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THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release July 25, 1995

REMARKS BY THE PRESIDENT
ON 30TH ANNIVERSARY OF MEDICARE

The U.S. Capitol

11:06 A.M. EDT

THE PRESIDENT: Thank you very much, Mr. Vice President, for your introduction and your leadership. Senator Kennedy and Congressman Dingell, thank you for your incredible inspiration to the country and to me. Mr. Glover, thank you and thank you for your speech. To Congressman Gephardt and Senator Daschle, I want all of you to know that they lead well and they are doing well for our country. (Applause.)

To my friend, Arthur Fleming, and his family, and Mother Johnson and her family; and to all of you seniors who are here, I am honored to be here and I have loved listening to these stories and these speeches and hearing this commitment.

I am honored to stand in the tradition of the Presidents who fought for Medicare. I believe that President Roosevelt and President Truman and President Kennedy and President Johnson were right. And I think those who oppose them were wrong. (Applause.)

If you really think about Medicare and Medicaid, which was also passed at the same time, they've given all of us stories. I loved hearing the Vice President talk about his wonderful mother.

All of you know that since I've been President I have lost my mother and my fine step-father, but what you may not know is that my step-father had a heart attack 10 years before he died, in the middle of one of my inaugural speeches for governor. And when he woke up from his surgery -- his quadruple bypass -- I told him it was not that good a speech. (Laughter.) But because he was a senior citizen covered by health care, he had 10 more good years. And my mother had a very difficult fight with cancer, which she lost. But because she was a senior citizen covered by good health care, she lived to see her son become President of the United States. (Applause.)

I ran for President because I wanted to broaden that sense of security and opportunity for our people. I wanted middle class Americans to have family wage jobs, and be able to educate their children, and have the same health security we had given to senior citizens, as Congressman Dingell said.

And the same crowd that killed Harry Truman's plan for health, the same crowd that fought against Medicare, were successful in derailing what we tried to do last year. But they did it in a brilliant way, because by last year Medicare had become so much of our common ground as Americans, so much a part of the fabric of our daily lives, that no one anymore thought about these members of

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Congress having anything to do with it. It was just a part of our daily lives, just like getting up in the morning and seeing the sun shine. And so these people, the same crowd that fought it tooth and nail 30 years ago, came up with this brilliant argument that because I said when they denied it, the Medicare Trust Fund was in trouble

and we had to reform health care, that I wanted to see the government mess with their Medicare.

And we had people all over America coming up to me, or the First Lady, or to Senator Kennedy, saying, don't let the government mess with my Medicare. People had actually forgotten where it came from, as if it sort of dropped out of the sky. (Laughter.) Well, I got the message of the 1994 election and I'm not going to let the government mess with your Medicare. (Applause.)

I really thought Medicare had passed beyond the partisan and political divide into the generational life of our country. The people who passed it did it for their parents' generation and knew that they would have it when they came along, and knew that in so doing, they would relieve a burden from their children, who could then focus on building good lives for themselves and their children. It was sort of a part of the social compact of the American family.

Now, the Vice President's father, who's been mentioned several times, and is a particular favorite of mine, said that the absence of health care for the elderly was "a disgrace in a country such as ours". We got rid of the disgrace, and along with Social Security, as Secretary Shalala has said, we at least have finished that part of our country's work.

We still have a lot of work to do. But the answer to the problems of the great American middle class, the answer to the problem of curing the American deficit, the answer to the problem of dealing with the challenge of educating a new generation of Americans for a new, highly competitive economy -- surely the answer to those problems is not break down the one thing we have done right completely, which is to keep faith with our elderly people. (Applause.)

I want to talk just a little bit about what this could mean to you. As I said, in 1965, the legislation which created Medicare also created Medicaid. A lot of Americans think it's just a program for poor people. Well, it did provide desperately needed care for poor children and their mothers, but it also provided more care for older and disabled Americans, especially long-term care. Two-thirds of the Medicaid budget goes for older Americans and disabled citizens. Without Medicaid, middle class families struggling to pay their own bills and raise and educate their children could face nursing home bills for their parents averaging $38,000 a year.

I remember what those nursing homes looked like before Medicaid. Some of you do, too. We need to celebrate and recommit ourselves to this. And we need to ask ourselves, what is the future. We are at an historic moment. For the first time in a long time there is a willingness to try to bring the budget into balance, a willingness to try to secure the Medicare Trust Fund. But I know we can do both, while maintaining our generational commitment. I know we can do both without returning Medicare to the area of American

partisan politics and to nightmares for the elderly people and their children in this country. We can do it. (Applause.)

As Mr. Gephardt said, the congressional majority appears to be choosing for the first time ever to use the benefits we provide under Medicare, paid for by a dedicated payroll tax, as a piggybank to fund huge tax cuts for people who don't really need them. But we showed that you could have a balanced budget plan with no new Medicare costs for older Americans that stabilized the Medicare Trust Fund. We know that. They, instead, would cut $270 billion from Medicare and raise Medicare premiums and out-of-pocket costs an average of $5,600 per couple over seven years, even for people who don't have enough money to get by as it is. They want to use this to

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pay for a $245 billion tax cut.

If they would just reduce the size of the tax cut, target the middle class families and their basic needs, string out the time which we take to balance the budget, we would not need one penny -- not a red cent -- of the Medicare beneficiary cuts they've proposed.

Don't you let anybody tell you that we have to do that to stabilize the Trust Fund or to balance the budget. We do have to stabilize the Trust Fund. We should balance the budget. But we don't have to raise the roof on the beneficiaries to do it. We do not have to break our generational commitment to do it. Do not let anybody tell you that. It is simply not true. (Applause.)

This plan kind of sounds good in the rabid, antigovernment atmosphere in which we live today -- their plan does. The majority's plan in Congress would provide older Americans with a voucher for a set amount each year. They almost make it sound like you can make a profit out of it. It supposedly would cover enough to buy medical insurance. The problem is that private health care costs are projected to increase 40 percent more than the value of the voucher. So if you're over 65 and you're healthy as a horse, this might be a good deal for you. But what if you get sicker as you get older? If the vouchers are inadequate, the elderly must make up the difference out of their own pockets.

There's no clear provision that would give a larger voucher for a patient like my mother who developed cancer as opposed to one the same age who was healthy; not even a clear provision to give a larger one to seniors who are fortunate enough to live into their 80s. That's the fastest growing group of elderly people in America, in percentage terms, people in their 80s. But to be healthy in your 80s you just naturally use the health care system more. There's no clear provision to take care of that.

No clear provision to stop companies from simply turning seniors down because of their medical condition, or cutting them off when they get sick. In the past, various experts have suggested that Medicare budget cuts will inflict harm and financial suffering on the elderly, but as the grisly details of the plan become known, it becomes clearer and clearer that we could actually see a denial of medical care to those who need it. That was the very thing Medicare was designed to do away with.

You know, my mother was a nurse, anesthetist. I can remember what it was like before there was any Medicare or Medicaid. I remember people that actually would come to our house with a bushel basketful of peaches, for example, trying to pay in kind for the medical service my mother had rendered. And I remember that the old folks weren't healthy enough to go pick peaches. I remember these things. And we should not forget. We can change without wrecking, and we need to be awfully careful before we buy a pig in a poke.

It is easy to see how, in all but the direst of

emergencies, millions of older Americans would actually just give up the medical attention to which they are entitled and which they need. Let me just give you some examples of what could happen. These are real examples of what could happen.

Suppose a 75-year-old woman has exhausted her savings and is too sick to work, but her voucher isn't enough to permit her to afford any health insurance plan anymore. She'd have to reach into her own pocket, but she doesn't have any money there. She can't get to the hospital unless it's a dire emergency because she's got to pay a $750 deductible for that. So she can't got to the doctor's office because she can't pay the extra premium there. So the woman is stuck -- and no care.

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Or suppose you have a 75-year-old man who gets a voucher that just about covers the cost of his health insurance, and in three years his voucher only goes up five percent a year, but the health insurance premium goes up 10 percent a year. So after three years, the gap is so wide he can't afford to pay. He doesn't have the money. He dropped his Medigap coverage because he was persuaded this voucher system would work. So he's stuck -- no care.

A 70-year-old man with open-heart surgery recovered enough to go home and be treated by a visiting nurse, but under the plan of the congressional majority, he must now pay $1,400 in copayments for that visiting nurse. He can't afford that, so he stays in the hospital at three or four times the cost to the taxpayers. But after a while, Medicare stops paying for that, too. So he's stuck.

Now, these are things that can happen. Those who want to keep what they have now will have to pay significantly more. Every person on Medicare will spend $1,650 more over seven years. The average person who receives care at home -- something we need more of, not less of -- will pay $1,700 more in the year 2002 alone for the same health care. Remember, these are people who already pay over 20 percent of their income for health care.

So I ask you, can the elderly really afford $1,650 more for premiums to cover their doctor bills? Can the elderly really afford $1,700 more for the same home health care in one year alone? Will vouchers cover them against sudden premium increases if they get sick? That's what health insurance is supposed to do, you know -- cover you when you get sick, not when you're healthy. Will the medical costs stay sufficiently under control to permit these vouchers to cover the full cost of care? No expert thinks so.

Is it fair to make older Americans give up their doctors and be forced into managed care, instead of giving the option to them to go into a managed care network? Is it really necessary to balance the budget and to stabilize the Medicare Trust Fund to do what the congressional majority proposes? The answer to every single one of these questions is, no. No.

Those who want to gamble with Medicare are asking Americans to bet their lives. And why should they bet their lives? Not to balance the budget, not to strengthen the Medicare Trust Fund, but simply to pay for a big tax cut for people who don't need it. It's a bad deal; we ought not to do it. It will break up America's common ground. And you can help to stop it. (Applause.)

If the Congress and the majority really wants to balance the budget and reform the Medicare Trust Fund, let me ask them to join with me in a real commitment to health care reform that can be achievable, even by their standards. Senator Kennedy has already introduced a bill with Senator Kassebaum that goes part of the way.

Let us require insurance plans to cover those with preexisting conditions. Let us make a commitment to preventive and

long-term care. (Applause.) Let us encourage home care as an alternative to nursing homes and give folks a little help to have their parents there -- (applause.) Let us let workers take their insurance coverage with them when they change jobs, and crack down on fraud and abuse, and give people the option to choose a managed care option if they want it; don't force people to take something they don't want. (Applause.)

If we really want to work together, there ought to be four basic principles that everybody, without regard to party, signs off on. We have to make sure that good, affordable health care is available to all older Americans. That's what we do now; let's don't stop it. (Applause.)

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We must not cut Medicare to pay for a bigger tax cut than can be justified, that goes to people who don't really need it, a lot of whom don't even want it. We ought not to do that. (Applause.)

We must be committed to reducing medical cost inflation and stabilizing the Medicare Trust Fund through genuine reforms, not by destroying Medicare and hurting the people who are on it. (Applause.) We must not balance the budget by cutting Medicare to older Americans.

We do not have to do any of these things. This is a time of great and exciting change. I know that. But, you know, the conservatives are supposed to be in charge around here and conservatism means if nothing else, if it ain't broke don't fix it. (Applause.) And do no harm. That's the first principle.

My fellow Americans, this is a big fight, but it's not just for the seniors in this audience and in this country. It's for all their children. Most senior citizens have children that are working harder for the same or lower pay they were making five or 10 years ago. They have their own insecurities and their own problems. They need their jobs and their incomes and their children's education and their own health care stabilized. We don't need to do something that makes their lives worse, either. And it's for all their children, the people on Medicare's grandchildren. They deserve a chance to have a good education, to be sent to college. Their parents should not wake up in the middle of the night torn between their own parent's health care and their children's education.

This is not just a senior citizens issue. We need to increase opportunity and security for all Americans. And the worst thing we could do is to tear down Medicare. That would increase insecurity not just for the elderly, but for all Americans. It would cloud the future of this country.

We have come a very long way by pulling together. Do not let this budget debate tear this country apart. Do not turn back on Medicare. Stand up and say, if you want to do something to balance the budget and stabilize the Medicare Trust Fund in a way that helps the elderly people of this country, we will stand with you. But if you want the government to mess with my Medicare, the answer is, no. (Applause.)

Thank you, and God bless you. (Applause.)

END 11:26 A.M. EDT

Medicare at 30

Preparing for the Future

Medicare's 30th anniversary is an appropriate time for celebration. Few programs, public or private, have had so demonstrably beneficial an impact on so many Americans as Medicare. But it is also a time both to reflect on Medicare's role in our society at large and to think strategically about how Medicare can fulfill its missions in the years ahead. In the increasingly contentious political environment, Medicare has been called a dinosaur—a program that is too costly, is too inefficient, and has outlived its usefulness. In the view of Medicare's critics, radical restructuring is the only cure. Although improvements can and should be made to Medicare, those calling for the end of Medicare as we know it are most charitably described as misguided. Medicare is responsible for major improvements in the health of elderly and disabled citizens, is well managed, and provides the financial underpinning for much of the US health care system.

Medicare Insures 37 Million Elderly and Disabled People

Before Medicare's enactment, 50% of elderly people had no health insurance. Now more than 97% of senior citizens are insured by Medicare, as are more than 90% of those who have end-stage renal disease and 3.6 million disabled people. Medicare has relieved elderly people of the terrible anxiety they suffered when they did not have health insurance and could not pay for their own care.

Medicare has dramatically increased access to health care. In 1964, just before Medicare's enactment, there were 190 hospital discharges per 1000 elderly people. By 1973, that number had increased to 350 discharges—one indication that Medicare helps elderly people get the health care they need at the time of their lives they need it most.[1-3] Although it is difficult to prove a causal relationship, Medicare—and the increased access to health care it provides—has undoubtedly contributed to increased longevity among the elderly. In 1960, men who survived to 65 years of age could expect to live to 78 years of age; by 1992, they could expect to reach 81 years of age. Women achieved similar gains.

Most Medicare beneficiaries rely on the financial security and access to health care that Medicare provides. In 1992, 83% of Medicare spending was on behalf of beneficiaries with annual incomes less than $25 000 (Figure 1). Fully 20% of beneficiaries are either 85 years of age and older (most of whom are women) or persons with disabilities or end-stage renal disease (Office of the Actuary, Health Care Financing Administration [HCFA], unpublished data from the Medicare Current Beneficiary Survey, 1992). Providing health care to our most vulnerable citizens is a significant accomplishment of which all Americans should be justly proud.

Most beneficiaries think that Medicare is valuable to them. Nearly 90% of beneficiaries are satisfied with the overall quality of their health care, have a regular source of health care, and have great confidence in their physicians (Office of the Actuary, HCFA, data from the Medicare Current Beneficiary Survey, 1992).

Medicare Provides Vital Support to the Health Care Infrastructure

Viewing Medicare as simply a health insurer for 37 million people ignores its larger role in the health care system. In 1993, Medicare accounted for 28% of all hospital expenditures; 20% of physician expenditures; the preponderance of income for home health care agencies, hospices, and renal dialysis facilities; and significant shares of the revenues of clinics, laboratories, ambulance services, and other provider services.[4]

In addition to paying for services to beneficiaries, Medicare makes supplemental payments to provide additional support to hundreds of hospitals across the country. Without Medicare's substantial financial support, a number of these "safety net" institutions could close, leaving many Medicare, Medicaid, and uninsured people without access to health care. (Congress authorized additional payments to disproportionate share hospitals and sole community hospitals beginning in the mid 1980s.)

Medicare makes supplemental payments to (1) hospitals serving a disproportionate share of low-income individuals; (2) teaching hospitals for extra costs associated with teaching programs (indirect medical education); and (3) sole community hospitals to enhance their viability in isolated rural communities.

In 1995, nearly 12% of the $65 billion Medicare will pay to hospitals are for these larger purposes. Disproportionate share payments will total $3.7 billion or an extra 13 cents for every dollar paid to these institutions. For large urban public hospitals, the additional payment averages 25 cents for every $1 paid. Payments to teaching hospitals for indirect medical education are projected at $3.8 billion or an extra 14 cents for every $1 paid for direct care to Medicare beneficiaries. For major public teaching hospitals, the additional payment av-

From the Office of the Administrator, Health Care Financing Administration, Washington, DC

Reprint requests to Medicare 30th Anniversary, Health Care Financing Administration, Office of Professional Relations, Room 423H, Hubert H. Humphrey Bldg, 200 Independence Ave SW, Washington, DC 20201 (Dr Vladeck).

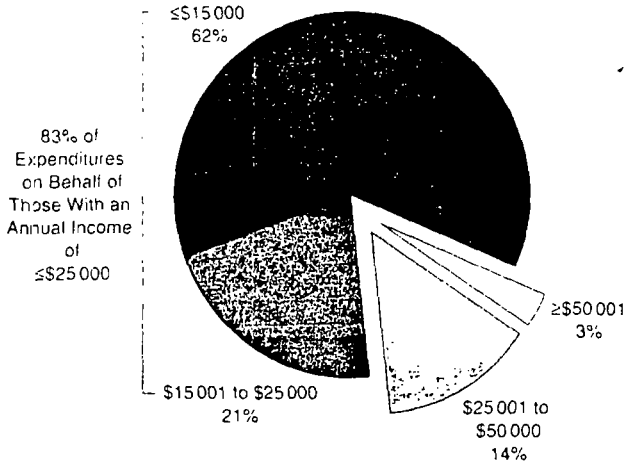

Figure 1.—Share of program expenditures by income of Medicare individuals or couples, 1992 (from the Office of the Actuary, Health Care Financing Administration).

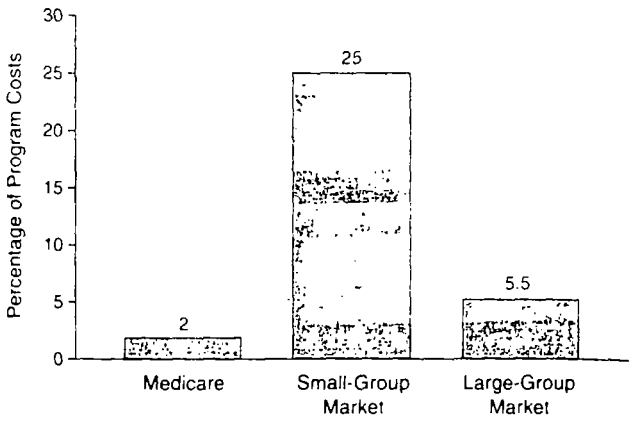

Figure 2.—Administrative costs for Medicare vs private plans (from the Office of the Actuary, Health Care Financing Administration; Congressional Research Service. *Costs and Effects of Extending Health Insurance Coverage*. Washington, DC: Congressional Research Service; 1988). Small-group market indicates firms with less than 50 employees; large-group market, firms with 10 000 or more employees.

erages 35 cents for every $1 paid. Sole community hospitals will receive more than $200 million or an extra 12 cents for every dollar paid. Medicare also plays a broader societal role in financing graduate medical education. It is the only health insurer to make payments earmarked specifically for training physicians. In 1995, Medicare will pay hospitals $1.8 billion for direct costs of training physicians and other health professionals (HCFA, unpublished data, 1995).

Precisely because of its size and national character, Medicare also has a profound effect, whether intended or not, on the shape and character of health care and medical practice throughout the country. Medicare pioneered the development of a prospective payment system for inpatient hospital care, a resource-based fee schedule for physicians' services, both in-hospital and external utilization review programs, quality standards for new services such as hospice and ambulatory surgery, and outcome measures in nursing home care. In recent years, Medicare too often lagged behind, rather than led, the private sector in the development of new methods of defining and ensuring access and quality. Through the Medicare Health Care Quality Improvement Program and similar initiatives in facility certification and managed care monitoring, Medicare is once again reasserting its leadership role.[5,6]

Comparison of Medicare and Private Health Spending

The rate of growth in Medicare spending has come under sharp attack in recent months. Critics point to data showing that private health spending in the last few years increased more slowly than Medicare spending as proof of Medicare's inefficiency. The fact that Medicare spending per enrollee increased less rapidly than private spending from 1983 through 1991 is not, however, cited as evidence that Medicare was more efficient than private health plans during those years (Office of the Actuary, HCFA, unpublished data, 1994).

These criticisms miss their mark on several counts. First, data from 1 year, or even 2 years, are not a sufficiently accurate or reliable source on which to base conclusions or major changes in public policy. At least several years of data are needed to determine whether the trend represents a real shift in behavior or merely an aberration. Second, Medicare beneficiaries are different from workers in large companies—the source of most of the private-sector data. Medicare beneficiaries are older and sicker than working people, so it is unrealistic to expect the rate of expenditure growth to parallel that of other health plans. On average, expenditures for health services for elderly people are four times greater than for their younger counterparts.[7] Further, as discussed herein, Medicare is much more than a health insurance program for the elderly and disabled; it also plays a key role in supporting graduate medical education and institutions that serve vulnerable populations. Medicare also covers some services not typically covered by private health plans, including home health care services and skilled nursing care. Spending for these services has been increasing much more quickly than for other services. If Medicare expenditures for hospital and physician spending only are compared with private-sector expenditures for the last several years, the rates of growth are comparable. And in at least one area—administrative expenses—Medicare's performance far exceeds that of the private sector. Medicare spending for administrative expenses has averaged less than 2% of program spending in recent years, compared with an average of about 17% in the private sector—about 5.5% in the large-group market and 25% in the small-group market (Figure 2).

The Future of Medicare

Medicare is highly effective, but there is considerable room for improvement. Although Medicare beneficiaries have lower incomes, on average, than other insured persons, their out-of-pocket expenses for health care are far greater. Medicare requires beneficiaries to make substantial payments for coinsurance, co-payments, deductibles, and premiums. On average, older Americans spend 14% of their disposable incomes on health care, compared with 4% for the nonelderly (Office of the Actuary, HCFA, unpublished data, 1995). Further, Medicare does not cover outpatient prescription drugs or most institutional long-term care. Many elderly people are forced into poverty to pay for nursing home care, while the high cost of prescription drugs means that some beneficiaries

do not get the drugs they desperately need. Obviously, in the current political climate, adding these two benefits appears unrealistic, but, over time, these problems need to be addressed.

Medicare covers some preventive services, such as screening mammography and flu vaccination. However, use of these services is not as high as it should be. From 1992 through 1993, only 37% of female beneficiaries had screening mammograms; the rate among African-American women was even lower at 28%.[8] Steps have been taken to improve this record. A new consumer information initiative is providing beneficiaries with more information about Medicare coverage for preventive services and encouraging appropriate use of these services.

Changes should also be made to allow beneficiaries to choose from a broader range of health plans. Medicare beneficiaries should have as many choices as the most forward-thinking employers provide to their workforce. Historically, enrollment of Medicare beneficiaries in managed care has lagged behind the private sector. Since 1993, however, enrollment in Medicare managed care has increased rapidly; enrollment in risk contracts increased more than 25% and enrollment among all health maintenance organizations (HMOs) increased slightly more than 16% between 1993 and 1994. Currently, more than 9% of Medicare beneficiaries (3.1 million people) are enrolled in managed care options, and 74% of beneficiaries have access to a managed care plan (Office of Managed Care, HCFA, unpublished data, 1995).

The US Department of Health and Human Services is committed to increasing the range of managed care options and to making current options work more effectively. An option to allow Medicare beneficiaries to enroll in preferred provider organizations (PPOs) is under development and should receive legislative attention in the next few months. PPOs are networks of health care clinicians and institutions who agree to provide services to beneficiaries enrolled in the network at a discount. (Some PPOs select providers who have cost-efficient practice styles or agree to abide by certain utilization review criteria.) Many consumers have access to PPOs in the private-insurance market, and we would like to offer Medicare beneficiaries the same option. Our objective is to allow beneficiaries to go to any health care clinician or facility at any time, if they are willing to pay more for services outside the network. We also hope that PPOs would result in savings for both Medicare and beneficiaries because plans would limit their selection of network physicians to those with high-quality and cost-effective practice styles.

The Department of Health and Human Services has also been working to improve the performance of our current managed care contracts and to increase the number of contractors. Some caution is warranted, however. The HMO industry has expressed reservations about its capacity to absorb a large infusion of Medicare beneficiaries within a short period. While it welcomes the opportunity to enroll more Medicare beneficiaries, the industry urges that expansion be phased in during a longer period as capacity increases. The industry is also concerned that accelerated expansion and formation of managed care plans could jeopardize the ability of both the government and private accrediting bodies to maintain the highest standards of certification and oversight.

The Department of Health and Human Services' goal of expanding the number of managed care options is impeded by some difficult technical and policy issues. Perhaps the most important, at least from a financing standpoint, is that flaws in the payment mechanism established by Congress cause Medicare to pay, on average, 5.7% more for every enrollee in managed care than it would have paid if the beneficiary had stayed in Medicare's traditional fee-for-service system. The Medicare payment level for risk contracts is set at 95% of fee-for-service costs in the area where the beneficiary resides. Beneficiaries enrolled in risk contracts are healthier than those in fee-for-service systems (HCFA, unpublished data, February 1993). As a result, the 95% payment level is higher than it would have been if Medicare had made fee-for-service payments for these beneficiaries. The reason for this higher payment is "favorable selection"—the fact that HMOs attract enrollees who are healthier than the average beneficiary and tend to use fewer services than the average beneficiary. One of the reasons for this occurrence is that beneficiaries in poor health typically have established relationships with physicians and are hesitant to enroll in managed care plans. Although both we and the HMO industry have undertaken several research projects to develop a payment adjustment to account for the fact that healthier people tend to enroll in managed care plans, neither of us has been successful yet.

Another troubling issue revolves around the use of fee-for-service data in setting the HMO payment rate. The current formula adversely affects some regions of the country where fee-for-service costs are low. These low costs result in low Medicare HMO payments, making some managed care plans reluctant to participate in Medicare risk contracts. In other areas with high fee-for-service costs, the Medicare HMO payment rate is probably excessive.

The persistence of technical problems such as these suggests that proposals to shift large numbers of Medicare beneficiaries into managed care plans within a short period is neither feasible nor likely to result in large savings to Medicare. A more rational strategy is to expand choice, improve the information available to consumers and purchasers, and develop better payment and oversight methods. This strategy will permit consumer choice to drive the program in the direction of managed care during a relatively short period if managed care plans can indeed deliver better services and higher consumer satisfaction at lower costs.

Conclusions

Efforts to improve Medicare's performance as a purchaser of managed care services also serve as a paradigm for choices about Medicare's future as these efforts are debated in the Congress and elsewhere in the nation. Like any 30-year-old program, Medicare has flaws and idiosyncracies that can and should be corrected. Over time these corrections should make Medicare less costly as well as more effective. There is significant danger, however, in the current political climate. Congressional pressure to balance the budget could produce payment reductions and policies that will permanently weaken Medicare and make long-term improvements impossible.

Medicare currently accounts for about 10% of the total federal budget, yet for reasons having little to do with health care and everything to do with politics, it has become a major target for balancing the federal budget. At the same time, Congress is considering significant tax reductions for large businesses and wealthy individuals, while the elderly and

children would bear the brunt of the reductions. Cuts driven by arbitrary budget targets would not only leave some of America's most vulnerable citizens significantly worse off, but also would jeopardize Medicare's continued existence and inflict substantial damage on health care clinicians and institutions and the structure of the US health care system.

Some have also suggested that Medicare spending could be controlled by turning Medicare into a voucher program—where the federal government would give beneficiaries a fixed amount of money to purchase private health insurance of their choosing. While this may appear to be an appealing concept, it is a shortsighted approach that would disadvantage many beneficiaries, particularly the oldest or most disabled ones. Relatively young and healthy beneficiaries would probably be able to obtain adequate private health insurance, but few insurers would be willing to sell comprehensive insurance to 85-year-old people or those with significant health problems. Moreover, if the fixed payment were set too low initially or not increased at roughly the same rate that the costs of providing health care are increasing, the value and the benefits of this insurance would erode over time.

Despite the fact that Medicare is now at the vortex of the balanced budget debate, HCFA cannot lose sight of its mission to administer Medicare in a responsible, cost-effective way and to think strategically about how Medicare can serve the beneficiaries of the future. One of the more difficult tasks will be to plan for the impact of the baby boom on Medicare. The increase in the number of enrollees is currently less than 2% a year and is expected to remain at that level for the next 16 years. After that, the increase will be between 2% and 3% annually as the baby boom retires between 2010 and 2030 and much less than 1% annually after that (Office of the Actuary, HCFA, unpublished data, 1995). There can be no doubt that retirement of baby boomers will pose serious challenges, but it is shortsighted to consider it as a Medicare problem only. Many other public programs, including education, public safety, and housing, will need to be reexamined and reconfigured in light of changing demographics. Careful stewardship in the short run combined with strategic planning for the long term will ensure Medicare's viability far into the next century—so that it will be there when both we and our children need it.

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The First 30 Years of Medicare and Medicaid

Medicare is a uniform national health insurance program for the aged and certain disabled persons. Medicaid is administered by the states within broad federal guidelines and finances health services for certain low-income groups.

Trends in Enrollment, Spending, Health Status, and Managed Care

Enrollment.—The enactment of Medicare and Medicaid in 1965 provided health insurance coverage to millions of Americans. Medicare enrolled 19 million elderly in 1966. Medicaid was phased in by states, except Arizona, and by 1972 enrolled 18 million poor elderly, disabled, and families with dependent children. In 1972, Medicare was amended to include persons younger than 65 years with disabilities who were receiving Social Security disability benefits for 24 months or persons with end-stage renal disease (ESRD), nearly 2 million people.[1]

Since the mid 1980s, Medicaid eligibility has been significantly expanded: enrollment increased 50% from 22 million in 1985 to 33 million in 1993. In recent years, the share of the population younger than 65 years with employer-sponsored health insurance has declined. Medicaid eligibility expansions have somewhat offset these reductions in private-sector coverage, thereby moderating growth in the uninsured population.[2]

Enrollment in each program has increased substantially since enactment, resulting in a larger share of the US population receiving coverage. Since the early 1970s, the share of the population covered by Medicare increased from about 10% to 14%, and Medicaid's share increased from about 8% to 13%.[1,3] Thirty years after enactment, in 1995, Medicare and Medicaid provide health insurance coverage to about 70 million elderly, disabled, or low-income people: nearly 38 million in Medicare, 36 million in Medicaid, and about 5 million dually entitled to Medicare and Medicaid, or about 25% of all Americans.

Spending.—The enactment of Medicare and Medicaid, coupled with expansions in private health insurance coverage, fundamentally changed the way US health care is financed. No longer would people pay more than half of their health bills out-of-pocket. Third-party insurance has become the predominant payer, with people now paying 18% of their

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Table 1.—Medicare and Medicaid Spending as a Share of Federal and State and Local Budgets*

Program	Federal Budget, %		State and Local Budgets, %	
	1970	1993	1970	1993
Medicaid	1	5	2	5
Medicare	4	10	...	...

*Data from the Office of the Actuary, Health Care Financing Administration. These figures are based on total federal, state, and local government expenditures reported in the *Survey of Current Business*, July 1994, vol 74, issue 7, compiled by the US Department of Commerce, Bureau of Economic Analysis. Ellipses indicate not applicable.

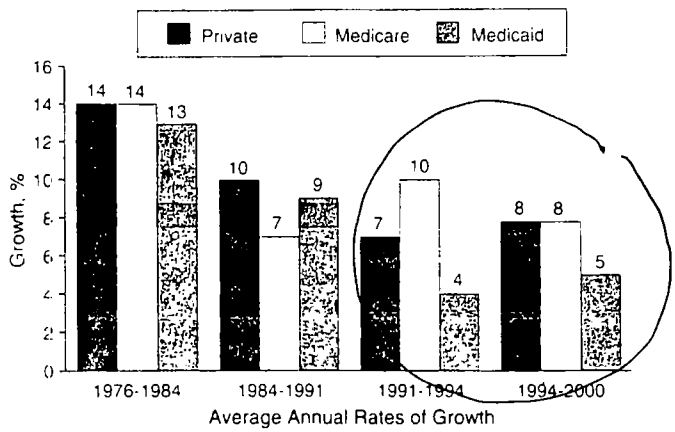

Figure 1.—Per enrollee rate of increase in expenditures for private health insurance, Medicare, and Medicaid (data from the Office of the Actuary, Health Care Financing Administration). For 1994 to 2000, the numbers indicate the projected rates of increase. For the purpose of the National Health Accounts, certain Medicaid disproportionate share payments to hospitals that were offset by donations and taxes paid by the same facilities were excluded. Medicare and Medicaid expenditures are per beneficiary; private health insurance benefits are per insured person

health bills out-of-pocket.[1] Even with Medicare coverage, out-of-pocket payments for health expenses consume about 14% of the average Medicare beneficiary's income compared with about 4% for the population younger than 65 years (Office of the Actuary, Health Care Financing Administration [HCFA], unpublished data, 1995).

The federal government is the single largest payer for health care services, primarily through the Medicare and Medicaid programs. In 1993, these programs spent $272 billion (including the $55 billion state share of Medicaid). This amount represents 31% of all health spending and 70% of public funding for health care. Together, they financed 41% of all hospital spending, 28% of all physician spending, and 61% of all nursing home spending.[1]

Health spending in the United States increased by 12% per year from 1970 to 1992. Annual spending in both Medicare and Medicaid increased faster at 14% and 16%, respectively.[1] This rapid spending growth outpaced that of federal and state and local revenues; thus, a growing share of public spending has been devoted to Medicare and Medicaid (Office of the Actuary, HCFA, unpublished data, 1970 and 1993) (Table 1).

One of the reasons for rapid spending growth has been increased enrollment, as noted herein, in Medicare and Medicaid. When spending trends are examined on a per enrollee basis, the rate of increase in spending on Medicare and Medicaid in recent years has slowed relative to historic trends (Figure 1).

From 1984 to 1991, the rate of increase in Medicare and Medicaid spending was lower than that of the private sector. The slower rate of increase in Medicare spending has been attributed in part to implementation of the hospital prospective payment system and limits on provider payment levels.

From 1991 to 1994, the rate of increase in private-sector spending was higher than Medicaid, but lower than Medicare. The lower rate of increase in private-sector spending has been attributed to rapid growth in managed care enrollment, reductions in health benefits for current workers and retirees, and more aggressive negotiations with health plans and providers.

Medicare beneficiaries have greatly increased their utilization of skilled nursing facility and home health care services in recent years, which has contributed to Medicare's higher rate of increase in spending. When these services are excluded, and Medicare and private-sector spending for hospital and physician services are compared, Medicare and the private sector have similar per enrollee rates of increase at about 7% annually (data not shown).

From 1994 to 2000, similar rates of increase in spending are projected for both Medicare and the private sector with somewhat lower rates of increase for Medicaid. Medicaid's rate of increase in spending has slowed due in part to new controls on the ability of states to increase their federal matching payments through provider tax and donation programs.

Health Status.—During the past 30 years, Medicare and Medicaid have provided the nation's most vulnerable groups—the elderly, disabled, and poor—with access to health services.[4-7] As a consequence, Medicare and Medicaid have made significant contributions to improvements in health status for beneficiaries whose health needs are greater than those of the general population. While the precise impact of the two programs on health status is difficult to determine, the country has made significant progress on key health status indicators, such as infant mortality and life expectancy at 65 years of age, in part due to access to health services financed by Medicare and Medicaid (Table 2). Moreover, the two programs have helped underwrite significant expansions in the health care system, including medical technology and capital facilities and equipment.

Managed Care.—Medicare and Medicaid have primarily paid providers on a fee-for-service basis. This arrangement is changing as beneficiaries increasingly enroll in managed care plans. Although enrollment levels are still lower than those in the private sector, there is strong growth. In 1994, Medicare accounted for 25% and Medicaid 42% of the enrollment growth in health maintenance organizations (HMOs) (Group Health Association of America and HCFA, unpublished data, 1994). Currently, 74% of Medicare beneficiaries live in areas where Medicare managed care plans are available, and 9% (more than 3 million) have chosen to enroll. About 23% of Medicaid beneficiaries (nearly 8 million) are enrolled in managed care plans in 45 states.

A Portrait of Medicare

Medicare is administered by HCFA.

Who Is Eligible for Medicare?—Workers and their dependents earn Medicare Part A eligibility, hospital insurance, through payment of the hospital insurance payroll tax (2.9% of wages, half of which is paid by the employer and half by the employee) during their working years. Those entitled to Medicare Part A receive coverage when they become 65 years old or earlier if they qualify for Social Security disability benefits or have ESRD.

Enrollment in Medicare Part B, supplementary medical insurance, is voluntarily obtained through payment of a monthly premium (currently $46.10) when eligibility for Medicare is established or on reaching 65 years of age.

How Is Medicare Financed?—Part A is entirely financed by payroll tax contributions. Hospital insurance spending is increasing faster than revenues: the trust fund is projected to be exhausted in 2002.

Part B is financed by general federal revenues (about 75%) and beneficiary premiums (about 25%). Unlike the Part A trust fund, which is financed by payroll taxes, the Part B trust fund is financed on a yearly basis with premiums and federal revenues being drawn as needed to cover program spending. Rapid growth in Part B spending has increased both the beneficiary premium and taxpayers' contributions.

Who Are Medicare Beneficiaries?—The elderly comprise 90% of the Medicare population; the disabled and those with ESRD comprise the remaining 10%. People older than 85 years, the disabled, and those with ESRD have been the fastest growing groups of Medicare beneficiaries during the last decade (annual growth rates of 3%, 4%, and 10%, respectively).

The aging of the population coupled with increased longevity are expanding both the number of people eligible for Medicare as well as the proportion of beneficiaries older than 85 years. These trends will have an impact on the nation's health care spending: the elderly consume four times as much health care per capita as the population younger than 65 years, with those older than 85 years consuming an even larger share.[8]

More than 25% of Medicare beneficiaries (nearly 10 million) live alone. Many of these beneficiaries are in poor health: about 2.5 million rate their health as fair or poor compared with their peers, and 1 million have several functional impairments (eg, difficulty eating, toileting, or dressing) (Office of the Actuary, HCFA, unpublished data from the Medicare Current Beneficiary Survey, 1992). These people are most at risk for long-term nursing home placement, a service for which Medicare coverage is limited.

The elderly's poverty rate has declined dramatically during Medicare's history from 29% in 1966 to 12% today, lower than that of the general population, because of a number of factors, including Medicare's coverage of health expenses.[9,10] While not as likely to be poor as in the 1960s, today's Medicare beneficiaries have modest incomes: nearly 80% have less than $25 000 in gross family income (Office of the Actuary, HCFA, unpublished data from the Medicare Current Beneficiary Survey, 1992). Most aged Medicare beneficiaries depend on Social Security for the majority of their income; 60% rely on Social Security for at least half of their income.[11]

What Services Does Medicare Pay for?—Medicare pays for acute care services including inpatient and outpatient hospital services, physician services, durable medical equipment, home health care, and short stays in skilled nursing facilities. Services such as long-term nursing home care, hearing aids, and outpatient prescription drugs are not covered. Medicare coverage has recently been extended to certain preventive services including hepatitis B, flu, and pneumococcal vaccines; screening mammography; and Papanicolaou tests.

Medicare pays 45% of the elderly's health bills, private sources (private insurance and patient co-payments) pay 37%, Medicaid pays 12%, and other public sources pay 6%.[5] When long-term nursing home care is excluded, Medicare pays 55% of the elderly's health bills. Of the services that Medicare covers, it pays 85%, and beneficiaries pay the remaining 15% in the form of coinsurance and deductibles.[12] In 1995, Medicare cost sharing includes a $716 hospital deductible, $100 annual Part B deductible, $46.10 monthly Part B premium, and coinsurance for skilled nursing facility, extended hospital stays, physician services, durable medical equipment, and supplier and hospital outpatient services. To meet these and other health expenses not covered by Medicare, the majority of aged Medicare beneficiaries have supplemental insurance called Medigap (Figure 2).

Where Does the Medicare Dollar Go?—Similar to other insurance programs, Medicare spending in any given year is concentrated on a small group of beneficiaries. Nearly 70% of program payments are made on behalf of 10% of beneficiaries. This

Table 2 —Health Status Indicators*

Indicator	Then (1965)	Now (1992)
Life Expectancy at Birth, y		
Female	73.7	79.0
Male	66.8	72.3
Life Expectancy at 65 Years of Age, y		
Female	16.3	19.1
Male	12.9	15.5
Infant Mortality Rate (per 1000 Live Births)		
Total	24.7	8.5
White	21.5	6.9
Black and other	40.3	14.4
Top Five Causes of Death		
	Heart disease	Heart disease
	Cancer	Cancer
	Stroke	Stroke
	Accidents	Chronic obstructive pulmonary disease
	Chronic obstructive pulmonary disease	Accidents

*Data from US Dept of Health and Human Services, Health Care Financing Administration. *1995 Data Compendium*. Baltimore, Md: Health Care Financing Administration; 1995; US Bureau of the Census. *Statistical Abstract of the United States: 1994*. Washington, DC: US Bureau of the Census; 1994; US Bureau of the Census. *Historical Statistics of the United States, Colonial Times to 1970, Bicentennial Edition, Part 1*. Washington, DC: US Bureau of the Census; 1975; and National Center for Health Statistics. *Health, United States, 1993*. Hyattsville, Md: National Center for Health Statistics; 1994.

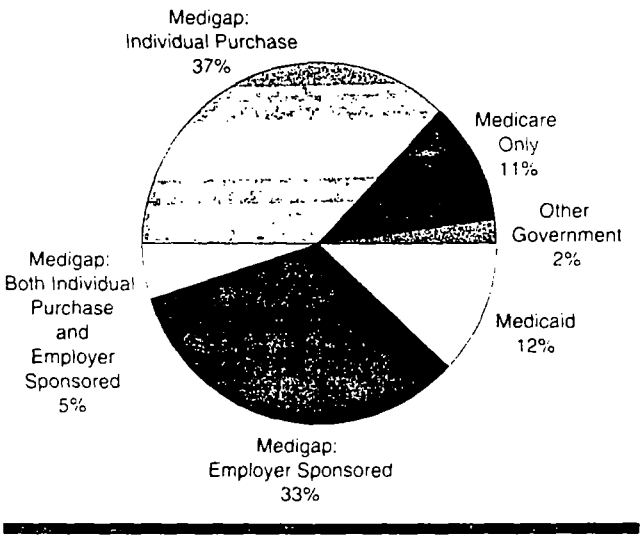

Figure 2.—Insurance holdings of aged Medicare beneficiaries (data from Chulis G, Eppig FJ, Hogan MO, Waldo DR, Arnett RH. Health insurance and the elderly: data from MCBS. *Health Care Financing Rev*. 1993;14:163-181).

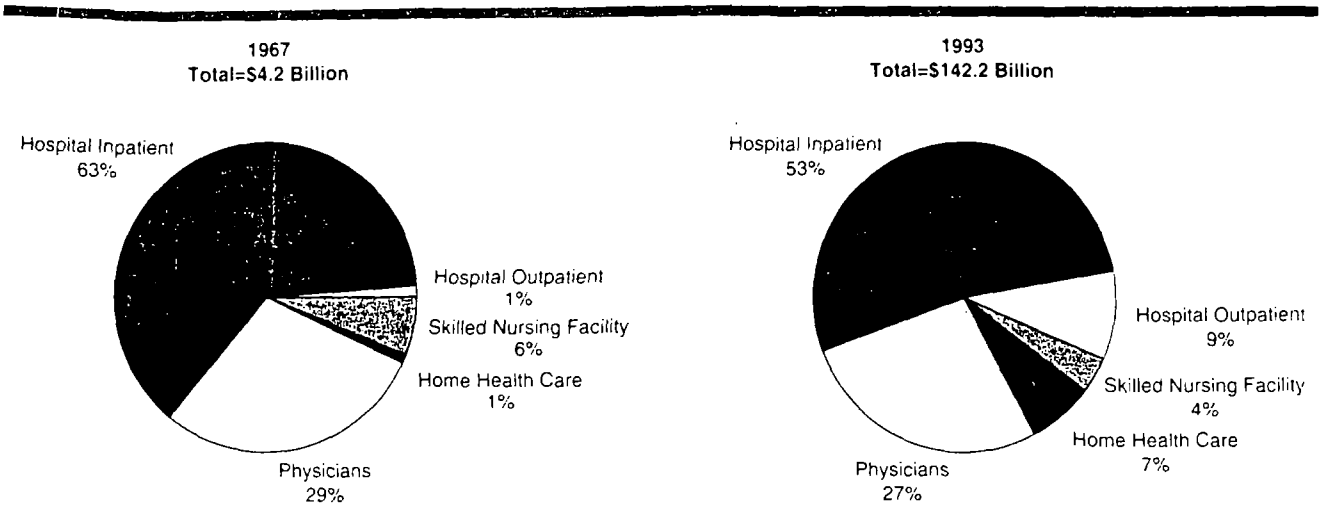

Figure 3.—Where the Medicare dollar goes (data from Health Care Financing Administration[3,12]).

proportion has remained stable over time. High-cost groups include those with ESRD, those who died, and/or those who were hospitalized. About 22% of beneficiaries had no program payments made on their behalf; an additional 30% of beneficiaries incurred 2% of program spending or less than $500 per enrollee. While spending is concentrated on a small group in any 1 year, over a lifetime Medicare beneficiaries may have high-cost and low-cost years, which may average out over time.[12]

The share of Medicare spending by type of service has changed significantly during the last 30 years as medical care moved from the inpatient hospital setting to numerous outpatient settings (Figure 3). Recent years have seen especially rapid growth in home health care and skilled nursing facility spending as coverage rules for both benefits were liberalized, patients were discharged earlier from hospitals, and the number of providers participating in the Medicare program substantially increased. From 1982 to 1993, the percentage of Medicare beneficiaries receiving skilled nursing facility or home health care services more than doubled.

Do Beneficiaries Have Access to Care?—Growth in the percentage of Medicare beneficiaries receiving covered services has been a significant factor in increasing expenditures; it also indicates improvements in access to care. While Medicare beneficiaries are generally considered to have good access to care, some groups, including the disabled, poor elderly, minorities, and the very old, have access problems.[13]

When physician payment reform was enacted, some were concerned about its impact on access. Physician visits per enrollee have increased since the fee schedule was introduced in 1992. Moreover, participating physicians (those physicians who accept Medicare's approved amount, plus the 20% beneficiary coinsurance, as payment in full on all claims) accounted for almost 90% of Medicare physician spending in 1994. Nearly 75% of physicians and other practitioners signed participation agreements in 1995, a record high since the participating physician program began in 1984.

A Portrait of Medicaid

Medicaid is administered by the states within broad federal guidelines regarding the scope of services, provider payment levels, and population groups eligible for coverage. At the federal level, Medicaid is administered by HCFA.

Who Is Eligible for Medicaid?—Eligibility for Medicaid is determined by states within broad federal guidelines. Uniformly, states must cover certain persons who are poor, aged, blind, disabled, or pregnant or are either a child or the parent of a dependent child. States further define eligibility rules (eg, maximum income and assets) within certain broad parameters. Generally, people receiving welfare (Aid to Families With Dependent Children or Supplemental Security Income) automatically qualify for Medicaid. Some states opt to cover the "medically needy" (those whose medical expenses are high enough to reduce their income to Medicaid qualifying levels and who otherwise meet Medicaid eligibility requirements). Beginning in the mid 1980s, Medicaid eligibility was expanded to pregnant women and infants in families with incomes up to 133% of the poverty level and children in families with income less than 100% of the poverty level. Thirty states have opted to further expand eligibility to pregnant women and infants in families with income up to 185% of the poverty level.

On a national basis, Medicaid covered nearly 50% of Americans younger than 65 years below the federal poverty level in 1992. However, this percentage varies considerably, ranging from a low of 29% in Nevada to a high of 61% in Washington, DC. Individuals younger than 65 years who are not pregnant and have no children or disabilities do not qualify for Medicaid, no matter how poor they are or how high their medical expenses are. The share of the poor covered by Medicaid is expected to increase to 58% in 1994.[14]

How Is Medicaid Financed?—Medicaid is jointly financed by federal and state governments. Some states, such as New York and California, require local government contributions toward the state share. The federal government matches state spending on a sliding scale based on state per capita income. States with high per capita income, like New York, receive a 50% federal match rate. States with low per capita income, like Mississippi, receive a higher federal match rate, up to about 80%. The national average federal match rate is 57%.[12]

What Services Does Medicaid Pay for?—Because Medicaid is intended to provide access to health services for those in poverty, it covers a broad range of preventive, acute, and long-term care services with few or no cost-sharing requirements. States

determine limits on the amount, duration, and scope of covered services. Federal statute requires states to cover inpatient and outpatient hospital services; physician, midwife, and nurse practitioner services; laboratory, x-ray, nursing home, home health care, and family planning services; and early and periodic screening, detection, and treatment for children. The early and periodic screening, detection, and treatment requirement covers preventive services and attempts to detect and treat conditions early to mitigate disability in later years.

States have the option to cover additional services, and many do so, such as prescription drugs, hearing aids, prosthetic devices, and intermediate care facilities for the mentally retarded.

Where Does the Medicaid Dollar Go?—Poor adults and their dependent children comprise the vast majority of Medicaid beneficiaries, but they account for a small share of Medicaid spending (Figure 4). The small share of beneficiaries who are aged or disabled account for the majority of Medicaid spending primarily because of their use of long-term care services. The average Medicaid payment per user of services in 1992 was $971 per child, $1762 per Aid to Families With Dependent Children–related adult, $7759 per aged person, and $7578 per disabled person.[12]

The cost of a long-term nursing home stay is beyond the means of many elderly who eventually "spend down" to Medicaid eligibility after exhausting their resources as private pay patients. Medicaid is the nation's primary payer of nursing home services; it covers more than half of the national nursing home bill. Medicare only covers short-term nursing home stays. Private long-term-care insurance, although growing, is still a small share of total nursing home spending.

Medicaid is a significant source of health coverage for certain population groups. For example, Medicaid covers 33% of all births, 25% of all children, and at least 40% of people with acquired immunodeficiency syndrome (AIDS). Many people with AIDS become disabled, lose employment and health insurance, and qualify for welfare (described herein) and hence Medicaid. Medicaid's increasingly important role in financing maternal and child health services reflects the impact of eligibility expansions noted previously, which have greatly increased Medicaid's coverage of low-income pregnant women and children.

The share of Medicaid spending by type of service has changed since 1975 as medical practice and the enrollment mix of Medicaid beneficiaries have changed (Figure 5).

Do Beneficiaries Have Access to Care?—Medicaid has improved beneficiary access to care to levels similar to those with private insurance. An Institute of Medicine study found that 8% of Medicaid beneficiaries in poor to fair health did not see a physician compared with 9% of those with private insurance and 22% of those with no insurance.[13] Medicaid coverage has improved birth outcomes, childhood immunization rates, access to well-child preventive services, and the health of children (Office of Research and Demonstrations, HCFA, unpublished data, 1995).[16,17]

The poor who are not covered by Medicaid have less access to health care than those with Medicaid.[7] Moreover, those who lose Medicaid coverage and become uninsured are at risk of losing access to care for needed services.[18] Because Medicaid

Figure 4.—Medicaid beneficiaries and expenditures by enrollment group, 1993 (data from Bureau of Data Management and Strategy, Health Care Financing Administration). Unknown represents 0.4% of recipients and 0.2% of vendor payments. AFDC indicates Aid to Families With Dependent Children.

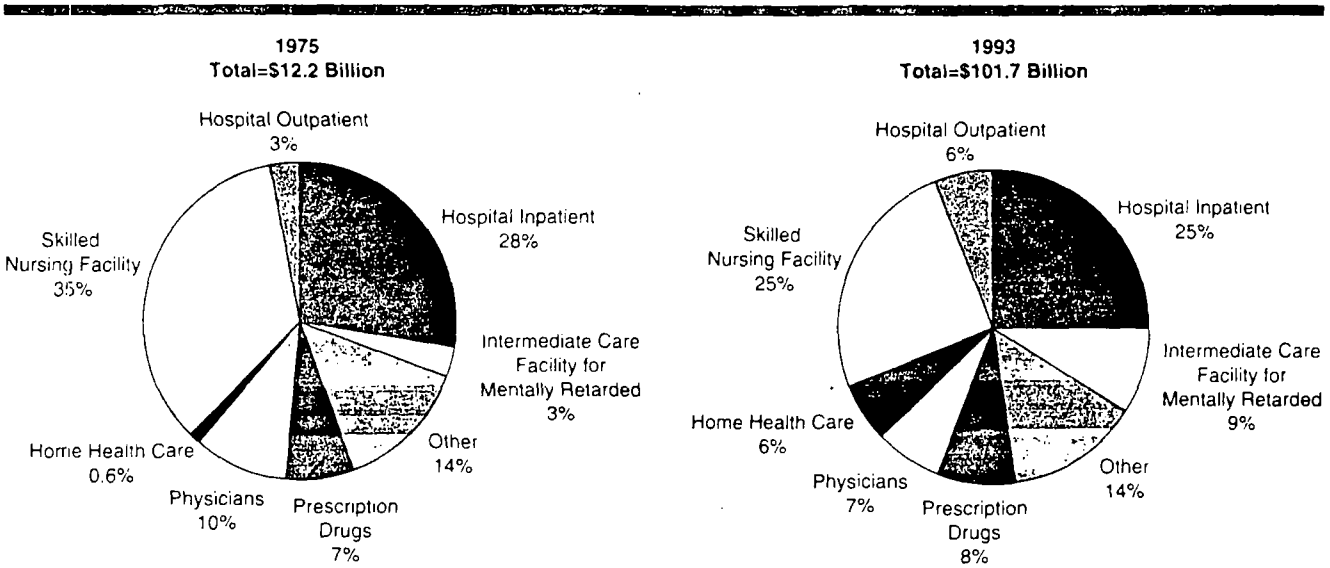

Figure 5.—Where the Medicaid dollar goes (data from Health Care Financing Administration[3,12]).

eligibility is often tied to welfare programs, if a person leaves welfare to take a job without health insurance, they may risk losing their Medicaid coverage and access to needed services.

What Flexibility Do States Have?—Recently, states have been requesting waivers to undertake innovative managed care demonstrations and, in some cases, to expand eligibility to uninsured families. Eleven states (Arizona, Delaware, Florida, Hawaii, Kentucky, Massachusetts, Minnesota, Ohio, Oregon, Rhode Island, and Tennessee) have received federal approval; others have proposals under review. Generally, states have targeted these demonstrations to low-income adults and their dependent children rather than the aged and disabled. Managed care models range from primary care case management to networks contracting with providers at discounted rates to traditional HMOs.

All states have waivers of federal requirements to offer home-based and community-based services to beneficiaries at risk of nursing home placement.

Forty-five states have waivers of the freedom of choice of provider requirement to require certain Medicaid beneficiaries to enroll in managed care programs. Absent such waivers of federal law, Medicaid beneficiaries may receive services from any provider who participates in the Medicaid program and may not be required by states to enroll in managed care programs.

Conclusion

The enactment of Medicare and Medicaid 30 years ago extended health insurance coverage to our nation's poorest, sickest, and most vulnerable population groups: the elderly, disabled, and poor families with dependent children. Before enactment, many of these individuals were unable to secure health insurance in the private marketplace because of inability to pay the cost of private insurance premiums or because of health conditions that insurance companies refused to cover. Many elderly, disabled, and low-income parents worried that the onset of serious illness could force them to go without care, turn to charity, or rely on family members to finance needed health services.

In the past 30 years, Medicare and Medicaid have improved access to care and health status for program beneficiaries. They have been a major source of financial support for the entire health care system, which has in turn benefited all Americans. Covering nearly one in four Americans and spending nearly $1 in $3 of all health care dollars, the importance of the two programs to the US health system can hardly be overstated.

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Medicaid

The Role of the States

MEDICAID is a federal program, but because it is administered by the states, it is they who are often held directly accountable by providers and beneficiaries for the program's shortcomings, even when those shortcomings are part of federal law. For states, frustration with the federal program rests largely in three areas: (1) eligibility requirements that are cumbersome to administer and restrict coverage only to certain groups among the poor; (2) reimbursement rate protections for hospitals and nursing facilities that result in disproportionate reductions in fees paid to physicians, home care, and other provider groups when budgets must be constrained; and (3) requirements that the program must provide "cookie cutter" services statewide to any and all persons eligible for Medicaid. States point out that from 1987 through 1992, the federal government imposed no fewer than 30 new mandates on them related to program eligibility, reimbursement, and services.[1] Many of those mandates were created by a Congress seeking less state-by-state variability in the program to ensure some consistency of care for low-income Americans, regardless of the state in which they reside. The federal government also sought to limit state initiatives that resulted in the federal government's share of program costs increasing

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faster than those of state general revenues.

Medicaid has grown to be the second largest expenditure item in state budgets: it accounts for nearly 20% of state general revenue spending.[2] State officials, who complain about the program and its growth in their budgets, have engaged in controversial cost containment, but have also used the program creatively to care for the poor and, increasingly, as a base for health system reform initiatives.

Indeed, two key players in state health system reform initiatives are physicians who saw the limits and possibilities of Medicaid firsthand in their practices. For John Kitzhaber, MD, the program's eligibility restrictions raised issues of equity. By federal law, Medicaid limits eligibility for the program to those who are on welfare or meet other restrictive criteria of low-income status that limit a state's capacity to serve all the poor. States have flexibility in determining income levels for welfare eligibility, and therefore there is considerable variability in eligibility from state to state. For Dr Kitzhaber, an emergency department physician, leader in the state senate, and now governor of Oregon, such a system meant some poor persons had extensive coverage, while others had absolutely none because they were ineligible for Medicaid. The Oregon Health Plan he sponsored was enacted despite considerable opposition. With hard-won waivers from federal Medicaid rules, the program is redesigning Medicaid to ensure that more persons living below the poverty line will receive a standard, if reduced, benefit.

Similarly, Governor Howard Dean of Vermont makes the case for a state-based Medicaid program, rather than a federal system like Medicare. Citing his problems as a family practice physician attempting to resolve billing questions, Governor Dean has called Medicare a "national nightmare"[3] and has criticized the complexity of the Medicare program, its administrative demands, and the remoteness of officials who run the program. He argues that states are closer and more responsive to providers and beneficiaries and therefore views the state-administered Medicaid program as a vehicle for health system reform.

Medicaid as a Vehicle for Health System Reform

Oregon and Vermont officials are not alone in their belief that states can redesign Medicaid to expand state-based health care access for the poor and to reduce cost growth. The federal government allows states to develop proposals to restructure the existing Medicaid program to test new approaches to deliver care. Forty-nine states have received waivers of current Medicaid requirements to redirect spending from institutions to home and community care. These waivers responded to a concern by states that the cost of nursing homes was not sustainable and to the recognition that the elderly and persons with disabilities sought home care options. Thirty-seven states now operate waivers that facilitate enrollment into managed care by restricting a beneficiary's freedom of choice [Section 1915(b)]. More recently, 11 states have developed and received federal approval for research and demonstration waivers (Section 1115) to test major overhauls of Medicaid; many more states have submitted or are developing similar waiver requests. Most of these waiver programs revise eligibility requirements to allow some low-income, uninsured persons who are not now eligible to be covered by the existing Medicaid program, and these waivers expand the use of managed care. Because experience and research suggest that managed care saves Medicaid programs about 5% to 15% of costs,[4] states anticipate significant savings through managed care and other program changes. Those savings are used to expand access to more of the uninsured and to reduce program costs.

How states approach the use of Section 1115 waivers for Medicaid reform varies, as seen in the following examples:

- Oregon is testing a somewhat reduced benefit package, increased managed care enrollment, and is paying providers their full costs.
- Tennessee is exerting its role as purchaser and negotiating with plans for the best price while aggressively enrolling Medicaid beneficiaries into managed care.
- Rhode Island has a smaller initiative to enroll Medicaid mothers and children into managed care and has developed specific health outcomes that managed care plans must meet to improve health status of Medicaid enrollees.
- Massachusetts is increasing managed care enrollment and using savings to fund subsidies that allow low-income persons and employers to afford the purchase of private insurance.

Interest of state officials in the Section 1115 waiver mechanism attests to their belief that states can administer the Medicaid program more efficiently and effectively without excessive federal government intervention. Through this vehicle, states have an opportunity, otherwise not available, to negotiate with the federal government and, in partnership with it, to redesign the Medicaid program. Perhaps fueled by their engagement in Medicaid redesign through the waivers, many governors are now supporting pending congressional proposals to make Medicaid a block grant to states. Some governors are prepared to accept considerable reductions in the growth of federal payments for Medicaid in exchange for more state discretion.

But how effectively states can run the program and whether such state-by-state diversity ought to be encouraged remain concerns of policymakers. A review of the program's history, however, may illuminate some questions about Medicaid's future.

Program Innovation in Medicaid

Medicaid has experienced rapid and consistent growth and has experienced significant change since its inception 30 years ago. Today it serves not only the welfare recipients for whom it was primarily created, but middle-class elderly who have spent so much on health care that they meet the Medicaid test of having low incomes, persons who are physically disabled and chronically ill, and pregnant women and children living in families with incomes up to 133% and often 185% of the poverty line. Thirty-six states, at their option, provide Medicaid to at least some "medically needy"—those persons who meet the nonfinancial criteria of eligibility who do not meet the income or asset requirements, but who have spent so much on medical costs that they have become eligible.[5] The program covers a wide array of services needed by these diverse populations, including medical care, some social services, and long-term care. Further, although states are mandated to provide only 13 Medicaid services, such as physician, hospital, and nursing facility service, every state provides a number of the 30 optional services. In 1994, for example, all states elected to cover optometrists, dental care, drugs, and transportation to medical appointments for at least some

persons eligible for Medicaid. And the vast majority of states cover nursing homes for persons with mental retardation, podiatrists, physical therapy, hospice care, and a variety of rehabilitative services.

Over the years states have balanced increased demand against requirements to balance the budget by experimenting with a variety of reforms in service delivery, reimbursement policy, claims processing, and service management. For example, states were early leaders in advancing case management as a vehicle to ensure appropriate service use and have had demonstrated success in increasing preventive and prenatal services and avoiding institutionalization.

But budget restraints have resulted in low rates of reimbursement, particularly for physicians. Medicaid today pays providers 73% of Medicare rates and only about 47% of private insurance rates.[6] States have created new reimbursement strategies, notably to increase the availability of obstetric and gynecologic services, and have contracted selectively and competitively with providers to ensure volume of caseload in exchange for an agreed-on fee. Medicare's diagnosis related group payment system was initially implemented in New Jersey's Medicaid program and its resource-based relative value scale was tested first in state Medicaid agencies. States are also experimenting with reimbursement reforms in nursing facilities. Rather than pay those facilities with a flat rate for all residents regardless of level of need, these reforms recognize that there is a mix of cases in any facility—some persons require more care than others and reimburse the facilities accordingly.[1] Maine, Kansas, South Dakota, and Mississippi were the leaders in launching this new approach called "case mix reimbursement."

States have been creative in their approaches to beneficiary enrollment and service as well, seeking out low-income persons through extensive outreach programs in communities and by colocating services in schools, community centers, and public housing. A number of states have allowed the uninsured, notably pregnant women and children, to purchase coverage through Medicaid. One such demonstration enrolled school-aged children and their siblings up to 185% of the poverty line, charging premiums based on the same fee schedule as the school lunch program.[7]

States have also launched on-line eligibility verification and billing systems to ensure that providers receive timely payment and are notified of service and eligibility limits prior to providing treatment. A number of other administrative advances have improved Medicaid's efficiencies. Despite the complexity of the program, states administer it for about 4% of total program costs, compared with administrative costs nearly four times greater for private insurers.[8]

States Move to Managed Care in Medicaid

More recently, states have sought to improve access to care and reduce costs by enrolling Medicaid beneficiaries in managed care (Table). Forty-four states and the District of Columbia now enroll 25% of all Medicaid beneficiaries in managed care.[9] Mothers and children make up most of that enrollment. States are moving aggressively to increase managed care enrollment, using both fully and partially capitated plans as well as primary care case management approaches. In the latter, physicians and others generally receive a monthly fee for managing services and continue to be paid on a fee-for-service basis.

Summary of Selected Medicaid Initiatives by States

Program Innovation	No. of States Providing*
Home- and community-based waivers	49
Freedom-of-choice waivers (Section 1915(b)) to provide mandatory managed care	37
Section 1115 waivers for state-wide reform—managed care/coverage of uninsured	11
States enrolling some beneficiaries in managed care	45
Coverage for "medically needy"	36
Medicaid coverage of key optional services: optometrists, dental, drugs, medical transportation	All
Quality Assurance Reform Initiative in managed care	17

*Includes District of Columbia. Data from National Academy for State Health Policy, May 1995.

How well managed care is working remains a subject of debate. For example, as states increase their use of managed care, traditional public health providers, such as public hospitals and community health centers, express alarm over potential revenue loss and concern about the capacity and willingness of managed care plans to meet the special needs of Medicaid beneficiaries. Particular concerns include the need for plans to be sensitive and responsive to cultural differences and to enroll and serve all Medicaid enrollees, regardless of their special needs. In some states, Medicaid agencies have facilitated relationships in which health maintenance organizations subcontract with public providers to ensure that special needs are met; in others, community providers have formed their own health maintenance organizations; and in others, community health centers are receiving transition payments to assist them to develop the capacity to compete in an increasingly competitive managed care environment. But as managed care enrollment increases, concern remains that states are not sufficiently protecting Medicaid beneficiaries and the providers that have traditionally served them. State efforts to increase the use of Medicaid managed care have sometimes met with opposition. In Tennessee, providers resisted the program; in Florida, Medicaid health maintenance organizations have been sanctioned for quality problems and a national trade association has sued the federal government to overturn current Medicaid Section 1115 waivers and prohibit future waivers that would result in wide-scale enrollment of Medicaid into managed care.

In response, states are increasing their efforts to build responsible and effective quality assurance systems. For example, 17 states are already implementing the Health Care Financing Administration Quality Assurance Reform Initiative, which is designed to improve the monitoring of quality in Medicaid managed care and to test approaches to assess the outcomes of care.[9]

Medicaid's Role in Improving the Health of Beneficiaries

States have undertaken many initiatives to improve outreach, access, and quality of care for those who receive Medicaid. Numerous studies suggest those efforts are reaping some success. But what has been Medicaid's role in health improvement for beneficiaries? Little is known about the outcomes of care or how effectively various interventions

affect improvements in health status, regardless of payment source. But some indicators do exist. The Physician Payment Review Commission found that low fees do dissuade some office-based physicians from treating Medicaid patients, but do not appear to reduce the number of services Medicaid beneficiaries receive.[10] In 1994, the commission found that 8% of those privately insured reported that they did not receive care when needed, compared with 10% of those on Medicaid, and 34% of the uninsured.[9(p12)]

Reports comparing the health status of adult, nonelderly Medicaid recipients with those who are privately insured or uninsured show considerably more Medicaid recipients reporting poor health status than their peers. However, it is difficult to draw conclusions from such findings, since nonelderly adults receiving Medicaid are disproportionately representative of those with significant health care needs. Most adults receive Medicaid because they are pregnant or are experiencing a major disability. Healthy young men are rarely Medicaid recipients, for example. However, when adults were asked to report on the health status of their children, 4% of all children were identified as in fair or poor health compared with 9.4% of children receiving Medicaid and 11.6% of those who are uninsured. The same self-reported data show little variation in rates of up-to-date immunizations between all children and Medicaid beneficiaries, and Medicaid beneficiaries younger than 6 years are more likely to be screened for potential lead poisoning than the uninsured or those privately insured.[11]

The Kaiser Commission on the Future of Medicaid notes that low-income Americans have a greater need for health care, have poorer pregnancy outcomes, are more likely to be in poor or fair health, have more disabling conditions, and have higher mortality rates than higher-income Americans. But almost half of the uninsured poor had no physician visit in a year compared with only 22% of those receiving Medicaid. The commission concludes that "Medicaid coverage has made an enormous difference in reducing inequities in access to care for low income Americans."[12]

As states grapple with the management of the complex Medicaid program, they seek flexibility to create a program that is cost-effective, of high quality, accessible, and appropriate for Medicaid beneficiaries. States vary considerably in their approach to change, and some are far more generous or more able than others to provide additional state revenues to build the program.

The many competing demands of the Medicaid program defy a simple solution. Serving all those who are eligible, covering required services and providers, and meeting reimbursement and other mandates within a constrained budget while dealing with health care cost inflation challenges states. Cost-containment efforts inevitably lead to charges of underpayment and of inappropriately low levels of service.

The Medicaid program must be administered within balanced budgets and limited revenues must be allocated against the competing demands for public services placed on state governments. With a projected annual growth of about 10%, Medicaid budgets are anticipated to grow three times faster than state budgets themselves. States clearly must seek ways to lower the expenses of the Medicaid program. Because 68% of Medicaid spending is on 27% of beneficiaries who are elderly or persons with disabilities, state proposals to reduce the cost of long-term care and to enroll these beneficiaries into managed care are emerging rapidly.

Medicaid's future depends in large measure on congressional action. If congressional proposals to significantly reduce the rate of growth in Medicaid are realized, states will be confronted with difficult choices regarding Medicaid coverage. Those choices will be especially complicated for states that have already taken measures to reduce program growth. Even if Congress provides flexibility to states to craft their own programs, it is unlikely that administrative savings could be realized to offset the loss of federal revenue. Indeed, because of the low administrative costs of Medicaid and continued health care cost inflation beyond Medicaid's control, states would likely need to look at (1) reducing the number of persons eligible; (2) reducing provider reimbursement levels; and (3) restricting services even as they use newfound flexibility to restructure their programs. If fewer persons are eligible for Medicaid coverage, the cost of their care will be shifted to private insurance premiums and to local, public providers. If states are not given flexibility to adjust hospital and nursing home reimbursement, physician and other providers would be disproportionately affected by reductions in provider fees. This would encourage providers to leave the Medicaid program, causing access problems for beneficiaries. It is not clear how states would respond to increased flexibility coupled with a reduction in federal funding. Given the program's history and the diversity of the states, there will likely be both successes and failures.

In the debate about the future of Medicaid, policymakers have considerable evidence to show that the states have been largely successful in administering the program. States have done so under constant scrutiny, with insufficient financing and with regular but unpredictable change from the federal government. It is this dynamic of the federal-state relationship and of a constantly evolving Medicaid policy that brings about controversy and confusion. But in the final analysis, states have done much to serve the nation's most vulnerable citizens through Medicaid.

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Medicaid at 30

New Challenges for the Nation's Health Safety Net

Since its enactment in 1965, Medicaid has been on the front lines in meeting the health needs of our nation's most vulnerable populations. It has evolved from the companion legislation to Medicare that provided health financing to states for coverage of their welfare population, to a program that now finances health and long-term care services for one in eight Americans. In its 30 years, Medicaid has enabled millions of low-income Americans to gain access to needed health services, helping to close the gaps in care between the poor and nonpoor, ease financial burdens, and provide a safety net for the most needy Americans.[1]

Today, Medicaid's role as a health insurer and safety net for vulnerable Americans is visible throughout the health care system. Medicaid finances care for one in four American children, pays for one third of the nation's births, assists 60% of people living in poverty, pays for half of all nursing home care, and accounts for 13% of all health care spending.[2,3] It is the source of insurance for 13% of the nonelderly population and supplements Medicare by paying premiums and cost sharing for one in 10 elderly and disabled Medicare beneficiaries.[4] Its funding is the major source of federal financial assistance to the states, accounting for 40% of all federal grant-in-aid payments to states.[5]

As it enters its 30th year, Medicaid is at a critical juncture. In its role as a medical safety net, Medicaid financed care for over 82 million of the poorest, sickest, and most disabled Americans at a cost of over $125 billion to federal and state governments in 1993.[6] As the number of Americans without health insurance continues to grow, Medicaid's role as the insurer of low-income Americans is particularly important. Expansions in Medicaid coverage of the low-income population over the last decade has mitigated the growth in America's uninsured population and has been the cornerstone of virtually all state health care system reform activities.[7]

But Medicaid has been a victim of its own success. At the same time as the program was broadening its reach in providing health insurance to the poor and becoming the mainstay of financing for long-term care, spending was rapidly rising. A doubling of program costs over the last 5 years has raised new questions about the ability of the federal and state governments to sustain such growth.

Proposals to restructure the program to limit federal spending, promote broadened use of managed care, and give states additional flexibility over program design are now under active consideration. Some proposals would convert the program from an entitlement that guarantees coverage to all eligible individuals, to a block grant providing states with federal funds for indigent care and few or no requirements on how those funds are used. By the end of its 30th year, Medicaid could be dramatically reshaped with a substantially reduced federal role and new responsibilities for states.

Medicaid: The Safety Net for Low-Income Americans

Over the last 30 years, Medicaid has been a major force in shaping health and long-term care services for the most vulnerable and needy Americans. Before Medicaid, the poor saw physicians less often than the nonpoor and faced serious financial burdens in obtaining care.[8] Medicaid has helped to close gaps in access to care between the poor and the nonpoor and established a safety net for health and long-term care services for the poor and the disabled.

In reality, Medicaid is four programs, configured and operated somewhat differently in each of the 50 states and the District of Columbia. For 16 million children and 7 million adults in low-income families, Medicaid is a health insurance program with comprehensive benefits and little or no cost sharing. For nearly 4 million low-income elderly people and 5 million low-income people with disabilities, Medicaid has multiple roles.[9] It is a long-term care program for home- and community-based services and the dominant source of financing for nursing home care. It is a supplementary insurance program to Medicare paying Medicare's premiums and cost sharing and covering additional services, most notably prescription drugs and long-term care, for low-income Medicare beneficiaries. Finally, Medicaid is a health insurance program for low-income disabled adults who do not have Medicare coverage.

Although Medicaid is generally perceived as a program for low-income families, most Medicaid dollars go to services for the aged and disabled. Adults and children in low-income families make up nearly three fourths of beneficiaries, but account for only 27% of spending. The elderly and disabled account for the majority (59%) of spending because of their intensive use of acute care services, the cost of Medicare premiums and cost sharing, and the costliness of long-term care in institutional settings. In 1993, the average per capita cost for a child on Medicaid was $955 compared with $7216 per disabled beneficiary and $8704 per elderly beneficiary.[9]

Stresses in the Safety Net

Despite Medicaid's success in improving access to care for the poor and the substantial role it plays in providing health insurance protection to the low-income population and long-term care for those with severe disabilities, the growing cost of its services and the resulting strain on federal and state budgets have placed Medicaid's future in jeopardy. There is intense pressure on the program to stretch its reach to insure more low-income Americans and improve access to care, but also to limit its costs. Finding the balance in these conflicting goals is Medicaid's most daunting challenge.

Providing Health Insurance Through Medicaid

Today, 41 million Americans, two thirds of whom have incomes below 200% of the federal poverty level, are uninsured.[4]

From the Henry J. Kaiser Family Foundation, Washington, DC.
Reprint requests to the Henry J. Kaiser Family Foundation, 1450 G St NW, Suite 250, Washington, DC 20005 (Dr Rowland).

Medicaid is the primary source of financing and coverage for the low-income population and has been a critical force in moderating the growth in America's uninsured population. Fifty-eight percent of all Americans living in poverty and 82% of all poverty-level pregnant women and young children now are covered by Medicaid.[2] If the growth in Medicaid over the last 5 years had not offset the decline in employer-based insurance for working families, an additional 9 million Americans would be uninsured today, increasing the percentage of nonelderly Americans without insurance from 18% to 22%.[7]

But Medicaid as it is currently structured is limited in its ability to broaden coverage of the uninsured. Medicaid is a means-tested entitlement program. Only persons who meet stringent and state-specific income and assets limits and who fall into particular "categories," such as people receiving cash assistance or low-income children and pregnant women, are eligible. Despite recent extensions of coverage to poor children and pregnant women, millions of uninsured low-income Americans, most notably poor single individuals and childless couples, remain beyond the program's reach.

As a result, many states have sought waivers from the federal Medicaid eligibility requirements in order to use Medicaid as a building block in their state health care system reform efforts.[8] With waivers, federal matching funds can be used to help pay the cost of insuring low-income individuals who are not in Medicaid's traditional coverage categories. Eleven states now have federal waivers of Medicaid law (known as Section 1115 waivers) that allow them to experiment with changes in the scope and structure of their Medicaid programs to cover additional low-income uninsured people and to use managed care to restructure the delivery and financing of services.[9] With the collapse of the federal efforts at overall health system reform and the growing budgetary pressures on states, many states are turning to 1115 waivers as a way to gain broader flexibility over their Medicaid programs.

Expanding the Use of Managed Care

Medicaid has demonstrated that improved financing of care for the poor can help to eliminate differentials in use of health services, but it has fallen short in ensuring access to mainstream medical care. Low levels of participation in Medicaid by private physicians, heavy reliance by program beneficiaries on care in clinics and hospital emergency and outpatient departments, and concerns about both the cost and quality of care raise questions about the appropriateness and accessibility of care that Medicaid provides for its covered population. These cost and access concerns with the fee-for-service medical care system have led many states to turn to managed care as a model to coordinate care for the Medicaid population and help control costs. Medicaid managed care enrollment has grown steadily in the last decade from 800 000 enrollees in 1983 to 7.8 million in 1994.[10] Today, 28% of Medicaid beneficiaries, predominantly poor children and their parents, are enrolled in managed care.

More than half of Medicaid managed care enrollees are in health maintenance organizations (HMOs) or similar organizations that provide a full range of services for a fixed capitation payment per enrollee. The remainder are either in fee-for-service primary care case management programs that contract with a primary care provider to provide or approve all covered services to plan enrollees, or in prepaid health plans that provide a fixed capitation fee per enrollee for a limited range of services and reimburse other services on a fee-for-service basis.[11] The recent enrollment growth is mostly in HMO-type capitated plans at full financial risk for delivering services to the enrolled population.

Managed care has the potential to improve the delivery of care by integrating and coordinating services to enrollees and promoting early intervention and primary care to reduce hospitalizations and reliance on emergency departments as a site of care. Capitated managed care systems also offer the potential to constrain Medicaid costs and make spending more predictable by setting a fixed payment per enrollee and putting the health plan at risk for delivering needed services.

Managed care is not, however, an instant solution to Medicaid's access and cost problems. Managed care works most effectively if the enrolled population is stable and can receive ongoing preventive and primary care, but the means-tested Medicaid program has significant eligibility turnover because people lose coverage due to fluctuations in income and employment. As a public program, Medicaid operates under budget constraints that have often resulted in substandard provider payment rates. In a capitated managed care arrangement where the incentive is to keep utilization low, substandard payment rates could discourage participation by mainstream plans and compromise quality and access. Moreover, achieving significant overall program savings from managed care will be difficult without enrolling the costly disabled and elderly populations. There is limited experience with these populations in managed care, and more work needs to be done to develop appropriate managed care models and integrate Medicaid and Medicare services for these populations.

Curbing Costs

Concern with Medicaid costs has unquestionably become the dominant issue shaping the debate over the program's future. From 1988 to 1993, total program spending more than doubled from $51 billion to $125 billion.[6] It is projected that total federal and state spending for Medicaid will exceed $158 billion this year and grow to $262 billion by the year 2000.[12] Medicaid now accounts for 6% of the federal budget and 20% of most state budgets.

Spurred by federal requirements to increase coverage of pregnant women and children, state efforts to cover more low-income uninsured, and court-required expansions in coverage of the disabled, enrollment increased from 22 million in 1988 to 32 million in 1993.[6] But enrollment growth was not the major force behind the Medicaid cost explosion. Much of the growth in Medicaid spending, especially from 1990 through 1992, was due to expanded state use of financing strategies.[13] States generated additional federal dollars from Medicaid by using provider taxes and donations and disproportionate share hospital (DSH) payments intended for hospitals serving large numbers of uninsured and low-income patients to increase the base payments that had to be matched by the federal government. The federal share of DSH payments alone grew from $800 million in 1990 to $10.1 billion in 1992, with DSH now accounting for 14% of all Medicaid spending.[14]

With legislation in 1993 to restrict state use of tax and donation financing strategies and curb the growth in DSH payments, the annual rate of growth in Medicaid spending has now dropped back to historical levels from the 20% increase from 1990 to 1991 and the 30% increase from 1991 to

1992.[13] From 1992 to 1993, the program grew by 11%. Future projections assume an annual growth rate of about 10%.[15]

Yet, given the size and scope of Medicaid, sustaining an annual increase of 10% requires a substantial commitment of new funds each year. With budgetary pressure and the desire to reduce spending at both the federal and state levels, restraining the annual increases in Medicaid spending has taken on new urgency. How expenditures for the program are shared and managed between the federal and state governments is at the heart of the policy debate over Medicaid's future.

Meeting the Challenges Facing Medicaid

Since its enactment in 1965, Medicaid has improved access to health care for the poor, pioneered innovations in health care delivery and community-based long-term care services, and stood alone as the primary source of financial assistance for long-term care. Today, Medicaid continues to play a critical role in providing acute and long-term care services to our nation's most vulnerable people, but its widening safety net responsibilities and spending growth are straining both federal and state budgets. The most critical issue facing Medicaid today is how this safety net program can best be structured to meet the needs of low-income Americans at the most reasonable cost to the federal and state governments.

Some of the proposals being discussed would dramatically alter the program structure and beneficiary protections by replacing the current federal and state entitlement program with a block grant to the states. Instead of guaranteeing insurance coverage and federal financing for all individuals who meet Medicaid's eligibility criteria, a block grant would provide states with federal funds and the flexibility to decide how those funds can be used. Under the proposals being discussed, states would gain discretion over the scope and design of the program, but lose unrestricted federal matching payments because federal payments to the states would be capped. The full impact of such proposals is highly dependent on the level of cuts in federal funding and the degree of flexibility given to individual states.

Today the Congress is proposing to curb Medicaid spending to realize savings of over $175 billion from projected federal spending between 1996 and 2002.[16] This would amount to an 18% reduction in federal support for Medicaid over this period.[17] A significant reduction in federal Medicaid spending and an end to the entitlement nature of Medicaid are likely to result in reduced program coverage, leaving some currently eligible individuals without health insurance coverage and swelling the ranks of the uninsured. Reductions in federal funds could also result in reduced payments to providers, undermining the ability of hospitals and clinics with high volumes of Medicaid patients to continue to serve Medicaid beneficiaries and uninsured Americans. Such reductions or program modifications could also have a major financial impact on both state and local governments, which would be under pressure to increase their support for care of the poor and disabled and for safety net providers, such as public hospitals.

The outcome of the policy debate over Medicaid's future is obviously of great import to the states, the low-income people who now rely on Medicaid for health and long-term care services, and the providers that serve them. Will Medicaid remain an entitlement or be converted to a block grant? Will Medicaid be shifted from a joint federal-state program to a state program with limited federal assistance? Can greater flexibility to the states and broadened use of managed care produce the needed savings, or will services and beneficiaries have to be cut? What will the impact of these changes be on the uninsured and their providers of care? Will there still be a safety net for society's most needy? The stakes are high and the implications of many of the policy choices are difficult to predict.

There are no simple solutions to reducing the cost of providing care to the over 35 million Americans who now depend on Medicaid or the millions more who are uninsured and fall just beyond its reach. The dilemma policymakers at both the federal and state levels face is how to restrain the rising cost of care for the vulnerable populations served by Medicaid without compromising the vital safety net role of the program in ensuring access to essential health services for the needy. Until the nation ensures that universal health care coverage is provided to all persons, determines how to finance that care, and finds a way to effectively constrain system-wide costs, we will continually be asking how best to provide care to the poor. But we should take care that in implementing quick solutions to meet the crises of today, we not undo the progress Medicaid has made in improving health care for tens of millions of low-income and elderly and disabled Americans.

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The Politics of Medicare

This year, Americans are celebrating 30 years of health security provided to the nation's seniors and poor, a result of the Democratic party's ongoing response to their needs.[1]

In this article, my observations pertain only to Medicare. Medicaid is run under state control. The House of Representatives Republican plan virtually freezes Medicaid payments to the states for 5 years, ties a block grant around the program, and tosses it overboard.[2] Bon voyage! Rather than abandoning the Medicaid population as congressional Republicans have proposed, many independent commissions and politicians (including myself) have long advocated subsuming Medicaid into Medicare.

Polls show the American public consistently and strongly in support of Medicare.[3] Three quarters of the population younger than 65 years favor having the option to choose Medicare for their health insurance coverage.[4] Medicare has historically garnered the support of a large group of Republican members of Congress, many of whom simply have found support of Medicare a political necessity.

Medicare is a single-payer system. More than 6000 hospitals, 300 000 physicians, and 250 health maintenance organizations (HMOs) contract with Medicare to provide care to 35 million Americans.[5] More than 70% of Medicare beneficiaries have access to an HMO option.[6] Medicare is efficient and popular with beneficiaries and providers.

The oft-repeated Republican mantra is that government is inept. The 30-year record of Medicare produces quite a different conclusion. Medicare is the most efficient health insurance *program* in the country. It is also the only comprehensive health insurance *system* available to protect seniors from the cost of illness.

Medicare outperforms private health insurance in controlling costs.[6] This has been true during the past 30 years and the past decade.[7] In the past 3 years, Medicare's total physician payments increased by just 4% per year, while procedure fees increased much faster (Physician Payment Review Commission, oral communication, April 20, 1995). The average fee increase was 7.7% for all physician services in 1995. This record is the result of the 1989 Resource Based Relative Value Scale physician payment system. Impressed with Medicare's success, many private health plans across the country have adopted the Medicare physician payment mechanism.[8]

Medicare introduced hospital payment reforms in 1983, a product of the Reagan administration. Since their implementation, Medicare's real per-person hospital inpatient costs have increased at a rate 40% lower than those of the private sector.[6] More than 90% of Medicare's payments to hospitals today are on a capitated basis, and many private health plans use the diagnosis related group hospital payment mechanism.[9]

Medicare beneficiaries are happier with their health insurance coverage than are privately insured patients. Robert Blendon, chairman of the Department of Health Policy and Management in the Harvard School of Public Health, found that beneficiaries gave Medicare a 90% rating in the areas of quality and ease of using primary care, quality and ease of using specialist care, and overall satisfaction.[10] In each of these ratings, Medicare outperformed private indemnity and managed care plans. That's a pretty good record for a program that Speaker Gingrich has characterized as "clunky and inefficient."[11]

Mr Gingrich should note that Medicare's overhead costs are a fraction of the level found in private plans. Medicare spends only 3 cents of each dollar for overhead, leaving 97 cents for direct health care services.[6] The piece of the pie going to overhead is much greater in private plans, with multistate Medicare HMOs consuming 23% of revenues for administrative expenses.[12] Administrative costs of private insurance plans are increasing at four times the rate of Medicare.[7]

Why then is Medicare under attack by Republicans today? In the last campaign Republicans preached smaller government, less regulation, and more personal responsibility. Campaigning, however, is not governing. Newt Gingrich and his disciples made wildly inconsistent promises, such as cutting taxes, increasing defense spending, and balancing the budget.[13] Republicans need to dip into Medicare's funds to pay for tax cuts for the most well-to-do.

Republican rhetoric notwithstanding, there is no way—mathematically or thematically—to maintain Social Security, increase defense spending, honor payments on the debt, achieve a balanced budget, and give away nearly $700 billion in tax breaks without raiding Medicare. One trillion one hundred billion dollars in cuts must be found to balance the federal budget by 2002.[14] The Medicaid freeze saves about $187 billion over 7 years. A 22% cut in nondefense discretionary spending saves $481 billion, leaving $432 billion in cuts yet to be identified for a balanced budget (Democratic staff, Joint Economic Committee, written communication, April 24, 1995). Add the $353 billion 7-year cost of the House tax cut bonanza (actually $663 billion during 10 years) and you see the impetus to raid the Medicare program.[15]

Should the Republicans cut benefits or provider payments or raise out-of-pocket beneficiary costs? Each creates severe political problems and threatens the access to and quality of care for millions.[16] In their first foray, House Republicans raided the Medicare Part A Trust Fund of $87 billion to pay for tax cuts for upper-income seniors.[17] This Hobson's choice has created near hysteria in the debate over Medicare.

Congress is divided into two health care camps. Many, like myself, believe Medicare changes and improvements should be made judiciously. Others feel that a quick "conversion" of Medicare to the tenets of the sermon on the Grand Teton (delivered by the gurus of the Jackson Hole Group) will somehow cut costs, increase benefits, and improve quality. The Republicans' voucher proposal for Medicare is the latest incarnation of the managed competition approach.[18] These believers have a childlike faith that "managed care" or "entrepreneurial creativity" will yield huge savings for Medicare, or at least help finance their ill-conceived campaign promises.

The more likely result of privatizing Medicare through a voucher system will be a steady erosion of the buying power of the voucher as private health insurance premiums outpace the dollar value of the voucher. The Republicans' voucher proposal allows total Medicare expenditures to increase at an annual rate of 5.3%.[19] After taking into account increased Medicare enrollment, this proposal provides for a 3.9% annual per capita increase—barely enough to keep pace with general inflation and

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well below the 7.6% growth rate in private health insurance spending projected by the Health Care Financing Administration.[15] If this proposal is enacted, there will be no anniversary celebration for Medicare in 10 or 30 years.

Outside government, the beneficiary and provider groups are apprehensive about losing revenues, benefits, and quality care. The newest arrivals on the Medicare scene—the entrepreneurs, Wall Street bankers, and insurers and agents of the managed care industry—are overstimulated by the scent of huge profits. They try to convince Congress that only managed care can drive out the excesses in physician and hospital practices.

The beneficiaries, I believe, are the key to the outcome of this passion play. Led by the large, wealthy American Association of Retired Persons, the beneficiaries could become a political whirlwind. The National Committee to Preserve Social Security and Medicare and other groups with smaller but easily agitated constituencies can add spice to the senior lobby. Unfortunately, some find it in their interests to mislead and frighten the elderly. Alarmed, agitated, and activated, they are among the most potent political forces in America ... not ignoring the American Medical Association (AMA), the Veterans of Foreign Wars of the USA, the American Federation of Labor and Congress of Industrial Organizations, or the National Rifle Association.

The inability to achieve consensus diminishes the role of "organized" medicine. The AMA often splits over differences between the specialty and subspecialty groups in its membership. The AMA's conservative leaders, mesmerized by tax cuts and "smaller" government, garble their message on Medicare. The same point applies more specifically to the American Hospital Association (AHA), which cannot abide any hospital closing or revenue loss. A surefire formula for dissension among its membership is a reduction of hospital payments. The AHA has become a "Johnny-one-note" in the squabble over Medicare.

The managed care industry has gained new prominence from their recent alignment with the Republicans to force Medicare beneficiaries into managed care. This is an interesting change of tune for President Clinton's adversaries who opposed his reform on the erroneous grounds that it would limit patient choice. Puffed up by tough fee cutting, bloated overhead charges in the range of 15% to 40%, and adulation from Wall Street, the managed care industry is flexing mighty political muscle.[20]

Unfortunately, this new cult of managers, gatekeepers, and hucksters has done little but limit access, reduce choice, and cut provider income. While some HMOs provide high-quality care to Medicare beneficiaries, the new kids on the managed care block seem to believe that executive salaries outrank patient care in the claim on insurance premiums.[21] Beneficiaries are denied access to high-quality care, while premiums go to political contributions and extravagant lobbying campaigns. If nothing else, it will be interesting to watch Harry and Louise claiming to worry about Mom's health care.

Once the Republicans propose a detailed budget, all parties can assess the potential damage. I expect beneficiaries will revolt and force Congress back to its traditional role of fine-tuning and incremental improvement of Medicare.

Many deficit hawks continuously wring their hands over the impending depletion of the Medicare Trust Fund. Outside broader health system reform, I believe we can make marginal changes in Medicare's expenditures in the magnitude of $50 billion to $80 billion within 10 years. We cannot ignore the fact that 85% (or $48 billion) of the cuts made in the Omnibus Budget Reconciliation Act of 1993 have yet to go into effect (Congressional Budget Office, written communication, August 4, 1993). If we cut further, this could pose serious trouble for our increasingly precarious health care system. Extreme cuts in public programs, tougher HMO bargaining, and self-insured employers' demands for discounts will force hospitals to cut services to the poor and uninsured.[22]

After the current hysteria dies down, I believe we can achieve health system reform in the next decade. First, we must determine how we will subsidize or otherwise pay for health care for the uninsured poor and marginally employed. Most any system would be more fair and efficient than our current random cost shifting. Second, there must be strict health insurance regulation: eliminating medical underwriting, preexisting condition limitations, and age-adjusted premiums and creating open enrollment. When we make those changes, we could make larger reductions to Medicare—but only with the savings reinvested for medical education, research, charity, and uncompensated care.

Ultimately, I believe the debate will come full circle, with Republicans coming around most of the way. Ironically, last year Republicans on the Ways and Means Committee voted unanimously to eliminate Medicare savings in the health reform bill because they were too harsh.[23] This year they propose far deeper cuts in Medicare to finance tax cuts for the wealthy.[22,24] The desire to spend Medicare dollars on tax cuts will keep Republicans from returning to a position of no cuts. I anticipate Republicans will realize that a 300% to 500% increase in Medicare cuts will prove impossible to sustain—politically, systemically, intellectually, or morally.

The sooner the new Republican leadership recognizes this fact, the quicker we can get on with improving America's health care program.

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1965-1995: Medicare at a Crossroads

How Medicare Grew

In 1965, after years of debate, Republicans and Democrats joined to pass legislation establishing the Medicare program. Designed originally to provide health insurance coverage for America's low-income elderly, the program has since been expanded beyond its initial scope. Medicare now covers nearly all Americans over the age of 65 and includes benefits not envisioned by the original intent of the program, which have increased costs to the taxpayer and skewed the original sharing formula between the government and beneficiary. We are to the point now where on the 30th anniversary of the establishment of Medicare we are faced with a fundamental challenge: how to make the Medicare Hospital Trust Fund solvent and improve the program through additional choices for our Medicare beneficiaries.

Medicare Part A was designed originally in 1965 to pay for the in-hospital expenses of America's seniors. It was set up to be a self-supporting system financed exclusively by a payroll tax—split equally between employees and employers. The life expectancy of Americans has increased and the cost of hospital stays has become more expensive under Medicare's fee-for-service program; with the number of participants increased, current spending on the program by the federal government exceeds the payroll tax.[1]

Medicare Part B was set up to be a voluntary program to provide additional low-cost health insurance to seniors to help them pay for physician visits and outpatient hospital services. The costs were supposed to be equally shared (50-50) between the federal government and the senior citizen who chose to participate. But as out-of-pocket spending grew for seniors, the taxpayers began to pick up more of the cost. Today, premiums paid by participants cover only 30% of the cost of the program; the remaining 70% is subsidized by taxpayers under 65 years of age, who receive no direct Medicare benefits. In 1994, Part B per-beneficiary costs were $2046 annually; the beneficiary paid $500 and the taxpayer paid the remaining $1500. In 7 years, by 2002—the year in which the Medicare Trustees predict bankruptcy for the Part A program—the cost per beneficiary is estimated to increase more than 200%, to $4430 per year. This is an unacceptable and unsustainable rate of growth.[1]

A program that started 30 years ago and cost $3 billion a year at its beginning now costs $180 billion annually! Over the last 7 years, more than $844 billion has been paid out by Medicare. If we stay on the current path—that is, if we do nothing—over the next 7 years we'll be spending $1.8 trillion. That is more than double the amount spent in the past 7 years, according to the trustees: Medicare will go bankrupt.[1] No claims will be paid—by law.

Changes in Medicare

Over the years Medicare has seen many changes. Those that follow are some of the more major changes made to the program:

- 1972: Extended coverage to disabled persons entitled to cash benefit under the Social Security or Railroad Retirement programs and to certain individuals with end-stage renal disease after a 24-month waiting period. No change in payroll tax or beneficiary cost sharing.
- 1980: Liberalized home health benefits by eliminating the number of visit limits, the prior hospitalization requirement, and the deductible for any benefits provided under Part B. No other changes in payroll tax or beneficiary cost sharing.
- 1981: Increased the multiplier for computing the inpatient hospital deductible by 12.5%. Increased Part B deductible from $60 to $75. (The multiplier is the ratio between the average daily rate in the current year [in this case, 1981] and the calendar year 1966 corresponding rate; changed in 1986.)
- 1983: Expanded coverage to hospice care for terminally ill beneficiaries whose life expectancy is 6 months or less. In addition, a prospective payment system for Medicare payments for inpatient hospital services was established. No change in payroll tax or beneficiary cost sharing.
- 1985: Extended mandatory Medicare coverage to nearly all state and local government employees hired after December 31, 1985. Medicare was also made secondary payer for all workers aged 65 years or older and their spouses, who elected to be covered by employment-based health insurance through an employer with 20 or more employees. No change in payroll tax or beneficiary cost sharing.
- 1986: Made Medicare secondary payer for all disabled Medicare beneficiaries who elected to be covered by employment-based health insurance as a current employee (or family member of such employee) of an employer with at least 100 employees. Also, Medicare was expanded to cover certain outpatient immunosuppressive drugs furnished to transplant patients. Changed the annual indexing of the Part A deductible to reflect hospital prospective payment rates.
- 1987: Increased the maximum covered payment for mental health services and certain covered outpatient mental health services along with the services of certified nurses, midwives, clinical social workers, clinical psychologists in rural health clinics, and physician assistants in rural health manpower shortage areas. No change in payroll tax or beneficiary cost sharing.
- 1989: Revised the physician payment system and implemented a new fee schedule, based on a resource-based relative

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value scale that measured the time, training, and skill required to perform a given service, adjusted for overhead and geographical differences.

• 1990: Increased the Part B deductible from $75 to $100 beginning on January 1, 1991. Standards for Medigap policies—private supplemental insurance designed to pay for deductibles, coinsurance, and some health services not covered by Medicare—were also set and cancellation of such policies by the insurer based on beneficiary health status was disallowed.

• 1993: Removed the wage base cap for wages and self-employment income subject to the Medicare hospital insurance tax. Part A premiums were reduced on a phased-in basis for individuals and their spouses with at least 30 quarters of Social Security coverage. The Part B premium was set to cover 25% of program costs for beneficiaries, and 75% was covered by general revenues.

• 1995: House and Senate passage of Medicare Select legislation to extend program to all 50 states. Medicare Select is a Medigap preferred provider organization option that is currently available in 14 states. (The current [1995] figures for beneficiary deductibles are as follows: Part A deductible, $716 per episode, and Part B deductible, $100 per year.)

But despite these and other modest efforts to contain costs and change the program over the last decade, Medicare continues to grow at a rate well exceeding the rate of inflation.

Private vs Public Health Care Costs

Beneficiaries would argue that Medicare has been generally successful in consistently providing high-quality health care for our nation's elderly. This perception of the program is attributable in part to the health care network of physicians, hospitals, clinical laboratories, and others who provide the service, and it is a testament to the abilities of these groups. However, the reality is that Medicare has failed to keep pace with new and novel innovations in health care delivery pioneered in the private sector. The private sector, without government interference, has dramatically addressed the issue of rising costs through the increased use of coordinated care structures, including group practices and managed care arrangements that have helped cut the rate of health care inflation to half the rate in the Medicare system. Some Medicare beneficiaries (fewer than 10%) have access to managed care plans, but these plans are reimbursed by Medicare under an artificial formula used in the fee-for-service program, which does not serve as a model for reform. Government can and must look to the private sector for solutions to the challenge facing the Medicare system: how to make it solvent and keep the promise made to our elderly citizens now and in the future.

When Medicare spending is compared with private sector health spending, government spending on health care services continues to far outpace other private health care programs. Medicare spending now grows at a rate of 10.5% annually—almost double that of private health insurance. In addition, the amount paid out by enrollees (out-of-pocket spending) in private health plans is far less than in Medicare. The private sector has learned how to become more efficient through utilization review programs and consumer education—programs that, if they exist, exist minimally in Medicare. Our government-run Medicare program is saddled with an out-of-date system run by bureaucrats who do not understand the delivery of health care the way providers do.[1]

The Challenge Facing Congress and America

In April, in their report to Congress, the Medicare trustees reported that next year, the trust fund that finances benefits under the Medicare hospital (Part A) program will pay out more than it collects in payroll taxes; in other words, it is going broke. Worse, the fund will be depleted (bankrupt) in 7 years. And when the fund is bankrupt, by law, no payments by Medicare for hospital or other trust-paid health services can be made. Medicare hospital payments for 38 million Americans would cease, and millions more who have been paying into the fund through payroll taxes will lose their investment.[1]

All of this will happen despite the changes previously made in the program. Old solutions are not adequate. At best they will postpone, not solve, the problems within our Medicare system.

The report of the trustees, three of whom are President Clinton's cabinet secretaries, offers no answers to this dilemma. In addition, the president's original budget submission did not contain any proposals to protect Medicare. He chose to punt. It seems he thought that it was politically more risky to propose solutions to Medicare's impendig bankruptcy than it was to pretend the bankruptcy was not going to happen. However, in mid June, the president changed his mind. With his revised budget plan, the president has acknowledged what Republicans have known for some time: Medicare must be saved before it goes broke.

Myths vs Facts

What is surprising to many is the fact that, on average, the vast majority of Medicare beneficiaries use far more benefits and services than can be paid for by the individual's payroll tax contribution. It is estimated that in 1994, on behalf of the average one-earner couple in which the breadwinner retires this year at the age of 65, the government spent approximately $126 700 more on Medicare benefits than the recipients paid for in taxes and premiums, including earned interest. A two-earner couple received $117 200 more. A single woman received $65 100 more, and a single man received $40 300 more (due to lifespan differences between men and women—women live approximately 7 years longer).[1]

Besides the imbalance of payments vs benefits, the number of people reaching age 65 (which is usually the age of eligibility for Medicare) is dramatically rising. Thanks to better medicine and healthier lifestyles, Medicare beneficiaries are living longer, are using more Medicare benefits, and are using them over a longer period. Although longer lifespans are wonderful and welcome news for our seniors, their children, and their grandchildren, it has increased pressure on the system. In 1965, when Medicare was first established, Americans reaching age 65 were expected to live an additional 13 years. Today, we are expected to live an additional 17 years past age 65. As a result, the number of taxpayers supporting the Medicare program, relative to the number of beneficiaries, continues to drop. Today, almost four workers pay in for every beneficiary collecting benefits. In 20 years, if the program has not disappeared, even before the majority of baby boomers enter retirement, that ratio will decrease to only two workers paying into the trust fund for everyone receiving benefits; the result will be a higher price tag on fewer shoulders.[1]

With all the billion-dollar increases and the increased utilization of services, the Medicare program is not delivering to beneficiaries better coverage, or better care, or better choices. Medicare's benefit structure was designed for the way medicine was practiced in 1965—not 1995. The old-fashioned system offers

beneficiaries limited choice of delivery systems and limited choice of benefits. Medicare's bloated bureaucracy is no longer capable of providing the choices to seniors on an individual basis that they deserve, nor is it capable of providing the cost-efficiencies that the private sector has implemented in the last few years. Today's senior citizens and future generations deserve better.[1]

Toward a Better Medicare

We must and can do better. Medicare can offer more choices to beneficiaries, similar to private-sector coverage, with high-quality care and lower out-of-pocket costs. We must look beyond the original 1965 program and bring the newer and better elements that exist today in the private market into the program. The longer we delay, the solutions we have to choose from to prevent bankruptcy will be fewer and more severe.

Even today, we have fewer choices than we would like. We have the old Democratic solution—we can pay for future benefits by raising revenues through higher payroll and other taxes. The current monthly payroll tax rate—almost 3%—would need to be at least doubled to keep the fund solvent. A tax increase would be a further burden on employers who want to hire new workers, and a burden that is already high would go higher. In addition, raising taxes does not solve the inflation problem that is driving Medicare to bankruptcy. I reject this approach. A better alternative is to change the way Medicare is run, so that benefits are delivered with more efficiency and providers are able to practice medicine in the way that they and their patients—not government bureaucrats—believe is best. Making the program more efficient and shrinking the government's role in running the program would improve the quality of benefits and the choices available to retirees, while reducing the double-digit rate of Medicare inflation. We need to bring the choices available in the private sector to Medicare beneficiaries and we need to bring the efficiencies along as well.

As we move forward with proposals, we are looking for ways to make Medicare more efficient, both for today's senior citizens and future generations who are now paying into the system. We know one thing for sure: without any changes, Medicare will go bankrupt. But with the right changes that give beneficiaries more choices, we can guarantee the Medicare program for today's and tomorrow's beneficiaries. This is the challenge before Congress and the American people. Together we can solve this challenge.

Bill Thomas

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The Compromise and the Afterthought

Medicare and Medicaid After 30 Years

IT HAS BEEN an eventful time since, on July 30, 1965, then-President Lyndon Baines Johnson signed Public Law (PL) 89-97, the Social Security amendments that brought into being the Medicare and Medicaid programs. The legislation represented an unrivaled turning point in American health policy. It embroiled the American Medical Association (AMA) in the fight of its political life—which it lost. It changed how hospital, medical, and other health care services were financed; altered the shaky relationship between the federal government and the states; and spawned a long parade of political, financial, social, and moral events that continues to unfold today.

Deep Roots

Its roots run deep.[1-5] Politically, they reached back to the unsuccessful presidential campaign of Theodore Roosevelt in 1912; he included in his Progressive ("Bull Moose") platform a call for "health insurance for industry" that would guarantee coverage for working Americans. He lost the election to Woodrow Wilson.

That was followed by a flurry of activity in support of several proposals, including a "model" bill for compulsory health insurance that was submitted in many state legislatures. Despite intense efforts in some states, including California and New York, none of the proposals passed, and by 1920 the campaign had lost all momentum.[1]

In 1921, Congress passed the Sheppard-Towner Act, which subsidized maternal and child health care programs; it was allowed to expire in 1929, just in time for the crash of the stock market and the sinking of the nation into the worst economic depression in its history.

A more determined approach began to emerge in 1932, when the Committee on the Cost of Medical Care, a private body supported by academic institutions and philanthropies, issued a draft report on its 5-year study of the health care system in the United States. Actually, it issued two draft reports. The majority report endorsed group practice for physicians and prepayment of health care costs by groups of subscribers. The minority report, issued by nine dissenting members (eight of whom were physicians), endorsed total control of medical care by physicians without any involvement by lay persons, and gave barely lukewarm support to prepayment—and even then only if it were strictly voluntary.

At the same time, Morris Fishbein, MD, the powerful and influential editor of *JAMA*, became involved in the discussion in a passionate way. In 1932, in response to the Committee on the Cost of Medical Care reports, he wrote in an editorial that the committee members advocating prepaid health insurance represented "the great foundations, public health officialdom, social theory—even socialism and communism—inciting to revolution."[6] In the words of historians Lewis Weeks and Howard Berman, Fishbein's "characterization of health insurance, whether voluntary or public, served to set the dominant ideological and controversial note for some 33 years after that."[1] Efforts to achieve universal or at least broad health insurance coverage would continue unabated from then on; AMA opposition would continue into the late 1960s. Beginning around 1970, the AMA began to support moderate expansions of government-subsidized coverage.

It is interesting to note that the American Hospital Association took a different tack, approving the concept of voluntary

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hospital coverage in 1933 and playing a pivotal role in the creation and growth of Blue Cross. Later it also strongly supported the development of Medicare and Medicaid.

The long presidency of Franklin D. Roosevelt could have been a watershed period, given the wide range of social legislation he was able to usher successfully through Congress. Indeed, he might not have needed to submit a bill; the 1930s and 1940s were marked by repeated efforts on the part of congressmen and senators to enact their own proposals. Among the foremost proponents of increased coverage were Democratic senators Huey Long (D, La), Robert F. Wagner (D, NY), and James Murray (D, Mont), Rep John Dingell (D, Mich), and, in the 1950s, Rep Aime Forand (D, RI).

None of these bills would prove successful; the AMA, generally considered to be the most powerful lobby in the United States in those years, waged successful campaigns against most of them, usually joined by conservative Democrats and most Republicans.[1,2] Equally important was the fact that President Roosevelt declined to include health insurance in his New Deal in the 1930s because opposition to it would likely have derailed all his other proposed programs. The only initiatives that went to Congress in the mid 1930s—and passed—provided support for public health and maternal and child health activities.[1] Meanwhile, by the 1940s the infant Blue Cross and Blue Shield plans were making broader private coverage possible.

However, by 1943 the country was involved in World War II, and new needs were emerging. That year the Emergency Maternal and Infant Care Act was passed to provide access to care for the dependents of low-ranking members of the armed forces. In 1944, Roosevelt called for "the right to adequate medical care" in his State of the Union address; he made a similar statement early in 1945, but died on April 12 of that year.

His successor, Harry S Truman, was profoundly interested in the issue and immediately called for national health insurance, something he would do repeatedly. Another version of what was now called the Wagner-Murray-Dingell bill was introduced in Congress in 1945; like all the others, it failed to pass.

During the 1950s, activist congressmen and senators kept trying, and even the conservative Eisenhower administration supported modest subsidy of private insurance premiums for low-income individuals. Nothing much occurred beyond hearings and discussions, however, until 1957, when the canny Rep Wilbur Mills (D, Ark) became chairman of the House Ways and Means Committee. Highly skilled politically, although cautious, he believed in health care coverage for vulnerable Americans. Within 3 years, he had engineered passage of the Kerr-Mills legislation (1960), which provided federal funds to help certain states pay for medical care for low-income residents.

The Stage Is Set

The final push came when John F. Kennedy was elected president in 1960. He sent Congress a special message on health care early in his presidency, and in 1962, before a carefully assembled group of cheering senior citizens in Madison Square Garden, he called for universal access to care for the elderly. The AMA then rented Madison Square Garden, where 2 days later, the eloquent Edward Annis, MD, delivered the AMA's televised rejoinder to an empty stadium. It is generally thought that his speech was much better than Kennedy's had been.

But the AMA was losing the battle. Beginning in 1961, legislation sponsored by Sen Clinton Anderson (D, NM) and Rep Cecil King (D, Calif) was repeatedly introduced. It called for federal coverage of specified amounts of hospital, outpatient, nursing home, and home care for 14 million Social Security beneficiaries. It excluded physician services. It did not pass, but it drew a great deal of attention and support; indeed, hearings on the King-Anderson proposal were being held the day Kennedy was assassinated, November 22, 1963.

A plan similar to the King-Anderson bill nearly passed in 1964; a measure creating such a program passed the Senate that year, but died when House and Senate conferees could not work out a compromise. That November, Lyndon Johnson won a landslide victory in an election that also swept out of office many opponents of Medicare-type legislation in the House and Senate.

Thus, in 1965, the stage was set. Johnson, a master of congressional politics, was president. Mills was chairman of Ways and Means. The King-Anderson bill was once again introduced, this time as HR 1 and S 1, indicating its importance to the president.

Organized medicine was still officially opposed to the concept, but many physicians were not only more receptive; they were hoping to be eligible for any program that passed. The AMA's last offensive was to propose "Eldercare," which would have subsidized private coverage for the elderly with federal and state money. It, too, failed. However, the AMA did support Medicaid when it was proposed by Mills' committee.[4]

The Three-Layer Cake

Meanwhile, Rep John Byrnes (R, Wis) introduced a bill that also called for government subsidy of private insurance, but would pay for it, in part, with deductions from Social Security checks. Mills seized on Byrnes' idea of having beneficiaries pay premiums. He produced a three-part compromise. The first part would pay for physician services for Social Security beneficiaries; one third of the funds would come from co-payments and two thirds from federal funds. By co-opting Byrnes' idea, Mills essentially read the Republicans in on the act. The second part of the plan would cover hospital care through payroll and employer taxes.

The third part, which no one had expected, would broaden Kerr-Mills coverage of low-income Americans through a joint federal-state program known as Medicaid. It would also cover services for "aged, blind, or permanently and totally disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services."[5]

Medicaid was not exactly at the heart of the proposal; it was really an afterthought and was a rider on the main bill until shortly before passage. It was also peculiarly constructed. Medicaid would be grafted onto state welfare programs; federal funding would be computed according to a formula based on the wealth of each state; and unlike Medicare, which was a universal entitlement, Medicaid would be means-tested. Furthermore, states were given wide latitude in setting eligibility standards and benefits. Perhaps most tellingly, those covered under the program were referred to as "recipients," in keeping with the welfare mentality; those covered by Medicare were "beneficiaries," as in private insurance. A recipient could become a beneficiary through the simple act of turning 65.

Wilbur Cohen, who had worked in the Roosevelt administration, was serving as Johnson's undersecretary of health in the then-Department of Health, Education, and Welfare, and played a critical role in the enactment of the Medicare-Medicaid legislation. He later explained that there were reasons for the bizarre architecture of Medicaid.[1,5] First, the reason the program was created was that Kerr-Mills was not working satisfactorily, and

proponents of universal coverage were complaining bitterly that Medicare protected only the elderly. Since Kerr-Mills had been a state-federal partnership, Medicaid would be one as well.

Second, the only social agency present in every state was the welfare agency, so it made sense to house Medicaid there, rather than requiring states (some of which were not very enthusiastic about the program) to create a new bureaucracy.

Third, Cohen and his colleagues believed that either Johnson or Sen Hubert H. Humphrey (D, Minn) would be elected president in 1968, and that some form of national health insurance would follow shortly. As a result, Medicaid was put together in a rather slapdash manner, because it was assumed it would soon be superseded by a larger program. But Richard M. Nixon won the election, and the larger program never happened (although Nixon did propose one).

The political fighting wore on, with battles on several fronts. But Mills won the day. His bill passed the House on July 27 and the Senate on July 28. On July 29, Johnson met with a group of AMA leaders. He appealed for their cooperation, and read them the provision of the legislation that protected patients' ability to "obtain health services from any institution, agency or person qualified to participate" in the program.[7]

He also read them this provision: "Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided. . . ."[7] The president signed the bill into law on July 30, 1965.

A New Day

A month later, Kenneth Williamson, associate director of the American Hospital Association and a key figure in passage of the bill, wrote: "Although some of the implications of this new law can be visualized at this time, there is much that cannot. Only time and experience will reveal its full impact. One thing is certain: It is a new day in health affairs. Things are not the same either for hospitals or physicians or the public. Things will never be the same again."[8] He was right.

Some effects were immediate. Johnson, fearing a shortage of physicians in the face of the enfranchisement of millions of people, acted to increase enrollment in medical schools, a strategy that worked all too well. The number of Medicaid recipients was soon 10 times higher than expected, partially because estimates of need were based on extremely soft and dubious data, and partially because some states, seeking to attract federal funds, set eligibility levels quite high. In New York State, 45% of the population became eligible.[5]

Testifying before the Senate Finance Committee on May 11, 1965, then-AMA president Donovan F. Ward, MD, had warned that "there is no effective method or methods which will keep the costs of the program under control."[4] Although a world of good was done with the money, his prediction was entirely accurate. Even before some states had implemented their Medicaid programs, Congress was trying to slow down the explosion in costs.

The cascade of legislation bred by PL 89-97 in subsequent years included amendments in 1967 that limited states' ability to set high eligibility levels, and legislation, also passed in 1967, that established the National Center for Health Services Research, with a prime mission of gathering and analyzing data on cost, utilization, and other aspects of health care.[9] Amendments passed in 1972 provided for extensive Medicare coverage of services for patients with end-stage renal disease, inspired by news reports that castigated the rationing of kidney dialysis and by a kidney patient undergoing dialysis at a congressional hearing. That same year, Medicaid costs had risen so high that the original title's optimistic call for "comprehensive health care" for all the needy was repealed, giving states a freer hand to trim the program.

Medicare and Medicaid also gave birth to health planning legislation, which was passed in 1974 and was the object of intense opposition until it expired in the 1980s; professional standards review organizations and, later, professional review organizations, which scrutinize medical services for Medicare beneficiaries and are also less than universally popular; diagnosis related groups as the basis of hospital payment in 1983; and the resource-based relative value scale as the basis of physician payment in 1989. Legislation passed in 1973 set federal standards for health maintenance organizations, and various other statutes set standards and encouraged or prohibited certain provider behaviors.

Weeks and Berman[1] have written, "It is both a flaw and a strength of human nature that one tends to forget the circumstances that surrounded the need for and that shaped certain decisions and actions." There are few areas of policy in which that is more true than in Medicare and Medicaid.

The many laws, regulations, failures, and controversies that followed in their wake have tended to obscure the fact that, in many ways, these programs successfully addressed the problem they were supposed to fix: lack of access to, and financing for, health care services for some vulnerable members of this society.[10-12] By reducing the amount of money the elderly had to pay for health care, Medicare and Medicaid lifted millions of these people out of poverty, and kept them out; although Medicaid's track record is decidedly more mixed, there is ample evidence that it has contributed to both better access and improved health status for low-income women and children and many disabled people. Medicaid has also made a vast difference in the lives of millions of Americans who need nursing home care.[10-12]

Although that is the chief legacy of the programs, it is not the only one. Wilbur Cohen wrote of the Medicare and Medicaid experience, "It is always wise, when changes occur, to expect the unexpected."[13] If the programs fulfilled many of the hopes people had for them, they also produced a large number of consequences that were unintended.

Unintended Consequences

A Glut of Hospitals.—Stuart Altman, PhD, dean of the Heller School at Brandeis University and chairman (as of this writing) of the Prospective Payment Assessment Commission, has stated that when PL 89-97 was passed, hospitals were "underfinanced" and in need of capital; he believes that Medicare, with its generous capital reimbursement, was designed to help solve that problem.[14] However, it is axiomatic that if a person or organization is paid to do something, he, she, or it will do it; in the case of hospitals, this meant a 20-year building spree that eventually produced an overbuilt sector. As is the case with the physician oversupply and maldistribution, this expensive dilemma will be solved only with great pain.

Payment Inequities.—Howard Newman, the administrator of the Health Care Financing Administration in the last year of Jimmy Carter's presidency, has said that "Medicaid [and, by inference, Medicare] has been an important experience in terms of what happens when you pay for part of a health care system."[5] What happens, as it turns out, is cost shifting: hospitals, physicians, or other health care entities that seek higher payment than government programs offer simply compensate by charging private payers more.

As a result, private insurance costs started climbing, which, in time, led to an explosion in employer self-insurance and managed care, neither of which are so vulnerable to cost shifting. Premiums for smaller employers, who cannot conveniently self-insure, rose even faster, and the number of uninsured working Americans rose as well, as small employers found themselves unable to subsidize coverage.

Meanwhile, Medicaid's payment rates became so unattractive to physicians that in many states, physician participation in the program declined markedly, along with the availability of physician services to Medicaid patients. Patients who ended up on the wrong end of these events also tended to end up in hospital emergency departments. The compartmentalization of health care payment and the inevitable concomitant reduction in cross-subsidization can be traced back to diminishing Medicare and Medicaid payments over the years.

The Medicaid Christmas Tree.—Howard Newman also once observed that Medicaid's main problem was that it was too complicated.[5] Over the years, it only became more so. In the first place, it had at least four distinct groups of patients: families receiving welfare support, the blind, the low-income aged (for whom Medicaid paid Medicare physician [Part B] premiums), and the disabled. Each state had a different benefit package and income eligibility level, and some states chose to cover other groups as well.

Medicaid was soon serving another purpose. As Diane Rowland, ScD, executive director of the Kaiser Commission on the Future of Medicaid, has noted, the program became "the one train pulling out of the station that you could attach improvements to."[15] Especially in times of cutbacks, through the congressional budget reconciliation process, new programs, expansions of existing programs, and new dollars could be slipped into Medicaid. The program became a kind of Christmas tree, with maternal and child health hanging here, long-term care hanging there, AIDS services up there, care of the homeless down there, subsidy of migrant health centers over there. "In every instance, if you look at the problems we have been trying to solve over the last ten years, Medicaid became the logical vehicle to use," Rowland said in 1991.[15] Not surprisingly, the program also became the victim of a tug-of-war among the various constituencies it supposedly protected.

The Birth of an Industry.—Medicare and Medicaid also encouraged the growth of three health care endeavors. The original legislation included a 7.5% return on equity for investor-owned facilities, which helped fuel the expansion of for-profit hospital chains in the 1970s and early 1980s. It has been superseded since.

Medicaid legislation, with its open-ended coverage of nursing home services for those who could not afford them (and, in the course of a long illness, hardly anyone can), "really created the nursing home industry," in the words of Karen Davis, PhD, president of the Commonwealth Fund.[16] This has led to overdependence on institutional solutions and slow growth in home- and community-based alternatives. It can also be argued that it slowed what might have been quicker and more successful development of private long-term care insurance. Medicaid also covered care in "intermediate care facilities," which were ill-defined and really did not exist; as a result, applications for certification as intermediate care facilities were received from institutions as unlikely as orphanages and homes for unwed mothers.

The End of Segregation.—In one of its most important side effects, PL 89-97 put an end to segregation of health care facilities, a process that had started years before because of lawsuits by African-American physicians. On March 4, 1966, then-Surgeon General William H. Stewart, MD, issued an opinion stating that "to be eligible to receive federal assistance or participate in any federally assisted program, a hospital must be in compliance with Title VI [of the Civil Rights Act of 1964]," which "prohibits discrimination on the basis of race, color, or national origin in federally assisted programs."[17]

It was a historic and controversial ruling, but it was upheld in the courts, and one of the ugliest traditions in American health care slowly came to an end—at least in theory. The downside of this shift was that dozens of historically black hospitals closed as patients migrated to better-equipped, larger facilities.[17]

The Data Revolution.—Stuart Altman and Wilbur Cohen have both noted that some of the larger errors in the configuration of Medicare and Medicaid can be ascribed to an absence of reliable data.[14,18] Cohen, for example, pointed out that in terms of Medicaid, "We just thought that we were extending Kerr-Mills a modest bit. We thought in terms of several million persons, but never 10 or 20 million. . . . We saw it as a supplemental system to take care of a few residual cases."[5] Similarly, Karen Davis laments that "we didn't know much about long-term care back then."[16]

If that was the situation in 1965, it has changed radically; indeed, the health care system reform debate of 1994 was shaped by an avalanche of data, many of them conflicting. For a new science has been born: the desire for better information led to the discipline of health services research. And Medicare and Medicaid led to vast databases that those researchers could, and did, use. Many of the crucial tools in health care today, from study of medical practice pattern variations to utilization review to managed care, were refined and proven using Medicare and Medicaid data.

The Worst Fears Realized.—But the richest irony of all is that, in many ways, the AMA opponents of Medicare have been vindicated: for better or worse, many of their fears were well founded. Their concerns about skyrocketing costs were justified, as today the nation ponders how to prevent Medicare from running out of money in a few years. In 1961, an AMA leader stated that the fee schedule for hospitals, nursing homes, and nurses in the King-Anderson bill "panics the medical leadership. They anticipate a time when doctors' services will be covered and hence a fee schedule will be used."[3] That time did come, in 1989.

Part of the AMA campaign against King-Anderson included a poster directed to patients that read, in part: "Freedom is what we all stand to lose. Your freedom to choose the doctor you believe is best for you. And your doctor's freedom—his freedom to treat you in an individual way, adapting his knowledge and skills to your particular problems. . . ."[3] In an era of practice guidelines, closed-panel health maintenance organizations, and managed care, the poster's warnings seem eerie, with one exception: The diminution in patient and physician freedom of choice has largely occurred in the private sector and Medicaid. Medicare, the program the AMA fought tooth and nail, remains the last bastion of fee-for-service and unlimited patient choice of physician, along with those patients who choose to pay for care out-of-pocket.

What Can Be Learned?

It is unfortunate that few of the lessons of Medicare and Medicaid have been applied to recent health policy debates, or to those that are occurring in 1995. These programs have been the key forces shaping American health care for nearly a third of a century, and they have much to teach us.

Among those lessons is that policies and programs that are based on guesses or insufficient or inaccurate data will not look like what they were supposed to look like. However, that is true of any major new social program, with or without data. But even if data are available, they may not be used well; quantitative information can also destroy programs or prevent new ones from being initiated. We have gone from one extreme to another, from a data vacuum to data overload.

To paraphrase Howard Newman's observation cited earlier in this article,[5] paying for part of a population is also instructive. Of course, the dice were loaded to begin with against the means-tested Medicaid welfare patients, who were far weaker, politically, than the elderly who were covered by a universal entitlement and who would use the Medicaid long-term care benefit the most. That, as much as anything, explains the differing political fates of the two populations. Separating the powerless poor and the powerful elderly into different programs was not the best idea the framers of PL 89-97 had.

Medicare's granting of an entitlement to people with end-stage renal disease has also proven problematic.[19-22] It favored one diagnosis over another. It also skewed resources; kidney patients garner far more Medicare dollars than their numbers would suggest.[19] Equally troubling, in the words of dialysis pioneer Belding Scribner, MD, it produced a "lack of restraint" on the part of physicians who soon initiated dialysis with no use of clinical judgment. "Our learning curve was interrupted by the entitlement of 1972," Scribner said in 1984. "We have now gone to the opposite extreme."[20]

However, policymakers in such situations face Hobson's choice. If a program is universal, as Medicare is, it inevitably subsidizes wealthy beneficiaries. If it is means-tested, it will be politically weaker than an entitlement that includes the nonpoor, but it will target the vulnerable more precisely. That is, if it does not end up being the vehicle for a dozen or more different programs and agendas, as Medicaid did.

Medicaid and Medicare also have taught us that specifying the services to be covered will automatically create endless haggling. Especially when these programs' benefits influence private benefit packages, every possible health and health-related service and practitioner will demand to be part of the program. It is difficult to know where to draw the line, as state Medicaid programs have learned to their sorrow.

Delineating benefits precisely can be especially bothersome when they were not well thought out to begin with. Hindsight is often better, of course, but it is difficult not to question a Medicare benefit package that excluded most preventive care, eyeglasses, hearing aids, mammography (until 2 years ago), and most long-term care, but covered inappropriate kidney dialysis without question. On the other hand, an open-ended or vague benefit package can lead to widespread abuses and even fraud.

On the financial side, Medicare, especially, has taught a vital lesson, one that the AMA predicted 30 years ago: If a payer is big enough—and Medicare is—that payer will come to control much of what goes on in health care. And that payer's decisions will have an enormous influence on what the health care system comes to look like. American health care, once the fiefdom of physicians and hospitals, is now largely directed by third-party payers,[23] and that transfer of power began with PL 89-97.

Finally, we have learned in these 30 years that the making of health policy should be objective, bipartisan, and above petty politics—but that it never will be. This is due, in part, to the manner in which social programs are created: much of the time, the rich tax the middle class to pay for a program for the poor.[5] This almost guarantees that the program will be a bone of contention until its last gasp.

But the politics of health go beyond the politics of class; they are rooted in the fact that the health care system reflects every beauty and every wart, every triumph and every failure of the society that creates and sustains it. Therefore, the funding of health care, the shape of health care, the scope of health care, even the purpose of health care is, and always will be, in the eye of the beholder. As was true of Medicare and Medicaid, much of what succeeds will not do so through consensus, but rather through compromise, subtlety, incrementalism, luck—and, on occasion, desperation.

Medicare and Medicaid were supposed to last 5 or 6 years; they have lasted 30, and remain with us—incomplete, imperfect, illogical, and under attack, as always. Their survival is indeed remarkable, but it was not accidental. So far, we have been unable, as a nation, to come up with better means of addressing the basic, visceral human troubles that Medicare and Medicaid seek to alleviate; until we do, these programs remain the best answers we have. And their underlying mission remains necessary, even as they are reconfigured, as they have been so often. For no matter how many times they have failed, they have accomplished much; and it is painful to contemplate the burden of suffering that Americans would have borne without their protection.

Emily Friedman

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July 24, 1995

30TH ANNIVERSARY OF CONGRESSIONAL PASSAGE OF MEDICARE

DATE:	Tuesday, July 25
TIME:	10:00 am
LOCATION:	Cannon Caucus Room, Cannon House Office Building
FROM:	Alexis Herman Andre Oliver

I. PURPOSE

To commemorate the 30th anniversary of Congressional passage of Medicare/Medicaid, highlighting your commitment to protecting Medicare, securing its future financial viability, and contrasting Republican proposals to substantially cut Medicare to fund tax cuts for the wealthy.

II. BACKGROUND

HISTORY: On July 30, 1965, President Johnson, in the presence of former President Harry Truman, signed into law Medicare and Medicaid in Independence, Missouri at the Truman Library. That simple ceremony marked the end of a long struggle for Democrats trying to enact the measure.

President Franklin Roosevelt began the process with his vision for financial security for retired Americans by passing the Social Security Act in 1935. President Harry Truman proposed the a federal program of health insurance under Social Security during a special message to the Nation on November 19, 1945. President Kennedy made health care for seniors an issue in his 1960 campaign and saw his plan defeated in Congress.

President Johnson took over JFK's efforts on behalf of Medicare, urging enactment of a "medicare bill" during his "State of the Union" speech. During Senate debate on a bill to increase Social Security benefits in July of 1964, **Senator Albert Gore, Sr.** offered a medicare bill as an amendment. Although it was defeated that year, Senator Albert Gore called for the 1964 election to be a mandate on Medicare, a call that President Johnson took up as well. The Democrats that year picked up 37 House seats and two Senate seats, helping Congress to pass Medicare the following year.

With the majority of Republicans voting against Medicare, calling it socialized medicine, few issues have so consistently been identified with Democrats. Twelve times during its 30 year history it has needed steps to shore up its financial viability, and each time Democrats took the leadership to protect it.

EVENT: The National Council of Senior Citizens began organizing this event several months ago to recognize the 30th anniversary of when Congress gave final passage to Medicare and Medicaid (July 25). Rep. Gephardt has organized an additional recognition event in Independence on Sunday, July 30. Secretary Shalala will represent the Administration at the Independence event.

At the event will be the twelve members of Congress who voted for passage and still serve in Congress. One Republican remains, Congressman Joseph McDade (R-PA), and he plans to be at the event. Speaking on behalf of these twelve original signatories will be Senator Kennedy and Rep. Dingell. Standing next to you at the podium will be Arthur Flemming and four generations of his family, and Genevieve Johnson and four generations of her family.

At 90 years old, Arthur Flemming is probably the most recognized senior activist and advocate. His resume dates back to the Roosevelt Administration (1936) when he was appointed the youngest Civil Rights commissioner since Theodore Roosevelt. He has served in Eisenhower, Nixon, and Reagan Administrations, and has been President of Ohio Wesleyan University, University of Oregon, and Macalester College in St. Paul, Minnesota. In the Eisenhower Administration he served at secretary of HEW. It was during the Nixon Administration that he became the full-time chairman of the White House Conference on Aging and has retained that position ever since. He will be joined by three generations of his family to help send the intergenerational message.

At 96, Mrs. Genevieve Johnson is President of the National Council of Senior Citizens's District of Columbia State Council of Senior Citizens. Known by everyone as "Mother" Johnson, she is the founder of the annual District-wide senior citizens prayer breakfast. She was a founding member of the DC Commission on Aging and remains a leading advisor on issues of concern to the elderly. Mother Johnson is one of the earliest recipients of Medicare. She will be joined by three generations of her family to help send the intergenerational message.

The audience of 250 will be comprised largely of seniors, including Council on Aging delegates, organization leaders and seniors living in NSCS housing units.

The National Council of Senior Citizens was founded in 1961 for the sole purpose of winning enactment of a national health program to protect older Americans. It was closely aligned with labor and the Democratic Party to secure passage, and it was singled out in President Johnson's remarks at the signing ceremony, "without the National Council of Senior Citizens, there would have been no Medicare program." Eugene Glover has been President of NCSC since 1989, having retired from the International Association of Machinists and Aerospace Workers.

It will be important to recognize NCSC's commitment and dedication to Medicare and Medicaid in your remarks. Also, Larry Smedley, the NCSC's longtime executive director is retiring next week.

III. PARTICIPANTS

Speakers include Eugene (Gene) Glover, President of the National Council of Senior Citizens; Congressman Dick Gephardt, Senator Tom Daschle, Senator Edward Kennedy, Congressman John Dingell and the Vice President. Also on the podium, but not speaking will be Arthur Flemming, Genevieve (je-ne-veeve) "Mother" Johnson and their families.

IV. SEQUENCE OF EVENTS

- President arrives Cannon Caucus Room
- Eugene (Gene) Glover begins program
- Congressman Gephardt gives remarks
- Senator Daschle gives remarks
- Senator Kennedy, Congressman Dingell give remarks (representing the original signers from each body)
- Vice President gives remarks, introduces the President
- The President gives remarks.
- On conclusion of remarks, the President heads towards "Mother" Johnson and Arthur Flemming families for informal greetings before departure.

V. Press

Open Press

VI. Remarks

Prepared by Speechwriting

July 18, 1995

MEMORANDUM FOR **MOLLY BROSTROM**
CHRIS JENNINGS
JENNIFER KLEIN

FROM: Zoë Neuberger
Katie Smeltz

SUBJECT: Medicare

You will find attached the information and quotes we have gathered on Medicare. The material is divided into four sections:

- The original debate (Democratic statements in support of Medicare and Republican statements against it)
- Quotes from Congress (recent statements on Medicare and proposed spending cuts by Democrats and Republicans)
- Quotes from advocacy groups (statements on proposed Medicare and Medicaid spending cuts by health care, senior, child, and people with disabilities advocacy groups)
- The impact of Medicare and Medicaid on seniors

THE ORIGINAL DEBATE

The Social Security Act amendments establishing Medicare were approved by the House on April 8, 1965. The vote was 313-115. Republicans voted 65-73 and Democrats voted 248-42. Then Representative Bob Dole voted against Medicare.

Medicare was approved by the Senate on July 9 by a vote of 68-21. Democrats voted 55-7 and Republicans voted 13-14.

President Johnson signed Medicare into law on July 30, 1965.

The AMA opposed Medicare. (Source: *Congress and the Nation, Volume II*)

Democratic Statements For Medicare (1965)

Source: Democratic Policy Committee, United States Senate, Special Report: *Medicare's 30th Anniversary*, July 14, 1995. (DPC)

Senator Gore:
"We are dealing with the most pressing, unmet problem of our society... What happens when a serious illness strikes? Current income which is needed for groceries and rent must go for medical care. Savings must be depleted. The home may have to be sold. Then, hat-in-hand, this formerly self-sufficient, self-reliant, respected member of the community must go to the welfare people and beg for a handout. This is a disgrace in a country such as ours."

President Johnson before Congress:
"the specter of catastrophic hospital bills can (now) be lifted from the lives of our older citizens."

Democratic Rep. Cecil King (CA), introducing the first medicare bill:
"...We can no longer permit hospital costs - to deprive our elderly citizens of the security and peace of mind that should be their due after a lifetime of work."
"We will be able to take great pride in having had a hand in bringing financial security and peace of mind to millions of older Americans."

Democratic Senator Anderson:
"I feel certain that historians will mark this year as the turning point in our long struggle to solve . . . the problem of financing the costs of hospital care for the aged, costs which now represent the major remaining cause of personal financial disaster among our aged citizens."
"Every month that delay in providing the needed protection means that more and more elderly persons will be forced to look to public welfare programs for help in getting the health care they need."

Republican Statements Against Medicare (1965)

Source: Democratic Policy Committee, United States Senate, Special Report: *Medicare's 30th Anniversary*, July 14, 1995. (DPC)

They called it socialism.

Republican Representative James Utt (CA):
"Let me tell you here and now it is socialized medicine."

They said it would destroy the best health care system in the world.

Republican Senator James Pearson (KS):
"American medicine has achieved an unprecedented level of development through its own efforts... It would appear foolish to endanger this high level of initiative and performance by imposing the heavy blanket of government supervision. A Federal health program, financed under Social Security, would represent such a danger."

They said it would not work.

Republican Senator James B. Pearson:
"It would achieve little for those who need it, while subjecting the very fabric of American life to the strain of severe and unnecessary sacrifices."

They said it was too bureaucratic.

Republican Senator Roman Hruska:
"With Federal funds come federal control. In the area of medical care, Federal interference presents frightening prospects."

Republican House Leader and future President Gerald Ford (MI): "We are going to find our aged bewildered by a multiheaded bureaucratic maze of confusion over what program covers what and who is on first base."

And they said it was a threat to Social Security.

Republican Representative Bob Dole (KS):
"The real opposition to the bill stems from the fact hospitalization benefits are to be financed by a compulsory payroll tax ... Adequate medical protection should be made available to the aged but it should be voluntary and should reflect the ability to pay... This one provision poses an enormous threat to the cash benefit programs under the social security programs."

QUOTES FROM CONGRESS

The leadership, then and now

Senator Bob Dole

Bob Dole voted against Medicare in 1965.

1965:
"The real opposition to the bill stems from the fact hospitalization benefits are to be financed by a compulsory payroll tax ... Adequate medical protection should be made available to the aged but it should be voluntary and should reflect the ability to pay... This one provision poses an enormous threat to the cash benefit programs under the social security programs." (DPC)

July 30, 1985:
"Much of our significant gains and life expectancy, improvement in the quality of life, and decreases in infant mortality can be directly attributed to the passage of the Social Security Amendments of 1965. The Medicare and Medicaid programs have played a central role in improving both access to and quality of health care services for the country's elderly, poor, and disabled. Equally significant, it may be argued that Medicare and Medicaid have provided a foundation for the phenomenal growth and the dissemination of new medical technologies that now contribute to the well being of all the people of all nations." (DPC)

May 8, 1995:
Said "it's going to be very difficult" to save money without reducing benefits or raising premiums. (*The New York Times*, May 8, 1995)

Speaker Newt Gingrich

January 30, 1995:
"we are going to rethink Medicare from the ground up"
"We will make every decision within the context of a balanced budget"
"Everything is on the table except social security" (*The New York Times*, January 31, 1995)

April, 1995:
Described Medicare as "a centralized bureaucracy with all the inefficiency and all the obsolete technology and all the obsolete approaches and all the waste and fraud you would associate with a centralized bureaucracy." (*Newsday*, May 3, 1995)

May 1, 1995:
"Every penny saved in Medicare should go to Medicare . . . It should not be entangled in the budget debate." (*The Wall Street Journal*, May 1, 1995)

May 7, 1995:
"Forget the budget pressure, let's find out what number saves Medicare. We'll plug that into the budget. We're not going to find out what number the budget needs and try to reshape Medicare to that effect." (Democratic Staff of the Committee on Ways and Means, United states House of Representatives, *Previous Republican Statements on Cutting Medicare*, May 8, 1995)

House Majority Leader Richard Armey

Describes Medicare as "a program I would have no part of in a free world" and "deeply resents the fact that when I'm 65 I must enroll in Medicare." July 10, 1995 (*Chicago Tribune*, July 11, 1995)

Republican Representatives during the 1994 health care reform debate

(Source: Democratic Staff of the Committee on Ways and Means, United states House of Representatives, *Previous Republican Statements on Cutting Medicare*, May 8, 1995.)

Members of the House Ways and Means Committee commented on the Health Security Act, which would have achieved $168 million in Medicare savings over seven years, all of which would have been redirected to expand health care coverage. Republicans now propose to reduce Medicare spending by $270 million over seven years and not reinvest the savings in health care.

Congress Member Bill Archer (June 25, 1994):
"Make no mistake about it for the elderly in this country, [these cuts are] going to devastate their program under Medicare."
"I just don't believe the quality of care and availability of care can survive these additional cuts. And that is the price that is going to have to be paid to pay for these cuts. "

Congress Member Clay Shaw (June 25, 1994):
"The Medicare cuts proposed by the President would devastate the Medicare program . . . The committee must not approve these destructive Medicare cuts." May 18, 1994
"The Republicans are attempting to secure the program which would be almost absolutely destroyed and trashed if the cuts that have been brought into the bill are established."

Congress Member Jim McCrery (June 25, 1994):
"I would love to believe that we could achieve the level of cuts that you have in this bill . . . But history tells us that this isn't possible."

Republican members of the House Ways and Means Committee (July 14, 1994):
"For more than a decade Congress has cut back on payments to doctors and hospitals until they no longer cover the cots of care for Medicare . . . patients--and the additional massive cuts in reimbursement to providers proposed in this bill [H.R. 3600] will reduce the quality of care for the nation's elderly. There will be no place else to shift."

Democratic statements supporting Medicare

President Clinton (October 23, 1994):
"My position is, I haven't and don't support cuts in Social Security, and I would support savings in the Medicare program only if they're used to advance the cause of health care."

Senator John D. Rockefeller IV (WVA) (April 22, 1995):
"Though they [the Republicans] claim they want to save the Medicare trust fund, they don't plan to put the savings in the fund. It's all for deficit reduction or tax cuts." (*Congressional Quarterly*)

QUOTES FROM ADVOCACY GROUPS

The Association of American Medical Colleges says:

"Massive reductions in Medicare reimbursement for activities related to graduate medical education will, when coupled with private sector losses, and other cuts in Medicare reimbursement, have a very negative impact on our continued excellence. Every American's quality of life will suffer as a result." (July, 1995)

"... budget proposals that could cut billions of dollars in funding will devastate academic medicine's ability to care for the American people and to ensure quality through medical education and research."(May 16, 1995)

"Funding cuts of this magnitude will push medical schools and teaching hospitals to the brink of financial ruin and put our nation's highest quality health care services in serious jeopardy."(May 16,1995)

Jordan Cohen, president of the Association of American Medical Colleges, said, *"We are concerned about the prospect of losing as much as 60 percent of the $5.2 billion a year that teaching hospitals get from Medicare for the 'indirect' and 'direct' costs of training residents and other health professionals." (July 15, 1995)*

The American Hospital Association says:

"One of every four hospitals in the United States is in 'serious trouble,' and with deep reductions in Medicare growth will be forced to cut services or 'close its doors.'" (April 13, 1995)

"The wrong way [to reform Medicare] is to do business as usual, letting short-sighted political pressures squeeze Medicare spending and weaken a program that needs to remain strong for our nation's seniors." (February 6, 1995)

"Sixty-four percent of the electorate believes that if you ran for office saying that you would not cut social security, and if Congress votes this year to cut Medicare then that Member of Congress has broken their campaign promise." (April 1995 Polling Data Report)

The American Medical Association says:

"A balanced budget cannot be 'balanced' on the back of one program and those who provide that program's services. Serious, and perhaps irreversible, consequences to patient care could flow from yet another series of ill-considered cuts." (April 6, 1995)

The Catholic Health Association says:

"If Medicare and Medicaid payments, which provide 40 to 60 percent of all reimbursements, are cut by more than 20 percent, the result will be nothing less than devastating...nursing and

physician staffs will have to be cut, research and training programs will need to be reduced, whole medical departments may even have to be eliminated, and purchases of new medical technologies may have to be postponed or foregone completely..." (March 16, 1995)

"Catholic Health Association opposes the severity of the Medicare and Medicaid spending reductions proposed in the congressional Budget Resolution. They are too large, unprecedented, and unacceptable. If enacted, they could threaten the viability of these two publicly-funded health insurance programs and endanger continuity of services to the elderly, vulnerable women and children, and people with disabilities." (July 17, 1995)

"Catholic Health Association opposes transforming Medicaid into a block grant program. Any attempt to restructure the Medicaid program should maintain federal minimum standards for Medicaid eligibility and services." (July 17, 1995)

The Federation of American Health Systems says:

"Cuts of this magnitude are far too severe for the system to handle." (July 15, 1995)

The American Association of Retired Persons says:

AARP has conducted numerous focus groups across the country in the last few months' and found that the elderly had little idea that the new Republican-controlled Congress wants to cut projected Medicare spending over the next seven years by as much as $300 billion dollars. (July, 1995)

AARP estimates that these proposals to reduce Medicare spending would mean that the average Medicare beneficiary would pay approximately $3,400 more out-of-pocket over the next seven years. Estimates are based on the assumption that one-half of proposed Medicare spending reductions come from beneficiaries. (July 15, 1995)

"Interest groups such as the AARP and the medical associations, as well as many Democrats, agree that Medicare's finances need urgent attention. So far, however, they have argued that the financial issues cannot be addressed alone but rather in the context of a broad health care reform effort." (July 15, 1995)

"Medicare was hardly discussed in the last election; and there was certainly no mandate from the electorate to change the system." (March 28, 1995)

The National Committee to Preserve Social Security and Medicare says:

"Reductions of the magnitude discussed by Congressional leaders will jeopardize the viability of this important program and hurt society's most vulnerable citizens." (May 2, 1995)

The National Council of Senior Citizens says:

"What is being contemplated is the undermining of the cornerstone of the American health insurance system. We see a disruption of health services for millions and a threat to

thousands of health care institutions which depend on a stable Medicare system" (April 1995)

"The facts do not warrant a panic approach or a fundamental recasting of Medicare. The trust fund is not about to go belly-up; a seven-year window does not merit a panic button." (April 1995)

"The levels of the cuts in Medicare contemplated will not just devastate the finances of millions of older citizens but more importantly, they will devastate the hopes for a secure and healthy old age for all Americans." (April 1995)

The Older Women's League says:

"We receive hundreds of letters from women who are already forced to choose between paying for food or rent and buying much needed medicine that is not covered by their Medicare. Substantial cuts in Medicare will literally take food out of the mouths of these older women. Medicare must be protected and strengthened. Efforts to control Medicare spending should be part of a system-wide approach to cost containment and should not simply shift costs to beneficiaries and providers." (July, 1995)

The National Association of Manufacturers says:

"Across the board reductions in [Medicare and Medicaid] should be avoided, since they are likely to exacerbate cost-shifting to the private sector." (February 11, 1995)

Medicaid Specific:

20 major health care provider organizations including American Hospital Association, American Medical Association, American Health Care Association, Federation of American Health Systems, National Association of Children's Hospitals & Related Institutions, and Catholic Health Association say:

"Medicaid cuts could devastate families...by the end of the decade, drastic Medicaid cuts could result in 31% fewer Americans receiving financial help with long term care... dramatic reductions will seriously jeopardize the ability of doctors, hospitals, and others to continue providing high-quality health care to our nation's elderly, disabled, women, and children."(May 17,1995)

The Women's Legal Defense Fund says,

It would be devastating to women if in the effort to dramatically cut government spending, Congress destroyed Medicaid -- a health care program of unparalleled importance to women and their children. More than 25 million women and their children rely on Medicaid for essential health care services. They receive life-saving services like treatment for heart disease and cancer, long term care services, and critical preventive services such as prenatal care, immunizations, family planning services, Pap smears and mammograms.

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001. memo	Personal (Partial) (1 page)	07/18/1995	P6/b(6)

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b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

The Alzheimer's Association says:

"The elderly who rely on Medicaid do not have options. Without these benefits, many would literally have to make impossible choices between food, shelter and health care. Their health problems are not going to go away, and they are not suddenly going to find hidden resources to pay their health bills. There are not any easy alternatives for meeting their health and long term care needs."(July, 1995)

"Medicaid is not perfect. But Congress will not solve the problems in the program by abdicating the federal role and sending the money out to the states in a block grant. It could just make matters worse." (July, 1995)

Families USA Foundation says:

"These cuts would pull the rug out from under the sick, the elderly, vulnerable women, children and people with disabilities who rely on health and long term care protection from Medicaid and Medicare." (July 15, 1995)

Karen (b)(6) of (b)(6) whose seven-year-old daughter, Alison, has a disabling illness, said:

> *"Deep cuts in Medicaid home care would force many families like mine to face financial ruin. A terrible illness can strike a family at any time. Disabilities know no boundaries and have no prejudice of sex, age, race, economic status or political affiliation. As members of Congress consider cutting Medicaid, they should remember this: Medicaid gives us the peace-of-mind of knowing that if something horrible happened it would not have to tear our families apart." (July 15, 1995).*

"Extreme and disproportionate cuts in the Medicaid program will push more Americans into a health crisis...cuts of this magnitude will endanger the millions of Americans who only have the Medicaid program to provide them with basic and essential health and long term care services." (May 1, 1995)

The Children's Defense Fund says:

"Some governors are seeking total state flexibility, through a Medicaid block grant, to determine eligibility and benefits, while projecting that they would continue to cover children and pregnant women at current eligibility levels. Maternal and child health advocates appreciate their commitments. However, we have several concerns. States will be forced to seek ways, in addition to managed care, to save money, including changes in eligibility and coverage, which disproportionately affect children." (July 15, 1995)

Medicaid now covers nearly one-third of the births in this country and covers more than 17 million children overall -- one in four children. Given the long-term trend of steadily eroding private health insurance, it is imperative to preserve the national Medicaid safety net for pregnant women and children. Doing otherwise could add significantly to the numbers of uninsured children and pregnant women. (July 15, 1995)

"States could make these cuts in several ways: by raising taxes substantially; by excluding groups of children from programs or putting them on waiting lists; by reducing benefits or the quality of services; or by making low-income families pick up more costs through co-payments and fees. Regardless of which method is chosen, the overall effect would be large." (April 19, 1995)

The Consortium for Citizens with Disabilities says:

"Proposals to significantly cut Medicaid would disproportionately affect people with disabilities and would have a devastating impact on them. For many people with disabilities, Medicaid is the only way they can access health services." (April 1995)

If Medicaid is no longer an entitlement, millions of people, including those on SSI, will lose access to critical health and long-term services and supports. For persons with disabilities the lack of services and supports may well lead to an exacerbation of existing health conditions, the emergence of additional health problems and.secondary disabilities, and in some cases, to inappropriate institutionalization. (July, 1995)

THE IMPACT OF MEDICARE AND MEDICAID

Medicare

- Prior to the enactment of Medicare, 50% of America's elderly had no health insurance. Today, 97% of America's senior citizens are insured by Medicare. (HCFA)

- Medicare has dropped the poverty rate among America's elderly by 13.4 percent. (DPC)

- Before Medicare's enactment, hospital discharges for the elderly were 190 for every 1,000 admissions; by 1973, that number had climbed to 350 discharges. (HCFA)

- Medicare has contributed significantly to an increase in life expectancy. In 1960, men who survived to the age of 65 could expect to live to age 78; today, they would reach age 81. The gains for women are slightly higher. (HCFA)

- More than 36 million Americans are protected by Medicare. (DPC)

- Nearly 83% of Medicare spending is for seniors who live on annual incomes of less than $25,000. (HCFA) Only 3 percent goes to elderly individuals or couples with incomes in excess of $50,000. (DPC)

President Clinton:
- "In 1982 . . . it became true for the first time that older Americans were less likely to be poor than the average American." (White House Conference on Aging)

President Clinton:
- "since 1959, the poverty rate among the elderly has declined by more than 65 percent." (White House Conference on Aging)

- 89 percent of Americans want Medicare to continue. 75 percent of Americans oppose cutting Medicare in order to balance the budget. (DPC)

- Medicare's administrative costs average two percent of program outlays, compared with 25 percent in small group market plans and 5.5 in large group plans. (DPC)

- Recent Kaiser Family Foundation research found that seniors have "peace of mind" because of Medicare, which they characterized as 'care without worries.' The Kaiser survey found that beneficiaries applaud the program because it is: "affordable," "provides secure health for most," and "offers easy, automatic enrollment." (HCFA)

Medicaid

- One out of every nine Medicaid beneficiaries are elderly, for a total of 4.1 million elderly people. In 1993, the average state Medicaid expenditure for each elderly beneficiary was $8,704, which is nine times what was spent on each enrolled child. Medicaid pays for half the nation's nursing home costs. (*Congressional Quarterly*, June 10, 1995)

Document No. _____

WHITE HOUSE STAFFING MEMORANDUM

DATE: 07/24/95 ACTION/CONCURRENCE/COMMENT DUE BY: ASAP

SUBJECT: PRESIDENTIAL REMARKS: MEDICARE EVENT, 07/25

	ACTION	FYI		ACTION	FYI
VICE PRESIDENT	☐	☐	McGINTY	☐	☐
PANETTA	✓	☐	NASH	☐	☐
McLARTY	☐	☐	QUINN	☐	☐
ICKES	☐	☐	RASCO	☐	☐
BOWLES	✓	☐	SOSNIK	✓	☐
RIVLIN	☐	☐	STEPHANOPOULOS	✓	☐
EMANUEL	☐	☐	TYSON	✓	☐
GEARAN	☐	☐	WEBSTER	☐	☐
GIBBONS	☐	☐	WILLIAMS	☐	☐
GRIFFIN	☐	☐	SPerling	✓	☐
HALE	☐	☐	J. Klein	✓	☐
HERMAN	☐	☐	Baer	☐	✓
HIGGINS	☐	☐	_____	☐	☐
LAKE	☐	☐	_____	☐	☐
LINDSEY	☐	☐	_____	☐	☐
MIKVA	☐	☐	_____	☐	☐
McCURRY	✓	☐	_____	☐	☐

REMARKS: Please provide any comments to Don Baer.

RESPONSE:

Staff Secretary
Ext. 6-2702

REMARKS BY PRESIDENT WILLIAM JEFFERSON CLINTON
30TH ANNIVERSARY OF MEDICARE
THE U.S. CAPITOL
JULY 25, 1995

95 JUL 24 P9:53

[Acknowledgements: Vice President Gore for introduction; Eugene Glover, President, National Council of Senior Citizens (NCSC); Larry Smedley, retiring Executive Director, NCSC; Senator Kennedy; Senator Daschle; Congressman Dingell; Congressman Gephardt; Dr. Arthur Fleming and family; Genevieve "Mother" Johnson and family, 96-year-old seniors' advocate and president of NCSC's D.C. State Council of Senior Citizens]

Standing here in the shadow of the U.S. Capitol, we also stand in the light of all of you and so many others who worked so hard to create the great social contract we call Medicare.

We stand in the light of Franklin Roosevelt, who understood more than 60 years ago society's moral obligations to its elders.

We stand in the light of Harry Truman, who said more than 50 years ago that the time had come for America to help its senior citizens achieve and enjoy good health.

We stand in the light of John F. Kennedy who would not live to see his dream of health security for older Americans realized.

We stand in the light of Lyndon Johnson, who on July 30, 1965 honored millions of older Americans who had looked with such hope to that day. He said, "There are those, alone in suffering, who will now hear the sound of some approaching footsteps coming to help. There are those fearing the terrible darkness of despairing poverty -- despite their long years of labor and expectation -- who will now look up to see the light of hope and realization."

Thirty years ago the American people reached common ground on the need to provide guaranteed health security to older Americans. One generation came together and demanded the passage of Medicare so that another generation would be protected and they themselves could look forward to that same protection. It took vision and courage. It ~~took the joint efforts of Democrats and Republicans~~. It took the common sense to apply those same values that we use in our families to our larger national family: We must take care of those who have taken care of us.

It is important to remember what our nation looked like before Medicare. Fifty percent of the elderly had no health insurance. Older Americans who had fought our wars and built this country from the ground up were forced to choose between food and shelter and medical care. Men and women who had given a life-time to raising families and serving their communities were one illness

Some crowd who hailed it & killed our hc plan last year.

Forgot that Medicare was a govt program.

And I'm not going to let the govt mess with your Medicare!

I thought Medicare had moved from partisan pol- become part of our social compact w/ generations

away from total destitution. As the Vice President's father, Senator Al Gore, Sr. said in 1965, this was "a disgrace in a country such as ours."

The American people deserved better, and many of you in this room were directly responsible for what has become, along with Social Security, the most important legislation on behalf of American seniors in the history of this great country.

And Medicare has worked. It has relieved older Americans of the terrible anxiety they suffered when they had no way to pay for care. It has given new meaning to a value as old as America: the belief that all Americans should have the chance to make the most of their own lives -- for as long as they live.

And let's not forget that America gave birth to twins in July of 1965. The same legislation that created Medicare also created Medicaid, which provides desperately needed health care for children, their mothers, older and disabled Americans. Fully two-thirds of the Medicaid budget goes to care for older Americans and disabled citizens. Without Medicaid, middle class families struggling to raise and educate their children, would face nursing home bills for their parents that average $38,000 a year. So we need to celebrate and recommit ourselves to Medicaid today too.

As I have said, we are at a historic moment. For the first time in a long time, ~~leaders of both parties~~ agree that we must balance the budget. And we agree we must take steps to insure that the Medicare Trust Fund remains strong. ~~My balanced budget~~ does both.

But, beyond that, the Congressional majority is ~~calling our common ground into question~~. Some in Congress would choose for the first time ever to use the benefits we provide under Medicare as a piggy-bank to fund their huge tax cuts. That is wrong.

~~My balanced budget plan~~ provides for no new Medicare cost increases for older Americans. But, the majority in Congress passed a very different plan. They would cut $270 billion dollars from Medicare and raise Medicare premiums and out-of-pocket costs by $700 a year.

And why must their budget come down so hard on Medicare beneficiaries while mine can afford to protect them? The difference is simple. They want to use Medicare cuts to pay for a huge $245 billion tax cut. I have proposed a $105 billion tax cut that benefits middle class Americans who need it most. If they targeted their tax cut, as I have, we would not need one penny of the Medicare beneficiary cuts they propose.

The cuts proposed by the Congressional majority mean that for the

first time in 30 years, we are at risk of retreating from our common ground. Millions of older Americans face the real risk of not being able to afford the medical care most have today.

Sounds like a good deal.

The Congressional majority's plan would provide older Americans with vouchers for a set amount each year. The voucher would supposedly cover enough to buy medical insurance. But each year, private health care costs would increase ~~30~~ over 40 percent more than the value of a voucher.

If you are over 65 and in the best of health, this might work for you. But what if you get sicker as you get older? If the vouchers are inadequate, the elderly must make up the difference out of their own pockets. There is no clear provision to give a larger voucher for a patient with cancer than for one who is healthy. There is no clear provision to stop companies from turning people down based on their medical condition. There is no clear provision to stop companies from cutting people off when they get sick.

change w/out wrecking — don't buy a pig and a pok

In the past, various experts have suggested that the Medicare budget cuts will inflict harm and financial suffering on the elderly. But as the grisly details of this plan become known, it is becoming clearer and clearer that it will also actually deny medical care to elderly who need it. In all but dire emergencies, it is all too easy to see how millions of older Americans will actually be denied the medical attention they need.

Here are some examples of how that might happen. A 75 year-old woman has exhausted her savings and is too sick to work. Her voucher isn't enough to permit her to afford any health insurance plan. She would have to reach into her own pocket, but her pocket is empty. She can't get into a hospital unless it's a dire emergency because she can't pay the $750 deductible. And she can't go to a doctor's office, because she can't pay the extra premium. Now that woman is stuck. And she can't get care.

Or take the man who is 75 years-old now. He gets a voucher that just about covers the cost of his health insurance. In three years, his voucher goes up by only five percent a year. But his premium goes up by ten percent a year. After three years, the gap is so wide that he can't afford to pay. He dropped his Medigap coverage because he was persuaded the voucher system would work. Now that man is stuck. And he can't get care.

A 70 year old man has just had open heart surgery. He has recovered enough to go home and be treated by a visiting nurse. But under the plan of the Congressional majority, he must pay $1700 in copayments to get the visiting nurse. He can't afford that, so he stays in the hospital for months, at three or four times the costs. Now that man is stuck. And he too can't get care.

Those who want to keep what they have now will have to pay significantly more. Every person on Medicare will pay $1650 more over 7 years in premiums to cover their doctor bills. The average person who receives care in their own homes will pay at least $1700 more in the year 2002 alone. Remember, these are people who already pay 21 percent of their income on health care.

Can the elderly afford $1650 more for premiums to cover doctor bills?

Can they afford $1700 more for home health care in one year alone?

Will vouchers cover them against sudden premium increases if they get sicker?

Will medical care costs stay sufficiently under control to permit the vouchers to cover the full costs of care?

Is it fair to make older Americans give up their doctors and be forced into managed care?

I believe the answer to all these questions for millions of our elderly is: No. Those who want to gamble with Medicare are asking older Americans to bet their lives. And why must they bet their lives? Not to balance the budget. We can do that anyway. But the Congressional majority cuts $146 billion more than I want from Medicare to pay out $140 billion more than I want in tax cuts. America must decide if it's worth it. I say no.

Didn't use -- just to pay for huge tax cut.

We can balance the budget, ~~while~~ protecting older Americans from any Medicare cost increases. The way to do it is to require insurance plans to cover those with pre-existing conditions. To make a commitment to preventive and long-term care. To encourage home care as an alternative to nursing homes. To let workers take insurance coverage with them when they change jobs. To crack down on fraud and abuse, and improve the health care system.

Ken-Kass bill goes part of the way.

And most of all, we need to achieve these reductions over a decade -- not try to compress them into seven years as the majority in Congress proposes.

So, let us come back to the common ground we have all held for thirty years. Let the Congress join me in four basic principles:

1. We must be sure all that good, affordable health care is available to older Americans.

2. We must not cut Medicare ~~just~~ to have a bigger tax cut that goes to people who don't need it.

3 We must reduce medical cost inflation over a decade through real reforms -- not by destroying Medicare.

APPLAUSE

Option to choose man. care -- not force them.

Stabilize Trust Fund.

4. We must not attempt to balance the budget by cutting ~~medical~~ health care for older Americans.

~~Medicare~~ originally was not just common ground between Democrats and Republicans. More important, it was common ground between generations of Americans. Younger Americans could use their resources to send their children to college, because if their parents became sick, Medicare was there. And it has been there now for an entire generation of American families. But if the Congressional majority has its way about Medicare, the average American family will have to choose between opportunities for their children and compassion for their parents.

That is not the way to strengthen our families. More than anything else, the achievement we celebrate today is really about the sacred bonds between generations. We expect and hope that people who have gained and given so much from and to America will keep their commitments to the generations that come after. That means support for health care, safe communities and the education and training opportunities we know all our young people need to compete in the global economy. That is the obligation that one generation has to the generations that come after.

But that obligation goes in both directions. Just as we must pass down the chance for stronger lives to those coming after, so too we must keep faith with those who have come before. Medicare, as much as anything we have done in the last half century, is about keeping that faith -- and I am committed to keeping it strong for the future. With your help, that is exactly what we will do.

Thank you and God bless you.

7/24/95

REMARKS BY PRESIDENT WILLIAM JEFFERSON CLINTON
30TH ANNIVERSARY OF MEDICARE
THE U.S. CAPITOL
JULY 25, 1995

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who had given a life-time to raising families and serving their communities were one illness away from total destitution. As the Vice President's father, Senator Al Gore, Sr. said in 1965, this was "a disgrace in a country such as ours."

The American people deserved better, and many of you in this room were directly responsible for what has become, along with Social Security, the most important legislation on behalf of American seniors in the history of this great country.

And Medicare has worked. It has relieved older Americans of the terrible anxiety they suffered when they had no way to pay for care. It has given new meaning to a value as old as America: the belief that all Americans should have the chance to make the most of their own lives -- for as long as they live.

And let's not forget that America gave birth to twins in July of 1965. The same legislation that created Medicare also created Medicaid, which provides desperately needed health care for children, their mothers, older and disabled Americans. Fully two-thirds of the Medicaid budget goes to care for older Americans and disabled citizens. Without Medicaid, middle class families struggling to raise and educate their children, would face nursing home bills for their parents that average $38,000 a year. So we need to celebrate and recommit ourselves to Medicaid today too.

As I have said, we are at a historic moment. For the first time in a long time, leaders of both parties agree that we must balance the budget. And we agree we must take steps to insure that the Medicare Trust Fund remains strong. My balanced budget does both.

But, beyond that, the Congressional majority is calling our common ground into question. Some in Congress would choose for the first time ever to use the benefits we provide under Medicare as a piggy-bank to fund their huge tax cuts. That is wrong.

My balanced budget plan provides for no new Medicare cost increases for older Americans. But, the majority in Congress passed a very different plan. They would cut $270 billion dollars from Medicare and raise Medicare premiums and out-of-pocket costs by $700 a year.

And why must their budget come down so hard on Medicare beneficiaries while mine can afford to protect them? The difference is simple. They want to use Medicare cuts to pay for a huge $245 billion tax cut. I have proposed a $105 billion tax cut that benefits middle class Americans who need it most. If they targeted their tax cut, as I have, we would not need one penny of the Medicare beneficiary cuts they propose.

The cuts proposed by the Congressional majority mean that for the first time in 30 years, we are at risk of retreating from our common ground. Millions of older Americans face the real risk of not being able to afford the medical care most have today.

The Congressional majority's plan would provide older Americans with vouchers for a set amount each year. The voucher would supposedly cover enough to buy medical insurance. But each year, private health care costs would increase 30 percent more than the value of a voucher.

If you are over 65 and in the best of health, this might work for you. But what if you get sicker as you get older? If the vouchers are inadequate, the elderly must make up the difference out of their own pockets. There is no clear provision to give a larger voucher for a patient with cancer than for one who is healthy. There is no clear provision to stop companies from turning people down based on their medical condition. There is no clear provision to stop companies from cutting people off when they get sick.

In the past, various experts have suggested that the Medicare budget cuts will inflict harm and financial suffering on the elderly. But as the grisly details of this plan become known, it is becoming clearer and clearer that it will also actually deny medical care to elderly who need it. In all but dire emergencies, it is all too easy to see how millions of older Americans will actually be denied the medical attention they need.

Here are some examples of how that might happen. A 75 year-old woman has exhausted her savings and is too sick to work. Her voucher isn't enough to permit her to afford any health insurance plan. She would have to reach into her own pocket, but her pocket is empty. She can't get into a hospital unless its a dire emergency because she can't pay the $750 deductible. And she can't go to a doctor's office, because she can't pay the extra premium. Now that woman is stuck. And she can't get care. provision, doctors won't be required to see them when they need care.

Or take the man who is 75 years-old now. He gets a voucher that just about covers the cost of his health insurance. In three years, his voucher goes up by only five percent a year. But his premium goes up by ten percent a year. After three years, the gap is so wide that he can't afford to pay. He dropped his Medigap coverage because he was persuaded the voucher system would work. Now that man is stuck. And he can't get care.

A 70 year old man has just had open heart surgery. He has recovered enough to go home and be treated by a visiting nurse. But under the plan of the Congressional majority, he must pay a $1700 in copayments to get the visiting nurse. He can't afford

that, so he stays in the hospital for months, at three or four times the costs. Now that man is stuck. And he too can't get care.

Those who want to keep what they have now will have to pay significantly more. Every person on Medicare will pay $1650 more over 7 years in premiums to cover their doctor bills. The average person who receives care in their own homes will pay at least $1700 more in the year 2002 alone. Remember, these are people who already pay 21 percent of their income on health care.

Can the elderly afford $1650 more for premiums to cover doctor bills?

Can they afford $1700 more for home health care in one year alone?

Will vouchers cover them against sudden premium increases if they get sicker?

Will medical care costs stay sufficiently under control to permit the vouchers to cover the full costs of care?

Is it fair to make older Americans give up their doctors and be forced into managed care?

I believe the answer to all these questions for millions of our elderly is: No. Those who want to gamble with Medicare are asking older Americans to bet their lives. And why must they bet their lives? Not to balance the budget. We can do that anyway. But the Congressional majority cuts $146 billion more than I want from Medicare to pay out $140 billion more than I want in tax cuts. America must decide if it's worth it. I say no.

We can balance the budget, while protecting older Americans from any Medicare cost increases. The way to do it is to require insurance plans to cover those with pre-existing conditions. To make a commitment to preventive and long-term care. To encourage home care as an alternative to nursing homes. To let workers take insurance coverage with them when they change jobs. To crack down on fraud and abuse.

And most of all, we need to achieve these reductions over a decade -- not try to compress them into seven years as the majority in Congress proposes.

So, let us come back to the common ground we have all held for thirty years. Let the Congress join me in four basic principles:

1. We must be sure that good, affordable health care is available to older Americans.

2. We must not cut Medicare just to have a bigger tax cut.

3 We must reduce medical cost inflation over a decade through real reforms -- not by destroying Medicare.

4. We must not attempt to balance the budget by cutting medical care for older Americans.

Medicare originally was not just common ground between Democrats and Republicans. More important, it was common ground between generations of Americans. Younger Americans could use their resources to send their children to college, because if their parents became sick, Medicare was there. And it has been there now for an entire generation of American families. But if the Congressional majority has its way about Medicare, the average American family will have to choose between opportunities for their children and compassion for their parents.

That is not the way to strengthen our families. More than anything else, the achievement we celebrate today is really about the sacred bonds between generations. We expect and hope that people who have gained and given so much from and to America will keep their commitments to the generations that come after. That means support for health care, safe communities and education and training opportunities we know all our young people need to compete in the global economy. That is the obligation that one generation has to the generations that come after.

But that obligation goes in both directions. Just as we must pass down the chance for stronger lives to those coming after, so too we must keep faith with those who have come before. Medicare, as much as anything we have done in the last half century, is about keeping that faith -- and I am committed to keeping it strong for the future. With your help, that is exactly what we will do.

Thank you and God bless you.

Bob Lehman

Remarks
As Prepared For
Vice President Al Gore
At
Medicare's 30th Anniversary Celebration
July 25, 1995

(ACKNOWLEDGEMENTS FROM ADVANCE)

There is nothing an embroidery worker values more than his vision. So, when a 65-year old embroidery worker from New York named Eugene Schneider checked into the hospital at a minute after midnight, one day in 1966, it wasn't for a trivial matter. He was trying to save his eyesight.

But in so doing, he benefitted from the vision of many others. Because in that minute, he -- along with an Illinois man -- became the first American to benefit from Medicare, the program whose 30th Anniversary we celebrate today.

It was a plan whose wisdom had been apparent for some time.

After all, in those days, life was bleak for older Americans. People over 65 were twice as likely to be chronically ill as those under sixty-five -- and were hospitalized twice as long. But most of them had no health insurance at all. Those who <u>had</u> insurance saw only seven cents on the dollar covered. And older Americans then had an average income of only $1200 a year.

Of course, it was not enough to see the need. Health care for older Americans wouldn't be won without a fight. And I remember that fight well.

I especially remember one man standing up on the floor of the Senate in 1964, offering an amendment to the bill under debate which would protect senior citizens from being decimated by illness.

The Amendment was Medicare.

The man was my father.

And while the bill was to die in Committee, it came back again the next year. That was the Congress so cooperative with President, so willing to pass his legislation, that Barry Goldwater called it the "xerox Congress."

Mr. President -- those were the days.

The debate lasted two days in the House, three in the Senate. And so it was that on July 30, 1965, President Johnson flew to Independence Missouri, to sign the bill in the hometown of another man who had spoken out on this need: Harry Truman.

What a difference it has made.

It is a plan that protects 36 million Americans. It has dropped the poverty rate over 13 percent for Seniors. And it has given 83% of its benefits to those with incomes less than $25,000.

Now, this plan has historically divided the two parties. Thirty years ago Republicans called it "socialized medicine." So it is not a total surprise to see that Republicans are not as sold on Medicare on Democrats -- the Majority Leader, for example, who said a few weeks ago that Medicare "is a program I would have no part of in a free world."

I must admit, though, I was surprised to read that Republican Caucus memo on Sunday that said that seniors are "pack-oriented and very suceptible" to being led.

I'd like to introduce them to my parents.

Perhaps the Majority Leader doesn't realize that it is this generation of Medicare recipients who bequeathed this free world to us. And perhaps the Majority Leader doesn't realize how much the generation that devised Medicare has extended America's freedom -- our freedom from devastating illness.

Senior citizens don't want to be led. They have led the way.

We don't want to scrap Medicare. Or even trade it in. But it needs some work. 30 years ago, my father referred to medical care for the elderly as " the most pressing, unmet problem in our society..." For the most part, the problem has been met. But with the number of senior citizens growing at the rate of 400,000 a year, and with 20% of Americans predicted to be over the age of 65 by the year 2030, there is still much to be done.

That is why, as we celebrate this milestone in America's past, it is my great pleasure to present a leader who can carry Medicare into the future. He is a President who first came to Washington in the days when Medicare was being debated. I look forward to hearing him talk about the issues at stake today.

Ladies and gentlemen, the President of the United States: Bill Clinton.

MESSAGE IDEAS FOR THE REMARKS OF THE PRESIDENT ON THE 30TH ANNIVERSARY OF MEDICARE

- Medicare and Medicaid have provided an important safety net for our nation's elderly for 30 years. **[ISSUE: Do we focus on Medicaid as well as Medicare?]**

- This year, as we celebrate the 30th anniversary of their passage, we need to preserve and strengthen these programs.

Start w/ Medicare

  - Before Medicare, about 45 percent of the elderly had no health insurance and even more were uninsured. For 30 years, Medicare has guaranteed health security to older Americans -- even as the number of uninsured in this country continues to rise.

  - And Medicaid has helped middle class families who have exhausted their savings manage the overwhelming costs of nursing home care. Without Medicaid, families with a parent or spouse who needs long-term care would face nursing home bills that average $38,000 a year.

- But I know we all agree that we've got to get health care spending under control. I also believe that we need to balance the budget. **[ISSUE: How to discuss his balanced budget proposal at an event designed to show unity among Democrats?]** But there is a right way and a wrong way to do it. **[ISSUE: Do we contrast ourselves with the Republicans or do we just attack them?]**

  - That's why I presented a budget proposal that reaches balance in ten years but that protects Medicare beneficiaries from any new cost increases, strengthens the Medicare Trust Fund, preserves Medicaid coverage, and takes the first steps toward health care reform.

  - And that's why I oppose the Republican plan to cut Medicare by $270 billion to pay for unnecessary tax cuts.

Hit hard on benef.

    - The Republican's tell you that, under their proposal, Medicare beneficiaries have more choice. Some choice: you can choose to pay more or you can choose to get less.

    - Instead of secure coverage for all necessary medical care from the doctor you choose, beneficiaries would be given a so-called voucher to purchase medical insurance on the open market. Those beneficiaries who wanted to keep the plan they have today -- that lets them see any doctor they choose -- would pay more. Between 1996 and 2002, the average person on Medicare would pay about $3,000 more to stay in today's system.

If they were doing my tax cut, they would not need to do 1 penny of cuts

Cuts have nothing to do w/ part A Trust Fund

Don't have to give up on a tax cut

Don't give up on strengthening the Trust Fund

- Since 75% of Medicare beneficiaries have incomes below $25,000, it's hard to imagine how they could afford to pay so much more. Those who couldn't would be forced into managed care. And because the Republicans would let Medicare grow by much less than costs in the private sector, the value of the voucher would go down over time and beneficiaries would be able to buy less and less.

- Instead, we need to fight to protect and improve the Medicare program for it's next 30 years. We're doing it already. By cracking down on fraud and abuse through programs like "Operation Restore Trust" -- which we put in place last month. By providing more preventive benefits and long-term care and by educating people on Medicare about the benefits available to them. By getting simpler, more understandable information to them and listening to their needs. And by expanding choices for Medicare beneficiaries so that they have the same managed care choices that are available in the private sector.

RNC TALKING POINTS

DEMOCRATS "EXPLOIT" MEDICARE

July 6, 1995

"The natural inclination for people is to think that the GOP wants to cut Medicare--not to make it more efficient but to hurt the elderly --We need to exploit this."
--from notes of a confidential meeting of Democratic senators and political consultants

The Democrat strategy on Medicare can be summed up in two words: Scare Seniors. The Democrats have no plan to save Medicare, but they do have a plan to "exploit" the issue by charging that Republicans want to "hurt the elderly."

This is not the first time Democrats have resorted to scaring senior citizens. Just a few months ago, Bill Clinton and the Democrats defeated the balanced budget amendment by claiming Republicans would cut Social Security to balance the budget. There was no truth to that claim, and Republicans have proven it false by passing a balanced budget that does not touch Social Security. Likewise, there is no truth to the claim that Republicans are "cutting" Medicare. Here is the truth:

Under the Republican budget, Medicare spending will increase from $178 billion this year to $274 billion in 2002--a 54% increase in spending over seven years.

Spending per senior will increase from $4,800 a year today to $6,700 a year in 2002--an increase of almost $2,000.

Medicare will grow at an annual rate of 6.4%--twice the rate of inflation and far outstripping health care spending in the private sector which grew at only 4.4% in 1994. Medicare will increase much faster than the senior population itself which went up only 1.5% last year.

Next to Social Security, Medicare will be the fastest growing program under the Republican budget. Under the GOP plan, Social Security, Medicare and Medicaid will account for three-quarters of all the growth in federal spending over the next seven years.

The facts are plain: Republicans are not "cutting" Medicare. Yet Democrats and the White House spinmeisters continue to use this rhetoric claiming Republicans are "cutting Medicare twice as much" as Clinton. The truth is, nobody is cutting Medicare.

Democrats have no leg to stand on when it comes to attacking Republicans on Medicare "cuts." Bill Clinton himself has proposed that Medicare spending should continue to increase by almost the same rate Republicans propose.

Clinton and the Democrats have been very skillful at scaring seniors about imaginary "cuts" in Medicare. But they have failed to take action on the the real problem seniors should be worried about--Medicare's impending bankruptcy. Democrats claim Republicans are "cutting" Medicare to balance the budget, but they don't tell seniors that even if we had a balanced budget today, we would still have to take steps to save Medicare.

The Medicare Board of Trustees, which includes three members of Clinton's own Cabinet, has repeatedly warned that the Medicare Trust Fund is going

bankrupt in seven years. When the Trust Fund runs out of money, that's it. By law, no checks can be sent, leaving 37 million elderly and disabled Americans without hospital insurance.

Yet despite the seriousness of the crisis, Bill Clinton has no plan to save Medicare. Republican leaders in Congress have repeatedly urged the president to join them in a bipartisan effort to save the system, but the White House response has always been, "Not interested." When it comes to finding solutions to Medicare's impending bankruptcy, Bill Clinton has been AWOL (Absent Without Leadership).

Seniors should ask Bill Clinton and the Democrats the following three questions:

If Republicans increase Medicare spending from $4,800 today to $6,700 in 2002, where's the cut?

Do Democrats accept the warning of the Medicare Trustees and three Clinton Cabinet members that Medicare is going bankrupt in seven years?

What is the Democrat plan to save Medicare?

Democrats can "exploit" the Medicare issue for political gain, but Republicans will not let Medicare go bankrupt. We are reaching out to a variety of experts, organizations and the American people to solicit ideas and help in achieving the changes necessary to save the system from bankruptcy and preserve and improve it for today's seniors and the generations who will follow. That's what leadership is all about.

"RNC Talking Points" are published by the Republican National Committee's Communications Division. For more information, call 202-863-8614.

MEDICARE

- **REPUBLICANS' UNPRECEDENTED CUTS:** The Republican Budget Resolution Conference Agreement would cut $270 billion from the Medicare program over the next seven years -- $71 billion in the year 2002 alone. This approximately triples anything previously enacted.

- **CUTS ARE REAL:** Republicans will call their proposal an increase, not a cut, since spending will be higher in 2002 than it is today. But by that logic, reducing the Social Security cost-of-living adjustment (COLA) would not be considered a cut. In fact, the Republicans' out-of-pocket increases would have the effect of taking half of the Social Security (COLA) from the pockets of the average Medicare beneficiary.

- **BILLIONS ADDED TO OLDER AMERICANS' ALREADY HIGH COSTS:** The Republican Budget would increase beneficiaries' out-of-pocket costs by tens of billions of dollars. Assuming their cuts were equally divided between beneficiaries and providers:

  - o **In the year 2002 alone, each beneficiary could pay $625 more in out-of-pocket costs than under the President's proposal; couples could pay $1,250 more.**

  - o **Over the seven-year period, beneficiaries may be forced to pay an additional $2,825 ($5,650 per couple) out-of-pocket relative to the President's proposal.**

- **VOUCHERS AREN'T CHOICE, THEY'RE FINANCIAL COERCION:** Republican proposals that promise choice through Medicare "vouchers" actually threaten to undermine fundamental Medicare protections.

  - o Medicare guarantees beneficiaries that it will pay the cost of covered services, subject to fixed and predictable cost-sharing requirements. That's a benefit guarantee.

  - o A voucher would replace this benefit guarantee with a fixed dollar amount. This means that beneficiaries would be on their own to find a health plan, with a voucher that is losing value over time.

  - o Republicans claim you can keep the Medicare coverage you've got. How can you keep what you can't afford? The only way for Republicans to achieve the level of savings they are proposing is through requirements that beneficiaries have to pay much more to stay in the current Medicare program. That's not choice, that is financial coercion.

- **NO NEW BENEFICIARY CUTS IN THE PRESIDENT'S PROPOSAL:** While the Republicans would cut beneficiary protection to finance tax cuts for the well off, the President would strengthen Medicare financing <u>without new burdens</u> for beneficiaries. The President's proposal would:

  - o Reduce Medicare spending by $124 billion -- less than half the Republican cuts;

  - o Ensure Medicare trust fund solvency through at least 2005, without any new beneficiary cuts;

  - o Accompany reductions in Medicare spending with: 1) new prevention and long-term care benefits; 2) more plan choices for beneficiaries; 3) aggressive pursuit of fraud and abuse; 4) insurance reform; and, 5) important new insurance affordability protections for small businesses and working families.

Draft Testimony for Judy Feder, House Commerce Committee

Mr. Chairman. Thank you for the opportunity to testify before you on the subject of restructuring the Medicare program. As Medicare approaches its thirtieth birthday, I think it is especially appropriate that we have this discussion. Medicare is a successful program which has significantly improved the lives of the vulnerable population it serves. We need to work together to improve the program's success and strengthen Medicare so it thrives for another 30 years.

Any discussion of reforming Medicare must begin with an examination of those features of the program worth keeping, as well as those in need of change. Three features of the Medicare program, in particular, constitute the core of its protection for senior and disabled citizens and must be preserved.

First, Medicare coverage is available to everyone, regardless of health status. The elderly cannot be denied nor charged more for Medicare coverage because of their health status or preexisting conditions. Indeed, disabled citizens are entitled to Medicare coverage because of their health status. This security of Medicare coverage must not be tampered with. It is fundamental to the contract our nation has made with our elderly and disabled citizens.

Second, a basic level of coverage is guaranteed by Medicare. Medicare covers medically necessary hospital, physician, skilled nursing and home health services and equipment. For this coverage, beneficiaries contribute payroll taxes during their working life and pay premiums after retirement. Medicare coverage is already limited and most beneficiaries feel compelled to obtain supplemental coverage through private medigap insurance. Some low income beneficiaries have coverage supplemented by Medicaid. On average, seniors today pay 21 percent of their income for out-of-pocket health care expenses. Cuts in Medicare coverage -- whether in the form of reduced benefits, increased cost sharing, increased premiums, or easing of balance billing limits -- would hurt beneficiaries and would be strongly opposed by the Administration.

Medicare buys meaningful access to health care. A Medicare card today guarantees access to virtually every hospital and physician. Choice of providers and institutions is important to all Americans, but it is even more important to the elderly and disabled Medicare population given their multiple and complex health problems. Efforts to control Medicare spending over the years have had to strike the balance between cost containment and maintaining access to mainstream care. Sustaining that balance remains critically important.

As important as it is to the well being of 37 million

Americans, the Medicare program is far from perfect. Strengthening reforms in several key areas are desirable.

Reforms to expand beneficiary choice - Today Medicare offers a choice between managed care and traditional fee for service coverage. Over 70 percent of enrollees have access to managed care and more than half have a choice of 2 or more managed care options. Medicare managed care enrollment is growing at a rate of more than one percent per month. In the first six months of this year we have already seen a 9 percent overall increase in managed care enrollment, and by the year's end expect an 18 percent increase in enrollment. More than 250 managed care organizations -- 165 on a risk basis -- currently contract with HCFA to serve Medicare beneficiaries. Still we can do more.

As we have testified previously, we are working to expand choices for Medicare beneficiaries. The Health Care Financing Administration (HCFA) has announced "Medicare Choices," a new demonstration project designed to expand the types of managed care plans available to Medicare beneficiaries and to test different payment methodologies. We also support opening the Medicare program to participation by PPOs. To make managed care choices more meaningful, HCFA also is working on improvements and alternatives to the Adjusted Average Per Capita Cost (AAPCC), the existing method of paying Medicare HMOs. Employing competitive pricing as an alternative to the AAPCC is one method currently

under development.

Reforms to promote quality - We continue to strengthen our Peer Review Organization (PRO) quality review for traditional fee for service Medicare. Our move to the new Medicare Transactions System (MTS) also will provide us better data on the services all Medicare beneficiaries receive so that stronger quality assurance programs can be developed. To strengthen quality assurance for those beneficiaries enrolled in managed care, HCFA has embarked on a number of initiatives. For example, HCFA has joined with the private sector, the Department of Defense, and others to improve managed care quality and plan accountability. We expect to complement existing quality assurance and accrediting organizations, such as the National Committee for Quality Assurance and the Joint Committee for the Accreditation of Health Organizations, and have received their support.

Reforms to protect against fraud and abuse - The Administration recently transmitted to the Congress our proposal for Operation Restore Trust. This plan would create new capabilities in HCFA and our carriers and intermediaries to fight fraud in the Medicare program, in particular by relying on better payment screens rather than old pay-and-chase methods. Administration witnesses will provide you with a more detailed description of Operation Restore Trust at your hearing on fraud and abuse tomorrow.

Reforms to contain costs - Finally we continue to pursue reforms to control program costs while protecting access to care, the quality of care, and beneficiary choice. In his balanced budget proposal, the President called for $124 billion in net Medicare savings over 7 years. Three billion dollars in savings would be used to finance improvements in coverage. Specifically cost sharing would be eliminated for mammograms to improve use of this important preventive service; and a new respite care benefit would be available for families of beneficiaries with Alzheimer's disease.

The savings proposed by the President would not only help to reduce the deficit but, equally important, would extend the life of the Medicare trust fund through at least 2005. None of these savings would come at the expense of beneficiaries. As the President has promised, we are ready to work with the Congress to achieve these savings while protecting access, quality and choice. We will fight changes that threaten these goals.

Vouchers

Our efforts in the areas of choice, quality of care, fraud and abuse and cost containment are intended to build upon the choice, coverage, and access that are the foundations of Medicare. As such, they need to be distinguished from Republican efforts to reform Medicare that are more concerned with budgets than beneficiaries.

Let me be clear. Republican proposals to save $270 billion through vouchers are about reducing federal spending at beneficiaries' expense--not about reforming Medicare. Talking about these proposals in terms like "defined contribution" and "FEHBP-like" imply that vouchers are mainstream and safe. But any voucher plan based on $270 billion in Medicare cuts can only be disastrous to beneficiaries' security and an abrogation of our 30 year contract with elderly and disabled Americans.

Some have proposed that Medicare be restructured to look more like the Federal Employees Health Benefit Program (FEHBP). We, too, believe that beneficiaries should have as broad a range of choice as offered in the FEHBP. But we also know that the purchasing power and health care needs of the Medicare population are very different from younger, healthier, and employed FEHBP enrollees'. Furthermore, health coverage through the FEHBP is an employee benefit. Medicare, like Social Security, is a social contract that guarantees beneficiaries coverage in return for contributions made during their working years.

Finally, under FEHBP government's contribution is determined by the costs of the participating plans. It is not a fixed dollar amount, indexed to a predetermined annual growth rate. Consequently, the Republican voucher plan as outlined by the Shays Task Force would not give Medicare beneficiaries the protection that members of Congress now enjoy through the Federal

Employees Health Benefit Program (FEHBP).

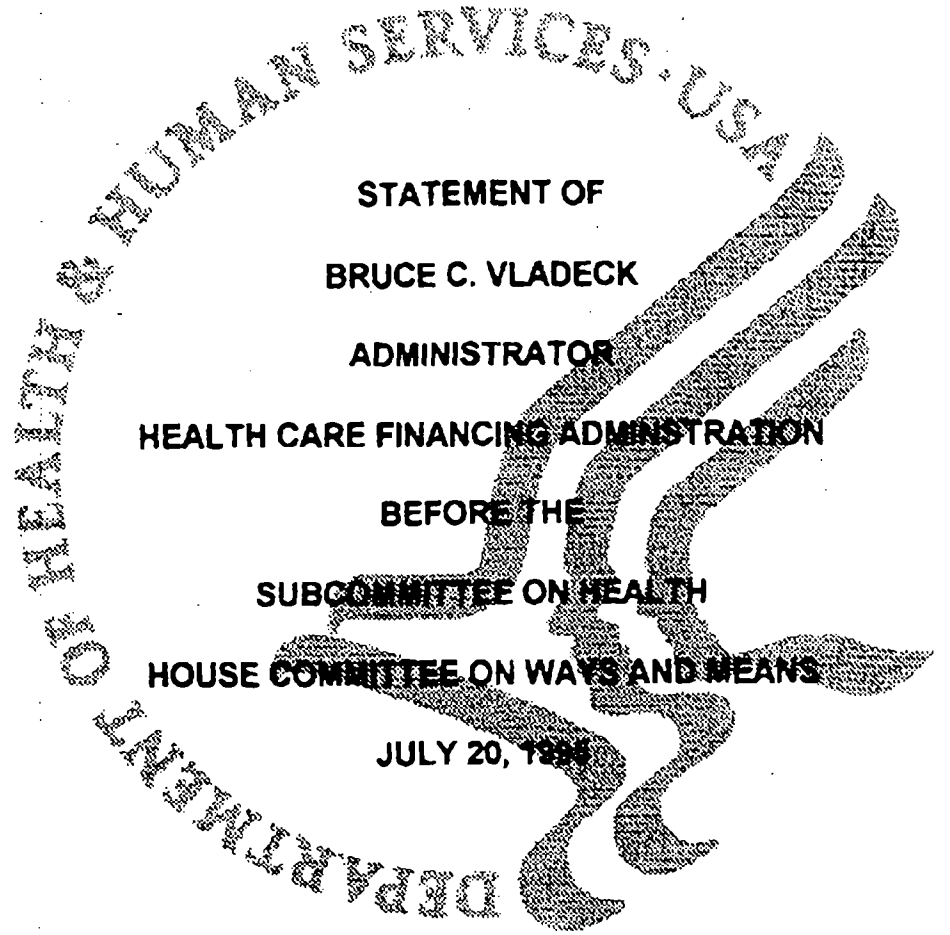
Private health care spending per insured person will grow at 7.1% per year from 1996 to 2002 according to CBO data. In contrast, the Republican budget conference agreement would have voucher payments grow at 4.9%. That means that every year, for every Medicare beneficiary, the cost of what they'll need to buy will grow faster than the voucher Republicans would give them to buy it with.

What would the Republican voucher really mean to beneficiaries? At best they would have to pay more to keep the coverage they have today. However, since three-fourths of Medicare beneficiaries have incomes below $25,000, it's hard to imagine how they would be able to pay more. At worst, beneficiaries would be forced to buy coverage that is insufficient to meet their needs. That's not choice; it's financial coercion.

Conclusion

This Administration is committed not only to modernizing and strengthening the Medicare program, but also to preserving the fundamental protection the program is structured to provide. In evaluating any structural changes to Medicare, this Committee must join us in this resolve. Medicare enrollees must continue to be assured coverage regardless of health status. A basic

level of benefits must be guaranteed, as it is today. And access to and choice of providers must be maintained. The Republican voucher proposal that is designed to produce $270 billion in savings does not meet these standards. Instead, it would turn back the clock 30 years to a time when the elderly and disabled struggled in a discriminatory and expensive insurance market to buy decent coverage with limited funds. We can and must do better.



STATEMENT OF

BRUCE C. VLADECK

ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON HEALTH

HOUSE COMMITTEE ON WAYS AND MEANS

JULY 20, 1995

HCFA
MEDICARE · MEDICAID
Health Care Financing Administration

INTRODUCTION

Thank you for the opportunity to testify today on approaches to restructuring Medicare. As the 30th anniversary of this enormously successful and enormously popular program approaches, we should approach any Medicare reform agenda with a healthy respect for the Medicare program's strengths and a determination to preserve the fundamental health security it offers Americans.

Medicare is universal. Because of the contract this nation made with its citizens in 1965, all Americans -- no matter how rich or poor, no matter how important or humble -- can count on health security in their retirement years or in the event of a severe disability.

Medicare is always available. Americans are not barred from Medicare due to preexisting conditions, nor are they charged more for Medicare because of their age or health status.

Medicare is portable. It costs beneficiaries the same amount and covers the same services, no matter where they live or how their personal circumstances might change.

And, Medicare provides choice. It is especially important to elderly and disabled beneficiaries, many of whom have multiple and complex health problems, to be able to select their own doctors.

This Administration is committed to preserving these essential strengths of the Medicare program, even while we pursue reforms to make the program even stronger and more beneficial to the 37 million Americans it serves today. In particular, I would like to testify today on our strategies for strengthening Medicare by expanding beneficiary choices, enhancing the quality of care and consumer information, and improving customer service.

In addition, I will testify on the Administration's strategy for containing Medicare costs, extending the life of the Medicare trust fund, and moving toward a balanced federal budget -- a strategy that is consistent with our goal of protecting beneficiaries and respecting Medicare's social contract.

Finally, I will distinguish our reform strategies from those of Congressional Republicans which we believe would fundamentally undermine Medicare's protections and harm its beneficiaries.

I. THE ADMINISTRATION'S STRATEGY FOR REFORM

Since we came into office 30 months ago, the Clinton Administration has pursued a multi-faceted approach to reforming Medicare in the context of our efforts toward broader health care reform. We are increasing the number of beneficiaries and plans participating in Medicare managed care and are testing new managed care options. To make possible well-informed decisions by our beneficiaries, we are developing improved consumer information and quality measures. Finally, we are continuing our efforts to improve customer service.

A. Giving Beneficiaries More Choices

Over the past two years, Medicare managed care enrollment has increased dramatically. In the first six months of 1995 we have already seen a nine percent increase in managed care enrollment, an acceleration over last year's annual rate of 16 percent growth. Currently, 9.5 percent of all Medicare beneficiaries -- over 3.5 million people -- have chosen to enroll in managed care plans. Seventy-four percent of Medicare beneficiaries have access to a managed care plan, and 57 percent have a choice between two or more plans.

More than 250 managed care organizations currently contract with the Health Care Financing Administration (HCFA) to serve Medicare beneficiaries, including 165 that do so on a risk basis. Interest in the Medicare managed care program continues to increase. In the last three weeks alone, we received 17 new applications. Much of the recent growth in new contracts has been in regions that have not had a strong Medicare managed care presence in the past.

As you know, however, most of the growth in managed care in the private sector in recent years has involved plans other than traditional closed HMOs. The centerpiece of our reform strategy is making such choices available to Medicare beneficiaries. We believe beneficiaries should have a wide range of choices and good information in a fair and non-coercive marketplace.

"Medicare Choices"

Just a few weeks ago, we announced "Medicare Choices," a demonstration program designed to expand the types of managed care plans available to Medicare beneficiaries and to test different payment methodologies. HCFA has invited a wide variety of managed care organizations to participate in this demonstration, including preferred provider organizations (PPOs), HMOs, and integrated delivery systems.

Nine geographic areas have been targeted for the demonstration: Jacksonville, Florida; Sacramento, California; Hartford, Connecticut; Philadelphia, Pennsylvania; Atlanta, Georgia; New Orleans, Louisiana; Columbus, Ohio; Louisville, Kentucky; and Houston, Texas. We chose these markets to build on the strong base of private sector plans currently available in these communities. We will, however, accept applications from innovative plans in other areas, and we are particularly interested in those that offer to extend coverage to rural areas and those that emphasize primary care case management.

Pre-application forms have already been distributed to over a thousand interested organizations. Based on the response to these initial forms, selected plans will be invited to submit more detailed final applications in the Fall, and we anticipate enrollments will begin early next year.

New Pricing Approaches

We are also exploring alternative payment methodologies and improvements to our current payment systems for managed care.

For example, we are planning to test competitive pricing as an alternative to the Adjusted Average Per Capita Cost (AAPCC) payment methodology, which is now used to establish Medicare's payment to entities that accept full risk for paying for patient care. The AAPCC payment methodology, required by statute, has long been a source of discontent. Plans have been concerned with the AAPCC's adequacy, stability, and equity. The best evidence available indicates that Medicare, using this methodology, has paid more than it would pay for comparable populations of beneficiaries who remain in the fee-for-service program.

We think that competitive pricing is a promising idea, and we would like to test variants of it in a number of geographic areas. We would be interested in working with the Subcommittee on the structure of a competitive pricing demonstration since specific legislation will be necessary to implement this demonstration.

HCFA has entered into discussions with Kaiser Permanente to develop a demonstration of an alternative risk payment methodology based on rates established by competition in the commercial (non-Medicare) marketplace. Rates offered to commercial accounts would be adjusted for the Medicare benefit package and the higher risk of serving Medicare enrollees.

For the past decade, HCFA has been a leader in supporting research to develop health status adjusters for risk payments. Current research efforts should soon produce health status adjusters that can be used on a pilot or demonstration basis. HCFA has also undertaken a demonstration project in which we are

working collaboratively with participating HMOs in Seattle to develop a high-cost outlier pool risk-adjustment mechanism.

Finally, HHS is working with the HMO industry to explore their technical concerns with the AAPCC methodology. For example, the industry has expressed interest in using Metropolitan Statistical Areas (MSAs) rather than counties for geographically adjusting Medicare's payment rate to HMOs.

New Options

As I previously explained to the Subcommittee, we also want to make available to beneficiaries a PPO option. This option has proven to be very popular in the commercial market. Under the PPO option, beneficiaries would face nominal copayments if they stayed in plan but would have the option to go to any physician at any time, if they were willing to pay the additional cost-sharing. Implementing such a change would require a change in statute.

HCFA is also currently developing guidelines, under existing statutory authority, for current risk contractors to offer a "point-of-service" (POS) option, with implementation anticipated for the 1996 contract year. The option would be similar to "point-of-service" plans that HMOs offer in the commercial marketplace.

B. Quality Measures and Consumer Information

HCFA is committed to ensuring that beneficiaries -- whether they are served by traditional Medicare, HMOs, or one of the new managed care options described above -- receive high quality care. A major facet of our strategy for Medicare reform involves the development of quality measures and enhanced consumer information.

As I mentioned to this Subcommittee in March, HCFA has reinvented and modernized its Medicare fee-for-service quality assurance and improvement activities under our Health Care Quality Improvement Program (HCQIP). HCQIP gives providers the tools to achieve continuous quality improvement, allows for the external monitoring of how well providers are improving quality, and supports the development of quality improvement projects throughout the country.

We are equally interested in assuring that as Medicare managed care options evolve, we have adequate measures in place to assure quality of care. As Medicare beneficiaries' options expand, beneficiaries will require reliable information to make well-informed choices about their health care. We are working on a number of fronts simultaneously to achieve this goal.

For example, HCFA, together with the Department of Defense and the Federal Employees Health Benefits Program, has joined private sector health purchasers, including GTE, AT&T, and PepsiCo, to explore the formation of a new organization for quality improvement and managed care accountability. This group represents more than 80 million insured individuals. The group will leverage the collective buying power of the participating organizations to ensure that our beneficiaries' needs are met and to eliminate unnecessary duplication of individual quality improvement and accountability efforts. We expect our efforts to complement the initiatives of existing quality assurance and accrediting organizations, such as the National Committee for Quality Assurance (NCQA) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and have received their support.

HCFA also plans to collaborate with the NCQA, with the support of the Kaiser Family Foundation, to modify the Health Plan Employers Data and Information Set (HEDIS) to incorporate measures more germane to the Medicare population.

In May 1995, we launched a pilot test of the three core performance measures, developed by the Delmarva Foundation and Harvard University, to be used by Peer Review Organizations (PROs) in their external review of HMOs. The Delmarva contract was intended to help HCFA and the PROs shift from the current retrospective case review method of HMO oversight to one based on outcomes measurement and continuous quality improvement.

At this stage in the evolution of measures of plan quality, there is no single best approach. We intend to continue to work with a broad range of private sector organizations, as well as pursuing our own developmental work, to move forward as quickly as possible.

C. Improve Customer Service.

In everything HCFA does, we are focused on our strong commitment to improve customer service. To meet the President's call for increased customer satisfaction, we have set standards of service that meet or exceed the best practices in the public and private sectors. Today's HCFA is a significantly different organization from that of just two years ago. As we have embraced an ethic of customer service and beneficiary outreach, we have reinvented our agency to cultivate a consumer-focused workforce and partnership, responsive to the changing needs of our beneficiaries.

Under our consumer information strategy, we are improving opportunities to develop a dialogue with beneficiaries, to educate them about the programs and services available under Medicare, and to disseminate reliable data to foster informed

beneficiary choices about their health care needs and the providers who furnish care.

With the assistance of our contractors, we are redesigning our Explanation of Medicare Benefits (EOMB) form to consolidate Part A and Part B notices into a single, standardized, easy to understand benefits summary.

We have already totally revised the way in which we evaluate Medicare contractors to encourage better customer service, and we will also be proposing legislation to change the way we contract with fiscal intermediaries and carriers to make them more service oriented -- to both better adapt to changing program needs and improve the cost-effectiveness of the Medicare contractor budget.

We are also collaborating with contractors to fulfill our responsibility of fiscal stewardship. The Secretary has recently sent to Congress draft legislation to establish a Benefit Quality Assurance Program (BQAP) to ensure a stable level of funding for our critical payment safeguard activities. The legislation would enhance our ability: (1) to educate providers regarding payment integrity and benefit quality assurance; (2) to determine those situations in which Medicare should have been a secondary payer and recover payments that should not have been made; (3) to target our cost report auditing priorities toward focused field reviews which provide a high return on investment; and (4) to develop clear medical and utilization review policies and communicate those policies to providers.

Operation Restore Trust, the health care anti-fraud demonstration announced by the President in May, is a major effort to develop better methods to protect the fiscal integrity of the Medicare and Medicaid programs. An interdisciplinary team from HCFA, the Office of the Secretary, the HHS Inspector General, the Department of Justice, State governments, and the private sector will test the most effective approaches to combat fraud, waste, and abuse associated with certain Medicare and Medicaid providers and suppliers. The demonstration will target five States (New York, Florida, Illinois, Texas, and California) that account for more than a third of all Medicare beneficiaries in the country and nearly 40 percent of all Medicaid recipients.

II. THE ADMINISTRATION'S STRATEGY FOR COST CONTAINMENT

Many of the operational reforms I have described will produce significant long-term savings, but the President is also committed to reducing the growth of Medicare outlays in the shorter term as part of his plan to achieve a balanced federal budget. The Administration has offered a responsible deficit reduction plan that balances the budget and strengthens the Medicare trust fund while protecting beneficiaries.

The Administration has a three-pronged strategy for controlling costs in Medicare. First, we need to protect beneficiaries' access to affordable, quality health care. Second, necessary reductions in Medicare should serve to extend the solvency of the Hospital Insurance (HI) Trust Fund. Third, we want to take advantage of changes in the health care marketplace.

A. Protect Beneficiaries

Beneficiaries come first. We do not believe that Medicare beneficiaries, the majority of whom have incomes of $25,000 or less, should be forced to pay thousands of dollars more to keep Medicare in order to finance the tax cuts for the wealthy.

Out-of-pocket costs are already too high for those aged 65 and older, currently accounting for 21 percent of their income. Massive reductions in Medicare spending of the magnitude in the Republican budget resolution achieved by shifting costs to beneficiaries would increase the financial burden on the nation's most vulnerable elderly. Furthermore, almost 60 percent of senior citizens rely on Social Security for 50 percent or more of their income. Shifting costs to these beneficiaries is the equivalent of reducing their Social Security checks.

Medicare has made significant contributions to improving the health status of the nation's elderly and disabled. Significant increases in beneficiaries' out-of-pocket costs could cause them to forgo needed health care services and might result in erasing some of the gains in health status that have been achieved since the implementation of Medicare.

B. Focus Deficit Reduction Efforts on Preserving Medicare

The President has proposed a plan to balance the Federal budget that presents a reasonable approach to ensure Medicare's financial solvency into the 21st century. The proposal includes $124 billion in net spending reductions over the next seven years and extends the life of the HI trust fund through at least the year 2005.

The plan contains no new increases in out-of-pocket costs for beneficiaries, but does revise the Medicare benefit package by providing respite care for beneficiaries with Alzheimer's disease and by eliminating the copayment for mammography services.

C. Take Advantage of Private Sector Innovations

A major aspect of our cost-containment strategy will be to take advantage of some of the changes now occurring in the health care marketplace. Medicare has historically been a leader in

cost containment. The prospective payment system for hospitals and the physician fee schedule for physicians were groundbreaking payment systems that have become the basis for many payment systems in the private sector. However, the statutory constraints on Medicare's payment rates preclude us from taking advantage of changes in the market as rapidly as the private sector has done.

For example, competition for services has increased substantially in the private sector, with employers and insurance companies demanding large discounts on charges in return for an agreement to send patients to those providers. Given Medicare's large market share, we should be able to extract discounts, as the private sector does, in a wide variety of settings.

We also would like to work with the Subcommittee to establish competitive bidding for certain Part B services, such as clinical laboratory and certain types of durable medical equipment (DME). HCFA is now statutorily prohibited from engaging is such competition.

III. ALTERNATIVE PROPOSALS FOR MEDICARE REFORM

We believe our plan for Medicare represents the right way to balance beneficiary needs, program modernization and deficit reduction. In contrast, the Republican plan to cut $270 billion from Medicare over the next seven years is the wrong way. It will do damage to beneficiaries and the entire health care system.

The $270 billion in Medicare cuts that the Republicans have proposed is three times anything previously enacted. A quick review of the Republican Medicare reform working document suggests that Medicare beneficiaries would be required to pay substantially more just to keep their current coverage and access to their doctors. Specifically, preliminary HCFA estimates show that such beneficiaries would need to pay $403 more in Part B premiums than they would under the President's plan in 2002. Additionally, they would face new coinsurance on home health and skilled nursing care that would cost the average person using these services in excess of $1,000 for each benefit in 2002.

American Medical Association Proposal

Another wrong way to reduce Medicare spending is contained in the proposal by the American Medical Association (AMA) to end the current safeguards on beneficiary liability for charges for physician services. Extra billing limits give beneficiaries financial protection against unlimited charges by physicians. Under the AMA proposal, physicians would be allowed to charge beneficiaries an unlimited amount over and above what Medicare

pays for a service. A preliminary estimate is that removal of the extra billing limits could cost beneficiaries more than $900 in out-of-pocket costs in the year 2002 alone.

Medicare has had limits on what physicians can charge since 1984. The current extra billing limits were an essential part of the physician payment reform package established in 1989, which consisted of (1) a fee schedule, (2) extra billing limits, and (3) the Medicare volume performance system. The AMA strongly supported the fee schedule, which was explicitly designed to rearrange Medicare physician payments across procedures and geographic areas while remaining budget neutral. The extra billing limits were an integral companion of the fee schedule, providing essential protection for beneficiaries in these circumstances -- otherwise any losing physician could simply shift the cost to the beneficiary.

We believe that the AMA's new proposal to repeal the limits on how much physicians can charge beneficiaries calls into question the entire political compromise represented by the Medicare physician payment reform and is nothing short of outrageous.

Voucher Proposals

Finally, I would like to comment specifically on the Republican proposals to convert Medicare into a "defined contribution" or "voucher" program. Instead of secure Medicare coverage for all medically necessary care from the provider of their choice, beneficiaries would be given a voucher to purchase medical insurance on the open market.

Advocates of voucher-like approaches frequently suggest that Medicare should emulate the private sector and therefore benefit from private-sector-like growth rates. CBO data indicate that the private sector per capita growth rate would be 7.1 percent from 1996-2002. However, the Republican Budget Resolution would require an incredibly tight 4.9 percent per capita growth rate for Medicare.

Constraining the costs of providing care for a much more vulnerable Medicare population to a rate of increase so much smaller than that of the private sector is, at best, unrealistic. The resulting impact would be that the value of the voucher would very quickly erode. Beneficiaries would be forced to pay a substantial new "premium" for exercising the choice to buy a policy that covers what Medicare covers today. Such an approach would put all the risk of increased medical care costs on the beneficiaries.

In view of the fact that 75 percent of Medicare beneficiaries have incomes below $25,000, most seniors will find it extremely difficult to pay these additional amounts to keep their current Medicare benefits. The Republican voucher proposal would likely coerce many seniors into buying less coverage -- for example a medical savings account-like policy with a $10,000 deductible that Republicans also are advocating.

If beneficiaries wanted not only to retain their current level of Medicare benefits, but also to remain in traditional fee-for-service Medicare so that they could continue to see their own doctors, their out-of-pocket costs could be much, much greater. Especially if adverse selection meant that sicker people were more likely to want fee-for-service coverage, the cost of traditional Medicare coverage could skyrocket.

In short, the choice beneficiaries would face under the Republican voucher plan would be to either pay significantly more or to get significantly less. We do not believe that this is the type of choice Medicare beneficiaries seek.

Even if the Republicans vouchers were adequately indexed, however, we have other concerns. First, for the Republican voucher system to work properly, there should be a wide range of plans available to Medicare beneficiaries, and beneficiaries would not be denied enrollment because of their medical conditions or subjected to pre-existing condition requirements. Our experience to date on how insurers behave vis-a-vis the Medicare population raises questions about how insurers might behave under a voucher system. Indeed, the Medicare program was created 30 years ago precisely because insurers did not make coverage available to the elderly except at prohibitively high premiums, and insured persons were at risk of losing their coverage after a serious illness.

The problems in the current "Medigap" market illustrate some of the problems that could be expected to arise if the health insurance market were not properly regulated. After the creation of Medicare, insurers began to offer Medigap policies to the elderly to fill in the "gaps" in Medicare. Medigap policies cover Medicare deductible and coinsurance costs, and some cover extra-billing by physicians and outpatient prescription drugs. The current market provides incentives to avoid risks by health screening or using medical underwriting criteria to offer coverage only at an unaffordable price. They also establish premiums that climb steadily as the beneficiary ages and becomes more likely to need expensive medical services, and hence to need Medigap insurance.

Of course, in principle, one could establish a set of market rules that would prevent such behavior. In fact, the Republican Medicare restructuring document seems to acknowledge this by

directing the Secretary to regulate this type of behavior in numerous instances throughout the document. This is ironic in light of the anti-regulatory agenda currently pursued by many in Congress.

Even more basically, there is a strong correlation among Medicare beneficiaries -- as in most populations -- between income and health status. Our poorest beneficiaries are also our sickest. A poorly designed voucher system could systematically disadvantage the most vulnerable.

IV. CONCLUSION

There is right way and a wrong way to reform Medicare. The right way is to protect beneficiaries' access to quality care and strengthen the HI Trust Fund while pursuing the broader goal of balancing the Federal budget in a reasonable time frame. The wrong way -- the way the Republican budget resolution has turned -- would demolish the basic protections embodied in Medicare in order to finance tax cuts for the wealthy. We believe that the right way is more consistent with rational health policy, fiscal prudence, and the overwhelming preferences of the American people.

Thank you for the opportunity to testify on this important subject. I would be happy to answer any questions you may have.

Numbers Cited by the President on Medicare

1. "They would ... raise premiums and out-of-pocket costs by **$1,250** per couple in 2002, ... by **$5,600** over seven years".

The Republican Conference Agreement estimates of saving were released on June 30, 1995. That document contained:

- $270 billion in Medicare cuts over seven years;
- $71 billion in Medicare cuts in 2002 alone.

The Republicans gave no indication of how those savings targets would be met. To estimate the impact of these cuts on beneficiaries, it was assumed that 50% of the total cuts would be borne by beneficiaries. This is consistent with the recent Republican Ways and Means document outlining Medicare cuts. These estimates assume that the current policy of setting the Part B premium at 25% will be extended when it expires in 1998.

For couples, this increase in premiums and out of pocket costs is multiplied by two. For the seven year period, the increases in each year are added together to get a cumulative total.

2. "But each year, private health care costs increase over **40%** more than the value of a voucher."

Data from the Congressional Budget Office (CBO) suggest that the projected private sector spending per insured person will grow at 7.1% between 1996 and 2002. The Republican Conference Agreement estimates of spending after their cuts show Medicare spending per beneficiary growing at 4.9%. The private rate of 7.1% is about 44% higher than the Republican Medicare growth rate per beneficiary of 4.9%.

3. "But under the plan of the congressional majority, he must pay **$1,400** in copayments to get the visiting nurse."

The Congressional Budget Office, in its "Reducing the Deficit: Spending and Revenue Options", estimated the cost of a 20% coinsurance for all home health care for Medicare beneficiaries. Their 2000 estimate, extended to 2002, was divided by the projected number of users of home health to get an average of $1,400 in 2002. This is consistent with the AARP's analysis of the same policy, which showed the increase cost of $1,200 in the year 2000.

4. "Every person in Medicare will pay **$1,650** more in premiums over seven years to cover their doctor bills."

In the Republicans' Ways and Means document outlining potential premium increases, they listed increasing the premium to 31.5%, 33%, or 35%. The Congressional Budget Office has estimated the change in premiums for several different levels. These estimates suggest that the monthly premium would be $109 under the mid-range option of 33% in 2002, relative to $61 under current law, and $83 if the current policy of 25% is extended beyond its expiration in 1998. When the 33% premium is subtracted from the 25% premium, multiplied by 12 to get the annual savings, this means a $320 increase in 2002, and approximately $1,650 increase over the seven years.

5. "The average person who receive care in their home will pay at least **$1,700** more in the year 2002 alone"

This estimate of $1,700 includes the increased premium in 2002 (about $300) plus the average increase in coinsurance for home health users ($1,400).

6. "Remember these are people who already pay **21%** of their income on health care."

The Urban Institute estimated that in 1994, the elderly paid on average $2,519 in out-of-pocket costs for health care, which translates into 21% of their income. This is more dramatic for the poor elderly, who pay 34% of their income for out-of-pocket costs, and for the oldest elderly, who pay on average $3,782 in out-of-pocket costs. (See: "Out-of-Pocket Health Care Costs for Older Americans in 1994", The Urban Institute, May 1995).

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dpc special report

Medicare's 30th Anniversary

- ❑ A Democratic Vision
- ❑ An American Success

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Medicare's 30th Anniversary

❑ A Democratic Vision
❑ An American Success

On July 30, 1965, President Lyndon B. Johnson traveled to Independence, Missouri, and, in the presence of former President Harry Truman, signed Medicare into law. That simple ceremony marked the end of a long struggle for Democrats trying to enact the measure, and the beginning of a new era of health and economic security for America's seniors.

President Franklin D. Roosevelt envisioned an America with financial security for Americans who retire after years of hard work and a health care safety net for all Americans. He was able to achieve part of that dream, when he signed Social Security into law in 1935. But the struggle for health care protections would last for decades. The historical record is clear: If it had been up to the Republican Party, Medicare never would have been enacted.

President Harry Truman offered several proposals to Congress. President John F. Kennedy made health care for seniors an issue in his 1960 campaign and saw his plan defeated in the Congress. Only after Democrats called the 1964 election a "mandate" for Medicare, and Democrats triumphed at the polls, did the Democratic vision of Medicare become a reality. Even then, the majority of Congressional Republicans voted against it.

Today, Medicare provides health care security for more than 36 million Americans. It is the only way most seniors could ever acquire adequate health care in today's health care market. Medicare helps seniors both obtain the health care they need *and* remain financially secure and independent.

Medicare is an efficient program. Administrative costs are only two percent of its budget—a fraction of the administrative costs of private health care plans. It is a responsible program: Beneficiaries contribute to the medical expenses through premiums, co-payments, and deductibles.

Public support for Medicare is extremely high. Eighty-nine percent of Americans support Medicare, and that support is strong among all age groups.[1] Medicare can be improved; but it must be protected. It should not be assaulted under the guise of deficit reduction or to provide tax breaks for the wealthy—as Republicans now propose.

Thirty years ago, Medicare was part of the Democratic vision for a better America. Today, it still is. This report chronicles the struggle to enact Medicare, and shows how, three decades later, Medicare truly is an American success story.

A Democratic Vision from the Start

In his message to Congress on January 17, 1935, urging passage of Social Security, President Franklin Roosevelt explained that the goal of the program was to provide for:

> *"the security of the men, women, and children of the Nation against certain hazards and vicissitudes of life."*

An important part of that security, President Roosevelt explained, was health care. Social Security would become law and provide what President Roosevelt called "some measure of protection...against poverty-ridden old age."[2]

But a national health care plan in any form was repeatedly met with intense, well-financed opposition.

In Congress, Democratic Senators Robert Wagner (NY) and James Murray (MT) and Representative John Dingell (MI) introduced several national health care proposals. No action was taken on any of them.

With the administration of President Harry Truman, the idea of national health care gained strength and momentum. Shortly after taking office, President Truman proposed a comprehensive, prepaid medical insurance plan for persons of all ages. In his Special Message to Congress Recommending a Comprehensive Health Program (November 19, 1945), Truman declared:

> *"Millions of our citizens do not now have a full measure of opportunity to achieve and enjoy good health. Millions do not now have protection or security against the economic effects of sickness. The time has arrived for action to help them attain that opportunity and that protection."*

Congressional Republicans opposed this effort by raising the specter of government controlled medicine—in a word, socialism.

Senator Robert Taft (OH), the leading Republican spokesperson in Congress at the time, called it:

> *"the most socialistic measure that this Congress has ever had before it."* [3]

Republican Representative Charles A. Plumley (VT) charged:

> *"Behind this alleged humanitarian program is to be found the basis and genesis for a planned and socialized America....It is a proposal to establish a form of socialism, a socialistic government as unadulterated as if it came from the sanctified pen of Karl Marx himself."* [4]

Hearings were held, but no further action was taken.[5]

President Truman's Second Effort

Two years later, President Truman was back with another proposal for national health insurance. In his "Special Message to the Congress on Health and Disability" (May 19, 1947), he declared:

> *"A great and free Nation should bring good health care within the reach of all its people....Healthy citizens constitute our greatest national resource."*

"With Republicans in control of both chambers of Congress in 1947-48," as *CQ Almanac* later noted, "there was no chance for enactment."[6] Again, hearings were held, but no further action was taken.[7]

President Truman Persisted

In a Special Message to the Congress on the Nation's Health Needs (April 22, 1949), President Truman, for the third time, called for national health insurance:

> *"The best hospitals, the finest research laboratories, and the most skillful physicians are of no value to those who cannot obtain their services."*

Republican opposition again appeared in full force. This time, Senate Republican Leader Senator Robert Taft (OH) exclaimed:

> *"This is not insurance. It is a plan for government administration of all medical services....Regardless of form, first a socialization of medicine, and second, a transfer of all control over health activities from the States and local government to a Washington Bureau."* [8]

Again, no action was taken.[9]

Democrats Focus on Seniors

In the face of staunch and well-financed Republican opposition to providing health care security for all Americans, Democrats decided to focus their efforts on America's elderly.[10]

According to the Truman Health Commission, the elderly were poorer and less insured than the general population. For one thing, health insurance firms would not insure such high-risk groups without exorbitantly high premium payments.[11] With their low income levels, America's aged often could not afford health insurance. As proponents of Medicare pointed out, "the cost of medical care is beyond the reach of many older citizens."[12] Sometimes the elderly found themselves uninsurable regardless of cost—largely because of their age or medical condition.

Congressional efforts. In 1957, Democratic Representative Amie Forand (RI) proposed a Social Security approach to health care for the elderly, the first "Medicare"-type proposal. Several versions of this proposal were offered in Congress, but all of them met similar fates—committee hearings were held, but no action taken.

In 1960, the "medicare" concept gained an important supporter. Democratic Senator John F. Kennedy (MA) sponsored a version of the Forand bill, pointing out:

> *"Unfortunately, voluntary health insurance has not and cannot do the job....The very competition between insurance companies tends to either exclude older people or limit their protection. If benefits are restricted, the very purpose of the insurance is defeated."* [13]

Senator Kennedy then quoted a letter from a constituent that read:

> *"It is impossible for a wage earner to put away enough in a lifetime to pay for six months in a hospital."* [14]

Later that year, JFK became the Democratic presidential nominee and announced that enactment of "medicare" legislation was one of his chief legislative goals for the August session.[15]

The Eisenhower Administration, which considered such national health care programs as "socialistic," opposed the Democratic proposal.[16]

Congressional Republicans also assailed the plan.[17] It was wrong, Senator Barry Goldwater (AZ) explained, because:

> *"social welfarism, in its most advance form, has always been an inseparable part of totalitarian systems, ancient and modern, Fascist and Communist, openly brutalitarian or heavily disguised as benevolent despotisms."* [18]

As a result of this Republican opposition, on August 23, 1960, the Senate defeated Kennedy's first attempt to provide health insurance for the Nation's elderly. Ninety-seven percent of Republican Senators voted no.

President Kennedy's Priorities

Presidential candidate John F. Kennedy made health insurance for the elderly a campaign issue in the 1960 presidential election. As president, he was determined to see Medicare enacted.

In a Special Message to the Congress on Health and Hospital Care on February 9, 1961, President Kennedy proposed a health care program for the aged to be financed by an increase in the Social Security tax. President Kennedy declared:

> *"Twenty-six years ago this Nation adopted the principle that every member of the labor force and his family should be insured against the haunting fear of loss of income caused by*

retirement, death, or unemployment....But there remains a significant gap that denies to all but those with the highest incomes a full measure of security—the high cost of ill health in old age."

A few days later, President Kennedy's Medicare plan was introduced in both Houses of the Congress. The *Hospital Insurance Benefits Act of 1961* (King-Anderson bill), was introduced in the Senate by Democratic Senator Clinton Anderson (NM) and in the House by Democratic Representative Cecil King (CA).[19]

Hearings were held, but there was no further action.

President Kennedy Persists

In the second year of his Administration, President Kennedy renewed his push for Medicare. The Kennedy administration promised a "great fight across this land" to secure the enactment of Medicare.[20]

On May 20, 1962, at a Sunday afternoon rally in Madison Square Garden in New York City sponsored by the National Council of Senior Citizens, President Kennedy launched a new campaign for what became his "Medicare" health care program. The speech was carried via closed circuit television to similar rallies in 32 major cities at which cabinet members and other public officials spoke to mass gatherings in support of the needed health benefits.[21]

Republicans again raised the specter of socialized medicine. Republican Senator Carl Curtis (NE) exclaimed:

"The enactment of the Kennedy proposal means government medicine." [22]

This time Medicare came to a vote in the Senate when Democratic Senator Clinton Anderson tried to add it to a Social Security measure. In a dramatic, down-to-the-wire roll call vote on July 17, 1962, however, the measure lost by two votes. Once again, Republicans were united in their opposition—86 percent of Republican Senators voted against it.

JFK's Third Effort

With the opening of the 88th Congress, President Kennedy, for the third time, requested passage of Medicare in his "Special Message on Aiding our Senior Citizens" (February 21, 1963). Democratic Representative King and Senator Anderson again introduced the Medicare bill.[23]

Again, Republicans quickly rose to denounce it.[24]

In the 88th Congress, there were hearings but no further action.[25]

President Johnson Takes Up the Cause

After President Kennedy's assassination, President Johnson took over JFK's efforts on behalf of Medicare. When second session of the 88th Congress opened, President Johnson urged enactment of a "medicare bill."[26]

During the Senate debate on a bill to increase Social Security benefits in July of 1964, (**H.R. 11865**), Senator Albert Gore, Sr. (TN) offered a medicare bill as an amendment.

Senator Gore proclaimed:

> *"We are dealing with the most pressing, unmet problem of our society....What happens when a serious illness strikes? Current income which is needed for groceries and rent must go for medical care. Savings must be depleted. The home may have to be sold. Then, hat-in-hand, this formerly self-sufficient, self-reliant, respected member of the community must go to the welfare people and beg for a handout. This is a disgrace in a country such as ours."* [27]

Opponents of Medicare were as determined to defeat the needed health care measure as President Johnson and Congressional Democrats were to enact it.

Congressional Republicans seemed to come up with every possible excuse to oppose and vote against health care for America's elderly.

They called it socialism.

- Republican Senator Gordon Allott (CO) called it a "foot in the door" for socialized medicine.[28]

They said it would destroy the best health care system in the world.

- *Republican Senator James Pearson (KS):* "American medicine has achieved an unprecedented level of development through its own efforts....It would appear foolish to endanger this high level of initiative and performance by imposing the heavy blanket of government supervision. A Federal health program, financed under Social Security, would represent such a danger."[29]

They said it would not work.

- *Republican Senator Carl Curtis:* "This amendment would be a great disappointment to older people."[30]

- *Republican Senator James B. Pearson:* "[I]t would achieve little for those who need it, while subjecting the very fabric of American life to the strain of severe and unnecessary sacrifices."[31]

They said it was too bureaucratic.

- *Republican Senator Roman Hruska charged:* "With Federal funds come Federal control. In the area of medical care, Federal interference presents frightening prospects."[32]

They said it would wreck the Social Security System.

- *Republican Senator Jack Miller (IA):* "I believe that most people do not wish to have the social security program threatened by any unsound financial tinkering such as this amendment represents."[33]

- *Republican presidential nominee, Senator Barry Goldwater (AR) characterized* Medicare as the "most significant step" in making Social Security a relief and charity organization.[34]

This time, the Senate approved the Medicare amendment by a vote of 60-28 on September 3, 1964. Again, a majority of Republican Senators acted against Medicare. Eighty-five percent voted to kill it. The measure did not survive the joint House-Senate conference on **H.R. 11865**, the *Social Security bill.*[35]

The National Referendum

In an important, dramatic move, the sponsor of the 1964 Medicare amendment,[36] Democratic Senator Albert Gore (TN) called for the 1964 election to be a "mandate" on Medicare. Senator Gore proclaimed:

> *"This means that the President will go to the people and ask for a mandate on this issue."* [37]

President Johnson took up the challenge. Throughout the 1964 political campaign, he promised, if elected, to seek the passage of Medicare."[38] During a press conference, President Johnson explained:

> *"I think Senator Gore very properly presented the situation when he said that it is now a matter that the people of this country can pass judgment on. I hope that we can get a mandate in November."* [39]

The news media also began to consider the 1964 election a "mandate on Medicare."

> *New Republic:* "The current Medicare strategy is based on a major Johnson mandate on election day."[40]
>
> *Business Week:* "Tuesday's election will be a key to whether the [Medicare] issue will be resolved quickly in Congress next year....Medicare proponents say a Johnson landslide, bringing 20 additional Democrats into the House, would insure passage of the legislation."[41]

In the 1964 election, Democrats picked up 37 seats in the House along with two in the Senate. As a result:

- in the House of Representatives, Democrats outnumbered Republicans 295-140; and,

- in the Senate, Democrats outnumbered Republicans 68-32.

The Democratic Victory

The "sweeping Democratic victories," according to *CQ Almanac*, "made passage [of Medicare] almost a foregone conclusion."[42]

President Johnson went before Congress to proclaim:

> *"the specter of catastrophic hospital bills can [now] be lifted from the lives of our older citizens."* [43]

The first bill introduced in each House of the 89th Congress was the King-Anderson bill to establish "Medicare" as a permanent part of the social security program.[44]

In introducing the measure, Democratic Rep. Cecil King (CA) said:

> *"The results of the November election should leave no doubt in anyone's mind over how the American voters feel about these measures....We can no longer permit hospital costs—or the fear of hospital costs—to deprive our elderly citizens of the security and peace of mind that should be their due after a lifetime of work.*
>
> *"We will be able to take great pride in having had a hand in bringing financial security and peace of mind to millions of older Americans."* [45]

Democratic Senator Anderson explained:

> *"I feel certain that historians will mark this year as the turning point in our long struggle to solve the major part of what has become one of the most urgent issues of public policy—the problem of financing the costs of hospital care for the aged, costs which now represent the major remaining cause of personal financial disaster among our aged citizens.*
>
> *"Every month that we delay in providing the needed protection means that more and more elderly persons will be forced to look to public welfare programs for help in getting he health care they need."*[46]

Despite the Democratic victories and Democratic determination, Congressional Republicans were not ready to give up their fight against health care for America's elderly.

Once again, they came up with every possible excuse to vote against the needed measure and to try to defeat it.

Once again, they said it was socialism.

- *Republican Representative James Utt (CA):* "I do not happen to be one of those who is dazzled by the great majority President Johnson obtained last November....Let me tell you here and now it is socialized medicine."[47]

- *Republican Representative Delbert Latta (OH):* "Believing as I do that Medicare is the first step towards socialized medicine in America, I intend to vote 'no' on final passage."[48]

Once again, they said it was too bureaucratic.

- *Republican House Leader and future President Gerald Ford (MI):* "[W]e are going to find our aged bewildered by a multi-headed bureaucratic maze of confusion over what program covers what and who is on first base."[49]

Once again, they said it would destroy the best health care system in the world.

- *Republican Representative Utt:* "Let us not go on the assumption here that we are not destroying the quality and the quantity of medicine and that we are not socializing medicine, because that is exactly what we are doing."[50]

And they said it was a threat to Social Security.

- *Republican Representative Bob Dole (KS):* "[T]he real opposition to the bill stems from the fact hospitalization benefits are to be financed by a compulsory payroll tax....[A]dequate medical protection should be made available to the aged but it should be voluntary and should reflect the ability to pay...This one provision poses an enormous threat to the cash benefit programs under the social security programs."[51]

In a last-ditch attempt to defeat Medicare, Republicans came up with an "alternative" plan—a voluntary system in which the elderly would pay their own premiums. The majority of Congressional Republicans supported this plan—but Democrats prevailed and brought Medicare to a vote.

Representative Dole and a majority of Congressional Republicans again voted against Medicare.

Congress finally passed (Senate, 70-24; House, 307-116) the Medicare bill which President Johnson promptly signed into law on July 30, 1965. President Johnson traveled to Independence, Missouri, to sign Medicare into law, so that former President Harry Truman could participate in this ceremony, and to underscore Democrats' long-standing commitment to our Nation's seniors.

Chronology of Passage of Medicare, 1965

1/4 ------- President Johnson's State of the Union Address listed health care for the elderly as a high priority.

1/4 ------- Representative King and Senator Anderson introduced identical Medicare bills in each House of Congress.

1/7 ------- President Johnson's message on "Advancing the Nation's Health" assigned top priority to the President's recommendations for a health insurance program for the elderly.

4/8 ------- House approved Medicare.

7/9 ------- Senate approved Medicare.

7/14 ------- Conference on Medicare began.

7/21 ------- Conference committee reached agreement upon a compromise.

7/27 ------- House ratified the conference agreement.

7/28 ------- Senate ratified the conference agreement.

7/30 ------- President Johnson signed the bill in Independence, making it Public Law 89-97.

Medicare—An American Success

"From the beginning," reports the Urban Institute, "[Medicare has] proved remarkably successful" as it has contributed to the well-being of America's oldest and most disabled citizens.

Medicare has achieved its goal of providing increased access to health care among the Nation's elderly.

- By 1970, nearly all the Nation's elderly were enrolled in the Medicare program.

- Today, more than 36 million Americans are protected by Medicare.

Medicare has improved the quality of life among the America's elderly.

- Medicare has dropped the poverty rate among America's elderly by 13.4 percent.[52]

Medicare is an efficient health program.

- Medicare's administrative costs average two percent of program outlays, compared with 25 percent in small group market plans and 5.5 in large group plans.[53]

Medicare benefits all Americans regardless of income status.

- Eighty-three percent of Medicare outlays go to beneficiaries with incomes of $25,000 or less.[54]

- Only three percent goes to elderly individuals or couples with incomes in excess of $50,000.[55]

Medicare is a popular health care program.

- Eighty-nine percent of Americans want Medicare to continue.[56]

- Ninety-two percent of Americans say Medicare is the only way many older Americans can possibly obtain adequate health care.[57]

- A Kaiser-Commonwealth Fund 1993 health insurance survey found that 52 percent of Medicare beneficiaries are very satisfied with their Medicare insurance compared to 44 percent of families covered by employer-provided private coverage, and 30 percent of those whose purchase private health insurance individually.[58]

- Seventy-five percent of Americans oppose cutting Medicare in order to balance the budget.[59]

- When asked what should be the most important goal for the budget, the number one answer was "protecting Medicare and Social Security."[60]

Medicare has become so successful that Senator Dole, who voted against enactment of Medicare, now praises it:

> *"Much of our significant gains and life expectancy, improvement in the quality of life, and decreases in infant mortality can be directly attributed to the passage of the Social Security Amendments of 1965. The Medicare and Medicaid programs have played a central role in improving both access to and quality of health care services for the country's elderly, poor, and disabled. Equally significant, it may be argued that Medicare and Medicaid have provided a foundation for the phenomenal growth and the dissemination of new medical technologies that now contribute to the well-being of all the people of all nations."*[61]

But today, Medicare is once again under Republican attack. House Majority Leader Richard Armey says he "deeply resents the fact that when I am 65, I must enroll in Medicare." He calls it part of government that "teaches dependence," and says it is a program I would have no part of in a free world."[62]

Once again, Republicans are proposing voluntary systems, such as medical savings accounts, or plans which would require seniors to shop for their own coverage or pay much higher premiums.[63] Republicans would use the savings to pay for tax breaks for the wealthy.

These proposals always have been and still are unacceptable to Democrats. Senate Democratic Leader Tom Daschle has declared:

> *"In three decades, Medicare has come to symbolize this Nation's commitment to the health and financial security of our elderly citizens and their families. It is the fulfillment of the dreams as well as the efforts of Presidents Truman, Kennedy and Johnson and hundreds of Congressional Democrats. On this, the 30th anniversary of Medicare, it is important to recall the long and difficult struggle to enact this much-needed program and applaud its success and recommit ourselves to keeping the program strong and viable."* [64]

End Notes

[1] AARP poll, July 11, 1995.

[2] Statement upon signing the *Social Security Act* into law on August 14, 1945.

[3] *Congress and the Nation, 1945-1964*, "A Review of Government and politics in the Postwar Years," 1965, p. 1152. The American Medical Association's (AMA's) efforts to defeat national health insurance also must be recognized. The AMA compared Truman's health care proposal to the "totalitarianism of [Nazi] Germany." "Fishbein Assails New Health Plan," *New York Times*, November 27, 1945. For AMA's official position, see "AMA Vote Assails Health Insurance," *New York Times*, December 5, 1945, and "Dentists Oppose U.S. Health Plan," *New York Times*, December 7, 1945.

[4] "The Proposal for a Federal Compulsory Insurance System, of Citizens Medical Care," *Congressional Digest*, August-September, 1946.

[5] *Congress and the Nation, 1945-1964*, p. 1152.

[6] *1965 CQ Almanac*, p. 244.

[7] *Congress and the Nation, 1945-1964*, p. 1152.

[8] "Medical Insurance for the U.S., Voluntary or Compulsory?" *Congressional Digest*, March 1949. Again, the AMA's role in the defeat should not be underestimated. In unprecedented lobbying efforts, the AMA spent $1,522,683 in 1949 and $1,326,078 in 1950 for lobbying purposes—the two highest lobby spending reports ever filed by any organization until that time. It sent each member of Congress a pamphlet, "A Simplified Blueprint of the Campaign Against Compulsory Health Insurance," and a booklet, *25 Questions You want Answered on Compulsory Health Insurance Versus Health the American Way*. State organizations worked to get important national and local organizations to come out against the measure, and each of 10,234 opposing endorsements was to be sent to the appropriate Member of Congress and the President. *1965 CQ Almanac*, pp. 246-247: *1949 Congressional Almanac*, p. 294.

[9] *Congress and the Nation, 1945-1964*, p. 1152.

[10] Theodore Marmor, *The Politics of Medicare*, London, Routledge and Kegan, p.19.

[11] *Congress and the Nation, 1945-1964*, "A Review of Government and Politics in the Postwar Years," 1965, p. 1152.

[12] Michael Alderman, "Why We Need Medicare," *New Republic*, October 26, 1964, pp. 17-20. Dr. Aldelman was an MD who broke ranks with the AMA's opposition to Medicare to point out that the elderly were not able to afford the medical treatment they needed.

[13] *Congressional Record*, January 26, 1960, 1241-2.

[14] *Congressional Record*, January 26, 1960, 1241-2.

[15] *1965 CQ Almanac*, p. 243.

[16] *Congress and the Nation, 1945-1964*, p. 1154.

[17] *1962 CQ Almanac*, pp. 192-930; *1965 CQ Almanac*, pp. 236-237: *Congress and the Nation, 1965-68*, p. 754.

[18] *Congressional Record*, August 25, 1960.

[19] *Congressional Digest*, "The 'Medicare' Controversy in the Current Congress, Pro & Con," March 1965, p. 74. The AMA, Chamber of Commerce, and health insurance associations promptly opposed this new health care measure. They testified to the committees holding the hearings and lobbied individual offices, warning of dire consequences if Medicare became a reality. Dr. Edward R. Annis of the AMA warned that Kennedy's proposal "would have disastrous effects on the quality of medical care our patients would receive." "The Controversy Over the Administration's New Medicare Plan for the Aged," *Congressional Digest*, January, 1962.

[20] *Congress and the Nation, 1945-1964*, "A Review of Government and Politics in the Postwar Years," 1965, p. 1154.

[21] To counter President Kennedy's efforts, the AMA purchased time on national television to rebut his remarks. AMA President Dr. Leonard Arson said the Kennedy bill would deprive older people of a private system of medical care. AMA advertisements ran in 29 leading newspapers and on 40 FM radio stations across the country. And the AMA flooded the country with posters with the headline: "Socialized Medicine and You," and the warning: "your freedom is at stake." "Health-Plan Battle: The AMA or JFK," *Newsweek*, May 8, 1962.

[22] Address before National Retail Merchants Association, April 5, 1962, excerpted in *Congressional Digest* "The Question of Expanding Social Security to Provide More Medical Care for the Aged," August-September 1963.

[23] *Congressional Digest*, "The 'Medicare' Controversy in the Current Congress, Pro & Con," March 1965, p. 74.

[24] See, for example, Rep. Frank Row, Address to American Academy of General Practice, Chicago, April 1, 1963, excerpted in *Congressional Digest*, "The Question of Expanding Social Security to Provide More Medical Care for the Aged," August-September 1963.

[25] *Congressional Digest*, "The 'Medicare' Controversy in the Current Congress, Pro & Con," March 1965, p. 74.

[26] *Congressional Digest*, "The 'Medicare' Controversy in the Current Congress, Pro & Con," March 1965, p. 74.

[27] *Congressional Record*, August 31, 1964.

[28] *1962 CQ Almanac*, p. 196.

[29] *Congressional Record*, August 31, 1964.

[30] *Congressional Record*, September 1, 1964.

[31] Senate Speech, August 31, 1964 in, "The Medicare Controversy," *Congressional Digest*, March 1965.

[32] *Congressional Record*, September 2, 1964.

[33] Senate Speech, September 2, 1964 in, "The Medicare Controversy," *Congressional Digest*, March 1965.

[34] "President's Plan for Care of Aged Voted by the Senate," *New York Times*, September 3, 1964.

[35] Congressional Digest, "The 'Medicare' Controversy in the Current Congress, Pro & Con," March 1965, p. 74.

[36] Milton Viorst, "How Medicare Was Lost This Year," *New Republic*, October 17, 1964, pp. 6-7.

[37] "Aid to Appalachia, Medicare Die in Adjournment Push," *Washington Post*, October 3, 1964.

[38] "Medicare Set For Next Round," *Business Week*, October 31, 1964, p. 32.

[39] News Conference, October 3, 1964.

[40] "How Medicare was Lost this Year," *New Republic*, October 17, 1964, pp. 6-7.

[41] "Medicare Set for the Next Round," *Business Week*, October 31, 1964, p. 32.

[42] *1965 CQ Almanac*, p. 247.

[43] 1965 State of the Union Address.

[44] *Congressional Digest*, "The 'Medicare' Controversy in the Current Congress, Pro & Con," March 1965, p. 74.

[45] *Congressional Record*, January 4, 1965.

[46] *Congressional Record*, January 6, 1965.

[47] *Congressional Record*, April 8, 1965, pp. 7389-90.

[48] *Congressional Record*, April 8, 1965, p. 7420.

[49] *Congressional Record*, April 8, 1965, p. 7434.

[50] *Congressional Record*, April 8, 1965, pp. 7389-90.

[51] *Congressional Record*, April 3, 1965, p. 7375.

[52] Based on Census Bureau's "Valuation of Non-Cash Benefits," 1993.

[53] Bruce Vladeck, Administrator, Health Care Financing Administration (HCFA), May 15, 1995: Karen Davis, President of Commonwealth Fund, "Medicare Solvency and Financial Security for Beneficiaries," testimony before U.S. Senate Budget Committee, May 3, 1995.

[54] Karen Davis, President of Commonwealth Fund, "Medicare Solvency and Financial Security for Beneficiaries," testimony before U.S. Senate Budget Committee, May 3, 1995: HCFA, "Medicare Fact Sheet," January, 1995.

[55] Karen Davis, President of Commonwealth Fund, "Medicare Solvency and Financial Security for Beneficiaries," testimony before U.S. Senate Budget Committee, May 3, 1995.

[56] DYG, Inc. poll for AARP, July 11, 1995.

[57] DYG, Inc. poll for AARP, July 11, 1995.

[58] Karen Davis, President of Commonwealth Fund, "Medicare Solvency and Financial Security for Beneficiaries," testimony before U.S. Senate Budget Committee, May 3, 1995.

[59] ICR Survey Research Group, for AARP, May 5-14, 1995.

[60] Gallup/*USA Today* Poll, June 5-6, 1995.

[61] *Congressional Record*, July 30, 1985, p. S10367.

[62] "GOP Leader Lashes Out at Medicare," *Chicago Tribune*, July 11, 995.

[63] "Private Solutions Eyed for Medicare," *Washington Times*, July 8, 1995.

[64] Remarks recognizing the forthcoming 30th Anniversary of Medicare, July 12, 1995.