

MEDICAID: ANATOMY OF A DILEMMA*

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The Medicaid program—title XIX of the Social Security Act—was passed amid great hope on the part of the liberals as the so-called “sleeping” of the Social Security Act of 1965. The optimistic saw Medicare (title XVIII) as a step towards a Swedish form of social insurance and title XIX as a step towards something like the British National Health Service. They could not have been more wrong. While title XVIII has achieved general acceptance, title XIX has lived up to almost none of the expectations of its proponents; it has served only to confirm many of the doubts about government programs of medical care on the part of professional critics and fiscal conservatives.

One of the great attractions of the United States to those who have studied other developed societies is the reluctance of American reformers to be daunted by disaster. If one solution has failed, then their urge is to try another—preferably pouring in still more money. Yet this willingness to try ever newer innovations is coupled with a surprising reluctance to analyze the failure of earlier schemes. Evaluations of existing or earlier programs have far less attraction than some new program, with the prospect of yet more demonstration projects. Of all western societies, the United States is the most ahistorical. Thus today, the medical care establishment, or at least its reformist wing, is in hot pursuit of health insurance; and that may well be an admirable goal. But it may also be that blind adherence to the goal of insurance, without an evaluation of the mistakes of Medicaid, will head its proponents squarely into the same road-blocks which proved the undoing of the earlier program.

It is still too early to pass final judgment on all aspects of Medicaid. Indeed,

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it may be premature to make final judgments on any of its aspects, since so little work has been undertaken¹ even in relatively narrow areas—in terms of economic, sociological, and political studies. Methodologically reliable studies of the quality of care or the impact of Medicaid on providers have yet to appear.² Even policy studies on the implementation of title XIX are as yet unpublished.³ We have therefore been driven both to rely on information which is not as reliable as we would have liked, and on other occasions to delve more deeply into detail than we would have wished had an adequate literature on Medicaid existed. Bearing these reservations in mind, however, there are certain basic questions which must be asked and hypotheses and theories which may be offered.

How did it come to pass that, in five brief years between 1965 and 1970, title XIX grew astronomically in its financial demands (it was originally projected to cost the federal government \$.7 billion annually and by 1970 was in fact costing Washington \$2.8 billion—with a total estimated annual cost from all governmental sources of some \$5.5 billion) and yet failed to satisfy the persons it was supposed to serve as well as the hopes of its supporters?

The answers are vital, and we suggest that they include these: Medicaid was built on a program—Kerr-Mills—which was itself a failure; the structure of the program ensured that it would never be able to escape the debilitating effect of its welfare parentage; the concept of “medical indigency” was (and is) meaningless; the administration of the program was a failure at every level; and finally one can posit the proposition that there can be no breakthroughs in the delivery of medical care until there is reform and restructuring among the providers of medical care.

While the details of these assertions will have to emerge in this paper, at least some of the issues raised have to be aired at this stage. The “Kerr-Mills parentage” and the “Welfare Stigma” are inevitably related, and are based on twin assumptions. The first is that adequate medical care is unlikely to be available for the poorer groups in society unless it is provided as an integral part of a nationwide system of health care. The second assumption is that the historical baggage of the welfare system, and especially the means test, insured that the stigma of welfare would attach to Medicaid and that the idea of “pauperization” would inevitably be attached to the program’s image. If the American public schools were available only on a means-test basis they would no doubt soon be used only by those on or near welfare, their standards would fall, and efforts to raise those standards would

¹ This may explain why the literature on Medicaid is so sparse. The best—and only—bibliography is E. FEINGOLD, *REFERENCES TO BACKGROUND MATERIALS ON MEDICAID* (1969). For a related collection of materials, see NATIONAL INSTITUTE FOR EDUCATION IN LAW AND POVERTY, *MATERIALS ON HEALTH LAW* (Northwestern University, 1970).

² Such studies, funded by the federal government, are currently being undertaken at Columbia University and the University of Pittsburgh.

³ Such a study is currently being undertaken by the Brookings Institution, under the editorship of Professor Eugene Feingold.

doubtless meet many of the same political problems encountered in Medicaid. Services tied to the means-test image of cash payments have a built-in failure factor.

The inappropriateness of a welfare-means-test approach is not only particularly noticeable in a program of services but is also economically unrealistic in connection with the provision of medical services. "Medical indigency" is a more meaningless concept than "poverty" itself, if only because the breakthroughs and potential of modern medicine make it possible for virtually any American to be "medically indigent." A heart transplant could be paid for by very few Americans out of their own assets. What has happened is that perhaps half the nation, basically that half in middle-class employment or with membership in a strong trade union, is spared the fear of medical indigency because of the intervention of health insurance. Thus, the concept of "medical indigency" is economically deceptive. What a significant percentage of the American population is suffering from is a "health insurance indigency," and this perhaps might be better remedied through making health insurance more readily available rather than attempting to extend concepts of public welfare, which have been under increasingly heavy attacks for the past few years.

Finally, it will be suggested that Medicaid failed because of inadequate administration. In terms of the federal bureaucracy, its supervision was assigned to a division with insufficient prestige and resources either to administer or to police, or in some ways even to advise, the program. In terms of the states, administration was equally unsatisfactory, for rather similar political reasons, although at a somewhat lower administrative level. Both these administrative weaknesses, coupled with Congressional unwillingness to come face to face with the powerful medical lobbies, meant that the traditional medical monopolies, privileges, and forms of practice were left totally untouched. The economic advantage of the providers over the purchasers, coupled with the inadequate administrative safeguards, virtually assured that the Medicaid program would be plagued by a series of financial crises.

In an attempt to test these assumptions, we shall look first at the pre-Medicaid history of public medical care, second at the passage and implementation of the program, third at the financial pressures on and from Medicaid, and finally at the administrators, providers, and recipients. A brief conclusion attempts to emphasize the positive aspects of Medicaid which might be relevant for future programs.

I

THE COMING OF MEDICAID

A. 1935 and All That

The provision of medical care to the poor has for long been a recognized part of the American system of public relief. Early arrangements were made on an ad hoc, decentralized, local, and often erratic basis, following the patterns of cash relief in the towns, counties, and states. With the introduction of federal grants-in-aid

under the Social Security Act of 1935⁴ for population groups who were at that time most urgently in financial need, came old-age assistance (OAA), aid to the blind (AB), and aid to dependent children (now aid to families with dependent children, AFDC).⁵ A fourth categorical cash assistance program, aid to the permanently and totally disabled (APTD), was added in 1950. These joined the earlier programs of general assistance by the states or local government units, and in large part supplanted them, although joining in categorical programs remained voluntary for the states. Thus, between 1940 and 1966 the number of individuals receiving cash payments under general assistance declined from four million to less than 600,000, while the number receiving categorical assistance rose from three million to over seven million persons.⁶

Federal-state grants for certain medical services were made available as separate programs under the 1935 legislation, most notably for maternal and child health services and for services to crippled children, all service programs provided by the states and not directly related to welfare programs. No separate provisions were made, however, for health services in the federal matching grants for categorical assistance programs; the federal sharing applied only to payments made directly to welfare recipients and not to physicians, nurses, or hospitals. In some areas, notably California and the City of New York, as a matter of policy, health services at low cost for the indigent were provided in public hospitals and clinics. But in general the provision of health services for the poor remained, at best, a subsidiary part of cash benefit programs and a neglected area of state and local welfare responsibilities, until the establishment of a federally-supported program of vendor payments for medical care in 1950.

If Congress or the states had enacted a comprehensive system of health insurance or service for the whole or a substantial sector of the population, health services and income maintenance programs would have been long ago divorced in the United States, as they are in the United Kingdom and many other western European countries. Health services would have been made available to the poor and to other beneficiaries as an entitlement (similar to education in the public school system) quite apart from programs of cash assistance and other supporting services. But the early movements for health insurance failed; first in the period 1915-20, when state health

⁴ Ch. 531, 49 Stat. 620.

⁵ The Social Security Act provided the umbrella legislation for an array of federally-supported programs. These included both contributory, work-related programs of social insurance (programs financed through Social Security contributions with benefits by entitlement) and programs of public assistance in which there are no contributions and in which eligibility is determined by a means test. It may be noted that much of the subsequent debate over the federal role in paying for health services hinged on the inclusion of both principles under the same legislation; arguments were polarized in favor of health insurance as a right through a contributory social insurance system, or in favor of health services to the poor through public assistance. For the early background of the categorical programs, see R. LUBOVE, *THE STRUGGLE FOR SOCIAL SECURITY 1900-1935* (1968).

⁶ U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE, *SOCIAL SECURITY PROGRAMS IN THE UNITED STATES* 14 (1968).

insurance plans were actively discussed; then in the rejection of health insurance as an integral program within the 1935 Social Security Act; and again in a continuing but unsuccessful push for national health insurance legislation which reached its zenith in the years 1945 to 1949.⁷ Lacking a separate administrative structure for the provision of health services, the poor continued to be dependent on haphazard and unequal medical care, which varied from place to place and from state to state.

The Social Security Act Amendments of 1950,⁸ however, were designed to reverse, at least somewhat, the formal federal unconcern with medical care. Under these amendments, the federal government agreed to share with the states the cost of direct payments to those physicians, hospitals, and the like who provided medical care to persons on public assistance. With the availability of these federal grants-in-aid for vendor payments the states began providing medical services on a much larger scale. By 1960, vendor payments under all public assistance programs had reached a total of \$514 million, well over half of which was for hospital and nursing home care.⁹ These payments were still, however, limited to persons on the existing welfare rolls, for almost all of whom the states were also recovering part of their cash benefits from the federal government through one of the categorical assistance programs.¹⁰

Concern over the plight of the elderly during the 1950s eventually focused Congressional attention on the medical needs of that increasingly articulate, numerous, and socially dependent group. By 1960, there were 16.5 million people sixty-five years of age and over, representing 15.4 per cent of the population twenty-one years and over.¹¹ This sizeable proportion of potential voters could not be ignored politically, and Congress became increasingly concerned about improving medical services for the aged. In the face of the substantial and well-funded opposition from the AMA and other groups, the movement for national health insurance for all had been dropped. It was replaced in 1950 by a demand for the more limited goals of hospital insurance benefits for the aged, available to all those eligible for Social Security retirement benefits. Health Insurance for the Aged, the forerunner of hospital benefits under Medicare, appeared forcefully in 1957 under the sponsorship of Senator

⁷ See ROBERT STEVENS, *STATUTORY HISTORY OF THE UNITED STATES: INCOME SECURITY* 275-89, 401-36 (1970) [hereinafter cited as *STATUTORY HISTORY OF THE UNITED STATES*]; ROSEMARY STEVENS, *AMERICAN MEDICINE AND THE PUBLIC INTEREST* ch. 13 and *passim* (forthcoming 1971).

⁸ Ch. 809, 64 Stat. 477.

⁹ U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE, *MEDICAL RESOURCES AVAILABLE TO MEET THE NEEDS OF PUBLIC ASSISTANCE RECIPIENTS*, H.R. REP. NO. 1799, 87th Cong., 1st Sess. 31 and *passim* (1961) [hereinafter cited as *MEDICAL RESOURCES*].

¹⁰ Since these payments had to be within the existing maxima on federal sharing, which was at that time on an individual case basis, federal financial participation was limited. In 1956 an amendment was adopted which provided for separate matching for vendor medical payments with the maximum based on the monthly average payment per recipient. Federal matching for vendor medical payments and cash payments was recombined in 1958, and the averaging formula basis was retained.

¹¹ STAFF OF SPECIAL SENATE COMM. ON AGING, 87TH CONG., 1ST SESS., *NEW POPULATION FACTS ON OLDER AMERICANS*, 1960, at 10 (Comm. Print 1961).

Aimé Forand. Others were meanwhile pressing for expanded medical care through the categorical forms of public assistance.

By 1960 health insurance for the aged had become a major political issue.¹² In part this was a reflection of the inadequate services made available under public assistance vendor payments to the two million persons on old-age assistance.¹³ In part it was a reflection of inadequate levels of retirement benefits under Social Security. But above all was the impelling factor of the rapidly rising costs of medical care, which, especially as far as the elderly were concerned, were pricing vital health services out of reach. The average annual medical bill per OAA recipient in the relatively generous scheme in New York in 1960 was \$700.¹⁴ This was not only higher than the cash benefits provided to the elderly in that state even as an average, but it was appreciably more than many of those not on public assistance could afford for medical services. Persons sixty-five and over were reportedly twice as likely as other members of the population to need medical care, and at the same time held significantly less private health insurance (and because of their high medical risk were unable to buy health insurance at prices they could afford).¹⁵ These and other problems besetting the elderly were emphasized in House and Senate hearings on the Forand bill in 1960.¹⁶ The health insurance principle was again vigorously opposed, but at least there was a willingness to upgrade medical benefits under the welfare system.

In 1960, as a countermeasure to the proposals for hospital insurance for the aged, the Eisenhower Administration proposed a new federal-state program to protect the low-income aged against the cost of long-term illness. This proposal would have

¹² The development of the Forand bill and the subsequent bills and debates which led to Medicare in 1965 have been well documented. See J. SUNDQUIST, *POLITICS AND POLICY: THE EISENHOWER, KENNEDY, AND JOHNSON YEARS 287-321* (1968) [hereinafter cited as *POLITICS AND POLICY*].

¹³ Information from the Bureau of Public Assistance for the calendar year ended December 31, 1960, noted 10 states and jurisdictions which made no vendor payments. And in states with a federal-state vendor payments program, there were wide variations. Under OAA, the monthly amount paid for medical care per recipient varied from 19 cents (Montana) to \$43.93 (Wisconsin). Services to be covered also varied widely, some states covering hospitalization but not physician services, some excluding hospitalization, and so on; and there were often variations from county to county. For a comprehensive description, see *MEDICAL RESOURCES*, *supra* note 9, at 46, 48-51, 54-56, 59-62, 80.

¹⁴ W. KAUFMAN, *ANALYSIS OF MEDICAL CARE EXPENDITURES BY LOCAL PUBLIC WELFARE DISTRICTS FOR PUBLIC ASSISTANCE RECIPIENTS IN NEW YORK STATE DURING 1960* (New York State Department of Public Welfare, Special Research Statistical Reports No. 17, Sept. 1961).

¹⁵ U.S. PUBLIC HEALTH SERVICE, *HEALTH STATISTICS FROM THE U.S. NATIONAL HEALTH SURVEY: OLDER PERSONS, SELECTED HEALTH CHARACTERISTICS, JULY 1957-JUNE 1959* (Public Health Service Pub. No. 584-C4, 1960).

¹⁶ A number of analyses have been done on the political and legislative background of the Medicare legislation, of which the Forand proposals were an important part. See O. ANDERSON, *THE UNEASY EQUILIBRIUM: PRIVATE AND PUBLIC FINANCING OF HEALTH SERVICES IN THE UNITED STATES, 1875-1965* (1968); P. CORNING, *THE EVOLUTION OF MEDICARE* (Social Security Admin., Office of Research and Statistics, Research Report No. 29, 1969); E. FEINGOLD, *MEDICARE POLICY AND POLITICS: A CASE STUDY AND POLICY ANALYSIS* (1966); R. HARRIS, *A SACRED TRUST* (1966); M. SKIDMORE, *MEDICARE AND THE AMERICAN RHETORIC OF RECONCILIATION* (1970); Marmor, *The Congress: Medicare Politics and Policy*, in *AMERICAN POLITICAL INSTITUTIONS AND PUBLIC POLICY: FIVE CONTEMPORARY STUDIES 2-67* (A. Sindler ed. 1969); *POLITICS AND POLICY*, *supra* note 12, at 287-321.

established a national means-test eligibility level for assistance, with specified medical, hospital, and nursing benefits.¹⁷ But this, too, was rejected by the House Ways and Means Committee. Instead, similar proposals sponsored by the committee chairman, Representative Wilbur Mills of Arkansas, and by Senator Robert Kerr of Oklahoma, were added to the omnibus social security bill (H.R. 12580) and enacted into law as the Kerr-Mills Act of 1960.¹⁸ Health insurance for the aged was defeated.

B. Kerr-Mills

The Kerr-Mills Act provided more generous federal matching grants for vendor medical payments under old-age assistance.¹⁹ But it also included a new category of assistance in a separate program of federal grants to the states, medical assistance to the aged (MAA), with respect to the "medically needy" aged; after 1962 the blind and disabled were included under a similar category (title XVI). These new beneficiaries were to be defined as elderly or blind persons (or totally disabled persons over twenty-one) not on public assistance, whose income might be above state eligibility levels but was not high enough to meet their medical bills. There was thus a new assistance category of "medical indigence," but primarily for those sixty-five years of age and over. The new program provided matching grants to participating states of fifty to eighty per cent of the cost of vendor payments.

The structure, to be followed later by Medicaid, was one of open-ended federal cost sharing, without limitations on individual payments or total state expenditures; cost control was left to the states. The matching formula favored lower-income states, including incidentally those of Representative Mills and Senator Kerr, but state participation was optional, as with other assistance titles. Unlike the Eisenhower proposal, each state would set its own definition of the limits and scope of medical indigence. The act did, however, suggest a broad range of hospital, nursing home, physician, and other services. In addition it required each plan to include both institutional and noninstitutional care as a condition of federal sharing. Thus while the new program was left in the hands of state administrators, it included as an important precedent the concept of federal standard-setting of benefits. There

¹⁷ The suggested income level was \$2500 for an individual, \$3800 for a couple. As an option, cash benefits would be provided for the purchase of private health insurance. The proposal was revealed in testimony before the House Ways and Means Committee on May 4, 1960. A strong supporter was Vice President Richard Nixon. See CONGRESSIONAL QUARTERLY SERVICE, CONGRESS AND THE NATION 1945-1964, at 1153-54 (1965) [hereinafter cited as CONGRESS AND THE NATION]; POLITICS AND POLICY, *supra* note 12, at 287-305.

¹⁸ Pub. L. No. 86-778, 74 Stat. 987.

¹⁹ Under the 1950 authorization for vendor medical payments for OAA, AB, and APTD, the federal government matched the state budget on the equivalent of \$30 of the first \$50 of a state's combined monthly payments for living expenses and vendor payments for welfare recipients. The formula was revised upwards in 1952, 1956, and 1958. Under the latter change the federal share was between \$41.50 and \$46.75 of the first \$65 a month of the state's combined outlay per client, with the greater share going to the poorer states. The Kerr-Mills Act added on to this a federal matching payment of 50% to 80% (depending on the state) of the next \$12 a month spent on medical care for OAA recipients (that is, over and above the \$65 limit for all vendor payment recipients of categorical assistance). CONGRESS AND THE NATION, *supra* note 17, at 1154.

were provisions that a recipient could not receive medical care under both OAA and MAA,²⁰ that states were not to set up enrollment fees for participation, and that (as with other categorical public assistance programs) the program had to be in effect in all administrative subdivisions of a state.

Two innovations were also included which set the new MAA apart from other public assistance programs: States were not to impose residency requirements on participants except for current residence, nor were they to impose liens on the recipient's property during his lifetime or that of a surviving spouse.²¹ The Department of Health, Education, and Welfare was made responsible for approving state plans, issuing guidelines, and receiving reports on their operation. The program was to begin on October 1, 1960.²²

In theory the new program could have provided extensive services to a substantial proportion of the elderly population and to the other two adult groups included in at least some of its provisions. It could have thus met a considerable share of the needs of those who fell into the gap between adequate coverage of their medical bills through private health insurance schemes and those receiving cash payments under public assistance.²³ But in fact the nature of Kerr-Mills was predetermined by its heritage as a political compromise in Congress, staving off the threat of hospital insurance for all the aged, and also by its formulation as a supplement to existing forms of poor relief.

Kerr-Mills was also, importantly, a means of increasing federal grants for vendor payments in the states. The many counties in the United States which were subsidizing medical relief could look upon Kerr-Mills as a source of additional state support; hospitals and doctors could view it as a means of reducing their own private contributions to medical care to the indigent by the introduction of more realistic fees for welfare patients who were elderly;²⁴ and the states had the pleasant

²⁰ For the breakdown between OAA and MAA in these early years, see U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE, MEDICAL RESOURCES AVAILABLE TO MEET NEEDS OF PUBLIC ASSISTANCE RECIPIENTS 29 (Comm. Print 1961).

²¹ Under other public assistance programs, it is open to the state to make a recipient liable in perpetuity should he ever earn enough to repay sums received by way of welfare payments. See Graham, *Public Assistance: The Right to Receive; The Obligation to Repay*, 43 N.Y.U.L. REV. 451 (1968).

²² SOC. SEC. BULL., Nov. 1960, at 12-15.

²³ Secretary of Health, Education, and Welfare Arthur Flemming, speaking in favor of the original Eisenhower Administration proposal, estimated that 75% of all persons over 65 would be eligible to participate under the initial plan (thus providing a major system of free or "socialized" medicine to the elderly). See STATUTORY HISTORY OF THE UNITED STATES, *supra* note 7, at 559-60.

²⁴ Services given to the poor of all age levels by physicians were estimated in 1960 to be worth \$658 million. Voluntary hospitals were estimated to be providing at least \$180 million of care without charge from their own resources (income from endowments, fees from paying patients, gifts and other income). Many of the providers of care, particularly physicians, were presumably subsidizing their welfare practice through higher charges to other patients; thus the net amount of charity was not as great to the providers as might be supposed. Nevertheless, hospitals were by 1960 beginning to feel crimped by rising prices and salary levels; between 1945 and 1960 hospital room rates had tripled. They could not afford much longer to continue to care for heavy loads of welfare patients without adequate reimbursement. See MEDICAL RESOURCES, *supra* note 9, at 64, 69-70; H. SOMERS & A. SOMERS, DOCTORS, PATIENTS, AND HEALTH INSURANCE 195 and *passim* (1961).

prospect of expanded federal funding. California defined its new MAA program quite clearly as being designed "to supplement the financial ability of counties to meet the health needs of aged persons."²⁵

At the federal level, the program was administered by the Bureau of Public Assistance, not by the Public Health Service. Without exception the states in implementing their programs designed means tests for the medically indigent under MAA, which, while more liberal than the means test for both cash and health programs under OAA, were similar in administration and intent.²⁶ Nor were the benefits much more generous than those available under the previous programs.²⁷ In terms of vendor payments, Kerr-Mills extended OAA at a somewhat higher income level. The atmosphere of "welfare" was all-pervasive.

No one seriously pretended that Kerr-Mills was the final answer to meeting the health needs of the elderly. Nevertheless the program was disappointing to conservatives and liberals alike. It did not vindicate the view of those who saw the long-term answer to health care financing as a mix of private health insurance backed by public assistance, rather than as comprehensive national health insurance; nor did it begin to meet the concern of those who looked for a full range of preventive as well as curative services for the elderly as a means of forestalling possible indigence. Under MAA, the elderly were forced to spend down to the relatively low income eligibility limits of the program before receiving any benefits. As Secretary Celebrezze pointed out in the 1963 hearings on hospital insurance for the aged, Kerr-Mills did not prevent dependency but only dealt with it after it had happened.²⁸

²⁵ SUBCOMM. ON HEALTH OF THE ELDERLY OF THE SPECIAL SENATE COMM. ON AGING, 88TH CONG., 1ST SESS., MEDICAL ASSISTANCE FOR THE AGED, THE KERR-MILLS PROGRAM 1960-63, at 75 (Comm. Print 1963) [hereinafter cited as MEDICAL ASSISTANCE FOR THE AGED].

²⁶ E.g., New York's relatively comprehensive and liberal MAA program, begun in April 1961. The basic income levels were \$1800 for a single applicant and \$2600 for a married couple. Applicants were allowed health insurance policy premiums of up to \$250 a year for married applicants, life insurance with a cash surrender of \$500, and cash reserves of \$1300 per married couple. The home was exempt from means test levels, as were clothes and household effects. "Nonessential" property (as defined by the public assistance case worker in terms of regulations in the state manual and the plans of the local welfare district) and excess assets were applied against the costs of medical care. In addition there was provision for recovery from the estate of a deceased recipient (though not a live one), and the spouse, parents, and children of the recipient were liable for payment of medical bills when they were found able to assist. Patients in medical or nursing institutions for chronic care were allowed up to \$10 a month for personal care items. These provisions followed the provision of other state welfare programs. *Id.* at 89.

²⁷ E.g., Kentucky inaugurated a vendor payment plan under the federally aided programs (including MAA) in January 1961. Hospital care was included, but only in cases of acute, emergency, and life-endangering conditions, and only, as of June 1, 1961, for 6 days per admission. MEDICAL RESOURCES, *supra* note 9, at 52. When asked what happened if the patient were still sick after 6 days, the Kentucky commissioner for economic security replied, "We pay only for 6 days. If the patient is in the hospital longer, the care may be paid for by a relative or a charity, or the hospital may discharge him. We do not know what happens after our responsibility is met." MEDICAL ASSISTANCE FOR THE AGED, *supra* note 25, at 5. For a survey of programs in effect in 1961, see U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE, SOCIAL SECURITY ADMINISTRATION, DIVISION OF PROGRAM RESEARCH, THE HEALTH CARE OF THE AGED: BACKGROUND FACTS RELATING TO THE FINANCING PROBLEMS 122-23 and *passim* (1962).

²⁸ *Hearings on H.R. 3920 Before the House Comm. on Ways and Means*, 88th Cong., 1st & 2d Sess. 31 (1963-64) [hereinafter cited as 1963 *Hearings*].

C. Implementation of Kerr-Mills

The implementation of Kerr-Mills in the states was similar in flavor to the later implementation of Medicaid. The Bureau of Public Assistance, renamed the Bureau of Family Services of the Welfare Administration, issued a series of State Letters summarizing the provisions of the legislation and reflecting the department's view that both the extended OAA vendor payment provisions and the new MAA program would result in the improvement of programs of health care for the elderly. The bureau also prepared information leaflets, met with state directors of public assistance, appointed a group of consultants on medical matters, prepared a guide and a handbook of regulations, published statistics, and assisted the states through technical medical consultation.²⁹ As a voluntary program of grants-in-aid, however, MAA imposed little responsibility on the Department of Health, Education, and Welfare. Apart from exhortation, the federal role was minor.

In the states, the new program was embraced as an extension of existing welfare programs and as a new source of federal budgetary assistance. Because of the higher federal sharing provisions under MAA there was an immediate incentive, particularly in the richer states with large vendor payment programs, to shift part of their existing programs into the new category. This was also encouraged by the provision that a recipient could receive medical care through OAA or MAA, but not both. A study of the impact of MAA in Connecticut found that in its first month of operation (April 1962) 3887 of the total of 3929 individuals placed on MAA were already receiving welfare assistance through OAA; and the transfers continued.³⁰ Altogether, it was estimated that nearly 100,000 persons then on other welfare programs in the states were moved to the new program,³¹ thus frustrating the intention of Kerr-Mills to provide a major new source of services to the elderly. Indeed, one report in 1963 found that the combined percentage of old people who were covered for medical care under OAA and MAA had actually declined after the adoption of the new program, from fourteen to thirteen per cent.³²

An important byproduct of the funding arrangements was that, instead of encouraging services where they were most needed through higher federal matching grants to the low-income states, Kerr-Mills proved more attractive to states which already had substantial vendor programs. By 1965, the five states of New York, California, Massachusetts, Minnesota, and Pennsylvania, which together included about thirty-one per cent of the aged in the country, were receiving about sixty-two

²⁹ See MEDICAL ASSISTANCE FOR THE AGED, *supra* note 25, at 65-72.

³⁰ A. Snoke & P. Snoke, *How Kerr-Mills Works in Connecticut*, MODERN HOSPITAL, Aug. 1963, at 79. A ready device for such transfers was for states to drop the expensive services, notably nursing home care, from OAA and transfer them to MAA; the person needing these services was thus transformed into an MAA recipient.

³¹ MEDICAL ASSISTANCE FOR THE AGED, *supra* note 25, at 2.

³² NEW YORK STATE DEPARTMENT OF SOCIAL WELFARE, OFFICE OF MEDICAL ECONOMICS, MEDICAL CARE EXPENDITURES FOR THE AGED IN THE UNITED STATES UNDER THE FEDERALLY AIDED PUBLIC ASSISTANCE PROGRAMS, JANUARY-MARCH 1963 (1963).

per cent of federal MAA funds.³³ Forty-four of the fifty-four jurisdictions had some program in effect, but in many cases programs were minimal and there were wide and confusing variations. Only five jurisdictions were judged to provide comprehensive medical services.³⁴ Eligibility levels varied widely; indeed, in fourteen of the states the MAA income levels were found in 1963 to be more rigidly interpreted and often lower than those for OAA.³⁵ The continuation of family responsibility for the medical care of elderly relatives,³⁶ the custom of attaching property after death (although forbidden during the recipient's lifetime), and the pauperization provisions of the means test all added to the failure of Kerr-Mills to provide even a minimal alternative to a general program of health care benefits for the aged.

One major difficulty—which was to be transported lock, stock, and barrel into Medicaid—was the financial inability and thus unwillingness of low-income states to afford a medical assistance program even when the federal matching grant was up to eighty per cent of the total cost. Georgia, for example, authorized MAA in 1961 and Mississippi in 1964, but no state funds were ever appropriated. Even the richer states were already aware of state funding problems. Governor Brown of California stated in 1963 that the cost of making MAA a comprehensive medical care program in that state “would bankrupt the State and county governments.”³⁷

Kerr-Mills was built on the dilemma which foreshadowed Medicaid. Benefits for the medically indigent could be viewed as a program of health services, or even as a form of private health supplement. But if this were so, there was no particular virtue in attaching them administratively to a program of public assistance cash benefits whose primary capability lay not in providing services but in determining individual eligibility through means tests. Educational services for the poor were not channelled through public welfare departments. The problem of health care was that no separately subsidized or organized alternative existed. If Kerr-Mills (and Medicaid) were to be seen as an integral part of the welfare structure, logic would suggest the development of medical assistance along similar administrative lines to cash assistance; that is, with the state establishing or expanding public medical clinics and hospitals where state employees would provide health services at minimal costs to those eligible. But the concept of medical indigence as proposed for Kerr-Mills rejected the latter approach. While determination of medical indigence was universally interpreted in the states in terms of standard means-test provisions, the

³³ Testimony of Wilbur Cohen, *Hearings on H.R. 6675 Before the Senate Comm. on Finance*, 89th Cong., 1st Sess. 166 (1965) [hereinafter cited as *1965 Hearings*].

³⁴ Indiana, Massachusetts, Minnesota, New York, and North Dakota. *Id.* at 163.

³⁵ There was also the problem of the arbitrary cut-off when a recipient's income was above the state eligibility level (now referred to as the “notch” effect). A Michigan case was cited in which a needy man was refused services under MAA because his annual income was \$1542, while the MAA level was \$1500. In this case he was, however, still eligible for the more flexible eligibility provisions of OAA. MEDICAL ASSISTANCE FOR THE AGED, *supra* note 25, at 35-36.

³⁶ In Connecticut, for example, 75% of MAA applications which were refused were for reasons of family responsibility. Testimony of Joseph C. Bober, *1963 Hearings*, *supra* note 28, at 1410.

³⁷ Testimony of Edmund Brown, *id.* at 920.

"medically indigent" were emphatically not "indigent" in the sense of being on cash relief; thus public hospitals and clinics, with their stigma of welfare, were not necessarily appropriate places for treatment. Kerr-Mills thus fell between two stools. It was both a reflection of inadequate medical services to those with low and middle incomes and an extension of traditional notions of assistance.

D. More Radical Changes?

While the Kerr-Mills programs were being developed in the states side-by-side with the continuing vendor payments under the other categorical assistance programs, further pressures were building up in the Congress for hospital insurance for the aged through Social Security for persons at all income levels; that is, the provision of specific services as a covered benefit under the Social Security program, free of state variations and of the administration of a means test. The two movements—the growing failure of Kerr-Mills and the pressures for health insurance for the aged—gathered momentum in the years after 1960, culminating in the Social Security Amendments of 1965, which established both Medicare and Medicaid.

President Kennedy strongly endorsed hospital insurance for the aged through Social Security in his health message to Congress in 1961.³⁸ This was followed by an Administration bill introduced in the Senate by Senator Clinton Anderson and in the House by Representative Cecil R. King.³⁹ Opposed on the outside by the AMA and by the Health Insurance Institute, representing the private insurance interests, and with little chance of support from Representative Mills's powerful Ways and Means Committee, the King-Anderson bill was initially unsuccessful; and a similar proposal offered by Senator Anderson as an amendment to the Public Welfare Amendments in 1962 suffered a resounding defeat.⁴⁰ Nevertheless, supporting evidence was slowly being built up. Hearings by the Ways and Means Committee in 1961 documented the continuing failure of the existing system to meet the medical bills of the elderly. Hospital expenses had risen from \$9.39 a day in 1946 to \$32.23 in 1960, and were rising increasingly rapidly.⁴¹ Born of the continuing increase in medical costs and encouraged by the lack of effectiveness of the Kerr-Mills program, by the changed composition of the Senate after the 1962 elections, and perhaps even by the sheer familiarity of the emotive phrases and the lessening of credibility in the AMA's position, support for health insurance for the aged was rising. President Kennedy outlined his proposals for hospital insurance in a Special Message of February 1963; the King-Anderson bill was introduced again, and the House Ways and Means Committee again held hearings.⁴² The following year, after

³⁸ 17 CONGRESSIONAL QUARTERLY SERVICE, CONGRESSIONAL QUARTERLY ALMANAC 870 (1961).

³⁹ CONGRESS AND THE NATION, *supra* note 17, at 1154.

⁴⁰ *Id.* at 1154-55.

⁴¹ *Hearings on H.R. 4222 Before the House Comm. on Ways and Means*, 87th Cong., 1st Sess. 40 (1961).

⁴² President Kennedy's proposals were submitted to Congress on February 21, 1963, as part of the message "Aiding Our Senior Citizens." He called for Social Security payment of inpatient hospital

bipartisan efforts to break the deadlock and reach agreement on some constructive health proposal, the Senate for the first time passed a proposal for hospital insurance for the aged as an amendment to the Social Security Bill of 1964; but it died in a House-Senate conference committee.⁴³

With the Democratic landslide in the elections of November 1964, the composition of the House of Representatives (and of the Ways and Means Committee) was changed in favor of compulsory hospital insurance. President Johnson at once called for action on the King-Anderson proposals—Medicare—as a first priority of business. Hospital insurance for the aged through Social Security appeared as the first bill on the calendar for both Senate and House in 1965—S. 1 and H.R. 1 of the 89th Congress. The proposals were incorporated into the over-all aims of the new Administration's program for a "Great Society." Hearings were held by the House Ways and Means Committee in January and February 1965. While the AMA continued to claim that "we physicians care for the elderly and know their health needs better than anyone else" and that health insurance controlled by Washington was incompatible with "good medicine,"⁴⁴ the tide was turning in favor of including compulsory hospital insurance as a benefit of Social Security.

Other proposals for financing health care were, however, by no means dead. Indeed, it was the eventual combination of several major proposals which was to give the 1965 legislation its peculiar and distinctive character. In 1961 Senator Jacob Javits had revived the Eisenhower proposal for federal support of extensive state programs for those over sixty-five whose individual incomes did not exceed \$3000 or whose joint incomes did not exceed \$4500. The AMA developed its own "Eldercare" proposal, sponsored in the Congress by Representatives Curtis and Herlong and by Senator Tower. This called for a federal-state program which would subsidize private insurance policies for the elderly, for hospital, doctor, and drug bills. A similar bill was sponsored by Representative John W. Byrnes and endorsed by the House Republican leadership. The Byrnes bill, "Bettercare," suggested a federal (rather than a state) program whereby the elderly would be encouraged to contribute part of the premiums of a voluntary health insurance program with public subsidy of the remainder. There was also continuing proposals for tax credits and deductions for health insurance premiums, and for expanding the struggling Kerr-Mills program.⁴⁵

costs for the elderly of up to 90 days with some contributions from the patient, of up to 180 days with the patient making a greater contribution, or of all costs for 45 days. The proposals also included up to 180 days of nursing home care and 240 home health-care visits. The Administration bill was introduced by Representative King (H.R. 3920) and Senator Anderson (S. 880) in February 1963, and initial hearings were held in November. CONGRESS AND THE NATION, *supra* note 17, at 1155.

⁴³ *Id.*

⁴⁴ Testimony of Dr. Donovan Ward, *Executive Hearings on H.R. 1 Before the House Comm. on Ways and Means*, 89th Cong., 1st Sess. 741-47 (1965).

⁴⁵ For a report of the congressional history of the different bills, see 21 CONGRESSIONAL QUARTERLY SERVICE, CONGRESSIONAL QUARTERLY ALMANAC 248-69 (1965).

Representatives Mills, King, Herlong, Byrnes, and Curtis were all members of the House Ways and Means Committee. The full range of points of view was present in Congress's vital committee, and the outcome of the debate over Medicare was thus by no means predictable. In the end, the bill reported out of the Committee was not one bill but a compendium of three originally separate, and in some respects competing, proposals. The Administration's proposals for hospital insurance for the aged, financed through the Social Security system, would provide basic inpatient and nursing home coverage for all those eligible for Social Security retirement benefits. As a second layer, there would be a system of federal subsidies to enable old people to buy into a voluntary program of insurance for their doctors' bills (the Byrnes proposal), with the federal government setting premiums and benefits but with the administration of the scheme being funneled through insurance companies and nonprofit agencies. These two proposals were to become, respectively, parts A and B of title XVIII of the Social Security Amendments of 1965. They provided the two interlocking parts of Medicare.⁴⁶

At the same time, a third proposal was made to liberalize and extend the program of federal grants to states for the indigent and medically needy. This last proposal became title XIX of the Social Security Amendments, popularly known as Medicaid. The different points of view over medical care financing were thereby brought together. In one fell swoop the elderly were offered compulsory hospital insurance through Social Security, subsidized voluntary health insurance for their medical bills, and the expanded program of benefits under the rubric of "medical indigence," a program now to be available on a more general basis. In terms of passage, this strange mixture, brewed by adept political alchemists, proved to be brilliantly successful. The revised proposals passed the House, survived hearings by the Senate Finance Committee, were voted with some modifications in the Senate, were further modified in conference committee, and Public Law 89-97 was signed by President Johnson, amid some flourish and in the presence of former President Truman, on July 30, 1965.

Title XIX (Medicaid) was based not on the insurance principles of specified benefits for specified contributions which distinguish Medicare but on the time-worn structure of federal grants-in-aid to states for medical assistance. While appearing in

⁴⁶ Pub. L. No. 89-97, 79 Stat. 343. Under part A, the hospital insurance program of title XVIII, funding is provided through Social Security contributions paid by the working population; in return, beneficiaries are entitled at age 65 to specified hospital and related benefits. Part B of Medicare is also based on the insurance principle, although it is outside the compulsory Social Security contributory scheme. This part is a federally-subsidized voluntary insurance scheme with deductible and co-insurance features to which those over 65 may contribute on a monthly basis. The federal government matches—from general revenues—the subscribers' voluntary contributions. Its basic provisions extend to physician bills (inside or outside hospitals), other medical services and supplies such as injections and dressings, and a specified number of home and health agency visits. Payments are geared to customary and prevailing fees. For a discussion of the impact of Medicare, see H. SOMERS & A. SOMERS, *MEDICARE AND THE HOSPITALS* (1967).

the same legislative package as Medicare, its origins and underlying assumptions were quite different. It was, in fact, Kerr-Mills applied to a much wider audience: an extension of state welfare provisions rather than a new health service program.

II

TITLE XIX AND ITS IMPLEMENTATION

The somewhat vague—or at least poorly drafted—provisions of title XIX took up only nine pages in the official version of the act—a relatively small space for what was to become one of the more expensive and most controversial pieces of federal legislation of the 1960s. Such brevity was not always matched by clarity of expression.

A. The Provisions of Public Law 89-97

Title XIX extended medical assistance to all those in the categorical public assistance programs, thus applying across-the-board the principle which had been introduced for the aged by MAA and extended to other groups by title XVI. In addition it combined the separate public assistance medical vendor programs for cash recipients into a single program. The act did not require the states to establish such a program, but it put very considerable pressure on them to do so by providing that after December 31, 1969, there would be no further federal funds for medical vendor payments under the categorical titles for OAA, AFDC, AB, APTD, and Kerr-Mills. Perhaps even more important as an inducement—especially to the larger states, which had “suffered” under the earlier variable formula—was the provision in title XI (section 1118) allowing states establishing title XIX programs to use the more favorable title XIX reimbursement formula for their other categorical assistance programs. The pressures were effective. Although some states barely made the deadline—for example, Alabama, Arkansas, and Mississippi commenced their programs on January 1, 1970—only two, Alaska and Arizona, failed to implement it at all, pleading extenuating circumstances in that, since virtually all Eskimos and Indians would be eligible, the potential costs would be “unbearable.”

The 1965 law, as interpreted by the regulations, required the states to provide five basic services for those covered by Medicaid: physician's services, skilled nursing home services, inpatient hospital services, outpatient hospital services, and other laboratory or x-ray services. The states also had the option of providing a number of other services, including “medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practices as defined by State law,” home health care services, private duty nursing services, clinic, services, dental services, physical therapy, drugs, dentures, eyeglasses and prosthetic devices, “other diagnostic, screening, preventive and rehabilitative services,” and “inpatient hospital services and skilled nursing home services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases.” Finally, in a

catch-all provision, the subsection allowed the states to provide "any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary."⁴⁷ At the same time it was clear that benefits might differ between those covered by cash programs and those categorized as medically needy, and also that, provided it was done uniformly, a state was free to reduce benefits.

While it is relatively easy to describe what was covered, it is appreciably less easy to describe and analyze who was covered. No lawyer finds it easy to dissect the poorly drafted legal prose of title XIX—a task made significantly more difficult with each amendment—and it is clear that many state health departments and welfare departments have had similar problems. Nevertheless, it is generally accepted⁴⁸ that title XIX has three aspects in terms of coverage.

First, the state Medicaid plan *must* include those receiving aid under the four categorical assistance programs (OAA, AB, AFDC, APTD) or the combined adult medical group (title XVI), those who would be included in such programs were it not for a state provision invalidated by title XIX (for example, section 1902(b)(3) prohibited durational residence requirements, which many states still had in 1965 for public assistance programs), and those under twenty-one who would be eligible for AFDC if they were under eighteen. In the curious prose of officialdom, these latter two groups are often known as "categorically related needy."⁴⁹

There are then three other categories of persons who *may* be included in the Medicaid program and for whom federal cost-sharing is available. This first category includes two groups—those who could be covered by federal categorical programs if the state had adopted the broadest programs possible,⁵⁰ and those who would be eligible for assistance if they were not in a medical facility (excepting those under sixty-five who are in mental or tuberculosis institutions).⁵¹ This category is also included under the rubric of "categorically related needy." The second category—the "categorically related medically needy"—allowed the states to include "all individuals who would, if needy, be eligible for aid or assistance under any such State plan and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical or remedial

⁴⁷ Pub. L. No. 89-97, § 1905(a), 79 Stat. 351.

⁴⁸ The generally accepted categories of covered persons were clarified in ADVISORY COMMISSION ON INTERGOVERNMENTAL RELATIONS, INTERGOVERNMENTAL PROBLEMS IN MEDICAID 10-12 (1968) [hereinafter cited as INTERGOVERNMENTAL PROBLEMS]. See also CCH MEDICARE & MEDICAID GUIDE paras. 14,211-71; U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE, HANDBOOK OF PUBLIC ASSISTANCE ADMINISTRATION: SUPPLEMENT D paras. D-4010-50 (1966) [hereinafter cited as SUPPLEMENT D].

⁴⁹ We are here using the terminology of INTERGOVERNMENTAL PROBLEMS, *supra* note 48, rather than SUPPLEMENT D, *supra* note 48. Their relationship is described in CCH MEDICARE & MEDICAID GUIDE para. 14,251.

⁵⁰ The categorical forms of public assistance are, in general, voluntary not compulsory. The federal government will provide funds under the formula only after the appropriate state legislation has been passed. For instance, some states do not have AFDC-UP programs.

⁵¹ The provision in the 1965 act making it possible to provide medical assistance to those in mental institutions is known as the Long Amendment. It was the first time that medical assistance or vendor payments had been extended to this group.

care and services."⁵² Third, the state might cover all those who were under twenty-one and "medically indigent" even if they were not eligible for another categorical program—that is, were not blind, disabled, or in a family eligible for AFDC; this group was then called "nongategorically related medically needy."⁵³

Finally, the 1965 legislation allowed the states to include a category which covered various groups for whom there were no matching funds for services but for whom the federal government was prepared to share in the administrative cost only. This category included those who qualified for general assistance⁵⁴ (that part of public assistance not yet absorbed by federal categorical programs) and others between twenty-one and sixty-five who were "medically needy" but who did not fall into a "categorically related" definition⁵⁵ (for example, persons who might be unemployed and without children, or even working but with an income insufficient to meet medical bills).

The 1965 law normally required payments directly to the providers of services. In the case of hospitals it was provided that the test of reimbursement should be "reasonable cost." This phrase was also applied to hospital reimbursement under Medicare. While there was no requirement that Medicaid and Medicare regulations be combined (or even similar), it was agreed after debate in HEW that hospital reimbursement under Medicaid would follow the same broad test as in Medicare. With respect to other medical services, states were free to apply their own standards, although there was a hope that other medical providers would be paid according to locally prevailing fees. The 1965 law also prohibited deductions and cost sharing at least for those recipients also receiving money payments, while states were required to meet, for those sixty-five and over and covered by Medicaid, the cost of any deductibles under Medicare. Liability of relatives—which some states still impose on recipients of public assistance—was prohibited, the prohibition of liens on the later income of recipients was carried over from Kerr-Mills, and states were free to determine their own notions of who was "medically needy."⁵⁶

⁵² 42 U.S.C. § 1396a(a)(10)(B)(i) (Supp. I, 1965). It is this provision which, coupled with *id.* § 1396d(a)(ii), enabled states to pay the medical expenses of families with children who did not qualify for public assistance. The latter provision included within the definition of "medical assistance" parents or relatives with whom a child was living.

⁵³ This was the group inserted under the Ribicoff Amendment. It should be noted that in one sense this group was categorically related—to title IV. A further group was added in this category by the 1967 Amendments—the "essential person" category. See note 124 *infra*.

⁵⁴ SUPPLEMENT D, *supra* note 48, notes, however, at D-4040(a)(6), "Persons currently receiving general assistance could meet the test of 'categorically needy,' using the standards of assistance in the most nearly related approved State public assistance plan."

⁵⁵ This is interpreted in *id.* para. D-4040(B) as follows: "Self-supporting individuals between 21 and 65 years of age, whose income and resources cover their maintenance needs according to the income and resources level for the 'medically needy,' but not their needs for medical care, could be included as 'medically needy.' (Such individuals, whose income and resources are below the level of maintenance of OAA, AB, APTD, AABD, or AFDC, as appropriate, would qualify as 'categorically needy.')

⁵⁶ Again the states were encouraged to be liberal. State plans had to "include reasonable standards (which shall be comparable for all groups) for determining eligibility for and the extent of medical assistance over the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards

The minimum federal contribution to the states' eligible Medicaid programs was fifty per cent with a maximum of eighty-three per cent, based on the variable-grant, federal-state matching formula, which pays most to the state with the lowest per capita income. The federal government covers seventy-five per cent of professional administrative costs and fifty per cent of other administrative costs. The law also sought to prevent the states from using the new federal medical care dollars to replace existing state expenditures; in other words, Medicaid programs had to be incremental.⁵⁷ As with other federal-state programs, certain administrative standards had to be met, in terms of designating a single state agency for administration and providing uniformity throughout the state, equality of medical care in the different categories, fair hearing procedures, confidentiality, and similar requirements.⁵⁸ Nor should the importance of these changes be underestimated. The requirement of equal medical treatment in all categories was an important step forward, while the end of relatives' responsibility was to have an important effect on the utilization of nursing homes.

Convolved as the wording was, the main thrust of title XIX was expansionist. Section 1903(e), for instance, set the long-term goal:

The Secretary shall not make payments under the preceding provisions of this section to any State unless the State makes a satisfactory showing that it is making efforts in the direction of broadening the scope of the care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance, with a view toward furnishing by July 1, 1975, comprehensive care and services to substantially all individuals who meet the plan's eligibility standards with respect to income and resources, including services to enable such individuals to attain or retain independence or self-care.

At least some states took the encouragement seriously.

B. Implementation 1965-67

After the passage of the 1965 legislation, as suggested earlier, many saw title XIX as the "sleeper." Some saw it as more important than title XVIII (Medicare),⁵⁹ while others saw it as the National Health Program of the future.⁶⁰ Certainly, for those who saw evil in Medicaid, the months of implementation early in 1966 were a cause of excitement and trauma. For a while most states moved to implement Medicaid at fairly modest levels; Pennsylvania set \$4000 as a limit of "medical dependency" for

prescribed by the Secretary, available to the applicant or recipient" 42 U.S.C. § 1396(a)(17) (Supp. I, 1965).

⁵⁷ This was known as the concept of "state effort." The rules for "Payment to States" are codified at 42 U.S.C. § 1396b (Supp. I, 1965).

⁵⁸ See *id.* § 1396a, which deals with "State Plans for Medical Assistance."

⁵⁹ E.g., "Because of the limited scope of Title 18 in terms of persons covered, types of health service insured against, and the presence of deductibles and coinsurance, it is Title 19 that we shall find it necessary to rely on as the main instrument for ensuring that no one who needs health services is denied them." Burns, *Some Major Policy Decisions Facing the United States in the Financing and Organization of Health Care*, 42 BULL. N.Y. ACAD. MED. (2d ser.) 1072, 1080 (1966).

⁶⁰ E.g., Werne, *Medicaid: Has National Health Insurance Entered by the Back Door?*, 18 SYRACUSE L. REV. 49 (1966).

a family of four ("Pennsycare"), while Illinois set it at \$3600. Two states, however, New York⁶¹ and California,⁶² established programs which were shortly the center of violent controversies. Moreover, the effects of the disputes in Albany and Sacramento were soon felt in Washington, D.C.

New York—and especially New York City—had a relatively generous program of medical care for those on public assistance and Kerr-Mills, and so it was not surprising that, when the time came to prepare state legislation early in 1966, Governor Rockefeller should propose a base of \$5700 for a family of four, while Speaker Travia, the Democratic leader, proposed a base of \$6700,⁶³ or that ultimately a compromise of \$6000 was agreed upon. What was rather more surprising was that only one day's hearings were held on the bill. The Travia bill passed the Democratic-controlled Assembly and the Rockefeller bill the Republican-controlled Senate, both almost without debate, during March 1966. In April, after a warning by Rockefeller that New York stood in danger of losing possible new federal funds, the Speaker and the Governor met, worked out the \$6000 compromise with reasonably generous provisions for excluding essential property and savings,⁶⁴ and the bill shot through both chambers⁶⁵ with remarkably little dissent.⁶⁶ In signing the bill, Governor Rockefeller called it "the most significant social legislation in three decades."⁶⁷

It was only after the bill had passed that the fireworks began. The eligibility standards⁶⁸ came under vigorous attack. It was appreciated, by many for the first time, that some 8,000,000 people, or forty-five per cent of the population of the state, would

⁶¹ On the New York experience, see *id.* at 49; *Furor Over Medicaid*, 3 COLUM. J. LAW & SOC. PROB. 158 (1967); R. B. Titus, *New York's Medicaid: A Study of the Development of a State Title XIX Program—Its Problems and Prospects*, 1968 (paper presented at Yale University Law School on file with the authors). The authors acknowledge their debt, especially to the last of these, in their description of the early stages of Medicaid in New York.

⁶² M. GREENFIELD, *MEDI-CAL: THE CALIFORNIA MEDICAID PROGRAM (TITLE XIX) (1969)* [hereinafter cited as *MEDI-CAL*]; A. C. BARNES, *A DESCRIPTION OF THE ORGANIZATION AND ADMINISTRATION OF THE CALIFORNIA MEDICAL ASSISTANCE PROGRAM: TITLE XIX (1968)* [hereinafter cited as *BARNES*].

⁶³ N.Y. Times, Mar. 21, 1966, at 26, col. 3; *id.*, Mar. 29, 1966, at 27, col. 1. Republican legislators alleged that Travia was the "tool" of Senator Robert Kennedy in these proposals and that the package was "designed to steal Republican thunder." *Id.*, Mar. 30, 1966, at 48, col. 1.

⁶⁴ Details of these are set out by Werne, *supra* note 60, at 53-56.

⁶⁵ It passed the Assembly 136-15 and the Senate 64-1. See N.Y. SOC. WELFARE LAW § 363 *et seq.* (McKinney 1966).

⁶⁶ Commenting that few legislators appreciated the scope of the program, one Senator later commented: "And it's a damn good thing . . . because they would never have voted for it if they had." N.Y. Times, May 21, 1966, at 14, col. 6. For what legislators had thought they were voting for, see *New Worry for Medicare*, U.S. NEWS & WORLD REPORT, June 20, 1966, at 54.

⁶⁷ N.Y. Times, May 1, 1966, at 1, col. 2.

⁶⁸ N.Y. SOC. WELFARE LAW § 366 (McKinney 1966). Annual Net Income Allowable:

Number of Persons in Household	No Wage Earner	One Wage Earner	Two Wage Earners
1	\$2300	\$2900	\$—
2	3250	4000	4850
3	4350	5200	6050
4	5150	6000	6850
5	6000	6850	7700
6	6850	7700	8550

now be eligible for Medicaid.⁶⁹ Governor Rockefeller, in a statement which tells much about medical care in America, vainly protested that experience showed that only twenty-five per cent of potential participants signed up for public assistance medical programs.⁷⁰ He also argued that, despite the increase in eligibility, the new program would actually save money for the state and local authorities.⁷¹ The Governor appeared on television in a vain effort to quell the rising hostility,⁷² most of it from upper New York State, where average incomes were lower than in and around New York City. It was claimed that in some up-state counties seventy per cent of the population would be eligible for Medicaid, a prospect which offended local authorities, who at that time were required to provide a quarter of the cost, and local physician groups, who saw the possible evisceration of their practices. Farmers' groups, employers' lobbies, and medical groups⁷³ (although not the state medical society)⁷⁴ lobbied for repeal. In an unusual move, the legislature held post-passage joint hearings to allow the hostility to be aired, but the only important legislative change to come out of the hearings was a limited one per cent of earnings deductible for those families earning more than \$4500.⁷⁵ The Governor was still being heckled about Medicaid in his campaigning for re-election up-state,⁷⁶ but by then the program was ready to be implemented.

⁶⁹ Comparable figures of potential coverage were: California 13%, Connecticut 10%, Maryland 9.7%, Massachusetts 7%, Oklahoma 16%, Rhode Island 8%, Utah 20%, and Washington 8%. U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE, TITLE XIX FACT-SHEET *passim* (1966-1967). The median family of 4 or 5 members had an income of \$6371 in New York State in 1965. U.S. BUREAU OF THE CENSUS, U.S. STATISTICAL ABSTRACT: 1966, at 338 (87th ed. 1966).

⁷⁰ The estimate was roughly correct. HEW reported first year utilization of Medicaid in New York at 2,000,000 or 11% for the entire population of the state. Other states (and Puerto Rico) had the following first year figures: California 5% (1,000,000), Hawaii 5% (34,000), Illinois 5% (500,000), Kentucky 10% (300,000), Maryland 7.2% (260,000), Michigan 4% (330,000), Minnesota 5% (72,000), North Dakota 2.5% (16,640), Oklahoma 8% (195,000), Pennsylvania 6% (583,000), Puerto Rico 50% (1,200,000), Utah 4% (40,000), and Wisconsin 6.3% (262,000). TITLE XIX FACT SHEET, *supra* note 69, *passim*.

⁷¹ The Governor estimated the comparison as follows:

Total		Federal Share	State Share	Local Share
		(in millions of dollars)		
1965	429	59	172	198
1966	532	217	171	144

19 N.Y. STATE DEP'T HEALTH WEEKLY BULL. 118 (July 25, 1966).

⁷² N.Y. Times, May 19, 1966, § L, at 49, col. 1; *id.*, May 23, 1966, at 1, col. 2.

⁷³ E.g., the Erie County Medical Society was demanding repeal. Later the Suffolk County Medical Society labelled Medicaid "socialized medicine," designed "to deprive physicians of their constitutional rights to practice medicine in a free society." N.Y. Times, June 4, 1966, at 1, col. 2; *id.*, June 5, 1966, at 66, col. 3.

⁷⁴ The State Medical Society was in a difficult position. The AMA was committed to an extension of "welfare medicine" rather than Medicare, and the State Society had in fact supported higher eligibility standards in earlier years. As it was, at the State House of Delegates' meeting in May, the resolutions were limited to those aimed at ensuring strong physician control over the program. 22 N.Y. MED. 384 (1966).

⁷⁵ N.Y. Times, July 2, 1966, at 1, col. 6, and at 7, col. 5; Werne, *supra* note 60, at 57-58. Speaker Travia had used various procedural devices in an attempt to block the amendments. N.Y. Times, June 30, 1966, at 19, col. 1.

⁷⁶ N.Y. Times, Aug. 18, 1966, at 24, col. 1.

First, however, HEW had to approve the New York plan, and so opponents had further opportunity to intervene. Litigation, alleging abuse of administrative power by establishing unreasonable standards, failed in the New York courts.⁷⁷ But this time there were various New York groups attempting to persuade HEW not to approve the plan, including the Citizens Committee for Responsible Government and the Association of New York State Physicians and Dentists.⁷⁸ Eight state legislators from Erie and Niagara counties formally asked HEW to disapprove the plan, and soon Congressman Stratton from Rochester was organizing the opposition in Washington.⁷⁹

At the same time, the Governor and his advisers were communing with HEW, although the Department was by then showing some reluctance to move since Congress had become increasingly concerned about the cost of title XIX. On Capitol Hill, Senator Saltonstall took the same line that some of the New York legislators had espoused:

There was little discussion of title 19; which certainly has proved to be the "sleeping" in the bill. I am certain no one dreamed that within the next five years, "medicaid" as the program established by that title is called, could come to dwarf medicare.⁸⁰

Meanwhile, the architect of title XIX, Chairman Wilbur Mills of the House Ways and Means Committee, was holding closed hearings. HEW was in a difficult position. There was no legal reason why they should not approve the New York plan, yet that plan alone would use up almost all the money which, one year earlier, had been estimated as the total federal cost of title XIX.⁸¹ Before the Committee, Robert Myers, Chief Actuary of the Social Security Administration, was blunt about the potential fiscal situation:

It seems quite likely that under "mature" conditions, with full utilization of the provisions by those eligible to do so, and with expansion of the provisions of many of the State plans . . . so that they become much more like the New York plan,

⁷⁷ *Robinson v. Wyman*, 51 Misc. 2d 480, 273 N.Y.S.2d 450 (S. Ct. 1966). The petitioner alleged that he stood "aggrieved by the administrative act, not only as a general taxpaying citizen of New York State, but also as a man who runs his own business in this state; that if this program is allowed, a tremendous tax burden will be placed on both individuals and businesses in New York State and your petitioner frankly believes said burden, as hereinafter set forth, will force him to move his business elsewhere." 51 Misc. 2d at 480-81, 273 N.Y.S.2d at 451. Justice Koreman held that the petitioner lacked standing.

⁷⁸ *Furor Over Medicaid*, *supra* note 61, at 165-66.

⁷⁹ N.Y. Times, June 24, 1966, at 7, col. 8.

⁸⁰ 112 CONG. REC. 20,267 (1966) (remarks of Senator Saltonstall).

⁸¹ When Mills had proposed his tripartite solution for medical care, HEW had estimated that title XIX would "increase the Federal Government's contribution about \$200 million in a full year of operation over that in the programs operated under existing law"—that is, approximately \$950 million per annum. S. REP. NO. 404, 89th Cong., 1st Sess. 11 (1965). Even by August 1966, with only 22 programs projected, the estimates had been revised upward to \$1.3 billion. See Soc. SEC. BULL., July 1966, at 5; *id.*, Aug. 1966, at 2. The various cost estimates for the 17 programs actually in existence in August 1966 appear in 112 CONG. REC. 20,268 (1966). The implications of these estimates are discussed at length at pp. 378-80 *infra*.

the Federal cost for Title XIX as it now exists would be as much as \$3 billion per year (or even more).⁸²

The committee report noted that "while most of the State plans raise no question at this time, a few go well beyond what your committee believes to have been the intent of the Congress."⁸³ The mood was set for continuing Congressional watchfulness of Medicaid in the states. Increasingly Medicaid was to be regarded not as one component of state welfare programs but as a substantial national commitment of funds for medical services.

While consideration of the New York plan continued in the executive branch, the legislature sought ways to tame the financial ogre with which it now saw itself faced. Senator Javits suggested more flexibility in deductions for services under Medicaid, variations in the type of services offered to different groups within Medicaid, and variations in eligibility standards in different parts of a state.⁸⁴ While Javits was essentially seeking to save the New York legislation, the Ways and Means Committee was working on long-term solutions to control the federal costs of Medicaid. After considering abolishing the "open-ended" funding of title XIX by putting a ceiling on the federal contribution, fixing a maximum percentage of the population which might be covered in any one state,⁸⁵ and fixing a standard for "medical indigency" beyond which states could not go,⁸⁶ the committee finally came down in favor of cutting back certain groups which might be covered—in particular those relatives with whom children were living who were not already receiving cash payments under AFDC.⁸⁷ Ultimately, however, in the shadow of impending elections, it was decided to delay changes in title XIX until the Ninetieth Congress; and on November 15, 1966,⁸⁸ HEW formally approved the New York program, with the expectation that the federal government would meet the first \$217 million out of a total annual cost of \$532 million (including services not covered by federal matching provisions).⁸⁹

⁸² HOUSE WAYS AND MEANS COMMITTEE, LIMITATIONS ON FEDERAL PARTICIPATION UNDER TITLE XIX OF THE SOCIAL SECURITY ACT, H.R. REP. No. 2224, 89th Cong., 2d Sess. 8 (1966) [hereinafter cited as HOUSE REPORT].

⁸³ *Id.* The total cost (federal, state, and local) if all states adopted a New York type plan was estimated at \$6.4 billion annually. N.Y. Times, Oct. 24, 1966, at 23, col. 1.

⁸⁴ Office of Senator Javits, Press Release, June 16, 1966. Some of the amendments appeared in S. 3513.

⁸⁵ This was similar to Congressman Stratton's solution. N.Y. Times, June 24, 1966, at 30, col. 1.

⁸⁶ *Id.*, Sept. 8, 1966, at 27, col. 1.

⁸⁷ HOUSE REPORT, *supra* note 82, at 3-6. This would have called for the addition of the words "if money payments with respect to such child are being made under the state plan approved under Title IV, or if such money payments would upon application be made . . ." to § 1905(a)(ii). The *House Report* also called for a right to "buy in" to XVIII-B selectively, a weakening of the comparability provisions, a relaxation of "state effort," and increased matching for administration—all provisions destined to appear in the 1967 amendments. The change would have cost New York between \$20 million-\$25 million a year in federal funds. N.Y. Times, Oct. 7, 1966, at 20, col. 5.

⁸⁸ N.Y. Times, Nov. 16, 1966, at 56, col. 1. In theory HEW had violated the law by waiting more than 90 days to approve the plan.

⁸⁹ However, the federal government refused to pay for expenses before March 31, 1966, despite alleged earlier representations that it would. *Id.*, Jan. 7, 1967, at 29, col. 1.

But approval was only the beginning of other types of problems. The New York program ran into criticisms from a variety of sources and at a variety of levels as implementation proceeded. The health professions were dissatisfied with their conditions. Dentists, who were paid on a fee schedule, protested that (in the words of the Eighth District Dental Society), "Fee schedules will be determined by men who sit behind desks who have not been in practice and have no clinical experience."⁹⁰ Physicians in New York City opposed a recommendation by the state that there should be a penalty clause for physicians who abused the plan as being "unduly punitive and arbitrary."⁹¹ Pharmacists refused to comply with a New York City order that they substitute cheaper generic drugs for brand names.⁹² A citizen's committee accused the New York City Welfare Department of "gross negligence" in its administration of the program, and cited its "incomprehensible forms, unnecessary red tape and confused administration."⁹³ Meanwhile, especially in upstate New York, there was growing pressure to curb the spiraling costs of the program, particularly by limiting the number of non-welfare recipients.⁹⁴ Medicaid was already beginning to appear to be a program which gave the poor services at vast and uncontrollable cost and which, at the taxpayers' expense, made the doctors rich.

Moreover in the very same month that HEW approved the New York program—November 1966—a new political crisis broke in Medicaid in the state which had the second largest program, California. The idea of Medicaid was viewed by the state administration in California not so much as one of extending the number of people covered as one of liberalizing the type of care available to recipients.⁹⁵ An act to

⁹⁰ Dr. Joseph D. Giovino, *AMA News*, Jan. 2, 1967.

⁹¹ *AMA News*, Jan. 16, 1967. New York City also attempted to impose qualifications on physicians as a condition of participation, but these were dropped following professional opposition. All practitioners became eligible to participate. *AMA News*, July 3, 1967. There were also complaints by the President of the New York State Medical Society that Medicaid "had degenerated into an extended welfare program," presumably in contrast to the hopes of physicians that the scheme would approximate private practice. Dr. John A. Lawler, *MED. TRIBUNE*, June 12, 1967. Claims processing was so far behind that in 1967 a private corporation began to purchase Medicaid bills from physicians at 90% of their collection value. This was stopped on the grounds that the law provided payments only to the actual vendors. *AMA News*, June 19, 1967. But for later developments see notes 115 & 127 *infra*.

⁹² *MED. TRIBUNE*, Aug. 28, 1967.

⁹³ Much of the criticism came from the chairman, Frederick W. Richmond, honorary president of the Urban League of Greater New York and a member of the City Commission on Human Rights. *N.Y. Times*, Jan. 20, 1967, at 88, col. 1.

⁹⁴ Indeed, Representative Stratton of New York would have imposed cuts much more drastic than those actually made in the 1967 amendments. His proposals would have barred federal approval for Medicaid plans that made more than 20% of a state's residents eligible to participate, or made free medical care available to anyone whose income was more than 90% of the national average. Noting that the New York program made about 40% of the population eligible, the Congressman stated, "in some counties, including my own county of Montgomery, the figure is as high as 79 per cent." *N.Y. Times*, Jan. 20, 1967, at 88, col. 1.

⁹⁵ While the California program covered fewer persons, it was actually costing more. Between April and September, 1966, the New York program cost \$120,749,017, while the California program cost \$226,197,342. The federal share of the programs for calendar year 1966 was expected to be \$217 million and \$210 million respectively. See *MEDI-CAL*, *supra* note 62, ch. 1 & app. A; BARNES, *supra* note 62, § 2.

implement title XIX as "Medi-Cal" had been approved late in 1965, and the program began in March 1966. There were the usual complications involved in the implementation of any federal-state program, but the first few months of the program did not cause the storm which they provoked in New York.⁹⁶ While the range of services was wide, the eligibility levels were relatively low; this was still a program for the destitute, not for low-income workers.⁹⁷ At the financial level the initial concerns were more closely connected with establishing better care and paying providers more quickly than with the actual cost of the program. A comprehensive group of services was offered to public assistance recipients, replacing previously fragmented and incomplete programs. But in addition efforts were made to abolish the stigma of second-class poor relief in medicine by dropping previous requirements that the poor (including Kerr-Mills recipients) could only be cared for in county hospitals and clinics.

California epitomized the views of those who wished to bring medical care for the poor into the "mainstream"—that is, to treat the poor as well as the rich in private hospitals and through private medical practice. To advance this aim Medi-Cal introduced a system of payment to physicians according to their usual and customary fees, instead of through the fixed fee schedules of earlier assistance programs. Administration was shifted from county social welfare departments to an office of Health Care Services within the state Health and Welfare Agency, thus emphasizing the health rather than welfare attributes of the program. At the same time Blue Cross and Blue Shield were designated as state fiscal agents of Medi-Cal for processing and reviewing claims. Taken together these moves represented a significant shift in emphasis, away from a minimal direct-service welfare system to a system more like private health insurance.

It was expected in the debates over Medi-Cal in the legislature that the substantial additional costs of the program—the amount of vendor payments per capita nearly tripled between 1965 and 1967⁹⁸—would be largely absorbed through additional federal matching funds. But in November 1966, after the election of Governor Reagan but before his inauguration, the Administrator of the Health and Welfare Agency announced that Medi-Cal was running out of money and that either the legislature would have to vote more funds or benefits would have to be reduced

⁹⁶ See *MEDI-CAL*, *supra* note 62, chs. 3-7; *BARNES*, *supra* note 62, §§ 3-7.

⁹⁷ Eligibility for service in California was limited until January 1, 1967, to persons considered needy or medically needy under state programs in effect as of December 1965. The initial thrust of the program was a considerable expansion of services to those eligible, stressing comprehensive health benefits and continuity of care. As of September 1967 the per-month subsistence amounts for medical indigency were fixed at \$289 for two persons, plus \$26 for each additional person in the immediate family. But even this per-year total of \$4092 for a family of four was low compared with New York's initial means test of \$6000. See *MEDI-CAL*, *supra* note 62, at 17-18, 31.

⁹⁸ Taking total vendor medical payments divided by the population of the state, per capita payments rose from \$10.69 in 1965 to \$29.44 in 1967. *TAX FOUNDATION, INC., MEDICAID: STATE PROGRAMS AFTER TWO YEARS 70* (1968) [hereinafter cited as *MEDICAID*].

before the end of the fiscal year.⁹⁹ By the spring of 1967, with bills for services coming in slowly, it was estimated that in the first sixteen months of the program the state would be "in the red" to the amount of \$130 million, with a further deficit of \$80 million for the following fiscal year.¹⁰⁰

It was in this atmosphere that Governor Reagan delivered a televised "Report to the People" on July 10, 1967, arguing that the program was likely to increase in cost fifty per cent each year and that "something must be done before this ill-conceived program bankrupts the state." The premature release of the information caught the program administrators by surprise and had the effect of legitimating the amount of the projected budget deficit, and of providing ammunition for the Governor's office to castigate the profligacy of the previous Democratic administration. In fact, both the estimate and the multiplier proved to be inaccurate, but they had become political facts of life.¹⁰¹

In California, staff work on possible cutbacks in the Medicaid program began in the summer of 1967. More than forty per cent of the estimated program expenditures were on behalf of 200,000 persons classified as medically needy, but a substantial minority of these were old and disabled persons in nursing homes whose benefits could not be cut off without a resulting public outcry.¹⁰² Instead of reducing the number of beneficiaries, the staff recommended the reduction of available services, from the relatively comprehensive benefits then available to the five basic services then required under the federal legislation (inpatient care, nursing home care, physician services, laboratory services, and outpatient clinic services). In addition, other savings were suggested, including a rollback in physician fees to the level of "usual and customary fees" prevailing as of January 1, 1967. These cutbacks were announced in August 1967 and received widespread public attention. They were immediately deplored by an effective alliance between professional organizations in the health field and representatives of poverty groups in the state.

This opposition was crystallized in a restraining order obtained the same month by California Rural Legal Assistance (a legal services program funded by the Office of Economic Opportunity) temporarily blocking the cutbacks. Attorneys representing medical, dental, and pharmaceutical groups appeared as *amicii curiae*. Despite claims from the state that it would lose \$5 million a day if reduction in service were not

⁹⁹ The reasons given to Governor-elect Reagan were the nursing profession's demand for higher salaries and an unanticipated increase in the number of elderly and disabled persons receiving nursing home benefits. *MEDI-CAL*, *supra* note 62, at 53.

¹⁰⁰ Half of this would be from state funds. *BARNES*, *supra* note 62, at 127-28.

¹⁰¹ There were a byzantine series of announcements as to the extent of the deficit which would be carried over into the state budget for 1967-68. One problem involved the use of accrual accounting in recording expenditures, *i.e.*, including all outstanding but unpaid obligations rather than utilizing a straight month-by-month outflow method. The higher figures were ascertained by use of the former method. Eventually, the estimate was reduced to \$35.5 million in terms of payments from the California General Fund. But the action was too late to stem the political action which followed in the state. The history of the deficit and subsequent reactions to it are presented in *MEDI-CAL*, *supra* note 62, at 53-60; *BARNES*, *supra* note 62, at 125-47.

¹⁰² *BARNES*, *supra* note 62, at 131.

made, the Superior Court in Sacramento made the order permanent. The state appealed the case, but lost its appeal in November 1967, the California Supreme Court ruling that the Health and Welfare Agency had authority to reduce the program but that the manner in which the reductions were made was ultra vires the 1965 and 1967 Medi-Cal laws, the latter requiring either elimination of medically needy beneficiaries or a proportional reduction of all services as opposed to elimination of particular services.¹⁰³ Governor Reagan immediately put the question of Medi-Cal before the legislature, then meeting in special session, and warned that he would be forced to remove benefits from the medically needy unless the projected cutbacks could be made; the supposed deficit for 1967-68 was then claimed by the Reagan Administration to be \$71 million.¹⁰⁴ As the months went by, however, the fiscal situation changed significantly. By the spring of 1968, the deficit had not only disappeared; a *surplus* of \$31 million was allowed for carryover into 1968-69.¹⁰⁵ But that announcement coincided with the signing of the 1967 Social Security Amendments in Washington; Congress had acted.¹⁰⁶

C. The Social Security Amendments of 1967

Hearings on the 1967 Social Security amendments had begun before the House Ways and Means Committee on March 1, with proposals by Secretary Gardner. As it happened, Medicaid was overshadowed both by legislative changes in the OASDHI program and, in political terms, by the House-inserted amendments about the "mandatory work provisions" and the AFDC "freeze" in the nonmedical parts of the public assistance program. Behind the scenes there was no doubt political bargaining. Secretary Gardner was known to be anxious that title XIX be treated as a

¹⁰³ *Morris v. Williams*, 67 Cal. 2d 733, 433 P.2d 697, 63 Cal. Rptr. 689 (1967). See especially Justice Sullivan's comments:

"Our function is to inquire into the legality of the regulations, not their wisdom. Nor do we superimpose upon the Agency any policy judgments of our own. . . .

[W]e have concluded that the regulations under review are violative of the pertinent law in two major respects: (1) by restricting physicians' services for recipients of public assistance without eliminating the medically indigent from the Medi-Cal program; and (2) by eliminating certain services entirely in the absence of a showing that proportionate reductions were not feasible to some extent."

Id. at 737, 433 P.2d at 700, 63 Cal. Rptr. at 692.

¹⁰⁴ *MEDI-CAL*, *supra* note 62, at 59; *BARNES*, *supra* note 62, at 144 and *passim*.

¹⁰⁵ *BARNES*, *supra* note 62, at 147. The story is chronicled in detail in *id.* chs. 8 ("The Case of the Disappearing Deficit") and 9 ("The Sound and Fury").

¹⁰⁶ While income eligibility levels were reduced in California, major cutbacks in service were not made. The California program remains relatively comprehensive in services, while continuing to have relatively low eligibility limits. The maximum income allowable for a single person in 1967 was \$2028; it was \$3900 for a family of four (including liquid assets). The present basic income scale is \$1944 for a single person and \$3792 for a family of four. Besides the basic services, California includes services such as those of chiropractors, podiatrists, and optometrists, home health services, special duty nursing, rehabilitation center services, dentistry, physical therapy and other therapeutic services, drugs, eyeglasses, and other appliances. *MEDICAID*, *supra* note 98, at 62; Medical Services Administration, Social and Rehabilitation Service, Selected Characteristics of the Medical Assistance Program Under Title XIX of the Social Security Act, June 10, 1969 (mimeo. rev.)

health care program, while Chairman Mills saw the legislation very much as part of the welfare program.¹⁰⁷ The Ways and Means Committee, moreover, was on record as saying that it had never been intended that the federal government should subsidize the medical care "of the considerable portion of the adult working population."¹⁰⁸

HEW compromised by coming to the Congress with a bill (H.R. 5710) which would have limited federal sharing under title XIX to those whose income was no more than fifty per cent higher than the categorical assistance maxima in the state. In addition, the bill would have allowed states to buy into title XVIII, part B, not only for those who were receiving cash benefits under public assistance but also for those who were "medically indigent." Moreover, services provided by such "buying in" procedure were exempted from the "comparability" provisions of the 1965 legislation in the hope that not requiring the states to include the same services for recipients under age 65 as were available to aged recipients would encourage buying in. In addition, the HEW bill would have increased the scope of the federal seventy-five per cent administrative sharing arrangement, at the same time covering agencies other than the one directing the program. The proposed bill would also have established the free choice of physicians, created a Medical Assistance Advisory Council, and set up certain new programs for children under twenty-one, at the same time linking the program more clearly with title V (Maternal and Child Welfare).

The House hearings took their predictable directions.¹⁰⁹ The limitations on federal participation in title XIX (section 220) were supported by groups including the American Life Convention and Life Insurance Association (who would have preferred dollar limits on federal participation), Blue Cross, Blue Shield, various chambers of commerce, the International Association of Health Underwriters, the National Association of Life Underwriters, various medical groups, and, once again, Representative Stratton (who thought H.R. 5710 did not go far enough). The federal cutback was opposed—predictably enough—by the AFL-CIO, the Community Council of Greater New York, the International Ladies' Garment Workers Union, the National Association of Social Workers, the National Urban League, the Physicians Forum, and the United Auto Workers.

But when all the rhetoric was done, the Committee decided to produce its own "clean" bill (H.R. 12080), and, at least with respect to federal funding of title XIX, the new bill was more restrictive than the administration one. It limited federal participation in medical indigence categories to payments on the behalf of individuals

¹⁰⁷ For a general background to the legislation, see *WELFARE IN REVIEW*, May-June 1968, at 1. For detailed comparisons with the earlier law, together with statistics, see *SENATE COMM. ON FINANCE, 90TH CONG., 2D SESS., THE SOCIAL SECURITY AMENDMENT OF 1967—PUBLIC LAW 248, 90TH CONGRESS: BRIEF SUMMARY OF PROVISIONS AND DETAILED COMPARISON WITH PRIOR LAW* (Comm. Print 1968).

¹⁰⁸ *HOUSE COMM. ON WAYS AND MEANS, SOCIAL SECURITY AMENDMENTS OF 1967, H.R. REP. NO. 544, 90TH CONG., 1ST SESS. 118 (1967)* [hereinafter cited as *AMENDMENTS OF 1967*].

¹⁰⁹ *Hearings on H.R. 5710 Before the House Comm. on Ways and Means, 90th Cong., 1st Sess. (1967)*.

and families whose income was no more than 133 $\frac{1}{3}$ per cent of the highest amount of cash assistance ordinarily paid to a family of the same size on AFDC.¹¹⁰ In other respects the Committee generally followed the administration bill, except that states were given the right to pay recipients directly (or at least those not receiving cash under a categorical program) who would then pay providers, rather than paying the providers directly, and states were also put under pressure to collect fees on the behalf of any Medicaid patient who was legally entitled to recover from another (as in an accident).¹¹¹ The states were also partially relieved of their obligation not to use the new federal money merely to replace other state effort in the field of medical care ("State effort"). The new section 221 allowed other payments to be taken into account so that, in the words of the Committee report, "no State is penalized for limiting its medical assistance program to what it conceives to be sound and proper levels."¹¹² Finally, instead of having to provide five basic services under the program, states were given the alternative either of including those five or any seven out of the fourteen which the 1965 legislation had enumerated as approved for federal matching.

The House bill, introduced, as is traditional with Social Security bills, under a closed rule, passed in mid-August, and the Senate began hearings at the end of the month. Secretary Gardner attacked the House's limitation on federal participation ("We believe it to be too constrictive a definition of medical indigence"¹¹³), and the cry was taken up in Undersecretary Wilbur Cohen's detailed evidence.¹¹⁴ While the inaccurate projections for Medicaid made in 1965 and 1966 hindered the presentation, Cohen stressed that the House restrictions would be likely to force a cutback in fourteen of the thirty-five states which had Medicaid programs.¹¹⁵ To a very large extent the testimony before the Senate Finance Committee was similar to that before Ways and Means. The AMA testimony was sympathetic to title XIX,¹¹⁶ while a Medicaid lobby appeared to protest section 220¹¹⁷ and New York's Commissioner of

¹¹⁰ AMENDMENTS OF 1967, *supra* note 108, at 119. This was for states beginning Medicaid programs. For those states with a program already in existence, the proportion would be 150% until December 31, 1968, and 140% until December 31, 1969. The 133 $\frac{1}{3}$ % limitation would apply thereafter.

¹¹¹ *Id.* at 123-24. For the general Committee position, see *id.* at 118: "Your Committee expected that the State plans submitted under title XIX would afford better medical care and services to persons unable to pay for adequate care. It neither expected nor intended that such care would supplant health insurance presently carried or presently provided under collective bargaining agreements for individuals and families in or close to an average income range."

¹¹² *Id.* at 119.

¹¹³ *Hearings on H.R. 12080 Before the Senate Comm. on Finance*, 90th Cong., 1st Sess. 217 (1967) [hereinafter cited as *1967 Hearings*].

¹¹⁴ *Id.* at 274-82.

¹¹⁵ *Id.* at 279-80. "The House limitation will destroy the concept of medical indigence in a number of States."

¹¹⁶ *Id.* at 755. "We recommend, therefore, that any income limit placed on eligibility for title XIX benefits should not be so rigid as to exclude those who are clearly unable to pay for needed health care, especially those whose need is such that they are already receiving cash assistance . . ."

¹¹⁷ *Id.* at 1591-92. The Chairman of the Citizens' Committee for Medicaid stated that Congress should "make no mistake, if H.R. 12080 passes in its present form, it will strike hardest at those

Social Services argued that all his state was doing was attempting to meet the "comprehensive services" requirement.¹¹⁸

As reported out,¹¹⁹ the Finance Committee restored the 150-per-cent-of-AFDC-payments formula to the bill. At the same time the Senate proposed altering the variable grant formula, by keeping the fifty to eighty-three per cent share with respect to those covered by categorical programs of public assistance but having a variable grant of twenty-five to sixty-nine per cent for the medically needy.¹²⁰ There were other important changes. The new bill called for licensing of those nursing homes in which Medicaid patients were living, as well as the licensing of nursing home administrators. The Finance Committee accepted the House alternative of any seven out of fourteen of the allowable services under section 1902(a) for the medically indigent, but it required states to continue to provide the five basic services for those receiving cash payments through public assistance. Home health services were also added as a mandatory service for certain groups by 1970 as were "early and periodic screening and diagnosis" of those under twenty-one.¹²¹ It was made clear that deductibles could be imposed at least for the medically indigent,¹²² and the authority of the General Accounting Office to hold spot checks was underlined. Dentists were added to the direct-payment-to-recipients provision.¹²³ And in one important respect the scope of the program was expanded, by adding a new category of possible beneficiary—the "essential person" defined as "the spouse of a cash public assistance recipient who is living with him, who is essential or necessary to his welfare, and whose needs are taken into account in determining the amount of his cash benefit."¹²⁴ Elsewhere in the bill, the Senate restored the administration's proposal for federal matching funding for "intermediate care facilities," which would handle those persons who were not able to live at home but did not need the services of a hospital or a skilled nursing home.¹²⁵

families who have managed to pull themselves up from the lower depths of poverty, who are just beginning to see daylight and learning to become productive members of society. . . . We cannot rationalize the anguish of the medically needy with the unrealistic formula of H.R. 12080."

¹¹⁸ *Id.* at 1547. George K. Wyman stated, "In fact New York is the only State which has met the 1975 deadline established by Congress in title XIX which requires all States by that time to have provided comprehensive medical care for all needy persons."

¹¹⁹ The revised version of H.R. 12080 is Calendar No. 728. SENATE COMM. ON FINANCE, SOCIAL SECURITY AMENDMENTS OF 1967, S. REP. NO. 744, 90th Cong., 1st Sess. 32-36, 175-90 (1967).

¹²⁰ This suggestion was made by Senator Long, Chairman of the Senate Finance Committee. He re-introduced the proposal the following year. See note 199 *infra*.

¹²¹ SENATE COMM. ON FINANCE AND HOUSE COMM. ON WAYS AND MEANS, 90TH CONG., 1ST SESS., SUMMARY OF SOCIAL SECURITY AMENDMENTS OF 1967, at 23 (Comm. Print 1967).

¹²² *Id.*

¹²³ *Id.*

¹²⁴ *Id.* There was at least one other expansionist aspect of the 1967 legislation. The "earned income disregard" incorporated into the AFDC program increased the number of persons eligible for cash programs and thus for title XIX.

¹²⁵ This eventually became § 1121, part of title XI, the "General Provisions" title of the Social Security legislation. The Conference Committee, however, clearly saw the section as basically part of Medicaid. *Id.* at 22. "There is no Federal vendor-payment matching for people who need institutional care in the intermediate range between that which is provided in a boarding house (for which eligible

The Senate debates were dramatic, but more because of the increases in Social Security and what many regarded as the repressive changes in AFDC;¹²⁶ and only one important change was made in the Committee bill with respect to Medicaid, the amendment by Senator Ribicoff requiring state plans to provide utilization review procedures.¹²⁷ The bill finally passed on November 22 and went to conference. With the exception of the federal financial provision, where the House formula for matching grants was adopted, the Senate version of the bill generally prevailed. The House easily accepted the Conference bill. Because of the AFDC provisions there was thought to be a possibility it might not pass the Senate, but it did in December and was signed by the President in January 1968.¹²⁸ The first stage of the history of Medicaid was complete.

Of twenty-three states providing care to the medically needy, eleven cut back or adjusted their income eligibility levels following the 1967 amendments; these included California and New York.¹²⁹ Governors of nine states whose eligibility levels were cut back, and twenty-five without cutbacks were polled in the summer of 1968. Six of the former and nineteen of the latter considered the cutbacks desirable, on such grounds as that the limits were realistic and reasonable, that the limits would force states to raise public assistance levels, and that this would keep the wealthier states from taking an undue share of available federal money.¹³⁰

The dilemmas of Medicaid were evident; they revolved around the continuing question of whether Medicaid was primarily a welfare program or primarily one for medical care. As a service program attached to a system of cash assistance benefits, Medicaid lacked the financial controls of other aspects of public assistance. As a system of public purchase of services in the private medical sector, Medicaid had little or no authority over medical care providers. The administrative structure of the program assumed that Medicaid could be viewed as one more categorical assistance program; the role of HEW was therefore limited, with major devolution

persons may receive a money payment under the money payment programs), and those who need the comprehensive services of skilled nursing homes. . . . This provision should result in a reduction in the cost of title XIX by allowing States to relocate substantial numbers of welfare recipients who are now in skilled nursing homes in lower cost institutions." The cost of ICFs, however, is not included in the Medicaid budget.

¹²⁶ STATUTORY HISTORY OF THE UNITED STATES, *supra* note 7, at 823 *et seq.*; 23 CONGRESSIONAL QUARTERLY SERVICE, CONGRESSIONAL QUARTERLY ALMANAC 909-16 (1967).

¹²⁷ WELFARE IN REVIEW, May-June 1968, at 16.

¹²⁸ Social Security Amendments of 1967, Pub. L. No. 90-248, 81 Stat. 821.

¹²⁹ The 1967 legislation encouraged cutbacks to 150% of the top AFDC level by July 1, 1968; to 140% by January 1, 1969; and to the final 133 $\frac{1}{3}$ % by January 1, 1970. It was still possible, of course, for states to go beyond these limits, but only if the financing was exclusively from state funds, a generally difficult hurdle to clear. The result was that eight states felt obliged to come down to the 150% level (California, Delaware, Kentucky, Maryland, New York, Oklahoma, Pennsylvania, and Rhode Island) although, in effect, Pennsylvania avoided the cutback by raising its maximum AFDC payment levels. Two other states (Connecticut and Illinois) imposed cutbacks by January 1969. One state with a new program (Iowa) imposed a cutback to reach the 133 $\frac{1}{3}$ % level by July 1968. ADVISORY COMMISSION ON INTERGOVERNMENTAL RELATIONS, INTERGOVERNMENTAL PROBLEMS IN MEDICAID 33-34 (1968).

¹³⁰ *Id.* at 34-35.

of programs to the states. Instead, then, of a unified national policy toward Medicaid from the executive, the growing budgetary problems in the states ricocheted back to the Congress. Powerful spokesmen such as Representative Mills, Senators Russell Long, Jacob Javits, and Clinton Anderson brought the experiences in their own states back for committee consideration in the House and the Senate. The 1967 amendments tied the means-test levels for medical indigence to other public assistance means tests in the states. Medical indigence was thereby restrictively defined, with Medicaid eligibility more firmly linked than before to the operation of other public assistance titles. Nor were Medicaid's other problems eased. They were problems not of any one organization's making; rather, they were inherent in the system itself. They were expressed in terms of Medicaid's spiralling and uncontrollable costs, but they were at root problems of goals, authority, and administration.

III

COSTS AND FINANCING

A. Rising Medical Care Costs

From its beginning, as has been seen, the Medicaid program was bedeviled by problems of costs and expenditures. The 1967 amendments attempted to provide cost brakes by tying state Medicaid eligibility requirements, for the purposes of federal cost-sharing, to AFDC income levels. In theory, too, the newly-invented category of intermediate care facilities was expected to remove part of nursing home expenditures from Medicaid. All else being equal, a reduction in the total costs of Medicaid might have been expected. Yet the rapidly rising costs of medical care and Medicaid's acceptance of reimbursement mechanisms which were tied into these rising costs—an essential feature of the public-private mix—contributed to continuing increases in Medicaid expenditures. The patterns and pressures were similar to those experienced under Kerr-Mills.

Legislators and their staffs at all levels of government were unprepared for Medicaid's fiscal impact. In January 1967, before the passage of the restrictive Social Security Amendments, the President's budget predicted total federal and state vendor medical payments of \$2.28 billion in fiscal 1968, with forty-eight states participating. The actual expenditures for that year, with only thirty-seven states having operating programs, were \$3.54 billion. For fiscal 1970, the estimated expenditures are \$5.5 billion, of which the federal share is \$2.8 billion.¹³¹ Between 1965 and 1970 federal expenditures for vendor medical payments will have had a five-fold increase, with similar increases in the states. And there is no sign of any lessening of the cost acceleration.

The difficulty of making accurate cost estimates for the federal share under

¹³¹ STAFF OF SENATE COMM. ON FINANCE, 91ST CONG., 1ST SESS., MEDICARE AND MEDICAID: PROBLEMS, ISSUES, AND ALTERNATIVES 4, 42 (Comm. Print 1970) [hereinafter cited as 1970 STAFF REPORT].

Medicaid has been a focus for sharp criticism in Congressional hearings. According to the Chief Actuary of the Social Security Administration, Robert J. Myers, the initial additional cost for Medicaid for noninstitutionalized recipients was estimated as \$238 million in the first full year of operation, calendar year 1966. This figure, however, reportedly excluded the costs of patients in institutions, who were to form an important group for Medicaid payments, as well as the new Medicaid category of medically indigent children—the so-called Ribicoff Amendment added during the passage of the 1965 act. Altogether it was estimated that additional costs would be \$353 million, added on to the previous medical vendor payments through the categorical assistance and MAA programs (an estimated \$678 million); the total cost would thus be over \$1 billion.¹³² These total costs were important because Medicaid involved substantial shifts of money among the previous categories. As states moved into title XIX their vendor payments under OAA, MAA, AB, APTD, and AFDC were absorbed into the states' medical assistance (MA) programs. In the month of December 1969, for example, forty-five jurisdictions were receiving payments under title XIX (a total of \$342.8 million in that month), and another nine were still working through previous arrangements (a total of \$17.7 million).¹³³ Not surprisingly, there was confusion as to what, then, were the costs of "Medicaid." This was reflected in questions by Senator John Williams to Undersecretary Wilbur Cohen in the Finance Committee hearings on the 1967 amendments:

Your first estimate on the cost of Title XIX was \$238 million, if I understand it correctly. Then you were going before the committee a year ago and were shocked to find it was going to cost around \$2 billion Now, what is the estimated cost of this Title XIX as it stands, about \$3 billion or more, is it not?¹³⁴

Although Undersecretary Cohen reiterated the explanation of the partial and additional nature of the \$238 million, the initial obfuscation has hindered all later HEW attempts to explain the early estimates.

There remained, in any event, the basic fact that the total federal share of medical vendor payments had still been consistently underestimated, and this was a critical factor in growing Congressional concern. This fact was brought out succinctly in evidence to the Finance Committee in further hearings in 1969. The estimate for fiscal 1969 made in December 1967 was \$1.58 billion in federal funds; a month later the estimate was enlarged by \$450 million; by January 1969 it had had another \$200 million added to it; and in the revised budget three months later another \$40 million had appeared. The resulting estimate was thus fifty per cent greater than the initial estimate.¹³⁵ The potentially unsatisfactory financial position was

¹³² R. MYERS, *MEDICARE* 282-85 (1970).

¹³³ U.S. DEPT OF HEALTH, EDUCATION, AND WELFARE, *SOCIAL AND REHABILITATION SERVICE, PUBLIC ASSISTANCE STATISTICS DECEMBER 1969*, table 13 (NCSS Report A-2, 1969).

¹³⁴ 1967 *Hearings*, *supra* note 113, at 275-76.

¹³⁵ *Hearings Before the Senate Comm. on Finance*, 91st Cong., 1st Sess. 6-7 (1969) [hereinafter cited as 1969 *Hearings*].

underlined by three reports published during 1968—one private¹³⁶ and two official.¹³⁷

The problems of cost estimation were not confined to Medicaid. Caught in the same medical price spiral, the Medicare program, too, consistently underestimated its fiscal needs. Little more than a year after the Medicare program started, Congress increased Medicare taxes by some twenty-five per cent to meet unexpected hospital cost increases under Medicare's part A. The contributory premium paid by the elderly under Medicare's part B for physician services was also increased from the initial \$3 a month to \$4 a month, and later to \$5.30 a month, effective July 1, 1970, each sum being matched by concomitant increases in federal matching funds.¹³⁸ Both parts of Medicare are, however, self-limiting in that they have identifiable contributions into national trust funds, with income matched to expenditure. Medicaid, even with the 1967 retrenchments, continued to be relatively uncontrollable, because its financing was open-ended. Rising expenditures meant increased pressures on hard-pressed tax funds in the states. In the Congress, the combined and rising expenditures of both Medicare and Medicaid focused attention on the purpose of the latter.

In 1968 the Chairman of the Senate Finance Committee—Senator Russell Long—reintroduced his measure for reducing the federal share of Medicaid from the range of fifty to eighty-three per cent to the range of twenty-five to sixty-nine per cent—a measure designed to save \$310 million in fiscal 1969.¹³⁹ With little debate—and opposition only from Senator Case of New Jersey—the amendment was passed, forty-four to twenty-five, as part of the so-called “Christmas Tree” Tax Reform Bill. After passage, however, there was an outcry both from HEW and the states. While Long argued that the states “with the connivance and cooperation [of HEW] have found ways to make all kinds of people eligible that nobody in Congress ever intended to make eligible,” Wilbur Cohen, by then Secretary of HEW, responded that “it is absolutely unrealistic to expect states to put up \$500 million additional this year to keep the Medicaid program at its present level.”¹⁴⁰ Liberals in the Senate—particularly those from states hardest hit by the cutback—threatened a “minibuster.”¹⁴¹

¹³⁶ MEDICAID, *supra* note 98.

¹³⁷ REPORT OF THE STATE-FEDERAL TASK FORCE ON COSTS OF MEDICAL ASSISTANCE AND PUBLIC ASSISTANCE (1968); INTERGOVERNMENTAL PROBLEMS IN MEDICAID, *supra* note 129.

¹³⁸ The actuarial estimate of 1970 costs for Medicare part A made in 1965 was \$3.1 billion; the current estimate is \$5.8 billion. The federal share of part B costs rose from \$623 million in fiscal year 1967 to an estimated \$1245 million in fiscal year 1971, with equal matching from the personal contributions of the elderly. 1970 STAFF REPORT, *supra* note 131, at 3-4.

¹³⁹ \$129 million from New York alone. \$27.5 million would have been cut from California, \$40 million from Massachusetts, \$16 million from Minnesota, and \$30.5 million from Pennsylvania. All told 23 states and the District of Columbia (but no southern states) would have been affected. *Id.* at 202.

¹⁴⁰ AMA News, Oct. 7, 1968. Long's chief complaint was that “The federal share of Medicaid is \$700 million more than they said it would be in December. . . . That is getting pretty badly off on a program of this size.”

¹⁴¹ Senator Mondale called the vote a “hasty and unwise decision.” For further details of his views, see 24 CONGRESSIONAL QUARTERLY SERVICE, CONGRESSIONAL QUARTERLY ALMANAC 633 (1968). The minibuster was led by Senators Javits and Goodell of New York.

Senator Long capitulated, and the amendment was withdrawn.¹⁴² But Medicaid's cost problems remained.

Estimates of total public and private health expenditures for fiscal 1969 reached \$60.3 billion. This represented additional expenditures of \$18 billion over fiscal 1966, and in total accounted for 6.7 per cent of the gross national product. In fiscal 1966, the public sector funded about twenty-two per cent of total expenditures for medical care; three years later the proportion had risen to thirty-six per cent.¹⁴³ Despite Medicare's contribution to financing health care for the aged, because of accelerating prices the contribution of other public programs—notably Medicaid—was maintained at about the same proportional level. Instead, then, of Medicaid acting as a relatively limited backstop to a social insurance program, it appeared to have an important and continuing financial responsibility; but the nature of the responsibility was such that Medicaid was blamed for failures which were essentially caused by the inadequacies of other programs.

The primary reason for rising expenditures lay in the costs of providing in-hospital and nursing home care. Expenditures for hospital care increased by seventeen per cent within one year to a total of \$22.5 billion in fiscal 1969.¹⁴⁴ Only part of these increases could be attributed to expanded or better services.¹⁴⁵

These general cost trends had specific implications for Medicaid. Inpatient hospital care represented 37.5 per cent of expenditures of \$4.3 billion for medical assistance in fiscal 1969, and nursing home care another 29.8 per cent, a combined total of 67.3 per cent.¹⁴⁶ The 1965 legislation specified that inpatient hospital care (though not nursing home care) under Medicaid should be reimbursed on a "reasonable cost" basis (rather than, for example, on a statewide fee schedule).¹⁴⁷ The Medicare interpretation of reasonable cost, defined in regulations by the Social Security Administration, was adopted for interim payments under title XIX.¹⁴⁸

¹⁴² N.Y. Times, Oct. 12, 1968, at 1, col. 2. The only legislation relating to Medicaid which passed in 1968 was a provision in the Revenue and Expenditure Control Act of 1968, Pub. L. No. 90-364, § 301 *et seq.*, 82 Stat. 273, extending the time during which states might sign up Medicaid patients under XVIII B without losing matching funding. For details see 24 CONGRESSIONAL QUARTERLY SERVICE, CONGRESSIONAL QUARTERLY ALMANAC 265 (1968).

¹⁴³ U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE, SOCIAL SECURITY ADMINISTRATION, RESEARCH AND STATISTICS NOTE (Nov. 7, 1969).

¹⁴⁴ The total cost of hospital care was reported in 1966-67 as \$16.8 billion and nursing home care as \$1.7 billion. Nursing home expenditures rose to \$2.4 billion in 1968-69. These figures refer to expenditures in all institutions, paid for from both private and public funds. *Id.*

¹⁴⁵ A study by the Social Security Administration of the \$2.1 billion increase in hospital expenditures for the elderly between fiscal years 1966 and 1968 estimated that 61% of the increase was the result of price changes and another 7% could be attributed to population increases. This left only 32% of the increases for changes in the provision of services. Similar cost rises could be observed for the non-elderly population. *Id.* (July 16, 1969).

¹⁴⁶ U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE, SOCIAL AND REHABILITATION SERVICE, MEDICAID FISCAL YEAR 1969, table 1 (NCSS Report B-5, 1969).

¹⁴⁷ Pub. L. No. 86-97, § 1902(a)(13)(B), 79 Stat. 345 (1965).

¹⁴⁸ The reasonable cost regulations were introduced in May 1966 as Principles of Reimbursement for Provider Costs. These were adopted by the Social and Rehabilitation Service (SRS) in January 1969 as the standard for hospital reimbursement under title XIX. The objective of the principles is that the

The arrangement greatly facilitated the accounting procedures for payment for hospital services on behalf of elderly persons who were recipients of both Medicare and Medicaid.¹⁴⁹ But, at the same time, reasonable cost reimbursement tied states to the rising costs of hospital care. The total costs of hospital care for the elderly rose from \$4.17 billion in fiscal year 1967 to \$6.53 billion in 1969; nursing home costs rose from \$1.52 billion to \$2.17 billion in the same period.¹⁵⁰ Similar increases were observed for hospitalization with respect to other age groups. As hospital costs rose, so in large part did Medicaid reimbursement rates.

There was no similar provision in the legislation that nursing home costs be reimbursed by Medicaid on a reasonable cost basis. Apart from hospitals, suppliers of services were to be reimbursed according to state policies, which were to "provide such safeguards as may be necessary to assure that . . . such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients."¹⁵¹ This principle was elaborated in the requirements for a state plan of medical assistance in terms which defined the "best interests of the recipients" as receipt of medical care and services included in the plan "at least to the extent these are available to the general population."¹⁵² California was one state which interpreted the intent of Medicaid as being to provide services to the poor on the same basis as services were provided to the middle-class population through the private sector—a stand which argued for payment of services through

public program pays all allowable costs with respect to an individual patient, and that no part of the individual's allowable cost is subsidized by, or is subsidizing others. Methods of apportioning allowable costs under the Medicare regulations include (1) Departmental Method—Ratio of Charges to Costs (*e.g.*, if X per cent of a hospital's x-ray charges are for services used by the Medicare patients, Medicare pays that percentage of the total allowable costs of the department); and (2) Combination Method, which includes the hospital's average daily charge for routine inpatient services, together with appropriate apportionment of charges for special services such as x-ray, laboratory, and operating room. Besides these two methods, a third and simpler formula was developed by SRS for Medicaid—Gross Ratio of Hospital Cost to Hospital Charges. Under this, the total allowable annual inpatient cost of operating a hospital is divided by the total annual charges for inpatients. The percentage which results is applied to the bill of each inpatient covered by Medicaid. Following discussions between SRS and SSA (the administrator of Medicare), it was agreed to limit the third method to hospitals not participating in title XVIII. All formulae were for the determination of interim payments, with final settlement subject to audit. *See Reasonable Cost of Inpatient Hospital Services*, CCH MEDICARE & MEDICAID GUIDE para. 14,725; Tierney, *Incentives and Hospital Cost Reimbursement*, Titles XVIII and XIX, Nov. 2, 1967 (paper presented to the Secretary's Advisory Committee on Hospital Effectiveness, Washington, D.C.). Hospitals were also reimbursed an additional 2% of allowable costs for depreciation and other overheads; this was abolished in 1969.

¹⁴⁹ Part A of Medicare today provides hospital services after an initial deductible of \$52 and with cost-sharing by the patient of \$13 per day from the 61st through the 90th day of hospitalization, with an additional 60 days provided as a lifetime reserve with a \$26 co-insurance feature. Medicaid is required to pay the initial deductible for cash-assistance recipients, and it may pay the other hospital costs and receive federal financial participation. An estimated 2.9 million persons 65 years of age and over received medical assistance (but not all in hospitals) through federally-aided programs in fiscal year 1969. MEDICAID FISCAL YEAR 1969, *supra* note 146, table 2; SOC. SEC. BULL., Dec. 1969, at 77.

¹⁵⁰ U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE, SOCIAL SECURITY ADMINISTRATION, RESEARCH AND STATISTICS NOTE (June 18, 1970).

¹⁵¹ Pub. L. No. 89-97, § 1902(a)(19), 79 Stat. 347 (1965).

¹⁵² SUPPLEMENT D, *supra* note 48, para. D-5320.

Medicaid under similar arrangements to those made by private insurance schemes or Medicare. This interpretation appeared to be also the original policy of the Social and Rehabilitation Service. For institutions other than hospitals, states were advised that fee structures should focus on payment on a reasonable cost basis, equivalent to the reimbursement methods under part A of title XVIII.¹⁵³ Prior to title XIX, the usual method of vendor payment for skilled nursing home care by state welfare departments was on the basis of negotiated fees, per diem or monthly flat rates which were in many cases below the institutions' operating costs. In states which shifted to reimbursement methods more nearly reflecting the costs incurred, immediate increases in expenditures were observed.¹⁵⁴

A second factor in increasing nursing home expenditures under Medicaid was the immediate boom in nursing home development, largely the result of private speculation which accelerated rapidly following the passage of Medicare and Medicaid. In Connecticut, for example, the number of beds in nursing homes expanded from 7725 in 1961, to 11,284 in 1966, to 14,305 in 1970; applications for another 900 beds had been approved by the state Hill-Burton agency.¹⁵⁵ Nursing home care appears to be particularly elastic in terms of demand; to this point, at least, the more beds, the greater their utilization. In states such as Connecticut, where the great majority (seventy per cent) of nursing home beds are filled with welfare recipients, the expansion of facilities led to an unexpected increase in the number of eligible recipients and thus to an unexpected rise in nursing home costs; and to a greater or lesser extent this was true of all states with relatively generous Medicaid provisions. Expenditures on nursing home care being met from public sources (chiefly Medicare and Medicaid) more than doubled between fiscal 1966 and fiscal 1968.¹⁵⁶ Medicaid thus became a part of the cause of the rising costs of nursing home care as well as a victim of their implications.

¹⁵³ In a later State Letter (No. 1063, Mar. 13, 1969), the Social and Rehabilitation Service stated that this policy was not to apply to skilled nursing home care, and that provisions for the application of upper standards of reimbursement for skilled nursing home care would be clarified when regulations governing the standards for payment for such care were issued. These clarifications were, however, never issued. Effective July 1, 1970, the upper limits for payment for skilled nursing home services, outpatient hospital services, and clinic services are "customary charges which are reasonable." Fee schedules are acceptable provided they fall within the reasonable charges established for Medicare. CCH MEDICARE & MEDICAID GUIDE para. 14,723.

¹⁵⁴ In Connecticut, for example, where reimbursement levels are set annually by a state Hospital Cost Commission, skilled nursing homes were reimbursed a maximum of \$10.50 a day under title XIX in fiscal year 1967, and between \$15.00 and \$16.00 a day in fiscal year 1970. Personal communication from Connecticut State Department of Welfare.

¹⁵⁵ This expansion caused the Connecticut legislature to put controls on further construction. Effective July 1, 1970, nursing home construction in the state is conditional upon the issuance of a certificate of need by the State Department of Health. CONN. GEN. STAT. ANN. § 19-32 (Supp. 1970). The rapid expansion, however, was probably already over. B. Sullivan, A Patient Origin Study of Connecticut Nursing Home Residents, 1970 (essay presented to the Department of Epidemiology and Public Health, Yale University Medical School, in candidacy for the degree of Master of Public Health).

¹⁵⁶ From \$604 million to \$1490 million. The great majority (\$1364 million) of the latter sum represented care of the elderly. U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE, SOCIAL SECURITY ADMINISTRATION, RESEARCH AND STATISTICS NOTE (July 16, 1969).

The initial approximation of reimbursement methods under Medicaid to the methods used in Medicare was not limited to institutions. The coincidence of passage of Medicare and Medicaid in the same legislation, and a prevailing mood in Secretary John Gardner's Department of Health, Education, and Welfare that medical care for the poor should be provided with equal dignity and through similar channels as the medical care of other members of the population, made this approximation inevitable.¹⁵⁷ This was a question not merely of political philosophy but also of encouraging effective professional participation in the program. Fee structures, it was emphasized in 1966, should be "realistic to assure eligible persons medical care and services in sufficient quantities."¹⁵⁸ As a minimum, the participation ratio determined separately for each profession, and for specialties within a profession, should be approximately two-thirds of such practitioners in the state.¹⁵⁹

In terms of physician participation at least, this suggested the incorporation into Medicaid of fees similar to those charged in private practice. As a result there was a movement, led by state medical societies, to establish payment of physicians on the basis of their "usual and customary fees" in the developing Medicaid programs. A review in 1967 found that fifteen title XIX programs had established payment of physicians through their usual and customary charging structure; only one of these states (Idaho) had previously paid on this basis.¹⁶⁰

The success of this policy in encouraging physician participation was universally commended by physician organizations. The president of the Illinois State Medical Society, for example, ascribed the jump in physician involvement in Medicaid in that state, from 3228 MDs in 1967 to over 6000 in 1969, to the move from the previous pattern of closed panel "welfare physicians" to one which allowed all physicians to participate.¹⁶¹ At the same time, a commitment by states to pay the charges as determined by physicians, with only minimal state controls, added to the inflationary characteristics of Medicaid programs. A survey of states with programs early in 1968 found fourteen states reporting unwillingness of physicians or other suppliers to participate, chiefly because of inadequate fees; on the other hand, seventeen states reported sharp rises in fees and charges, and already there were charges of profiteering and racketeering on the part of providers.¹⁶² For reasons both of extended services and rising fees, the amount paid to physicians

It is, of course, true that even before Medicare and Medicaid a large share of nursing home beds were occupied by welfare patients. The effect of the 1965 legislation was to increase competition for available beds, which, coupled with a rapid rise in the standards demanded, forced welfare departments to pay more substantial rates.

¹⁵⁷ Cf. J. GARDNER, *NO EASY VICTORIES* ch. 10 (1968).

¹⁵⁸ SUPPLEMENT D, *supra* note 48, para. D-5340.

¹⁵⁹ *Id.* para. D-5330.

¹⁶⁰ The common pattern prior to title XIX was payment of welfare patients' physicians according to negotiated fee schedules. Personal Communication, Social and Rehabilitation Service.

¹⁶¹ AMA News, Jan. 13, 1969. See also pp. 418-19 *infra*.

¹⁶² MEDICAID, *supra* note 98, at 42.

under medical assistance programs increased five-fold between 1965 and 1969; by the latter year physician fees absorbed twelve per cent of expenditures of assistance programs.¹⁶³

While many of the additional expenditures represented extra services and possibly extra time spent with medical assistance patients (and perhaps even less tangible elements such as greater personal attention to welfare patients), there was undeniable evidence that much of the benefit of the additional expenditures was flowing into the pockets of providers—hospitals, nursing homes, physicians, laboratories, and other participating facilities and services. The providers had, after all, previously provided a substantial subsidy to welfare recipients.¹⁶⁴ Cost increases in Medicaid between 1968 and 1970 were estimated to be three times as great as the increases in the number of persons served by the programs;¹⁶⁵ a remarkable phenomenon even taking over-all inflation into account.

It was thus in an atmosphere of concern about rising costs that the debates over Medicaid continued after the 1967 amendments as before. Senator Long expressed the increasing interest of the Senate Finance Committee in cost controls over Medicaid and Medicare in announcing further hearings in 1969. Medical care provided under the programs, he emphasized, should be of high quality; "but we think it should be provided on the basis that is efficient and economical, not on a basis which is wasteful and extravagant."¹⁶⁶

B. Medicaid Budgets in the States

Medical vendor payments represented less than one third of state welfare budgets in 1965. By 1969 medical vendor payments had risen to well over forty per cent of the welfare budgets.¹⁶⁷ It was reported that one out of every three states had been forced to raise its taxes, at least in part because of Medicaid.¹⁶⁸ California, Michigan, and New York had run into fiscal difficulties even before the end of the 1967 fiscal year. By 1968 three other states, Maryland, Nevada, and Oklahoma, were running ahead of their budgets. Except for Nevada, categor-

¹⁶³ In calendar year 1965, \$121.6 million were spent on physicians' services; in fiscal year 1969, the figure was \$523.3 million. MEDICAID FISCAL YEAR 1969, *supra* note 146, table 1.

¹⁶⁴ On this see p. 409 *infra*.

¹⁶⁵ In 1968, Medicaid served 8.6 million people; in 1970, an estimated 10.2 million. Expenditures, meanwhile, increased from \$3.5 billion to \$5.5 billion. 1969 *Hearings*, *supra* note 135, at 8-9.

¹⁶⁶ Senate Committee on Finance, Press Release, June 26, 1969, included in *id.* at 3.

¹⁶⁷ Vendor medical payments for medical care from state funds amounted to \$1.52 billion in fiscal year 1969; total state funds for federally subsidized public assistance amounted to \$3.47 billion. Taking all funding sources together (federal, state, and local), 9 states and Puerto Rico spent more than half of their welfare funds on medical care. U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE, SOCIAL AND REHABILITATION SERVICE, SOURCES OF FUNDS EXPENDED FOR PUBLIC ASSISTANCE PAYMENTS, tables 2, 3, 8 (NCSS Report F-1, 1969).

¹⁶⁸ Data Presented by Staff of Senate Finance Committee. 1969 *Hearings*, *supra* note 135. The Tax Foundation survey noted, however, that state tax increases were associated with expansions in more than one government program. There was some evidence that Medicaid was being used as a convenient scapegoat. MEDICAID, *supra* note 98, at 40.

ical coverage in these states was quite broad. In Maryland, Michigan, and New York, moreover, substantial proportions of the Medicaid payments were being made for nonwelfare cases.¹⁶⁹ The states were thus subject to a number of pressures. First, their welfare budgets were being strained, with payments for medical care competing and in some cases threatening to overrun funds for direct cash assistance. Second, Medicaid was becoming unpopular politically, especially in terms of requiring additional taxes on those lower income groups whose own medical care was not always adequate. There thus seemed to be no alternative to an attempt to cut back coverage and tighten payments to providers. State retrenchments therefore joined retrenchments by the federal government.

Some sense of the impact of the 1967 amendments in the states may be gleaned from the reactions in California and New York. California's plight during its period of apparent deficit and service reduction had a major impact not only on the passage of the 1967 Social Security Amendments and subsequent concern in Washington but also on political reactions to Medicaid in other states which in the event were not so fortunately situated. New York had similar visibility and national importance. Taken together, in the fall of 1967 the two states accounted for nearly half (48.5 per cent) of payments to medical vendors and for about thirty-seven per cent of all recipients of medical assistance in the country.¹⁷⁰ The experiences in these two states were thus of particular importance to the general development of Medicaid programs.

Governor Rockefeller's situation was unlike Governor Reagan's in that New York had established what other states felt to be abnormally high eligibility levels. The New York situation was thus one of justifying population coverage rather than services. But again there were immediate problems of costs exceeding budget estimates. Initial estimates stated that during fiscal 1967, the Medicaid program would raise public assistance costs by \$36 million; this was to be accompanied, as a bonus, by expected increased federal funding of \$114 million and a decreased state and local share of \$78 million. In fact, costs increased sharply for all three levels of government. Original total outlays of \$350 million were expected for fiscal 1967. The actual expenditures reached \$461 million, and further deficits were expected for fiscal 1968.¹⁷¹ By fiscal 1969 New York State was spending \$426 million from state funds alone; the total cost of the program (federal, state, and local) was \$1.29 billion.¹⁷²

¹⁶⁹ MEDICAID, *supra* note 98, at 35-39.

¹⁷⁰ *Id.* at 35. Even with expanded programs in other states, New York and California continue to dominate Medicaid. In fiscal year 1969 New York accounted for 28.1% of all medical assistance expenditures, and California for 17.1%—a total of 45.2%. MEDICAID FISCAL YEAR 1969, *supra* note 146, chart 1.

¹⁷¹ These deficits occurred in spite of the fact that less than half of the estimated eligible population applied for participation in the program in fiscal 1967.

¹⁷² SOURCES OF FUNDS EXPENDED FOR PUBLIC ASSISTANCE PAYMENTS, *supra* note 167, table 8. Out of this New York spent \$54 million (including \$14 million in state funds) on administering the program, including determining eligibility. U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE, SOCIAL AND RE-

Although Governor Rockefeller had joined Mayor Lindsay in urging that President Johnson not sign the bill which became the 1967 Amendments, once it was law the Governor was faced with a need to raise an extra \$150 million in connection with the different welfare changes made. No less than twenty-eight municipalities had raised their sales tax, and nearly all sixty-two counties had raised their property tax, virtually all alleging the "Medicaid problem." Governor Rockefeller admitted he had been mistaken to be so enthusiastic about Medicaid and called for cutbacks in the program in his budget message to the Legislature. The state Senate—controlled by the Republicans—cut back the program with little debate. In the Assembly, Speaker Travia hoped to keep the bill bottled up in committee, but eventually a group of upstate Democrats forced him to release it, fearing a taxpayer revolt in their constituencies. After an emotional three-hour debate, the bill was passed, Travia declaring it a "day of infamy" when the needy ill were sold for "a few paltry pieces of silver." Although the bill made greater cuts than he requested, Governor Rockefeller signed the bill almost as soon as it reached his desk—some said in the hope of obtaining conservative backing for his Presidential campaign. The cost of the state's Medicaid program would, it was estimated, be cut by some \$300 million (although experience did not bear this out), while the new eligibility levels—down to \$5300 from \$6000 for the family of four¹⁷³—were expected to remove roughly a million persons from the nearly three-and-a-half million who had by that time enrolled. Mayor Lindsay claimed that New York City would lose \$120 million a year and have to curtail services (and he also argued that Washington and Albany had flunked the first test posed by the National Advisory Commission on Civil Disorders). But even at \$5300, New York's was still the most generous Medicaid program in the nation.¹⁷⁴

The medical care needs of the people cut off the rolls in New York City, as elsewhere, did not of course suddenly go away. Mayor Lindsay estimated that the eligibility cuts would mean a loss of about \$80 million in state aid to municipal and voluntary hospitals and could mean closing public health facilities.¹⁷⁵ Part of the costs were thus shifted from one public pocket to another; indeed, to help those dropped from Medicaid, the New York City Department of Hospitals was forced to cut its own fees in municipal outpatient departments.¹⁷⁶ The situation thus

HABILITATION SERVICE, PUBLIC ASSISTANCE COST OF STATE AND LOCAL ADMINISTRATION, SERVICES AND TRAINING, table 8 (NCSS Report F-3, 1969).

¹⁷³ In certain cases counties could lower eligibility still further. The new state legislation also disqualified working persons between 21 and 65, except in cases of catastrophic illness where medical cost exceeded more than 25% of a patient's annual income.

¹⁷⁴ For a study of the politics of reduction in New York, see M. Petrina, *A Look at Medicaid*, 1969 (paper on file with the authors).

¹⁷⁵ N.Y. Times, Mar. 15, 1968, at 35, col. 1.

¹⁷⁶ The standard fee was to be \$16, graduated down to \$3 a visit for a family of four with an income of \$5300. The department took the step reluctantly, after pressure from house staffs and from the HEW Regional Office.

aggravated the already perilous financial situation of the city hospital system. With the coming of Medicaid, much of the former private subsidy of welfare cases had been replaced by public subsidy; Medicaid had in large part eliminated "charity." The voluntary and proprietary hospitals and, for that matter, private practitioners in the health fields, were not prepared simply to revert to the pre-existing situation. The voluntary hospitals, in particular, could not afford it. It was by then illegal, moreover, for welfare workers to press a recipient's relatives to contribute. There was no adequate resource to pick up the services and patients that Medicaid dropped. All in all, the medical care available to the many thousands of poor in New York City who were no longer eligible for assistance was worse in 1968 than it was before Medicaid was enacted.

Yet still the budget rose; and the New York legislature took further measures to attempt to control it in 1969. Effective July 1, 1969, the eligibility level for a family of four was reduced to \$5000 (eliminating another 200,000 persons from New York City's Medicaid rolls, leaving about 650,000 low-income participants, together with the one million welfare recipients). Reimbursements to hospitals were frozen and a general cutback of twenty per cent in fees was ordered effective as of June 1. For the medically indigent (but not those on welfare), doctors, dentists, and pharmacists were to collect twenty per cent of bills directly from Medicaid recipients.¹⁷⁷ On behalf of users of the programs U.S. District Judge Constance Baker Motley in New York City issued a temporary restraining order against the putting into effect of the regulation for compulsory contributions from the medically indigent,¹⁷⁸ although this was dissolved after a hearing before a three-judge court.¹⁷⁹ But another three-judge federal court in Brooklyn struck down Medicaid reimbursement restrictions on hospitals in New York, on the ground that they violated federal law.¹⁸⁰ But the eligibility levels stuck, and Albany's efforts to curb the state Medicaid budget continued.

The problems of Medicaid in California and New York were paralleled by similar budgetary increases (if on a lesser scale) in other states. In Oklahoma in fiscal 1968 the Welfare Department's cash reserve became so low that the state was forced to draw federal funds in advance to make monthly welfare payments; as a result, services under the Medicaid program were cut for all persons receiving aid (predominantly for payments to hospitals and physicians), and the number of people classed as categorically related was reduced.¹⁸¹

¹⁷⁷ N.Y. Times, June 24, 1969, at 20, col. 3; *id.*, Aug. 13, 1969, at 33, col. 5. The latter was an article entitled *Medicaid Shifts Cause Bewilderment*, and included a photograph showing a line of persons outside a medical center waiting "to clarify their status."

¹⁷⁸ AMA News, July 21, 1969.

¹⁷⁹ O'Reilly v. Wyman, 305 F. Supp. 228 (S.D.N.Y. 1969). Despite its success, the state decided to delay implementation. The order requiring a twenty per cent contribution is now due to go into effect on December 1, 1970. N.Y. Times, Oct. 28, 1970, at 53, col. 7. For a similar proposal in California, see AMA News, June 16, 1969, at 3.

¹⁸⁰ See p. 411 *infra*.

¹⁸¹ MEDICAID, *supra* note 98, at 38. In that state some 145,000 persons on welfare were eligible, to-

In Maryland, which initially offered services to all eligible categorical groups (for federal cost sharing) and to the medically indigent in the twenty-one to sixty-four age group (from state and local funds), medical vendor payments were running at the end of 1967 at a rate nearly four times that of calendar year 1965.¹⁸² To pay for the unexpected costs of the program (which were ascribed to increased costs of hospital care) a transfer of money was made from the 1969 capital construction fund. In this state as elsewhere there was growing concern over where Medicaid money was going. In July 1968 Governor Agnew cut eligibility for a family of four from \$3120 to \$3000 and for a single person from \$1800 to \$1500, in the expectation of cutting 22,000 persons out of the Medicaid program. In addition, for the "medically indigent" (who received a special card to distinguish them from other "indigents") a \$40 deductible for each admission to hospital was imposed, together with a twenty-one-day maximum stay, and partial charges were imposed for use of dental services and emergency rooms, for drugs, and for visiting a physician.¹⁸³ The state medical society resolved at its 1969 meeting that Medicaid services for hospital inpatients and outpatients should continue to be reimbursed at the usual and customary levels until the budget was depleted; physicians would then give care without charge.¹⁸⁴ Even this apparently generous gesture was insufficient. By the end of 1969, hospital officials claimed the state owed Baltimore hospitals more than \$6.3 million in unpaid bills.¹⁸⁵

State legislatures were increasingly reflecting the hostility of Congress to the Medicaid program. New Mexico, which did not even cover the "medically indigent," was faced with a legislature which refused to allocate enough funds to pay even for the barebones program.¹⁸⁶ Nevertheless medical vendor payments in that state rose from \$5.4 million in 1965 to \$16.9 million in fiscal year 1969.¹⁸⁷ A series of budget cuts were made in 1968, including a reduction in physician fees by twenty-five per cent.¹⁸⁸ But these measures were not enough. New Mexico became the first (and so far only) state to close down its Medicaid program (on May 1, 1969); the program was reinstated after nine days, although remaining

gether with 35,000 of the "medically indigent." The cutbacks were made primarily among the providers and included limiting physicians to one hospital visit per day, two nursing home visits per month, and so forth. But for recipients, hospital stays were limited to 10 days, and recipients were exposed to an information program "urging them to carefully use the benefits available." *AMA News*, June 24, 1968.

¹⁸² About 70% of Medicaid payments were being made on behalf of the medically indigent. *MEDICAID*, *supra* note 98, at 36.

¹⁸³ The program was designed, in the words of the *Maryland State Medical Journal*, to "weed out certain persons" and not to affect "the legitimate indigent." Details from *AMA News*, July 8, 1968, and Oct. 14, 1968. There were still deficit problems. *See id.*, Oct. 17, 1968.

¹⁸⁴ *Id.*, May 5, 1969.

¹⁸⁵ *Id.*, Jan. 19, 1970.

¹⁸⁶ *Id.*, June 24, 1968.

¹⁸⁷ *MEDICAID*, *supra* note 98, at 70; *MEDICAID FISCAL YEAR 1969*, *supra* note 146, table 4.

¹⁸⁸ Other attempted tightening included limitation of payments for diagnostic radiology and pathology to specialists in these areas, payment to nursing homes only when care was certified by a physician, and limitation of drugs to listed items. *AMA News*, Feb. 10, 1969.

chronically underfunded.¹⁸⁹ The state welfare department of Nebraska was forced to seek a \$1 million deficit appropriation in 1969, three-fourths of which was attributable to Medicaid.¹⁹⁰ In August 1968, Louisiana retrenched, cutting inpatient stays, drugs, and payment of co-insurance under Medicare's part B;¹⁹¹ even then there were demands for further cutbacks.¹⁹² In Connecticut, after beginning its program in 1966, the eligibility levels were actually raised slightly in 1967, only to be reduced again in 1969.¹⁹³ And the story has been similar in various other states¹⁹⁴—or at least in those which instituted the program well before the December 1969 deadline.¹⁹⁵ In some states, however, such cutbacks were difficult, if only because there were no "medically indigent" categories.¹⁹⁶

C. Medicaid Budgets and Controls: Increasing Federal Intervention

The defeat of the Democrats in the Presidential election in November 1968 signalled a rethinking and re-appraisal of Medicaid. In 1965, the message of Medicaid had seemed to be one of purchasing health services of a quality equal to private services for a substantial proportion of the population under basically state-controlled programs. Title XIX, as passed in 1965, had it been fully implemented, could have covered as many as thirty-five million Americans and cost as much as \$20 billion a year.¹⁹⁷ From the time of the 1967 amendments, and especially since the beginning of the Nixon Administration in 1969, the prevailing Congressional view of Medicaid has been quite different. A shift is now apparent towards greater federal control over Medicaid (the federal audits of 1969 were one indication), engendered by concern over rising budgets, and at the same time

¹⁸⁹ A meeting of the New Mexico legislature on April 11, 1969, had ordered the state to withdraw from its relatively liberal Medicaid program and re-enter with a reduced program. But this was contrary to federal regulations. *AMA News*, Apr. 28, 1969, and July 7, 1969. It was this fact which prompted Senator Clinton Anderson to sponsor a relaxation in the federal requirements. Pub. L. No. 91-172 (1 U.S. CODE CONG. & AD. NEWS 816 (1969)).

¹⁹⁰ *AMA News*, Apr. 7, 1969.

¹⁹¹ *Id.*, Sept. 2, 1968.

¹⁹² *New Orleans Times-Picayune*, Dec. 28, 1968; *id.*, Dec. 29, 1968.

¹⁹³ For details see CCH MEDICARE & MEDICAID GUIDE para. 15,566. For some of the political implications, see *New Haven Register*, Sept. 24, 1969 (editorial).

¹⁹⁴ Eligibility standards were reduced in California in January 1969 and in Virginia in July 1969. CCH MEDICARE & MEDICAID GUIDE paras. 15,560, 15,652. Maryland cut 22,000 people off the Medicaid rolls in the summer of 1968 and restored them in January 1969. *AMA News*, Jan. 29, 1969. Massachusetts reduced eligibility by executive order. *Id.*, Feb. 3, 1969, and Mar. 3, 1969. For details of the reduction in New York, particularly with respect to the property disqualification, see *N.Y. Times*, June 24, 1969, at 20, col. 3; *id.*, Aug. 13, 1969, at 33, col. 5.

¹⁹⁵ The "poorer" states (*e.g.*, Mississippi) and the more fiscally conservative (*e.g.*, New Jersey) delayed action until the last moment and in general put in modest plans. See, *e.g.*, on New Jersey proposals, *AMA News*, July 22, 1968. For some of Florida's fears about "spending millions on indigents," see *Miami Herald*, June 2, 1967. The Florida program actually began in January 1970.

¹⁹⁶ For instance, while some states, such as Texas and Louisiana, began without a "medically indigent" category, others dropped them—*e.g.*, Iowa in February 1969. CCH MEDICARE & MEDICAID GUIDE para. 15,586.

¹⁹⁷ Fred H. Steininger, Director of Family Services, HEW, *The New Medical Assistance Program*, cited in MEDICAID, *supra* note 98, at 51.

a recognition that Medicaid cannot and should not be regarded as providing the equivalent of middle-class medicine. This last point of view was stated succinctly by Dr. Roger Egeberg of HEW in the summer of 1969. Claiming that title XIX would never provide a single standard of services for rich and poor under the present system of distribution of health services, Egeberg said the slogan "let's get everybody into the mainstream" (that is, the private medical care system) should never have been used.¹⁹⁸

In the Congress, concern over medical costs increased still further in 1968. HEW was discovered to have made an error in estimates of nearly \$1 billion.¹⁹⁹ Although Senator Long withdrew his amendment calling for the reduction of matching grants for the "medically needy,"²⁰⁰ he continued to be sharply watchful of accountability under and administration of Medicaid, both individually and through his chairmanship of the Senate Finance Committee. This committee held highly critical hearings on Medicaid and Medicare in both 1969 and 1970.²⁰¹ In addition, the Finance Committee staff began a probing analysis of Medicare and Medicaid, whose results, published in 1970, provided the most detailed review as yet of management practices and cost deficiencies in these programs.²⁰²

At the same time a general concern over health care costs was building in the Congress. Hearings on health care in America before Senator Abraham Ribicoff's Subcommittee on Executive Reorganization of the Committee on Government Operations in August 1968 focused on the costs of medical services.²⁰³ This subcommittee sent out questionnaires in 1969 to all of the twenty-four federal government agencies and departments found to be involved in health, and in 1970 produced a major report.²⁰⁴ The conclusion of the report (which was emphasized

¹⁹⁸ AMA News, July 21, 1969.

¹⁹⁹ 25 CONGRESSIONAL QUARTERLY SERVICE, CONGRESSIONAL QUARTERLY ALMANAC 203 (1970). It should be noted that the estimating process has been fraught with some unavoidable difficulties. These have included the difficulty of estimating accurately the size of the potentially eligible population and the rate of enrollment; estimates of service utilization by the population; problems of assessing the amount of funds transferred to Medicaid from other state and local programs; lack of adequate estimates of the combined effect of both Medicare and Medicaid on the medical care economy as a whole; and the lack of controls over provider participation and charges. Inaccurate budget estimates were a reflection of the more general administrative deficiencies in the areas of management information about the programs and of inadequate mechanisms for cost controls.

²⁰⁰ Long's amendment was attached to a tax bill relating to farm improvement costs (H.R. 2767). It was withdrawn after liberal Senators threatened to defeat the entire bill through a filibuster. 24 CONGRESSIONAL QUARTERLY SERVICE, CONGRESSIONAL QUARTERLY ALMANAC 633 (1969); 25 *id.* at 203 (1970).

²⁰¹ *Hearings on Medicare and Medicaid Before the Senate Comm. on Finance*, 91st Cong., 2d Sess. (1970) [hereinafter cited as 1970 *Hearings*].

²⁰² 1970 STAFF REPORT, *supra* note 131. The staff also published a report of background information for the 1969 hearings. STAFF OF SENATE COMM. ON FINANCE, 91ST CONG., 1ST SESS., DATA RELATING TO MEDICARE—MEDICAID STUDY (Comm. Print 1969) [hereinafter cited as 1969 STAFF REPORT].

²⁰³ *Hearings Before the Subcomm. on Executive Reorganization of the Senate Comm. on Government Operations*, 90th Cong., 2d Sess. (1968).

²⁰⁴ In reply to the questionnaire, HEW noted no problems, but stated that Medicaid was in effect in 43 jurisdictions and being provided by physicians who represented 50 to 95% of all physicians in a state, and compared the much wider coverage and individual expenses under medical assistance in 1968 than in 1965. The blandness of this and other replies was roundly castigated in the Report. SUBCOMM.

in a special analysis made for the subcommittee)²⁰⁵ was that government expenditures of all kinds ought to be used to further an integrated federal health policy, and that this policy should attempt to influence and improve the system for providing medical care. The presumption was that the previous isolation of Medicaid from other health programs was untenable.

Interest was also developing in other Congressional committees. The Senate Special Committee on the Aging and its subcommittees held some thirty days of hearings during 1969 in Washington and around the country. An advisory committee on health costs and aging, assisting Senator Muskie's Subcommittee on Health of the Elderly, came out in favor of "comprehensive compulsory health insurance for all Americans," and its testimony underlined the deficiencies in Medicaid, "a poor program with no standards, no quality controls."²⁰⁶ The Subcommittee on Long-Term Care also held hearings in 1969 on regulations for nursing homes. Other Senate committees with an active or stated interest in health organization and costs by the end of 1969 included the Senate Committee on Public Welfare's Health Subcommittee, and the Antitrust and Monopoly Subcommittee, which was particularly interested in proprietary health institutions, especially those owned by physicians. All of this interest ultimately resulted from concern over costs and possible exploitation in publicly financed health programs. Medicaid, accounting for nearly one fourth of all public medical expenditures,²⁰⁷ would have been a target for probing criticism even without its obvious difficulties.

Beside rhetoric, concrete actions were taken to control the costs of Medicaid from the beginning of the Ninety-first Congress in the wider frame of the Nixon Administration's attempt to control increases in federal appropriations. In March 1969 HEW announced that procedures for reviewing the appropriate use of services would be required for state Medicaid programs, as well as for Medicare. The regulation, whose purpose was to give effect to the legislative intent first expressed in 1967, was to provide methods for policing costs²⁰⁸ by requiring that each state plan encourage its hospitals and nursing homes when possible to use the existing utilization review mechanisms set up under Medicare. Where these did not exist, the state agency was required to perform utilization review

ON EXECUTIVE REORGANIZATION AND GOVERNMENT RESEARCH OF THE SENATE COMM. ON GOVERNMENT OPERATIONS, *FEDERAL ROLE IN HEALTH*, H.R. REP. NO. 91-809, 91st Cong., 2d Sess. 220-22 (1970).

²⁰⁵ Dr. James Shannon, *Health Activities: Federal Expenditures and Public Purpose*, analysis made pursuant to S. Res. 320, 91st Cong., 2d Sess. (June 1970).

²⁰⁶ Testimony of Dr. John Knowles, 25 CONGRESSIONAL QUARTERLY SERVICE, CONGRESSIONAL QUARTERLY ALMANAC 850 (1970).

²⁰⁷ See Cooper, *Medical Care Outlays for Aged and Nonaged Persons 1966-69*, U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE, RESEARCH AND STATISTICS NOTE (June 18, 1970).

²⁰⁸ This provision was added in the 1967 amendments. Pub. L. No. 90-248, 81 Stat. 821. The intention was that methods and procedures would "safeguard against unnecessary utilization," and that payments would "not [be] in excess of reasonable charges consistent with efficiency, economy, and quality of care." 42 U.S.C. § 1396a(a)(30) (Supp. IV, 1969). The new regulations were issued in 34 Fed. Reg. 3745 (1969).

services itself or to monitor services performed by others. Review of services by existing peer review mechanisms was encouraged to the fullest possible extent.²⁰⁹

Behind this provision there lies the supposition that review of how and by whom services are used, for how long, and with what effect, is a necessary and desirable administrative mechanism. In any profit-making organization, the board of directors would expect that some form of production (if not quality) control would be applied to a major program of expenditures. So far in Medicaid such had not been the case. Indeed Medicaid did not have a board of directors (nor, incidentally, does Medicare)—and this fact was at the root of many of its problems and much of the concern.

The early development of the program was a matter largely of trial and error in the states.²¹⁰ With the accelerating costs and the apparent lack of dynamism, courage, power, or authorization in HEW to take firm control of the Medicaid program—even to the extent of publicizing standards and detailed critiques of the programs in the states—concern about shortcomings in management grew in the Congress. The Senate Finance Committee, in particular, has become a powerful substitute for a board of directors.

Utilization review procedures (which are now in the process of being developed²¹¹) were by no means the only attempted controls on Medicaid providers and services in 1969. One of the primary targets for cost controls was physicians' fees. As part of its growing investigation of Medicare and Medicaid costs, the Senate Finance Committee requested from HEW in April 1969 a list of all practitioners who received \$25,000 or more under Medicaid in 1968. This was followed in June by an announcement by Senator Long that the resulting names would be turned over to the Internal Revenue Service.²¹² Only a week after this announcement HEW officials revealed that payment schedules would be set up for Medicaid and that these would be based on the lowest Blue Shield payment plans. Fees would thus be deliberately fixed on a lower scale than those for Medicare, which were actually higher than the average Blue Shield fees.²¹³ This announcement,

²⁰⁹ "Peer review" means nothing more sinister than that services provided by physicians should be evaluated by physicians, and so on. One caveat is made; a practitioner may not review cases when he is the attending practitioner or has had significant professional responsibility; nor may he sit on a title XIX review committee of the institutions in which he has a significant ownership interest. The detailed regulations specify that each state must have a professional medical review committee under which periodic evaluations of patients in nursing homes and mental hospitals are made, to ensure that such patients are receiving the proper care in an appropriate setting. See CCH MEDICARE & MEDICAID GUIDE paras. 14,731, 21,720.

²¹⁰ Even in the question of hospital reimbursement, which was established in the law on the basis of "reasonable cost," Connecticut successfully challenged HEW to accept its own hospital reimbursement rates, established by a state Hospital Cost Commission, as "reasonable costs," although this method reportedly costs \$4 million to \$5 million less a year than if hospitals in the state were reimbursed for Medicaid on the same basis as for Medicare. 1970 STAFF REPORT, *supra* note 131, at 50.

²¹¹ W. Nelson, Utilization Review—Medicaid's Salvation?, 1970 (paper on file with the authors).

²¹² WASHINGTON REPORT ON MEDICINE & HEALTH, Apr. 14, 1969. See also pp. 412-15 *infra*.

²¹³ N.Y. Times, June 23, 1969; *id.*, Apr. 21, 1969.

which came as a shock both to physicians and to those who still hoped to see Medicaid with a reimbursement program tied to full private fees, was followed by a statement from HEW Secretary Robert Finch in June 1969 that payments to physicians would indeed be limited. Also to be eliminated from both Medicaid and Medicare was the two per cent "cost-plus" beyond identified costs, a payment which had been allowed by government to nonprofit hospitals and nursing homes, and a similar one and a half per cent cost-plus factor which had been granted to proprietary institutions.²¹⁴

Following a series of discussions in HEW and with professional organizations, the interim regulations for physicians and other individual practitioners appeared in July 1969.²¹⁵ The link to Blue Shield was dropped. Instead the regulations limited Medicaid fees to seventy-five per cent of physicians' customary charges in January 1969. Subsequent increases would be tied to changes in the Consumer Price Index or in an alternative index developed by the Secretary. Moreover, before increases were to be allowed there had to be evidence that the state and the profession concerned had established an effective utilization and quality control system, including provision for disqualifying practitioners found to have defrauded, overutilized, or otherwise abused the program. These regulations thus froze physician fees at a given level (although administratively that level was difficult to define), providing for each physician a kind of personalized fee schedule. With the new regulations two levels of payment were recognized, one for Medicare and one for Medicaid, with lower fees for the latter. For the elderly who were entitled to Medicare but part of whose medical bills were picked up under Medicaid, the situation was anomalous. On the one hand they possessed recognized rights to medical care in the private sector; on the other, they were once more "welfare" patients with physicians donating to them at least one fourth of their normal fee. Physicians themselves responded in different ways. The AMA, protesting the move, questioned whether HEW had the authority to set up nationally applicable regulations.²¹⁶ But meanwhile the AMA itself urged local medical groups to establish the effective controlling mechanisms to review services and fees which were the necessary alternative to future fee reductions.²¹⁷

At the same time that cost controls were beginning to be developed through federal intervention in Medicaid, there was a movement—again from within the Senate Finance Committee—to slow the expansion of services which had been

²¹⁴ 25 CONGRESSIONAL QUARTERLY SERVICE, CONGRESSIONAL QUARTERLY ALMANAC 204 (1970).

²¹⁵ 34 Fed. Reg. 11,098 (1969); CCH MEDICARE & MEDICAID GUIDE para. 14,723.

²¹⁶ AMA News, Aug. 11, 1969. It should be noted in passing that the announcement of the regulations coincided with the withdrawal of the nomination of Dr. John Knowles as Assistant Secretary of HEW—a move widely heralded as being a victory for the AMA, but one which cost the Association dearly in terms of further political leverage.

²¹⁷ AMA News, June 30, 1969. Peer review was also made the central topic of the AMA Clinical Convention in December 1969, and led to AMA endorsement in 1970 of so-called "peer review organizations" as an integral part of national financing schemes.

envisaged in the initial development of Medicaid. On the proposal of Senator Clinton P. Anderson of New Mexico a rider was attached to a tax bill in May 1969, permitting states to cut back some Medicaid services and suspending the requirement that states provide comprehensive care to all the medically needy by July 1, 1975. The Senate Finance Committee, expressing its concern over the "sharp, accelerated and unanticipated increases in the cost of Medicaid,"²¹⁸ supported the rider and a compromise version was passed by the Senate; the compromise extended the deadline requirement until July 1, 1977, and set conditions for cutting back Medicaid services in the meantime. In the House the amendment, supported by Chairman Mills of the Ways and Means Committee, was passed by voice vote, and the Anderson amendment was duly signed into law—part of an act continuing "the existing suspension of duty on certain copying of shoe lathes."²¹⁹ Under the amendment states could not eliminate the five basic Medicaid services. They could from then on, however, reduce or eliminate other services such as payment for drugs or dentistry. States were thus given a green light to amend their Medicaid programs by reducing services in order to cut costs. Meanwhile, the prospect of comprehensive health services for a relatively large group of persons—the original apparent implication of Medicaid—was receding rapidly.

The dual effort by the Congress and by HEW (through power of regulation) to cut back services and to increase centralized control in Medicaid—both primarily for fiscal reasons—promised to continue. Secretary Finch encouraged a much more active control of the program from Washington; the new regulations to limit payments to providers under Medicaid were a primary example. Dr. Francis Land, Commissioner of Medical Services Administration (the HEW bureau charged with administering title XIX), after announcing on July 16, 1969, that he had not even considered resigning, resigned on July 25—the day a Task Force on Medicaid (the McNerney Task Force) was established within HEW with the announcement that the program was "badly conceived and badly organized."²²⁰ The Task Force, whose staff was believed to be larger than MSA, the object of its investigation, issued its interim report in November 1969 and its final report in June 1970.²²¹

²¹⁸ 25 CONGRESSIONAL QUARTERLY SERVICE, CONGRESSIONAL QUARTERLY ALMANAC 203 (1970).

²¹⁹ Pub. L. No. 91-172 (1 U.S. CODE CONG. & AD. NEWS 819 (1969)) amended sections 1902 and 1903 of the Social Security Act. Section 2(d) allowed states to "modify" their programs providing, among other things, that the over-all amount of nonfederal funds being spent on medical assistance in the state was not cut back, that the state was conforming to the requirements for utilization procedures under § 1902(a)(30), and that the cutbacks were not being made to pay large fees to providers under some other part of the program.

²²⁰ 25 CONGRESSIONAL QUARTERLY SERVICE, CONGRESSIONAL QUARTERLY ALMANAC 204 (1970).

²²¹ TASK FORCE ON MEDICAID, INTERIM REPORT (1969) [hereinafter cited as INTERIM TASK FORCE REPORT]; REPORT OF THE TASK FORCE ON MEDICAID AND RELATED PROGRAMS (1970) [hereinafter cited as TASK FORCE REPORT].

By that latter date the Social Security Amendments of 1970 (H.R. 17550) had passed the House. The new bill would repeal section 1903(e)—the ultimate goal of comprehensive services—entirely; limit increases in physicians' fees; allow states to determine reasonable hospital costs rather than following the Medicare formula; encourage cost savings in various areas and especially intermediate care facilities; require Medicare-type utilization review committees for hospitals and skilled nursing homes participating in Medicaid; extend the power to apply deductibles to recipients; and, among other things, provide federal incentives for administrative innovation. Most significant, however, is the proposed formula change for federal involvement. Section 225 of H.R. 17550 suggests an over-all increase of twenty-five per cent in the federal share of outpatient hospital services and home health care services up to a maximum of ninety-five per cent, but, after sixty days in a general hospital or ninety days in a skilled nursing home or mental hospital, the federal share would be reduced by $33\frac{1}{3}$ per cent. Whether these proposals will be enacted and whether they will be any more successful than their predecessors in cutting costs, is still to be seen. But while, at the time of writing, the Senate has yet to act, it is clear from the February hearings on the Finance Committee's Staff Report²²² that the "economy" approach is in the ascendant. This was made clearer still by President Nixon's August 1970 statement saying that there would be further cuts in fiscal 1971.²²³

²²² See 1970 Hearings, *supra* note 201.

²²³ CCH MEDICARE & MEDICAID GUIDE, Report Letter No. 22, at 1 (Aug. 25, 1970). The President explained that savings would be accomplished "by changing administrative regulations to reduce certain excessive charges far above the national average imposed by some medical institutions." At the time of writing (October 1970), H.R. 17550 had passed the House but had not been reported out of the Senate Finance Committee. It was likely that the latter would adopt the tone, if not all the recommendations, of the House Ways and Means Committee Report. The key issues stressed in the House report and in the Senate hearings on the bill were methods of approving administration and developing more effective utilization review.

On the latter point the House report recommended the full adoption for Medicaid of the utilization review provisions required under Medicare. In the Senate, however, a radically different proposal was developed by Senator Bennett (with the help of the Senate Finance Committee staff, and following guidelines for peer review organizations developed by the AMA) and referred to the Finance Committee (of which the Senator is a powerful member) on August 20, 1970. The Bennett amendment to H.R. 17550 would establish national, state, and local networks of Professional Standards Review Organizations (PSRO), which would be responsible for reviewing professional activities and institutional medical services given under Medicaid, Medicare, federally-sponsored maternal and child programs, and any other designated federal programs. A PSRO would be designated by the Secretary of HEW in each area and would represent at least 300 physicians. The first group to be considered as such an organization would be the relevant state or county medical association. Over-all standards and norms for services would be developed by a national committee, also composed of physicians, with technical assistance from HEW.

This proposal, which would recognize medical societies as agents of the federal government (PSROs would be appropriately reimbursed for their activities) and set up a national peer-review policy network, is strongly opposed by the hospital associations, whose hospital utilization review committees would presumably be replaced by local medical society review. It was also initially opposed by the AMA with respect to a requirement that prior approval should be sought by a physician from his PSRO before undertaking elective procedures; but this requirement was subsequently modified to require prior approval only in selected circumstances. With this and certain other modifications the amendment was reported to have been approved by the Finance Committee. It is also understood that HEW has given

The combination of generally rising health care costs with the resulting budgetary difficulties in the states made increasing federal intervention and the economy approach inevitable. Moreover, Medicaid must be seen in the more general context of concern over its relationship with any potentially larger scheme of national health insurance. At hearings before the Senate Committee on Labor and Public Welfare in September 1970, John Veneman, Undersecretary of HEW estimated that cradle-to-grave insurance would cost \$77 billion in its first year of operation, fiscal 1974, a sum "equivalent to a Federal health tax of over \$1,000 a year for every household in the United States."²²⁴ This figure may be inflated. Nevertheless it illustrates the dimension of the cost issues and an important relationship between Medicaid and future payment schemes. If Medicaid, a program designed to provide medical services for the poor, often without the amenities expected in suburban middle-class medicine, cannot control its costs, how—it can be argued—will proposals for national health insurance succeed?

In terms of the controls themselves, however, the Medicaid program is in constant danger of having the argument of costs used not to provide services more efficiently but to cut down the provision of services to those who need them the most. The program needs stronger federal direction to protect the consumer against this contingency, not merely to issue a series of requirements for monitoring and reporting fraud, or for collecting information. It was this message, that Medicaid should be federally organized as a health program rather than an economy-drive, which formed the primary theme of the report of the Task Force on Medicaid.²²⁵ Indeed, the Task Force went much further, arguing that the structure of health services themselves needs to be reformed, and that Medicaid should play a deliberate part (with other federal programs) in initiating structural change through providing funds for stimulating new local systems of health care delivery.

Translating such proposals into action is, however, still in the future. For the present, Medicaid is trapped in its own history. Its forms of administration, its relationship with providers and recipients, are the present actualities. As such they deserve more detailed analysis.

the amendment its support in return for Senator Bennett's support of another controversial proposal in H.R. 17550—the development of "health maintenance organizations" under Medicare. This latter proposal would allow Medicare funds to be paid on a direct capitation basis for comprehensive services to be provided by designated health care systems. The intention of the provision as written is to support two goals: (1) the encouragement of preventive care through such payment arrangements (Medicare pays for care when people are sick but not for general health maintenance); and (2) an expected reduction in Medicare costs, on the basis of fixed annual budget reimbursements to health maintenance organizations, and a provision that reimbursements be at the level of only 95% of prevailing Medicare expenses.

Action is expected on H.R. 17550 after the 1970 election recess, and the Bennett amendment is thought to have a good chance of passage. Its long-term result would appear to be delegation of authority over the quality aspects of Medicaid to the providers. It would pose even more serious problems of quality control if a national health insurance program is developed.

²²⁴ Reported in N.Y. Times, Sept. 24, 1970, at 21, col. 1.

²²⁵ See TASK FORCE REPORT, *supra* note 221, at 2-3 and *passim*.

IV

ADMINISTRATION, PROVIDERS, AND RECIPIENTS

Medicaid has provided an opportunity to assess state behavior in organizing a major health planning program. It has also offered the vehicle for evaluating the realities of federal health administration. In the long process of cost acceleration, what have been the stumbling blocks, who were the villains?

In terms of administration Medicaid has fallen between several potential villains. Its link with the welfare system has had disastrous financial implications both for Medicaid and for funding programs of cash benefits. The welfare system itself is under increasing attack on the one hand as racist, demeaning, and demoralizing and on the other as inflationary and soft. The last five years have, moreover, seen a growing scepticism about federal grants-in-aid to the states, a scepticism which rubrics like "creative federalism" have not managed to stifle. At the local level, Medicaid could not be further out of touch with the ideas of community control,²²⁶ which were legitimated by the "maximum feasible participation" amendments to the poverty program. At the same time the administration of Medicaid has been hampered not only by political pressures, inflation, budget cutbacks, and the rest, but also by a shortage of medical resources—especially physicians—and a tradition of *laissez faire* which has frequently prevented an intelligent deployment of such medical resources as do exist. It is with these factors in mind that the operation of Medicaid should be evaluated.

A. Federal Administration of the Program

The federal role in Medicaid, following the Kerr-Mills experience, began by being weak and is only belatedly being strengthened. But at the same time the organizational problems of HEW itself have also to be taken into account. The unwieldiness inherent in the congeries of empires which make up the nation's major social policy agency is in danger of becoming an American tradition.²²⁷ It is no secret that HEW has not always been presided over by effective Secretaries; and, in any event, their rate of turnover has ensured that little will be done to break down the traditional lines of demarcation in the Department.

Despite a series of departmental reorganizations in recent years, even the nation's top health official, Dr. Roger Egeberg, Assistant Secretary for Health and Scientific Affairs, has "effective control" over only twenty-two per cent of HEW's health budget; Medicaid is not included in that fraction.²²⁸ The Assistant Secretary is responsible for the U.S. Public Health Service, which contains the Health Services

²²⁶ But see 1970 Hearings, *supra* note 201, at 25; TASK FORCE REPORT, *supra* note 221, § D.

²²⁷ President Johnson described the nation's health programs as "a programmatic and bureaucratic nightmare." 2 PUBLIC PAPERS OF THE PRESIDENTS OF THE UNITED STATES: LYNDON B. JOHNSON 1967, at 1099 (1968).

²²⁸ H.R. REP. No. 91-809, 91st Cong., 2d Sess. 29 (1970).

and Mental Health Administration (a sprawling complex of different programs with a budget of nearly \$1.2 billion), the National Institutes of Health (\$1.4 billion), and the Consumer Protection and Environmental Health Service (\$0.2 billion). These three divisions are supposedly the Department's major health foci. Yet Medicare (with \$7.3 billion in the trust funds for part A and part B) because of its organization as part of the Social Security system, is administered by the well-entrenched and secure Social Security Administration, a separate arm of HEW. Medicaid (\$2.7 billion in federal funds), to add to its woes, is run by the Medical Services Administration (MSA), a division of the separate Social and Rehabilitation Service (SRS)—what used to be the Welfare Administration.²²⁹ Unfortunately that was not, and is not, the most powerful empire in HEW; its purpose was to make grants to states rather than to innovate or run services; it was not loved on the Hill; and it had not the power or prestige to deal with the powerful professional groups who were the providers of Medicaid.

To these difficulties were added the chronic understaffing of MSA throughout its career. Not only did its leadership feel itself impotent and change frequently; not only were senior posts left unfilled; but the staff of MSA was so small that even had it had the will, power, and prestige to press states and providers, or to face other problems squarely, it would not have had the manpower to follow through.²³⁰ The unwillingness to staff MSA adequately must be counted as a major contributing factor in the "Medicaid Crisis." Title XIX, as passed in 1965, was so vague that only a well-staffed department could have implemented it effectively. The refusal to support MSA was a tragedy.

As it was, mandatory dates were not met (for example, Arizona and Alaska failed to meet the December 1969 deadline for producing a state plan for Medicaid), and cutoffs in state funds (which could, for instance, be imposed on those several states who have not met utilization review requirements) were not only not made but never considered very seriously. Despite the fact that each year Medicaid took an increasingly significant share of the federal budget, the issuing of regulations—the very core of an effective federal-state grant-in-aid program—proceeded remarkably slowly. The basic regulations for administration of the program were not issued until

²²⁹ SRS is also responsible for an array of health programs for children (\$0.2 billion), run through the Children's Bureau. Altogether the HEW health budget in fiscal year 1970 was almost \$13.5 billion, out of a total federal health budget of nearly \$18.8 billion. Medicaid thus represents 20% of the HEW health budget and 14.4% of all federal health expenditures. *Id.* at 9, 206-07.

²³⁰ In July 1965, when Medicaid was authorized, there were only 23 persons—including secretaries—employed in the Medical Services Division of what was then the Bureau of Family Services. Thirty-five more positions were authorized after the law was passed. This small group was made responsible for federal direction of the new multi-million dollar program. By mid-1969 the renamed Medical Services Administration, as part of the Social and Rehabilitation Service, only had 76 positions—again including secretaries—in Washington and 24 in the SRS Regional Offices, for communicating with 44 states' Medicaid programs, for guiding in program planning and development, and for providing program evaluation. *1969 Hearings, supra* note 135, at 112. Since the arrival of Dr. Howard Newman as Commissioner, the staff of MSA has expanded considerably.

1969,²³¹ and, for instance, MSA only just made the deadline provided by the 1967 legislation, which required federal standards for licensing of nursing home administrators²³² and definitions of a skilled nursing home²³³ by July 1970. Even then, some of the regulations were provisional, with the result that regional offices and state welfare departments treated them with some suspicion lest the offices and departments commit limited resources only to find the regulations withdrawn.

The Medical Services Administration also had difficulties in making use of its Advisory Council, established by the 1967 amendments, and also its representatives in the regional offices.²³⁴ The Medical Assistance Advisory Council was "one of

²³¹ Reg. 250.20, "Utilization review of care and services," was eventually made in March 1969. 34 Fed. Reg. 3745 (1969). Other regulations published are: Reg. 250.21, *id.* at 14,649; Reg. 250.30, "Reasonable charges," *id.* at 1244 (Jan. 1969), revised, 35 *id.* at 10,013 (June 1970); Reg. 250.13, "Payments for medical services and care by a third party," 34 *id.* at 752 (Jan. 1969); and Reg. 250.41, "Consultative services to medical institutions," 35 *id.* at 6322 (Apr. 1970).

Two further regulations, representing interim policy, have been issued. Reg. 250.71 "Information reporting requirements, Internal Revenue Code," *id.* at 3898; Reg. 250.80, "Fraud in the medical assistance program, 34 *id.* at 19,775 (1969). There is now a further proposed regulation—251.10—on "Interrelations with State health and State vocational rehabilitation agencies, and with title V grantees." 35 *id.* at 8664 (1970).

For two related regulations see Reg. 250.120, "Staffing for administration of medical assistance programs, Federal financial participation," and Reg. 250.210, "State financial participation; State plan requirements," 34 *id.* at 205 (1969).

The enacted regulations mentioned above are codified at 45 C.F.R. § 250 *et seq.* (1970). For details of all regulations see CCH MEDICARE & MEDICAID GUIDE para. 21,241 *et seq.*

²³² Interim regulations were issued on February 28, 1970. See 35 Fed. Reg. 3968 (1970). For an outline of regulations on state licensing, see MED. TRIBUNE, July 17, 1969.

For the somewhat strange role of the MSA in the state implementation of § 1908, see Sullivan & Byron, Nursing Home Administrator Licensing Under Section 1908 of the Social Security Act, 1970 (paper on file at the Yale Law School Library). This is one of a series of clinical studies into the nursing home industry undertaken by students of the Yale Law School and the Department of Epidemiology and Public Health of the Yale Medical School.

²³³ Herein lies a curious tale of the way some regulations are written. A nursing home consultant was retained by both HEW and the American Nursing Home Association to work with Medicaid staff in drafting new nursing home standards, required under § 1902(a)(28) by the 1967 amendments of the Social Security Act. Earlier drafts of these regulations were felt by the ANHA to be unrealistic because of a shortage of nurses. An initial draft of the new regulations, on which he consulted, would have eliminated the nurse requirement altogether from the third shift; but this was turned down by HEW. Interim regulations, published June 24, 1969, stated that in the future an RN must be in charge of the day shift but that the charge nurse on the other two shifts need only be approved by the state licensing agency (statewide standards were lower than title XVIII requirements). A deluge of complaints followed, chiefly from consumer groups on the grounds that the standards would lower nursing home quality, and hearings were called by Senator Moss for July 30, 1969. WASHINGTON REPORT ON MEDICINE & HEALTH, June 30, 1969, and Aug. 4, 1969. Final regulations for skilled nursing homes were published in April 1970. They require a professional RN or licensed practical nurse on duty at all times. The latter must be a graduate of a state-approved school of practical nursing. Until July 1, 1970, provided that they were working as a charge nurse on July 1, 1967, practical nurses recognized by the state licensing authority as having equivalent background were allowed, but after this date they must also have equivalent training. CCH MEDICARE & MEDICAID GUIDE paras. 14,752 & 21,633.

²³⁴ The title XIX staff of the nine regional offices was also inadequate to handle the work load and ill-equipped to deal with the medical profession (and sometimes the state health departments). Moreover the Associate Regional Commissioners for Medical Services are not subordinate to the MSA staff in Washington but are responsible to regional SRS Commissioners—adding further to the administrative confusion.

In Boston, for instance, a staff of three and one secretary handle Medicaid for the six New England states. The work of the regional office is largely an advisory and auditing one. The Boston office is

the least-used panels in HEW's large stable of advisory councils," partly because it was uncomfortably attached to Medicaid after the program had been in existence two years and partly because it was thought not to have the support of the then HEW Secretary.²³⁵ Even the Nixon Administration seemed disinterested in using the Council. It was not consulted when Dr. James Haughton was appointed to review Medicaid's reimbursement for physician, dentist, and other health professional services, and this was reported as "bruising the already battered feelings" of the Council.²³⁶ While the new so-called "1970 Broom" announced the "reactivation" of the Medical Assistance Advisory Council,²³⁷ it has yet to be seen whether the Council will be able to find a role working with the present Commissioner of MSA, Howard Newman.

The "1970 Broom" was a direct result of the two McNerney Task Force Reports and the Senate Finance Committee's Staff report.²³⁸ Even before the first McNerney Report was issued, the preliminary findings of the Finance Committee staff had appeared:

Federal officials have been lax in not seeing to it that States establish and employ effective controls on utilization and costs, and States have been unwilling to assume the responsibility on their own. The Federal Medicaid administrators have not provided states with the expert assistance necessary to implement proper controls. Also, they have not developed mechanisms for coordination and communication among the States about methods of identifying and solving Medicaid problems.²³⁹

Belatedly, in 1968 HEW had set up a scheme for standard audit in sixteen major Medicaid states; the reports were released during 1969. Among the findings were that Illinois had drawn nearly \$1 million in federal funds improperly,²⁴⁰ that New York City has wasted as much as \$9.7 million in federal funds because of alleged procedural violations and administrative laxness,²⁴¹ that Texas was using procedures which resulted in the loss of interest income to the federal government of \$48,750 a month.²⁴² All told, the audits reportedly revealed weaknesses in management

thought to have mediated the dispute between the ophthalmologists and optometrists under the Rhode Island program, and the staffs of all regional offices join the Washington staff in a bi-annual or tri-annual review of each state's program. Often, however, regional offices see themselves as defenders of "their" states against Washington. The over-all result has been considerable conflict between Washington and the regions. On these generally see K. Gideon, *The Role of the HEW Regional Office in the Administration of Medicaid, 1970* (paper on file with the authors).

²³⁵ WASHINGTON REPORT ON MEDICINE & HEALTH, Mar. 10, 1969.

²³⁶ *Id.*, May 19, 1969.

²³⁷ 1970 Hearings, *supra* note 201, at 24. The new chairman was Donald C. Smith, M.D., of the University of Michigan. The 1970 STAFF REPORT, *supra* note 131, at 133-34 recommended the merging of the MAAC with HIBAC, the title XVIII advisory council.

²³⁸ See notes 202 & 221 *supra*.

²³⁹ 1969 STAFF REPORT, *supra* note 202.

²⁴⁰ AMA News, July 21, 1969.

²⁴¹ *Id.*, Sept. 8, 1969.

²⁴² The Texas case is interesting in that the State Department of Public Welfare made an agreement with Group Hospital Service, Inc. (Blue Cross-Blue Shield of Texas) to "insure" Medicaid recipients;

controls, procedures for processing claims, eligibility, and other areas amounting to a minimal "questionable dollar impact" (that is, waste) of \$318 million.²⁴³ These audits served to emphasize two major features of Medicaid. The first was the administrative inefficiency in the states, the second the lack of adequate federal guidelines, methods, and controls in a program which is substantially federally funded. It is illustrative of the low-keyed central role of SRS in Medicaid's early years that not until June 1970 was a federal regulation proposed for Medicaid to require that a state, in discharging its fiscal accountability, "maintain an accounting system and supporting fiscal records adequate to assure that claims for federal funds are in accord with applicable Federal requirements."²⁴⁴ A layman (or taxpayer) might have supposed that such records were already available, with state accountants acting busily and inventively to increase productivity and save costs under the watchful eye of federal administrators. Such was not the case.

This absence may be attributed in part to the very real difficulties in establishing adequate guidelines for reimbursement of health services. It may be noted, in defense of Medicaid, that the federal Medicare program, despite a battery of regulations over reimbursement formulae and utilization controls, is barely more advanced in its accounting procedures.²⁴⁵ At the same time, however, Medicaid has suffered from its initial development as a program of only loosely supervised federal grants-in-aid to states. Mismanagement by some of the states or their fiscal agents led to "duplicate payments," inadequate utilization review, and waste of resources in determining eligibility.²⁴⁶ These events were allowed to occur because there were

the audit found that in fact GHS was acting under a fiscal agent agreement for the state, merely administering the state program rather than providing full insurance coverage. Between September 1, 1967, and June 30, 1968, it was noted that GHS had accumulated more than \$14 million of state money as premiums for medical services in excess of actual disbursements. The state held that this was in accordance with the state interpretation of the agent function and that such accumulations were a hedge to offset future claims. Experience bore this out; by June 30, 1969, GHS expenditures exceeded receipts by almost one half million dollars. The state claimed that this method resulted in a reduction in premium rates and better administration of services. The HEW Audit Agency ruled that the arrangement with GHS was not insurance since the element of risk for GHS did not exist, and it therefore did not comply with the requirements of SUPPLEMENT D, *supra* note 48, paras. 5520A, 5830. This ruling was upheld by the administrator of SRS. Also at issue was the sum of nearly \$888,000, which represented the difference between federal matching at the 50% rate for administrative costs and the higher matching at the medical assistance rate. This latter sum is still in dispute in appeals and decisions involving the state, SRS, and the HEW Regional Office. See 1969 *Hearings*, *supra* note 135, at 72-73; 1970 *Hearings*, *supra* note 201, at 106-07.

²⁴³ The greatest single cost (\$126 million) lay in determining eligibility. 1970 STAFF REPORT, *supra* note 131, at 245.

²⁴⁴ 35 Fed. Reg. 8780 (1970). This regulation would also apply to titles I, IV-A, X, XIV, and XVI of the Social Security Act. Agencies would be required to maintain accounting records for each title for a period of a minimum of 3 and a maximum of 5 years after the end of each fiscal year, subject to the timing of federal audit.

²⁴⁵ A Senate Finance Committee report of 1970 (nearly 4 years after the initiation of Medicare) noted the lack of data to assess the financial position of hospitals under Medicare reimbursement, deficiencies, abuses, and "lack-luster administration" in paying for physician services, a widespread failure to apply utilization review procedures (required for hospitals under title XVIII), and other areas of abuse and laxity in administration. 1970 STAFF REPORT, *supra* note 131, at 4, 10, 18 and *passim*.

²⁴⁶ *Id.* at 204.

inadequate staffs in the regions, without clear lines of command, and without "definitive guidelines relating to policies, procedures and goals."²⁴⁷ There was inadequate follow-up of PREP (Program Review and Evaluation Projects) reports on the operation of the program in the different states, and there was considerable evidence of approval of plans and arrangements which did not conform to the federal law.²⁴⁸ MSA, with only fifty professionals and thirty-five support staff in Washington, was found wanting in many areas. "Responsibilities had not been discharged," manpower was inadequate, too much time was spent "putting out fires," regulations had been delayed and guidelines implementing them had not been issued, while there was no real procedure for reviews.²⁴⁹

After the Preliminary Staff Report in July 1969 and the Audit Report published in August, it seemed there was little more that could be said about the shortcomings of MSA. But such an assumption was wrong. In addition to calling for better coordination in all health programs, the first McNerney Report called for more information about title XIX, better training of staff, new management techniques, 125 new positions in Washington, and a restructuring of MSA both in Washington and in the regions.²⁵⁰ The report of the Finance Committee staff, in addition to specific recommendations,²⁵¹ put the general need bluntly:

While the Medical Services Administration probably requires additional personnel if effective Federal supervision of Medicaid is to be realized, it appears vital that any additional personnel—including officials—operate with a greater sense of responsibility and direct involvement than has been manifested heretofore. The Medical Services Administration needs dynamic, concerned, and qualified leadership and staff if a complex, costly and important program such as Medicaid is to be soundly administered.²⁵²

So, too, the Final Report of the McNerney Task Force, while re-echoing the need for review of the whole federal apparatus in health and better integration of health programs and the health bureaucracy, did note that

the haste with which it [the 1965 legislation] had to be implemented left little time for meaningful planning or imaginative leadership. MSA's management style has been characterized by a crisis orientation to the detriment of sound management practices and long-range planning.²⁵³

²⁴⁷ *Id.* at 236.

²⁴⁸ *Id.* at 238-39.

²⁴⁹ *Id.* at 239-42. In fact 106 additional accountants had been hired by SRS earlier in 1969 to make regular visits to every state possible. AMA News, Mar. 31, 1969.

²⁵⁰ INTERIM TASK FORCE REPORT, *supra* note 221, at 27-41. In the covering letter, the Chairman said the basic findings were that Medicaid "has serious organizational, financing, productivity and access problems, and (2) bolder moves than have characterized the last five years are required to achieve measurable improvement."

²⁵¹ The actual recommendations on federal administration appear in 1970 STAFF REPORT, *supra* note 131, at 131.

²⁵² *Id.* at 127.

²⁵³ TASK FORCE REPORT, *supra* note 221, at 104.

1970 well and truly drove home the points of 1969; and the present Administrator of SRS (John Twiname) has already announced changes—including new staff, a new structure for MSA, and development of program management procedures.²⁵⁴

B. Administration in the States

It would be wrong to leave a discussion of the administration of Medicaid without some look at its operation in the states. The majority of states make the welfare department or its equivalent the primary administrator of the program, while some states leave it to the health department. Neither arrangement has been entirely satisfactory. The choice of welfare departments was partially encouraged by HEW in Washington, and this was a disappointment to those who hoped the 1965 legislation was a move away from the welfare image.²⁵⁵ More important still, welfare departments were often thin in top-level talent and rarely had the political influence to buck powerful lobbies such as the providers of medical care in their state. Even state health departments, whether the primary administrators or consultants to the welfare departments, were similarly rarely headed by physicians of sufficient prestige to stand up to leaders of the professions or the legislatures.

The results have been predictable. For instance, the Finance Committee "Staff Data" found that "a number of States have yielded to demands that they reimburse skilled nursing homes on the more generous basis under which extended care facilities are paid under Medicare."²⁵⁶ New York City had to give up its efforts to authorize only certain physicians and specialists under title XIX.²⁵⁷ It seemed natural (if regrettable) to state welfare and health departments in most states that, when cuts were made in Medicaid programs, recipients rather than providers were the first ones to be axed.²⁵⁸ In general, states have often not lived up to the requirements laid down from Washington,²⁵⁹ and the use of state advisory councils has frequently been ineffective.

²⁵⁴ 1970 *Hearings*, *supra* note 201, at 26-27. Recent innovations in MSA include new auditing procedures, experiments in quality control, and use of prepaid programs in lieu of Medicaid (e.g., in Baltimore and Hawaii). See Schmeck, *Medicaid Leaders Trying New Ideas*, N.Y. Times, Sept. 27, 1970, at 42, col. 1. The attempts to reform and restructure MSA are recorded in its new monthly, *Medicaid*, published since April 1970.

²⁵⁵ See, e.g., AMERICAN PUBLIC WELFARE ASS'N, SURVEY OF STATE PUBLIC WELFARE DIRECTORS REGARDING PROBLEMS IN IMPLEMENTING THE PROVISIONS OF TITLE XIX OF THE SOCIAL SECURITY ACT 15 (1969) [hereinafter cited as APWA SURVEY]. Medical witnesses in 1965 had argued in favor of using welfare departments rather than health departments. *Contra*, 1965 *Hearings*, *supra* note 33, at 641.

²⁵⁶ 1969 STAFF REPORT, *supra* note 202, at 30. See also note 151 *supra*.

²⁵⁷ AMA News, Oct. 3, 1966; N.Y. Times, July 21, 1966, at 35, col. 8; *id.*, Sept. 15, 1966, at 45, col. 1.

²⁵⁸ E.g., cutbacks in the Louisiana program, where physicians' usual and customary fees were protected. AMA News, Sept. 2, 1968.

²⁵⁹ One example may suffice. SUPPLEMENT D, *supra* note 48, para. D-5140, states that the title XIX agency should also participate actively in community planning for facilities where it is a substantial purchaser—e.g., skilled nursing home care. This has been more honored in the breach than the observance.

The administrative structures of Medicaid in most—if not all—states have indeed favored the providers (just as welfare administration and funding fluctuates according to the perceptions and interests of persons other than the recipients). Advisory committees have tended to reflect majority interests. Connecticut, for example, set up a medical advisory committee to assist the welfare commissioner review claims for payment to physicians. The committee consisted entirely of physicians—fifteen selected from a list of nominees submitted by the state medical society and eight others added by the commissioner, the latter including university medical school representatives and medical administrators from three major insurance companies.

Medicaid programs were also allowed to use private fiscal agents to administer the program. In Connecticut, where the insurance industry has a powerful lobby, an insurance company was appointed as fiscal agent.²⁶⁰ In theory, the use of private agents was similar to the use of fiscal intermediaries and carriers under Medicare, and it might have been supposed that the opportunity would be firmly grasped in the states to run both programs on a similar basis.²⁶¹ But, in at least one state which expected such intermeshing of administration, the levels of usual and customary fees for physicians as determined under Medicare were held by the carrier to be confidential information and were not released to the Medicaid administrators, and the situation is thought to have been similar in other states.

The use of fiscal agents, in some cases for different parts of one state program, added to the confusion in available information about Medicaid in all the states: the California budget crisis of 1967 was merely the most spectacular example. Budgetary confusion was compounded by the problem of whether the amounts “tossed out” from time to time were the total costs of all payments for medical care to welfare recipients and the medically needy, whether state costs alone were being quoted, whether the costs of services to welfare recipients and the medically needy were separated, and so on. Over and above this was a serious deficiency in information about the extent and costs of the services which were actually being provided.

²⁶⁰ Freeland, *Medicaid in Connecticut: The First Year, 1968* (paper on file with the authors).

California also used three fiscal agents rather than having direct payment to providers. See note 262 *infra*. Although incurring a good deal of criticism (e.g., APWA SURVEY, *supra* note 255, at 15; BARNES, *supra* note 62, at 101-06; MEDI-CAL, *supra* note 62, at 40-42) the idea of using outside agencies for administration was endorsed by the TASK FORCE REPORT, *supra* note 221, at 100. On the operation of the fiscal agents, see R. Girard, *The Use of Fiscal Agents in Medicaid: Who Does What, Why and How, 1970* (paper on file with the authors).

Alabama has the most curious method in terms of fiscal agents for Medicaid. Inpatient, outpatient, and emergency hospital services, together with skilled nursing home services are reimbursed through Blue Cross-Blue Shield of Alabama as the fiscal agent. Laboratory and x-ray services outside these categories, physician services, eyeglasses, and optometric services are reimbursed through the Equitable Life Assurance Society. Prescribed drugs and non-legend drugs are reimbursed, for reasons unexplained, through the State National Bank of Decatur. CCH MEDICARE & MEDICAID GUIDE para. 15,550. 1970 STAFF REPORT, *supra* note 131, at 285 also notes that Blue Shield (and not Equitable) is carrier for Medicare part B, while Blue Cross and Mutual of Omaha are carriers for part A. *Id.* at 262, 267.

²⁶¹ On the functions of such intermediaries under title XVIII, see 42 U.S.C. § 1395h (Supp. I, 1965), “Use of public agencies or private organizations to facilitate payments to providers of services” under part A), and *id.* § 1395u, “Use of carriers for administration of benefits” under part B.

The welfare departments in smaller states have been hard-pressed enough in accounting to their legislatures for expanding welfare budgets and at the same time explaining their limited services to welfare rights organizations, let alone in proposing expensive new systems for data collection and analysis.

But the larger states have fared little better.²⁶² Across the country huge multi-million dollar programs were established without the basic mechanisms of program accountability. The tradition of inadequate statistical data was carried through from the welfare programs into Medicaid. As a result, the administrators of the Medicaid programs (and other interested groups, including the recipients themselves) had little ammunition to defend the operations or to justify the rapidly increasing expenditures.²⁶³

Everywhere states seemed to have basic problems of effective administration. New York's administration was a kind of standing complaint with the federal government, providers, and recipients. During 1968, private hospitals even evicted Medicaid patients, and the drug stores held a brief boycott of Medicaid.²⁶⁴ There have been standing disputes between the state Department of Social Welfare and New York City since the program began because the city was anxious to have a rigorous audit of physicians, and saw the need to have some limits on freedom of choice for Medicaid patients.²⁶⁵ But the city was also in trouble with the state because of its plan to mix payments made for Medicaid patients being treated in the municipal hospitals with general city funds.²⁶⁶ While that dispute was settled in favor of the state, the city in late 1968 refused to go along with a state rule requiring payment of doctors in teaching hospitals for general supervision of

²⁶² Officials in California made more strenuous and imaginative efforts than most states to set up statistical reporting methods; information such as type of procedure and primary diagnosis was coded by a clerk in the offices of the fiscal agents, together with other information such as date and type of service, amount of payment, claim and check number, and identification of recipient and vendor. Each month the agents sent the resulting tapes to the state Department of Health, which was the responsible agency until September 1967 (when responsibility was shifted to the Welfare Agency). Such information was, however, limited in usefulness. It only referred to bills paid (and there was an initial allowable time lag of up to seven months between service and payment) and comprised relatively crude data, since it was derived from claim forms carried over from the time of hand-processing and providing far from specific information about service utilization. The head of the Medi-Cal Surveillance Unit later remarked, "The possible uses of computers within the new health care programs have scarcely been touched." See Anderson, *Statistical Surveillance of a Title XIX Program*, 59 AM. J. PUB. HEALTH 275 (1969).

²⁶³ States reported a total sum of \$172 million spent on the costs of administering medical assistance payments in fiscal 1969, of which 52 per cent was from federal funds (and 9 per cent from local funds). Much of this was, however, being funneled to pay the salaries of social workers and supporting welfare offices, in the expensive process of determining a potential recipient's eligibility, rather than in ensuring the efficient operation of the whole system. PUBLIC ASSISTANCE COST OF STATE AND LOCAL ADMINISTRATION, SERVICES AND TRAINING, *supra* note 172, table 8.

²⁶⁴ Petrina, *supra* note 174, at 27.

²⁶⁵ N.Y. Times, Dec. 9, 1966, at 35, col. 5. The city also wanted to license under Medicaid only these nursing homes licensed under Medicare. *Id.*, Dec. 31, 1966, at 1, col. 1.

²⁶⁶ *Id.*, Oct. 27, 1966, at 29, col. 1; *id.*, Dec. 18, 1966, § 4, at 13, col. 5; *id.*, Jan. 6, 1967, at 32, col. 4. By the end of 1966, the hospitals were in desperate financial shape in New York City because of the delays in reimbursement of Medicare and Medicaid. *Id.*, Dec. 3, 1966, at 1, col. 4; *id.*, Dec. 4, 1966, at 1, col. 1.

Medicaid patients.²⁶⁷ New York City has also perpetuated other crises, being not only a center of alleged fraud, but being in the lead in most disputes.²⁶⁸ And when New York City has not taken the lead, the state has, as with the attempts to freeze payments to hospitals despite the reimbursement requirements in the law.

Perhaps the weaknesses in state welfare and health departments are insuperable. The disenchantment with state administration was so widespread that even the Senate Finance Committee staff, working for a committee dominated by Southerners, demanded far more rigorous federal control. But it may well be questioned how far such guidelines would help unless there were also radical restructuring of the departments within the states. The second McNerney Report made it clear that the ideal would be to federalize health care almost entirely, although it suggested that some improvements might be attempted in state administration in the meantime.²⁶⁹ That the urge was to give more power to HEW, whose defects in this field were manifest, was a mark of the even graver defects in state administration.

The ultimate solution will not be easy. We would argue that if medical care is to be considered a right and some administration is to be provided which will stand up to the powerful providers of medical care, then it will have to have a federal base. Even with federal administrative back-up, however, it would not be easy for the majority of states to enter into this role. Regional HEW offices would have the capability, but only if their purpose were fundamentally altered. The political attraction of giving even greater power to fiscal agents is obvious. But if that line of development is followed, it may have to be coupled with some type of federally chartered and regulated medical care corporations.

C. Relations with Providers

The providers of services under title XIX have basically been dealing with the state agencies in the absence of federal legislation or effective regulation from MSA—at least during the crucial period of development of the program. The one exception to this is inpatient hospital care, where the 1965 legislation laid down the test of “reasonable cost,” which, as has been seen, was linked with the Medicare test.²⁷⁰ But elsewhere the battles have normally been between providers’ groups and state agencies, and, as the Senate Finance Committee data revealed, normally the providers have fared well.²⁷¹ It is true that occasionally the battles have been between groups

²⁶⁷ They would have been paid for patients seen by residents and interns. The Citizens Committee for Children, a private group, deplored this “Medicaid windfall of over \$20 million a year” for physicians while eligibility levels were being cut. N.Y. Times, Aug. 20, 1968, at 44, col. 2.

²⁶⁸ E.g., the refusal to reimburse corporations formed to advance fees to doctors and to collect them from the welfare agency. Petrina, *supra* note 174, at 28-29. The 1970 STAFF REPORT, *supra* note 131, at 130, recommends the end of such collection agencies. That recommendation has yet to be implemented.

²⁶⁹ TASK FORCE REPORT, *supra* note 221, at 53-70.

²⁷⁰ See p. 364 *supra*.

²⁷¹ Thus some skilled Nursing Homes did better under state Medicaid programs than they were doing as Extended Care Facilities under title XVIII. 1969 STAFF REPORT, *supra* note 202, at 30.

of providers as when the specialists fought the general practitioners in Kentucky over differential fees²⁷² or when internecine warfare broke out over differentials between optometrists and ophthalmologists in Rhode Island.²⁷³ But where the providers have been united, it has generally been the recipients who have suffered.

Much of the difficulty lies with the very concept of vendor payments. The state neither employs nor contracts with its providers of services; it has merely paid the bills according to established criteria. When these criteria revolved around reduced fees—for example, lower fees for welfare patients than for private patients—the state (and the vendor) might well take the view that the provider of services (hospital, doctor, dentist) was doing the state a favor. The provider was part of the charity system. (Indeed there are still some hospitals in this country with the word *charity* in their name.) With Medicaid's on the whole much more generous reimbursement procedures, this aspect of favor was taken away. Yet the relationship between state welfare department and vendor was not substantially changed. While being paid more reasonably, the aspect of favor on the part of providers has remained. Providers have tended to react with surprise at any apparent limitation on their freedom of action under Medicaid. States, on the other hand, have tended to accommodate themselves to the wishes of the providers to ensure widespread participation in their Medicaid programs.²⁷⁴

Such a situation is barely surprising in view of the methods which Congress adopted for the administration of Medicaid. Indeed had the states not been pliable the net result would merely have been to ensure a lower rate of participation on the part of providers. As suggested in the previous section, the only solution may be to develop some new hybrid creature to administer the program in the sense of purchasing the services of providers. Some such powerful monopsony may, in the long run, be the only way of coping with the various legalized monopolies which comprise the providers of medical care.

These administrative and economic weaknesses, however, are equally apparent in the unfair contest between the providers and the understaffed, undervalued, and underinformed members of the welfare and health departments in the different states.

²⁷² AMA News, July 4, 1966.

²⁷³ For a detailed study of this on-going battle, see B. Burke, Medicaid Negotiations in Rhode Island: A Case Study, 1970 (paper on file with the authors).

²⁷⁴ One example of this is Tennessee, where the Medicaid program was reported early in 1970 to be hamstrung by ineffective physician participation, although the president of the Tennessee Medical Association stated that doctors were in fact seeing poor patients but "just aren't following through with the forms." To counter this, physician fees under Medicaid were doubled, retroactive to January 1, 1970—from 50% to 100% of a rate equivalent to three fourths of usual and customary fees. AMA News, Jan. 12, 1970, and Feb. 2, 1970.

Providers have also complained about the additional work involved in making claims. For example, the Massachusetts Medical Society (a state which spent nearly 8% of its \$236 million Medicaid budget on physician services in 1969) protested vigorously against the introduction of new, more complicated vendor payment forms designed by the Department of Welfare as part of a new computerized administrative system. AMA News, Oct. 6, 1969. From the management viewpoint the issue is one of delicate balance between the exercise of public accountability and the ability to offer adequate services to patients.

The most interesting of these battles has been between the most prestigious and highly paid of the health professions—the physicians—and the state departments. It has not been an entirely noble story. The AMA opposed Kerr-Mills because it claimed that physicians already provided care to the elderly poor free of charge.²⁷⁵ It opposed the medical care package in 1965 on the ground that no one in the United States went without medical care merely because he was poor.²⁷⁶ Thus when physicians began to be paid for their services under Kerr-Mills in 1960 and under title XIX in 1965, they received a sudden and significant increase in their incomes,²⁷⁷ allegedly for services they were already donating.

In view of the emphasis the medical profession places on public service—an emphasis heavily underlined in all Congressional hearings on medical care since the days of the New Deal—one might have expected that they would be satisfied

²⁷⁵ *Hearings Before the Subcomm. on Problems of the Aged and the Aging of the Senate Comm. on Labor and Public Welfare*, 86th Cong., 2d Sess. 38-42, 228 (1960). Dr. James Z. Appel of the AMA Board of Trustees described the AMA view of the aged: "[n]o other age group is likely to have as favorable a liquid asset position," and "[m]ost older people are in good health." He also reaffirmed the AMA view that "[m]edical care is available to every man, woman, and child in the United States regardless of his or her ability to pay. . . . Physicians themselves are doing what they can as individuals to soften medical expenses for persons over 65 with modest resources. Public welfare, religious, and fraternal programs and donated services by doctors provide care for the indigent." The *AMA News* had an editorial urging "State medical groups to publicize the fact that no one who needs medical attention need go without it because he is without funds."

The AMA took the same line in the hearings on the Social Security Amendments of 1960—which gave rise to the Kerr-Mills program. See *Hearings on H.R. 12580 Before the Senate Comm. on Finance*, 86th Cong., 2d Sess. 203, 206 (1960). Dr. Leonard Larson, President-Elect of the AMA asserted that "[t]he financial problems of the aged have also been greatly exaggerated . . . we have proved, again and again, that no person in the United States need go without medical care because he is unable to pay for it."

²⁷⁶ 1965 *Hearings*, *supra* note 33, at 602-12 contained the testimony of Dr. Donovan F. Ward, the President of the AMA. He observed, "[w]e believe, and have consistently held, that all Americans should have available to them the best medical care, when they need it, regardless of their ability to pay for it. This care is primarily a personal responsibility, but where the individual requires financial assistance, we believe that such aid should come from his family, his community, and where necessary, from all levels of government." But "[l]ong waits, poor equipment and facilities, short, impersonal examinations, and lots of record-keeping appear to be the major accomplishments of nationalized health systems." Among other things, Dr. Ward noted that "physicians have a far better record than hospitals in keeping the price of their services within bounds. In the past 25 years, physicians' fees have risen only 100 per cent while the overall cost of living has increased 115 per cent." The Medical Association of Alabama opposed the legislation because "the administration of the proposed program will result in control of both the vendor and the recipient of the services. We sincerely believe that such a step would be dangerous to the physical health of our people, not in the public interest, and an improper function of the Federal Government. The practice of medicine—art and science—is a highly individualized endeavor, fitting particular needs with best available remedies, and does not lend itself to rigid rules or regimentation. . . . The physicians of Alabama respectfully remind you that we have always given freely of our time and talents for the needy. We desire and expect to continue to contribute our time and efforts, and we believe that we can best serve our patients without third-party interference." *Id.* at 664-66.

²⁷⁷ *Id.* at 681. The immediate past president of the Pennsylvania Medical Society stated "[t]hat Pennsylvania physicians provided \$41,969,000 worth of free care during 1960. This free care was apportioned on the following basis: 28.4 per cent resulted from treating private patients without charge; 37.3 per cent resulted from hospital ward service; 24.3 per cent was provided in outpatient clinic service; 10 per cent resulted from free care to all other persons"

with any reasonable and unexpected increase in their incomes. But the conjunction of Medicaid with Medicare raised a new possibility—that physicians would be able to release themselves and their patients from the clutches of welfare reimbursements, in favor of “usual, customary, and prevailing” fees—the title XVIII basis of payment. In fact, the general impression has been created that physicians have on the one hand been ungrateful with respect to the financial bonus and, at the same time, frequently insensitive to the attempts to change the psychological atmosphere of welfare medicine. Worse still, there has been extensive evidence of profiteering, fraud on the Medicaid program, and, allegedly, a propensity to cheat the Internal Revenue Service on the part of some members of the medical profession.

The battle about usual or customary fees and the fee schedule has marked the disputes about Medicaid from the very beginning. It was in the end to lead to federal intervention at the White House level to curb fees in 1969. But, in the meantime, it had soured relations in many states. Inevitably in New York there were problems. While the state medical society had in general supported Medicaid, by mid-1966 there was trouble about fees. During May, a task force from the state Budget Bureau drew up a suggested scale of charges, while the medical society endorsed a more generous one.²⁷⁸ The Governor claimed that the state fee scale was slightly above the ones which the private insurance carriers had been paying,²⁷⁹ while the doctors still argued that the “rates [were] considerably below those in most, if not all, communities.”²⁸⁰ In the end some kind of compromise was worked out with a gubernatorial Interdepartmental Committee on Health Economics, which represented the state²⁸¹ but was assisted by a five-man advisory committee of the state medical society.²⁸²

A large state with a powerful governor was able to resist pressure from physicians. For instance, California, while providing for reasonable charges in the light of usual and customary fees, put ceilings on the amounts the fiscal agents could in fact pay.²⁸³ But in other states the pressure for establishing Medicaid often came from the physicians—for example, in Virginia²⁸⁴—but on the condition that the physician fee arrangements were the same as in Medicare. In Pennsylvania, the state medical society organized an elaborate lobbying program to show how much they were subsidizing title XIX because they were being paid on a fee scale rather than their usual and customary fee. Each physician was asked to send statements to patients and to the state welfare department showing the degree of “subsidization” in each

²⁷⁸ The scales are set out in *Minutes of Special Meeting of House of Delegates, May 26, 1966*, in 66 N.Y. STATE J. MED. 2332 (1966).

²⁷⁹ N.Y. Times, July 5, 1966, at 76, col. 1.

²⁸⁰ *Id.*, Dec. 18, 1966, § 4, at 13, col. 5.

²⁸¹ *Id.*, Aug. 6, 1966, at 10, col. 7.

²⁸² 19 N.Y. STATE DEP'T HEALTH WEEKLY BULL. 191 (Nov. 28, 1966).

²⁸³ BARNES, *supra* note 62, at 108 *et seq.*

²⁸⁴ *M.D.'s Request Title XIX*, AMA News, Nov. 13, 1967.

case.²⁸⁵ In other states—for example, Massachusetts—physicians lobbied for the appointment of Blue Shield, a physician dominated organization, as the fiscal agent.²⁸⁶

Connecticut provides an example of a middle-of-the-road state. It established a relatively cautious program in 1967 with moderate eligibility standards and a fee schedule for physicians and other individual providers with a Hospital Cost Commission for reimbursing the hospitals. The latter has had a long history in Connecticut, having been first established in 1949.²⁸⁷ Indeed its tradition was so strong that for the first few years of Medicaid it refused to apply the federal formula for reimbursement and actually paid hospitals less—a fact that clearly surprised the federal officials when Connecticut was given its first PREP at the end of 1967.²⁸⁸ More interesting, however, was the pressure put on the legislature to drop the fee schedule and pay physicians their usual and customary fees. The administration of the program in Connecticut is subject to a battery of committees—a Professional Policy Committee, a Professional Advisory Committee, and a Medical Advisory Committee, a configuration which helped to confuse even federal officials.²⁸⁹ Ultimately, despite the financial crisis in the state Medicaid program, the legislature passed Public Act 548 in 1967, which called for the payment of usual and customary fees for an experimental period between March 1968 and March 1969. The experiment was tried; physicians participated more readily, but costs skyrocketed.²⁹⁰ After hearings in February 1969, and the listing by name of major physician beneficiaries of Medicaid in local Connecticut newspapers, Connecticut returned to a fee schedule. The medical profession was displeased, but in the end it was the recipients who suffered—it became much more difficult to persuade a physician to take a title XIX patient.²⁹¹ Compared with the physicians, the other providers caused

²⁸⁵ *Id.*, Apr. 1, 1968. The bills were to be marked: "The difference between the state payment and the customary fee represents the service gratuitously provided by the physicians."

²⁸⁶ *Id.*, Dec. 9, 1968.

²⁸⁷ N. Gellman, Hospital Reimbursement Under Medicaid in Connecticut 12 *et seq.*, 1970 (paper on file with the authors).

²⁸⁸ CONNECTICUT TITLE XIX MEDICAID PREP REVIEW, November-December 1967, at 9. The 1967 legislature passed an act to allow appeals from the HCC to the regular courts, and under that legislation a number of hospitals brought a successful action against the HCC, the latter being found to have abused its discretion. The Commission was ordered by the Superior Court to reconsider its rates in accordance with the mandate of the statute. It refused! And the 1969 legislature abolished appeals from the HCC to the courts, substituting binding arbitration. On this and related matters, see Gellman, *supra* note 287, at 16-19.

New York was less successful in its efforts to avoid paying the hospitals under title XIX according to the title XVIII formula. In *Catholic Medical Center v. Rockefeller*, 305 F. Supp. 1256 (E.D.N.Y. 1969), the court refused to give a preliminary injunction until it had heard HEW as amicus curiae, but it expressed serious doubt that a New York statute freezing hospital rates under Medicaid at their March 31, 1969, levels was lawful.

²⁸⁹ See Freeland, *supra* note 260, at 8 and *passim*.

²⁹⁰ In April 1968, physician services had cost Connecticut Medicaid \$66,718. By December, the sum was \$518,347. New Haven Register, Jan. 20, 1969.

²⁹¹ T. Mitchell, Physician Participation in Medicaid in New Haven, Connecticut, 1970 (paper on file with the authors).

little problem.²⁹²

In any event, by the summer of 1969 the idea of "usual and customary" fees was almost a dead issue in the title XIX program, for the federal government had moved to freeze physician fees.²⁹³ The rather rapid change of heart had come because of the general rise in costs described earlier and because a pattern of excessive payments to physicians and dentists had emerged and with them growing evidence of fraud on the part of various groups of providers.

The first rumblings of these matters were heard shortly after the beginning of title XIX. At the end of 1966, in New York State, Senator Thaler of Queens claimed misuse of funds by a Staten Island hospital.²⁹⁴ Early in 1967 the General Accounting Office reported rumors of physician misuse of drugs and nursing homes in the Cleveland area.²⁹⁵ By August of that year, as part of a campaign by Senator Thaler to expose New York City's hospitals, there were allegations of excessive visits and prescribing under title XIX in New York City—a state of affairs conceded to exist by the city's Health Services Administration.²⁹⁶ By the time the Senate held hearings on the 1967 amendments later in the fall, the Finance Committee was prepared to investigate the increasing allegations of abuses—a procedure in which the Chairman of the AMA's Board of Trustees concurred.²⁹⁷ But already—particularly in California—the allegations of fraud by physicians, pharmacists, dentists, and others were reaching epidemic proportions. The October issue of *Parade* charged that during the first eighteen months, 1200 physicians had been paid an average of nearly \$70,000 each.²⁹⁸ Although the President of the California Medical Association denied that there had been abuse by providers, and instead claimed that Medi-Cal had saved taxpayers millions because of effective utilization review,²⁹⁹ there was increasing evidence from all over the country that many physicians had at least not been particularly restrained in their billing;³⁰⁰ and this was true, on a lesser scale, of other groups.

Inappropriate care, high costs, and fraud were not of course necessarily related,

²⁹² The worst problem came from the dentists, whose leadership has boycotted the program from time to time; but according to PREP roughly half the dentists in the state have actually participated. For a study of the politics of this, see R. Gomes, *The American Dental Association and the Connecticut State Dental Association Policies Regarding Participation in the Medicaid Program, 1970* (paper on file with the authors).

²⁹³ For details see part III, section C. For implementation of the 1969 charges see State Letter No. 1063, Medical Services Administration, Social and Rehabilitation Service, Mar. 13, 1969; *SOME IMPLICATIONS OF THE INTERIM POLICY PUBLISHED 1 JULY 1969 ON REIMBURSEMENT OF INDIVIDUAL PRACTITIONERS BY STATE UNDER TITLE XIX OF THE SOCIAL SECURITY ACT* (July 10, 1969).

²⁹⁴ N.Y. Times, Oct. 25, 1966, at 34, col. 1.

²⁹⁵ 200 J.A.M.A. 47 (1967).

²⁹⁶ N.Y. Times, Aug. 16, 1967, at 1, col. 2.

²⁹⁷ 202 J.A.M.A. 46 (1967).

²⁹⁸ AMA News, Nov. 13, 1967.

²⁹⁹ MED. TRIBUNE, Nov. 6, 1967.

³⁰⁰ E.g., at hearings in Elmira, New York, in 1968, a chiropractor was discovered to have billed Medicaid for the spinal manipulation of a seven-month-old infant, a dentist to have received \$80,000 from Medicaid in 1967. N.Y. Times, Jan. 25, 1968, at 26, col. 1.

but they became so in the press, as concern over all three mounted simultaneously. The line between inept management on the part of administrators and fraud on the part of providers is never clear. The existence of fraud was, however, the most flagrant administrative deficiency, and on a major scale the easiest to identify. Moreover as time passed, the rumors of fraud were being shown to have more than a core of truth. In November 1967, the California Department of Justice held hearings in Los Angeles, and, while it gave the nonprofit hospitals a clean bill of health, it found that overservicing, kickbacks, and duplicate billings "seem to be predominant in physician-owned hospitals."³⁰¹ The following month the state Attorney General made public a report showing that \$8 million had been "drained" from Medi-Cal by unethical means. Hospitals, doctors, the fiscal agents, and almost all providers came in for attack.³⁰² The Attorney General of Maryland announced he was investigating frauds by physicians, dentists, and pharmacists.³⁰³ By the end of the month, providers in Massachusetts were under attack (one dentist was said to have grossed \$164,000 in 1968 from Medicaid),³⁰⁴ and the prosecution of ten physicians for fraud had begun in Maryland.³⁰⁵

The new administration had inherited accumulated evidence of fraud. On taking office as Undersecretary of HEW, John Veneman announced, "We have to move toward eliminating greed in Medicare and Medicaid whether on the part of the recipients or the vendors."³⁰⁶ The press was increasingly reporting incidents of fraud; and the position was not helped when HEW announced that forty-seven doctors had been paid more than \$50,000 under title XVIII during the previous year. The collapse of the Medicaid program in New Mexico was attributed by some to the greed of the providers;³⁰⁷ while in May, in reporting the Senate's investigation, the Associated Press report carried the theme that "Medicaid Reported Bilked Out of Hundreds of Millions of Dollars."³⁰⁸ Even the *Chicago Tribune*, normally more harsh on recipients than providers, was forced to admit that "in the health programs the cheating is being done mainly by unscrupulous doctors and sticky-fingered functionaries."³⁰⁹

There was inevitably a demand for the publishing of the names of highly paid physicians. As Senator John Williams of Delaware put it, "The only way to end this sort of thing is to name names and sums of money and put it on the front pages all over the country."³¹⁰ The states complied. For instance, in Maryland it turned out

³⁰¹ THIS WEEK FOR HOSPITALS, Nov. 15, 1968.

³⁰² AMA News, Dec. 2, 1968.

³⁰³ *Id.*, Dec. 23, 1968.

³⁰⁴ *Id.*, Dec. 9, 1968.

³⁰⁵ *Id.*, Dec. 30, 1968.

³⁰⁶ *Id.*, Feb. 17, 1969.

³⁰⁷ Rocky Mountain News, Feb. 18, 1969 (Denver).

³⁰⁸ *E.g.*, Press Herald, May 16, 1969 (Portland, Me.).

³⁰⁹ AMA News, July 21, 1969.

³¹⁰ *Id.*, Mar. 10, 1969.

that one-fifth of the \$4 million paid to 2470 physicians under Medicaid had gone to twenty-eight of them. One physician received almost \$50,000 while thirteen others got more than \$30,000. Thirty-nine dentists were paid more than \$10,000, and one drug store received \$245,497.³¹¹ By April 1969 the Senate Finance Committee was notifying states that it wanted data on all physicians paid more than \$25,000 under title XIX in 1968.³¹² The AMA expressed concern about abuse by physicians,³¹³ but many local medical societies were protective about their members. The California legislature introduced special legislation to punish defrauding providers,³¹⁴ while Senator Long pressed for sending data to the IRS.³¹⁵

While some doctors no doubt were paid large sums under title XIX because they chose to work in low-income areas, some of the data which gradually emerged was remarkable.³¹⁶ In Maryland, after a "nolo" plea, six physicians and a dental intern were put on probation and returned \$68,000 to the state, a sum which had been illegally billed to Medicaid. The highest payment to a physician in Michigan proved to be \$169,000, while three osteopaths were alleged to have filed over \$800,000 in claims. In Kentucky, ten physicians received more than \$50,000 each; the highest payment to a physician in Illinois was \$110,806; and Kansas reported cases of revoking licenses and banning participation for fraud.³¹⁷ It finally emerged that, in 1968, at least 1329 MDs received more than \$25,000 and 290 received more than \$50,000 from title XIX, while over 7000 received more than \$25,000 from Medicare.³¹⁸

In many ways, the physicians looked better than the nursing homes in the 1969 hearings—for weak administration in Washington and the states had made the nursing home industry the center of shady business deals and gross fraud;³¹⁹ but when the 1968 payment statistics were released as part of the 1970 Staff Study it was the physicians who received pride of place.³²⁰ Moreover, there was further

³¹¹ *Id.*, Mar. 17, 1969.

³¹² *Id.*, Apr. 7, 1969.

³¹³ *Id.*, Apr. 21, 1969.

³¹⁴ *Id.*, Apr. 21, 1969, and May 26, 1969. Similar legislation was also proposed in Massachusetts. *Id.*, Apr. 29, 1969.

³¹⁵ *Id.*, June 30, 1969. See also 1969 *Hearings*, *supra* note 135, at 92 *et seq.* Changes were made in the IRS reporting requirements in November 1969, but the 1970 *Staff Report* still considered the arrangements open to abuse. 1970 *STAFF REPORT*, *supra* note 131, at 145.

³¹⁶ The figures, as originally issued, had shown 68 physicians collecting more than \$200,000 per annum from Medicaid. AMA News, July 21, 1969.

³¹⁷ *Id.*

³¹⁸ 1969 *Hearings*, *supra* note 135, at 161-62. But even these were incomplete figures and had to be revised upwards later. See note 321 *infra*.

³¹⁹ The casualness of administration in California, for instance, allowed 225 ineligible nursing homes to participate. AMA News, July 21, 1969; 1969 *Hearings*, *supra* note 135, at 115-22. See also 1970 *STAFF REPORT*, *supra* note 131, at 97-104.

³²⁰ It finally emerged that, under Medicaid, solo practitioners had been paid the following sums over \$100,000 in 1968: California—\$101,968, \$121,188, \$105,513, \$132,975, \$152,458, \$101,061, \$132,921; Illinois—\$103,698, \$104,872, \$102,357, \$110,806; Kentucky—\$119,768, \$103,255, \$108,490; Michigan—\$100,508, \$107,758, \$122,464, \$112,451, \$169,061, \$203,402; New York—\$155,134, \$363,101, \$1,356,978, \$111,869, \$110,592, \$101,604, \$292,304, \$113,781, \$142,208, \$113,146, \$121,025, \$115,752, \$123,774, \$106,618, \$119,611, \$151,932; Oklahoma—\$100,623. 1970 *STAFF REPORT*, *supra* note 131, at 163-98.

agitation when, later in 1970, the Treasury Department claimed that one-third of the physicians with large payments under Medicaid had cheated in their tax returns.³²¹

Nevertheless, it was increasingly accepted that the freezing and utilization changes made in 1969 had taken care of the worst abuse problem. Indeed, the action appeared to have shifted to the government's right to police the quality of care in Medicaid and other programs of governmental health care. In July 1969, the AMA passed a resolution opposing any governmental auditing of quality care in favor of professional peer review.³²² In a biting response the New York City Department of Health refuted the AMA position, pointing out the large amount of low-quality care being provided under Medicaid—at least in New York City.³²³ The lines were being drawn for the next step in the battle.³²⁴

D. Recipients

Fraud on Medicaid is not limited to providers. There have been well-documented frauds among recipients ranging through the usual frauds associated with any means-test program to examples of impersonation and "doctor shopping."³²⁵ But the recent study from the New York City audit program has concluded, "In comparison to the abuse emanating from providers of care, we estimate the dollar cost of patient abuse to be relatively negligible."³²⁶ Indeed, the first McNerney Report, in its effort to

³²¹ Evidence presented by the Treasury Department to the Senate Finance Committee showed that some 4000 of those 11,000 physicians who had earned more than \$25,000 from Medicare and Medicaid in 1968 had failed to report all or most of it. In some cases the unreported income exceeded \$100,000. N.Y. Times, Sept. 22, 1970.

³²² The more socially aware spirit abroad among members of the medical profession was the product of various influences, not least of these was the profession's own public image. The President of the New Haven County Medical Society (Dr. Charles Verstandig) warned members "we've got to quit strangling the goose that can lay those golden eggs. . . . The temptation to get rich while the getting's good is powerful. . . . A lot of our group have payments to make on their apartment house complexes, their shopping centers, their outside business interests. . . . You can't blame the average patient for thinking that we doctors are living much too high on the hog." New Haven Register, Mar. 28, 1969.

That the problem has survived is reflected in the frankly mercenary approach to Medicaid on the part of some professionals. For example in the "Professional Practices for Sale" section of the N.Y. Times, Oct. 11, 1970: "General medical practice. Tremendous Medicaid area. Gold mine. Rent or sale."

³²³ Bellin & Kavalier, *Policing Publicly Funded Health Care for Poor Quality, Over-utilization, and Fraud—the New York City Medicare Experience*, 60 AM. J. PUB. HEALTH 811 (1970). In a study of optometric service, for instance, 17.2% of patients had received "unsatisfactory care." In 1968 the New York City auditing program for Medicaid cost \$681,475 and saved \$27,398,737. For a detailed analysis of the New York "Watchdog" System for Medicaid, see 1970 STAFF REPORT, *supra* note 131, at 249-52.

³²⁴ Unfortunately, we know far too little about Medicaid seen from the point of view of providers. HEW has commissioned only one study, now being done at the Graduate School of Public Health at the University of Pittsburgh. In an attempt to find out about use and attitude, four questionnaires have been developed; they are directed to hospital administrators, physicians, dentists, and community groups. Preliminary results should be available shortly. Letter from Edmund M. Ricci, Graduate School of Public Health, University of Pittsburgh, to authors, Apr. 21, 1970.

³²⁵ Because of the freedom of choice provision, Medicaid patients sometimes see a number of physicians in connection with the same problem. For an example, see 1970 STAFF REPORT, *supra* note 131, at 128. This kind of problem is avoided in the national health programs of most developed societies by requiring that beneficiaries register with one primary physician or facility.

³²⁶ Bellin & Kavalier, *supra* note 323, at 815.

provide a method "for determining eligibility" that would "be simple and fast and . . . preserve dignity and self-respect of applicant" came down in favor of the declaration system in place of the formal means test.³²⁷

Unfortunately, getting on Medicaid has not always been as easy as it might have been.³²⁸ It will be remembered that, in New York, Governor Rockefeller justified the apparently generous eligibility level on the ground that he was expecting only twenty to twenty-five per cent to sign up, an expectation that was largely fulfilled. Thus, although New York City made efforts to register the "medically indigent,"³²⁹ culminating in "Medicaid Alert" in January 1967,³³⁰ most of the enrollees were already on welfare rather than being "medically indigent." Connecticut claimed to have handled its sign-up program more vigorously. Indeed, State Welfare Commissioner Bernard Shapiro explained the discrepancy between his claim that title XIX would cost the state no more than existing vendor payment programs³³¹ and the \$15 million deficit at the end of 1967 in terms of the widespread publicity.³³² But the PREP Report made at the end of 1967 still found that the state did not provide adequate arrangements for emergency eligibility services and that "the agency has been taking far too long to determine eligibility."³³³

The difficulty of obtaining Medicaid care became proverbial in New York, but there were other weaknesses in the system. The *New York Times* claimed that the form to be filled in to obtain Medicaid was "at least as difficult as the long-form tax return" and "could prove an impenetrable barrier to the least affluent who also tend to be the least educated."³³⁴ More confusing still for the potential recipient was the reflection of the confusion felt by many Welfare Departments about the categories of eligibility under title XIX. As suggested earlier, out of the patchwork of the 1965 and 1967 laws, a series of courageous glossators have suggested cate-

³²⁷ INTERIM TASK FORCE REPORT, *supra* note 221, at 1-2.

³²⁸ There is still too little data about "getting off" Medicaid. The details of the fair hearing procedure, required under the 1965 legislation, were laid down in a regulation published in January 1969, but the studies of the operation of the fair hearing procedures in the New York and Connecticut programs, currently being undertaken at Yale, are not available. For some of the problems encountered in a Maryland fair hearing situation, see MATERIALS ON HEALTH LAW, *supra* note 1, at 381-83.

³²⁹ N.Y. Times, Sept. 15, 1966, at 45, col. 1; *id.*, Oct. 4, 1966, at 37, col. 4; *id.*, Nov. 28, 1966, at 1, col. 4. The N.Y. Times, Jan. 28, 1967, at 26, col. 2, editorialized that the "slow rate of enrollment has given rise to worries exactly the opposite to those expressed by many critics when the enabling legislation was rushed through the State Legislature . . . the people who are supposed to benefit from it most are the people who know about it least." See *id.*, Dec. 12, 1966, at 63, col. 1.

³³⁰ By November only 18,500 out of a possible 4 million had registered in New York City. *Id.*, Nov. 28, 1966, at 1, col. 4. Welfare recipients were paid \$1.50 an hour to sign up new enrollees. *Id.*, Jan. 20, 1967, at 88, col. 1.

³³¹ STATE OF CONNECTICUT, PUBLIC WELFARE TRENDS 10-11 (Oct.-Dec. 1965).

³³² Address by Commissioner Shapiro to Lions Club of Hartford, Conn., in PUBLIC WELFARE TRENDS (July-Sept. 1967). By that time, some 16,218 out of a possible 50,340 eligible for Medicaid as "medically indigent" had signed up.

³³³ PREP REVIEW, *supra* note 288, at 2, 13. Of the PREP Report, the State Welfare Department noted only that "An Administrative review by the Federal Government of this program (Title XIX) resulted in commendations to the State for the services available and program administration." CONN. DEP'T OF WELFARE, ANNUAL REPORT TO THE GOVERNOR 46 (1968-1969).

³³⁴ N.Y. Times, Jan. 28, 1967, at 26, col. 2.

gories of persons who may be covered. But decisions made in the state capital do not always filter down to the local welfare department or individual social workers.³³⁵

The potential recipient of Medicaid, then, may be faced with a humiliating and complex means test and either confusing or inadequate advice. He will also be faced with gradually receding eligibility levels and marked differences in entitlement and services among the states. New York State in 1968 spent \$63.95 per inhabitant while twenty-one states spent less than \$10 per inhabitant.³³⁶ The year before it had been estimated that potential coverage ranged from forty-five per cent of the population in New York to seven per cent in Massachusetts, with actual utilization ranging from a high of eleven per cent in New York to a low of 2.5 per cent in North Dakota.³³⁷

Recipients might well be thought to be discriminated against by the variation of services available to them in the different states. For those receiving cash under federally supported public assistance, programs had to provide seven basic services by July 1970: inpatient hospital care, outpatient hospital services, other laboratory or x-ray services, skilled nursing home services for those over twenty-one, screening and treatment for those under twenty-one, physician services, and home health services. But beyond that, states had great latitude. Alabama, Arkansas, Colorado, Florida, Georgia, Indiana, Iowa, Louisiana, Maine, Mississippi, Missouri, Montana, Nevada, New Jersey, New Mexico, Ohio, Oregon, South Carolina, South Dakota, Tennessee, Texas, West Virginia, and Wyoming offered no program to the "medically indigent." Mississippi provided no services other than the required ones to the groups compulsorily covered, while Wyoming offered only transportation by way of such service. New Mexico, on the other hand, although having no program for the categorically related or the "medical indigent" category, offered to welfare recipients home health services, drugs, dental services, eyeglasses, hearing aids, prosthetic devices, physical therapy, private duty nursing, optometrists' services, podiatrists' services, chiropractic services, clinic services, transportation, and other diagnostic services. At the other end of the scale, California, Connecticut, Minnesota, New York, and North Dakota offered every additional service for which a federal contribution was available to those covered by the categorically related programs.³³⁸

³³⁵ For instance, the title XIX informational pamphlet issued in July 1969 and entitled *Medical Care for People in Connecticut* classifies as a category "Parents or other relatives with whom a child under 21 years of age is living with sufficient income or resources to meet their general living expenses but not enough to meet the cost of medical care." But spot checks have shown that social workers in Connecticut (including those working in the hospitals) have advised their clients that this is not a category of "medical indigence" in Connecticut, except for those under 21. For a study of the procedures for applying for Medicaid in Connecticut, and especially the risk of being refused after services have been performed, see Lahav, *The Treatment of Title XIX Patients in Health Care Facilities 2-6, 1970* (paper on file with the authors).

³³⁶ U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE, SOCIAL AND REHABILITATION SERVICE, NATIONAL CENTER FOR SOCIAL STATISTICS, *MEDICAID: SELECTED STATISTICS, 1951-1969*, at 59 (1970).

³³⁷ Puerto Rico, which presents special problems, is excluded. Titus, *supra* note 61, at 37.

³³⁸ CCH MEDICARE & MEDICAID GUIDE para. 15,504.

For the "medically indigent" as a whole, the differences were even greater and more erratic. As one aging Vermont recipient was alleged to have said: "Your program isn't much good if you can't help me when my eyes get so bad I can't see and my teeth get so bad I can't chew."³³⁹ It was arguable that the level of medical care in the United States had become more uneven rather than less in the years since 1965.³⁴⁰

Excluding the issue of different services in different states for a moment, there is still the problem recipients may find in attempting to obtain the services to which they are entitled. The professional press is full of examples of appeals to providers to cut back on title XIX services.³⁴¹ But recipients may just find that providers refuse to join the Medicaid program at all. A year after Medicaid began only 4500 of New York City's 15,000 physicians³⁴² and only 2400 of the city's 7500 dentists were registered for Medicaid.³⁴³ Indeed New York ultimately avoided the problem by no longer requiring licensed providers to sign up for the program.³⁴⁴ But such moves did not stop boycotts by pharmacists in New York City³⁴⁵ and dentists in Connecticut,³⁴⁶ nor, in October 1970, a boycott by skilled nursing homes in Massachusetts. But perhaps the most sordid boycott of all was in the nation's capital—the hospitals' boycott of the D.C. Medicaid program. As the result of a dispute about payment for outpatient services, only two of the city's ten hospitals agreed to

³³⁹ SOCIAL WELFARE IN VERMONT: BIENNIAL REPORT TO THE GOVERNOR AND GENERAL ASSEMBLY 18-19 (July 1966-June 1968).

³⁴⁰ In response to this, and in an effort to expand the concepts of "equal protection" developed in *Shapiro v. Thompson*, 394 U.S. 618 (1969), the welfare rights movement has begun to test the constitutionality of these discrepancies in the court. In *Dimery v. Dep't of Social Services*, — F. Supp. — (S.D. Iowa 1969), the plaintiff, a permanently disabled boy of 14, was denied medical assistance under title XIX in Iowa because his father was employed and therefore the boy was not covered by Iowa's AFDC program or, therefore, by its title XIX program. Had the state had the voluntary AFDC-UP categorical program the family would have been covered and the boy would thus have been eligible for Medicaid. While not dwelling at length on that point, a three-judge federal district court held that the Iowa Medicaid statute represented an undue delegation of legislative power to the welfare agency. The state appealed to the Supreme Court. See *Dep't of Social Services v. Dimery*, 398 U.S. 322 (1970), which in a memorandum decision, with Justice Douglas dissenting, vacated the judgment and remitted it to the District Court, for reconsideration in the light of another decision holding that a plaintiff who had not exhausted his state remedies could not test the constitutionality of a statute. *Reetz v. Bozanich*, 397 U.S. 82 (1970). See also MATERIALS ON HEALTH LAW, *supra* note 1, at 197 *et seq.*

³⁴¹ E.g., Kansas physicians have been urged to use special restraint in hospitalizing Medicaid patients. *AMA News*, Apr. 21, 1969. A more general appeal in connection with all services was made by the Governor of Virginia. *Id.*

³⁴² "I wouldn't call it a boycott," said a surgeon who was coordinating the five county medical societies, "this is merely an expression of the way doctors feel about the program." *N.Y. Times*, Dec. 5, 1966, at 1, col. 1. Physicians in Suffolk County did in fact boycott the program. *Id.*, June 23, 1966, at 1, col. 2. In contrast see the revealing study of physicians' changing support for Medicare. *Colomboros, Physicians and Medicare: A Before-After Study of the Effects of Legislation on Attitudes*, 34 AM. SOCIOLOGICAL REV. 318 (1969).

³⁴³ *AMA News*, Jan. 2, 1967. There were higher percentages among optometrists and podiatrists. *N.Y. Times*, Dec. 5, 1966, at 1, col. 1.

³⁴⁴ *Petrina, supra* note 174, at 17.

³⁴⁵ On the 1967 boycott, see *id.* at 27; on the 1969 boycott, see *N.Y. Times*, June 23, 1969, at 1, col. 2.

³⁴⁶ *PREP REVIEW, supra* note 288, at 5.

cooperate.³⁴⁷ For a year the burden on the hospitals cooperating was intolerable.³⁴⁸ Then in the summer of 1969 (the program had begun on July 1, 1968) a compromise was finally worked out,³⁴⁹ and Medicaid became generally available in Washington hospitals.³⁵⁰

Perhaps more frequent were the situations where providers were evasive. This appears to have been the situation after Connecticut reverted to a fee schedule for physicians, following the twelve-month experiment with usual and customary fees, in March 1969. The medical profession was not well pleased with the change. The *AMA News* announced: "Medicaid Killed in Connecticut,"³⁵¹ while *Medical Economics* described the twelve-month experiment as the "one glorious year" when Medicaid "really worked."³⁵² Apparently during that year, 3000 out of a possible 4500 physicians took part in the program. After the fee schedule was re-introduced, these reports suggested that only about 1000 doctors took part. And the reports would seem to be borne out by studies made in the New Haven area early in 1970.³⁵³ To the geographical and social problems³⁵⁴ involved in reaching some physicians has been added a noticeable reluctance to treat Medicaid patients on the part of many physicians. For a profession that elleged it willingly treated poor patients gratis before 1965, the situation is confusing.

In the 1970 hearings, John Twiname announced that "over twelve million will receive aid this year" and that "public assistance recipients who are eligible for medicaid are getting more health care than other low-income people who are not eligible."³⁵⁵ If this is so it raises basic issues about whether the federal government should allow states indefinitely to offer widely varying programs to differing groups. The 1970 Finance Committee staff study moved a long way to question such dis-

³⁴⁷ *AMA News*, Oct. 21, 1968. The District Health Department proposed paying only 80% of the cost of such bills. *Id.*, Sept. 2, 1968. See also *id.*, Nov. 18, 1968.

³⁴⁸ Neighborhood Legal Services Program, Washington, D.C., Medicaid in the District of Columbia, Mar. 1969 (mimeo.).

³⁴⁹ *AMA News*, Apr. 14, 1969.

³⁵⁰ For a critique of the services of Medicaid in Washington in October 1969, see Testimony of Margaret Ewing of Neighborhood Legal Services Program before the D.C. Council's Committee on Health and Welfare (Oct. 27, 1969). See also MATERIALS ON HEALTH LAW, *supra* note 1, at 228 *et seq.*

³⁵¹ *AMA News*, Dec. 14, 1969.

³⁵² Lavin, *What to Expect from Washington Now*, MED. ECON., Jan. 20, 1969, at 21.

³⁵³ A spot check of 15 physicians who were paid more than \$2500 in 1968 from Medicaid funds resulted in 8 responses (3 specialists, 5 general practitioners), all of whom had become more restrictive in accepting Medicaid patients since March 2, 1969. In a more general (though not statistically reliable) survey, it was estimated that 58% of practitioners in the New Haven area were willing to take Medicaid patients. Mitchell, *supra* note 291, at 10.

³⁵⁴ For a description of some of these psychological barriers, see Lahav, *supra* note 335, at 6-8.

³⁵⁵ 1970 Hearings, *supra* note 201, at 19. The figures are based on preliminary data from the federally financed study at the Columbia School of Public Health to determine the quality of care under Medicaid. With this thought compare the Dimery decision, *supra* note 340. Data are still scarce about Medicaid. A recent Report to the Governor of Vermont noted: "There is a regrettable lack of meaningful statistical data available on the operation of the Medicaid Program in Vermont. For example, as recently as April of this year, the Department had no reliable statistics on how many persons were receiving Medicaid benefits." REPORT OF THE GOVERNOR'S COMMITTEE INVESTIGATING SOCIAL WELFARE 74 (1969).

criminary support; and the final report of the McNerney Task Force called for a basic federal floor³⁵⁶ as one step towards the full federalization of health care. Medicaid as described in this paper may be on the wane.

V

CONCLUSIONS

While the future of medical care in this country, in terms either of funding through federally sponsored health insurance or of provision through health maintenance organizations, is beyond the scope of this paper, there is little doubt that Medicaid as it is known today is destined to be phased out during the next decade.³⁵⁷ Current White House proposals call for a Family Health Insurance Program as part of the Administration's Family Assistance Plan to cover what is now covered by Medicaid with respect to young, low-income families. The combination of this with an expanded and more effective program for the elderly and disabled under Medicare would reduce the need for other forms of medical assistance among the most needy population groups. Or perhaps Medicaid will be replaced by something more exclusively "medical," through the development of comprehensive health services under the impact of national health insurance. The Health Security proposals being sponsored by Senator Kennedy are a notable example of such an approach.³⁵⁸

Yet even if the present program is transitional or moribund, the study of Medicaid is vital. It is vital because, as Secretary Richardson has recently made clear, the program will not disappear overnight and insurance, in its various guises, still has many hurdles to clear. And it is vital, too, because, while in so many ways Medicaid is a museum of the defects of a medical care program, it is a remarkably instructive museum for future planners. If the new long-term solution for health care in the United States is to be a success, then its architects would do well to reconsider the Medicaid experience.

Title XIX, as drafted, was bound to be ineffective in its double role as a health service program and as an expansion of public assistance. Indeed, it was the combination of a program of services and a program of cash assistance which provoked Medicaid's initial dilemmas. Whether Medicaid was in fact to be regarded as a health care program or part of a broader program of income maintenance was never sufficiently elucidated. The discovery of the intention of Congress, as lawyers have long known, is at best a slippery process. While there is evidence that some legis-

³⁵⁶ *E.g.*, "We recommend converting Medicaid to a program with a uniform minimum level of health benefits financed 100 per cent by Federal funds," TASK FORCE REPORT, *supra* note 221, at 14, and "the commitment to provide comprehensive care to substantially all needy and medically needy should be reaffirmed." *Id.* at 15. Few states would probably quibble with that. See, *e.g.*, REPORT OF THE GOVERNOR'S COMMITTEE INVESTIGATING SOCIAL WELFARE, *supra* note 355, at 73.

³⁵⁷ The Task Force Report put it more tactfully: "Medicaid . . . should not . . . be relied upon indefinitely as the Nation's primary approach to [medical care]." TASK FORCE REPORT, *supra* note 221, at 13.

³⁵⁸ S. 4297, 91st Cong., 2d Sess. (1970).

lators intended to provide a new concept in medical care, there is ample evidence that other legislators, even among those who were in favor of title XIX, saw no need for any radical change from earlier policies under which health care was purchased from private vendors on the same kind of peripheral basis as that under which other goods (bedding, pots and pans, and so forth) are purchased for cash assistance recipients.

The lack of clearly stated national goals for Medicaid in 1965 was a major and reverberating deficiency. Congress, in so many ways, made a series of classic errors which were transmitted down the line as the programs were developed in the states. These errors led to conflict in interpreting Medicaid between powerful committees in Washington and the legislatures of major states (particularly New York and California), to state budgetary crises, and to the sometimes selfish behavior of the medical providers. In that sense the villains portrayed in these pages were themselves the victims of confusion in the Congress.

Why was there this initial confusion about the purposes and goals of Medicaid? There can have been few legislators who were unaware in 1965 that Kerr-Mills was somewhat less than a success. Kerr-Mills had indeed received substantial publicity in the debates preceding the 1965 legislation. That program had already demonstrated the basic characteristics which were later to plague Medicaid: the transfer of funds by states from one public pocket to another under the stimulus of greater federal matching funds; the unevenness of programs from state to state; the implications of attaching a system of medical vendor payments to an administrative structure of grants-in-aid which relied on minimal federal direction; the interpretation of "medical indigency" as a rather rigid test of means, albeit at a somewhat higher average level than for cash assistance; the greater interest by the state legislatures in balancing their budgets than in reorganizing medical care; and, in the state bureaucracies, the inadequate administrative expertise for running a major medical program. Yet title XIX was developed under similar principles.

Those loath to ascribe confusion as a natural attribute to Congress might assume that the adoption of the Kerr-Mills strategy for the much larger program of Medicaid was predicated on deliberate doctrine, founded perhaps on recondite principles of marginal gain or of greater chaos. Medicaid has brought medical care to many thousands of persons, with less individual financial anxiety than had the program not been developed; in this sense the gains are real, albeit marginal and expensive, and the balance sheet should be so interpreted. In this argument the major defects of Medicaid lie in the lack of adequate cost projections and cost-benefit analyses. Those favoring a doctrine of greater chaos might point to Medicaid's intrinsic social importance in accelerating Congressional and general concern over the costs and provision of health services. Without a doubt the Medicaid experience, coupled with some rather similar concerns over Medicare, has been a salient factor in the development of proposals for national health insurance. In retrospect, the muddle of

Medicaid will undoubtedly be seen as a necessary forerunner of rationalization of health services in the United States in the 1970s or 1980s, part of what may be essential chaos which precedes and precipitates major legislative reform. Under this argument, Medicaid's problems were inevitable, and the program itself was born to be transitional.

But while both these approaches contain at least a grain of truth, such considerations assume that the Congress, or at least its leaders in the health and welfare areas, did in fact have a planned long-term objective for Medicaid. The evidence does not bear this out. Medicaid appears to have been enacted almost as an afterthought—hence its early description as the “sleeper” of the Medicare legislation. Medicaid was the culmination of a long and continuing thread of argument in the Congress, going back at least to the 1940s, calling for an approach to medical care provision through welfare instead of through a general program of health insurance. Medicaid thus appears as the natural conclusion of a gathering momentum, built up through reams of Congressional documentation, rather than a reasoned approach to medical care. Built on the rhetoric of the past rather than the realities of the present, it was a necessary, if expensive and somewhat painful, transition from the 1940s to the 1970s. The lesson for the future lies in attempting to build a program with stated aspirations and a vision which looks forward rather than back.

In its shape as well as its intentions, Medicaid began with inbuilt deficiencies. The assumption that effective and economical medical services can be provided through existing structures of health services and public assistance was challenged almost as soon as the program was implemented. The problem was in the program itself, not in the reactions of the various states; for Medicaid, nominally an assistance program, was blessed (or cursed) with attributes which were inappropriate to the welfare tradition. Unlike other forms of assistance, Medicaid was asked to do more than fill a gap or provide a back-up service for reasonably effective programs (such as jobs or housing) in the private sector. In health, the other programs themselves were insufficient. If Medicare, designed to provide health care as an entitlement to the whole population over age sixty-five, had been sufficiently comprehensive, Medicaid's substantial and growing commitment of services to the elderly would have been unnecessary. Similarly, if private health insurance had effectively covered the working population (including continuing coverage for survivors and dependents, and in times of sickness and temporary unemployment) the concept of medical indigency need not have been invented. As it was, Medicaid, with its uncontrollable budgets and rising costs, has been a reflection of broader deficiencies in the health sector.

At the same time, Medicaid raised serious questions about the use of welfare structures to administer a system of vendor payments. The purchase of services by a public agency in the private sector is an appealing prospect. It is one, incidentally, which is continuing to appear in proposals for health payment schemes, ostensibly

including the Administration's proposed Family Health Insurance Program. But the philosophy of the public-private mix contains its own dilemmas, not the least of which is the tacit assumption that the private sector itself is efficient. Yet by the very fact that the medical care industry is dominated by legalized monopolies, there is reason to question this assumption. Certainly the Medicaid experience gives little ground for optimism that the private sector can regulate itself efficiently.

Over and above this basic inconsistency in the philosophy of vendor medical payments, Medicaid tested, and found wanting, the traditional federal grant-in-aid when it applies to a service rather than a cash payment program, particularly where that service has generalized standards and is subject to Congressional review in terms of national rather than state intent. The evidence of Medicaid suggests that if it is the purpose of the Congress to bring medical care to every person in the country, control of these services cannot be left to the fifty states and to other governmental units. The present state of Medicaid raises vital issues of equal protection. Even with respect to cash payments, the Nixon Family Assistance Plan is moving towards nationwide standards and administration. A fortiori this central control will have to apply to the service aspects of the largely federally-funded Welfare State.

These observations point to tighter federal regulation over providers of care and increasing federal standards for services under Medicaid, or for whatever scheme replaces it, as the essential part of public purchase of services in the private sector. It is clear that any program with national goals which wishes to administer an effective program in the private sector as it presently exists will have to include (and to enforce) national standards and appropriate regulatory mechanisms over the operation and charges of providers who are themselves organized either as monopolies or oligopolies. A vendor payment system cannot exist without adequate controls. If the intention is that a revised Medicaid program is to be a national one, then the national government is going to have to set standards and to take a major part in dealing with the providers. The restructuring of medical providers almost certainly calls for greater political strength and acumen than any single state can provide, and for a federal role which is immensely stronger than that yet developed for Medicaid.

At the same time the implicit advantages of utilizing the private sector also need to be examined. Besides the familiarity of vendor medical payments as a means of providing public assistance health care in the states, there appear to have been two basic assumptions behind the adoption of vendor medical payments in Medicaid. The first was that services are more likely to be available and are of better quality through purchase in the private sector rather than through the development of a publicly financed and controlled system of hospitals and clinics. Existing problems in public hospital systems (of which New York City is a notable example) would seem to bear out this assumption. Moreover, many states and counties, having relied for years on vendor medical payments, did not have a ready-made public

system for development. The chief deficiencies in implementation of expanded vendor payments were that the private sector itself, as already suggested, was not prepared to respond efficiently to vast infusions of public funds, and that the public agencies developed no adequate machinery of public accountability. Both of these deficiencies could be rectified, however, through modifications of Medicaid or the development of a new program.

A second basic assumption of vendor payments in Medicaid, at least in its first two years, was the acceptance of a social ethic of equal opportunity in medical care. There was (and remains) a commitment by many reformers to provide medical services to the poor of roughly the same quality as those provided to other members of the population; this was interpreted as meaning provision of services through one set of providers rather than espousing a separate-but-equal philosophy of medical care. Medi-Cal was the most publicized example of this "mainstream" approach, in that state administrators embarked on a deliberate program to break down California's separate public hospital system as the locus of medical care for the indigent. Taking Medicaid as a whole, however, it has proved impossible to overthrow centuries of poor-law mentality, and present philosophies appear to accept the continuation of two classes of medical care.

Underlying both these assumptions was a further assumption. Medicaid fell, if not initially, then very shortly after it began, into the persistent and debilitating welfare myth that somehow or other there is a financial shortcut to "solving" welfare and medical care "problems." The truth is that to "solve the welfare problem" in America is likely to cost far more than the present public assistance programs cost. The same is true of bringing medical care to the poor. Even bringing minimal services will be expensive; to give middle-class medicine to the so-called "medically indigent" will involve spending billions of dollars more than are currently being spent under Medicaid. It is then especially unfortunate in retrospect that the early projections of Medicaid's cost were either understated or misleading; and, at least in present terms, it is tragic that so many state welfare departments tried to sell Medicaid as something which, in the long run, would cut state contributions to the welfare budget. With this advance publicity, there was little hope for a "new" approach. As an axiom, any system of medical care which resolves to reach more people more effectively, including national health insurance, should be expected to cost much more than present programs even if the envisaged system is more efficient.

In summary, then, the faults of Medicaid, epitomized by lax administration and unanticipated costs, were inherent even in the legislation. A more effective design would demand the establishment of clear goals and expectations for Medicaid, either as a broad health services entitlement or as a fringe benefit of a cash assistance program. It would set up appropriate regulatory machinery to fulfil its goals, and would be organized on a national rather than a state basis. Such action could be taken through a revised form of Medicaid. In the long term, however, the only

satisfactory answer to problems implicit in equal medical opportunity is a system of comprehensive health insurance in which all members of a population are covered for similar benefits. A concomitant of this is that the providers of benefits will have to be encouraged to develop new systems to deliver the services they provide. In universal health insurance as in the more limited program of Medicaid, the question is one of a stronger federal role and careful public regulation.

Such are Medicaid's major problems. It would be wrong to conclude, however, without considering some of the benefits of Medicaid. In most states, for those on Medicaid the provision of care is better than it was before 1965. At least in established health facilities—OEO health centers and the like have a special status—there is now probably less of a gap between the services provided for the poor and the nonpoor than there was before. Even in the most conventional hospital, the notion of the "welfare patient" is less rampant. There has been an increasing realization of the fact that health services should be treated as divorced from the cash payments in the welfare system.

Moreover, as the country moves toward the 1972 elections, with the almost inevitable further politicization of national health insurance and its alternatives, there are more fundamental lessons to be learned from Medicaid. To have an effective medical care program, it must have the support of the administration—both in Washington and the states—in the legislature and in the executive. A sop to welfare recipients is not a satisfactory basis for a good medical care program. There must also be a commitment on the part of the providers and recipients to make certain the program is equitable, efficient, and fairly utilized. Providers will have to be convinced that the program is not a license to print money and that professions are professions because they owe a peculiar fiduciary responsibility to the public. Recipients will have to be assured of sufficient dignity so that they treat the program with respect. Federal supervision, and probably control, will have to be far more effective if the program is not going to be bankrupted; and the medical providers will have to learn to live with such control. If only some of these lessons are learned from Medicaid, the program will have served a valuable function.

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† Published in two parts, priced separately.