RESTRUCTURING MEDICARE FOR THE LONG TERM PROJECT

Study Panel on

Medicare Management and Governance

# Reflections on Implementing Medicare

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# Preface to the Second Edition

In the spring of 1993, the National Academy of Social Insurance released the first edition of this report. The centerpiece of the document was a dialogue that took place in January 1992 among Robert M. Ball, Social Security Commissioner from 1962 to 1973, Arthur E. Hess, the first Director of Health Insurance for Medicare from 1965 to 1967, and members of a National Academy of Social Insurance (NASI) study panel examining implementation issues associated with reforming America's health care system. In anticipation of significant health reform legislation, the study panel wanted to talk with individuals who had been responsible for implementing a law that provided coverage to millions of Americans who previously did not have health insurance.

The report provides historical reflections on Medicare's earliest days. One is struck by the enormity of the task that faced the Social Security Administration in 1965 and the creativity employed to meet the challenge. Some of the story, such as the role Medicare played in desegregating the nation's hospitals, had not been widely discussed. Although the major health care reform anticipated at the beginning of the 1990s did not come to pass, the material in this report continues to provide valuable context and lessons for the decisions policymakers will face in the next decade.

In the summer of 2000, NASI convened a new expert group to examine management and governance issues for Medicare's future. Over the next year, this Study Panel on Medicare Management and Governance will commission new analyses and issue a report of its own. As policymakers contemplate what administrative structure and resources will best serve beneficiaries and providers over the next generation, the Study Panel believes this report provides useful insights into the intentions of Medicare's founders and an historical benchmark against which to gauge the program's evolution over the last three-and-a-half decades.

Part I of the report is the 1992 dialogue among Bob Ball, Art Hess, and the NASI Study Panel on Implementing Health Care Reform. Part II is a report by Bob Ball to his staff at the Social Security Administration in November of 1965 reporting on implementation of the 1965 Medicare legislation. Part III is a chart presentation that Bob Ball made to President Johnson's Cabinet in 1966. The parts of the report are communications among people who were present during the early years of Medicare. This edition includes an Introduction that provides historical context for readers less familiar with the players and events leading up to the implementation of Medicare.

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# Introduction

*Reflections on Implementing Medicare* is about the administrative challenges of launching the Medicare program when it was enacted in 1965 to provide health care coverage to 19 million elderly Americans. As policy makers today consider broad structural changes, as well as significant administrative changes, in Medicare and Social Security, practical questions arise about how such changes would be implemented. In this context, it may be useful to review how implementation tasks were carried out when the Medicare program began.

The report is largely a personal account told by Robert M. Ball and Arthur E. Hess. Bob Ball was Commissioner of Social Security from 1962-1973 — years that spanned the Kennedy, Johnson and first Nixon administrations. Unlike other Social Security Commissioners, Ball had been a career civil servant in the Social Security Administration (SSA), where he began by taking retirement benefit claims in a local office in New Jersey. After he retired as Commissioner in 1973, Ball remained active in Social Security and Medicare policy. He served on three different statutory Advisory Councils that advised on Social Security and Medicare policy and reported, respectively, to the Carter administration in 1979, the Bush administration in 1991, and the Clinton administration in 1996. Ball also filled a pivotal role as a member of the Greenspan Commission, whose report to President Reagan set the blueprint for legislation that restored financial stability to Social Security in 1983.

Art Hess was the first Director of Health Insurance for Medicare in 1965-1967. Hess later became Deputy Commissioner of Social Security and became Acting Commissioner when Ball left the government. Before Medicare, Hess had been SSA's first Director of Disability Insurance and was charged with implementing the extension of Social Security benefits to disabled workers and their families in the late 1950s. The disability program, like the Medicare program later, had been strongly opposed by the American Medical Association (AMA). It feared that federal involvement in medical decisions about disability would lead to federal control over the practice of medicine. That fear was assuaged to some degree by a political compromise in the disability legislation that gave states (rather than the federal government) authority to make disability decisions. That compromise also gave Hess the Herculean task of implementing a disability benefit program that was paid solely from federal funds and was governed solely by federal rules, but whose rules were to be carried out by state employees, who worked under the jurisdictions of the 50 state governors.

Wilbur Cohen is mentioned frequently in the report that follows. He was the Deputy Assistant Secretary for Legislation in the Department of Health, Education and Welfare during the Kennedy Administration and later became Under Secretary of the Department. Cohen had been a long-time advocate of Medicare. He was a skilled negotiator and worked closely with the Congress during the Kennedy and Johnson Administrations. Cohen is described by Ball as the one person, more than any other, who was responsible for getting Medicare enacted. Cohen died in 1987 at the age of 73.

## ENACTING MEDICARE

The story of enacting Medicare is one of persistent political struggle and eleventh hour compromise. There was growing recognition in the late 1950s and early 1960s of the need for federal action to help meet the high cost of health care for the Nation's elderly. But there were sharply different views about how to do it.

One camp, which was led by organized labor and senior citizen groups and included Ball, Hess, and Cohen, favored a social insurance approach that would build on the existing Social Security program. Proponents of this vision focused on covering hospital care, post-hospital nursing home care, and home health services. They did not seek to include outpatient medical care in their plans, due in large part to the powerful opposition of the AMA. In the social insurance approach, almost all elderly would become immediately entitled to health insurance coverage through their past contributions to Social Security. The costs would be met through new payroll contributions paid by workers and matched by employers. In turn, the future elderly would gain entitlement to this coverage through their past contributions to the program.

One competing approach to health coverage for the aged called for a system financed by general revenues and premiums paid directly by beneficiaries. In contrast with the social insurance approach, this plan called for voluntary participation. It was advocated by Republican members of the Ways and Means Committee.

Another competing approach to health coverage for the aged favored means-tested assistance that would be administered through the states. In this model, federal matching funds would be granted to states that put up some of their own money for this purpose and states would retain discretion about who would be eligible for the benefits and how doctors, hospitals and other providers would be paid. This model was advocated by the AMA. It was also a more comfortable position for conservative political leaders, who typically favored states rights over direct federal involvement in social policy.

In the early 1960s, the tension between states rights versus direct federal provisions for citizen protections was playing out on a separate track in the debate over civil rights. That debate culminated with enactment of the Civil Rights Act of 1964. Title VI of that act provided that "no person in the United States shall, on the grounds of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity receiving federal assistance." Because almost all hospitals in the country were involved in treating the elderly (whose care would be covered under Medicare), the civil rights law, which was enacted only 12 months before Medicare, would have important implications for implementing Medicare.

Both Social Security and public assistance legislation were under the jurisdiction of the Ways and Means Committee in the House of Representatives and the Finance Committee in the Senate. Wilbur Mills (D, AR) chaired the Ways and Means Committee from 1957-1974 and Senator Harry Byrd (D, VA) chaired the Senate Finance Committee from 1955-1965, when he was succeeded by Senator Russell Long (D, LA).

The Eisenhower Years – 1952-1960. Bills to provide hospital insurance to the aged as part of Social Security were introduced in

every Congress from 1952 through 1965. They first received active consideration by the House Ways and Means Committee in 1958, but the Committee concluded that more information was needed and took no action.

In 1959-1960, the Ways and Means Committee held public hearings on Social Security bills, including one to provide insurance against the cost of hospital, nursing home and surgical services for persons eligible for Social Security. The committee concluded that federal action was needed, but did not recommend the social insurance approach. Instead, it proposed federal grants to states for means-tested medical assistance — a proposal often referred to as the Kerr-Mills program. In the Senate floor debate on the Kerr-Mills bill, Senator John F. Kennedy (D, MA) and nine other Senators offered an amendment to add a program of hospital insurance for the aged as part of Social Security. That amendment was defeated on the Senate floor by a vote of 51-46. Only the Kerr-Mills program was enacted into law.

The Kennedy Johnson Years – 1961-1968. With the election of President Kennedy in 1960, extending health coverage to the aged through Social Security became part of the Administration's agenda. In his February 1961 message on the Nation's health, President Kennedy elaborated on his plan for hospital insurance and limited post-hospital nursing care. The Kennedy proposal was introduced in the House and Senate in 1961, but it was not taken up by either the Ways and Means Committee or the Finance Committee.

When the 88th Congress took office in January 1963, President Kennedy again urged enactment of a program of hospital insurance as part of Social Security. The details followed the general blueprint laid out in 1961. Kennedy also called for an increase in Social Security cash benefits and improvements in medical assistance programs for the needy. After President Kennedy was assassinated in November of 1963, President Johnson continued the Administration's three-pronged agenda for a Social Security cash benefit increase, hospital insurance for the aged through Social Security, and improvements in medical assistance for the needy.

In July 1964, the Ways and Means Committee reported out a bill to increase Social Security cash benefits, but did not include either of the President's health proposals. The Social Security provisions passed the House 388-8. In considering that bill, the Finance Committee also rejected amendments to add hospital insurance for the aged. On the Senate floor, however, an amendment to add hospital insurance was adopted by a vote of 49-44. The House and Senate conference committee failed to reach agreement on the controversial hospital insurance provisions and the entire bill died when Congress adjourned in October 1964.

After his landslide election victory in 1964, President Johnson reiterated his agenda for hospital insurance for the aged, a Social Security benefit increase and improvements in medical assistance in his 1965 State of the Union address. Johnson's three-part proposal was introduced on January 4 as HR-1 in the House and as S-1 in the Senate.

In January, the Ways and Means Committee began deliberations in executive session on HR-1. The Committee also considered two competing approaches: a state-administered means-tested approach advocated by the AMA; and a voluntary plan advocated by ranking minority member Rep. John Byrnes

(R, WI) and most of the other Republicans on the Committee. The latter plan was more comprehensive than President Johnson's proposal in that it covered physicians services as well as in-patient hospital care.

After two months of deliberations within the Ways and Means Committee, Chairman Mills struck a compromise that combined all three approaches: Part A of Medicare was a hospital insurance program similar to President Johnson's plan; Part B covered outpatient physician services through a supplementary program that embodied the principle of voluntary participation by doctors and patients that was advocated by Committee Republicans; the third approach, for means-tested assistance, that had been advocated by the AMA became the blueprint for the Medicaid program for low-income families with children as well as the aged, blind and disabled. As Ball and Hess recount, Part B came as a surprise and Administration officials had only a weekend to work with Committee staff to flesh out the details. The compromise bill, which also included Social Security benefit increases, was reported to the House on March 29, 1965. After two days of debate (under a closed rule, which precluded any amendments) the House passed the bill 313 to 115.

The Senate Finance Committee held 15 days of public hearings on the House-passed bill. Testimony focused on the health insurance programs. Opposition came largely from the AMA, although some medical groups spoke in favor of the bill. During executive session the Finance Committee adopted several changes in the health and Social Security provisions of the bill and reported it out on June 30. On July 9 the Senate passed its version of the bill 68-21.

The House and Senate conferees met to settle differences between the two bills and reported their agreement on July 26; the House passed it 307-166 on July 27; the Senate passed it 70-24 on July 29; and President Johnson signed it into law on July 30.

## IMPLEMENTING MEDICARE

One part of this report is an address given by Commissioner Ball to SSA employees three and a half months after Medicare was enacted. It summarizes the actions underway and planned to put in place the Social Security and Medicare provisions of the law. It reports briefly on implementing the Social Security benefit changes — themselves a major undertaking. Implementing the Social Security changes called for: (a) raising cash benefits by 7 percent retroactively to January 1, (b) certifying eligibility of 18-21-year-old full-time students who became newly eligible for benefits as children of retired, disabled and deceased workers, (c) applying a revised test of disability for applicants for disability benefits, and (d) determining eligibility for divorced spouses who became newly eligible for benefits.

The rest of Mr. Ball's report to SSA staff describes the five-pronged approach for implementing the Medicare provisions. They included:

(1) Enrolling elderly individuals. While participation in Part A hospital insurance was automatic for current Social Security beneficiaries, new applications were needed from persons age 65 and older who had not yet retired and / or who were not otherwise eligible for Social Security. Because participation in part B was voluntary, all persons age 65 and older had to be informed about the new program

and given a chance to enroll and agree to pay the $3 monthly premium for coverage.

(2) Enrolling hospitals, nursing homes, home health agencies, and fiscal intermediaries in Part A. Providers had to be informed about the program and given a chance to apply for a determination of whether they met standards for participation. Working with governors, SSA engaged state agencies to certify individual institutions throughout the country. That certification included compliance with the Civil Rights Act. Participating hospitals could choose which fiscal intermediary (Blue Cross or another insurance company) they wished to have administer their federal payments. SSA negotiated contracts with the intermediaries to cover their administrative costs and work out the details.

(3) Engaging insurance carriers and informing doctors about Part B. Insurers (Blue Shield and others) were given a chance to apply for the job of administering the Part B program, and doctors had to be informed about their own and their patients' rights and responsibilities under the new program.

(4) Coordinating activities within the federal government. While primary responsibility for implementation was delegated from the Secretary of Health, Education and Welfare to SSA, many functions had to be performed by other agencies, including the Public Health Service (to advise on quality of care and professional relations), the Welfare Administration (to enroll assistance recipients), the Internal Revenue Service (to contact elderly tax payers who were not receiving Social Security), the Civil Service Commission (to notify federal retirees about their rights under the program), the General Services Administration (to obtain new field offices), the Postal Services (to help publicize the new program), and even the U.S. Forest Service.

(5) Developing policy. Many policy details had to be worked out about standards and methods for paying hospitals, doctors and other providers as well as for paying administrative costs to insurers. These issues were extremely important to providers, fiscal intermediaries and insurance carriers. The law called for a Health Insurance Benefits Advisory Council (HIBAC) to advise on administration and regulations. SSA's policy development involved widespread consultation with stakeholders, staffing HIBAC, and ultimately setting the details of reimbursement and payment policies.

Another part of this report is a chart presentation given by Mr. Ball to President Johnson's Cabinet outlining the activities being undertaken to implement Medicare.

The first part of this report is a dialogue between Bob Ball and Art Hess and a study panel on Implementation Aspects of National Health Care Reform that was convened by the National Academy of Social Insurance (NASI) in 1992. The purpose of that dialogue was to draw insights from the implementation of Medicare for the Panel's study of implementation issues that would need to be considered under proposals to expand health insurance to uninsured Americans. At the time, proposals to move the Nation toward more nearly universal health care coverage were actively considered by the Bush Administration and the Congress.

The 1992 study panel was chaired by Bruce Vladeck, who at the time was President of the United Hospital Fund of New York. He later became Administrator of the Health Care Financing Administration (HCFA) in

the Clinton Administration and is now Director of the Institute for Medicare Practice at Mt. Sinai School of Medicine. He also now serves on NASI's Board of Directors.

Other panelists who participated in the session with Ball and Hess were:

Daniel P. Bourque is senior vice president of Voluntary Hospitals of America. He served as deputy executive secretary of the Department of Health and Human Services in 1981-1982 and was Deputy Administrator of HCFA in 1982-1984. He had also served as a professional staff member of the Senate Labor and Human Resources Health Subcommittee.

William D. Fullerton worked in SSA during the 1960s and was the first executive secretary of HIBAC. He later served as chief of the professional health staff of the Ways and Means Committee and later became the first Deputy Administrator of HCFA in 1977-1978.

Lawrence F. Lewin is the founder of Lewin and Associates, a health policy consulting firm. He has also served on the NASI Board of Directors.

Jerry L. Mashaw is Sterling Professor of Law at Yale University. He specializes in administrative law and has written widely on social insurance issues, including Social Security disability insurance and health insurance reform.

John C. Rother is director of legislation and public policy at AARP. He also served for eight years as Staff Director and Chief Counsel of the Senate Special Committee on Aging.

Dallas L. Salisbury is founder and President of the Employee Benefit Research Institute. He played a major role in the implementation of the Employee Retirement Income Security Act of 1974 (ERISA) and formerly served on the NASI Board of Directors

C. Eugene Steuerle is a senior fellow at the Urban Institute. Earlier in his career he was Deputy Assistant Secretary for Tax Analysis at the U.S. Department of the Treasury. He has written widely on tax and benefit policy.

Stanford G. Ross is a partner in the law firm Arnold & Porter. In his public service, he has served in the U. S. Treasury Department, on the White House domestic policy staff, as Commissioner of Social Security and as Chairman of the Social Security Advisory Board.

In their conversation with Ball and Hess, panel members discussed how contemporary challenges in building consensus for, and then actually implementing, broad policy changes in the 1990s and beyond could be very different from how they were in the 1960s. Nonetheless, they found much of value in the discussion of factors underlying the successful implementation of Medicare. According to Ball and Hess, those included: (a) An experienced nationwide organization with field offices throughout the country; (b) skilled central planners; (3) delegation of authority directly from the President to the Secretary of Health, Education and Welfare to SSA, combined with a high level of cooperation across government agencies; (4) an extraordinary degree of consultation with private stakeholders before fleshing out policy details; and finally (5) a strong sense of mission among participants that they were accomplishing something truly important for the American people.

Virginia P. Reno
Director of Research

Part I

# Dialogue on Implementing Medicare

January 31, 1992

Robert M. Ball
*Commissioner of Social Security*, 1962-1973
Arthur E. Hess
*Director, Bureau of Health Insurance*, 1965-1967

## Other Participants*

Daniel P. Bourque, Voluntary Hospitals of America

Robert B. Friedland, Project HOPE (Rapporteur)

William D. Fullerton, Health Policy Consultant

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Stanford G. Ross, Law Firm of Arnold & Porter

Dallas L. Salisbury, Employee Benefit Research Institute

C. Eugene Steuerle, The Urban Institute

Bruce C. Vladeck, United Hospital Fund

* Affiliations as of January 31, 1992.

Mr. Vladeck: (Following preliminary remarks)

The main course for today's agenda is a very, very special opportunity and, I think, a very special treat: Bob Ball and Art Hess to tell us what really happened in late 1964-65 into 1966 with the implementation of the Medicare program.

Since the thrust of this health care study group is to look at potential implementation issues in any kind of health care reform that might emerge over the next several years, I don't think there is a better place to start than with people who actually have done it. We are just really very fortunate that they are with us and that they are going to tell us the story.

It seems to me that it would be idiotic to get into these implementation issues and not draw, as fully as we can, from experience and knowledge and expertise of Bob and Art, as well as other folks, including Bill Fullerton.

I am hopeful that today's session, while getting us going, will not be the end of the extent to which we draw on their experience and experiences to inform the work of the study group as we go forward trying to grapple with some of these implementation issues.

Mr. Ball: What Art and I plan to do is make a joint presentation, rather than dividing the subject up; I will start and Art will just join in when he has relevant comments to make, except for when we get to the question of the process that we used to form policy. I have asked him to take the lead on that, since Art, really more than I, was dealing with a whole series of outside groups that we put together to help us develop policy.

The first thing I want to say is this: I am not sure how relevant some of this Medicare implementation is going to be to the new program that is ultimately going to pass. You want to keep in mind that, from the very beginning, Medicare has been a totally federal program, using, for certain purposes, other institutions. But in terms of the responsibility for setting it up — policy, program, and for defending it and taking responsibility — it was all federal.

State involvement was under contract with us. Intermediaries contracted with us. Nobody followed their own policy independently, though sometimes we had a little trouble getting them to follow the policy that they were supposed to follow. That is a little different issue. So, there is that to keep in mind as we go through this.

Also, the program was designed to assure payment for a defined range of services to a segment of the population for care as it was conventionally available in the existing medical care environment. There was overwhelming political agreement that Medicare did not have a mission to reform delivery of, or payment for, medical care.

Another background point, which is familiar to many of you — Bill Fullerton, of course, knows all this background backward and forward, if he hasn't tried to forget it — but for the rest of you, just a quick reminder. The provisions of the hospital insurance part — Part A — were really honed over several years during the early 1960's. Introduced by various House and Senate sponsors and subject to extensive hearings, the basic framework of part A began to reflect accommodations between the sponsors, the Administration and the American Hospital Association (AHA). Unlike the American

Medical Association (AMA), the AHA saw the handwriting on the wall and began to cooperate in drafting a bill. We kept working on the provisions and negotiating new points and modifying them for political reasons and for administrative reasons. We kept doing better, mostly.

That was one thing: to implement something that had been really worked hard on.

Part B, on the other hand, came out of an unexpected Ways and Means [Committee] compromise, and the legislation was written literally almost overnight. [Committee Chairman Wilbur] Mills took the physician part of John Byrne's (ranking Republican on the Committee) voluntary plan based on an Aetna health insurance policy and made it a voluntary part of the new federal program. I never thought it would last 25 years — pretty much without change. I mean, it is a strange concept. We started with 50 percent general revenue. This subsidy was necessary because charging full premiums related to cost, it would have been way too much for the age group, say, 75 or 80 and above. And if you charged an average rate for all ages only the very old would have signed up. So, you had to have a big general revenue subsidy, which has now grown to 75 percent.

But, it was a voluntary program based on a private insurance model. Wilbur Mills said: "Let's take the Administration's proposal on hospitals, Mr. Byrnes' proposal on voluntary coverage and use it for physicians, and the AMA proposal for a means-tested program, which became Medicaid, and put them all together." He hoped this combination would get general support.

The Administration and its allies bought it after a few hours of private discussion. Labor dragged it feet on the way physicians were covered — it really wasn't a good proposal — and, yet, quickly came around to saying: "Well, we hadn't planned on covering doctors' services, but we clearly have an opportunity to do this only on a voluntary basis and maybe we can improve it later." There were very few handholds for any kind of cost controls in Part B.

Mr. Hess: Mills said to Wilbur Cohen on Friday afternoon about five: "Can you draft this up by Monday morning?" Wilbur look at us and looked at the Ways and Means people and said: "Yes, we will have you a draft on Monday morning." That's the way it went.

Mr. Fullerton: My recollection is that the benefit package — just to carry this one stp further — came from the Federal Employees' Program.

Mr. Ball: Aetna's plan, right?

Mr. Fullerton: That is where it came from, and you can still find some of the same words in the statute that they had.

Mr. Ball: So, the implementation of Part B was of a program we knew nothing about in the sense of appreciating the implications of its basic assumptions or working out the bugs. People thought that since it was based on the regular practices and operations of private insurance and Blue Shield that its administrative feasibility was established, and we could rely on their know-how. But this turned out to be a mistaken premise, and a year or two later we made some unpleasant discoveries as to the lack of capacity and experience of some of our contractors. We had very different tasks and problems of policy formation with Part B than with Part A.

Those are a couple of background points to keep in mind.

The staff passed out to you — I hope you have had a chance to look at them — two pieces. One was a report I made to our own staff about three and a half months into the implementation of the program. It gives a pretty full description of what the administrative tasks were and how we went about them. It was a talk to our top regional and other field people. I hope you have or will read this because it goes into much more than we can in this discussion with you. [It is now the second section of this document.]

The other is a chart talk with various numbers attached to implementation tasks [third section]. I kept giving that talk at different places. I gave it to the Cabinet. I gave it in the East Room of the White House when we brought in the AMA and the Hospital Association and other people who were involved.

I think the main point of both of those pieces — I don't want to spend time on them unnecessarily — is to show the vastness of the work that had to be done; the enormity of the tasks and, in the talk to staff, how we went about getting the job done.

Just let me touch lightly on a couple of headings here. In hospital insurance, all the aged including everybody in Social Security and in the Railroad Retirement program were automatically eligible. But, nevertheless, we had to take 8 million applications for the hospital insurance from people over 65 who, at that time, weren't as yet Social Security or Railroad Retirement beneficiaries. Since all the elderly had to have a chance to be enrolled for the voluntary plan, we had to get a clear yes or a no, supposedly with some understanding, out of each person over 65. We had nine months to do that. There was a March 31st deadline with coverage going to go into effect on July 1st, 1966.

I didn't think we could even reach 95 percent of the people, but we actually signed up 95 percent.

A lot of it was done by a punch card application that went out to all beneficiaries and other lists we had. We followed up at least three times. Of course, there was tremendous enthusiasm among the elderly about the program. We were able to reach a great proportion by mail, and then we had contracts with aging groups to go knock on doors in places the mailing lists didn't cover.

People were very enthusiastic about it. I remember one guy. We had a yes-no place to check on a punch card form. He actually took a pair of scissors and cut the "no" out of the punch card in case we might get confused over his choice. Of course, that didn't work very well in the automatic machine that was dealing with the punch card.

Mr. Vladeck: Let me interrupt, Bob. I was thinking, looking at the paper, about the one thing we might have going for us now, as opposed to 1965, was some advances in the technology; certainly on the computing and list maintenance and so on and so forth.

Mr. Ball: Yes

Mr. Vladeck: Then, I realized, on the other hand, that you were able to count on the post office for much of this communication. So, I am not sure how much better situated we are now than then. Just to think back and to think of the technology you were working with, with numbers of that scale, as opposed

to what we would take for granted now, is really a leap into —

Mr. Hess: — In thinking also about the universe of people, we have got a much better handle through all of the programs we have today, including Supplemental Security Income (SSI) with its Medicaid tie-in, as to who would either be affected or need to be informed as to what was going on.

Mr. Ball: If most of you have those two things I have passed out, I don't want to go through all these numbers. A main point was this: In the amendments there wasn't only the implementation of Medicare. We had major cash benefits changes to make at the same time. We had to open a hundred district offices. We had to hire thousands of people. There were 19 million cards to be issued indicating whether people had only Part A eligibility or both A and B. As I look back on it, and read over my report to the staff, I don't know how in the hell we did it, to tell you the truth.

Mr. Ross: — Before you go on, could I ask you one question that is right at this point in your story? With the Congressional compromise on John Byrne's plan, why was Part B passed in the form of a trust fund? It didn't have any of the characteristics of any of the other trust funds or a trust fund. Why?

Mr. Ball: I don't think it ever occurred to anybody not to do it. It was dedicated money.

Mr. Fullerton: [Chairman] Mills liked trust funds because he wanted to separate it from all the other things. Remember, he actually wanted to have your payslip show which went for which. That kept everything separate; a trust fund for everything. He loved it.

Mr. Hess: Mills was very, very concerned about a commitment he had to the physicians, that they would not be in a compulsory program, and that is why it turned out to be voluntary. But, at the same time, I think, he felt the political pressures from the other side of making sure that a lot of people would feel that Medicare was pretty much of a cohesive program; that it wasn't two quite different kinds of things.

Mr. Fullerton: He went for the "three-layer cake" by adding Medicaid.

Mr. Ross: It was just to segregate monies, in other words? It was the economics, since contributions were voluntary.

Mr. Ball: Put in trust funds so that they couldn't be touched.

Mr. Ross: And, the government general revenues that were being put in for this purpose?

Mr. Ball: As soon as the government revenues went in, they became dedicated revenues and the match was needed to make the program work.

Mr. Ross: Right.

Mr. Fullerton: It was for no other purpose but that.

Mr. Ross: A public accounting device?

Mr. Lewin: Given the discipline that is implied in the trust fund, Bob, in retrospect was it a good idea?

Mr. Ball: Sure. Sure, it was a good idea. It seems to me that if — what is the alternative to making it a trust fund, to set up an account within appropriations?

Mr. Ross: Like Medicaid, there weren't any other government programs.

Mr. Fullerton: But remember the premiums are coming in there, too.

Mr. Ball: As it started, premiums were matched by general revenues. They are all dedicated to a single purpose. I don't think either the Congress or people generally would have felt secure with an appropriation each year. They were paying for something ahead and half of it depended on general revenues.

Mr. Hess: The premiums were identified with an individual. We had an enrollment process, and it was a process that if you didn't enroll originally, then after some period of time you could enroll but you had to pay more. Part B was really set up on almost an individual account basis.

Mr. Fullerton: The money came out of their monthly Social Security check. They saw the money going away. Where was it going? They wanted to see it dedicated to this purpose.

Mr. Steuerle: Was there some concern on your part about the separation of A and B and the incentives this might create down the road for separation of Part A from B altogether? In terms of not only the administration but in terms of how patients might react or where they got their services in the hospital or out of the hospital — long term financing considerations?

Mr. Ball: Well, it didn't take us very long to have concern. You know, it was put together as directed. There was no option. I mean, nobody said, "Should we have this as a combined plan or should we have it as a separate plan?"

Clearly, it had to be voluntary to pass Mills and that made it a separate thing. The whole way of financing made it separate. But it wasn't very long before many of us advocated combining the two programs on the principles of Part A, making it a compulsory, single program. I guess now it must be over 25 years that I have been saying that.

Mr. Newman: I just wanted to offer a comment from my own personal experience relative to this issue of how could they have done this incredible task of getting this thing started in the magnitude and complexity that it was. I spent a year once around that time in the Bureau of Budget, which was, in those days, the strongest, and I think, had the best people in government, generally speaking —

Mr. Hess: — It was a can-do agency.

Mr. Newman: I mention that because one of the most respected people there, whom I knew at the time, said to me that if the President of the United States were to be selected on his managerial ability, as a public administrator, he would vote for Bob Ball. I say that, partly because I am glad to have a chance to say that in public, but also because I think, when we talk about implementation — which, of course, is the subject here of this group's consideration — I don't think we should lose sight of the fact that it is people, after all, who have to do these things that we are talking about. In those days, as incredible as the task was, there were people — I would say two of whom are on my left and one of whom is across the table from us (Fullerton, Hess, and Ball) — who had a lot to do with this happening. I just thought I would say that.

Mr. Mashaw: Were implementation issues considered in the Congress in terms of plan design, or was that completely separate?

Mr. Ball: I would say that in Part A, where we had so long to see it coming, they weren't considered very seriously as separate administrative issues. But, we had no difficulty with the Congress about such things. Let me give you a couple of legislative provisions that were very helpful to us in the implementation.

Congress accepted the lead time of a year in hospitals and a year and a half for nursing homes. So, they could be on two separate tracks. They accepted the idea that we should start in July, when hospital occupancy is at its lowest.

We made the proposals, but the Congress had no objections, they were not pushing us, saying: "Do it in nine months instead of 12." We said, "Twelve is what we need." However, if we had said two years, I think we would have had trouble.

There is a real question about how much lead time, politically, you can ask for in a program that people are waiting for, once you have got it passed. All signals are go. In this program for older people, potential beneficiaries were dying at high rates.

One of the most interesting implementation issues in Medicare was never publicly discussed, and that is the application of Title VI, the Civil Rights Act nondiscrimination provisions, to the hospitals. The only legislative basis — not even legislative, but the interpretation of Congressional intent — for our applying Title VI in Medicare to the hospitals, beyond just general reasoning, was an exchange on the floor of the Senate.

Mr. Ross: — When was Title VI enacted? Was that the 1964 act?

Mr. Ball: Yes.

Mr. Ross: So, it was bang, bang and you would have been in somebody's consciousness.

Mr. Ball: So, we didn't want it brought up legislatively. It would have been a big barrier to passage in the Senate, particularly, if it had been clear that this was going to be applied. I think everybody knew it, but they didn't want to have to go on record about it. So, it was just one of these colloquies on the floor. It was, at our suggestion, [Senator] Ribicoff [R, CN] and somebody else that pinned down the fact: "Is it going to apply? Yes, sure, it is going to apply." And, that was about all that was said.

Mr. Lewin: What was the White House's role? Did the White House play an active role in insisting that Title VI required integration of the hospitals?

Mr. Ball: I don't think they needed to, but they would have.

It really came to a head toward the end of the implementation period when The New York Times was saying things like, "The Administration better make up its mind. Does it want the hospitals integrated or does it want Medicare to provide services on the effective date."

We were going full steam ahead, not simply having hospitals develop plans for integration

throughout the South and a few other places where there wasn't already integration. Of course, in the South there were big problems.

We did not accept just plans for later integration, as was done in education; we demanded actual demonstrations that they had integrated before we would certify them to receive payment. In other words, Medicare became the vehicle that forced prompt action in many places where there would otherwise have been long delays and much local contention.

Remember now, this was the older population which had been brought up in segregated areas, and we are talking about two beds in the same room. Art Hess made the point the other day, when we were talking about this: "Well, if you were sick enough, that probably did not matter, but it was the patient's family and friends who were visiting who were more difficult to reconcile to such a big change."

We had 1,000 people — 500 from Social Security and 500 from the Public Health Service — surveying these hospitals in the spring of 1966 and down to the wire in June. We were really focused on this and were keeping track of it, hospital by hospital, because either way, if you did or didn't certify them, you had a big problem. Promised benefits would not have been available.

Mr. Hess: Within the Department, an Office of Equal Health Opportunity had already been established in the Public Health Service with overall responsibility for moving the nation's medical facilities into compliance with the Civil Rights Act. It was logical for them to have the lead for this aspect of Medicare, but obviously they had not been created or geared up, nor were they and the States staffed, to take on such a monumental task in a very tight time frame. The focal point for training was in Atlanta at the Center for Disease Control headquarters where personnel on detail from SSA field offices all over, but mainly from the South, received training and guidance on what to expect when they went out to do on-site inspections. We had numerous consultants from human rights organizations — especially the Urban League officials from large cities — help with this training.

Absent the Medicare imperative, it could have taken many years instead of a few months to get reasonable compliance from most of the segregated hospitals. I say "most" because I don't want to leave the impression that all who gave assurances or demonstrations of compliance did so in full good faith. There are anecdotes of some local hospitals that put on a good show for the inspectors and then went back to business as usual after the visitors left. But our field inspectors could often sense those situations and go back later for unannounced visits. And, of course, we could rely on our managers who knew a great deal about most of the communities in their service areas to tip off the inspectors when they got complaints or sensed the probability of noncompliance. And we often had local press interest too. Moreover, I think the word got around from one hospital to another pretty quickly that on this issue there was no room for bargaining.

Mr. Hess: But there was a lot of concern.

Mr. Ball: Yes.

Mr. Hess: President Johnson personally was concerned to the point where we had an

alternate Plan B to use Veterans Administration and army hospitals in some places.

Mr. Ball: But not because of the civil rights issue so much as what some thought would be a rush to the hospitals by elderly people with a backlog of unmet need for care.

Mr. Hess: True, but if a hospital didn't come in with a plan, it could not qualify as a provider.

Mr. Ball: Let me tell you now what I want to do next so you can see whether you want to go to that right away or whether you really would like to discuss the tasks described in the papers. What I intend to do next — when we dispose of any questions about the tasks — is to try to extract from our experience what factors helped make the implementation work. How do you explain that it really did go off very, very smoothly?

Whatever you think of Medicare, later on or now, it is true that, on July 1, 1966, it went into effect very smoothly and worked well. It started to cost a lot more money than we wanted, but in terms of the administration and the mechanics of it, it was in good shape from the very beginning.

Let me list some of the things that, in retrospect, we think made that possible:

The first thing, that has already been hinted at is that, being a nationwide program, it was absolutely necessary to its success that the work was given to an existing very experienced nationwide organization, not with Medicare, but a very experienced organization in dealing with the public: disciplined, high morale, and eager to do this job.

There just isn't any truth to the idea — as all of you who are administrators know — that people shy away from hard work. On the contrary, they are stimulated by a big challenge, and I think morale was never better at Social Security while working overtime at these almost impossible tasks. Now you can't have such a situation go on too long, but for a while it is a big lift to an organization.

We are talking about hundreds and hundreds of district offices and large installation of employees at various points. There was a very high morale. The people were very well trained, in general, and very disciplined and very responsive to leadership.

Whether there is something comparable in the Federal Government today, I am not absolutely sure.

Mr. Bourque: Bob, that was absolutely true with the advent of the Prospective Payment System [in 1983], too; which was, probably, the next big change that commanded the agency's attention. Even though there were, probably, many who didn't believe in what they had to do, the morale was high and people really pitched in.

I wonder if the recent experience with Resource Based Relative Value Scale [in 1989] — not having been there — was similar or whether that has been — I don't know what the experience has been, there. But you are absolutely right: people really just wanted to — the spotlight was on them.

Mr. Ball: It is probably not surprising that the district office people were perfectly willing to have night hours and so on in order to sign up these voluntary applicants; they went at it with great enthusiasm and great skill. But the test may be that those 500 people I

was talking about, who actually surveyed the hospitals to see that they really were assigning blacks and whites as they came in, and seeing that they were actually in the beds in two-bed rooms. Now, some of them may have jumped in the bed just before the inspector came, but that couldn't have happened very often.

The surveyors were southerners. We used our southern district office managers to do these surveys, and I am not sure they were 100 percent enthusiastic about their task. They lived in those communities. They were local people looking at local hospitals under this federal direction when civil rights was quite new on the country's agenda.

So, that was the first key. The job was handed to an experienced nationwide organization of high morale, and the workers were enthusiastic about doing it.

The other factor is really a corollary of that: There was a group of central planners and leaders who were extraordinary: Bill (Fullerton), and Art (Hess), and really dozens of others, Irv Wolkstein, and a whole lot of long-time Social Security people. They had been working on planning the hospital insurance part. Their enthusiasm and imagination and leadership qualities would be very rare in any organization. That had to be there and —

Mr. Rother: — And that group had to be attached to the existing national organization.

Mr. Ball: Yes, absolutely. I don't think you can do tasks nearly as well for some other organization, like Social Security attempts to do now for the Health Care Financing Administration (HCFA). There are certain assigned jobs that Social Security is supposed to do in the district offices in terms of giving help and information and so on; but in a pinch — and, there is always a pinch on the amount of staff you have — your own work versus the other agency's work just gets priority.

So, these people were all connected. A lot of them had come up through the other parts of the organization. It was a real career service.

Mr. Hess: The other thing is that you had to have a big pool of manpower. Social Security was not over-staffed in terms of the job that was to be done for Social Security, but there was a pool of manpower and Social Security workloads that could be compressed or rearranged. So, if you needed 500 people to do something, or if you needed to pick six key people out of a computer planning setup, you could say, "Drop everything you are doing, and come on over and join us." We had to have task forces, and it was just a "detail" process. You didn't have to go through any significant paperwork to get these people together.

Mr. Ball: I am not trying to do this list in order. I don't know which of these factors is more important that others. I think they were all essential to do it in the time required.

The third may be kind of remarkable to those of you who have worked in government. There was almost a complete delegation of authority and responsibility to the Social Security Administration from higher levels. I don't think I can exaggerate the degree of this.

I made a point of keeping Wilbur Cohen, [Undersecretary of the Department of Health, Education, and Welfare,] informed of progress but the thought from above was: "We are not going to try to, in any way, interfere with the agency's sole responsibility to put this thing into effect."

That doesn't mean that there weren't occasional sorties into the process on some very sensitive aspect. When it became a question of whether we were going to certify Johnson City Hospital in Texas, which was a little tiny hospital of six to nine beds, there was keen interest. We had a requirement that there had to be a nurse on duty, 24 hours a day, and Johnson City didn't meet the requirement.

We had to stretch slightly and say that we would count a doctor as if he had the same skills as a nurse. If the doctor were there and available at night, that would count. That concern came from a fairly high level. And, that was somewhat of an interference. But they weren't interfering with the broad implementation of the plan.

Mr. Lewin: Bob, does this reflect a change, a difference in the way government is carried out? Was the fact that we then had a single party in both houses important? I know this is a hard question for you to answer because you had a track record and you and your staff had a track record and there was a lot of confidence in the Social Security Administration. If you and Art were in charge of HCFA today, would the same kinds of things happen, or have we just gone through a sea change in the Executive Branch of government that makes something like that, really, not possible?

Mr. Ball: I think it makes it much more difficult, and there are a lot of personal relations in this. Wilbur Cohen was — I don't know what title he had, whether it was Assistant Secretary or Deputy Secretary or Under Secretary at that time —

Mr. Fullerton: — Under Secretary —

Mr. Ball: — by that time, but it didn't really matter because, when he was Under Secretary, he operated the same way as when he was Assistant Secretary. Coupled with full delegation, we always got instant access, if necessary.

The organization had implemented the disability insurance program and had extended coverage — it sounds easy to extend coverage to farmers, but that was one of the toughest things that Social Security ever undertook — and we had a reputation that went beyond what we should have had. I think we were pretty good, but people thought we were even better than we were. We worked at that and avoided any blood in the water that would stir up the sharks.

Mr. Ross: There was another thing going on. I was working in Treasury in those days. In that era this was true across the board: tax legislation or anything. There was total delegation. Part of it was that you didn't have staffs up there who were hostile and over proliferated.

I think this raises a very basic issue for this study, which is that, in the modern era when you have all these subcommittees and their staffs and all these monitors, will it ever be possible to get enough discretion into the Executive Branch to implement anything.

Mr. Ball: We had really more trouble with Congressional staff (which I will come to in a minute) than we did with the Executive Branch staff. There were real differences between the House and the Senate — not just the staffs but the principals; and, then, the staffs, of course, not only reflect differences but exaggerate the different positions. But, that was really in the Congress.

Mr. Hess: May I say this? I think you are right that there has been a sea change in many respects. I think, aside from that, the key element is that it was absolutely clear, from the White House right down through, that this was a program that everyone was committed to, and that anything we needed we went and got.

Within the department we needed a lot from the Public Health Service. We didn't go any place except just to our planning counterparts in the Public Health Service and say: "Here is your job. Here is what we want from you." Bob dealt with the Surgeon General, Bill Stewart. He was totally committed to both the new program and to civil rights. The Secretary's Office didn't have to coordinate the two agencies.

When we wanted the General Services Administration's [GSA] help to get space all across the country, we just said: "It has got to be. Here is our timetable, and there was no timetable negotiation."

Mr. Lewin: Gosh, I don't see any change.

Mr. Ball: There was absolutely complete cooperation within the government.

Mr. Vladeck: And, that came from the White House?

Mr. Ball: I don't think it was necessary.

Mr. Hess: It was just the way it was.

Mr. Ball: I don't think they issued a single order.

Mr. Hess: No.

Mr. Ball: But they would have.

Mr. Hess: It was just a question of knowing that the President had campaigned on that.

Mr. Ball: Let me enlarge on what Art said. We had been dealing with the General Services Administration on the procurement of district offices for a long time and had a hell of a lot of trouble. They were exercising their independent judgment about renting offices and selecting locations and taking weeks to move. Suddenly we had to put 600 offices — or, about that — into place. Cooperation became complete. They tried to do everything we wanted.

The Civil Service Commission had to take actions related to our hiring thousands of people. It went smoothly and quickly. It was true everywhere. The Post Office put up huge billboards on the side of all their trucks about the March 31st deadline for signing up. the Forest Service had forest rangers out in the woods looking for hermits to sign up on the voluntary plan.

Everybody was completely cooperative, and it didn't take coercion. But we had to think up what they should do. And within Social Security huge tasks fell outside the Bureau of Health Insurance: the field organization, of course, the record-keeping and computer operations and all the staff services and so on. All had to work together. No time for infighting.

Let me tell you about the General Accounting Office (GAO) for a minute. GAO is not supposed to be part of the Executive Branch, right? When we had a fuss in the implementation of the reimbursement principles with the Senate Finance Committee — this was just a month or two before we were going to start. We issued our reimbursement principles, and Bill's (Fullerton) old friend, Jay Constantine at Senate Finance, had the view that we were being too generous. He let us know, and they set up a hearing.

We had had prolonged, hard bargaining on this extremely technical subject for months and finally arrived at principles all parties thought they could live with, at least for a start. Of course, politically, everyone realized they were not carved in stone. But precisely how the principles would work out in the highly diverse hospital industry could only become clear with experience over time. For example, would non-profits and proprietaries both come out with fair results under the rules for return on investment, depreciation, special nursing needs of aged patients, etc.

Well, this was a fairly crucial time to start questioning reimbursement principles that had been negotiated in good faith with hospitals and the contracting intermediary payment organizations. So, I went around to see Elmer Staats [Comptroller General] at GAO because part of the basis for the hearing was whether we had the authority to do what we had done, whether it was actually within the law.

GAO agreed to testify, not necessarily that what we were doing was the right thing to do, but that it was clearly within our authority and that the Senate Finance Committee staff's feeling that we had exceeded our authority was wrong.

So, I don't know whether negotiating with GAO ahead of time, in the light of a hearing, is very customary; but it was very helpful at that time. And, Staats taking that position made a lot of difference to us.

Mr. Steuerle: The issue you raised, Stan (Ross), I think is even more profound than whether the committees on the Hill do things. As you know, when we tried to get this financing study out of Treasury the last time around, the problem was that no one was in charge.

Mr. Ross: Right.

Mr. Steuerle: And, this meant that there were, potentially, ten veto areas throughout the Executive Branch. Part of this is not just that the power has been diffused throughout the Executive Branch, but there is also not trust placed in any one organization or any one individual. It may be that Bob and Wilbur and these people at Social Security were also highly trusted and, therefore, there was this delegation, in some sense — if you will, an hierarchial sense — even by their peers to let them decide. Without that, it may make it very difficult — even the Executive Branch — to put forward something that works.

Mr. Ball: I think that is absolutely right. They did get excited at upper levels just two or three weeks, as I remember it, before the program went into effect. It was almost as though they had turned it over to us and said: "You do it. We know it will work fine. And so on." But, then about two or three weeks before it was to go into effect, there was a spate of local press stories featuring

interviews with hospital administrators about bed capacity. I don't know what got into the President, but something made him very nervous that all the elderly who had been saving up all their ills for the last 65 years would suddenly show up at the hospitals on the day Medicare was going to be implemented.

Although the numbers are such that you could have had a 20-percent increase in elderly utilization at that time, and it would have been only a five-percent increase in bed occupancy — those broad generalizations didn't do any good with him.

And, then, of course, the Secretary got excited when the President did, and we had to locate the hospitals that did have high occupancy rates and locate them by pins on a map. We had the army hospitals and the veterans hospitals alerted, and there were plans even to use helicopters to move people from one place to another. The fear was that there would be lines all around many hospitals and so forth.

But it went in very smoothly on the day of implementation. We had a big press conference in Baltimore. We started to track the situation state-by-state across the continent.

There weren't any lines anywhere. There wasn't any problem anywhere. We didn't need a single Army bed anywhere. We didn't need a single helicopter.

That was the only significant "interference" I can think of. It was perfectly understandable. We had a war room and pins on the map. But that was at the very end.

Mr. Mashaw: I take it nobody said words like "notice and comment for rulemaking" and "class action" and "Regulatory Flexibility Act" and "Paperwork Reduction Act."

Mr. Hess: Well, although there were a good many givens in the law, I think I could generalize by saying that there was a lot less indication or guidance as to how to implement policy and even operations than one might have expected.

I should say — and, this is pertinent to what we have been saying about civil rights and so on — that no hospital was required to participate. This was optional. If they didn't want to meet our requirements, of course, their patients didn't get paid for out of the programs. Very few hospitals were willing to face that possibility!

No doctor was required to participate. Part B was voluntary. Just as the elderly person's coverage was elective, so also was the physician's billing. He could choose assignment of a bill for some or all services, thereby receiving 80 percent of his reasonable charges directly from the carrier and look to the patient for only the remaining 20 percent. Or, he could charge the patient whatever fee he wished, and the patient would then have to claim reasonable reimbursement from the carrier. We, of course, tried very hard to get doctors to take assignments and tracked this closely with public informational and professional relations campaigns.

And, so, there were a lot of problems of consensus building, but the regulations took the form of a whole year of consultation with literally hundreds and hundreds of people in identified areas of concern. The potential intermediaries for Part A could by law be nominated by the hospitals. And, the AHA, of course, got 95 percent of the hospitals to nominate Blue Cross, which at that time

consisted of more than 50 separate state-based plans with great variations in capacity and management.

Selecting insurance "carriers" to administer Part B was a much different kind of a thing. There was no nomination, there. There was a selection by us with approval by the Secretary. And, there was a tremendous amount of negotiation on the operating side to see which carriers would have the capacity to gear up for the expected loads.

But, on the policy side, there were literally dozens of major policy categories that were finally boiled down and assigned to about nine major task forces. There it was necessary to explore, first of all, what the facts were and accommodate various interests in being heard and doing more consensus building, which, incidentally, we had been doing long before the passage of the law, sometimes on a sub-rosa basis. We had been consensus building with various groups which ranged all the way from the American Nurses Association, who reversed their stand and actually came out for Medicare, and the American Hospital Association which said, "Well, maybe, yes." We worked closely with hospital associations' staffs, both nationally and on the state level.

But this was not the case with the AMA, which, from their Board of Trustees' end of it — you couldn't even talk to them. But we talked down in the bowels of that organization to staff. And we talked to state medical societies, some of whose officers were more inclined to face the inevitable.

To get to your point, Jerry, though we were under the Administrative Procedure Act, there was not as tight a structure as we have today for notice of proposed rulemaking and comment. But, we had to, ultimately, publish the equivalent of regulations, so we could operate before final formal rule making.

We had also a statutory requirement that there was to be a Health Insurance Benefits Advisory Council with a very high level representation of about 16 people reflecting different points of view, and widely varying fields of relevant expertise.

They were not nominated by associations or organizations. They were selected by the Secretary, and their function was to pass on and recommend to the Commissioner the conditions that were worked out for all aspects of policy.

However, before anything even went to the Health Insurance Benefits Advisory Council (HIBAC), we had had about six to nine months or more of several hundred meetings, with groups as small as six and as large as 40 or 50, around areas that permitted individuals to indicate concern and interest. Most organizations self-nominated who should be in these work groups. It was holding informal hearings, but consensus buildings hearings — and sometimes our limited staff did not even chair the meetings. We always staffed the meetings and often had consultants participate. We had Red Somers or someone else, take an area, and we would set it up, and notes would be taken, and positions would be heard. And, over a two or three week period, we had back and forth, and tried to come up with proposed solutions in each area. Often we would have to reopen what we thought was settled as new complications from other subject areas began to create cross-cutting problems.

Nothing was presented to HIBAC before it had had a pretty thorough airing and a lot of staff work. But obviously, after the airing,

you didn't always get a clear consensus. In some areas you could. In others you couldn't. It ranged all the way from principles of institutional reimbursement, which has been pretty thoroughly already worked out in a general way for their own purposes between Blue Cross and the Hospital Association over a period of several years, to issues like reasonable fees for physician services, where there was a tremendous amount of detail that was highly controversial.

It ranged from that to standards of participation for home health agencies, for which there were no precedents. New York had done something along this line, but I think we issued the first regulations in that area.

HIBAC had not simply the justification and options that we as staff proposed after our extensive consultation. It had access to reports on the details of all our consultations. HIBAC members, individually and as a group, made tremendous contributions to policy. They were directly importuned at times by various organizations, just as we, at the commissioner's level and on the Hill and so forth, were importuned. They helped reconcile some very knotty problems.

But we didn't have time to do a formal notice of proposed rulemaking and issue final regulations. We were concerned that any regulation, if it was issued, would have to be changed pretty soon.

We tried to avoid a situation where, because of the voluntary aspect of a lot of this, you would appear to be dictating inflexible conditions that people couldn't possibly accept. So we held out hope for mutually acceptable future changes as experience might prove them necessary.

Mel Blumenthal, our General Counsel for Old-Age, Survivors and Disability Insurance (OASDI), came up with a wonderful idea. We would call these rules "conditions of participation." If you wanted to meet the conditions of participation, fine; and if you didn't, you could stay out, or you could take your chances and try to argue some more. So, we actually started operation with no regulations, as such on the standards that had to be met by participating organizations. The conditions of participation were put in The Federal Register. But sometimes it was a while before we caught up with final rulemaking.

This brings me back to the broader question that Jerry asked. We are talking about implementation in this day and age. In Medicare we never had a class action suit in the first or second year. Ten years earlier, in the disability program, when we put that into effect, I didn't know what a class action suit was. We never had one.

There were no strong advocacy groups following our every move during early disability days, and there was little litigation, except on the basis of individual claims, that went past the appeals process. By the time Medicare was implemented, major interest groups were involved — the AFL-CIO and senior citizen organizations for example — but they worked with us for change rather than filing suits. More recently, when implementing SSI, we were tied up almost from day one with class action suits.

Mr. Ball: The advocacy groups in Medicare were on our side. Mostly they were the aging groups. And we had contracts with them to help us.

Mr. Lewin: I am just wondering about this. Obviously, part of the reason that this succeeded was that, despite the opposition of the AMA board, the physicians and hospitals and nursing homes of the nation, obviously, were willing to come forward and participate in this program.

Mr. Hess: Well, it was 30 or 40 percent of hospital business and 10 percent plus of physician business.

Mr. Lewin: I understand that, but they were still willing to participate with a minimum of hassle and litigation.

Now, the hospitals and physicians and nursing homes of the nation have had nearly 30 years experience of doing business with the Federal Government, and I am wondering whether or not it is prudent to assume that the same level of participation voluntarily with the —

Mr. Hess: — That is why I made the point. I agree with you: there has been a sea change — in the climate of litigation, in the experience and knowledgeability of the providers, in the growth of strong advocacy groups on behalf of providers, beneficiaries and the public, and all kinds of other things that would make it —

Mr. Fullerton: — Let me add one thing to that, Art, if I could. We didn't have very many health policy analysts in the country. We had about half a dozen. We did it all.

Mr. Lewin: That is Bruce's (Vladeck) thesis, that health policy analysis is a major obstacle to change.

Mr. Steuerle: Isn't putting more money in a strong incentive for people to want to jump into it?

Mr. Lewin: You obviously anticipated. You didn't know that you were going to get cooperation.

If we were going into a major program in 1995 that required a change in the way hospitals and physicians were to be reimbursed or any changes of that nature, is there anything that we should be thinking about that, based on your experience, ought to be built into the system that is not obvious?

Mr. Ball: I think Art made it sound just a little too easy, as far as the physicians were concerned. The hospitals were prepared to cooperate by the time the law passed. Organized medicine fought it right up to the last moment. I think this is, perhaps, in part a tribute to the American character, but it really happened, that once Medicare became law, the people we selected to help implement the program and give advice tried very hard to help. Of course, they wanted to be part of it partly because they wanted to get the best deal they could, but it went beyond that.

People who would not have been in the same room with each other a month before were on these task forces that Art was talking about. We would have representatives of group practice pre-payment plans, of labor, of the American Medical Association, all working together.

I really think they went beyond self interest and were trying to make the law of the land work. It is true that this came about in part because of tremendous outreach on our part, as Art indicated. I think that is a lesson. It

may be much harder to do next time, but we didn't do anything without consultation all over the place. We didn't have to take all the advice we got, and we had enough balancing people who were giving different advice. We didn't even have to take HIBAC's advice. We usually did. The law said they had to be consulted and had to comment on regulations but not that we had to take it.

HIBAC was an extraordinary group of people, and that is another lesson. I think you would want something like that.

Kermit Gordon, who was head of Brookings at that time, chaired the group, and Nathan Stark was Acting Chair when Kermit couldn't be there. We selected people from the hospitals and from labor and from physician groups who were good and respected. Everybody really worked well together.

It helped a little to be snowed in for three days at a motel. The bar was open fairly early in the process.

Mr. Fullerton: I gave them all a ride home.

Mr. Ball: Those people got to trust each other. And, I would say throughout the country there was great trust in the Social Security organization. They thought that maybe we were going to do something they didn't like, on occasion, but they thought we wouldn't do it without understanding their position and their problems. We wore ourselves out in consultation.

I think I am right, Art, that the House of Delegates of the American Medical Association actually ended up in an unprecedented action — they passed a resolution of appreciation of Art Hess's role in implementing the program.

Mr. Hess: Some commentators later, in effect, took that sort of thing as an indication that we had rolled over and played dead in relationship to the forces that were out to get everything they could. I don't think so. I think probably the process of public administration is that, at the very beginning of a program like this, you have to make a judgment of what you want to get criticized for later. It is going to be for something. There is no way you can put in something like this into effect without it being possible to criticize it.

And, I think that what you do is settle the things that you need to make it work, and then you continue to tighten and you continue to use whatever handholds you have to increase the administrative tightness of the thing. We thought that the most important aspect was to be able to deliver services at the time that people were first eligible, and we pushed as hard as we could to get what we needed like hospital integration and still come out with that.

A good example of this was the dilemma in certifying hospitals for participation. Though we took an uncompromising stand on civil rights, there were some other areas involving community standards of medical practice where we could make progress only incrementally and through compromise. Example: participation conditions included a broad range of institutional requirements (for hospitals and some health agencies, and later for skilled nursing facilities) that were fairly stringent and reflected the strong convictions of U.S. Public Health staff as well as HIBAC. They really brought a national perspective to bear on what medical care standards ought to be. However, SSA contracted with State health departments for their inspectors, who also enforced State licensing requirements, to make the Medicare inspections for us and

advise on whether these greatly varying institutions all over the country individually qualified for participation in the new program. When the States started to inspect just months before "M Day", to their dismay and our surprise, we found that a literal application of the standards was going to disqualify quite a large number of small-town and rural institutions, as well as some big-city public hospitals that provided care mainly to the poor. Remember, many had even been built earlier to Federal standards with Federal money under the Hill-Burton Act! Could the Feds now say they could not qualify?

Nationally about two out of every seven hospitals applying had one or more deficiencies that PHS considered serious but that the State health inspectors were willing to excuse, at least temporarily. Often these were in extremely sensitive political areas and where people had no ready access to any other facility. We simply had to find ways to qualify most, if not all, without fundamentally watering down the standards for the long run. So, we administratively created categories of "substantial compliance" and "emergency access" hospitals subject, however, to an agreement to move toward correction of the deficiencies and to frequent periodic inspections to see if progress was being made. Some of the compliance called for required us to recognize very real and serious local obstacles to early attainment, such as large capital expenditures, and we concluded the law did not intend for us to hold Medicare beneficiaries hostage. We got criticism, but as Bob indicated, you had to keep an eye on the big picture.

On March 25, in Baltimore the first five hospitals were signed up — all from the State of Washington. By midnight June 30, over 6200 had Medicare and civil rights clearance. A monumental task, but in the overall picture just one more troublesome detail.

Mr. Bourque: It seems to me that, from what you are saying, the broad organizational relationships are awfully important, here. It seems to me a lot has changed since those days in terms of HCFA now being together and being a part of the department. There is the physical aspect. I know that even implementing something much less monumental — PPS — the fact that most of the work was happening in Baltimore was a big advantage, as opposed to it happening — to keep the political people away from the process.

Mr. Ball: Right. I think that is part of the delegation.

Mr. Bourque: Now, you have HCFA so politicized with an administrator and another layer of appointees, who are each carrying their own bucket of water in terms of what they might want to get done. The fact that the people who knew how to deal with it were out in Baltimore really helped because — you are right — the Congress now has staff that wants to monkey, and the Office of Management and Budget [OMB] wants to monkey, and everything.

Mr. Ross: There is a broad point here because even in those days the Internal Revenue Service (IRS) cooperated with taxpayers on regulations and cases. In other words, something broader is going on. It is true that SSA was a premier organization and much trusted, compared to today, but also all government agencies were far more trusted. IRS, for example, got enormous delegations to settle cases and things.

One thing which has really happened, which I think is an issue for this group to really focus on, is whether, in all these days of cross checks and mistrust within the Executive Branch and between the Hill and so on, if you just take one little corner, like the recent physician payment regulations, and you look at the amount of consultation back and forth and then, finally, Stark, the proposer, is going to legislate to stop it but which he couldn't get any support for, I assume.

I really think you have to take seriously whether any broad-based implementation of anything is possible in this day and age, without allowing for an enormous amount of friction and sand in the gears.

Mr. Hess: I don't want to prolong this, but I must make this point. You need lead time. You need to expect a lot more sand in the gears. You need to get a lot more building of consensus with groups that you know are ultimately going to be involved.

The other thing is that you need to anticipate things so you don't get surprised. Bob [Ball] mentioned the Friday night decision on Part B that we have lived with ever since. Well, ten years earlier we had a similar situation in disability insurance, where a last-minute compromise on the basic legislation was made. States were made the agents for determination of disability (on a program in which they have no fiscal participation) on the theory that they were in the rehabilitation business and they had experience, and were already dealing with doctors, and the doctors would have less concern about dealing with a state agency than with Social Security. And it turned out they were totally inexperienced with the concepts and functions the law required.

Well, regarding the state mechanism, there was no precedent for it. It was something that you could hardly make work. Yet, we had to find a way to make it work. And we did. And we haven't gotten rid of it in 40 years! There was something to be said for it politically. You could reach for all kinds of rationalizations. But the main one was that this was the expedient that got the law enacted.

No matter how hard you plan and no matter how far out you reach for consensus, you also have to have somebody covering the contingencies. What are the unexpected things that are likely to happen in the last minute, and will they permit a successful start in the given lead time?

Mr. Ball: If we are shifting a little bit, not just from a listing of what we think made that work, but to a question suggested by Stan [Ross], "Can you do it now?", I think there is actually a supportive atmosphere created by something very big. It is probably harder to implement a relatively small program without objection. If everybody understands that this is an emergency and that if you are going to make it work, you have got to take extraordinary measures.

Some of the nitpicking and some of the looking over shoulders and some of the clearances and so on go by the board if — for instance, if you had — not that I expect it to happen that way — actually a one-payor national health insurance system. It would be such a huge change that I think the atmosphere within the government, at least, would be more conducive to some of the things we did than just a relatively small change here or there.

And, also, there is the advantage that any expansion of Medicare, for example, insofar as you use a Medicare expansion, you already have it going. That is much easier than setting up the whole thing from the very beginning.

But, at the same time, there is now an accumulation of bad feeling between the regulated and the regulators in the Federal Government so that I have come to the view that you may want to set up a device, like a quasi-governmental organization rather than adding it to the present structure. Providers and others have had too much trouble with those people on relatively small things.

Mr. Salisbury: In view of your earlier comments, doesn't that create a huge difficulty of not having any kind of a pool or structure already existing? I mean, you are truly starting from level zero.

Mr. Ball: Unless they are asked to administer, say, an extension of an existing program or existing employer-based plans — "Play or Pay" doesn't seem to me to have quite the same problem of starting from scratch or an extension of Medicare starting from scratch; even though you create this new entity.

To some extent it is a public relations thing, but, nevertheless, I think it is real that the non-governmental groups feel they have got more of a chance to influence things if they have board members who are chosen from them and that some negotiation can take part within the structure.

I am not completely convinced of this. Maybe HCFA should do it. But I am convinced, as I guess all of you are who have dealt with providers, that they are pretty mad. They really don't like HCFA very much. They have lost the consulting aspect. We didn't consult just at the beginning. We consulted on regulatory changes, later. Art and I wouldn't have dreamed of making major regulatory changes that took people by surprise. We didn't always accept their ideas, but before formal issuance and then comment, a lot of talk and a lot of consultation took place. But new directions at HCFA might work.

Mr. Lewin: Bob, would it help to restore something like HIBAC? I always felt that when HIBAC was killed, it was a very chilling signal. I guess it was the Nixon Administration that killed it, but did they really understand just how important — I know why they killed it. It was that they didn't want to get some of the advice they were getting. But I don't think anyone really understood how chilling that message was, given the history of HIBAC.

Mr. Ball: At the same time, Larry, the program had moved into a period when it wasn't nearly as important. It was in the implementation period when Kermit Gordon and, later, Charlie Schultze chaired, when it was very necessary to the government. Later on what it was doing was much less significant.

Mr. Lewin: That is when all the cost-containment stuff started to come along. It was just that one very brief period in the early 1970s where it didn't seem to be so important.

Mr. Ball: Anyway, I agree with your basic idea. I don't think you would want to set up major changes without that kind of a non-government entity. Art or I — usually both — attended every single meeting of HIBAC.

We were very active in the discussions, but the group itself was all non-government.

Mr. Ross: But even on that relatively narrow point, Jerry Mashaw's point should not be lost sight of. As you have just gone through with the [1991] Social Security Advisory Council and as Gwen King mentioned last night, there are so damn many rules about how you can hold a meeting of an advisory group or this or that, that those people would not be able to assemble in a room, like in the so-called good old days, and really consult.

You have the Administrative Procedure Act and conflict of interest rules and so many things going on that it is almost — Gwen sort of hinted at it last night on her SSI outreach, and you have just lived through it with the advisory council.

Mr. Ball: I think you would have to change some of those things to make it work. Just suspend them. Wipe them out for the larger purpose of implementing a big new program. The administrative aspects of supply for Desert Storm might be a good model.

Mr. Fullerton: See if my memory is right. One of the first things HIBAC did was to decide whether they were going to do this in public or private. They didn't have to worry about somebody else's rules. They decided to meet in private. So, though they were supposed to be representing their group, they wanted to be able to say how it really was and not worry about it getting back to the constituency they were supposed to represent. My reaction at that time was this: "These guys know exactly what they are doing." That is one of the reasons that it worked.

Mr. Ball: I agree with that. We have gone too far with all the sunshine business.

Mr. Fullerton: Absolutely.

Mr. Ball: In the Congress, too. It just forces people to do it in the halls. You are not going to get either Congressmen or advisors to say the same things in front of newspapers. They can frequently work things out, if you give them a little running room. That is very undemocratic but, nevertheless, it is true. You have to bring the agreement back in the end, and then it is subject to discussion. And, nobody wants to be on the side of saying, "Let's do things in the closet." But it really works better on some sensitive issues if you do that.

I am just going to make one other point. Then, if you have questions and comments beyond what we have already said, that's fine.

We were willing to take some chances. That may be clear already. A lot of work was done before we had authorization. The law was not yet passed. A lot of work was done to get a running start on the things we knew we had to do. We were spending money — lots of money — preparing stuff that would have been wasted if the law hadn't been signed. We had 100 million leaflets out in the first few months. We didn't write them all after the law passed. We had all kinds of process-and-design things, which, it seemed to us, was our responsibility, if we were going to do it. But, I guess a strict interpretation of appropriation language would have said, "What are you doing with Old-Age, Survivors, and Disability Insurance program money, doing this pre-enactment planning for Medicare?"

We could have gotten called on it. So? I would have chosen to be criticized for that

rather than have messed up the implementation.

Mr. Ross: — The problem in today's administrative environment, where there is an Inspector General in that department, is such that not only can't you do that, but if you do do that, it isn't just your job that is on the line or your neck; but it is the Secretary and *The New York Times* and *The Washington Post*. You jeopardize the whole effort because they will jump the gun on you with one whistle blower.

Mr. Hess: I have a comment on that. I don't know whether it is practical or not, but I was going to say that one of the things that we had experienced in almost all of our major areas of program extension in Social Security — starting with a big extension to the self-employed and the farmers and disability insurance and Medicare and SSI — is that there is always a bothersome hiatus. The legislative authorization for a program and the later appropriations and budgeting process are out of sync. There is a hiatus in there, even though you may be able to tap contingency funds or a deficiency apportionment, but it's never enough. OMB tends to want to wait for firm staffing plans and an appropriation authorization to do some —

Mr. Fullerton: — We had to get a loan for Part B, remember.

Mr. Hess: — To do some recruitment. There ought to be an agreement within the Congress and with the Appropriations Committees, if it looks like there is a totally new program coming down the track, there ought to be some authorization for prior planning. That means you have to identify the agency that is going to be handling it. In these cases we knew it was going to be Social Security, and we weren't taking too much of a chance. If it had ended up with somebody else handling it, the lead time and staffing up might have been impossible.

Mr. Ball: — They really didn't have any choice.

Mr. Hess: There ought to be something that very quickly and, perhaps, at the moment of final passage of the law provides an emergency appropriation and makes you honest on the things that you are going to have to do.

Mr. Ball: We had very hot lawyers, too. They gave us good interpretations.

Mr. Fullerton: Just to give you one illustration of that, I remember the Ways and Means Committee deliberations in executive session, which is the way they actually constructed this bill, were not public; but they did keep a written record of all their sessions. They also keep that — you can't go up and get a copy of that now, but they have it up there.

Mr. Ball: I think it is secret for about 25 years.

Mr. Fullerton: But we had a deal. I don't know if you two (Ball and Hess) know this. We made a deal with the committee staff to give a copy of that whole thing over to our General Counsel who promised to keep it right like this (folded arms) all the time so that they could make sure that what we were doing was consistent with what the committee had said.

Mr. Ball: Yes. One thing that we haven't talked about that is tough on any administrator of any program at any time, but which was particularly difficult in this is that you

have two houses of Congress. They like to be different.

Mills thought up this Part B business, and he was very sympathetic to our problems, though he had a couple of bad ideas that he had made commitments on, like how to treat radiologists and pathologists, that we couldn't get changed. But he was amazed that we made it work — he really was — as far as Part B was concerned.

On the other hand, in the Senate it wasn't really anything that they had thought of, and they had quite different ideas than Ways and Means and were prepared to be quite critical of whatever moves we took. I would say that the staff of the two committees had different views. I think the Senate Finance Committee wanted a real role after passage and since they hadn't had too much to do in the shaping of the legislation, they could take a very aggressive stand in terms of critiquing what went on.

But you have to remember the uses of adversity. They gave us a lot of trouble, but we, in turn, used that trouble to improve the performance of the intermediaries, which is what a lot of the criticism was about.

Mr. Rother: I want to go back to the very first thing you said, Bob, in terms of an observation that what we have here is a totally federal program. Many of the health reform proposals today build in a pretty significant role for the states. I would just appreciate any comments you might have on whether that solves some of these problems or whether it just compounds. If you changed an implementation from direct federal with the federal role being more rule setting and the states actually running it, is that a solution?

Mr. Ball: I think it makes it harder. From that, don't draw the conclusion that I necessarily want it totally federal because there are all kinds of political considerations that outweigh administrative considerations. But in terms of implementing something, if you have to depend on 50 jurisdictions, as against one that tells people what to do and gets their cooperation and makes contracts with them, then it is just bound to be harder. And, the unevenness of state ability. You know, there are some states that —

Mr. Ross: — You are still seeing that with the disability program.

Mr. Ball: And, even that is really a contract arrangement.

Mr. Ross: It is relatively simple compared to what you have been describing here.

Mr. Hess: In the disability program we reimburse the states — I say "we;" I mean, Social Security — 100 percent for personnel and administration.

Mr. Ball: And, they are supposed to follow federal rules.

Mr. Hess: From the very beginning, SSA put cash on the barrel head, and yet some states would not recruit and they would still not staff up because they have the equivalent of a state OMB and of the presidential/governor concept that they want to hold down personnel growth.

Mr. Lewin: And, they don't know when the "Feds" are going to pull out.

Mr. Hess: Well, that is the other thing, but once in the picture state interests get so vested, that's less likely to happen — even though it did with SSI.

Mr. Lewin: But, Art, in 1969 you and I went to advise on the Medicaid program. I guess it was pretty close in time, but I guess I am impressed by a couple of things.

First of all, the Medicaid program turned out the way it did largely because it simply said to the states: "Just go do it, and we are not going to supervise." I think the lesson there is that, if you just simply hand out money and if the Federal Government is little more than a income-transfer agent, then we shouldn't be surprised.

And, of course, in those days the states had very, very little experience or role at all with the health care system. That has changed a little bit — in some states a lot — and I agree with you that it is a lot harder to do with the states. But I think we have to be a little careful in drawing too many direct lessons from the Medicaid experience because that was really a very weak federal presence —

Mr. Ball: — And a very tiny staff.

Mr. Lewin: Yes.

Mr. Steuerle: I have a similar question about what you didn't do and the extent to which administrative considerations affected it, and that was the alternative proposal at the time to try to — in today's language — provide voucher credits to allow people to buy private insurance. Was that rejected largely on administrative considerations or was it more political?

Mr. Hess: That was not part of —

Mr. Steuerle: — The Republicans weren't very powerful, but I thought that was one of the alternatives that they kept throwing out.

Mr. Fullerton: According to the bill that John Byrnes had, it wasn't anything like that. All the Republicans fell behind him. He was a very strong character. The Republicans would find out what John Byrnes would say on issues. Really, what happened, as Bob (Ball) said, Mills picked up Part B because of that. He was a little worried about people expecting to get physician services, and here was a way to do three or four things at once. He was a legislative genius, again.

Mr. Ball: But it was a voluntary plan of specified benefits; not a voucher to go out and get what you wanted with the money.

Mr. Steuerle: There are all sorts of ranges. You can have vouchers where the benefits are really specified.

Mr. Fullerton: I made a presentation to the Ways and Means Committee about five years ago or so, and when I told them about all these things that happened — they didn't know how all this got started that we have just heard — and when I described the Johnny Byrnes Republican proposal, there wasn't a Republican in that room who would have supported it, if they had been a Republican at that time. It was just too damn liberal. Nobody thought about giving these people — 20 million old people — vouchers. I wonder what they would do with them.

Mr. Ball: What people forget is that then you say people "over 65", their average age is 72 or 73, and there are a lot that are pretty damn old and find things like selecting among benefit packages pretty hard to handle.

Wilbur Cohen and I had one of our biggest arguments — and we didn't have many — over the idea of asking people to select bene-

fit packages. I was concerned to the extent that I finally took it to the President.

We were trying to convince about five or six Republican Senators to go along because the vote was very close in the Senate. Javitts was leading that group, and he was trying to think of something that would put a Republic stamp on the plan. Voluntarism was the thing that struck him, so Wilbur [Cohen] came up with the idea of offering old people different packages of benefits, like three or four packages of benefits that they could chose among. That was the voluntary part.

Wilbur said, in effect, "Don't worry about it; we will get rid of it in the legislative process before it passes." I had been around long enough to know that sometimes you get rid of a bad idea [and sometimes you don't]. I couldn't conceive of trying to administer a program where you had to sign up what then was about 18 million older people, giving them each a choice among these benefit packages and then, in addition, answering their letters when it became clear they had chosen the wrong package and wanted to go back and choose the other. They would be writing to the President and the Congress and so on.

So, I asked to see the President to get rid of this voluntary thing. It was probably a dumb thing to do because, when I came into the Oval Office, Ted Sorensen and Wilbur [Cohen] were already there. They had already been talking to the President. At one point I said, "you know, Mr. President, there would be chaos." When he made his decision, in favor of Wilbur's position, he leaned over and patted my knee, and, said, "Bob, let's have a little chaos."[1] So, that was the decision on that. Of course, we did get rid of it before passage.

But, I can't really see that population trying to buy their own protection with vouchers in a way that they, or somebody else, would be satisfied. On that kind of thing, I am pretty paternalistic.

Mr. Vladeck: We have seen the experience when they bought their own kind of supplemental protection.

Mr. Hess: You asked about state agencies, John. The experience with private-sector intermediaries and carriers was also very interesting on the question of using other agencies. It was assumed that they knew how to process claims; they knew how to recognize valid utilization and invalid utilization. It was assumed that they knew how to create physician profiles and do all the other things.

We found after the program got going that even the best of the insurance companies and Blue Cross and Blue Shield plans didn't know beans about processing claims the way this program required them to be processed. We had to put resident SSA personnel into some of them to find out what was going on and get them to work up to our standards of performance.

Now, they have learned a hell of a lot in the meantime, and so have we; and they may be on the leading edge of some of these things at this point, but you have got to face up to the question that, if the program is going to substantially use, in whole or in part, states or private insurance intermediaries and carriers, then it is going to be one that you won't have adequate control over — not only cost

[1] Mr. Ball's quote of President Kennedy's reaction to his plea for a mandatory benefit was inadvertently ommitted from the first edition of this report.

control, but also standards of public service. In other words, there is a price you pay when you have to deal with sole-source contracts and other agencies. Maybe, today, we are far enough along to get true, competitive alternative options.

I was surprised that we didn't have more flack on the Part B carriers that we chose. They weren't all interested in competing. This time, anybody who is in the health care or health insurance business is going to be interested in having a piece of the action.

Mr. Lewin: Art, on that score, presumably you had some conversations with Kaiser at the time.

Mr. Hess: Yes.

Mr. Lewin: What role did Kaiser choose to play or not play in the original Medicare program?

Mr. Ball: In setting it up or afterwards?

Mr. Lewin: Participation.

Mr. Hess: Well, we had a serious problem that had hardly been anticipated in the legislation. We had to make special arrangements for Group Practice Pre-payment Plans [like Kaiser]. After all, the whole Part B concept and the specific provisions of law were built around paying fee-for-service practices for defined, limited benefits.

Mr. Fullerton: As I recall it, the G.P.P. Plans wanted to be able to do business as usual: "would you sort of promise us that?"

Mr. Hess: Yes, But there were lots of special arrangements needed to make crossovers between the payment mechanism that you would have on an "a la carte" fee medicine, and the equivalent premium that we would calculate for group practice benefits. Where you ran into the problem was they gave comprehensive benefits, and our program didn't and there was a hell of a lot of negotiation as to just how much of a total premium cost we would pick up and how much cost they would have to carry, because of preventive care and other non-covered services which were the essence of their plans.

Mr. Lewin: Was the fact that they did not participate on a capitation basis, their usual basis in Medicare, a result of their unwillingness or your inability to give them a capitated rate that you were comfortable with?

Mr. Fullerton: They didn't want to do it, at the beginning.

Mr. Lewin: The suspicion was that they just didn't want it.

Mr. Hess: At the beginning they didn't want to, but when we got going they did, and we found out that it was extremely technical to work out.

Mr. Fullerton: That particular group never had anything to do with Washington and never wanted to have anything to do with Washington. They only started having anything to do with Washington at all when Medicare passed. They said: "How can you treat us so we can keep on doing what we are doing, not getting messed up?" But that was different, though.

Mr. Ball: I have to say that there was a lot of discussion with the group practice prepayment people before passage, including Edgar Kaiser coming to see Wilbur and me with Lloyd Cutler, his legal advisor, but we couldn't give them the very special treatment they wanted without endangering the legislation.

Mr. Ball: I will close with what I started with, and that is to say that I am not really sure how relevant all this is to the future. I think some of it is, but I certainly wouldn't want to leave you with the impression that we necessarily think that a total federal system — because it worked in Medicare — is necessarily the right way to go. There are a lot of other considerations to be taken into account.

There is Art's illustration of the intermediaries. I would think that, had the government been given the total job, without intermediaries being in it, we would have had a hard time getting started. It helped to "spread the heat". Some of the criticisms were directed at them.

Mr. Hess: There was also the manpower problem.

Mr. Ball: They had a lot of people. They didn't know what they were doing, but they had a lot of people that we could get trained. We had to bail them out frequently. But, in retrospect, I think it helped to get off the ground better. Probably, ten years later we would have been better off if it had been our own operation, but I am not sure it would have gotten to that. It would have been harder to start without them.

So, there are all kinds of considerations. I don't want this to sound like this is a big pitch for doing the same thing as Medicare did. Nor do I want to leave the impression that all this was done without criticism. In a very few years the staff of the Senate Finance Committee wrote a report that was highly critical of many things that had been done or were being done. The Committee held hearings on this report and later Senator Long, the Chairman, and Senator Williams, the ranking Republican member, were also highly critical. They argued principally that supervision of the contractors had been insufficient and that money was being wasted.

Mr. Vladeck: Let me just say a couple of things. Unless Bob or Art has any objection — as you know, we have been recording this session — we are going to have it transcribed and we are going to make it available to the members of the panel who are here and those who weren't; and we are going to use it.

The second thing is this. As I said at the outset, we don't mean to use the arbitrary constraint of time to cut off this discussion. We are just going to suspend it for a while, I think, and pick it up again as we go along, some of it, probably, before people leave this room and some of it as the work of the study group goes forward.

Let me just — at this half-time or intermission or time out in this conversation — conclude by expressing again my enormous personal appreciation for one of the best lessons in government history and public administration I have ever had. I think I can speak for everybody around the table that it has been an extraordinary experience for us, and we are going to do it again, in one form or another, before very long.

Does anyone else have a final word? John?

Mr. Rother: I can't resist asking a final question, which is that if you were doing this today, apart from the lack of a cost containment mechanism, what is your biggest single regret or the biggest single thing you would have changed applied to today's situation, if you understand what I am after, here. Is there one thing you would have done differently on the implementation?

Mr. Ball: Implementation of the law as it was or how we would have changed the law?

Mr. Rother: Okay. Take your pick.

Mr. Ball: The implementation of the way the law was, I think we did pretty well. Nothing really leaps to mind of how I would have chosen to do that differently, even from the standpoint of more time.

Most administrators say, "Oh, if you could only give me another six months." I think that the deadline didn't do us any harm. I think the sense of urgency and excitement and so on was part of the success.

So, I don't think implementing it the way it was set up — maybe Art has some ideas of how we could have done it better and I am sure there were, if you go over it in detail, but nothing leaps to my mind.

Mr. Hess: If you define implementation broadly over the years, I think my biggest regret is the circumstance later on that caused us — the government — to pull the Social Security district offices out of the interface with the client, the patron, whatever you want to call the applicant. The intermediaries and the carriers were not in a position, and were never put in a position, where they could be on a face-to-face basis with people who had problems with Medicare and needed outreach or help. In the earlier days of implementation, Social Security did this.

So, I regret the later lack of resources by SSA to deal with continuing Medicare issues.

Mr. Ball: You see, we quickly slip into what has gone wrong since.

Mr. Hess: That is part of implementation.

Mr. Salisbury: But, Art, a piece of that, as you are saying, is that we shouldn't get carried away or allow people in this debate to get carried away thinking that low administrative cost is definitely good.

Mr. Hess: Yes. I am saying, "Don't implement it with an organization or a plan that will never have the capacity to continue human interface with the people who need it."

Mr. Ross: This is a subject for another day, too, which is that HCFA, in some ways, has a problem which is that it is an agency with no public contact. And, as a result, it doesn't have the experiences and capacities to be in a position to do the kind of things that SSA could do.

That's a subject for another day, but I don't think it should get lost.

Mr. Ball: I would even carry over what Art said to the providers. I don't see how you run any big operation without paying attention to the morale of the key people performing services. It is true in the armed forces. People in the armed forces, underneath, have got to have a high morale and a sense of mission. And, you spend a lot of time trying to provide that.

I don't think you can run a medical program and have all the doctors feel they are being treated unfairly. Somehow or other it can't be a confrontational situation all the time with doctors and hospitals. If you are going to run a medical system, those guys are the ones who are going to really perform the services; and you can't be seen as harassing them, continually.

Mr. Vladeck: This meeting is at an end. Thank you all for coming.

Part II

# Report to Social Security Administration Staff on the Implementation of the Social Security Amendments of 1965*

By

Robert M. Ball
*Commissioner*

November 15, 1965

* As delivered to the Central Office staff, Regional Assistant Commissioners, and Regional Representatives of the Social Security Administration, November 15, 1965, in Baltimore, Maryland. The Social Security Amendments of 1965 created Medicare program.

The last time we met as a group was on July 26, the day after the President had announced the reorganization of the Social Security Administration. This was just 4 days before the Social Security Amendments were signed into law on July 30.

Today I would like to tell you in very summary form what has been done since we met last about putting those amendments into effect. Because everyone has been participating in this work, all of you will know some of the things I'll be talking about and some of you will know a great many of them. But I believe it is important that we now all review together how the individual contributions which we have each been making fit into the whole. As I review the progress for you, I will also be indicating some of the tasks that are still ahead and what we will be doing about accomplishing what we yet have to do.

## SOCIAL SECURITY AMENDMENTS

As I pointed out to you the morning after the House of Representatives passed the Social Security Amendments of 1965, no other Social Security amendments have approached the scope of these amendments. The increase in Social Security payments will be about $6 billion in the first full year of operation — about a third greater than the estimated expenditure under the program as it was before passage of the amendments. We will be administering benefit payments of about $25 billion for 1967, as compared with $19 billion for 1967 under the old law.

The changes in the program will do incalculable good for older people, widows and orphans and the disabled of the country. For many older people living on the edge of poverty, the cash benefit increase will help make the difference between enough to eat and not enough. For many orphans the provision for paying benefits to age 22 can mean finishing high school, or technical school, or college — can mean for many, therefore, a different *quality* of life ahead. For many disabled the provision for paying benefits where none were available before will turn despair into hope. The program will lift from the shoulders of older people the fear that their lifetime savings will be wiped out by the heavy costs of major illness, or that they will have to turn to public welfare or to private charity or to sons and daughters for help in meeting those costs.

All this has been done in a way that strengthens Social Security as a continuing institution. This is not just a program, or collection of programs, for those who are already old or already disabled or who for some other reason currently have a special need for a benefit. Rather, the basic program and the amendments that have been made to it are designed as long-term solutions to persistent problems.

Thus the Social Security Amendments of 1965 are a victory not only for older people today but for generations yet unborn. All, for example, will contribute during their working years with the knowledge and expectation that when they reach retirement age they will have cash income and the protection of hospital insurance without further contribution in retirement. The fundamental ideas of work and contribution as the basis of benefits and the payment of benefits without regard to need are preserved and strengthened in the new program.

But no matter how good a law is, it is at first only words on paper. It takes the hard work, imagination, and devotion to duty of thousands and thousands of people like you to

bring into reality a law of the scope and complexity of this one. It is your work under the law which brings the benefits to the old people and the widows and the orphans and the disabled people of the country. And how well we do our job makes all the difference.

We have been doing a lot and we have been doing it well. The payment of retroactive checks for 21 million beneficiaries was accomplished accurately and on time, as was the conversion of the benefit rates for the continuing rolls. No other job, like this, in terms of volume, has ever been done before, anywhere. No beneficiary roll was ever this large. The job could not have been done without our having planned ahead for conversion of the benefit payment process from punchcard to electronic processing. It couldn't have been done, either, without the skillful and imaginative work of those in charge of the equipment and the planning.

This was our first big task, to figure the retroactive amounts and change the going rate for the 1 out of 10 Americans who depend upon Social Security benefits. But other parts of the job could not be held up while we performed this task. For example, the children who were preparing to go to school again in September had to file applications, and we had to develop proof of school attendance and make determinations for them. By the end of October over a quarter of a million applications for children in the 18-21 age group had been filed.

One of the most important jobs at the very beginning of the administration of the new legislation was to get the right people to come to our 618 offices around the country. And, without seeming unfriendly, we had to suggest to other people that they could be well taken care of without visiting the offices at a time when they might have overwhelmed the facilities and made it impossible for us to serve the public well. Thus our information program has throughout the period been an important part of the administration of the program.

One of our first efforts at widespread informational activity under the amendments was a story of the do's and don't's for potential beneficiaries, stressing that those who were already beneficiaries would get their increases without contacting us. It was important to get out the story of rights and responsibilities under the new amendments to all who were affected. We were ready to go with two basic leaflets — one describing the new health insurance program and one describing, briefly, all the amendments — by the time the bill was signed into law. In fact, I made the first distribution of these leaflets on the Presidential plane going to the signing ceremony in Independence, Missouri.

To date, over 25 million of these two leaflets have been distributed throughout the country. And taking into consideration all leaflets describing the various amendments, we have now put into the hands of the public over 60 million individual copies. Television and radio spots, newspaper articles, and speeches: All were in high-gear production as soon as the law was signed.

Even if there had been no new health insurance program in these amendments, the other provisions alone would have constituted great administrative challenges and would have made us stretch our reach. But it is, of course, the new health insurance program that in terms of administrative challenge dwarfs everything else. I would like, therefore, to report to you more specifically on

the various aspects of the administration of the health insurance program.

## IMPLEMENTING MEDICARE

As I hope most Americans are learning, there are, of course, two separate health insurance programs for older people in these amendments. We have certain special administrative problems in relation to the basic Hospital Insurance program. That program is automatic in its protection of most people already 65 and over in the sense that they will not have to pay specifically for the protection. Either they will receive it as a result of their having been covered by Social Security or Railroad Retirement or they will have it paid for from general revenues. Some, of course, need to file applications to establish their eligibility, whereas our own beneficiaries and Railroad Retirement beneficiaries do not need to establish eligibility for this part of the protection.

We have a different set of problems for the voluntary supplementary protection, which covers primarily physicians' fees.

I would like to organize my report to you around five major topics: (1) Getting applications from potential beneficiaries and determining their eligibility, (2) getting the providers of service and the fiscal intermediaries under the basic Hospital Insurance program ready to do their part, (3) working with the providers of other health services and the carriers under the voluntary program so that they will be ready to do their part, (4) administrative actions internal to the Federal Government, and (5) the process of policy development.

Getting people 65 or older ready to participate. First, then, the task of getting applications from those older people who need to file to establish their eligibility for Hospital Insurance and getting applications for the supplementary voluntary plan from as many as possible of the 19 million people who will be 65 or over when this program goes into effect: With very few exceptions, every person 65 or over must be informed that he is potentially covered under the voluntary plan and to know what his rights are under the basic hospital insurance plan.

We have until March 31 of next year to get this story across; the first enrollment period ends at that time. The penalties for failure to act on time in connection with the voluntary plan are quite severe. In general, unless people who are 65 before the first of the year sign up for the voluntary plan by March 31, they will have to wait 2 more years and then have to pay higher premiums when they do sign up.

We have worked out ways to reach, either by personally addressed letters or, in some few instances, through small groups, all but perhaps 600,000 or 700,000 — that is, all but about 4 percent — of the 19 million people who will be 65 or over on July 1 of next year.

This does not mean, of course, that all we reach individually will understand their rights and what is expected of them, but it does mean that we can be sure of putting the information, and in most cases actual applications, into the hands of the potential beneficiaries. We will be backing up this direct contact with a great deal of general information through press, radio, and television. Most of the direct contacts will be made in a controlled way so that we can follow up on nonresponse and supply more information.

I'm sure that most of you know that between September 1 and October 15, we mailed special punchcard application forms, together with background pamphlets, to 15 million Social Security and Railroad Retirement beneficiaries on the rolls. This group, of course, does not need to do anything about the basic Hospital Insurance protection, but they do need to file an application for the voluntary plan.

As of this morning, we have had returns from over 8 million of this group and 88 percent of them have indicated that they do want the supplementary insurance. I rather doubt whether at any time in history over 7 million people in the course of about 10 weeks have ever before signed up to pay $3 a month on a continuing basis for *anything*.

Our plan is that when the returns from this first mailing decline to a relatively low rate, we will make a second mailing to those we have not heard from. Since the mailing is controlled in the magnetic tape records of the Bureau of Data Processing and Accounts, it will be possible to send a second, and later perhaps a third, mailing to those who do not respond.

The rate of return from the first mailing is still very substantial. Last week we had nearly 400,000 replies; the week before something over 500,000; the previous week 800,000; before that, a million. In any event, we plan to make the second mailing to those we haven't heard from no later than January 10.

We also plan to conduct a study on a sample basis through interviews which will give us an idea of why it is that some people have not responded and why others have indicated that they do not want the coverage. We can then determine whether we need to emphasize any special matters in our information program, and whether, perhaps, we should recontact those who have indicated that they do not want the coverage, because it may be that they misunderstand the nature of what is being offered. Of course, if they do understand and have indicated that they do not want it, that is their right and we would have no concern.

The rest of the people 65 and over, a total of nearly 4.5 million, need to file an application for both basic Hospital Insurance protection and, if they wish it, the supplementary voluntary protection. (The reason why this 4.5 million figure is as large as it is is that of the 15 million people on the Social Security and Railroad Retirement rolls to whom we mailed cards only 14.6 million will be alive on July 1, 1966). Eight hundred thousand of this group will be reached through personal interviews because they will be filing applications for cash benefits between now and the time the program goes into effect.

Another 1.1 million will be reached on an individual basis because they are welfare recipients. We have a special program, which will be operated state by state, of cooperation with the Welfare Departments. They will contact each of these 1.1 million people to explain to them what the State welfare program intends to do about the voluntary coverage — either buying in for the whole group or otherwise, usually, allowing the $3 premium payment in the assistance allowance. They will also tell the assistance recipients what they need to do to get the hospital insurance protection, to which they are entitled without any payment.

We have a joint project in process with the Civil Service Commission in which informa-

tion will be mailed to the over 300,000 civil service annuitants over the age of 65 who are not social security beneficiaries.

Beginning this coming weekend, we will make a direct mailing to about 1.2 million people over 65 for whom we have secured recent addresses from the Internal Revenue Service. (These people are in addition to the 2.2 million people in the 3 groups I just described.) The Bureau of Data Processing and Accounts has searched its magnetic tape records and found the people over 65 who have been issued account numbers but who have not filed applications for benefits. In order to get a recent address, this tape has been matched with a tape from the Internal Revenue Service listing all those who have recently filed income tax returns. This, of course, could not have been done until recently, when income tax payers were first required to get social security account numbers and when the Internal Revenue Service's data processing development had reached a point where tape matching was feasible.

The majority of the people in this group will be people who are insured under social security but who have not filed applications because they are still at work and could not get cash benefits if they did apply. We will now be telling them that they are entitled to hospital insurance whether they retire or not, and that they need to consider whether they want the supplementary medical insurance. We will also be telling them about the automatic recomputation provision in the new law and stressing that they will not lose under the cash benefits program through filing promptly. We will be mailing them not only information, but also a simple punchcard application, which will be controlled for possible follow-up. Filing this punchcard application will fix the date of eligibility for both cash and health insurance benefits, but the application will need to be perfected by district offices since this group has not yet established proof of age and the other conditions of entitlement.

In this project we are receiving the cooperation not only of the Internal Revenue Service but of the Post Office Department, which has agreed to deliver a return application which has as an address only the words "Social Security District Office" — that is, no street address or city is indicated. It was important for us to have the Post Office Department do this since the district office is the first work station that needs to take action on these applications and we have no quick way centrally to sort these 1.2 million cards down to district office location.

The various mailings that I have referred to so far account for all but a million of the people who will be age 65 when this program goes into effect. We are also working with State and local retirement systems about mailings to their beneficiaries.

We will also mail to the executives of all the homes for the aged and skilled nursing homes of the country information about the program for their residents with an indication that district office personnel would be glad to come to the home in order to take applications. We also have in mind preparing special material for physicians to have in their offices to answer inquiries from older patients, particularly those who are not covered by social security. Then we have about ready to go a joint project with the Office of Economic Opportunity in which they will hire older people to assist in arranging group meetings for hard-to-reach older people, in locating shut-ins, and so on.

In late January or early February we expect to start mailing identification cards to those people who have by that time had their eligibility for the basic hospital plan determined. These cards will be similar in purpose to Blue Cross cards and will also show whether the person is covered for the voluntary plan. Of course it is important that these people have certain other information, such as what third party they should deal with, if any, under the supplementary plan. Whether we can accomplish the whole job in one mailing or two is still a matter open for consideration.

Let me stress, however, that we have only four and a half months remaining in which to accomplish the job of getting applications for the voluntary plan. This means a tremendous load in the field. When you realize that the January-February-March quarter is the high quarter for normal claims processing every year and then when you add to the normal load the millions of claims arising from this new program, there is just no doubt that after the first of the year district offices will be harder hit, by far, than ever before in history.

Getting hospitals and other institutions ready. The second heading under which I want to report to you is the steps that need to be taken in connection with hospitals, nursing homes, and home health agencies in order to have them ready to participate in the program when it becomes effective. So far, we have mailed general information — a pamphlet and a question-and-answer booklet to the 10,000 institutions in the country that consider themselves hospitals, 15,000 nursing homes, and about 1,000 home health agencies.

Last week we mailed the same institutions another pamphlet which focuses on their right, working through their associations or through groups that they may form, to nominate fiscal intermediaries to perform major administrative functions under the program.

The actual dealing with hospitals, extended care facilities, and home health agencies under the program will probably be done most frequently by Blue Cross or commercial insurance carriers rather than directly by the Social Security Administration. The intermediary would have the primary function of paying the bills and determining costs locally. If we agree that the nominated intermediary can do the job in a way that is efficient and effective for the total program, it will take on this function. An individual hospital does not have to go along with the nomination made by its association or group, but can elect out, as it were, and select some other intermediary that has been approved or deal directly with us.

Another step will be to determine which of the nominated intermediaries can do an effective and efficient job, and then to negotiate with the intermediaries contracts covering their costs of administration and to work with them on the details of this function.

The American Hospital Association has already nominated the Blue Cross organization for its membership, although some member hospitals will undoubtedly elect out of this arrangement. We have proceeded very far in the development of working arrangements with Blue Cross, although no formal approval as a fiscal intermediary has yet been given them. In the same way we have been working with commercial carriers about their possible role.

The next step for the providers of service is for the provider to file an application request-

ing that a determination be made as to whether it is eligible to participate in the program. The law provides certain minimum standards that a hospital, for example, must meet to participate in the program. In addition, the Secretary is given the authority to establish certain additional standards in the area of health and safety. A hospital that meets accreditation standards under the voluntary accreditation procedure is automatically included if it meets one additional requirement — that of having a utilization review committee.

The task of looking at the individual institutions — nursing homes, hospitals, and home health agencies — will not be performed by the Federal Government but will be done by State agencies under contract with the Federal Government. We have written the Governors of the 55 jurisdictions asking them to designate a State agency to do this task for us. We have had designations from 52 jurisdictions at this point and have proceeded to work with them. We have already signed agreements with 12 State agencies and agreements with 30 others are very near completion. Consequently, as soon as we get out applications to the providers of service so that they can indicate their desire to have eligibility determination made, we will be ready to go in this area.

One final step will then be necessary. After there has been an eligibility determination, based, for example, upon an application by a hospital, we will write back to the institution saying that it is eligible. At that point, we will tell the hospital whether any association or group of which it is a member has designated a fiscal intermediary and whether the fiscal intermediary has been approved. And at that point we will include an agreement for the institution to sign, in which it will agree not to charge people for the same services that we are reimbursing it for and to abide by the nondiscrimination requirements of Title VI of the Civil Rights Act.

Arranging for participation of physicians. Under the third heading, also — the tasks that need to be performed in connection with getting ready to administer the voluntary supplementary plan — we are nearly ready for a new step. In this program, too, major administrative functions, notably the handling of claims and the payment of doctors' bills, will be performed by third parties, in this case called "carriers." Here we will undoubtedly have a combination of commercial insurance companies, Blue Shield organizations, and group health prepayment plans. They will be paid their administrative costs for performing defined functions for the Government. It is very necessary that we come rather quickly to conclusions as to what company or organization will operate this program in what specific geographical area. We hope this week to send to the roughly 230 organizations that have expressed an interest in working with us as carriers, and also to publish it so that it will be in the public domain, a statement of broad criteria which these third parties would have to meet to be considered for performing these functions. We hope to publish these criteria in the next few days and to invite formal proposals, by those interested, to reach us no later than the middle of December.

We also plan rather soon to send a special pamphlet to the 200,000 physicians in the country, who, of course, will be operating in connection with both the basic part of the health insurance program and the voluntary supplementary part. We want to describe for

them the program and their role in it. They will need to understand the rights of their patients, the payment process in the voluntary part of the plan, the alternatives that are available to them, their role as certifying physicians in relation to hospital and nursing home care, the function of utilization review committees, and so on. We also, as I indicated earlier, hope to elicit their help in informing their patients of their rights.

Collaborating with other government agencies. The fourth subject that I want to review briefly relates to matters that can best be grouped under administration in the Federal Government. As you know, the Social Security Act, legally and technically, assigns responsibility for the administration of Social Security to the Secretary, who then in turn delegates his authority in defined instances to subordinates. One of the first steps that was taken under this program when the bill was signed was that the Secretary delegated the primary operating and policy-making role in the administration of the new health insurance program to the Social Security Administration. Moreover, he defined a role for the Public Health Service as advisory in the area where quality of health care, professional relations, and so on are involved, and another role for the Welfare Administration where the program touches the operation of the assistance program.

As you know, the President had announced an internal reorganization of the Social Security Administration just a few days before signing of the amendments. The reorganization was for the purpose of putting the Social Security Administration in a position, organizationally, where it could take on its additional responsibilities. The implementation of that reorganization has been moving right ahead and the people are being assigned to the various positions in the reorganization. We have now completed all assignments in the field part of the organization and the Regional Representatives of the various Bureaus and the Regional Assistant Commissioners are here this week for their first combined field conference under the reorganization.

To accomplish all of the work that I have described will, of course, take more money and more staff. We expect by next July 1 to have on duty a net increase of some 8,000 employees over and beyond the 35,000 who were on duty when these amendments were signed into law. About 5,000 have already been hired and are at work. There is need, particularly in the field for recruitment to continue at a rapid pace, since the greatest workload impacts are yet ahead.

In the hiring that has been done and in the hiring that is yet to be done, very careful attention has been paid to the matter of fair employment opportunity. In the Social Security Administration we have moved beyond the mere absence of discrimination in job selection and promotion to make sure that opportunity is truly present for minority groups. What are the barriers that still prevent our having Negroes reasonably represented in office staffs in all parts of the country at all grade levels? How can we overcome these barriers? We are making substantial progress. We have greatly increased the number of offices, particularly in the South, in which we have Negro staff members. And the number, the proportion and the grades of Negro employees have continued substantially up. Of course this must be done in a way that is fair to all employees.

We have an approved supplemental budget which I believe gives us sufficient funds to do the job that we need to do. The Congress approved the entire amount of our request of $125 million over and beyond what we had in our regular budget.

We have planned the opening of some 80 additional offices around the country and additional points at which people can get service. Many are already in operation. Many offices have established evening and Saturday hours, the better to serve the public. All over the organization, of course, we are working overtime, because this is the only way that the job can get done. We just couldn't do it entirely with new people.

And speaking of physical facilities, we are going ahead with new building plans here in Baltimore. Before the new buildings are completed it will be necessary for us to move part of our operation again to downtown Baltimore. We are sorry about this and we recognize the inconvenience to employees, but there is just no help for the fact that we need to bring more than 2,000 additional employees into the work of headquarters offices.

My last point under this heading of internal administration is that our systems planning for the health insurance program has proceeded rapidly. The decision has been made that we will maintain the records under both parts of the health insurance programs centrally so that they will be available to all third parties regardless of where the person moves and so that we can rapidly give the information that is needed on such matters as prior use of services. An extensive statistical program has been developed to get the proper information to study these new programs. We are confident that we will be able to do the record keeping well and on time when the program starts. Who will do what and where, both in terms of our own role and that of the Blue Cross-Blue Shield and the private commercial companies, has been rapidly falling into place, and the design nears completion.

Policy development. The final topic that I want to comment on is the process of policy development. In the new health insurance program, there are a large number of areas, both big and small, that require interpretation and development. Many of them are sensitive areas to the doctors of the country, to the hospitals and nursing homes, and to the patients of these doctors and institutions. Many of the policy decisions that must be made will have great influence on the Blue Cross-Blue Shield plans of the country, on commercial companies, and on the way hospitals operate, and will have an influence on the organization of medical care in this country for decades to come. For these reasons, as well as for sound administration, we have been developing policy in consultation with all of the interested groups throughout the country. It is an exhausting and time-consuming process but of great importance.

This is the way we have gone about it. First of all, the important policy areas have been the subject of intensive work by Social Security staff people, helped and backed by staff of the Public Health Service and, where appropriate, the Welfare Administration. Then there have been extensive consultations with the groups with particular interests and with outside consultants, whom we have temporarily hired. The American Hospital Association and the American Medical Association have each established special committees to work directly with us on these policy matters.

Following these activities, we have convened nine working groups, representative in each case of the major professional and institutional interests. Typical groups will be composed of people suggested by the American Medical Association, the American Hospital Association, the commercial insurance companies, the Blue Cross, the Blue Shield, the Public Health Service, the Welfare Administration, and the American Nursing Home Association, and will include representatives of the nursing profession, various specialists within the health professions, and experts that we ourselves have selected.

These nine groups have developed with us refined policy positions, alternatives, and background materials in each of the most critical areas. They have worked on such matters as the conditions which hospitals will need to meet in order to participate in the program, what will be required of physicians in the way of certification, cost reimbursement, procedures for the payment of physicians, special questions connected with psychiatric services, and many, many others.

Art Hess and his staff have done an amazing job in bringing together people of diverse opinions and getting them to focus on the problem of making this program work. Their contributions have been given in a constructive and helpful spirit and the people in all organizations are cooperating. We have now throughout the country some 300 people who have participated in this policy development and who are quite well-informed on our attitudes and points of view as well as the specifics of policy.

All of this in the area of policy formation is preliminary to consideration of the policy questions by the statutory Health Insurance Benefits Advisory Council. This Council is charged with giving us advice on administration and regulations. The Council met with us for the first time on last Friday and Saturday, November 12 and 13. We had some orientation sessions and then they went right to work on some of the most important policy issues. We will meet with them again all next Sunday, November 21, and into Sunday evening. They are an outstanding group of leading experts and representatives of professional fields in the area of health care and health insurance. The Chairman is Kermit Gordon, Director of the Bureau of the Budget in the Kennedy and Johnson administrations and now Vice President of Brookings Institution, who is an outstanding economist. The Council met in a spirit of harmony and cooperation and made good progress in its first meeting, and I believe will make very substantial progress again next Sunday.

## CONCLUSION

All in all, I think we are well on our way. I think what we have done so far is good and that the organization has a right to be proud of itself. Everyone has had a role and has performed it well. We could not have done without the cooperation, and the willingness to put out with all one has, of hundreds and thousands of people throughout Social Security. It could not have been done without the spirit of let's-get-the-job-done rather than concern for who gets the credit. The fine attitude and hard work has been evident to me at all levels and in all parts of the organization. In the days ahead we will need this spirit even more than in the days that have passed. We will need the support and help of each employee, of the union, and of management. We will need imaginative thinking and individual contributions of workers at every

level and grade. For the job ahead is greater than what we have so far done. We face great difficulties, but I have a confidence in you that matches these difficulties.

Let us, as we work, remember that each is a part in the whole effort, and that the job cannot be done without the help of each, whether you are a punchcard operator in the Bureau of Data Processing and Accounts, or whether your job is in the files, whether you have the responsibility to supervise others or to perform a journeyman's job, whether you write procedure or carry it out. Each job is essential and it is essential because it is needed to serve the American people, particularly the elderly people, the widows and orphans, and the disabled of the country.

As we go about our separate tasks, remember that because of what we do — as the President said on July 30, 1965 when he signed the Social Security Amendments of 1965:

"There are men and women in pain who will find ease. There are those alone and suffering who will now hear the sound of approaching help. There are those fearing the terrible darkness of despair and poverty — despite long years of labor and expectation — who will now see the light of hope and realization."

Part III

# Implementation of Medicare
# A Chart Presentation to the Cabinet of President Lyndon B. Johnson

By

Robert M. Ball
*Commissioner of Social Security*

May 1966

# Introduction

Outside of the military, I believe that the implementation of Medicare represents the largest management effort anywhere during the last 9 months. I have grouped the tasks that needed to be performed under four headings:

## Chart 1 - Implementing Medicare

- GETTING PEOPLE 65 OR OVER READY TO PARTICIPATE IN THE PROGRAM
- GETTING HOSPITALS AND OTHER INSTITUTIONS READY
- ARRANGING FOR PARTICIPATION OF PHYSICIANS
- TOOLING UP FOR INTERNAL OPERATIONS

# Chart 2
# Getting People 65 Or Over Ready

- 8 MILLION NEW APPLICATIONS
- 17.2 MILLION (90 PERCENT) ENROLLED
- 19 MILLION HEALTH INSURANCE CARDS
- OVER 100 MILLION BOOKLETS

# Chart 2
# Getting People 65 Or Over Ready

8 Million New Applications…

- Hospital insurance under medicare is automatic for people getting social security and railroad benefits. But others had to file applications and prove their age. Our social security field organization has had to double its normal claims workload this year.

17.2 Million (90 Percent) Enrolled…

- For the voluntary medical insurance plan (mainly doctor-bill insurance) *all* the aged had to be given an opportunity to say "yes" or "no". Through mailing punchcard applications (exhibit #1 in your kit) when we had an address, general publicity and the assistance of many other government and voluntary agencies, 17.2 million (90 percent of all persons 65 and over) have signed up to pay $3 a month. I doubt if ever in history has there been such a comprehensive and successful program of communication with older people — almost every one of whom was personally reached by mail or word of mouth.

19 Million Health Insurance Cards…

- A personal health insurance card (exhibit #2) and a handbook (exhibit #3) explaining the benefits and procedures are being issued to each of the 19 million older people. Most have received the card, and the handbooks are now in the mail.

Over 100 Million Booklets…

- The social security information program has wide coverage on a sustained basis but it was greatly increased during the 9 months of the Medicare enrollment program. All the television and radio time is donated.

# Chart 3
# Getting Hospitals and Other Institutions Ready

- QUALITY STANDARDS AND REIMBURSEMENT PRINCIPLES
- ELIGIBILITY SURVEYS BY STATE AGENCIES
- CIVIL RIGHTS SURVEYS
- BLUE CROSS AND INSURANCE COMPANY PREPARATIONS
- SECURING AGREEMENTS FROM OVER 7,000 HOSPITALS

# Chart 3
# Getting Hospitals and Other Institutions Ready

Quality Standards and Reimbursement Principles…

- To establish the quality standards for participation by hospitals and other institutions, hundreds of professional persons were involved in work groups and task forces. These standards (see exhibits 4-7) as well as the principles for cost reimbursement then went to the Health Insurance Benefits Advisory Council. All major policy has been established after extensive consultation.

Eligibility Surveys by State Agencies…

- State health departments must certify whether quality standards are met by institutional providers. The States may recommend qualifying the facility temporarily, despite deficiencies, if there is a shortage of facilities in the area. All hospitals must file a utilization review plan. While accredited hospitals do not need to be surveyed, other hospitals do. This work is largely completed.

Civil Rights Surveys…

- Even though the institution meets Medicare standards, its participation is dependent on compliance with Title VI. We have met with a large number of national and State organizations, including the medical societies and hospital associations, labor organizations, senior citizen organizations, social welfare organizations, and with State and local officials to build a broad national and community support for the effort of voluntary compliance. Many hospitals have changed their practices and come into compliance. Tailor-made efforts aimed at the 300 institutions that have been definitely identified as having a compliance problem are now going on. As we complete our analysis of the surveys that have been conducted, perhaps 300 more will fall into the category requiring special action.

Blue Cross and Insurance Company Preparations…

- We have entered into agreements with the Blue Cross Association and nine other health insurers to serve as administrative agents for the hospital insurance part of the program. Blue Cross will handle about 85 percent of the hospital beds of the country.

Securing Agreements From Over 7,000 Hospitals…

- After eligibility is established an agreement is completed and a plaque delivered (exhibit #8) to tell the public of the hospital's participation. This process will be completed for most hospitals well before the end of June.

# Chart 4
# Arranging for Participation of Physicians

- INFORMATIONAL ACTIVITIES AND CONSULTATION
- BLUE SHIELD AND INSURANCE COMPANY PREPARATIONS
- POLICIES ON REIMBURSEMENT AND CERTIFICATION

# Chart 4
# Arranging for Participation of Physicians

Informational Activities and Consultation…

- A physicians' reference guide (exhibit #9) was mailed to every doctor in the country this past weekend. Starting before passage of the act there has been almost constant consultation with national and State medical leadership. We have made 2,000 group talks, mostly before local medical organizations. But about 100 have involved major appearances by headquarters personnel before medical associations at the national and State levels.

Blue Shield and Insurance Company Preparations…

- We have selected 33 Blue Shield plans, 15 commercial insurance companies and 1 independent plan to act as agents for the medical insurance part of the program. The agents have hired and trained staff and have secured space and equipment. Group practice prepayment plans such as the Kaiser Foundation, the United Mine Workers, and Group Health in Washington, D.C., will handle their own over-65 members.

Policies on Reimbursement and Certification…

- Working with the intermediaries, whose responsibility it is to determine "reasonable charges" for physicians' services, and working with organized medicine and the Health Insurance Benefits Advisory Council, we have developed standards for determining physicians' charges and for certification by physicians of need for hospitalization. Under the medical insurance program the doctor can continue to bill his patient, if he wishes, and the patient can claim reimbursement or the doctor can be paid directly. A very simple claim form (exhibit #10) — acclaimed by organized medicine — has been developed.

# Chart 5 - Tooling Up for Internal Operations

- 100 NEW OFFICES OPENED
- 9000 NEW STAFF HIRED AND TRAINED
- NEW ELECTRONIC CONTROL SYSTEM

# Chart 5 - Tooling Up for Internal Operations

100 New Offices Opened…

- The 100 new offices brings the total of social security district offices across the country to 724. Employees of these offices also service some 3500 regularly scheduled contact points such as post offices. All offices during the 9-month scheduled either evening or Saturday hours to make it more convenient for working applicants since, unlike cash social security benefits, it is not necessary to retire to get the benefits of the Medicare program.

9000 New Staff Hired and Trained…

- The electronic data processing system of the Social Security Administration now used for the maintenance of lifetime earning records and the payment of claims under the cash benefit program had to be substantially expanded so as to issue premium notices to people not under social security (exhibit #11), keep track centrally of hospital and doctor bills paid, and give notice to beneficiaries of the remaining amount of their coverage, make quick determinations of eligibility and be programmed for statistical by-products to study costs and utilization.

# Chart 6
# Effect of Medicare on Hospital Utilization

25% OF BED DAYS X MAXIMUM INCREASE FOR AGED OF 20%
= 5% MORE UTILIZATION

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# Effect of Medicare on Hospital Utilization

25% of Bed Days X Maximum Increase for Aged of 20% = 5% More Utilization

- Although there will undoubtedly be some overcrowding of hospitals because of medicare, it would be easy to exaggerate the impact of the program. The aged now use 25 percent of bed days in general hospitals and thus even an increase by the aged of as much as 20 percent in utilization — a percentage which seems high — would lead to an increase of only 5 percent in over-all utilization. After all, most of the aged did get hospitalization in one way or another when they needed it prior to Medicare; half of them had some hospital insurance before, and public assistance and charity was available to many others. Moreover, across the country hospitals are not now utilized to anything like capacity: average utilization for adult beds runs about 80 to 85 percent. And, in addition, July is a low utilization month (about 10 percent below the peak of January).

- Nevertheless, there are places in the country where hospital facilities were inadequate before Medicare and where a combination of circumstances leads to the possibility of serious pressure on existing facilities. Although very few places in July, after Medicare, will have any more of a problem than they did in January without Medicare, in July the program may get the blame.

- On the next chart I have indicated what we are doing about possible problem situations.

# Chart 7 - Action on Possible Trouble Spots

- IDENTIFICATION OF AREAS
- DEVELOPMENT THROUGH AMERICAN HOSPITAL ASSOCIATION OF SUGGESTIONS TO HOSPITAL ADMINISTRATORS
- ON THE SPOT VISITS
- TASK FORCE AND SITUATION ROOM

# Chart 7 - Action on Possible Trouble Spots

Identification of Areas…

- We have analyzed, county by county, the average utilization of hospitals during the year, the proportion of the aged in the local population and, to the extent possible, the amount of private insurance coverage which the older people had prior to Medicare (since it can be assumed that Medicare will increase utilization primarily among those who did not have previous protection) and then we checked out our results, community by community, to see if there had been recent building development and if the people on the spot had anything to add to our analysis.

- Our analysis shows that there are a little over 100 counties in the United States, containing somewhat under 4 percent of the United States population where we would estimate that utilization of the local hospitals in July is likely to be 90 percent or more. Not all of these areas will be trouble spots but we are watching them closely and taking specific action in connection with many of them. There is also crowding now in some of the best hospitals in the country even though there are empty beds in other hospitals in the same community.

Development Through AHA of Suggestions to Hospital Administrators…

- We are working with the American Hospital Association on a brochure which they would issue, giving hospital administrators in potentially crowded areas several suggestions on how to cope with the problem.

On the Spot Visits…

- As needed, our central, regional and field people will work with the local doctors, hospital administrators, and the community on the orderly scheduling of admissions for elective procedures, on emphasizing the importance of utilization review to eliminate unnecessarily long stays, on arrangements for alternative care where medically indicated such as home health care, on the possibilities of 7-day-a-week use of hospitals (little now goes on over the weekend), on arrangement for courtesy staff privileges if a doctor has difficulty getting his patient into a hospital in which he does not have regular privileges, and on expansion of capacity — for short periods of time many hospitals now expand for seasonal peaks by such devices as 3 beds in 2-bed rooms.

Task Force and Situation Room…

- We have organized a top-level task force in the Department with two Assistant Secretaries, the Surgeon General and the Commissioner of Social Security to take action in anticipation of problems under Medicare arising from the application of the Civil Rights Act to hospitals and to take action in anticipation of possible overcrowding in some areas. We have established a situation room with full-time staff to keep track of developments in these two areas.

Beginning on July 1 we shall also have a full-time group expediting solutions for individual problem cases.

# Conclusion

This is a vast undertaking and there will certainly be some rough spots in the early period of the program. We believe, however, that our work and planning is on schedule and that the program will be launched on July 1 with a minimum of disruption.

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