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March 19, 1994

REMARKS OF THE FIRST LADY
AT GANNETT GRIDIRON LUNCH,
AND QUESTIONS AND ANSWERS

MRS. CLINTON: Thank you very much. I wish I could take credit for those headlines, but I didn't even have a chance to talk with John before I came. So I didn't really know what he was going to say, but it's almost as though he were plugged into sources in my former life, because his comments about "The Chicago Tribune" brought to mind an incident when I was a senior in high school.

I was in a government class. We had these two very eager, young masters-in-teaching candidates, one who had graduated from Smith, and one who had graduated from Wellesley, who were getting their masters in teaching at Northwestern and were coming out to high schools to do their actual teaching.

And I remember walking into this government class, and this young -- young teacher, young woman, said that she wanted us to expand our horizons and read something besides "The Chicago Tribune." And I said -- having been raised on the "Tribune" and raised by a father who thought the "Tribune" was too liberal -- I said, What do you want us to read? And she said, Well, you know, like, "The New York Times" or "The Washington Post."

And I said, I'm not reading those voices of the eastern establishment. I could never go home and tell my father I was doing that. So there is a lot of truth, that we are raised to a great extent and have our views shaped by those early impressions of what comes across in the newspapers of the regions and the cities where we grow up.

I wanted to spend a few minutes talking about health care, and then have time for questions about anything that you would all like to talk about, because I want you to have some sense of how we see health care reform right now,

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and what we think is happening, and where we think it's going. And I would start by saying that we are very optimistic about what we see happening on the Hill.

We have spent a lot of time in the last month with members of both parties who are acting in good faith in trying to come up with health care reform, and in particular in the last month, have seen enormous progress taking place at the subcommittee and committee level. Probably I have met in the last three weeks with maybe 80 members of congress, about 15 or 20 in long one-on-one sessions, and then in groups of members.

And what is coming across is a seriousness of purpose about analyzing the alternatives and understanding fully what the financial implications of any decisions that are made would be. So we are at the stage where we had hoped we would be, despite some view that trying to push the congress this hard would not be useful, because they do have their own rhythm.

We really believe that the effort to try to put this on the agenda, to keep it there, to have the congress take it seriously, is really paying off, so that we are now engaged at the level of analysis about alternatives that we anticipated we would be. And that is very heartening to us. And so the kind of give and take that we have always looked forward to in the congress is taking shape.

And there will be changes made in the President's approach. Other people will have ideas. But from the beginning we have said there were certain principles that we thought needed to be met.

And there was an overriding goal, namely, guaranteed insurance coverage for every American that had to be part of the final legislation, but that much of the rest of the debate would concern details, and to some extent even technicalities, about how best to achieve that goal and how to meet the principles that we thought were most important. And let me just briefly run through the five major principles that underlie the President's approach.

The first is guaranteed private insurance. We are not talking about a government insurance system, we are talking about guaranteeing private insurance and building on the public-private health care system we have in our country.

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We have a public health system, we have charity hospitals, we have a public program for people over 65, we have a public program for the poor, but the bulk of us get our insurance in some way through the private insurance marketplace, and we want guaranteed private insurance for every American.

With that should come a guaranteed set of benefits. And we have the view that those benefits should be a basic package of benefits that tries to emphasize preventive care as an investment in the future and as a way of eventually saving money within the health care system.

That is not what insurance was originally meant to do when it began in the health field back in the '30s, with the original Blue Cross-Blue Shield policies. It was always for catastrophic acute care, with the net result that you do not get coverage in most private policies for the well-child exam, for the mammogram, for the cholesterol screening, for the kinds of things that will save us money in the long run.

The second point is, we do want to eliminate the discriminatory insurance practices that have driven up costs for millions of Americans and actually made private insurance unavailable to millions more. And there are three basic discriminatory practices we want outlawed.

Number one, we want to outlaw preexisting conditions being used as a means for either pricing insurance so high people cannot afford it, or pricing it so high that it is affordable only at an extraordinary cost in terms of percentage of income. We believe that there should be no preexisting exclusion, so that if you have diabetes, if you had cancer 20 years ago, you should be both entitled to insurance, and be able to obtain it at an affordable cost.

Secondly, we want to eliminate lifetime limits. If you read the fine print in most insurance policies, you will find a lifetime limit. It may be as little, relatively, as \$50,000, or as high as \$1 million, but in the face of acute and chronic care needs, those lifetime limits are easily reached.

And I have met literally hundreds and have heard from hundreds and even thousands more Americans who are well paid, they have good jobs, they've always paid for their own insurance, and then something happens. The child with the acute problems is born, and they reached their lifetime

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limits within the space of a year. The accident occurs to the teenager. They discover their 20-year-old has schizophrenia. I mean, all kinds of problems which then bust those limits.

And the third discrimination we want outlawed, which I feel more strongly about every year that goes by, is the discrimination against older people in favor of younger people. And everybody in this room ought to support that, because what we now have is the 22-year-old immortal being able, even if they choose to get insurance, doing so at a rate far below even the healthy 45-year-old, because of the differences in age ratings.

And the final thing I would say about outlawing discrimination, particularly when it comes to preexisting conditions, is that -- I was recently out at NIH. And at the rate that their work is proceeding on the human genome project, at which they are discovering the genes that cause numerous diseases -- they found the gene for Huntington's, for example. They are on the track of genes for everything from breast cancer to leukemia, to diabetes.

By the turn of the century, most of us will have more information about our own genetic makeup. We are already seeing that relatives of people with genetically transmitted diseases are being denied insurance coverage unless they take a genetic screening test, and if they have the genes they are then denied the coverage.

So by about the year 2,000 no one will be eligible for insurance coverage, because our genetic makeup will have told us that we are all going to suffer from something eventually. So there is a timetable attached to this.

The third issue is, the President wants to guarantee choice of doctor and choice of health plan. There has probably been more misinformation about this particular feature than anything else.

In the current insurance marketplace, in which employers -- like many of your companies -- make the decision about health insurance coverage for employees, in conjunction with whatever insurance company or broker you do business, you are, by necessity, under cost pressures, depriving your employees of choice every single week. Because you are saying, here are the doctors you can go to, here are the

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hospitals you can use.

And what is happening is that the children's hospitals around the country, the academic health centers, all of which have higher built-in costs because of the complexity of the care they deliver, are being taken off the approved list for patients to be able to use and be paid for that use. We want to reverse that trend. We want to guarantee choice of doctor and choice of health plan.

If we do nothing I can absolutely tell you, based on all of the data available, you will find yourself, if you are in the private insurance market, by this time next year seeing less and less choice available to you as a means to try to control costs. If we guarantee choice, we need to do it in a number of ways.

I want to say just a word about this particular part of the world, Washington, D.C., Maryland, Virginia. People have gotten confused about what their choices would be under the kind of proposal we have put forward. They would be very much like what the federal employee health benefits plan does now.

The federal government is the employer of more than 9 million Americans, including the President. They have dependents. And every year the federal government, as employer, puts up 75 percent of the cost of health insurance for employees. Every year the federal government, as employer, goes into the insurance market. And then plans come and basically lay out their options to those of us who are under that plan.

We make the choice. The federal government, as the employer, does not make the choice. And if we live in Washington, D.C., we choose from plans that may be based in Virginia, they may be based in Maryland, they may be based in New York. They contract with physicians in all three of the areas immediately surrounding here. We are not confined to choosing a plan that only uses Washington, D.C. physicians or facilities. We have a broad range of choice.

That is what we want for the whole country. That is the idea behind the alliance. It's like a buyer's club. It's like a purchasing cooperative. It does not tell you where you get your insurance. It does not make those decisions. It guarantees a choice of health plan across

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state and other geographic boundaries.

The fourth principle is, we want to preserve and improve Medicare. And that is very important, because the current Medicare budget is under a lot of pressure. It was reduced in its rate of growth during the budget of last year, but it is also fair to say that most elderly Americans are totally dependent, either in whole or in significant part, on Medicare.

And we are about to see a big age curve increase. The fastest growing population group in America are people over 80. And we are about to see even more people eligible for Medicare. What we need to do is to control the costs within Medicare, but make sure it is on a strong financial footing, and we also need to reallocate the resources within Medicare to be used in ways that will meet people's needs, and actually save us money.

So we have proposed to cover prescription drugs and to make prescription drug coverage part of Medicare coverage for two reasons. Because there are many low-income Americans over the age of 65 who really, literally, choose between food and prescription drugs at the end of every month, so there is a cost factor. But there is also a medical reason.

Many older Americans are admitted and readmitted to the hospital because of failures related to medication usage. Often because they did not -- they could not afford the full regimen of drugs that were prescribed, or because -- which is frequently the case -- they self-medicate. They get that bottle of pills and it says, take four each day. They say, boy, that was really expensive. I'm going to take one a day and have it stretch out longer, which of course doesn't do any good for them. So approximately a quarter of the admissions of older people to hospitals are medication related.

If we prescribe a prescription drug coverage package for older Americans, we will save money. That's one of the clear signals you get if you look at other countries where they are much more generous in covering prescription drugs, and much less of their funds go into hospitalization.

We also want to provide long-term care options besides nursing homes for older Americans. We want to support people who want to keep their relatives at home and

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only need a little bit of help. They need a visiting home health nurse. They maybe need a piece of equipment that they need a little subsidy to help buy. Or they want to be able to keep their relative at home, but have them go out during the day to an adult day care center, which is very important, particularly for Alzheimer's and stroke patients. Or to be able to go an independent congregate living, all of which are cheaper alternatives than nursing homes.

And what we do to people now -- and I've seen it all over the country -- is we say we're not going to help you keep your mother, your grandfather, your aunt at home with you, even though you want to do that. Spend their assets down, get them eligible for Medicaid, then we'll stick them in the nursing home and pay literally thousands of dollars for them instead of a few hundred to help support you at home.

And the final principle is, we've got to pay for this. And what we think -- the best way to do that is to build on the existing employer-employee system. If you believe, as we are committed to reaching universal coverage within a reasonable period of time, there are only three ways to get there.

You either have a large tax increase that substitutes for the entire private insurance investment -- and that is the so-called single-payer system. That is, by the way, how Medicare is funded. I cannot tell you how many audiences I have been in, particularly medical audiences, where someone stands up and starts railing against government medicine.

I then ask if they have Medicare patients, and they say, of course we do. And I say, do you know how Medicare is funded? They say no. I say, well let me just advise you that Medicare is funded by a payroll tax, by employers and employees. It is a taxpayer-financed, government, single-payer medical system. And most people are amazed to understand that that's how it works.

We don't want that to be the model for the entire system. What we want is to have a system in which individuals and their employers continue the contributions they are making now and expand it to those who do not contribute. Some have argued we should have only an individual requirement.

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For a number of reasons, we do not think that would work, not the least of which is, we frankly do not want to tell employers they no longer have to make a contribution. Because if they began to dump into the insurance market, millions of workers, particularly lower paid workers -- the amount of federal subsidy required to support what would be the exorbitant cost faced by those low-waged workers would be rather significant.

We believe we should build on the system that enables most of us in this room to get our health insurance, and to do so by making sure we have good discounts for small business, that we have subsidies for low wage workers. And we know that if we reform the insurance market we remove the incentives for cherry picking and experience rating.

We will save money for the vast majority of businesses that currently insure. Yes, we will ask businesses that have never contributed, and the nearly 40 million uninsured, 85 percent of whom work every day, to contribute, but we think that is the appropriate place to ask that responsibility be met.

So those are the five main points that we are intent upon: guaranteed private insurance, outlawing the discriminatory insurance practices, guaranteeing choice of doctor and health plan, preserving and improving Medicare, and providing insurance to the work place, which is where most of us get it.

This has been, for us, the best way to put together the pieces that we see out there, because we admit and are proud that we have the finest health care system in the world, the best doctors and nurses, and hospitals. But as I have said on numerous occasions, we have the stupidest financing system for health care in the world.

We are literally throwing away billions and billions of dollars because of perverse incentives in our system, unnecessary paperwork that is driven by the way that we permit insurance to be written in the health care field, fears of malpractice, which result in defensive medicine. So we address those, all of the various features that are not related to patient care.

But I guess I would just close by saying that this is a debate that goes far beyond what happens in congress. I

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have, like, a movie going through my head of all the people that I have met in the past year as I've traveled around the country, who have written me the million letters that I have received about health care, sharing their stories with me, telling them what's going -- telling me what's going on in their lives. And I have this feeling that this debate is really about what kind of country we're going to be.

It is very hard to go into a business where people have worked 15, 20 years, have no health insurance, and have a woman tell me, as she did in New Orleans, that she'd always tried to take care of herself -- she's a bookkeeper, a single woman. She always goes to the doctor. She went to the doctor, he found a lump in her breast, he sends her to a surgeon. The surgeon says to her, well, if you had insurance we would biopsy it, but since you don't, we will just watch it.

Or to be in Las Vegas with a husband and wife in a hospital where the wife was about to have their fifth child, and where the husband worked every day, and where insurance was offered, and they made the family decision that he couldn't insure both his four children and his wife, so they decided he would insure himself and the four children. Shortly after that she got pregnant.

And I sat there with this woman as she told me that she had made the decision she wouldn't have anesthesia for this baby because the shot would be \$1200, and that was a house payment. And I thought to myself, there is not one spouse of one member of congress who has to face that particular choice.

Or the small business people who are so discriminated against, with insurance rates 35 or 40 percent higher than what many of you in much larger companies are able to negotiate -- telling their sons that they had to drop insurance, so they can't go out for sports anymore because they're afraid they might get hurt.

I want to be able to go back to every place I've been and tell those people that they do now have guaranteed health insurance at an affordable price. And they deserve to have it, because they're working hard every day, doing their best for themselves, for their families, and for this country. And that to me is what this debate is really all about. Thank you very much.

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Well, John said we'd take questions, and I guess people will just have to stand up and identify themselves, and yell. Is that what we're going to do? Larry?

Q Well, two things. Ross Perot's idea of doctors contributing and doctors coming up with a plan -- your thoughts on that.

MRS. CLINTON: Well, doctors have contributed. We've had thousands of doctors involved. Many doctors, through their associations, have written their own plans, or have endorsed the President's plan. So I think there's already a great amount of physician involvement in the whole health care debate.

I have no problem with Mr. Perot or anybody else coming up with more ideas, but I don't -- there aren't that many ideas around. I mean, this is a complex matter, but there are only a limited universe of ways of getting at where we need to go, and it's -- if it were easy, somebody would have done it before. The hard part is not what the suggestions are, but having the political will to make the decisions.

Q But are you confident we're going to have a new health plan in this country?

MRS. CLINTON: Yes.

Q This year?

MRS. CLINTON: Yes. This year.

Q September?

MRS. CLINTON: Or before. Yes.

Q Coming from Germany, (inaudible) not exposed (inaudible) are very (inaudible). I have two questions. First of all, how can you keep the costs of health care at an acceptable level if you do not make it obligatory for those -- that part of the population, which is the young people, to contribute at a time when they do not charge the system, and sort of equal out the older people who have more -- have their costs with the young ones who don't? First question.

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Second question. I must admit I haven't read all of your 1300 pages, so I'm -- you know, mea culpa. But what do you intend to do about the cost factor which is put on your system by the malpractice suits you have in this country which drive up enormously the insurance premiums for physicians?

MRS. CLINTON: Let me repeat. This gentleman is from Germany. And he said, as a German he is very interested in health care reform. And he asked two questions: How can you have health care reform if the young do not contribute while they are young and healthy to the entire pool? And secondly, what are we planning to do about malpractice, which drives up the costs for doctors? Is that it?

Q. Right.

MRS. CLINTON: Germany is a very interesting example of a private-public mix of health care reform. And there is an excellent report that was written in this country by a journalist on the staff of "The Boston Globe" about the German health care system, which we have used a lot.

Because Germany, if you go back to the late '70s and the early '80s, did not have a handle on their costs. Physicians' salaries in Germany were actually going up faster than physicians' salaries in America. And it was at that point that the German government decided that they did not want to spend increasing amounts of their gross domestic product delivering health care, that there was no reason to do that. And that's when the German model began to try to contain costs.

There is no way to contain costs unless you have everybody in the system, and that includes the young, the old, the healthy, the sick. And we have, with the German model, the belief that, although we are proposing an American solution, everyone must have some form of insurance, otherwise you will always have the option of shifting costs and gaming the system that will keep lots of cost pressures going.

And it is very important that young people contribute. I have answered that question many times on college campuses, where they say, you know, I used to be under my parents' policy. Now I'm in school, or I'm beginning to work, I can't afford insurance, and I don't need

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it. And we talk about what that means, especially since they could go out tomorrow and get hit by a car and be taken to the hospital, and we would all pay for it. So they do need to be insured.

The second issue, about malpractice. We have looked very closely at what the real costs of malpractice are, and it is more the chilling effect. It is what doctors fear, which then pushes them to order more tests and procedures, even more than the actual cost of any kind of lawsuit.

So we do think that a cap lawyers' fees -- we ought to require alternative dispute resolution. We ought to have certificate of merit, so you cannot go to court unless you've got an independent party saying it's a worthwhile law suit. We believe you've got to move to get those costs down.

Q Thank you.

MRS. CLINTON: Yes.

Q Mrs. Clinton, in view of (inaudible) I'm Dave (inaudible) mandate with the practice (inaudible)?

MRS. CLINTON: Well, I would say there is no precedent for that because, you know, when you, as a business, are required to pay the minimum wage, that is not considered a tax increase, and it does not go on the federal budget. When you as an employer are required to comply with government regulations at either the federal or state level, like OSHA regulations, you have to expend money. That has never been considered a tax.

And you are required in many states to have auto insurance. That has never been considered a tax. It has always been considered a premium, even though government requires you to do so. We are not talking about really much analytical difference between requiring employers and employees to go out into the insurance market and buy insurance than the three examples that I just gave you.

So I think that precedent, if I were a judge, would be on the side of saying that, yes, it's a government requirement to have shared responsibility. But there isn't any reason to believe it is a tax.

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Q Mrs. Clinton, my name is Lester (inaudible) live in Washington. I'd like to (inaudible) on the previous questions if I may. I think we've met with a few employers (inaudible) and their argument was that (inaudible) industry (inaudible) their business, while on the other hand the health care plan would require them to put up 80 percent for their employees.

Many of the employees (inaudible) and indeed my (inaudible) hire part-time employees in order to evade (inaudible). How would you answer (inaudible)?

MRS. CLINTON: Well, employers are hiring part-time employees now to evade their benefit obligations. That is going on. Temporary employment is the fastest growing sector in the economy right now. Under this plan, they will have to make a contribution for part-time employees, also, once they employ them over a certain amount of time, so that we do avoid just that kind of subterfuge.

When employers hire somebody part time, they pay FICA, they pay social security. It's going to be one more line on the form. It is not going to add additional paperwork or create any obligation very different from what they're already meeting.

We have looked, really, as closely as we can at this whole job argument, and all I can tell you is that, based on the work that has been done by the administration, by the congressional budget office, by Brookings, Urban Institute, by other independent economic analysts, it looks to be about a wash. We don't see a lot of job loss at all.

We see job growth in some sectors of the economy, like home health, prescription drugs, which will be made available to everybody. We see a redistribution of existing resources. When you take businesses that are paying a very high percentage of their payroll for health benefit, then you begin to lower that, that's money that goes to the economy, and that's money that goes down the pipeline to smaller vendors and other companies. So the CBO basically said they found no evidence that there would be job loss.

Now we can't speak for every single firm everywhere in the country, but it's like the old arguments that are always brought out when the minimum wage is increased. I mean, the minimum wage has been increased a number of times

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in the past several years. There is no evidence of any kind of significant job loss in the economy. So you know --

(End side 1.)

Q Mrs. Clinton, I'm Alan Newhart (phonetic). I think John Curley (phonetic) said I used to work here. In recent days a lot of newspapers represented in this room have devoted a great deal of ink to two aspects of your former private life. On the one hand they have either credited you with or blamed you for making a lot of money in commodities, but on the other hand they have either blamed you for or asked you about losing money in real estate.

What would you like to tell this audience of newspaper people from around the country that they could do to help the reader understand that aspect of your (inaudible)?

MRS. CLINTON: Well, I do want people to understand better. I suppose the headline would be: Don't Make Money or Don't Lose Money, you know, which is good advice, if you can afford to live on that basis. I want people to understand and to know what went on.

And of course, from my perspective, having made investments 16 years ago, I don't see a lot of the interest that has been generated, but since it is there, I want people to understand. And I want people to fairly report what has happened or not happened, and I want people to have some sense of what it is we're talking about.

When I'm asked if I made money in the commodities trading in 1978 and '79, the answer is yes. And I didn't know there was anything wrong with having a stock account and trading futures. And I got out of it because I got pregnant and had a baby, and I couldn't stand it. It was too never-wracking. So I don't know what the -- where the story is there, but I'm glad to tell people that's what happened.

And we've been saying the same thing for more than two years, now. We made a land investment when land looked like it was going to keep going up in Arkansas. It went down, and we lost money, and we didn't pay very much attention to it, because we weren't responsible for it. And now there's a special counsel.

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We are doing everything that we can to cooperate. We have waived every privilege known to man or president. We have given every scrap of paper. I wish the report could be written tomorrow. I mean, I am anxious for the whole story to get out. So that's -- I mean, I don't know how to tell you how to do your job. I can only tell you that we have tried to answer questions to the best of our ability.

But so many of those questions are about things we had no knowledge of. We did not keep the books and records of that little company. We never had an S and L loan. We never did any business with an S and L. We had commercial bank loans. We paid every one of them back.

We turned over all our tax information every year to certified CPAs. They filled out our tax returns for us. You know, I don't know what else to say, besides that. So we'll just have to try to keep answering your questions as they come up.

Q Can I follow that up?

MRS. CLINTON: Sure.

Q It's my profession. It's hard not to do. I think I can speak for everyone here in saying that you look fantastic.

MRS. CLINTON: Thank you. (Applause.)

Q My question is, how are you holding up under this?

MRS. CLINTON: Well, I'm holding up fine, except it's lonely in the bunker. I want you all to come visit me. (Laughter.) You know, it is -- it breaks my heart for people to think that either my husband or I did anything wrong -- very painful. So that's hard, but you know, I guess that's the way it's played today. So we'll just keep doing what we're doing.

Q (Inaudible.)

MRS. CLINTON: Oh, no, I'm fine, don't worry.

Q I'm Elizabeth Perry (phonetic). I'm at the University of Chicago (inaudible) and I was heartened to hear

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you say that you think that we have the highest quality, highest caliber health (inaudible) and I was wondering if you could comment on what degree of (inaudible) in that quality that the administration is doing to effect -- to implement this massive financing?

MRS. CLINTON: Absolutely none. This has nothing to do with the quality of our health care system. This has to do with how we finance it. And what I fear -- you're pregnant, apparently. Congratulations. (Laughter.) What I fear is what I see happening in the marketplace today.

I have now visited -- I don't know, maybe 12 or 15 of our premier medical institutions around the country, the places where if you really get sick and you're looking for the best specialist in America, you go: the Johns Hopkins, the Washington universities, the Sloane Ketterings, the -- you know, those places around the world -- the Mayos. What is happening is that those institutions usually are bearing a much higher percentage of the uncompensated care.

In fact, the academic health centers probably carry 50 percent of the uncompensated, uninsured care in America. They then have to be able to attract paying insurance premium patients to make that up, and they have to get subsidies from government to make that up.

What is happening, as I referred to earlier, is that many insurance companies and employers are trying to restrict access to the highest quality institutions in the country. Children's hospitals are on very tenuous financial footing right now, because a lot of insurance companies won't pay to send somebody to a children's hospital any more.

At the same time that you see the insurance market trying to squeeze out costs by cutting back on funding the highest cost care, you've got increasing pressures on the public side. I mean, there will be continuing calls in the next several months to reduce the Medicare and Medicaid budget, and buried in those are lots of payments to hospitals like the ones I just mentioned, to make up for the uncompensated care.

So if you look closely at the financial footing of a lot of our most high quality, complex institutions, it's very uneven right now. Combine that with the increase in the uninsured, because many companies are cutting back on

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benefits. They're hiring temporary workers.

People are losing jobs at IBM and finding jobs that don't give them benefits. There is an upward cycle of the uninsured which is being projected, which then puts more cost pressures on the system, which then can't be met unless we have either higher insurance premiums or higher public outlays.

So from our perspective, looking at all of this, the worst alternative for continuing the high quality that American medicine has been known for, is the status quo. If we do not shore up and change the incentives in our financing system -- yes, probably the people in this room, because of your own individual financial capacity, will be able to continue to find what you need. But it won't be very far down the income scale before that will not be available to most Americans any longer. It's a very serious problem.

Yes, Andrea?

Q You talked about being flexible on details. Can you imagine any way to get to your goals of cost containment without some kind of purchasing arrangements or cooperatives? Is there any other mechanism in order to reach that goal?

MRS. CLINTON: Well, that's a really good question, because -- Andrea's question was: Is there any way to get to cost containment without having some kind of purchasing cooperatives or alliances as we have recommended. Well, the alternative is a very heavily regulated system. And there are some in congress who favor that, who believe that we should continue the trends of the 1980s, which is to try to price every single procedure, try to tell doctors when they can and cannot order such procedures, have insurance companies second-guessing doctors.

I don't know if you've had the experience, yet, where your doctor has to call an insurance company bureaucrat to ask permission to run a test on you, but it happens now, all the time. So yes, there is an alternative, which is a more burdensome, more heavily regulated medical system, where we really try to put down the screws on the cost in the private system as well as the public system. We just don't think that's a good idea. We think that has huge costs built in. We don't like the idea of micromanaging doctors.

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To go back to your question about American medicine, I don't want -- I had a doctor tell me he called to ask permission to run a test, a man who has been in practice for 35 years. He got somebody on the other end of the line, at an insurance company, who was giving him a hard time about his clinical judgment.

He said, Who are you, and how much education have you had? And it was some poor young female clerk who had about two years post-high school. And this doctor told me with -- he was just enraged. He said, I did not go to medical school and do all my post-medical training to be told by some 20-year-old girl in an insurance company office that I can't order these tests on my patients.

So we don't want to go that way. We think that is a dead end. We believe that by people pooling their health care moneys in these purchasing coops, and then going into the marketplace and having health plans compete on quality and price, the market will enable us to get to the point where the decisions are made at the local level by qualified medical personnel, not by government bureaucrats at HICFA (phonetic), or by insurance company bureaucrats.

So that's why we think trying to get the money pool, and then putting some kind of a cap over the budget that is available, which is a -- you know, making it a high cap -- is a much better way for decisions to be made than what we do now, trying to micromanage it. So that's -- that's our thinking behind the way we went.

Q Larry has another question.

Q I saw Dick Cheney is here, and I know that Mr. Cheney may be running against your husband in a couple of years. It's nice to see you, Dick. (Laughter.) On a show of mine recently, Dick said that -- eloquently said -- that we have a great health care system. There is a problem, but it's not as great a problem as you've expressed. How great is the problem?

MRS. CLINTON: Well, I think it is a structural problem that is very great, and very visible in many parts of the system, that is beginning to crack to the surface. So even those of us who are well insured, and have access to the finest medical care, are beginning to see that.

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You cannot go to a hospital, like I did -- Kings County Hospital in Brooklyn -- and see the health care system falling apart before your very eyes, and not believe there is not a crisis. And you cannot go and talk to doctors, like I do -- the one I just gave you an example of, who is spending his time arguing with insurance company workers -- and not believe there is something seriously wrong with the way we are financing health care.

Separate those two issues. The quality and the training, and the research, is finer than any place in the world. But because we have perverse incentives built into our system, in both the insurance market and in the public sector, we are undermining the very qualities we pride the most. And if we do nothing -- and if you look at the trends that are out there -- the trends will move the system into more and more precarious financial conditions, where decisions will be made that are not in the best interest of quality.

I go around a lot with Dr. Koop, and you know, being with him is like being with a prophet from the old testament. And he stands up there with me, and when somebody asks a question that he thinks is not founded correctly, he will intervene.

And we were together at a big forum, and somebody stood up and said, well, you know, I don't want to change the system, because I don't want people to ration care. I don't want to be in long lines, et cetera. And Dr. Koop said, well, let me tell you, we are already rationing care. If you are uninsured in this country you have a three time greater chance of dying from the same disease than if you are insured.

And somebody argued with Dr. Koop -- which is not a smart thing to do -- and said, oh, that must mean because they don't get care before they get to the hospital. He said, no, even when you get into the hospital. If you come in without insurance you are three times more likely to die. And he then went on, chapter and verse, talking about what is eating away at the structure of our health care system, what is draining the time, the energy, the resources out of our hospitals, our doctors, our nurses.

So the status quo, and tinkering around the edges -- a little insurance reform, you know, a little bit of

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malpractice reform -- will not change the underlying perverse incentives. And if we do not change the direction we're going, then we will have a crisis that will be easily visible to everyone.

Thank you. (Applause.)

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