

Health Care Reform In America: The Good, the Bad and the Ugly

by: Jerry W. Taylor



Introduction

As we prepare for the roll out of the Patient Protection and Affordable Care Act—whether with trepidation or optimistic anticipation—it may be instructive or at least insightful to examine past attempts at major health care reform in the United States. 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.

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 been good, some have been bad, and the political process has nearly always being 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, 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 third 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 over \$1.3 billion.² The consequences of the rapid and un-regulated growth in health care facilities would require future legislation 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.

illustrated 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." He was wrong. Opposed by the powerful A.M.A. 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, 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 A.M.A. and some conservative Republicans,⁶ the Medicare and Medicaid legislation steam-rolled 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. 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 ground work 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 run-away 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, thirty-six 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 A.M.A., 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

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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 wide-spread 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 (OBRA) of 1989 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% 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 was 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.

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almedia.pdf (Jan. 4, 2012) [hereinafter "National Risk Alert"].

¹⁷ 17 C.F.R. § 206(4)-7 (2013).

¹⁸ U.S. Sec. & Exch. Comm'n, *General Information on the Regulation of Investment Advisers*, <http://www.sec.gov/divisions/investment/iaregulation/memoia.htm> (modified Mar. 11, 2011).

¹⁹ National Risk Alert, *supra* note 9 at 2.

²⁰ *Id.* at 4-5.

²¹ FINRA, Regulatory Notice 10-06: Social Media Websites, (Jan., 2010), <http://www.finra.org/web/groups/industry/@ip/@reg/@notice/documents/notices/p120779.pdf>.

²² FINRA, Regulatory Notice 11-39: Social Media Websites and the Use of Personal Devices for Business Communications, (Aug. 2011), <http://www.finra.org/web/groups/industry/@ip/@reg/@notice/documents/notices/p124186.pdf>.

²³ Christopher Garcia & Melanie Conroy, *Reg FD Alert*, WEIL, GOTSHAL & MANGES LLP (Dec. 2012) (Client Alert) available at http://www.weil.com/files/upload/Weil_Alert_Sec_Lit_Enforcement_Dec_21_2012.pdf.

²⁴ FINRA modified NASD Rule 2210, but the rule is now codified as FINRA 2210. FINRA became the successor for NASD in 2007 when the SEC approved the formation of a new regulator which combined the member regulation and enforcement functions of NASD and the arbitration functions of the New York Stock Exchange. FINRA, NASD 2210: Communications with the Public, http://finra.complinet.com/en/display/display_main.html?rbd=2403&element_id=3617.

²⁵ *Id.* at (d)(1)(A).

²⁶ Regulatory Notice 10-06, *supra* note 14 at 4.

²⁷ *Id.* at 5.

²⁸ 17 C.F.R. § 240.17a-3 (2013) (specifying the records to be made by certain exchange members, brokers and dealers).

²⁹ 17 C.F.R. § 240.17a-4 (2013) (explaining the records to be preserved by certain exchange members, brokers and dealers).

³⁰ NASD Rule 3110 is still the current rule. FINRA has not issued a replacement rule.

³¹ Regulatory Notice 10-06, *supra* note 14 at 3. NASD Rule 2310 is now FINRA Rule 2111: Suitability. Rule Conversion Charts, FINRA, <http://www.finra.org/Industry/Regulation/FINRARules/p085560> (last visited Aug. 12, 2013).

³² NASD Rule 3010 is still the current rule. FINRA has not issued a replacement rule.

³³ FINRA, Filing Communications for FINRA Review, <http://www.finra.org/Industry/Issues/Advertising/FAQ/#4-1>.

³⁴ See Letter from Alexander Gavis, FMR LLC Legal Department, to U.S. Sec. & Exch. Comm'n (Aug. 24, 2011), available at <http://www.sec.gov/rules/interp/571100/gavis1.htm>.

³⁵ U.S. Sec. & Exch. Comm'n, *Report on Massachusetts Registered Investment Advisers' Use of Social Media* (2012) available at <http://www.sec.state.ma.us/sct/sctmediasurvey/socialmedia.pdf>.

³⁶ Nick Paraskeva, *Social Media Broker-Dealer Compliance Checklist*, 2 Checklists for Corporate Counsel § 12:14 (April 2013).

³⁷ This paper does not reflect the views of the Tennessee Department of Commerce and Insurance or any other government agency. All views expressed are my own and have no reflection on the views of the Tennessee Department of Commerce and Insurance.

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% 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 (PPACA) 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*, 567 U.S. _____ (2012). In a creatively crafted opinion, Chief Justice Roberts wrote for the majority upholding the constitutionality of all but one of the major provision 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% 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.

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Conclusion

The PPACA 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 PPACA 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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(Endnotes)

¹ *Hospital-Aid Plan Has 347 Projects*, N.Y. TIMES, July 2, 1948.–

² areppim, Mathematical and Financial Calculators, http://stats.areppim.com/calc/calc_usdldrdeflator.php.

³ Hospitals & Health Networks, *American Presidents and Health Reform: A Chronology*, H&HN MAGAZINE (Feb. 2009), available at http://www.hhnmag.com/hhnmag/jsp/articledisplay.jsp?dcrpath=HHNMAG/Article/data/02FEB2009/0902HHN_CoverStory_WebExtra&domain=HHNMAG.

⁴ *Kennedy Exhorts Public To Support Medical Care Bill*, N.Y. TIMES, May 21, 1962.

⁵ Following the elections the Democrats held close to a 3/4 majority in the Senate and approximately a 2/3 majority in the House of Representatives. Social Security Admin., *Vote Tallies for Passage of Medicare in 1965*, <http://www.ssa.gov/history/tally65.html>.

⁶ Among the notables opposing the Medicare legislation were Ronald Reagan, Bob Dole, George H.W. Bush, and Barry Goldwater. Igor Volsky, *Flashback: Republicans Opposed Medicare in 1960s by Warning of Rationing "Socialized Medicine"*, ThinkProgress (July 29, 2009), <http://thinkprogress.org/health/2009/07/29/170887/medicare-44/>.

⁷ The vote tally was 70-24-6 in the Senate, and 307-116-10 in the House. Social Security Admin., *supra* note 5.

⁸ The Kaiser Foundation, *Total Number of Medicare Beneficiaries* (2012), <http://kff.org/medicare/state-indicator/total-medicare-beneficiaries/>.

⁹ Census Bureau, *The 2012 Statistical Abstract*, http://www.census.gov/compendia/statab/cats/health_nutrition/medicare_medicaid.html.

According to the Centers for Medicare and Medicaid Services (CMS), at any one time approximately 15% of the total Medicaid population is also enrolled in Medicare Terrence Jeffrey, *Medicaid and Medicare Enrollees Now Outnumber Full-Time Private Sector Workers*, cnsnews.com (Oct. 12, 2012), <http://cnsnews.com/news/article/medicaid-and-medicare-enrollees-now-outnumber-full-time-private-sector-workers>.

¹⁰ Elizabeth Goodridge & Sarah Arnquist, *A History of Overhauling Health Care*, N.Y. TIMES (2010), http://www.nytimes.com/interactive/2009/07/19/us/politics/20090717_HEALTH_TIMELINE.html?_r=0.

¹¹ H&HN, *supra* note 3.

¹² American Health Planning Assoc., *Certificate of Public Need* (2009), <http://www.ahpanet.org/copn.html>.

¹³ Christine Delargy, *Jimmy Carter: We Could Have Had Health Care Reform in the 1970s*, CBS News (Dec. 1, 2010), http://www.cbsnews.com/8301-503544_162-20024330-503544/jimmy-carter-we-could-have-had-health-care-reform-in-1970s/.

¹⁴ See *Retreat in Congress; The Catastrophic-Care Debacle-A Special Report; How the New Medicare Law Fell on Hard Times in a Hurry*, Special to N.Y. TIMES, Oct. 9, 1989.–

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

¹⁶ Boundless, *The Health-Care Plan of 1993*, <http://www.boundless.com/u-s-history/the-challenges-of-globalization-and-the-coming-century-after-1989/the-clinton-administration/the-health-care-plan-of-1993/>.

¹⁷ See H&HN, *supra* note 3.

¹⁸ 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, *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, *supra* note 18.