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History of health care financing in the USA

Introduction

During the US presidential election of 2008, US Senator Hillary Rodham Clinton proposed the enactment of a universal mandated health insurance plan as part of her campaign platform when contesting for the presidential nomination of the Democratic Party. Her advocacy of such a position is not new in American history. In fact, the very principle of compulsory participation can be traced as far back as 1798, when the US government established a marine service hospital (forerunner of the US Public Health Service), and required owners of merchant ships to contribute 20 cents a month into a sickness fund for each seaman in their employ. In fact, the basic principle of individuals pooling their resources in order to spread their economic risks can be traced as far back as the so-called funeral societies of ancient Greece. Originally established to pay members' funeral costs, the societies ultimately came to have a variety of social and relief functions. Similarly, medieval craft guilds, forerunners of modern labor unions, often established welfare funds to assist sick and/or needy members. As the industrial revolution gathered momentum in the 19th century, a number of labor unions and individual employees required that workers join relief funds, many of which eventually came under government regulation.

In addition to the previous principle of pooling resources to spread economic risks, the idea that government should share some of the responsibility for health care can be traced as far back as Greece and its city states where citizens enjoyed the services of tax-supported public physicians. Centuries later, the first broad-gauged compulsory health insurance law was enacted by the state of Prussia in 1854, 29 years before Germany was united under Chancellor Otto von Bismarck. The Chancellor was thus able to draw upon this precedent in 1883 when he persuaded the German Reichstag to extend compulsory health insurance to workers throughout the German nation. When Bismarck's program proved highly successful, it soon spread to other European countries, notably the UK, and eventually expanded into the

comprehensive system of worker protection that is known today as 'social insurance.'[1] In 1911 David Lloyd George, UK Chancellor of the Exchequer, convinced parliament to pass the National Health Insurance Act, which provided a cash payment in the event of maternity or disability and medical services if a worker became ill. Other countries, including Austria, Hungary, Norway, Russia, and the Netherlands, also took the same steps through 1912. In addition, other European countries, including Sweden in 1891, Denmark in 1892, France in 1910, and Switzerland in 1912, subsidized mutual benefit societies that workers had established among themselves. Meanwhile, during this same period of time the USA did not take any action to subsidize voluntary funds or make sickness insurance mandatory, because the federal government thought this responsibility belonged to the states. The states, in turn, thought this function was the responsibility of private and voluntary programs. Thus, the national debate in the USA as to how best to protect American citizens against the costs of ill health has never concluded – a debate that has now extended into the 21st century.

Today, all kinds of proposals are being offered to help Americans pay for their health care services. Nationally, it is proposals for a national health insurance program. Some want it to be mandated, others do not. In the private sector, there are all kinds of plans like health savings accounts, managed care, private health insurance policies, and other private programs for those who are working. For senior citizens, whether they are still working or not, there is not only Medicare and Medicare supplementary health insurance (known as Medigap), but also managed care plans under Medicare as well as Medicare's new prescription drug program that began in 2006 for those who find drug costs a financial burden. So, how did America reach this point in its history where so many different proposals, both public and private, are being implemented or proposed to resolve its health care cost crisis? It is the intent of this chapter to present a brief historical overview of how America reached the situation today where the receipt and purchase of health care services have become more of a burden rather than a relief for America's citizenry, regardless of their socioeconomic and demographic status.

The 19th century

Private health insurance originated in the USA in the middle of the 19th century when a few insurance companies responded to the public's demand for coverage against rail and steamboat accidents. Then, during the latter half of the 20th century, the concept of the mutual aid society which had originated in Europe, notably in Germany, was adopted in the USA. As already noted, small contributions were collected from each member in return for the promise to pay a cash benefit in the event of disability through

accident or sickness. Early providers of health insurance, therefore, included fraternal benefit societies. Also, a number of mutual benefit associations, called 'establishment funds,' began to be formed in 1875 within the USA. Comprising the workers of a single organization, these funds, sometimes partially financed by employers, provided small payments for death and disability. Toward the end of the 19th century, with the entry of accident insurance companies into the field, health insurance began to demonstrate substantial growth. At about the same time, life insurance companies made accident and health insurance available. Thus, between two eras – the mid 19th and the mid 20th century – the private health insurance industry dramatically evolved.

The Progressive Era

As the 19th century melded into the 20th century, the Progressive Era emerged in the USA. Reformers sought to improve the social conditions of the working class. In the early 1900s, patients either lived or died. Care was largely confined to preventing disease, by keeping clean, recommending good diets, providing good nursing, performing basic surgery, and praying for rapid recovery. Unlike in Europe, there was no strong support emanating from the working class for social insurance, which is an insurance program carried out or mandated by a government. Social insurance protects against various economic risks such as loss of income due to sickness, old age, or unemployment, and is considered one kind of social security, though both terms are used interchangeably. In addition, labor and socialist parties were not united in their support for health insurance or sickness funds and benefits, as they had been in Europe. Even though President Theodore Roosevelt supported health insurance and the Progressive Party, for which he was the presidential nominee and candidate, in 1912 included in its party platform a national health insurance proposal for the USA, the federal government did not act. However, there was support for such a program outside government. One such progressive group was the American Association of Labor Legislation (AALL). It was co-founded in 1905 by John R. Commons, an economist at the University of Wisconsin, to lobby for health reform, and disbanded in 1943. The AALL sought to reform capitalism rather than abolish it, and campaigned for health insurance in 1906. In 1915 it drafted a model bill that limited coverage to the working class and all others who earned less than $1200 a year, including dependants. The bill included the services of physicians, nurses, and hospitals as well as sick pay, maternity benefits, and a death benefit of $50 to pay for funeral expenses. The model was a blend of health insurance and disability. It would have covered both health care costs and sick pay for 26 weeks. Costs were to be shared between workers, employers, and the state.

Even the American Medical Association (AMA) at that time was in favor of a compulsory health insurance plan and by 1916 was working with the AALL on such a proposal. In 1917 the AMA's House of Delegates favored compulsory health insurance, which the AALL had proposed. However, many state medical societies were not in favor of such a program and because the manner in which physicians were to be paid could not be agreed upon, the AMA leadership soon disavowed that it had ever favored such a proposal.

In the meantime, the president of the American Federation of Labor (AFL) denounced compulsory health insurance as an unnecessary paternalistic reform. (This is in contrast to its advocacy as the American Federation of Labor–Congress of Industrial Organizations (AFL–CIO) (now renamed) in 1955.) The reasons for the denunciation were that now the state would have created a system to supervise people's health and, by taking over the union's role in providing social benefits, the government would weaken the union's strength. Remember, at this time labor unions did not have the legal right to engage in collective bargaining. Another group opposed to compulsory health insurance at the time was the commercial insurance industry. The reformers' health insurance plan contained benefits that paid for funeral expenses, which was in direct conflict with the insurance industry that also sold policies to working-class families which paid for death benefits and covered funeral expenses. Thus, life insurance companies saw a compulsory health insurance plan as a threat to their income. Then, in 1917, the USA entered World War I and bad feelings against the Germans increased. The government even commissioned articles that denounced 'German socialist insurance' and the opponents of health insurance called it a 'Prussian menace' that was not in line with American values. Also, in 1917 the War Risk Insurance Act was passed and extended medical and hospital care to veterans, amending the War Risk Insurance Act of 1914 that insured American shipping and cargo.

The 1920s

During the early 1920s the USA went through a period called the Red Scare, when the nation sought to eliminate the remnants of radicalism from its midst. Opponents of compulsory health insurance associated this idea with the bolshevism of the Soviet Union and buried the concept under a torrent of anticommunist rhetoric. This ended the debate over enacting a compulsory health insurance plan in the USA until the 1930s.

Meanwhile, the costs of health care, especially those of hospitals, began to rise slowly. From 1918 to 1929 hospital costs increased from 7.6% of total family medical bills to 13%.[2] According to the *Historical Statistics of the United States*,[3] average annual earnings in all industries and occupations in 1926, when farm labor was excluded, were $1473.[4] Surveys of medical

expenditures from 1928 show that US urban families, with above-average annual incomes of $2000–3000, and that had no expenses for hospitalization, spent an average of $67 a year (2–3% of their income) on medical care. With hospitalization, the average was $261 or 8–13% of annual income.[4] In spite of price increases, most people still paid for medical care out of their own pockets. Estimated health expenditures in 1929 were $3649 million. Of that amount consumers paid $2937 million, public sources paid $495 million, and philanthropy paid $217 million.[4] However, the year 1929 was also the beginning of another great event in American history: the Great Depression, that extended itself throughout the 1930s. As the Depression became worse and unemployment rose, the public became increasingly aware that new methods were required to help pay the costs of medical care. These conditions led a number of teachers and the Baylor Hospital in Dallas, Texas, to develop an arrangement whereby the teachers would receive 21 days of hospitalization care on a prepayment basis for $6.00 per year.[4] This development had a significant effect on the insurance industry, foreshadowing the arrival of reimbursement policies for hospitals and surgical care. At the same time, another form of prepayment services was beginning in Los Angeles, California, where a group of health care providers assumed the responsibility for organizing and integrating medical services on a prepaid basis, that is, combining group practice with prepayment. This physician-sponsored organization, known as the Ross–Loos Medical Group, named after its founders Donald Ross and H. Clifford Loos, contracted with the Los Angeles Department of Water and Power to provide prepaid comprehensive health care to its employees and their dependants. This group was the predecessor of programs such as the Kaiser Foundation Health Plan of California and served as the prototype of today's emerging medical care foundations and health maintenance organizations (HMOs).

The 1930s

Beginning in 1927 and ending in 1932, a committee appointed by President Calvin Coolidge and composed of 50 economists, physicians, public health specialists, and major interest groups, met as a group called the Committee on the Costs of Medical Care (CCMC). Privately funded by philanthropic organizations such as the Rockefeller, Milbank, and Rosenwald Foundations and established because of concerns over the costs of and distribution of medical care, they published their findings over a period of 5 years in 26 research volumes and 15 smaller reports. The CCMC documented the severe and widespread problems Americans faced in obtaining and paying for medical care and recommended that more national resources ought to be directed to medical care. The CCMC saw voluntary, not compulsory, health insurance as a means to cover these costs and the care, which is provided through groups,

would be paid for by taxation or insurance. The AMA considered the report as a radical document promoting socialized medicine.

Meanwhile, hospitals that were hit hard by the Great Depression wanted to make sure they were paid and rushed to embrace plans for prepaid health care. Bank failures began to mount and Americans were not going on spending sprees. By 1931, private hospitals had their occupancies reduced to 62%, while public hospitals that accepted charity care filled 89% of their beds.[5] Whether their income was declining or not, and whether patients were using the facilities or not, hospitals still had to support their physical plant and pay their staff. Hospitals knew that prepaid health plans could help them greatly by providing them with a steady source of income. Therefore, the American Hospital Association began to market prepaid hospitalization plans as something that could be financially beneficial to hospitals and patients alike and relieve patients, especially those on low income, of a financial burden when they became sick. Since hospitals operated their own prepaid plans, they began to compete with each other. To diminish this competition, community hospitals began to organize with each other to offer network hospital coverage. These plans eventually came together under the auspices of the American Hospital Association, which, in 1939, adopted the Blue Cross name and logo as the national symbol of plans that met the American Hospital Association's requirements. Member hospitals began offering discounts to Blue Cross plans in the 1930s. State legislatures were more than agreeable to permit the American Hospital Association to establish the terms under which hospital health insurance would operate. States did not consider Blue Cross plans as insurance because hospitals owned the plans. Thus, states exempted the Blue Cross plans from normal insurance company requirements. The Blue Cross plans were permitted to operate as nonprofit corporations and did not have to pay the taxes of 2–3% of premiums that most states levied upon and received from private insurance companies. States also exempted the Blue Cross plans from reserve requirements that were designed to make sure that regular insurance companies were solvent. Since Blue Cross brought hospitals together into a network that impeded competition from stand-alone institutions, its structure made it very difficult for any kind of insurer to offer benefits that were very different from the Blue Cross standard. When the Blues began, in their early years, they used a method of establishing health insurance premiums called *community rating* in which everyone, regardless of age, sex, or preexisting condition, paid the same premiums. And when private insurance companies entered the market they used a methodology to establish premiums called *experience rating* which calculated relative risk and avoided the riskiest potential customers altogether. Experience rating is computed on the basis of past losses and expenses which are incurred by the insurance company in the settlement of claims and other expenses involving a particular group of risks. To survive as business entities, the Blues eventually adopted

this method of establishing premiums, and for the most part, have lost their tax advantages and are basically like other health insurers.

Meanwhile, as hospitals began operating their own prepaid health plans, the idea of enacting a US national health insurance plan had not yet died. The first attempt was made in 1935 when the social security legislation came up for a vote in the US Congress. With millions of people out of work, unemployment insurance became an administration priority, followed by old age benefits. President Roosevelt's Committee on Economic Security, which the president established in 1934, was afraid that if national health insurance, which the AMA opposed, was included in the social security bill, it would threaten the passage of the entire social security legislation. Therefore, national health insurance was omitted from the social security bill, which did become law. The Social Security Act of 1935 (PL 74-241) established a categorical assistance system in which the federal government shared with the states the cost for providing maintenance to the aged who were needy, the blind, families with dependent children, and, subsequently, the permanently and totally disabled. The Social Security Act did not make any special provisions for medical assistance, but it included the cost of medical care in the individual's monthly assistance payment, for which federal participation was available. Without any restrictions on how to spend their payments, many welfare recipients neglected their personal medical care – often because states set the overall payments so low that it was not enough to pay even for basic food and shelter. However, the Roosevelt administration made one more attempt in the 1930s to enact national health insurance through the Wagner National Health Insurance Act of 1939. While not totally supported by President Roosevelt, the proposal emanated from the president's Tactical Committee on Medical Care, established in 1937. The national health plan was to be supported by federal grants to states and administered by states and localities. The essential elements of the technical committee's reports were included in the Wagner bill. However, the bill was never enacted into law because of the declining fortunes of the New Deal as the 1930s neared its end and World War II began.

While the debates over national health insurance continued at the national level, and as hospitals during the Depression established their own prepaid plans to buttress their own financial viability, physicians began to be concerned that hospitals would expand the prepaid concept to embrace physician services as well. In 1934 the AMA adopted 10 principles that were directed at answering proponents of national health insurance and hindering hospitals from underwriting physician services. Legislation exempting prepaid physician service plans from insurance regulations and establishing their nonprofit status was passed, along with requirements that made sure that there was physician representation on plans that provided prepaid physician services. In 1939, the first prepaid physician services began operations in California. The

AMA encouraged state and local medical societies around the country to establish similar plans, and in 1946 they affiliated and became known as Blue Shield. By the end of the 20th century, the individual entities, the Blue Cross Association and the Blue Shield Association, had merged under the single banner of the Blue Cross and Blue Shield Association, representing the political and economic interests of its members on a national level.

The 1940s

In 1939, private health insurance covered only 6% of the American population for hospitalization. By 1941, the number had risen to 12.4%. Fifty-one percent of those covered had a Blue Cross–Blue Shield policy, 33% had group or individual polices from insurance companies, and almost 14% received insurance coverage from community groups, individual practice plans, unions, private group clinics, or similar arrangements.[4] Then, on December 7, 1941, the Japanese attacked Pearl Harbor, Hawaii, and the USA entered World War II. During this time a major change took place in the health insurance field. The 1942 Stabilization Act imposed price controls on employers by limiting employee wage increases. However, since price controls also have problems, at the request of employers the Act included a loophole permitting employers to compete for scarce workers by offering health insurance to employees as a pre-tax fringe benefit. Fringe benefits then became a significant part of collective bargaining, eventually including group health insurance.

In the postwar years, three powerful forces came together to provide modern health insurance with its strongest impetus to growth. First, in 1948 a decision by the US Supreme Court held that fringe benefits, including health insurance, were a legitimate part of the collective bargaining process; the second was the sharply increasing costs of medical care; and third was the capability of the private health insurance industry to introduce new kinds of coverage and broaden existing benefits. An important spur in the growth of group health insurance, for example, was the favorable treatment that group coverage received.

However, despite the development of Blue Cross and Blue Shield plans at this time and the expansion of commercial health insurance, interest in passing a national health insurance plan for the entire country had not waned. The Wagner bill of 1939 (Senator Robert Wagner, Democrat – New York (D-NY)) had changed from a proposal for federal grants-in-aid to a proposal for national health insurance. First introduced in 1943, it became known as the Wagner–Murray–Dingell bills for its sponsors in both the US Senate and US House of Representatives and, subsequently, reintroduced into Congress in 1945, 1947, and 1949, all to no avail in terms of its passage. The bill called for compulsory national health insurance and a payroll tax. Opposition to

the bill was immense. Although there was a great deal of debate, with very great opposition to the bill, the US Congress never passed it, despite its constant reintroductions. Had the bill passed, the law would have established a national health insurance program, funded by payroll taxes.

After Harry S. Truman had succeeded Franklin D. Roosevelt as US president upon the latter's death on April 12, 1945, the president thoroughly supported the enactment of a national health insurance program. However, after the end of World War II the US Cold War with the former Soviet Union ensued and the opponents of national health insurance began equating it with 'socialized medicine' which, in turn, became a symbolic issue in the enlarging crusade against communism in the USA. Unlike President Roosevelt's national health insurance plan of 1938, which was a separate proposal for the medical care of the needy, President Truman's plan was a single universal comprehensive health insurance plan for all Americans, regardless of class, rather than just for the working class. And the president even eliminated the funeral benefit that contributed to the defeat of national health insurance during the Progressive Era. But opposition to the plan was intense and included opponents such as the American Hospital Association, American Bar Association, and the AMA. When the Republican party took control of the Congress in the 1946 elections, it had no interest in the concept and viewed national health insurance as one part of a large socialist scheme. When President Truman was reelected in 1948, again national health insurance was linked with socialism and, as anticommunist feelings rose in the USA, the Korean war began in 1950. Truman's proposal died in Congressional Committee – even compromises could not save it – and proponents of national health insurance began to direct their attention to a more modest goal: hospital insurance for the elderly and the beginnings of Medicare. Rather than have a single system of national health insurance for the entire population, the USA would have a system of private health insurance for those who could afford to purchase it and public welfare services for the poor.[6]

The 1950s

As already noted, the Social Security Act of 1935 allowed the cost of medical care to be included in the monthly assistance payments, but the rate for such payments was so low recipients could barely afford food and shelter and, therefore, neglected their personal medical care. Beginning in 1950, Congress passed a series of amendments to the Social Security Act that expanded the public definition of public assistance to include money for 'vendor payments' – that is, direct payments by the state to physicians, nurses, and health care institutions, rather than to welfare recipients. This change created an administrative framework for a welfare medical program. By

1958 the federal government was sharing not only in cash payments but also in a separate category of medical payments to those who met the state's definition of being 'needy.' As of 1960, most of the states made vendor payments in federally aided categorical assistance programs and many states, in calculating their cash payments to welfare recipients, also allowed for the purchase of some items of medical care.[7]

Meanwhile, by 1952 the Truman administration had turned away from trying to enact a national health insurance program and in 1952 began advocating for a medical care for the aged program – what would become Medicare in the 1960s. The AMA opposed it. In 1957 the debate over Medicare reached new heights of discussion when Congressman Aime Forand (D-RI) introduced a bill in the House Ways and Committee to cover hospital costs for the aged on social security and, again, the AMA and other opponents were able to prevent it from being reported out of the Committee for a Congressional vote. The AMA portrayed a government insurance plan as a threat to the patient–doctor relationship but the tenor of the debate had shifted. Rather than seeking to cover the entire American population with a national health insurance plan, its proponents were now seeking to cover only the elderly. At this time organized labor united for the first time behind the idea for Medicare. For nearly a decade with the AMA and its allies on one side and some politicians and elements of the public on the other side, the debate over Medicare resulted in a Congressional standoff with no Congressional action. Finally, a compromise proposed by Senator Robert Kerr (D-OK) and Representative Wilbur Mills (D-AR) sought to substitute, in place of a federal Medicare program covering aged social security beneficiaries, a state-based welfare program covering only the medically indigent, persons who did not qualify for welfare but were still too poor to purchase medical care (the 'medically needy'), and the aged state welfare rolls. This program was enacted into law in September 1960. Kerr–Mills differed from Medicare in three ways: (1) it was a welfare benefit in its scope for those able to demonstrate a lack of financial means; (2) it was state-based rather than federal; and (3) the program was entirely an option of the state. If a state chose not to contract a health care program (Kerr–Mills), it did not have to do so. Initially even this program was opposed by the AMA, but finally, giving in to political reality, the AMA dropped its opposition to Kerr–Mills. By November 1964, 39 states and the District of Columbia had established programs providing medical assistance for the aged. All covered hospital services, 30 covered nursing home care, 34 covered physician visits, and 25 covered prescription drugs.

While these activities were being pursued on a national level in the public sector, in the private sector health insurance continued to be innovative in terms of new products and expand in terms of beneficiaries who were covered. In the early 1950s insuring organizations introduced the most comprehensive insurance coverage yet developed – major medical expense coverage. This

policy had been defined as insurance especially created to offset heavy medical expenses resulting from catastrophic or prolonged illness or injury. From its beginning, major medical has grown rapidly as families responded to the need to protect themselves against quickly rising hospital, medical, and surgical costs. Benefit levels under comprehensive major medical expense policies increased from a range of $50 000 to that of several million dollars. The rapidly developing economy in the years following World War II also led to the emergence of protection in the form of long-term disability benefits, stressing once again the idea of income replacement during times of disability and other financial emergencies.[4,8] In addition, the insurance industry began selling other forms of insurance. Vision insurance was introduced in 1957 and in 1959 extended-care facility benefits as well as insurance for dental care became available to the public.

The 1960s

As the 1960s began, Kerr–Mills was the law of the land, but the debate was still not over in terms of federal financing of medical costs. Those who were still proposing a Medicare program for the elderly had not given up on trying to enact such a program. After the Forand bill was defeated and John F. Kennedy was elected president in November 1960, Medicare's proponents introduced a new version of the legislation, called the King–Anderson bill, named after its sponsors Congressman Cecil King (D-CA) and Senator Clifford Anderson (D-NM). The King–Anderson bill was the predecessor of the Medicare program and would have paid for the hospitalization of the elderly through the social security system, and covered 14 million recipients of social security over the age of 65. The King–Anderson program was only half of the Medicare program which itself came into existence in 1965, but it did have President Kennedy's support. It proposed to cover the costs of hospital and nursing home care, as already noted, but not surgical costs and not outpatient physician services. It was scaled back from the Forand bill, which, in addition, offered coverage for surgical expenses. Between 1960 and 1965, the King–Anderson bill never received Congressional approval. After the assassination of President Kennedy on November 22, 1963, his successor, President Lyndon B. Johnson, took up the cause to enact a Medicare program and failed in his attempt to pass his hospitalization bill in 1964.

After the 1964 presidential election, when the Democrats took control of the US Congress, the climate that eventually allowed for the passage of Medicare and Medicaid had changed. However, before that had happened, the AMA developed an alternative to the Medicare proposals which they called Eldercare, an expansion of the Kerr–Mills program. It promised much more generous benefits than Medicare but again was limited to the welfare population rather than to all aged social security beneficiaries. The program,

a voluntary insurance plan with broader benefits and physician services, was to be operated by insurance carriers and states, with premiums for the low-income elderly subsidized out of federal–state revenues. In response, the government expanded its proposed legislation to cover physician services and what came of it were Medicare and Medicaid. Finally, with debates over Medicare still proceeding in July 1965, Wilbur Mills, Chairman of the House and Ways Committee, substituted his own bill and King–Anderson was eventually voted out of Committee, the Senate approved the bill, and Medicare became law on July 30, 1965 (the Social Security Amendments of 1965, PL 89-97).

The Act was developed in closed sessions of the Ways and Means Committee without any public hearings that would have stimulated public debate. During the closed sessions the necessary political compromises and private concessions were made to the doctors (reimbursements for customary, reasonable, and prevailing fees), to the hospitals (cost plus reimbursement), and to the Republicans was granted a three-part plan. This plan included the Democratic proposal for comprehensive health insurance (Part A), the revised Republican program of government-subsidized voluntary physician services (Part B), and Medicaid, a federal means-tested program for the poor in which federal and state governments shared the costs, half and half, and offered a minimum set of benefits to those who were eligible, with other benefits being made optional, allowing states to devise their own programs. Because the federal government paid half of all charges it encouraged states to replace the state programs that previously helped the poor and the ill and essentially removed all financial responsibilities from consumers. Medicare at the time was expected to help relatively few people aged 65 years and older since men born in 1950 had a life expectancy of 66 years and women, 71.7 years.[9]

The 1970s

As the 1960s turned into the 1970s, rising health expenditure continued to be a problem and a new administration was now in Washington, that of President Richard M. Nixon. From 1950 through 1965, when Medicare became law, national health expenditures (NHE) rose from $12.7 billion to $41.8 billion or an increase of about $29 billion in 15 years. From 1965, after Medicare was enacted into law to 1970, NHE increased from $41.8 billion to $73.1 billion or about $32 billion in just 5 years.[8] In other words, the amount of NHE expended in just 5 years (from 1965 to 1970) was equivalent to the amount spent in the 15 years before the enactment of Medicare and Medicaid. Consequently, when health care costs began to rise dramatically in the period following the implementation of Medicare and Medicaid, a reexamination of the health system seemed urgent. The Nixon administration undertook such a study. In the course of analyzing the system, the administration considered

health maintenance as one means of containing the runaway costs of health care. After a thorough study of the concept, the government decided to promote health maintenance organizations (HMOs) as a major federal initiative.[10] Former President Nixon announced this undertaking in his 1971 message to Congress. The administration noted in a White Paper on health care that HMOs emphasize prevention and early care; provide incentives for holding down costs and for increasing the productivity of resources; offer opportunities for improving the quality and distribution of care; and by mobilizing private capital and managerial talent, HMOs reduce the need for federal funds and direct control.[11]

But despite this prognosis, there were still various reasons why prepaid group practice required federal assistance at this point in history. First, the movement was growing at a very slow rate. While older plans such as the Kaiser Foundation Health Plan and the Health Insurance Plan of Greater New York were well established, there was not enough pressure or incentives for their expansion or for the development of new plans in other locations. Second, health care providers were not really convinced that HMOs should grow in great number. Hospitals had little to gain from a system which stressed outpatient care; and many medical professionals viewed any form of organization, even if privately controlled, as a step toward socialized medicine. Furthermore, the AMA, in strong opposition, had raised serious questions about the ability of HMOs to deliver high-quality care. Even without opposition from the health care establishment, HMOs' growth faced an uphill battle. Financial requirements for organizing even a modest HMO system and covering its operational deficits were prohibitive to all but the wealthiest of potential sponsors. Consumers were expected to support the HMO movement once they understood its long-range promise of financial savings and better care, but consumer education is an expensive effort. Finally, the laws in many states were unfavorable to the operation and formation of HMOs. The existence of these impediments made it clear that the federal government had to give some kind of assistance if a substantial number of HMOs were to develop.[12] Consequently, a series of bills were introduced by the Nixon administration, another by Senator Edward M. Kennedy (D-MA) and still another by Congressman William R. Roy (D-KS). Public hearings were held on the bills and discussions took place with representatives of various elements of the health care industry. Legislative language was revised, compromises achieved, and, finally, in the late fall of 1973, Congress passed the Health Maintenance Organization Act of 1973 (PL 93-222) and President Richard M. Nixon signed it into law in December of that year.

But the federal government was not the only resource developing HMOs in this period. The private sector also began to examine these prototype organizations as another way of lowering the costs of delivering health care. Physician and consumer groups, Blue Cross–Blue Shield, and commercial

insurance carriers, to name but a few sponsors, began to establish HMOs. From February 1971 to December 1975 the number of HMO-like delivery systems had increased from 33 to 178 organizations, serving almost 6 million persons compared to 3.6 million in 1971.[13] In fact, by the mid-1970s 30 Blue Cross plans were involved in 98 HMO-like organizations. During 1975 enrollment in Blue Cross-affiliated HMOs increased by 14% to 1 168 900 people compared with estimated 8% nationally for all HMOs. Blue Cross estimated at the time in the 1970s that by 1980 it would have invested $57 million in an effort to offer subscribers HMO programs as an alternative to traditional health coverage.[14] Thus, in the 1970s when the Blue Cross efforts were coupled with that of other insurance carriers and groups, the HMO movement looked promising in terms of future growth. To spur their growth even further, in 1976 Congress passed the Health Maintenance Organization Amendments, which relaxed requirements for HMOs to qualify for federal assistance. Like the Blues, initially, HMOs were mainly nonprofit entities, but once business saw an opportunity to make a profit, these profit-making HMOs' share of the market increased to about two-thirds by 1997. Oriented to the bottom line, for-profit HMOs became more aggressive about denying treatments. While HMOs were able to contain cost increases for a while during the 1990s, they could not contain them forever and eventually costs began rising again slowly, contributing to the current US crisis and the renewed call for a national health insurance plan in the Democratic presidential campaigns of 2008.

But HMOs were not the only federal efforts being undertaken in terms of health care financing during this decade. In 1972 Congress passed the Social Security Amendments (PL 92-603), which expanded Medicare by extending health insurance benefits to the disabled and to end-stage renal disease patients, These 1972 amendments also established professional standard review organizations (PSROs) whose purpose was to monitor the quality of health care by determining, for example, whether the hospitalization of Medicare, Medicaid, and Maternal and Child Health program recipients is necessary, of appropriate duration, and met professional recognized standards of quality, in part to control costs. In October 1977 the Medicare and Medicaid Anti-Fraud and Abuse Amendments (PL 95-142) broadened the mandate of the PSROs to undertake ambulatory care review within 2 years of becoming designated as a PSRO. These PRSOs eventually evolved into the professional review organizations (PROs) of the 1980s, which, in turn, evolved into the quality improvement organizations (QIOs) of the early 21st century.

Then, in 1974, private health insurance received another form of expansion when Congress passed the Employee Retirement Income Security Act (PL 93-222), also known by its acronym ERISA. As a result of this law, which encouraged the growth of self-insurance and because of rising health care

costs, various companies rapidly began to develop self-insurance plans in which the companies themselves pay their employees' doctor and hospital bills, providing the company with significant cost advantages. The original purpose of the law was to protect workers' fringe benefits. Although the law was primarily directed at pensions, the courts over the years have interpreted ERISA as overriding state regulation of employee health insurance plans in instances where the employer insures itself. In the 1970s before ERISA became law such corporate self-insurance was rare. Today, as a result of ERISA more than one-half of all US workers are employed by companies that self-insure, compared to only 5% in the 1970s, because self-insurance is less expensive than purchasing health insurance from a third party. The reason for this is that self-insurance allows companies to cover only those ailments which they choose and to exclude a wide variety of coverage that the state laws require of conventional insurance. In addition, to lower their medical bills further some large corporations have begun to combine their self-insurance system with the provision of general medical services by in-house medical clinics, staffed by their own doctors, or provided by contract medical firms. Besides saving on drugs and tests, companies can save money by avoiding unnecessary hospitalizations through careful case monitoring and negotiating lower fees with hospitals – a possibility when a firm can guarantee a hospital a lot of patients.

And once again, despite all these other financial developments in the health care field during the 1970s, the issue of enacting national health insurance as in previous decades was never far from a president's agenda, whether it be a Republican like Richard M. Nixon or a Democrat like Jimmy Carter. A few days after what would turn out to be his final State of the Union address on February 6, 1974, President Nixon introduced his Comprehensive Health Insurance Act and called for universal access to health insurance. He told the American public that his program with vastly improved protection against catastrophic illnesses would assure comprehensive health insurance protection to millions of Americans who, at the time, could not receive or afford it. President Nixon stated that his plan would build on existing employer-sponsored insurance plans and would provide government subsidies to the self-employed and small businesses to ensure universal access to health insurance without creating a new federal bureaucracy. His plan also did not require all Americans to purchase health insurance. President Nixon's interest in national health insurance in 1974 was not new. In fact, as a conservative Congressman in 1947 from California, he first proposed the enactment of national health insurance because, after losing two brothers to tuberculosis and then seeing the disease cured, the necessity for such a private–public partnership was very personal to him. Despite his problems with the widening Watergate break-in and cover-up scandal that eventually led to his resignation, his proposal was wending its way through Congress

but then, according to a political almanac published by the *Congressional Quarterly*,[15] a national leader in political journalism since 1945, the AFL-CIO and United Automobile Workers Union lobbied successfully against its passage, hoping to get a better deal after the 1976 presidential elections. In his 1992 book, *Seize the Moment*,[16] President Nixon wrote, 'we need to work out a system that includes a greater emphasis on preventive care, sufficient public funding for health insurance for those who cannot afford it in the private sector, competitions among health care providers and health insurance to keep down the costs of both, and decoupling the costs of health care from the cost of adding workers to the payroll.'[17]

Four days after President Nixon resigned on August 8, 1974, his successor President Gerald Ford addressed Congress and asked for a bipartisan effort to pass national health insurance. But the economy was deteriorating and President Ford wanted to contain government spending and national health insurance did not move out of Congress. However, the Ford administration did create one program that impacts on the purchasing of prescription medicines by public programs. In August 1976, a new program called maximum allowable cost (MAC) went into effect. The program places a price ceiling on prescription drugs whose patents have expired, which are produced by more than one company, and which are covered by Medicare, Medicaid, and Maternal and Child Health Programs. At that time, Part D of Medicare (Medicare's new prescription drug benefit program) was still almost 30 years away from becoming federal law. In 1975, the AMA, the Pharmaceutical Manufacturers Association, and five physicians filed a suit against the US Department of Health, Education, and Welfare (HEW), which developed the MAC program, in the Chicago District Court. The AMA argued that the MAC program would interfere with the traditional prerogatives of the physician. The Pharmaceutical Manufacturers Association argued that the program would intrude on the professional prerogatives of the doctor and the pharmacist, would disrupt pharmaceutical distribution patterns, and possibly result in inferior drugs for Medicare and Medicaid patients. In March 1977, the Chicago Federal District Court dismissed the suit against HEW with a 74-page opinion which concluded that all of the objections to the MAC program were without merit. In establishing the MAC program, HEW announced that it would send lists of drug price comparisons to physicians and pharmacists alike to encourage them to reduce patient costs. HEW considered the MAC program as essential and one of the building blocks to control health care costs in the event any national health insurance program would be enacted.

While the Watergate scandal ruined the presidency of President Nixon, it did help propel a Democrat named Jimmy Carter into the presidency in the 1976 elections. With his election the debate about national health insurance continued. The Carter administration in 1979 put forth a plan – Health

Security – that combined requirements for employers to offer health insurance to their employees with tax credits for small business, together with an expansion of the Medicare and Medicaid programs. Health costs were to be controlled by employing high patient out-of-pocket spending requirements. Senator Edward M. Kennedy (D-MA) and Representative Henry Waxman (D-CA) also promoted their own bill – Healthcare for All Americans Act – that combined a national health budget with insurance plans offered to all employers and individuals through a consortium of companies. With a non-unified Democratic party and the continued opposition, as in the past, of organized medicine, business, the insurance industry, and conservative Republicans, the possibility of legislative action was nonexistent. In the aftermath of this failure, Medicaid was modestly expanded to include coverage for pregnant women and children, and in 1983 new reimbursement methods under Medicare for hospitals were introduced in an effort to contain their costs. The political atmosphere at the time of the Nixon and Carter administrations helped contribute to the defeat of national health insurance proposals. One was the threat that any reform would certainly increase pressure on the federal budget. Another was that the public seemed to prefer a smaller government. The third was the inability to agree on just one single proposal.

The 1980s

In the administrations of Ronald W. Reagan as well as of George H.W. Bush (1981–1993), the focus of health policy was principally on cost containment rather than expanding coverage through programs such as national health insurance. However, the private health insurance industry was not quiescent during the 1980s in seeking to control health care costs and introduced new insurance products. Managed care was beginning to attract more and more subscribers such as businesses, for example, which sought to contain their own health costs, but also the insurance industry began to introduce new forms of health delivery systems. One such popular system by the mid-1980s was called preferred provider organizations (PPOs). PPOs are a combination of traditional fee-for-service and HMOs. When patients use doctors and hospitals that are part of a PPO – these providers are called 'preferred' and at other times, 'network' providers – patients can have a larger part of their medical bill covered. Patients can use other doctors who are out-of-network providers, but at a higher personal cost. Basically, a PPO is a group of doctors and/or hospitals that negotiate a contract with a company, union, or insurance firm to provide medical services for reduced fees. In return, that provider (doctor or hospital) is promised increased patient volume and prompt payments. Evolving from the concept of PPOs and HMOs, other kinds of health delivery plan developed, such as point of service (POS) plans and exclusive provider organizations (EPOs). The POS plan contains the features of both

PPOs and HMOs, sometimes called HMO–PPO hybrids or open-ended HMOs. The health plans allow the covered person a choice to receive care from a participating or nonparticipating provider, with a different set of benefits associated with the use of participating providers. It is an HMO option that permits the beneficiary to use doctors and hospitals outside the plan for additional cost. On the other hand, an EPO is an organization that allows provider coverage for services only from network providers.[18] In this arrangement health care providers deal directly with buyers of health care services rather than deal with middlemen like insurers or HMOs, according to a negotiated discount or fee schedule.

Meanwhile, while private health insurers were introducing new products into the marketplace, the US Congress was passing new laws that altered the health care delivery system while trying to control its costs. In 1982, Congress passed the Tax Equity and Fiscal Responsibility Act (TEFRA), which made Medicare the secondary payer, brought federal employees under Medicare, and made changes in hospital reimbursement under Medicare. In 1983, in response to TEFRA, Congress enacted a payment system for hospital care for Medicare enrollees. The payment system is called a prospective payment system (PPS) and is a method for reimbursement in which Medicare payment is made, based upon a predetermined fixed amount. In other words, the Centers for Medicare and Medicaid Services (CMS), then called the Health Care Financing Administration, switched from a retrospective fee-for-service system to PPS, under which hospitals receive a fixed amount for treating inpatients diagnosed with a given illness, regardless of the length of stay or type of care received. The payment amount for particular services is derived based upon a classification system of that service (for example, diagnosis-related groups for inpatient hospital services). CMS today uses separate PPS for reimbursement for inpatient hospitals, home health agencies, hospice, hospital outpatients, inpatient psychiatric services facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities.

The Omnibus Deficit Reduction Act (PL 98-369) in 1984 extended Medicare as a secondary payer for elderly spouses of workers under 65. Then, on July 1, 1986 Congress passed the Consolidated Omnibus Budget Reconciliation Act (PL 99-272), also known by the acronym COBRA, which required that employer group health plans offer continued coverage to workers and their dependants upon termination of employment and to workers' spouses and dependants who would lose such coverage because of the death of the worker, divorce, or Medicare eligibility. The Act made the coverage of private employers' health care plans primary to Medicare coverage that was now secondary for active workers and their spouses who also have Medicare coverage, required that third-party payers reimburse for certain care rendered in government-operated veterans and military hospitals, and established a task force to study long-term care insurance policies.

Also, in 1986 Congress passed the Tax Reform Act (PL 99-514), which, in part, removed the federal tax exemption for Blue Cross–Blue Shield organizations providing commercial-type insurance. Then, in 1988, Congress passed the Medicare Catastrophic Coverage Act (PL 100-360), which represented the largest expansion of the Medicare program since its establishment in 1965. Benefit changes included the elimination of all cost sharing for inpatient hospital care after meeting the hospital deductible, a cap of $1370 on out-of-pocket expenses for physicians' services, and minor changes in skilled nursing home, home health, and respite care benefits. A phased-in outpatient drug benefit was to be added to Medicare in 1991. But the financing of the program by the elderly caused so much controversy that Congress eventually repealed the law in 1989. The Medicare beneficiaries were to pay for the added benefits through premium increases and an income surtax.

Thus, throughout the 1980s active debate over national insurance coverage lay rather dormant with both the private insurance industry and the Congress concentrating on new insurance products, new reimbursement systems, altering the relationship between private and public insurance coverage when a beneficiary has both kinds of coverage, protecting workers for a period of time from losing health insurance coverage when they leave one job for another, as well as other proposals for containing health care costs.

The 1990s

Then, in 1990, as part of the Omnibus Budget Reconciliation Act, Congress passed reforms (Medigap Insurance Reforms) to help states regulate Medicare supplementary insurance. Two of the most significant provisions were designating only 10 Medicare supplementary packages as marketable and requiring that all policies be guaranteed renewable.[8]

In February 1992, President George H.W. Bush announced a health insurance proposal which included vouchers for the poor to purchase private health insurance and tax credits or deductions for families with incomes up to $80 000, as well as the creation of small business pools and health insurance networks. In November 1992, William J. Clinton was elected president and national health insurance continued to be at the fore of national debate. After his election the president designated the First Lady, Hillary Rodham Clinton, to lead administration efforts to design and pass a national health insurance bill. On September 22, 1998, Clinton addressed a joint session of Congress to describe the plan, historically titled 'Health Security.' The Clinton plan took elements of previous plans with complex and new ideas for cost containment and a management of insurance companies. The principal concept of the Clinton plan would have mandated employer-purchased coverage through 'accountable' provider plans contracting with state-regulated consumer alliances. Employers were required to pay 80% of the premium (up to a

maximum of 7.9% of payroll), with the family share of premiums not to exceed 3.9% of income. Low-wage employees, self-employed, and the near poor would be subsidized by public funds. The alliance would manage competition to make sure there was access to health care services and risk pooling. The plan was to be financed by substantial Medicare and Medicaid savings, an increase in the tobacco tax, and cross-subsidies among employers within risk pools. But the plan's complexity, the administration's poor management of the political process, and strong opposition by insurance company health plans and organized medicine combined to defeat the Clinton plan. The after-effects of the health care reform debacle helped elect the conservative Republican Congress in 1994 and, once again through 2008, national health insurance in terms of any kind of enactment went into Congressional hibernation.

While the attempt to establish a national health insurance plan was one of the highlights and failures of the Clinton administration to reform the health care delivery system, much smaller legislative steps were enacted by Congress in the following years. In 1996, Congress passed the Health Insurance Portability and Accountability Act of 1996 (also known as the Kennedy (D-MA) and Kassebaum (R-KA) bill) and whose acronym is HIPAA. The Act's principal focus is to make health insurance coverage portable and continuous for workers. Employees who change or lose jobs and meet eligibility conditions must either be accepted into a group plan or offered an individual policy. Also, under HIPAA Congress established as a test medical savings accounts (MSAs) as a way to pay medical bills: policyholders and employers were not taxed on their contributions. From 1997 through the year 2000 insurance companies could sell up to 750 000 high-deductible policies for large medical expenses. Deductibles were established between $1600 and $2400 for individuals and between $3200 and $4800 for families. Money in the account can be withdrawn tax-free to pay for medical care expenses, including premiums. After age 65 the money can be withdrawn for any reason, but under age 65 any withdrawals, unless for medical expenses, are subject to income tax, plus a 15% penalty. MSAs have now been supplanted by health savings accounts (established by the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003), into which they can be rolled over. While existing MSAs can continue, new ones cannot be created.

In that same year of 1996, Congress also passed the Mental Health Parity Act, which requires a group health insurance plan, if they choose to offer mental health benefits, to provide the same level of coverage for such benefits as they provide for medical and surgical benefits, including the same aggregate lifetime limits and the same annual limits, if any. The Act does not apply to groups of fewer than 50 persons, substance abuse or chemical dependency treatment, or to groups whose health plan costs would increase at least 1% because of such an offering. This Act was amended on October 3,

2008 when Congress passed the Paul Wellstone and Peter Domenici (US Senators) Mental Health Parity and Addiction Equity Act of 2008 which closed loopholes that existed in the 1996 Mental Health Parity law. The law does not require that health insurers cover mental health. However, if insurers do offer this benefit, they must provide coverage and treat psychological and addictive disorders just like any other physical medical condition. Thus, they cannot limit the number of outpatient visits or allowable days in hospital or charge higher deductibles or copayments. Mental health care must be equal to the benefits an insured individual receives for any other disease, also including day limits, dollar amounts, coinsurance, and out-of-pocket maximums. As in the case of the 1996 Mental Health Parity Law, the 2008 law applies to health plans covering more than 50 employees, preserves state mental health parity laws which typically do not govern large corporate health plans as covered by federal law and consumer protection laws, and extends protection of mental health services to 82 million Americans not protected by state laws. The law ensures coverage for both in-network and out-of network services. According to the National Institutes of Mental Health, more than 57 million Americans suffer from a mental health disorder. The nonprofit Mental Health Association estimates that 67% of adults and 80% of children requiring mental health services do not receive assistance, in large part because of discriminatory insurance practices.[19–21]

Then, in 1997, Congress enacted the Balanced Budget Act, which introduced several legislative initiatives that affected the health insurance industry, from both a public and private perspective. The Act:

- expanded private plan alternatives to the original fee-for-service program (Part B) of the Medicare program through Medicare + Choice (Part C: managed care, now renamed Medicare Advantage)
- created a new state health insurance program for children: the Children's Health Insurance Program
- clarified the tax provisions contained in the HIPAA 1996 for long-term care insurance.

Thus, the US Congress continued to deal with the problems of health insurance coverage in a partial rather than comprehensive fashion.

The 21st century

In 2000, Congress passed the Long-Term Care Security Act, which provided for the establishment of a program under which long-term care insurance would be available to federal employees, members of the uniformed armed services, and civilian and military retirees. Thus, after being defeated in its enormous effort to redesign the US health care delivery system, the Clinton administration and Congress chose smaller steps to expand, protect, and offer

new choices for health insurance coverage for the elderly, children, and the working population. As already noted, trying to resolve the problems of containing health care costs was still being dealt with in piecemeal fashion after efforts to control health care costs and improve its quality through a wholly revamped systematic approach were defeated.

When President George W. Bush came into office, the concept of enacting a national health insurance plan was not on the agenda of the Republican Congress. Rather, Congress's emphasis on controlling health care costs was through consumer-driven plans in which consumers became responsible for their own health expenses as well as protecting the elderly from the rising costs of prescription drugs.

As the 21st century began, other new programs began emerging in the private sector. In these programs providers like physicians are being reimbursed on the basis of their performance because in providing services they attain goals of quality of care. This is in contrast to the system that reimburses doctors, hospitals, or other providers regardless of whether they provide good services or whether patients are satisfied with their care. In requiring high quality, the programs are trying to eliminate from the health system expensive mistakes as well as inefficiencies relating to various kinds of medical treatments and the management of patient care. As a result, doctors are reimbursed at higher fees, those in the middle are reimbursed with standard payments, and the worst providers receive a reduction in fees. As pay-for-performance develops over time, the next logical step would be to supply consumers with a shopping guide that gives them information about their provider's cost and quality of care. As new challenges arise, the health insurance field continues to demonstrate its innovation and flexibility to meet them.

Another major development occurred in 2003 when Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (PL 108-173). Aside from covering the elderly for the costs of prescription drugs under Medicare, this law created a new kind of mechanism for consumers to pay for their health care costs. It is called a health savings account. Basically, the health savings account is a combination of a type of individual retirement account (IRA) with insurance policy directed at only medical expenses. The health savings account can be used to pay for routine medical bills and the insurance policy for larger medical expenses. Participants can choose among an array of investment options within the IRA-like account – that is, the money can be invested in a mutual fund, brokerage, bank account, or the like. Each year consumers or their employers can fund the health savings account with an amount equal to the deductible, subject to a limit, and the amount issued to pay for health expenses or to be invested. The money going in would be pretax dollars and withdrawals for medical expenses would be tax-free. If consumers use the money for nonmedical expenses before age 65, they pay a penalty in addition to

income tax. After age 65, consumers do not incur a penalty if they use the money for nonmedical expenses, but would still have to pay income tax on the money. As long as the high deductible health plan meets the requirements of this federal program, it can be an HMO, PPO, or an indemnity plan. This arrangement, sometimes called a 'consumer-driven plan,' is intended to encourage workers to look for inexpensive treatment and to avoid unnecessary spending.

As noted, the creation of health savings accounts was just one program in a law that essentially broadened the scope of Medicare itself by creating a new prescription drug benefit known as Part D – the fourth element of Medicare after the hospitalization insurance (Part A), voluntary medical services insurance (Part B), and managed care plans or Medicare Advantage (Part C). This is a voluntary insurance program that everyone can join if they are enrolled in the original Medicare program (with either Part A or Part B coverage, no matter what their income may be), or in a Medicare Cost plan, or in a Medicare Fee-for-Service plan that does not cover prescription drugs. Consumers do not have to take any physical examination for this coverage nor can the program turn consumers down for health reasons. In addition, consumers do not have to sign up and enroll in this prescription drug program if they do not wish to do so. For purpose of definition a consumer cost plan is a kind of HMO. In a Medicare Cost plan, if a patient receives services outside the plan's network without a referral, the patient's Medicare-covered services will be paid under the original Parts A and B of Medicare, except the cost plan does pay for emergency services or urgently needed services outside the service area. A private fee-for-service plan is a kind of Medicare Advantage plan (Part C) in which a patient may go to any Medicare-approved physician or hospital that accepts the plan's payment. The insurance plan, rather than Medicare, decides how much it will pay and what consumers will pay for the services they receive. Consumers pay more or less for Medicare-covered benefits and may have extra benefits which Medicare does not cover. Despite the establishment of Medicare Part D, Medicare Part B will continue to cover drugs such as those administered in a hospital or a doctor's office as it has in the past.

As a final example, when the US Congress enacted the Deficit Reduction Act of 2005 (PL 109-171) it also established elements of consumer-driven plans called health opportunity accounts for Medicaid patients to use in these state programs.

The year 2012

The year 2012 marks the 100th anniversary since Teddy Roosevelt ran as a candidate of the Progressive Party for the presidency of the USA with the enactment of national health insurance as a plank in his political party's

platform. Since that time, almost every administration since President Roosevelt has proposed the enactment of such a program for the USA, yet all have failed. Meanwhile, running almost in parallel with the health activities of the federal government, as in the enactment of Medicare and Medicaid, HMOs, HIPAA, COBRA, prescription drug coverage, PROs, ERISA, and TEFRA, and other programs which were enacted into law, the private sector in the form of the insurance industry has developed all kind of programs to protect consumers from the costs of ill health and to ensure they receive quality care. These include programs such as major medical insurance, disability income insurance, dental insurance, vision insurance, HMOs, PPOs, POS, long-term care insurance, and other programs to insure against the costs of medical care. Yet, nothing has stemmed the tide of rising costs. Today, employers are placing more and more of the burden of paying for their own health care services on employees by reducing or simply eliminating health care benefit coverage; hospitals are merging and becoming less friendly to low-income patients; and more and more of the population cannot afford to buy health insurance at all and, thus, remain uninsured as the portion who can afford it continues to decline in direct proportion to the increase in the number of uninsured. In 1950 the USA spent $12.1 billion on health care and in 2007 an estimated $2.2 trillion, and the costs keep rising. No one knows what new proposals the next few years until 2012 and beyond will bring to resolve America's health care crises, not only for those who have insurance and find they must pay more and more of the costs out of their own pocket, but also for the 47 million Americans who cannot afford insurance at all. The only reality that the country knows is that by August 2009, with just a few years remaining until the arrival of the hundredth anniversary of the first national health insurance proposal in this country, none had become law; public and private programs have not worked to stem the tide of the rising costs of health care as well as solve problems of access to quality health care; shortages of health professionals in various parts of the country, rural and urban, have not been eliminated; the US population is aging, living longer and with longer lives come more illnesses that may be very costly to treat, yet the costs of programs such as Medicare to pay for such illnesses are dependent upon the payroll deduction contributions of a smaller workforce than in the past as the baby boomers of the 1940s begin to join the ranks of senior citizens.

If the past is any prologue, the national debate over the enactment of a national health insurance plan is not yet over and the private sector will continue to develop programs as yet unknown to try and stem the tide of rising health care expenses and improve the quality of care. Thus far, be they public or private, programs in existence today have not enjoyed a permanent success for the nation as a whole as more of the nation's medical expenditure becomes a larger part of gross national domestic product (the total market value of all the goods and services produced in the USA), although, on an

individual personal budget level for many, but not all, persons, the opposite may be true. Somewhere in the future there is the answer, as yet to be discovered, that is appropriate to the USA to resolve its health care crisis.

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