
Medicare and Medicaid: The Past as Prologue

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On July 30, 1965, President Lyndon B. Johnson signed the Social Security Amendments of 1965 into law. With his signature he created Medicare and Medicaid, which became two of America's most enduring social programs. The signing ceremony took place in Independence, Missouri, in the presence of former President Harry S. Truman, as if to indicate that what President Truman and other Presidents before him had tried to get done had now been accomplished. Yet, for all of the appearance of continuity, the law that President Johnson approved differed in significant ways from the law that President Franklin D. Roosevelt would have passed in the thirties or President Truman would have signed in the forties. The very idea of national health insurance underwent a major transformation between the beginning of the century and 1965. Even as the passage of Medicare became assured late in 1964 and in 1965, the legislation remained fluid, with important matters related to consumer choice and the basic design of the program in constant flux.

CHANGING CONCEPTS OF HEALTH INSURANCE

Progressive Era

In the progressive era at the beginning of the twentieth century, reformers with an interest in labor legislation understood what we now call health insurance to be something called sickness insurance. If

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a worker became ill, the reasoning went, his family needed protection against the costs of his absence from work. These costs included some sort of monetary reimbursement for time lost on the job as well as the costs of paying for medical care. Hence, a plan put forward by the Social Insurance Committee of the influential American Association for Labor Legislation contained provisions for both wage replacement and medical services, such as physician visits, surgery, nurses, drugs and supplies (Hoffman, 2001).

Americans interested in bringing sickness insurance to this country looked to Europe for inspiration. In 1911, for example, the English passed the British National Insurance Act, which complemented existing programs in Germany, Austria, and Hungary, as well as parts of Scandinavia and eastern Europe. Although the German program contained such features as surgical and medical care for as many as 26 weeks, it, like its European counterparts, emphasized cash benefits to workers that were designed to replace a portion of foregone wages. Only manual laborers and other members of the working class were covered by the German program. In England, the emphasis on workers, rather than the entire population, meant that even the wives of workers were not covered for primary benefits (Rubinow, 1916; Falk, 1936).

American reformers with an interest in establishing a sickness insurance program in the U.S. noted the wages that workmen lost due to illness cost far more than the costs of medical care. Rubinow (1916) cited a 1911 American study conducted for the

Commission on Industrial Diseases that showed the amount of lost wages as \$366 million and the expenses for medical care as \$285 million. Hence, what later came to be called temporary disability insurance took precedence over health insurance.

In common with other progressive reformers, Rubinow did not dismiss the problem of paying for medical care. He pointed to data from the eighteenth annual report of the U.S. Bureau of Labor that showed even relatively well-off working class families paid less than \$30 a year in medical expenses and some of that money went to pay for a funeral. Without need of further research, he judged that amount to be too little to spend on medical care and argued American workers deserved to receive more medical care (Rubinow, 1916). Still, he kept the primary focus of social insurance related to health on cash benefits rather than on the payment of medical services.

Rubinow concentrated on the passage of sickness insurance laws in the States, rather than on the creation of a national health insurance law. At the time, the focus of social reform was on the State and not the Federal Government for reasons related to the weight of precedent, the constitutional constraints on Federal activity, and the heterogeneous conditions across the American continent. A program that worked well in rural Nevada might not be appropriate for a heavily urban State in the northeast. Hence, the major battles over health insurance in the progressive era took place in Sacramento, California and Albany, New York rather than Washington, D.C. (Hoffman, 2001; Hirshfield, 1970).

Despite the fact that New York, California, and other States made careful investigations of the need for sickness insurance and gave serious consideration to creating such programs between 1918 and 1920, the measure was defeated in every State in

which it was raised (Hirshfield, 1970). Unlike workers' compensation, which covered the costs of industrial accidents, including medical care for injured workers, health insurance or sickness insurance proved to be a relatively controversial item. The fact that it was so closely associated with Germany detracted from its popularity during the First World War (Lubove, 1968). More importantly, the American Medical Association (AMA), which represented the interests of doctors across the Nation, came out against the measure that had been developed by the American Association of Labor Legislation and discussed in a number of States by 1920 (Hoffman, 2001; Numbers, 1978). The AMA, in common with many Americans, thought of medical care as largely a private transaction between a medical practitioner and a patient. There was no need for the State to intervene in this relationship.

New Deal Era

In the face of political difficulties and the opposition of the medical profession, reformers continued to study the measure in the next two decades. By the middle of the thirties, some 25 countries in Europe, South America, and Asia had some form of national health insurance program. The most significant American development was the transformation of the measure from sickness insurance to what could properly be described as health insurance. Falk (1936) wrote the definitive New Deal-Era study of health insurance in which he announced that the costs of medical care were now a greater concern than the costs of foregone wages due to illness. This "... is a new condition," he wrote, "... different from what prevailed in other times and in other countries when they faced the problem for planning for economic security against sickness."

The new conditions reflected improvements in medical care and the rise of the hospital as an important center for the provision of medical care (Rosenberg, 1987). Falk and many of his contemporaries owed their interest in health insurance to the studies made by the Committee on the Costs of Medical Care during the twenties. This Committee funded for 5 years by eight private foundations interested in medical research and medical care, issued reports between 1927 and 1931. The reports highlighted the costs of medical care and the need to make some sort of societal provision to assure an adequate supply of medical care and a means for people to pay for it. The committee therefore, publicized the need for medical insurance, but it did not necessarily endorse national health insurance. Indeed, a majority of the committee members thought that health insurance could be provided through a voluntary, private system (Fox, 1986).

Those who favored national health insurance, such as Falk, hoped that the New Deal might provide the political means to assure its passage. The 1935 Social Security Act served as a possible legislative vehicle to create a Federal health insurance program. In 1934, Falk and a colleague went to Washington to advise the cabinet-level committee in charge of what became the Social Security legislation on the subject of health insurance. They argued that, not only should the payment of medical care be recognized as an important barrier to economic security; but that a national health insurance scheme would be relatively easy to implement. Sickness pay, they admitted, was a tricky concept to enact during a time of major depression when jobs were scarce and people were looking for any means of income available. For that reason Falk and his colleague wanted a strict separation between disability insurance and health

insurance and did not want treating doctors to certify people for disability insurance. They envisioned health insurance as a means of budgeting health care costs on a group basis. Instead of paying highly variable costs out-of-pocket, a worker could pay the average, rather than the individual, cost of care, thus making health care affordable (Berkowitz, 1991).

In the depression, however, national health insurance was not a particularly pressing concern. The more general problem of unemployment took precedence. Progressive reformers tended to think of sickness insurance as an investment in the Nation's productivity. Healthy workers were also productive workers. As Falk (1936) wrote, "... the money value of man, arising from his productive powers, depends largely or entirely on his health." He estimated that the great depression, with its widespread unemployment and falling wages, lowered the money value of man by as much as 50 percent. Hence, the investment in health care promised to pay lower dividends in the thirties than in the twenties—an argument against giving it priority among the hierarchy of the Nation's needs.

Nonetheless, Falk and his colleagues continued to press for the inclusion of national health insurance in the 1935 Social Security Act and, failing that, in separate legislation, such as the bill introduced by Senator Robert Wagner (D-NY) in 1939. If health insurance had been passed in this era, it would have featured State-run programs (Hirshfield, 1970; Poen, 1979; Gordon, 2003). Falk and others understood the Federal Government's role as establishing minimum standards for health insurance practice and as providing subsidies, grants or other financial aids to the States. There should also be no commercial or other intermediary agents between

the insured population and the professional agencies which serve them (Committee on Economic Security, 1935).

Second World War and Its Aftermath

By 1939, the Second World War had already begun in Europe, and the U.S. would enter the war by the end of 1941. During the war years, the idea of national health insurance underwent another transformation. The most important change was the transition from the States to the Federal Government as the preferred administrators of health insurance and other forms of social insurance. The change reflected changing attitudes on the part of Federal officials who worked in Washington administering the programs created by the Social Security Act. Some of the programs, such as unemployment insurance, were run by the States with Federal oversight, and other programs, such as old-age insurance, were administered at the Federal level. In time, Federal officials came to regard the States as unreliable and inefficient partners who, by handling the same social problems in such disparate ways, created chaos rather than coherence (Altmeyer, 1966). States, lauded as the laboratories of reform, often produced inferior products, and a race to the bottom—a desire to keep social welfare taxes and expenditures below those of competing States—only reinforced that tendency. Falk in speaking about the conversion of public officials to the superiority of Federal over State administration of social welfare programs, said he and his colleagues went through “... not just a political but sort of an intellectual and religious reformation. We began to come out with a perspective that none of us had when we first began doing these things. Between 1939 and 1942 we were changed persons ...” (Berkowitz, 1979).

It was tempting and, in the mobilization for war, apparently plausible for the Social Security Board to take the daring step of recommending to Congress that the States be bypassed in any national health insurance program that Congress chose to create. State administrators, such as Mary Donlon of the New York State Workmen’s Compensation Program, of course felt differently about being superceded in the administrative structure of the American welfare State (Howard, 2002). As a practical matter, the States were already too imbedded in the welfare system to be swept aside. Federal bureaucrats nonetheless entertained notions of making unemployment compensation Federal and of creating national, rather than State, health insurance and disability programs. They hoped this manner to establish a unified comprehensive system of contributory social insurance with no gaps, no overlaps, and no discrepancies (Altmeyer, 1943).

Legislative proposals for national health insurance which appeared in 1943, 1945, and 1947—the latter two with the endorsement of President Truman—thus featured Federal rather than State administration. If national health insurance had passed in this era, it would have provided health care for people of all ages (Poen, 1979). National health insurance, which formerly had been linked with the States and the unemployment insurance program, now became associated with the old-age insurance or the Social Security program. In effect, health insurance was to be an extension of Social Security (David, 1985).

There were two major problems with this approach. One was the fact that until 1951 the Social Security Program covered only about one-half of the workers in the labor force. Agricultural workers and self-employed people were excluded from coverage. Hence, national health insurance was

attached to a vehicle that was not yet widespread enough to be particularly popular. Congress narrowed, rather than widened, the scope of Social Security during the 1940s, by further reducing the occupations that the program covered. The other problem was that, as the forties progressed, private health insurance became more and more common, thus undercutting political support for public health insurance (Klein, 2003). By 1951, for example, community based Blue Cross[®] plans, which helped to finance the costs of hospital care, covered more than 37 million people. More than one-half of the hospital patients in America entered with some form of health insurance (the percentage had been 9 percent in 1940); in that same year, more than 40 million people had some form of private insurance to pay for doctors' bills. The private sector had scooped the public sector (Berkowitz, 1991; Hacker, 2002). This tendency not only blocked the passage of national health insurance; it also reinforced the tendency to think of health insurance as a State program, rather than a Federal program concern, since private health insurers were regulated at the State level.

Health Insurance in the Fifties

These problems led to yet another iteration of the national health insurance idea during the fifties. As Social Security became more popular in that decade and Congress passed bills raising Social Security benefit levels in 1950, 1952, 1954, 1956, and 1958, reformers thought in terms of extending health insurance coverage to Social Security beneficiaries who were, with the exception of the dependents of deceased workers and other beneficiaries, elderly individuals (Derthick, 1979). These individuals fared less well in the private health insurance market than did their younger counterparts. Many of them, after all, had lost

their ties to employers, who had financed their health care (at least at the end of their working lives, as employer-based health insurance became more common). With relatively high morbidity rates, they represented a particularly bad risk for private companies to insure (Marmor, 1973). The Federal Government could therefore insinuate itself as a provider of health insurance through the creation of what ultimately came to be called Medicare. First proposed publicly in 1952, this idea of limiting federally financed national health insurance to the elderly received attention in Congress beginning in 1957 (Corning, 1969; David, 1985).

MEDICARE AS A FORM OF NATIONAL HEALTH INSURANCE

By 1961, a Medicare bill had received the endorsement of President John F. Kennedy, and a long campaign for its congressional passage began. By now, the idea of national health insurance had undergone, if not another transformation, then at least a major change in an effort to find common ground with private health care providers. Wilbur Cohen, who coordinated the legislative activities related to Medicare for Presidents Kennedy and Johnson, expressed what the legislation would not do, rather than what it would do. Cohen (1961) said that the proposal would "... not provide a single medical service...physicians' services would not be covered or affected and the proposal provides that the government would exercise no supervision or control over the administration or operation of participating institutions or agencies." Beyond the political expediency of restricting benefits to the elderly and concentrating on hospital, rather than physician care, the limits that Cohen set on Medicare reflected the increasing prominence of the hospital as a provider of medical care (Fox, 1986).

As the campaign for Medicare unfolded, the desire to accommodate private health providers continued to play an important role. In 1962, Senator Jacob Javits (R-NY) helped to negotiate a feature, accepted by the Kennedy administration, which allowed elderly people with private health insurance coverage to keep their coverage. Medicare would reimburse the private carriers for benefits that coincided with those covered by the program. With this feature, the Medicare supporters hoped to gain leverage in the Senate (Berkowitz, 1995). Despite this feature, the Senate narrowly defeated the measure in 1962. The matter never came up for a vote in the House of Representatives in that year.

In 1964, as the measure came close to another important congressional vote, another device to accommodate the private sector appeared. In that year the Senate, but not the House, passed a Medicare bill, and the measure was carried over to the new Congress that would convene in 1965 (Berkowitz, 1995). Despite the failure to enact Medicare in 1964, elements from that debate influenced the legislation that passed the next year. In particular, Wilbur Mills, the powerful head of the Ways and Means Committee, requested that the Social Security Administration develop a plan that allowed the use of the Blue Cross® plans to administer hospital insurance. That plan led to what would later be called fiscal intermediaries, charged with the task of administering Medicare's billing operations. As originally designed, the intermediaries, who were assumed by Mills and by administration officials to be local Blue Cross® plans, would handle all the bills generated by hospitals for the care of Medicare patients and keep the Federal Government removed from getting involved in the routines of health care finance (Cohen, 1964a).

O'Brien (1964) the chief congressional liaison in the Johnson White House, called this proposal to involve fiscal intermediaries and in particular the Blue Cross® plans in Medicare "...entirely acceptable..." and "...especially helpful..." Earlier scruples about having no "...commercial or other intermediary agents between the insured population and the professional agencies which serve them..." were apparently forgotten. At the time Wilbur Cohen and Robert Ball (1964b) of the Social Security Administration described the intermediary device as "brilliant" and thought that the Blue Cross® plans, with their wide reach and non-profit status, would be particularly appropriate for the task.

Senator Javits remained active in Medicare deliberations in 1964. Although by then he accepted the basic notion of having hospital insurance provided through what contemporaries called the "social security mechanism," he also proposed the creation of what he termed "complementary private health insurance" for elderly individuals. Senator Javits explained that he wanted to limit the Federal Government's role to covering the costs of hospitalization and skilled nursing home care. At the same time, Javits (1964c) hoped to cover doctor's bill and outpatient care through what he described as "...low-cost private insurance plans to be developed on a non-profit, tax-free basis with special provision for concerted selling and risk pooling."

Important to Javits' proposals and to other alternatives offered at the time was the notion of choice. Representative John Lindsay (R-NY), proposed that consumers be given a fundamental choice. They could either accept government health insurance, to be run by the States, or a private health care plan. If they chose the private health plan, they would receive an increase in their social security benefits.

Both Javits' and Lindsay's ideas were incorporated in the administration's Social Security proposals at the end of 1964 and the beginning of 1965. The Javits "complementary private insurance" notion remained in the bill that the administration presented to Congress in 1965. Although the terms of the Lindsay bill were not included in the administration's proposal, the notion of consumer choice survived in the form of the proposed benefit package. In the administration's November 1964 working draft of the legislation, for example, Medicare beneficiaries were offered a choice of 45 days of hospital care with no deductible, 90 days with a variable deductible of \$10 a day, or 180 days with a flat deductible of \$100. Hence, the elements of choice and the encouragement of private plans were part of the Medicare planning process.

In the course of congressional deliberations in 1965, the Javits "complementary private insurance" concept disappeared from the legislation, a victim of opposition from Democrats and from the private insurance industry itself. The idea of choosing among different benefit packages also got deleted from the final bill. Even with these deletions, Medicare incorporated the concept of consumer choice through what came to be known as Medicare Part B. Part B owed its existence to the efforts of Representative John Byrnes, the ranking Republican on the Ways and Means Committee, who offered an alternative proposal to Medicare in January 1965. He suggested a voluntary health insurance program that was to cover both medical and hospital costs, funded in part by the beneficiaries themselves and in part through general revenues. Observers at the time compared it to the indemnity plan offered to Federal employees that paid the billed charges of doctors and hospitals (minus the amount that the beneficiary himself paid). The

administration proposal, by way of contrast, resembled a Blue Cross® plan that Federal or other workers might get through their employers. The Republicans searching for an alternative to the administration's bill rallied around the Byrnes bill, rather than Javits' or Lindsay's bills. Policy insiders predicted that, although the Byrnes proposal would not be reported out of the Ways and Means Committee, it would be offered on the House floor as a measure to recommit the Medicare legislation back to the committee (Berkowitz, 1995).

As it happened, however, the Byrnes bill became an integral part of the bill that the Ways and Means Committee sent to the House of Representatives. The key date turned out to be March 2, 1965. On that afternoon, Representative Mills completed his review of the major health insurance bills before his committee. As the committee's closed executive sessions—attended only by members of the committee and their staffs, representatives of key interests whose presence was specifically requested by the committee and people invited to testify that day—wound down, Mills turned to Cohen with a surprising request. He asked that Cohen (1965d) and others working for the administration develop a bill that included the administration's Medicare plan for hospital care and the Byrnes approach to care provided by a doctor. This suggestion provided the foundation for Medicare Parts A and B—programs that remain in existence today.

MEDICAID

In the high profile negotiations over Medicare, what ultimately became known as Medicaid took a back seat. Still, the idea of financing medical care for public assistance beneficiaries had its own long history. The earliest New Deal relief efforts, for example, made at least some provisions

for providing medical care. In 1950, in the same legislation that established a new welfare category for the permanently and totally disabled—to complement the existing categories of the elderly, blind, and dependent children—Congress started a program of vendor payments that allowed Federal money to be spent on the medical care of welfare beneficiaries (Stevens and Stevens, 1974). In 1960, as the battle over Medicare heated up, Congress established the Kerr-Mills program that initiated Federal grants to the States to pay for medical services for the medically indigent elderly (Berkowitz, 1995; Corning, 1969).

After the death of Kerr at the beginning of 1963, the Kerr-Mills program remained an item of interest to Mills. Stalling for time in the Medicare debate, Mills argued that the Kerr-Mills approach, with its emphasis on the States and benefits for the poor, should be given time to develop to determine if it was adequate to handle the problem of health insurance for the elderly. The program started slowly. By 1963 only 30 States had initiated Kerr-Mills programs and the program was well-developed in only a few States (Berkowitz, 1991). Mills responded to this slow start by pushing for the program's expansion. At the beginning of 1964, he wanted to create provisions that would make Kerr-Mills more acceptable to the States (perhaps creating financial incentives that would encourage States to start the Kerr-Mills programs), and that would fill in the gaps in medical coverage for people on welfare (perhaps extending Kerr-Mills from the elderly to other welfare beneficiaries).

Federal officials working in the Welfare Administration in the Department of Health, Education, and Welfare shared Mills' interest in expanding the Kerr-Mills program. They wanted, in particular, to make sure that children on welfare, who, in fact, made up the single largest category

of welfare beneficiaries, had access to health care. Hence, they developed what they called the Child Health and Medical Assistance Act for consideration in the administration's 1965 legislative program. Cohen (1964c) noted that the intention was "... to make the Kerr-Mills MAA (Medical Assistance to the Aged) program apply across the board on a non-discriminatory basis to the other three federally-aided public assistance programs." In other words, Federal grants for medical care to children on welfare should be as generous as were the grants for the medically indigent who were elderly.

In March 1965, Mills then decided to combine the administration's and the Byrnes approaches to health insurance, he also recommended that "...a supplemental and expanded Kerr-Mills program along the lines of the Administration's Child Health and Medical Assistance Act..." be included in the package. In creating what became Medicaid, he managed to incorporate elements of proposal that had been pushed by the AMA, known as Eldercare, into the large omnibus legislation. The AMA wanted to expand the Kerr-Mills program as a means of providing medical care to the elderly. The administration acquiesced in this request, but thought of a program like Eldercare as a supplement to Medicare rather than as a substitute for it. Medicaid made it into the 1965 law as a supplement, but one that would play a key role in the future of health care finance.

MEDICAL INFRASTRUCTURE AND NATIONAL HEALTH INSURANCE

Medicare and Medicaid were the primary, but by no means only, ways in which the Federal Government became involved in the field of health care finance. Ever since universal health care had become a significant social policy ideal in the

twenties, reformers had been interested in what Derickson (2005) has called the supply-side solution to the problem of access to medical care. This solution concentrated on insuring that an adequate number of doctors and hospitals were available to treat and serve patients. Beginning in the forties, the Federal Government made significant investments in what might be described as the medical infrastructure. These included grants to the States for hospital construction in a program, known as the Hill-Burton program, started in 1946 and expanded many times after that, and subsidies for medical research and medical education. Unlike national health insurance, Federal grants for these purposes attracted little political opposition, as increasing congressional appropriations for the National Institutes of Health in the forties, fifties, and sixties indicated (Strickland, 1972). Melvin Laird, (R-Wisconsin) captured the appeal of Federal support for medical research in the saying that, “Medical research is the best kind of health insurance” (Fox, 1986). They were a consensus item in health policy, supported by both the proponents and opponents of Medicare. Cohen noted in 1961, “I have the greatest respect and admiration for the ideals and the contribution which the medical profession has made.” He demonstrated his admiration through his support for pending legislation to encourage medical education, scholarships, and medical research (Cohen, 1961).

At the same time that Medicare was passed in 1965, the Johnson administration also was interested in a program designed to counter the risks of heart disease, cancer, and stroke. The administration proposed to spend \$1.2 billion over 6 years to establish 32 university-based medical complexes that would contain diagnostic and treatment centers for these diseases. The administration also favored aid to

medical schools—institutional support with the objective of increasing the number of doctors and dentists available for private practice as well as \$15 million for the construction and renovation of medical libraries (Cohen, 1964e). Variations of each of these proposals became law during the same session that Congress passed Medicare.

PAST AS PROLOGUE

One might argue that what led up to Medicare is irrelevant and that what matters is the shape of the final Medicare law and the ways it has been subsequently amended to reflect the predilections of policymakers from the era of Richard Nixon to the era of George W. Bush. After the passage of Medicare and Medicaid in 1965, controversy over national health insurance quickly yielded to consensus (Oberlander, 2003; Feder, 1977). Items that might have been controversial, such as whether or not the elderly would elect the voluntary Part B coverage for Medical bills and accept the resulting deductions from their Social Security checks, proved not to be. Instead, the Social Security Administration conducted a media blitz and sold the public on the idea that Part B was a good deal. These efforts were so successful that the voluntary feature of the program became almost insignificant, since nearly everyone elected to receive Part B coverage (Berkowitz, 2003).

As for the doctors who had worried about Federal interference in the private practice of medicine, they discovered, particularly in the years between 1965 and 1972 that Federal administrators honored their intention not to interfere. To be sure, the Federal administrators made demands of private hospitals and private medical practitioners, as in the insistence that any hospital that received funds from

Medicare should be racially integrated. But the law tempered such demands with a very permissive method of cost reimbursement that allowed hospitals and doctors to capture nearly all of their costs in treating elderly patients (Feder, 1977). If anything, Medicare and Medicaid made doctors richer and preserved their autonomy, rather than making doctors' wards of the State. Partly as a result of the money that Medicare pumped into the system, doctors became solid members of the upper middle class. Gone forever were the depression days in which one third of the physicians in the U.S. received an income deemed to be inadequate (below \$2,500 a year) as had been the case in 1929 (Falk, 1936).

Despite this initial lack of political conflict in the Medicare and Medicaid Programs, tension ultimately arose that recapitulated some of the themes of the historical transformation of health insurance in the twentieth century and the political debate over Medicare in the sixties. Medicaid, for example, emerged in 1965 as a program aimed at the poor and administered by the States. In these respects, it resembled the concept of sickness insurance that had been prevalent in the progressive era, although it covered the costs of health care rather than providing temporary disability insurance and it did not reach the entire working class, just those members of it who happened to qualify for welfare. Over the past 40 years and in particular since the 1980s, Medicaid has expanded beyond its roots as a welfare program to cover more people in need of medical services. In 1987, Congress widened the scope of the program to cover pregnant women and children living in families with incomes nearly 100 percent above the Federal poverty level (Morgan, 1994). As a result of such actions, a State program endures, even thrives, as a major component of the U.S. approach to national health insurance, a fact that might have

surprised the creators of Medicare in 1965. Suggestions that the Federal Government take over the Medicaid Program arise periodically, as in 1982 when President Reagan suggested that the States take over the Aid to Families with Dependent Children Program and that the Federal Government pick up all the costs of Medicaid (Berkowitz, 1984). However, none of these suggestions have moved beyond the proposal stage.

As for Medicare, it was modeled on health insurance practice that was current in 1965 in ways that respected the contribution that the private sector had made to health care delivery and finance. No one in Congress seriously proposed that the Federal Government should get directly involved in the health care business by operating hospitals or drafting doctors into national service. The program also reflected some of the wisdom of Falk et al. from the thirties and forties who had wanted a health insurance program run separately from cash disability programs. The doctor who treats a patient does not also have the right to certify him or her for disability benefits (Berkowitz, 1987). Furthermore, Medicare was a national program, rather than a source of funds for State programs.

Still, the story of Medicare over the past 40 years has been one of experimenting with elements of choice and of cost containment while trying to maintain the quality of care for the Nation's elderly. State waivers, which permitted variations in practice from State-to-State, figured prominently in the development of Medicare in the seventies and eighties. The program's demonstration waiver made it possible for States to test the prospective payment system for hospitals that ultimately became a formal part of the program in 1983 (Shirk, 2003).

The prospective payment system itself reflected a major change from the Medicare cost-reimbursement model that prevailed

in the program's early years. Its creation reflected the fact that, despite the deference paid to private health practitioners in 1965, the law became much more regulatory in its approach as time progressed. Increasingly, the government wanted to reign in the costs of medical care, of which Medicare and Medicaid were prominent components, by providing financial incentives that encouraged effective, but less costly care. Liberals worried that rising costs would crowd out the funds available for the expansion of the program to cover groups other than the elderly or to pay for new types of benefits such as prescription drugs or long-term care. Conservatives, who were opposed to the idea of government regulation, nonetheless saw the need to reign in costs. Hence, prospective payment in the form of diagnosis-related groups to cover the costs of treating Medicare patients in hospitals became a feature beginning in 1983, and prospective payment for doctor fees soon followed in 1989 (Oberlander, 2003).

After 1965 the element of choice, which had been so important in the debate over Medicare between 1961 and 1965, also resurfaced. At first policy insiders were confident that, if there was ever to be a Medicare Part C, it would be an extension of the program so that it covered people in different age groups, such as children or people in their fifties (Berkowitz, 2003). The events immediately following passage of Medicare appeared to confirm this expectation, as the expansion of the program to cover beneficiaries of social security disability insurance and people with end stage kidney disease in 1972 seemed to indicate. Yet, a Part C that would be America's national health insurance program that assured all Americans' access to medical care continued to elude policymakers, even in periods, such as the early

seventies, when the passage of such a program appeared, if not likely, then at least plausible (Berkowitz, 2006).

As matters turned out, Part C took a long time to arrive and when it did it was something completely different than what the creators of Social Security would have expected. Explaining the new program to seniors, a financial journalist reflected the popular understanding of Part C's purpose. "Congress created Medicare Part C under the Balanced Budget Act of 1997 to incorporate the cost-saving measures of 'managed care' into the Medicare Program" (Savage, 1998). "Think of Medicare Part C as your choice of health insurance plans, rather than a government reimbursement plan. In fact, under M+C, seniors will have a choice of three basic types of 'health insurance' programs" (Savage, 1998). Hence choice, such as Javits and Lindsay might have favored, was once again in vogue.

The decision to link public financing of medical care and private health care plans run by private companies was also a prominent feature of Medicare Part D. This feature of the Medicare law arrived in 2003 as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. It laid the groundwork for a prescription drug benefit for seniors and people with disabilities on Medicare, something that reformers had sought as early as 1966. As created in 2003, the benefit featured a scheme that allowed Medicare beneficiaries to enroll in private plans that would contract with CMS to provide prescription drugs to patients. Here was another feature that took a different form than most would have expected in 1965, but that Javits and Lindsay would have found congenial (Henry J. Kaiser Foundation, 2005; Centers for Medicare and Medicaid Services, 2003).

CONCLUSION

As a historical piece this article has dwelled on the transformation of the idea behind national insurance during the period from 1900 to 1965. As demonstrated in this article, such modern phenomena as State management of health care finance programs, consumer choice over the type of health care plan an individual elects to join, and collaborative efforts between the public and private sectors to provide vital services all have their antecedents in the long debate over the passage of Medicare in 1965. Specific acts, such as Mills' decision to blend Republican and Democratic approaches to health insurance, have shaped the development of Medicare and Medicaid over the course of their 40 year histories. In a more general way, the long run transformation of health insurance between the progressive era and the great society has also left its mark on the programs. These programs, whose anniversaries we celebrate, have therefore, resulted from a complex process of continuity and change.

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