Medicare's Origin: The Economics and Politics of Dependency

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Americans now stand on the brink of transferring massive additional powers over their personal health care to the federal government. Politico-economic techniques used to pass the original Medicare legislation in 1965 are being employed again in the 1990s to secure passage of expansive new health care measures despite resistance of the public at large. Passage in 1996 of the Health Insurance Portability and Accountability Act—whose less publicized provisions criminalize aspects of the practice of medicine and jeopardize the privacy of doctor-patient relations through a compulsory nationwide electronic database—was achieved largely through techniques similar to those used to pass Medicare. Correct interpretation of Medicare's politico-economic history is therefore central to understanding ongoing attempts to enlarge the federal government's role in the market for medical care.

This article analyzes the nature and timing of Medicare's origin. My objective is not only to chronicle Medicare's evolution but to evaluate its history in a consistent theoretical framework. Based on thousands of pages of original congressional documents—House and Senate hearings, House and Senate reports, the Congressional Record, and other sources cited below—I show that Medicare's passage was achieved through government officials' deliberate decisions to restructure political transaction costs to overcome the widespread public opposition which had prevented passage of such bills for more than 50 years. History shows that Medicare did not and could not achieve passage without the misrepresentation, cost concealment, tying, and incrementalism to which its supporters ultimately resorted.

The 20th century has seen a transformation of unprecedented magnitude in the provision of U.S. health care. Governments now exert

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significant control over health care markets, and—despite the 1996 act's commitment to a limited federal experiment with individual "Medical Savings Accounts"—federal control is likely to grow. Medicare dramatically influenced this transformation, making the federal government the biggest purchaser of health care services and a primary determinant of the type, quality, and cost of health care services in major segments of the U.S. health care market. For decades Medicare payroll taxes have required low-income workers to subsidize medical care for more affluent retirees, while individuals as consumers of medical services increasingly have been constrained by a web of government controls.

Like the Social Security Act that it amended, the 1965 Medicare program was ostensibly a vehicle for reducing dependency in old age. In reality, both laws were dependency-shifting rather than dependency-reducing: mandated dependence of the elderly on the federal government and taxpayers replaced potential dependence on family and charity. This paper investigates how and why Medicare became law and considers what the observed pattern of institutional change implies for America's future.

Political Transaction Costs: A Theoretical Framework

Diverse theories of institutional change resonate strongly with U.S. political experience in the 20th century—theories based on interest-group politics, crisis, rent seeking, credit claiming, blame avoidance, and cost concealment, to name but a few.[1] With the advent of public choice economics, scholars have taken an ever closer look at the often self-interested motivations of political actors. Much of my work in recent years has involved developing and testing a theory of government manipulation of ("constitutional-level") political transaction costs. As explained below, it is a theory of government officials' rent-seeking by means of political transaction-cost augmentation. While no theory supplies the only viable explanation of politics and institutional change, transaction-cost augmentation theory provides a useful predictive lens through which to perceive how and why institutions change. It is a particularly useful lens in the case of the evolution of Medicare.

The central idea behind the theory is that government officeholders, as individuals, have strong incentives to alter important political transaction costs facing the public and facing others in government in

[1]See, for example, Weaver (1986), Mayhew (1974), Tullock (1967), Higgs (1985, 1987, 1988).

order to secure more of what they want with less resistance. As economists use the term, transaction costs are costs to individuals of negotiating and enforcing market exchange agreements, including information costs, negotiation costs, enforcement costs, and the like. Accordingly, I define political transaction costs—in particular, constitutional-level political transaction costs—as the costs to individuals of negotiating and enforcing collective political agreements that alter the role and scope of government.[2] Constitutional-level political transaction costs thus denote not only information costs, but also what I term "political agreement and enforcement costs." Whereas political information costs influence people's perceptions of the costs and benefits of government authority in a given sphere, political agreement and enforcement costs alter the costs of acting upon those perceptions. One might have perfect information and yet be deterred from taking political action if these other costs of taking political action were increased.

It is clear that government officials often take deliberate steps to increase the information costs to private citizens (and to each other) of accurately perceiving measures that change the scope of government authority. For instance, titles of bills often imply laudable objectives inconsistent with legislation's full impact—as exemplified recently by the Health Insurance Portability and Accountability Act, a significant part of which jeopardizes private medical practice as well as the privacy of people's personal medical records. In such a case, how many see beyond the language of "portability" and "accountability"? All manner of political misrepresentation falls into the information cost manipulation category.

It is equally clear that government officials often take deliberate steps to increase agreement and enforcement costs to private citizens of taking collective political action on measures that change the scope of government authority. For instance, when government officials spread the costs of a measure while concentrating its benefits, when they pursue incremental strategies for political change, when they tie controversial measures to more popular legislative proposals, when they differentially burden third political parties, and when they alter the locus of decisionmaking authority so as to shift the transaction-cost burden of changing the government's role, they increase the costs

[2]In what follows, when I refer to political transaction costs, I mean "constitutional-level" political transaction costs.

to private citizens of taking collective action to resist proposed changes in government authority.[3]

Deliberate government actions that increase constitutional-level political transaction costs thus drive a wedge between people's preferences and the political expression of those preferences. The theory's predictive power, however, lies in specifying circumstances that encourage government officials to approve such transaction-cost-increasing measures. In previous work I have identified the following variables as positively associated with an individual government official's decision to support a measure that increases the cost to the public (or to other government officials) of understanding or taking political action on a measure that alters the scope of government authority. A government officeholder's decision to support a transaction-cost-increasing measure is posited to be a positive function of (1) the political job security and perquisites promised by the measure; (2) third-party payoffs to the decisionmaker; (3) executive support for the measure; (4) party support for the measure; (5) the measure's complexity; (6) its perceived importance to constituents; and (7) the existence of an appealing rationale for the measure.[4] Support is posited to be a negative function of publicity accorded the transaction-cost-increasing features of the measure. Ideology and time also are expected to play important roles. For instance, *ceteris paribus*, a congressman's ideology is expected to encourage him to support measures that increase the transaction costs to the public of resisting changes in the scope of government authority that are congenial to his ideology. The influence of time's passage is less predictable, since it facilitates both wider dissemination of information and entrenchment of beneficiary interest groups, disparate impacts whose relative magnitudes cannot be known *ex ante*.[5]

[3]A classic example of the latter is the historical increase in the power of the U.S. Supreme Court to expand the scope of government authority in ways that otherwise would have required amendment of the U.S. Constitution.

[4]The complexity and appealing rationale variables require further comment. An issue's complexity may be either unavoidable or itself a product of transaction-cost augmentation. Similarly, an appealing rationale may be either false or true. In either case, the direction of impact on an officeholder's decision regarding a transaction-cost-increasing measure is as described in the text. Issue complexity, like the existence of an appealing rationale, makes it harder for citizens to perceive transaction-cost-increasing features of policy proposals. Moreover, both of these conditions allow politicians greater room to credibly claim to have made a "mistake" if negative public reaction to the measure's transaction-cost-increasing features does materialize.

[5]More detailed treatment of transaction-cost augmentation theory is available elsewhere (Twight 1983, 1988, 1994).

Political transaction-cost augmentation proved to be the lifeblood of the 1965 Medicare legislation. Misrepresentation, cost concealment, tying, incrementalism, and procedural stratagems all were used by government officials to raise the transaction costs to voters of resisting Medicare. As explained below, in 1965 for the first time all of the determinants enumerated in the preceding paragraph favored pro-Medicare transaction-cost augmentation. In that year, Congress relied heavily on such strategies to pass a Medicare bill laden with transaction-cost-increasing features. Consider first the Medicare idea's early history in the United States.

Compulsory Health Insurance Proposals before 1964

For more than 50 years before the 1965 enactment of Medicare, the American people repeatedly rejected the idea of government-mandated health insurance. Yet advocates of such federal power inside and outside of government did not take no for an answer. Year after year they kept coming back—pursuing incremental strategies, misrepresenting their proposals, even distributing propaganda paid for with government money in apparent violation of existing law. In the end Medicare's passage was anything but a spontaneous societal embrace of one of the pillars of President Lyndon Johnson's "Great Society."

The federal government's involvement with this issue began in earnest in 1934.[6] In that year President Franklin Roosevelt established the Committee on Economic Security (CES) and charged it with drafting a Social Security bill. Although the original CES report on Social Security stated with Roosevelt's approval that a "health insurance plan would be forthcoming," the CES statement caused such a stir that Roosevelt decided to postpone the health insurance issue, fearing that it jeopardized passage of the Social Security bill (Corning 1969: 38). Accordingly, the provision in the original Social Security bill proposing a "Social Insurance Board" and authorizing study of

[6]Widespread interest in compulsory national health insurance had been inspired by Bismarck's 1883 program in Germany, a program rapidly emulated by other nations. In 1906 activists formed the American Association for Labor Legislation (AALL), an organization that would take up the cause in this country. Centralized control over health care was much in the air as Britain adopted a compulsory national health system in 1911. For discussion of the history of federal treatment of health care issues from 1793 forward, beginning with federal reaction to the early yellow fever epidemics and debates over federal quarantine authority, see Chapman and Talmadge (1970). See Wasley (1992: 49–50, 55–8) regarding the federal government's role in stimulating employer-provided, first-dollar coverage health care as well as its efforts (along with those of state governments) to benefit Blue Cross to the detriment of other insurers.

health insurance was changed so as to delete all reference to health and rechristen the board as the "Social Security Board" (Chapman and Talmadge 1970: 342). President Roosevelt had decided that "health insurance should not be injected into the debate at that point, nor should the final report on health be made public as long as the social security bill was still in the legislative mill." Indeed, as of 1969 the final CES report on health still had not been made public (Corning 1969: 40, n. 17).

Governmental advocacy of compulsory health insurance was in no way hindered by these developments: government officials proceeded as if the original statutory language had been retained. The Social Security Act signed into law on August 14, 1935, empowered the Social Security Board (SSB) to study "related" areas, and on August 15, 1935, Roosevelt appointed an Interdepartmental Committee to Coordinate Health and Welfare Activities to pursue the health insurance issue. Then in 1936 the SSB hired Isidore S. Falk, a key figure in the subsequent development of Medicare, to work on health insurance.[7] The following year the Interdepartmental Committee established a "Technical Committee on Medical Care" whose members decided in a private conference that "it would be desirable to formulate a comprehensive National Health Program." The Technical Committee published its report in February 1938, soon thereafter sponsoring a "climate-building" three-day National Health Conference to promote the issue (Corning 1969: 45–6). Resultant Interdepartmental Committee recommendations included a "general program of medical care, paid for either through general taxation or social insurance contributions," as well as federal support for hospital expansion, disability insurance, public health services (including maternal and child health), and state programs for the "medically needy" (Poen 1979: 19).

With the ground thus prepared, health care legislation was introduced in virtually every session of Congress from 1939 forward.[8] Senator Robert Wagner (D., N.Y.) introduced a bill in 1939 (S. 1620) incorporating the recommendations of the National Health Conference.

[7]Falk had been associated with the Committee on Economic Security and was a strong advocate of national health insurance. Poen (1979: 17) wrote of Falk: "At a March 1934 meeting of the Milbank Fund, Isidore Falk outlined a plan for national health insurance, and Harry Hopkins told the gathering, 'You aren't going to get health insurance if you expect people to do it voluntarily. I am convinced that by one bold stroke we could carry the American people along not only for health insurance but also for unemployment insurance. I think it could be done in the next eighteen months.' "

[8]Regarding Medicare's early legislative history, see Corning (1969), Feingold (1966: 96–156), Marmor (1970, 1973), Myers (1970), Poen (1979), Anderson (1966), and Derthick (1979: 316–38).

Beginning in 1943 a series of bills, known as the Wagner-Murray-Dingell bills in recognition of sponsors Senator Robert F. Wagner (D., N.Y.), Senator James Murray (D., Mont.), and Rep. John Dingell (D., Mich.), explicitly sought to establish universal compulsory national health insurance at the federal level, insurance that "covered virtually all kinds of care for virtually the whole work force and their dependents" (Derthick 1979: 318). Having developed the 1943 bill for Senator Wagner, the Social Security Board in 1944 specifically recommended to Congress that compulsory national health insurance be made part of the Social Security system.[9] As Derthick (1979: 317) stated, "Nowhere is the aggressiveness of social security program executives better demonstrated than in these early campaigns for national health insurance."

Legislative efforts in the 1930s and 1940s went nowhere. The American Medical Association (AMA) strongly opposed compulsory national health insurance, denouncing it as socialized medicine and mounting costly efforts to defeat it.[10] President Roosevelt withheld his active support. Opinion polls indicated strong public opposition, with 76.3 percent of the public in a 1942 *Fortune* poll saying that the government should not provide free medical care (Cantril 1951: 440).

Nonetheless, advocates of compulsory national health insurance carried out an extensive media campaign to sway public opinion on the issue (Poen 1979: 42–45, 50). Governmental influence was sometimes overt, as in the publication of an important article in the December 1944 issue of *Fortune* magazine:

> At first, the magazine had planned to conclude the story with a judgment adverse to the W-M-D [Wagner-Murray-Dingell] bill, but thanks to [Senator] Wagner's tactful protest and the information supplied by [SSB official] Falk, the finished article portrayed a picture decidedly favorable to the proposed health program [Poen 1979: 45].

When Harry Truman became president in 1945, health insurance advocates gained a more committed if less charismatic ally in the executive branch. In November 1945 Truman submitted to Congress the first ever presidential message devoted exclusively to health care (Poen 1979: 64).

Developments in 1950–51 proved pivotal to eventual passage of Medicare. In the off-year 1950 elections, incumbents who had supported compulsory national health insurance were defeated. Moreover, while retaining control of Congress, Democrats suffered

[9]The 1943 bill was developed by Social Security Board (SSB) chairman Arthur Altmeyer, his assistant Wilbur Cohen, and SSB research director Isidore Falk (Poen 1979: 33–4).

[10]The AMA's history and practices are discussed in Goodman (1980).

net losses in the House and Senate. Wilbur Cohen and Isidore Falk, key Social Security Administration (SSA) officials instrumental in the push for Social Security and government health insurance since the early days, came to believe that universal compulsory health insurance could not be passed. With this realization came the idea of restricting their proposal to the elderly, an idea first suggested by Dr. Thomas Parran of the Public Health Service in 1937 and by Merrill G. Murray (Social Security Administration official) in 1944 (Corning 1969: 71; Marmor 1970, 1973: 14). When Federal Security Administrator Oscar Ewing independently developed the same concept in December 1950 and began to explore the idea in the spring of 1951, Cohen and Falk already had developed the materials he needed (Poen 1979: 189–91).

Recrafting the proposal as compulsory federal health insurance for the aged thus reflected a deliberate decision to use an incremental strategy, initially targeting the group of recipients who would evoke the greatest sympathy with the public. However, despite this foot-in-the-door approach, resistance continued. With Eisenhower's election in 1952, Medicare advocates sought to keep the issue alive by continuing to introduce bills in every session of Congress (Cohen and Ball 1965: 3). Their proposals invariably encountered strong opposition from the AMA and the medical community, remaining unsuccessful even with coverage limited to hospital and nursing home care for the elderly. How to proceed?

Again, incrementalism was part of the answer. Disability coverage was added to Social Security in 1956, a step Martha Derthick (1979: 319) viewed as an essential part of the incremental process leading to passage of Medicare, "a necessary prelude." Describing the evolution of the disability program, Derthick noted that "incremental change . . . has less potential for generating conflict than change that involves innovation in principle" causing program executives, "even when undertaking an innovation in principle," to try "to cut and clothe it in a fashion that made it seem merely incremental" (Derthick 1979: 314).

With disability coverage in place, in 1957 the AFL-CIO recommitted itself to the fight for compulsory health insurance. Accordingly, a group of long-time Medicare advocates—Wilbur Cohen, then a professor at the University of Michigan; Isidore Falk, then working as a consultant for the United Mine Workers; Robert Ball, long-time SSA official; and Nelson Cruikshank, director of the AFL-CIO's Department of Social Security—formulated a bill proposing hospital, surgical, and nursing home benefits for Social Security recipients (Poen 1979: 217; Derthick 1979: 320–21; Marmor 1970, 1973: 30). They persuaded Rep. Aime J. Forand (D., R.I.) to introduce the bill:

hearings were held in 1958–59, and the Forand bill was rejected by the House Ways and Means Committee in 1959. Then in 1960 Congress passed the Kerr-Mills bill (P.L. 86-778) to provide medical aid for the aged poor, establishing a needs-based program of Medical Assistance for the Aged (MAA). Championed by House Ways and Means Committee chairman Wilbur Mills (D., Ark.) and Senator Robert Kerr (D., Okla.) and drafted by Cohen at their request, the Kerr-Mills approach was a preemptive effort by those who hoped that providing medical care for the aged poor would deflect broader efforts to inject government into the market for medical care.

Their hope was misplaced. No sooner had Kerr-Mills been adopted than renewed efforts were made to craft a politically viable bill to provide compulsory health care insurance for the aged. In 1961 and again in 1963 Rep. Cecil King (D., Calif.) and Senator Clinton Anderson (D., N.M.) introduced measures patterned on the Forand bill (the King-Anderson bills). A competing approach that would have permitted individuals to choose comparable private insurance coverage was offered in 1962 by Senator Clinton Anderson (D., N.M.), Senator Jacob Javits (D., N.Y.), and numerous cosponsors (the Anderson-Javits bill).[11] Although proposed coverage was restricted primarily to hospital care and some nursing services in the effort to find a thread that would pass through the eye of the legislative needle, still the bills did not move forward. Despite President John F. Kennedy's support for Medicare in 1960 and thereafter, the political calculus did not change until 1964.

Medicare 1964–65: Reshaping Political Transaction Costs

By 1964 sustained efforts to legislate compulsory health insurance at the national level had continued for three decades. For 30 years since the Committee on Economic Security first endorsed the idea, Congress and the public repeatedly rejected it. In these circumstances, how could a Medicare bill possibly be passed in 1965? First, as shown below, the 1965 bill and the procedures employed in its passage were rife with transaction-cost augmentation, allowing government officials who supported it to impede public opposition. Second, consistent with the theory, concurrent changes in the variables posited to be determinants of this behavior more strongly encouraged legislators to

[11]For a detailed summary of the differences between these bills, see Feingold (1966: 102, 115, 122–23, 125).

support such transaction-cost-increasing measures on the Medicare issue than at any previous time in U.S. history.

Politically, what changed in 1964 was the resounding victory by Democrats in the general elections in November. Many perceived the election of Lyndon B. Johnson as an endorsement of compulsory national health insurance and other social programs regarded as pillars of his personal vision of the "Great Society." Congress was heavily in the hands of the Democrats. Moreover, a Gallup poll released on January 3, 1965, showed that efforts to sway public opinion on the national health insurance issue had been at least superficially successful: 63 percent of respondents now approved of the idea of a "compulsory medical insurance program covering hospital and nursing home care for the elderly . . . financed out of increased social security taxes"—even though 48 percent of those interviewed still did not know why the AMA opposed the program[12] (Gallup 1972, Vol. 3: 1915).

Political and ideological winds had shifted, nursed by the incremental politics of preceding years. But they had not shifted enough to procure compulsory health insurance for Social Security beneficiaries without deploying a full arsenal of transaction-cost augmenting stratagems to deflect and silence the opposition.

Transaction-Cost Augmentation and the 1965 Medicare Bill

The scope of transaction-cost augmentation used in designing and passing what came to be known as the 1965 Medicare bill defies brief description. We have seen the incrementalism that set the stage for the events of 1964–65. In 1965 transaction-cost augmentation took both of the general forms discussed earlier: raising information costs facing political decisionmakers and raising their costs of taking political action to resist the Medicare proposal.

[12]Consistent with the political transaction-cost augmentation described in this paper, three trends are evident in relevant polls despite variations in pollsters' questions. First, public awareness of the existence of various statutory proposals increased over time [for example, changing from the 63 percent who reported they hadn't heard of Truman's health insurance plan (the Wagner-Dingell-Murray bill) in April 1946, to the 34 percent who hadn't heard of it by December 1949]. Second, public resistance to the idea of government-provided health care benefits decreased (contrast the 76.3 percent who said in September 1942 that government should *not* provide free medical care to the 63 percent who approved of targeted compulsory medical insurance in 1965). Third, as noted in the accompanying text, even in 1965 most people continued to be ill-informed about issues surrounding the substantive provisions of the proposed measures. As late as 1962, although 81 percent reported they had heard of the Kennedy administration's Medicare plan, only approximately 41 percent of all respondents knew how it would be paid for, and only 9 percent knew who would be covered. See Gallup (1972, Vol. 1: 578; Vol. 2: 886; Vol. 3: 1781); Cantril (1952: 440, 443). Regarding polls conducted by members of Congress, see Skidmore (1970: 156–9); U.S. House Hearings (1963–64: 419).

Manipulation of Political Information Costs. Government officials misled the public regarding the content of the bill. The Johnson administration's 1965 Social Security amendment bills, which began the year as H.R. 1 and S. 1, reflected the general approach contained in the King-Anderson bills introduced in 1961 and 1963. The 1965 bill proposed compulsory hospital insurance financed through the Social Security payroll tax, payable to persons over 65 years of age.[13] After a small deductible, hospital bills would be covered for 60 days. Ancillary coverage was to be provided for 60 days of nursing home care. Not covered were physicians' services outside the hospital, catastrophic illness that lasted more than 60 days, and therapeutic drugs.

The gulf between what the public thought and what was actually in the bill was enormous. The most pressing rationale for compulsory health insurance continually put forward by government officials and echoed by the public was the specter that responsible older people could be ruined financially by catastrophic illness. *Yet neither the 1963 nor the 1965 proposal provided coverage for catastrophic illness.* During the 1965 Senate Finance Committee hearings, Chairman Russell Long (D., La.) asked HEW Secretary Anthony Celebrezze, whose department had written the bill, "Why do you leave out the real catastrophes, the catastrophic illnesses?" (U.S. Senate Hearings 1965: 182). When Celebrezze replied that it was "not intended for those that are going to stay in institutions year-in and year-out," Senator Long countered: "Well, in arguing for your plan you say let's not strip poor old grandma of the last dress she has and of her home and what little resources she has and you bring us a plan that does exactly that unless she gets well in 60 days."

Celebrezze concurred, stating that means-tested public assistance would provide "additional help" (U.S. Senate Hearings 1965: 182–83). Long added that "Almost everybody I know of who comes in and says we ought to have medicare picks out the very kind of cases that you and I are talking about where a person is sick for a lot longer than 60 days and needs a lot more hospitalization" (U.S. Senate Hearings 1965: 184).[14] Yet the very element that

[13]Coverage included those who either were eligible for Social Security benefits, eligible for railroad retirement benefits, or reached age 65 in 1967 or later and met certain OASI work requirements before reaching age 65 even though not eligible for social security benefits. See Feingold (1966: 102, 115, 122–23, 125, 139).

[14]For discussion of the Medicare Catastrophic Coverage Act passed by Congress in 1988 and repealed in 1989, see Moon (1990).

government officials continued to cite to win public support for Medicare was deliberately omitted from the administration's bills.

Despite their limited coverage, the bills came to be known as "Medicare," a term coined by a reporter to describe a previously established comprehensive health care program for military dependents. Many people therefore assumed that the bills before Congress would cover all forms of medical care, including outpatient physician fees and extended illnesses. When Rep. Albert Ullman (D., Ore.) cited allegations that the "public is somehow being hoodwinked" and "being misled" and asked HEW's Wilbur Cohen about the degree to which the public misunderstood the program, Cohen stated that "we do recognize this problem and I think it has been complicated by the use of the term 'medicare' which is an erroneous term when applied to this program" (U.S. House Hearings 1965: 104). Although government officials sometimes expressed dismay about this public misimpression, the misinformation nonetheless fueled support for passage of a bill they strongly supported.

A central rationale offered to the public for the bills that became Medicare was that they would enable people to "avoid dependence" in old age. In fact it was a bogus rationale that served as a key form of transaction-cost augmentation used to secure the bill's passage. That this rationale was not believed by the bills' authors in HEW is clearly indicated by Celebrezze's acknowledgments above regarding the omission of coverage for catastrophic illness. Nonetheless, government officials' repeated assertions that Medicare would "avoid dependence" made it more difficult for voters to understand that dependence in old age would not be forestalled by these measures, thereby diminishing resistance to the bills.

The appealing rationale of "avoiding dependence" provided a fig leaf for all manner of practical politics. Indeed, this form of transaction-cost manipulation hid one of the underlying political motives for the legislation: the desire of adult children to avoid the responsibility for their elderly parents. As Marmor (1970, 1973: 17) put it, "Strategists expected support from families burdened by the requirement, moral or legal, to assume the medical debts of their aged relatives." When Senator Clinton Anderson (D., N.M.) asked Celebrezze, "Isn't it true that younger persons would have lifted a heavy financial burden sometimes as a result of taking care of the aged in their family?" Celebrezze agreed (U.S. Senate Hearings 1965: 122). Warning that soon after enactment the public would discover the actual benefits to be much less than expected,

Senator Allen Ellender (D., La.) stated on the Senate floor that "many sons and daughters whose mothers and fathers are growing old are of the belief that under the pending bill they will be able to get the Government to take care of their older parents, in the event they become ill for long periods of time" (*U.S. Cong. Rec.-Senate* 9 July 1965: 16072). The political undercurrent was that the "avoiding dependency" rationale gave a respectable gloss to adult children's desire not to support their aging parents which could be counted on to buttress political support for the Medicare measures.

Another important underpinning of the "avoiding dependency" rationale was the widely trumpeted portrait of elderly Americans as an impoverished group whose plight made them a sympathetic object of tax-supported medical insurance. Misrepresentation of the financial condition of the elderly helped to paint this portrait, as government officials advocating Medicare repeatedly cited statistics showing lower incomes received by the elderly in comparison with other age groups. Yet the income statistics by themselves were misleading because they did not include asset ownership, and the elderly as a group had more substantial assets than other segments of the populace. Rep. Thomas B. Curtis (R., Mo.) repeatedly challenged HEW officials regarding the "incompleteness of the income statistic," noting that "just as they have relatively low incomes as a group because they are on retirement, so they have more wealth than any other age group" since "they have been saving longer" (U.S. House Hearings 1963–64: 96).

The pro-Medicare pitch was that this presumptively deserving and financially precarious group should receive medical benefits without regard to need in order to protect elderly persons from the indignity of a means test. However, data submitted for the record from a 1960 University of Michigan study showed that "87 percent of all spending units headed by persons aged 65 or older" had assets whose median value matched asset ownership of people aged 45–64 and exceeded the asset ownership of people under age 45 (U.S. House Hearings 1963–64: 242–43). While HEW Secretary Celebrezze waxed eloquent about the necessity to furnish protection "as a right and in a way which fully safeguards the dignity and independence of our older people," Rep. Curtis questioned whether it was appropriate to "change the basic system" when 80 to 85 percent of the aged were able to take care of themselves under the existing system, recommending instead that we "direct our attention to the problems of the 15 percent, rather than this

compulsory program that would cover everybody" (U.S. House Hearings 1963–64: 31, 392).

Some in Congress clearly recognized that one effect of the proposed program was to require the working poor to support the retired rich, as when Senator Long (D., La.) asked, "Why should we pay the medical bill of a man who has an income of $100,000 a year or a million dollars a year of income?" (*U.S. Cong. Rec.-Senate* 9 July 1965: 16096). Nonetheless, the predominant political motif was misleading allusion to the financial plight of the elderly, what Rep. James B. Utt (R., Calif.) called the false assumption "that everyone over 65 is a pauper and everyone under 65 is rolling in wealth" (*U.S. Cong. Rec.-House* 8 April 1965: 7389).

A major obstacle to Medicare legislation was widespread fear that compulsory federal insurance would result in federal control over medicine and over doctor-patient relationships. To counter this fear, the bill's authors drafted a provision specifically disavowing such control, the same strategy used to secure passage of public education bills in 1958 and 1965 (Twight 1996). Questioned about whether the 1964 bill represented socialism, Celebrezze directly addressed the issue of control, stating: "There is nothing in this bill which tells a doctor whom to treat or when to treat him. . . . There is nothing in this bill by which the Government would control the hospital, and as I understand socialism, it is Government control and operation of facilities. . . . It is merely a method of financing hospital care, and that is all" (U.S. House Hearings 1963–64: 50). He added,

> We are a paying agency and I don't see where you get any control of any kind out of that. Naturally, . . . there will be minimum requirements like these which are required now under Blue Cross. I see no evidence where this would lead to control over the doctors [U.S. House Hearings 1963–64: 54].

The AMA had a different view of the power of the federal purse. AMA President-Elect Dr. Norman A. Welch testified that "It is axiomatic . . . that *control follows money* when the Government steps in" (U.S. House Hearings 1963–64: 652; emphasis added). Citing the 1942 case of *Wickard v. Filburn*, Dr. Welch quoted the U.S. Supreme Court's statement that " 'It is hardly lack of due process for the Government to regulate that which it subsidizes' " (317 U.S. 111 at 131, 63 S.Ct. 82, 1942). More concretely illustrating such regulation and control, Dr. Austin Smith and Dr. Theodore G. Klumpp testified on behalf of the Pharmaceutical Manufacturers Association that, of the 200 most commonly prescribed drugs in the United States in 1964, 91 would not be covered by the revised 1965 Medicare bill

(described below), in effect telling doctors that they could use "only these tools and not the others" to treat disease (U.S. Senate Hearings 1965: 767–8).

In the 1965 House hearings, Rep. Wilbur Mills (D., Ark.) put the control issue clearly. First he quoted the bill's provision that "Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided." Then he quoted other language in the bill specifying that amounts paid by the government to "any provider of services" under the bill "shall be the *reasonable cost* of such services, *as determined in accordance with regulations* establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, services, and agencies." Mills concluded that "In spite of what we say here the Secretary has to get into some kind of an agreement with hospitals or hospital [sic] as to what the reasonable costs of taking care of a patient are" (U.S. House Hearings 1965: 136, 139, 142; emphasis added). Exactly so.

Rep. Curtis (R., Mo.) was even more outspoken about the control-creating effects of the agreements that would govern the relationship between the government and the hospitals, which he described as putting the federal government and HEW "into the business of making final determinations as to whether these charges are reasonable and whether these services are the kinds that are to be covered." He continued,

> We must recognize that this is the heart of this bill. . . . This is the way the HEW says to the hospitals, "Yes; this is what will be done." I am glad to have these words in the beginning of the bill saying that there is no Federal interference, and that there will be free choice of the patients guaranteed. But this is not the real test [U.S. House Hearings 1965: 308].

Nonetheless, the ostensible disavowal of control allayed public fears and thus increased the costs to private citizens of fully understanding the likely impact of the bill.

HEW also raised information costs to the public by engaging in lobbying practices of questionable legality. Citing HEW's pamphlet entitled "Health Insurance, Why We Need It," Rep. Curtis (R., Mo.) charged that HEW's use of public funds to prepare and distribute the pamphlet was "undermining the very process of representative government" (U.S. House Hearings 1963–64: 271). Since "those who disagree" had "no opportunity to present their side or their arguments about it," the pamphlet amounted to "propaganda and lobbying" in Curtis's view (U.S. House Hearings 1963–64: 79). Senator Karl E.

Mundt (R., S.D.) further alleged that HEW had used public funds to carry out "deliberate sabotage" of the needs-based Kerr-Mills legislation passed in 1960 in order to stimulate support for the King-Anderson compulsory hospital insurance. Citing specific examples from his home state—including an HEW workshop conference on April 6, 1962, that "was open only to persons who opposed Kerr-Mills and supported King-Anderson"—Mundt described "public servants, paid with public funds, traveling at public expense, charged with administering a Federal law, going about the country trying to destroy public confidence in a law enacted by this Congress" (U.S. House Hearings 1963–64: 259–60).

Moreover, the method of financing the proposed medical insurance concealed its present and future cost to private citizens, further diminishing resistance to Medicare. It was to be piggy-backed on the Social Security payroll tax, with the additional payroll tax nominally split between employer and employee. As with the OASDI (Old Age, Survivors, and Disability Insurance) portion of the payroll tax, the nominal splitting of the Medicare tax would have no economic effect other than to hide the full cost from the worker (Browning 1975). Yet the director of the Bureau of the Budget, economist Kermit Gordon, testified that he didn't know the "ultimate incidence of a payroll tax," hadn't discussed it with HEW officials, and "[didn't] share [the] view that the payroll tax constitutes a significant deterrent to the employment of labor and stimulus to the substitution of capital for labor" (U.S. House Hearings 1965: 811, 813). Mandated employer withholding of payroll taxes from workers' paychecks likewise would increase the cost to workers of perceiving the magnitude of Medicare taxes paid (Twight 1995). The payroll taxes collected were to be put in a "trust fund" that was "separate" from the OASDI Social Security trust fund. People were told that during their working years they would be paying for "insurance" to defray the costs of illnesses in their old age. Supporters of Medicare repeatedly downplayed the regressivity of payroll taxes. In their view the taxes were not even taxes: according to government officials, they represented an "opportunity" to make "contributions" (U.S. House Hearings 1963–64: 67). In short, all the familiar lies and misrepresentations honed so well in the passage of the 1935 Social Security Act (Twight 1993) were trotted out again.

They worked just as well the second time. People believed the oft-repeated myth about "splitting" the proposed additional taxes. And, despite protestations from some congressmen, many voters did not understand that, far from putting funds into a paid-up insurance policy, they would be taxed today to pay for other people's benefits

today, with no guarantee that the program would pay comparable benefits to them when they reached age 65.

Many government officials understood these matters clearly. Even HEW officials, when speaking to congressmen, sometimes dropped the "contributions" language and stated openly that the government's participation through Medicare "would be on a compulsory tax basis as social security is basically" (U.S. House Hearings 1963–64: 61). In executive hearings in 1965 not open to the public, Rep. John W. Byrnes (R., Wisc.) asked HEW's Robert Myers whether "fundamentally what we are doing here is *not* prepaying, but . . . having the people who are currently working finance the benefits of those currently over 65" (U.S. House Hearings 1965: 20). Myers replied, "I think it can be viewed that way, just as the old-age and survivors insurance trust fund can" (U.S. House Hearings 1965: 20, emphasis added). He added,

> You can also view that it is prepayment in advance on a collective group basis, so that the younger contributors are making their contributions with the expectation that they will receive the benefits in the future—*and not necessarily with the thought that their money is being put aside and earmarked for them,* but rather that later there will be current income to the system for their benefits [U.S. House Hearings 1965: 20, emphasis added].

Despite this moment of candor, three months later Celebrezze returned to his standard theme, testifying before the Senate Finance Committee that the Medicare payroll taxes were "earmarked" taxes and that by "this method, people can contribute during their productive years toward the hospital insurance that they will need in later years" (U.S. Senate Hearings 1965: 93).

Highlighting the transaction-cost-increasing aspects of this insurance imagery, Rep. Curtis (R., Mo.) noted that "private insurance has a very definite concept in the public's mind along with the terms 'premium,' 'prepayments' and 'actuarial soundness' and so forth. . . . Whether trading in on the fine reputation that insurance has in our society is intential [sic] or not, that is actually what is happening and there is a great public misunderstanding because of these terms" (U.S. House Hearings 1965: 35). Even SSA official Robert Myers acknowledged that "the use of the term *paid-up insurance* by the proponents tends to be misleading and creates false impressions that individual equity is present" (Myers 1970: 31).

Underlying government officials' support for the insurance approach and the myth of the separate trust fund was their desire to remove the associated taxing and spending from the official budget. Such off-budget strategies exemplify a recurrent form of political transaction-cost augmentation in the United States (Twight 1983).

Testifying before the House Ways and Means Committee, HEW Secretary Celebrezze stated that "what we are attempting to do . . . is that we are trying to get away from making the assistance program our first line of defense—to get away from heavy Government expenditures out of general funds" (U.S. House Hearings 1963–64: 67). They succeeded, at least initially. As Marmor (1970, 1973: 22) noted, the Social Security programs were "financed out of separate trust funds that were not categorized as executive expenditures; the billions of dollars spent by the Social Security Administration were until 1967 not included in the annual budget the president presented to Congress."

Manipulation of Political Agreement and Enforcement Costs. In addition to manipulating political information costs in the ways described above, governmental supporters of national health insurance used a variety of other transaction-cost-increasing strategies to increase the costs of taking political action to resist the Medicare proposal. Even in 1965, proponents of compulsory health insurance feared that it could not be passed as a stand-alone measure. Accordingly, they packaged it with the "Social Security Amendments of 1965." Most politically irresistible among the measures contained in the amendments was an across-the-board 7 percent increase in cash benefits to Social Security recipients, a benefit increase made retroactive to January 1, 1965. The Social Security amendment package also contained politically appealing benefits such as grants for maternal and child health services, liberalization of disability coverage, and the like. Without doubt, these linkages increased the political transaction costs facing the public and facing members of Congress of resisting the compulsory medical insurance proposal.

The tying was not happenstance. In 1964 hearings had been held by both the House and Senate on Social Security amendments, including compulsory medical insurance as well as an increase in Social Security benefits. The House and Senate passed different versions of the bill increasing benefits, with the medical insurance provisions omitted from the House bill but included as an amendment to the Senate bill. When the conference committee appointed to reconcile the two bills ended in deadlock over the Medicare issue, conferees decided to forgo the Social Security benefit increase passed by both the House and the Senate in a deliberate effort to give Medicare another chance in the following year. As Rep. Byrnes (R., Wisc.) put it, "The amendments to the old-age survivors disability insurance sections of this bill could have been passed last fall if the word had not come down, and the insistence made that 'Oh, no, you have to tie all of these together because

of the fear that the medical part of this program could not stand on its own merits' " (*U.S. Cong. Rec.-House* 7 April 1965: 7219). The administration's insistence on this linkage was central to its transaction-cost-increasing strategy.

The incrementalism that had characterized the previous 30 years of Medicare's evolution also was written into the bill's financing provisions. Payroll-tax increases extending to 1987 were specified in the bill, thereby lowering the apparent present cost to workers of the health insurance provisions. The planned pay-as-you-go financing, disguised by the bogus Medicare "trust fund," further concealed the full cost of the proposed program.[15] But chief among the incremental financing strategies was the intention, partly written into the bill, to gradually increase the wage base to which payroll taxes would apply and thereby increase payroll tax revenues to finance Medicare while avoiding politically difficult increases in payroll tax rates. Even congressmen sometimes had to dig to get the truth from administration witnesses on this topic. HEW's Robert Myers testified in 1964 that "the financing provided in the bill . . . will be sufficient to finance the proposal for all time to come," avowing that "the income in the early years is estimated to be more than sufficient so as to make up for the fact that later on the benefits will rise as there become relatively more and more beneficiaries" (U.S. House Hearings 1963–64: 58). He later admitted under questioning his underlying assumption that the "earnings base" would have to rise (via legislation) in the future to make his cost estimates valid, implying that without such increases in the earnings base for Medicare his cost estimates would greatly understate the true costs (U.S. House Hearings 1963–64: 141–46). Accordingly, planned increases in the wage base were written into the 1965 bill. Noting that the "rate of tax and the wage base is [sic], however, escalated in subsequent years," the minority report on the 1965 House bill concluded that "this 'gimmick' merely postpones the full impact of the cost" and causes Medicare's "real burden" to be "shifted to the future" (U.S. House Rept. 213, 1965: 249). Although Rep. Joel T. Broyhill (R., Va.) in his separate statement protested the fact that "the first population group that will bear the full brunt of the tax burden is the group of citizens to be born 6 years from now," concealment and shifting of the costs were keys to the bill's political viability (U.S. House Rept. 213, 1965: 261).

[15]For a discussion of pay-as-you-go financing and the "chain-letter economics of medicare," see Goodman and Musgrave (1992: 385–460).

Another deliberate change in political transaction costs that increased the costs of resisting the Medicare proposal involved the very structure of the House Ways and Means Committee. After the 1964 elections, the House of Representatives took the "unusual" step of altering the composition of the committee with jurisdiction over the Medicare bill (Cohen and Ball 1965: 5). The result was that thenceforth there would be two Democrats on the committee for every one Republican, making it more difficult for opponents to block favorable committee action on the bill.[16]

Mills's Three-Layer Cake: Intra-Government Manipulation of Transaction Costs. Until November 1964 Wilbur Mills as chairman of the House Ways and Means Committee had been one of the primary obstacles to passage of compulsory national health insurance. After the political realignments brought about by the 1964 elections, however, he concluded that some form of Medicare inevitably would be passed. As a southern Democrat, he believed there was much to fear from allowing politics to run its course on this issue without his guiding hand. Perceiving Medicare's open-ended commitment to pay for services as a grave threat to the entire Social Security program, he wanted to control the form that Medicare would take.

Accordingly, he devised additional transaction-cost-increasing strategies to that end. Some of these strategies were aimed at the public; others were aimed at his fellow congressmen. First, he insisted that there not be any open public hearings on Medicare in 1965: the 1965 Ways and Means Committee hearings were held in executive session. Some individual witnesses were invited, but they were only allowed to discuss the technical aspects of the Medicare bill, not the philosophy behind it. Only the initial part of the hearing was published—even that duly expurgated, with many discussions omitted as "off the record." Much of the hearing was totally closed.

In the executive sessions, Mills asked witnesses to make recommendations regarding "specific technical aspects" of the bills then before the House of Representatives. Chief among those bills was H.R. 1, the King-Anderson measure discussed above. But there were other measures as well. Rep. Byrnes (R., Wisc.), the senior

[16]This change meant that the House Ways and Means Committee would consist of 17 Democrats and 8 Republicans, in contrast to its previous composition of 15 Democrats and 10 Republicans. In addition, to help the party leadership advance its agenda, the House Rules Committee had been enlarged on a temporary basis in January 1961 and on a permanent basis in 1963 (Feingold 1966: 126, 140; Marmor 1970, 1973: 60).

Republican on the House Ways and Means Committee, had introduced a bill (dubbed "Better-care") providing for a voluntary insurance program that would cover both hospital and other medical expenses, financed partly by the government and partly by premiums to be paid by those who elected coverage. There was also an AMA-sponsored "Elder-care" bill introduced by Rep. Curtis (R., Mo.) and Rep. Albert Herlong (D., Fla.), the thrust of which was to strengthen the existing Kerr-Mills program that paid medical expenses for the aged poor.

Stripped of most ideological discussion by Mills's edict, the hearings were a pretty dull affair. Nonetheless, the aspirations of Blue Cross executives and Mills's vision of Blue Cross's intermediary role became evident as never before.[17] Walter J. McNerney, president of the Blue Cross Association, recommended that, under Medicare, "it would be desirable . . . to have one carrier, perhaps with the Secretary [of HEW] authorized after consulting with the hospitals to contract with this carrier." He added,

> Whether it is on the basis of a low responsible bid or whether it is on the basis of the prejudice expressed by the providers of care, I have no explicit preference. However, we are equipped and would be able to move into action within days in our traditional capacity of, after initial eligibility has been established, doing the rest of the job [U.S. House Hearings 1965: 160].

Rep. Albert Ullman (D., Ore.) later remarked that "it has been generally prognosticated here that the probable carrier would be Blue Cross, and probably on a nationwide basis" (U.S. House Hearings 1965: 490). This much was unvarnished interest-group politics.

But Mills had more in mind than benefiting Blue Cross. It became clear that he envisioned Blue Cross as an intermediary capable of mitigating resistance to the Medicare program. Mills asked McNerney, "Could we proceed with the statutory requirement administered by you without the charge being made in the confrontation between hospital and Government that Government was trying to some extent to intrude in medicine and hospitalization, do you think?" (U.S. House Hearings 1965: 177). Hospital representatives sounded the same theme. Kenneth Williamson, Associate Director of the American Hospital Association (AHA) stated, "We would like Blue Cross in to handle the payments to hospitals, to administer the cost formula negotiated with the Secretary for reimbursement purposes. . . . We would like them to provide all relationships between the Federal Government."

[17]Wasley (1992: 47–58) provides insightful discussion of the history and impact of Blue Cross and Blue Shield.

Williamson added that the AHA preferred to have Blue Cross provide all hospital "utilization review," because having the federal government do it would cast the government in the role of "appearing to question or interfere in medical practice" in a way that would "cause considerable furor" (U.S. House Hearings 1965: 287).

In short, in Mills's vision Blue Cross would deflect opposition to the expanded involvement of the federal government in crucial medical decisions affecting the survival of older patients—just as employers had deflected public opposition to government by becoming tax collectors under the Social Security and federal income tax withholding laws (Twight 1993, 1995) and just as local draft boards had deflected opposition to military conscription in World War I (Higgs 1987: 133–34). Blue Cross would serve as a lightning rod, increasing the transaction costs to the public of resisting involvement of the federal government in the practice of medicine.

Despite the constraints Mills set on the 1965 House hearings, committee members' fear of the incremental expansion of Medicare was palpable. Rep. Curtis (R., Mo.) said he "would be less worried if this really were the limit of what you are doing, and not . . . just a foot in the door on which to further get the government in" (U.S. House Hearings 1965: 58). Similarly, Rep. Harold R. Collier (R., Ill.) asked HEW's Wilbur Cohen, "Don't you feel that . . . within 4 to 6 years this program . . . would be expanded to full and complete medical coverage of all types?" (U.S. House Hearings 1965: 123). Cohen replied,

> I think that is not necessarily so. . . .[I]t seems to me that it could be avoided by so designing a system of what some people have either called a *three-legged stool, or a three-layer cake*, of basic protection through social security, through Kerr-Mills, and private insurance [U.S. House Hearings 1965: 123–24, emphasis added].

It was the first mention of an idea that was to shape subsequent government involvement in U.S. health care.

To the surprise of many, what emerged from the House Ways and Means Committee with a recommendation for passage was just such a "three-layer cake." In executive sessions closed to the public, Mills proposed and got his committee to approve legislation along the lines suggested by HEW's Cohen. The first layer was compulsory federal hospital insurance under the Social Security program, financed by additional payroll taxes. The second layer was "voluntary" medical insurance ("supplemental medical insurance") that would pay physicians' fees, with premiums half financed by subscriber and—despite the claimed voluntary nature of the insurance—half financed out of general revenues of the federal government. The third layer was an

expansion of the Kerr-Mills program of medical assistance for the elderly poor, financed partly by the federal government and partly by the state governments. The redrafted Medicare provisions were included in a Social Security Amendments bill that was rechristened as H.R. 6675.

Why the three-layer cake? Mills himself stated that inclusion of supplemental medical insurance would "'build a fence around the Medicare program'" (Marmor, 1970, 1973: 69); Derthick (1979: 332) described it as "a buffer against further changes in social insurance."[18] Viewed in terms of transaction-cost-augmentation theory, Mills successfully increased the transaction costs to other legislators and to the public of opposing the Medicare bill. It became a tied "package deal" within the overall package deal of the Social Security Amendments of 1965. There was something in it for everyone. Indeed, many of the standard arguments against compulsory government health insurance were countered by inclusion of programs that were ostensibly "voluntary," that provided for routine doctors' bills, and that increased government medical programs for the needy.

Moreover, following the general practice of the Ways and Means Committee, Mills insisted that the committee's bill be considered by the House under a "closed rule" that prevented floor amendments. In floor discussion, representatives complained bitterly about these transaction-cost-increasing strategies. Rep. Curtis (R., Mo.) said he had "urged that there should be open hearings and people with knowledge in our society on this subject should be given the opportunity to come before us" (*U.S. Cong. Rec.-House* 4 April 1965: 7229). Curtis recounted the secretive nature of the committee's deliberation:

> There was H.R. 1, which was a new bill, 139 pages long, and the confidential print which the chairman had made up for the committee of some 250 pages, which many of us had not seen until it came in. Under the orders of the chairman, this print was not to be taken out of the committee room [*U.S. Cong. Rec.-House* 7 April 1965: 7231].

Rep. Durward G. Hall (R., Mo.), a physician, judged the fact that "at no time during the week this bill was drafted, were the Nation's doctors asked to contribute to the deliberations" to be "the most brazen act of omission ever committed on a piece of major legislation" (*U.S. Cong. Rec.-House* 7 April 1965: 7394). Rep. James D. Martin (R., Ala.) stated that he "would have preferred that hearings be held on the specific legislative proposals now before us so that [he] could

[18]For a contemporaneous account of the emergence of Mills's three-part Medicare program, see Meyers (1965).

study that record" (*U.S. Cong. Rec.-House* 7 April 1965: 7416). Protesting that "for this House to be denied the opportunity to amend such a comprehensive bill—denied even the opportunity to strike one of its titles—is beyond belief," Rep. Delbert Latta (R., Ohio) asked "why the administration and the medicare backers were afraid to let this so-called medicare part of this bill come to the floor of the house by itself—or at least under a rule permitting amendments—and be voted up or down on its own merits" (*U.S. Cong. Rec.-House* 8 April 1965: 7420).

Sentiments ran so high that, despite the Democrats' two-thirds majority, on a motion to recommit the bill 191 representatives voted in favor of the motion, 236 against—perhaps a stronger indication of House sentiment than the vote immediately thereafter on passage of the bill (313 yeas; 115 nays) (*U.S. Cong. Rec.-House* 8 April 1965: 7443–44). Nonetheless, both votes signaled the success of Mills's transaction-cost-increasing strategies.

The bill (H.R. 6675) then went to the Senate, where floor action was not constrained by a closed rule. After voting 64–26 (10 senators not voting) against striking the Medicare provisions from the bill, the Senate voted 68–21 (11 senators not voting) for the bill's passage (*U.S. Cong. Rec.-Senate* 9 July 1965: 16100, 16157). Following conference committee deliberation, Congress adopted the conference committee report: the House of Representatives on July 27 by a vote of 307–116; the Senate on July 29 by a vote of 70–24. President Lyndon B. Johnson signed the Social Security Amendments of 1965 into law on July 30, 1965.[19] As Wasley (1992: 65) put it, "In an instant, with the passage of Medicare and Medicaid, the government had become the largest single purchaser of health care."

Determinants of Transaction-Cost Augmentation in 1965

Political transaction-cost augmentation was indispensable to passage of the 1965 Medicare legislation. We have seen the misrepresentation, cost concealment, tying, incrementalism, and procedural stratagems by which government officials raised the transaction costs to voters of resisting passage of Medicare. Were contemporaneous changes in the posited determinants of political transaction-cost augmentation consistent with the observed outcome?

[19]See Cohen and Ball (1965) for further discussion of congressional action on the Social Security Amendments of 1965 as well as H.R. 6675's substantive provisions. For a useful summary of the differences between the 1965 King-Anderson bill (H.R. 1 and S. 1), the Mills bill (H.R. 6675) as passed by the House, H.R. 6675 as recommended by the Senate Finance Committee, H.R. 6675 as passed by the Senate, and H.R. 6675 as enacted into law, see Feingold (1966: 148–55).

The answer is yes. Some of the determinants, while supportive of government officials' decisions to employ transaction-cost augmentation, did not change in 1965. Several of the key determinants, however, showed changes that gave unique impetus to pro-Medicare political transaction-cost augmentation in 1965.

In 1965 the executive support, party support, ideology, and media publicity variables more strongly favored transaction-cost augmentation on the Medicare issue than in any previous year. Both President Roosevelt and President Truman had favored compulsory national health insurance, but for a variety of reasons—Social Security, World War II, the Korean War—each had had to put Medicare legislation on the back burner. President Kennedy was constrained by his narrow electoral margin. In contrast, after making Medicare a major campaign issue, President Lyndon Johnson won a landslide victory and proceeded to support Medicare actively as one of the pillars of his "Great Society" agenda. Active presidential support for Medicare and the transaction-cost-increasing measures needed to pass it thus encouraged other government officials to employ transaction-cost-augmenting measures on this issue as never before.

Party support for such measures likewise reached unprecedented levels in 1965. With the 1964 elections, Democrats held not only the White House but also two-thirds of the seats in the House and in the Senate, making the 89th Congress "the most heavily Democratic Congress since Franklin Roosevelt's 1936 sweep" (Feingold 1966: 137). The ideology variable also suggested the observed outcome. In 1964 not only were more Democrats elected, but anti-Medicare Democrats were replaced by pro-Medicare Democrats. With more government officials both in Congress and in the administration ideologically favorable to the expanded role for the federal government represented by Medicare, the model would predict that these individuals would be more likely to favor transaction-cost-augmenting measures to that end.

The fact that no public hearings were held in the House of Representatives in 1965 meant that the media were less able to inform the public regarding transaction-cost-increasing features of the legislation. Rep. James F. Battin (R., Mont.) noted that if open hearings had been held "the working press of the country could then have advised the people of all 50 States on what the proposals were, the arguments for and against, and then we as representatives of the people could have had an expression from our constituents on their thinking" (*U.S. Cong. Rec.-House* 8 April 1965: 7399). The lack of publicity given to transaction-cost-increasing features of the legislation also favored government officials' support for such measures.

Variables that continued to influence government officials to support Medicare's transaction-cost-increasing features in 1965 as in previous years included the measure's appealing justification, complexity, perceived importance to constituents, and conduciveness to third-party payoffs and political job security. Medicare was continually represented as, in HEW Secretary Celebrezze's words, a measure designed for the "prevention of dependency and destitution" (U.S. House Hearings 1965: 3). Questioning the validity of that rationale, Senator Long (D., La.) stated that he believed that he "could defeat any Senator in any area of the Nation by showing that old Grandpa Jones had been thrown out for the vultures to take care of after he had exhausted his resources and the benefits available to him under the bill" (*U.S. Cong. Rec.-Senate* 7 July 1965: 15823).

Medicare's complexity also was conducive to transaction-cost augmentation, making it easier for experts to dissemble and for nonexperts to err. Senator Philip A. Hart (D., Mich.) called the 296-page 1965 bill "one of the broadest and most complex collections of social security amendments ever brought before this body" (*U.S. Cong. Rec.-Senate* 7 July 1965: 15812). From a congressman's perspective, the apparent importance of Medicare to major groups of constituents—such as the elderly and adult children with aged parents—also favored transaction-cost augmentation in support of such legislation. The Medicare program also promised third-party payoffs, given the diverse and powerful special-interest groups involved. The passage of time in the years leading up to 1965 served chiefly to entrench beneficiary interest groups. Finally, Medicare heralded enhancement of political job security by creating new and broad-based dependence on government.

For the first time, in 1965 all of the determinants of transaction-cost augmentation pushed in the same direction on the Medicare issue. Concomitantly, after decades of rejecting compulsory health insurance, Congress relied heavily on transaction-cost augmentation in passing Medicare legislation.

Conclusion

Congress members knew in 1965 that in passing Medicare they were legislating for all time to come. Political transaction costs had been molded to accomplish precisely that end. Senator Mundt (R., S.D.) regarded it as an "irreversible step" in that Medicare "would be exceedingly difficult to discontinue without breaking faith with those who have to pay the tax" (U.S. House Hearings 1963–64: 264). Senators and administration officials alike understood that they were

"legislating in perpetuity" and would face strong pressures to expand the program (U.S. Senate Hearings 1965: 134). They also knew that Medicare would create a vast new public dependence on the federal government for financial security in old age, continuing the pattern set by Social Security in 1935. Senator Mundt (R., S.D.) described it as "another step toward destroying the independence and self-reliance in America which is the last best hope of individual freedom for all mankind" (*U.S. Cong. Rec.-Senate* 9 July 1965: 16122). Moreover, legislators knew that Medicare would take money from the poor and middle classes to subsidize the rich. Senator Gordon Allott (R., Colo.) described it to the Senate as a "program of 'Robin Hood in reverse' " that showed "complete disregard for need in disbursement" and represented a "giant step" toward making "every citizen as dependent as possible on his Government for his every need" (*U.S. Cong. Rec.-Senate* 8 July 1965: 15935).

But they also knew that Medicare would serve their political interests. As majority leader Rep. Carl B. Albert (D., Okla.) told his colleagues on the House floor, H.R. 6675 "is a bill which in my opinion will serve well those of us who support it, politically and otherwise, through the years" (*U.S. Cong. Rec.-House* 8 April 1965: 7435). Or, as Rep. Phillip Burton (D., Calif.) more crassly expressed it, "This bill is going to put into the pockets of my fellow Californians some $213 million its first year . . . All in all our fair State and its people in the first year will be favored to the tune of some $550 million, a not modest sum" (*U.S. Cong. Rec.-House* 8 April 1965: 7429). Without doubt, the Social Security Amendments of 1965 were "so drafted that quite a bit of honey [had] been placed under the beehive in order to attract the bees" (*U.S. Cong. Rec.-Senate* 9 July 1965: 16071).

We have seen that political transaction-cost augmentation enabled government officials to embed Medicare in America's institutional structure at precisely the time when all the theoretical determinants of such behavior supported its pro-Medicare use for the first time in U.S. history. Indeed, the strategies most influential in passing and entrenching Medicare had as their goal and effect the manipulation of political transaction costs. By tying Medicare with a 7 percent increase in Social Security benefits, proceeding incrementally, narrowing the bill's coverage, misrepresenting its content, concealing its costs, and using countless other transaction-cost-increasing strategies described in this paper, government supporters of Medicare were able to achieve their objectives. These same tools, so instrumental in passing Medicare, today continue to serve those who seek further increases in federal control over U.S. health care. Their recent use in enacting previously reviled features of President Clinton's 1993

Health Security Act as part of the Health Insurance Portability and Accountability Act of 1996 warns anew of their potent ongoing role in the growing power of the federal government to control personal health care decisions (Twight 1998).

On the day the House of Representatives passed the Social Security Amendments of 1965, Rep. Hall (R., Mo.) spoke at length about the attempt being made under Medicare "to conceal the grant of power which would be extended to the Secretary of Health, Education, and Welfare to interfere with administration and medical practice in participating hospitals." Explaining why the federal government could not tell engineers and bookkeepers how to do their jobs, he remarked that "Men bred in freedom learn to like the taste of it" (*U.S. Cong. Rec.-House* 8 April 1965: 7392). From the perspective of many government officials who had pushed for decades to institutionalize Medicare, that was the point. In the future, fewer would learn to like the taste of it. So it has been. Americans' willingness in 1993 to seriously discuss a virtual government takeover of medical practice in the United States via President Clinton's 1,342-page Health Security Act attests to the long-run power of such changed institutions to reshape people's ideologies and thus the degree of government authority to which they acquiesce.

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The Market Value of Family Values

Ralph Chami and Connel Fullenkamp

Recently, family issues have received much attention from politicians and social commentators. The debate has centered, for the most part, on the decline of "family values" and the commensurate decline of "work ethic" among partcipants in the labor market. Although economists have no way of measuring values or work ethic directly, they may nonetheless be able to find evidence of changes in values and work ethic to the extent that these changes affect different markets. An extensive literature on the economics of the family has emerged over the past 20 years that documents and analyzes economic interactions between family members, such as bequests and gifts, or inter vivos transfers. When it comes to showing the impact of these family interactions on labor and financial markets, however, economists for the most part have remained on the sidelines. In this paper, we bring economics to the heart of the discussion of family values by using the insights gleaned from existing and recent work on the family to forge and highlight the integral link between the family and the market.

Family Income Transfers and Family Values

Among economists it is well known that familial economic support—whether between parents and children or between spouses—is quite common and represents a significant portion of U.S. wealth accumulation. Moreover, there is now an extensive literature on these transfers that documents their size. Kotlikoff and Summers (1981) estimate bequests to account for four-fifths of U.S. wealth accumulation, Cox (1987) gives an estimate of 63 billion dollars in inter vivos transfers and 40 billion dollars in bequests (in 1979 dollars), and more recently

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