PHOTOCOPY PRESERVATION

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tenure of office, and compensation of personnel." The reason given by a leading member of the committee, Fred M. Vinson of Kentucky, who later became Chief Justice of the United States Supreme Court, was colorfully expressed as follows: "No damned social workers are going to come into my State to tell our people whom they shall hire."

The other change was to create a new and independent federal administrative agency to be known as the Social Security Board to administer old age insurance, unemployment insurance, old age assistance, and aid to dependent children. The Cabinet committee had recommended that a Social Insurance Board within the Department of Labor should administer old age insurance and unemployment insurance, but that the Federal Emergency Relief Administration should administer old age assistance and aid to dependent children. There was no disagreement between the Cabinet committee and the congressional committee that the Children's Bureau should administer the maternal and child health and welfare programs and the U.S. Public Health Service administer the public health program.

There was much to be said for the congressional committee's decision to make a single, permanent federal agency responsible for the administration of both the social insurance and public assistance programs included in the Social Security Act. The reason the Cabinet committee had separated the two was that it believed the social insurances were a phase of labor legislation which should be administered by the Department of Labor. The Cabinet committee felt that public assistance should be related to the work relief programs administered by the Federal Emergency Relief Administration, which, it expected, would eventually be succeeded by a permanent federal agency.

The congressional committee, in making the change, did so for a variety of reasons. It probably was impressed with the close relationship between social insurance and public assistance and also disliked placing the administration of a permanent program in the hands of an emergency agency. However, it must be recorded that influential members of both houses of Congress disliked the Department of Labor, because they considered it pro-labor, and also the Secretary of Labor. It is my opinion that the personal dislike of the Secretary of Labor was due largely to the

fact that she was a woman and an articulate, intelligent woman at that, as well as to the fact that she was not sufficiently amenable to patronage needs.

The executive sessions of the Ways and Means Committee ended on April 5, at which time the committee took a vote on recommending the passage of the bill as amended. All of the Democratic members, except one, voted for the bill, and all of the Republican members voted against it. The Republican members filed a minority report in which they stated they were opposed to the old age insurance provisions of the bill. The reasons they gave, in addition to contending these provisions were unconstitutional, were as follows:

> These titles impose a crushing burden upon industry and upon labor.
>
> They establish a bureaucracy in the field of insurance in competition with private business.
>
> They destroy old-age retirement systems set up by private industries, which in most instances provide more liberal benefits than are contemplated under title II.

In addition to these reasons, at least one of the influential minority members was inclined to favor the Townsend plan. It seemed incongruous at the time that a conservative should consider a universal pension plan paying a large, flat amount, irrespective of need, to be less of a threat to our existing institutions than a contributory social insurance system paying benefits related to wage loss.

The bill, as amended, was called the social security bill and was reported to the House on April 5. The debate in the House of Representatives lasted from April 11 to April 19. About fifty amendments were offered, none of which was adopted. The one which received the largest vote would have provided for federal grants to the states to cover the entire cost of $50 a month old age assistance grants without requiring any matching by the states. Amendments to substitute the Townsend plan or the Lundeen bill received about fifty votes each.

Some of the language used by leading Republican members in the debate was rather purple. Thus, in the debate on April 19, 1935, Congressman John Taber of New York said, "Never in the history of the world has any measure been brought here so

insidiously designed as to prevent business recovery, to enslave workers and to prevent any possibility of the employers providing work for the people.

Congressman Daniel Reed, also of New York and a member of the Ways and Means Committee, predicted, "The lash of the dictator will be felt and 25 million free American citizens will for the first time submit themselves to a fingerprint test."

Congressman James W. Wadsworth, likewise of New York, alleged that, "This bill opens the door and invites the entrance into the political field of a power so vast, so powerful as to threaten the integrity of our institutions and to pull the pillars of the temple down upon the heads of our descendants."

The decisive motion to recommit the bill with instructions to eliminate the old age insurance provisions was made by Congressman Treadway, ranking Republican member of the Ways and Means Committee. This motion lost, although all the Republican members of the House who voted, except one, supported it. The final vote was 371 to 33 in favor of the bill. This large vote for the bill in the exact form recommended by the Ways and Means Committee was due in considerable part to the fact that this committee is undoubtedly the most powerful committee of the House. It not only has jurisdiction over all tax bills but is also the committee on committees which recommends to the House who shall serve as members of other committees.

While, as previously stated, the public hearings began simultaneously before the committees in the House and Senate, those before the Senate proceeded at a more leisurely pace. This was because of the custom in the Senate of holding committee hearings only in the morning, before the Senate convened.

There was a wide range in the general attitudes of the Senate committee members. At one extreme, concern was expressed that the proposed program substituted social security for the struggle for existence and took the private property of one individual to give it to another who, the government determined, needed it more. This point of view was expressed by blind Senator Gore of Oklahoma, who finally asked Miss Perkins this question (which does not appear in the printed hearings): "Now, Miss Perkins, wouldn't you agree that there is a teeny-weeny bit of socialism in your program?"

At the other extreme was the view of Senator Black (now Justice Black) that a considerable part of the cost of unemployment insurance and old age insurance should be met out of progressive taxes. He was of the opinion that sole reliance on payroll taxes resulted in persons with low incomes being obliged to pay, both as workers and as consumers, too heavy a share of the cost.

In the hearings before the Senate Finance Committee, as in the hearings before the Ways and Means Committee, it was necessary for Dr. Witte to testify ahead of Miss Perkins, because she had not yet completed her testimony before the Ways and Means Committee. Dr. Witte testified at length, both before and after Miss Perkins appeared. However, he did not have the opportunity that he had had in the House committee hearings of making a complete statement before questioning began.

Most of the questioning had to do with old age security, particularly old age assistance. Senator Byrd of Virginia focused his questioning on the requirement to be met by states, in order to receive federal grants for old age assistance, that a state plan must furnish assistance at least great enough to provide, when added to the income of the aged recipient, "a reasonable subsistence compatible with decency and health."

Dr. Witte pointed out that this provision was taken from the Massachusetts and New York laws and constituted a flexible standard related to varying circumstances throughout the country. However, Senator Byrd forced Dr. Witte to admit that in the final analysis this requirement meant that a federal official had the right to determine what constituted reasonable subsistence compatible with decency and health. The result was that the committee eliminated this clause from the bill.

The Senate Finance Committee completed its public hearings on February 20 but did not begin to hold executive sessions until the first week in May. At that time it proceeded to consider the social security bill as passed by the House, not the economic security bill as introduced by Senator Wagner. This was in accordance with its usual legislative procedure.

On May 6, a few days after the Senate Finance Committee began its executive sessions, the United States Supreme Court held the Railroad Retirement Act unconstitutional. This added to

carefully all his recommendations for appointment of personnel. This untenable situation was partially resolved in 1937 by the appointment of a new Director, who relied almost entirely upon the Assistant Executive Director of the Board to administer the bureau. However, it was not until July 1, 1938, that the Assistant Executive Director was actually appointed Director of the bureau (the name of which had been changed to Bureau of Old Age Insurance in September 1937).

It was due to the unusual ability of this man that the administration of this tremendous social insurance system was finally established on such a successful basis.

But in July 1936, the situation was so desperate that, with the approval of the President, I asked the Postmaster General to assume the responsibility of assigning social security numbers to employees and employers. He agreed to do so, and in a few weeks plans were completed for carrying out this gigantic task through the 45,000 post offices, beginning November 16, 1936. I had urged that the assignment of account numbers should not begin until then in order to avoid becoming involved in the presidential campaign of that year. Another member of the board, Mr. Miles, had urged it to begin in October, and Chairman Winant had been undecided.

It was fortunate that the later date was selected because on September 27, 1936, like a bolt from the blue, the Republican candidate in a speech at Milwaukee denounced the old age insurance system. He said, "And to call it 'social security' is a fraud on the working-man. The saving it forces on our workers is a cruel hoax." The Republican member of the board, John G. Winant, a former Republican Governor of New Hampshire and later our wartime Ambassador to Great Britain, immediately resigned in protest, and the President appointed me Acting Chairman. In his letter of resignation Mr. Winant said, "Governor Landon has made the problem of social security a major issue in this campaign and I cannot support him. I do not feel that members of independent Commissions or Boards, such as the Social Security Board, should take an active part in politics and moreover, I was appointed and confirmed as the minority member. While I retain this position, I am not free to defend the Act."

A week before the election the Industrial Division of the Republican National Committee flooded employers with millions of pamphlets, posters, and pay envelope inserts attacking the old age insurance system. The pay envelope inserts were headed, "Notice—Deductions from Pay Start Jan. 1," and at the bottom were the following words in large black letters: "Social Security Board, Washington, D.C." This gave the appearance of an official notice. There was no mention of the benefits payable.

The Hearst press ran front-page stories the day before the election attacking the old age insurance system. They were illustrated by a picture of a man stripped to the waist, wearing a chain with a dog-tag. It was captioned "Snooping-Tagging" and carried this explanatory statement beneath: "Each worker would be required to have one for the privilege of suffering a pay cut under the Social Security Act, which is branded as a 'cruel hoax.'" Curiously enough, this newspaper story apparently was based upon a proposal made by the Addressograph Corporation to furnish nameplates, which I had rejected, although its acceptance had been recommended by the planning officials of the Board. As a souvenir of this episode, I still carry with me the sample nameplate that was submitted.

Fortunately, the Social Security Board had prepared an explanatory leaflet for use in connection with the assignment of social security numbers. There were 50 million of these stored at various places throughout the country. Immediately upon learning of the distribution of the misleading and deceptive pay envelope inserts, it distributed the entire 50 million to workers at factory gates throughout the country, largely through the cooperation of labor unions. It also released explanatory movie films for use in theaters. One copy of this film was run continuously on Times Square the last day of the presidential campaign.

The Board had feared that the political attack might hamper the assignment of social security numbers. The Board also feared that many employers would refuse to cooperate because the constitutionality of the law had not yet been decided. However, this did not happen. A large proportion of the initial distribution of 26,000,000 application forms was returned during the ensuing three weeks, and by June 30, 1937, when the Social Security Board took over the task, 30,296,471 applications for social secu-

WHERE HEALTH CARE REFORM STANDS IN CONGRESS

Legislation to reform health care must follow the path below before being enacted by Congress and signed into law by President Clinton. Five committees with jurisdiction over different health issues are developing recommendations for broad health plans.

■ On March 23, a bill largely similar to Clinton's proposal—requiring employers to pay 80 percent of their workers' insurance premiums—moved out of the **House Ways and Means health subcommittee** on a 6 to 5 vote. A modified version of that bill is now before the full committee.

■ On May 25, a similar bill was approved 17 to 10 by a **House Education and Labor subcommittee.** This legislation would allow discounts for very small firms and is awaiting action by the full **Education and Labor Committee.**

■ **The House Energy and Commerce health subcommittee** abandoned efforts to produce a bill and the full committee appears gridlocked.

■ **The Senate Labor and Human Resources Committee** (which does not have a subcommittee that votes directly on health issues) on June 9 approved a bill similar in most respects to Clinton's proposal that would require all employers except for very small businesses to pay about 80 percent of the health insurance premiums for their workers.

■ A similar bill has been proposed by **Senate Finance Committee** Chairman Daniel Patrick Moynihan (D-N.Y.) and will go directly to the full committee for action. It has not been formally considered there yet.

HOUSE

1. Subcommittees did preliminary work.

Health	Health and the Environment	Labor-Management Relations
Approved a bill	*Unable to reach agreement*	*Approved a bill*

SENATE

Senate bill markups don't occur at the subcommittee level.

2. Committees with broad jurisdiction now send recommendations to leaders.

Ways and Means
Rep. Sam Gibbons (D-Fla.), chairman

Working on subcommittee bill

Energy and Commerce
Rep. John D. Dingell (D-Mich.), chairman

No action so far

Education and Labor
Rep. William D. Ford (D-Mich.), chairman

Working on subcommittee bill

Committees with jurisdiction over special subjects may make recommendations to leaders:
- Armed Services
- Judiciary
- Veterans' Affairs
- Government Operations
- Post Office
- Natural Resources

Labor and Human Resources
Sen. Edward M. Kennedy (D-Mass.), chairman

Approved a bill

Finance
Sen. Daniel Patrick Moynihan (D-N.Y.), chairman

About to start work

YOU ARE HERE: The debate over national health care legislation is at this stage in the lengthy process detailed here.

Committees with jurisdiction over special subjects may make recommendations to leaders:
- Armed Services
- Judiciary
- Veterans' Affairs
- Indian Affairs
- Governmental Affairs

3. Leaders meld bills.

House Speaker **Thomas S. Foley** (D-Wash.), left, and Majority Leader **Richard A. Gephardt** (D-Mo.), right, meld bills into one and send to Rules Committee.

Senate Majority Leader **George J. Mitchell** (D-Maine) may blend bills into one before sending to floor.

4. Members debate bills.

House debates bill. Substitutes may be offered.

Senate debates bill. Substitutes may be offered

5. Bill goes to conference.

House/Senate conference committee reconciles differences and sends final version back to each chamber.

6. Each chamber votes.

House votes on a final "conference report" version.

Senate votes on a final "conference report" version.

Congress hopes to pass a bill by the end of this session in October.

7. Bill goes to President Clinton.

—Compiled by Spencer Rich

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count for the 1961 legislative outcome, one must turn from the public debate to the internal character of the Committee on Ways and Means. Only by doing so can one explain why the Medicare bill, initiated by the President and acceptable to a majority of Americans polled on the issue, could be undramatically defeated at the committee stage of the legislative process.

Medicare's Near Miss, 1964

Between the defeat of President Kennedy's initial Medicare proposal in 1961 and the national elections of 1964, none of the major congressional obstacles to its enactment were fully removed. The Democrats maintained control of the Congress after the 1962 elections, but the pro-Administration bloc was, as usual, never as large as the number of Democrats. In 1961, HEW's congressional liaison staff estimated the House Medicare breakdown as approximately twenty-three votes short of a 218 majority. The Ways and Means Committee never gave them the chance to check the accuracy of their estimates, and attempts to circumvent the committee with rider strategies proved abortive in 1962 and 1964. Each year hearings were held on Medicare, and by 1964, thirteen volumes of testimony had been compiled, totalling nearly 14,000 pages. But Wilbur Mills and his committee were not ready to report a Medicare bill.

The Administration's pro-Medicare strategy included continued efforts to change votes on the committee. Two methods were employed. First, HEW officials were directed to respond to the objections of the key Southern Democrats in hopes of bringing them around on the King-Anderson bill. When HEW Assistant Secretary Wilbur Cohen was informed of President Kennedy's assassination on November 22, 1963, he was in the midst of preparing changes in the Administration bill which would answer some of Mills' criticisms. Cohen and his staff spent far more time courting critics than they did working with pro-Medicare members of the committee. The Administration, through the influence of House Democratic leadership over members of the regional caucusses, also took steps

to enlarge the size of the pro-Medicare group. After 1961, no new member of the committee was elected who had failed to assure the House leadership that he would vote for Medicare or, at the very least, would support its being reported out of the Ways and Means Committee. By 1964, these efforts had brought the total of pro-Medicare Democrats to twelve, one short of a committee majority. Three of the anti-Medicare Southern Democrats of 1961, Frazier, Harrison and Ikard had been replaced by fellow Southerners who were willing to support the King-Anderson bill, Richard Fulton, Pat Jennings and Clark Thompson, the latter the most reluctant. All the other Democratic newcomers between 1961 and 1964 were, like their predecessors, firm Administration supporters.

This weakening of the anti-Medicare coalition revealed both the opportunities and risks which the politics of legislative possibility entail for Democratic reformers. Sensing victory within the Senate and realizing the narrow margin enjoyed by Medicare opponents within Ways and Means, President Johnson and congressional leaders thought again of a rider amendment in the Senate. But Ways and Means opponents were equally aware of the changed probabilities and nearly pulled off a clever legislative coup in the early summer of 1964. The senior Republican, John W. Byrnes of Wisconsin, proposed that the 5 percent increase in social security benefits which the committee had approved in earlier deliberations be increased to 6 percent. This would have raised social security taxes to 10 percent, widely accepted within Congress at that time as the upper social insurance tax limit, and thus leave no fiscal room for Medicare in the future. The pro-Medicare committeemen realized the trap, but only 11 of their number were at the roll call vote. The anti Medicare group seemed to have a winning margin, 12–11. But the final vote cast was by Bruce Alger, an arch-conservative Republican from Dallas. Unwilling to play the game, Alger voted with the Democratic majority, explaining later that "since he opposed the entire Social Security system, consistency would not permit him to expand it," even to undermine the chances of Medicare (Harris, 1966, 164).

Having observed their House brethren come close to catastrophe, Senate Democrats acted to attach the Medicare rider to the social security bill which the House had already passed in 1964. But Mills had anticipated that move and, fearing that Ways and Means would lose control over the content of any Medicare bill, had taken steps to thwart it. He promised pro-Medicare Democrats on his committee that Medicare would be the "first order of business" in 1965; in return he received their support in rejecting the rider in the conference committee. With the House and Senate Republican conferees already anxious to stop Medicare, Mills had enough votes to accomplish this task. On October 4, the conference announced its deadlock over the entire social security bill, thus postponing both the social security cash benefit increases and Medicare until the following year.

The circumstances of Medicare's defeat in the fall of 1964 illustrated how substantially the possibilities of enactment had increased since the first Kennedy effort in 1961. The Senate was on record favoring the King-Anderson bill and the key bottleneck of 1961, the Ways and Means Committee, was within one vote of a health insurance majority. Wilbur Mills' promises for 1965 evidenced the weakened position of the anti-Medicare coalition. In September and December of 1964, Mills suggested to audiences in Little Rock that a soundly financed Medicare bill would gain his support in the next session of the Congress. Having already stated that medical care insurance would be the first order of business for his committee the following January, Mills expressed his concerns about the discrepancies between popular conceptions of Medicare and the content of the King-Anderson proposals. "The public," Mills warned in his Little Rock speech of December 7, "must be under no illusion regarding the benefits . . . [and must understand that] Medicare does not refer to doctor services' or general outpatient medical care" (Mills, 1964).

Mills' worry was not ill-founded. "Medicare," a term which originally referred to the comprehensive health program run for servicemen's families by the Defense Department, was a misleading slogan for the King-Anderson bill. "Hospicare" would have been a more appropriate epithet. Despite the accretion of support between 1961 and 1964, the King-Anderson bills had changed only slightly. After 1963, Medicare was altered to include non-social security beneficiaries for a limited period, and here and there changes were made in the level of benefits. But the bill over which the conference committee deadlocked in 1964 remained basically a hospital insurance measure. When the deadlock was announced, observers, taking their cue from Mills' promises, assumed the King-Anderson proposal would be close to passage in 1965. In the meantime, the election of November, 1964, changed practically every political consideration; and Mills' ruminations in December about the unrealistic conception Americans held of Medicare was the first sign that anyone read the striking electoral victory of the Democrats to mean anything more than speedy enactment of a bill providing hospitalization and nursing home insurance for the aged. The *Congressional Quarterly* (5, 1965) soberly observed that "some type of medical care program for the aged is expected to be enacted by Congress in 1965."

Claiming their "program offered more benefits for the elderly at less cost to the taxpayers," the AMA charged, as did some Republicans, that the public had been misled by the connotations of the "Medicare" epithet. Seventy-two percent of those questioned in an AMA-financed survey during the first two months of 1965 agreed that doctors' bills should be insured in a government health plan. Sixty-five percent of the respondents preferred a selective welfare program which would "pay an elderly person's medical bill only if he were in need of financial help" to a universal social security plan which would "pay the medical expenses of everyone over 65 regardless of their income." Armed with these figures, the AMA once again launched a full-scale assault on the King-Anderson bill, hoping to head it off with what amounted to an extension of the Kerr-Mills program.

By February, the issue was once again before the Ways and Means Committee. Pressure groups—medical, labor, hospital and insurance organizations primarily—continued to make public appeals through the mass media and made certain their viewpoints were presented to the committee. Ways and Means had before it three legislative possibilities: the Administration's H.R. 1, the AMA's Eldercare proposal, and a new bill sponsored by the senior Republican committee member, John Byrnes.

The Ways and Means Committee and the House Take Action: January-April

For more than a month Ways and Means worked on H.R. 1, calling witnesses, requesting detailed explanation of particular sections, and trying to estimate its costs and benefits. Executive sessions, closed to the press and one mark of serious legislative intent, began in January. The atmosphere was business-like and deliberate; members assumed the Administration bill would pass, perhaps with minor changes, and there was little disposition to argue the broad philosophical issues that had dominated hearings in the preceding decade. When spokesmen for the AMA invoked their fears of socialized medicine, they irritated committee members intent on working out practical matters, and chairman Mills refused to consult AMA representatives in further sessions of the committee's officially unreported deliberations.

Mills led his committee through practically every session of hearings on the Administration bill, promising to take up the Byrnes bill (H.R. 4351) and the Eldercare bill in turn. By March 1, there had been continued reference to the exclusions and limits of the King-Anderson bill, with the charges of inadequacy coming mostly from the Republicans. On March 2, announcing his concern for finding "some degree of compromise [that] results in the majority of us being together," Mills invited Byrnes to explain his bill to the committee.

The Byrnes bill was ready for discussion because the Republicans on the committee, in the wake of the 1964 election, wanted to prevent the Democrats from taking exclusive credit for a Medicare law. The Republican staff counsel, William Quealy, had explained this point in a confidential memorandum in January, reminding the Republican committeemen that they had to "face political realities." Those realities included the certain passage of health insurance legislation that session and excluded the strategy of substituting an expanded Kerr-Mills program. "Regardless of the intrinsic merits of the Kerr-Mills program," Quealy (1965) wrote, "it has not been accepted as adequate . . . particularly by the aged, [and a] liberalization of it will not meet the political problem facing the Republicans in this Congress." That problem was the identification of Republicans with diehard AMA opposition to Medicare, which some Republican leaders thought contributed heavily to their 1964 electoral catastrophe. Hence Byrnes, who had been working since January on a Republican alternative, was anxious to distinguish his efforts from those of the AMA. At the same time, with the AMA spending nearly $900,000 to advertise its Eldercare plan, the criticism of H.R. 1's "inadequacies" was given wide circulation.

Byrnes emphasized that his bill, which proposed benefits similar to those offered in the Aetna Life Insurance Company's health plan

for the federal government's employees, would cover the major risks overlooked by H.R. 1, particularly the costs of doctors' services and drugs. He also stressed the voluntary nature of his proposal; the aged would be free to join or not, and their share of the financing would be "scaled to the amounts of the participants' social security cash benefits," while the government's share would be drawn from general revenues (Cohen and Ball, 1965, 5). The discussion of the Byrnes bill was spirited and extended; the AMA's Eldercare alternative, not promoted vigorously by even its committee sponsors, was scarcely mentioned.

The Byrnes and King-Anderson bills were presented as mutually exclusive alternatives. HEW officials were exhausted from weeks of questioning and redrafting, and viewed the discussion of the Byrnes bill as a time for restful listening. But Mills, instead of posing a choice between the two bills, unexpectedly suggested a combination which involved extracting Byrnes' benefit plan from his financing proposal. On March 2, Mills turned to HEW's Wilbur Cohen and calmly asked whether such a "combination" were possible. Cohen was "stunned," and initially suspicious that the suggestion was a plot to kill the entire Administration proposal. No mention had even been made of such innovations. Cohen had earlier argued for what he called a "three-layer cake" reform by Ways and Means: H.R. 1's hospital program first, private health insurance for physician's coverage, and an expanded Kerr-Mills program "underneath" for the indigent among the aged. Mills' announcement that the committee appeared to have "gotten to the point were it is possible to come up with a medi-elder-Byrnes bill" posed a surprise possibility for a different kind of combination. That night, in a memorandum to the President, Cohen reflected on Mills' "ingenious plan," explaining that a proposal which put "together in one bill features of all three of the major" alternatives before the committee would make Medicare "unassailable politically from any serious Republican attack" (Cohen, 1965). Convinced now that Mills' strategy was not destructive, Cohen was delighted that the

Republican charges of inadequacy had been used by Mills to prompt the expansion of H.R. 1.

Byrnes himself was reluctant to approve the dissection of his proposal, humorously referring to his bill as "better-care." Nonetheless, from March 2 to March 23, when the committee finished its hearings, Ways and Means members concentrated on the combination of what had been mutually exclusive solutions to the health and financial problems of the elderly. Mills presided over this hectic process with confident but gracious assurance, asking questions persistently but encouraging from time to time comments from other members, especially from the senior Republican, Byrnes. The Byrnes benefit formula was slightly reduced; the payment for drugs used outside hospitals and nursing homes, for instance, was rejected on the grounds of unpredictable and potentially high costs. After some consideration of financing the separate physicians' insurance through social security, the committee adopted Byrnes' financing suggestion of individual premium payments by elderly beneficiaries, with the remainder drawn from general revenues. But while Byrnes had proposed that such premiums be scaled to social security benefits, the committee prescribed a uniform $3 per month contribution from each participant. The level of premium was itself a matter of extended discussion: HEW actuaries estimated medical insurance would cost about $5 per month, but Mills cautiously insisted that a $6 monthly payment would make certain that expenditures for medical benefits were balanced by contributions *(Congressional Report* 1, 1965).

HEW was of course vitally interested in the uses to which Mills put the Byrnes plan. As one of the chief HEW participants, Irwin Wolkstein, explained (1968),

> Many features of the Byrnes Bill which had been objectionable were changed to be sure to keep administration support although some objections remained—including inadequate protection of beneficiaries against over-charging, absence of quality standards, and

alizing how much the Johnson landslide of 1964 had changed the constraints and incentives facing the 89th Congress. President Johnson, busy with the demands of a massive set of executive proposals, was willing to settle for the hospitalization insurance which the election had guaranteed. Liberal supporters of the Johnson Administration were astounded by Ways and Means' improvement of Medicare and befuddled by its causes. *The New Republic* (1965) captured the mood of this public at the time of the House vote, suggesting that the Mills bill could "only be discussed in superlatives":

> Fantastically enough, there was a tendency to expand [the Administration's bill] in the House Committee. Republicans and the American Medical Association complained that Medicare "did not go far enough." Trying to kill the bill they offered an alternative—a voluntary insurance plan covering doctor's fees, drugs, and similar services. What did the House Ways and Means Committee do? It added [these features] to its own bill. Will this pass? We don't know, but some bill will pass.

H.R. 6675 Passes the Senate: April-July

There was really no doubt that the expansion of Medicare would be sustained by the more liberal Senate and its Finance Committee. But the precise levels of benefits and form of administration were by no means certain. The Finance Committee Chairman, Russell Long (D., La.), held extended hearings during April and May, and the committee took nearly another month amending the House-passed bill in executive sessions. Two issues stood out in these discussions: whether to accept the payment method for in-hospital specialists on which Mills had insisted, and whether even more comprehensive benefits could be financed by varying the hospital deductible with the income of beneficiaries.

The first issue was taken up, with White House encouragement, by Senator Paul Douglas (D., Ill.). The question of specialist payment brought out in the open a dispute within the medical care

industry. The American Hospital Association told the Finance Committee that encouraging hospital specialists to charge patients separately would both "tend to increase the overall cost of care to aged persons" and imperil the hospital as the "central institution in our health service system" (Feingold, 1966, 114). HEW's general counsel, Alanson Willcox, prepared a list of supporting arguments which Wilbur Cohen supplied in defense of the Douglas amendment to pay RAPP specialists as specified in the original H.R. 1. "These specialists," Willcox pointed out, "normally enjoy a monopoly of hospital business' and yet they seek the 'status of independent practitioners' without the burden of competition to which other practitioners are subject" (HEW 2, 1965).

The AMA responded with fury to Douglas' revisions. Defending the specialists, the AMA hailed Mills' payment plan as a way to break down the "corporate practice of medicine" which made radiologists, anaesthetics, pathologists, and physiatrists coerced "employees" of hospitals. "Medical care," the AMA told the Finance Committee, "is the responsibility of physicians, not hospitals" (Somers and Somers, 1967, 136). Apparently unconvinced, the Senators approved the Douglas amendment in early June.

In mid-June the Finance Committee approved a plan to eliminate time limits on the use of hospitals and nursing homes. The supporters of this amendment were a mixed lot of pro- and anti-Medicare Senators, and it was clear the latter group thought this change might deadlock the entire bill. For those who wanted more adequate protection against financial catastrophe there was the subsequent realization that a well-intentioned mistake had been made. With the White House and HEW insisting on a reconsideration, the committee scrapped the amendment on June 23 by a vote of 10–7. In its place, it provided "120 days of hospital care with $10 a day deductible after 60 days" (Wolkstein, 1968).

The Finance Committee also took up a variety of provisions within the Mills bill which Administration spokesmen considered "important defects." The Medicare sponsor in the Senate, Clinton Anderson, argued that paying physicians their "usual and custom-

ary fees" (the Byrnes suggestion) would "significantly and unnecessarily inflate the cost of the program to the tax-payer and to the aged." The House bill had left the determination of what was a "reasonable charge" to the insurance companies, which would act as intermediaries for the medical insurance program, and Anderson saw no reason why these companies would save the government from an "open-ended payment" scheme (Bray, 1965). Medical spokesmen, however, were so critical of the overall Medicare legislation that fears of a physicians' boycott persuaded Senate reformers not to raise further the sensitive topic of fee schedules for physicians.

The Senate, unlike the House, does not vote on social security bills under a closed rule. This meant further amendments and debate would take place on the Senate floor on the Finance Committee's somewhat altered version of the Mills bill. On July 6 debate was opened and the Senate quickly agreed to accept the recommendation to insure unlimited hospital care with $10 co-insurance payments after 60 days. Three days later, after heated discussion, the Senate finished with its amendments, and passed its version of Medicare by a vote of 68–21. On the crucial but unsuccessful vote to exclude Part A from the insurance program, 18 Republicans and 8 Southern Democrats took the losing side. According to newspaper estimates, the expanded bill passed by the Senate increased the "price tag on Medicare" by $900 million. The conference committee was certain to have a number of financial and administrative differences to work out through compromise.

Medicare Comes out of the Conference Committee: July 26, 1965

More than 500 differences were resolved in conference between the Senate and House versions of Medicare. Most of the changes were made through the standard bargaining methods of *quid pro quo* and splitting the difference. The most publicized decision was the rejection of the Douglas plan for paying RAPP specialists under the hospital insurance program. Mills' theory in this score was to cause

much further alarm in the months to come, when the Social Security Administration began its administrative task of preparing for Medicare's initiation, July 1, 1966.

The bulk of the decisions were compromises between divergent benefit levels. The changes of duration and type of benefit involved either accepting one of the two congressional versions or combining differing provisions. The decisions on the five basic benefits in the hospital plan aptly illustrate these patterns of accommodation:

1. *Benefit duration*—House provided 60 days of hospital care after a deductible of $40. Senate provided unlimited duration but with $10 co-insurance payments for each day in excess of 60. *Conference* provided 60 days with the $40 House deductible, and an additional 30 days with the Senate's $10 co-insurance provision.
2. *Posthospital extended care (skilled nursing home)*—House provided 20 days of such care with 2 additional days for each unused hospital day, but a maximum of 100 days. Senate provided 100 days but imposed a $5 a day co-insurance for each day in excess of 20. *Conference* adopted Senate version.
3. *Posthospital home-health visits*—House authorized 100 visits after hospitalization. Senate increased the number of visits to 175, and deleted requirements of hospitalization. *Conference* adopted House version.
4. *Outpatient diagnostic services*—House imposed a $20 deductible with this amount credited against an inaptient hospital deductible imposed at the same hospital within 20 days. Senate imposed a 20 percent co-insurance on such services, removed the credit against the inpatient hospital deductible but allowed a credit for the deductible as an incurred expense under the voluntary supplementary program (for deductible and reimbursement purposes). *Conference* adopted Senate version.
5. *Psychiatric facilities*—House provided for 60 days of hospital care with a 180-day lifetime limit in the voluntary supplemen-

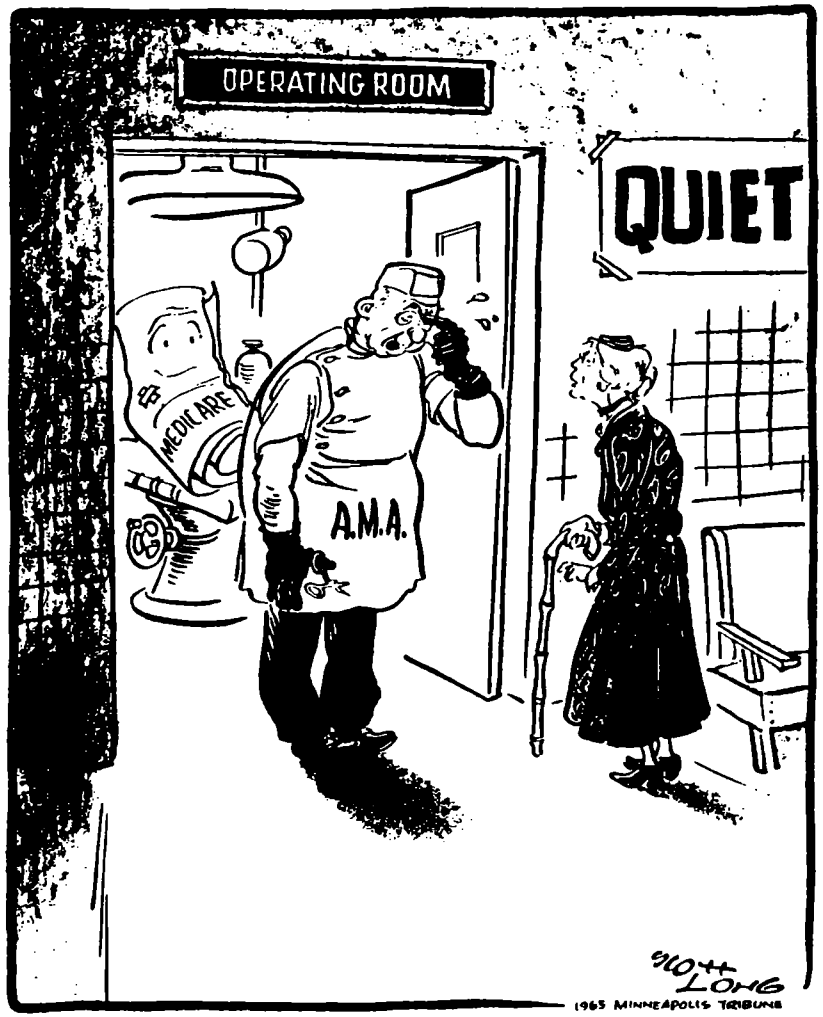
tary program. Senate moved these services over into basic hospital insurance and increased the lifetime limit to 210 days. *Conference* accepted the Senate version but reduced the lifetime limit to 190 days *(Congressional Report* 3, 1965, 4).

None of these compromises satisfied the pro-Medicare pressure groups which had been anxious to make the law administratively less complicated. By late July, the conference committee had finished its report. On July 27, the House passed the revised bill by a margin of 307–116 and the Senate followed suit two days later with a 70–24 vote. On July 30, 1965, President Johnson signed the Medicare bill into Public Law 89–97, at the ceremony in Independence, Missouri described at the beginning of this study.

The Outcome of 1965: Explanation and Issues

One of the most important lessons of Medicare's enactment is that the events surrounding its passage were atypical. The massive Democratic electoral victories in 1964 created a solid majority in Congress for the President's social welfare bills, including federal aid to education, Medicare, and the doubling of the "war on poverty" effort. To find the most recent precedent, we must go back almost 30 years, to Franklin Roosevelt's New Deal Congresses. In the intervening years, we find a different pattern. Democratic majorities in the Congress have not been uncommon, but normally the partisan margins have been sufficiently close on many issues to give the balance of power to minority groups within the party. Under these circumstances, states' rights Southern congressmen in coalition with Republicans have often been successful in blocking or delaying bills which entail the expansion of federal control.

The fragmentation of authority in the Congress compounds the opportunities for minorities to block legislation; bills must be subjected to committees, sub-committees, procedural formalities, and conference groups. To be sure, overwhelming majority support for a given bill can ensure that it will emerge, more or less intact, as



"THE OPERATION IS A FAILURE!... THE PATIENT IS GOING TO LIVE!"

law, even though it may pass under the jurisdiction of hostile congressmen in the process. However, it is extraordinarily difficult to create a congressional majority committed to an issue out of Democratic congressional partisans. President Kennedy, in 1961, avoided a major confrontation over Medicare because it was uncertain whether the bill could pass a House vote and because he needed the support of Ways and Means members for his other programs. Congressmen must frequently make similar decisions; for example, many representatives who supported Medicare before 1965 were nonetheless unwilling to launch major drive to extract it from Ways and Means. Like the President, they often needed the support of Medicare opponents for other legislation which they believed was more important or had a better chance for successful enactment. Within this context, backers of controversial legislation generally adopt a strategy which looks to the gradual accretion of support. They frame the issue so that opponents will find them difficult to attack, then set out to accumulate both mass public support and the necessary congressional votes. Particular attention is given to crucial committee bottlenecks. The Executive relies heavily on the influence of the House and Senate leadership in this effort, and acts on the assumption that although it is seldom possible to change the mind of a congressman on the merits of an issue, it is sometimes possible to change his vote. While the congressional leaders lack formal means for enforcing party discipline, they have a variety of other resources. Their personal influence with the regional caucuses who selected Ways and Means committeemen, for example, allowed them to deny assignments to Medicare opponents and thereby to alter gradually the voting margin on the committee.

By 1964, the use of this accretionist strategy by Medicare supporters seemed on the verge of success; and had the elections of that year resulted in the usual relatively close partisan margins in the Congress, the Medicare Act of 1965 would have been much narrower in scope, and its passage would stand as a vindication of the incrementalist strategy. In fact, the 1964 elections returned a

Congress in which many of the usual patterns of bargaining were less relevant. The Medicare bill which finally emerged as law must be analyzed in terms of the various responses to the highly unusual circumstances in that Congress.

In seeking answers as to why the legislative outcome differed so markedly from the Administration's input, three separable issues are involved. Why did the traditional hospitalization insurance proposal pass as one part of the composite legislation. The congressional realignment after the elections of 1964 provides the ready answer. Why the legislation took the composite form it did is partly answerable in this way as well. The certainty that some Medicare bill would be enacted changed the incentives and disincentives facing former Medicare opponents. Suggesting a physicians' insurance alternative offered an opportunity for Republicans to cut their losses in the face of certain Democratic victory and to counteract public identification of Republican opposition with intransigent AMA hostility to Medicare. Wilbur Mills' motives are fully comprehensible only in the context of congressional conventions especially the relationship of the Ways and Means Committee to the House, and the committee's tradition of restrained, consensual bargaining among its partisan blocs. However, if the political needs of the minority party and the Ways and Means members account for the Republican alternative bill and the committee's expansion of Medicare, the limits of that expansion require further explanation.

The context of the debate over government health insurance sharply delimited the range of alternatives open to innovators. That long debate—focused on the aged as the problem group, social security vs. general revenues as financing mechanisms, and partial vs. comprehensive benefits for either all the aged or only the very poor amongst the aged—structured the content of the innovations. The political circumstances of 1965 account for why innovation by Republicans and conservative Democrats was a sensible strategy. The character of more than a decade of dispute over health insurance programs for the aged explains the programmatic features of the

combination that Wilbur Mills engineered, President Johnson took credit for, and the Republicans and American Medical Association inadvertently helped to ensure.

The outcome of 1965 was, to be sure, a model of unintended consequences. The final legislative package incorporated features which no one had fully foreseen, and aligned supporters and opponents in ways which surprised many of the leading actors. Yet the eleventh hour expansion of Medicare should not draw one's attention away from the constricting parameters of change. Were a European to reflect upon this episode of social policy making in America, his attention would be directed to the narrow range within which government health proposals operated. He would emphasize that no European nation restricted its health insurance programs to one age group; and he would point out that special health "assistance" programs, like that incorporated in Title 19, had been superceded in European countries for more than a generation. The European perspective is useful, if only to highlight those features of the 1965 Medicare legislation which were *not* changed.

Although the new law was broader than the King-Anderson bill in benefit structure, it did not provide payment for all medical expenses. P.L. 89–97 continued to reflect an "insurance" as opposed to a "prepayment" philosophy of medical-care financing. The former assumes that paying substantial portions of any insured cost is sufficient; the problem to which such a program addresses itself is avoidance of unbudgetable financial strain. The latter view seeks to separate financing from medical considerations. Its advocates are not satisfied with programs which pay 40 percent of the aged's expected medical expenses (one rough estimate of Medicare's effects); only full payment and the total removal of financial barriers to access to health services will satisfy them. In Medicare's range of deductibles, exclusions, and co-insurance provisions, the "insurance" approach was followed, illustrating the continuity between the first Ewing proposals in 1952 of 60 days of hospital care and the much-expanded benefits of the 1965 legislation.

Nor were major changes made in the group designated as beneficiaries under the insurance program. The Administration had single-mindedly focused on the aged and the legislation provided that "every person who has attained the age of 65" was entitled to hospital benefits. Though this coverage represented an expansion over the limitation to social security eligibles in bills of the 1950s and early 1960s, the legislation provided that, by 1968, the beneficiaries under Part A would be narrowed again to include only social security participants. (This provision "applied only to persons first attaining age 65 in 1968 and after—only a very small fraction of the current aged—and the test of social security eligibility is less strict than is the test for cash benefits" [Wolkstein, 1968].) The persistent efforts to provide Medicare benefits as a matter of "earned right" had prompted this focus on social security and, as a result, on the aged. While the social security system was not the only way to convey a sense of entitlement (payroll taxes in the Truman plans were included for the same purpose), the politics of more than a decade of incremental efforts had effectively undercut the broad coverage of the Truman proposals.

Title 19, establishing the medical assistance program popularly known as "Medicaid," made exception to the age restrictions. This bottom layer of the "legislative cake" authorized comprehensive coverage for all those, regardless of age, who qualified for public assistance and for those whose medical expenses threatened to produce future indigency. As in the Kerr-Mills bill which it succeeded, financing was to be shared by federal government general revenues and state funds. The Medicaid program, too, owed much to the past debates, growing as it did out of the welfare public assistance approach to social problems. Its attraction to the expansionists in 1965 did not rest on its charitable features alone. In the eyes of Wilbur Mills, it was yet another means of "building a fence" around Medicare, by undercutting future demands to expand the social security insurance program to cover all income groups.

The voluntary insurance scheme for physicians' services, Part B of Title 18, represented a return to the breadth of benefits suggested in the Truman plans (although, unlike the Truman proposals, it

cial problems of the aged. He would expect monitoring of the program as part of the effort to increase the level of achievement of the original national goal.*

Contrast these predictions with those a bargaining analyst would make on the basis of chapter 4. He would expect future outcomes to vary with what one might call the deal of the electoral cards. Since the innovations of 1965 were so much the result of the atypical partisan makeup of the 88th Congress, he would predict less innovation in more typical Congresses. He would not expect the Committee on Ways and Means, for instance, to preoccupy itself with improving the program, or to seek aggressively alternative means to meet the health needs of other Americans not assisted by Medicare.

Political recommendations would be equally different. One could imagine problem-solvers trying to convince the congressional committee that new difficulties, such as higher medical prices, have arisen for the aged, or that more serious health and financial problems are being felt by the disadvantaged and poor. The emphasis here would be on identifying the social ills for which national action is required. Students of bargaining would offer different recommendations. They would stress continued efforts to reshape the Committee on Ways and Means, taking cues from the "packing" of the committee after 1961. They would advise political investments of this kind, rather than a search for problems, as the best means of insuring action on health problems we are already well aware of. Viewed from the anti-Medicare perspective, bargaining students would firmly recommend prevention of these long-term investments. These illustrations—admittedly brief and elliptical—are examples of the differences which analytic lenses may make in what we see, predict, and recommend about public policy.

* This follows from the assumption that the problem was financial inability of the aged to manage their health costs. If the "problem" had been defined as coping with the demand by unions, the aged, and others for "some" health care assistance, the legislation of 1965 might well be considered a rational (and nearly complete) solution.

Processes and Policy in American Politics: The Case of Medicare

The preceding analytic discussion raised issues about studying American public policy that were not explicitly discussed in the case study itself. In turning to the relation between Medicare politics and more general characterizations of American political life, I will try to make systematic the observations and connections that were intermittently raised in the first five chapters. There is a substantial literature on American political processes and considerable evidence of what is taken to be distinctive about the politics of some subject matter (tariffs or housing) or some broad class of policies (regulatory or distributive). The first part of the following discussion will compare Medicare findings with these broader generalizations; its aim is to present evidence why some generalizations appear plausible, though, by its nature, case study material cannot constitute a definitive test. The second part will compare the substance of Medicare policy with other views of the typical allocative and redistributive policies generated in American politics.

Political scientists have expended great efforts in recent years trying to specify the ways by which different issues are raised, disputed, coped with, and sometimes "solved." Lowi (1964) has provided a typology for discriminating among public policies which usefully categorizes the Medicare case. He describes three major patterns of political conflict which are said to be associated with three different types of public policies—*distributive, regulative,* and *redistributive*. Distributive policies, which parcel out public benefits to interested parties, provoke a stable alliance of diverse groups that seek portions of the pork barrel. Regulative policies, which constrain the relations among competing groups and persons, provide incentives for shifting coalitions, pluralistic competition, and the standard forms of compromise. Redistributive policies, which reallocate benefits and burdens among broad socioeconomic population groups, foster polarized and enduring conflict in which large national pressure groups play central roles.

Lowi characterizes three patterns of conflict, but identifies them by their putative cause—the type of policy.* It is clear that actual policies are never so distinct. All public programs redistribute resources, but most are not primarily attempts to do so. Likewise, all government programs depend upon an ultimate capacity to regulate the conduct of citizens, but most do not make such regulation their prime object. And almost all government programs involve the distribution of goods and services among different groups, though the question of which county or which social class should receive them is not always salient. But whatever the cause of the pattern of conflict, one can assess which pattern is illustrated by individual policy conflicts like Medicare.

The conflict over Medicare mirrors the political processes Lowi identifies with "redistributive" policies. The themes of that conflict —the threat of "big government," the interests of the have-nots vs. the haves—illustrate the cluster of issues that arise when a policy question "involves the issue of whether broad categories of persons are to be better or worse off." (Lowi, 1964, 689) The debate over Medicare was in fact cast in the terms of class conflict, of socialized medicine vs. the voluntary "American way," of private enterprise and local control against "the octopus of the federal government." Moreover, though the program most immediately affected the aged, physicians, and hospitals, broad strata of the population were directly or indirectly involved—the families of the aged, all present social security contributors, and the entire health industry.

Not only the themes of the conflict, but the antagonists and their adversary methods illustrate that might be called "class conflict" politics. The dispute over Medicare re-enacted the polarization that characterized earlier fights over national health insurance. The leading adversaries—national business, health, and labor organizations—participated in open communication (though not to their mutual enlightenment) and brought into the opposing camps a

* This formulation of the Lowi scheme owes much to an unpublished paper by Paul Peterson of the University of Chicago: "The Politics of Welfare," 1969.

large number of groups whose interests were not directly affected by the Medicare outcome. In the process, ideological charges and counter-charges dominated public discussion, and each side seemed to regard compromise as unacceptable. In the end, the electoral changes of 1964 reallocated power in such a way that the opponents were overruled. Compromise was involved in the detailed features of the Medicare program, but the enactment itself did not constitute a compromise outcome for the adversaries. In all these respects, Medicare politics differed from the discrete and localized pursuit of pork barrel benefits or the shifting coalitions and compromises of regulatory politics.

Battles like Medicare are fought in public but settled in private. The national pressure groups concerned made enormous and costly efforts to define the dispute over Medicare in ways acceptable to their members. But within the government bureaucracy, there were continuing efforts to articulate and balance these rival claims in the legislation proposed to the Congress. The consultation was sometimes explicit and detailed, as when the AFL-CIO and the Blue Cross Association met regularly with HEW officials during the early 1960s. In other cases, consideration of group interest was tacit and intermittent, particularly in the case of the AMA. Overall, the executive proposals sent to Congress reflected a typical pattern; major compromises were built into Medicare bills proposed by the executive branch, anticipating the pressure group claims that would otherwise have to be balanced in the Congress.

The role of Congress in dealing with policy problems like Medicare is to "ratify the agreement" that arises out of "the bureaucracy and the class agents represented there" (Lowi, 1964, 711). Had Medicare passed in 1964, this characterization of executive preeminence would have been fully warranted; the bill of that year was a hesitantly redistributive version of hospital insurance for the aged, designed to assist the aged but shaped to serve and meet the economic demands of insurance companies and the hospitals as well. The fact that Congress unexpectedly added physician insurance to the program enacted in 1965 represents a departure from the modal

processes of redistributive politics, a departure that can be explained by the extraordinary electoral context of 1965. The significant changes in the Administration bill were made almost exclusively in committee deliberations. Minor adjustments arose from Senate debate, none from the House, where the vote on Medicare took place without amendment. The Executive branch was throughout the locus of legislative planning and drafting; the peculiarities of the 1965 Congress should not obscure the patterns of the preceding decade.

The polarization elicited by issues like Medicare shapes the behavior of all the interested pressure groups. Medicare was one of those issues that separates the "money-providing" and "service-demanding" groups in a society—a division which "cuts closer than any other along class lines" (Lowi, 1964, 707, 711). This promotes cohesion among groups that otherwise have much to disagree about; the existence of a common fear promotes a public united front. So, for instance, the conflicting interests of the American Hospital Association (certain to be assisted by Medicare's underwriting of the hospital expenses of the aged) and the American Medical Association (violently opposed to Medicare, despite its members' short-run economic interests) were muted through most of the fight over Medicare. Hospital Association officials felt constrained to take the "health industry's" position against Medicare, though in private (and in meetings with HEW), their willingness to go along with the legislation was apparent. The health industry's public opposition was fused with that of almost every national commercial, industrial, and right-wing group in American politics. The united front of "service-demanders" was equally apparent in the Medicare fight. The ultimate consumers—the aged and their organizations—were sometimes overshadowed in the procession of "liberal" professional, labor, and service organizations championing their cause.

Finally, the processes of Medicare politics involved stabilizing and centralizing conflict in ways characteristic of redistributive disputes (Lowi, 1964, 715). The initiation of Medicare demands in

the early 1950s—when the issue was simply whether the social security system would provide 60 days of hospital insurance for its beneficiaries—revealed the pattern of conflict which would follow. Specters of the future—fearful or hopeful—dominated the ideological charges of the national pressure groups. The liberal-conservative split that emerged remained stable throughout, with few defectors as the proposals shifted. The Department of Health, Education and Welfare centralized much of the battle. Congress, whose fiscal committees are short of staff and unequipped to conduct independent research on health affairs, "listened" to the repetitive debates and, in the end, ratified the Administration's bill, adding its own special imprint.

Most Medicare bills did not propose massive redistribution of income, and in this sense the association of Medicare with Lowi's redistributive politics may appear problematic. But the central feature of the Medicare dispute was whether the federal government should engage in whatever limited redistribution Medicare proposals entailed. The fight centered on whether the redistribution was warranted (were the aged needy enough?), the instrument of change (charity or insurance?), and the sources of financing (general revenues or social security taxes?). This redistributive frame of reference determined the shape of the conflict, not the scale of redistribution that would in fact be involved.

Medicare thus appears to be an instance of a much larger class of conflicts in American politics associated with issues of income redistribution and zero-sum political conflicts. Our findings about Medicare can be used, however, to illustrate more than classificatory generalizations. More general questions—involving the structure of power in the United States—are relevant. What was the role of public opinion in this major public policy choice? How influential were pressure groups and whom did they seek to pressure?

The Medicare case illustrates the comparative irrelevance of mass public opinion in federal policy-making (Key, 1961; Bauer *et al.*, 1963). Public support for health insurance under social security declined slightly as remedial proposals were more specifically de-

programs and added another—Comprehensive Health Services.

In the 1967-68 authorization bill Congress added four more national community action programs: Follow Through, an extension of the Head Start program to the early school years; Emergency Food and Medical Service; Family Planning, a voluntary program for the poor; and Senior Opportunities and Service, a program for needy persons over 60. Showing its frustration with problems in the antipoverty programs, Congress in 1966 had earmarked specific amounts for each national program. But the following two-year authorization eliminated earmarking, and left the distribution of funds ($950 million for all local and national community action programs) up to the OEO.

Work and Training Programs. The manpower activities of the antipoverty program were considerably less controversial than the community action provisions and the Job Corps. These provisions included the Neighborhood Youth Corps, one of the original OEO programs *(see box p. 746)*, "Operation Mainstream," a 1965 program to employ the chronically unemployed on community beautification projects; "New Careers," a 1966 program to train the poor to be aides to professionals in such fields as education, health and welfare; and a 1967 concentrated employment program. Congress in 1967 combined all of these activities in Part B of Title I. The Senate Labor and Public Welfare Committee, which initiated the consolidation, said it would give participants an unbroken sequence of services to help them obtain and hold a job.

Other Programs. Other OEO programs were relatively uncontroversial. From the original 1964 authorization, these included the VISTA program (the domestic peace corps) and programs directed specifically at rural and migrant families. Noncontroversial programs added to the Act after 1964 included a 1966 Title I Special Impact Program to employ residents of slum neighborhoods in projects aimed at rehabilitating those neighborhoods; a 1966 Emergency Family Loan Program; and a 1967 Day Care program.

Administrative Restrictions. While Republicans were never successful in their continuing effort to dismember the OEO, the ambivalent Congressional attitude toward the anti-poverty programs was reflected in a number of administrative restrictions imposed on the programs for several years. Other restrictions grew out of widespread criticisms, especially in the area of salaries.

Among such actions were 1966 amendments requiring the OEO to give Congress a list of local antipoverty officials earning more than $10,000 a year; providing that no CAA or Job Corps official earning over $6,000 could earn more than 20 percent over his previous salary; providing that no new supergrade jobs (GS 16-18) could be created by the OEO in the fiscal year; and temporarily limiting administrative expenses for the OEO to 10 percent of the total funds authorized under the Act. Further restrictions in 1967 required public announcement of OEO contracts, prohibited use of OEO funds for partisan or nonpartisan political activities (such as voter registration), and limited the length of time a consultant could be employed by the OEO.

Chronology Of Legislation On Welfare

1965

Medicare

CONGRESS in 1965 passed the bill which was not only the most important welfare legislation of the Johnson Administration, but was also generally considered the most important welfare measure since passage of the original Social Security Act in 1935. The bill (HR 6675—PL 89-97) established a medical care program for the aged under the Social Security System, a goal of liberals throughout the postwar period. But the 'medicare' program finally enacted was much more far-reaching than the plan which liberals had proposed unsuccessfully for years. Moreover, HR 6675 made a multitude of other changes in Social Security law, including a 7-percent increase in retirement benefits.

The medicare program which had been sought by liberals in the Kennedy-Johnson Administrations had been limited in an attempt to win more support for enactment. Essentially, that program called for compulsory hospital insurance for the aged covering spells of hospital and post-hospital care, financed through an increase in the Social Security tax. Surgical and other doctor bills were deliberately not included in an effort to counter the American Medical Assn.'s (AMA) charge that the program would lead to "socialized medicine." At the outset of 1965, medicare backers would certainly have been content with enactment of this program alone, and it was only this program that was proposed by President Johnson when the 1965 session began (HR 1, S 1).

But the final bill, in addition to that basic Social Security hospital care plan, also provided for a second, voluntary, Government-administered plan covering surgical and other doctor bills, laboratory tests and other services. Ironically, the broader bill was a result of the AMA's last-ditch stand against medicare. Ascertaining that a large percentage of the population thought the Administration bill would cover doctor costs and approved of this, the AMA began an intensive campaign attacking the Administration bill largely on the grounds that doctor bills were not included. The AMA proposed its own alternative plan which covered doctor bills. This plan, dubbed "eldercare," called for voluntary comprehensive medical insurance for the aged which would be optional with the states and which would vary in cost according to the income of recipients.

The eldercare program did not win the support of Congressional Republicans, but it prompted the drafting of another bill (HR 4351) which was introduced by ranking minority Ways and Means Committee member John W. Byrnes (R Wis.) with the blessing of the GOP leadership. This was also voluntary and covered 80 percent of

doctor bills and most other costs of illness to the aged, but was administered by the Federal Government. When the Administration plan came before the Ways and Means Committee for consideration, a majority of the committee voted to report a clean bill which included both the basic medicare hospitalization plan and the essence of the Byrnes bill without hospitalization provisions, which medicare rendered unnecessary. Administration officials and long-time medicare backers were delighted with the new two-pronged program, but the original proponents of the voluntary plan refused to support the revised bill. (House action on medicare bills was crucial because the legislation had to originate in that chamber.

Summary of HR 6675

BENEFITS

Basic Health Plan. Benefits about 19 million aged; provides up to 90 days of hospital care, 100 days of nursing-home care and 100 home health-care visits and outpatient diagnostic services. Some deductions required.

Supplementary Health Plan. Benefits about 16.9 million aged; pays 80 percent of the cost of a variety of health services, including services of doctors, after a $50 annual deduction.

Kerr-Mills. Medical assistance to the needy aged was extended to needy persons under all public assistance programs, and federal funds for the programs increased. About 8 million persons would be benefitted.

Child Health Care. Federal funds increased for existing programs, and new programs added.

Social Security. Cash benefits for about 20 million persons increased by 7 percent, and regulations liberalized to provide further benefits. Coverage extended to self-employed doctors and to tips.

Public Assistance. Federal funds increased, and income exemptions liberalized.

EFFECTIVE DATES—Increased Social Security payments—retroactive to Jan. 1, 1965. Most of the other Social Security benefits—effective Sept. 1, 1965. Increased federal funds for most child health care programs—retroactive to July 1, 1965. Increased federal funds for the new Kerr-Mills program and the public assistance programs—available Jan. 1, 1966. Most benefits under the basic and supplementary health plans—effective July 1, 1966, with the remainder becoming effective Jan. 1, 1967.

FINANCING—Increased Social Security benefits and most of the basic health program—financed by payroll taxes. The supplementary health plan—financed by contributions from participants and general revenue. All other benefits in the bill—to be financed by general revenue. First full year cost of operation (1967): basic health plan $2.5 billion; supplementary health plan $1.2 billion; Kerr-Mills $200 million; Social Security benefits $2.3 billion; child health and public assistance $339 million; grand total $6.5 billion. Sources of financing: $4.5 billion from payroll taxes; $1.4 billion from general revenue; $600 million from contributions from individuals.

For a discussion of the key role played by the House Ways and Means Committee see box p. 756.)

Once the proposal reached the House floor, where it was considered under a rule that prohibited floor amendments, it moved through Congress with little controversy and great ease. The House passed it April 8 by a key **313-115** roll-call vote. The only House provision that was opposed by the Administration transferred from the basic hospital insurance plan to the supplementary plan coverage of services furnished by specialists in radiology, anesthesiology, pathology and physical medicine.

The Senate passed the bill July 9 by a key **68-21** roll-call vote. Before passage it returned the services of specialists to the basic plan and made numerous other changes. None of the amendments altered the basic structure of the bill, although several were very important. Some of these eliminated the 60-day hospitalization period under the basic plan (to provide for catastrophic illness), made further increases in payroll taxes and lowered the retirement age for Social Security cash benefits. The only amendment accepted over opposition of the Democratic leadership substantially expanded the disability insurance program for the blind. In all, the Senate changes increased the annual cost of the bill by about $1.4 billion, to $7.6 billion.

House-Senate differences were resolved in six meetings of the conference committee. One-year costs under the final bill were estimated at $6.5 billion, and the provisions were very similar to the original House version—conference chairman Wilbur D. Mills (D Ark.) said over 95 percent of them came from the House. The only major Senate amendment retained in the final bill was the additional increase in payroll taxes to finance medicare and the enlarged Social Security benefits. Hospitalization benefits were also longer than those under the House version (90 days), but were not unlimited. Services of specialists were placed in the supplementary plan.

President Johnson signed HR 6675 into law (PL 89-97) July 30, proclaiming that, "No longer will older Americans be denied the healing miracle of modern medicine." He said the bill had a few defects, "such as the payment of certain specialists," but that he was confident they would be quickly remedied.

In October the AMA ended months of suspense on the subject by making clear that it would not sponsor an organized boycott of the medicare program. In a sense it signaled acceptance of the program by resolving to participate in advisory committees "and to contribute whatever advice and suggestions are deemed advisable and necessary in the formulation and revision of regulations."

Comparison With Earlier Votes. As with much of the other liberal legislation passed by the 89th Congress, the key reason for the ease with which medicare was enacted in 1965 was the big Democratic victory in the November 1964 elections. Although the already heavily Democratic Senate gained only two more Democrats in the 1964 elections, the margin in favor of medicare on the 1965 key vote was far wider than on the favorable 1964 vote—68-21 contrasted with 49-44 the previous year. The new margin of support was widely believed to be a recognition that the 1964 elections had shown the popular appeal of medicare.

Medicare passed the House in 1965 by a whopping **313-115** roll-call vote. But a more revealing roll call was the **191-236** vote by which the Byrnes (GOP) plan to sub-

stitute a voluntary program for the Administration bill was defeated. The closeness of that vote gave some substance to speculation that medicare could not have passed the House prior to 1965 even if the Ways and Means Committee had permitted it to come to the floor for a vote.

1965 Request

Failure of medicare in 1964 had been one of President Johnson's few serious legislative defeats. In 1965 he took no risks. It was assigned the numbers HR 1 and S 1, and the President's first special message to the 89th Congress dealt with health legislation. In the message he called 1965 the year "when, with the sure knowledge of public support, the Congress should enact a hospital insurance program for the aged.... In this way, the spectre of catastrophic hospital bills can be lifted from the lives of our older citizens."

The 1965 hospital care bill was very similar to the bills proposed by the Kennedy-Johnson Administrations since 1961. The major difference was that the new bill provided coverage for a flat 60 days of hospital care instead of a benefit option of 180, 90 or 45 days with varying deductibles. Other major provisions called for the following additional benefits: 60 days of nursing home care, 240 home health-care visits, and outpatient hospital diagnostic services. The program would cover all persons 65 and over, except Government workers with federal insurance and certain aliens. It would be financed mainly by increases in the Social Security tax rate, which would reach 7.8 percent in 1971. The taxable annual earnings base would be increased to $5,600. The money would go into a separate trust fund within the Social Security System. Total costs were estimated at $2 billion in the first full year of operation.

HR 1 and S 1 also included a bipartisan-backed provision for a general 7-percent increase in Social Security benefits, retroactive to Jan. 1, 1965. It brought self-employed physicians into the Social Security System (a move opposed by many doctors) and required that Social Security taxes be paid on tips.

Alternative Proposals. With most political observers predicting that the landslide Democratic victory in the 1964 elections ensured enactment of the medicare plan, the American Medical Assn. came forth with the most vigorous campaign of its years of opposition to the proposal. In its last-ditch stand against medicare, the AMA switched its major argument against the program. In previous years anti-medicare advertising had stressed that the plan would "lead the country down the road to socialized medicine." In 1965, the AMA apparently decided that its most effective argument against the bill was not that it would go too far, but that it would accomplish too little. A Jan. 2 Gallup Poll had shown that only 23 percent of persons questioned knew that fees of doctors, surgeons and dentists would not be covered under the Administration's proposal. Of those who thought doctors' fees would be covered, 73 percent approved of the program. Of those who thought such fees would not be covered, 56 percent approved. Building on the idea of more comprehensive coverage, the AMA in January mobilized an intensive campaign of newspaper and television advertising attacking the Administration bill and proposing a new, alternative "eldercare" plan.

The eldercare plan was introduced Jan. 27 in the House (HR 3727, 3728) by Ways and Means Committee members Thomas B. Curtis (R Mo.) and A. Sydney Herlong Jr. (D Fla.). It called for a voluntary comprehensive medical insurance program which would be available to persons over 65 if their state government signed up for the program. The program would be financed by matching federal-state funds and by variable contributions from recipients.

Instead of endorsing the AMA proposal, the House Republican Leadership set forth its own bill (HR 4351) introduced by the ranking minority member of the Ways and Means Committee, John W. Byrnes (R Wis.). Like the eldercare program, HR 4351 provided a voluntary health insurance program for all persons over 65, which would cover a large proportion of most costs of illness in old age. Unlike the eldercare plan, it would be administered by the Federal Government. It would be financed by a graduated premium contribution based on the individual's ability to pay, by contributions from states and by an annual appropriation from the Federal Government. Supporters estimated that the program would cost $3.4 billion annually with full participation.

House Action

The Ways and Means Committee Jan. 25 decided not to hold public hearings on HR 1, the Administration medicare bill, on the grounds that it had heard extensive testimony on similar proposals in recent years. It then began holding regular executive sessions on the 1965 proposals which continued until March 24 when it ordered reported a clean bill (HR 6675) that was broader in scope. Whereas HR 1 had been introduced by second ranking Ways and Means Committee member Cecil R. King (D Calif.), the new bill was introduced by Committee Chairman Wilbur D. Mills (D Ark.), once medicare's most influential opponent. President Johnson praised Mills "for his statesmanlike leadership in working out, on a sound and practical basis, a solution to one of the most important problems which has been pending before the Congress for nearly 15 years."

Major Provisions, Changes. The basic hospital care plan included in HR 6675 was similar to that in HR 1, but provided somewhat different and slightly fewer benefits. The basic hospital coverage remained the same (60 days) but post-hospital care was changed from a flat 60 days to 20 days plus additional time for each day a person's hospital stay had been less than 60 days; the number of home health-care visits was reduced from 240 to 100 a year. Social Security tax rates for medicare were somewhat higher than contemplated in HR 1 and the Social Security taxable earnings base was increased to $6,600 in 1971 as opposed to $5,600 in 1966 under HR 1. In line with Chairman Mills' concern about keeping the Social Security retirement and hospital funds separate, the Committee report on HR 6675 said "the hospital insurance program will in no way impinge upon the financial soundness of the Old-Age, Survivors and Disability Insurance trust funds." It said this separation would be assured through such devices as separate trust funds and a separate statement of the hospital insurance tax on W-2 tax forms. Also, unlike the OASDI system, the hospital insurance system would be financed on the assumption of rising earnings levels and rising hospitalization costs (in-

Medicare Enactment Ends 20-Year Issue

President Truman in 1945 made the first proposal for enactment of a federally operated health insurance program. The Truman plan would have covered the entire population, not just the elderly. The proposal immediately brought forth the lobbying might of the American Medical Assn., the organization which was chief opponent of federal hospital insurance through the years. The AMA was joined in opposition by the insurance industry and conservative business groups. Labor unions and liberal organizations worked for enactment of the Truman proposal and the more limited medicare plan that followed, but there was no one organization that was as important in support of a medicare program as the AMA was in opposition.

The lobbying campaign for and against the Truman proposal reached a peak when the President pushed for Congressional action in 1949-50. Hospital insurance became one of the major issues of the session; when Congress adjourned without taking any action, the AMA was considered to have won a notable victory. Its warnings that national health insurance would mean "socialized medicine" and Government interference in medical practice were generally credited with being the major factor in the outcome. The campaign had been costly; in 1949-50 the AMA filed the two highest lobby spending reports ever.

After 1950 the issue subsided for awhile; the Eisenhower Administration, which came to office in 1953, opposed any such plan. But in 1957 the issue returned to public prominence with introduction by Rep. Aime J. Forand (D R.I.) of a bill which covered hospital and surgical costs of the aged under the Social Security retirement system. This became a major part of the legislative program of the AFL-CIO and the AMA began another nationwide publicity campaign in opposition. This marked the start of the struggle which ended with enactment of medicare in 1965.

By 1960 the Forand bill (as medicare was then tagged) had become a very hot political issue. However, the rules of the House were such that the proposal could not be brought to the House floor for debate unless it was reported by the House Ways and Means Committee. The Committee in 1960 voted 17-8 against the proposal, and was never to vote in favor of it until 1965. *(For box on the crucial role of the Ways and Means Committee, see box, p. 756.)*

With House action blocked, medicare supporters worked on getting the bill through the Senate, even though there seemed to be little chance of enactment.

Kennedy Administration bills covered only hospital and post-hospital costs; not surgical bills as proposed by Forand. Medicare produced another major Senate fight in 1962. Concessions were made to win five Republican votes, but the Administration nevertheless suffered a stunning defeat when the plan was tabled, 48-52. Medicare finally passed the Senate for the first time in 1964, as an amendment to a House-passed bill raising Social Security retirement benefits by 5 percent. But the bill died in conference when a majority of House conferees opposed any medicare plan and a majority of Senate conferees held firm in favor. As the 1964 bill died, President Johnson spoke of hopes for a mandate in the November election, and pledged that he would try again for medicare in 1965.

Chronology

Following is a chronology of the major legislative landmarks in the drive for medicare up to 1965:

1935—The report of President Roosevelt's Committee on Economic Security, which formed the basis of the Social Security Act passed later that year, endorsed the principle of compulsory national health insurance.

1943—Sens. Robert F. Wagner (D N.Y.) and James E. Murray (D Mont.) and Rep. John D. Dingell (D Mich.) introduced the first "Wagner-Murray-Dingell" bill, proposing a broadening of the entire Social Security Act, including a compulsory national health insurance system financed by a payroll tax.

1945—President Truman's message on health legislation proposed a comprehensive, prepaid medical insurance plan for persons of all ages to be financed by raising the Social Security tax.

1949-50—President Truman's health insurance proposals were among the hardest-fought of all issues before Congress, but no action resulted.

1954—President Eisenhower's plan to help meet the cost of health care proposed that the Government reinsure private insurance companies against unusually heavy losses on health insurance.

1957—Rep. Aime J. Forand (D R.I.) introduced a bill proposing that Social Security payroll taxes be raised to provide hospital care for old-age assistance beneficiaries.

1960—Democratic Presidential nominee John F. Kennedy (D Mass.), who had sponsored a Senate version of the Forand bill, announced in July 1960 that its enactment was one of his chief legislative goals for Congress' post-convention August session. Sen. Clinton P. Anderson (D N.M.) proposed a revised version of the Forand-Kennedy bill as a floor amendment to the omnibus Social Security bill. Opposed by President Eisenhower, the amendment was defeated 44-51 Aug. 23. The medical care provisions later added to the bill, and called the Kerr-Mills program after its sponsors, established a state-administered, flexible matching grant program for medical aid to needy persons not poor enough to qualify for public assistance.

1962—President Kennedy's 1961 medical care proposal, sponsored by Sen. Anderson and Rep. Cecil R. King (D Calif.), died in the House Ways and Means Committee. When Sen. Anderson offered a revised amendment to the Public Welfare Amendments bill, it was tabled (defeated) by a 52-48 Senate vote.

1963-64—Mr. Kennedy's 1963 proposals for health care were again introduced by King and Anderson. The Administration achieved a major but temporary victory Sept. 2, 1964, when a medicare amendment to the Social Security Amendments bill passed the Senate, 49-44. The amendment, sponsored by Sen. Albert Gore (D Tenn.), and similar to the Administration bill, died in conference.

House Key Votes—89th Congress—1965

1. H Res 8. Adoption of House rules for the 89th Congress. Amend the rules to permit the Speaker to recognize a Member to call up for floor action a bill that had been before the Rules Committee for 21 days without being granted a rule, and make other changes in House rules. Albert (D Okla.) motion to consider the previous question, cutting off debate and precluding amendments. Motion agreed to 224-202: R 16-123; D 208-79 (ND 185-4; SD 23-75), Jan. 4, 1965. The President did not take a position on the motion.

2. S 3. Passage of the Appalachian Regional Development Act of 1965 authorizing $1,092,400,000 for road construction, health facilities, vocational schools, housing, sewage works, land improvement and other activities to aid the 11-state Appalachian region. Passed 257-165: R 25-109; D 232-56 (ND 173-15; SD 59-41), March 3, 1965. A "yea" was a vote supporting the President's position.

3. HR 2362. Passage of the Elementary and Secondary Education Act of 1965, providing: a three-year program of grants to states for allocation to school districts with large numbers of children from low-income families; grants for purchase of books and library materials; funds to improve educational research; and grants to strengthen state departments of education. Passed 263-153: R 35-96; D 228-57 (ND 187-3; SD 41-54), March 26, 1965. A "yea" was a vote supporting the President's position.

4. HR 6675. Social Security Amendments of 1965 providing a basic, compulsory, payroll-tax-financed health insurance program for the aged, a supplementary voluntary health insurance program and other Social Security and welfare benefits (see next roll call). Byrnes (R Wis.) motion to recommit the bill to the House Ways and Means Committee with instructions to report it back with the provisions of a substitute bill, HR 7059, which provided a voluntary, comprehensive health insurance program for the aged financed by general revenue and contributions from participants. Rejected 191-236: R 128-10; D 63-226 (ND 3-188; SD 60-38), April 8, 1965. A "nay" was a vote supporting the President's position.

5. HR 6675. Passage of the Social Security Amendments of 1965 to: provide a basic compulsory health insurance program for the aged, financed primarily by a payroll tax; a supplementary voluntary health insurance program financed by general revenue and contributions from participants; increases in Social Security cash benefits; and expansion of the Kerr-Mills health program, child health-care programs and other federal-state public assistance programs. Passed 313-115: R 65-73; D 248-42 (ND 189-2; SD 59-40), April 8, 1965. A "yea" was a vote supporting the President's position.

6. H J Res 1. Passage of the bill proposing a constitutional amendment to permit the Vice President to become Acting President if the President were unable to perform his duties, and to provide for filling a vacancy in the office of Vice President. Passed (two-thirds majority required) 368-29: R 122-8; D 246-21 (ND 172-6; SD 74-15), April 13, 1965. A "yea" was a vote supporting the President's position.

	1	2	3	4	5	6
ALABAMA						
3 Andrews	N	N	N	Y	N	N
8 Jones	Y	Y	?	X	?	?
5 Selden	N	N	N	Y	N	Y
4 Andrews	N	N	N	Y	N	Y
6 Buchanan	N	N	N	Y	N	N
2 Dickinson	N	N	X	Y	N	Y
1 Edwards	N	N	N	Y	N	Y
7 Martin	N	N	N	Y	N	N
ALASKA						
AL Rivers	Y	Y	Y	N	Y	Y
ARIZONA						
3 Senner	Y	Y	Y	N	Y	Y
2 Udall	Y	Y	Y	N	Y	Y
1 Rhodes	N	N	N	Y	N	Y
ARKANSAS						
1 Gathings	N	N	N	Y	N	Y
4 Harris	N	Y	N	N	Y	Y
2 Mills	Y	Y	Y	N	Y	Y
3 Trimble	Y	Y	Y	N	Y	Y
CALIFORNIA						
5 Burton	Y	Y	Y	N	Y	Y
7 Cohelan	Y	Y	Y	N	Y	Y
33 Dyal	Y	Y	Y	N	Y	Y
9 Edwards	Y	Y	Y	N	Y	Y
18 Hagen	Y	Y	Y	N	Y	Y
34 Hanna	Y	✓	Y	N	Y	Y
2 Johnson	Y	Y	Y	N	Y	Y
4 Leggett	Y	Y	Y	N	Y	Y
15 McFall	Y	Y	Y	N	Y	Y
8 Miller	Y	Y	Y	N	Y	Y
3 Moss	Y	Y	Y	N	Y	Y
16 Sisk	Y	Y	Y	N	Y	Y
38 Tunney	‡	Y	Y	N	Y	Y
37 Van Deerlin	Y	Y	Y	N	Y	Y
14 Baldwin	N	N	Y	-	‡	‡
1 Clausen	N	N	N	Y	N	Y
10 Gubser	N	N	N	Y	Y	‡
6 Mailliard	N	N	N	✓	?	Y
12 Talcott	N	N	N	Y	Y	Y
13 Teague	N	N	N	Y	Y	Y
35 Utt	N	N	N	Y	N	Y
36 Wilson	N	N	N	Y	N	Y
11 Younger	N	N	N	Y	N	Y

	1	2	3	4	5	6
Los Angeles Co.						
29 Brown	Y	Y	Y	N	Y	Y
25 Cameron	Y	Y	N	N	Y	Y
22 Corman	Y	Y	Y	N	Y	Y
21 Hawkins	Y	Y	Y	N	Y	Y
19 Holifield	Y	Y	N	N	Y	Y
17 King	Y	Y	Y	N	Y	Y
26 Roosevelt	Y	✓	Y	N	Y	‡
30 Roybal	Y	Y	Y	N	Y	Y
31 Wilson	Y	Y	Y	N	Y	Y
28 Bell	N	N	Y	Y	N	Y
23 Clawson	N	N	N	Y	N	Y
32 Hosmer	N	N	Y	Y	N	Y
24 Lipscomb	N	N	N	Y	N	Y
27 Reinecke	N	N	N	Y	Y	Y
20 Smith	N	N	N	Y	N	Y
COLORADO						
4 Aspinall	Y	Y	Y	N	Y	Y
3 Evans	Y	Y	Y	N	Y	Y
2 McVicker	Y	✓	Y	N	Y	Y
1 Rogers	Y	Y	Y	N	Y	Y
CONNECTICUT						
1 Daddario	Y	N	Y	N	Y	Y
3 Giaimo	Y	N	Y	N	Y	Y
6 Grabowski	Y	N	Y	N	Y	Y
4 Irwin	Y	N	Y	N	Y	Y
5 Monagan	Y	N	Y	N	Y	Y
2 St. Onge	Y	Y	Y	N	Y	Y
DELAWARE						
AL McDowell	Y	Y	Y	N	Y	Y
FLORIDA						
2 Bennett	N	N	N	Y	N	Y
4 Fascell	Y	Y	Y	N	Y	Y
9 Fuqua	N	N	N	Y	N	Y
10 Gibbons	Y	Y	Y	N	Y	Y
7 Haley	N	N	N	Y	Y	Y
5 Herlong	N	N	N	Y	Y	Y
8 Matthews	N	N	N	Y	Y	Y
3 Pepper	Y	Y	Y	N	Y	Y
6 Rogers	N	N	N	Y	Y	Y
1 Sikes	N	Y	N	Y	Y	Y
12 Cramer	N	N	N	Y	Y	Y
11 Gurney	N	N	N	Y	Y	Y

	1	2	3	4	5	6
GEORGIA						
7 Davis	N	Y	Y	Y	N	Y
6 Flynt	N	Y	N	Y	N	N
1 Hagan	N	Y	N	Y	N	Y
9 Landrum	N	Y	Y	N	Y	Y
4 Mackay	Y	Y	Y	N	Y	Y
2 O'Neal	N	N	N	Y	N	N
10 Stephens	N	Y	Y	Y	N	Y
8 Tuten	N	Y	N	Y	Y	Y
5 Weltner	Y	Y	Y	N	Y	‡
3 Callaway	N	N	N	Y	N	N
HAWAII						
AL Matsunaga	Y	Y	Y	N	Y	Y
AL Mink	Y	Y	Y	N	Y	Y
IDAHO						
1 White	Y	Y	Y	N	Y	Y
2 Hansen	N	N	N	Y	N	Y
ILLINOIS						
21 Gray	Y	Y	Y	N	Y	Y
24 Price	Y	Y	Y	N	Y	Y
19 Schisler	Y	Y	Y	N	Y	Y
23 Shipley	Y	Y	Y	N	Y	?
16 Anderson	N	N	N	Y	N	Y
17 Arends	N	N	N	Y	N	Y
14 Erlenborn	N	N	N	Y	N	Y
20 Findley	N	N	N	Y	N	Y
12 McClory	N	N	N	Y	Y	Y
18 Michel	N	N	N	Y	N	‡
15 Reid	N	N	N	Y	N	Y
22 Springer	N	N	-	Y	N	Y
Chicago—Cook Co.						
7 Annunzio	Y	Y	Y	N	Y	Y
1 Dawson	Y	Y	Y	N	Y	?
5 Kluczynski	Y	Y	Y	N	Y	?
3 Murphy	Y	Y	Y	N	Y	Y
2 O'Hara	Y	Y	Y	N	Y	Y
11 Pucinski	Y	Y	Y	N	Y	Y
6 Ronan	Y	Y	Y	N	Y	Y
8 Rostenkowski	Y	Y	Y	N	Y	-
9 Yates	Y	Y	Y	N	Y	‡
10 Collier	N	N	N	Y	N	Y
4 Derwinski	N	N	N	Y	N	Y
13 Rumsfeld	N	N	N	Y	N	Y

- KEY -

Y Record Vote For (yea).
✓ Paired For.
‡ Announced For, CQ Poll For.
N Record Vote Against (nay).
X Paired Against
- Announced Against, CQ Poll Against.
? Absent, General Pair, "Present," Did not announce or answer Poll.

	1	2	3	4	5	6
INDIANA						
3 Brademas	Y	Y	Y	N	Y	Y
8 Denton	Y	Y	Y	N	Y	Y
9 Hamilton	Y	X	Y	N	Y	Y
11 Jacobs	Y	Y	Y	N	Y	Y
1 Madden	Y	Y	Y	N	Y	Y
5 Roush	Y	N	Y	N	Y	Y
4 Adair	N	N	N	Y	N	Y
7 Bray	N	N	N	Y	N	Y
2 Halleck	N	N	N	Y	N	Y
10 Harvey	N	N	N	Y	N	‡
6 Roudebush	N	N	N	Y	N	Y
IOWA						
4 Bandstra	Y	Y	Y	N	Y	Y
2 Culver	Y	Y	Y	N	Y	Y
6 Greigg	Y	Y	Y	N	Y	Y
7 Hansen	Y	Y	Y	N	Y	Y
1 Schmidhauser	Y	Y	Y	N	Y	Y
5 Smith	Y	Y	Y	N	Y	Y
3 Gross	N	N	N	Y	N	N
KANSAS						
1 Dole	N	N	N	Y	N	Y
3 Ellsworth	N	X	Y	Y	N	Y
4 Shriver	N	N	Y	Y	N	Y
2 Mize	N	N	Y	Y	N	Y
5 Skubitz	N	N	N	Y	N	Y
KENTUCKY						
4 Chelf	N	Y	Y	Y	Y	Y
3 Farnsley	Y	Y	Y	N	Y	Y
2 Natcher	N	Y	Y	Y	Y	Y

Democrats in this type; *Republicans in italics*

Senate Key Votes—89th Congress—1965

7. S 1837. Foreign Assistance Act of 1965. Church (D Idaho) amendment to reduce the fiscal 1966 and fiscal 1967 authorizations for foreign military assistance by $115 million each year, to an annual authorization of $1,055,000,000. Rejected 38-43: R 10-18; D 28-25 (ND 21-17; SD 7-8), June 11, 1965. A "nay" was a vote supporting the President's position.

8. S J Res 1. Presidential Continuity. Adoption of the conference report on the bill proposing a constitutional amendment to permit the Vice President to become Acting President if the President were unable to perform his duties, and to provide for filling a vacancy in the office of Vice President. Adopted (two-thirds majority required) 68-5: R 21-1; D 47-4 (ND 31-3; SD 16-1), July 6, 1965. A "yea" was a vote supporting the President's position.

9. HR 6675. Social Security Amendments of 1965. Curtis (R Neb.) amendment to delete the compulsory hospital insurance plan for persons 65 or older, financed by a payroll tax, and the voluntary, supplementary health insurance plan for persons in the same age group, financed by general revenues and by contributions from participants. Rejected 26-64: R 18-11; D 8-53 (ND 0-43; SD 8-10), July 9, 1965. A "nay" was a vote supporting the President's position.

10. HR 6675. Passage of the Social Security Amendments of 1965, providing a basic compulsory hospital insurance program for the aged financed primarily by a payroll tax and a supplementary, voluntary health insurance program financed by general revenue and contributions from participants; increasing Social Security cash benefits; and expanding the Kerr-Mills health program, child health care programs and other federal-state public assistance programs. Passed 68-21: R 13-14; D 55-7 (ND 43-0; SD 12-7), July 9, 1965. A "yea" was a vote supporting the President's position.

11. S 2213. Housing and Urban Development Act of 1965. Tower (R Texas) amendment to delete a provision authorizing a program of rent supplements for low-income families. Rejected 40-47: R 24-5; D 16-42 (ND 6-35; SD 10-7), July 15, 1965. A "nay" was a vote supporting the President's position.

12. S J Res 66. State Legislative Apportionment. Passage of the bill proposing a constitutional amendment, sponsored by Dirksen (R Ill.), to permit one house of a state legislature to be apportioned on the basis of geography and political subdivisions as well as on the basis of population. Rejected (two-thirds majority required) 57-39: R 29-3; D 28-36 (ND 10-33; SD 18-3), Aug. 4, 1965. With 96 Senators voting, 64 votes were needed for passage. The President did not take a position on the amendment.

	7	8	9	10	11	12
ALABAMA						
Hill	N	Y	N	Y	Y	Y
Sparkman	-	Y	N	Y	X	Y
ALASKA						
Bartlett	Y	‡	N	Y	N	Y
Gruening	Y	Y	N	Y	X	Y
ARIZONA						
Hayden	-	Y	N	Y	N	-
Fannin	N	Y	Y	N	Y	Y
ARKANSAS						
Fulbright	Y	?	?	✓	N	Y
McClellan	‡	Y	N	Y	✓	Y
CALIFORNIA						
Kuchel	N	Y	N	Y	Y	Y
Murphy	-	‡	Y	N	Y	Y
COLORADO						
Allott	Y	Y	Y	N	Y	Y
Dominick	N	‡	Y	N	Y	Y
CONNECTICUT						
Dodd	N	Y	N	Y	N	N
Ribicoff	N	Y	N	Y	N	N
DELAWARE						
Boggs	N	Y	N	Y	Y	N
Williams	Y	Y	Y	N	Y	Y
FLORIDA						
Holland	N	Y	Y	N	Y	Y
Smathers	N	Y	N	Y	X	Y
GEORGIA						
Russell	?	Y	N	‡	Y	Y
Talmadge	‡	Y	N	Y	✓	Y
HAWAII						
Inouye	N	Y	N	Y	N	N
Fong	-	‡	N	Y	Y	Y
IDAHO						
Church	Y	Y	N	Y	X	Y
Jordan	N	Y	Y	N	✓	Y
ILLINOIS						
Douglas	Y	Y	N	Y	N	N
Dirksen	N	Y	?	✓	Y	Y

	7	8	9	10	11	12
INDIANA						
Bayh	Y	Y	N	Y	N	N
Hartke	?	✓	N	Y	N	N
IOWA						
Hickenlooper	N	Y	Y	X	Y	Y
Miller	N	Y	Y	X	Y	Y
KANSAS						
Carlson	Y	‡	N	Y	Y	Y
Pearson	X	Y	Y	X	✓	Y
KENTUCKY						
Cooper	N	Y	N	Y	Y	Y
Morton	N	Y	Y	N	Y	Y
LOUISIANA						
Ellender	Y	✓	✓	X	N	Y
Long	Y	Y	X	Y	N	✓
MAINE						
Muskie	?	Y	N	Y	N	N
Smith	N	Y	N	Y	N	Y
MARYLAND						
Brewster	-	Y	N	Y	N	N
Tydings	N	Y	N	Y	N	N
MASSACHUSETTS						
Kennedy	Y	Y	N	Y	N	N
Saltonstall	Y	‡	X	Y	Y	Y
MICHIGAN						
Hart	Y	Y	N	Y	N	N
McNamara	N	Y	N	Y	N	N
MINNESOTA						
McCarthy	N	N	N	Y	X	X
Mondale	N	N	N	Y	N	N
MISSISSIPPI						
Eastland	N	✓	Y	N	Y	Y
Stennis	N	Y	Y	N	Y	Y
MISSOURI						
Long	?	?	N	Y	N	N
Symington	Y	Y	X	✓	Y	✓
MONTANA						
Mansfield	N	✓	N	✓	X	Y
Metcalf	N	Y	N	Y	N	Y

	7	8	9	10	11	12
NEBRASKA						
Curtis	✓	Y	Y	N	Y	Y
Hruska	Y	✓	✓	X	Y	Y
NEVADA						
Bible	Y	‡	N	Y	Y	Y
Cannon	N	✓	N	Y	Y	Y
NEW HAMPSHIRE						
McIntyre	N	Y	N	Y	N	N
Cotton	Y	?	Y	Y	Y	Y
NEW JERSEY						
Williams	N	Y	N	Y	N	N
Case	N	Y	N	Y	N	N
NEW MEXICO						
Anderson	Y	X	N	Y	Y	N
Montoya	Y	X	N	Y	-	N
NEW YORK						
Kennedy	N	Y	N	Y	N	N
Javits	N	Y	N	Y	N	N
NORTH CAROLINA						
Ervin	Y	Y	Y	N	Y	Y
Jordan	N	‡	Y	Y	Y	Y
NORTH DAKOTA						
Burdick	Y	Y	N	Y	N	N
Young	N	Y	Y	N	Y	Y
OHIO						
Lausche	-	N	N	Y	Y	Y
Young	Y	Y	N	Y	N	N
OKLAHOMA						
Harris	X	Y	Y	N	N	Y
Monroney	N	Y	N	Y	N	Y
OREGON						
Morse	Y	‡	N	Y	N	N
Neuberger	‡	‡	-	Y	N	N
PENNSYLVANIA						
Clark	Y	Y	N	Y	N	N
Scott	N	Y	N	Y	N	Y
RHODE ISLAND						
Pastore	N	Y	N	Y	N	N
Pell	Y	Y	N	Y	N	N

Y Record Vote For (yea)
✓ Paired For.
‡ Announced For, CQ Poll For.
N Record Vote Against (nay)
X Paired Against
- Announced Against, CQ Poll Against.
? Absent, General Pair, "Present," Did not announce or answer Poll.

	7	8	9	10	11	12
SOUTH CAROLINA						
Russell	N	Y	Y	Y	Y	Y
Thurmond	N	Y	Y	N	Y	Y
SOUTH DAKOTA						
McGovern	Y	Y	N	Y	N	N
Mundt	N	Y	Y	N	Y	Y
TENNESSEE						
Bass	?	Y	N	Y	N	N
Gore	Y	N	N	Y	Y	N
TEXAS						
Yarborough	Y	Y	N	Y	N	N
Tower	N	N	Y	N	Y	Y
UTAH						
Moss	Y	Y	N	Y	N	Y
Bennett	Y	‡	Y	N	Y	Y
VERMONT						
Aiken	Y	‡	N	Y	N	Y
Prouty	Y	Y	N	Y	✓	Y
VIRGINIA						
Byrd	✓	‡	✓	N	✓	Y
Robertson	Y	Y	Y	N	Y	Y
WASHINGTON						
Jackson	N	Y	N	Y	N	N
Magnuson	-	X	N	Y	N	N
WEST VIRGINIA						
Byrd	N	Y	N	Y	Y	Y
Randolph	Y	‡	N	Y	N	N
WISCONSIN						
Nelson	Y	Y	N	Y	N	N
Proxmire	Y	Y	N	Y	N	N
WYOMING						
McGee	N	Y	-	✓	N	N
Simpson	Y	‡	Y	N	Y	Y

Democrats in this type; *Republicans in italics*

Politics of Medicare
Ted Marmor

Congressional
NY Times Index Medicine-U States
NEOB Old NY Times 1930+

PASSAGE OF MEDICARE

H.R. 6675 passed House Ways and Means Committee on March 29, 1965 Vote 11 - 8; all Democrats supporting and all Republicans (Battin, Betts, Broyhill, Byrnes, Collier, Curtis, Schneebeli, and Utt) opposing.

On floor, bill passed by a vote of 313-115; only one Republican changed his vote - Schneebeli.

Conference Report #682 filed July 26, 1965; floor action July 27, 1965; Rollcall vote 203 - yeas 307; nays 116; not voting 11. On the final passage, 3 Republicans from Ways and Means voted yea - Broyhill, Byrnes, and Schneebeli.

H.R. 6675 passed the Senate Finance Committee on June 30, 1965 11 D / 6 R (Bennett, Carlson, Curtis, Morton, Dirksen, Williams); On floor, bill passed by vote of 68-21; 11 not voting. Only 1 Republican switched votes - Carlson; note: Dirksen did not vote.

committee composition on they don't have the committee vote

On passage of the Conference Report floor action July 28, 1965; Rollcall vote 201 - yeas 70; nays 24; not voting 6. There were no cross over votes, however, Curtis and Dirksen did not vote.

Date of enactment July 30, 1965; P.L. 89-97.

PASSAGE OF SOCIAL SECURITY

H.R. 7260 passed House Ways and Means Committee on April 5, 1935 (House report #615)

Passed House on April 15, 1935

Conference report final action August 8, 1935 by voice

H.R. 7260 passed Senate Finance Committee, May 13, 1935 (Senate report #628)

Conference report August 12, 1935; voice

Date of enactment August 14, 1935; P.L. 74-271.

use bullets

(2)

THE COST OF SUBSTANCE ABUSE TO AMERICA'S HEALTH CARE SYSTEM } Bold.

The Center on Addiction and Substance Abuse (CASA), located at Columbia University, has published a report on the cost of substance abuse to America's healthcare system. ~~This study was conducted under the direction of Jeffery Merrill, Vice President for Policy and Research and a professor at Columbia University School of Public Health, and Kimberly Fox, senior program manager.~~ In this report CASA reveals that Medicaid and Medicare inpatient hospital costs attributed to substance abuse produces a large toll on their budgets. The goals of CASA, as outlined in this study are to:

1. identify the cost of substance abuse,

2. inform the American people of those costs and the impact of substance abuse on their lives,

3. find out what works in prevention and treatment,

4. encourage all individuals and institutions to take responsibility to deal with substance abuse.

~~The~~ Cost implications to Medicaid } all caps / bold.

~~The~~ CASA study was completed in two phases. The first phase primarily concentrates Medicaid costs. Through this study CASA found that:

1. two-thirds of the costs of substance abuse to Medicaid were related to short-term health problems ~~where the impact on health can be seen almost immediately~~,

2. for ~~diseases and~~ health conditions such as cancer, stroke, heart disease, AIDS, trauma, and birth complications, substance abuse ~~has been documented to be~~ is a major risk factor,

3. medicaid patients with a secondary diagnosis of substance abuse stayed twice as long as Medicaid patients not diagnosed with substance abuse,

4. in 1991, ~~one in five dollars was spent in the Medicaid program for substance abuse-related conditions~~ cost medicaid 1 in 5 } cost medicaid 20% of their ~~money~~ budget

5. in 1994, one in five hospital days under Medicaid ($7.4 billion of Medicaid hospital costs) could be linked with the use or abuse of alcohol, tobacco or drugs.

substance abuse related cases cost medicaid ~~by~~ 7.4 billion dollars

Concern is over all

CASA looked at Medicare costs in the second phase of their study and compared their findings with Medicaid costs. Through their study of Medicare costs, they found that:

1. substance abuse-related cases cost more to treat than cases unrelated to substance abuse,

2. treatment is more expensive because substance abuse-related cases require almost 26% more hospital staff and other resources than Medicare discharges that are unrelated to substance abuse,

3. more than sixty conditions are associated with substance abuse covering virtually every major disease category:
   -- over 50% cardiovascular diseases
   -- 15% for respiratory diseases
   -- 12% for neoplasms
   -- 7% for burns and trauma

4. Medicare patients with a secondary diagnosis of substance abuse stayed on average 1/2 day longer than Medicare patients not diagnosed with substance abuse and up to twice the time of non-substance abuse patients,

5. in 1991: a. complications resulting from a secondary diagnosis of substance abuse accounted for $108 million in added cost to Medicare.

b. more than 80% of substance abuse-related Medicare hospital costs was for treating smoke-related medical conditions,

c. for certain diseases (such as malignant neoplastic disease) some scientific evidence suggests that once smokers have reached a certain threshold of smoking (more than 10 cigarettes per day for more than 35 years), their relative risk is not diminished by cessation,

d. in 1991, 2.2 million tobacco, alcohol, or drug-related Medicare admissions accounted for 20% of all Medicare hospitalizations,

e. one out of every four dollars Medicare spent on inpatient hospital care are attributable to substance abuse,

f. 97% of Medicare inpatient substance abuse costs was for medical treatment of illnesses and conditions attributable to the abuse of alcohol, drugs, and tobacco,

g. the amount actually paid out by Medicare for substance abuse-related care accounted for 23% of the total Medicare payments for hospital care ($13 billion of its $57 billion,

6. in 1994 it is estimated that substance abuse-related Medicare hospital costs: %20 billion. These costs include substance abuse-related care for both elderly and disabled Medicare recipients (disabled comprising 12% of these costs),

7. over the next seven years, substance abuse will cost Medicare almost $170 billion.

8. over the next twenty years, substance abuse will cost the Medicare program one trillion dollars.

9. a ten percent reduction in the amount of substance abuse would save Medicare $100 billion over the next 20 years.

3

THE COST OF SUBSTANCE ABUSE TO AMERICA'S HEALTH CARE SYSTEM

The Center on Addiction and Substance Abuse (CASA) located at Columbia University, has published a report on the cost of substance abuse to America's healthcare system. In this report CASA reveals that Medicaid and Medicare inpatient hospital costs attributed to substance abuse produces a large toll on their budgets. The goals of CASA, as outlined in this study are to:

- identify the cost of substance abuse;
- inform the American people of those costs and the impact of substance abuse on their lives,
- find out what works in prevention and treatment,
- encourage all individuals and institutions to take responsibility to deal with substance abuse.

COST IMPLICATIONS TO MEDICAID

The CASA study was completed in two phases. The first phase concentrated on Medicaid costs, and CASA found that:

- two-thirds of the costs of substance abuse to Medicaid were related to short-term health problems,
- substance abuse has been documented to be a major risk factor in cancer, heart disease, AIDS, trauma, and birth complications,
- medicaid patients with a secondary diagnosis of substance abuse stayed twice as long as patients not diagnosed with substance abuse,
- in 1994, substance abuse-related conditions cost Medicaid 20% of its budget,
- in 1994, substance abuse-related conditions is predicted to cost Medicaid $7.4 billion.

COST IMPLICATIONS TO MEDICARE

CASA looked at Medicare costs in the second phase of their study and found that:

- substance abuse-related cases cost more to treat than non-substance abuse-related because they require nearly 26% more hospital staff and other resources.

- more than sixty conditions are associated with substance abuse:
  - over 50% cardiovascular diseases
  - 15% for respiratory diseases
  - 12% for neoplasms
  - 7% for burns and trauma

- Medicare patients with a secondary diagnosis of substance abuse stay 1/2 day to twice as long as non-substance abuse patients.

- In 1991:
  - complications resulting from a secondary diagnosis of substance abuse cost Medicare $108 million,
  - 97% of Medicare inpatient substance abuse costs were for treating conditions attributable to the abuse of alcohol, drugs, and tobacco,
  - treatment of smoke-related medical conditions formed more than 80% of substance abuse-related Medicare hospital costs,
  - scientific evidence suggests that smoking more than 10 cigarettes per day for more than 35 years may have an irreversible oncogenic effect which is not altered by quitting.
  - 2.2 million substance abuse-related Medicare admissions accounted for 20% of all Medicare hospitalizations,
  - one in four dollars Medicare spent on inpatient hospital care was attributable to substance abuse,
  - Medicare spent $13 billion of its $57 billion for substance abuse-related care,
  - estimated substance abuse-related Medicare hospital costs in 1994 is $20 billion,

- Substance abuse will cost Medicare almost $170 billion over the next seven years.
- Substance abuse will cost the Medicare program one trillion dollars over the next twenty years.
- A ten percent reduction in the amount of substance abuse would save Medicare $100 billion over the next 20 years.