Preface

As I began writing, President Obama had just signed into law a landmark healthcare reform bill; a feat several of his predecessors could not achieve, declaring "it will set into motion what a generation of Americans have fought for."

Healthcare reform was one of President Obama's campaign pledges and he tirelessly engaged key Republicans, reluctant Democrats, and the public at large in efforts to neutralize growing public skepticism in part fuelled by well-publicized *Tea Party* protesters opposed to the emerging healthcare bill. In the end, the House approved (219 yeas to 212 nays) the Senate's *Patient Protection and Affordable Care Act* bill (H.R. 3590) passed on Christmas Eve and the Reconciliation Act of 2010 (H.R. 4872) by 220 to 211, which had yet to be approved by the Senate. Both H.R. 3590 and H.R. 4872[*] passed without Republican support and 34 so called *Blue Dog Democrats*[**] voted against H.R. 3590, and 33 voted against H.R. 4872. Passage especially of H.R. 3590 was credited to the stewardship of Speaker Nancy Pelosi (D-CA). Her political *savoir-faire* might "change some of the ways that we look at effective speakers… under incredibly difficult circumstances," according to former House historian Ray Smock.[1] Her victory culminated a yearlong acrimonious debate in both the House and the Senate over substantive and ideological issues raised mostly by pro-lifers and fiscally conservative lawmakers. Credit also went to Senate Majority Leader Harry Reid (D-NV) who, after much cajoling and concessions to reluctant colleagues, including Senator Ben Nelson (D-NE) securing the 60th Senate vote needed to prevent a Republican filibuster and ensure advancing the process to the reconciliation of the House and Senate bills.[2] However, the upset victory of Republican Scott Brown in a special election to the seat vacated by the death of Senator Ted Kennedy (D-MA), held a month later reshaped the political landscape requiring a new Democratic strategy. It consisted of resorting to the *self-executing rule* a.k.a. *deem and pass* a parliamentary maneuver whereby House approval of a Senate package of fixes to the Senate bill would signify lawmakers deem the final bill passed. This maneuver has been used frequently before but never to force approval of such a massive, consequential, and controversial piece of social legislation, as pointed out by the bill's opponents. For historical perspective, it should be noted that the socially impacting Social Security Act passed in 1935 with strong bipartisan House and Senate support (371 to 32 and 77 to 6 votes, respectively).[3] Likewise, 30 years later the Medicare Act passed the House and Senate with strong bipartisan majorities (307 to 116 and 70 to 24, respectively).[4]

Undoubtedly, reducing U.S. healthcare costs, which doubled between 1996 and 2006 reaching 17.3% of Gross Domestic Product (GDP) in 2009 and stands as the highest among developed nations,[5] is a desirable goal for it swells the massive federal budget deficit despite excluding 35.9 million Americans in 2008.[6] Hence, the dual goal of ACA: to extend health coverage to all Americans and curb health costs. To this effect, the Congressional Budget Office (CBO) and the Joint committee on Taxation (JCT) estimated that by 2019,

> "The combined effect of enacting H.R. 3590 and the reconciliation proposal [H.R. 4872] would be to reduce the… uninsured by about 32 million…

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[*] Jointly referred to as Affordable Care Act (ACA).

[**] A group of 25 fiscally conservative House Democrats that form the Blue Dog Coalition.

> [Increasing insurance coverage] from about 83 percent [of Americans] currently to about 94 percent… and would produce a net reduction in federal deficits of $143 billion over the 2010–2019 period."[7]

Such encouraging figures seem to vindicate our legislators' wisdom. However, they are estimates based on interdependent assumptions and long-term projections that will likely prove inaccurate. For instance, the 32 million uninsured Americans expected to be covered by the bill is predicated on expectations that most will purchase insurance encouraged by government subsidies and penalties to those unforthcoming, and on projected additional enrollees in both Medicaid and the Children's Health Insurance Program (CHIP). Likewise, projected costs of subsidies provided through insurance exchanges, increased net outlays for Medicaid and CHIP, and tax credits for small employers are to be offset by revenues from an array of still undetermined new taxes on *Cadillac health plans*,* dividend, interest, and high-earners' income. The bills also include "various other changes to the federal tax code, Medicare, Medicaid, and other programs."[8]

Implementation of all the law's mandates and directives in a timely manner is unlikely given political vagaries and CBO's projected deficit reduction will be wide off the mark because industry-wide pricing power remains unaffected. Moreover, minor deviations from initial assumptions can lead to massively different long-term outcomes; a phenomenon called the *theory of chaos*[9] or the *butterfly effect*[**10] well known to mathematicians and weather forecasters. Long-term projections contingent on human behavior are notoriously vulnerable to the chaos theory, especially when the behavior involved is policy-makers'. For instance, not expecting major fiscal policy changes and American involvement in two wars that reversed balanced budgets achieved during President Clinton's second term in office CBO projected continuous budget surpluses after 2001 reaching $ 5.6 trillion by 2011. On another front, let us not forget that in 1969 advocates of a national cancer program expected a cure of cancer by the country's 200th birthday. Yet, four decades later overall cancer incidence, survival, and mortality rates remain essentially unchanged and its cure a distant goal.[11] Likewise, the war on drugs launched in 1973 by President Nixon to curb drug use and reduce crime has achieved neither. Nearly four decades and $ 1 trillion later, "drug policy dictates the arrest, prosecution, and incarceration of mostly petty offenders that clutter courts, overcrowd prisons, and divert resources," drugs are more plentiful and cheaper that ever, and crime fostered by the drug trade keeps rising.[12]

Efforts to provide health insurance to all Americans date back to Theodore Roosevelt's nomination acceptance speech before the 1912 Progressive Party Convention where he declared,

> "The human wreckage due to wear and tear, and the hazards of sickness, accident, invalidism, involuntary unemployment, and old age should be provided for through insurance. This should be made a charge in whole or in part upon the industries, the employer, the employee, and perhaps the people at large."[13]

Nearly a century later and many failed attempts by subsequent presidents, the U.S. healthcare system is a disjointed amalgam shaped by circumstances and by multiple

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* High-premium insurance plans.

** Technically called *sensitive dependence on initial conditions*.

pieces of legislation over many years, each nuanced by influential constituents and powerful interest groups. Is it likely that the current healthcare bill will achieve president Obama's dual goals of providing universal healthcare and curb escalating costs? The answer is obvious particularly because the bill fails to address the real root-causes of the runaway healthcare costs and the dogged determination of opponents not to see it through. By lacking vision and surrendering to lobbyists' pressure, our legislators continue business as usual, perpetuating the status quo where interests of a few prevail over the needs of the majority. Hailed by proponents as being on a par with the Social Security Act and denounced by opponents as a Frankenstein bill, its passage was portrayed as *the end of the beginning* by Republicans who vouched to repeal it and attorneys general of 14 Republican states who challenged its constitutionality in the courts within minutes of the White House signing ceremony.[14]

Unlike politically correct books that shun controversial issues, this book offers an objective, factual, and forthright critique of all wanted segments of the US' current and projected health system under ACA. It shows that responsibility for the inequitable and costly health system rests on caregivers and consumers, insurance and drug companies, malpractice attorneys, and even policy makers whose self-interest must be subordinated to the general good. Only then will it be possible to curb the profit-driven health industry they helped create and to endow America with an affordable and equitable universal health system that is responsive to its citizens' healthcare needs, while remaining even-handed to providers and suppliers. In the last chapter, I propose specific steps that would help us reach that goal.

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