Introduction to U.S. Health Policy

The Organization, Financing, and Delivery of Health Care in America

THIRD EDITION

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CHAPTER 1

The Affordable Care Act and the Politics of Health Care Reform

The headlines in March 2010 just about said it all. On March 22, a *New York Times* editorial declared, "Health Care Reform, at Last." Two days later, the *New England Journal of Medicine* announced, "Historic Passage—Reform at Last" (Iglehart 2010b). President Barack Obama had signed the Patient Protection and Affordable Care Act (ACA)—the most significant reform of our health care system since the 1965 enactment of Medicare and Medicaid under President Lyndon Johnson. After what Bruce Vladeck, administrator of the Health Care Financing Administration under President Bill Clinton, characterized as "the epochal, exhausting, and contentious task of enacting comprehensive health care reform" (Vladeck 2010, p. 1955), the tumultuous process that had begun more than a year before with the release of President Obama's first federal budget proposal had finally come to a conclusion.

The passage of reform legislation over the unanimous and strident opposition of congressional Republicans was assuredly a major step in the evolution of health care in America. Unless it somehow is repealed or substantially altered, ACA will extend publicly funded health insurance coverage to millions of formerly uninsured adults whose income falls near or below the federal poverty line (FPL). ACA will also make reasonably affordable health insurance available to millions more Americans who are not poor, yet who previously could not afford the cost of acquiring health insurance in the private marketplace.

As it moved through Congress, the proposed health care reform legislation exposed deep divisions among politicians and within the U.S. population over core issues of health policy. Do Americans have a right to health care? What should the role of government be in financing or regulating health care and health insurance? To what extent

should we rely on the private marketplace as the source of health insurance? How much should government pay for health care? Perhaps even more important, how much can the government *afford to pay* for health care?

The passage of ACA did not provide definitive answers to these questions. We may well be discussing and debating them again in the not-too-distant future. In light of the likelihood of this ongoing discussion and debate, it is appropriate to look more closely at the process by which Congress and the president enacted the reforms included in ACA and then to place that reform process in the considerably broader context of the history of health care reform efforts in the United States.

HEALTH CARE REFORM AND THE 2008 PRESIDENTIAL ELECTION

The presidential election scheduled for November 4, 2008, began in earnest with the primary elections in January and February of that year. Before the first vote was cast, health care reform was an important issue in the minds of most voters. A series of public opinion polls conducted between 1994 (the year the Clinton health reform proposals collapsed) and 2007 showed that "about 90% of Americans were fairly consistent in agreeing that the U.S. health care system should be completely rebuilt or required fundamental changes" (Jacobs 2008, p. 1881).

In January 2008, Robert Blendon and his colleagues published the results of a series of opinion surveys of likely primary voters from thirty-five states with early presidential primaries (Blendon et al. 2008b). They found widespread awareness of problems inherent to health care in the United States among both Republicans and Democrats. While Republicans and Democrats were in general agreement on the need to enact some type of health care reform, however, they were divided on what the reform should look like. Among Democrats, 65 percent favored providing health insurance to "all or nearly all of the uninsured" and were willing to accept substantially increased government spending to accomplish this goal. By contrast, 42 percent of Republicans supported extending coverage "to only some of the uninsured," with an additional 27 percent preferring "keeping things basically as they are now" (Blendon et al. 2008b, p. 420). Before the first vote was cast in the presidential primaries, our country was divided largely along political party lines as to how we should address health care reform.

In November 2008, Blendon and colleagues reported a second series of opinion polls, this time comparing those who had voted for John McCain in the primary with those who had voted for Barack Obama (Blendon et al. 2008a). Consistent with the earlier polls, most Obama voters wanted the government to take responsibility for extending health insurance to the uninsured, while McCain voters were of the view that responsibility for acquiring health insurance should rest with the individual con-

sumer. Obama voters favored a larger, more comprehensive reform plan, while McCain voters favored a more limited, smaller-scale approach. Before President Obama was to take office, a substantial polarization of views between Democrats and Republicans was already in place.

Shortly after his inauguration, President Obama released his first budget proposal. In it he called on Congress to work collaboratively with the White House to design major reform of the health care system. It was clear, though, that Obama had learned the lesson of the failed Clinton reform proposals of 1993–94, which I describe in Chapter 5. Rather than defining the specifics of the reform proposals himself, President Obama wanted Congress to take the lead in developing reform legislation.

Within a few months of Obama's budget message, Congress had begun to work on reform legislation. The process of developing the actual legislation fell to five separate congressional committees: two in the Senate and three in the House of Representatives. A consensus began to emerge that the most promising approach to expanding health insurance coverage would be through requiring all U.S. residents to carry health insurance (individual mandate) while also requiring most U.S. employers to offer health insurance to their employees (employer mandate). This approach mirrored reforms that had been adopted in Massachusetts a few years earlier.

It did not take long in this process for the political divide evident in pre-election polls to resurface. Mandating health insurance coverage would require creating a place for individuals and employers to go to acquire coverage. As part of its mandate program, Massachusetts had created a central clearinghouse to connect insurance companies offering coverage options with individuals or employers seeking coverage. Fairly quickly, leaders of the Senate committees dealing with reform agreed to adopt a model similar to that in Massachusetts. They would establish health insurance "exchanges" through which those seeking insurance could select from among the insurance options various companies had available.

As chair of the Senate Finance Committee, Senator Max Baucus (D-Montana) initially proposed that among the insurance options available through these health insurance exchanges would be a "public option," an insurance plan analogous to Medicare, organized and administered by the federal government. Almost immediately, Senate Republicans condemned the public option approach. Senator John Cornyn (R-Texas) criticized the public option approach as "a Washington-directed unfair-competition plan" (quoted in Iglehart 2009a, p. 2386). Senator Charles Grassley (R-Iowa) argued that the Democrats' approach "would cause us to slide rapidly down the slope towards increasing government control of health care" (Grassley 2009, p. 2397).

President Obama countered these criticisms in a *New York Times* Op-Ed. He argued that the Democrats' plan "is not about putting the government in charge of your health

insurance. I don't believe anyone should be in charge of your health care decisions but you and your doctor—not government, not bureaucrats, not insurance companies" (Obama 2009b).

With substantial majorities in both houses of Congress, Democratic leaders pushed for a comprehensive expansion of the existing health insurance system to include most of those who were without insurance. The federal government would take principal responsibility for organizing and financing this expansion. Republicans, on the other hand, with substantial support from the health insurance industry, argued for a more limited approach. As described by Karen Ignagni, CEO of America's Health Insurance Plans (a leading industry group), Congress should instead focus on "building on the strengths of the present public-private health care system rather than replacing it" (Ignagni 2009, p. 1134).

By the fall of 2009, the debate over health care reform had hit an impasse. There was a line drawn in the congressional sand separating Democrats from Republicans. It appeared there was no room for compromise—Democrats would not accept the approach supported by Republicans, and Republicans were equally unwilling to consider seriously the Democrats' proposals. It seemed to many that, once again, health care reform might end in failure.

At this point, President Obama chose to take decisive action, addressing a joint session of Congress in front of a prime-time viewing audience. Chiding both sides of the aisle for their impasse, Obama stated, "now is the season for action." He indicated that, from that point on, he was going to assert his leadership in the effort to enact health care reform. He identified three overarching goals for the reform effort: (1) expanding health insurance coverage to those who lacked it, (2) constraining the rising cost of health care, and (3) improving the security of coverage for those with chronic illness (Obama 2009a).

With a great deal of political maneuvering, carried out in the face of substantial public confusion, each house of Congress enacted health care reform legislation: the House of Representatives on November 7 and the Senate on December 24. While each bill had many things in common, each had unique features. Some form of compromise between the two versions would need to be agreed upon. Usually this process would involve the creation of a House-Senate Conference Committee, made up of members of both houses. The compromise struck by the Conference Committee would then be taken back for final approval in each house before being forwarded to the president for his signature.

This process turned out not to be an option, though. Senator Ted Kennedy of Massachusetts, a leader of Senate Democrats and for more than four decades a leading voice in the U.S. Senate for health care reform, died of cancer. A special election in Massachusetts to fill his seat resulted in a Republican being elected, thereby giving

the Republicans the forty-one votes needed to mount and sustain a filibuster in the Senate. With unanimous Republican opposition to passage of any health reform bill approved by Democrats, there was no chance for compromise legislation coming out of a House-Senate Conference Committee to gain passage in the Senate. Nor was there any chance the Senate would simply approve the reform bill passed previously by the House. There was only one option open to the Democrats: for the House of Representatives to approve the bill passed by the Senate, even though the Senate bill had several provisions to which House Democrats were opposed. Following House passage of the Senate bill, however, the House and Senate could then agree on a series of modifications to the bill under a special provision referred to as "reconciliation."

Not being a scholar of the intricacies of the legislative process, I will leave it to others to describe in more detail the history, purpose, and intended use of the reconciliation process in Congress (Herszenhorn 2010; Iglehart 2010a). As I understand it, the reconciliation process was established by Congress in 1974 as a simplified means of changing federal programs or policies to align them more closely with previously established budget policy. If legislation is passed that is inconsistent with the budget guidelines set by Congress, or, similarly, if an existing program is inconsistent with those guidelines, Congress can change the programs or policies to align them with the budget. Making these changes under the reconciliation process requires a simple majority vote in both houses of Congress—and therefore is not subject to a filibuster in the Senate.

Congress had previously used the budget reconciliation process at various times and for various purposes. One of the best-known instances of reconciliation is the Consolidated Omnibus Budget Reconciliation Act, passed by Congress in 1986 and best known by its acronym, COBRA. COBRA gives employees who have lost their jobs the right to continue their previous group health coverage for a period of time. People frequently talk of their "COBRA benefits."

Sensing a potential procedural impasse, on February 25 President Obama convened an urgent summit meeting of leading Democrats and Republicans to discuss, and in front of a national television audience to debate, competing perspectives on health care reform. The political impasse that preceded Obama's summit was still there after it was over. All Republicans in Congress remained opposed to the bills that had been passed by the House and the Senate. President Obama and Democratic leaders had no choice but to invoke the budget reconciliation process. In an all-day session on Sunday, March 21, the House approved the health reform bill previously passed in December by the Senate, and on March 23 President Obama signed it into law. Then, on March 25, both the House and the Senate passed, by simple majority vote, the reconciliation bill that made a series of changes to the original bill that bridged the divisions between the original House and Senate bills. In essence, the reconciliation process replicated what the House-Senate Conference Committee process is intended to do: to find a middle

ground between similar bills passed in the House and the Senate, and then to gain final approval of both houses of the compromise bill.

As Congress completed passage of ACA, the rhetoric on both sides made clear the continued deep divisions between Democrats and Republicans over how health care in the United States should be organized and financed, and the role government should play in the health care system. On the day he signed ACA, President Obama hailed the historic step that had been taken: "Today, after almost a century of trying . . . health insurance reform becomes law in the United States of America . . . We have now just enshrined the core principle that everybody should have some basic security when it comes to their health care" (Obama 2010).

Republicans were not so sanguine. Representative Marsha Blackburn (R-Tennessee), following the House vote in favor of the ACA legislation, remarked, "Freedom dies a little bit today" (quoted in Hulse 2010). Carl Hulse, reporting on the House's approval of ACA, reported that "Republicans were outraged, characterizing the legislation as a major step toward socialism and an aggressive government takeover of the health care system" (Hulse 2010). These comments echoed those made a few months earlier by Representative Michele Bachmann (R-Minnesota), that Democrats were pushing for "socialized medicine" and a "government takeover" of the American health care system (quoted in Herszenhorn 2009).

This continued polarization over what ACA represented for the United States—a new "core principle" assuring access to health care, or a "government takeover" and a step closer to "socialized medicine"—remained in the wake of the year-long health care reform process. It would be easy to point to President Obama and the political parties in Congress as the source of this polarization. It is fundamental to our understanding of U.S. health care reform, however, to consider, again, what President Obama said when he signed the ACA: "Today, after almost a century of trying . . . health insurance reform becomes law in the United States of America."

The health care reform process did not begin with the inauguration of President Obama. Nor did it begin with the presidential campaign leading up to his election. The United States had been arguing over health care reform for nearly a century before President Obama was elected. A review of the repeated efforts over that century for or against reform reveals a striking similarity between what was proposed in 2009–10 and what had been proposed previously, as well as a striking similarity between the rhetoric of health care reform in the past and the rhetoric of 2009–10.

A CENTURY OF TRYING TO ACHIEVE HEALTH CARE REFORM IN THE UNITED STATES

Theodore Roosevelt first attempted to reform U.S. health care during his presidential campaign in 1912. As part of the Progressive Party's platform, Roosevelt proposed a

system of national health insurance, modeled after the German system, to be administered by a new National Health Department. Those supporting national health insurance viewed health care as a right of all members of our society, analogous to the recently recognized right to a publicly financed education for children. Teddy Roosevelt lost the 1912 presidential election to Woodrow Wilson, however, and health care reform had to wait for another day.

In 1927, a group of physicians, public health professionals, and others concerned with national health care issues came together to form the Committee on the Costs of Medical Care (CCMC) (Ross 2002). CCMC was an independent group, and was supported by a number of foundations. Committee members set in motion a five-year project to study and report on the economics and organization of health care in America. On March 10, 1931, the *New York Times* carried an article entitled "Family Health Bill Put at $250 a Year" in which the CCMC was cited, stating that "the average family of five in an American city" spent $250 per year on medical care, a figure that raised serious concerns about the rising costs of medical care in a time of economic hardship. The committee's majority report, issued in 1932, recommended shifting the delivery of most medical care to a model that emphasized organized medical groups and prepayment of health costs through either insurance premiums or taxation. The American Medical Association (AMA), however, was stridently opposed to this approach, labeling such prepaid medical groups "medical soviets" and suggesting that "such plans will mean the destruction of private practice . . . they are, in a word, 'unethical'" (American Medical Association 1932, p. 1950). The AMA's House of Delegates unanimously approved a motion to oppose the majority report of the CCMC, and to mount "an intensive campaign . . . among the medical profession and the public" to prevent adoption of the CCMC's recommendations. A follow-up report to the House of Delegates reported that "all the facilities of the American Medical Association have been used to oppose this trend and the propaganda in support of it" (American Medical Association 1934b, p. 2200). The AMA prevailed in its efforts to block the recommendations of the CCMC's report, and the report was shelved.

Franklin Roosevelt took up the issue of health care reform in 1934 as part of his initial proposals for old age security and unemployment insurance for workers. In response to Roosevelt's early proposals to include national health insurance as part of Social Security, the AMA House of Delegates passed a resolution reiterating its position that "All features of medical service in any method of medical practice should be under the control of the medical profession. No other body or individual is legally or educationally equipped to exercise such control" (American Medical Association 1934b, p. 2200). When it appeared as though health insurance might be added to the pending legislation for creation of the Social Security system, the AMA House of Delegates met in special session to reiterate its "opposition to all forms of state medicine"

and to "reaffirm its opposition to all forms of compulsory sickness insurance" (American Medical Association 1935, pp. 750–51). Once again AMA opposition to government involvement in health care was effective, and when Roosevelt signed the Social Security Act in 1935, health insurance was not part of it.

Roosevelt continued to support the creation of a system of national health insurance, and appointed an "Interdepartmental Committee to Coordinate Health and Welfare Activities," charging it with studying the issue of extending Social Security benefits to include health care. At a national conference held in July 1938, the committee proposed a series of changes to U.S. health care, including "a ten year program providing for the expansion of the nation's hospital facilities" and "a comprehensive program designed to increase and improve medical services for the entire population" (Interdepartmental Committee to Coordinate Health and Welfare Activities 1938, p. 433).

One month later, the AMA convened an emergency meeting of its House of Delegates to respond to the government's "campaign for some radical changes in medical practice" (American Medical Association 1938, p. 1192). The speaker of the House of Delegates reminded the delegates that the AMA had consistently "opposed legislation which would have the effect of vesting in some governmental agency power to enforce its decrees on patients and doctors" (p. 1192). The AMA president then addressed the delegates, stating that "the Association has constantly opposed the adoption of any form of state medicine by any definition of that term" (p. 1194).

It is interesting to note that at this special session, the leaders of the National Medical Association (NMA)—the national association of black physicians, most of whom were prevented from joining the AMA because of their race—were (after majority vote of the AMA delegates) invited to address the meeting. The past president of the NMA voiced his support for the position of the AMA, arguing that "if we have socialized medicine in America, I am very sure, as you must be sure, that the standards of medical practice will degenerate . . . and the patients again will suffer as they have suffered in Europe" (p. 1211).

Once again, fears that "governmental agency power" over the financing of health care would lead to "state medicine" and "socialized Medicine" were sufficient to derail Roosevelt's efforts. Health care reform would have to wait another decade before it was back on the table.

In January 1948, President Harry Truman asked Oscar Ewing, one of his senior administrators, to prepare a report on the status of health care in the United States. Released in September of that year, the Ewing Report outlined a series of steps the federal government should take to make health care more available. As Roosevelt's Interdepartmental Committee did in 1938, this report recommended extensive new hospital construction and a compulsory "system of Government prepayment health insurance" (Furman 1948) that over a period of three years would provide universal

insurance for both hospital care and physician care, as well as coverage of certain prescription medicines.

The response of the AMA to the Ewing proposals is interesting. The AMA first went through a formal procedure to adopt the following definition: "*Socialized medicine*—Socialized medicine is a system of medical administration by which the government promises or attempts to provide for the medical needs of the entire population or a large part thereof" (American Medical Association 1948, p. 685). A few weeks later, Morris Fishbein, the longtime editor of the *Journal of the American Medical Association*, published a special editorial in which he warned physicians that the profession of medicine was "at a point of decision which may well determine the nature and the freedom of medical practice for many years in the future" (Fishbein 1948, p. 1254). Responding to politicians who denied that President Truman's proposals for national health insurance constituted "socialized medicine," Dr. Fishbein argued that "nations that embark on such programs move inevitably into a socialized state in which . . . practically all public services become nationalized, private responsibility and ownership disappear, individual initiative is destroyed and the result is a socialized state" (p. 1256). As reported by the *New York Times*, the AMA fought Truman's proposals "with all the vigor and manpower it [could] assemble" (Phillips 1949), with the result that, once again, the efforts at health care reform went down to defeat in Congress.

It would be seventeen years before Congress would take up health care reform again, this time under the leadership of President Johnson. With large majorities in both houses of Congress following the 1964 election, Johnson moved quickly to enact Medicare (health care for the elderly) and Medicaid (health care for the poor) as amendments to the Social Security system. Headlines in the *New York Times* announced, "A.M.A. Opens Bid to Kill Medicare" (Wehrwein 1965). Testifying before the Senate Finance Committee, Dr. Donovan Ward, president of the AMA, warned senators, "This may be your last chance to weigh the consequences of taking the first step toward establishment of socialized medicine in the United States" (American Medical Association 1965, p. 16).

In 1965, Congress was not swayed by claims that government financing of health care for the elderly and the poor constituted a government takeover of the health care system. It was swayed even less by claims that the proposed Medicare and Medicaid programs would be "the first step toward establishment of socialized medicine in the United States." By substantial margins, both houses of Congress passed the Social Security Act of 1965, establishing the Medicare and Medicaid programs. President Johnson flew to the Missouri home of Harry Truman to sign the legislation in the presence of the former president.

Of course, providing government payment for health care for the elderly and the poor was only a partial fulfillment of earlier proposals for universal health insurance.

As monumental an accomplishment as it represented, the passage of Medicare and Medicaid left substantial segments of the American population without the means to pay for health insurance. As we will see in later chapters, the aggregate cost of health care began to rise sharply in the years following the enactment of Medicare and Medicaid. By 1970, both President Richard Nixon and Senator Ted Kennedy were calling for expanded health insurance coverage to help individuals and families offset the rising costs of care. Nixon's plan called for private financing through what we today would call an employer mandate. Kennedy's plan called for direct government financing of care. Neither plan gained approval, and any further steps toward health care reform were lost in the wake of the Watergate scandal and President Nixon's resulting resignation.

Health care reform was again on the table in the early years of President Clinton's administration, as I discuss in Chapter 5. An effective national ad campaign by the health insurance industry, warning of a new, massive federal bureaucracy taking over American health care, coupled with a shift of congressional control from Democrat to Republican majorities, led to the defeat of the Clinton reform proposals. As many had warned, in the years following the defeat of the Clinton proposals health care costs continued their steep rise, and growing numbers of Americans became or remained uninsured against the cost of illness or injury—the situation confronting the candidates in the 2008 presidential election.

PLACING THE OBAMA REFORMS IN THE HISTORICAL CONTEXT OF PREVIOUS REFORM EFFORTS

During the intensity of the yearlong debate over President Obama's proposals for health care reform, it was often difficult to gain a clear sense of what the core issues were. The heated rhetoric from all sides led to widespread confusion as to what the proposed reforms would or would not accomplish. A national poll (Kaiser Family Foundation 2010b) taken two weeks after President Obama signed ACA showed that 55 percent of respondents were confused about what was in the new law. Support for the law fell largely along party lines, with 79 percent of Republicans having an unfavorable view of the law and 77 percent of Democrats having a favorable view.

Which view was correct? Would the law assure most Americans access to needed health care, as many people seemed to believe? Or would it mean the potential destruction of our health care system through a government takeover, as many others appeared to believe?

Taking a step back from this debate, it is informative to compare ACA and the political response to it with various proposals for health care reform made over the last century. As illustrated in Table 1.1, there is a remarkable similarity between what ACA was intended to accomplish and what earlier proposals hoped to accomplish, and an

Table 1.1. A History of Arguments for and against Health Care Reform

Year/President	Argument in Favor	Argument Opposed
1931 / Herbert Hoover	Modern medicine can be brought within reach of persons of average means. —Committee on the Cost of Medical Care	Medical soviets . . . such plans will mean the destruction of private practice. —American Medical Association
1934–38 / Franklin Roosevelt	A comprehensive program designed to increase and improve medical services for the entire population. —Committee to Coordinate Health and Welfare Activities	Opposition to all forms of state medicine. —American Medical Association If we have socialized medicine in America . . . standards of medical practice will degenerate . . . and patients will suffer. —National Medical Association
1948 / Harry Truman	A system of Government prepayment health insurance to provide universal access to hospital and physician care. —Ewing Report	Nations that embark on such programs move inevitably into a socialized state in which . . . practically all public services become nationalized. —American Medical Association
1965 / Lyndon Johnson	To improve health care for the American people, [I propose] hospital insurance for the aged under social security. —President Johnson, 1965 budget message to Congress	The President's proposal would be the first step toward establishment of socialized medicine in the United States. —American Medical Association
1993 / Bill Clinton	We must make this our most urgent priority: giving every American health security, health care that can never be taken away. —President Clinton, special address to Congress, September 1993	New government bureaucracies will cap how much the country can spend on all health care. —"Harry and Louise" TV ads, sponsored by the Health Insurance Association of America
2010 / Barack Obama	We have now just enshrined the core principle that everybody should have some basic security when it comes to their health care. —President Obama, on signing the health reform law	A major step toward socialism and an aggressive government takeover of the health care system. —Congressional Republicans

equally striking similarity between the rhetorical opposition to ACA and the rhetoric in opposition to those earlier proposals.

In 1931, when the Committee on the Cost of Medical Care recommended programs to bring health care "within reach of persons of average means," the opposition predicted that the programs would "mean the destruction of private practice." When Franklin Roosevelt proposed "to increase and improve medical services for the entire population," the AMA labeled his proposals "socialized medicine" and predicted that, if Roosevelt's plan were implemented, "standards of medical practice will degenerate . . . and patients will suffer." Truman's proposal for "universal access to hospital and

physician care" was predicted to lead to "a socialized state in which . . . practically all public services become nationalized." Johnson's proposal for Medicare and Medicaid would, the AMA predicted, "be the first step toward establishment of socialized medicine in the United States." President Obama's proposals were characterized by many Republicans as "a major step toward socialism and an aggressive government takeover of the health care system."

The history of health care reform in the United States is the history of our deep-seated divisions over core principles of health care delivery and of the role of government in the provision of health care. Is a basic level of health care a right of all Americans? If so, should the government enact and enforce the mechanism to ensure that right? Alternatively, is it inappropriate for government to interfere in the private provision of health services? Our society has struggled with these issues for a century. The kerfuffle surrounding the passage of ACA was simply the latest episode in our attempts as a society to address these divisions.

Despite the confusion surrounding it, it is clear that ACA will bring major change to our health care system. Among other things, it will:

- Extend Medicaid coverage to an estimated 16 million people living in or near poverty who are currently uninsured
- Provide health insurance to an additional 16 million uninsured people with low to moderate incomes through a combination of regulated insurance exchanges and tax subsidies for the cost of insurance
- Make a series of changes to regulations affecting companies that provide health insurance with the intent of making that insurance more affordable
- Make a series of changes in the Medicare program to reduce costs and improve benefits
- Create a series of new sources of tax revenues to support these programs

When Congress passed Medicare and Medicaid in 1965, our health care system was changed fundamentally. Yet those changes stopped short of solving many of the policy issues at the heart of our health care system. Nor did the passage of Medicare and Medicaid resolve our national ambivalence over what the role of government should be in our health care system.

When Congress passed ACA in 2010, our health care system was again changed fundamentally. Yet Congress again left unaddressed many continuing core questions. In future years and in future Congresses we will undoubtedly again be talking about health care reform. Rather than debating how to extend coverage to the uninsured, we likely will be debating how to rein in the incessantly rising cost of health care. When we have these discussions, the appropriate role of government will again be a topic of sharp debate.

Rather than trying to describe in one place what the ACA does and does not do, I instead address the changes contained in the 2,000-plus-page ACA legislation sequentially as we go through this book. In the following chapters I address issues of the cost, quality, and availability of health care; the cultural factors unique to the United States that surround health care; the professional organization of health care; the various private and public mechanisms for financing health care; and specific health care issues such as pharmaceutical policy and long-term care. In each chapter I describe how these aspects of health care have evolved to what they are now. I then address specifically how the new policies enacted by ACA will affect or change the topic under discussion. At the end of the book I address what ACA has left undone—the problems in the organization, financing, and delivery of American health care that have yet to be resolved. Finally, as an appendix to the book, I provide a comprehensive listing of the various components contained in ACA.