Health Insurance Reform from Pre-1965 to Post-2010

by Neal E. Cutler, PhD

Abstract: The more things change, the old saying goes, the more they stay the same. Reflecting on the historic Medicare conflict and compromise of 1965 in the context of the recent acrimonious health reform debate, we can see several parallels in the financial and social politics of these events. These include, for example, the role of Congressional committees, the political use of labels and slogans, the importance of House versus Senate rules, and of course the significance of the larger historical context of politics and ideology—and even the parallel salience of tea and coffee!

The 1950s

The 1950s saw substantial presidential and Congressional interest in health insurance for older people. There was conflict among several social, political, ideological, and professional interests, but the primary battles took place in Congressional committees. Like the health reform politics of 2009-2010, the Congressional politics of what eventually came to be Medicare were inextricably intertwined with larger historical and political issues. In his now classic *The Politics of Medicare*, Theodore Marmor notes that most interest groups took the same ideological positions in the Eisenhower years as they had taken during the Truman years. Health insurance engendered a classic "liberal" versus "conservative" battle: government versus private health insurance, state versus federal government, "free enterprise" versus "socialism." These ideological differences were central not only for Medicare but also for federal aid to education, Worker's Compensation, disability benefits, and civil rights.  

As Larry DeWitt, an official U.S. Social Security Administration historian, notes, "Starting in 1945, shortly after assuming the Presidency, Truman began advocating national health insurance for all Americans." All his proposals for universal health insurance "went nowhere" in Congress, such that "by the close of the Truman Administration officials at the Social Security Administration had developed a scaled-down proposal to cover only persons receiving Social Security retirement benefits—those aged 65 or older. This would become the key idea behind Medicare."  

The giants of the interest group battles were the American Medical Association and organized labor, the AFL-CIO. The AMA opposed proposals more on the global grounds of its opposition to "socialized medicine" than on the particulars of the various Medicare proposals. Ironically, as the story unfolds, relatively late in the Congressional process the AMA proposed its own version of government-organized health insurance, which circuitously found its way into the 1965 Medicare legislation, although not in the way the AMA wanted.

Historian DeWitt suggests that the AMA's campaign against the Truman pre-Medicare proposals marked the beginning of its role as a political lobby. It is apparent that some of the same political perspectives and negative "labeling" of proposals in the 1950s have been a part of the current health debate. In this early Medicare debate the AMA was battling against "socialized medicine" in a Cold War environment in which Soviet Communism was the large external danger. As long as the "enemy" was
socialized medicine, the AMA and its political allies had a relatively easy target. By the late 1950s, however, those who favored some kind of national health insurance for people of all ages had narrowed their goal.

The new goal became health insurance for older people. And the new message focused on health insurance, not health care. The discussion was no longer about the National Health Service of England in which doctors are the employees of the national government. To quote Marmor, “it was one thing to write off socialism, but the risk of withdrawing the aged would give the wise politician some second thoughts.” The shift from “health care” where the financial risk is to physicians (nominally the good guys) to “health insurance” where the risk is to corporate profit-makers (nominally not the good guys) also changed the dialog. One can only wonder what the health politics of 2009-10 might have been like if the shift to “health insurance” from “health care” had come earlier in what evolved into such an acrimonious debate over, among other things, “socialism.” Indeed, as we reported in these pages last year, analysis of a 2009 national public opinion poll on health care issues documented that “many Americans are fundamentally confident and satisfied about the quality of their own health care.” In dramatic contrast, however, the same public is dissatisfied with the cost of their health insurance and with the cost of care not covered by their health insurance.”

The 1960s

Senator John F. Kennedy made health care for Social Security beneficiaries a major priority of his 1960 presidential election campaign. He described his own Senate legislative proposal as one in which workers would make a contribution to the Social Security fund so that when they retired they would receive financial assistance from the fund to pay for their hospital costs. To accomplish this goal, in 1961 the newly elected president supported the King-Anderson bill, which proposed amendments to the Social Security Act to provide a government-sponsored program with three limiting attributes: (1) it was about health insurance, not government-employed physicians; (2) it was insurance to cover hospital expenses, not to pay for physician services; and (3) it would be only for the elderly.

In her recent textbook Medicare: A Policy Primer, economist Marilyn Moon emphasizes the significance of the hospital-only focus of these early Medicare proposals. In political strategies to win a Congressional majority, the proponents linked the proposed health insurance benefits for retirees to the then-current health insurance benefits received by most workers. Back then, Dr. Moon noted, “Medical care needs and insurance looked very different than they do today. For example, many workers had only hospital coverage, in part because...expenses such as physician services were not inordinately expensive.” Because the costs that would more likely financially devastate a family were catastrophic hospital costs, hospital insurance became the primary focus of the early Medicare proposals. Indeed, in the national battle of the slogans (similar but less venomous than in 2009-10) the Kennedy Administration proposal became known as “Hospicare.”

Still, the AMA campaigned against the legislation and did not compromise its opposition to any kind of “socialized medicine.” The AMA campaign materials relabeled the administration’s proposal as “Fedicare,” maintaining that the issue was one of big government inserting its hands into citizens’ medical treatment. Historian DeWitt notes that as part of its public campaign, the AMA organized thousands of small local meetings in homes, hosted by the wives of AMA physicians. The purpose of these informal “coffees” was to create local letter-writing campaigns to Congressmen, petition drives, and connections with like-minded groups. The AMA’s name for this activity was “Operation Coffee Cup.”

As it turns out, the most potent “enemy” of Medicare/Hospicare/Fedicare wasn’t the AMA but a committee of the U.S. Congress. Because King-Anderson was an amendment to Social Security, which is tax legislation, it had to start in the House Ways and Means Committee which constitutionally has first authority over all tax legislation. Thus, the chairman of House Ways and Means was a very powerful politician. The power of Arkansas Democrat Wilbur Mills derived not only from his Congressional seniority and chairmanship of the committee but also from his experience and expertise in the substance and the politics of tax legislation. Although in 1961 Democrats controlled the Senate, the House, and the presidency (further parallels to nowadays), a majority coalition of conservative (Southern) Democrats and Republicans controlled this crucial Congressional committee. The political context beyond health insurance included Cold War Communism plus intractable Southern opposition to all federal activism, especially in the area of civil
identified a relevant piece of tax legislation (which happened to be Social Security amendments with no health components) that had already gone through the Committee, been voted on by the House, and was on its way to the Senate. Since the rules for amendments in the Senate are less strict than in the House, Senators could simply add a version of King-Anderson as an amendment to that already passed House bill and then vote for the now amended piece of legislation.

The U.S. Constitution requires that for a bill to be signed into law by the president it must have been passed by both the House and the Senate in identical wording. The process for combining inevitable variants of House- and Senate-passed versions of a bill is an ad hoc committee created anew for each piece of legislation—called simply the Conference Committee. Although not mentioned in the Constitution, political scientists often refer to it as the "third house of Congress."

Each newly created Conference Committee includes Senate and House members of both parties, in rough proportion to their numbers in each chamber. These Senate and House conferees are typically the policy specialists for the particular subject and legislation. Within elaborate rules the conferees craft a compromise, and the new text is sent back to each chamber. Anticipating an ideological battle within the Conference Committee, President Johnson, the former Senate master deal-maker, communicated that there were a couple of compromises he could support in order to produce a Medicare bill that a majority of the conferees could agree upon.

Seeing all of this, recognizing that the 1964 elections were about to change the Congressional landscape, and not wanting to lose his influence over this important legislation, Chairman Mills proposed a different kind of compromise. As it turned out, the November election not only gave Johnson a landslide victory over Senator Barry Goldwater, but it brought in 32 new Democrats that gave them a two-to-one majority in the House. Anticipating such an outcome, Mills knew that even though he would retain his chairmanship, the composition of his committee would change. Mills told the president that instead of the "indirect" Senate tax amendment approach relying on the Conference Committee, he would directly support a Medicare bill after the 1964 elections and make it the highest priority in the new Congress.

Mills' anticipations were borne out; the 1964 election produced the biggest Democratic majority in the House since the mid-1930s. Johnson could claim an electoral mandate for Medicare. In the new 89th Congress, membership of the House Ways and Means Committee indeed did move in a more liberal direction. True to his word Mills arranged to have King-Anderson introduced as S. R. 1 (and it was also S. 1 in the Senate).

However, as we see in those late-night cable- TV ads: "But wait, there's more!" Although it appeared that "Hospicare" was about to become law, the AMA reentered the picture. They too saw the emerging inevitability of hospital insurance for the elderly. Since they still opposed large-scale government involvement in health care they decided to switch from opposition to federal health insurance to support for a state-focused approach. Further, to gain support for this new approach to
health insurance the new AMA campaign argued that the Democrats’ hospital-only legislation provided too little help for the elderly. Consequently, they proposed a more generous insurance program that would pay not just for hospital care but also for doctors, prescriptions, lab fees, and additional medical services. To limit the cost and scope of these expanded benefits the insurance would be for poor elderly only; the AMA labeled this proposal “Eldercare” to emphasize it was not national health insurance for everyone.

But wait, again there’s still more. Another proposal that turned out to influence the ultimate shape and scope of Medicare was placed on the table. Senior Republicans on the House Ways and Means Committee did not want Republicans to be left out of the political rewards of the now inevitable Medicare legislation, but they did not want to endorse the AMA’s state-administered Eldercare proposal limited to poor elderly. A different approach was selected: adding coverage of physician and related medical services as optional and voluntary insurance as an addition to the hospital insurance that was the original purpose of the Democrats’ Medicare proposals. Thus, hospital insurance would be the core insurance paid for by payroll taxes, but the optional physician and medical services insurance would be paid for by separately billed premiums. This additional Republican proposal was dubbed “Bettercare.”

Compromise and Consensus

And so in 1965 there were three major proposals: (1) Medicare, the Democratic bill, fundamentally Hospicare insurance for all elderly covered by Social Security and administered nationally; (2) Eldercare, the AMA’s state-administered insurance program only for poor elderly, but which would expand hospital coverage to include physician and medical services; and (3) the Republican Bettercare proposal, which added Eldercare’s physician and medical services coverage to Medicare’s hospital coverage as voluntary, optional insurance whose premiums would be paid by the consumer, not through payroll taxes.

Just as Lyndon Johnson is seen as the most effective senator in U.S. history, Wilbur Mills has been described as one of the most knowledgeable House members in the area of both tax policy and tax policy politics. To build a new consensus for H.R. 1 and S. 1, Mills crafted a dramatic compromise by combining the pieces of these major proposals into a single bill. After a few days of discussion and assurances that this was not a legislative trick, the Johnson Administration graciously acknowledged AMA claims that the Democratic (Hospicare) bill was not strong enough, and supported adding the Republicans’ Bettercare provisions for optional physician insurance to a nationally administered program of health insurance for all Social Security beneficiaries. Hence, Part B (the AMA’s proposal for physician coverage) was added to Part A (the original King-Anderson hospital coverage) to create Section 18 of the Social Security Act: Medicare.

Lyndon Johnson signed Medicare into law on July 30, 1965, with Harry Truman at his side at the Truman Presidential Library in Independence, Missouri. At the end of his prepared remarks Johnson then signed the application papers making Truman the first Medicare beneficiary, saying “We wanted you to know, and we wanted the world to know who is the real daddy of Medicare.”

And what of the AMA proposal for a state-administered insurance program for poor elderly? Congress simultaneously passed Section 19 of the Social Security Act as a joint federal-state insurance program for the poor, providing both physician and hospital payments, not just for the elderly but for all medically poor persons: Medicaid.

Postscript

As it turns out, the use of labels as political weapons in the pre-1965 and 2009-10 health insurance debates (e.g., Hospicare, Fedicare, Bettercare, Obamacare, socialized medicine) is not unique in American history. When drafting this column I recalled a public radio program from a few weeks earlier. The online transcript of American Public Media’s “Market Place” documented an intriguing 1912 connection to the 2010 health politics debate, drawing from Princeton Professor Paul Starr’s 1983 Pulitzer Prize-winning book, The Social Transformation of American Medicine. Building on Teddy Roosevelt’s campaign platform in his failed run for the presidency in 1912 as the candidate of the Progressive Party, several economists, physicians, and politicians drafted proposals for compulsory health insurance, something most European countries already had but the United States did not. Among other innovations, the Progressives’ 1916 proposal would pay doctors a lump sum for each patient rather than payment for separate services—a 1916 HMO? The proposal was opposed by big business, labor unions, and the
AMA, whose strategy used a patriotic theme. Since the United States was about to go to war with Germany, and since Germany was the first country to enact universal health care, the opponents attacked the health insurance proposals as a German plot to undermine the American government. “Germans,” “Prussians,” and “Europeans” were doing the work of the Emperor of Germany. The Markes: Place program ended by noting that in the 1920s health reformers were called socialists, and in Truman’s era they were called Bolsheviks and Communists.

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(7) DeWitt, “The Medicare Program as a Capstone to the Great Society.”

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Choosing the Best Retirement Plan for Supplemental Earnings
Kann Beam Tacchino, JD, LLM
This column addresses the retirement needs of individuals who have income from part-time self-employment (Schedule C income) in addition to wage income (W-2 income) from a regular job. The author first espouses a need for supplemental retirement savings from supplemental earnings in order to effectively and adequately fund retirement. The column then proceeds to address the most suitable type of plan to use.

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Economic Substance “Codified” in Health Care Reform Bill
Thomas F. Committo, JD, LLM, CLU, ChFC, AEP
IRC 7701(o)(1) provides that the economic substance doctrine must adhere to a “two-pronged” or “conjoint” test. In other words, there must be an inquiry regarding the objective effects of the transaction on the taxpayer’s economic position as well as an inquiry regarding the taxpayer’s subjective motives for engaging in the transaction.

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Business Cycles and Investment Strategy
Somnath Basu, PhD
Considering the investment implications the current macroeconomic environment imposes on security markets is an interesting and attractive proposition. No matter in which direction the economy moves, if we can attain even some insight about the economy’s future direction, we can position ourselves (our client portfolios) in the financial and real asset markets in such a way as to create value and benefit from the expected changes.

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Enhance Your Estate Planning: Diversification, GRATs, and Putting in One Egg per Basket!
Mark R. Pathamer, Esq
We find out how one can structure and manage GRATs to allow for a successful wealth transfer without the need for skyrocketing growth, thus enabling more mundane assets, such as publicly traded stocks, to be effective GRAT assets. The secret? Isolating assets within GRATs to expose their raw volatility and then capturing that volatility through the power of substitution.

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Things You Can and Can’t Do with Loan Regime Split-Dollar Plans
Richard D. Landsberg, JD, LLM, CLU, ChFC, RFC, AIF
Below-market loan treatment for loan regime split-dollar arrangements may be more advantageous than reporting income based on current life insurance protection (as was the taxation of the old collateral assignment technique). Financial projections must still be performed to determine how a loan regime split-dollar plan will advance the goals of the employer and the executive.

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Long-Term Care Financing through the CLASS Act
John M. Comman
Caryl E. Carpenter, PhD
The Community Living Assistance Services and Supports Program (CLASS), a section of the recently enacted federal health reform legislation, establishes a long-term care insurance program funded by voluntary participant premiums, which can be deducted from a worker’s paycheck. CLASS brings up the daunting complexities of making quality long-term care affordable to middle-income families and retirees. To understand why, the column first describes briefly those complexities and then what CLASS will and will not do. The column concludes with some modest suggestions for how to address the challenge of providing affordable, quality long-term care.

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Mechanics in the Business Market
Tom Virkler, JD, CLU
This article identifies the simple issues that underlie every businessperson’s life insurance planning concerns, suggests a method of approaching business prospects, and then discusses a simple business planning device that can serve as a foundation for further dialogue that could end in a sale and a new client.

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Roth Conversion Strategies for Beneficiaries
April Caudill, JD, CLU, ChFC, AEP
The combination of a Roth conversion and a long-term "stretch" strategy is a powerful estate planning tool and may be more appealing to a client than a lifetime Roth conversion. Advisors who recognize the planning issues and pitfalls can help their clients make a real difference with their retirement assets. Life insurance can help facilitate these strategies.

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Game Changer
Richard M. Weber, MBA, CLU, AEP
Consider that IPad ushers in a new era of portable entertainment and Internet access to accompany the rapidly expanding availability of media and social networking resources. As “apps” and Web sites focus on iPad, you will discover the extent to which this walk-around gadget becomes your game-changing media and business device of the present and future.