

The Health-Care Legacy of the Great Society

Paul Starr

The Medicare and Medicaid programs enacted in 1965—the largest and most durable health-care initiatives of the 1960s—exemplify the greatest and the worst aspects of Lyndon B. Johnson’s leadership and legacy. Johnson was instrumental in passing the legislation, and the programs it established have undoubtedly improved the financial security and access to medical care of the elderly and the groups among the poor eligible for coverage.

But Medicare and Medicaid have also created severe and lasting problems for both health care and government in the United States. So eager were Johnson and other Democratic leaders to placate health-care interest groups that the financing provisions, particularly for Medicare, sharply inflated medical costs, sowed doubt that a universal program was feasible, and distorted the allocation of public spending for decades to come. The legislation institutionalized two tiers of public health-care finance. Singling out seniors for special treatment encouraged them to regard themselves as a distinct interest group, more deserving than others in need. Establishing Medicaid as a separate program, to be run by the states, relegated the poor to a variable, lower tier of protection, with sharply restricted eligibility in the South and Southwest. The link between Medicaid and welfare eligibility increased the work disincentives of welfare. The complicated structure created by the 1965 legislation added to the complexity and administrative burden of the health-care system. In these and other ways, what some regard as high achievements of the Johnson years contributed to the gravest failings of America’s health-care and social-welfare systems.¹

In sheer cost, Medicare and Medicaid came to outstrip by a wide margin all other domestic programs dating from the Johnson years. While many other initiatives of that era were later ended or substantially altered, Medicare and Medicaid became all too entrenched in more or less their original form. Congress later did change some critical aspects of the programs, such as Medicare’s payment methods, but most of the central, structural features of the two programs still remain intact.

The policy experts who originally conceived Medicare hoped that it would develop through incremental expansion, as Social Security did, ultimately leading to a system of universal health coverage. Partly because of the decisions made at its inception, however, Medicare proved difficult to extend to other groups. Instead of leading to a universal system, the political forces generated by Medicare obstructed reform. When Democrats in 2010 finally passed a program for near-universal coverage, they did so over the resistance of the elderly, and they did not build on

¹ This article draws on arguments and evidence developed at greater length in Starr 2011a.

Medicare; rather, they extended Medicaid and private insurance. On taking control of the House of Representatives the next year, Republicans voted not only to repeal the 2010 legislation but also to replace the traditional Medicare program with a “premium support” for private insurance and to turn Medicaid into a block grant to the states. Progressives would still like to make the traditional Medicare program the basis for universal coverage, but “Medicare for all” faces political obstacles that, if anything, have grown with time. Half a century after they were enacted, the healthcare programs of the Johnson years continue to have an uncertain and contested legacy.

THE ORIGINS OF MEDICARE AND MEDICAID

The origins of Medicare and Medicaid lie in the peculiar sequence of development of social policy in the United States. The major European nations enacted health insurance programs for industrial workers in the late nineteenth and early twentieth centuries, typically in the same period when they established related programs for industrial-accident insurance, unemployment compensation, and old-age pensions. In the United States, however, a series of efforts to establish publicly financed health insurance met defeat. Between 1915 and 1919, after a successful campaign for industrial-accident insurance, Progressive reformers failed to secure passage of compulsory health insurance at the state level. In 1935, when Congress passed the Social Security Act, it provided for income protection during unemployment and in old age but not for protection against the costs of illness. Those choices reflected the urgent priorities and political pressures of the time: the Depression focused attention on unemployment, while the Townsend movement pressed for income relief for seniors. But the American Medical Association opposed publicly financed health insurance and threatened to sink the entire Social Security bill if it covered health care. In 1938, when some members of his administration sought to revive health insurance, Roosevelt retreated again in the face of opposition from the AMA and conservatives in Congress. The failure to enact a health insurance program early in the twentieth century then opened the way for the rise of employment-based private health coverage. That system was gaining a firm foothold by the late 1940s when Harry Truman became the first president to call for national health insurance. But Truman was decisively defeated by a coalition organized by the AMA and backed by business that attacked the proposal as “socialized medicine” and exploited the rising ideological tensions of the Cold War (Starr 1983).

As a result of these developments, the United States, unlike other advanced societies, introduced old-age insurance before health insurance and created a corps of policy experts and federal program executives whose vision for health care reflected their experience in initiating and building Social Security. Some members of this bureaucratic elite—such as Wilbur Cohen, the go-to expert in the field during the middle decades of the twentieth century—served almost continuously in the federal government from the New Deal through the 1960s (Derthick 1979; Berkowitz 1995). After Truman’s defeat on national health insurance, it was the Social Security policy experts who in 1951 proposed to add a limited hospital-insurance benefit for the elderly on Social Security. By the time the political winds shifted in a more liberal direction in the 1960s, the idea of a limited program of hospital insurance for seniors had taken on a life of its own.

No other country has created a separate health insurance system for the elderly; it is a peculiar American invention, established without a full appreciation of its political implications. To be sure, once employer-based insurance had taken root, a separate program for seniors had a

definite rationale. The elderly didn't fit into an employer-based model, and most couldn't afford to buy coverage, especially as Blue Cross moved away from community rating in the face of competitive pressures from commercial insurers in the early post-World War II decades. In that period, seniors also continued to be a relatively needy group, with a higher poverty rate than was true for the working-age population. The supporters of a hospital insurance program for seniors believed that integrating it into Social Security would give it immediate legitimacy. As the elderly had a right to their Social Security benefits earned by contributions during their working years, so they could now be understood to have earned a right to hospital insurance. All these considerations lent persuasiveness to the idea of introducing national health insurance for the elderly alone.

While Medicare grew out of the social-insurance tradition, Medicaid grew out of systems of public assistance for the poor. Before the 1930s, charity hospitals and clinics for the poor were established and financed at the state and local level, often as private, voluntary institutions. During the New Deal, however, the federal government began providing support for relief, and local welfare agencies began recognizing medical care as an "essential relief need." Some voluntary hospitals and clinics then billed welfare agencies for services previously provided for free, so the localities could shift some of the cost to the federal government. Gradually, a function that had been mostly private and entirely local became increasingly public and partly federal. In 1950 Congress enacted a small program of federal aid to the states for the medical costs of welfare recipients. This federal assistance was the direct antecedent of Medicaid.

In Congress the first effort to pass a health insurance program for seniors began in 1957 with the introduction of a bill by a Rhode Island representative, Aimee Forand. Recognizing the appeal of adding hospital insurance to Social Security, congressional opponents tried to preempt the idea in 1960 by enacting a program targeted to the elderly poor and run by the states. Known as Kerr-Mills for its two sponsors, both Democrats—Senator Robert Kerr of Oklahoma and Representative Wilbur Mills of Arkansas, the chairman of the House Ways and Means Committee—the program extended to the medically indigent elderly the earlier federal aid to the states for welfare recipients' medical care. Under the program, the federal government paid 50 percent to 80 percent of a state's costs for medically impoverished seniors. The lower a state's per capita income, the higher the share of its spending the federal government reimbursed.

Kerr-Mills, however, did not stop the political movement for what became popularly known as Medicare. John F. Kennedy made it a prominent issue in his 1960 presidential campaign, and public opinion polls indicated wide support for the measure. But despite the limited scope of the proposed coverage, the opposition from organized medicine and conservative Republicans was just as fierce as it had been to national health insurance. While President Kennedy was alive, a coalition of Republicans and southern Democrats blocked Medicare and many other liberal initiatives. As chairman of Ways and Means in the House, Rep. Mills was the single most formidable congressional obstacle to the hospital-insurance measure, though support for it was growing in his committee as Democrats were added in the early 1960s (Marmor 1973).

Mills's objections to the Medicare proposal concerned its fiscal ramifications. He was worried that increases in payroll taxes would eventually lead to a revolt against the whole Social Security system. In addition, while Social Security used wage-related contributions to pay for

wage-related benefits, there would be no such relationship between contributions and benefits in the coverage of hospital costs. Once a federal program paid the hospital bills of the elderly, there would also inevitably be demands to cover doctors' bills and other health-care expenses. In short, while not opposed to Medicare in principle, Mills wanted to prevent it from setting in motion a chain of consequences that he thought could ultimately destroy Social Security itself. He also did not want to support a bill until he was sure he would have the votes to pass it (Mills 1971, 1987; Zelizer 1998).

THE SHAPING OF THE LEGISLATION

After becoming president, Johnson used his mastery of Congress to push Kennedy's priorities, including Medicare. In 1964, the administration's allies added the hospital insurance proposal to a Social Security bill in the Senate, which passed it 49 to 44 (filibusters were rare in those days, except on civil rights). The House remained the obstacle. As taped White House telephone conversations show, President Johnson talked with Mills in June about expanding Medicare in the House to cover physicians' services, which the president referred to as an addition with "sex appeal." Although Johnson courted Mills relentlessly, insisting the congressman would get all the credit and the glory ("It will be the biggest thing you have ever done for your country"), Mills backed off and blocked the hospital insurance program from becoming law (Zelizer 1998; Blumenthal and Morone 2009). But the huge Democratic congressional majorities elected in 1964 shifted the odds in favor of Medicare, and Mills as well as some other prominent southern Democrats moved to support the legislation in the wake of the Democratic landslide.

In 1965 the great surprise lay in how broad a bill Congress adopted, covering not only the hospital costs of the elderly but also their physicians' bills (as Johnson had urged the previous year), as well as expanded services to the poor on welfare. The expansion, however, came about in a surprising way that made it appear to be a concession to conservatives, which in some ways it was.

As 1965 began, the AMA and Republicans were criticizing the Democrats' Medicare proposal not only because it established a form of compulsory insurance, but also on the grounds that a program limited to hospital coverage was too meager. Many Democrats, including Mills, were also worried that Medicare would disappoint the elderly if it failed to cover doctors' bills. In February 1965, the ranking Republican on Ways and Means, John Byrnes of Wisconsin, offered a plan called Bettercare: a voluntary insurance program for the elderly, partly subsidized out of general revenue, which would cover bills from physicians, hospitals, and nursing homes. Byrnes's model was the Federal Employees Health Benefit Plan (the original model for what are now called insurance exchanges). In what came off as a grand synthesis, Mills combined three elements: the Democrats' compulsory hospital insurance program, which became Part A of Medicare; the Republican voluntary program, which would cover physicians' bills and become Medicare Part B (though without private insurers); and an expansion of the Kerr-Mills program (no longer restricting it to the elderly poor), the approach favored by the AMA, which became Medicaid. This "three-layered cake" was the basis of the legislation—the Social Security Amendments of 1965—passed by both houses of Congress and signed into law by President

Johnson on July 30 in a ceremony at Independence, Missouri, in honor of the 81-year-old former President Truman.

Who was responsible for the final shape of the 1965 legislation? Although some historical accounts focus entirely on Mills, the most influential analysis has emphasized what Martha Derthick (1979) calls “the dynamic of the two Wilburs”—not just Mills but also Wilbur Cohen, who as under secretary of Health, Education, and Welfare represented the Johnson administration in shepherding the bill through Congress. But in a 2009 book *The Heart of Power*, David Blumenthal and James A. Morone claim that Johnson himself played a co-equal role with Mills: “We now know—through extensive White House telephone tapes and memos—that LBJ was in on the legislative coup. He cooked up the entire business with Mills—always promising that Wilbur Mills would reap all the credit. Mills later acknowledged as much: ‘We planned that, yes. Oh, yes’” (Blumenthal and Morone, 164).

But Blumenthal and Morone overstate their case. Consider the quotation from Mills—“We planned that, yes. Oh, yes”—which Blumenthal and Morone quote twice as if it proved their argument. The quotation comes from a series of oral history interviews that Mills gave the LBJ Presidential Library, but the full transcript does not bear out the claim that Mills was talking about Johnson when he said “We planned that.” Asked “where the idea of combining... three different proposals” had come from, Mills said: “I think it came from us on the committee. ... Oh, I developed the whole thing in the committee. I mean, we did, with the help of the staff people, by my questions and other questions of other members we developed the idea and the program.” After noting that Cohen had reacted with “amazement” to the idea of combining the three proposals, the interviewer asked whether the bill was “pieced together,” but Mills replied, “No, it was planned. ... We planned that, yes. Oh, yes.” (Mills, 1987) Contrary to what Blumenthal and Morone say, there is no indication that the “we” in that sentence included Johnson. “We” plainly refers to the members of the committee. When Mills elsewhere gives credit to Johnson, he credits Johnson’s general efforts in pushing the legislation.

The telephone conversations cited by Blumenthal and Morone date from the spring of 1964, a year before the law passed Congress, and show only that Johnson encouraged Mills to add coverage of physicians’ services, not that Johnson had anything to do with the idea of co-opting the Republican and AMA proposals and adding them to the Democrats’ hospital insurance bill. Since Byrnes introduced his proposal in February 1965, the conversations in 1964 could not have anticipated how shrewd it would be politically to add physicians’ services on the basis of a subsidized, voluntary program. If Johnson “cooked up the entire business with Mills,” Blumenthal and Morone do not have the evidence to prove it.

Moreover, the three “layers” of the 1965 legislation, each with its own separate financing, make sense from the standpoint of concerns that Mills, not Johnson, raised from the beginning of the Medicare debate. Mills wanted to prevent overreliance on the payroll tax, and that is what his final bill achieved; the federal share of Medicare Part B and Medicaid would come out of general revenues. By enacting those parts of the legislation at the same time, Mills also walled in Medicare Part A, limiting future demands for program expansion on a social-insurance basis. In that respect, Mills was successful, and the liberals who thought Medicare would lead to national health insurance were outflanked and beaten. Just as Mills wanted, the United States has not

extended Medicare into a universal health system paralleling Social Security. But in a larger sense, Mills failed. While he limited the scope of health insurance financed by payroll taxes, he approved payment methods and other policies that produced the long-term fiscal damage that he was trying to avoid.

From a short-term political perspective, Mills's synthesis was a success. The incorporation of the Republican and AMA proposals gave the legislation a bipartisan air. Although only 10 Republicans in the House voted for the bill on the critical motion, many more joined in on the final roll call, and it passed 313 to 115. A year later, on July 1, 1966, the start-up went off without a hitch: The doctors and hospitals cooperated, and there were no waiting lines for care, as some had feared. Moreover, the ideological as well as interest-group resistance disappeared, partly because the doctors discovered how much money they could make from Medicare and no longer had any interest in rousing popular opposition to "socialized medicine."

THE COSTS OF POLITICAL ACCOMMODATION

Mills's maneuver has generally been regarded as a brilliant legislative coup and a liberal victory. It was a brilliant coup, but not exactly a liberal one.

By establishing separate and unequal programs for the elderly and the poor—one piggy-backed on the shoulders of Social Security, the other shackled to public assistance ("welfare")—the 1965 legislation created two moral frameworks for public financing of healthcare. The benefits for the elderly in the upper tier have been understood as an earned right, even though seniors have never paid enough in payroll taxes to earn their insurance coverage (in fact, the first wave of beneficiaries didn't pay anything). That moral claim has nonetheless given Medicare political security, making it unthinkable—at least until recently—to rescind the program, cap it, or cut it in a recession. In contrast, the recipients of Medicaid, like welfare, are not regarded as having earned a right to coverage, and that lack of a moral claim has made Medicaid politically insecure and more vulnerable to cutbacks.

The legal provisions for the two programs reflect this difference in their moral underpinnings. While Congress established Medicare on a national basis, it left Medicaid to the vagaries of the states; Medicare provided the same benefits to the elderly wherever they lived, but Medicaid did not do the same for the poor. States did not have to participate in Medicaid (Arizona did not establish a Medicaid program until 1982), and they had wide discretion about eligibility criteria, the scope of covered services, and payments to health-care providers. According to a formula favoring the poorer states, the federal government paid between 50 percent and 77 percent of a state's Medicaid expenditures, but the states in the South and Southwest, bearing the smallest share of costs, nonetheless restricted eligibility the most severely. The federal law originally linked eligibility for Medicaid to eligibility for welfare, thereby limiting the program to the poor who fit into the eligible categories: the aged, blind, disabled, and families with dependent children. Single, able-bodied adults couldn't get Medicaid coverage no matter how poor they were. If a state agreed to run a Medicaid program, it had to cover all welfare recipients (and after 1972 all recipients of Supplemental Security Income), though it could also receive federal funds for covering the poor with incomes up to 133 percent of the state's cutoff for welfare as long as

they fell into the eligible categories. But because states varied in their criteria for welfare and their willingness to cover others among the poor, many of the poor who could qualify for Medicaid in, say, New York could not qualify in Mississippi. As a result, the proportion of the population without health coverage remained far greater in the more conservative states, typically those in the South and Southwest; nationally, 60 percent of Americans living below the poverty level remained ineligible for Medicaid nearly two decades after it was enacted (Davis and Rowland 1983). The more liberal states were also more liberal in the range of services they covered. Even in those states, however, the lesser moral standing of Medicaid was reflected in payment rates to doctors that were so low that many refused to take Medicaid patients.

In a universal system, people do not have to be poor enough to qualify for health care. But because eligibility for Medicaid was tied to welfare, it created a problem analogous to job lock. Just as many people found themselves unable to quit a job to start a business of their own because they would lose health benefits, so many welfare beneficiaries faced the loss of health coverage if they took the kind of job typically available to them—low-wage work without health insurance. Consequently, Medicaid recipients who suffered from chronic health problems or had a sick child had a strong incentive not to take a job. The Medicaid-welfare link, according to one study, increased the welfare rolls by about one-fourth (Moffitt and Wolfe 1992).

Although Medicare was universal among the elderly, its benefit package was not generous. To pass the legislation in the Senate, the Johnson administration and party leaders fought off efforts by liberals to add coverage of prescription drugs and catastrophic medical costs. Seniors who could afford supplemental insurance would buy it. But the limited benefit package in Medicare would leave many lower-income elderly exposed to substantial financial burdens from illness, and the limitations would prove exceedingly difficult to correct in future years.

While the scope of benefits was limited, Medicare's financing provisions for the services it did cover were all too generous. Spooked by the long opposition of the AMA to a federal program and anxious to have the full cooperation of doctors and other health-care interests, the Johnson administration and Congress failed to impose any cost restraint on health-care providers. The Medicare legislation explicitly denied the government any power to set rates: "Nothing in this title shall be construed to authorize any federal officer . . . to exercise any supervision or control over the . . . compensation of any institution . . . or person providing health services" (Sec. 102A). Following the practice of Blue Cross (which the hospitals had originally established), Medicare Part A and Medicaid paid hospitals according to their costs. The higher a hospital's costs, the more it would be paid—a surer way of promoting healthcare inflation could not have been devised. Any hospital that cut its cost would be reimbursed less. Medicare Part B paid doctors their "customary" fees, assuming them to be in line with "prevailing" rates in their area or to be "reasonable." But the legislation set no standard for reasonableness, and it required the government to outsource claims payment to the insurance industry. Acting as "carriers," merely passing along the costs to the government, the private insurers had no incentive to exert any control.

As the administration's representative in the negotiations over Medicare, Cohen bears primary responsibility for the legislation's abject concessions to the healthcare industry. Why did the legislation pay hospitals according to their costs? Because, Cohen later explained, that is what

the American Hospital Association wanted (Cohen 1984). Taped White House conversations during the congressional proceeding show that Cohen kept Johnson informed about important financing provisions. When Cohen updated the president about decisions in Ways and Means on March 23, 1965, Johnson asked whether the bill would allow a doctor to “charge what he wants”:

Cohen: No, he can't quite charge what he wants to ... What the Secretary of HEW would have to do is make some kind of agreement with somebody like Blue Shield, let's say, and it would be their responsibility ... [to] regulate the fees ... of the doctor. ... What he [Mills] tried to do is be sure the government wasn't regulating the fees directly, that you deal with the individual doctor. ... This intermediary, the Blue Shield, would have to do all the policing so that the government would have its long hand —

LBJ: All right, that's good. (Beschloss 2001, 241)

But it wasn't good to turn over responsibility for the fees to private insurers and give them no incentive to rein in those charges. Like hospital costs, doctors' fees surged immediately after Medicare went into effect in 1966. In the final decisions on the bill, the Johnson administration lost on only one issue related to the cost of the program. Fulfilling a promise to the AMA, Mills insisted that hospital-based specialists such as pathologists, radiologists, and anesthesiologists, who were typically paid by salary at the time, instead be paid fee-for-service under Medicare Part B—a provision that led to the vast enrichment of those specialties in years to come.

As ingenious as it was as a political compromise, Mills's three-layered cake and related provisions added a tremendous amount of complexity to health-care finance. The law resulted in four different systems for financing health care for the elderly. Medicare itself was divided into two parts working on different principles. Its limited benefit package led many of the elderly to buy private supplemental insurance. And if they were poor enough or spent down their assets and ended up in a nursing home, seniors would also be covered by Medicaid. To be sure, Medicare's administrative costs were lower than those of private insurance because the government didn't do any marketing, medical underwriting, or even much questioning of claims—it just paid them. But like the multiplicity of private insurance plans, the multiplicity of government payment systems created under the 1965 legislation inflicted an enormous paperwork burden on patients and families and required providers to hire legions of administrative personnel. Critics of a single system of national health insurance had said it would be top-heavy with bureaucracy, but the more unified or standardized systems in other advanced countries have much less administrative complexity. It was political compromise in America that made healthcare in the United States a bureaucratic nightmare.

From the start, the costs of Medicare and Medicaid proved to be much higher than the Johnson administration projected (Derthick, 1979). In his oral history interviews in 1987, Mills said the biggest mistake had been underestimating the cost, and he cited what happened with Medicaid: “We were told by Bob [Myers], the actuary, that the cost of Medicaid over Kerr-Mills in the first year would be \$250 million, nationwide. It was \$250 million in New York State alone” (Mills 1987).

Over the next several decades, Medicare and Medicaid skewed public spending *toward* health care and *within* health care. The programs resulted in the medicalization of social-welfare

expenditures. Medicaid, which accounted for less than 5 percent of means-tested program outlays in 1966, represented 30 percent by 1972 and 40 percent by 1985 (Burtless 1986). Together, Medicare and Medicaid soaked up so much of the public budget at both the federal and state levels that other social programs were starved for funds. Within health care, both programs also heavily favored technologically intensive, hospital-based services over public health and preventive care and promoted the procedurally oriented medical and surgical specialties over primary practice. Medicare, as Rick Mayes and Robert A. Berenson put it, became “the leading vehicle for the federal government’s subsidization and massive expansion of the U.S. healthcare system” (Mayes and Berenson 2006). For example, Medicare reimbursement of hospitals included the costs of capital expenditures, and because Medicare beneficiaries represented roughly 40 percent of hospital revenue, the program defrayed 40 percent of the cost of any new hospital investment. The federal government did not cover 40 percent of a new school building that a local district wanted to build, but it did pay for 40 percent of a new wing built by the local hospital, no questions asked. The contrast in the physical plant and technological resources of hospitals and schools in the United States is partly the result of this difference in policy.

The 1965 legislation produced these effects on government spending and public investment not only because of its financing provisions, but also because of the political forces the program generated. Although there had not been much of a senior lobby before 1965, Medicare encouraged its development; the American Association of Retired Persons (AARP) built its membership through the sale of Medigap insurance. For-profit hospitals had been of minor importance before 1965, but Medicare’s payment provisions encouraged the conversion of nonprofit into for-profit hospitals and the growth of the commercial health-care industry (Starr 1983). Medical schools became the center of sprawling networks of high-technology health care. Together with seniors, the hospitals, medical schools, doctors, and others who profited from Medicare represented an overwhelming force favoring the persistence of the program’s original structure.

POLICY CHANGE AND STRUCTURAL PERSISTENCE

The legacy of any law, program, or policy depends on how deeply it becomes entrenched. By “entrenchment” I don’t mean only institutionalization—that is, the adoption of formal regulations, administrative routines, and other practices and norms concerned with implementing a policy. Entrenchment also depends on whether a policy generates effects on politics and society that feed back positively or negatively on the policy itself (Pierson 2004; Hacker 2002). A policy or program becomes more fully entrenched when 1) it develops self-reinforcing support from well-organized stakeholders; 2) it becomes embedded in social relationships and expectations; 3) private organizations create complementary arrangements and enterprises (for example, supplemental insurance); and 4) additional layers of law and policy are built on top of the original program and become interdependent with it. On all these dimensions, Medicare and Medicaid became strongly entrenched—so strongly that most of their central features remain intact nearly a half-century later, despite important changes.

Consider the legacies left by five aspects of the original legislation: 1) the basic duality between Medicare and Medicaid; 2) the complexity of financing arrangements; 3) the fee-for-service insurance model and methods of payment; 4) covered benefits; and 5) eligibility rules.

1. *The basic duality.* The two programs continue to be separate, and no significant effort has been made to consolidate them. Medicare remains a universal federal program, Medicaid a means-tested, federal-state program. The former still falls within a social-insurance framework; the latter within a public-assistance framework. The financing of Medicare Part A continues to come from payroll taxes, which flow into a dedicated trust fund, while the money for Medicare Part B comes from general revenues and premiums paid by the beneficiaries. Although the exact provisions have changed, Congress continues to set a floor of requirements for Medicaid and to share some of the cost if states provide wider coverage and additional benefits above that floor. Depending on political ideology and partisan control, states vary sharply in the share of their population they cover, and thanks to the Supreme Court decision on the Medicaid provisions of the Affordable Care Act (ACA), those state-to-state variations have become even more extreme.

[skip 1 line]

2. *Program complexity.* Subsequent legislation has, if anything, made the system even more complex than it was at the start. In addition to the four separate arrangements for paying for seniors’ health care created as a result of the 1965 law, Congress created a fifth in 2003 when it added a prescription-drug plan (Medicare Part D) on a different basis from Parts A and B. The establishment of the State Children’s Health Insurance Plan in 1997—which states could run as a separate program, an expansion of Medicaid, or a combination of the two—added one more layer to government finance of health care. The insurance exchanges and affordability subsidies under the ACA represent another financing layer. This is not to say that Medicare prescription-drug coverage, the children’s program, or the new subsidies are ill-conceived. The pattern, however, has thus far been not to consolidate but to add layer upon layer to the financing system, partly to avoid disturbing the interests in established programs. Health policy in the United States is a case of path-dependent policy development run wild.

[skip 1 line]

3. *Fee-for-service insurance and methods of payment.* Congress modeled Medicare and Medicaid on the private, fee-for-service insurance system prevailing at the time the legislation was enacted. Medicare's payment provisions—retrospective reimbursement of hospital costs and payment of reasonable charges to doctors—followed the practices that Blue Cross and Blue Shield had established at the behest of the providers. In the language of institutional analysis, the structures of Medicare and the dominant form of insurance were “isomorphic.” In the 1980s, however, seeking to control expenditures, Congress changed Medicare's payment methods, and because the changes held down federal spending, Congress continued to maintain Medicare in its traditional form—that is, fee-for-service coverage by any willing provider—even as that system virtually disappeared from private insurance. In this respect, a change in policy has contributed to structural persistence in Medicare and a growing divergence between Medicare and private insurance.

Originally, Medicare had no provision for making prospective, monthly payments for enrollees in prepaid group practice plans, the forerunners of “health maintenance organizations” (a term introduced in 1971). HMOs were an anomaly in Medicare's fee-for-service universe, where hospital and doctors' services were paid separately and no organization had any incentive to limit hospital use. Even when Congress provided for Medicare to pay HMOs on a capitation basis in the 1970s, the plans continued to enroll only a small share of Medicare beneficiaries. Although some state Medicaid programs began shifting the poor into HMOs, scandals in California and elsewhere initially set back that movement as well.

The biggest change in Medicare payment came in 1983, when in the midst of a Social Security financing crisis, the Reagan administration proposed and Congress approved a shift to paying hospitals prospectively per hospital stay according to the patient's diagnosis, instead of retrospectively on the basis of their costs. Yet even then, Medicare continued to pay hospitals retrospectively for the costs of capital investments and graduate medical education. Initially, the new system was a boon to hospitals, which made huge profits from it. Those high returns then led Congress to cut payment rates, slowing Medicare's expenditure growth. (Mayes and Berenson 2006). In the belief that prospective hospital payment had been a success, Congress went on to introduce a parallel reform in the payment of physicians. Adopted in 1989 and carried out three years later, the new method replaced the payment of “reasonable” charges with a fee schedule based on an analysis of the resources required for different services (a “resource-based relative value scale,” or RBRVS).

This sequence of developments opened up a gap between Medicare and private insurance in two respects. First, Medicare payment rates began to be significantly lower than those paid by private insurers to both hospitals and doctors. And, second, partly because hospitals were able to charge more for privately insured patients, driving up premiums, employers and insurers sought ways to reduce their own costs and began promoting HMOs as well as a wider range of alternatives to traditional insurance that came to be called “managed care.” By the mid-1990s, the managed-care revolution was in full swing in the private sector.

In response to fiscal pressures, some states also moved toward greater use of managed care in their Medicaid programs. The Clinton administration encouraged that change, offering states waivers from federal requirements if they used the savings from managed care to extend Medicaid eligibility to people previously excluded from the program (Smith and Moore

2008). Managed-care plans made some inroads in Medicare as well in the early 1990s, and when Republicans took control of Congress in 1995, they argued that the traditional Medicare program was a “dinosaur” and needed to be “modernized” by turning it into a voucher system for private insurance. A voucher worth a fixed amount of money, however, would no longer ensure access to the full benefits that Medicare had previously provided. Similarly, Republicans wanted to turn Medicaid into a block grant to the states, which would effectively end the entitlement of the eligible poor to specific benefits under federal law. In a historic confrontation with the Republican Congress, President Clinton defeated those efforts. But in 2003, Republicans in control of both Congress and the White House passed the Medicare Modernization Act, creating a prescription-drug benefit that would be provided entirely through private insurers. The same legislation sharply increased Medicare payments to private managed-care plans; in fact, as of 2008 Medicare was paying private plans \$1,100 more per beneficiary than it would have cost the federal government if those beneficiaries had remained in traditional, fee-for-service Medicare (Medicare Payment Advisory Commission 2008). The private insurers were using some of the extra money to provide extra benefits to entice seniors to enroll, and about 25 percent of Medicare beneficiaries did make that shift. Nonetheless, with three-quarters of the elderly in the traditional program, the policy legacy of Medicare’s original structure remained strong.

[skip 1 line]

4. *Covered benefits.* Like the reliance on fee-for-service payment, the original limits of the Medicare benefit package—particularly the omission of prescription-drug and catastrophic coverage—reflected patterns of private insurance that were common in the 1960s. But while the scope of private, employer-based coverage expanded in the ensuing decades, it proved difficult to make corresponding changes to Medicare. Many of the affluent elderly purchased supplemental coverage or received retiree health benefits from companies they had worked for. Consequently, they had little interest in broader Medicare benefits, especially if they had to pay more for them.

The difficulties of expanding the Medicare benefit package were nowhere better illustrated than in the passage of the Medicare Catastrophic Coverage Act of 1988 and its repeal the following year. The chief source of hostility to the law, which provided coverage for prescription drugs as well as catastrophic medical bills, lay in its financing provisions. President Reagan had insisted that he would not sign the legislation if it included a tax increase, and to comply with that demand and avoid adding to the deficit, Congress required seniors to pay the entire cost of the added coverage through two kinds of premiums. A flat monthly premium of \$4 to be paid by all seniors would pay for one-third of the program’s cost, while the remainder would be covered by an additional, income-related premium due from seniors who paid income taxes of at least \$150. These premiums would take the form of a surtax of 15 percent on their tax liability in 1989, up to a maximum of \$800 for individuals and \$1,600 for couples; in 1993 the surtax would rise to 28 percent, capped at \$1,050 for individuals and \$2,100 for couples. At the time the law passed, the media gave little attention to the financing provisions. But once the more affluent elderly realized that they would have to pay a surtax for a program that many of them did not need, there was a sharp political backlash, and Congress repealed the program (Himelfarb 1995).

During the 1990s, proposals to expand Medicare benefits focused primarily on the costs of prescription drugs, which were rising sharply. In 1993, as part of his comprehensive reform

plan, President Bill Clinton proposed adding prescription-drug coverage to Medicare, and he introduced a new proposal for prescription drugs during his second term, again without success. After Al Gore took up the issue in his 2000 presidential campaign, George W. Bush also committed himself to adding prescription-drug coverage to Medicare, insisting that he would succeed where the Democrats had failed. For Bush, prescription-drug coverage served as a way to revive what had all along been the Republican alternative to Medicare—subsidized private insurance—and to build political support among the elderly, a crucial constituency for his political fortunes given the pivotal role of Florida in the 2000 election and its potential importance in 2004. But the initial reaction of seniors to the program passed by Congress in 2003 was not favorable. Under the original provisions, seniors would pay \$35 in monthly premiums, an annual deductible of \$250, one-fourth of the cost of drugs between \$250 and \$2,250, *all* of the cost from \$2,250 to \$5,100 (the so-called “donut hole”), and 5 percent of the cost above that level. In other words, out of the first \$5,100 in yearly drug costs, they would have to pay \$4,020 (79 percent) out of pocket. The legislation also barred them from purchasing supplemental “wraparound” coverage to reduce any of this amount (Oliver, Lee, and Lipton 2004). At the time Bush signed the bill, polls showed only 26 percent of seniors approved of the program, with 47 percent against and the rest undecided. Among the public as a whole, opinion ran against the legislation 56 percent to 39 percent (Oliver, Lee, and Lipton 2004). In a poll in January 2006, when the program went into effect, 77 percent of seniors said it was “too complicated” (Hamel, Deane, and Brodie 2011). But unfavorable polls did not dissuade the Republicans from going through with the program, and the prescription-drug benefit has since been provided entirely by private insurers.

Nursing-home care was another area where Medicare benefits were originally limited, and that limitation has remained. As a result, instead of being protected against the financial risks of long-term care on a social-insurance basis, the elderly must spend down their assets to qualify for coverage under Medicaid. (The ACA originally included a voluntary, governmental program for long-term care insurance, but Congress repealed it in 2012 after the Obama administration declared that it could not carry it out.) Leaving long-term care to Medicaid has had political consequences. At the state level, nursing-home interests often have more influence in the budgetary process than do the low-income young families on Medicaid or the community health centers and other providers that serve them. Nonetheless, Medicaid has in one respect been more generous than Medicare. The benefit package has generally been broader, particularly in the more liberal states, though other factors, such as low payment rates, often impede the effective access of the poor to medical care.

[skip 1 line]

5. *Eligibility rules.* In 1972 Congress extended eligibility for Medicare to two groups below age 65: end-stage renal disease patients (who faced a life-or-death need for kidney dialysis), and people with disabilities who had qualified for Social Security disability insurance for two years. At that time, these steps were generally thought to be interim measures because both President Nixon and congressional Democrats were offering proposals for national health insurance. But the moment for bipartisan agreement on universal coverage was lost when the two parties failed to settle their differences before Nixon’s fall from power.

Since 1972, no major changes have been made in Medicare eligibility. In the late 1990s, Clinton proposed allowing 55- to 64-year-olds to buy into the Medicare program if they had no

other coverage, while a national commission on Medicare in 1997 called for an increase in the Medicare eligibility age to 67. But nothing was done either to lower or to raise the age of eligibility.

In recent decades, the growth in public coverage has come through Medicaid and the State Children's Health Insurance Program (SCHIP). In 1984, largely through the work of Rep. Henry Waxman, chairman of the health subcommittee on Energy and Commerce, Congress began extending Medicaid coverage for low-income children and pregnant women. Year by year, Congress extended coverage a little further, typically first as an option for the states and then as a mandate. The biggest steps came in 1989 and 1990 when Congress mandated that states phase in Medicaid coverage of all children in families with incomes beneath the federal poverty level and all children up to age five in families with incomes up to 33 percent above the poverty level (Smith and Moore 2008). These requirements reduced some of the state-to-state variation in Medicaid eligibility and weakened the Medicaid-welfare link. That link was further reduced with welfare-reform legislation in 1996, which enabled those cut off from cash benefits to retain eligibility for Medicaid. The enactment of SCHIP in 1997, another means-tested expansion focused on the young, provided access to health coverage for children in families who earned too much to qualify for Medicaid but not enough to afford private insurance. Unlike Medicaid, SCHIP was set up not as an entitlement but rather as a program with a fixed budget.

[skip 1 line]

The introduction of prospective payment in Medicare and the expansion of eligibility for Medicaid are the most important changes in those programs since 1965. But on the whole, the institutional structure of Medicare and Medicaid has been remarkably stable. The full range of mechanisms of entrenchment mentioned earlier has been at work: the creation of strong stakeholder interests in the status quo; socially embedded expectations, as individuals and institutions have come to rely on the programs; complementary businesses, such as supplemental insurance, which have helped to support and wall in the programs; and layers of additional law and policy.

I am not arguing that change is impossible. On the contrary, change will ultimately be inevitable because of the underlying problems of cost and coverage that the programs have aggravated or failed to correct. From 1970 to 2009, health care expenditures jumped from 7 percent to 17.7 percent of gross domestic product in the United States—an increase that was out of line with the experience of the other rich democracies, where costs rose but still averaged only 9.3 percent of GDP (OECD 2013). Over the same four decades, the proportion of Americans without health coverage increased from about 10 or 12 percent to 16.7 percent (Starr 2011a; U.S. Bureau of the Census 2010). Rising costs contributed to the growth of the uninsured population; as health-care costs increased while median income stagnated, the number of Americans unable to afford coverage went up. That, in turn, increased the demand for government intervention. Medicare and Medicaid have actually been cheaper than private insurance; still, Americans pay more in taxes for their limited public programs than the citizens of all other nations pay for national health insurance. As two critics of the American health-care system point out, Americans have been “paying for national health insurance—and not getting it.” (Woolhandler and Himmelstein, 2002)

Thanks to slower than anticipated cost increases since the passage of the ACA, the projections of future spending on Medicare and Medicaid have dropped sharply. If the rate of

spending growth since 2010 continues over the long term, the fiscal pressures created by the two programs will dissipate. But spending slowed in the 1990s only to grow again, and it is a brave forecaster who will take the slow growth from 2009 to 2013 as proof that the health-cost beast has been tamed. More likely, with institutions thus far little changed, the long-run patterns will return, and with them the sharp divisions between Republicans and Democrats over how to respond. In the face of Republican efforts to turn the programs from defined-benefit to defined-contribution systems, Democrats will face hard choices. To defend the programs, they will have to change them, imposing stricter controls on payment, perhaps extending them to the system as a whole to avoid widening disparities between public and private payers (see Starr 2011b).

THE LIVING POLITICAL LEGACY

In the early 1970s under President Nixon, Democrats and Republicans came close to agreeing on a plan for universal health insurance. But in the following two decades, the divisions between the two parties on health-care reform widened until they took positions in sharp contradiction to each other. In 1993 Clinton proposed a system that would have made health insurance a right of all Americans. Two years later, led by Newt Gingrich, Republicans proposed turning Medicare into a voucher and Medicaid into a block grant, which would effectively have ended the rights to health benefits that at least some Americans had enjoyed under federal law.

Much the same pattern unfolded under President Barack Obama. In 2010 Democrats passed the ACA, which at the time was expected to extend coverage to about 32 million people without insurance—half of them through an expansion of Medicaid, half through subsidized private insurance coverage to be provided through new state-based insurance exchanges. But after taking control of the House of Representatives in 2011, Republicans voted to repeal the ACA and to end the earlier federal health entitlements. As in 1995, they sought to replace Medicare with a “premium support” for private insurance and Medicaid with a block grant to the states—policies that would allow the federal government to wash its hands of the problem of health-care cost containment. Blocked from achieving their goals at the federal level, Republicans were nonetheless able in many of the states to prevent Medicaid from being expanded and to enact laws interfering with enrollment in the insurance exchanges.

Although the two parties’ positions are antithetical, they do have one thing in common: Neither party has recently proposed to expand Medicare or to create a system for the under-65 population on a social-insurance basis. In that respect, the legacy of Medicare has fallen short. In the 1960s, many Democrats hoped that they would be able to achieve with Medicare what they had achieved with Social Security: start out with a program that offered limited benefits and didn’t cover everyone, but gradually raise the standards and expand the coverage until the program provided a decent floor of protection for everyone. But the Social Security analogy proved to be wrong.

From its establishment in 1935, Social Security was well suited to incremental expansion. The generation that initially entered the program—many of whom had lost their savings during the Depression—received an especially good deal in retirement income, and every time Congress extended the program to cover additional workers, contributors increased faster than recipients,

improving the program's finances. Social Security was also entirely compatible with private employer pensions; the program provided a base retirement income, which pensions and individual savings could supplement. This experience suggested health insurance could also follow an incremental path.

Yet the 1965 legislation establishing Medicare did not create the same favorable conditions for program expansion. The failure to build in cost controls at the inception of the program led many people to conclude that a universal program built on Medicare's principles would be fiscally irresponsible. Medicare encouraged seniors to see themselves as a separate group with interests morally superior to those of the poor on Medicaid. The growth of supplemental insurance led the more affluent elderly to resist broader benefits, at least if they had to pay for them on a progressive basis. Together with the federal tax expenditures for employer-provided insurance, Medicare helped to create a large bloc of voters who were unaware how much of a public subsidy they received and who believed that other people shouldn't expect government to pay for their health care. In short, federal policy toward health insurance exhibited a pattern that was the reverse of Social Security. Instead of leading step by step to a universal system, incrementalism worked against it.

Paradoxically, although seniors like Medicare—in fact, they are the age group most satisfied with their health insurance (Hamel et al. 2011)—they are also the most resistant to a universal, public program. In 2008, a national survey by the Harvard School of Public Health and Harris Interactive asked whether the health-care system would be better, worse, or about the same if the United States had “socialized medicine.” Among those who said they understood the term, there was a striking difference in responses by age. Fifty-five percent of the youngest group—18 to 34 years old—said socialized medicine would be better, while 30 percent said it would be worse. Among the 35- to 64-year-olds, 45 percent said it would be better, while 38 percent said it would be worse. Just one age group had a majority against socialized medicine—the one age group that, according to conservatives' definition of the term, has socialized medicine: 57 percent of people over age 65 said it would be worse, while only 30 percent thought it would be better (Blendon and Benson 2011).

The Affordable Care Act was not socialized medicine; it was an effort to fill in the holes of the existing insurance system with a minimum of disruption to established institutions and the protected public. But much of the protected public could never be won over to a program that they perceived as primarily benefiting the poor and minorities. No age group was more opposed to the Affordable Care Act than the elderly. Indeed, in some polls, they were the only age group opposed to the law; a Gallup poll in June 2010 found 60 percent of seniors saying the adoption of reform was a “bad thing,” while 57 percent of 18- to 29-year-olds and a plurality of other age groups said it was a “good thing” (Saad 2010). Beginning with Sarah Palin's “death panel” scare in 2009, Republicans and conservative organizations played on the fears of the elderly that health-care reform would hurt them and during the campaign ran ads accusing the Democrats of cutting Medicare. Then after winning the 2010 election—thanks in part to a 21-point swing toward the GOP among elderly voters—Republicans in the House of Representatives turned around and voted to end the traditional Medicare program altogether, beginning with people turning 65 in 2022. Under the 2011 House Republican premium-support plan, according to the Congressional Budget Office, the typical 65-year-old in 2022 would pay twice as much a year

out of pocket as under current Medicare—\$12,500 compared with \$6,150 (CBO 2011). Subsequent iterations of the Republican proposals backed away from eliminating the traditional public Medicare program, but they continued to call for gradually raising the age of eligibility for Medicare to 67, without any measure to replace coverage for 65- and 66-year-olds.

For thirty years after the adoption of Medicare and Medicaid, Republicans and Democrats cooperated in sustaining the programs (Oberlander 2003). Although that politics of consensus broke down in 1995, Clinton's success in defending the programs from Gingrich's attacks seemed to reassert the earlier view that the basic policies were too popular to be overturned. But the Republicans' revival of efforts to eliminate the health-care entitlements in 2011 suggests that at some point when their party controls both Congress and the presidency, they may well end the commitments that the United States made in 1965.

Those commitments were an extraordinary step in a country that had so long resisted making the cost of health care a public responsibility. But that does not excuse the mistakes made by Johnson, Mills, and other Democrats when they passed Medicare and Medicaid. Assessing Johnson's role, Blumenthal and Morone write, "He stands alone as the most effective healthcare president in American history" (Blumenthal and Morone 2009, 205). If the standard of judgment is only the ability to pass legislation, Johnson deserves that praise. But if the standard is whether the legislation adopted serves the nation's long-run interest, the historical judgment cannot be so generous. The Medicare and Medicaid programs helped to give the United States the most costly and inequitable health-care system in the advanced democracies. There can be no exempting Johnson or his administration from responsibility for the resulting damage to the public welfare and the national interest.

References

- Berkowitz, Edward D. 1995. *Mr. Social Security: The life of Wilbur Cohen*. Lawrence, KS: University Press of Kansas.
- Beschloss, Michael, ed. 2001. *Reaching for glory: Lyndon Johnson's secret White House tapes, 1964-1965*. New York: Simon & Schuster.
- Blendon, Robert J., and John M. Benson. 2011. Attitudes about the U.S. health system and priorities for government action. In Robert J. Blendon et al., *American public opinion and health care*. Washington, DC: CQ Press, 39-59.
- Blumenthal, David, and James A. Morone. 2009. *The heart of power: health and politics in the Oval Office*. Berkeley, CA: University of California Press.
- Burtless, Gary. 1986. Public spending for the poor: Trends, prospect, and economic limits. In Sheldon H. Danziger and Daniel H. Weinberg, eds., *Fighting poverty: What works, what doesn't*. Cambridge, MA: Harvard University Press.
- Cohen, Wilbur H. 1984. Medicare: 1965-1985-2000. Speech at conference on "Medicare reaffirming the vision, retooling the instrument," Woodrow Wilson School of Public and International Affairs, Princeton University. November.
- Congressional Budget Office (CBO). 2011 Long-Term Analysis of a Budget Proposal by Chairman Ryan. April 5.
- Davis, Karen, and Diana Rowland. 1983. Uninsured and underserved: Inequities in health care in the United States. *Milbank Memorial Fund Quarterly/Health and Society* 61: 149-76.
- Derthick, Martha. 1979. *Policymaking for Social Security*. Washington, DC: The Brookings Institution.
- Hamel, Elizabeth C., Claudia Deane, and Mollyann Brodie. 2011. Medicare and Medicaid. In Robert J. Blendon et al., *American public opinion and health care*. Washington, DC: CQ Press, 151-88.
- Himelfarb, Richard. 1995. *Catastrophic politics: The rise and fall of the Medicare Catastrophic Coverage Act of 1988*. University Park, PA: Pennsylvania State University Press.
- Marmor, Theodore R. 1973. *The politics of Medicare*. Chicago: Aldine.
- Mayes, Rick, and Robert A. Berenson. 2006. *Medicare prospective payment and the shaping of the U.S. health care*. Baltimore: Johns Hopkins Press.
- Medicare Payment Advisory Commission, 2008. *Report to the Congress: Medicare payment policy*. Washington, DC: March.
- Mills, Wilbur. 1971. Oral history interview I, by Joe B. Frantz, Internet Copy, LBJ Library. Online: <http://www.ssa.gov/history/pdf/mills1.pdf>.
- Mills, Wilbur. 1987. Oral history interview II, by Michael L. Gillette, Internet Copy, LBJ Library. Online: <http://www.ssa.gov/history/pdf/mills2.pdf>
- Moffitt, Robert, and Barbara Wolfe. 1992 The effect of the Medicaid program on welfare participation and labor supply. *Review of Economics and Statistics* 74: 615-26.
- Oberlander, Jonathan. 2003. *The political life of Medicare*. Chicago: University of Chicago Press.
- Oliver, Thomas R.; Phillip R. Lee; and Helene L. Lipton. 2004. A political history of Medicare and prescription drug coverage, *Milbank Quarterly* 82: 283-54.

- Organization for Economic Cooperation and Development. 2013. "OECD Health Data 2013 – Frequently Requested Data." Online: <http://www.oecd.org/els/health-systems/oecdhealthdata2013-frequentlyrequesteddata.htm>.
- Pierson, Paul. 2004. *Politics in Time: History, Institutions, and Social Analysis*. Princeton: Princeton University Press.
- Saad, Lydia. 2010. Verdict on healthcare reform bill still divided. Gallup, June 22. Online at <http://www.gallup.com/poll/140981/verdict-healthcare-reform-bill-divided.aspx>.
- Smith, David G., and Judith D. Moore. 2008. *Medicaid politics and policy, 1965-2007*. New Brunswick, NJ: Transaction Publishers.
- Starr, Paul. 1983. *The social transformation of American medicine*. New York: Basic Books.
- Starr, Paul. 2011a. *Remedy and reaction: The peculiar American struggle over healthcare reform*. New Haven: Yale University Press.
- Starr, Paul. 2011b. "The Medicare Bind," *American Prospect* (November), 24-35
- U.S. Bureau of the Census. 2010. Uninsured rose to 16.7% in 2009. [MORE INFO AVAILABLE?]
- U.S. Department of Health and Human Services. 2009. National health expenditures: 2009 highlights. Online at <https://www.cms.gov/NationalHealthExpendData/downloads/highlights.pdf>.
- Woolhandler, Steffie, and David U. Himmelstein. 2002. "Paying For National Health Insurance—And Not Getting It," *Health Affairs* 21: 88-98.
- Zelizer, Julian E. 1998. *Taxing America: Wilbur D. Mills, Congress, and the state, 1945-1975*. New York: Cambridge University Press.