Opening Remarks

These opening remarks were made by Max Sherman, Dean *of the Lyndon B. Johnson School of Public Affairs, Austin, Texas, on May 6, 1996, as an introduction to the proceedings of the Symposium `Medicare: Advancing Towards the 21st Century."*

It is a rare occurrence for the venue of a meeting to be as closely associated with the purpose and topic of that meeting as when the Lyndon Baines Johnson Presidential Library and the Lyndon B. Johnson School of Public Affairs host the symposium celebrating the 30th anniversary of Medicare. We were deeply honored to be invited by the Health Care Financing Administration to be the site for the day-long symposium on May 6. We are grateful for the generous grants from the Commonwealth Fund, the Kaiser Foundation, and the Robert Wood Johnson Foundation, which made the event possible. We appreciate the dedication and support of the HCFA staff and the impressive roster of symposium speakers and panelists. In the following pages, you will find summaries of the contributions made by the speakers.

Lyndon Johnson's vision for America was that of the Great Society, a society with equitable access to the Nation's resources for all. This vision was an expansion of the New Deal of the 1930s; but where the New Deal had been reactive to the national disaster of the Depression, the Great Society aimed at being proactive in providing a government guaranteed safety net for all. In the mid-1960s, many of us were planning or embarking on our professional careers; we were thinking about the families we were going to have, we were mapping our lives. Medicare was something worthwhile for our parents, something that one day, in what seemed like a very distant future, would also benefit us. What many failed to realize then, and what is so often missing from the public dialogue, especially the inter-generational dialogue, is the fact that young and middle-aged Americans draw an immediate and substantial benefit from Medicare. Medicare assured us that we would never have to face the heart-wrenching dilemma of paying for our kids' education or our parents' health and nursing care; of having to support our parents, impoverished by illness, at the expense of our young families.

Our country seems to be struggling at the moment with defining the role of government: How much government should there be in our lives? Should government be the guarantor of a democratic, law-based society and provider of last resort, or should government seek to be a partner in a civil society and use its influence in shaping everybody's future? President Johnson adhered to a simple mission for government: Good government is what provides the greatest good to the greatest number of people. While a program like Medicare obviously fits this postulate, Johnson saw clearly that for this program, and all others, to continue to play their role in the lives of all Americans, they could not be allowed to be static; instead, after the initial launch and fine-tuning, it was necessary to re-evaluate and determine relevancy, effectiveness, and purpose. Maybe the notion of "re-inventing government" is not as new as many now seem to think.

The initial formulation of public policy and the on-going monitoring of that policy require people capable of seeing the big picture while focusing on every detail.

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These processes require people who are trained and educated in a multidisciplinary institution, people to whom the complexities of society in general, and government in particular, are a source of stimulation, not frustration. The government that Lyndon Johnson knew, both in Washington and back here in Texas, was run, by and large, by professionals with law degrees, many of those earned from law schools in the Northeast. While still in the White House, the late President developed a plan for a multidisciplinary school, in his home State of Texas, to prepare promising young graduate students for careers in the public sector. The Lyndon B. Johnson School of Public Affairs is the realization of that plan.

So while we celebrate the 30th anniversary of Medicare, recognizing that the program will continue to evolve in the light of changes in social and fiscal realities, we are proud to be the institution that trains the next generation of policy and decision-makers who will ultimately guarantee the survival of the program into the 21st century.

Overview

Margaret H. Davis

This overview discusses articles published in this special 30th Anniversary of Medicare issue of the Health Care Financing Review. *The authors whose work appears in this special commemorative issue all participated in a policy symposium held on May 6, 1996, at the Lyndon B. Johnson Library in Austin, Texas. The symposium,* Medicare: Advancing Towards the 21st Century, *was held in honor of the 30th anniversary of the implementation of the Medicare program. Cosponsors of the symposium included the Health Care Financing Administration, the Lyndon B. Johnson Library, the Lyndon B. Johnson School of Public Affairs at the University of Texas at Austin, the Commonwealth Fund, the Robert Wood Johnson Foundation, **and the Henry** J. Kaiser Family Foundation.*

This 30th Anniversary issue of the *Health Care Financing Review* begins with a sociological and historical analysis of the U.S. health care system in the 1950s and 1960s, and how the Medicare and Medicaid programs fit into that system. In "Health Care in the Early 1960s," Rosemary Stevens argues that "to study health care, with all its contradictions and complexities, in the 1960s as in the present, is to explore the character and ambiguities of the United States itself...." At the time, national leaders were stressing idealistic, unifying social principles. Yet there were great rifts and gaps in the health care system, particularly for the poor, the chronically ill, minorities, and populations in inner cities. Stevens outlines some defining themes for the years before the Medicare program was enacted. One is the nature and concept of social entitlement: "The contrast between wish and reality (the wish for a truly Great Society and the reality of conflict and division) forms an essential first theme for understanding the years before Medicare. In effect, Medicare was to be a means of transforming the elderly into paying consumers of hospital services." The elderly were singled out as a "deserving" and privileged population, and Medicare was designed as "socially unifying legislation in that it embraced all social classes on equal terms within one age group...." Stevens argues that a second defining theme is the emphasis placed on a curative approach to acute illnesses, over preventive and palliative care, and that "Medicare was designed to be responsive to the technological and high-cost side of medicine rather than to chronic illness." Steven concludes her historical and sociological review by describing the Medicare program as a paradox: "On the one hand, it has provided untold benefits for millions of elderly and disabled Americans... .a lasting national commitment to equal opportunity. On the other hand, Medicare has camouflaged the wider issues for which the Great Society was supposed to find solutions: providing for the health coverage of all Americans, from acute sickness to chronic illness."

Today, older Americans generally enjoy better health, longer lives, and improved quality of life, in part, because of Medicare. The second paper in this issue, by Dorothy P Rice, "Beneficiary Profile: Yesterday, Today, and Tomorrow," begins by presenting

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some basic demographic trends of the elderly population. The demographic shifts Rice describes highlight that the U.S. population is aging, and the aged are predominantly female. The elderly, especially those 85 years of age or over, have been the fastest growing segment of the population; mortality rates for the elderly have declined; and life expectancy has increased for both males and females. Rice also points out that, although the economic status of the elderly has improved significantly over the past 30 years, about 12.2 percent of the elderly lived in poverty in 1993, and many elderly rely significantly on programs like Medicare and Social Security: "If Social Security and other government programs were not counted, the poverty rate for the elderly would be four times higher than the current rate, and one-half of the persons age 65 and over would live in poverty."

The next group of articles examine how health care has changed in the past 30 years and the role Medicare has played. Authors focused their analyses on what Medicare has meant for beneficiaries, including the elderly, poor, minorities, and the disabled. Marilyn Moon's article, "What Medicare Has Meant to Older Americans," highlights the overwhelming success and popularity of the Medicare program, the crucial role Medicare has played in the lives of many elderly and disabled Americans, and emphasizes that future reforms should build on the program's strengths and learn from its weaknesses. Medicare has achieved nearly universal coverage for persons 65 years of age or over-it has delivered on its original promise to change the nature of health care access for older Americans. Access to health care services has expanded significantly-for example, the proportion of the elderly using physician services jumped from 68 to 76 percent between 1963 and 1970. Medicare has brought relief to the elderly and disabled from the financial costs of health care. By creating a large risk pool over which to spread costs, and efforts such as setting limits on payments to hospitals and physicians and limits on balance billing, Medicare has helped shield beneficiaries from the substantial growth in health care costs that has occurred over the past 30 years.

Of course, significant challenges lie ahead for the program. One of which is to make sure the program is there in the future by assuring its financial health. Another challenge is to assure access to care. As Moon describes, Medicare has made great progress in improving access to care for the elderly-but much more needs to be done. For example, regardless of race, low income beneficiaries face greater barriers to care than their better off counterparts. Furthermore, beneficiaries who are eligible for both Medicare and Medicaid, who are members of a minority group, or those who are disabled have higher rates of avoidable hospital admissions than other groups of beneficiaries. The next article in this issue, "Medicare, Medicaid, and the Elderly Poor," by Diane Rowland, profiles the economic and health status of the low-income elderly population served by Medicare, assesses the impact of Medicare, and examines the role Medicaid plays as a supplement to Medicare. Rowland notes that there are 5.9 million poor and near-poor elderly living in the community, and an additional 1.4 million residing in nursing homes. The likelihood of living on a low income is greatest for women, minorities, and the oldest-old. Low-income elderly are particularly vulnerable because they tend to be in poorer health than higher income elderly, and have few financial assets to draw on if they incur high medical costs. For these individuals, Medicare coverage is particularly critical. However, Medicare

has substantial cost-sharing requirements and financial obligations that can be barriers to care for many low-income elderly. For some, Medicaid has served as a supplemental insurance policy to fill in the gaps. Medicaid plays a role in providing protection for Medicare premiums and cost-sharing requirements, and is a major payer of long-term care services. Rowland also focuses on the impact of insurance on access to services, noting statistics that show elderly with low incomes and covered only by Medicare have a number of access problems, including lower utilization rates, no usual source of care, difficulties in obtaining care, and lower satisfaction levels for particular aspects of care.

Dorothy Height, president of the National Council of Negro Women, and a soon-to-be member of Medicare's "oldest old," emphasized the impact that Medicare has had on black Americans and other racial minorities. She notes that Medicare was one of three critical events that improved access to medical care for all people of color: the Civil Rights Act of 1964, Medicaid, and Medicare. These laws were critical to reducing some of the significant racial disparities that existed in use of health care services. However, Height notes that there continue to be a number of barriers facing elderly minority beneficiaries, particularly the combined effect of poverty and race on health status and access to health care. Black beneficiaries, who are disproportionately distributed in lower income categories, continue to have higher mortality rates than white beneficiaries, and have fewer physician visits but higher rates of hospitalization than white beneficiaries. Black beneficiaries also are less likely than white beneficiaries to have supplemental health insurance, leaving them vulnerable to the often high cost sharing requirements of Medicare.

Robert J. Master and Carol Taniguchi, in their article titled "Medicare, Medicaid, and People With Disability," address some of the critical issues facing beneficiaries with disability. The article describes the historic imperative for publicly financed insurance programs for people with disabilities, the characteristics of Medicare and Medicaid eligible recipients with disability, the array of services now available through the programs, and obstacles to and opportunities for continued reform. Their article recalls some of the history of our society's treatment of persons with disability. Thirty years ago, persons with disability were "for the most part, nameless, faceless, and dependent on segregated institutions or a myriad of distinct State government or charity programs. Care was not an entitlement but a by-product of whatever public generosity or charitable instincts that existed." They note that Medicare and Medicaid entitlement for persons with disability resulted in the rapid development of a new and unique set of services designed to promote independence and autonomy, and contributed to the substantial de-institutionalization that occurred over the past 20 years. The authors stress the importance of further development and reform, and assert that the continuation of Medicaid entitlement and the rapid growth in managed care are central issues in the current policy debate.

The last article in the series examining the impact of Medicare on beneficiaries focuses on long-term care. "Why Medicare Matters to People Who Need Long-Term Care," by Judith Feder and Jeanne Lambrew, outlines how Medicare's functionally impaired beneficiaries, who have disproportionately high medical costs, depend on Medicare to finance their medical care, and how they are affected by Medicare policies regarding its post acute

benefits, home health, and skilled nursing facility care. Feder and Lambrew outline the history and importance of Medicare's home health and SNF benefits. Medicare's home health benefit was established to facilitate hospital discharge. Over the 30 years of Medicare, Congress and Administrations have expanded and restricted the home health benefit, driving costs up or down depending on how narrow or broad the benefit was implemented. Most recently, in 1989, HCFA both broadened and clarified its interpretation of skilled care, resulting in a rapid growth in the number of persons utilizing the home health benefit and increases in expenditures: Feder and Lambrew report that between 1989 and 1994, Medicare spending on home health grew at an average annual rate of more than 35 percent per year. In addition, between 1988 and 1991, the proportion of home health users with more than 100 visits more than doubled, from 26 percent to 53 percent. In 1994, about 10 percent of users received more than 200 visits, accounting for 42 percent of total home health spending. Although Medicare's home health benefit remains, for the most part, a short-term, post-acute benefit, a small proportion of Medicare users in need of long-term care get a significant amount of personal care from the program.

The next series of articles looks at the impact of the Medicare program from the perspective of providers and insurers. "Medicare and Hospitals," by Mitchell T Rabkin, outlines some of the dramatic changes that occurred for hospitals as a result of the Medicare program. Rabkin argues that the Medicare hospital payment methodology, which included the concept of funding reasonable hospital costs, was instrumental in providing the funds that allowed hospitals to modernize their facilities and improve their ability to acquire new and advanced technology. "Medicare made a new and important societal statement, with its commitment to equal treatment for elderly and disabled and its thrust to improve their care." In particular, his article notes the important role Medicare has played for teaching hospitals, by financing graduate medical education (GME) payments and "indirect" medical education (IME) payments. Rabkin states that this significant resource has enabled teaching hospitals to train and educate interns and residents, empowered technological sophistication, increased the range of technical expertise, and bolstered medical research. He comments on the concept of payment by diagnosis-related groups (DRGs), noting what he believes to be a number of weakness in the payment methodology, and expresses concerns about the "disservice" of including GME, IME, and disproportionate share hospital payments in the capitated payments to Medicare health maintenance organizations.

"Medicare and Physician Autonomy," by Richard Culbertson and Philip R. Lee, examines some of the issues surrounding the changes over time in the economic and clinical autonomy of physicians, and the role that Medicare policies have played in the evolution of those changes. Culbertson and Lee pose the question of whether or not, over time, physicians have traded a reduction of clinical autonomy for the preservation of economic autonomy. Their article reviews a number of authors' perspectives on the concept and defining characteristics of physician autonomy, concluding with a summary of Uwe Reinhardt's "Irony" or "Law": "In modern health care systems, the preservation of the healers' economic freedom appears to come at the price of their clinical freedom." The article then reviews the history of the establishment of the Medicare program, and notes that, in order to pacify physician opposition to the legislation, the program was designed specifically to

build on the existing health care and private insurance systems. Inherent in the original legislation was a distinct commitment to respect and reinforce the clinical, and to a large extent the economic, autonomy of physicians. For example, Congress initially adopted a payment methodology favorable to physicians-basing payments on "customary, prevailing, and reasonable" charges-and allowed balance billing. However, rapidly rising costs in the Medicare program quickly led to modifications in the economic realm. By outlining a series of Medicare policy changes dating back to the Wage and Price Controls implemented by the Nixon Administration in 1971, Culbertson and Lee argue that, although Medicare has moved directly to limit physician discretion in economic matters, the program has essentially stuck to the original Congressional mandate of noninterference in the private practice of medicine. The effects of Medicare policy on clinical autonomy have been limited or indirect, especially in contrast to the methods used by private insurers.

Perhaps even more profoundly than hospitals and physicians, Medicare has impacted the private health insurance industry in a number of broad areas. Stanley B. Jones, in "Medicare's Influence on Private Insurance: Good or Ill?" presents a framework for understanding Medicare's past and future influence in the private insurance market, from the perspective of private insurers. His analysis uses the concepts of shifting paradigms to highlight his predictions for the future of the health insurance industry. In the area of insurance market opportunities, Jones notes how the enactment of the Medicare program was a windfall for private insurers, especially related to the expansion of administrative technology (the Medicare legislation called for the use of private intermediaries and carriers to handle administrative processing) and growth of an entire new market for Medicare supplemental policies. Jones sees a paradigm shift occurring where increased enrollment in Medicare prepaid, at risk health plans is eroding both the administrative services market and the Medigap market for private insurers. The second area Jones highlights is insurance payment technology and credentialing infrastructure. "Medicare's vast enrollment and the high proportion of physician, hospital, and other revenues represented by its population, have made its payment systems and licensure requirements into de facto standards for private industry." The paradigm shifts he notes in this area include a shift from cost reimbursement to the use of premiums and a shift from provider credentialing to the measurement of outcomes and satisfaction. This shift is reflected by efforts such as Medicare's work to develop HEDIS-like reporting and measurement systems. Jones goes on to discuss his predictions for changes in provider and buyer cultures and expectations of insurance. One of the changes he focuses on is what he believes is the shift from the provider as advocate of the patient to the provider as a partner in the health plan. In his view, physicians operating under the Medicare of yesterday had no financial "stake" in the cost of the program, and were more closely tied to the patients, determining services and treatments with little or no connection to overall cost implications. Jones sees this alliance between patient and provider as first weakened somewhat by the DRG system, and predicts an even greater shift with the growth in capitated plans or systems that often give providers a financial stake in the health plan's costs.

"The House That Medicare Built: Remodeling for the 21st Century," by Merwyn R. Greenlick, metaphorically reflects on the "remodeling" that needs to be

done to the American health care system as we move into the 21st century, and focuses particular attention on the future of the relationship between Medicare and managed care. Greenlick outlines how the "house" of Medicare was remodeled over the years regarding its involvement in managed care. Like Culbertson and Lee, he reminds us that the Medicare program was designed within the constraints of the dominant American medical system, which at the time had a very limited role for prepaid group practice plans. Although the few plans that existed at the time the legislation was enacted generally supported the concept of the Medicare program, they initially were frustrated in their attempts to negotiate capitated payment arrangements for Medicare beneficiaries in their plans, and ended up with a patchwork method called the group practice prepayment plan-a prospective cost-for-service methodology, with retrospective reconciliation. Under this system, very few plans showed interest in enrolling Medicare beneficiaries. Based on research conducted by HCFA in the late 1970s and early 1980s, Congress passed legislation allowing managed care plans to be paid using risk-based, prospective payment methodologies, and since then enrollment in plans has increased at a steady rate. However, Greenlick believes that the evolution of these plans has only just begun: "Current managed care plans are primitive versions of the ultimate models that will emerge. And I think it possible, perhaps even likely, that we will be able to develop humanistic forms of health care for the 21st century." Greenlick gives us his predictions for the health care system over the next 20 years, and outlines his vision of what he characterizes as a "humanistic" health care system: "it links each individual to his or her health care system, one person at a time, on the basis of that individual's needs, desires, aspirations, risks, disease condition, and health and functional status," and its success will be measured by its cost effectiveness and ability to prevent disease and maintain optimal mental, social, and physical functioning. He outlines the various elements of the structure of this humanistic health care system, including the nature of physician practices, where and how people receive care, payment methodologies, the role of government, and the role of technology. Of course, we have a way to go before our house is completely "remodeled," and despite the "cataclysmic forces" that are occurring in our current health care system, Greenlick identifies a number of barriers that must be overcome in order to achieve that "bright new model" house. In particular, he urges the redefinition of clinical care to include as a primary objective the prevention of disease and the maintenance and improvement of function.

The third series of articles looks at some of the politics surrounding the development of health policy in the United States, both from a historical perspective starting in the 1960s, as well as an analysis of current issues in health policy development. The two articles presented here give us both an "insider's" and an "outsider's" perspective on the political scene that preceded the enactment of the Medicare program. William D. Fullerton's article, "Politics of Federal Health Policy, 1960-1975: A Perspective," provides a unique look into the workings and politics of the committees of jurisdiction over health insurance legislation, with particular emphasis on the powerful Committee on Ways and Means in the House. Fullerton has worn many hats during his career, including time as a professional staff person for the Committee, and a stint as Deputy Administrator of HCFA. Fullerton explains for us the intimate details of how Congress worked with the Administration to craft,

pass, and implement the Medicare legislation-highlighting the significant changes in process that have occurred over the past 30 years. For example, at the time Medicare was enacted, Congressional Committees had no professional staff: "During this period, anyone who wanted to influence Congress, or have someone in Congress influence the Medicare administrators, had to deal directly with the members, or their staffs, because there was no Committee staff to deal with...." Congressional committees often relied on members of the Executive Branch for technical assistance, from writing up Committee reports to providing data and analyses on health insurance issues. With his on-the-scene perspective, Fullerton details many of the changes that have occurred in Committee structure and power.

Lawrence D. Brown presents a lively commentary on health policy issues in "The Politics of Medicare and Health Reform, Then and Now." His article builds on the details of Fullerton's picture of health politics in the 1960s, and explores two alternative views of the factors that contributed to the passage of such a major piece of social welfare legislation. The first portrays Medicare as a result of "relentless incrementalism," an additional pillar to the welfare protections that included social security, unemployment compensation, and income support for the poor. The second view is that Medicare succeeded as a result of unique and rare "political convergences and coalitions" that are unpredictable in U.S. politics. Brown lists 10 favorable political and economic conditions that were in place in 1965, and contrasts them to an equal number of difficult or unfavorable conditions that existed in 1993 when the Clinton Administration proposed a major reform to our health care system. Essentially, Brown's analysis lends credence to both views. On the one hand, he argues that the health system "obeys no laws of inevitable progress": "If and when windows of opportunity happen to open, what (if anything) goes through them will depend on the convergence of political interests with intellectual currents, and the latter derive partly from expertise and entrepreneurial skill." However, he also notes that in the recent health reform debate, many activists "dismissed incrementalism as a strategy for sissies," and cautioned that many of the proposals put forth "were crafted by people with grand goals, big ideas, and expansive systems-visions, but also with little (or no) political experience, limited feel for what could fly legislatively, and not much taste for listening to and learning from Congress." Brown also expresses concern about the diminishing importance given to the concept of social insurance as a fundamental public philosophy in U.S. social policy.

Finally, the last article in this special issue, "Thirty Years of Medicare: Impact on the Covered Populations," by Gornick et al., is an update to a series of classic articles that focused on the impact of Medicare on the beneficiaries after 10 and 20 years of operation. It provides a detailed overview of 30 years of Medicare program data, and discusses Medicare's role in the evolving U.S. health care system. The article concludes with an overview of major issues and challenges for the future of Medicare.

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