I have a confession to make. I find it fascinating to pour over committee reports and legislative history from decades past on issues related to health insurance. This, I know, will undoubtedly result in my being seated with the actuaries and insurance salespeople at the next wedding I attend. But how could one fail to be fascinated by discovering that problems similar to a number our country faces today concerning Medicare and Medicaid were already played out in Congress decades earlier? And how could one also fail to be enthralled by what these days appears to be an almost quaint concern with a program requirement’s affront to the personal dignity of recipients and the dependency fostered by imposing rigorous means tests?

Medical Assistance to the Aged (MAA), established through enactment of the Kerr-Mills bill in 1960 and repealed only a few years thereafter, was a forerunner of sorts to both Medicare and Medicaid. Congress intended MAA to provide “broad medical services to the many aged needing [medical assistance] but ineligible or unwilling to apply for relief.”1 It was a compromise program, intended to avoid universal public coverage for the elderly by making it available to a special group of individuals age 65 and older: the “medically indigent,” or those who didn’t have health insurance yet needed it, and who couldn’t afford to obtain coverage through the private market yet weren’t so impoverished that they qualified for cash welfare.2 As would be the case with Medicaid, MAA was a voluntary program administered at the state level, in which the federal government provided matching funds for every dollar of state funds spent. Unlike Medicaid, however, Congress largely failed to set any baseline package of services that states must provide if they wished to operate an MAA program.3

In the years following the creation of the MAA program, the Senate Special Committee on Aging produced reports gauging the program’s effectiveness and progress. Neither the 1962 nor the 1963 report had anything particularly flattering to say about how well MAA was fulfilling its purpose. While it was expected that “[t]he financial incentive in the plan should enable every state to improve and extend medical services to aged

2 Id., see also ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID 28 (2ND ed. 2004).
3 According to the Stevens, states were only required to provide “both institutional and noninstitutional care.” STEVENS & STEVENS, supra note 2, at 30.
persons,” by 1963 only twenty-eight states and four other jurisdictions had operational MAA programs. Most of those with an MAA program offered almost no assistance: Kentucky, for example, was among fifteen jurisdictions that limited the days of care and conditions covered, and paid for only ten days of hospital care per admission for “acute, emergency, and life endangering” conditions only. Other jurisdictions, such as Illinois, only paid after the applicant incurred medical bills totaling over ten percent of his or her annual income. Only four jurisdictions provided hospital care, physicians’ services, nursing home care, prescribed drugs, and dental care, without any substantial limitations.

The committee reports noted the deleterious effect of these limitations on applicants and their families. One example the report cited the following:

Recipient has congestive heart failure. She was admitted to the hospitals and remained 15 days. After 1 week at home it was necessary to be readmitted to the hospital for treatment.

Mrs. P. has no income and is entirely dependent on her daughter for support.

MAA has provided 15 days’ hospitalization for the recipient but cost for additional days in the hospital will have to be paid for by the daughter who works to meet her own needs. (emphasis in original)

Can you imagine a congressional staff report in 2007 expressing such earnest shock that an elderly woman and her working daughter might be forced into such a precarious financial position? Such an attitude requires not merely an underlying assumption that the state or another entity should not permit such a situation to come to pass, but also that the individuals in question are respectable and worthy of support. Today, such an attitude seems quaint, almost naïve. Yet I worry that this change in the ensuing forty or more years does not bespeak a maturation of our society and mores, but rather a breakdown in them.

The structure and substance of our legislation represent not merely responses to issues perceived to be in need of address, budgetary exigencies, capitulation to certain interests, and the like. Rather, they also reveal, or at least offer an approximation of, our underlying attitudes towards these issues and the people affected by them. They show how we have grappled with these issues, and the extent to which competing philosophies

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4 STAFF, 87TH CONG., supra note 1, at 17.
6 Id. at 44.
7 Id. at 45.
8 Id. at 41 – 42, n.2.
9 Id. at 45.
and interests vie for expression and relative supremacy. Our decision to permit a “doughnut hole” in Medicare prescription drug coverage for all but the most impoverished of beneficiaries, or to allow states to impose an asset test on Medicaid applicants, or to require that states place liens on certain beneficiaries’ homes – all such choices speak to our society’s values and interests, as well as our collective views of our responsibilities in these matters and of the individuals affected by the legislation. In the coming weeks, I’ll have more to say on these issues.

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