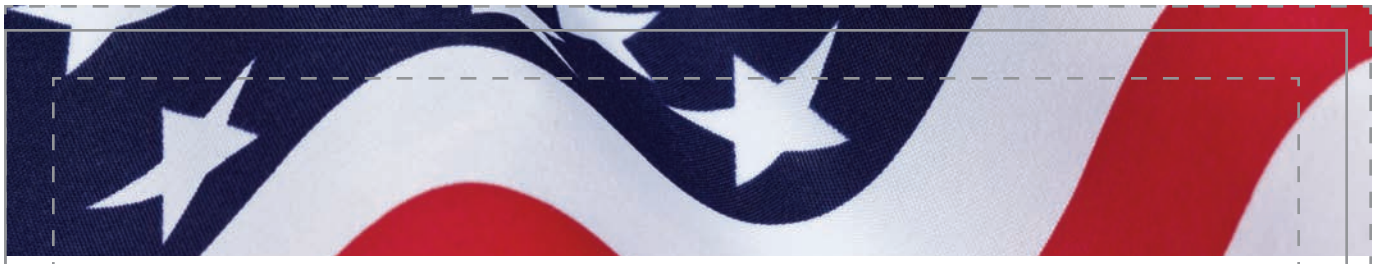

CHAPTER 2

Benchmark Developments in U.S. Health Care

CHAPTER OVERVIEW

This chapter describes important legislative, political, economic, organizational, and professional influences that transformed health care in the United States from a relatively simple professional service to a huge, complex, corporation-dominated industry. The effects of medical education, scientific advances, rising costs, and American values along with assumptions regarding health care are discussed. The chapter concludes with a brief discussion of the enactment of the Patient Protection and Affordable Care Act of 2010 (the ACA) and summaries of its major provisions.

From its earliest history, medical care was dominated by physicians and the hospitals they operated. In the 1800s and early 1900s, participation in U.S. medicine was generally limited to two parties—patients and physicians. Diagnosis, treatment, and fees for services were considered confidential between patients and physicians. Medical practice was relatively simple and usually involved longstanding relationships among physicians, patients, and their families. Physicians set and often adjusted their charges to estimates of patients' ability to pay and collect their own bills. This was an intimate physician–patient relationship that the profession held sacred.

Free from outside scrutiny or interference, individual physicians had complete control over where, when, what, and how they practiced. In 1934, the American Medical Association (AMA) published this statement: "No third party must be permitted to come between the patient and his physician in any medical matter."[1] The AMA was concerned about such issues as non-physician-controlled voluntary health insurance, compulsory health insurance, and the few prepaid contracts for medical services negotiated by remote lumber or mining companies and a few workers' guilds. For decades, organized medicine repeatedly battled against these and other outside influences that altered "the old relations of perfect freedom between physicians and patients, with separate compensation for each separate service."[1]

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As early as the 1800s, some Americans carried insurance against sickness through an employer, fraternal order, guild, trade union, or commercial insurance company. Most of the plans were simply designed to compensate for lost income during sickness or injury by providing a fixed cash payment.[1] Sickness insurance, as it was originally called, was the beginning of social insurance programs that mitigated the risks of income interruption by accident, sickness, or disability. Initially such insurance was provided only to wage earners. Later, it was extended to workers' dependents.[2]

About 1915, the drive for compulsory health insurance began to build in the United States, after most European countries had initiated either compulsory programs or subsidies for voluntary programs. The underlying concern was to protect workers against a loss of income resulting from industrial accidents that were common at the time. Families with only one wage earner, often already at the edge of poverty, could be devastated by loss of income caused by sickness or injury, even without the additional costs of medical care.

At the time, life insurance companies sold "industrial" policies that provided lump-sum payments at death, which amounted to $50 or $100 to pay for final medical expenses and funerals. Both Metropolitan Life and the Prudential Insurance Company rose to the top of the insurance industry by successfully marketing industrial policies that required premium payments of 10–25 cents per week.[2]

In 1917, World War I interrupted the campaign for compulsory health insurance in the United States. In 1919, the American Medical Association (AMA) House of Delegates officially condemned compulsory health insurance with the following resolution:[3]

> The American Medical Association declares its opposition to the institution of any plan embodying the system of compulsory contributory insurance against illness or any other plan of compulsory insurance which provides for medical service to be rendered to contributors or their dependents, provided, controlled, or regulated by any state or the federal government.

Most physician opposition to compulsory health insurance was attributed to an unfounded concern that insurance would decrease, rather than increase, physician incomes and to their negative experience with accident insurance that paid physicians according to arbitrary fee schedules.[1]

The Great Depression and the Birth of Blue Cross

As the Depression of 1929 shook the nation, it also threatened the financial security of both physicians and hospitals. Physician incomes and hospital admission rates dropped precipitously as individuals were unable to pay out of pocket for medical care, and hospitals began experimenting with insurance plans. The Baylor University Hospital plan was not the first, but it became the most influential of those insurance experiments. By enrolling 1,250 public school teachers at 50 cents a month for a guaranteed 21 days of hospital care, Baylor created the model for, and is credited with the genesis of, Blue Cross hospital insurance. Baylor started a trend that developed into multihospital plans that included all hospitals in a given area. By 1937, there were 26 plans with more than 600,000 members, and the American Hospital Association began approving the plans.[4] Physicians were pleased with the increased availability of hospital care and the cooperative manner in which their bills were paid. The AMA, however, was hostile and called the plans "economically unsound, unethical, and inimical to the public interest."[5]

The AMA contended that urging people "to save for sickness" could solve the problem of financing health care.[2] Organized medicine's consistently antagonistic reaction to the concept of

health insurance, whether compulsory or voluntary, is well illustrated by medicine's response to the 1932 report of the Committee on the Costs of Medical Care. The committee's establishment represented a shift from concern about lost wages to concern about medical expenses. Chaired by a former president of the AMA and financed by several philanthropic organizations, a group of prominent Americans from the medical, public health, and social science fields worked for five years to address the problem of financing medical care. After an exhaustive study, a moderate majority recommended adoption of group practice and voluntary health insurance as the best way of solving the nation's healthcare problems. However, even this relatively modest recommendation was rejected by some commission members who in a minority report denounced voluntary health insurance as more objectionable than compulsory insurance. Health insurance, predicted the minority, would lead to "destructive competition among professional groups, inferior medical service, loss of personal relationship of patient and physician, and demoralization of the profession."[6] In 1933, the AMA's House of Delegates again reiterated its longstanding opposition to health insurance of any kind by declaring that the minority report represented "the collective opinion of the medical profession."[7] The dissenting physicians did, however, favor government intervention to alleviate physicians' financial burden, resulting from their obligation to provide free care to low-income populations.

From the early 1900s to the present, there have been many efforts to enact various forms of compulsory health insurance. When the proponents of government-sponsored insurance limited their efforts to older adults and low-income populations, they finally were able to succeed in passing Medicaid and Medicare legislation in 1965. Voluntary insurance against hospital care costs became the predominant health insurance in the United States during those decades. The advocates of government-sponsored health insurance had little success in improving patient access to medical care, but the Blue Cross plans effectively improved hospitals' access to patients.

Following World War II, the federal government boosted the private health insurance industry by excluding health insurance benefits from wage and price controls and by excluding workers' contributions to health insurance from taxable income. The effect was to enable employees to take wage increases in the form of health insurance fringe benefits rather than cash. Also following World War II, the federal government began subsidizing the healthcare industry's expansion heavily through hospital construction and medical research, with physician compensation as an overriding policy objective.

Because insurance companies simply raised their premiums rather than exerting pressure on physicians and hospitals to contain costs, the post-World War II private health insurance system pumped an ever-increasing proportion of the national income into health care. There was little regard for cost growth, with attention focused on avoiding any infringement on physicians' or hospitals' prerogatives to set prices and costs. Medicare and Medicaid followed the same pattern.

Dominant Influence of Government

Although the health insurance industry contributed significantly to the spiraling costs of health care in the decades after World War II, it was only one of several influences. The federal government's coverage of health care for special populations also played a prominent role. Over the years, the U.S. government developed, revised, and otherwise adjusted a host of categorical or disease-specific programs designed to address needs not otherwise met by state or local administrations or the private sector. Today, federally sponsored programs account for about 43 percent of U.S. personal healthcare expenditures.[8]

In the evolution of the U.S. healthcare delivery system, the policy implications of certain federal initiatives are very important. The government increased its support for biomedical research by establishing the National Institutes of Health in 1930 to support categorical programs that addressed heart disease, cancer, stroke, mental illness, mental retardation, maternal and infant care, and many other conditions. In 1935, by granting federal aid to the states for public health and welfare assistance, maternal and child health, and children with disabilities services, the Social Security Act became the most significant social policy ever passed by any Congress. The Social Security Act was the legislative foundation for many significant health and welfare programs, including the Medicare and Medicaid programs.

Programs such as direct aid to schools of medicine, dentistry, pharmacy, nursing, and other professions and their students along with support of health planning, healthcare regulation, and consumer protections, were all part of the Kennedy–Johnson presidential policy era called "Creative Federalism." The aggregate annual investment in those programs made the U.S. government the major player and payer in the healthcare field. Between 1964 and 1968, total grant awards to states excluding Social Security and Medicare nearly doubled, rising from $10.1 billion in 1964 to $18.6 billion in 1968.[9]

Several programs in addition to Medicare and Medicaid began during the Johnson administration to address mental illness and to support the healthcare professionals' role. The Health Professions Educational Assistance Act of 1963 provided direct federal aid to medical, dental, nursing, pharmacy, and other professional schools, as well as to their students. The Nurse Training Act supported special federal efforts for training professional nursing personnel. During the same period, the Maternal and Child Health and Mental Retardation Planning Amendments initiated comprehensive maternal and child health projects and centers to serve people with mental retardation. The Economic Opportunity Act supported the development of neighborhood health centers to serve low-income populations.[10]

In 1970, in a direction labeled "New Federalism," President Nixon expressed his intent to rescind the federal government's direct administration of several healthcare programs and shift revenues to state and local governments through block grants. Block grants are consolidated grants of federal funds, formerly allocated for specific programs, that a state or local government may use at its discretion. In the meantime, with no effective controls over expenditures, federal and state governments underwrote skyrocketing costs of Medicare and Medicaid. The planners of the Medicare legislation had made several misjudgments. They underestimated the growing number of U.S. older adults, the scope and burgeoning costs of new technology, and the public's rising expectations for use of advanced diagnostic and treatment modalities.

The Medicare and Medicaid programs provided access to many desperately needed healthcare services for older Americans, people with disabilities, and low-income populations. Because rising Medicare reimbursement rates set the standards for most insurance companies, however, their inflationary effect was momentous. In the mid-1960s, when Medicare and Medicaid were passed, the United States was spending about $42 billion on health care, or approximately 8.4 percent of the gross domestic product. The costs of U.S. health care now exceed $3 trillion and consume more than 17 percent of the gross domestic product.[11]

Three Major Health Care Concerns

The three major healthcare concerns of cost, quality, and access have comprised a generations-long conundrum of the U.S. healthcare delivery system. Virtually, all attempts to control one or two of these concerns exacerbated the one or two remaining. The federal government's improvements

in access to care by measures such as post-World War II hospital expansions and Medicare and Medicaid legislation were accompanied by skyrocketing expenditures and quality issues. These measures resulted in the healthcare system's expansions beyond actual need and, while virtually unchecked, funding improved access to competent and appropriate medical care for many; they also resulted in untold numbers of clinical interventions of questionable necessity.

Almost all the federal health legislation since the passage of Medicare and Medicaid and the Balanced Budget Act of 1997 was targeted at reducing costs but with little focus on the reciprocal effects of attenuating access and quality of healthcare issues. The ACA changed this trend by promoting and requiring value-based, rather than volume-based reimbursement.[12]

Efforts at Planning and Quality Control

The federal government did not ignore the issues of cost and quality, but efforts to address those concerns were doomed to be ineffectual by their designs. Powerful medical and hospital lobbies exerted great influence over any legislation that might alter the existing constellation of healthcare services or that would scrutinize the quality of clinical practice. Bowing to powerful lobbyists, federal legislation required allowing physicians, hospital administrators, and other health professionals to maintain control over how the legislation was interpreted and enforced.

Two initiatives of the 1960s typified circumstances surrounding federal legislative efforts to address cost, quality, and access concerns. In 1965, the Public Health Service Act was amended to establish the Regional Medical Program initiative, a nationwide network of medical programs in designated geographic areas to address the leading causes of death: heart disease, cancer, and stroke.[13] Through regional medical programs, physicians, nurses, and other health professionals deliberated innovative ways to bring the latest in clinical services to patients. However, representatives of each constituency focused on advocating for funding in their respective disciplines. As a consequence, the regional medical programs added educational and clinical resources but did not materially improve prevention or cost reductions in the treatment of the target conditions. A parallel program, the Comprehensive Health Planning Act, was passed in 1966 to promote comprehensive planning for rational systems of healthcare personnel and facilities in designated regions. The legislation required federal, state, and local partnerships and also required a majority of consumers on every decision-making body.[14]

Almost all the Regional Medical Programs and Comprehensive Health Planning Act programs were dominated by medical and hospital leaders in their regions. Many productive outcomes resulted from the two programs, but conflicts of interest regarding the allocation of research and development funds were common. There was general agreement that the programs were ineffective in achieving their goals.

The Johnson-era programs of 1966–1969, especially Medicare and Medicaid, entrenched the federal government in the business of financing health care. President Johnson's ambitious creative federalism enriched the country's healthcare system and improved the access of many citizens, but it also fueled a persistent inflationary spiral of healthcare costs.

The National Health Planning and Resources Development Act of 1974 combined the Regional Medical Health Program and Comprehensive Health Planning Act programs with political rather than objective assessments. Congress apparently assumed that combining two ineffective programs would result in one successful program. Nevertheless, the legislation established new local organizations, Health Systems Agencies (HSAs), which required representation of healthcare providers and consumers on governing boards and committees to deliberate and

recommend healthcare resource allocations to federal and state authorities.[15] HSAs were largely ineffective for many of the same reasons as their predecessor organizations and failed to develop meaningful strategies to address cost, quality, and access concerns. The ineffectiveness of HSAs in their regions was acknowledged by withdrawal of federal support.[15]

Managed Care Organizations

In 1973, the Health Maintenance Organization Act supported the development of health maintenance organizations (HMOs) through grants for federal demonstration projects. An HMO is an organization responsible for the financing and delivery of comprehensive health services to an enrolled population for a prepaid, fixed fee. HMOs were expected to hold down costs by changing the profit incentive from fee-for-service to promoting health and preventing illness.

The concept was widely accepted, and between 1992 and 1999, HMOs and other types of managed care organizations experienced phenomenal growth, accounting for the majority of all privately insured persons. Subsequently, the fortunes of managed care organizations changed as both healthcare costs and consumer complaints increased. By the 1990s, a consumer and provider backlash resulted in all 50 states enacting protections against managed care access and cost restrictions.[16]

Beginning in 2001, a derivative of managed care organizations, preferred provider organizations (PPOs), gained in popularity. Although PPOs encompass important managed care characteristics, they were organized by physicians and hospitals to meet the needs of private, third-party, and self-insured firms. By 2002, PPOs had captured 52 percent of covered employees.[17] Today, PPOs remain the most popular form of employer-sponsored health insurance.[18]

The Reagan Administration: Cost Containment and Prospective Hospital Reimbursement

The Reagan administration of the 1980s continued efforts to shrink federally supported programs begun in the 1960s and 1970s. One effort was decentralization of program responsibility to the states through block grants. Block grants consolidate grants of federal funds, formerly allocated for specific programs, so that states may use funding at their discretion and presumably more efficiently than the federal government.

One of the most significant health policy changes of the past decades occurred with the Reagan administration's implementation of the Medicare prospective payment system in hospitals. Based on diagnosis-related groups (DRGs), the system shifted hospital reimbursement from a fee-for-service retrospective mode to a pre-paid prospective mode based on patient diagnosis. Designed to encourage efficient use of resources, the DRG system put hospitals at financial risk for charges that exceeded per-case DRG limits. It also created an opportunity for hospitals to retain, if any, the portion of the unexpended predetermined case payment.[19] This unprecedented effort to contain healthcare costs was widely adopted as a standard by the health insurance industry.[19]

In an effort to reign in spiraling physician Medicare charges, the administration also created a new payment method, the resource-based relative value scale (RBRVS) to make physician payments equitable across various types of service, specialties, and geographic locations.[20]

Biomedical Advances: Evolution of High-Technology Medicine

Health care in the United States dramatically improved during the 1900s. In the first half of the century, the greatest advances led to the prevention or cure of many infectious diseases. The development of vaccines to prevent a wide range of communicable diseases, from yellow fever to measles, and the discovery of antibiotics saved vast numbers of Americans from early death or disability.

In the second half of the century many technologic advances that characterize today's health care were developed, and the pace of technologic development accelerated rapidly. The following are a few of the seminal medical advances that took place during the 1960s:

- The Sabin and Salk vaccines ended annual epidemics of poliomyelitis.
- The tranquilizers Librium and Valium were introduced and widely prescribed, leading Americans to turn to medicine to cure their emotional as well as physical ills.
- The birth control pill was first prescribed and became the most widely used and effective contraceptive method.
- The heart–lung machine and major improvements in the efficacy and safety of general anesthesia techniques made possible the first successful heart bypass operation in 1964.

In addition, in 1972, computed tomography was invented. Computed tomography (CT), which unlike x-rays can distinguish one soft tissue from another, is installed widely in U.S. hospitals and ambulatory centers. This valuable and profitable diagnostic imaging device started an extravagant competition among hospitals to develop lucrative patient services through major capital investments in high-technology equipment. Noting the convenience and profit associated with diagnostic devices such as CT, and a few years later, magnetic resonance imaging (MRI), medical groups purchased the devices and placed them in their own facilities. The profit-driven competition and resulting redundant capacity continued to drive up utilization and costs for hospitals, insurers, and the public. Competition continued unabated with the introduction of even more sophisticated and expensive technology over succeeding years.[21]

New technology, new drugs, and new and creative surgical procedures have made possible a wide variety of life-enhancing and life-extending medical accomplishments. Operations that once were complex and hazardous, requiring hospitalization and intense follow-up care, have become common ambulatory surgical procedures. For example, the use of intraocular lens implants after the removal of cataracts has become one of the most popular surgical procedures. Previously requiring hospitalization, these implants are performed in outpatient settings on more than 3.6 million Americans annually.[22] The procedure takes less than one hour.

Technical Advances Bring New Problems

Almost every medical or technologic advance seems to be accompanied by new and vexing financial and ethical dilemmas. The increased ability to extend life raises questions about the quality of life and the right to die. New capabilities to use costly and limited resources to improve the quality of life for some and not others create other ethical problems.

Both the AMA and the federal government developed programs to explore these issues and to provide needed information for decision makers. The AMA established three programs to assess

the ramifications of medical advancements: the Diagnostic and Therapeutic Technology Assessment Program, the Council on Scientific Affairs, and the AMA Drug Evaluations.[23]

In the Technology Assessment Act of 1972, Congress recognized that "it is essential that, to the fullest extent possible, the consequences of technologic applications be anticipated, understood, and considered in determination of public policy on existing and emerging national problems."[24] To address this goal, Congress created the Office of Technology Assessment (OTA), a nonpartisan support agency that worked directly with and for congressional committees. The OTA relied on the technical and professional resources of the private sector, including universities, research organizations, industry, and public interest groups, to produce their assessments and provide congressional committees with analyses of highly technical issues. Established by a Congress controlled by Democrats out of a distrust of the Nixon administration, it was intended to help officials sort out increasingly complex scientific information without advocating particular policies or actions. The OTA was shut down in 1995 as a result of political controversies adverse to the then Republican-controlled Congress.[25]

The Agency for Health Care Policy and Research, created by Congress in 1989 and now called the Agency for Healthcare Research and Quality, supports research to better understand the outcomes of health care at both clinical and systems levels. It has a challenging mission as technologic and scientific advances make it difficult to sort out the complexities of health care and determine what works, for whom, when, and at what cost.

Roles of Medical Education and Specialization

Medical schools and teaching hospitals in the United States are the essential components of all academic health centers and are the principal architects of the medical care system. In addition to their research contributions to advancements in health care and their roles as major providers of health services, they are the principal places where physicians and other professional personnel are educated and trained.

From post-World War II to the mid-1970s, there were numerous projections of an impending shortage of physicians. The response at federal and state levels was to double the capacity of medical schools and to encourage the entry of foreign-trained physicians.[26]

The explosion of scientific knowledge in medicine and the technologic advances in diagnostic and treatment modalities encouraged specialization. In addition, the enhanced prestige and income of specialty practice attracted most medical school graduates to specialty residencies. It became evident that specialists were being produced in numbers that would lead to an oversupply. Also, because they wished to be close to their referring doctors and to associate with major hospitals, graduates tended to concentrate in urban areas. At the same time, the shortage of primary care physicians among rural and inner-city populations grew.

In response, medical schools and hospitals developed new physician workforce policies to maintain or increase their training capacities.[27] Schools erroneously assumed that producing more physicians would result in larger numbers of primary care physicians to work in underserved rural and inner-city areas. Unfortunately, this trickle-down workforce policy did little to change supply distribution problems and only added to the swelling ranks of specialists. Hospitals added to the problem by developing residencies that met their own service needs without regard for oversupply. Supplemental Medicare payments for teaching hospitals and indirect medical education adjustments for hospital-based residents were and still are strong incentives for specialty medicine.[28]

The rapid growth of managed care plans in the 1990s with their emphasis on prevention and primary care was expected to produce profound changes in the use of the physician workforce and cause a significant oversupply of specialists by the year 2000. To stave off the surplus, many medical schools and their teaching hospitals endeavored to produce equal numbers of primary care and specialist physicians instead of the one-third to two-thirds ratio that had existed for years. However, as soon as the effort produced a sizable increase in the number of primary care physicians, new medical workforce projections refuted the prior predictions and forecasted a shortage, rather than a surplus, of specialists. Clearly, estimating a future physician shortage or surplus is a tenuous endeavor.

Influence of Interest Groups

Many problems associated with U.S. health care result from a system shared among federal and state governments and the private healthcare industry. The development of fully or partially tax-funded health service proposals initiated waves of lobbying efforts by interest groups for or against the initiatives. Federal and state executives and legislators receive intense pressure from supporters and opponents of healthcare system changes.[29] Lobbying efforts from special interest groups have become increasingly sophisticated and well financed. It is common for former congressional staffers to appear on the payrolls of private interest groups, and former lobbyists assume positions on Capitol Hill. This strong connection between politicians and healthcare lobbyists is evidenced by the record number of dollars spent to defeat the Clinton Health Security Act of 1993 and both "for" and "against" President Obama's healthcare reform plans.

Five major groups have played key roles in debates on tax-funded health services: providers, insurers, consumers, business, and labor. Historically, physicians, the group most directly affected by reforms, developed the most powerful lobbies. Although the physician lobby still is among the best financed and most effective, it is recognized as not representing the values of large numbers of physicians detached from the AMA. In fact, several different medical lobbies exist as a result of political differences among physicians.

The American Medical Association

The American Medical Association (AMA), founded in 1847, is the largest medical lobby, with a membership of 224,503 individuals, yet it represents only 25.6 percent of physicians and medical students.[30] At the height of its power from the 1940s to the 1970s, the AMA opposed government-provided insurance plans every president from Truman through Carter introduced. Compromises gained in the final Medicare bill still affect today's program.

In 1989, the AMA changed its relationship with Congress. Initially locked out of White House discussions on the Clinton plan, the AMA was later included and supported, at least publicly, by the Obama plan for expanding healthcare access to all Americans. At the height of its power from the 1940s to the 1970s, the AMA opposed government provided insurance plans proposed by every President from Truman through Carter.[31]

Insurance Companies

Even more than physicians, nurses, or hospitals, insurers' political efforts have been viewed as self-serving. The efforts of insurance companies to eliminate high-risk consumers from the insurance

pools and their frequent premium rate increases contributed significantly to the focus on cost containment and the plight of the uninsured and underinsured in the debate on healthcare reform.

Insurance companies played a strong role in the debates about President Obama's healthcare reform effort by appearing to support the general idea while vigorously opposing the idea of a public option that would severely limit their profits. The amount of dollars spent in lobbying efforts by insurers and others with vested interests in the status quo and in misinforming the public to raise unwarranted fears about the proposed healthcare reform legislation hit a new high in deception and a new low in political machinations.[32]

Consumer Groups

Although provider and insurance groups have been most effective in influencing healthcare legislation, the historically weak consumer movement gained strength. Much of the impetus for healthcare reform on the national scene was linked to pressure on politicians from consumers concerned about rising costs and lack of security in healthcare coverage. Despite widespread disagreement among groups about the extent to which government involvement was needed, all were concerned about the questions of cost, quality and access in the current healthcare system.

Better educated and more assertive citizens have become more cynical about the motives of leaders in both the political and the health arenas and have become more effective in influencing legislative decisions. A prominent example is the American Association of Retired Persons (AARP). Founded in 1958, the AARP is one of the most influential consumer groups in the healthcare reform movement. Because of its size and research capability, it wields considerable clout among legislators who are very aware that the AARP's 38 million older citizens are among the most determined voters.[33]

Business and Labor

The National Federation of Independent Businesses, founded in 1943, has 350,000 individual members and is the largest representative of small firms.[34] The National Association of Manufacturers founded in 1895 represents the interests of large employers and has a current membership of 11,000.[35] The U.S. Chamber of Commerce was founded in 1912 and represents 3 million businesses of all sizes.[36]

Whenever business groups are involved in an issue, and especially one of the magnitude of health reform, labor unions will have a strong presence to represent their members' interests. The American Federation of Labor and Congress of Industrial Organization (AFL-CIO), with 12.5 million members,[37] has had a tremendous influence on national health policy. Closely connected with the AFL-CIO is the Service Employees International Union, founded in 1921. It is the largest union representing healthcare workers, with a membership of 1.1 million.[38] During the mid-1940s, labor unions demanded and received healthcare benefits as an alternative to wage increases prohibited by postwar wage and price controls. The two major national unions, the AFL and the CIO, consolidated their power by merging in 1955. During the late 1960s, they were able to address the issues of occupational safety and health and achieved passage of the Occupational Safety and Health Act of 1970. Today, occupational safety and health hold prominent places on the national agenda.

Pharmaceutical Industry

In recent years, the highly profitable pharmaceutical industry increased its spending on lobbying tactics and campaign contributions to unprecedented levels. With prescription drug prices

and pharmaceutical company profits at record highs, the industry correctly anticipated public and congressional pressure to legislate controls on drug prices and drug coverage for older adults on Medicare.

In 2003, as lawmakers moved to add a prescription drug benefit to Medicare that would include price controls, the pharmaceutical industry deployed more than 1,000 lobbyists.[39] The pharmaceutical industry played a major role in crafting the 2003 Medicare Part D prescription drug benefit plan. As a result, the final plan prohibited Medicare and the federal government from using its enormous purchasing power to negotiate prices with drug companies.[39]

Public Health Focus on Prevention

Although the groups discussed in the previous section are primarily concerned with the diagnostic and treatment services that constitute more than 95 percent of the U.S. healthcare system, there is an important public health lobby that speaks for health promotion and disease prevention. Often overlooked because of this country's historical emphasis on curative medicine, public health organizations have had to overcome several negative perceptions. Many health providers, politicians, and others associate public health with governmental bureaucracy or link the care of low-income populations with socialism. Nevertheless, the American Public Health Association, founded in 1872 and having an aggregate membership of approximately 25,000, has substantial influence on the national scene through its organized advocacy and educational efforts at the federal, state, and local levels.[40]

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) was enacted under the Clinton administration in 1996. It had two primary purposes. The first was to help ensure that workers could maintain uninterrupted health insurance coverage if they lost or changed jobs by enabling them to continue coverage through their prior employer's group health plan.[41] Employees using this provision reimburse their former employer directly without company subsidy for their premium costs. The law mandated the renewal of insurance coverage except for specific reasons, such as the nonpayment of premiums. The Act also regulated circumstances in which an insurance plan may limit benefits due to preexisting conditions and offered special enrollment periods for individuals who experience certain changes in family composition, such as divorce or the addition of a dependent.[41]

HIPAA's second primary purpose concerned the privacy of personal health information. Prior to HIPAA, no generally accepted set of security standards or general requirements for protecting health information existed in the healthcare industry. At the same time, new technologies were evolving, and the healthcare industry began to shift from paper processes to the use of electronic information systems to pay claims, answer eligibility questions, provide health information, and conduct many other administrative and clinically based functions.[42]

Known as the "Administrative Simplification" provisions of the law, they mandated the Department of Health and Human Services (DHHS) to establish national standards for regulations protecting the privacy and security of certain health information. To fulfill the mandate, DHHS published national standards known as the "Privacy Rule" and "Security Rule" applicable to virtually all organizations and providers with access to individuals' personal health information. The Security Rule particularly applies to certain health information that is held or transferred in

electronic form.[42] In 2013 DHHS issued final rules under a 2009 law that significantly extended HIPAA's Privacy and Security provisions beyond healthcare organizations and providers to their subcontractors and other business entities which handle electronic patient information.[43] The DHHS Office of Civil Rights has responsibility for enforcing the Privacy and Security Rules with voluntary compliance activities and civil money penalties.[42]

The Balanced Budget Act of 1997

The federal budget negotiations for 1997 reflected pressures to produce a balanced budget and to respond meaningfully to national health issues from consumer and cost-containment perspectives. The resulting Balanced Budget Act (BBA) created sweeping new policy directions for Medicare. The BBA proposed to reduce growth in Medicare spending through savings of $115 billion over five years and targeted hospitals for more than one-third of the savings.[44] The act increased cost sharing among Medicare beneficiaries and extended the prospective payment system introduced with DRGs to hospital outpatient services, home health agencies, skilled nursing facilities, and inpatient rehabilitation facilities.[45] The BBA also opened the Medicare program to private insurers through the Medicare + Choice Program (later renamed Medicare Advantage).

Declines in Medicare spending growth between 1998 and 2002 demonstrated the immediate impact of the BBA. After growing at an average annual rate of 11.1 percent for 15 years, the average annual rate of Medicare spending growth between 1998 and 2000 dropped to 1.7 percent, resulting in approximately $68 billion in savings.[46] Finally, the BBA included an initiative, the "State Children's Health Insurance Program" that complemented the Medicaid program by targeting uninsured children whose family income was too high to qualify for Medicaid and too low to afford private health insurance.[47] Subsequently renamed the "Children's Health Insurance Program" (CHIP) and with the goal of enrolling 10 million children, it was the largest expansion of health insurance coverage for children in the United States since Medicaid began. The CHIP has been continuously funded since inception and currently serves more than 8 million children.[45,48]

Oregon Death with Dignity Act and Other End-of-Life Legislation

November 8, 1994, was a pivotal date in U.S. social legislation when Oregon voters approved the Oregon Death with Dignity Act.[49] The Act legalized physician-assisted suicide by allowing "an adult resident of Oregon, who is terminally ill to voluntarily request a prescription for medication to take his or her life."[50] The person must have "an incurable and irreversible disease that will, within reasonable medical judgment, produce death within six months."[50] The Death with Dignity Act was a response to the growing concern among medical professionals and the public about the extended, painful, and demeaning nature of terminal medical care for patients with certain conditions. An additional consideration was the worry that the extraordinary costs associated with lengthy and futile medical care would exhaust their estates and leave their families with substantial debts.

A survey of Oregon physicians showed that two-thirds of those responding believed that physician-assisted suicide is ethical in appropriate cases. Also, almost half of the responding physicians (46 percent) said they might assist in a suicide if the patient met the criteria outlined in the Act.[51]

The issue of euthanasia and physician-assisted suicide has been debated for years in other countries. Although among Westernized countries only Northern Australia has legalized physician-assisted suicide, the Netherlands has a long history of allowing euthanasia within the medical community.[52]

Oregon physicians must meet multiple requirements before they can write a prescription for a lethal combination of medications. The physician must ensure that the patient is fully informed about the diagnosis, the prognosis, the risks, and likely result of the medications and alternatives including comfort care, pain control, and hospice care. A consulting physician must then confirm that the patient's judgment is not impaired and that the decision is fully informed and voluntary. The patient is then asked to notify next of kin, although family notification is not mandatory. After a 15-day waiting period, the patient must again repeat the request. If the patient does so, the physician is then permitted to write the fatal prescription. Although it varies from year to year, not all patients requesting physician prescriptions opt to use them.[53] In Oregon as in other states which subsequently passed similar statutes, state departments of health are charged with tracking and reporting applications of the right-to-die laws.

In November 2008, the State of Washington initiated a Death with Dignity Act similar to Oregon's.[54] Effective in 2010, the Supreme Court of the State of Montana ruled to maintain the state law that protects doctors from prosecution for helping terminally ill patients die.[55] In 2013, Vermont enacted a "Patient Choice and Control at End-of-Life Act."[56] In June 2016, California became the fifth state to enact a death-with-dignity statute, the "End-of-Life Option Act.[57] In 2016, the New Mexico Supreme Court continued deliberations on a right-to-die statute.[58]

With the burgeoning aged U.S. population and this population group's increasing political strength in numbers, consumer pressure for more states to enact "right-to-die" legislation will be a subject of increasing interest. "Right-to-die" legislation does not only concern older Americans. In 2014, the case of a 29-year-old woman with terminal brain cancer brought national attention to this subject. A resident of California, the woman moved to Oregon to be able to control her end-of-life decisions.[59] As she intended, publicity surrounding her situation sparked much media attention and influenced passage of California's law in 2016.

Health Information and Technology for Economic and Clinical Health Act (HITECH)

The federal government took the most significant step in the history of health information technology on April 27, 2004, when President Bush created the Office of the National Coordinator for Health Information Technology (ONCHIT or "the ONC") by Executive Order.[60] The ONC was legislatively mandated in the American Recovery and Reinvestment Act (ARRA) when signed by President Obama on February 17, 2009.[61] Part of ARRA is the Health Information Technology for Economic and Clinical Health Act (HITECH) that designated $36.5 billion to promote the development of a nationwide network of electronic health records (EHRs). A law enacted in 2015 concerning providers' use of EHRs is presently in the federal rule-making process that may significantly alter the HITECH parameters for provider use of EHRs.

The Internet and Health Care

Because data collection and information transfer are critical elements of the healthcare system, the Internet has become a major influence in U.S. health care. A 2012 Pew Foundation survey report noted that "one in three U.S. adults has gone online to diagnose a condition and about half consulted a medical professional about what they found."[62] The Internet provides consumers with access to vast resources of health and wellness information, the ability to communicate with others sharing similar health problems, and the ability to gain valuable data about medical institutions and providers that permit well-informed choices about services and procedures. Internet users are becoming more educated and participatory in clinical decision making, challenging physicians and other providers to participate with a more knowledgeable and involved patient population.

Physicians and other healthcare providers also are entering the online world of healthcare communication. After a slow start, provider-sponsored websites are proliferating at a rapid pace. In addition to information for consumers about providers' training, competencies, and experience, many encourage email exchanges that invite queries and provide opportunities to respond to consumers' informational needs.

A wide variety of other web-based entrepreneurial ventures have also begun to take advantage of the huge and growing market of smartphone users with apps that "give consumers access to health information wherever and whenever they need it."[62] Both professionally reliable and questionable entrepreneurs offer consumers opportunities to shop online for pharmaceuticals, insurance plans, medical supplies and equipment, physician services, and other health-related commodities, making the public well advised in exercising caution.

The Patient Protection and Affordable Care Act of 2010

"The first promise Obama made as a presidential candidate was to enact a universal healthcare plan by the end of his first term."[63] Many months prior to his inauguration, senate Democrats—led by Senator Max Baucus, chair of the powerful Senate Finance Committee, and Senator Edward Kennedy—were collaborating with a diverse group of stakeholders to craft a plan.[63] Some in the new administration opposed advancing the cause of universal coverage at a time when the President also had to advance his pledges for an economic stimulus package, education reform, and bailouts for banks and the auto industry.[64] Nevertheless, believing "that rising medical costs were crippling average families, cutting into corporate profits, and consuming more and more of the federal budget,"[64] President Obama moved the healthcare agenda forward through a tortuous and rancorous maze of political machinations and public reactions.[65] Decades-long analyses and assessments by the most prestigious academic research and industry experts overwhelming noted that U.S. healthcare system focused on providing excellent care for the individuals with acute conditions, but virtually ignored the more basic health service needs of larger populations who could benefit from primary preventive care. The system continued to reward providers for the volume of services delivered with piecemeal reimbursement rather than with financial incentives to maintain or improve health status among populations of service recipients.

Given that a succession of federal administrations beginning in 1945 with President Truman had proposed and failed at enacting some form of universal healthcare coverage, the ACA was an

achievement of historic proportion. The groundbreaking nature of the ACA resides in its addressing what were historically intractable systemic problems of cost, quality, and access.

The ACA intends to reverse incentives that drive up costs; to enact requirements that increase both accountability for, and transparency of, quality; and by 2019, to increase access by expanding health insurance coverage to several million Americans.[66,67] The ACA also adds consumer protections and enhances access to needed services for the nation's most vulnerable populations.[68]

Judicial Challenges to the ACA

On the day the ACA was signed into law, the state of Florida filed a federal district court lawsuit challenging the constitutionality of the law's requirement for individual coverage and its expansion of the Medicaid program. Twenty-five additional states, the National Federation of Independent Businesses, and other plaintiffs also filed suit in Florida.[69] The Virginia state attorney general filed a separate lawsuit challenging the federal requirement for individuals to purchase health insurance.[70] The primary issues of contention were whether Congress had the authority to impose the individual coverage mandate with personal financial penalties for noncompliance under either its authority to regulate interstate commerce or its taxing power; and whether Congress had the authority to make all of a state's existing Medicaid funding contingent on compliance with the ACA's Medicaid expansion provisions.[69] The U.S. Supreme Court agreed to decide the two issues and heard oral arguments from proponents and detractors of the ACA provisions during the spring of 2012. On June 28, 2012, in a 5 to 4 decision, the Court upheld the constitutionality of the individual mandate with Chief Justice Roberts writing, "The mandate is not a legal command to buy insurance. Rather, it just makes going without insurance just another thing the government taxes."[71] The Court determined that the Medicaid expansion as described in the ACA was unconstitutionally coercive of states but remedied this violation of states' rights by prohibiting the federal government from making states' existing Medicaid funding contingent on participation in the expansion. The Court's decisions made no changes to the preexisting Medicaid law and the federal government's authority to require states' compliance with existing Medicaid program rules.[69] In 2015 the ACA survived another challenge when the Supreme Court negated a lawsuit alleging that federal tax subsidies to help offset health insurance costs for individuals in certain states were illegal.[72]

The ACA Implementation Provisions

The ACA is more than 900-pages long and written under 10 titles.[73] It is organized under four broad goals:

- Providing new consumer protections
- Improving quality and lowering costs
- Increasing access to affordable care
- Holding Insurance Companies Accountable

Following is a brief summary of the law's major provisions excerpted and edited from DHHS websites and categorized by the ACA's major goals listed above.[74,75] In addition, the Kaiser Family Foundation lists ACA implementation activities year-by-year with the status of the law's provisions.[76] For more detailed information, readers are encouraged to use this chapter's references and Internet links. The law's provisions are being implemented sequentially with all provisions expected to be in effect by 2019.

New Consumer Protections

- Establishes a website on which consumers can compare health insurance coverage options and choose their preference.
- Prohibits insurance companies from denying coverage of children based on preexisting conditions.
- Prohibits insurance companies from refusing to sell coverage or renew policies for adults because of preexisting conditions and prohibits insurance companies from charging higher rates because of gender or health status.
- Prohibits insurance companies from denying payments for a subscriber's illness because of technical or other errors discovered in a subscriber's original insurance application.
- Prohibits insurance companies from imposing lifetime dollar limits on essential benefits, such as hospital stays.
- Prohibits insurance companies' use of annual dollar limits on the amount of insurance coverage a patient may receive under new health plans in the individual market and all group plans.
- Provides consumers with a way to appeal coverage determinations or claims to their insurance company and establishes an external review process.
- Provides federal grants to states to establish or expand independent offices to help consumers navigate the private health insurance system.
- Prohibits insurers from dropping or limiting coverage because an individual chooses to participate in a clinical trial; applies to all clinical trials that treat cancer or other life-threatening diseases.

Improving Quality and Lowering Costs

- Provides small business health insurance tax credits to offset costs of employers' contribution to employees' health insurance premiums.
- Provides relief for older Americans' prescription drug costs.
- Requires that all new health plans cover certain preventive services, such as mammograms and colonoscopies without charging a deductible, co-pay, or coinsurance.
- Establishes a new $15 billion Prevention and Public Health Fund to invest in proven prevention and public health programs.
- Invests new resources and requires new screening procedures for healthcare providers to boost federal antifraud and waste initiatives in Medicare, Medicaid, and Children's Health Insurance Program.
- Provides certain free preventive services, such as annual wellness visits and personalized prevention plans for Medicare beneficiaries.
- Establishes a Center for Medicare & Medicaid Innovation to test new ways of delivering care to patients to improve the quality of care and reduce the rate of growth in costs for Medicare, Medicaid, and the Children's Health Insurance Program.
- Establishes a Community Care Transitions Program to help high-risk Medicare beneficiaries avoid unnecessary hospital readmissions by coordinating care and connecting patients to services in their communities.
- Establishes a new Independent Payment Advisory Board to develop and submit proposals to Congress and the President focused on ways to target waste in the system, recommend ways to reduce costs, improve health outcomes for patients, and expand access to high-quality care.

- Establishes a hospital Value-Based Purchasing program in traditional Medicare, offering financial incentives to hospitals to improve the quality of care; requires hospitals to publicly report performance for certain diagnoses and patients' perceptions of care.
- Provides incentives for physicians and hospitals to join together to form "Accountable Care Organizations" to better coordinate Medicare beneficiary patient care and improve the quality, help prevent disease and illness, and reduce unnecessary hospital admissions.
- Institutes a series of changes to standardize billing and requires health plans to begin adopting and implementing rules for the secure, confidential, electronic exchange of health information.
- Requires any ongoing or new federal health program to collect and report racial, ethnic, and language data to help identify and reduce disparities.
- Provides new funding to state Medicaid programs that choose to cover preventive services for patients at little or no cost to expand the number of Americans receiving preventive care.
- Establishes a national pilot program, Bundled Payments for Care Improvement (BPCI), to encourage hospitals, doctors, and other providers to work together to improve the coordination and quality of patient care by paying a flat rate for a total episode of care rather than billing Medicare for individual services.
- Pays physicians based on value not volume through a provision tying physician payments to the quality of care provided.
- Imposes an excise tax on high-cost insurance plans to limit the costs of health insurance plans to a tax-free amount with the intent to generate revenue to help pay for covering the uninsured.

Increasing Access to Affordable Care

- Provides a preexisting condition insurance plan with new coverage options for individuals who have been uninsured for at least six months because of a preexisting condition.
- Extends coverage for young adults who will be allowed to stay on their parents' plan until they turn 26 years of age.
- Expands coverage for early retirees through a $5 billion program to provide financial help for employment-based plans to continue providing health insurance coverage to people who retire between the ages of 55 and 65, as well as their spouses and dependents.
- Rebuilds the primary care workforce through new incentives to expand the number of primary care doctors, nurses, and physician assistants through scholarships and loan repayments for primary care doctors and nurses working in underserved areas.
- Provides eligibility for $250 million in new grants to states that have or will implement measures requiring insurance companies to justify premium increases; also may bar insurance companies with excessive or unjustified premium levels from participation in the new health insurance exchanges.
- Provides federal matching funds for states covering some additional low-income individuals and families under Medicaid for whom federal funds were not previously available.
- Provides increased payments to rural healthcare providers to help them attract and retain providers.
- Provides new funding to support the construction of and expand services at community health centers, allowing these centers to serve some 20 million new patients across the country.
- Allows states to offer home and community-based services to disabled individuals through Medicaid rather than institutional care in nursing homes through the Community First Choice Option.

- Requires states to pay primary care physicians no less than 100 percent of Medicare payment rates in 2013 and 2014 for primary care services, with full federal funding of the increase.
- Provides states with two additional years of CHIP funding to continue coverage for children not eligible for Medicaid.
- Makes tax credits available for middle-class individuals with incomes between 100 percent and 400 percent of the federal poverty level who are not eligible for other affordable coverage.
- Enables individuals to purchase health insurance directly in the health insurance marketplace if their employers do not offer health insurance.
- Enables Americans who earn less than 133 percent of the federal poverty level eligible to enroll in Medicaid; provides states with 100 percent federal funding for the first three years to support this expanded coverage, phasing to 90 percent federal funding in subsequent years.
- Requires most individuals who can afford it to obtain basic health insurance coverage or pay a fee to help offset the costs of caring for uninsured Americans; if affordable coverage is not available to an individual, he or she will be eligible for an exemption.
- Creates Health Care Choice Compacts that allow selling health insurance across state lines to increase competition among plans and give consumers more choices.

Holding Insurance Companies Accountable

- Ensures that premium dollars are spent primarily on health care by generally requiring that at least 85 percent of all premium dollars collected by insurance companies for large employer plans are spent on healthcare services and healthcare quality improvement; for plans sold to individuals and small employers, at least 80 percent of the premium must be spent on benefits and quality improvement; failing to meet these goals, insurance companies must provide rebates to subscribers.
- Eliminates additional Medicare costs from Medicare managed care plans (Medicare Advantage) and provides bonus payments to Medicare Advantage plans that provide high-quality care.

As noted above, all provisions of the ACA will become fully effective by 2019 and some have already undergone change as the implementation process has proceeded. However, centerpieces of the law such as the new availability of affordable insurance plans and the Medicaid expansion are yielding material results. At only six full years since its enactment, it remains early to speculate on the ACA's success in achieving its overall intended changes in the organization, delivery, efficiency, and effectiveness of a monstrously complex industry. Outcomes will unfold over the next several years. Regulatory and legal changes enacted by the ACA are indeed only two components of the equation. A multitude of other factors such as the nation's economy, the political environment, and provider and consumer reactions and behaviors, to name only a few, will determine the outcomes of this landmark legislation.

KEY TERMS FOR REVIEW

Block Grants
Diagnosis-Related Group (DRG)
Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH)
Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Health Maintenance Organization Act of 1973
Medicaid
Medicare
Oregon Death with Dignity Act of 1994
Social Security Act of 1935

CHAPTER ACRONYMS

AMA American Medical Association
CHIP Children's Health Insurance Program
HMO Health maintenance organization

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