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REMARKS OF THE FIRST LADY  
AT THE ASSOCIATION OF  
AMERICAN MEDICAL COLLEGES

MS. CLINTON: Thank you very much, Dr. Koop, for that introduction and, beyond that, for your continuing leadership and commitment to health care, and for your persistence in seeing that we, as a nation, continue to follow through on what is a most important domestic issue confronting us.

Thank you, Dr. Foreman (phonetic). I appreciate the invitation to be here today. Thank you, Dr. Petersdorf (phonetic) for opening this opportunity to me, particularly the chance, after some initial remarks, to answer questions from this distinguished audience.

I must tell you I have given I don't know how many speeches by now, certainly dozens, maybe hundreds. Dr. Phil Lee, who is here at the head table with me, and I have traveled literally from coast to coast and from the Canadian to the Mexican border together, but this audience does strike a little bit of terror in my heart. I am conscious of the extraordinary commitment to excellence among the institutions represented here and to the variety of the institutions represented here.

There is no more important part of that we do as we embark upon the forum than what is entrusted to the member institutions, training the next generation of health professionals, maintaining and enhancing quality, going beyond the boundaries of current research, and providing, really, the foundation upon which the excellence of the American health care system is built.

So we have taken, very seriously, the challenge faced by all of us to bring about reform by preserving what is best about the American health care system while fixing what needs to be changed.

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The most important aspects of what we are attempting to do will be to insure, as soon as possible, universal health care coverage for all Americans that represents not only a commitment to coverage and access but which ensures comprehensive benefits so that we establish, in effect, a floor below which no American can fall.

If we fulfill our commitment to that fundamental principle, than many of the other issues that concern you and me will be taken care of. If we do not fulfill that primary commitment, then we will continue merely to carry out marginal kinds of reforms with unattended consequences that do not lead either to the financial stability of our current system, to a guarantee that we can maintain the excellence that you represent, or that we can continue to afford to provide the quality of care we currently do.

The president has said, and we have repeated in every speech that anyone representing him has made in the weeks since he presented the legislation to Congress, that he will not sign any bill that does not guarantee universal coverage with comprehensive benefits. That has to be the bottom line.

But as Dr. Koop has pointed out, there are many areas of the reform package that we are continuing to seek consultation on. There is no reason why we cannot work out any of the technical details that concern any particular constituency, at least to arrive at what is the best possible outcome under the circumstances available to us.

So with those two thoughts in mind, that universal coverage, the comprehensive benefits, is non-negotiable but that many of the detailed and technical issues certainly are, let me briefly run through some of the issues that I know are a concern to you.

Under the current proposed reform plan, we will be provided a funding screen for academic health centers. That funding screen will actually total more money over the five years of the initial reform implementation than would otherwise be available if we were to maintain the current formulas for graduate medical education, both direct and indirect within the medicare system today. The difference would be approximately 50 billion compared to 46 billion. That funding screen will be routed in a commitment of a percentage of funds from those who are in the health care

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system paying premiums.

In other words, all Americans who will be obtaining benefits will be paying a portion of their premium costs, about one-and-a-half percent, to maintain and enhance these services that we take for granted and are really dependent upon provided by academic health centers.

We know that any change is likely to cause some concern. Change makes people anxious. My husband is very fond of saying that people always are in favor of change in general but not often in particular. I think that in today's current climate, that is certainly true. People know things have to change. They are just not sure what direction or what specifics the change should take.

In our efforts to maintain and enhance the roles of academic centers, we believe we are provided a firm funding base that will actually produce more income to the institutions than would be available under current conditions. That is certainly true if instead of health care reform, what we spend our time on in the next month is capping entitlements such as medicare and medicaid.

We have a very difficult situation confronting us today in Washington because many in the political arena have determined that the most effective political statement to make, in effect, to try and be on the right side of change, as they define it, is to cap medicare expenditures in order to lower the deficit.

I cannot stress strongly enough how dangerous that is to every institution represented here today. If we cap the rate of growth in medicare and medicaid in order to obtain further deficit reduction in the absence of health care reform, you will get the worst of all possible worlds.

You will see your income from medicare through both indirect and direct medical education grants diminish rather dramatically over the next years. You will see further very little chance of obtaining further funding because one of the issues you will confront is what is called caps on discretionary spending. So you will have the money taken away from the medicare system decreasing and will find it extremely difficult to add to it because of these caps.

A second and equally threatening development is the

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balanced budget amendment. I mentioned that because it would have an even more dramatic impact, almost immediately upon its passage, on institutions such as the ones represented here and nearly every other forum of domestic spending. Now, no one argues that we need to begin to decrease the rate of growth in both medicare and medicaid.

That is why in the president's proposal we do achieve reduction in the rate of growth, but they are reductions that are taken in the context of overall health care reform. We have the kind of funding base that will come from the premiums that will be a secure, and new, and larger funding stream while we reduce the rate of increase in medicare and medicaid.

In medicare, we will provide benefits for older Americans, including prescription drugs and the beginning of long-term care. We also intend to continue both medicare and medicaid disproportionate payments so that the kind of uncompensated care that will remain after universal coverage is achieved will be taken care of.

Now, I mentioned these issues at the front of my remarks because I know they are in the minds of many of you, and I want to put them into a context. Oftentimes, in the face of efforts to reform any system, people become very focused on the details of that reform; in effect, focusing on the trees and perhaps losing the forest.

If we do not permit the growing movement for capping medicare and medicaid, if we do not talk sensibly about a balanced budget amendment that can only, only, balance the budget on the backs of the health care spending that are in the budget, because every other form of discretionary spending has been basically frozen, and defense has been lowered as much as anyone feels is appropriate, all that is left is health care.

To take that money and use it for deficit reduction would mean will never, at least in the foreseeable future, have health care reform, and your institutions will be further impaired by financial cuts that will be unpredictable, arbitrary, and not replaced with any other funding stream.

Now, usually when I speak about the health care reform, I talk about the principles that underlay what we are

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attempting to do. I want briefly to mention those, but I would have felt quite remiss if I had not tried to place in context for you what we are up against at this point in time as we move forward. I believe that we may discuss some of those specifics even further with Dr. Koop or with some of you in your questions.

For the basic principles that underlay what we are attempting to do is number one, security which gives universal coverage with comprehensive benefits. Those comprehensive benefits include preventive health care. They include the kind of preventive health care that for too long has not been reimbursed by either the public or the private insurance systems.

They include even some forms of preventive care that we believe are so justified, according to the recommendations of the United States Preventive Services Task Force, that they will be free to every American. It is important for us to try to stress preventive care because we view it as one of the openings to more responsibility for individuals and for the entire system.

Another feature of the comprehensive benefits package that I want to mention is that it includes mental health benefits and substance abuse treatment. If we do not include those two particular services in the benefits package, we will not have recognized the full range of needs that our people have, but it will be a fight to keep both of them in there.

We have twice the benefits package with the extraordinary help of not only all of the government actuaries but outside economists, and actuaries, and benefit specialists as well. The kind of financing that we are putting forth in the plan is more than sufficient to fund those benefits for every American because in addition to reallocating some of the funding currently provided by the federal government, we will be asking all of those who are currently not contributing to do so.

The second principle is savings. We believe there are savings to be obtained in the system, and we have been particularly moved by research that a number of the institutions represented here this afternoon have done in the past years, demonstrating the lack of correlation often between costs and quality. The incredible inefficiency often

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found in the delivery of the same services in one region of the country compared to another region to the same type of patients or the same kind of procedure.

We know that we can obtain savings if we run more efficiently. There are some simple things that many of you are already doing and that we will provide opportunities for you to do further. We are changing the anti-trust laws so there can be more corroboration and collaboration.

We are asking that institutions take a hard look at the kind of uses they're getting of technology so that that expensive piece of equipment, rather than being run from 7 to 4 or 7 to 5 be run from 7 to midnight, things like that which, in some places, have already been tried are maybe small steps toward becoming more efficient, but aggregated will be extraordinarily impacted on what we can expect in order of a degree of safety.

The third principle is simplicity. Here we are doing our best to move toward a single claim system both for providers and for patients. There isn't any doubt, and I doubt there is anyone in this room, who would argue that we could free up literally thousands, hundreds of thousands of hours of time for professionals, as well as dollars, by eliminating paperwork that is unrelated to the delivery of quality health care.

There have been too many examples of that even to quote, but in every institution, given the current financial pressures in the existing system, I know that steps are being made to move towards simplification. We want to accelerate that by moving nationally in the same direction.

The fourth principle is choice. There has hardly been a more misunderstood concept and one that has given more horror to the defenders than the status quo. Choice, in today's current health care system, is diminishing on a daily basis. Many of you who run institutions that are academic health centers, or in some way affiliated with one, have had the experience in the last several years of losing patients because their choices were decreased by employer decisions about what health could would be available to them.

When I served on the board of the Arkansas Children's Hospital, which is affiliated with University of Arkansas' Medical Sciences Campus, we were continually

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getting reports of large insurance plans that would no longer refer patients or permit patients to go under the plans provisions to the Arkansas Children's Hospital because it was thought to be too expensive in its delivery of high quality tertiary care.

Choice is decreasing as we sit here today, choice both for patients and for physicians who are being told that if they join one particular kind of health plan, they cannot join any other.

Under the president's plan, we reverse that decline in choice. Choice is given not to the employers but to the individuals. Every year the individual will determine what plan he or she will join. Physicians will be permitted to join more than one plan at their choice not at the plan's direction.

So, in fact, we will be increasing choice. In every area, there will probably be at least three and many more plans including an HMO, including a network or a PPO, and a mandate fee-for-service network. A physician under the plan will, at his choice, be able to join all three if that's his decision.

The fifth principle, quality, is one where we will be looking particularly to you for help. We intend to utilize the academic health centers and the other medical centers around the country to really serve as quality providers and to hold the system accountable for quality. That will be, in part, some of the funding that will come to you directly from the premium base that I referred to earlier.

We want to have health plans issuing report cards on themselves. We want to make better use of the clinical information available and to disseminate it more widely so that plans can make decisions about what is and isn't appropriate care. So quality will be a major feature of what we are attempting to achieve.

Finally, the last principle is responsibility. Here we mean a number of things. We mean the individuals need to be more responsible for their own health care. We mean that the profession needs to take increased responsibility to make some of the difficult decisions that confront us with respect to appropriate procedures and the

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like. We also mean that a system of universal coverage must be responsibly and fairly financed.

There are only three ways to finance universal coverage. You can either have a tax, which is a very broad-based tax that replaces the existing private investment, sometimes referred to as a single payor system. Our country would require a tax increase of somewhere between four and five hundred billion dollars. Or you have an individual mandate in which individuals are told they must buy health insurance such as now happens in some states where individuals are told they must buy auto insurance.

We looked at both of those alternatives. For a number of reasons, we decided it was not the best choice to pursue either of those. With respect to the single payor system, we absolutely embrace the goal of universal coverage and the kind of simplification and decreased administrative costs that come with it.

But we did not think that we were in a position to try to replace the kind of private sector investment in health care and, in fact, wanted to retain different kinds of approaches to the delivery of health care and financing of health care as we evolved a universal system.

With respect to the individual mandate, we are very concerned as to how one would administer such a mandate and how we would keep track of it, how we would determine who was and wasn't covered, and if we had, as we would have to have, some kind of federal subsidy for that individual mandate, at what level it would be set and how we would either discourage or prohibit employers who currently help to pay for their employee's insurance from deciding not to, which would shed employees into the subsidy pool, or determining that they would keep employee's wages just below the level at which they would have to pick up any of the costs.

So, for a number of reasons, largely administrative, we could not see how that could operate effectively. We determined their floor to build on what works for the 90 percent of insured Americans currently, an employer/employee system.

In fact, we believe that of the insured, 70 percent will actually pay the same or less for same or better benefits because once they are all pooled into these

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alliances that are task groups, they are purchasing cooperatives, they are not meant to be regulatory. They are meant to pool the resources so that we can get the best possible price value for all citizens that are now available only to the biggest companies, that we will actually be saving the vast majority of insured Americans money.

Now, all of these issues will be debated vigorously in the next month. What we ask, those of us who are committed to seeing health care reforms through and committed to seeing that Congress act on this in 1994, is that we spend our time debating over real issues, and that we appreciate what is at stake, and that where we agree, do so in a unified manner and where we have disagreed work them out among us.

The biggest threat to reform is the same threat that Franklin Roosevelt faced when he tried to provide health security as a second part of social security, the same threat that Harry Truman faced when in 1945 he presented a comprehensive health care reform bill remarkably similar in many respects to what this president has presented, the same kind of opposition that Lyndon Johnson faced when he finally got medicare and medicaid available for the elderly and the poor, and the same kind of opposition that even Richard Nixon faced when, in 1970, he presented a bill that would have required an employer/employee system for funding health care.

That opposition has been the status quo in its defenders. We have to do better this time. In 1945, we were spending four percent of our national income on health care. Today we spend 14 percent with no end in sight, knowing full well that 100,000 Americans a month lose permanently their health insurance, knowing full well that your hospitals get burned more and more every year by uncompensated, uninsured care.

We have a historic opportunity, and I believe we are going to step up and meet it. That's our most fervent hope. We know that many of you in this audience will be our most committed allies because you see every day what is at stake. Thank you very much. (Applause)

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