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DOCTORS, POLITICS, AND HEALTH INSURANCE FOR THE AGED: THE ENACTMENT OF MEDICARE

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# Doctors, Politics, and Health Insurance for the Aged: The Enactment of Medicare

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# Congress and the Executive Branch: The Politics of Medicare

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On July 30, 1965, President Johnson flew to Independence, Missouri to sign the Medicare bill in the presence of former President Harry S. Truman. The new statute--technically Title 18 of the Social Security Amendments of 1965--included two related insurance programs to finance substantial portions of the hospital and physician expenses incurred by Americans over the age of 65. The bill-signing ceremony in Missouri was attended by scores of government officials, health leaders, and private citizens, many of whom had participated in the long fight for social security health insurance during the Administrations of Presidents Roosevelt, Truman, Eisenhower, Kennedy, and Johnson. That afternoon, Johnson reviewed the two decades which had culminated in the Medicare legislation, and observed that the surprising thing was not "the passage of this bill...but that it took so many years to pass it."

President Johnson's remark underscored the obvious fact that good health, like peace and prosperity, are laudable goals, widely shared by Americans. Yet the President was too astute a practitioner of politics to be really surprised by the delay in devising an acceptable federal health insurance program. Public attempts to improve American health standards typically have precipitated bitter debate, even as the issue has shifted from the professional and legal status of physicians to the availability of hospital care, from quackery among doctors and druggists to the provision of public health programs. The beginning of the American Medical Association itself (1847) was part

of the broader effort to define the legitimate medical practitioner and to raise the educational standards expected of him. Later in the nineteenth century, licensure of physicians by the states and the regulation of drugs were fought for by the AMA. Hospital care, once almost exclusively supported by private institutions, became politically controversial once general hospitals grew with the support of local tax funds. Sanitation measures, disease control through mass inoculation, state regulation of hospitals--all commanded increasing public attention as Americans left the countryside to congregate in large urban centers after the Civil War.

It was not until the twentieth century, however, that medical care problems, always of concern to local government, generated interest at the level of national politics. That interest, particularly in the period after the second World War, focused on three features of the American system of medical care: medical research, hospital construction, and Federal health insurance programs. Since 1945, the Federal government has massively increased its support of medical research (primarily through the National Institutes of Health), and, under the Hill-Burton Act of 1946, has subsidized a major portion of the nation's postwar hospital construction. By 1960, Federal, state and local governments together expended almost $7 billion of the $29 billion Americans spent in that year for health services. "In few fields," concluded the Congressional Quarterly, "were there more new Federal programs established in the postwar era, or more significant changes

made, than in health."

Americans have been no less concerned about expanding the Federal government's role in providing health insurance, but in this controversial area postwar government action has not paralleled the rapid expansion of support for research and hospital facilities. This inaction has persisted despite public sentiment to the contrary. Opinion surveys from 1943 to 1965 have shown a relatively stable two-thirds majority of Americans favoring government assistance in the financing of personal health services.

The legislative activity of the United States Congress, however, is never simply a matter of ratifying public opinion polls. For controversial legislation to be enacted, the public must be sufficiently organized to make its views felt. Beyond that, the support of executive agencies is normally required in framing complex legislative proposals. Bills must have sponsors and floor-managers in both houses of the Congress, and they must pass through a maze of obstacles: committee hearings, placement on the agenda by the House Rules Committee, votes in both houses, and, if successfully passed, a conference committee in which differences between House and Senate versions are ironed out. It was not until 1965 that a health insurance bill for the aged emerged from the congressional maze to become public law. To understand how that bill became law is to understand some of the ways by which divisive public issues run the obstacle course in American politics from initial demands to statutory enactment.

Twentieth Century Medicine: The Paradoxes of Progress

By the close of the first decade in this century, medical science had reached, in the words of a distinguished Harvard professor, a "Great Divide" when "for the first time in human history, a random patient with a random disease consulting a doctor chosen at random stands a better than 50/50 chance of benefiting from the encounter." Subsequent developments have fully borne out this prediction of remarkable advances in medical science, technology and therapy. One by one, dread diseases--tuberculosis, cholera, diptheria, pneumonia, smallpox, polio--have been controlled. Surgical and drug therapy have dramatically reduced the impact of diseases and maladies unconquered by preventive medicine. These changes, along with substantial improvements in the general American standard of living, have not resulted in diminished morbidity (illness), but have startlingly altered mortality rates. The new-born child in 1900 had a life expectancy of 47 years; by 1950 the average was 70 years. In what Herman and Anne Somers have called the "paradox of medical progress" however, "as we preserve life at all age levels, there is more illness, more enduring disability, for the population as a whole."

The demand for medical care has increased both through improved capacity and heightened expectations among longer-living populations. Changes in the organization of medical care have accompanied the rapid increase in utilization. Since 1930, the average number of patient visits to the doctor has more than doubled, increasing from 2.6 to 5.3

visits per year. The type of doctors Americans visit has changed in the process: whereas in 1930, two-thirds of American physicians were general practitioners, two-thirds were specialists three decades later. The focus of medical activity has shifted to the hospital, and the costs of those activities have steadily increased. Between 1953 and 1963, expenditures for all health services more than doubled. The price of hospital beds rose 90 per cent while physicians' fees increased 37 per cent. The mean expenditure of American families for medical care during this decade grew by 70 per cent. Figures on mean expenditures fail to show, however, the uneven distribution of illness throughout the society, and its financial implications. In fact, a recent study concluded, people with illness "requiring hospitalization account for one-half of all private expenditures, but amount to only 8 per cent of the population."

The combination of increased medical competence, heightened consumer expectations and utilization, and rising costs have shaped the environment for public policy demands. But these experiences, common to western industrial countries, have not predetermined either the proposals for government action or their fate. Bismarck's Germany initiated health insurance for industrial workers as early as 1883; in 1911 England incorporated health insurance for low-income workers into a social security program providing pensions, unemployment compensation, and sickness benefits. By 1940, no western European country was without a government health insurance program for at least its low-income workers, though there were substantial differences in

beneficiaries, benefits and financing mechanisms. The advent of Medicare in 1965 illustrated the belatedness of America's entry into compulsory health insurance, and its restriction to the aged alone was quite unlike the patterns established in other industrial countries.

Origins of the Government Health Insurance Issue

Demands in America for government involvement in health insurance date back to the first decade of the twentieth century. The impetus in these early efforts came from academics, lawyers, and other professionals, organized in the American Association for Labor Legislation. During the years 1915-1918, this group made a concerted effort to shepherd its model medical care insurance bill through several state legislatures, but with no success. The American Medical Association, whose officials had initially co-operated with the AALL, found local medical societies adamantly opposed to the state health insurance bills, and in 1920 the AMA House of Delegates announced

> its opposition to the institution of any plan embodying the system of compulsory contributory insurance against illness, or any other plan of compulsory insurance which provides for medical service to be rendered contributors or their dependents, provided, controlled, or regulated by any state or Federal government.

Even more disappointing to the labor reformers was the unequivocal opposition of Samuel Gompers, the president of the American Federation of Labor, to the model bills. The strength of the opposition precluded America from following England's example of insuring low-income workers against illness. During the 1920's, a variety of groups undertook studies of health care financing in the United States, and attention

turned to the feasibility of group medical practice and of pre-payment medical plans. But it was not until the onset of the Great Depression, in an atmosphere of general concern for economic insecurity, that a sustained interest in government health insurance reappeared. The evolution of the 1965 Medicare Act reaches back to this New Deal period. To understand the particular form of the Medicare legislation, and to explain the two decades of controversy and delay at which President Johnson expressed surprise, one must begin the story here.

The source of renewed interest in government health insurance was President Roosevelt's advisory Committee on Economic Security, created in 1934 to draft a social security bill providing a minimum income for the aged, the unemployed, the blind, and the widowed and their children. The result was the Social Security bill of 1935, which, in addition to providing for insurance against potential loss of income, broached the subject of a government health insurance program. Edwin Witte, a former professor of Economics at the University of Wisconsin who was executive director of the committee, described the extent of the committee's involvement with health insurance and the response:

> When in 1934 the Committee on Economic Security announced that it was studying health insurance, it was at once subjected to misrepresentation and vilification. In the original social security bill there was one line to the effect that the Social Security Board should study the problem and make a report to Congress. That little line was responsible for so many telegrams to the members of Congress that the entire social security program seemed endangered until the Ways and Means Committee unanimously struck it out of the bill.

Roosevelt's fears that the controversial issue of government health insurance would jeopardize the Social Security bill and, later, his

chances for reelection, kept him from vigorously sponsoring the proposal. For many of his advisors in the Committee on Economic Security, however, the discussions in Washington in the mid-thirties marked the beginning of an active interest in the subject. The divorce of compulsory health insurance from the original Social Security program of 1935 had alerted the critics within the medical world to the possibility of attempts to enlarge the partial government program to "get a foot-in-the-door for socialized medicine." Their response was to reverse their former opposition to private health insurance alternatives; in an effort to forestall Federal action, the AMA began to promote Blue Cross and commercial hospital insurance, and, in the case of state Blue Shield plans, actively to organize private insurance plans for surgical and medical expenses. In the meantime, passage of the Social Security Act had freed advocates of compulsory health insurance from their concerns about providing income protection for the aged, the blind, and dependent women and children. Their attention was now directed to the broad social question of how equitably medical care was distributed in post-Depression America. From 1939 onwards, their activities were reflected in the annual introduction of congressional bills proposing compulsory health insurance for the entire population. An orphan of the New Deal, government medical care insurance was to become one of the most prominent aspirations of Harry Truman's "Fair Deal."

Universal Health Insurance Proposals in the Fair Deal

Although the government health insurance issue was originally raised in conjunction with social security income protection, New Deal-Fair Deal champions of medical care proposals did not view it primarily as a measure to further income security but as a remedy for the inequitable distribution of medical services. The proponents of Truman's compulsory insurance program took for granted that financial means should not determine the quality and quantity of medical services a citizen received. "Access to the means of attainment and preservation of health," flatly stated the 1952 report of Truman's Commission on the Health Needs of the Nation, "is a basic human right." The health insurance problem in this view was the degree to which the use of health services varied with income (and not simply illness). In contrast, for those who considered minimum accessibility of health services a standard of adequacy, the provision of charity medicine in doctors' offices and general hospitals represented a solution, and the problem was to fill in where present charity care was unavailable.

The Truman solution to the problem of unequal accessiblity to health services was to remove the financial barriers to care through government action. As set forth in his State of the Union message in 1948, his goal was "to enact a comprehensive insurance system which would remove the money barrier between illness and therapy,...[and thus] protect all our people equally...against ill health." Bills embracing such goals had been introduced as early as 1935, but the first to receive widespread public attention was S. 1620, introduced by Senator

Robert Wagner (D., N.Y.) in 1939. A decade later, in Truman's term of office, it was S. 1679 which Senator Wagner, Senator Murray (D. Mont.) and Representative Dingell (D., Mich.) presented for congressional consideration. By 1949, the introduction of a Wagner-Murray-Dingell bill had become an annual event which was invariably followed by congressional refusal to hold hearings on the bill.

Through the decade, public opinion polls continued to report favorable reactions to Federal involvement in health insurance. However, although from 1939 to 1946 the Democrats controlled both houses of Congress, the partisan majority did not make up an issue majority. There were too few legislative supporters to bring the repeatedly introduced bills through the stages of committee hearings, committee approval, and congressional passage. By 1945, officials within the Social Security Board* had secured presidential endorsement of the Wagner-Murray-Dingell proposal, in Truman's Health Message of 1945, but the advantage of Truman's support was offset by the congressional elections the following year, which returned Republican majorities in both the House and the Senate. This Congress, it has been observed, "was generally at loggerheads with Truman in domestic affairs," and in the campaign of 1948, the President used its inaction, on health insurance and other domestic issues, to berate the "do-nothing Republican

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*The three key officials--Arthur Altmeyer, Wilbur Cohen, and I. S. Falk--worked in the Social Security Board, a division of the Federal Security Agency. The FSA, created in 1939 to oversee the Board, the Public Health Service, and the Office of Education, was in 1953 replaced by the Cabinet-rank Department of Health, Education and Welfare.

80th Congress." The election of 1948, returning the presidency to Truman and control of the Congress to the Democrats, left Truman and his advisors with high hopes for enactment of the domestic proposals that had highlighted his "Fair Deal" campaign against Dewey.

Early in 1949, in keeping with his recent campaign pledges, the President requested congressional action on medical care insurance. The specifications of the proposal repeated those of previous Wagner-Murray-Dingell bills:

--the insurance benefits would cover all medical, dental, hospital and nursing care expenses

--beneficiaries would include all contributors to the plan and their dependents, and for the medical needs of a destitute minority which would not be reached by the contributory plan, provisions were made for federal grants to the states

--the financing mechanism would be a compulsory 3 per cent payroll tax divided equally between employee and employer

--administration would be in the hands of a national health insurance board within the Federal Security Agency

--to minimize the degree of Federal control over doctors and patients, it was specified that doctors and hospitals would be free not to join the plan; patients would be free to choose their own doctors and doctors would reserve the right to reject patients whom they did not want; doctors who agreed to treat patients under the plan would be paid for their services by the national health board, and the question of whether they would be paid on a stated-fee, per capita or salary basis would be left to the majority decision of the participating practitioners in each health service area.

The bill's reception in the 81st Congress was bitterly disappointing to the Truman Administration. Although the Democrats had gained 75 seats in the House, a coalition of anti-Truman Southern Democrats and Republicans blocked most of Truman's major domestic proposals. Despite

some success in housing and social security legislation, the Federal aid to education bill floundered, and the Administration's health insurance plan was not reported out of committee in either house.

The Democrats had their House majority reduced from 263-171 to 235-199 in the elections of 1950, and barely maintained control of the Senate by a margin of two. Attempts to leave doctors' participation in the national health insurance plan voluntary had failed to placate the American Medical Association. The organization had been roused to a nationwide propaganda campaign, directed by the California public relations firm, Whitaker and Baxter, and financed by "taxing" every AMA member $25. The doctors had enlisted hundreds of voluntary organizations and pressure groups to oppose compulsory health insurance, holding out horrific visions of a socialized America ruled by an autocratic Federal government. Ignoring the stipulations that doctors would remain free to choose their own patients, and patients to choose their own doctors, the AMA campaign pictured an impersonal medical world under the national health plan in which patients and doctors were forced unwillingly upon each other. In 1950, the AMA took the issue of "socialized medicine" to both the primary and general elections, and their propaganda was credited with the defeat of some of the Senate's firmest supporters of health insurance, including Claude Pepper (D., Fla.), Frank Graham (D., N.C.), Elbert Thomas (D., Utah), and Glen Taylor (D., Idaho).

Though Truman persisted in requesting compulsory health insurance in 1950, 1951, and 1952, his advisors agreed that after 1949 the prospects

for such a broad program were bleak. Among those advisors were Federal Security Agency officials, Wilbur J. Cohen and I. S. Falk,* the two men who had had most to do with the drafting of health insurance proposals since 1935. Recognizing the need to "resurrect health insurance" in a dramatically new and narrower form, Cohen and Falk worked out a plan that would limit health insurance to the beneficiaries of the Old Age and Survivors' Insurance program. Oscar Ewing, head of the Federal Security Agency, considered this approach "terrific," and it shaped the entire strategy of health insurance advocates in the period after 1951. Thus the stage was set in early 1951 for what has come to be called "Medicare" programs. Millions of dollars spent on propaganda, the activation of a broad cleavage in American politics, the framing of choice in health insurance between socialism and "the voluntary way," the bitter, personally vindictive battle between Truman's supporters and the AMA-led opposition--these comprised the legacy of the fight over general health insurance and provided the setting for the emergence of Medicare as an issue.

## The Politics of Incrementalism: Turning Towards the Aged

Major shifts in the demands brought to the Congress seldom derive from dispassionate analysis of contemporary social conditions. The

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*Wilbur J. Cohen, who in 1965 was Under-Secretary of the Department of Health, Education, and Welfare, became HEW Secretary in March, 1968. Cohen was a member of the staff of the original committee that drafted the Social Security Act of 1935. He was, in 1950-52, on the staff of the Social Security Administration within the Federal Security Agency, as was I. S. Falk. Falk recently retired as Professor of Public Health at Yale University.

decision to pare down President Truman's health insurance aims to a more modest hospitalization insurance program for the aged was no exception to this pattern. In 1951 and 1952 extended discussions took place among Truman's social security advisors about how to deal with congressional reluctance to enact his Administration's health program. In October of 1951 Presidential Assistant David Stowe outlined for Truman three ways of responding to the bleak legislative prospects for general health insurance: "softpedal the general health issue; push some peripheral programs in the area but not general insurance; or appoint a study commission to go over the whole problem." Three days later Truman accepted his staff's recommendation of the study commission and charged them with finding "the right people." But the effort to "push some peripheral programs" had already begun, with the President's passive acquiescence. In June, 1951, Oscar Ewing, acting on the suggestions of Cohen and Falk, announced a new plan to insure the 7 million aged social security beneficiaries for 60 days of hospital care a year. "It is difficult for me to see," said Ewing to an assembled corps of reporters, "how anyone with a heart can oppose this [type of program]."

Ewing, Cohen, and Falk assumed the Administration could most easily build an issue majority in the Congress by narrowing previous demands and tailoring them to meet the objections of congressmen and critical pressure groups. The major objections to the Truman health program which the Medicare strategists felt they had to meet included charges that: 1) general medical insurance was a "give-away" program which made no distinction between the deserving and undeserving poor;

2) that it would substantially help too many well-off Americans who did not need financial assistance; 3) that it would swell utilization of existing medical services beyond their capacity, and 4) that general medical insurance would produce excessive Federal control of physicians, and would constitute a precedent for socialism in America. In connection with the latter objection, there was the widespread fear, grounded in the bitter, hostile propaganda of the AMA, that physicians would refuse to provide services under a national health insurance program.

To meet these objections, the proponents of "peripheral programs" turned from the health problems of the general population to those of the aged. As a group the aged could be presumed to be both needy and deserving because, through no fault of their own, they had lower earning capacity and higher medical expenses than any other adult age group. Since the proponents wished to avoid imposition of a means test to determine eligibility within the ranks of the aged, they limited the beneficiaries to those persons over 65 (and their spouses) who had contributed to the social security program during their working life. As an additional advance concession to spike the guns of those opponents who could be counted on to assault the program as a "give-away," benefits were limited to the 60 days of hospital care. Finally, physician services were excluded entirely from the plan in hopes of softening the hostility of the medical profession. What had begun in the 1930's as a movement to redistribute medical services for the entire population turned into a proposal to help defray some of the hospital costs of social security beneficiaries only.

The Appeal of Focusing on the Aged

The selection of the aged as the problem group is easily comprehensible in the context of American politics, however distinctive it appears in comparative perspective. No industrial country in the world has begun its government health insurance program with the aged. The typical pattern has been the initial coverage of low-income workers, with subsequent extensions to dependents and then to higher-income groups. Insuring low-income workers, however, involves use of means tests, and the cardinal assumption of social security advocates in America has been that the stigma of such tests must be avoided. In having to avoid both general insurance and the humiliating means test the Federal Security Agency strategists were left with finding a socio-economic group whose average member could be presumed to be in need. The aged passed this test easily; everyone intuitively knew the aged were worse off. Cohen was later to say that the subsequent massing of statistical data to prove the aged were sicker, poorer, and less insured than other adult groups was like using a steamroller to crush an ant of opposition.

Everyone also knew that the aged--like children and the disabled--commanded public sympathy. They comprised one of the few population groupings about whom one could not say the members should take care of their financial-medical problems by earning and saving more money. The American social security system makes unemployment (except for limited part-time work) a condition for the receipt of pensions, and a fixed retirement age is widely accepted as desirable public policy.

In addition, the postwar growth in private health insurance was uneven, with lower proportions of the aged covered, and the extent of their insurance protection more limited than that enjoyed by the working population. Only the most contorted reasoning could blame the aged for this condition by attributing their insurance status to improvidence. Retirement forces many workers to give up work-related group insurance, and the aged cannot easily shift to individual policies because as a high-risk group insurance companies are reluctant to cover them except at high premium rates. The aged thus were subject to inadequate private coverage at a time when their medical requirements were greatest and their financial resources were lowest. Under these circumstances many of the aged fell back upon their children for financial assistance, thus giving the Medicare emphasis upon the aged additional political appeal. The strategists expected support from families burdened by the requirement, moral or legal, to assume the medical debts of their aged relatives.

The same strategy of seeking broad public agreement was evident in the benefits and financial arrangements chosen. The 1951 selection of hospitalization benefits reflected the search for a narrower and less disputable "problem" than Truman's 1949 proposals. General health insurance was a means for solving the problem of the unequal distribution of medical care services; its aim was to make health care more equally accessible by removing all financial barriers to utilizing those services, an aim broadly similar to that of the British National Health

Service. In contrast, a program of hospital insurance identifies the aged's problem not as the inaccessibility of health services, but as the financial consequences of using those services. The hospital benefit was designed not so much to cope with the health problems of the elderly as to reduce their most onerous financial difficulties. Medicare proponents were well aware that this shift in emphasis left gaping inadequacies when compared with earlier insurance proposals; but in the political context of the early 1950's, they took for granted that broader conceptions of the aged's health problems were less likely to receive legislative backing.

The differences between making health services more accessible and coping with the financial consequences of medical utilization were continually revealed in the next decade and a half. The statistical profiles of the aged--first provided by the Truman health commission of 1952--uniformly supported the popular conception of the aged American as sicker, poorer, and less insured than his compatriots. For example, in 1958, the median income of families whose head was 64 or younger was $5,455, and over 75 percent of this age category had some form of sickness insurance. By contrast, the median income of families whose head was 65 or older was $2,666; roughly half had some form of health insurance, but it was usually expensive and limited, and one national survey of hospital patients found that insurance did not meet more than 1/14 of the total cost for all the aged; the incidence of illness, chronic disabilities, and hospitalization was twice that of younger age groups; and the average yearly medical expenses were

twice as high. There could be no question that the aged faced the most serious problems coping with health expenses, though it was easy to point out that averages conceal the variation in illness, income, and insurance coverage among the aged.

For those who saw Medicare as prevention against financial catastrophe, the vital question was not what health care the aged could buy with their limited income, but which bills were the largest for any spell of illness. The ready answer was hospital care. One in six aged persons enters a hospital in a given year, and his total medical costs are four to five times those incurred by the non-hospitalized. Hospitalization insurance was, according to this information, a necessity which the aged had to have to avoid financial catastrophe. It should be pointed out, however, that by limiting the insurance coverage to 60 days and excluding custodial nursing home care altogether, the Medicare protection against catastrophic medical bills was incomplete. Ewing and his advisors were aware of the gap between the problem and the proposed remedy, but they feared that unlimited coverage would inflate the estimated costs of the program to a point where the price tag would become a major political liability.

The concentration on the burdens of the aged was a ploy for sympathy. The disavowal of aims to change fundamentally the American medical system was a sop to AMA fears, and the exclusion of physician services benefits was a response to past AMA hysteria. The focus on the financial burdens of receiving hospital care took as given the existing structure of the private medical care world, and stressed the issue of spreading the costs of using available services within that

world. The organization of health care, with its inefficiencies and resistance to cost-reduction, was a fundamental but politically sensitive problem which consensus-minded reformers wanted to avoid when they opted for 60 days of hospitalization insurance for the aged in 1952 as a promising "small" beginning.

Focusing on Social Security Contributors

The financing of the Truman health program had deliberately been left vague by its backers; the Murray-Wagner-Dingell bill of 1949 mentioned a 3 per cent payroll tax, equally divided between worker and employer, and administered by a new division within the Federal Security Agency. In the 1951 promotion of a Medicare program, the financing of hospital insurance was to be through the already established Old Age and Survivors Insurance system (OASI), enacted as part of the Social Security package in 1935. The use of social security funding was an obvious effort to tap the widespread legitimacy which OASI programs enjoyed among all classes of Americans. Yet social security financing would in 1952 have restricted Medicare benefits to 7 million pensioners out of the 12-1/2 million persons over 65, thus overlooking 5-1/2 million aged whose medical and financial circumstances had been used to establish the "need" for a Medicare program in the first place. Nonetheless, social security financing offered so many other advantages that its advocates were prepared to live with this gap between problem and remedy.

The notion that social security recipients pay for their benefits

is one traditional American response to the charge that government assistance programs are "give-aways" which undermine the willingness of individuals to save and take care of their own problems. The Ewing group thought they had to squash that charge if they were both to gain mass public support and to shield the aged from the indignity of a means test. The contributory requirement of social security--the limitation of benefits to those having paid social security taxes--gives the system a resemblance to private insurance. Thus, social security members would appear to have paid for hospital insurance. In fact, social security beneficiaries are entitled to pensions exceeding those which, in a strict actuarial sense, they have "earned" through contributions. But this is a point generally lost in the avalanche of words about how contributions, as the present head of Social Security, Robert Ball, has said, "gives American workers the feeling they have earned their benefits." The notion that contributions confer rights analogous to those which premiums entail within private insurance was one which deeply permeated the advocacy of Medicare.

The public legitimacy granted the social security program made it an ideal mechanism for avoiding the stigma attached to most public welfare programs. The distinction between public assistance for the poor and social security rights for contributors is, in fact, less clear in law than might be expected. Rights are prescriptions specified in law, and welfare legislation--for any class of persons--confers rights in this sense. But those who insist on the distinction between public assistance and social security focus less on the legal

basis of rights than on the different ways these programs are viewed and administered. Social security manuals insist on treating beneficiaries as "claimants," and stress that the government "owes" claimants their benefits. The stereotype of welfare is comprised of legacies from charity and the notorious Poor Laws, a combination of unappealing associations connected with intrusive investigations of need, invasions of privacy, and loss of citizenship rights. The unfavorable stereotype of welfare programs thus supports the contention that social security funds are the proper financing instrument for providing benefits while safeguarding self-respect.

Ewing and his aides were no less concerned about securing the support of governmental elites as of interest groups and the electorate. They proposed social security financing partly because of the political advantages it offered a president sympathetic to health insurance, but concerned about levels of administrative spending. Social security programs are financed out of separate trust funds that are not categorized as executive expenditures; the billions of dollars spent by the Social Security Administration each year are not included in the annual budget the president presents to Congress, a political advantage not likely to be lost on Democratic presidents worried about the perennial charge of reckless Federal spending.

These structural features of the politics of social welfare in America largely account for the type of "incremental" health insurance strategy adopted at the end of the Truman Administration. They help explain why the postwar Truman plans of comprehensive government health

insurance gave way to a proposal to help defray some of the hospital costs of Americans over 65 who participated in the social security system. The strategy of the incrementalists after 1952 was consensus-mongering, the identification of narrower problems and the advocacy of narrower solutions which ideological conservatives would have difficulty in attacking. "In the beginning," recalled Wilbur Cohen, one of the co-authors of the first Medicare bill, "we looked at [its introduction in 1952] as a small way of starting something big."

Pressure Groups and Medicare: The Lobbying of Millions

Serious congressional interest in special health insurance programs for the aged developed in 1958, six years after the initial Medicare proposal. From 1958 to 1965, the Committee on Ways and Means held annual hearings, which became a battleground for hundreds of pressure groups. The same intemperate debate of the Truman years (and often the same debaters) reappeared. The acrimonious discussion of the problems, prospects, and desires of the aged illustrated a lesson of the Truman period: the Federal government's role in the financing of personal health services is one of the small class of public issues which can be counted on to activate deep, emotional, and bitter cleavages between what political commentators call "liberal" and "conservative" pressure groups. In the press, commentators felt compelled to write blow-by-blow descriptions of pressure group harangues and congressional responses. Within the Congress, clusters of Republicans and conservative Southern Democrats allied to oppose "government medicine"

and to declare war against this "entering wedge of the Socialized State." The president of the AMA captured the mood of Medicare's critics in testifying before the Ways and Means Committee in 1963; hospital insurance for the aged, he said was not "only unnecessary, but also dangerous to the basic principles underlying our American system of medical care."

For all the important differences in scope and content between the Truman general health program and the Medicare proposals, the line-up of proponents and opponents was strikingly similar. Among the supporters organized labor was the most powerful single source of pressure for favorable congressional action. The AMA sparked the opposition and framed its objections in such a way that disparate groups only tenuously involved with medical care or the aged could rally around their leadership. A small sample, representing a fraction of all groups involved in the lobbying, illustrates the continuity between the broad economic and ideological divisions of the Truman fight and that over health insurance for the aged:

| For | Against |
|---|---|
| AFL-CIO | American Medical Association |
| American Nurses Association | American Hospital Association |
| Council of Jewish Federations & Welfare Funds | Life Insurance Association of America |
| American Association of Retired Workers | National Association of Manufacturers |
| National Association of Social Workers | National Association of Blue Shield Plans |
| National Farmers Union | American Farm Bureau Federation |
| The Socialist Party | The Chamber of Commerce |
| American Geriatrics Society | The American Legion |

Three features of this pressure group alignment merit mention. First, the adversaries who are "liberal" and "conservative" on that issue are similarly aligned on other controversial social policies like Federal aid to education and disability insurance. Second, the extreme ideological polarization promoted by these groups has remained markedly stable despite significant changes in the actual objects in dispute, such as the much narrower scope of health insurance proposals since 1952. Proposals for incremental change in social policy typically fail to avoid an escalation of the disagreement back to "first principles." Finally, public dispute continued to be dominated by the AFL-CIO and the AMA, lobbying organizations capable of expending millions in the effort to shape the range of debate and to influence legislative results. Since the 1940's these two chief adversaries have engaged in what The New York Times characterized as a "slugging match," a contest of invectives. Aaron Wildavsky's description of the conflict between public and private power advocates in America is just as apt for the contestants over Medicare:

> [They] have little use for one another. They distrust each other's motives; they question each other's integrity; they doubt each other's devotion to the national good. Each side expects the other to play dirty, and each can produce substantiating evidence from the long history of their dispute.

The American Medical Association is an organization with conflicting roles. As a type of trade union, it is committed to improving the status of physicians. As a scientific organization, the AMA sponsors research and regulates medical practice to improve the quality of

persistent AMA involvement with public policy issues since the second World War has increased the risks that an image of the rich and greedy physician will replace that of the noble general practitioner and thus undermine the widely accepted role of the AMA (and its local affiliates) as controllers of medical practice. In these areas, organizations like the AFL-CIO feel less tension; their straightforward championing of the interest of wage-earners means that opponents have little opportunity to dwell upon the gap between the pronouncements of selflessness and the practice of self-interested manuevering.

Both the AFL-CIO and the AMA have the membership, resources, and experience to engage in the lobbying of millions. Their members are sufficiently spread geographically to make congressional electioneering and pressure relatively easy to organize. In 1965, the AMA had 159,000 dues-paying members, and expended a budget of approximately 23 million dollars. The AFL-CIO's 129 affiliated unions represented in the mid-1960's over thirteen million workers. Lobbying--personal contact between organization officials and members of the government--keeps substantial full-time staffs busy in Washington, but the largest organizational expenditures are for what is euphemistically called "public education." In 1965, the AMA lobbyists spent just under a million dollars, of which $830,000 went for the newspaper, radio and television campaign against the Medicare bill. Both organizations control legally separate political bodies that try to influence elections and mobilize members for political action. The AFL-CIO's Committee on Political Education (COPE) and the AMA's Political Action Committee (AMPAC) are financed

by voluntary contributions, and most of their funds are used in election campaigns. In 1964, COPE made campaign contributions of almost a million dollars.

During the debates of the 1940's and early 1950's, the AMA and its allies in big business and big agriculture tellingly focused the debate on the evils of collectivism and socialized medicine. The narrowing of health insurance proposals from universal coverage to the aged, however, set new constraints on the anti-Medicare campaigns. The aged themselves began to organize into such pressure groups as the Senior Citizens Councils and the Golden Ring Clubs. Although the financial and membership resources of these groups were slim compared to the better organized lobbies, the AMA could hardly afford to engage in open warfare with them as it had with the powerful AFL-CIO. AMA reiteration of stock ideological objections to Medicare would run the risk of the AMA being labeled the enemy of America's senior citizens. One effect was the appearance of a conservative willingness to offer alternatives which in turn helped shape the congressional response, especially in the early 1960's.

## Medicare Under a Republican President: The Politics of Legislative Impossibility

At no time during the Eisenhower Administrations (1953-60) did the Medicare bills have a chance of congressional enactment. Hospital insurance for the aged lacked the political sponsorship required to transmute controversial proposals into law. President Eisenhower had campaigned in 1952 against "socialized medicine," by which he meant

both the Truman health plan and the more modest proposals for the aged. In addition, members of the tax committees responsible for social security bills (Ways and Means in the House, the Finance Committee in the Senate) were in the main uninterested or hostile. Among congressmen generally there was not an intensely committed majority disposed to force those committees to report health insurance legislation. Even when the Democrats regained control of the Congress in 1954, the partisan majority did not comprise a favorable Medicare majority. In fact, the legislative prospects were so slight that no committee hearings were held until 1958.

Despite the decline of Medicare as a legislative issue under Eisenhower, a group of men who had played important roles in the Truman health insurance efforts pursued their strategy of gradualism. Annually from 1952 to 1960 modest Medicare bills were introduced in the Congress, not with any hopes for immediate enactment, but simply to keep alive the idea of health insurance under social security. At the same time, these promoters turned their energies towards other social insurance reforms. Wilbur Cohen, Director of Research for the Social Security Administration until 1956, actively campaigned for disability insurance covering workers over the age of 50. He did so on the assumption that by slowly expanding the number of impoverishing conditions insured against by social security, the risk of catastrophic health expenses would be left as the obvious major omission within the social insurance program requiring remedial legislation.

Once disability insurance was enacted in 1956, the strategists of gradualism concentrated once more on Medicare. The four most active members of this group included Cohen, in 1956 about to take up a professorship of welfare administration at the University of Michigan; I. S. Falk, then a consultant to the United Mine Workers; Nelson Cruikshank, head of the AFL-CIO's Department of Social Security; and Robert Ball, a highly respected career official in the Social Security Administration. They sought to prompt congressional interest in Medicare by persuading a well-placed congressman to sponsor the bill, and to elicit wide public concern about the health and finances of the aged through an AFL-CIO propaganda campaign, and they were successful in both efforts.

Although the three most senior members of the Ways and Means Committee rebuffed the Cohen group's entreaties to sponsor its bill, the fourth-ranking Democrat, Aime Forand, from Rhode Island, responded. In 1958, hearings were held on the Forand bill. Organized labor, which through most of the early 1950's had concentrated on securing health insurance for its members through collective bargaining, whipped up a campaign for Medicare in anticipation of the Forand hearings. The holding of hearings prompted the AMA into action as well; it raised its 1958 lobbying budget five-fold, and spent a quarter of a million dollars criticizing the Forand bill. The propaganda battle of the 1940's resumed, with each side matching the other in press releases, speeches, pamphlets, and harangues. Since the hassle inevitably

directed public attention towards health insurance for the aged, Congressman Forand was accurate when he facetiously expressed his indebtedness to the "American Medical Association for publicizing my bill so well." Nonetheless, in 1959 the Ways and Means Committee rejected the proposal by a decisive margin, in a 17-8 vote.

The Forand Bill vs. the Welfare Approach

The debate over the Forand bill revealed a pattern of disagreement which would continue to limit the alternatives facing the Congress. Both the problems defined as warranting public action and the type of proffered solution remained relatively stable from the time of Medicare's first introduction in 1952. The information gathered on illness, income, insurance status, and health care utilization almost invariably fell into the simple categories of the aged and the non-aged. When Forand's critics attacked his bill, they, too, shared the common focus of attention on the aged. Their argument from the Truman days that all Americans are not equally poor enough to warrant compulsory government health insurance turned into the argument that not all the aged are poor. That there were substantial health and financial problems among the aged was no longer disputed by the late 1950's. But the extent of those problems amongst the aged, and the means of remedy remained the controversial subjects provoking polarized positions.

The disagreement over the merits of the Forand bill illustrated the persistent divergent approaches to problems of social welfare in American politics. One, the so-called social insurance approach, seeks

partial solutions to commonly recognized problems through a financing mechanism that is regressive in character. That is, equal rates of taxes are paid by all contributors irrespective of level of income, with the result that lower income persons pay a larger proportion of their income in social security taxes than do higher paid workers. It selects beneficiaries not through tests of destitution, but by tests of presumptive need: the orphaned, the widowed, the disabled and the aged are presumed to be in need of assistance. Contribution to the social security system thus entails automatic payments of benefits to all those who fall into recognized circumstances of risk, regardless of income.

The alternative approach is that of private and public charity, based on the assumption that most members of a society protect themselves against unfortunate contingencies through savings and insurance. The remaining needs are those of the improvident, the impoverished, and the unlucky, for which the appropriate remedies are private charity, or failing that, local, state, and, sometimes, Federal "charity" programs. Levels of payments under these programs are determined individually, by measuring the gap between the financial resources and the needs of the beneficiary. And the means of financing the benefits are either, in the case of private charity, the largesse of the successful, or, in the case of government welfare programs, the general revenues of the Federal treasury and/or state funds. General revenue funding in principle provides a more progressive tax base than that of

social security in that, under general revenue taxing procedures, the higher the income the higher the tax that is levied. The social security approach relies upon Federal action; the welfare view is that the resort to Federal action is the least desirable alternative.

This ideological division revealed itself in the Forand controversy on a variety of issues, but particularly over the questions of who needed help, what aid the needy required, and which financing and administrative mechanisms were most appropriate to the remedy.

1) On the question of who needed help, the Forand bill specified all the aged participating in the social security system irrespective of their present income. Statistical profiles of the aged which were mustered in support of social security coverage emphasized

--the high proportion of low-income persons among the aged (U. S. Census data indicated that in 1958, about three-fifths of all persons aged 65 and over had less than $1,000 in money income, while another one-fifth received $1,000-$2,000).

--the greater incidence of illness amongst the aged (one indication of this was the National Health Survey finding that the aged received approximately twice as much hospitalization as those under 65).

--the inadequacy of private insurance coverage in meeting the needs of the elderly (social security administrators claimed that 53.9 per cent of the non-institutionalized aged were without any form of hospital insurance in 1959, although it was admitted that coverage amongst this high risk group was increasing. Forand backers, however, stressed the shortcomings of private insurance in meeting the total medical costs of the policy holders).

The critics frequently contested these and similar statistics on the aged, but their main theme was the numbers of aged who enjoyed good health, secure incomes, and private health insurance policies. Conceding that widespread health and financial problems did exist amongst the

elderly, advocates of a welfare approach argued that the Forand bill did not address itself exclusively or effectively to those "who really need help," the very poor among the aged.

2) The problem to which Forand directed attention was the catastrophic effects of large hospital and surgical bills; hence his benefits were limited to those expenses associated with expensive hospitalization and in-hospital doctor's care. Welfare approach opponents emphasized the inadequacy of surgical-hospital insurance for those whose means had been exhausted and who required out-patient care and drugs. They stressed the need for comprehensive benefits for those aged who could not deal with health expenses through savings, private insurance, medical charity, or state and local assistance.

3) On the question of administration and financing, the Forand bill called for a Federal program financed by social security taxes, emphasizing the contributory nature of OASDI and the desirability of not forcing the elderly to submit to the humiliation of a means test. Many conservative critics, who conceded that Federal funds might be necessary to assist the medically indigent aged, nonetheless argued that expansion of Federal power was undesirable. A more palatable alternative, to their way of thinking, was to share the financing of any medical assistance program with the states, reserving to the latter the role of administration and of setting standards according to local needs.

The irony of the dispute should now be evident. The social security approach advocated by most liberals in Congress had several features

which appeared less generous than the alternatives suggested by conservative proponents of the welfare method. What led liberals to support the Forand bill was a skepticism that a means-tested, state administered assistance program would in fact be generously implemented. The chart below illustrates the major differences in approach:

| | Forand Social Security Approach | Welfare Approach |
|---|---|---|
| Beneficiaries: | The aged covered under social security | Persons over 65 whose resources were insufficient to meet their medical expenses |
| Benefits: | Hospitalization, nursing home and in-hospital surgical insurance (Medicare bills introduced after 1959 excluded surgical insurance) | Comprehensive benefits for physicians' services, dental care, hospitalization, prescribed drugs, and nursing home care |
| Source of financing: | Social security taxes | Federal income tax revenues, plus state matching funds |
| Administration and setting of standards: | Uniform national standards administered by the Social Security Administration | Standards varying by state, administered by state and local officials |

Kerr-Mills Bill of 1960

The welfare perspective on the health and financial problems was reflected in three stages. An initial skepticism about the extent of the crisis among the aged subsequently gave way to hope that the substantial health costs of the aged could be coped with by the private insurance industry. Finally, there was the acceptance of the need for Federal action. The Kerr-Mills bill of 1960 reflected the

conception of appropriate Federal responses which conservative congressional leaders felt compelled to offer as a substitute for Medicare proposals. The beneficiaries would be limited to those in severe financial need, but the benefits were subject to few limits. The question of standards of need would be left to the various states, and the funding would be grants-in-aid, from general treasury funds, to state administrations that agreed to provide their share of the funds for "medical assistance to the aged." These were the characteristics of the bill which Senator Robert Kerr of Oklahoma and Representative Wilbur Mills of Arkansas offered as a substitute for the Forand bill. In 1960, that alternative was adopted by both tax committees of the Congress and ultimately passed as Public Law 86-778.*

The Kerr-Mills program was broad and generous in theory. The Federal government would provide between 50 and 80 per cent of the funds for states used in medical assistance for the aged, with the higher percentages going to the poorest states. Such arrangements, in the opinion of the Senate Finance Committee, would "enable every state to improve and extend medical services to aged persons." The expectation was that the 2.4 million persons on old-age assistance and the estimated 10 million medically indigent would share in the program. Senator Pat McNamara (D., Mich.) was more prescient. "The blunt truth," he

*It is noteworthy that Wilbur J. Cohen, a life-long advocate of health insurance under social security, wrote much of what became the Kerr-Mills law. Experts like Cohen were so familiar with the localistic, means test approach to social problems that Kerr and Mills, who both had had long experience with Cohen, rather naturally called him from the University of Michigan to help draft their bill.

told the Senate in August of 1960, "is that it would be the miracle of the century if all of the states--or even a sizeable number--would be in a position to provide the matching funds to make the program more than just a plan on paper." Three years later, McNamara's predictions were confirmed by a report of the special Senate Committee on Aging. In 1963, 32 of the 50 states had programs in effect, and the provision of funds was widely disparate among the states. Five large industrial states--California, New York, Massachusetts, Michigan, and Pennsylvania--were receiving nearly 90 per cent of the Kerr-Mills funds, and yet their aged populations represented only 32 per cent of the total population over 65.

These outcomes were not, of course, apparent to the promoters of medical assistance to the aged in 1960. Both Mills and Kerr were concerned about solving the worst problem--the health costs of the very poor among the aged--as a way of avoiding Medicare programs in the future. Both were quick to point out that their program allowed for more generous benefits than alternative social security proposals. In an interview with a national business magazine, Kerr insisted on this contrast:

> The Kerr-Mills program provides greater benefits to those over 65 who need those benefits. The benefits include doctors, surgeons, hospitalization, nurses and nursing care, medicines and drugs, dentists and dental benefits--even false teeth. Each state can provide what is needed by the people within the state. The...social security approach for aged care would provide mainly hospital and nursing home payments.

Few states were in fact to provide such broad benefits; by 1963, only four states were providing the full range of care allowed for in the Kerr-Mills bill, and most programs imposed strict limitations on the conditions for care and the extent of care. But the program satisfied both those who genuinely believed in the desirability of state rather than uniform national administration and those who hoped even an unsuccessful Kerr-Mills program would head off the steam for Medicare.

The American Medical Association, though originally opposed to the Kerr-Mills bill, soon came to understand its political virtues. In 1961, President E. Vincent Askey, M. D., urged the states to "implement [the Kerr-Mills program] for the needy and near-needy." Many of the state medical societies did not join in Askey's enthusiasm, but the cause of the AMA's alarm was clear. The election of John F. Kennedy, who had pledged to promote enactment of a compulsory health insurance law for aged social security beneficiaries, had returned Medicare proposals to the front pages of the nation's newspapers. In late 1960, Kennedy recalled Cohen to Washington from his professorial position in Michigan to head a health task force asked to draft a Medicare bill for introduction in the first session of the 87th Congress. When a policy has presidential sponsorship and favorable reactions in public opinion polls, and the partisan alignments in the Congress are supportive of the President, the chances of legislative adoption escalate. The election of 1960 thus marked a pronounced shift for Medicare from the politics of legislative impossibility characteristic of the previous eight years to the politics of possibility.

The Politics of Legislative Possibility: Medicare, 1961

Kennedy had labeled his platform "The New Frontier," and included within it a variety of proposals for domestic change which he said "would get this country moving again." As a part of the New Frontier, Kennedy prominently included a hospital insurance program for the aged. Shortly after his inauguration as President, Kennedy made good that campaign promise. On February 9, 1961, a presidential message to the Congress called for the extension of social security benefits for 14 million Americans over 65* to cover hospital and nursing homes costs, but not, in contrast to the Forand bill, surgical expenses. These benefits were to be financed by a one-quarter of one per cent increase in social security taxes.

The New York Times headlined the proposal and forecast a "STIFF FIGHT" over the Forand bill's successor. The narrowing of benefits was but one obvious indication that the President and his advisors were aware of the strong opposition to his bill and that they concurred with the strategy long used by Wilbur Cohen. That strategy, designed to modify congressional intractability, soft-pedaled the innovative character of the program in an attempt to widen agreement on the legitimacy of government involvement in health insurance. "The program," President Kennedy reiterated, "is not socialized medicine...It is a program of prepayment for health costs with absolute

*The 14 million figure was an estimate for 1963, the first full year in which the Kennedy Medicare program could have operated. The projection of 14 million social security beneficiaries, out of a total aged population of 17 3/4 million in 1963, left an estimated 3 3/4 million aged uncovered by the Kennedy proposal. The proportion of the aged ineligible for social insurance benefits had been sharply declining since the original Medicare bill. Between 1950 and 1960 the number of aged receiving social insurance benefits more than quadrupled, from 2.7 million to 11.6 million. In 1961, approximately 4 million were ineligible for social security benefits.

freedom of choice guaranteed. Every person will choose his own doctor and hospital."

Senator Clinton Anderson of New Mexico and Representative Cecil King of California--second-ranking members of the Senate Finance Committee and the House Ways and Means Committee respectively--simultaneously and enthusiastically introduced the President's bill the second week in February. Neither, however, was regarded as the preeminent Democrat on his committee, and presidents typically try to have controversial bills introduced by dominant figures like Senator Kerr or House Ways and Means Committee Chairman Mills. The lesser prominence of Kennedy's sponsors, coupled with the fact that the Kerr-Mills program was in its first year of operation as an alternative to Medicare, left no one in doubt that Kerr and Mills would prove formidable obstacles to the President's Medicare hopes. The ideological composition of the tax committees provided additional basis for skepticism about likely enactment. That the skepticism was well-founded was illustrated by the way Ways and Means dealt with the King-Anderson bill.

The Obstacle Course in Congress: First Try with Ways and Means

Kennedy's Democratic majority in the Congress presaged no clear majority favorable to Medicare, and only a majority vote of the entire House could extract the bill from a hostile Ways and Means Committee. Legislative liaison officials within the Department of Health, Education and Welfare counted only 196 House members certain to vote for Medicare in 1961--twenty-three votes short of a simple majority. The House

decision on Medicare thus would rest with Ways and Means.

The composition, style, and leadership of that committee provided ample grounds for predicting Medicare's defeat at the first stage of the formal legislative process. The 17-8 defeat of the Forand bill in 1959 indicated the combined strength of the Southern Democrats and conservative Republican bloc on the committee. Kennedy's Medicare strategists would have to confront this coalition: in 1961, sixteen Ways and Means committeemen were known to oppose the bill, including Chairman Wilbur Mills (D., Ark.), whose influence within the committee was formidable. Under those circumstances, the Gallup poll findings that "two out of three persons interviewed would be in favor of increasing the social security tax to pay for old-age medical insurance" provided little comfort to President Kennedy. Four votes--either of Southern Democrats or Northern Republicans--would have to change for the President to have a Medicare majority within the committee, and the prospects were not good.

Of twenty-five Ways and Means committeemen, fifteen were Democrats, eight of whom were from Southern or Border states. Among the Democrats, there was a clear ideological division between six of the Southern members and the others. The New Republic, a liberal weekly committed to a much expanded social welfare role for the Federal government annually evaluates congressional voting behavior. On twelve roll-call votes during the first session of the 87th Congress (1961), The New Republic found nine of the Democrats in perfect agreement with the magazine's position. The six other Democrats--all from Southern or

Border states--voted in accord with the magazine's position 60 per cent of the time or less. Among the ten Republicans on the committee, seven were in disagreement with the magazine's position 100 per cent of the time; the remaining three, 75 per cent of the time. The officially non-partisan Congressional Quarterly studies bear out The New Republic characterization of a substantial partisan cleavage, with a swing group of six Southern and Border state Democrats. Although the Congressional Quarterly analyses of the 87th and 88th Congress found Ways and Means Democrats and Republicans to be "more liberal" and "less liberal" respectively, than their party colleagues in the House, the Democratic showing was traced to the nine generally urban, pro-labor members on the committee. Thus, despite the high average support among the Democrats for "liberal" measures, the coalition of ten partisan Republicans and the six more conservative Southern Democrats easily comprised a negative majority on bills expanding the social welfare role of the Federal government.*

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*The New Republic evaluation of Ways and Means Democrats, 87th Congress, First Session:

| 100% average approval | with 60% approval or less |
|---|---|
| King (California) | Mills (Arkansas) |
| Karsten (Missouri) | Harrison (Virginia) |
| Burke (Massachusetts) | Herlong (Florida) |
| Keough (New York) | Frazier (Tennessee) |
| O'Brien (Illinois) | Ikard-Thompson (Texas) |
| Boggs (Louisiana) | Watts (Kentucky) |
| Machrowicz-Griffiths (Michigan) | |
| Green (Pennsylvania) | |
| Ullman (Oregon) | |

The conservative coalition opposing Medicare in 1961 was not a happenstance, but a predictable result of the committee's process of recruitment. Democrats on Ways and Means enjoy a unique source of influence, since they also comprise their party's Committee on Committees, the group which makes all Democratic committee assignments. By convention, however, when new Democratic members of the Ways and Means Committee are to be chosen, the Committee on Committees defers the choice to regional party caucuses. For example, during the first session of the 87th Congress, two Democratic openings on the committee occurred through resignation: Thaddeus Machrowicz of Michigan and Frank Ikard of Texas. Their replacements illustrated the pattern of geographical continuity: Martha Griffiths of Michigan replaced Machrowicz and Clark Thompson of Texas replaced Ikard. The effect of this customary practice has been to freeze the existing geographical distribution favoring Southern representation and thereby to prevent additions to the urban, pro-labor group among the Democrats.

Further, most Ways and Means members enjoyed an independence which made it unlikely that the President and the party could effectively pressure them into changing their votes. Widely regarded as one of the most prestigious House committees, Ways and Means attracts senior and influential members. Members stay on this preeminent committee a long time, and are more likely than other representatives to feel insulated from external pressures. Among the 1961 Democrats, for example, Frazier, Mills and Herlong had served continuously since the Truman Administration and many of the Southern Democrats, including Chairman Mills, have run

unopposed as often as opposed in their districts. In the 1960 congressional elections, when twenty-one fewer Democrats were returned to the House than in 1958, no Democratic incumbent of Ways and Means lost his seat. Ways and Means is thus a kind of old-timers' club within the House; its members are beyond the range of pressure from House and Executive leaders which younger congressmen, particularly those who need party help with re-election, may face.

As a rule, the committee is far more responsive to the wishes of the House of Representatives than it is to other sources of pressure. When a bill which is before the Ways and Means Committee has a strong majority on the floor waiting to enact it, the committee members usually feel a responsibility to report it. When, however, a controversial bill faces a bitter and close floor fight, the House frequently depends on the committee to "save it from itself." This gives Ways and Means the option of not reporting the bill at all or, if it chooses to report the measure, of writing partisan compromises into it first.

The success which Chairman Mills has in satisfying the House of Representatives is reflected in the reception which Ways and Means bills have had there. The bills reported by Ways and Means are generally voted on under a "closed rule," that is, no amendments are permitted, only limited debate and acceptance or rejection. This convention gives the committee great discretionary power in deciding what to write into their reported bills. House members go along with the convention because many of them have neither the time nor the expertise

to master the complex technical details involved in tax, trade and social security bills and because they prefer to avoid the pressure from interest group lobbies which those bills generally elicit. Maintaining the closed rule convention for Ways and Means bills does, however, constrain the committee to deal responsibly with legislative proposals. Thus, despite the deep partisan cleavages on the committee, Mills has maintained a reputation for not allowing partisan considerations to interfere unduly with its collective judgment on the technical merits of bills it handles. When partisan conflict is unavoidable, Mills takes pains to contain it by compromises which seek to prevent massive Republican or Democratic defections from the bill as it is reported from committee. The pride which Ways and Means members take in the regular House acceptance of their reported bills further insures their cautious handling of controversial measures like Medicare.

The Southern Democrats

The chairman of Ways and Means had a pivotal role in the fate of the 1961 Medicare legislation. In less than a year after his own bill, co-sponsored with Senator Kerr, had become public law, Mills again faced hospital insurance proposals he had helped to defeat in the previous session and which threatened now to displace the Kerr-Mills program. At the same time, his influence within the Ways and Means Committee was such that, could he be persuaded to support Medicare, it was likely that he could carry the committee with him.

When it came to dealing with Mills over the King-Anderson bill of 1961, Kennedy was in a difficult position. Medicare was only one of

several major items on the Administration's agenda. The President had initiated trade and tax bills of high priority to his domestic program, and these also fell within the jurisdiction of Mills' committee. Since Mills had agreed to introduce these bills in the House, and his support was requisite to their enactment, Kennedy and the House party leaders were at a disadvantage in pressing demands on him to back Medicare as well.

Mills' position in 1961 was affected by an accentuation of his own localistic considerations. The 1960 census returns required that Arkansas lose two of its six congressional seats, and in the process of redistricting it appeared that Mills would have to oppose Dale Alford in the district which included the whole of Little Rock. Alford was one of the two most conservative and anti-Administration of the Arkansas congressmen. An electoral contest with him would have been the most serious Mills had faced in a House career dating back to the New Deal. It seemed reasonable to suppose that Mills would be disinclined to support legislation, such as Medicare, which in the minds of many Little Rock voters would be too closely associated with an excessive role for the Federal government in social welfare policy.

In addition to the chairman, five other Southern Democrats on Ways and Means were opposed to the King-Anderson bill. The President needed at least thirteen pro-Medicare votes to have the bill reported to the floor, and took for granted that none of the ten Republicans on the committee would defect from his party's position. Hence, four affirmative votes were required from among those Southern and Border

state Democrats who had voted against the Forand bill in 1960.

The 1961 Congress strikingly illustrated a key difference between the legislative politics of America and those of a cabinet-parliamentary system like that of England. Party, executive, and legislative leadership in the U. S. is not, as in England, in the same hands, and the platform on which a president rides into office need not reflect the aims of many of his fellow partisans whose assistance is crucial in the committee and floor stage of the legislative process. Kennedy's prospects for changing the votes of the crucial Ways and Means Democrats hinged on the House Democratic leadership: the Speaker, the party whip, the floor leader, and the relevant committee chairman, Mills. While Speaker Rayburn was ready to support the President's Medicare proposal, he lacked formal means to enforce party discipline on recalcitrant Democrats.

Of the six Democratic opponents of Medicare, Burr Harrison of Virginia was the least likely candidate for persuasion: a conservative Southerner, he was both fixed in his ways and immune from pressure. At the other extreme was John Watts of Kentucky. He was reportedly willing to be the thirteenth vote for the King-Anderson bill if twelve others could first be mustered, although he faced enough anti-Administration sentiment in Kentucky to make conspicuous support of President Kennedy a personal liability. Among the other possibilities were the chairman, already a publicly announced opponent, and Herlong, Frazier, and Ikard, all at least six-term veterans of the House with conservative predilictions. Yet, since they were old acquaintances

of Speaker Rayburn, they might have been expected to go along with him in the absence of special district concerns.

Unfortunately for the legislative fate of the Medicare bill, at the very time when all the resources and skills of the House leadership were needed, the Speaker himself was in failing health. Majority Floor Leader McCormack increasingly took on many of the informal leadership functions that Rayburn in the past exercised so skillfully. The Massachusetts Democrat, though thoroughly schooled in the norms and sentiments of House veterans, could not be expected to have Rayburn's influence, enjoying neither the Speaker's office nor the immense personal popularity Rayburn, a Texan, had with Southern Democrats of the Watts and Ikard type.

The absence of Rayburn's highly personal legislative management, coupled with the past reluctance of the six "swing" Democrats to support health insurance under social security, meant that Chairman Mills' position was unlikely to be challenged within his committee. The New York Times' Washington correspondent, Russell Baker, judged this correctly only days after the King-Anderson bill was introduced. "The President's medical program," reported Baker, "despised by many of his own party inside the House Ways and Means Committee, was in great trouble."

Earlier in the month, the Times had emphasized the equally important fact that Ways and Means faced a "heavy schedule of high priority legislation," with the controversial Medicare bill unlikely to be discussed in hearings until late in the session. The certain opposition

of Mills and Harrison, and the probable opposition of the four remaining members of the conservative Southern group, held out dim hopes for those late-session hearings. In the meantime, the problem facing the President was not only to secure these Southern votes on medical care legislation, but have this group follow party leadership on the foreign aid, depressed areas, tax, housing and trade bills.

When, as with the King-Anderson bill of 1961, it appears that a committee will not report favorably on a presidential proposal, the President and his allies have alternative strategies. The question facing President Kennedy was whether anything could be gained by any of three possible offensive strategies.

Kennedy could concentrate his bargaining resources on medical care, taking the chance of alienating support on other high-priority bills. Since the outlook for Kennedy's trade and tax legislation was otherwise favorable, both the President and his advisors agreed it would be unwise to press the Ways and Means Committee too forcefully. Moreover, the Democratic margin in the House (263-174) did not assure passage of the King-Anderson bill even if it were somehow to get to a floor vote: sixty or more of those Democrats appeared unwilling to pass Medicare in 1961. Hence a determined bid for House action was rejected by the President.

The second possibility was to try by-passing the House of Representatives with a Medicare rider to another bill. A rider is a bill which is attached as an amendment to another bill that has already passed one house. In April, 1961, an increasing number of reports

suggested the Administration was preparing for a move in that direction. Senator Javits (R., N.Y.) expressed "dismay at reports that the Administration had decided to put off a request for Congressional action until next year," and argued that "nothing will happen unless the Administration gives [Medicare] priority at this session." The support of liberal Republican senators, coupled with broader sponsorship of Medicare among some Democratic Senators, led Senator Anderson, Medicare's co-sponsor, to deny late in April that legislative efforts for the session had been abandoned. The proposal was to add a Medicare amendment to the House-approved social security bill then before the Senate Finance Committee.

The Senate Democratic leadership, however, saw strong arguments against the rider tactic. Even if the composite bill passed the Senate, it would be reviewed by a House-Senate conference committee, and Mills' bipartisan influence within his committee was sufficient to force a choice between the social security bill stripped of the Medicare amendment or no bill at all. Kennedy and his advisors discarded the rider alternative, for the time being, and press speculations faded out.

A third option for Kennedy, the one he was to choose, involved accepting the defeat of the bill for that year, but using it to attract public attention to his thwarted campaign pledge. Although he had rejected the use of arm-twisting tactics within the Congress, Kennedy hoped to put indirect pressure on legislators by going to the public with an educational campaign about the legislation denied him

in 1961. Whatever its short-term effects, that strategy had prospects of beneficial longer-term consequences.

The Kennedy Administration Versus the AMA

Even before the King-Anderson bill was introduced in February, representatives of the Kennedy Administration had begun castigating the AMA for trying, as Wilbur Cohen said at a Washington conference on the aged, "to thwart the will of the majority of the people" by "methods of vilification and intimidation." Although clearly the most immediate threat to enactment was the bottleneck within the Ways and Means Committee, it was the AMA and its supporters who drew most of the Administration's fire.

The American Medical Association offered, to be sure, a conspicuous target. Eschewing compromise, the AMA employed every propaganda tactic it had learned from the bitter battles of the Truman era. "The surest way to total defeat," cautioned Dr. Ernest Howard, the organization's assistant executive vice-president, "is to say that the AMA should try to sit down and negotiate something reasonable." Instead, AMA-sponsored newspaper advertisements and radio and television spots indicting the King-Anderson bill began appearing throughout the nation. Waving the red flag of socialism, these messages held out horrifying visions of a "new bureaucratic task force" entering "the privacy of the examination room," depriving American patients of the "freedom to choose their own doctor" and the doctor of the freedom "to treat his patients in an individual way."

The AMA simultaneously launched less publicized efforts to mobilize local communities against the Kennedy bill. Congressional speeches criticizing H.R. 4222 were reproduced and distributed to newspapers and voluntary organizations. An "Operation Hometown" campaign began, enlisting county medical societies in a variety of lobbying tasks. The AMA equipped local medical leaders with a roster of ready-made speeches, reprints, pamphlets, sample news announcements, a "High School Debate Kit," radio tapes and scripts, and a list of guidelines for using the materials most effectively in reaching "every segment of the American public through every possible medium, [and stimulating] every voter to let his Congressman know that medicare is really 'Fedicare'--a costly concoction of bureaucracy, bad medicine, and an unbalanced budget."

Since King-Anderson supporters could do little to bring direct pressure on the pivotal congressmen in Ways and Means they hoped their representation of the AMA as an unscrupulous and inordinantly powerful interest which was successfully thwarting the public would cause congressional critics of Medicare to suffer guilt by association. In April, HEW Secretary Abraham Ribicoff debated Senator Kenneth Keating (R., N.Y.) on television over the King-Anderson bill, and used the opportunity to lash out against the "scare tactics" of "organized medicine's" campaign against compulsory health insurance for the aged.

The Ways and Means hearings of July and August provided another prominent occasion for continuing the bid for public support. The

testimony of representatives from the Department of Health, Education and Welfare linked the well-known case for the King-Anderson bill to a blistering attack on the pressure groups opposing it. The Administration spokesmen, along with those of the AFL-CIO, diverted their attention from the specifications of the Medicare bill to the methods and interest of their medical, business, and hospital critics. The testimony of Secretary Ribicoff attempted to discredit AMA predictions of creeping socialism and the end of freedom by outlining again the modest character of Medicare. "The bill is designed," he said,

> only to take care of the aged. It is not my intention to advocate that we take care of the medical needs and hospital needs of our entire population, and the reason is that insurance is available for younger people. Blue Cross is available and it can be paid for by our working population.

The press gave prominent coverage to the summer hearings, but the behavior of the committee members indicated that the bill's fate was a foregone conclusion. The Southern Democrats, whose views were central to the committee outcome, were relatively quiet. Chairman Mills, who ordinarily takes a dominant role in hearings over major bills, missed two of the nine sessions, and remained dispassionate during most of those he chaired. Questioning was left primarily to a few of the anti-Medicare Republicans and pro-Medicare Democrats who were amenable to joining the propaganda battle being waged by the testifiers.

At the end of nine days, on August 4, 1961, the hearings ended undramatically. A week later The New York Times reported that no further action on the King-Anderson bill was contemplated for that session.

Amidst the national concern over Berlin and the call-up of reserve units, many Americans were unaware of the fate of what had been a campaign issue, or of the fact that the committee had failed even to take a vote on the bill. Chairman Mills, unwilling as ever to highlight the partisan cleavages within the committee, and sharing with his fellow committeemen, and congressmen generally, a reluctance to clarify their public record with anything so concrete as a yes or no vote when there was little to be gained by it, preferred to let the bill die an anonymous death. If future events should force a reconsideration of the committee's position on Medicare--and Mills was aware of the possibility--a tell-tale 1961 vote might prove an embarrassment. Nor did the Kennedy Administration, with an interest in future negotiations with Ways and Means, wish to burden Medicare with the legacy of a negative vote. The quietness of Medicare's burial made it easier for the bill's supporters to blame its murder on the AMA while diverting attention from the active complicity of the House committee and the passive complicity of the Kennedy Administration.

Medicare's Near Miss, 1964

Between the defeat of President Kennedy's initial Medicare proposal in 1961 and the national elections of 1964, none of the major congressional obstacles to its enactment were fully altered. The Democrats maintained control of the Congress after the 1962 elections, but the pro-Administration bloc was, as usual, never as large as the number of Democrats. In 1964, HEW's congressional liaison staff

estimated the House Medicare breakdown as approximately twenty-three votes short of a 218 majority. The Ways and Means Committee never gave them the chance to check the accuracy of their estimates, and attempts to circumvent the committee with rider strategies proved abortive in 1962 and 1964. Each year hearings were held on Medicare, and by 1964, thirteen volumes of testimony had been compiled, totaling nearly 14,000 pages. But Wilbur Mills and his committee were not ready to report a Medicare bill.

The Administration's pro-Medicare strategy included continued efforts to change votes on the committee. Two methods were employed. First, HEW officials were directed to respond to the objections of the key Southern Democrats in hopes of bringing them around on the King-Anderson bill. Cohen and his staff spent far more time courting critics like Herlong, Watts, Harrison and Mills than they did working with pro-Medicare members of the committee. The Administration, acting through the influence of House Democratic leadership over members of the regional caucuses, also took steps directed to enlarge the size of the pro-Medicare group. After 1961, no new member of the committee was elected who had failed to assure the House leadership that he would vote for Medicare or, at the very least, would support its being reported out of the Ways and Means Committee. By 1964, these efforts had brought the total of pro-Medicare Democrats to twelve, one short of a committee majority. Three of the anti-Medicare Southern Democrats of 1961, Frazier, Ikard and Harrison, had been replaced by fellow Southerners who supported the King-Anderson bill, Richard Fulton,

Clark Thompson and Pat Jennings. All the other Democratic newcomers between 1961 and 1964 were, like their predecessors, firm Administration supporters.

Sensing the rising support for Medicare, its opponents on Ways and Means nearly pulled off a clever legislative coup in the early summer of 1964. The ranking Republican, John W. Byrnes of Wisconsin, proposed that the 5 per cent increase in social security benefits which the committee had approved in earlier deliberations be increased to 6 per cent. This would have raised social security taxes to 10 per cent, widely accepted within Congress as the upper tax limit, and thus leave no fiscal room for Medicare in the future. The pro-Medicare committeemen realized the trap, but only eleven of their number were at the roll call vote. Mills, Herlong and Watts supported Byrnes' amendment, giving the anti-Medicare group what seemed a winning margin, 12-11. But the final vote cast was by Bruce Alger, an arch-conservative Republican from Dallas. Unwilling to play the game, Alger voted with the Democratic majority, explaining later that "since he opposed the entire Social Security system, consistency would not permit him to expand it," even to undermine the chances of Medicare.

Having observed their House brethren come close to catastrophe, Senate Democrats acted to attach the Medicare rider to the social security bill which the House had already passed in 1964. But Mills had anticipated that move and, fearing that his committee would lose control over the content of any Medicare bill, had taken steps to thwart it. He promised pro-Medicare Democrats on his committee that

Medicare would be the "first order of business" in 1965; in return he received their support in rejecting the rider in the conference committee. On October 4, the conference announced its deadlock over the entire social security bill, thus postponing both the social security cash benefit increases and Medicare until the following year.

Medicare's defeat in 1964, compared to Kennedy's failing effort in 1961, presaged its enactment in 1965. The Senate was on record favoring the King-Anderson bill and the key bottleneck of 1961, the Ways and Means Committee, was within one vote of a pro-health insurance majority. Wilbur Mills' promises for 1965 evidenced the weakened position of the anti-Medicare coalition. In September and December of 1964, Mills suggested to audiences in Little Rock that a soundly financed Medicare bill would gain his support in the next session of the Congress. Having already stated that medical care insurance would be the first order of business for his committee the following January, Mills expressed his concerns about the discrepancies between popular conceptions of Medicare and the content of the King-Anderson proposals. "The public," Mills warned in his Little Rock speech of December 7, "must be under no illusion regarding the benefits...[and must understand that] Medicare does not refer to doctor services" or general out-patient medical care.

Mills' worry was not ill-founded. "Medicare," a term which originally referred to the comprehensive health program run for servicemen's families by the Defense Department, was a misleading slogan for the King-Anderson bill. "Hospicare" would have been a more appropriate

epithet. Despite the accretion of support between 1961 and 1964, the King-Anderson bills had changed only slightly. After 1963, Medicare was altered to include non-social security beneficiaries for a limited period, and here and there changes were made in the level of benefits. But the bill over which the conference committee deadlocked in 1964 remained basically a hospital insurance measure. When the deadlock was announced, observers, taking their cue from Mills' promises, assumed the King-Anderson proposal would be close to passage in 1965. In the meantime, the election of November, 1964, changed practically every political consideration; and Mills' ruminations in December about the unrealistic conception Americans held of Medicare was the first sign that anyone read the electoral victory of the Democrats to mean anything more than speedy enactment of a bill providing hospitalization and nursing home insurance for the aged.

The Impact of the Election of 1964

The electoral outcome of 1964 guaranteed the passage of legislation on medical care for the aged. Not one of the obstacles to Medicare was left standing. In the House, the Democrats gained thirty-two new seats, giving them a more than two-to-one ratio for the first time since the heyday of the New Deal. In addition, President Johnson's dramatic victory over Goldwater had some of the features of a popular mandate for Medicare. The President had campaigned on the promise of social reforms--most prominently Medicare and Federal aid to education--and the public seemed to have rejected decisively Goldwater's

alternatives of state, local, and private initiative.

Within the Congress, immediate action was taken to forestall recurrence of the dilatory methods previously employed against both Federal aid to education and medical care bills. Liberal Democratic members changed the House rules so as to reduce the power of Republican-Southern Democrat coalitions on committees to delay proposals. The twenty-one day rule was reinstated, making it possible to dislodge bills from the House Rules Committee after a maximum delay of three weeks. On the Ways and Means Committee, the traditional majority party-minority party ratio of three-to-two was altered to the partisan ratio of the entire House (two-to-one). In 1965, that meant a shift from fifteen Democrats and ten Republicans to seventeen Democrats and eight Republicans, thereby producing a pro-Medicare majority. Enactment of the King-Anderson program, only a legislative possibility until the election of 1964, had now become a certainty. The only question remaining was what its precise form would be.

## The Administration's Suggestion: H.R. 1 & S. 1

Administration leaders assumed after the election that the Ways and Means Committee would report a bill similar to the one rejected by the conference in 1964. Hence, Anderson and King introduced on January 4, 1965, respectively in the Senate and House, the standard Medicare package: coverage of the aged, limited hospitalization and

nursing home insurance benefits, and social security financing. The HEW staff prepared a background guide on the bill which continued to emphasize its modest aims. For example, the guide included assurances that the bill's coverage of hospitalization benefits "left a substantial place for private insurance for nonbudgetable health costs, [particularly for] physicians' services." It described H.R. 1 as "Hospital Insurance for the Aged through Social Security," and no doubt would have encouraged the substitution of "Hospicare" for "Medicare" as its popular name, had this been still possible by 1965.

Social Security experts within HEW, with a rich history of sponsoring unsuccessful health insurance bills, were doubly cautious now that success seemed so near at hand. Wilbur Cohen, for instance, busied himself with Johnson's blessings convincing congressional leadership to give Medicare the highest priority among the President's Great Society proposals: hence Medicare became H.R. 1 and S. 1. Its content, however, remained essentially unchanged. The HEW leaders, like everyone else, could read newspapers and find criticisms that Medicare's benefits were insufficient, and that the aged mistakenly thought the bill covered physicians' services. The strategists believed, however, that physicians' care could wait: the reformers' fundamental premise had always been that Medicare was only "a beginning," with increments of change set for the future.

If the 1964 elections promoted satisfaction among H.R. 1's backers with their customary position, it provoked significant shifts among Medicare's opponents. Both Republican and AMA spokesmen shifted to

discussions of what one AMA official, Dr. Ernest Howard, called "more positive programs." These alternatives grew out of the familiar criticisms that the King-Anderson bills had "inadequate" benefits, would be too costly, and made no distinction between the poor and wealthy among the aged. The AMA gave the slogan "Eldercare" to its bill, and had it introduced as H.R. 3737 by Thomas Curtis (R., Mo.) and A. Sydney Herlong (D., Fla.), both Ways and Means members. In comparing its bill and H.R. 1, the AMA earnestly stressed the disappointingly limited benefits of the latter:

> Eldercare, implemented by the states would provide a wide spectrum of benefits, including physicians' care, surgical and drug costs, nursing home charges, diagnostic services, x-ray and laboratory fees and other services. Medicare's benefits would be far more limited, covering about one-quarter (25%) of the total yearly health care costs of the average person....Medicare would <u>not</u> cover physicians' services or surgical charges. Neither would it cover drugs outside the hospital or nursing home, or x-ray or other laboratory services not connected with hospitalization.

Claiming their "program offered more benefits for the elderly at less cost to the taxpayers," the AMA charged, as did some Republicans, that the public had been misled by the connotations of the "Medicare" epithet. Seventy-two per cent of those questioned in an AMA-financed survey during the first two months of 1965 agreed that doctors' bills should be insured in a government health plan. Sixty-five per cent of the respondents preferred a selective welfare program which would "pay an elderly person's medical bill only if he were in need of financial help" to a universal social security plan which would "pay the medical expenses of everyone over 65, regardless of their income." Armed with

these figures, the AMA once again launched a full-scale assault on the King-Anderson bill, hoping to head it off with what amounted to an extension of the Kerr-Mills program.

By February, the issue was once again before the Ways and Means Committee. Pressure groups--medical, labor, hospital and insurance organizations primarily--continued to make public appeals through the mass media, but they also made certain their viewpoints were presented to the committee. Ways and Means had before it three legislative possibilities: the Administration's H.R. 1, the AMA's Eldercare proposal, and a new bill sponsored by the ranking Republican committee member, John Byrnes.

The Ways and Means Committee and the House Take Action: January-April

For more than a month the committee worked on H.R. 1, calling witnesses, requesting detailed explanation of particular sections, and trying to estimate its costs and benefits. Executive sessions closed to the press, one mark of serious legislative intention, began on February 17. The atmosphere was business-like and deliberate; members assumed the Administration bill would pass, perhaps with minor changes, and there was little disposition to argue the broad philosophical issues that had dominated hearings in the preceding decade. When spokesmen for the AMA invoked their fears of socialized medicine, they infuriated committee members intent on working out practical matters, and Chairman Mills refused to permit AMA representatives to attend further sessions of the hearings.

Mills led his committee through practically every session of hearings on the Administration bill, promising to take up the Byrnes bill (H.R. 4351) and the Eldercare bill in turn. By March 1, there had been continued reference to the exclusions and limits of the King-Anderson bill, with the charges of inadequacy coming mostly from the Republicans. On March 2, announcing his concern for finding "some degree of compromise [that] results in the majority of us being together," Mills invited Byrnes to explain his bill to the committee.

The Byrnes bill was ready for discussion because the Republicans on the committee in the wake of the 1964 election, wanted to prevent the Democrats from taking exclusive credit for a Medicare law. The Republican staff counsel, William Quealy, had explained this point in a confidential memorandum in January, reminding the Republican committeemen that they had to "face political realities." Those realities included the certain passage of health insurance legislation that session and excluded the strategy of substituting an expanded Kerr-Mills program. "Regardless of the intrinsic merits of the Kerr-Mills program," Quealy wrote, "it has not been accepted as adequate..., particularly by the aged, [and a] liberalization of it will not meet the political problem facing the Republicans in this Congress." That problem was the identification of Republican with die-hard AMA opposition to Medicare, which some Republican leaders thought contributed heavily to their 1964 electoral catastrophe.

Byrnes emphasized that his bill, which proposed benefits similar to those offered in the Aetna Life Insurance Company's health plan for

Federal employees, would cover the major risks overlooked by H.R. 1, particularly the costs of doctors' services and drugs. He also stressed the voluntary nature of his proposal; the aged would be free to join or not, and their share of the financing would be "scaled to the amounts of the participants' social security cash benefits," while the government's share would be drawn from general revenues. The discussion of the Byrnes bill was spirited and extended; the AMA's Eldercare alternative, not promoted vigorously by even its committee sponsors, was scarcely mentioned.

Increasingly, the Byrnes and King-Anderson bills were discussed as mutually exclusive alternatives. HEW officials--Cohen, Ball, Irwin Wolkstein of the Social Security Administration, and several others--were exhausted from weeks of questioning and redrafting, and viewed the discussion of the Byrnes bill as a time for restful listening. But Mills, instead of posing a choice between the two bills, unexpectedly suggested a combination which involved extracting Byrnes' benefit plan from his financing proposal. On March 3, Mills turned to HEW's Wilbur Cohen and calmly asked whether such a "combination" was possible. "Stunned," Cohen was initially suspicious that the suggestion was a plot to kill the entire Administration proposal. Cohen had earlier argued for what he called a "three-layer cake" reform by Ways and Means: H.R. 1's hospital program first, private health insurance for physicians' coverage, and an expanded Kerr-Mills program "underneath" for the indigent among the aged. Mills' surprise proposition "to come up with a medi-elder-Byrnes bill" posed for Cohen an innovative and

unforeseen possibility. That night, in a memorandum to the President, Cohen reflected on Mills' "ingenious plan," explaining that a proposal which put "together in one bill features of all three of the major" alternatives before the committee would make Medicare "unassailable politically from any serious Republican attack." Convinced now that Mills' strategy was not destructive, Cohen was delighted that Republican charges of inadequacy against H.R. 1 had been used by Mills to prompt the expansion of that bill.

Byrnes himself was reluctant to approve the dissection of his proposal, humorously referring to his bill as "bettercare." Nonetheless, from March 3 to March 23, when the committee finished its hearings, Ways and Means members concentrated on the combination of what had been mutually exclusive solutions to the health and financial problems of the elderly. Mills presided over this hectic process with confident but gracious assurance, asking questions persistently but encouraging from time to time comments from other members, especially from the senior Republican, Byrnes. The Byrnes benefit formula was slightly reduced; the payment for drugs used outside hospitals and nursing homes, for instance, was rejected on the grounds of its unpredictable and potentially high costs. After some consideration of financing the separate physicians' insurance through social security, the committee adopted Byrnes' financing suggestion of individual premium payments by elderly beneficiaries, with the remainder drawn from general revenues. But, while Byrnes had proposed that such premiums be scaled to

social security benefits, the committee prescribed a uniform $3 per month contribution from each participant. The level of premium was itself a matter of extended discussion: HEW actuaries estimated medical insurance would cost about $5 per month, but Mills cautiously insisted that a $6 monthly payment would make certain that expenditures for medical benefits were balanced by contributions.

In its transformation into the "first layer" of the new "legislative cake," H.R. 1 was not radically altered. Levels of particular benefits were changed, reducing, among other things, the length of insured hospital care, and increasing the amount of the hospital deductible and co-insurance payment beneficiaries would have to pay. (Deductibles are the payments patients must make before their insurance takes over, and co-insurance contributions are the proportion of the remaining bill for which patients are responsible.) The continuing debate over these matters illustrated the divergent goals of those involved in reshaping Medicare. High deductibles but no limit on the number of insured hospital days were sought by those anxious to provide protection against chronic and catastrophic illness. Others insisted on co-insurance and deductibles so that patients would be given a stake in avoiding overuse of hospital facilities. But the most contested changes made in H.R. 1 involved the methods of paying hospital-based RAPP specialists (radiologists, anesthesiologists, pathologists, and physiatrists) and the level of increase in social security taxes required to pay for the hospitalization plan.

The Johnson Administration recommended that the charges for services like radiology and anesthesiology be included in hospital bills unless hospitals requested some other form of payment. Mills, however, insisted that "no physician service, except those of interns and residents under approved teaching programs, would be paid" under H.R. 1, now Part A of the bill Mills had renumbered H.R. 6675. His provision required changes in the customary billing procedure of most hospitals, and became the subject of bitter disagreement. Such an arrangement, hospital officials quickly reminded the committee, would cause administrative difficulties and upset existing arrangements. But Mills stuck by his suggestion and easily won committee approval. More than any other issue, the method of paying these hospital specialists was to plague efforts in the Senate and conference committee to find a compromise version of the bill Mills steered through the Ways and Means Committee.

Ways and Means also required more cautious financing of the hospital program than the Administration suggested. Social Security taxes--and the wage base on which those taxes would be levied--were increased so as to accommodate even the most extraordinary increases in costs. The final committee report announced with some pride that their estimates of future hospital benefits reflected a "more conservative basis than recommended by the [1964 Social Security] Advisory Council and, in fact, more conservative than those used by the insurance industry in its estimates of proposals of this type." (Mills'

penchant for "actuarial soundness" was justified by Medicare's costs during the first year of operation; in 1966 both hospital and physician charges more than doubled their past average rate of yearly increase, thus substantially inflating program costs beyond HEW's initial predictions.)

Throughout March, Mills called on committee members, HEW officials, and interest group representatives to lend their aid in the process of drafting a combination bill. The advice of the Blue Cross and American Hospital Associations was taken frequently on technical questions about hospital benefits. HEW spokesmen were asked to discuss many details with directly interested professional groups and report back their findings. Blood bank organizations, for instance, were consulted on whether Medicare's insurance of blood costs would hamper voluntary blood-giving drives. Their fear that it would prompted the committee to require that Medicare beneficiaries pay for or replace the first three pints of blood used during hospitalization. Throughout, Mills left no doubt that he was first among equals--he acted as the conciliator, the negotiator, the manager of the bill, always willing to praise others, but guiding the "marking up" of H.R. 6675 through persuasion, entreaty, authoritative expertise, and control of the agenda.

The Medicare bill the committee reported to the House on March 29, 1965, included parts of the Administration bill, the Byrnes benefit package, and the AMA suggestion of an expanded Kerr-Mills program. These features were incorporated into two amendments to the Social

Security Act: Title 18 and 19. Title 18's first section (Part A) included the hospital insurance program, the revised version of H.R. 1. Part B represented the modified Byrnes proposal of voluntary doctors' insurance. And Title 19 offered a liberalized Kerr-Mills program that, contrary to AMA intentions, was an addition to rather than a substitution for the other proposals.

On the final vote of the committee, the Republicans held their ranks, and H.R. 6675 was reported out on a straight party vote of 17-8. When the House met on April 8th to vote on what had become known as the Mills bill, they gave the Ways and Means Chairman a standing ovation. In a masterly explanation of the complicated measure (now 296 pages long), Mills demonstrated the thoroughness with which his committee had done its work. Byrnes presented his alternative bill after Mills had finished, and a vote was taken on whether to recommit H.R. 6675 in favor of the Republican alternative. The motion to recommit was defeated by 45 votes; 63 Democrats defected to the Republican measure, and only ten Republicans voted with the Democratic majority. Once it was clear that H.R. 6675 would pass, party lines re-formed and the House sent the Mills bill to the Senate by an overwhelming margin of 315-115.

What had changed Mills from a Medicare obstructionist to an expansion-minded innovator? Critics speculated on whether the shift represented "rationality" or "rationalization," but none doubted Mills' central role in shaping the contents of the new legislative proposal. The puzzle includes two distinct issues: why did Mills seek to expand

the Administration's bill, and what explains the form of the expansion he helped to engineer?

By changing from opponent to manager, Mills assured himself control of the content of H.R. 1 at a time when it might have been pushed through the Congress despite him. By encouraging innovation, and incorporating more generous benefits into the legislation, Mills undercut future claims that his committee had produced an "inadequate" bill. In both respects, Mills became what Tom Wicker of The New York Times termed the "architect of victory for medical care, rather than just another devoted but defeated supporter" of the Kerr-Mills welfare approach. Mills' conception of himself as the active head of an autonomous, technically expert committee helps to explain his interest in shaping legislation he could no longer block, and his preoccupation with cautious financing of the social security system made him willing to combine benefit and financing arrangements that had been presented as alternatives. The use of general revenues and beneficiary premiums in the financing of the physicians' insurance was the committee's way of making certain the aged and the Federal treasury would have to finance any benefit changes, not the social security trust funds. In an interview during the summer of 1965, Mills explained that inclusion of medical insurance would "build a fence around the Medicare program" and forestall subsequent demands for liberalization that "might be a burden on the economy and the social security program."

In sharp contrast to Mills' flexibility, HEW cautiously had settled for proposing its familiar King-Anderson plan. More than the

committed Medicare advocates, Mills was the more astute in realizing how much the Johnson landslide of 1964 had changed the constraints and incentives facing the 89th Congress. President Johnson, busy with the demands of a massive set of executive proposals, was willing to settle for the hospitalization insurance which the election had insured. Liberal supporters of the Johnson Administration were astounded by Ways and Means' improvement of Medicare and befuddled by its causes. The New Republic captured the mood of this public at the time of the House vote, suggesting that the Mills bill could "only be discussed in superlatives:"

> fantastically enough, there was a tendency to expand [the Administration's bill] in the House Committee. Republicans and the American Medical Association complained that Medicare "did not go far enough." Trying to kill the bill they offered an alternative--a voluntary insurance plan covering doctors' fees, drugs, and similar services. What did the House Ways and Means Committee do? It added [these features] to its own bill. Will this pass? We don't know, but some bill will pass.

H.R. 6675 Passes the Senate, April-July

There was really no question that the expansion of Medicare would be sustained by the more liberal Senate and its Finance Committee. But the precise levels of benefits and form of administration were by no means certain. The Finance Committee Chairman, Russell Long (D., La.), held extended hearings during April and May, and the committee took nearly another month amending the House-passed bill in executive sessions. Two issues stood out in these discussions: whether to accept the payment method for in-hospital specialists which Mills had insisted

upon, and whether even more comprehensive benefits could be financed by varying the medical insurance premiums with the income of beneficiaries.

The first issue was taken up, with White House encouragement, by Senator Paul Douglas (D., Ill.). The question of specialist payment brought out in the open a dispute within the medical care industry. The American Hospital Association told the Finance Committee that permitting hospital specialists to charge patients separately would both "tend to increase the overall cost of care to aged persons" and imperil the hospital as the "central institution in our health service system." HEW's general counsel, Alanson Willcox, prepared a list of supporting arguments which Wilbur Cohen supplied in defense of the Douglas amendment to pay RAPP specialists as specified in the original H.R. 1. "These specialists," Willcox pointed out, "normally enjoy a monopoly of hospital business" and yet they seek the "status of independent practitioners without the burden of competition to which other practitioners are subject."

The AMA responded with fury to Douglas' revisions. Defending the specialists, the AMA hailed Mills' payment plan as a way to break down the "corporate practice of medicine" which made many radiologists, anesthesiologists, pathologists, and physiatrists coerced "employees" of hospitals. "Medical care," the AMA reminded the committee, "is the responsibility of physicians, not hospitals." Apparently unconvinced, the Senators approved the Douglas amendment in early June.

In mid-June the committee approved a plan to eliminate time limits on the use of hospitals and nursing homes. The supporters of this amendment were a mixed lot of pro- and anti-Medicare Senators, and it was clear the latter group thought this change might deadlock the entire bill. For those who wanted more adequate protection against financial catastrophe there was the subsequent realization that a well-intentioned mistake had been made. With the White House and HEW insisting on a reconsideration, the committee scrapped the amendment on June 23 by a vote of 10-7. Instead, the Finance Committee provided unlimited additional days of hospital care for which the patient would contribute $10 per day.

The committee also took up a variety of provisions within the Mills bill which Administration spokesmen considered "important defects." The Medicare sponsor in the Senate, Clinton Anderson, argued that paying physicians their "usual and customary fees" (the Byrnes suggestion) would "significantly and unnecessarily inflate the cost of the program to the tax-payer and to the aged." The House bill had left the determination of what was a "reasonable charge" to the insurance companies, which would act as intermediaries for the medical insurance program, and Anderson saw no reason why these companies would save the government from an "open-ended payment" scheme. Medical spokesmen, however, were so critical of the overall Medicare legislation that fears of a physicians' boycott, and the absence of an obviously attractive alternative, persuaded Senate reformers not to raise further questions about the sensitive issue of what constituted reasonable charges.

The Senate, unlike the House, does not vote on social security bills under a closed rule. This meant further amendments and debate would take place on the Senate floor on the Finance Committee's somewhat altered version of the Mills bill. On July 6 debate was opened and the Senate quickly agreed to accept the committee recommendation to insure unlimited hospital care with $10 co-insurance payments after 60 days. Three days later, after heated discussion, the Senate finished with its amendments, and passed its version of Medicare by a vote of 68-21. On the crucial but unsuccessful vote to exclude Part A from the insurance program, 18 Republicans and 8 Southern Democrats took the losing side. According to newspaper estimates, the bill passed by the Senate added $900 million to the "price tag on Medicare." The conference committee was certain to have a number of financial and administrative differences to work out through compromise.

Medicare Comes Out of the Conference Committee: July 26, 1968

Over 500 differences were resolved in conference between the Senate and House versions of Medicare. Most of the changes were made through the standard bargaining methods of quid pro quo and splitting the difference. The most publicized decision was the rejection of the Douglas plan for paying RAPP specialists under the hospital insurance program. The bulk of the decisions were compromises between divergent benefit levels. The changes of duration and type of benefit involved either accepting one of the two congressional versions or combining differing provisions. The decisions on the five basic benefits

in the hospital plan aptly illustrate these patterns of accommodation:

1. Benefit duration--House provided 60 days of hospital care after a deductible of $40. Senate provided unlimited duration but with $10 co-insurance payments for each day in excess of 60. Conference provided 60 days with the $40 House deductible, and an additional 30 days with the Senate's $10 co-insurance provision.

2. Posthospital extended care (skilled nursing home)--House provided 20 days of such care with 2 additional days for each unused hospital day, but a maximum of 100 days. Senate provided 100 days but imposed a $5 a day co-insurance for each day in excess of 20. Conference adopted Senate version.

3. Posthospital home-health visits--House authorized 100 visits after hospitalization. Senate increased the number of visits to 175, and deleted requirements of hospitalization. Conference adopted House version.

4. Outpatient diagnostic services--House imposed a $20 deductible with this amount creditable against an inpatient hospital deductible which was imposed at the same hospital within 20 days. Senate imposed a 20 per cent co-insurance on such services, removed the credit against the inpatient hospital deductible but allowed a credit for the deductible as an incurred expense under the voluntary supplementary program (for deductible and reimbursement purposes). Conference adopted Senate version.

5. Psychiatric facilities--House provided for 60 days of psychiatric hospital care with a 180 day lifetime limit in the voluntary supplementary program. Senate moved these services over into basic hospital insurance and increased the lifetime limit to 210 days. Conference accepted the Senate version but reduced the lifetime limit to 190 days.

None of these compromises satisfied the pro-Medicare pressure groups which had been anxious to make the law administratively less complicated. By late July, the Conference Committee had finished its report. On July 27, the House passed the revised bill by a margin of 307-116 and the Senate followed suit two days later with a 70-24 vote. Only July 30, President Johnson signed the Medicare bill into Public

Law 89-97, at a ceremony in Independence, Missouri described at the outset of this study.

The Outcome of 1965: Explanation and Issues

One of the most important lessons of Medicare's enactment is that the events surrounding its passage were atypical. The massive Democratic electoral victories in 1964 created a solid majority in Congress for the President's social welfare bills, including aid to education, Medicare and the Economic Opportunity Act. To find a precedent, however, we must go back almost thirty years, to Franklin Roosevelt's New Deal Congresses.

In the intervening years, we find a different pattern. Democratic majorities in the Congress are not uncommon, but normally the partisan margins are sufficiently close to give the balance of power to minority groups within the party over many issues. Under these circumstances, state rights Southern congressmen in coalition with Republicans are generally successful in blocking or delaying bills which entail the expansion of Federal control.

The fragmentation of authority in the Congress compounds the opportunities for minority figures to block legislation; bills must be subjected to committees, sub-committees, procedural formalities, and conference groups. To be sure, a solid majority support for a given bill can ensure that it will emerge, more or less intact, as law, even though it may pass under the jurisdiction of hostile congressmen in the process. Ordinarily, however, it is difficult to create a committed

majority. President Kennedy, in 1961, avoided a major confrontation over Medicare because it was uncertain whether the bill could pass a House vote and because he needed the support of Ways and Means Committeemen for his other programs. Congressmen must frequently make similar decisions; for example, many representatives who supported Medicare before 1965 were nonetheless unwilling to launch a major drive to extract it from Ways and Means. Like the President, they often needed the support of Medicare opponents for other legislation which they believed was more important or had a better chance for successful enactment.

Within this context, backers of controversial legislation generally adopt a strategy which depends on the gradual accretion of support. They frame the issues in terms which opponents will find difficult to attack, then set out to accumulate the necessary votes. Particular attention is given to crucial committee bottlenecks. The Executive relies heavily on the influence of House and Senate leadership in this effort, and acts on the assumption that although it is seldom possible to change the mind of a congressman on the merits of the issue, it is sometimes possible to change his vote. While the congressional leadership lacks formal means for enforcing party discipline, they have a variety of informal resources. Their personal influence with the regional caucuses who selected Ways and Means Committeemen, for example, allowed them to deny assignments to Medicare opponents and thereby to gradually alter the voting margin on the committee.

By 1964, the use of this accretionist strategy by Medicare supporters seemed on the verge of success; and had the elections of that year resulted in the usual relatively close partisan margins in Congress, the Medicare Act of 1965 would have been much narrower in scope, and its passage would stand as a vindication of the incrementalist strategy. In fact, the 1964 elections returned a Congress in which many of the usual patterns of bargaining were irrelevant. The Medicare bill which finally emerged as law must be analyzed in terms of the various responses to the highly unusual circumstances in that Congress.

In seeking answers as to why the legislative outcome differed so markedly from the Administration's input, three separable issues are involved. Why did the traditional hospitalization insurance proposal pass as one part of the composite legislation? The congressional realignment after the elections of 1964 provides the ready answer. Why the legislation took the composite form it did is partly answerable in these terms as well. The certainty that some Medicare bill would be enacted changed the incentives and disincentives facing former Medicare opponents. Suggesting a physicians' insurance alternative offered an opportunity for Republicans to cut their losses in the face of certain Democratic victory and to counteract public identification of Republican opposition with intransigent AMA hostility to Medicare. Wilbur Mills' motives are fully comprehensible only in the context of congressional conventions, especially the relation of the Ways and

Means Committee to the House, and its intra-committee tradition of restrained, consensual bargaining among partisan blocs. However, if the maintenance needs of the minority party and the Ways and Means members account for the Republican alternative bill and the committee's adoption of an expansionary strategy on Medicare, the limits of the expansion require further explanation.

The context of the debate over government health insurance sharply delimited the range of alternatives open to innovators. That longstanding debate had focused on the aged as the problem group, social security or general revenues as financing mechanisms, and partial or comprehensive benefits for either all the aged or only the very poor amongst the aged. The character of more than a decade of dispute over health insurance programs for the aged explain the programmatic features of the combination that Wilbur Mills engineered, President Johnson took credit for, and the Republicans and American Medical Association inadvertently helped to insure.

The outcome of 1965 was, to be sure, a model of unintended consequences. The final legislative package incorporated features which no one had fully foreseen, and aligned supporters and opponents in ways which surprised many of the leading actors. Yet the eleventh hour expansion of Medicare should not draw one's attention away from the constricting parameters for change. Were a European to reflect upon this episode of social policy making in America, his attention would be directed to the narrow range within which government health proposals operated. He would emphasize that no European nation restricted

its health insurance programs to a single age group; and he would point out that special health "assistance" programs, like that incorporated in Title 19, had been superseded in European countries for more than a generation. The European perspective is useful, if only to highlight those features of the 1965 Medicare legislation which were not changed.

While the new law was broader than the King-Anderson bill in benefit structure, it did not provide payment for all medical expenses. P.L. 89-97 continued to reflect an "insurance" as opposed to a "prepayment" philosophy of medical care financing. The former assumes that paying substantial portions of any insured cost is sufficient; the problem to which such a program addresses itself is avoidance of unbudgetable financial strain. The latter view seeks to separate financing from medical considerations. Its advocates are not satisfied with programs which pay 40 per cent of the aged's expected medical expenses (one rough estimate of Medicare's effects); only full payment and the total removal of financial barriers to access to health services will satisfy them. In Medicare's range of deductibles, exclusions, and co-insurance provisions, the "insurance" approach was followed, illustrating the continuity between the first Ewing proposals of 1952 of sixty days of hospital care and the much-expanded benefits of the 1965 legislation.

Nor were changes made in the group designated as beneficiaries under the insurance program. The Administration had single-mindedly focused on the aged and the legislation provided that "every person

who has attained the age of 65" was entitled to hospital benefits. While this coverage represented an expansion over the limitation to social security eligibles in bills of the fifties and early sixties, the legislation provided that by 1968, the beneficiaries under Part A would be narrowed again to include only social security participants. The persistent efforts to provide Medicare benefits as a matter of "earned rights" had prompted this focus on social security and, as a result, on aged beneficiaries. While the social security system was not the only way to convey a sense of entitlement (payroll taxes in the Truman plans were included for the same purpose), the politics of more than a decade of incremental efforts had effectively undercut the broad coverage of the Truman proposals.

Title 19, establishing the medical assistance program popularly known as "Medicaid," made exception to the age restrictions. This bottom layer of the "legislative cake" provided comprehensive coverage for all those, regardless of age, who qualified for public assistance and for those whose medical expenses threatened to produce future indigency. As in the Kerr-Mills bill which it succeeded, financing was to be shared by the Federal government general revenues and state funds. The Medicaid program, too, owed much to the past debates, growing as it did out of the welfare, public assistance approach to social problems. Its attraction to the expansionists in 1965 did not rest on its charity features alone. In the eyes of Wilbur Mills, it was yet another means of "building a fence" around Medicare, by cutting into future demands to expand the social security insurance program to cover

all low-income groups.

The voluntary insurance scheme for physicians' services, Part B of Title 18, represented a return to the breadth of benefits suggested in the Truman plans (although, unlike the Truman proposals, it was neither compulsory nor available to all age groups). Since the adoption of an accretionist strategy in the wake of the Truman health insurance defeats, coverage of physicians' costs had been largely dropped from proposals. Throughout the 1950's, reformers had focused attention on rising hospital costs and the role which the Federal government should play in meeting those costs. With the exception of the Forand bills, proposals for health insurance between 1952 and 1964 fastidiously avoided the sensitive issue of covering doctors' care. Even when the election of 1964 eradicated the close congressional margin which had prompted the accretionist strategy in the first place, the Administration continued to follow it. It was Wilbur Mills, and not the presidential advisors, who most fully appreciated the changed possibilities. Once again acting to build a fence around the program and ensure against later expansion of the social security program to include physicians' coverage, he pre-empted the Byrnes proposal with a general revenue-individual contribution payment scheme.

For a decade and more, the American Medical Association had been able to dictate many of the terms of debate, particularly on the matter of physicians' coverage. And although the election of 1964 revealed how much the power of AMA opposition to block legislation depended on the make-up of Congress, the provisions for paying doctors under Part B

of Medicare reflected the legislators' fears that the doctors would act on their repeated threats of non-cooperation in implementing Medicare. To enlist the support of the medical profession, the law avoided prescribing a fee schedule for physicians, and directed instead that the doctors of Medicare patients be paid their "usual and customary fee," providing that the fee was also "reasonable." Moreover, it was not required that the doctor directly charge the insurance company intermediaries who were to handle the government payments; he could bill the patient, who, after paying his debt, would be reimbursed by the insurance company. This left a doctor the option of charging the patient more than the government would be willing to reimburse. But sympathy with the doctors' distaste for government control, and fear that doctors would elect not to treat Medicare patients under more restrictive fee schedules, made "reasonable charges" appear a sensible method of payment.

The eligibility requirements, benefits, and financing of the Medicare program represent a complex political outcome, a mixture of continuity and surprise not typical of the legislative histories of other social welfare measures. The long process of building support for a hospitalization program covering the aged had not prepared the Johnson Administration for the unpredictable opportunities of 1965. Instead of the King-Anderson bills of the 1960's, the Department of Health, Education, and Welfare had the Mills bill to turn into an operational Medicare program by July, 1966. The politics of congressional bargaining