

# The Clinton Election: Implications for Healthcare

BY WILLIAM J. COX

**B**ill Clinton's presidential election victory will significantly accelerate the pace of the national healthcare reform debate. Although it may not result immediately in the enactment of *fundamental* healthcare reform legislation, the stakes are exceedingly high. How the debate develops during the presidential transition and in the 103d Congress could largely determine the final design of healthcare system reform—even if it is still several years away.

## WHAT THE ELECTION MEANS

For several economic and political reasons, healthcare system reform is not optional for either President Clinton or the new Congress. First, the demand for system reform is driven less by ideological conviction than by the sheer economic threat that rapidly rising healthcare expenditures present to the U.S. economy in general and to businesses, families, and individuals in particular. In the 11 years between 1983 and 1994, U.S. healthcare spending will have increased \$700 billion. At the current rate of growth the next \$700 billion will be spent in just six years. This would result in an average annual health insurance premium for a family of four of \$28,000—more than the family spent on healthcare, transportation, food, and housing *combined* in 1990.

Clinton understands the implications of this reality very well and has noted his belief that healthcare reform is necessary to address both the healthcare system crisis *and* its broader impact on the economy. He also understands that the federal deficit cannot be reduced without slowing the growth of Medicare and Medicaid expenditures, and effective expenditure controls in those two programs will require overall reform. Thus Clinton's first mention of healthcare reform will likely come in late January or early February 1993, when he submits to Congress his budget for fiscal year 1994.

Second, Clinton regularly promised voters dur-



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ing the presidential campaign that, if elected, he would send a reform plan to Congress within the first 100 days of his administration. This commitment has created high expectations within the Democratic party and the general public, and it must be fulfilled. Institutional and political realities dictate that, to be successful, the president must begin advancing his reform agenda during the first six months of his term (the traditional "honeymoon period"). Clinton does not necessarily have to have every aspect of his reform plan implemented immediately nor even by the end of his first term, but the blueprint needs to be agreed to, the direction set, and progress made on the issues of cost and access. Failure to take full advantage of this opportunity could doom both the president's healthcare reform agenda *and* his effort to develop an effective governing coalition.

Third, virtually all congressional candidates also focused on healthcare reform. Although it is not yet clear where each new member of Congress stands on reform, most members clearly appreciate its growing importance to their constituents. Every public opinion survey noted that, after the economy and jobs, healthcare was the most prominent issue in the campaign.

Taken together, the economic and political factors cited above virtually guarantee that the first serious and focused debate on the elements of national healthcare system reform will occur during the 103d Congress.

## THE POLITICS OF REFORM

Although the president and the new Congress have powerful incentives to enact real reforms, they will face several major challenges in doing so—the first and most significant of which will be to forge a broad working coalition in Congress on healthcare reform. This will not be easy because, although healthcare emerged as a significant issue during the campaign, the election failed to produce a consensus around the elements of a specific approach to reform.

As a result, most members of the new Congress will not have a clear idea about how much reform their constituents will actually support. Congressional caution on reform will be reinforced by memories of the Medicare catastrophic insurance debacle, where legislated good intentions were rejected by a powerful minority of voters. Thus Congress will approach system reform cautiously. This will give reform opponents an important initial advantage: They know exactly what they do not want and will spend heavily to frustrate the reform effort by exploiting congressional uncertainty. The advantage will be temporary, however, since the economic insecurity generated by rising healthcare costs will gradually but inevitably overwhelm special interest pleading.

At the outset, however, a congressional working consensus will be tough to achieve and maintain in the face of grassroots uncertainty about the elements of reform and skepticism about Washington-designed solutions. A "leadership system reform package" (i.e., a set of reforms agreed to by Clinton and key congressional leaders) will almost certainly be presented to Congress. But the House of Representatives demonstrates regularly that it can be independent, and unless the president and congressional leaders take the time to sell their package outside the Beltway, it will likely fail.

Another important challenge for Clinton will be to harmonize his healthcare reform plans with his other economic objectives. For instance, if one of his primary goals is to create jobs, he may find it difficult to achieve this and at the same time support employer-mandated health insurance, which would raise the cost of labor for many employers, especially small businesses. If another goal is a middle-class tax cut, it is not clear how that goal can be squared with an elimination or reduction in the value of the tax exclusion for employer-provided health insurance, which would amount to a tax increase.

Finally, the president will be challenged *not* to accede to the temptation to focus solely on expenditure controls in healthcare to the neglect of universal access. Covering the uninsured will initially be expensive and possibly unpopular. Furthermore, most Americans equate improved access with lower-cost healthcare. The president may conclude that all he needs to do is demonstrate he has placed significant controls on providers.

### **THE CONSERVATIVE DEMOCRATIC FORUM**

As this year's congressional debate on system reform develops, it is likely to center on Clinton's

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approach to the Conservative Democratic Forum's (CDF's) healthcare reform proposal. Led by Reps. Jim Cooper, TN, and Charlie Stenholm, TX, the CDF comprises conservative Democratic representatives and some senators. It is the leading congressional proponent of "managed competition," the reform approach developed by the Jackson Hole Group and Stanford University's Alain Enthoven. Clinton will find significant compatibility between his view of the government's role in healthcare and the view of the CDF. Clinton was a founder of another group of conservative Democrats, the Democratic Leadership Council, whose executive director, Al From, was in charge of the president's domestic policy transition team. Atul Gawande, a former member of Cooper's staff, is deputy to Judith Feder, who headed the transition health team and was staff director of the "Pepper Commission."

As managed competition gained support, it became a more prominent part of Clinton's campaign proposal. Importantly, the proposal incorporated central elements of managed competition with a "budget target" approach to controlling the rate of growth in healthcare expenditures. Budget targeting is *not* part of the CDF's proposal, *nor is universal access*. Nevertheless, it appears that Clinton's plan will rely substantially on managed competition strategies, with a budgeting backstop, to control healthcare spending.

The political implications of pursuing a managed competition-budget target strategy are significant. First, it is a clear departure from the Canadian approach to healthcare reform. To avoid a schism on the left, Clinton will have to reach out to those members of Congress who are advocating such an approach. Most important, he will have to demonstrate to them how his plan will achieve universal access. Simultaneously, Clinton must bridge his difference with CDF over budget targets and universal access to sustain the support of CDF and other more conservative members.

Finally, the role of Republican members is unclear. Many Republicans will be strongly drawn to the CDF plan; some moderate Republicans may even view Clinton's inclusion of budget targets and universal access as acceptable. Still others can be expected to attack the plan on both policy and partisan grounds.

### **IMPLICATIONS FOR CHA**

Clinton's election, the socioeconomic healthcare crisis, and the "honeymoon" period demand that the Catholic healthcare community carefully con-

sider its options, opportunities, and interests in the coming months.

Catholic healthcare facilities have two broad healthcare reform goals:

- To be effective advocates on behalf of a *just* healthcare system that makes affordable, high-quality healthcare available to all
- To be involved (early) in the *design* of the restructured healthcare system, since it will have many implications for the future of Catholic healthcare facilities

The Catholic Health Association (CHA) reform proposal, though still a working proposal, contains several fundamental objectives on which there is broad agreement. They are:

- The importance of values as the foundation for reform (It does make a policy difference whether healthcare is viewed primarily as a *service* to people in need or a *commodity* to be bought, sold, and traded in private competing markets.)
- The importance of delivery reform to patient-centered, affordable healthcare (Clinical effectiveness and cost efficiency cannot be balanced in the

**Both CHA's proposal and Clinton's plan advocate new incentives to encourage preventive and primary care.**

absence of integrated delivery networks.)

- The importance of a *new* role for government to provide the right incentives to a reformed delivery system and strike the right balance in the public-private healthcare partnership

In many respects, the Clinton healthcare plan, at least as articulated during the campaign, is similar to CHA's working proposal. Both plans include:

1. Universal access.
2. A national health board to set a national healthcare budget to control the growth in healthcare spending. The board would establish a healthcare budget for each state. The Clinton board would also define a core benefit package and develop strategies for controlling the costs associated with the acquisition and use of technologies.
3. Reform of the delivery system with much greater reliance on "managed care networks" (the Clinton term) or "integrated delivery networks" (IDNs) (the CHA term) with capitated reimbursement.
4. The development (in Clinton's plan) of health insurance purchasing cooperatives (HIPCs), large purchasing groups that would enable small employers and those outside the work force to exercise market clout and economies of scale in the purchase of health insurance. HIPCs are in many ways similar to CHA's state health organizations.
5. New incentives to encourage preventive and primary care.
6. Use of "smart cards" to achieve new administrative efficiencies and permit the collection of data to assist the development of practice guidelines and other strategies to avoid unneeded and ineffective care and procedures.

In other respects the Clinton plan and the CHA plan are dissimilar:

1. Although both plans ensure universal coverage, the Clinton plan does so by way of an employer mandate and by covering people outside the work force through the publicly sponsored, privately operated HIPCs. Health insurers would be required to use community rating and to accept everyone regardless of their health status. Small employers and those outside the work force would obtain coverage through HIPCs. Insurers and networks would bid for the opportunity to cover individuals who are part of an HIPC. By comparison, CHA would gradually eliminate indemnity insurers and provide universal coverage through a system of unified financing. The insurance function would be incorporated

*Continued on page 29*

## WHAT TO DO NOW

The Catholic Health Association (CHA) has been carefully considering how CHA and its members might work with the new administration and Congress to achieve reforms consistent with the principles that have guided development of our working proposal. During the campaign, CHA sent its working proposal with accompanying materials to every candidate for federal office. CHA also closely monitored Clinton's transition process.

Now several additional steps need to be taken. Some require action by CHA staff; others will take place only if our members act.

1. CHA will seek out and work with other groups committed to achieving universal coverage, delivery reform with incentives for patient-centered care, and realistic expenditure controls. We have already begun to do this, and we hope to develop means to coordinate our policy and advocacy activities.

2. CHA members should reach out to their members of Congress, especially to newly elected senators and representatives. Most of them will be eager to visit with healthcare executives and learn about their staffs, the problems they confront, and the solutions they offer to the nation's healthcare crisis.

3. CHA has already begun to plan grassroots activities to support healthcare reform, recognizing that Congress will likely begin considering Clinton's healthcare plan quickly. CHA will present a specific legislative action plan to respond to Clinton administration healthcare initiatives in a series of seven meetings to be held in Los Angeles (February 10), San Francisco (February 11), Dallas (February 24), St. Louis (February 25), Chicago (February 26), Boston (March 4), and Philadelphia (March 5). Call 314-427-2500 to register.

**LAW***Continued from page 19*

the JRC upheld several criticisms of Austin's performance, and that it recommended conditions be imposed on his practice, the court stated that "no reasonable jury could find that the JRC report is sufficient to establish the nonexistence of the defendants' 'reasonable belief' and 'reasonable effort.'" Accordingly, the court said that HCQIA's presumption of immunity (in favor of the defendants) was satisfied.

Austin also contended that many of the peer review activities occurred before HCQIA's effective date, and thus immunity should not apply, at least to those activities. The court concluded, however, that *all* the defendants' peer review activities and actions were entitled to immunity because the summary suspension of Austin, which constituted a "professional review action," included all the "professional review activities" that led to or related to the peer review decision, whenever those activities occurred.

Finally, the court of appeals considered Austin's additional claims that the defendant physicians refused to provide coverage for him and openly criticized him. Although these allegations do not fall within HCQIA's immunity, the court reviewed them and, in applying a rule of reason, held that Austin had not made a sufficient showing of antitrust violation. Accordingly, the court of appeals upheld the lower court's judgment on these nonimmune actions as well.

**THE SIGNIFICANCE**

The Ninth Circuit's decision is good news for participants in professional peer review activities and the organizations in which they are performed. In upholding the HCQIA immunities, the court made it clear that HCQIA's purpose (to encourage effective professional peer review) can be achieved. The decision may also have a far-reaching effect for health-care facilities and professional peer reviewers throughout the United States as other federal courts review HCQIA immunity cases. □

**PERSPECTIVE***Continued from page 18*

ed into the IDNs, which in turn would decide how to pay providers.

2. The Clinton plan permits fee-for-service medicine to continue, though it would provide strong incentives for employers and individuals to choose managed care delivery systems. The CHA plan would permit fee-for-service medicine to continue, whenever desirable, within an IDN or within a geographic location that cannot support one or more IDNs.

3. The Clinton plan allows for competition based on price. The CHA plan would anchor competition in quality and service only.

On balance, however, we believe the Clinton and CHA plans have more similarities than differences.

**TIME FOR ACTION**

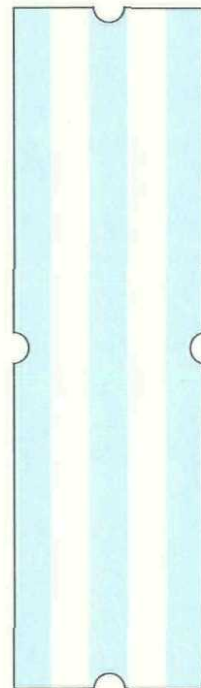
The CHA Division of Government Services will be carefully considering how CHA might work with the new administration and the Congress in achieving reforms consistent with the principles that have guided the development of our working proposal (see **Box**, p. 18).

It is likely that the president will move expeditiously to further develop his plan, to seek input from a wide array of interests, and to fashion a political strategy to achieve the reforms he ultimately submits to Congress. CHA is prepared to participate actively in this process as the opportunities present themselves.

The coming year will be filled with opportunity and excitement. Both the president and Congress seem committed to reforming the nation's healthcare system so that affordable healthcare is available for all. Catholic healthcare providers will play a key role in achieving that objective. We can be leaders in the nation's hospital community; we can be leaders in our local communities. We must be sure to seize the opportunity and meet our responsibility to both. □

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