generally considered as inadequate for the 1961 standard of living in the United States. The latest income data published by the Census Bureau show that one-third of the families headed by an aged person in 1959 had a total money income of less than $2,000; 80 percent of aged unrelated persons had a money income of less than $2,000. Table 7 shows also that one-half of the unrelated individuals had incomes of less than $1,000 per year.

TABLE 7.—*Total money income of persons 65 years and older, 1959*

Income	Percent families age of head 65 years and older	Percent of unrelated individuals 65 years and older	Income	Percent families age of head 65 years and older	Percent of unrelated individuals 65 years and older
Less than $1,000	10.8	49.8	$3,000 to $4,999	19.6	5.9
$1,000 to $1,999	23.0	30.3	$5,000 to $9,999	21.0	3.5
$2,000 to $2,999	19.2	9.7	Over $10,000	6.4	.8
Subtotal	53.0	89.8	Total	100.0	100.0

Source: Bureau of Census.

There were 6.2 million families in 1959 headed by an aged person; of these, 3.3 million had an income of less than $3,000. The median income for the 6.2 million families was $2,831. The median income for all families in the United States was $5,417.

Unrelated aged individuals numbered over 3.6 million in 1959; of these, about 3 million had an income of less than $2,000. The median income for this group of aged persons was $1,006.

Using income data for all aged individuals slightly less than three-fifths had less than $1,000 money income in 1959. The income status of the aged has not improved in the last decade at the same rate as it has for younger-aged groups: For example, taking only aged men, their median income in 1949 was 43 percent of the median for all men 14 and over; by 1959, it was only 39 percent of the median for all men, 14 and over.

About 30 percent of the spending units headed by aged persons in 1959 had no liquid assets (bank accounts or savings bonds), and another 20 percent had less than $1,000 in assets. Of those with an income less than $3,000, 47 percent had less than $200 in liquid assets.

Sources of income.—At the end of 1960, less than one-fourth of the aged (4.1 million) were receiving income from either full- or part-time employment as earners or their wives. Of these, 1.2 million had income from employment and from other public programs. The vast majority of the aged are dependent, then, on social security, private pensions, and public assistance for their income. There are nearly 12 million aged persons receiving social security benefits. The average payment for a retired worker in October 1960 was $74.02. Public assistance is received by 15.3 percent of the aged; the average old-age assistance payment in October 1960 was $69.45.

The number and percent of the aged receiving money income from employment and public programs is shown in table 8.

TABLE 8.—*Estimated number of persons aged 65 and over in the United States [1] with money income from employment or public programs, December 1960*

[Number in thousands]

Type of money income	Total	
	Number	Percent
Total population aged 65 and over	16,960	100.0
Employment, total [2]	4,110	24.2
Employment and no income from public programs	1,160	6.9
Employment and social insurance benefits	2,550	15.0
Employment and payments under other public programs	400	2.3
Social insurance (retirement and survivor) benefits, total [3 4]	12,010	70.8
Benefits and no earnings or veterans' or public assistance payments	7,700	45.4
Benefits and veterans' payments	1,020	6.0
Benefits and public assistance	740	4.4
Veterans' pension or compensation, total [4]	1,670	9.8
Veterans' payment and no earnings or social insurance [5]	340	2.0
Public assistance, total [6]	2,410	14.2
Public assistance and no earnings or payments under other public programs	1,560	9.2
No income from employment or public programs	1,490	8.4

[1] The 50 States, the District of Columbia, Puerto Rico, and the Virgin Islands.
[2] Includes 3,220,000 earners and an estimated 890,000 nonworking wives of earners.
[3] Includes persons with income from one or more of the following sources: old-age, survivors, and disability insurance, railroad retirement, and Government employees retirement. (See table 4.) Excludes persons with benefits under unemployment or temporary disability insurance or workmen's compensation programs.
[4] Includes estimated number of beneficiaries' wives not in direct receipt of benefits.
[5] Includes a small number receiving supplementary public assistance.
[6] Old-age assistance recipients and persons aged 65 and over receiving aid to the blind or to the permanently and totally disabled, including a small number receiving vendor payments for medical care but no direct cash payment either under old-age assistance or medical assistance for the aged.

Source: U.S. Department of Health, Education, and Welfare, Social Security Administration, Division of Program Research.

CHAPTER II

DEVELOPMENT OF NEW PROGRAMS FOR MEDICAL CARE

INTRODUCTION

The need for new programs to meet the spiralling medical costs of the Nation's senior citizens has become widely recognized. National attention is now focused on the 17 million Americans aged 65 or over. Widespread congressional concern has developed about the health and income problems of this population, summarized in the previous chapter.

Legislative proposals for the medical care for the aged in the 86th Congress took several forms. One of these called for including paidup medical care for the aged among the benefits provided under the social security old-age survivors and disability insurance (OASDI) program—prepaid social insurance financed through matching employer and employee payroll tax deductions during a worker's productive years of employment.

At first, the administration seemed to favor this approach, for on February 3, 1960, President Eisenhower revealed that his administration was considering the possibility of asking Congress to raise payroll taxes one-quarter of 1 percent in order to "make greater provision for the care of the aged." But on March 30, he reversed himself.

In May, the administration proposed an alternative: Medicare, calling for Federal grants to spur State programs for the medical care of the aged and for Federal subsidies to aid the aged in the purchase of private medical insurance protection.

Criticisms of this proposal included the following: (1) There was no guarantee that all the States would choose to participate in the program; or (2) that the participating States would provide adequate benefits to their aged; (3) the plan involved unnecessary subsidies for private insurance firms; and (4) the plan would require annual congressional appropriations from the General Treasury, rather than the automatic financing provided under the social security payroll deduction scheme.

HOUSE ACTION

On June 9, 1960, the Ways and Means Committee of the House of Representatives approved H.R. 12580. Included in this bill were medical care provisions other than those of either the administration's medicare or the social security approach.

The bill as reported by the committee authorized annual Federal grants to assist the States in providing medical care for the aged whose income and assets did not entitle them to old-age assistance, but who nevertheless needed aid in meeting their medical expenses. Participation in the plan would be voluntary for each State and each State would determine the level of its benefits within certain broad limitations. The Federal share of the program's costs would range from 50

to 65 percent paid out of General Treasury funds. It was estimated that 10 million aged would be potentially eligible for help, with 500,000 to 1 million persons annually expected to incur medical costs sufficient to receive payments under the means standards expected to be instituted by the States. Cost estimates were $325 million ($185 million paid by the Federal Government, $140 million by the participating States).

H.R. 12580 passed the House of Representatives on June 23, 1960, by a vote of 381 to 23.

SENATE ACTION

On February 23, 1960, the Subcommittee on Problems of the Aged and Aging of the Senate Committee on Labor and Public Welfare released its report on the extensive hearings and studies conducted in 1959, "The Aged and Aging in the United States: A National Problem." Among other recommendations it called for a new medical aid to the aged program financed under the social security system. (Senators Dirksen and Goldwater dissented.)

In the June 29–30 hearings on House-passed H.R. 12580, the Senate Committee on Finance heard HEW Secretary Arthur Flemming testify that the House's bill would not cover long-term illnesses as well as the administration's medicare proposal (Senator Saltonstall's S. 3784). At the same time, there was a continued effort to promote a variety of bills based on the social security financing approach, an approach which had been endorsed by a 30 to 13 vote of the 52d Annual Governors' Conference on June 29, 1960.

On August 13, the Senate Finance Committee followed the lead of the House of Representatives, again avoiding both the medicare voluntary insurance and the contributory social security approaches. The committee's medical care formula advocated a Federal-State program conferring benefits only upon the "medically needy" rather than upon the broader coverage of those eligible to receive social security benefits.

It was presented to the Senate as a "reasonable and workable" health care plan of financial incentives which should "enable every State to improve and extend medical services to aged persons." It increased the Federal maximum grant from 65 to 80 percent. It was predicted that from 500,000 to 1 million persons annually would require medical services resulting in payments under the Federal-State matching proposal.

H.R. 12580 was accepted by the Senate, 91 to 2, on August 23. The plan provided by this legislation was criticized for rejecting "the sound, dignified way of meeting the cost of medical care for the aged" through social security; and for the "humiliation of the means test" required in H.R. 12580. Some critics also predicted that State programs under the plan could not avoid being "grossly inadequate" due to the "impossible financial burden" placed upon the States.

PASSAGE OF PUBLIC LAW 86–778 AND SUBSEQUENT DEVELOPMENTS

H.R. 12580, a compromise measure reported by House-Senate conferees (H. Rept. 2165) was accepted by the House of Representatives on August 26 by a vote of 369 to 17 and by the Senate on August 29 by a vote of 74 to 11. In its final form, H.R. 12580 (subsequently popularly termed "Kerr-Mills") resembles the Senate's bill most closely

in that it provides a higher Federal matching formula than that originally authorized by the House. (See section below on provisions of the law.)

The bill became Public Law 86–778 on September 13 when President Eisenhower approved H.R. 12580 without comment.

PROVISIONS OF THE NEW LAW

Public Law 86–778 contains medical care for the aged provisions in two basic categories:

(1) Increased Federal matching fund grants for medical care under existing Federal-State old-age assistance programs (OAA), and

(2) The new Federal-State matching programs to aid "medically needy" aged persons (medical assistance for the aged—MAA) not otherwise eligible to receive old-age assistance in their respective States.

Both categories became eligible to receive Federal funds on October 1, 1960, according to the option of each State to participate in one, both, or neither of these programs.

(For Federal financial participation in these optional State programs, see ch. III.)

MAA authorizes Federal financial assistance where a State determines an aged person is eligible for OAA because of excess financial resources or because of other provisions of State assistance plans. Within the scope of medical benefits that may be provided as determined by the States, Federal contributions are authorized for 50 to 80 percent of total State disbursements for medical vendor or insurance premium payments. Provided that both institutional and noninstitutional services are available to the recipient, that no residence requirements are established to exclude any residents of that State, and that there are no enrollment fees, any of the following may be covered, if the State chooses:

(1) Inpatient hospital services;
(2) Skilled nursing home services;
(3) Physicians' services;
(4) Outpatient hospital services;
(5) Home health care services;
(6) Private duty nursing services;
(7) Physical therapy and related services;
(8) Dental services;
(9) Laboratory and X-ray services;
(10) Prescribed drugs, eyeglasses, dentures, and prosthetic devices;
(11) Diagnostic, screening, and preventive services; and
(12) Any other medical care or remedial care recognized under State law.

On September 14, the Department of Health, Education, and Welfare announced that almost $72 million in State funds would be freed from existing State OAA programs as the result of the availability of new Federal funds. Under the new matching formula, many States would receive added Federal money for programs already in operation. Thus, if a State's existing program was deemed adequate, some of the State's contribution to financing its OAA program might be released

for other purposes. Hopefully, declared HEW, this "freed money" would be used to initiate new aid programs for the medically needy.

ACTIVITIES UNDER PUBLIC LAW 86–778

I. OAA Programs

Of the 54 jurisdictions (50 States plus the District of Columbia Guam, Puerto Rico, and Virgin Islands) eligible to receive Federal funds under the old-age assistance program, 11 of them, or 20 percent of all jurisdictions, operated no vendor payment medical care programs whatsoever prior to enactment of the 1960 legislation. Among the 43 jurisdictions which did provide vendor medical care under their State old-age assistance plans, 16 of them, or 29 percent of the total, furnished direct or money payments for all essential items of medical care.[1]

Progress in implementing the new provisions for OAA medical care was far from rapid. As of November 15, 1960, 6 weeks after enactment of the legislation, 9 States reported expansion of coverage or services, 9 said that expansion plans were being developed, and 18 announced that additional funds would be used within the scope of existing medical care provisions. Other jurisdictions reported varying lesser stages of development.[2]

As of March 31, 1961, 6 months after funds for expanded OAA medical care programs first became available, the number of jurisdictions providing or planning expanded coverage or content of services under OAA was 18, or one-third of all jurisdictions. Twenty-five jurisdictions, however, were using their additional Federal funds without substantial change or expansion from the pre-Public Law 86–778 program level of September 1960. There were five new programs in operation or definitely to be inaugurated soon, while six States still had no plans for taking advantage of Public Law 86–778.

(See table 9 for a detailed breakdown of State action under the OAA program.)

II. MAA programs

Progress in implementing the new MAA provisions in the first 6 months after enactment of Public Law 86–778 was even slower than under the expanded OAA programs.

As of March 31, 1961, MAA programs were in effect in only seven States, 14 percent of all States. Five States reported legislation enacted and funds appropriated available but programs not yet operative, and 20 jurisdictions informed the Senate Special Committee on Aging that legislation was still pending to provide a legal basis and provide appropriations for such new programs. Fifteen jurisdictions reported little planning for MAA programs and/or no legislation pending to institute such programs.

[1] See table 1, "Social Security Amendments of 1960," report of the Committee on Finance to accompany H.R. 12580 (Rept. No. 1856) Senate Calendar No. 1928, Aug. 19, 1960, p. 282.

[2] See table II, "Activities of the 54 jurisdictions to put into effect the new program of medical assistance for the aged and to use the additional Federal funds made available for old age assistance medical care," HEW, Social Security Administration, Bureau of Public Assistance, Division of Program Operations, Nov. 15, 1960.

Projections beyond April 1, 1961, indicate that no more than 16 additional States expect to have any form of MAA program in operation before 1962 and of these, program details and the availability of appropriations are problematical in all but a few jurisdictions.

(See table 10 for State responses as of March 31, 1961, on State plans beyond that date and table 11 for current report of Department of Health, Education, and Welfare.)

(Table 12 reports number of OAA recipients and expenditures for various existing medical programs.)

TABLE 9.—*States making use of additional funds available for old-age assistance medical care as of Mar. 31, 1961*

A. States making vendor payment before September 1960 for medical care costs for old-age assistance recipients, 43 States:

1. Extent of coverage or content of services for OAA has been expanded from level of September 1960, 18 States:

California	Michigan	Utah
Florida	North Carolina	Vermont
Idaho	Ohio	Virginia
Iowa	New Jersey	Virgin Islands
Louisiana	Oklahoma	Washington
Maryland	Tennessee	West Virginia

2. Using additional Federal funds within scope of State's plan provisions; no substantive change from level of September 1960, 25 States:

Arkansas	Massachusetts [1]	North Dakota
Colorado	Minnesota	Oregon
Connecticut	Missouri	Pennsylvania
District of Columbia	Montana	Rhode Island
Hawaii	Nebraska	South Carolina
Illinois	Nevada	Wisconsin
Indiana	New Hampshire	Wyoming
Kansas	New Mexico	
Maine	New York	

B. States not making vendor payments for costs of medical care in OAA before September 1960, 11 States:

1. New provisions for vendor payment adopted, in operation, 5 States:
   - Alabama, effective November 1960.
   - Kentucky, legislation in 1960, effective January 1961.
   - Mississippi.
   - Puerto Rico, effective October 1960.
   - South Dakota.
2. Need legislation for making vendor payments, 6 States:
   - Alaska (bill introduced).
   - Arizona.
   - Delaware.
   - Georgia.
   - Guam.
   - Texas.

[1] Nursing home care withdrawn from scope of OAA and assigned to MAA.

Source: Department of Health, Education, and Welfare, Social Security Administration, Bureau of Public Assistance, Division of Program Operations.

TABLE 10.—*State activity to implement MAA program as of Mar. 31, 1961*

State	Program in effect	Not in effect but legal base and appropriation available	Appropriation needed	Bill before legislature	Proposal being prepared and recommendations decided upon	Proposal under study; no recommendations	Program not under consideration	Program in effect as of Apr. 1, 1961	To go into effect before June 1, 1961	To go into effect before Sept. 1, 1961	To go into effect before Dec. 31, 1961	To go into effect in 1962	No program expected before 1962	Unknown
Alabama						X					Date uncertain [1]			
Alaska				X									X	
Arizona							X						X	
Arkansas		X								July 1 [2]				
California				X								Jan. 1		
Colorado							X						X	
Connecticut				X		X							(2)	
Delaware						X							X	
District of Columbia					X					(4)			X	
Florida			(5)											
Georgia				X						July			X	
Hawaii		X								do				
Idaho				X										X
Illinois				(5)									X	
Indiana				X								Jan. [4]		
Iowa				(6)									X	
Kansas								X						
Kentucky	X				X						October			
Louisiana				X							(2)			
Maine		X							May 1					
Maryland								X						
Massachusetts	X							X						
Michigan	X			X						(7)				
Minnesota							X						X	
Mississippi				X									X	
Missouri														

Montana							X						X	
Nebraska				X							(4)			
Nevada							X						X	
New Hampshire					X					July				
New Jersey						X								X
New Mexico			(5)										X	
New York	X							X						X
North Carolina				X										
North Dakota		X								July				
Ohio				X									X	
Oklahoma	X							X						
Oregon				X							October			
Pennsylvania						X								X
Puerto Rico	X							X						
Rhode Island							X						X	
South Carolina				X						X				
South Dakota				(6)									X	
Tennessee						X				August [8]				
Texas				(9)									X	
Utah		X								X				
Vermont				X									X	
Virgin Islands	X							X						
Virginia						X							X	
Washington	X							X						
West Virginia	X							X						
Wisconsin				X										X
Wyoming							X						X	

[1] No program details developed.
[2] Program details indefinite.
[3] However, detailed program has been prepared for subsequent enactment.
[4] If passed, but passage doubtful; no program developed.
[5] Legislature has adjourned without action.
[6] Legislature rejected proposal and adjourned.
[7] If passed, but passage doubtful.
[8] Limited program planned.
[9] Constitutional amendment needed.

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Projections beyond April 1, 1961, indicate that no more than 16 additional States expect to have any form of MAA program in operation before 1962 and of these, program details and the availability of appropriations are problematical in many of the jurisdictions. The following is based on what the State reported as of March 31, 1961.

Programs in effect as of April 1, 1961, seven States.

Programs not in effect as of April 1, 1961, but expected to go into effect before 1962, 16 States:

1. Expected to go into effect before 1962, program details outlined, nine States:

Maryland	North Dakota	Utah
Hawaii	South Carolina	Louisiana
New Hampshire	Tennessee	Oregon

2. Expected to go into effect before 1962, program details indefinite, four States: Arkansas, Alabama, Idaho, Maine.

3. Doubtful whether will go into effect before 1962, three States: Florida, Minnesota, Nebraska.

No program scheduled during 1961, 28 States:

1. Expected to go into effect in 1962, two States: Connecticut, California.

2. No prediction as to whether will go into effect in 1962, 26 States:

Alaska	Iowa	North Carolina
Arizona	Kansas	Ohio
Colorado	Mississippi	Pennsylvania
Delaware	Missouri	Rhode Island
District of Columbia	Montana	South Dakota
Georgia	Virginia	Texas
Vermont	New Jersey	Wisconsin
Illinois	Nevada	Wyoming
Indiana	New Mexico	

TABLE 11.—*Activities of the 54 jurisdictions to put into effect the new program of medical assistance for the aged, as of June 5, 1961*

A. Programs in effect,[1] 9 States:

Kentucky	New York (April)	Virgin Islands
Massachusetts	Oklahoma	Washington
Michigan [2]	Puerto Rico	West Virginia

B. Plan submitted; not in effect, 3 States: Arkansas (in regional office), Maryland, Oregon (in regional office).

C. Legislation enacted; plan not yet submitted, 5 States:

Idaho (effective July 1, 1961)	Tennessee (effective July 1, 1961)
North Dakota (effective July 1, 1961)	Utah (effective July 1, 1961)
South Carolina (effective July 1, 1961)	

D. Legislation in process to give basis for program or to provide appropriation, 14 States:

Passed: Illinois (1 house).

Bill introduced: Alabama, California, Connecticut, Maine, Missouri, Nebraska, New Hampshire, North Carolina, Ohio, Pennsylvania, Vermont, Wisconsin.

Other status (drafted): New Jersey.

E. Considering possible action by legislature, 6 States:

Delaware [3]	Florida	Louisiana
District of Columbia	Guam [3]	Minnesota

F. Need legislation; no action is anticipated in 1961, 14 States:

In session: Rhode Island, Texas.[3 4]

Adjourned without action: Alaska,[3] Arizona,[3] Colorado, Hawaii, Indiana, Kansas, Montana, Nevada, South Dakota,[3] Wyoming.

Session in 1962: Mississippi, Virginia.

G. Have authority for MAA; not expected to implement in 1961-62; legislature adjourned, 3 States:

Georgia: [3] Enacted 1961; no appropriation.

Iowa: Enacted 1961; no appropriation.

New Mexico: Plan in abeyance; no appropriation.

[1] Plans of these States are approved, except New York.
[2] Regular session/acting to expand eligibility and content of MAA.
[3] Do not have in operation vendor payment for medical care in OAA.
[4] Introduced proposed constitutional amendment for a future MAA program.

Source: Department of Health, Education, and Welfare, Social Security Administration, Bureau of Public Assistance, Division of Program Operations.

TABLE 12.—*Population and recipients of medical care, by States*

	Population 65 and over, 1960	OAA recipients April 1960	OAA recipients receiving vendor medical care July 1959 to June 1960	Aged individuals receiving medical care programs with no Federal funds	Total vendor payments for OAA [1] medical care July 1959 to June 1960	Total vendor payments for medical care under general assistance [1] July 1959 to June 1960	Total cost of medical services to aged under State-local programs with no Federal funds July 1959 to June 1960	Number expected to be eligible for MAA
Alabama	261,100	98,800	[2] 1,700	Unknown	$12	$1	$12,454.12	Unknown
Alaska	5,400	1,400	None	Unduplicated count unavailable.		466	$20,234.58	Unknown
Arizona	90,200	14,000	None	None			None	Unknown
Arkansas	194,400	55,300	18,000	4,000	3,984	427	Not available	82,000
California	1,376,200	256,100	198,000	No information	26,567	947	No information	535,000
Colorado	158,200	47,300	36,425	Unknown	10,021	2,021	Unknown	Unknown
Connecticut	242,600	14,600	17,071	do	3,322	[2] 2,736	do	30,000
Delaware	35,700	1,300	None	None			None	Unknown
District of Columbia	69,100	3,100	570	do	293	7	do	Unknown
Florida	553,100	69,700	6,600	Not available	4,255		Not available	Unknown
Georgia	290,700	96,900	None	do			do	Unknown
Hawaii	29,200	1,500	1,400	532	134		$73,000	1,200
Idaho	58,300	7,400	661	Not answered	407		Not answered	Unknown
Illinois	974,900	74,500	75,000	Not available	25,638	16,465	Not available	Unknown
Indiana	445,500	27,900	Unknown	Not answered	6,182	3,689	Not answered	Unknown
Iowa	327,700	34,600	[4] 28,050	2,816	2,744	2,897	$354,000	Unknown
Kansas	240,300	28,700	[5]	None	4,064	771	None	Unknown
Kentucky	292,300	56,400	None	do			do	87,000
Louisiana	241,600	124,800	2,755	do	2,912	59	do	60–85,000
Maine	106,500	11,800	3,600	2,350	1,600	1,559	$360,000	Unknown
Maryland	226,500	9,500	9,000	None	599		None	95,000
Massachusetts	571,600	79,700	81,641	500 cases	40,504	1,898	$300,000	475,000
Michigan	638,200	62,000	13,565	Not available	5,146	16,690	Not available	60,000
Minnesota	354,400	47,400	42,000	None	19,377	4,088	None	17,500
Mississippi	190,000	80,000	None	do			do	Unknown

Missouri	503,400	116,700	4,252	Unknown	222	127	Unknown	Unknown
Montana	65,400	7,000	None	Not available	16	2,520	Not available	Unknown
Nebraska	164,200	15,100	(6)	Not answered	4,103	840	Not answered	Unknown
Nevada	18,200	2,600	2,100	Unknown	188	1,044	Unknown	Unknown
New Hampshire	67,700	4,900	4,834	Not available	1,100	280	Not available	21,283
New Jersey	560,400	18,800	4,000	do	7,352	2,098	do	Unknown
New Mexico	51,300	10,700	7,797	None	1,094	176	None	Unknown
New York	1,687,600	83,300	70,000	60,000	32,700	7,145	$30,000,000	[7] 800,000
North Carolina	312,200	48,700	6,950	6,000	1,169	2,850	$1,041,000	Unknown
North Dakota	58,600	7,300	5,961	Unknown	2,682	277	Unknown	11,496
Ohio	897,100	89,700	60,000	1,000–2,000	11,164	17,384	do	Unknown
Oklahoma	248,800	90,000	26,843	Not answered	12,625		Not answered	40,000
Oregon	183,700	17,100	(5)	Not available	5,447	436	Not available	55,000
Pennsylvania	1,128,500	50,100	30,000	22,000	2,256	2,061	$5,000,000	610,000
Puerto Rico			None	None			None	70,000
Rhode Island	89,500	6,700	(3)	Unknown	1,146	769	Unknown	Unknown
South Carolina	150,600	32,700	3,570	Not available	814	143	Not available	50,000
South Dakota	71,500	9,000	None	do		1,460	do	Unknown
Tennessee	308,900	55,200	7,533	330	875		$58,480.67	Unknown
Texas	745,400	221,700	None	120,000			$19,735,000	Unknown
Utah	60,000	7,900	(3)	None	407	17	None	16,000
Vermont	43,700	5,700	559	Unknown	291		Unknown	Unknown
Virgin Islands			561	Not available	3	2	Not available	925
Virginia	289,000	14,800	1,350	5,550	1,200	156	$683,651	Unknown
Washington	279,000	49,600	(3)	3,000	17,199	1,625	$1,000,000	60,000
West Virginia	172,500	19,700	17,268	156	826	205	Improper answer	102,559
Wisconsin	402,700	35,800	22,240	Unknown	17,283	2,363	Unknown	Unknown
Wyoming	25,900	3,300	1,079	Not available	361	449	Not available	Unknown

[1] Amounts in thousands.
Only nursing home.
Estimated.
Medical service and drugs.
[5] Not available.
[6] Not answered.
[7] Maximum.

CHAPTER III

FINANCING OAA AND MAA

THE FEDERAL-STATE FORMULA

A single Federal appropriation is made to meet the costs of grants-in-aid for old-age assistance and medical assistance for the aged (the combined total appropriation includes grants for aid to dependent children, aid to the blind, and aid to the permanently and totally disabled). It is an open-end grant, and the amount of the appropriation depends upon the amount of the States' expenditures for each program. The Federal share of total expenditures for each program is computed in accordance with the formula for that program specified in the Social Security Act.

Table 13 shows the amount of the appropriation for public assistance programs in operation in selected years prior to October 1960.

TABLE 13.—*Selected appropriations for public assistance, 1937–61*

[In thousands]

Fiscal year	Appropriation [1]	Expenditures for—			
		OAA, ADC, AB, and APTD, combined [2]		OAA only	
		Federal	State and local	Federal	State and local
1937	$146,000	$142,568	$167,326	$125,050	$131,192
1941	330,000	333,474	369,965	263,343	272,311
1947	619,000	615,923	648,349	495,337	465,026
1949	948,000	939,509	872,145	726,672	599,248
1951	1,280,000	1,188,179	1,069,987	832,126	717,069
1952	[3] 1,150,000	1,209,076	1,111,222	826,101	746,689
1953	[4] 1,340,000	1,358,827	1,117,751	920,063	751,742
1954	[5] 1,398,000	1,406,030	1,111,155	943,562	740,847
1955	[6] 1,438,000	1,440,720	1,168,865	933,904	752,404
1956	1,447,000	1,463,618	1,244,893	937,063	798,375
1957	[7] 1,575,000	1,610,338	1,296,793	1,009,966	822,224
1958	[8] 1,770,600	1,757,078	1,387,376	1,058,651	852,566
1959	1,957,960	1,972,918	1,426,885	1,149,520	823,569
1960	2,037,500	[9] 2,060,300	[9] 1,483,600	[9] 1,173,900	[9] 838,300
1961	[10] 2,173,000				

[1] Includes regular and supplemental appropriations. See footnote 2.

[2] Data are for the programs of old-age assistance (OAA), aid to dependent children (ADC), and aid to the blind (AB) from 1937 to date; for aid to the permanently and totally disabled (APTD) from 1951 to date; and for medical assistance for the aged (MAA) beginning in 1961.

[3] In addition $22,400,000 from the 1953 appropriation was used for part of the 1952 grants to States.

[4] Includes $22,400,000 used for part of the 1952 grants to States; excludes $20,400,000 from the 1954 appropriation used for part of the 1953 grants.

[5] Includes $20,400,000 used for part of the 1953 grants to States; excludes $9,300,000 from the 1955 appropriation used for part of the 1954 grants.

[6] Includes $9,300,000 used for part of the 1954 grants to States.

[7] In addition, $11,400,000 from the 1958 appropriation was used for part of the 1957 grants to States.

[8] Includes $11,400,000 used for part of the 1957 grants to States.

[9] Partly estimated.

[10] Includes proposed supplemental estimate of $90,000,000.

1. For OAA, the method of distributing funds to the 50 States is for Federal funds to equal four-fifths of the first $30 of a maximum average monthly payment of $65 per recipient plus a percentage of the next $35 of such average payment, based upon the State's per capita income in relation to the national per capita income. The Federal percentage applied to that part of the average grant above $30 ranges from 50 percent to 65 percent.[1]

The average monthly payment is based on expenditures for money payments to recipients and payments to vendors for medical or remedial care. The 1960 legislation provided an additional sum of Federal participating money based upon State expenditures for vendor medical payments.

This additional amount is the larger of the two following alternatives:

A. Federal medical percentage (which varies among States according to per capita income in relation to national per capita income, not less than 50 nor more than 80 percent) of expenditures for vendor medical payments, up to $12 per recipient, that are above $65;[2] or

B. Fifteen percent of expenditures for vendor medical payments up to $12 per recipient.[3]

In addition, Federal funds cover half the costs of State and local administration of the State plan.

The formula used for distributing the funds in this program are intended to provide the highest percentages of Federal participation to the low income States, which generally have relatively large proportions of needy persons and make relatively low assistance payments. The device to accomplish this latter objective is the use of the per capita ratio between the State and the Nation on the assistance above $30. (See table 14.)

Federal funds are computed for each month, but the grants are requested quarterly by the States in advance, on an estimated basis. These amounts are adjusted after actual expenditures for the quarter are known.

[1] See table 14 and explanatory footnote for details.
[2] Legislation adopted this year has increased vendor payments from $12 to $15, raising maximum average payment for which Federal participation can be received from $77 to $80 a month. This is effective July 1, 1961.
[3] Ibid.

TABLE 14.—*Federal percentages and Federal medical percentages* [1]

State	Oct. 1, 1960, through June 30, 1961		July 1, 1961, through June 30, 1963	
	Federal medical percentage (I)	Federal percentage (II)	Federal medical percentage (I)	Federal percentage (II)
Alabama	79.15	65.00	79.04	65.00
Alaska	50.00	50.00	50.00	50.00
Arizona	63.23	63.23	58.39	58.39
Arkansas	80.00	65.00	80.00	65.00
California	50.00	50.00	50.00	50.00
Colorado	53.42	53.42	52.78	52.78
Connecticut	50.00	50.00	50.00	50.00
Delaware	50.00	50.00	50.00	50.00
District of Columbia	50.00	50.00	50.00	50.00
Florida	59.68	59.68	58.44	58.44
Georgia	74.36	65.00	75.04	65.00
Hawaii	53.38	53.38	53.38	53.38
Idaho	67.04	65.00	66.29	65.00
Illinois	50.00	50.00	50.00	50.00
Indiana	50.00	50.00	52.03	52.03
Iowa	63.23	63.23	58.48	58.48
Kansas	60.78	60.78	57.52	57.52
Kentucky	76.94	65.00	75.57	65.00
Louisiana	72.00	65.00	72.55	65.00
Maine	65.23	65.00	66.60	65.00
Maryland	50.00	50.00	50.00	50.00
Massachusetts	50.00	50.00	50.00	50.00
Michigan	50.00	50.00	50.00	50.00
Minnesota	58.57	58.57	57.96	57.96
Mississippi	80.00	65.00	80.00	65.00
Missouri	53.42	53.42	52.91	52.91
Montana	54.07	54.07	55.74	55.74
Nebraska	63.41	63.41	56.86	56.86
Nevada	50.00	50.00	50.00	50.00
New Hampshire	57.91	57.91	58.18	58.18
New Jersey	50.00	50.00	50.00	50.00
New Mexico	67.99	65.00	65.22	65.00
New York	50.00	50.00	50.00	50.00
North Carolina	77.46	65.00	77.47	65.00
North Dakota	74.18	65.00	72.44	65.00
Ohio	50.00	50.00	50.00	50.00
Oklahoma	67.54	65.00	66.53	65.00
Oregon	52.58	52.58	52.40	52.40
Pennsylvania	50.00	50.00	50.00	50.00
Rhode Island	50.00	50.00	51.09	51.09
South Carolina	80.00	65.00	80.00	65.00
South Dakota	75.42	65.00	72.16	65.00
Tennessee	76.55	65.00	75.87	65.00
Texas	61.36	61.36	60.79	60.79
Utah	65.44	65.00	63.74	63.74
Vermont	65.82	65.00	67.07	65.00
Virginia	65.44	65.00	64.91	64.91
Washington	50.00	50.00	50.00	50.00
West Virginia	72.69	65.00	70.32	65.00
Wisconsin	54.60	54.60	53.10	53.10
Wyoming	50.92	50.92	50.86	50.86
Guam	50.00	----------	50.00	----------
Puerto Rico	50.00	----------	50.00	----------
Virgin Islands	50.00	----------	50.00	----------

[1] In brief and simplified form, these percentages are used as follows in determining the Federal share of assistance under OAA and MAA for each of the 50 States and the District of Columbia:

A. OAA: The Federal Government pays 80 percent of the average monthly grant per recipient up to $30. Of the amount in the average grant above $30 and up to $65 the Federal Government pays the "Federal percentage." Of the amount in the average grant above $65 and up to $77 [a]—assuming this amount equals or is less than the average vendor payment for medical care—the Federal Government pays the "Federal medical percentage;" as an alternative to this last provision, however, the State may receive from the Federal Government 15 percent of the average vendor payment for medical care up to $12.[b]

B. MAA: The Federal Government pays the "Federal medical percentage" of total medical care costs under the program.

[a] Effective July 1, 1961, this figure is raised to $80.

[b] Effective July 1, 1961, this figure is raised to $15.

2. In MAA, the amount of Federal funds is derived from application of the Federal medical percentage (which, to repeat, varies among States according to per capita income, not less than 50 percent nor more than 80) of total expenditures for vendor medical payments. (See table 14.) In addition, Federal funds cover half the costs of State and local administration of the State plan.

ESTIMATED COST OF MAA PROGRAM

Twenty States provided information on the estimated cost of 1 year's MAA program, based upon estimates as of March 31, 1961. The total estimated cost of a year's medical service under MAA for the 20 States is $330,050,622, of which the Federal share would be $171,867,492. The State and local share would be $158,183,170. (See table 15.)

TABLE 15.—*Anticipated 1 year cost of MAA service and source of funds* [1]

	Expected total cost of services	Source of funds			New State and local appropriations needed for program	State and local funds representing transfer of expenditures from other health or welfare programs
		Federal	State	Local		
Total, 22 jurisdictions	$331,007,370	$172,345,846	$98,460,772	$60,200,752	$33,389,426	[2] $124,023,562
Arkansas	6,000,000	4,800,000	1,200,000		1,200,000	
California	79,596,000	39,798,000	20,341,000	19,457,000	2,446,000	37,300,000
Connecticut	6,600,000	3,300,000	3,300,000		3,300,000	
Hawaii	200,000	106,760	93,240			93,240
Kentucky	1,974,800	1,493,000	481,800		481,800	
Louisiana	4,155,000	2,991,460	1,163,540			1,163,540
Maine	3,375,000	1,625,000	[3] 1,750,000		1,000,000	825,000
Maryland	1,995,800	997,900	997,900		241,850	756,050
Massachusetts	37,724,000	18,315,000	12,886,000	6,523,000		18,315,000
Michigan	9,600,000	4,800,000	3,840,000	960,000	1,710,000	3,120,000
Minnesota	20,131,000	11,341,000	4,395,000	4,395,000	2,496,000	6,294,000
New Hampshire	595,250	345,250	250,000		250,000	
New York	115,000,000	57,500,000	28,750,000	28,750,000	10,250,000	47,250,000
North Dakota	4,200,000	3,042,480	1,041,768	115,752	123,746	1,033,774
Oklahoma	900,000	607,860	292,140			292,140
Pennsylvania	28,875,000	14,437,500	14,437,500		7,837,500	6,600,000
Puerto Rico	876,708	438,354	438,354			230,818
South Carolina	2,500,000	2,000,000	500,000		500,000	
Utah	1,500,000	1,000,000	500,000		500,000	
Virgin Islands	80,000	40,000	40,000		40,000	
Washington	1,500,000	750,000	750,000			750,000
West Virginia	3,628,812	2,616,282	1,012,530		1,012,530	

[1] As of Mar. 31, 1961, for those States reporting such information.
[2] Total of last 2 columns does not equal State and local total due to State report inconsistencies.
[3] Excludes State share of administrative cost.

In these 20 States there is an aged population of 8,200,000, but on the basis of the eligibility criteria proposed by the States, only 3,300,000 would qualify for MAA, as seen in table 12.

On the basis of $330 million that the States estimate they would spend for medical services in 1 year, the per capita assistance would be $100 per MAA eligible. However, using only the experience of the six States actually operating programs, the $100 figure is more than twice the per capita assistance provided by the six States (see ch. V).

Of the non-Federal funds expected to be expended on medical assistance, $97,982,418 would come from State treasuries and $60,200,752 would come from local finances.

However, nearly $4 out of every $5 provided by the 20 State and local governments are being transferred from existing programs.

The total estimated cost of a year's medical services under MAA for the six States with operating programs is $55,327,612, of which the Federal share would be 51.7 percent, or $28,582,142 and the State-local share, 48.3 percent, or $26,745,470.

These six States have a total aged population of 2,202,100, but on the basis of the eligibility criteria proposed by the States, only 824,559 would qualify for benefits under the MAA program. This represents 37.4 percent of the aged in those States.

Of the $157,142,170 [3] being appropriated by State and local governments, $123,792,744 is money being transferred from other existing programs.

One example of this is the proposed program in Minnesota. The annual cost estimate of MAA is $20,131,000. The State and local governments are sharing equally the non-Federal costs of $8,790,000. But of this total, $6,294,000 is being transferred from other programs. In other words, only $2,496,000 is the actual new net non-Federal increase.

Information from the Minnesota questionnaire indicates that program costs and appropriations would be reduced in OAA and aid to the blind. It also reported that nursing home cases and chronic disease hospital cases will receive MAA but not OAA or AB.

A proposed Pennsylvania program would cost $28,875,000, of which the State will appropriate $14,437,500. But of this, $6,600,000 is being transferred from the State aid-to-hospitals program. All 65-and-older persons would be eliminated from the State aid-to-hospitals program.

North Dakota proposes to spend $4,200,000 on its MAA program, of which $1,041,768 is State money and $115,752 is local. New net dollar expenditures account for $123,746, while transferred funds total $1,033,774.

The North Dakota questionnaire indicates that it will decrease State and local appropriations for old-age assistance by $1,033,774.

The proposed annual expenditure for MAA in California is $79,596,000, of which the State and local share is $39,798,000. Of this, $37,300,000 is money being transferred from its county hospital care program. Thus, the new net increase in State costs is only $2,498,000.

Massachusetts' matching requirement for MAA is $18,315,000, all of which is being transferred from other programs. The State does not have to increase its costs at all.

Before MAA, New York was spending $75 million, of which $10 million were Federal funds. The MAA program will cost $115 million, of which $57,500,000 will be Federal funds. The cost to State and local units combined will decrease $7,500,000. Actually, this decrease will be in New York City, for the most part, with the remainder in upstate counties. The State is increasing its share of the total by

[3] The difference between this figure and $158,183,170 is due to inconsistencies in replies to the State questionnaire.

$10,250,000. New York City will reduce its expenditures by $16,350,000.

The New York questionnaire reported that the locally financed programs of hospital care for medical indigents will become part of MAA. Annual expenditures of $30 million by local communities will be reimbursed 50 percent from Federal funds and 25 percent from State funds.

About 17,500 institutionalized OAA recipients will be transferred to MAA. OAA costs will thereby be reduced by about $48 million, according to New York's report.

Table 14 lists the responses of the States to the question inquiring into estimated costs and source of funds for MAA in the first year of a program or contemplated program as of March 31, 1961.

REASONS FOR FUND TRANSFERS

There are several reasons for the transferring of funds from existing programs to MAA.

In many instances the States stand to make a substantial financial gain by transferring cases from OAA to MAA. For example, a State whose "Federal percentage" and "Federal medical percentage" in the matching formula are both at the 50-percent level, and whose average assistance payment is about $77, including an average vendor payment for medical care of at least $12, will receive $47.50 per month in Federal funds for each recipient of OAA. If its nursing home payments are $200 a person a month, the Federal share of this payment is $47.50. But, if the nursing home patient is transferred to MAA, the Federal grant then becomes $100 instead of $47.50. This is because under MAA the total expenditures are matched 50–50, with no limitation on the average payment to be matched, as in OAA. Thus, instead of spending $152.50 a month, the State will have to spend only $100 in State funds per nursing home patient.

However, under such a transfer, the money does not provide for care of any additional individuals, unless the State uses in the MAA program money freed from its OAA program as a result of the transfer. In the meantime, there has been no reduction in the proportion of Federal funds used by the States in its OAA program because it already was receiving its maximum grant per recipient.

Similarly, if the State's average monthly OAA payment is $100, it is receiving a maximum Federal grant of $47.50 a recipient. Thus, if the State reduces this average to $77 and transfers $23 in State funds the State will still receive the maximum Federal grant of $47.50 for OAA and an additional $23 in a Federal grant under MAA. But to do this the State must reduce the amount of aid given under OAA.

In other cases, money is being transferred from a program which receives no Federal grants-in-aid and thus the transfer of individuals who would be eligible for MAA to an MAA program increases the amount of total Federal money a State would receive.

(NOTE.—See app. A for the actual estimates and expenditures reported to Department of Health, Education, and Welfare of States with operating MAA program.)

CHAPTER IV

MEDICAL CARE THROUGH OLD-AGE ASSISTANCE

Forty-three States provided some medical care to old-age assistance recipients through vendor payments in September 1960, prior to enactment of the new legislation (Public Law 86–778). The content of the medical care provisions of these State programs varies widely—from extremely limited benefits to somewhat comprehensive services. Examples of limited provisions—discussed below—are found in several States providing only emergency hospital or nursing home care to cases with extreme need. There was obviously room for improvement in nearly all State OAA medical care provisions in September 1960.

GENERAL DEVELOPMENT

The decision as to the content and amount of medical care to be provided under old-age assistance rests with the State agency. Payments for medical care available to recipients of old-age assistance are made in two ways: (1) directly to the suppliers of such care (vendor payments); and (2) by including amounts for medical care in the requirements on which money payments to recipients are based to enable the recipients to purchase their own care (money payments). The new legislation, however, provides that additional Federal funds may be obtained only for medical services through vendor payments. States have the option of transferring part or all of the money payments now made for medical services to vendor arrangements.

Vendor payments

Of the 43 States that made vendor medical care payments in September 1960, 27 made changes in their OAA vendor medical care provisions by the end of April 1961, or were planning to make some improvements in 1961. These 27 States are:

Arkansas	Maine	Ohio
California	Maryland	Oklahoma
Connecticut	Michigan	Tennessee
District of Columbia	Missouri	Utah
Florida	Nevada	Vermont
Idaho	New Jersey	Virginia
Indiana	New Mexico	Virgin Islands
Iowa	New York	Washington
Louisiana	North Carolina	West Virginia

The other 16 States reported no improvements in OAA vendor medical care since September, nor were they known to be planning changes within the next few months:

Colorado	Montana	Rhode Island
Hawaii	Nebraska	South Carolina
Illinois	New Hampshire	Wisconsin
Kansas	North Dakota	Wyoming
Massachusetts	Oregon	
Minnesota	Pennsylvania	

Eleven States were making no vendor payments for costs of medical care under OAA prior to October 1960. Of these, five have either begun to make vendor payments or are planning to do so in 1961: Alabama, Kentucky, Mississippi, Puerto Rico, and South Dakota. The remaining six States are not expected to begin making vendor payments in this program before the end of the year: Alaska, Arizona, Delaware, Georgia, Guam, and Texas. These States require either new legislation or additional appropriations before they can begin to make such payments.

CHANGES IN MEDICAL SERVICES

In summary, then, 32 of the 54 States have taken or are planning to take action in the near future to implement the provisions of the 1960 amendments of the Social Security Act designed to encourage improvements in vendor payment medical care for recipients under State old-age assistance programs. No improvements have as yet been made or are planned to be made in the other 22 States; of these 22 States, 16 already provide some medical care to recipients through vendor payments, while 6 do not.

Highlights of other specific changes under Public Law 86–778 may be summarized as follows:

INPATIENT HOSPITAL CARE

Prior to enactment of Public Law 86–778, all needed inpatient hospital care was provided in 28 of the 50 States. Two additional States (Idaho and Vermont) implemented inpatient hospitalization service in March 1961 and South Dakota expects to have this service in effect by September 1961. Colorado will eliminate this benefit.

Thus, 40 percent of the States do not provide all inpatient hospital care.

Emergency hospital care exclusively was provided in nine States before passage of Public Law 86–778. One State (Kentucky) had added emergency care programs by March 1961 and two States (Alabama and Mississippi) were planning to initiate programs before Setember 1961. At least eight States (Alaska, Arizona, Delaware, Georgia, Iowa, Montana, Nevada, and Pennsylvania) report that they will offer no hospitalization services through OAA by September 1961.

NURSING HOME CARE

Prior to passage of Public Law 86–778, nursing home care was available to OAA recipients in all but three States (Arizona, Montana, and Nevada). No additional States report their intention to institute such service by September 1961.

DENTAL CARE

Little expansion in provision of dental care is reported under the operations of Public Law 86–778. Twenty-one States did not provide such services in September 1960. Again, 18 report that they will probably not offer dental care services before September 1961.

TABLE 16

CONTENT OF OAA MEDICAL PROGRAMS[1]

	INPATIENT HOSPITAL CARE									NURSING HOME CARE			DENTAL CARE			EYE CARE			PRESCRIPTION DRUGS			PHYSICIANS SERVICES									OTHER PRACTITIONERS SERVICE			OTHER CARE		
	All Needed Inpatient Care			Emergency Care Only			Other															Hospital Inpatient Service			Hospital Outpatiert Service			Office Calls			Home Calls							
	9/60	3/61	9/61	9/60	3/61	9/61	9/60	3/61	9/61	9/60	3/61	9/61	9/60	3/61	9/61	9/60	3/61	9/61	9/60	3/61	9/61	9/60	3/61	9/61	9/60	3/61	9/61	9/60	3/61	9/61	9/60	3/61	9/61	9/60	3/61	9/61
ALA.						V				M	V	V																								
ALAS.										M	M	M																								
ARIZ.																																				
ARK.	V	V	V							V	V	V				V	V	V	MV	MV	MV				V	V	V									
CALIF.	M	M	M							M	M	M	M	V	V	M	V	V	MV	V	V	M	M	M	V	V	V	V	V	V	V	V	V	V	M	MV	MV
COLO.	V	V				V	V	V		V	V	V				V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	
CONN.	V	V	V							M	M	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V
DEL.										M	M	M	M	M	M	M	M	M	M	M	M							M	M	M	M	M	M	M	M	M	
D.C.		V	V								M	M	V	V	V	V	V	V	V	V	V		V	V						V				V	V	V
FLA.				V	V	V				M	V	V							V	V	V													M	M	M
GA.										M	M	M																								
HAWAII	V	V	V							M	M	M	V	V	V	V	V	V	V	V	V	V	V	V				V	V	V	V	V	V			
IDAHO		V	V							V	V	V					V	V					V	V		V	V		V	V					V	V
ILL.	V	V	V							V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V
IND.	V	V	V							MV	MV	MV	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V			
IOWA										M	V	V	V	V	V	V	V	V	V	V	V				V	V	V	V	V	V	V	V	V			
KANS.	V	V	V							M	M	M	M	M	M				V	V	V	V	V	V	V	V	V	V	V	V						
KY.					V	V				M	M	V		V	V					V	V								V	V						
LA.				M	V	V				V	V	V	MV	MV	V	MV	MV	V	MV	MV	V							MV	MV	V	MV	MV	V			
ME.	V	V	V							MV	V	V																								
MD.	V	V	V							M	M	M			V			V	V	V	V							V	V	V	V	V	V			
MASS.	V	V	V							V	V	V	V	V	V	V	V	V	V	V	V	V	V	V				V	V	V	V	V	V	V	V	V
MICH.	V	V	V				M	M	M	M	M	MV	M	M	M	M	M	M	M	M	M	V	V	V	M	M	M	M	M	M	M	M	M	M	M	M	V	V
MINN.	V	V	V							V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V
MISS.						V				M	M	M																								
MO.	V	V	V							M	M	V	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	
MONT.																V	V	V																		
NEBR.	V	V	V							V	V	V	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	
NEV.													MV	V	V	MV	V	V	V	V	V				V	V	V	V	V	V	V	V	V	V	V	V	V
N.H.	V	V	V				V	V	V	MV	MV	MV				V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V
N.J.	V	V	V							V	V	V	M	M	MV	M	M	MV	M	M	MV				M	M	MV	M	M	MV	M	M	MV	M	M	MV	
N.M.	V	V	V				V	V	V	MV	V	V	V	V	V	V	V	V	V	V	V	V	V	V				V	V	V	V	V	V	V	V	V	V
N.Y.	V	V	V							MV	MV	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V
N.CAR.	V	V	V							M	M	M																									
N.DAK.	V	V	V							V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V
OHIO	V	V	V							M	M	M	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V
OKLA.				V	V	V				V	V	V										V	V	V		V	V		V	V					V	V
ORE.	V	V	V							V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V			
PENNA.										M	M	M	V	V	V	V	V	V	V	V	V				V	V	V	V	V	V	V	V	V	V	V	V	V
P. RICO		V	V									V	2/			2/			2/				V	V		V	V									
R.I.	V	V	V							M	M	M	V	V	V	V	V	V	V	V	V							V	V	V	V	V	V	V	V	V	V
S.CAR.				V	V	V				MV	MV	MV																								
S.DAK.			V							M	M	V	M	M	M	M	M	M	M	M	V														M	M	M
TENN.				V	V	V				M	V	V																								
TEXAS				M	M	M				M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	
UTAH	V	V	V							M	V	V	V	V	V	V	V	V	M	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	
VT.		V	V							V	V	V													V				V				V				
VIRG. IS.		V	V											V	V	V	V	V	V	V	V		V	V		V	V								V	V	V
VA.	V	V	V							V	V	V	M	M	M	M	M	M	M	M	V				M	M	M	M	M	M	M	M	M	M	M	MV	
WASH.	V	V	V							V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	
W. VA.				V	V	V	V	V	V	M	M	V	V	V	V	V	V	V	M	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	
WISC.	V	V	V							V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	
WYO.	V	V	V							V	V	V							V	V	V	V	V	V				V	V	V	V	V	V				

1/ M - Money Payment
V - Vendor Payment
MV - Money or Vendor Payment

2/ - Included in inpatient care.

EYE CARE

Idaho has begun an eye care program under Public Law 86–778 while Maryland has announced its intention to commence limited service by September 1961. As of that date, 15 States will still be without eye care programs through OAA payments.

PRESCRIPTION DRUGS

Prescription drug service has been instituted by Kentucky under Public Law 86–778. By September 1961, 13 States will still not support needed drug services.

PHYSICIAN SERVICES

Hospital inpatient physician services prior to Public Law 86–778 were limited to 25 States. Only Idaho has since provided this service and no other State reports its intention to do so by September 1961.

Hospital outpatient physician services prior to Public Law 86–778 were available in only 25 States. Since September 1960, Idaho and Oklahoma have provided this benefit and Vermont has announced its intention to do so by September 1961, thus leaving 23 States without any physician outpatient coverage.

Physician office call benefits were provided by 33 States in September 1960. Idaho, Kentucky, and Oklahoma had extended this service by March 31, 1961. Vermont planned to do so by September.

Physician home call coverage was provided by 33 States in September 1960. In addition, three States (Idaho, Kentucky, and Oklahoma) together with the District of Columbia had extended this benefit by March 31, 1961, and Vermont indicated it would do so by September.

(Content of OAA medical program is outlined in table 16.)

PENDING CHANGES IN OAA MEDICAL BENEFITS

Six States that now provide nursing and convalescent home care only through money payments expect to be providing such care through vendor payments by September 1961: Connecticut, Kentucky, Michigan, Missouri, South Dakota, and West Virginia. Puerto Rico, which does not now provide nursing and convalescent home care for OAA recipients, expects to start doing so by September. Three States—Alabama, Mississippi, and South Dakota—plan to begin providing some inpatient hospital care through vendor payments by September.

Illustrations of how other States are planning to change medical care through OAA are demonstrated in table 16a.

TABLE 16a.—*Reported ways in which OAA medical care programs are expected to change by September 1961 as reported by the States, Mar. 31, 1961*

States	*Description of changes expected*
Alabama	Prior to Oct. 1, 1960, payment for care in a licensed nursing home was included in the money payment to the client. Beginning Oct. 1, 1960, the department of pensions and security began vendor payments for OAP cases in licensed nursing homes. A hospitalization program for OAP recipients began on Apr. 1, 1961, using vendor payments. A $2,500,000 hospital program is estimated for the remainder of the State fiscal year ending Sept. 30, 1961, or a $5,000,000 annual program. We believe sufficient funds will be available next year to continue to finance the program at this rate.
Colorado	Effective Apr. 1, 1961, hospital care will be limited to inpatient care for medical emergencies only. Hospital stays beyond 18 days subject to approval by an admission and discharge committee. Office calls and home calls are limited to a total of 2 of any combination during a calendar quarter. Effective Apr. 1, 1961, vendor payments for ambulant patients with no specialized nursing needs will be discontinued.
Connecticut	Effective Apr. 1, 1961, we will pay an additional $0.50 per day for care in convalescent homes with approved recreation programs. Effective July 1, 1961, we will be paying for convalescent home care on a vendor basis. It is anticipated that sometime after July 1, 1961, our medical fee schedules will be raised about 20 percent.
Florida	Hospitalization: maximum days increased from 12 to 30 in any 12-month period, effective Jan. 1, 1961. Nursing home care-vendor payment up to $100, effective Jan. 1, 1961. Previously included in money payment within $66 maximum payment. Prescribed medicine, tranquilizers, and vitamins for treatment of specific illnesses included in list of compensable items, Oct. 1, 1960.
Maine	Increased rates for hospital and nursing home care have gone into effect since September 1960. A project to demonstrate the results of comprehensive rehabilitation recently was initiated for a 2-year period. Services include physical restoration, including complete medical and surgical service on an inpatient or outpatient basis; allied services and training including physical, occupational and speech therapy, and rehabilitation nursing; fitting for, provision of, and training in the use of and the upkeep of prosthetic appliances; psychiatric and psychological services; transportation.
Missouri	Effective May 1, 1961, nursing home care in licensed nursing homes will be provided through vendor payment plan. State also increased per diem rate of payment for inpatient hospital cases from $5 to $10, effective Apr. 1, 1960, and from $10 to actual per diem or billed charges on Nov. 1, 1960.
Nevada	Visiting nurse services extended to OAA recipients effective Jan. 1, 1961, for 1 year in the one county where services are available. Rehabilitation therapy (rehabilitation nursing, occupational therapy, physical therapy, etc.), to institutionalized patients to encourage increased self-care and/or independent living (Apr. 1, 1961). Vendor payments will be made for those recipients selected for rehabilitation therapy.
North Carolina	Expansion of vendor payments for hospitalization of persons not eligible for money payments, effective May 1, 1961.
Puerto Rico	Possibility of expansion of nursing home services.

TABLE 16a.—*Reported ways in which OAA medical care programs are expected to change by September 1961 as reported by the States, Mar. 31, 1961*—Continued

States	*Description of changes expected*
South Dakota	The 1961 legislature appropriated State funds for medical care for OAA recipients effective July 1, 1961. OAA recipients without other means to meet medical care costs have had to request county poor relief. Department workers report that many recipients go without medical care or use their subsistence grant money to pay medical bills rather than ask for county aid. A statewide administration will mean more recipients will receive medical care, the adoption of uniform payment schedules throughout the State, and 100-percent payment of charges as billed, if in line with agreed-upon rates.

EFFECTS OF FINANCIAL INCENTIVES TO IMPROVE VENDOR MEDICAL CARE IN OAA

Public Law 86–778 provided no financial incentive to 15 States to improve their provisions for vendor medical care in old-age assistance. This is because of the fact that in each of these 15 States the average OAA payment per recipient in September 1960 (including both money payments to recipients and vendor payments) was $77 or higher and the average vendor payment was $12 [1] or higher. These States began, in October 1960, to receive the maximum Federal participation per case in assistance payments, and therefore any improvements made after October 1, 1960, in vendor medical care for recipients already on the rolls, would have been entirely at the expense of State or local funds. Ten of the fifteen States reported no improvements in their OAA vendor medical care provisions following enactment of Public Law 86–778:

Colorado	Minnesota	Oregon
Illinois	New Hampshire	Rhode Island
Kansas	North Dakota	Wisconsin
Massachusetts		

The other five States reported that changes had been made or planned, in spite of the fact that all the cost of additional services would have to be borne by the State or local government. These States are: Connecticut, New Jersey, New York, Oklahoma, and Washington.

Thus, of the 22 States that have neither made nor planned any improvements in OAA vendor medical care since Public Law 86–778 became effective, 10 States were actually offered no incentives in the form of additional Federal funds for making any such improvements. All these States, however, did receive increased Federal participation in what they were already spending on the program, which had the effect of freeing State or local funds for use in improving their OAA or other programs.

[1] Legislation adopted this year increases the $12 medical vendor payment to $15 a month, effective July 1, 1961.

Among the 54 jurisdictions, then, there were 12 which were offered financial incentives in the form of added Federal participation to initiate or increase vendor medical care in OAA but which have nevertheless failed completely to take advantage of the opportunity:

Alaska	Guam	Pennsylvania
Arizona	Hawaii	South Carolina
Delaware	Montana	Texas
Georgia	Nebraska	Wyoming

TRENDS IN OAA VENDOR PAYMENTS, SEPTEMBER 1960 TO SEPTEMBER 1961

There has been a gradual tendency, following the intent of Public Law 86–778, for States to replace money payments with vendor payments. Inpatient hospital care, for example, is now covered by vendor payments in 38 of the States as compared with 33 in September 1960.

In nursing home care benefits, 17 States used vendor payments, 24 used money payments, 6 used both methods, and 4 provided no nursery home care in September 1960. One year later, 30 are expected to use vendor payments, only 14 plan to continue exclusive use of money payments, 4 will use both methods and 3 still will provide no nursery home care.

With regard to dental care, 20 States provided vendor payments in September 1960; 24 did so as of March 1961.

As table 16 shows, the same trend to vendor payments is demonstrated in other benefits undertaken by the States since passage of Public Law 86–778.

In the above discussion, States are classified according to whether or not they have made or are planning to make improvements in OAA vendor medical care. The magnitude of change is not reflected in this classification. States making improvements include some making very minor changes, others making moderate improvements, and still others that are adding large areas of service to their programs. An indication of the actual magnitude and relative importance of changes in States' vendor payment provisions may be obtained by comparing average OAA vendor payments in States in September 1960, the last month before Public Law 86–778 became effective, with average vendor payments in the last month for which data are available, currently February 1961 (table 17).

In September 1960 the average (mean) vendor payment under OAA for all States combined was $10.75 per recipient. In February 1961 the average (mean) vendor payment was $10.86, only 11 cents higher than in September. However, it would be erroneous to conclude from this fact that Public Law 86–778 had only a negligible effect on OAA vendor payments. The fact is that average vendor payments have generally been rising by sizable amounts in recent months. The median [2] vendor payment average, however, rose from

[2] The median is the midpoint for the 54 States; that is, half of the States had lower averages and half had higher averages.

$8.21 in September to $10.29 in February. The reason the national mean average did not rise more than 11 cents is found in a program change in Massachusetts, where over 12,000 OAA nursing home and other institutional cases were transferred to the State's new program for medical assistance for the aged between September and February. This resulted in a reduction in the average OAA vendor payment in Massachusetts from $45.86 in September to $16.61 in February (the only very large drop occurring in any State during the period).

This program change in one State affected radically the national figures: excluding Massachusetts data, the remaining 53 States had average vendor payments of $9.54 in September and $10.70 in February, or an increase of $1.16 (12 percent) in the average vendor payment over the 5-month period.

Comparing average OAA vendor payments for September and February, it was found that 29 States had increases in the average amounting to $0.20 or more. Only seven States had decreases in the average vendor payment amounting to $0.20 or more. There were nine States that still made no vendor payments in February, and there were nine States that had changes of less than $0.20 in the average vendor payment between September and February.

There were 22 States in which the average vendor payment increased by $1 or more from September to February. In contrast, there were only three States in which the average vendor payment decreased by $1 or more from September to February; one of these States was Massachusetts, whose circumstances were noted above, and in the other two States the decreases appear to represent random month-to-month fluctuation rather than any actual downward trend.

Some of the increases in State averages may also represent random month-to-month fluctuation; however, this is certainly not true for most of the States whose average vendor payments increased by a sizable amount over the 5-month period and in which an upward trend is clearly discernible.

EFFECTS OF INCREASE IN VENDOR PAYMENTS

To some extent, increases in average vendor payments have come at the expense of decreases in average money payments. Under the revised formula for Federal participation in OAA, it was to the advantage of some States that formerly had low average vendor payments to begin paying for certain types of medical care through vendor payments rather than through money payments to recipients. For example, in some States nursing home care was formerly paid for through money payments but is now paid for through vendor payments, and the shift in payment method has brought a drop in average money payments together with the increase in average vendor payments. Among the 22 States in which the vendor payment averages had increased more than $1 by February, there were seven States in which the money payment averages decreased more than $1 and four States in which the average money payment decreased by as much as $0.20 but less than $1. However, in 4 of these 22 States the money

TABLE 17.—*Old-age assistance: Average payment per recipient for all assistance, for money payments to recipients, and for vendor payments for medical care, September 1960 and February 1961, and changes in averages from September to February, by State*

State	September 1960			February 1961			Change, September 1960 to February 1961		
	All assistance	Money payments to recipients	Vendor payments for medical care	All assistance	Money payments to recipients	Vendor payments for medical care	All assistance	Money payments to recipients	Vendor payments for medical care
Total, all States	$68.75	$58.00	$10.75	$68.73	$57.87	$10.86	$0.02	−$0.13	$0.11
Total, without Massachusetts	67.43	57.89	9.54	68.23	57.53	10.70	.80	−.36	1.16
Alabama	52.88	52.87	.01	52.78	50.97	1.81	−.10	−1.90	1.80
Alaska	64.34	64.34	----------	65.08	65.08	----------	.74	.74	----------
Arizona	61.41	61.41	----------	61.14	61.14	----------	−.27	−.27	----------
Arkansas	52.63	45.95	6.68	53.04	45.46	7.58	.41	−.49	.90
California	90.19	80.43	9.76	88.65	79.58	9.07	−1.54	−.85	−.69
Colorado	100.55	83.53	17.02	100.37	82.20	18.17	−.18	−1.33	1.15
Connecticut	109.42	90.56	18.86	114.67	91.45	23.22	5.25	.89	4.36
Delaware	50.48	50.48	----------	50.24	50.24	----------	−.24	−.24	----------
District of Columbia	64.92	56.52	8.40	66.15	56.47	9.69	1.23	−.05	1.29
Florida	56.24	50.21	6.02	58.29	48.39	9.90	2.05	−1.82	3.88
Georgia	47.26	47.26	----------	47.13	47.13	----------	.13	.13	----------
Guam	29.24	29.24	----------	31.18	31.18	----------	1.94	1.94	----------
Hawaii	63.42	57.68	5.74	68.42	61.97	6.45	5.00	4.29	.71
Idaho	69.61	60.19	9.42	83.60	57.21	26.39	13.99	2.98	16.97
Illinois	77.98	43.83	34.15	78.07	43.89	34.17	.09	.06	.02
Indiana	64.90	44.15	20.75	64.40	44.28	20.12	.50	.13	.63
Iowa	82.05	74.03	8.02	87.40	62.87	24.53	5.35	11.16	16.51
Kansas	80.24	68.11	12.13	82.12	68.68	13.45	1.88	.57	1.32
Kentucky	50.34	50.34	----------	50.16	50.11	.05	.18	.23	.05
Louisiana	71.19	69.14	2.05	70.93	68.83	2.11	.26	.31	.06
Maine	66.39	53.39	13.00	60.19	47.19	13.00	6.20	6.20	----------
Maryland	62.41	56.88	5.53	62.76	57.51	5.25	.35	.63	.28

Massachusetts	106.89	61.03	45.86	86.54	69.93	16.61	20.35	8.90	29.25
Michigan	76.59	65.93	10.66	79.06	65.91	13.15	2.47	.02	2.49
Minnesota	89.46	52.40	37.06	92.16	52.27	39.89	2.70	.13	2.83
Mississippi	34.61	34.61	----------	34.57	34.57	----------	.04	.04	----------
Missouri	60.12	59.74	.39	61.05	59.78	1.27	.93	.04	.88
Montana	64.00	63.74	.27	63.93	63.68	.25	.07	.06	.02
Nebraska	71.99	47.04	24.95	76.77	49.61	27.16	4.78	2.57	2.21
Nevada	74.96	68.98	5.97	80.40	70.98	9.42	5.44	2.00	3.45
New Hampshire	79.21	62.11	17.10	85.43	67.70	17.73	6.22	5.59	.63
New Jersey	90.11	55.05	35.06	90.88	55.15	35.74	.77	.10	.68
New Mexico	68.17	59.64	8.54	69.86	59.19	10.67	1.69	.45	2.13
New York	107.87	74.42	33.45	109.32	77.79	31.53	1.45	3.37	1.92
North Carolina	44.00	41.72	2.28	44.64	42.36	2.28	.64	.64	----------
North Dakota	90.18	55.41	34.76	97.18	65.49	31.69	7.00	10.08	−3.07
Ohio	75.80	65.01	10.79	76.32	64.73	11.58	.52	−.28	.79
Oklahoma	79.14	67.16	11.99	84.59	66.66	17.93	5.45	−.50	5.94
Oregon	80.21	51.56	28.65	81.72	52.41	29.31	1.51	.85	.66
Pennsylvania	68.54	64.69	3.85	68.09	64.49	3.60	.45	−.20	−.25
Puerto Rico	8.24	8.24	----------	8.27	8.27	----------	.03	.03	----------
Rhode Island	80.77	65.77	15.00	80.81	65.81	15.00	.04	.04	----------
South Carolina	40.94	38.05	2.88	42.63	38.29	4.34	1.69	.24	1.46
South Dakota	62.51	62.51	----------	63.67	63.67	----------	1.16	1.16	----------
Tennessee	41.86	41.26	.60	43.44	40.64	2.80	1.58	−.62	2.20
Texas	52.90	52.90	----------	52.75	52.75	----------	−.15	−.15	----------
Utah	72.19	67.20	4.99	77.34	51.38	25.96	5.15	−15.82	20.97
Vermont	64.98	51.48	13.50	71.29	49.96	21.33	6.31	−1.52	7.83
Virgin Islands	26.86	26.36	.50	26.77	26.42	.35	−.09	.06	.15
Virginia	46.58	37.52	9.06	54.13	41.47	12.66	7.55	3.95	3.60
Washington	87.83	57.30	30.53	89.97	57.14	32.83	2.14	−.16	2.30
West Virginia	39.07	34.13	4.93	38.92	33.98	4.95	−.15	−.15	.02
Wisconsin	84.01	38.62	45.39	86.82	38.31	48.51	2.81	−.31	3.12
Wyoming	71.06	61.87	9.19	75.94	65.04	10.90	4.88	3.17	1.71

Source: U.S. Department of Health, Education, and Welfare, Social Security Administration, Bureau of Public Assistance, Division of Program Statistics and Analysis, May 5, 1961.

payment average increased by more than $1, and in 3 other States it increased by $0.20 to $0.99 (table 18).

TABLE 18.—*Old-age assistance: Distribution of States by amounts of increase or decrease in average money payment and average vendor payment per recipient from September 1960 to February 1961*

Change in average vendor payment	Change in average money payment					
	Total	Decrease of—		Change of less than $0.20	Increase of—	
		More than $1	$0.20 to $1		$0.20 to $1	More than $1
All jurisdictions	54	8	12	16	7	11
Decrease of more than $1	3					3
$0.20 to $1	4		2	1	1	
Change of less than $0.20	9	1	2	5	1	
Increase of $0.20 to $1	7		2	2	1	2
More than $1	22	7	4	4	3	4
No vendor payment, September or February	9		2	4	1	2

Source: U.S. Department of Health, Education, and Welfare, Social Security Administration, Bureau of Public Assistance, Division of Program Statistics and Analysis, May 5, 1961.

On the whole, average OAA money payments declined slightly from September to February: The national average dropped by $0.13, from $58 in September to $57.87 in February. Excluding Massachusetts from the calculations, the money payment average dropped $0.36, from $57.89 to $57.53, while the vendor payment average increased by $1.16.

Thus, the increase in the vendor payment average for the 53 States more than made up for the decrease in the money payment average, and the overall average (money plus vendor payment) rose by $0.80, from $67.43 in September to $68.23 in February.

The net change from September 1960 to February 1961 in the distribution of States by size of average OAA vendor payment is shown in charts 1 and 2. These charts show that in September there were 33 States with average OAA vendor payments of less than $10, but by February the number of such States had dropped to 27. In September there were only 11 States with average vendor payments of $20 or more; by February there were 15 such States.

In February there were still 30 States which had average vendor payments of less than $12 and which were therefore failing to take full advantage of the Federal participation in vendor payments made possible by Public Law 86–778.

ADEQUACY OF MEDICAL CARE

It cannot be stated categorically that States with relatively high average vendor payments provide comprehensive and high-quality medical care for OAA recipients and that States with low averages have inadequate programs in all instances. There are a number of variables other than the scope and quality of care received by recipients which influence the level of average vendor payments—variations in costs of medical care, availability of medical personnel and facilities, access of recipients to other medical care programs, provision of medical care through money payments to recipients, etc. But for most States, the amount of the average vendor payment does tend to reflect the relative adequacy of medical care available to OAA recipients. The increases in average vendor payments since October 1, 1960, furnish a rough gage of the improvements in medical care for the recipients since that date; and the large number of States still remaining with relatively low average vendor payments is a rough indication of the improvements still needed in medical care provisions for recipients of old-age assistance.

CHART 1.—OLD-AGE ASSISTANCE: DISTRIBUTION OF STATES BY AVERAGE AMOUNT PER RECIPIENT OF VENDOR PAYMENTS FOR MEDICAL CARE, SEPTEMBER 1960 AND FEBRUARY 1961

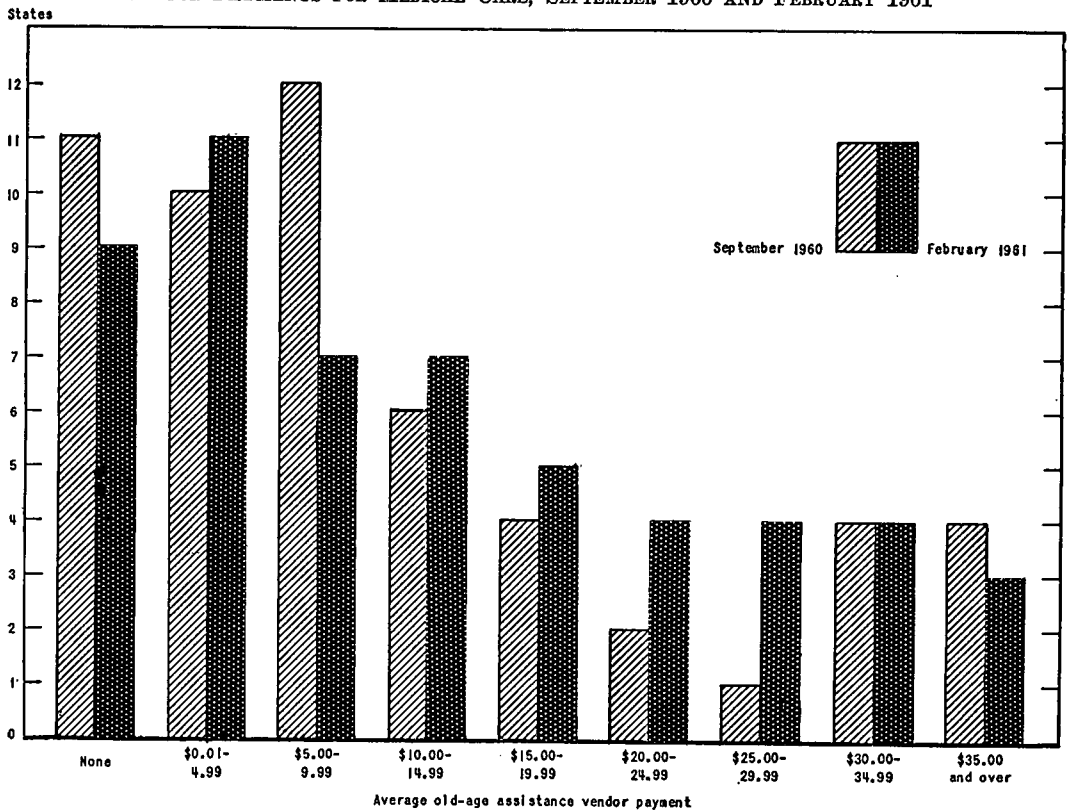
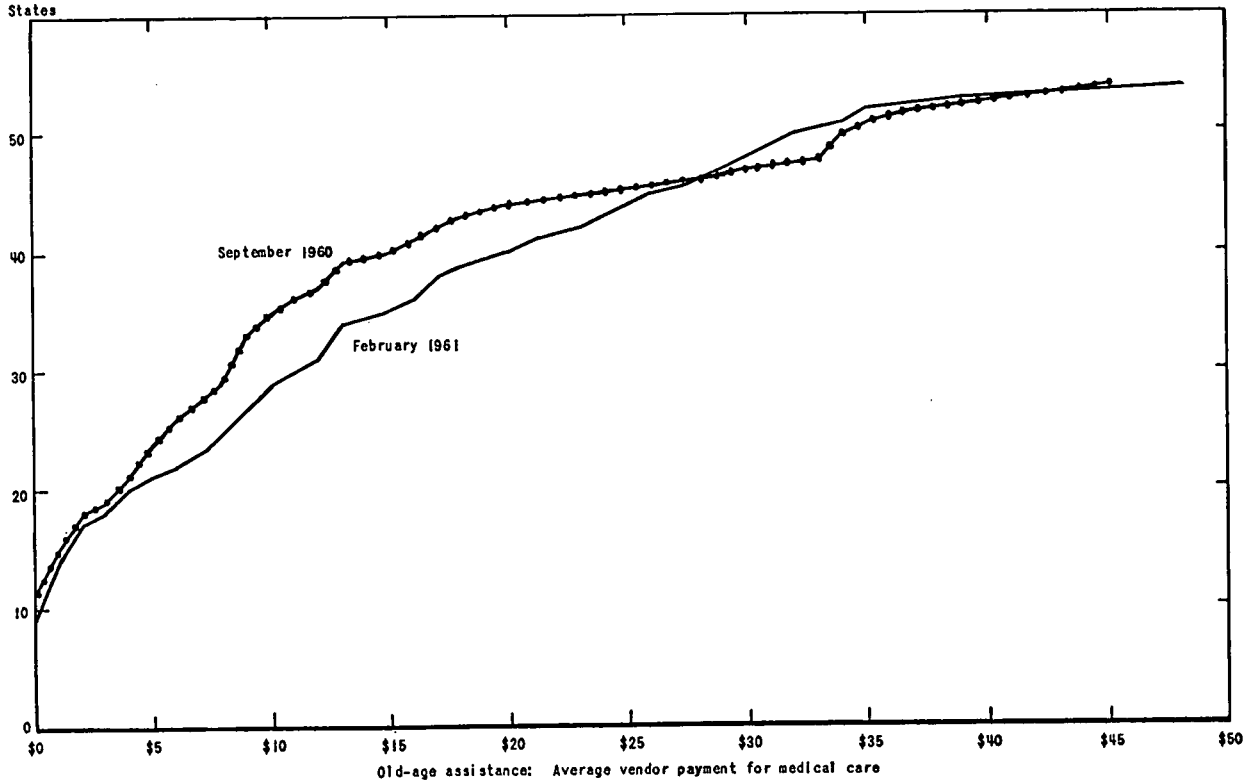


CHART 2.—OLD-AGE ASSISTANCE: NUMBER OF STATES WITH AVERAGE VENDOR PAYMENT FOR MEDICAL CARE AT OR BELOW SPECIFIED LEVELS, SEPTEMBER 1960 AND FEBRUARY 1961



CHAPTER V

THE DEVELOPMENT AND OPERATION OF MAA PROGRAMS

Between the adoption of the 1960 amendment to the Social Security Act in September 1960, and March 31, 1961, six States and two territories put into operation a program of assistance for the aged (MAA). Fourteen other States have developed, to some extent, a potential program of services to be provided and the criteria of eligibility.

There have been some changes in program content since March 31, 1961. One additional State (New York) has put a program into effect, several others will put programs into effect by July, and some States which reported no program development as of March 31, 1961, have begun to formulate some plans. Still other States have made changes in their operating programs or contemplated programs.

However, the information in this chapter taken from questionnaires completed by the States themselves provides some indication of what will be the ultimate development of an MAA program across the Nation.[1]

This chapter summarizes the replies of the several States in terms of the content of an MAA program, eligibility criteria, costs of service, administrative plans, experience of the operating programs, and reasons for denying services. The information is based upon what the States anticipated as of March 31, 1961.

SERVICES PROVIDED

The foundation of any program of medical aid to the aged is the medical services provided. There are two ways of assessing such a program to determine how comprehensive it is: (1) Measuring the program in terms of the number of different kinds of medical services provided, and (2) measuring each of the different types of medical services provided in terms of the extent of the service.

It is one thing if a program provides all hospital inpatient needs, home and office doctors' visits, prescription drugs, and nursing home care. But it is quite a different thing if the hospital care is limited, for example, to 30 days (considering that surveys show aged have longer hospital stays), home and office visits limited to two a month (or limited in terms of dollar allowances), and if prescription drug payments begin only after a $25 deductible.

The examination in this section concerns itself with the comprehensiveness of a program primarily in terms of quantity.

A maximum of 25 States and 2 territories have informed the committee that they expect to have an MAA program in effect by January 1962. Five of these States report that they have yet to develop the specific services which will be provided, and 13, as of March 31, 1961, needed legislative authority.

[1] The programs and the experience of the two territories are not included in the analysis in this chapter because of the different relationship of these territories to the Federal Government. However, the statistics from the two territories are included in the accompanying tables. Guam, which has a small aged population, did not complete a questionnaire and is not included in the tables.

But even though only an approximate two-fifths of the States have determined, or tentatively determined, the services to be included in their MAA program, some implications of what other States will eventually do can be drawn by relating the MAA programs now operating, or expected to be operating, with what each State's practice is under old-age assistance medical programs.

For example, Arkansas, under its OAA medical vendor payments, provides for physician services used in outpatient clinics. Its proposed MAA program will include the same service but no additional physician services. On the other hand, Minnesota provides vendor payments for OAA recipients for inpatient, outpatient, home and office physicians' services and proposes to provide the same services under its projected MAA program.

For a comparison of medical services provided under OAA and MAA, table 16 should be compared with table 19.

Among the 20 States which have reported a program in operation or proposing to put one into effect, the three items most generally included are: (1) all needed hospital inpatient care, (2) home and office physician services, and, (3) prescription drugs.

Specifically, 15 States plan to provide for all types of needed hospital inpatient care while the remaining 5 provide or will provide only for emergency hospital care. Fourteen States either do or will provide for home and office visits by physicians and 13 will provide for prescription drugs.

However, nearly all of these States have limitations on the amount of each service available to the individual. The limitation either is in the form of regulations (discussed below) or, as in every case, the limit is dictated by the amount of dollars appropriated, the costs of service, and the number of applicants.

As the number of approved applicants and the costs of service increases, the amount of service per person will decrease, unless the States have open-end appropriations.

The Federal legislation authorizing the programs can be divided into four broad areas of coverage: (1) institutional care (hospital and nursing home), (2) physicians services, (3) prescription drugs, and, (4) miscellaneous services.

A State may be considered as providing relatively comprehensive medical care under MAA if its plan makes provision for the following four areas of service: (1) all needed inpatient hospital care, (2) nursing home care, (3) physician's service, both for hospital inpatient and for others, and (4) prescription drugs. (See table 19.)

On this basis slightly less than one-third of the States with a program or proposed program (6 out of 20) might at best be considered as having a comprehensive program in terms of the number of different medical services provided: Hawaii, Massachusetts, Minnesota, New York, North Dakota, and Oregon.

The above statistics are based upon what the States report they will have, or plan to have, in effect by January 1962, 16 months after passage of the Federal legislation.

The States were somewhat erratic in reporting regulatory and legislative restrictions on the amount of care allowable under each type of service provided. Two reasons are apparent for this. One is the indefinite nature of a number of the proposed programs and the second is the lack of experience needed as a guide to costs.

TABLE 19.—*Content of MAA programs* [1]

	Inpatient hospital care			Nursing home care	Physicians' services					Other services			
	All needed inpatient	Emergency care only	Other		Hospital inpatient visits	Hospital outpatient clinic visits	Office calls	Home calls	Other practitioners' services	Dental care	Eye care	Prescription drugs	All others
Arkansas	X			X		X					X		
California	X			X	X	X	X	X					
Hawaii	X			X	X		X	X		X	X	X	
Kentucky		X		X			X	X					
Louisiana	X												
Maine	X						X	X				X	
Maryland	X		X				X	X		X	X	X	
Massachusetts	X			X	X		X	X	X	X	X	X	X
Michigan	X		X	X	X	X							X
Minnesota	X			X	X	X	X	X	X	X	X	X	
New Hampshire	X		X				X	X				X	
New York	X			X	X	X	X	X			X	X	X
North Dakota	X			X	X	X	X	X	X	X	X	X	X
Oklahoma		X			X		X	X					X
Oregon	X			X	X		X	X				X	
Puerto Rico	X			X	X	X				X	X	X	
South Carolina	X			X									
Tennessee		X										X	
Utah	X				X	X	X	X			X		
Virgin Islands	X				X	X				X	X	X	
Washington		X		X	X	X	X	X	X	X	X	X	X
West Virginia		X	X	X	X	X	X	X	X	X	X	X	X

As contemplated on Mar. 31, 1961, to be put into effect between Apr. 1, 1961, and January 1962.

PROGRAM LIMITATIONS

Thirteen of the States reporting program details cited program limitations. Five of these indicate no limitation as to the quantity of each service provided: New York, North Dakota, Michigan, Massachusetts, and Washington. However, New York indicated that procedural limitations would affect quantity of care and the State has established a fee schedule.

The same is true in Massachusetts where 14 fee schedules limit amounts to be paid for specific services in individual cases. Michigan relates its limitations to those in the comprehensive Blue Cross-Blue Shield policies available in the State which sets maximum hospital usage.

Only North Dakota and Washington clearly state no limit on the quantity of services.

A. Generally, the limits imposed or proposed to be used by the States deal with hospitalization:

Oklahoma to limit hospital care to 21 days for a single admission.

Oregon to limit hospitalization to 30 days a year.

New Hampshire to provide 7 days a year hospitalization.

Maryland to provide up to 21 days, but may extend the duration as long as medically justified.

Kentucky to provide 3 days per admission with payments limited to a maximum of 50 percent above the State's average daily hospital costs.

Hawaii to limit hospital care to 30 days.

West Virginia and Louisiana to limit hospital care to 30 days a year.

California to provide for hospitalization after the first 30 days but may reduce this to 21 days, depending upon its experience under the program.

South Carolina reported that its program limitations are contingent upon appropriations by the legislature.

B. Present or proposed limitations on physicians services vary to a greater degree than hospital services:

Oregon to require a $100 deductible for each illness.

New Hampshire to limit home and office calls to six a year.

Maryland to review doctors bills and may limit physicians' visits in individual instances.

Kentucky to provide for two visits a month at $2 an office visit and $3 a home call.

Louisiana plans a fee schedule on surgical costs and a $25 a month deductible for drugs.

CHANGES UNDER CONSIDERATION

Six States reported changes in program content under consideration which are expected to be implemented by September 1961.

The most extensive report of contemplated changes was made by New Mexico. However, since the New Mexico Legislature did not appropriate funds for any MAA program, the changes were irrelevant.

Changes in the other States include the Massachusetts plan to encourage clinical or group health plan diagnostic services for well, aged people. Michigan will add up to 90 days nursing home care after acute hospitalization to its program.

Louisiana's Welfare and Health Departments will cooperate in a study to establish the need for public health visiting nurse services and to determine a cost basis for such a service.

West Virginia plans to increase the number of hospital days allowed in a year and increase nursing home care and dental service.

Summary

There is wide variation from State to State in the type of services provided and the amount of services provided. Every State with an existent or proposed MAA program provides some hospitalization—from a 3-day-emergency-care-only allowance to an unlimited allowance. A majority provide for some physicians services.

The reports of the States are sketchy in indicating the basis for determining the types of services and the amounts. The reason for such incompleteness is probably the fiscal problems of the States.

STATE EXPERIENCE

Transfer of OAA to MAA.—Admittedly the reports of the six States with an operating MAA program in the 6 months following the passage of Federal legislation are somewhat inconclusive and tentative. They do reveal, however, one definite pattern: a heavy transfer of cases from OAA to MAA. (See table 20.)

TABLE 20.—*Experience of the States under MAA through Mar. 31, 1961*

State	Months of operation	Total applications received	Applications approved			Applications denied	Different individuals receiving service	Total cost of services provided	Administrative costs
			Total	Transferred from OAA	Nontransfers				
Kentucky	3	646	394	None	394	68	(1)	(2)	(3)
Massachusetts	6	20,397	17,829	14,657	3,172	1,048	17,747	$14,140,000	$675,177
Michigan	6	8,875	6,930	2,591	4,339	1,438	4,345	2,587,937	125,565
Oklahoma	5	821	371	None	371	187	327	85,122	6,796
Puerto Rico	2	713	664	None	664	None	(1)	219,180	(1)
Virgin Islands	2	132	88	None	88	7	(1)	[4] 950 [5] 125	1,320
Washington	6	2,805	2,455	5	2,450	339	2,000	[4] 692,533 [5] 419,836	21,600
West Virginia	6	14,623	12,125	None	12,125	557	3,063	474,822	274,809

[1] Data not available.
[2] No payments to date.
[3] Unknown.
[4] Obligated.
[5] Paid.

For example, the total number of individuals receiving MAA from October 1, 1960, through March 31, 1961, was 27,482. This includes reports from four States with 6 months' experience and one with 5 months' experience. The sixth State, Kentucky, with 3 months' experience, did not report the number of different individuals receiving MAA but total applications approved in Kentucky was 394, which would make no substantial change in the total for the five States.

But of this total, 17,253 were individuals who had already been receiving medical assistance through OAA, prior to adoption of the Social Security Amendments of 1960. For the most part, they were nursing home patients transferred on paper from the OAA program to the MAA program. Thus, deducting these transfers from the

figure in the previous paragraph leaves 10,229 new individuals receiving MAA.

The bulk of the transfers were the 14,657 in Massachusetts alone.

The total number of applications received by the six States in the same experience period was 48,167. The number approved for MAA was 40,704. Slightly over 8 percent of the applications processed were denied or withdrawn.

The six States report 22,851 MAA cases (as distinguished from individuals) which were not transferred from other medical programs, primarily OAA. The caseload figure compared with the number of individuals receiving MAA indicates a high repeating rate, that is, either individuals who are receiving service in more than 1 month or individuals who are receiving service for more than one illness.

The highest case rate of the operating programs was in Massachusetts where the heaviest transfer of cases occurred. In that State, where a comprehensive program is available, there were 3,172 cases other than transfers, while 1,048 applications were denied or withdrawn.

West Virginia has had the second highest experience in caseload and has had no transfers from other programs. In the 6 months ending March 31, 1961, West Virginia received 14,623 applications, denied 557 and approved 12,125. Some 6,357 of these cases received medical assistance and the fact that this was reported as about 3,063 different individuals would indicate that each individual received service for about 2 months, on the average.

The wide discrepancy between the 6,357 caseload reported and the 12,125 approved in the same period results from the West Virginia practice of taking applications and determining eligibility before the need for medical care arises.

Michigan reported the third largest caseload. In the same 6 months it had received 8,875 applications and approved 6,930 while rejecting or having had withdrawn 1,438. The balance was pending. Some 2,591 of its cases were transferred from OAA and the number of different individuals receiving service in the 6-month period totaled 4,345.

The State of Washington received 2,805 applications, approved 2,455, while rejecting 339. The number of different individuals receiving service totaled 2,000.

In March 1961, in five reporting States, 21,330 individuals were counted as receiving services. However, this is not an accurate reflection of the grand total because it actually includes only those for whom bills were received in March, even though the service might actually have been received in February or January.

These 21,330 individuals received about $4.5 million in services in March at an administrative cost of $243,339. This means that about $11 was spent to administer an average of $200 of services for each individual.

It should be remembered that three of these five States have relatively comprehensive programs and that the other two States have somewhat less comprehensive programs.

DENIALS AND WITHDRAWALS

None of the States with an operating MAA program compiles details of the reasons for denying applications for MAA or the reasons why

individuals withdraw applications. But all of the six States submitted summaries of the reasons for denial or withdrawal.

Most denials result from the applicant having income or resources determined by the State as in excess of the eligibility requirements. Of the nearly 700 denied by West Virginia in the 7 months ending April 30, 1961, 204 were denied because of excessive income and 150 because of excessive assets. Massachusetts reported similarly that the great majority of the 950 cases disapproved in the 6 months ending March 31 1961, were rejected because the examination showed the applicants were determined by the State to have adequate financial resources.

The State of Washington reported that 87 percent of all denials resulted from the applicant having financial resources insufficient to pay medical needs. Michigan also reported that most denials were based upon the applicants' excessive income or excessive assets. However, Michigan in the first month of operation rejected nearly 1,300 individuals who thought that the program was an insurance one and who had no need for medical services at the time of inquiry.

In West Virginia, 68 denials were made on the basis of the individual being "uncooperative." West Virginia also found that 22 persons were getting assistance from other agencies and that 19 were eligible for other public assistance programs. Sixty-five were underage in West Virginia.

Massachusetts reported that denied cases never should have been referred by general hospitals and that they would not have been referred if a proper screening of family and individual resources had been conducted. In a minority of cases, individuals withdrew applications voluntarily because:

(1) Financial resources of the family were adequate to meet medical care costs; and

(2) Some resentment both mild and marked at the notion of being referred by the hospital to the local welfare department for assistance.

Other reasons for denial besides excess income, excess property, and underage, where death before eligibility could be established, and medical service completed before application was made. A number of persons in several States were found not to need medical service.

COSTS OF SERVICES

Experience cost figures are available from five States (Michigan, Massachusetts, Oklahoma, West Virginia, and Washington).

Nineteen States, including the above five, provided raw data information on which their costs estimates were based. Idaho, Tennessee, and Hawaii, which indicated they would have a program in effect by January, 1962, did not provide raw data on cost estimates. Connecticut and Pennsylvania, which indicated they would not have a program in operation by January 1962, did provide the raw estimate for proposed programs.

The overall experience data of five States with an operating MAA program reveal the following: An estimated 737,000 aged individuals are ostensibly eligible in these States for medical assistance (the aged population in the five States is 1,910,100). Of these 737,000 in the 6 months ending March 31, 1961, some 27,482 individuals received

medical assistance at a total cost of $17,707,717, exclusive of administrative costs (see table 21).

TABLE 21.—*Cost of MAA services through Mar. 31, 1961*

	Total	Inpatient hospital care	Nursing home care	Physicians services	Other practitioners service	Dental care	Eye care	Prescription drugs	Other care
Kentucky [1]									
Massachusetts	$14,140,100	$3,250,000	$9,500,000	$220,000	$19,000	$12,000	$14,000	$435,000	$690,000
Michigan	2,587,937	1,078,331		80,800					[2] 1,684 [3] 1,427,122
Oklahoma	85,122	69,342		15,299					481
Puerto Rico	219,180	124,571	(1)	(1)		(1)	(1)	(1)	94,609
Virgin Islands	125							38	87
Washington	419,836	387,287	6,910	22,153	22	32	(1)	1,025	2,387
West Virginia	474,822	346,275	1,086	72,127	3,055	479	4,841	40,531	6,426

[1] Data not available.
[2] Outpatient clinics.
[3] Chronic care hospitals.

The per capita assistance for the total number eligible amounts to $24 for 6 months. The average value of service for each individual receiving MAA is $644 for 6 months—exclusive of administrative costs.

If the experience of these States remains the same for a full year, the annual per capita value of services would be $48, and the average value of services to individuals receiving MAA would be $1,288. However, such estimates, based on the early months of the program were necessarily much too low. As stated in chapter III such figures seem to indicate an actual expenditure 50 percent below the estimate for the first full year by 20 States.

If the same number of individuals receive services during the second 6 months at the same average cost per individual, at the end of the full year. The five States with actual experience will have spent twice the amount they spent during the first 6 months, or almost $36 million. This would amount to about 67 percent of their total expected costs for the full 12-month period.

Inpatient hospital care for the five States totaled $5,131,235 while nursing home care totaled $9,507,996. Massachusetts and Michigan provided $4,300,000 of the inpatient hospital care and Massachusetts provided $9,500,000 of the nursing home care. Thus two States alone accounted for more than 80 percent of expenditures on inpatient hospital care, and one State for virtually 100 percent of nursing home care expenditures.

The estimated average daily hospital costs expected to be incurred under MAA range from $15 in New Hampshire to $35 in Oregon.[3] The expected average daily hospital cost estimate for 17 States reporting such costs is $23.50. The average length of stay estimated per patient for 15 States reporting such information is 15 days (a figure which matches the national average in studies of all the aged). The range on average length of stay varies from an estimate of 7 in New Hampshire to 35 in Michigan. Kentucky, which provides only 3 days of emergency hospital care, estimates an average of 17 days stay per individual.

[3] See table 22 for average total expense of hospital care per patient day by State for all ages.

TABLE 22.—*Average total expense of short-term general hospital care per patient-day by State, 1959*[1]

State	Expense per patient-day	State	Expense per patient-day
Alabama	$26.05	Montana	$28.24
Alaska	43.19	Nebraska	24.95
Arizona	30.36	Nevada	33.42
Arkansas	24.34	New Hampshire	28.90
California	38.20	New Jersey	30.46
Colorado	29.53	New Mexico	29.57
Connecticut	37.79	New York	32.58
Delaware	33.30	North Carolina	22.98
District of Columbia	35.32	North Dakota	23.17
Florida	30.65	Ohio	31.41
Georgia	26.61	Oklahoma	25.33
Guam	22.38	Oregon	35.42
Hawaii	32.92	Pennsylvania	25.86
Idaho	31.96	Puerto Rico	14.47
Illinois	31.97	Rhode Island	33.86
Indiana	28.92	South Carolina	19.99
Iowa	25.57	South Dakota	23.70
Kansas	24.14	Tennessee	26.33
Kentucky	27.49	Texas	29.35
Louisiana	25.45	Utah	31.69
Maine	26.73	Vermont	30.06
Maryland	28.04	Virgin Islands	17.83
Massachusetts	36.50	Virginia	24.54
Michigan	34.38	Washington	37.72
Minnesota	30.88	West Virginia	23.90
Mississippi	22.72	Wisconsin	27.14
Missouri	26.84	Wyoming	26.59

[1] Journal of the American Hospital Association, Aug. 1, 1960.

Nursing home care cost estimates range from $110 a month in Washington up to $228 a month in California. The estimated number of nursing home patients per month ranges from 10 in Washington to 22,000 in New York.

The average costs of physicians services per month for each person receiving such services range from $2.60 in Kentucky to $35 in Michigan.

The States reporting monthly average physician costs and estimated monthly caseloads are as follows:

State	Average monthly costs	Estimated number receiving physicians' service
California	$13.50	5,000–10,000
Connecticut	8.36	2,500
Kentucky	2.60	[1]
Maryland	3.57	[2] 6,054
Massachusetts	4.50	12,000
Michigan	35.00	800
New Hampshire	[3]	1,135
New York	10.00	40,000
North Dakota	21.58	1,814
West Virginia	23.20	1,950

[1] No estimate.
[2] May be a duplicated count.
[3] Not available.

Estimates of costs for dental care and eye care are extremely limited. Massachusetts plans an average cost of $48 a month for dental care for a caseload of 70 a month. North Dakota plans an average cost of $27.47 a month for a caseload of 109 persons.

Cost estimates for eye care by five reporting States range from an average $29.70 a month in West Virginia for a caseload of 100

persons to an average $3.13 a month in Maryland for a caseload of eight persons.

Estimates of the cost of prescription drugs range from an average $5.04 a month for caseload of 6,038 persons in Maryland, up to an average $22.85 a month for caseload of 1,814 persons in North Dakota.

ELIGIBILITY CRITERIA AND AGED POTENTIALLY COVERED

Twelve of the 19 States which have developed or tentatively developed some criteria of eligibility for receiving MAA may have conceivably included as potential recipients 30 to 45 percent of their population 65 or over. (See table 23.)

TABLE 23.—*Selected characteristics of MAA programs*

	Financial criteria for eligibility for medical assistance to the aged in 20 States and territories [1]				Medical costs recipient must pay before MAA funds used	Estimated aged population meeting financial eligibility criteria excluding OAA recipients
	Maximum income		Maximum resources			
	Per individual	Per couple	Per individual	Per couple		
Arkansas		[2]			Not determined	82,000
California [3]						535,000
Hawaii [4]					Income for personal needs exempt.	1,200
Kentucky	$1,000	$1,500	[5]	[6]	None, except portion paid by insurance, if any.	87,000
Louisiana	1,800	2,700	1,500	2,000	Medications, $25 month. Physicians' care, other than surgical.	60,000–85,000
Maryland	1,140	[7] 1,560			None	95,000
Massachusetts	1,800	2,750	2,000	3,000	do	475,000
Michigan	1,500	2,500	1,500	2,500	None, except portion paid by insurance, if any.	60,000
Minnesota	OAA	OAA	500	750	"What he can"	17,500
New Hampshire	1,200	1,800	[8] 500	800	None	21,283
New York	1,800	2,600	900	1,300		[9] 800,000
North Dakota	1,200	1,800			[10]	11,496
Oklahoma [18]	[11]	[12]	[13]	[14]	None	40,000
Oregon	1,500	2,000	1,500	2,000	Not yet determined	55,000
Puerto Rico [15]			[15] 1,500	[15] 3,000	None	70,000
South Carolina	1,000	2,000	Homestead.	Homestead.	do	50,000
Utah	1,200	2,040	1,000	2,000	$10 month	16,000
Virgin Islands	1,200	2,400	[16] 1,200	2,400	None	925
Washington [17]					do	60,000
West Virginia	1,500	3,000	5,000	7,500	None, except portion paid by insurance, if any.	102,559

[1] For those States reporting such information, based on expectations as of Mar. 31, 1961.
[2] Probably $1,500 couple.
[3] Income for next year not to exceed cost of maintenance and medical costs as under OAA.
[4] Not yet established.
[5] Personal property, $500; life insurance, $3,000; real property, $5,000.
[6] Personal property, $750; life insurance, $3,000; real property, $5,000; homestead excluded.
[7] If no adult children.
[8] Excludes life insurance, personal effects, homestead.
[9] Minus those able to pay.
[10] First $50 per year.
[11] Homeowners, $924; renters, $1,188.
[12] Homeowners, $1,500; renters, $1,824.
[13] Home equity, $8,000; life insurance, $1,000; tools of trade, $1,500; small business, $2,500; others, $700.
[14] Home equity, $8,000; life insurance, $2,000; tools of trade, $1,500; small business, $2,500; others, $1,000.
[15] Total annual income and available resources, combined, not over $1,500 per person. Real property, except homestead and life insurance included in definition of resources.
[16] Recipient may own $10,000 in land value, excluding his homestead.
[17] Income less than required to meet basic standards; home furnishings and automobile exempted from criteria.
[18] As of May 5, 1961, Oklahoma's income levels were changed to the following: Maximum for (*a*) persons owning and occupying own home, single person, $1,500 annually; man and wife, $2,000. (*b*) renting or making payments on home, single person, $1,500; man and wife, $2,000.

The range is from a low of 10 percent of the total 65 or older population in Michigan to a high of about 80 percent in Massachusetts. But the vast majority of the States estimate that, on the basis of the eligibility criteria, between 30 and 45 percent of the aged population in their States would qualify for MAA.

In so doing, most States used measurement standards based upon statistics available from the Census Bureau or the Department of Health, Education, and Welfare. A few States reported making just an "educated guess."

The general method of determining the number of eligible persons was to obtain a Census Bureau estimate of the number of aged, subtract the number currently receiving OAA and then take roughly 30 to 50 percent of the remainder, depending upon the maximum income requirements. The higher the income ceiling, the larger the percentage of aged persons included.

The range on maximum income allowed single individuals in order to be eligible for MAA is from $1,000 to $1,800 a year. Such criteria would include roughly one-half to two-thirds of individuals 65 or older living alone or with nonrelatives. However, in the States requiring the smaller amount of income, the personal resources requirement is correspondingly limited. In other words, even though a State may take in one-half to two-thirds of the aged living alone, it requires such persons to exhaust, for medical expenses, all resources above $500 to $1,000, except for the homestead, and varying limits of life insurance.

In some instances there is a maximum exclusion on home equity. This means that if an individual or couple were living in a home with an equity greater than the State allows, but whose income and other resources were nevertheless under the maximum, they would still be ineligible for MAA until the equity were sold and disposed of for medical expenditures.

Another limitation on eligibility not apparent in the statistical tables provided by the States is the "relative responsibility law." A number of States have such legislation but did not provide specific information as to the effect this would have on reducing the number of individuals eligible for MAA.

The maximum allowable income for a couple where one or both members meet the age requirements ranges from $1,500 to $3,000. The percentage of aged qualifying under this allowance is less than under the criteria for individuals.

One-third of the families or couples headed by an aged person in 1959 had income under $2,000; another third had incomes between $2,000 and $4,000. West Virginia, of the States setting a dollar limit on income, is the only State with an annual income as high as $3,000 for eligibility. Presumably this would include the vast majority of the aged because of the State's generally lower income status.

West Virginia estimates that 102,500 of the State's aged population of 172,500 would be eligible for MAA. Another 19,000 already receive OAA.

Two States, Washington and California, report that they set no dollar limits on eligibility. But there is a sharp contrast between their approaches to eligibility. Washington declares as eligible all individuals whose income is less than that needed to meet his basic and

special requirements as measured by the State's standards of assistance.

California proposes to make eligible those individuals whose average monthly income over the ensuing 12 months is not expected to exceed cost of maintenance based upon OAA standards plus medical care. It has the same property restrictions as in its OAA program.

ADMINISTRATION

According to the data reported by the 5 States on their administrative costs during the 6 months ending March 31, 1961, it cost $1,103,947 to administer the $17,707,717 medical services.

This may not be a completely accurate reflection of the administrative costs for that amount of medical services, and may be an underestimation of long-run costs. For example, Massachusetts transferred some 14,000 nursing home patients from OAA to MAA. Thus, the administrative costs of opening those cases is not included in that State's figure. The Massachusetts director of welfare, for example, has estimated the administrative costs of opening an OAA case at $200 an individual.

However, it appears that the national average administrative costs for MAA at the present time are between 7 and 10 percent, but as net new cases (nontransfers) are added to the rolls, this percentage may rise.

The costs arise partly from the need for increased agency personnel to handle the applications and fieldwork.

Costs are not the only administrative problem faced by the States. An equally great problem has been that of obtaining qualified personnel to do the job. West Virginia, for example, reported (as of early May 1961) that it needs nine supervisors but has been able to hire only one qualified person out of many applicants. It has had similar trouble getting qualified staffworkers. The State merit system has failed 10 percent of the applicants.

TABLE 24.—*Anticipated personnel needs for MAA operation* [1]

	Total additional staff needed	Classification of staff							State	Local
		Administrative and supervisory	Medical consultants	Medical social work consultants	Other technical consultants	Case workers	Clerical workers	Other		
Arkansas [2]	47.0			1		42	4		7.0	40
California	8.4	1	0.4	1	2		4		8.4	
Hawaii	8.0					6	2		8.0	
Maryland	23.0	1			1	12	9		1.0	22
Massachusetts	80.0	4			9	30	37		20.0	60
Michigan	50.0	3				39	8		6.0	44
Minnesota	30.0					30				30
North Dakota	13.5		0.5			4	9		4.5	9
Oklahoma	3.0			1			2		3.0	
Oregon	102.0	6	1.0	1	3	10	25	56	17.0	85
Puerto Rico	25.0	15					10		15.0	10
Utah	24.0			1		14	9		3.0	21
Virgin Islands	2.0					2			2.0	
West Virginia	198.0	11				75	112		19.0	179

[1] As reported on Mar. 31, 1961.

[2] Only those States reporting information, are presented here, except for New Hampshire which anticipates no additional staff needs

Thirteen States reported details of administrative plans. (See table 24.) Of these, New Hampshire anticipated no additional personnel needs, indicating it would utilize personnel now administering OAA. Oklahoma reported the lowest increase in staff personnel, numbering three. At the other extreme was West Virginia which reported a projected staff increase of 198.

The total additional staff (including part-time personnel) needed by the 12 States amounted to a full-time equivalent of 614 workers. Of these nearly 114 were needed on the State level, and 500 on the local level. The largest single need was for caseworkers, a total of 262.

CHAPTER VI

SOME GENERAL CONSIDERATIONS

THE ROLE OF PUBLIC ASSISTANCE IN PROVIDING MEDICAL CARE

Beginning in 1950, a series of amendments to the Social Security Act has served to strengthen the role of public assistance in providing medical care to the needy and medically needy aged. In these laws Congress specifically authorized the use of Federal funds for medical care for the four categories of recipients of public assistance. By increasing the maximum in which the Federal Government will share the States have been encouraged to provide more comprehensive medical services to the needy aged.

Despite increasing support for medical care in these programs, and even though there has been substantial progress, there are important deficiencies still existing in a number of States with respect to the provision of medical care for the needy aged. Inadequate legislation in some States, insufficient appropriations in others, and administrative complexities in still others, have resulted in very uneven programs of medical care among the States. No more than about a third of the States have programs in which the needy aged can receive all the medical care they need. The other States have programs which provide only limited medical care, financing one or more services but not the broad scope which is needed by sick people.

With the expansion and maturing of our social security programs (private as well as public) a larger proportion of the aged receiving public assistance have become eligible because of large medical needs. This is true even though public assistance rolls may decline in proportion to the aged population in the future. A growing *number* of persons in old age assistance require continuous and costly nursing home care. Many are chronically ill and in need of costly types of medical service in their homes as well as in the hospital.

Expenditures for medical care for the needy aged will tend to increase as the aged population and the need for medical care increase. Voluntary health insurance, geared to covering a working population and to providing benefits for short-term hospitalized illness, does not readily lend itself to meeting the medical needs of aged persons. It is not likely to cover all or most low-income aged persons in the near future.[1] Hence, some new arrangements had to be developed to meet the health needs of aged persons, particularly those with low incomes and with unusual health needs.

The Social Security Amendments of 1960 continued the increases in the Federal financing of medical care for those on old-age assistance. This legislation also authorized the extension of these programs to provide for the low-income aged who need medical care, by giving the States a financial incentive to establish a new category of

[1] See the staff report of this committee, "Basic Facts on the Health and Economic Status of Older Americans," June 2, 1961.

recipients of public assistance, medical assistance to the aged. As with the program of medical care for recipients of old-age assistance, the States would have broad latitude in determining eligibility for benefits and the scope and nature of the services to be provided.

TWO APPROACHES TO FINANCING

In extending public assistance medical care to meet the health needs of the aged who are not recipients of public assistance, Congress chose, as a matter of public policy, the tax-supported approach of financing medical care over the social insurance approach.

In general, the two approaches view differently the role of public assistance in meeting medical care needs of the aged. Public assistance, including MAA, is considered in the one approach as the primary resource for dealing with the Nation's problem of financing care for the aged. The social insurance approach sees the primary solution to this problem coming out of a system of uniform benefits over the Nation as a whole for all insured persons, with public assistance acting as a second line of defense for those services not provided under insurance or for those persons who are not beneficiaries of the insurance program.

The social insurance approach provides uniform and standard benefits for all eligible persons regardless of the State in which they live. On the basis of typical current legislative proposals following this approach, such benefits would include hospital and nursing-home care and nursing services in the home to all eligible aged in all the States. The legislation does not contemplate including physicians' services in the home, office or hospital, or dental care.

The public assistance approach, on the other hand, permits each State to determine the range of benefits to be provided for its aged population. Depending on the State's fiscal situation and its orientation to public welfare medical services, the range of medical services available under MAA programs may vary from the relatively comprehensive (including hospitalization, physicians' services in the home, office and hospital, nursing-home care and prescribed drugs) in some States, to the provision of very limited services by other States, e.g. nursing-home care only.

Under both the social insurance and public assistance approaches, some areas of medical need will remain uncovered by either type of program. The benefits contemplated under social insurance financing thus would constitute a "floor" of protection for all aged persons insured under the program. Similarly, the scope of services provided through MAA in those States with less than comprehensive programs, also constitute a "floor" of medical care. However, because eligibility under the two programs differs, the degree of protection afforded differs for the two populations. Under the social insurance approach protection against the high costs of hospital and nursing-home care would relieve the beneficiary from meeting these costs out of his retirement income and thus enable him to meet the costs of needed physicians' care and other medical services not covered by the program. The MAA program is designed for persons who are unable to pay for needed medical care regardless of the type of care required. If such a person requires some category of medical care other than that provided through the program, it must be obtained in some other way. However, it is the intent of the legislation to

help the States extend such programs so that they provide a more comprehensive scope of benefits.

Under the social insurance approach, all the insured would be eligible for benefits. Benefits are available by reason of being in an insured status, rather than by reason of need for medical assistance. The public assistance approach is predicated on the view that government action should be limited to persons with demonstrated need as established by a means test. As with benefits, eligibility under the social insurance approach is uniform; under the public assistance approach, criteria of eligibility are determined by the individual States, and thus are not uniform.

PRINCIPLES OF MEDICAL ASSISTANCE TO THE AGED PROGRAM

The underlying premise of Public Law 86–778, in respect to its provisions for assistance to medically needy aged persons not receiving old-age assistance, is that it represents an adequate solution to the problem of medical care costs for the aged. It has been referred to as a "significant advance in responsible welfare legislation" and it has been predicted that it will prove to be both "effective and popular when fully implemented."

An evaluation of this program must address itself to its stated objectives. The degree to which the stated objectives are being met can be determined on the basis of the program's accomplishments to date, as reported by the 53 jurisdictions responding to the questionnaire of the Special Committee on Aging. This evaluation can be meaningfully formulated in relation to the medical, social, and economic aspects of the program.

Evaluation of medical aspects

The scope of medical services is determined by the States. However, it is clear that the intent of the MAA program is to provide a comprehensive range of services, since the Federal Government will participate in financing a program with a very broad range of both institutional and noninstitutional services.

Medical care of good quality cannot be obtained unless a complete range of services is available. Particularly important in the care of the aged are services for preventive and rehabilitative measures. Such preventive measures as provision for the early diagnosis and prompt treatment of illness, and rehabilitation programs which lead to self-sufficiency and self-care, must be included.

However, current State reports indicate that only 6 of the 20 States with definite program plans have a broad range of services which provide the necessary base for a comprehensive medical program of good quality.

The remaining 14 States have major limitations in services so that there are serious doubts that the program objectives can be met. In those States which provide only institutional care, there is the further problem of utilizing hospital and nursing-home beds inappropriately because alternative services such as physicians' home and office care and nursing care in the home, are not provided.

Evaluation of social aspects

The intent of the new program is to furnish medical assistance to aged persons not on old-age assistance, but whose income and resources are insufficient to meet the costs of necessary medical services.

The program could provide potential protection for as many as 10 to 15 million persons aged 65 and over who may be medically needy. It has been estimated that if and when all State plans are in full operation, one-half to 1 million persons may receive medical services annually under this program.

When these goals for including a large proportion of the aged are compared with the States' projected programs, there are serious doubts that such goals might be achieved. For the 20 States providing estimates on the number of persons eligible under their MAA programs, only 3.3 million out of 8 million aged would be potentially covered.

Some caution must be used in projecting this proportion to the Nation's entire aged population of 16 million. However, the States reporting their plans are reasonably well distributed with respect to per capita income and aged population. With this in mind, it would be reasonable to infer that no more than 6 to 7 million aged in the Nation as a whole would be potentially covered. Even so, experience to date has shown that a sizable proportion of those certified as eligible and receiving services under the program have in fact been transferred from the old age assistance caseload.

Viewed from a broader perspective, our expanding programs of private and social insurance appear to represent the pattern for meeting income maintenance needs as well as security against the costs of illness.

A medical care program in a public assistance framework does not appear to be consistent with this development, and the aged, with their heavier burden of illness and reduced resources, are being isolated from the rest of the population in respect to their medical care.

Evaluation of economic aspects

In the first year after the enactment of the legislation it was expected that an estimated $120 million (approximately half of which is Federal) will be expended on MAA. This was based on the fact that relatively few States would have developed comprehensive programs. The 20 reporting States anticipated total costs for the first year of operation of about $330 million. For just five States, those with MAA programs already in operation, about $18 million was spent for the first 6 months.

Not only are current estimates by the States far exceeding those made when the legislation was passed, but it would appear that annual costs for this program would rise substantially if the medical and social purposes of the program are fully implemented. Thus, if comprehensive services are provided for the potential eligible population of 10 million aged, annual costs may be expected to exceed well over a billion dollars.

At the present time, it appears doubtful that the large sums required to implement the full scope of the MAA program will be made available by the States even with the Federal Government providing at least half the total costs. The States already are experiencing difficulty in financing other essential programs and many have consistently failed to take advantage of all Federal matching money now available for public assistance. The danger emerges therefore that the economic burden of the MAA program will tend to restrict the scope of benefits and the aged population to be covered, and thus fail to meet the long-range legislative intent of the program.

APPENDIX

APPENDIX A

TABLE 1.—*Estimates from States with plans for medical assistance for the aged in operation for the January–March 1961 quarter*

State name	Total	Federal share	State share
West Virginia:			
Total	$680,000	$453,450	$226,550
Assistance	500,000	363,450	136,550
Administration	180,000	90,000	90,000
Massachusetts:			
Total	9,700,000	4,700,000	5,000,000
Assistance	9,300,000	4,500,000	4,800,000
Administration	400,000	200,000	200,000
Michigan:			
Total	2,430,000	1,215,000	1,215,000
Assistance	2,330,460	1,165,230	1,165,230
Administration	99,540	49,770	49,770
Virgin Islands:			
Total	13,300	6,650	6,650
Assistance	12,500	6,250	6,250
Administration	800	400	400
Oklahoma:			
Total	153,500	103,060	50,440
Assistance	150,000	101,310	48,690
Administration	3,500	1,750	1,750
Washington:			
Total	304,134	152,067	152,067
Assistance	293,334	146,667	146,667
Administration	10,800	5,400	5,400
Kentucky: [1] Administration only	50,000	25,000	25,000
Puerto Rico: [2] Assistance only	219,180	109,590	109,590

[1] Claimed administration only because no bills for services rendered in quarter were paid before the end of the quarter.
[2] Claiming assistance only because of grant limitations.

TABLE 2.—*Estimates from States with plans for medical assistance for the aged in operation for the April–June 1961 quarter*

State name	Total	Federal share	State share
West Virginia:			
Total	$980,000	$671,520	$308,480
Assistance	800,000	581,520	218,480
Administration	180,000	90,000	90,000
Massachusetts:			
Total	10,394,000	5,045,000	5,349,000
Assistance	9,984,000	4,845,000	5,139,000
Administration	410,000	200,000	210,000
Michigan:			
Total	2,850,000	1,425,000	1,425,000
Assistance	2,750,460	1,375,230	1,375,230
Administration	99,540	49,770	49,770
Virgin Islands:			
Total	19,550	9,775	9,775
Assistance	18,750	9,375	9,375
Administration	800	400	400
Oklahoma:			
Total	231,818	155,465	76,535
Assistance	225,000	151,965	73,035
Administration	7,000	3,500	3,500
Washington:			
Total	310,800	155,400	155,400
Assistance	300,000	150,000	150,000
Administration	10,800	5,400	5,400
Kentucky:			
Total	183,600	150,488	66,112
Assistance	156,600	120,488	36,112
Administration	60,000	30,000	30,000
Puerto Rico: [1] Assistance only	219,180	109,590	109,590
New York:			
Total	31,958,500	15,979,250	15,979,250
Assistance	28,750,000	14,375,000	14,375,000
Administration	3,208,500	1,604,750	1,604,250

[1] Claiming Federal participation in assistance only because administration subject to grant limitations in sec. 1108.

TABLE 3.—*Expenditures of States with medical assistance for the aged plans in operation for January–March 1961 quarter*

	Total	Federal share	State share
West Virginia:			
Total	$621,757.08	$411,574.29	$210,182.79
Assistance	443,789.10	322,590.30	121,198.80
Administration	177,967.98	88,983.99	88,983.99
Massachusetts	(1)	(1)	(1)
Michigan:			
Total	2,351,986.17	1,175,993.08	1,175,993.08
Assistance	2,282,779.27	1,141,389.63	1,141,389.63
Administration	69,206.90	34,603.45	34,603.45
Virgin Islands	(1)	(1)	(1)
Oklahoma:			
Total	84,225.28	55,963.92	28,261.35
Assistance	78,969.71	53,336.14	25,633.57
Administration	5,255.57	2,627.78	2,627.78
Kentucky:			
Total	6,328.55	3,164.27	3,164.27
Assistance	0	0	0
Administration	6,328.55	3,164.27	3,164.27
Puerto Rico	(1)	(1)	(1)

[1] Not received as of May 15, 1961.

APPENDIX B

RESPONSIBILITY OF RELATIVES FOR SUPPORT OF APPLICANTS AND RECIPIENTS OF OLD-AGE ASSISTANCE, 54 JURISDICTIONS, DECEMBER 1960

A. Statutory provisions are a part of the public assistance law or are construed as applying to old-age assistance, 38 States:

1. Ability of relative to support is established by income scale or other prescribed method set forth in State law or in State plan provisions, 30 States:

California	Maryland	Ohio
Connecticut	Massachusetts	Oregon
Delaware	Michigan	Pennsylvania
District of Columbia	Minnesota	Puerto Rico
Georgia	Montana	Rhode Island
Hawaii	Nebraska	South Dakota
Illinois	Nevada	Virgin Islands
Iowa	New Jersey	Virginia
Kentucky	New Mexico	West Virginia
Maine	New York	Wisconsin

2. Without income scale or similar method of determining ability of relative to support; determination is according to the circumstances of the case, 8 States:

Alaska	New Hampshire	Vermont
Indiana	North Dakota	Wyoming [1]
Kansas [1]	Texas [1]	

B. General support legislation exists (not specifically applying to old-age assistance); State plan has provisions for establishing ability of specified relatives to support, 5 States:

1. Ability of relative to support is established by income scale or other prescribed method set forth in State plan provisions, 2 States: Arkansas and Mississippi.

2. Determination of ability of specified relatives is part of investigation of individual case, 3 States: Idaho, Louisiana, and Utah.

C. No legislation prescribing responsibllity of relatives to support; State plan provides that available contributions are taken into account and that ability of other relatives is explored as a resource according to the circumstances of the individual case, 11 States:

Alabama	Guam	South Carolina
Arizona	Missouri	Tennessee
Colorado	North Carolina	Washington
Florida	Oklahoma	

[1] Provision relates to spouse only.

APPENDIX C

QUESTIONNAIRE FROM SENATE SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

The following questions pertain to State activity in providing medical care for the aged in relation to PL 86-778. Certain questions are not applicable in every State. Please answer in the greatest detail possible those questions which are applicable.

Please estimate any figures not readily available if you have a reasonable basis for such estimate. Indicate by an asterisk (*) any figures which are estimated.

A. Medical Assistance Given Aged Persons in Fiscal Year 1960:

1. How many different old-age assistance recipients received vendor payment medical care in the period July 1959 through June 1960? _____

2. How many individuals 65 years of age and over received medical care under exclusively State and/or local public assistance programs during the period July 1959 through June 1960? _____

   What was the total cost of services given to such persons under these programs? $_____

B. Status of MAA ("Medical Assistance for the Aged")

1. The status of medical assistance for the aged in your State: (Check the appropriate answer)

   a. MAA program currently in effect. _____

   b. MAA is not currently in effect, but State has the necessary legal base and the required funds have been appropriated. _____

   c. State has the necessary legal base but the required funds have not been appropriated. _____

   d. A bill for MAA is currently before the legislature. _____

e. MAA proposal currently being prepared for presentation to the legislature, the principal recommendations having been decided upon. _____

f. MAA proposal currently under study; decisions have not yet been reached as to the principal features of the program to be recommended. _____

g. MAA program not currently in effect and not under study. _____

2. If your State has no MAA program in effect as yet, do you expect the program to be in effect in the State before 1962? _____ If yes, approximately what date do you expect MAA to begin? _____ (Please give the beginning date which seems most likely to you in view of the present prospects for new legislation, appropriations, and/or administrative decision.)

C. Improvements in Medical Care Programs since September 1960:

1. Please indicate by entering appropriate letters the kinds of medical and remedial care, according to method of payment, provided under OAA (old-age assistance) in September 1960 and March 1961 and under MAA in March 1961, and the kinds expected to be provided under OAA and MAA in September 1961.

Type of Medical or Remedial Care	OAA 1/			MAA 2/	
	Sept. 1960	Mar. 1961	Expected 3/ Sept. 1961	Mar. 1961	Expected 3/ Sept. 1961
Inpatient hospital care:					
Emergency care only					
All needed inpatient care					
Other: (Specify) _____					
Nursing home care					
Physicians' services:					
Hospital inpatient visits					
Hospital outpatient clinic visits					
Office calls					
Home calls					
Other practitioners' services					
Dental care					
Eye care					
Prescription drugs					
Other care (Specify)					

1/ Enter "M" if service is provided through money payment only, "V" if through vendor payment only, "MV" if through either money or vendor payments, and "O" if the type of care is not provided.

2/ Enter "V" if the type of care is provided, "O" if it is not provided.

3/ Show in these columns, by using the appropriate symbols, the types of service which you expect to be provided under OAA and MAA in the month of September 1961. Take into consideration, in determining your expectations for next September, new legislation anticipated by then, the program content to be made possible through available funds, & anticipated policy decisions affecting program content.

2. Please indicate any additional ways, not clear from the above Table, in which the scope or content of medical care provided under OAA or MAA is expected to change -- either increasing or decreasing -- between September 1960 and September 1961. (Specify program) _____

3. Describe resources or facilities for medical or remedial care, generally available throughout the State to recipients of public assistance which the agency takes into account as being available to meet recognized needs of recipients and, therefore, does not include in its planned provisions for medical or remedial care. (Example: State mental and tuberculosis hospitals, mental health clinics, public health visiting nurse programs, county and municipal hospitals, Lions Club provisions for eye care, etc.) _____

D. Experience under MAA

If your State now has an MAA program in effect, please complete the following items with respect to applications, cases, and expenditures, by month, to date under the program:

	Month					
	1960			1961		
	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.
Applications for MAA received						
Applications for MAA approved						
Of these applications approved, how many were transferred from OAA?						
Applications for MAA denied or withdrawn by applicant						
Persons receiving services under MAA 1/						
Cost of services provided under MAA 2/	$	$	$	$	$	$
Estimated cost of administering MAA	$	$	$	$	$	$

1/ How many different individuals had received medical or remedial care under MAA by the end of March 1961? _____

2/ Please give the total cost of MAA services through March 31, 1961, by type of service:

Total cost of services	$
Inpatient hospital care	
Nursing home care	
Physicians' services	
Other practitioners' services	
Dental care	
Eye care	
Prescription drugs	
Other care (specify)_____	
_____	

If an MAA program has been adopted in your State, or if the MAA proposal is sufficiently definite to determine its scope, please answer the following sections E and F.

E. Estimated Scope and Costs of MAA

1. What are the criteria for financial eligibility for MAA in terms of the individual's or couple's income and resources?

2. Indicate what, if any, of the medical costs the recipient must pay before MAA funds can be used on his behalf.

3. What is your estimate of the number of aged persons in your State who meet these criteria (excluding OAA recipients)? _____

How was this estimate calculated? Explain:

4. How many persons per month on the average, are expected to receive services under MAA in the first full year of operation? _____

5. What is the total cost of medical and remedial services provided under MAA expected to be in the first 12 months of operation? $_____

   a. The expected source of these funds: Federal $_____
      State $_____
      Local $_____

   b. Estimate in dollar amounts, if possible, how much of the State and local funds are entirely new revenue dollars not transferred from any other health or welfare program. $_____

   c. Estimate, if possible, how much of the State and local funds represent a transfer of expenditures from one or more other programs now administered under health or welfare. $_____

   d. If transfer of funds has taken place or is anticipated, describe the effect this will have on the programs from which the appropriations were transferred.

   e. If possible, explain how the legislature plans to obtain new revenue dollars where new dollars are needed to implement MAA or replace funds transferred from other programs to MAA.

6. If inpatient hospital care is to be covered, how many persons per month on the average, are expected to be admitted for such care in the first year? _____

   How many days of covered inpatient hospital care do you expect hospital admissions to average?

   What is the expected average MAA cost per care day? $_____

7. If nursing home care is to be covered, how many persons per month on the average, are expected to receive this type of care in the first year? _____

   What is the expected average cost per month per recipient of nursing home care? $_____

8. If physicians' services are to be covered, how many persons per month on the average, are expected to receive this type of service in the first year? _____

   What is the expected average cost per month per person receiving such services? $_____

9. If dental care is to be covered, how many persons per month on the average, are expected to receive this type of care in the first year? _____

   What is the expected average monthly cost per person receiving such care? $_____

10. If eye care is to be covered, how many persons per month on the average, are expected to receive this type of care in the first year? _____

    What is the expected average monthly cost per person receiving such care? $_____

11. If prescription drugs are to be covered, how many persons per month on the average, are expected to receive this type of care in the first year? _____

    What is the expected average monthly cost per person receiving such care? $_____

12. For any of the services listed in #6-11 above, give any limitations specified in the State's plan, e.g., duration of each admission to hospital, total hospital days per year per case, maximum number home visits per month by physician, dollar limitation on the specific service.

13. Are available State and local funds, with the addition of Federal matching funds, sufficient to cover the estimated costs of the program during the first 12 months of operation? _____

If no, what is the size of the anticipated deficit, and what administrative action is expected to meet the problem?

F. Plans for Administration of MAA

1. Describe the application process, including determination of financial eligibility and medical need.

2. Describe the process of determining continuing eligibility.

3. Indicate, in full-time equivalents, the increase in staff expected to be needed to administer MAA:

	Total	State	Local
Total additional staff needed....			
Administrative & supervisory..			
Medical consultants.....			
Med. Social Work Consultants..			
Other technical consultants...			
Case workers.....			
Clerical workers.....			
Other (specify):_____			

4. What is the anticipated cost of administering MAA in the first full year of operation? $_____

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