

Reflections on the enactment of Medicare and Medicaid

by Wilbur J. Cohen

Wilbur J. Cohen has been a Professor at the Lyndon B. Johnson School of Public Affairs at the University of Texas at Austin since 1980. He served as Chairman of President John F. Kennedy's Task Force on Health and Social Security (1960-61). Between 1961 and 1968, he served as Assistant Secretary,

Under Secretary, and Secretary of the Department of Health, Education, and Welfare, the only person ever to hold all three positions. He was one of the principal architects of Medicare and Medicaid and had primary responsibility for piloting the legislation through Congress, and for its initial implementation.

Introduction

To place my present-day comments in historical perspective, it must be appreciated that I spent 15 significant years of my life (1950-65) helping to design the basic framework and pilot through the Congress¹ what became known as Medicare and Medicaid. I spent an additional 3½ years (1965-68) helping to make the initial decisions relating to the implementation and administration of both programs. Understandably, I have a personal and even an emotional concern about these programs for which I, and many of my associates, expended so much time and energy.

It is difficult for many younger people today to realize how harsh many of the criticisms and arguments against these health proposals were.² For instance, the Scripps-Howard newspapers on June 20, 1966, had an article with the headline "AMA Sees Wilbur Cohen as 'Enemy No. One.'" At the 1966 American Medical Association House of Delegates, resolutions were introduced by physicians from Florida and Louisiana asking "President Johnson to launch an investigation of Mr. Cohen, culminated by a swift booting out of office." Now 20 years later, despite the various criticisms, problems, and proposals, there is no substantial or responsible individual or group that I know of that advocates the total repeal of either of these once-controversial programs. But there are various proposals for restricting, restructuring, or even expanding them.

For 9 years (1957-65), Medicare and Medicaid were highly controversial issues. To understand some of the legislative provisions that were incorporated into these programs, it is necessary to recall the ethos of the 1950's and 1960's when some of the fundamental decisions were made. There was only a limited amount of experience with large-scale, nationwide, health reimbursement programs. There was a good deal of rhetoric and little empirical information. There was an extensive outpouring of ideology and a limited amount of research. These facts had a significant bearing on the outcomes.

¹An extensive legislative history of the 1965 Act is provided by Cohen and Ball (1965) and Cohen and Peerboom (1966).

²Some of the pamphlets, headlines, and various arguments are included in Campion (1984) and Harris (1966). Detailed commentary on the legislative struggle is presented in a dozen oral histories, Columbia University Library, New York City, summarized in Corning (1969).

The beginnings

In the following discussion, I will selectively recall and examine some provisions in Medicare and Medicaid that have not been previously discussed, and for which I participated in the decisionmaking process. I chose those provisions or policies in the two laws about which some ambiguity, misunderstanding, or misconception still remains. I will not discuss those aspects of the development of the legislation that are recorded in existing publications (Harris, 1966; David, 1985; Marmor, 1970; Myers, 1970; Corning, 1969; and Campion, 1984).

The full story of the development and history of Medicaid prior to its enactment has not yet been told, although some discussion is provided in Stevens and Stevens (1974) as well as some of the references previously cited that deal with the legislation. The inclusion of Medicaid in the 1965 law evolved when Mr. Wilbur Mills asked me what his answer should be to the inevitable question he thought he would be asked during the legislative debate: "Isn't Medicare an 'entering wedge' to a broader program of nationwide 'compulsory' insurance coverage of everyone?" I suggested that if he included some plan to cover the key groups of poor people, he would have a possible answer to this criticism. Medicaid evolved from this problem and discussion. I developed most of the provisions by expanding the plan requirements in the Kerr-Mills bill of 1960, taking into account the views of State welfare directors. Most Federal and State public health officials had no interest in administering such a program because of the fear that it would involve them in disputes with physicians.

Although I had been a strong advocate of a comprehensive and universal nationwide health insurance plan since 1940,³ I was conscious of the monumental administrative and management problems involved in such a large undertaking. My professors and mentors had stressed administrative competence in social legislation. The merits of the incremental approach to implementing the social security system, which began in 1938 under the leadership of Arthur J. Altmeyer, was always in the forefront of my mind. Underlying this approach was

³I assisted in the drafting of the Wagner-Murray-Dingell comprehensive national health insurance bill of 1943, and the Truman health message of 1945.

the acceptance of the desirability of learning by doing—a pragmatic approach of trial and error—and of resolving problems arising from the unintended consequences of legislative action that affected human and institutional behavior.

As questions arose in 1949, both in the Congress and in the marketplace, on innumerable economic, medical, and political issues on public and private health plan proposals, I began to wonder whether some more limited or experimental public plans might provide the Social Security Administration with needed administrative experience. We might learn of acceptable as well as unacceptable responses to various problems, such as accreditation of hospitals, reimbursement policies, Federal-State roles, and the participation of physicians and other providers as well as prepaid group practice plans. In 1950, I drew up a strategy that involved congressional authorization for “vendor payments” for medical assistance to the aged, blind, and disabled (enacted in the Social Security Amendments of 1950, 1956, and 1960); medical determination for a disability “freeze” (1952 and 1954),⁴ disability insurance benefits (1956), and Medicare and Medicaid (1965). This sequence of events brought the Federal Government into the mainstream of health policy administration. I felt we had to get our feet wet in working with hospitals and physicians to discover ways and means of resolving problems, rather than debating ideology in a vacuum.⁵

It is frequently overlooked that the American Medical Association (AMA) originally opposed early versions of even a limited Medicaid proposal. On April 24, 1956, the AMA informed Congress:

“The American Medical Association is vigorously and firmly opposed to this step.

“First, we see no need for the establishment of medical care as a fifth and separate category of Federal aid in public assistance programs. Pooling arrangements now available to the States under the existing program can accomplish more flexibly and less dangerously all the new proposals seek.

“Second, such a new program would burden the community with regulations and restrictions inconsistent with local problems, local laws, or local customs. As an example, amendments to the aid-to-

⁴The disability freeze provided that when a person became disabled, his or her social security earnings record would be frozen and the period of disability omitted from the computation of the old age or death benefit. It is comparable to a waiver of premiums in private life insurance policies, which provides for a paid-up life insurance policy at the time of disablement without payment of any future premiums. The disability freeze was first enacted in the Social Security Amendments of 1952, but it never went into effect. I had suggested this unusual compromise provision to Representative Wilbur D. Mills (Truman, 1952). An operative provision was enacted in the Social Security Amendments of 1954.

⁵Although the Maternal and Child Health and Crippled Childrens’ Services legislation had been enacted in 1935 and provided reimbursement policies for hospitals and physicians (which were known and available), these programs did not become a significant factor in reimbursement discussions in the formulation of Medicare and Medicaid. A careful study of public sector reimbursement policies and history before 1965 is needed. No responsible person that I know of suggested a practical and acceptable alternative to reasonable costs or reasonable charges during the 1940-65 discussions.

blind program under the Social Security Act have granted to optometrists since 1952 the privilege of diagnosing pathological conditions of the eye. This privilege, until 1952, had been uniformly denied to them by state licensure laws.

“Third, this section is totally inconsistent with the philosophy heretofore underlying Federal participation in public assistance programs. This philosophy, as expressed in the other titles of the pending bills, presupposes that Federal participation in such programs is a temporary expedient, necessary only because the old age and survivors benefits are not yet sufficiently matured to furnish the basic protection required. As the old age and survivors benefits mature, it has always been supposed that Federal participation in public assistance would be reduced. The medical provisions of the pending bills represent an expansion in Federal participation, contrary to this established policy.

“Fourth, we cannot escape the conclusion that injection of medical care as a separately matched category of expenditure under public assistance is only a forerunner to the injection of medical care as a categorical benefit under old age and survivors insurance. You are aware of the overwhelming rejection by both the American people and the medical profession of this philosophy. As physicians, we must continue to oppose programs which, in the guise of improving medical care, will lead to the destruction of the system which has produced the best medical care ever enjoyed by any people.

“In summary, the American Medical Association is vigorously opposed to the proposed changes in the medical care provisions of the public assistance sections of the Social Security Act. We are opposed to those changes because they are needless, wasteful, dangerous, and contrary to the established policy of gradual Federal withdrawal from local public assistance programs.” (U.S. Congress, 1956)⁶

The primary source of my early and long association with Medicare is that I suggested it to Oscar Ewing in 1950 as a fall-back position after the defeat of the Truman national health insurance proposal and the Wagner-Murray-Dingell bill to carry it out.⁷

Then, later in 1957, I helped to draw up Senator John F. Kennedy’s program for the aged, which included Medicare. This became the basis for the Kennedy-Johnson Administration support for

⁶These bills were introduced at the request of the Eisenhower Administration as Administration proposals. The AMA has been supportive of the principle of Federal financial assistance for maternal and child health and crippled childrens’ services since 1935 and to the elderly poor since the Kerr-Mills bill of 1960. The 1956 position remains unexplained even to this late date.

⁷If any should get the credit for the earliest suggestions in 1937 of what eventually became called Medicare, it was Dr. Thomas Parran, the Surgeon General of the Public Health Service (Corning, 1969). From a practical point of view, the idea came from Merrill G. Murray, Assistant Director of the Bureau of Old Age and Survivors Insurance in two 1944 memos. (Copies of these memos are in my possession, along with numerous other documents on Medicare and Medicaid).

Medicare in 1960 and between 1961 and 1965.

In 1960, President-elect Kennedy appointed me Chairman of a Task Force on Health and Social Security, which recommended Medicare and other health proposals (Cohen, 1961). Shortly thereafter, he nominated me Assistant Secretary of Health, Education, and Welfare for Legislation; this involved assigning me primary responsibility for both the formulation and design of the Medicare program and for piloting the legislation through Congress.

The ideological and political issues between 1960 and 1965 were so dominating that they precluded consideration of issues such as reimbursement alternatives and efficiency options. However, utilization review and health maintenance organization (HMO) relationships did receive attention. But it was deductibles and the duration of hospital benefits that received primary political attention and involved controversial alternatives.

Several differences about policy and strategy arose while Congress considered the legislation during the Kennedy Administration (1961-63).

Ivan Nestingen, the Under Secretary of the Department of HEW, had been the mayor of Madison and was a friend of Kenneth O'Donnell, the Appointment Secretary to President Kennedy. He persuaded O'Donnell and several others in the White House to augment grass roots pressure on Wilbur D. Mills, Chairman of the House Committee on Ways and Means, to report out the Medicare bill. Nestingen believed I was working too closely with Mills, but not pressuring him politically. He was correct in his observation. I felt we just did not have the votes in 1961, 1962, or 1963 in the House Committee and had to rely on an increase in congressional supporters in the 1964 election. Nestingen tried to put political pressure on Mills, but Mills told the White House he would not deal with Nestingen, and Nestingen's apparatus fell apart. However, it was a strain on me as tensions rose between Nestingen's friends and mine. Nestingen eventually resigned after Lyndon B. Johnson became President.

The second problem arose out of the strong opposition of Senator Pat M. McNamara (D., Michigan) to any deductible on hospital insurance. Most other Administration supporters wanted a modest deductible with a longer duration of hospital benefits at the same cost. To placate McNamara, I suggested to Theodore Sorensen, President Kennedy's assistant, that we revise the Administration bill to provide a uniform duration with no deductible, but with a provision whereby individuals could elect once a year to change to a longer duration with a deductible. Sorensen thought this was a reasonable way out of our conflict with McNamara and cleared the idea with President Kennedy. When Robert M. Ball, the Commissioner of Social Security, heard about my suggestion from me, he said it was administratively unworkable. He convinced HEW Secretary Anthony J. Celebrezze to give him an opportunity to see President Kennedy on the matter. Celebrezze, Ball, and I had a conference with

Kennedy and Sorensen in the Oval Office. When Ball said the proposal would result in administrative chaos, President Kennedy replied with a smile, "Well, then, let's have a little chaos." The Congress, however, was strong for a deductible and, as I predicted, my idea for an alternative never got to first base.

The third big issue was the use of Blue Cross plans as fiscal intermediaries in the administration of the hospital insurance program. Ball felt the Social Security Administration could do a more effective, efficient, and responsible job than the many diverse private plans. But political leaders were worried about whether the program could be satisfactorily administered. So the use of fiscal intermediaries was inevitable.

President Johnson was concerned over the possibility of failure of an aged person to gain access to a hospital bed because of an abnormal number of backed-up admissions for elective surgery on the first day or two of the program. He authorized me in 1966 to use Federal military and veterans' hospitals for emergency cases. Special arrangements were established under the supervision of the Assistant Secretary for Health to handle such emergencies. The special arrangements proved to be unnecessary.

Later, I persuaded President Johnson to set up a mechanism in 1968 to review and consider a coordinated policy for all federally financed hospital programs. The President announced the policy, but it never went into effect because of the opposition of veterans' groups and their congressional supporters. This early attempt at a cost-constraint approach on a limited basis fell flat on its face under the vested interest of veterans' organizations.

Legislative process: 1964-65

The influential Wilbur J. Mills was a strong supporter of the contributory social security system. He was both a fiscal conservative and a conscientious and cautious legislator. Prior to 1965, he was not a sponsor of the Medicare proposal. He was always careful, however, in articulating his opposition to the Medicare legislation to allow himself room to adapt to future possibilities. He would commit himself to opposition, specifically to the "King-Anderson" bill, but he was careful not to oppose outright the principle of health insurance for all the aged, although he had doubts about doing so through the social security system. He would identify problems, issues, and questions, but he was continually searching for solutions to the difficulties he saw as political objections to enactment of a law.

With the decisive victory of Lyndon B. Johnson in the 1964 election campaign, Chairman Mills immediately realized he should support some kind of measure along the lines of the Medicare proposal advocated by the Johnson Administration. Johnson was keenly aware of Mills' legislative skill and his technical knowledge of social security legislation. He appreciated the need to give Mr. Mills some time and elbow room. President Johnson did not try to second

guess Mills as to how to get a bill reported out by the Committee. In addition, President Johnson gave me no specific instructions as to how to deal with Chairman Mills on substantive or procedural issues. Johnson's legislative relationships with Mills were handled primarily by Larry O'Brien and Henry Hall Wilson directly from the White House. Mr. Mills went about holding public hearings in 1965 and private consultations in his usual businesslike and thorough manner. Although he consulted frequently with me, he also consulted with Robert M. Ball, Robert J. Myers, and many of his staff and other outside people.

With the Johnson election victory, the AMA finally and belatedly decided to sponsor a counterproposal to Medicare. So did some of the Republican members of the Committee. These two proposals had one element in common—they were broader than hospital care and provided for covering physicians' services. The proposals were also based on the principle that they were not related to social security or the contributory and compulsory payroll tax basis, which was a continual point of opposition by the AMA and the Republican supporters.

At the time (February 1965), there were three options being proposed: (1) a program that would be income-tested rather than "insurance", (2) a program divorced from the social security system, and (3) a voluntary program.

When the public hearings in 1965 were concluded, executive discussions began on January 27, 1965, to hammer out the specific details of a bill which, inevitably, would be a Mills bill rather than a King-Anderson bill. Day after day we would meander through various technicalities. In off moments, when the Committee was in recess, a staff member of the senior Republican Committee member, John W. Byrnes, would ask me why I did not support some broader coverage proposal such as the one available to Federal employees through commercial insurance (the Aetna plan). I knew I had no authority to support a commercial-insurance-type proposal. Besides, the main supporters of Medicare were opposed to such an indemnity plan. Consequently, I never brought the idea to the attention of the White House. The private relationship, voluntary election, and broader coverage were tied together by those advocating a counterproposal.

I have no specific information on how Mills came to his position to include physicians' services. He did not give any advance indication of his willingness to do so. Although Mills was not an impulsive decisionmaker who would do something monumental on the spur of the moment, he was insightful and sensitive. He instinctively realized that this was a way to capture the support of his Republican colleagues. Mills wanted his colleague John Byrnes and some Republicans to support the legislation; he worked hard at trying to find a way to bring Byrnes and some, if not all, of the Republicans or the Committee to a consensus. This was Mills' general way of working on tax and other major bills.

One afternoon, as we went through questions and answers as usual, Byrnes again raised his broader proposal idea. I was the primary Administration representative, seated in the center of a group of Departmental experts at a long table below the great, raised horseshoe table at which sat all the members of the Committee. Without any advance notice, Mills asked me why we could not put together a plan that included the Administration's Medicare hospital plan with a broader voluntary plan covering physician and other services. I answered that it was possible. I had no specific authority from anyone to underwrite such a proposal, but I had enough common sense not to dismiss it out of hand. Then we wrote up the new proposal, virtually overnight.

Mills did not spell out any specifics to me. Rather, he urged prompt action on a draft of such a proposal. I asked for a little more time to complete such a major undertaking. Mills said no, he wanted it the next day. I felt he sensed that he had caught the critics off guard, and he did not want them to have time to regroup. He was like a general who saw he could rout his opposition and follow them as they retreated. Mills recessed the Committee in his eagerness to forge ahead under the momentum that had been created. It was a brilliant tour de force. And it provided me with an opportunity to quietly steal away to touch base with my principals. I left Bob Ball with the responsibility of having his staff draft up the specifications that eventually became Part B of the Medicare program. Larry Tilson, of the staff of the Congressional Legislative Counsel, had primary responsibility for drafting the legislation, in cooperation with Ed Craft and Sidney Saperstein of the General Counsel's office of HEW, and Irwin Wolkstein and Alvin David of the Social Security Administration.

I went back to the office and, fortunately, found President Johnson in the nearby office occupied by John Gardner, the Secretary of HEW. I barged in and briefly told the President what had occurred. I told him that it would probably cost \$500 million or so in general revenues the first year. The President did not bat an eye. He accepted the situation calmly, which I took for approval and clearance. It was a strange and unique way in which to make a major policy decision. There was no policy clearance with others in the Department or in the Budget Bureau or White House.⁸ Mills had scored a coup. Johnson immediately realized it. I was the intermediary for a major expansion of our proposal without any intervening review of the details of the proposal as developed by the staff. In this case, the Federal Government was moving into a major area of medical care with practically no review of alternatives, options, trade-offs, or costs. Physicians and the AMA

⁸As a matter of fact, I never discussed any policy elements in any detail with Douglas Cater or Joseph Califano, the President's assistants during the Johnson Administration. My dealings on any substantive matters were exclusively with Larry O'Brien of the legislative staff, and his assistants, Harry Hall Wilson and Mike Manatos. In the Kennedy Administration, however, I discussed substantive issues with Theodore Sorensen, the President's assistant.

were also caught off base as the ball game quickened and the players sensed something radically new had affected the ball game. I raised no basic questions either within the Administration or in the Committee. It was like the ball game was in the ninth inning, with two outs, two strikes, and three balls on the batter. One more pitch would or could decide not only the game, but the World Series.

For me, at the moment, the big question was not on the method of reimbursement to physicians but rather on the "voluntary" nature of Part B. That was a sharp divergence from a compulsory social insurance philosophy. But I felt that Part B was a big step forward, even if we did not have specific administrative plans on how to implement it.

Moreover, no one on the Committee raised any questions about the radically new principal of using Federal general revenues—equal to 50 percent of the cost of the plan. We felt that such a subsidy would be necessary to make a voluntary plan accepted by low-income retired people.

As I recall it, no major question arose in the House, Senate, or Administration on this unexpected addition of Part B, except for the issue of how to reimburse specialists like radiologists, pathologists, and anesthesiologists. We had always assumed they would be reimbursed from the hospital insurance program (Part A).

My view, and that of my colleagues, had been that these three specialties were traditionally hospital-based physicians who should be reimbursed under Part A as part of the hospital reimbursement and not in Part B as independent entrepreneurs.

My first glimmer of the problem, which was soon to emerge as the key controversial issue affecting Parts A and B, was when Mills asked me to meet with him in his private office off the floor of the House of Representatives. When I entered the office, I found Mills with a radiologist from Little Rock, Arkansas, who was quietly telling Mills he was not an employee of the hospital and did not want to be. He was making the same basic argument that I had heard over the years by newspaper boys, truck drivers, and salesmen, that they were "independent contractors". Mills must have given instructions to the draftsmen who were under his control as to how to change the bill. Mills was adamant despite our pleas to keep the specialists in Part A. We planned to ask the Senate to reverse the decision. However, when the bill was about to come to the full House of Representatives for consideration, President Johnson telephoned me and instructed me to get this particular action reversed because of the additional costs involved. He may have also telephoned Speaker John McCormack on this matter. I have no information as to whether he had discussed it with Chairman Mills or not.

I went up immediately to Speaker McCormack's office in the Capitol. There were at least six or seven of the key congressional leaders seated with him. Mr. Mills was absolutely opposed to changing his decision. He would not come into the meeting. It was a tense situation. Speaker McCormack was not persuasive

with Mills, but felt he should report developments to the President. He telephoned the President and, when he finally reached the President, he said, "Wilbur Cohen will explain the situation to you." I had been quietly seated, waiting for the Speaker to handle this matter. When I answered the phone, the President was clearly unhappy about developments; he was annoyed at the interruption because of the negative response to his demands.

During the next few weeks in the Senate and the Conference Committee, Robert Ball and I tried to work out a solution to this problem. At one time, we thought Mr. Mills and Representative Hale Boggs had agreed to a compromise that we had worked out, but in the end Mr. Mills rejected it. That is how radiologists, pathologists, and anesthesiologists came to be included in Part B in the 1965 law. Mr. Mills demonstrated he could withstand pressure from the President, the Speaker, and his experts. It underscores the importance of having had Mills on your side in every aspect of the legislative process, and the significance of grass roots influence on legislation.

Implementation

The hospital part of Medicare had been in one or another stage of staff discussion since 1942 when the first Federal nationwide hospital insurance bill had been introduced in Congress (Brewster, 1958 and 1962). The many different versions of such legislation had resulted in pinpointing administrative and policy questions and tentatively deciding ways to handle them. The enactment of the disability insurance provisions in the early 1960's helped substantially to assist the staff in working out medical certification policies and forms, developing relationships with physicians and hospitals, and becoming knowledgeable about key participants in the health insurance connection. Responsibility for these disability laws was assigned to Arthur Hess, who thus became the appropriate person to initially head up the Medicare program. Hess did a remarkable job in winning the professional support of physicians and hospitals for the program.

A significant factor in the initial acceptance of physicians and other providers of the policies, forms, and regulations of the Medicare program was the participatory role of the Health Insurance Benefits Advisory Council. Representatives of the American Medical Association, American Hospital Association, the American Federation of Labor-Congress of Industrial Organizations, and other groups had a recognized statutory place to communicate and exchange ideas with the administrators of the program. The importance of this institution during 1965-70 cannot be overemphasized. I personally selected the members of the first Council to be sure there was adequate representation from former critics and supporters of the law.

In addition, I conscientiously carried out the promise I made in the executive session of the House Committee on Ways and Means that private commercial insurance carriers would receive equal consideration with nonprofit organizations as fiscal intermediaries for supplementary medical insurance. This required some persuasion and handholding with the carriers who initially did not believe the Government would do this. I personally assured the private commercial insurance carriers of this policy in a special meeting with them. With Robert Ball, I selected the initial private commercial insurance carriers and other fiscal agents in each of the States and territories to assure an equitable and fair division of responsibilities.

Successful implementation of Medicare required the cooperation of hospitals, physicians, nurses, carriers, intermediaries, and other providers. The primary objective of 1965-67 was to get off to a good start, to avoid any strike, slowdown, or other uncooperative action.

One feature that I build into the legislation was making the effective date July 1, 1966. Respiratory diseases have a low incidence in summer, and elective surgery is at a low ebb immediately before the July 4th holiday period. We needed every day of the approximately 11 months we had to prepare for putting the law into effect. I think initiating the law during a low-admission period in the summer substantially helped to make the initiation of the program successful.

Reimbursement policy under Medicare and Medicaid

The principle of "reasonable cost" for in-patient hospital services embodied in section 1814(b) and 1861(v) of the Social Security Act was never seriously debated or opposed during the period 1961-65, as far as I can recollect. The provision in the latter subsection that "the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations," was accepted by the Congress and the providers. No one criticized it during the legislative process as a "cost-plus" principle. No one thought of it as a basis for inflationary price or cost rises. It was accepted not only because no other alternative was proposed, but because conventional wisdom at the time accepted reasonable cost as a reasonable principle.

With the acceptance of "reasonable cost" in Title XVIII, I arranged for the inclusion of "reasonable cost" in section 1902(a)(13)(B) of Title XIX but omitted the detail contained in section 1861(v) on the assumption that this would give the Secretary and the States somewhat greater flexibility in a State-by-State administration of Title XIX.⁹

⁹Section 1902(a)(13)(B) provided for "payment of the reasonable cost (as determined in accordance with standards approved by the Secretary) and included in the plan." The Kerr-Mills Act of 1960

However, I told the members of the House Committee on Ways and Means in executive session in 1965 that payment of comparable reasonable costs in Title XIX would upgrade medical services to the needy and assist in carrying out the "amount, duration, or scope" of equality of treatment requirements in section 1902(a)(10). Chairman Mills accepted this policy enthusiastically on behalf of the Committee (Williamson, 1983; Weeks and Berman, 1985). It was part of the effort to improve and assure quality and equality of treatment of the poor. It must be kept in mind that hospital per diem costs were relatively low during 1935-40 because of low wages paid to nurses and other hospital employees¹⁰ and the absence of fringe benefits (Brewster, 1962). The efforts up through the 1950's were to assure and enhance the quality of hospital service by a more adequate reimbursement of the employees working in the hospital.

Prohibition against Federal interference

Section 1801 of the Medicare law provides: "Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person."

Section 1801 was included in the law to offset the criticism made by opponents of the proposal that Federal legislation would give Federal officials the opportunity and the right to interfere in the diagnosis and treatment of the individual. Similar language was also included in bills and laws relating to education. The basic provision was originally included in the Forand bills, in 1957 and 1959 (section 226(d)(5), made more specific and enlarged by the legal staff of the Department of Health, Education, and Welfare when President Kennedy's Administration bill was introduced by Representative Cecil King (D., California) and Senator Clinton Anderson (D., New Mexico) on February 13, 1961. No effort has been made, as far as I know, to amend or repeal this general provision.

(Public Law 86-778) had used only the term "cost" (section 6(b)). The Eisenhower-Flemming proposal of 1960 (S.3/84) used the phrase "rates of payments for institutional services" and "schedule of fees or rates of payment for other medical services" (section 1602(a)(5)(D)). The authorization for vendor payments in 1950 did not refer to costs.

¹⁰In 1946, the average annual earnings of full-time general hospital employees was 52 percent of that of a full-time worker in industry; in 1959, it was 60.4 percent; in 1955, it was 66.6 percent; and in 1960, it was 68.9 percent. Total hospital payroll thus assumed an increasingly larger share of hospital expenses.

Evolution of Medicaid

The basic pressure for a Medicaid-type program began to develop in 1942 when Rhode Island wanted to utilize some of the existing public assistance funds under the Social Security Act for direct payments to vendors of medical care. The Social Security Board, however, decided that the law did not permit such a "restricted" payment. This gave rise to proposals within the staff of the Social Security Board to modify the law (Title I, IV, and X) specifically to authorize such "vendor payments."

The Board recommended in 1949 that a new title be added to the law to create a Federal-State comprehensive public welfare program which would include authorization for "medical assistance." The definition of medical assistance meant "medical services for needy individuals, provided by the State agency through payments (including payments of insurance premiums therefor) to persons, agencies, or institutions furnishing or procuring such services, but does not include (certain public institutions, tuberculosis, or mental illness)." (U.S. Congress, 1949)

The Federal share, based on the State per capita income, was limited to \$6 per month for the average number of needy adults and \$3 per month for needy children receiving payments under the State plan (U.S. Congress, 1949).

The Board's proposal was not approved by the House Committee on Ways and Means. It was too broad a proposal. When it seemed like no provision for medical assistance to needy persons would be included in the bill, I asked Elizabeth Wickenden, a long-time friend of mine in New York City, to remind Representative Walter Lynch (D., New York), a member of the Committee on Ways and Means, about introducing the concept of the "average" into the financial reimbursement provisions of public assistance. With Representative Lynch's help, I was able to develop such an amendment, which was adopted by the Committee and the Congress and incorporated into the 1950 Social Security Amendments (Public Law 734). Thus, in a miniscule manner, the Federal role in financing medical care for the poor began. Additional improvements were added in 1966 when the \$6-\$3 pooled plan of 1949 was adopted in the Social Security Amendments of 1956 as a method of financing medical assistance to the categorically needy (Schottland, 1956 and 1958).

In 1953, with the inauguration of President Dwight D. Eisenhower, the HEW Secretary Oveta Culp Hobby advocated a program of reinsurance of voluntary health insurance. This proposal failed to be enacted. In 1954, the HEW Under Secretary Nelson Rockefeller, asked for a substitute proposal, and I assisted in the formulation of a Medicaid-type proposal for the needy. This proposal was rejected on cost grounds by the Bureau of the Budget.

Then, in 1960, Robert P. Burroughs¹¹ and HEW Secretary Arthur S. Flemming, urged President Eisenhower to endorse a Medicare-type plan financed through the social security system. The President initially did so, but subsequently withdrew his support because of the view that it was "socialized medicine" (Flemming, 1985). Secretary Flemming then developed a substitute proposal, submitted to Congress in 1960, based on an income threshold of \$2,500 for an aged individual and \$3,800 for an aged couple, to be financed from general revenues (Mitchell, 1960).

The House Committee on Ways and Means, under Chairman Mills, developed an alternative proposal. When the bill came to the Senate, in the summer of 1960, Senator Kerr requested me to review it and propose any changes to him within a few days. The changes I suggested were adopted without discussion by the Senate Finance Committee, the Senate, and by the Conference Committee. They became known as the Kerr-Mills bill (Mitchell, 1960).

Shortly thereafter, President-elect Kennedy appointed me Chairman of his Task Force, and subsequently, HEW Assistant Secretary for Legislation. All during the years 1960-65, I took the position that both Medicare-type and Medicaid-type programs were necessary and desirable and were not in conflict with each other. Mr. Mills readily accepted this view. The only other strong Medicare supporter I was able to persuade to take this view was my long-time friend, Senator Paul Douglas (D., Illinois), and Senator Albert Gore (D., Tennessee.)

The leading opponent was Senator Pat McNamara (D., Michigan), the Senator from my home state. Senator McNamara and his staff were critical of my views and my strategy (Perrin, 1966). Senator McNamara was not only strongly opposed to any deductible in Medicare, but to any income test. A number of other issues relating to the Older Americans Act and the Elementary and Secondary Education Act resulted in his criticism of my views and official positions. He vigorously criticized any "means tested" approach during an airplane ride to Ann Arbor, in 1964, when President Johnson went to the University of Michigan to make his Great Society speech. I went with the President because my son Christopher was graduating. The Michigan congressional delegation accompanied the President on Air Force One. Former Governor G. Mennen Williams was on the plane, as was Representative Martha Griffiths (D., Michigan), a member of the House Committee on Ways and Means. The President, however, never instructed me on how to handle Senator McNamara. None of the participants on the plane defended my position. The inclusion of Medicaid in the 1965 law would not have occurred without the explicit support of Chairman Mills.

Many people, since 1965, have called Medicaid the "sleeper" in the legislation. Most people did not pay

¹¹Burroughs was a member of the 1953 "Consultants on Social Security." A pension consultant, he had a direct contact with President Eisenhower and initially had persuaded him to endorse Medicare.

attention to that part of the bill (embodied on pages 124-146 of a 296-page piece of legislation or discussed on pages 63-75 of a 264-page Committee Report under the heading "Improvement and Extension of Kerr-Mills Program"). Title XIX was not a secret, but neither the press nor the health policy community paid any attention to it because of the dazzling bewilderment of the adoption of Part B. The proponents of Medicare were delighted with their victory; the opponents were demoralized. Those of us concerned with the legislation became preoccupied with the Senate amendments and the Conference Committee compromises. The full awakening to the scope of the Medicaid legislation did not come until much later. The health policy community in 1965 was a small band of brothers and sisters concerned about the controversial elements in Medicare and unaware of the possibilities inherent in Medicaid. But the idea of Medicaid developed in my mind as early as 1942. I waited for the right time when someone would ask me to develop it into a law. The year 1965 was that time.

Broadening and liberalizing requirement

Section 1903(e) and the 1965 Medicaid law provided:

"The Secretary shall not make payments under the preceding provisions of this section to any State unless the State makes a satisfactory showing that it is making efforts in the direction of broadening the scope of the care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance, with a view toward furnishing by July 1, 1975, comprehensive care and services to substantially all individuals who meet the plan's eligibility standards with respect to income and resources, including services to enable such individuals to attain or retain independence or self-care."

I included this provision in the Medicaid law because I was acutely aware of the inadequacies of the State medical assistance plans in the 1960's. I knew we had to start from where we were, but my hope was to broaden and improve the program over a 10-year period. There was no opposition to this ambiguous and general provision in 1965. However, the attempt to implement this provision met resistance in New York State. Governor Nelson Rockefeller opposed its enforcement because of the cost, and the provision was repealed at his request in the 1972 amendments. A review of the New York State Medicaid plan in 1966-68 is provided in Myers (1970). Mr. Mills subsequently said he "was not aware really at the time of what it would do . . . I know later on Nelson Rockefeller and other governors told me that it required them to enlarge their programs that they operated under Kerr-Mills." (Mills, 1980). I have always thought this was an unfortunate and backward step. We might have had a more comprehensive "safety net" for the poor if this provision had

remained in the law or had been modified to accommodate New York's special problems.

Summary

As I look back on the 45 years I worked on health policy issues, programs, and policies (1940-85) and, especially, the Medicare-Medicaid period (1950-68), I see the Medicare and Medicaid legislation of 1965 as part of a long-time process—a continuation from the past, a creation in a particular moment of time, an incremental evolution for the future. There have been some improvements since 1965, some setbacks, and some changes whose eventual impact is still unclear. We have learned much in the ensuing 20 years.¹²

I do not see the 1965 legislation in terms of good or bad, right or wrong, or in terms of an expanded or restricted role of the Federal Government. The Federal Government's intervention was necessary and desirable in 1965. It was not the only form that intervention could have taken. If the States had taken action during the period 1912-60, the roles of the Federal and State governments in health and medical care economics might have been different today. But individual States were unable to take up the opportunity in the face of the competitive costs to the employers in those States which enacted laws before others did. If the private insurance industry had supported specific proposals, which both the Republicans and Democrats offered during 1945-60, the current situation might be different. But they did not. They waited. They postponed action. They argued for delay. Time was running out.

Today, Medicare and Medicaid are part of a nationwide safety net. What their role will be in the future depends on many factors. But I am happy to have played a role in bringing these programs into being and giving a challenge to the health delivery sector of our economy to do better for present and future generations. I believe we will build a better program on the basic foundation of Medicare and Medicaid.

References

- Brewster, A. W.: *Health Insurance and Related Proposals for Financing Personal Health Services*. Division of Program Research. Social Security Administration. Washington, U.S. Government Printing Office, 1958.
- Brewster, A. W.: *The Health Care of the Aged, Background Facts Relating to the Financing Problem*. Division of Program Research. Social Security Administration. Washington. U.S. Government Printing Office, 1962.
- Campion, F. D.: *The AMA and U.S. Health Policy Since 1940*. Chicago. Chicago Review Press, 1984.
- Cohen, W. J.: *New Frontiers of the Kennedy Administration, The Texts of the Task Force Reports Prepared for the President*. Washington. Public Affairs Press, 1961.

¹²I have summarized these lessons in an article, "Medicare, Medicaid: 10 Lessons Learned," in *Hospitals* 59:44-47, Aug. 1, 1985.

- Cohen, W. J., and Ball, R.: Social Security Amendments of 1965, Summary and legislative history. *Soc. Sec. Bulletin* 28:1-19, Sept. 1965.
- Cohen, W. J., and Peerboom, P.: The Social Security Amendments of 1965. *1965, Year of Legislative Achievements in Health, Education, and Welfare*. Office of the Secretary, U.S. Department of Health, Education, and Welfare. Washington. U.S. Government Printing Office, 1966.
- Cohen, W. J.: In First Person, An Oral History. Hospital Administration Oral History Collection. Chicago. American Hospital Association, 1983.
- Corning, P. A.: *The Evolution of Medicare, From Idea to Law*. Research Report No. 29. Office of Research and Statistics, U.S. Department of Health, Education, and Welfare. Washington. U.S. Government Printing Office, 1969.
- David, S. I.: *With Dignity, The Search for Medicare and Medicaid*. Westport, Conn. Greenwood Press, 1985.
- Harris, R.: *A Sacred Trust*. New York. The New American Library, 1966.
- Flemming, A. S.: Washington. Personal communication, 1985.
- Hirshfield, D. S.: *The Lost Reform: The Campaign for Compulsory Health Insurance in the United States from 1932 to 1943*. Cambridge, Mass. Harvard University Press, 1970.
- Marmor, T.: *The Politics of Medicare*. Chicago. Aldine Publishing Co., 1970, (revised edition 1973). London. Routledge and Kegan Paul, 1970.
- Mills, W. D.: In First Person, An Oral History. Hospital Administration Oral History Collection. Chicago. American Hospital Association, 1983.
- Mitchell, W. L.: Social Security legislation in the 86th Congress. *Soc. Sec. Bulletin* 23:5-15, Nov. 1960.
- Murray, M. G.: Washington. Personal communication, 1944.
- Myers, R. J.: *Medicare*. Homewood, Ill. Richard D. Irwin, 1970.
- Myers, R. J.: *Social Security*. Third Edition. Homewood, Ill. Richard D. Irwin, 1985.
- Perrin, R.: Oral History. New York. Columbia University Library, 1966.
- Schottland, C. I.: Social Security Amendments of 1956, A summary and legislative history. *Soc. Sec. Bulletin* 19:12, Sept. 1956.
- Schottland, C. I.: Social Security Amendments of 1950, A summary and legislative history. *Soc. Sec. Bulletin* 21:12, Oct. 1958.
- Spiegel, A. D., and Podair, S.: *Medicaid: Lessons for National Health Insurance*. Rockville, Md. Aspen Systems Corp. 1975.
- Speigel, A. D.: *The Medicaid Experience*. Germantown, Md. Aspen Systems Corp., 1979.
- Stevens, R., and Stevens, R.: *Welfare Medicine in America, A Case Study of Medicaid*. New York. The Free Press, 1974.
- Truman, H. S.: *Public Papers of the Presidents of the United States, Harry S. Truman, 1952-53*. Washington. July 1952.
- U.S. Congress: House Committee on Ways and Means. Public Assistance Titles of the Social Security Act, Hearings on H.R. 2892. 81st Congress, First Session, 1949.
- U.S. Congress: House Committee on Ways and Means. Public Assistance Titles of the Social Security Act, Hearings on H.R. 9120. 84th Congress, Second Session, 1956.
- Weeks, L. E., and Berman, H. J.: *Shapers of American Health Care Policy*. Ann Arbor. Health Administration Press, 1985.
- Williamson, K.: In First Person, An Oral History. Hospital Administration Oral History Collection. Chicago. American Hospital Association, 1983.