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REMARKS BY THE FIRST LADY  
TO NORTH CAROLINA CONGRESSIONAL DELEGATION  
WASHINGTON ISSUES SEMINAR

Thank you very much. It is a great treat for me to be here and to have a chance to join the Members of Congress who have sponsored this event, every one of whom I know that you are very proud of, but they are also Members of Congress who the President and this Administration have particularly enjoyed working with because they have the unusual combination of common sense and guts on many important issues that we are very appreciative of.

So I personally would like to thank Congressman Hefner for that introduction but also Congressmen Neil and Valentine and Lancaster and Rhodes for the many good ideas and support that they have given.

And I want to take just a few minutes to talk about health care, but I want to start by talking about one of the prior votes that these members made and why it is so important to understand the relation between health care and the future prosperity of businesses and individuals in our country -- and that is the vote on budget.

I know that several speakers have appeared before me. I hope I don't repeat anything that they said. It's very important that you understand that, from the President's perspective, getting our fiscal house in order means not only moving on the deficit and beginning to have the economic recovery that is really taking hold but it also means doing something about our health care system. They are inextricably combined.

So now, for the first time, because of the President's budget program and because of the votes of the members which (inaudible) and which drew a lot of criticism from people who didn't understand what was at stake, the deficit will be cut in half and it is now coming down for three years in a row.

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That is the first time that our federal government deficit has gone down three years in a row since Harry Truman was President, so I think it's very significant that the budget proposal is working in one of the areas it was targeted to affect -- namely, deficit reduction -- and we now project that the United States will have the lowest deficit as a percentage of national income of any major world economy by 1995.

I want to stress again how important this is because, from 1980 to 1992, we ballooned our deficit. Our deficit, as a percentage of our national income, was much greater than most of the countries with whom we competed. We saw an outflow of all kinds of jobs and capital. We could not sustain the kind of economic growth that we needed in the private sector because of the huge demand on capital that the public sector was taking out of the economy because of the absolutely out of control deficit.

Because of a responsible President and some very courageous Members of Congress, we are now finally on the right track when it comes to deficit reduction. That's important, for many reasons.

One, those of you in business know that with credible deficit reduction we have seen not only interest rates drop but also we have seen the creation of now more than 3 million private sector jobs in 16 months. That is seven times the rate that private sector jobs had been created previously.

So, for the first time in 1993, we could see new business start up dramatically, new business investments higher than it had been for 20 years. It was the best year for business incorporation since Dunn and Bradstreet started keeping records back in 1946.

I think these underlined economic and budgetary points are important because it is against that backdrop that we need to consider health care reform because, although we have made progress with deficit reduction, it is clear that even under the budget that was passed, the deficit (inaudible) begin to go back up in a couple of years, and it does so for one reason only, and that is that Medicare and Medicaid are projected to grow by more than 10 percent each year for 10 years.

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I just want to paint this picture for you. This Administration, with the help of Members of Congress like the ones here, has eliminated more than several hundred programs completely, has gotten the federal work force on a trend where it will be the lowest it has been in many decades when the work that the President and the Vice President, with reinventing government, has finally played out and the (inaudible) federal work force has shrunk.

Discretionary spending has been held even. It has been under the toughest caps -- budget caps -- that have ever been imposed, so even this defense spending, which fuels the huge deficit reduction, is being downsized in the safest way we can think of.

What is left is certainly payment on the debt -- we built it up; we are going to have to pay it off -- and the increase in entitlements. But when the word "entitlements" is used, it usually is shorthand for Medicare and Medicaid, because that is the part of the budget that is continuing to grow and will continue to put budget pressures on the federal government which will lead to an increase in the deficit.

Why does that have anything to do with health care? Well, let me just focus for a minute on North Carolina.

North Carolina businesses, according to the University of North Carolina, pay on average 30 to 40 percent above the cost of health care. You pay, for those of you who insure yourselves and/or your workers or are insured yourselves, you pay much higher than average costs. Why?

Well, because the other large payers in the health care system in North Carolina and (inaudible) around the rest of the country are the big (inaudible) programs of Medicaid and Medicare. The average hospital in North Carolina gets about 90 percent of its costs paid for by Medicaid or Medicare. It makes up the costs it doesn't get by charging businesses and individuals more, which is why your average costs are 30 to 40 percent higher.

Now, if you will, think about what will happen in the next several years. Think of the political rhetoric that will fill the airwaves in places like North Carolina. We've got the deficit going down. We've got jobs being created at the fastest pace anyone has seen in a very long time. Although the recovery hasn't touched everybody, it's

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beginning to make an impact (inaudible).

And then, all of a sudden, we see the deficit start to go up again with all the resulting consequences, with capital getting tight again, with interest rates going up again, with jobs beginning to shrink again, and we'll all sit around and we'll say (inaudible) and people will turn to blame the President or they'll turn to blame a Member of Congress when, in fact, it is because of Medicaid and Medicare, which has continued to grow.

So what will the likely political consequences be? There will be calls in the Congress. Some of you will be in groups that will pass resolutions which will say: "Lower entitlements. Get them down. Get the deficit back under control."

The only way to do that, in whatever package of ideas anyone puts together, is to include dramatic cuts in Medicaid and Medicare. You cannot continue to reduce the deficit unless you're willing to make the hard political decision to do that.

Assuming there is a political will to further slow down the increase in Medicare or Medicaid, to try to really cut to the bone as much as possible on what we reimburse hospitals and physicians and everybody else, what will be the impact?

Well, we will certainly see an increase in the shifting of costs from the public sector to the private sector -- namely, to you and to anyone who is privately insured. That is the only way, in a system that has no comprehensive plan for containing costs, that is the only way Congress, with its blunt instruments of Medicare and Medicaid, can try to deal with the deficit.

So the impact will be, in places like North Carolina, hospitals will close, more and more doctors will refuse to take Medicare and Medicaid patients or at least refuse to take the payment available, because it cannot cover the costs they have, which are continuing to escalate in the absence of any systemic reform. The costs will be shifted onto the backs of businesses already paying.

Many businesses that are already paying -- and I have a chart from the University of North Carolina which

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shows that the vast majority of workers in both public and private sector North Carolina are insured, no matter how small the employment but, under increasing cost pressures, because of this downward pressure from Medicaid and Medicare cutbacks, businesses will have to begin cutting back in insurance, eliminating insurance, which will throw more and more people into the ranks of the uninsured, which will put increasing pressures on hospitals in this community as more and more workers show up at the last possible moment at the emergency room to get health care because they are no longer insured and, those who remain insured, if they are not among the biggest possible employers, will not have access to the kinds of discounts that big government and other government, along with big employers, have been able to bargain for, and they will incur an increasing amount of the cost of the entire health care system.

Private insurance today amounts to a (inaudible) tax, in many respects, on those of our businesses and individuals who pay it, because you basically are covering everybody else who works for a competitor or works for a neighbor down the street who is not making any contribution and you are picking up the difference between what the public programs believe they can afford to pay and what the direct cost of the (inaudible) is that the hospital and the doctor then tries to make up by coming to you.

Now, this is what we're looking at, and I think there are very few people who will honestly look at the situation and argue that these are the likely consequences. What is it we need to do to try to get ahead of this curve?

We need to understand that comprehensive health care reform has several features that work together. First of all, unless everyone is covered, you cannot stop cost shifting. If you leave loopholes, if you leave people uncovered, then you will be holding onto a balloon at one end and it will be popping up and, even if you try to move up to get the top smaller and smaller, it will still distort the entire system.

So universal coverage, as it's called, guaranteed health insurance, is not only the right thing to do, the humane thing to do; it is the economically smart approach to take. If you look at other countries, even with their heavy government bureaucracies, even with their inefficiencies -- which many of those other countries in Europe and Canada and

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Japan -- have in their health care systems, they will manage to spend less money per capita than we do because they've got everybody in the system.

The closest analogy we have in the United States is the state of Hawaii which started in 1974 by mandating employer contributions for worker insurance. Twenty years later, Hawaii pays less of its gross domestic product, if you will, for health care than any other state.

Its citizens actually pay more visits to doctors than citizens in North Carolina do because they go for preventive health care, which is paid for, and they therefore are treated less expensively than what often happens in North Carolina where the uninsured or the grossly underinsured postpone going to the hospital until their problem is real serious and very expensive.

And that very expensive is what happens to you because when you, then, go to the hospital and you find that \$25 charge for Tylenol, you are paying for the uninsured or the underinsured who have been taken care of but at the most expensive cost.

So if we look at universal coverage, which is what the President has been stressing over and over again, it is important to stop cost shifting, number one. Number two, it is important to begin to get some effective cost containment because until the public system and the private system are insuring people in a comprehensive health care system, you cannot begin to get costs under control and you cannot change the incentives that exist in the system.

That brings me to the second point. Comprehensive health care reform needs to preserve what works -- mainly, our doctors, our nurses, our hospitals -- but fix what does not -- namely, the financing system.

I have been very surprised at how many people have been willing to accept a financing system for health care that they would not tolerate for one minute in their own businesses. Imagine, if you will, that every cost you paid out in your own business carried with it a 20 to 26 percent administrative charge. That's what the private insurance market charges for health insurance in our country -- 20 to 26 percent.

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Compare that with the cost of administering Medicare, which can obviously be improved -- it's not perfect by a very long shot -- but the cost of administering Medicare with government workers is less than 3 percent. Compare that with the 20 to 26 percent administrative cost which goes right into your (inaudible).

I've also been amazed at how the incentives in medicine drive the financing and most businesspeople, again, would never put up with this. In medicine, you don't get paid by the outcome or the efficiency of your delivery; you get paid by how many procedures or tests you've run.

Dr. Koop just said that there are probably \$200 million of unnecessary tests and procedures run every year in our health care system. Now, that has become -- that is how we have structured our financing of health care, and so you have many, many examples every day in North Carolina where decisions are made driven by financing -- by an insurance company that makes a decision about what appropriate care is, by a physician who has to be thinking about the finances in order to deliver the care, by a hospital that decides whether or not to admit somebody without insurance.

So if we look at health care from what I view as a business-oriented perspective, you could make the following points very clearly:

American business is getting a very poor financial deal for what it currently spends for health care right now.

Secondly, every company that pays anything for insurance is giving a competitive advantage and basically paying a hidden tax that subsidizes every company that pays nothing for health insurance.

Number three, the number of the uninsured working Americans is increasing. When we started this work, it was 37.5 million; it is now approaching 40 million. That number will undermine the financial stability of everyone's private insurance.

And, number four, in the absence of comprehensive health care reform, the desire to keep the deficit going down will be to cutting entitlements, which everybody says they are for, but the two major entitlements -- Medicaid and Medicare -- as they are cut, either we will see decreasing

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medical quality, very large numbers of facilities closing, or the costs will have to be made up by increasing costs to the private sector.

So from the perspective of this Administration, and the reason that my husband became so adamant about health care, is that he was a governor for 12 years. He watched manufacturers disappear. He watched costs going up so that we were no longer competitive. He saw companies unable to keep businesses in our state and not even be able to keep them in the United States during the 1980s. And he saw the role that out-of-control health care spending played in our business lives.

And he made a vow, then, that there were two things he was going to get done:

Number one, have honest budgeting with honest numbers that would give the American public an honest accounting of what our fiscal situation was and bring down the deficit and bring about comprehensive health care reform because, in the absence of it, we cannot stabilize our economic base for the long term.

If we do it right, however, we can begin to take back some of those dollars we now spend on health care and invest them here at home in new jobs, new kinds of expansion, and a bright future. And that's how the budget deficit and health care work together and that's why they're so intent on getting health care reform passed this year.

Thank you very much. (Applause.)

Q (Inaudible) answer some questions on what we would like to do (inaudible) every district will have a chance to have somebody from that district ask some questions. So we're going to take a few minutes here and have Mrs. Clinton perhaps answer a couple of questions. The lady here.

Q Yes. Mrs. Clinton, thank you very much for an (inaudible) description of our health care situation. We who live in rural areas particularly appreciate that.

I'm the president of (inaudible) Congress in Mount Olive (phonetic), North Carolina, and we're a rural area of about 5,000 people. We also are the home of the North

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Carolina Pickle Festival and we've brought you and your family a tee-shirt just in case you'd like to remember that.

But my questions relate to (inaudible) very serious (inaudible) health care (inaudible).

In our town, we have four physicians. Two are in their 40s and two are of retirement age -- one is 60 and one is 70. They would like very much to retire but they can't, because their job is just so significant.

(Inaudible) attract other physicians to come in to practice with them and, as a result of that, our Chamber of Commerce has founded and put together a foundation in which (inaudible) recruit physicians to our community.

We've had some success with (inaudible). However, we have more money than we can give away, and we would like to know if there are any initiatives in your plan for improving the health care system that take into consideration particularly recruiting doctors, family physicians, to rural areas.

MRS. CLINTON: Yes, and that's a very important part of health care reform. It will not do us any good at all to say that we have universal coverage and not have physicians and other professionals available to take care of people.

There are several things that we think should be done.

The first is, I want to repeat that part of the problem in rural America, as in underserved urban America, is the financial base for maintaining doctors has been shrinking. The number of uninsured, the number of people on Medicare in rural areas, is often much higher than in other parts of the state, and that is true in North Carolina, so that you don't have the same financial rewards for practicing in a rural area and, as I pointed out, if Medicare keeps being cut, with the number of elderly people who live in rural areas, you will have even more difficulty keeping physicians.

Secondly, if you can stabilize the financial base by having universal coverage -- which means everybody comes with a payment stream attached to them -- you will take a big

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step towards eliminating some of the problems that exist -- the financial problems -- but you have to do some other things.

We want to designate certain hospitals in rural areas as essential community providers. They need to be there and they need to be given some extra funds in order to keep in business so they can serve as the center for health care.

We need to help medical students and other health care professionals pay off their loans and be able to afford to live in a rural area, and we have loan repayment programs and other financial incentives for locating in areas that are underserved.

We need, in both private and public health insurance programs, to change the way doctors are paid, which goes to a point I briefly made before. If you are paid on the basis of tests or procedures, that very much advantages physicians whose practice includes that primarily, whereas a family physician or an internist is really judged on his or her clinical diagnostic skills.

Sometimes the most important thing to do for a patient, particularly an elderly person in a rural area, is to spend time with them in trying to figure out how to take care of that person. Under many of our health insurance plans, in both the private and the public sector, you don't get reimbursed very much for doing what is the job of a family physician.

So we have designated five types of physicians as primary care physicians -- family physicians, internists, pediatricians, OB/GYNs, and general practitioners -- and we're changing the way we reimburse those particular physicians, so it won't be such a losing proposition to be one of a very few doctors.

And then, finally, we really think that investing in technology will be a big advantage for rural physicians because, if we can solve the financing problem, if we can solve the facility and reimbursement problem, there is still the problem that many physicians today don't want to be isolated from their colleagues in larger areas and so if, by technology -- (inaudible) medicine for example -- we can connect physicians in Mount Olive with physicians at

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(inaudible), that eliminates the kind of professional isolation that also prevents many physicians from feeling confident and comfortable practicing in a rural area.

So all of those things are in the President's bill and there would be a very big difference in the number and quality of rural health care physicians if we were able to get that passed.

Q Thank you for your support, and my friend has a tee-shirt for you. (Laughter.)

Q The gentleman here (inaudible).

Q My name is Floyd Oliver (phonetic) and I (inaudible) North Carolina (inaudible) the home of Hillcrest (inaudible) the world's best (inaudible) product. I didn't bring any great gifts, but (inaudible). (Laughter.)

(Inaudible). Yesterday the (inaudible) a story that indicated it was a compromise (inaudible) for health care legislation. The article stated that President Clinton would not insist on having health care insurance for every American if Congress agrees to phase in, in the next -- the program, in the next several years.

Is there a compromise in the works to get the legislation passed and, if so, how will it affect the legislation?

MRS. CLINTON: Well, let me just clarify what the newspaper said. And this is not to knock the newspaper, but I spend a lot of time clarifying what newspapers say.

And what the President has indicated all along is that a phasing in of universal coverage is acceptable but it has to be done by a date certain and it has to be done, in his view, sooner instead of later.

If that is part of the bill that is passed, then that is in line with what the President has always (inaudible). There may be some steps that have to be taken or goals that have to be met or approaches that can be tried and it all has to be within the legislation that is passed.

And the bottom line is, still, whatever legislation is passed has to achieve universal coverage, but there are

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many ways of getting there. And we have tried, during this entire debate, to be as open and forthcoming as we could about what we thought would work but also saying that, if others have better ideas to reach universal coverage, that was something that this Administration would consider.

So there's really not that much difference in what is being said now and what we have said for more than a year.

Q (Inaudible) this gentleman here. Where are you from, sir?

Q (Inaudible).

Q Okay.

Q (Inaudible). I'm (inaudible) from (inaudible), North Carolina. (Inaudible) and share your concern concerning health care. My question is the concern for Medicare and Medicaid participants and why Medicare participants were not part of the President's health care program.

MRS. CLINTON: Because we already have a universal system for Medicare. Everyone is eligible after a certain age. And, from the perspective of the Administration, it seems more prudent to create a system for the under-65 before we try to in any way dramatically change the Medicare system.

There should be some changes in Medicare, which are part of the Administration's proposal, but the Medicare system itself, we thought, was performing a very important function for our elderly citizens and we wanted to work on the under-65 first.

So there will be some changes and there will be some new incentives for Medicare recipients, we hope, that will help keep costs down in the Medicare program, and we think eventually there should be a merger of the systems. But we can't merge Medicare into nothing. We have to have a system first before we can look at how that merger might work.

Q (Inaudible). Is that not done in (inaudible)? It doesn't consider all (inaudible) Medicare does it?

MRS. CLINTON: It is a fairly comprehensive

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percentage. I can't list out you everything that is in it right now but it is a fairly comprehensive listing of the administrative costs that are directly attributable to Medicare so that (inaudible) the (inaudible), the claims, the utilization reviews, and the like.

Q (Inaudible) help (inaudible) fund these programs that the federal calls for 26 percent compared to 5 (inaudible) health care (inaudible) 15 percent.

MRS. CLINTON: I've never seen that. I'd be glad to look at it. But that is certainly not the results of the research and analysis we have looked at.

Q (Inaudible).

MRS. CLINTON: I'd be happy to look at it. We have a wonderful North Carolina economist here who knows everything there is to know about the costs of these systems and I'd be happy to have you talk with him afterwards.

Q (Inaudible).

MRS. CLINTON: One of the points that I always like to make about Medicare is that, in audiences I've been in -- I won't exclude this audience from any of the others I've been in -- often, when I ask people if they know how Medicare is paid for, there are a surprising number who don't know.

How many in this audience know how Medicare is paid for?

(A show of hands.)

MRS. CLINTON: That's -- I think that the Members of Congress will find that very interesting, because Medicare is a single-payer, government-financed, tax-paid health care system. It is, if you want to think about it, a Canadian single-payer system for people over 65.

And I haven't heard very many complaints about having it. I hear lots of complaints, about -- arguments about it. You know, "They didn't pay for this; they didn't pay for that." But much of the debate in the last year has been against the government running health care; and Medicare is paid for by a payroll tax. It comes out of your check every week or every two weeks. Your employer contributes and you contribute and you, therefore, pay for the health care of

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your mother or father or aunt or uncle or grandparents.

It is important to know that, because there has been so much misinformed and downright inaccurate propaganda put out about health care and what the President's proposal is, because the President did not propose a single-payer system or a government system for health care. He proposed it build on the public-private system that we currently have for those of us who are under 65 and which is available for Medicare recipients by coverage over and above what Medicare pays for.

But I think it's very significant that very few of the most well-informed people in North Carolina, just like every audience I've been in -- and I've been in an auditorium of 3,000 doctors, and I've had a doctor stand up and say to me, "I can't afford these government-funded health care systems for anybody; you're trying to (inaudible) the life out of me."

And I said, "Well, do you take Medicare patients?" He says, "Well, I sure do; what does that have to do with anything?"

I said, "Well, do you know how Medicare is paid for?" "Well, no, but what does that have to do with anything?" (Laughter.)

So then I said, "Well, how many doctors know how how Medicare is paid for?" And I got about as many hands as I got here -- about 10 as I could best count them here.

And then I said: "Well, it's paid for by a payroll tax. The employer pays, the employee pays. It's a single-payer, tax-financed system that those of us who are working pay for to take care of people who are older."

So I think it's important to know our facts if we engage in these debates and not let people, you know, get into a rhetorical battle that may or may not have anything to do with the real issues in front of us.

Q Yes (inaudible) general commerce and I'm also the chief operating officer of our (inaudible) hospital in (inaudible) North Carolina, which is a 275-bed hospital (inaudible) provider.

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We certainly see the patients coming into our emergency department who are uninsured and (inaudible) and we applaud the Administration for bringing (inaudible) so that universal coverage will eventually (inaudible).

One thing that you mentioned about Medicare is certainly we've operated our hospitals at 90 percent of cost as, I think, you indicated and I think our hospital (inaudible) the health care system in the country would not be as it is today. And, of course, you cannot operate a system losing money every day.

My major question to you is, in all the debate (inaudible) do not hear much about rationing of health care, and (inaudible) looked at the (inaudible) system and talked about that until we get to that point in this country. And, as you know, in all other major countries with a single-payer system, that's what they're doing, is rationing health care by not providing certain things.

What is the Administration's view on rationing of health care and how are you going to approach that in your plan?

MRS. CLINTON: Let me say a couple of things about that. We ration health care now but we ration it on your capacity to pay for it.

One of the most astonishing statistics that Dr. Koop uses whenever we speak together is that an uninsured person has three times more likely the chance to die from the same illness as an insured person. The first time he said that, I couldn't believe it, but I have learned never to question Dr. Koop. He knows, and he gave me all of the research and the backup. But I was stunned by it.

So we ration already. I think that if we're going to be honest, we should admit that. And we ration, not by any rational means, but by who gets paid and who doesn't get paid and who can afford what.

It's very difficult, in a system where people are left out, to talk about rationing. That is why our position has been, we need to achieve universal coverage so everybody is covered.

If any of you were to lose your job, if any of you

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were to all of a sudden have a (inaudible) devastating accident and you used up the lifetime limits on your insurance policy within six months to a year, and you found yourself among the uninsured, you would understand very clearly what it is like to be on the other side of that line.

So, from our perspective, until everybody is covered, we cannot fairly talk about rationing service. We do, at some point, need to become more efficient and we absolutely think efficiency in our health care system is a much better goal than having to invoke some kind of rationing.

Let me just give you a few quick examples:

If we had an efficient system for delivering prenatal care to pregnant women in our country, we would save a lot of money.

If we had an efficient system for analyzing the relative cost and outcomes of various procedures, we would end up saving money. The state of Pennsylvania has done this. They have taken every coronary bypass that is performed in Pennsylvania, they have seen how much it costs, what the complications were, whether the patients died, and they have (inaudible) every hospital.

And guess what? The cost runs from about \$20,000 in some hospitals to \$80,000 in other hospitals, for the same operation on the same kind of patient. There is no difference in outcome. In fact, there is some argument that those on the slightly medium end of the scale are actually more efficient.

We could perform more bypass surgery if more people were performing closer to the 20s than closer to 80, but there's no incentive in our system for a hospital to be able to get that done.

So, from our perspective, we don't need to talk about rationing, other than to recognize we already do it for financial reasons, but we do need to get everybody covered and then begin to squeeze the system so that it becomes more efficient.

Whenever we talk about that somebody always says, "Well, that means, then, we won't get the quality of care

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that we deserve to have." And again, I would just urge you to look at what is actually paid for the same kind of services in different parts of the country.

For example, there is no rational reason in the world why the same surgery costs three times more in Miami, Florida than it does in Minneapolis, Minnesota or why a hospital stay in New Haven, Connecticut is one-half the cost as the same hospital stay for the same illness in Boston, Massachusetts.

There are system problem that can be solved, and that's what we want. We want to start getting the health care we deserve to have but at a more cost-effective rate than what we're currently paying for, and we don't think that will diminish quality but, in fact, will spread the benefits of health care much more broadly and save us money because more people will get preventive care early.

Q I'm Lewis Carroll (phonetic) from (inaudible) Chamber of Commerce (inaudible) foothills of (inaudible) and it's a rural area. Our people are basically farmers or tobacco farmers.

We are all very excited about what you and President Clinton are doing (inaudible) this country (inaudible) financial base and what's being done with health care. We have great concern that tobacco has been the only sin that's been identified so far is helping pay for this.

Now, we want to help pay our share but my question is do you think there will be some other sins identified to share some of this burden? (Laughter.)

MRS. CLINTON: It would be great if we could tax all of them. (Laughter.)

We are very sensitive to the, not only economic, but, really, cultural concerns surrounding tobacco in a state like North Carolina, and there are Members of Congress who are here, I can assure you, who are very vigilant in trying to make very clear the economic impact that singling out tobacco would have. There is a lot of discussion going on, particularly in the Hour of Representatives, led by Members who are present here, to try to make sure that tobacco is treated fairly.

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I don't think the Administration really would rule out taxing anything else that people thought was appropriate that could be taxed if there was the kind of support for it and relationship to health care reform that seems to be targeted now only on tobacco. I believe that is what the House Ways and Means Committee and others are struggling with right now.

So I know that many of you have a deep interest in this and we want to be very sensitive to what your legitimate concerns are. We have obviously health care concerns about tobacco that we think fairly suggest that tobacco is a target for some revenue but how that all plays out is something that we're really watching now as it's worked out in Congress.

But we have no problem with whatever the outcome or the remedies might be that the Congress (inaudible).

Q (Inaudible). (Applause.)

I think that that (inaudible) has to be at another meeting and we want to thank you for (inaudible), and I think people are obviously impressed with (inaudible) questions (inaudible) warn you about asking questions because they would be (inaudible). (Laughter.)

I want to thank you for coming and being with us and (inaudible). (Applause.)

(End of tape.)

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