
Perspectives On Medicare

What Medicare's Architects Had In Mind

by Robert M. Ball

The enactment of Medicare three decades ago left an incomplete paper trail. Although the public record leading up to enactment is extensive—dozens of hearings, speeches, debates, reports, and committee reports of congressional intent—there are also gaps, mostly to do with what we who advocated Medicare had in mind. Because I was deeply involved in the development, enactment, and implementation of the program, my recollections may be of use in rounding out the historical record.

How It All Began

What were we hoping to accomplish when we proposed a national hospital insurance plan for the elderly? No other country, as far as I know, had ever considered such an approach. Certainly the elderly were the most expensive and difficult group to cover, and, for the money spent, they clearly would yield the least return of any age group. Why not cover children and pregnant women, as has been discussed from time to time since? That would seem to have made more sense.

A first step toward universal coverage. For persons who are trying to understand what we were up to, the first broad point to keep in mind is that all of us who developed Medicare and fought for it—including Nelson Cruikshank and Lisbeth Schorr of the AFL-CIO and Wilbur Cohen, Alvin David, Bill' Fullerton, Art Hess, Ida Merriam, Irv Wolkstein, myself, and others at the Social Security Administration—had been advocates of universal national health insurance.¹ We all saw insurance for the elderly as a fallback position, which we advocated solely because it seemed to have the

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best chance politically. Although the public record contains some explicit denials, we expected Medicare to be a first step toward universal national health insurance, perhaps with "Kiddicare" as another step.

We and the principals for whom we worked-AFL-CIO President George Meany, Social Security Commissioner Arthur Altmeyer, and others-had become discouraged about the prospects of enacting universal national health insurance as such. The idea had never gotten very far in the United States. Ironically, national health insurance was advocated in 1916 by the leaders of the American Medical Association (AMA), who were favorably impressed by the systems that had been established in Germany (1883), Britain (1911), and several other countries around that same time.² Equally ironically, much of the American labor movement in 1916 was opposed. Samuel Gompers, president of the American Federation of Labor, preferred collective bargaining to political solutions and feared that if workers began leaning on government, they might begin to look generally in that direction, rather than to unions, for help.

In due course, these positions were exactly reversed. Organized medicine's support was short-lived; by 1920 the AMA was firmly established in opposition. The unions, on the other hand, eventually went all out for national health insurance and indeed provided the backbone of its support. These two powerful groups became the main antagonists, first over national health insurance and then over the much more modest recommendations for Medicare. The unions still had the alternative of turning to collective bargaining to get health care for their members; they did so-but with reluctance, as also in the case of pensions-when enacting adequate programs through government seemed hopeless.

National health insurance was deliberately not included in the 1934 report of the Committee on Economic Security, whose recommendations formed the bases for the legislation that established Social Security in 1935. President Franklin Roosevelt feared that health insurance was so controversial, because of doctors' opposition, that if he included it in his program for economic security he might lose the entire program. Later, over the years, Roosevelt often commented favorably about universal health coverage, but he never specifically offered or endorsed a national health insurance plan. At one time he called for social insurance "from the cradle to the grave," and in his 1944 State of the Union message, looking to the nation's postwar needs and goals, he proposed an "Economic Bill of Rights" that would have included "the right to adequate medical care and the opportunity to achieve and enjoy good health." But, occasional rhetorical sorties aside, he was generally content to let the Social Security Board push for national health insurance without adding his personal endorsement.

President Harry Truman, on the other hand, specifically advocated a

national health insurance plan. But his ability to get any domestic legislation passed was always weak, both while he was filling out Roosevelt's unexpired fourth term and even after he had surprised everyone but himself by getting elected on his own in 1948. Facing hostile Republicans in control of both houses of Congress, he had no chance at all of getting universal compulsory health insurance enacted—a fact that everyone but the AMA seemed to understand.

The AMA's opposition approached hysteria. Members were assessed dues for the first time to create a \$3.5 million war chest—very big money for the times—with which the association conducted an unparalleled campaign of vituperation against the advocates of national health insurance.³ The AMA also exerted strict discipline over the few of its members who took an “unethical” position favoring the government program. This was a warm-up for later campaigns against Medicare.

Even before the AMA launched its attack, however, the Truman administration had given up on a universal health plan and was casting about for something less ambitious that might have a better chance. That is how Medicare was born. It was publicly advocated for the first time by a government spokesman when Oscar Ewing, head of the Federal Security Agency (later the Department of Health, Education, and Welfare and now the Department of Health and Human Services), unveiled the plan 26 February 1952. The idea was to cover all Social Security beneficiaries (the elderly, widows, and orphans; persons with disabilities were not yet under Social Security). The Social Security program was part of the Federal Security Agency, and we had worked up the plan for Ewing.

Initially, it went nowhere. President Truman never specifically endorsed the shift from support of universal health insurance to the limited Medicare program, but even if he had, he would not have been able to get Congress to consider it. He was within a few months of the end of his term, and his would-be successor, Adlai Stevenson, was soon to be overwhelmingly defeated by General Dwight Eisenhower.

Basis of Medicare's design. The design of Medicare—taking shape in an unsympathetic political climate—was based entirely on a strategy of acceptability: What sort of program would be most difficult for opponents to attack and most likely to pick up critical support? Later modifications, to include just the elderly rather than all Social Security beneficiaries and to cover them only for hospitalization, had the same motivation. By the time John Kennedy campaigned on the issue in 1960, we had decided that even trying to provide coverage for inpatient surgery was a mistake. If physician services were left out entirely, we reasoned, the AMA's opposition would have less standing. By that time, it was clear that the elderly had the most political appeal and potentially the most muscle. We wanted to get some-

thing going, and this seemed a politically plausible first step.

The elderly were an appealing group to cover first, in part because they were so ill suited for coverage under voluntary private insurance. They used, on average, more than twice as many hospital days as younger persons used but had, on average, only about half as much income. Private insurers, who set premiums to cover current costs, had to charge the elderly much more, and the elderly could not afford the charges. Blue Cross, which had started out with the principle of community rating (that is, charging everyone the same), had been forced to abandon that approach because its rates, averaging in the elderly, were becoming noncompetitive with commercial insurance. Group health insurance, then as today, was mostly for the employed and was not available to the retired elderly. The result of all this was that relatively few of the elderly had health insurance, and what they had was usually inadequate, often paying only so much per day for hospitalizations of limited duration. So the need of the elderly was not hard to prove, nor was it difficult to prove that voluntary individual insurance was not only not meeting the need, but that it really could not.

Late in the argument, commercial insurers in some states sought to refute this last point by developing special plans for the elderly that avoided selling costs and provided coverage at group rates. They did this by offering to cover anyone over age sixty-five who would cut out a newspaper coupon and send it in; because even group rates for the elderly were high, they did not get many takers. In any case, the fact that they were even trying was attributable not so much to their eagerness to sell to the elderly as to their fervent desire to keep government from penetrating further into the insurance business. They went to considerable lengths to try to close the door. Although most business groups opposed Medicare, the insurance industry was the AMA's main ally.

The Social Security connection. The success of Social Security played an important part in making the case for Medicare. The slogan became "health insurance through Social Security," and references to the "tried and true method of Social Security" abound in the record of the debates. Much was meant by these references to Social Security, some of it explicit and some subliminal. On the one hand, supporters made clear that although a cash payment per month could be made reasonably adequate to cover regular recurring costs such as food, housing, and clothing, it could not meet the unpredictable cost of major illness. There was no way for persons to budget for the unpredictable. Only insurance, which took care of very high costs by averaging them in with all costs, could do the job.

It thus was quite clear that a secure retirement—the objective of Social Security—required that health insurance, particularly hospital insurance, be added. Moreover, Social Security's funding method—having everyone

pay in while working in order to earn paid-up protection, without further payment when work ceased—was considered a big success. Also, it was widely acknowledged that the Social Security program was well administered, even in the case of disability insurance, for which the government had surprised its opponents by adhering to standards more conservative than those of private disability insurance. Then, too, the basic concept of insurance—that everyone could be protected against large losses by paying a premium related to average losses—was becoming more widely valued. But more than anything else, the concept of providing medical insurance “through Social Security” meant providing it without a means test, and as an earned right, that is, based on past earnings and contributions (except for those already aged).

President Eisenhower, however, was steadfastly opposed to a social insurance plan for health care. His first term saw the consideration of two alternatives: a reinsurance plan and later a plan for pooling poor risks. Both were designed to help private insurance cover hard-to-cover groups and to sidetrack Medicare-like proposals; neither became law.

Medicare’s two predecessors. Even in the inhospitable climate of the Eisenhower years, there were developments that had a bearing on the Medicare issue. Health insurance protection for dependents of armed forces members—the first program to be given the name “Medicare”—was enacted in 1956. And, in that same year, Social Security cash benefits for the totally disabled were enacted, over the strong objections of the AMA.

The AMA saw the cash benefit disability program as a step toward health insurance, because the government, in making medical determinations of disability, would have to establish working relationships with the medical profession. The AMA thought, correctly, that this might lead somewhere. Indeed, administering the disability insurance program turned out to be a useful experience for those who were to administer Medicare (Art Hess, who was put in charge of administering disability benefits in 1956, became the first administrator of Medicare in 1965), and many doctors discovered that the government could really be quite reasonable. (One of the physicians who fearlessly took this position was Philip Lee, who would become a key figure in the Kennedy and Johnson administrations and has had a second incarnation as a public servant, overseeing public health policy for President Bill Clinton as assistant secretary of health and human services.)

The big push. Proponents of Medicare organized the first serious push for enactment in 1957 when Rep. Aime Forand of Rhode Island, at the urging of the labor movement, introduced the first of a series of bills. From then until passage in 1965, Medicare became an increasingly hot issue—although if there had been no landslide victory for Lyndon Johnson in 1964, it is unlikely that Medicare could have mustered the necessary votes for

enactment the following year.

When Medicare was first advocated, there were no effective organizations of older people ready to help in the campaign. The American Association of Retired Persons (AARP) was not yet very large and, moreover, was heavily involved with (some say the creature of) the Colonial Penn Insurance Company, which had been formed to sell health insurance to the elderly and had exclusive access to the AARP membership list. So the AARP was, at best, a lukewarm ally of government insurance.

The potential for help from an organization of older persons supporting the health insurance plan seemed large, however, and in due course the Democratic National Committee and the labor movement formed the National Council of Senior Citizens. The nucleus of the new organization came from the retiree groups of some of the big unions, such as the United Auto Workers and the United Steelworkers of America. Under the direction of Bill Hutton, a public relations professional, the council became an important pressure point in the push for Medicare, holding giant rallies, organizing major letter-writing campaigns to Congress, vigorously picketing opponents such as *Reader's Digest*, and so on. At this same time (the early 1960s) Medicare advocates enlarged their appeal to include the sons and daughters of the elderly, the people who were most at risk for the hospital bills of their parents. One of our most effective pamphlets, in fact, was called "Medicare for Three Generations."

Bringing Health Care For The Elderly Into The Mainstream

Hospital reimbursement and quality standards. We did not propose a program to reform the health care delivery system. We proposed assuring the same level of care for the elderly as was then enjoyed by paying and insured patients; otherwise, we did not intend to disrupt the status quo. Had we advocated anything else, it never would have passed. Thus, the bill we wrote followed the principles of reimbursement that hospitals all over the country had worked out with the Blue Cross system. Hospitals would be allowed to nominate an intermediary to do the actual work of bill payment and to be the contact point with the hospitals. Government would be unobtrusive. The carrot was that many hospital bills that had previously gone unpaid because the elderly had no money would now be paid.

What the hospitals had worked out with Blue Cross was retroactive cost reimbursement. Hospitals had an even better deal with the commercial insurance companies, which based their reimbursement on hospital charges-ordinarily, higher than costs. But at that time we had no plans for prospective payment or even prospective budgeting. The more progressive elements in the hospital field welcomed us, because they expected us to pay

attention to health and safety and to force substandard hospitals to upgrade quality. By and large, our posture at the beginning was one of paying full costs and not intervening very much in how hospitals, at least the better ones, conducted their business. In fact, the first section of Title XVIII of the Social Security Act providing for health insurance for the elderly was a “Prohibition Against Any Federal Interference . . . or the exercise of supervision or control over the practice of medicine . . . or over any institution, agency or person providing health services.”

We soon found that this prohibition had to be interpreted narrowly. We did have to interfere, but the provision illustrates where we started. We intended to bring the elderly, and under Medicaid the poor, up to the same standard of treatment as that for paying patients. At the time, amenities for the poor were few, and the aged, who were mostly poor, were usually treated in hospital wards where their care was often left to interns and medical students. Indeed, one of organized medicine’s objections to Medicare and Medicaid was that these programs would close down their main sources of teaching material. (Of course, that did not come to pass. After the Medicare legislation passed, it soon became evident that insured elderly patients would happily cooperate with student caregivers under proper supervision.)

So the standard of quality for Medicare was to be the standard for the paying patient. That meant, among other things, being cared for in the relative luxury of a two-bed, semiprivate room. It meant being treated with respect and, under Title VI of the Civil Rights Act, the end of discrimination against patients on the basis of race. (There is a small book, and a good one, waiting to be written by someone on this issue alone. Suffice it to say here that at one point the Social Security Administration and the U.S. Public Health Service each had 500 people inspecting hospitals, mostly in the South. Before a hospital could be certified for Medicare, it had to do more than have a plan to end discrimination: It had to demonstrate nondiscrimination.)

We believed that to make all of this happen, Medicare had to pay its own way. We believed in paying fully. We opposed shifting costs to other payers, and we avoided discounts beyond what our contractors might have secured for their own insured persons (Medicare now pays about 10 percent less than its fair share to hospitals and perhaps a third under market rates to physicians). We pursued a careful, minute accounting for the cost of treatment for the elderly because the rule was to pay for them but for no one else. We would not pay a share of a hospital’s bad debts because we paid fully for our patients, but we would pay a share of teaching costs because we believed that everyone ultimately benefited from that. We were willing to allow a somewhat higher reimbursement rate for nursing the elderly on the theory that it took longer, but we insisted on lower per diem costs because of the

longer stays of the elderly and the concentration of many hospital costs in the first few days after admission.

We were frustrated by the bad state of accounting in many if not most hospitals, which shared an unbusinesslike approach to management that was common at the time to many church-run and other nonprofit organizations. Nevertheless, we kept pushing ahead with the notion that it was possible to get good data on what it cost to take care of just the elderly.

With regard to quality standards for hospitals applying for Medicare certification, the law provided for approval of any hospital certified by the private Joint Commission on the Accreditation of Hospitals if the hospital also had a utilization review committee and met the civil rights standard. We set up quality standards for other hospitals, mostly smaller ones, and contracted with state public health agencies for their inspection, a move that greatly improved hospital care in many parts of the country.

Physician reimbursement and quality control. The principle of mostly accepting the going situation is even better illustrated in the case of Medicare Part B, covering physician services. In Part B there was no civil rights or utilization review requirement. Part B was explicitly based on a private insurance plan, an Aetna plan for federal workers under the Federal Employees Health Benefits Program (FEHBP). It was to be voluntary, not paid-up insurance but financed by a current premium with half paid by the elderly who elected coverage and half by the federal government.

Part B had been added to the administration's hospital insurance plan at the last moment by Wilbur Mills, chairman of the House Ways and Means Committee, who wanted part of the plan to follow the principles advocated by some of the congressional Republicans. The government subsidy, now still controversial, was an unavoidable result of making Part B voluntary. Without it, rates based on the average cost of all of the elderly would have been unattractive to younger and healthier elderly persons, but if the rates were varied by age, the premiums would have been prohibitive for persons over, say, age eighty.

We had only one weekend in which to try to adapt the Aetna plan to a government-run plan. There were no quality standards and no cost controls other than a vague stipulation that services had to be "medically required." Reimbursement was to be a "reasonable" charge determined by the customary charges of the particular physician and the prevailing charges in the locality for similar services.

We had considerable concern about such a plan, as did our allies in the labor movement, but decided, on balance, that it was better than not covering physician services at all and that this was our only chance. Moreover, at that time we had a naive faith that we could get reasonable changes made on the basis of experience.

The Impulse To Reform

In point of fact, we could not have entirely avoided making changes in the existing health care system even if we had wanted to. Some of the provisions of the original act were designed to hold down costs and improve quality, and they were an advance over the existing system. First, Medicare cut down on physician incentives to hospitalize patients by paying doctors for services, wherever they were rendered, whereas commercial insurance usually paid physicians, if at all, only for services provided in a hospital.

Second, Medicare invented an “extended care benefit,” which reimbursed care in a lower-cost institution for patients who otherwise would have been kept longer in an expensive hospital. The idea here was not to pay for ordinary nursing home care for patients who were no longer being actively treated, but rather to pay for care for persons who no longer required the intensive facilities of a hospital but either were not yet ready to go home or were near death. Medicare never intended to cover the ordinary nursing home stay that lasts months or years; extended care was strictly intended to be a substitute for hospital care.

The law’s requirement that the attending physician had to certify and recertify the need for hospital care, with utilization review by a committee of peers, certainly did not add up to adequate utilization control, but these steps probably did some good. We took the issue of “necessary services” seriously, to the extent of requiring conformity with generally accepted medical standards in the community, and were able to use the “prevailing” standard to reduce payments well beyond the insurance companies’ customary cutoff at about 90 percent of the high end of a range of physician fees.

With a government program, sooner or later, public policy concerns such as cost and quality move front and center; in the case of Medicare, these concerns caused the program to become a leader in the health insurance field. After-the-fact reimbursement for hospital costs clearly was flawed, and within a couple of years I and other government officials were calling for some form of prospective payment. When Medicare finally adopted the diagnosis-related group (DRG) system, it was an important advance for all who reimbursed for hospital care, and it has made lengths-of-stay in U.S. hospitals the shortest in the world.

Similarly, we knew from the beginning that we needed some kind of fee schedule in Part B, but we had to struggle with the term reasonable, defined as customary and *prevailing* for many years. When Medicare finally developed the resource-based relative value scale (RBRVS), it was again pioneering a technique that helped other insurers. Also, our insistence on more careful administration by our contractors than they were used to, and better accounting by hospitals, constituted real contributions.

Return To Leadership

Medicare has done well what it was designed to do. Because of Medicare, hundreds of millions of older people and their sons and daughters have been better off. Not only has the cost of medical bills been made bearable, but the quality of life of the elderly has been greatly improved because of the availability of many modern medical techniques that otherwise might have been affordable only for the affluent. Cataract removal, artificial hip joints and other body parts, transplants, and cardiac bypasses, just to name a few, have all helped to promote better health and greater well-being. Medicare also has undoubtedly contributed to the fact that the United States (with Japan) leads the world in longevity beyond age sixty-five. Public health and prevention measures such as better diet, exercise, and reduced smoking probably play a greater role than medical care in reducing mortality rates, but medical care assuredly counts. In its present form, however, Medicare is clearly not prepared to cope with the huge increase in numbers of beneficiaries that will take place beginning about 2010. To keep the program solvent and viable, changes will have to be made. But whatever form they take, they should not lead to reductions in necessary care.

It is as true now as it was thirty years ago that the Medicare program is needed to give the elderly the same health care under the same conditions as is available to insured, paying, and younger patients. Now, as then, most group insurance is furnished through employment, and individual insurance is simply too expensive for an age group (and those with disabilities also are now in the group) that needs much more health care and, on average, has lower incomes than younger and employed persons have. For elderly persons—and for the family members who otherwise would be saddled with their medical bills—Medicare continues to be, figuratively and often quite literally, a lifesaver.

But it is a lifesaver in need of shoring up. Medicare, once a leader, has fallen behind. First of all, Medicare's benefit package falls considerably short of those of the better employer plans, and in any long-range reform the package should be improved, particularly by including a stop-loss provision to protect beneficiaries and their families against catastrophic costs and by adding drug coverage and more prevention services. Medicare also needs to take the lead once again in developing important cost reduction techniques that can be followed in private plans, as it did with the invention of DRGs and the RBRVS.

Whatever else is done, however, we should avoid changing Medicare from a defined-benefit to a defined-contribution plan, as would happen under some current voucher proposals. This would lay the groundwork for cutting benefits in the future whenever the government's contribution

requires trimming to fit arbitrary budget-balancing goals. Rather, as former Congressional Budget Office (CBO) Director Robert Reischauer suggested in his May 1995 testimony before the Senate Finance Committee, Medicare needs to move carefully to a system of competing organizations bidding to supply the defined benefit package in a given area. The most economical organizations probably will be managed care organizations, and it probably would make sense to provide the additional benefits described above only to beneficiaries who elect to join such organizations.

If the government payment is related to the average bid, beneficiaries would be protected against cuts in benefits, and the prospect of gaining access to additional benefits would provide a reasonable incentive for the elderly to move away from more expensive fee-for-service care. A carefully developed system of competitive bidding could point the way for the whole health care system, with Medicare once again in a leadership role.

This approach holds hope for the long run, but, as Reischauer and others have noted, it cannot make much of an impact in the next seven years, the period chosen by the congressional majority for balancing the budget. Unfortunately, Medicare's problems do not lend themselves to a quick fix. As in the past, sensible solutions will take a long time to figure out and apply. A \$270 billion cut within a seven-year span, as proposed in Congress, could lead to changes so abrupt and far-reaching that they might all but wreck the program, causing hardship to beneficiaries and their families.

That would be the worst possible outcome for Medicare "reform"—and one that would be starkly at odds with everything we have learned throughout the program's entire history. Building Medicare, as we who did some of the initial heavy lifting discovered firsthand, required time and patience. Impatience must not be allowed to wreck it.

NOTES

1. Nelson Cruikshank headed the AFL-CIO Social Security Department; Lisbeth Schorr directed its work on health insurance. During the Kennedy and Johnson administrations, Wilbur Cohen was initially assistant secretary for legislation at the Department of Health, Education, and Welfare; then undersecretary; and then secretary. Alvin David was assistant director of the Bureau of Old-Age, Survivors, and Disability Insurance in the Social Security Administration; Bill Fullerton and Irv Wolkstein were key analysts working under David. Ida Merriam headed the Bureau of Research and Statistics of the Social Security Administration. I was commissioner of Social Security from 1962 to 1973, and for the ten years prior to that was deputy director of the Bureau of Old-Age, Survivors, and Disability Insurance. Art Hess was in charge of the Disability Insurance program in that bureau, was later in charge of Medicare, and, after I left, served as acting commissioner of Social Security.
2. P.A. Coming, *The Evolution of Medicare from Idea to Law*, Research Report no. 29 (Washington: Office of Research and Statistics, Social Security Administration, 1969).
3. R. Harris, *A Sacred Trust* (New York: New American Library, 1966).