

The History of Federal Health Care Spending



*A Comparison of Original and
Current Program Outlays*

U.S. Senator Tom Coburn, M.D. | February 2014

Introduction

Federal spending on health care continues to be the largest driver of the national debt, and health spending consumes a larger portion of the federal budget each year. Most economists and budget experts agree: to get a handle on our debt and deficit, we must slow the growth of health spending. Unfortunately, instead of addressing the issue, the federal government continues to create new health care programs and expand existing ones.

Nearly four years ago, President Obama signed into law the largest health reform overhaul in history, the Patient Protection and Affordable Care Act (ACA, or “Obamacare”). The law’s supporters have suggested it will reduce the deficit, lower costs, and decrease health spending in the long-term.

So far, the ACA has yet to deliver on many of the aspirations and promises that were invoked to secure the law’s passage. Non-partisan experts confirm the law is increasing both health costs and federal health care spending. In fact, data shows the law will increase spending by more than \$2 trillion once fully implemented.¹

Many supporters of the law say we must move “forward” with the law and press on to make the law successful. They argue repealing the law would mean a return to a broken status quo. Certainly, our health care system was broken even before the ACA, but Obamacare failed to address the underlying problems. That’s why I worked with my colleagues to draft an Obamacare alternative in 2009 and recently introduced another alternative with Senators Burr and Hatch.

Regardless of whether policymakers want to see the ACA improved or replaced, both sides can benefit from learning about the health policy experiments of the past. They reveal two valuable lessons:

First, the federal government’s spending on health care programs usually outpaces economic growth.^{*} This fact presents a significant challenge to policy-makers—as the growth in these programs crowds out other budgetary priorities. It also presents an increasing threat to taxpayers and consumers, who will, as a result, either face higher tax burdens, larger debt, or reduced focus on other important federal priorities.

Second, compared with initial government estimates and outlays, most programs have experienced exponential growth in real terms when compared to initial estimates. Certainly, a variety of modifications to eligibility and benefits have been made in these programs by Congress since their inception. And it is also true over the longer-term, demographic and market changes (like innovations in medical technology and longer life-expectancy) have significantly impacted the growth in spending within these programs. But the historical trend is clear: federal spending on health care programs will increase vastly and outpace economic growth. Moreover, the original estimates of program outlays are relatively poor indicators of actual spending over a longer period of time.

Based on a review of the facts, readers have solid ground for concluding the federal government has a poor track record of constraining health care spending over time. Accordingly, in light of the reality of past trends, concern about the trajectory of the future health care spending – whether in the ACA, Medicare, Medicaid, or other programs—is well placed.

^{*} Economic growth (in terms of Gross Domestic Product) from 1965 to 2013 was about 322% (inflation adjusted). Source: Bureau of Economic Analysis, “Current-dollar and ‘real’ GDP,” last updated January 30, 2014. <http://www.bea.gov/national/index.htm#gdp>.

Methodology

This report reviews federal health care programs and compares the initial spending of each program to recent outlays.

The report uses the data provided by the Office of Management and Budget (OMB) and the President's FY2014 Budget to compare initial outlays with outlays in 2012. OMB indicates "to the extent feasible, the data have been adjusted to provide consistency with the 2014 Budget and to provide comparability over time."²

The report also notes estimates, appropriations, and outlays (as available) for initial program spending. Initial estimates or original expenditures for each program are underlined throughout the report. These estimates vary in their quality and specificity, but all are the earliest estimates available from official government sources which were obtained by the Congressional Research Service (CRS). The original cost estimates underlined throughout the report have not been adjusted to reflect general inflation.

The report also contrasts the total number of people enrolled in each program (as available) at inception and in recent years. The report acknowledges an increase in the number of people enrolled in each program is attributable to a combination of general population increases, legislative and regulatory expansion of the program, and other demographic and economic factors. However, the general trend is unmistakable: in each case, the population served by the program has greatly increased since its creation.

Federal Health Care Programs

Overview of Outlays and Enrollment Increases

<u>Program</u>	<u>Early Figures</u>	<u>Recent Figures</u>	<u>Change</u>
Medicaid	\$800 million (1966)	\$250.5 billion (2012)	 + \$249.7 billion 31,212.5% increase
	4 million enrollees (1966) ³	55.6 million enrollees (2012) ⁴	 +51.6 million 1,290% increase
Medicare	\$2.8 billion (1967)	\$471.8 billion (2012)	 + \$469 billion 16,750% increase
	Part A—18.9 million enrollees (1966) ⁵	Part A—47.1 million enrollees (2010) ⁶	 +28.2 million 149.2% increase
	Part B—17.6 million enrollees (1966) ⁷	Part B—43.8 million enrollees (2010) ⁸	 +26.2 million 148.9% increase
	Part D—3.8 million enrollees (2006) ⁹	Part D—34.5 million enrollees (2010) ¹⁰	 +30.7 million 807.9% increase
	End Stage Renal Disease (ESRD)—11,000 enrollees (1974) ¹¹	ESRD—453,443 enrollees (2008) ¹²	 +442,443 4,022.2% increase
Defense Health Programs	\$3.7 billion (1980)	\$53.5 billion (2012)	 + \$49.8 million 1345.9% increase
	8.3 million eligible enrollees in TRICARE (1995) ¹³	9.7 million eligible enrollees (2011) ¹⁴ in TRICARE	 +1.4 million 16.9% increase
Veterans Medical Care	\$1.1 billion (1962)	\$50.6 billion (2012)	 + \$49.5 billion 4,500% increase
	4.3 million enrollees (1999) ¹⁵	8.6 Million enrollees (2011) ¹⁶	 +4.3 million 100% increase
Other Federal Health Care Programs	\$1.1 billion (1962)	\$94.5 billion (2012)	 + \$93.4 billion 8,490.9% increase
	Indian Health Service (IHS)— 626,688 enrollees (1977) ¹⁷	IHS—1.6 million enrollees (2011) ¹⁸	 +1.3 million 155.3% increase
	State Children's Health Insurance Program (SCHIP)—3.3 million enrollees (2000) ¹⁹	SCHIP—8.7 million enrollees (2011) ²⁰	 +5.4 million 163.6% increase

Source for Costs: President Obama's FY 2014 Budget, Historical Table 16, all costs have been adjusted to be consistent with the 2014 Budget

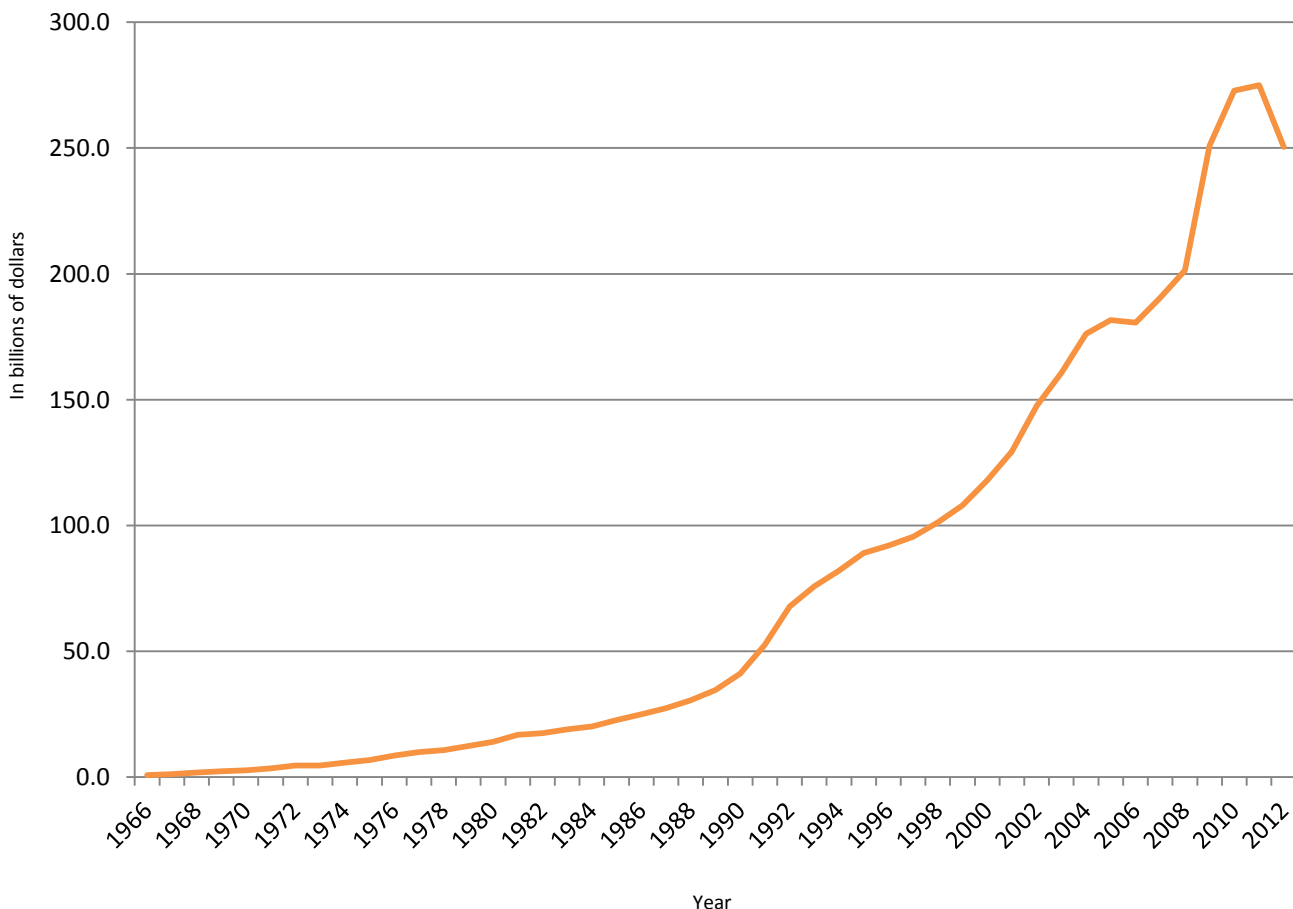
Medicaid

The Social Security Amendments of 1965 established the Medicaid program. Medicaid grew out of and replaced two earlier programs of federal grants to states that provided medical care to welfare recipients. The new program, officially named “Title XIX: Grants to the States for Medical Assistance Programs,” formed a centralized program in which vendor payments meeting the requirements of Medicaid could be administered. States participating in this program were required to cover inpatient and outpatient hospital services; laboratory and X-ray services; skilled nursing home services; and physicians’ services. Services such as home health, clinic service, private duty nursing service, dental, physical therapy and prescribed drugs were left to the states’ discretion. In a March 1965 report by the House Ways and Means Committee on the Social Security Amendments of 1965, it was estimated Medicaid would cost \$238 million in 1966, the program’s first fiscal year.²¹ A report by the Senate Committee on Finance in June 1965 came to the same conclusion.²²

Today, Medicaid is required to cover inpatient hospital service; laboratory and x-ray services; physician services; pregnancy-related services; nursing facilities services; home health; and services provided by federally qualified health centers to those who qualify. Qualifications for the Medicaid depend on categorical traits, such as coverage to those with disabilities, as well as financial requirements.

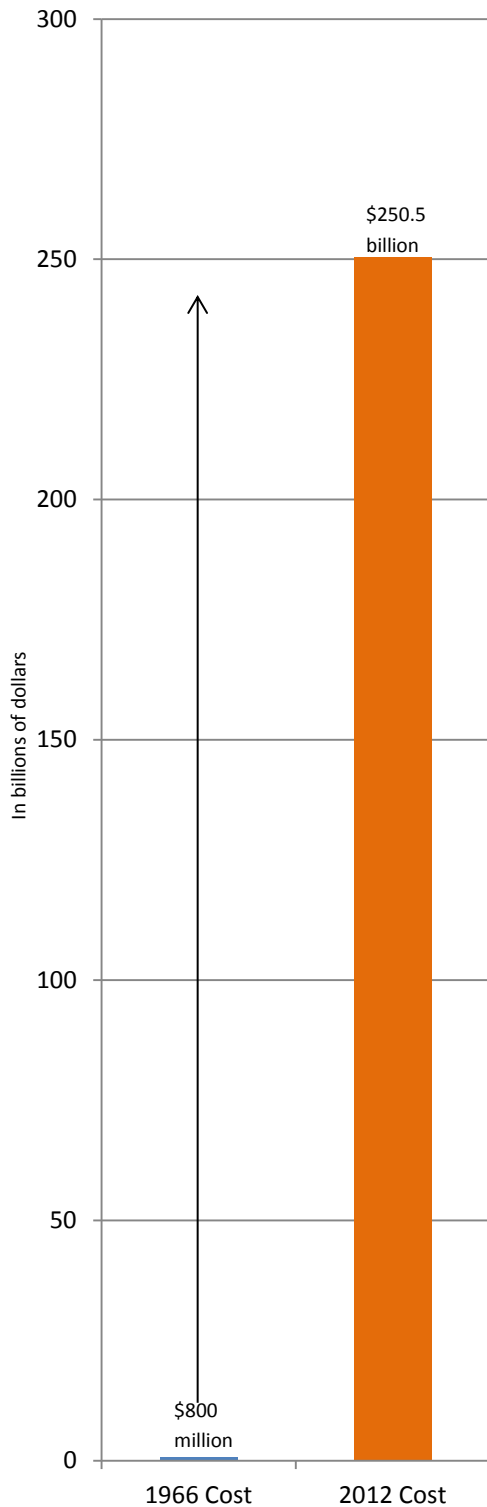
Medicaid was most recently expanded by the Patient Protection and Affordable Care Act (ACA). The ACA expands eligibility for the program to all individuals under age 65 with income up to 133 percent of the federal poverty level. Twenty-five states and the District of Columbia will expand their Medicaid programs by April 1, 2014. Due to the Supreme Court’s decision that made the Medicaid expansion optional for states, the cost of expanding Medicaid remains unclear.

Medicaid Outlays



Source: President Obama’s FY 2014 Budget, Historical Table 16

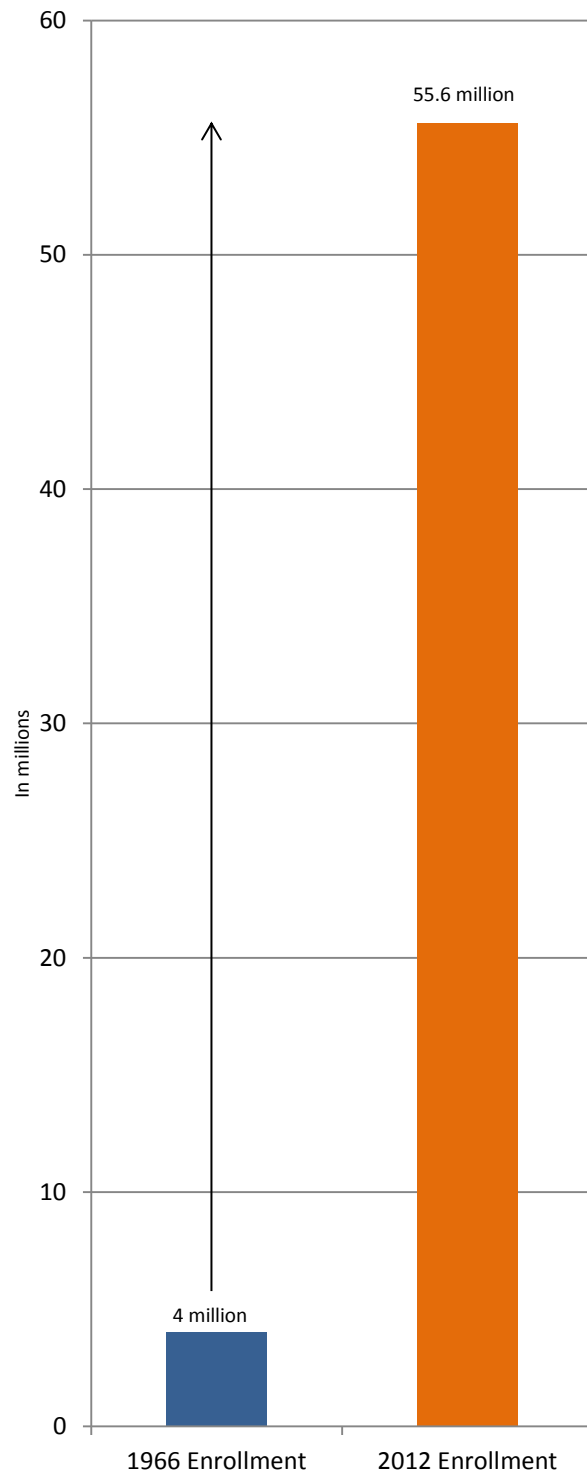
1966 vs. 2012 Outlays



According to OMB, Medicaid spent \$250.5 billion in 2012, compared to \$800 million in 1966. Medicaid has grown by 31,212.5% in 46 years.

Source: President Obama's FY 2014 Budget, Historical Table 16

1966 vs. 2012 Enrollment



According to the Department of Health and Human Services (HHS), and Centers for Medicare and Medicaid Services (CMS), 55.6 million people were enrolled in Medicaid in 2012, compared to 4 million people in 1966. Enrollment increased by 1,290% in 46 years.

Sources: HHS (endnotes 3,4)

Medicare

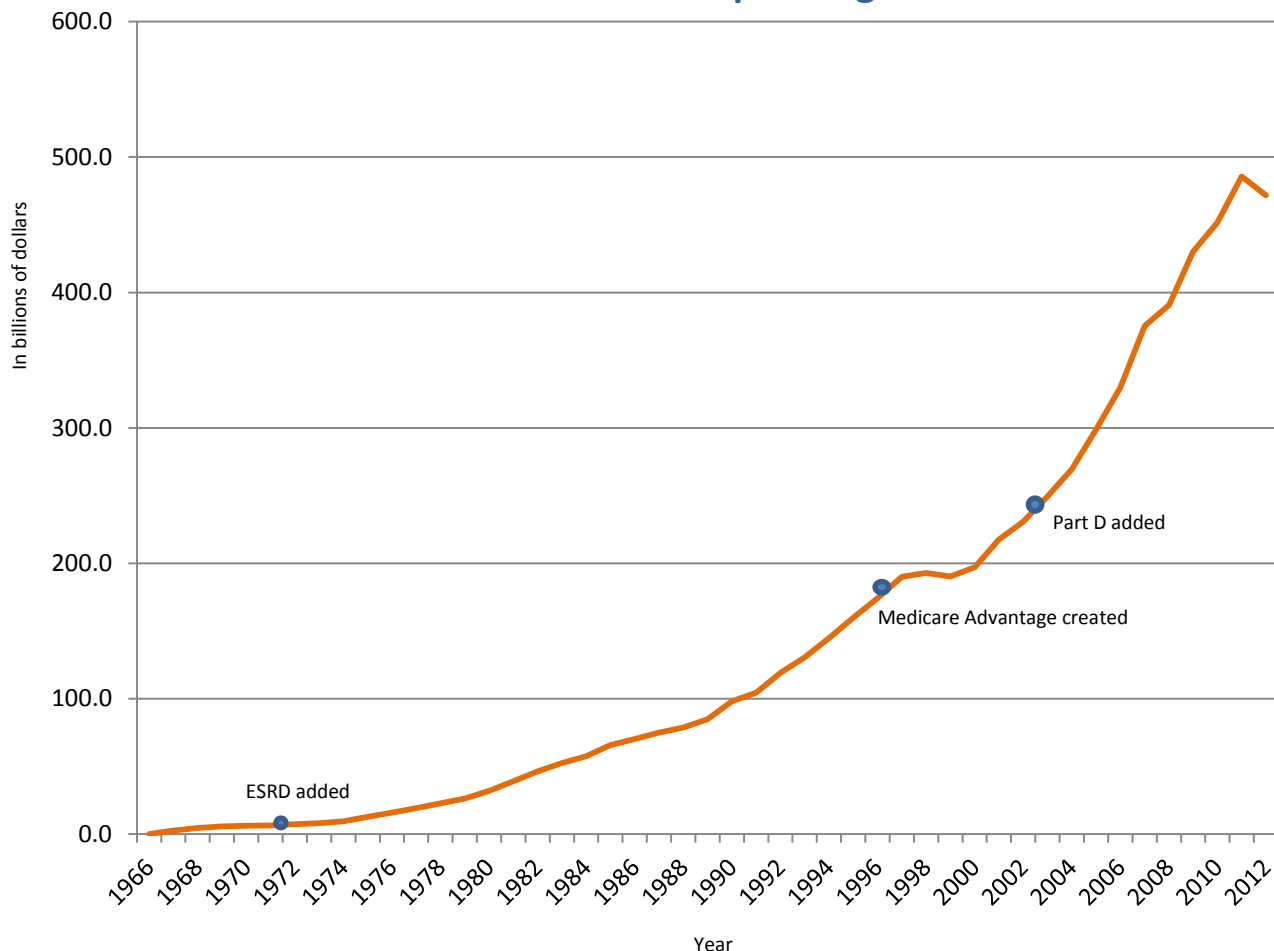
Medicare was established with the enactment of the 1965 Social Security Amendments. The program was created to provide health insurance for the elderly and certain people with disabilities. The original program was comprised of two parts: Part A, the hospital insurance program; and Part B, the supplementary medical insurance program. The provisions of the Social Security Amendments of 1965 granted almost all citizens over 65 years of age access to Medicare Part A. Part A is funded by payroll taxes shared between employees and employers. In 1965 it was estimated total Medicare Part A costs would be \$1 billion in 1966, including benefits and administration costs.²³ Medicare Part B is funded by a combination of premiums paid by beneficiaries and other Federal revenues. Enrollment in Part B is voluntary, and about 93 percent of seniors are enrolled in Part B. Since Medicare Part B is voluntary, two estimates were given for 1966 costs. It was expected, at most, the federal government would contribute \$203 million for Medicare Part B, including benefits and administration costs in 1966.²⁴

The End State Renal Disease (ESRD) provision was included in the Social Security Amendments of 1972.²⁵ The program provides Medicare benefits for ESRD patients, regardless of age, who need dialysis or a kidney transplant. The program is funded by both Medicare Part A, the hospital insurance program, and Medicare Part B, the supplemental medical insurance program. The Medicare Board of Trustees' projected costs would be \$98 million in 1974.²⁶ In 1973, coverage for citizens with disabilities was added.

The Balanced Budget Act of 1997 created the Medicare + Choice program, later known as Medicare Advantage, which established options for Medicare beneficiaries to utilize private plans.

Medicare Part D was created when Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The bill established a voluntary prescription drug benefit program that was to be administered by private insurance. It was estimated outlays for Medicare Part D would be \$32 billion in 2006.²⁷

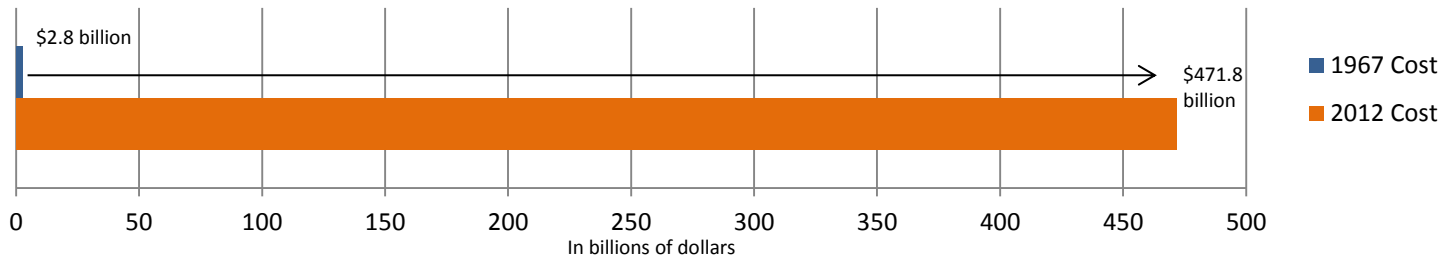
Medicare Spending



Source: President Obama's FY 2014 Budget, Historical Table 16

1967 vs. 2012 Spending

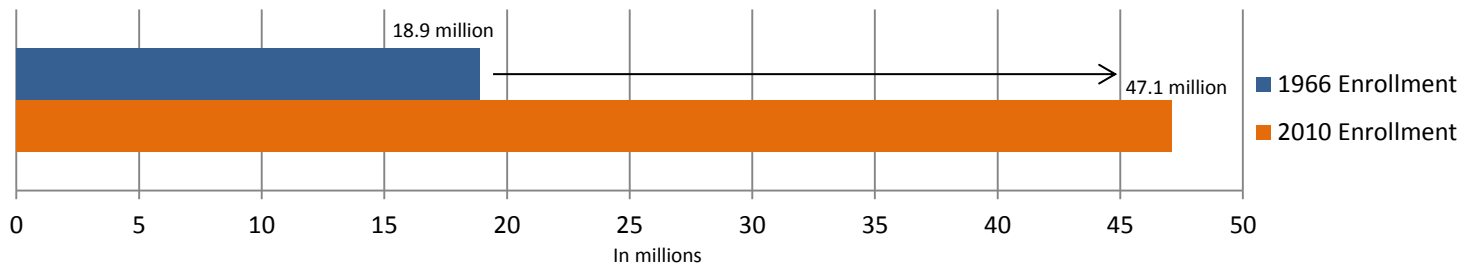
According to OMB, Medicare spent \$471.8 billion in 2012 compared to \$2.8 billion in 1967. Program spending increased by 16,750% in 45 years.



Source: President Obama's FY 2014 Budget, Historical Table 16

1966 vs. 2010 Medicare Part A Enrollment

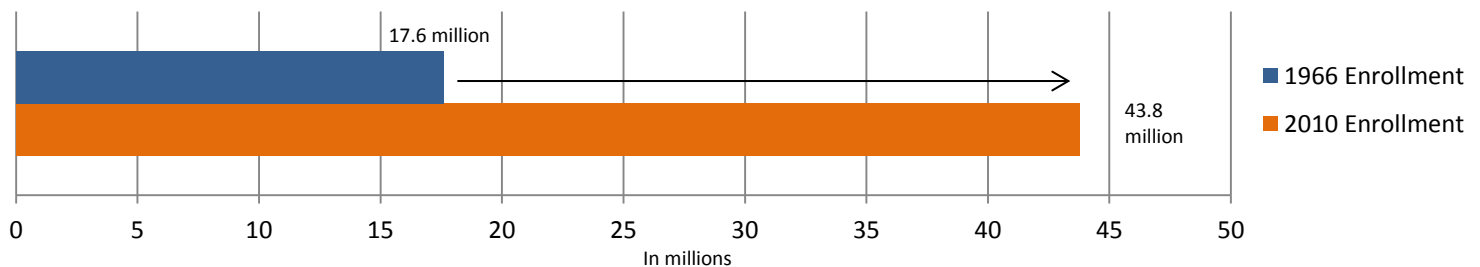
In 2010, there were 47.1 million people enrolled in Medicare Part A compared to 18.9 million people in 1966. Enrollment increased by 149.2% in 44 years.



Sources: SSA, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (endnotes 5,6)

1966 vs. 2010 Medicare Part B Enrollment

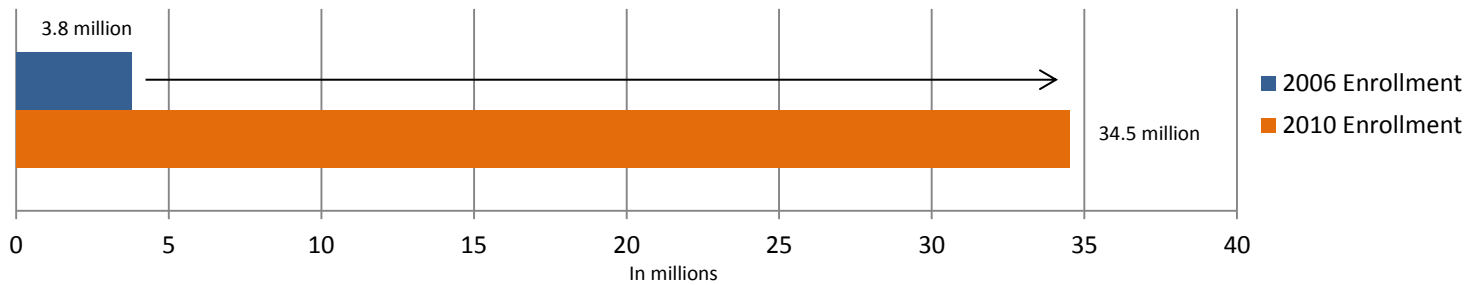
In 2010, there were 43.8 million people enrolled in Medicare Part B compared to 17.6 million people in 1966. Enrollment increased by 148.9% in 44 years.



Sources: SSA, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (endnotes 7,8)

2006 vs. 2010 Medicare Part D Enrollment

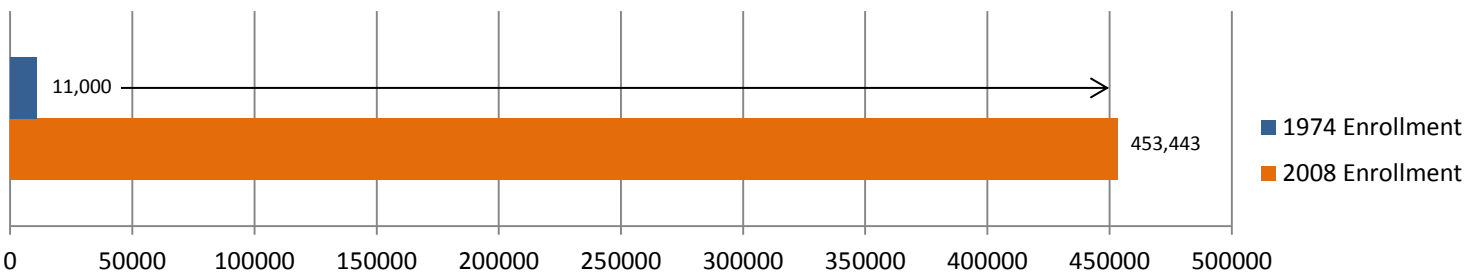
In 2010, there were 34.5 million people enrolled in Medicare Part D compared to 3.8 million people in 2006. Enrollment increased by 807.9% in 4 years.



Sources: CBO, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (endnotes 9,10)

1974 vs. 2008 ESRD Enrollment

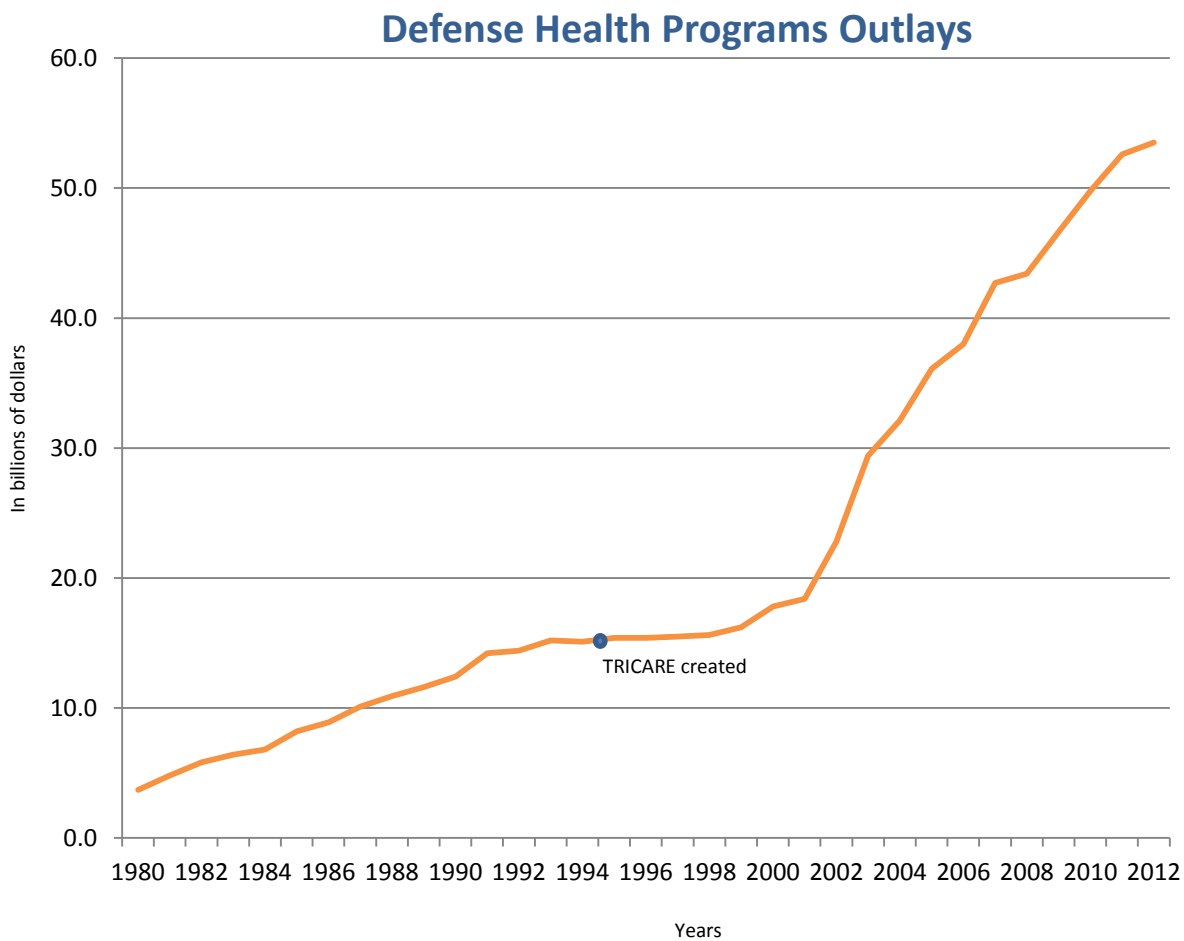
In 2008, there were 453,443 people enrolled in ESRD compared to 11,000 people in 1974. Enrollment increased by 4,022.2% in 34 years.



Sources: Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, U.S. Renal Data System (endnotes 11,12)

Department of Defense Health Programs

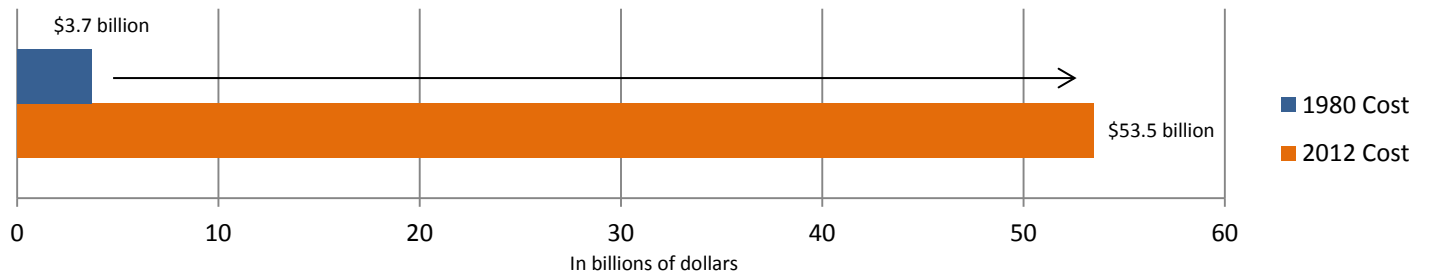
Prior to 1994, military health care programs had included individual programs for specific branches of the military; coverage for military retirees and dependents; and for the provision of civilian health care to retirees less than 65 years of age, service members, survivors and their dependents. TRICARE was established by the 1994 Department of Defense appropriations act. The program established a nationwide managed health care program for active-duty uniformed personnel and their dependents, eligible members of the Reserve Component and their dependents, and uniformed services retirees and their dependents and survivors. The TRICARE program provided a uniform and cohesive benefit structure that featured a three-option benefit structure based in a region-by-region approach to the health management system. TRICARE sought to minimize costs by providing incentives including “gate keeping” via annual enrollment stipulations, open competition for contracts, and capitation budgeting. In 2001, the National Defense Authorization Act allowed health care and pharmacy benefits to be expanded to include Medicare-entitled military retirees, family members, and even former spouses who met the program requirements. In 1995, the Government Accountability Office (GAO) estimated five-year appropriations for TRICARE at \$17 billion, an average of \$3.4 billion per year.²⁸



Source: President Obama’s FY 2014 Budget, Historical Table 16

1980 vs. 2012 Outlays

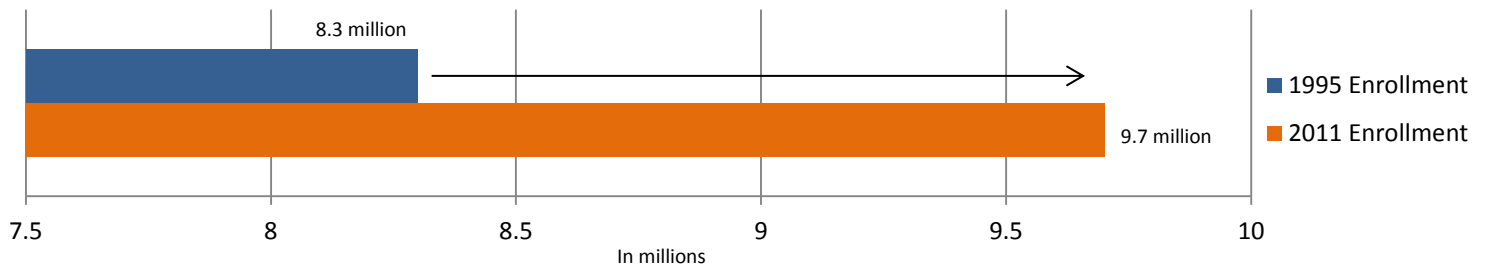
According to OMB, defense health programs spent \$53.5 billion in 2012, compared to \$3.7 billion in 1980. The program has increased by 1345.9% in 32 years.



Source: President Obama's FY 2014 Budget, Historical Table 16

1995 vs. 2011 TRICARE Enrollment

In 2011 there were 9.7 million enrollees in TRICARE compared to 8.3 million in 1995. Enrollment in TRICARE has increased by 16.9% increase in 16 years.

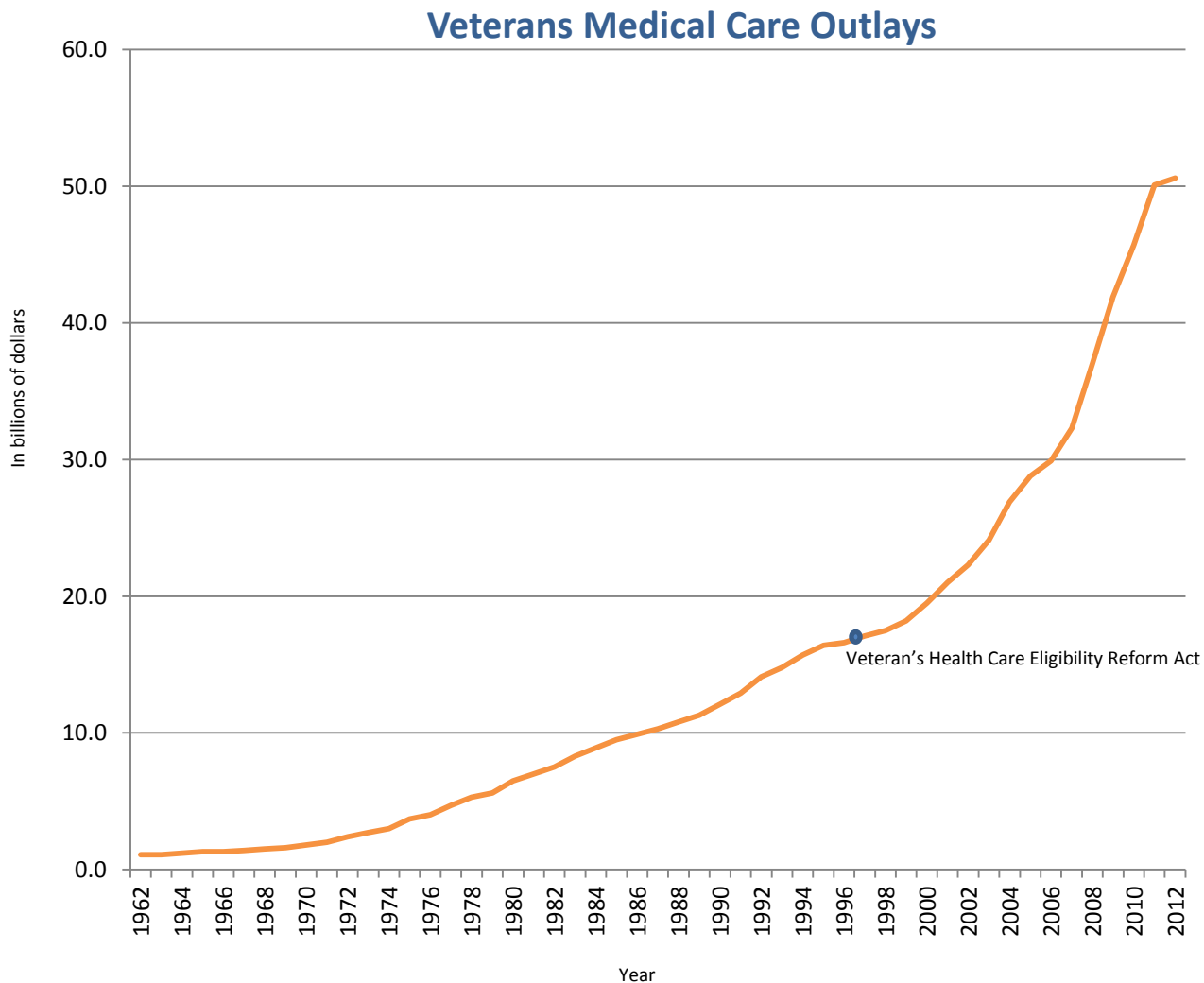


Sources: GAO, OMB (endnotes 13,14)

Veterans Medical Care

The United States has a long history of providing health care to veterans, but significant steps toward current health care benefits began with WWI and WWII veterans.²⁹ By the mid-1980s, the Department of Veterans Affairs (VA) had been given the authority to administer health care, including hospital, nursing home and domiciliary care for most veterans. In 1986, the low-income requirement was dropped, making veterans with service- and non-service conditions eligible for treatment. In 1996, with the passage of the Veteran's Health Care Eligibility Reform Act, the VA created a category system to track enrollment of VA health services. Currently, the Veterans Health Administration seeks to cover four health areas; providing medical and rehabilitation services, conducting medical research, providing graduate medical education, and administering emergency management. In 1996, the CBO estimated appropriations for veterans' medical care to be \$16.9 billion in that year.³⁰

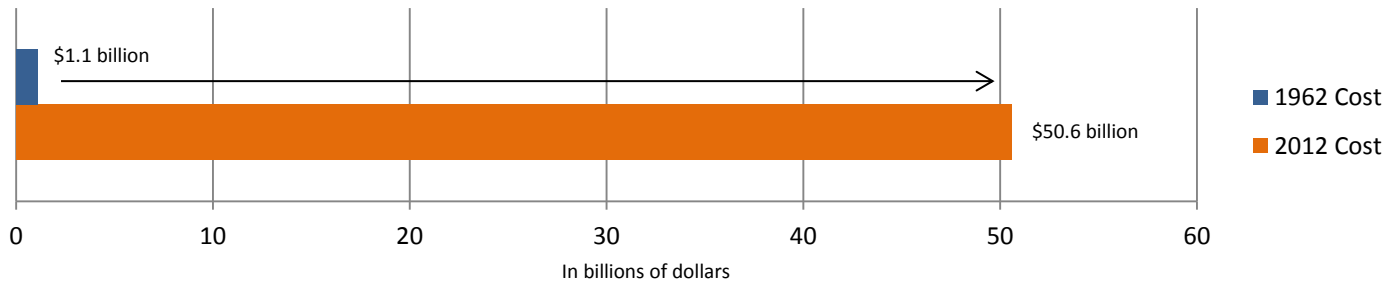
The VHA now provides and administers inpatient and outpatient care, nursing homes, and primary care to veterans with service-connected disabilities or to those with low incomes.



Source: President Obama's FY 2014 Budget, Historical Table 16

1962 vs. 2012 Outlays

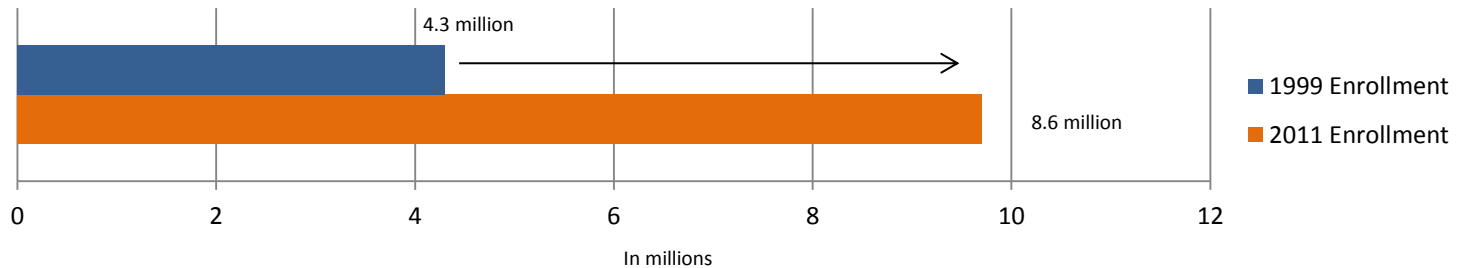
According to OMB, medical care for veterans cost \$50.6 billion in 2012, compared to \$1.1 billion in 1962. Program outlays increased by 4,500% in 50 years.



Source: President Obama's FY 2014 Budget, Historical Table 16

1999 vs. 2011 Veterans Health Administration Enrollment

In 2011, 8.6 million people were enrolled in veterans' health care, compared to 4.3 million in 1999. Enrollment in the program has increased by 100% in 12 years.



Sources: CBO, VA (endnotes 15, 16)

Other Health Care Programs

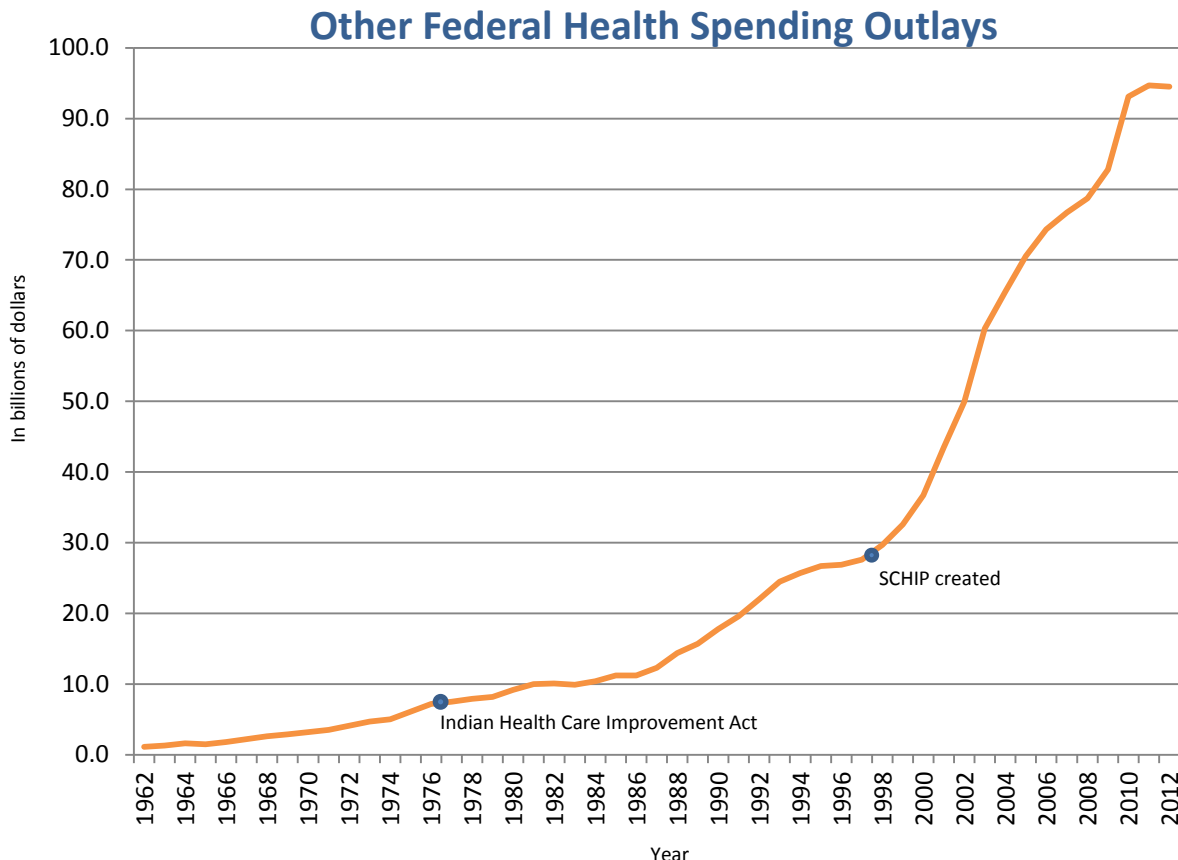
The Indian Health Service and State Children’s Health Insurance Program are two of the largest health programs that were not separately listed in OMB’s table of historic health spending.

Indian Health Service (IHS)

The 1921 Snyder Act authorized the first health services created specifically for Native Americans. The 1954 Transfer Act, moved the administration of Indian health from the Bureau of Indian Affairs to the Public Health Service. The 1976 Indian Health Care Improvement Act authorized and estimated many specific modern IHS activities, including funding for health services, supporting the renovation and construction of health and environmental properties, extending Medicaid eligibility to IHS recipients, and expanding services being provided to urban Indians. Today, the IHS administers a variety of health programs, including emergency, ambulatory, inpatient, dental, public health nursing, and preventive health care services. IHS also administers mental and substance-abuse care. A 1975 report on the Indian Health Care Improvement Act by the Senate Committee on Interior and Insular Affairs estimated the total costs of the program would be \$232.2 million in 1977.³¹

State Children’s Health Insurance Program (SCHIP/CHIP)

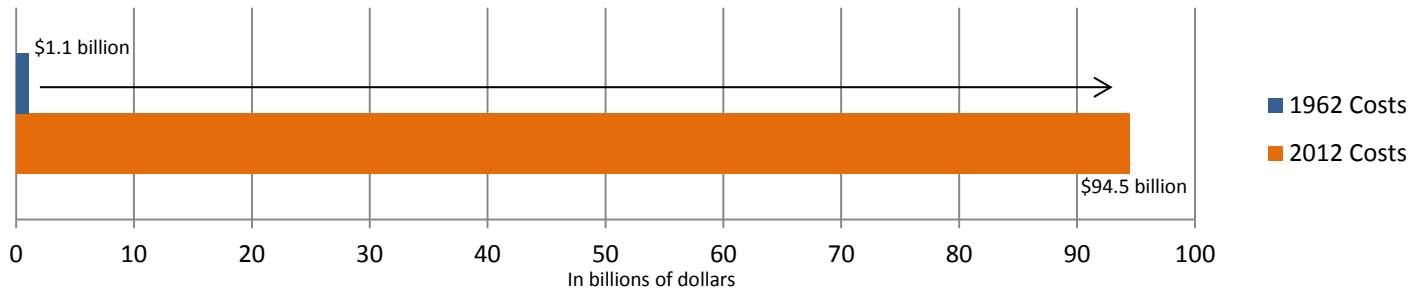
The State Children’s Health Insurance Program was established through the 1997 Balanced Budget Act under Title XXI of the Social Security Act. According to the language in the Balanced Budget Act of 1997, “The purpose of this title is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.”³² The program was intended to provide federal matching funds, allowing states to target low-income, uninsured children for health insurance. The law provided that SCHIP funds would be used by states to expand health insurance access for children by acquiring health coverage, providing necessary health care services, expanding Medicaid coverage, or a combination of the three. The program was extended through the Medicare, Medicaid, and SCHIP Extension Act of 2007 through March 2009. In 2009, the Children’s Health Insurance Program Reauthorization Act (CHIPRA) provided \$44 billion in funding through FY2013 for the program.³³ While the SCHIP was established through the Balanced Budget Act of 1997, the program was not fully operational in all states until 2000, and federal expenditures for the program in that year were \$1.9 billion.³⁴



Source: President Obama’s FY 2014 Budget, Historical Table 16

1962 vs. 2012 Other Health Care Program Outlays

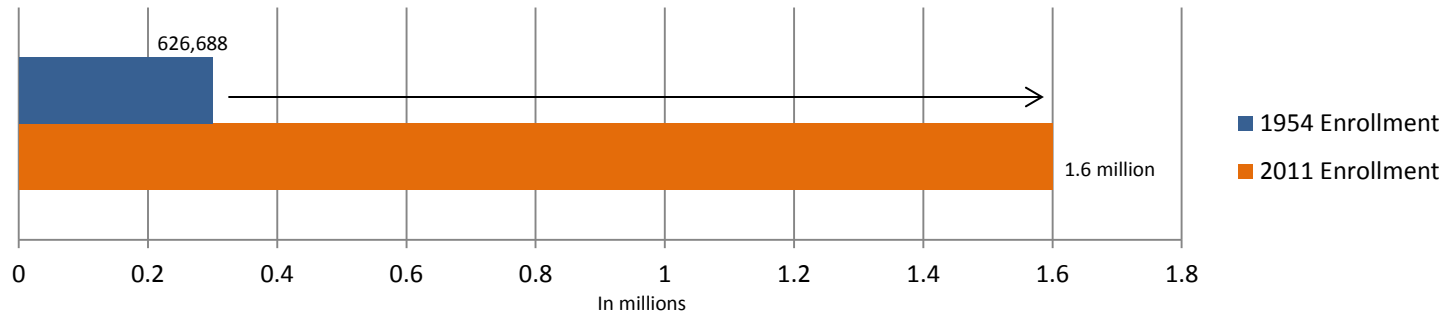
According to OMB, other health care programs outlays equaled cost \$94.5 billion in 2012, compared to \$1.1 billion in 1962. The program outlays increased by 8,490.9% in 50 years.



Source: President Obama's FY 2014 Budget, Historical Table 16

1954 vs. 2011 IHS Enrollment

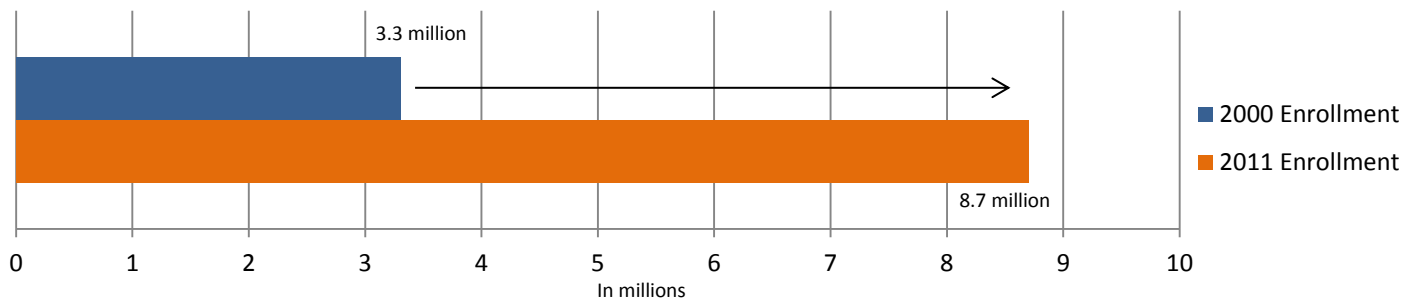
In 2011, enrollment in IHS was 1.6 million compared to 626,688 enrollees in 1977. Enrollment increased by 155.3% in 34 years.



Sources: IHS (endnotes 17, 18)

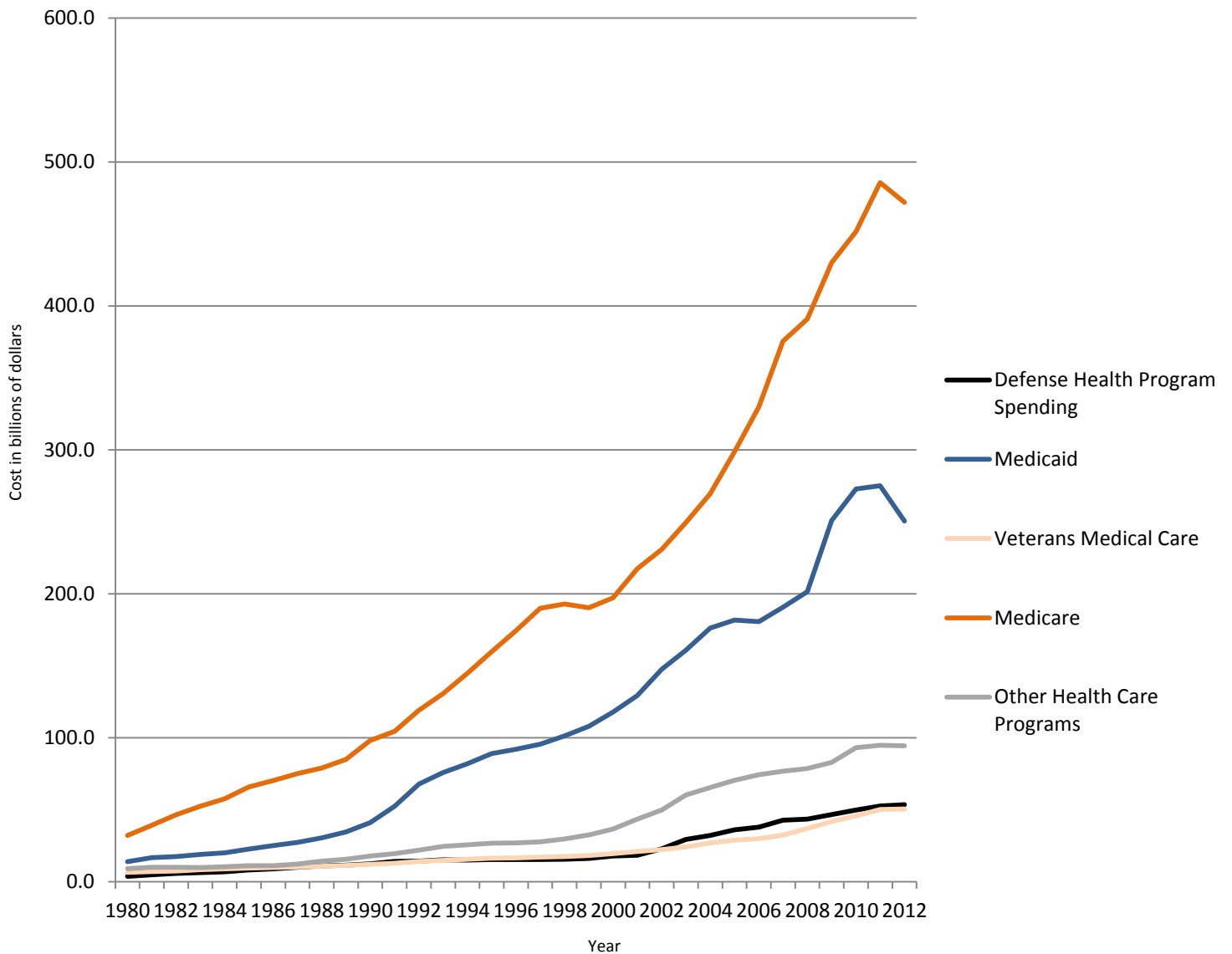
2000 vs. 2011 SCHIP Enrollment

In 2011, enrollment in SCHIP was 8.7 million compared to 3.3 million enrollees in 2000. Enrollment increased by 163.6% in 11 years.



Sources: HHS (endnotes 19, 20)

Spending on All Federal Health Care Programs for 1980-2012



Source: President Obama's FY 2014 Budget, Historical Table 16

Endnotes

- ¹ Appendix B: Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act, Congressional Budget Office, July 24, 2013, <http://www.cbo.gov/sites/default/files/cbofiles/attachments/45010-breakout-AppendixB.pdf>.
- ² "Historical Tables," Office of Management and Budget, The White House, <http://www.whitehouse.gov/omb/budget/Historicals>. Table 16.1.
- ³ "2012 Actuarial Report on the financial outlook for Medicaid," Department of Health and Human Services, <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/medicaid-actuarial-report-2012.pdf>.
- ⁴ "Fiscal Year 2013 Budget in Brief: Strengthening Health and Opportunity for All Americans," Department of Health and Human Services, <http://www.hhs.gov/budget/budget-brief-fy2013.pdf#page=71>.
- ⁵ Social Security Administration, History of SSA During the Johnson Administration 1963-1968, <http://www.ssa.gov/history/ssa/lbjmedicare3.html>
- ⁶ The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2011 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS, May 13, 2011; p. 9 [PDF p. 15] pdf
- ⁷ Social Security Administration, History of SSA During the Johnson Administration 1963-1968, <http://www.ssa.gov/history/ssa/lbjmedicare3.html>
- ⁸ The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2011 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS, May 13, 2011; p. 9 [PDF p. 15] pdf
- ⁹ CBO, Letter to the Honorable William "Bill" M. Thomas, Chairman, Committee on Ways and Means, November 14, 2003; p. 2 [PDF p. 2] <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/48xx/doc4807/11-14-medicareletter.pdf>
- ¹⁰ The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2011 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS, May 13, 2011; p. 9 [PDF p. 15] pdf
- ¹¹ Board of Trustees Federal Supplementary Medical Insurance Trust Fund, 1973 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund, July 16, 1973; p. 24 <http://www.docstoc.com/docs/116753881/Board-of-Trustees-Federal-Supplementary-Medical-Insurance-Trust-Fund-1973-Annual-Report>
- ¹² U.S. Renal Data System, USRDS 2010 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2010, p. 368 [PDF p. 2 or 16 20] http://www.usrds.org/2010/pdf/v2_11.pdf
- ¹³ GAO, DEFENSE HEALTH CARE Issues and Challenges Confronting Military Medicine, GAO/HEHS-95-104, March 22, 1995, p. 23 [PDF p. 25]
- ¹⁴ Office of Management and Budget, Fiscal Year 2013 BUDGET of the U.S. Government, pl. 271 [PDF p. 271] <http://www.whitehouse.gov/sites/default/files/omb/budget/fy2013/assets/mil.pdf>
- ¹⁵ CBO, *Future Medical Spending by the Department of Veterans Affairs*, Statement of Allison Percy, Principal Analyst, Testimony Before the Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, Committee on Veterans Affairs, U.S. House of Representatives, February 15, 2007; p. 3 [PDF p. 5]
- ¹⁶ Department of Veterans Affairs, *FY2013 Budget Submission, Medical Programs and Information Technology Programs*, Volume 2 of 4, February 2012 p. 1B-3 [PDF p. 37] http://www.va.gov/budget/docs/summary/Fy2013_Volume_II-Medical_Programs_Information_Technology.pdf
- ¹⁷ Selected Vital Statistics for Indian Health Service Areas And Service Units, 1972 to 1977; see Table 1.
- ¹⁸ Indian Health Service, User Population Report (HQ Summary) Three Year, Age Groups and Sex By Areas and Service Units of Residence, FY 2011 [Excel spreadsheet]. Rockville, MD: Indian Health Service, Congressional and Legislative Affairs Office, Line 1639 <http://www.docstoc.com/docs/116755011/IHS-FY-2011>
- ¹⁹ Mathematica Policy Research, Children's Health Insurance Program: An Evaluation (1997-2010), Interim Report to Congress, December 21, 2011, Table A.9 [PDF p. 177] <http://aspe.hhs.gov/health/reports/2012/CHIPRA-IRTC/index.pdf>
- ²⁰ FY 2013 Budget in Brief: Children's Health Insurance Program, US Department of Health and Human Service, p. 71 [PDF p. 76] <http://www.hhs.gov/budget/budget-brief-fy2013.pdf#page=77>
- ²¹ The Government Printing Office, SOCIAL SECURITY AMENDMENTS OF 1965, REPORT OF THE COMMITTEE ON WAYS AND MEANS ON H.R. 6675, March 29, 1965; p. 75 [PDF p. 81]
- ²² The Government Printing Office, SOCIAL SECURITY AMENDMENTS OF 1965, REPORT OF THE COMMITTEE ON FINANCE UNITED STATES SENATE TO ACCOMPANY H.R. 6675, June 30, 1965; p. 85 [PDF p. 2]
- ²³ Congressional Research Service, Health Care Fact Sheet: Original Medicare Cost Estimates, September 22, 1993; p. 2 [PDF p. 2] pdf
- ²⁴ Congressional Research Service, Health Care Fact Sheet: Original Medicare Cost Estimates, September 22, 1993; p. 2 [PDF p. 2] pdf

²⁵ Blagg, Christopher, American Journal of Kidney Disease, World Kidney Forum, The Early History of Dialysis for Chronic Renal Failure in the United States: A View From Seattle, Vol 49, No 3, March 2007; p. 492 [http://www.docstoc.com/docs/116753614/Blagg - Christopher--The-Early-History-of-Dialysis-for-Chronic-Renal-Failure](http://www.docstoc.com/docs/116753614/Blagg_-_Christopher--The-Early-History-of-Dialysis-for-Chronic-Renal-Failure)

²⁶ Board of Trustees Federal Supplementary Medical Insurance Trust Fund, 1973 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund, July 16, 1973; p. 24 http://www.docstoc.com/docs/116753881/Board-of-Trustees-Federal-Supplementary-Medical-Insurance-Trust-Fund_-1973-Annual-Report

Board of Trustees Federal Hospital Insurance Trust Fund, 1973 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund, July 16, 1973, p. 29 [PDF p. 11 of 18] <http://www.ssa.gov/history/reports/trust/1973/1973hos2.pdf>

²⁷ CBO, Letter to the Honorable William “Bill” M. Thomas, Chairman, Committee on Ways and Means, February 9, 2005, p. 3 [PDF p. 3] <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/60xx/doc6076/thomasltr2-9-05.pdf>

²⁸ U.S. General Accounting Office, DEFENSE HEALTH CARE Issues and Challenges Confronting Military Medicine, GAO/HEHS-95-104, March 22, 1995; p.9 [PDF p. 11] <http://archive.gao.gov/t2pbat1/153790.pdf>

²⁹ The history of providing veterans with modern health care services began in 1924 when Congress allowed World War I veterans access to hospital care. Prior to this service, veterans could only receive hospital care for treatment of conditions service-connected and incurred during wartime. In 1924, Congress granted hospital access to World War I veterans that had nonservice-connected ailments on a space-available basis. These recipients were also required to sign an oath of poverty. Later in 1943, Congress allowed World War II veterans with nonservice-connected ailments access to hospital care. Outpatient hospital care was added as a benefit for veterans; however, only those with service-connected conditions could participate. Congress then extended outpatient treatment for nonservice-connected conditions in 1960. Eligibility requirements were further loosened, and by 1973 all low-income veterans, with both service- and nonservice-related conditions, were granted care.

³⁰ West Group, UNITED STATES CODE CONGRESSIONAL AND ADMINISTRATIVE NEWS, 104th Congress-Second Session 1996. Volume 6, June 1997; p. 3596 [PDF p. 6].

³¹ Government Printing Office, INDIAN HEALTH CARE IMPROVEMENT ACT, REPORT OF THE COMMITTEE ON INTERIOR AND INSULAR AFFAIRS UNITED STATES SENATE together with ADDITIONAL VIEWS TO ACCOMPANY S. 522, May 13, 1975, p. 148 [PDF p. 153] <http://www.ihs.gov/adminmngrrsources/ihcia/documents/SRept94-133-IHCIA.pdf#page=153>

³² GPO, PUBLIC LAW 105–33, AUG. 5, 1997, p. 302 [PDF p. 302] <http://www.gpo.gov/fdsys/pkg/PLAW-105publ33/pdf/PLAW-105publ33.pdf>

³³ FY 2013 Budget in Brief: Children’s Health Insurance Program, US Department of Health and Human Service, p. 71 [PDF p. 76] <http://www.hhs.gov/budget/budget-brief-fy2013.pdf#page=77>

³⁴ Children’s Health Insurance: SCHIP Enrollment and Expenditure Information, Government Accounting Office, July 25, 2001, <http://www.gao.gov/assets/100/90787.pdf>.