

HEALTH POLICY REPORT

Mary Beth Hamel, M.D., M.P.H., *Editor***Medicare at 50 — Origins and Evolution**

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Many Americans have never known a world without Medicare. For 50 years, it has been a reliable guarantor of the health and welfare of older and disabled Americans by paying their medical bills, ensuring their access to needed health care services, and protecting them from potentially crushing health expenses. However, as popular as Medicare has become, Congress created the program only after a long and deeply ideological struggle that still reverberates in continuing debates about its future. Nor was the Medicare program that was signed into law by President Lyndon B. Johnson on July 30, 1965, identical to the program we know today. As we mark the beginning of Medicare's 50th anniversary year, this first report in a two-part series recounts the history of this remarkable health care initiative and explains how it came to be, what it has accomplished, and how it has evolved over the past five decades. In the second report in the series, we will describe the ongoing challenges of the program and discuss proposals to address them.

ORIGINS OF MEDICARE

Medicare was born out of frustration, desperate need, and political opportunity. The intellectual and political architects of the program did not set out to create a health care system for the elderly (defined here as persons 65 years of age or older). Starting in the early 1930s, during President Franklin D. Roosevelt's New Deal, they sought a much grander prize: the enactment of universal national health insurance for all Americans. However, opposition from Republicans, conservative Democrats, and organized medicine frustrated those ambitions. Even after Harry Truman became the first president to unreservedly advocate national health insurance in 1948, his proposal stalled on Capitol Hill. Supporters reluctantly concluded they would have to pursue more modest goals, so they targeted health insurance for elderly Americans.

The logic for this new focus was compelling. The health care situation of retirees was desperate. Bills for health care in this population were roughly triple those of younger Americans, but retirees did not have access to employer-sponsored coverage and they were unattractive to private insurers in the individual health insurance market.¹ In the early 1960s, only about half of Americans who were 65 years of age or older had any health insurance, and many of their policies did not offer meaningful health care coverage.² Politically, the elderly were also an attractive constituency. They showed up at the polls, and even in the mid-20th century, demographic trends showed that their numbers would surge.

These circumstances led to several congressional efforts during the 1950s to pass legislation providing health coverage to retired Americans. As he prepared to run for president, a young Democratic senator named John F. Kennedy became a forceful Senate advocate of what came to be called Medicare. He campaigned on the issue in 1960, and though he lost a Senate Medicare vote by a 52-to-48 margin in 1962, his staff was meeting in Washington, D.C., at the very moment of his 1963 assassination in Dallas to discuss how to revive the legislation.

Medicare thus became part of the Kennedy legacy to which his successor committed himself. Johnson also saw in Medicare a huge political opportunity to mobilize elderly voters for his 1964 presidential campaign. Johnson's landslide victory, which gave him large Democratic congressional majorities, made the passage of Medicare much more likely. However, Johnson took nothing for granted. Using his unequalled legislative skills, he worked tirelessly on the conservative Southern Democrats who chaired the key committees that could have continued to block Medicare. In negotiations with Wilbur Mills (D-AR), the chair of the House Ways and Means Committee, Johnson helped engineer the

broad outlines of the legislative package that ultimately emerged from the committee and passed in both the House and the Senate. This package included hospital coverage under Part A of Medicare, physician coverage under Part B, and a new addition, Medicaid. It was Mills's idea to add coverage for the poor to the Medicare package. A firm opponent of national health insurance, he calculated that by insuring not only the elderly but also the poor, he would deprive advocates of their most compelling remaining argument for comprehensive national health insurance: the need to cover poor Americans against the cost of illness. Mills's political firebreak against expanded health care coverage held until the passage of the Affordable Care Act (ACA) in 2010.

Having lived through the long effort to pass first national health insurance and then Medicare, Johnson understood the latter's link to the former. That was why he signed the Medicare legislation in Harry Truman's hometown of Independence, Missouri, with the former president and national health insurance advocate looking on.

MEDICARE AT ITS BIRTH

Like any legislation, the original Medicare program bore the imprint of its turbulent journey through Congress and the conventions of its time. After years of fruitless struggle, Medicare advocates tried to minimize opposition by designing a comparatively modest insurance package. To limit costs, the program required substantial deductibles, copays, and premium contributions from beneficiaries and did not include coverage for long-term care, prescription-drug benefits, or limits on out-of-pocket costs.

In separating hospital coverage (Part A) from outpatient coverage (Part B), the program also imitated the prevailing structure of private insurance, such as the then-independent Blue Cross and Blue Shield plans, which in the 1960s often sold separate plans for hospital and outpatient care. And Medicare paid providers in the same way that private companies did: by basing physician payments on local usual and customary charges and reimbursing hospitals for their reasonable costs. These and other attributes of the

original Medicare program would become increasingly problematic over time and created an agenda for Medicare reformers over the first 50 years of the program.³⁻⁶

EFFECT OF MEDICARE ON COVERAGE AND CARE

Whatever its original limitations, Medicare has had a major effect on the lives of its beneficiaries. First and foremost, it has improved protection against financial hardship from medical bills, which was a major concern for older Americans and their adult children before enactment. Today, only 2% of the elderly lack health insurance, as compared with 48% in 1962.^{2,7} With reduced financial barriers to care, the use of services by the elderly immediately increased. Between 1963 and 1970, the rate of hospital admissions per 100 elderly Americans rose from 18 to 21 annually, and the proportion of elderly persons who had contact with a physician each year increased from 68% to 76%.⁸ From 1965 to 1975, the rate of cataract procedures among seniors doubled.⁹

Between 1965 and 1984, life expectancy at the age of 65 years increased by 15%.¹⁰ Of course, improvements in clinical care and other factors undoubtedly contributed to these health care gains, but before Medicare, many elderly persons might not have had access to the biomedical advances that were developed during that time.¹¹

One of the indirect positive effects of the implementation of Medicare occurred because the program stopped providing reimbursement to racially segregated health care facilities, in compliance with the Civil Rights Act of 1964. The result was the immediate desegregation of hospitals throughout the United States.¹²

In 2013, Medicare covered 52.3 million Americans, almost one sixth of the U.S. population, at an annual cost of \$583 billion, making it the nation's largest insurer, public or private (though Medicaid will likely soon be larger).¹³ As insurance, Medicare is very popular among its users. Its beneficiaries are less likely to report not being able to get needed care or having burdensome medical bills or a negative insurance experience than are those under the age of 65 years who have employer-sponsored or individual plans (Fig. 1).¹⁴

EVOLUTION OF MEDICARE

Medicare has undergone substantial changes during the past five decades (Table 1). These changes have reflected developments in the health care system in general, as well as a desire to cover additional vulnerable populations and to address limits of the original program. Medicare reforms have often blazed trails for the rest of the health care system in the United States and even in the rest of the world.

COVERING NEW POPULATIONS

Medicare was originally a program exclusively for persons who were 65 years of age or older. That changed in 1972, when Congress extended Medicare eligibility to persons under the age of 65 years who qualified for Social Security disability payments (with a 2-year waiting period) or who had end-stage renal disease. These additions covered two groups of persons who had difficulty finding private insurance and faced very high health care costs. In 2013, a total of 8.8 million of the 52.3 million Medicare beneficiaries were under the age of 65 years and disabled.¹³

EXPANDED BENEFITS

The gaps in the original benefits of Medicare generated efforts to enrich its benefit package. In 1988, President Ronald Reagan successfully sponsored the Medicare Catastrophic Coverage Act, which added prescription-drug coverage and limits on out-of-pocket expenses. In a dramatic reversal, Congress repealed the law in 1989 because of opposition to the increases in Medicare premiums required to finance these new benefits.

In 2003, President George W. Bush strongly advocated Medicare prescription-drug coverage, which passed Congress as part of the Medicare Modernization Act of 2003 (MMA). This new drug coverage (under a new Medicare Part D) reflected the preference of conservatives that private plans have a larger role in providing Medicare benefits. The MMA made a prescription-drug benefit available, on a voluntary basis, only from private plans, with a premium paid directly to the plan. In 2013, a total of 39.1 million Medicare beneficiaries were enrolled in a Medicare prescription-drug plan.¹³ Other beneficiaries have similar prescription-drug coverage from other sources, including Medicaid and re-

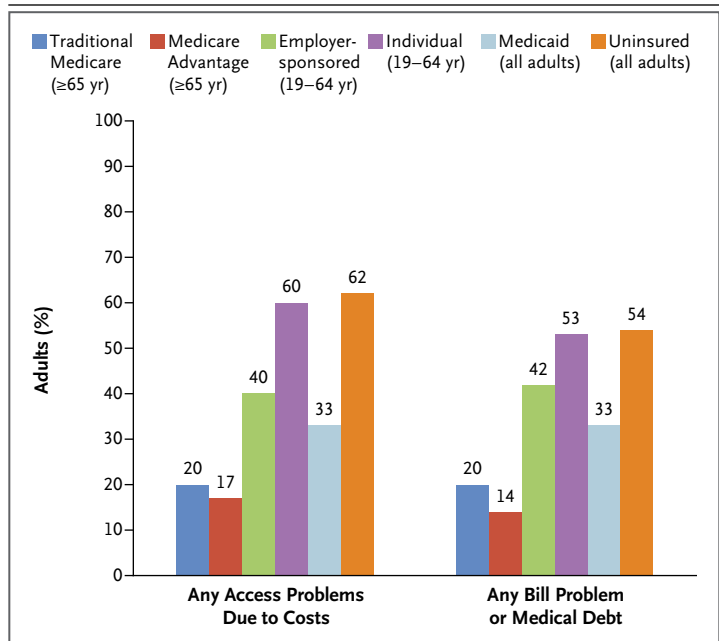


Figure 1. Access to Care and Financial Burden among Adults 19 Years of Age or Older in 2012, According to the Source of Health Insurance Coverage.

The percentage of adults with access problems or bill problems is shown by the height of the bar for each category. Included among the access problems due to costs were filling prescriptions, receiving required specialist care, undergoing recommended tests or follow-up, and arranging a doctor visit for a medical problem. Included among problems with bills or medical debt were not being able to pay bills, being contacted by a collection agency for unpaid medical bills, having to make lifestyle changes because of medical bills, and having to pay off medical debt over time.

tiree health plans, but an estimated 12% continue to lack such coverage.¹⁵

Though the ACA has filled in some remaining gaps in Medicare benefits, the program still has substantial limitations in coverage. To protect against these remaining gaps in coverage, 90% of Medicare beneficiaries have supplemental insurance, either through Medicaid or private Medigap plans.¹³

EFFORTS TO CONTROL COSTS THROUGH PAYMENT REFORM

Spending per Medicare beneficiary increased from \$385 in 1970 to \$12,210 in 2013. Aggregate spending has grown from 0.7% of the gross domestic product (GDP) in 1970 to 3.5% today.¹³ These rapidly escalating costs have motivated many of the most energetic and innovative reforms of the program, starting with changes in provider payment.

Table 1. Legislative Milestones in the Evolution of Medicare Coverage, Payment, and Quality Improvement.

Year	Milestone
1965	The Social Security Amendments of 1965 (Public Law 89-97) created Medicare and Medicaid. Medicare coverage for hospital (Part A) and physician (Part B) services began on July 1, 1966.
1972	The Social Security Amendments of 1972 (Public Law 92-603) extended Medicare eligibility to persons under the age of 65 years with long-term disabilities and those with end-stage renal disease (beginning in 1973) and established the Professional Standards Review Organizations (PSROs) to review appropriateness of care.
1982	The Tax Equity and Fiscal Responsibility Act (Public Law 97-248) added a Medicare hospice benefit for terminally ill beneficiaries, established a risk-contracting program for private plans (beginning in 1985), set limits on Medicare hospital payments per case and required the development of a prospective payment system for inpatient hospital services, and replaced the PSROs with Peer Review Organizations.
1983	The Social Security Amendments of 1983 established a Medicare prospective payment system for inpatient hospital services.
1987	The Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) established quality standards for Medicare- and Medicaid-certified nursing homes.
1988	The Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360) established an outpatient prescription-drug benefit and a cap on beneficiaries' out-of-pocket costs. The major provisions of the law were repealed in 1989.
1989	The Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239) established the Resource-Based Relative Value Scale (RBRVS) for physician services, which was used to set Medicare physician fees beginning in 1992.
1997	The Balanced Budget Act of 1997 (Public Law 105-33) implemented prospective payment systems for hospital outpatient services and post-acute care and established the Medicare+Choice program (Part C), which expanded the types of private plans available to Medicare beneficiaries.
2003	The Medicare Modernization Act (Public Law 108-173) established a prescription-drug benefit (Part D), which was available to all Medicare beneficiaries beginning in 2006, and replaced the Medicare+Choice program with the Medicare Advantage program, making additional types of private plans available to beneficiaries and substantially increasing payments.
2010	The Affordable Care Act (Public Law 111-148) strengthened Medicare coverage of preventive care, reduced beneficiary liability for prescription-drug costs, instituted reforms of many payment and delivery systems, and created the Center for Medicare and Medicaid Innovation.

Medicare's original payment methods lacked any incentive to control costs. The more physicians charged and hospitals spent, the more they got paid. As early as 1967, Congress authorized demonstration projects to test alternatives to retrospective cost reimbursement of hospitals. These experiments ultimately led in 1983 to the well-known Medicare Prospective Payment System (PPS), which pays hospitals on the basis of diagnosis-related groups (DRGs). The PPS changed Medicare payment from retrospective cost reimbursement to prospective payment and established the hospital stay as the unit of payment. The use of DRGs subsequently spread not only to many private payers in the United States but also to many other countries.^{16,17}

In 1989, Congress reformed the system of physician payment, replacing reimbursement of reasonable and customary charges with a physician fee schedule derived from a resource-based

relative-value scale (RBRVS), which was designed to reflect the resources required to perform each of thousands of individual services. The RBRVS was intended in part to correct a perceived overcompensation of procedures with respect to cognitive services, but the implementation of the program has been criticized as continuing to favor specialties over primary care.¹⁸ Nonetheless, the RBRVS has been used widely by other payers, either directly to determine physician fees or as a benchmark in negotiating payments.¹⁹

A particularly controversial aspect of the Medicare system for paying physicians is the use of the sustainable-growth-rate (SGR) formula. Concerned about the potential for increased volume and intensity of services to push spending higher when physician fees were limited, Congress enacted a mechanism to reduce fees if Medicare spending on physicians' services ex-

ceeds an aggregate target. The SGR formula has mandated reductions in physician fees every year since 2002, but Congress has consistently deferred reductions in physician payments owing to worries about beneficiaries' access to care.²⁰ There is now bipartisan agreement that the SGR system ought to be repealed, but Congress has yet to agree on how to pay for the projected costs of doing so.

CHOICE, COMPETITION, AND PRIVATE PLANS

Throughout the history of Medicare, some observers have held that private plans are inherently more efficient than government programs and that government-sponsored coverage for Medicare beneficiaries should be provided through private insurers. Competition among such plans, they argue, will increase the choice for beneficiaries and control costs as plans vie for business. It is also argued that private plans that emphasize managed care, such as health maintenance organizations (HMOs), can better address beneficiaries' needs for care coordination than can traditional Medicare, which is based on fee-for-service payments.

The validity of these arguments continues to be debated, but they have substantially influenced the structure of Medicare. In 1982, Congress established a Medicare risk-contracting program that increased beneficiaries' access to private HMOs.²¹ Enrollment started slowly but grew rapidly in the early and mid-1990s as managed care became more prevalent in the private sector as well. In 1997, Congress expanded the private-plan option by creating Medicare Part C and making additional types of plans eligible to serve Medicare beneficiaries. However, less generous payment rates led to the withdrawal of many private plans and a drop in Part C enrollment. In 2003, the Congress increased payments to private plans and further expanded the types of plans that are eligible to serve Medicare beneficiaries. Payments to these plans under what is now called Medicare Advantage were set higher than the costs of covering the same beneficiaries under traditional Medicare.²² Medicare Advantage enrollment subsequently grew rapidly, and despite payment restrictions introduced in 2010 by the ACA, reached almost 15 million in 2013.¹³ However, the debate over the ability of private plans to reduce Medicare costs continues.^{23,24}

QUALITY-IMPROVEMENT INITIATIVES

When Medicare was adopted, the quality of health care was not yet widely recognized as an issue in the United States. Over time, however, concern about the quality and appropriateness of care that was provided to Medicare beneficiaries and other Americans has increased. Evidence of geographic variation in use of services by Medicare patients has been one important source of this concern, as have the findings of other studies.²⁵

Medicare has responded to perceived quality deficiencies by requiring that hospitals, nursing homes, home health agencies, and dialysis facilities report data on their processes and outcomes of care. These data are publicly available through the Medicare Compare websites. Physician-reporting requirements were implemented beginning in 2007, and the Meaningful Use program enacted in 2009 uses Medicare and Medicaid incentive payments and penalties to encourage the electronic reporting of quality data with the use of electronic health records.

Medicare has also attempted to address flaws in the current payment system, which rewards the volume and intensity of services provided but not their quality, appropriateness, or value. It has developed models for rewarding quality of care by hospitals and physicians, as well as nursing homes and home health agencies, and has begun to implement value-based purchasing models for all these providers. Initiatives to improve provider performance, such as the Hospital Quality Incentive Demonstration and the Physician Group Practice Demonstration, provided the basis for developing broader value-based purchasing approaches and laid the groundwork for a number of the reform initiatives, including the Accountable Care Organization (ACO) model and other reforms authorized by the ACA.

DEALING WITH AN AGING, SICKER POPULATION

Medicare was conceived and designed in 1965 to meet the acute care needs of elderly Americans. However, as the number of very elderly Medicare beneficiaries has grown, so has the complexity and extent of their health care problems. Two thirds of beneficiaries have multiple chronic conditions, and almost 40% have four or more conditions.²⁶ Medicare has attempted to adapt to the changing needs of its beneficiaries by conducting a series of demonstrations aimed at improving coordination of care, such as the Medi-

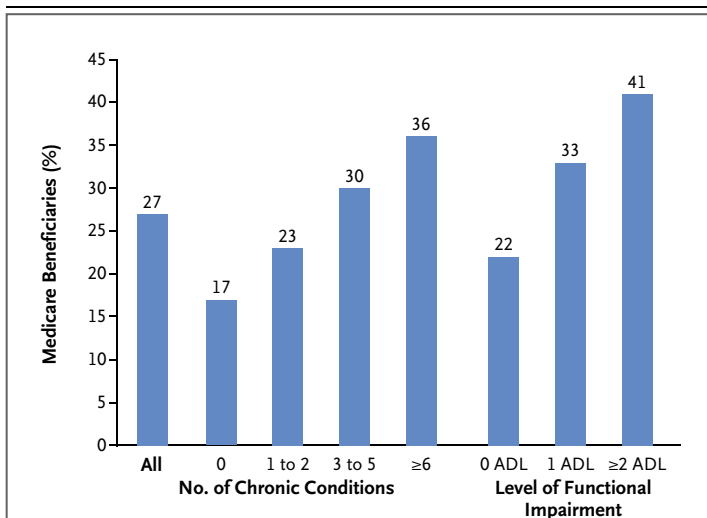


Figure 2. Proportion of Medicare Beneficiaries with Out-of-Pocket Spending for Health Care Totaling at Least 20% of Their Income in 2010.

Data are from the Medicare Current Beneficiary Survey, 2010. Scores on the Activities of Daily Living (ADL) scale range from 0 to 6, with higher scores indicating a greater number of impediments.

care Care Management Demonstration for High Cost Beneficiaries.

However, the separation of Medicare into four different parts (A through D), each with its own rules, is a continuing obstacle to effective coordination of services. A further challenge has been the increasing role of Medicaid as the funder of long-term care and other services for impoverished older Americans. Coordinating the 56 quasi-independent state and territorial Medicaid programs with Medicare has added another layer of complexity to the goal of providing seamless care to Medicare beneficiaries.

THE ACA AND MEDICARE

The ACA included important reforms in the Medicare program that built on previous changes and addressed some of the continuing challenges. With respect to Medicare benefits, the ACA covered all effective preventive services without cost sharing with patients. It also made Medicare prescription-drug coverage more affordable by gradually closing the gap in Part D coverage, known as the “doughnut hole,” which required covered beneficiaries to pay for drugs out of their own pockets after they reached a certain spending level and before a catastrophic

drug-coverage threshold was met. Since 2010, the prescription-drug provisions of the ACA have saved 8.2 million Medicare patients more than \$11.5 billion.²⁷

The ACA also expanded on past reforms in Medicare payment of providers in a number of important ways. In the Medicare Shared Savings Program (MSSP), the ACA has made it possible for providers who form ACOs within the traditional Medicare program to share responsibility for the quality and cost of care provided to the beneficiaries they treat. Other ACA payment provisions created incentives to reduce hospital readmissions and hospital-acquired conditions (e.g., infections) and expanded pay-for-value programs. The ACA also used a quality-rating system for Medicare Advantage plans to provide higher payments to plans earning higher ratings.

Perhaps the most important Medicare-reform initiative of the ACA was the creation of the Center for Medicare and Medicaid Innovation, which received \$10 billion to develop, assess, and disseminate innovations that improve the two programs. Congress granted authority to the secretary of Health and Human Services (without prior congressional approval) to adopt program-wide any innovation that is certified by the Offices of the Actuary and Administrator of the Centers for Medicare and Medicaid Services as reducing costs without reducing quality or increasing quality without increasing costs.

FUTURE CHALLENGES

Medicare is a much larger, more comprehensive, and more complex program than it was in 1965. In its response to cost and quality concerns, it has also become much more assertive in trying to improve the performance of the national health care system. For much of its history, Medicare just paid bills. Now, it has joined private-sector insurers in the effort to manage care as well.

Despite these changes, however, Medicare continues to face major challenges, which will be discussed in more detail in part two of this series. Perhaps the most important of these challenges is its cost. Growth in Medicare spending per beneficiary has slowed sharply in recent years, and although that slowdown is projected to continue over the next few years, the growth in total program spending is projected to outpace

that in the overall economy as the retiring baby-boom generation increases the number of beneficiaries.¹³ This will put more pressure not only on Medicare finances but also on the federal budget, with Medicare spending projected to rise as a share of federal revenues from 17% in 2014 to 27% in 2050 and to approach 40% by the end of the century.²⁸

The current structure of Medicare is anachronistic and unnecessarily complex. Most employers offer their employees a comprehensive benefit package that includes hospital care, physician services, and prescription drugs. Medicare, in contrast, offers its beneficiaries fragmented coverage, with separate parts for each of these services. As a result of its substantial deductibles and the lack of a ceiling on out-of-pocket costs, most beneficiaries purchase supplemental private insurance to cover gaps in Medicare. Low-income beneficiaries, unable to afford care provided through substantial cost sharing in Medicare, can enroll in Medicaid to obtain help in paying Medicare premiums and out-of-pocket costs, but each state has its own income and asset rules. As a result, the complexity of the current insurance system for the elderly becomes truly startling. This complexity frustrates efforts to coordinate care for the sickest and frailest patients and to create an understandable and consistent set of incentives for providers.

Despite the importance of Medicare in improving its beneficiaries' access to care, the program does have substantial limitations in coverage. These limitations result in large out-of-pocket payments for the most vulnerable beneficiaries (Fig. 2). Although Medicare covers some rehabilitation services and limited home care, it does not pay for extended long-term services and supports, a gap that surprises many elderly persons and their families when they need such care. Medicaid does cover these benefits but only for the poorest elderly. The role of Medicare in addressing growing societal needs for long-term services remains uncertain.

These and other issues suggest that preserving and strengthening Medicare over the next 50 years will continue to require active, wise, and humane policy development. Such a task would be a challenge for the federal government under any circumstances but particularly if the current intense partisan divisions persist. In part two of this series, we will describe some of the

reform options that national leaders may consider as they address the future of Medicare.

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