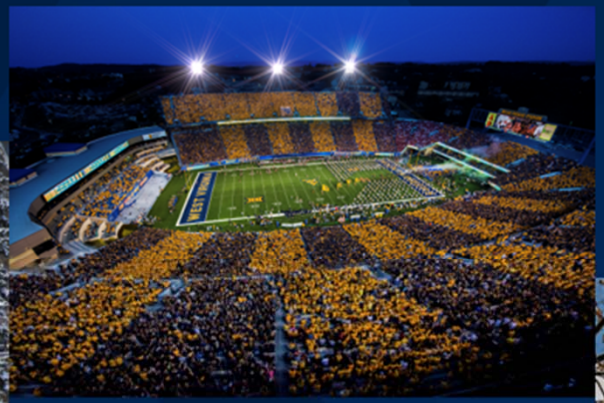

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Inching Toward Universal Coverage

State-Federal Health-Care Programs in Historical Perspective

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UNPRECEDENTED

ObamaCare

- “**unprecedented** new access and powers to bureaucrats”
- “**unprecedented** expansion of government”
- “**unprecedented** expansion of federal power”
- “**unprecedented** expansion of government intrusion into health care decisions”
- “**unprecedented** expansion of power and control over Americans' lives”
- “**unprecedented** expansion in the size and scope of the federal government”
- “**unprecedented** expansion of executive power”
- “**unprecedented** expansion of Congress's power”
- **“unprecedented** expansion of the regulatory powers”
- “**unprecedented** expansion of the Medicaid program”
- “**unprecedented** expansion of the welfare state”

SIMON F. HAEDER AND DAVID L. WEIMER

Inching Toward Universal Coverage: State-Federal Health-Care Programs in Historical Perspective

You Can't Make Me Do It, but I Could Be Persuaded: A Federalism Perspective on the Affordable Care Act

Simon F. Haeder
David L. Weimer

Shared Governance Programs

- Programs jointly implemented and administered by federal and state governments
- Direct results of constitutional limitations put on federal government
- Affordable Care Act
  - Pre-existing Condition Insurance Plan
  - Marketplaces
  - Medicaid Expansion

The Evolution of Shared Governance

- Continental Congress
- Land grants starting with Ohio in 1802
- National Guard
- Morrill Acts
- Hatch Act
- Weeks Act
- Smith-Lever Act
- Federal Aid Road Act
- Federal Highway Act
- Hayden-Cartwright Act
- Smith-Hughes Act

Side Note: Some Direct Services

- Native Americans
- Inmates
- Military personnel and veterans
- Merchant seamen
- Freed slaves
- Migrant workers

Federalism Has Shaped Health Reform

- Coverage expansion through **shared governance**
  - Federal financing & state implementation
- **Conflict** at federal and state level, and between
- **Variation** in terms of implementation & programs
- Accommodation and **evolutionary expansion**

Federalism Has Shaped Health Reform

1. **Neither content nor implementation are unprecedented**
2. **Future expansions are likely headed on a similar path**

Seven Themes

1. Implementation Is Often Slow and Uneven
2. Programs Vary Widely Across States
3. The Federal Government Is Usually Extremely Accommodating
4. Ideological Conflict Permeates Enactment and Early Implementation
5. Grants Create Incentives and States Respond to Them
6. Not All Eligible Individuals Enroll
7. Past Programs Serve as Stepping Stones and Wedges

7. Past Programs Serve as Stepping Stones and Wedges

Programmatic Antecedents to the ACA

- Chamberlain-Kahn Act (1918)
- Sheppard-Towner Act (1921)
- Federal Emergency Relief Administration (FERA) (1933)
- Rural Health Programs (1935-1945)
- Social Security Act (1935)
- Federal Emergency Maternal and Infant Care Program (1943)
- Vocational Rehabilitation Act/Barden-La Follette Act (1943)
- Hospital Survey and Construction Act (1946)
- Kerr-Mills Act (1960)
- Medicaid (1965)
- Disproportionate Share Hospital Funding (DSH) (1981)
- Health Insurance Portability and Accountability Act of 1996 (HIPAA) (1996)
- State Children's Health Insurance Program (S-CHIP) (1997)
- Trade Act (2002)

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- Trade Act (2002)

Chamberlain-Kahn Act (1918)

- Purpose and Importance
  - **First federal public health program**
  - **Covers venereal diseases**
- Incremental Precedents for the Affordable Care Act
  - **Shared Governance and voluntary implementation**
  - **Federal role in public health**

Sheppard-Towner Act (1921)

- Purpose and Importance
  - **First direct federal grant program to any group for health services**
  - **Covers maternal and infant health**
- Incremental Precedents for the Affordable Care Act
  - **Federal provision of targeted medical care**

Federal Emergency Relief Administration (FERA) (1933)

- Purpose and Importance
  - **First federal program that provides medical services to able-bodied adults**
  - **Significant powers for federal government to enforce state compliance**
- Incremental Precedents for the Affordable Care Act
  - **Extension of medical care to able-bodied adults**
  - **Federal fallback and partnership option**
  - **Extensive use of regulatory authority by executive branch**

TABLE I

MINIMUM, MAXIMUM, AND AVERAGE FEES FOR VARIOUS TYPES OF MEDICAL SERVICE UNDER FERA NO. 7 ARRANGED ACCORDING TO TYPE OF SERVICE AND GROUP APPROVING FEE

Type of Service	Scales not accepted by medical profession				Accepted by profession and administrator				Other scales of special status				All Scales			
	No.	Min.	Max.	All	No.	Min.	Max	All	No.	Min.	Max.	All	No.	Min.	Max.	All
Office calls[1]	3	$ .75	$ 1.00	$ .83	24	$ .50	$ 1.25	$ .90	3	$ .50	$ 1.34	$ .95	30	$ .50	$ 1.34	$ .90
House, by day	3	1.25	1.50	1.42	24	1.00	2.00	1.59	3	1.00	2.00	1.50	30	1.00	2.00	1.59
House, by night	3	1.25	2.00	1.58	23	1.00	3.50	1.99	3	1.00	2.00	1.50	29	1.00	3.50	1.73
Mileage, per mi[2]	3	.10	.15	.12	16	.00	.80	.31	3	.00	.17	.09	22	.00	.80	.25
Obstetrical																
Normal	3	10.00	15.00	13.33	24	10.00	30.00	17.89	3	12.50	20.00	15.83	30	10.00	30.00	17.23
Instrumental[3]	3	10.00	15.00	13.33	18	12.00	50.00	21.25	.	.....	.....	.....	21	10.00	50.00	20.12
Fractures, min.	2	1.00	2.50	1.75	3	2.50	10.00	6.67	.	.....	.....	.....	5	1.00	10.00	4.70
Fractures, max.	2	15.00	37.50	26.25	5	10.00	50.00	34.00	.	.....	.....	.....	7	10.00	50.00	31.79
Surgery																
Minor, minimum	2	1.00	5.00	3.00	7	1.00	10.00	3.71	.	.....	.....	.....	9	1.00	10.00	3.56
Minor, maximum	2	5.00	5.00	5.00	8	3.00	25.00	10.69	.	.....	.....	.....	10	3.00	25.00	9.55
Major, minimum	2	20.00	25.00	22.50	7	12.50	50.00	24.29	.	.....	.....	.....	9	12.50	50.00	23.79
Major, maximum	2	20.00	25.00	22.50	10	20.00	75.00	44.50	1	.....	.....	50.00	13	20.00	75.00	41.54

[1]Office calls not permitted in several large cities in states setting these fees.

[2]One way. Usually begins at the city limits or 2 miles from physician's office and is ordinarily reduced for distances over 10 miles.

[3]Several states making a set fee for normal delivery placed instrumental or other complications on an individual basis. All obstetrical fees include prenatal and postnatal care.

Rural Health Programs (1935-1945)

- Purpose and Importance
  - **Variety of insurance and healthcare programs that offered extensive and comprehensive services to millions of farmworkers, migrants, and farmers as well as their families**
- Incremental Precedents for the Affordable Care Act
  - **Predecessor to modern insurance (risk pooling, capitation, third-party payments, free provider choice within networks, focus on prevention, voluntary participation by providers)**
  - **Ability to pay (sliding scale and subsidies)**
  - **Comprehensive benefits**
  - **Federal government cooperation with private partners (insurance providers and medical societies)**

Social Security Act (1935)

- Purpose and Importance
  - **Major expansion in type and extent of federal involvement for mothers, infants, dependent children, and the blind**
  - **Various expansions over time**
- Incremental Precedents for the Affordable Care Act
  - **Medical vendor payments**
  - **Coverage expansion**

Federal Emergency Maternal and Infant Care Program (1943)

- Purpose and Importance
  - **Largest public medical program at the time**
  - **Significantly expands medical care to wives and children of servicemen**
  - **Children's Bureau initiates program based on Sheppard-Towner and Social Security Act background**
- Incremental Precedents for the Affordable Care Act
  - **Detailed & frequent regulations & strict oversight by state & federal governments**
  - **Minimum benefits**
  - **Direct payment to physicians by federal government**
  - **Extensive use of regulatory authority by executive branch**
  - **Capitation**

Vocational Rehabilitation Act/Barden-La Follette Act (1943)

- Purpose and Importance
  - **Authorized all services necessary to rehabilitate individuals with disabilities including hospitalizations, physical examinations, and psychiatric treatments**
- Incremental Precedents for the Affordable Care Act
  - **Comprehensive services**

Hospital Survey and Construction Act (1946)

- Purpose and Importance
  - **Federal matching for healthcare facilities construction**
  - **Inventory of state healthcare infrastructure**
- Incremental Precedents for the Affordable Care Act
  - **Uncompensated care requirements expand medical services beyond categorically eligible**

Kerr-Mills Act (1960)

- Purpose and Importance
  - **Major expansion to the aged, disabled, and blind**
  - **Open-ended cost-sharing**
  - **Matching rates**
- Incremental Precedents for the Affordable Care Act
  - **Open-ended cost-sharing; matching rates**
  - **Foundation for Medicaid**
  - **Allows states to purchase private coverage**

Medicaid (1965)

- Purpose and Importance
  - **Major expansion to indigents**
  - **Significant expansions over the years in terms of populations and (optional) services covered**
- Incremental Precedents for the Affordable Care Act
  - **Direct foundation for ACA Medicaid expansion and ACA marketplaces through waiver for Massachusetts**

Disproportionate Share Hospital Funding (DSH) (1981)

- Purpose and Importance
  - **Strengthens commitment to indigent without coverage by providing funding for safety net hospitals**
- Incremental Precedents for the Affordable Care Act
  - **DSH payments support medical care services beyond categorically eligible**

Health Insurance Portability & Accountability Act of 1996 (HIPAA) (1996)

- Purpose and Importance
  - **Ensures insurance portability for group coverage**
- Incremental Precedents for the Affordable Care Act
  - **High-risk insurance pools**

State Children's Health Insurance Program (S-CHIP) (1997)

- Purpose and Importance
  - **Major expansion for children (and their parents) above the poverty line**
- Incremental Precedents for the Affordable Care Act
  - **Foundation for ACA extension above poverty line**

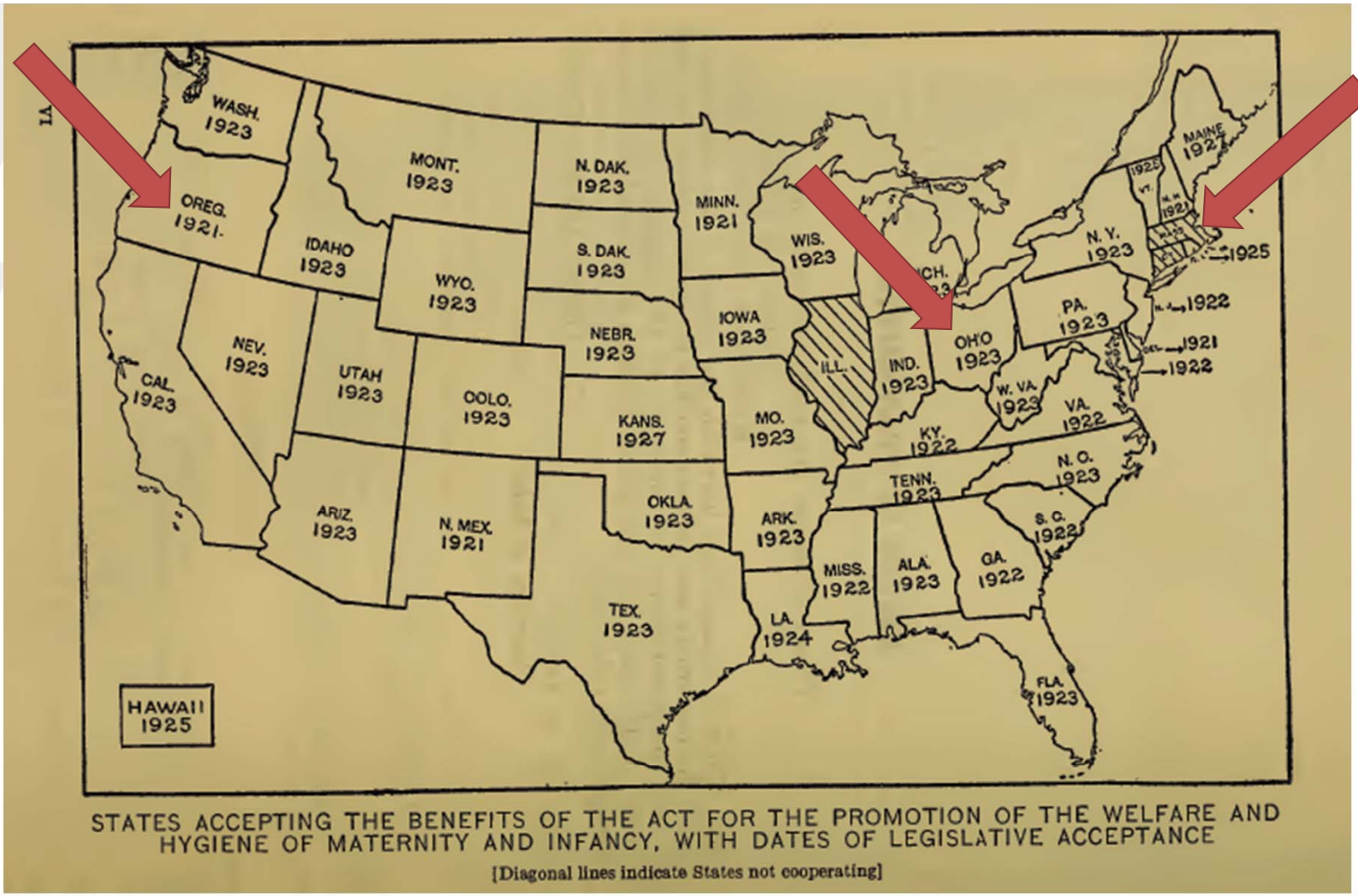
Trade Act (2002)

- Purpose and Importance
  - **Advanceable and fully refundable tax credits for adults and their families**
- Incremental Precedents for the Affordable Care Act
  - **Use of tax code as policy vehicle (mandate)**

… to the ACA

UNPRECEDENTED

1. Implementation Is Often Slow and Uneven



STATES ACCEPTING THE BENEFITS OF THE ACT FOR THE PROMOTION OF THE WELFARE AND HYGIENE OF MATERNITY AND INFANCY, WITH DATES OF LEGISLATIVE ACCEPTANCE

[Diagonal lines indicate States not cooperating]

TABLE 6.—*Number of group medical care units in each State by type of service offered and plan of operation, whether fee-for-service or capitation, showing number of counties represented, the membership and its distribution by type of service, the average annual membership fee paid for the different combinations of service, and the percentage relationship of this fee to the average annual net income of Farm Security Administration borrowers, as of June 30, 1941*—Continued

Region and State	Type of service	Plan of operation	Number of units	Number of counties	Membership		Percent of families by type of service	Average annual income	Average annual membership fee	
					Families	Persons			Amt.	Percent of income
Missouri total			54	56	3,492	16,943	100.0	625.00		
	1	Individual	3	3	70	303	2.0		27.75	4.44
	1,2	Fee	50	52	3,380	16,336	96.8		23.00	3.68
	1,2,4	do	1	1	42	304	1.2		26.00	4.16
Ohio total			40	41	2,842	13,848	100.0	784.00		
	1	Individual	2	2	108	402	3.8		26.00	3.33
	1,2	Fee	38	39	2,734	13,446	96.2		22.12	2.82
U. S. Total			703	881	104,224	545,673	100.0			

[2] Type of service: 1, physicians'; 2, surgeons'; 3, hospital; 4, drug; 5, dental.

TABLE 7.—*Group dental care units among Farm Security Administration clients, counties involved, families and individuals holding membership, and average annual membership fee, June 30, 1941*

Region or State	Units	Counties	Families	Individuals	Average fee
	Number	*Number*	*Number*	*Number*	*Dollars*
United States, total	159	167	23,450	124,021	5.49
Region II	10	10	225	907	(1)
Michigan	8	8	173	662	(1)
Wisconsin	2	2	52	245	(1)
Region III	4	4	147	741	----
Missouri	3	3	58	252	----
Ohio	1	1	89	489	----

TABLE I.—*Activities of the 54 jurisdictions to put into effect the new program of medical assistance for the aged, June 1, 1962*

A. Programs in effect (27): [1]

Alabama
Arkansas
California
Connecticut (April)
Guam (February)
Hawaii
Idaho
Illinois
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
New Hampshire
New York
North Dakota
Oklahoma
Oregon
Pennsylvania
Puerto Rico
South Carolina
Tennessee
Utah
Virgin Islands
Washington
West Virginia

B. Plan submitted (not in effect): None.

C. Legislation enacted; plan not yet submitted (two States):
Vermont,[2] Virginia.[3]

D. Legislation in process to give basis for program or to provide appropriation (one State):
New Jersey.

E. No legislation (21):
1961 session adjourned without action:
Alaska [4]
Arizona [4]
Colorado
Delaware [4]
District of Columbia
Florida
Indiana
Kansas
Minnesota
Missouri
Montana
Nebraska
Nevada
North Carolina
Ohio
Rhode Island
South Dakota
Texas
Wisconsin
Wyoming

1962 session: Adjourned without action.
Mississippi.

F. Have authority for MAA; not expected to implement in 1961–62 (three States):
Georgia, enacted 1961; no funds available.
Iowa, enacted 1961; no appropriation.
New Mexico, plan withdrawn; no appropriation.

TABLE I.—*Activities of the 54 jurisdictions to put into effect the new program of medical assistance for the aged, June 1, 1962*

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Alabama
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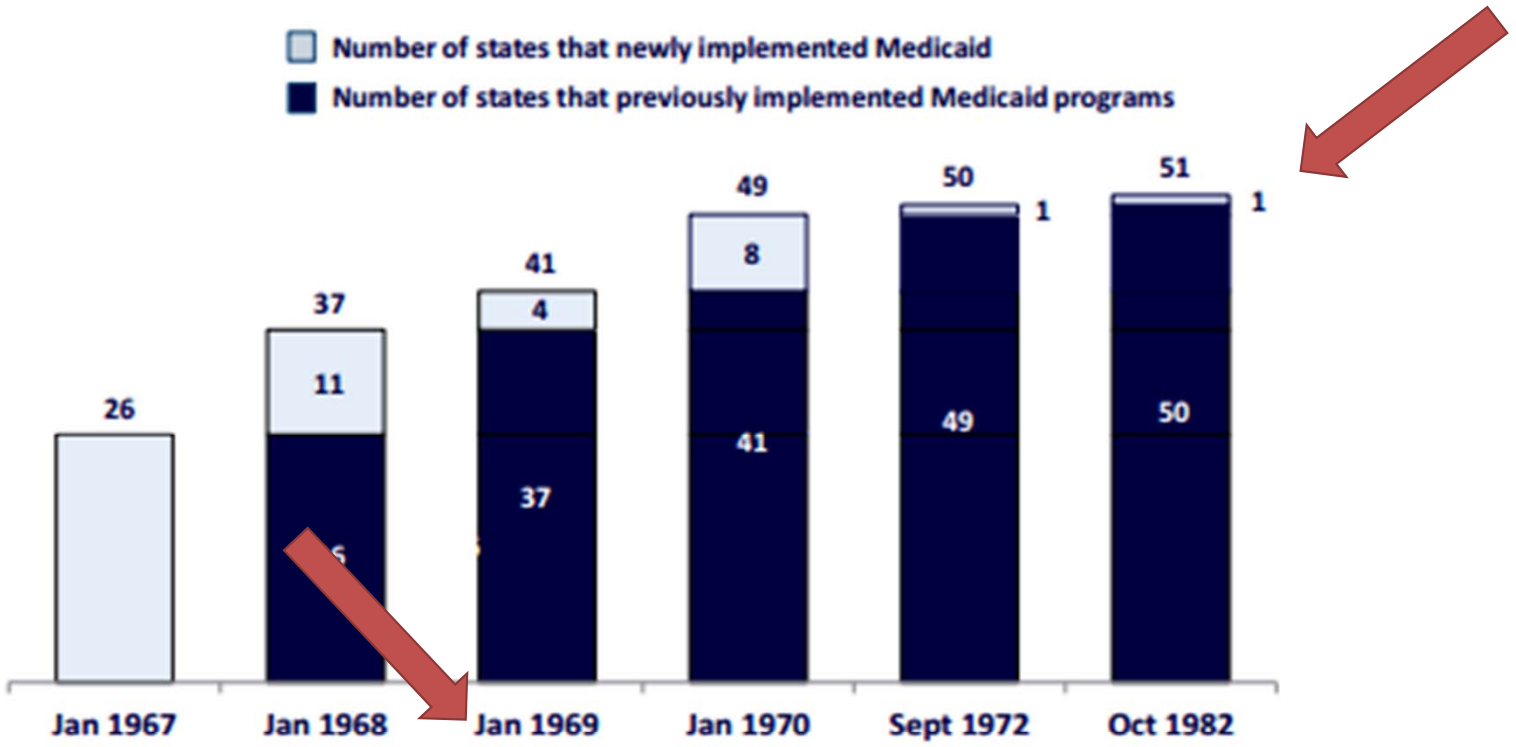
California
Connecticut (April)
Guam (February)
Hawaii
Idaho
Illinois
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
New Hampshire
New York
North Dakota
Oklahoma
Oregon
Pennsylvania
Puerto Rico
South Carolina
Tennessee
Utah
Virgin Islands
Washington
West Virginia

TABLE 1

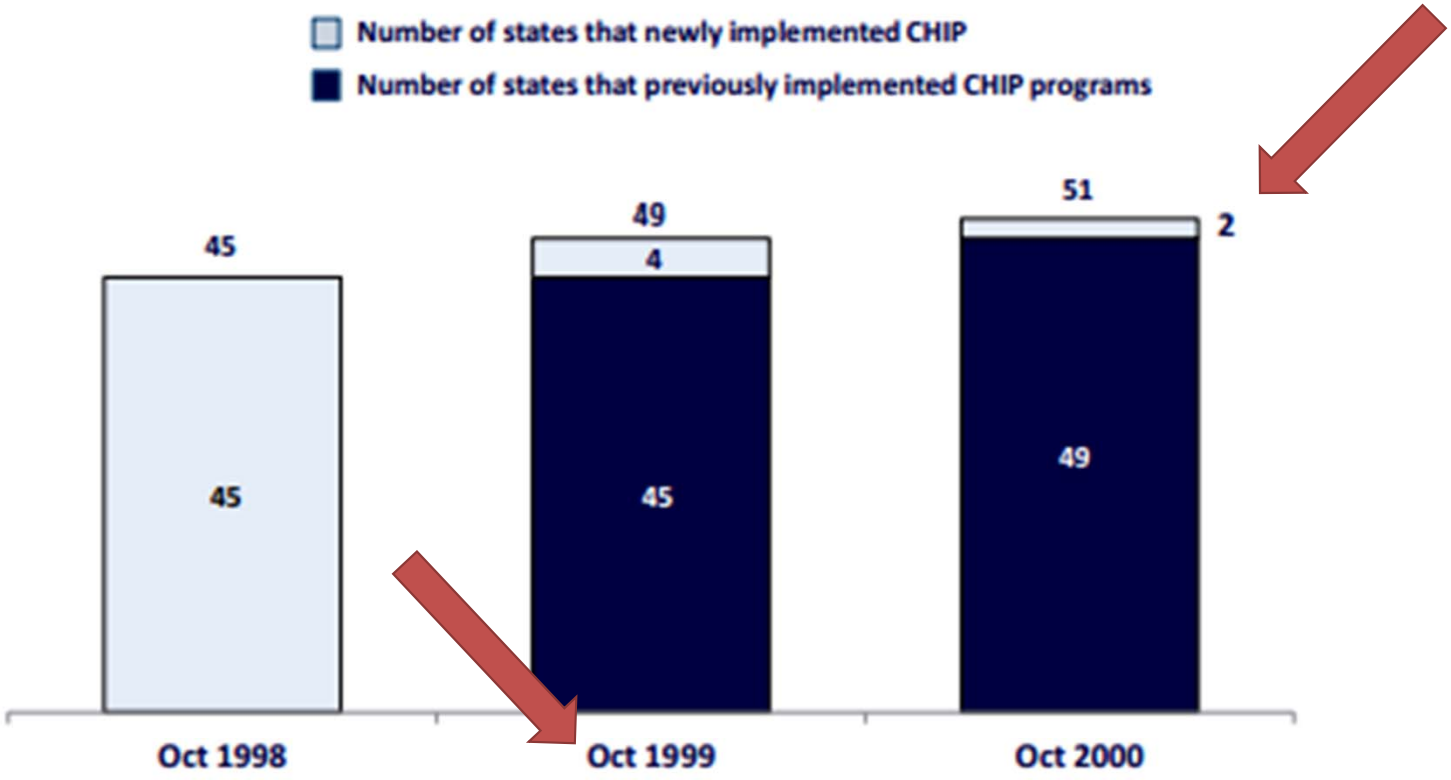
Month and Year	Number of States* Whose Plans Were Approved in Specified Month	Cumulative Total
1943		
April	13	13
May	16	29
June	10	39
July	3	42
August	3	45
September	2	47
October	0	47
November	1	48
December	2	50
1944		
January	0	50
February	1	51
March	1	52

State Implementation of Medicaid by State



SOURCE: National Bureau of Economic Research. "Means-Tested Transfer Programs in the United States." 2003

State Implementation of CHIP by Date



SOURCE: National Governors' Association and National Conference of State Legislatures. State Children's Health Insurance Program: Annual Report. 1999

Federal Emergency Relief Administration (FERA) (1933)

- Beyond withdrawal of funds
  - Federal assumption: IL, KY, OK, ND, ME, MA, OH, LA, GA
  - Partnership: AR, CO, WA

2. Programs Vary Widely Across States

TABLE II.—*Cumulative payments from inception of medical assistance for the aged program through March 1962, by totals, Federal matching and percentage distribution, by jurisdiction*

Jurisdiction	Began payments	Total payments			Federal share of payments		
		Amount	Percent	Cumulative percent	Amount	Percent	Cumulative percent
Total		$166,899,530	100.0		[1] $85,313,5	100.0	
New York	April 1961	79,504,128	47.6	47.6	39,752,064	46.6	46.6
Massachusetts [2]	November 1960	52,050,342	31.2	78.8	26,025,172	30.5	77.1
Michigan	do	18,416,345	11.0	89.0	9,208,173	10.8	87.9
West Virginia	do	4,494,866	2.7	92.6	3,195,002	3.7	91.6
California	January 1962	4,052,596	2.4	95.0	2,026,298	2.4	94.0
Washington	November 1960	1,743,668	1.0	96.0	871,834	1.0	95.0
Idaho	August 1961	1,294,470	.8	96.8	858,104	1.0	96.0
Maryland	June 1961	1,013,876	.6	97.4	506,938	.6	96.6
North Dakota [3]	August 1961	921,848	.6	98.0	667,786	.8	97.4
Oklahoma	December 1960	763,638	.5	98.4	510,170	.6	98.0
South Carolina	August 1961	466,214	.3	98.7	372,972	.4	98.4
Hawaii	July 1961	405,221	.2	98.9	216,307	.3	98.7
Illinois	November 1961	351,935	.2	99.2	175,967	.2	98.9
Utah	September 1961	270,821	.2	99.3	172,622	.2	99.1
Pennsylvania	February 1962	188,320	.1	99.4	94,160	.1	99.2
Kentucky	April 1961	181,229	.1	99.5	137,005	.2	99.4
Arkansas	October 1961	172,247	.1	99.6	137,798	.2	99.5
Puerto Rico [4]	January 1961	168,658	.1	99.7	84,329	.1	99.6
Maine	January 1962	157,547	.1	99.8	104,926	.1	99.8
Louisiana	December 1961	96,343	.1	99.9	69,897	.1	99.8
Tennessee	August 1961	81,772	(5)	99.9	62,042	.1	99.9
Oregon	January 1962	45,450	(5)	99.9	23,816	(5)	99.9
Alabama	February 1962	35,761	(5)	99.9	28,265	(5)	99.9
Virgin Islands	May 1961	13,147	(5)	99.9	6,574	(5)	99.9
New Hampshire	December 1961	9,088	(5)	100.0	5,287	(5)	100.0

FREE DRUGS FURNISHED INDIGENT PATIENTS

Free drugs for the treatment of indigent patients have been provided for several years in 30 States and the District of Columbia, at least to a limited degree. They are now distributed in seven additional States, viz, Idaho, Louisiana, Mississippi, Missouri, Montana, South Carolina, and Washington. In Missouri and Montana no other new work is reported as having been started by October 1, 1936. On that date, Arkansas, Colorado, Kansas, Nevada, North Carolina, North Dakota, Texas, Utah, and Wyoming were not providing antisyphilitic drugs through their State health departments.

DARK-FIELD EXAMINATION FOR PRIVATE PATIENTS

Vermont is the only State in which dark-field examination for private patients has been provided for from Social Security funds, making 21 States in which this service is now available. These States are Delaware, District of Columbia, Georgia, Illinois, Louisiana, Maine, Maryland, Michigan, Minnesota, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Rhode Island, Utah, Vermont, West Virginia, and Wisconsin. Is your State among these?

FAMILY RESPONSIBILITY LAWS

An aspect of the means test which has been particularly subject to criticism, is the "family responsibility" provision. Such provisions are found in almost all OAA programs and, in one form or another, in the MAA programs of the following 12 States:

Connecticut
Hawaii
Illinois
Maine
Massachusetts
Michigan
New Hampshire
New York
North Dakota
Pennsylvania
Utah
Vermont

TABLE VIII.—*Limitations on annual income affecting eligibility for MAA, June 1, 1963*

State [1]	Aged individual	Aged couple	State [1]	Aged individual	Aged couple
District of Columbia	$2,100	$2,400	Louisiana	[6] $1,500	[6] $2,100
Oklahoma	2,000	3,000	Maine	1,500	2,100
New Hampshire [2]	1,800	3,000	Oregon	1,500	2,000
Massachusetts [2 3]	1,800	2,700	South Carolina	1,300	2,100
New York [2 3]	[4] 1,800	[4] 2,600	Alabama	1,200	1,800
Illinois	[4] 1,800	[4] 2,400	North Dakota [2 3]	1,200	1,800
Kentucky	1,600	2,400	Arkansas	1,200	1,500
Connecticut [2 3]	[4] 1,550	[4] 2,200	Maryland	[7] 1,140	[7] 1,560
West Virginia	1,500	3,000	Tennessee	1,000	1,500
Michigan	1,500	2,500	California [8]		
Pennsylvania [2 3]	1,500	2,400	Hawaii [9]		
Utah	1,500	2,400	Idaho [2 10]		
Vermont	[5] 1,500	[5] 2,250	Washington [11]		

TABLE XII.—*Medical assistance for the aged. Vendor payments for medical care by jurisdiction and by type of service, calendar year 1962*

[Amount in thousands]

Jurisdiction	Total	Percentage distribution by type of service						
		Physicians	Other practitioners	Inpatient hospital	Prescribed drugs	Nursing home	Dentists	Other
Total: [1]								
Amount	$250,836	$5,452	$3	$121,057	$5,122	$117,343	$213	$1,312
Percent	100.0	2.2	0.1	48.3	2.0	46.8	0.1	0.5
Alabama [2]	$393	.6		99.4				
Arkansas	810	6.3	(3)	70.2		18.0	1.8	3.6
California	46,046	1.0	.2	54.7		42.5	.1	.6
Connecticut [2]	6,731	.9	.2	5.1	2.4	90.8	.1	.6
Guam [2]	11		30.3	63.2	6.5			
Hawaii	1,195	.3	.1	12.4	.7	86.3	(3)	.2
Idaho	2,090	10.1		18.6		71.3		
Illinois	2,414	4.6		95.4				
Kentucky	535	19.0		58.1	22.2		.7	
Louisiana	793	11.5		83.0	.2	5.2	(3)	(3)
Maine	750			100.0				(3)
Maryland	2,557	7.1		77.1	14.1		.2	1.4
Massachusetts	43,111	2.0	.4	21.6	5.2	69.8	.2	.9
Michigan	18,726	3.7		93.5		2.4		.4

Of the 25 States, and 4 other jurisdictions with programs in effect on June 1, 1963, only 4—Hawaii, Massachusetts, New York, and North Dakota—have plans which can be classified as "comprehensive"

[1] App. D consists of a summary of the eligibility requirements and the scope and contents of services for each of the 29 jurisdictions with MAA programs in operation on June 1, 1963.

TABLE IX.—*Medical assistance for the aged: Expenditures for administration as percent of assistance payments, calendar year ended Dec. 31, 1961*

State	Total administrative expenditures	Administrative cost as percent of assistance payments	State	Total administrative expenditures	Administrative cost as percent of assistance payments
Arkansas	$34,00	63.9	New York	$4,683,000	8.6
California	64,000	(1)	North Dakota	69,000	13.5
Hawaii	10,000	4.4	Oklahoma	30	5.3
Idaho	78,000	9.9	Oregon	66,	(1)
Illinois	18,000		Puerto Rico	7,00	8.9
Kentucky	105,000	124.0	South Carolina	97,000	(1)
Louisiana	15,000	(1)	Tennessee	83,000	(1)
Maryland	82,000	12.3	Utah	6,000	
Massachusetts	1,897,000	5.0	Virgin Islands	17,000	
Michigan	345,000	2.5	Washington	51,000	3.9
New Hampshire	(2)	(1)	West Virginia	630,000	17.3

3. The Federal Government Is Usually Extremely Accommodating

Funding and Target Populations

- Social Security Act Amendments
  - Medical payment matching rate increases 1956
  - Variable matching rate and increases 1958
- Disproportionate Share Hospital Payments
- S-CHIP
- Medicaid waivers

Pathways to Implementation

- Sheppard-Towner
- HIPPA compliance
  - High-risk pools
  - NAIC model acts
  - Other innovative mechanisms
- Trade Act

B. State-based continuation coverage provided by a state under state law requiring such coverage;

C. Coverage offered through a state high-risk pool;

D. Coverage under a plan offered for state employees;

E. Coverage under a state-based plan that is comparable to the plan offered for state employees;

F. Coverage through an arrangement entered into by a state and a group health plan, an issuer of health insurance, an administrator, or an employer;

G. Coverage through a state arrangement with a private sector health care purchasing pool; and

H. Coverage under a state-operated plan that does not receive any federal financing.

4. Ideological Conflict Permeates Enactment and Early Implementation

Quote #1:

- the […] plan represents the frenzied extreme, but it does not stand alone. It is allied with […] various radical schemes inaugurated in different European countries […] where socialistic doctrinaires have long insisted upon the establishment of […] benefit systems […] All of such plans involves the assumption by the State of the authority to interfere in the family relations. They imply the right of State visitation and espionage. Such doctrines are not tolerated in a free country.

Quote #2:

- This threat is with us and at the moment is more imminent. One of the traditional methods of imposing … socialism on a people has been by way of medicine. It's very easy to disguise a medical program as a humanitarian project. […] Now, the American people, if you put it to them about socialized medicine and gave them a chance to choose, would unhesitatingly vote against it. […] The doctor begins to lose freedom. […] And from here it's only a short step to dictating where he will go. […] From here it's a short step to all the rest of socialism

Quote #3:

- When the government controls everybody's health care, pays for everybody's health care, it is the government controlling everything. They have the power then to tell everybody how much they should put in, how much they take out. How much more socialist can you get than a government telling everybody what they can do, what they can't do, how they can live. Individual liberty is gone. Once you go socialist and buy into the notion that you've got to forget individual liberty, forget individual freedom, it's all about the greatest good for the greatest number of people

262 U.S. 447

43 S.Ct. 597

67 L.Ed. 1078

COMMONWEALTH OF MASSACHUSETTS
v.
MELLON, Secretary of the Treasury, et al. FROTHINGHAM v. SAME.

Nos. 24, Original, and 962.

Argued May 3 and 4, 1923.
Decided June 4, 1923.

ACTIVITIES OF THE FARM SECURITY ADMINISTRATION

REPORT

OF

SELECT COMMITTEE OF THE HOUSE COMMITTEE ON AGRICULTURE TO INVESTIGATE THE ACTIVITIES OF THE FARM SECURITY ADMINISTRATION

MAY 6, 1944

UNITED STATES
GOVERNMENT PRINTING OFFICE
WASHINGTON : 1944

5. Grants Create Incentives and States Respond to Them

States Maximize Funding & Flexibility

- SCHIP
- Kerr-Mills
- Disproportionate share hospital funding

States Are Hesitant to Act Alone

- Sheppard-Towner

6. Not All Eligible Individuals Enroll

TABLE III.—*Number of different recipients who received MAA care, by jurisdiction, fiscal year 1962* [1]

Jurisdiction	Average monthly number of recipients	Number of different recipients during year	Jurisdiction	Average monthly number of recipients	Number of different recipients during year
Total [1]	394	217,797	Michigan	4,649	13,585
Alabama	126	706	New Hampshire	25	120
Arkansas	820	3,836	New York	27,791	69,900
California	10,624	18,572	North Dakota	650	1,237
Connecticut	3,948	4,347	Oklahoma	309	2,363
Hawaii	267	783	Pennsylvania	1,935	12,915
Idaho	1,068	2,441	Puerto Rico	1,417	8,732
Louisiana	211	1,465	South Carolina	441	3,217
Maine	265	1,470	Tennessee	282	1,921
Maryland	4,638	8,807	Utah	332	956
Massachusetts	18,557	30,133	Washington	563	3,723
			West Virginia	6,685	26,568

[1] Data not yet available for Guam, Illinois, Kentucky, Oregon, and Virgin Islands.

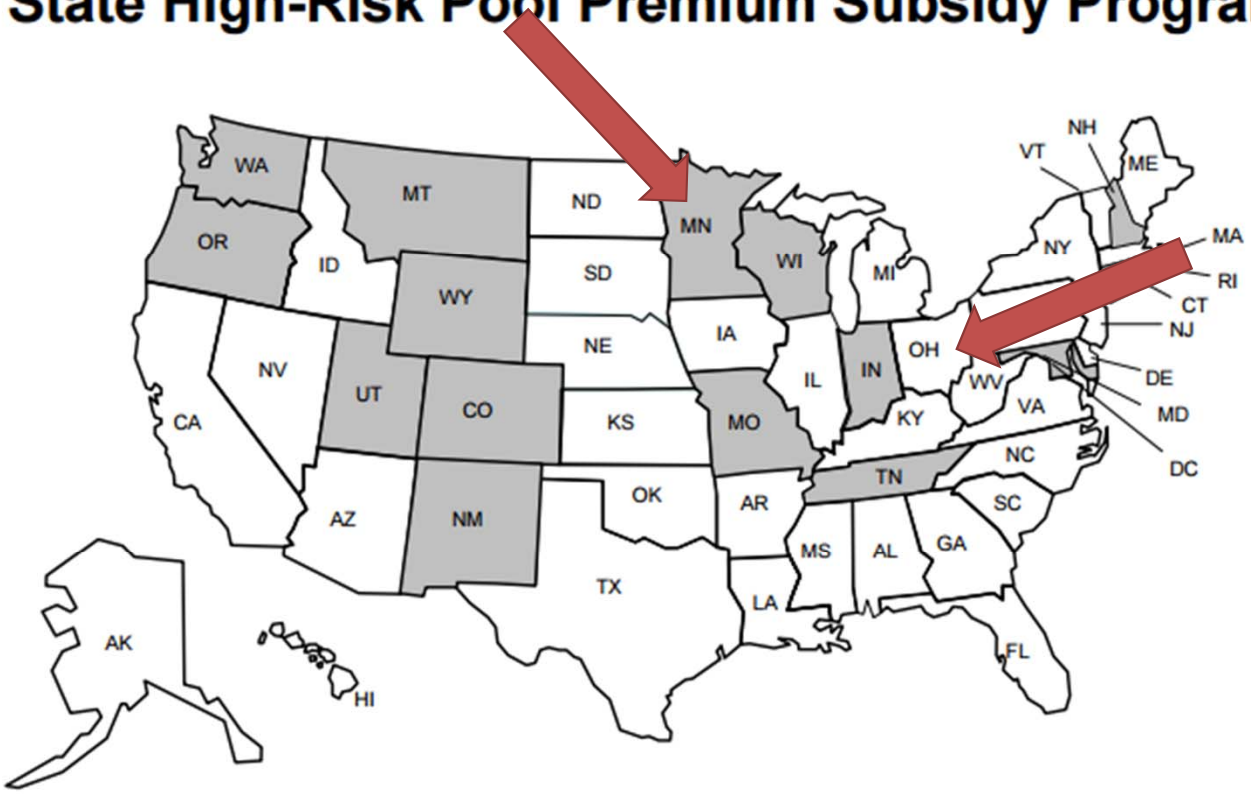
AVERAGE TAKE-UP			
Davidoff et al. (2004)	NSAF, 1999	54%	36%-81%
Davidoff et al. (2005)	NSAF, 2002	52%	32%-76%
TRIM (2006)	Administrative data, plus CPS	80.7%	N/A
TRIM (2008)	Administrative data, plus CPS	81.3%	N/A
Sommers & Epstein (2010)	CPS, 2007-2009	62%	44%-88%

Ongoing Issues with High Risk Pools

-There is limited evidence that high risk pools have had a significant impact on the uninsured (NASHIP 2007).

The number of participants in state high risk pools range from 236 participants in West Virginia to 30,000 in Minnesota in 2006 (NASHIP 2007). Most states have a participation rate from .05 to .33% of the population. Participation in the largest pool, Minnesota, still represents less than 1% of the population.

State High-Risk Pool Premium Subsidy Programs



15 State High-Risk Pools with a Premium Subsidy Program

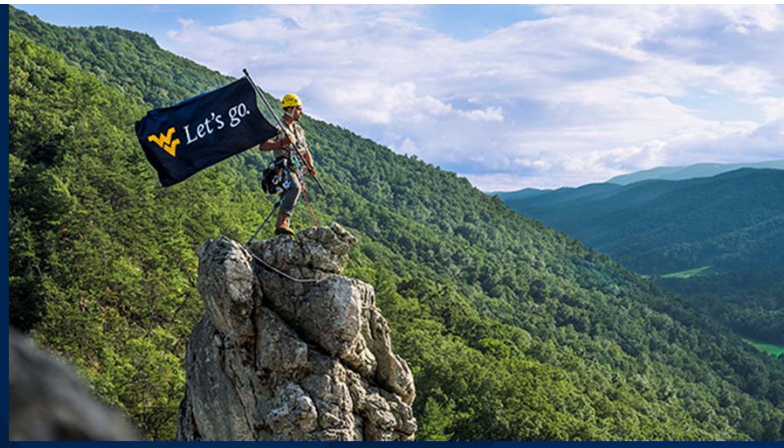
NOTE: Oregon's Family Health Insurance Assistance Program (FHIAP) provides premium subsidies for people to buy private insurance or high-risk pool coverage.
SOURCE: State Health Facts. State High-Risk Pool Premium and Cost-Sharing Subsidies, as of February 2009.

Seven Themes

1. Implementation Is Often Slow and Uneven
2. Programs Vary Widely Across States
3. The Federal Government Is Usually Extremely Accommodating
4. Ideological Conflict Permeates Enactment and Early Implementation
5. Grants Create Incentives and States Respond to Them
6. Not All Eligible Individuals Enroll
7. Past Programs Serve as Stepping Stones and Wedges

Future Reforms

- Looking back is usually a good idea going forward
- Evolutionary developments: size, scope, number, involvement
  - Coverage
  - Grant making
- Reforms will still have to deal with federalism
- States programs will differ



Thanks