

Withdrawal/Redaction Sheet

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
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001. paper	Remarks of the First Lady to the Brookings Institution; RE: private information [partial] (13 pages)	03/01/1994	P6/b(6)
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COLLECTION:

Clinton Presidential Records
 First Lady's Office
 First Lady's Press Office (Lissa Muscatine)
 OA/Box Number: 20107

FOLDER TITLE:

FLOTUS Statements and Speeches 12/2/93--4/26/94 [Binder] : [3/1/94 Brookings Institute]

2011-0415-S
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RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

Freedom of Information Act - [5 U.S.C. 552(b)]

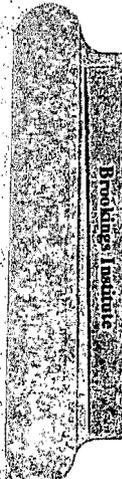
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- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
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THE WHITE HOUSE

Office of the Press Secretary

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March 1, 1994

REMARKS OF THE FIRST LADY
TO THE BROOKINGS INSTITUTION

Thank you, thank you very much. Thank you very much, Bruce. That was one piece of writing nobody had discovered. (Laughter.) I'm sure you'll be hearing about it in speeches and it will be used as part of a fund-raising letter on the part of those who are not as enthusiastic as I about policy issues like the ones I was talking about, with respect to Mr. Steiner's book. It is a real pleasure and honor for me to be here with you tonight.

Those of us who bear the title "policy wonk" with some pride have always looked to Brookings for the kind of thoughtful, analytic work that has tried to push the boundaries of the public debate beyond the usual partisan, ideological back and forth, seeking solutions, evaluations, and looking toward some resolution of policy issues that are at the root of our political process, as we attempt to deal with the problems of our time.

It is certainly fair to say that Brookings has helped to shape our political atmosphere, and one could say that it has done so with both the blessing and the curse of various people who have resided at 1600 Pennsylvania Avenue.

But it has always served such an important purpose. And there were a number of people in the White House who, upon learning I was going to have the privilege of addressing you tonight, said to be sure not only to mention our gratitude that you have offered so many from among you to be part of this administration, but that you have also continued to provide such helpful, constructively critical advice, as we have moved toward this past year.

And one particular comment that someone made to me that I wanted to share with you was the hope that Joe Peckman (phonetic) would be proud of what was accomplished this past year, in trying to make our tax code more progressive. (Applause.)

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But you have been helpful in a number of issues, both because of the work that you have always done, that you continue to press forward on, but also the ideas that have germinated here on deficit reduction, NAFTA and GATT, the breakup of the Soviet Empire, so many other important issues.

What I want to talk about briefly tonight is one that several among you, and many others of you, have been interested in, both professionally and politically, and that is health care reform.

And it is something that a number of your scholars and analysts and colleagues have been helpful to the White House on, both directly by serving, as was mentioned, on the task force, but also indirectly, by asking hard questions, by op-eds, and editorial commenting, and congressional testimony, which we have taken very seriously and followed very closely.

We are, as I don't think I need to really tell you, at a terrifically historic opportunity. As we attempt to try to deal with the problems posed by the health care reform, we know clearly that there is no easy answer waiting in the wings. If there were, Brookings would have proposed it and somebody would have adopted it.

Instead, we know that the kinds of issues that intersect in the debate over health care reform are extremely hard. They raise economic, political, social, cultural, moral, ethical considerations that have to be dealt with.

And what the President has tried to do in the past year, and certainly those of us who have worked with him and for him on health care reform have tried to fulfill, with respect to his request, was to create a health care proposal that was both substantively and politically appropriate for our times, with the chance of putting together not only a consensus, but a majority in the Congress for enactment this year.

Now, there were many choices that we were confronted with initially, and those choices have been made a certain way by the administration. They are being looked at by members of Congress and we will watch as the process unfolds. But there were several key choices that I want to mention tonight, and then to have a chance to visit

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informally, and answer questions or discuss with you further not only the choices I talk about, but others.

The first and most fundamental is whether we would propose to have some form of incremental reform that would then be built upon, hopefully, in years to come. The history of incremental reform in our health care system is not an especially positive one. We have tried often to make changes and to adjust the system around the edges.

The net result is that, as you all know so well, we are spending, as of this year, nearly a trillion dollars. The number of the uninsured has gone up. The drain on federal, state and local budgets from Medicaid expenditures continues unabated. For the first time, in 1993, states will spend more on Medicaid expenditures than on higher education, a traditional state responsibility.

In addition, the kinds of hard decisions about how to deal with those expenditures have been, to a large extent, postponed. There have been a number of interventions made into the system to try to control costs, and there has been, this past year, some slowing of the rate of growth. But we're talking about, still, a rate of increase at above 8 percent, when inflation is far below that.

So when we looked at perhaps proposing insurance reform, dealing with some of the other issues that are important, trying to provide some stability in the system, we concluded that short of an attempt to comprehensively reform this system, we did not think we could reach universal coverage and achieve cost containment.

Once you conclude that, and there are others who will obviously argue as to whether that is the right choice, there are only three ways we have been able to determine as to how one would reach universal coverage.

You can either have a broad based tax, which replaces the private premium system, the Canadian system, for shorthand, which many in this country refer to it. It is also the kind of approach that would put more financial control into the hands of government, not necessarily, though, control over the delivery system or the choice of service that would be available to the consumer.

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You may also move, as some in Congress have advocated, toward an individual mandate. And we looked very closely at that, as we did with the single-payer, government-financed form of health care financing. And with respect to the individual mandate, we concluded that there were a number of attractive features to it. It did recognize the essential requirement of having either a mandate or a tax to achieve universal coverage. It did impose individual responsibility.

But it had a number of drawbacks that we rejected. It would not, from our perspective, be easily administered. An individual mandate would require a rather substantial investment, most likely in the internal revenue system, in order to keep track of the individual requirement. It would require a subsidy so that those individuals whose wages fell below a certain level could be subsidized.

That would create inequities on its own. If one had a sliding scale, where would the cutoff be? If you set it at 200 percent of poverty, what about people who lived at 201 percent of poverty? How would you track wages going up and down? It would have, we believe, the effect of, at least, not inviting but tacitly permitting employers who currently insure from dropping employees from health care coverage.

If they chose they could drop all of their employees, but it might seem more likely that they would drop those who are among their low-wage employees, because they would fall into the subsidy pool, which would make it difficult to predict the amount of subsidy the federal government would need to set aside to enable an individual mandate to work.

And there is an extraordinary amount of leakage with individual mandates. We looked closely at auto insurance, which has been used as an example. States that require individuals to have auto insurance have a great deal of problems enforcing that.

That left what exists for most people. Ninety percent of those of us who are insured are insured through our work place. It is a tradition that grew up and took steam during the Second World War. It is one that many Americans are comfortable with and feel suits their particular health care insurance needs.

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Now, obviously, in order to move from the numbers who currently insure to a requirement that all insure would be a political challenge, and we understood that from the beginning. But the advantages of the employer-employee joint responsibility outweighed, for us, the political difficulty of achieving that particular outcome.

And we also recognize that we would have to subsidize, in this system as well, small employers and low-wage workers, in order for them to be able to afford the insurance. So the first choice, once we looked at universal coverage, was to determine the financing mechanism. And all through this past year, the President and I and others have repeatedly said our primary objective is to guarantee insurance for every American.

We stopped using the term "universal coverage" because most people outside of places like Brookings, in Washington, didn't know what it meant. They couldn't figure out what "universal" meant. They didn't know if that meant we were going to insure people in other parts of the world.

So we decided we would stick with phraseology that people were familiar with, and that was "guaranteed private insurance," which is the model that the President chose to pursue.

Once you reached that kind of decision in this process, that you wanted to achieve universal coverage, in fact, thought it essential to do so if you ever hoped to be able to contain costs in both the public and private sectors, and were willing to face the issue of the financing mechanism, which many people who say they're for universal coverage or guaranteed insurance won't get to -- I mean, that's one of the frustrating parts of this debate: the people who stand up and say they're for universal coverage, but they won't tell you how to finance it.

Once we got to that, then there were a number of other issues that had to be addressed. One would be how we determine what the standard benefits package would be for Americans, because we knew that if you did not have a standard benefits package for all Americans that served as the base, it would be very difficult to cost out what the system would require, in both the private and the public sectors, and to tell the American people what they would be

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buying if their representatives voted for a benefits package or for any kind of health care reform.

That, too, was a decision point. A number of the alternative approaches on the Hill do not describe the benefits package. They say, instead, that a national board will be created and that after health reform is passed, this board will then decide what is in the benefits package.

That struck us as very hard to sell, politically, and also wrong substantively. Substantively, we couldn't understand how you could price the system, determine what the costs were, establish whatever subsidies would be required, if you did not assign an actuarial value to the benefits package. One can argue about what should be in it and what should be out of it, but as a base there needed to be such a package determined.

And secondly, it seemed very difficult to us to try to figure out how we would go to the country and tell people that health reform had been passed, but we weren't going to tell them what they were getting for it. I don't think any of you would buy an insurance policy that you didn't know what was in it at the time that you bought it.

So we determined to go through what turned out to be, as Alice will tell you, one of the most challenging, difficult enterprises, but an absolutely necessary one, which was to go ahead and bite the bullet and determine what we thought the benefits package would cost.

And it was the first time -- at least those of us in working in this for the administration were told -- the first time ever that all of the necessary actuaries and economists and policy makers from other parts of the government all got together to work on this.

It is no surprise that the budget, in many efforts in the past, including the 1990 budget deal, could not be successfully addressed because health care costs were not accurately estimated -- or insofar as accuracy is possible, estimated -- when there had never even been a process before that put the people from HHS and OMB and Treasury and VA and everywhere else that anybody makes assessments about health care into the same room for months on end to struggle over these costs.

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The benefits package, therefore, is key, not only to costing the system the best we know how, but also for telling the American people what they are buying.

And then the third choice that I wanted to raise, just in a very brief way, is the choice of cost containment. This is one of the most challenging pieces of this. And it is important to look at the entire context in which these decisions about containing costs will be made.

We have been operating, traditionally, with a regulatory model that attempts to set prices on various procedures and services in the public sector, by the government, in the private sector, by a combination of, in some respects government action, but more so insurance companies, employers who, as the primary payers, are attempting to control costs.

We have built onto what is, in many respects, a piecework payment system, a complex and very leaky regulatory system. By that I mean that we have developed, through what we call the fee-for-service means of paying for medical care, the idea that some of the most highly educated professionals in our country should be paid on the basis of piecework.

How many tests did they run today? What kinds of procedures did they order? With the result that we are always one step behind those who are the providers, who are attempting to try to figure out how to maximize their income from an increasingly interfering regulatory system.

So that in the private sector it is not uncommon for doctors now to have to call insurance companies to request permission to run a test. They are not paid for their capacity to care for a particular patient or group of patients unless they are in some kind of managed system. So they have to seek permission if their clinical judgment falls on the edge, or outside what is the parameter established by the insurance company.

Literally 40 to 50 percent of the incomes of many physicians are, today, spent on bookkeeping and clerical help that spends its day arguing with insurance companies and government payers about whether or not something should be reimbursed.

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So we have this piecemeal system, with this regulatory model imposed upon it, and every time costs go up, or as they continue to do so at an accelerated rate, both the public and the private sides have tried to ratchet down the costs by imposing all means of attempting to rein them in, whether one calls them DRGs or whatever one wants to refer to them as, in the parlance of the regulatory model.

We decided to take a different approach. Our view was that the amount of time, money and energy that has been spent on trying to regulate prices and control them, in both the public and the private sector, could be better spent on trying to encourage the decision makers in the medical system to make their own decisions based upon budgetary parameters.

And so, from our perspective, we wanted to say to local areas: Here is how much we think you should spend on health care -- not based on what the government's going to tell you, but on how much the cost of health care, on average, is in your community.

And health plans that wish to compete for the business of individuals will be expected to operate within a budget. But you are no longer going to have to argue with an insurance company bureaucrat or a government bureaucrat over how that money should be spent.

You are going to have to decide among yourselves, and individuals will be the ultimate decision maker, because we will remove the choice of insurance plan from the employer and place it in the hands of the consumer. And if they are not satisfied, if the lines are long, if they don't feel they're given enough attention, whatever the problem is, they can move their business somewhere else.

And the great debate is whether any kind of cost containment should be imposed on the private sector, whether they're called premium caps or a budget with a target that would have some kind of an enforcement mechanism, or whether they are the extension of some kind of price control mechanism, such as being considered in at least one of the committees in the House as they look at health care reform.

We think a better approach is to try to have some budgetary discipline with enough room for people to make decisions and then try to fine tune it, based on individual health plans that go beyond that budgetary requirement.

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Those are three of the big decisions that we had to address. There are a number of others that I'm sure we can talk about. But the important point for us was how to design a reform system that was as much like what people are used to today.

And it's been very interesting to me to watch the opposition to health care reform attempt to try to paint a picture of the President's proposal that is a big-government, heavily bureaucratic, regulatory proposal, when, from our perspective, what we attempted to do was to say, "Build on the employer-employee system, the contribution will flow."

Not to the government, but to what we call health alliances, which, in the parlance of a friend of mine, are really buyer's clubs. Everybody's money goes in, much as the federal government currently provides insurance for its employees. As the employer of those employees, it collects the money. It does not administer the health care system; it does not tell you what health care plan to join.

Every year, if you are a federal employee, you choose from among all of those plans that compete for your business. We want the same kind of system, where money is collected and consumers are empowered to make decisions among health plans. And the alliance idea was one that struck us as parallel to large groups of individual employers coming together to achieve that bargaining power within the marketplace.

It is also important to have a means of enforcing community rating. In the absence of some bargaining power that enforces community rating, you need a regulatory system to do so. And again, we are trying to deregulate, as much as we are able, the kind of health care system that we see in the future.

Having said all of that, about all of the decisions we made and all the policy debates we had, this is really not about that, at bottom. It is about trying to ensure that every American, no matter where he or she works, and whether he or she has ever been sick, will always have health insurance to take care of their health care needs.

And I wish every one of you could have traveled with me this past year and have met the people that I have met, who much more vividly and dramatically display, for the

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world to see, the reasons why we need to do this. Yes, we need to do it because even with the budget proposal that was passed and the deficit going down more than we predicted, it will go back up because of health care expenditures.

Yes, we need to do it because it does have a set of perverse incentives in the existing system that drive extra utilization and the over-reliance on procedures that instead we should be looking to be more cost effective and quality driven, rather than trying to bundle procedures for paying doctors.

All of those, and many of the other things which you all have written about, are true. But what I'm interested in doing is making sure that we deal with the real life problems of the people who are out there waiting for this problem to be solved.

Women like the ones that I have met who found lumps in their breasts by their physical exam and were referred to surgeons who said, "If you had insurance I'd biopsy you, but since you don't, we'll just watch."

Couples like the ones that I have met, where they had to make a difficult decision about who they could insure because they didn't have enough money to insure everybody. And they insured maybe the husband and the children.

And like the family that I met in Las Vegas: The wife, after they made that decision, learns she is pregnant. By the time I meet her, she is two months away from delivery, and she and her husband are telling me they have decided she will try to have her child without any anesthesia, because they can't afford that extra payment.

Or the small business people, who are the most discriminated against in the insurance market, many of whom want help to insure their employees but can't see their way clear to do so in the existing system.

Story after story, person after person. What I hope this debate will never lose sight of is it is not about warring statistics or even warring TV ads. It is about trying to provide a stable financial base for our public and private insurance systems to try to stem the deterioration that is eating away at the stability of both, and to try to provide real health security to every American. Thank you

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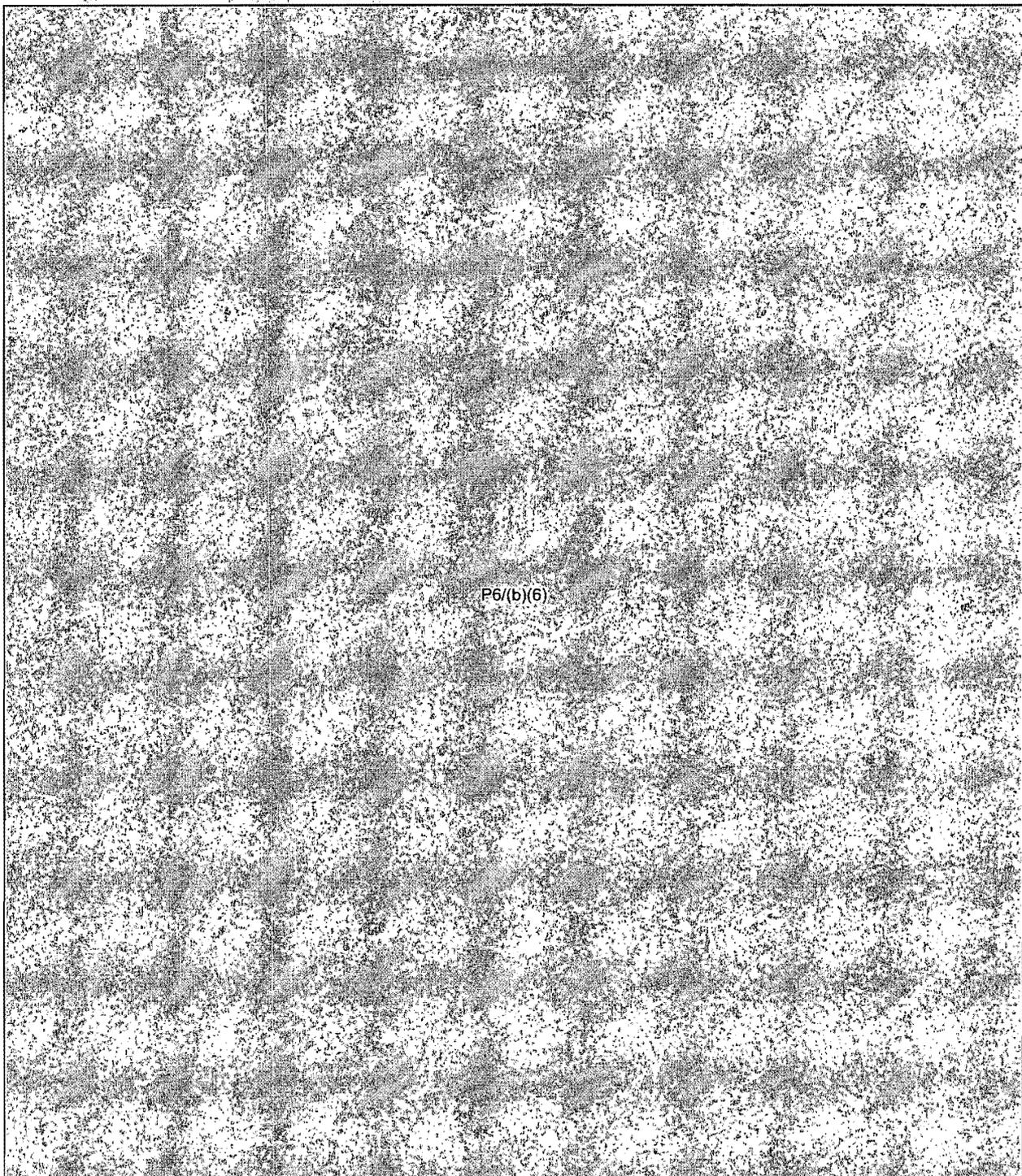
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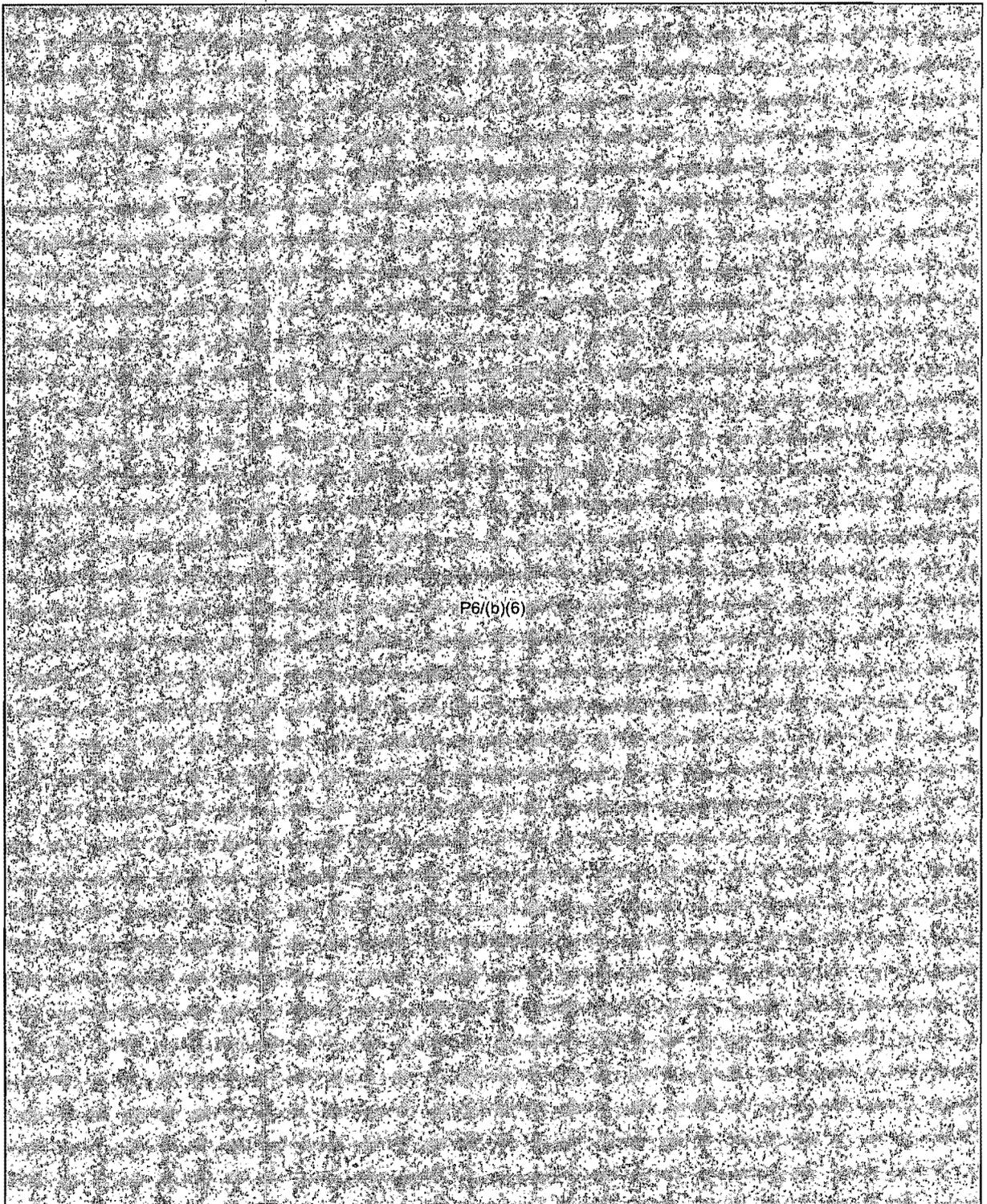
very much. (Applause.)



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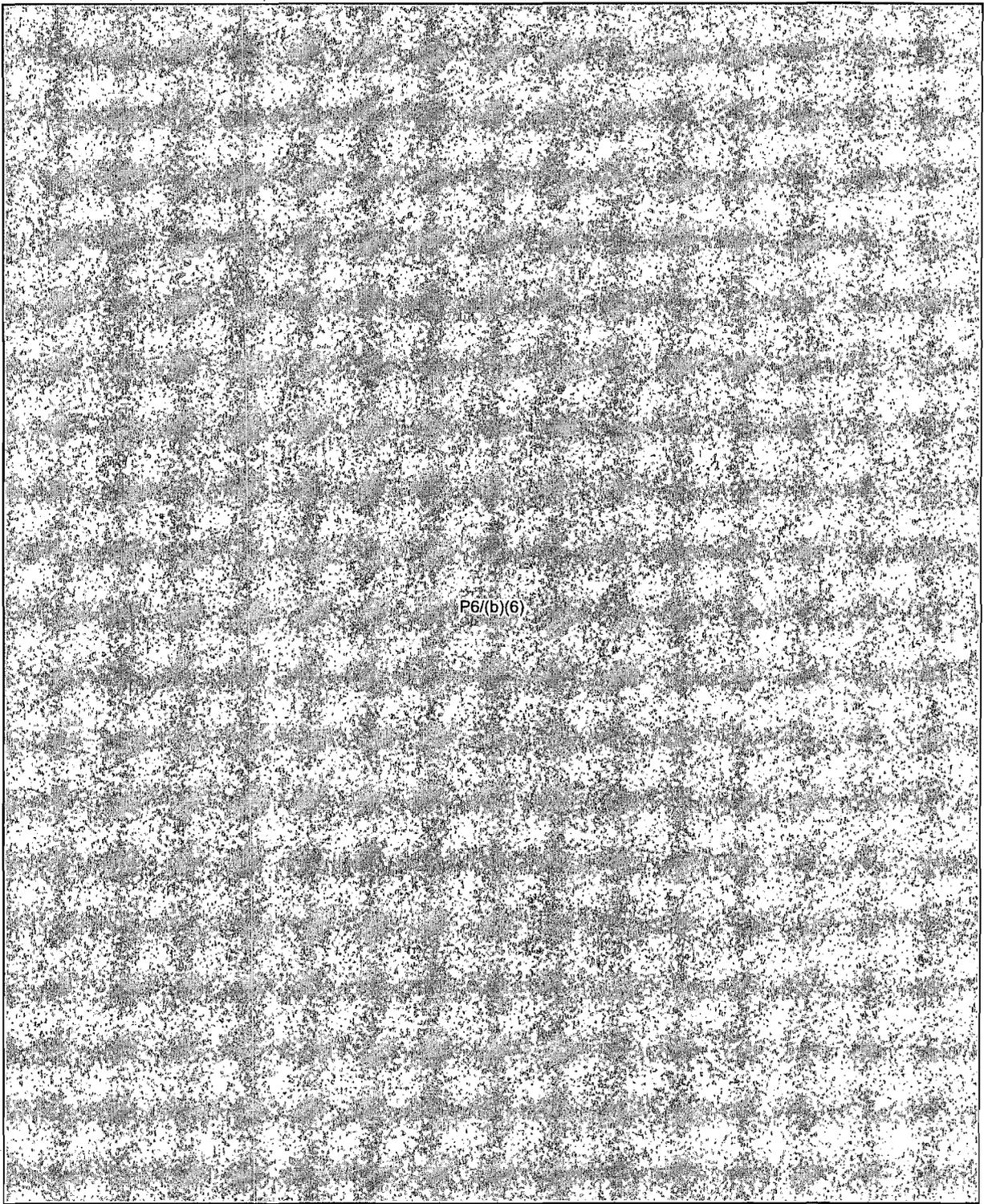
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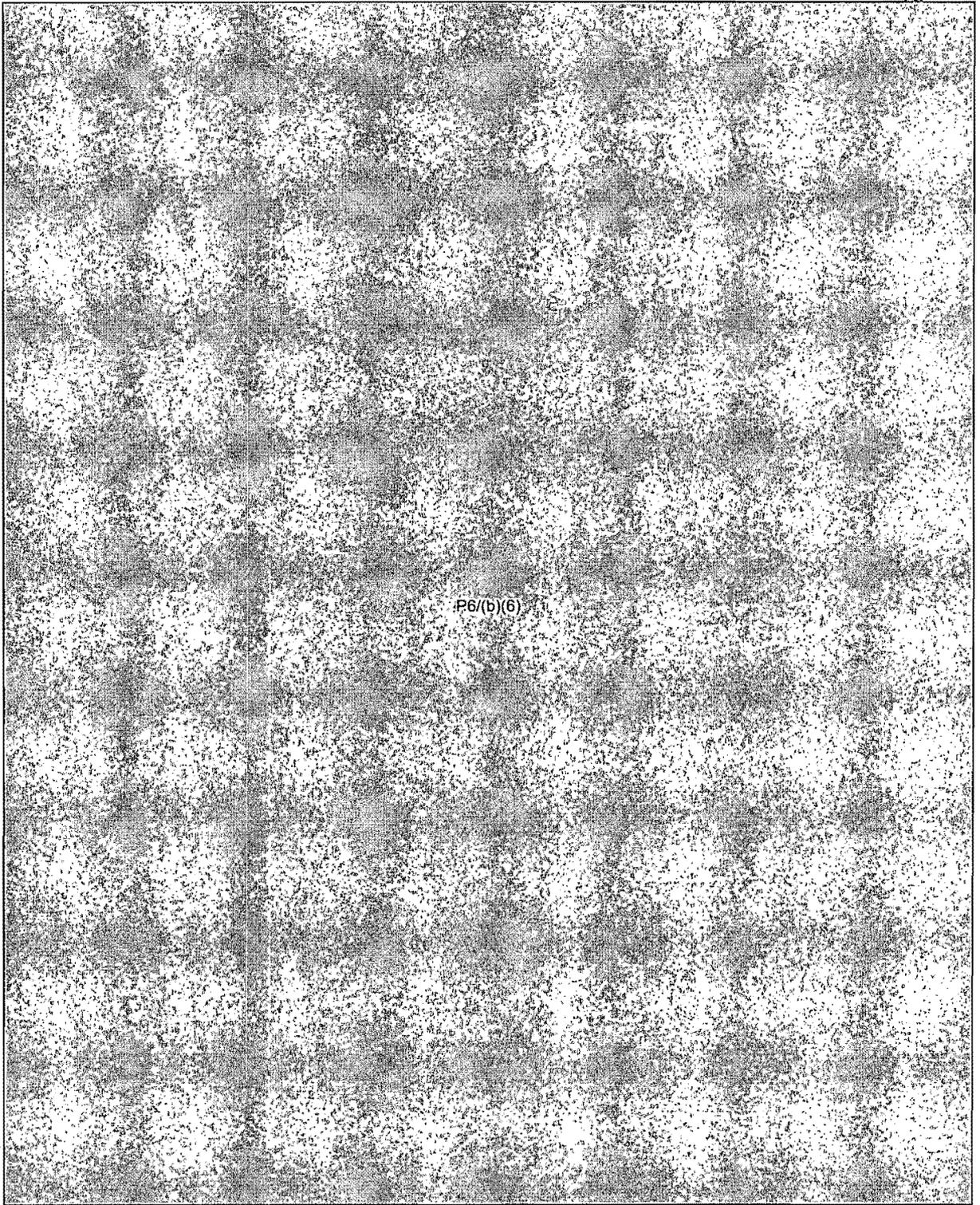


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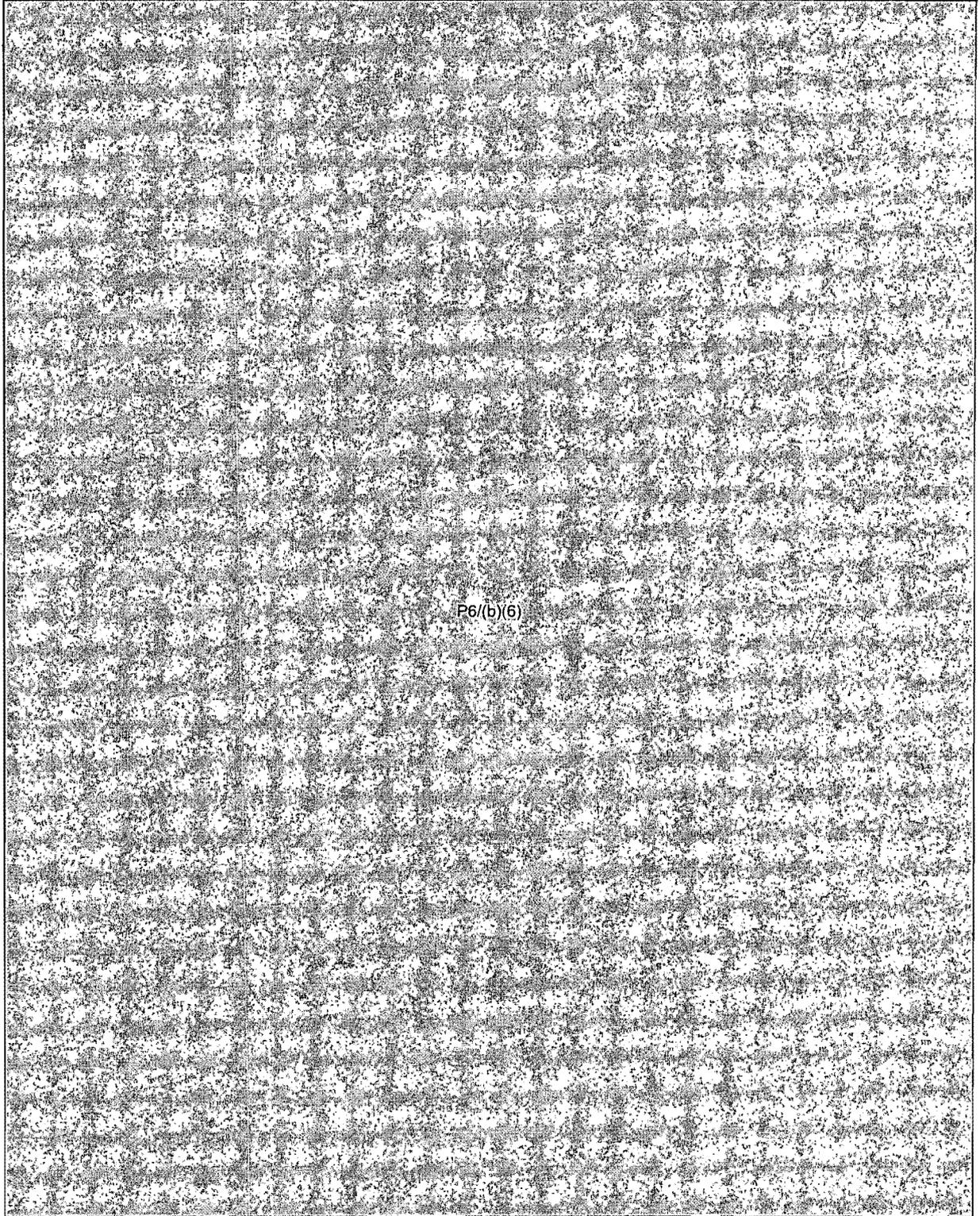
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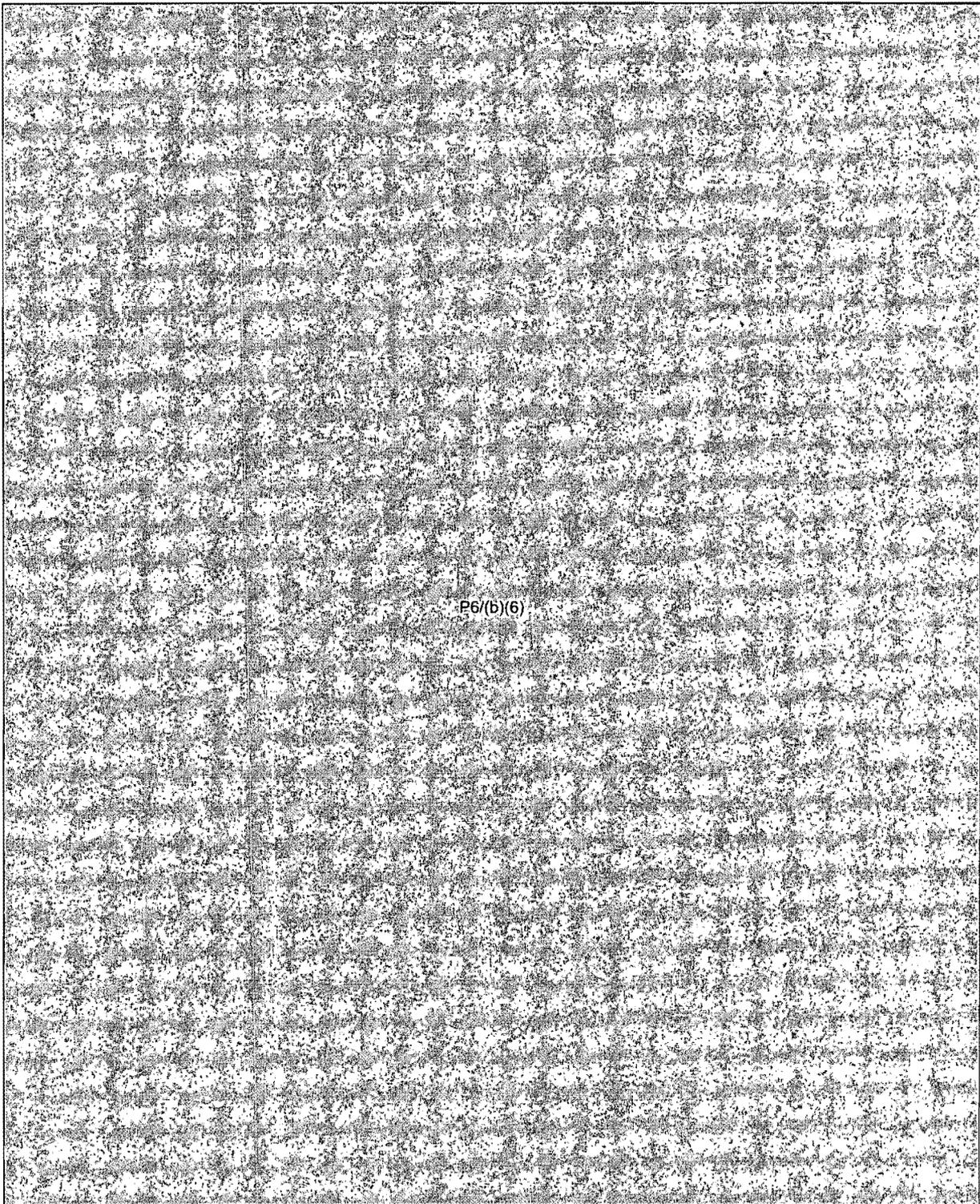
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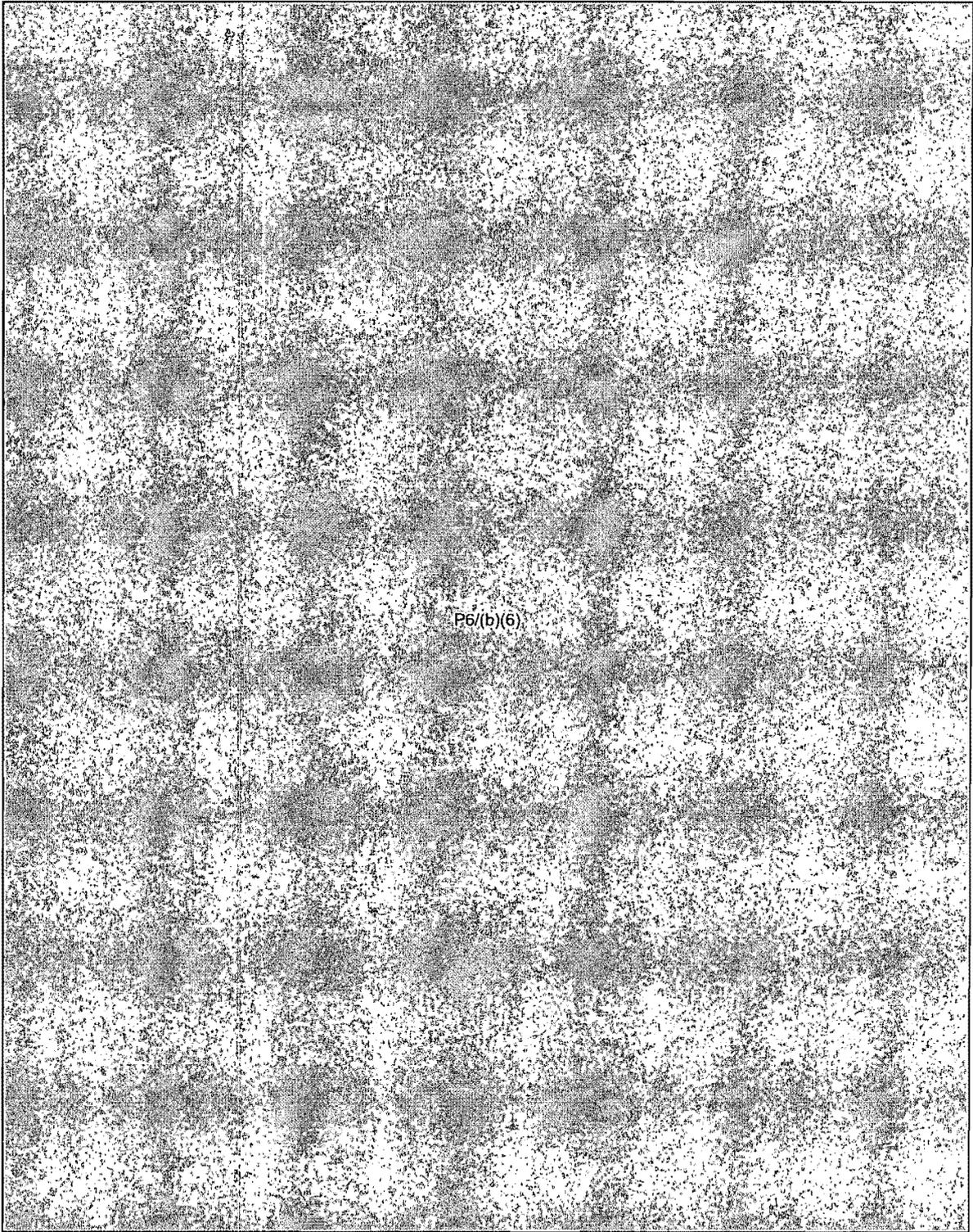
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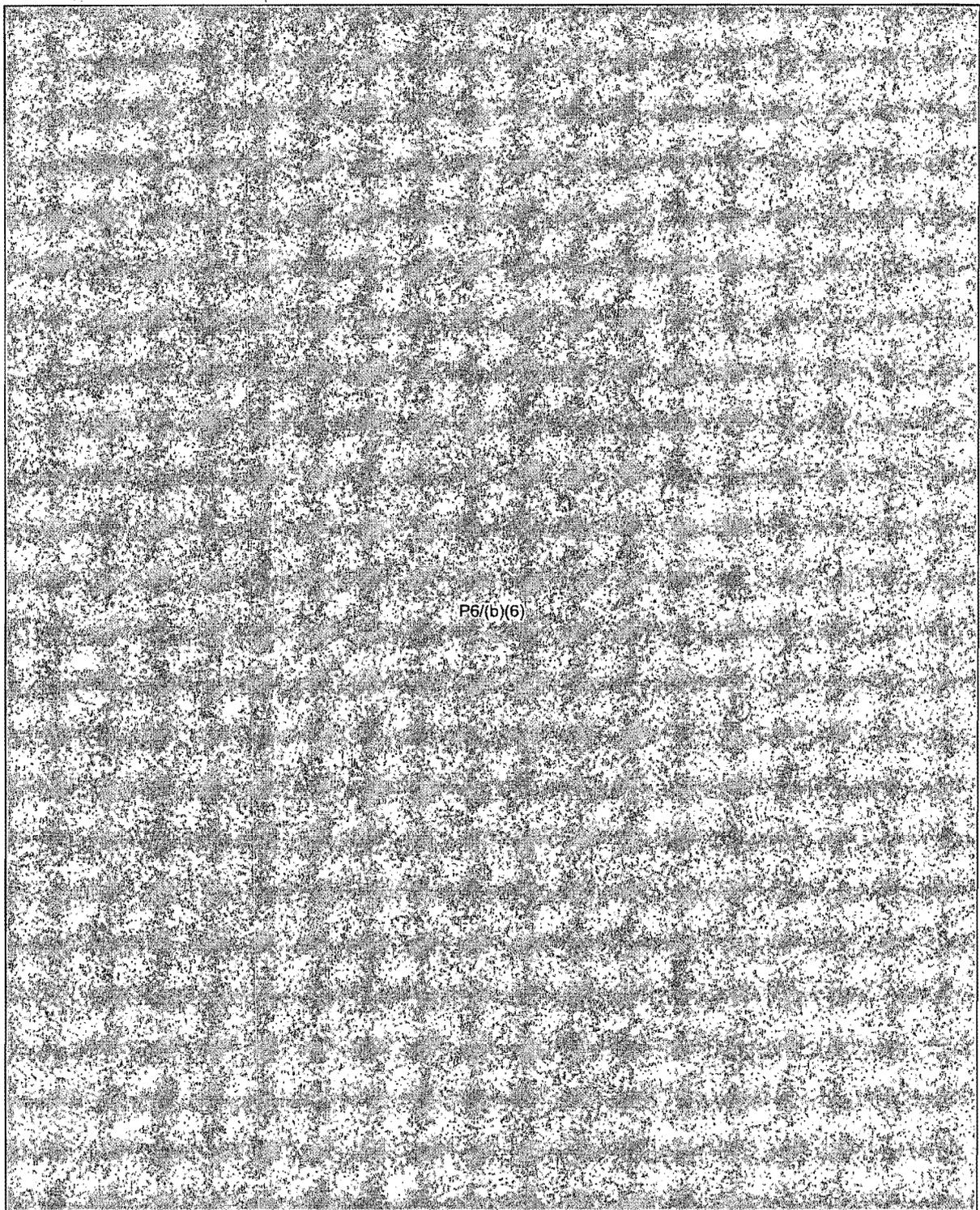


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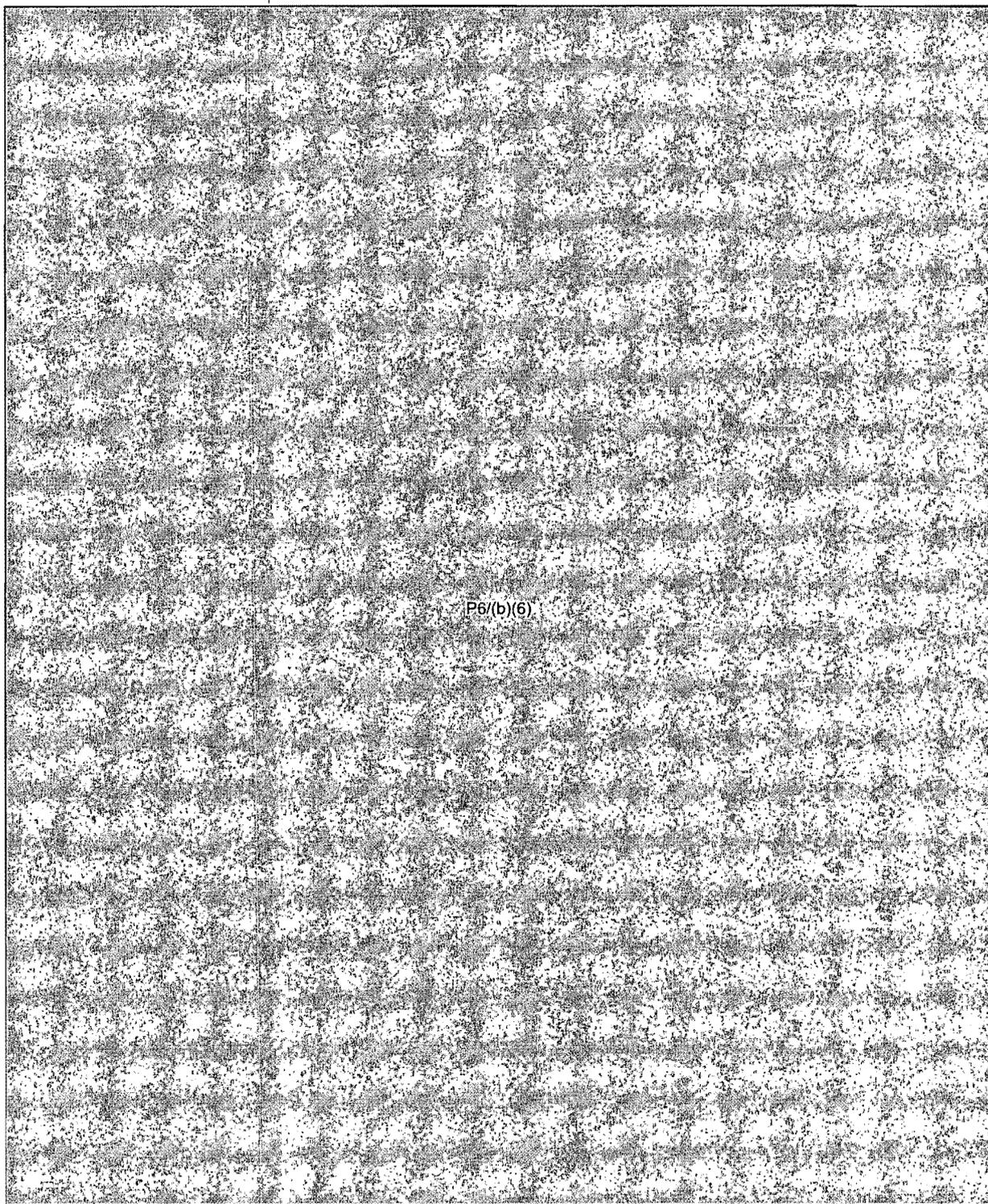
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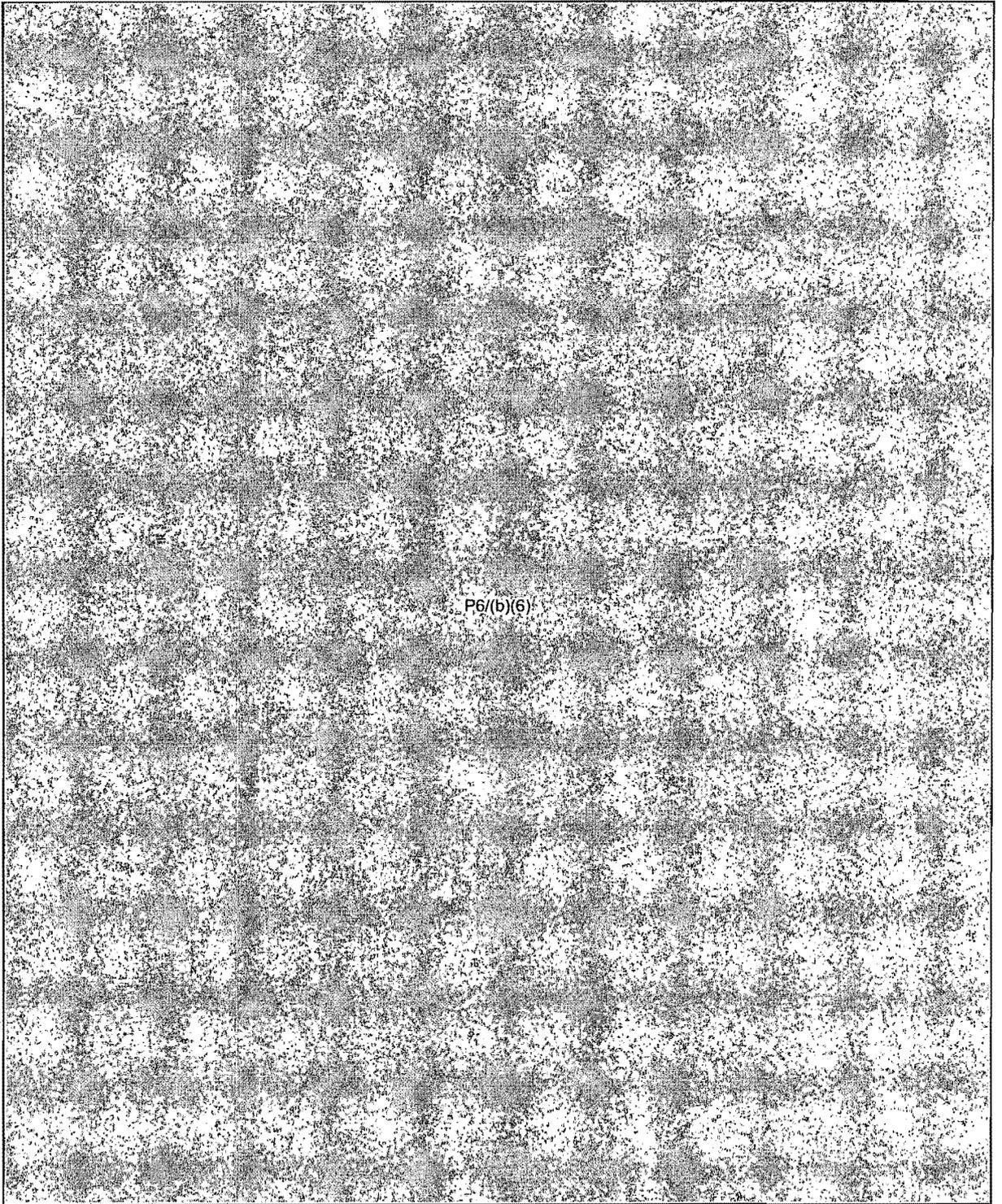
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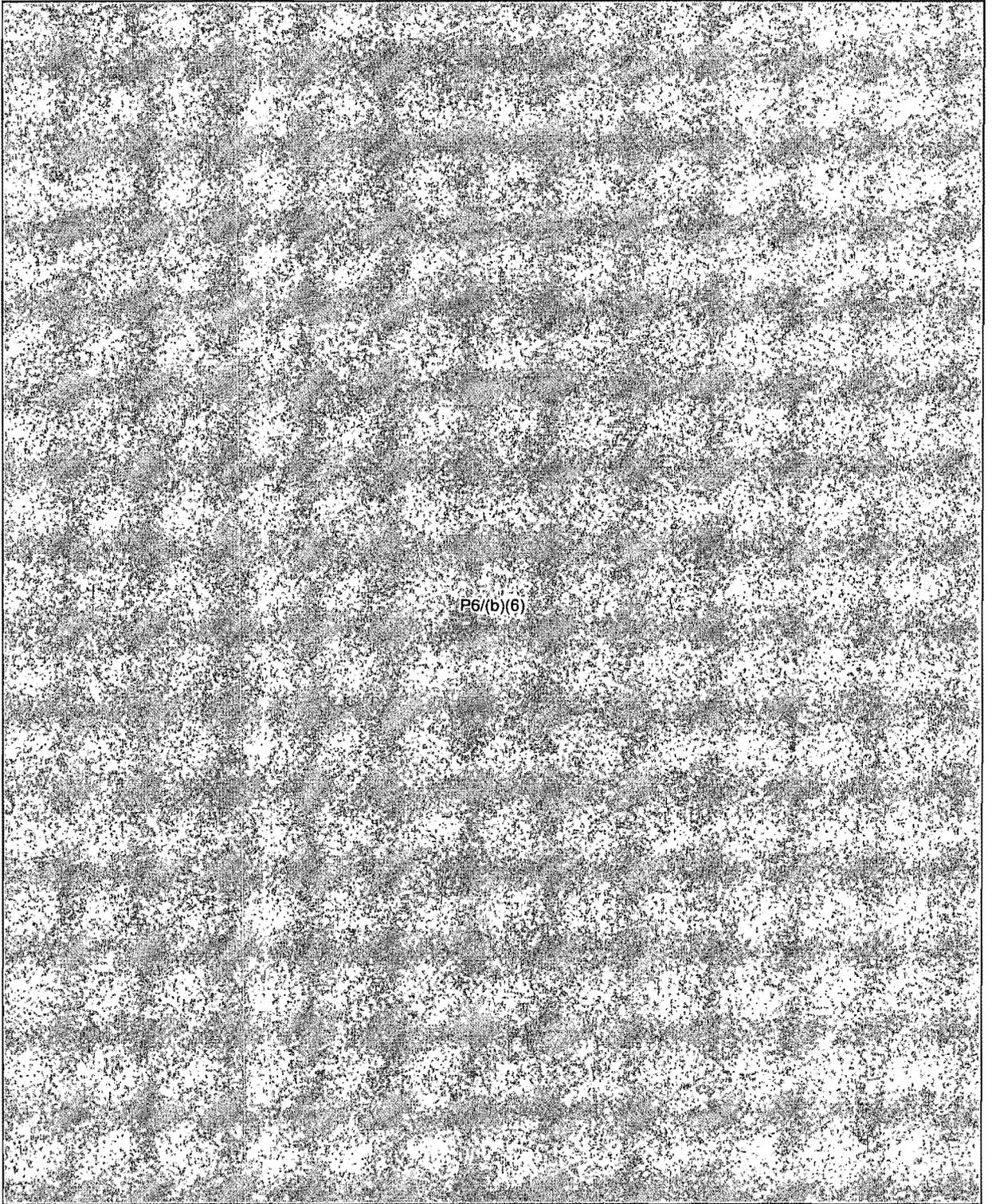
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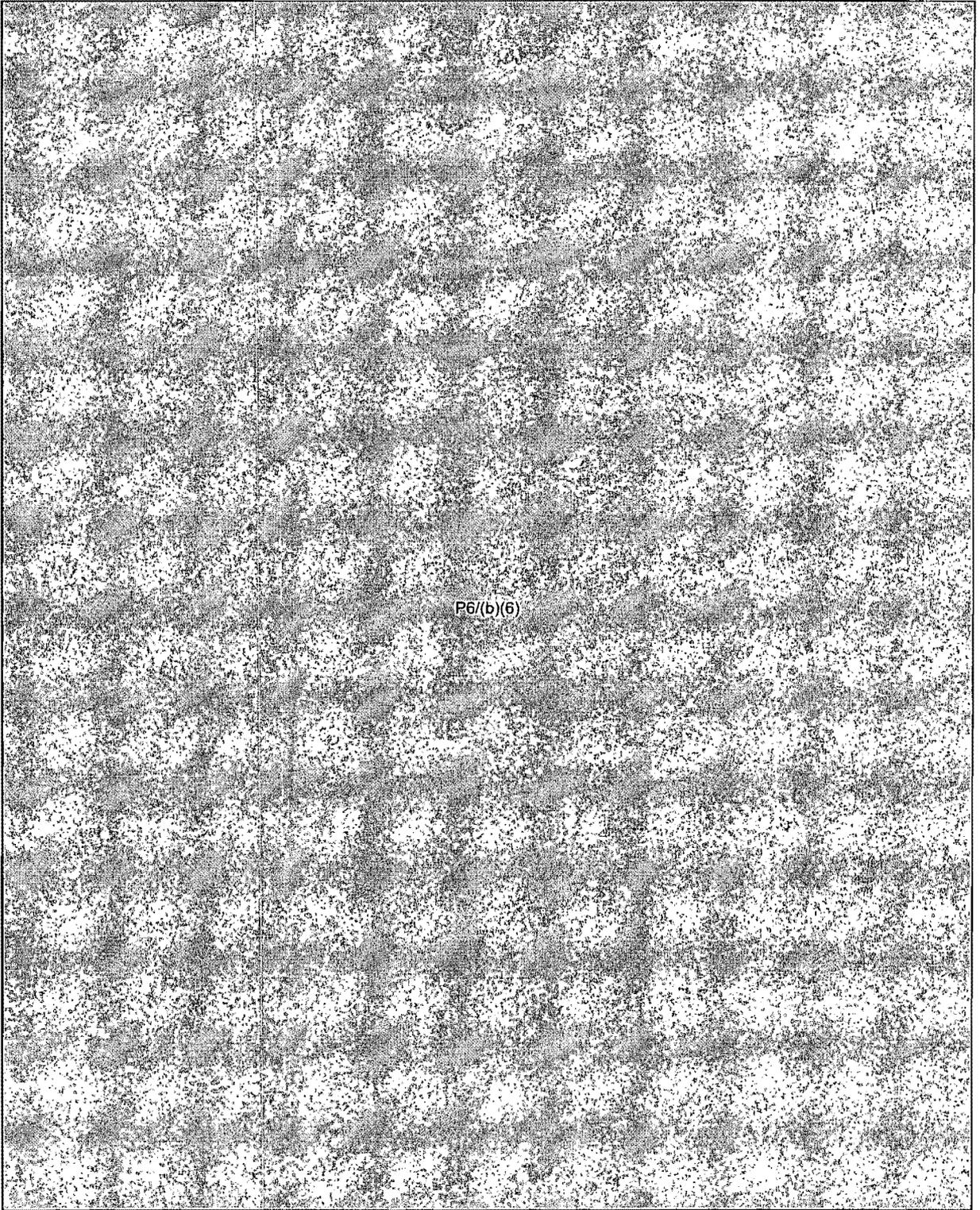
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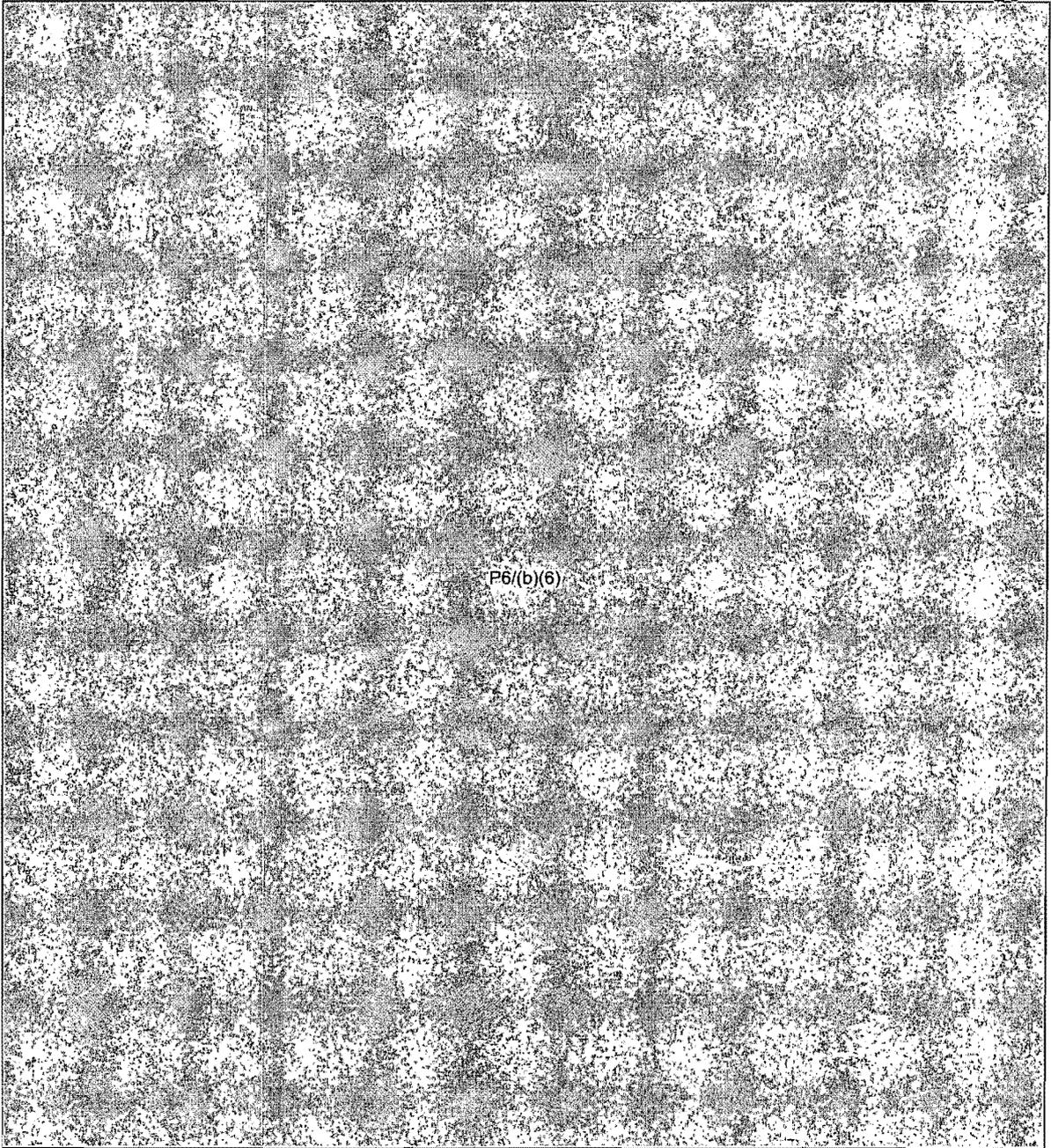
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