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The Evolution of Medicare and Medicaid and the Challenges Ahead

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by David Warner

The process by which Medicare and Medicaid came to be passed and the compromises that were required to achieve passage and widespread acceptance of these initiatives have formed the evolution of these programs over the last 43 years. Now the new administration faces challenges and opportunities in reworking these programs within the context of far broader and cost-effective assurances for all Americans.

The Great Society health programs Medicare and Medicaid emerged from the conditions of the day, the statutory structure of the Social Security Act, the Kerr Mills legacy of vendor payments for the indigent elderly and disabled, and a number of compromises and decisions that have determined their configuration and evolution to the current day. When Lyndon Johnson became president in November 1963, a bill providing hospital care for elderly Social Security beneficiaries, King-Anderson, had already been filed. It resembled the fall-back bill filed at the end of the Truman administration to provide hospital care to the elderly after the failed fight for national health insurance.[1] During the first half of 1964 the Senate passed a version of King-Anderson. In the House Wilbur Mills, the Chairman of the House Ways and Means Committee, was more interested in modest expansion of Social Security coverage for widows aged 50-62 and a modest increase in monthly Social Security payments. The House passed a bill that expanded this coverage and when the Senate and House came together in conference the membership of the conference committee was stacked against reporting out King Anderson. President Johnson, in discussions with selected Congressional leaders, stated it was better to have no bill than to just have modest revisions to Social Security. He told Wilbur Mills in June 1964 that he had just seen a Vermont poll that “we are not doing enough for old folks.”[2] So neither passed and President Johnson was able to take “health care” into the general election as an issue. He saw health care initiatives as a continuation of Truman’s proposals. In 1964 not only was President Johnson elected but a Congress that was much more favorably disposed to do something about medical care for the elderly and the poor was also installed.

Elizabeth Wickenden Goldschmidt, a long-time acquaintance of President Johnson and an expert on Social Welfare programs, in her oral history interview said “Medicare passed because it was transparently clear that private insurance companies could not meet the need.”[3] Blue Cross Blue Shield had developed with community rating in the 1930s and continued that way into the late ’40s, but the growth of commercial insurers who experience rated large groups meant that the Blues were no longer competitive with private employers, so they began to experience rate as well. This meant that insurance

for the elderly became extremely expensive, and as it became more expensive led to even more adverse selection.[4] Similarly coverage for the indigent depended primarily upon charitable and state and local resources, which were often quite limited. Persons with dementia, for instance, were often warehoused in overcrowded mental hospitals.

The President's Task Force on the 1965 Legislative Program on Health provided some telling numbers in support of the need for legislation:

> Of the 17 Million persons 65 years and over, almost 8 million (46 percent) did not have any health insurance in 1963. Of the 55 million persons with incomes less than $4,000, 31 million (56 percent) did not have any health insurance in 1963…. "(N)either commercial insurance or Blue Cross has been sufficiently effective in providing coverage for low income families, the aged or groups with a high risk of illness.[5]

It is worth noting that the total U.S. population at the time was roughly two-thirds the current U.S. population of approximately 300 million. And that while many are currently without health insurance, nearly everyone over the age of 65 now has Medicare at least.

With the Democratic landslide in 1964 LBJ believed he had a mandate to accomplish a lot but at the same time was very aware of how Congress can slow things down after the first 100 days. Wilbur Cohen, who at the time was Assistant Secretary of HEW, characterized his role in this, as in other initiatives with Congress, as working in situations in which at all times the secret was to find "that modification, that compromise, that adjustment that permits the man in Congress to accommodate himself to what the Chief Executive recommends."[6] The accommodations and changes which were developed in passing Medicare and Medicaid were part of the "Three Layer Cake" that was ultimately developed to push the whole program through.

There were three battling proposals in early 1965: the King Anderson hospital bill which was tied to Social Security and was limited to institutional care so as to not activate the opposition of the AMA; a proposal by Congressman Byrnes, ranking Republican on House Ways and Means, to develop a comprehensive federal program in which the federal government subsidized the purchase of private health insurance conforming to federal standards; and the AMA "Eldercare" proposal which called for a federal-state program to subsidize care at the state level and to be administered by the states.[7] Instead of continuing to argue that King-Anderson would lead to socialism the AMA attacked it as doing do too little since it only covered hospital care.[8] When the AMA spokesman testified before the Ways and Means Committee "'What is the point of giving an old person a hospital room if you don't give him a doctor?' [Wilbur] Mills said, just like that, 'We'll give him a doctor if that is what you want. We'll give him a doctor.[9]'"

What then ensued built, in effect, on the three proposals. Medicare Part A, which was fairly close to the King Anderson bill, would provide hospital care as well as some skilled nursing and home health care post-hospitalization to elderly Social Security recipients. It would be financed with an increase to the Social Security tax as well as co-payments and

deductibles from beneficiaries. Medicare Part B, which covered physician's and outpatient services and incorporated the Byrne bill's federal standards, would be financed by individual payment of premiums (initially 50 percent) along with federal subsidies from General Revenue and co-payments and deductibles. And Medicaid, which built on the earlier Kerr Mills legislation, was designed along the lines laid out by the AMA for the more comprehensive Eldercare proposal. It was funded at the federal level from general revenue to be matched at the state level with a match determined by the state's average per capita income. President Johnson was involved throughout the process. He was able to get Senator Harry Byrd to commit to fairly prompt hearings in the Senate Finance committee.[10] He was able to talk to all his old friends in Congress and was sensitive of their prerogatives while understanding their needs and foibles. Senator Clinton Anderson said, in describing the process for King Anderson," [President Johnson] gave unqualified and intelligent support. You've got to have intelligent support along with the rest of the things."[11] Social Security Commissioner Robert Ball stated that "throughout his entire administration President Johnson has strongly and actively and personally supported every single advance in the Social Security program."[12]

In order to pass this legislation and to assure the cooperation of hospitals and physicians it was believed to be necessary to make a number of concessions. These concessions included a commitment to freedom of choice of physician, to not interfering in the practice of medicine, and to paying reasonable charges through insurance carriers. With regard to hospitals a commitment was made to pay reasonable cost through fiscal intermediaries. In addition it was agreed that cost would include reimbursement for depreciation even though much of the hospital capital had been raised through government grants (like the Hill Burton program) or charity. Phil Lee, Assistant Secretary for Health, remembered that hospitals had been slow to comply with the Civil Rights Act prior to the implementation of Medicare. He said that "President Johnson had a meeting of hospitals and physicians from across the country at the White House on June 15, 1966, and LBJ made it abundantly clear in no uncertain terms that he fully supported the position of the Secretary (John Gardner) on the matter of integration and compliance with Title VI of the Civil Rights Act. There was no question that that was the turning point in my opinion in the whole business. Up until that time there was a tremendous amount of pressure and resistance. After that many hospitals signed agreements."[13]

President Johnson was not just focused on Medicare and Medicaid. In health and public health alone he presided over the passage of legislation that for the first time provided meaningful federal support to training of health professionals, he oversaw the passage of the Older Americans Act, the Community Mental Health Centers Act and the other programs detailed in Table 1. His accomplishments in Education, Community Development, and Civil Rights were similarly path-breaking.

Table 1. Selected Health Legislation Johnson Administration[14]

Bill	Title	Date Passed
88-443	Hospital and Medical Facility Amendment 1964 (Hill Burton)	
88-587	Nurse Training Act of 1964	9/4/64
88-597	Hospitalization of Mentally Ill Act	9/15/64
89-73	Older Americans Act 1965	7/14/65
89-92	Federal Cigarette Labeling Act	7/27/65
89-97	Social Security Amendments of 1965 (Medicare and Medicaid)	7/30/65
89-105	Community Mental Health Centers Act 1965	8/4/65
89-239	Regional Medical Programs: the Heart Disease, Stroke and Cancer Amendments of 1965	10/6/65
89-290	Health Professions Act Amendment of 1965	10/22/65
89-751	Allied Health Professions Personnel Training Act of 1966	11/3/66

Source: Budget FY 1968, Special Analyses, pp. 110-122.

In the first year after implementation of Medicare and Medicaid on July 1, 1966, nearly 90 percent of the elderly people in the country signed up for Medicare[15] and due to accommodations made to both the hospitals and physicians and President Johnson's stand on Civil Rights there was widespread access to providers for those who signed up. Of course these same accommodations made the program expensive from the beginning and, combined with the entitlement aspect of eligibility, generated costs that have proven to be uncontrollable and soon will be unaffordable.[16] Medicaid had a slower and more complex beginning with some states initially adopting very extensive and expensive programs and others not implementing the program at all.

The next major set of changes for both Medicare and Medicaid came with the Social Security amendments of 1972. With regard to Medicare these amendments extended Medicare coverage to certain disabled persons under 65 after receiving Social Security disability benefits for at least two of the prior five years, and coverage was also extended to those with end stage kidney disease (ESRD) who became eligible on diagnosis and did not have to wait two years for coverage. Other than adding those diagnosed with Lou Gehrig's disease in 2000 there have not been material changes in the beneficiaries eligible for Medicare that were not, in part, offset by a significant growth in the number of persons contributing to the program as occurred when federal employees were included in the program.[17]

For Medicaid, the amendments of 1972 were of major importance. They included the full federalization of payment for the aged, blind, and disabled (SSI) along with a federal floor on income eligibility for the restructured program. This had the effect of essentially defining a uniform group of mandatory Medicaid beneficiaries as well.[18] Other provisions relating to Medicaid in the 1972 bill included adding mandatory family planning services; and including among the optional benefits care in intermediate care facilities, intermediate care facilities for the mentally retarded, mental hospitals for the under 21 population, and stipulating that optometrists and chiropractors could be reimbursed as providers.[19] Similarly a three-month retroactive clause for coverage was

included from time of enrollment.[20] Medicaid was permitted to contract with HMOs, states were no longer required to maintain their historic Medicaid expenditure levels, and they were allowed to define reasonable costs differently than by Medicare methods.[21] So by 1972 Medicare and Medicaid had begun to diverge and, with Medicaid, states were given an increasing level of control along with a number of options for caring for populations and the provision of services that were not covered by Medicare.

In the early 1980s the authorization of prospective payment for hospital care in both Medicare and Medicaid led indirectly to the federal defunding of the local health planning agencies and the elimination of certificate of need requirements at least west of the Mississippi. It was believed that elimination of cost plus reimbursement would eliminate the incentives for unneeded or excessive capital expenditure. The Disproportionate Share method of financing care for the uninsured by Medicaid was first permitted in the early 1980s as well. This delinked reimbursement for services from the actual cost of delivering the service by permitting hospitals to receive add-ons if they treated a disproportionate number of Medicaid and uninsured patients.

The adoption of the Budget Reconciliation approach in the federal budget process, while it replaced many specific social programs with block grants, also ironically provided a way around the limitations of the Gramm-Rudman budgetary process since Medicaid was exempt from the annual sequestration aspect of the act.[22] In addition states were given increased flexibility with 1915(b) and 1915(c) waiver authority. This permitted them to request waivers from the freedom of choice requirement in order to contract with HMOs (b) and to replace institutional services with home and community based services for certain beneficiaries (c). From 1984 through 1990 Medicaid was amended many times to increase coverage of women and children (delinking their eligibility from cash welfare benefits) and to increase mandates on the states as well as adding a number of optional programs and populations.[23] These mandates and options carried with them "unfunded federal mandates" for the state match for many of these programs. States developed a number of donation and provider tax initiatives through which they could in effect draw down additional federal money without increasing taxes on their citizens. This created a fiscal imbalance towards social services that could be reformulated as "Medicaid" and eligible for a federal match with little restraint on state inventiveness. The act limiting Medicaid contributions and provider taxes in 1991 was the first stand-alone Medicaid act ever enacted.[24] It should be noted that this act only constrained, it did not eliminate, some of the imaginative state resource mobilization techniques that remains one of the hallmarks of the Medicaid program.

Changes in the 1980s in Medicare financing served to extend the fiscal solvency of the program. These changes included mandating that the 2.9 percent HI portion of the tax on earned income for OASDHI would apply to all earned income and not be limited to the cap applied for the other items. Similarly the portion of Part B costs covered by beneficiary premiums was mandated to be 25 percent of the cost.[25] And persons 65-70 (and eventually all persons over 65) who were fully employed by an employer that

provided health insurance found that Medicare paid after the private insurance rather than before as previously.

By the early 1990s Medicare and Medicaid were set in their respective very different roles. Although Medicare had significant gaps, notably in drug coverage and long-term care, for many, these gaps were partially filled by retiree coverage, Medigap policies, or Medicaid. In 1993 Medicare began the implementation of the Resource Based Relative Value Scale (RBRVS) system of payment of physicians, which ironically froze in place the kind of relative value scale which up to that time the Federal Trade Commission considered to be anti-competitive. It was at this time that any significant balanced billing by physicians for Medicare patients was eliminated. Medicaid continued to expand not only as a hospital and physician care program for the categorically poor, but also as the gap filler in Medicare for the elderly and disabled poor and near poor. And increasingly Medicaid became the indirect funder of hospital care for the uninsured and the primary funder of long-term care, both in nursing facilities and outside as waivers and the Americans for Disability Act as interpreted by the Olmsted decision mandated de-institutionalization.

For the last 25 years Medicaid has increasingly been effectively the principal way in which states have been able to fund a wide variety of social services. The hands-off nature of Medicare payment and beneficiaries along with the rapid expansion of Medicaid has had an overwhelming effect on health care costs, has probably crowded out expenditures for non medically related social services or for services for those not eligible for Medicaid., as well as squeezing funds for physical infrastructure and educational investments, and has created incentives for the medical care system that have led to many anomalous and suboptimal results.

Attempts at cost control have been generally unsuccessful in part because they have been partial, of short duration, or have come up against powerful opposition in a political system that makes real change very difficult. Some cost saving initiatives have included a general price freeze under President Nixon that was extended for hospitals; a health planning act under President Ford that lost much of its impact within 10 years; prospective payment for nursing homes and hospitals enacted under President Reagan that was subverted from the beginning by creative accounting and coding; a major cost cutting initiative under President Clinton and the Gingrich congress in 1997 that was partially rolled back in 1999; an HMO initiative in the private sector extending to Medicare and Medicaid in the mid 1990s that was blunted by major legislative action nationally and at the state level by provider groups pushing for "patient protection";[26] and attempts to limit provider taxes and imaginative accounting in Medicaid by the George W. Bush Administration that Congress has continued to delay. Excess health care inflation is referred to as a fact of life rather than as an artifact of existing institutional arrangements. And entitlements remain partial and hedged in one way or another.[27]

While the U.S. in 1966 spent about the same percentage of GDP on health care as did most other Western European countries, by 2006 the U.S. was spending close to 17

percent of GDP while most of Western Europe was spending about 10 percent.[28] It appears that the difference has been due to the fact that countries with universal coverage are more able to constrain capital expansion, unnecessary specialty care, and levels of reimbursement than those with a mixed system. In fact our mixed system has led to constant emerging deficits in coverage and allocations of funds to more and more dysfunctional systems such as insurance companies and private hospital chains that morph from public to private ownership periodically while permitting owners and top executives to rake off huge returns. Facilities and firms are managed for short-term returns and profit maximization, and have the option to provide very limited care for those who do not have the right kind of coverage.[29] Even the nonprofit health sector has been a major beneficiary of this system of multiple funding sources and discretionary coverage.

This system which has run on now for 40 years has a number of consequences which have become increasingly salient. From the point of view of coverage the elderly have had hospital and physician coverage as well as short-term skilled nursing and home health care post-hospitalization. While the lowest income elderly with limited resources have had Medicaid to fill the gaps in Medicare coverage, beneficiaries with moderate incomes may struggle to pay their medical bills.[30] For example, beneficiaries hitting the "doughnut hole," the annual pharmaceutical costs between $2,510 and $5,726 that Part D enrollees must cover out-of-pocket, may cause them to cut back on their doses in the second half of the year.[31] Most elderly persons cannot sustain a nursing home stay of more than six months without severely depleting their resources and leaving their spouses at serious financial risk. Gaining Medicaid eligibility is difficult as it is necessary to become indigent and also have very limited resources. Thus for many in the middle 60 percent of the income distribution, medical indigence in old age is a likely final chapter in their lives. This is becoming even more likely as corporations and, in the future, possibly government employers continue to unilaterally cancel health coverage for retirees.[32]

The employer-based health insurance system has become increasingly problematic in terms of its capacity to provide reliable coverage to all workers, its impact on corporate competitiveness, the fairness of the tax deductibility of premiums, and inconsistent availability. The more than 45 million uninsured and the many that are under insured are only part of the story. A recent study found that 79 million U.S. adults had medical bill problems or were paying off medical debt.[33] It is the risk of not being able to obtain insurance at a reasonable cost faced by almost every family at some time that also erodes the fabric of society. This is amplified by increased employment insecurity and changing employment patterns over the life span. And while the impact of medical debt falls disproportionately on the poor and the working class the recent bankruptcy reforms means that persons with higher incomes no longer have the option of Chapter 7 in case of catastrophic illness. The increasing likelihood that medical providers will sell their receivables makes the prospects of unaffordable medical debt particularly grim.[34] Indeed while uninsured rates are not as stark as they were at the inception of the Great Society, the overall cost to society of lack of coverage combined with growing medical costs has generated a new tipping point that indicates the need for major changes in public policy.

Our system of medical education and medical specialization has also been significantly distorted in part because of the ways it has been subsidized by Medicare and Medicaid over the years. Clinical professors are financed largely from practice plan receipts and hospitals with residency programs receive 24-hour staffing from residents while receiving substantial subsidies from both Medicare and Medicaid for such programs. These subsidies persist even though medical schools and teaching hospitals have experienced substantial growth in endowments and increases in funding from the doubling of NIH budgets[35] in recent years. The more than 130 medical and osteopathic schools are a great resource, yet they can be extremely inefficient and costly. And since they are spread across many states and Congressional districts medical schools often are a destination for earmarks. This is in part a result of the kinds of resources that have had to be mobilized to meet the guidelines of the American Association of Medical Colleges (AAMC) and the AMA who historically have constrained the growth of capacity of medical schools. The recent decision, by the AAMC, to let medical schools increase enrollment by up to 30 percent may spread the overhead costs more efficiently and narrow the gap between the numbers of physicians demanded and the number produced domestically.

Yet now in part because of the levels of payment under Medicare, Medicaid and private insurance for specialists and procedures as opposed to internal medicine and family practice physicians there is a significant deficit in the numbers of medical students choosing to go into primary care. The most competitive residencies, which attract the students with the highest grades and test scores, are plastic surgery and dermatology.[36] It is hard to see how this allocation of the best and the brightest is in the public interest. Lawrence Weed in a prescient but underappreciated piece in the New England Journal of Medicine 27 years ago entitled "Physicians of the Future" said that the question of what the physician of the future should look like is best addressed by looking at it in the broader context of "What is the best combination of systems, tools, and people for solving any health-care problem in the context of the individual patient's life?"[37] He posited that the then-current system of episodic uncoordinated care with little involvement of the patient, which was dependent on each physician knowing more than it was reasonable to expect, with limited feedback loops and unsystematic record keeping, was far from an ideal system. His views of the systematic capabilities needed by the system also led him to deplore the structure of medical education at the time. It is hard to say that the overall system has improved in the interim.

The U.S. medical system, however, has been particularly undiscriminating in the incentives toward more capital intensive treatment, the proliferation of new diagnostic and treatment facilities that are reimbursed by the government and third-party insurers, and in the limited screening for the appropriateness, effectiveness, and cost-effectiveness of treatments.[38] Although during the period of increased managed care during the 1990s a number of hospitals closed or were consolidated, in recent years there has been a proliferation of surgical centers, diagnostic centers, and physician-owned or physician-affiliated specialty hospitals that usually provide a limited amount of charity care. By 2007 there were a total of 109 physician-owned specialty hospitals with a number more anticipated.[39] Such facilities have the capacity to provide care efficiently but physician

ownership may create a bias toward procedures and diagnostic tests and is thought to skim the cream from existing community hospitals.

With regard to facilities and medical equipment available per capita the U.S. far exceeds the level of other nations. This may be the result of financial incentives to develop expensive, if untested, therapies such as proton beam therapy for prostate and possibly breast cancer. The price tag on one of these units is well in excess of $120 million.[40] Although the efficacy of such therapy is established for some cancers the push to use it more broadly has meant that, as of mid-2007, in addition to five existing centers there were eight additional in development.[41] Because the FDA usually approves devices on a fast track review with little attention to effectiveness or superiority over existing treatments, physicians are free to prescribe expensive poorly evaluated regimens over existing treatments that may be much cheaper and compensate the physician or the practice less. Medical devices have become a $75 billion a year industry and promise to continue to grow rapidly unless some attempt is made to control the rate of dissemination.[42]

Medicare tends to reimburse more for innovative techniques, which may push providers strongly in the direction of as yet unproven procedures. Medicare policy also tends to be followed by private insurers who believe they will face lawsuits if they do not pay for FDA-approved Medicare-covered procedures that a physician in his clinical judgment has prescribed. It is often said with regard to rapid proliferation of new devices and techniques that each one (surgeon or other specialist) learn one, each one do one, and each one teach one. As an example of how ingrained Medicare reimbursement can be the attempt to introduce competitive bidding in durable medical equipment for Medicare beneficiaries, which had been authorized by Congress in the Medicare Modernization Act in 2003, was deferred recently although it was estimated to save as much at $1 billion annually if implemented and allowed to grow.[43]

Projected future costs of Medicare and Medicaid are unsustainable. The Medicare and Social Security actuaries project future Medicare costs from both trust funds to increase from 3.2 percent of GDP in 2007 to 10.8 percent in 2082. Because they estimate that health costs will continue to increase faster than inflation they project Medicare spending will exceed Social Security payments by 2028. In fact contributions to the Medicare trust fund plus interest on the funds, even with the enhancements of earlier years, are estimated to be less than expenditures from the trust fund in 2008. By 2019 HI trust fund assets are projected to be depleted under current payroll tax and benefit arrangements.[44] The fundamentally unsustainable level of Medicare projections are well illustrated by a recent piece by the financial columnist Scott Burns, who points out that a model 30-year-old couple with two children would be able to educate their children at moderate-cost colleges and still have a reasonably comfortable retirement, if Medicare costs only rose with inflation. But, he points out, if Medicare costs continue to increase with “medical inflation” that their increased Medicare Part B premiums would make this goal impossible.[45] Ironically he does not realize that their Part B premiums are only 25

percent of the cost of Part B and the other 75 percent will have to be paid by taxpayers—including by this couple in the 35 years prior to their retirement.

Medicaid has also grown rapidly. In fiscal 2007 Medicaid expenditures for Medical Assistance amounted to $313.5 billion, of which $128.7 billion was for acute care, $99.9 billion was for long-term care, $66.6 billion was for capitation payments, and Disproportionate Share payments were $15.8 billion and included $2.4 billion adjustments. Children comprised almost 50 percent of enrollment and 20 percent of expenditures, adults a little more than 20 percent of enrollment and 14 percent of expenditures, the blind/disabled category about 16 percent of enrollment and about 40 percent of expenditures, and the aged a little more than 10 percent of enrollment and a little less than 25 percent of expenditures. The office of the CMS actuary projects that total Medicaid expenditures will increase to $673.7 billion by 2017.[46]

Instead of projecting these program costs for Medicaid and Medicare to the sky based on past trends, it may be instructive to see what would be possible if Medicare and medical costs increased at less than inflation—in some sense regressed toward the mean of western economies. In a sense it can be said that 40 years after the passage of Medicare and Medicaid the U.S. is currently spending at least $500 billion annually above what comparably affluent western European comprehensive health systems would cost. In such a context it is ridiculous to think that going forward costs could not be reduced relative to inflation. This is especially true in a period of plunging home values, financial instability, and expanding public debt where debt service will become a growing part of the federal budget.

A number of participants in the health system have benefited substantially from this fractionated and free-wheeling system. Special arrangements made under public financing programs to accommodate their special status may no longer be needed because of their fiscal health. Also if a means to provide health insurance coverage to a significantly higher percentage of the population is developed then subsidies to cover the uninsured may no longer be required. Some of these entities include foundations that were developed as a result of nonprofit hospitals, insurers, and other entities becoming for profit. Most of these, whose assets on conversion were $15.2 billion[47] and probably much more today, have chosen to spend a substantial amount on advocating for the uninsured or developing clinics or other programs to provide services to this population.

Similarly foundations such as the Robert Wood Johnson Foundation (assets $10.7 billion in 2007), Henry J. Kaiser Family Foundation (about $.6 billion), Commonwealth Fund (about $.7 billion), and a number of others are focused on the health system. There are a number of children's hospitals that receive special funding from Medicaid that have substantial margins each year, and who have significant fund balances and endowments accumulated and who enjoy an ability to be reimbursed at charges by many third-party payers because of their unique position in the health care system. The same is true of comprehensive cancer centers that have a plethora of sources of financing and seem to have very robust margins. The Guidestar website shows that Memorial Sloan Kettering

had an excess of revenues over expenses of $289 million in 2006 and their net assets increased to $3.6 billion by the end of the period. Similarly M.D. Anderson in Houston was reported to have had a net profit of $310 million in 2007 with cash, investments, and endowment totaling nearly $1.9 billion.[48] Similarly public hospitals and others would not need as much of the more than $15 billion in Disproportionate Share funding they receive to care for the uninsured and to compensate for inadequate rates.

What then is the way forward to fill in the gaps in the existing health care system and to motivate the appropriate allocation of resources towards enhancing the nation's health while at the same time not bankrupting the education system, the already underfunded physical infrastructure, the arts, and investment in new technology, which are vital if we are to advance as a nation? It seems that there is fair agreement that reform should: 1) enhance primary care while providing better coordination for care and enhancing the capacity of individuals to monitor and improve their health status; 2) reduce spending on procedures which are not effective while moving towards cost-effectiveness as a criterion as to which procedures or therapies should be pursued when there is little or no difference in appropriateness of the therapy; and 3) develop improved record-keeping and communication technology to reduce cost and make care more appropriate. In fact Karen Davis, drawing from the recent Commonwealth Fund Report on High Performing Health Systems,[49] identified these as examples from high performance, less costly health systems in Europe in a recent piece in the *New England Journal of M*edicine.[50]

Developing a medical home is a solution advocated by many. In this model patients have a primary care physician who oversees their care, helps them understand options and strategies for preventing disease and enhancing health, and monitors their progress through the medical care system. Such an arrangement would necessitate increasing the number of primary care physicians who are also better trained in navigating the health system. Developing electronic medical records or similar aides to document vital signs, lab tests, and procedures is also often promoted as a necessary step. There are also various proposals on how better use of nurses, websites, and other provider extenders care could make care more efficient and effective.[51] The migration of physicians away from primary care has been a barrier to this—a problem exacerbated by the Medicare fee structure. One observer has pointed out that this can only be solved by the federal government adopting a new reimbursement structure, which Congress has been unwilling to do.[52] In fact a new structure not only should improve reimbursement for primary physicians and management services but it should also reduce aggregate reimbursement for some specialty care as well.

Electronic medical records may be a larger capital expenditure than smaller medical practices are willing to make. Even if they do invest, the system they choose may be incompatible with those chosen by the hospitals with which they are affiliated and other provider groups. Although hospitals are often willing to finance EMRs physicians may be hesitant to be beholden to a single hospital. Many of the initiatives seem to be mostly focused from the perspective of the insurance industry or possibly from the point of view of government. If the federal government is going to be involved it must make sure

consistent and compatible standards are enforced. Other initiatives may be those such as Microsoft's Health Vault, which lets individuals maintain their records and provides an opportunity to providers to be involved in that process by seeing the information and uploading information to the site. Thirty-five years ago I and a coauthor proposed that patients should be routinely provided a copy of their medical records and argued that would provide them with a source of information which providers would feel more obligated to make understandable. The patient could then take the record to another provider or an objective third party to have their situation assessed without great expense.[53] We believed that objectifying the process of care could lead to better results and make physicians' jobs more satisfactory and concrete and provide a vehicle to improve communication and coordination.

There is inadequate examination of effectiveness, let alone cost-effectiveness of either procedures or therapies in Medicare and Medicaid as well as by private insurers. It is also difficult for such payers to stop paying for ineffective technologies after a vested group of physicians, pharmaceutical companies, and device-makers are established and earning incomes based on the technology. It has long been a matter of concern that there is a wide variation in the use of different procedures with little to no difference in outcomes between different parts of the country. The Dartmouth Atlas has been documenting these variations for the last 20 years, primarily using Medicare data. In a recent examination of care in the last two years of life Dartmouth researchers found a great deal of variation not explained by quality of care. In general they found that higher-spending regions had more hospital and physician resources but that physicians reported less communication. Higher-spending regions also had slightly worse results and patients reported worse access to care.[54] In comparing world class hospitals Dartmouth researchers found that costs for patients in their last two years of life ranged from $93,842 and $85,729 at UCLA Medical Center and Johns Hopkins hospital respectively to $55,333 and $53,432 at the Cleveland Clinic and the Mayo Clinic respectively.[55] In spite of the difference in expenditure the higher-cost academic health centers did not have appreciably better results. Dartmouth researchers concluded that the "major structural problems behind the unwarranted variation are …(1) inadequate science; (2) poor coordination of care and overuse of acute care hospitals; and (3) a flawed payment system that rewards overuse."[56]

Some solutions for controlling costs include promoting further travel abroad for care to certified facilities where the cost can be as little as one-tenth to one-sixth that in the U.S.,[57] the establishment of national technology assessment agencies as in Australia and Great Britain in order to identify cost-effective therapies and procedures, and reinstating certificate of need for new facilities and major equipment purchases. Organized medicine and the hospital associations generally oppose insurance or Medicare and Medicaid paying for services abroad. Pharmaceutical and medical device manufacturers have not been supportive of governmental technology assessment. And the FTC and the Anti-trust Division of the Department of Justice recently submitted testimony that concluded that Certificate of Need laws "are not (on balance) successful in containing

health care costs, and ….they pose serious anticompetitive risks that usually outweigh their purported benefits.[58]

Because of the political difficulty of getting control of these costs and also making judgments about which procedures and regimens should be reimbursed and how much, several observers have made a recommendation that an independent agency be established at the national level to make these determinations.[59] Dr. Arnold Relman also makes a recommendation that a Federal Reserve-like agency be set up to oversee the national health system he proposes, which would then contract with physician-dominated regional entities that would administer his proposed national health plan.[60]

Another source of excess spending in the U.S. health system is the high cost of drugs and the marketing techniques of the pharmaceutical companies. The costs of similar drugs in the U.S. and Europe are generally higher in the U.S. with some exceptions. In addition to being particularly profitable, firms in the pharmaceutical industry have taken advantage of tax law to move their patents offshore,[61] which along with other, sometimes over-the-line, tax tactics leads to billions of dollars in lower tax receipts to the U.S. Treasury.[62] Merck in 2007 settled a case with the IRS over unpaid taxes of $1.5 billion and $800 million in penalties over transfer pricing abuses with a subsidiary in Bermuda.[63]

The Priorities for the Next Administration

The first priority of the Obama Administration should be implementing the candidate's proposal for expansion of coverage. Some analysts disagree. Henry Aaron for instance argues that given the controversial nature of comprehensive proposals that the sensible first step would be to gather low-hanging fruit such as passing the SCHIP expansions that Congress approved, but President Bush vetoed last year, and to start testing comparative effectiveness with an earmark of 1 percent of Medicare revenues, encourage state's efforts and create a national health insurance clearinghouse.[64] He believes that a comprehensive plan would be unnecessarily divisive. Nonetheless his proposals do little for expansion of coverage at a time when many are losing their jobs, others are being threatened with bankruptcy, and firms are continuing to drop coverage for retirees and employees. The lessons of President Johnson's administration show that the first 100 days are a meaningful and important period. It would seem that the time to make major progress in expansion would be in that initial period—especially since most interest groups from the drug companies to the AMA to AARP say they are for such an expansion. An expansion of SCHIP along with a mandate on children's coverage as well as pay or play for major companies and subsidies for small employers and a national insurance exchange as proposed by Obama should be a realistic goal. The funds can be found either through hypothesized savings in Medicaid (disproportionate share and some reimbursement adjustments), improved tax collection especially on companies in the medical care sector, and the tax on the top 5 percent of the income distribution. In fact, some savings in Medicare could be gained from improved access to drugs and primary care for the 50-65 population, which could delay or even prevent the onset of conditions like diabetes, end stage renal disease, and other extremely costly conditions. If there

were a great deal of opposition to the cost of this perhaps a 1 percent assessment on the assets of all hospital, health insurance, and health policy nonprofits including foundations could be written in as a fall-back if receipts from other sources were deemed insufficient. This could serve as an offset of the 5 percent community benefit requirement that many are required to undertake in lieu of taxes.

It goes without saying that as with President Johnson's successful initiatives, this will require that the proposal come from Congress and be of Congress in some sense. Because of the fact that it is easier to expand programs than to cut them and that the devil is in the details I believe that the proposal should focus on expanding coverage as much as possible. It would be a mistake to rely too much on the states. They do not have an adequate fiscal base. They are often captured by medical and hospital associations, insurance companies, the plaintiff's bar and other special interests which are inimical to developing a flexible but national coverage initiative.

As part of the expansion however it is important to make plans for Medicare and Medicaid and overall cost savings in the sector. With regard to Medicare it might be best to follow the suggestion of Senator McCain in the second debate with Senator Obama. He said that the interest groups were too strong for the problem of the great cost of Medicare to be resolved through normal Congressional consideration. He cited the example of the National Commission on Social Security Reform appointed by President Reagan in the early 1980s.[65] President Obama thus should as part of the expansion discussed above also appoint a bipartisan Commission on Medicare which not only examines eligibility issues but also coverage issues such as a meaningful long-term care benefit, reimbursement methodologies, effectiveness testing, licensure and accreditation barriers and requirements, and other topics. One mandate should be how to keep cost increases under the general rate of inflation and even how to recapture some of the $500 billion or so annually that is being wasted by an inefficient medical system. This is where the battles will be fought but it should be here and not in overly constricting the coverage expansion initiative.[66]

Part of this mandate should be developing a way to evaluate and test innovative initiatives. By illustration one example would be whether or not it would be cost-effective and appropriate to cover retirees in Mexico under Medicare to some limited degree. This is an initiative which I have recommended as a demonstration waiver over the last 18 years and one which is becoming increasingly important not only for those who have already retired to Mexico but also for those who would have a much higher and independent quality of life if they could retire there with Medicare coverage. As the more than 13 million Mexican-born U.S. residents age this initiative could be even more important as a means of making it possible for them to return home in retirement and to live independently within often limited means from Social Security and need no additional assistance for housing, social services, or long-term care.[67]

Medicaid is a different story and probably requires a different task force or commission which would include governors and others. This task force should not be set up until

after the expansions are legislated and the Medicare task force has done its work. In the short run Medicaid is so much a creature of the gaps in Medicare such as long-term care, disability determination, and reliance on Medicare reimbursement and coverage criteria that it does not make sense to figure out how it should be changed until the context is determined. Further, Medicaid is now a major source for social service funding which is quite different from paying for medical care. Post Olmstead there are all sorts of interesting experiments and initiatives such as "money follows the client." But it is important that funding for these activities as well as long-term care be divorced from the current addiction at the state level to just drawing down federal funds. In the short run then it makes sense to not make major changes in Medicaid but to plan to restructure after the first two initiatives are out of the way. The National Governors Association sponsored a Task Force on Medicaid in 2005 which called for the ability to get greater discounts on prescription drugs, more flexibility in copays, more aggressive recoupment policies for long-term care recipients, comprehensive waiver reforms and flexibility in benefit packages. Some of these were enacted but it would work much better if this commission, which would include some governors but also federal-level participants and outside experts, were to be able to work from more or less settled national coverage and Medicare reform packages.

Wilbur Cohen often stated that major social policy reforms in the United States occurred in increments of 30 years. He would point to President Theodore Roosevelt and the Square Deal in the first decade of the last century and then President Franklin Roosevelt and the New Deal in the 1930s, and President Lyndon Johnson and the Great Society in the 1960s. This led him to predict that national health coverage would be achieved in the 1990s. He missed by at least a decade but we are now at a point where I believe his vision can be achieved.

David C. Warner is the Wilbur Cohen Professor of Public Affairs, LBJ School of Public Affairs, The University of Texas at Austin. The research and editorial assistance of Paige Jennings is gratefully acknowledged.

Notes

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[17] See Marilyn Moon, "Medicare: A Policy Primer," pp. 54-55. She points out that extension of coverage to state and federal workers who had initially been exempt made sense because then they could contribute to the program and many of them would have been eligible based on other work history or their spouse's eligibility. Requiring beneficiaries over 65 whose employer provides health insurance to use that benefit first also was a cost-saving initiative and reduces the number of effective beneficiaries.

[18] Stevens and Stevens, p. 337.

[19] Stevens and Stevens, p. 339; and Eldridge, p. 163.

[20] Stevens and Stevens, p. 339.

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[22] Eldridge, p. 200.

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[25] Marilyn Moon, p. 147.

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