...And the pursuit of national health : the incremental strategy toward national health insurance in the United States of America

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"Medicare need not just be for people over 65," as President Lyndon B. Johnson announced on April 8, 1966, "That is where we started." Even though Johnson was merely suggesting including the disabled and medically indigent children within the scope of Medicare, his comments did strengthen the fears of the opponents that Medicare was indeed the first step toward a system of national health insurance. Wilbur Cohen, by then promoted to the position of HEW undersecretary, denied that Medicare would be extended to include the remaining segments of the population. As Cohen told journalist Richard Harris:

In the beginning, we looked at [Medicare] as a small way of starting something big – what the AMA likes to call a “foot in the door.” But in time the bill we wrote – or, anyway, the idea behind it – became our only goal. Although the doctors are convinced that we intend to expand it downward, to individuals under sixty-five, I don’t believe any responsible person in the government has any such intentions. As far as I’m concerned, this is America’s form of national health insurance.

Wilbur Cohen talked to Harris right after Medicare had been enacted. As he was responsible for the implementation of the new program, Cohen was eager to maintain a good relationship with all parties involved, including the medical profession. He therefore deliberately avoided any statement that could suggest that the Johnson administration wanted to go beyond the limited scope of Medicare. Social security commissioner Robert Ball, however, was less hesitant to admit that a system of national health insurance was indeed the ultimate goal. "We all saw insurance for the elderly as a fallback position, which we advocated solely because it seemed to have the best chance politically," as Robert Ball would later recall. "Although the public record contains some explicit denials, we expected Medicare to be a first step toward universal national health insurance."

The social security policymakers believed in the incremental character of the Social Security Act. While the advocates of a single national health insurance program hoped that Medicare and Medicaid would be extended to include the entire population, the social security policymakers expected that the program would be extended by category. After the inclusion of the elderly and the welfare poor, the targeted groups could be children, the disabled, and single

parents with dependent children. Similar to the American social security and public assistance programs — but quite the opposite to most other western government health insurance programs — Medicare and Medicaid would initially not include able-bodied individuals between the age of 21 and 65. Eventually, as the social security policymakers expected, all (medically) needy Americans who could not afford private health insurance, including the uninsured working poor, should be covered by Medicare and Medicaid. As Wilbur Cohen predicted, “by 1975, the medical assistance program [Medicaid] will include practically every person who cannot afford to pay for the medical care he needs. This could mean approximately 30 to 35 million medically needy people — or about 1/5 of our population.”

The result would be an American system of national health insurance, consisting of private, employer-based health insurance for the American workers and their dependents, and government health insurance for the elderly, the disabled, children, and the uninsured working and unemployed poor. Even though universal coverage might not ever be achieved, each step would help to come closer to that goal. As Wilbur Cohen stated, “They will be important steps — some big, some little — but not perfect or complete.”

With the enactment of Medicare and Medicaid in 1965, the first major steps toward universal coverage had been taken. Political developments, however, threatened to blunt the drive for extension. While 1965 had been the year of legislative triumph, 1966 was the year of implementing a rather costly Great Society. At the same time, the political climate began to change. In addition to the escalation of the war in Vietnam, urban unrest arose as the civil rights struggle shifted from the rural South to the Northern cities. The American people no longer unconditionally believed that Johnson’s Great Society would be a big success. The costs of the war in Vietnam were undermining the budget for domestic reforms. In spite of President Johnson’s claims, few Americans believed that the nation could have both “Guns and Butter.” HEW secretary John Gardner was extremely worried about the direction the domestic reforms were going. “Our domestic program is suffering from a loss of momentum,” as he told President Johnson. “When momentum gives out, the inertial forces of society take over. People become preoccupied with self-serving, feuding, settling old scores. ... It takes a surge of forward

movement to lift people out of the petty preoccupations. This nation needs a new burst of momentum that will carry it into the 1970s.” President Johnson agreed with Gardner that the Great Society could be built in spite of the war in Vietnam. In his State of the Union address of January 12, 1966, he told Congress: “This Nation is mighty enough, its society is healthy enough, its people are strong enough, to pursue our goals in the rest of the world while still building a Great Society here at home.”

THE IMPLEMENTATION OF MEDICARE

Between July 30, 1965, the day President Lyndon B. Johnson signed Medicare into law, and July 1, 1966, the day Medicare went into effect, a massive operation took place to make America ready for its first national health insurance program. “Even in this Cybernetic Age, no program as large as medicare springs to life with the flick of a switch or the expression of good intentions,” as Wilbur Cohen stated. “It takes a forest of people, a mountain of skills, and rivers of perspiration.” 19 million elderly were to be enrolled in Medicare Part A, and also had to make a choice whether or not to participate in Medicare Part B. The Social Security Administration tried everything to get the message across to the American elderly. At the suggestion of President Johnson, famous “older” Americans such as comedians Jimmy Durante and Bob Hope promoted Medicare in television ads. Another presidential suggestion was to present the first Medicare benefit cards to former President Harry S. Truman and his wife Margaret. Subsequently, Truman taped a Medicare television ad in which he called Medicare “a step from charity, to security with dignity.” To reach those elderly without television, the Forest Service carried Medicare application forms into the isolated woods and mountains. The Public Health Service (PHS) distributed Medigame, a board game similar to Monopoly, which helped the senior citizen to understand all benefits Medicare had to offer. As Wilbur Cohen concluded, “We have

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6 John Gardner to Bill Moyers, 4 August 1966, Cater to Johnson, 4 August 1966, Cater Papers, box 15, LBJ Library.
9 John Gardner to Douglass Cater, 19 January 1966, Gardner to Johnson, 3 March 1966, Johnson to Harry S. Truman, 8 March 1966, Truman to Johnson, 15 March 1966, Johnson to Truman, 23 March 1966, Ex IS, box 1, LBJ Library. Truman wrote to Johnson that, due to the success of Medicare, “In my opinion, there is good reason for you to expect that you will be ranked with our great Presidents.”
10 Interview with Robert Ball by David G. McComb, 5 November 1968, LBJ Library, 38; “Medigame – Makes It Fun To Learn,” Medicare File, Office of the historian of the Social Security Administration, Altmeyer building, Baltimore, Maryland.
prepared special materials for doctor's offices and pharmacies. We've done special work with labor, religious, business, community, and service organizations. We've translated pamphlets into 22 languages. From radio and TV, through newspapers, magazines, and journals to posters on mail trucks, buses, and subways, medicare news is in front of, in back of, and alongside of the American public!"\(^{11}\)

The deadline for Medicare enrollment was set on March 31, 1966, while three months later, on July 1, 1966, Medicare would go into effect. The first day of July was deliberately chosen at the suggestion of former social security policymaker I.S. Falk. Already in 1949, when he was contemplating the implementation of President Truman's National Health Plan, Falk had stated that "Any 'effective date' should be July 1, when morbidity and demand for medical and hospital services are minimal, so that the initial benefit load under the new system of arrangements will be minimal."\(^{12}\) In 1965, after Falk had reminded Cohen of the effective date, Cohen added another reason. Starting the program a couple of days before Independence Day (July 4) was practical, as most people would try to avoid using the hospital during a holiday.\(^{13}\) With the deadline of March 31, 1966, approaching, ninety percent of the elderly had been enrolled in the Medicare program. The enrollment campaign had been "one of the widest and most successful canvassing drives in history," as *Time* magazine reported, but, "if one sheep be lost, would not Lyndon Johnson leave the flock to go in search of it?"\(^{14}\) Johnson was indeed not satisfied and he requested Congress to extend the enrollment deadline to May 31, 1966.\(^{15}\)

With the exception of two minor incidents, the campaign to get the American elderly enrolled in Medicare ran smoothly. Those elderly who were not covered by the social security system (around two million Americans) had to proclaim that they did not belong to any "Communist-action organization, Communist-front organization or Communist-infiltrated organization." The American Civil Liberties Union immediately filed a complaint and the Johnson administration promised to change the application forms.\(^{16}\) Another complaint

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12 Falk to George St. J. Perrott, 7 February 1949, Falk Papers, box 69, folder 700, Yale Library.

13 Interview with Wilbur Cohen by David G. McComb, 8 December 1968, LBJ Library, tape II, 12.


came from Vice President Hubert Humphrey who accused the Social Security Administration of "a total lack of imagination." Instead of a prominent politician, the Medicare television ads featured "a Mr. Ball" as spokesman. "Why can't the President or at least the secretary of HEW, a Presidential appointee, be the spokesman?" Humphrey's complaint apparently did get through, as the vice president himself was featured as Medicare's spokesman in the HEW film "YOU AND MEDICARE." 17

The only two major obstacles in the implementation process were the desegregation of Southern hospitals (which will be discussed later on in this chapter) and the expected lack of sufficient facilities. By early 1966, alarming stories appeared in the press, stating that the shortage of medical facilities would constitute a major crisis. Most alarming was a Life magazine article entitled "Medicare Is Launched into a Shambles," which featured pictures of overcrowded hospitals and littered emergency rooms. "Because of the nurse shortage, the weary and overworked doctors must clean up the mess." 18 The expected overcrowding of hospitals was also reported by the influential journalists Rowland Evans and Robert Novak. "Administration officials carefully explain that the new law does not guarantee hospital, diagnostic, outpatient, nursing-home or home nursing care. It simply guarantees partial payment of the bill by Uncle Sam. But that explanation may not sit well with people who suddenly become eligible for treatment they could never afford before, and then find it isn't available because of lack of space, doctors, nurses or technicians." 19

President Johnson was extremely disturbed by these "hysteria stories." Instead of Medicare horror stories, he wanted to have positive messages in the press. Johnson asked Wilbur Cohen to talk with the columnists of the major newspapers to get across that all the preparations needed were made to make Medicare a success and that the president himself was personally involved in these preparations. 20 Cohen subsequently tried to point out that the fear for overcrowding was unnecessary. Even with a utilization increase of twenty percent, there would not be a problem, as the elderly only made up twenty-five percent of hospital days. The overall increase would only be five percent and such an increase could easily be handled by most hospitals in the country. Moreover, the administration was working together with the American

17 Humphrey to Jack Valenti, 13 August 1965, Ex IS, box 1; "YOU AND MEDICARE," film produced by the Social Security Administration, LBJ Library.
18 "Medicare Is Launched into a Shambles," Life, 3 September 1965, 52B-58.
Hospital Association (AHA) to provide alternative care in the “trouble spots.”\(^\text{21}\)

The Johnson administration also denied Evans and Novak’s claim that the federal government merely saw Medicare as a cash program. “You do not agree with the attitude expressed by some bureaucrats that ‘Medicare only provides the payments. It is the job of the community to provide the services,’” as presidential aide Douglass Cater told the president. “You also do not agree with those who say we should never have started Medicare simply because it will put a strain on our nation’s facilities. You have fought for legislation to increase medical personnel. The victories have been hard won.”\(^\text{22}\)

In spite of the reassurances by the social security policymakers that there would not be any overcrowding, President Johnson remained worried. “I don’t know what got into the President, but something made him very nervous that all the elderly who had been saving up all their ills for the last 65 years would suddenly show up at the hospitals on the day Medicare was going to be implemented,” as social security commissioner Robert Ball remembered. “And, then, of course, the Secretary got excited when the President did, and we had to locate the hospitals that did have high occupancy rates and locate them by pins on a map. We had the army hospitals and the veterans hospitals alerted, and there were plans even to use helicopters to move people from one place to another.”\(^\text{23}\)

Subsequently, the HEW department established a temporary Referral Center for Medical Emergency Cases in the Medicare Program. When confronted with life-threatening emergencies, the center could refer patients to military and Veteran Administration hospitals. In the end, the “war room and pins on the map” proved to be unnecessary. As Robert Ball concluded, “There wasn’t any problem anywhere. We didn’t need a single army bed anywhere. We didn’t need a single helicopter.”\(^\text{24}\)

THE HEALTH INSURANCE BENEFITS ADVISORY COUNCIL

In spite of the AMA’s opposition to Medicare, the Johnson administration wanted to secure the cooperation of the medical profession in the implementation of Medicare. The two visits of the AMA officials with President Johnson in July and August 1965 had opened the door to a more

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21 Cohen to Cater, 8 June 1966, Cater to LBJ, 9 June 1966, Cater Papers, box 15, LBJ Library.
22 Gardner to Johnson, 10 June 1966, Cater Papers, box 15; Cater to Johnson, 25 May 1966, Cater to Johnson, 27 May 1966, Cater Papers, box 14, LBJ Library.
constructive relationship between the federal government and organized medicine. Even though Johnson continued to distrust the AMA, he had told the HEW officials to do their best in revising the Regional Medical Program and the Heart Disease, Cancer, and Stroke bill to make them acceptable to the AMA. The AMA leadership valued the willingness of the Johnson administration to listen to the physicians' point of view and subsequently announced that it would cooperate in the implementation of Medicare. This promise to cooperate surprised many of the AMA's rank and file. As one AMA member exclaimed, “We have learned that the AMA leadership is negotiating with the federal employees who for 30 years have been trying to impose socialized medicine on physicians of the country, and we hear such words as collaboration, cooperation, and deals, which leave us ever more confused and ever more bewildered.”

The Johnson administration was extremely pleased that the AMA was cooperating “wholeheartedly.” Only a small group of doctors organized in the Association of American Physicians and Surgeons (AAPS), an organization of rightwing physicians who believed that the AMA policies were “too liberal,” was still trying to sabotage Medicare. The AMA leadership, however, supported Medicare by taking part in the Health Insurance Benefits Advisory Council (HIBAC). Vice president of the Brookings Institution and former budget director Kermit Gordon chaired the HIBAC, which consisted of sixteen members. Unlike its predecessor the Advisory Council on Social Security, which only included one physician (namely, Kenneth W. Clement of the African-American National Medical Association), the HIBAC included nine physicians. Labor was represented by AFL-CIO’s Nelson Cruikshank. According to Wilbur Cohen, who claimed to have “personally selected the members of the first Council to be sure there was adequate representation from former critics and supporters of the law,” the importance of the HIBAC could not be overemphasized. The HIBAC was, in the words of Judith Feder, the “original cornerstone of the balancing process.” In this way, representatives of the medical profession, the hospitals, the insurance companies, labor, and consumer groups were able to bridge the gap between the different interests and create consensus. As the HIBAC membership was on personal title, the

26 Gardner to Johnson, 13 December 1965, Ex IS, box 1.
representatives of the different organizations could go further than the organizations officially would go, enabling a better compromise.  

Even though federal officials were officially not part of the council, the social security policymakers initiated and organized most of the meetings. To their surprise, the meetings were far more successful than had been anticipated. "It helped a little to be snowed in for three days at a motel," as Robert Ball remembered, referring to one of the first HIBAC meetings. "The bar was open fairly early in the process."  

However, all interest groups involved realized that the "honeymoon" could soon be over. The AMA, the AHA, Blue Cross, and Blue Shield used the HIBAC to influence the determination of "reasonable costs." The social security policymakers, on the contrary, used the HIBAC in attempt to curtail the expected inflationary pressures on Medicare. One month after Medicare had gone into effect, the HIBAC held its tenth meeting. "Surprisingly enough they all agreed [Medicare] had gotten off to a pretty good start," as AFL-CIO's Nelson Cruikshank told Senator Clinton P. Anderson. "Of course the AHA thought there should be more money for hospitals, and the AMA complained about the paper work as did Aetna and Blue Cross - but they all admitted their complaints were minor!" Chairman Kermit Gordon shared Cruikshank's positive views and wrote to President Johnson that, even though not all problems had been solved, constructive progress had been achieved.  

Up to 1970, the HIBAC met regularly to discuss policy questions concerning the Medicare program. The AMA involvement in the HIBAC proved that the cordial relationship between the AMA and the federal government could last. In addition to the meetings of the HIBAC, the social security policymakers met directly with the AMA's Council on Legislative Activities, chaired by Samuel Sherman, who was also a HIBAC member. Wilbur Cohen hoped that the "open door" policy between the Johnson administration and the AMA would secure the cordial relationship. The AMA's attitude suggested that would be the case. "You have acquired a fan club consisting of all persons present from our group," as Sherman told Cohen after one of their meetings. "I don't know who is doing the brain-washing but I like the results and the feeling of mutual respect, empathy and trust which

32 Kermit Gordon to Lyndon B. Johnson, 2 August 1966; Johnson to Gordon, 3 August 1966, Cohen Papers, box 10, folder 9, State Historical Society of Wisconsin.
prevailed.”33 Ironically, the successful efforts of the Johnson administration to cooperate with the AMA led to complaints by the American Hospital Association. “The hospital people were very pessimistic and frustrated,” as Wilbur Cohen told HEW secretary John Gardner. “They had cooperated with us. The American Medical Association which had not cooperated with us in the enactment of the legislation was getting ‘everything it wanted.’ It seemed like the best thing for the hospitals to do was to be critical and recalcitrant – like the AMA – and they would get more from us.”34

The Desegregation of Southern Hospitals

Another obstacle in the implementation of Medicare was the desegregation of Southern hospitals. To secure equal health care facilities throughout the nation was important to the Johnson administration, as it would protect the universal character of Medicare. During the first eight months of Medicare’s implementation, however, the desegregation of Southern hospitals was not an urgent issue on the Medicare agenda.35 This changed in March 1966 when the HEW department established the Office of Equal Health Opportunity. A rushed desegregation effort followed. The delay had been a deliberate move of the Johnson administration. Assuming that a majority of the Southern hospitals already anticipated the requirement to desegregate and subsequently were prepared to do so, the Johnson administration tried to discourage the remaining and less-willing hospitals from organizing opposition.36 In this way, desegregation was enforced within a period of four months, leaving little time for organized protests. To investigate the status of compliance, questionnaires were sent to hospitals all throughout the nation. Even though desegregation was an important requirement, other requirements included good hygiene and the availability of services such as x-ray facilities. If the questionnaire suggested that further inspection was needed, or if the questionnaire was never returned, then the inspectors of the Public Health Service and the Social Security Administration would visit the hospital. Both HEW agencies had

36 Draft Memo for the President [no author], 10 April 1965, Ex LE/IS, box 75, LBJ Library.
hired around five hundred inspectors who had received a short training by consultants, including representatives of the National Urban League and other civil rights specialists.\textsuperscript{37} Not surprisingly, most of these inspections were to be made in the South, particularly in the Deep South states (Alabama, Georgia, Louisiana, Mississippi, and South Carolina) and in Virginia.\textsuperscript{38}

Ending segregation meant more than merely taking down the “White” and “Colored” signs and forcing all-white hospitals to accept African-American patients. The hospital staff of doctors and nurses needed to be desegregated, enabling equal chances for all personnel to receive staff privileges or to qualify for special training. To desegregate all-black hospitals, the often lower-quality service had to be improved through funding to attract a white clientele. Ironically enough, not only white hospitals but also African-American hospitals were reluctant to desegregate, as African-American physicians feared that they would lose their professional autonomy when working in a desegregated hospital. Most important, desegregation meant a change in attitude. HEW officials had to explain again and again that Medicare did not require “a quota of Negroes in a hospital nor a Negro and white patient in every room.”\textsuperscript{39} Decisions were to be based on medical grounds only, rather than on race, color, or nationality. The biggest obstacle proved to be the desegregation of room assignments. As social security commissioner Robert Ball stated, “Remember now, this was the older population which had been brought up in segregated areas, and we are talking about two beds in the same room.”\textsuperscript{40} Once the inspections of the Southern hospitals had started, rumors appeared that hospitals did anything to provide a false appearance of full desegregation. In one hospital, African-American patients were “wheeled briskly from room to room while Federal examiners were being distracted,” and in another white and black babies were placed side to side in the nursery, only to be separated again once the inspectors were gone.\textsuperscript{41} According to Robert Ball, however, these actions were merely incidents. “I think the word got around from one hospital to another pretty quickly that on this there was no room for bargaining.”\textsuperscript{42}

One month before Medicare would go into effect, the Johnson administration accelerated the drive for desegregation. All hospitals not in

\textsuperscript{38} Farris Bryant to Lyndon B. Johnson, 23 May 1966, CF HE5, box 17, LBJ Library.
\textsuperscript{39} F. Peter Libassi to Cater, 28 June 1966, Cater Papers, box 15, LBJ Library.
compliance were sent warning letters, followed by a phone call from the regional office. Larger hospitals could expect a personal visit by HEW inspectors within seven days. In addition to these inspections, political pressure was put on the Southern senators, governors, and mayors. All connections were used to “encourage the communities involved to serve their self-interest by bringing pressure on their hospitals to comply.” HEW officials conducted meetings with the congressional delegations from the Southern states. At the request of President Johnson, Vice President Hubert Humphrey contacted the mayors of the Southern cities to point out the “dire consequences of failing to be ready for Medicare,” while Governor Farris Bryant from Florida met with the governors of the Deep South states. With the exception of Governor George Wallace from Alabama, most governors and mayors were cooperative in pressuring the local hospital administrations to fulfil compliance. Moreover, in spite of their earlier opposition to Medicare, the desegregation effort was also supported by the medical profession and the nonprofit insurers. The Journal of the American Medical Association printed an article by surgeon general William H. Stewart in which he asked for the cooperation of the medical profession. The AHA contacted the state hospital associations in the South, urging them to support desegregation. The Blue Cross representatives informed the administrations of Southern hospitals that most Blue Cross payments for patients over 65 would no longer be paid after Medicare had started and that non-complying hospitals would thus no longer receive Blue Cross payments.

During a special meeting with the Southern senators and their staff representatives, two days before Medicare was to go into effect, the senators complained that the Johnson administration was too strict in its desegregation effort. Senator Russell Long proposed a compromise by asking HEW secretary John Gardner to “use discretion and judgment in the enforcement of Title VI.” The Johnson administration, however, refused to give in, at least in public. The night before Medicare’s official start, HEW secretary Gardner announced that the requirements would not be loosened. “To lower the standards for hospitals that have delayed coming into compliance would be to

44 Gardner to Cater, 13 June 1966, CF HE5, box 17, LBJ Library.
45 Lyndon B. Johnson to Hubert H. Humphrey, 10 June 1966, CF HE5, box 17, LBJ Library.
46 Department of Health, Education, and Welfare, “Highlights of Public Information Activities in Connection with Hospital Compliance with Title VI of the Civil Rights Act,” 13 June 1966, Cater Papers, box 15, LBJ Library.
48 F. Peter Libassi to Cater, 18 June 1966, CF HE5, box 17, LBJ Library.
49 Cater to Johnson, 28 June, CF HE5, box 17, LBJ Library.
reward delay and to discriminate against those hospitals which came into compliance earlier and met the standards fully.” However, in spite of these good intentions, HEW officials had quickly realized that they needed to be inclusive if they wanted hospitals to desegregate. As one HEW official told Judith Feder: “If we took them in, they would integrate. If we’d closed them down, they would have said it was because we were forcing them to integrate. Then we’d have a race thing on our hands.” A “race thing” was exactly what the Johnson administration wanted to avoid. Instead, the Johnson administration believed that a “positive approach” would encourage further desegregation. Once a majority of the Southern hospitals was in compliance, the rest would naturally follow. In attempt to include as many hospitals as possible, the HEW department introduced the so-called “substantial compliance” category. Instead of refusing to certify Southern hospitals that were in partial compliance, the HEW department certified them on the condition that they move toward full compliance in the future. As a result, a large number of hospitals could be certified at the last moment.

In August 1966, President Johnson proudly announced that the “old blot of racial discrimination in health is being erased in this land we love.” The days when “a sick man whose skin was dark was not only a second class citizen, but [also] a second-class patient” were finally over. Civil rights advocates, however, were not convinced. Two months earlier, the National Urban League had already expressed its concern to President Johnson that the HEW department had certified hospitals in Atlanta that were known to be segregated. In the Senate, liberal Democrats attacked the Johnson administration’s strategy of substantial compliance. “Hundreds of hospitals were certified after agreeing to some HEW demands in the last 2 weeks before the deadline.” Those segregated but certified hospitals in Atlanta were no exceptions, but the rule. As the liberal Democrats concluded, “In short, no matter how loudly the administration claims that it refused to accept tokenism in place of performance, it is clear that in reality the opposite was true.”

51 Feder, Medicare, 12.
54 Whitney M. Young, Jr. (executive director National Urban League) to Johnson, 17 June 1966, Ex IS, box 3, LBJ Library.
spite of all the criticism, however, even the liberal Democrats had to admit that desegregation under Medicare had been at least partially successful. Complying Southern hospitals seemed to work fine and had even recognized the practical advantages of desegregation. As the administrator of one Virginia hospital stated: “Sometimes we used to have shortages of colored beds. Other times we had shortages of white beds. Now that a bed is a bed, we always have one available.”

The Johnson administration’s strategy of pragmatic politics over upholding a strict principle eventually paid off. Medicare may have not ended segregation and discrimination in Southern hospitals, but it undoubtedly sped up the desegregation process.

THE COSTS OF MEDICAID

While most attention was given to the implementation of Medicare and the obstacles of the supposed lack of medical facilities and the desegregation of Southern hospitals, the other health insurance program enacted in 1965, Medicaid, received little attention. As Wilbur Cohen remembered:

Title XIX [Medicaid] was not a secret, but neither the press nor the health policy community paid any attention to it because of the dazzling bewilderment of the adoption of [Medicare] Part B. The proponents of Medicare were delighted with their victory; the opponents were demoralized. ... The full awakening to the scope of the Medicaid legislation did not come until much later. The health policy community in 1965 was a small band of brothers and sisters concerned about the controversial elements in Medicare and unaware of the possibilities in Medicaid. But the idea of Medicaid developed in my mind as early as 1942. I waited for the right time when someone would ask me to develop it into a law. The year 1965 was that time.

Wilbur Cohen’s initial vision of Medicaid was based on the belief that a public assistance program was needed to cover those Americans who were not able to obtain coverage through private health insurance or government social security insurance. This intention, however, was not clear to many politicians, as no one seemed to know how Medicaid would develop. Moreover, unlike Medicare, the Medicaid legislation was poorly drafted, leaving a lot of the issues open to wide interpretation. “Actually, Medicare could be more realistically compared to a two layer cake plus the recipe for the third layer,” as commissioner of welfare Ellen Winston stated, referring to the popular three-layer cake metaphor. “Medicare provides the recipe ... and a good portion of the ingredients. However, it is up to States and communities to bake the cake.”

There were major differences between Medicare and Medicaid. Unlike Medicare, Medicaid build on the already existing Kerr-Mills legislation, which was a joint federal-state program. Medicare was a universal program based on the social security system and administered by the federal government. Medicaid, on the contrary, was a public assistance program targeted at certain categories of the welfare poor. This division was also reflected in the implementation of the programs. Medicare, as a prestigious program of the Johnson administration, was executed by the ever-growing Social Security Administration, while Medicaid was placed under the responsibility of the understaffed Welfare Administration. As a joint federal-state program, Medicaid was based on the matching principle. The federal government funded fifty to eighty-three percent of the costs of the state program. The initiative to start Medicaid, however, was left to the individual states. Once a state had established a Medicaid program, it had to receive the approval of the HEW department. Medicaid started out on an open-ended federal budget, meaning that Congress was unable to control the costs for the federal government. The federal costs depended on the actions of the individual states. If the states set up extensive programs, the federal costs would increase. The only way Congress could control costs was by cutting the federal funds of the program. The deadline for states to get their Medicaid program accepted by the federal government had been set on December 31, 1969. By then all but two states (Alaska and Arizona) had established a Medicaid program.59

Most politicians in Congress had assumed that the Medicaid program would merely be an extension of the already existing Kerr-Mills program. Medicaid, however, was more than merely a revised Kerr-Mills. The eligibility requirements were less strict, as adult children were no longer considered to be responsible for the health care costs of their aged parents and residence requirements could no longer be used to determine eligibility. While Kerr-Mills had been based on vendor payments, the Medicaid payments were based on the private insurance principle. In this way, Medicaid beneficiaries were brought into the “mainstream” of medical care. Moreover, Medicaid provided far more comprehensive services than Kerr-Mills had done.60 Medicaid was based on a complex categorization of possible beneficiaries, who were divided in the “categorically needy,” the “categorically related needy,” the “categorically related medically needy,” and the “noncategorically related medically needy.” The first category to be covered by Medicaid was the group of public assistance beneficiaries, including the elderly poor, the blind and disabled, and families who received AFDC (Aid to Families with Dependent Children) benefits. The

second category included “comparable” groups of elderly, the blind and disabled, and families with children who earned too much to be eligible for general public assistance, but who could not afford to pay for their own medical care. The third category, also known as the Ribicoff provision (named after Senator Abraham Ribicoff who had introduced it in Congress), were all medically indigent children under 21, regardless of whether or not their parents were unemployed or on welfare. The fourth category consisted of all remaining medically indigent, including the uninsured working population between the age of 21 and 65. This last category was expected to be included within Medicaid by 1975.61 In practice, most Medicaid programs did not go beyond the first two categories, building on the already existing public assistance tradition of only including those who were eligible because they were old, blind, disabled, or a dependent child. Being merely poor or so-called medically indigent was in most states not enough to be eligible for Medicaid.

Once Medicare had successfully been implemented, both politicians and press began to give more attention to the Medicaid program. In July 1966, an editorial in Life magazine warned to “Watch Out” for Medicaid. The program went far beyond its limits, the editors claimed. “The Congress must add a set of guidelines that will allow the separate states to write laws that will solve the medical problems of their citizens who are truly in need — without bankrupting the rest of us.”62 The revived attention had been prompted by the introduction of the Medicaid plans of California and New York. Both states were known for their comprehensive public medical services. Their Kerr-Mills programs had been the most advanced of all medical assistance programs on state level. The politicians in Congress were particularly worried about the Medicaid program in New York. Due to the differences in the cost of living between New York City and Upstate New York, the New York Medicaid program had a high eligibility level to enable the inclusion of the urban medically indigent. However, the New York Medicaid program could cover more than the uninsured welfare poor and medically indigent alone. Depending on which statistics were used, it had been estimated that between thirty to forty-five percent of the New York population would be eligible for Medicaid, including many of the working population who were already covered by private, employer-based health insurance.63 To many politicians in Congress, the New York Medicaid plan was unacceptable, and they wanted to revise Medicaid. When the New York Medicaid plan was up for approval by the HEW


63 Myers, Medicare, 288-294; Stevens and Stevens, Welfare Medicine in America, 92-95.
department in Washington, DC, Wilbur Mills asked Wilbur Cohen to delay action in anticipation of legislative changes in the Medicaid law.\textsuperscript{64}

The New York controversy made Medicaid a hotly debated issue in Congress. While the Republicans believed that Medicaid was far too liberal, the liberal Democrats, led by Senator Robert Kennedy from New York, opposed any cuts in the Medicaid program. On August 22, 1966, Senator Leverett Saltonstall, a Republican from Massachusetts, stated that he was amazed by the unexpected scope of the Medicaid program, an amazement that was undoubtedly shared by many senators. "There was little discussion of title 19, which certainly had proved to be the 'sleeper' in the bill. I am certain that no one dreamed that within the next 5 years, 'medicaid' ... could come to dwarf medicare." Saltonstall objected to the inclusion of medically indigent persons between 21 and 65. Senators had been under the impression that Medicaid would merely be an extension of Kerr-Mills. Moreover, they had expected that the states would be as slow and conservative with Medicaid as they had been with Kerr-Mills. Instead, states were handing in comprehensive plans. "Clearly this approach goes beyond the kind of program Congress supported in Kerr-Mills, and which it thought, with some modest increases, it simply would be continuing under title 19." If the trend toward comprehensive coverage under Medicaid would continue, Senator Saltonstall warned, "we will be embarking on a program Congress never intended to promote, one far more revolutionary in its impact than medicare itself.\textsuperscript{65}

Senator Saltonstall's objections were confirmed by a report of the House Committee on Ways and Means that stated that many Medicaid plans, and the New York plan in particular, went "well beyond what your committee believes to have been the intent of the Congress." The committee emphasized that Medicaid should be limited to the welfare poor and the medically indigent and not provide benefits to "the adult working population of moderate income."\textsuperscript{66} While the views of the Republicans and liberal Democrats in Congress were clearly defined, the position of the Johnson administration was ambiguous. On the one hand, cuts in the Medicaid budget were needed as it became clear that the federal spending on Medicaid would exceed the amount that had been anticipated. On the other hand, cutting a program before it had been established in all states would be a blow to the promise of the Great Society. Publicly, President Johnson continued to support the extension of Medicare and Medicaid. However, when in December 1966, Charlie Schultze, the director of

\textsuperscript{64} Cohen to Cater, 19 August 1966, Cohen Papers, box 89, folder 4, State Historical Society of Wisconsin.


the Bureau of the Budget, provided President Johnson with his financial estimates on the Medicaid program for the coming years, Johnson scribbled as answer on the memo: "See how you can cut down Medicaid." The negative image of Medicaid caused by the unexpected increase of costs was enhanced by the stories of fraud in the Medicaid program. Both the physicians and the patients were accused of cheating the system. Doctors allegedly performed unnecessary services and charged for house calls that were never made. Patients were believed to take joyrides in ambulances and to request extensive gold dental work. These stories were—of course—in line with the "general" stigmatization of welfare programs and welfare beneficiaries, often based on class and racial prejudice. Even though stories about fraud in the Medicare program also appeared in the press, they seemed far less influential in the process of cutting funds than was the case with the Medicaid program. The distinction between Medicare and Medicaid was perhaps best summed up by an article in Time magazine: "MEDICARE: Expensive & Successful, MEDICAID: Chaotic but Irrevocable." Both programs proved to be more expensive than had been anticipated, but only Medicaid was perceived as an irrevocable failure. "Medicare can be treated as marked success both for the aged treated under it and for the hospitals treating them," as Time reported. "Medicaid is suffering from all kinds of inflammatory ills, plus

67 Charles Schultze to Califano, 21 November 1966, Cater Papers, box 19, LBJ Library; Schultze to Johnson, 22 December 1966, Johnson to Schultze, 30 December 1966, Ex IS, box 1, LBJ Library.
69 Ad Hoc Committee on Title XIX to Douglass Cater, 11 December 1967, WE 6, box 19, LBJ Library.
massive financial hemorrhaging, and is headed for drastic surgery before Congress quits for Christmas.\(^7^1\)

With the social security amendments of 1967, Congress cut Medicaid funds by making the requirements for eligibility more strict. Most important, the income of Medicaid beneficiaries could no longer be more than one-third higher than the income of a family on welfare, strengthening the ties between welfare and Medicaid.\(^7^2\) The Johnson administration claimed to be "very disappointed" and feared that the cuts would lead to social unrest, particularly in the inner cities.\(^7^3\) Yet, in spite of the social security amendments of 1967, rapidly increasing costs continued to plague the Medicaid program. By 1968, the costs of Medicaid had exceeded the original 1966 budget estimates by more than fifty percent. According to the Johnson administration, it was the "lack of experience" with the new Medicaid program that was partially to blame for the incorrect calculations. Moreover, while most states had taken a long time to get the Kerr-Mills programs started, most states acted quickly on Medicaid, thus accelerating the costs.\(^7^4\)

The increase of Medicaid costs were caused by five major developments. First, the number of welfare recipients, particularly those receiving AFDC, rose rapidly. As AFDC beneficiaries were automatically eligible for Medicaid, the number of Medicaid beneficiaries rose as well. Second, the welfare poor were far better informed of the possibilities to receive public assistance than they had been before. Third, the increase of Medicaid costs ran parallel to the general increase of the costs of medical care. Fourth, the Medicaid programs were slowly expanding to include coverage of more comprehensive services. Fifth, as Medicare did not cover nursing home care, a large part of the Medicaid budget was spent on paying nursing home care for the elderly and disabled poor. While cutting funds seemed to be the only solution, the expansion of the Medicaid program was out of the question. By 1968, Wilbur Cohen had come to realize that the original ideal of including all medically indigent by 1975 had to be reconsidered.\(^7^5\)

\(^7^2\) Stevens and Stevens, *Welfare Medicine in America*, 118-121.
\(^7^4\) Charles J. Zwick to Johnson, 24 February 1968, Ex I8, box 1, LBJ Library.
Already in 1965, even before the war in Vietnam had escalated and the popularity of President Johnson was dwindling, the Johnson administration worried about the public image of the Great Society. Presidential aide Harry McPherson told the president that the American public had to be made aware of the “magnitude of what the Great Society has accomplished so far.” “The legislative record is dazzling, but I believe in the minds of the people it is still just that: a Washington accomplishment that has not yet been translated into reality.” Many of the Great Society programs that were enacted, including Medicare and Medicaid, seemed to promise more than they could realistically offer. McPherson suggested a public tour of federal officials throughout the nation, explaining the actual scope of the Great Society to the general public. At the same time, McPherson warned, such a public exposure could lead to higher expectations than the budget would allow—“raising hopes and then crushing them because of budgetary limitations is worse than leaving the public in the dark about the new programs.” Nevertheless, such a public tour could convince the American public that “we are not closing the door on the Great Society, we are just muting our welcome to it because of Viet Nam.” In April 1966, when President Johnson was about to sign the Medicare enrollment extension bill, Wilbur Cohen gave him similar advice. “You can keep the initiative by indicating in your statement that you plan to: increase insurance benefits ... improve the medicare program, [and] keep the program up to date. ... It would also serve notice to Vietnam critics that you intend to pursue your Great Society program.”

Even though the war in Vietnam did burden the budget of the Great Society, the biggest problem facing Medicare and Medicaid was the rapid increase of health care costs. As medical science continued to be advanced, so did the expectations of the patients, who received more hospital care than ever before. The education of the general public, the growing number of elderly, and the expansion of health care facilities, all stimulated the health care costs to rise even more. In addition, the expansion of health insurance coverage, both private and governmental programs, led to more medical care. The enactment of Medicare and Medicaid did not necessarily cause the increase of costs, but did enhance the already existing inflationary process, especially in hospital care. As a report of the HEW department read: “The rise in hospital daily charges was especially sharp in the second half of 1966. In the first six months of 1966, hospital daily charges increased 4.5 per cent. In the second half, they

76 Harry McPherson to Johnson, 1 December 1965, McPherson to Bill Moyers, 13 December 1965, McPherson Papers, box 11, LBJ Library.
77 Cohen to Johnson, 6 April 1966, Ex IS, box 1, LBJ Library.
rose 11.5 per cent. In contrast, physicians’ fees increased 3.8 per cent in the first half of 1966 and another 3.8 per cent in the second half.”

While to many the influence of Medicare on the increase of hospital care costs seemed obvious, the social security policymakers did not believe that the enactment of Medicare had been the direct cause of the increase. Instead, as Wilbur Cohen argued, the increase was caused by the rising wages of the professionals and the “increases in the price of things that hospitals buy.” Moreover, when Medicare had gone into effect, hospital administrations reviewed their “reasonable costs” and “customary charges,” and, as Cohen believed, increased them more and sooner than they might have done if Medicare had not been enacted. Whether or not Medicare was the direct cause, the rising costs worried the politicians both within and outside the Johnson administration. President Johnson told Wilbur Cohen that Wilbur Mills of the House Committee on Ways and Means was “all over the ticker” because of the escalating health care costs in the Medicare program. Wilbur Cohen again blamed the hospitals for “pressing for a liberalization of policies which, if adopted, could increase costs substantially beyond what was financed in the 1965 Medicare law.”

Medicare and Medicaid were, however, not the only Great Society programs that were burdened by budgetary strains. The escalating war in Vietnam had forced the Johnson administration to discuss the issue of “Guns or Butter.” Could President Johnson continue the war in Vietnam without hurting the domestic reform programs at home, including Medicare and Medicaid? The popular view was shifting toward a negative answer, stimulated by the opponents to the war in Vietnam who used the budgetary problems of the Great Society and the increasing urban unrest as anti-war arguments. “Martin Luther King has become the crown prince of the Vietnics, and along with the ADA [Americans for Democratic Action] blames the war for our failure to remedy social ills,” as presidential aide Harry McPherson told President Johnson. “Though this will not bear scrutiny, it will gain currency the more it is repeated by the liberal and civil rights establishments. It is a lot easier to make Vietnam the villain than to face (1) the problem of managing the new social programs, (2) the apparent failure of Negroes and other minorities to make substantial gains, or (3) the reluctance of Congress and the voting public to support new

80 Cohen to Gardner, 8 March 1967; Cohen to Johnson, 8 March 1967, Cohen Papers, box 91, folder 7, State Historical Society of Wisconsin.
programs, or adequate funds for existing programs.” McPherson made a valid argument. Even though the war in Vietnam did enhance the budgetary problems of the Great Society, the programs themselves constituted the core of the problem. The fears of the fiscal conservatives who had opposed drastic domestic reforms had come true. The Great Society cost much more than Congress was willing to spend.

The increasing social unrest in the inner cities created a frustrating dilemma for the Johnson administration. On the one hand, the Great Society programs were too expensive and did not seem to succeed in their objectives to end poverty and relieve social suffering. One could even argue that the failure of the Great Society to provide for the benefits that it seemed to promise, contributed to the feelings of dissatisfaction among the urban poor. On the other hand, as the Johnson administration believed, only more social programs could counter the social unrest in the inner cities. President Johnson saw Medicare and Medicaid, among the other social welfare programs, as part of the solution to end the urban violence. “I would say jobs, health, education, and housing are all contributing to this general dissatisfaction that results in violence on occasions, and we have to accelerate our efforts there,” as Johnson told the press. Nevertheless, he also believed that the Great Society had accomplished much already. “We are spending three times as much on health today as we were 4 years ago, and the poor are the primary beneficiaries of Medicare and Medicaid. They can have their hospital bills paid now. They can have their doctors paid now.” To counter the social unrest in the inner cities, the Johnson administration started a pilot project in Washington, DC, in cooperation with the National Medical Association (NMA), the African-American counterpart of the AMA. The health section of the pilot project consisted of using federal subsidies to establish community health care centers and to promote group practice. The Washington, DC, project was the first of more pilot projects in fourteen cities. As far as the president was concerned, rapid action was needed. “The quicker the better. Yesterday. It will take months. We will survey, explore, consider, collaborate, have criteria and all of these gobbledygooks, but if we just hammer enough, it will get done.”

In the meantime, HEW secretary John Gardner continued to worry about the direction the domestic reforms were going. “We can no longer continue the

81 McPherson to Johnson, 4 April 1967, McPherson Papers, box 15, LBJ Library.
82 Lyndon B. Johnson, “A Conversation With the President,” Joint Interview for Use by the Television Networks,” 19 December 1967, Public Papers, 1158-1173.
great American tradition of stumbling into the future. Change is too swift, and the consequences of change too troublesome,” as Gardner told President Johnson. “We must look ahead, identify our problems as they emerge, and study them systematically. Only thus are we likely to gain command of the problems that threaten to overwhelm us.” As Gardner believed, the Johnson administration was not doing enough to counter the social unrest. More programs were needed to provide for the poor in the inner cities. Then, in January 1968, Gardner decided to resign. Rumor had it that Gardner clashed with President Johnson over the war in Vietnam, but Gardner’s dissatisfaction with the domestic reforms seemed a more logical reason for his resignation. As chair of the National Urban Coalition, a private antipoverty organization, Gardner continued to work on the problem of urban poverty. Four months later, President Johnson appointed Wilbur Cohen as the new secretary. At Cohen’s swearing in ceremony, Johnson praised his incremental strategy. “In a time when we are hearing so much about power, black power, white power, green power, and student power, perhaps someone should do an analysis of another kind of power – ‘Wilbur Power.’ ... It is the power of the patient, persistent reformer over the noisy zealot.” Johnson’s praise of Cohen’s incrementalism came at a time when liberal Democrats became dissatisfied with the slow and pragmatic strategy of the social security policymakers. The protests and calls for social action that dominated American politics during the late 1960s were also reflected in the national health insurance debate. Even within the HEW department, voices of opposition to incrementalism could be heard. To the younger generation in the department, Wilbur Cohen had become to symbolize the “survival of the old system in which important issues are evaded and powerful political interests are reconciled.”

NATIONAL HEALTH INSURANCE OR THE EXTENSION OF MEDICAL CARE

Whether or not the enactment of Medicare and Medicaid should be seen as a step toward national health insurance remained open to debate. The construction of the two government health insurance programs both obstructed and encouraged their expansion. “Isn’t Medicare a ‘entering wedge’ to a broader program of nationwide ‘compulsory’ insurance coverage of everyone?” as Wilbur Mills had asked Wilbur Cohen in 1965. As Cohen remembered, “I suggested that if he included some plan to cover the key groups of poor people, he would have a possible answer to this criticism. ... Medicaid evolved from

84 Gardner to Johnson, 30 October 1967, Cater Papers, box 17, LBJ Library.
87 Berkowitz, Mr. Social Security, 276.
As Cohen had envisioned, Medicaid functioned as a buffer against the extension of Medicare. The incremental character of the Social Security Act, on the contrary, invited the slow expansion of Medicare and Medicaid. Even before Medicare and Medicaid were implemented, the Johnson administration was already considering proposals to extend both programs. Categories that could be included consisted of disabled workers, dependent children of disabled or deceased workers, and the mothers of these children.89 Basically, the Johnson administration had three choices: 1) changing Medicare into a system of national health insurance, thus also covering the uninsured working population between the age of 21 and 65, 2) extending Medicare and/or Medicaid to include certain segments of the population, such as the blind, disabled, or dependent children, or 3) returning to the expansion of medical care. Even though the advocates of national health insurance hoped that the Johnson administration would pursue the first strategy, a combination of the second and third strategy would be most logical, as it was in line with the incremental development of the Social Security Act.

Throughout the Medicare debate, the AMA had warned that Medicare would eventually be extended to include the entire population. In his speech “Government Health Care: First the Aged, Then Everyone,” the AMA’s most persuasive speaker Edward Annis stated: “As surely as night follows day, enactment of Social Security health care for the aged would bring constant political pressure for further expansion. With all covered persons paying a higher Social Security tax, but with benefits limited to a particular age group, it is not difficult to imagine the inevitable political appeal of expanding both benefits and eligibility.”90 Even though Annis’ speeches were often filled with charged rhetoric, his claim that Medicare and Medicaid invited expansion of the programs was valid. In fact, Wilbur Cohen had seen the enactment of medical vendor payments in 1950, the disability freeze in 1952, disability insurance in 1956, and Kerr-Mills in 1960 as stepping stones to Medicare and national health insurance. “This sequence of events brought the Federal Government into the mainstream of health policy administration,” as Cohen explained. “I felt we had to get our feet wet in working with hospitals and physicians to discover ways and means of resolving problems, rather than debating ideology in a vacuum.”91

The politically most attractive program to extend Medicare and Medicaid became known as Kiddy Care (sometimes also referred to as Medikid). Wilbur Cohen remembered a phone call from presidential aide Jack Valenti that he received in the middle of night sometime in 1966. President Johnson was going

89 Cohen to Johnson, 16 March 1966, Cater Papers, box 20, LBJ Library.
to sign a bill and wanted "something" that could add "drama" to the occasion. Cohen suggested to announce the intention to extend government health insurance to children. One hour later Valenti called back, telling Cohen that President Johnson thought it "was a great idea" and that he wanted a specific program as soon as possible. Cohen preferred to add Kiddy Care to Medicare, as it would create a balance between the young and the elderly, thereby bringing Medicare closer to a program for the entire population. "I'm in favor of the salami-slicing approach which is to take one step at a time. It's almost impossible to put into effect successfully a program that goes from covering twenty million people to two hundred million people," as Cohen explained. "It's just too big of a bite at one time to digest without getting yourself into so many problems that you can't see the end of it. So Kiddy Care represents to me not only an establishment of a new system of priorities by directing our attention now to children as against the aged, but at the same time it helps you to swing into an evolutionary process where over a course of time you could end up with a more comprehensive program than you have today." Kiddy Care would become Wilbur Cohen's "pet project." However, the eventual draft proposals were far more limited than initially planned. Instead of extending the Medicare and Medicaid programs to include comprehensive health insurance for all children, Kiddy Care would provide for subsidized maternal care, both prenatal and postnatal, and baby care up to the age of 1. By limiting the proposal to maternal and baby care, its political chances increased, as, in Wilbur Cohen's words, no one could object to a program that enabled every child to "be born with the best medical care and have a good start in life." Even though children were politically the most attractive category to include within Medicare health insurance overage, the Johnson administration chose to focus on the extension of medical care instead. When, in June 1966, Wilbur Cohen was interviewed for the "From the People" television program, he repeatedly tried to ignore the question about the extension of Medicare, but emphasized the need for more medical care. "It is a matter of producing doctors, the dentists and the nurses through our educational institutions to see that they are available," as Wilbur Cohen explained. "All the money in the

92 Interview with Wilbur Cohen by James E. Sargent, 17 August 1974, Columbia University of Oral History Collection (microfiche edition, Roosevelt Study Center), 201-202. Even though Cohen does not explicitly state which bill signing he is talking about, Cohen is most probably referring to the signing of the Medicare Extension Bill, which extended the deadline for Medicare enrollment. See Lyndon B. Johnson, "Remarks in San Antonio at the Signing of the Medicare Extension Bill," April 8, 1966, Public Papers, 404-410
93 Interview with Wilbur Cohen by David G. McComb, 8 December 1968, LBJ Library, tape II, 10-11.
94 Berkowitz, Mr. Social Security, 265.
world will not produce a doctor if you don’t have a medical school and a faculty that will train the doctor."  

The return to promoting the extension of medical care over the extension of health insurance coverage was a logical step. As a matter of fact, the federal government had never retreated from subsidizing the extension of medical care. In addition to Medicare and Medicaid, a large number of medical bills had been signed by President Johnson, including the Nurses Training Act of 1964, the Health Research Act of 1965, the Health Personnel Training Act of 1966, and the Comprehensive Health Planning and Service Act of 1966. Moreover, the Medicare bill itself included — similar to the Social Security Act of 1935 — measures to extend public health services. The Johnson administration placed a strong emphasis on improving “the quality and lower the cost of medical services for all Americans” by training more physicians and medical personnel and by constructing new hospitals and community health centers. In a letter to HEW secretary Gardner, which was released to the press, President Johnson called for “a partnership in health with the states and communities,” which predominantly meant more federal programs to subsidize the extension of medical care. As far as Johnson’s political opponents were concerned, the president’s request for more money to subsidize medical care was just another attempt to increase the funding of the already expensive Great Society. President Johnson disagreed. As he told Congress on February 28, 1967, “I do not recommend more of the same — but more that is better.” That same day, he repeated the comment on national television.

Even though the extension of health insurance coverage under Medicare and Medicaid had become less important than the extension of medical care, the Johnson administration continued to propose Medicare coverage for the disabled. The inclusion of the disabled made perfect sense. Most of them already received social security and disability insurance benefits. Moreover, as non-working citizens, they were not covered by private, employer-based health

96 Califano to Johnson, 1 October 1965, Cater to Johnson, 27 December 1965, Ex HE5, box 17, LBJ Library.
insurance. However, plans to include other categories, such as the uninsured, able-bodied workers between the age of 21 and 65, were no longer seriously considered. Instead, the Johnson administration promoted the extension of private health insurance. Speaking before the National Conference on Private Health Insurance, Wilbur Cohen stated that at least ninety percent of the health care costs should be covered by both private and government health insurance. Cohen used the old argument of the social security policymakers by suggesting that Medicare and Medicaid had been enacted as an attempt to avoid the establishment of a system of national health insurance. If the combination of both government and private, employer-based health insurance programs succeeded in providing (almost) universal coverage for the entire population, the American form of national health insurance would prevail. However, as Wilbur Cohen warned, “If we do not find a way to increase private health insurance protection, there will be a gap which the public will want medicare or medicaid to fill.”

As the Johnson administration placed the strongest emphasis on the extension of medical care, while merely proposing small extensions of Medicare and Medicaid, the issue of health insurance coverage disappeared from the political agenda. Quoting the National Advisory Commission on Health Manpower, HEW secretary John Gardner reported: “The overall national policy that good medical care should be available to all citizens is being implemented through a jumble of disparate, competitive programs that threaten to envelop the health care system in an administrative morass.” However, instead of extending health insurance coverage under Medicare and Medicaid, Gardner suggested to make the existing programs more “efficient” and to increase the subsidizing of the delivery of medical care and medical facilities. As has been discussed earlier on in this chapter, the social security amendments of 1967 closed the door for achieving universal coverage by extending Medicaid to include the uninsured working population between the age of 21 and 65. When President Johnson signed the social security amendments, a mood of disappointment prevailed. In his statement, Johnson admitted that welfare in America was “outmoded and in need of a major change.” The Great Society seemed to have failed. “The welfare system today pleases no one,” Johnson stated. “It is criticized by liberals and conservatives, by the poor and by the wealthy, by social workers and politicians, by whites and by Negroes in every area of the Nation.” Congress had taken over control of the Great Society. According to Johnson, Congress ignored his recommendations and merely enacted “severe restrictions” instead, endangering the position of the welfare poor. To control the damage as much as possible, President


Johnson announced that the administration would work together with the
governments of the individual states "so that compassionate safeguards are
established to protect deserving mothers and needy children."\textsuperscript{102}

By then, the advocates of a single national health insurance program had
become disillusioned by the incremental strategy of the Johnson administration.
The advocates wanted universal health insurance for the entire population, not
merely for the elderly and a few underprivileged children. Public opinion
seemed to be on the advocates' side. According to a 1967 poll by Louis Harris,
a majority of the American public favored the expansion of Medicare to include
the entire population.\textsuperscript{103} The revived movement for national health insurance
was led by Walter Reuther, president of the United Auto Workers. In 1968, he
established the Committee of One Hundred for National Health Insurance,
which included prominent national health insurance advocates such as I.S.
Falk, Mary Lasker, and Nelson Cruikshank. Another prominent member was,
in the words of AMA's Edward Annis, Walter Reuther's "most faithful rubber
stamp in Congress, Senator Edward Kennedy, who professed to be deeply
concerned for the health of Americans."\textsuperscript{104} For the first time in twenty years,
the movement for national health insurance was again focused on providing
universal coverage for the entire population. No longer willing to wait for the
next small incremental steps as promoted by pragmatics such as Wilbur Cohen,
the advocates designed national health insurance plans that eventually would
lead to the Kennedy and Griffiths proposals of the early 1970s.\textsuperscript{105}

At the end of 1968, after the Republican presidential candidate Richard
Nixon had been elected, HEW secretary Wilbur Cohen presented his final
report to President Johnson, summing up the accomplishments of the HEW
department between 1963 and 1968. Ironically, both the success and failure of
the Medicare program were expressed by its high costs. Cohen proudly
announced that, since July 1966, 59.9 million bills had been paid, amounting
to $5.7 billion for inpatient hospital care, $2.1 billion for physician and other
medical services, and $420 million for extended care. Even though he realized
that the increasing health care costs remained a problem, Cohen's solution was
more and more programs. "Seeds for future improvements in health, education,
and welfare are contained in the legislative accomplishments of the past five

\textsuperscript{102} Lyndon B. Johnson, "Statement by the President Upon Signing the Social Security
Amendments and Upon Appointing a Commission To Study the Nation's Welfare

\textsuperscript{103} Louis Harris, "The Harris Survey: Most Americans Now Favor Medicare For
Papers, box 379, LBJ Library.

\textsuperscript{104} Edward R. Annis, \textit{Code Blue: Health Care in Crisis} (Washington, DC: Regnery
Gateway, 1993), 76.

\textsuperscript{105} David, \textit{With Dignity}, 155; Paul Starr, \textit{The Social Transformation of American
Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry}
years. The vision of a better society inspired these legislative enactments, and must inspire future legislative proposals,” Wilbur Cohen concluded. “America must dream big dreams, set high goals, and work to achieve them if our commitment to human well being is to be honored.”

By then, of course, Cohen was a lame duck HEW secretary, working within the lame duck Johnson administration. The goals described in the report were set unrealistically high. Nevertheless, Cohen did not use the opportunity to propose a system of national health insurance. The goal for 1976 was the same old story: “Comprehensive health insurance (private and public) combined with the availability of high quality medical service for all Americans.” Again, Cohen envisioned an American form of national health insurance by extending Medicare and Medicaid to include the uninsured population, but also with a stronger emphasis on the extension of medical care. Lyndon Johnson shared Cohen’s view of the need for legislative action. In his “first major statement since leaving the White House,” he called the enactment of Medicare and Medicaid “gratifying,” but he added that “no American with a conscience can escape being haunted by an awareness of the distance yet to go. The nation that trained the surgeon who made the first heart transplant, whose scientists have practically created life in a test tube, and that has wiped out polio has still not assured the right of good health to all its people.” The rhetoric of “more, more, more” had not changed, but without the liberal Democrats in the White House, the expansion of Medicare and Medicaid toward universal coverage seemed unlikely. With the departure of the Johnson administration, the strategy of incrementalism came to an end.

CONCLUSION

Immediately after Medicare and Medicaid had been enacted, the advocates of national health insurance perceived it as a victorious sign that national health insurance could be enacted in the near future. “The door was open to possible extensions of health insurance to other segments of the population,” as Rosemary Stevens has stated. “The passage of Medicare marked a new era.” The strategy of incrementalism, which basically had begun with the enactment of the Social Security Act of 1935, seemed to be working. While attempts to establish a national health insurance program for the entire population had

failed in the 1940s, the incremental extension toward national health insurance through relatively small but significant steps had succeeded: vendor payments in 1950, the disability freeze in 1952, disability insurance in 1956, Kerr-Mills in 1960, and Medicare and Medicaid in 1965.

Even though the social security policymakers, particularly Wilbur Cohen, continued to publicly state that Medicare was not a step toward a national health insurance program, the intention was to eventually include the entire uninsured population within the government health insurance system. Cohen did not favor a single-payer system, meaning that the government would be the only third party in medical care. He strongly believed in a combination of private, employer-based health insurance and government health insurance, a preference undoubtedly shared by President Johnson. In an attempt to maintain the coverage of the government health insurance program as limited as possible, Cohen encouraged the private health insurance industry to keep private health insurance affordable. However, universal coverage continued to be the ultimate goal.

Medicare and Medicaid could only succeed if consensus could be reached between the government, the medical profession, the hospitals, and the private health insurance industry. Even though the relationship between the social security policymakers and the AMA had been based on conflict, Wilbur Cohen and the AMA both successfully tried to maintain a cordial relationship. The effective way to strengthen consensus was the establishment of the Health Insurance Benefits Advisory Council. The different interest groups also effectively worked together to monitor the implementation process of Medicare, including the desegregation of Southern hospitals.

The ideal picture of Wilbur Cohen’s universal health insurance system began to crumble when the implementation of the Medicaid program proved to be problematic. In Congress, complaints were heard about the costs of the program. Medicaid turned out to be the “sleeper” of the government health insurance programs. As the debates in Congress had always been focused on Medicare, only a few people, including Cohen, had fully realized the importance of Medicaid. Particularly the proposed comprehensive Medicaid program of New York caused panic in Congress. Drastic cuts were recommended. The social security amendments of 1967 can be seen as a turn around in the Medicare / Medicaid debate. Instead of discussing the extension of the program, cutting the program became the dominant issue.

The end of Medicare incrementalism cannot be discussed without taking in account that the American political scene was going through a dramatic change. The war in Vietnam, the student protests, and the social unrest in the inner cities, all contributed to the loss of faith in incrementalism. However, the changing times merely made the strategies of the social security policymakers outdated and old-fashioned. In times of conflict, consensus was by definition considered to be a compromise. However, even though the end of Medicare incrementalism did fit within the mood of the times, the conflict was within the
system itself. Part of the problem was the continuing distinction between social insurance and public assistance. To include the entire uninsured population within Medicare and Medicaid, the segment of the uninsured but working population between the age of 21 and 65 had to be become eligible for Medicaid. The inclusion of the non-poor within a public assistance program proved to be impossible. Instead of a national health insurance program targeted at the working population of moderate income, as had been the tradition in other western industrialized nations, the American system was based on categories that were associated with public welfare: the elderly, the disabled, and families on welfare.

Over the years, Medicare and Medicaid have been criticized from both the conservative and the progressive side of the political spectrum. Instead of the solution to the problem of inadequate access to medical care due to financial inability, Medicare and Medicaid are now perceived as part of the problem of the continuously rising health care costs. The main beneficiary of government health insurance appears to be the health care providers. In addition, more and more advocates of national health insurance believed that Medicare was not a step toward but instead a substitute for national health insurance. In the meantime, the American elderly have grown accustomed to their Medicare. Subsequently, the elderly became reluctant to support national health insurance out of the fear that such a program would undermine their Medicare benefits. In spite of the criticism by professionals, Medicare and Medicaid continued to be popular among the general public, which was recognized by the populist politician Ross Perot in 1996. Known as an anti-federal politician, Ross Perot's praise of Medicare and Medicaid is a telling example of the popular support. "Programs such as Medicare and Medicaid prove that the federal government can make a meaningful difference in improving our society," as Ross Perot writes in his book Intensive Care: We Must Save Medicare and Medicaid Now. "Even though their costs are growing too fast, the programs serve a very important function in our society."110

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