Medicare History
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Medicare in the United States is an outgrowth of a larger conversation about how health care was organized and paid for, as well as the political and philosophical debates about the roles of the federal government in social welfare.

This conversation included topics such as states’ rights and responsibilities; economics; the role of employers; various models of insurance; changes in science, the practice of medicine, and technology; and uniquely American ideas of liberalism and the limits of government. The dialogue at times highlighted two parallel yet often clashing visions of the American dream that date back as far as founding fathers Thomas Jefferson and Alexander Hamilton. On the left of the conversation were those who saw the American promise as a pledge, as a society, to take care of those who are sick, elderly or cannot help themselves. On the right were those who saw the promise as a place where individuals who innovate, further knowledge and the science of medicine should not be restricted by taxes, regulations or other burdens of government programs.

Early Steps

There were many evolutionary changes in American society over the centuries that made the ground fertile for the eventual passage of Medicare. Federal legislation on behalf of the indigent insane and the blind, deaf and “dumb” was proposed by activist Dorothea Dix and passed as early as the mid-19th century by Congress, though they were vetoed by President Franklin Pierce, who argued that social welfare should be left to the states. After the Civil War, on behalf of freed slaves the federal government established the Freedmen’s Bureau, the first national medical care system, but it was short-lived, lasting only five years.

In 1912 Theodore Roosevelt, running as a Progressive with the support of health care reformers, was the first to suggest social insurance in the United States, the beginning of the process that eventually led to the creation of Social Security and Medicare.
By the early 1900s, U.S. health care was improving, as the American Medical Association (AMA) began to standardize the requirements for medical licensure. A private reform group, the American Association for Labor Legislation, organized the Social Insurance Committee in 1912; and in 1915 it published a model health insurance bill, although much of their effort was aimed at the individual states.

Around this time, U.S. employers began to offer their employees the opportunity to buy what was called sickness insurance. This marked a very different trajectory of health care coverage on this side of the Atlantic.

In 1921 Congress enacted the Sheppard-Towner Act, which provided federal funding for maternity and child care. Massachusetts, Connecticut and Illinois never participated in the program, and opposition by the AMA led to it not being renewed in other states. The AMA saw it as a socialist threat, despite the fact that its own Pediatric Section of its House of Delegates had endorsed renewal. The controversy led the Pediatric Section to break away and to establish the American Academy of Pediatrics.

The Great Depression, Prepaid Health Plans and the Formation of the Blues

During the Great Depression, the need for medical care for the elderly became particularly visible because older people were relying on their children, who were themselves out of work. This caused attention to be placed on both health care, leading to the rise of prepaid health plans, and on the elderly, which gave rise to Social Security.

Prepaid health plans were advantageous to subscribers as a way to afford hospital care and to hospitals as a way to stabilize revenues. In 1929 a group of teachers in Dallas contracted with Baylor University to provide 21 days of hospitalization for a fixed $6.00 payment. As other single hospital plans were developed, community hospitals began to work with each other to reduce competition. In 1939, under the auspices of the American Hospital Association, these plans eventually combined under the name Blue Cross. Blue Cross prepayment plans were distinct from single-hospital plans as they required that subscribers have their choice of physician and hospital.

Physicians were slower to provide prepaid health care because they were worried that a third-party system of payment would lower their income and affect their ability to charge customers different rates depending on their ability to pay. The success of Blue Cross led them to also worry that hospitals would start to offer prepaid physicians’ services; and, at the same time, feared that the conversation about Social Security would lead to its logical extension of mandatory health insurance. As a pre-emptive measure, physicians developed their own prepaid plans. The doctors’ first Blue Shield Plan was created in California in 1939, and in 1948 nine plans came together and officially adopted the Blue Shield symbol.
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Social Security

As the Depression wore on, poverty among the elderly approached 50 percent, and it should be noted that it was mostly women and minorities who were not covered by unemployment insurance and pensions. In 1934 President Franklin D. Roosevelt described the need for a national system and created the Committee on Economic Security, which was assigned the task of studying how to provide security for the elderly and disabled. Opponents called the idea socialist.

In 1935 the Social Security Act was passed, which provided benefits to retirees and the unemployed, as well as money for states to provide assistance for various public health services.

The program was funded by a payroll tax, so it did not use general revenue funds to pay benefits. The amount people received depended on the amount they had contributed into the system. The Social Security Board was established to administer the tax and the program. There have been many changes to Social Security over the years, from the age of retirement, to the amount of earnings subject to the tax, to instituting yearly cost-of-living (COLA) adjustments.
In a 1945 address to Congress, President Harry S. Truman proposed national health insurance to be run through Social Security, but Congress rejected the idea. In 1949 the Murray-Wagner-Dingell bill, which would have provided comprehensive national health insurance, was defeated with heavy lobbying from the AMA.

Political and Economic Factors in World War II and the Eisenhower Years

During the Second World War, employers faced a labor shortage and used health insurance as a means to lure employees. At the same time, unions were becoming more powerful and were negotiating health coverage for members. These factors further helped cement the system of employer-provided coverage in the United State. This change in health insurance can be seen in the fact that by 1958 nearly three-quarters of Americans had some type of coverage through work. During President Dwight D. Eisenhower’s administration, there were no serious health care proposals, but proponents, looking ahead to a more responsive political climate, began to shift the conversation to health care for the elderly. Those over age 65 were generally less able to pay for health care and were among the most in need of medical care.

The Kerr-Mills Act Leads the Way for Senior Health Care

In 1960 the Kerr-Mills law gave money to states for older Americans’ health care, though by 1963 only 32 states had adopted it. At that point only half of Americans age 65 and older had health insurance: private coverage was either unavailable (because of pre-existing conditions) or too expensive. While this group of Americans had half as much income as younger people, they paid nearly three times as much for health insurance.

The Health insurance Benefits Act of 1961, known as the King-Anderson bill and primarily backed by Democrats, provided inpatient hospital services, skilled nursing home services, home health services and outpatient hospital diagnostic services to people covered by Social Security or the Railroad Retirement Act. The Herlong-Curtis bill, introduced in 1965, incorporated an eldercare proposal developed by the AMA. The Byrnes bill, backed by Republicans, called for coverage of hospital and physician services for the aged through private insurance with federal administration and financing from both general revenues and pension deductions of individuals who chose to participate. Various perspectives from all these bills were merged into the Medicare law.
Medicare is Established

In 1965, under pressure from President Lyndon Johnson, and with a Democratic Congress, national health insurance for older adults, newly dubbed Medicare, was passed under Title VIII of the Social Security Act, and still over the objections of the AMA. Medicare was designed to provide health insurance to people age 65 and older, regardless of income or medical history. At the same time, a health care program for families and individuals with low income, called Medicaid, was established under Title XIX of the Social Security Act.

President Truman is credited with being the first to suggest that a program like Medicare was needed, and he was so recognized by President Johnson at the signing of the Medicare legislation in 1965. President Truman would also be the first to enroll in the program once it was established.

At its inception, Medicare covered doctors visits and hospitals stays, and prohibited any interference by the government in actual medical practice. It was funded by taxes on workers’ earnings that were matched by employer contributions.

The Medicare Part A deductible was $40 per year and the Part B premium was $3 per month. Private companies were selected to perform administrative functions of processing bills and payments.

The program was immediately popular: one million people enrolled in the first week. By the time coverage began on July 1, 1966, more than 19 million people had enrolled.

The effect of Medicare was felt throughout the country. Before its passage, 56 percent of people over the age of 65 did not have hospital insurance. That was reversed by 1970, with 97 percent of that population being covered. By 1975, the number of elderly people living in poverty had been cut in half.

Medicare and Civil Rights

Medicare played a significant role in the fight for civil rights in America, too. Before 1965 many hospitals and even physicians’ offices were segregated. Medicare included a
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provision that reimbursement was only available to integrated facilities. This was directly responsible for health facilities throughout the United States becoming integrated shortly after Medicare became law.

The American Medical Association and Medicare

The American Medical Association was against the first health maintenance organizations (HMOs) during the Depression, seeing them as a violation of anti-trust laws. Physicians' contentious attitude toward the concept of Medicare had them opposing it even before it was created because they thought it would significantly impact their income, their practice of charging for services according to patients' ability to pay and the rights of patients to select their own doctor. The campaign against Medicare, dubbed Operation Coffee Cup, included organizing through home meetings and even an LP record featuring Ronald Reagan. Today, the reverse is true, as the AMA now opposes cuts to Medicare funding.

Additions and Changes to Medicare

In 1972 President Richard M. Nixon signed the first major adjustment to Medicare since its passage. The program was expanded to include coverage for wellness physicals, chiropractic and physical therapies, payments to health maintenance organizations (HMOs), coverage for people younger than 65 on permanent Social Security Disability Insurance and those with permanent kidney failure (end-stage renal disease, or ESRD).

The Health Care Financing Administration Formed

In 1977 Joseph Califano, Secretary of the then-Department of Health, Education and Welfare sought a more efficient means of handling payments. At the time, Medicare was administered under Social Security and Medicaid under Welfare programs. He created the Health Care Financing Administration (HCFA) to administer both Medicare and Medicaid, thus consolidating what had been separate payment functions and disentangling Medicare from Social Security.

By 1982 people were living longer because of both medical advances and better health care. End-of-life issues were now drawing the spotlight, and hospice benefits were added to Medicare, first on a temporary basis and then, in 1984, as a permanent part of the program. At this same time, Medicare spending was on the rise. The Balanced Budget and Emergency Deficit Control Act of 1987 was passed, freezing Medicare payment rates in an effort to hold the line on spending.
The Battle Over Medicare Catastrophic Coverage

In 1988 the Medicare Catastrophic Coverage Act of 1988 was passed; this was the largest expansion of Medicare since its inception. This expansion included outpatient prescription drug coverage, a cap on out-of-pocket expenses and expanded hospital and skilled nursing facility benefits.

How this expansion was to be paid for, however, became very controversial. A supplemental, means-based premium was enacted, which was basically an income tax on 40 percent of the senior population, marking the first time beneficiaries were asked to pay the entire benefit bill.

Most seniors were strongly against this new legislation, and a huge public outcry arose. The seniors who would have been taxed did not want to finance expanded coverage for everyone. This was particularly the case for higher income people who already had extensive retiree coverage from their former employers.

The outcry was so strong that Congress repealed most of the act in 1989, including the outpatient drug benefit and the cap on out-of-pocket expenses.

In 1990 the “Pepper Commission,” named after Congressman Claude Pepper of Florida, and officially known as the U.S. Bipartisan Commission on Comprehensive Health Care, recommended that a new Medicare program be created to provide long-term care that included nursing home and home- and community-based services. This program was never created.

Advent of Private Medicare Plans

The Balanced Budget Act of 1997 marked the first time that private insurers were allowed to participate in Medicare outside of their administrative role. As part of this bill, Medicare+Choice was created, which gave beneficiaries the option of enrolling in one of several different types of private plans instead of Traditional Medicare. The options included health maintenance organizations (HMOs), preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service plans, medical savings accounts (MSAs) and high-deductible insurance plans. The program also gave participants the opportunity to obtain prescription drug coverage and other services not included in Traditional Medicare.
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The Balanced Budget Act also established the sustainable growth rate (SGR, also known as the “doc fix”) as a means of controlling physician costs. The SGR creates limits to physician charges, and these limits are tied to the gross domestic product (GDP). To lessen the impact on doctors over the years, however, Congress has usually limited reductions to physician pay.

In 2001, people younger than age 65 with amyotrophic lateral sclerosis (ALS, or Lou Gehrig’s disease) were added to the Medicare program and the name HCFA was changed to the Centers for Medicare & Medicaid Services (CMS).

The Medicare Modernization Act of 2003

Newer and more expensive drugs were coming to the market, but seniors found them harder to afford. The Medicare Modernization Act of 2003 (MMA), championed by President George W. Bush, was primarily enacted to add a prescription drug benefit, known as Part D, to Medicare, and it took effect in 2006. Under Part D, beneficiaries pay a premium, a deductible and a co-payment for prescriptions.

The MMA contained provisions reflecting the various constituencies in the political climate in which it was enacted. These include a subsidy for large employers to encourage them to provide prescription drug coverage to retired workers, a measure preventing the government from negotiating discounts with drug companies and another measure preventing the government from establishing a formulary (list of approved medicines), although it does not prevent private insurers from doing so.

The MMA also created the so-called “donut hole,” in which a Medicare beneficiary would be covered to a certain total cost of drugs ($2,800 in 2010) but who would then have to pay out-of-pocket the full costs of drugs until the ceiling was reached ($4,550 in 2010). Once this was reached, the beneficiary would pay only a small co-payment until the end of the year.

In addition to the prescription drug benefit, the MMA expanded Medical Savings Accounts to allow contributions and employer participation, gave extra money to rural hospitals, required higher fees from wealthier seniors, added a pretax health
savings account for working people and required Part D plans to support electronic prescriptions. The MMA also streamlined claims administration through the creation of Medicare Administrative Contractors in fifteen jurisdictions.

Medicare Advantage

The MMA changed the private insurance program, renaming Medicare+Choice, Medicare Advantage. The new program included provisions so that beneficiaries could enroll only for a year at a time (allowing them to change plans if they wanted), care could be restricted to a provider network, formularies could be used to restrict drug choices, care other than emergency care could be restricted to a particular region, prescription coverage could be deferred to the patient or a Medicare Part D plan and federal reimbursement could be adjusted according to enrollee health risk.

The Affordable Care Act

In 2008, President Barack Obama, coming into office in 2009, made health insurance a priority of his administration. The ensuing battle opened deep rifts in the country and Congress, though the Affordable Care Act (ACA) was passed in 2010.

The ACA made many changes to Medicare, aimed at strengthening the program, providing stronger benefits and slowing growth in costs. The Act provided beneficiaries in the donut hole with various rebates and discounts, and it will phase out the donut
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hole by 2020. After that, beneficiaries will pay only 25 percent of the cost of their prescription drugs.

In addition to phasing out the “donut hole,” it is expected to: slow increases in Part B physician premiums and lower them over time; slow the increase in co-payments and co-insurance under Parts A and B through slowing the growth of payments to hospitals and other providers; and provide many preventive services to seniors at no additional cost. The average Traditional Medicare beneficiary is expected to save about $3,500 over 10 years. The ACA will also save about $500 billion over 10 years through the reduction in extra subsidies paid to Medicare Advantage plans, reductions in the growth rate of provider payments and efforts to reduce fraud and abuse. Through various measures, the ACA also extended the life of the Medicare Trust Fund to at least 2029.