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what can we *really* expect from healthcare reform?

Sorting through all of the charges and countercharges that have been raised against the various healthcare reform bills is a challenge as we enter what is likely to be the final critical period that will determine the fate of healthcare legislation in 2009. It's probably not surprising that this is where we find ourselves.

Few areas evoke the same level of passion as health care and healthcare reform. Health care is a very personal service—especially when we or our loved ones are faced with a serious illness. And because most of us will experience a major encounter with the healthcare system at some point in our lives, it's not surprising that most of us have developed strong feelings about what we like and don't like about it—what we are willing or want to see changed, and what we think is best left as is.

The dollars involved in paying for nation's health care are huge—$2.4 trillion, or almost 17 percent of our entire economy. More important, given the present recession, health care remains one of the few sectors where employment is expanding. For this reason, any sudden shift in how and how much we spend on health care not only would affect the pocket books of many individuals, but also runs the risk of increasing unemployment across the nation. Massachusetts, in particular, where one in five jobs are associated with health care, will be facing such challenges in the near term as it attempts to slow its spending.

So there is good reason for the nation to be wary about some of the unintended consequences that might be associated with healthcare reform. Yet Americans are also challenged to sift through the political rhetoric and develop an informed and accurate perspective on the changes being proposed.

Some Myths

Some unfortunate myths have been circulating regarding "death panels" and proposals to limit care to individuals with disabilities. Both of these are false, and the second has been used to malign the reputation of Zeke Emanuel, a respected bioethicist who has served as a health policy adviser to Peter Orzag, director of the Obama administration's Office of Management and Budget.

The death panel charge refers to the proposal in the House Tri-Committee bill that would allow physicians to be paid for visits requested by senior citizens once every five years to obtain information about hospice benefits or end-of-life care. Rumors have circulated that seniors would be required to indicate how they want to die. These charges ignore the fact that hospice has been a Medicare-covered benefit for years, available to seniors if requested during a terminal illness. The opportunity for giving "advance directives"—where individuals indicate how they wish to receive care in the event they cannot communicate on their own and who should represent their wishes—has been a part of the Medicare program since the early 1990s. Whenever a senior is admitted to a hospital or a nursing home, information on whether the senior has an advance directive is supposed to be noted in the patient's record.

A provision paying for a physician visit requested by a senior to discuss hospice care or advance directives should be viewed as a way to empower seniors to make their wishes known—if that is their desire. And because such visits are purely optional, such a provision cannot be correctly characterized as a forcing mechanism.

The accusations on limiting care to people with disabilities came from a discussion a decade ago about how organs might be allocated when there is

a shortage of organs relative to their demand that necesssitates allocation decisions. Zeke Emmanuel came under attack in part because he had indicated that projected longevity has been proposed as one of the criteria used in allocation decisions. But he has also been an explicit opponent of physician-assisted suicide, and the charge that he proposed withholding services to individuals with disabilities is a distortion of his writings and comments. False charges such as these only distract from the real issues that ought to be discussed.

The Facts

The facts about healthcare reform are complicated, and many remain subject to speculation as we await more details about the bills yet to emerge from the House and Senate and, assuming their passage, learn how they are reconciled in conference. Nonetheless, some conclusions are clear.

As long as any legislation is passed, spending by the federal government on health care will increase substantially. How much will be a function of how many people below and above the poverty line are covered by Medicaid, how much the states contribute (if anything) to expanding coverage under Medicaid, how much in subsidies (if any) are provided to people not included in an expanded Medicaid program, and how far up the poverty line such subsidies would go. The total cost is unclear, but it is likely to be in the $850 billion to $900 billion range. A fully financed program would probably be closer to $1.5 trillion over 10 years.

In addition to increased spending, there is likely to be substantially more government regulation, particularly at the federal level. Changes will also include shifts in regulatory control from the legislative branch to the executive branch and from the state to the federal level. Historically, insurance regulation—excluding firms covered under ERISA—has resided at the state level. Every insurance reform that has been proposed, including proposals to guarantee coverage and renewability and to enforce nondiscrimination according to health status, involve shifts of regulatory control from the state to the federal government.

Assuming an insurance exchange is a part of the final legislation, it is unclear whether the exchange will be governed by federal, state, or regional authority. Whatever the level, it will require more regulation. Similarly, if there is a public plan in the final legislation, an agency like the Centers for Medicare & Medicaid Services will be required to manage and operate the public plan.

Any additional changes at the federal level resulting from healthcare reform also will depend on the specifics of the legislation passed. Will there be a "MedPAC on steroids," where an agency similar to the Medicare Payment Advisory Commission will be responsible for recommending changes in coverage and reimbursement that will be implemented by either Congress or the executive branch? If there is an individual mandate, which branch of government will enforce it? If there is a play-or-pay provision, which seems likely, who will enforce it, what kind of minimum benefit will be required, and what will be tax penalty for those that do not play and how will it be enforced?

The Inevitable Result of Reform

Any affirmative answers to these questions will surely mean more power to the federal government. And the increased levels of spending coupled with insurance reform will only add to this increase in the federal government's power. This effect of healthcare reform is one fact that anyone can point to rightly and with confidence, just as surely as one can assert that death panels are myths.

In the end, one pivotal question remains: Is it a fact or a myth that increased spending on insurance expansions will also slow the growth of healthcare costs in the future? Thus far, most of the focus has been on insurance reform rather than healthcare reform. Without a lot more attention to delivery system reforms, slower spending may well join the ranks of "future myths." We may have to see what passes as healthcare reform to find out the answer. ●

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