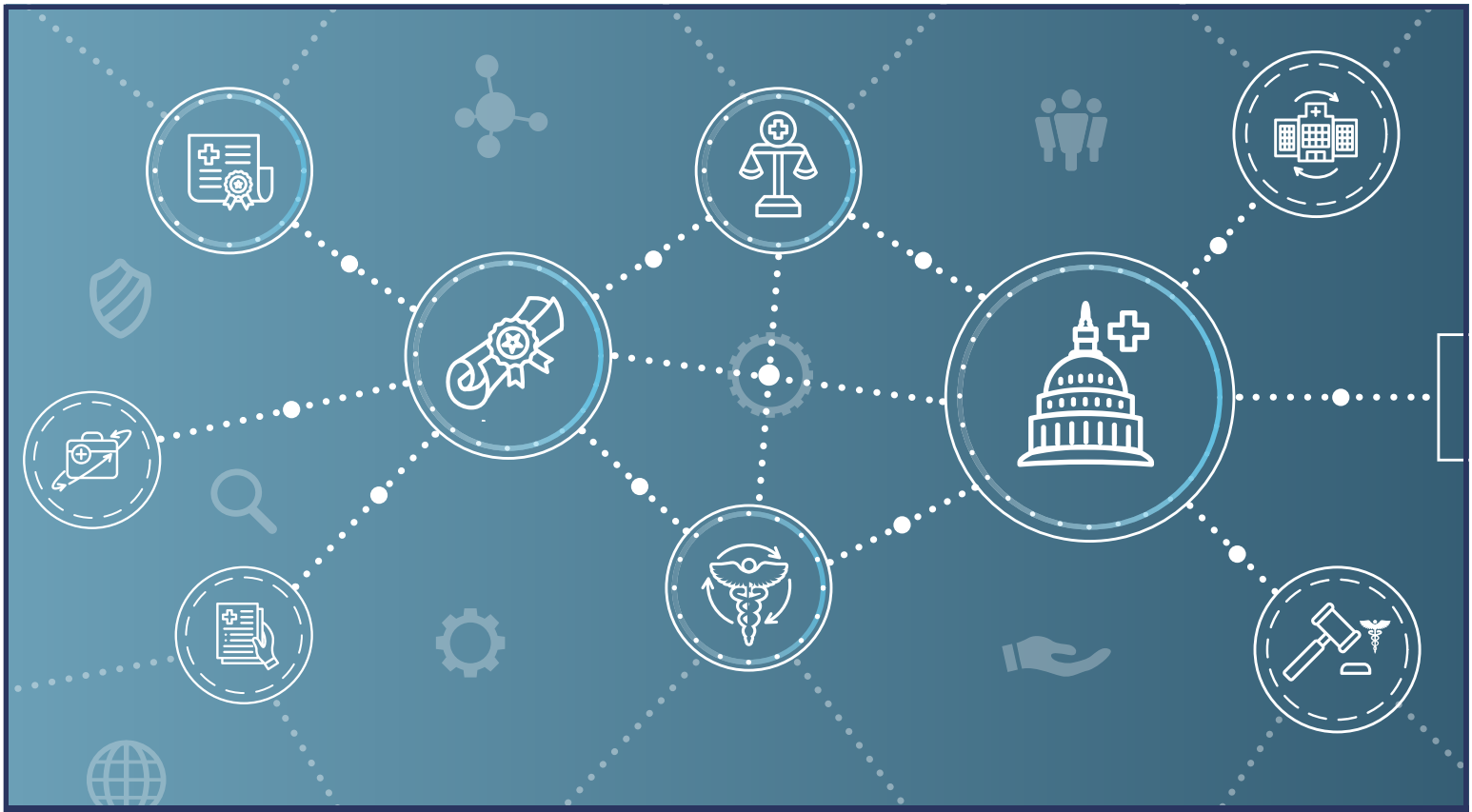

A Brief History of Government Intervention in the U.S. Healthcare System

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Right on Healthcare
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Introduction

In 21st century America, the concept of healthcare access has been conflated with health insurance coverage. Yet, this is a relatively new way of thinking. Less than 100 years ago, health insurance was not the primary conduit through which people arranged and paid for healthcare services.

In fact, before price controls during World War II led employers to begin offering health coverage benefits, most people simply paid for healthcare out of their own pockets. This direct payment system helped keep healthcare much less expensive than it is today. Yet there were more efficiencies to be found in the provision of healthcare, in addition to the need for helping those who could not afford even the modest costs of the day. The American penchant for forming "associations," as Alexis de Tocqueville described it, provided opportunities for both the more efficient and charitable provision of healthcare.

As de Tocqueville noted after his travels throughout America, "In the United States, as soon as several inhabitants have taken an opinion or an idea they wish to promote in society, they seek each other out and unite together once they have made contact" (de Tocqueville). One of the most pervasive of these ideas in 19th century America was the desire to provide healthcare to the poor.

One might expect this idea to take root in America's largest cities, and indeed that was the case. Marvin Olasky catalogues the numerous charitable associations offering healthcare in New York City: "Medical care was available at clinics throughout the city, including the Harlem Dispensary, the Bloomingdale Clinic for the Free Treatment of the Poor, the Good Samaritan Dispensary (which treated 73,363 new patients in 1891 and dispensed 85,752 prescriptions), and the North-Eastern Dispensary, which treated 22,431 persons, including 3,276 in their own homes—yes, clinic doctors even made free house calls" (83).

Private associations also led the way in developing insurance products for healthcare consumers. For instance, prepaid hospital plans arranged by professional groups surfaced in the late 1920s and precursed the more comprehensive hospital insurance plans of the 1930s. Prepaid plans for physician services spread and organized in the 1940s and eventually merged with hospital insurance. These innovative arrangements allowed individuals to finance medical care by leveraging group purchasing power and granted healthcare providers a reliable revenue source. The growth of these industries was aided by the minimal regulations imposed at the state level.

The growth of government brought about by World War II resulted in massive market intervention from Congress and President Franklin Roosevelt, which led to the "accidental" union of health insurance and employment. The traditional

Key Points

- Employer-sponsored healthcare insurance was initially created in response to the wage freeze in World War II as employers wanted to entice potential employees with benefit packages.
- Healthcare and health insurance have consistently been combined and confused for each other, creating the false narrative that the way for a person to get healthcare is only through the purchase of health insurance.
- Following the current trend of government intervention in the health insurance market, the likely end result will be a single-payer system administered by the federal government.
- If the Patient Protection and Affordable Care Act, stripped of its individual mandate penalty, is deemed unconstitutional, there may be a pathway for citizens to look outside of health insurance markets and toward other options—direct care, health sharing ministries, or health reimbursement arrangements.

doctor-patient relationship opened up to include third-party payers and fourth-party contributors. By 1953, the majority of Americans had employer-based health insurance (Davidson and Blumberg; Mihm). As the healthcare delivery model increasingly centralized and uniformized, it became a vulnerable target for government regulation.

States had full regulatory authority over private insurance until 1944, when the Supreme Court categorized insurance as interstate commerce (NAIC 2019b). Federal regulation of private insurance grew substantially in the 1970s, establishing managed care as the dominant delivery model at the heart of the U.S. healthcare system. Under President Nixon, the federal government began investing heavily in health maintenance organizations (HMOs) in an attempt to unify health services under one organization (Gruber et al., 197-198). Simultaneously, federal standards were imposed on employer-based health insurance plans. Eventually, employers would be liable to pay penalties—a minimum of $2,320 per full-time employee—for failing to offer comprehensive health insurance to their employees (Cigna).

States were responsible for medical welfare programs until the 1960s, when the federal government began financing state programs, eventually grabbing more and more control. The creation of Medicaid and Medicare set a national precedent that, to some extent, health care was an entitlement. These programs have been expanded countless times since. The most recent major expansion, the Patient Protection and Affordable Care Act of 2010, authorizes states to offer medical welfare to able-bodied, low-income adults with substantial federal subsidies.

Today, 67 percent of Americans think that the U.S. healthcare system is "broken" or "not working well" (RCP, 5). The normalization of government-regulated, government-funded, and government-administered health insurance, available to more and more populations, has set the stage for the present outcries that America has a moral imperative to adopt a universal healthcare system. Attempts to repeal or rollback the massive regulatory regime established over the past 50 years have met considerable obstacles with little success.

The normalization of government-regulated, government-funded, and government-administered health insurance has set the stage for outcries that America has a moral imperative to adopt a universal healthcare system.

A combined sense of urgency, confusion, and fear shrouds the issue of healthcare. While some advocate for socialized health insurance, others advocate for deregulation of the healthcare industry. Opponents of the former do not trust the government to make healthcare decisions for them; opponents of the latter do not trust that insurance companies and healthcare providers will be fair and available to them.

As long as Americans accept this false dichotomy—put yourself at the mercy of government or at the mercy of heartless corporations—they will be disarmed by fear and accept further encroachments on their rights and relationship with healthcare. We have become susceptible to trusting others with decisions about our health because we no longer trust ourselves. Whatever system the U.S. adopts moving forward must restore and nurture individuals' trust in themselves and satisfy the competing values of the American people, namely agency and peace of mind (Frontier Lab).

Early Market-based Healthcare and Insurance

At the turn of the 20th century, very few people had health insurance. Medicine had not yet developed into a reliable science. The field was dominated by superstition and unfounded theories, sans the drugs and technology that relieve pain or cure disease. The average American's healthcare expenditure was $5 per year, about $100 by today's standard, because paying for healthcare did not pay off (Davidson and Blumberg).

Healthcare moved away from cure-all potions toward science-based treatment in the 1920s. Accreditation standards for physician education were explored by the Council on Medical Education, formed by the American Medical Association (AMA) in 1904. The American College of Surgeons was formed in 1913 and pushed for higher professional standards among physicians and hospitals (Thomasson 2003). As the quality of medicine increased, people began receiving treatment in hospitals rather than at home. The average American family spent $108 on medical

expenses in 1929, 14 percent of which covered hospital costs. As business boomed, hospitals began looking for ways to increase consistent consumer healthcare spending, which would eventually lead to the first offerings of hospital insurance (Thomasson 2002, 236).

Before hospital insurance took off in the 1930s, people purchased accident and sickness insurance to hedge the risk of lost wages. The Massachusetts Health Insurance Company of Boston was the first to offer sickness insurance in 1847 (Wenck, 547). The earliest implementations of sickness insurance were industrial funds set up by individual companies, fraternal groups, or labor unions. In 1890, there were 1,259 of these funds nationwide. In 1910, the cost of membership in a fund was about 10 percent of the average worker's pay, about $10 per week. If a recipient was unable to work, he would be examined by a physician. After a one-week waiting period, he would receive half his weekly pay. The waiting period was intended to reserve benefits for the seriously ill and were generally actuarially fair based on the average amount of time a worker with serious illness or injury received benefits (Murray).

The first company to offer accident insurance was the Franklin Health Assurance Company of Massachusetts in 1850. In 1863, the Travelers Insurance Company began offering accident insurance that resembled today's policies. It originally covered railway mishaps but offerings grew to include other accidents. Insurance companies began offering combination accident and sickness insurance in 1890. Hospital insurance surfaced around this time but was not immediately popular (Wenck, 547).

The first general insurance law dates back to 1849 in New York state, prior to which insurance companies were chartered by special acts of the state Legislature. The law required insurance companies to submit incorporation papers to the secretary of state and authorized the state comptroller to regulate them. The comptroller could require insurance companies to submit financial statements and deny their rights to operate on the basis of insufficient financial security (DFS).

In 1866, the state of Virginia passed a law prohibiting the operation of insurance companies prior to their obtaining a license from the state. Licensure was contingent on the submission of particular bonds to the state treasurer. At the same time, Virginia passed another law prohibiting persons from acting as agents for "foreign insurance companies," including insurance companies incorporated in other states, without obtaining a license. Samuel Paul, a Virginia resident, was employed by fire insurance companies incorporated in New York to sell insurance in Virginia. His licensure to act as an agent of a foreign insurance company was denied due to his failure to comply with regulations. Paul proceeded to issue an insurance policy to a Virginia citizen on behalf of a New York company and was indicted. The case, *Paul v. Virginia*, advanced to the Supreme Court, which upheld states' authority to regulate intrastate insurance in 1869 (*Paul v. Virginia*). The ruling also clarified that the business of insurance was not "commerce" under the definition of the Commerce Clause, protecting it from federal regulation.

State insurance commissions began to coordinate in 1871, forming what would eventually become the National Association of Insurance Commissioners (NAIC). They produced regulations regarding multistate insurance providers and their financial reporting (NAIC 2019a). In 1908, the NAIC conducted a study of abusive business practices among accident and sickness insurance issuers with the intention of developing standard policies. The final product was the 1912 Uniform Standard Provisions Law, some form of which was adopted by 27 states and the District of Columbia (Wenck, 547). Provisions for group accident and sickness insurance were added to the Standard Provisions Law in 1939 (Wenck, 548).

In 1947, the NAIC's Accident and Health Committee began developing new standard provisions for the regulation of the accident and health business. They produced the Uniform Individual Accident and Sickness Policy Provision Law, which was adopted by the NAIC in 1950. All states adopted the policy or a modified version (Wenck, 548).

The NAIC's 1912 standard provisions did not specify policies for hospital insurance, as it was not offered separately from accident and sickness insurance at the time (Wenck, 548). The 1950 update included hospital insurance within the definition of accident and sickness insurance. The significant difference between these two standard provisions was that the 1950 version moved away from an "in-the-words-and-in-the-order" approach to an "in-substance" approach. The previous approach outlined the exact wording of provisions and required policies to include them, even if they did not pertain to a particular type of policy. The updated rule acknowledged that some provisions do not pertain to certain kinds of coverage and focused on a substance-based standard, rather than specific wording. This allowed insurers greater flexibility and aided the development of health insurance policies similar to those offered today (Wenck, 549; SOA, 411).

Prepaid Medical Care Programs

The first prepaid group medical care program in the U.S. was the Marine Hospital Service, established by Congress

in 1798 via "An Act for the Relief of Sick and Disabled Seamen" (SSA 2019a; NIH). The act created a network of marine hospitals and funded medical care through a hospital tax of 20 cents per month, deducted from sailors' income. In 1799, the program was expanded to cover all officers and sailors in the U.S. Navy (HHS 2019; NIH).

However, most early prepaid care programs began in the private sector. In the late 1800s, it became common for employers and unions to sponsor mutual aid programs or provide on-site medical care (Rosner and Markowitz). Railroad, mining, and lumbering industries kept employed company physicians to treat injuries and occasionally provide routine care as company doctors, particularly in the railroad and mining industries. Coal, steel, and automobile corporations hired physicians to provide emergency care or opened their own hospitals and clinics (Draper, 10). Company medical services were typically funded by a combination of employee wage deductions and industrial funds (EBRI, 1; Murray).

Baylor University Teachers' Hospital Prepaid Plan

After the stock market crash in October 1929, patients struggled to pay their hospital bills, and hospital occupancy fell. That same year, a group of teachers in Dallas contracted with the Baylor University Hospital to provide 21 days of hospitalization for an annual payment of $6 per member (Thomasson 2003). The arrangement was a prepaid direct group contract, rather than a group insurance plan. The first day the plan was available, 1,356 teachers signed up (Ballard et al., 279).

The Baylor plan covered 408 groups with 23,000 members within its first five years of operation. Dispersing medical expenditures into small monthly payments made it easier for patients to afford healthcare and provided hospitals reliable revenue (Ballard et al., 279; Thomasson 2003). The innovative payment arrangement was instrumental to meeting the rising demand for hospital care amidst an economic downturn.

Blue Cross

Prepaid hospital service plans spread throughout the country as the Great Depression deepened. Single-hospital prepaid plans increased competition among providers and incentivized community hospitals to cooperate on multi-hospital prepaid plans, which laid the foundation for modern-day health insurance (Thomasson 2003).

In 1933, the American Hospital Association (AHA) developed a multi-hospital insurance plan under the name Blue Cross (Thomasson 2003). The plan was popular because it offered more provider options than the Baylor plan's single-hospital model. However, the Blue Cross system originally only covered nonprofit hospital services to placate the AMA's concern that it would infringe on physicians' incomes (Niles, 10).

As Blue Cross plans spread, the AHA created the Special Commission on Hospital Service to determine standards for "associate institutional membership" and began certifying plans that met these standards (Consumer Reports Advocacy, 6). Blue Cross certification required plans to offer patients a choice of doctors and hospitals, eliminating the single-hospital plan model from consideration.

State-level legislation granted Blue Cross plans tax-exempt status and allowed them to operate as nonprofit corporations because they were considered charitable organizations (Austin and Hungerford, 4). This meant that Blue Cross plans did not have to meet the standard reserve requirements applicable to for-profit insurance companies. Blue Cross sold more health care coverage in low-regulation states that implemented these policies. By 1940, approximately half of the states had passed such legislation and six million people were covered by Blue Cross plans, approximately 4.5 percent of the population (Consumer Reports Advocacy, 6-7). By 1950, 57 percent of Americans had hospital insurance (Niles, 9).

Blue Shield

Physicians were hesitant to adopt the prepaid model out of concerns that a third-party payment system would limit their ability to control prices and would interfere with the physician-patient relationship. However, as Blue Cross plans increased in popularity, physicians feared hospitals would begin competing with them by offering insurance for physician services. Physicians were also concerned about the growing activism around social security legislation and a national healthcare program. To pre-empt the threats to their autonomy posed by both possibilities, physicians formed their own prepaid plans (Thomasson 2003).

In 1934, the AMA adopted a set of principles that ensured voluntary health insurance would remain under physicians' supervision and that physicians would retain their right to control prices for their services. The prepaid physician services model began with the California Physicians' Service in 1939 (Thomasson 2003). The California Medical Association created this nonprofit service plan to stave off attempts by the California governor to institute compulsory insurance (Consumer Reports Advocacy, 8).

Similar plans spread across the country and affiliated under the name Blue Shield in 1946 (Consumer Reports Advocacy, 8). The Blue Cross Commission was established

to create a nationwide network of physicians. Physicians retained their ability to control pricing by charging patients directly for the difference between the service cost and the amount reimbursed by Blue Shield prepaid plans (Thomasson 2003).

The standards set by the AHA Special Commission on Hospital Service in 1937 allowed physician prepaid plans to affiliate with Blue Cross (Consumer Reports Advocacy, 8). Throughout the 1940s, Blue Cross and Blue Shield collaborated to offer comprehensive coverage to the 24 million members of both plans (BCBS). The two organizations merged officially in 1982 to form the Blue Cross Blue Shield Association (BCBSA).

Medical Welfare Proposals

Early State and Local Welfare

Throughout America's early history, local governments and private charitable organizations provided public relief for the poor and needy (SSA 2019c, 1). It wasn't until the early 1900s that states, and soon after, the federal government, began experimenting with organized governmental welfare, including pension programs for single mothers with dependent children and aid to the blind and elderly. In the early 1930s, approximately 28 states had some form of old-age assistance program (VCU).

The first state workers' compensation law was passed in 1911 in Wisconsin and was quickly replicated by the majority of states through the 1930s. It was also common for states and local governments to have retirement programs for public employees, such as teachers, police, and firefighters.

Programs facilitating medical care were not common in the states at this time, likely due to the fact that medicine did not become reliable until the 1920s, as discussed earlier. Private charitable organizations, such as religious institutions and hospitals—which at the time were basically poorhouses for the dying indigent—primarily facilitated aid to the medically needy (Sheingold and Hahn, 21; Davidson and Blumberg).

Medical Welfare

Campaigns in support of national medical welfare appeared as early as the 1910s but did not see major success until the 1960s (SSA 1976, 35). Before the Great Depression, the popular belief was that it was the individual's responsibility to prepare for periods of illness, disability, and old age.

Concurrently, the general consensus among Congress, the Supreme Court, and constitutional lawyers was that authority to administer social welfare programs was reserved to the states (SSA 1976, 35). States were wary of implementing welfare programs, due to the high cost and risk of burdening local industries, limiting their ability to compete in the national market.

Great Britain instituted their national health insurance program in 1911, which inspired the American Association of Labor Legislation (AALL), a workers' rights advocacy group, to lobby for state-run health insurance. They produced model legislation in 1915, which included broad hospital and medical benefits for low-income employees and their dependents. In 1917, 12 states had introduced the legislation for consideration, eight of which also appointed study commissions to explore the issue. The state study commissions generally reported unfavorably on the policy (SSA 1976, 36).

In 1920, the AMA publicly opposed government health insurance, fearing government regulations would limit their fees (SSA 1976, 36; Thomasson 2003). Pharmacists opposed the legislation because it would force them to compete with the government in the prescription drug business. While it was uncommon for insurance companies to offer health insurance at the time, burial insurance was popular, and the legislation would prohibit commercial insurance companies from issuing burial insurance policies. Thus, it was also opposed by insurers. Ultimately, the AALL legislation did not pass in a single state (SSA 1976).

Meanwhile, health insurance regulation expanded at the federal level with the passage of the War Risk Insurance Act in 1914, during World War I. The law established a benefits program including health insurance for servicemen and their dependents (SSA 1976). Congress also passed the Sheppard-Towner Act in 1921, which created federal subsidies for state-administered child and maternal health programs. The program expired in 1929. Some scholars remark the Sheppard-Towner Act as "the first venture of the federal government into social security legislation" (Lemons, 776). In any case, it set precedent for the federal government to establish, fund, and regulate social welfare programs, after long consensus that this power belonged solely to the states.

The Social Security Act

The Great Depression dramatically shifted Americans' perspective on social welfare. In the early 1930s, countless movements sprung up all over the country calling for wealth redistribution and new tax-funded programs to provide old-age pensions, universal basic income, and other forms of financial assistance for those struggling to meet their basic needs (SSA 2019d).

In June 1934, President Roosevelt prompted Congress to take on "social insurance" for the elderly and unemployed (SSA 1934a). The same month, he issued an executive order establishing the Committee on Economic Security (CES), which would "study problems relating to the economic security of individuals" and make policy recommendation to "promote greater economic security" (SSA 1934b). The CES considered including health insurance in the social insurance package that President Roosevelt intended Congress to pass but was met with strong opposition from groups such as the AMA and the American Health Association (SSA 1976, 36; Buck). National health insurance was omitted from the final social security proposal, but the CES had produced "broad principles and general observations which appear to be fundamental to the design of a sound plan of health insurance" (Altmeyer).

The Social Security Act was signed on August 14, 1935. It met the rising demand for social welfare by establishing federal assistance programs for the elderly and unemployed. The only health provisions included in the original Social Security Act were grants to states to fund medical care programs for mothers with dependent children and appropriations to support public health work (SSA 1935).

By 1938, more than 30 million people were contributing to the Social Security retirement fund, and President Roosevelt returned his attention to nationwide healthcare coverage (Buck). He intended to make universal healthcare coverage part of his 1940 presidential campaign, but World War II "intervened" (Altmeyer). In his 1944 State of the Union address, President Roosevelt unveiled his Economic Bill of Rights, which included "the right to adequate medical care and the opportunity to achieve and enjoy good health" (Roosevelt).

No legislation reflecting a right to healthcare passed before President Roosevelt's death in March 1945. In 1950, the Social Security Act was amended to include federal matching funds for state medical care expenditures under their respective welfare programs. These were the first federal medical payments for welfare recipients in U.S. history (Moore and Smith, 45). The 1950 amendments also included the addition of disability insurance and increased funding for maternal and dependent child health services (Cohen and Myers).

Employer-Based Health Insurance

Employer-based health insurance was not common before World War II. On April 11, 1941, President Franklin D. Roosevelt issued an executive order establishing the Office of Price Administration and Civilian Supply (OPA) "for the purpose of avoiding profiteering and unwarranted price rises, and of facilitating an adequate supply and the equitable distribution of materials and commodities for civilian use, and...the stabilization of prices…in the interest of national defense" (Executive Order 8734). The order granted the OPA unlimited authority to control the prices of materials and commodities.

On January 30, 1942, President Roosevelt signed the Emergency Price Control Act of 1942, which formalized and strengthened the OPA's authority over the U.S. economy. The act authorized the OPA to freeze prices without investigation for up to 60 days (Roosevelt and Rosenman, 70). On October 2, 1942, an amendment to the Emergency Price Control Act was passed, authorizing the president to freeze wages, which he did via executive order on October 3, 1942 (Roosevelt and Rosenman, 398). The wage freeze, however, did not apply to employer-provided insurance and pension benefits.

Employers were left with no other options but to attract workers by offering competitive benefits packages, including health insurance. Employer-based health insurance was also attractive from a tax perspective. The Revenue Act of 1918 had established that compensation received through accident and health insurance or workers' compensation were tax-exempt (CRS 2011, 7). Amendments to the Revenue Code in 1939 and 1954 further clarified and expanded the health benefits tax advantage.

In 1949, the National Labor Relations Board ruled that "wages" included insurance and pension packages and therefore unions could negotiate benefit packages on behalf of workers. This ruling reinforced the institution of employer-based health insurance moving into the postwar era.

Employer-based health insurance soon outpaced community programs like Blue Cross and Blue Shield. By 1953, 63 percent of Americans had employer-based health insurance, compared to only 9 percent in 1940 (Davidson and Blumberg). Today, approximately half of the U.S. population received health insurance through their employer (KFF 2019).

The extent to which Americans rely on employers for health coverage sets them apart from people in other countries (Dolan). According to Dr. Edwin Dolan, economist at the Niskanen Center, "Germany is the only country [besides America] where employers play a large role in the insurance process, but German workers who lose or change jobs do not risk loss of coverage" (Dolan). Dr. Dolan refers to the problem of "job lock," the phenomenon created by employer-based health insurance, wherein individuals risk

losing health insurance when they change or lose their jobs. The problem of job lock leads to the question: Why is the connection between employment and health insurance so strong in the U.S.? It seems the union of these two institutions was an unintended consequence of the World War II price controls, which explains why some historians denote it as an "accident" of history (Davidson and Blumberg; Mihm).

The McCarran-Ferguson Act

In 1944, the Supreme Court issued a ruling in *United States v. South-Eastern Underwriters Association*, which overturned the Court's previous ruling in *Paul v. Virginia* (1869). The 1944 decision reclassified insurance as interstate commerce, subjecting it to federal regulation under the Commerce Clause (NAIC 2019b).

To protect states' authority over insurance and preserve 75 years of state insurance policy development, the NAIC drafted legislation that would allow Congress to delegate its newfound authority to the states (NAIC 2019b). Sens. Pat McCarran and Homer Ferguson sponsored the bill, which passed in 1945.

The bill established that "the business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business" with two caveats (15 U.S. Code § 1012). The first caveat is that the federal government may regulate insurance by stating explicitly in legislation that the provisions pertain to the business of insurance. The second is that the federal Sherman Act, Clayton Act, and Federal Trade Commission Act apply to the business of insurance to the extent states do not regulate it.

After the McCarran-Ferguson Act passed, state insurance regulators and the NAIC coordinated to strengthen their authority and respective regulatory frameworks, so as to minimize the possibility of federal intervention (NAIC 2019b). The result was stronger price controls, increased regulations on insurance rates, and prohibitions on rebates.

Kerr-Mills Act of 1960

By 1960, the vast majority of states had taken advantage of the federal-matching funds for payments to medical vendors servicing welfare recipients, established by the 1950 Social Security Act amendments (Moore and Smith, 45). While the stigma against welfare programs lingered, support for medical assistance had increased and states wanted more funding.

The Kerr-Mills Act of 1960 created the Medical Assistance to the Aged (MAA) program, providing federal-matching funds for state-facilitated medical benefits to elderly individuals who did not qualify for old-age assistance but whose income was insufficient to meet their medical needs (Moore and Smith, 46). It was the first time the elderly received direct aid in the form of medical coverage. Program eligibility standards and benefits levels were decided by the states, with some broad federal restrictions.

The union between employment and health insurance in the U.S. was an unintended consequence of World War II price controls, which explains why some historians denote it as an "accident" of history.

In 1965, 40 states had implemented MAA programs under Kerr-Mills, and three others had authorized implementation (Moore and Smith, 47). Several states, including Texas, worked in collaboration with Blue Cross plans to administer the MAA program (Consumer Reports Advocacy, 12). These partnerships proved cost-effective and allowed for the expansion of benefits. They also laid the foundation for the publicly funded, privately administered managed care system at the center of contemporary medical welfare programs.

Within its first five years of operation, MAA only covered 264,687 people, less than 2 percent of the elderly population (Moore and Smith 2006, 47). Seeing MAA as insufficient to meet the medical needs of the elderly, the Johnson administration began work on a more extensive and comprehensive medical welfare program, relying on Kerr-Mills and state partnerships with Blue Cross Blue Shield plans as models (Consumer Reports Advocacy, 12-13).

Medicare and Medicaid

Social security and the MAA normalized welfare and medical coverage for needy populations, and support for nationalized health insurance resurfaced (Thomasson 2003). America's elderly population was increasing, along with the cost of healthcare and health insurance

(Moore and Smith, 47). Investigations by the Senate and House Special Committees on the Aging confirmed limited access to healthcare among the elderly and the insufficiency of the MAA to meet demand. State officials also called on Congress to reform or replace the Kerr-Mills Act to alleviate the upward pressure on welfare spending (Moore and Smith, 47).

National advocacy groups, such as trade unions and public welfare associations, did not want to be left out of any future welfare reforms. They worked hard in the 1960s to increase attention on the financial difficulties of non-elderly, low-income populations (Moore and Smith, 47).

Congressman Wilbur Mills, of the Kerr-Mills Act, and Wilbur Cohen, assistant secretary of legislation for the Department of Health, Education, and Welfare, spearheaded the initiative to deliver a reform plan (Moore and Smith, 48). Their efforts culminated in the 1965 Social Security Amendments, establishing Medicare and Medicaid. The former established a comprehensive federal health insurance program for elderly Americans; the latter established a joint federal-state program to provide health insurance to low-income families with dependent children and people who are aged, blind, or permanently disabled.

Medicare originally consisted of two parts: a compulsory hospital insurance plan, also known as Medicare Part A, and an opt-in supplemental medical insurance plan, Medicare Part B (SSA 2019b). Part A covered inpatient hospital services, post-hospital extended care, outpatient hospital diagnostic services, and post-hospital home health services. Part B covered physician services, home health services, and various other services provided in and out of medical institutions. The legislation required the secretary of Health, Education, and Welfare to contract with private health insurance carriers for the administration of Part B (SSA 2019b).

Medicare would be funded through payroll and income taxes, collected in the Federal Hospital Insurance Trust Fund, and premiums collected under Part B, which would be matched by the federal government and collected in the Federal Supplementary Medical Insurance Trust Fund (Thomasson 2003; SSA 2019b). Part B premiums were originally set at $3 per month.

Medicare funds would be used to reimburse healthcare providers at the "usual, customary, and reasonable rate" for the cost of services rendered to enrollees (Thomasson 2003). This payment-per-service model is typically denoted as "fee-for-service." Providers retained the ability to bill patients directly for the difference between the total charge and the Medicare reimbursement. They were incentivized to participate, i.e., treat Medicare patients, because they retained the ability to control prices.

Medicaid was a relatively noncontroversial component of the 1965 Social Security Amendments (Moore and Smith, 48). It was modeled after the MAA in that it would be jointly funded by the federal and state governments on a matching basis and administered by the states on an opt-in basis (Moore and Smith, 48). The federal government laid out broad guidelines, including minimum mandatory eligibility and coverage standards, beyond which states had some flexibility to customize (Thomasson 2003).

Participating states were required to cover low-income families with dependent children, the aged, the blind, the permanently and totally disabled, and existing state welfare recipients—so long as these populations' incomes were "insufficient to meet the costs of necessary medical services" (P.L. 89-97 §1901). Mandatory coverage included physician services, skilled nursing home services, laboratory and X-ray services, outpatient care, and inpatient care (Moore and Smith, 50).

Medicare and Medicaid imposed a paradigm shift within healthcare. On July 1, 1966, millions of Americans lost total or partial financial responsibility for their healthcare. The compartmentalization of the consumer of health services (the patient) and the payer of health services (now the government or a private insurance company contracted by the government to administer payment) began the era of what is known as the "third-party payer" system. Congress would later grant third-party payers control over non-financial decisions for patients and healthcare providers.

The Health Maintenance Organization Act of 1973

Between 1965 and 1971, the cost of physician services increased 7 percent, and hospital charges increased 13 percent. During the same period, the Consumer Price Index increased only 5.3 percent, indicating that the spike in healthcare costs was a bona fide bubble, resulting from the government's injection of artificial liquidity into the market. National healthcare expenditures went from $39 billion in 1965 to $75 billion in 1971 (Brase).

The fee-for-service system created an incentive for providers to perform more treatments, to increase the quantity of reimbursements collected, and to inflate the price of each service, to maximize their reimbursements. Meanwhile, millions of Medicaid and Medicare patients were stripped of the incentive to economize and were handed a blank check

to use at the doctor's office. The result was massive inflation of healthcare and coverage costs.

The Vietnam War and steep inflation, not just in healthcare but across all industries, contributed to recession in the early 1970s. Congress responded to the nation's financial distress with the Economic Stabilization Act of 1970, which "conferred upon the President virtually unrestricted authority to institute and administer a system of economic controls" (Rigby, 458). President Nixon froze prices, wages, salaries, and rents from 1971 to 1974, including special regulations for the medical sector (Ozminkowski et al., 16).

In addition to price controls on the private sector, the Nixon administration implemented cost-containment initiatives within Medicare, such as reimbursement restrictions and new reimbursement methodologies (Ozminkowski et al., 17; Przybylski, 5). The most pivotal healthcare initiative, however, was the federal government's investment in health maintenance organizations (HMOs).

HMOs are insurance providers that offer medical coverage within a select network of healthcare providers. In-network healthcare providers contract with HMOs to determine rates of reimbursement for services provided to HMO enrollees. The providers have an incentive to join HMO networks because the HMO directs enrollees to them for care, which alleviates the pressure of competing for patients. Patients pay monthly premiums directly to HMOs in exchange for coverage, basic and/or supplemental, and access to its provider network.

On March 2, 1972, President Nixon sent a "Special Message to the Congress on Health Care," wherein he stated: "The Health Maintenance Organization concept is such a central feature of my National Health Strategy" (Nixon, 389). His first stated reason was that HMOs unified physician, hospital, laboratory, and clinical services under one central organization, making access and navigability better for patients. The second reason was that HMOs' financial model of contracting fixed annual sums in advance, rather than continuously reimbursing services with no limits, mitigated perverse incentives to over-treat patients and rewarded providers for preventing illness. In his address, President Nixon advocated for legislation to incorporate the HMO model into both Medicare and Medicaid (Nixon, 389).

Prior to receipt of legislative authority, the Nixon administration had authorized $26 million for 110 HMO projects in 1972 (Brase; Nixon, 389). Nixon allocated an additional $27 million "for HMO development" in the 1972 supplemental budget and requested from Congress $60 million to continue efforts in 1973 (Nixon, 390). The Senate passed a bill that would have allocated $5.2 billion, from 1973 through 1975 "for the establishment of [HMOs] to improve the nation's healthcare delivery system by encouraging prepaid comprehensive healthcare programs," but the bill failed to pass in the House (Brown, 250).

President Nixon signed the Health Maintenance Organization Act on December 29, 1973, appropriating $375 million over the first five years to aid the development of HMOs (Mueller, 37). The act set definitional and organizational requirements for HMOs, as well as requirements on their risk management, quality control measures, data reporting, and enrollment standards. HMOs servicing Medicare and Medicaid enrollees were exempt from the definitional requirements and reinsurance ceilings imposed by the act (Mueller, 38).

The HMO Act superseded all state laws that impeded HMO growth under the new federal standards (Mueller, 38). Several states had laws protecting physicians' autonomy over their practices and prices, which created a barrier for HMO expansion. Another barrier to HMOs was their difficulty competing in the employer-based health insurance market, due to their higher premiums (Brase). However, since HMOs were a government mandate on employers with 25 or more employees that offered health benefits, they are inherently not meant to be competitive within the health insurance market but rather act as a disrupter (Mueller, 38).

The HMO Act succeeded in popularizing the HMO model. In 1970, there were approximately 37 HMOs operating in 14 states with an estimated total enrollment of 3 million. By January 1975, 183 HMOs operated in 32 states and the District of Columbia, with an enrollment of 6 million (Gruber et al., 198).

In 1976, the HMO Act was amended to broaden the requirements for federal qualification and loosen the original financial and risk management requirements (Gruber et al., 199). By 1980, there were approximately 236 HMOs in the country.

The spread of HMOs marked the advent of the "managed care" healthcare system. Managed care refers to a healthcare delivery system in which a third-party-payer entity controls costs by managing reimbursements to healthcare providers and managing care options available to enrollees. By supporting HMOs and using them to administer Medicare and Medicaid, the federal government was able to centralize cost and outcome data, further remove patients and healthcare providers from healthcare decisions, and upend the healthcare system to flow downstream from third-party costs.

In June 1998, over 53 percent of Medicaid recipients were enrolled in managed care plans. In 2000, about 15 percent of Medicare recipients were enrolled in HMOs (Brase).

The Employee Retirement Income Security Act of 1974

In order to accommodate the increasing population of aging former employees, private businesses began setting up pension accounts in the late 19th century. These plans—typically only seen in the railroad and banking industries—did not offer retired employees lavish compensation, but rather half of what was their annual salary or approximately $500 (Bortz; Phipps).

In 1974, Congress enacted the Employee Retirement Income Security Act (ERISA) to create uniform regulations for pensions and retired employee benefit plans (Polzer and Butler, 93). There is no requirement that an employer must offer this, but those that do must follow the standards of participation, vesting, and funding established by ERISA (Purcell, 1). Employers can change the terms of their benefit packages at any time during an employee's retirement (DOL).

Government and religious institution retirement plans are exempt from ERISA standards. ERISA preempts state laws regarding private sector health plans. However, the Supreme Court ruled in *Metropolitan Life Insurance Co. v. Massachusetts* that states can indirectly regulate employee health plans through regulating health insurers.

There have been two notable changes to ERISA. The first was with the Consolidated Omnibus Budget Reconciliation Act of 1985. This requires that employee health benefit plans have to continue offering the agreed-upon coverage, at the cost to the employee, in the event that they no longer work there for at most 18 months (Polzer and Butler, 95). Secondly, when the Health Insurance Portability and Accountability Act was enacted in 1996, Congress amended ERISA by allowing access to the healthcare insurance market for people with chronic diseases after a maximum exclusionary period (Polzer and Butler, 99).

The Deficit Reduction Act of 1984

On July 18, 1984, President Reagan signed into law the Deficit Reduction Act of 1984 (DEFRA). This act had a wide scope of policy changes, including changes to the Medicare and Medicaid programs (IRS). This was a time when many Americans were concerned about excessive government spending, and in the realm of healthcare, DEFRA amended welfare benefit plans.

DEFRA limited cost increases in Medicare for a set amount of time. Physician fees were frozen at their June 1984 levels for 15 months. Hospitals were also only permitted to increase costs per case by 0.25 percent from fiscal years 1984 to 1985 (OLP, 11-12).

During this time, late enrollment surcharges were waived for those enrolling in Medicare Part B if a person was still receiving coverage on their employer group health plan. Medicare was also allowed to become secondary insurance for those still covered by an employer, until they turned 70 (OLP, 14).

Medicaid was also amended to assist those groups determined to be the most vulnerable in healthcare—pregnant women and children. If a pregnant woman or a child qualified for the federal cash assistance program, Aid to Families with Dependent Children, they were able to get healthcare coverage on Medicaid (OLP, 14).

The Consolidated Omnibus Budget Reconciliation Act of 1985

Before 1985, employer-sponsored health insurance did not follow an employee past a 30- to 60-day period after leaving the organization. A gap in coverage could potentially hurt an employee if they were seeking treatments, thus slowing down the process of finding new employment.

The Consolidated Omnibus Budget Reconciliation Act (COBRA) required employers with 20 or more employees to provide extended healthcare coverage for up to 18 months in the event of termination, reduction of hours, death of the employee, and divorce or separation. This act does not apply to small employers (less than 20 employees), church plans, or government employees (CRS 2013). Federal employees have been granted temporary extended coverage through the Federal Employees Health Benefits Program (OPM). State and local employees have continuation of coverage via the Public Health Service Act (42 U.S. Code § 300bb-1), which has very similar provisions to COBRA.

Under this extended coverage plan, the former employee is responsible for paying the entirety of the premium, and employers can charge up to 102 percent of the group plan premium; however, this is still normally cheaper than a private insurance plan. Noncompliance results in an IRS excise tax of $100 per day per beneficiary (CRS 2013).

COBRA affects employer-sponsored insurance plans with early retirees as well. When the employer does not have an established retiree health benefit plan, the former employer is still obligated to offer the 18-month COBRA coverage just as if they were terminated or fit one of the other qualifiers.

The Health Security Act of 1993

When Bill Clinton ran against President George H.W. Bush in 1992, one of his main campaigning points was reforming the healthcare system in the United States. Soon after his inauguration, he established a task force led by First Lady Hillary R. Clinton, with the purpose of providing health security and universal coverage to every American (Clinton).

Clinton's plan identified six principles that the plan would encompass: security, simplicity, savings, choice, quality, and responsibility. Under this proposal, every American was to have guaranteed healthcare coverage their entire lives. This plan was marketed as a way to decrease healthcare costs and increase patient choices, while also not adding to any administrative burdens (Clinton).

This initiative would have been the largest expansion into an industry by the federal government since World War II. It was projected to cost $331 billion from 1994 to 2000. In order to meet the goals outlined by President Clinton, two new government organizations would have to be created: the National Health Board, which would have oversight of the system, and Regional Healthcare Alliances, which would function at the state level and administer coverage. This plan would have set minimum coverage standards and required all employers to offer healthcare coverage through self-insurance, or with a Regional Healthcare Alliance (Moffit 1993, 1).

Pressure from the states to incorporate community engagement principles into Medicaid could eventually lead to major changes at the federal level.

The Health Security Act was unable to pass through the 103rd Congress, even with a Democrat majority in both the House of Representatives and the Senate. The 1994 midterm elections flipped both chambers to Republican, signaling to the president and Americans that a healthcare system run by the government was not something that was deemed necessary or needed by American voters.

The Health Insurance Portability and Accountability Act of 1996

As the 21st century loomed in the distance, policymakers in Congress saw a need to modernize parts of the healthcare system. The result is the Health Insurance Portability and Accountability Act (HIPAA), signed by President Clinton in 1996. Two of the main policy changes HIPAA had were to protect a person's insurance as they transition between jobs and to protect the movement of medical records and personal health information (Health Insurance Portability and Accountability Act of 1996).

This legislation applies to health plans, healthcare clearinghouses, and healthcare providers who electronically transmit healthcare information, including patient and billing information; as of 2013, any business associate that conducts functions on behalf of a covered entity must follow HIPAA guidelines as well (HHS 2013).

The Privacy Rule and Security Rule established under HIPAA are meant to protect any health information—including health status, treatment, or payment for services—that can be linked back to one specific patient (HHS 2003). Health data that has been collected can be used by a listed set of entities—such as research organizations and the government—in order to increase public health outcomes.

HIPAA works in tandem with COBRA when a person is signing up for a new employer healthcare insurance plan. Under HIPAA, a person can no longer be refused coverage due to a pre-existing condition 12 months after their initial enrollment. If on a COBRA plan, a person can meet the expectations of HIPAA's waiting period.

The last amendment to HIPAA was in 2013 with the Final Omnibus Rule. With the introduction of the Health Information Technology for Economic and Clinical Health Act (HITECH), patients were more easily able to request electronic copies of their health records from their providers. There was now a need to ensure the effectiveness of the privacy and security rules. The final rule also required covered entities to adopt HITECH, specifically the provisions dealing with HIPAA noncompliance (HHS 2013).

The Newborns' and Mothers' Health Protection Act and Mental Health Parity Act of 1996

Insurance companies became increasingly stringent on the amount of postpartum care they were willing to provide after a woman gave birth. Physicians were being pressured to not hold new mothers in the hospital for more than 24 hours, even if their expertise deemed a longer stay medically necessary (S. Rept.104-326).

As a result, the Newborns' and Mothers' Health Protection Act was signed into law on September 26, 1996. This act requires group health plans and individual health insurance policies to cover hospitals stays for 48 hours for vaginal deliveries or 96 hours for a cesarean delivery. The clock starts on this time minimum when the child is born, not prior. If a woman delivers her child outside of the hospital, she is allowed the same time coverage, which begins once she has been admitted (CMS 2019c).

The Mental Health Parity Act (MHPA) was also signed into law on September 26, 1996. MHPA required group health plans in firms with 50 or more employees that offered mental health benefits to offer the same lifetime and annual dollar limits for mental health coverage as medical and surgical benefits on their healthcare plan. Employers were not mandated to offer these benefits to their employees (Jenson et al., 201; Barry et al.).

The act did not fulfill its original intent since inequality in mental health coverage was still seen across plans. Plans were able to limit the amount of coverage enrollees received by restricting the level of inpatient and outpatient services a person could receive and raising deductibles (Jenson et al., 201).

MHPA included a sunset date of September 30, 2001, which would have ended the law on that date. The act was amended five times to push back the sunset date to December 31, 2007, when President George W. Bush signed the Tax Relief and Health Care Act of 2006 (EBSA).

Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act

The Mental Health Parity Act was superseded by the Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008, when President Bush signed the Emergency Economic Stabilization Act. Named after the two senators that championed mental health legislation since MHPA, MHPAEA sought to fix the loopholes insurers had found in MHPA.

This act required that healthcare plans that offered mental health or substance use disorder benefits had the same deductibles and copayments as the plan's medical and surgical benefits. The plans were no longer able to single out benefits with separate cost sharing requirements. Plans could not have different treatment limitations for mental health and substance abuse services from those offered for medical and surgical treatments (H.R. 1424).

When enacted, MHPAEA applied to group health plans. With the creation of the Patient Protection and Affordable Care Act, MHPAEA was expanded in scope to include individual insurance plans (CMS 2019b).

Balanced Budget Act of 1997

In order to reduce excessive spending, the Balanced Budget Act (BBA) was signed into law. This legislation signaled the parity between President Clinton and the Republican-held Congress. BBA shows examples of different priorities in the resulting changes to Medicaid and Medicare.

BBA included the largest reduction in Medicaid spending in almost two decades, with the Congressional Budget Office predicting $17 billion in savings over five years, and $61.4 billion over ten years. The act proposed doing this with three plans: limiting the amount of federal funding going to disproportionate share hospitals; eliminating the minimum payment standards that states had to follow for reimbursing hospitals, nursing homes, and community health centers; and allowing states to shift costs from low-income Medicare beneficiaries from Medicaid programs to physicians and other providers (Schneider).

BBA transformed Medicaid by allowing states new powers in how they chose to administer their Medicaid programs. States were now able to require those enrolled on Medicaid to only use managed care organizations that work with Medicaid for their services, without applying for an additional waiver from the U.S. Department of Health and Human Services (Schneider).

Two block grants were introduced in BBA. The first was given to states that did not reduce Medicaid eligibility to children. The grant could be used to expand access to more children who did not qualify under current eligibility requirements. The second was intended for Medicare Part B recipients that were between 120 and 135 percent below the poverty line. BBA increased the premiums for Part B and this block grant sought to reduce this burden some may have faced (Schneider).

BBA created the State Children's Health Insurance Program (CHIP). In 1997, 10 million children were in the Medicaid coverage gap. Their parents' incomes were above state eligibility minimums, but they were without health insurance (MACPAC). The program provides funding to states that expand the scope of children who qualify for healthcare coverage assistance, relative to the state's demographics. CHIP offers federal matching funds, with states having discretion on how they wish to allocate funds. They may expand their Medicaid programs, directly provide the coverage listed in BBA, or through a combination of both options (Snyder and Gerson).

An additional component was added to Medicare, Part C or Medicare+Choice. This allowed the Centers for Medicare and Medicaid Services (CMS) to contract with public or private organizations to offer healthcare plans with benefits that expanded past Part A and Part B. For those who were required to be on Medicare because of their age could now have options in what type of coverage they were able to get to match their healthcare coverage needs (CMS 2019a).

Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000

For the first time since the creation of Medicare, spending decreased from one year to the next from 1998 to 1999. Medicare enrollments also slowed down to only 1.5 percent for that year. This cannot be solely attributed to the BBA, as there was an improved economic forecast and an increase in anti-fraud activities (Chaikind et al., 1).

Providers that worked with Medicare continued to make the assertion that accepting Medicare patients was becoming more difficult under the BBA (Chaikind et al., 1). The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) aimed to alleviate this problem.

This plan aimed to increase spending for Medicare, as well as offer some adjustments to existing public healthcare programs. The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 increased Medicare payments to providers and managed care organizations, reduced some copayments, made adjustments to the Critical Access Hospital program, and increased coverage of preventative services under Medicare (H.R. 4577). The Congressional Budget Office estimated the legislation would increase Medicare spending by $32.3 billion (Chaikind et al., 4).

BIPA also included an extension on the sunset of transitional medical assistance for families eligible for welfare, as well as a new Medicaid prospective payment system (PPS) for qualified health centers and rural clinics (Koppen, 3). The new PPS utilized a classification system of healthcare services and predetermined, fixed amounts for reimbursement of those services (CMS). The goal was to incentivize efficient operations, as hospitals would only be paid up to the PPS limit unless another payment methodology was utilized by the state.

Once implemented, 39 states used the BIPA PPS system (GAO, 10). The new system however did not include all services required by Medicaid standards and did not specify rate adjustments for change in scope of services. States that utilized another payment system were required not to pay less than the PPS rate, but some states paid below that rate regardless. PPS standards were to be adjusted for overall inflation but did not adequately account for increase in cost of services, so some providers were shortchanged even by the federal PPS rate. Implementation of this service also was challenging due to vague requirements and little oversight by CMS to ensure compliance by the states (GAO, 4).

2003 Medicare Expansion

Toward the end of President Clinton's tenure in office, policymakers became concerned about increases in prescription drug prices. This was directly affecting a vulnerable population in society—senior citizens who have retired and may not have access to new or growing income.

From its inception, Medicare covered prescription drugs dispensed in a physician's office and not self-administered by a patient. Drugs which are used to treat end-stage renal disease, cancer, and antirejection medications for transplants, among a select few others, were amended onto the Medicare program (Oliver et al., 292).

The idea of a voluntary Medicare Part D plan began with President Clinton's 1999 State of the Union address and continued to pick up popularity in the 2000 presidential election. It did not begin to become a reality until halfway through President George W. Bush's first term. After the 2002 midterm elections, Republicans controlled both the presidency and both chambers of Congress and legislation began being seriously considered.

Following more than six months of draft legislation changes in both the Senate and the House of Representatives, a conference committee was called to negotiate the ideas set forth in bills offered by both chambers. The resulting legislation expanded the scope of the Medicare program. The act included a voluntary drug program, Medicare Part D, but allowed beneficiaries to maintain a private drug plan. However, enrolling in Part D meant beneficiaries could not purchase supplemental drug coverage plans. Beneficiaries who had a household income 135 percent below the federal poverty line would be able to receive drug discount cards. Medicare Part C was renamed to Medicare Advantage and drug benefits could be included in those plans. Elected members on both sides of the aisle felt alienated by the resulting legislation which narrowly passed the House 220 to 215 and passed the Senate 54 to 44 (Oliver et al., 311-318; 321).

The resulting legislation, the Medicare Prescription Drug, Improvement, and Modernization Act, was signed by President Bush in December 2003. While low-income beneficiaries were able to take advantage of subsidized prescription

drugs, gaps in coverage left many with annual expenses up to $3,600 or more. Only 26 percent of seniors polled the week after the law was signed approved of the plan (Oliver et al., 284-285).

Massachusetts Universal Coverage

In 2006, Massachusetts passed Ch. 58, An Act Providing Access to Affordable, Quality, Accountable Health Care. Nicknamed "Romneycare" for Gov. Mitt Romney, the healthcare reform combined the individual and small group markets and implemented an individual mandate that required people to purchase affordable health insurance (Anthony, 5).

Massachusetts was able to consider getting as close to universal healthcare coverage as possible because of its uniqueness as a state. The state did not have a high population of uninsured persons, maintained broad eligibility requirements for Medicaid, had a higher-than-many-states per capita income, and many employers offered coverage (Doonan and Tull, 66, 55-56). The target group for this legislation was working-aged adults (20-64) who could not afford private health insurance (Long and Stockley, 3).

In addition to an individual mandate, Romneycare also expanded healthcare reform with three programs. The state's Medicaid program, MassHealth, expanded eligibility requirements to include more children. Commonwealth Care was created to subsidize health insurance for families 300 percent below the federal poverty line. And Commonwealth Choice was created to offer unsubsidized plans to individuals and small businesses (Doonan and Tull, 56).

The minimum coverage on Romneycare included preventative and primary care, emergency services, hospitalization benefits, ambulatory patient services, mental health benefits, and prescription drug coverage (Commonwealth Health Insurance Connector Authority, 4). Annual deductibles were capped, with the highest limit being $4,000 a year for families (Doonan and Tull, 64).

There was an exclusive plan option for young adults who were no longer on their parent's health insurance plan and were not yet 26. Young adults are more likely to not be insured, but since they typically do not have severe health problems, they can be an asset to risk pools. The young adult plan had a lower deductible and a premium priced at approximately $130 a month. This option was meant to entice young adults to enter the insurance market and achieve universal coverage in the state (Doonan and Tull, 67).

A central challenge Massachusetts had in implementing this reform was defining affordability in order to require the individual mandate. The Commonwealth Health Insurance Connector Authority developed an affordability schedule, which deemed that those below the poverty line had zero responsibility in paying for monthly premiums, up to a family of four who had full responsibility for premiums after they surpassed an income of $114,401 (Doonan and Tull, 61).

Exemptions and waivers were added in order to mitigate different circumstances people faced. Approximately 60,000 residents were excluded from the enrollment mandate since the costs of buying into this insurance scheme was considered to be burdensome to their financial status; waivers were created for similar reasons for individuals and families that showed similar financial burdens. In the targeted uninsured population—working adults—there was a reduction of the uninsured by 70 percent, with 4 percent of that population still without health insurance (Long and Stockley, 3).

Massachusetts' healthcare plan demonstrated that near universal coverage does not guarantee access to affordable healthcare, as unmet need and difficulty paying medical bills are still prevalent.

Since 2008, Massachusetts has maintained a high rate of coverage. Between 2008 and 2016, the uninsured rate hovered at or below 5 percent. However, gaps in "universal coverage" still exist among nonelderly adults. Premiums have increased more than 50 percent between 2005 and 2014, with employers also shifting more costs to employees due to the increases in required benefits. Additionally, 20 percent of insured adults reported unmet healthcare needs due to cost, and more than 20 percent reported medical debt. Massachusetts' plan demonstrated that near universal coverage does not guarantee access to affordable healthcare, as unmet need and difficulty paying medical bills are still prevalent (Long et al.).

The American Recovery and Reinvestment Act and the HITECH Act

The adoption of health information technology (HIT) has been encouraged and included in healthcare reforms in recent years due to potential benefits to stakeholders. Coordinating the collection of this type of health information can potentially improve public health outcomes by agencies and approved administers conducting research on new drugs and vaccines.

The American Recovery and Reinvestment Act of 2009 (ARRA), in addition to appropriating billions for economic stimulus, appropriated $49 billion to go toward the adoption of Electronic Health Records (EHR) and diffusion of improved HIT through the Health Information Technology for Economic and Clinical Health (HITECH) Act, a part of the ARRA (Burke).

With the intent to digitize and modernize healthcare information, HITECH reformed HIPAA by revising the privacy and security rules and by broadening the scope of those who must comply with these legislations. With the enactment of HITECH, the definition of business associates included health information exchanges and organizations, and other groups that may transmit protected health information (Goldstein and Thorpe, 5).

In order to expedite the medical fields' shift to using EHR systems, HITECH allowed CMS to provide financial incentives to healthcare providers in Medicare and Medicaid that made the transition. Starting on the act's effective date, January 2010, providers who chose to take part in the incentive program had five years to show that their systems had meaningful use as defined by HITECH. This means utilizing e-prescribing, exchanging health information and care coordination over these systems, and reporting on quality measures set by CMS (Goldstein and Thorpe, 2).

The Patient Protection and Affordable Care Act

In June 2009, President Obama held a town hall in Green Bay, Wisconsin, to unveil his plan to overhaul health insurance in America. He focused on the increasing cost of healthcare even for those with insurance and noted that these increasing costs in health insurance were putting American businesses at a disadvantage. He argued that Americans spend 50 percent more on healthcare than any other developed nation. His plan was to create the Health Insurance Exchange, a market for shopping for healthcare coverage. President Obama added that no plan could turn someone away for a pre-existing condition. The other major element to President Obama's plan was the creation of a low-cost public option to encourage competition among private insurance companies. President Obama assured his audience that if someone had a private health insurance plan they liked, they could keep it (Obama 2009).

Despite being dubbed "Obamacare," the legislation text of the Patient Protection and Affordable Care Act (ACA) was not crafted by the executive. Rather, the Obama administration laid out key principles and let Congress draft the actual bill. The House took the lead and the first working draft was released in May 2009. It included provisions for a health insurance exchange, a public option health plan, Medicaid expansion, and insurance mandates for individuals and employers.

Following weeks of hearings, House committee leaders introduced House Bill 3200 (H.R. 3200), which included many of the original provisions of the working draft as well as a funding provision—a surcharge for wealthier Americans. Much of the discussion regarding amendments to the bill took place behind closed doors and not in publicly recorded hearings.

Three versions of H.R. 3200 emerged from the three committees. H.R. 3962 replaced H.R. 3200 as the main healthcare reform bill and contained many of the same provisions, as well as a tax on households with income over $1,000,000; the repeal of the McCarran-Ferguson Act, which had shielded insurance companies from federal antitrust laws; and an excise tax on medical devices. H.R. 3962 was not sent to any committee for review nor was it on the House calendar, but nevertheless it was called up on the House floor less than two weeks after it was introduced. It was moved to the House floor via House Rules Resolution 903, which set the time for debate, called for a vote at the end of the debate period, only allowed for two amendments to be discussed, and made changes to the bill itself. One of the amendments prohibited federal funds going toward abortion procedures for ACA beneficiaries; this ultimately was not included. Rewrites to the bill included the repeal of the McCarran-Ferguson Act and a perfecting amendment. Resolution 903 passed on November 7, 2009, and H.R. 3962 passed later that day (H.R. 3962).

Concurrently, the Senate also began writing bills to execute President Obama's vision. Senate committees on Health, Education, Labor and Pensions (HELP) and Finance coordinated to draft legislation. The unnumbered bill out of the HELP committee was similar to the House bills but did not include a public option. The bill included scaled back subsidies and created a public option, run by the Department of Health and Human Services. Between mid-June and mid-July, approximately 500 amendments were made to the bill. The HELP committee's bill, now titled the Affordable Health

Choices Act was introduced onto the Senate floor as Senate Bill 1679 in September 2009 (S. 1679).

The Finance committee struggled to reach an agreement on a healthcare reform bill. It did include a public option, but also an opt-out option for states that did not wish to participate. This proposal was not introduced as its own bill, rather as an amendment to the Service Members Home Ownership Tax Act of 2009 (H.R. 3590) in order to get it on the Senate Calendar of Business. This amendment, Senate Amendment 2786, struck the original text of H.B. 3590, which had become obsolete due to the passage of a similar bill a few weeks prior, and inserted the Senate healthcare reform proposal. Using a suspension of normal Senate amendment rules, the bill was continuously amended on the floor until mid-December. The public option element was dropped, and so was a Medicare buy-in option. Instead of taxing elective cosmetic surgery, indoor tanning services would be taxed. Abortion services coverage would be limited. These concessions were made to gain the support of moderates, whose votes the majority leader needed to pass the bill. The totally rewritten H.B. 3590 passed the Senate on December 24, 2009, which was now entitled the Patient Protection and Affordable Care Act (PPACA).

Instead of a congressional conference committee to reconcile differences between the ACA and House-originating healthcare reform, a "substitute" was used, whose authors included White House representatives and democratic congressmen, drafted a new version behind closed doors. Avoiding a conference committee meant avoiding filibuster opportunities, and both Congress and the White House wanted the bill passed before the State of the Union in late January of 2010.

On January 19, the Republican Scott Brown was elected in a special election to fill the Massachusetts seat held by the late Ted Kennedy, a Democrat. Democrat leaders in Congress had lost their 60 votes needed to pass their healthcare reform bill without a filibuster. In order to reconcile the ACA with House Democrats' demands, a procedural structure called reconciliation, originally intended for budgetary reconciliation, was used. The House and Senate would pass the ACA as is, then the House would pass reconciling legislation, H.B. 4872, or the Health Care and Education Reconciliation Act (HCERA), to amend the ACA, and the Senate would do the same (Democratic Policy Committee). Both pieces of legislation would go to the president, and the resulting healthcare reform would be comprised of two bills, not one. On March 25, 2010, after much debate and many amendment proposals, the House and Senate concurred on H.B. 4872, and it was sent to the desk of the president.

The issue of abortion coverage had shaped the healthcare reform debate, and some anti-abortion Democrats were concerned the ACA and the HCERA did not uphold the Hyde Amendment, which prohibited the use of federal funds for abortion services. To win the support of these Democrats, President Obama issued an executive order stating the Hyde Amendment applied to the ACA, further complicating, but finally ending, the legislative history of the ACA (Salganicoff et al.).

The major elements of the ACA were the individual mandate, employer requirements, premium subsidies, tax changes, essential benefits, and the health insurance exchange. All individuals were required to have health insurance or face a monetary penalty. Employers with more than 200 employers had to provide employer-sponsored health insurance and pay for any healthcare tax credits their employees may receive (Redhead and Kinzer).

Under the ACA, Medicaid was expanded to cover people with incomes up to 133 percent FPL, but it was up to the discretion of the states whether to opt in to this expansion. CHIP match rate was also increased, and children who were CHIP-eligible but unable to enroll due to enrollment caps would be eligible for tax credits. Medicare also received new investments, including adjustments to coverage gaps under Medicare Part D. Cost-sharing and premiums were also limited, and subsidized, and small businesses received tax credits to be able to provide healthcare for their employees. Flexible spending accounts for medical expenses were capped at $2,500. The ACA included a myriad of new taxes on the taxpayer as well as fees on the pharmaceutical industry (KFF 2013).

Perhaps the most significant, and controversial, aspect of the ACA was its creation of an "exchange" for individuals and small businesses to purchase healthcare coverage that was compliant with government mandates for the minimum standard of "essential" health benefits, plus additional tiered plan categories. Essential health benefits entailed a comprehensive set of services and was up to the discretion of the secretary of Health and Human Services to determine what those benefits were specifically. All private plans also had to cover the mandated essential health benefits, except for (unaltered) grandfathered plans. Private plans were subject to many new regulations, including no lifetime limit on dollar value of coverage, prohibitions on pre-existing condition exclusions, deductible limits, insurance for dependents up to age 26, and limits on waiting periods for new coverage (KFF 2013).

The constant reassurance out of the Obama administration was that if you liked your insurance, you could keep

your insurance. However, if a plan that did not meet ACA standards was altered after passage, the grandfathered clause would not apply. According to an NBC News investigation, the Obama administration estimated that this provision would affect between 40 and 67 percent of people on the individual market. After the passage of the ACA, that estimate was bumped up to between 50 and 70 percent of people who purchased their insurance on an individual basis, or about 14 million Americans. When the grandfathered clause ceases to apply to a policy, it is canceled, and oftentimes "similar" plans are suggested by the insurer. These replacement plans offer "better" coverage, meaning they offer more benefits, and therefore usually cost much more than the original plan. Despite the "if you like your health plan, you can keep your health plan" tagline, millions of people faced cancellations or expensive changes to their plans (Myers and Rappleye).

ACA Repeal Efforts

The enactment of the ACA in March 2010 showed how divided Congress was when issues about implementation came up. Specific sections and the entire act have been debated; defunding, delaying, amending, and repealing the law have repeatedly come up.

At the onset of the 112th Congress, H.R. 2 was introduced into the House of Representatives—Repealing the Job-Killing Health Care Law Act (H.R. 2). The bill passed 245-189, with all Republicans and three Democrats voting for it. House Democrats responded with a motion to recommit an amendment that would not allow a repeal of the ACA until a majority of the members in Congress opted out of the Federal Employees Health Benefit Program (Pelosi). This measure was voted down by House Republicans. H.R. 2 was amended in the Senate onto S. 223, the FAA Air Transportation Modernization and Safety Improvement Act, which failed (S.Amdt.13).

During the 112th Congress, the Supreme Court upheld the ACA as constitutional in *National Federation of Independent Business v. Sebelius*. The Court determined that the individual mandate as a tax, which required most people to have a minimum level of insurance beginning in 2014, was allowed. However, the Court determined that the Medicaid expansion was unconstitutional as it was coercive to states. This made the expansion optional to states (National Federation of Independent Businesses v. Sebelius).

In the 113th Congress, some Republican members in the House amended onto a bill that ACA funding should be eliminated in order for the rest of the federal government to be funded (H.R. 45). The Senate stripped this language from the bill. The House returned with a bill that delayed implementation for a year. This back and forth pushed the spending bill's vote past the end of the fiscal year, September 30, 2013, and effectively shut down the government (McCullough). On October 1, 2013, President Obama commented that the shutdown was a direct effect of Republican opposition to the ACA (Obama 2013). The shutdown did not delay implementation, however. The online market exchange opened the day after the shutdown, albeit to issues with the online servers (Payne et al.).

Republican House members introduced H.R. 3762 in the 114th Congress. It would have repealed health exchange and medical device subsidies, the Medicaid expansion, the "Obamacare Slush Fund" (i.e., the Prevention and Public Health Fund which allows the U.S. Department of Health and Human Services to spend allotted funds as they see fit), federal funding for Planned Parenthood, failure to comply with mandate penalties for individuals and employers, the "Cadillac tax" (i.e., a 40 percent excise tax on providers when benefits exceeded $11,200 for individuals and $30,150 for families), and other provisions. The Congressional Budget Office and the Joint Committee on Taxation determined that this bill would have reduced the deficit by $516 billion from 2016-2025 (House Republicans). After passing the Senate, the bill was vetoed by President Obama; the House was unable to have a supermajority vote to overturn the veto (H.R. 3762).

Prior to the inauguration of President Donald J. Trump, the Senate of the 115th Congress voted on S. Con. Res. 3, which included language to repeal the ACA through the budget reconciliation process; it passed the House 227-119, with nine Republicans voting with all Democrats against it (S. Con. Res. 3).

On his first day in office, President Trump signed Executive Order 13765, directing agencies that work under the ACA—such as the Department of Health and Human Services—to be prepared for policies that would be involved in repeal and replace (Executive Order 13765).

Throughout the 115th Congress, with a Republican majority Congress and a Republican president, many proposals came out of the chambers. The first notable one, the American Health Care Act (AHCA) of 2017, was introduced in the House and would have modified the monetary provisions of the ACA but did not repeal the act (H.R. 1628). The AHCA would have allowed states to determine what a minimum healthcare coverage plan looked like, not the federal government as in the ACA. AHCA also allowed states to include work requirements in their Medicaid programs and the choice to receive funding as a block grant or on a per-enrollee basis. Due to the reluctance of the House Freedom

Caucus to vote for the AHCA, the MacArthur Amendment was added (MacArthur Amendment). It retained provisions in the ACA that did not allow for discrimination based on pre-existing conditions, allowed young adults to remain on their parent's healthcare coverage until their 26th birthday, and dictated how much insurers could vary premiums across similar populations. The final revised version of the AHCA passed the House, 217-213 (House of Representatives Clerk).

Instead of initially continuing with the AHCA, the Senate proposed a whole new bill—the Better Care Reconciliation Act (BRCA) of 2017 (Morgan and Nicholson). After Republicans—who had a narrow majority in the chamber—could not agree on what should be included in BRCA, a motion-to-proceed vote on AHCA was held. The vote, held on July 25, was 51-50, with Vice President Mike Pence casting the tie-breaking vote in favor of proceeding.

Two days later, the Senate voted on an amendment by Senate Majority Leader Mitch McConnell. This "skinny bill" would have repealed the individual and employer mandates. It was rejected 51-49 (Diamond).

The 115th Congress made one final attempt to repeal the ACA with the Graham-Cassidy-Heller-Johnson amendment. GCHJ would have repealed the ACA and replaced it with block grants for states that they could have used the way they saw fit (Cassidy). The intent of this legislation was to allow states to develop their healthcare plans without Medicaid expansion being the only way. There was never a vote on this amendment.

On December 22, 2017, President Trump signed the Tax Cuts and Jobs Act (H.R. 1). This act maintained the individual mandate, but it made the tax penalty $0, rendering it invalid as a tax. This led to a lawsuit being filed to repeal the ACA on the grounds that there is no longer a revenue generating tax, meaning Congress no longer has any constitutional authority over this provision (Texas v. United States; Henneke). Without the individual mandate, the ACA does not have a foot to stand on and is an ineffective and now-irrelevant policy.

Universal Healthcare Proposals

When the Affordable Care Act went into full effect in 2014, so did temporary stabilization measures like reinsurance and risk corridors. These measures stabilized the insurance market by reducing the burden the ACA put on insurance companies. Both reinsurance and risk corridors take on excess cost and risk for insurance companies that now could not deny coverage based on condition, which had increased their risk. These measures artificially lowered their risk and kept premiums down. But these measures were temporary and when they were phased out in 2016, premiums began to rise at an alarming rate (Cox). In 2017, the average health insurance premium available on Healthcare.gov was $5,712, more than double the average premium on the exchange in 2013, which was only $2,784 (HHS 2017).

As premiums skyrocketed and insurers began to leave the individual market, some states sought 1332 state innovation waivers, which allowed them to alter some provisions of the ACA to improve market conditions for their residents. States like Alaska, Maine, New Jersey, and Oregon were approved for waivers to suspend the single risk pool requirement to the extent that they would be able to implement reinsurance programs to prevent further market exit by insurers and keep premiums down (Howard). Alaska, for example, was down to only one insurer on the individual market when their application was submitted in 2017 after the only other insurer left the market. Premiums in Alaska on the individual exchange were expected to increase 42 percent in 2017 alone (Walker 7). In 2018 after their waiver was granted, premiums on the individual exchange decreased an average of 26.5 percent (Thiessen).

> This increase in federal—and overall governmental—control since the 1930s has led to most of the healthcare problems America is dealing with today.

As states across the country begin to feel the effects of the end of temporary ACA measures and premiums continue to rise, healthcare reform is back on the front burner.

The most talked about plans are Medicare for All and public option plans, both of which would deviate heavily from the "solution" for universal coverage set up by the ACA. Medicare for All, S. 1129, would eliminate all private insurance in favor of a federal single-payer system. Private insurers would be barred from offering coverage that duplicates any benefits offered by the government. The extensive list of benefits within Medicare for All means one would be hard pressed to find a benefit that would not be covered (S.1129).

The popular example is insurance for elective cosmetic procedures, which does not exist (Sanger-Katz). The cost to taxpayers of Medicare for All is estimated to be $32.6 trillion over its first 10 years (Blahous, 3).

The public option plans, seen in bills like S.1033 (CHOICE Act), S.489 (State Public Option Act), and S. 1261 (Choose Medicare Act), entail the creation of a government-managed health insurance plan available on the exchange, presumably at a much lower cost than a private plan. Some plans do so through the extension of Medicare, a federally managed system, through Medicaid, a federal-state partnership system, or could create a new separate plan (S.1033, S.489, S.1261). Public option plans are generally considered more moderate when compared to the sweeping overhaul of Medicare for All systems since they do not put restrictions on the private market for health insurance, but rather add a new choice to the market. However, even public option plans are expected to lead to a single-payer system by virtue of pricing all private options out of existence.

Conservative leaders and lawmakers have yet to offer opposing legislation or plans with cohesive support on the scale of Democrat plans, such as Medicare for All which has 14 cosponsors in the Senate and its companion in the House has 117 cosponsors (S.1129, H.R. 1384).

Conclusion

As this paper documents, since the 1930s the federal government has continuously sought to increase its control of healthcare in the United States. This increase in federal—and overall governmental—control has led to most of the healthcare problems America is dealing with today. The push of advocates to provide absolute security and predictability in the form of government-guaranteed access to healthcare, has resulted in the exact opposite of what they desired. The problem they have encountered is that the healthcare market functions just like any other market, and to the extent government manipulates healthcare markets, prices will rise, quality will fall, options will disappear, and Americans will be further and further removed from understanding and controlling their own healthcare.

The only solution available to the nation is to untangle healthcare from the government and to return control of the healthcare system to patients and providers so that the American approach to healthcare is fully consistent with the demands of patients. To paraphrase Nobel Laureate Milton Friedman, a society that puts security before choice will get neither. A society that puts choice before security will get a high degree of both.

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