



The modern history of U.S. health care reform:

A primer for practicing surgeons, residents, and associate fellows

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It is clear that the current U.S. health care system is in need of reform. According to the Council of Economic Advisors, by 2040, health care expenditures will be 34 percent of the gross domestic product (GDP), with Medicare and Medicaid spending nearly 15 percent of the GDP.¹ In addition, nearly 54 million Americans who would not qualify for Medicare will be uninsured. However, throughout our country's history, there have been multiple attempts to restructure our health care system. Nearly 100 years ago, President Theodore Roosevelt and his Progressive Party unsuccessfully lobbied for national health insurance. Since Roosevelt's presidential run in 1912, our nation has seen the enactment of the Medicare and Medicaid programs signed into law by President Lyndon B. Johnson on July 30, 1965, followed by a series of health care reform "near misses." This multi-part article chronicles the development of Medicare and Medicaid, highlights some of the near misses in health care reform since enactment of that legislation, and outlines the timeline of the current health care debate.

The Medicare and Medicaid programs

by Carlos M. Mery, MD, MPH

Medicare is a federally sponsored health insurance program that covers the medical needs of Americans 65 years or older, those under 65 years of age with certain disabilities, and those

with end-stage renal disease.² The program consists of four parts. Part A (hospital insurance) is provided to all eligible individuals premium-free, and provides coverage for inpatient care, skilled nursing facilities, hospice care, and some home health services. Part B (supplementary medical insurance) is a voluntary program in which eligible individuals pay a monthly premium in exchange for coverage of physician fees, outpatient services, and other costs not covered by Part A. Part C, the Medicare+Choice program (now called Medicare Advantage), was added to Medicare in 1997 to allow beneficiaries to receive their benefits from private health insurance plans that include at least the current benefit package offered by Parts A and B. Part D, signed into law in 2003, is the prescription drug benefit plan for Medicare beneficiaries, and is administered by private companies with oversight by the Centers for Medicare & Medicaid Services.

Medicaid is a program jointly funded by the federal and state governments to assist states in providing medical assistance to people with low income. Each state decides the eligibility criteria, the type of services to provide, the rate of payment, and the administration of the program.²

The Medicare and Medicaid programs have their developmental roots in the health insurance programs introduced by Germany in 1883 and Great Britain in 1911.³ From 1912 to 1920, the American Association of Labor Legislation, a private multidisciplinary reform organization, initiated a movement to try to enact “sickness insurance” in the U.S. on a state-by-state basis. This insurance would include cash compensation and coverage of medical bills for sick workers. Despite initial support for the initiative in several states, by 1920 the measure was defeated in every state in which it was raised. The defeat was mainly due to the political climate; the resistance of states to undertake what, at the time, were perceived as costly social measures; and a lack of endorsement from the American Medical Association (AMA).^{4,5}

Several studies published during the 1920s and 1930s highlighted the high costs of medical care and the need for medical insurance by the states. This led to an attempt by President Franklin D. Roosevelt to incorporate a national health care provision as part of the 1935 Social Security Law. However, the measure failed again.³

The discussion over the issue of health care insurance continued over the next decade, to no avail. In 1945, President Harry S. Truman strongly endorsed the creation of a federally based national health insurance program. The result of this endorsement, the Wagner-Murray-Dingell bill, was debated, and eventually failed, secondary to opposition from multiple sources, including a difficult political post-war climate and the growing influence of private insurance companies.⁴ By 1951, more than half of patients admitted to hospitals in the U.S. had some form of private medical insurance.³

In the 1950s, in an effort to gain more support, health reformers limited the idea of national health insurance to elderly individuals, as they represented a high risk for private insurance companies. As a significant compromise, the Kerr-Mills bill was passed in 1960, creating the Medical Assistance for the Aged program. According to this program, the federal government would give matching funds to the states in order to provide medical assistance to those elderly deemed in need by each state. However, after more than three years, only 32 of the 50 states had created Kerr-Mills programs.⁶

The Kerr-Mills bill was insufficient to provide complete health care for the elderly. In 1961, President Kennedy endorsed the creation of a Medicare bill proposing coverage of hospital costs for the elderly. However, given the presence of a mild recession and the lack of support by Congress, he decided to postpone the introduction of the bill. In 1964, after Kennedy’s assassination, President Johnson made health care reform a priority. By then, the issue of national health insurance had gained public support, due to sharp decreases in personal income and greatly increased medical needs of the elderly.

After much debate, three alternative options emerged:⁶

1. Medicare, proposed by the Administration, would be a government-funded program similar to the private insurance programs, providing coverage for hospital costs of the elderly.

2. The AMA-proposed “Eldercare,” an expansion of the Kerr-Mills state-run program, including drug coverage.

3. A third proposal, by Rep. John Byrnes (R-WI), was the creation of a voluntary health insurance program that would cover medical and

hospital costs, funded in part by the beneficiaries and in part by the government.

The AMA proposal was eliminated, and a bill was drafted incorporating both the Medicare provisions (Part A) and Byrnes' proposal (Part B). In July 1965, the bill was passed in both chambers and was signed into law as Titles XVIII (Medicare) and XIX (Medicaid) of the Social Security Act.

Since its creation, Medicare has expanded to cover a greater portion of the population.⁷ In 1972, Medicare eligibility was extended to include individuals younger than 65 years of age with long-term disabilities and any individuals with end-stage renal disease.

In 1983, in an attempt to limit hospital medical costs, Medicare introduced the prospective payment system based on diagnosis related groups (DRGs).³ Under this system, a fixed amount is paid to the hospital for each patient stay based on a particular DRG, regardless of the actual amount of money spent. The hospital therefore absorbs the loss or makes a profit.

Similarly, since 1992, physicians are paid based on relative value units assigned for each procedure or intervention. In 1998, Medicare introduced the controversial sustainable growth rate formula (SGR) in an attempt to control costs. The SGR sets a target of expenditures on physician payments each year based on the GDP. If the actual spending surpasses the spending target for that year, reimbursement rates are decreased. Actual spending has surpassed the spending target every year since 2002, prompting cuts to physician reimbursement every year. As a result of pressure from the AMA and other medical organizations, including the American College of Surgeons, Congress has postponed these cuts every year. Recently, a bill was passed by the House of Representatives to eliminate the accumulated SGR debt and create a better system for physician reimbursement,⁸ but similar language failed to pass the Senate.

Near-misses

by Amy Liepert, MD

Although the enactment of the Medicare and Medicaid programs is the most tangible result of health care reform in this country, there are other notable attempts and near-misses that have occurred since the Johnson administration.

One such attempt was the Comprehensive Health Insurance Act (CHIP). CHIP was introduced to Congress and the American public on February 6, 1974, by President Richard Nixon during his presidential address. The need for a national health insurance act, at that time, was based on data that showed 25 million uninsured Americans, and health care costs that had increased 20 percent over the previous two-and-a-half years.

CHIP included three major programs: employee health insurance, assisted health insurance, and improved Medicare. The proposal was to make one of these three plans available to every American, but also to maintain voluntary participation. The employee health insurance program was designed to build on existing employer-sponsored plans, with government subsidies to help the self-employed and small businesses. This portion of the plan was designed to build upon a cost structure shared by employers and employees—which is often considered the historical design of health care in the U.S. The assisted health insurance program was designed for low-income earners who were not eligible to participate in the other two programs. Costs for this portion of the plan were split between federal and state funding. The improved Medicare portion of the plan was to be built on the existing Medicare system for people aged 65 and older, but would include additional benefits.

CHIP was designed to provide identical benefits to every American, without any exclusion. In addition, it was designed to include coverage for mental illness, alcoholism, drug addiction, nursing home care, and home health services. Children's services were to be covered, including preventive care up to age 6, as well as eye and hearing exams, and dental care up to age 13.

The design of the program was such that yearly costs per family were limited. Per-family maximum out-of-pocket expenses were not to exceed \$1,500, and would be adjusted down for lower-income families. The improved Medicare program had an annual maximum amount of \$750. The costs projected by the General Accounting Office were \$6.9 billion, plus additional costs during the transitional period to be divided between the federal and state governments, and were in addition to the costs of existing programs. On an individual level, the employee health insurance program was estimated to cost each individual employee

\$150 per year and each employer \$450 per year per employee.

The progression of this bill moved at a positive rate through Congress; however, it could not overcome the political debacle of the Watergate scandal. By the time Gerald Ford was elected President, the economy was facing another potential recession, and the political climate was unfavorable for a large piece of social legislation such as this.

In the mid-1980s, a modification to health care came in the form of the Consolidated Omnibus Reconciliation Act (COBRA) of 1985. This law, signed by President Ronald Reagan on April 7, 1986, focused on Americans who lost their insurance due to separation from employment.

A requirement was included in this large bill for insurance eligibility to continue for 18 months after separation from employment. Pre-existing conditions were covered without waiting periods, and the new insurance plan was required to provide comparable benefits to the previous plan. The premium was to be paid in full by the employee, and lack of payment resulted in immediate cancellation. An additional requirement mandated that any premium adjustments applicable to the previous employer would also apply to the individual. Extension to the 18-month limit was granted only for disability or multiple events. After the term of COBRA coverage, the enrollee must either be covered by another employer or purchase his or her own personal policy.⁹

This piece of legislation was designed as a bridge, providing insurance for those in between jobs. However, COBRA still left certain groups of people at risk for not receiving insurance coverage, including people working at a small business with fewer than 20 employees, people who lost their employment and for whom new employment was not available within 18 months, or individuals who could not pay for private insurance after job loss.⁹ While these gaps are widely criticized, the design of the bill was to provide an option for employees and their families in the circumstances of job loss, death, disability, or other major life event.

A decade after the COBRA legislation was enacted, President Bill Clinton's Administration attempted health care reform in the form of the Health Security Act of 1993. The Health Security Act would have used a complex system to develop universal health care by using private insurer

competition, mandates for employers as well as individuals, and by requiring heavy government oversight and regulation.¹⁰ Central to its structure was that the federal government would provide oversight of national standards for cost, quality, and benefits. A major component of this oversight was through the creation of a National Health Board.¹⁰ The states were to organize their own regional alliances, in order to provide universal coverage.

Three cost-sharing options were built into the Health Security Act. The first option—the low cost sharing option—was equated to a health maintenance organization-type system, in which users would be required to pay a small co-pay for outpatient care. The higher cost sharing option was equated to a fee-for-service system, in which an individual would pay a \$200 annual deductible and co-insurance up to \$1,500; families would have an annual \$400 deductible with a maximum of \$3,000 out-of-pocket expenses. The third option was the combination cost sharing option, which was equated to a preferred provider organization. As part of this plan, a \$10 co-pay would be necessary for in-network visits, along with a 20 percent co-insurance for any out-of-network service.¹¹

Under the proposed Clinton plan, each American would have been issued a health security card and would have been allowed to choose their own insurance from their local alliance or corporate alliance. Supplemental insurance could be purchased by each member. This did remain an employer-based insurance plan, with each employer required to pay a major portion for all employees, with the payment adjusted based upon the employee's work commitment. However, the adequate amount of votes were not garnered for the plan.

**Where are we now,
and how did we get here?**
by David T. Cooke, MD

After the failure of the Health Security Act, major health care reform was essentially tabled until the 2008 presidential election, when both major party candidates ran with the promise of meaningful health care reform prominent in their platforms. In 2009, President Barack Obama submitted his 2010 budget to Congress. President Obama requested that Congress reserve \$600 billion via changes in income tax deductions for health care reform initia-

tives over 10 years, and asked Congress to develop the specifics of health care reform legislation.

In June of that year, Democrats in the House submitted a bill that included a government-run insurance plan, or “public option,” with penalties on businesses that did not provide health insurance for their employees. Concurrently in the Senate, both the Senate Finance Committee and the Health, Education, Labor and Pension Committee prepared versions of these bills. On July 15, 2009, the Health Committee passed a bill that included a public option, with a requirement that employers with more than 25 workers would provide insurance coverage or pay an annual penalty fee to the government.

During his address to a joint session of Congress in September, President Obama increased estimates of 10-year costs for reform from \$600 billion to \$900 billion, expressed an interest in curbing the costly practice of defensive medicine, and reaffirmed his belief that health care in this country needs dramatic and lasting overhaul. Two days after President Obama’s address to Congress, several surgical organizations, including the American College of Surgeons, signed a letter addressed to Senate Majority Leader Harry Reid (D-NV) and the Speaker of the House Nancy Pelosi (D-CA), urging Congress to make medical liability reform a core component of any health care reform legislation.

In October, the Senate Finance Committee approved legislation backed by Sen. Max Baucus (D-MT). The Baucus Plan, per the Congressional Budget Office (CBO), would most likely diminish health care expenditures and reduce the federal budget. The plan would tax expensive premium or “Cadillac” health plans, and require businesses with 50 or more employees to reimburse the government for costs incurred by workers who purchase their own health insurance. The bill in its original form did not contain a public option. However, after the bill left committee, Senator Reid announced his intention for the bill to contain a public option, but it would also have a provision that would allow states to opt out of the public option.

On November 7, 2009, the U.S. House of Representatives passed its bill by a 220 to 215 vote. The concurrent House bill, containing a public option, would cover 36 million uninsured Americans and eliminate any policies excluding individuals with pre-existing conditions from insurance plans. Ac-


ording to the CBO, the House bill would drop deficits by \$109 billion over the span of a decade.

During the month of December, debate within the Senate led to a modification of its bill’s public option. In a new proposal, individuals between the ages of 55 and 64 could buy in to Medicare, and the federal agency known as the Office of Personnel Management could negotiate with insurance companies to offer national health benefit plans. However, the proposal for Medicare expansion was eliminated after opposition from Sen. Joseph Lieberman (I-CT). On December 24, the Senate passed the health care bill by a party line vote of 60 to 39.

At first glance, the passage of the Senate bill appeared to be a historic vote, bringing the nation closer to the elusive holy grail of comprehensive health care reform. Debate continued concerning how the House and Senate bills could be reconciled. However, on January 19 of this year, Republican candidate Scott Brown won the special election in Massachusetts to fill the Senate seat made available by the demise of Sen. Edward M. Kennedy (D-MA). Senator Brown’s victory eliminated the 60-vote Democratic filibuster-proof majority. Senator Brown’s election, for a seat once held by Senator Kennedy, is ironic, as Senator Kennedy referred to comprehensive health care reform as the “cause of my life.”

The race to reform health care hit a yellow flag, as other national issues became more prominent, specifically, the economy and high unemployment rates. The yellow flag was changed to green when, on February 25, President Obama hosted a bipartisan health care summit at the Blair House, in Washington, DC. At that meeting, and during press conferences following the summit, an up or down, or “reconciliation,” vote on health care legislation was considered, which would require a simple majority vote, and avoid a potential partisan filibuster. On March 17, the CBO concluded that the health care reform legislation being considered would cost approximately \$940 billion dollars over ten years, but would also reduce the deficit by \$138 billion over the same time period. Four days after the release of the CBO’s report, the House passed, with a 219 to 212 vote, the Senate health reform bill, H.R. 3590—the Patient Protection and Affordable Care Act.¹² On March 23, President Obama signed the bill into law in a packed ceremony in the East

Room of the White House, marking the enactment of the most significant social legislation since the Johnson Administration.

In conclusion, from Theodore Roosevelt, to the creation of Medicare and Medicaid, to multi-party attempts by Presidents Nixon and Clinton, modern health care reform has seen modest gains and numerous near misses. Now—although we have reached a monumental milestone—it is unclear if there is a final destination to the road to comprehensive health care reform. This article should read as a primer to help surgeons begin to understand the complicated history of health care reform in this country, and possibly spark interest in becoming an informed participant in the health care reform debate. 

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