Slammed Shut: a Critique of Characterizations of Medicare Under Lyndon B. Johnson

President Franklin Roosevelt led an unprecedented expansion of the federal government to bolster the state of both the American economy and the most financially desperate Americans.[[1]](#footnote-2)1 Even in his numerous accomplishments establishing a welfare system, he failed to legislate healthcare provisions for vulnerable parties.[[2]](#footnote-3)2 In 1945, President Truman tried—and failed—to garner enough support for an even more comprehensive bill guaranteeing a national health insurance.[[3]](#footnote-4)3 Following a legacy of defeated proposals, President Lyndon B. Johnson and his famed legislative prowess accomplished what his predecessors could not and signed the Social Security Amendments of 1965, establishing Medicare.[[4]](#footnote-5)4

In his book *Guns or Butter: The Presidency of Lyndon Johnson*, Irving Bernstein dedicates a chapter to the success of LBJ and his advisors’ remarkable efforts in passing this revolutionary measure.[[5]](#footnote-6)5 Although such political maneuvering resulted in one of America’s most important safety nets for citizens over the age of 65, the implementation of Medicare was not as characterized by Bernstein. In his excitement retelling the process of passing the bill, Bernstein claims that because of forward-thinking in expanding the volume of healthcare workers and “…careful planning and outstanding organization, Medicare opened its doors to the public on July 1, 1966, without a hitch.”[[6]](#footnote-7)6 Moreover, the program worked to “transform the status of old people in American society from a majority who live in or near poverty… to a majority who were comfortably off and able to qualify for hospital and medical care.”[[7]](#footnote-8)7 Though Bernstein accurately describes how a large proportion of aging Americans started using Medicare to the benefit of their health and finances he fails to capture the unfair exclusion of some people and the potent opposition that remained when Medicare transformed lives and “opened its doors without a hitch.”[[8]](#footnote-9)8 There were disadvantages and obstacles for people of lower socioeconomic standing, resistance from a variety of groups, and limitations on care eligibility based on potential political affiliations that deserve further consideration.

While Medicare opened its doors to many, its large enrollment did not require that all individuals receive the same standard of care. The data tabulated from the 1968 Current Medicare Survey offer some insight into examples of such inequality. For instance, for enrollees with an income of $5,000 or lower, the calculated Medicare reimbursement per person enrolled was $78.77, whereas enrollees with a higher income of $15,000 or more were recorded to have a reimbursement per person enrolled of $160.3.[[9]](#footnote-10)9 The curious observation, though, is these two income groups received a very similar number of reimbursable services per person.[[10]](#footnote-11)10 This suggests the more financially fortunate enrollees received more expensive (and presumably higher quality) care. The data do not explain the implications of the difference in cost of care; however, Karen Davis proposes in her 1975 evaluation that more affluent patients tended to see more expensive specialists, which can account for this difference in reimbursements.[[11]](#footnote-12)11 Additionally, the difference in qualifications of physicians implies a gap in the standard of care, since patients treated by specialists are likely to receive better medical attention.

Further supporting that Medicare left poorer Americans disadvantaged, many uneducated and illiterate people who qualified for Medicare were often unable to properly fill out Social Security paperwork. In 1966, *The Charlotte Observer* reported that only “50 per cent of the Social Security recipients eligible to receive Medicare failed to signify that they wanted it,” despite that applying only required individuals to check a box.[[12]](#footnote-13)12 The article then describes how “many poor and illiterate survivors of laborers covered by social security do not apply for death benefits…” that have already been paid for through the deceased’s payroll.[[13]](#footnote-14)13 It is reasonable to postulate poor and illiterate North Carolinians and Americans faced similar problems claiming Medicare coverage as they did claiming death benefits. Although this article was published before the official implementation date of Medicare, it provides a window into structural issues that made it difficult for some individuals to enroll. Coverage is hardly useful to Americans when they do not understand how to apply for it. Bernstein fails to mention that accessibility to the “open doors” he describes seems to have been hindered by not only income but also literacy and ability to fill out Social Security Administration documentation.

While patients’ income is relevant in understanding Medicare’s shortcomings not addressed by Bernstein, the financial landscape for healthcare providers also needs consideration. The worry and anxiety over decreasing profits or delayed payments led some private healthcare providers to not enroll in the Medicare system.[[14]](#footnote-15)14 Carolina nursing homes with “adequate facilities” avoided signing up as part of the Medicare system to see if the “paperwork snarl” state hospitals had faced after the introduction of Medicare would continue.[[15]](#footnote-16)15 Paperwork functioning to deter nursing homes from Medicare enrollment implies that private nursing homes did not view Medicare payments as enough of an incentive to endure the extra labor of Social Security Administration paperwork. This is supported by the same article’s statement that “many private nursing homes [were] unhappy with the amount the government will pay for caring for Medicare patients.”[[16]](#footnote-17)16 These facilities then indicate they avoided Medicare enrollment to protect their profits. This is not to assert that the government should have paid more for services rendered, but to demonstrate that, as a result of the chosen reimbursement policies—in the opening of Medicare doors supposedly “without a hitch”[[17]](#footnote-18)17—some healthcare institutions did, quite emphatically, shut their doors to Medicare patients.

Individual doctors also had monetary concerns. In 1966, a *U.S. News & World Report* article acknowledged that there was not the massive rush of patients as expected. The article also called Medicare’s beginning a “smooth start” twice.[[18]](#footnote-19)18 It seems to provide some support for Bernstein’s assertion that planning helped mitigate disaster. However, the article also addresses concerning developments how doctors planned on billing their Medicare patients. Physicians were reported as wanting to “bill patients directly, instead of collecting fees from the Government for reimbursement.”[[19]](#footnote-20)19 Patients would not have had a chance to apply for reimbursements by the time they were required to pay. It is feasible to propose that doctors pursued this path of billing because they did not believe the payment from the government would occur fast enough. Even if this billing procedure was warranted, it would have been problematic as patients could find themselves in an unfortunate position: not having enough funds to pay for their care, leading to financial struggles, directly opposing the idea that Medicare served to “transform the status of old people in American society” so that they were “comfortably off” as Bernstein asserted.[[20]](#footnote-21)20

Physicians had less selfish concerns, too. The American Medical Association (AMA) included approximately 65% of physicians during the 1960s,[[21]](#footnote-22)21 and had strong objections to Medicare.[[22]](#footnote-23)22 Bernstein documents the immense amount of political pressure the AMA applied to prevent the passage of Medicare,[[23]](#footnote-24)23 but he neglects to mention some of their concern over the three-day rule. An AMA report published in the healthcare journal *Hospital Topics* recommends that the current law stipulating that a patient must be in the hospital for three days to qualify for nursing home care be changed.[[24]](#footnote-25)24 The AMA declared that this requirement would lead to overcrowded hospitals and “interference with the physician's responsibility of determining the type of care and facilities needed by his patients.”[[25]](#footnote-26)25 This rule was not changed and remains today,[[26]](#footnote-27)26 serving to show that in some cases, the government put itself between physicians and their patients. Medicare was only available to accommodate older Americans and transform their lives if they met standards—even when not recommended by doctors—qualifying Bernstein’s argument.

The general public also pointed out perceived flaws with Medicare. Some believed that Medicare did not go far enough in insuring medical costs. In 1965, a *Life* magazine article described Medicare as “modest” compared to Kuwait’s healthcare system and declared that “Kuwait pays all medical expenses for everybody, even transients, without any charges at all.”[[27]](#footnote-28)27 This position shows that there was medical care that the Social Security Administration did not cover under Medicare.

This *Life* magazine article simply offered an observation by an author, but the experiences of Medicare patients provided a more personal perspective. In the early 1970s, the *Raleigh News and Observer* reported that Medicare failed to cover the hospital stays of two Medicare enrollees because the care was deemed “custodial” and not “skilled.”[[28]](#footnote-29)28 Perhaps this was a valid classification by Medicare, however, one of the patients had a nephew that was knowledgeable enough to have Medicare’s claim overturned.[[29]](#footnote-30)29 It is likely not all Medicare patients had nephews willing or able to fight perceived unfairness. The *Life* article and newspaper accounts of patients work together to show that not only were not all services covered, but that sometimes Medicare did not supply individuals with funds until someone challenged them. Denying patients the funds for reimbursable care was an obstacle for patients embedded in Medicare. Bernstein does not acknowledge this.

Bernstein likewise fails to mention how individuals were explicitly denied coverage or had their application delayed because they were unwilling to give information about their political affiliations to the Social Security Administration.[[30]](#footnote-31)30 Specifically, Medicare denied certain benefits to, in the words of one court case concerning this issue, “applicants who [were] members of organizations required to register under the Internal Security Act of 1950 as Communist-action, Communist-front, or Communist infiltrated groups.”[[31]](#footnote-32)31 The Internal Security Act of 1950 was passed during a surge of anti-communist sentiment.[[32]](#footnote-33)32 It was designed to protect the United States from communist activities with the main objective of criminalizing failure to “disclose the existence of Communist organizations” and “their officers and members.”[[33]](#footnote-34)33 The obvious ethical failure of denying or postponing funding for medical care on the basis of divulging a political alignment came to a head in *Reed v. Gardener* (1966).[[34]](#footnote-35)34

In *Reed v. Gardener*, Alda T. Reed, a 65-year-old woman who refused to declare that she was not “then or had been during the preceding 12 months, a member of any organization which is required to register under the Internal Security Act of 1950” on her Social Security information, sued the Department of Health, Education and Welfare.[[35]](#footnote-36) The government asserted that the question was not “required” for Medicare to grant insurance, however, there was evidence of persistent efforts to elicit an answer from Reed.[[36]](#footnote-37)36 Nonetheless, the court found evidence of contradictory actions as “the Government is saying on one hand that the question need not be answered and on the other that one failing to reveal such membership is subject to penalty.”[[37]](#footnote-38)37 The court decided that Reed was harmed by the delaying of her benefits and the question violated the First Amendment of the United States Constitution.[[38]](#footnote-39)38 This decision in the Supreme Court was handed down as a recent decision in Arizona was made “striking down” a loyalty oath, in line with *Reed v. Gardner*.[[39]](#footnote-40)39 The degree of exclusionary practice entrenched in the Social Security Amendments of 1965 rose to the level of being deemed unconstitutional, which is context that exemplifies both the limitations of Medicare and the shortcomings of Bernstein’s argument.

Medicare was expansive from its conception, with over 19.1 million people enrolling in the hospital insurance plan in its first year.[[40]](#footnote-41)40 Older Americans now had government-sponsored healthcare coverage. In *Guns or Butter: The Presidency of Lyndon Johnson*, Irving Bernstein captures the triumph of the work of President Johnson and his allies in the passing the Social Security Amendments of 1965.[[41]](#footnote-42)41 Bernstein, perhaps in an effort to emphasize the magnitude of the success of Medicare, asserts that forward-thinking plans and careful organization allowed Medicare to “open without a hitch” and “transform the status of old people in American society from a majority who live in or near poverty… to a majority who were comfortably off and able to qualify for hospital and medical care.”[[42]](#footnote-43)42 Although planning likely kept some problems at bay, the sorts of persistent issues discussed above nonetheless constituted significant “hitches.” Not all Americans over the age of 65 were able to experience the same level of life-altering access to covered healthcare. Acknowledging these shortcomings and examining their causes can illuminate the full range of Medicare results—beyond only its successes.

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