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# Historical Perspective on Adding Drugs to Medicare

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*This article describes the lengthy background and debate leading up to the passage of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). Full implementation of the prescription drug aspect of the law will not be completed for some time, and final assessment of its impact awaits a history yet to be written. Instead, this article summarizes the efforts of supporters until they finally managed to succeed after being stymied so many times in the preceding four decades.*

## INTRODUCTION

On December 8, 2003, as President George W. Bush prepared to sign the MMA into law, he took a moment to look back over the work that went into the legislation. "With the Medicare Act of 2003, our government is finally bringing prescription drug coverage to the seniors of America," he said. "The challenges facing seniors on Medicare [to be addressed by the Act] were apparent for many years. And those years passed with much debate and a lot of politics, and little reform to show for it." (Milbank, 2003.)

Indeed, the addition of a prescription drug benefit to Medicare has been a topic of considerable debate since before the program's creation. That such coverage was not included until almost four decades after Medicare was inaugurated was the result of a number of factors which speak to the difficulties in policymaking for the Nation's most important health care program.

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Medicare's passage under President Lyndon Johnson was the consummation of years of debate over a national health insurance policy dating back to the Truman administration. Like all legislation, it was the product of compromise, and proponents of the broadest possible program realized it did not meet all the requirements they had pressed for. Ironically, the two major counterproposals to Medicare during the policy debates of 1965 both included prescription drug coverage while Medicare did not.

The most important alternative proposal offered in 1965 was Eldercare, introduced by Curtis (R-MO) and Herlong (D-FL) and supported by the American Medical Association (AMA), which objected to Medicare as government interference with the traditional doctor-patient relationship. Eldercare was a proposed extension of the already existing Kerr-Mills program, a Federal-State initiative enacted in 1960 to support the medically indigent elderly, which included drug coverage. Eldercare's proponents in Congress and the AMA proposed that matching Federal grants would help the States pay for the program. Most observers believe that the AMA supported Eldercare mostly as a mechanism to defeat the passage of Medicare, particularly by making clear to Congress and the public how expensive expanded medical benefits under Federal health insurance would be.

In addition to Medicare and Eldercare, another proposal in the 1965 debates was offered by House Ways and Means Committee member Byrnes (R-WI). Byrnes offered a voluntary plan which would have created an insurance program with costs

shared equally by the government and the insured. Under his plan, 80 percent of the cost of prescription drugs would have been covered. Byrnes' bill, which drew on the existing plan for active and retired Federal employees in its enumeration of benefits, helped frame what became the Part B portion of Medicare in the final bill, but the prescription drug language did not survive the drafting process in the House.

Thus, Medicare's proponents on Capitol Hill and in the administration were well aware of the possibility of including prescription drugs in the benefits of the program. Such a benefit had not been a feature of previous Medicare proposals, dating back to the Kennedy administration, but could easily have been included as part of the legislative process in 1965. When the Senate took up the debate on the administration's Medicare bill that year, Javits (R-NY) proposed that a drug benefit be included. His proposed amendment was supplanted in the Senate's version of the bill by language calling for a study of drug coverage. Even this watered-down commitment to only study the matter was dropped in the House-Senate conference that led to the final wording of the bill that President Johnson signed into law on July 30, 1965. Although there has been speculation that Javits' amendment to include prescription drugs under Medicare was an effort, like the Eldercare proposal by the AMA, to drive up costs and thus make the entire program politically untenable, this seems unlikely given Javits' cosponsorship of similar legislation even after the program was passed.

The reasons why Medicare's proponents in Congress and the administration did not press to include an outpatient prescription drug benefit for the elderly (except those hospitalized or in nursing homes under the provisions of Part A) are not fully clear. There was little debate on this

particular facet of Medicare; instead, it was subsumed under the larger national debate over whether or not the Federal Government should be getting into the health insurance business at all. A number of possible reasons why prescription drug coverage was not included have been raised by those who have studied the matter; most likely, the confluence of these circumstances was the determining factor at the time. Costs were the primary concern: the fear was that drug costs would be a particularly unpredictable element in years to come, and there was no way to gauge how beneficiaries' usage of prescription drugs under the program in, presumably, very large numbers, would drive these costs in the future.

These and other concerns conspired to keep a prescription drug benefit out of the original Medicare Program. Most likely, Medicare's proponents might have fought harder for its inclusion, but the sense in Congress and the administration was that Medicare needed to be passed, with whatever limitations necessary to the political exigencies of the moment. Once the program was created, incremental adjustments over time could fix whatever problems existed or add whatever was missing. In this as in other areas, President Johnson sensed that he had a rare, but probably brief, mandate to expand the Federal Government's role in ways that would surpass even the programs of Franklin Roosevelt. His main concern was to set the agenda for what would follow: get the programs created, with whatever flaws were included in the legislative process.

After Medicare was enacted without a prescription drug benefit, its supporters and critics in Congress and the public promptly set about to fill in the gap. As early as 1966, Douglas (D-IL) and others introduced an amendment to a Social Security bill to add a prescription drug

benefit to Medicare. Although the Senate passed Douglas' amendment, the language was deleted in the House-Senate conference, much as had been the case a year earlier with Javits' language calling for a study of prescription drug coverage under Medicare.

However, by early 1967, President Johnson requested HEW Secretary John Gardner to convene the Task Force on Prescription Drugs, chaired by Assistant Secretary for Health and Scientific Affairs Philip Lee and including nine other members, the FDA Commissioner, the Surgeon General, and the Social Security Commissioner. While Gardner emphasized that "...the Task Force has no prior commitment to recommend for or against the inclusion of outpatient drugs in the Medicare program...", few observers doubted that the Johnson administration expected the Task Force's final report to make a case strongly for inclusion (U.S. Department of Health, Education, and Welfare, 1969).

The complexity of the job before the Task Force, however, led their studies into a number of valuable, but time-consuming, areas. While Gardner had asked for recommendations within 6 months, the Task Force instead offered five interim reports, beginning in March 1968, before a final report was issued in February 1969. This report argued "...In order to improve the access of the elderly to high quality health care, and to protect them where possible against high drug expenses which they may be unable to meet, there is a need for an out-of-hospital drug insurance program under Medicare." (U.S. Department of Health, Education, and Welfare, 1969). In creating such a program, the Task Force recommended limiting the number of drugs to be covered at first, due to costs and the complexity of administration, to only those "...most likely to be essential in the treatment of long-term illness."

(U.S. Department of Health, Education, and Welfare, 1969.) This in effect meant limiting coverage to chronic disease treatments and leaving acute cases outside of coverage. It also suggested limiting the drug benefit to beneficiaries age 70 or over and advocated cost-sharing provisions (including coinsurance, copayments, and a deductible). The Task Force strongly came down on the side of generic drugs, to "...be encouraged wherever this is consistent with high-quality health care." (U.S. Department of Health, Education, and Welfare, 1969.) It spoke strongly in favor of the formulary approach, calling it "...not a mark of second-class medicine..." but rather an approach "...associated with the provision of the highest quality of medicine in the outstanding hospitals in the Nation." A successful Medicare prescription drug program, in the Task Force's judgment, would be "...difficult if not impossible to achieve without" a formulary (U.S. Department of Health, Education, and Welfare, 1969). Moreover, while noting that the idea deserved further study, the Task Force argued against "...the direct purchase of drugs by the Federal Government for Medicare beneficiaries." (U.S. Department of Health, Education, and Welfare, 1969.)

While some Task Force recommendations led to specific Medicare enhancements, on the fundamental issue of adding a prescription drug benefit to Medicare, the Task Force did not help bring about any such program, or even specific legislative initiatives to accomplish that goal. Turning a 6-month mandate into a 20-month process certainly meant the Task Force issued its final report in a distinctly changed political environment. President Johnson had called for Gardner to undertake the study in early 1967. Instead, the Task Force's Interim Report, issued in March 1968, was forwarded to a chief executive who could count on little support in Congress due to

the crisis in Vietnam, and who announced at the end of that month he would not stand for re-election. By the time the final report was issued, in February 1969, President Nixon had been inaugurated and most observers assumed this holdover from his predecessor would be swept away with the change in administration.

Rather than ignore the Task Force recommendations, Nixon's new HEW Secretary, Robert Finch, named a committee to study its recommendations and report to him. This review committee, chaired by John T. Dunlop included 16 non-governmental members and representatives of the health care and pharmacy industries, reported its findings in July 1969.

Dunlop's committee supported the Task Force recommendation to have an outpatient prescription drug program under Medicare. On more specific recommendations, however, Dunlop's group disagreed with the Task Force. The review committee considered the Task Force's recommendation of excluding acute care drug coverage (focusing instead on chronic cases only) both inadvisable and difficult to administer. The committee strongly declared that "...[a]n age limitation other than over 65 is undesirable." On the matter of beneficiary payment, it described coinsurance provisions as "less desirable" than copayment features. Also, if a deductible were imposed, the committee noted the undesirability of requiring beneficiaries to keep records on their payment thereof, rather than government administrators. The committee also took issue with the Task Force's proposals for a formulary approach. Trade association representatives of pharmacists, retail druggists, and pharmaceutical manufacturers offered specific reservations about the effects of the reimbursement mechanism or the formulary approach on their members, but in general the review committee

was surprisingly positive in its response to the overall framework the Task Force had proposed (Coster, 1990).

Further impetus for a prescription drug benefit under Medicare came later in Nixon's first term from a 1971 report by a commission studying Social Security chaired by Arthur Flemming. The report emphasized the importance of prescription drugs for the elderly and called for "...a program with a flat cost-sharing payment of \$2 per new prescription and \$1 for refills, with financing to be on an equal tripartite basis from workers, employers, and general revenues." (Coster, 1990.) The White House Conference on Aging that same year also called for including prescription drugs in Medicare, in this case proposing a program to be entirely financed by "...payroll taxes and subsidies from general revenues" (Myers, 1972).

The Nixon administration thus had many reasons to urge the coverage of prescription drugs initiated by Lyndon Johnson in 1967. However, the issue was largely thrust aside by a number of other health initiatives that the Nixon administration increasingly focused on. Cost-containment efforts for Medicare were a particular concern as health care costs began their spiral, ahead even of the high overall inflation rate of the decade, making support for a potentially costly prescription drug initiative less likely. In 1972, Robert Myers, Chief Actuary of the Social Security Administration, announced that the administration had moved away from a broad-based prescription drug program under Medicare (Myers, 1972).

With the White House backing away from a comprehensive prescription drug initiative under Medicare, the best chance for such an effort had been lost for some time. For the rest of the 1970s, members of Congress, especially in the Senate, took

the lead, pressing the case in proposed legislation. The two most consistent in the late 1960s and early 1970s were Long (D-LA), and Montoya (D-NM). The 1972 Long-Montoya amendment turned out to be the closest proponents of a prescription drug benefit came to enactment for the rest of the decade. A number of factors played a role, including the distractions of the Watergate scandal, the increasingly precarious state of the U.S. economy, and the Federal budget during the decade of stagflation. So, although approximately 50 different pieces of legislation supporting prescription drug benefits under Medicare were proposed in the early post-enactment years, proponents had nothing to show for their efforts. Later proposals, including those sponsored by Church (D-ID), Thurmond (R-SC) and Kennedy (D-MA), and Pepper (D-FL) and Obey (D-WI), met similar fates later in the 1970s.

Instead of Medicare reform, the national health care discussion centered for most of the 1970s on the prospects for National Health Insurance (NHI), an idea seriously discussed at least since the Truman administration, but now strongly revived. Calls for prescription drug coverage under Medicare were largely put aside as redundant; under most NHI proposals the entire population would receive prescription drug coverage, either for all drugs or for those drugs most needed for the sort of chronic care required by the elderly. In hindsight, the failure of the Nixon, Ford, or Carter administrations to pass any form of NHI legislation further hindered the cause of a more specific prescription drug element within Medicare.

With the election of Ronald Reagan in 1980, the chances for either sweeping NHI legislation or a separate Medicare prescription drug benefit seemed strikingly diminished. However, supporters of health care reform adjusted their sights and focused

on smaller, more incremental changes in Medicare. In particular, the cause of a prescription drug benefit was pressed by some members of Congress and interest groups such as AARP. Numerous States had also implemented some form of prescription drug assistance programs by the mid-1980s, offering a range of models to draw on in the development of a national program, appropriate to the more State-oriented focus of Reagan administration policies.

One result of the smaller scale focus of reformers was the addition of coverage of immunosuppressive drugs under Medicare in 1987. A Task Force on Organ Procurement and Transplantation was authorized by Congress in 1984. Its discussions then laid the groundwork for the Immunosuppressive Drug Therapy Act, cosponsored by Kennedy (D-MA) and Hatch (R-UT). This legislation "...authorized \$15 million in block grants to the States for a period of 3 years [for fiscal years 1987-1989] for the purchase of immunosuppressive drugs. Each State would receive a minimum of \$50,000 per year." The legislation fit an incremental model of Medicare expansion and was partially the result of new attention to organ transplantation in the early years of AIDS. Reagan administration officials, led by HCFA Administrator William Roper, argued that there was little evidence to support the contention that the cost of immunosuppressive therapy was an impediment to patients obtaining necessary transplantation procedures. Despite cost concerns, the measure passed, eventually leading Medicare to cover the costs of immunosuppressive drugs "...within the first year of a Medicare-approved organ transplantation." (Coster, 1990.)

During Reagan's second term, supporters of a prescription drug benefit under Medicare took advantage of the unique opportunity presented by the President's

call for catastrophic coverage under Medicare to append their program to the administration's. The result was the short-lived Medicare Catastrophic Coverage Act (MCCA), passed in 1988 and repealed the following year. President Reagan made the issue of catastrophic coverage one of his top health care priorities in his 1986 State of the Union address, calling on HHS Secretary Dr. Otis Bowen to report by the end of the year with "...recommendations on how the private sector and government can work together to address the problems of affordable insurance for those whose life savings would otherwise be threatened when catastrophic illness strikes." (U.S. Government Printing Office, 1986.)

Advocates of Medicare expansion saw the catastrophic legislation as an opportunity to open the program into other areas, including prescription drugs. House Speaker Jim Wright met with Democratic leaders of the key committees in May to encourage the addition of a prescription drug benefit to the legislation. Wright's goal was to put a Democratic stamp on the legislation and ensure that the President would only get catastrophic coverage if he were willing to swallow the drug benefit as well. Later that month, Henry Waxman, chairman of the House Energy and Commerce Subcommittee on Health introduced a catastrophic coverage bill with a prescription drug benefit attached and held hearings on the drug benefit. Waxman's bill was approved by the subcommittee and later the full Energy and Commerce Committee in June. In the Senate, the legislation underwent a similar metamorphosis from 1987 to 1988. Bentsen (D-TX), who chaired the Finance Committee, introduced a version of the catastrophic legislation in May 1987, which did not include the drug benefit. By September of that year, however, Bentsen agreed to support a prescription

drug amendment, but only if it was phased in, "deficit-neutral with revenues more than sufficient to cover costs." (Himelfarb, 1995.)

President Reagan made the bill the subject of a weekly radio address on July 25, 1987, charging that Bowen's original proposal had been "...converted into a massive program that will impose a new tax on the elderly and soon threaten to bankrupt the Medicare trust fund." (U.S. Government Printing Office, 1987.) Costs were a major concern for critics of the addition of the drug benefit, although estimates varied wildly. HHS estimated the 1989 cost of the House Ways and Means plan at \$6.4 billion, while the U.S. Congressional Budget Office estimated the same plan's cost as "...only \$750 million." (Himelfarb, 1995.)

Attempts by fiscal conservatives to eliminate the prescription drug benefit were blunted, however, by the threat of an even more expensive alternative embodied in legislation proposed by Pepper (D-FL) in 1987 and 1988. The lobbying efforts of AARP was also crucial in the transformation of Reagan and Bowen's original proposal. The influential organization had objected to the financing mechanism of Bowen's original plan (which would have been met by the elderly population alone, rather than being spread throughout the general population) and had vigorously called for the inclusion of a prescription drug benefit.

The result was legislation passed by both Houses of Congress in early June 1988. Senator Bentsen's willingness, during negotiations with the White House, to place cost containment measures in the final version of the bill that mostly affected the actual catastrophic coverage portions of the program, helped administration officials come to terms with it financially. AARP and other advocates of the elderly

accepted these changes as a fair price to pay for the prescription drug benefit under Medicare. Thus, Reagan signed the bill into law on July 1, 1988.

The prescription drug benefit created in the MCCA of 1988 was designed to be phased-in over a number of years. The broadest prescription drug benefit, covering all drugs, was set to begin in 1991. Over-the-counter medications were not included in the program. Patients in 1991 would meet a deductible of \$600 after which Medicare would pay 60 percent of the costs of prescription drugs. The annual deductible was set to rise to \$652 in 1992, but Medicare would also cover more of the after-deductible costs (80 percent), and in the years following Medicare would cover 80 percent of patient drug costs after patients met the catastrophic deductible. This deductible was set to be indexed each year, with the intent that 16.8 percent of beneficiaries would qualify for the prescription drug benefit.

Overall, the MCCA (including its numerous provisions outside the scope of the prescription drug benefit) was a major expansion of the Medicare system. One year later, however, Congress repealed the program. A large and well-coordinated public outcry against the legislation, particularly its funding mechanisms, led to a series of confrontations. Fears about its potential costs had led lawmakers to develop new funding mechanisms for the overall program while phasing-in many of its benefits, especially the drug program, over time. Thus, many elderly Americans foresaw a scenario where they would be forced to pay up-front for benefits they were skeptical they would really receive. In addition, many already received drug benefits from their former employers.

The House of Representatives bowed to constituent pressure and repealed the entire MCCA in October 1989, and

Senate supporters could not keep the program alive. MCCA was officially repealed in November 1989. In both houses of Congress, supporters of the drug benefit tried to offer counterproposals that would have accepted repeal of the overall catastrophic program, but kept some or all of the prescription drug coverage, but their efforts were unavailing.

The 1989 repeal of the catastrophic coverage program, before its prescription drug benefit had even begun its phase-in, began a frustrating period for supporters of a drug benefit under Medicare. At no time during the remainder of the George H.W. Bush administration could advocates successfully press the issue on a wary Congress again. The election of Bill Clinton, in part due to his focus on health care issues, seemed to bode well, but debate over a drug benefit under Medicare was largely subsumed within the larger debate over the failed Clinton health plan in 1993 and 1994. Although shorter in duration, the situation was similar to that of the debates over national health insurance in the 1970s, where a much broader set of proposals meant there was less attention for the specifics of prescription drug coverage under Medicare. The architects of the Clinton health plan did include a prescription drug plan similar to the one under MCCA in their proposals, but it failed when the larger effort failed.

In Clinton's second term, however, public attention to the idea of a prescription drug benefit gained force. The President made regular calls for a drug benefit under Medicare a part of his health care stump speech after it was clear that the wholesale reform he had proposed was not going to occur. "We must find a way through Medicare," he told audiences, "...to provide a prescription drug benefit." (U.S. Government Printing Office, 1999a.) Clinton proposed the following in 1999:

“Medicare will pay for half of all the prescription drug costs, over the next few years, up to a ceiling of \$5,000.” (U.S. Government Printing Office, 1999b.) The Clinton plan would have included a co-pay and monthly premiums (except for people at or just above the poverty rate) with no deductible.

Although Clinton’s plan made no headway in Congress, his emphasis of the issue both reflected and fed rising public support for the addition of a prescription drug plan under Medicare. As a result, the topic of drug coverage under Medicare became one of most important health care issues in the 2000 presidential election, with both candidates pledging to act on the matter if elected. Interest groups, most notably AARP, also pressed the issue. Congress also responded in that crucial election year. The concurrent resolution on the budget in 2000 set aside \$40 billion over the next 5 years to address Medicare prescription drugs. House Republicans offered the Medicare Drug 2000 Act, designed to provide a voluntary prescription drug program which was to be administered by a new agency within HHS, the Medicare Benefits Administration (which would also, under the bill, administer the Medicare+Choice [M+C] program). This bill was favorably reported by the Ways and Means Committee to the House of Representatives, although it did not pass the Senate.

While passage of a prescription drug plan under Medicare was hardly insured—the long and tortuous history of the idea since before Medicare’s passage in 1965 is testament to that fact—the time seemed ripe at last. President George W. Bush made Medicare reform, including the addition of a prescription drug benefit, one of his centerpiece domestic issues, and his administration entered into negotiations with the crucial congressional committees

and interest groups such as AARP. The final result of these lengthy negotiations, the 2003 MMA, was signed into law by President Bush on December 8, 2003. The act reformed Medicare in a number of significant ways, although most of the public discussion of the legislation centered on the prescription drug elements under Title I of the act.

The legislation first provided for a transitional measure, Medicare-endorsed drug discount cards provided by the private sector, available to enrollees in either Parts A or B of Medicare after June 1, 2004. Lower-income seniors (not already receiving drug benefits from the Federal Government or Medicaid) became eligible for up to \$600 for prescription drugs during this phase of the plan. The full prescription drug benefit is legislated to begin on January 1, 2006. Under the full plan, eligible seniors have the option of a Part D Medicare, administered by private companies with CMS oversight. Seniors have the choice of at least one prescription drug plan and one integrated plan in each region. Beneficiaries are responsible for both a premium (about \$35 per month in the program’s first year) and a deductible (\$250 in 2006), with Medicare covering three-quarters of drug costs above the deductible, up to a ceiling of \$2,250. Beneficiaries have to pay the full amount of drug costs above that ceiling, but a catastrophic drug coverage provision is triggered once total out-of-pocket costs reached \$3,600, above which Medicare covers 95 percent of all drug costs. As in the transitional drug discount card phase of the plan, low-income seniors have additional assistance. Other titles of the act transmuted M+C into a new Medicare Advantage Program, provided improvements in rural health care, and amended existing provisions under Parts A and B of Medicare.



In the 2 years since the passage of the MMA, CMS has begun the implementation of the legislation. Full implementation of the prescription drug aspect of the law will not be completed for some time, and the final assessment of its impact on the Medicare population and on the Nation awaits a history yet to be written. Certainly, the prescription drug benefit signed into law in 2003 differed markedly from many earlier iterations of a drug benefit under Medicare. Nevertheless, supporters of prescription drug coverage were entitled to look back with some satisfaction that they had finally managed to make happen what had been stymied so many times, so many ways, in the preceding four decades.

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