



THE WHITE HOUSE  
OFFICE OF THE FIRST LADY

For Internal Use

May 25, 1993

Remarks of the First Lady  
at Families USA

Thank you. I am delighted to be here. I'd like to start by thanking Rob and Judy and all of you for really leading the way on health care reform. As Bob said and as I know so well there are many of you in this room who have been out working on behalf of health care reform for a very long time. I don't know if any of you were around in 1915 when the first national commission called for health care reform on a universal basis or were around in 1938 and '39 when the Murray Dingle Bill was introduced. Maybe some of you were around in the early 1970's when President Nixon introduced a very comprehensive national health care plan with an employer mandate. Some of you might find that hard to believe, but there were Republicans like that 20 or 30 years ago who took positions that now are considered more difficult for their party to embrace.

But I know that for at least the last decade many of you have been on the forefront of trying to educate the public about the issues confronting us as a nation both on a human scale and an economic one. And trying to do all you can to convince our fellow citizens that this is an effort whose time has come. That we can no longer deny what is happening in our health care system, pretend that it will go away, try to pay for it over or tinker with the margins. That it is indeed time for national health care reform.

I'm very grateful particularly to Ron and many of you for the work that you've provided over the last year and a half as my husband hammered out his own health care opinions and looked for ways to provide a comprehensive approach. And many of you were in rooms for very long meetings and briefings and question and answer sessions that led him to his absolute conviction that health care reform is something that he intends to tackle. Now it is no surprise that we are quickly discovering that real change is hard and that there are many arrayed against change for the own purposes. But if you believe as we do that part of what this election we held was about was accepting responsibility for the problems of this country and being willing to tackle some hard choices then I hope that you will stay with us as we travel down this road together. It will not be smooth, by any means, but I am confident that at the end of it we will feel that we've made our contribution in trying to put our country on the right

track and solve a lot of our problems, most particularly health care.

I want to say just a few things to start with and then mostly spend my time with you answering questions that you have on your minds. Because this is an audience that is very well educated and sophisticated about the nuances of health care reform. I want to share a few thoughts with you before we move to your questions and my attempts at answers.

There are a number of very difficult decisions that will confront us as a country when we unveil our health care reform proposals. All of them require that our people have a requisite level of understanding about what is at stake in this health care reform debate. I cannot emphasize too strongly how all of your grass-roots public outreach efforts are critical and need to be doubled and re-doubled again. Because, in my many travels and conversations around the country I've experienced what I'm sure many of you did, which is a kind of mixed message coming back at me. Many people are concerned, in general, about the health care situation, many are concerned, in particular, about their own situation with respect to the cost of their own insurance or their lack there of or the many other issues that come our way in this debate.

But in my conversations I often find many people don't draw relationships between how all of these things fit together into the whole that we have to address. And it is so important that we draw the connections for our fellow citizens. Let me give you just one example. As Mr. Blendon and others have argued repeatedly over the last months, we have to explain this proposal to people in a way they understand. Right now most people seem to be satisfied with their insurance coverage but scared about losing it, having it diminish, having it increase in cost. They are reluctant to pay very much more themselves, either in the form of taxes or any other contribution, to help cover people who themselves are uninsured. Because there is an enormous amount of economic and psychological insecurity out in the country. It makes a big difference to people who are worried about their own insurance if they understand that part of the reason for the underlying insecurity they feel is because there are so many of their fellow citizens who are uninsured. And to explain to people that the uninsured in our country do end up getting care, but they get care at the most expensive point of entry by going into the emergency room, often after a condition has deteriorated or become more acute and they have not sought primary or intermediary care. They then are put into the hospital in a room next to someone with insurance which is one of the reasons why the person with insurance ends up paying \$19 for a tylenol on his or her bill in order to help pay for the person in the room next door. Most people don't ever think of it that way, they don't

ever see the connections between uncompensated care and their own insurance bills. That is just one example of the many examples that we have to look for to help people understand what is at stake in this debate.

And there are really five words I'm using over and over and over again. Security, Cost, Quality, Choice, and Simplicity. Each of those five words stand for a series of attitudes, expectations, feelings, proposals that we hope we'll be able to make clear when we present a comprehensive plan.

Security is obviously number one. As Rob pointed out, this debate is being driven by people who will not have that sense of security even though they may be insured. When you have 100,000 Americans a month losing insurance, when you have employers shopping around and finding it increasing difficult to provide even the same benefits at the same costs with only inflation adjustments, when you have people who see their friends and neighbors being laid off or having their retirement benefits ripped out from under them there is a great deal of insecurity. So the primary objective of this reform is to make every American regardless of their insurance status today, regardless of their health status to feel they will be secure. They will have access to the health care system, they will be guaranteed a comprehensive benefit package, their package of benefits will travel with them from job to job, from state to state, so that they then can worry about something else. That security is key and don't just think about it in the terms of the uninsured, we can not when the national debate if that is the focus. The uninsured deserve to have security so that everybody will be more secure. Security is the first primary argument that underlies our hope to have universal access as quickly as we can realistically obtain it.

Second, cost. We have to be able to demonstrate that costs will be controlled effectively. And that through the effective control of cost will come a re-allocation of resources within the health care system that will do a better job taking better care of more people. And there are many examples that illustrate what we are talking about with respect to cost. And some of those I think can drive home our point again in ways that people understand. If people understand that the paper work hospital is growing 4 times faster than the real hospital and that much of their health care dollar, therefore, is going in to providing for clerks who are checking and filling out forms and insurance underwriters who are spending their time trying to figure out who does or does not need insured. And personnel and doctors, offices and hospitals who themselves are part of the paper work hospital that if we control costs what we are talking about is eliminating from the system a lot of those features that have very little or really nothing to do with the status of anyone's health. So part of what we have to persuade people is that we

are not asking them to pay more money for our health care system we are asking them to participate in a universal health care system that provides security and controls costs because we think there is money in there that can be better utilized than it is today.

Thirdly, quality. No one wants to do anything that undermines the quality of our health care system. That has to be the first and foremost position that we take when we're talking about what we hope to see at the end of all this reform. It's high quality, good doctor-patient relationships that lead to better outcomes, more opportunities for people to get information about quality so they know about outcomes so they can be better consumers of health care. And in the quality debate that will take place I will predict to you that, that will be where most of the special interest focus their opposition. Nobody is going to run an ad which says don't pass this reform it will cut our profits. That's not how this is going to be played out. It will be played out with somebody in a bright coat, probably depending upon the market, a male, a female, a black, a hispanic but somebody looking very official in a white medical coat. Who in very kind of Marcus Welby says, "Be careful we've always had the finest quality medical care in the world they, they want to take it away from you." That will be the argument because that will be where peoples desire for security will run straight up against their fear of change. As bad things are now, as expensive as it might be at least we feel somewhat comfortable in it. And so the quality issue is absolutely key. And frankly if we don't do a good job trying to enhance quality we're not going to have the kind of reform that you and I would want to see.

Fourth, is choice. That will be the second wave of commercials after the quality commercials. "They want to take your doctor away from you, they want to prevent you from seeing who you want to see." They'll probably have some older person saying, "But I've always gone to the same doctor and now there going to take my doctor away from me", and having this bad looking doctor with a clip board, you know, with his head bent over. That is what the ad is going to look like. What we have to do is to have a health care system that guarantees choice in so far as we possible can and that we intend to do.

And then the final word is simplicity. We can't explain this to people. If they can't feel comfortable they'll be able to navigate their way through it then that too will be a roadblock to reform. And so those are the kinds of hallmarks that we're attempting to achieve in effort to put together this comprehensive package.

So finally let me just say that many of you have involved in working with the task force in providing substantive and policy and political advice of all kind and I'm very grateful for that. I think though that as hard as we all have worked to try to get to this point in time it is only the beginning. It is something that we have to see as a long term commitment because after we introduce the legislation we will have the enormous task cut out for us in order to educate people and convince the Congress to vote for it. Then after we pass the legislation we will have an enormous task to make sure it works the way we want it to work. And at every step along the way and at every level in the process we will make advocates grassroots organizations, people like yourselves who are there to not only help move it along but to understand what should be done to make it successful. And it is very important for me to stress that I view all of us as having the same objective. Though there may be disagreements, there may ways your organization would have done it differently than somebody else's organization, but what I hope is that in so far as possible we will have a united front on behalf of health care. Because believe me there are people out there who don't want anything to change and who will be loaded for bear as they say in Arkansas. And if we are not as strongly united and are willing to reach across lines that divide us in order to have as strong as front as possible we will be picked off one by one. They've done it before they will do it again My good friend David Pryor from Arkansas tried to do something about prescription drugs a couple of years ago. Drug lobbies went to the grassroots organizations and convinced a lot of them to stand up against drug reform by convincing them that it would take their drugs away from them. We have to learn from our mistakes, keep open lines of communication and be ready to be united in this effort. So with that Ron I would be glad to answer questions.

## Question and Answer:

Q: Greg Hafley (National Health Law Program) Which is a legal services program working for low income people throughout the nation on health issues. And we applaud your efforts to work to cover the uninsured and to make access to health care more meaningful for people with medicaid. My question is can you tell us a little bit about how you envision having low income people, who are going to be subsidized in some fashion under health care reform, have access to the full range of plans based on what in theory may be some kind of limited subsidy? To make sure that those people are either not relegated to second tier plans or that, because of the limits in their subsidy their not subject to discrimination based on their financial ability to play by the plans that may want to keep them away or deny them care.

HRC: That's a very important question and one we have obviously given an extraordinary amount of thought to. Let me answer it in two different ways. We intend for the comprehensive benefit packages to be available to every American. That is not a negotiable part of any plan. That has to be provided so every low income person on whatever sliding scale with whatever amount of subsidy will have the same set of benefits which will be comprehensive as anybody else. So, if they choose from among plans we want them to be choosing, not on the basis of benefits but on the basis of other features. It may be that, as I have been traveling around the country and seeing how providers are beginning to think about this, it may be, as I've recently heard in New Orleans that a network of minority doctors is going to be trying to form itself into a health plan. So one person may prefer those physicians than another set of physicians. They may prefer an HMO or a fee for service network. But the level of benefits accessible to every American will be the same. There will opportunities for supplementals above that. That is something that, you know, is available at every country that were aware of. So that will be available, but that's why we want the benefit package to be a good one so that everybody is available, is able to get that.

Secondly, we have to beef up our public health infrastructure and then require that health plans utilize public health facilities as part of their integrated service network. It will not do us any good if we continue to have this desperate provision of health care that is not able to serve many undeserved areas in inner cities or in rural areas which is one of the whole reasons why we want to have an integrated delivery network. So we ought to have the plans have incentives and where necessary even requirements to make sure that all the people they are required to serve can be served. Because we expect to have the service delivery area defined geographically by population and any health plan that wants to bid for those patients has to be able to show that they are going to provide access to services throughout the geographic area. The only way to do that in many areas is by linking public health facilities with private

facilities in that kind of network. So, again in Louisiana I had a conversation with the medical director at Oxnars, which you know is a very well known tertiary clinic. They're already negotiating with public health clinics and others to be able to have this network.

Now, once we have a system in place that looks good on paper it's going to be up to consumers, it's going to be up to the people who run the alliances, which will have a lot of consumer involvement, to make sure it really works. Because you and I know matter how well you design a system there are impediments psychological, geographic, cultural that have to be overcome. And so we're going to design it in a way that we think will lead to that kind of positive outcome for low income people. But I'm not going to sit here and tell you that what's on paper is going to be translated in every community in America into what will work and that's why we're going to have to rely on the combination of consumers and oversight from the state and federal government to make sure every plan delivers to their low income members as well as the others.

Q: Sarah Casson (American Heart Association) Again, I just would like to thank you for all the attention you're putting on prevention. So many cardiovascular diseases are preventable and as you probably know tobacco use is the number one cause of preventable death in the United States. I would like to encourage you, I know there is a lot of talk about including an excise tax on tobacco in the health care reform package as a way to reduce consumption as well as a revenue enhancer. But I would like to just ask what kind of considerations you're giving to other prevention issues regarding tobacco? You mentioned that pharmaceutical companies and the administration has been very outspoken about concerns with them. But the tobacco industry is completely unregulated. And not necessarily within this health care reform package but I'm wondering if you could speak to what the administration might do later on prevention and regulating the tobacco industry as far as advertising and things that go into their products?

HRC: I can't really speak on that I've only focused on this one issue and that is the advisability and amount of any excise tax on cigarettes themselves and what that would be used for in terms of a designated funding stream within the health care reform and I haven't really gone beyond that.

Q: Sharon (American Psychiatric Association) We're very encouraged by the activities of the health care reform task force as it applies to those poor folks with mental illness and addictive disorders. Can you tell us in a benefit package will it end the discrimination against persons with mental illness and addictive disorders by providing parity and coverage with other chronic illness such as diabetes or hypertensive illness?

HRC: I doubt it. I don't think we can afford to do that at this point. I think that what you will find in the comprehensive benefit package is a very important statement that mental health and substance abuse are part of a comprehensive health care reform package. They will be covered and we will be looking for ways to expand that coverage over time. But I can't, I'm not going to sit here and tell you that it will be parity. I don't want to mislead you. I think we are engaged in a great battle, as you know better than I, to convince anybody outside of a very few that are already convinced that it should be in there at all. And that the costs dependant on trying to mandate a benefit package which includes mental health coverage of a significant amount plus substance abuse coverage is appropriate. And, so I think we're going to make a very good beginning, we will establish the legitimacy, we will create the opportunity for infrastructure and we will continue to build on that. But we can't, we can't I think financially or politically at this point claim we could reach parity with this first package.

Q: Judy Riggs (Alzheimer Association) And I just want to congratulate you and thank you for all the emphasis that has been put on long term care in this package. We represent probably 1/2 the people who are in nursing homes, but we still believe though the emphasis on home and community based care is absolutely right. That's where most people who need long term care are and that's where they want to be. And in fact it really is the public-private partnership we want between government and families. Can you talk at all about how you would structure that benefits so that it really provides the flexibility for families and people to get what they want and we don't end up with another medicare home health benefit that doesn't really help on long term care?

HRC: Right, I think that we are committed to providing a long term care package that makes a good start on creating a national infrastructure for long term care by emphasizing home based care, intermediary care and by doing it in partnership with the state because a number of the states are way out ahead of the federal government. They have been modeling some very effective programs that we think can serve as a model for the entire country. We also want very much to encourage intermediary care in settings like respite settings, day care settings, congregate housing. Things short of nursing homes in which families can participate in the ongoing care of their relative maybe not be able to shoulder the entire burden but to whatever extent feasible participate financially, and psychologically, emotionally, physically. So those are the kinds of values that are guiding us. And we think it is very important to make a statement now that long term care does not equal nursing home care. Long term care has to be part of our whole approach toward providing security and choice as I mentioned before. So we think that we

can actually cover more people in ways they want to be covered by eliminating the incredible preference and even requirement for nursing home care. And instead shifting resources, creating a new infrastructure, providing incentives for people to stay in their homes or into one of these intermediary steps and that's what we intend to do. And we intend to get as much as start on that by funding as much of it as we can as soon as possible. But we want to do it in a reasonable effective manner. And although there are some states that are way out ahead of the rest of the country, most states are not. Most states have largely responded to the nursing home lobby and built more nursing homes, more beds, required people to spend themselves down in order to get into that. So we have to change attitudes, and change the incentives and create infrastructure that will actually work.

The other piece of that is we have to provide more flexibility in a lot of the existing funding streams so that workers, para-professionals can go into homes to help families. You don't have to have registered nurses doing things that some one at a much less cost can do more effectively within the context of a home. So there is a lot of things, and I know Judy you know that Robinwood Johnson Foundation and others have been trying to fund programs to show us the way as to how to be more effective, reach more people, treat them with respect and give them choices and that's what our long term care program will be aimed at doing.

Q: Pat Weiss (Grey Panthers) There is a doctor in Northern Virginia who has diagnosed our society as having a terminally ill, we're a terminally ill patient due to greed. I hope that you will harness the greed of the doctors and hospitals and the pharmaceuticals but I would go further in suggest that you totally eliminate the health insurance companies. I can't see any real need for them in our, there rather superfluous and we pay there profits as well as all the paper costs, I think you see what I mean. Are you going to eliminate them?

HRC: No, but it's going to be kind of a Darwinian struggle for them for a change, and only the best and the fittest will survive instead of what we currently have. Moving from where we are to what our vision for health care in our country is, is going to require a necessary transition period. Health insurance is actually a relatively small part of the over all insurance business in this country. There are a number of insurance companies that have seen the writing on the wall and have moved more toward trying to work with large employers, for example, to help them understand the health care system and to be more effective consumers of it. So I predict that we will still have a health insurance industry, it will be a lot less than it is now, there will be far, far fewer companies and they will like everybody else go back to making money the old fashion way, a little bit of money and a lot of people. Instead of what they

have been doing which is through underwriting practices, eliminating anybody who ever might get sick. And so I think what we're looking at is a reasonable role for those insurance companies that survive this transition.

And the other side of the coin, you will also hear a lot about this depending upon what state you live in. The elimination of insurance companies means the elimination of lots of jobs of lots of people. Many women, many clerical workers, many people who I know because of these changes will be unemployed within the next several years, that is not an easy prospect to contemplate. There will also be significant unemployment in the paper work hospital, whether it's billing departments in hospitals or clerks and doctor's offices. The entire underwriter industry will be decimated in terms of health care. So when we're talking about eliminating anybody we are talking about social costs that I think we have to be very sensitive to because those people have to make a living and they have to put food on the table and they have to take care of their children when there sick.

Now the other side of the coin is that I anticipate an increase in employment in health care providers as opposed to paper pushers. And so that will occur and the net gain and the net loss we hope over the next several years will be basically a wash. And it will be good for the economy because we will be freeing up money that can be invested in other things and we hope put people to work making cars or widgets or what ever else they do. But don't over look the fact that in certain key states like Connecticut this reform will cause the shut down of insurance companies, the layoff of workers and it will have political as well as economic costs and those of you who are advocates need to be sensitive to that. It is not enough just to say eliminate the insurance companies when you go in to talk to the 2 Senators from Connecticut. You're going to have to be sensitive to what this means economically even though in the long run, I would argue in the medium term run the changes will be good for the economy of every single state. In the short term there's going to be some dislocation and some real loss that we are going to have to be willing to face up to, admit and then help deal with.

Q: Dan (National Council of Senior Citizens) For our organization thank you for your good works. I've got two brief questions. One, what is your sense of the wind, the schedule, the integration of medicare into the national system that your describing, number one? Number two, what is your sense of the level of involvement of consumers in the governance of help alliances or ? in terms of quality insurance, in terms of peoples rights and in terms of the confidence in the system?

HRC: Let me answer the second first. We anticipate a significant level of consumer involvement in the governing of these entities both in decision making roles and in evaluation and analytic roles. Part of the reason we hope this works the way we are talking about it, and that many of you have helped this thing through, is because we will make a better consumer out of people who are now in the health care market by giving them adequate information, by giving them roots to question decisions, by giving them the opportunity to really walk with their feet. They will no longer be tied to an employer's plan, they will no longer be tied to any particular plan, they will be able to vote with their feet as long as they are well informed about their choices. So consumer guidance on that is going to be key and I can see a whole new out growth coming up of newsletters and magazines, "Enter health plan", you know. Back and forth discussions about what works and what doesn't work and why does our health plan not have as good an outcome for, you know, heart disease as the health plan across the river. I mean I think there will be a great opportunity that many of your organizations will seize to help educate us. Right now American consumers are not well educated about their health choices so we have to involve them at every level of this process.

With respect to medicare, there will be, over time, a phase in of medicare we believed based on the objective reality that it will be better off for Senior Citizens. That it's not something that we are going to come out of the blocks with and say, "we're going to put all these big systems together" because we know there's going to be inevitable transitional problems that we are going to have to overcome. And we're not ready to just take medicare and try to start from the very first day try to integrate it. But we hope over time the integration becomes obvious and that we begin from the very first day to make the case for integration and move toward it but not start with it. And the time table on that I don't really know, it kind of depends on when we pass the legislation, when it gets implemented, when it starts proving itself so we can then move toward a truly integrated health care system that includes medicare.

Q: Marty (American Association of Dental Schools) I wonder if you can tell us whether the basic plan will include a least relief of pain and removal of infection when it's in the mouth? There have been lots of different reports about what your thinking is.

HRC: I hope so, I hope it includes dental care for children and acute dental care for adults. That's what we are hoping for.

Q: inaudible (President, National Association for Home Care) I would like to join in thanking you for what you have done. I think it's historic and I'm reassured that you will be successful working together with all of us in getting your plan through. My question relates to the most devastating epidemic that's faced this country in some time. And that is the epidemic of AIDS. And I'm wondering what is the present contemplation of the task force in terms of dealing with this problem? And it's a very difficult problem, as you know, and I'm just wondering what your current thinking is with respect to it.

HRC: Our current thinking is that AIDS will be treated like any other disease and with respect to the removal of pre-existing conditions it will certainly no longer serve as a bar to health, access to health care. A lot of the difficult issues about a disease like AIDS revolves around experimental treatments and research. How much we're able to really direct our attention to that within the context of the health care reform plan I'm not sure of. But in terms of treatment that is currently available and considered medically efficacious, you know, that will be available part of the comprehensive benefits package. Just as it would be if you had Multiple Sclerosis, Diabetes or any other chronic and perhaps eventually terminal disease.

Q: Terry (Human Rights Campaign Fund) Specifically in dealing with life threatening and serious illnesses many times there is no treatment that is approved and has been proven effectuates or some times even safe. Very often it's the choice and individual has to make weighing the risks and potential benefits of a treatment in determining whether or not they are going to use it. When you are looking at a life threatening situation if we remove availability of these treatments very often what you are telling people is that have no choice except to face the uncertainty of their illness and prognosis. And as a follow up to that also I know that there is a lot of support developing on the Hill for investment in medical research as part of health care reform. And I'm hoping that we will be able to build a bi-partisan alliance between the administration and Congress in pushing that forward. Specifically there is a proposal for a medical research trust fund, I'm hoping that you can comment on that.

HRC: I'm aware of that and I think those are all very important issues that we have to look at carefully. I'm a very big supporter of medical research and how much money we're able to put into medical research and where we direct it to go, what we think the cost-benefit analysis is with respect to research dollars and outcomes, is something that we are looking at very carefully. And I just can't tell you what the position of the administration will be about that. I know the options that are out there but that is something we have not made a determination of.

Q: Carolyn (National Association of Rehabilitation Facilities) And my question to you would be similar in considering the core benefits package. Whether or not it would be including medical rehabilitation services and if so if there are any limits what they might be?

HRC: You know, I don't, I can't answer that specific question. I'll find out for you and let you know, I just don't have that off the top of my head.

Q: Sam (National Caucus and Center on Black (inaudible)) I wondered what kind of specific expeditious procedures are you going to put into effect to insure minority providers as well as minority beneficiaries that they will be properly treated, that there will be a prompt procedure for dealing with any complaints that they might have?

HRC: Well I think that we will have a grievance procedure, and (inaudible), some kind of mechanism within the help alliance and within each health plan that will be available to every citizen. And again it's going to require individuals to become well informed and to make choices that are right for them. So we'll have the mechanism there but then we're going to have to do a lot of grassroots work to make sure people know about the mechanism and are well informed advocates for their own case. So that they can make best use of that. But that will certainly be one of the built in protections that I think will be especially important for low income consumers and minority consumers in many communities.

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