

MEDICARE:

Lessons from the Past: Major Policy Changes

Introduction

Medicare, along with Medicaid, became law on July 31, 1965, at a signing ceremony in Independence, Missouri. Now in its fifth decade, Medicare provides health coverage to virtually all of the nation's elderly and a significant share of people with disabilities – insuring over 44 million. Surveys find it to be one of the most popular government programs, rivaling Social Security. Equally striking, Medicare has narrowed socioeconomic and geographic differences in access to health care and helped raise seniors out of poverty. It offers lessons on politics as well, which will be critical as policy makers tackle the inexorable Medicare and health system challenges.

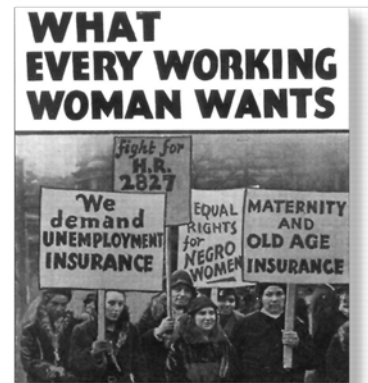
History of Medicare's Passage

Prior to Medicare's implementation in 1966, President Lyndon Johnson spoke about the grand aspirations for its passage: "Medical care will free millions from their miseries. It will signal a deep and lasting change in the American way of life. It will take its place beside Social Security, and together they will form the twin pillars of protection upon which all our people can safely build their lives and their hope."¹ Achieving these aspirations, however, was decades in the making.

Prior Universal Health Insurance Efforts.

Medicare was predated by several attempts to insure all Americans. The first serious bill to promise universal health insurance was introduced in 1939, during Franklin Roosevelt's second term. Periodically, similar bills were reintroduced in each succeeding Congress. President Truman was a particularly strong advocate. In 1948, he said, "Millions do not now have protection or security against the economic effects of sickness. The time has arrived for action to help them attain that opportunity and that protection."

Early Efforts for Coverage, 1935



Source: A.E. Birn et al. AJPH, 2003

A different type of momentum began to build during the Eisenhower administration. To generate the needed public sentiment for change, cries for health reform were increasingly tied to the plight of vulnerable Americans. Beginning with the bill of Representative Forand (D-RI) in 1957, most major proposals dealt specifically with health insurance for the elderly.² In 1960, the Annual Conference of Governors approved a resolution calling on Congress to pass health insurance legislation specifically for seniors. The Kerr-Mills Act was signed into law a few months later. It provided states with federal grants to pay for health care for the "medically indigent" elderly poor.³ The following year, the first White House Conference on Aging recommended health insurance for the elderly as a component of Social Security.

Kennedy Focus and Opposition. President Kennedy was arguably one of the first political leaders to fully embrace the voting elderly community, having made a campaign promise to enact hospital insurance legislation for seniors. A public poll in 1962 also revealed swelling popular support for such assistance, with 69 percent of Americans believing legislation was needed.⁴

Led by the American Medical Association (AMA), opponents of the federal government's involvement in health care recognized the growing support for a government program, and mobilized against it. Creating advertising, soliciting doctors speeches and generally planting seeds of doubt and frustration, the coalition worked hard to paint the Medicare initiative as socialized medicine. It also published research to show that elderly Americans could in fact afford health care. The AMA even created a political action committee that asked the personal doctors of members of Congress to call and advocate against the measure.⁵

When Kennedy tried to deliver on his campaign promise, the idea failed to win approval in the House Committee on Ways and Means. The committee's chairman, Wilbur Mills (D-Ark.), knew that he lacked the votes to move the bill. The majority of the Committee, strongly opposed the Democratic proposal for hospital insurance financed by a mandatory payroll tax. The Republicans favored a voluntary, premium and tax-financed plan to cover physician bills. Southern Democrats feared –correctly, as history shows – that a Federal program for hospital services would integrate the still-segregated health systems in the south.



Compromise Legislation. Then came President Kennedy's assassination and the Democratic landslide of 1964. President Lyndon B. Johnson adopted and expanded on Kennedy's domestic agenda. In his State of the Union address in 1965, President Johnson committed to passing Medicare, claiming it as one of his top priorities, stating, "Greatness requires not only an educated people but a healthy people."

Many members of the newly expanded Democratic majority were from northern and western states, and were inclined to support Medicare. Some were placed on the Ways and Means Committee. It became clear that a hospital insurance bill might pass even without Mills' support. Instead of opposing the bill, however, Mills worked with President Johnson's point man on health care legislation, Wilbur Cohen (a subsequent LBJ School professor), to design a compromise. The final bill combined mandatory hospital insurance financed by payroll taxes (the Democrats' plan) with voluntary coverage of physicians' services financed by premiums and general revenues (the AMA's plan), and means-tested health coverage of the poor (the Republicans' plan, built on Kerr Mills of 1960). The first two components constitute Medicare Parts A and B, the third Medicaid.

The House approved the bill by 315-115. A somewhat different version passed the Senate 68-21. The House-Senate conference compromise was passed with similar majorities.

Subsequent History of Medicare

Since 1965, numerous changes have been made to Medicare. Many of its payment system have become the industry standard. Its benefits have been updated to add prevention and, at long last, prescription drug coverage. And, it now allows private plans to offer an alternative way of receiving Medicare's services. At the same time, Medicare's system of parallel but separate plans – Hospital Insurance or Part A and Supplementary Medical Insurance or Part B – preserve the original insurance configuration of the separate Blue Cross and Blue Shield plans. And its status as a social insurance program has, largely, remain unchanged.

Social Security Amendments of 1972. After Medicare's passage, issues of access and quality quickly surfaced. People with disabilities, with heavier medical burdens, greater out-of-pocket expenses, more limited private insurance options, and lower income than their non-disabled counterparts, were clearly in need of greater support.⁶ In response, eligibility to Medicare was expanded in 1972 to include individuals under the age of 65 who were suffering from long-term disabilities (i.e., qualified for Social Security Disability Insurance) or end-stage renal disease.

The amendments signed by President Nixon also extended Medicare's demonstration authority, created professional standards review organizations, and supported health maintenance organizations.⁷

Cost Containment in the 1970s and 1980s.

By the early 1970s, health care costs were growing rapidly. Between 1970 and 1982, the economy grew by 208 percent, while spending by employers on health benefits grew by 700 percent.⁸ Medicare's growth in costs paralleled this trend.

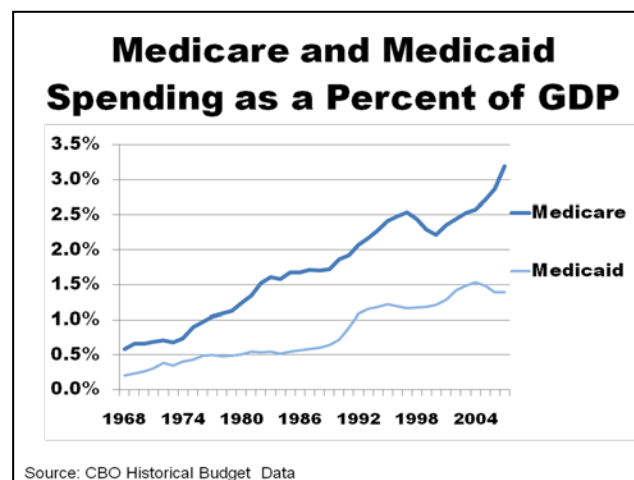
In 1982, Congress passed the Tax Equity and Fiscal Responsibility Act (TEFRA). TEFRA set the premium for Medicare Part B at 25 percent of costs. The law also encouraged participation by Health Maintenance Organizations (HMOs) by creating a new payment system for them. A ceiling on hospital discharge costs was imposed, and the Department of Health and Human Services was required to provide develop new methods for paying nursing homes and hospitals.⁹

In 1983, cost-containment efforts continued with the implementation of Diagnosis-Related Groups, or DRGs. This newly formed inpatient prospective payment system was designed to replace cost-based payments with pre-determined payments for providing care for specific treatments.¹⁰

Yearly legislative attempts at containing Medicare costs continued through the 1980s. In 1984, the Deficit Reduction Act placed a freeze on physician fees, and set a fee schedule for laboratory services. The next year, a freeze was placed on inpatient hospital payment rates. In 1986, the Omnibus Budget Reconciliation Act restructured payments for a number of Medicare services. In 1987, policy again modified payments.¹¹

Catastrophic Coverage Act of 1988. In 1988, Congress enacted the Medicare Catastrophic Coverage Act. Proposed by the Reagan administration, the legislation was passed by a Democratic Congress with bipartisan support. Among its numerous benefits, the law expanded hospital and skilled nursing home coverage, removed all limits on hospice coverage, and added low-income assistance programs and – most significantly – an outpatient prescription drug benefit with a high deductible.

A key to the political compromise was to finance the new benefits through a premium surcharge paid by roughly 40 percent of Medicare enrollees with the highest incomes. This turned out to be extremely unpopular. Most of the cost of the new benefits fell on Medicare beneficiaries who already had the promised benefits through retiree coverage. More enrollees mistakenly thought that they were net losers than was actually the case. The beneficiaries protested loudly and, on occasion, violently. Just sixteen months after its enactment, Congress overwhelmingly repealed the law.¹²

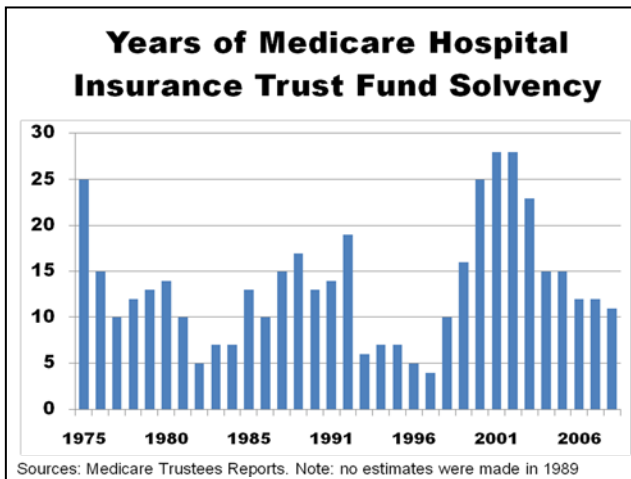


Balanced Budget Act of 1997 and Beyond.

In the early 1990s, next major changes to Medicare were proposed but rejected. President Clinton proposed to reduce Medicare spending and add a drug benefit in his 1993 health reform plan, which failed in 1994. In 1995, the new Republican Congress tried to cap Medicare outlays and lower spending by an estimated \$270 billion over seven years. Clinton vetoed this legislation. However, both parties agreed on the need to balance the budget which the groundwork for bipartisan legislation after the election in 1996.¹³

Congress enacted and the President signed into law the Balanced Budget Act of 1997 that included significant Medicare changes. It included new payment systems as well as reductions in the growth of provider payments. It supplemented Medicare preventive benefits and low-income protections. The law strengthened anti-fraud protections and created a bipartisan Medicare commission to identify policy ideas for the program's long-term challenges.

The law also addressed a looming Medicare financing crisis. In 1997, official projections indicated the Hospital Insurance Trust Fund would be insolvent in 2001.¹⁴ In addition to reducing Hospital Insurance costs, the Balanced Budget Act shifted some of its costs to Part B (the Supplementary Medical Insurance program), lessening pressure on the trust fund, but raising Part B premiums as a result.



Following this legislation, nominal Medicare expenditures per beneficiary fell in 1999 – the first absolute decline since the program was enacted. Responding to provider complaints that the cuts were too deep, Congress raised reimbursement rates. Even with these “give-backs,” the policies of the late 1990s contributed to delaying the insolvency of the Trust Fund for twenty-eight years, according to the 2001 Annual Report of the Medicare Trustees.¹⁵

One less successful part of the Balanced Budget Act was the creation of the Medicare+Choice program (i.e., Part C). It was designed to promote private health insurance options for Medicare beneficiaries. The rationale was that these private insurers would constrain costs through competition while having the flexibility to improve the outdated benefits offered through Medicare.

Neither private insurers nor beneficiaries responded as proponents desired. The Congressional Budget Office predicted a 34 percent enrollment increase by 2005. However, in the four years that followed, enrollment actually fell.¹⁶

The Medicare Modernization Act of 2003.

The next major policy change in Medicare occurred in 2003. Focusing on his 2004 reelection challenge, President George W. Bush made passage of an outpatient prescription drug benefit a top legislative priority. His original proposal of a limited drug benefit only accessible through Medicare HMOs was unpopular among Republicans as well as Democrats. After Republicans gained power in 2002 election, bills were passed in both chambers. Most Democrats opposed the bill that emerged from the conference committee in November of 2003 due to its heavy reliance on private health plans. Some Republicans also rejected it due to its price tag and insufficient market orientation. In the end, enough Democrats joined the Republican majority to pass the Medicare Modernization Act of 2003 (MMA).¹⁷

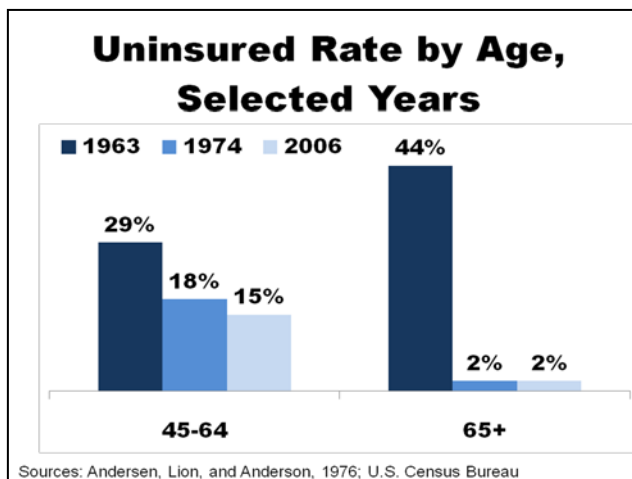
The drug benefit created by the MMA is delivered in two ways: through stand-alone prescription drug plans or through Medicare Advantage plans (the new name for Medicare+Choice or Part C). Medicare pays for prescription drugs indirectly, through fixed payments to private plans, rather than directly through price negotiation, competitive bidding, or regulation. Plans have flexibility in benefit design, pharmacy networks, formularies, and other key benefit parameters.

Once the drug benefit went into effect in 2006, its implementation was relatively smooth. Within a year, all areas of the country had a private drug plan, enrollment rose and beneficiary satisfaction was high. Even so, the MMA continues to be hotly debated, particularly because of its prohibition on government involvement in drug price negotiation and the role of private plans in Medicare.

The MMA changed other aspects of Medicare. It increased payments to private plans in Medicare Advantage to promote them as an alternative to the traditional fee-for-service system.¹⁸ It also established a “premium support” demonstration, scheduled to begin in 2010, that would put traditional Medicare in direct competition with private plan on the basis of price. Lastly, the MMA established a new measure of program insolvency, called a “trigger,” based on the proportion of total outlays covered by general revenues. These provisions, like the drug benefit itself, were controversial at passage and remain so.

Accomplishments

Medicare is hugely popular with both the public and policymakers. It provides nearly all people aged sixty-five and older, as well as those with certain disabilities, with health insurance that many would otherwise find unaffordable or unavailable. It offers beneficiaries more choice of providers than do most private health plans for workers. In addition, Medicare is an important source of employment, providing billions of dollars in income to health care providers as well as local economies throughout the nation.

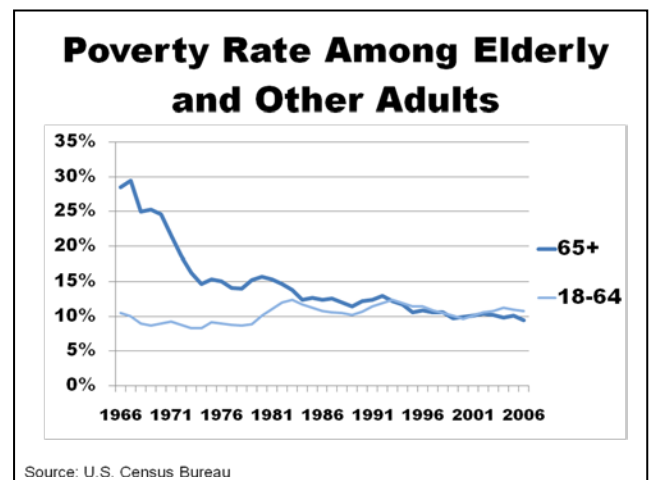


Access. Before Medicare, the elderly were the least likely to have health insurance. In 1963, almost half (44 percent) of seniors went without insurance and were left vulnerable to the financial and health challenges that come with ageing. Medicare has transformed that reality, and today is responsible for protecting 98 percent of seniors.

Medicare also contributed to balancing the racial divide that was particularly prevalent in America fifty years ago. Before Medicare, discrimination against African Americans and other racial and ethnic minorities was prevalent in hospitals. Many minorities were refused entry to medical facilities, and were forced to look elsewhere for what often amounted to inferior care. The passage of Medicare forced these hospitals to allow access to all Americans, and dissolved the two-tiered health care system. In 1963, the average number of doctor visits by minorities older than 75 was 4.8 per person. Just six years after Medicare's signing, minority visits grew to 7.3, similar to older white Americans.¹⁹

Satisfaction. Consumer satisfaction is an important component of high-quality health care. On this measure, Medicare ranks above its peers. In a Commonwealth Fund survey, Medicare patients ranked their care more favorably than did non-elderly patients covered by private insurance. About 66 percent of seniors on Medicare ranked their insurance as excellent or very good, compared to 54 percent of privately insured, non-elderly adults. These Medicare beneficiaries were also more satisfied with their quality of care and more confident in their future ability to get care than the privately insured.²⁰

Poverty Reduction. In addition to enabling access to valuable health care, Medicare strives to protect its beneficiaries from impoverishment due to excessive health costs. Medicare succeeded in improving the financial protection of seniors as well as reducing their rates of poverty. Before Medicare, seniors were financially much poorer than other populations. In 1966, nearly 30 percent of individuals age 65 and older were below the poverty line, as compared to 11 percent of those ages 18 to 64. At the close of the century, the percent of elderly living in poverty had fallen by two-thirds, to roughly 10 percent.



Before Medicare, seniors were responsible for 53 percent of all their health costs, which consumed 24 percent of their Social Security checks on average. In 1997, seniors were responsible for 18 percent of their health care costs, which accounted for a 17 percent of their Social Security checks.²¹

Conclusion

Despite its accomplishments, Medicare faces challenges. Costs continue to cause financial stress for beneficiaries as well as the budget. The quality of care is not commensurate with what Medicare pays for it. And disparities persist, along racial, socioeconomic, and geographic lines. These challenges will expand as the demographic wave of Baby Boomers retire and enroll in Medicare.

Yet, Medicare's past suggests promise for solving its future problems. In 1962, sociologist Michael Harrington wrote about "another America", where 40 to 50 million people suffered in poverty, waited desperately for adequate medical care, and remained largely invisible to most Americans. Of the nearly 18 million elderly citizens, 8 million were caught in a "downward spiral" of illness and seclusion.²² For several decades Medicare has helped to rewrite much of that history, and has fulfilled President Johnson's promise at its enactment of "care for the sick, and serenity for the fearful."

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¹ N. DeParle, "Celebrating 35 Years of Medicare and Medicaid," *Health Care Financing Review*, 22(1): 2-7, Fall 2000.

² R. Stevens, "Health Care Early 1960s," *Health Care Financing Review*, (18)2: 11-22, Winter 1996.

³ "Chronology of Significant Events Leading to Enactment of Medicare" *Social Security History*.
<http://www.ssa.gov/history/cornignappa.html> (April 17, 2008).

⁴ J. Quadagno, *One Nation Uninsured: Why the U.S. Has No National Health Insurance* (Oxford University Press, 2005), p. 67.

⁵ J. Quadagno, *One Nation Uninsured: Why the U.S. Has No National Health Insurance* (Oxford University Press, 2005), p. 67.

⁶ R. Master, and C. Taniguchi, "Medicare, Medicaid, and People With Disability", *Health Care Financing Review*, (18)2: 91-97, Winter 1996.

⁷ *Medicare: A Timeline of Key Developments* (Washington, D.C.: Henry J. Kaiser Family Foundation).
http://www.kff.org/medicare/timeline/pf_entire.htm (April 17, 2008).

⁸ J. Quadagno, *One Nation Uninsured: Why the U.S. Has No National Health Insurance* (Oxford University Press, 2005), p. 139.

⁹ *Medicare: A Timeline of Key Developments* (Washington, D.C.: Henry J. Kaiser Family Foundation).
http://www.kff.org/medicare/timeline/pf_entire.htm (April 17, 2008).

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http://www.kff.org/medicare/timeline/pf_entire.htm (April 17, 2008).

¹² S. Christensen and R. Kasten, "Covering Catastrophic Expenses under Medicare," *Health Affairs*, (7)5: 79-93, Winter 1988; T. Rice, K. Desmond, J. Gabel, "The Medicare Catastrophic Coverage Act: A Post Mortem," *Health Affairs*, (9)3: 75-87, Fall 1990.

¹³ E. Drew, *Showdown: The Struggle between the Gingrich Congress and Clinton White House* (New York: Simon & Schuster, 1996); D. Smith, *Entitlement Politics: Medicare and Medicaid, 1995-2001* (Edison, N.J.: Transaction, 2002).

¹⁴ *1997 Annual Report of the Board of Trustees of the Federal Hospital Insurance* (Washington, 1997).

¹⁵ *2001 Annual Report of the Board of Trustees of the Federal Hospital Insurance* (Washington, 2001).

¹⁶ B. Biles, G. Dallek, A. Dennington, "Medicare+Choice After Five Years: Lessons for Medicare's Future" *The Commonwealth Fund*, September 30, 2002,
http://www.commonwealthfund.org/usr_doc/biles_M+Cafterfiveyears_562.pdf?section=4039 (April 17, 2008).

¹⁷ "Medicare: How Your Senator Voted. Roll Call On Historic Medicare Bill" *CBS News*, November 25, 2003.
www.cbsnews.com/stories/2003/11/25/politics/main585501.shtml (April 17, 2008).

¹⁸ *Medicare Advantage Fact Sheet* (Washington, D.C.: Henry J. Kaiser Family Foundation).
www.kff.org/medicare/upload/Medicare-Advantage-April-2005-Fact-Sheet.pdf (April 17, 2008).

¹⁹ *Medicare Chartbook* (Baltimore, Maryland: Centers for Medicare & Medicaid Services, July 2000).

²⁰ K. Davis, C. Schoen, M. Doty, K. Tenney, "Medicare Versus Private Insurance: Rhetoric and Reality", *Health Affairs*, Web Exclusive: w311-w324, October 9, 2002.

²¹ *Medicare Chartbook* (Baltimore, Maryland: Centers for Medicare & Medicaid Services, July 2000).
<http://www.cms.hhs.gov/TheChartSeries/downloads/35chartbk.pdf> (April 17, 2008).

²² R. Stevens, "Health Care Early 1960s," *Health Care Financing Review*, (18)2: 11-22, Winter 1996.