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The Evolution of Medicare Legislation

The lack of health care legislation during the Eisenhower years should not be attributed entirely to Republican control of Congress, because between 1953 and 1954, when the Republicans had a majority, it was very slight and tenuous. When "Mr. Sam" Rayburn was again elected Speaker of the House in 1955, he also had a very slim majority. Even the election of President John F. Kennedy in 1960 was very close. In fact, the Democrats never had a comfortable majority until the 1964 Johnson landslide, which came on a wave of sympathy after the assassination of John F. Kennedy. A substantial majority of Democrats was needed to pass legislation over the opposition of the AMA and other conservative forces in both parties.

During the Eisenhower administration, various studies were done on the needs of the aged, liberal Republicans began to approve of health insurance for the aged, and the first White House Conference on Aging was planned.

The White House Conference on Aging

The White House Conference on Aging, which was to become a traditional meeting every ten years, was first held in 1961. Planning for it took place during 1960, the last year

of the Eisenhower administration, and was carried out by Republicans, closely watched by the AMA.

Nelson Cruikshank, director of the department of social security of the AFL-CIO, had great influence in the organizing of the conference and in the orchestration of the proceedings.[1]

Part of his influence was due to an arrangement George Meany, president of the AFL-CIO, had with Nelson Rockefeller, then under secretary of HEW. Rockefeller wanted to be on good terms with labor, particularly with Meany, and labor was eager to have sympathetic persons appointed to federal posts. One sensitive appointment was the commissioner of Social Security. During the early years of Eisenhower's administration, Rockefeller telephoned Cruikshank saying he wanted labor's opinion of Charles Schottland, a Republican from California whom Eisenhower was considering as commissioner. Cruikshank checked with California labor leaders and learned that Schottland, a "Warren Republican," was well thought of by labor. Schottland was appointed. Cruikshank relates how this appointment fit in with the White House Conference on Aging.

CRUIKSHANK:[2]

Schottland, as Social Security commissioner, was on the small steering committee from the administration that set up the machinery of the White House conference. The first thing was to get a chairman. We knew it had to be a Republican, because he was to be appointed by the president. There was a congressman from New Jersey–Kean it was spelled, but he pronounced it "Kane"–he had been very friendly to us on a number of occasions. He was a very broad-gauged fellow. He was on the Ways and Means Committee. He had *not* sponsored Medicare legislation, but he was on the Ways and Means Committee and he had given us several favorable votes on social security issues.

I think it was Arthur Flemming's suggestion that they could get Kean to chair the thing, and I said, "That would be great with us." He would not wield the power of the chair against us.

Then Schottland, on the planning committee, agreed with us that Medicare should be put in the income maintenance section. Medicare was a proposed amendment to the Social Security Act and therefore fit in income maintenance and as opposed to the health section. We also agreed that we would keep this assignment decision quiet.

Meanwhile the AMA was getting all of its constituent bodies to sign up for the health section. We said that was fine, we encouraged that. We knew that Medicare wouldn't be assigned to that section.

By this time we had developed quite a coalition of organizations that were for Medicare. We sent letters to them all asking who were their delegates

to the White House conference. We asked them if they would mind checking in with us and telling us what their room was, and where they were, and so forth. We had a card for everyone so that we knew the organizations and what committees they were assigned to, or what subgroups they were assigned to, what their room number was, what their phone number was, and all that.

Any time anyone tried to bring up Medicare in the health section or the education section or anywhere else, one of these delegates would phone our central office, then we would make a bunch of telephone calls, and people would converge on that meeting and object that it was out of order to bring up Medicare. Finally the doctors found out what was going on. They tried to object to the thing at the final plenary session. Kean was in the chair, of course. It was the final windup of the thing. The doctors all got together and were going to make an objection.

I went up to the platform and said to Kean, "These guys are trying. . ."
He said, "Take it easy, Nelson. I know what I am doing. Don't worry!" They went on and on. I thought he was letting them get away with murder and all. Finally he banged the gavel and said, "I find there isn't a quorum present and therefore the issue is out of order. Next question?"

He knew what he was doing all the time. They never got their objection before the body. Under the rules we had set up, the plenary session could not pass on policy issues. The policy issues were to be determined within the different subsections.

Of course, the White House Conference on Aging could not pass a bill. Cruikshank was asked if the report of the conference was generally favorable to Medicare.

CRUIKSHANK:[3]

Yes, but it was in the section that I can say now was loaded in its favor.

We knew it wouldn't pass a bill. It was just a recommendation of the White House conference. It didn't do an awful lot of good to forwarding the bill. However, had it gone the other way, it would have been an awful lot against the bill.

One of the positive outcomes of the conference was that several of the liberal Republican leaders were able to show their support for Medicare without overtly expressing an opinion counter to that of the Eisenhower administration. Cruikshank commented on this:

CRUIKSHANK:[4]

The interesting thing about that was that we had the administration people with us right under Eisenhower's nose. Charlie Schottland, Arthur

Flemming, and Congressman Kean–they were all Republicans.[5] This is the way they could be for Medicare without openly challenging the administration's position.

One other positive outcome of the White House Conference on Aging was the formation of the National Council of Senior Citizens from the many organizations that had worked hard to get a favorable report on Medicare out of the conference. Some 500 groups had supported Medicare on the floor in the conference.

Aime Forand saw the potential of a united effort among these organizations in publicizing the need for Medicare. He suggested an organization be formed to carry out this effort. Cruikshank explains the situation:

CRUIKSHANK:[6]

The delegates from the White House Conference on Aging met with Aime Forand. He wanted to meet with us. He was the author of our bill.

He said, "You've got a victory here in a way, and you have done a good job, but that isn't going to pass the bill. What you need is an organization that will implement this and carry it through. I think you people ought to form some kind of a permanent organization that will allow groups to work together actively in the legislative process."

The steelworkers put up some money, the autoworkers put up some money. They came to me and I put the arm on Mr. Meany and he put up some money. We got a little nest egg together to start what became the National Council of Senior Citizens.

It was an organization inspired primarily by Forand and primarily directed at the passage of Medicare.

The Kennedy Years

Forand didn't stand for reelection to Congress; he became the first president of the National Council of Senior Citizens and worked actively through the council to promote Medicare.

President-elect Kennedy in 1960 appointed a Task Force on Health and Social Security for the American People, chaired by Wilbur Cohen.[7] The task force reported on January 10, 1961, and recommended health insurance for the aged under Social Security

COHEN:[8]

In 1960 President Kennedy appointed me chairman of his Task Force on Health and Social Security, in which, with a number of other people, I recommended not only Medicare, but federal aid for construction of medical schools and tuition grants for physicians and other health personnel.

Although President Kennedy in his first State of the Union address, in January 1961, mentioned the need for health insurance under Social Security, he was realistic enough to know that there was little chance of such legislation's being passed in the current Congress. The Democrats had a 20-seat majority in the House and barely retained control of the Senate.

Nevertheless, Kennedy persisted. He sent a special health message to Congress on February 10 reiterating his request for action in this area. Three days later, Senator Clinton Anderson (D-N.M.) and Representative Cecil King (D-Calif.) introduced a health insurance bill in Congress. This was a successor to the Forand bill.

Possibly just as important as the national council's efforts in bringing the health insurance issue to public attention was the opposition action of the AMA. The AMA apparently felt the medical profession was threatened by the King-Anderson bill. The AMA assumed the attitude that there could be no compromise; the movement had to be stopped. In fact, a campaign was waged in which radio and television commercials were used extensively. Several million pamphlets were distributed. A speakers' bureau was established to spread the word, and a "letter to your congressman" effort resulted in a cascade of thousands of letters on Washington, D.C.

In the summer of 1961, members of the AMA also established the American Medical Political Action Committee (AMPAC) in anticipation of the 1962 elections.

In the meantime, the implementation of the Kerr-Mills program was going forward. Many of the opponents of Medicare hoped that Kerr-Mills would take care of the medical problems of the aged and poor. If so, they argued, it would obviate the need for Medicare. It was soon evident that Kerr-Mills was not solving the problems of the aged ill and indigent ill, particularly in the poorer states.

All in all, a great deal of publicity, pro and con, was generated about Medicare. On the pro side were labor unions, churches, the American Public Health Association, and others. Several prominent physicians formed the Physicians' Committee for Health Care Through Social Security.

Blue Cross, Blue Shield, and some of the commercial insurance companies began developing low-cost insurance programs for persons 65 and over. It was hoped that private insurance could help relieve the needs of the elderly.

Walter J. McNerney had moved from the University of Michigan to the presidency of the Blue Cross Association (BCA) in 1961. One of the first problems he faced was determining what the Blue Cross plans could do to offer health insurance coverage to the elderly at a cost they could afford.

McNERNEY:[9]

It would take a long time to spell out all that happened.

When the aging issue began to heat up in the early 1960s, there was a lot of tension and a lot of politicking.

I convinced Ed Crosby [executive director of the AHA] that the American Hospital Association and the Blue Cross Association should do a study on the aged and that its initial focus should be on what the problem was; that is, number of aged, age distribution, sex distribution, the amount they spent on health, their length of stay versus the same for the under-65 population, and so forth. We were trying to get a grasp of what the problem was. My thought, at the time, was that if we were able to define the problem better we would be serving a good public purpose. It would also make it clear we were not afraid of the problem.

In general terms, I think the AHA and BCA took some very responsible steps. We made some mistakes but, by and large, we took responsible steps.

We also took the initiative. We were the ones who came out during the debates and said, "There is absolutely no question that the aged are in a unique position. At a time in their lives when they can afford it the least, they have the most health care expenses." We documented that this was true and that there was an obverse relation between income and incidence of illness and that the private sector was incapable of producing, through subsidization from the insured working population, enough money to make health insurance premium rates generally affordable to the aged. Something had to be done about it.

Clearly there were quarrels about the best way to go about it. But AHA and BCA were on the line saying we have a problem here and also saying that the low-income group, whether they were aged or not, had a similar problem that had to be dealt with as well.

I said we made some mistakes. When the debate dragged out and it wasn't clear what was going to happen, I, particularly, took the point of view that, since we don't know when this is going to be resolved, how about Blue Cross making a special effort? So we talked about a national program that would improve our offerings to the aged. By that time we were doing better than any of our competitors. If everyone had the same percentage of aged enrolled as we did, there would have been a lesser problem. There would have still been a problem, but a far smaller problem.

I encouraged the Blue Cross plans to have some special open enrollments to make it

possible for the aged who hadn't been enrolled to come on board, and to do a better job for those who were on board. This was interpreted by some as an effort on my part to try to solve the problem naively, through just the private sector, undercutting, if you will, the legislative process. I don't think I was dumb enough to think our effort could or would fully solve the problem. On the other hand, I was a bit naive in regard to the timing and how our encouragement of this effort would be interpreted. I didn't anticipate that it would be used against us later the way it was, but that passed.

John R. Marmix was actively involved in the Blue Cross movement.[10] He was asked what he remembered about the Blue Cross attitude toward the elderly, particularly in the years before Medicare.

MANNIX:[11]

I was very much interested in Blue Cross and Blue Shield offering a program for the care of the elderly and advocated a program which I called the Golden Age Program.

I tried to develop such a program in the Cleveland area, in which the individual would pay a somewhat higher premium during his working years which would be adequate to cover the cost of his care after he retired. I did some work on a plan which would pay 75 percent at that time. The premium was on a graduated scale depending on his years of membership as a worker.

One of the interesting things about this was that labor opposed it. In the early 1960s, labor was very much in favor of a federal health insurance program. When I presented this program to the Ohio Insurance Department for approval, labor opposed it.

Medicare came a couple years later, and I think it leaves a lot to be desired. Medicare is paying only approximately 40 percent of the cost of health services of the elderly. Blue Cross and Blue Shield and private insurance companies supplement this with what is generally referred to as fill-in programs where they cover the benefits Medicare does not cover. This is a problem for the elderly.

Daniel W. Pettengill[12] was with the Aetna Life Insurance Company from 1937 to 1978. From 1964 to 1978 he served as a vice president of the company. During his career, Pettengill was a major force within the commercial insurance industry on matters of national health policy. He discusses how the commercial insurance companies approached the problem of how to provide health insurance protection for the elderly.

PETTENGILL:[13]

The hard fact remained that, for any employer, health care coverage for a retiree was about three times as expensive as for an active employee and hence was not a coverage to be purchased voluntarily. Furthermore, many unions were wary about using their bargaining power in this area. So insurance companies were left with the problem of how to provide coverage for the aged who needed it the most but who could afford it the least.

No one insurer could handle this problem alone. A joint effort was needed in order to obtain the large volumes of insureds needed to cover the extra risk and the expense. Unfortunately, the Southeastern Underwriters decision of 1944 had declared insurance to be interstate commerce and hence subject to antitrust statues. So a joint effort per se was illegal.

The matter stood at this impasse until one evening when George Light, an attorney for the Travelers, and I were returning to Hartford by train from an industry meeting in New York City. He said, "Look, we could do something for the aged population in Connecticut if we could get permission from the state for the companies to cooperate and to underwrite the coverage as a single pool." So the next day we went to our respective presidents and got permission to draft and seek passage of the necessary legislation.

That legislation did pass. As a result, we established the Connecticut 65 Plan, which offered reasonable benefits to persons age 65 and older residing in Connecticut. Connecticut 65 kept its expenses low but still had to charge a fairly high premium rate in order to cover its claims experience. Employers were encouraged to help pay the premium for their retirees, but few did so.

Connecticut, being a small state, did have difficulty getting the volume of coverage sold that was needed to make the pool self-supporting. But the idea caught on and, although I think there were only seven insurance companies that participated in the Connecticut pool, we were able to persuade the industry to set up similar pools in other states. I believe Massachusetts was next, followed by New York, California, and Ohio.

These state 65 Plans were just getting rolling when Lyndon Johnson's 1964 landslide election occurred. Johnson, with his mandate, was bound and determined to have a federal program for the aged. So the fact that the insurance industry was doing something constructive for the elderly was just lost on the Congress.

As a matter of fact, in late November 1964, following the election but before the new Congress started in the subsequent January, I talked with Wilbur Mills, who was then chairman of the House Ways and Means Committee. Mills said, "Dan, President-elect Johnson has called me and said we are to have a bill for the aged in the hopper as soon as

Congress convenes, and it is going to go through."

Hearings in the Ways and Means Committee on King-Anderson began in July 1961 and extended into August. It soon became apparent that there would not be enough favorable votes in the committee to report the bill out.

Although the King-Anderson bill died in committee in 1961, President Kennedy maintained his support of the principle in speeches and in interviews with the press. Public sentiment was rising in favor of Medicare (some pollsters reporting a 69 percent favorable response). Political conservatives were responding with reworked plans for federal subsidies of private insurance for the elderly. Even the AMA was beginning to think they might find acceptable some sort of federal subsidy for the needy among the aged. All of these swirls of action and proposed action climaxed (or anticlimaxed) in the spectacular event in Madison Square Garden on Sunday, May 20, 1962, when President Kennedy addressed a crowd of over 20,000 senior citizens. Nelson Cruikshank talked about his part in this event.

CRUIKSHANK:[14]

I had a very inglorious part in it. I was never much impressed by the effects of rallies. They were more of a CIO than an AF of L tradition. I came out of the AF of L side. I wasn't against them; however, if they weren't managed awfully well, they could do more harm than good. Also, if they are not a huge success, they are not a success at all.

I said OK. The people wanted to do it. I was certainly not going to try to stop it. I would play my part and do what I was told to do.

The idea was to have President Kennedy appear at Madison Square Garden. We would fill the Garden with labor people and senior citizen groups. Then we would have rallies all around the country in different cities. There would be a huge television screen at each of these local rallies, and at the right time President Kennedy would be wired in and we would fire up the whole thing.

At the actual rally, President Kennedy probably made the poorest speech he ever made. None of us ever quite knew why. He made a slip of the tongue; he said the cost of Medicare would be $12 a month instead of $12 a year.

On balance, the thing at Madison Square Garden, however, went all right. Then, you know, the American Medical Association came in and bought time on television to answer us. They made their famous speech to the empty chairs in Madison Square Garden.

The meetings out over the country were something else. There were about 20 of them set up. I was sent to Charleston, West Virginia. It was really something–the only time I

made the front page of the AMA *News,* in a way I wasn't happy about.

As soon as I got in town Saturday night, I could smell defeat right away. There were no ads, no posters. The evening paper had no story on it. The thing was going to be a flop.

(The person who was supposed to be in charge had left town and turned it over to somebody else.)

The labor people had organized a luncheon. There were about 15 or 20 people at the luncheon, and then we went right over to this huge hall. When we got there, the AMA had doctors at every entrance of the hall handing out leaflets. Practically nobody showed up. We addressed this sea of empty chairs, whereupon the AMA had pictures of these empty chairs with me addressing them. They put that picture on the front page of the AMA *News* with the caption, "This Is the Kind of Support Cruikshank Has for His Program." It was a large piece of humble pie I had to chew on.

As Nelson Cruikshank mentioned, Kennedy's speech in Madison Square Garden was one of the worst of his career. It has been said that he discarded the speech prepared for the occasion and attempted to write a new one on his way to the Garden in his limousine. Time was pressing, for the speech and ceremony at Madison Square Garden were to be on national television, so the President spoke extemporaneously–and badly.

His audience at the Garden was composed of elderly citizens. There was no need to impress them with the importance of health insurance for Social Security beneficiaries. However, out in the nation where a good impression was desired, the performance on television fell flat.

The AMA bought television time for a half-hour broadcast from Madison Square Garden two days later. The speaker for the AMA was Dr. Edward Annis of Miami, who became a spellbinding orator for the AMA in its fight against "socialized medicine." The contrast of Annis' speech with Kennedy's was pronounced.

One of the examples given by Annis of steps being taken to help the poor and indigent was the Kerr-Mills Act, which had been implemented just a year before. He pointed to the success of Kerr-Mills in 38 states. Actually, Kerr-Mills had only been approved in 24 states. Moreover, the Senate report on Kerr-Mills made shortly after the Annis speech showed that 90 percent of the federal funds were going to only four states, those which could afford to operate adequate Kerr-Mills programs.

A few weeks after the president's appearance at Madison Square Garden, an attempt was made to circumvent the usual practice of submitting a bill in Congress, having it reviewed in committee, and, if reported, having it voted on in the chamber where it was

With a few exceptions (including Kerr-Mills, total disability benefits under Social Security, military medicare) health bills had generally died in committee without a floor vote. The circumvention of normal procedures was the Anderson-Javits amendment, which was an attempt to attach an amendment to a Senate welfare bill which was under pressure for passage. The amendment, named for Anderson and Senator Jacob Javits (R-N.Y.), called for the main features of the King-Anderson Medicare bill plus some provisions for commercial insurance companies to participate.

It was a daring move, and it nearly succeeded in the Senate. However, the amendment was tabled on July 17, 1962, by the close vote of 52 to 48. Even had it passed in the Senate, it was thought unlikely to have passed in the House.[15]

Cruikshank talks about some maneuvering that went on in the attempt to attach the Anderson-Javits amendment to the welfare bill in the Senate.

CRUIKSHANK:[16]

In 1962 Mills said to us, "Take your bill over to the Senate." At that time we were within one vote of it in the Ways and Means Committee. Mills didn't want to give his vote, which would have broken the deadlock in the House. Of course, under the constitution that kind of act must originate in the House; it was technically a revenue tax act. "Take it over to the Senate and hook it onto something over there. Come back and we'll see what we can do."

We knew Wilbur Mills pretty well. This wasn't a definite promise; however, it was worth trying. So we hooked it onto something over in the Senate.

This became the Anderson-Javits amendment?

CRUIKSHANK:[17]

Yes. Javits came to us and said if there was a role for the insurance companies there were eight Republicans he had who would support it. We knew who a couple of them were. We weren't sure of Javits' comment, but he was an honest man . . . . We didn't know just what he meant by the role of insurance.

Once it was decided to go ahead with the amendment, a great deal of activity went into designing an amendment that would be satisfactory to Republicans and Democrats. Cruikshank tells of a night meeting suddenly called in the office of HEW secretary Abraham Ribicoff and attended by Wilbur Cohen, Senator Javits, and Cruikshank and Leonard Lesser representing the AFL-CIO. The key question was defining the role of insurance companies.

The union representatives were restricted by instructions from George Meany, who, according to Cruikshank, had said, "Don't let the insurance companies in."

Meanwhile Meany had gone to Europe to an international union meeting, so it was difficult at times to reach him for advice as negotiations developed. Meany evidently was afraid the insurance companies would secure an underwriting role.

CRUIKSHANK:[18]

When the insurance companies are in an underwriting role, every claim for benefits is in competition with profits. We had seen that in workman's compensation. We had seen the corrosive effect of commercial insurance.

The union representatives were not able to get a clear definition of what Javits wanted for the insurance companies, so Cruikshank took the initiative and called a Sunday meeting of insurance and legislative experts from the union. Together they wrote a suggested amendment to attach to a Senate bill and presented it to Javits; he agreed to go along with it.

CRUIKSHANK:[19]

We didn't think he would . . . but Javits was a different kind of Republican, always had been.

Cruikshank and Andrew Biemiller, the legislative expert for the AFL-CIO, telephoned Meany in Europe. Meany told them to do the best they could without giving the insurance companies an underwriting role.

The year 1963 began as many others had in the history of the evolution of Medicare. On February 21 President Kennedy sent a special message to Congress on the problems of the aged. On the same day a slightly revised King-Anderson bill was introduced in Congress. Hearings on the bill in the Ways and Means Committee were interrupted on November 22, the day President Kennedy was assassinated.

The death of the president aroused tremendous sympathy for Kennedy, for his family–and for his legislative goals. Lyndon B. Johnson, his successor, moved quickly on that wave of sympathy and pledged himself to carry out Kennedy's programs. Johnson put Medicare high on his list of priorities, a fact he mentioned in his first speech to Congress.

The Johnson Years

During those early months of Johnson's administration, public sentiment was rising for Medicare. Proponents of the measure thought the necessary votes might now be available in the Ways and Means Committee to report the King-Anderson bill out. Wilbur Mills was

keeping a tight hand on the Ways and Means Committee, however, and the bill was not reported.

Another bill (H.R. 11865) was reported, but it authorized only an increase in Social Security benefits–no health insurance. This bill was passed in the House and was sent to the Senate. In the meantime, the King-Anderson bill had failed to gain approval in the Senate Finance Committee, but there were enough votes in the Senate to attach it as an amendment to H.R. 11865, thus circumventing the finance committee.

Because of the amendment, the bill went to a conference committee of the House and Senate to work out compromises. To expedite matters, the Johnson administration proposed that a vote of the full House instruct the House conference committee members to vote for Medicare. This move was rather high-handed in the minds of many House members, and it failed. The committee was deadlocked; no compromise could be reached, so both the health insurance and the increase in Social Security benefits failed.

The failure of H.R. 11865 in the conference committee occurred in October 1964. The elections that took place in November of that year changed the nation's political complexion. Johnson was elected by the largest plurality ever registered up to that time. The House and the Senate both showed a two-to-one margin in favor of the Democrats. Several persons active in promoting Medicare at that time comment:

MILLS:[20]

Lyndon Johnson ran in '64 and was reelected in his own right. Then he announced to the Congress his desire to pass everything President Kennedy had advocated. Had President Kennedy lived, I don't know if Medicare would have passed. I don't think President Kennedy would have pushed it like President Johnson did. They were two different kinds of people. Not that Kennedy wasn't for it, it was just that President Johnson was far more tenacious about things.

CRUIKSHANK:[21]

It wasn't until the Democratic landslide of '64 that you had enough Northern Democrats to override the Southern Democrats. As a result, when '65 came around, President Johnson ordered Wilbur Mills to enlarge the House Ways and Means Committee and told him who to put on the committee, because, he said, "We are going to have a majority of your committee for Medicare."

PETTENGILL:[22]

Whenever a party gets a substantial increase in the number of their members in Congress, that party is entitled to take the committees and reratio the ratio of Democrats and Republicans. Because Lyndon's victory was a landslide, the Ways and Means Committee

was enlarged. In making that enlargement, President Johnson was very careful to be sure that the House leadership chose people who would be supportive of Medicare.

The Passage of Medicare

Events of 1965 moved along swiftly but in the familiar pattern. The president made his State of the Union speech to Congress in January and stressed his determination to see the King-Anderson Medicare bill passed. Almost simultaneously the bill was introduced in Congress as H.R. 1 and 5. 1, which seemed to indicate the party's estimation of its importance. In addition, Wilbur Mills was speaking in early 1965 as though the passage of the bill were certain and imminent.

The AMA again gathered its forces to resist. This time the resistance took the form of an AMA-supported bill called "eldercare." Eldercare would subsidize private health insurance for the elderly through federal and state grants. The bill was introduced in the House the day hearings began on King-Anderson.

Another alternative to Medicare was a bill introduced in the House by Representative John Byrnes (R-Wisc.). This bill called for federal subsidies for private health insurance for Social Security beneficiaries. The financing was to come two-thirds from the federal government and one-third from deductions from Social Security checks.

In the spring of 1965 there was a general feeling that some sort of Medicare legislation would pass in the current Congress. Public opinion polls showed that two-thirds of the respondents favored Medicare.

The tempo for moving the King-Anderson bill to the floor of the House for a vote picked up. Wilbur Mills now had a clear majority on his committee in support of a Medicare bill.

Mills was a superb politician who did not move until he had a situation under control. He knew Medicare was very likely to pass: he had found a way to pacify physicians (through Part B, which will be discussed later), and he had the Democratic majority in Congress necessary to pass the bill.

Mills, however, was faced with a wide spectrum of bills and amendments out of which the Ways and Means Committee had to write a bill. In order to clarify the situation, he asked Wilbur Cohen to appear before the committee and outline and discuss the various **MILLS:**[23]

Wilbur Cohen felt, as I did, that the program the administration espoused had to be improved.

I started off with the basic thought that the American people would feel that we misled them; and they'd be highly resentful if we did nothing more than just what President Johnson had initially recommended.

The administration's program would only take care of about a fourth of the total cost. People thought it was going to take care of it all. If we did no more than that, and they found out we were only taking care of a fourth, all of us would be in trouble. We had to find some way to take care of more of the cost.

I talked to the president about it and he agreed.

He didn't take the time to develop the ideas himself, but we had at our disposal all the ability of the members of the committee. Together we developed what was later called the "three-layer approach." We wanted to take care of the medical needs, fully, of those who were on welfare–everything–and we wanted to take care of the major portion of the needs of people on Social Security and Railroad Retirement.

After Cohen had finished describing the various bills and proposals on health insurance for the aged–the last plan discussed was the Byrnes "bettercare" bill–Mills said to Byrnes that he really liked Byrnes' idea of copayment out of Social Security checks. He said he saw this as a supplement to Medicare to help pay the cost of physicians' services.

In fact Mills, to the surprise of all the committee members, then suggested a three-layer approach. The top layer was the Byrnes payment plan for the physicians. The middle layer was for hospital care, financed by payroll taxes and employer taxes. The bottom layer represented an enhanced Kerr-Mills program for the low-income and indigent, or Medicaid, as it became known.

Cohen speaks about that third layer, which became Medicaid, as does Kenneth Williamson.

COHEN:[24]

While Medicare was being fought in the frontline trenches between those who favored it and those who opposed it, there was also the entire issue of what to do about people who were either not covered by Medicare or not adequately covered.

Medicaid came about because the welfare system for low-income and indigent persons was not adequate in the United States. However, since the welfare program was primarily related to the state operations, financed partially by federal funds and with federal standards, the Medicaid program became a federal-state system, whereas Medicare became primarily a federal system. That's how these two programs evolved.

However, the most unusual aspect of the Medicare program was the fact that in the

congressional consideration in the House Ways and Means Committee, a result of certain discussions between Wilbur D. Mills and John W. Byrnes (the Republican minority member of the Ways and Means Committee from Wisconsin), the entire idea of covering physicians' services on a voluntary basis was added to the program. This we now call part B, whereas the hospitalization insurance, which was compulsory in its coverage, was called part A.

This was rather unexpected on everyone's part and thus led to a good deal of interest. The most interesting aspect of that is that the part B was financed initially about half from general revenues and half from the beneficiaries, and today the general revenues portion has reached about 70 percent. As a result, we have general revenue financing a part of the Social Security and Medicare programs.

WILLIAMSON:[25]

One afternoon Congressman Wilbur Mills called me and told me about Medicaid. They had had the Kerr-Mills bill, which had preceded Medicaid. Mills and Senator Kerr drafted it, and it flopped. The states didn't support it. I was serving then as kind of a consultant to Mills. He would call me, and I would go over and talk to him about why the thing was a failure.

Anyway, he called me this one afternoon and said he would like to see me. I went up there. He had John Martin, his staff director, with him. Mills said, "We are drafting this program, Medicaid, for the poor. It will be a whole new thing." He sketched it out, and he said, "John will tell you the details. You can't talk about this, it is confidential at this stage. But," he said, "you have talked to me about hospitals and the way they should be handled, reimbursement and all." Then he said, "if you could put one thing in this bill in behalf of the hospitals, what would it be?"

I said, "That would be very simple. It would be to say that the states can't pay hospitals any less for care than Medicare pays. In other words, they must pay reasonable costs."

Mr. Mills accepted the idea and put it in the bill.

That has meant billions–not millions, billions–of dollars to hospitals. They have to fight for it now, they have had to go to court to justify it, but that wording raised the level of payment to hospitals enormously.

Anyway, Mills bought the idea. I often think that, in terms of money, there probably isn't anything I ever did that earned my pay more than that one day's work.

Mills gave the Republicans full credit for their contribution of the top layer of the three-layer cake.

MILLS:[26]

We finally worked out part B. Representative John Byrnes offered it. It was good that he did it. I was hoping that John would, because that meant it brought in Republican support. He brought them all with him. He brought them all in when he did it. John is entitled to an awful lot of credit in connection with the establishment of Medicare.

The basic thing was how to pay the doctors. The way Byrnes worked it out in his motion was that they (the beneficiaries) would be charged so much a month, and the federal government would put up a like amount [originally $3.00 per beneficiary per month from each source]. The Department of Health, Education, and Welfare came up with their estimates of what that premium should be. We tested it and found general acceptance of it.

The Republicans were astounded. Mills had stolen their thunder with his three-layer compromise program. The Ways and Means Committee approved the bill, 17-8, on a strict party-line vote.

President Johnson was delighted with the move and went on television the next day to tell the country the good news. Cohen had told him the three-layer approach might increase costs $500 million a year over the original plan, but Johnson did not seem concerned with the added costs.

PETTENGILL:[27]

Part B was the compromise which Mills gave to the Republicans who wanted an all-private plan. John Byrnes, from Wisconsin, was pushing this. And so Wilbur pulled a real coup by turning to Byrnes one day late in the discussion and saying to him, "OK, part A is going to be what we Democrats have been talking about, but we'll take your plan and limit it to just physician services. We'll insure it, and we'll hire the insurance companies and the Blues to be the carriers."

Byrnes was caught flatfooted. What was he to say? Here was the perfect political compromise. Part A was Lyndon Johnson's, part B was Johnny Byrnes', Republican. So, unfortunately, they agreed. It went so fast that neither one of them worried about cost.

MILLS:[28]

The AMA still opposed it [part B]. They met, they weren't going to participate, and some of the doctors didn't participate. They didn't want to get any payment from any source that had anything like the meaning of socialized medicine. Now I think they realize it's a gold mine. They can get things paid for that never otherwise would have been paid. They would have rendered the services and not been paid.

Nelson Cruikshank, of the AFL-CIO, commented on the Mills maneuver to bring out a bill that would provide for doctors' services as well as for hospital care.

CRUIKSHANK:[29]

He [Mills] worked out this compromise with the AMA. He didn't give the AMA very much, actually. He kind of took them at their word. He said that, "You talk about aid to the needy not the greedy. OK, we'll take care of the needy. We'll have a Medicaid bill and do that on a means test basis. The other people we'll handle on an insurance basis." You see, the AMA didn't want that part of it at all. He was able to kind of turn their propaganda against them and say that he was doing what they were asking. Of course he was doing a lot more. How could they object to that? They did object, but it didn't get anywhere.

The bill, with its compromises and a piece for everybody, passed the House on April 8, 1965. It was then sent to the Senate Finance Committee.

The passage in the House was nearly uneventful. One incident, however, showed that, without the new Democratic and Republican members favoring Medicare, the bill might have failed. A motion was made to send the Mills bill back to committee and substitute the original Byrnes bill. That motion lost by 45 votes, or one more than the number of new members favoring Medicare. Mills had been right: Medicare never would have passed in the 1963 session.

The Senate Finance Committee hearings on Medicare began in late April and were completed on May 19. The AMA's opposition was outspoken during those hearings, and the committee's response at times was acerbic. Furthermore, during the executive sessions of the committee, in which the Senate version of the House bill was being written, a major problem developed. Senator Russell B. Long (D-La.) announced a planned amendment to the bill. (This amendment certainly was known to the AMA, because one of its publications was in press with the news at the time.) The amendment called for unlimited hospital stays for persons age 65 and over. This was to be financed by a graduated scale of deductions based on income, ranging from 5 percent of the first $1,000 of income and 6 percent of the second, to 7 percent of any amount above that.

This maneuver by Long threw Anderson and others off balance, because it would load the bill with indeterminable added costs and would introduce a means test, which was anathema to most of the members.

Long's announcement came as a surprise, as did his request for a quick vote. The amendment carried in committee. The incident was darkened by Long's misuse of a proxy

from Senator J.W. Fulbright (D-Ark.). Further, Senator Paul Douglas (D-Ill.), a leading liberal, was misled into believing that this was the right thing to do until he began calculating cost and benefit figures. He was dismayed at how he had miscast his vote.[30]

Nelson Cruikshank was on the scene trying to help get the Medicare bill passed. He sat in on meetings in which the Democrats tried to plan a strategy to circumvent Long and get the Senate bill written so it would get out of committee and receive a favorable vote on the floor. He was asked what motivated Long.

CRUIKSHANK:[31]

It was awfully hard to tell what motivated him.

Senator Long was joined by Senator Abraham Ribicoff [D-Conn.). The Long-Ribicoff amendments would have made Medicare a catastrophic insurance thing. When Long and Ribicoff came up with their amendments, Paul Douglas supported it. Then Douglas' conscience started working on him–not only his conscience, but his brain. He was a trained economist, you know. He called me over and he said, "Here's what I have done, and I feel unsure of myself."

I said, "I am glad you do, because I think you have undercut the whole thing. Our whole long battle is lost. We can't support this kind of thing."

"Well," he said, "how can we reverse it?"

I said, "You voted for it, didn't you?"

He said, "Yes."

I said, "That puts you in a parliamentary position to ask for a reconsideration in the finance committee."

"But that's very hard to do. That's never done," he said.

"Well, Senator, it's a matter of principle." (You could talk principle to Paul Douglas.)

Then in that milieu emerged Senator Vance Hartke of Indiana, who also was a member of the Senate Finance Committee. He came up with a compromise. I forget just what it was, but both Long and Ribicoff could support it. It went a long way toward the Long-Ribicoff proposal.

As I said, Hartke came up with a proposal, a compromise proposal. He called me over to his office.

He said, "I can pass this. I have got enough assurance that I can pass this compromise. You can't pass the House version in this committee."

I said, "I don't know whether we can or not."

At that point I didn't want to close the door entirely. I said we would think it over. I went to Senator Clinton Anderson. That was the Anderson bill in the Senate, you know. I said, "Where do we stand on this?"

Now Anderson was an insurance man himself. He made his money in insurance.

He ran a big insurance company in New Mexico–workmen's compensation. He knew the insurance business. He used to tell his insurance colleagues, "You are crazy to oppose this. This is sound insurance."

Unfortunately, Anderson was not well. He was sick half the time. It was a heroic thing for him to even be on the floor during these battles. Anderson said that he would sound out the committee to see how many would stand by a vote to reconsider. Then, if they passed the vote to reconsider, he would put his original proposal forward for endorsement again by the Senate Finance Committee.

I said, "OK. See where you land, count your noses."

The meeting of the committee was to be held on Monday morning at 10 o'clock. I was in Anderson's office at 9 o'clock. He came out. He had worked over the weekend with his colleagues. There were 17 members on the committee.

I said, "Where do we stand, Senator?"

He said, "We've got nine people in favor of the original bill."

I said, "That's a majority of one."

He said, "That's right."

I said, "Who are they?"

He read them off. One was Senator Harry Byrd of Virginia, a conservative old character, you know.

I said, "My God, Clint, that's a weak reed to lean on. Maybe we've got to think of the Hartke proposal."

"Well," he said, "Senator Byrd said he would stand with me." And Anderson looked at me and said, "What do we do?"

I said, "Let's go for broke. We have compromised enough."

I'll never forget. He held on to my hand and said, "I hoped you would say that."

Later he told me that Senator Byrd voted with him and then in the committee he said, "I cast this vote this way, and I want to tell you why. I am going to vote against Medicare when it gets to the floor. I am against it on principle but I don't think the way to kill a bill is to load it up with ridiculous amendments. I think the bill ought to go before the Senate with a clean choice."

That was conservative old Byrd from Virginia. But that was touch and go. Years and years of work hung on that one vote.

The Anderson forces won in the next Senate Finance Committee vote against the proposed Long amendments. The bill was reported out, and on July 9 the Senate passed the Medicare bill. Because of the differences in the House and Senate versions, the two bills were sent to a joint conference committee. The bill had originated in the House,

so the committee was under the chairmanship of Wilbur Mills.

The joint conference committee took a week to complete proceedings and compromise on the differences in the bills. Both houses passed the compromise bill, which became part of the Social Security Amendments of 1965, by July 28, 1965. Two days later, President Johnson went to Independence, Missouri, for a ceremonial signing in the presence of former President Harry S. Truman. Several congressmen and others active in the writing and passing of Medicare and Medicaid were on the scene as witnesses. The event received wide television and press coverage.

Several persons have looked back at the legislative process of establishing, and the administrative process for implementing, Medicare and Medicaid. Walter McNerney, for 20 years president of the Blue Cross Association, commented on the compromises, the giving and taking, that went into the process of passing the legislation for Medicare.

McNERNEY:[32]

In the nature of compromise, under the general banner of pragmatism, there were arguments about whether there should be deductibles or copayments when planning Medicare. Some felt they should be included for no other reason than to keep the program financially sound.

It's wonderful to watch the government in action in this regard. I don't say this with disrespect, it's simply factual. When legislators and members of the administration saw the figures, they became concerned about the impact on the trust funds and on general tax revenues and began to talk deductibles and copayments. Evangelists for comprehensive coverage suddenly got very practical about matters and forgot the bad things they had said about indemnity or other forms of "inadequate" coverage.

The big issue over deductibles and copayments, aside from the precise design and amount, was could these be filled by private carrier coverages in the public market? Wilbur Mills tested the water on this issue and found out very fast, from other members of Congress and from the general public, that the public didn't want anybody stepping in the way. If they, the public, wanted to buy insurance to fill the gaps in Medicare, then they would fill them and to hell with the doctrine of whether deductibles and copayments would, could, or should be used. That water hasn't been tested since, because it came back so emphatically clear what the results would be.

I'd like to make one comment here.

It's very popular these days to point out that part of the bargain under the Medicare and Medicaid acts was that very little would be done to interfere with the practice of medicine or the operation of hospitals. You can point to it in the bill and in the committee reports. The implication is that, in order to get the deal swung, it had to be largely a

financing operation, so hands off medicine and hospitals. It becomes very convenient to say that's why we ran into inflationary problems, that's why in the seventies we have so many beds, etc., etc. I want to offer this small historical note.

There was a fair amount of discussion about controls–not with the sophistication we do it today, but still there was a fair amount of discussion. The state of the art differed. We didn't know as much about how to exercise control. But don't let anybody kid you, the questions of how to negotiate formulas, of how to define qualified hospitals, of the desirability of strengthening areawide planning were all discussed at that point in the sixties.

The polite language for the sake of the health establishment, that things wouldn't be touched, was a front piece. There was already concern about how to shape things so this program wouldn't get out of hand. In fact, if you read the bills closely, you can see that certain controls were actually instituted. However, the action was along an evolutionary path.

CRUIKSHANK:[33]
Nelson Cruikshank also gives his observation of Medicare in action.

I have often said I have been talking about hospitals and health care all my life but have never been hospitalized. But last winter I spent 16 days in the hospital. I had a $12,000 hospital bill. Medicare paid almost all of it. You see, it is a damned good program in circumstances like that. Now, if I had a bad nosebleed or an ingrown toenail or something like that, Medicare probably wouldn't even cover it. Those things go into the average. That also says something about the nature of a health program. The health program ought to take care of minor things as well as major things. Medicare is a better program than people give it credit for. Fourteen of $15 billion worth of health bills for older people are paid for out of the system. As I say, the big bills are pretty well taken care of.

Implementation of Medicare

A frequent topic of conversation about Medicare is the role of the private sector in administering it.

One factor should be stressed: the insurance companies had a claims-processing apparatus in use and experienced personnel to operate it. The federal government passed the Medicare law and specified it would go into effect within 11 months. Could they buy

the carriers for part B set up as a sop to the insurance companies, or could the claims services of insurance companies handle Medicare claims better than the government?

Wilbur Mills had no question about the need to use insurance companies. He saw them as fulfilling a need and also as a buffer mechanism.

MILLS:[34]

The use of private insurance was a means of softening the relationship between the doctor and the government. Get somebody in between you and the agency you deal with in the government. A provider's organization, primarily Blue Cross and Blue Shield, something they set up themselvesthat could be the intermediary.

The whole theory that we had was the more services you make available, the more people you're going to need to provide those services. You don't want to rule any of them out, nor wipe them out. But, no, this was not done as a sop to anybody. Rather, it was the recognition of what we thought was a fact. They're all going to be needed. So you have got to work it out on the basis that they will participate.

Wilbur Cohen saw the use of an intermediary as a way of building the relationship between the public and private sectors.

COHEN:[35]

I have strongly taken the position that, under any kind of national health insurance plan, whether a partial one like Medicare or a comprehensive one, the payment process should be handled by fiscal intermediaries such as Blue Cross, Blue Shield, and commercial insurance companies. I believe that this is a very practical way of both handling some of the day-to--day administrative problems and of forging an effective relationship between the public and the private sectors.

James Hague, former director of publications and corporate secretary of the AHA, and Kenneth Williamson, former director of the Washington Service Bureau of the AHA, speak about intermediaries.

HAGUE:[36]

The American Hospital Association didn't want the Social Security Administration to administer the Medicare program. The AHA by and large prevailed, removing Social Security from the active administration of Medicare–through the intermediaries.

We fought for them and won. The AHA staff did the scut work that led to the nomination by an overwhelming majority of hospitals of the Blue Cross Association as the

intermediary. First, saying there had to be an intermediary; and then, second, naming Blue Cross Association as the intermediary. By and large, it's worked quite well, I think.

WILLIAMSON:[37]

In the writing of Medicare there has been a lot of discussion, some of which is amusing to me, about the Blue Cross role. I can tell you one thing flatly, no "if" or "and," the role Blue Cross had in Medicare I negotiated. The intermediary was *my* idea. If Ed Crosby [executive director of AHA] were alive, I am sure he would say this. I talked with him about it at the time we got to the bill-drafting stages.

The hospitals needed protection. They needed somebody they trusted between themselves and the government. The House Ways and Means Committee was discussing how to administer Medicare as they drafted the bill. The first thought was to go to the states. However, most of the states had had no experience, no ability to organize a health program or to administer one. Private insurance? No. There was nothing in the government field with sufficient ability. The biggest supporting argument I had is that, with Blue Cross, you have the one entity organized in the field at the state level and coordinated nationally with the support of the people you must have, the hospitals–a voluntary approach, with all the strengths of that and the goodwill that would come from it.

The intermediary role had the strengths I have mentioned. Ed Crosby agreed with me. We needed to do something; there was no time to stop and talk and ask Blue Cross if they wanted it. As a matter of fact, I said that it was for their best interest if we decide this and just put it in. We decided, and we put it in, and they have suffered the benefit. Interestingly enough, over the years I have heard all sorts of talk about how Blue Cross worked in developing this role. Hell's bells, they had nothing to do with it!

I read that book Odin Anderson wrote about two years ago about Blue Cross. I was amused by Odin's discussion of the Blue Cross role. Well, Blue Cross picked it up and did a great job. However, during those times (of planning Medicare) I never remember Blue Cross being considered, or talked to, or having anything to do with the intermediary role in advance. It came about because the government at a point in these discussions said, "How are we going to administer Medicare?"

The arguments favored Blue Cross, fit the times, and I was able to sell it. Nelson Cruikshank and Wilbur Cohen and others bought it. Blue Cross didn't come to them with the idea at all. When it was an accomplished fact, Blue Cross Association had to go and sell their field on what to do about it.

Once the concept of the intermediary became a part of the bill, Daniel Pettengill of Aetna sought out Wilbur Cohen to get clarification of how the insurance company might participate. Pettengil speaks of this conversation.

PETTENGILL:[38]

When it became obvious that Medicare was going to go through, I went to Wilbur Cohen, who was then the assistant secretary of the Department of Health, Education, and Welfare, and said to him, "I realize that the nation is going to have this Medicare program. But there is a provision in the proposed legislation that Medicare shall be administered by the private sector, unless you find the private sector unable to do it."

Wilbur, who is a very pleasant individual even though he was not exactly in my corner, smiled at me and said, "Dan, I've been planning on this ever since the Great Depression. Because, you know, they tried to get this into the original Social Security Act and just missed by the skin of their teeth because President Roosevelt had a change of heart at the last minute."

Then Wilbur said, "I could do this all with my own hand, but you're right, Congress is putting that feature in, so I appreciate your coming and telling me that you are willing to participate."

I was able to persuade a number of other commercial insurance companies to participate. Walter McNerney, as president of the Blue Cross Association, was also in Washington saying that the Blues would be very happy to do it all.

So there was considerable competition between the Blues and the insurance companies over the administration of Medicare. I must confess, the Blues got a much larger share than we did.

Walter J. McNerney discusses the process of choice of intermediaries. (Blue Cross Association, through a subcontracting arrangement with individual Blue Cross plans, was chosen intermediary in a large majority of instances.)

McNERNEY:[39]

The particular design of the nomination process for choosing fiscal intermediaries to administer Medicare part A and the prime contract involving the Blue Cross Association, as intermediary, had this negotiation factor as a backdrop.

It was a very good way of getting the cooperation of the American hospitals–giving them the right of some say over the intermediary. The intermediary position itself was a compromise between those who wanted HEW to pay claims versus those who wanted private carriers to do it on an underwritten basis. Once that pragmatic compromise was

resolved, the hospitals said, quite rightly, that the use of intermediaries suggests that there are two ends. You have one end, we want the other. If you are going to have the right to administer the program, we want some say over who the intermediary is. It's a two-way street. The intermediary is almost a natural outgrowth of this realization.

Some of us put it in more concrete terms than others. At any rate, it became an attractive way of eliciting the support of hospitals and easing the interface between the public and private sectors, while capitalizing on existing and in-place institutions and expertise.

Blue Cross represented an attractive candidate for the intermediaryship. There were no profits to inure to individuals or groups of individuals. It made sense that intermediaries be largely community-oriented institutions. The fact that Blue Cross was there in that mold made it more or less a natural to get a lot of the nominations. The other side of the coin was that the nomination process became realistic because Blue Cross existed.

There are a lot of details about who felt how about what. I was impressed that Wilbur Mills, who at that point was playing a very prominent role, was simply trying to sift through a series of ideas that could be put into a workable framework, not trying to moralize on any perfect arrangement.

The Medicare part B side reflected a slightly different situation. A distinction was made between the carriers under part B and the intermediary under part A. It is interesting that the carrier had an extra function or two. Therefore, the buffer zone between the doctor and the government was presumably a little broader.

It didn't take a lot of intelligence to see that didn't mean anything extra special, because, whereas there might have been an extra function in the report, and bill language seemed to give the carrier a slightly more independent status, the secretary of HEW was empowered to designate the carriers by state and the physicians were not in the position to nominate by state. So it was about equal: what you lost in one variable you gained in another.

There were some interesting byplays in the nominations that the secretary made. For example, the number of states that went to Blue Shield as carrier was roughly proportionate to their percentage of population enrolled. It is interesting that the nomination design reflected in a way the history of hospitals versus doctors vis-a-vis the government.

McNerney also talks about the tremendous amount of work that had to be done by both government officials and Blue Cross, as the principal intermediary, in preparing to implement Medicare and Medicaid on July 1, 1966.

MCNERNEY:[40]

The implementation of Medicare and Medicaid led to a lot of work.

Here it was, it had to be made to go as of July 1. I spent a tremendous amount of time with Robert Ball (commissioner of the Social Security Administration) and Art Hess (deputy commissioner of the Social Security Administration) ironing out what our relationships, our relative roles, would be. That led to a lot of gutsy, protracted discussions. Obviously, there were differences. The Social Security Administration, as far as this program was concerned, envisioned itself as the administrator and Blue Cross as an agent for getting the thing done.

We at Blue Cross, as intermediaries, thought of ourselves in little grander terms than that. Because we were nominated by the hospitals, for example, we felt we had a dual accountability. Also, we thought that we could be quite useful in shaping the destiny and the goals of the program, as well as carrying out its administrative provisions.

Bob and Art are highly capable people. Whereas this tension existed, they were bright enough, and I trust we were too, to overlook it and get down to practicalities of getting Medicare off the ground. I don't think there is a serious doubt that the program couldn't have gotten off the ground as it did if it hadn't been for Blue Cross and others in the private sector. I am very proud of the fact that, with 90 percent of the business on the part A side, we were able to move in and get it going with little friction as far as the American public was concerned. Not that everything went totally well, but, my God, it was impressive!

We had some trouble, for example, with some of our elderly subscribers who didn't want to give up their Blue Cross coverage because they trusted us more than they did the government. We finally talked them into that and developed some supplementary coverages. We eased the transition into Medicare the best we could. What has followed in the operation of the program since 1965 has been a series of encounters, contracts negotiated and renegotiated–a perfecting and a honing of relative roles.

Before I get off 1965, I want to remark that the negotiation as to who would do what (HEW vis-a-vis Blue Cross and the hospitals) often involved many HEW lawyers, six or seven or eight staff members from HEW, and a lesser, but nevertheless large, number from Blue Cross and other private institutions sitting and talking. On a few occasions I would call Bob Ball and say, "How about you and I going into a room alone?"

To his credit, he would join me. We'd shut the door and decide things. It took that because many were watching their territory and rationalizing their sentiments and so forth. There just had to be some gut decisions made.

I never felt uncomfortable making them with him, because his eye was on performance and he had a concern that the aged not get lost in the process.

I have no qualms at all about whether it was a good thing to do in 1965 or 1966. I think it was a very effective way of getting Medicare going, both on the part A and B sides. It was the best compromise. Even in retrospect I think it was the best compromise.

For the first five or ten years of the program, the intermediary relationship, I think, was viewed pretty congenially by all parties. HEW could not have started the program without the intermediary. The hospitals and doctors were relieved to have an intermediary versus dealing directly with HEW. Somewhere in the early seventies, however, Blue Cross-Blue Shield was increasingly put in the position of being the messenger of bad news. The intermediary role got tarnished by the field's frustration over excessive regulation, excessive this, excessive that.

As a result, the intermediary relationship became a source of strain between doctors, hospitals, and HEW. In the last year or so I think the intermediary is beginning to move back to a more treasured and appreciated relationship.

It's important to realize that over the years the Medicare contract has changed. You could guess what would happen. As government has become increasingly informed, they have felt they should have more direct control over the program and that the intermediary role should be lessened. So each year the contract negotiation revolves more around this basic point of relative roles.

In recent years we even hear, "Thank you so much for helping us get this started, but now that we have got it established in Washington and in regional offices around the country, outside of a few inconveniences, we can handle it." That isn't said publicly, because it would be politically inflammatory, but in a sense it's an unspoken word behind contract negotiations. Things haven't come to that, and they won't. I think we have too much to offer for that. There is no question our performance is better than anybody else's, both from a cost point of view and a quality point of view.

The implementation of the part B portion of Medicare, physician services, represented a different kind of problem. Daniel Pettengill and Nelson Cruikshank discuss it.

PETTENGILL:[41]

Surgical schedules are another interesting story. When, in 1938, the first surgical benefit was written on a group basis, somebody designed the so-called $150 schedule. It paid up to $100 for an appendectomy, and for most procedures it paid considerably less than that, while for certain very

rare procedures it paid up to $150. If more than one procedure was performed, the maximum benefit for all procedures combined was $150.

When I first came to the group division at Aetna, in some of the lower cost areas of the country (and there wasn't that much variation in fees in those days) you would find doctors who would accept what was in that $150 schedule as their full fee. It was a convenience to their patients and to some extent to themselves, because there was no hassle.

The surgeon knew what the scheduled maximum amount was, what the individual had, and that's what he was most likely to collect as a fee. But then what happened was that surgeons began to say the payment rate was unrelated to the skill required to perform the surgery and you insurers ought to do something. So in 1945 the Society of Actuaries made a schedule based on actual charges under claims received by several of the major insurers . . . that's one of the first things I worked on. This new schedule had a maximum benefit of $200 and better relativity among the scheduled amounts for the various procedures.

Then in 1956 the Society of Actuaries made another study and came out with a $300 schedule. There never was another schedule made, basically for two reasons. First, the California doctors came out with the California Relative Value Schedule, which covered far more procedures than the typical insurance company schedules. Second, such a spread in medical care costs had developed from one part of the country to another that large employers who had employees all over the country were saying, "Look, there is no schedule that does us any good. If we take your $300 schedule and double it, why that might be appropriate for New York City and Chicago, but it's too low for San Francisco and Los Angeles and it's too high for New Orleans."

So insurers were forced to write an unscheduled benefit which would pay the surgeon's actual charge, provided it was reasonable. This was the reason that, when Medicare came along, the government said that for part B it would pay for 80 percent of the physician's usual and customary charge, but not more than the prevailing fee in the area.

Unfortunately, the government overlooked two very important facts. First, most insurance plans then in force still provided surgical benefits on a scheduled basis, so that physicians generally were not accustomed to benefits based on a usual and customary charge. Second, few, if any, insurers knew what each physician charged and had only a rough idea of the prevailing charge–and then only in areas where it had many people covered for major medical benefits. (Most major medical and comprehensive plans require that the service be necessary and the charge reasonable.) With Medicare saying that, "If you accept an assignment of benefits, you're going to get 80 percent of your usual and customary fee," many physicians in the country suddenly increased their usual and customary fees; but valid statistical proof of these increases was often lacking.

This was one of the many problems and changes caused by Medicare that affected all health insurance. Although I have no proof, I am reasonably sure that Secretary Cohen was instructed by President Lyndon Johnson to make the administration of part B of Medicare acceptable to organized medicine so that the physicians wouldn't strike and ruin the operation of the Medicare program.

Time and again I would say to Secretary Cohen, "Look, you don't want to do that. I know from personal experience it's going to cause all kinds of problems." But he would ignore my advice whenever the doctors would say, "We want it this way."

One of the best examples of sound advice ignored because of pressure from organized medicine was the handling of the charges for radiation therapy, diagnostic X rays, and pathology. Prior to Medicare, when a patient received one of these services in the hospital, the charge for it was considered as being a hospital charge. Indeed, the charge for the service normally came through on the hospital bill. There was not a separate bill from the physician involved. The physician generally had a separate arrangement with the hospital to pay him for his part in the service, but the hospital did not itemize this on its bill to the patient. So insurers paid the one charge as part of the hospital-ancillary service benefit.

The doctors came down and said, "Look, we don't want that. We want to bill the patient ourselves." And Secretary Cohen gave in to them, even after the hospitals said that they would continue to bill the patient for supplies and the use of equipment and hospital employees. What Secretary Cohen finally did was to permit the physician to charge for the professional component of the service and the hospital to charge for the nonprofessional component, the former to be covered under part B and the latter under part A of Medicare. [Wilbur Cohen says Congress did this against the administration's wishes.]

So overnight the cost of these services was virtually doubled, not just for Medicare, but for everyone, because physicians very quickly did this for all their patients, not just their Medicare patients. The result was a tragic increase in costs.

That was a battle, it was a bitter battle, but it was lost because Secretary Cohen, I believe, was under instructions from President Johnson to give in to the extent necessary to keep peace with the doctors. [Cohen says Pettengil is "absolutely wrong; L.B.J. was opposed."]

CRUIKSHANK:[42]

I was against Medicare B [he had expressed opposition to Medicaid]. Not on principle, but on tactics Leonard Lesser and I teamed up and appeared

before the committees and talked to our friends in the Ways and Means Committee, saying that our experience with negotiated health plans was that these doctors' services are the things that give us the most trouble. "Pass the hospital part, run that for a few years and digest it. Sure, the older people need the doctors' thing that's set up in part B, but let's not clog the machinery. Let's make this a bite at a time."

Our strongest friends on the Ways and Means said, "Aw, come on, fellows, you got what you want. Let's not be picayune. The hell with it. This is going to ride through. Don't try to stop it." So we had to ride with the punch. The fact is that our trouble with Medicare is in part B to this day.

On balance, Medicare has been a good program that has brought needed care to many elderly persons who might otherwise have gone without it. Billions of dollars have been paid in benefits, and the entire practice of medicine has been changed.

Many aspects of the Medicare program have developed differently than expected. For example, actuaries, both government and private, were unable to estimate accurately what the costs of the program would be. Their estimates were a fraction of actual costs. Now the nation is struggling to make adjustments in order to avoid bankruptcy for Medicare. Total expenditures are uncontrollable, and politically it is impossible to cut benefits.

Medicare B has been unsatisfactory in other ways. Doctors generally have not accepted the schedule of fees posted under Medicare, so in many cases patients have had to pay an additional fee. The copayment feature for financing part B began at $3.00 per month, deducted from the monthly Social Security check. The federal government matched this. The copayment fee has had to be raised nearly every year in order to meet expenses. Now, instead of being $3.00 per month, it is nearly five times that. Also, the government has increased its contribution from 50 percent to 75 percent.

Medicaid has not worked well either. It is still not a program of uniform benefits in all the states, and it has been a tremendous financial burden in many states.

All in all, however, Medicare and Medicaid have been steps forward. Practically no one would wish to return to the conditions that existed before 1966. Adjustments and changes will come, and obstacles will be overcome. Medicare and Medicaid will prevail, even if altered in a form to adjust to changing political and economic realities.

Notes

(Transcripts of the oral histories cited here are housed in the library of the American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois 60611. The Oral History Collection is a joint project of the Hospital Research and Educational Trust and the AHA.)

1. See Profiles of Participants, in the center of this book, for biographical information.
2. *Nelson Cruikshank, In the First Person: An Oral History.*
3. *Cruikshank, Oral History.*
4. Ibid.
5. Marion Folsom and Arthur Larson, both prominent Republicans, privately favored Medicare.
6. *Cruikshank, Oral History.*
7. See Profiles of Participants for biographical information.
8. *Wilbur Cohen, in the First Person: An Oral History.*
9. *Walter J. McNerney, In the First Person: An Oral History.* See Profiles of Participants for biographical information.
10. See Profiles of Participants for biographical information.
11. *John R. Mannix, In the First Person: An Oral History.*
12. See Profiles of Participants for biographical information.
13. *Daniel W Pettengill, In the First Person: An Oral History.*
14. *Cruikshank, Oral History.*
15. For a detailed account of the attempted Anderson-Javits amendment, see the monograph by Gary L. Filerman, *The Senate Rejects Health Insurance for the Aged*, available from University Microfilms, 300 N. Zeeb Road, Ann Arbor, Mich. 48107.
16. *Cruikshank, Oral History.*
17. Ibid.
18. Ibid.
19. Ibid.
20. *Wilbur D. Mills, In the First Person: An Oral History.* See Profiles of Participants for biographical information.
21. *Cruikshank, Oral History.*
22. *Pettengill, Oral History.*
23. *Mills, Oral History.*
24. *Cohen, Oral History.*
25. *Kenneth Williamson, In the First Person: An Oral History*. See Profiles of Participants for biographical information.
26. *Mills, Oral History.*
27. *Pettengill, Oral History.*
28. *Mills, Oral History.*
29. *Cruikshank, Oral History.*
30. Douglas' account of his activities during the passage of Medicare can be found in his autobiography, *In the Fullness of Time* (New York: Harcourt Brace Jovanovich, 1972), pp. 394-96.
31. *Cruikshank, Oral History.*
32. *McNerney, Oral History.*
33. *Cruikshank, Oral History.*
34. *Mills, Oral History.*
35. *Cohen, Oral History.*
36. *James Hague, In the First Person: An Oral History.* See Profiles of Participants for biographical information.

37. *Williamson, Oral History.*
38. *Pettengill, Oral History.*
39. *McNerney, Oral History.*
40. Ibid.
41. *Pettengill, Oral History.*
42. *Cruikshank, Oral History.*