
Legislating Medicaid: Considering Medicaid and Its Origins

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Medicaid, passed 40 years ago with Medicare, had roots in the decades-long public assistance programs which preceded it. These roots are still evident today. This article explores the origin and passage of the Medicaid Program in 1965, describes key statutory provisions, and reflects on the resulting strengths and weaknesses of the program today.

INTRODUCTION

Passed 40 years ago, along with Medicare, as Title XIX of the Social Security Amendments of 1965 (Public Law 89-97), Medicaid was a broad program to provide States the opportunity to receive Federal funding for services provided to many groups of categorically eligible needy people. In the intervening years, critics have found many faults with the program design and financing structure and alternative approaches to providing health care to uninsured and vulnerable people have been debated. Political and social consensus to assure broad health care coverage to all citizens has never emerged. All the while, Medicaid has continued to provide a safety net for millions.

A review of the origins and structure can help us understand the strengths and weaknesses of the program today, particu-

larly amid current discussion of Medicaid reform. It is appropriate to consider the origins of this program that now covers more than 54 million Americans, with spending of over \$320 billion in combined State and Federal funds projected in 2005, to better understand both the evolution of the program and add insights to the present debate.

PUBLIC ASSISTANCE HERITAGE

Unlike Medicare, Medicaid had deep and strong roots when it was enacted. The Medical Assistance Program (Title XIX) commonly known as Medicaid had extensive legislative and programmatic heritage in the public welfare system.

The first Federal medical payments for recipients of welfare were authorized in the 1950 public assistance amendments. This law provided Federal matching funds for a limited program of State medical payments to vendors (providers of health care) for people who were receiving cash welfare payments. This medical vendor payment program was followed in 1960 by the enactment of the Kerr-Mills legislation authorizing Medical Assistance to the Aged (MAA), which provided Federal funding to States to cover medical costs for the indigent elderly (Public Law 86-778). This legislation was really the template for Medicaid 5 years later.

Wilbur J. Cohen (then Assistant Secretary for Legislation in the Department of Health, Education and Welfare) (HEW) said that the idea of a Medicaid Program began to develop in his mind in 1942, when Rhode Island attempted to tap public assistance funds for

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NOTE: Throughout this article we refer to Title XIX of the Social Security Act. Additional information on Grants to States for Medical Assistance may be found at: http://www.ssa.gov/OP_Home/SSAct/Title19/1900.htm

vendor payments for medical care. Vendor payments in the 1950 amendments were the first Federal legislative action in this area. In 1954, Cohen worked with Nelson A. Rockefeller (then Undersecretary of HEW in the Eisenhower Administration) to develop a Medicaid type proposal for the needy (Cohen, 1985). Cohen (1985) was able to get a provision included in the Social Security Amendments of 1956 for a separate medical assistance funding match and an averaging formula helpful to State administrators. The Federal-State matching formula was subsequently liberalized in both 1956 and 1958. By 1960, four-fifths of the States had availed themselves of the medical vendor payment option and these vendor payments had grown from an estimated \$81 million to \$514¹ million (Social Security Bulletin, 1950). Although still far from meeting the need, these vendor payments for medical care nourished a growth industry within the States and created an appetite for more.

Cohen was criticized for brokering an alliance of welfare and medical care. Part of this criticism was due to the tie to a system designed to exclude workers and serve only those who were not expected to be in the labor market—people who were aged, blind, or women with dependent children—regardless of whether or not others might also need medical care. At the same time, this exercise in incrementalism² could be described as both ingenious and beneficial. The support provided by the vendor payments was needed and was also an important stimulus to support for legislation. In fact, between 1945 and 1960, few other health care initiatives succeeded.³ The legislative success in the 1950s was one of the keys to the evolution from

vendor payments to Kerr-Mills to modern day Medicaid, and continued a tradition of incremental change.

KERR-MILLS MAA

In 1960, Kerr-Mills introduced a relatively simple, semi-automatic matching formula with no global cap that distributed payments based on the per capita income of each State—a method which was politically acceptable to both rich and poor States. Eventually, this new approach, with its matching formula, would become a powerful base for adaptation and change within the Medicaid Program.

A most important innovation in the Kerr-Mills Act was to extend medical benefits to a new category generally known as the medically indigent—persons age 65 or over, not receiving old age assistance cash payments, but whose incomes would be “...insufficient to meet the costs of necessary medical services ...”. Qualifying people not because of eligibility under a public assistance category, but because they would be reduced to poverty by their medical expenditures was an idea pushed for years by Cohen.

An important negative feature of the law was that Kerr-Mills integrated medical assistance for the poor even more firmly and pervasively with public assistance. With this step, medical assistance was burdened with the social stigma and political disadvantages associated with a welfare program.

As with public assistance generally, the determination of eligibility standards and benefit levels were left, with minimum restrictions, to the States. Also, means and asset testing were administered by local welfare offices. Generally, the poorer the

¹ With 37 States reporting, estimates were difficult because State records were sparse and unreliable, with payments often buried or incorrectly classified.

² This kind of incrementalism was a series of marginal changes in a process designed to create a new capability, but leave the original system much the same.

³ There were a number of National Institute of Health initiatives, but these were primarily research and training, and except for the National Institute of Mental Health programs, not seen as health care coverage.

State, the poorer the welfare program. For the neediest, a likely result was a program that continued to inflict indignities on them while benefiting physicians, hospitals, and local health facilities that could now be paid for what had been unpaid or charitable services⁴ (Stevens and Stevens, 1974).

At the end of the first year of Kerr-Mills, 60 percent of the enrollees and almost 90 percent of the expenditures for the aged medically indigent were in three States: New York, Massachusetts, and California (U.S. Senate Special Committee on Aging, 1962). This distribution changed somewhat toward the end of the program, yet even in 1965, New York, California, and Massachusetts accounted for 45 percent of the recipients and the top five States (New York, Massachusetts, California, Pennsylvania, and Michigan) accounted for 62 percent of the total (Social Security Bulletin, 1965). By 1965, only 40 States had implemented Kerr-Mills, though three others had authorized it. Far from Kerr's estimate of coverage for 10 million people, or the more realistic early estimate of 2 million, Kerr-Mills covered 264,687 people in 1965—less than 2 percent of the elderly (Social Security Bulletin, 1965).

As with the earlier public assistance program, Kerr-Mills left coverage and eligibility almost entirely up to the States, except for specifying that there had to be some reasonable standards, consistent with the objectives of the title. Among the perverse consequences of Kerr-Mills was to bequeath to the future Medicaid Program the traditions of public assistance, welfare medicine, unmet need, and institutional biases, some of which persist to this day.⁵

⁴ Means and assets tests for Older Americans Act (1965) recipients were specifically required by law. According to Stevens and Stevens (1974), the States, without exception, applied means tests for applicants in implementing their programs for the medically indigent under the MAA. Means tests were not just a Federal requirement. States also used them for their own fiscal protection.

ORIGINS OF MEDICAID

One important factor in the passage of both Medicare and Medicaid was that the need and the clamor for health insurance kept increasing. The elderly population was growing, medical costs were rising sharply, and there was a general lack of affordable health insurance and health care options for many. These concerns received increased visibility through national advocacy groups (trade unions, public welfare associations, and advocates for the aged and nursing home reform), and the persistent and effective investigations and studies by the Senate and House Special Committees on the Aging. In addition, local administrators, State welfare commissioners, governors, and congressional delegations concerned about rising costs and increased welfare budgets were eager for relief and complained that Kerr-Mills needed expansion or replacement. Meanwhile, periodic reports on the progress of Kerr-Mills indicated that the program was not only failing to meet its objectives, but was also getting bad press and becoming an embarrassment (Gillette, 1987).

One of Cohen's recommendations was to cover key groups of the poor so that the incentive to expand Medicare would be lessened. According to Cohen (1985) "Medicaid evolved from this problem and discussion."

A succinct statement by Mills (1985) on the creation of Medicare and Medicaid:

"It became increasingly clear to me, however, as I studied the programs and consulted with many interested groups that a Medicare hospital insurance program for the aged alone was not sufficient to meet the many medical needs of the aged, blind, and disabled or the mothers and children receiving aid

⁵ Over one-half of Kerr-Mills funds went for hospitals and nursing homes.

for dependent children. With Wilbur Cohen's help, we developed what eventually became Medicaid (Title XIX) and Medicare. Then, with the support of John W. Byrnes, the ranking minority member on the Committee, we added voluntary coverage of physician's services in what became Part B or supplementary medical insurance (SMI)."

In a later account, Mills spoke less about his own perspective and more of the work of the House Ways and Means Committee as a whole. He emphasized that the three-part package (Medicare Parts A and B, and Medicaid) was not just pieced together, but intended as part of a long-term plan.

Although the origins of Medicaid may remain rather obscure, it is clear that the combination of the dissatisfaction with Kerr-Mills and the persistent interest of Cohen and Mills, played a pivotal role. In House and Senate debates, Medicaid occasioned little controversy. Many welcomed the extension and strengthening of Kerr-Mills. Some said the Medicaid legislation did not go far enough and disliked the vestiges of welfare, such as means and assets tests. There was so little comment that Medicaid did, indeed, seem like a casual add-on. A legislative draftsman said that he could scarcely recall working on Medicaid (Filson, 2002).

Throughout the legislative debate, attention was focused on Medicare, not Medicaid. Almost no one foresaw the potential of Medicaid or would have imagined that it one day would overtake Medicare and become, after Social Security, the country's largest entitlement program⁶ (Stevens and Stevens, 1974).

⁶ Robert J. Myers (1970) HEW actuary, predicted a figure of \$3 billion for Title XIX, a much larger number than had been assumed. Senator Saltonstall (R-MA) warned that, despite the lack of discussion, Title XIX was a sleeper in the bill, and within 5 years could dwarf Medicare. Both were wrong.

TITLE XIX IN 1965

Title XIX did not so much resolve tensions and strongly ground a new program as it ratified an existing situation, set some boundaries and rules, and left it to future partisans to resolve different agendas for the appropriate role of the program.

Much of the Medicaid legislation followed the Kerr-Mills (and public assistance) template with provisions for a single State agency and a State plan with a list of requirements. As with Kerr-Mills, State participation in the Medicaid Program was entirely voluntary, but there were strong incentives for States to join, because Kerr-Mills vendor payments under these titles would cease after December 31, 1969. An even more important inducement was the provision under Title XI, section 1118 that States participating in the Medicaid Program could use the more favorable matching rate under Title XIX for their other categorical assistance programs. As with MAA under Kerr-Mills, there was an open-ended Federal funding authorization balanced by categorical eligibility and means and assets testing. The Federal Government was to match State funds under the Federal medical assistance percentage, determined annually for each State based on a formula that compares a States' average per capita income level with the national average income level.

An important feature of the new act was the collection of provisions intended to equalize and standardize the services offered by creating Federal mandatory and optional benefits. The Medicaid legislation continued the basic State plan requirements of the Social Security Act, such as statewideness, use of a merit personnel system, and the right of recipients to fair hearing provisions, originally intended

largely to counter political spoils and racial discrimination, but promotive also of equalization and accountability in the States.

Beyond these requirements, the Medicaid legislation also had some important all-or-nothing provisions. Participation was still voluntary, but if a State chose to participate, it had to include all the public assistance categories: Aid to the Blind, Aid to Families with Dependent Children, and Aid to the Permanently and Totally Disabled, and make medical assistance available to all individuals receiving assistance under any of the State plans approved for those programs. Also, if a State elected to cover the medically indigent, it had to do so for all categories of aid and under comparable standards. Finally, medical assistance for any one group could not be less in amount, duration, or scope than for any other.

On the face, these provisions appear to be an effort to bring Medicaid eligibility and assistance determinations up to more common and generous standards. In fact, their main thrust was to protect the existing categorically eligible recipients of public assistance—to ensure that the neediest came first, that the income and assets determinations for them were accurate and fair, and to prevent discrimination with respect to the provision of medical care and services. One notable expression of this objective was the requirement that eligibility determination and means and assets testing at the State level be made “...by the State or local agency administering the State plan approved under Title I or Title XVI ...”—in most instances, the State welfare department, on the grounds that this agency would be most experienced. As further insurance, guidelines for reasonable determination would be prescribed by the Secretary.

One effect of these provisions, over time, was to continue the layered complexity of the Medicaid Program as State and

Federal administrators defined additional categorical eligibility groups. State and Federal officials continued to struggle with the meaning and application of statewide-ness, comparability, and amount, duration, and scope requirements. As a result, the laudable purpose of protecting the neediest also tied the Medicaid Program even more tightly to the theory and practice of welfare administration.

Medical indigence, originally introduced by Kerr-Mills and included in Title XIX, received little attention in this legislation or its legislative history. States that provided assistance and/or services for the medically needy still had to qualify individuals through one of the categorical eligibility pathways—for example, the individual had to be aged or blind. All categories of need had to be covered. And the coverage had to be comparable for all those included, regardless of category. This was a significant effort at mainstreaming, and the legislation seems to have been acceptable to those who worried about costs because it was based on a presumption—not unreasonable given the history of Kerr-Mills—that States would be slow and careful about taking up this option, would set eligibility standards and income and assets tests close to those for public assistance recipients, and would, therefore, limit both State and Federal financial outlays.

In any event, subsequent developments revealed some of the perversities of categorical schemes. Poorer States declined or were slow to take up the medically indigent option or raise the income levels for Medicaid eligibility. As a result the poor in the poor States suffered from the low eligibility levels which prevented them from getting coverage and also from the linking of their medical coverage to public assistance levels of income eligibility. This meant that they would lose Medicaid when their income rose above the State’s public

assistance level,⁷ even though they (or their family) continued to need medical assistance.

Under the statute, medical assistance was “...payment of part or all of the cost...” of a list of required and optional care and services. The five required benefits or services were (1) inpatient hospital care, not including care in hospitals for mental illness or tuberculosis; (2) outpatient hospital care; (3) laboratory and X-ray; (4) skilled nursing home services for those over age 21; and (5) physicians’ services. Notably absent from the required list were prescription drugs, dental care and dentures; eyeglasses and prosthetic devices; hearing aids; and physical therapy. These were included under a long list of optional services that States could choose to provide, ending with “...any other medical care [or] remedial care recognized under State law, specified by the Secretary.”

In retrospect, the coverage seems generous although the omission of prescription drugs and prostheses seems harsh. But getting all the States to participate and provide the required services was not obviously an easy task. Moreover, almost any legitimate health care or service was eligible for Federal matching and, with the more generous matching for poor States, provided an opportunity for rich and poor States alike to expand their programs. Time proved, in fact, that the Medicaid Program was much more expandable than anticipated.

Scant attention was given to quality of care. Cost containment also received relatively little attention, at least explicitly—which is surprising given the expansive potential of the program and Mills’ usual concerns

⁷ The so-called notch effect plagued welfare programs and their recipients for many years. For the medically needy there is no notch effect, so long as the recipient spends down to the medically needy income and asset levels.

about fiscal prudence and parsimony. One expectation was that State-defined eligibility requirements and the requirement for State matching would hold costs down.

One of the most remarkable paragraphs in the Medicaid statute appeared at the end of section 1903, Payment to States:

“The Secretary shall not make payments under the preceding provisions of this section to an State unless the State makes a satisfactory showing that it is making efforts in the direction of broadening the scope of the care services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance, with a view toward furnishing by July 1, 1975, comprehensive care and services to substantially all individuals who meet the plans eligibility standards with respect to income and resources, including services to enable such individuals to attain or retain independence or self care.”

Section 1903e illustrates both the promise and the peril of Cohen’s incremental strategy. Events quickly revealed that the time horizon described in section 1903, as well as the enforcement methods were politically unrealistic, and this section was repealed in 1972. Cohen said that he “...included this provision in the law because [he] was acutely aware of the inadequacies of the State medical assistance plans in the 1960’s [and] knew that we had to start from where we were, but my hope was to broaden the program over a 10 year period.” He added that “...there was no opposition to this ambiguous and general provision in 1965” (Cohen, 1985). His original hopes were not realized. Eventually, however, much of his vision with respect to Medicaid has been accomplished. Whether the incremental layering approach was the best way to do so, still remains to be seen.

DEBATE CONTINUES

Medicaid's origins and roots are evident in today's program, even after 40 years of change and a dramatically expanded program in terms of beneficiaries and cost. For example, the entitlement to medical assistance and the open-ended Federal funding structure and matching formula remains. The administrative requirements for State plans, statewideness, comparability, and amount, duration, and scope continue. States still determine eligibility and claim Federal matching funds by placing people into categories, even though there are simplified ways to do this.⁸ The benefit package, comprehensive in 1965, has been little changed and is still considered generous.

Whatever one's view of the statutory roots, Medicaid has survived at least in part because the law has proven to be remarkably adaptable. For example, the ability to add new layers of eligibility and benefit categories has produced creative eligibility expansions for pregnant women, children, low income elderly and disabled people, and some employed people. The program has become the primary public payer for long-term care, with many seniors and disabled people qualifying through Medicaid's medical indigence provisions. Likewise, waiver programs were developed allowing major State reforms, expanded benefits in home and community-based settings and managed care, and eligibility to people not associated with public assistance. Local and State needs have been addressed and clinical advancements have been covered for Medicaid's vulnerable beneficiaries over four decades of massive change in medical care delivery.

⁸ The Personal Responsibility and Work Opportunity Reconciliation Act (Public Law 104-192) de-linked Medicaid and welfare ending automatic enrollment for recipients in Medicaid, but also allowing States more flexibility in covering additional groups of people.

On the one hand, the origins and roots of Medicaid can be seen as a strong platform on which has been built expanded eligibility, benefits, and administrative change. On the other, Medicaid's heritage has clearly shaped a program steeped in public assistance and welfare mentality, seen by most observers as a tremendous weakness. As this review of the program's history indicates, even the authors saw Medicaid as an important, but limited step which left large gaps in coverage. If Medicaid is chosen to be the vehicle for health care coverage of even more working uninsured people in the U.S., who may never have any association with public assistance programs, the program will certainly need to move beyond its public assistance roots.

Medicaid has been there to serve millions when other programs were not. While fundamental reform may be long overdue, the basic principles established 40 years ago have proven difficult to redefine, so the debate about reform continues. A review of the Medicaid statute and its origins will hopefully remind us of not only how far we have moved, but how close we still are to a very old structure mired in the past.

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