Why Medicare Part A and Part B, as Well as Medicaid?

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In the years before the Medicare and Medicaid programs were enacted in 1965, various groups had strong ideas about their possible structures. At one extreme were those who believed that Medicare should be a social insurance program covering all health care for the persons covered, on a compulsory basis, financed by payroll taxes, with a public assistance program as a safety net. At the other extreme were those who supported having only a public assistance program. Also involved in the debate was the American Medical Association (AMA), which opposed any program, whether social insurance or public assistance, if the plan were compulsory, on the grounds that this would eventually lead to socialized medicine.

The final legislative process was a matter of political compromise and was not by any means dictated by actuarial principles. Those who believed in the full-social-insurance approach generally supported a plan called the King-Anderson Bill. They attempted to gain the support of other groups by limiting their proposal in various ways. For example, it was proposed that physician services (other than those provided by hospital staff) be covered only for inpatient surgery. Also, coverage would, as a compromise, be limited to persons age 65 or over. At no time was it provided that out-of-hospital prescription drugs would be covered, primarily because, at that time, such costs were quite low and were seldom covered by private health insurance. This restricted version of compulsory social insurance became the foundation for what is now Part A of Medicare.

Proponents of the public-assistance-only approach, realizing that they could not defeat a social insurance plan, supported, as a counterproposal, the Byrnes Bill, a compromise program that would cover all physician and other services but on a voluntary basis (to accommodate the strong views of the AMA), financed partly by the enrollees, with the remainder of the cost coming from general revenues. And so was born the foundation for Medicare Part B, whose benefit and financing provisions were similar to those of the Byrnes Bill, except that the hospital and related benefits were carved out (because they would be covered in Part A).

Meanwhile, the AMA had sponsored a third proposal, popularly known as Eldercare, that essentially would have expanded the existing Federal-State Medical Assistance for the Aged Program and would have provided subsidized private health insurance for low-income persons and a partial-payment plan for others. This proposal became the basis for Medicaid.

The three separate health-benefits approaches were viewed by the various groups as competing proposals. In order to get a broad base of support in the House of Representatives, however, Ways and Means Committee Chairman Wilbur D. Mills proposed a new bill that would, insofar as possible, incorporate the essential features of all three of the major pending proposals—the King-Anderson Bill, the

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Byrnes Bill, and Eldercare. This politically logical approach took virtually everybody by surprise, including the sponsors of the three approaches. Mills' consolidated proposal eventually prevailed, thus resulting in today's Part A, Part B, and Medicaid, complete with the well-known disparities in coverage, benefit, and financing provisions.

In summary, those who favored a complete-social-insurance approach for the provision of all types of health care services for persons age 65 or over (along with a public assistance program as a safety net) received, in essence, all that they wanted. Part A provided for inpatient hospital services, Part B provided virtually total coverage for physician services—because the vast majority of persons who could be covered elected to do so—and Medicaid served as the safety net. Thus, the Medicare and Medicaid programs were not systematically designed and enacted but were instead the direct result of long years of evolution, debate, and political compromise.

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