



## **The AMA and Medicare and Medicaid, 1965**

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There are several historical links between Medicare and Medicaid and the American Medical Association (AMA). The following is a brief essay on these links.

### *Background*

Although the AMA vehemently opposed the passing of the Hospital Insurance, Social Security, and Public Assistance Amendments to the Social Security Act that would become the Medicare and Medicaid programs in 1965, the AMA has never been opposed to the basic notion that health care is a right. As early as 1934, the AMA Judicial Council affirmed that, "One of the strongest holds of the profession on public approbation and support has been the age-old professional ideal of medical service to all, whether able to pay or not. The ideal is basic in our ethics." (HOD Proceedings, June 11-15, 1934: 29)

In fact, during the long and highly contentious debates over the role of government in the financing and administration of health care, and over Medicare in particular, "Neither side argued that the aged had no right to decent medical care; ever since the 1930's, medical care had been accepted as one of the basic necessities of life which, as a last resort, society itself must provide. And if the aged were unable to pay for their medical care, it was the responsibility of society somehow to finance it.

"The argument, then, centered on two issues: (1) Whether or not the aged, or a substantial number of them, did in fact need help with their medical bills; and (2) if they did, what mechanism should be employed to cope with the problem. As the debate progressed, the first point came to be accepted as true, although there continued to be differences over the seriousness of the problem. At the end the unresolved conflict was over *means*. Three basic alternative approaches were considered—either separately or in combination: (1) some form of Government subsidies for private insurance carriers as in ... the AMA's Eldercare; (2) direct Government payments for medical services to low-income elderly through State welfare agencies as in the ... Kerr-Mills programs; and (3) health insurance financed and administered through social security.

"Each of these alternatives, along with their various administrative and technical features, had important social, economic, and political implications that influenced the preferences of the opposing sides. And, in the end, the issue could only be resolved through the political process. It was finally resolved in favor of social security (Medicare) supplemented by an expanded Kerr-Mills program of direct payments for health services to the elderly and other poor (Medicaid)." (Corning)

### **The Jeffersonian-Hamiltonian Debate and US Public Policy**

The conflict over the proper role of government in health care—which was a centerpiece in debates over Medicare—reflects, more generally, a debate that has been raging on in the

US at least since the American Revolution. Today, historians often refer to this as the Jeffersonian-Hamiltonian debate, named after the most prominent proponents of either side—Thomas Jefferson (the US's 3rd President) and Alexander Hamilton (the US's 1st Secretary of the Treasury).

The core principle of the Jeffersonian perspective is "individual liberty," for it sees "the American Revolution as a liberation movement, a clean break not just from English domination but also from the historic corruptions of European monarchy and aristocracy.... It has radical and, in modern terms, libertarian implications, because it regards any accommodation of personal freedom to governmental discipline as dangerous. In its more extreme forms it is a recipe for anarchy, and its attitude toward any energetic expression of centralized political power can assume paranoid proportions." (Ellis 13-14)

The core principle of the Hamiltonian perspective is "collectivist rather than individualistic, for it sees the true spirit of [1776] as the virtuous surrender of personal, state, and sectional interests to the larger purposes of American nationhood.... It has conservative but also protosocialistic implications, because it does not regard the individual as the sovereign unit in the political equation and is more comfortable with governmental discipline as a focusing and channeling device for national development. In its more extreme forms it relegates personal rights and liberties to the higher authority of the state, which is 'us' and not 'them,' and it therefore has both communal and despotic implications." (Ellis 14)

These diverging visions of democracy, although at times antagonistic, were not necessarily mutually exclusive. Several politicians, even vocal proponents of one or the other faction, held conflicting values, and several lent their votes and energies to issues that seemingly bridged this ideological divide. However, this is not to say that opposing members of Congress—the founders of the US included—did not disagree heatedly and harbor a considerable amount of bitterness and resentment towards each other. Both sides of this story are, indeed, true.

What historians poignantly remind us, though, is that this debate was never resolved. Rather, it was "institutionalized" into the very fabric of the US's various sociopolitical institutions (Ellis 15). For example, the US has a representative democracy (reflective of Jeffersonian notions of "popular sovereignty") but, at the same time, maintains a fairly strong nation state (including a national debt, a federal Supreme Court, and a national army).

Generally speaking, since the American Revolution, the Jeffersonian-Hamiltonian dyad has remained a perennial feature of the US's political character—at times conflicting with each other and at times complementing each other. "On balance, though, the individualistic strain has been relatively stronger in this country than elsewhere, especially in the field of social welfare, where Americans of all classes have characteristically looked-upon Government as a 'last resort'" (Corning).

It was in this context that government-financed health insurance was first proposed.

### **Early Proposals for Government-Financed Health Insurance**

*American Association for Labor Legislation's Proposals*

One of the US's first proposals for government-financed health insurance came in the early twentieth century. In 1915, the American Association for Labor Legislation—an activist group comprising economists, physicians, lawyers, businessmen, professors, and social workers, among others—began publishing “a ‘standard’ health insurance bill, drafted into legislative language for the consideration of various State lawmakers. This ‘model bill,’ calling for the protection of all low-income workers and providing for cash compensation as well as broad hospital and medical benefits to both workers and their dependents, then became the focal point of the ensuing public debate.” (Corning)

Initially, AMA leadership expressed support for such legislation. And at the AMA annual meeting in 1917, a Committee on Social Insurance outlined “fundamental principles in the consideration of any insurance laws in relation to the medical profession”; namely, “that such legislation shall provide for freedom of choice of physician by the insured; payment of the physician in proportion to the amount of work done; the separation of the functions of medical official supervision from the function of daily care of the sick, and adequate representation of the medical profession on the appropriate administrative bodies.” (HOD Proceedings, June 4-7, 1917: 44-45)

“Despite a favorable attitude on the part of the AMA leadership and early signs that the group might eventually extend its official support, grass-roots sentiment within the medical profession turned increasingly against the proposal as time went on. A number of State medical societies came out against it and, by 1920, the AMA’s leadership (symbolized by Association President Dr. Alexander Lambert) was formally repudiated when the AMA’s House of Delegates passed a resolution expressing unequivocal opposition to the idea.” (Corning)

*“Resolved, That the American Medical Association declares its opposition to the Institution of any scheme embodying a system of compulsory contributory insurance against illness, or any other scheme, which provides for medical service to be rendered contributors or others, provided, controlled or regulated by any State or the Federal Government.”* (HOD Proceedings, April 26-30, 1920: 37)

Indeed, the position of the AMA House of Delegates reflected the prevailing national sentiment; by 1920, the American Association for Labor Legislation had admitted defeat. The AMA maintained its position on compulsory government-sponsored health insurance for decades to come, weighing in against such proposals as the President Truman-backed Wagner-Murray-Dingell bill (S. 1606), which would have established a compulsory national health insurance program financed under Social Security (the bill was defeated in Congress on numerous occasions).

#### *Taft-Smith-Ball Bill*

In 1946, the year the AMA-supported Hill-Burton Hospital Survey and Construction Act was passed, Senator Robert A. Taft of Ohio introduced the “Taft-Smith-Ball bill (S. 2143), authorizing some \$200 million in Federal matching grants to the States to subsidize [voluntary] private health insurance coverage for the medically indigent, [which] was favorably received (unofficially) by the American Medical Association.” (Corning)

No action was taken on the bill in Congress.

## **AMA Position on Government-Sponsored Health Care**

At its core, the AMA's opposition to government encroachment into health care was rooted in a strongly Jeffersonian value system—one that greatly esteemed individual freedom and viewed government involvement in what it believed to be private affairs as generally unnecessary, unwelcome, and, only if deemed necessary, as a last resort. The following statement is a useful summary of the AMA's position:

"Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and then only in conjunction with the other levels of government, in the above order. The determination of medical need should be made by a physician and the determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved. The use of tax funds under the above conditions to pay for such care whether through the purchase of health insurance or by direct payment, provided local option is assured, is inherent in this concept and is not inconsistent with previous actions of the House of Delegates of the American Medical Association." (HOD Proceedings, June 13-17, 1960: 89)

## **Medicare and Medicaid**

The amendments to the Social Security Act in 1965 that became the Medicare and Medicaid programs were, more or less, an amalgamation of four separate pieces of legislation—namely, the King-Anderson bill, the Kerr-Mills bill, the Byrnes bill, and the Eldercare bill. Nevertheless, much of the early debate over the government's role in health care for the elderly focused on the fate of the King-Anderson bill in Congress.

### *The King-Anderson Bill*

The Health Insurance Benefits Act of 1961 (H.R. 4222 and S. 909), more commonly known as the King-Anderson bill, was originally introduced into the House of Representatives by Rep. Cecil R. King (D-California) in February of 1961.

"This bill would amend the Social Security Law by adding a new title under which inpatient hospital services, skilled nursing home services, home health services, and outpatient hospital diagnostic services would be provided to any individual over age 65 who is entitled to monthly insurance benefits under the Social Security Law or under the Railroad Retirement Act.... Services would be provided only by written request filed by the individual, unless impractical, and only if certified in writing by a physician that the services are medically necessary.... The individual would have the right to have payment made to any provider of authorized services who has made an agreement under the bill and who agrees to provide the services.... Payment would be based on the 'reasonable cost' of services.... Payment would be made to the providers of services at such times as the Secretary of the Health, Education and Welfare deems appropriate." (These Are the Facts On)

Notably, "The bill has a prohibition against interference by any Federal official with the practice of medicine or in the selection, tenure or compensation of any provider of services or to exercise supervision or control over the operation of any provider of service, except as specifically provided." (These Are the Facts On)

### *AMA Objections to the King-Anderson Bill*

AMA President Leonard W. Larson and Edward R. Annis of Florida testified against the King-Anderson bill before the House Ways and Means Committee in August 1961. Here, AMA leaders laid out the organization's problems with the proposed legislation in a 91-page testimony. AMA representatives would make many more such testimonies. The AMA's objections are summarized below:

"They [the elderly] are oppressed with the feeling of not being wanted any longer, of not being useful, of not being important.... This is a sociological problem, and society is falling down on the job, not government....

"H.R. 4222 would lower the quality of medical care, for it would introduce into our system of freely practiced medicine the elements of compulsion, regulation, and control. A free system of medical care places emphasis on quality. But government-controlled medicine necessarily places its emphasis on the control of spending—with the consequent government domination of physicians and the purveyors of health services....

"the regulatory powers given the secretary of Health, Education and Welfare (HEW) constitute a blanket authorization for the Federal Government to control the providers of medical services. This control affects a patient's freedom of choice, not only of doctor but of hospital and nursing home. It also weakens the intimate doctor-patient relationship which is the basis of all good medical care....

"At least 3 mechanisms exist through which the aged can obtain the health care they require:

"1.—Voluntary health insurance and prepayment plans which now cover 132 million person; protect half of the elderly; and are expanding at such phenomenal rates that it is estimated by 1970 ninety per cent of those 65 and over will be covered.

"2.—Welfare programs, both public and private, including Old Age Assistance which is operative in every state in the Union.

"3.—The Kerr-Mills Medical Aid for the Aged Law...

"[T]he power to tax for purposes of Social Security could, if overused, destroy the system itself....

"To include a compulsory medical care plan for the aged in the Social Security mechanism departs radically from the 'floor of protection' principle upon which the Social Security Act was based....

"Legislation of H.R. 4222's ilk would curb community incentive to support hospitals, nursing homes, health campaigns and health centers; it would discourage freedom to experiment with new techniques ... [and usurp] the magnificent role played by our fraternal, civic, religious and philanthropic groups in the care of the aged....

"[The bill] would cover millions of people who neither need help in paying the costs of their health care nor want such help....

"the taxation burden ... would fall on the shoulders of younger working people at a time when they are incurring maximum expense in raising a family of their own....

"H.R. 4222 seeks to determine eligibility for medical aid on the basis of age rather than need. The [AMA] believes that those who need help should receive it—regardless of age....

"H.R. 4222 would destroy the concepts of individual and family responsibility. Independence and self-reliance have been traditional traits of Americans. We [AMA] are convinced that this is still true, and, accordingly we believe that personal health care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility properly passes to his family, then to the community, then to the state, and—when all these fail—to the federal government. It is now proposed that we reverse this chain of responsibility, giving the Federal government first priority and the individual last priority." (JAMA 177 (1961: 368-370)

#### *Dissenting Voices within the AMA*

Although the AMA's official statements reflected the views of the majority of physicians in the US and the AMA, it should be noted that several AMA members held divergent beliefs about the AMA's stance on the King-Anderson bill.

As Campion notes, "While the AMA may have presented a stone façade to the public, the physicians were not altogether of one mind. Many wished that the association's stand was not so uncompromisingly negative. Individual members, some county societies, and a few state associations informally submitted to the AMA hundreds of alternatives to King-Anderson." Several physicians, including Russell Roth, vice chairman of the AMA's Council on Medical Service in the early 1960s, also found fault with the AMA's alternative to the King-Anderson bill; namely, the Kerr-Mills bill (Campion 269).

#### *The Kerr-Mills Bill*

As an alternative to the King-Anderson bill, the AMA supported the expansion of the 1960 Kerr-Mills Law, which was sponsored by Rep. Wilbur Mills, D-Arkansas, the chair of the House Ways and Means Committee, and Sen. Robert Kerr, D-Oklahoma.

"Kerr-Mills authorized federal matching funds to support state administered programs to serve the needs of elderly people who were medically indigent, that is, those not so poor as to be welfare cases but not so well provided for that they could finance their own care. Its functioning demanded a determination by the states of an applicant's financial status (a means test). Medical Assistance for the Aged, as the operating program was called, reflected the AMA's traditional position: government assistance to those below certain income levels and the use of private resources for the self-supporting part of the population.

"Initially, when Mills first started to develop the legislation in 1959, the AMA wrote him urging caution and further study. But as the bill progressed through a tangle process of compromise and revision to eventual enactment, the AMA supported it." (Campion 257)

### *The Eldercare Bill*

In response to public criticism that “physicians had no positive program to offer instead of the King-Anderson proposal that they found so repugnant,” the AMA set up a series of meetings in late 1964 to discuss a formal proposal for expanding health coverage to the elderly (Campion 269, 273). What came out of these meetings was Eldercare.

“The Eldercare proposal was a plan of comprehensive health care for the elderly needy. A simple declaration of income (not assets) determined eligibility. Federal matching grants and state funds underwrote advances, which varied with income, for the elderly needy to purchase private health insurance. Those least in need received little or nothing toward the purchase of a private health insurance policy; those with the lowest incomes, in effect, received a paid-up policy. The federal outlays were to come from general revenues, not social security, and would be used to match state funding. The states would administer the program.” (Campion 273)

Endorsed by the AMA House of Delegates in February 1965, Eldercare (HR 3227 and HR 3728) was introduced into the House of Representatives by two Ways and Means Committee members, A. S. Herlong, Jr. of Florida and Thomas B. Curtis of Missouri. (Corning)

### *The Byrnes Bill*

In contrast to the largely Democrat-backed King-Anderson bill, Republicans in Congress lent their general support to the Byrnes bill. “The bill was submitted by Congressman Thomas W. Byrnes of Wisconsin. Like Eldercare, it called for coverage of hospital *and* physician services for the aged through the purchase of private insurance. Administration, however, was to be federal. Financing was to come two-thirds from general revenues and one third from deductions on the individual pension checks of those who voluntarily chose to participate in the program.” (Campion 274)

### *Passing of Medicare and Medicaid*

In the end, Wilbur Mills, chair of the House Ways and Means Committee, in March 1965 “proposed not a choice among the proposals but an amalgamation” of the essential features of the four major proposals: the King-Anderson bill, the Kerr-Mills bill, the Byrnes bill, and the Eldercare bill—what Mills referred to as “a three-layer cake.”

“Layer one, Medicare Part A, was very close to King-Anderson. It included hospital care for Social Security retirees, financed and administered by Social Security. Layer two, Medicare Part B, came out of the Byrnes bill—a supplemental, voluntary insurance plan covering physician services. It called for financing by uniform premiums from those beneficiaries who elected to participate and a matching contribution from general revenues.

“Layer three, Medicaid, grew out of the Eldercare bill, Kerr-Mills, and the AMA’s concern for the non-elderly needy.... Medicaid liberalized the eligibility requirements of Kerr-Mills and widened it to cover indigent people under sixty-five. It relied on matching federal-state funds and state administration, and permitted the use of private insurance carriers.” (Campion 275)

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