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Failure to launch: A short history of health care reform in the United States

Claire Talbert

Western Washington University

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Failure to launch: A short history of health care reform in the United States

Western Washington University

Honors Capstone

Claire Talbert

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Introduction

“Nobody knew health care could be so complicated.” (Conway, 2017)

- President Donald Trump

In early 2017, the current President of the United States stood before a group of health insurers and made a bold statement about the incomprehensibility of health care reform. Perhaps the president is correct. Perhaps there is no way to truly understand how complex the American health care system is and how difficult it is to change. Alternatively, maybe this is common knowledge. Maybe as a nation, Americans grasp that the health care system is more complicated than any given person can conceive it to be. Possibly, and even more likely, the incomprehensibility of the health care system has been revealed time and time again in this nation’s history, in the failures and triumphs of each and every administration.

The real question we should be asking about the United States health care system may not be in regard to its complexity, but rather how it has come to exist in its current state at all. How have we arrived at a system that is so unwieldy as to confuse a sitting president and strike fear into the eyes of a confused and concerned populous?

Oft-cited statistics reference the tremendously high costs of the United States health care system and a noticeable lack of positive health outcomes in return. In 2016, the United States spent 17.9% of Gross Domestic Product (GDP), an incredible \$3.3 trillion, on health care (Centers for Medicare & Medicaid Services, 2016). Despite spending an average of more than \$10,000 per capita annually, the United States continues to experience worse health outcomes than comparable high-income nations (Centers for Medicare & Medicaid Services, 2016; Schneider et al., 2017).

Compared to countries like Australia, Canada, and the United Kingdom, the United States performs poorly on population health measures such as infant mortality, life expectancy from birth, and chronic disease rates (Schneider et al., 2017). Measurements of health care efficiency indicate that the United States lags behind other countries in accessibility, administrative efficiency, and health disparities as well (Schneider et al., 2017). Comparisons between spending and health outcomes clearly demonstrate the inefficiencies of the American health care system, but these numbers fail to recognize the real impacts of this system on the population. To evaluate the actual effects of the health care system on a population, one can look at mortality amenable to health care. This measure estimates the number of deaths that occur from lack of health care or lack of quality health care during a given period. In 2016, the United States mortality rate amenable to health care was 112 per 100,000 people, or approximately 362,000 people annually (Schneider et al., 2017). Even that value, as startling as it may be, does not capture the actual American health care experience. To achieve a more complete understanding, past and current events reveal how this system was developed and how the effects manifest in real health outcomes.

The aim of this paper is to utilize past successes and failures in health care reform to gain a more comprehensive understanding of the current health care system in the United States and how it has come to exist in its current state. In addition to investigating the historical precedent of health care reform, this paper evaluates the role of traditional American norms and values in directing policy development. These norms and values are inextricably linked to the formation of health care opinions and policies. Finally, considering past reforms and the role of American values, this paper will speculate on the future of health care reform in America.

Norms, Values, and Attitudes

Norms, values, and attitudes are essential to the development and understanding of public policy (Ruger, 2007). Any attempt to determine how health care in the United States has developed requires an understanding of the values and attitudes that have come to define this nation (Ruger, 2007). From its early stages, health care has had more in common with social policies than fiscal reforms, and social policies are especially subject to the pervasive values and attitudes of a nation (Ruger, 2007). Investigations into the role of partisanship, individualism, cynicism, and incrementalism elucidate how these cultural and political norms, values, and attitudes have contributed to the health care system in the United States as it currently exists (Ruger, 2007).

Individualism

Social policies have a long and contentious history in the United States (Ruger, 2007). Legislation like Medicaid and other social programs like Social Security, unemployment insurance, and food stamps have all faced national ridicule because of well-established negative beliefs about welfare and social programming (Ruger, 2007). Opposition to social support legislation claims that welfare-style programs infringe on individual rights and freedoms (Ruger, 2007). Independence and individualism are hallmark values in the United States, and key values in the development of health care policy (Vladeck, 2003).

While evaluations of health care attitudes indicate that Americans believe health policy to be unique from other social policies, concerns about individual rights have contributed to more than one reform failure (Schlesinger, 1993). The general view seems to be that health needs are fundamental to the individual and outside of human control to a degree that other social statuses

like income, employment status, and criminality are not (Ruger, 2007). General consensus about the existence of a moral commitment to the uninsured exists; however, the acceptance of a need for health and health care conflicts with individualistic beliefs in reasoned self-interest and a pervasive unwillingness for self-sacrifice (Ruger, 2007). This dichotomy between individualism and a commitment to the health of others contributes to a social and political system that demands health care reform but is wholly unequipped to develop actual legislation.

A strong desire for health care reform has been well recorded in the United States since World War II, but there have been few successful nationalizing reform efforts (Schlesinger, 1993). Many major attempts at reform have been effectively eliminated because they appeared to promote anti-individualist sentiments like federalized or socialized health care (Blendon et al., 1994). Others have failed to ever make it out of Congress because they required compulsory enrollment, which some perceive as an infringement on the rights of the individual (Blendon et al., 1994). More recently, continuing complaints about the individual mandate under the Obama administration indicate that individualism is still a defining value in the health care debate, and one that has a well-established influence on public opinion and congressional support (Ferguson, Fowler, & Nichols, 2008).

Partisanship

Divided political discourse has long been an influential part of health care reform (Ferguson et al., 2008). Harkening back to the 1940s and fears of socialized medicine, partisanship has been a defining trait in the movement toward, or away from, national health care (Morone, 2016). Political scientists often consider partisan political ideas as a catalyst to popular choice, defining options and creating an environment where individuals can use political identity to align with specific policy ideals (Morone, 2016). The specific role of partisanship in health

care reform may hinder more than it helps, as the relationship between the two major political parties, Republicans and Democrats, is changing in the contemporary period. More recent debates around the Affordable Care Act (ACA) and the future of health care under the Trump Administration are uniquely influential in party politics (Morone, 2016).

Recent attempts at health care reform, particularly with the Obama administration, demonstrate a trend of long-enduring, partisan policy debates. Debates that sometimes continue long after reforms have been finalized (Morone, 2016). Opposition to the Patient Protection and Affordable Care Act, otherwise known as Obamacare, has continued for close to a decade, much longer than the partisan debates that occurred with the passage of Medicare and Medicaid in the 1960s (Morone, 2016). This trend indicates that, due to enduring partisan ideals, simply passing legislation may no longer be enough to bring closure to a period of health care reform.

The concept of bipartisan compromise on health care legislation has more or less become a thing of the past. (Ferguson et al., 2008). During the Clinton administration, fears of outright failure built a congressional space that involved somewhat more compromise than current or recent congresses, which have maintained hard, party-line stances on health policy (Ferguson et al., 2008). The result is, in essence, a race between two competing factions (Frakes, 2012). With both Republican and Democratic groups working to develop health care reform in whatever manner gives their party the most recognition for successful reform, sometimes to the deficit of actual legislative progress (Ferguson et al., 2008).

Partisanship is by no means a solely governmental value or attitude. The American public shows signs of high levels of political partisanship, especially in the years since the 2016 presidential election (Morone, 2016). The political identities of Republican or Democrat and conservative or liberal, are labels that voters use to inform their policy opinions completely

independent from the policy itself (Morone, 2016). This is an important phenomenon to consider when looking at Americans historically strong support for national health care, but lack of specific policy measures to achieve it (Ruger, 2007). Intensely heterogeneous beliefs in Congress, the executive branch, and among the public are important divisions to take in to account when evaluating the effectiveness of health care reform efforts in the United States.

Cynicism

The relationship between political partisanship, the federal government, and the American public is further complicated by cynical attitudes towards government interventions and institutions. Compared to other industrialized nations, United States residents have more negative attitudes toward government than their international counterparts (Vladeck, 2003). Since the 1960s, skepticism of government intervention has been increasing among the general public (Blendon & Benson, 2001). This trend holds true for opinions on government intervention in health care, as well (Blendon & Benson, 2001). Public support for government action in health care has been unstable in the post-World War II period, and many Americans report some degree of cynicism about the government's ability to design, implement, and effectively pay for health care reform (Blendon & Benson, 2001).

This 'crisis of confidence' creates issues for policymakers who have to generate legislation that addresses current issues, garners public support, and diverts feelings of cynicism and distrust in the government (Schlesinger, 1993). Diminishing faith in government institutions to execute even a well-proposed piece of legislation limits the degree to which reform can address large health policy issues. The more radical the reform, the less likely the public is to believe that the government can execute it (Schlesinger, 1993).

Not only do Americans believe that the government is unlikely to achieve successful reform, they also have generally negative views on the prospect of better health care systems in the future (Blendon et al., 1994). Negative views on the future of health care may engender more support for the status quo, if the future is perceived as a worse unknown than present dissatisfaction (Blendon et al., 1994). Cynicism towards the government, the current health care system, and the potential for successful future health care outcomes has contributed to a national tendency towards incrementalism in health care reform (Ruger, 2017).

Incrementalism

More than a value of the American people, incrementalism is a defining value of the United States political system (Ruger, 2007). The role of incrementalism is perhaps most evident in the historical inaction and failures of health care reform (Oberlander, 2007). A fragmented national system of policy making, weak political parties, strong interest groups, and reelection incentives all favor a system of incremental change (Ruger, 2007). The result is that, with the exception of a few reforms, health care has experienced minimal change over the last 200 years (Vladeck, 2003).

It seems that the longer the United States has gone without substantive health care reform, the harder it has been to convince politicians, interest groups, and the American people that health care reform is possible and maybe even necessary (Oberlander, 2007). On multiple occasions the nation has seemed poised for health care reform only to have strong opposition, national scandal, economic decline, or a lack of bipartisan support lead to legislation that is only a fraction of what was originally intended (Oberlander, 2007). In many cases, sustaining the status quo through incremental reform has seemed a better option than the risks associated with passing large scale reform and having it fail. This phenomenon does not occur with health care

alone (Vladeck, 2003). Preference for incremental change is built into the history and government of this country and affects policy at every level of the political system (Vladeck, 2003). Incrementalism may not be an intentional value of policy making in the United States; nonetheless, it has come to define a system of health care reform that is uniquely difficult to alter and notoriously slow to change (Ruger, 2007; Oberlander, 2007).

18th & 19th Century

Health Care in Early America

The founding documents of the United States, which form the basis for policy development, have a notable lack of any reference to health and health care. The Declaration of Independence names an inalienable right to life that some historians and scholars interpret to include a right to health, health care, or a basic minimum of health services (Hoffman, 2012). In 1776, when the Declaration of Independence was drafted, health was seen as a state largely outside of human control. An individual's status of sickness or health was under the dominion of God and deeply connected to religious devotion (Hoffman, 2012). The absence of an explicit reference to health or health care in the Declaration of Independence may reflect the religious values in the 18th century, though the absence has continued to affect policy development into the modern day.

Because there was a general lack of political or constitutional direction, health care during the 18th and 19th centuries was an informal industry with some private and some public components (Hoffman, 2012). Prior to 1789, the newly built federal government had taken no direct action to promote the public health or the health care industry, and a majority of Americans received intermittent care, at best, from private medical practitioners (Hoffman,

2012). Unfortunately, this group of practitioners and their small body of medical knowledge were unable to confront the ravages of disease that spread easily in the colonies (Shryock, 1950). Infectious diseases like smallpox, yellow fever, and typhoid plagued the new nation in the absence of modern day public health measures (Shryock, 1950).

John Adams (1797-1801)

The Act for the relief of sick and disabled seamen. In 1789, the federal government introduced the nation's first formal health care plan, The Act for the relief of sick and disabled seamen, which provided hospital insurance to members of the United States Navy (Jacobs-Kronenfeld & Kronenfeld, 2015). Collectors deducted twenty cents from the paychecks of seamen each month to pay for the hospital care of sick and disabled seamen. The government also used the funds from the payroll tax to build new hospitals to supply the needed medical services (Jacobs-Kronenfeld, 2015). President John Adams and the writers of this act targeted United States Navy workers specifically because their exposure to foreign disease-spreading agents put them at a high risk for both contracting and propagating infectious disease (Jacobs-Kronenfeld, 2015). This initial health care act is significant more for its existence than for its effects on the health status of seamen. The Act for the relief of sick and disabled seamen represents the first codified, federal health care effort in the United States (Hoffman, 2012). While the terms of this bill may not look all that similar to the health care reform of today, it was certainly foundational in establishing a precedent for federal intervention in health care (Hoffman, 2012).

The next notable move in United States health care reform came during the reconstruction period in the 1860s and 1870s, as a relatively young nation attempted to recover from half a decade of civil war. Compounding the losses in life and infrastructure, immigration

surged during the postbellum period (Steckle & Costs, 1997). As new immigrants came to the United States, they brought with them new infectious diseases that flourished in increasingly populated urban areas (Jacobs-Kronenfeld, 2015; Steckle & Costa, 1997). The distress that burgeoning disease brought to the United States was largely attributed to new immigrants; a direct reflection of the xenophobia that permeated American culture. These immigration and disease patterns resulted in a new emphasis on health in the United States, federal quarantine regulations, and the creation of public health departments at the state and community level (Jacobs-Kronenfeld, 2015). After making an initial debut into the consciousness of the American public and the United States government in the 18th and 19th centuries, health care would remain at the forefront of the national agenda into modern day.

20th Century

Woodrow Wilson (1913-1921)

At the opening of the 20th century, the United States still had little in the way of a cohesive health care system at the state or federal level (Jacobs-Kronenfeld & Kronenfeld, 2015). During the administration of President Woodrow Wilson, scholars from a variety of fields made new efforts to establish a bigger, better, and more regulated health care system (Hamovitch, 1993).

The Standard Bill. In 1912, the American Association for Labor Legislation (AALL), a group of economists, created the Committee on Social Insurance (CSI) with the purpose of developing health care legislation that would support the well-being of workers. The legislation that the AALL group drafted included specific and divisive regulations (Hamovitch, 1953). Generally, the proposal aimed to cover low income workers and their families, as this population

was especially vulnerable to financial crisis from illness or injury. Under the Standard Bill, these workers and their families would gain coverage for medical care, sick pay, maternity benefits, and funeral expenses financed through employer, employee, and state funds (Harrison, 2003).

Two portions of the Standard Bill, in particular, contributed to the numerous and heated debates that followed the release of the initial drafts (Hamovitch, 1953). First, the AALL believed that participation in the insurance model must be compulsory in order for the bill to be effective. Second, the draft excluded commercial insurance companies in order to avoid the potential for profiteering (Hamovitch, 1953). The Standard Bill was extremely partisan in a way that is, at its root, similar to the partisanship seen in health care reform today. Support for this piece of legislation existed on a continuum with the strongest support coming from AALL who was largely responsible for the bill (Harrison, 2003). Opposition came in the form of influential individuals like Samuel Gompers from the labor movement, organizations like the American Medical Association (AMA), and organized interest groups like business owners. Opponents of the bill cited excess government oversight, tyranny over the individual, and unacceptable similarities to German taxation laws (Hamovitch, 1953; Harrison, 2003).

The labor movement in particular was aggressively opposed to the Standard Bill, and would continue to oppose most efforts to reform the health care system into the next century. Members of the labor movement largely believed that compulsory participation would reduce worker autonomy and open opportunities for the government to prevent the formation of labor unions (Hamovitch, 1953). The AMA feared that the bill would diminish the doctor-patient relationship and reduce the status of doctors (Hamovitch, 1953).

In the end, the Standard Bill, like many subsequent legislative actions, was never passed. The strength of the opposition, in membership, financing, and political sway, proved too

powerful. This combined with the reduced support of social programs with the start of World War I, contributed to the failure of the Standard Bill (Harrison, 2003). Forward progress on health care would remain stalled until after World War I ended, and the nation was once again able to focus on domestic legislative action.

Warren Harding (1921-1923)

The Harding administration entered the White House at a time of unusual progressivism in the 20th century. The 19th amendment had just been ratified, bringing a group of well organized, albeit white, women to the voting booths and the forefront of the national political agenda (Lemons, 1969). Though the Harding administration was cut short by the death of President Harding in 1923, the health care and welfare legislation of the early 1920s was an important step toward the development of federal health care, a future emphasis on maternal and child health, and the eventual establishment of federal welfare legislation (Lemons, 1969).

Sheppard Towner Act. A series of unique conditions made it possible for the Harding administration to develop and pass the United States' first federal welfare program, an early version of federalized health care (Jacobs-Kronenfeld & Kronenfeld, 2015). The Sheppard Towner Act sponsored by Democratic Senator Morris Sheppard and Republican Representative Horace Mann Towner was passed in 1921. The program continued for eight years before being allowed to lapse in 1929 (Jacobs-Kronenfeld & Kronenfeld, 2015).

The primary purpose of the Sheppard Towner Act was to reduce maternal and infant mortality rates by increasing health and support services for pregnant women (Barker, 2003). The main provisions of the Sheppard Towner Act included state grants to build hospitals, provide education, and pay for nurses to treat women and infants in rural areas (Barker, 2003). The funds made available through the bill could not, however, be used to actually pay for

medical services (Hoffman, 2012). The Sheppard Towner Act is an excellent early example of the tendency in American health care legislation to focus on only specialized groups like pregnant women and children (Barker, 2003; Hoffman, 2012).

The passage of the initial Sheppard Towner Act was made possible by the weak status of organized labor in the early 1920s, a strongly decentralized state, and well-organized women's groups (Barker, 2003). This combination of political and social climates allowed for the development of what was termed at the time a 'maternalist welfare state'. The Children's Bureau was initially responsible for implementing the provisions of the Sheppard Towner Act before control was shifted to the Public Health Service (Barker, 2003). Public perception of the bill declined after the program was moved from the Children's Bureau, which was seen as responsive to the needs of women and children, to the primarily male-led Public Health Service (Baker, 2003).

Support for the bill came primarily from the women's groups who were instrumental in its passage (Jacobs-Kronenfeld & Kronenfeld, 2015). Some organizations, and the AMA in particular, opposed the Sheppard Towner Act, attaching the label of socialized medicine (Maslow, 1939). Other groups refused to show support for any bill that served people of all ethnicities, which, in theory, the Sheppard Towner act did (Barker, 2003).

Policymakers at the time identified that the Sheppard Towner Act faced an almost impossible double-standard (Barker, 2003). If the bill had offered free medical care, fears of socialism would have prevented its passage. If the bill had offered cash benefits, parents would have balked at the monetization of pregnancy. The result was a bill that was too weak to enact the kind of change that the drafters intended (Barker, 2003). Women who received social aid under the Sheppard Towner Act expressed dissatisfaction with the weak legislation that was

enacted because, by using an education-only framework, it inadequately addressed the actual determinants of maternal and infant health. (Barker, 2003). Given this double standard, the somewhat dissatisfied public response, and the initial indications of a coming economic depression, it is unsurprising that the Sheppard Towner Act was allowed to lapse in 1929 (Maslow, 1939).

Franklin Roosevelt (1933-1945)

Any discussion of health care reform under the Roosevelt administration is simultaneously a discussion of the successes and struggles of the Social Security Act (SSA; Hamovitch, 1953). President Roosevelt expressed explicit support of universal health care measures, but ultimately sacrificed an attempt at universal, government-funded health care in order to pass the SSA (Jacobs-Kronenfeld & Kronenfeld, 2015). Even though health care reform was ultimately excluded from the SSA, the Great Depression created new government interest in health care reform.

The period immediately following the Great Depression marked the beginning of large scale speculation into the possibility of a right to health care (Hoffman, 2012). Three senators were particularly influential in the development of the ultimately unsuccessful legislation that came about during this period: Democratic Senators Robert Wagner, James Murray, and John Dingell. These senators developed two bills that were, at the time, the closest the nation had yet come to major reform in favor of universal health care (Hamovitch, 1953; Harrison, 2003).

Wagner National Health Bill. In 1939, the Roosevelt administration created the Interdepartmental Committee to Coordinate Health and Welfare Activities, whose work would eventually become the basis for the Wagner National Health Bill (Hamovitch, 1953). The writers of the Wagner National Health Bill were heavily influenced by relevant socio-political factors,

among them, increasing medical advancements, a new emphasis on preventative health, growing capital for technology, and strong divisions of labor in the health field (Hamovitch, 1953). These factors are reflected in the bill's final provisions, many of which were highly contested (Maslow, 1939).

The Wagner National Health Bill, which was packaged as an amendment to the SSA, included federal grants for building hospitals and other public health initiatives (Maslow, 1939). These provisions were a reaction to conservative perspectives on social spending after the previous decade's economic depression (Hamovitch, 1953). In an attempt to address latent concerns about economic insecurity in the populous, the Wagner National Health Bill sponsored state grants to finance the expansion of existing voluntary insurance programs for low income individuals (Maslow, 1939). The bill maintained existing systems of temporary disability compensation and increased federal grants to fund health care for disabled children (Maslow, 1939). In many ways, the Wagner bill attempted to capitalize on the opening for social and economic change created by the Great Depression. The bill was to be implemented primarily by states and was left intentionally vague in the hopes of accruing fewer enemies (Hamovitch, 1953).

Despite the best efforts of the legislators, the Wagner National Health Bill was strongly opposed by medical professionals who believed it encouraged too much government intervention in health (Maslow, 1939). Labor groups, though they liked the content of the bill, stood opposed because the legislation did not go far enough (Maslow, 1939). Supporters included the National Organization for Public Health Nursing and the American Hospital Association (Maslow, 1939). In the end, the Wagner National Health Bill never made it out of congressional hearing because it was simultaneously too far reaching for some and not far reaching enough for others

(Hamovitch, 1953). This dilemma of change by degrees, too much and also too little, is a theme in health care reform and one that has contributed to the demise of numerous pieces of health care legislation (Oberlander, 2007).

Senators Wagner, Murray, and Dingell made a second attempt at health care reform in 1943. The Wagner-Murray-Dingell Bill of 1943 is distinct from the previous attempt made in 1939, but, like the other bill, was proposed as an amendment to the SSA. This bill received more unilateral opposition and was also never passed (Harrison, 2003; “The Wagner-Murray-Dingell Bill”, 1944).

Harry Truman (1945-1953)

After the Roosevelt administration enacted the Social Security Act without an attached national health bill, the Truman Administration had the opportunity to bring new health care legislation to a nation that seemed ready for vast changes in social support programs (Hamovitch, 1953). World War II also played a key role in growing political support for national health care legislation. About one-third of all conscripted World War II servicemen were rejected for health problems, and many more were discharged from service for health problems unrelated to combat (Jacobs-Kronenfeld & Kronenfeld, 2015). The establishment of a connection between declining health and national defense increased attention on public health efforts and the health care sector (Jacobs-Kronenfeld & Kronenfeld, 2015). President Truman viewed the lapse in healthy servicemen as an issue of national safety. The result of those feelings was another attempt at nationalizing health care reform (Schremmer & Knapp, 2011).

Wagner-Murray-Dingell Bill. In 1945, Senators Murray, Wagner, and Dingell redrafted their 1943 bill from the Roosevelt administration and added two new and important provisions (Harrison, 2003). The first, called Title One, increased spending on public and maternal health

initiatives. Title Two would have established compulsory national health insurance (Jacobs-Kronenfeld & Kronenfeld, 2015). When the newly drafted Wagner-Murray-Dingell Bill of 1945 first made it to Congress, the likelihood of passage seemed strong (Jacobs-Kronenfeld & Kronenfeld, 2015). Both houses of Congress were democratically controlled, though political and social leanings were generally more conservative in the post-war period (Schremmer & Knapp, 2011). The high taxes and strong government oversight that characterized New Deal legislation in the period after the Great Depression no longer had strong public support in the 1940s, opening an opportunity for increased social spending (Jacobs-Kronenfeld & Kronenfeld, 2015). Debate on the bill continued in committee until the midterm elections of 1946, in which the Republican Party gained majorities in both houses. Passage of a broad, compulsory, and expensive piece of federal legislation became less likely with the government under strong Republican control (Schremmer & Knapp, 2011).

Despite the conservative control in Congress, Truman ran for reelection in 1948 with nation health insurance as a major focus of his campaign. When Truman won his reelection, the Democratic Party also regained Congressional control (Schremmer & Knapp, 2011). The passage of national health legislation seemed imminent (Schremmer & Knapp, 2011). In response to growing public and political support for the Murray-Wagner-Dingell Bill of 1945, the AMA launched a massive anti-national health insurance campaign in 1948 (Jacobs-Kronenfeld & Kronenfeld, 2015). The organization claimed that Truman's plan was "socialized medicine", a label that proved particularly incendiary in the staunchly anti-communist period after World War II. The AMA spent \$4 million to lobby the public and Congress. It was, at the time, the largest lobbying campaign in history (Jacobs-Kronenfeld & Kronenfeld, 2015; Schremmer & Knapp, 2011). Like other major players in the health care debate, the AMA

preferred a private health care system over the compulsory and government run system that the Truman administration promoted (Jacobs-Kronenfeld & Kronenfeld, 2015).

Reactions to the Wagner-Murray-Dingell Bill of 1945 revealed four primary beliefs in oppositions to universal health care: universal health care would be a handout, wealthy Americans would receive unnecessary assistance, it would create more need than the medical infrastructure could support, and federal control of doctors would ruin the doctor-patient relationship (Jacobs-Kronenfeld & Kronenfeld, 2015). These four beliefs in combination with the political and economic power of the AMA, waning public support, and the start of the Korean War contributed to the ultimate failure of the second iteration of the Wagner-Murray-Dingell Bill of 1945 (Jacobs-Kronenfeld & Kronenfeld, 2015).

Looking back on the failure of the Truman Administration's "socialized medicine" reform efforts, many of the issues that sank national health insurance in the 1940s are still absolutely relevant today (Jacobs-Kronenfeld & Kronenfeld, 2015). In particular, the public's concern about health care handouts and the medical infrastructure would continue to appear in the health care debate for decades to come (Jacobs-Kronenfeld & Kronenfeld, 2015).

John Kennedy (1962-1963)

During the 1950s, the United States government made a concerted effort to develop the private insurance market (Zelizer, 2015). Businesses received subsidies for offering insurance to their employees, and many Americans enrolled with a private insurer through their employers (Zelizer, 2015). Even with this new, informal system of private insurance and Social Security benefits, many Americans struggled to pay for their health care costs. This was especially true for the elderly who spend more on hospital care than other age groups and tend to have lower incomes (Zelizer, 2015). Medical advancements during the middle of the 20th century

accelerated rates of hospitalization and brought the issue of health care for older Americans to the forefront of national and congressional agendas (Zelizer, 2015).

Forand Bill. In 1958, the Kennedy administration began a seven-year movement toward federally run insurance programs that would eventually end with the formation of Medicare and Medicaid under President Johnson (Jacobs-Kronenfeld & Kronenfeld, 2015). The Forand Bill aimed to cover hospital insurance for the elderly with an amendment to the SSA (Jacobs-Kronenfeld & Kronenfeld, 2015). Aime Forand and Cecil King, the primary drafters, proposed that Social Security benefits be expanded to include hospital care for people over the age of 65. The new expenses would be funded with an increase in the existing Social Security tax (Jacobs-Kronenfeld & Kronenfeld, 2015). Organized labor, which was especially powerful during this period of unionization, strongly supported the bill (Jacobs-Kronenfeld & Kronenfeld, 2015). A majority of Democrats in Congress and President Kennedy also came out in support of the Forand Bill (Jacobs-Kronenfeld & Kronenfeld, 2015). With backing from the president, the White House began a series of public-relations promotions for the SSA amendment (Zelizer, 2011). Soon after, the AMA launched an aggressive oppositional campaign in conjunction with Ronald Reagan and a group of insurance companies (Zelizer, 2011).

In contrast to previous unsuccessful attempts at health care reform, the end of the Forand Bill has been credited not to large lobbying organizations like the AMA, but rather to Democratic Senator and Chairman of the House Ways and Means Committee, Wilbur Mills (Zelizer, 2015). The high projected cost of the Forand Bill was not something that Mills, a strict fiscal conservative, promoted. As Chairman of the House Ways and Means Committee, Mills had control over what could go to a vote in committee, as well as committee assignments (Jacobs-Kronenfeld & Kronenfeld, 2015). Mills used his power as Chairman to repeatedly block

the Forand Bill from a vote. While the Forand Bill languished in committee, more conservative members of congress developed and promoted alternative bills including the Kerr-Mills Bill, a limited means-tested program, and the King-Anderson Bill, a weaker version of the original Forand Bill (Zelizer, 2015). As of 1962, none of the three primary proposals had made it out of committee. Then in 1963, the assassination of President Kennedy halted the movement towards what would be Medicare and Medicaid legislation until President Johnson took office (Jacobs-Kronenfeld & Kronenfeld, 2015).

Lyndon Johnson (1963-1969)

The passage of Medicare and Medicaid legislation is one of the hallmark achievements of the Johnson administration and of the 20th century as a whole (Berkowitz, 2005). Johnson's "Great Society" programs formed a solid foundation for the passage of social support legislation in the 1960s (Jacobs-Kronenfeld & Jacobs, 2015). With the progress made under the Kennedy administration, Presidents Johnson and the 89th Congress were prepared to enact legislative change during this period.

Medicare. In contrast with the rough beginnings of the Forand Bill under Kennedy, Medicare legislation passed relatively quickly after Johnson's election. With the 1962 elections, Johnson entered the oval office and the Democratic Party gained majorities in both the House and the Senate (Berkowitz, 2005). This shift in the political leanings of the executive and legislative branches paved the way for structural changes to the committee process that would eventually permit the passage of Medicare legislation (Berkowitz, 2005). The first of these structural changes to the committee system was the reconfiguration of the House Ways and Means Committee to make bipartisan review easier to achieve. The second change was the enactment of a 21-day limit on the review of a bill in committee (Jacobs-Kronenfeld &

Kronenfeld, 2015). Under these new conditions, Medicare legislation passed relatively quickly, especially when compared to the multi-year battle of the nearly equivalent Forand Bill (Jacobs-Kronenfeld & Kronenfeld, 2015).

The bill that eventually made it through Congress as Medicare combined aspects of the Forand Bill with elements of the King-Anderson and Kerr-Mills Bills previously mentioned, as well as a program promoted by the AMA titled Eldercare (Jacobs-Kronenfeld & Kronenfeld, 2015). Even with extensive reconfiguring of the final bill to incorporate elements from each of the main partisan bills, support for Medicare legislation fell along party lines (Moore & Smith, 2005). With Democratic majorities in both the House and the Senate, Medicare passed on July 30th, 1965 as Title XVIII of the Social Security Amendments of 1965 (Jacobs-Kronenfeld & Kronenfeld, 2015; Moore & Smith, 2005).

Medicare has become a staple of the American health care system, but current Medicare legislation is notably different from the original 1965 version. The flexibility of Medicare legislation has been key to its continued success, as the program has needed to grow and expand with an increasingly large 65 and over population, new medical advancements, and increases in the demand for medical services (Centers for Medicare & Medicaid Services, 2016).

Medicaid. In 1965, the 89th United States Congress also passed Medicaid legislation as Title XIX of the 1965 Social Security Amendments. The same issues that plagued the passage of Medicare as part of the Social Security Amendments of 1965 afflicted the passage of Medicaid Legislation, though Medicaid was often seen as a secondary piece of legislation (Berkowitz, 2005). When Medicaid final made it out of congress with approval, the program was still highly divisive and has remained so for the last fifty years (Rosenbaum, 2002).

The aim of the Medicaid program was to help states finance means-tested health initiatives to support low-income families. Legislators were incentivized to cede more authority to states to allow for greater flexibility in government supported health care and minimize federal control (Rosenbaum, 2002). The primary beneficiaries are low-income families, individuals with disabilities, and dual enrolled Medicare beneficiaries. Medicaid was originally structured as an entitlement program through state and federal funding (Rosenbaum, 2002). Because the program is an entitlement, anyone who meets the requirements is eligible to receive aid. While the entitlement status of Medicaid allows some flexibility in how programming is implemented, federal Medicaid laws are relatively stringent to reduce financial risk (Jacobs-Kronenfeld & Kronenfeld, 2015). Much like Medicare, the way in which Medicaid was structured has allowed the program to be incredibly adaptable over the last 50 years (Moore & Smith, 2005).

Medicaid's adaptability stems from two primary provisions: waiver programs and entitlement programs (Moore & Smith, 2005). The waiver program allows states to make Medicaid reform decisions as need changes. This, in combination with the structure as an entitlement program, has allowed Medicaid to expand with the growing population, increased need, increased medical expenses, advancements in care, and political changes (Moore & Smith, 2005).

Despite its adaptability, Medicaid is still limited in its scope. The application process is infamously difficult, definitions of disability are specific, and participation among physicians has always been low (Grogan, 1994). The program also only serves a specific and limited segment of the population. The many expansions of Medicaid services have never included low-income adults without children or disability, and this has been a notable absence since Medicaid legislation first made it through Congress (Moore & Smith, 2005). Additionally, Medicaid's

status as welfare legislation has been a main weakness of the program since its inception (Moore & Smith, 2005). However, Medicaid's identity as a welfare program has become more tenuous over time. As Medicaid has expanded to include more Americans, and Americans from higher-income brackets that have not traditionally used social support services, perceptions of Medicaid as a welfare service have been challenged (Moore & Smith, 2005).

Despite the challenges that Medicare and Medicaid have faced both in their initiation and over the past fifty years, the programs continue to insure millions of Americans, offering essential access to health services (Moore & Smith, 2005). The status of these social insurance programs will remain in question as new health care reformers must decide whether to simply modify these existing programs or completely eliminate Medicaid and Medicare from new legislation (Berkowitz, 2005).

Richard Nixon (1969-1974)

Nixon's presidency was defined by the Watergate scandal and his subsequent resignation. Much of the legislation pending in Congress in 1974 when Watergate broke became a victim of legislative inaction during this period, as all potential for political action was overshadowed by scandal (Wainess, 1999). Among the legislation that stalled in Congress in 1974 were multiple comprehensive national health insurance bills that seemed poised for success (Wainess, 1999). Scholars have posited that had Watergate not occurred under the Nixon administration, the United States would likely have obtained national health insurance before the midpoint of the 1970s (Wainess, 1999; Harrison, 2003).

National Health Insurance Partnership Act. A slew of unique conditions at the opening of the 1970s created an environment in which support for health care reform proliferated (Wainess, 1999). Health care expenses had been growing consistently since the passage of

Medicaid and Medicare ten years earlier. In 1974, price controls on both federal programs lifted causing expenditures to increase at alarming rates (Wainess, 1999). There were Democratic majorities in both the House and the Senate, but in general, both Nixon and Congress were more moderate than past governments (Wainess, 1999; Freed, 2015). Additionally, the House Ways and Means Committee did not have subcommittees during this period; subsequently, power was highly centralized, and legislation moved quickly. Under these conditions, the 93rd Congress gained more momentum towards developing successful national health insurance legislation than possibly any other government in United States' history (Wainess, 1999).

Taking advantage of this momentum and the mutual desire among Democrats and Republicans to move legislation quickly and receive credit for its passage, congresspersons began proposing reforms early in the decade (Wainess, 1999). The first major effort among these proposals was the Health Security Act of 1971, sponsored by Senators Ted Kennedy and Martha Griffiths. The bill was essentially a push for comprehensive national insurance, but the legislation appeared too much like a single-payer program to gain congressional and presidential support (Harrison, 2003). Ted Kennedy would be an important player in the health care reform debate for many years, and he is viewed, today, as an early and aggressive supporter of universal health care on the national stage (Wainess, 1999).

As the proposed Health Security Act was under review in Congress, Russell Long, Chair of the Senate Finance Committee, was working on a piece of near-universal, catastrophic-care legislation in conjunction with Senator Abraham Ribicoff (Harrison, 2003). The 1973 Long-Ribicoff Bill gained strong committee support but was viewed as too limited to be success in the Senate (Harrison, 2003). In 1974, two more comprehensive health care plans were added to the congressional docket: Nixon's National Health Insurance Partnership Act and a proposal out of

the House, the Kennedy-Mills Bill. Both pieces of legislation were serious contenders in the race toward universal health care (Freed & Das, 2015).

The content of the various reform proposals varied largely in benefits, coverage, and administration (Freed & Das, 2015). Many of the potential bills advocated for employer-based insurance with some supplementary system for the unemployed and the elderly, but they differed dramatically in what would be covered. The proposal headed by Senator Long offered substantially less coverage than the more comprehensive bills supported by Kennedy and Nixon (Harrison, 2003). The proposals also differed in the degree of government involvement, with some emphasizing private insurers and others aiming to increase the role of the federal government (Harrison, 2003). Notably, and also controversial, some of the plans intended to eliminate Medicaid and replace it with other, less costly systems (Wainess, 1999). The actual contents of these health care bills was definitively more important than the details of past reform attempts (Bodenheimer, 2003). The nation seemed poised to pass national health care legislation, and the matter at hand was what exactly that legislation would look like (Bodenheimer, 2003).

During this period, the AMA and organized labor both influenced the creation of proposals to reflect their organizational values (Wainess, 1999). These proposals, while generally less popular, were added to a growing list of what would be seven major proposals for health care reform before Congress in 1974 (Wainess, 1999). With so many options, it seemed likely that the United States would have a serious bid for national health insurance. That was until Watergate created massive scandal in the Nixon administration, with the end result being Nixon's resignation and a long-lasting mistrust of congressional and presidential power (Jacobs-Kronenfeld & Kronenfeld, 2015).

When former Vice President Ford took over after Nixon's resignation, there was still some hope that national health insurance would be realized in the 1970's; however, Ford had a history of voting against social legislation (Wainess, 1999). During his previous terms as a congressperson, Ford voted against every single piece of welfare and health legislation that came before the House. Despite his less than optimistic voting history, out of loyalty to Nixon, Ford proclaimed his support for the National Health Insurance Partnership Act (Wainess, 1999). After much debate in Congress, a compromise bill termed the Committee Print actually gained a majority in the House Ways and Means Committee, but only a one-vote majority (Wainess, 1999). The committee chair, Wilbur Mills, opted not to bring a bill with such marginal support before the floor (Wainess, 1999). Soon after this, Mills resigned from his committee position and left Congress amid a scandal involving a substance-use disorder and an assault on a relatively well-known sex worker (Wainess, 1999).

Without Mills' strong leadership, the House Ways and Means Committee failed to make any more progress on national health insurance compromise (Wainess, 1999). The 'Watergate Babies', congresspersons elected immediately after Watergate in 1974, were less prone to bipartisanship than their predecessors and quickly dismantled the axis of power that had formed around the House Ways and Means Committee under Mills. The result was seven bills for national health care reform languishing in committee that would never make it onto the Congressional floor, much less into law (Wainess, 1999; Jacobs-Kronenfeld & Kronenfeld, 2015).

The 1970s introduced a new issue to the discussion of health care reform. Prior to this period, the health care debate was largely between proponents and opponents of governmental health care (Bodenheimer, 2003). During the 1970s, the nation transitioned from this dichotomy

into a more complex discussion of how national health care could be achieved and not simply whether it should be achieved (Bodenheimer, 2003). This trend has persisted to influence much of the health care reform that has occurred since the 1970s.

James Carter (1977-1981)

President Carter made health care a priority issue in his 1976 campaign, and he was quick to begin developing proposals after taking office (Finow, 1998). In the wake of Watergate and the failures of health reform under Ford, the Carter administration faced significant political and economic challenges (Jacobs-Kronenfeld & Kronenfeld, 2015). Congress was generally distrustful of executive power during this period, so despite having Democratic majorities in Congress and a Democratic president, the administration struggled to transfer political aims into actual legislation (Jacobs-Kronenfeld & Kronenfeld, 2015). The late 1970s and the 1980s were marked by a strong desire to increase industry competition and reduce regulations on business in an attempt to encourage fiscal restraint and reduce inflation (Jacobs-Kronenfeld & Kronenfeld, 2015). Under these conditions, lawmakers made multiple attempts to develop national health reform legislation, but divisive views in Congress, economic pressures, and political mistrust prevented forward progress (Finow, 1998).

National Health Plan. President Carter contributed to numerous national health insurance proposals during his time in office (Finow, 1998). Initially, he was adamant in his support for a mass reform to create a universal health care system, but these sentiments faded as fears of inflation and politically inflammatory legislation took hold (Finow, 1998). In the end, politicians drafted and debated two primary bills. The first was a comprehensive, immediate reform bill sponsored by Joseph Califano Jr., Secretary of the Department of Health, Education, and Welfare (Finow, 1998). Califano had the support of organized labor, a group that had been

demanding immediate and total reform for decades (Finbow, 1998). The other bill was a universal catastrophic care plan, reminiscent of the one introduced under Nixon, and supported by White House officials like Senator Russell Long (Finbow, 1998).

In 1979, with President Carter's influence, the National Health Plan made it before Congress as a piece of incremental legislation to expand Medicaid and provide employee-based catastrophic coverage (Finbow, 1998). Carter and supporters of the bill were clear in their belief that the proposal was not a commitment to creating comprehensive health care in the future (Finbow, 1998). In Congress, the bill was stripped of many provisions that conservative members saw as welfare benefits (Finbow, 1998). Few Congresspersons actually supported the final version of the bill, which was seen as too expansive for most Republicans and some conservative Democrats and too weak for most liberal Democrats (Finbow, 1998).

Similar to some past legislative efforts, national health reform failed during the Carter administration for a multitude of reasons (Finbow, 1998; Bodenheimer, 2003). Chief among these was the ideological debate between incremental reform, which was associated with fiscal responsibility, and comprehensive reform. This debate has repeatedly ended in bills that are simultaneously too expansive and not expansive enough (Finbow, 1998; Bodenheimer, 2003). The failure of legislation during this period also exemplifies the long-lasting effect of Watergate on the political climate, and particularly the relationship between the executive and legislative branches (Jacobs-Kronenfeld & Kronenfeld, 2015). Some scholars have posited that residual distrust from the Watergate Scandal negatively impacted the outcome of reform attempts in the late 1970s, as the government was more concerned with anti-inflammatory politics than with legislative overhauls (Jacobs-Kronenfeld & Kronenfeld, 2015; Finbow, 1998).

William Clinton (1993-2001)

The early 1990s had the appearance of an era in which major health care reform would be not only possible, but probable in the United States (Skocpol, 1994). Health care expenses were increasing at previously unknown rates, and a record 40 million Americans were uninsured (Budetti, 2004). Under the advisement of the President's Task Force on National Health Reform, the Clinton administration actually came fairly close to achieving massive change to a system that was described by some at the time as "huge and unwieldy" (Skocpol, 1994). Despite the eventual failure of this health care reform attempt, the Clinton administration would go on to create the Health Insurance Portability and Accountability Act (HIPAA) in 1996 and the current State Child Health Insurance Program (SCHIP) in 1997. Both programs have had significant and measurable impacts on the health care delivery system in the United States (Jacobs-Kronenfeld & Kronenfeld, 2015).

Health Security Act. Soon after his election, President Clinton initiated the President's Task Force on National Health Reform, also known as the Health Security Task Force (HSTF). At the helm of this new legislative group was First Lady Hillary Clinton (Jacobs-Kronenfeld & Kronenfeld, 2015). The HSTF developed and drafted the 1993 Clinton Health Care Act, also known as the Health Security Act (HSA). This was a landmark piece of legislation that forsook the more incremental proposals of the past for rapid and far reaching reform (Harrison, 2003).

The proposed HSA included provisions for a government regulated system of managed competition. By grouping insurers into large cooperatives, the bill aimed to disperse risk and reduce the total number of private insurance companies (Harrison, 2003). It is important to note that at this time, health care was as much a private entity, through employer insurance, as it was a public entity, through programs like Medicaid and Medicare (Skocpol, 1994).

In order for the managed competition plan to work, the bill also included an individual mandate, a mandatory minimum of coverage, and subsidies for employers and low-income or unemployed individuals. In response to increasing costs, the HSA opted to privatize Medicaid by including beneficiaries in the provision for general health care plans (Budetti, 2004). In theory, this would have dispersed some of the financial risk associated with the Medicaid program and also increased the number of clinicians accepting Medicaid recipients. Clinicians would receive the same reimbursements for Medicaid patients as for non-Medicaid patients (Budetti, 2004). There has been rampant speculation as to why the HSA was not a success, and many of the proposed theories have as much to do with the political and social climate in 1993 as the actual contents of the bill (Jacobs-Kronenfeld & Kronenfeld, 2015).

President Clinton took office as a Democrat in the wake of ten years of Republican presidency, having defeated an incumbent president, and having won a minority of the electorate (Skocpol, 1994). Despite strong partisanship in Congress and somewhat low public support, the Clinton administration undertook truly monumental reforms (Skocpol, 1994). Some scholars have surmised that Clinton would have been more successful taking a less aggressive and more incremental approach, but history would indicate that incrementalism comes with its own difficulties (Blendon, Brodie, & Bendon, 1995). While a majority of Americans were likely in support of national-scale health care reform, approaching reform through the HSTF may have created too much distance between the policymakers and the policy beneficiaries. A public perception of a lack of transparency likely reduced overall support for the bill (Blendon et al., 1995).

In 1993, Congress had Democratic majorities in both houses; however, these majorities were not strong enough to ensure the passage of health care legislation (Skocpol, 1994).

Republican congresspersons supported the goal of decreasing the number of uninsured Americans, but similar to past legislative attempts, they were generally apprehensive to support such a major accomplishment under a Democratic President (Jacobs-Kronenfeld & Kronenfeld, 2015). The political climate in 1993 was not conducive to congressional action, and the social conditions at the time may have inhibited progression of the HSA to a similar extent (Skocpol, 1994).

In the early 1990s, the public was generally skeptical of government control and increasing bureaucracy. The HSA with its managed competition provision would have increased bureaucratic control of the health care economy to an extent that was unacceptable to the public at the time (Skocpol, 1994). Much like researchers who suggested an incremental plan may have been more successful, other scholars have posited that a single-payer plan would have been a better response to the bureaucratic fears of the public (Skocpol, 1994).

In 1994, the HSA was declared unpassable in the current Congress, and Senate leaders planned to delay passage of the bill until after midterm elections (Harrison, 2003). The Republican Revolution of 1994, led in part by Newt Gingrich, made the passage of the HSA or even a compromise bill a nearly impossible scenario with the 104th congress (Harrison, 2003). The growth of Republican control in Congress, political speculation as to the role of Hillary Clinton in the HSTF, and the break of the Lewinsky-Clinton scandal in 1998 more or less guaranteed the failure of national health care reform under the Clinton administration (Harrison, 2003). Though, the administration would go on to develop more successful health care legislation at the state level.

Balanced Budget Act of 1997. The State Children's Health Insurance Program (SCHIP) was established as part of the Balanced Budget Act of 1997, and the program has operated

continuously ever since (Centers for Medicare & Medicaid Services, 2015). SCHIP was created in response to the growing number of uninsured children in the United States in the mid-1990s (Shields, McGinn-Shapiro, & Fronstin, 2008). The proposed audience was children in families with an income above 100% the Federal Poverty Line (FPL). The provisions of the bill allowed states flexibility in deciding the degree to which they wanted to expand coverage to uninsured children, with the federal cap set at 200% of the FPL (Shields et al., 2008).

In order to achieve this flexibility, the bill is executed as a block grant. Block grants are funds given to states for a specific purpose provided that states meet federally mandated minimum benefit and coverage requirements (Rosenbaum, 2002). Providing greater control to states is seen as an essential characteristic of SCHIP, but the block grant status makes the continued funding of the bill tenuous (Shields et al., 2008). Many states have been forced to cut funding to other social programs to maintain SCHIP. In 2017, the tenuous status of SCHIP became glaringly clear when Congress nearly failed to continue funding the program (Rovner, 2018).

21st Century

George W. Bush (2001-2009)

Between 2000-2007, the cost of health benefits nearly doubled, but the average worker's wages increased by less than 25%. The growing costs of health care and insurance premiums were too much for many individuals and families to manage (Shields et al., 2008). In particular, those who worked for employers that did not provide health insurance, were ineligible for the insurance their employer offered, or were unable to pay for the offered insurance plans were becoming uninsured at an increasing rate (Shields et al., 2008). Financial concerns and high costs

were the defining characteristics of the reform efforts during this period (Shields et al., 2008). Despite the emphasis on reducing health care expenses, the Bush administration was relatively successful in pushing health care legislation through Congress (Oliver, Lee, & Lipton, 2004).

Health Savings Accounts. While not a specific health care reform effort, the Bush administration heavily promoted Health Savings Accounts as a potential solution to skyrocketing health care costs (Hoffman, 2006). Health Savings Accounts allow enrollees to open a private, tax-deductible savings account to be used exclusively for health care costs. These accounts are often accompanied by high deductible plans with especially low premiums (Hoffman, 2006). These plans were and are particularly attractive to low-income individuals, but they generally offer minimal coverage (Hoffman, 2006). Health Savings Accounts combined with high deductible health plans were very popular in the early and mid-2000s, but enrollees in these plans reported medical bill problems like inability to pay for tests or medications at much higher rates than individuals enrolled in other health plans (Hoffman, 2006). Nevertheless, Health Savings Accounts formed the foundation of health care under the Bush administration as skyrocketing costs forced beneficiaries to enroll in lower cost, more catastrophic-care plans.

Health Insurance Flexibility and Accountability Initiative. Soon after his initial election in 2001, President Bush announced the Health Insurance Flexibility and Accountability Initiative (HIFA; Rosenbaum, 2002). HIFA gave states the option to offer minimum health care coverage to individuals that were uninsured but did not qualify for Medicaid. This provision contributed to an increase in the insured population but came at the expense of the quality of benefits packages (Rosenbaum, 2002). In order to pay for the minimum benefits expansion, states had the option to reduce coverage for the existing population of Medicaid beneficiaries. In

the end, HIFA decreased the proportion of uninsured individuals nationally, but led to substantial losses in coverage for many Medicaid enrollees (Rosenbaum, 2002).

Medicare Prescription Drug, Improvement, and Modernization Act. A large portion of the growing medical costs during this period were attributed to Medicare, and more specifically, growing prescription drug costs among Medicare enrollees (Oliver et al., 2004). The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) was the Bush administration's attempt to reduce the burden of prescription drug costs on the elderly (Brinckerhoff & Coleman, 2005).

The MMA became law in 2003 after a tumultuous six months in Congress (Oliver et al., 2004). The bill set income and eligibility requirements for Medicare beneficiaries, and provided reduced prescription drug prices for those who qualified through the newly created Medicare Part D (Brinckerhoff & Coleman, 2005). Policy analysts and Medicare recipients expressed discontent with two aspects of the MMA (Brinckerhoff & Coleman, 2005). The first issue was deciding which prescriptions would be covered under the MMA. Consistent with the language of the original Medicare legislation, the MMA aimed to cover prescriptions that were considered necessary and reasonable. The clear question that emerges from that policy statement is what qualifies as necessary and reasonable (Brinckerhoff & Coleman, 2005). The second oft-cited issue with the MMA is a clear absence of coverage for those who did not qualify under the MMA, but who were still unable to pay for prescriptions in full. This group was a substantial and important part of the Medicare population that continued to struggle even after the MMA claimed to have made prescriptions more accessible for the elderly (Brinckerhoff & Coleman, 2005).

Barack Obama (2008-2017)

In 2008, the political and economic landscape in the United States was poised for major health care reform (Skocpol & Williamson, 2011). It had been nearly fifty years since any major health care reform had passed in the United States when President Obama won the 2008 election by a substantial margin and with strong public support. Additionally, Democrats grew their majorities in both the House and the Senate in the 2008 election (Skocpol & Williamson, 2011). President Obama maintained high public approval ratings through 2008 and into 2009, and the administration also had success in passing major legislation early on with the American Recovery and Reinvestment Act (Skocpol & Williamson, 2011).

The passage of health care legislation under these conditions was not, however, guaranteed. The economic recession threatened health care reform, as policy makers were cautious to increase spending on top of the already pricey stimulus package (Skocpol & Williamson, 2011). Another setback came in 2009 with the special election of Scott Brown in Massachusetts. In this special election, the Democrats lost what many considered to be a fool proof supermajority in Congress (Skocpol & Williamson, 2011). Lobbying groups also threatened the future of health care reform, as private insurance companies, clinicians, and hospital groups were profiting well under the current system. Even with this opposition, the Obama administration and 111th Congress would go on to pass comprehensive health care legislation in 2010 (Skocpol & Williamson, 2011).

Patient Protection and Affordable Care Act. In order to achieve health care reform, the Obama administration outlined general principles and objectives. They then transferred the role of developing detailed policy initiatives to Congress (Skocpol & Williamson, 2011). By limiting the role of the democratically controlled executive branch in the policy process, the Obama

administration hoped to encourage bipartisanship and compromise (Skocpol & Williamson, 2010). The resulting bill was termed the Patient Protection and Affordable Care Act (ACA), commonly known as Obamacare.

Since its passage, there has been a wealth of speculation as to why the ACA passed when so many other bills did not. In addition to the political and social factors that prepared the Obama administration to achieve this success, the bill was also intentionally written to address the many concerns of the very vocal opposition. The ACA included a provision specifically to address the guaranteed opposition from lobbying groups and physicians who feared losing profits under a changing system (Skocpol & Williamson, 2011). The Obama administration also directly addressed the economic concerns voiced by politicians and the public alike. In its communication with the public and lobbying groups, the Obama administration chose to emphasize how the bill would be paid for more than the actual contents of the legislation. The Congressional Budget Office had a substantial role in the evaluation of the drafted ACA legislation and was key to the economic arguments for radical health care reform (Skocpol & Williamson, 2011). In 2010, the 111th Congress passed the Patient Protection and Affordable Care Act as a budget reconciliation bill without a single Republican vote (Jacobs & Callaghan, 2013).

In its final form, the ACA is a well over 2,000-page document. The sheer quantity of information can be condensed into seven main provisions that appear to have been the most influential and controversial (Glied & Jackson, 2017; Centers for Medicare & Medicaid Services, 2015; Skocpol & Williamson, 2011; Jacob & Callaghan, 2013).

1. Insurers are not able to deny coverage to individuals or their dependents based on a pre-existing health condition.

2. Policies must meet a minimum of coverage, which includes ten essential benefits.
3. An individual mandate requires that individuals enroll in health insurance or pay an annual fee.
4. Health insurance exchanges create a central location for individuals not enrolled in employer or government insurance to find a health care plan.
5. Qualifying individuals and families that do not meet Medicaid eligibility can receive subsidies to pay for health care plans on the exchanges.
6. An employer mandate requires that employers of a certain size offer insurance for their employees.
7. Medicaid expansion permits states to increase the proportion of low-income families that can enroll in government insurance.

Among these seven main provisions, the individual mandate and Medicaid expansion have been the most controversial. After the ACA was passed, states were quick to identify these provisions as potential points for judicial debate (Glied & Jackson, 2017). The controversy surrounding these supposed constitutional breaches was taken to the Supreme Court soon after the passage of the ACA. In the case *National Federation of Independent Business (NFIB) v. Sebelius*, the Supreme Court ruled on the constitutionality of both the individual mandate and Medicaid expansion (Glied & Jackson, 2017).

The primary objective of the individual mandate is to encourage populations that have electively forgone insurance in the past, like young people, to enroll and maintain insurance (Glied & Jackson, 2017). Having more young, healthy individuals in the insurance pool reduces overall risk and expense. Arguments against the individual mandate assert that requirements to enroll in health insurance are an infringement on individual rights and an overextension of the

allowances of the Commerce Clause (Glied & Jackson, 2017). In *NFIB v. Sebelius*, the Supreme Court ruled that the individual mandate was both constitutional and a valid exercise of congressional taxing power (Glied & Jackson, 2017). The arguments around Medicaid were slightly more complicated and resulted in a more complex response from the Supreme Court.

By expanding Medicaid, the ACA aimed to increase the number of low-income families receiving health insurance through the government (Glied & Jackson, 2017). Originally, the ACA required that states expand Medicaid up to a certain percentage of the FPL or have federal funding for their existing Medicaid programs revoked (Glied & Jackson, 2017). In the same court case, *NFIB v. Sebelius*, the Supreme Court ruled that Medicaid expansion as written was overly coercive to the states. However, a second majority of justices ruled that limiting the power of the federal government to enforce the legislation would effectively negate the coercion without eliminating the legislation as a whole (Glied & Jackson, 2017). The court case essentially made Medicaid expansion optional, because states could opt out of expansion without losing all of their federal Medicaid funding (Glied & Jackson, 2017).

The tumultuous judicial beginnings of the ACA are just one indication of the controversy surrounding Obama era health care reform. As much as debates about American values and patient autonomy have come to define ACA implementation, the associated outcomes have been largely positive (Glied & Jackson, 2017). The total number of uninsured has dropped from about 44 million in 2013 to an estimated 27.6 million in 2016. The nonelderly uninsured rate dropped from 18.2% in 2010 to just 10.3% in 2016 (Kaiser Family Foundation, 2017). Recent research estimates that in addition to increases in the insured population, the ACA has saved Medicare recipients \$2.1 billion on prescription drugs and general consumers another \$1.2 billion in reduced premiums (Centers for Medicare & Medicaid Services, 2015).

Approximately two-thirds of the growth in the insured population has been attributed to Medicaid expansion; however, increases are not equally distributed nationally (Jacobs & Callaghan, 2013). Few Republican states have begun the process of expanding Medicaid, which leaves some residents, who would be eligible for Medicaid in other states, uninsured. In many cases, low-income, uninsured families would be eligible if they moved just one state away, from Missouri to Iowa or from Mississippi to Arkansas (Jacobs & Callaghan, 2013). The inconsistencies in expansion status are exacerbated by the hesitancy of many of the poorest states to take on the payment of 4% of Medicaid costs after federal funding reduces to 96% from 100% three years after expansion (Jacobs & Callaghan, 2013). The patterns of expansion disproportionately affect African Americans in Southern states, where eligibility can be as low as 44% of the FPL, and undocumented immigrants who remain ineligible for government insurance (Rowland & Lyons, 2016). In addition to these groups, about 30% of individuals who are uninsured report being uninsured because they fall into a well-defined coverage gap populated by individuals who make too much to qualify for Medicaid, but not enough to afford marketplace insurance (Rowlands & Lyons, 2016).

The insurance gap is just one of many problems that the ACA has faced since 2010. Marketplaces were fraught with technical difficulties and remain underpopulated by insurers and consumers alike (Kaiser Family Foundation, 2017). Lower competition has allowed premiums to remain at higher rates than were initially predicted (Kaiser Family Foundation, 2017). Many nonelderly adults remain uninsured despite the individual mandate and associated penalty (Kaiser Family Foundation, 2017). Outlandish and untrue claims about fake policy initiatives like “death panels” have become pervasive and influential. Even the popular moniker “Obamacare” has haunted the ACA as partisanship burgeoned with the 2016 election and “repeal

and replace” became the anthem of the opposition (Kaiser Family Foundation, 2017). While it is true that some Americans are worse off under the ACA and roll out has been bogged down by challenges, on the whole, the Patient Protection and Affordable Care Act represents one of the largest and most comprehensive pieces of health care reform in the nation’s history (Skocpol & Williamson, 2017).

Donald Trump (2017-present)

The 2016 presidential race between Donald Trump and Hillary Clinton was both chaotic and controversial. As policy issues like global warming, economic inequality, police brutality, and cybersecurity filled the news, voters were left largely uninformed about the candidates’ opinions on health care reform (Hatcher & Vick, 2017). “Repeal and replace” came to define the Republican position on health care reform, while the Hillary Clinton’s campaign emphasized loose policy aims like access to mental health services and rising health care costs (Hatcher & Vick, 2017). The lack of health-related communication on the part of the 2016 presidential candidates was representative of a general lack of attention to public health issues (Hatcher & Vick, 2017). When Donald Trump won the 2016 presidential election with minority support from Americans, the nation was quick to express concern about the future of health care under an administration that lacked clear policies and had a penchant for radical subjectivity (Allcorn & Stein, 2017). Increasing concerns over health care would plague the initial years of the Trump administration.

American Health Care Act. The nation’s most recent attempt at health care reform came in 2017 in the form of the American Health Care Act (AHCA). Speaker of the House, Paul Ryan, led the Trump administration in their promise to “repeal and replace” the ACA (Rudalevige, 2017). This promise was foundational to Donald Trump’s campaign in the 2016

presidential election and was key to his popularity with certain constituencies. The status of the ACA as a budget reconciliation act makes it difficult to alter, much less repeal; however, the contents of the AHCA would have undone many ACA provisions (Rudalevige, 2017).

The basis for the AHCA was refundable tax credits, similar to the subsidies under the ACA, but based on age rather than income. The tax credit would vary between \$2,000 and \$4,000 in value, with older Americans receiving larger tax credits (Wilensky, 2017). Under the AHCA, Medicaid would be largely defederalized and given back to the states as a block grant (Wilensky, 2017). This would be a major transition from the recent Medicaid expansions under the ACA that provide federal aid at a rate of about 95%, to federal aid at a rate closer to 50% (Wilensky, 2017). The bill would allow insurers to reduce benefits for many plans and eliminate the formal ban on refusing coverage due to a pre-existing condition (Abelson & Thomas, 2017). Individuals that experience lapses in insurance coverage would pay a surcharge of about 30% upon re-enrollment. This provision would replace the individual mandate, ideally without the associated limits on personal freedom (Abelson & Thomas, 2017).

Initial evaluations of the AHCA were less than complementary. The Congressional Budget Office estimated that 23 million Americans would become uninsured by 2026, and Medicaid spending would decrease by more than \$830 billion (Wilensky, 2017). These changes would be joined by a slight decline in premiums and a deficit reduction of approximately \$120 billion (Wilensky, 2017). Support for the plan came almost exclusively from the Republican Party, with opposition coming from many Democrats, hospital associations, and physicians (Abelson & Thomas, 2017). Reductions in Medicaid and Medicare spending would likely result in many current beneficiaries losing coverage, and these beneficiaries make up large portions of hospital and physician patients (Abelson & Thomas, 2017).

On May 4th, 2017, the AHCA passed in the House of Representatives without a single Democratic vote or the votes of 20 Republican representatives; however, the bill fell apart on the Senate floor and failed to pass with a majority vote (Wilensky, 2017). The end of the AHCA seemed inevitable to many given the strong opposition to its provisions and the growing annual support for the ACA (Rudalevige, 2017). The failure of the AHCA may be linked to a lack of clear direction, a deeply divided Republican Party, and the fact that “repeal and replace” is not a strong platform on which to develop concrete policies (Rudalevige, 2017). Record low presidential approval may have also made passage more difficult, despite efforts on behalf of the White House to distance President Trump from the AHCA (Rudalevige, 2017). The Trump administration has failed to make major health reform in the United States so far, and Americans are left wondering what is next for health care in this nation.

The Future

The future of health care in the United States is uncertain. There is little consensus among public health officials, policy analysts, and lawmakers on what the health care system will look like in two, five, or even ten years (Marmor & Gusmano, 2018). Especially as partisanship continues to expand in the legislature and among the public, there are few aspects of health care on which a majority of Americans can agree (Marmor & Gusmano, 2018). That is with the exception of strong and growing support for universal health care. A 2017 poll found that 60% of Americans and about 80% of Democrats believe the government has a responsibility to ensure that all Americans have health care coverage (Pew Research Center, 2017). Based on this statistic, universal coverage is the future of health care. If the legislative process functions as it claims to, future health care legislation will reflect the wants and the needs of the people by developing a system of health care that provides coverage and services to all Americans.

Universal Health Care

Support for universal health care has been growing nationally and will continue to do so with the aid of prominent political figures like Bernie Sanders (Gambino, 2017). A system of universal coverage offers the opportunity to reduce expenditures on health care, while increasing health outcomes for the population (Boudreau, 2017). By enrolling as many individuals as possible, universal coverage disperses risk, reducing the financial burden of expensive emergency care and health care for individuals with chronic, complex, or rare conditions (Boudreau, 2017).

Universal health care also has the potential to equalize systemic inequalities that are perpetuated under systems of selective coverage and exacerbate disparities like the health-wealth gradient (Boudreau, 2017). Historically marginalized groups tend to achieve worse health outcomes over their lifetimes but increasing access to health care could help offset the disadvantages that arise from having a worse overall health status, experiencing poverty, or living in an under-resourced community (Jones & Kantarjian, 2015). In other ways, access to health care can compensate for the inequalities that develop from the social and natural lotteries that persist for generations, such as the financial burden that accompanies hereditary illnesses or health-related accidents (Jones & Kantarjian, 2015).

Despite the potential positive impacts of expanding the health care system to create coverage for all, opposition to universal care is both strong and vocal (Boudreau, 2017). Many of the arguments against an expanded system are founded in entrenched beliefs about the role of government, opposition to welfare policies, and concerns about the cost to the individual and to the nation (Boudreau, 2017). This opposition is especially potent when it comes to the issue of universal health care through single-payer programming.

Single-payer programs are unpopular largely because they are expensive to fund initially, though they may result in an overall reduction in health care related expenses later on (Galea, 2017). Single-payer programs, if run by the federal government, can also be perceived as a massive, and unpopular, expansion of government control (Galea, 2017). Misconceptions about the relationship between single-payer programs and universal health care abound, and they limit the potential options in health care reform (Seervai, Shah, & Osborn, 2017). Single-payer programs are not mutually inclusive with universal health care, though these terms are often used interchangeably (Seervai et al., 2017). By nature, all the existing single payer health care systems in the world are also universal health care systems, but not all universal health care systems are single payer (Seervai et al., 2017).

Some of the most promising paths toward universal coverage in the United States are mixed public and private systems. Given this nation's historical and political penchant for incremental reform, a mixed private and public plan may be a more realistic option because it would require fewer changes to the existing system (Vladeck, 2003). Internationally, a majority of nations with universal health care use a mixed public-private model where individuals who can afford it enroll in voluntary or mandatory private insurance and the government supports those who are unable to pay (Seervai et al., 2017).

Some scholars have suggested that the United States could achieve similar results by addressing existing concerns with the Affordable Care Act (Abelson, Goodnough, & Thomas, 2017). Potential fixes to the ACA that could move the nation towards universal coverage include stabilizing insurance marketplaces, decreasing prescription drug prices, fixing the family glitch, and eliminating the insurance gap that exists for American that make too much for Medicaid but not enough to pay for private insurance (Abelson et al., 2017). Revising the ACA would, of

course, come with its own challenges just like single-payer programs. The stigma attached to the ACA because of its association with the Obama administration and *NFIB v. Sebelius*, as well as the actual difficulty of altering the existing legislation would present substantive challenges in revising the ACA to create universal coverage (Abelson, et al., 2017).

The future of health in the United States could very well lie in universal health care, or it could just as easily lie in a regression to a system that insures fewer individuals and rolls back Obama-era reforms. The result five or ten years from now is dependent on a multitude of political, economic, and social factors (Marmor & Gusmano, 2018). Contrary to what some may think, Democrats gaining congressional majorities in the 2018 midterm elections is not a guarantee that health care reform will happen any time soon, neither is a certain party winning the presidency in 2020. The individuals in office are only one factor among many. History demonstrates that the economy, public opinion, lobbying groups, and international affairs all dictate, to a certain degree, what is possible in health care reform. In reality, the future of health care is uncertain, and if the past offers insight into the future, no change may be the most likely outcome.

Conclusion

Health care reform has not and will not come easily in the United States. The political, economic, and social conditions in this nation have created our current health care system and, in all likelihood, those same conditions will work to maintain it. Where the future of health care is headed is a multi-trillion-dollar question, and one that no single policy analyst, politician, or economist can answer. What we do know is that the issue of health care reform is profoundly and alarmingly complex. When we conceive of health care reform as a simply partisan issue or a

simply economic issue, we ignore this complexity. The result is a legislature, a president, and a populous that defines health care reform as the antithesis of whatever the opposition has done.

There needs to be a fundamental shift in the way we develop and evaluate health care reform. As a nation, let's acknowledge that health care reform is difficult; that is sometimes horribly convoluted, and that it will almost always be egregiously expensive. A functional health care system is not, however, impossible to achieve or unworthy of the effort, because the health of our nation depends on it.

References

- Abelson, R., Goodnough, A., & Thomas, K. (2017, July 29) How to repair the health law (It's tricky but not impossible). *The New York Times*.
<https://www.nytimes.com/2017/07/29/health/aca-obamacare-repeal-how-to-fix-health-care.html>
- Abelson, R., & Thomas, K. (2017, May 4). In rare unity, hospitals, doctors and insurers criticize health bill. *New York Times*. <https://www.nytimes.com/2017/05/04/health/health-care-bill-criticisms.html>
- Allcorn, S., & Stein, H. (2017). The post-factual world of the 2016 American presidential election: The good, the bad, and the deplorable. *The Journal of Psychohistory* 44(4), 310-318.
- Barker, K. (2003). Birthing and Leucocratic Women: Needs Talk and the Definitional Legacy of the Sheppard-Towner Act. *Feminist Studies*, 29(2). <http://www.jstor.org/stable/3178513>
- Berkowiz, E. (2005). Medicare and Medicaid: The past as prologue. *Health Care Finance Review*, 27(2). <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4194925/>
- Blendon, R. J., & Benson, J. M. (2001). Americans' views on health policy: A fifty-year historical perspective. *Health Affairs*, 20(2). <https://doi.org/10.1377/hlthaff.20.2.33>
- Blendon, R. J., Benson, J. M., Shelter, M. C., Connolly F. J., & Kiley, T. (1994). The beliefs and values shaping today's health reform debate. *Health Affairs*. 13(1).
<https://doi.org/10.1377/hlthaff.13.1.274>

Blendon, R. J., Brodie M., & Benson, J. (1995). What happened to America's support for the Clinton Health Care Plan, *Health Affairs*, 14(2). <https://doi.org/10.1377/hlthaff.14.2.7>

Blumenthal, D. (2006). Employer sponsored health insurance in the United States: Origins and implications. *The New England Journal of Medicine*, 355(1).

Bodenheimer, T. (2003). The movement for universal health insurance: Finding common ground. *American Journal of Public Health*, 93(1).

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447703/pdf/0930112.pdf>

Boudreau, R. (2017). The plausibility of universal health care in the United States. *Journal of Clinical Research & Bioethics*, 8(298). <http://doi.org/10.4172/2155-9627.1000298>

Brinckerhoff, J., & Coleman, E. A. (2005). What you need to know about the Medicare Prescription Drug Act. *Family Practice Management*, 12(3).

<https://www.aafp.org/fpm/2005/0300/p49.html>

Budetti, P. (2004). 10 Years beyond the Health Security Act failure: Subsequent developments and persistent problems. *Journal of the American Medical Association*, 292(16).

Centers for Medicare & Medicaid Services, Department of Health and Human Services (2015).

Medicare & Medicaid: Milestones 1937-2015.

<https://www.cms.gov/About-CMS/Agency-Information/History/Downloads/Medicare-and-Medicaid-Milestones-1937-2015.pdf>

Centers for Medicare & Medicaid Services, Department of Health and Human Services (2016).

National health expenditures 2016 highlights. <https://www.cms.gov/Research-Statistics->

Data-and-Systems/Statistics-Trends-
andReports/NationalHealthExpendData/downloads/highlights.pdf

- Conway, M. (2017, Feb. 27). Trump: 'Nobody knew health care could be so complicated'. *Politico*. <https://www.politico.com/story/2017/02/trump-nobody-knew-that-health-care-could-be-so-complicated-235436>
- Ferguson, C. C., Fowler, E. J., & Nichols, L. M. (2008). The long road to health reform requires bipartisan leadership. *Health Affairs*, 27(3). <http://doi.org/10.1377/hlthaff.27.3.711>
- Finbow, R. (1998). Presidential leadership or structural constraints? The failure of President Carter's health insurance proposals. *Presidential Research Quarterly*, 28(1). <http://www.jstor.org/stable/27551838>
- Frakes, V. L. (2012). Partisanship and (un) compromise: A study of the Patient Protection and Affordable Care Act. *Harvard Journal on Legislation*, 49(1). <http://harvardjol.wpengine.com/wp-content/uploads/2013/09/Frakes1.pdf>
- Freed, G. L., & Das, A. (2015). Nixon of Obama: Who is the real radical liberal on health care? *American Academy of Pediatrics*, 136(2). www.pediatrics.org/cgi/doi/10.1542/peds.2015-1122
- Galea, S. (2017, July 18). IS the U.S. ready for a single-payer health care system? *Harvard Business Review*. <https://hbr.org/2017/07/is-the-u-s-ready-for-a-single-payer-health-care-system>

- Gambino, L. (2017, Sept. 13). Bernie Sanders unveils universal healthcare bill: 'We will win this struggle'. *The Guardian*. <https://www.theguardian.com/us-news/2017/sep/13/bernie-sanders-universal-healthcare-medicare-for-all>
- Glied, S., & Jackson, A. (2017). The future of the Affordable Care Act and insurance coverage. *American Journal of Public Health, 107*(4). <http://doi.org/10.2105/AJPH.2017.303665>
- Grogan, C. M. (1994). Political-economic factors influencing state Medicaid policy. *Political Research Quarterly, 47*(3). <http://www.jstor.org/stable/448845>
- Hamovitch, M. (1953). History of the movement for compulsory health insurance in the United States. *Social Services Review, 27*(1). <http://www.jstor.org/stable/30019116>
- Harrison, B. (2003). A historical survey of national health movements and public opinion in the United States. *Journal of the American Medical Association, 289*(9).
- Hatcher, W., & Vick, A. (2017). Public health issues in 2016 presidential campaign communications. *American Journal of Public Health, 108*(2). <http://doi.org/10.2105/AJPH.2017.304221>
- Hoffman, B. (2006). Restraining the health care consumer: The history of deductibles and copayments. *Social Science History, 30*(4). <http://www.jstor.org/stable/40267920>
- Hoffman, B. (2013). *Healthcare for some: Rights and rationing in the United States since 1930*. Chicago, IL: University of Chicago Press
- Jacobs-Kronenfeld, J., & Kronenfeld, M. (2015). *Healthcare Reform in America: A reference handbook* (2nd Ed.) Santa Barbara, CA: ABC-CLIO

- Jones, G. H., & Kantarjian, H. (2015). Health care in the United States – Basic human right or entitlement. *Annals of Oncology*, 26(10). <https://doi.org/10.1093/annonc/mdv321>
- Kaiser Family Foundation (2017). Key facts about the uninsured population. *Henry J. Kaiser Family Foundation*. <https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>
- Lawrence, J., & Callaghan, T. (2013). Why states expand Medicaid: Party, resources, and history. *Journal of Health Politics, Policy and Law*, 38(5).
<https://doi.org/10.1215/03616878-2334889>
- Lemons, S. (1969). The Sheppard-Towner Act: Progressivism in the 1920s. *The Journal of American History*, 55(4).
<http://www.jstor.org/stable/1900152>
<http://www.jstor.org/stable/1900152>
- Marmor, T., & Gusmano, M. K. (2018). The state of American health care: November 2016 to November 2020, a look forward. *Health Economics, Policy and Law*, 13(1).
<https://doi.org/10.1017/S1744133116000359>
- Maslow, H. (1939). The background of the Wagner National Health Bill. *Law and Contemporary Problems*, 6(4). www.jstor.org/stable/1189759
- Morone, J. A. (2016). Partisanship, dysfunction, and racial fears: The new normal in health care policy. *Journal of Health Politics, Policy and Law*, 41(4).
<http://doi.org/10.1215/03616878-3620965>
- Oberlander, J. (2007). Learning from failure in health care reform. *New England Journal of Medicine*, 357. <http://doi.org/10.1056/NEJMp078201>

- Oliver, T. R., Lee, P. R., & Lipton, L. L. (2004). A political history of Medicare and prescription drug coverage. *The Milbank Quarterly*, 82(2). <http://doi.org/10.1111/j.0887-378X.2004.00311>
- Pew Research Center (2017). Survey conducted June 8-18, 2017 [Poll]. *Fact Tank: News in the numbers*. <http://www.pewresearch.org/fact-tank/2017/06/23/public-support-for-single-payer-health-coverage-grows-driven-by-democrats/>
- Rosenbaum, S. (2002). Medicaid. *New England Journal of Medicine*, 346(8).
- Rovner, J. (2017, Dec. 13). Why do people hate Obamacare anyway? *Kaiser Health News*. <https://khn.org/news/why-do-people-hate-obamacare-anyway/>
- Rovner, J. (2018, Jan. 22). CHIP renewed for six years as Congress votes to reopen federal government. *Kaiser Health News*. <https://khn.org/news/chip-renewed-for-six-years-as-congress-votes-to-reopen-federal-government/>
- Rowland, D., & Lyons, B. (2016). Medicaid's role in health reform and closing the coverage gap. *Journal of Law, Medicine & Ethics*, 44(4). <https://doi.org/10.1177/1073110516684790>
- Rudalevige, A. (2017, March 24). President Trump couldn't pass the Obamacare repeal. Here's why. *Washington Post*. https://www.washingtonpost.com/news/monkey-cage/wp/2017/03/24/president-trump-couldnt-pass-obamacare-repeal-this-is-why/?noredirect=on&utm_term=.7c952f9c740e
- Ruger, J. P. (2007). Health, healthcare, and incompletely normalized agreements: A normative theory of health policy decision making. *Journal of Health Policy, Politics and Law*, 32(1). <http://doi.org/10.1215/03616878-2006-028>

Schlesinger, M., & Lee, T. (1993). Is health care different? Popular support of federal health and social policies. *Journal of Health Politics, Policy and Law*, 18(3).

<https://doi.org/10.1215/03616878-18-3-551>

Schneider, E. C., Sarnak, D. O., Squires, D., Shah, A., & Doty, M. M. (2017). Mirror, Mirror 2017: International comparisons reflect flaws and opportunities for better U.S. health care. *The Commonwealth Fund*.

<http://www.commonwealthfund.org/interactives/2017/july/mirror-mirror/>

Schremmer, R. D., & Knapp, J. F. (2011). Harry Turman and health care reform: The debate started here. *Pediatrics*, 127(3). <http://pediatrics.aappublications.org/content/127/3/399>

Seervai, S., Shah, A., & Osborn, R. (2017, Oct. 27). How other countries achieve universal coverage. *To the Point*, The Commonwealth Fund.

<http://www.commonwealthfund.org/publications/blog/2017/oct/universal-coverage>

Shields, A., McGinn-Shapiro, M., & Fronstin, P. (2008). Trends in private insurance, Medicaid/State Children's Health Insurance Program, and the healthcare safety net. *Annals of the New York Academy of Science*, 1136.

<https://doi.org/10.1196/annals.1425.029>

Skocpol, T. (1994). From social security to health security? *Journal of Health Politics, Policy and Law*, 19(1). <https://doi.org/10.1215/03616878-19-1-239>

Skocpol, T., & Williams, V. (2011). Obama and the transformation of U.S. public policy: The struggle to reform health care. *Arizona State Law Journal*, 42(4).

<http://nrs.harvard.edu/urn-3:HUL.InstRepos:25607237>

Steckel R. H., & Costa, D. (1997). Long-term trends in health, welfare, and economic growth in the United States. In Steckel, R. H., & Floud, R. (eds.), *Health and welfare during industrialization* (pp. 47-90). Chicago, IL: University of Chicago Press.

Vladeck, B. (2003). Universal health insurance in the United States: Reflections on the past, the present, and the future. *American Journal of Public Health, 93*(1).

Wainess, F. J. (1999). The ways and means of national health care reform, 1974 and beyond. *Journal of Health Politics, Policy and Law, 24*(2). <http://www.jstor.org/stable/3456236>

The Wagner-Murray-Dingell Bill. (1944). *The American Journal of Nursing, 44*(4).
<http://doi.org/10.2307/3456236>

Wilensky, G. (2017). The economics and politics of the American Health Care Act. *Milbank Quarterly, 95*(3). <https://www.milbank.org/quarterly/articles/economics-politics-american-health-care-act/>

Zelizer, J. E. (2015, Feb. 15). How Medicare was made. *The New Yorker*.
<https://www.newyorker.com/news/news-desk/medicare-made>