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Marilyn Moon

Urban Institute, Health Policy Center

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Policy Brief

Sixth Annual
Herbert Lourie Memorial Lecture on Health Policy

The Rhetoric and the Reality of Health Care Reform Legislation

Marilyn Moon

No. 4/1995

Marilyn Moon, Ph.D., is a senior fellow with the Health Policy Center of the Urban Institute. She has written extensively on health policy, policy for the elderly, and income distribution. Her most recent book, *Medicare Now and in the Future*, was published by the Urban Institute Press in 1993. She was recently appointed one of two public trustees for the Social Security Administration.

The **Herbert Lourie Memorial Lecture on Health Policy**, sponsored by the Maxwell School of Citizenship and Public Affairs of Syracuse University and the Central New York Community Foundation, Inc., honors the memory of Herbert Lourie, M.D. Generous contributions from his family, friends, colleagues and former patients have endowed this series. Past lecturers include John K. Iglehart (1993); Arnold S. Relman, M.D. (1992); Bruce C. Vladeck, Ph.D. (1991); Uwe E. Reinhardt, Ph.D. (1990); and Fred Frohock, Ph.D., Peter Black, M.D., and Daniel Callahan, Ph.D. (symposium 1989).

The Policy Brief series is a collection of essays on current public policy issues in aging, health, income security, metropolitan studies and related research done by or on behalf of the Center for Policy Research at the Maxwell School of Citizenship and Public Affairs.

Single copies of this publication may be obtained at no cost from the Center for Policy Research, Maxwell School, 426 Eggers Hall, Syracuse, NY 13244-1090.

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The Rhetoric and the Reality of Health Care Reform Legislation

Marilyn Moon

A plethora of political autopsies have been performed on the Clinton Administration's failed health care reform of 1994—it was too much; it was too late; there was too much pandering; there was too little pandering. Such critiques of this complex undertaking are at least partially correct. It was probably hubris to believe that such a comprehensive health care reform package could be proposed and passed in a single year. But much of the instant analysis of its failure has repeated the rhetoric of the debate rather than stepping back and placing the events of 1994 in perspective. Here I focus on five areas where rhetoric confused the debate and compare them with the underlying realities of health care reform.

◆ Financing

Proponents of the Administration proposal argued that universal coverage could be achieved primarily by redirecting existing revenue flows. It offered almost no new revenue sources—aside from a “sin tax” on tobacco. The reality is that to achieve universal coverage, we all have to pay for it, either directly or indirectly. And indirect payments can cause serious problems.

◆ Controlling Costs

In an attempt to make cost containment efforts seem less onerous on individuals, the rhetoric offered two somewhat contradictory strategies of imposing *price controls* on health care providers and introducing market reforms, called *managed competition*. Presumably, managed competition would also automatically eliminate fraud, waste, and abuse, and in some unspecified way painlessly discipline the market for health care. The reality is that people must face difficult choices if we are to control costs of health care. Cost containment is a much more controversial

issue than the Administration admitted. Many persons are nervous about the impacts of such controls.

◆ **Choice**

The Administration went out of its way to promise choice, often in ways that complicated the plan. Opponents countered that the Administration's plan would actually limit choice. But what did they mean by choice? If they meant choice of doctors and hospitals, or choice of insurance plans, the Administration's plan stacked up very well. But the right to choose any kind of health care at any time would have been restricted under the Clinton proposal. Moreover, choice has long been eroding for most Americans as employers and insurance companies have imposed more control on insurance. In this case, the rhetoric of the opponents won out over the reality of what is already happening in our health care system.

◆ **Incremental Reform**

Opponents of the Administration's proposal claimed that successful health care reform could be achieved by "tinkering around the edges," keeping what was right about the health care system and getting rid of what was wrong. The reality is that changes in one area of health care provision affect other areas, in ways that are not always understood or anticipated, and there is little consensus on what should be kept and what should be changed under an incremental approach.

◆ **Nostalgia**

Many of those who opposed health care reform altogether expressed a longing to return to a health care system that they remember and think still exists, but that probably hasn't been in place for the last decade. Their warning that we should not surrender what we have for something less was given more credence than the Administration and other reformers realized. The reality is that health care has already changed rapidly and will continue to change with or without health care reform legislation. The Clinton Administration assumed that Americans understood the current status of national health care, including its flaws, and assumed this meant they had a mandate for change.

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The confusing rhetoric of the debate came from both proponents and opponents of health care reform legislation. In the end, Americans seemed more comfortable with the devil they knew than one they didn't. It is useful to look back at the events of 1994 to sort out fact from fiction, in anticipation that we will someday return to a serious discussion of health care reform. Let me begin with the last area where rhetoric confused the debate.

1. Nostalgia

When proponents of the status quo describe characteristics of the health care system that they want to retain, I wonder, "Does such an idealized system still exist, if it ever did?" Despite a resurgence of family practitioners, few people have a personal family doctor who answers their questions, handles every aspect of their primary care, makes referrals when necessary, and cheerfully accepts reasonable payments from insurance companies. Few doctors deliver care with no concern about the requirements of insurers or employers who provide that insurance.

Furthermore, the golden years of employer-based insurance coverage—where voluntary employer benefits were readily and generously provided—ended in the mid-1980s. Since then, the share of people who have insurance through employers and the comprehensiveness of that insurance have declined. Most employers now substantially restrict what they cover, usually with the help of insurance companies that, either as direct insurers or as claims handlers, impose substantial controls on the use of care. And many employees are required to pay substantial amounts of money toward premiums and cost-sharing for covered services.

The reason we haven't seen an enormous growth in the number of uninsured people in recent years is because Medicaid—the program for low-income people in the United States—has expanded rapidly. It covered many mothers and children, who would otherwise have been uninsured, in the late 1980s and early 1990s. Thus there has already been a large shift to government-provided health care. Those who deplore the growth in Medicaid must recognize that it is filling the widening gaps in our private employer-based system.

Federal and state governments now pay for about 43% of all acute care services. Government has a major stake in what happens to health care. To argue that government should *stay out* of the system is to ignore reality; government is already heavily involved. One of my favorite quotes from 1994 came from a lady who said she didn't want government-controlled health care. She just

wanted the government to get out of the way and let Medicare do what it did for her best. Obviously, there was some misunderstanding about the role of government in the health care system.

Reformers often misunderstood and underestimated the fact that Americans in many cases prefer the devil they know to the devil they don't know. During the debate, I wrote a weekly health care column for *The Washington Post*, answering questions that people sent in about reforms. I was struck by the complex and often convoluted ways people cobbled together their own health care. It seemed only logical that people would welcome major change to simplify the system and make it fairer. But if you have already worked out your cross-subsidy—perhaps you're a private contractor and you have a small business that doesn't provide health insurance, but you get your health insurance through your wife, who works for some large employer—you are satisfied. It may not be fair for you to be subsidized by that other employer, but you're happy with that arrangement and you don't want to lose it. And so to say that we were going to reform the system by making everybody pay their fair share sounded good to people who were burdened with subsidizing others, but not so good to people who had figured out how to adjust their employment or other circumstances to get subsidized insurance. Even a fairer system would create losers as well as winners.

Finally, many people don't want to consider what would happen if the system deteriorates further. If your *ad hoc* arrangements are working for you right now, it's easier to ignore what might happen if your circumstances change and you lose your insurance. Many people believe that they've found a way to permanently game the system. We paid too little attention in this debate to how to minimize transitory disruptions to individuals as we made changes that would improve the overall system.

2. Financing

One of my colleagues noted that if you looked at the 1,342 pages of the Clinton proposal, all of this talk about how many pages there were was just a ruse, because the debate never got past page 6.

Page 6 says “Employers will pay for insurance for all of their employees.” The Clinton Administration believed—and with good reason if you looked at the polls—that Americans

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thought this was a good way to finance reform and hence this approach would not be very controversial. Small business would squawk, but big business would line up behind the Administration, and the public would accept an employer mandate as a reasonable approach. Small business did hate mandates and, despite some opposition by big business, were able to convince Americans that there were major reasons to be worried about such mandates.

Mandates do create problems. An employer mandate is not the fairest way to finance health care, and trying to make an employer mandate fairer adds a great deal of complexity to any plan, as a reading of the portions of the Clinton bill that describe which employer's insurance pays what for which person attests. The Clinton plan proposed adjustments to improve the fairness of the mandate, but it meant changing the rules for lots of people. For example, there were many pages devoted to who gets what kids, and how employers should pay on the basis of family type. While this sounds extremely complex, it's no more complex than the current health care system. Most two-earner families now have two sets of health insurance, and they may or may not know how their employers decide who covers what kid. Usually it's by a birthday rule—sometimes it's every other child, sometimes it's odd-even birthday. If you were born on the 13th you belong to one insurer, if you were born on the 12th you belong to another insurer. The problem is those insurers don't agree on what the rules are. Sometimes people have to negotiate over who pays for which children.

The difference between what happens now and what happens under an employer mandate is that all these rules must be codified into law, to decide who pays when, how part-time employees are treated, whether special protections are granted in various instances. These things make the system very complicated. It is also very difficult to make a mandated system fair, because employers will bear differential burdens as a share of the wages that they pay their workers: wages vary substantially across employers, labor costs are more important to some employers than others, and different employers have large numbers of part-time workers versus full-time workers. It is no accident that companies like McDonald's and Pizza Hut were very worried about employer mandates.

Among the possible financing alternatives, a mandate seemed the “least worst” option. Revenues must come from somewhere. If you want health care reform and if you really want universal coverage, there are four broad ways to get there, each with substantial disadvantages.

Taxation

Taxation offers the most direct financing scheme. The single payer people were the most honest people in this debate. They were also ignored after the second day of the debate because they said “You have to raise taxes and you have to raise taxes substantially.” The McDermott bill, which was the chief single payer bill under consideration, would have raised taxes by approximately 500 billion dollars per year. That’s breathtaking! But it would have saved approximately that much in health care payments elsewhere in the economy. Employers would have paid more taxes and smaller insurance premiums. But it still sounds like a lot of money to be funneled through the federal government, and it scared people, particularly given the low trust in government. You can also raise taxes less and only finance subsidies for those who cannot afford insurance. But even then you’d have to substantially raise taxes if you’re going to bring everybody into the system.

Employer Mandates

Mandating employer payments would ensure coverage for most Americans. Mandates operate very much like a tax. They are compulsory. But they build on existing financing so the net increases in spending are small and do not get channeled through the tax system, and thus they seem less bureaucratic. That’s one of the major reasons the Clinton Administration proposed their use.

Cost Containment

Containing costs means liabilities are reduced and less financing is required. Realistically, if you want to maintain reform for more than a few years, cost containment is necessary. Costs are growing so fast that there is no tax revenue source or employer base that will fund health care reform for all Americans ten years into the future without continual increases in burdens unless we slow the rate of growth of health care spending. Cost containment thus represents an essential financing mechanism.

But the Clinton plan also used cost containment to limit the need for new tax revenues to cover the unemployed uninsured. Since cost containment would eventually save the federal government and employers a lot of money, the Clinton Administration believed it could require employers to pay more up front initially, while using monies saved from Medicare and Medicaid through cost

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containment to help bring the uninsured into the system. The financing mechanism in the Clinton plan created a giant pot of funds. By throwing lots of money into the pot from many sources, it was possible to create some subtle cross-subsidies. However, such complicated cross-subsidies require a comprehensive plan, and thus prevented an orderly retreat to incremental reforms, since to do so meant there weren't really sufficient revenue sources to finance even a substantially scaled-back version of reform. The Administration thus had little money to bargain with in the summer of 1994 unless mandates and these cross-subsidies were retained.

Redefine Universal Coverage

The final financing “strategy”—used very late in the game, and not by the Administration but by others— was essentially to redefine universal coverage. Under such a strategy, universal coverage was no longer 98% or 100% of all Americans, but “well, maybe 95%,” and then 91%. The view was to declare victory at that point, and go home. Such a strategy would rely less on employers, taxes, and cost containment because you simply don't cover all Americans. Only small scale subsidies for the very poor would be needed.

The way to justify this is to ask why certain groups don't have coverage and then rule some of them out as needing help. For example, you throw out the uninsured 25-year-olds who could afford insurance but think that they're going to live forever and don't need insurance. You ignore people with high incomes who can insure themselves. And you assume that the very poor are going to be covered under a limited incremental subsidy, or by private charity as we have under the present system. If the number who have coverage plus those you decide are not worthy of attention brings you above 90%, it may be politically easier to simply declare universal coverage a non-issue.

But this does not ultimately solve the problem, because we still would have a large chunk of Americans left without insurance who we presumably wanted to help. This includes many young working families with children who cannot afford insurance unless their employers contribute. These are people who make \$25,000 a year, well above the poverty level in the United States, but who cannot afford \$6,000 a year for insurance if they have to buy it on their own. If you want to help those people, you have to find new dollars to give them subsidies. Either require their

employers to do it or give them direct subsidies, which means higher taxes. You can lower their insurance costs through cost containment. But even if you reduce health insurance costs for that family with \$25,000 a year in income from \$6,000 to \$5,000, they'll still be uninsured. It would take many years of health costs growing slower than incomes to make a dent in the problem of affordability.

So, if we want to cover those people and make sure they get insurance, we have to raise taxes or require employers to subsidize coverage. Cost containment or redefining the problem will not on their own achieve universal coverage. And until we're a little bit more honest about that, we're never going to get past page 6, and we're never going to move on to some of the other equally tough questions that have to be answered if we want health care reform.

3. Controlling Costs

Another area that's a major stumbling block, that didn't get much of an airing because it is so politically sensitive, was cost containment. There was a lot of rhetoric but very little realistic discussion. Slogans conjured up various images on both sides of this issue. Cost containment ultimately comes down to a couple of very tough decisions. Two things are driving spending: prices and use of health care services. If you want to slow the rate of growth of health care spending, any economist will tell you that you must slow the growth of *prices* or *volume* of services.

Americans feel a lot more comfortable talking about lowering prices. That sounds straightforward: get rid of the five dollar Tylenol in the hospital and everything will be fine. But even if we freeze the price of health care services over time, which is not very realistic, growth in the volume of services—especially in terms of the complexity of services—will itself drive the cost of health care up faster than incomes for most Americans. So we have to make some tough choices and begin to ask about what services are not necessary, and whether we can find ways to become more efficient, to find more cost saving ways to do things. All of these imply limiting the freedom of consumers to use whatever services they wish.

The question then becomes, who do we trust to manage cost containment for us into the future? If you believe the market will do it, you essentially are saying you believe that competing entities, be they HMOs or insurance companies or any of the other new health care organizations that are

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arising out there, are going to find ways to be more efficient. That does not mean that there will be no tough choices. Rather, you are saying you trust the competition of the marketplace and insurance companies to make these tough decisions. Or you must rely on the government, through regulatory actions, to make these decisions. If you're really serious about cost containment, some group is going to have to impose restrictions on American consumers. At the beginning of the debate, many Americans were enthusiastic about reining in their insurance companies. But they did not warm to the idea of replacing those insurers with government control.

Further, it is not enough to simply say "the market will do it" and suddenly, somehow, prices and costs go down. There has to be some kind of intervention in the system. We haven't yet had a very serious debate about this, and the rhetoric implied that once we chose who to put in charge, the world would automatically change.

If we really want to slow the overall growth rate of health care spending, some basic things must happen. And some current "remedies" will not work. For example, when groups have been able to treat themselves as separate from everybody else—for example, Medicare or large employers—they have been able to seek special discounts and therefore hold down their own costs. This has helped some of these large employers or managed care plans appear very successful at cost containment. But the rest of the system may be bearing the costs of those discounts if they have not led to more efficient delivery of care. If so, we're not solving the problem for society, we're only solving it for certain groups. Once the market gets savvier, once more and more people find ways to band together and get similar kinds of market power, everybody's going to want discounts and that nice avenue is not going to be available. Then we'll have to face some of the tougher choices of how to truly manage care.

4. Choice

Choice was another scare issue well manipulated by opponents of the Clinton proposal. While health care alliances represented a clever element in the Clinton health care plan, they also played well into fears about choice.

Ironically, health care alliances will probably flourish voluntarily specifically because they help with choice. That is, small businesses may be able to band together and get enough power to compete effectively with large businesses for discounts and other preferential treatment that will level the playing field a bit. Alliances also can be very useful if we move to a managed care environment. I'm not afraid of managed care, of being in an HMO, if I can choose which HMO. If

workers can choose among competing health care plans, that will put further pressure for quality on the system. And this is exactly what alliances are intended to do.

Choice of physician is another goal of many Americans. Again, the Clinton proposal actually went out of its way to require that plans have “point of service” options so people could go to non-network doctors. There was also a requirement to keep so-called indemnity plans that allow individuals to have fee-for-service insurance if they wished. Thus, many of the criticisms leveled at the Clinton plan regarding choice were unfair.

On the other hand, choice was used in other ways by some who objected to the plan. For example, if you meant by choice making sure that all insurance companies regardless of quality stayed in business, then the Clinton approach was bad. This was essentially the theme of the insurance industry during the debate—and presumably the motivation behind the Harry and Louise ads.

Or if you meant that you wanted to choose whether or not to have insurance, then the Clinton plan and all other serious health proposals limited this choice. This is because if we really want to pool risks and do what I think insurance means, which is sharing risk, then everyone needs to be in the system. This type of choice thus undermines other goals.

Remember, too, that *choice adds complexity*. Offering choice was a second major factor making the Administration’s proposal very complex. There were many requirements to permit people to choose among plans, including assuring that insurance companies would compete fairly. The best way for an insurance company to do well in today’s market is to insure only healthy people. If you can make sure that all you insure are healthy people, you can keep premiums low and appear to be successful at containing costs. If we want a world in which we have good choice but we also share risk, a number of additional protections are needed—all of which make the system more complex.

Mechanisms for selecting risks can be very subtle or very crude. If you put the HMO signup office for Medicare beneficiaries on the third floor when there’s no elevator in the building, that’s one way to get a healthy pick of folks. In contrast, I was struck by how cleverly a Washington-based health care plan was advertising to attract good risks. This plan offered discounts in health clubs, and if you had a great interest in making sure that your holiday spa membership was subsidized,

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the plan would do that. It's a good idea; they're encouraging you to get exercise. But that's going to be a lot more appealing to young folks who like spandex than to some of the rest of us. The plan also offered child care information and some child care subsidies. That meant it would probably attract people who are healthy enough to have two parents working and a child that they can put in child care, which means the insurer is going to get a healthy selection of families. The more choice and flexibility allowed in terms of services offered, the greater the opportunities for selecting on risk.

So one of the big questions is what does choice mean? What are we willing to accept or not accept? And what additional complications are added by choice? Cooler heads did not prevail in this part of the debate.

5. Incremental Reform

Finally, I would argue that incremental reform is not nearly as simple as people have suggested, making it in reality a less viable option. Consider a couple of examples.

Selection

One of the people who wrote to my column about incremental reform asked "Why can't we just keep everything that's good and not get rid of anything that we like, and only get rid of stuff we don't like? For example, I like the fact that my insurance company charges me less because I'm healthy and as a consequence I pay less for health care than all these other people who have unhealthy lifestyles." This is the person who must have just joined the Washington health plan I mentioned earlier, got his health club subsidy, and is happily exercising in the weight room. By not sharing risks, the costs of insurance to a family with a sick child will be higher. The problem is that incremental reform is very difficult to do in a world in which you allow a lot of activities that are good for individuals but not good for society. Selection is one of them. But there are others.

Pre-existing Conditions

Most everyone would agree we should get rid of pre-existing conditions. Senator Robert Dole said that he was going to make sure that everybody was happy with his incremental plan because

he would eliminate pre-existing conditions. His plan did, but only if you already had insurance. If you changed jobs and you had insurance at your old job, you could not be denied immediate coverage for any pre-existing condition. If, however, you did not have a job, or you did not have insurance, you had to wait as long as a year under his bill before pre-existing limitations would be lifted for you.

There's a simple reason for that. If you have a voluntary system where not everybody is insured, you must allow insurers to penalize people who want to sign up at the last minute. You don't want that 25-year-old "immortal" guy who's out there pumping iron to come in when he needs knee surgery, sign up the day before, get his knee surgery, and then withdraw from the plan. You want him to have to buy insurance and stay in the plan. Thus, it would be unrealistic for Senator Dole to truly eliminate pre-existing conditions in an incremental plan.

Portability

Similarly, we heard promises that portability would be allowed in incremental approaches. Someone came up to me after a speech and asked, "What could be the problem if health insurance is portable? I work for IBM right now, and I really love their health care plan. But if I'm thinking of going out and working for a small firm, I'll just take that health care plan with me when I go. And everything will be fine."

Portability doesn't work that way in a world in which you don't have universal coverage. What portability means is that if you change jobs and *if* your new employer offers insurance and *if* your old employer offered insurance, you can sign up for whatever your new employer offers. You don't get to take the good stuff with you, once you find it. You get what's available at the next job—if anything.

In practice, it is very difficult to wring out some of the things that are bad about the health care system and that people don't like without disadvantaging someone else. There is no free lunch here. If we want to eliminate high cost insurance for people who are sick, healthy people must pay higher costs. There's no magic to it, but that doesn't make it any easier to do.

The Future

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So let me look very briefly into my crystal ball. In 1995 or 1996 we are likely to see an attempt to re-energize health care reform. The Clinton Administration has tied so much of its existence to health care reform that it will be very difficult for them to say “We lost, we’re going home, we’re not going to do anything about this for two years unless you re-elect us.” And it will be difficult for some of the more moderate opponents of comprehensive reform to say “We really didn’t mean it anyway, we don’t want to do anything, we’re happy with the way things turned out.” But although we will talk about it, we’re likely to see little real action. Even incremental reforms will be controversial since it will be difficult to find agreement among various bills that don’t agree on how long pre-existing condition limits should last, how much restriction there should be on the selectivity bias that’s out there, or what kinds of controls to put on the system. So we’re likely to get pretty bogged down.

The Clinton Administration might consider doing “something for kids.” It sounds good; it’s awfully hard to be against covering children. Plus children are very cheap to insure since not many of them get sick, although when they do it’s a big problem. But even this will be difficult, however, because just to provide additional coverage for children would still require new revenues, and those won’t be easy to identify.

States are poised, however, to do some interesting things with the Medicaid program. We have seen a number of applications of states for Medicaid waivers to experiment with new ways to expand coverage. We’re going to see more of those in the future.

And there is going to be considerable change at the federal level even if there is no serious attempt at health care reform. Medicare is likely to be up for more cuts, in some cases serious cuts. We’re also likely to talk about what to do about Medicaid, which is an extremely expensive program, has been growing rapidly and will continue to do so. The whole question of federal largesse is extremely important. Forty-three percent is a lot of the health care bill to fund, and it means that if the federal government decides to tighten up on Medicare and Medicaid, we’re going to be squeezing down on the health care sector, which will have impacts on all the rest of us who are not necessarily directly involved.

As I’ve already mentioned, the golden age of employer-based coverage is over, so coverage is likely to continue to be more of a problem, particularly if growth in health care spending picks up again. That growth has slowed somewhat, and prices have moderated, but we don’t know how

much of this is legitimate change that will last for a long time and how much is either the traditional reaction of the private sector when they're afraid that government controls are coming

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or one-time adjustments to changes in the health care market. At the end of the Carter Administration there was a very good example of reaction to fear of government control on hospitals. Hospital controls were being threatened. Hospital spending went down from double digits to single digits. But the year after hospital cost containment legislation failed to pass they were back up to around 20% a year for a while. And restructuring in the private market place, where, for example, employers are driving tougher bargains concerning health care spending, may be one-time adjustments as employees are shifted into more stringent managed care plans. So we are likely to see another jump in the not too distant future in some of these prices.

My most certain prediction is that this will be a period of full employment for health economists, as we go through a time of great flux and change. Although opponents of health care reform should not celebrate too much, we are unlikely to see a serious debate of major reform in the next couple of years. Instead, we are likely to just muddle through for the next decade or more.