# A REVIEW OF STATE LEGISLATION RELATING TO MEDICAL SERVICES AND TO CASH PAYMENTS FOR DISABILITY, PROPOSED DURING 1939

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DURING 1939 the legislatures of 44 States (all but Kentucky, Louisiana, Mississippi, and Virginia) convened in regular session, and introduced about 200 bills relating to medical and hospital care or to cash benefits for disability. The bills dealt with (1) regulation of nonprofit hospital and medical-service corporations, (2) provision of medical care and cash payments for needy persons suffering from temporary or permanent disability, (3) establishment of State-wide medical services for the entire population, (4) establishment of compulsory health insurance, (5) inclusion within the framework of existing unemployment compensation laws of unemployment benefits for workers temporarily disabled, and (6) regulation of commercial health and accident insurance companies. All these bills were concerned either with the authorization of medical services or disability benefits to groups which previously had had little or no medical care at public expense or with the establishment or regulation of private plans for furnishing such services. With few exceptions, the bills that will be discussed relate specifically to new provisions for medical services or cash benefits to individuals suffering from temporary or permanent disability rather than to programs already authorized by law, such as aid to the blind, aid to crippled children, and maternal and child health.

Of 200 bills introduced, in the categories listed above, 65 were passed (tables 1 and 2). While pains have been taken to make this survey reasonably complete, some bills may have been overlooked. Another analyst might include in one of the categories here listed some of the 90 bills discussed later under Miscellaneous Provisions and so might arrive at different totals, although the grand total (page 50) would remain the same. The small percentage of bills passed is indicative primarily of opposition or indifference to the legislation. However, the discrepancy is also due to the fact that final action may be taken on but one of two companion bills introduced simultaneously in both branches of the legislature or on the last draft of a succession of amended drafts each of which is designated by a different number.

More than two-fifths of the 65 bills enacted were in the field of nonprofit voluntary health insurance. A comparison of this type of legislation with that relating to social insurance and to other tax-supported medical services shows that action in State legislatures was directed primarily toward expansion of voluntary plans and secondarily toward provision of services for indigents. Legislation liberalizing tax-supported hospital and medical-care programs or authorizing compulsory health insurance either met open opposition or was allowed to die for lack of support. Legislative approval of measures providing tax-supported medical services was generally accorded only to bills drawn to fit within the framework of the old poor laws and was designed to provide services to indigents who could demonstrate their financial eligibility for public care by passing a means test.

A survey of all the legislative proposals made in the States indicates but little interest in the legislatures in preparing for a national health program or in providing medical services for any considerable part of the population. Bills authorizing State health departments or State welfare departments to cooperate with the Federal Government in developing State health programs usually failed of enactment, as did all bills providing cash benefits to workers unemployed because of illness. In only one State (New York) was legislation proposed to make medical services free to the entire population on the same basis as public education. The proposal was defeated. No State legislation was passed in favor of compulsory health insurance or of general medical care either for the entire population or for a major portion of the population. In this respect, there was a sharp contrast between discussion and activity at the State and Federal levels. As against the limited State proposals, the subjects of greatest interest in Congress with respect to health legisla-

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**Table 1.—*Number and type of bills relating to medical services or cash payments for temporary or permanent disability proposed and enacted by State legislatures in session in 1939*** [1]

| State | Total number | | Voluntary health insurance (nonprofit hospital or medical-care plans or both) | | Medical care and cash payments for needy persons with temporary or permanent disability | | | | | | | | Public medical care—no means test | | Compulsory health insurance | | Compensation for unemployment due to sickness | | Regulation of private health and accident insurance companies | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Medical assistance for needy persons | | Assistance for needy persons with permanent disability | | | | Assistance (medical or cash or both) for tuberculous persons | | | | | | | | | |
| | | | | | | | Medical assistance | | Cash payments | | | | | | | | | | | |
| | Proposed | Enacted | Proposed | Enacted | Proposed | Enacted | Proposed | Enacted | Proposed | Enacted | Proposed | Enacted | Proposed | Enacted | Proposed | Enacted | Proposed | Enacted | Proposed | Enacted |
| Total | [2] 200 | 65 | 62 | 27 | 64 | 22 | 6 | 0 | 17 | 2 | 4 | 1 | 4 | 1 | 9 | 1 | 10 | 1 | 24 | 10 |
| Alabama | 2 | 1 | 1 | 1 | 1 | 0 | | | | | | | | | | | | | | |
| Arizona | 1 | 0 | | | 1 | 0 | | | | | | | | | | | | | | |
| Arkansas | 8 | 4 | 1 | 0 | 7 | 1 | | | | | | | | | | | | | | |
| California | 16 | 3 | 5 | 2 | 1 | 0 | 1 | 0 | 3 | 0 | 2 | 1 | | | 1 | 0 | 2 | 0 | 1 | 0 |
| Colorado | 1 | 0 | | | 1 | 0 | | | | | | | | | | | | | | |
| Connecticut | 6 | 2 | 3 | 2 | 2 | 0 | | | | | | | | | 1 | 0 | | | | |
| Delaware | 4 | 2 | | | 4 | 2 | | | | | | | | | | | | | | |
| District of Columbia | 1 | 1 | 1 | 1 | | | | | | | | | | | | | | | 6 | 3 |
| Florida | 13 | 5 | 3 | 1 | 4 | 1 | | | | | | | | | | | | | | |
| Georgia | 7 | 1 | 3 | 0 | 2 | 1 | | | 2 | 0 | | | | | | | | | | |
| Idaho | 1 | 0 | | | | | | | 1 | 0 | | | | | | | | | | |
| Illinois | 4 | 0 | 2 | 0 | 2 | 0 | | | | | | | | | | | | | | |
| Indiana | 5 | 2 | 1 | 0 | 4 | 2 | | | | | | | | | | | | | | |
| Iowa | 2 | 2 | 1 | 1 | | | | | | | | | | | | | | | 1 | 1 |
| Kansas | 2 | 0 | | | | | 1 | 0 | 1 | 0 | | | | | | | | | | |
| Maine | 4 | 2 | 3 | 2 | | | | | 1 | 0 | | | | | | | | | | |
| Maryland | 2 | 2 | | | | | | | | | | | | | 1 | 1 | | | 1 | 1 |
| Massachusetts | 19 | 4 | 2 | 2 | 6 | 1 | | | 1 | 0 | | | | | 1 | 0 | 6 | 0 | 3 | 1 |
| Michigan | 4 | 4 | 2 | 2 | 2 | 2 | | | | | | | | | | | | | | |
| Minnesota | 10 | 1 | 2 | 0 | 2 | 0 | | | 2 | 1 | 2 | 0 | | | | | | | 2 | 0 |
| Missouri | 2 | 0 | 1 | 0 | | | | | 1 | 0 | | | | | | | | | | |
| Montana | 3 | 1 | | | 3 | 1 | | | | | | | | | | | | | | |
| Nebraska | 2 | 0 | 1 | 0 | | | | | 1 | 0 | | | | | | | | | | |
| Nevada | 3 | 1 | | | 2 | 1 | | | | | | | | | | | | | 1 | 0 |
| New Hampshire | 3 | 3 | 1 | 1 | | | | | | | | | | | | | 1 | 1 | 1 | 1 |
| New Jersey | 1 | 1 | | | | | | | | | | | | | | | | | 1 | 1 |
| New Mexico | 3 | 2 | 3 | 2 | | | | | | | | | | | | | | | | |
| New York | 12 | 1 | 4 | 1 | 3 | 0 | 2 | 0 | | | | | 1 | 0 | 2 | 0 | | | | |
| North Carolina | 1 | 1 | | | 1 | 1 | | | | | | | | | | | | | | |
| North Dakota | 0 | 0 | | | | | | | | | | | | | | | | | | |
| Ohio | 4 | 1 | 2 | 1 | 1 | 0 | 1 | 0 | | | | | 1 | 0 | | | | | | |
| Oklahoma | 4 | 1 | | | 3 | 1 | | | | | | | | | | | | | | |
| Oregon | 1 | 1 | | | 1 | 1 | | | | | | | | | | | | | | |
| Pennsylvania | 14 | 4 | 4 | 2 | 4 | 1 | | | | | | | | | 1 | 0 | 1 | 0 | 4 | 1 |
| Rhode Island | 2 | 1 | 1 | 1 | | | | | | | | | | | 1 | 0 | | | | |
| South Carolina | 3 | 3 | 1 | 1 | 2 | 2 | | | | | | | | | | | | | | |
| South Dakota | 0 | 0 | | | | | | | | | | | | | | | | | | |
| Tennessee | 3 | 1 | 1 | 0 | | | | | | | | | 2 | 1 | | | | | | |
| Texas | 6 | 2 | 2 | 1 | 2 | 0 | 1 | 0 | | | | | | | | | | | 1 | 1 |
| Utah | 3 | 1 | 2 | 0 | 1 | 1 | | | | | | | | | | | | | | |
| Vermont | 3 | 3 | 2 | 2 | | | | | 1 | 1 | | | | | | | | | | |
| Washington | 8 | 0 | 4 | 0 | 2 | 0 | | | 2 | 0 | | | | | | | | | 2 | 0 |
| West Virginia | 3 | 0 | 1 | 0 | | | | | | | | | | | | | | | | |
| Wisconsin | 3 | 1 | 2 | 1 | | | | | | | | | | | 1 | 0 | | | | |
| Wyoming | 1 | 0 | | | | | | | 1 | 0 | | | | | | | | | | |

[1] Excludes Kentucky, Louisiana, Mississippi, and Virginia, in which legislatures were not in session.

[2] This total does not include two bills of broad scope cutting across several categories of legislative proposals: Assembly Int. 11-X, New York, extending life of Temporary State Commission to study and recommend means of promoting the health of all persons in the State (approved July 11, 1939), and A. 844A, Wisconsin, creating a committee on the cost of medical care (defeated July 7, 1939).

**Table 2.—*Cross-reference table.—New law citations for bills relating to medical services or cash payments for temporary or permanent disability passed by State legislatures during 1939***

| State | Bill No. | Citation |
|---|---|---|
| Alabama | S. 320 | Act 491. |
| Arkansas | S. 62 | Act 127. |
| | S. 404 | Act 300. |
| | S. 469 | Act 333. |
| | S. Con. Res. 6 | Omitted from Session Laws in error. |
| | H. 449 | Act 310. |
| | H. 480 | Act 249. |
| California | S. 1171 | Ch. 895. |
| | A. 610 | Ch. 112. |
| | A. 1117 | Ch. 1070. |
| | A. 1712 | Ch. 523. |
| Colorado | S. 93 | Ch. 30. |
| Connecticut | S. 57 | Ch. 150. |
| | S. 749 | Ch. 185. |
| | H. 857 | Ch. 338. |
| | H. 1084 | Ch. 142. |
| | H. 1679 | Ch. 277. |
| Delaware | S. 10 | (1). |
| | S. 153 | (1). |
| | S. 257 | (1). |
| District of Columbia | H. R. 6266 | Pub. Law 395, 76th Cong. |
| Florida | S. 214 | Ch. 19,307. |
| | S. 218 | Ch. 19,306. |
| | S. 219 | Ch. 19,305. |
| | S. 606 | Ch. 19,267. |
| | H. 762 | Ch. 19,108. |
| | H. 1041 | Ch. 19,969. |
| | H. 1106 | Ch. 20,034. |
| | H. 2014 | Ch. 19,421. |
| Georgia | S. 23 | Act 56. |
| Idaho | S. 1 | Ch. 37. |
| | S. 101 | Ch. 136. |
| | S. 130 | Ch. 198. |
| | H. 428 | Ch. 206. |
| Illinois | S. 178 | Laws 1939, pp. 396-399. |
| | H. 989 | Laws 1939, p. 323. |
| Indiana | H. 74 | Ch. 6. |
| | H. 133 | Ch. 44. |
| Iowa | H. 136 | Ch. 223. |
| | H. 307 | Ch. 222. |
| Kansas | H. 454 | Ch. 166. |
| Maine | H. 931 | Ch. 24. |
| | H. 1433 | Ch. 149. |
| Maryland | H. 347 | Ch. 528. |
| | H. J. Res. 32 | Res. No. 12. |
| Massachusetts | S. 493 | Ch. 205. |
| | S. 533 | Ch. 312. |
| | S. 614 | Res. Ch. 65. |
| | H. 197 | Ch. 125. |
| Michigan | S. 130 | Pub. Act 304. |
| | S. 307 | Pub. Act 283. |
| | H. 145 | Pub. Act 109. |
| | H. 160 | Pub. Act 308. |
| | H. 215 | Pub. Act 108. |
| Minnesota | S. 13 | Res. No. 6. |
| Missouri | H. 603 | Laws 1939, p. 420. |
| Montana | H. 125 | Ch. 31. |
| | H. 133 | Ch. 129. |
| Nevada | A. 319 | Ch. 195. |
| New Hampshire | H. 38 | Ch. 106. |
| | H. 232 | Ch. 80. |
| | H. 327 | Ch. 206. |
| | H. 342 | Ch. 156. |
| | H. 343 | Ch. 92. |
| New Jersey | S. 280 | Ch. 305. |
| New Mexico | S. 30 | Ch. 229. |
| | S. 111 | Ch. 65. |
| | S. 112 | Ch. 66. |
| New York | S. 48 | Ch. 2. |
| | S. 1970 | Ch. 608. |
| | S. 2205 | Ch. 609. |
| | S. 2257 | Ch. 893. |
| North Carolina | S. 342 | Ch. 325. |
| | S. 395 | Ch. 332. |
| | H. 870 | Ch. 470, Public—Local Laws. |
| North Dakota | S. 98 | Ch. 187. |
| Ohio | S. 181 | (1). |
| | H. 290 | (1). |
| Oklahoma | H. 512 | Ch. 24, Art. 15. |
| Oregon | S. 426 | Ch. 494. |
| | H. 419 | Ch. 241. |
| Pennsylvania | S. 317 | Act 75. |
| | S. 677 | Act 194. |
| | H. 418 | Act 57A. |
| | H. 610 | Act 321. |
| | H. 657 | Act 383. |
| | H. 685 | Act 398. |
| | H. 686 | Act 399. |
| | H. 1215 | Act 40A. |
| | H. 1580 | Act 58A. |
| Rhode Island | H. 583 | Ch. 719. |
| South Carolina | S. 734 | Gov. No. 438. |
| | H. 575 | Gov. Act 245. |
| | H. 815 | Gov. Act 660. |
| South Dakota | H. 47 | Ch. 106. |
| Tennessee | H. 836 | Ch. 102. |
| Texas | S. 36 | Act 207. |
| | S. 135 | Act 113. |
| | H. 191 | Act 296. |
| | H. 927 | (2). |
| Utah | S. 297 | Ch. 86. |
| Vermont | S. 60 | Act 175. |
| | H. 56 | Act 127. |
| | H. 68 | Act 174. |
| | H. 280 | Act 134. |
| Washington | S. 47 | Ch. 25. |
| Wisconsin | S. 281 | Ch. 147. |
| | S. 288 | Ch. 118. |
| | A. 191 | Ch. 142. |
| Wyoming | S. 99 | Ch. 88. |

[1] Laws not yet published.
[2] Not printed in the Session Laws.

tion were Senator Wagner's proposed National Health Act of 1939 (S. 1620), the hearings on this bill, and the report to the Senate made by Senator Murray for the Committee on Education and Labor (S. Rept. 1139).

In the following discussion some of the more important provisions of the 1939 legislative proposals will be discussed. Considerable attention will be given to bills that were not enacted, for among the measures that lacked support or were openly opposed are a few which may ultimately be more significant than some that were passed.

## Voluntary Nonprofit Health Insurance Plans

Prior to 1939 only 12 States had special enabling acts authorizing the incorporation of groups wishing to establish nonprofit hospital plans. During 1939 thirteen additional States passed such legislation, bringing the total number to 25.[2] (See table 3.) Activity in this field has been marked. No other type of State legislation dealing with medical services has shown such concerted action by the legislators and such similarity in the provisions of the bills introduced in the various States.

During the year 1939, 62 bills were introduced in 29 States and the District of Columbia to authorize and regulate voluntary nonprofit health insurance plans; 27 of these bills were passed in 18

[2] There is no special enabling act for the District of Columbia, but in 1939 Congress passed a bill authorizing Group Hospitalization, Inc., which was already operating without special permission, to incorporate as a nonprofit hospital corporation.

States and the District of Columbia (table 4). In 11 States the legislators defeated all voluntary health insurance bills, including special enabling acts in 9 States[3] which had not previously had such provisions on their statute books and amendments to existing legislation in 2 States[4] which already had enabling acts. For the most part voluntary health insurance legislation has been confined to authorization and regulation of plans for hospital service rather than for general medical care. Enabling acts have stressed the philanthropic character of these plans and have exempted group hospital insurance corporations from taxes and from most of the provisions of State insurance laws. The State commissioner of insurance, however, is generally authorized to approve charters, reserves, and contractual agreements entered into by nonprofit hospital-service corporations.

Only one of the enabling acts passed during 1939 placed a ceiling on operating costs. In Texas these costs were limited to "15 percent of all dues or payments collected . . . subject to the . . . approval of the Board of Insurance Commissioners." In Connecticut, Florida, Iowa, Michigan, New Hampshire, New Mexico, Rhode Island, and South Carolina, approval of costs was left to some State agency or official, usually the commissioner of insurance, while in Maine, Ohio, Vermont, and Wisconsin, the new enabling acts contained no limitation on costs. An unsuccessful attempt was made in California (S. 548) to repeal certain sections of the Insurance Code relating to nonprofit hospital-service plans and to substitute regulatory sections more favorable to the corporations. It was proposed to amend the 1935 law, which had limited combined administrative and acquisition costs to 25 percent of the "aggregate amount of gross premiums actually received during the year," by increasing allowable costs to 40 percent of gross premiums the first year after incorporation, 35 percent the second year, and 30 percent thereafter. The bill was not enacted.

Similarly, the enabling acts of 1939, like those of previous years, contained limited or no statutory safeguards regarding the amount of a reserve fund. The California law of 1935 made specific provisions, but in many States the law does not mention such a fund. Enabling acts passed in 1939 did not provide for reserve funds in Connecticut, Iowa, New Hampshire, New Mexico, Rhode Island, South Carolina, Texas, Vermont, and Wisconsin, while in Maine and Michigan the new legislation authorized the insurance commissioner to determine the size of an adequate reserve.

During 1939 new enabling acts or amendments to existing acts showed a tendency to benefit or protect subscribers by a liberalization of the definition of hospital services and the inclusion of specific statements concerning the responsi-

**Table 3.—*State enabling legislation for voluntary nonprofit hospital service corporations***

| State | Date of enabling act | Citation |
|---|---|---|
| Alabama | Sept. 14, 1935 | Gen. Laws 1935, Act No. 544; amended L. 1936, Act No. 169; amended L. 1939, Act No. 491. |
| Arizona | | |
| Arkansas | | |
| California | July 5, 1935 | Stats. 1935, ch. 380. |
| Colorado | | |
| Connecticut | May 23, 1939 | S. 57. |
| Delaware | | |
| District of Columbia[1] | | |
| Florida | May 20, 1939 | H. 762. |
| Georgia | Mar. 30, 1937 | Acts 1937, Act No. 379. |
| Idaho | | |
| Illinois | July 6, 1935 | Sess. Laws 1935, H. R. 814. |
| Indiana | | |
| Iowa | Apr. 12, 1939 | H. 307. |
| Kansas | | |
| Kentucky | May 31, 1938 | Acts 1938, ch. 23. |
| Louisiana | | |
| Maine | Mar. 30, 1939 | H. 1433. |
| Maryland | Apr. 15, 1937 | Sess. Laws 1937, ch. 224. |
| Massachusetts | June 23, 1936 | Acts 1936, ch. 409. |
| Michigan | May 17, 1939 | H. 145. |
| Minnesota | | |
| Mississippi | Mar. 25, 1936 | Laws 1936, ch. 177; amended L. 1938, ch. 195. |
| Missouri | | |
| Montana | | |
| Nebraska | | |
| Nevada | | |
| New Hampshire | Apr. 13, 1939 | H. 232. |
| New Jersey | June 14, 1938 | Laws 1938, ch. 366. |
| New Mexico | Mar. 8, 1939 | S. 112. |
| New York | May 10, 1934 | Sess. Laws 1934, ch. 595; amended L. 1935, ch. 320 and L. 1939, ch. 882. |
| North Carolina | | |
| North Dakota | | |
| Ohio | Apr. 12, 1939 | S. 181. |
| Oklahoma | | |
| Oregon | 1917 | Laws 1917, ch. 173, secs. 1-9; amended L. 1933, ch. 96, sec. 1, ch. 98, sec. 1. |
| Pennsylvania | June 21, 1937 | Sess. Laws 1937, Act No. 378. |
| Rhode Island | Feb. 8, 1939 | H. 583. |
| South Carolina | June 24, 1939 | H. 845. |
| South Dakota | | |
| Tennessee | | |
| Texas | May 10, 1939 | H. 191. |
| Utah | | |
| Vermont | Apr. 7, 1939 | H. 68. |
| Virginia | | |
| Washington | | |
| West Virginia | | |
| Wisconsin | May 27, 1939 | S. 288. |
| Wyoming | | |

[1] H. R. 6266, enacted by Congress and approved Aug. 11, 1939, is not a general enabling act but provides only for the incorporation of certain persons as Group Hospitalization, Inc.

[3] Arkansas, Indiana, Minnesota, Missouri, Nebraska, Tennessee, Utah, Washington, and West Virginia.

[4] Georgia and Illinois.

**Table 4.—*Status of 1939 State legislation on voluntary nonprofit hospital and medical service corporations***

| State | Bill number | Scope | Date proposed | Final disposition |
|---|---|---|---|---|
| Alabama | S. 320 | H [1] | July 28 | Approved Sept. 16. |
| Arizona | | | | |
| Arkansas | S. 304 | MC [2] and/or H. | Feb. 9 | Died in Senate. |
| California | S. 548 | MC & H. | Jan. 23 | Do. |
| | A. 610 | H. | Jan. 13 | Approved May 5. |
| | A. 1712 | H. | Jan. 24 | Approved June 13. |
| | A. 2491 | MC & H. | Jan. 25 | Died in House. |
| | A. 2501 | MC & H. | Jan. 25 | Do. |
| Colorado | | | | |
| Connecticut | S. 57 | H. | Jan. 12 | Approved May 23. |
| | H. 186 | H. | Jan. 13 | Withdrawn. |
| | H. 857 | MC. | Jan. 19 | Approved June 20. |
| Delaware | | | | |
| District of Columbia | H. R. 6266 | H. | May 10 | Signed by President Aug. 11. |
| Florida | S. 149 | H. | Apr. 11 | Died in Senate. |
| | H. 74 | H. | Apr. 6 | Died in House. |
| | H. 762 | H. | Apr. 27 | Approved May 20. |
| Georgia | H. 238 | H. | Jan. 26 | Died in House. |
| | H. 459 | H. | Feb. 14 | Do. |
| | H. 643 | H. | Feb. 27 | Do. |
| Idaho | | | | |
| Illinois | S. 555 | H. | June 6 | Do. |
| | H. 977 | MC. | May 2 | Do. |
| Indiana | H. 241 | H. | Jan. 25 | Pocket vetoed Mar. 11. |
| Iowa | H. 307 | H. | Feb. 10 | Approved Apr. 12. |
| Kansas | | | | |
| Kentucky [3] | | | | |
| Louisiana [3] | | | | |
| Maine | H. 931 | H. | Feb. 2 | Approved Mar. 2. |
| | H. 1432 | H. | Feb. 9 | Withdrawn. |
| | H. 1433 | H. | Feb. 9 | Approved Mar. 30. |
| Maryland | | | | |
| Massachusetts | H. 197 | H. | Jan. 4 | Approved Apr. 14. |
| | S. 533 | H. | May 17 | Approved June 26. |
| Michigan | H. 145 | H. | Jan. 31 | Approved May 17. |
| | H. 215 | MC. | Feb. 20 | Do. |
| Minnesota | S. 1248 | H. | Mar. 24 | Died in Senate. |
| | H. 1367 | (Same as S. 1248.) | Mar. 23 | Withdrawn. |
| Mississippi [3] | | | | |
| Missouri | H. 620 | H or MC. | Mar. 10 | Died in House. |
| Montana | | | | |
| Nebraska | 507 | H. | Mar. 29 | Died. |
| Nevada | | | | |
| New Hampshire | H. 232 | H. | Jan. 24 | Approved Apr. 13. |
| New Jersey | | | | |
| New Mexico | S. 111 | H. | Feb. 8 | Approved Mar. 8. |
| | S. 112 | H. | Feb. 8 | Do. |
| | H. 58 | H. | Jan. 23 | Killed in Senate. |
| New York | S. 1667 | H, MC, or MI [4]. | Mar. 23 | Died in Senate. |
| | S. 2257 | H or MI. | May 11 | Approved June 16. |
| | A. 569 | H & MC. | Jan. 30 | Killed in Committee |
| | A. 1982 | H or MI. | Mar. 14 | Died in House. |
| North Carolina | | | | |
| North Dakota | | | | |
| Ohio | S. 104 | MC. | Feb. 8 | Died in Senate. |
| | S. 181 | H. | Feb. 13 | Approved Apr. 12. |
| Oklahoma | | | | |
| Oregon | | | | |
| Pennsylvania | S. 732 | H. | Apr. 26 | Died in House. |
| | H. 685 | MC. | Mar. 21 | Approved June 27. |
| | H. 686 | MC. | Mar. 21 | Do. |
| | H. 934 | MC. | Apr. 3 | Died in House. |
| Rhode Island | H. 583 | H. | Jan. 24 | Approved Feb. 8. |
| South Carolina | H. 845 | H. | Apr. 20 | Approved June 24. |
| South Dakota | | | | |
| Tennessee | H. 997 | H. | Feb. 17 | Died in House. |
| Texas | S. 127 | H. | Jan. 31 | Died in Senate. |
| | H. 191 | (Same as S. 127.) | Jan. 23 | Approved May 10. |
| Utah | S. 176 | H & MC. | Jan. 31 | Died in House. |
| | S. 177 | H & MC. | Jan. 31 | Do. |
| Vermont | S. 60 | MC. | Mar. 16 | Approved Apr. 14. |
| | H. 69 | H. | Jan. 24 | Approved Apr. 10. |
| Virginia [3] | | | | |
| Washington | S. 131 | H. | Jan. 25 | Died in Senate. |
| | S. 311 | H & MC. | Feb. 10 | Do. |
| | H. 199 | H & MC. | Feb. 1 | Died in House. |
| | H. 209 | H. | Feb. 1 | Do. |
| West Virginia | S. 107 | H. | Jan. 31 | Do. |
| Wisconsin | S. 288 | H. | Mar. 17 | Approved May 27. |
| | A. 519 | H. | Mar. 21 | In Committee. |
| Wyoming | | | | |

[1] Hospitalization.
[2] Medical care.
[3] No session.
[4] Medical indemnity.

bility of contracting hospitals to furnish services. That is, the subscriber who joins a group hospital association is now assured in some States that he will receive hospital care even if the association subsequently finds itself financially unable to meet its obligations to the contracting hospital.

Prior to 1939 "hospital services" were generally defined negatively and by indirection. Definitions followed the dictum of the House of Delegates of the American Medical Association that in group hospitalization plans "the subscriber's contract should exclude all medical services—contract provisions should be limited exclusively to hospital facilities." [5] State laws have emphasized what hospital services should *not* include rather than what they should include. Thus, the Georgia enabling act of 1937 provides that nonprofit hospital service corporations—

> shall not contract to furnish to the member a physician or any medical services, nor shall said corporation control or attempt to control the relations existing between said member and his physician, but said corporation shall confine its activities to rendering hospital service only through such type of hospitals as are in this Act specified, without restricting the right of the patient to obtain the services of any licensed doctor of medicine; and any hospital, which shall contract with such corporation for the furnishing of hospital care, shall accept a member or subscriber of said corporation with the physician of his choice in charge of his treatment at such hospital.

The Kentucky law defines hospital service as "meaning only hospital care without medical attention" (sec. 2089l, 5, Acts 1938).

In 1939, presumably in anticipation of some form of national health legislation, certain legislatures passed liberalizing amendments to their insurance codes or welfare laws as these related to group hospitalization plans. This was done in California where "hospital services" may now—

> include any or all of the following services: maintenance and care in hospital, nursing care, drugs, medicine, physiotherapy, transportation, material appliances and their upkeep, and indemnification of the beneficiary or subscriber for the costs and expense of professional medical service rendered during hospitalization.

New York likewise amended its membership corporation law and its cooperative corporation law to permit a hospital-service corporation and a medical-expense indemnity corporation to issue a combined contract providing for hospital service

[5] *Journal of the American Medical Association*, Vol. 109, No. 18, Oct. 30, 1937, p. 651B.

and medical-expense indemnity, but neither corporation alone is permitted to issue a contract providing both service and indemnity. In other words, the person seeking insurance against the total cost of hospitalization will be able to secure it from two types of nonprofit corporation. This legislation is a step in the direction of more complete voluntary health insurance provision for that part of the population which can afford it.

Despite liberal legislation in California and New York, Wisconsin in 1939 provided that all contracts between a hospital-service corporation and a subscriber "shall provide for hospital service only and shall not embrace medical services." (Laws 1939, ch. 118, approved May 27, 1939.) Similarly the new Texas law provides—

> that such corporations shall not contract to furnish to the member a physician or any medical services, nor shall said corporation contract to practice medicine in any manner . . . but said corporation shall confine its activities to rendering hospital service only through such type of hospitals with whom it has contracts, without restricting the right of the patient to obtain the services of any licensed doctor of medicine. (Laws 1939, p. 123.)

The Iowa enabling act of 1939 states that "Hospital service is meant to include bed and board, general nursing care, use of the operating room, use of the delivery room, ordinary medications and dressings and other customary routine care." Under the 1939 enabling act in Vermont, existing hospital-service associations are authorized not only to fulfill old contracts but to enter into new ones to provide "medical, surgical and nursing as well as hospital services."

The organized medical profession, especially through State and county medical societies, had a considerable influence on voluntary health insurance legislation during 1939. Much of the original opposition of the profession to group hospitalization and medical-care plans has recently disappeared and has been replaced by marked activity in favor of such plans. While most of the activity has been directed toward extension of enabling legislation for group hospitalization plans, some attention has been given to developing similar legislation for group medical-care plans. In 12 States 21 bills were introduced authorizing nonprofit plans under one or more of the following categories:

1. Medical care alone;
2. Medical care or hospitalization;
3. Medical care and hospitalization;
4. Hospitalization or medical-expense indemnity;
5. Medical-expense indemnity, medical care, or hospitalization.

Six of the bills were enacted. Five authorized nonprofit plans for medical care alone (Connecticut, Michigan, Pennsylvania (two bills), and Vermont), while one authorized plans providing hospitalization or medical-expense indemnity (New York).

It should be noted that the newly enacted California law (A. 1712), amending the insurance code as it relates to nonprofit hospital-service plans, approaches the New York hospitalization or medical-indemnity law (S. 2257) in scope. The California statute, while not including indemnity for medical services in the home, does go so far as to extend the definition of hospital services to include "indemnification . . . for the costs and expense of professional medical services rendered during hospitalization." The California law thus stands midway between the customary hospital-service enabling act and one which authorizes voluntary nonprofit plans for either hospital service or medical indemnity. In no State has legislation been passed authorizing combined nonprofit hospital and medical-care plans. Nine bills of this type introduced during 1939 failed of enactment.

Enabling legislation passed in Michigan (H. 215) provided that a majority of the directors of a nonprofit medical-care corporation should "be at all times persons approved by the officers of the medical profession duly organized to promote state-wide the science and art of medicine." A corporation so authorized was empowered to "accept from governmental agencies payments covering all or part of the cost of subscriptions to provide medical care for needy persons." Similarly, in Pennsylvania two bills (H. 685 and 686) were approved on June 27, 1939, giving broad powers to doctors of medicine in the control and administration of nonprofit medical-service corporations. The new laws provide that a majority of the members of the board of directors of such corporations "shall at all times be doctors of medicine." An innovation in this type of legislation is found in the provision that relief officers of State and local governmental agencies in Pennsylvania may use pub-

lic funds to purchase, from privately owned and operated medical-service corporations, subscriptions providing medical-care services to recipients of public assistance. Both the Michigan and Pennsylvania acts are noteworthy because they authorize welfare authorities to purchase subscriptions for the needy in medical-service corporations. Under this authorization public funds may be expended to enroll the needy in privately controlled medical-care corporations operated under the auspices of State or county medical societies.

In Connecticut a bill (H. 857) was approved on June 20, 1939, authorizing the State and county medical societies jointly or severally to incorporate for the purpose of operating a medical-service corporation. A nonprofit medical-care enabling act passed in Vermout (S. 60) provided that three or more members of the State medical or dental societies or of the county medical societies might organize a medical-service corporation.

*Summary.*—During 1939 thirteen States passed enabling acts authorizing the incorporation of nonprofit group hospital-care associations. The Federal Government approved the incorporation of Group Hospitalization, Inc., in the District of Columbia, but did not pass a general enabling act. Twenty-five States now have special enabling acts applying to group hospitalization. During 1939 legislation was enacted in four States authorizing the formation of nonprofit medical-care corporations. In one State enabling legislation applied to the organization of nonprofit hospital-care or medical-indemnity plans.

Under these laws groups of doctors, hospital directors, welfare workers, and other persons interested in organized efforts to solve the joint economic problems of the producers of medical services and the consumers of those services are authorized to incorporate as charitable, benevolent corporations. Being defined as nonprofit corporations, they are generally exempt from taxation and from all but a few provisions of State insurance laws. Most enabling acts either fail to limit administrative and acquisition costs or leave the determination of "reasonable costs" to some State agent—generally the commissioner of insurance. These nonprofit voluntary health insurance corporations are required to submit annual reports to the State and to have their books available for inspection by State authorities, but such inspection is generally not mandatory on the State agency and in some States is required only once in 3 years. Few statutes provide for the establishment of reserve funds to guarantee the financial ability of the corporations to meet their contractual obligations, but the commissioner of insurance or other State agent may require such reserves at his own discretion. Laws authorizing group hospital-service plans generally exclude physician's services in accordance with the policy of the organized medical profession.

## Medical Care and Cash Payments for Needy Persons With Temporary or Permanent Disability

Legislation providing tax-supported medical services and cash payments for disabled persons has been directed almost exclusively toward persons who could demonstrate need under the poor laws. The majority of bills proposed and passed in this field during 1939 provided medical assistance for needy persons in general rather than for special groups such as needy tuberculous or permanently disabled persons.

### *Medical Assistance for Needy Persons*

The term "medical assistance," as used in this paper, is defined to mean medical services, including hospitalization, physician's services, nursing care, drugs, laboratory tests, or appliances, furnished by organized public or private agencies to persons who are unable to pay for such services and who receive them after passing a "means test" or test of financial eligibility. Medical assistance is administered as a form of relief usually by public welfare officials who are charged with responsibility for the care of indigents or by private welfare agencies cooperating with voluntary hospitals. Recipients of medical assistance prior to the depression of the 1930's were generally the "chronic poor" or indigents who were entitled to meager medical services under the poor laws. During the past decade many persons who were not indigents in the strict legal sense and who would not have applied to welfare authorities for food, clothing, or shelter found themselves unable to meet the costs of medical care. These persons have sometimes been referred to as the "medically needy," although the term is also used in a more general sense to designate all persons who are unable to pay for medical services in whole or in part.

In recent years some States have broadened their concept of public responsibility for persons in need to include not only those in need of the so-called necessaries of life but also those requiring hospital care and other medical services. The public welfare law of New York State, as passed in 1929 and successively revised during the depression period, exemplifies the more liberal attitude toward provision of public medical care which is emerging within the framework of public welfare legislation. The New York law is as follows:

*Responsibility for providing medical care.*—The public welfare district shall be responsible for providing necessary medical care for all persons under its care, and for such persons otherwise able to maintain themselves, who are unable to secure necessary medical care. Such care may be given in dispensaries, hospitals, the person's home or other suitable place. (Laws 1929, ch. 565, art. X, as amended by ch. 494, Laws 1935.)

During 1939 State legislatures were unusually active in proposing measures dealing with some phase of the study or administration of medical assistance to needy persons. Sixty-four bills were proposed in 26 States, and 22 were passed in 15 States (table 5). The proposals included provision for a survey of the health needs of the needy in Massachusetts, creation of a State Department of Hospitalization and Medical Care in Texas, new and broader definitions of public assistance in Pennsylvania and Oregon, and specific provisions of medical-care services either for all indigents or for particular categories, such as the blind, the aged, and "indigents injured on highways."

The bills which failed to pass because of legislative opposition or veto by the governor indicate, as clearly as those which were enacted, some of the present attitudes toward progressive health legislation. The Arkansas legislature, noting that "many persons in the State of Arkansas are now suffering from sickness and disease because of their inability to obtain hospitalization and medical care and attention," proposed a bill (S. 496) providing that "any person whose income, or that of his family, does not exceed thirty dollars ($30.00) per month from all sources, may, upon application to the County Welfare Director" be certified as eligible for hospitalization and medical care. Furthermore, the bill authorized the State Department of Public Welfare "to cooperate with the Federal Government in matters of mutual concern pertaining to the free medical treatment and hospitalization of indigent sick persons." Children and expectant mothers were placed in a preferred class and were to "be given preferential treatment when and where necessary." This bill was passed by the State legislature, but was vetoed by the Governor on March 18, 1939.

That the need for funds for public medical care existed in Arkansas is indicated by the fact that "funds for providing free hospitalization and medical care for the indigent sick . . . became exhausted on December 15, 1938," according to Senate Concurrent Resolution No. 6 adopted on January 17, 1939. Nearly a month passed before the House introduced a bill (H. 480) appropriating $50,000 for hospitalization of the indigent sick and stating "it is found by the General Assembly that great suffering and in many instances unwarranted deaths are arising in this State because of lack of funds for proper hospitalization of the State's indigent sick." This bill was finally approved by the Governor on March 10, 1939, nearly 3 months after funds for hospital and medical care for indigents had been exhausted.

In California an effort to pass legislation enabling the State to cooperate with the Federal Government, if and when a national health bill should be enacted, met with failure. On January 24, 1939, Assembly bill 1874 was introduced providing for public medical care for needy persons and placing upon the State Department of Public Health responsibility for "control or administration of all public medical-care activities, including preventive, diagnostic, and treatment services and care for all types of physical illnesses and defects." The State Department of Public Health was authorized to "cooperate with the Federal Government in matters of mutual concern pertaining to medical care" and to assume responsibility for the establishment and administration of a comprehensive, coordinated State and local program of public medical-care activities. The bill died in the House.

Efforts to make more adequate provision for the medical needs of persons receiving old-age assistance failed in Connecticut (S. 875 and H. 1335) and Ohio (H. 37). One of the Connecticut bills proposed that the State "provide reasonable medical and hospital care for beneficiaries who are in need of such care," while the Ohio bill proposed

**Table 5.—*Scope and final disposition of bills relating to medical assistance introduced in State legislatures in session in 1939*** [1]

| State | Bill No. | Scope | Final disposition |
|---|---|---|---|
| Alabama | H. 1002 | Provides hospital care for indigents; authorizes cooperation with Federal Government | In Committee. |
| Arizona | H. 276 | Prescribes residence qualification for medical assistance | Died in House. |
| Arkansas | S. 260 | Creates health and welfare funds, including State special welfare fund for hospital and medical care of indigents. | Do. |
| | S. 367 | Regulates expenditures for medical care and hospitalization of persons employed on State and Federal projects. | Died in Senate. |
| | S. 469 | Provides for public welfare fund; appropriates for hospitalization of indigents | Approved, Mar. 16. |
| | S. 496 | Provides hospital and medical care for indigents | Vetoed, Mar. 18. |
| | S. Con. Res. 6 | States funds for hospital and medical care for indigents are exhausted | Adopted, Jan. 17. |
| | H. 449 | Authorizes taxes for hospitalization of indigents and for other health purposes | Approved, Mar. 15. |
| | H. 480 | Makes supplemental appropriation for hospitalization of indigents | Approved, Mar. 10. |
| California | A. 1874 | Empowers Department of Public Health to cooperate with Federal Government and provide medical-care services. | Died in House. |
| Colorado | S. 162 | Provides assistance, including hospitalization, for needy aged | Died in Senate. |
| Connecticut | S. 875 | Provides medical care for recipients of old-age assistance | Do. |
| | H. 1335 | Provides medical and hospital care for recipients of old-age assistance | Died in House. |
| Delaware | S. 10 | Makes appropriation for relief of indigent sick of New Castle County | Approved, Apr. 24. |
| | S. 257 | Amends law providing for relief and care of indigent sick of Sussex and Kent Counties | Approved, May 4. |
| | H. 397 | Makes appropriation to State Board of Health for surgical treatment for indigents | Stricken from calendar, Apr. 13. |
| | H. 482 | Provides State-wide relief and medical assistance for indigents; appropriates money therefor | Vetoed, May 15. |
| Florida | S. 501 | Authorizes county tax levy for maintenance of hospital for indigents | Died in House. |
| | S. 589 | Requires certain municipalities to provide venereal disease treatment for indigents | Died in Senate. |
| | H. 705 | Relates to hospitals and homes for indigents | Died in House. |
| | H. 1041 | Authorizes Board of County Commissioners of Martin County to provide medical and hospital care for indigents. | Approved, May 19. |
| Georgia | S. 23 | Authorizes counties to levy tax not exceeding 1 mill for medical and hospital care of indigents | Approved, Feb. 21. |
| | H. 123 | Authorizes counties to levy unspecified tax for medical and hospital care of indigents | Died in House. |
| Illinois | S. 9 | Relates to old-age assistance and provides from $5 to $15 per month for medical services | Died in House. |
| | H. 624 | Revises pauper law of 1874; restricts authorization of expenditures for medical services and burial of paupers. | Do. |
| Indiana | H. 74 | Provides medical and surgical care and hospitalization for indigents | Approved, Feb. 15. |
| | H. 133 | Relates to poor-relief laws and payment of free medical and hospital care | Approved, Mar. 7. |
| | H. 213 | Amends poor-relief laws governing application for emergency medical and hospital care | Died in House. |
| | H. 487 | Provides that township trustees shall pay for hospital care including services of attending physician for indigents in tax-supported hospitals. | Do. |
| Massachusetts | S. 466 | Provides for commission to study old-age assistance law and benefits to crippled and totally disabled persons. | New Draft, S. 614. |
| | S. 614 | Essentially the same as S. 466 | Approved, Aug. 12. |
| | H. 856 | Provides for survey of health needs of the needy by a special commission | Killed in House and Senate. |
| | H. 1277 | Authorizes towns to compensate physicians for services to needy persons not in institutions | Do. |
| | H. 1416 | Authorizes towns to compensate physicians "registered with the department of civil service" who render services to needy persons not in institutions. | Next General Court. |
| | H. 1419 | Amends law relative to reimbursement of cities and towns by the Commonwealth for hospital care for certain needy persons. | Do. |
| Michigan | S. 130 | Amends Afflicted Adults Act which provides hospital and medical care for indigent adults and pregnant women. | Approved, June 22. |
| | S. 367 | Provides medical and surgical treatment for afflicted children | Approved, June 16. |
| Minnesota | S. 1289 | Provides hospital care for indigents injured by motor vehicles | Died in Senate. |
| | H. 1454 | Same as S. 1289 | Died in House. |
| Montana | H. 133 | Defines duties of State Department of Public Welfare; defines "assistance" to include medical and hospital care. | Approved, Mar. 9. |
| | H. 223 | Provides medical and hospital care for persons unable to pay therefor | Died in House. |
| | H. 362 | Amends laws relating to contract care for poor, sick, and infirm; proposes County Medical Service Plan for indigents. | Killed in House. |
| Nevada | S. 20 | Amends law providing maintenance and medical and hospital care for expectant mothers | Senate failed to concur. |
| | A. 319 | Similar to S. 20; includes appropriation of $1,000 | Approved, Mar. 25. |
| New York | S. 1927 | Provides home relief be given *wholly* in cash; medical assistance may be in cash, by order, or in kind. | Died in Senate. |
| | A. 130 | Provides medical facilities for indigents | Killed in Committee. |
| | A. 2107 | Provides freedom of choice of physician or dentist by recipients of home relief | Died in House. |
| North Carolina | H. 870 | Provides medical and hospital care for indigents of New Hanover County and City of Wilmington. | Ratified, Mar. 31. |
| Ohio | H. 37 | Provides medical and hospital care for recipients of old-age assistance | Died in House. |
| Oklahoma | S. 253 | Provides medical and hospital care for indigents and makes appropriation therefor | Died in Senate. |
| | H. 203 | Provides assistance to needy, aged, blind, and cripples; authorizes cooperation with Federal Government. | Died in House. |
| | H. 512 | Makes appropriation for public welfare; authorizes expenditures for optometrical and dental work for indigents. | Approved, Apr. 21. |
| Oregon | H. 419 | Provides for cooperation with Federal Government; "general assistance" defined to include "medical, surgical, and hospital care." | Approved, Mar. 6. |
| Pennsylvania | S. 1001 | Allocates part of appropriation of Department of Public Assistance to Department of Health for medical care to indigents. | Died in House. |
| | S. 1002 | Authorizes Department of Public Assistance to cooperate with Federal Government; redefines "assistance" to exclude medical care. | Do. |
| | H. 657 | Authorizes Department of Public Assistance *to cooperate with Federal Government*; "assistance" redefined to include "money, milk, goods, shelter, services, or burial." | Approved, June 26. |
| | H. 1409 | Provides for hospitalization of indigents injured by motor vehicles | Died in House. |
| South Carolina | S. 734 | Provides levy for hospital and medical care of indigents in Darlington County; American Red Cross to administer services. | Approved, May 26. |
| | H. 575 | Similar to S. 734 | Approved, Apr. 12. |
| Texas | H. 144 | Creates State Department of Hospitalization and Medical Care; authorizes cooperation with Federal Government. | Died in House. |
| | H. J. Res. 22 | Proposes State constitutional amendment providing tax levy for public health and care of indigent sick. | Do. |
| Utah | S. 297 | Provides medical and surgical eye care; authorizes cooperation with Federal Government | Approved, Mar. 15. |
| Washington | S. 187 | Provides medical care for prevention of blindness without deducting costs from grants of blind assistance; prescribes administrative procedures. | Died in Senate. |
| | H. 461 | Companion to S. 187 | Died in House. |

[1] The legislatures of Kentucky, Louisiana, Mississippi, and Virginia were not in session.

that the State bear the expense for hospitalization and for necessary medical and dental treatment of recipients of old-age assistance. Similarly, two bills introduced in Washington (S. 187 and H. 461) providing "medical care or other corrective treatment" for the prevention of blindness failed of enactment.

In Oklahoma Senate bill No. 253 provided $500,000 annually for each of the fiscal years 1940 and 1941 for medical care and hospitalization of indigents and expectant mothers. It defined the term "indigents" to mean "those persons who are destitute and unable to secure employment by reason of physical or mental disability, infirming or temporary illness or other disability which prevents such person from securing ordinary employment." Administrative authority for the medical-care program was given to the State Board of Public Welfare, and it was provided that maximum fees for "medical, surgical, and hospital treatment and medicine for indigent persons should be set by agreement between the State Board of Public Welfare and the State Department of Public Health." Indigents were guaranteed freedom of choice in selecting their doctors and hospitals. The bill was not passed nor was House bill No. 203 which authorized the Oklahoma Public Welfare Commission to "cooperate with the Federal Social Security Board . . . or other like agency created by Federal Congress . . . to qualify for Federal aid to States in providing assistance to needy persons." This measure would have provided for the granting of assistance not only to dependent children, the aged, and the blind, but also to crippled adults and children.

The Texas legislature introduced two important bills directed toward greater State activity in the furnishing of medical services for indigents. An amendment to the State Constitution was proposed (H. J. Res. 22) providing a tax to be used for public health and the indigent sick. The second bill (H. 144) created a State Department of Hospitalization and Medical Care which was empowered to acquire and operate State hospitals and clinics and to arrange for the care of the indigent sick in privately owned hospitals and other institutions. This new State department was also authorized "to provide for hospitalization and treatment of indigent and destitute sick persons, including expectant mothers who are indigent or destitute and who are unable, through other sources, to obtain necessary hospitalization and medical care." The care to be given to indigents was to include "proper dental, medical, surgical, and other treatment of a preventive or corrective nature when such service is not available from any other source." Both bills died in the House.

Turning now from the State legislative proposals for medical assistance that were not enacted, let us analyze the bills that received the support of the lawmakers. On the whole, the laws passed in this field were not directed toward the development of State health programs that might be integrated into a national health program. Little attempt was made to reorganize State health and welfare departments so that they might provide more adequate public medical services. Most legislatures failed to propose bills or to pass those that were proposed authorizing cooperation with the Federal Government and designating an appropriate State agency to accept grants-in-aid or other Federal funds for the development of State medical-care plans should funds become available under a Federal health bill.

Most of the bills providing medical care and hospitalization which were finally passed restricted such services to persons who were already public charges or to those near the indigency level. The bills were in large part devoted to definitions of indigents, to detailed procedures to be followed by a person in need of medical care or hospitalization, to eligibility requirements, and to accounting procedures for reimbursing counties, hospitals, or other jurisdictions for services rendered. Little or nothing was said of the quality or extent of services to be given and of the qualifications of professional personnel. Medical care for indigents was to be provided in the same fashion as general relief or other forms of public assistance. The legislation was so drawn as to discourage any general use of public medical-care facilities by sick persons too poor to pay for services of physicians, surgeons, nurses, and hospitals. No special provision was made for preventive health services; rather, the bills stressed the fact that indigents should avail themselves of public services only in the last extremity. The chronically ill were generally excluded from the public services offered, and frequently the applicant for medical care was required to demonstrate to the authorities that

his condition was susceptible of improvement before he might obtain that care.

As illustrative of this type of legislation, we may cite the bills passed in Delaware, Florida, and Montana. The Delaware bill (S. 257) appropriated small annual sums for hospital care for indigents in two of the three counties in that State and amended the law providing for relief of the indigent sick of one of the counties in such a way as to give private physicians and hospitals considerable authority in determining the indigency of persons applying for tax-supported hospital care. The only new legislation dealing with public medical-care services passed in Florida in 1939 was a bill (H. 1041) providing "medication and hospitalization for the indigent citizens" of a county with a population of about 5,000 persons. Montana, in amending numerous sections of its Public Welfare Act, provided that "an applicant for assistance including medical care and hospitalization" shall be eligible only after investigation by the county department of public welfare "reveals that the income and resources are insufficient to provide the necessities of life" (H. 133). The services provided by the county commissioners must be approved by the State Board of Health or the State Medical Association under one of the new amendments to the Montana welfare law. Medical assistance is to be paid for from the county poor fund and administered as a part of the relief program on a "minimum subsistence" basis.

Legislation passed in Michigan and Oregon improved administration of medical assistance and broadened the scope of services to be extended. Senate bill No. 130 of Michigan amended the Indigent Afflicted Adults and Pregnant Women Act of 1915, generally referred to as the Afflicted Adults Act, by transferring administrative jurisdiction from the probate court to the County Department of Social Welfare and broadening the coverage. Under the amended act, hospital service and medical and surgical treatment are to be given to indigent adults and to pregnant women who are financially unable to secure proper care. In a similar way in Michigan the Afflicted Children's Act of 1913 (Act 274) and the Crippled Children Act of 1927 (Act 235) are modified in Senate bill No. 367 to bring about a unification in administration of the two acts and more adequate provision of medical-care services for all children under 21 years of age. Oregon likewise passed a bill (H. 419) amending and improving various welfare statutes. It broadened the scope of public services to the needy and provided for cooperation with the Federal Government in providing all forms of assistance, including medical and hospital care, for needy persons.

*Summary.*—Twenty-six States proposed 64 bills dealing with medical assistance for needy persons; 22 bills in 15 States were passed. This legislation provided general medical assistance for all needy persons rather than special services for tuberculous or permanently disabled persons. For the most part the legislation enacted did not include provisions that would enable the States to take advantage of possible Federal legislation. The more liberal bills, including several authorizing cooperation with the Federal Government in developing broad health programs, were killed or died for lack of support. Certain States, such as California, Connecticut, Massachusetts, New York, Ohio, Pennsylvania, and Texas, which were sponsoring legislation for voluntary health insurance plans, failed to enact bills that had been introduced providing medical services under public-assistance or compulsory insurance plans. Other States—Iowa, Maine, New Hampshire, New Mexico, Vermont, and Wisconsin—enacted voluntary insurance laws, but failed to introduce any legislation providing public medical services for that large portion of the population which needs medical services and cannot afford to pay for them on an individual basis or as members of group hospitalization or group medical-care plans.

### *Medical Assistance and Cash Benefits for Permanently Disabled and Tuberculous Persons*

State legislators passed only 3 out of 27 bills introduced relating to the medical needs of permanently disabled and tuberculous persons. This count does not include 17 bills, 10 of which were enacted, which provided for the erection of hospitals and for administrative procedures relating to hospitals furnishing care for the tuberculous. These bills are discussed below under Miscellaneous Provisions. Legislative proposals in a few States showed a desire to assume public responsibility for medical care and rehabilitation of crippled adults, but the proposals did not meet general favor.

In California, in A. J. Res. No. 17, it was pointed out that "one of the obligations of civilized communities . . . was to afford assistance to those of its people who are in need" and that the cooperation of Federal and State governments was necessary for the successful performance of this function. To this end a joint resolution of the Assembly and Senate of California was introduced, declaring "That the President and the Congress of the United States be memorialized to extend the Social Security Act to provide grants-in-aid to States which afford assistance to needy persons who are physically handicapped." However, this resolution asking for the cooperation of the Federal Government was not adopted, and the California legislature likewise failed to enact bills providing financial assistance or medical care to disabled persons (Assembly bills 102, 608, and 1734) and one bill (A. 1307) providing financial assistance to convalescent tuberculous persons who are in need.

Several States introduced legislation providing monthly grants of assistance to cripples, but none of the bills was passed. Among these bills were A. 608 in California, which provided $35 monthly to permanently disabled persons; S. 44 in Georgia, which provided public assistance not to exceed $15 per month for persons over one year of age who were 50 percent disabled; H. 99 in Kansas, which provided county "pensions" [7] to persons over 21 who have lost both hands; H. 1702 in Maine, which provided a $20 monthly "pension" to cripples between the ages of 21 and 65; and Senate bills 260 and 270 in Washington and H. 13 in Wyoming, providing assistance to the physically disabled. Vermont appropriated $5,000 to "give aid to deserving crippled or otherwise physically disabled persons over twenty-one years of age, who are not eligible to receive aid under existing agencies functioning under the Federal Security Act" (H. 280). In Texas an amendment to the State Constitution was proposed (H. J. Res. 12) providing assistance for needy permanently disabled and crippled persons over 21 years of age. The bill died in the House.

New York introduced companion bills (S. 1786 and A. 2251) providing medical care and hospitalization for the physical repair of adult unemployed persons between the ages of 21 and 65 who are physically handicapped. Neither bill was passed. Similarly, Ohio tried without success to pass a bill (H. 78) establishing a bureau of aid for needy physically handicapped persons between the ages of 18 and 65. In Missouri it was proposed (S. J. Con. Res. 1) that there be submitted to the voters of the State a constitutional amendment authorizing assistance to persons over 65 years of age "who are incapacitated from earning a livelihood and without means of support." The proposal died in the Senate.

## Public Medical Care for the Entire Population

Those who believe that health for the entire Nation is as necessary and desirable as education, and that preventive and curative medical services should be as available to all as public education, will be greatly interested in a bill proposed in New York by Assemblyman Goldstein (A. 523). This bill, which died in committee, amended the public-health law by transferring to the State Department of Health all the functions of the State Department of Social Welfare, the Department of Labor, the Department of Education, and other departments—

> which in any manner, directly or indirectly, pertain or relate to medical activities, medicine, dentistry, pharmacy, nursing, technicians and laboratory work, the maintenance and operation of public or private hospitals, sanitoriums and other institutions for the care and treatment of the sick, the health and lives of the people of the state or of the wards of the state, including the sick, the feeble minded and the insane.

Provision was made for a salaried professional staff under civil service and for the establishment of four new divisions in the Department of Health, namely, divisions of medical care, dental care, nursing care, and pharmacy.

This enlarged Department of Health in New York was to have the following objective and goal:

> To improve and maintain the health of the people of the state and to render free of charge, under rules and regulations to be prescribed by the department, all medical, surgical, dental, nursing care and treatment and all other services and facilities known to science and designed or adapted for use in all cases of sickness, accidents and childbirth, to and for residents of the state, including free transportation to and from hospitals, maintenance in hospitals, the furnishing and supplying without cost of medicines, drugs, and all medical, surgical, dental and pharmaceutical supplies and appliances required or deemed

[7] The term "pension" as used in some State legislation is synonymous with "public assistance"; it refers to monthly cash allowances paid by welfare authorities to needy persons on the basis of need and not as a matter of right nor for meritorious service.

advantageous for the care, treatment, recovery and rehabilitation of a sick or injured person . . .

Another bill designed to remove administration of public medical services from the jurisdiction of public-assistance agencies was one introduced in Oklahoma by Senator Phillips (S. 17) "providing medical treatment free of charge to persons who are unable to provide such treatment for themselves." That administration of these services should in no way be regarded as part of the relief set-up, the bill stated:

In order for a person to be entitled to receive medical treatment under this Act, it shall not be necessary that such person be on a relief roll, Works Progress Administration Roll or other government set up, but such person, or the parents or guardian of such person shall make affidavit that they are unable to provide such medical treatment.

Provision likewise was made to place administration under the State Commissioner of Health. The bill died in the Senate.

Tennessee is believed to be the only State which enacted legislation designed to reorganize health and welfare administrative machinery in anticipation of the passage of a national health bill and which lifted public medical care out of the group of services available only to indigents able to demonstrate need under the pauper laws, placing such care on a level with other public services available to all persons seeking them. The new Tennessee law (H. 836) creates the Medical Care Division in the State Department of Public Health and authorizes this division to administer and expend not only any State funds which may subsequently be allotted for medical-care services, but also any funds which may be "allotted or contributed for medical care in accordance with any future act of the General Assembly of the State of Tennessee or the Congress of the United States having as its objective the inauguration of a State and/or national program of medical care." The law further specifies that the medical-care services to be furnished are separate from, and in addition to, the services customarily rendered by public health departments and that the purpose of the act is—

to coordinate, improve and better supervise the expenditure of public funds appropriated and designed for medical care and medical service to citizens of the State, generally, who under future laws shall become entitled to receive medical care or medical service at public expense under the proposed National program of medical care.

This bill, proposed on February 13, passed quickly through both houses and was approved by the Governor on March 6, 1939.

## Compulsory Health Insurance

There was scarcely any State legislative activity in the field of compulsory health insurance in 1939 although ample evidence was available that a major part of the population of this country, including the otherwise self-supporting as well as indigents, was unable to afford adequate preventive and curative medical services and although testimony presented at the Federal hearings on the Wagner bill indicated that need for public medical services existed in nearly every part of the United States. As we have seen, the only legislation acted upon favorably by the States was that which provided public medical services for the indigent or needy and that which authorized the formation of voluntary hospital and medical-care corporations to furnish limited medical services to persons who could afford such services. Only nine States introduced bills relating to some aspect of compulsory health insurance. All told, 19 bills were introduced but only two were passed (table 6). Attempts to make more adequate provision for the medical needs of the workers of the country failed as did isolated attempts to establish comprehensive State medical-care programs for all persons seeking medical services. (See preceding section.)

Legislative proposals for compulsory health insurance showed two different approaches: one called for compulsory health insurance legislation generally along the lines laid down by the American Association for Social Security in its model Social Security Bill for Health Insurance; the other called for the inclusion of health insurance benefits within the framework of existing unemployment compensation laws.

The only legislation passed that was directed toward some form of compulsory health insurance, outside the unemployment compensation laws, was House Joint Resolution 32 in Maryland. The purpose of this bill was to explore the possibility of transforming voluntary hospital insurance into compulsory hospital insurance. The bill called attention to the fact that although Maryland in 1937 had passed an enabling act for nonprofit hospital-service plans and although

corporations were operating under this act, there were many persons who had not taken advantage of the plan. The legislature therefore requested the Governor "to appoint a commission to study the question of compulsory hospital insurance" and to report to the General Assembly on or before January 15, 1941. If a compulsory hospital insurance plan should be inaugurated, it would represent a limited form of compulsory health insurance.

The only bill passed linking health insurance with unemployment compensation was H. 327 in New Hampshire. This bill authorized the establishment of a commission to study the possibilities of protecting individuals unemployed because of sickness or ill health. An appropriation of $2,500 was made available to the commission.

The Maryland and New Hampshire laws both called for study of the possibilities of compulsory health insurance without actually approving any particular program. California, Massachusetts, New York, Pennsylvania, Rhode Island, and Wisconsin, on the other hand, introduced several bills for State systems of compulsory health insurance, but none was passed. Connecticut failed to pass a bill (H. 1495) authorizing the appointment of a commission to study and report on the problem, and Wisconsin took the same action on a similar bill (A. 844).

Two bills seeking to establish State-wide compulsory health insurance in California were opposed by the State Medical Association and by other groups and failed of enactment. Senate bill No. 551 proposed the creation of a Division of State Health Insurance in the Department of Industrial Relations and established a State health insurance fund. The program was to be financed by contributions—divided equally between employers and employees—amounting to 6 percent of wages plus a State contribution of one-tenth of this joint contribution. Benefits were to include cash and medical benefits for employees and their dependents. Broad coverage was to be made possible by providing voluntary insurance for persons employed in employments not covered by the act. The bill died in the Senate.

California Assembly bill No. 2172 illustrates a second legislative device for setting up a compulsory health insurance system. Whereas Senate bill No. 551, patterned after the model compulsory health insurance bill, proposed an independent health insurance system, Assembly bill No. 2172, drafted as an amendment to the California Unemployment Reserves Act of 1935, contemplated a compulsory health insurance system within an existing unemployment compensation system, with which it was integrated and upon which it was dependent. The original title of the 1935 act was to be changed to the "Social Insurance Act" as an indication of the broader scope of the proposed bill. The existing Department of Employment, which is charged with the dual responsibility of administering unemploy-

**Table 6.—*Scope and final disposition of State legislative proposals for compulsory health insurance made in 1939***

| State | Bill No. | Scope | Final disposition |
|---|---|---|---|
| | | **Compulsory health insurance** | |
| California | S. 551 | Provides State system of health insurance | Died in Senate. |
| Connecticut | H. 1495 | Provides appointment of commission to study health insurance | Killed in House Mar. 30. |
| Maryland | H. J. Res. 32 | Requests Governor to appoint commission to study compulsory hospital insurance | Approved, Apr. 26. |
| Massachusetts | H. 1898 | Provides State system of health insurance | Killed in both Houses. |
| New York | A. 2241 | do | Died in House. |
| | A. 2252 | do | Do. |
| Pennsylvania | H. 671 | do | Do. |
| Rhode Island | H. 809 | do | Do. |
| Wisconsin | A. 807 | do | Killed in Assembly. |
| | | **Unemployment compensation for sickness** | |
| California | S. 1128 | Establishes system of social insurance; includes health and unemployment insurance | Died in Senate. |
| | A. 2172 | Provides system of health insurance within system of unemployment reserves | Killed in Assembly. |
| Massachusetts | H. 387 | Provides benefits for sick employees under unemployment compensation | Killed in both Houses. |
| | H. 933 | do | Do. |
| | H. 1075 | do | Do. |
| | H. 1651 | do | Do. |
| | H. 1781 | do | Do. |
| | H. 1876 | do | Do. |
| New Hampshire | H. 327 | Establishes commission to study protection of persons unemployed because of sickness | Approved, June 16. |
| Pennsylvania | H. 450 | Provides unemployment compensation for sick or physically disabled employees | Died in House. |

ment compensation and the State employment service, was to be designated as the Department of Social Insurance and Employment Service. Medical benefits were to be administered by a Bureau of Medical Service in the Division of Social Insurance in the enlarged Department. A health insurance fund, separate from the unemployment fund, was to be created in the State treasury and was to consist of: (1) the 1 percent employees' contribution collected for unemployment compensation under the original Unemployment Reserves Act, (2) medical-benefits contributions comprising employers' and employees' contributions of 1 percent each with respect to wages paid, (3) any money that might be appropriated by the State for medical benefits, (4) any money that might be received for disability unemployment benefits or medical benefits or for both from the United States or from any other source, and (5) earnings on investments, fines, and other miscellaneous items.

The close integration of the three administrative branches of the proposed department and the dependence of the program of cash benefits for disability unemployment on the unemployment compensation program were indicated by the provision that employee contributions collected on and after January 1, 1940, for unemployment compensation were to be put into the health insurance fund and not into the unemployment fund. The cost of the three programs was to be distributed as follows: unemployment compensation was to be financed by employers, the State, and the Federal Government; the cash benefits program of the compulsory health insurance scheme was to depend primarily upon a 1 percent unemployment contribution from employees and secondarily upon such appropriations as might be made from State and Federal funds; and, finally, the medical-benefits program of the compulsory health insurance plan was to be financed by contributions from employers, employees, and the State, together with possible grants from the Federal Government. The bill was defeated in the Assembly by a vote of 48 to 20.

Within the short period of a single week seven bills were introduced in Massachusetts, six providing that the unemployment compensation law be expanded to include benefits for sick employees and one providing for health insurance along the lines suggested by the American Association for Social Security. All seven bills were defeated, as were the bills providing medical services for the needy and one bill proposing a survey of health needs. In Massachusetts, as in California, New York, and Wisconsin, the only medical-service bills enacted were new enabling acts or amendments to previous enabling acts for voluntary group hospital-service or medical-service plans.

In New York two compulsory health insurance bills were introduced on the same day, one by Assemblyman Boccia (A. 2241) and one by Assemblyman Wagner (A. 2252). The two bills were similar, and both followed closely the model Social Security Bill for Health Insurance sponsored by the American Association for Social Security and popularly known as "the Epstein bill." Both bills placed administrative authority in a health insurance board to be created in the State Department of Health. The former bill used the premium rates recommended in the model bill and provided for contributions of 6 percent of wages, requiring employers and employees together to pay 4½ percent on a graduated scale, and the State to pay 1½ percent. This is the rate believed by many to be necessary for a sound health insurance scheme. The Wagner bill departed from the recommendations in the model health insurance bill by requiring total contributions of only 5 percent of wages, by omitting provisions for local administrative procedures, by not separating funds for cash benefits from those for medical benefits, and by providing more generous cash benefits. Both of the New York bills were defeated.

In Pennsylvania the Tronzo compulsory health insurance bill (H. 671), placing administrative responsibility in the State Health Department and providing the premium rates of the model health bill, and a bill (H. 450) extending the unemployment compensation law to include benefits to persons unemployed by reason of sickness or physical disability, were defeated.

The Rhode Island compulsory health insurance bill introduced by Representative Romano (H. 809) followed the model bill almost verbatim. It did, however, place administrative authority in a Division of Health Insurance to be created in the Department of Public Welfare, whereas the model bill did not link health insurance with the welfare department. The Romano bill died in committee.

Assemblyman Biemiller in Wisconsin introduced

a compulsory health insurance bill (A. 807A) which differed considerably from other bills in this field and from the model health insurance bill. Contributions by employers and employees to the health insurance fund were put on a flat 2 percent basis for each group instead of being graduated. No provision was made for a State contribution. The bill provided for "health benefits" (i. e. medical services) but not for cash benefits. One of the unusual features of the bill was the definition of "health services" to include, among other things, "services and supplies for the prevention, cure, or alleviation of mental defect." No provision was made for services for mental disease, a condition more amenable to treatment than mental defect. Unusual powers were accorded to the director of health insurance, who was to be appointed by a State health insurance council instead of by the Governor, as is customary for such appointments. The Wisconsin Assembly killed both this bill and one (A. 844A) creating an interim committee on the cost of medical care.

## Regulation of Health and Accident Insurance Companies

Only brief mention will be made here of the bills introduced in many States for the purpose of regulating insurance companies which offer health and accident policies. One of the manifestations of increased interest in providing protection against the costs of medical care and the loss of income due to disability is the willingness of the public to purchase various types of insurance from commercial companies. The recent rapid increase in membership in voluntary nonprofit health insurance plans has apparently encouraged private insurance companies to expand their health insurance business.

This increased activity has resulted in amendment of the laws in many States to enable insurance companies to write additional forms of insurance, to regulate business procedures, and to protect the interests of the insured. At least 24 bills are known to have been introduced in 12 States, and 10 of these bills in 8 States were passed. Most of the bills dealt with definitions of health and accident policies, procedures to be followed regarding cancelation, permissible coverage, and other regulatory and enabling provisions.

## Miscellaneous Provisions

In addition to the bills analyzed in preceding pages, at least 90 were introduced relating to appropriations, administration, hospital construction, and other matters less directly concerned with the furnishing of medical services. Of these, 49 bills were passed in 26 States appropriating funds to continue or to expand county health services, to aid crippled children, and to erect hospitals for indigents, the insane, and the tuberculous; empowering the State Board of Health to receive and expend funds from the Federal Government for the promotion of health activities (New Hampshire H. 343); establishing the Division of Public Health in the Department of Public Welfare (Idaho S. 1) and the Bureau of Industrial Hygiene in the State Division of Public Health (Idaho S. 101); regulating rates of payment for treatment of patients in public hospitals; guaranteeing freedom of choice of physician or other medical practitioner under any public-health program financed in whole or in part from State funds (South Dakota H. 47); establishing a State Cancer Commission (Vermont H. 56); and providing for other financial aid and administrative procedures. Among the miscellaneous bills enacted were 5 authorizing State and/or local governments to make contracts with life insurance companies for group life, health, and accident policies for government employees and, except in Florida, to collect premiums through pay-roll deductions (Delaware S. 153, Florida H. 688 and H. 1106, New York S. 1970, Pennsylvania H. 640).

Among these miscellaneous provisions were 17 bills, 10 of which were enacted, relating to institutional care for the tuberculous. The measures included two introduced but not passed in Alabama (H. 155 and H. 156), proposing State aid to counties for the construction of hospitals for the tuberculous; one passed in Arkansas (S. 404), authorizing an appropriation for the Arkansas Tuberculosis Sanatorium; one introduced but not enacted in Connecticut (H. 1507), proposing that charges for care of patients in tuberculosis sanatoria and other institutions be financed by the State instead of by towns; one passed in Georgia (S. 1), creating the State Hospital Authority and authorizing the issuance of bonds

for construction of hospitals, sanatoria, and other institutions; two introduced but not passed in Idaho (H. 374 and H. 375), providing for the construction of a State hospital for the tuberculous if Federal funds should become available; one passed in Idaho (S. 139), establishing standards of hospital care for the tuberculous; one defeated in Illinois (H. 224), proposing the establishment of the Illinois State Tuberculosis Hospital under the administrative control of the State Department of Public Welfare, and appropriating $1 million therefor; one passed in Missouri (H. 603), giving to city hospitals the same State reimbursement for care of tuberculous indigents as is now given to county hospitals; one passed in Montana (H. 125), providing for construction of additions to the State Tuberculosis Sanitarium; three passed in North Carolina, including one (S. 342), which establishes a State tuberculosis sanatorium, one (S. 395), relating to settlement requirements for persons seeking care in the State sanatoria, and one (H. 741), authorizing counties and municipalities to spend tax funds for erection and maintenance of tuberculosis hospitals; two companion bills introduced but not passed in New York (S. 841 and A. 1125), amending the public-health law regarding State hospitals for the tuberculous; and one bill enacted in Wisconsin (A. 194), making an appropriation for State aid to sanatoria for the tuberculous.

## Trends in Legislative Proposals

During the year 1939, legislators in 44 States introduced approximately 285 bills dealing directly or indirectly with provision of medical services, with payment of cash benefits for disability, or with regulation of public or private agencies engaged in the promotion of health activities. Of these bills, 110 were passed. One clear trend was observable: legislation favored the encouragement of local voluntary efforts to cope with health problems rather than the development of a comprehensive State plan to be integrated into a national health program. Legislators supported measures providing for voluntary group hospital or group medical-care plans and likewise extended the fields of operation of private insurance companies to include individual, family, and group health and accident insurance. Four States authorized pay-roll deductions for premiums to be paid to private insurance carriers for group health and other insurance for public employees. At the same time practically the only legislation enacted for State-wide medical services was that relating to indigents. The States declared themselves overwhelmingly in favor of furnishing tax-supported medical services on a charity basis only. The benefits of public medical services were consistently denied to persons above the pauper level, as legislators proposed and enacted bills limiting such services to "indigents," "paupers," "the needy," or "persons with no legally responsible relative."

Only 9 States introduced bills dealing with compulsory health insurance. Of 19 bills introduced, 3 authorized or requested the creation of commissions to study the possibilities of health insurance, 6 proposed State-wide systems of compulsory health insurance patterned after the system outlined in the model health bill of the American Association for Social Security, and 10 proposed State-wide systems developed along different lines. The most noticeable trend in compulsory health insurance proposals was the introduction of a new legislative device to obtain the desired end of protecting workers and their dependents against the hazards of temporary and permanent disability by adding provisions for cash benefits or cash and medical benefits to existing unemployment compensation laws instead of setting up new systems for compulsory health insurance. These proposals differ in many respects from the independent compulsory health insurance schemes which are not related to unemployment compensation. Most of the bills integrating health and unemployment insurance have made no provision for additional contributions to meet the expense of additional benefits. The bill introduced as the Social Insurance Act of California (A. 2172) is an example of this new type of legislative proposal. It would provide for the financing of health insurance partly from new contributions and partly from employee contributions already being collected for unemployment compensation. Massachusetts and Pennsylvania attempted a similar approach through existing unemployment compensation laws. All 16 bills proposing State-wide systems of compulsory health insurance—6 in general conformity with the model health bill and 10 drawn along different lines—were defeated.

A broad view of all the legislative proposals which have been discussed shows that, with a few exceptions, little effort was made by the States to attack the major health problems which are known to exist. Some legislative provision was made for the poorest part of the population—persons already public charges or those very near the level of public dependency—and for persons financially able to purchase insurance. Most of the bills enacted provided for one kind of medical care for indigents and another for persons in moderately comfortable circumstances. Sporadic efforts made in a few States to provide medical services for the entire population met with defeat. In the main, legislation was not directed toward the health problems of the large group of persons with low incomes who cannot afford to purchase limited medical services under voluntary insurance plans and who will not ordinarily seek public medical services so long as these are available only after submission to a public welfare means test. Legislative proposals for compulsory health insurance and for public medical care for the entire population were defeated.

On the whole, therefore, it may be said that during 1939 State legislative proposals for medical services continued to place emphasis on care of indigents and plans for voluntary health insurance rather than on more comprehensive tax-supported health programs for all or nearly all the people. This was particularly noticeable in California, Connecticut, New York, and Pennsylvania.