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REMARKS BY THE FIRST LADY
IN SPEECH TO CSIS CONFERENCE

Capitol Hill

MRS. CLINTON: Senator Nunn and Senator Domenici and ladies and gentlemen, thank you for this opportunity. And, Senator, because I know you're committed to responsible deficit reduction -- you just go right back to that -- (laughter) -- you're going to try to move this agenda forward so that we can continue to get the country back on the right track that will lead to the strengthening of America, which is a commitment that all of us share and which Senator Nunn and all of you have been leading spokespeople for and for which I am very grateful.

I welcome this opportunity to visit with you about health care. And what I would like to do is to speak for a few minutes, but mostly to have time to answer any of your questions or, as Senator Domenici suggested, to take advantage of your suggestions about how we proceed with this extraordinarily important and very complex matter.

I don't think that I need to remind this group what is at stake in health care reform, because you have been looking at what needs to be done to reverse the kind of economic stagnation and undermining of our future that has gone on because of decisions that we have failed to make over the last several decades. But it is clear that, in the absence of serious health care reform that controls costs and puts, finally, some discipline into the health care market, we are unlikely to be able to deal with the federal budget, the deficit, the debt, and we are going to continue to be undermined in the private sector with respect to our competitiveness. So there could not be a more timely issue for this group to address.

There are a number of competing proposals that have been analyzed and worked on for several years as to how we best go about reforming our health care system to assure security to every American so that we reach universal coverage that will enable us to provide a comprehensive benefits package at affordable cost, and will control costs, therefore, within both the public and the private sectors.

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There has been an enormous amount of good and thoughtful work that has gone on. And I was pleased to receive a draft copy of the "Vision and Principles" paper that CSIS is working on, and add that to the list of organizations that are taking a responsible approach to this complex issue.

In the work that we have been doing in conjunction with many groups in both the public and the private and the nonprofit arenas, we have attempted to analyze every single proposal from a variety of perspectives, and to how well it reaches the principles that we think are essential -- principles that you, too, have adopted in your approach in this draft paper.

It became quickly apparent that there were strengths and weaknesses to every one of these independent approaches that had to be taken into account, and that what we would have to do to come up with a system that we thought met the underlying principles in a timely and affordable manner, was to create an American solution to this American problem. There was no model anywhere that could be adopted wholesale. And that we needed to build on the strengths of our health care system while we tended to shoring up and eliminating where possible its weaknesses.

And what I would like quickly to do is to run through your "Visions" paper so that we can put the discussion into the terms that you have already been working on and point out the similarities and the approach we're taking and discuss areas where we need, perhaps, to continue consultations.

We believe, along with you, that we need a market-based approach to the financing and delivery of health care that will create sound and effective consumer decision-making. This is an area that individuals like in which information that is readily usable is rare. I wouldn't embarrass anyone, including myself -- if I wanted to, I could, though -- by asking each of you to tell me exactly what your insurance coverage is and all of the rest that goes into it, and how you shop to make your choices, and if you didn't, who made the choices for you and on what basis they did.

It would be a relatively short conversation, because I've done this in many groups with many well-educated people, and there's been embarrassed silence and then a scrambling to say something. If I'm contract, I would ask you why did you buy the car you most recently bought, we could have a very well informed conversation and a good debate back and forth, as Sam Nunn argued with Jim Cooper, who argued with somebody else about why they chose whatever car they bought and what kind of deal they got for it and how they negotiated the best price.

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There is nothing like that in our current system. The kind of system we envision relies fundamentally on empowering and informing consumers to make those kinds of decisions. In order to do that, we need to create options among the choices that are available to consumers, and we agreed with your approach of providing what we call "accountable health plans," and you do as well, that will provide a basic benefit package that will be required by the federal government and the basic option available to every consumer.

Now, accountable health plans can deliver those benefits in a variety of ways -- through an HMO, a PPO, a fee-for-service network, some as yet undiscovered ways of delivering services the market will help to generate. And we will encourage that kind of competition and choice because we think there should be that availability of options within the delivery of health care.

In order for that system to work effectively, we will have to have adequate information, the use of report cards -- a term that you use in your draft is one that we have also used. We will go, in addition to reporting what is currently available in the market, we will have to create new sources of information better than what we have currently been able to produce. And we will have to start comparing apples to apples instead of apples to oranges. Because, as has been pointed out in many of the discussions I've had, the primitive use of information can be contrary to the outcome's quality measurements that we are looking for. So there will have to be some real thought given to creating an effectively functioning data collection system that can be easily accessed and reported to consumers and providers.

We certainly believe that there has to be the integration of providers in the delivery of services. It has been very interesting and encouraging to me to watch other organizations reach the same conclusions. Catholic Health Association, for example, studying health care reform for two years, issued its report before the President was inaugurated. It is very much along the same lines as what we are proposing, what is in the CSIS draft paper. Because if you look at our system, one of the clearest needs is for increased coordination and better integrated delivery systems, which we believe will be created by the kind of emphasis on incentive for cooperation through the creation of these accountable health plans.

Preventive health care will be a major part of the benefits package. This is a change in direction from where we have come from. And if one goes back and looks at the history of how we got into the rather anomalous situation of insuring against the disease or the chronic condition and not insuring against the preventive measure, the well child care, the other kind of diagnostic tests that lead to discovery of illness, it is a national outgrowth

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of the early decisions to insure against catastrophic instances which, of course, all of us would agree with.

But the result of that, going back to the 1930s with the very first private health insurance plan is that we worked our way out of a market for primary preventive health care. We have to create that market, we have to mandate it as part of the benefits package. We strongly agree with you that we must look at ways of providing organized, coordinated care within a budget.

There are a number of laws at both the state and federal level that interfere with competition. But, more importantly, interfere with coordination. We have to think about the kind of arrangement of care we need and the best and highest use of providers within those arrangements. And so, looking at changing anticompetitive practices or laws is very important. Looking at the federal antitrust laws so that collaboration will be permitted instead of prohibited is key.

We also think, along with you, that once we establish a comprehensive benefits package -- and we are looking at a package that is approximately what one would expect from the good federally qualified HMO, the Blue Cross-Blue Shield package with the primary and preventive care in it -- then we have to be willing to remove tax deductibility for benefits above that level. So that we will continue tax deduction treatment for what is in the comprehensive benefits package. But after-tax dollars will then be used for any benefits or ancillary services beyond that package.

This is a key part of making it possible to extend such a benefits package to the underinsured and the uninsured and give those who are currently insured the security that even though they are currently insured, none of us can predict whether they will even be employed next year, let alone what their benefits level will be, and that they will always have the security that this level of benefits will be available to them. And that it will be affordable, it will remain with them whether they are employed or unemployed, because we think what we need to do is to enhance the existing employer-employee system by bringing Medicaid recipients into the same purchasing pools so that there will be both federal and private money, as well as whatever state contributions are required to cover the entire population.

We, too, agree that there need to be purchasing arrangements created to empower the consumer and to negotiate with the accountable health plan. We are referring to the entity that's health alliances, because they bring together in one entity consumers and providers, businesses, labor -- all will be available through

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that alliance to negotiate for the best possible health plans which will then be open for enrollment by any citizen.

Even if one continues to finance health care through an employer-based system, consumers will be free to enroll in any accountable health plan -- not the only one that is selected by the employer.

Clearly, one of the hopes behind our reform is to reduce the costs and redundancy of health care administration, and there are a number of reforms that we believe will bring that about. Community rating is a key which will eliminate the expensive underwriting and experience rating procedures currently driving much of the costs.

If we are able to bring about these health care reforms in the administrative areas we will be able to stabilize the costs. -- it's a chicken and egg issue, how do we get to universal coverage with affordable benefits package while sweeping out the administrative costs so that those costs can be recycled through the economy and even through the health care system. We have to proceed, in our view, on both fronts at once.

We also believe we have to create a framework, as you have suggested, to eliminate excessive expenses associated with malpractice litigation and with defensive medicine that is driven by fears of such litigation. We are also concerned, as you are, about creating some kind of consensus about the appropriate treatment that is available in the last months and days of life. And Senator Domenici has already left, but he took a step toward this with the Patient Self-Determination Act, in the last Congress I believe, and we think it is appropriate to move as you do on encouraging consumers when they sign up for health plans to complete a living will, or at the very least, to have the kinds of issues that they may face in an emergency situation explained to them so we have better informed decisions being made.

An absolute red-line, bottom-line principle for us is that all Americans have to be secure. There should be no prohibition of health insurance or access to health care to anyone. And the kind of benefits package and the delivery of it will be key to that.

I could not say better than what is said in your paper that the perfect is the enemy of the good. There is no way we will create a system either that is perfect or that will satisfy everybody. I have thought for quite some time now, perhaps necessity being the mother of invention, that if everybody is a little bit put out we're probably doing the right thing. But we have to look for the best possible system in order to deliver that security which is the key to whether or not we will have a successful reform.

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We agree that biomedical innovation and the appropriate use of technology and the continued role of medical research is essential, because, we think, it is one of the few ways open to us to actually improve productivity in the delivery of health care. And so the suggestions that you include in your paper about innovation and research are ones that we take very seriously and have had a number of conversations with medical research groups, academic medical centers and others who are at the forefront of assuring that the American health care system stays on the cutting edge of the development of treatments that will enable us to deliver care more efficiently.

It is also absolutely essential that we control the growth of federal spending for health care. But it is also essential that we control the growth of private spending for health care because one of the net effects of reducing federal spending, as many of you who are providers around this table know, is that it shows up in the bills that you and I pay because we carry insurance. And it particularly becomes an additional burden on the large employers, those who are providing the bulk of the private money that is funding our health insurance system. So, yes, we need to weigh in and budget the federal contribution, but we also need to be sure we have some discipline that is imposed through the market on the private sector.

And let me say a word about this because there has been a great deal of conversation about budget in this situation and how budgets do or do not correspond with competition. It is our view that we need to start with the idea of a budgeted system that is based on the average weighted premium cost that will be paid through comprehensive benefits package. That budget, we believe, should become redundant. It is a backstop, if the market works as we expect it to work. But in the absence of budget targets, of some kind of discipline as states and accountable health plans and providers adapt to this new system, we are afraid that the controlling of the costs in the federal system without some kind of discipline in the private system will further discourage the kind of steps toward more efficient delivery than we have seen in the last years and put more pressure in turn on the federal system.

Every time you cap a federal entitlement program in health care, in the absence of reforming the market in the private sector, you shift cost to the private sector, which has a result of eliminating people from coverage either because their employers no longer can provide it, or the co-pay and deductible become so high they no longer participate in it, or they get laid off, or something else happens to them. They then join the 100,000 people a month who lose their insurance. They then find their way on the public rolls

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for some period of time, which then busts the cap on the public system.

This is a total system that feeds on each part of it. So from our perspective we have to define the costs within the federal system according to a formula that is paid to what we believe should be the budget for the entire system, and that we then have to do everything we can, as I said before, to make that budget with respect to the private sector largely redundant. It would only apply to the comprehensive benefits package premium costs. Anything that is bought with after tax dollars would obviously be available for any of us to do whatever we chose to do with. But with respect to how we try to get the whole system operating under some kind of discipline until we think these reforms can kick in this one of those areas that we have thought about very hard.

And one of the people working with us said, you know, the traditional way of trying to restrain health care costs has been to put a leash around every cow and try to keep it in one spot and not let them move. What we're trying to do is just put a fence around the whole system and let people decide within it how they can allocate the federally mandated part of the expenditures and the accountable health plans marketing of and delivering of the comprehensive benefits package.

Now, finally, I think it is absolutely essential that we do everything we can to come up with a system that is understandable and workable and in the eyes of the vast majority of Americans, a positive change from what they have now.

And what we hope to be able to do is to come up with such a plan that will be as inexpensive as our entire economy can manage to make it in terms of both new private sector contributions and any new revenue. We believe that an employer-based system, which is what we have now, that has a very wide range of contributions within it from zero, as you all know, to a high -- employer high of 25 percent of payroll for health benefits, but most start at the eight to 15 range with the costs going up at 10 or 11 percent a year and they're trying to keep cost increases down to eight percent.

Most of us are working off the premise that we are not going to replace our existing system, we are not going to look for public past monies to replace the existing kind of contribution to the health care system. So therefore, how do we create a system with the least amount of disruption and the least amount of new revenues required. And what we are attempting to do is to create a premium that is paid to this benefits package that will enable most employers who currently provide the comparable benefits to realize considerable savings over the next years and those employers who do not make any

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contribution now or whose contribution is inadequate to fund that comprehensive benefits package --

(End Side 1)

(Begin Side 2, in progress)

-- in any way pay their fair share now, but who in many ways burden the system that the rest of us pay for.

So, finally, this system is not going to be changed by any wave of a magic wand or any silver bullet. It is, however, a system that we're convinced we need to take a comprehensive approach to initially even if we choose to phase in that approach; rather than taking an incremental step now and then hoping for an incremental step later. Because there are too many interactions among the systems not to try to lay out an approach that will affect the very pieces of it so that we can watch it being phased in, largely by the states, through a market-driven approach.

Q Let's open the floor to questions, so why don't we start around and whoever has a question --

Q Thank you so very much for being here today. The statement that we should not put anymore into the system than we absolutely have to that is already there, I think is what we really need to do. So how, when we consider the fact that 14 percent of our gross domestic product now goes to health care, more than any other industrialized nation, something that we -- (inaudible) -- how can we justify putting additional money in, which will make that percentage even greater?

MRS. CLINTON: Well, Congressman, this is one of those dilemmas that we are stuck with because of our current system. In order to control costs, you have to have everybody in the system. In order to get everybody in the system, everybody has to bear their fair share of the responsibility. At this moment in time, you have 40 million Americans who do get health care -- they show up at our emergency rooms, as you well know. They get taken care of, usually at the highest cost at the last possible moment.

We are unable, therefore, to control their access and usage of that system. In addition, we have a public system that goes up and down based on political decisions as opposed to being incorporated within the broader market system. And we see it going up and down depending upon decisions that are made that often impact adversely on the costs then in the private system. So we think it's a chicken-and-egg kind of a problem.

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If we can get everybody into the system with a rather limited new amount of money that comes primarily from the private sector, which is the primary funder now, but which for the first time expects everyone to participate, then we will actually begin to see the kinds of costs savings that can come from administrative savings and from better utilization of the existing system.

It will be a great accomplishment for our economy if we in the first years freeze our GDP percentage at its current rate, because right now we are looking at moving to 19 percent by the end of this decade. So if we can freeze and then move down, that would be the most likely and least disruptive way of getting this situation under control.

Q I'm with an organization called Georgia Health -- (inaudible) -- in a community-based effort in understanding some of the problems in our state. One of my fears and one that we hear over and over again is the lack of infrastructure in much of the rural areas of our country. It's true in Georgia, and it's true across the nation. There's also a major infrastructure problem in some of our inner urban areas also. It would seem that even though I certainly understand that we all do the deed for fiscal restraint, there's going to need to be some infusion of capital from somewhere to provide the bricks, the mortar, the buildings to people to go out and deliver the care where it just simply isn't right now. I wonder if you have any comment on that.

MRS. CLINTON: Yes, sir. We absolutely agree with that -- that the underserved urban and rural areas have got to be given a health care infrastructure and personnel in order for universal coverage and cost containment to work. And we have several approaches to that. We do think that the federal government will have to raise some funds in order to beef up the public health infrastructure.

We also believe that the accountable health plans will have to utilize those existing structures in order to serve the population that they're going to be bidding on to serve. And they will have an incentive to do that, which they don't currently have, which is a reimbursement stream, so that the level of uncompensated care that often burdens inner city and rural providers, will be dramatically lifted. I'm not going to say it will be eliminated, because we won't know how this all works until we get into it. But I do know it will be dramatically reduced; so that there will be for the first time in many years a much fairer return for those people who are actually willing to deliver the care in those underserved areas.

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Additionally, we have to look for ways to make it attractive for physicians, nurses and other medical personnel to provide care in those areas. And our plans there range from everything from providing a much broader loan forgiveness and loan program for people who are willing to serve in those areas, to a higher reimbursement rate by encouraging plans to be able to provide services in those areas and looking at some of the models that have worked, to better use of technology, because it's not just a question of pay, it's also a question of professional isolation and the like.

And we are very encouraged by how these kinds of networks of cooperation in which rural and inner city practitioners would become a part would help to create a climate in which they were much better supported, could provide better care, in which reimbursements would flow to them. So we've thought very carefully about that and think we've got to wade through the system to fund it and to continue to provide it.

Q I appreciate very much the logic and care which you've laid out the problem and principles. I'd like to ask a question about process. And that is, by what process do you anticipate in determining the coverage contained in the comprehensive package, including deductibles, copayments and so forth, since I would assume and I believe that that will strongly influence the cost, even I hope the calculated budget premiums and so forth in such matters as deductibles, copayments, even if the federal government takes care of them or reduces them for poor people -- actually have been shown I think by tests to have a substantial effect on the cost of the program.

MRS. CLINTON: You're absolutely right about the benefits package and its cost being the key to all of this. And it has been probably the most complicated task we have faced among many. Just as an aside, which I told several of the senators -- Senator Lieberman and others here probably heard me say this before -- but one of the first tasks that we did was to get into one room all the federal government actuaries who dealt with the cost projected on health care programs that were run by or funded by the federal government. They had never been at a meeting before ever.

And if you wonder why we have problems in America and in our government, just think about how driving a factor health care costs have been in the last 10 years in every budget that has ever been put together; and the actuaries have never met before I got together in a room. And they've been meeting continually since then.

And they, along with an outside panel of actuaries whom we've convened, have worked very hard to cost out the benefits package. It will include copays, and it will include deductibles,

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because most of the actuarial matters and as a matter of personal responsibilities, we think that the important part of the whole approach to reforming health care. We are trying to keep the costs as low as possible. So we are looking very hard at the benefits and in the costs of them.

But we have a problem, which I never knew was a problem until I came to Washington, and that's called something called scorability. And when one presents a budget to the federal government, we end up with these kinds of arcane or -- maybe they're not arcane, they're just rules of budgeting I've never encountered in my prior life before -- in which issues like competition and the savings from competition are not giving any weight whatsoever.

And so we have tried very hard to come up with a benefits package that is a reasonable package that most Americans who are insured will feel good about, and which is affordable on actuarial tables and which in a market-driven system will generate savings that are real that can be filed back, to go back to Dr. Roland's point, even if they can't be scored in the federal budget.

So that's the key to trying to keep -- this is the centerpiece of making all this happen, as Dr. Brown clearly put his finger on. And we think we're going to come up with a benefits package that is comparable to what a federally qualified HMO would offer, an average Blue Cross-Blue Shield policy, which we think is pretty good to be available to the entire country. It won't make everybody happy, because some people, as you know, have first dollar coverage and a lot more benefits. But we think as a national guarantee package is certainly one that should be supported.

Q You mentioned personal responsibility, and a lot of the health problems and a lot of -- (inaudible) -- responsibility. Is there some way of incorporating in this formulation a disincentive for -- (inaudible) -- or an incentive for living -- (inaudible.)

MRS. CLINTON: I joked the other day that if there were a way to do that, it would probably be a disadvantage, because the actuaries would then claim people would live longer and it would cost more. So, I mean, it's like -- this is like a never-ending set of issues. But we do want to discourage unhealthy behavior. And one of the reasons we are looking at funding the public health infrastructure through some of the research improvements that we're thinking of, through a combination of tobacco and liquor is because we do think that's sends a disincentive.

Now, I'm also hopeful that once we get this system up and running, we will begin to look at some of the other ways we could provide incentives for healthy kinds of behavior. It is not easy to

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build those into the benefits package or to really monitor them carefully. But I'm hopeful that once we are running, the accountable health plan, we'll be able better to compete on the basis of what kinds of additional services they're able to afford because they get the costs of the benefits package down, which will keep those people who enroll in them cheaper, which will have the benefit that you're talking about. But we do think that cigarettes and alcohol are key to preventable health care, and that we need to take a look at those for sources of funds.

Q Just following up a question, I wonder if I could suggest -- (inaudible) --

MRS. CLINTON: What you ask -- and I had a meeting yesterday with 25 physicians and other health care providers from Houston with Congressman Andrews. And Red Duke, the TV doctor, was there, and he said that he believes that we could have a massive public education campaign on accident prevention and other community public health problems, it would be one of the quickest ways to cut our costs. And he has some proposal that we're going to try to implement through this kind of process of creating models and then distributing them to states through their alliances and their health plans so that we can actually do exactly what you're saying, because that is where there are huge savings available if we can change community activities as well as individual behavior.

Q Hillary, you haven't said anything about the drug industry yet. Do you envisage it being part of the basic package? And secondly, do you envisage interim price controls for that industry?

MRS. CLINTON: Well, we do envisage their being a prescription drug benefit that would be part of the basic package as well as part of Medicare. Again, it would have a cost attached to it, but we think a reasonable cost. That would provide a significant increase in the funding available for prescription drugs, if we're able to get this actuarially squared with what we think our affordable costs are.

On the issue of price controls, this is one of the more emotional and thorny issues that confront us, because there are many who, frankly, believe that in the absence of some kind of price restraint -- whether it be freezes, controls, rate settings -- that the competitive system alone is inadequate, at least in the short run, to deal with the kinds of costs that are built into the system.

And there others -- and you know the arguments very well -- that it distorts the market, it leaks, it doesn't work -- I mean,

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there are arguments on both sides and I don't think it will ever be fully resolved to anybody's total satisfaction.

But I do think that it would be very helpful for us to try to create an environment in which voluntary action on the part of providers was part of our initial presentation of this package. That would include the drug manufacturers and everyone else. I've had conversations with some of the manufacturers, I've had conversations with other entities who represent major parts of the health care system who seem to be moving towards a willingness to talk about voluntary restraint, some kind of freeze, however it could be structured.

There might also, though, need to be in the legislation some kind of trigger for this transition period that would help enforce that in the event that we were unable to achieve the kinds of initial savings that we think will help fund the whole system. There's been no final decision on that. This is something we welcome everybody to weigh in on. It is highly emotional. It's hard to kind of cut through the emotion to get to what actually would or would not work. But in any event, we would only be looking at either a voluntary system or a system with a trigger for a very short transition period. We want to stabilize the system.

And one of the big problems we've got is the huge differential in practice patterns and costs around the country. I mean, if you can pick an average and try to say this is the average hospital cost, the is the average physician cost for this kind of procedure, you literally have a 100 percent variation on both sides of that average at work right now. And it is something that you cannot overnight change those practice patterns and eliminate the excess costs in those systems in many parts of this country. But without some discipline, it will take longer than we might have in order to get ahead of the curve. So those are the kinds of issues we're struggling with.

Q The question I have is to administrative costs. Currently, in some states, my hospitals will in a year undergo a Medicare inspection, joint -- (inaudible) -- inspection a Department of Health inspection, a Department of Mental Health inspection and a CHAMPUS inspection. And a lot of times, being inspected, we'll spend hundreds of thousands of dollars and hours dealing with those and when we should be delivering care. My question to you is what are the certification for provider empowerments you envision from the alliances and the health plans, or is this going to be another layer of life insurance certification that providers have to deal with and adds administration costs?

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MRS. CLINTON: Well, the answer better be no. Otherwise, we won't have done our job. What we think is that much of what you now are subjected to in terms of monitoring and checkers checking checkers and utilization review and the like, derives from a regulatory model that attempted to micromanage the delivery of health care. With a capitated model -- with some kind of budget backup, so that people know when they're running up against the limits of what we as a country or Georgia as a state is willing to pay for health care, we think better decisions will be made and we also believe, frankly, quality will be enhanced. Because for every doctor that a hospital has been able to hire in the last two years, they've had to hire four administrators in order to do exactly what you just described. So cut the difference -- give us two doctors and another trained nurse and you'll get better care at less cost and less hassle probably.

So, yes, we think that this capitated, market approach will eliminate much of what you are now putting up with. You will still have to report -- (inaudible) -- compile the kind of report card mechanism that will enable the health plan and then the consumer to make good decisions. But that we think is a minor burden that will be much more easily borne compared to what you're having to do now.

Q I'm very intrigued with the proposals that are being made because tough competition reduces costs. And I also understand the necessity to allow the states to make individual decisions about their own health care programs. Having spent quite a bit of time in Canada, I'm very familiar with the single payor system. And I wonder about the compatibility of single payor system with the notion of competition amongst the kind of health plans. And I was just wondering if there's any way -- or if you've thought about that problem and what your views on it are.

MRS. CLINTON: I think that the single payor system can be viewed as either a single payor financing system or a single payor government-driven delivery system. And what a number of governors have said to us, particularly of smaller states with very rural populations, is they don't have any idea how they can generate the kind of competition among accountable health plans that I presume will be available in Atlanta or Chicago or most of the larger areas.

So they are asking for the option of being able to provide a system within this plan that is close to a delivery system that integrates all of their existing providers. So that, for example, Montana, with a Republican governor, has just passed a piece of legislation setting up a commission to determine whether my payor should be a multi-payor or a single payor system. They have 800,000 people in that huge land mass. Their primary medical center is

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Billings. They believe that they create a system that creates collaboration in Billings among their tertiary and secondary care facilities, they will then be able to contract out, those facilities will, out into the areas that are very rural with lots of need.

I don't know that they would consider that a single payor system under the Canadian model, but I think they would consider it, given their circumstances, the best they could probably put together in one, maybe two, accountable health plans. But that's something we want to let them have a choice in making. It will not change the amount of money that goes into the system. They will still have to provide the same benefits package and consumers will still have some choice in determining what the outcome is. But we don't believe from the federal government we're in a position to say to Montana, you've got to do exactly what Chicago does, and if you don't have competition, get out there and create it somehow. We just don't think that will work.

So we're going to try to provide enough flexibility so that states can make some of those decisions on their own.

Q We promised to get Mrs. Clinton out at 3:00 p.m., and she's been very gracious with her time. Let me get two more questions. And then I think if you have more time, we will respect your schedule, and let that be the end of the questions.

Q The question I'd like to ask gets back to your speech before Johns Hopkins about a week or so -- two weeks ago, and after that -- (inaudible) -- also a major source of progress and -- (inaudible) -- In a world that is largely composed of accountable health plans with this competition, there's some question as to whether or not academic health centers can survive. As we now note, there's also some question as to whether they should survive -- (inaudible).

Are you contemplating -- is the task force contemplating a separate mechanism for financing academic health centers to some sort of a pooled fund or will they be subject to the prices as computed -- (inaudible.)

MRS. CLINTON: No. We believe that academic health centers and the comprehensive cancer centers and some of the other freestanding tertiary care facilities that are at the high end of the system should be supported by the entire population so that there will be a pooling of funds to be able to support those. Now, as you well know, academic health centers have a variety of missions. They have a research -- important research mission which will have to have continued help from the federal government, and I would argue, increasing our research capacity and commitment will be a very good

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investment that will save us money in the long run if we're able to do that. So we want to have a funding strain that supports that.

Secondly, they have an obligation to train medical students, and we do have to make some changes there. The current imbalance between specialists and generalists cannot continue if we expect to have a health care system that puts an emphasis on primary and preventive health care. So we have to change some of the incentives that go into medical education.

And then, thirdly, most academic health centers take care of patients. They run emergency rooms often and they certainly take care of physician-referred patients as well as, in Johns Hopkins case, serving as the primary care giver for low income areas.

So in our conversations with them, they have taken their respective mission and looked at them as independents to some extent because it very well could be that you might have a Johns Hopkins accountable health plan, just as Mayo's is now doing in Minnesota. So that Johns Hopkins would be the tertiary care center and might even, through medical students and others, help to staff clinics, but also might contract with local physicians and even contract with some independent hospitals. I mean, that is an option that many other medical centers are looking at.

Or they might be part of an integrated network that somebody else runs, but they would be the referral place. So there are a number of available ways for the independent functions of the academic health centers to be funded and to be delivered. And I'm delighted at the result of the conversations we've been having with them because I think they're beginning to understand their opportunities and not just the changes that they're facing.

Q You mentioned the term -- (inaudible) -- and market-oriented health care on a number of occasions. Have you thought about what would happen -- (inaudible) -- but have Medicare, which is clearly not either capitated or market-oriented, going on for the over 65? I don't know whether you or members of the task force have given thought about what if anything to do with Medicare, how soon it would even need to be done, and finally, whether the types of changes you envision in the under 65 population would occur -- (inaudible) --

MRS. CLINTON: We've given lots of thought to that because it's one of the key phase-in issues. I personally favor the eventual phase-in of Medicare into the entire system. And I think that that will happen. But in the short-run, while we're trying to get the alliance -- (inaudible) -- running, while we're trying to deal with the problems of the insured and the uninsured, our

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perspective has been we need to get this system running. Because as much as people complain about the Medicare system -- and I always get two reactions when I speak to groups of senior citizens. I ask if they think it could be done better, and of course, they all yell and clap and say it can. And then I ask if they want to give it up immediately and try something different, there's a reluctance there. Because they've got it and the rest of us don't, as we all know.

But I think that in the transition to an alliance-based system that delivers care to the under 65 -- and one thing we're considering is making the alliances available to Medicare recipients who could choose to go in and purchase an accountable health plan with some transfer of funds from Medicare into the alliance; and depending upon where the benefits package ends up, with perhaps a supplemental, it would go into the alliance in order to pay for any additional benefits that would be otherwise unavailable in Medicare -- we think we can prove over the course of several years that this system will work. And we strongly believe that Medicare ought to be a part of it.

We don't think we can bite that all off at once, which is why it's very important to continue to do all we can to control expenditures within the Medicare system and stop the cost shifting so that we can get to a phasing-in of Medicare eventually as well.

(Lunch break. End of tape.)

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