Federal Involvement in Medical Care Is Not the American Way

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"Those who will learn nothing from the past are condemned to repeat it."
--George Santayana

This year marks 75 years of unparalleled advocacy by the Association of American Physicians and Surgeons (AAPS) for the preservation of the practice of private medicine and the sanctity of the patient-physician relationship. This anniversary is a time to reflect on the genesis of the federal government's incursion into medical care so we are better equipped to combat it.

Often legislation, rather than being based on abiding principles, is grounded in a reaction to attention-grabbing events. Through a calculated narrative that seized upon emotions, the public attitudes about social welfare have shifted from Thomas Jefferson's "that government is best which governs least" to Franklin Roosevelt's "cradle-to-grave" social insurance philosophy.[1]

Brief History of Pensions in America

Our social welfare tradition began with the original English-speaking colonists who brought their "poor laws" to their new country.[2] The principle was that all relief for the poor was a local obligation and was supported by local taxes. The American way was to address social problems through self-reliance and voluntarism.

Until the 20th century war veterans, appropriately, were the only group that received government pensions, assistance, and health insurance. Toward the end of the 19th century several factors coalesced to spur the movement for state-run pensions. The tradition of family members caring for the elderly was disrupted when industrialization drew workers away from family farms and relatives began going their separate ways around the country. Further, the depression of the 1890s left many Americans unemployed and financially strapped.[3]

By 1932, 21 states had adopted old-age assistance laws that gave benefits based upon need. But there were two notable problems: the elderly were reluctant to take welfare, and some states feared that social welfare programs would place the tax burden on manufacturers, putting them at a nationwide competitive disadvantage. This opened the door for the introduction of a national old-age pension program.

The Social Security Act of 1935

The dire circumstances of the 1930s Great Depression provided a window of opportunity for President Franklin Roosevelt to rally Americans to support government intervention on a massive scale with the creation of 37 new government "alphabet soup" agencies and reams of regulations.[4] The President also ordered all citizens to turn in any gold coins to the nearest bank in exchange for dollars.

Proposals for old-age pensions had been floating around for years, but a 1933 plan devised by a 66-year-old physician from California got traction.[5] Dr. Francis Townsend began championing his cause with a letter to the editor in the local paper. Soon there were 7,000 Townsend Clubs around the country with more than 2.2 million members. Under the Townsend Old Age Revolving Pension Plan, the federal government would provide a pension of $200 per month to every citizen 60 or older with funding coming from a 2 percent national sales tax.

President Roosevelt's Committee on Economic Security (CES), created in 1934 and headed by Secretary of Labor Frances Perkins, was charged with devising a social welfare program for the aged and disabled. The CES proposal borrowed from the Townsend Plan and also included health-related provisions. The American Medical Association agreed to support public health measures, medical care for the poor, and taxes for tuberculosis, mental, and rural hospital construction, but strongly objected to health insurance for all beneficiaries.[6] Vociferous opposition by physicians and others led Roosevelt to abandon health insurance for fear of losing support for the remainder of the social security program.

On Aug. 14, 1935, the 29-page Social Security Act became law. The two major sections pertaining to the elderly were Title I, "Grants to States for Old-Age Assistance," which supported state welfare programs for the aged, and Title II, "Federal Old Age, Survivors and Disability Insurance" (OASDI).[7] Title II created an Old Age Reserve Account in the U.S. Treasury and authorized future appropriations annually by Congress to fund "old-age payments." Title VIII, "Taxes with Respect to Employment," had not a single word indicating that the newly enacted payroll taxes would be used for Social Security benefits.

Compounding the chicanery, the Social Security Act expanded the government's role beyond that of an administrator of a pension program. Section 702 authorized the Social Security Board (later Administration) to play a policy-making role. Soon the Board began to draft legislation. (What happened to separation of powers?) Thus began the era of legislative sleight-of-hand and out-of-control regulatory capture.

It is worth noting that when Roosevelt proposed his pension program for the aged, it was to be "voluntary contributory annuities by which individual initiative can increase the annual amounts received in old age."[2] Congress

reckoned otherwise. The Social Security Act was, and continues to be funded by mandatory—not voluntary—payroll taxes. Contemporary critics of Social Security noted, "The implicit annuity that young workers are investing in has such a low yield that it's doubtful that many would have participated in voluntary annuities managed by the federal government."[2]

Constitutionality of the Social Security Act

The Social Security Act mainly provides constitutionally valid grants to the states addressing various social welfare issues. However, finding a constitutional basis for the old age insurance program (OASDI) was an obstacle. The program was not an exercise of any specified federal power and was an invasion of matters reserved to the states (or to the people) under the Tenth Amendment.

When fashioning the legislation, the CES questioned whether to rely upon the Commerce Clause or the broad power to levy taxes and expend funds to "provide for the general welfare." Frances Perkins got her answer at one of Associate Supreme Court Justice Harlan Stone and his wife's Wednesday afternoon tea parties. As she related the story, upon hearing of her quandary, Justice Stone looked around, leaned over to her and whispered, "the taxing power of the Federal Government, my dear; the taxing power is sufficient for everything you want and need."[8]

On the 20th anniversary of the Social Security Act, the CES executive director revealed that most of the Senate Committee on Finance "believed old-age insurance to be unconstitutional."[9] And with good reason. The Supreme Court had recently overturned the Railroad Retirement Act of 1934 as an invalid application of the Commerce Clause.[10] Justice Owen Roberts, the opinion's author and a swing voter, envisioned how the Railroad Retirement Act's purpose of guaranteeing a trouble-free retirement could open the door to a massive federal welfare state: the "[p]rovision for free medical attendance and nursing, for clothing, for food, for housing, for the education of children, and a hundred other matters, might with equal propriety be proposed as tending to relieve the employee of mental strain and worry."[11]

The powers-that-be knew the Social Security Act read like the Railroad Retirement Act, which ordered all railroad workers into a compulsory government pension program funded by a payroll tax apportioned between them and their employers. Additionally, several other New Deal programs were ruled unconstitutional in 1936 by a politically evenly split court.

Enter unabashed politics. Roosevelt asked Congress to grant him the new power to add additional judges to federal courts wherever there were sitting judges aged 70 or older who refused to retire. Roosevelt would be free to appoint younger judges to the court who, of course, held his views on social programs. Apparently to save his job, Justice Roberts then changed his views and upheld New Deal legislation exactly like laws that he had voted to invalidate. This sudden switch by Justice Roberts is known as "the switch in time that saved nine."[11]

In short order, the payroll deductions mandated by the Social Security Act were challenged in the courts as unconstitutional. The lower court held that Title II (OASDI) ran afoul of the Tenth Amendment, and that Title II, in collapsing, carried Title VIII (Taxes with Respect to Employment) along with it. As Justice Stone predicted, the Supreme Court ruled 7-2 that the new Social Security program was constitutional, based on the government's broad power to tax for the general welfare.[12] The Court reasoned: "The concept of 'general welfare' is not static, but adapts itself to the crises and necessities of the times" citing the "nationwide calamity that began in 1929" and the hope to save elders from the "poor house."[12] While stressing that it was ruling on congressional powers, not the wisdom of the law, the Court cited the litigant's attorney's argument "that aid from a paternal government may sap those sturdy virtues and breed a race of weaklings."[12] Sadly, this is precisely what has happened.

In 1960, the law again was challenged, seeking a ruling that Social Security benefits are "an earned right."[13] Citing the Act's "Reservation of Power" clause giving Congress "the right to alter, amend, or repeal any provision of this Act," the Court ruled that that entitlement to Social Security benefits is not contractual right. As President Gerald Ford later said, "A government big enough to give you everything you want, is a government big enough to take away everything that you have."

Social Security Amendments

The justification for the Social Security program was to assist a specified group of our citizenry: the blind, the needy aged, and dependent children—all in 29 pages. Four thousand pages with increased taxation and millions of new beneficiaries later, the original Act is unrecognizable. By far, the biggest additions were Medicare and Medicaid in 1965.

The Road to Medicare

The first broadly successful campaign for government-sponsored health insurance was the adoption, by 30 states, of workers' compensation insurance in 1915. This was accomplished with the help of, among others, the AMA and the American Hospital Association. The positive reception of workers' compensation insurance coupled with the passage of the British National Health Insurance program in 1911 fueled the movement to enact health insurance for low-income workers on a state-by-state basis. AMA leadership was leaning in favor of the idea, but individual members were strongly against it.[14]

Despite lackluster public support, in 1927 activist philanthropists established the Committee on the Costs of Medical Care (CCMC) to study the economics of the nation's medical care. The CCMC did not recommend compulsory government health insurance, but rather private insurance, noting America's deeply rooted tradition of private enterprise. The concept was rejected by individual physicians and AMA leadership who, at that time, were opposed to all forms of insurance to pay for medical care. [See Sidebar.]

The pro-compulsory health insurance movement led

to the introduction of the National Health Insurance Act of 1939 (the "Wagner bill").[15] Financed by a payroll tax, the bill provided federal monies to the states for expanding public health, maternal and child health services, medical care for the low-income, short-term disability insurance, hospital construction, and prepaid medical insurance. Organized labor and several civic, welfare, and agricultural groups testified in favor of the bill; AMA, the American Hospital Association, and American Dental Association, among others, testified against it. The bill died in committee.

World War II's effect on the home front was the impetus for 1943 amendments to the Social Security Act to create a system of emergency health services for the dependents of servicemen in the lower pay grades. In its six years of operation, the Emergency Maternity and Infancy Care (EMIC) became the largest public medical care program ever implemented in the U.S.[16]

Immediately after President Roosevelt's 1943 State of the Union's cradle-to-grave social insurance vision, the Social Security Board drafted an expansion bill to be sponsored by Democratic Senators Wagner, Murray, and Dingell (the W-M-D bill). *This bill inspired the founding of AAPS*. After heated debate, the bill died. Undeterred, President Truman backed a re-drafted 1945 W-M-D bill. The insurance would be financed by a tax of four percent on the first $3,600 of wages and salaries. Truman argued that this plan was not socialized medicine because people could choose their own doctors and hospitals, and providers did not work for the government. Although actively campaigning against the bill, during the W-M-D hearings AMA proposed its plan with private insurance options.[17] But AMA unofficially supported the 1946 Republican Taft-Smith-Ball compromise bill, which called for matching grants to states to subsidize private health insurance for the medically indigent. President Truman rejected the compromise, believing the law might placate his universal care supporters.

Despite the congressional setbacks, Truman pressed on with his goal of government-sponsored medical care for all. In 1952, the administration proposed enactment of health insurance for Social Security beneficiaries, but his proposal ended with his presidency.[18]

After a 1959 Health Education and Welfare Department (HEW) finding that the aged needed medical care financial assistance, and a push by the labor unions for government health insurance, the Kerr-Mills Act (Medical Assistance for the Aged) was passed as part of the Social Security Amendments of 1960.[19] This law authorized open-ended federal matching payments to states for health care provided to the elderly either on welfare or in the new category of the "medically indigent," i.e., those who could not afford their medical expenses but did not qualify for public assistance.[20]

Kerr-Mills did not satisfy presidential candidate Sen. John F. Kennedy. Accordingly, he made "Medicare" for all elderly a popular campaign issue. The King-Anderson Medicare bill was quickly introduced after President Kennedy's election and AMA vowed to fight it. The chief strategist of the anti-Medicare campaign told his colleagues, "The surest way to total defeat is to say, we are now going to sit across the negotiating table and see what you will give us."[20] The Kennedy assassination put the Medicare bill on hold and the war in Vietnam dominated the public's attention.

With a Democratic majority in Congress, in January 1965 the King-Anderson bill was re-introduced, prompting several alternate bills. Despite the tough talk, AMA leaders presented their "Eldercare" program, funded by federal and state monies and operated through private insurance carriers and the states. AMA claimed Eldercare's benefits outshone Medicare's. This claim only served to induce the Ways and Means Committee to expand Medicare benefits.

An alternative plan by Republican Rep. John Byrnes proposed a voluntary insurance program financed by premiums and general federal revenues.

The final Medicare Act (part of the Social Security Amendments of 1965) was a two-part insurance program. The King-Anderson bill became Part A (hospital) with mandatory premiums extracted from Social Security checks. The Byrnes plan served as the basis for Medicare Part B (non-hospital services). Importantly, hospitals and health professionals were paid based on "reasonable costs" of rendering care. Probably to its chagrin, AMA's Eldercare proposal formed the basis of Medicaid for all low-income by federal-state matching funds.[21]

The Medicare package was passed in 1965 as Title XVIII of

Unintended Consequences[21]

- *In 1929 when their pre-paid medical clinic began to grow, the founders of the Ross-Loos Clinic in Los Angeles were expelled from the county medical society. This mattered: hospital bylaws required medical staff members to be members in good standing of the local medical society.*
- *Dr. Michael Shadid formed a pre-paid plan with Oklahoma farmers. The state medical society opposed the plan, attempted to deprive Shadid of his license to practice, expelled him from the medical society, and kept other physicians who were willing to practice with him out of Oklahoma through license denials.*
- *In 1933, Dr. Sidney Garfield established the Kaiser Foundation Health Plan in California. He was charged with unprofessional conduct, and the state board of medical examiners suspended his license to practice. The courts overturned the suspension. As late as 1959, Kaiser physicians were still excluded from the San Francisco Medical Society.*
- *Similar actions were directed against group practice plans in Milwaukee, Chicago, and Seattle. Plan physicians were denied membership in their local medical societies and denied access to hospitals. As a result of being denied access to hospitals, the early pre-paid plans were forced to build and use their own hospitals.*

the Social Security Act. Beginning in 1972, major changes were enacted, including new categories of beneficiaries, managed care as Medicare Part C, and prescription drug coverage as Medicare Part D. Over the years Medicare has had multiple additions, subtractions, and escalating controls on physicians with the stated purpose of improving patient care and saving the government money. Thus far, neither has happened. In the private sector, a program that fell so short of its goals would be jettisoned. But Medicare occupies a sacrosanct place in the federal bureaucracy with its own special, untouchable trust funds. The Hospital Insurance (HI) Trust Fund gets its Medicare funding primarily from payroll taxes, income tax on Social Security benefits, and interest earned on the monies in the HI trust.[22] The estimated depletion date for the HI trust fund is 2026.[23] The Supplemental Medical Insurance Trust Fund, which pays for Part B services and Part D prescription medications, is funded through congressional appropriations and premiums for Medicare Part B and Part D. This fund is propped up by increasing the premiums.

Medicaid

Medicaid (Title XIX of the Social Security Act) was created in 1965 along with the Medicare program. Medicaid was an expansion and replacement of the Kerr-Mills Act of 1960 and includes certain medically indigent of all ages. While Medicare is fully federally funded, Medicaid is a cost sharing program in which the federal government pays states for a specified percentage of program expenditures.[24]

Participation by the states in Medicaid is voluntary, but states were required to cover "mandatory" groups (Aid to Families with Dependent Children (AFDC) and other cash assistance recipients) and services (physician, inpatient and outpatient hospital, laboratory and X-ray, skilled nursing facility). Participating states must also provide supplemental coverage to low-income Medicare beneficiaries for services not covered by Medicare. States had the option to offer additional services (e.g., prescription drugs, home health care, dental, physical therapy, preventive, and rehabilitative services) and to include other beneficiaries in their program.

Over the years Medicaid has seen multiple expansions of the scope of the program, adding more categories of eligible beneficiaries: Social Security's Supplemental Security Income (SSI) recipients; home and community-based long-term care services; and treatment of emergency medical conditions for illegal immigrants otherwise eligible for Medicaid, among many others. A notable subtraction was the elimination of required federal matching for "unnecessary" tests (by whose standard?).

The change that was most destructive to patient care was allowing the states to implement mandatory managed-care enrollment of most beneficiaries. For example, Oregon determined the level of covered services based on the state's budgetary resources (a.k.a. rationing). As time wears on, we have discovered that many more folks are eligible for coverage under Medicaid, but fewer and fewer receive timely, individualized care.

Bait and Switch

Physicians and patients alike were lured into embracing Medicare and Medicaid by promises that the government would not interfere in the practice of medicine. This tantalizing bait was memorialized in the opening provision in the Medicare law:

> 42 U.S. Code § 1395 - Prohibition against any Federal interference:
> Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

If only Uncle Sam were merely an annoying meddler in our medical care! The Social Security Act's mission creep has resulted in numerous restrictions unfriendly to physicians and patients alike. Worse yet, over the years a disturbing pattern emerged: persuasion became coercion, and voluntary became mandatory.

Conclusions

History has shown the prescience of AAPS: the federal government—despite the letter of the law—is controlling the practice of medicine. Federal interference has only served to increase medical costs, herd patients into managed care, and marginalize private medicine, fertilizing the turf for the corporate takeover of medicine.

Since 1943, AAPS has cut through the clutter, political correctness, and compassionate-sounding buzzwords. We have refused to figuratively turn our gold coins over to the government. AAPS's forged-in-steel principles ensure that we will not trade in individualized care for algorithms and guidelines created with input from profiteers who benefit from their use.[25,26] AAPS will always follow Hippocrates's promise: "I will take care that [patients] suffer no hurt or damage."

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AAPS Principles of Medical Policy

Medical care is a professional service, not a right. Rights (as to life, liberty, and property) may be defended by force, if necessary. Professional services are subject to economic laws, such as supply and demand, and are not properly procured by force.

Physicians are professionals. Professionals are agents of their patients or clients, not of corporations, government, insurers, or other entities. Professionals act according to their own best judgment, not government "guidelines," which soon become mandates. Physicians' decisions and procedures cannot be dictated by overseers without destroying their professionalism.

Third-party payment introduces conflicts of interest. Physicians are best paid directly by the recipients of their services. The insurer's contract should be only with subscribers, not with physicians. Patients should pay their physician a mutually agreed-upon fee; the insurer should reimburse the subscriber according to the terms of the contract.

Government regulations reduce access to care. Barriers to market entry, and regulations that impose costs and burdens on the provision of care need to be greatly reduced. Examples include insurance mandates, certificate of need, translation requirements, CLIA regulation of physician office laboratories, HIPAA requirements, FDA restrictions on freedom of speech and physicians' judgment, etc.

Honest, publicly accessible pricing and accounting ("transparency") is essential to controlling costs and optimizing access. Government and other third-party payment or price-fixing obscures the true value of a service, which can only be determined by a buyer's willingness to pay. The resulting misallocation of resources creates both waste and unavailability of services.

Confidentiality is essential to good medical care. Trust is the foundation of the patient-physician relationship. Patient confidences should be preserved; information should be released only upon patient informed consent, with rare exceptions determined by law and related to credible immediate threats to the safety or health of others.

Physicians should be treated fairly in licensure, peer review, and other proceedings. Physicians should not fear loss of their livelihood or burdensome legal expenses because of baseless accusations, competitors' malice, hospitals' attempts to silence dissent, or refusal to violate their consciences. They should be accorded both procedural and substantive due process. They do not lose the basic rights enjoyed by Americans simply because of their vocation.

Medical insurance should be voluntary. While everyone has the responsibility to pay for goods and services he uses, insurance is not the only or best way to finance medical care. It greatly increases costs and expenditures. The right to decline to buy a product is the ultimate and necessary protection against low quality, overpriced offerings by monopolistic providers.

Coverage is not care. Health plans deny payment and ration care. Their promises are often broken. The only reliable protection against serious shortages and deterioration of quality is the right of patients to use their own money to buy the care of their choice.