Notes and Brief Reports

Chronology of Health Insurance Proposals, 1915-76*

In July 1935, 1 month before the signing of the Social Security Act, the first government health insurance bill in U S history was introduced in Congress Sponsored by Senator Arthur Capper of Kansas, the legislation would have provided compulsory protection on the State level for virtually all American wage-earners It attracted little notice, however, because it lacked the backing of key legislators and, even more important, the support of the President

Franklin D Roosevelt's Cabinet Committee on Economic Security earlier had recommended including health insurance in the social security bill But the opposition of the American Medical Association (AMA) and other groups convinced the President that the presence of a health insurance provision might jeopardize acceptance of the rest of the package With his advisors divided over the proposal, he decided against asking for it

Failure to bring the issue to a vote in 1935 was not the first setback for the advocates of government health insurance, nor was it to be the last Some 20 years earlier, during the high-tide of the progressive era, prospects for such legislation had appeared rather promising—only to worsen following World War I Thirty more years were to pass before any major form of government health insurance protection was enacted into law

Four factors help explain the 50-year delay between idea and law (1) The prevailing American attitudes toward social welfare measures, (2) problems implicit in the Federal-State governmental structure, (3) the complexity of the legislative process and its vulnerability to opposition, and (4) the opposition of major interests

Unlike Europe, the United States in the early 1900's experienced no great pressure for social legislation from either a radical political party or a militant labor movement Instead, a strong belief that people should plan ahead for their own security during periods of sickness, disablement, and old age persisted well into the first third of the century It took a "hard push from below"—provided by the Great Depression—before major social welfare programs could be implemented on the Federal level

Moreover, during pre-New Deal days, Congress, the Supreme Court, and leading constitutional lawyers generally interpreted the Constitution as giving the principal social welfare responsibility to the States State governments proved to be reluctant to undertake costly social welfare measures on anything less than a nationwide basis for fear of imposing burdens on locally based industries that would put them at a competitive disadvantage in the national market

A change in the public attitude toward social insurance and a shift from State to Federal responsibility for implementation both appeared to be prerequisites for enactment of a system of government health insurance The main obstacle, however, was the complex system of checks and balances built into the Federal legislative process

Political power in this country is widely diffused through several layers of government, numerous interest groups, political party organizations, and the news media Organized interests not only have the right to make representations to the legislatures on political issues but may try in a variety of ways—including public relations campaigns—to influence the voters and through them their elected representatives Because many private groups are relatively powerful, an important element in the success of any legislative effort is to ensure the support, or at least the acquiescence, of those organizations most likely to be directly affected by the proposed legislation In the case of government health insurance, the issue created a profound cleavage, with some of the most important interest groups becoming adamantly opposed There followed a polarization of opinion that persisted throughout nearly a half century of national debate on the issue

1915–20

A movement to enact social insurance programs on a State-by-State basis began in the United

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States soon after the passage in 1911 of a national health insurance program in Great Britain In its early years, the effort was spearheaded by the American Association for Labor Legislation (AALL), a private organization made up of about 3,000 reform-minded physicians, lawyers, businessmen, professors, labor leaders, politicians, and social workers The first major legislative campaign, in behalf of State workmen's compensation laws, achieved considerable success By 1915, 30 States had passed such legislation

The AALL turned next to enactment of government health insurance on the State level After 3 years of studying various approaches, the organization's social insurance committee in 1915 produced a standard health insurance bill, drafted into legislative language for the consideration of the lawmakers and private interest groups The bill called for the protection of all low-income workers and provided for cash compensation and broad hospital and medical benefits to both workers and their dependents

By 1917, sponsors had been found to introduce the measure in 12 State legislatures, eight of which also appointed study commissions Furthermore, the leaders of several important interest groups—notably the AMA, the National Association of Manufacturers, and the American Hospital Association—decided to study the proposal During World War I, the War Risk Insurance Act (which established a comprehensive system of benefits—including health insurance—for servicemen and their dependents) was passed

Between 1918 and 1920, however, several State-appointed study commissions reported unfavorably on the issue, and in New York and California health insurance was defeated in key tests In 1920, the AMA's House of Delegates, which 3 years earlier had passed a resolution setting forth principles to be followed in government health insurance plans, reversed its position, declaring itself opposed to such coverage Union leaders began seeing in the proposal a threat to the prerogatives and influence of the labor movement and launched a campaign against it Not a single State adopted the measure

1921–27

The next dates of significance were 1921, when the Sheppard-Towner Act established Federal subsidies for State-run child and maternal health programs, and 1927, when the Committee on the Costs of Medical Care (CCMC) was established by several foundations to conduct the Nation's first comprehensive study of medical economics Among other things, the committee endorsed group practice, extension of public health services, and the expansion of voluntary—not government—health insurance In 1929, the Sheppard-Towner Act expired

1932–44

Between the time the CCMC began work and the publication of its final report in October 1932, the Nation was plunged into the Great Depression Following Franklin D Roosevelt's election to the Presidency, numerous emergency measures were enacted in response to demands for Government action to provide jobs, direct relief, and some guarantee of future security One newly created agency, the Federal Emergency Relief Administration, among other things provided for medical care to the needy

Eventually, more permanent measures—such as those embodied in the Social Security Act of 1935—were undertaken When it became known that the Committee on Economic Security was considering health insurance as one of the coverages under the social security program, however, strong complaints were voiced As noted earlier, health insurance was omitted from the final draft of the social security bill

For the remainder of the decade, health insurance advocates attempted to obtain a climate of support via the educational process In 1937, the Federal Government set up a Technical Committee on Medical Care and, a year later, at a National Health Conference held in Washington, D C, a National Health Program (NHP) which included among its five recommendations a plan for grants to the States to encourage the establishment of statewide health insurance programs financed either through general revenues or social security taxes, was introduced The NHP was transmitted to Congress for study in January 1939 and, shortly thereafter, was submitted in the form of a bill The AMA opposed the legislation, which died in committee after several months of hearings Plans were laid to report out

an amended bill in the next session, but World War II, which began in Europe during September 1939, brought about a change in concerns

Though health issues received a relatively low priority in the early 1940's, they were not entirely set aside In 1942, Congress authorized an emergency maternity and infancy care program for dependents of low-ranking servicemen One year later, the first Wagner-Murray-Dingell bill, providing for comprehensive health insurance coverage under the Social Security Act, was introduced It failed to survive committee hearings

In his State of the Union message in January 1944, President Roosevelt urged an "economic bill of rights," including the "right to adequate medical care and the opportunity to achieve and enjoy good health " A week later, the Social Security Board, in its annual report to Congress, suggested compulsory national health insurance, a program referred to as "extended social security, including medical care" in President Roosevelt's next budget message

Presumably, the President intended to give the issue a high priority once the war was over A special message on health matters awaited his pleasure, but he died in April 1945

1945–56

President Harry S Truman supported the proposal and made it a key legislative recommendation Shortly after the Japanese surrender, he sent a health message to Congress along with a redrafted Wagner-Murray-Dingell bill In May 1946, the Taft-Smith-Ball bill, authorizing grants to the States for medical care to the poor, was introduced as a counterproposal to the administration bill No action was taken on either piece of legislation

President Truman concluded early in 1948 that Government health insurance would have to be considered an ultimate aim rather than an immediate possibility By 1952, he tacitly acknowledged the continuing stalemate by omitting the proposal from his annual State of the Union message for the first time since 1948

President Dwight D Eisenhower, who took office in 1953, had opposed Government health insurance during the campaign His administration favored helping needy citizens meet the cost of medical care, however, and, during the next few years, proposals to facilitate coverage under private health insurance through "reinsurance" and "pooling" arrangements were introduced but failed to win sufficient support for congressional enactment In 1956, a program providing Government health protection for dependents of servicemen was introduced and payments to medical vendors for the provision of health care to welfare recipients, introduced in 1950, were expanded Also in 1956, the social security program of cash benefits for totally and permanently disabled persons aged 50 and over was enacted

1957–65

In the early 1950's, the Social Security Administration began suggesting the idea of limiting Government health insurance benefits to aged persons, and a bill embodying that approach was introduced in 1952 Near the close of the 1957 session of Congress, Representative Aime J Forand of Rhode Island introduced a revised version of this plan

Years of debate and refinement still lay ahead Between the introduction of the original Forand bill and the passage of Medicare in July 1965, some 80 revisions, compromises, and alternatives to the proposal were drafted Congressional committees conducted no fewer than eight sets of public hearings on the issue and the House Ways and Means Committee devoted more time to Medicare during this period than to any other subject

In 1957, the AFL-CIO adopted the issue as its number-one legislative priority Inconclusive hearings over the next 2 years led, in 1960, to three committee votes—all opposed to the measure In May, Secretary of Health, Education, and Welfare, Arthur Flemming, presented an administration plan providing for Federal grants out of general revenues to help the States subsidize private health insurance premiums for the low-income elderly A majority of Congressmen did not support it

In June 1960, Chairman Wilbur Mills of the Ways and Means Committee devised a plan to expand greatly the program of medical vendor payments provided under the Federal-State public assistance programs by creating a new category to aid elderly persons not on the welfare

rolls but too poor to pay medical bills A modified version of this plan, known as the Kerr-Mills bill, was enacted into law in September

Calling the legislation inadequate, Senator John F Kennedy made "Medicare," as the proposal came to be called, a major issue in his campaign for the Presidency. Following his election, he urged reintroduction of the legislation, now officially the King-Anderson bill Over the next 2 years, advocates and opponents of Medicare carried on an intense public debate In mid-November 1963, public hearings on the issue began before the Ways and Means Committee, only to be disrupted by the assassination of President Kennedy

In February 1964, the new chief executive, Lyndon B Johnson, sent Congress a special health message that strongly advocated Medicare Though the measure ultimately passed the Senate, it failed to gain approval in a Senate-House conference committee late in 1964

When the legislation was submitted anew to the 89th Congress, in January 1965, it was the first bill introduced in each chamber (H R 1 and S 1) Shortly thereafter, Chairman Mills took charge of redrafting the bill in its final form, which provided aged persons with basic hospital insurance financed through social security taxes plus supplementary medical insurance, paid for by beneficiary premiums and Federal Government contributions

On March 23, the Ways and Means Committee approved the Medicare measure, now called the Mills bill, and on April 8, after 1 day of floor debate, it passed by a 313–115 vote The Senate Finance Committee held hearings on the bill in late April and early May, followed by extended executive sessions The legislation was finally reported out—with 75 committee amendments—on June 24 and, after 3 days of debate on the Senate floor, was passed by a vote of 68–21 A Senate-House conference committee then reconciled 513 differences between the two chambers, after which the final bill was approved in the House and the Senate and was formally signed into law by the President

1967–72

Arguing that the disabled share certain key characteristics with the aged—including low incomes, high medical bills, and high-risk status with insurers—Government health insurance advocates began urging the extension of Medicare benefits to members of this group In a 1967 omnibus proposal for changes in the social security program, President Johnson recommended that coverage be made available to disability beneficiaries eligible for cash benefits, but Congress did not act in the measure

In 1972, under the Nixon Administration, the Social Security Act was amended to extend coverage to disabled beneficiaries and the tax schedule was revised upward, partly in order to finance this protection Benefits currently are available to all the disabled—including disabled workers under age 65, disabled widows and dependent widowers aged 50–64, and children aged 18 or over who were disabled before reaching age 22—entitled to benefits for at least 2 years The program also covers persons not on the beneficiary rolls having an end-stage kidney disease requiring renal dialysis or transplant if the individual is fully or currently insured, is the spouse or dependent child of an insured person, or is entitled to monthly benefits under the social security or railroad retirement program

1973–76

Over the past decade, the need for a national health insurance program has been the focus of much discussion, and various proposals aimed at bringing such a plan into being have come under consideration The Ford Administration introduced a measure in the 93d Congress but has not reintroduced it in the current session because of the state of the economy As of February 1976, however, 17 other measures had been introduced in the 94th Congress[1]

The proposed programs are designed to help meet several major objectives One is to provide basic protection against health care costs for the entire population and to eliminate the financial hardships imposed by medical bills It is argued that the present system of voluntary

[1] Saul Waldman, *National Health Insurance Proposals Provisions of Bills Introduced in the 94th Congress as of February 1976* (Miscellaneous Report), Office of Research and Statistics, 1976

health insurance and Government medical care programs has left gaps in coverage and has provided inadequate protection for substantial segments of the population National health insurance is also viewed as a vehicle for implementing controls over mounting costs for the entire medical economy [2]

National health insurance is no longer defined only in terms of a compulsory Government program representing an extension of social insurance into the area of health benefits Opinions vary widely concerning the most desirable method of implementing such a program The proposals contain numerous options relating to the utilization of the private sector and Federal and State governments in the areas of administration and financing, as well as to the degree of voluntariness that should be incorporated in a plan The proposed programs can, with some oversimplification, be classified under three approaches [3]

Public-private approach—One method of implementing national health insurance would be to use a mixed public and private mechanism that would build onto the present structure of private health insurance and Government programs The private health insurance mechanism would be retained for the working population, but employers would be required to make available to their employees a plan providing specified health services The plan would usually be insured through private carriers, with employers paying part of the cost Private insurance would also be retained for the self-employed, farmers, and others not in an employment group under provisions designed to facilitate coverage for the group or under other special arrangements A uniform Government program for the nonemployed and the poor would also be established, to be financed and administered either by the Federal Government or jointly by Federal and State Governments Under most variations of this approach, the Medicare program would be integrated into the national plan and would continue to be financed mainly by the Federal Government Although they differ in many details, plans of this general type have been proposed by representatives of the hospital industry, the medical profession, the commercial insurance industry, and certain business groups

Social insurance approach—Supported by most of organized labor, this proposed program would cover the entire population under one plan, to be financed by social insurance taxes on employers, employees, and other income receivers and by contributions from general revenues The program would be administered by the Federal Government, which each year would establish a national health budget and allocate funds by type of service to the various regions of the Nation The Government would be given considerable administrative discretion in allocating funds, establishing standards for providers of service, establishing reimbursement policy, and conducting reviews of utilization

Catastrophic coverage—A program of this type would be designed to pay benefits only to persons who incur unusually high health care expenses One such proposal, for example, would provide hospital benefits after the 60th day of hospitalization and medical benefits after the first $2,000 of expenses borne by the patient This approach is based on the concept that the role of a national health insurance program should be limited to the financing of extraordinary expenses

A plan to add catastrophic coverage to the basic benefits under the Medicare program was proposed by President Gerald R Ford in his February 1976 message to Congress on Federal programs to aid the elderly Personal liability for the costs of hospital and medical care under the Medicare program would be limited in two ways (1) The ceiling on the number of covered days of care in hospitals and skilled-nursing facilities would be removed and (2) no beneficiary would be required to pay more, out of pocket, than $500 each year for covered services in hospitals and skilled-nursing facilities or more than $250 annually for physician and other noninstitutional services

[2] Dorothy P Rice and Douglas Wilson, *The American Medical Economy—Problems and Perspectives*, paper prepared for the International Conference on Health Care Costs, sponsored by the Fogarty International Center, June 2–4, 1975

[3] *Ibid*