

BURR ARTICLE

Health Care Reform in America: The Good, The Bad And The Ugly



Health care providers, the insurance industry, and all of us as health care consumer continue to experience the difficult birth pangs of the Patient Protection and Affordable Care Act ("ACA" or the "Act"). Political battles rage in many states over whether to adopt the Medicaid expansion option called for by the Act, numerous congressional attempts to repeal parts or all of it have been mounted and not doubt will continue, and two lawsuits challenging important provisions of the Act have reached the United States Supreme Court. The natural inclination is to view the ACA as unique in its scope, impact and political implications. But such a view is myopic, for the road to health care reform in America is well traveled. Every American presidential administration following the end of World War II has, to some extent, proposed or supported changes to the health care system in this country. And many of those previous reform proposals hold similarities to some provisions in the ACA.

This is not the first time the nation has debated controversial health care reform proposals. This is not the first time bitter partisan politics have complicated, and sometimes obfuscated, attempts at reform. Some attempts at health care reform have succeeded and some have failed, and the political process has often been ugly and divisive. Here is a look at some past attempts at health care reform in the post war era: the good, the bad, and the ugly.

The Truman Administration (1945-1953)

The first attempt at health care reform in the post-war era occurred during the administration of President Harry S. Truman. His predecessor Franklin D. Roosevelt did little to advance the cause, and health care accessibility was one of the few societal needs not addressed in the New Deal programs. There is evidence President Roosevelt intended to pursue some form of health care reform after the end of World War II, but he died before then, in April 1945.

President Truman recommended to Congress a proposal known as the Wagner-Murray-Dingell bill consisting of nine goals to be achieved over a ten-year period. Universal health insurance coverage, administered and paid for by a National Health Insurance Board, was third down the list of priorities. The first two priorities were increasing the number of medical practitioners—primarily doctors and nurses—and increasing hospital expansion and construction. Opponents of the proposal, including the American Medical Association (AMA), decried it as “socialized medicine” and the bill died in Congress. Truman made a second effort at health care reform in 1948, following his re-election, but the outbreak of the Korean War proved to be the death knell of the proposal.

The Truman administration’s efforts were not all for naught, however; the second priority of Wagner-Murray-Dingell, increasing the number of hospitals in the U.S., was achieved. The Hospital Survey and Construction Act of 1946 (commonly known as the Hill-Burton Act), was passed by Congress in 1946. The

law provided federal grants and loans to build, expand and modernize hospitals. In the first six months of the program, grants were approved for 347 hospital projects, adding 11,346 new hospital beds at a cost to the federal government of \$160,734,258.¹ In today's dollars, adjusted for inflation, that amounts to more than \$1.3 billion.² The consequences of the rapid and unregulated growth in health care facilities would require future legislation, during the Ford administration, to bring it under control.

The Eisenhower Administration (1953-1961)

With its focus on the emerging Cold War, the Eisenhower administration supported only limited health care reform proposals. In 1956 the "Military Medicare" program was enacted, providing payment for health care services for military dependents.³ The administration supported the Forand bill, which would provide health insurance for Social Security beneficiaries. Despite support from the AFL-CIO, the Forand bill never gained much traction in Congress.

The Kennedy Administration (1961-1963)

The Kennedy administration pursued a more modest form of health care coverage than that proposed in the Wagner-Murray-Dingell bill. Under the King-Anderson bill coverage would be limited to those 65 years of age and older, and be part of the Social Security benefits package. In so doing, Kennedy laid additional blocks to the foundation of what would ultimately become Medicare.

Frustrated by the efforts of "special interests" to kill the proposal, President Kennedy took his case on the road directly to the public. On May 20, 1962, a series of 33 public rallies were simultaneously held in various parts of the country. The President made a personal appearance and a nationally televised speech at the largest of those—Madison Square Garden in New York City with 17,500 attendees inside and a crowd estimated at 2,500 in standing-room-only outside the arena.⁴

In a speech at the rally, President Kennedy confidently predicted the King-Anderson bill would pass Congress "this year, or as inevitably as the tide comes in, next year." President Kennedy was wrong. Opposed by the powerful AMA and with help from conservative Democrat Wilbur Mills, Chairman of the House Ways and Means Committee, the bill was defeated in Committee. President Kennedy did not live to see the proposal's chances through the following Congress, and the mantle was passed to Lyndon Johnson.

The Johnson Administration (1963-1969)

Lyndon B. Johnson won a landslide victory to be elected to a full term as president in November 1964. The concurrent Senate and House of Representatives races were virtual Democratic sweeps, giving the Democrats a super-majority in both houses,⁵ and President Johnson a receptive body for the extensive social reforms he dubbed the Great Society.

Despite continued vocal opposition from the AMA and some conservative Republicans,⁶ the Medicare and Medicaid legislation steamrolled through Congress. It was introduced in the House Ways and Means Committee in March of 1965, gained final approval by the Senate on July 28, 1965 and was signed into law by President Johnson on July 30, 1965.⁷

As originally enacted, the Social Security Amendments of 1965 provided health care coverage to those 65 years of age and older, and to the poor, blind and disabled. It covered health care services provided by hospitals, physicians, nursing facilities and home care providers. As of 2012, there were approximately 40.5 million Medicare beneficiaries.⁸ As of 2009, there were approximately 62 million Medicaid

beneficiaries.⁹ It would not be long before proposals for health coverage for those not covered under Medicare/Medicaid would surface.

The Nixon Administration (1969-1974)

In 1971, the Nixon administration proposed the National Health Insurance Standard Act (NHISA). The proposal called for government-prescribed minimal levels of insurance coverage, mandated to be provided through employers and financed by payment of premiums by employers and employees. This plan would maintain competition between private insurers and expand coverage. The NHISA would also provide government subsidies for premiums for certain employees.

A competing proposal was advanced by a familiar Nixon nemesis, the Kennedys; this time it was Sen. Edward M. Kennedy of Massachusetts. Kennedy introduced the Health Security Act, calling for a single federal payor, providing comprehensive health coverage for nearly all Americans. Although the Health Security Act never advanced far in Congress, it was the beginning of a career-long effort by Sen. Kennedy at major health care reform.¹⁰

While the NHISA did not pass, Nixon was successful in gaining passage of the Health Maintenance Organization Act of 1973, which laid some of the groundwork for managed care. Also enacted during Nixon's term of office were relatively minor amendments to the Medicare program, expanding coverage to certain recipients of Social Security disability benefits and to individuals with end-stage renal disease.¹¹

The Ford Administration (1974-1977)

The abbreviated Ford presidency was consumed by healing the nation's post-Watergate wounds ("our long national nightmare," as President Ford termed it), and fighting runaway domestic inflation. The unrestrained and federally incentivized growth of health care facilities, ushered in by Hill-Burton in 1946, and exacerbated by the infusion of vast federal funds into the health care payment system, were seen as contributing causes to medical inflation. The National Health Planning and Resources Development Act of 1974 (HPRDA) was an effort to reign in escalating health care costs.

The HPRDA called for local health resource planning within federally designated health planning areas across the country. The goals were to reduce and avoid unnecessary duplication of facilities and services, provide for a rational allocation of needed health care services, and facilitate equal access to quality care at reasonable cost. The HPRDA essentially mandated Certificate of Need (CON) programs in the states. Although the CON mandate of the HPRDA was repealed in 1986, 36 states, including Tennessee and the District of Columbia operate CON programs today.¹²

The Carter Administration (1977-1981)

Jimmy Carter campaigned for president calling for national health care insurance with universal coverage, and as president he went to work to prepare a legislative proposal for the same. The American Hospital Association endorsed the concept in principle, but had reservations about any system that took a universal, "one size fits all" approach. The details of President Carter's plan never received much of a congressional or public audience, as a deep recession and other economic issues took priority.

Other than the tepid support of the AMA, little other health care industry or public support was apparent. President Carter later maintained he had strong support from the chairmen of the House and Senate committees with responsibility for health care legislation, and could have succeeded in passing his proposal had it not been for the abrupt withdrawal of support by one of those chairmen. Ironically, the

vacillating Senate committee chairman was none other than Sen. Edward M. Kennedy.¹³ (Senator Kennedy was to run against Carter for the Democratic presidential nomination in 1980.)

The Reagan Administration (1981-1989)

In his inaugural address, after lamenting the consequences of excessive government borrowing and deficit spending, President Reagan declared: “In this current crisis, government is not the solution to our problem. Government is the problem.” There were no administration proposals for new government run or administered health care programs under President Reagan.

During President Reagan’s term of office several new laws were enacted, aimed primarily at reducing the growth in federal spending on health care and improving efficiencies. This was to be accomplished by changing Medicare reimbursement methodologies—in most cases reducing reimbursement to hospitals and physicians—and stepping up anti-fraud measures.

But the Reagan Administration also advanced through Congress the first major expansion of Medicare benefits: the Medicare Catastrophic Coverage Act of 1988 (MCCA). The law expanded Medicare coverage for outpatient drugs, put a ceiling on out of pocket co-pays for hospital and physician services, and modestly expanded payments for long term care. The program was to be funded entirely by Medicare beneficiaries through increased premiums, and a surtax on wealthier beneficiaries based on income.

The George H.W. Bush Administration (1989-1993)

President George H.W. Bush inherited a political catastrophe in the Medicare Catastrophic Coverage Act of 1988. Among the elderly there was widespread disappointment over the level of expanded benefits and strong resentment over having to pay higher premiums and taxes to fund it.¹⁴ These sentiments led to a senior revolt against the law, and in 1989—just 17 months after it was enacted—a bipartisan effort in Congress repealed most of the MCCA.

President Bush’s agenda for health care legislation consisted of additional measures to reduce the growth of federal health care spending and reduce fraud and abuse in the Medicare and Medicaid programs. Notable among the enactments in the Omnibus Budget Reconciliation Act of 1989 (OBRA) were changes in Medicare physician payments from a charge-based system to the Resource Based Relative Value Scale (RBRVS), and a prohibition on physician “self-referrals” for clinical laboratory services (Stark I).

The Clinton Administration (1993-2001)

Bill Clinton was the first Democrat elected president in 12 years, and his administration wasted little time in proposing major health care reforms. After the release of a report by a highly controversial task force headed by First Lady Hillary Clinton, President Clinton sent the American Health Security Act of 1993 (AHSa) to Congress. It proposed to provide affordable health insurance for all through a concept called “managed competition.” Health insurance coverage would be provided through private insurers competing for customers in a highly regulated market, overseen and coordinated by regional health alliances to be established in each state. All health plans would be required to provide a minimum level of benefits. Employers would be required to provide insurance coverage for their employees and pay 80 percent of the premium.¹⁵

The AHSa was opposed by much of the health care industry and the health insurance industry. It was subjected to bitter partisanship in Congress, with even Democratic lawmakers split and some offering

alternative or compromise plans. By September 1994, the proposal was declared dead by Senate Majority Leader George Mitchell.¹⁶

Other important health care reform measures were enacted during President Clinton's term of office.¹⁷ Among the notable reforms were The Health Insurance Portability and Accountability Act (HIPAA), which greatly improved the continuity or "portability" of health insurance plans, and authorized the promulgation of regulations protecting the privacy of health records, now the hallmark of HIPAA. The Stark physician self-referral law was significantly expanded to cover additional clinical services, and extended to cover Medicaid as well as Medicare (Stark II). The State Children's Health Insurance Program (SCHIP) was created, providing federal matching funds for pooled risk health insurance coverage for families of modest income with children.

The George W. Bush Administration (2001-2009)

President George W. Bush bore the burden of being President during the tragedy of 9/11. Much of his presidency, especially his first term, was consumed with the aftermath of that and the war on terrorism at home and abroad. It is understandable that health care reform was not at the top of his agenda for many practical as well as political reasons.

President Bush's domestic legacy does, however, include one of the largest expansions of Medicare in the program's history. The Medicare Drug Improvement and Modernization Act of 2003 (MMA) made numerous changes to the Medicare program, the most important of which is the prescription drug coverage benefit, created as Medicare Part D.

The MMA allows for voluntary participation by Medicare enrollees, and is available only through private insurers offering Medicare Advantage plans. The most controversial aspect of the Part D prescription drug benefit is the so-called "doughnut hole," a coverage gap requiring the beneficiary to pay 100 percent of drug costs when the cumulative annual cost of drugs is between approximately \$2,200-\$5,000.¹⁸

The MMA passed by narrow margins in both the House and the Senate. In each chamber, the vote was almost straight down party lines, with Republicans controlling the "Yea" vote.¹⁹ The Part D benefit is still confusing and frustrating to many Medicare beneficiaries.

The Obama Administration (2009-present)

It came as little surprise that President Obama made health care reform one of his first priorities: he campaigned on the promise of sweeping changes to the health care system in an effort to reduce costs and make coverage available to most Americans. He sent a major reform bill to Congress within six months of the inauguration.

A painful political process ensued. Bitter partisan divisiveness, debates over the public option health plan, public misinformation (e.g., allegations the legislation provided for "death panels"), and charges of socialized medicine filled the airwaves, Internet and print media. After much political maneuvering and intrigue rarely seen even in Washington, the legislation gained the final necessary House of Representatives approval on March 21, 2010.²⁰ The Patient Protection and Affordable Care Act was signed into law on March 23, 2010.

On June 28, 2012, the United States Supreme Court issued its ruling in *National Federation of Independent Business v. Sebelius*, 132 S.Ct. 2566 (2012). In a creatively crafted opinion, Chief Justice Roberts wrote for the majority upholding the constitutionality of all but one of the major provisions of the ACA. The Court

ruled: (1) the individual mandate is a permissible exercise of Congress' taxing power and thus constitutional, and (2) the Medicaid expansion "cram down" provision (essentially requiring all states to expand Medicaid coverage to all otherwise eligible individuals with incomes up to 133 percent of the federal poverty level) is an impermissible exercise of Congressional power and thus unconstitutional.

In its irreducible essence, the ACA provides for: (1) a mandate for "large" employers to provide health insurance coverage for its employees; (2) a mandate for virtually all citizens to have health insurance coverage through an employer sponsored plan, a government plan, or an individual plan; (3) creation of federal and/or state health care exchanges to facilitate obtaining health care insurance; (4) federal financial subsidies for health care insurance for individuals meeting low income standards; (5) a mandate that all plans provide a certain minimal level of essential benefits; and (6) prohibitions against denials of coverage based on pre-existing conditions and against lifetime benefit limits.

Conclusion

The ACA is in some respects a conglomeration of some of the pieces of past proposals for major health care reform. The provision of health insurance coverage through private insurers instead of directly through the government, employer mandated health insurance, the creation of state, regional or national clearinghouses for insurance, federal subsidies for low-income individuals, and "guaranteed eligibility" have all been proposed in previous attempts at reform.

Partisan divisiveness, bitter congressional fights, grass roots campaigns and political intrigue have been ubiquitous characteristics of health care reform efforts. But in the end, the democratic process has worked. Legislation deemed not in the public interest has been defeated in Congress, and enacted legislation that proved to be unpopular or unworkable has been repealed. When the final chapter on the efficacy of the ACA is written, it is hoped history will record that the American system worked yet again—the good, the bad, and the ugly.



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15. See Goodridge & Arnquist, *supra* note 10.

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17. See H&HN, *supra* note 3.

18. [Govtrack.us](https://www.govtrack.us), H.R. 1 (108th): *Medicare Prescription Drug, Improvement, and Modernization Act of 2003*, <https://www.govtrack.us/congress/bills/108/hr1>; Ellen Shaffer, *The Medicare Prescription Drug Improvement and Modernization Act, Our Bodies, Ourselves Health Resource Center* (rev. June 2004), <http://www.ourbodiesourselves.org/book/companion.asp?id=26&compID=96>.

19. The House vote was 220 Yea (204 R, 16 D)-215 Nay (25 R, 189 D, 1 I). The Senate vote was 54 Yea (42 R, 11 D, 1 I)-44 Nay (9 R, 35 D) [Govtrack.us](http://www.govtrack.us), *supra* note 18.

20. The final vote tally was Senate Yea 60 (58 D, 2 I)-Nay 39 (0 D, 39 R); House Yea 219 (219 D, 0 R)- Nay 212 (34 D, 178 R). [Govtrack.us](http://www.govtrack.us), *supra* note 18.