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# Overview: 40th Anniversary of Medicare and Medicaid

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## INTRODUCTION

The *Health Care Financing Review* is celebrating the 40th anniversary of Medicare and Medicaid with articles on the following three themes: (1) the development of Medicare and Medicaid; (2) the significance of Medicare and Medicaid for the health and well-being of beneficiaries and their impact on the practice of medicine; and (3) future challenges facing the programs.

The goal of this issue is to take stock of the programs as several important milestones have been reached:

- Medicare is finally able to celebrate the addition of an outpatient prescription drug benefit, some 40 years after President Johnson first asked a task force to consider adding the benefit (U.S. Department of Health, Education, and Welfare, 1969). A Medicare drug benefit was frequently discussed and debated in the Halls of Congress resulting at one time in enactment of a drug benefit in 1988 only to see it repealed in 1989. Oral history interviews with many of the participants in the congressional debate surrounding the Medicare Catastrophic Coverage Act, are available on the CMS history page: <http://www.cms.hhs.gov/about/history/>. Many of the articles in this issue discuss the new drug benefit: its history, why it was so long in coming, and the challenges it poses for the future.
- Medicaid is now the larger of the two programs both in terms of persons enrolled and dollars spent; something not remotely envisioned at enactment or in most of the decades since.
- In fiscal year 2003, Medicaid had 41.4 million persons enrolled, compared to Medicare's 41.3 million and in fiscal year 2002, Medicaid spending by both Federal and State governments was \$259 billion, which was greater than Medicare's spending of \$256 billion.<sup>1</sup>

Medicare and Medicaid together serve about 1 in 4 Americans and spend about 1 in 3 of the Nation's health dollars. Both programs have grown substantially both in terms of the percentage of the population served and the dollars spent. For example, Medicare alone accounts for about 1 in 5 of the Nation's health dollars, about twice the share of the Nation's health spending as the 1 in 10 in 1970.

## Articles in this Issue

To appreciate the role of these programs in the American political landscape, we begin the issue by taking a step back in time, viewing the enactment of Medicare and Medicaid in the broader historical context of reform movements in the twentieth century. The article by Berkowitz brings an historian's eye to what would have been called "sickness insurance" had it passed at the turn of the century, or a

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<sup>1</sup>As the baby boom ages, CMS actuarial projections suggest that Medicare enrollment will surpass Medicaid enrollment and as Medicare covers drugs in 2006, Medicare spending will again surpass Medicaid.

State-based program had it passed during the New Deal, or federally administered national health insurance for all ages had it passed in the 1940s. It was during the New Deal that concern over wages lost from illness was overtaken by the cost of treating the illness itself. During the World War II years, States were viewed by Federal officials as unreliable and inefficient partners who were pushed by a need to keep taxes low to a race to the bottom when it came to social programs. Such officials began to view health insurance as a Federal responsibility in order to create a comprehensive system without gaps. Hence, legislation in the 1940s featured Federal administration. In the 1950s, the idea of tying health insurance to Social Security served to keep it Federal and restricted coverage to the elderly. By the time Medicare and Medicaid were enacted in 1965, after decades of incubation, they represented a blend of a number of these approaches. Medicare was federally administered for the elderly on Social Security. Medicaid was State based and targeted to the poor on welfare.

Santangelo's article gives an historical perspective of why it took nearly 40 years to add drugs to Medicare. It is a story of much passion and deliberation in the halls of Congress and how hard it can be to come to a solution even when there is bipartisan agreement that there is a problem. Prescription drugs were in some of the bills Congress considered in 1965, but Senate efforts to include prescription drugs failed to emerge in the final conference report language in 1965, 1966, and 1972.

President Johnson called on Health, Education, and Welfare to study the inclusion of drugs in Medicare in 1967. The report was released in February 1969 (by which time President Nixon had taken office) and recommended limited Medicare

coverage of drugs with coverage starting at age 70 and restricted to chronic illness. The Nixon administration studied the drug issue in several different commissions and while they differed on some points, still supported adding drugs to Medicare in the first term. Concern about costs and the administrative workload reduced the administration's enthusiasm as time passed. Attention moved to ways to slow Medicare costs, which were growing much faster than predicted. Medicare drug coverage was subsumed in the larger national health insurance debate for much of the 1970s, although persistent members of Congress continued to introduce Medicare drug bills in both Houses of Congress. Frequent features of these bills were: formularies developed by expert bodies who would determine which drugs Medicare would cover and at what price, and financing from beneficiaries and taxpayers.

The Medicare Catastrophic Coverage Act, enacted in 1988 added an outpatient prescription drug program, but it was repealed in 1989 after higher-income elderly protested their required contributions even though many of them already had drug coverage from former employers. The Clinton administration included a Medicare drug benefit in its ill-fated Health Security Act in 1993 and ended the decade advocating a Medicare drug benefit. Santangelo concludes his history with Congress' final effort to pass a drug benefit, which President Bush lobbied hard for and signed into law in December 2003, after so many false starts.

The Congress was much more successful in passing legislation relating to changes in Medicare payment policy over this period, motivated by concern over rampant growth in Medicare spending. The Newhouse article brings an economist's perspective to those congressional changes in Medicare payments to fee-for-

service providers as well as managed care plans. In 1965, Congress built Medicare on the foundation of private health insurance payment methods. As Medicare costs escalated faster than predicted, the hunt for ways to control payments to providers was on. Over the years, the Part A providers: hospitals, skilled nursing facilities, and home health agencies were all moved from cost reimbursement to costs subject to limits to prospective payment systems. Part B payments for ambulatory services have also moved from charge-based systems to fee schedules for certain providers, a relative value scale for physicians, and an outpatient prospective payment system for hospitals.

These efforts to contain the growth in spending all spawned unanticipated consequences, that provided fodder for yet more legislative fine-tuning. Newhouse notes both the problems in getting each individual payment system right as well as the challenges in rationalizing payment across post acute providers. On the physician side, he discusses the significant challenge of modifying the payment system to both reflect the increase in volume of services provided by physicians as well as the ability of the Federal budget to absorb those increases. Turning to private plans and the efforts to increase choice in Medicare, he describes the new Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) plan options and the favorable prospects for growth in enrollment. He notes that Medicare has evolved to balance the needs of the elderly and the burden on the taxpayers and ends with the certain prediction that there will “surely be more important changes in the future.”

While Medicare received the bulk of congressional attention at enactment and for much of the intervening decades, in the article by Moore and Smith we learn that Medicaid was not created out of thin air in

1965. Rather, it was built on the foundation of two earlier pieces of legislation: in 1950 a State-based vendor payment program was established to cover medical care for people on welfare, and in 1960 this program was extended to cover indigent elderly who weren't on welfare, but couldn't afford their medical bills. Wilbur Cohen got the idea for Medicaid by a rogue State looking for funding: “...in 1942 Rhode Island attempted to tap Public Assistance funds for vendor payments.” He was able to enact the start of such a program in 1950. There has been much angst spent on behalf of Federal and State officials in arm-wrestling over how States can tap additional Federal Medicaid funds in recent years (Wilensky, 2005). They end by noting that Medicaid has been termed an after-thought or step-child by some in relation to Medicare, but note that it has grown to be an even larger program than Medicare, which was not on anyone's radar screen at enactment.

Davis and Collins take stock of the program in their article by comparing Medicare beneficiaries to other Americans with either no insurance or other coverage in a recent Commonwealth survey (Collins et al., 2004). They find that Medicare beneficiaries are much more likely to report high satisfaction with their health care and their health insurance, less than one-half the rate of access to care problems, less likely to be paying-off medical debt, and were less likely to spend more than 5 percent of their income on health care. Among Medicare beneficiaries, failure to fill a prescription was the most common access problem affecting 1 in 10 elderly and 1 in 4 disabled. With the start of the new Medicare drug benefit, these access problems to prescription drugs should be rectified. Medicare beneficiaries have higher levels of confidence in being able to get excellent medical care and in the choice of where to receive it than other Americans.

Moving from their survey, they find that Medicare has met its twin goals of access to health care services while averting the financial devastation that can accompany significant use of health care services. To continue to meet these goals for future decades, they propose a panoply of recommendations including: increasing use of preventive services, better managing chronic illness, increasing workers' savings for their own out-of-pocket Medicare health costs, increasing insurance coverage for those in their 50s and early 60s who are in the years before Medicare eligibility, providing Medicare beneficiaries with their own medical history from billing records, improving Medicare's benefit package by folding Medigap into Medicare as an option, encouraging beneficiary use of high value providers, accelerating adoption of modern information technology, and promoting diffusion of best practices through the quality improvement organizations.

Rowland begins her article with the different population groups served by the Medicaid Program—low income children and their parents, disabled adults, and the elderly—and how Medicaid coverage has been expanded for those groups over the last 40 years. While congressional action on Medicare has often focused on payment policy, as discussed by Newhouse, for Medicaid it has often focused on incremental expansions in eligibility.

The collective result of these incremental expansions is that Medicaid is now the Nation's largest health program: it covers 1 in 4 children, 1 in 3 pregnant women, and nearly 1 in 5 Medicare beneficiaries. She notes Medicaid's critical role in providing coverage to millions who would otherwise add to the growing ranks of the uninsured. She closes with a discussion of the challenge facing the Medicaid Program: how

to finance care for a growing population in need of services within Federal and State budget constraints.

DeWalt, Oberlander, Carey, and Roper turn our attention to the chasm between the Medicare Program's first statutory provision which precludes Federal officials from "...exercising any supervision or control over the practice of medicine...", and the reality which has turned out to be quite different. To make this point, they draw on five examples: (1) end stage renal disease program, (2) professional standards review organization, (3) effectiveness initiative and guideline development, (4) financing of graduate medical education, and (5) State Medicaid activities.

The authors note that what at enactment was a political imperative, to allay fears among physicians, has become an anachronism. Indeed, they argue that Medicare and Medicaid should take on a leadership role in a number of areas to improve the quality of medical care. For example, they suggest collaboration with other payers to pool data in efforts to improve health care as well as helping move the health financing system away from an acute care model toward one that focuses on chronic illness.

Quality of care is joining Medicare payment policy as a hot topic among policymakers because of the synergistic impact of using the latter to stimulate improvement in the former. Milgate and Hackbarth begin their article with a review of the history of quality improvement in Medicare. From almost the inception of the program, quality was a concern. It has moved higher up the agenda over time, as costs continue to grow. Pay for performance is advocated by the authors as a way to stimulate providers' attention to quality improvement. Linking provider payment to quality measures can be done through existing

payments by withholding a percentage of payment and rewarding those providers who meet the quality targets. They think that implementing such a strategy requires addressing how to balance the breadth of the pool getting the reward with the depth of the reward among other issues.

As a reform strategy, they argue that pay for performance is not in and of itself sufficient. To rectify other quality related problems (such as the need to coordinate care across multiple settings and over time for a patient population burdened with multiple chronic illnesses) they suggest improved communication across providers through use of an electronic patient health record. They end with a call to CMS to lead efforts to improve health care by starting with pay for performance programs focused on individual providers and then moving toward programs that measure care over time and across settings. They conclude with the prospect that such an approach may become an important tool in managing the ever increasing costs of Medicare.

Antos describes some of the complexity of the long awaited new Medicare drug benefit, and discusses the challenges it brings. Specifically, the key challenge will be finding the right balance between cost and access in an area where costs have been growing rapidly over the last decade. He notes that contrary to predictions that there might not be enough private drug plans, the launching of the drug benefit has attracted many private plans which brings the concomitant challenge of educating beneficiaries about their options.

Dowd, Coulam, Feldman, and Pizer state that the question is not whether, but how, Medicare fee-for-service and private plans should coexist. By posing the question in such a way, they hope to move beyond the controversy of recent years. They detail

the advantages that each brings to the Medicare Program. Despite the political difficulties in launching a competitive market demonstration, they argue that questions of economic efficiency and the long run fiscal health of the Medicare Program justify its continued examination. They note that the Federal Government made hold harmless payments to participants in the national health insurance experiment in the 1970s and that it might be worth making the same investment in this context.

Foster and Clemens' article is a discussion by Medicare's actuaries of how three terms differ: financial status, impact on the Federal budget, and sustainability. The authors provide several ways of understanding the concept "sustainability" and how it is both similar to and different from financial status of the trust fund where the primary question is whether the trust fund is in balance or not, and Medicare's impact on the Federal budget, where the primary question is whether the program contributes to or draws from the budget. Their article ends with a discussion of sustainability—the substantial challenge to the Nation in providing Medicare to the baby boom and subsequent generations.

## CONCLUSION

There is no better way to end this overview and this issue than with the challenge that the actuaries make so clear: how to continue to provide Americans with the benefits provided by the Medicare and Medicaid Programs over the long term at a cost that the country can afford. The programs have benefited countless Americans over the last 40 years, it is our challenge as a Nation to ensure that they can continue for the next 40.

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