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Health Care Providers, OK

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REMARKS OF THE FIRST LADY IN OKLAHOMA
TO THE HEALTH CARE PROVIDERS

MRS. CLINTON: Thank you very much for gathering. I want to apologize for being a little bit late, but there was such an enthusiastic welcome at the restaurant and the people out in the driveway that we couldn't walk away. Sorry I kept you waiting.

I want to thank Mike and Dave for being here and, more than that, for the work. It's a real pleasure to sit between people who are committed to the same kind of change and progress and different in Washington as they are. I also want to thank my friend for being with me today as well. I'm delighted to be able to spend time with her and catch up.

I don't want to say very much. I want to listen and try to answer questions because what I find as I continue to travel around the country -- and I guess this week, if I remember right, I've been to Chicago, Illinois; Rochester and Syracuse, New York; meetings in Washington; and now here in -- is that most I think most people are beginning to think seriously of the probability at we're going to have significant health care reform legislation this year.

The more we can talk about what should be in there and the more accurate information that people like yourself and others particularly interested in positions have access to, the better the will be and the better the final product is going to be. So I welcome the opportunity. I spent much of last year going around and talking with and listening about the problems. Now we have a lot of approaches and ideas and solutions on the table that we want to get continuing health.

Very briefly, the president knew that this was going to be a very challenging enterprise, to come forward and seek the legislation, but felt it absolutely imperative to get the ball rolling and be able for all of us to focus on what the real choices were. He got some hard choices, but he

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is beginning, I think, to kind of move forward successfully.

The action is now in the Congress. There are at least three major committees in the House struggling with the legislation, two in the Senate and others that will have pieces of it. But what I have been struck by is the quality of the debates thus far and the seriousness of purpose that is being brought to bear on his nostalgia.

The president has said repeatedly that he is open and very willing to talk about the different ways of reaching the ultimate goal. But he does have an ultimate goal in mind. As he said in his State of the Union, he believes for both the human and moral and ethical reasons, as well as economic ones, we have to insure everybody in this country. It is the right thing to do and it is the cost effective thing to do in both the short and long term.

So very succinctly what he's looking for is a bill that he can sign which will guarantee private insurance coverage to every American with a candid benefits package. I want to stress that because a lot of the opposition to health care reform is using the same language they used when Roosevelt proposed it, when Truman proposed it, when Eisenhower proposed.

I just got a load of documents about President Eisenhower taking on health care reform and some of the things he said. I must admit I'd forgotten (inaudible). So he was picking on some of the same issues. So every president, both Republican and Democrats, have tried to struggle with this issue, including Kennedy, Johnson, Nixon's proposal for a health care system, and Jimmy Carter.

We haven't really done a lot except patch around the edges and increase the mandates on states that expend more money with less health care over the last 12 years. So guaranteed private insurance with a standard set of benefits which people can buy above if they want more. That's not going to cover everything, but at least it should be here for everyone.

Secondly, we want to eliminate insurance practices that discriminate against individuals. That means eliminate preexisting conditions, not just saying that insurance companies have to sell to you if you've got a preexisting condition because they can charge an arm and a leg, but eliminate preexisting conditions as a term for any kind of underwriting and for insurance, eliminating lifetime limits

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which are often one of the cruelest surprises for people when they do finally get sick and, and we also believe we should eliminate age discrimination.

We have an old-fashioned idea that we ought to go back to insuring the way Blue Cross/Blue Shield got started in the late 30s and 40s where you insure the entire community at a community rating. Everybody was in it together; the old, the young, the sick, the well. Every one of us is going to get old. Most of us at some point will get sick.

We also want to guarantee choice. I want to stress this because that's been one of the really big issues get the president's plan totally in its reform. What is happening right now, and we've heard about this from several of the farm families, is that they are being told that under their insurance policy they can only use doctors in and health plans in Oklahoma City. If you're in Muskogee, that's not real.

They want to be able to have choice of doctors and choice of health plans. But as we sit here right now, Oklahoma is just like every other state. It's only now beginning to really hit you. But in any other state, fewer than 50 percent of the insured population any long has a choice of doctors or a choice of health plans.

It's the height of irony that the opposition to the president's reform has viewed that we're going to take away choice when what we want to do is guarantee it and expand it. I will sit here and tell you that if we do nothing, the current status quo is going to undermine the financial stability of a lot of hospitals, particularly higher, first year hospitals where all community hospitals are going to be written out of the insurance plans and are going to be eliminating from coverage doctors just left and right.

I was talking to the congresswoman from Arkansas who told me what I thought was the most absurd story that I've heard in a long time. That in, Arkansas, one of the big employers there that's on the Mississippi River had signed on to the insurance plan whose only doctors were in Little Rock. That's three hours away. Memphis is across the river (inaudible). But in the name of cost containment, the only doctors these employees could use are in Little Rock. We want a guaranteed choice to put in the hands of the individuals so that every year they get to choose their doctors and their health plan.

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We also want to extend health care at the workplace. This is not a government program. You know, I know that it's the same thing that has been said every time health care has come up with an issue, people say oh, government, socialists. It is not. What we are trying to do is to pool people into big purchasing co-ops or buyer's clubs so they can pool their dollars to get the best possible bargain for the purchase of health care, not that they get their health care through those buying co-ops. It is a financial device for maximizing your buying power, the same thing that Dave and Mike and I get because I'm married to one and they are federal employees.

The money that is used to provide the choices for health plans to federal employees comes from our employer, namely the federal government and ourselves. Every year the federal government, as our employer, goes out and says to the doctors and hospitals and networks and HMOs and PPOs and all the others you can bid for our business. But the government is not the doctor and the government is not the health plan. It is the pass through collection processing.

That's what we want for every state so that everybody pools their dollars. Then they go into the marketplace to buy their health care. So every December when the annual enrollment is up for federal employees, we choose. The president and I make a choice. David and make a choice. Mike makes a choice. It's our choice. There's no government doctor. There's no government health plan. That's what we are talking about when we talk about co-op and buying clubs for alliances.

The final point I'm making, we want to preserve and improve Medicare. Medicare has done a very decent job of keeping our older Americans out of health care crisis and. If you go back to your readings of some of the hearings and the testimony of the 1950s when Congress was considering Medicare, there were horrible stories about older people who were denied care, not getting access to care.

We've done a good job, but there are two things that we been able to deal with. One is prescription drugs which are often one of the biggest costs for older people. I've met a pharmacist family physicians or interns. I am told all the time that older patients are given a prescription when the pharmacists know they cannot afford the bill or if they bill, they then sell to Medicaid.

If they're supposed to take four a day for 10 days,

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they take one a day thinking they can spread it out longer. The latest statistics are that 23 percent of the hospital admissions of older Americans, Medicare-eligible, are due to inadequate or for unaffordable medication problems. So we pay for them when they go into a hospital, but we won't support the medication that will keep them out of the hospital. It's a very cost ineffective government decision.

We do the same thing with long-term care. If you spend yourself into poverty and you qualify for a nursing home, we'll pay for it. But if you want to stay at home with your family and have a visiting nurse or a piece of equipment that will help you maintain your family connections or if you want to go to a center during the day so your family members can go out to work, we're not going to help you with that.

So again, we make these decisions that are just not very. Those are the kinds of sensible ideas that we think will help kind of get the financing in line with the quality of health care in this country. We've got the best quality, the finest doctors, nurses and hospitals, but as I've said many times, we have the stupidest financing system. We spend billions and billions of dollars inappropriately and unnecessarily on things that have nothing to do with actually delivering health care to patients. That is what we want to try to get away from so that money can be spent on health care or even freed up for other economic activities in our country.

So with that.

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MRS. CLINTON: I'm glad you asked that because we spent a lot of time trying to get to the bottom of that. This is one of those issues that has so much really get as close to what we thought were the real problems in the system and then tried to come up with some. You put your finger on one of the issues that we had.

Part of the problem if you look at what I consider to be fairly accurate studies to the best of my knowledge spent the most time and money in both the government and through the medical society trying to get to the bottom of it, what is the malpractice problem.

When you break it up, what you get are. You do have a problem with frivolous lawsuits that are absolutely brought for harassment or for potential gain or for -- you

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know, it's like a lottery. They are brought oftentimes by the same lawyers against the same doctors. There is a pool of doctors in every state.

I can't speak for Oklahoma, but in all the states we've gotten good statistics, there's a pool of doctors who have more than their share of malpractice suits. There is a group of lawyers who are primarily the ones who bring the frivolous cases to court.

What do we do to try to eliminate that? First of all, we say that you've got to have a certificate of merit from an independent expert that you've got a working lawsuit. Even then, though, you've got to have some kind of alternative dispute resolution outside the court before you can get to court. We think health plans and other entities ought to be preventing those and that ought to be a door that you have to open.

Thirdly, we think that as we're building this into the plan, we ought to be developing standards of practice as a presumption of because what you just said is absolutely right. The independent clinical judgment of physicians is no longer enough to be able to keep. That's not the way it should be. What we want to do is have a specialty organization to develop standards that any doctor can say I abided by those standards. Unless they overcome that presumption, they can't get in the door.

We think that is the best way to deal with the defensive medicine people and the malpractice people at the same time. The State of Maine has done some real good work in this area. We're beginning to see some results. You're aware of that. I'm real pleased about that. They've taken a couple of diagnoses and procedures and outlined the clinical standards. I think that's working out.

We also want to limit attorney's fees. We think that is very important. Now, where we have not gone is the recommendation that we limit the level of judgment at a federal level. We think that every state has a different pay. The limit in California is \$250. The limit in Louisiana is \$500. The limit in some other states -- every state should have their own limit.

The reason we decided to do that is because in this piece of legislation, it is very hard to prove on a national basis that there is a big problem with big verdicts across the nation. There are some states and some areas of states

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that have gone wild, but most states have stayed pretty constant. They don't have wild out-of-the-way verdicts. So we think that ought to be a state responsibility. Most states have already moved in that direction.

There's not much evidence, I must tell you, that having a cap on those damages keeps malpractice premiums down because what happens is if you think health insurance costs have gone up, malpractice insurance costs have gone way up. They go up based on our studies without any direct relationship with verdicts. They just go up.

So there needs to be some self-insurance by physicians and there needs to be limits on attorney's fees. We really believe that that combination of clinical judgment, limiting attorney's fees, bars from getting into the court unless you can overcome three different hurdles will put a real chill on frivolous lawsuits without eliminating the possibility of somebody who is the victim of genuine negligence. That's the balance we've tried to draw.

Q Mrs. Clinton, I'd like to also say thank you for coming to Oklahoma and spend time with us. There is so much being said about health care reform that we simply ought to remember that the physician is the focus. The three of us manage hospital in the metropolitan area. We choose to do that. We like living there. The doctors that come to us like living. Unfortunately, the incentives to come to rural Oklahoma are not there. We sure would like to see something done relative to helping us attract physicians.

MRS. CLINTON: Yes, and we have some specific provisions and incentives in the president's approach and others like Dave and Mike who are concerned about rural health care and working on how to make sure that we do what you're talking about. There are several different elements of this.

The first is that if we have everybody insured, you have a more secure financial base than you do now. In most rural areas, you have a disproportionately high number of Medicare patients, Medicaid patients and uninsured patients. So it a difficult financial situation because unlike some of your colleagues in Tulsa, Oklahoma, you don't have populations to shift costs to. I mean, they have a much bigger insured base that they can shift costs to than you do. So you take the burden of trying to balance your books with many fewer resources coming in.

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If we have everybody insured, we have a reimbursement attached to every patient you've got. That's a big plus. Secondly, we are trying to change the payment level for Medicare for rural hospitals and rural states because we don't think you've been treated fairly. Thirdly, we've got direct financial incentives for physicians and nurses to practice in rural areas. That is something that we really believe in, everything from loan forgiveness, bonuses, plus we've got a process for funding facilities in rural areas that we would be the essential community providers. The only hospital in certain area can be permitted to shut down if you're going to be able to provide true access under universal coverage in that area.

Then, finally, we have incentives for physicians to be able to band together in networks to be part of health care. We actually have loans for small groups of physicians to be linked together so that they can compete with HMOs or big insurance companies. Also, I would add that we have some incentives for technological advances that would enable physicians in your part of the state to be hooked into the medical schools. That, we think, holds great promise for not only getting state of the art medical care out of your communities but for supporting your position.

I mean, it's not just a question of money for a lot of physicians in rural areas; it's working conditions and the lack of peer support that finally gets to them. So we're trying to figure out ways to network better. We've got money for such technology that will help link up. When I was in Syracuse, I visited a computer project they're doing that we see as sort of fiber optics superhighway that the vice president is very committed to as having incredibly (inaudible) with the medical ramifications, to be able to get hospitals and clinics linked up so that you literally don't have to move.

I personally sat in a room in Syracuse University with a doctor standing by me who was a pediatric cardiologist. On the computer screen it would flip. The doctor who had the baby patient would talk to this doctor. He could see the baby and then he could see the results of ultrasound on the screen. the physician said I can see by the way the child is moving and what extension her arms are and I can see through the ultrasound that this child does need to see a specialist. But I could see a child just a few hours ago that I could tell did not. That's what we're hope to move for. That would be incredible for rural hospitals.

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Q pilot administration projects figure out where the money is coming from? The other thing is that you are aware that we're 48th in the country people. One of the things we also quadruple the national health care service (inaudible) be recognized (inaudible) both rural and inner-city must be taken care of if we're going to make this thing work. Let me ask (inaudible).

A PARTICIPANT: (Inaudible)

Q Before you answer that, let me ask (inaudible) anything to add to that?

A PARTICIPANT: (Inaudible). She's worked 16 hours a day 7 days a week. I do have some resolutions from (inaudible) concerns about (inaudible) health care providers (inaudible) health service (inaudible). I have one other comment of concern. In reviewing insurance packages, (inaudible) to find out the people that are (inaudible) now are still not (inaudible).

To give you an example, in my own family, my sister (inaudible) had an aneurysm, had an insurance company (inaudible) who is now (inaudible). But fortunately, (inaudible). They are losing their insurance (inaudible). How can you pay for insurance when you don't have any money, plus you've had an aneurysm, been in the hospital three months? If she hadn't (inaudible).

Now, these HMOs, after I find out (inaudible) hospital (inaudible) in Tulsa do not have rehabilitation for (inaudible) patients and rehabs. I mean, as a nurse, I'm employed at a hospital (inaudible) not a rehab. A lot of these companies select and have them (inaudible). So your age group right now for any (inaudible) is age 33 to 62.

This has been the (inaudible). When they have a stroke, of course they can't get on Medicare for two years. Then her husband is losing his job and he's worked all his life. It's a real problem.

Q (Inaudible)?

MRS. CLINTON: You are absolutely right. One of the biggest reasons for the health care reform is (inaudible) people without insurance. It's because all of us with insurance who are seeing benefits decrease, the cost increase and losing benefits because of employment changes or other circumstances. That's what I hear.

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I've got a million letters back at the White House. I'd say the vast majority of them are from people who are insured who are complaining about the costs going up, about finding their insurance companies cover rehab or didn't cover preventive care or didn't cover something (inaudible). So this is really an issue that cuts across any socio (inaudible).

I think that the real issue for us is (inaudible). It's time to come up with a standard benefit package that barely takes care of the major hospitalization and outpatient needs that people have and also through preventive care. I think health promotions, really, when you look at it closely, has to be about preventive care because you can lecture people all you want, but if they don't get the vaccination, if they don't go get (inaudible), and they don't go get the well-child exam, what good is the health promotion. So it's got to be both. So we've tried to emphasize preventive care so that we can begin (inaudible) responsible.

One example we know about this is Hawaii. Now, people always say to me well, you know, Hawaii is an island. Yes, and the cost of living in Hawaii, because it is an island, is higher on average than Oklahoma, Arkansas and most other parts of the country. But health care is lower. It's because they covered everybody starting about 74 through an employer-based plan. They included preventive care.

The average Hawaiian actually goes to the doctor more frequently than the rest of us. But because they get (inaudible), they don't get as sick as chronically as long or hospitalization stays, so their overall costs are actually less. Their per capita expenditure is about 9 percent as opposed to our 14-1/2 percent. So preventive maintenance, getting people to doctors, getting them to take care of themselves is a big part of what we've got to decide.

Q (Inaudible) --

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