FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

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NATIONAL HEALTH INSURANCE—A Brief History of Reform Efforts in the U.S.

Introduction

Many believe the United States is on the brink of national health reform. Health care costs seem uncontrollable while 46 million Americans remain uninsured. Millions more are under-insured—and even more worry that they are under-insured. The quality of health care is in question as more come to realize that the U.S. does not lead the world in the health of its people. These problems resonated during the 2008 presidential campaign where health reform held its own among the top issues, even after the economic crisis began to overshadow the election. Health care and its costs were seen as a large part of Americans' pocketbook concerns. And now a White House Office on Health Reform is being newly established, while seasoned Members of Congress are readying proposals of their own.

The country has been on the verge of national health reform many times before however. In the early 1900s, smaller proposals began to pave the way. In 1912, Theodore Roosevelt's Bull Moose party campaigned on a platform calling for health insurance for industry; and as early as 1915, Progressive reformers ineffectively campaigned in eight states for a state-based system of compulsory health insurance. The prominent reformers of the 1920s, the Committee on the Costs of Medical Care, proposed group medicine and voluntary insurance—modest ideas, but enough to raise opposition, and the term "socialized medicine" was born.

Over the years the American public, as measured in opinion polls as far back as the 1930s, has generally been supportive of the goals of guaranteed access to health care and health insurance for all, as well as a government role in health financing. However, support typically tapered off when reforms were conditioned on individuals needing to contribute more to the costs. While the general public may largely support reforming the health system, no particular approach towards achieving it rises above another in polls—perhaps not surprising given how complicated, yet personal, health care policy is.

Historians debate the many reasons why National health insurance (NHI) proposals have failed, including the complexity of the issues, ideological differences, the lobbying strength of special interest groups, a weakened Presidency, and the decentralization of Congressional power. While short of NHI, major health reforms have been enacted in the past fifty years that have proved to be broadly popular and effective in improving access to health care for millions through Medicare, Medicaid and the Children's Health Insurance Program. Important lessons can be gleaned from how these major reforms were accomplished, as well as the attempts to achieve NHI—lessons that may lead to new health reform paths while steering us away from previous mistakes.

As the nation prepares for the next opportunity, this issue brief highlights the major national health reform efforts that were undertaken in the 1900s. It describes the economic and political context in which each reform was forwarded and the key reasons it failed to achieve universal coverage.

1934-1939	NHI and the New Deal
1945-1950	NHI and the Fair Deal
1960-1965	The Great Society: Medicare and Medicaid
1970-1974	Competing NHI Proposals
1976-1979	Cost-Containment Trumps NHI
1992-1994	The Health Security Act

1934 – 1939: NHI and the New Deal

THE ECONOMY

The Great Depression (1929-1939) had been preceded by a period of growing income inequality and a shrinking middle class. The worst years were 1933-34 with unemployment as high as 25 percent. Income disparities in access to health care had grown much worse, medical costs were rising, and sickness became a leading cause of poverty. More physician and hospital care went unpaid and welfare agencies began to help pay for medical costs for the poor.

ORIGIN OF HEALTH REFORM

Citizen groups were organizing—workers and the unemployed, veterans, the elderly, and others—calling for government relief, including government-sponsored health protection. However unemployment, not NHI, was their top priority. In his first term, President Roosevelt appointed a Committee on Economic Security which was to report with a program that addressed old-age and unemployment issues, as well as medical care and health insurance (1934). This committee worked in private, without soliciting public input, and recognized from the start that NHI was of lower priority than a retirement benefit and unemployment insurance. While NHI made it into a preliminary report, it was left out of the final Social Security bill. After the Social Security Act was passed however, a second group of federal agency representatives was convened in 1937 (the Technical Committee on Medical Care) to advance health reform again.

ELEMENTS OF REFORM

Both committees called for a state-run system with compulsory health insurance for state residents, but states could choose whether to participate. The federal government was to provide some subsidies and set state minimum standards. There were other goals put forth by the committees as well, including expanding hospitals, public health, and maternal and child services. Recognizing strong opposition from the AMA, the Committees' principles made many assurances that the medical profession would maintain control over the practice of medicine.

CONGRESSIONAL ENVIRONMENT

Large Democratic majorities existed in both the House and Senate. However, worried that major health reform would defeat the entire Social Security proposal and believing NHI might be forwarded later, Roosevelt did not include major health reform in his proposal. The Social Security Act was introduced and passed in both houses with a wide margin in 1935. The second push for NHI, coming from the Technical Committee on Medical Care and momentum from a National Health Conference held in the summer of 1938, also failed. By 1938, southern Democrats aligned with Republicans to oppose government expansion, in part to protect segregation, making additional New Deal social reforms nearly impossible to pass.

OPPOSITION

An increasingly powerful AMA opposed NHI efforts believing physicians would lose their autonomy, be required to work in group practice models and be paid by salary or capitated methods. In addition, business and labor groups were not supportive, nor was the emerging private health insurance industry.

HEALTH REFORM'S DEFEAT

Recommendations from the Committee on Economic Security on health insurance to the President were never made public, fearing its opposition would weaken the Social Security bill. While NHI was not included in the Social Security Act, it did however provide matching funds to states for expanded public health and maternal and child health services. Roosevelt believed NHI could be achieved after the Social Security Act passed however. Following the National Health Conference, President Roosevelt wanted to make NHI an issue in future elections, but failed to do so in either 1938 or 1940. By 1938, Congress was no longer supportive of further government expansion.

1945 – 1950: NHI and the Fair Deal

THE ECONOMY

During World War II, The War Labor Board ruled in 1943 that certain work benefits, including health insurance coverage, should be excluded from the period's wage and price controls. Using generous health benefits then to draw workers, employers began to bolster group health insurance plans.[1] The economy expanded greatly following WW II, building and responding to the needs of growing families, in an era when American capitalism flourished. Large American businesses (e.g., U.S. Steel, GM, AT&T) faced little competition and were sufficiently profitable that unions could successfully negotiate for greater fringe benefits, including health insurance.

ORIGIN OF HEALTH REFORM

Roosevelt had indicated he wanted to press for health insurance once the war was over, as part of an economic bill of rights. Three months after World War II ended, President Truman picked up the mantle, calling upon Congress to pass a national program to ensure the right to medical care, part of his "Fair Deal" agenda.

ELEMENTS OF REFORM

Reformers had shifted away from a state-administered system and were proposing that health insurance be national, universal, comprehensive, and run as part of Social Security. These elements were built into earlier Senate legislation (the Wagner-Murray-Dingell bill of 1943), and became the major NHI legislation of the Truman era. Truman's own plan proposed a single insurance system that would cover all Americans with public subsidies to pay for the poor. Medical services were to be unchanged, with doctors and hospitals allowed to choose their payment method. Truman also prioritized hospital construction and expansion which Congress actually did pass in a separate legislation in 1946 (the Hill-Burton Act).

CONGRESSIONAL ENVIRONMENT

Challenged by the transition from a war-time economy, Truman lost the public's confidence. The Republicans gained the majority in both houses of Congress in 1946, creating the perception that the President was a lame duck. Truman then campaigned in 1948 promising to extend the New Deal and targeted the Republican Congress for opposing NHI. Not only did Truman win the election with a mandate from the people for NHI, but Congress also swung back to a Democratic majority. It was not enough, however. Southern Democrats in key leadership positions blocked Truman's initiatives, partly in fear that federal involvement in health care might lead to federal action against segregation at a time when hospitals were still separating patients by race.

SUPPORT/OPPOSITION

Labor unions were somewhat split on government-sponsored insurance. The AFL-CIO and United Auto Workers backed Truman's NHI proposal, but at the same time, the UAW accepted General Motors' offer to pay for health benefits and pensions. As workers gained better benefits from their employers, unions believed they could negotiate even more in the future.

The AMA vigorously opposed the Truman plan, ramping up its public campaign and lobbying after Truman was re-elected—using the fear message of "socialized medicine." Following the AMA's campaign, and as anticommunist sentiment rose, public support for NHI dropped markedly in 1949. Other groups only supported voluntary and private insurance, including the American Hospital Association, American Bar Association, Chamber of Commerce and the National Grange, as well as most of the nation's press.

HEALTH REFORM'S DEFEAT

Opponents were effective in eroding public support using the fear of government control and socialism at a time when communism was growing in Germany and China in the late 1940s. Meanwhile, businesses along with labor unions were growing the private, employer-based health insurance plans we have today. While Democrats held the majority in Congress in 1950, Republicans made enough gains to prevent progress on NHI.

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[1] It was not until 1954 that federal law excluded employers' contributions to health benefits from taxation (treating them as business expenses), which created the foremost incentive to offer job-based health coverage.

1960 – 1965: The Great Society – Medicare and Medicaid

THE ECONOMY

Productivity swelled in the 1960s as did the middle class, with a well-educated workforce financed by the G.I. bill and following the peak of labor union membership in the 1950s. President Kennedy sought to accelerate economic growth through increased government spending and decreased taxes. From this base, Johnson began to build a "Great Society".

ORIGIN OF HEALTH REFORM

The failure of universal health insurance in 1950 as employer-based coverage was growing tempered health reformists. However, as private plans increasingly began to use "experience rating" to set health premiums, those who were retired and sicker found it harder to get affordable coverage. While Eisenhower proposed measures to reinsure private insurance companies and then later, permit small companies to pool their resources to expand coverage, the elderly and poor became the focus for health reformers. Congress passed the Kerr-Mills Act in 1960, giving states federal grants to cover health care for the elderly poor. But this proved ineffective when by 1963, only 28 states chose to participate and many of them had not budgeted sufficiently.

ELEMENTS OF REFORM

When the House Ways and Means Committee began its work on the Medicare proposal from the White House in 1965, there were two other proposals on the table as well: an expansion of Kerr-Mills ("Eldercare, supported by AMA) and a proposal for federal subsidies to purchase private coverage ("Bettercare" from the insurer Aetna).

Elements of each were eventually merged into a single bill with three layers: Medicare Part A to pay for hospital care and limited skilled nursing and home health care, optional Medicare Part B (paid in part by premiums) to help pay for physician care, and Medicaid, a totally separate program to assist states in covering not only long-term care for the poor but also to provide health insurance coverage for certain classes of the poor and disabled. The final bill left the elderly in need of private coverage for some services such as prescription drugs, long-term care, and eyeglasses. No government cost controls were enacted and the government even distanced itself by selecting "fiscal intermediaries" (largely Blue Cross insurance organizations) to apply their standards of "reasonableness" for physician fees.

CONGRESSIONAL ENVIRONMENT

Congressional Democrats began to advocate for health coverage for the elderly in the late 1950s. In 1962, President Kennedy supported legislation (Medicare) for hospital coverage for seniors under Social Security, but opposing southern Democrats in the House blocked it. After Johnson's landslide election in 1964, he made Medicare his highest legislative priority and acted quickly. The election also brought a large liberal Democratic majority to both houses of Congress. Firmly influenced by President Johnson, Wilbur Mills, a southern Democrat and Chair of the House Ways and Means Committee who had opposed Medicare, changed his position and crafted the Medicare and Medicaid legislation. Potential Senate opposition was deftly managed by Johnson to ensure passage.

SUPPORT/OPPOSITION

Labor unions (recognizing the high cost of insuring retirees) and civil rights organizations endorsed coverage for the elderly. The AFL-CIO created the National Council of Senior Citizens (comprised of retired union members) to campaign for Medicare as other senior citizens also organized for rallies and marches to demonstrate their support. The American Hospital Association and the health insurance industry acknowledged that care for the elderly was costly and unprofitable and would thus require government support. The AMA opposed Medicare, again characterizing it as socialized medicine, and created a political action arm to increase lobbying efforts.

1960 – 1965: The Great Society – Medicare and Medicaid (continued)

HEALTH REFORM'S SUCCESS

Both Medicare and Medicaid were incorporated in the Social Security Act as it was signed by President Johnson in July 1965, with Truman by his side. The confluence of presidential leadership and urgency, Johnson's political skills in working with a large Congressional Democratic majority, growing civil rights awareness, public support, and the support of hospitals and the insurance industry contributed to the achievement of the most significant health reform of the century. The federal agencies that now estimate the economic costs of legislation did not yet exist. Cost projections, while considered, were not as central to the Congressional debate as they would become later.

1970 – 1974: Competing NHI Proposals

THE ECONOMY

The economy continued to grow but inflation was becoming a serious problem and rising health care costs were becoming a growing concern. In 1971, President Nixon instituted wage and price freezes in an effort to curb inflation. With the implementation of Medicare and Medicaid, health care costs had grown rapidly from 4 percent of the federal budget in 1965 to 11 percent by 1973, while millions of those under age 65 still had no health coverage. Under the wage and price controls, medical care was singled out for specific limits on annual increases in physician and hospital charges. These were lifted in 1974, over a year after most other economic controls had ended. An era of health care regulation began, leading to certificate-of need programs, state hospital rate-setting, requirements on HMOs (in return for support to help them expand) and health planning to control growth.

ORIGIN OF HEALTH REFORM

Sen. Ted Kennedy, supported by the elderly and the labor-led Committee for National Health Insurance, held hearings around the country and issued a report entitled, "The Health Care Crisis in America" generating support for his NHI plan. President Nixon countered with his own plan in 1971.

ELEMENTS OF REFORM

Kennedy's original idea—the "Health Security Act"—was a universal single-payer plan, with a national health budget, no consumer cost-sharing, and was to be financed through payroll taxes. In 1974, Nixon expanded upon his own proposal. His Comprehensive Health Insurance Plan (CHIP) called for universal coverage, voluntary employer participation, and a separate program for the working poor and the unemployed, replacing Medicaid. Requiring employers to contribute 65% of the premium cost was controversial, but fundamental to the plan's financing. Taxing employer health premiums as personal income had also been proposed as another source of revenue for CHIP, but Nixon overruled the idea. Democratic Sens. Long (chair of Senate Finance) and Ribicoff had their own incremental plan to provide catastrophic illness coverage and federalize Medicaid (1970). Other serious health care proposals also surfaced, complicating negotiations and splintering support.

CONGRESSIONAL ENVIRONMENT

Rep. Mills, still chairing House Ways and Means, again took up the cause by cosponsoring Nixon's CHIP. Realizing the potential for universal coverage, Kennedy then teamed with Mills to produce a middle-ground bill with an employer mandate and personal cost-sharing, using private insurers as intermediaries—but distinct from CHIP in requiring employees to participate and it was to be financed by a payroll tax. Sen. Long rejected the Kennedy-Mills bill, but agreed that he would not block the progress of health reform on its way to any future conference committee. Republican legislators were divided, feeling the need to support CHIP or a catastrophic coverage plan in order to block even broader NHI, while other Republicans wanted neither, but were muted by the President's goals. By the spring of 1974 there was bipartisan support for health reform, with no members wanting to be seen blocking it.

1970 – 1974: Competing NHI Proposals (continued)

SUPPORT/OPPOSITION

The Washington Business Group on Health and the Chamber of Commerce endorsed Nixon's plan. The insurance industry believing NHI loomed, supported more incremental reforms. Labor groups chose not to support the Kennedy-Mills compromise, believing that a larger Democratic majority in the next Congress would make for a stronger (less compromised) and veto-proof bill. The AMA continued to lobby against NHI, but after the Medicare experience, did not try to defeat it altogether. As for Nixon's CHIP, the AMA tag of socialized medicine failed to fit, given Nixon's anti-Communist credentials.

HEALTH REFORM'S DEFEAT

Those supporting NHI in 1974 were more bipartisan and willing to compromise than in any other NHI effort. However, the wide mix of competing proposals complicated the legislative process, while the Watergate hearings that led to Nixon's resignation dominated Congress, eroded presidential leadership and overshadowed any action on NHI. Despite President Ford's support for NHI legislation in 1974, and Rep. Mills drafting yet another compromise bill that encompassed principles from CHIP, and both Kennedy's and Long's plan—the bill never reached the House floor for lack of committee consensus. When personal problems and scandal forced Mills to leave Congress, the coalitions he had built did not hold and the opportunity for health reform in this era passed.

1976 – 1979: Cost-Containment Trumps NHI

THE ECONOMY

Stagflation—stagnant economic growth and continuing inflation, combined with increasing unemployment—characterized the period. President Carter attempted to jump-start the economy through tax cuts, and voluntary wage and price guidelines, but they were not effective.

ORIGIN OF HEALTH REFORM

In response to President Ford's decision to withdraw his administration's NHI plan, believing that it would make inflation worse, Carter pledged as a presidential candidate to support a comprehensive NHI plan. Once in office however, President Carter shifted priorities to emphasize health care cost containment, specifically hospital cost control, and said that NHI would have to wait until costs were checked and the economy was stronger—and then should be phased in. Sen. Kennedy disagreed, grew impatient waiting for the administration's plan, and drafted another proposal.

ELEMENTS OF REFORM

Sen. Kennedy's new proposal called for private insurance plans to compete for customers who would receive a card to use for hospital and physicians' care. The cost of the card would vary by income and employers would bear the bulk of the cost for their workers, with the government picking up costs for the poor. Insurers would be paid based on actuarial risk, and payments to providers set through negotiated rates.

Carter's plan, released a month after Kennedy's plan, proposed that businesses provide a minimum package of benefits, public coverage for the poor and aged be expanded, and a new public corporation created to sell coverage to everyone else. It was not to go into effect until 1983.

CONGRESSIONAL ENVIRONMENT

Neither the Kennedy nor Carter proposals had much of a chance. Despite a Democratic Congress, conservatism was on the rise. Congressional committees had been reformed in the wake of Watergate with the intention of decentralizing and redistributing the power of chairmen which required more coalition building in order to pass bills. For example, bills reported by the Ways and Means Committee could now be amended by any member on the House floor, and jurisdiction over health reform was now spread over four as opposed to two committees. After three years of effort, a hospital cost-containment bill was unable to make it through Congress.

1976 – 1979: Cost-Containment Trumps NHI (continued)

SUPPORT/OPPOSITION

NHI was not the priority it once had been, leaving special interest groups with much less to lobby for or against. Hospitals however, in an effort to fend off cost containment legislation, initiated a "voluntary effort" to control their costs. It proved to be short-lived and unsuccessful, leaving policymakers to find a way to control hospital costs through new regulation.

HEALTH REFORM'S DEFEAT

NHI efforts were completely stalled in the face of an economic recession, inflation, and uncontrollable health care costs. Debate on hospital cost-containment during this period however laid the foundation for the Medicare Prospective Payment System enacted in 1983 which changed the way the government paid for hospital care in a major way—from a charge-based system to a predetermined, set rate based on the patient's diagnosis.

1992 – 1994: The Health Security Act

THE ECONOMY

Under the Reagan administration's policies in the 1980s—that included substantial tax cuts, large increases in defense spending and moderate cuts in domestic programs—federal debt reached record levels. The Federal Reserve Board succeeded in acting to control inflation, and after a severe 1981-82 recession, levels of unemployment decreased over the 1980s. Health care costs continued to escalate rapidly up to and through this period. Even some in the business sector came to accept that fundamental health reform was needed as the health care sector grew to comprise 12% of the nation's GDP in 1990. The income gap between the lower and upper classes was widening and a recession in 1990-91 added to financial insecurity, eventually focusing the 1992 presidential campaign on the economy.

ORIGIN OF HEALTH REFORM

Public opinion polls in the early 1990s found more Americans worrying about losing their health benefits and not being able to pay their medical bills in the future. The come-from-behind election to the U.S. Senate of Pennsylvania's Harris Wofford in a special election in 1991 based on his advocacy for health reform convinced many that the time was ripe for a renewed national health reform effort. A large and varied mix of proposals surfaced: market-oriented reforms expanding the private system, public single-payer plans, employer mandates (play-or-pay), and from President Bush, health care tax credits and purchasing pools. As the 1992 election approached, the "managed competition" approach gained traction and eventually was favored by President Clinton. The new president initially hoped to send Congress a health reform plan within one hundred days of taking office.

ELEMENTS OF REFORM

Clinton's plan, the Health Security Act, called for universal coverage, employer and individual mandates, competition between private insurers, and was to be regulated by government to keep costs down. Under managed competition private insurers and providers would compete for the business of groups of businesses and individuals in what were called "health-purchasing alliances". Every American would have a "health security card".

CONGRESSIONAL ENVIRONMENT

Congressional leaders waited as the Health Care Task Force, chaired by First Lady Hillary Clinton and managed by presidential aide Ira Magaziner, processed the input from 34 closed working groups comprised of over 600 experts, aides, and officials. Not until after the budget was passed were copies of the complex plan shared and presented by the president before a joint session of Congress in September 1993. While the Democrats held the majority in both houses, they were divided on some issues, including how to achieve health reform. They sponsored other NHI bills, including a single-payer bill backed by labor and various consumer and advocacy groups (Rep. McDermott and Sen. Wellstone) and a managed competition plan without universal coverage and price controls (Rep. Cooper)—both of which splintered the support of Democratic lawmakers, interest groups and the general public.

1992 – 1994: The Health Security Act (continued)

SUPPORT/OPPOSITION

Support for the complex Clinton plan from key stakeholders was often conditional. Some labor unions and other public health advocacy groups did not want to be seen as opposed to Clinton's plan, yet backed the single-payer bill. Not wanting to organize public campaigns against Clinton, they hoped to effect change from inside. Many groups supported pieces of the plan, but held back their support wanting to modify the parts they opposed. The Health Insurance Association of America (HIAA) and the National Federation of Independent Businesses (NFIB, mostly small businesses) led the opposition. HIAA worried that its smaller members would be forced out of business and NFIB believed the employer mandate would create a hardship for small businesses and their workers. Both ran effective phone and letter-writing campaigns to Congress. HIAA also produced television ads that got widespread media coverage, depicting a middle-class couple feeling threatened by health reform.

HEALTH REFORM'S DEFEAT

President Clinton, having been elected with less than a majority of votes, lacked the large electoral mandate typically required to achieve sweeping change and any prospects for success were further weakened by his Administration's strategy and tactics for managing the bill through Congress. The size and complexity of the plan (nearly 1400 pages) not only slowed its passage through Congress but also made it difficult to generate popular activism. The opposition was effectively organized and the divided Democratic majority in Congress could not muster enough votes to pass a bill. However, incremental reform was not dead. In 1997, with a Republican Congress and bipartisan support, the Children's Health Insurance Program was enacted, building on the Medicaid program to provide health coverage to more low-income children.

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