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The Cost of the Benefit: How Wilbur Mills's Expansion of Medicare Led to Escalating Medical Costs

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THE COST OF THE BENEFIT: HOW WILBUR MILLS'S EXPANSION OF
MEDICARE LED TO ESCALATING MEDICAL COSTS

Thesis submitted in partial fulfillment of Honors

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ABSTRACT

For much of the early 1960s, House Ways and Means chairman Wilbur Mills represented the “One-Man Veto” on Medicare before eventually offering his reluctant support to the measure in 1964 and 1965. Ironically, this longtime opponent would be the one to suggest an expansion in the scope of the bill. Early proposals for Medicare only offered to cover hospital costs; Mills would call for physician costs to be covered, as well. The aim of this thesis is to show how Mills’s expansion of Medicare benefits in 1965 caused health care costs to skyrocket in the late 1960s, causing the fiscally conservative Mills to co-sponsor legislation for a single-payer national health insurance program along with Senator Edward Kennedy almost a decade later.

INTRODUCTION

“The greatest threat to America's fiscal health is not Social Security, though that's a significant challenge. It's not the investments that we've made to rescue our economy during this crisis. By a wide margin, the biggest threat to our nation's balance sheet is the skyrocketing cost of health care. It's not even close.”¹

- Barack Obama, March 2009

In an article published in the June 2009 issue of *The New Yorker*, staff writer Atul Gawande put forth a damning report on the nation's health care system. Gawande, who is also a general surgeon at Brigham and Women's Hospital in Boston, traveled to Texas to visit the city of McAllen, which is one of the most expensive cities in the country with respect to health care. Medicare expenditures serve as a good gauge of health care spending, and “in 2006, Medicare spent fifteen thousand dollars per enrollee [in McAllen], almost twice the national average.” This amount was also three thousand dollars more than McAllen's per capita income; however, spending more on health care than the average citizen in McAllen earns did not result in more quality care, Gawande found. In terms of the metrics used by Medicare to rank hospitals nationwide, “McAllen's five largest hospitals performed worse, on average, than El Paso's,” which spends significantly less money on health care.²

McAllen thus represents a microcosm of American health care at-large. The system is too costly. Roughly \$2.7 trillion is spent on health care-related expenditures annually.³ That

¹ Barack Obama, “Remarks by the President on the Opening of the White House Forum on Health Reform” (speech, Washington, D.C., March 5, 2009), The White House, <http://www.whitehouse.gov/the-press-office/remarks-president-opening-white-house-forum-health-reform>.

² Atul Gawande, “The Cost Conundrum: What a Texas Town can Teach Us about Health Care,” *The New Yorker*, June 1, 2009.

³ Donald M. Berwick, “The Toxic Politics of Health Care,” *Journal of the American Medical Association* 310, no. 18 (2013): 1921-1922.

means close to “one in every six dollars spent in the world’s most powerful economy [goes] to health care,” amounting to approximately seventeen-percent of the nation’s GDP.⁴ With regards to health indices, though, the United States lags behind many other countries that spend less on health care. For instance, in contrast to “16 other high-income countries (such as England, Japan, and Australia), Americans younger than 75 years have one of the shortest life expectancies.”⁵ Among all nations, “that means the world’s richest country ranks forty-seventh, just ahead of Cyprus and a little behind Bosnia and Herzegovina, in terms of longevity.”⁶ When adjusting for the effects of chronic illness, individuals living in the U.S. can expect a life of “full health” for seventy years. This merits the country a ranking of twenty-fourth, still behind other wealthy, industrialized democracies.⁷

In an effort to address this paradox of American health care, the Patient Protection and Affordable Care Act was passed by Congress in March 2010. Health care reform had been a central piece of the Democratic agenda for decades, and comprehensive legislation to that effect was finally able to come to fruition under President Barack Obama. The debate surrounding the Affordable Care Act was just beginning, however, as political and legal challenges abounded.

In the midterm elections of 2010, Republicans were able to wrestle control of the House of Representatives away from the Democrats by running on a platform that included the repeal of what they coined “Obamacare.” Many of these newly-elected congressmen received the backing of an upstart political movement known as the Tea Party. Waving flags that read “Don’t Tread

⁴ Marcus Brauchli, foreword to *Landmark: The Inside Story of America’s New Health-Care Law and What It Means for Us All*, by The Washington Post. (New York: PublicAffairs, 2010), vii.

⁵ Deborah T. Sugarman and Edward H. Livingston, “US Health Compared with Like Countries,” *Journal of the American Medical Association* 310, no. 18 (2013): 1996.

⁶ T.R. Reid, *The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care* (New York: Penguin Press, 2009), 253.

⁷ *Ibid.*, 256.

on Me,” members of this movement called for a reduction of the national debt through cuts in federal spending, in addition to a total repeal of President Obama’s most significant first term accomplishment, the Affordable Care Act. Indeed, the Republican-controlled House of Representatives would pass legislation aimed at a repeal of the law dozens of times beginning in January 2011.

The most significant challenge to the new health care law would occur in the summer and fall of 2012 with the Supreme Court ruling on the law and the presidential election, respectively. By a vote of 5-4, the Supreme Court of the United States upheld the bulk of the Affordable Care Act on June 28, 2012. Chief Justice John Roberts was the deciding vote and penned the majority opinion. Immediately following the high court’s announcement, Republican presidential candidate Mitt Romney took to a podium to deliver his response to the decision. In his speech, Romney stated, “What the Court did not do on its last day in session, I will do on my first day if elected President of the United States. And that is I will act to repeal Obamacare . . . Our mission is clear: If we want to get rid of Obamacare, we’re going to have to replace President Obama. My mission is to make sure we do exactly that.”⁸ In the weeks and months leading up to the November election, the Affordable Care Act would take center stage at political rallies across the country and in the 2012 presidential debates. In what became billed as a referendum on the health care law, President Obama would be reelected by a margin of 3.5 million popular votes and win 332 electoral votes.

Despite the reelection of President Obama, another hurdle emerged in September 2013 – just weeks before the health care exchanges called for by the law would open on October 1st.

⁸ Mitt Romney, “Remarks on the Supreme Court’s Decision on the Affordable Care Act” (speech, Washington, D.C., June 28, 2012), *The Wall Street Journal*, <http://blogs.wsj.com/washwire/2012/06/28/transcript-of-romneys-remarks-on-the-supreme-court-ruling/>.

With September 30th representing the last day in the federal government's fiscal year, Congressman Mark Meadows of North Carolina's Eleventh District would write to Speaker of the House John Boehner and House Majority leader Eric Cantor:

Since much of the implementation of ObamaCare is a function of the discretionary appropriations process, including the operation of the "mandatory spending" portions of the law, and since most of the citizens we represent believe that ObamaCare should never go into effect, we urge you to affirmatively de-fund the implementation and enforcement of ObamaCare in any relevant appropriations bill brought to the House floor in the 113th Congress, including any continuing appropriations bill.⁹

Another eighty congressmen would add their signatures in support of Congressman Meadows's suggestion, including Representative Phil Roe from Tennessee's 1st Congressional District.

Speaker John Boehner agreed with Congressman Meadows and the Tea Party Caucus. When he failed to hold a vote on a so-called "clean" continuing resolution bill, a spending bill not calling for the defunding of the Affordable Care Act, the federal government shutdown. With the Democratic-controlled Senate tabling any defunding bills passed by the House of Representatives, the result of such political brinksmanship was a partial government shutdown lasting for some sixteen days and a near-default on the federal debt.

While it remains to be seen what the full impact of the Affordable Care Act will be, histrionics and political spectacle have obscured some of the deeper issues of health care in the United States. As journalist Steven Brill noted in an investigative report on medical pricing published in *Time* magazine in March 2013, the core issues in health care are the "lopsided pricing and outsize profits in a market that doesn't work."¹⁰ An editorial that appeared in a November 2013 issue of the *Journal of the American Medical Association (JAMA)* was even

⁹ Mark Meadows to John Boehner and Eric Cantor, August 21, 2013, http://meadows.house.gov/uploads/Meadows_DefundLetter.pdf.

¹⁰ Steven Brill, "Bitter Pill: how Outrageous Pricing and Egregious Profits are Destroying Our Health Care," *Time*, March 4, 2013, 55.

more direct in its analysis, stating that “price increases (rather than greater provisions of services) are driving increased [health care] costs.”¹¹ This, of course, has implications for the federal deficit. Out of the nation’s total health care expenditure, “about \$800 billion will be paid by the federal government through the Medicare insurance program for the disabled and those 65 and older and the Medicaid program, which provides care for the poor.” As prices for medical goods and services increase, the amount that the federal government pays will increase, too. Thus far, that amount has continued to rise “far faster than inflation and the gross domestic product,” propelling the deficit.¹²

Although it may seem as if exorbitant health care spending is a contemporary issue, in fact it is not. During the late 1960s, “politicians and the public began to view total medical expenditures as too high for what the public received back in terms of its health. They no longer equated medicine with ‘clinical successes’ but with ‘socioeconomic problems.’ When the word ‘medicine’ appeared in a headline it was paired with ‘catastrophe’ and ‘chaos.’”¹³ The cause of such anxiety was the explosive growth of the costs of Medicare and Medicaid. Spending on these government programs had greatly overshot congressional projections, and there were fears of strong inflationary pressures elsewhere in the economy.

As designed, these programs - particularly Medicare - were supposed to limit and contain spending. Indeed, Congressman Wilbur Mills of Arkansas, the powerful chairman of the House Ways and Means Committee and reluctant architect of Medicare, had sought to fence in the

¹¹ Joshua Sharfstein, Phil B. Fontanarosa, and Howard Bauchner, “Critical Issues in US Health Care: Health Care on the Edge,” *Journal of the American Medical Association* 310, no. 18 (2013): 1945-1946.

¹² Brill, 21-22.

¹³ Ira M. Rutkow, *Seeking the Cure: A History of Medicine in America* (New York: Scribner, 2010), 269.

program with the financing measures that he established. Yet the costs associated with Medicare soared in spite of these measures. The topic of this thesis is to make sense of this phenomenon.

Evidence suggests that price increases were the culprit for the skyrocketing cost of medical care. The difference, however, lies in what drove the increases. Unlike hospital chagemasters, an internal hospital list of every medical procedure with seemingly arbitrary prices that Steven Brill identifies as pushing current-day costs, the primary driver of price increases in the late 1960s were physician fees themselves. The central irony of these increases is the fact that physician services were never intended to be covered in the original proposals for Medicare legislation; early calls for medical care for the elderly focused on the costs associated with hospitalization only. Coverage for physician costs would come from an unlikely source. Wilbur Mills, the longtime Medicare opponent-turned-reluctant supporter, called for physician fees to be covered by Medicare legislation, in part as an effort to co-opt possible future demands from the public to liberalize the benefits provided. The main argument of this thesis is that Mills's expansion of the benefits provided by Medicare caused health care costs to skyrocket in the late 1960s, causing the fiscally conservative Mills to co-sponsor legislation for a single-payer national health insurance program with Senator Edward Kennedy almost a decade later. To understand this irony, this thesis takes a chronological approach to both Mills's career and the development of health care in America. Further, this thesis seeks to combine and synthesize the work of various scholars, ranging from Julian Zelizer's masterful study of Mills and the tax community during the mid-twentieth century to Theodore Marmor's in-depth analysis of the passage of Medicare. Stuart Altman and David Shactman's *Power, Politics, and Universal Health Care*, combined with Paul Starr's account of health care in America, serve to

contextualize the topic of reform. Further, Ira Rutkow's *Seeking the Cure* provides a short history of the medical profession in the United States.

Chapter 1 begins by briefly examining the early career of Wilbur Mills. During these years, the young Mills would begin to develop the skills that would serve him throughout his congressional career. The child who invented and played a game of "House of Representatives" would travel to Harvard Law School as a young man in an effort to learn how "to talk to President Roosevelt." Returning home to Arkansas, Mills would take up position as a county judge and begin his career in public life.

Chapter 2 introduces the modern concept of health care by placing it in the context of the New Deal and Fair Deal, respectively. The liberal dream for a national health insurance program faced stiff opposition from conservatives and organized medicine. In the end, President Roosevelt failed to procure any major health care provisions in the Social Security Act of 1935, and his successor failed with his own proposals, too.

Chapter 3 begins with the calls for medical care for the elderly in the early 1960s by President Kennedy, in addition to Mills's opposition to these measures. With the assassination of Kennedy serving as an impetus for action and the 1964 election bringing in a number of Medicare-supporting Democrats into office on the coattails of President Johnson's victory, Mills promised to make health insurance for the elderly a priority in Congress. In a great legislative feat, Mills was able to combine various proposals into a single bill that garnered strong congressional support. The resulting bill would not only cover hospital costs but physician fees, as well. Medicare legislation was signed into law a few months later in July 1965.

The final chapter discusses the financial impact of Medicare on health care costs in the late 1960s. The cost of the program greatly exceeded estimated projections. Mills's attempt to "fence in" Medicare had failed as physician fees proved to be driving the cost of care upwards. As a result, new proposals would emerge for comprehensive health care reform in the 1970s. Despite bipartisan willingness on Capitol Hill to address the issue of reform, no concrete legislation would come out of these talks, which involved the Nixon administration, Senator Ted Kennedy, Wilbur Mills, and various other groups. As such, health care reform would have to wait for another day.

CHAPTER 1: WILBUR MILLS – THE EARLY YEARS

“I wanted to get myself where I could explain a complicated tax bill on the House floor without having notes in front of me; I wanted to know it all.”¹⁴

- Wilbur Mills, 1977

December 28, 1938. Just three days after Christmas, Congressman Wilbur Mills would travel to Washington to find lodging accommodations for the upcoming legislative session. Little did he know it at the time, but the twenty-nine year old, Arkansas Democrat would remain on Capitol Hill for the next thirty-eight years. In his first few weeks, Mills was able to meet with Vice-President John Nance Garner and President Franklin Roosevelt, respectively. While meeting with the latter, the man who brought Social Security into the state looked at the one who would later usher Medicare through Congress and reportedly said, “We are not only electing them younger every year but also better looking.” Although the encounter was brief, the young man who had gone to Harvard Law School to learn to “speak to President Roosevelt,” finally received the opportunity to do so.¹⁵

Born on May 24, 1909, in Kensett, Arkansas, to Ardra Pickens and Abbie Lois Mills, Wilber Daigh Mills had been named after Wilbur Wright of the Wright Brothers’ fame. From a young age, Mills took a keen interest in politics, an ambition that could be traced back to encounters with William Oldfield, congressman of Arkansas’s Second District. On trips to his district, Representative Oldfield “frequently dined with local political and business leaders . . . [including] the banker Ardra Pickens Mills, whose son Wilbur was privileged to attend some of

¹⁴ Arkansas Gazette, June 26, 1977, 5A.

¹⁵ Kay C. Goss, *Mr. Chairman: The Life and Legacy of Wilbur D. Mills* (Little Rock: Parkhurst Brothers, Inc., 2012), 47-48.

these meetings.”¹⁶ At these gatherings, a young Wilbur Mills received encouragement to enter politics from Oldfield, who himself was seated on the House Ways and Means Committee. So impressionable was the young Mills that he would, as his biographer Kay Goss describes, play “‘U.S. House of Representatives’ in his own back yard, instead of robbers or cowboys and Indians.”¹⁷

Academically, Mills excelled in school and graduated second in his class at Hendrix College, in addition to earning a seat at Harvard Law School. While Mills would return to Arkansas one semester shy of earning his J.D in part because he did not fit in well in Boston, the Harvard years were nevertheless in some form beneficial to Mills, particularly in furthering his drive for public service. With the country reeling from the stock market crash of 1929, professor and future Supreme Court justice Felix Frankfurter “urged his young students to go to Washington, D.C. or to go home and run for office . . . [and] to become a part of the governing process and be involved in an exciting new reform movement.”¹⁸ As such, Wilbur Mills found himself back in Kensett in March 1933 sans a law degree but full of ambition.

In May 1934, Mills would begin campaigning for the position of county judge for White County. The Depression had been particularly harsh in White County during this time period. Unemployment hovered around fifty-percent, “the county was in debt . . . diseases were spreading, stiff cases of tuberculosis and pneumonia among them . . . [and] there were few other points of support, optimism, or hope in [Kensett] or the county.”¹⁹ To address the fiscal

¹⁶ Julian E. Zelizer, *Taxing America: Wilbur D. Mills, Congress, and the State, 1945-1975* (Cambridge, UK: Cambridge University Press, 1998), 27.

¹⁷ Goss, *Mr. Chairman: The Life and Legacy of Wilbur D. Mills*, 20.

¹⁸ Kay C. Goss, "The Grassroots Politics of Hard Times: Wilbur D. Mills' Career as White County Judge," *The Arkansas Historical Quarterly* 59, no. 2 (2000): 186.

¹⁹ *Ibid.*

problems that the county was facing, Mills “said he would put the county on a cash basis in his first year. He promised to cut his salary that first year and take no salary the second year if he were unable to balance the county’s budget as well as pay off the county’s \$15,000 debt from previous years.”²⁰ In addition to his father’s financial backing of the campaign, Mills would impress voters with the oratory skills he had honed through competitions in college while engaging the incumbent Judge Foster White in debates held throughout the county. The result was a surprise victory in the August 1934 election.

Once elected, Mills began to put the bookkeeping methods he had cultivated to use. He instituted a salary system for county officials as opposed to the fee-based system that had existed previously and placed the purchasing of county supplies on a competitive-based bidding process. Along with other measures, Mills was able to actually generate a surplus for the county. As reported in the *Searcy Daily Citizen* on January 6, 1936, the county had a little more than a \$5,000 surplus at the end of Mills’s first year as White County judge.²¹

Two years later in 1938, Mills would have the chance to follow in Representative William Oldfield’s footsteps in Congress, after a vacancy was created in Arkansas’s Second District. Beginning his career on the House Banking and Currency Committee, Mills maintained a dogged work ethic. “He spent almost twelve hours a day at the office, rarely attended Washington cocktail parties, and used his free time to scan the daily newspapers and analyze specialized economic reports.”²² The young congressman’s efforts would not be enough on their own, however, to capture a seat on the Ways and Means Committee. During his second term, “the Democratic caucus had three vacancies to fill on the committee,” and Mills independently

²⁰ Goss, *Mr. Chairman: The Life and Legacy of Wilbur D. Mills*, 30.

²¹ *Ibid.*, 36.

²² Zelizer, *Taxing America*, 31.

organized a campaign to fill one of the vacancies.²³ Yet, “he neglected to discuss his plans with the Democratic leadership, and as a result, he was soundly defeated.”²⁴ In defeat, though, Mills did garner the attention of Speaker of the House Sam Rayburn, who offered Mills the next available opening on the Ways and Means Committee in October 1942. Moreover, Rayburn decided to invite Mills to his informal “board of education” meetings, where select members of the Democratic leadership would gather to discuss political strategy.

Aside from the tutelage of Sam Rayburn, Wilbur Mills would also work on his own to further his political acumen and expertise. As Kay Goss notes, Mills “read the Internal Revenue Code. He read the Social Security regulations. He read trade legislation. He asked the Library of Congress for copies of all major bills that had passed Ways and Means since its creation in 1789.”²⁵ In practice, Mills’s ever expanding body of knowledge would continue to grow in response to legislative efforts such as the Social Security Amendments of 1950 and the Internal Revenue Recodification of 1954. In the case of the Social Security Amendments, Mills worked alongside Social Security officials to hone his understanding of the program, its financing mechanisms, and the long-term actuarial soundness of the popular social insurance program. Further, Mills served as a conduit between Social Security policymakers and Congress, particularly the Ways and Means Committee. As such, Mills “carved a professional niche [for himself in Congress] through Social Security in 1950.”²⁶ He would cement this niche through congressional studies conducted in the mid-1950s after House Republicans revised the tax code. As Julian Zelizer writes, “Just as he spent the 1940s learning about the use of earmarked payroll taxes [to finance Social Security], Mills spent the 1950s studying the economic and political

²³ Goss, *Mr. Chairman: The Life and Legacy of Wilbur D. Mills*, 53.

²⁴ Zelizer, *Taxing America*, 33.

²⁵ Goss, *Mr. Chairman: The Life and Legacy of Wilbur D. Mills*, 73.

²⁶ Zelizer, *Taxing America*, 99.

functions of the income tax.”²⁷ Through hearings conducted by the House Ways and Means Committee and reports published by the Joint Economic Committee, Mills positioned himself as the leading tax and fiscal policy expert on Capitol Hill. As a consequence, Mills’s political mentor Sam Rayburn would begin to regularly turn “to [him] for advice on tax issues.”²⁸

By December 1957, Wilbur Mills stood poised to become the next chairman of the Ways and Means Committee with the death of Jere Cooper. The young boy who wished to learn how to “speak to President Roosevelt” had already had the privilege of doing so. As the new chairman of Ways and Means, Wilbur Mills would now become the man who presidents and other officials would wish to speak on matters concerning economic and tax policies.

²⁷ Ibid., 82.

²⁸ Ibid.

CHAPTER 2: NO DEAL – THE DEFEAT OF NATIONAL HEALTH INSURANCE UNDER THE NEW AND FAIR DEALS

“Wise and prudent men- intelligent conservatives—have long known that in a changing world worthy institutions can be conserved only by adjusting them to the changing time. In the words of the great essayist, "The voice of great events is proclaiming to us. Reform if you would preserve." I am that kind of conservative.”²⁹

- Franklin Roosevelt, 1936

March 4, 1933. Almost one year before he would quit Boston for his hometown of Kensett in order to pursue a career in public life, Wilbur Mills undoubtedly tuned in along with millions of others across the nation to listen to President Franklin Roosevelt as he delivered his inaugural address. Somber yet determined in terms of tone, Roosevelt declared that the country’s problems thankfully concerned “only material things” and that broad, speedy action would be needed to combat the Depression.³⁰ Along with a speech made earlier during his campaign in which he called for experimentation in government, this philosophy of “direct, vigorous action” would form the bedrock of Roosevelt’s presidency.

The times merited such a position. Following the stock market crash of 1929, “stock prices had plunged 85 percent. Manufacturing had all but ground to a halt. The automobile industry was operating at 20 percent of capacity, and the steel industry at just 12 percent. Between one-quarter and one-third of the workforce was jobless.”³¹ Farming communities across the country fared terribly, too. As the price of farming goods fell, income “plunged from

²⁹ Franklin D. Roosevelt, “Address at the Democratic State Convention” (speech, Syracuse, New York, September 29, 1936), The American Presidency Project, <http://www.presidency.ucsb.edu/ws/?pid=15142>.

³⁰ Franklin D. Roosevelt, “Inaugural Address of President Franklin D. Roosevelt” (speech, Washington, D.C., March 4, 1933), Franklin D. Roosevelt Presidential Library and Museum, http://www.fdrlibrary.marist.edu/aboutfdr/pdfs/inaug_33address.pdf.

³¹ Adam Cohen, *Nothing to Fear: FDR's Inner Circle and the Hundred Days that Created Modern America* (New York: Penguin Press, 2009), 14.

\$6.7 billion in 1929 to just \$2.3 billion in 1932.”³² Unable to make ends meet, banks were forced to foreclose on the farmland of rural Americans. One of the richest farming states, Iowa, for instance, lost one out of every seven farms to foreclosure.³³ Given this state of affairs, Roosevelt and his New Dealers were pressed into action and represented a stark contrast from the laissez-faire approach of Herbert Hoover’s outgoing administration.

In the following weeks and months, “Congress and the country were subjected to a presidential barrage of ideas and programs unlike anything known to American history.”³⁴ The media would dub this period of legislative industry the Hundred Days. During this timeframe, Roosevelt “sent fifteen messages to Congress, guided fifteen major laws to enactment, delivered ten speeches, held press conferences and cabinet meetings twice a week, conducted talks with foreign heads of state, sponsored an international conference, made all the major decisions in domestic and foreign policy, and never displayed fright or panic and rarely even bad temper.”³⁵ Among these laws were the Emergency Banking Act, the Glass-Steagall Banking Act, the Agricultural Adjustment Act, and the National Industrial Recovery Act – all of which were aimed at resuscitating and stabilizing various sectors of the economy. As renowned historian Arthur Schlesinger described in his *The Coming of the New Deal*, the result of such action was the reestablishment of resolve and purpose throughout the nation. It was as if “a despairing land had a vision of America as it might some day be.”³⁶

This greater vision would begin to materialize in part during the next year. In June 1934 – the same month that Wilbur Mills would launch his candidacy for White County judge –

³² Ibid., 16.

³³ Ibid.

³⁴ Arthur M. Schlesinger, Jr, *The Coming of the New Deal* (Boston: Houghton Mifflin, 1958), 20.

³⁵ Ibid., 21.

³⁶ Ibid., 22.

President Roosevelt outlined to Congress his objectives with regards to social insurance. Economic security, he stated, “was attained in the earlier days through the interdependence of members of families upon each other and of the families within a small community upon each other.” Industrialization and urbanization, however, made such forms of security less viable. As such, Roosevelt felt “compelled to employ the active interest of the Nation as a whole through government in order to encourage a greater security for each individual.”³⁷ Later in the month, the president would issue Executive Order No. 6757, which created the Committee on Economic Security. This committee would “study problems relating to the economic security of individuals” and put forth its recommendations in a report to Roosevelt by December 1934.³⁸ It would be chaired by Frances Perkins, Roosevelt’s Secretary of Labor.

In addition to studying issues like unemployment and old-age insurance, the group “included medical care and health insurance in its research,” as well.³⁹ From the beginning, however, health insurance was a low priority for the Committee for three specific reasons. The first was the context of the Depression. Given that “millions [were] out of work in the thirties, unemployment insurance became the leading priority.”⁴⁰ Political pressure from the elderly - as symbolized by the grassroots movement which formed around Dr. Francis Townsend and his Old-Age Revolving Pension Plan - further pushed the concept of national health insurance out of the political arena, as individuals began to demand some form of action with respect to old-age assistance. The second and perhaps greater reason that the Committee failed to draw concrete

³⁷ Franklin D. Roosevelt, “Message to Congress Reviewing the Broad Objectives and Accomplishments of the Administration” (speech, Washington, D.C., June 8, 1934), Social Security Administration, <http://www.ssa.gov/history/fdrstmts.html#message1>.

³⁸ Franklin D. Roosevelt, “The Initiation of Studies to Achieve a Program of National, Social, and Economic Security,” Executive Order No. 6757, June 29, 1934, <http://www.ssa.gov/history/fdrstmts.html#exec>.

³⁹ Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982), 267.

⁴⁰ *Ibid.*, 266.

policies regarding health insurance was the potential opposition from the medical establishment. Because President Roosevelt advised against a piecemeal approach to social insurance in his address to Congress, many on the Committee believed that “health insurance would have to be delayed because the [American Medical Association’s] opposition might sink the entire bill.”⁴¹ Finally, concerns over integration led southern lawmakers to resist any efforts that might upset the racial hierarchy of the Jim Crow South. As such, the Social Security Act that emerged from Congress in August 1935 included no provision for a national health insurance system.

Two years later, a brief window of opportunity would present itself to President Roosevelt to push for action on health care. As Harvard sociologist Paul Starr notes:

In 1937 the president authorized another internal administration group [the Technical Committee on Medical Care] to work on a proposal for a national health program, which he received the following February. Besides urging federal aid for maternal and child health care, hospital construction, and the disabled, the proposal called for two kinds of grants to states: the first for medical care of the poor and the second for health insurance for the general public.⁴²

The National Health Conference was convened in July 1938, bringing together individuals from various sectors of the economy to explain the new committee’s proposal. Much like 1935, however, stringent opposition from the AMA made certain that no concrete legislation would pass Congress. Additionally, a new and equally powerful foe to social insurance reemerged in 1938, as a consequence of presidential miscalculations. President Roosevelt’s scheme to pack the Supreme Court with justices favorable to the New Deal “destroyed [his] reputation for political sagacity . . . and revived old enemies, who now vowed to fight the New Deal on other

⁴¹ Paul Starr, *Remedy and Reaction: The Peculiar American Struggle over Health Care Reform* (New Haven: Yale University Press, 2011), 38.

⁴² *Ibid.*

fronts as well. The onset of the recession in 1937 added to his political woes.”⁴³ As such, conservatism made major headway in the midterm elections of 1938, which coincidentally was the same year in which Wilbur Mills was first elected to Congress. Republicans added “eight Senate seats and nearly doubled their numbers in the House from 88 to 170.”⁴⁴ This strengthened the congressional alliance between conservative Dixiecrats and Republicans, thus making “any further innovations in social policy extremely difficult.”⁴⁵ This alliance between congressional Republicans and the southern bloc of the Democratic Party would remain in place through the presidency of Harry Truman and through the administration of Lyndon Johnson.

If the bulk of Congress following the 1938 elections resisted the idea of a system of national health insurance, there were some that did favor the proposal. Senator Robert Wagner of New York put forth a bill in early 1939 that included many of the recommendations made by the Technical Committee on Medical Care. Yet, “although the Wagner bill . . . was reported to face only minor opposition in the Senate,” President Roosevelt failed to endorse the bill, possibly out of “concern about the cost [of the legislation] or election-year implications.”⁴⁶ Regardless, with the dark clouds of war looming in Europe, the administration began to orient itself away from domestic issues like health insurance and more towards matters relating to foreign affairs.

In the early years of World War II, there was little to no movement regarding national health insurance legislation. As the tide of war began to swing in favor of the Allies, the country began to plan for the post-war world. In June 1943, Senator Wagner introduced a much broader bill for national health insurance in conjunction with Senator James Murray of Montana and

⁴³ Michael E. Parrish, *Anxious Decades: America in Prosperity and Depression, 1920-1941* (New York: W.W. Norton, 1992), 380.

⁴⁴ *Ibid.*, 385.

⁴⁵ Starr, *The Social Transformation of American Medicine*, 277.

⁴⁶ *Ibid.*

Representative John Dingell of Michigan. Under this plan, “when sickness struck, the family doctor (if he participated in the system) would care for an individual’s needs with his fee paid – subject to a rate limitation imposed by the government – through a fund established and maintained by payroll taxes.”⁴⁷ Provisions also existed for coverage of costs associated with hospitalization. Although he did not specifically endorse the Wagner-Murray-Dingell bill in 1943, the ideas of economic security that the bill raised certainly influenced his thoughts concerning his domestic agenda after the war. In his 1944 State of the Union address, Roosevelt stated, “We have come to a clear realization of the fact that true individual freedom cannot exist without economic security and independence . . . In our day these economic truths have become accepted as self-evident. We have accepted, so to speak, a second Bill of Rights under which a new basis of security and prosperity can be established for all regardless of station, race, or creed.” These rights related to jobs, housing, education, and social insurance, including “the right to adequate medical care and the opportunity to achieve and enjoy good health.”⁴⁸ The task of realizing these rights, however, would fall on the shoulders of Harry Truman with the death of Roosevelt in April 1945.

Standing before Congress on November, 19, 1945 – only three months after the end of World War II – President Harry Truman recommended the passage of a health insurance bill that eluded his predecessor during his presidency. “Millions of our citizens,” he stated, “do not now have a full measure of opportunity to achieve and enjoy good health. Millions do not now have protection or security against the economic effects of sickness. The time has arrived for action to

⁴⁷ Monte M. Poen, *Harry S. Truman versus the Medical Lobby: The Genesis of Medicare* (Columbia: University of Missouri Press, 1979), 32.

⁴⁸ Franklin D. Roosevelt, “State of the Union Message to Congress” (speech, Washington, D.C., January 11, 1944), Franklin D. Roosevelt Presidential Library and Museum, http://www.fdrlibrary.marist.edu/archives/address_text.html

help them attain that opportunity and that protection.”⁴⁹ In the second half of his address, Truman proposed a solution to this problem that “urged adoption of a comprehensive national health program to provide federal grants for construction of hospitals and other health centers, to expand public health services, and to assist mothers and children. Grants would also be earmarked for research programs and medical education.”⁵⁰ A host of factors, however, would prevent any legislation relating to a national health insurance program from passing through Congress under the Truman administration.

The first was the lobbying effort of organized medicine. After Truman called for the creation of a national health insurance initiative, the AMA “reacted swiftly and furiously. It assessed each of its members – almost 75 percent of American physicians – a special \$25 fee to fund a coordinated opposition. These contributions allowed it to spend money on a scale that no other lobbying group had ever approached: \$1,552,683 in 1949 and \$1,326,078 in 1950.”⁵¹ Furthermore, the advertising campaigns of the AMA and other affiliated groups, such as the Blue Cross and Chamber of Commerce, often looked to exploit Cold War-era fears of the Red Menace. A 1949 AMA pamphlet, for example, argued that “socialized medicine” was a cornerstone of communism.⁵² Moreover, underlying such lobbying efforts was the fear that a government-imposed insurance plan would restrict the autonomy of physicians in the fees they charged and the services they could perform. Many physicians believed that “any interference in the privacy of their relationship with patients would trigger a deterioration in the quality of medical care, and they assumed that government control would lead inevitably to a loss of

⁴⁹ Harry S. Truman, “Special Message to the Congress Recommending a Comprehensive Health Program” (speech, Washington, D.C., November 19, 1945), Harry S. Truman Library and Museum, <http://www.trumanlibrary.org/publicpapers/index.php?pid=483&st=&st1=>.

⁵⁰ Poen, 64.

⁵¹ Rutkow, 256.

⁵² Poen, 148-149.

professional independence.”⁵³ As such, some AMA advertisements clearly ignored “stipulations that doctors would remain free to choose their own patients, and patients to choose their own doctors, [and] pictured an impersonal medical world under the national health plan in which patients and doctors were forced unwillingly upon each other.”⁵⁴ Generally speaking, the lobbying and propaganda campaign was successful. “In 1945, 75 percent of Americans supported national health insurance; by 1949, that figure had declined to only 21 percent.”⁵⁵

The second factor was the Republican-controlled Eightieth Congress, which stood as an obstacle to Truman’s domestic agenda from 1946 to 1948. Measures for funding hospital construction and medical research were passed, but the Republican Congress refused to consider legislation on national health insurance. In fact, Republican Senator Robert Taft of Ohio declared that Truman’s health plan had “come straight out of the Soviet constitution” and boycotted hearings on the bill in 1946.⁵⁶ Even after Democrats regained control of both chambers in the 1948 elections, the conservative coalition of Dixiecrats and Republicans proved as formidable as it had ten years prior. Indeed:

Despite his party’s numerical majority in both the Senate and the House, the southern bloc remained overwhelmingly opposed to his all-inclusive health insurance proposal or to any other major new adventures in behalf of labor-supported, urban-oriented social and economic reform. Extension of some existing (and by 1949 much less threatening) New Deal-type programs might win their support, but this, too, proved highly unpredictable because of the president’s championing on civil rights. Especially grating to southern sensitivity was Truman’s policy of desegregating the armed forces and his continued

⁵³ Rutkow, 255.

⁵⁴ Theodore R. Marmor, *The Politics of Medicare* (Chicago: Aldine Pub. Co., 1973), 13.

⁵⁵ Jill Quadagno, "Why the United States Has No National Health Insurance: Stakeholder Mobilization against the Welfare State, 1945-1996," *American Sociological Association* 45 (2004): 25-44.

⁵⁶ Poen, 88.

assistance that Congress reestablish and make permanent a fair employment practices committee charged with policing job discrimination.⁵⁷

As such, even though hearings on proposed health insurance legislation did occur in 1949, “the Administration’s health insurance plan was not reported out of committee in either house.”⁵⁸ Further, the so-called “loss of China” to communist forces in October 1949, the beginning of the Korean War in the following year, and the national hysteria that ensued as a result of Senator Joseph McCarthy’s Second Red Scare all conspired together to create a hostile atmosphere for any additional discussion on a national health insurance program. Reform in health care would have to wait until the 1960s.

⁵⁷ Ibid., 164-165.

⁵⁸ Marmor, 12.

CHAPTER 3: ASSEMBLING THE CAKE – MILLS AND THE CONSTRUCTION OF MEDICARE

“No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents, and to their uncles, and their aunts.”⁵⁹

- Lyndon Baines Johnson, 1965

May 20, 1962. In front of tens of thousands of senior citizens, President John Kennedy took to the stage to deliver an address on one of his campaign pledges – a government program to assist the elderly with their medical costs. Indeed, the issue of health care for the elderly played a role (albeit a minor one) in Kennedy capturing the White House. As historian Ira Rutkow notes, “Opinion polls showed that [Kennedy’s] advocacy for this had been among the key issues that differentiated him from his Republican rival, Richard Nixon.”⁶⁰ His televised speech from Madison Square Garden that day would serve to galvanize the public in favor of congressional action on that front. Speaking on the topic, Kennedy painted a scene with which many in attendance could surely have empathized. He described a typical man who had “worked hard all his life . . . [and] always wanted to pay his own way.” Unfortunately, when the man’s wife needed an extended hospitalization stay after battling an illness, the costs quickly became burdensome. The man depleted his life’s savings, mortgaged his house, struggled to make the medical payments out of what he received in Social Security, and was forced to resort to his adult children for help. Finally, he had to turn to public assistance to simply keep afloat. In

⁵⁹ Lyndon B. Johnson, “Remarks with President Truman at the Signing in Independence of the Medicare Bill” (speech, Independence, Missouri, July 30, 1965), Lyndon B. Johnson Presidential Library and Museum, <http://www.lbjlib.utexas.edu/johnson/archives.hom/speeches.hom/650730.asp>.

⁶⁰ Rutkow, 256.

short, Kennedy described what today is known as medical bankruptcy. Continuing his speech, Kennedy said, “I can’t imagine anything worse, or anything better, to sap someone’s self-reliance, than to be sick, alone, broke – or to have saved for a lifetime and put it out in a week, two weeks, a month, two months.”⁶¹ He spoke of efforts in Congress, chiefly the King-Anderson bill, which were seeking to rectify such conditions. In his conclusion, Kennedy hearkened back to some of the same principles Franklin Roosevelt had outlined in his Economic Bill of Rights and that Harry Truman had sought to accomplish with his Fair Deal. Health care for the elderly, however, was quite a far cry from a national health insurance program for all citizens.

Although President Truman’s plan for national health insurance had been resoundingly defeated during the late 1940s, the proposal did bring the issue of health insurance to the forefront of the public. When the president’s plan stalled in Congress, “potential supporters of national health insurance sought other remedies to their problems. The middle class continued to buy private [employer-based] insurance, and the unions began to look to collective bargaining for health benefits.”⁶² American veterans could turn to the Veterans Administration (VA). As public health researchers Elizabeth Bradley and Lauren Taylor write in *The American Health Care Paradox: Why Spending More is Getting Us Less*:

For employers, the offer of medical insurance to workers began as an innovative and effective means to create a competitive advantage for their businesses during the wartime wage freezes. Given the rising expenses of medical care, employees gladly accepted employer-paid health insurance in lieu of salary increases. Congress amended the Internal Revenue Code to make employer-sponsored health insurance tax-exempt, and the US Supreme Court ruled that employee benefits, including health insurance, could be bargained as part of the union-employer contracting. Employer-based insurance quickly

⁶¹ John F. Kennedy, “Address at a New York Rally in Support of the President’s Program of Medical Care for the Aged” (speech, New York City, New York, May 20, 1962), The American Presidency Project, <http://www.presidency.ucsb.edu/ws/?pid=8669>.

⁶² Starr, *The Social Transformation of American Medicine*, 289.

took root in the wake of these developments, with private insurance companies largely administering the financing and payment of health care services.⁶³

As such, the 1950s saw a large increase in private health insurance. President Dwight Eisenhower would run on a platform against national health insurance in 1952, and once elected would call for expansion in private insurance. In fact, President Eisenhower called for a program known as “re-insurance” in a 1955 address to Congress.⁶⁴ Under such a program, private insurance companies would be asked to extend coverage to many without it and receive reimbursements from the federal government for doing so. No legislation for re-insurance was passed; nevertheless, private health insurance grew throughout the decade on its own. In 1950, the private health insurance market was a \$1 billion industry; by 1965, it was an \$8.7 billion one.⁶⁵ Outside of the private insurance and health benefits open to the middle class and unions, respectively, American veterans were also able to procure access to medical care through the VA. They were “entitled not just to treatment for war-related injuries, but to all medical care to the extent the VA had room for them,” meaning that “this large group of working-class, predominantly white males was able to receive government-financed health services, which when advocated for other Americans were denounced as likely to undermine self-reliance.”⁶⁶

While members of these three groups – the middle class, unions, and veterans – were able to gain access to affordable medical care, “some Americans were getting priced out of the marketplace,” chiefly minorities, the elderly, and the poor.⁶⁷ The latter two groups were not

⁶³ Elizabeth H. Bradley and Lauren A. Taylor, *The American Health Care Paradox: Why Spending More is Getting Us Less* (New York: PublicAffairs, 2013), 36.

⁶⁴ Dwight D. Eisenhower, “Special Message to the Congress Recommending a Health Program” (speech, Washington, D.C., January 31, 1955), The American Presidency Project, <http://www.presidency.ucsb.edu/ws/?pid=10399>.

⁶⁵ Bradley and Taylor, 36.

⁶⁶ Starr, *The Social Transformation of Medicine*, 289.

⁶⁷ Rutkow, 254.

mutually exclusive either. A 1960 report estimated that “25 percent of the low-income persons in the nation are aged.”⁶⁸ Further, the medical expenses of the elderly were much greater than the general population. Even for those “insured aged, a survey of hospital patients reported, only 1/14 of their total costs of illness was met through insurance.”⁶⁹ As such, public policy began to shift away from a national health insurance program and focus increasingly on health care for the aged, specifically hospitalization costs. As President Truman’s efforts were blocked by Congress, Wilbur Cohen, I.S. Falk, and Oscar Ewing of the Federal Security Agency “worked out a plan that would limit health insurance to the beneficiaries of the Old Age and Survivors Insurance program (the national, contributory, earnings-related pension program for the retired aged and their survivors, established by the Social Security Act of 1935).”⁷⁰ This plan would slightly be modified to cover 60 days of hospital costs per year. The plan, which would serve as the genesis for Medicare, was introduced in Congress each year from 1952 to 1960, “not with any hopes of enactment [under a Republican president], but to keep alive the idea of health insurance under social security.”⁷¹

In 1958, congressional hearings would take place on such a proposal when Congressman Aime Forand of Rhode Island, the fourth-ranking Democrat on the Ways and Means Committee, would sponsor legislation to that effect. The Forand bill would provide “sixty days of hospitalization per year (including surgeon’s fees), 120 days of nursing home care per year, and inpatient lab and x-ray. The government would pay for the program by increasing the social security tax one-quarter of 1 percent for both employers and employees on the first \$4,800 of

⁶⁸ Wilbur J. Cohen, “Health Insurance Under Social Security,” reprinted from the *American Journal of Nursing* 60 (April 1960): 5.

⁶⁹ Marmor, 18.

⁷⁰ *Ibid.*, 14.

⁷¹ *Ibid.*, 30.

income.”⁷² Although a modest proposal that provided relatively limited benefits, the bill would not make it out of the Ways and Means Committee, defeated by a 17-8 vote. Further, even if it did, President Eisenhower threatened to veto such legislation, calling the bill “a definite step toward socialized medicine.”⁷³ (Ironically, the VA with its government-employed medical providers and government-financed care never merited a denunciation as “socialized medicine” from Eisenhower.) Organized medicine also rallied against the Forand bill and Medicare legislation in general. In once such ad for the AMA, future president Ronald Reagan reminded Americans that if they did not oppose Medicare legislation, then it would “pass just as surely as the sun will come up tomorrow. And behind it will come other federal programs that will invade every area of freedom as we have known it in this country. Until one day . . . we will awake to find that we have socialism.” As such, the old forces that had doomed national health insurance under the Truman administration once again trounced proposed legislation on health care.

Although the Forand bill had been defeated, public opinion on health care for the elderly was beginning to shift. Constituents looked favorably on the issue of hospital care for the aged, and “within two years, congressmen were reporting more mail on the subject than on any other pending legislation.”⁷⁴ With the election of Kennedy in 1960, it seemed as if public opinion and policy would align. Yet, even the optimistic Kennedy knew that a formidable opponent would have to be overcome if Medicare were to ever become law – Wilbur Mills. Confiding in his advisor Theodore Sorenson, Kennedy stated that “[Mills] knows that he was chairman of Ways

⁷² Stuart Altman and David Shactman, *Power, Politics, and Universal Health Care: The Inside Story of a Century-Long Battle* (Amherst: Prometheus Books, 2011), 127.

⁷³ Eugene Feingold, *Medicare: Policy and Politics* (San Francisco: Chandler, 1966), 10.

⁷⁴ Starr, *The Social Transformation of American Medicine*, 368.

and Means before I got here and he'll still be chairman after I've gone – and he knows I know it. I don't have any hold on him.”⁷⁵

As the debates over Medicare demonstrated, Kennedy's analysis was rather prescient. Mills had ascended to chair the Ways and Means Committee after the death of Congressman Jere Cooper in 1957. The position was a powerful one and gave Mills great sway in Congress. As Mills's biographer Kay Goss points out:

Mills's influence over the Committee on Ways and Means was substantial, for he determined if bills were to be considered, arranged the committee's agenda, called committee meetings, decided if and when to hold hearings, directed the staff, presided at committee meetings, reported committee bills to the floor, testified at Rules Committee hearings, managed bills on the floor, headed the House delegation to conference committee on their bills, chaired the conference proceedings, and was the most knowledgeable and involved member of the committee, the House, the conference, and the Congress on matters involving his committee.⁷⁶

Thus, if Medicare were to have any chance of passing through Congress, it would need the approval of the powerful chairman. Up until 1964, however, Mills would fail to offer his backing to any Medicare proposal.

Of course, this is not to suggest that Wilbur Mills necessarily opposed government intervention in assisting the aged with respect to health care. In line with many other congressmen, he “agreed that the government should provide some type of medical assistance to those who lacked adequate care, [and] once the lobby for Medicare began in 1952, Mills had put forth various alternatives during his deliberations with Cohen, Myers, and Ball that kept health care out of Social Security.”⁷⁷ This is a key point particularly because Mills was concerned

⁷⁵ Theodore Sorenson, *Kennedy* (New York: Harper and Row, 1965), 426.

⁷⁶ Kay C. Goss, “Congressman Wilbur D. Mills' Influence on Social Legislation,” *The Arkansas Historical Quarterly* 54, no. 1 (1995): 2-3.

⁷⁷ Zelizer, *Taxing America*, 215.

about the actuarial soundness of the Social Security system. Too much strain on payroll taxes that financed Social Security, he believed, would have a negative economic impact on the country. As such, Mills favored “a program targeted to the elderly poor and run by the states.” Along with Senator Robert Kerr of Oklahoma, Mills would sponsor a program in 1960 that “extended to the medically indigent elderly the earlier program of federal aid to the states for welfare recipients’ medical care. Under the program, the federal government paid 50 percent to 80 percent of a state’s costs for medically impoverished seniors.” In theory, the benefits provided by Kerr-Mills were much more generous than those offered under the Forand bill; “nonetheless, many southern and other states with large low-income (and, not incidentally, minority) populations restricted eligibility and covered only very limited services or did not participate in Kerr-Mills.”⁷⁸ Southern states, in particular, “believed that any federally administered program would force them to integrate hospitals and other health care facilities that were still segregated throughout the South.”⁷⁹ Thus in practice, over ninety percent of Kerr-Mills funding went to five states – New York, California, Massachusetts, Michigan, and Pennsylvania. With respect to the total population of the aged, these five states accounted for only one-third of those over 65.⁸⁰ In other words, two-thirds of the elderly were still left without adequate protection against medical costs.

Given the inadequacies of Kerr-Mills and the growing number of voices calling for a federal program that covered hospitalization costs for the elderly, Representative Cecil King of California and Senator Clinton Anderson of New Mexico would resurrect a modified version of the Forand bill in 1961. This Medicare proposal included benefits such as “hospital care, skilled

⁷⁸ Starr, *Remedy and Reaction*, 44-45.

⁷⁹ Altman and Shactman, 129.

⁸⁰ Marmor, 37.

nursing home care, and home health care visits” to those receiving Old Age, Survivors, and Disability Insurance (OASDI) and would be financed by “a higher payroll tax and wage base schedule.”⁸¹ The Kennedy administration supported the King-Anderson bill and encouraged movement in Congress to see its passage into law. Nothing would come out of such efforts in the three years from 1961 to 1963 because of Wilbur Mills’s objections, which stemmed from two specific reasons. The first was Mills’s objection to the financial details of King-Anderson. Believing that “skyrocketing prices combined with constituent pressure for liberalized benefits – once recipients discovered that Medicare did not include the cost of physicians – would force Congress to raise Social Security taxes beyond reasonable levels,” Mills was reluctant to take action on the bill.⁸² Secondly, there simply were not enough votes in the Ways and Means Committee to bring the bill to the House floor. Although there were fifteen Democrats to ten Republicans on the committee, “six of the Democrats, including Wilbur Mills, were from southern states and had opposed Forand. That left supporters four votes short, and the only possible chance to turn them was the persuasive power of Chairman Mills.”⁸³ Mills’s objection to King-Anderson’s financing structure coupled with his consensus-building approach as chairman meant that he would not cast the deciding vote if there was a deadlock. Further, even if the King-Anderson bill managed to pass Ways and Means, its legislative future on the House floor was uncertain. Sam Rayburn – the influential Speaker of the House and King-Anderson supporter – was in failing health for much of 1961, “at the very time when all the resources and skills of the House leadership were needed” to corral support for the proposed measure.⁸⁴

⁸¹ Zelizer, *Taxing America*, 216.

⁸² *Ibid.*

⁸³ Altman and Shactman, 130.

⁸⁴ Marmor, 46.

While the King-Anderson bill and the rest of Kennedy's domestic agenda languished on Capitol Hill, tragedy would strike on November 22, 1963, with the assassination of President Kennedy. Lyndon Johnson would assume the role of Commander-in-Chief. The political savvy Texan seemed resolved to see the domestic agenda of his predecessor come to fruition. In his State of the Union address given seven weeks after Kennedy's assassination, Johnson stated, "Let us carry forward the plans and programs of John Fitzgerald Kennedy – not because of our sorrow or sympathy, but because they are right."⁸⁵ He declared a war on poverty and announced many of the programs that he would like to see passed and which would later become hallmarks of the Great Society. Included in his address was the hope that Medicare would finally pass Congress in 1964.

For much of the early half of 1964, it seemed as if Medicare might finally gain traction. Wilbur Mills was more open to negotiations with administration officials, such as Wilbur Cohen. Yet the Ways and Means committee remained deadlocked, and neither Mills nor the other southern Democrats were willing to be the deciding vote. Further, "several pro-Medicare representatives urged Mills to wait until after the elections before proposing any legislation so that they could avoid having to take a definitive stand. Representatives from New Mexico, Idaho, southern Illinois, Pennsylvania, Ohio, Indiana, and Texas – non-southern rural Democrats who supported the bill – suggested to the chairman that they opposed a vote at this time."⁸⁶ As a result, Mills made two attempts to make sure that any discussion of Medicare would have to wait until after the 1964 election. The first was an effort to increase Social Security benefits, which had not seen an increase since 1958. A proposal for a six percent increase was introduced by

⁸⁵ Lyndon B. Johnson, "Annual Message to the Congress on the State of the Union" (speech, Washington, D.C., January 8, 1964), The American Presidency Project, <http://www.presidency.ucsb.edu/ws/?pid=26787>.

⁸⁶ Zelizer, *Taxing America*, 227.

Republican John Byrnes, which would raise payroll taxes to ten percent and “leave no room in the future to fund King-Anderson.”⁸⁷ Ultimately, this proposal would be defeated when Republican Congressman Bruce Alger unexpectedly joined with the Democratic majority. Alger had been opposed to Social Security since its inception and so could not find it in himself to vote for an increase in benefits, even if such an increase would make it impossible for Medicare to be enacted.⁸⁸ In response to the political ploy made by Ways and Means Republicans and supported by Wilbur Mills, Senate Democrats acted to attach King-Anderson as an amendment to the Social Security bill being discussed in the upper chamber. The maneuver succeeded, and the resulting legislation would be put before a House-Senate conference.⁸⁹ It seemed that Medicare might pass in 1964. In the conference, however, Mills “promised pro-Medicare Democrats on his committee that Medicare would be the ‘first order of business’ in 1965; in return he received their support in rejecting the rider in the conference committee . . . On October 4, the conference announced its deadlock over the entire social security bill, thus postponing both the social security cash benefit increases and Medicare until the following year.”⁹⁰ Wilbur Mills was labeled as the “one-man veto” on Medicare.

The election of 1964 would serve to weaken the “one-man veto.” On November 3, “Democrats gained 38 seats in the House, reducing the Republicans to their lowest level since the Democratic landslide of 1936. The new congressional balance was 295 Democrats to 140 Republicans in the House and 68 Democrats to 32 Republicans in the Senate. Additionally, three anti-Medicare Republicans on Ways and Means were defeated.”⁹¹ After the election, Mills made

⁸⁷ Altman and Shactman, 133.

⁸⁸ Marmor, 55.

⁸⁹ Altman and Shactman, 134-135.

⁹⁰ Marmor, 56.

⁹¹ Zelizer, *Taxing America*, 230.

conciliatory remarks with respect to Medicare, largely because he hoped to shape the bill as it made its way through Congress. Further, Mills was held to his promise of making Medicare the first order of business in the new session when the Johnson administration “convinced congressional leadership to give the proposed health care bills . . . the numeric symbols of highest priority, H.R. 1 and S.1, respectively.”⁹² Congressional hearings would begin in January 1965.

Understanding that health care legislation would pass in 1965, a number of groups brought forth their own proposals. By March, three major proposals stood out. The Democrats reintroduced King-Anderson, meanwhile “the AMA and Republicans were criticizing the Democrats’ Medicare proposal not only because it established a form of compulsory insurance, but also on the grounds that it covered only hospital costs. Now, for the first time, Republicans offered a serious alternative: a federally subsidized, voluntary insurance program that would cover physicians’ bills as well.”⁹³ This plan was known as “Bettercare” and had been introduced by John Byrnes. (The AMA, for their part, offered a bill called Eldercare which “expanded Kerr-Mills: The bill offered voluntary medical insurance for the elderly, distributed on the basis of need in participating states.”)⁹⁴ By covering physician fees, Bettercare offered an attractive alternative to King-Anderson in the mind of Wilbur Mills because it would prevent further demands for liberalizing the benefits. In a speech made just before the beginning of the new congressional session, the chairman warned that “the public must be under no illusion regarding the benefits . . . Medicare does not refer to doctor services’ or general outpatient care.”⁹⁵ The

⁹² Rutkow, 258.

⁹³ Starr, *Remedy and Reaction*, 46.

⁹⁴ Zelizer, *Taxing America*, 229.

⁹⁵ Wilbur D. Mills, “Financing Health Care for the Aged” (speech, Little Rock, Arkansas, December 7, 1964), duplicated in *HEW Background for the 1965 Legislative Session*, IX b-1, Jan. 25, 1965.

drawback to the Bettercare proposal was the financing mechanism. Costs would be paid through general revenues as opposed to a separate trust fund. For Mills, this meant eliminating the distinction between social insurance and welfare. The dilemma was how to reconcile these separate proposals.

A breakthrough occurred in a Ways and Means committee meeting on March 2, 1965. Mills, “in what came off as a grand synthesis, combined [the] three elements: the Democrats’ compulsory hospital insurance program, which became Part A of Medicare; the Republican voluntary program to cover physicians’ bills, which became Medicare Part B; and an expansion of the Kerr-Mills program (no longer restricting it to the elderly poor), the approach favored by the AMA, which became Medicaid.”⁹⁶ This “three-layer cake” approach left many stunned because of its ingenuity. Wilbur Cohen commented, “It was the most brilliant legislative move I’d seen in thirty years. The doctors couldn’t complain, because they had been carping about Medicare’s shortcomings and about it being compulsory. And the Republicans couldn’t complain, because it was their own idea. In effect, Mills had taken the AMA’s ammunition, put it in the Republican’s gun, and blown both of them off the map.”⁹⁷ The resulting Mills’s bill would easily be approved by the House and Senate, and on July 30, 1965, President Johnson and some members of Congress traveled to Independence, Missouri – the home of former President Truman to sign the bill into law. President Johnson had made Harry Truman’s dream come true, but neither he nor Wilbur Mills could have predicted the nightmare of inflation in medical costs that would occur as a result of the law.

⁹⁶ Starr, *Remedy and Reaction*, 46.

⁹⁷ Richard O. Harris, *A Sacred Trust* (New York: New American Library, 1966), 187.

CHAPTER 4: BROKEN FENCES – SKYROCKETING MEDICAL COSTS IN THE LATE 1960s

“Nineteen months ago I said that America’s medical system faced a ‘massive crisis.’ Since that statement was made, that crisis has deepened. All of us must now join together in a common effort to meet this crisis – each doing his own part to mobilize more effectively the enormous potential of our health care system.”⁹⁸

- Richard Nixon, 1971

June 1974. Two months before President Richard Nixon would resign from office as a result of the Watergate scandal, administration officials met clandestinely with representatives of Senator Edward Kennedy and Congressman Wilbur Mills, respectively. The expressed agenda for these secret meetings in the basement of St. Mark’s Episcopal Church was to negotiate a compromise between various proposals for comprehensive health care reform. The meeting between these three different groups may have seemed out of place given the animosity between Republicans, liberal Democrats, and southern Democrats during the Medicare debate a decade prior; however, the state of health care in America in the late 1960s and early 1970s served as an imperative to bring lawmakers to the negotiating table. Rising medical costs threatened the nation’s health care system. Indeed, President Nixon remarked in July 1969, “We face a massive crisis in [health care] . . . Unless action is taken within the next two or three years . . . we will have a breakdown in our medical system.”⁹⁹

Anxiety over health care costs was palpable during the time period after the implementation of Medicare and was well-founded. The rate of annual growth in medical costs

⁹⁸ Richard M. Nixon, “Special Message to the Congress Proposing a National Health Strategy” (speech, Washington, D.C., February 18, 1971), The American Presidency Project, <http://www.presidency.ucsb.edu/ws/?pid=3311>.

⁹⁹ *New York Times*, July 11, 1969.

“more than doubled, from 3.2 percent in the seven years before 1965 to 7.9 percent in the five years after. From 1965 to 1970, state and federal health expenditures rose at an annual rate of 20.8 percent.”¹⁰⁰ In terms of actual dollars spent during this same timeframe, overall spending on health care reached \$70 billion by 1971, while “government spending on health care increased almost 150 percent to nearly \$30 billion annually.”¹⁰¹ With such explosive growth in medical costs, many looked at Medicare and Medicaid as the culprit for the skyrocketing of the cost of care.

In messages to Congress in both 1971 and 1972, Nixon reiterated this view. He declared, “This growing investment in health has been led by the Federal Government. In 1960, Washington spent \$3.5 billion on medical needs – 13 percent of the total. This year it will spend \$21 billion – or about 30 percent of the nation’s spending in this area.”¹⁰² In a follow-up address one year later in 1972, Nixon was even more forthcoming in his analysis of the health care problem facing the nation. “Medicare and Medicaid did deliver needed dollars to the health care problems of the elderly and the poor,” he said, “But at the same time, little was done to alter the existing supply and distribution of doctors, nurses, hospitals, and other health resources. Our health care supply, in short, remained largely the same while massive new demands were loaded onto it.”¹⁰³ In other words, Medicare and Medicaid increased demand for medical services, shifting demand to the right on the cost-curve. At the same time, prices for these services necessarily increased because supply had been held constant. Thus, the result was the price inflation gripping the country’s health care system. Seductive in its reasoning, this argument was

¹⁰⁰ Starr, *Remedy and Reaction*, 52.

¹⁰¹ Rutkow, 269.

¹⁰² Nixon, “Special Message to the Congress Proposing a National Health Strategy.”

¹⁰³ Richard M. Nixon, “Special Message to the Congress on Health Care,” (speech, Washington, D.C., March 2, 1972), The American Presidency Project, <http://www.presidency.ucsb.edu/ws/?pid=3757>.

overly simplistic, though. In fact, supply in health care was not constant and had not been since the years post-World War II.

While President Truman's national health insurance plan languished in the Republican-controlled Eightieth Congress in the late 1940s, legislation for hospital construction passed largely with bipartisan approval. Leading the charge on Capitol Hill for this issue was Democratic Senator Lister Hill of Alabama. As medical historian Ira Rutkow notes:

Hill held sway over the country's health care policies because he oversaw the distribution of federal dollars to state and local governments as well as to public and private institutions. Between 1950 and 1970, the approximate years of Hill's peak political powers, national health care expenditures rose 500 percent, from \$12 billion to \$69 billion (hospital expenses alone increased from \$2 billion to \$28 billion. Funds for medical research grew almost 1,000 percent (from under \$250 million to \$2 billion). By comparison, the country's nominal gross domestic product grew less than 400 percent during those twenty years. The health care workforce also swelled by 225 percent (from 1.2 to 3.9 million people) at a time when the general population increased a mere 34 percent, from 151 million to 203 million.¹⁰⁴

Clearly then, the supply of health care did not remain constant as President Nixon suggested. For example, looking more closely at hospital construction, the Hospital Survey and Construction Act of 1946 – also known as the Hill-Burton Act – led to the creation of new community hospitals in the growing suburbs and rural areas across the country. As a result, “two decades after the law's enactment, the nation had 9,200 new hospitals, nursing homes, rehabilitation centers, and outreach health clinics, collectively containing more than 416,000 beds.”¹⁰⁵ Thus, the blame for price inflation in health care costs during the late 1960s and early 1970s could not be attributed to a shortage in supply of medical care providers or facilities.

¹⁰⁴ Rutkow, 231.

¹⁰⁵ Ibid.

Of course, the issue of supply was more nuanced, especially with regards to the number of physicians. Using stagnant medical school enrollments in the 1950s as a proxy for the supply of health care, traditional historiography has argued that “the great increase in demand for medical care, with no corresponding increase in the supply of physicians, was to have repercussions for years.”¹⁰⁶ Yet, such a position fails to recognize that any such shortage in the supply of physicians could be accounted for by the growing specialization within the medical profession during the 1950s and 1960s. In fact, specialization – as opposed to a stagnant growth rate in the number of medical school matriculants – created the conditions for a perceived supply shortage in the late 1960s and early 1970s.

With respect to specialization, the number of “American doctors identifying as specialists rose dramatically in the postwar period, from 50 percent in the early 1950s to 80 percent by 1970.” The number of specialty residencies reflected this trend as the “number of approved residency positions available for specialists rose from 5,000 in 1940 to 30,000 in 1950 and 65,000 by 1970.”¹⁰⁷ As Paul Starr notes:

Three structural factors were especially important in producing the rising rate of specialization. First, the system for certifying medical specialists that had developed in the 1930s included no regulation of the size or distribution of the specialties. Second, beginning in the war, hospitals (and their associated physicians) had strong incentives to set up training programs for specialists – indeed, to create more openings for specialty training than there were American graduations to fill them. And, third, government subsidies, the high returns to specialty practice created by health insurance, and the lack of a corrective mechanism that would have reduced specialist incomes as their numbers increased gave physicians strong, continuing incentives to pursue the training opportunities hospitals created.¹⁰⁸

¹⁰⁶ Starr, *The Social Transformation of American Medicine*, 347.

¹⁰⁷ Rutkow, 251.

¹⁰⁸ Starr, *The Social Transformation of American Medicine*, 356.

As a consequence, the growth in specialists had an inverse relationship with the number of general practitioners. In fact, by “1970 fewer than 12 percent of new medical school graduates became family practitioners.”¹⁰⁹ (Attempts to remedy this situation in the 1970s would lead to the creation of new medical schools across the country, such as the James H. Quillen College of Medicine at East Tennessee State University, aimed at training more primary care physicians.) The notion of the town physician who provided a number of services to the community was now receding from the American medical landscape. At the same time as the rise in specialists, academic medical centers began to truly take off. This created a new dynamic within medicine, as the medical profession and organized medicine began to fracture.

In the postwar period, the medical world would become cleaved between academic and community-based physicians. From 1940 to 1957, “institutionally employed physicians jumped from 12.8 to 26.5 percent of the profession. Doctors in private practice on the other hand declined not only as a proportion of physicians, but also in relation to population, down from 108 to 91 per 100,000 people.”¹¹⁰ Those physicians “affiliated with teaching institutions shared similar professional interests that grew out of the nature of the environment in which they practiced. Their daily routines included educating and training physicians as well as conducting research.”¹¹¹ Many were also salaried, and so did not feel the pressures of running a profitable practice. The community-based physicians – whether running their own private practices or working in a hospital setting – did not have this luxury. As a result, “through the 1960s community-based private practitioners embodied the organized medical establishment, supporting the AMA. Private practice clinicians, and with them the AMA, opposed government

¹⁰⁹ Rutkow, 252.

¹¹⁰ Starr, *The Social Transformation of American Medicine*, 359.

¹¹¹ Rutkow, 236.

interference in medicine more vocally than their academic counterparts.”¹¹² Ironically enough, though, it was this group that would financially benefit the most with the government’s passage of Medicare in 1965.

As the “three-layered cake” of the Medicare legislation made its way from bill into law during the winter and spring months of 1965, lawmakers sought to appease the AMA and other physician groups into cooperation. Medicare historian Theodore Marmor coined this process the “politics of accommodation.” In other words, legislators and administration officials hoped to mollify the medical field in order to ensure a smooth implementation of the law once it went into full effect in July 1966. As such, the federal government agreed to reimburse physician fees at rates that were “customary, prevailing, and reasonable.” Further, no real efforts were made to regulate these fees for two specific reasons. The first was the success organized medicine had in the previous two decades in opposing federal involvement in medicine. This longstanding opposition created such a strong anti-statist culture that “the Johnson administration and Congress failed to impose any cost restraint on health-care providers.”¹¹³ Indeed, the Medicare law itself stated, “Nothing in this title shall be construed to authorize any federal officer . . . to exercise any supervision or control over the . . . compensation of any institution . . . or person providing health services.”¹¹⁴ The second reason was due to partial naivety on the part of lawmakers. As previously mentioned, Wilbur Mills’s overriding concern when negotiating a deal on Medicare was “safeguarding Social Security and protecting the general operating budget.”¹¹⁵ The main emphasis was placed not on controlling costs associated with physician

¹¹² Ibid.

¹¹³ Starr, *Remedy and Reaction*, 48.

¹¹⁴ Public Law No. 89-97, Sec 102A.

¹¹⁵ Eric M. Patashnik and Julian E. Zelizer, “Paying for Medicare: Benefits, Budgets, and Wilbur Mills’s Policy Legacy,” *Journal of Health Politics, Policy and Law* 26, no. 1 (February 2001): 20.

and hospital fees, but instead on establishing separate trust funds for Part A and Part B of Medicare to soundly finance the system. As Robert Ball, the head of Social Security, stated “Perhaps we were a bit naïve . . . We thought that if we paid medical providers appropriately they would increase spending in a reasonable way. Well, their definition of reasonable and ours were not the same.”¹¹⁶

Despite minor protests by organized medicine initially after the passage of Medicare, “over time, however, the medical establishment embraced Medicare. By 1970, most doctors not only accepted the program but considered it a financial pot of gold.”¹¹⁷ With respect to physician fees, “in the year between enactment of the Medicare law and its initial operation, the rate of increase . . . more than doubled.”¹¹⁸ Additionally, the rate of inflation in physician fees also doubled that of inflation in the economy at-large as measured by the consumer price index. One factor was the inability to apply the standard of “customary, prevailing, and reasonable” charges when determining medical billing. In spite of these seemingly straightforward and well-intentioned definitions:

This standard was unworkable in the context of Medicare’s first year. No one knew what doctors were customarily charging. There was no agreement among doctors or government officials about what constituted the upper limit of ‘prevailing charges.’ And, although Blue Shield and commercial insurance companies had evidence about their own past payments, there was no agreement about what constituted ‘comparable services’ in ‘comparable circumstances.’ Medicare thus began with an open-ended payment method for physicians. Doctors were as uncertain as everyone else about how the law would be construed, and fears that insurance intermediaries would codify and freeze their definitions of ‘reasonable charges’ gave physicians every incentive to raise their fees.¹¹⁹

¹¹⁶ Altman and Shactman, 208.

¹¹⁷ Rutkow, 264.

¹¹⁸ Marmor, 86.

¹¹⁹ *Ibid.*, 85-86.

Further, fees climbed even higher when “some young doctors, who had no record of charges, billed at unprecedented levels and were paid. When their older colleagues saw what was possible, they, too, raised their fees, and soon what was customary was higher than ever before.”¹²⁰ Indeed, this was a fairly easy tactic to implement. Because the “customary and prevailing payment system was designed to pay physicians no more than they charged private patients,” physicians simply “increased what they usually charged private patients in expectation that in future years the higher rates would become the new accepted Medicare fees.”¹²¹ As such, the fence that Wilbur Mills had sought to build around Medicare in 1965 was undermined by provisions within the legislation itself. Actual expenditures for Medicare in its first year after enactment was \$2 billion more than estimated.¹²² With respect to hospital spending, actual costs in 1970 were \$15.1 billion - double the original projections of \$7.1 billion.¹²³ In a telling remark, Senate Finance Committee Chair Russell Long, a leading expert along with Mills in the tax community and the son of the late Senator Huey Long, “called Medicare a ‘runaway program.’”¹²⁴

Mending the broken fence around Medicare and reigning in such a “runaway program” would become a bipartisan affair. On August 15, 1971, President Nixon would take a drastic step to combat inflation when he issued an executive order “freezing all wages and prices in the country.”¹²⁵ By December of that year, “the program singled medical care out for special treatment, limiting doctors’ fees to annual increases of 2.5 percent and hospital charges to

¹²⁰ Starr, *The Social Transformation of American Medicine*, 385.

¹²¹ Altman and Shactman, 209.

¹²² House of Representatives, Committee on Ways and means, Subcommittee on Oversight, “Hearing: Administration of Medicare Cost-Saving Experiments,” May 14-17, 1976, 94th Congress, 2nd sess.

¹²³ *Ibid.*

¹²⁴ Altman and Shactman, 208.

¹²⁵ *Ibid.*, 204.

increases of 6 percent (about half the inflation rate in medical care preceding the freeze).” Price controls would be lifted in January 1973, but were kept in place for “health care and for the food, oil, and construction industries. The decision to maintain controls on health care reflected concern about structural flaws in the industry that were felt likely to generate raging inflation again.”¹²⁶ New amendments would be added to Medicare in 1972, and a series of proposals would be set forth in the early 1970s to address the structural flaws in American health care. President Nixon would first turn to Dr. Paul Ellwood of the University of Minnesota. Ellwood would suggest the “adoption of a health maintenance organization (HMO) model,” which would lead to the HMO Act of 1973.¹²⁷ HMOs would provide payment to “health-care providers for comprehensive services per person (capitation payment) rather than by individual fee for service.”¹²⁸

By 1974, Nixon would make an even broader proposal with his Comprehensive Health Insurance Program (CHIP). This plan “relied on an employer mandate to cover workers and their dependents and a public program for everyone not otherwise insured.”¹²⁹ Senator Ted Kennedy would counter with a proposal for a single-payer system financed through general revenue. Wilbur Mills would back this measure, too. Such a move represented a stark break from Mills’s position on health care just a decade prior. In the negotiations leading to the passage of Medicare, Mills had been adamant that distinct trust funds and not general revenue were the best structure for financing the program. Almost ten years later, though, the Ways and Means chairman was willing to utilize general revenue funds to pay for a national health care system. In part, such a change of heart had been grounded in discussions with Kennedy during

¹²⁶ Starr, *The Social Transformation of American Medicine*, 399.

¹²⁷ Bradley and Taylor, 38.

¹²⁸ Starr, *Remedy and Reaction*, 54.

¹²⁹ *Ibid.*, 56.

the months leading up to the 1972 Democratic primaries. Kennedy staffers Lee Goldman and Stan Jones believed that Mills would be receptive to working with Kennedy on health care reform in 1972, if the former thought that the latter would capture the Democratic nomination and select him as a vice presidential candidate. While Senator Kennedy would choose not to run for president in 1972, the ploy did work. Mills, who had felt hoodwinked by the Johnson administration when actual Medicare costs far outpaced estimates, was willing to negotiate with the liberal Massachusetts senator. A series of secret meetings resulted in a forerunner to the Kennedy-Mills bill of 1974, and a single-payer proposal was included in the 1972 Democratic platform.¹³⁰

Aside from CHIP and Kennedy-Mills, at least twelve other reform proposals were put forth in 1974. Indeed, “no less than thirteen of the twenty-five members of the Ways and Means Committee were sponsors of their own bills.”¹³¹ With so many proposals, the ability to compromise would determine whether comprehensive health care legislation would pass. Unfortunately, neither the Nixon administration, Ted Kennedy, Wilbur Mills, nor any of the other major figures in the discussion could come to a satisfactory agreement. The Nixon administration wanted “Kennedy to support an employer mandate in which employers purchased coverage from private insurance companies.”¹³² Yet, Kennedy was facing intense pressure from organized labor who in their eyes viewed the senator as already compromising too much on health care reform. In a move that he would later regret, Kennedy could not come to terms with Nixon on health care. By the second half of 1974, optimism for reform would be dashed as President Nixon resigned in August as a result of the Watergate scandal. Further, Wilbur Mills

¹³⁰ Altman and Shactman, 32.

¹³¹ *Ibid.*, 60.

¹³² *Ibid.*, 58

would become embroiled in a scandal of his own involving his growing alcoholism and affair with an Argentinean stripper. Although Ted Kennedy would continue the push for health care reform, it would take an additional three decades before any meaningful legislation would be passed to that effect.

CONCLUSION

“We choose to go to the moon. We choose to go to the moon in this decade and do the other things, not because they are easy, but because they are hard, because that goal will serve to organize and measure the best of our energies and skills, because that challenge is one that we are willing to accept, one we are unwilling to postpone, and one which we intend to win, and the others, too.”¹³³

- John Kennedy, 1962

July 30, 2015, will mark the fiftieth anniversary of the signing of Medicare into law. By and large, the program that Wilbur Mills reluctantly ushered through Congress has been popular with constituents. In fact, when the Reagan administration added catastrophic insurance to Medicare in July 1988, many of the elderly revolted, believing that such an intrusion would result in decreased benefits. Just one year later, “both houses of Congress voted overwhelmingly to repeal [Medicare Catastrophic].”¹³⁴ With that said, it is clear that Medicare has become a cherished symbol of social insurance in America.

Of course, program costs are still a major concern. The government will spend close to \$800 billion on Medicare and Medicaid this year alone, and that number will surely rise. This means that:

As our population ages and medicine evolves, almost always more expensively, our society (as is the case with all mature industrial nations) will have to grapple with how best to furnish and afford health care services for the elderly – not to mention the rest of the population. However Medicare is organized and financed, the growing numbers of

¹³³ John F. Kennedy, “Address at Rice University on the Nation’s Space Effort” (speech, Houston, Texas, September 12, 1962), John F. Kennedy Presidential Library and Museum, <http://www.jfklibrary.org/Asset-Viewer/MkATdOcdU06X5uNHbmqm1Q.aspx>.

¹³⁴ Altman and Shactman, 161.

seniors will need medical care, and each new generation of treatments is likely to be more costly than the one that came before.¹³⁵

Prognostics aside, there is a glimmer of hope, however. As Steven Brill demonstrated in the reporting for his 2013 piece in *Time*, Medicare is paving the way in bending the cost-curve in health care. Yet, as this study has sought to demonstrate, this current reality was not always the case.

Inflation in medical costs skyrocketed in the late 1960s and early 1970s following the passage of Medicare and Medicaid, which were far outgrowing congressional estimates. This explosive growth, though, was not inevitable. Nor was it simply an issue of inadequate supply for increased demand, as President Nixon would suggest in his special messages to Congress on the topic of health care. Rather, the growth was linked to something much simpler – the liberalization of Medicare benefits suggested by Wilbur Mills in early 1965. Initial proposals for Medicare dating back to 1952 focused solely on the issue of hospitalization costs. It was not until Mills, the longtime chairman of the House Ways and Means Committee, constructed the “three-layer cake” that physician fees were added to the benefits package.

Coupled with exogenous factors, the conditions aligned for inflation in medical costs. The persistent opposition of organized medicine and the conservative coalition in Congress dating back to the New Deal caused an anti-statist atmosphere to permeate throughout the nation. Attempts by President Truman to enact a national health insurance program were labeled by opponents as the beginning of “socialized medicine” in America. By the time President Kennedy would turn his attention to Medicare, he had to be particularly careful to note that a federal program to pay hospital costs for the elderly was not a form “socialized medicine.” As

¹³⁵ Mark A. Peterson, “Editor’s Note: Medicare Intentions, Effects, and Politics,” *Journal of Health Politics, Policy and Law* 26, no. 1 (February 2001): 2.

such, when Congress passed Medicare legislation in 1965, there were no regulatory measures put in place to control physician fees or hospital costs. Any stipulations to that effect would have been considered anathema. In fact, administration and congressional officials hoped to accommodate and appease the medical profession into cooperation with the new law. In “a promise to the AMA, Mills even insisted that hospital-based specialists such as pathologists, radiologists, and anesthesiologists, who were typically paid by salary at the time, instead be paid fee-for-service under Medicare Part B.”¹³⁶

The lack of regulations and the politics of accommodation then were a boon to physicians, in particular those in private practice. Organized medicine began to fracture in the 1950s between doctors associated with academic medical centers and those who were community-based practitioners. The latter group faced much more daily pressure to keep their practices financially viable. Thus, the passage of Medicare was a positive for this group because the law served to reinforce the fee-for-service model. As Paul Starr points out, “Since under fee-for-service, doctors and hospitals make more money the more services they provide, they have an incentive to maximize the volume of services. Third-party, fee-for-service payment [in this case shouldered by Medicare] was the central mechanism of medical inflation.”¹³⁷ Then and in some respects now, this mechanism gave credence to the idea that “the most expensive piece of medical equipment . . . is a doctor’s pen.”¹³⁸

Since the rapid inflation in medical costs during the 1960s and early 1970s, regulations have been put in place to curb Medicare spending. The law was amended in 1972, and today, “Medicare takes the cost reports – including allocations for everything from overhead to nursing

¹³⁶ Starr, *Remedy and Reaction*, 48.

¹³⁷ Starr, *The Social Transformation of American Medicine*, 385.

¹³⁸ Gawande, “The Cost Conundrum.”

staff to operating-room equipment – that hospitals across the country are required to file for each type of service and pays an amount equal to the composite average costs.”¹³⁹ In essence, the statute on “customary, prevailing, and reasonable” fees from the original law has been strengthened, giving the Centers for Medicare and Medicaid Services more clout to bend the cost-curve. Yet, the lesson went unheeded in 2003 when prescription drug coverage (Part D) was added to Medicare. When it comes to prescription drugs:

Federal law also restricts the biggest single buyer – Medicare – from even trying to negotiate drug prices. As a perpetual gift to the pharmaceutical companies (and an acceptance of their argument that completely unrestrained prices and profit are necessary to fund the risk taking of research and development), Congress has continually prohibited the [CMS] from negotiating prices with drugmakers. Instead, Medicare simply has to determine that average sales price and add 6% to it.¹⁴⁰

Although it remains to be seen if the lack of regulation will lead to rampant inflation in drug costs, early indicators are not positive. The cost that Medicare pays for cancer medication has increased rapidly, ballooning from “\$3 billion in 1997 to \$11 billion in 2004 . . . and must now be more than \$20 billion.”¹⁴¹

This is the state of health care in America. Estimates project health care spending to rise to more than nineteen percent of GDP by 2019.¹⁴² Currently, “health spending already accounts for about 20 percent of the entire federal budget, higher than Social Security or defense.”¹⁴³

Over time, the Affordable Care Act may help to bring down costs. Yet, even it has its limitations. As T.R. Reid states, “The sad truth is that, even with this ambitious reform, the

¹³⁹ Brill, “Bitter Pill,” 48.

¹⁴⁰ *Ibid.*, 46

¹⁴¹ *Ibid.*

¹⁴² Christopher J. Truffer et al., “Health Spending Projections Through 2019: The Recession’s Impact Continues,” *Health Affairs* 29, no. 3 (2010): 522-529.

¹⁴³ Altman and Shactman, 344.

United States will still have the most complicated, the most expensive, and the most inequitable health care system of any developed nation.”¹⁴⁴ Steven Brill paints an even gloomier portrait:

Over the past few decades, we’ve enriched the labs, drug companies, medical device makers, hospital administrators and purveyors of CT scans, MRIs, canes and wheelchairs. Meanwhile, we’ve squeezed the doctors who don’t own their own clinics, don’t work as drug or device consultants or don’t otherwise game a system that is so gameable. And of course, we’ve squeezed everyone outside the system who gets stuck with the bills.¹⁴⁵

Seen in this light, the Affordable Care Act is merely an opening salvo, rather than the dénouement of comprehensive health care reform in the United States. As Ezekiel Emanuel, a prominent physician and brother of former White House Chief of Staff Rahm Emanuel, argues in an opinion piece in a November issue of the *Journal of American Medical Association*, the American health care system needs to set an audacious goal similar to the moonshot during the 1960s, such as making an effort to have “per capita health care costs [increase by] no more than gross domestic product (GDP)+0%” by 2020.¹⁴⁶ Controlling inflation in medical costs is certainly a laudable goal and was even the aim of Wilbur Mills, Ted Kennedy, and the Nixon administration during the early 1970s. Regardless of whether or not current policymakers actively and willingly pursue this goal, though, it is certain that mending the U.S. health care system is an issue that cannot be postponed. Whether it is an issue the nation intends to win remains to be seen.

¹⁴⁴ Reid, 251.

¹⁴⁵ Brill, “Bitter Pill,” 55.

¹⁴⁶ Ezekiel Emanuel, “Going to the Moon in Health Care: Medicine’s Big Hairy Audacious Goal (BHAG),” *Journal of the American Medical Association* 310, no. 18 (2013): 1925.

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