At the end of this lecture you will:

1. Be familiar with the historical policy making process that led to the enactment of the Medicare and Medicaid legislation in the U.S. We will compare and contrast these programs with public programs in other countries. Be prepared to furnish this analysis in class for the country your group has chosen to study. This discussion will stress the social, political, and economic determinants of policy formation. Understanding of this process will help you gain an appreciation for the social, political and economic determinants of policy formation in the United States as well as other countries.

2. Understand the structure and funding of the Medicare and Medicaid programs.

3. Understand the background of the Canadian System.

4. Be familiar with the DRG payment system, including its advantages and disadvantages. This system is being adopted by countries around the world – from Eastern Europe to Singapore and Australia.

5. Have a framework for understanding the structure of the health care insurance system in the country you have chosen to study.

I. Medicare – Example of a National Program for the Elderly

A. History – recall our discussion from the first class session and think about whether or not there is a constitutional right to healthcare in the United States and the other countries on which we are focusing in class.

1883 - German national compulsory health insurance program

1911 - British national health insurance program

1912 - Progressive Party candidate Theodore Roosevelt endorses social insurance - including health insurance.

1916 - Congress holds hearings on health insurance. AMA recommends compulsory, state-run health insurance.

1917 - AMA House of Delegates passes a resolution stating principles to be followed in government insurance health plans.
1918 - California voters defeat a referendum that would have permitted the establishment of a state health insurance plan.

1919 - New York State Assembly defeats a health insurance bill previously approved by the state Senate.

1920 - AMA House of Delegates reverses its position, declaring itself in opposition to government health insurance.

1932 - American Federation of Labor endorses social insurance.

1934 - FDR appoints Committee on Economic Security to study reforms in social welfare - health insurance was not part of the Social Security program. Compare this development to the history of insurance - death and disability benefits were established before health insurance.

1935 - January - Committee on Economic Security sends a report to Congress endorsing the principle of compulsory health insurance. No recommendations were made for implementation.

February - An emergency session of the AMA House of Delegates was held to pass a resolution declaring: "unyielding opposition" to government health insurance.

July - Sen. Arthur Capper (R-Kansas) sponsors first health insurance bill introduced into Congress.

August - Social Security Act signed into law - without a health insurance provision.


1943 - FDR, in his state of the union address, calls for social insurance from "the cradle to the grave."

1944 - FDR calls for an "Economic Bill of Rights" that includes "the right to adequate medical care and the opportunity to achieve and enjoy good health."

1945-47 - Truman proposes a national medical insurance plan for all agencies financed by higher social security taxes. No action was taken by Congress on this proposal.

1948 - AMA launches its national education campaign against national health insurance. This campaign lasted to 1965.
1952 - Federal security administrator Oscar Ewing proposes enactment of health insurance for social security beneficiaries.

1954 - Eisenhower proposes a government reinsurance plan for the aged. Plan was defeated in the House and the Senate did not act on it.

1960 - August - Senate defeats a version of a bill originally proposed in 1957 by Rep. Forand (D-RI). Bill was co-sponsored by JFK. Instead, the Kerr-Mills Bill was passed. It called for a voluntary federal-state program of aid for medically indigent elderly persons. This bill was supported by organized medicine and was viewed as a means of liberalizing federal participation in state old-age assistance programs. By 1965, less than half of the states had set up such plans.

1961 - JFK backs a hospital insurance bill (variation of the Forand Bill) sponsored by Rep. Cecil King (D-Cal.) and Sen. Clinton Anderson (D-NM). AMA continues its opposition and forms the American Medical Political Action Committee (AMPAC), which is still in existence.

1962 - Senate rejects King-Anderson Bill when it is offered as an amendment to the public welfare law.

1963 - February - Slightly revised King-Anderson Bill reintroduced.

November - House Ways and Means Committee hearings interrupted by news of JFK’s assassination.

1964 - LBJ wins election by a landslide. He views these results as a mandate from the electorate. All parties are now willing to compromise.

1965 - July 30 - At Truman's home in Independence, Missouri, LBJ signed the Medicare/Medicaid legislation stating: "No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that have been so carefully put away."

*Parts of the above history were taken from "The Internist," March, 1985 and "Health Care Financing Review," 1985 Annual Supplement.*

1965 – 1988 Read the articles about the Medicare Program from the Kaiser Family Foundation and make sure you understand the general principles behind the operations as well as benefits and sources of payment for the Medicare Program.
1982 – Tax Equity and Fiscal Responsibility Act (TEFRA). This legislation had six major effects on the healthcare system.

1. In implementing the DRG system, it abolished the periodic interim payment method of paying hospitals. This method gave hospitals a steady cash flow, with reconciliations occurring quarterly. The DRG system forced hospitals to submit claims for services on an individual case basis, thus slowing collections.

2. Implementation of the DRG System also caused an increase in tension between physicians and hospitals in three areas. First, to maximize timely reimbursement, hospitals must make sure that physicians complete their charting accurately and promptly. Physicians, of course, have no economic incentive to do so. Physician billing is separate from hospital billing and, therefore, physician reimbursement does not depend upon prompt charting. A second area of conflict between hospitals and physicians deals with the opposing reimbursement incentives. Under the DRG System hospitals achieve maximum profitability from patients who have shorter stays with efficient resource utilization for their care. Physicians, on the other hand, get paid by the visit (usually daily charge) or by the level of technology which they bring to diagnosis and/or treatment of illness. While utilization review procedures have mitigated this conflict somewhat, these opposing incentives still remain. Third, a further source of conflict is potential malpractice suits. In some cases, physicians may order more services in order to cover themselves against possible future legal action. Such protection costs them nothing since the hospital pays the bill for these services from its DRG budget.

3. The TEFRA established the Medicare HMO enabling legislation.

4. Implementation of the DRG system led to reduced Medicare revenues for many hospitals. As a result, they increased charges to private payers in a process commonly called “cost shifting.” Since private insurance companies found themselves paying for higher hospital charges, they increased their premiums. In the face of these double digit increases, employer groups increasingly turned to self-insurance plans and/or purchased services from managed care companies.

5. The TEFRA required formation of two organizations to oversee, respectively, hospital and physician payment mechanisms and amounts. These organizations were the Physician Payment Review Commission (PPRC) and Prospective Payment Assessment Commission (ProPac). The Balanced Budget Act of
1997 merged these two groups into the Medicare Payment Assessment Commission (MEDPAC).

6. Prior to the TEFRA, professional standard review organizations (PSROs) were responsible for the oversight of the quality and appropriateness of care in hospitals. The TEFRA changed these organizations to Peer Review Organizations (PROs) that have the same broad mandates. They are independently contracted companies often closely aligned with medical societies.


This Act expanded coverage for Medicare recipients but was a major departure from the traditional program, since premiums were to be income-based. Coverage for long-term care was not included in this legislation. Of additional current interest is that a provision of the Act called for implementation of coverage for out-patient prescription drugs, similar to what was part of the Clinton proposal and is currently being discussed. A great debate ensued about this provision since no one had a clear idea of what it would cost. A national formulary was even proposed to limit potential cost overruns. Congress repealed the Act because of political pressure from the elderly - they wanted more benefits but apparently did not want to pay for them.

1996 influencing all insurance payers, providers and suppliers. We will discuss this topic with the information technology lecture.

1997 Balanced Budget Act (BBA)

The provisions of this act are extremely extensive and detailed. You can access the full text on the worldwide web from the Centers for Medicare and Medicaid Services (CMS – formerly HCFA) home page. One of the significant changes mandated by the BBA was the creation of an out-patient prospective payment system (APCs). This payment method became operational August 1, 2000. We will discuss some key features of this system in class. It has profound implications not only for hospitals but also pharmaceutical and medical equipment companies.

2003 Medicare Prescription Drug Improvement and Modernization Act (MMA)

The provision of this law that has received the most attention deals with prescription drugs. See the “Medicare at a Glance” article for an explanation of how this benefit works.
B. How the Plan Works

1. Sources and Uses of Funds

2. Concept of Fiscal Intermediary or Carrier

   Instead of directly administering the Medicare plan, the federal government contracts with local entities to do so. These entities are most often Blue Cross plans, but traditional insurance companies, or data systems companies have also been awarded contracts. It is important to note that while federal guidelines for Medicare benefits are usually clear, in many cases the local agency has discretion over how these benefits are administered.

II Canadian Medicare – Example of National Insurance for All

A. History
B. Unique Features
C. Founding Principles

III. Medicaid – Example of a National Program for the Poor

   This program is the U.S. Federal initiative for the poor as well as aged, blind, and disabled. In order to prepare for this discussion, read the Executive Summary and Summary of Findings from the *Kaiser Commission on Medicaid and the Uninsured*. Make sure you understand some major points about eligibility as well as covered populations and where the money is spent. An interesting ongoing experiment has been the Medicaid program in the State of Oregon. Read the article by Bodenheimer and skim the table that follows it in order to get an idea of where the program originated and its current status.

   Read the article by Maarse and Paulus

   Make sure that you understand the framework they are using for comparison of social health insurance reform across the four countries studied. This type of analysis is very important when deciding about a country’s health policy (essentially the mission statement for its healthcare system).