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A Brief History of Health Care Reform in America

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I. Introduction

On March 23, 2010, President Barack Obama signed the *Patient Protection and Affordable Care Act* (Affordable Care Act). The measure became law when, on March 30, 2000, he also signed the *Health Care and Education Reconciliation Act of 2010* which had been passed by both the House and the Senate. By many accounts, the resulting law is one of the most sweeping and far-reaching national reform acts since the *Civil Rights Act of 1964*. Indeed, it promises to reform the national health care system in a variety of ways that will impact virtually every member of American society -- personally, financially and/or professionally.

Although the *Affordable Care Act* marks an important time in American politics, national health care reform is not a modern concept. Rather, it is an idea that finds its roots in models that European countries first used in the late 1800's and has been a consistent piece of the American political dialogue since the early 1900's. Understanding the prior efforts at – and obstacles to – national health care reform therefore is essential to understanding how the Affordable Care Act became law. It also provides an important context that should prove useful when trying to forecast exactly how the Affordable Care Act will shape the future of American society.

The Late 1800's: European Examples

A number of developed countries have had some form of social (or "national") insurance since the late 19th century. One of the first was Germany, which adopted compulsory sickness insurance for workers in 1883. Over the next few decades, other European nations (including Austria, Hungary, Norway, Britain, Russia and the Netherlands) followed suit. During that time, Sweden (in 1891), Denmark (in 1892), France (in 1910) and Switzerland (in 1912) all began subsidizing the mutual benefit societies that their countries' workers had formed for themselves.

Most historians observe that the European social insurance programs were not initially conceived to help individuals pay for medical care. Instead, they were primarily designed to help stabilize incomes by protecting workers against a loss of wages when they got sick.

The Early 1900's: Teddy Roosevelt and The Progressive Era

By the early 1900's, the United States was an industrialized nation, and reformers of the time were working to improve social conditions for the working class. However, there was not enough popular or political support to enact broad social insurance programs. As a result, the federal government took no action to make sickness insurance mandatory and did not act to

subsidize private funds being used to pay for medical care. Rather, it left such matters to the states which, in turn, largely left them to private and voluntary programs.

One of the first American politicians to address the subject was Teddy Roosevelt. In August of 1912, he delivered an address at the *National Progressive Party*'s convention in Chicago which both cited the European examples of social insurance and stressed the importance of a social welfare system to the American economy. In his words:

> "*It is abnormal for any industry to throw back upon the community the human wreckage due to its wear and tear, and the hazards of sickness, accident, invalidism, involuntary unemployment, and old age should be provided for through insurance. This should be made a charge in whole or in part upon the industries the employer, the employee, and perhaps the people at large, to contribute severally in some degree. Wherever such standards are not met by given establishments, by given industries, are unprovided for by a legislature, or are balked by unenlightened courts, the workers are in jeopardy, the progressive employer is penalized, and the community pays a heavy cost in lessened efficiency and in misery. What Germany has done in the way of old age pensions or insurance should be studied by us, and the system adapted to our uses, with whatever modifications are rendered necessary by our different ways of life and habits of thought."*

The National Progressive (or "*Bull Moose*") Party then adopted the concept of social insurance as part of its platform. In the ensuing election, though, Roosevelt and William Howard Taft divided the Republican vote, and Woodrow Wilson (the Democratic nominee) was elected President.

World War I: Polarized National Debate

In 1915, the *American Association of Labor Legislation* (AALL) drafted a model bill which called for workers, employers and states to share in the cost of making the services of physicians, nurses and hospitals available to the working class (and others earning less than $1,200 per year). It also provided for sick pay, maternity benefits, and a modest death benefit to cover funeral expenses.

The *American Medical Association* (AMA) initially supported the model bill, forming a committee to work with the AALL in 1916 and endorsing its compulsory health insurance proposal in 1917. Nevertheless, there was no consensus about how physicians would be paid, and many state medical societies opposed it. As a result, the AMA's leadership later denied it had ever favored the measure.

Meanwhile, the president of another labor organization – the *American Federation of Labor* (AFL) – objected that compulsory health insurance would create a system of state supervision over people's health that was both unnecessary and would weaken unions by usurping their role in ensuring social benefits for workers. The commercial insurance industry also opposed the measure, in part because the modest death benefit for which it would provide would compete with a profitable line of life insurance being marketed at the time.

While opposition from the medical community, organized labor, the insurance industry and business all contributed to the initial failure of the AALL's proposal for a compulsory national health insurance program, that opposition gained even greater strength when the United States entered World War I. The government commissioned articles denouncing "German socialist insurance," and opponents deemed it a "Prussian menace" that was inconsistent with American values. The anti-Communist rhetoric of the day therefore stalled any meaningful effort at national health care reform.

The 1920's: Committee on the Cost of Medical Care

During the 1920's, health care costs began to rise, both because the middle class began using hospital services and because hospital expenses started to increase. Medical care was becoming a larger part of family budgets, and controlling those costs was regarded as a more serious problem than protecting workers against the loss of wages because of sickness.

In 1926, a collection of philanthropic organizations formed the *Committee on the Cost of Medical Care* (CCMC), a privately-funded group that included economists, physicians, public health specialists and members of certain interest groups. The CCMC's research concluded that more medical care was needed for all Americans, and it recommended that more of the nation's resources be devoted to medical care. However, most of the CCMC's members opposed compulsory health insurance. As a result, the group advocated voluntary health insurance as the best way to provide for the rising costs of medical care.

Appealing to the anti-Communist sentiment of the time, the AMA characterized the CCMC's recommendations as a call for socialized medicine and "an incitement to revolution." In any event, the economic pressures of the *Great Depression* postponed any meaningful attempt to act on those recommendations.

1930-1945: FDR and The New Deal

With millions of Americans out of work, unemployment insurance and "old age" benefits were a greater priority during the early portions of Franklin D. Roosevelt's tenure (1933-1945). The *Committee on Economic Security* therefore feared that including compulsory health insurance – which the AMA opposed -- as part of the Social Security Bill would threaten its passage. In turn, FDR excluded it from the bill, choosing instead to provide matching funds to states for expanded public health and maternal/child health services.

In 1937, FDR formed a *Tactical Committee on Medical Care* to further study the nation's health insurance needs. Many of the committee's recommendations were incorporated into the *National Health Act of 1939* (aka "*The Wagner Bill*"), which generally supported a national health program that would be funded by federal grants and administered by state and local governments. However, the 1938 election brought a conservative resurgence to American politics, and the declining fortunes of the New Deal made such an innovation in social policy difficult to enact.

Over time, the *Wagner Bill* evolved from a proposal for federal grants into a proposal for national health insurance. It was re-introduced in 1943 as the *Wagner-Murray-Dingell Bill*, a piece of legislation which called for compulsory national health insurance that would be funded by payroll taxes. In 1944, the *Committee for the Nation's Health* (a group representing

organized labor, progressive farmers and liberal physicians) aggressively lobbied for the bill's passage. However, the support that organized labor gave to the bill served only to intensify opposition to it. As a result, Congress never passed the *Wagner-Murray-Dingell Bill* – even though it was re-introduced in every session for the next 14 years.

1945-1953: Truman and The Cold War

Although his presidency was characterized by the Cold War and Communism, Harry Truman revived the American political debate over health care reform by fully endorsing a national health insurance program.

FDR had previously proposed a program that would provide medical care for the needy. In contrast, Truman's plan was strongly committed to a universal and comprehensive health insurance plan that would include all classes of American society. To minimize opposition from the insurance industry, Truman dropped any provision for a death benefit that would cover funeral expenses. To combat the growing crusade against Communist influence in America, he also emphasized that it did not call for "socialized medicine." Regardless of those efforts, many in Congress seized the opportunity to politicize the issue: the Chairman of the House Committee was an anti-union conservative who refused to hold hearings; a senior Republican senator described the proposal as "the most socialistic measure this Congress has ever had before it."

Other groups (including the *American Hospital Association* and the *American Bar Association*) publicly opposed Truman's plan. The AMA expressed its opposition by, among other things, claiming it would turn doctors into slaves.

When the Republican Party took control of Congress in 1946, it charged that national health insurance was part of a larger socialist scheme and clarified that it had no interest in passing such a proposal. In the 1948 election, Truman responded by renewing his focus on a national health bill. Fearing that Truman's surprise victory in the election was a sign that momentum was shifting, the AMA assessed its members an extra $25 apiece to resist national health insurance, then spent a staggering $1.5 million on lobbying efforts opposed to Truman's measure. Whether because of those efforts, Congressional opposition, or the public's rising anti-Communist sentiment as the nation entered the Korean War, Truman's plan ultimately died in committee.

1954-1968: Eisenhower, Johnson and The Great Society

After World War II, the private insurance system expanded to the point that many members of the most influential groups in American politics were satisfied without a national health insurance program. Because unions also began negotiating with employers for health care benefits, the American public started to see organized labor as the primary vehicle for obtaining health insurance.

To promote those ends, Dwight D. Eisenhower proposed a federal reinsurance program, ostensibly to enable private insurers to cover broader groups of people. Around the same time, Congress passed the *Revenue Act of 1954* to exclude employers' contributions to employee plans from taxable income. Perhaps because his military roots made him acutely aware that the American military could not otherwise rely on its "employer" for health care benefits, Eisenhower

also introduced a "military medicare" program to provide government health insurance for dependents of people in the Armed Forces.

In 1958, Rep. Aime Forand (D-R.I.) introduced a new proposal that would cover hospital costs for another group which could not rely on employers or unions: aged persons on Social Security. Recognizing the high costs of insuring retirees, organized labor supported the measure. In contrast, the AMA opposed it as a threat to the doctor-patient relationship, but responded to growing support for the needs of older Americans by proposing an "eldercare plan" that would rely on voluntary insurance to provide access to broader benefits, including physician services. In turn, Congress responded by expanding the proposed legislation to include both hospital costs and physician services.

Congress also passed the *Kerr-Mills Act* in 1960, giving federal grants to states for the purpose of covering health care for the elderly poor. By 1963, however, only 28 states chose to participate in the program, and many had not budgeted sufficiently for the related costs. As a result, the law proved to be ineffective.

A series of compromises and concessions to doctors (e.g., agreeing to reimburse their customary, reasonable and prevailing fees), hospitals (e.g., agreeing to pay costs plus reimbursement) and political foes later produced a 3-part plan which included: the Democratic proposal for comprehensive health insurance (Medicare "Part A"), the Republican proposal for government-subsidized voluntary physician insurance (Medicare "Part B"), and Medicaid. Seizing the rare harmonic convergence of collective political support, Lyndon B. Johnson signed the measure into law as part of his *Great Society Legislation* in 1965.

1968-1980: Discovering a Need for Cost-Containment

After they became law, the Medicare and Medicaid programs quickly caused insurance rolls to swell. However, they still left millions of Americans under age 65 without access to health coverage. Richard M. Nixon therefore initially followed up on Johnson's *Great Society* by expanding the availability of the existing federal programs and by taking a stand for universal health insurance.

Politically, Nixon's efforts were harshly criticized as being soft on big business. At the same time, inflation was becoming a growing concern, and the costs of making health care more available to the elderly and poor were exceeding most projections: according to the White House's *Office of Management and Budget* and the *Congressional Budget Office* -- both created during the Nixon administration -- health care costs accounted for 4 percent of the federal budget in 1965 and grew to 11 percent of the budget by 1973.

Changes in medical care, including a greater use of technology, medications, and conservative approaches to treatment, all contributed to those costs. At the same time, the Medicare and Medicaid programs called for providers to be paid any fee that was "reasonable and customary," leaving the government with little control over fees. In 1971, Nixon therefore included the health sector in an Executive Order by which he put a wage and price freeze on the entire economy. Later that year, the freeze was replaced by an initiative with specific inflation targets for each sector of the economy. By 1972, a ceiling of 5.5 percent on health care wage increases, 2.5 percent for non-labor costs, and 1.7 percent for new technology and services was imposed.

During that same time, Sen. Edward Kennedy (D-MA) held hearings around the country and issued a report entitled "*The Health Care Crisis in America.*" With support from the elderly and the labor-led *Committee for National Health Insurance*, his efforts generated support for a new proposal for national health insurance. Kennedy's original idea -- the *Health Security Ac*t -- was a universal single-payer plan, with a national health budget, no consumer cost-sharing, and was to be financed through payroll taxes. In response, other Congressmen wrote more incremental plans, all of which splintered support for any one reform.

Ostensibly to make lower cost insurance available to everyone, Congress separately passed the *HMO Act of 1973.* Nixon also proposed the *Comprehensive Health Insurance Plan* (CHIP) – a measure which called for universal coverage, voluntary employer participation, and a separate program for the working poor and the unemployed which would replace Medicaid. Ultimately, those efforts to reform the American health care system were overshadowed by the Watergate hearings and Nixon's resignation. By the time Gerald Ford took office, the country also had begun to face economic difficulties, and concerns over frugality quashed all efforts to see health care reform legislation pass into law. Therefore, even though Ford supported national reform and Congress introduced a compromise bill, its progress stalled.

When Jimmy Carter assumed office in January 1977, hospital expenses were increasing annually 8.7 percent faster than the overall inflation rate, posing a serious obstacle to his plans to balance the federal budget and expand health insurance coverage to the entire population. The next month, Carter made a new appointee at the *Department of Health, Education, and Welfare*. In April 1977, he also submitted to Congress a plan to limit the rate of increase in hospital revenues for all patients to 3 percentage points over the overall inflation rate.

The industry responded by asserting that it could voluntarily contain costs without federal legislation. After extensive debate and Committee action, a bill passed the Senate in late 1978 that provided for a period of voluntary restraints on hospital cost growth, with a trigger for initiating mandatory controls if the voluntary effort failed. However, the session ended without action on the House floor, so the Carter administration introduced a new hospital cost-containment bill in 1979 that contained a voluntary trigger and specified that mandatory limits would only be imposed if national, state, and individual hospital voluntary limits that were comparable to industry voluntary goals were not met. The bill passed three major committees, but was defeated on the House floor in November 1979.

A coalition of health care provider organizations (including, among others, the *American Hospital Association*, the *Federation of American Hospitals*, the *American Medical Association*, and *Blue Cross/Blue Shield*) then launched a formal effort to voluntarily control health care costs. Their initial goal of reducing by 2 percentage points the annual rate of increase in 1978 was met. As the costs of health care in America continued to soar, though, all of the coalition's subsequent goals were substantially exceeded.

Despite those escalating costs, the "Boren amendment" to the *Omnibus Reconciliation Act of 1980* (OBRA 80) required that Medicaid nursing home rates be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards." State Medicaid officials opposed the

amendment as impossible to operationalize, adding that they were being forced to spend too much on nursing homes at the expense of other services.

1980-1992: Shifting the Financial Burdens

Governor Ronald Reagan (R-CA) had publicly criticized Medicare while supporting Barry Goldwater's presidential campaign in 1964. During a televised debate in the 1980 campaign, President Carter therefore charged that Reagan "began his political career campaigning around this nation against Medicare." By many accounts, Reagan's memorable response ("*There you go again*") was a shrewd retort that deftly charged Carter with mischaracterizing his comments. At the same time, it provided Reagan an opening to suggest that he had opposed Medicare only because he preferred a Republican alternative that had been proffered at the time: a voluntary insurance program funded by Social Security.

By the time Reagan took office, the fiscal strength of the Social Security system was uncertain, Medicare had its own financial problems, and the American economy was in a recession. Politically, he therefore faced a seemingly inconsistent set of objectives: control the cost of the programs through which government was making medical care available to citizens while avoiding any perception that he was dismantling them.

To those ends, Reagan used the *Ominbus Budget Reconciliation Act of 1981* (OBRA 81) to create a "freedom-of-choice" waiver that allowed states to mandate that certain Medicaid populations enroll in managed care systems. To promote savings in the federal budget, though, OBRA 81 also reduced certain federal matching payments to the states.

Other laws enacted during the Reagan administration allowed states to expand the scope of services provided or persons served by Medicaid. In 1982, for example, the "Katie Beckett" option allowed states to cover children with disabilities who did not qualify for Medicaid if they required institutional care but could be cared for at home. *The Deficit Reduction Act of 1984* mandated coverage of young children of families eligible for *Aid to Families with Dependent Children* (AFDC). Together with the *Consolidated Omnibus Budget Reconciliation Act of 1985* (COBRA), it also mandated coverage for all pregnant women who were AFDC-eligible. In addition, the *Omnibus Reconciliation Act of 1986* (OBRA 86) and the *Emergency Medical Treatment and Active Labor Act* (EMTALA) required states to screen and stabilize all emergency room patients – including undocumented immigrants – regardless of their ability to pay. The *Omnibus Reconciliation Act of 1989* (OBRA 89) separately required that states cover services provided by Federally-Qualified Healthcare Centers (FQHC's).

To offset some of the related costs, OBRA 81 repealed the requirement that state Medicaid programs pay hospital rates equivalent to those paid by the Medicare program. The *Tax Equity and Fiscal Responsibility Act of 1982* (TEFRA) also revised previous Medicaid cost-sharing policies to expand the states' options for imposing nominal cost-sharing on certain Medicaid beneficiaries and services.

An even greater change came with the *Social Security Amendments of 1983*, which fundamentally altered how Medicare paid for hospitals. Previously, Medicare was obligated to pay whatever hospitals billed the government as their costs, plus an additional profit-margin. As a result, Medicare hospital payments had increased by 88 percent from 1970 to 1980. The new law created a *Prospective Payment System* (PPS), under which Medicare would pay a fixed

price that was linked to each patient's clinical condition, or Diagnosis-Related Group (DRG). Although certain factors (e.g., regional wage levels) could make those prices vary, they essentially were set in advance.

The system was developed, in part, from a desire to change the way hospitals were managed, to change how physicians practiced in hospitals, and to change the relationship between physicians and hospital management. Its engine was a set of financial incentives that were designed to encourage more cost-efficient management of medical care. In essence, efficiently-run hospitals would profit, while inefficient hospitals would lose money.

The effects of that change were immediate and dramatic. While the Medicare hospital payment rate had grown 16.2 percent between 1980 and 1983, PPS produced a 52 percent decrease in the Medicare hospital payment rate between 1985 and 1990, then another 37 percent decrease between 1990 and 1995. During that time, the average length of Medicare hospital stays also decreased. In light of those successes, a series of Congressional changes later applied PPS-based approaches to Medicare payments for outpatient hospital services, skilled nursing facilities, home health agencies and hospice organizations.

After the implementation of PPS, several researchers examined the characteristics of those hospitals that succeeded and those that did not. Those which failed seemed to have weaker financial controls and management systems, rudimentary utilization control practices, less aggressive coding practices to increase revenues, and lower volumes overall.

Although *Health Maintenance Organizations* (HMO's) and similar institutions first developed in the 1930s, they concurrently emerged as a viable means of financing the costs of health care. In theory, HMO's were expected to better control prices by promoting free-market participation. By limiting participants to a pre-approved network of doctors, taking a role in determining whether care was necessary, and requiring prior approval for referrals and certain procedures, they were expected to produce savings that would allow HMO's to offer lower premiums and lead a charge in the market for greater efficiency and quality care. The success of that model allowed many HMO's to offer more comprehensive care—including some preventative care—while offering still lower prices than competitors.

In turn, for-profit businesses and the stock market began to play a major role in the expansion of HMO's. Newly formed corporations as well as some established insurers sponsored HMO's in that period. The trend toward commercialization accelerated in the 1980's and, by 1992, for-profit HMO's surpassed non-profits in enrollment. Between 1987 and 1990, though, the industry's aggressive growth stalled. Indeed, while well-run HMO's continued to prosper, 76 HMO's went out of business from 1988 to the middle of 1990.

1992-2000: Clinton and The Health Security Act

In the 1990s, the HMO industry continued its impressive growth: the escalating costs of health care and the re-emergence of health insurance reform as a major national issue helped the industry to double in size. In addition, many employers felt they had little choice but to convert to HMO insurance as a low cost alternative to rapidly escalating health insurance premiums. As a result, HMO enrollment exploded from 3 million in 1970 to over 35 million in 1991. However, the geographic dispersion of HMO enrollment had no obvious or predictable

pattern. Therefore, while national enrollment grew at a relatively steady rate, enrollment across individual states and cities was uneven.

At the same time, health care fraud was contributing to rising costs and a shaky financial future for the Medicare program. Indeed, the available data suggested that the Medicare Trust Fund would run out of money in 1999. Other problems began to plague those who obtained health insurance coverage through their employment: although COBRA had mandated that employees be permitted to continue their health insurance coverage when changing jobs, those rights were temporary and expensive. There also were no other federal protections to ensure the portability of health benefits for workers in between jobs or to ensure that their health status would not be a barrier to obtaining new coverage. For a variety of reasons, then, the number of uninsured Americans was growing.

Bill Clinton therefore campaigned heavily on health care in 1992. Almost immediately after his inauguration, he appointed the First Lady (Hillary Rodham Clinton) to chair a task force that was charged with devising a comprehensive plan for providing universal health care for all Americans – an objective which was to be a cornerstone of the administration's first-term agenda.

Among other things, the plan that had been produced by the *Task Force on National Health Reform* called for an enforced mandate that employers provide health insurance coverage to all of their employees through competitive but closely-regulated HMO's. In a joint session of Congress, President Clinton emphasized the need for such a mandate by stating:

> *"Millions of Americans are just a pink slip away from losing their health insurance, and one serious illness away from losing all their savings. Millions more are locked into the jobs they have now just because they or someone in their family has once been sick and they have what is called the preexisting condition. And on any given day, over 37 million Americans -- most of them working people and their little children -- have no health insurance at all. And in spite of all this, our medical bills are growing at over twice the rate of inflation, and the United States spends over a third more of its income on health care than any other nation on Earth."*

The plan was nonetheless fiercely opposed by conservatives, the AMA and the health insurance industry, and their collective opposition prompted several Democrats to offer competing plans. As a result, Clinton was unable to garner enough political support for his *Health Security Act*, and the final "compromise" bill died in the fall of 1994.

Given that political climate, Ted Kennedy adopted a new strategy of reshaping the American health care system through incremental measures. In 1996, for example, he and Sen. Nancy Kassebaum (R-KS) sponsored the *Health Insurance Portability and Accountability Act* (HIPAA), which sought (among other things) to ensure that employees could take their health insurance coverage from job to job. That same year, he sponsored the *Mental Health Parity Act*, which required that insurers apply the same aggregate and annual dollar limits to mental health issues as for other health issues. In 1997, he teamed with Sen. Orrin Hatch (R-UT) to propose the *State Children's Health Insurance Program* (SCHIP), a measure designed to provide health insurance for uninsured children and funded by an increase in cigarette taxes. The following year, he was one of 31 co-sponsors of the *Patient Bill of Rights*, a measure that

aimed to protect members of managed care plans from (among other things) being denied care for the purposes of cost-containment.

The Clinton Administration separately set out to reform Medicare. To help achieve the goal of balancing the federal budget by 2002, the *Balanced Budget Act of 1997* (BBA 97) included language trimming growth in Medicare spending by $116.4 billion over five years, most of which was due to reductions in payments to health care providers (hospitals and doctors). The legislation also increased Medicare Part B premiums, established new *Medicare+Choice* managed care plans, and created a bipartisan commission to study Medicare's long-term finances and report back to Congress.

That commission, also known as the *National Bipartisan Commission on the Future of Medicare*, formed a plan to remodel Medicare based on the federal employees' system of choices and competing health plans. In addition to the new competitive system, the plan added benefits for prescription drugs and it limited beneficiaries' out-of-pocket costs for hospital and physician services. To save money, however, the Commission's plan would have raised Medicare's eligibility age and added some new beneficiary copayments.

Partly because the commission's plan ignored his call to transfer Medicare some of the budget surplus expected over the next ten years, Clinton refused to urge his own nominees on the commission to support the plan. He also released his own set of recommendations which embraced the federal employees' system as a model for competition, but added measures to protect the traditional fee-for-service program from the full force of market prices. In so doing, it anticipated that the new competitive system would save beneficiaries money, but limited the amount the government would save. To promote further savings, the Clinton plan also raised the eligibility age. However, the Clinton plan also would have subsidized prescription drug benefits for all seniors and formed the new drug benefit on the traditional fee-for-service model, with the government poised to dictate payment policies and rates.

The Clinton plan also included a provision to use $794 billion in surplus general tax revenues to extend Medicare's insolvency date. However, Congress instead began to more modestly reverse some of the spending cuts which had been mandated by BBA 97. In late 1999, for example, Congress enacted legislation restoring $35 billion in Medicare and Medicaid funding to hospitals, nursing homes and health plans over five years. In 2000, it restored another $16 billion in Medicare funding to various providers. Ultimately, though, further efforts at significant structural reforms were put on hold.

2000-2008: George W. Bush

By the time of the 2000 presidential campaign, Medicare still was facing two major problems: its beneficiaries were still having trouble in finding affordable care, and the program itself was not properly funded. George W. Bush therefore openly criticized the Clinton-Gore administration for failing to lead on Medicare and other issues. Three years later, he signed the *Medicare Prescription Drug, Improvement and Modernization Act of 2003*, a measure which was heralded the single largest expansion of Medicare since the program had been created.

In part, the Act called for the expansion of community and rural health centers that would serve approximately 9.1 million more patients. It also called for Medicaid and SCHIP changes that would extend eligibility to 2.6 million more Americans. Nevertheless, its most prominent

reform was the addition of a voluntary outpatient prescription drug benefit for people on Medicare, known as Part D.

The estimated costs of providing that prescription drug benefit were substantial: $400 billion. However, private health plans had largely been successful in negotiating discounts with pharmaceutical manufacturers, so the Act was structured to rely on competition among private plans to limit drug prices and drug spending. To that end, it replaced the *Medicare+Choice* program with *Medicare Advantage*, a system that would allow beneficiaries to choose from a wider range of health coverage products, including preferred provider organizations (PPO) and HMO options. By opening up the Medicare program to commercial health coverage designs which had proven more cost-effective than traditional fee-for-service indemnity insurance products, the theory was that competition with the private sector would ultimately drive down the cost of drugs.

The *Medicare Prescription Drug, Improvement and Modernization Act of 2003* also authorized health savings accounts (HSA), tax-advantaged medical savings accounts that would allow taxpayers in certain high deductible health plans to use pre-tax dollars to pay for qualified medical expenses at any time without federal tax liability or penalty.

To further reduce the burden of health care costs on small business owners and employees, Bush also proposed the *Small Business Health Fairness Act of 2005*, a measure which would have amended the *Employee Retirement Income Security Act of 1974* (ERISA) to let small businesses pool together as *Association Health Plans* to negotiate lower health care costs and provide health insurance to their employees. Although the House approved the bill, it never came up for a vote in the Senate.

To help the uninsured obtain health coverage, Bush later proposed reforming the tax treatment of health insurance by capping the tax deduction of employment-based health insurance premiums, imposing both payroll tax and income tax on the value of employer-provided health insurance, and creating a standard tax deduction for anyone who buys health insurance in the individual, private insurance market. However, his proposal was viewed as unlikely to help those most in need of health coverage and, as a result, never became law.

2008-2010: Obama and The Affordable Care Act

During the 2008 presidential campaign, the major parties' nominees offered contrasting positions on health care.

The proposals offered by Sen. John McCain (R-AZ) focused on open-market competition, rather than government funding. To that end, he supported Bush's proposal to give tax credits of $2,500 to individuals and $5,000 to families who do not subscribe to or do not have access to health care through their employer. To help people who are denied coverage by insurance companies due to pre-existing conditions, he also proposed working with states to create what he called a *Guaranteed Access Plan*. Sen. Barack Obama (D-IL) called for universal health care and the creation of a *National Health Insurance Exchange* that would include both private insurance plans and a Medicare-like government run option. Under his plan, coverage would be guaranteed regardless of health status, and premiums would not depend on a person's health status.

After the election, the details of President Obama's plan started to take more shape. During a June 2009 speech, he hinted that it would involve measures aimed at the quality of health care: promoting electronic record-keeping; preventing expensive conditions; reducing obesity; refocusing doctor incentives from quantity of care to quality; bundling payments for treatment of conditions rather than specific services; better identifying and communicating the most cost-effective treatments; and reducing defensive medicine. During a September 2009 speech to a joint session of Congress, Obama revealed some of his plan's fiscal components: deficit neutrality; not allowing insurance companies to discriminate based on pre-existing conditions; capping out of pocket expenses; creating an insurance exchange for individuals and small businesses; giving tax credits to individuals and small companies; creating independent commissions to identify fraud, waste and abuse; and funding projects to reform malpractice laws.

On February 22, 2010, Obama formally released his plan for health care reform. Three days later, he presided over a "*Bipartisan Health Care Summit*" at *Blair House*. The event identified several issues on which Republicans and Democrats appeared to agree, such as: preventing waste and fraud in Medicare and Medicaid; addressing medical malpractice reform; reforming the insurance market; giving individuals more choices in coverage, and giving small businesses the opportunity to pool coverage for their employees. Afterwards, he sent a letter to congressional leaders to identify four Republican ideas that seemed worthy of further exploration: undercover investigations of health care providers that receive reimbursements from Medicare, Medicaid, and other Federal programs; expanding the proposed grants for states that demonstrate alternatives to resolving medical malpractice disputes; increasing Medicaid payments to doctors; and the possibility of expanding HSA's.

In a further attempt to garner bipartisan support for his proposal, Obama gave a speech in Glenside, Pennsylvania on March 8, 2010 which emphasized the country's need for a sustainable health care system. When describing the difficulties his predecessors had encountered when trying to effect meaningful reforms, he explained:

> *"We've been talking about health care for nearly a century. I'm reading a biography of Teddy Roosevelt right now. He was talking about it. Teddy Roosevelt. We have failed to meet this challenge during periods of prosperity and also during periods of decline. Some people say, well, don't do it right now because the economy is weak. When the economy was strong, we didn't do it. We've talked about it during Democratic administrations and Republican administrations."*

To further galvanize support for taking action, Obama also cast blame on the health insurance industry, stating:

> *"Every year, the problem gets worse. Every year, insurance companies deny more people coverage because they've got preexisting conditions. Every year, they drop more people's coverage when they get sick right when they need it most. Every year, they raise premiums higher and higher and higher".*

Obama then described his plan as one designed to achieve three primary objectives: reform the insurance industry; ensure that Americans have affordable choices in the marketplace for

health insurance; and reduce the overall cost of health care. In a final call to action, he added that "*The need is great. The opportunity is here. Let's seize reform. It's within our grasp.*"

II. Pending Legal Challenges

As final Congressional approval neared for the *Affordable Care Act*, its opponents shifted from parliamentary and procedural opposition to legal challenges of the law's constitutionality. For example, the Virginia General Assembly passed the *Virginia Health Care Freedom Act* to prohibit any individual from being required to purchase health insurance, and the Virginia Attorney General filed a lawsuit (*Commonwealth v. Sebelius*) challenging the Constitutionality of the insurance requirement.

On August 2, 2010, the District Court denied the Justice Department's motion to dismiss that lawsuit, explaining that the case raises Constitutional issues -- mainly whether Congress has the right under the Commerce Clause to regulate and tax a person's decision not to participate in interstate commerce – which will need to await resolution after a hearing on the merits. Although lengthy appeals are anticipated, the trial of that case currently is set to begin on October 18, 2010.

Together with the States of South Carolina, Nebraska, Texas, Utah, Louisiana, Alabama, Michigan, Colorado, Pennsylvania, Washington, Idaho and South Dakota, the State of Florida separately filed a lawsuit to repeal the *Affordable Care Act*. Like the Commonwealth of Virginia's case, it primarily challenges those portions of the *Affordable Care Act* which require that individuals either purchase health insurance or pay a penalty. By June 2010, at least 20 states had some role in support of this legal challenge. The *National Federation of Independent Business* and two individuals also have joined the lawsuit as additional plaintiffs. As of this writing, the Eastern District of Michigan had yet to rule on the plaintiffs' motion for a preliminary injunction against any enforcement of those provisions.

Importantly, the consolidated version of the *Affordable Care Act* has no severability provision. For that reason, any lawsuit that successfully invalidates any part of it could unwind the entire piece of legislation.

III. Conclusion

When consolidated with the *Health Care and Education Reconciliation Act of 2010*, the *Affordable Care Act* consumes 954 pages text which implement an ambitious piece of legislation with several objectives. In certain ways, those objectives seem inconsistent with one another. For example, the *Affordable Care Act* seeks to improve the quality of health care while, at the same time, lowering the costs of delivering it. It also seeks to make health care available to more people while, at the same time, ensuring that the government-run programs through which many Americans gain access to it are more financially secure.

Toward those ends, the *Affordable Care Act* calls for numerous insurance reforms and changes in the Medicare and Medicaid programs. It also invests in and creates standards for new care environments. In addition, it changes tax laws by giving certain credits, closing certain loopholes, and imposing new taxes and fees.

While many of the changes mandated by the *Affordable Care Act* are new, others are not. Rather, many of the *Affordable Care Act*'s provisions serve to give life to old ideas and programs that were considered (if not tried) in the past, and some serve only to expand the scope of existing programs. Collectively, though, they promise to re-shape the American health care system – and the way for which Americans pay for their health care – in significant ways.

Only time will tell if the *Affordable Care Act* can achieve its stated objectives. In the interim, some will likely fare better, while others may fare worse. Further changes in the American health care system – through the legislative process, the judicial system, the insurance industry or other sources -- therefore are a virtual certainty. In the end, then, the *Affordable Care Act* may mark only the latest chapter in an important political debate that already has consumed one century – and may yet consume another.

About the Author

Robert R. Pohls is the Managing Attorney of *Pohls & Associates,* a California law firm that he founded in 1999 to represent life, health, disability and long term care insurance companies in bad faith, ERISA and other complex forms of litigation. A litigator by trade, Mr. Pohls has earned a national reputation for his distinctive ability to achieve favorable outcomes in disputes that involve challenging facts and/or novel legal questions. However, he is equally skilled at helping his insurance clients manage difficult claims and, when possible, avoid litigation altogether. In addition, Mr. Pohls regularly assists his insurance clients when they must respond to regulatory inquiries.

Mr. Pohls is an active Member of *DRI*'s Life, Health & Disability Committee and a DRI Spokesperson on Health Care Reform. He also is a Member of the *Association of Life Insurance Counsel*, a Member of the *Northern California Life Insurance Association*, and a former Chair of the *ABA*'s Health & Disability Insurance Law Committee.

Mr. Pohls graduated from *Bucknell University* in 1984, earning a Bachelor of Arts Degree in Political Science. In 1987, he received a *Juris Doctor* degree from *King Hall School of Law* at the *University of California, Davis*.