the HEALTH CARE of the AGED

background facts relating to the financing problem

UNITED STATES ~~DEPARTMENT OF~~ HEALTH, EDUCATION, AND WELFARE
Social Security Administration
Division of Program Research

the HEALTH CARE of the AGED:

background facts relating to the financing problem

UNITED STATES ~~DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE~~
U.S. Social Security Administration
Division of Program Research

[Washington, U.S. Govt. print. off., 1962]

U.S. Government Printing Office
Washington : 1962

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington 25, D.C. - Price 50 cents

Foreword

When the Supreme Court of the United States sustained the constitutionality of the old-age insurance provisions of the Social Security Act, Mr. Justice Cardozo, in writing the opinion of the Court, said, "the hope behind this statute is to save men and women from the rigors of the poor house as well as from the haunting fear that such a lot awaits them when journey's end is near." Now, a quarter century later, that hope has been largely realized. The social security program, founded on sound principles and since strengthened, has indeed done a great deal to provide economic security in old age and to relieve the haunting fears of poverty.

For the vast majority of the aged, however, there remains a major obstacle to their peace of mind and for all too many to their security and independence. It is the high costs of ill health in old age and the inability of many of the aged to meet these costs. A nation that cherishes independence and self-reliance and that has undertaken to help maintain these values through a sound system of social security cannot afford to let catastrophic health costs stand in the way of old-age security. The considerations that led to the enactment of the social security program more than a quarter century ago now point unmistakably to the addition of health insurance for the aged to this program.

As life expectancy has increased, bringing with it increased medical burdens of old age, it has become clear that provision for basic health insurance must be made a part of the program of retirement protection in the Social Security Act. Seeing the plight of their parents, people are coming to realize that insurance protection against the costs of hospital care in old age, like insurance providing for basic retirement income, requires use of the social security method. Nongovernmental programs, of course, are an important way of supplementing old-age insurance, and public assistance is a necessary back-stop for those with special needs.

It is plain from the wealth of data set forth in this report that the aged as a group have much greater health care needs than younger people and that the costs of meeting these needs are much greater than the aged, with their limited resources, can possibly afford to pay. Their incomes are lower than those of younger persons. Likewise, health insurance for the aged is far more expensive than for younger

persons, and adequate health insurance is beyond the reach of most of the aged. Public assistance programs are least effective in the low income States, where need is most prevalent. Some people cannot undertake to meet the cost of the serious illnesses of their aged parents without themselves suffering hardship. Some cannot take on this burden without facing the painful decision to do less than they should in providing education for their children and meeting other basic family needs.

It is imperative that the aged have basic insurance protection against the cost of needed hospital care. Of all health costs faced by the aged, the cost of hospital care is the one most likely to be catastrophic. Insurance to cover the costs of such care cannot be financed solely out of the incomes of the aged themselves. Social security protection, financed by payments made during the working years, supplemented by private programs and backed up by the Federal-State public assistance provisions for medical care, is the only way to a truly effective solution of the problem.

We have in our social security system an effective mechanism for providing retirement income in old age. This same system enables us to finance health care for the aged. It is time we used it for this purpose. Without health insurance protection under social security, the promise of freedom from the fear of want in old age cannot be truly met.

ABRAHAM RIBICOFF,
Secretary of Health, Education, and Welfare.

Preface

Financing the health care of aged persons is now widely acknowledged to be a matter of social concern. Decisions as to how community responsibility in this area is to be met should rest on a full appraisal of needs and existing resources.

Within the past year there has become available new and current information relating to the health needs of the aged and the relative incomes of young and of older families. These data present the same general picture of greater medical need and more limited income and resources among the aged that emerged from earlier studies, which were summarized in the Reports submitted by this Department to the Committee on Ways and Means of the House of Representatives in April 1959 and July 1961. The new data fill in certain details as to how the aged manage and the nature of the problem for them and their children, that have not hitherto been available.

There has now been almost a year and a half of experience under the new program of medical assistance for the aged that was adopted in 1960. We are thus in a position to appraise what this program is accomplishing.

It has seemed useful and timely to bring together under one cover the most current information and background facts relating to the health care problems of the aged and the existing methods of meeting their medical care costs, including private health insurance and public programs.

An appendix to this report summarizes the many and varied proposals that have been made since the late 1930's for Federal legislation to provide health insurance for the aged, to stimulate the spread of voluntary health insurance or to support State medical care programs.

No one report can provide all the reference data that may be needed by those who are concerned with the formulation of detailed policy relating to so important and far-reaching a problem as the health care of the aged. This report attempts to present the more significant background facts in a form that will be useful to anyone who is seriously studying the problem and the issues it raises.

IDA C. MERRIAM,
Director, Division of Program Research.

Contents

TEXT TABLES—Continued

TEXT TABLES—Continued

SUMMARY

New developments in medicine and the better living conditions attendant upon our growing productivity now keep more and more people alive beyond the biblical span of three-score-and-ten. At the same time, there is a tendency to retire the worker from active employment at a progressively younger age—leaving him more years to get along on reduced income.

OASDI and related income-maintenance programs developed over the last quarter century assure continued basic self-support for most persons after they reach age 65. Years of prosperity and advancing wage levels bring to many persons in later life some security in owned homes and other savings accumulated during the working years. But for nearly all the burden of health costs casts a heavy shadow over the prospects of retirement.

Persons 65 and over now total over 17 million, and their number is growing faster than the rest of the population. Today out of every 11 persons, one has passed his 65th birthday. By 1980, the proportion may well be more than 1 out of 10 and the number 25 million. Because women tend to outlive men, the aged population includes a disproportionate share of widows. Indeed, the 65 and over group has almost as many widows as married men. Close to half of the widows are past 75. It is in the oldest age groups that illness costs become especially high, and it is usually the widows who have the least financial resources.

The majority of the aged maintain independent living arrangements: About 7 in 10 live alone or with a spouse or one other relative; little more than half a million in all live in institutions. While independent living brings its own satisfactions, it usually means living on a rather restricted budget, and often with no one at home to help out during illness.

Few at age 65 can count on continuing to earn their living for the remaining years of life. In mid-1961, fewer than 1 in 4 of those 65 and over had any income from employment, even counting wives whose husbands worked. Furthermore, most of those who worked were not working full-time, merely supplementing payments under a public program. More than 9 in 10 aged persons now receive income from some public program, whereas only 1 in 20 is still working and drawing no income from a public program.

Public programs obviously are limited in what they pay. On the average, the aged person has to get along on only half as much income as the younger person in a family of the same size. While the older person's total needs are less than those of the younger person, they are far from 50 percent less.

Today 9 out of 10 workers are accumulating credits towards retirement benefits under the OASDI program. Persons currently drawing benefits, or eligible to do so if they choose to retire, already number three-fourths of those 65 or older and eventually should include almost every one. (The few not included will for the most part come under one of the other public retirement and income-support programs.)

Although OASI benefits to retired workers have been rising, the current average monthly payment of $76, or even the current maximum of $125 for a retired worker or $187 for an aged couple, is not likely to make for comfortable living without additional resources, particularly when serious illness strikes.

Medical bills for the aged person come high, judged both in terms of the dollar total and in the light of his limited resources. Older persons pay out more for medical care than young persons, and these payments take a larger share of their small income—and the share would be even greater if all the elderly got and paid for the care they needed.

How much care do the aged need? Persons 65 and over are twice as likely as younger persons to suffer a chronic condition, and 6 times as likely to have one restricting or limiting activity. By age 75 every fourth person (not in an institution) is totally unable to carry on normal activity—work or keep house. The average old person is incapacitated 5 weeks of the year by illness or injury, with two of these weeks spent in bed.

Aged persons as a group see doctors and get medical attention more than younger persons, but many, particularly those with low income, go without care that could bring relief. From 40 to 50 percent of those who have arthritis and rheumatism, or hernias, or who have trouble seeing or hearing, for example, and one out of 7 with a heart condition, are not currently under medical care. It is the aged in families with low incomes who are more likely to have incapacities and illnesses, but it is those in families with high incomes who see the doctor more often.

Hospital care for anyone poses a special problem because of the large and usually unexpected bills, making it difficult to plan ahead of time. It is especially difficult for the aged. The aged person has a 1 in 6 chance of going to a hospital in a given year, somewhat higher odds than for the person under 65. Also, once he is admitted, the aged person can count on staying an average of two weeks, as opposed

to one week for younger patients. Thus, he can expect a hospital bill twice that of his younger fellow patient. What makes the situation still worse is that less of the older person's bill will be met by insurance.

Among the aged, as among the rest of the population, it is those most in need of health insurance who are least likely to have it: The chronically ill, the ones not working, and those with low income. Such persons generally either find the costs of insurance beyond their means, or are considered too poor a risk for the commercial insurer. Some who have protection find the policy cancelled when they most need it—when they develop expensive long-drawn out "conditions," or when they reach the older age brackets, although currently more noncancellable policies are being written.

Sometimes the aged person himself discontinues the protection he had before retirement, because he no longer has the advantage of the lower group rate and must pay more on an individual basis—and usually for less adequate benefits. In addition the share paid by the employer is often stopped altogether, leaving much higher premium costs at the time income is sharply cut.

No more than half the aged today have any protection against hospital costs—the most common form of health insurance. According to the National Health Survey, just about half the elderly patients discharged from a short-stay hospital had no part of the hospital bill paid by insurance. Such insurance as was available was more likely than not to cover only short stays. Insurance took care of as much as three-fourths of the bill for 6 out of 10 stays under a month, and fewer than 5 out of 10 lasting a month or more.

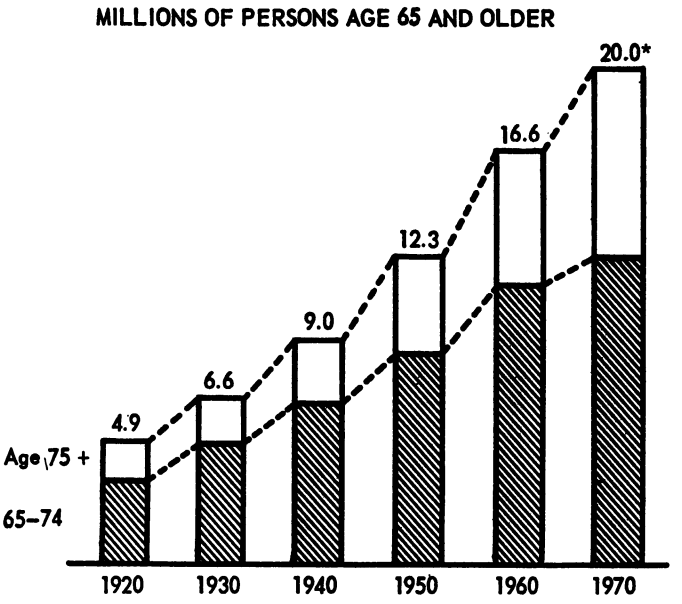
Although the average elderly patient leaves the hospital within two weeks, nearly 1 in 10 remains a month or longer. The longer his hospitalization lasts the more likely is the aged person to need help in paying for his care. Among OASI beneficiaries in a general hospital 3 out of 4 of those staying as long as 2 months, and 1 out of 2 of those hospitalized for shorter periods could not assume responsibility for all of their own medical costs.

The burden of paying for hospital care is even greater when one takes account of those who do not leave the hospital alive. Terminal illnesses often are especially expensive and those at the older ages, most likely to die, are least likely to have any insurance. Often they leave a legacy of debt with a heavy burden on surviving widows.

No one can foresee just when he will enter the hospital—although 9 out of 10 persons who reach age 65 are sure to go at least once in their remaining lifetime. But all the evidence indicates that the year one does have to go will be characterized by unusually high medical bills of all kinds. In 1957–1958, for example, hospital care costs, excluding those paid out of public funds, averaged $49 per person 65 or older.

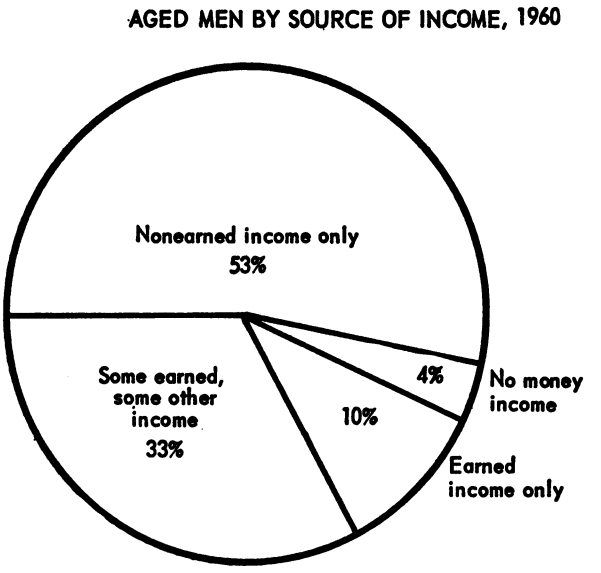
HEALTH PROBLEMS OF THE AGED

1. More and more people live to increasingly older ages.



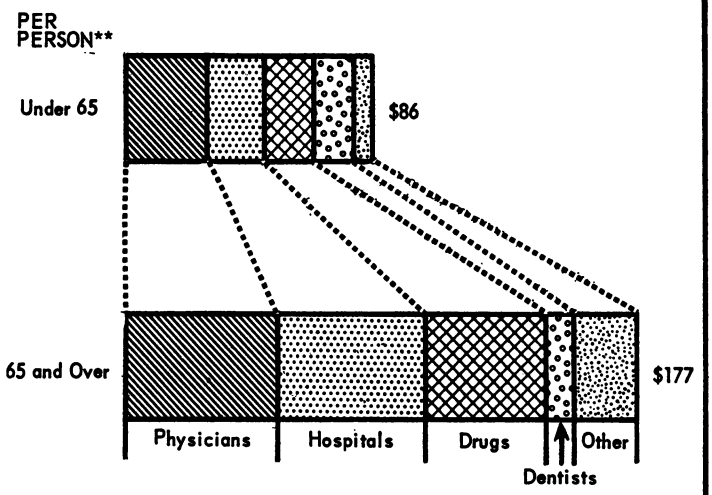
*Projected

2. Few men over 65 are still working; most depend in part on public programs.



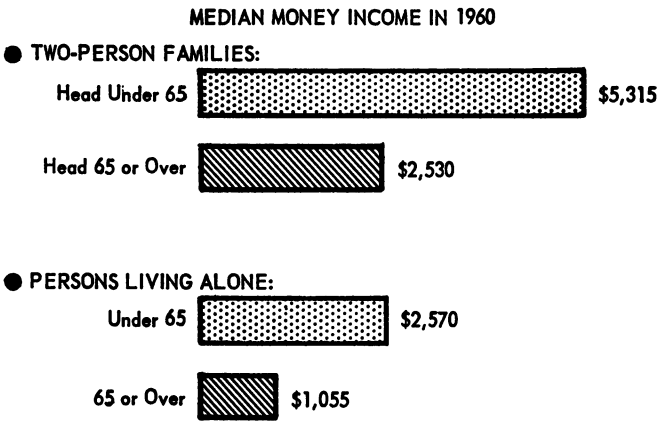
636202—62——2

3. Average medical expenses in a year are at least twice as high in old age.



**In 1957–58; excludes private expenditure for nursing home care and all care at public expense.

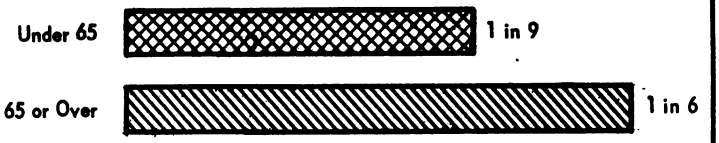
4. With most of them retired, income of the aged average much lower than the rest of the population.



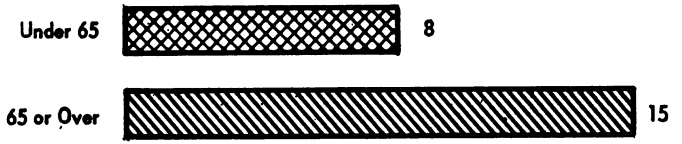
HEALTH PROBLEMS OF THE AGED

5. Old people go to the hospital more often and stay longer than younger persons.

PERSONS IN SHORT-STAY HOSPITALS DURING A YEAR, 1958–60*



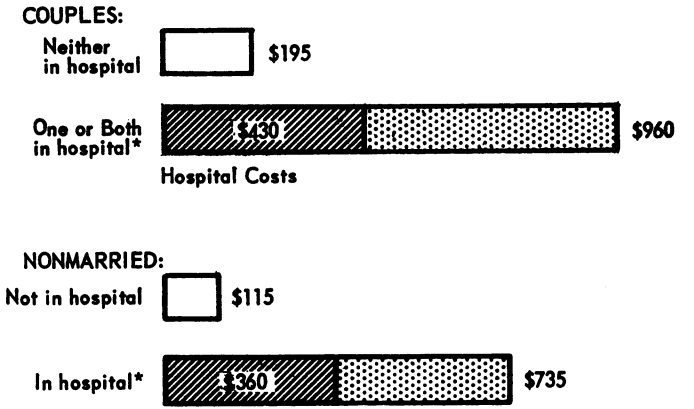
AVERAGE DAYS IN HOSPITAL PER PATIENT*



*Adjusted to allow for decedents.

6. Hospital stays bring extra large total medical bills for the year.

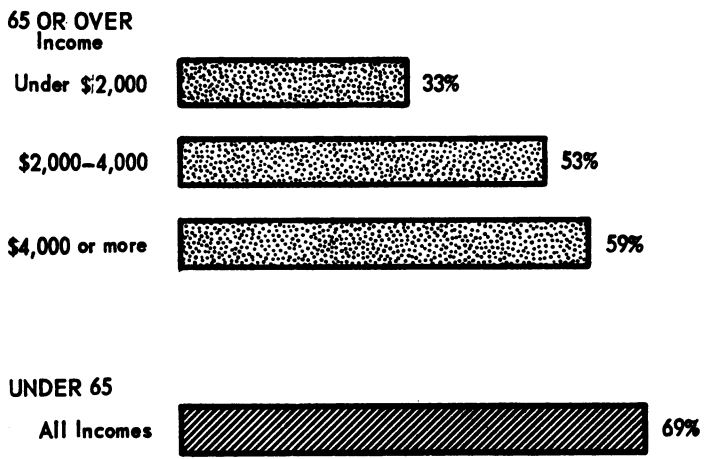
AVERAGE MEDICAL COSTS OF AGED BENEFICIARIES 1957



*General hospital; excludes persons in chronic-care institution only.

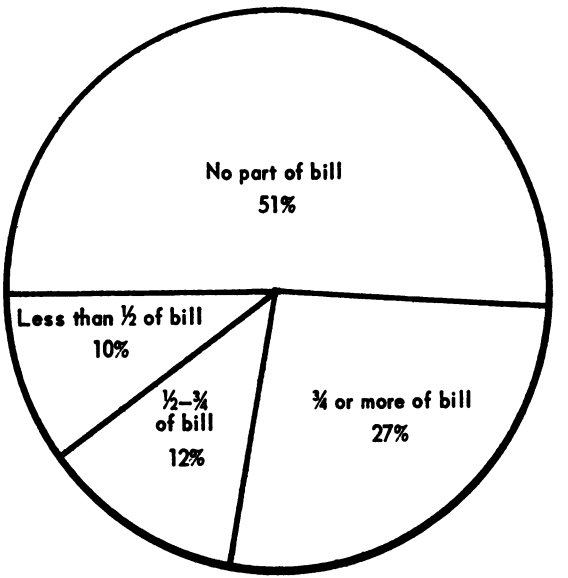
7. Only half of the aged have any insurance for medical bills.

HOSPITAL INSURANCE, 1959



8. For a majority of the hospital stays of the aged, insurance pays less than half of the bill.

PORTION OF HOSPITAL COSTS MET BY INSURANCE FOR EPISODES IN SHORT-STAY HOSPITALS, 1958–60



For those who actually had a hospital illness, however, costs were 7 times this much. Their doctors' fees for inhospital visits were twice as great as the average total bill for all doctors' visits in the year—in or out of hospital.

Aged OASI beneficiaries in general hospitals during 1957 had total medical bills for the year 5 times as high as those with no hospital illness—not counting the costs of persons unable to report them, often because some care was given without charge or paid for directly by a public or private agency. For beneficiaries who went to a hospital, the hospital charges alone represented close to half the total medical bills for the year. They were two to three times as large, on the average, as the total medical costs for the year for beneficiaries who did not have a hospital illness.

At December 1961 prices an elderly couple with one or both members receiving hospital care could expect their combined total medical bills for the year to total about $1,160. For the elderly person without a spouse, a hospital stay might mean average medical bills for the year of about $895. With half the aged couples having less than $2,500 income and more than half the other aged persons less than $1,000 it is obvious that most of them would be hard put to pay such a bill and still have enough left for groceries and housing—unless they had the benefit of health insurance, could count on getting free care or received help from relatives. Indeed, more than two-fifths of the beneficiary couples and roughly three-fifths of the nonmarried beneficiaries who were in a general hospital in 1957 did not meet all the year's medical costs out of their own income, assets or health insurance.

Except for an owned home, few of the aged have assets in substantial amounts. Those who do are more likely to be the relatively small number who already have the advantage of higher income. Sometimes the aged person with low income and some savings must choose between using them for every day needs, or doing without some essentials so as to leave savings intact for a medical emergency.

How then do the aged manage when ill? Some seek help from relatives, and failing that, from public assistance. Some borrow money. A small number can manage on their own, especially if they have insurance. Some, as is true of all low-income groups, probably never get the care they need. Relatives provided help with medical bills for every seventh OASI beneficiary couple and every fourth nonmarried beneficiary who went to a hospital. Many beneficiaries who "paid their own bill" could do so only because relatives had either taken them into their own home or contributed in cash to their living expenses. Typically, the relatives to whom old people must turn for help already have families and children to take care of, or are themselves old enough to be facing their own problems of retirement.

Some aged persons with medical problems ask for public assistance—either to meet the emergency itself, or for regular living needs after using their resources to pay for the medical care. In the first half of 1961, just about every third person approved for old-age assistance needed it directly or indirectly as a result of health difficulties. Among recipients getting the assistance to supplement OASI benefits—generally those with the greatest economic resources of their own—the proportion obtaining assistance on account of medical needs was as high as 2 in 5. Currently about half the aged going on the OAA rolls are OASI beneficiaries.

The kinds of medical services and the amount of care provided through public assistance vary greatly from State to State. Some State public assistance programs pay for relatively comprehensive services, others meet emergency medical needs only. In January 1962, vendor payments for medical care under old-age assistance averaged $13.62 per recipient; the range was from a low of 24 cents to a high of $61.29 per recipient per month.

The 1960 Amendments to the Social Security Act increased the Federal matching funds for vendor payments under old-age assistance. They also provided Federal matching grants for a new program of medical assistance to aged persons not eligible for old-age assistance but whose income and resources are insufficient to meet the cost of needed medical care. As of March 1962, medical assistance for the aged programs were in effect in 23 States, Puerto Rico, the Virgin Islands and Guam. The services provided under these new programs also vary widely. Currently, about five-sixths of all expenditures under the MAA program are being made in two States, States that transferred to MAA most of the nursing care cases on their OAA rolls. Liberalization of the Federal contribution in the federally-aided assistance programs, has often meant more improvement in States already doing a better-than-average job than in those where standards and available funds were low.

Many aged persons get medical care at public expense or at reduced rates. Probably close to 30 percent of total public expenditures for patient care in hospitals goes for treatment of the aged, who comprise only 9 percent of the population.

Hospital care, more costly and more often emergency in character, may be more likely to be obtained without charge than other types of service. In any case, aged persons with no health insurance and in need of hospitalization are more likely to go to a public hospital than patients with health insurance. Public hospitals more commonly than private institutions must tailor their charges to ability to pay, including taking as a public charge those who cannot pay at all.

Total public and private expenditures for medical care for aged persons are estimated to have been about $5 billion in 1960, or ap-

proximately 1 dollar out of every 5 spent for personal medical care services. Only 1 person in 11 is aged 65 or over. Public programs are now responsible for more than 1 dollar in every 4 spent for medical care for persons aged 65 and over. Thus much of the burden of medical care of the aged population already falls on the community at large. One may well question, however, whether the cost of this burden is prorated among all our citizens in the most efficient and equitable fashion.

Over the past decade, prices of all goods have gone up, but not as much as has income of the population. Real income, as measured in purchasing power, has improved for most Americans. On the other hand, medical care prices, and especially the cost of hospital care, have risen more than other prices, and by and large have outstripped gains in income. This has been a serious problem for all low-income groups; and particularly so for persons currently age 65 and over—many of whom receive retirement benefits based on low lifetime earnings.

A part of the increase in the cost of hospital and medical care has resulted from improvements in the earnings and conditions of work of hospital employees who have been among the relatively lowest paid groups and are of the last to move from a 12- to 8-hour working day. Changes in medical technology, such as the increasing use of specialized equipment and expensive drugs and antibiotics, while increasing the power of medicine have also made it more costly.

Wage and salary levels of hospital employees have now largely caught up with those in other service industries and will probably increase in the future at more or less the same rate as general wage levels. We have certainly not reached the end of changes in medical science and technology. New breakthroughs in knowledge which can be expected from the large investments now being made in medical research may further increase the unit cost of medical care or they may drastically reduce prolonged illness and the cost of medical services.

The organization of medical services is also in process of change. The hospital is assuming a new importance as the center for medical care in a community, at the same time that more effective use of home health services and skilled nursing home or other arrangements is making it possible to transfer many long-term patients out of the hospital, to their benefit as well as that of the community. The further development of a wide range of community and social services can have a significant effect on medical care problems.

By and large, in planning for the next decade, it seems reasonable to assume that the overall cost of medical care will increase at about the same rate as our total national output. Whatever the future costs may be, the question of how the benefits of modern medicine can best be assured to all who need them will be one of the most important challenges to our social ingenuity.

PART I

Characteristics and Health Needs of the Aged

CHAPTER 1. NUMBER AND CHARACTERISTICS OF THE AGED

The United States has a rapidly growing total population and an even more rapidly expanding population 65 years and older. Advances in medical technology, improvements in living standards, and other factors have increased life expectancy at birth to an overall average of 70 years. Those who live to be 65 can look forward to reaching on the average age 79 or 80. This lengthening life span, accompanied by a lowering of the age at which workers voluntarily or involuntarily withdraw from the labor force, brings with it its own special problems. A growing number survive to face the illnesses and infirmities of age, but many do not have the income to pay for the care they need and which modern medicine has to offer. For most of our aged, basic self-support in retirement is largely assured by old-age, survivors and disability insurance and related income-maintenance programs developed over the last quarter century except for burden of medical care costs in retirement.

Persons aged 65 and over now number about 17¼ million, or more than 9 percent of the population of the United States, and in less than another decade, it is expected they will exceed 20 million, and by 1980, 25 million. During the 1950's the proportion of persons aged 65 and over in the population increased 35 percent (table 1), or from 1 in 12 to 1 in 11, and by 1980, they may well make up more than 1 in 10 of the total.

In two-fifths of the States at least 10 percent of the population was aged 65 and over on April 1, 1960 and in only eight States and Puerto Rico were there fewer than 7 percent. (Appendix A, table 1)

Characteristics of persons 65 and over

The growth in the aged population has been accompanied by a change in its composition. There has been an increase in the relative numbers of women and, also, of persons in the 85 and over age group. These are trends which will continue.

TABLE 1.—*Age and Sex: Number and distribution of persons 65 and over in the United States,[1] 1950 and 1960*

	Age						
	Total	65 to 69	70 to 74	75 to 79		80 to 84	85 and over
Number (thousands):							
Total, 1960	16,560	6,258	4,739	3,054		1,580	929
Male	7,503	2,931	2,185	1,360		665	362
Female	9,057	3,327	2,554	1,694		915	567
Total, 1950	12,295	5,013	3,419		[2] 3,284		578
Male	5,813	2,431	1,633		1,511		238
Female	6,482	2,582	1,786		1,773		340
Percent distribution:							
Total, 1960	100.0	37.8	28.6	18.4		9.5	5.6
Total, 1950	100.0	40.8	27.8		26.7		4.7
Percent female of total:							
1960	54.7	53.2	53.9	55.5		57.9	61.0
1950	52.7	51.5	52.2		54.0		58.8
Percent increase, 1950 to 1960:							
Total	34.7	24.8	38.6		41.1		60.7
Male	29.1	20.6	33.8		34.0		52.1
Female	39.7	28.9	43.0		47.2		66.8

[1] Includes Alaska and Hawaii in 1950 as well as 1960.
[2] Breakdown not available for 1950.

Source: Bureau of the Census, *United States Census of Population: 1960, General Population Characteristics, United States Summary* (Final Report PC (1)-1B), August 1961.

On reaching 65, women now have a life expectancy of 15.5 years; men, a life expectancy of 12.7 years.[1] In 1960, among the aged 65 and over there were more than 6 women to every 5 men (Chart 1). By 1980 the ratio will approach 7 to 5.

Accompanying the change in sex composition will be further aging of the population 65 years and older. Persons 85 and older made up 5.6 percent of the older population in 1960 as compared to 4.7 percent 10 years earlier, and may reach 8 percent by 1980.

In light of the sex-age composition of the 65 and over group, it is not surprising that the widowed make up almost two-fifths of this age group. Men are almost twice as likely as women to be living with a spouse, because their average age is less than that of women and, also, typically their wives are younger than they. About 7 in 10 of the men, but fewer than 4 in 10 of the women 65 and over, live with a spouse. Women are two and one-half times as likely as men to be widowed. Indeed, there are almost as many aged widows as there are married men aged 65 and over in the United States. Almost half of these widows are 75 and over (table 2).

With 2½ million who have passed their 80th birthday, and well over 900,000 who have passed their 85th, it might be expected that substantial numbers would be in institutions such as chronic care hospitals, nursing homes, and homes for the aged. The decennial

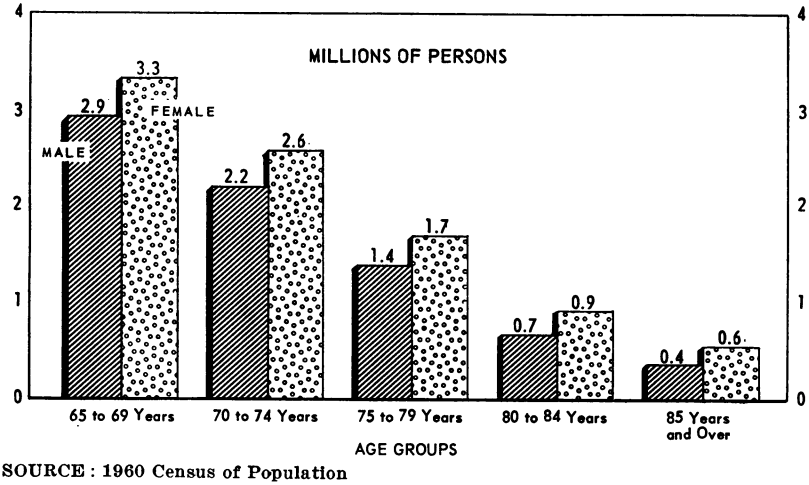
[1] Public Health Service, National Office of Vital Statistics, *Life Tables*, 1959, 1961.

TABLE 2.—*Marital Status and Living Arrangements: Distribution of persons 65 and over, by sex and age, for the United States, March 1961*

Status	Total 65 and over	Male			Female		
		Total	65 to 74	75 and over	Total	65 to 74	75 and Over
Total, 65 and over	100.0	44.8	29.8	15.0	55.2	35.0	20.2
Married, spouse present	50.9	31.2	23.0	8.3	19.7	15.5	4.1
Other, by marital status:							
Widowed	38.6	9.1	3.8	5.3	29.5	15.5	14.0
Separated	2.1	1.1	.8	.4	1.0	.8	.2
Divorced	1.5	.6	.4	.2	.9	.6	.3
Never married	6.8	7.7	1.8	.8	4.1	2.6	1.6
Other, by living arrangements:							
In families	23.1	6.0	2.6	3.3	17.2	8.8	8.4
Family head (spouse not present)	8.2	2.0	1.2	.8	6.2	3.7	2.5
Relative of head (other than wife)	14.9	4.0	1.4	2.5	11.0	5.1	5.9
Living alone or lodging	22.3	6.1	3.5	2.7	16.2	9.6	6.6
In institutions	3.7	1.5	.7	.7	2.2	1.1	1.1

Source: Bureau of the Census, *Current Population Reports; Population Characteristics*, Series P-20, No. 114. "Marital and Family Status: March 1961," January 31, 1962; and preliminary count of institutional inmates from the 1960 Census of Population.

Chart 1. U.S. Population 65 Years and Over, by Sex, 1960



SOURCE : 1960 Census of Population

Census, however, shows that only 615,000, or less than 4 percent of all persons 65 and over, were in institutions in 1960. Persons not in institutions, and not living with a spouse, divide almost equally between those who live with relatives and those who live alone or with nonrelatives (table 2). In all, about 7 in 10 aged persons live alone or in 2-person families.[2]

[2] Data for March 1959 (from Bureau of the Census, *Current Population Reports: Population Characteristics*, "Marital and Family Census: March 1961," Series P–20, No. 112, December 29, 1961) show 61 percent of all family members aged 65 and over were in 2–person families.

While more and more persons live to age 65, relatively fewer of them can count on continuing to earn their own living—or having husbands who do.

The long-run decline in employment of men 65 years or older has continued if not accelerated in recent years. During 1960, only one-sixth of the aged men worked full-time, one-third less than in 1950; only 43 percent worked at any time during the year, compared to 49 percent 10 years earlier. On the other hand, one-sixth of the aged women had work experience during 1960—a proportion considerably more than 10 years earlier (table 3).

TABLE 3.—*Work Experience: Distribution of persons 65 and over by sex, 1950 and 1960*

[Noninstitutional population of the United States]

Work experience	Men		Women	
	1960	1950	1960	1950
Total	100.0	100.0	100.0	100.0
Did not work during year	56.9	50.7	84.2	88.2
Worked during year	43.1	49.3	15.8	11.8
At part-time jobs	16.5	11.6	8.2	5.6
1 to 26 weeks	6.7	4.5	3.1	1.9
27 to 49 weeks	3.1	3.2	1.9	1.3
50 to 52 weeks	6.7	3.9	3.2	2.4
At full-time jobs	26.6	37.7	7.6	6.2
1 to 26 weeks	5.1	4.5	1.8	1.4
27 to 49 weeks	4.6	7.4	1.5	1.3
50 to 52 weeks	16.9	25.8	4.3	3.5

Source: Bureau of the Census, *Current Population Reports: Labor Force*, Series P-50, No. 35, "Work Experience of the Population in 1950," October 26, 1951; and Carl Rosenfeld, "Work Experience of the Population in 1960," *Monthly Labor Review*, December 1961.

In June 1961 fewer than 1 in 5 aged persons had any paid employment—about 3 in 10 of the men and 1 in 10 of the women. (Another 1 in 10 aged women were married to workers). Various public income-support and retirement programs—notably old-age, survivors, and disability insurance—have been developed to replace part of the income lost when earnings cease. A substantial majority of those with earnings were in fact retired, working as they could to supplement benefits. Only about 1 in every 20 persons 65 years or older has earnings and has no income from any public program (Appendix A, table 5). Private pension plans, whose coverage has expanded rapidly since they first became a prime objective of collective bargaining in 1950, are another important source of support for a relatively small number of retired workers many of whom draw benefits under a public program also.

The aged eligible for OASI benefits

Retirement and survivor benefits under the OASDI program were paid to more than two-thirds of all persons aged 65 and over in mid-1961. Including the 1.1 million insured workers (with 270,000 dependents) eligible for benefits but not receiving them because of employment, the proportion eligible was close to 75 percent.

By State the proportion of aged persons actually receiving OASI benefits in mid-1961 ranged from three-fourths in Rhode Island to less than half in Louisiana and the territories (Appendix A, Table 4). In 24 of the 50 States, at least two-thirds of all aged persons were on the OASDI rolls. Of the 13 States with the lowest rates, 10 were in the South; of the 13 with the highest rates, 9 were in the Northeast. The differences reflect, in large part, the fact that farmers and some farm laborers, domestics and urban self-employed were not covered until 1955.

Over 9 out of 10 of all those now reaching age 65 in the United States are eligible to draw benefits if they (or their husbands) retire. By the start of 1964, the proportion of aged persons who would have protection should exceed 80 percent, with 14.4 million, of the 17.9 million aged persons in the population, eligible under the OASDI program (Appendix A, table 2). By 1970 it is expected that all but 15 percent of those 65 and over will be eligible for OASI benefits and by 1980, all but 11 percent. In the long run 95 percent of the entire group 65 years and over will be eligible.

CHAPTER 2. HEALTH CONDITIONS OF THE AGED

Not only is the number of persons 65 and over growing rapidly, but those most likely to need medical care and least likely to have the resources to finance such care are increasing at an even more rapid rate.

The successes of modern medicine in preventing epidemics and curing or controlling diseases such as pneumonia, tuberculosis, and other once fatal infectious diseases have made it possible for an increasing proportion of the population to reach the age when they are more vulnerable to arthritis, rheumatism, heart disease, cancer, and other chronic illnesses. This development along with the high incidence of crippling accidents among the aged has brought the chronic conditions of old age to the fore as their major health threat.

The aged naturally face special health problems since advancing age is accompanied by a decline in health and physical capacity. Older people as a group naturally are more prone to chronic illness and, as a result, more likely to be partially or completely limited in activity than those of younger ages.

Chronic conditions

Older persons are twice as likely as younger persons to have one or more chronic conditions. The National Health Survey shows that almost four out of five aged persons are afflicted with one or more chronic conditions as contrasted with less than two out of five persons under 65.

Persons over 65 who were not institutionalized but who had one or more chronic conditions numbered approximately 11.8 million in 1960. This group represented almost four-fifths of all persons over 65 (Table 4). While the aged constitute 9 percent of the total noninstitutionalized persons, they make up 16 percent of all persons with chronic conditions.

Limitation of activity

Not all chronic conditions are necessarily disabling although such conditions often require medical care. However, reported limitation resulting from these chronic conditions provide a measure of the

TABLE 4.—*Chronic Conditions and Limitation of Activity: Percent distribution of persons by age, July 1959–June 1960*

[Noninstitutional population of the United States]

Age	Total	With no chronic conditions	With one or more chronic conditions		
			Not limited	Limited	
				Partially	Completely
65 and over, total	100.0	22.5	34.1	28.2	15.2
Under 65, total	100.0	62.3	30.2	6.4	1.0
75 and over	100.0	16.1	28.2	31.7	24.0
65 to 74	100.0	25.8	37.2	26.3	10.6
55 to 64	100.0	35.0	41.9	18.5	4.5
45 to 54	100.0	42.5	43.7	12.2	1.6
Under 45	100.0	69.0	26.6	4.0	0.5

Source: Public Health Service, U.S. National Health Survey, *Duration of Limitation of Activity Due to Chronic Conditions, United States, July 1959–June 1960* (Publication No. 584-B31), January 1962.

health status of the aged in relation to younger persons. Data from the National Health Survey for the 12-month period ending June 1960 indicate that older persons are more likely to be partially or completely limited in activity as a result of these chronic conditions than younger persons (Chart 2). Over 40 out of 100 elderly persons have some limitation of activity—6 times as many as for those under 65. One out of ten persons 65–74 is completely unable to work or keep house, and the proportion rises after 75 to almost one out of four persons (Table 4).

Days of disability

Days of restricted activity and bed disability are two measures of the extent of chronic and acute conditions in the population used by the National Health Survey in their household survey of civilian noninstitutional population of the United States. The survey for the year ending June 1960 gives further evidence that the impact of illness becomes more severe as age increases. Persons 65 and over reported an average of 38 days (more than 2½ time as many days as younger persons) during the year when their usual activities were restricted because of illness or injury. On 14 of these days, the aged person was confined to bed all or most of the time as compared with 5 days for the younger person. Also, according to the same survey data, the lower the family income, the greater the number of days of restricted activity or confinement to bed (Table 5).

Prevalence of specific chronic conditions

Arthritis, rheumatism, heart disease, and high blood pressure cause much disability in later life. More than 1 out of 4 aged persons

TABLE 5.—*Restricted-Activity and Bed-Disability Days: Number per person per year by age and family income, July 1959–June 1960*

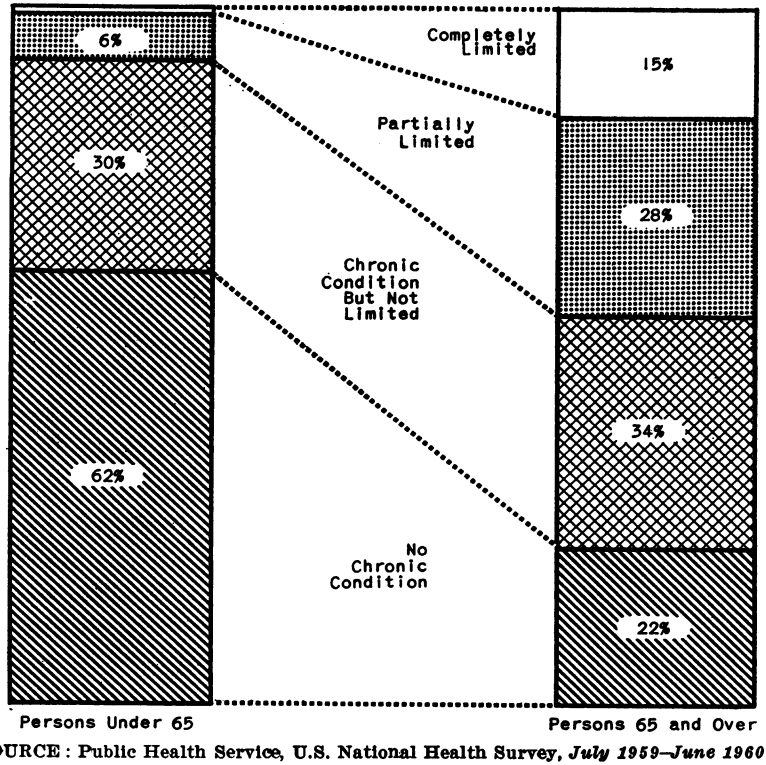
[Noninstitutional population of the United States]

Family income	Restricted-activity days		Bed-disability days	
	65 and over	Under 65	65 and over	Under 65
Total	37.8	14.2	13.6	5.3
Under $2,000	48.2	21.7	16.2	7.8
$2,000 to $3,999	32.0	15.1	11.5	5.7
$4,000 to $6,999	30.9	12.8	11.3	5.0
$7,000 and over	33.4	11.9	13.5	4.4

Source: Public Health Service, U.S. National Survey, *Disability Days, United States, July 1959–June 1960* (Publication No. 584–B29), September 1961.

suffers from arthritis and rheumatism; and 1 out of 8 has high blood pressure. The prevalence of physical impairments also increases with advancing age, particularly visual impairments, blindness and hearing deficiencies. Many aged persons suffer from more than one chronic condition—one-fifth had two and almost one-third had three or more

CHART 2. CHRONIC CONDITIONS AND LIMITATION OF ACTIVITY



SOURCE: Public Health Service, U.S. National Health Survey, *July 1959–June 1960*

such conditions. Although the percentage of cases that had never been seen by a physician was negligible or small in most diagnostic categories, a substantial portion of those with chronic conditions were reported as not under care at the time of the interview (Table 6).

TABLE 6.—*Selected Chronic Conditions: Rates per 1,000 persons 65 and over and percent medically attended, July 1957–June 1959*

[Noninstitutional population of the United States]

Selected conditions	Rate per 1,000 persons	Medically attended		Never Medically attended
		Under care	Not under care	
		Percent		
Arthritis and rheumatism	266	42.7	38.3	19.0
Hearing impairments	172	14.1	44.2	41.7
Heart conditions	149	83.1	15.6	1.3
High blood pressure	129	75.8	22.9	1.4
Visual impairments	103	40.8	51.9	7.3
Hernia	55	42.4	42.9	14.6
Asthma-hay fever	54	45.8	32.8	21.4
Diabetes	40	92.2	7.6	(1)
Paralysis of major extremities and/or trunk	22	53.4	43.6	(1)
Peptic ulcer	22	75.2	23.9	(1)
Chronic bronchitis	19	39.4	51.3	9.4

[1] Less than 0.05 percent.

Source: Public Health Service, U.S. National Health Survey, *Older Persons, Selected Health Characteristics, United States, July 1957–June 1959* (Publication No. 584–C4), September 1960.

Acute conditions and injuries among the aged

In addition to their many chronic conditions, aged persons have substantial problems with acute illness. Approximately 134 acute conditions for every 100 aged persons were reported in the 12 month period ending June 1959. Roughly three-fifths of the acute conditions involved the respiratory system and one-fifth a result of injuries. About 1 out of 4 older persons is injured annually, with about two-thirds injured in accidents occurring in the home. About 85 percent of the bed-disability days resulting from injuries were associated with fractures, dislocations, sprains, strains, contusions, and superficial injuries.[3]

Summary

The data on health conditions of the aged from the National Health Survey indicate clearly the extent to which aged persons are more prone to illness and disability than younger persons. These data are based on household interviews and exclude persons in nursing homes, homes for the aged and long-stay hospitals as well as persons

[3] Public Health Service, U.S. National Health Survey, *Older Persons, Selected Health Characteristics, United States, July 1957–June 1599* (Publication No. 584–C4), September 1960.

whose illness resulted in death during the survey year. The health situation of older persons, therefore, is actually more unfavorable than these data indicate.

Another factor in the possible underestimation of the severity of chronic conditions of the aged may well be the inaccuracy or under-reporting resulting from self-evaluation in the household interview. Methodological studies by the National Health Survey have shown that chronic conditions as diagnosed by the physician do not necessarily match the conditions as reported by the respondent in the household interview.[4] Other studies have also shown that some types of chronic conditions are actually under-reported in the household interview.[5]

---

[4] Public Health Service, U.S. National Health Survey, *Health Interview Responses Compared With Medical Records* (Publication No. 584–D5), June 1961.
[5] Trussell, R. E., and Elinson, J., "Chronic Illness in a Rural Area," from *Chronic Illness in the United States*, Vol. III, 1959.

CHAPTER 3. USE OF HEALTH SERVICES BY THE AGED

Precise measures of the needs of the aged for medical care are not available. However, the fact that the aged are more prone to illness and disability has been well documented. Evidence of their special needs is the higher rate of utilization of health services as compared with that of younger persons. They use a greater volume of physicians' services. They are admitted to hospitals more frequently and stay longer. They are heavy users of nursing homes and other long-stay institutions. They receive considerably more care at home, part of which is provided by nurses. They need and use more drugs. However, they do use less dental services than younger persons.

Physicians' services

Aged persons interviewed in household surveys averaged 6.8 physician visits per year—2 more visits than persons of younger ages—and would have been more had those who died in the survey year been included. One of the limiting factors in persons of any age getting all the care they need is the ability to pay. Persons with lower family incomes visit doctors less frequently than those with higher incomes, notwithstanding the fact that the former group has a higher rate of disability and a higher prevalence of chronic illness. (Table 7).

Persons with limitation of activity due to chronic conditions consult physicians more frequently than those reporting no such condition. The more severe the limitation, of course the higher the frequency of visits (Table 8).

TABLE 7.—*Physician Visits:* [1] *Number per person per year by age and family income, July 1957 to June 1959*

[Noninstitutional population of the United States]

Family income	Age	
	65 and over	Under 65
Total [2]	6.8	4.8
Under $2,000	6.5	4.0
$2,000 to $3,999	6.6	4.4
$4,000 to $6,999	6.9	5.0
$7,000 and over	8.7	5.6

[1] Includes consultation by telephone or in person, at the office, hospital clinic or home visit but does not include services to hospital inpatients.
[2] Includes a small number not reporting income.

Source: Public Health Service, U.S. National Health Survey, *Volume of Physician Visits, United States, July 1957–June 1959* (Publication 584–B19), August 1960.

TABLE 8.—*Physician Visits: Number per person per year for persons 65 and over by chronic condition status, July 1957 to June 1959*

[Noninstitutional population of the United States]

Chronic condition status	Number of visits
Total	6.8
No chronic condition	2.2
One or more conditions:	
No limitation of activity	5.3
Partial limitation	8.5
Major limitation	14.3

Source: Public Health Service, U.S. National Health Survey, *Older Persons, Selected Characteristics, United States, July 1957–June 1959* (Publication No. 584–C4), September 1960.

Other studies of aged persons and their utilization of medical services are in accord with the findings of the National Health Survey that aged persons use a great volume of physicians' services. One sample survey of a cross-section of aged persons conducted in 1957 by the National Opinion Research Center found that persons 65 and over averaged 7.6 annual out-of-hospital contacts with doctors.[6]

Since the aged enter hospitals oftener and stay longer than the rest of the population, presumably they also have a higher rate of use of physicians' services in the hospital. Recent data from the National Health Survey show that aged persons are more apt than younger persons to be hospitalized for conditions not requiring surgery—about two out of five aged persons discharged from general hospitals had surgery, as compared with three out of five younger persons. The length of stay for aged persons undergoing surgery is longer than for those aged discharged without surgery, while for younger persons it is just the opposite—shorter stay for those undergoing surgery than for those in for other reasons.[7]

Utilization of general hospitals

The use of hospitals varies by sex, income, and insurance status. The relationship of these factors to hospital utilization can be determined from information that is available from the results of some of the hospital utilization surveys. Measures of utilization of hospitals, used by the various surveys, include hospital admissions or discharges, length of stay, days of care, and the number of persons hospitalized. The number of persons hospitalized, if measured by either admissions or discharges, is overstated since some persons enter the hospital more than once in a year. This, despite the fact

[6] Health Information Foundation, "Use of Health Services by the Aged," *Progress in Health Services*., April 1959.

[7] Public Health Service, U.S. National Health Survey, *Hospital Discharges and Length of Stay: Short-Stay Hospitals, 1958–60* (Publication No. 584–B32). (In press.)

that these surveys generally omit from their count persons in the hospital on the survey date and those who have died during the year.

Results of the National Health Survey for the 2-year period ending June 1960 show that hospital stays of persons 65 and over discharged alive averaged approximately 15 days, and that there were almost 15 discharges per 100 hospitalized. (Chart 3) For younger persons, the average stay was about half as long as that of older persons and there were only 11 discharges per 100 persons. For every 100 aged persons (whether or not hospitalized) the survey shows a total of 218 days of hospital care—more than 2½ times the average for younger persons. (Table 9)

TABLE 9.—*Hospital Utilization:*[1] *Annual rates in short-stay hospitals by age, July 1958 to June 1960*

[Noninstitutional population of the United States]

Age	Discharges per 100 persons	Average length of stay	Hospital days per 100 persons
65 and over, total	14.6	14.9	217.6
Under 65, total	11.2	7.6	85.0
75 and over	15.4	15.8	243.5
65 to 74	14.1	14.4	204.1
55 to 64	12.2	12.2	148.7
45 to 54	11.1	11.5	128.0
Under 45	9.0	6.3	70.1

[1] Living at time of interview.

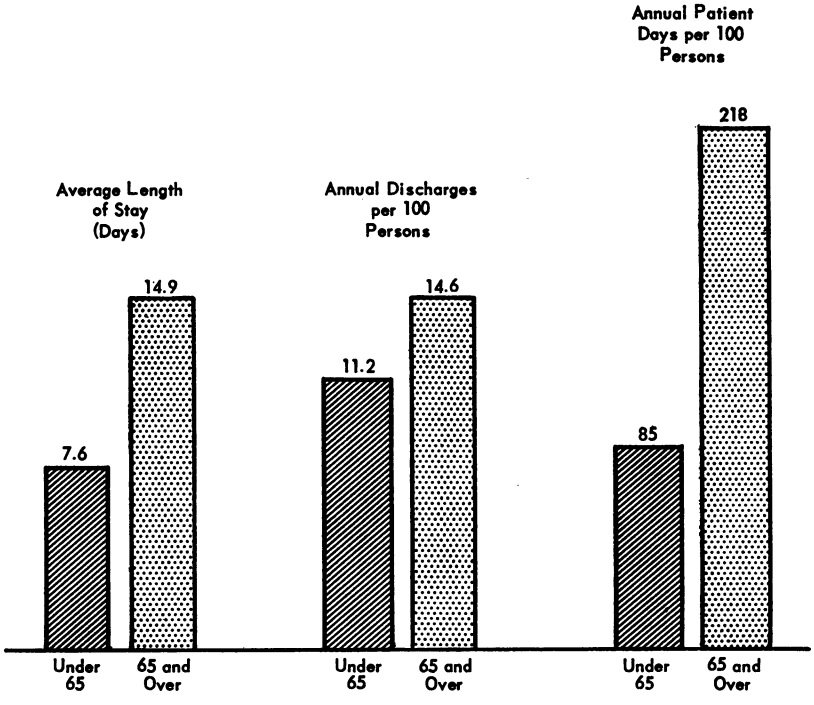
Source: Public Health Service, U.S. National Health Survey, *Hospital Discharges and Length of Stay: Short-Stay Hospitals, 1958-60* (Publication No. 584-B32). (In press.)

The national survey of old-age and survivors insurance beneficiaries aged 65 and over conducted in late 1957 found that an average of 11.1 out of every 100 beneficiaries[8] used 236 days of general hospital care. The average number of days per year per person hospitalized was 21.2 as compared to the 15 days per stay shown by the National Health Survey. The difference is accounted for in part from the fact that the National Health Survey includes aged persons in the labor force, who are less likely than the retired to be hospitalized, and in part from the fact that it is restricted to the noninstitutional population, whereas the beneficiary survey includes time spent in a general hospital by persons who were otherwise in an institution.

Averages do tend to obscure the actual length of time that persons aged 65 and over are in hospitals. For example, 19 percent of the hospitalized stayed from 15 to 30 days per year, and an additional 9 percent stayed more than 31 days, for the two-year period ending June 1960. (Table 10.)

[8] Includes aged beneficiaries and their spouses aged 65 and over.

CHART 3. UTILIZATION RATES IN SHORT-TERM GENERAL HOSPITALS*



*Based on household interviews of persons living at the time of interview.
SOURCE: Public Health Service, U.S. National Health Survey, *1958–60*

TABLE 10.—*Hospital Discharges: Percent distribution of patients discharged annually from short-stay hospitals by age and length of stay, July 1958 to June 1960*

[Noninstitutional population of the United States]

Length of stay	Age	
	65 and over	Under 65
Total	100.0	100.0
1 day	4.1	11.8
2 to 5 days	22.6	49.9
6 to 14 days	44.1	28.9
15 to 30 days	19.4	6.6
31 days or more	8.7	2.6
Unknown	1.1	0.2

Source: Public Health Service, U.S. National Health Survey, *Hospital Discharges and Length of Stay: Short-Stay Hospitals, 1958–60* (Publication No. 584-B32). (In press.)

The beneficiary survey of 1957 reported 21.2 days of care per hospitalized beneficiary, with beneficiaries (and their spouses aged 65 and over) distributed as follows by days in hospital, regardless of the number of hospital episodes within the year:

Days spent in hospital	Percent Hospitalized
Total	100.0
1–30 days	81.9
31–60 days	12.4
61–90 days	3.2
91 days and over	2.5

Factors affecting time spent in general hospitals

Various household surveys have shown that aged men are usually admitted more frequently and stay longer in hospitals than aged women. The National Health Survey reported that aged men are discharged at the rate of 16.5 per 100 persons a year; the discharge rate for women 65 and over is 13.0 per 100 persons. Aged men remain in hospitals an average of 15.9 days or approximately 2 days longer than aged women.

Data from the National Health Survey, based on live discharges, show no discernible relationship between discharge rates and income. However, there is an association between length of stay and income—the lower the family income, the longer the hospital stay. (Table 11) It cannot be assumed, however, that aged persons in the lower income groups (under $4,000) are currently getting all the hospital care they need since a greater portion of them have chronic and disabling illnesses (Table 5).

TABLE 11.—*Hospital Utilization: Annual rates in short-stay hospitals by age and family income, July 1958 to June 1960*

[Noninstitutional population of the United States]

Family income	Discharges per 100 persons		Average length of stay	
	65 and over	Under 65	65 and over	Under 65
Total [1]	14.6	11.2	14.9	7.6
Under $2,000	14.3	10.5	15.7	9.6
$2,000 to $3,999	14.8	11.7	15.0	7.4
$4,000 to $6,999	13.2	11.2	13.6	7.1
$7,000 and over	16.9	10.6	14.6	6.9

[1] Includes a small number not reporting income.

Source: Public Health Service, U.S. National Health Survey, *Hospital Discharges and Length of Stay: Short-Stay Hospitals, 1958–60* (Publication No. 584–B32). (In press.)

Various studies have shown that persons having insurance protecting them against the costs of hospitalization are more likely to enter a hospital than those with no insurance protection. The 1957 OASI beneficiary survey found 14 per 100 aged insured beneficiaries (and their spouses aged 65 and over) had been in a hospital during the year as against 9 per 100 uninsured. However, because the length of stay was often longer for the uninsured patient (17 days for in-

sured; 26 days for noninsured), the total days of care received in the year was almost as much for the uninsured person as among the insured. These data suggest that persons without insurance may tend to postpone entering a hospital until the need is critical and that they then require longer care for recovery.

There is further evidence from the National Health Survey of the association between health insurance and recourse to hospital care. The interim data showed that elderly persons with insurance were hospitalized each year at a rate over 1½ times that for the uninsured. At age 75 and over, the differences in the proportions hospitalized of the insured and uninsured are even greater, as shown below:

Age	Percent of persons 65 and over hospitalized	
	Insured	Not insured
65 and over, total	13.7	8.2
65 to 74	12.9	8.7
75 and over	16.3	7.6

Utilization in last year of life

The National Health Survey data on hospital utilization exclude the 12-month period prior to the household interview of the persons who died in that period. Since the mortality rate of the 65 and over age group is high, household surveys considerably understate the hospital utilization of aged persons.

On the basis of a survey in the Middle Atlantic States, it is estimated that the inclusion of hospitalization received by decedents during the survey year results in increases of one-fourth to one-third in the total volume of hospitalization reported for persons 65 and over. Since the death rate for persons under 65 is substantially lower, the adjustment in hospital utilization for decedents in this age group is estimated to be considerably less than for older persons.[9] On this basis it may be estimated that aged persons are now receiving about 270–285 days of hospital care per 100 persons per year, as contrasted with about 90 days for persons under 65. In similar fashion, the number

[9] Data from the U.S. National Health Survey (*Hospitalization in the Last Year of Life*, Public Health Service Publication No. 584–D3, June 1961) suggest that at the time of the study in 1957, including the experience of persons dying during the survey year would increase by about 40 percent the earlier estimates of days of hospital care used by aged persons, and by about 10 percent the utilization rate for persons under 65, derived solely from the experience of survivors. However, current National Health Survey statistics for hospital utilization of the population alive at time of interview are already higher than heretofore as a consequence of improved collection procedures. Thus the rates obtained from the current National Health Survey data need be increased by a smaller amount to allow for days used by decedents, namely by no more than a fourth to a third in the case of the aged and only about one-sixteenth in the case of the younger population.

of aged persons likely to enter a hospital over the period of a year is estimated at 1 in 6—taking account of the experience of those who will die during the course of the year as well as those who survive, and allowing for those who go to the hospital more than once. As would be expected this 1 in 6 represents a somewhat higher incidence of hospitalization than the number of hospital discharges per 100 persons computed solely on the basis of the experience of aged persons alive at the end of a 12-month period (table 9).

The 1957 survey of OASI beneficiaries also gives some indication of the heavy volume of hospitalization which may characterize a person's last illness. Data for a small number of persons who died leaving a spouse drawing a retired worker's benefit (nonmarried beneficiaries dying during the survey year were not included) show that three times as many had one or both members hospitalized during the year as among those where both partners survived the year.

Nursing homes and other long-stay institutions

In addition to their high rate of utilization of general hospitals, aged persons are the primary users of nursing homes and chronic disease hospitals. A substantial portion of the patients in mental hospitals and tuberculosis sanatoriums are also elderly.

There are very little current data on the characteristics of the patients in these long-term care facilities. A 1953–54 survey of nursing homes in 13 States found the average age of patients was 80 years. One-fifth of the patients were bedfast; more than one-half were disoriented at least part of the time; one-third were incontinent; two-fifths of the patients had a cardiovascular condition which represented the main medical reason for their need for care in the nursing home. Public assistance financed, entirely or in part, the cost of care of one-half of all the patients in these nursing homes.[10]

A 1958 study of 530 residents of five Jewish homes for the aged which provide nursing-home type care found that half of the persons in the homes were 80 years of age or over and widows constituted the largest group.[11] A 1957 study of nursing home facilities in Michigan found that the average age was 76 years and that 63 percent of all patients in these facilities were 75 years of age or over.[12] A 1953–54 Public Health Service Survey of chronic disease hospitals in five States found that the patients' average age was 70 years, or 10 years younger than nursing home patients.[13]

[10] Public Health Service, *Nursing Homes, Their Patients and Their Care* (Public Health Monograph No. 46), 1957.
[11] Goldmann, Franz, *"Residents of Homes for the Aged: Their Health Conditions and Needs,"* 1959.
[12] Winter, Kenton E., *Michigan Nursing Facilities and Their Patients: A source book of State and County Data*, 1960.
[13] Public Health Service, *Nursing Homes, Their Patients and Their Care* (Public Health Monograph No. 46), 1957.

Aged persons in mental and tuberculosis hospitals also represent a substantial portion of the total patients. The National Institute of Mental Health reports that one in every three beds in public mental hospitals is occupied by a person 65 or older and that one-fourth of the patients admitted for the first time to such hospitals are aged 65 and over. Of this group, more than half (55 percent) were 75 or over.[14] The Public Health Service estimates that 20 percent of all patients in tuberculosis hospitals are aged 65 and over.

The 1957 survey of OASI beneficiaries found that there was one beneficiary aged 65 and over receiving care in a long-stay institution for every five beneficiaries (and their spouses aged 65 and over) in a general hospital. However, the aggregate number of days was close to two days in a long-stay institution for every one day in a general hospital. (Table 12.)

TABLE 12.—*Utilization of Long-Stay Institutions: Annual rates for aged OASI beneficiaries by type of institution, 1957*

Type of institution	Per 1,000 beneficiaries [1]		Average length of stay in days
	Number in institutions	Aggregate days	
Total	23.1	4,482	194
Nursing homes	13.2	2,759	209
Mental institutions	3.5	972	277
Tuberculosis sanatoriums	3.2	526	164
Other	3.2	225	70

[1] Includes aged beneficiaries and their spouses aged 65 and over.

Source: "Aged Beneficiaries of Old-Age and Survivors Insurance: Highlights on Health Insurance and Hospital Utilization, 1957 Survey," *Social Security Bulletin*, December 1958.

Another source of current data on the utilization of long-term care facilities by elderly persons is the volume of patient care as reported by the American Hospital Association for long-term hospitals and estimates based on Hill-Burton State Plan data for nursing home beds, which report 326,000 beds in nursing homes as of January 1, 1961.[15] Assuming that 85 to 95 percent of the nursing home beds were occupied by aged persons and assuming further an 80 to 85 percent occupancy rate, it may be estimated that nursing homes are annually providing between 480 and 580 days of care per 100 persons aged 65 and over. The nursing homes listed in the State Plans are those classified by the States as providing skilled care. In practice, there may be variations among the States so that the number reported may actually include some homes which are providing mainly custodial care.

[14] Elias S. Cohen, *Mental Illness Among Older Americans*, prepared for the U.S. Senate, Special Commitee on Aging (Committee Print, 87th Cong., 1st sess.), Sept. 8, 1961.

[15] Division of Hospital and Medical Facilities, Public Health Service, *Hospital and Medical Facilities in the United States as of January 1, 1961.*

The American Hospital Association reports an average daily census of 618,057 [16] in civilian long-term hospitals. Assuming, on the basis of various studies, that aged persons constitute one-third of the patients in mental hospitals, one-fifth of those in tuberculosis hospitals and approximately half in the remaining long-term hospitals, it estimated that these facilities are annually providing 450 days of care per 100 aged persons. Thus, it estimated that all long-term institutions are annually providing between 930 and 1,030 days of care per 100 aged persons—a considerably greater volume of care than that given to aged in short-term general hospitals.

Nursing services

Specific data are not available on the volume of special nursing care in the hospital or home received by aged persons in comparison with those of younger ages. The National Health Survey provides data on personal care in the home, but excludes all of the nursing services provided in hospital, nursing homes, and other institutions for the care of the sick, handicapped or aged persons in the population. However, on the basis of the data previously cited on the high rate of utilization of hospitals, nursing homes and other long-stay institutions by older persons, it may be concluded that the per capita amount of nursing services is much greater for older persons than for those of younger ages.

Data from the National Health Survey on the volume of personal care in the home show that the proportion of elderly people under constant or part-time care at home is far greater than among the rest of the population. Persons 65 and over are 15 times as apt to receive personal care at home than younger persons. These include persons who require constant or part-time help or nursing care for eating, dressing or toilet activities. As would be expected, the amount of constant or part-time care given at home increases substantially with age. Thus, the rate for persons 75 and over is 4 times that of persons 65 to 74 years of age (Table 13).

The National Health Survey data also show that care is provided by a nurse in 12 percent of the cases of persons receiving constant care at home and in 4 percent of the cases receiving part-time care. The available data do not show whether the situation varies markedly by age, but suggest that the aged receive far more nursing care at home than do younger people.

Further evidence of the volume of care at home required by aged persons is afforded by the 1957 survey of aged persons conducted by the National Opinion Research Center. This survey reported 74 per

[16] *Hospitals* (American Hospital Association), Guide Issue, August 1, 1961.

TABLE 13.—*Persons Receiving Care at Home: Rates per 1,000 population by age and type of care, July 1958 to June 1959*

[Noninstitutional population of the United States]

Age	Rates per 1,000 population		
	Total	Constant	Part time
65 and over, total	44.3	24.8	19.5
Under 65, total	3.0	1.8	1.2
75 and over	87.7	52.7	35.0
65 to 74	21.9	10.4	11.5
55 to 64	9.6	5.9	3.7
45 to 54	4.0	2.2	1.8
Under 45	2.0	1.2	0.8

Source: Public Health Service, U.S. National Health Survey, *Persons Receiving Care at Home, United States, July 1958–June 1959* (Publication No. 584–B28), October 1961.

1,000 aged persons had personal care at home with 80 percent provided by a relative.[17]

Drugs

Many elderly people having chronic illnesses are constantly in need of one or more drugs. The volume of drugs used by the aged may be measured by expenditures for this purpose. Average annual expenditures of aged persons for medicines (prescribed and unprescribed) are well over twice those of the entire population (Table 14).

TABLE 14.—*Drug Expenditures: Amount by private individuals, by age, 12-month period, 1957–58*

Age	Amount
Total	$19
0 to 5	14
6 to 17	9
18 to 34	13
35 to 54	22
55 to 64	31
65 and over	42

Source: Health Information Foundation, *Family Expenditure Patterns for Personal Services, 1953 and 1958* (Research Series, No. 14), p. 14.

Dental care

Dental care is the one health service of which the aged have less than the rest of the population. Data from the National Health Survey show that persons over 65 average 0.8 dental visits per capita per year compared with 1.5 for the entire population. There are 0.5 visits for aged persons in families of under $2,000 income compared with 1.1 in families of over $7,000 income, but in each income group the aged have fewer dental visits than those of younger ages.

[17] Health Information Foundation, "Use of Health Services by the Aged," *Progress in Health*, April 1959.

CHAPTER 4. HEALTH EXPENDITURES

Another measure of the medical needs of the aged is how much it costs to provide the care they receive. Expenditures by private individuals indicate the direct impact upon the aged themselves—or on the relatives and other persons who help assume some of the responsibility for payment. It is possible also to take cognizance of the care provided at public expense to those who cannot afford to pay. There then still remain some further costs not accounted for—namely, the value of services provided by doctors and other individuals at free or reduced rates as their personal recognition of a special problem.

Older persons not only spend more on medical care than younger persons, but these expenditures represent a larger share of their family's money income. The lower income of retired families is only partially offset by lessened needs of the aged for some items such as food, clothing, and transportation. Their outlays for medical care, on the other hand, average higher and would be higher still if they got all the care they needed and were themselves to pay for all they received.

Total medical costs

Combined public and private expenditures for medical care for aged persons in 1960 are estimated at about $5 billion, out of a total of $24.5 billion for medical care for the entire population. Thus approximately 1 dollar out of every 5 of the Nation's bill for personal medical care services is currently going for the care of someone age 65 or older, whereas only 1 person in 11 falls in this age group. Like other low-income groups the aged receive some of their care at public expense. Of the public funds expended for civilian patient care probably close to $1½ out of every $5 today goes to pay for an aged patient.[18]

The major portion of the aggregate outlay for personal health services for persons 65 and over represents expenditures by private individuals. In 1960, 72 percent of the total was spent by aged persons themselves or by relatives or friends on their behalf. More than

[18] See Appendix C; and Merriam, Ida C., "Social Welfare Expenditures, 1959–60," Social Security Bulletin, November 1961.

one-fourth of the expenditures were made by public agencies. A very small share of the total represented care provided by philanthropic agencies. The latter proportion would be larger if it included the value of services provided without charge to the aged by private physicians. The estimated aggregates for 1960 are as follows:

Source of funds	*Total (millions)*
Total	$5,045
Private persons	3,615
Public agencies	1,330
Private philanthropy	100

Leaving aside care provided out of the public purse, average private expenditures for medical care (counting costs met by insurance as well as bills paid directly by individuals) are at least twice as much for a person 65 or more as for one younger—e.g., $177 vs. $86 in 1957–58, according to the Health Information Foundation. These calculations take no account of the heavy costs of terminal illness for persons who were living alone at time of death—an omission of particular significance for the aged. If allowance is made for the costs incurred in their last illness by persons living apart from relatives, as well as for payments by individuals for medical care of inmates of nursing homes and other institutions, private medical expenditures probably would have averaged $187 per person in 1957–58 rather than the $177 shown in table 15.

TABLE 15.—*Per Capita Medical Expenditures: Amount by private individuals by age and type of service, 12-month period, 1957–58*

Type of service	Per person 65 and over		Per person under 65	
	Amount	Percent	Amount	Percent
Total [1]	$177	100	$86	100
Physicians	55	31	29	34
Hospitals	49	28	19	22
Drugs	42	24	18	21
Dentists	10	6	14	16
Other [2]	21	12	6	7

[1] Excludes expenditure for nursing home care.
[2] Special nurses in hospital or at home, optometrists and other health personnel, eyeglasses and other appliances, ambulance fees, nonhospital diagnostic procedures.

Source: Health Information Foundation, *Family Expenditure Patterns for Personal Health Services, 1953 and 1958* (Research Series, No. 14).

Not only is the expenditure for the older person's care greater than for a younger person but it differs also in the way it is distributed among the various types of service. In line with the utilization data presented earlier, the one item for which the older person spends less on an annual basis is dental care. His higher expenditures for doctor and hospital care and drugs, however, far outweigh his lower dental

costs. It is much more common, too, for older persons to have an "unusual" year in the sense of above-average expenses.

According to the Health Information Foundation the proportion of individuals in each age group who experienced "gross expenditures" of $200 or more for health services in a 12-month period in 1957–58 was as follows:

	Percent
All ages	13
0–17	5
18–54	15
55–64	17
65 and over	22

"Gross expenditures" as used here do not include the costs of free care. They cannot indicate how many aged persons not reporting as much as $200 in actual expenditures may have received at least that amount of care as gift or charity, or did not apply for what they could not afford.

Medical costs and income

Studies over the years have shown consistently that the amount of medical care (measured in dollar costs) a family obtains is influenced by the size of its income, and that the low-income family—though it spends less than one with high income—nevertheless assigns more of its current funds for the purpose. Older families, of course, are subject to the double jeopardy of low income and high medical need. With the large majority of the aged having little better than $1 in disposable income per person for every $2 in a younger family of the same size, it is obvious that their higher medical needs—needs which becomes increasingly greater with advancing age—can take a heavy toll of their meager resources, the more so because like other low-income families they often are without the benefit of health insurance to help foot the bill.

Thus moving from gross health expenditures, which include those financed in any part by insurance, to only those the family pays directly, a U.S. Department of Agriculture survey in 1955 for farm families reported on medical expenditures relative to the family's economic position. The fifth of the farm families headed by an operator 65 years of age or older had lower total income than the younger farm families. The older families, however, consistently spent more per person for their medical care than the younger families. The expenses incurred during the year—over and above any defrayed by health insurance—for physicians, dentists, surgeons, hospital care or medical insurance premiums (items accounting for two-thirds of the total medical care dollar of a farm-operator family) represented 13

percent of the net family income for families with a head age 65 or older, compared with 9 percent for all other families. With two-thirds of the aged farm families having net cash income less than $2,000, this level of spending can cut deep into the resources available for the other things which all families must buy, even when some of their food and housing is farm-furnished. The average aged farm-family with net cash for the year of less than $1,000 spent as much as 20 percent of its income for the medical services listed.[19]

The Health Information Foundation reported families with income under $2,000, many of whom are the aged, having out-of-pocket expenses for health services in 1957–58 (including health insurance premiums) amounting to 13 percent of their total income for the year. For families at all ages and all income levels the out-of-pocket cost came to no more than 5½ percent of aggregate income. Among families at all income levels with an aged head, one in six used at least 20 percent of money income for the year for health care, whereas only one in twenty families with head under 65 used so much income for this purpose (table 16).

TABLE 16.—*Out-of-Pocket Medical Costs:*[1] *Distribution of families by percent of income spent, 1957–58*

[In percent]

Percent of family income[2]	Family head 65 and over	Family head under 65
All families	100	100
No outlay	6	1
Under 5 percent	38	55
5 to 9 percent	20	27
10 to 19 percent	20	12
20 to 49 percent	12	4
50 percent or more	4	1
Aggregate outlay as percent of aggregate family income	7	5

[1] The family's actual cash outlay during the 12-month survey year for personal health services and the voluntary prepayment for such services. Includes medical bills as yet unpaid, that were incurred during the survey year.

[2] Gross family income (i.e., before deduction for taxes) from business, profession, or farm, from wages and salaries, and from all other sources such as interest, rents, and pensions. Excluded are income in goods and services, the value of free rent, and other noncash benefits.

Source: Health Information Foundation, National Opinion Research Center, unpublished data.

A study of hospital and medical expenses of Michigan residents in 1958 found aged families with less than $3,000 income—a group including nearly 3 out of 4 of all aged families in the sample—averaging out-of-pocket expenses of $242, about one-seventh of their average income of $1,700. The families incurred a sizeable amount of expense in addition, for which a welfare or other agency paid, raising the gross medical expense to the equivalent of nearly one-fifth of family

[19] Cowhig, J. D. and Stewart, E. O., "The Older Farm Family and Medical Costs," *Agricultural Information Bulletin* (Department of Agriculture) No. 235, December 1960, pp. 4–5.

income. By contrast the Michigan families headed by a person under 65 averaged medical costs representing only 5 percent of income for the medical bills they paid themselves, or 6 percent if costs paid by others are included.

Hospital costs

The large bills which come without much warning and must be paid all at once make a hospitalized illness the kind of emergency for which it is difficult to budget. Other medical costs also tend to be much larger when there is a period of hospitalization or nursing home care. For the aged person, who uses about three times as much hospital care a year, on the average, as the younger person, the spectre of heavy expenses attendant on hospitalization looms particularly large. Not only are the odds greater that he will enter a hospital, but when he does he is likely to be faced with a bigger bill than is common for the younger patient.

The average gross medical expenditure for an aged person in 1957–58 included $49 for hospital care, 28 cents out of every dollar spent for medical care. For persons under 65, hospital costs claimed 22 cents out of every dollar spent. The larger share of the older person's outlay going for hospital care is a particular burden because no more than half the aged have any insurance covering hospital bills, compared with about 7 out of 10 persons under 65. (These gross expenditure figures include costs met out of health insurance but not the costs of care coming out of public funds.)

As a measure of individual need, expenditures averaged over the total population have their limitations. This is particularly true for hospital care: The overall average greatly understates the burden of cost when the need does arise. As opposed to the average private expenditure for hospital care per person of only $49 for a 12-month period, aged persons who actually went to a hospital had total costs of $352—more than twice the bill for patients of all ages combined. On top of this a hospital admission for an aged person entailed an additional doctor's fee of $101 for inhospital care or a surgeon's fee of $160, rather than the average per person payment of $55 for all physicians' services in the year—in or out of hospital—as shown in table 15.

Similarly, elderly patients in Michigan general hospitals in 1958 ran up bills averaging about $400—counting all hospital charges regardless of who footed the bill, an individual or a welfare agency. For some conditions common to the elderly the costs were much higher. For example, hospitalization for fractures of the hip, to which aged persons are prone, resulted in an average bill of about $700 (table 17). For patients under 65 (other than newborn infants)

TABLE 17.—*Hospital Charges for Selected Diagnosis Categories: Average per patient by age, Michigan hospitals,*[1] *1958*

Diagnostic categories	Age of patient		
	Under 65	65 to 69	70 and over
All categories (excludes newborns)	$217	$404	$396
10 most frequent diagnostic categories:			
Diseases of circulatory system	276	339	398
Nervous system and sense organs	252	315	460
Malignant neoplasms	585	602	505
Diseases of digestive system	292	523	342
Accidents, etc	196	199	329
Diseases of genito-urinary system	217	607	383
Acute myocardial infarction	653	556	411
Fracture of neck of femur	764	840	671
Bones and organs of movement	275	388	284
Diabetes mellitus	374	376	334

[1] All types of hospitals combined: total charges include those footed by public or private welfare agencies as well as costs met out of insurance benefits or paid directly by private individuals.

Source: *Basic Facts on the Health and Economic Status of Older Americans: A staff report to the Special Committee on Aging*, U.S. Senate (Committee Print, 87th Cong., 1st sess.) June 2, 1961, p. 8.

the average bill was little more than half that of the aged person. The longer stay of the latter would be expected to result in higher total costs for the hospital room. In addition his laboratory, drug, and other ancillary costs are also greater than the younger patient's, as the figures in table 18 illustrate.

Information on the impact of hospital costs on aged persons is available also from the 1957 survey of OASI beneficiaries. Although limited to persons receiving OASI benefits, in several respects the data are more complete than those of other studies cited. First, they obtained detail not only on general hospitals, but on episodes in chronic-care institutions and nursing homes as well. Furthermore, they make it possible to study the total medical costs—including those not directly associated with the hospitalization. And finally they have been analyzed for married couples separately from other aged beneficiaries, an analysis particularly meaningful in considering

TABLE 18.—*Charges for Hospital Services: Average per patient by age, Michigan hospitals, 1958*

Selected hospital services	Age of patient	
	65 and over	Under 65
Total hospital bill [1]	$399	$217
Accommodation charges	228	117
Ancillary services	171	100
Laboratory	38	22
Drugs, dressings, supplies, oxygen	69	35
X-ray	23	12
EKG and BMR	6	2
Other	35	29

[1] All types of hospitals combined.

Source: *Basic Facts on the Health and Economic Status of Older Americans: A staff Report to the Special Committee on Aging*, U.S. Senate (Committee Print, 87th Cong., 1st sess.), June 2, 1961, p. 8.

ability to pay. It is the combined resources of husband and wife that will be tapped in the event either becomes ill.

Among married couples,[20] every fifth had one or both spouses in a hospital sometime during the survey year and just about one in seven of the nonmarried beneficiaries were in a hospital also. Almost all the married patients (96 percent) were in a general hospital (including short-stay special hospitals), but about 1 out of 5 of the nonmarried beneficiaries reported as hospitalized were treated in a chronic-care institution or nursing home.

Roughly a fourth of the hospitalized beneficiaries could not report in detail cost of their hospital care, because they did not know how much had been paid by others, they had not yet received the bill, or they knew only the combined total for hospital and doctor. As used here, costs include all incurred expenses regardless of how or by whom they were paid. About half of those not reporting costs had been treated in a public hospital where presumably limited ability to pay was a factor in admission. Of those who did report costs, half the couples with a general hospital stay incurred hospital charges of $250 or more, and half the nonmarried had charges of at least $200 (Appendix A, table 11). The average cost however, was much higher—a total of $430 per couple and $360 per nonmarried beneficiary.

Impact of hospitalization on total medical costs

Although 1 in 6 aged persons enters a hospital during a given year (counting those who died during the year), all must be prepared for the eventuality. It has been estimated that 9 out of 10 persons who reach age 65 will be in a hospital at least once in their remaining lifetime, and as many as 2 out of 3 will be in more than once. No one can foretell just when his turn will come, but all the evidence indicates that the year it does will find him experiencing considerably higher total medical costs than before. Thus, among OASI beneficiary couples with neither member hospitalized in 1957, median total medical costs for the year were $150 (excluding those unable to report costs). For couples having one or both members hospitalized in either a short or long-stay hospital median total medical costs for the year were $700—nearly 5 times as high. Corresponding median costs for the year for nonmarried beneficiaries were $600 for those with a hospital illness ($500 if only general hospitals are considered) and $80 for those without.

[20] As used here and throughout this report, the survey data for married couples apply to aged beneficiaries and their spouses, whether or not entitled to benefits. In some instances the spouses were under age 65.

Of the beneficiaries hospitalized in a general hospital and able to report all their costs, 1 out of 3 couples and 1 out of 5 nonmarried beneficiaries incurred at least $1,000 in total medical bills during the year (Appendix A, table 12). The average total medical bill for the year for those with a general hospital stay amounted to $960 for the couples, and $735 for the nonmarried. The hospital care costs alone represented about 45 percent and 49 percent, respectively, of these total costs for the year. If medical costs could be computed for all beneficiaries with a hospital illness, including those who did not pay their own way, the hospital expense might represent an even larger share of the year's total medical costs because hospital care is probably obtained free or at reduced rates more often than out-of-hospital services.

A beneficiary in a hospital sometime during the year was likely to find the hospital costs alone came to more than twice the medical costs of all kinds for the whole year by a beneficiary with no hospitalized illness, as the following figures illustrate:[21]

	Average medical costs incurred in 1957	
	Total	Hospital costs
Couples:		
One or both in general hospital	$960	$430
Neither in general hospital	195	----
Nonmarried beneficiaries:		
In general hospital	735	360
Not in general hospital	115	----

With the general climb in prices of medical care items since 1957, particularly marked in the case of hospital accommodations, aged persons having a hospital illness would face costs totaling considerably higher today. For instance, half the beneficiary couples with either or both members in a hospital at today's prices would be likely to incur total medical bills for the year of at least $825 rather than the $700 which represented median incurred costs under similar conditions in 1957. Total medical bills for the year at December 1961 prices would average about $1,160, of which hospital costs alone would represent 49 percent as opposed to the 45 percent of 4 years earlier.

[21] Based on those able to report costs. Hospitalization here implies a stay in a general hospital—including short-stay special hospitals. A small number of beneficiaries, mostly nonmarried, who spent no time in a general hospital but did have a stay in chronic-care institutions are excluded entirely. Adding in their costs would raise the average total costs for the year for beneficiaries not in a general hospital from $195 to $205 for the couples and from $115 to $145 for the nonmarried.

Limitations of expenditure data as a measure of need

Because of the difficulties of determining the dollar value of care for which they do not themselves pay, expenditures for medical care computed solely on the basis of reports by private individuals—as in the beneficiary survey or the HIF series—cannot measure the full impact of medical need: They leave out the experience of those who cannot themselves assume financial responsibility for their care because resources are inadequate or the need too great, as well as some cases where the individual does not feel it necessary to keep track of costs met by prepayment. They also give little indication of the share of the burden assumed by others—the adult children or other relatives, the community at large, or the paying patients whose charges may be greater because of others who do not pay their way.

Data for the aged, with their high mortality rates, are affected in addition by the omission of costs incurred in the last year of life by persons living apart from relatives at the time of death. The extent of utilization of hospitals in terminal illness was discussed in Chapter 3. The heavy cost of terminal illness is illustrated by data for a small group of OASI beneficiaries whose spouse had died during the 1957 survey year. The total medical expenses for the beneficiary and deceased spouse were more than twice those for other couples.

PART II

Individual Resources for Meeting Health Needs

CHAPTER 5. RESOURCES AND BUDGET NEEDS

While persons 65 and over have medical costs at least twice as large as younger persons, they have, on the average, only about half as much income. This discrepancy is not offset to any great extent by differences in needs for other goods and services. To be sure, aged persons are more likely than the younger persons to own a mortgage-free home and other assets, but relatively few, particularly among those with the lowest income, have enough cash savings or assets to finance a major illness.

Money income

Income and retirement.—Retirement from employment usually brings a sharp drop in income. For example, in 1960 aged men who did not work at all had only a third as much income as aged men with full-time jobs all year, and less than half as much as those who had full-time jobs during part of the year. Looked at in another way, those who had no earnings had on an average not much more than half as much as the men who did have earnings as well as other income. (Table 19)

Although women look to their husbands for some or all of their support, more than three-fifths of the women past 65 years of age must depend on themselves or on benefit rights earned by their deceased husbands. In 1960, nearly a fourth of all older women reported no cash income while the remaining ones had a median income of only $820, in some cases supplementing their husband's income and in other cases the income was the sole source of their support. As in the case of men, the large number of women who reported no earnings from employment had roughly half as much income as the small number who did have some earnings.

As would be expected, the association of income and extent of employment reflects itself in the income of families. In 1960, of the families with head 65 or older, a third reported no earnings and had

TABLE 19.—*Money Income of Men Aged 65 and Over: Annual amount and percent distribution by work experience and source of income, 1960*

[Noninstitutional population of the United States]

Characteristic	Percentage distribution	Percent with income	Income recipients		
			Median income	Percent with—	
				$1 to $1,499 or less	$4,000 and over
Total	100.0	96.4	$1,698	45.1	17.2
Work experience: [1]					
Did not work in 1960	56.8	94.7	1,363	57.2	5.1
Worked during 1960—					
At part-time jobs:					
49 weeks or less	9.8	99.6	1,560	48.3	9.1
50 to 52 weeks	6.7	99.1	1,779	43.9	17.1
At full-time jobs:					
49 weeks or less	9.7	99.0	2,930	20.8	34.1
50 to 52 weeks	16.8	97.6	4,115	18.5	51.0
Source of income: [1]					
No income	3.6				
Nonearned income only	53.1	100.0	1,324	59.7	4.3
Some earnings—					
And other income	33.4	100.0	2,482	27.4	29.5
No other income	9.9	100.0	3,604	26.8	46.0

[1] The data on income by source and by work experience differ slightly because the former were obtained in March 1961 and the latter in February 1961. Not all reports on income could be matched with those on work experience.

Source: Bureau of the Census, *Current Population Reports; Consumer Income*, Series P-60, No. 37, "Income of Families and Persons in the United States: 1960," January 17, 1962.

a median income of only $1,920. Only 10 percent of the families reported all their income from earnings, and they averaged $4,570 for the year (Appendix A, Table 6).

For aged persons living apart from relatives (23 percent of the aged population), three-fourths reported no earnings and had about half as much income as those with earnings.

Since most persons 65 and over have no earned income, and public maintenance programs are limited in what they pay, it is not surprising that most older persons must get along on relatively low incomes. Counted as individuals, more than half (53 percent of those not in institutions) had less than $1,000 in 1960 and 3 in every 4 had less than $2,000. (Appendix A, Table 7.) How "low" this is depends on the need for income and also how it compares in amount with the income of others in the population.

Income and family situation.—For 2-person families, which represent nearly three-fourths of all older families, the median income in 1960 was less than half as large when the family head was aged 65 or over—$2,530—as when he was under age 65—$5,314 (Table 20 and Appendix A, Table 8).

For persons living alone or lodging with nonrelatives, the economic disadvantage of the aged is even more marked (Table 21). This is because only about one-fourth of the former, as compared with more than five-sixths of younger persons in a similar situation had any earnings in 1960.

TABLE 20.—*Money Income of Families: Annual amount and percent distribution by amount of income, age of family head, and size of family, 1960*

[Noninstitutional population of the United States]

Income and age of family head	All families [1]	Families containing—			
		2 persons	3 persons	4 persons	5 or more persons
Median money income of family:					
Head 65 and over	$2,897	$2,530	$4,122	$6,100	$5,727
Head under 65	5,905	5,314	5,930	6,300	6,074
Percent of families with income of—					
Under $2,000:					
Head 65 and over	31.4	35.7	20.3	17.6	17.9
Head under 65	10.2	16.0	9.0	6.5	8.9
$7,000 and over:					
Head 65 and over	16.4	11.5	23.5	41.4	37.9
Head under 65	37.1	31.1	37.8	41.0	38.8
Percentage distribution by size:					
Head 65 and over	100.0	72.9	16.4	5.1	5.6
Head under 65	100.0	26.4	21.6	22.9	29.1

[1] Mean sizes: 65 and over, 2.5 persons; under 65, 3.9 persons.

Source: Bureau of the Census, *Current Population Reports: Consumer Income*, Series P-60, No. 37, "Income of Families and Persons in the United States: 1960," January 17, 1962.

The very large disparity in income for 2-person families doubtless reflects the relatively large proportion of older 2-person families in which neither member worked during 1960. Three-person families, often including an adult child living at home, are more likely to have at least one regularly employed member. Their median income was only about 30 percent less than that of younger families. For even larger families, which are very few in number, there was no significant difference in the average income, presumably because many of these families with an aged head contained several adults, including younger ones, in the productive ages. Regardless of the size of family, the proportion with less than $2,000 in 1960 was at least twice as large when the family head was over 65 as when he was younger (Chart 4).

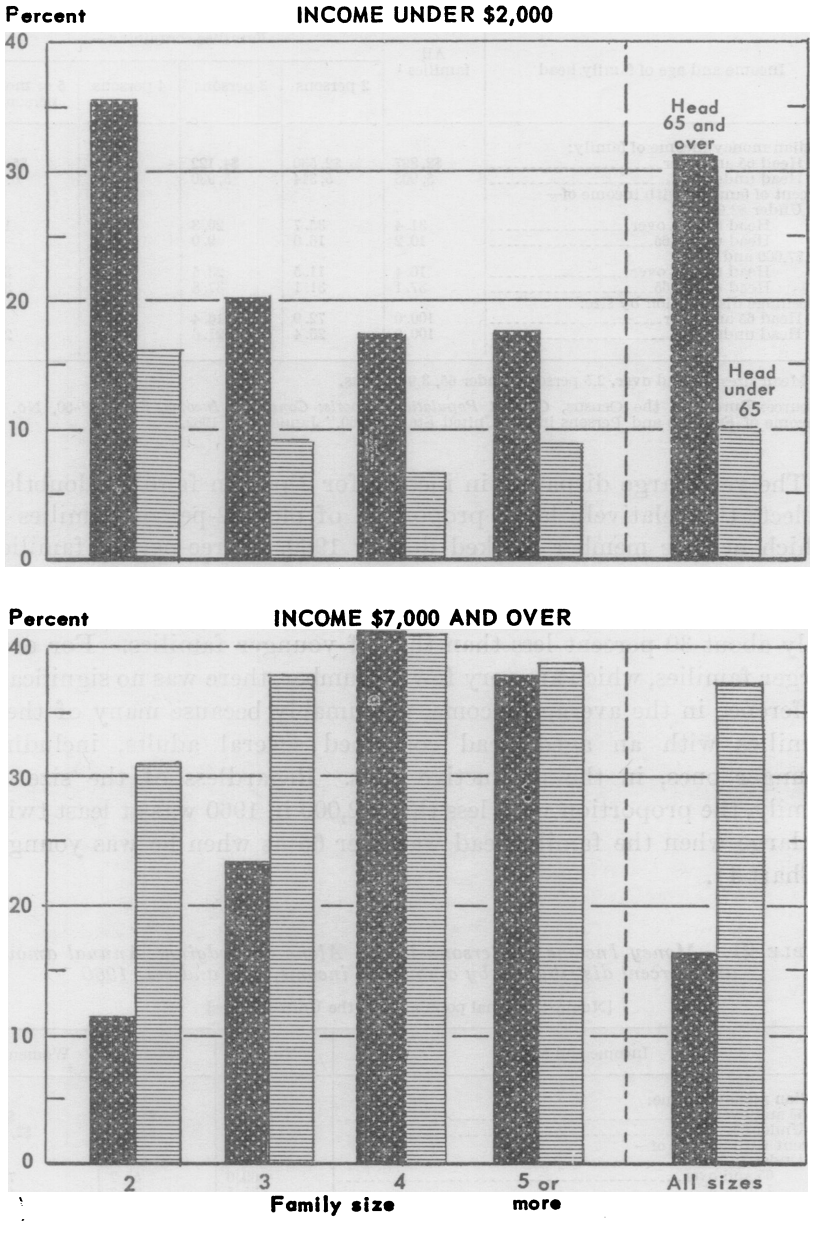
TABLE 21.—*Money Income of Persons Living Alone or Lodging: Annual amount and percent distribution by amount of income, age, and sex, 1960*

[Noninstitutional population of the United States]

Income and age	Total	Men	Women
Median money income:			
65 and over	$1,053	$1,313	$960
Under 65	$2,571	$3,371	$2,152
Percent with income of—			
Under $1,500:			
65 and over	69.0	59.2	72.9
Under 65	35.5	28.7	40.9
$4,000 and over:			
65 and over	6.4	9.8	5.0
Under 65	31.4	42.7	22.7
Percent distribution by sex:			
65 and over	100.0	27.5	72.5
Under 65	100.0	44.0	56.0

Source: Bureau of the Census, *Current Population Reports: Consumer Income*, Series P-60, No. 37, "Income of Families and Persons in the United States: 1960," January 17, 1962, and related unpublished data.

CHART 4. MONEY INCOME OF FAMILIES, BY FAMILY SIZE, BY AGE OF HEAD, 1960



SOURCE: Bureau of the Census

In assessing income figures, allowance must be made for the fact that some types of income, such as realized capital gains and lump-sum insurance payments, are not included in the income definition used in the survey. The Bureau of the Census report calls attention also to the fact that understatements of income in field surveys tend to be more serious for nonearned than for earned income. It concludes, however, that even after allowance for these factors, available evidence suggests that a substantial proportion of older nonearner families still had incomes totaling less than $2,000 in 1960.[22]

Aged persons living in the homes of relatives (who "disappear" in any analysis of family income) typically have little or no income of their own. In 1960 more than half the aged men and four-fifths of the aged women in this situation had less than $1,000 cash income. Two-fifths of these older persons were living in the home of married couples, usually their married children likely to have dependent children also. A special analysis for March 1959 shows that of the aged persons who lived in the home of relatives and who had less than $1,000 income of their own in 1958, about one-third were members of families whose total money income was below $3,000. Half were in families with less than $5,000.

Other financial resources

Older persons are somewhat more likely than younger persons to have some savings, but in general those with the smallest incomes are the least likely to have other resources to fall back on. Moreover, most of the savings of the aged are tied up in their homes or in life insurance, rather than in a form readily convertible to cash.

According to the 1960 Survey of Consumer Finances, almost as many "spending units" [23] with head 65 and over had less than $200 in liquid assets, bank accounts or savings bonds, as those who had $2,000 or more (Table 22). Moreover, their liquid assets position was not strikingly better than that of spending units with younger heads, at least than those with heads 35–64. The relative number with no assets or less than $200 was about the same, at all ages; the number with $5,000 or more was progressively larger the older the unit. But fewer than one-fourth had as much as $5,000 even in the case of those 65 and over.

---

[22] U.S. Bureau of the Census, *Current Population Reports: Consumer Income*, Series P–60, No. 37, "Income of Families and Persons in the United States: 1960," January 17, 1962, p. 11.

[23] A spending unit is defined to consist of related persons who pool their incomes. Married couples and their children under 18 are always considered members of one spending unit. Other related persons are separate spending units if they earn more than $15 per week and do not pool their income. Persons 65 and over living with and dependent on relatives (whose situation is not reflected by these data) almost certainly have fewer assets than the financially independent spending units with head aged 65 and over.

TABLE 22.—*Value of Liquid Assets: Distribution of spending units by size of holdings and age of head, early 1960*

[Noninstitutional population of the United States]

Value of liquid assets	Age of head			
	65 and over	45 to 64	35 to 44	Under 35
Total	100	100	100	100
Do not own	30	22	20	26
Own:				
$1 to $199	6	11	18	54
$200 to $999	14	22	26	
$1,000 to $1,999	10	13	14	17
$2,000 to $4,999	18	15	12	
$5,000 and over	22	17	10	2
Median value:				
All spending units	$1,000	$800	$700	$400
Holders only	$3,000	$1,100	$900	$700

Source: University of Michigan, Institute for Social Research, Research Center, *1960 Survey of Consumer Finances*, 1961.

It is noteworthy, also, that, in a special study of low-income families, about two-thirds of the older spending units who reported less than $500 liquid assets, had not had $500 within the previous 5 years.[24]

Relatively few of the aged hold any marketable securities (Appendix A, Table 9), and those who do usually are the ones who have other liquid assets also. Only one in seven of the aged spending units reported owning corporate stock in 1960. Three years earlier, when this question was last studied for the Federal Reserve Board, only one in nine had corporate stocks or bonds and virtually all of these stockholders were among the group that had over $2,000 in other liquid assets. About one in five in 1960 reported some real estate other than their own dwelling, but it appears from other sources that not infrequently this was a rental unit in their home, which therefore could not easily be converted to cash.

Having savings, as might be expected, is related to income. The 1959 Survey of Consumer Finances, conducted for the Federal Reserve Board, found that among spending units with head 65 and over:

When income was less than $3,000 (70 percent of the total)
- 47 percent had less than $200 in liquid assets, and
- 44 percent had liquid assets of $500 or more

When income was $3,000 to $5,000
- 21 percent had less than $200 in liquid assets, and
- 70 percent had liquid assets of $500 or more

Relatively few of the aged, according to the 1960 Survey of Consumer Finances, have more than one type of asset other than equity in a home. The distribution by number and pattern of their holdings for spending units with head 65 and over is shown in Table 23.

[24] Morgan, James, and David, Martin, "The Aged and Their Economic Position—Some Highlights of a Survey Taken Early in 1960," in *Retirement Income of the Aging, Hearings before the Special Committee on Aging*, U.S. Senate, (87th Cong., 1st sess.), 1961, Appendix IV.

TABLE 23.—*Pattern of Asset Holdings: Distribution of spending units by age of spending unit head and number and type of holding, early 1960*

Number and type of holding	Age of head			
	65 and over	45 to 64	35 to 44	Under 35
Total	100	100	100	100
None	13	11	13	20
1 only	30	25	23	44
Liquid assets	15	15	17	37
Equity in home or farm	13	9	5	5
1 other	1	1	1	1
2 only	34	36	39	25
Liquid assets and equity	26	29	32	17
2 others	8	7	7	8
3 only	19	21	20	8
Liquid assets, equity and stock	7	8	8	2
Liquid assets, equity and other real estate	11	9	7	3
3 others	1	4	5	3
4 or 5	4	7	5	3

Source: University of Michigan, Institute for Social Research, Survey Research Center, *1960 Survey of Consumer Finances*, 1961.

Reports on the value of the various types of assets (as shown in Appendix A, table 9) make it clear that in amount as well as frequency of ownership, the home is far more important than any other asset. Even with the equity in the home included, more than one-third have total assets of less than $5,000; only two-fifths have $10,000 or more.

In an effort to determine the relative numbers with various combinations of resources to meet medical care costs, data from a Survey Research Center study were tabulated by income in 1959, by savings cross-classified by whether or not any type of health insurance was owned. They show that while some older people have substantial resources in the bank or in Government bonds, the great majority do not (Appendix A, table 10). About 70 percent of the couples with head aged 65 or over and 85 percent of the other persons 65 years or over had less than $5,000 in savings. Almost three-fifths of these couples and almost three-fourths of the other aged persons with less than $5,000 savings had no health insurance.

This, as other studies, shows that the lower their income the less likely are the aged to have either substantial savings or any health insurance. Indeed, of these in the lowest income group (under $2,000 for couples, under $1,000 for others, including more than one-third of the couples and more than half the other aged) almost 90 percent had less than $5,000 savings with nearly four-fifths of them having no health insurance at all.

Life insurance is a fairly common form of saving, although less so among the aged than among younger families. The policies of the aged have a relatively low face value, and some of them have no cash

surrender value. The proceeds are therefore more likely to be used for burial costs or some of the bills outstanding after a terminal illness, than to meet costs of current medical care.

Among OASI beneficiaries studied in the fall of 1957, 71 percent of the married couples and half of the other aged beneficiaries carried some life insurance. The median face value was $1,850 for the policies carried by couples and less than half as much for nonmarried beneficiaries. More than two-thirds of all the beneficiaries either held policies with a face value of less than $1,000 per person, or had no insurance at all.

Home ownership

Equity in a home is the most common "saving" of the aged and represents the major portion of their net worth. Like other forms of saving, the advantage of home ownership is more common among those with higher incomes.

In early 1960, almost two-thirds of the nonfarm families headed by a person 65 and over owned their homes, with more than four-fifths of the homes clear of mortgage debt.

Among OASI beneficiaries studied in 1957, about two out of three of those married and one out of three of the nonmarried, owned a nonfarm home. Most of these homes were mortgage free, but the equity was relatively modest: The median amount was about $8,000 for couples and widows and about $6,000 for single retired workers. Nearly eight out of 10 of the beneficiary couples with income of $5,000 or more, but fewer than two out of three with less than $1,200, owned their homes.

While home ownership, particularly mortgage-free, can mean lower out-of-pocket costs, still it does not mean living without significant housing costs. Data from the 1957 beneficiary survey indicate that urban couples keeping house alone in a paid-up home averaged only about 30 percent less for taxes, upkeep and utilities than the average outlay for rent and utilities by couples renting their living quarters.

Noncash income

Many aged persons have noncash resources which enable them to enjoy better living than their money resources alone could make possible. Such "nonmoney" income, however, does not necessarily release an equivalent number of dollars for purchasing goods and services, such as health care.

According to the 1957 survey of OASI beneficiaries, four out of 5 couples and three out of five nonmarried beneficiaries had some non-

cash income of one or more of the following types: An owned home or rent-free housing, food home-grown or obtained without cost, or medical care for which the beneficiary did not pay.[25] Others received some support from the children or relatives with whom they lived.

A fourth of all beneficiary couples and almost a tenth of all other aged beneficiaries raised some food. Such food makes for a better and more interesting diet, but the net saving in family food expenditures is likely to be considerably less than dollar for dollar.

Evaluation of these noncash resources requires so many arbitrary decisions that it is rather seldom attempted. Survey Research Center staff members, however, did estimate for their analysis of income distribution and factors affecting low-income families, not only the imputed rental income earned on the net equity in owner-occupied homes, and the value of free medical care, but even the value of food and housing contributed by relatives in the same household and the money saved by growing food and doing home repairs. They report that adding such nonmoney components of income increases the income averages for couples and other persons aged 65 and over by only $300 or $400. It reduces the proportion with less than $2,000 in 1959 from 46 percent to 35 percent for units consisting of aged couples or nonmarried males; from 89 percent to 79 percent for aged women.[26]

Measures of need

Questions are raised from time to time as to the relative income needs of aged persons and of younger families. It is suggested that the actual incomes received by aged persons are not as low as they appear to be relative to those of younger persons, in view of the lesser budgetary needs of the aged.

Budget needs of retired and younger worker families.—Family budgets, designed to provide a measure of the amount of money required to support a given level of living, have usually been developed for a specific type of family. Comparisons between budgets have to take into account not only differences in family size and composition but also differences in concept and in implied standards of adequacy. Shared items of expense, such as housing, have a different impact on

[25] This assumes that home ownership yields noncash income in the long run, although about one-fifth of the homeowners reported current housing expenses for the survey year that exceeded the estimated rental value of the home. Roughly every third homeowner reported noncash income from another source, usually food, because homeowners are more likely than renters to have garden space.

[26] Morgan, James, and David, Martin, "The Aged and Their Economic Position—Some Highlights of a Survey Taken Early in 1960," in *Retirement Income of the Aging, Hearings Before the Special Committee on Aging*, U.S. Senate (87th Cong., 1st sess.), 1961, Appendix IV. Fuller description of procedures will be provided in a book entitled *Income and Welfare in United States*, to be published during 1962 by McGraw-Hill Book Co.

the total budget of a large family than on that of a single person or a couple.

The budget for a City Worker's Family of four persons and the budget for a Retired Couple, released by the Bureau of Labor Statistics in 1960, use the same methodology; both represent a "modest but adequate" level of living.[27] Since the City Worker's Family Budget applies to a family of 4 persons, the budget amounts cannot be compared directly with those for an elderly couple. Nor would it be entirely fair to place both budgets on a per capita basis. In order to compare the two budgets, an adult-equivalent relationship was used; specifically the amounts in the elderly couple's budget were divided by 2, those in the 4-person family budget by 3½, treating the 13-year old boy as an adult, the 8-year old girl as half an adult. The relationship between the per-adult cost for elderly couples and for a young worker's family is shown in table 24 for six cities in different regions of the country.

TABLE 24.—*Budget Costs: Relative costs for retired persons and members of city worker's family by category, 1959*

Item	Relative costs [1]					
	Atlanta	Boston	Chicago	Los Angeles	St. Louis	Washington, D.C.
Estimated total cost [2]	84	92	90	87	87	87
Cost of goods and services	98	108	105	102	103	103
Food and beverages	89	90	89	90	90	90
Housing	119	145	135	129	130	131
Rent, heat, utilities	118	145	135	128	131	131
House furnishings	86	89	89	87	87	86
Household operation and communications	181	210	200	219	189	195
Clothing	68	68	69	68	68	68
Medical care	156	172	176	151	160	156
Transportation	58	61	60	58	61	59
Other goods and services	102	108	106	106	105	107

[1] Ratio of per capita cost of retired elderly couple's budget to per adult equivalent cost of city worker's family budget, in which the boy is treated as an adult; the girl 8 as half an adult.

[2] Includes life insurance, occupational expenses, and personal taxes for the worker's family. The budget for a retired couple makes no allowance for life insurance nor Federal income taxes.

Source: "The Interim City Worker's Family Budget," *Monthly Labor Review*, August 1960, and "The BLS Interim Budget for a Retired Couple," *Monthly Labor Review*, November 1960.

With some variations from one city to another the amounts of money required for medical care of aged persons in reasonably good health were 50 to 75 percent higher than the comparable (per adult-equivalent) amounts for younger families. Housing costs were also significantly higher for the older persons, as might be expected with the smaller size household. Food costs were somewhat lower, the costs of clothing and transportation substantially lower. The cost of all the

[27] A detailed description of these budgets may be found in "The Interim City Worker's Family Budget," *Monthly Labor Review*, August 1960; "The BLS Interim Budget for a Retired Couple," *Monthly Labor Review*, November 1960; and Orshansky, Mollie, "Budget for an Elderly Couple: Interim Revision by the Bureau of Labor Statistics," Social Security Bulletin, December 1960.

goods and services budgeted for an aged person was very close to or slightly above the per adult-equivalent cost of all goods and services for the members of a younger family. However, when account is taken of the personal taxes, life insurance, and occupational expenses that would be paid by the younger families, the total costs incurred by an aged person are between 84 and 92 percent of the per adult-equivalent cost for a member of a young worker's family.

While the BLS budgets relate to families and elderly couples living in large cities or their suburbs, there is no reason to think that the *relationship* between the costs for older and for younger families would be markedly different in small cities or in rural areas.

By contrast, as previously noted, 2-person families have only half as much income on the average when the head of the family is 65 and over (including any still working) as when the head is younger. And almost three-fourths of all older families consist of only a husband and wife or the head and one relative.

Although older persons are somewhat more likely than younger persons to have some savings, as already mentioned, those with the smallest incomes are the least likely to have other resources, and most of their savings are tied up in their homes or in life insurance, not readily convertible to cash. Moreover, when a younger family goes into debt to purchase a home or durable goods, or to pay for medical care, it does so in the expectation of being able to pay off the debt from future earnings. When a retired aged person draws on his savings to pay for medical care, he does so without hope of recovering his former position.

Tax provisions favoring the aged

Federal tax provisions recognize the special problems encountered by older persons. It is apparent, however, that as with savings, home ownership and similar resources of the aged, the more favorable their income situation, the greater the advantage.

Federal tax savings.—The Treasury Department estimates that during the 1961–62 fiscal year, persons aged 65 and over will have a total tax savings of $742 million as a result of three special tax provisions of the Federal income tax. Of the total tax benefit, the double exemption for persons aged 65 and over accounts for $482 million in tax savings, the retirement income credit accounts for $120 million in tax savings, and the special medical expense deduction, over and above the deduction available to all age groups, accounts for $140 million.

State and local tax provisions.—No overall appraisal is available of the extent to which State and local taxes affect the aged. Of the 35 States that levy personal income taxes, 17 allow additional deductions for the aged. Some have favored treatment for older home owners in respect to real estate taxes.

CHAPTER 6. PRIVATE HEALTH INSURANCE

Availability of health insurance to the aged

The extent and quality of health insurance coverage of the aged is influenced by many factors: on the one hand, by their ability to pay full cost premiums which are likely to be high because of their morbidity rates; and on the other hand, the opportunities they have either to carry over into retirement the insurance they had while employed or to purchase insurance after reaching age 65.

Group coverage before retirement.—To the extent that the aged are gainfully employed, they have much the same opportunities as other active workers to obtain health insurance on a group basis. But only a small proportion have full-time employment and many of these are apparently in jobs for which health insurance is not available on a group basis through their work. The 1958 HIF–NORC study found that 93 percent of the uninsured individuals 65 and over in the labor force reported health insurance coverage was not offered through their work.

While in the early years of the Blue Cross movement, many plans would not enroll persons who were 65 years or older, these restrictions have been discarded except for some of the smaller plans. The practices of Blue Shield plans are virtually the same as Blue Cross. Neither has age restrictions on continuation of enrollment of elderly persons already in a group.

Some of the insurance companies formerly imposed age restrictions on employees for group coverage but these carriers now generally accept older employees in the work group enrollment unless the employer insists, due to cost factors, on age restrictions.

Few, if any, of the so-called independent plans have age restrictions on initial or continued enrollment of elderly persons under group enrollment.

Group coverage after retirement.—During the last 5 or 10 years, many employers and jointly managed union-management welfare funds have developed various types of plans to include retired em-

ployees under their group health insurance program.[28] Benefits may be the same as for active employees or they may be curtailed in various respects. The cost sharing arrangements as between the employer and employee may be the same as for active employees or different.

The extent to which health insurance is made available to retired employees depends not so much on the carriers as on whether the employer, union, or welfare fund will pay the added costs involved in coverage of the high-risk retired. Many Blue Cross and independent plans will also extend coverage to such groups of retired employees. Where the plans experience rate—and most Blue Cross-Blue Shield Plans now do—there is no problem for them in covering retired employees. Where the plan does not experience rate, acceptance of retired persons makes for problems for the carrier since the group in question is then apt to have higher than average utilization and costs.

No comprehensive data are available as to the extent to which health insurance has been made available to retired employees. However, the Bureau of Labor Statistics did make a study [29] of the provisions of 300 collectively bargained health and insurance plans in 1959 each with more than 1,000 workers. It showed that provisions for continuing hospital care insurance after retirement have been steadily increasing under collectively bargained plans, averaging about 1 to 2 percentage points a year from 1955 to 1959. Of the surveyed employees about 42 percent were in firms that provided hospital protection both before and after retirement. Major negotiations, since 1959, in the steel, aluminum and meatpacking industries for extending hospital insurance after retirement have brought this coverage figure up to an estimated 53 percent.

There are a number of important limitations on extension of hospital care protection to retired workers through employee-benefit plans even through the large, collectively bargained plans. First, even when such benefits are incorporated in a plan, they may refer only to future pensioners, not to those already retired.[30] Second, in

---

[28] Usually there is a requirement that the employee must have worked for the company or in the case of a multi-employer welfare fund, in the industry, for a designated period, say, five years preceding retirement.

[29] Bureau of Labor Statistics: *Health and Insurance Plans Under Collective Bargaining: Hospital Benefits, Early 1959* (Bulletin No. 1274), 1960; *Health Insurance Plans Under Collective Bargaining: Surgical and Medical Benefits, Late Summer 1959* (Bulletin No. 1280), 1960; and *Health and Insurance Plans Under Collective Bargaining: Major Medical Expense Benefits, Fall 1960* (Bulletin No. 1293), 1961.

[30] A 1960 BLS study shows that 69 percent of the plans that continued hospital benefits after retirement, covering 87 percent of the employees in such plans, provided hospital benefits to both prior and future pensioners; the remaining plans covered future pensioners only.

most instances, to continue receiving hospital expense protection workers must have had at least 5 to 15 years of service or of participation in a hospital expense plan. Third, because of the relatively high costs involved in providing elderly persons with hospital care protection, many plans extending such protection reduce the benefit provisions after retirement in a variety of ways—such as placing monetary or time limits on benefits. This particular limitation was true of 41 percent of the plans with hospital benefits for retired workers, covering 27 percent of the employees. Fourth, many plans require workers after retirement to bear a larger share of the costs. According to the BLS study, 3 out of 4 employees in plans where preretirement hospital benefits were jointly financed had to pay the entire cost after retirement.

The plans studied by the Bureau of Labor Statistics are more or less typical of those in unionized industries and among large employers and refer to less than 10 percent of all wage and salary workers. They undoubtedly do not reflect the situation in smaller or nonunionized firms, which generally offer less in the way of health and welfare benefits. It seems clear that fewer than half of today's workers can count on the extension of present health benefits into retirement years.

Policy conversion.—The Blue Cross and Blue Shield plans, without exception, have always followed the policy of permitting members, irrespective of age, who leave their groups to continue membership on an individual basis. The benefits offered under these group conversion contracts are generally reduced and the cost is higher because of adverse selection among these electing to convert and the higher administrative expense of non-group business.

Insurance companies formerly did not offer to persons leaving a group the right of conversion to an individual policy. However, today many companies writing group health insurance offer conversion privileges, i.e., will offer it if the employer or welfare fund wants this feature and is willing to pay any increased cost involved. Some of the independent plans serving the general public follow similar policies, i.e., permit subscribers leaving employed groups to convert to an individual contract; some do not.

Thus, to a very large extent, older persons retiring from employment have an opportunity to convert to an individual policy any health insurance which they had held as an employee. In general, however, the benefits are considerably reduced and the cost substantially increased on conversion, in large measure because the employer no longer shares in the cost.

Initial nongroup enrollment.—The situation is less favorable with regard to purchase of health insurance on an individual basis by older persons not in the labor force. There are a number of problems apart from cost. Some aged persons cannot buy insurance because of age-limits on nongroup enrollment or because they are poor risks due to pre-existing conditions. Some can obtain policies only if they accept a waiver of coverage for pre-existing conditions. Some find it impossible to renew individual policies or may have their policies cancelled. In all these respects, however, the situation has improved in recent years.

Restrictions because of age.—Almost all of the Blue Cross and Blue Shield plans now have non-group enrollment provisions. As of January 1962, all but 2 of the 79 U.S. Blue Cross plans had nongroup enrollment, but only 18 had no age limits for individual enrollment. Thirty-one plans among the 79 also offered "senior" certificates, i.e., without age limit, but these commonly restrict benefits and/or cost more as compared with nongroup contracts offered to younger persons. Nearly one-fourth of the plans did not accept initial nongroup enrollment from persons over 65 (table 25). All but 2 of the 68 U.S. Blue Shield plans had nongroup enrollment, 16 with no age limits, and 27 offering "senior" certificates. Although data on membership are not available by age limits, the situation seems somewhat more favorable than appears from a count of plans because the larger plans tend to have fewer age restrictions.

TABLE 25.—*Blue Cross and Blue Shield Plans: Age limits on initial non-group enrollment, end of 1961*

Age limits	Blue Cross plans	Blue Shield plans
Total	79	68
"Senior" certificates offered	31	27
No age limit	18	16
70 years	2	1
66 years	1	
65 years	15	17
60 years	10	4
56 years		1
No nongroup enrollment	2	2

Source. *Blue Cross Guide*, January 1, 1962, and *Blue Shield Manual*, late December 1961.

Although some of the 730 insurance companies which write individual (nongroup) policies do not sell insurance to individuals past 60 or 65, the majority now accept applications from persons up to 70 or even 75, and some have no age limits. All such insurance is written at rates which vary with age and sex, however. Rates for those persons 65 to 70 years are 50 to 100 percent higher than for persons of, say 30 years, and mount sharply for those beyond 70. Moreover, policies available to persons 65 and over generally have more limited benefits than those offered to younger persons.

Restrictions because of ill health.—The great majority of the Blue Cross and Blue Shield plans which enroll aged persons on a nongroup basis require a health statement from the person applying for coverage. An applicant with a health history which indicates that he may be a poor risk is apt to be rejected or the policy written with a waiver of coverage for specified conditions. Many of the plans exclude coverage for pre-existing conditions for a year or two, or even for life.

Nearly all insurance companies require a health history statement of the prospective individual enrollee with rejection likely if his statement indicates he is a poor insurance risk. In some cases policies sold contain a waiver of benefit for one or more specific conditions.

Renewal guarantees.—The assurance that a policy is non-cancellable and guaranteed renewable is always important to policyholders, but especially for those 65 years and older.

Most Blue Cross and Blue Shield plans follow a policy of never cancelling or refusing to renew a member's certificate because of his age or conditions of health. Exceptions are very rare.

The great majority of insurance companies, on the other hand, have reserved the right to refuse to renew an individual hospital, surgical or medical insurance policy on its anniversary date. Despite steady public complaint over the years, most individual health insurance policies are renewable only at the option of the company and companies do not hesitate to refuse to renew a policy on an insured person who has become a poor risk.

These practices are less common than they were, however. Some 30 to 40 commercial companies now issue policies which are guaranteed non-cancellable and renewable for life. If the company wishes to raise the rate on an individual policy of this character, it can do so only if it raises the rate on all policies of the same class. An estimated 500,000 of the 2½ million aged persons covered by insurance companies have individual policies which are guaranteed renewable.[31]

New York State prohibits cancellation or refusal to renew an individual policy, unless similar action is taken with respect to all policies of the same class. North Carolina has enacted similar legislation and some other States have considered or are considering such legislation.

Promotion of sales to the aged.—Availability of individual policies without age restrictions does not mean that the Blue Cross-Blue Shield Plans or the commercial companies make an effort to sell such insurance. Indeed, some contracts may be available to aged persons only during a limited period, such as two weeks or a month, each year.

A number of insurance companies have experimented with mass sales to older persons of policies which are guaranteed non-cancellable

[31] U.S. House of Representatives, *Health Services for the Aged Under the Social Security Insurance System, Hearings Before the Committee on Ways and Means on H.R. 4222* (87th Cong., 1st sess.) 1961, Vol. 2, p. 853.

and renewable. The policies are made available, without a health history inspection, to all aged persons in a city or some larger area for a limited period following extensive advertising. One company has a contract with the American Association of Retired Persons for specified health insurance benefits for all members who desire to take such insurance. Over 400,000 aged persons are reported to be covered under these contracts.

The State of Connecticut passed legislation authorizing cooperative action among insurance companies which offer health insurance "against major financial losses" to aged persons. An organization known as Associated Connecticut Health Insurance Companies has been formed, underwritten by some 30 companies. The organization offers a number of major medical and basic benefit policies to all aged persons in the State, such policies being available during limited enrollment periods. During the first enrollment period—the month of September 1961—21,850 persons enrolled. Some of them may already have other coverage. Losses or gains are shared among the companies on a prearranged basis.

Low benefit ratio on individual insurance.—Individual insurance, which is all that is available to many aged persons, is a relatively poor buy as compared to group insurance. In 1960 benefits amounted to only 53 percent of premiums, on the average, in the case of individual health insurance policies sold by commercial companies.[32] This compared with 90 cents in benefits per premium dollar for group enrollees with insurance companies and 92 cents for Blue Cross-Blue Shield plans (the latter including some individuals but mainly group coverage). The operating expenses of individual health insurance are necessarily high because of high initial sellings costs and subsequent premium collection costs.

Paid-up-at-retirement policies.—There has been considerable discussion of paid-up-at-retirement policies. Such a policy guarantees that a specified set of health insurance benefits will be available to the policyholder during the remainder of his life. The benefits are on a cash indemnity basis (a specified number of dollars for up to a specified number of days of care, plus an allowance for hospital extras). It would be very difficult for an insurance company to estimate the future cost of a service benefit (guaranteeing up to a specified number of days of care regardless of rising hospital costs). This is a new approach and little of this type of coverage has been sold. If the policy is not purchased until the date of retirement, the initial costs are high ($700 to $1,300 per individual). Similarly, even if purchased prior to retirement, the annual payments required for persons already approaching retirement would be substantial.

---

[32] Reed, Louis S., "Private Medical Care Expenditures and Voluntary Health Insurance, 1948–60", *Social Security Bulletin*, December 1961.

If the costs were spread over the full working life of the individual, the annual payments would be small, and might be coupled with current health insurance premium payments throughout his working life. There is a practical barrier, however, since most workers obtain their health insurance through their place of employment. Few persons spend their entire working lives with one employer, so continuous coverage under a single insurance carrier would be difficult to maintain. Aside from the uncertainty as to whether they will still be with the same employer when they retire, there are other factors that could make workers reluctant to participate in purchasing this form of insurance. They may anticipate that their existing health insurance coverage will continue after retirement or they may fear that a specified set of cash indemnity health benefits may prove inadequate if the trend of rising medical costs continues.

The extent of health insurance protection for the aged

It is estimated that about 8.7 million persons aged 65 and over had some protection against hospital costs as of July 1, 1961, and about 7.9 million against surgical costs. This assumes the same ratio of duplication (i.e., coverage under more than one policy) among Blue Cross-Blue Shield plans, insurance company policies and independent plans as assumed by the Health Insurance Council for the population of all ages.

The Blue Cross plans reported in July 1961 that they had 4,250,000 persons enrolled who were aged 65 and over and the Blue Shield plans had 3,250,000 aged members.[33] Virtually all of the Blue Shield members are included among those who have Blue Cross coverage. On the basis of a recent survey in which 90 companies that write two-thirds of the health insurance business participated, the Health Insurance Association of America estimates that some 4¾ million aged persons have hospital coverage through insurance companies. This is after allowance for duplication of persons with both group and individual policies sold by insurance companies.[34] Assuming that the pro-

[33] Colman, J. Douglas, and Stubbs, Donald, M.D., Statements in *Health Services for the Aged Under the Social Security Insurance System, Hearings Before the Committee on Ways and Means on H.R. 4222*, U.S. House of Representatives (87th Cong., 1st Sess.), 1961, Vol. 3, pp. 1692 and 1718.

[34] The Association supplied the following unpublished summary of the responses by the 90 companies as of July 1, 1961, in thousands:

Type of coverage	Total	Group	Individual or family
Hospital	3,615	1,715	1,900
Surgical	3,186	1,711	1,475
Regular medical	1,099	952	147
Major medical	730	595	135

portion of members who are aged 65 and over is the same as for all other types of health insurance coverage, there would have been nearly 370,000 aged persons in independent plans with hospital protection and about 430,000 with medical-surgical service coverage.

These figures are based in considerable degree on estimates and may be somewhat wide of the mark. The estimated net numbers with hospital and surgical care protection are equivalent to 51 and 42 percent, respectively, of the total aged population as of July 1, 1961, compared to 73 and 68 percent for the population of all ages.

Probably more reliable data on the extent of health insurance among the aged come from a survey conducted by the National Health Survey in July–December 1959.[35] They found that of all aged persons not in institutions, 46 percent had some type of hospital insurance, 37 percent had surgical insurance and 10 percent had insurance covering doctors' visits in the home, office, and hospital. Among the general population, by contrast, 67 percent had hospital, 62 percent surgical, and 19 percent medical insurance. Some part of the difference between the National Health Survey figures and the estimates set forth above may be due to growth in coverage of the aged between July–December 1959 and the middle of 1961; a part may also be due to underestimation by the Health Insurance Council of the extent of duplicating coverage.

As might be surmised, persons 65 to 74 are more likely to have insurance protection than those 75 and over. The data from the National Health Survey on the percent with insurance follows:

Age group	Hospital	Surgical
65 to 74	53	44
75 and over	32	24

Of the aged who had hospitalization insurance, the survey found:

43 percent were covered by Blue Cross;

7 percent by a "Blue Plan" and other type of plan;

49 percent by some other plan, i.e., an insurance company or independent, and

1 percent did not know the type of insurer

A survey by the Health Insurance Institute in 1957 found that among persons 65 and over who had health insurance, approximately twice as many had "individual" as had "group" insurance.[36]

[35] Public Health Service, U.S. National Health Survey, *Interim Report on Health Insurance, United States, July–December 1959* (Publication No. 584–B26), December 1960.

[36] Health Insurance Institute, *A Profile of the Health Insurance Public*, 1959, p. 9.

The proportion of the aged having health insurance was greater in urban than in rural areas and higher in the Northeast and North Central areas than in the South and West.

The extent of health insurance coverage is much lower among the aged with low incomes than among those of middle or high income. Thus, as with the general population, they are least able to meet sickness costs out of pocket. (See Table 26).

TABLE 26.—*Insurance Coverage of Aged Persons: Percent of aged persons with hospital insurance by income, July to December 1959*

[Noninstitutional population of the United States]

Family income	Percent
Total	46.1
Under $2,000	33.3
$2,000 to $3,999	53.2
$4,000 to $6,999	59.6
$7,000 and over	59.4

Source: Public Health Service, U.S. National Health Survey, *Interim Report on Health Insurance, United States, July-December 1959* (Publication No. 584-B26), December 1960.

The proportion of the aged with some type of health insurance has been increasing. Thus, two surveys conducted by the Census Bureau found 26 percent of persons 65 and over had some type of health insurance in March 1952 and 37 percent in September 1956.[37] Another pair of surveys found an increase from 31 percent in mid 1953 to 43 percent in mid 1958,[38] compared to the 46 percent found by the National Health Survey in the second half of 1959.

Figures showing the percent of the aged who have some health insurance must be understood for what they are. The scope and adequacy of coverage varies widely. An aged person who has hospital insurance paying $5 a day for 30 days against the room cost and $50 against the cost of the specific services ranks on the same footing as one who has insurance that will pay all of his bill in semi-private accommodations for 180 days or more.

Among all cases of aged persons discharged from short-stay hospitals during a survey, July 1958–June 1960, some portion of the bill was paid by insurance in 51 percent of the cases. Three-fourths or more of the hospital bill was paid in 30 percent of the cases.[39] Among persons under 65, insurance met some part of the hospital bill in 70 percent of all discharged cases, and three-fourths or more of the bill in 54 percent of the cases.

[37] Division of Program Research, Social Security Administration: *Health Insurance Coverage by Age and Sex*, by Agnes W. Brewster (Research and Statistics Note No. 13), 1958; and *Health Insurance in the Population 65 and Over*, by Agnes W. Brewster (Research and Statistics Note No. 17), 1958.

[38] Health Information Foundation, "Voluntary Health Insurance: 1953 and 1958," *Progress in Health Services*, May 1959.

[39] Public Health Service, U.S. National Health Survey, *Proportion of Hospital Bill Paid by Insurance, Patients Discharged From Short-Stay Hospitals, United States, July 1958–June 1960* (Publication No. 584-B30), November 1961.

Reasons why aged persons do not have insurance

There are various reasons why those of the aged who do not have health insurance are without it. Inability to afford it, unavailability of insurance, unawareness of any need for it, indifference, neglect—all play a part. Some indication of the relative role of these and other factors is given by various surveys.

A study conducted by the National Opinion Research Center for the Health Information Foundation found that in 1957 about half the aged persons without health insurance would have liked to be covered, just over one-quarter had not thought about it, and just under a quarter didn't want it.[40] Among those who wanted coverage, 68 percent couldn't afford it and 32 percent had been refused insurance or had insurance formerly but it had been cancelled.

About one-sixth (16 percent) of the aged surveyed in this HIF–NORC study had formerly been covered by health insurance but were not covered at the time of the survey. Among the reasons given for not continuing health insurance were: Could no longer afford it (31 percent); retired or gave up working (26 percent); dissatisfied with policy's coverage (24 percent). Other reasons were that "company discontinued plan"; "did not feel need"; "job change without policy's carrying over."

A similar picture emerges from the responses of OASI beneficiaries to the question as to why they do not have health insurance. According to a survey of beneficiaries in 1957, 68 percent of the aged beneficiaries who did not have hospitalization insurance had never had such insurance. Thirty percent had been insured at one time, but the policy was dropped before the survey year. For 2 percent the insurance status before the survey year was unknown. The reasons given by those without insurance for not having it are given in Table 27.

Cost and benefits under current policies and recent proposals for the aged

Some indication of the extent to which aged persons may find health insurance to be beyond their economic reach is given by consideration of charges for health insurance in comparison with income of aged persons.

One insurance company widely advertises a "senior citizen" health insurance policy which provides up to $10 a day for hospital room and board charges for up to 31 days per hospital confinement, up to $100 toward the cost of the special hospital services (operating room, X-ray, drugs, etc.) and reimbursement of costs of surgery in accordance with

[40] Health Information Foundation, "Voluntary Health Insurance Among the Aged," *Progress in Health Services*, January 1959.

TABLE 27.—*Reasons for No Hospitalization Insurance: Percent of aged OASI beneficiaries who did not have insurance, 1957*

Reason	Percent
Aged beneficiaries never insured	100
Could not afford it	41
Never thought about it	30
Not interested	18
Refused by insurance company	9
Other reasons	2
Insured at one time, policy dropped	100
Could not afford it	39
Group policy could not be converted at retirement	29
Not interested	14
Cancelled by insurance company or terminated at deaths of husband	13
Other reasons	5

Source: Bureau of Old-Age and Survivors Insurance, Social Security Administration, *1957 National Survey of Old-Age and Survivors Insurance Beneficiaries.*

a schedule that pays a maximum of $200 for the most expensive operation. (The policy has a six months' waiting period for pre-existing conditions but no other limitations because of physical condition.) The premium charged is $6.50 a month—$78 a year.

The average daily room and board cost in general non-Federal hospitals in 1961 was approximately $16; total costs including special services such as operating room, X-ray, etc., averaged $32 a day. A benefit of $10 a day and up to $100 for extra services would cover a varying proportion of hospital costs, but in few cases would it provide full coverage.

The American Association of Retired Persons offers to its members a hospital and out-of-hospital major medical plan. This is under a contract written with an insurance company. The hospital contract provides $10 a day against room and board costs for up to 31 days per hospital confinement, 50 percent of the cost of the hospital extras up to a maximum payment per confinement of $125, 50 percent of outpatient hospital charges for care in an accident, and reimbursement of surgical costs in accordance with a schedule with maximum payment of $200. The cost is $6 a month.

The out-of-hospital major medical contract pays 80 percent of eligible expenses above a deductible of $100 in any calendar year, and up to a maximum of $2,500 in any year. Eligible expenses include prescribed drugs, doctor visits in the office and home and hospital consultation, nursing home care up to $10 a day and up to a maximum of $500, diagnostic X-ray and laboratory services and special nursing in the patient's home up to $10 per shift. The cost is $7.50 a month.

For both these contracts an aged person would pay $13.50 a month or $162 a year, and would not receive any benefits under the second contract until he has paid $100 out-of-pocket.

Still another illustration may be given. The American Hospital Association and the Blue Cross Association have outlined a Blue Cross contract of hospital and related benefits which they say should be made available to all aged persons. The contract would provide complete hospital care for 70 days in accommodations of three or more beds, emergency outpatient care within 72 hours of an accident, up to 210 days care in a skilled nursing home upon discharge from a hospital or in lieu of hospital care, and up to 70 visiting nurse visits per year. They estimate the cost of such a contract at about $12 per aged person per month.

The American Medical Association and the Blue Shield plans have outlined a Blue Shield contract which they hope to make available to all aged persons. This contract would pay the cost of surgery, the cost of non-surgical physician care in a hospital (up to 30 to 70 visits a year) and X-ray and laboratory services in a physician's office. Physicians would accept a specified fee schedule as full payment of their charge for a single person with annual income under $2,500 and a couple with annual income of $4,000. The estimated costs of such a contract is $3 a month.

For both contracts the annual cost would be $180 a year for a single person, $360 for a couple. Clearly, policies that cost these amounts are beyond the reach of a substantial portion of elderly persons. The AHA and Blue Cross have recognized this and have proposed that the Government help pay the cost of the premium for aged persons who meet an income test.[41]

---

[41] See recommendations from January, 1962 meetings of Blue Cross Association and American Hospital Association in *Hospitals*, February 1, 1962.

CHAPTER 7. METHODS OF PAYING FOR MEDICAL CARE

Many older persons, as has been demonstrated, have large medical bills, more so than younger persons. For most young families the uneven and unpredictable impact of heavy medical costs is likely to be offset at least in part by private health insurance. Relatively fewer retired aged persons, particularly those in poor health and in the older age groups where the burden of medical costs is greatest, have such protection. Older persons too, lack the possibility often open to those younger of accommodating to a medical emergency through increasing family earnings.

For medical care expenditures, more than for other items of family living, there is wide variation not only from family to family but for any given family from year to year. An unanticipated medical emergency can change expenditures from a comfortably manageable level to a new peak of crisis.

How then, do the aged manage when ill? A number are able to manage on their own, especially if they have insurance against some costs. Some seek help from others—relatives if there are any, and public assistance if relatives cannot help. Some get free care under other public programs or through private charity. Some borrow money. And there are probably some, albeit an unknown number, who do not get care they need.

Using own resources

A 1957 study for the Health Information Foundation (HIF) on resources to pay for health services among those aged 65 and over reported as follows:

"In early 1957 the older population could be divided into three groups: Those who had resources from which they could meet a medical bill as large as $500; those who had no ready resources for meeting such a bill; and a small amorphous middle group whose position cannot be clearly ascertained * * *. No categorical statement can be made to summarize how older people said they would meet a large medical bill. Some felt they could pay a medical bill as large as $500 from a combination of current income and savings. This group included roughly six of every ten couples, five of every ten unmarried older men, and four of every ten unmarried older women. On the other hand, some older persons would have to mortgage property, borrow on life insurance, ask help from their children, turn to public assistance or charitable aid, or say in despair, 'No one

would charge me that * * * I just couldn't pay it.' This group included about three of every ten couples, four of every ten unmarried older men, and five of every ten unmarried older women." [42]

The HIF study asked people how they thought they would handle a large bill. The OASI survey in the same year obtained fairly comprehensive data on the means by which aged persons actually met their medical emergencies. More than two-fifths of the couples and roughly three-fifths of the nonmarried beneficiaries studied who spent some time in a general (or short-stay special) hospital in 1957 did not meet all the year's medical costs out of their own income, assets and health insurance. Almost all beneficiaries hospitalized paid some of their medical bills from their own income and savings, but those with very long stays were least able to stretch their resources to cover all costs. For example, 78 percent of the nonmarried beneficiaries in a general hospital longer than 60 days did not assume responsibility for all their own medical costs for the year, compared with 55 percent of those hospitalized for shorter periods.[43]

Medical debts were incurred—or increased—by 21 percent of the couples and 12 percent of the nonmarried beneficiaries with a hospital episode during the year. (For all the beneficiaries, whether or not hospitalized, the proportions were much smaller—7 percent and 3 percent, respectively.) And this does not count the cases where a doctor, for example, reduced his fees because he knew that the patient could not pay. Moreover, a considerable number of the beneficiaries who had more unpaid medical bills at the end that at the beginning of the year got help from outside as well.

Help from others

Fifteen percent of the couples and 29 percent of the nonmarried beneficiaries who had a hospital episode relied for at least part of their medical care on public assistance agencies, hospitals, or other public and private health and welfare agencies. Less than half as many of the nonhospitalized beneficiaries had to turn to welfare agencies.

The number receiving help from relatives in one form or another was at least as large. When beneficiaries were asked how they met their medical bills, 15 percent of the couples and 26 percent of the nonmarried with one or more hospital episodes reported that relatives helped pay for them. (Less than half as many of the other beneficiaries had to turn to relatives.) Some additional beneficiaries with hospital bills in effect received as much or more help with their medi-

[42] Health Information Foundation, *Meeting Medical Care Costs Among the Aging* (Research Series, No. 17), 1960, p. 26.

[43] Bureau of Old-Age and Survivors Insurance, Social Security Administration, *Impact of Hospitalization Costs on Aged Beneficiaries*, by Edna C. Wentworth (1957 National Survey of Old-Age and Survivors Insurance Beneficiaries, Highlight Report No. 6), 1961, table 4.

cal costs from relatives who helped support them either by sharing their home or by paying other regular living expenses.

The longer the period of hospitalization the more frequently relatives contributed to help out with expenses. Most of the relatives who were contributing to an aged person living in the household were themselves in the middle or lower end of the income scale.

If the relatives—both in and out of the household—on whom responsibility fell were typical, many would have children of their own to take care of. Others, with no children, were themselves already at or close to the age when their own problems of retirement would loom large. The aforementioned study by the HIF asked the persons 65 and over to whom they would turn (other than their own husband or wife) in event of illness. More than 6 in 10 named a son or daughter or the spouse of a son or daughter. Those designated were described as follows:

"Those to whom older people would turn for help in a health crisis were already involved with many family responsibilities. If these individuals were sons or daughters of older people they were usually young or middle-aged adults. Three of every four among them (73 percent) had children of their own . . . The relatives to whom older people without children would turn for help were themselves likely to be in the older age groups, and many of these were over 65 years of age; also, many were widowed or single." [44]

When asked how they would pay a medical bill of $500 or more, about one-fourth of the aged women who were widowed, divorced or single, and about one-eighth of the men who were not married, said they would turn to children or other relatives. Fewer of the married persons—1 in 13—mentioned relatives as a resource presumably because those still married tend to be younger and to have more income and savings than the widowed.[45]

Medical need and public assistance

The exact number of aged who must seek public assistance because of medical need cannot be measured with exactitude. Depending on facilities available for the medically indigent and on local assistance practices, as well as on personal differences in reaction to a means test, some come for help at the time of medical need while others come to seek help in meeting daily living expenses only after using up their resources to pay their medical bills.

For example, the 1957 BOASI survey found that among all aged beneficiaries who incurred medical costs during the survey year, about 1 in 14 of the couples and 1 in 8 of the nonmarried were on public assistance at some time during the same 12-month period.

---

[44] Health Information Foundation, *Family Relationships of Older People* (Research Series, No. 20), pp. 11–13.

[45] Health Information Foundation, *Meeting Medical Care Costs Among the Aging* (Research Series, No. 17), table 12.

An analysis of the reasons for approving old-age assistance grants in about half the States in January–June 1961 shows that nearly 1 in 3 recipients needed assistance, at least in part, as a result of health problems in the 6 months preceding. Interestingly enough, aged persons receiving OASI benefits (numbering just about every other newly approved assistance recipient) were more likely to require the aid because of medical needs. Health problems of one sort or another were the reason for opening the case for two-fifths of the recipients drawing benefits as against one-fourth of those not on OASDI (See table 28).

TABLE 28.—*Old-Age Assistance: Distribution of cases opened by reasons for opening, by OASDI status, 25 States, January–June 1961*

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

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

Although OASI beneficiaries who receive supplementary old-age assistance are older, have smaller benefits and less income from other sources, are in poorer health and experience considerably more hospital illness than other beneficiaries, they are younger, in better health, and have more resources on the average than the recipients of assistance not on the OASDI rolls.[46]

New York State, which has one of the better medical care programs for old-age assistance recipients, reported that 54 percent of all payments for old-age assistance in 1960 represented expenditures for medical care. This proportion takes into account not only payments made directly to the vendors by the assistance agency, but also the amount included in the cash grant for the recipient himself to spend on his medical requirements. The average annual medical bill per recipient was over $700, while payments for living costs averaged only $600. Much of this medical bill represented payments for care of the chronically ill in public and private nursing homes, but a fourth went to pay for hospital stays:[47]

[46] Ossman, Sue, "Characteristics of Aged Old-Age and Survivors Insurance Beneficiaries Who Also Receive Public Assistance," *Social Security Bulletin*, October 1959.

[47] New York State Department of Public Welfare, *Analysis of Medical Care Expenditures by Local Public Welfare Districts for Public Assistance Recipients in New York State During 1960*, by W. Kaufman (Special Research Statistical Reports, No. 17), September 1961.

	(Millions of dollars)
Total assistance payments	$106.6
Medical expenditures	57.8
Nursing home care for chronically ill	37.0
Hospital care	14.8
All other medical	5.9

With New York one of the States now participating actively in the Medical Assistance to the Aged program, data for 1961 will be somewhat different. Much of the nursing home care previously provided under old-age assistance is transferred to the new program.

The role of hospital insurance

Were it not for health insurance many more aged persons would have to turn to relatives or welfare agencies, or both, to meet their pressing medical needs.

Having the protection of prepayment for some or all hospital costs is an extension of individual ability to pay for illness when it strikes. As such it has been shown to have a bearing on the decision to seek (or accept) admission to a hospital and on the length of stay. It can affect also the hospital chosen—as between a voluntary or proprietary institution, and one maintained by public funds. The actual differentials between those with insurance to defray hospital costs and those without are in some measure obscured by the fact that the latter as a group tend to be the more disadvantaged in health and economic status.

Among the aged, perhaps even more than among the working population, those most likely to need the benefit of health insurance—the chronically ill and those with the lowest income— are least likely to have the advantage of prepayment. Even those who do have insurance often find their protection incomplete, either because many costs are excluded from coverage or because a protracted illness outlasts the benefit period.

Length of stay and portion of bill covered.—Data from the National Health Survey for 1958–60 reveal that for half the short-stay hospital episodes of aged persons during a year health insurance paid no part of the bill.

Even when insurance was available to the aged it was less effective for long than for short stays, defraying three-fourths of the hospital bill for 47 percent of the stays lasting over a month, compared with 60 percent of those lasting no more than 30 days (table 29). Although the average elderly patient in a general hospital who leaves the hospital alive does so within 15 days, nearly 1 in 10 remains a month

TABLE 29.—*Insurance Coverage of Hospital Costs: Distribution of short-stay hospital discharges according to proportion of bills paid by insurance, by age and length of stay, July 1958–June 1960*

[Noninstitutional population of the United States]

Age and length of stay	Total discharges	Proportion of bill paid by insurance			
		None of bill	Any part of bill		
			Less than ½	½ to ¾	¾ or more
65 and over	100.0	48.8	9.0	11.9	30.3
1 to 5 days	100.0	48.9	10.1	11.5	29.4
6 to 14 days	100.0	46.4	8.6	11.9	33.1
15 to 30 days	100.0	49.8	9.2	11.0	30.0
31 or more days	100.0	54.7	8.1	15.8	21.4
Under 65	100.0	30.0	4.9	11.2	53.8
1 to 5 days	100.0	31.6	4.6	11.1	52.7
6 to 14 days	100.0	25.1	5.3	11.7	57.9
15 to 30 days	100.0	28.2	5.2	12.3	54.4
31 or more days	100.0	49.1	7.2	8.7	34.7

Source: Public Health Service, U.S. National Health Survey, *Proportion of Hospital Bill Paid by Insurance. Patients Discharged From Short-Stay Hospitals, United States, July 1958-June 1960* (Publication No. 548-B30), November 1961.

or longer. The longer his hospitalization lasts, the more likely it is the aged person will have to seek help from others to pay for his care.

The OASI beneficiary survey also provides a measure of the degree to which insurance met hospital costs of aged patients. About 1 in 5 married beneficiaries and 1 in 4 of the nonmarried with insurance found it met all of the hospital charges. On the other hand about 5 percent of those with a hospital insurance policy found it did not cover any of the costs of their care in a nongovernmental general hospital (table 30).

For all the aged who go to a hospital the actual proportion of hospital bills paid in some part by insurance is probably smaller than shown, because terminal illness cases are excluded. Those at the older ages, most likely to die, are least likely to have any insurance and thus often leave a heavy legacy of expenses. The small number of beneficiaries (referred to previously) in the OASI survey whose spouse died during the survey year reported greater difficulty in meeting total medical costs for the year than other beneficiaries. Insurance covered some medical costs in only one-fourth of the cases where one of the partners had died, and a fourth of the survivor beneficiaries reported they still had unpaid bills at the end of the survey year.

Amount of insurance and amount of hospital utilization.—That ability to pay affects the rate at which people can get needed care was demonstrated in Chapter 3. Aged persons having insurance against costs appear to enter a hospital with greater frequency but have a shorter average stay than those with no insurance protection. The

TABLE 30.—*Insurance Coverage of Hospital Costs of OASI Beneficiaries: Distribution of aged beneficiaries in general hospitals according to proportion of costs paid by insurance, by marital status and hospital ownership, 1957*

Proportion of general hospital costs paid by insurance [1]	Married couples [2] [3]		Nonmarried beneficiaries	
	Total	Non-Government	Total	Non-Government
Total hospitalized	100	100	100	100
With no hospital insurance	43	39	48	41
With some hosp. insurance	57	61	52	59
With some hosp. insurance	100	100	100	100
No costs met by insurance	7	6	9	5
Less than 25 percent met by insurance	7	8	4	3
25 to 49 percent met by insurance	18	20	6	5
50 to 74 percent met by insurance	22	22	29	30
75 to 99 percent met by insurance	20	19	21	23
100 percent met by insurance	19	19	24	27
Unreported amount met by insurance	6	6	6	7

[1] Excludes surgeons' and inhospital physicians' fees. In the case of married couples, with both members hospitalized, represents hospital costs for the couple. (General hospitals include short-stay special hospitals.)

[2] Insurance status for married couples refers to the hospitalized person. If both were hospitalized, but only one insured, the couple is classified in the "with insurance" category and by the proportion of total general hospital costs for the couple which was met by the insurance.

[3] Aged beneficiary and spouse, whether or not entitled to benefits; spouse may be under 65 years of age.

Source: Bureau of Old-Age and Survivors Insurance, Social Security Administration, *1957 National Survey of Old-Age and Survivors Insurance Beneficiaries.*

inhibiting effect of limited resources for payment can be demonstrated further by the finding that even among those with insurance, differentials exist corresponding to the degree of protection provided: Those with a higher benefit policy use the hospital more often than those with a lower benefit policy. A study of subscribers to the Rhode Island Plan in 1959 showed considerably more hospital use among the subscribers to the higher cost (benefit) plan—primarily because of higher admission rates. The average length of stay is only modestly greater for those with better coverage. Among individual subscribers aged 65–69 years, there were nearly twice as many hospital cases per 100 contracts on the $20 a day plan as on the $8 a day plan. Among the 70–79 year old subscribers, there were about 1⅔ as many admissions per 100 $20-plan contracts as on the $8-plan contracts.[48]

In like fashion, the study of hospital use in Michigan in 1958 noted with respect to ability to pay that "persons with the highest degree of coverage (70 percent and more of hospital bill paid by coverage) had almost twice the admission rate of those without insurance after allowing for the effects of [age, sex, family income, family composition, attitudes towards early medical care, education, and region where family head grew up]." [49]

[48] Blue Cross Association and American Hospital Association, *Financing Health Care of the Aged, Part I. A Study of the Dimensions of the Problem.* 1962.
[49] *Ibid.*

Public hospitals more commonly than private institutions must be prepared to provide care at charges geared to ability to pay—including care at no charge to those who cannot pay at all. In many localities State, county, and municipal hospitals provide much of the care for assistance recipients by arrangement with local welfare departments. Some persons with insurance who need to go to the hospital will select a Government institution out of preference; others, because they know the current illness will not be covered under terms of their contract; and some, because they cannot afford the doctor's fees and other charges attendant upon a stay in a private hospital. But persons with no insurance whatever are much more likely to go to a public institution than those who have insurance to defray some of the bills.

The National Health Survey found about one out of three hospital discharges with no part of the bill paid by insurance came from Government hospitals, as compared with 1 in 7 of those for which insurance did pay part of the bill. These proportions are the same for patients under 65 as for persons 65 and over. However, because fewer of those over 65 have any insurance, the Government hospitals accounted for a somewhat larger share of total general hospital stays of the aged than of persons under 65 (23 percent vs. 20 percent respectively). The fact that the aged patient is likely to remain in hospital longer than the younger patient gives this differential added significance.[50]

The 1957 OASI beneficiary study also demonstrates the effect of ability to pay—as measured by health insurance protection—on the type of hospital used and on completeness of reporting of medical costs. Among four out of five of the couples with either member hospitalized and a little better than 7 out of 10 of the nonmarried, the hospitalization took place in a nongovernment hospital. But, as table 31 indicates, beneficiaries with no hospital insurance policy were just about twice as likely to enter a Government hospital for their care as those who could anticipate insurance defraying some of the bills. Moreover, although very few of the hospitalized beneficiaries received their care in a Federal general hospital, almost all who did came from among the noninsured.

About 1 in 4 were not able to report their medical costs in detail, often because they had received some care free.[51] As one might expect, having to go to a hospital was a prime factor in the situation. Al-

---

[50] Public Health Service, U.S. National Health Survey, *Proportion of Hospital Bill Paid by Insurance, Patients Discharged from Short-Stay Hospitals, United States, July 1958–June 1960* (Publication No. 584–B30), November 1961.

[51] Care supplied by a hospital or doctor who tended no bill to anyone or care for which a public assistance agency paid directly to the hospital or doctor. Bureau of Old-Age and Survivors Insurance, Social Security Administration, (*Social Security: Aged Beneficiaries and Older Workers Under OASDI*), September 1960, table 11.

TABLE 31.—*Insurance Status and Hospitalization in Public Institutions: Distribution of aged OASI beneficiaries in general hospitals by hospital ownership and insurance status, 1957*

Hospital ownership [2]	Married couples [1]		Nonmarried beneficiaries	
	With no hospital insurance [3]	With hospital insurance [3]	With no hospital insurance	With hospital insurance
Total hospitalized	100.0	100.0	100.0	100.0
Nongovernment	72.3	85.2	61.5	83.5
Government	30.1	17.0	39.2	16.5
State, county, and city	26.6	16.2	31.5	15.8
Federal	3.5	.9	7.7	.7
Hospital costs reported	100.0	100.0	100.0	100.0
Nongovernment	84.1	88.6	76.4	83.8
Government	18.6	14.1	23.6	16.2
State, county, and city	18.6	14.1	22.2	16.2
Federal			1.4	
Hospital costs not reported [4]	100.0	100.0	100.0	100.0
Nongovernment	50.0	71.1	43.1	81.8
Government	51.7	28.9	58.6	18.2
State, county, and city	41.7	24.4	43.1	13.6
Federal	10.0	4.4	15.5	4.5

[1] Aged beneficiary and spouse, whether or not entitled to benefits; spouse may be under 65.
[2] A few had more than 1 stay in a general hospital involving more than 1 type of ownership. (General hospital includes shortstay special hospital.)
[3] For the hospitalized person. If both members were hospitalized but only one had hospital insurance the couple is classified in the "with insurance" category.
[4] In many cases, includes some "free" care, i.e., no bills rendered to anyone, or vendor paid directly by public assistance or other agency.

Source: Bureau of Old-Age and Survivors Insurance, Social Security Administration, 1957 National Survey of Old-Age and Survivors Insurance Beneficiaries.

though a fifth of all couples and a seventh of all nonmarried beneficiaries had been hospitalized, half of those who could not state their total medical expenses for the year had been in a hospital. The data for hospitalized beneficiaries show that those unable to report hospital costs more often were beneficiaries with no insurance (Appendix A, table 11). Furthermore among both the insured and the uninsured, those unable to report costs were more likely to have been treated in a public hospital than other beneficiaries (table 31).

PART III

Public Programs and Philanthropic Arrangements for Medical Care

CHAPTER 8. MEDICAL CARE UNDER THE OLD-AGE ASSISTANCE PROGRAM

Public programs are now responsible for more than $1 in every $4 spent for medical care for persons 65 and over. It is estimated that public expenditures for medical care for the aged amounted to $1.3 billion in 1960 [52] and that about two-thirds of these public funds went for care in hospitals (Table 32).

TABLE 32.—*Public Expenditures for Medical Care for the Aged: Estimated amount by type of program and type of care, 1960*

[Millions of dollars]

Type of medical care	Total	Public assistance	Veterans' Administration	Other
Medical care, total	$1,330	$455	$265	$610
Hospital care, total	895	100	235	560
General	470	100	165	205
Mental and tuberculosis	425		70	355
Other	435	355	30	50

Source: Division of Program Research, Social Security Administration.

Some medical care programs—notably those under public assistance and those for veterans' nonservice-connected disabilities—are open only to the needy. Others—notably those for veterans' service-connected disabilities, or for military personnel and their families—provide for all in these special population groups without regard to income or ability to pay. Publicly administered general hospitals in many localities provide care at no charge, or at charges related to income, for persons who cannot afford to pay in full. Traditionally, nongovernmental hospitals also provide some free medical care to the needy, but these hospitals are increasingly being paid for their services to the needy through public programs and public grants.

[52] See Appendix C for sources and methodology of estimates.

The public assistance programs are the most important single source of public funds for medical care for aged persons outside of mental and tuberculosis hospitals. From the beginning of the Federal-State old-age assistance program in 1935, the cost of medical care could be included in monthly cash payments to OAA recipients. However, the fact that the monthly payments for a recipient were subject to Federal and State maximums very much limited the care made available in most States.

In 1950 the Social Security Act was amended to permit Federal matching of payments for medical care made directly to suppliers. However, these so-called vendor payments had to be within existing maximums on Federal participation in payments. In 1956, old-age assistance was again broadened by establishing separate Federal matching for medical care payments over and above the cash assistance payment. In 1958, the effective ceiling on Federal matching was increased.

The 1960 (Kerr-Mills) amendments to the Social Security Act provided two extensions of medical care for the aged under the public assistance program: (1) increased Federal matching of medical care payments under old-age assistance, and (2) a new program of medical assistance for the aged, designed to provide help with medical bills for the so-called medically indigent. The 1961 amendments included an additional liberalization of the Federal matching provisions for vendor medical payments under old-age assistance. Since 1960 the Federal Government has matched State expenditures in the form of vendor payments to old-age assistance recipients on a more favorable basis than expenditures made for assistance in the form of money payments.[53]

Some 2.3 million persons—more than 13 percent of all those 65 years and older—are presently receiving old-age assistance. The proportion varies widely from State to State, however, from 3 percent

[53] Prior to the 1960 amendments, the Federal Government matched State expenditures for assistance in an amount equal to (a) 80 percent of expenditures up to an average of $30 per month per recipient, plus (b) 50 to 65 percent—depending upon relative State per capita income—of expenditures over an average of $30 and up to an average of $65 per month per recipient including vendor medical payments. Under the Kerr-Mills amendments, as further modified by the 1961 amendments, if the average payment exceeds $66, the Federal Government matches from 50 to 80 percent—depending on relative State per capita income—of the amount of vendor medical payments up to an average of $15 a month per recipient, or the amount by which the average payment exceeds $66, whichever is less. For States with average monthly payments of $66 or less the Federal share in average vendor medical payments up to $15 a month is an additional 15 percent over the usual Federal percentage applicable to the amount of payments falling between $31 and $66. This percentage, when added to the usual Federal percentage for the second part of the formula for payments, gives a total Federal share of 65–80 percent. The additional Federal share of 15 percent is also available to States with average monthly payments of more than $66, when it is advantageous to them as an alternative to the method described above.

in Delaware and New Jersey to 51 percent in Louisiana. In general, it is high in the rural Southern States and low in the industrial Northern States (Appendix A, Table 4). In some States the public assistance agencies assume virtually complete responsibility for providing all needed medical care to public assistance recipients. In a few States the public welfare agencies make no provision for medical care of recipients. Most States fall between these extremes.

To receive Federal aid for its old-age assistance program a State must submit a State Plan which meets certain requirements laid down in Federal law. Among the requirements are that the program be operated or supervised by a single State agency, be effective in all parts of the State, provide for appeal by persons denied assistance, etc. Within the terms of Federal aid, the States have considerable leeway in operating their programs, including determining standards of eligibility and of need.

Services provided under Old-Age Assistance

There is considerable variation among the States with respect to the amount of care and types of health services that are provided under the OAA programs. In those States which provide medical care to OAA recipients by means of vendor payments, various limitations are placed on the amount of care provided. When a State pays for care through money payments, there is usually a maximum which limits the amount of care which can be paid for. A summary of the number of States providing services under the OAA programs and the method of payment for each service provided, i.e., by vendor payments or through money payments is shown in Table 33. The specific limitations on the amount of payments and care provided are shown in detail by State in Appendix B, Table 14.

TABLE 33.—*Old-Age Assistance Programs: Summary of number of States providing major types of medical services by method of payments, October 1, 1961*

Type of service [1]	Number of States		
	Total	Money payments [1]	Vendor payments [1]
Hospital care	46	3	43
Physicians' services	42	7	35
Office visits	39	7	32
Home calls	42	7	35
Hospital inpatients	26	5	21
Hospital outpatients	29	6	23
Dental care	36	10	26
Fillings	32	7	25
Extractions	34	8	26
Dentures and repairs	33	10	23
Prescribed drugs	40	[2] 12	[2] 31
Nursing home care	48	[3] 28	[3] 31

[1] There are substantial limitations among the States on amounts and care provided. See Appendix B, Table 14 for the detail by State.
[2] Includes 3 States using both money and vendor payments.
[3] Includes 11 States using both money and vendor payments.

Source: Bureau of Family Services, Social Security Administration.

In 46 States the assistance agency assumed some responsibility for the provision of hospital care as of October 1, 1961, the latest date for which State Plan characteristics have been summarized.[54] In 25 of these States necessary hospital care for all types of cases (except care in mental or tuberculosis hospitals) is provided for as long as may be needed. In the remaining States limitations are imposed relating to type of conditions which may be hospitalized—acute, critical, life-endangering illnesses or accidents, the number of days covered, and the maximum payments per day.

Some responsibility for the provision of some physicians' services under OAA is taken in 42 States. Home calls are provided in all of these States, but definite limitations are imposed in many States on the number of calls or visits that will be paid for in a given time period or case of illness. A few States pay for physicians' services only in acute conditions and/or life endangering conditions.

Dental services are provided to old-age assistance recipients in 36 States. Some States providing dental services under vendor payments limit these to emergencies, or when required for care of a medical condition, or to maximum payments. Most of the States providing dental care through money payments have grant limitations which would curtail the amount of dental care that could be paid for in this way.

Prescribed drugs for old-age assistance recipients are provided in 40 States, with limitations in some States on the maximum allowable or the type illness for which drugs may be prescribed.

Nursing home care is provided in 48 States, with maximum monthly limitations in many States ranging from $40 to $200. In 10 States the maximum grant is $100 or less.

Selection of physician, hospital, dentists, etc.

Analysis of State plans suggests that in most States which provide for physician service under the OAA program through vendor payments, recipients have free choice among the doctors in the area who are willing to serve assistance recipients at the fees paid by the assistance agency. No information is available, however, as to the proportion of physicians in the various States who have agreed to accept welfare fees and to serve assistance recipients.

Where money is included in the grant to pay for services of physicians or dentists, the assistance recipient makes his own arrangements and may choose among those physicians or dentists who are willing to accept the fees he can pay. Where the assistance agency pays for

[54] Bureau of Family Services, Social Security Administration, *Characteristics of State Public Assistance Plans Under the Social Security Act: Provisions for Medical and Remedial Care* (Public Assistance Report No. 19), 1962.

physicians' services in the office or home but not in the hospital, recipients requiring hospitalization ordinarily must go to hospitals where the medical staff has agreed to provide service free to welfare patients.

With respect to drugs, assistance recipients generally have a choice among the pharmacists in their localities. However, in those States where local welfare departments have entered into agreements with individual pharmacists who are willing to provide drugs at less than the going rate, welfare recipients have to purchase their drugs from these pharmacists.

If an aged recipient needs nursing-home care his choice is apt to be confined to those homes which are willing to accept welfare rates. Welfare departments pay for approximately half of all nursing home care in the United States—almost all of it for old-age assistance recipients. The low amounts which they pay for such care have, in considerable measure, set the standards of nursing home care in this country and set them at low levels.

Payment of physicians, hospital, etc.

In States and localities where medical care is paid for through vendor payments, the physicians, hospitals, and other suppliers are paid on the basis of rates mutually agreed upon. In most States the rates are negotiated on a State-wide basis between the welfare department and the State hospital association, State medical association, or other appropriate group. Comprehensive data are not available as to how these rates or fees paid compare with those paid by the general public.

In most States hospitals are paid either on the basis of a flat negotiated per diem rate or on their per diem cost but not in excess of a specified limit. Hence, many of the hospitals receive less than cost, some very much less. Hospitals generally hold that they should be paid for services to welfare recipients on a basis which reflects costs. State and local welfare departments frequently plead inability to pay full cost. Hospitals frequently agree to accept less than their costs on the assumption that some payment is better than none.

Administration

In most States (31 of 54) the OAA program is administered by a State agency—the State welfare or assistance department. This department usually has local or district offices. In the other 23 States the program is administered by the welfare departments of local political subdivisions (counties and cities, etc.) under supervision of the State agency. In the State-supervised programs the State agency

sets the main policies and procedures (including standards of eligibility, standards of assistance, medical care to be furnished, etc.) and the local welfare departments must hold to these policies. In 4 States (New York, Indiana, Kansas, and Wyoming) the program is administered by the counties under procedures in which the counties have considerable freedom of action but must submit a plan which meets State approval.

In the States with State administered programs the State generally bears the full cost of the program over and above Federal aid; in the State supervised programs, the localities generally bear a portion of the cost. In the State administered programs, arrangements for the provision of and payment for medical care are uniform throughout the State. In the State-supervised programs, there may be difference among the local subdivisions in the rates of payment for care and other particulars.

In a number of States the State welfare department has entered into arrangements with the State health department for administration of, or assistance in administering, the medical care part of the assistance program. In a number of States contracts have been entered into with Blue Cross plans, Blue Shield Plans or State or local associations of physicians or other professional groups for the provision of care or for paying hospitals, physicians, etc., for services or supplies provided to recipients.

In Puerto Rico, the Virgin Islands, and the District of Columbia the health department operates major facilities serving the whole population or the indigent and medically indigent and is reimbursed by the welfare department for services provided to assistance recipients.[55]

Utilization

Tables 34 and 35 present data on hospital, nursing home, medical service and drug utilization by OAA recipients in States which have thus far developed data of this type. Mainly these are States which are making above average expenditures per recipient for medical care.

From these data, it is apparent that at least in some States, OAA recipients are a most atypical population. In the general population 65 and over about 1 in 6 is admitted annually to general hospitals, and it is estimated that aged persons are receiving 270 to 285 days of hospital care annually per 100 persons (after adjustments for decedents). By contrast, in some States as many as a quarter or a third of all old-age assistance recipients were hospitalized, and in a recent year assistance recipients in 2 States received 1,221 and 1,348 days of hospital care per 100 recipients—approximately 5 times the expected

[55] See Appendix B, Table 15, for a more detailed description of these arrangements.

rate for the general population of this age. Part of this extraordinary use of service is undoubtedly due to the fact that old-age assistance recipients as a group are of advanced age—much older than the general population 65 and over. (The median age of all persons receiving OAA in 1960 was 76.4 years as compared with 72.1 for all persons 65 and over.) But in addition, it seems plain, illness and the need for medical care have been major reasons for persons coming on to the public assistance rolls.[56]

TABLE 34.—*Old-Age Assistance: Hospital utilization rates of recipients, selected States, recent periods*

State	Report period	Percent of recipients hospitalized	Rates per 100 recipients		Average days of care
			Hospital admissions	Days of care	
Colorado	1959	27.5	42.7	505	11.8
Connecticut	(1)	19.0	28.5	560	19.4
Florida	Nov. 1959–Oct. 1960	(1)	12.1	121	10.1
Illinois	Jan. 1958–June 1958	(1)	(1)	(1)	16.7
Maryland	(1)	[2] 10.0	13.0	240	17.2
Massachusetts	Fiscal year 1959–60	(1)	(1)	1,348	(1)
Michigan	1955	(1)	(1)	1,221	(1)
New Mexico	Fiscal year 1959–60	19.6	(1)	270	[2] 13.8
North Carolina	Fiscal year 1957–58	11.8	15.6	195	12.5
North Dakota	Fiscal year 1959–60	33.3	(1)	911	[2] 27.3
Oklahoma	Fiscal year 1959–60	(1)	23.1	(1)	(1)
Rhode Island	Fiscal year 1957–58	16.2	22.0	328	14.9

[1] Not reported.
[2] Estimated.
[3] Average days per patient rather than for hospital admission.

Source: Bureau of Family Services, Social Security Administration.

TABLE 35.—*Old-Age Assistance: Percent of recipients receiving nursing home care, physicians' services and drug prescriptions paid for through vendor payments, selected States, recent periods*

State	Report period	Percent of recipients receiving—		
		Nursing home care	Physicians' services	Drug prescriptions
California	November 1957 to April 1958	(1)	51.4	44.5
Colorado	1959	9.5	(1)	(1)
Connecticut	(1)	(1)	62.0	65.0
Illinois	August 1960	14.5	(1)	(1)
Maryland	(1)	(1)	62.0	56.0
New Mexico	Fiscal year 1959–60	6.3	65.3	(1)
North Dakota	Fiscal year 1959–60	9.1	67.6	65.1
Oklahoma	Fiscal year 1959–60	[2] 10.0	(1)	(1)
Rhode Island	Fiscal year 1957–58	(1)	69.9	77.9

[1] Not reported.
[2] Includes some duplication of cases.

Source: Bureau of Family Services, Social Security Administration.

Expenditures for medical care under OAA

Expenditures for medical care for old-age assistance recipients in the form of vendor payments amounted to $315 million in 1961. It will shortly be possible to estimate the amount of expenditures for medical

[56] See Chapter 7, Table 28.

care provided through money payments to recipients on the basis of special statistical reports for January 1962 to be submitted by the States by April 1962. Expenditures in this form have undoubtedly dropped below the 1960 level (of $149 million) both because of transfers from OAA to MAA and because of changes in method of payment for medical care under OAA, but probably by not much more than the increase in vendor payments under OAA.

In January 1962 vendor payments for medical care averaged $13.26 per recipient.[57] Four States made no vendor payments; the range among the States which made vendor payments—from a low of 13 cents per recipient per month in Georgia to a high of $61.29 per recipient in Connecticut—was as follows:

Average Monthly Vendor Payments for Medical Care	*Number of States*
Total	50
Under $5.00	9
$5.00–$9.99	9
$10.00–$14.99	11
$15.00–19.99	6
$20.00–$24.99	4
$25.00 and over	11

The proportion of OAA expenditures going for medical care through direct payments to vendors is large—18.7 percent for the country as a whole in January 1962, the latest month for which data are available. In some States a major portion of all OAA funds are going for medical care in the form of vendor payments, e.g., 60 percent in Wisconsin, 57 percent in Connecticut, 49 percent in Minnesota, 44 percent in Illinois, and 43 percent in New Jersey.

Effect of 1960 amendments

The 1960 Social Security Amendments have resulted in increases in vendor payments under old age assistance in a number of States. By March 26, 1962, 8 States which had no vendor payment programs for OAA recipients before September 1960 had placed such provisions in operation. Some 26 States[58] which already had vendor payment programs have made their programs more comprehensive, i.e., provide services which they formerly did not provide through vendor payments.

The extent of improvement in services provided, however, varies considerably among the States. A change in method of payment may

[57] The number of recipients, total, and average payments by State are shown in Appendix B, Table 13.

[58] Arkansas, California, Connecticut, District of Columbia, Florida, Hawaii, Idaho (Nursing home care withdrawn from scope of OAA and provided in MAA), Indiana, Iowa, Louisiana, Maine, Maryland, Michigan, Missouri, Nevada, New Mexico, Ohio, Oklahoma, North Carolina, Tennessee, Utah, Vermont, Virginia, Virgin Islands, Washington, West Virginia.

or may not be important to the recipient. It could result in more adequate cash payments to meet both his subsistence needs and also his medical needs. Changes in average vendor payments provide a more definite indication of the impact of the 1960 amendments, even though OAA recipients in States with relatively high vendor payments do not necessarily receive comprehensive and high quality medical care, and those in States with relatively low vendor payments may receive care through other programs.

Between September 1960, the month before the amendment was effective, and January 1962 the U.S. average vendor payment per recipient increased from $10.75 to $13.26. Ten States did not make vendor payments for medical care for old-age assistance recipients in September 1960, but six of these States were providing vendor payments in January 1962. In 37 States average vendor payments per recipient were higher in January 1962 than in September 1960, but in 21 of them average money payments were lower, presumably at least in some cases because the State changed its method of payment to take advantage of more favorable matching provisions for vendor than for money payments. One State reported the same vendor payments and 6 States smaller average vendor payments in January 1962 than 16 months earlier. In 4 of these 6 States, the decrease was due to transfer of cases to the new medical assistance for the aged program, and opening new nursing home cases under MAA, also in order to take advantage of the more favorable Federal matching. Massachusetts and New York gained most, by transferring most of their nursing home cases from OAA to MAA.

Further consideration of overall changes in expenditures for medical care for aged persons who are needy or medically indigent will follow the description of the MAA program in Chapter 9.

Summary

It is clear that in some States the medical needs of OAA recipients are not being met through assistance programs. Four States assume no responsibility whatever under their old-age assistance program for provision of medical care through vendor payments. In 29 other States average expenditures for medical care in January 1962 through vendor payments were less than $15 a month per recipient, an amount certainly well below that required for purchase of adequate care.[59]

[59] The AHA and AMA proposals for Blue Cross and Blue Shield contracts (see Chapter 6) which they would like to see available to all aged persons, would cost in the neighborhood of $15 a month, and would provide services which would meet only about 50 percent of the total health needs of aged persons. Old-age assistance recipients, being older than the whole body of aged persons and having more illness and disability, require more care on the average than other aged persons.

The limitations imposed by many State programs on the conditions for which care will be provided or the amount or duration of care furnished also preclude provision of adequate care to old-age assistance recipients through the assistance programs.

Of course, in many States other medical resources are available to old-age assistance recipients: other public programs for providing medical care to the indigent and medically indigent; charity services of physicians; care paid for by community chests; free care provided by hospitals. The availability of these resources, which will be briefly described later, varies from State to State, and within States. It is difficult to assess their contribution. A recent attempt at such assessment reached the conclusion that in many States and localities assistance recipients were not obtaining adequate care.[60]

---

[60] *Medical Resources Available To Meet the Needs of Public Assistance Recipients;* Report by the Department of Health, Education, and Welfare to the Committee on Ways and Means, U.S. House of Representatives (Committee Print, 87th Cong., 1st sess.) 1961.

CHAPTER 9. THE MEDICAL ASSISTANCE FOR THE AGED PROGRAM

The 1960 (Kerr-Mills) amendments to the Social Security Act provided, effective October 1, 1960, not only for additional matching of expenditures under OAA in the form of vendor payments for medical care but also for Federal aid to the States in providing medical assistance to aged people not receiving old-age assistance whose income and resources are insufficient to meet the cost of needed medical care.

To obtain Federal aid, a State must submit a plan providing for medical assistance to the aged which meets certain requirements laid down in the Act. In addition to meeting most of the same requirements as those for old-age assistance the State's plan for medical assistance for the aged must provide (a) for some institutional and some noninstitutional services; (b) that no enrollment fee, premiums or special charges will be imposed as a condition of eligibility; (c) for service to individuals who are residents of the State but absent from it; (d) reasonable standards for determining eligibility and the extent of medical assistance given; (e) that no lien may be imposed against the property of any individual prior to his death on account of medical assistance properly paid in his behalf and that there shall be no recovery from his estate until after the death of the surviving spouse, if any; (f) that there shall be no durational residence requirement; and (g) that there will be no disclosure of information concerning benefits paid on behalf of individual recipients.

A State plan of medical assistance for the aged must be administered by the same State agency that administers old-age assistance.

In MAA the Federal Government participates only in expenditures made in the form of vendor payments, i.e., payments to hospitals, physicians, etc., for medical care provided to recipients. It does not participate in amounts paid directly to recipients.

There is, however, specific provision in the statute for Federal financial participation in State expenditures "for insurance premiums for medical or any other type of remedial care or the cost thereof" paid as medical assistance in behalf of eligible individuals.

The extent of Federal aid varies from State to State within a range of 50 to 80 percent, depending upon relative State per capita income. There are no limitations upon the amount in which the Federal

Government will participate for any one individual or for the State as a whole, as contrasted with OAA, in which Federal participation is limited to payments up to a specified maximum on the average. For this reason States whose average payment is above this maximum can increase Federal payments by transferring high cost medical care cases from OAA to MAA.

Through the end of March 1962, programs were in effect in 26 States (23 States plus Puerto Rico, Virgin Islands, and Guam).[61]

According to reports from State welfare directors, it is likely that programs will be placed in operation in 2 other jurisdictions early in 1962.[62] New Jersey still has under consideration legislation to begin an MAA program. Since very few State legislatures meet in 1962, it is unlikely that during 1962 many of the remaining 24 States will pass the required legislation or appropriate funds to implement legislation already passed. Five States have chosen to expand their old-age assistance programs for medical care to include needy persons who need only medical care, rather than to begin MAA programs. Under these programs, the same requirements apply as do for the States' OAA program generally including durational residence requirements, current liens on recipients' estates, and the publication of lists of recipients, where these are applicable.

Services provided

The services provided under the MAA programs of the States vary widely. A summary of the number of States providing these services is shown in Table 36. Detail on limitations by State may be found in Appendix B, Table 16.

TABLE 36.—*Medical Assistance for the Aged: Summary of number of States providing major types of services, October 1961*

Type of service [1]	Number of States
Hospital care	21
Nursing home care	14
Physicians' services	20
Office	16
Home or in nursing home	17
Hospital outpatient	16
Hospital inpatient	12
Dental care	10
Prescribed drugs [2]	12

[1] There are substantial limitations among the States on amounts and care provided. See Appendix B, table 16.

[2] Other than for hospitalized patients; drugs for hospital patients are included as part of hospital care.

Source: Bureau of Family Services, Social Security Administration.

[61] Alabama, Arkansas, California, Guam, Hawaii, Idaho, Illinois, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New York, North Dakota, Oklahoma, Oregon, Pennsylvania, Puerto Rico, South Carolina, Tennessee, Utah, Virgin Islands, Washington, West Virginia.

[62] Connecticut and Vermont.

Of the 21 States for which detailed data were available as of October 1, 1961, all provided some inpatient hospital care. However, 11 States imposed limitations on the number of days covered and/or the type of condition hospitalized. Several States also specified that the patient must pay part of the cost.

Nursing home care was provided under MAA programs in only 14 States as of October 1, 1961. Most of these States had limitations with respect to the number of days covered or the maximum payment allowed. Some had further qualifications relating to provision of care only on transfer from a hospital.

Physicians' services were provided in 20 of the 21 States having MAA programs. The physicians' services in the office, home, or outpatient department were generally limited in terms of visits or services paid for in a given period.

Ten States provided some dental services, but frequently provided only in emergencies, for relief of pain, or for treatment of acute infection. The services were usually limited to extractions and fillings.

Twelve States paid for some drugs outside the hospital, with limitations in some States on type of illness for which they may be prescribed.

With respect to the extent of overall coverage of the major kinds of services, three States [63] provided all types with no significant limitations, fourteen States [64] provided what might be termed intermediate coverage because of the limitations affecting one or more of the services, and four States [65] provided what might be termed a minimum coverage—only two major services.

The States vary widely in the conditions of eligibility for MAA. Some 17 States set maximums on the income and assets a recipient may have; an aged person with income or assets under these limits is eligible; one with income or assets above these limits is ineligible no matter what his medical needs or costs. Other States (four) say, in effect, "*A certain* level of income and resources is necessary for subsistence; any amount *beyond* this level will be evaluated to determine its availability to meet medical need. If the amount available is still not enough to pay for the person's necessary medical care, he is eligible for medical assistance for the aged."

The maximums on income and assets established by the States for a single recipient with no dependents range from $1,000 to $3,000. Varying allowances are made for dependents. Again it should be emphasized that these maximums take no account of a person's previous or anticipated medical costs. Thus, in a State with an income

[63] Hawaii, North Dakota, and Puerto Rico.
[64] Arkansas, Idaho, Kentucky, Louisiana, Massachusetts, Maryland, Michigan, New York, Oklahoma, Oregon, South Carolina, Virgin Islands, Washington, and West Virginia.
[65] Illinois, New Hampshire, Tennessee and Utah.

limit of, say, $1,200, an aged person with an income of $1,400 a year, who has Parkinson's disease and needs medical and nursing home care costing some $3,000 a year, is ineligible for medical assistance because of his income. (See Appendix B, Table 17 for detailed eligibility provisions.)

All States with a medical assistance program for the aged exempt the real property used as a home in determining eligibility, i.e., an aged person would not be required to sell his home or to place a mortgage upon it. Some, however, place a maximum on the equity allowable. West Virginia, which originally excluded the homestead as a resource, when tightening its eligibility requirements inserted "up to a value of $15,000." All States take into account the resource value of other real estate, although about half the States do not require liquidation. Most of the States exempt a life-insurance policy with a small cash surrender value. Medical insurance policies and similar resources designed to meet medical need are also considered as assets to be taken into account in determining whether payment will be made for medical care and in what amount. A number of States exclude premiums for such insurance, up to a stated maximum, from inclusion in income of an individual or a couple.

A small reserve of cash or "resources convertible to cash" is specifically permitted in most States. The amount permitted a single person ranged from $300 in Arkansas to $2,500 in Maryland.

Provisions regarding relatives' responsibility, i.e., the extent to which relatives will be held responsible for care, vary widely. Of the 21 States, 13 do not require that relatives of the aged applicant for medical assistance must contribute to the extent that they can towards the cost of needed care; 8 have a requirement which is identical with or similar to their requirement under OAA for support of applicant by relative.[66] The States vary in the standards used to assess the ability of relatives to pay for medical care of an applicant and the circumstances under which they will deny an application of an aged person if his children or other relatives are considered able to pay for the care required, often without regard to whether the relative fulfills this obligation.

Administration

Federal law requires that this program must be administered by the same agency as administers the State's OAA program. Hence, the administration of MAA programs is similar to that described above regarding OAA programs.

[66] California, Maine and Pennsylvania—which are not among these 21 states but which have begun MAA programs—also require relative responsibility.

Practices in opening MAA cases vary among the States. In 8 States, persons may apply concurrently with or in advance of their need for medical care. Once eligibility is established they remain eligible for any and all needed medical care for a continuing period, usually a year. After a year or some shorter period specified, continuing eligibility for medical care assistance is redetermined for all open cases.

The general practice in the other 13 States is to determine eligibility anew each time medical care may be needed, taking account of the kind and cost of the medical care needed. West Virginia, which initially provided for preauthorization as to financial eligibility for persons who were not immediately in need of medical care discontinued this practice effective December 1, 1961 and notified all persons who had been certified eligible for MAA (30,567 as of end of November) but who had not found it necessary to use the services that their cases would be closed, but that they could re-apply if in the future they needed medical services.

Selection of hospital, physician, etc., and method of payment

In all or virtually all States the provisions affecting choice or lack of choice of hospital, physician, nursing home, and druggist, which apply under the OAA program apply also under the MAA program. With minor exceptions in the case of States using a pooled fund for OAA, hospitals, physicians and other suppliers of care would be paid in the same way and on the same basis under both programs.

In general, the States which have for their OAA program contractual arrangements with the health department, Blue Cross or Blue Shield plans, or State or local medical societies either to provide service or to act as fiscal agents in paying for services (as described in Appendix B, Table 15), use the same arrangements for their MAA programs.

It is noteworthy that West Virginia, which was among the first States to initiate a program for MAA originally planned the schedule of fees and limitations of services for hospital, physician, and drug services to be identical with that of the general medical care program for other categories of assistance. This schedule was liberalized about January 1, 1961 for recipients of MAA. Thus, where the hospital rate was 90 percent of hospital costs up to $20 per day for the regular assistance recipients, the rate for MAA was actual reimbursable cost without maximum. Other items in the schedule were correspondingly higher for comparable services under MAA. In the late summer, the agency became concerned that the rate of expenditure under MAA would exhaust appropriations. It began making plans for a general modification of procedures as to authorization, tighten-

ing financial eligibility requirements, and bringing the fee schedules and limitations on service back in line with that prevailing for other categories of assistance.

Recipients and expenditures under the program

The number of recipients [67] of medical assistance to the aged increased gradually from October 1960 through December 1961 (table 37) as the programs in effect got under way and additional States established programs. In December 1961, there were 72,159 persons receiving medical assistance to the aged and in January 1962, 64,690 as West Virginia deferred payments for January causing a decrease of 8,100 recipients and Maryland changed its method of reporting, resulting in a decrease of 3,300. Payments, which had increased steadily up to November when they were just over $15 million, amounted to $14.9 million in January.

In January, 82 percent of all recipients were in three States, Massachusetts, Michigan, and New York (table 38). Of the total payments for medical care for recipients some 92 percent were made by these three States.

TABLE 37.—*Medical Assistance for the Aged: Number of States reporting, number of recipients, and total payments, each month, October 1960 to January 1962*

Year and month	Number of States reporting	Number of recipients [1]	Payments
1960			
October	0		
November	3	12,791	$2,441,175
December	5	14,922	2,922,261
1961			
January	5	16,734	3,437,412
February	5	18,678	3,852,628
March	5	21,492	4,033,741
April	7	27,998	5,890,726
May	8	41,388	8,295,631
June	9	46,247	9,311,027
July	10	52,030	10,943,079
August	14	59,093	11,959,747
September	15	60,928	12,654,268
October	16	66,396	13,681,550
November	16	71,655	15,015,298
December	18	72,159	13,919,808
1962			
January [2]	22	64,690	14,852,990

[1] Number of recipients are persons on whose behalf payments were made during the report month to suppliers of medical services.
[2] For State detail, see table 38.

Source: Bureau of Family Services, Social Security Administration.

[67] The term "recipient" means the number of persons for whom bills from suppliers of medical care were paid in the report month. The bills generally represent the services provided in a preceding month. The count of recipients does not necessarily reflect the number of persons actually receiving medical care services during the month covered by the report.

TABLE 38.—*Medical Assistance for the Aged: Recipients and payments for recipients, by State, January 1962* [1]

State	Number of recipients	Payments for recipients	
		Total amount	Average
Total	64,690	$14,852,990	$229.60
Arkansas	667	29,729	44.57
California	600	89,946	149.91
Hawaii	*230*	*44,996*	*195.63*
Idaho	1,060	165,112	155.77
Illinois	*181*	*91,738*	*506.84*
Kentucky	1,444	22,558	*15.62*
Louisiana	129	29,429	228.13
Maine	*432*	*97,896*	*226.61*
Maryland	3,510	124,492	35.47
Massashusetts	18,637	[2] 3,283,182	176.16
Michigan	4,741	1,463,361	308.66
New York	29,915	8,908,818	297.80
North Dakota	691	[2] 129,114	186.85
Oklahoma	267	67,180	251.61
Oregon	65	15,647	240.72
Puerto Rico	224	3,672	16.39
South Carolina	781	121,759	155.90
Tennessee	210	12,897	61.41
Utah	457	66,324	145.13
Virgin Islands	85	2,222	26.14
Washington	312	78,200	250.64
West Virginia	52	4,718	90.73

[1] Figures in italic represent program under State plan not yet approved by the Social Security Administration. All data subject to revision.
[2] Excludes money payments not subject to Federal participation as follows: $97,817 in Massachusetts and $2,226 in North Dakota.

Source: Bureau of Family Services, Social Security Administrstion.

Prior to the inception of the MAA program New York and Massachusetts had a considerable number of cases on their OAA rolls who were in nursing homes. Since average monthly assistance payments per recipient in both States were well above the maximum of $65 per recipient matchable by the Federal Government, these two States received relatively little Federal aid toward the cost of care for these nursing home cases. At the start of their MAA program, or soon after, both States transferred all or most OAA cases receiving nursing home care to their MAA program, because of more advantageous Federal matching. (It is apparent that these two States have recived a very large portion of all Federal aid under the MAA program.) Just over half of all MAA cases opened in these two States through December 1961 were transfers from OAA: 63 percent in Massachusetts, 41 percent in New York. In Idaho and North Dakota about two-thirds of the MAA cases opened through December were transfers from OAA. By contrast, in the other 17 States reporting on openings, only about 5 percent of the cases opened were transfers from OAA. (Table 39.)

About 1 percent of all cases opened in the United States had previously received other types of assistance and about one-fifth of this small group continued to receive other assistance: needy persons may not receive MAA and OAA simultaneously, but they may receive MAA and other types of assistance concurrently.

TABLE 39.—*Medical Assistance for the Aged: Cases opened by type of previous assistance, if any, October 1960 to December 1961*

State	Total cases opened	Assistance received previously			
		OAA	AB, APTD, ADC	GA	None
Total	166,851	45,900	1,574	600	118,777
Arkansas	2,103	0	0	0	2,103
Hawaii	397	148	0	0	249
Idaho	1,663	977	51	0	635
Illinois	696	0	0	0	696
Kentucky	5,294	0	0	180	5,114
Louisiana	110	0	0	0	110
Maine	244	0	0	0	244
Maryland	7,524	0	0	0	7,524
Massachusetts	29,191	18,439	443	70	10,239
Michigan	14,557	2,743	85	258	11,471
New Hampshire	66	0	0	0	66
New York	54,910	22,768	701	82	31,359
North Dakota	1,042	786	0	0	256
Oklahoma	2,589	0	0	0	2,589
Oregon	2,852	10	92	4	2,746
South Carolina	2,645	0	0	0	2,645
Tennessee	2,441	0	0	0	2,441
Utah	582	0	198	0	384
Virgin Islands	365	0	1	0	364
Washington	3,649	29	3	6	3,611
West Virginia	33,931	0	0	0	33,931

Source: Bureau of Family Services, Social Security Administration.

In January 1962, payments under MAA were half as much as total vendor payments under OAA ($30 million) for the country as a whole (table 40). The relation between the two programs varies widely from State to State. In some States (Massachusetts, New York, Michigan, West Virginia, Hawaii, Idaho and Maryland) the MAA expenditures are larger than the vendor payments under OAA. New York's MAA program dwarfs not only its OAA vendor payments but total payments under OAA. Massachusetts is spending almost three times as much for medical care under MAA as under its OAA program. On the other hand, in other States the expenditures thus far under MAA have been trifling as compared with vendor payments under OAA.

Summary and appraisal

Some 26 States now have MAA programs in effect. Undoubtedly these programs have been and will be useful in bringing medical care to aged persons who might otherwise have gone without, have exhausted slender resources to pay medical bills or been forced to ask for private charity.

In assessing the accomplishments of the Kerr-Mills provisions, OAA and MAA must be considered simultaneously. In effect, in many States MAA is not a new program. Many States previously took aged persons on their OAA rolls who needed only medical care,

TABLE 40.—*Vendor Payments Under OAA and MAA Programs: Comparison of expenditures in States with MAA programs, January 1962*

State	Vendor payments under OAA	Payments under MAA
All States	$29,941,701	$14,852,990
States reporting MAA payments	14,774,903	14,852,990
Arkansas	394,626	29,729
California	3,228,464	89,946
Hawaii	15,185	44,996
Idaho	45,451	165,112
Illinois	2,463,206	91,738
Kentucky	167,388	22,558
Louisiana	1,219,760	29,429
Maine	240,134	97,896
Maryland	53,133	124,492
Massachusetts	911,655	1,283,182
Michigan	707,238	1,463,361
New York	972,116	8,908,818
North Dakota	138,485	129,114
Oklahoma	1,301,775	67,180
Oregon	546,714	15,647
Puerto Rico	17,207	3,672
South Carolina	160,771	121,759
Tennessee	244,673	12,897
Utah	195,002	66,324
Virgin Islands	1,683	2,222
Washington	1,625,343	78,200
West Virginia	124,894	4,718
Other States	$15,166,798	----------

Source: Bureau of Family Services, Social Security Administration.

and many aged persons were taken on the rolls because an illness had used up available financial resources.

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

Thus far the 1960 amendments liberalizing Federal matching for medical care have been advantageous chiefly to the high income States. Federal matching provisions are such that it makes little or no difference to many lower income States whether they provide medical care through OAA or MAA. But to higher income States MAA offers increased opportunities for Federal matching of expenditures for medical care of the indigent or medically indigent aged. New York alone

accounts for almost two-fifths ($5.1 million) of the $13.4 million increase in total monthly payments under OAA and MAA combined, when January 1962 expenditures are compared with those for September 1960. The additional Federal share in these payments was $4.0 million, or about 80 percent of the total increase. Massachusetts, the other high income State which has transferred its general nursing home caseload from OAA to MAA, had increased total expenditures by about $25,000 when the two months are compared. The Federal share in these two programs in Massachusetts increased by about $1,455,000.

With respect to the adequacy of care provided to MAA recipients, it is clear that most States with programs limit the types and extent of care provided and some States the conditions for which care will be provided, as is true of medical care for OAA recipients. The low-income States where need is likely to be greatest have the greatest difficulty in financing even minimal services.

CHAPTER 10. OTHER PROGRAMS AND PHILANTHROPIC PROVISIONS FOR MEDICAL CARE FOR THE AGED

In addition to the medical services provided to needy or medically indigent persons through public assistance, a substantial amount of medical care is provided to aged persons through other public programs.

Public mental hospitals

The greater part of all prolonged hospital care for persons suffering from mental illness or who are mentally defective is provided by mental hospitals owned and operated by the State governments. The cost of such care represents in almost all States the largest single health expenditure of State governments.

State mental hospitals customarily provide care whether or not the patient or his family is able to pay any part of the cost. A few States provide free hospitalization for all, making no charge to anyone. However, in most States the patient or family is asked to pay as much of the cost as they can, with some examination being made of the person's or family's resources so as to determine how much it is feasible for them to pay. Some States bill the localities for care provided to their residents who cannot pay. For the country as a whole, total receipts from patients or from local governmental units on behalf of their resident patients have amounted in recent years to about 13 percent of the total maintenance costs of State and local mental hospitals.

In 1960 there were 313 State and local mental hospitals, with 704,000 beds and an average daily census of 658,000.[68] Almost one in three beds in these hospitals is occupied by a person 65 and over. Twenty-seven percent of all first admissions in 1960 were of persons 65 and over.

There seems little question but that many of the aged now in public mental hospitals could be better cared for at home or in a local nursing home or chronic hospital or hospital wing, if only the needed services were physically and financially available to them. Undoubtedly there

[68] *Hospitals* (American Hospital Association), Guide Issue, August 1, 1961, pt. II.

will be a decrease in the aged population of mental hospitals as more nearly adequate local services for older people are developed and brought within their financial reach.

Other public hospitals

Traditionally State and local governments have assumed responsibility for the care of persons with tuberculosis, with such charges as might be made for their care ordinarily scaled to the person's or his family's ability to pay. In many States, hospitalization for tuberculosis is available as a free public service—no charge being made to any patient.

As of the end of 1960, there were 207 State and local governmental tuberculosis hospitals, with 48,000 beds, an average daily census of 36,000. Approximately 20 percent of the beds in these public tuberculosis hospitals were occupied by persons 65 and over.

Many State and local governments own and operate general hospitals. Some of these hospitals serve the general population, are conducted like voluntary community hospitals, and their operating expenses are met wholly or mainly out of payments by or on behalf of patients. Other State, county, and city general hospitals are designed primarily to serve indigent or medically indigent persons and their operating expenses are met wholly or mainly from tax funds. The cost of care for public assistance recipients in some State or local governmental hospitals is paid for by the public assistance agencies; in other hospitals they will receive care without cost to the public assistance agency. A one day census of hospitals made by the American Medical Association in 1953 showed that patients 65 and over comprise 26 percent of the patients in all non-Federal governmental general hospitals.

Veterans Administration care for the aged

The Veterans Administration operates the largest organized medical care system in the United States—170 hospitals with 120,542 beds, and 93 outpatient clinics. Generally, three groups of veterans are eligible for care in Veterans Administration hospitals. Those needing care for service-connected disabilities are unconditionally eligible for hospital care. Veterans with service-connected compensable disabilities who need care for nonservice-connected disabilities are eligible for care if a bed is available. War veterans with no service-connected disabilities needing care are eligible for care if a bed is available and if they sign an affidavit certifying their inability to defray the cost of hospitalization.

Some 22.4 million men and women are veterans. Of these about 2.2 million or over 9 percent are 65 and over. More than 28 percent of the patients in Veterans Administration Hospitals in 1961 were 65 and over. By 1965 the proportion of patients who are 65 or over is expected to reach 40 percent.

Care for the aged through private charity

A certain amount of medical care is available through private charity to aged and other persons unable to pay for the care they need.

Services by the medical profession.—The medical profession has always given much service to those unable to pay.

On the basis of a questionnaire survey of its readers, the magazine, New Medical Materia, estimated that physicians in this country provided $658 million worth of free care in 1960—$3,360 worth per general practitioner and $4,812 worth per specialist. Of the total value of free service 39.9 percent was reported as given to private patients, 22.7 percent in outpatient clinic service, 26.5 percent in hospital ward service and 10.9 percent to courtesy cases, athletes, blood donors, etc.[69]

A recent survey by the Louisiana State Medical Society of its members found that the average doctor gave $3,531 worth of free service annually.[70] A survey in 1960 by the Philadelphia County Medical Society found that the physicians in the city gave free care to a value of $6,431 per physician.[71] The Texas Medical Association has estimated that the average doctor in that State contributed 15 percent of his working hours to free treatment.[72]

Voluntary agencies.—There are some 60 to 70 national voluntary organizations with primary interest in the health field. These include such well-known organizations as the American National Red Cross (though it is mainly concerned with relief aid in national calamities), American Cancer Society, the National Foundation, National Tuberculosis Association. Total receipts of all these organizations are estimated at about a third of a billion dollars in 1960.

The health agencies spend their funds for research, lay and professional education, community services and medical care. No satisfactory data are available as to total expenditures of these organizations for medical care. Nine major health organizations reported expenditures of $31 million for medical care in a recent year and the Red Cross reported additional expenditures of approximately $7,000,000 for health and safety services. All health agencies may have spent in the neighborhood of $50 million a year for health serv-

[69] *New Medical Materia*, October 1960, p. 35.
[70] *Medical Economics*, December 7, 1959, p. 1.
[71] AMA *News*, May 16, 1961, p. 13.
[72] Texas Research League, *Indigent Medical Care Service for Texas Public Assistance Recipients*, 1961, p. 23.

ices. How much of this went for persons 65 and over can only be conjectured.

A certain amount of medical care for the indigent and medically indigent is paid for by United Fund and Community Chest agencies and service organizations, such as Rotary, Lions and Shriners. In 1960, of the sums raised in all united fund and community chest campaigns, some $127 million were allocated to health agencies and purposes. Of this amount $21 million went to hospitals and clinics largely, if not entirely, for care of the indigent, $57 million to the Red Cross, and $49 million to various health agencies, including visiting nurses associations and national health agencies dealt with above.

Services by voluntary hospitals.—While most of the care provided by hospitals to "free" or charity cases is paid for in one way or another by Government or community organizations, a considerable amount of care is provided by hospitals without reimbursement from any other party. This "free care" includes services provided to persons for whose care no governmental or other agency will assume responsibility, and services for which the hospital charges but is unable to collect.[73] It includes also the difference between the cost to the hospital of providing care and the amount actually paid by governmental or community agencies for the care of indigent and medically indigent persons. Frequently welfare departments, other State and local governmental units and community agencies pay hospitals for indigent care at rates below the full cost of care.[74]

Some of the free care provided by hospitals from their own resources is made possible by income from endowments and private gifts and contributions and governmental grants or subsidies. However, in all probability much the larger share is financed by paying patients who are billed at higher rates than would otherwise be necessary. Thus, paying patients, in effect, help to subsidize care for the indigent.

---

[73] The 1959 rate survey of the AHA found that among responding hospitals 5.1 percent of the billed hospital charges were "uncollected." (AHA, *Hospital Rates 1959*, pp. 34–6).

[74] Some instances follow: In Delaware the counties have been paying hospitals at the rate of $4 a day for the indigent cases. Pennsylvania under its statewide program has been paying hospitals $10 a day for care which it costs them $25 to $30 to provide. New York City has been paying voluntary hospitals $24 a day for care costing at least $32. North Carolina pays hospitals $8.50 per diem for inpatients on old-age assistance; the average cost to the hospitals is $22.98 per diem. New Hampshire pays from $4 to $18 a day; New Mexico from $12.19 to $18.50; Maryland pays 80 percent of costs but not in excess of 60 percent of the statewide average. (Data from various sources, including (a) American Hospital Association, *Report on Survey of Hospital Reimbursement Under State Public Assistance Programs, July 1959*, and (b) *Medical Economics*, January 19, 1961, p. 111).

PART IV

Trends in Health Services and Health Costs of Older Persons

CHAPTER 11. TRENDS IN SELECTED HEALTH SERVICES AND COSTS

Outstanding advances in scientific medicine have contributed not only to improved health and the well being of people generally, but in addition have made for higher medical care costs. New advances in medicine are already in sight and the tremendous investment now being made in medical research promises still further discoveries and changes. The dynamic nature of modern medicine makes it very difficult to predict what the medical services of the future will be. It is possible to identify certain developments that are already in process.

Changing health care technology

Medical research has made it possible for many people, with the support of continuing care from physicians and other health personnel, to live useful lives despite the handicaps of heart disease, arthritis, and other chronic diseases. But the adequate care of chronic illness is aptly termed "extensive" and over time usually requires a wide variety of health specialists and often varying facilities such as the specialty hospital, general hospital, nursing home, or organized home health service organization.

Accompanying the advances in health care technology, there has been a sharp increase in the number of professional health personnel other than physicians. In 1900, for every physician in practice there was one other professional health practitioner. Today there are four such persons including nurses, laboratory technicians, therapists, and other health professionals for every physician.[75] The professional health care team today comprises more than thirty auxiliary or "paramedical specialty" occupations.

---

[75] Public Health Service, *Physicians for a Growing America* (Publication No. 709), September 15, 1959, p. 65.

Enlarging role of hospitals.—In the modern hospital, the full complex of health care technology is represented both in range of specialized personnel and number of types of facilities to serve the needs of both inpatients and outpatients.

There has been a pronounced increase in the ratio of full-time hospital personnel per 100 patients during the past decade. In 1950, there were 178 such hospital personnel per 100 patients while by 1960 the ratio had stepped up to 226 full-time hospital personnel per 100 patients.

There has been a significant increase generally in the proportion of hospitals offering more of certain specialized services (table 41).

TABLE 41.—*Special Services in Short-Term General and Other Special Hospitals: Percentages with selected services, 1950 and 1960*

Service	1950	1960
Clinical laboratory	84	96
Electrocardiograph	76	93
Blood bank	45	56
Pathology laboratory	(1)	49
Physical therapy department	35	41
Radioactive isotope facility	(1)	22
Electroencephalograph	10	14
Home care program	(1)	3

[1] Data not available.

Source: *Hospitals* (American Hospital Association), Guide Issue, June 1, 1951, and August 1, 1961.

The range of hospital services indicates that the modern general hospital represents a "pooling of resources" to provide "specialized equipment and highly trained personnel that no patient or doctor could provide individually, and which no patient could afford to use and maintain by himself." [76]

It is likely that the trend toward more complete availability of a wide range of technical equipment will continue with more area-wide pooling of the more expensive and specialized equipment such as the electroencephalograph. Sharing in use of specialized equipment is a major benefit of active working relationships among hospitals in a given area or region.

In both urban and rural areas, the general hospital is increasingly a principal center of health care activities. Some 15 years ago, the Commission on Hospital Care recommended that the general hospital be the center for preventive, curative, and rehabilitative services to the chronically ill as well as the acutely ill. There is high unanimity among professional health personnel with respect to the central role of the general hospital in modern health care.

The experimentation and development of arrangements for inpatient hospital care underway in several hospitals often bear directly on the functioning of the hospital as a community health center in-

[76] Public Health Service, *Principles for Planning the Future Hospital System*, by Ray E. Brown (Publication No. 721), 1959, p. 4.

cluding care for older people. An approach for tailoring services to the needs of the individual patient has been termed "progressive patient care."

Another significant trend is the movement away from specialized hospitals to the provision of as full a range of services in general hospitals as circumstances permit. General hospitals today are covering more long-term illness care through having specialized units for such service, by having nursing homes affiliated with them, and in development of organized home care services.

Of particular interest to the older patients with chronic illnesses, active interrelationships are developing among hospitals. Transfers of patients from community hospitals to the larger hospitals for specialized treatment including radioisotope treatments for malignant neoplasms, working relationships between hospitals for intensive laboratory analyses, and the regularized services of highly specialized medical personnel from the larger hospitals to community hospitals in anesthesiology and radiology are illustrations of types of systematic and regular teaming up of services of two or more hospitals.

Developments in skilled nursing homes.—Of all the inpatient facilities, nursing homes have had the most rapid development in recent years. As of January 1, 1961 there were approximately 326,000 skilled nursing home beds in the country as reported under the Hill-Burton Program.[77] Availability of skilled nursing homes is of particular importance to older people. Various studies have shown that the nursing home is primarily a long-term care home for the aged, many of whom are disabled and chronically ill. Some of the care provided in these skilled nursing homes is also custodial.

Increasing attention is being directed to differentiation of nursing homes in accordance with service requirements of patients, to improved licensure and regulation of nursing homes, and to the quality of care provided including around-the-clock presence in the facility of a registered nurse. All of the States now license nursing homes although the standards vary considerably among the States. Considerable progress has been made in recent years in revising and improving nursing home laws and regulations which have resulted in raising standards. With the continued growth and upgrading in quality of nursing homes, with more active working relationships with other health services and particularly general hospitals, and with increased coverage under health insurance these facilities will be strengthened as a resource for health care.

Rise of home care services.—Home health services include community visiting nurses, organized home care programs, and homemaker services.

---

[77] Public Health Service, Division of Hospital and Medical Facilities, ***Hospital and Medical Facilities in the United States as of January 1, 1961.***

As of 1957, there were 8,200 public health agencies employing some 29,400 public health nurses. However, not all of these agencies provided bedside care of a nurse functioning under the direction of a physician. Visiting nurse associations serve 88 percent of the cities with populations of 100,000 or more and almost half of the smaller cities of 25,000 to 100,000.[78]

In July 1961, there were 45 communities in 25 different States having organized home care programs.[79] These programs are intended to meet the needs of homebound patients who generally require the services of several health specialities. Such programs may be headquartered in a hospital, visiting nurse association, health department, or other agency. They often involve a team of health workers for consultation and services, including medical specialists, physical and occupational therapists, medical social workers, and psychologists. The relationships between the patient, his family, his physician, and nurse are nevertheless important in home care. This type of care is particularly appropriate for the long-term illness of the elderly—heart disease, cancer, arthritis, and other illness. For some individuals, it reduces the length of stay and the number of readmissions to the hospital and for other persons it replaces need for custodial institutional care.

Homemaker service programs were functioning as of July 1961, in 163 communities in 38 different States.[79] There were 215 agencies which sponsored these programs, 70 having been established since 1958. This sizeable increase indicates how readily this type of program can be developed when large numbers of professionally trained personnel are not involved. Homemaker services are a substitute for the personal care and homekeeping duties that adult family members would ordinarily perform if they were available and able to do them.

Community facilities development.—Since 1946, the Federal Government has provided funds for hospital construction. Last year, it extended its support to a wide range of community health facilities. Matching funds are now available to the States to build up community health services and for the construction of nonprofit nursing homes. Expanded homemaker services and home nursing care can also be supported under the program. Special project grants are available to develop improved methods of providing out-of-hospital community health services particularly for the chronically ill and aged. This new program should stimulate and encourage the more rapid expansion of newer types of services of special importance to the aged.

---

[78] Public Health Service, *Areawide Planning for Hospitals and Related Health Facilities* (Publication No. 885), July 1961, p. 39.

[79] U.S. Senate, *Problems of the Aging, Hearings Before the Subcommittee on Federal and State Activities of the Special Committee on Aging*, (87th Cong., 1st sess.), 1961, Part 1.

Health care costs

The rising costs of health care are of particular concern for older people because of their relatively high utilization of hospital and other health services and their comparatively low financial resources for meeting such costs.

Trends in health care costs.—The standard measure of price movements in the United States is the Bureau of Labor Statistics' Consumer Price Index. The "price" of medical care began to climb in 1941, but the big increase came after 1950. Between that year and 1961, medical care prices went up more than twice as much as the average "price" for all the goods and services used by families, whereas over the longer period, from 1940 to 1961, they went up only slightly more than the average for all goods and services (Table 42).

TABLE 42.—*Consumer Price Index: Percent increase by category and for selected medical care items, 1950 to 1961 and 1940 to 1961*

Item	1950 to 1961	1940 to 1961
All items	24.3	113.4
Medical care [1]	51.8	121.3
Hospital daily service charges	109.7	376.8
Physicians' fees	43.0	99.6
Dentists' fees	29.0	96.7
Prescriptions and drugs	16.7	45.8
Food	19.7	153.3
Apparel	12.3	107.1
Housing	24.9	73.4
Transportation	32.9	111.9
Personal care	32.5	125.2
Reading and recreation	20.0	93.6
Other goods and services	26.6	83.0

[1] Includes optometric examinations and eyeglasses not shown separately. Hospitalization and surgical insurance included in the index for 1961 but not for the two earlier years.

Source: Bureau of Labor Statistics, *Price Indexes for Selected Items and Groups.*

Hospital daily service charges (and hospitalization insurance premiums) have risen most among the components of the medical care index. The rise in physicians' fees, dentists' fees, eye examinations, surgical insurance, and drug outlays has been more in line with the general price increase, or at least the increase in prices of other services, such as transportation and personal care.

Total expense per patient day in nonfederal short-term general and special hospitals, as reported by the American Hospital Association, somewhat more than doubled between 1950 and 1960, going from $15.62 to $32.23. This was slightly more than the increase in the price index of hospital daily service charges, presumably because the expense per patient day reflected some increases in services provided. Comparable data on expense per patient day are not available prior to 1946 when the average was only $9.39, hospital wages and hours were generally at pre-war levels, and there were severe staff shortages.

Factors in rise of health costs.—With the array of technological facilities in the hospital today, there has been need for a larger proportion of skilled workers plus an attempt to bring hospital salaries into line with the general wage level. In 1946, the average annual earnings of full-time general hospital employees was only $1,226, or approximately half as much as that of a full-time worker in industry (Table 43). In the 14-year period since 1946, annual earnings for all hospital employees nearly tripled, while those of industrial workers doubled. This means that in 1960, the earnings of the average hospital employee ($3,240 a year) had gone up to almost 70 percent as much as those of the average industrial worker. Accompanying the rise in earnings has been a significant reduction in the length of the work week in hospitals, and a corresponding increase in the number of hospital employees needed.

TABLE 43.—*Earnings of Hospital Employees and Industrial Workers: Comparison of earnings and payroll costs as percent of total hospital expenses, 1946–60*

Year	Payroll costs as percent of total hospital [1] expenses	Annual earnings		
		Hospital [1] employees	Industrial workers	Hospital employees as percent of industrial workers
1946	53.0	$1,226	$2,356	52.0
1950	56.7	1,817	3,008	60.4
1955	61.6	2,563	3,847	66.6
1960	62.3	3,240	4,705	68.9

[1] Short-term general and other special hospitals.

Source: *Hospitals* (American Hospital Association), Guide Issue, August 1, 1961, and Department of Commerce, *Survey of Current Business*, July 1961.

Hospital payrolls have thus assumed an increasingly larger share of the hospital expenses, constituting a significant factor in the increased cost of hospital care. In 1946, payroll accounted for a little more than one-half of total hospital expenses. In the ten year period, 1946 through 1955, the percent increased steadily to 61.6. In the next 5 years, however, the ratio of payroll to total hospital expenses remained relatively stable at approximately 62 percent (except for a slight decrease reported in 1957 and 1958), indicating that other factors are contributing toward the increased costs during this period (table 43).

The labor displacement possibilities, with the introduction of new types of hospital equipment, are limited.[80] Expensive hospital equipment has often required additional and more costly labor. "As newly developed and diagnostic and treatment equipment is added to hospitals, more—not fewer—people are required to operate it. Hos-

[80] Brown, Ray E., "The Nature of Hospital Costs," *Hospitals*, (American Hospital Association), April 1, 1956.

pital equipment is expensive, its cost is impressive, but the enduring element of cost for these new services is the newly trained personnel who must accompany it." [81]

In attempting to anticipate trends in health costs for the next 15 to 20 years, there are many pertinent factors to be considered. On the supply side there are the changing medical technology and hospital payroll costs. Progress toward regional and community planning offers promise for slowing the increase in hospital rates. As hospital wage rates, hours and other conditions of employment meet prevailing community standards, this component of hospital costs will probably rise at a slower rate. On the demand side is the growing size of the older population, probable changes in their ability to pay for medical care, the strengthening interest in greater health protection, resulting in higher standards of care, and the expanding scope of services. All of these point toward further increases in the cost of health care.

Costs of health care will probably rise over the next 15 or 20 years at least as much as the rise in general price level. However, it seems fairly certain that the increase in health costs, particularly hospital costs, will not continue to exceed the increase in the general level of prices to the extent they have in the last decade.

Overall health costs and prospects.—Public and private expenditures for health services, health research, construction of health facilities, and public health activities in 1960 took 5.4 percent of the Nation's total output.[82] In 1929, all such health expenditures amounted to about 3.5 percent of the gross national output. Whether the proportion of the national output going into health services in the next two decades will change significantly depends both upon developments in the health technology and applied health care fields and upon the rate of growth of total output. The public needs and demands for health protection, including services for older people, will be a basic factor in determining its priority in relation to other living needs for sharing in the national income. If the productivity of our economy continues to grow, we shall be able to expand our health services well beyond present levels without strain and without significant change in the present ratio of health expenditures to total output.

---

[81] Nelson, Dr. Russel A., "The Case for Hospitals," statement before the Insurance Commission for the State of Maryland, May 26, 1958.

[82] Merriam, Ida C., "Social Welfare Expenditures, 1959–60," *Social Security Bulletin*, November 1961, p. 9.

APPENDIXES

APPENDIX A

TABLE 1.—*Population Aged 65 and Over: Number, percent of total population, and percentage increase, by region and State, April 1, 1960 and 1950*

Region [1] and State	Number of persons (thousands)		Percent of total population		Percent increase 1950–60
	1960	1950	1960	1950	
Total (including Puerto Rico and the Virgin Islands)	16,684.0	12,382.3	9.2	8.1	34.7
United States [2]	16,559.6	12,294.7	9.2	8.1	34.7
New England	1,121.8	906.6	10.7	9.7	23.7
Maine	106.5	93.6	11.0	10.2	13.9
New Hampshire	67.7	57.8	11.2	10.8	17.2
Vermont	43.7	39.5	11.2	10.5	10.6
Massachusetts	571.6	468.4	11.1	10.0	22.0
Rhode Island	89.5	70.4	10.4	8.9	27.2
Connecticut	242.6	176.8	9.6	8.8	37.2
Mideast	3,708.0	2,785.8	9.6	8.3	33.1
New York	1,687.6	1,258.5	10.1	8.5	34.1
New Jersey	560.4	394.0	9.2	8.1	42.2
Pennsylvania	1,128.5	886.8	10.0	8.4	27.3
Delaware	35.7	26.3	8.0	8.3	35.8
Maryland	226.5	163.5	7.3	7.0	38.5
District of Columbia	69.1	56.7	9.0	7.1	22.0
Great Lakes	3,358.5	2,595.9	9.3	8.5	29.4
Michigan	633.2	461.6	8.2	7.2	38.2
Ohio	897.1	709.0	9.2	8.9	26.5
Indiana	445.5	361.0	9.6	9.2	23.4
Illinois	974.9	754.3	9.7	8.7	29.2
Wisconsin	402.7	309.9	10.2	9.0	29.9
Plains	1,720.0	1,377.6	11.2	9.8	24.9
Minnesota	354.4	269.1	10.4	9.0	31.7
Iowa	327.7	273.0	11.9	10.4	20.0
Missouri	503.4	407.4	11.7	10.3	23.6
North Dakota	58.6	48.2	9.3	7.8	21.6
South Dakota	71.5	55.3	10.5	8.5	29.3
Nebraska	164.2	130.4	11.6	9.8	25.9
Kansas	240.3	194.2	11.0	10.2	23.7
Southeast	3,256.4	2,298.1	8.4	6.8	41.7
Virginia	289.0	214.5	7.3	6.5	34.7
West Virginia	172.5	138.5	9.3	6.9	24.5
Kentucky	292.3	235.2	9.6	8.0	24.3
Tennessee	308.9	234.9	8.7	7.1	31.5
North Carolina	312.2	225.3	6.9	5.5	38.6
South Carolina	150.6	115.0	6.3	5.4	30.9
Georgia	290.7	219.7	7.4	6.4	32.3
Florida	553.1	237.5	11.2	8.6	132.9
Alabama	261.1	198.6	8.0	6.5	31.5
Mississippi	190.0	153.0	8.7	7.0	24.2
Louisiana	241.6	176.8	7.4	6.6	36.6
Arkansas	194.4	149.0	10.9	7.8	30.5
Southwest	1,135.7	784.6	8.0	6.9	44.7
Oklahoma	248.8	193.9	10.7	8.7	28.3
Texas	745.4	513.4	7.8	6.7	45.2
New Mexico	51.3	33.1	5.4	4.9	55.1
Arizona	90.2	44.2	6.9	5.9	103.9
Rocky Mountain	367.7	270.6	8.5	7.8	35.9
Montana	65.4	50.9	9.7	8.6	28.6
Idaho	58.3	43.5	8.7	7.4	33.8
Wyoming	25.9	18.2	7.8	6.3	42.6
Colorado	158.2	115.6	9.0	8.7	36.8
Utah	60.0	42.4	6.7	6.2	41.3

See footnotes at end of table.

TABLE 1.—*Population Aged 65 and Over: Number, percent of total population, and percentage increase, by region and State, April 1, 1960 and 1950*—Continued

Region [1] and State	Number of persons (thousands)		Percent of total population		Percent increase 1950–60
	1960	1950	1960	1950	
Far West	1,891.6	1,275.6	8.8	8.3	48.3
Washington	279.0	211.4	9.8	8.9	32.0
Oregon	183.7	133.0	10.4	8.7	38.1
Nevada	18.2	11.0	6.4	6.9	65.4
California	1,376.2	895.0	8.8	8.5	53.8
Alaska	5.4	4.7	2.4	3.7	13.6
Hawaii	29.2	20.4	4.6	4.1	46.0
Puerto Rico	122.2	85.6	5.2	3.9	42.8
Virgin Islands	2.2	2.0	6.9	7.5	9.7

[1] The regional classification follows that now used by the Department of Commerce for analysis of personal income by State.
[2] Includes Alaska and Hawaii for 1950 as well as for 1960.

Source: Bureau of the Census, *United States Census of Population: 1960, General Population Characteristics, United States Summary* (Final Report PC (1)-1B) August 1961.

TABLE 2.—*Aged Population and Eligibility for OASI: Estimated number of persons by age, 1964, 1970, and 1980*

[In millions]

Age	January 1, 1964	July 1, 1970	July 1, 1980
Total population:			
Total 65 years and over	17.9	20.2	25.3
68 years and over	13.7	15.8	19.8
70 years and over	11.2	13.1	16.4
72 years and over	9.1	10.7	13.5
Total 62 years and over	22.4	25.5	31.4
Total eligible for OASI:			
Total 65 years and over	14.4	17.1	22.6
68 years and over	10.5	13.2	17.6
70 years and over	8.6	10.7	14.4
72 years and over	6.7	8.8	12.0
Total 62 years and over	18.2	21.5	27.9

Source: 1970 and 1980—Chief Actuary, Social Security Administration; 1964—Actuarial Branch, Division of Program Analysis, Bureau of Old-Age and Survivor's Insurance, Social Security Administration.

TABLE 3.—*Aged Population Eligible for OASI: Estimated number of persons aged 65 and over, by State, January 1, 1964*

[In thousands]

State of residence	Number[1]	State of residence	Number[1]
Total	14,448	Montana	57
		Nebraska	137
Alabama	195	Nevada	15
Alaska	4	New Hampshire	63
Arizona	83	New Jersey	541
Arkansas	148	New Mexico	39
California	1,191	New York	1,555
Colorado	122	North Carolina	271
Connecticut	233	North Dakota	50
Delaware	33	Ohio	788
District of Columbia	47	Oklahoma	176
Florida	535	Oregon	175
Georgia	208	Pennsylvania	1,024
Hawaii	27	Rhode Island	86
Idaho	53	South Carolina	117
Illinois	856	South Dakota	61
Indiana	410	Tennessee	243
Iowa	276	Texas	565
Kansas	198	Utah	53
Kentucky	239	Vermont	38
Louisiana	156	Virginia	239
Maine	96	Washington	250
Maryland	189	West Virginia	149
Massachusetts	505	Wisconsin	377
Michigan	624	Wyoming	22
Minnesota	304	Puerto Rico	83
Mississippi	137	Virgin Islands	1
Missouri	404		

[1] Excludes eligible persons residing outside the United States and about ½ million eligible under the railroad retirement program.

Source: Bureau of Old-Age and Survivors Insurance, Social Security Administration.

TABLE 4.—*Aged Population Receiving OASDI and OAA Benefits: Number and percent of aged population, June 30, 1961*

State of residence[1]	Total number		Percent of aged population		
	OASDI	OAA	OASDI	OAA	OASDI or OAA or both
Total	11,256,125	2,296,190	65.7	13.4	74.9
Alabama	149,941	99,881	56.2	37.4	84.2
Alaska	3,326	1,420	57.3	23.7	72.3
Arizona	57,784	14,136	59.6	14.6	69.6
Arkansas	115,814	56,414	58.8	28.6	82.1
California	911,147	253,937	63.7	17.8	72.6
Colorado	94,898	51,270	58.6	29.3	75.7
Connecticut	182,838	13,871	73.1	5.5	76.1
Delaware	25,364	1,205	68.6	3.3	71.0
District of Columbia	37,158	3,045	53.1	4.4	56.0
Florida	375,772	70,100	62.4	11.6	69.7
Georgia	159,260	95,325	53.6	32.1	79.5
Hawaii	20,332	1,439	67.8	4.8	71.4
Idaho	41,858	7,253	69.8	12.1	77.8
Illinois	672,656	70,259	67.3	7.0	72.3
Indiana	327,065	26,157	72.4	5.8	76.7
Iowa	221,542	33,480	66.9	10.1	73.9
Kansas	157,126	27,531	64.4	11.3	72.7
Kentucky	189.106	55,727	63.9	18.8	78.7
Louisiana	118,673	126,040	47.9	50.8	82.9
Maine	78,561	11,072	73.4	10.3	79.7

See footnote at end of table.

TABLE 4.—*Aged Population Receiving OASDI and OAA Benefits: Number and percent of aged population, June 30, 1961*—Continued

State of residence [1]	Total number		Percent of aged population		
	OASDI	OAA	OASDI	OAA	OASDI or OAA or both
Maryland	145,665	9,615	62.5	4.1	65.6
Massachusetts	405,306	62,766	69.9	10.8	75.0
Michigan	486,718	56,494	73.9	8.6	79.5
Minnesota	238,578	45,627	65.7	12.6	74.3
Mississippi	106.900	81,132	55.7	42.3	85.7
Missouri	320,785	113,361	62.7	22.1	77.3
Montana	44,999	6,484	67.2	9.7	73.6
Nebraska	109,814	14,377	65.8	8.6	72.2
Nevada	11,577	2,535	60.9	13.3	67.1
New Hampshire	50,497	4,834	74.3	7.1	78.6
New Jersey	418,353	18,952	72.1	3.3	74.2
New Mexico	28,936	11,061	53.6	20.5	70.3
New York	1,219,081	61,297	70.3	3.5	72.5
North Carolina	209,457	47,593	65.5	14.9	77.7
North Dakota	39,762	7,075	67.4	12.0	76.4
Ohio	621,809	89,814	68.0	9.8	74.5
Oklahoma	137,520	88,161	54.4	34.8	80.0
Oregon	137,691	16,469	72.9	8.7	78.3
Pennsylvania	807,802	49,977	70.2	4.3	73.2
Rhode Island	69,017	6,615	75.8	7.3	79.9
South Carolina	90,741	30,928	59.3	20.2	77.9
South Dakota	48,687	8,479	66.7	11.6	75.4
Tennessee	187,444	53,995	59.5	17.1	74.5
Texas	426,550	220,594	55.2	28.5	76.4
Utah	40,682	7,516	65.6	12.1	74.4
Vermont	30,825	5,611	70.1	12.8	78.3
Virginia	186,605	14,459	63.3	4.9	67.6
Washington	196,302	46,930	68.9	16.5	78.6
West Virginia	119,716	18,678	69.2	10.8	78.8
Wisconsin	298,321	33,542	72.4	8.1	77.8
Wyoming	17,292	3,105	64.0	11.5	71.0
Puerto Rico	61,714	37,926	49.0	30.1	79.0
Virgin Islands	738	527	32.8	26.4	59.1
Guam	20	99	1.8	9.9	11.7

[1] Distribution by State estimated for OASDI beneficiaries.

Source: Bureau of Family Services and Bureau of Old-Age and Survivors Insurance, Social Security Administration.

TABLE 5.—*Persons Aged 65 and Over in the United States With Money Income: Estimated number and distribution of persons by type of money income, June 1961* [1]

Type of money income	Number (in thousands)			Percent of total		
	Total	Men	Women	Total	Men	Women
Total population aged 65 and over	17,130	7,760	9,370	100.0	100.0	100.0
Employment, total [2]	4,100	2,290	1,810	23.9	29.5	19.3
Employment and no income from public programs	910	630	280	5.3	8.1	3.0
Employment and social insurance benefits	2,610	1,230	1,380	15.2	15.9	14.7
Employment and payments under other public programs	580	430	150	3.4	5.5	1.6
Social insurance (retirement and survivor) benefits, total [3] [4]	12,430	5,940	6,490	72.6	76.5	69.3
Benefits and no earnings or veterans' or public assistance payments	7,950	3,660	4,290	46.4	47.2	45.8
Benefits and veterans' payments	1,090	710	380	6.4	9.1	4.1
Benefits and public assistance	780	340	440	4.6	4.4	4.7
Veterans' pension or compensation, total [4]	1,890	1,110	780	11.0	14.3	8.3
Veterans' payment and no earnings or social insurance [5]	310	30	280	1.8	.4	3.0
Public assistance, total [6]	2,400	820	1,580	14.0	10.6	16.9
Public assistance and no earnings or payments under other public programs	1,510	420	1,090	8.8	5.4	11.6
No income from employment or public programs	1,390	310	1,080	8.1	4.0	11.5

[1] The 50 States, the District of Columbia, Puerto Rico, and the Virgin Islands.

[2] Includes 3,200,000 earners and an estimated 900,000 nonworking wives of earners. The figures on earners differ from those published by the Bureau of Labor Statistics, not only because of the inclusion of Puerto Rico and the Virgin Islands but, more important, because they take account of the larger-than-expected number of persons aged 65 and over reported in the Decennial Census and not yet reflected in the population totals shown in the Monthly Reports on the Labor Force.

[3] Includes persons with income from one or more of the following sources: old-age, survivors, and disability insurance, railroad retirement, and Government employee retirement as follows:

Type of money income	Number (in thousands)			Percent of total		
	Total	Men	Women	Total	Men	Women
Old-age, survivors, and disability insurance	11,260	5,389	5,880	65.7	69.4	62.8
Railroad retirement	640	320	320	3.7	4.1	3.4
Government employee retirement	1,040	520	520	6.1	6.7	5.5

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 relatively small number receiving vendor payments for medical care but no direct cash payment under either old-age assistance or medical assistance for the aged.

Source: Lenore A. Epstein, "Sources and Size of Money Income of the Aged," *Social Security Bulletin*, January 1962.

TABLE 6.—*Money Income of Families: Distribution by amount for families with head aged 65 and over, by source of income, and number of earners, 1960*

[Noninstitutional population of the United States]

Money income class	Total	No earnings [1]	Some earnings			
			And other income	No other income	1 earner	2 or more earners
Total	100.0	100.0	100.0	100.0	100.0	100.0
Under $2,000	31.4	53.6	19.8	18.7	23.3	13.1
Under $1,000	9.2	15.4	5.0	10.9	7.2	3.5
$1,000 to $1,499	10.3	16.4	7.3	5.6	8.0	5.5
$1,500 to $1,999	11.9	21.8	7.5	2.2	8.1	4.1
$2,000 to $3,999	32.4	37.0	31.1	24.8	34.6	22.6
$2,000 to $2,499	11.6	18.8	8.5	4.9	10.1	4.0
$2,500 to $2,999	8.8	9.4	9.0	5.3	9.4	7.1
$3,000 to $3,999	12.0	8.8	13.6	14.6	15.1	11.5
$4,000 and over	36.1	9.3	49.2	56.6	42.1	64.2
$4,000 to $4,999	8.4	3.8	10.8	10.9	11.5	9.8
$5,000 to $6,999	11.3	2.6	16.0	15.6	15.6	16.7
$7,000 to $9,999	8.5	1.4	11.4	17.0	8.6	19.0
$10,000 and over	7.9	1.5	11.0	13.1	6.4	18.7
Median income	$2,897	$1,916	$3,925	$4,571	$3,423	$5,519
Percent distribution	100.0	35.8	54.4	9.9	40.9	23.4

[1] Includes a small group with no income.

Source: Bureau of the Census, *Current Population Reports: Consumer Income*, Series P-60, No. 37, "Income of Families and Persons in the United States: 1960," January 17, 1962, and related unpublished data.

TABLE 7.—*Money Income of Persons 65 and Over: Distribution by amount and sex, 1960*

[Noninstitutional population of the United States]

Money income class	Total [1]	Men	Women
Total	100.0	100.0	100.0
Less than $1,000	52.6	27.1	73.9
Zero	14.5	3.6	23.6
$1 to $499	11.7	5.5	16.8
$500 to $999	26.4	18.0	33.5
$1,000 to $1,999	23.7	32.0	16.8
$1,000 to $1,499	15.3	20.1	11.2
$1,500 to $1,999	8.4	11.9	5.6
$2,000 to $2,999	10.2	17.3	4.2
$3,000 to $4,999	7.2	11.8	3.4
$5,000 or more	6.3	11.8	1.7
Median income, all persons	$950	$1,620	$640
Income recipients	1,150	1,698	821
Year-round, full-time workers	3,630	4,115	2,838

[1] The distributions for men and women were combined using population figures estimated in the Division of Program Research by updating the decennial census counts after adjustment to exclude institutional inmates.

Source: Bureau of the Census, *Current Population Reports: Consumer Income*, Series P-60, No. 37, "Income of Families and Persons in the United States: 1960," January 17, 1962, and related unpublished data.

TABLE 8.—*Money Income of Families and Persons Living Alone or Lodging: Distribution by amount and age, 1960*

[Noninstitutional population of the United States]

Money income class	All families		Families containing specified number of members								Persons living alone or lodging	
			Two		Three		Four		Five or more			
	Head 65 and over	Head under 65	Head 65 and over	Head under 65	Head 65 and over	Head under 65	Head 65 and over	Head under 65	Head 65 and over	Head under 65	65 and over	Under 65
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Under $2,000	31.4	10.2	35.7	16.0	20.3	9.0	17.6	6.5	17.9	8.9	79.4	41.2
Under $1,000	9.2	4.4	10.0	7.0	8.0	3.7	7.2	2.8	3.6	3.9	47.7	26.2
$1,000 to $1,499	10.3	2.8	11.5	4.4	6.8	2.3	5.2	1.8	9.4	2.4	21.3	9.3
$1,500 to $1,999	11.9	3.0	14.2	4.6	5.5	3.0	5.2	1.9	4.9	2.6	10.4	5.7
$2,000 to $3,999	32.4	16.5	35.5	18.8	28.2	16.6	15.7	14.5	20.0	15.8	14.1	27.4
$2,000 to $2,499	11.6	3.5	13.7	4.1	5.9	3.5	7.1	3.1	4.0	3.2	6.2	7.8
$2,500 to $2,999	8.8	3.5	9.8	4.2	6.6	3.7	2.9	2.6	8.0	3.4	3.2	6.6
$3,000 to $3,999	12.0	9.5	12.0	10.5	15.7	9.4	5.7	8.8	8.0	9.2	4.7	13.0
$4,000 and over	36.1	73.3	28.8	65.1	51.6	74.6	66.6	79.1	62.0	75.3	6.4	31.4
$4,000 to $4,999	8.4	10.8	7.9	11.2	12.2	11.5	8.6	10.5	4.9	10.3	2.4	12.8
$5,000 to $6,999	11.3	25.4	9.4	22.8	15.9	25.3	16.6	27.6	19.2	26.2		
$7,000 to $9,999	8.5	21.8	5.9	18.7	14.8	22.5	18.6	24.5	17.4	21.8	4.0	18.6
$10,000 and over	7.9	15.3	5.6	12.4	8.7	15.3	22.8	16.5	20.5	17.0		
Median income	$2,897	$5,905	$2,530	$5,314	$4,122	$5,930	$6,100	$6,300	$5,727	$6,074	$1,053	$2,571
Mean size	2.5	3.9	2.0	2.0	3.0	3.0	4.0	4.0	6.4	6.2	1.0	1.0
Percent distribution	100.0	100.0	72.9	26.4	16.4	21.6	5.1	22.9	5.6	29.1	----------	----------

Source: Bureau of the Census, *Current Population Reports:* Consumer Income, Series P-60, No. 37, "Income of Families and Persons in the United States: 1960," January 17, 1962, and related unpublished data.

TABLE 9.—*Total Assets: Distribution of spending units with head 65 and over according to type by value of assets, 1960*

Value of assets	Total assets	Liquid assets	Corporate stock	Equity in home	Other real estate	Unincorporated business
Do not own	13	30	86	36	79	97
Own	87	70	14	64	21	3
Less than $1,000	8	20	2	1	3	1
1,000 to 4,999	15	29	3	14	5	1
5,000 to 9,999	22	10	2	18	3	(1)
10,000 to 24,999	23	8	2	26	6	(1)
25,000 and over	18	4	3	4	3	(1)
Not ascertained	2	(1)	1	(1)	1	(1)
Total	100	100	100	100	100	100
Median, all spending units	$8,000	$1,000	0	$4,700	0	0
Median, holders only	$9,400	$3,000	$7,500	$9,700	$8,300	(2)

[1] No cases reported or less than one-half of 1 percent.
[2] Too few cases.

NOTE.—Details may not add to totals because of rounding. There were 425 cases in the sample.

Source: University of Michigan, Institute for Social Research, Survey Research Center, *1960 Survey of Consumer Finances* (1961).

TABLE 10.—*Savings and Health Insurance: Distribution of couples with head aged 65 and over and other persons aged 65 and over according to savings and insurance coverage by money income, 1959*

[Noninstitutional population of the United States]

Money income class	Total	Less than $5,000 in savings		$5,000 or more in savings
		No health insurance	Health insurance	
COUPLES WITH HEAD 65 AND OVER				
Total	100	42	29	29
Under $2,000	100	68	20	12
$2,000 to $2,999	100	42	34	24
$3,000 to $4,999	100	28	44	28
$5,000 to $7,499	100	14	45	41
$7,500 and over	100	7	16	77
OTHER PERSONS 65 AND OVER				
Total	100	62	23	15
Under $1,000	100	73	16	11
$1,000 to $1,999	100	59	23	18
$2,000 to $2,999	100	44	28	28
$3,000 and over	100	11	69	20

Source: University of Michigan, Institute for Social Research, Survey Research Center, unpublished data.

TABLE 11.—*Hospital Costs: Distribution of costs of hospital care for hospitalized aged OASI beneficiaries by marital status and insurance status, 1957*

Cost of hospital care [2]	Married couples [1]				Nonmarried beneficiaries			
	All [3] hospitals	General hospitals [4]			All [3] hospitals	General hospitals [4]		
		Total	With no hospital insurance [5]	With hospital insurance [5]		Total	With no hospital insurance	With hospital insurance
Total hospitalized	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Costs reported	72.5	73.9	65.3	80.3	70.4	70.0	55.4	84.2
Less than $100	13.6	14.2	16.2	12.7	16.8	20.4	20.8	20.1
$100 to $199	16.5	17.7	17.9	17.5	12.3	15.2	13.8	16.5
$200 to $299	10.5	10.9	9.8	11.8	6.9	8.1	6.9	9.4
$300 to $399	6.0	6.0	4.0	7.4	6.9	7.4	4.6	10.1
$400 to $499	5.7	6.2	5.2	7.0	3.6	3.7	1.5	5.8
$500 to $999	11.7	11.7	8.1	14.4	11.1	11.1	5.4	16.5
$1,000 to $1,499	3.8	3.7	2.3	4.8	5.1	2.2	.8	3.6
$1,500 to $1,999	2.4	2.0	1.7	2.2	4.2	1.1	.8	1.4
$2,000 to $2,499	1.0	.7	--------	1.3	2.4	.4	--------	.7
$2,500 or more	1.2	.7	--------	1.3	1.2	.4	.8	--------
Costs not reported [6]	27.5	26.1	34.7	19.7	29.6	30.0	44.6	15.8
Nongovernmental hospitals	15.1	15.4	17.3	14.0	14.7	15.9	19.2	12.9
State, county and city hospitals	10.3	9.0	14.5	4.8	12.3	10.4	19.2	2.2
Federal hospitals	2.2	2.0	3.5	.9	3.0	3.7	6.9	.7

[1] Aged beneficiary and spouse, whether or not entitled to benefits (spouse may be under 65).
[2] Hospital costs do not include fees of surgeon or inhospital physician. For married couples, includes hospital costs of the hospitalized member. If both were hospitalized, data tabulated represent the combined costs for both members.
[3] Includes chronic-care institutions and nursing homes.
[4] Includes short-stay special hospitals.
[5] For the hospitalized person. If both spouses were hospitalized, but only one insured, the couple is classified in the "with insurance" category.
[6] In many cases, includes some "free" care, i.e., no bills rendered to anyone, or vendor paid directly by public assistance or other agency.

Source: Bureau of Old-Age and Survivors Insurance, Social Security Administration, 1957 National Survey of Old-Age and Survivors Insurance Beneficiaries.

TABLE 12.—*Hospitalization and Total Medical Costs: Distribution of total medical costs for the year incurred by aged OASI beneficiaries with a general hospital stay, by marital status and insurance status, 1957*

Total medical costs incurred [2]	Married couples [1]			Nonmarried beneficiaries		
	Total	With no hospital insurance [3]	With hospital insurance [3]	Total	With no hospital insurance	With hospital insurance
Total hospitalized [4]	100.0	100.0	100.0	100.0	100.0	100.0
Costs reported	81.3	75.1	86.0	71.5	61.5	81.3
Less than $100	1.2	2.3	.4	2.2	3.1	1.4
$100 to $199	3.7	4.6	3.1	11.5	10.0	12.9
$200 to $299	5.7	5.2	6.1	9.3	11.5	7.2
$300 to $399	8.0	6.9	8.7	7.0	6.2	7.9
$400 to $499	9.5	8.7	10.0	7.0	4.6	9.4
$500 to $999	25.1	24.3	25.8	18.9	15.4	22.3
$1,000 to $1,499	13.9	12.1	15.3	8.5	4.6	12.2
$1,500 to $1,999	6.7	4.0	8.7	3.7	4.6	2.9
$2,000 to $2,499	3.2	4.0	2.6	1.5	----	2.9
$2,500 or more	4.2	2.9	5.2	1.9	1.5	2.2
Costs not reported [5]	18.7	24.9	14.0	28.5	38.5	18.7
Nongovernmental hospitals	10.2	10.4	10.0	14.4	13.1	15.8
State, county and city hospitals	6.2	11.0	2.6	10.0	18.5	2.2
Federal hospitals	2.0	3.5	.9	3.7	6.9	.7
Two stays involving two kinds of ownership	.2	----	.4	----	----	----

[1] Aged beneficiary and spouse whether or not entitled to benefits (spouse may be under 65).
[2] For the survey year. For married beneficiaries, represents total medical costs for the couple.
[3] For the hospitalized person. If both spouses were hospitalized, but only one insured, the couple is classified in the "with insurance category."
[4] In general hospital, including short-stay special hospital.
[5] In many cases, includes some "free" care, i.e., no bills rendered to anyone, or vendor paid directly by public assitance or other agency.

Source: Bureau of Old-Age and Survivors Insurance, Social Security Adminstration, 1957 National Survey of Old-Age and Survivors Insurance Beneficiaries.

APPENDIX B

TABLE 13.—*Old-Age Assistance: Recipients, total payments, and average money and vendor payments per recipient, by State, January 1, 1962*

State	Number of recipients	Total assistance payments	Average payment per recipient			Vendor payments as percent of total
			Total	Money payments to recipients	Vendor payments for medical care	
Total [1]	2,258,450	$160,190,570	$70.93	$57.67	$13.26	18.7
Alabama	100,185	6,038,900	60.28	55.44	4.83	8.0
Alaska	1,401	97,314	69.46	69.46	----	----
Arizona	13,945	828,626	59.42	59.42	----	----
Arkansas	55,640	2,821,927	50.72	43.63	7.09	14.0
California	252,043	25,441,412	100.94	88.13	12.81	12.7
Colorado [1]	50,002	4,873,165	97.46	80.52	16.94	17.4
Connecticut	13,906	1,489,286	107.10	45.81	61.29	57.2
Delaware	1,156	56,893	49.22	49.22	----	----
District of Columbia	3,032	205,898	67.91	55.09	12.81	18.9
Florida	70,239	4,177,373	59.47	46.69	12.79	21.5
Georgia	93,657	4,353,392	46.48	46.35	.13	0.3
Hawaii	1,239	77,217	62.32	50.07	12.26	19.7
Idaho	5,989	412,894	68.94	61.35	7.59	11.0
Illinois	68,005	5,615,074	82.57	46.35	36.22	43.9
Indiana	25,327	1,666,318	65.79	44.43	21.36	32.5
Iowa	32,532	2,793,971	85.88	58.31	27.58	32.1
Kansas	26,666	2,243,131	84.12	69.17	14.95	17.8
Kentucky	55,796	2,970,319	58.24	50.24	3.00	5.6
Louisiana	126,601	9,566,678	75.57	65.93	9.63	12.7
Maine	11,169	773,289	69.24	47.74	21.50	31.1
Maryland	9,505	617,843	65.00	59.41	5.59	8.6
Massachusetts	61,648	5,103,068	82.78	67.99	14.79	17.9
Michigan	54,458	4,330,076	79.51	66.53	12.99	16.3
Minnesota	44,624	4,080.882	91.45	46.50	44.95	49.2
Mississippi	79,749	2,788,541	34.97	33.64	1.33	3.8
Missouri	111,121	6,727,119	60.54	55.29	5.25	8.7
Montana	6,347	417,918	65.84	65.61	.24	0.4
Nebraska	13,931	1,057,999	75.95	48.01	27.93	36.8
Nevada	2,530	206,695	81.70	66.06	15.64	19.1
New Hampshire	4,726	424,515	89.83	67.83	21.99	24.5
New Jersey	18,566	1,745,756	94.03	53.56	40.47	43.0
New Mexico	10,884	758,473	69.69	55.86	13.83	19.8
New York	59,271	4,923,090	83.06	66.66	16.40	19.7
North Carolina	46,428	2,312,894	49.82	44.82	5.00	10.0
North Dakota	6,385	522,911	81.90	60.21	21.69	26.5
Ohio	88,777	7,023,691	79.12	64.00	15.12	19.1
Oklahoma	86,742	7,164,797	82.60	67.59	15.01	18.2
Oregon	16,099	1,363,006	84.66	50.70	33.96	40.1
Pennsylvania	49,077	3,292,783	67.09	62.85	4.24	6.3
Rhode Island	6,375	519,715	81.52	66.52	15.00	18.4
South Carolina	29,685	1,306,696	44.02	38.60	5.42	12.3
South Dakota	8,397	637,253	75.89	64.01	11.88	15.7
Tennessee	52,058	2,338,346	44.92	40.22	4.70	10.5
Texas	219,158	13,887,113	63.37	54.38	8.98	14.2
Utah	6,932	553,584	79.86	51.73	28.13	35.2
Vermont	5,518	405,587	73.50	47.99	25.52	34.7
Virginia	14,312	774,890	54.14	41.34	12.80	23.6
Washington	45,551	4,145,058	91.00	55.32	35.68	39.2
West Virginia	17,944	745,823	41.56	34.60	6.96	16.7
Wisconsin	32,563	2,942,096	90.35	36.44	53.91	59.7
Wyoming	2,859	223,326	78.11	64.14	13.97	17.9
Puerto Rico	37,045	325,878	8.80	8.33	.46	5.2
Virgin Islands	539	17,985	33.37	30.24	3.12	9.3
Guam	116	2,086	17.98	17.98	----	----

[1] Includes 3,658 recipients aged 60–64 in Colorado and payments of $308,011 to these recipients. Such payments were made without Federal participation.

Source: Bureau of Family Services, Social Security Administration.

TABLE 14.—*Old-Age Assistance: Provision of major types of medical care to recipients of old-age assistance and methods of payment by State, October 1, 1961*

State	Hospital care	Physicians' services				Dental care			Prescribed drugs	Nursing home care
		Office visits	Home calls	Hospital		Fillings	Extractions	Dentures and denture repair		
				Inpatient	Outpatient					
Alabama	V									V
Alaska										
Arizona										
Arkansas	V	V	V		V		V		B*	V
California	M*	V	V		V	V	V	V	V	M
Colorado	V	V	V	V	V				V	MV
Connecticut	V	V	V			V	V	V	V	V
Delaware		M*	M*	M*	M*	M*	M*	M*	M*	M*
District of Columbia	V		V			V	V	V	V	M[1]
Florida	V							M*	B*	V
Georgia										M*
Guam										
Hawaii	V	V	V	V	V	V	V		V	M
Idaho	V	V	V	V						
Illinois	V	V	V	V	V	V	V	V	V	MV
Indiana [1]	V	V	V	V	V	V	V	V	V	MV
Iowa		V	V		V	V	V	V	V	V
Kansas [1]	V	V	V	V	V	M	M	M	V	M
Kentucky	V	V	V			V	V		V	M*
Louisiana	V	V	V	V					B*	V
Maine	V									V
Maryland	V	V	V		V	V	V	V	V	B*
Massachusetts	V	V	V			V	V	V	V	V
Michigan	V	M*	M*	M*	M*		M*	M*	M*	M*
Minnesota	V	V	V	V	V	V	V	V	V	MV
Mississippi	V									M*
Missouri [2]	V	M*	M*	M*	M*	M*	M*	M*	M*	V
Montana	V	V	V	V	V					V
Nebraska	V	M*	M*	M*	M*	M*	M*	M*	M*	V
Nevada	M	V	V		V	V	V	V	V	M
New Hampshire	V	V	V	V	V	V	V	V	V	B*
New Jersey		M	M			M	M	M	M	V
New Mexico	V	V	V	V		V	V	V	V	V
New York [1]	V	V	V	V	V	V	V	V	V	MV
North Carolina	V									M
North Dakota	V	V	V	V	V	V	V	V	V	V
Ohio	V	V	V	V	V	V	V	V	V	M
Oklahoma	V			V	V					MV
Oregon	V	V	V	V	V	V	V	V	V	V
Pennsylvania		V	V		V	V	V	V	V	M
Puerto Rico	V								V	
Rhode Island	V	V	V			V	V	V	V	M
South Carolina	V								M*	V
South Dakota	V	V	V					M	M	M
Tennessee	V									MV
Texas	M*	M*	M*	M*	M*	M*	M*	M*	M*	M*
Utah	V	V	V	V	V	V	V	V	V	V
Vermont	V	V	V							V
Virgin Islands	V		V			V	V	V	V	
Virginia	V	M	M		M	M	M	M	M	V
Washington	V	V	V	V	V	V	V	V	V	B*
West Virginia	V	V	V	V	V	V	V	V	V	M*
Wisconsin	V	V	V	V	V	V	V	V	V	V
Wyoming [1]	V	V	V	V						MV

[1] Medical care provisions in Indiana, Kansas, New York, and Wyoming are based on individual county (or welfare district) plans, subject to State review; hence there is some area variation in the method of paying for a given service but the scope, content, and general policies are applicable to all jurisdictions within the State.

[2] Missouri has an additional maximum $100 for completely bedfast or totally disabled persons.

CODE

V—Vendor payments to suppliers of medical care.
M—Money payment to recipient.
M*—Money payment to recipient, subject to maximum on money payment.
MV—Combined money and vendor payment.
B—Both methods used, each in particular situations.
B*—Same as B, but money payment is subject to a maximum.

Source: Bureau of Family Services, Social Security Administration.

TABLE 14 (Continued).—*Limitations (excluding those which can be lifted by administrative action)*

Hospital care:
- Alabama: Acute conditions and major injury only; 15 days per fiscal year.
- Arkansas: Acute conditions primarily; 30 days per year. Up to 90% of costs up to $20 per day.
- California: 2 months except for diagnoses.
- Colorado: Critical or serious conditions or with prior approval.
- Florida: Acute conditions only; not to exceed 30 days in 12 months' period.
- Kentucky: Acute and life-endangering conditions only; 6 days per admission.
- Maine: 45 days per year. Not to exceed $20 for first 10 days, $15 for remaining 35 days.
- Mississippi: Acute conditions only; 15 days per year. $15 per day maximum.
- Missouri: Medical emergency or acute serious illness only; 14 days per admission.
- Montana: Only for remedial eye care for prevention of blindness or restoration of sight.
- Nevada: Room and board only, up to $75 per month.
- New Mexico: Primarily for life-endangering illness, accidents, relief of severe pain, and diagnostic procedures.
- North Carolina: Up to $16 per day.
- North Dakota: 60 days per year.
- Oklahoma: Life-endangering, emergency conditions, and sight-endangering conditions only.
- South Carolina: Acute conditions only; 40 days per year.
- South Dakota: 30 days per admission.
- Tennessee: Acute conditions only; 10 days per admission with a maximum of 30 days in any year (85% of reimbursable cost).
- Utah: 30 days per admission. Essential care.
- Vermont: 30 days per admission or within a quarter.
- Virginia: 28 days per year. Maximum $24.65 per day.
- West Virginia: Acute conditions 30 days per year; defined remedial care as needed.

Physicians' services:
- Arkansas: 2 home visits per month to patients in nursing home, 2 office or clinic visits per month for all others.
- Colorado: As a standard, same number of visits as is set in Blue Shield policy, plus 2 additional visits per quarter, home or office; for patients in nursing homes, 12 visits per quarter.
- Illinois: Acute conditions: home visits, 1 daily per week; office visits, 6 per 30 days. Long term conditions: 2 home visits or 2 office visits per month. Inpatient hospital calls also limited.
- Kentucky: Payment will be made for 2 visits per month per patient.
- Louisiana: Only for persons with approved medical care plan for treatment of serious continuing illness requiring care for relief of severe suffering or for correction of or prevention of permanent impairment.
- Montana: Limited to ophthalmologist (and optometrist) for prevention of blindness and restoration of sight.
- Nebraska: Acute illness, 1 per day; for chronic conditions, 1 per week.
- New Hampshire: Home, office, or clinic: for chronic illness, 2 calls per month. Hospital, inpatient: 14 calls per 30 days of hospitalization.
- North Dakota: For patients in hospital for more than 30 days, payment will be made for not more than 3 calls per week.
- Ohio: For acute conditions, 10 calls per month; for chronic, 2 calls per month.
- Oklahoma: Outpatient clinic, for acute injury only; home or hospital, no limitation on condition.
- Pennsylvania: For chronic illness, 3 calls per month. For acute, no limit.
- Rhode Island: For chronic illness, 2 per month. For acute conditions, as needed.
- South Dakota: Limited to 14 visits per year.
- Texas: Only for chronic illness. $6 per month except for cancer and certain eye conditions.
- Utah: Limited to 4 calls in 60 days for chronic conditions.
- Vermont: Limited to 12 necessary visits in any calendar quarter.
- Virgin Islands: Home calls made only to patients under the Home Care Program.
- West Virginia: Services relating to acute and life-endangering conditions or those which enable an increase in self-support and self-care, or strengthen family life.

Dental Services:
- Arkansas: Relief of pain and X-ray and dental surgery in approved clinics.
- Hawaii: Emergency care only.
- Kansas: Dentures and bridges only when ordered by a physician.
- Kentucky: Only for relief of pain and treatment of acute infection; $16 per month, $48 per year.
- Maryland: Dentures limited to replacement and repairs.
- Michigan: Services other than those related to dentures included only when recommended by a physician as part of other medical procedures.
- North Dakota: Dentures and bridgework provided only if extraction of recipient's teeth occurred within previous 5 years.
- New Mexico: Limited to relief of pain and infection.
- Oklahoma: Only services performed in licensed general hospital for life-endangering conditions involving fractures, infections, and mouth tumors.
- Puerto Rico: Only as included in hospital care.
- South Dakota: Up to $55 for purchase or repair of dentures.
- Texas: Up to $40 for cost of dentures; other services planned for only as part of treatment for chronic illness, maximum of $40.
- West Virginia: Emergency and defined remedial care.

Prescribed Drugs:
- Arkansas: Drugs dispensed by approved outpatient clinic or for patient in nursing home up to $5 per month.
- Colorado: Only for patients in nursing homes.
- Puerto Rico: Only for drugs prescribed while person is hospitalized.
- South Carolina: Verified cost of drugs up to a maximum of $15 per month per individual for chronic conditions. For non-chronic conditions, up to $5 per month may be budgeted monthly and payment prorated over 12-month period.
- South Dakota: As prescribed on a continuing basis for treatment of heart conditions, diabetes, and anemia.
- Texas: Treatment for chronic illness only.
- Utah: Essential needs up to $20 per month.

TABLE 14 (Continued).—*Limitations (excluding those which can be lifted by administrative action)*

Nursing Home Care:
- Alabama: $125 monthly maximum.
- Arkansas: $90 monthly maximum.
- California: $116 monthly maximum.
- Colorado: $195 monthly maximum.
- Delaware: $75 monthly maximum.
- Florida: $100 monthly maximum.
- Georgia: $65 monthly maximum.
- Kentucky: $110 monthly maximum.
- Maine: $180 monthly maximum.
- Maryland: $116 monthly maximum. In addition, nursing home care paid for by vendor payment in 5 chronic care homes.
- Massachusetts: Short-term care only.
- Michigan: $90 monthly maximum.
- Mississippi: $40 monthly maximum.
- Missouri: $65 monthly maximum; $100 if recipient is completely bedfast or totally disabled.
- Montana: Only for remedial eye care.
- Nevada: $135 monthly maximum.
- New Hampshire: $165 monthly maximum. Vendor payment for care in public nursing homes; money payment for care in private nursing homes.
- New Jersey: $180 monthly maximum; $190 in exceptional cases.
- North Carolina: $175 monthly maximum; limited to post-hospital care.
- North Dakota: Limited to 30 days per year (long-term care under MAA).
- Oklahoma: $129 monthly maximum plus room and board.
- Oregon: $192 monthly maximum.
- Pennsylvania: $165 monthly maximum.
- Rhode Island: $185 monthly maximum.
- South Carolina: $150 monthly maximum; limited to post-hospital care.
- Tennessee: $80 monthly maximum.
- Texas: $71 monthly maximum.
- Utah: $200 monthly maximum.
- Vermont: $165 monthly maximum.
- Virginia: $150 monthly maximum.
- Washington: $191 monthly maximum.
- West Virginia: $100 monthly maximum.
- Wyoming: $180 monthly maximum.

TABLE 15.—*Old-Age Assistance: Welfare department arrangements with health departments, Blue Cross, Blue Shield, or other groups for provision of services to old-age assistance recipients*

State	*Health Department Arrangements*
Alabama	Health department has contracted with the welfare department to perform certain specified services relating to hospital care for OAA recipients.
District of Columbia.	Health department administers the D.C. General Hospital which provides virtually all hospital inpatient and outpatient care to indigent persons and in addition operates a program whereby physician home calls to indigent persons are provided by a number of "District" physicians employed for this purpose. The welfare department reimburses the health department for inpatient and outpatient care provided to OAA recipients.
Florida	State Board of Health acts as the fiscal agent of hospitals; it pays the hospitals for services provided to OAA recipients and is reimbursed by the welfare department. In Kentucky the State Health Department provides professional guidance on medical aspects of the welfare medical program.
Maryland	The State Health Department handles all aspects of medical care for welfare recipients except in Baltimore County; in Baltimore these functions are performed by the Baltimore Health Department. The State Welfare Department pays the two health departments a stipulated amount per month for each welfare recipient; the health departments pay hospitals, physicians, dentists and other suppliers for services provided.
Puerto Rico	The Health Department operates most of the large hospitals on the island—hospitals which provide over 50 percent of all patient days of care in general hospitals. The Health Department's hospitals provide inpatient and outpatient care (including the services of the medical staff) to all welfare recipients, and are paid by the welfare department for services to OAA recipients. A similar arrangement exists in the Virgin Islands where the Health Department of the Territory operates all hospitals on the Islands.

Source: Bureau of Family Services, Social Security Administration.

TABLE 15.—*Old-Age Assistance: Welfare department arrangements with health departments, Blue Cross, Blue Shield, or other groups for provision of services to old-age assistance recipients*—Continued

State	*Blue Cross, Blue Shield, or Other Arrangements*
Colorado	The Welfare Department has contracted with the Blue Cross and Blue Shield plans, acting as the fiscal agent for the hospitals and doctors, respectively, to pay hospitals and physicians for services provided to old-age pensioners. The Welfare Department supplies a list of these to Blue Cross–Blue Shield and pensioners are provided with identification cards. Upon admission of a pensioner the hospital applies to the Blue Cross plan for confirmation of eligibility in the same way as for Blue Cross members. Blue Cross pays the hospitals on the same basis as for its own members and is reimbursed for its administrative expenses at the rate of $2 for each claim paid. Blue Shield pays physicians in the same manner as for its own members and is reimbursed by the welfare department for its outlays together with a payment to cover administrative expense.
Kansas	Welfare departments in 23 counties have entered into group prepayment contracts with the local medical society; the welfare department pays a stipulated amount per recipient per month to cover a defined content of care and the medical society in turn contracts with and pays local hospitals, physicians and pharmacists for services provided to recipients.
Mississippi	State Welfare Department has an agreement with the Mississippi Hospital and Medical Service (Blue Cross) which acts as fiscal agent for the hospitals. Admission notices and billings are reviewed by the Blue Cross, but payments are made by the Department of Public Welfare directly to hospitals.
Nevada	State Welfare Department has a group prepayment plan contract with the State Medical Association covering physicians' services, dental care and drugs, and another prepayment contract with the State Optometric Association covering the services of optometrists. The Welfare Department pays a stipulated amount per recipient per month. The professional associations under contract have responsibility for fee schedules, proportion of payment when necessary, audit, medical review of services and practices, and paying physicians, dentists, optometrists and druggists for services and drugs supplied.
New Mexico	Welfare Department has a contract with the State Pharmaceutical Association. Pharmacists submit their bills to the latter association which prices them according to a pricing formula and submits them to the Department of Public Welfare; the latter makes payment to the individual pharmacists.
South Dakota	State Welfare Department has agreements with the Blue Cross and Blue Shield plans in accordance with which these plans pay hospitals and physicians, respectively, for services provided to welfare recipients. The same type of arrangement exists in Utah.
Texas	Effective January 1962, the Welfare Department contracts with the Texas Blue Cross and Blue Shield plans for hospital care and for surgical, physician inhospital visits and X-ray and laboratory services for all OAA recipients. The department pays $8.68 per month per recipient. For this the plans provide 15 days of hospital care per admission with half benefits thereafter and the specified physician services. If, after six months' experience, the amounts paid out by the Blue Cross and Blue Shield plans are less than 97 percent of the premiums—3 additional percent being allowed for administrative expenses—benefits will subsequently be adjusted upwards. If the costs to Blue Cross-Blue Shield are more than the premiums receivd, the plans bear any loss.

TABLE 15.—*Old-Age Assistance: Welfare department arrangements with health departments, Blue Cross, Blue Shield, or other groups for provision of services to old-age assistance recipients*—Continued

State	*Blue Cross, Blue Shield, or Other Arrangements*
Washington	State Welfare Department purchases medical and dental services for recipients through Washington Physicians' Service and Washington Dental Service, respectively. Washington Physicians' represents the County Medical Service Corporation or Bureaus which have signed agreements with individual physicians to participate in the Public Assistance Medical Program. Washington Dental Service represents individual dentists who have signed agreements to participate in the dental program. The Department of Public Welfare pays to each organization a stipulated amount per OAA recipient per month. In return the two organizations agree that stipulated services will be available to welfare recipients. The two organizations pay the bills submitted by physicians and dentists, respectively, prorating when total bills exceed the amount available.

TABLE 16.—*Medical Assistance for the Aged: Provision of major types of services under State plans, October 1961*

State	Hospital care	Nursing-home care	Physicians' services				Dental care	Prescribed drugs [1]
			Office	Home or in nursing home	Hospital			
					Out-patient	In-patient		
Arkansas	X	X	X	X	X	--	X	X
Hawaii	X	X	X	X	X	X	X	X
Idaho	X	X	X	X	--	--	--	--
Illinois	X	--	X	X	X	X	--	--
Kentucky	X	--	X	X	--	--	X	X
Louisiana	X	X	X	X	X	X	--	X
Maryland	X	--	X	X	X	--	X	X
Massachusetts	X	X	X	X	--	--	X	X
Michigan	X	X	X	--	X	X	--	--
New Hampshire	X	--	X	X	X	X	--	--
New York	X	X	X	X	X	X	--	X
North Dakota	X	X	X	X	X	X	X	X
Oklahoma	X	X	--	X	X	X	X	--
Oregon	X	X	X	X	X	X	--	--
Puerto Rico	X	X	--	--	X	--	--	--
South Carolina	X	X	--	--	X	--	--	--
Tennessee	X	--	--	--	--	--	--	X
Utah	X	--	X	X	X	X	--	--
Virgin Islands	X	--	--	X	--	--	X	X
Washington	X	X	X	X	X	X	X	X
West Virginia	X	X	X	X	X	X	X	X

[1] Other than for hospitalized patients; drugs for hospital patients are included as part of hospital care.

NOTE.—Code:
X—Service is provided.
--—Service is not provided.

Source: Bureau of Family Services, Social Security Administration.

TABLE 16 (Continued).—*Limitations (excluding those which can be lifted by administrative action)*

Hospital care:

Arkansas: To 15 days in any 12-month period. Maximum daily rate $25.50.

Idaho: For care of acute conditions and emergencies only; 14 days per admission.

Kentucky: For care of acute, emergency and life endangering conditions only; 6 days per admission. No limit on number or frequency of admission.

Louisiana: Up to 30 days.

New Hampshire: 7 days per admission, plus a maximum of $75 for auxiliary services. No eye care.

Oklahoma: Care for conditions which endanger life or sight only; not to exceed 6-months care in any 12-month period.

Oregon: Up to 14 days per year. Patients pays $7.50 per day for first 10 days up to maximum of $75 per year.

South Carolina: Care only for acute illness, injury or condition that endangers sight; not to exceed 40 days per year.

Tennessee: Care only for acute illness or injury; up to 10 days per year. Patient pays first $100 in any year.

Utah: Up to 30 days per admission. Patients pays first $50 per admission.

Washington: Care only for acute and life-endangering conditions.

Nursing home care:

Arkansas: Up to maximum of $90 per month.

Idaho: Up to maximum of $175 per month.

Louisiana: Only for persons eligible for OAA except for durational residence requirement. Up to $165 monthly.

Michigan: Only within 30 days following hospitalization for acute illness and limited to 90 days in a 12-month period.

Oklahoma: Limited to 6 months care in any 12-month period. Excludes room and board.

Oregon: Upon transfer from hospital. Number of days available is based on hospital entitlement—14 days per year—with allowance of 4 days of nursing home care for each remaining day of hospital entitlement. Up to $6 per day.

South Carolina: Following hospitalization. Ordinarily up to 90 days per year. Maximum payment, $150 per month.

Virgin Islands: Facilities not available.

West Virginia: After hospitalization or to prevent hospital care. Limited to acute conditions. Maximum payment $100 per month.

Washington: Care only for acute and life-endangering conditions.

Physicians' services:

Idaho: Acute conditions; 2 calls per month. Nursing Home: 1 call per month. 1 eye examination per 6-month period.

Illinois: Only in 30-day period immediately following release from hospital. Acute conditions: 1 home call daily for 1 week, 6 office calls per 30-day period. Chronic care: 2 home calls per month, 2 office calls per month.

Kentucky: 2 office and/or home calls per month.

Louisiana: Serious continuing illness requiring care for relief of severe suffering or for correction or prevention of permanent impairment.

Michigan: Office services limited to emergency treatment, office surgery, and procedures involving therapeutic X-ray.

New Hampshire: 6 office and/or home calls per year.

North Dakota: Inpatient hospital care of more than 30 days limited to 3 calls per week.

Oklahoma: Patients receiving nursing care: 2 calls per month. In hospital not more than 15 visits per month in certain hospitals, less in others.

Oregon: Patient pays first $50 of any combination of physicians' services, X-rays, or laboratory procedures; then eligible for maximum of $150 for physicians' care and maximum of $500 for surgery, $100 for X-rays and laboratory costs.

South Carolina: 3 clinic visits per month.

Utah: Patient pays first $20 per benefit period of 90 days; if more care is needed and authorized patient pays first $20 for each additional benefit period.

Virgin Islands: Available to patients under Home Care program.

Washington: Only for acute and life-endangering conditions.

West Virginia: Services must be related to acute and life-endangering conditions or defined remedial care.

TABLE 16 (Continued.)—*Limitations (excluding those which can be lifted by administrative action)*

Dental services:
- Kentucky: Services as related to relief of pain and treatment of acute infection. Up to $16 per month and $48 per year.
- Maryland: Restorative dental care only, including repair and replacement of dentures.
- North Dakota: Dentures and bridgework limited to when extractions occurred within previous 5 years.
- Oklahoma: Only for in-hospital patients having life endangering conditions involving fractures, infections, or tumors of the mouth.

Prescribed drugs other than for hospitalized patients:
- Arkansas: Maximum of $5 per month and dispensed only by an approved clinic. Maximum of $5 per month for patient in nursing home.
- Louisiana: Only for patients in nursing homes.
- Washington: Only for acute and life-endangering conditions.
- West Virginia: Limited to 1 refill for care of acute illness.

TABLE 17.—*Medical Assistance for the Aged: Financial eligibility provisions, income and property holdings, by State, October 1961*

State	Income	Assets		Use of own resources as a condition of receiving assistance
		Real property	Personal property	
Arkansas	Cash income for single person not to exceed $1,200 annually; for family $1,500.	May have home or an equity in home not to exceed $7,500. Value of other real property must come under the maximum on personal property.	Including value of non-home real estate, livestock, motor vehicle, tools, equipment, and cash surrender value of life insurance. Household furnishings are excluded. Applicant may have a cash reserve of up to $300 for one person and an additional $300 for dependents, with a family maximum of $600. Total value of all other property and resources may not exceed $2,500.	Benefits from health or hospitalization insurance must be applied to that portion of the hospital bill (based on the hospital's established reimbursable cost figure) which comes within the MAA maximum rate of $25.50 per day before MAA funds are used. (Revision since October 1961.)
Hawaii	Insufficient to meet the standards of assistance established for MAA, including non-medical and medical requirements (approximately $50 per month above the standards of assistance for OAA) and if the resources available to him within 12 months after date of application are insufficient to pay the cost of needed medical care.	Home with tax-appraised value of less than $14,000 is exempt; also other real property with value not to exceed $150. All excess value is considered a resource for payment of medical costs.	All liquid assets beyond $50 cash savings (of unemancipated minor) are considered available after allowances for payments on obligations contracted for defined essential purposes. May own automobile 4 years old or older or when necessary for essential transportation. Full loan value of life insurance is resource. Under exceptional circumstances, conservation of readily available resources allowed.	Health insurance, Veterans Administration care, workmen's compensation, and similar resources must be taken into account in determining extent to which MAA is needed.
Idaho	Cash income from all sources is considered available to meet costs of medical care except for amount needed to meet "ordinary expenses and obligations" (calculated on basic requirements in State's "Standards of Assistance" plus $50 a month additional allowance to cover other obligations); in addition, for any month, 1/12 of the savings and cash resources owned above $2,000 and less than $10,000 is considered available.	May own home not excessive in value in relation to community standards. Value of other real property which can be made available is considered among cash assets. Total available assets—real and personal—may not exceed $10,000.	Value of real property other than home plus personal property other than exclusions listed below may be held up to $2,000. Value in excess of this amount and under the maximum is considered available to meet costs of medical care, as stated in Income. Excluded from assets available are: household furniture and personal possessions of reasonable value, a "popular priced" car.	Eligibility is determined after medical care has been provided and is directly related to the costs of medical care incurred or predicted and the applicant's resources considered available to meet such costs. (Potential eligibility is determined when there is a "complaint of illness or injury" for which medical care is sought.)

TABLE 17.—*Medical Assistance for the Aged: Financial eligibility provisions, income and property holdings, by State, October 1961*—Continued

State	Income	Assets		Use of own resources as a condition of receiving assistance
		Real property	Personal property	
Illinois	Maximum gross income (after deducting amounts necessary to maintain in force a medical, surgical, hospital, or other health insurance policy) for single person, $1,800; for applicant and spouse or other dependent, $2,400; plus $600 for each dependent living with applicant. Contributions received from responsible relatives are included in income.	Value of property used as a home and contiguous land is excluded.[1]	Value of all other property (except for exclusions listed below) may not exceed $1,800 for single person; $2,400 for applicant and 1 dependent; plus $400 for each additional dependent living with applicant. Excluded from consideration as liquid or marketable assets are: clothing, personal effects, automobile, life insurance with a face value of $1,000 or less, and tangible personal property used in earning income with a fair market value of $1,000 or less.[1]	MAA is not available unless cost of allowable medical care exceeds 10% of total income of applicant (or 10% of combined income of applicant and dependents living with him). Benefits from health or hospital insurance policies covering applicant may meet or be applied to this "deductible" or to apply toward further cost of medical care.
Kentucky	Annual gross income for single person may not exceed $1,200; for couple, $1,800. Special provisions for determining income from self-employment or from farming operations.	Homestead is not considered; the equity in nonhomestead real property may not exceed $5,000, single person or married couple.	Limited to $750 for single person, $1,000 for applicant and spouse; excluding cash surrender value of life insurance not to exceed $3,000. (Personal property is defined as "cash on hand, money in the bank, stocks, bonds, and other resources that can be converted into liquid assets"; excluded from consideration is cash surrender value of insurance within the maximum stated and tangible personal property not listed in definition.)	Availability of health insurance is to be determined and evaluated.
Louisiana	Income in excess of maximum allowable monthly income of $250 for single person or $325 for couple disqualifies; income less than this amount but in excess of (1) basic income and (2) allowable increases, as defined below, must be applied to costs of needed hospital care. (1) Basic income: $125 single; $175 married couple, combined income. (2) Allowable increases: $30 per month for each dependent minor child or disabled adult declared as dependent on applicant's income tax return; $15 additional income allowable for single person with hospitalization insurance, $25 for couple with such insurance.	May own home as defined for homestead tax exemption; other real property not to exceed $5,000 assessed value if income-producing or $1,000 value if not income-producing; excess value is considered a liquid asset.	Liquid assets not to exceed $1,000 for single, $1,500 for couple; excludng: insurance with cash or loan value up to $1,500 (couple $2,000), motor vehicle used for transportation, farm equipment or business assets which are income producing. Excess value of insurance, care or non-home real property must come under the liquid assets maximum.	Persons with a monthly income of over $90 ($140 for couple) participate in payment of the first $50 of costs of hospital care when the cost of such care exceeds $10; the amount of participation is based on a sliding scale applied to available income. Medical insurance must be utilized fully and must be assigned to hospital before MAA is used; amounts thus paid toward hospital costs considered "participation". Free resources for medical care, available from other than State facilities, must be used if possible to do so without undue hardship.

Maryland	Regular income not to exceed: (1) in Baltimore city and 5 larger counties—$1,140 for single person; $1,560 for applicant with 1 dependent; plus allowances for additional dependents; (2) in 18 other counties—$1,080 for single person; $1,500 for applicant and 1 dependent. Income includes that of spouse or of any other person claimed as dependent. Scale of value for income-in-kind.	Home is exempt; real property other than home is included in other resources convertible to cash.	Resources in cash or convertible to cash (savings, insurance, real property other than the home) may not exceed $2,500 cash value.	A person is ineligible who has any insurance or other benefit the terms of which provide for payment for the medical care items included in the plan.
Massachusetts	Income (for married couple it is combined income of husband and wife) in excess of amount stated is deemed available to meet costs of medical care: (1) *receiving medical care in own home*—single, or married and husband is applicant, $150 a month; if wife is applicant, $225 a month, combined income. (2) *receiving medical care in a hospital, nursing home, or public medical institution*—(a) *short-term:* single person or, if married, for spouse remaining at home, $150 a month; income between $150 and $300 a month is deemed available for costs of medical care for 3 to 6 months based on amount of excess; income beyond $300 a month disqualifies; (b) *long-term:* patient, $15 a month for personal needs; for a spouse remaining at home, $150 a month.	Real estate used as home does not disqualify; ownership of any interest in other real property disqualifies.[1]	Value may not exceed $2,000 if single or if married and applicant is the husband; $3,000 if married and the applicant is the wife, including combined ownership of husband and wife.[1]	Liability of adult children for costs of medical care of parents is established by statute according to income scale, with additional exemptions to meet specified needs of the immediate family of such adult child.
Michigan	Not more than $1,500 annual income for single person; $2,500 if married and living with spouse, including income of spouse.	Homestead is excluded from assets; value of other real property is included in limits on marketable assets given in personal property.[1]	Liquid or marketable assets may be held not to exceed $1,500 for single person, $2,000 for married couple living together. Excluded in making this determination are: clothing and household effects; cash surrender value (not value of matured policies) of life insurance; personal property used in earning income of fair market value not exceeding $1,000. All other property, real and personal, must be considered under the $1,500 and $2,000 maximum on marketable assets.[1]	"Income" includes contributions which son, daughter, or estranged spouse should be making to applicant, according to agency standards or court determination. However, such contributions are not included in computing income during the first 30 days of hospitalization for each determination or redetermination of relative's ability to make contributions.

See footnote at end of table.

TABLE 17.—*Medical Assistance for the Aged: Financial eligibility provisions, income and property holdings, by State, October 1961*—Continued

State	Income	Assets		Use of own resources as a condition of receiving assistance
		Real property	Personal property	
New Hampshire	Annual net income from all sources may not exceed $1,200 for single person, $1,800 for married couple living together; plus $600 allowed for support of each dependent child. If both members of a couple are in the same nursing or boarding home, they are considered as single individuals.	Home owned and occupied by applicant is excluded. Also excluded is net equity in other real property up to $500 for 1 person, $800 for couple. Net equity beyond $500 but less than $4,500 for single person (beyond $800 but less than $4,800 for couple) does not disqualify if real property is income-producing.[1]	May hold livestock and equipment used to earn income up to a net cash value of $1,500; net cash equity of all other personal property, including cash value of life insurance, may not exceed $500 for single person, $800 for married couple.[1]	All medical resources, e.g., health insurance or workmen's compensation, are taken into account in determining extent of need for MAA. Ability of adult children to support parents is determined according to income scale, with provision for taking into account specified family expenses of the adult child if they exist.
New York	(1) Person in medical or nursing institutions for chronic care may have up to $10 a month for personal items, annual premium for health insurance policy up to $150 for single person or $250 for married recipient if policy covers spouse also; if married, up to $1,800 for support of spouse, including any income of spouse. (2) Person not in facility for chronic care may have $1,800 for single applicant, $2,600 for married applicant living with spouse; health insurance premiums up to $150 per year for single recipient or $250 if married and policy includes spouse also. All income in excess of these amounts is deemed available to apply to costs of medical care.	Home is exempt; other real property must be utilized to apply to costs of care.[1]	May have life insurance with cash surrender value of not more than $500 (single person or couple); excess value of insurance or non-essential personal property must be utilized; clothing and household effects are excluded. *Cash reserve*, for person not living in a medical facility, may be held up to $900 for single or $1,300 for married couple. If value of non-home real estate, non-essential personal property, and excess insurance together with cash or liquid assets does not exceed "cash reserve" maximum, such resources need not be utilized and applied to costs of care.[1]	All income and resources shall be deemed available to meet costs of medical care except the amounts and kinds of resources specified in the columns on *Income* and *Assets*.
North Dakota	Annual income in excess of the following is deemed available to meet costs of medical care: single person, $1,200; married couple, $1,800. Living in nursing home or hospital: single, $96; married, both in such institution, $192; one of married couple in nursing home or hospital, the other not, $1,296.	Homestead is exempt (town: house and up to 2 acres of land; rural: 160 acres contiguous to house). Other real property that is saleable or in which applicant has an equity must be utilized to apply to medical care costs.[1]	Total value not to exceed $2,500, of which not more than $500 for single or $1,000 for married couple may be in cash, stocks, or bonds. Cash value of insurance comes under total value maximum but not under liquid assets maximum. Excluded from consideration as personal property are household goods, wearing apparel, or personal effects.[1]	An applicant must have paid or obligated himself to pay $50 for medical care during the 12 months preceding the application; benefits paid from health or hospital insurance will be considered as meeting this requirement.

Oklahoma	Annual income, single person, up to $1,500; for man and wife, up to $2,000. Exempts the income required by legal dependents according to ADC standards.	May have equity up to $8,000 in home owned and occupied as home (urban includes necessary lots; rural includes up to 40 acres of land). Equity above this amount and value of other real property are considered among "other resources." Home to which recipient or spouse has no feasible plans to return is no longer considered eligible for exemption as home occupied by recipient.	Maximum set for each of 4 kinds of property: (a) insurance—single person, cash value of first $1,000 face value; married, cash value of first $2,000 face value; married, living together and having separate policies, cash value of first $1,000 face value for each; (b) equity in tools for earning a living, up to $1,500; (c) equity in small business which he operates, up to $2,500; (d) "other resources" limited to $700 for single person or $1,000 for married couple, including cash, stocks, bonds, etc., automobiles, excess of value of items listed in (a) and (b) preceding, excess equity of home, or property of any kind which can be made available for use of recipient or spouse.	Eligibility is determined concurrently with need for medical care as defined in State's plan and is directly related to total resources of applicant available to meet known or predictable costs of such care.
Oregon	Single person, less than $1,500; married, combined income of husband and wife less than $2,000. Where it is not possible to determine the income of an absent spouse, applicant is treated as a single person.	Home used by applicant or legal dependents, exempt; value of other real property together with personal property may not exceed $5,000 fair market value.[1]	Excluded from consideration are: 1 automobile; household furnishings; personal property holdings used in earning a living (clothing, tools, machinery, and other goods and equipment). All other property must come under maximum. (See column 2.) *Liquid assets* (cash or equivalent) shall be less than $1,500 for single person, $2,000 for couple. Excluded from consideration is cash surrender value of life insurance held by applicant not to exceed $1,000.[1]	Recipient participates in payment of costs through a system of deductible amounts related to the kind of care received. Private medical insurance policies may be utilized in payment of such "deductible" and must be utilized to the fullest extent possible as an "offset" before MAA benefits are payable. MAA and partial benefits supplement each other.
Puerto Rico	Annual income and available liquid resources of individual may not exceed $1,500.	Home where applicant resides is excluded from consideration; all other real property is taken into account in determining eligibility.	Loan value of life insurance and any other available resources will be taken into account.	Membership in organizations which provide medical care or payments therefor (such as Blue Cross, Blue Shield, State retirement or compensation systems, health insurance of any appropriate type, and veterans' benefits) make applicant ineligible for MAA.

See footnote at end of table.

TABLE 17.—*Medical Assistance for the Aged: Financial eligibility provisions, income and property holdings, by State, October 1961*—Continued

State	Income	Assets		Use of own resources as a condition of receiving assistance
		Real property	Personal property	
South Carolina	Maximum annual income for single person is $1,000; for married couple, combined income may not exceed $1,800. In determining income from the operation of a business, net income will be considered.	Home and land upon which it stands. Owned and occupied by applicant or to which he has reasonable plans to return, is exempt as a resource. Other real property may be held if income-producing; if non-income producing, sale value of the property is considered under the income maximums.	May hold (1) savings of $500 if single or $800 combined savings of married couple; (2) insurance with cash, loan, or surrender value of $1,000 for single person and of $2,000 for married couple. Savings and insurance in excess of these amounts are considered under the maximum on income. Not considered as assets available for payment of medical care costs is value of such personal property as automobile needed for transportation, household furnishings, and farm equipment.	Eligibility is determined concurrently with need for medical care as defined in State's plan and is directly related to total resources of applicant available to meet known or predictable costs of such care.
Tennessee	Maximum annual income $1,000 for single, $1,500 for couple; excluding actual cost of support of totally dependent children. Special provision for application of any benefit designated specifically for support of such dependent child (e.g., VA or SSA) who lives in applicant's home.	Equity in all real property (including the home) owned by applicant cannot exceed $5,000 and the total real value of such property cannot exceed $7,000 (figured on the county assessment percentage for the county in which the real property is located).	Total of cash, savings, or items readily convertible into cash may not exceed $1,000 for single person or $1,500 for married couple, excluding cash value of life insurance up to $1,000 for single person or $1,500 for a couple. Excess cash value must be considered under the liquid assets maximum. Contributions by friends or relatives for the particular purpose of meeting costs of allowable medical care will be taken into account in determining amount of MAA needed.	For hospital care, applicant must have incurred hospital expenses amounting to $100 within a fiscal year before MAA is available. Benefits from hospital insurance of applicant may be applied to meet this $100 prior to being considered available to meet costs of days of care for which MAA would be charged.
Utah	Net monthly income available may not exceed $110 for single person, $170 for two persons or couple, $210 for three persons.	Home owned and occupied is excluded; net value of other real property is included in total allowable as available to meet costs of medical care needed.[1]	Net value of all property other than the home and excluded non-liquid assets defined below may not exceed $10,000. Negotiable or liquid assets available to meet costs of medical care may not exceed $1,000 for single, $2,000 for couple or family. Amounts in excess of these maximums must be applied to cost of major medical care before MAA may be granted to cover additional costs. Excluded from consideration as liquid assets are: furniture, household equipment, livestock, implements, tools, and a necessary automobile.[1]	Patient pays first $50 of cost for each hospital admission; first $20 of costs of physician's services for each benefit period of 90 days. Health and hospital insurance will be applied on medical bills in determining amount of MAA needed or may be assigned to the hospital or to the county department of public welfare to fulfill the "deductible" requirement.

Virgin Islands	Current continuing gross annual income of $1,200 or less for single persons, $2,400 for married couple living together.	Total real property, including home owned and occupied, may not exceed $10,000.	Cash assets, or those readily convertible into cash, may not exceed $1,200 for single person, $2,400 for married couple living together.	Health insurance and "government entitlement such as Veterans Medical Services" are available assets which are taken into account in determining need for and extent of MAA.
Washington	Net income (cash or kind) regularly and predictably received by the applicant, the combined dollar value of which is in excess of that needed to meet his and his legal dependents' maintenance requirements as measured by the Department's OAA Standards of Assistance, is considered as income available which must be applied toward meeting the cost of approved medical care.	Home used by applicant or his legal dependents, together with reasonable amount of contiguous land, is not considered as a available asset. Value of other real estate is included in total of assets available.	All other resources and liquid assets, including cash surrender value of life insurance, are considered to determine extent to which they may be utilized for payment of needed medical care, except; household furnishings and personal clothing, 1 automobile, and personal property "used and useful or of great sentimental value".	Medical insurance in force at time of application and any potential compensation for injury must be utilized to the fullest extent.
West Virginia	Annual net income may not exceed $1,500 for single; $3,000 for married person living with spouse, combined income. Includes contributions received from relatives.	Homestead is excluded. Value of all other real property limited to $15,000 for single person, $20,000 for a man and wife residing together.	All other liquid or marketable assets, limited to $5,000 for single person or $7,500 for combined assets of husband and wife. (Excludes clothing, jewelry, household effects, livestock, farm machinery, and other needed vehicles.)	Insurance for medical purposes or eligibility for payment of medical services from other agencies and organizations, such as Veterans Administration, United Mine Workers of America, Workmen's Compensation, must be taken into account in determining the amount of MAA to be granted. (Revision as of December 1, 1961: "* * * applicant will be ineligible for payment of medical services (from MAA) until such time as the benefits are exhausted.")

[1] Has provision for recovery from estate of deceased recipient after death of surviving spouse, if any.

Extracts from Bureau of Family Services, Social Security Administration, *Characteristics of State Public Assistance Plans Under the Social Security Act: Provisions for Medical and Remedial Care* (Public Assistance Report No. 49), 1962.

Appendix C

Aggregate Expenditures for Medical and Hospital Care for the Aged

Estimating aggregate medical expenditures for any particular segment of the population is, at best, an inexact art, and may be approached in different ways. The estimates that follow nevertheless supply a reliable indication of the magnitude which medical expenditures for the aged have reached and the relative importance of various sources for these expenditures.

Estimated Total Expenditures for Medical Care of the Aged, 1960

Source of funds	*Amount (millions)*
Total expenditures for medical care	$5,045
Private expenditures	3,715
Personal expenditures [1]	3,615
Philanthropy [2]	100
Public Expenditures	1,330
Public Assistance Programs	455
Veterans Administration Program	265
Other public programs	610

[1] Includes expenditures by recipients of care and on their behalf by relatives or friends and by health insurance.
[2] Does not include payments made on behalf of particular individuals.

Personal medical care expenditures by and for the aged were estimated as a proportion of total private medical care expenditures as reported for 1960 (at $19.6 million) in the December 1961 Social Security Bulletin. It was assumed that the ratio of per-capita expenditures for persons 65 and over and under 65 was the same as reported by the Health Information Foundation Study for medical services exclusive of nursing home care, in 1957–58. For nursing home care in 1960, personal expenditures are estimated at $280 million, and it is assumed that some 85 percent of nursing home beds are used by aged persons. Total personal expenditures for medical services for aged persons thus derived amount to $3,615 million.

Total *philanthropic expenditures* for medical care in 1960 are estimated at $715 million, following concepts used in the social welfare expenditure series published each year in the November issue of the Social Security Bulletin. If it is assumed first that about one half of this total, or $360 million, was expended for personal medical care services, and second that roughly one quarter of the latter was expended for the aged, the philanthropic expenditures for medical care for the aged would approach $100 million. Included are funds raised by philanthropic institutions or by organized fund drives, such as United Givers Funds, or the American Heart Association. (A cumulation of estimated expenditures in behalf of the aged by such organizations yields roughly the same total). Services that physicians or hospitals provide without the anticipation of payment are not included. Such services, along with the sources of philanthropic funds, are discussed in Chapter 10.

Public expenditures for medical care for aged persons in 1960 are for the most part known in the case of Federal or Federal-State programs and may be estimated for other categories on the basis of expenditure trends since earlier estimates were prepared.

The public assistance total comprises all vendor payments for medical care under the old-age assistance and medical assistance for the aged programs, half of those under the aid to the blind program, and estimated expenditures for medical care provided through the money payments under old-age assistance.

In estimating Veterans Administration expenditures, the age distribution by type of condition of the patient load on census survey days was taken to represent the age distribution of patients in hospitals for these types of conditions throughout the fiscal year in which the census day fell. The percentages of aged persons obtained in this manner were applied to the costs of maintaining and operating the Veterans Administration's neurological and psychiatric, tuberculosis, and general medical hospitals in fiscal years 1960 and 1961. The average of these expenditures was used to represent calendar year 1960. Expenditures for contract hospitalization were estimated on the basis of the age distribution of patients in contract hospitals on the census days, and estimates for fiscal years 1960 and 1961 were likewise averaged to obtain a calendar year 1960 estimate. Expenditures for outpatient care for the aged were estimated at about 30 percent of the total expenditures for outpatient care.

The estimates of expenditure for the aged under other public programs are based upon estimated unreimbursed expenditures for care of the aged in State and local hospitals (as described below), augmented by $75 million for other public expenditures, including items such as payments for care in nonprofit hospitals, Health Department medical services to the aged, care in U.S. Public Health Service hospitals, publicly owned nursing homes and infirmaries, workmen's compensation medical care and care provided Indians.

Estimated public expenditures for hospital care of the aged, 1960

[In millions of dollars]

	All hospitals	General hospitals	Mental and tuberculosis hospitals
Total	895	470	425
Public assistance	100	100	----
Veterans' Administration	235	165	70
Other	560	205	355

The estimated expenditures under public assistance programs for hospital care include vendor payments for hospital care plus an estimated share of the money payments for medical care.

The estimate of expenditures by the Veterans Administration for hospital care was developed as described above.

The estimate of expenditures in other hospitals includes a portion of the reported expenditures of State and local mental, tuberculosis, and general hospitals which are not met through patient payments, the proportion being determined by the estimated aged patient load in these institutions—26 percent in general hospitals, 20 percent in tuberculosis hospitals, and 33 percent in mental institutions. An estimated $25 million was assumed to cover the care of aged persons under Federal auspices in Public Health Service hospitals, in military hospitals, and in the Soldiers' Home infirmary, and also the hospitalization of aged Indians.

Appendix D

Major Legislative Proposals for Financing Personal Health Services for the Aged, 1939–1961

Many and varied proposals have been made over the years for Federal legislation to provide health insurance, to stimulate the spread of voluntary health insurance, or to support State medical care programs. The various proposals which have been made in bills introduced in the Congress since the late 1930's and which relate to the aged are summarized below.[1]

The following discussion of these proposals is not limited to those specifically designed to provide insurance against the cost of hospitalization, or hospital and nursing home care, for the beneficiaries of old-age, survivors, and disability insurance. It is limited, however, to approaches that could be used for this purpose. It omits, therefore, proposals in which the primary basis for selecting the population group is not only unrelated to age but is one which is likely to encompass only a few aged people or a specified limited group of aged persons, such as retired Federal employees. Thus excluded are proposals relating to exemptions or credits on Federal income taxes for amounts paid as health insurance premiums, or to special groups such as farm families or migrant workers, and temporarily unemployed persons.

Also omitted, although they may affect substantial numbers of aged persons, are proposals related to the public assistance system. The role of the public assistance programs in providing medical care is described in chapters 8 and 9, with additional detail in Appendix B. Some proposals express their coverage in terms of "low income families" or "medically indigent" persons wherever found in the total population. They are included because most aged persons could come within the scope of programs with such comprehensive coverage.

The detailed summary which follows includes only those bills which were introduced before 1962, that is, bills introduced prior to the second session of the 87th Congress. Up to March 15, 1962, three new bills of major importance had been introduced; S. 2664, H.R. 10513, and H.R. 10755. S. 2664, introduced on January 11 by Senator Javits, would provide every "retired" person aged 65 or over who is not receiving medical care through the public assistance program with a choice among several health insurance benefit packages. The benefits generally follow those in S. 937 (described below). Benefits for old-age and survivors beneficiaries would be financed by an increase in the payroll tax; those for persons not eligible for such benefits, from general revenues. H.R. 10513, introduced by Congressman Durno, would establish a National Advisory Medical Commission of 21 members to study the proper role of the Federal Government in relation to the States and private agencies providing medical care and insurance and to report by January 31, 1963, on a plan to provide adequate medical, hospital, outpatient and nursing home care for the aged. H.R. 10755, introduced by Congressman Bow, would use the income tax mechanism to distribute a Federal

[1] For a detailed legislative history of health insurance considerations during the Eighty-sixth Congress, see William L. Mitchell, "Social Security Legislation in the Eighty-sixth Congress," *Social Security Bulletin*, v. 23, no. 11, November 1960.

subsidy of up to $125 per aged person toward the purchase of private health insurance for the aged which provides certain Federally-established minimum benefits.

A. HEALTH INSURANCE FOR OASDI BENEFICIARIES

The first bill embodying a proposal for hospitalization benefits for beneficiaries under Title II of the Social Security Act was introduced into Congress in 1952. With minor variations, similar proposals have been introduced in each of the Congresses since then. However, as interest in health care for the aged increased, the variations among the proposals for financing health insurance through the old-age, survivors, and disability insurance system became more significant and bills incorporating modifications from those introduced earlier became more numerous.

1. Proposals Before the 82nd Through 85th Congress

The essential features of the proposals advanced between 1952 and 1957 are as follows: Persons eligible for insurance benefits, whether currently drawing benefits or not, would be insured for up to 60 days in a year for semiprivate room care in short-term hospitals. The hospital benefit would be a service benefit and would include those services, drugs and supplies which the hospital customarily furnishes its bed patients. The Forand bill (H.R. 9467) in 1957 also proposed to pay the costs of skilled nursing home care for patients transferred from the hospital (up to a total period, including the hospital stay, of not more than 120 days in a year) and of surgical services provided in a hospital (or, in case of emergency or minor surgery, in the outpatient department of a hospital or in a doctor's office).

Hospitals would be paid on a cost-incurred basis or on a reasonably equivalent basis. The methods of paying the hospital varied with the administrative arrangements suggested in the various bills. Under the early proposals where the Federal Government was to use State agencies as its agent, the State agency would either pay hospitals within the State for the care rendered eligible persons or would utilize private nonprofit health insurance plans to negotiate with and pay the hospitals. Under more recent proposals national administration has been proposed, with the Secretary of HEW given authority to negotiate agreements directly with hospitals or to use the services of such agencies as Blue Cross.

Benefits would be financed through the social security payroll tax paid compulsorily by covered employees, their employers, and the self-employed. The amount of the additional payroll tax would, of course, depend on the exact benefits proposed. The level premium cost of the Forand proposal for hospitalization, nursing home and surgical benefits was first estimated at one-half of 1 percent of covered payrolls, and taxes were set at that level.

The earliest proposals contemplated that the program would utilize the States, and preferably the State public health agencies, as administrative agents. Only in a State which did not effect an agreement to administer the program would the overall administrative functions be performed federally. (Necessary regulations relating to the program in general and determinations as to an individual's insured status would, of course, be made at the Federal level). As a result

of the post-1952 development of national Blue Cross contracts and the implementation of Medicare, the later proposals contemplated national administration of the hospitalization benefits.

The following bills have embodied this proposal:

Year	Congress	Session	Bill Number	Sponsor
1952	82d	2d	S. 3001	Murray.
1952	82d	2d	H.R. 7484	Dingell.
1952	82d	2d	H.R. 7485	Celler.
1953	83d	1st	H.R. 8	Dingell.
1953	83d	1st	H.R. 390	Celler.
1953	83d	1st	S. 1966 [1]	Murray, Humphrey, and Lehman.
1955	84th	1st	H.R. 638	Celler.
1955	84th	1st	H.R. 2384	Dingell.
1956	84th	2d	H.R. 9868	Dingell.
1956	84th	2d	H.R. 9980	Metcalf.
1957	85th	1st	H.R. 1092	Celler.
1957	85th	1st	H.R. 4765	Dingell.
1957	85th	1st	H.R. 9448	Roberts.
1957	85th	1st	H.R. 9467 [2]	Forand.

[1] Includes provisions permitting States to extend hospitalization coverage to noninsured aged persons.
[2] Includes nursing home benefits and surgery.

Hearings before the House Committee on Ways and Means on all titles of the Social Security Act, in June 1958, included testimony on H.R. 9467.

2. Bills Introduced During the 86th Congress

The bills introduced during the first session of the 86th Congress followed much the same pattern as those introduced in earlier Congresses. However, those introduced during the 2nd session show a wider variety in both coverage and in benefits provided.

Essentially, the tendency in the later proposals was to concentrate upon the aged or upon a retired or presumed retired group of the aged old-age and survivors insurance beneficiaries rather than all beneficiaries. Indeed, as the issue came to be viewed more explicitly as a problem of the aged, several bills provided for the extension of coverage to all retired aged, irrespective of whether they were eligible for old-age and survivors insurance benefits. Under these proposals, benefits for old-age and survivors insurance eligibles were to be financed by an increase in the payroll tax, while those for persons not eligible for old-age and survivors insurance were to be paid for from general revenues.

Under all proposals the basic benefit was hospitalization, with individual variations in the duration of the benefit and the use of a deductible which must be paid by the beneficiary. Aside from this base benefit, the proposals varied in their inclusion of skilled nursing home services, outpatient diagnostic services, home health services, physicians' services, and assistance in the purchase of drugs.

The unifying feature of all bills was that benefits for old-age, survivors, and disability insurance beneficiaries were to be financed through an increase in the payroll tax. All proposals called for Federal administration and administrative responsibility; some provided for a delegation of certain administrative functions to either State agencies or to voluntary, nonprofit health insurance plans.

The following bills introduced during the 86th Congress would provide health benefits for certain old-age, survivors, and disability insurance beneficiaries:

Bill number	Sponsors	Persons covered	Benefits
H.R. 4700	Forand	All OASDI eligibles, except disability insurance beneficiaries.	(*a*) Hospitalization up to 60 days; (*b*) skilled nursing home services following and associated with hospitalization up to 120 days less days of hospitalization; and (*c*) surgical services.
H.R. 10816	Harmon		
H.R. 11093	Gilbert		
S. 881 [1]	Morse		
S. 1151 [2]	Humphrey	Same as H.R. 4700	Same as H.R. 4700, except omits surgical services.
H.R. 412	Roberts	All OASDI eligibles	Hospitalization up to 60 days.
S. 2915	Kennedy and Hart	All OASDI eligibles	(*a*) Hospitalization up to 90 days; (*b*) skilled nursing home care (following hospitalization), and (*c*) home nursing services (following hospital or nursing home stay), with overall 120-day combined care limit on (*a*), (*b*), and (*c*): 1 day of (*a*), 1½ days of (*b*), or 2 days of (*c*) equals 1 combined-care-day; and (*d*) diagnostic outpatient hospital services.
H.R. 12255	Gallagher		
H.R. 12418	Metcalf	(*a*) OASI eligibles aged 68 or over; (*b*) all noneligibles 68 or over (except railroad retirement or Federal civil service retirement eligibles).	(*a*) Hospitalization up to 365 days, with initial 3 days deductible, and additional 3 days deductible after 24 days; (*b*) skilled nursing home care (after and associated with hospitalization) up to 18 days; (*c*) visiting nurse services up to 365 days; and (*d*) for OASI eligibles, $4 a month additional cash benefit if elected in lieu of (*a*), (*b*), and (*c*), above.
Amendment 6-30-60—B to H.R. 12580.	Anderson, Humphrey, and McCarthy.	OASI eligibles aged 68 or over	(*a*) Hospitalization up to 365 days, with $75 initial deductible and $75 additional deductible after 24 days; (*b*) skilled nursing home care (after hospitalization) up to 180 days; and (*c*) visiting nurse services up to 365 visits.
Amendment 8-17-60—A to H.R. 12580.	Anderson, Kennedy, Humphrey, Douglas, Gore, McNamara, McCarthy, Hartke, Randolph, and Engle.	OASI eligibles aged 68 and over	(*a*) Hospitalization up to 120 days after an initial $75 deductible; (*b*) skilled nursing home services (after hospitalization) up to 240 days; (*c*) home health services up to 365 visits; and (*d*) outpatient hospital diagnostic services.
S. 3503 [3]	McNamara, Kennedy, Clark, Randolph, Symington, Humphrey, Williams of New Jersey, Magnuson, McGee, Young of Ohio, Douglas, Gruening, Long of Hawaii, Murray, Hart, Morse, Hennings, Jackson, Pastore, McCarthy, Bartlett, Engle, Green, and Mansfield.	(*a*) Retired OASI eligibles aged 65 (62 for women) and over. Retired when earnings less than $2,000 in preceding year or $100 in each of preceding 3 months, or if aged 72 or over; (*b*) all other aged persons meeting same requirements as OASI eligibles, except railroad retirement and Federal civil service rotirement eligibles.	(*a*) Hospitalization up to 90 days; (*b*) skilled nursing home services up to 180 days; and (*c*) home health services up to 240 days, with overall limit of 90 service units, and 1 day of (*a*), 2 of (*b*), or 2½ of (*c*) equal 1 service unit; (*d*) diagnostic outpatient services, and (*e*) very expensive prescribed drugs, per Secretary's regulations.

Bill Number	Sponsors	Persons covered	Benefits
S. 3763	Gore and Yarborough	Same as S. 3503	(*a*) Hospitalization up to 60 days; (*b*) skilled nursing service up to 120 days; (*c*) home health services up to 180 days; and (*d*) medical services up to 25 home or office visits, with an overall limit of service units, and with 1 day of (*a*), 2 of (*b*), 3 of (*c*), or 2 home or 4 office visits equal to 1 service unit; (*e*) surgical services; (*f*) diagnostic outpatient services; and (*g*) specified prescribed drugs, per Secretary's regulations.

[1] Amendment 6-27-60—F to H.R. 12580 is identical.
[2] Amendment 6-28-60—G to H.R. 12580 is identical.
[3] Amendment 6-24-60—C to H.R. 12580 is similar.

NOTE.—Hearings were held on H.R. 4700 by the Committee on Ways and Means in July 1959. Medical care for the aged also was the primary issue discussed during hearings before the Senate Committee on Finance in June 1960, on the Social Security Amendments of 1960 (H.R. 12580), which provided for the medical assistance for the aged program and for increased Federal participation in medical vendor payments under the old-age assistance program. Likewise, medical care for the aged was a major element in the hearings before the Senate Subcommittee on Problems of the Aged and Aging throughout the session. Hearings specifically related to health needs of the aged and aging were held in April 1960.

3. *Proposals Introduced During the 87th Congress, 1st Session*

During the first session of the 87th Congress, the primary new measure introduced was the Administration-sponsored King-Anderson Bill, under which the cost of certain hospitalization, skilled nursing home, home health, and outpatient hospital diagnostic services would be provided for persons who have reached age 65 and are entitled to monthly cash benefits under the old-age, survivors and disability insurance or railroad retirement systems. The identical bills which were introduced are as follows:

Bill No.—	*Sponsors*
S. 909	Anderson, Douglas, Hartke, McCarthy, Humphrey, Jackson, Long of Hawaii, Randolph, Engle, Magnuson, Pell, Burdick, Neuberger, Morse, Long of Missouri, Moss, and Pastore.
H.R. 4222	King.
H.R. 4309	Dingell.
H.R. 4313	Karsten.
H.R. 4314	Machrowicz.
H.R. 4315	Green.
H.R. 4316	Ullman.
H.R. 4447	McFall.
H.R. 4534	Pucinski.
H.R. 4921	O'Neill.
H.R. 7793	Santangelo.

The services for which payment would be made under the proposal would be:

(1) inpatient hospital services for up to 90 days, subject to a deductible amount of $10 a day for up to 9 days, with a minimum of $20; hospital services would include all those customarily furnished by a hospital for its patients; payment would not be made for the hospital services of physicians except those in the fields of pathology, radiology, physical medicine, and anesthesiology provided by or under arrangement with the hospital, or services provided by an intern or resident-in-training under an approved teaching program;

(2) skilled nursing home services, after the patient is transferred from a hospital, for up to 180 days;

(3) outpatient hospital diagnostic services, as required, subject to a $20 deductible amount for each diagnostic study;

(4) home health services for up to 240 visits during a calendar year. These services would include intermittent nursing care, therapy, and part-time homemaker services.

No service would be covered as a nursing home, outpatient diagnostic, or home health service if it could not be covered as an inpatient hospital service.

An individual could be eligible for up to 90 days of hospital services and 180 days of skilled nursing home services in each period of illness, but subject to a maximum of 150 "units of service." A unit of service would be equal to 1 day of inpatient hospital services or 2 days of skilled nursing home services. A "new period of illness" would not begin until 90 days had elapsed in which the patient was neither in a hospital or a skilled nursing home.

Payments to the providers of service would be made on the basis of the reasonable cost incurred in providing care for beneficiaries. The amount paid under the program would be payment in full for covered services, except that the provider could charge the patient the

deductible amounts and extra charges for a private room or private duty nursing.

Responsibility for administration of the program for social security beneficiaries would rest with the Secretary of Health, Education, and Welfare. The Secretary would consult with appropriate State agencies and recognized national accrediting bodies in formulating the conditions of participation for providers of service. Provision would be made for the establishment of an Advisory Council which would advise the Secretary on policy matters in connection with administration. In order to be eligible to participate in the program, providers of service would have to meet specified conditions to assure the health and safety of the beneficiaries. State agencies could be used in ascertaining whether providers met these qualifications and in providing consultative services to them. If it desired, a State could recommend that more strict conditions be applied with respect to providers of service within the State than elsewhere.

The program would be financed by an increase in the social security contribution rates of ¼ of one percent on employers and ¼ of one percent on employees and of ⅜ of one percent for the self-employed, and by the net increase in income to the system from raising the annual taxable earnings base from $4,800 to $5,000. (According to testimony by the Secretary of HEW in July 1961 before the House Committee on Ways and Means the increase should be to $5,200 in order to meet in full the estimated costs of the proposal.) Raising the earnings base would in addition improve the benefit structure of the system.

Hearings were held by the Committee on Ways and Means during July and August, 1961 on H.R. 4222.

Several proposals from earlier Congresses were resubmitted. The following bills, identical to the Forand Bill (H.R. 4700 in the 86th Congress) were introduced:

Bill No.—	*Sponsor*
H.R. 94	Holland.
H.R. 676	Gilbert.
H.R. 1765	Dulski.
H.R. 4168	St. Germain.

H.R. 2762, introduced by Representative Gilbert, provides for the same benefits as did the Forand Bill, but extends the scope of those eligible for benefits to encompass all persons eligible for old-age, survivors, and disability insurance benefits, including persons eligible for disability insurance benefits.

The McNamara Bill from the 86th Congress was reintroduced with minor changes in both the Senate and the House of Representatives, as follows:

Bill No.—	*Sponsor*
S. 65	McNamara.
H.R. 2407	Dingell.
H.R. 2518	Rabaut.

Representative Roberts reintroduced, as H.R. 2443, a proposal for hospitalization benefits for all persons eligible for old-age, survivors and disability insurance benefits identical to H.R. 412 which he had introduced during the 86th Congress. The bill proposed during the 86th Congress by the then-Senator Kennedy (S. 2915) was reintroduced as H.R. 195 by Representative Ashley.

Representatives Kowalski and Halpern introduced bills (H.R. 3448 and H.R. 4111 respectively) which would extend hospitalization, skilled nursing home, and surgical benefits identical with those in the Forand bill (H.R. 4700, 86th Congress) to aged persons. In addition, under H.R. 4111 diagnostic outpatient services would be provided. In essence, these bills would provide for extending health insurance benefits to all persons entitled to old-age, survivors and disability insurance benefits and to all persons who would be entitled if their earnings prior to January 1, 1962 from railroad or Federal civil service employment were counted as covered earnings, and automatically, to all persons attaining retirement age (65 for men, 62 for women when bills were introduced), before January 1, 1964. For health insurance benefits under the old-age, survivors and disability insurance program for future beneficiaries, there would be a new test for insured status, with a person insured if he had one quarter of coverage for each two of the quarters elapsing after December 31, 1961, or if later, the year in which he became 21 and the year in which he reached retirement age (or died, if earlier), and six quarters of coverage. Earnings from employment by the railroads or as a Federal civilian employee would be counted in determining quarters of coverage. Special provisions are included for States to enter agreements to extend benefits to their employees. The program would be financed by an increase in the payroll tax of ¼ percent each on employers and employees (⅜ percent for self-employed) and an increase in the earnings base to $6,000 and making such increase applicable to Federal civilian and railroad employment. Self-employed persons not presently covered by the old-age, survivors and disability insurance system might elect to become eligible for health insurance benefits by an irrevocable decision to pay the taxes associated with the health insurance benefit.

B. FEDERAL GRANTS FOR STATE PROGRAMS OF HEALTH INSURANCE FOR THE AGED

During the 86th and 87th Congresses, several proposals were advanced for programs of Federal grants to the States to help finance health insurance programs for aged persons. The proposals all provided that coverage for eligible aged individuals under the program depended upon their electing such coverage, and established or authorized enrollment fees to be paid by the individual. They all also provided for State administration, either directly or through contracts with insurance carriers.

1. The Javits Proposal[1]

This proposal would authorize Federal grants to participating States which extend health insurance to persons aged 65 or over and their spouses, either through an insurance carrier set up by the State for the purpose or by private commercial, prepayment or nonprofit insurance carriers under contract with the State. A choice between service and indemnity benefits must be offered. Physicians' home and

[1] This discussion relates to Amendment 6–27–60–H to H.R. 12580, rather than the earlier S. 3350. These differ in that the earlier bill established no minimum benefit and contained an individual contribution schedule ranging from nothing for persons with incomes under $500 in the preceding year to $13 a month (or the cost of the policy, if less) for those with incomes of $3,600 or over.

office visits and other ambulatory treatment must constitute one third of the premium cost. The substitution of skilled nursing home care for care of equal cost in hospitals must be permitted. As a minimum, the health insurance shall insure against the cost of 21 days a year of hospital care or equivalent nursing home care, physicians' services up to 12 home or office visits per year, the first $100 of ambulatory, diagnostic, laboratory and X-ray services a year, and visiting nurse services for not less than 24 visits a year.

The program would be financed by individual contributions, State moneys, and Federal appropriations from general revenue. Individual contribution schedules were to be established by each State, with contributions based upon the income of the subscriber and with a maximum of the total premium cost if this were less than $13 a month. The Federal portion of the Federal-State share of the program would range between 33⅓ and 75 percent of the premium cost up to $13 a month per capita less the individual contributions.

Bills embodying this approach were:

Bill No.—	*Sponsors*
S. 3350	Javits, Cooper, Case of New Jersey, Scott, Fong, Aiken, Keating, and Prouty.
Amendment 6-27-60-H to H.R. 12580	Javits, Cooper, Scott, Fong, Aiken, Keating, and Prouty.
H.R. 11661 [1]	Weiss.
H.R. 11677 [1]	Lindsay.
H.R. 11683 [1]	Pirnie.
H.R. 11685 [1]	Riehlman.
H.R. 11702 [1]	Dwyer.
H.R. 11820 [1]	Glenn.
H.R. 13020 [2]	Lindsay.

[1] Identical to S. 3350.
[2] Identical to Amendment 6-27-60-H to H.R. 12580.

2. The 1960 Administration Proposal

As embodied in S. 3784, introduced by Senator Saltonstall, the proposal would authorize Federal grants to the States to assist them in establishing health insurance programs for persons electing to participate who were aged 65 and over and who did not pay an income tax in the preceding year or whose adjusted gross income, plus old-age and survivors insurance benefits and railroad retirement and veterans pensions, in the preceding year did not exceed $2,500 ($3,800 for a couple).

Benefits would be provided in any year after an eligible person had incurred medical expenses of $250 ($400 for a couple). The insurance program would then pay 80 percent (100 percent for old age assistance recipients) of the cost of hospital care up to 180 days, skilled nursing home care, organized home-care services, surgical procedures, laboratory and X-ray services (up to $200), physicians' services, dental services, prescribed drugs (up to $350), private duty nurses, and physical restoration services. For old age assistance recipients, the initial $250 would be paid by the public assistance program.

An eligible person so electing could receive 50 percent up to a maximum of $60 a year of a private major medical insurance policy in place of the benefits under the government program.

The program would be financed by individual enrollment fees, and Federal and State funds. Persons participating in the government

benefits (except old age assistance recipients, would pay a $24 annual enrollment fee. The Federal share of government costs would be 50 percent on the average, ranging from 33⅓ to 66⅔ percent depending upon the relative per capita income of the State.

3. The Javits-Saltonstall Amendment

Amendment 8–20–60–A to H.R. 12580, sponsored by Senators Javits, Cooper, Scott, Aiken, Fong, Keating, Kuchel, Prouty and Saltonstall, blended the earlier Javits proposal with the Administration proposal. Under this program, the Federal Government would provide grants to the States to help pay for health services for all persons aged 65 and over who did not pay an income tax or whose income, including old-age and survivors insurance benefits, railroad retirement and veterans pensions did not exceed $3,000 ($4,500 for couples) in the preceding year and who elected to participate.

The States were required to offer each participant a choice of 1) a diagnostic and short-term illness plan providing as a minimum, 21 days of hospitalization or equivalent skilled nursing home services, 12 physicians' visits in home or office, diagnostic laboratory and X-ray services up to $100, and organized home health care services for up to 24 days; or 2) a long-term illness benefit plan providing as a minimum after a deductible of $250, 80 percent of the costs of 120 days of hospital care, up to a year of skilled nursing home and home health services, and inpatient surgical services; or 3) an optional private insurance benefit plan providing 50 percent of the cost of a private insurance policy up to a maximum of $60 a year. In addition, the Federal Government would share in the cost of improved programs of the first two types up to a maximum per capita cost of $128 a year.

To be eligible for benefits of the first two types, the individual was required to pay the fee established by the State in a schedule related to participants' income. This fee may not be less than 10 percent of the estimated full per capita cost of the benefits provided under the program. The Federal share of the government costs of the program would range from 33 1/3 to 66 2/3 percent, depending upon the relative per capita income in the State.

During the 87th Congress, 1st Session the Javits-Saltonstall Amendment was reintroduced by Senator Javits and by two Representatives. The bills embodying the proposal are as follows:

Bill No.—	*Sponsors*
S. 937	Javits, Cooper, Scott, Aiken, Fong, Cotton, Keating, Prouty, Saltonstall, and Kuchel.
Amendment 6–22–61–B to H.R. 6027	Javits, Cooper, Scott, Aiken, Fong, Cotton, Keating, Prouty, Saltonstall, and Kuchel.
H.R. 4731	Curtis of Massachusetts.
H.R. 4766	Stafford.

4. The Gubser Proposal

In H.R. 12272, Representative Gubser proposed a system of Federal grants to the States to provide for voluntary health insurance for persons aged 65 and over who pay a $5 enrollment fee and whose net taxable income in the preceding year did not exceed $4,900 ($6,200 for couple).[2] The States must contract, subject to the approval of

[2] H.R. 12670 is a reintroduction of H.R. 12272 correcting technical errors and making some minor substantive changes.

the Secretary of Health, Education and Welfare, with private insurance companies for service benefit plans, indemnity benefit plans, employee organization plans, group practice prepayment plans and individual practice prepayment plans. The Federal grant to the States operating the program would be a specified amount per participating individual, the amount based upon the individual's income and ranging from $5 a month for persons with net taxable incomes of $2500 or below the previous year ($3800 for couples) to $3 a month for persons with net taxable incomes between $3,700 and $4,900 the previous taxable year ($5,100 to $6,400 for couples).

Representative Gubser has reintroduced his bill as H.R. 6181 in the 87th Congress.

C. OTHER FEDERALLY OPERATED HEALTH INSURANCE

Various proposals have been made over the years for national health insurance operated by the Federal Government. These include a proposal for voluntary insurance, one which combines compulsory coverage for workers with low earnings with voluntary coverage for others, and a proposal for compulsory hospital insurance for persons covered by old-age, survivors, and disability insurance.

1. National Voluntary Health Insurance

As proposed by Senator Hunt in 1950 in S. 2940 (81st Cong., 2d sess.), any individual who, with his dependents, had an annual income of $5,000 per year or less, who applied for the insurance, and who paid the prescribed premiums would be covered along with his dependents.

The benefits contemplated included medical, surgical, and dental services regardless of location; home nursing care; hospital care and related services for up to 60 days per person per year; such auxiliary services as laboratory tests, X-ray, diagnosis or treatment, optometrists' services, appliances, unusually expensive drugs, and so forth.

The program would be administered by a National Health Insurance Board with the Surgeon General as chairman and four additional appointive members, within a proposed Cabinet-level Department of Health.

Insured persons would be free to select and change physicians, dentists, hospitals, and so forth.

It was proposed that a Personal Health Insurance Account be created in the U.S. Treasury. All premiums, as set by the National Health Insurance Board, would be paid into this account. Reserves in the account could be invested in the same manner as those of the Federal old-age and survivors trust fund. Congress was authorized to appropriate additional money to the account when needed to carry out the program. No participation by State or local governments or private organizations is indicated in this proposal.

Payments to the providers of medical care benefits were to be made directly from the personal health insurance account under regulations promulgated by the National Health Insurance Board.

2. National Health Insurance Combining Compulsory and Voluntary Coverage

In 1938 Congressman Treadway introduced this proposal in H.R. 9847 (75th Cong., 2d sess.). Compulsory coverage was proposed for almost all employees (including dependents) earning $1,800 per year or less (agricultural employees excepted), with voluntary coverage for all other persons.

The proposed benefits included almost all physicians' services; hospital services up to 10 consecutive weeks per illness per person; "necessary" drugs and laboratory and diagnostic services. Services for diagnosis and treatment of any disability or disease for which public care was available "free" or "at nominal charges" or for which some agency or other person was required to pay would not be included.

Each employee covered compulsorily would contribute 2 percent of his remuneration, but not less than 35 cents per week nor more than 70 cents per week or $36 per year. His employer would contribute 1 percent of such employee's remuneration, but not less than 20 cents per week nor more than 35 cents per week or $18 per year.

All voluntarily covered persons would make sufficient contributions, as determined by Federal authorities, to pay benefit and administrative costs for such persons.

Moneys would become part of a "health insurance fund" operated by a "Health Insurance Commission" set up as a public corporation to administer the plan.

The Commission could pay physicians on a salary, a capitation, or a fee-for-service basis, except that, if fees were paid, maximum amounts, based on the number of patients, would be set and fees prorated accordingly.

Workers in any industry having a private medical services insurance plan would be excepted from compulsory coverage if the private benefits were at least equal to those under the public plan.

3. Compulsory Hospitalization Insurance for Persons Covered by OASDI

The Eliot and Green bills (1942–45) included provisions for a federally operated program of hospitalization insurance through an expansion of the coverage and benefits of the old-age, survivors, and disability insurance system.

Almost all employed and self-employed persons would have been covered by OASDI, and they and their dependents insured for up to 30 days of hospital care. (Government employees could be covered by special arrangements.)

The hospital insurance would be financed through payroll taxes, applying to the same portion of earnings taxed for purposes of cash benefits.

Administration was to be entirely through the Social Security Board. The Board would pay hospitals directly for the costs of hospital care or might accept and pay claims from insured individuals who have received care. Participating hospitals would be approved by the Board with respect to care offered.

The proposal was introduced by Congressman Eliot in 1942 (H.R. 7534) and by Senator Green in 1943 (S. 281) and 1945 (S. 1188).

D. NATIONAL COMPULSORY INSURANCE WITH STATE OPERATIONS

A series of proposals for a national compulsory system of health benefits was introduced by Senators Wagner and Murray and Congressman Dingell during the period 1943–61. These proposals provided for the setting up of a separate account in the U.S. Treasury and for payments to this account computed as a percent of the taxable earnings of insured persons.

The compulsory coverage of the proposals included almost all employees and self-employed in private pursuits, Federal civilian employees and annuitants, and persons entitled to OASDI benefits, and their dependents. Groups not compulsorily covered, such as recipients of public assistance, the unemployed, and certain persons in temporary employment (and their dependents) could be insured for any periods for which payments were made by or for them or for which guarantees of payment were made by any local, State, or Federal agency.

The benefits proposed included almost all physicians', dental, and home nursing services; hospital services for periods up to 60 days per beneficiary per year; prescribed auxiliary services and appliances and usually expensive drugs. All benefits except general practitioner and dental services would be available only by referral or prescription.

Since the Wagner-Murray-Dingell proposal was introduced as a health rather than a tax measure, the exact methods of raising Federal revenues to finance the benefits were not specified in the bill itself. However, the bill was so drafted as to make it clear that revenues would come, in the main, from payroll taxes.

The proposals contemplated administration by the States as agents. Any State could assume responsibility for administering the specified benefits within its boundaries by submitting to the National Insurance Board a plan which complied with listed provisions in the bill. The National Insurance Board could itself administer the program in States without approved plans.

Federal authorities would divide funds among the States on the basis of population, availability of health resources, and differing costs of services in various areas. State administrative agencies would contract with providers of care and fix rates of payments for services; State agencies would pay providers' bills or might utilize local health region officials or nonprofit voluntary prepayment plans as agents for making such payments. Physicians would select the manner in which they would be reimbursed, whether by fee-for-service, capitation, or salary.

This proposal was included in the following bills:

Year	Congress	Session	Bill Number	Sponsors
1943	78th	1st	S. 1161 [1]	Wagner and Murray.
1943	78th	1st	H.R. 2861 [1]	Dingell.
1945	79th	1st	H.R. 395	Dingell.
1945	79th	1st	S. 1050	Wagner and Murray.
1945	79th	1st	S. 1606	Wagner and Murray.
1945	79th	1st	H.R. 4730	Dingell.
1947	80th	1st	S. 1320	Wagner, Murray, Pepper, Chavez, Taylor, and McGrath.
1947	80th	1st	H.R. 3548	Dingell.
1947	80th	1st	H.R. 3579	Celler.
1949	81st	1st	S. 5	Wagner, Murray, Pepper, Chavez, Taylor, and McGrath.
1949	81st	1st	H.R. 345	Celler.
1949	81st	1st	H.R. 783	Dingell.
1949	81st	1st	S. 1679	Wagner, Murray, Pepper, Chavez, Taylor, McGrath, Thomas, and Humphrey.
1949	81st	1st	H.R. 4312	Biemiller.
1949	81st	1st	H.R. 4313	Dingell.
1950	81st	2d	H.R. 6766	Bosone.
1951	82d	1st	H.R. 27	Celler.
1951	82d	1st	H.R. 54	Dingell.
1953	83d	1st	H.R. 1817	Dingell.
1955	84th	1st	H.R. 95	Dingell.
1957	85th	1st	S. 844	Murray.
1957	85th	1st	H.R. 3764	Dingell.
1959	86th	1st	H.R. 4498	Dingell.
1959	86th	1st	S. 1056	Murray.
1961	87th	1st	H.R. 4413	Dingell.

[1] These 1943 bills called for Federal administration rather than a State plan.

There were hearings on S. 1606 in April–July 1946; on S. 1320 in May–July 1947 and January, February, May, and June, 1948; on S. 1679 in May and June 1949; and on H.R. 4312 and H.R. 4313 in July 1949.

E. OTHER FEDERAL GRANTS FOR STATE HEALTH PROGRAMS

These earlier proposals for Federal grants to State-operated medical care programs lay out only broad outlines of the type of program envisaged, leaving to the States the specific provisions.

1. The Wagner Proposal of 1939

The coverage of the Wagner proposal of 1939 was in terms of all persons included in benefits of those State plans approved by the Social Security Board "for extending and improving medical care"; persons living in rural areas and those in greatest need were specifically mentioned. Similarly, the benefits contemplated were to be determined by the States in plans approved by the Social Security Board and could include "all services and supplies necessary for the prevention, diagnosis, and treatment of illness and disability."

State funds were to be provided according to a variable matching formula, but no Federal matching was allowed for so much of the State expenditure as was in excess of $20 a year per individual eligible for medical care.

The method of paying the providers of services was left to the State.

This proposal was included in S. 1620 (76th Cong., 1st sess.) introduced by Senator Wagner in 1939. There were hearings on this bill in the period April to July 1939.

2. The Capper Bills (1939–41)

The Capper bills were designed to foster State programs of medical care for lower income workers with coverage, for most of them, on a compulsory basis. The population groups to be covered were to be determined by the State, with workers' contributions related to their income and with Federal financial participation limited to persons with lower earnings.

Minimum benefits to be provided in approved State plans were specified. Details differed in various versions of the proposal but, in general these included general practitioners' services in the home, office, and hospital, most dental services, home nursing care, maternity care, and if prescribed, hospital and specialists' and laboratory services and care.

Contributions would be made to a health insurance fund in each State by the Federal and State Governments, by compulsorily covered workers and their employers and by other workers requesting voluntary coverage. While details differed, each of the bills introduced by Senator Capper (S. 658 in 1939; S. 3660 in 1940; and S. 429 in 1941) provided that the amounts of workers' contributions would vary directly with their incomes, with compensating increases for the lowest income workers from either employer or State-Federal contributions.

The method of paying the providers of care would be determined by the States or by local areas within the States.

3. The Taft Bills (1946–49)

Another proposal in which Federal grants would be used for State-operated programs was embodied in the Taft bills of 1946–49. In these proposals it was recognized that the State-operated programs might utilize voluntary health insurance in the provision of service.

The Taft proposals would have covered all those families and individuals in the State unable to pay the whole cost of needed medical and dental services.

Federal grants would be made to each State, on the basis of State population, to carry out surveys of existing medical, hospital, and dental services and to formulate "in detail" a 5-year plan for extending such services to persons unable to pay. The Federal share was to be matched by each State.

Federal matching grants for carrying out approved State plans would be made on a variable matching basis, varying between 33⅓ and 75 percent inversely with each State's per capita income.

Total contributions from the State and from local governments could not be less than their expenditures for medical services to the covered groups prior to initiating the program and not less than the difference between the Federal grant and the cost of the approved State plan. Contributions from private institutions were allowed.

Collection of part of the costs of services from those patients or their families able to pay part of such costs could be provided for in the State plan.

Each State might choose any one (or a combination) of several ways to provide and to pay for services to eligible recipients. Use of nonprofit prepayment plans as insurers or agents and the reimbursement of local governments and private, nonprofit organizations for services rendered to eligible recipients were mentioned.

This proposal was embodied in the following bills:

Year	Congress	Session	Bill number	Sponsors
1946	79th	2d	S. 2143	Taft, Smith of New Jersey, and Ball.
1947	80th	1st	S. 545	Taft, Smith of New Jersey, Ball, and Donnell.
1949	81st	1st	S. 1581	Taft, Smith of New Jersey, and Donnell.

There were hearings on S. 545 in May, June, and July 1947 and January, February, May, and June 1948. Hearings on S. 1581 were held in May and June 1949.

4. The Lodge Bills (1940–49)

This proposal restricted the subsidization to certain high-cost drugs and medical services and would not have covered hospitalization costs.

The population group affected was described in terms of "such persons as may require 'X-ray services, laboratory diagnostic services, respirators, and the drugs useful in treating or preventing the listed diseases' and such other infectious or chronic diseases as the Surgeon General may from time to time prescribe."

Federal grants to each State would constitute one-half of all funds spent under the State's plan. Conditions under which recipients would pay for part of these services, while not mentioned in the proposal, could presumably be specified in State plans and could include use of voluntary health insurance plans.

Senator Lodge introduced the proposal in 1940 (S. 3630), 1947 (S. 678), and 1949 (S. 1106). There were hearings on S. 678 in April 1948 and on S. 1106 in May and June 1949.

F. FEDERAL SUBSIDIES TO PRIVATE CARRIERS

In recognition of the problem to low-income groups, including the aged, of financing their own voluntary health insurance premiums, there have been a variety of proposals whose aim is to provide a form of Federal subsidy for either part of their premiums or the excessive cost of the care they will require, or both.

The purpose of these proposals is to make possible the inclusion under voluntary health insurance of groups inadequately represented in the existing enrollment without excessive financial burdens on those with low incomes and without either a differential premium on high cost risks or higher premium rates for the entire enrollment.

1. Flanders-Ives Proposal

This proposal, incorporated in a series of bills introduced during the period 1949–55, would have built on existing nonprofit plans subsidizing them from Federal funds indirectly through State plans.

Among its more important features were (1) scaling of premiums to income; (2) encouragement of expansion of coverage and improvement in the scope of benefits by subsidizing premiums of low-income families and losses incurred from above average risks; (3) recognition of the fact that existing prepayment plans vary widely in the scope of the benefits they provide—the program was designed to be adaptable to the existing level of voluntary health insurance benefits; (4) costs reflecting local scales of payment to hospitals and pro-

viders of services; (5) State operation and control of the program; (6) development of health service areas.

The bill did not attempt to secure uniformity of prepaid protection throughout the Nation, or even within a given State, leaving the scope of benefits to be determined locally in relation to those locally available.

Any resident of a State having an approved State plan would be eligible for participation. Eligible persons could request payroll deductions for premiums. Premiums could be paid on behalf of welfare clients.

The bill spelled out a rather complete list of personal health services which might be provided including hospital room and board, services of physicians, dentists, nurses, and other auxiliary personnel, and related drugs, appliances, and ambulance service.

The regional health authority was to determine for its locality which of the benefits spelled out above might be included in contracts with prepayment plans in their local area. The regional health authority and each local prepayment plan would then enter into a contract for specific benefits selected from among these. The premiums established under these contracts were to be determined by the relationship of the benefits afforded to a so-called cost norm, priced to provide fairly complete coverage of physicians' services and 30 days of hospital care per person per year.

Financing the costs of the benefits agreed on would involve funds from three sources—subscriber premiums which would be related to family income as well as benefits insured; State and local subsidies to bring actual premium income up to an "allowed cost"; and Federal grants to the States, varying according to the State's per capita income, to share one-third to three-fourths of the subsidies paid to the prepayment plans.

Under the Flanders-Ives proposal, the local prepayment plan could provide either service benefits or cash indemnification of the claimant.

The following bills embodied this proposal:

Year	Congress	Session	Bill number	Sponsors
1949	81st	1st	S. 1970	Flanders and Ives.
1949	81st	1st	H.R. 4918 through H.R. 4924.	Case of New Jersey, Fulton, Hale, Herter, Javits, Morton, and Nixon.
1949	81st	1st	H.R. 5087	Auchincloss.
1951	82d	1st	H.R. 146	Auchincloss.
1953	83d	1st	S. 1153	Flanders and Ives.
1953	83d	1st	H.R. 3582	Hale.
1953	83d	1st	H.R. 3586	Javits.
1953	83d	1st	H.R. 4128	Scott.
1955	84th	1st	S. 434	Case of New Jersey, Flanders, and Ives.
1955	84th	1st	H.R. 481	Scott.

Hearings held in June 1949 included testimony on S. 1970; hearings were held on H.R. 4918 and other identical bills in July 1949.

2. *Hill-Aiken Proposal*

These bills (1949–53) were intended to provide voluntary health insurance for persons unable to pay part or all of the usual premium. Each State was to establish a State agency which would administer the means test. It would collect the portion of the premium from persons able to pay part of the cost, and pay the insurance plan the entire premium with respect to all such insured persons. The State agency

would reimburse the plan for payments made to hospitals, etc., for care of persons certified as eligible for State payment (i.e., unable to pay any of the cost).

The plan contemplated service benefits covering 60 days of hospital care per year; surgical, obstetrical and medical services in the hospital; and diagnostic and outpatient services in hospitals or diagnostic clinics.

Of the public outlays for low income groups paying none of their costs or only part of their premiums, the Federal Government would provide from one-third to three-fourths (depending on the State's financial ability) and States and localities would share equally the remainder.

It was specifically provided that persons eligible for State payment were to be issued "membership cards," indistinguishable from those of regular members.

This proposal was introduced in the following bills:

Year	Congress	Session	Bill number	Sponsors
1949	81st	1st	S. 1456	Hill, O'Connor, Withers, Aiken, and Morse.
1951	82d	1st	S. 2171	Hill and Aiken.
1953	83d	1st	S. 93	Hill and Aiken.

Hearings were held on S. 1456 in May and June 1949.

3. The Smathers Proposal

In 1960, during the 86th Congress, Senator Smathers introduced a bill (S. 3646) which would provide tax credits for any life insurance company to the extent of the company's net losses from approved health insurance policies issued persons aged 65 and over. Life insurance companies (as defined in the Internal Revenue Code), including companies issuing noncancellable or guaranteed renewable health insurance policies under Section 802 of the Code, would be eligible to receive the credit for their losses on policies submitted to the Secretary of Health, Education, and Welfare and approved by him. To be approved, the contract would be required to provide insurance against the total cost of not less than 60 days of hospital care a year, not less than 120 days of nursing home care per year, and the total cost of drugs above $50 a year. In addition, the policy premium could not be greater than $72 a year. The policy also could not impose unreasonable standards for filing and proving claims, waiting periods, loss of insurability, or any limitation unreasonably restricting the right to benefits.

(In addition, the bill provided for increased medical care income tax deductions for aged persons and altered the formula for Federal sharing in vendor payments for medical care under the old-age assistance program.)

G. REINSURANCE, POOLING, AND REGULATION

These proposals were designed to encourage the growth of voluntary health insurance without requiring any permanent form of Federal subsidy or tax. They therefore held Federal subsidization to a minimum, involving only direct Federal expenditures for costs of administration and for sums needed to launch the proposed reinsurance cor-

poration. They were intended to encourage expansion of the availability of voluntary insurance coverage (1) through legislation waiving the antitrust laws so as to permit insurance carriers to pool their resources in developing policies and methods for extending insurance to substandard health risks, (2) through Federal participation in the reinsurance, and (3) through Federal regulation of interstate insurance.

1. Reinsurance and Pooling

Existing antitrust laws constitute a barrier to collective efforts of groups of private insurance carriers who might wish to pool their experience and technical know-how and their financial resources in the development of new policies to cover unusual risks.

A bill whose purpose was "to encourage the extension and improvement of voluntary health prepayment plans or policies" was introduced in the 2d session of the 84th Congress. It authorized the Secretary of Health, Education, and Welfare, after consultation with the Federal Trade Commission and approval by the Attorney General, to approve voluntary agreements between certain private insurance organizations to make available new or improved types of insurance coverage.[1]

While the population groups affected were not spelled out, proponents of the proposal believed carriers might be more willing to experiment with coverage of substandard risks such as the aged or those with disabling conditions if they were able to take collective action to develop such policies. Experiments in coverage of rural and low income families might also have been undertaken.

Improvements in benefits could have been tried, such as the sale of more noncancellable policies, extension of existing benefits, major medical expense policies, and the like.

No Federal funds were involved in this proposal. The insurance carriers would fix their own premiums.

The following congressional bills embodied this proposal:

Year	Congress	Session	Bill number	Sponsors
1956	84th	2d	H.R. 12153	Priest.
1956	84th	2d	H.R. 12140	Thompson.
1956	84th	2d	S. 4172	Hill and Smith.
1957	85th	1st	H.R. 489	Thompson
1957	85th	1st	S. 1750	Hill and Smith.
1957	85th	1st	H.R. 6506	Harris.
1957	85th	1st	H.R. 6507	Wolverton.

2. Federal Reinsurance Corporation

These proposals contemplated the formation of a federally operated reinsurance fund to which the Federal Government would make an initial contribution and to which insurance carriers would contribute a small percentage of their premium income. The fund would provide partial idemnification to the companies for extraordinary losses experienced under those health insurance contracts which were reinsured.

[1] Also the 1957 proposal applied only to nonprofit plans and to the smaller commercial companies (defined as companies paying out less than 1 percent of all health insurance benefits or having less than 0.5 percent of the assets of all health insurance companies and plans in the United States).

As first roughly outlined in a proposal made by Mr. Harold Stassen in 1950 the reinsurance fund would have repaid insurance carriers for a portion of any hospitalization claims exceeding a maximum such as $1,000 and for medical-surgical bills above a certain maximum. Bills actually introduced in Congress have taken three forms.

(a) *The 1950 Wolverton reinsurance proposal.*—Congressman Wolverton's proposal embodied the Stassen suggestions with some additional features. It contemplated a Federal Health Reinsurance Corporation. Nonprofit organizations could reinsure their health service contracts with this corporation for a premium if these contracts met some specific criteria as to population groups covered and benefits offered. Separate funds to reinsure hospitalization and medical care were to be established. The reinsurance could be invoked and the corporation become liable for 66⅔ percent of each claim in excess of $1,000 for any 12-month period for any one individual.

Subscription charges for the contracts were to be related to subscribers' incomes, to encourage participation of low income families.

The benefits contemplated were as follows: Six months of hospital care per year with the subscriber himself to pay 5 percent or $1 a day whichever was less as coinsurance; 95 percent of physicians' charges in hospitalized cases; 12 visits with a doctor in his office or at home with the subscriber paying out-of-pocket 25 percent. The scale of charges to be paid by the insurer was to be fixed; the doctors were to agree not to make an additional charge of more than the 25 percent the subscriber was to pay directly. The plan did not cover the first visit to the doctor.

The sources of financing the reinsurance corporation proposed were $50 million from Federal general revenues divided equally into the hospital and the medical care funds, and 2 percent of gross premiums received for health service contracts.

The following bills embodied this proposal:

Year	Congress	Session	Bill number	Sponsors
1950	81st	2d	H.R. 8746	Wolverton.
1954	83d	2d	H.R. 6949	Wolverton.
1955	84th	1st	H.R. 400	Wolverton.
1955	84th	1st	H.R. 401	Wolverton.

(b) *The 1954 administration proposal.*—The administration's proposal for reinsurance departed from the earlier concept of repaying insurance carriers a portion of an individual's claims and dealt with a carrier's average losses which resulted when the plan paid out more than it received in premiums. Both nonprofit and commercial insurance companies could participate.

Encouragement of underwriting major medical expense was anticipated as well as broadening of basic benefits, noncancelable insurance, etc. The 1954 proposal would have established a reinsurance fund which would pay 75 percent of a plan's losses on reinsured contracts that exceeded the premium income of the contracts less 87.5 percent of the administrative expenses predetermined for the contract. The Federal Government would lend the fund $25 million which would eventually be refunded from reinsurance premiums. Premiums of unspecified size (but 2 percent of reinsured premium income was discussed) would be paid by the carriers to the fund.

The 1954 administration proposal was introduced in the following bills:

Year	Congress	Session	Bill number	Sponsors
1954	83d	2d	H.R. 8356	Wolverton.
1954	83d	2d	S. 3114	Ives, Flanders, Purtell, Cooper, Upton, Ferguson, Bush, and Saltonstall.
1955	84th	1st	H.R. 2533	Wolverton.

There were hearings on H.R. 8356 in March, April, and May 1954 and on S. 3114 in April 1954. The House Committee on Interstate and Foreign Commerce reported out H.R. 8356, but it failed to carry and was referred back to the committee, which took no further action.

(c) *The 1955 administration proposal.*—A revised version of the reinsurance proposal of the 83d Congress was included as title I of an omnibus health bill introduced in 1955. The reinsurance fund was divided into four parts and each separate fund was to receive an initial $25 million in Federal money to launch it. The four funds dealt with: (1) plans for low and average income families, (2) major medical expense contracts, (3) plans specifically designed for rural areas, and (4) certain other plans.

Other features, including the terms of the reinsurance premiums and the claims formula, were the same as in the earlier administration proposal.

A type of contract providing a wide range of benefits but with coinsurance features was included for low income families.

Under the 1955 proposal, the Federal Government would contribute up to $100 million which would eventually be paid back. Participating insurance companies were to pay the fund an unspecified percentage of their premium income as reinsurance premiums.

The following bills embodied the proposal:

Year	Congress	Session	Bill number	Title or part of bill	Sponsor
1955	84th	1st	H.R. 3458	Title I	Priest.
1955	84th	1st	H.R. 3720	Title I	Wolverton.
1955	84th	1st	S. 886	Title I	Smith and others.
1957	85th	1st	S. 1750		Hill and Smith.
1957	85th	1st	H.R. 6506		Harris.
1957	85th	1st	H.R. 6507		Wolverton.

3. Federal Regulation

In 1956 and 1957 three bills were introduced in the House of Representatives whose purpose was to encourage improvements in available voluntary health insurance policies, and thus indirectly to promote the spread of such protection. The method proposed was to prohibit the issuance of health insurance policies which could be canceled after a stated period for any reason other than nonpayment of premiums. The prohibition would apply to insurers engaged in interstate business.

Through applicable both to group and individual policies, the prohibition would be most meaningful in relation to individually purchased policies. Such policies are frequently the only ones older

persons, rural residents, widows and the self-employed can purchase.

Bills introduced in sessions of the U.S. Congress were as follows:

Year	Congress	Session	Bill number	Sponsors
1956	84th	2d	H.R. 8216	Christopher.
1957	85th	1st	H.R. 116	Christopher.
1957	85th	1st	H.R. 5041	Rhodes.
1957	85th	1st	H.R. 7087	Christopher.