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REMARKS BY THE FIRST LADY
TO LEHMAN BROTHERS HEALTH CORPORATION

MRS. CLINTON: I appreciate your putting this issue into such a broad context, which it certainly deserves to have, and what I hope we can do this afternoon during the time that I am with you is to focus on several aspects of health care reform and to try to envision the various paths that lie before us and the choices we have to make in light of the options currently being considered in Congress and then to perhaps discuss in the question and answer period any concerns or suggestions that you might have that you believe should be considered and added to this process.

As Mr. Frank said, this is an effort that has been culminating in a lot of attention and activity this year but which has a very long history. We could go back and look even before Franklin Roosevelt, but certainly starting with him, at efforts to try to create a more uniform, comprehensive health care system, and we can see how at every step along the way, instead of dealing comprehensively, we have made incremental changes that have in some respects not only unintended consequences but exacerbated the underlying problems that they were meant to resolve.

It is certainly clear to those of you in this room who have followed this debate that because everyone has some experience with health care, everyone has a very strong opinion about what should or should not be done, and there is a very difficult task in trying to forge a consensus in the face of so many competing opinions. But I think there are several major areas where at least if one is addressing the issue in good faith, there is a clear consensus that we should keep in mind as we move forward with the reform effort.

The first is that health care reform is essential for the long-term economic well-being of our economy both in the public and the private sectors. That sounds like a simplistic, self-evident statement, but it is one of the hardest issues to convey effectively to Americans, whether they sit on Capitol Hill or on Main Street.

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It is difficult for people to grasp what it means for the rest of the economy that now nearly 15 percent of GDP is spent on health care. It is difficult for people to understand why in the face of the 1993 Budget Act, which will finally produce for the third time in a row a reduction in the deficit, and that has only happened once since Harry Truman -- namely, under this President -- why the downward trend in the deficit will be short-lived in the absence of comprehensive health care reform.

So, the economic stakes in health care reform need to be understood and explained clearly, and then one can make whatever decision one chooses. There are those who benefit from 15 percent of DDP spent on health care. There are those who don't believe that the deficit going down is important for sustained economic recovery and long-term job prospects. But I think the bulk of opinion is on the other side with respect to those two issues. So, the economic stakes in this debate are ones that we should acknowledge and deal with honestly, although they are difficult to convey and to discuss with large numbers of people.

Secondly, the level of information and understanding about how the health care system currently functions is extremely low among decision-makers as well as citizens, and I don't think you can even imagine, those of you who deal with this on a daily basis from a position of expertise, how low that understanding is, and I will just give you one example.

In every large group in which I have appeared for the last several months, I have tried to answer questions about how the system functions. And often in response to people's questions I will ask them a question. I will ask them if they know how Medicare is paid for. And rarely, no matter what the group is, no matter how large, or what the particular subject that brought them together is, there are not more than 10 hands that go up.

I had the same experience over and over again, as recently as yesterday, when I spoke to 450 business leaders from North Carolina. And I said, "Well, how many of you know how Medicare is paid for?" And literally there were not 10 hands that went up. And I then said, "Well, do you know what FICA is? Do you ever look at your pay stub on your check, or what you do for your employees?"

So, I cannot stress how difficult the task is in crafting reform of a system that people don't understand to start with, and it has been one of the great challenges that

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this Administration and members of Congress as well as leaders in the areas that you are involved in have confronted.

Thirdly, in the struggle for health care reform, particularly as it shapes up in the Congress, the trees are always easier to discuss than the forest, and so the trees become an excuse for discussion and a route to paralysis. That is what has usually happened when we have tackled health care reform in the past, and it is one of the great challenges we confront now.

The overall issues of how we reform the system or what changes need to be made are certainly ones that have to be discussed and delved into in detail, but they give people headaches, and it is hard work, and it is difficult because there are no easy political 100-percent answers. And so, instead of trying to piece together the comprehensive reform, people go off on certain tangents.

And many of the groups whom you represent or whom you invest in have been in and out of the various offices on the Hill or in the Administration and have said, "Well, we're 90 percent for reform. We know that's the right thing to do. But this 10 percent piece has to be fixed this particular way or we can't support reform at all." So there's an incredible sense of dispute -- disputing going on in the very effort to get health care reform because of the anxiety of many groups about whether or not they will get their particular piece done exactly as they want even though they agree with the general direction.

Fourthly, one of the great problems in our health care system is there is no reward for efficiency and there is no means for altering the incentives and the disincentives that currently drive the financing of the system. If there were, there would be many more Mayo Clinics and many more efficient HMOs today, even though the trends are picking up, than there -- than there are, but there have been no real incentives for people to reorganized care differently.

And if reform fails, there will still be no real incentive. Every time serious reform has been introduced, whether you look at the Nixon bill or Carter's efforts, there was an immediate reaction by the market. Rates went down. Prices went down. People made efforts to become efficient. And as soon as the pressure was off and the incentives didn't change, it was back to the status quo ante.

Now, that is in the interests of some, but it is not

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in the interest either of many of the current trends for more efficient health care delivery nor, I would argue, in the public interest, but that is the history of what happens in the face of reform, which is why the recent decreases in price escalation and many of the moves on the part of HMOs and other entities to merge and become more efficient some would say has every tendency to continue on its own.

I would argue that in the absence of reform and in the absence of pressure, the incentives are still in the wrong direction, and that that will not be a trend that continues at the same pace that it has in the last two to three years.

Finally, this is an issue that has ramifications beyond the economic, and I was pleased that Mr. Frank alluded to that. But because I believe that issues of social justice and political gridlock and questions of community ethics are also economic in the sense that a more productive, better functioning citizenry and more effective community and political structures will continue to support the kind of economic growth that we want to take for granted in our country, they are also related.

And so when we talk about the, if you will, noneconomic functions of health care reform, we are also very mindful of how we believe that creating a more just allocation or access to health care resources provides security for every American so that there can be increased job mobility, there can be increased entrepreneurial activity, there can be more of a willingness to engage in productive work by people who are currently on welfare with health benefits that are not available to low-wage workers, there are many economic consequences of attempting to deal with what superficially are often viewed as only social or political issues.

So with those comments, I'll stop and be glad to answer any of your questions.

Q If anyone has any more questions to be collected, by the way, hold them up, and we will (inaudible).

Our first question comes from Joe Higgins (phonetic) of Swiss Re (phonetic) Advisors, and this is one of several questions that we received on this topic. The question as he phrased it is, would soft or hard trigger provisions in -- in the legislation satisfy President Clinton's desire for universal coverage? And I would ask that -- what is your assessment of whether the votes are (inaudible)?

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MS. CLINTON: Well, I don't like the term "soft or hard trigger" because nobody can tell me what it means. It's an excuse for, you know, a conversation that should occur, and it is hardly as yet an analytical concept. But if you're going to use the word "trigger", then I would say you say triggers that work, and triggers that work have to be triggers that result in universal coverage by a date certain.

And if such triggers can be designed and the legislation can embody them, then that meets the President's bottom line of achieving universal coverage. But if they are an excuse for once again postponing the inevitable and refusing to deal with the hard choices that health care reform presents, then they're not acceptable, whether they are hard, soft, or, you know, medium well done. They're just bad.

Q The second half of the question being your sense of whether there would be Congressional support.

MRS. CLINTON: Nobody has yet written in legislative language what a trigger is, so nobody knows whether there is support for it. I mean, it's very easy to throw around these phrases. It's very hard to come up with legislative language that describes what that trigger is, and there are many intermediate problems with such a trigger design that have to be dealt with.

For example, what happens during the transition? If there is a trigger with a date certain that triggers an employer mandate, what happens during the transition? Are existing employers to be frozen in place and told they cannot drop health benefits, or are they going to be permitted to be able to drop health benefits? I mean, there are lots of questions.

That's just one of many that have to be analyzed, and then you will have to cost out, insofar as that is possible, what the implications of the transition would be. And one of the serious issues of any kind of trigger is what's the subsidy level, for how long, for how many will people be subsidized until at what point would a trigger be pulled, and then there's the obvious issue about how it's pulled, and if it requires additional legislative action, how can anyone be sure that that will be taken?

And so then there's all kinds of issues about is it a fast track process, is it a base closing process, but until somebody shows us some legislative language, this is all very abstract, and it would be nice to have the people that are

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talking about it have to go to the test of putting it down and seeing what it looks like and then having it costed before anybody responds.

Q The next question here comes from Sam Nevin (phonetic) of Rayth Cyproth (phonetic) Company. The question reads, the President has spoken favorably of managed care as an approach to reduce health care inflation. One way to do this is through negotiated volume discounts with providers. Do you think that managed care plans are able to negotiate these discounts and chose the most cost-effective providers if they must include in their provider networks the unwilling providers?

MRS. CLINTON: Well, I think "willing provider" can be defined in such a way as willing to accept the -- the prices offered. What we have found is, the main objection to some of the actions of managed care entities toward providers is that there at least seem to be other factors at work determining whether or not someone is permitted to be a member of a certain organized care institution.

For example, many minority physicians are very concerned that they are being, in effect, redlined by HMOs and other managed care organizations, and they believe that they are being redlined because of the neighborhoods in which they practice, often because of the morbidity of the patients whom they serve, because of the hospitals that they use to admit, and I think that if you're a willing provider, willing to take the amount of money that's been negotiated for whatever, that should open the door to your being able to be part of that network until or unless you do something that disqualifies you.

So I don't know that willing provider means you should have to take people who aren't willing to take the prices that you offer, but if they are, then I think willing provider should be a guide for who you let into your network.

Q Aren't there two pieces to being a willing provider? One is willingness to accept the reimbursement, and the other one is to practice medicine efficiently? We had some data yesterday from one of the speakers who showed that certain physicians traditionally ordered to take too many tests. Do you think that any willing provider legislation should be allowed to exclude the less efficient providers?

MRS. CLINTON: I would not start with exclusion. I would start with some kind of, in effect, retraining and

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repositioning of health care providers so that they understand what it means to be efficient. We have no track record for most physicians. We have paid them like they were piecework textile manufacturing employees, and as many shirts as they turned out or as many tests as they prescribed, they were paid by that.

And I think it's very difficult to go cold turkey, if you will, and say to providers who have been living by the fee for service reimbursement system all of a sudden that they could no longer do exactly what they were doing that was rewarded for all of these years. So I think (inaudible) network as an obligation to work with physicians, to begin to try to help retrain them, if you will. It also requires that there be changes in the malpractice laws and that there be the development of clinical guidelines and other standards that would hold providers harmless for not ordering every test that any patient might demand.

So it is a much bigger issue, but I think it would be a great mistake, and I think it would result in discrimination against underserved populations and minority physicians if all of a sudden people were excluded on the basis of statistical analyses of efficiency without being given a chance to change their practice styles so that they are more able to practice in ways that you're trying to achieve.

The only other point I would make is, very often, at least in some of the tests, the analyses that I've looked at, there is a very strong argument that could be made to undercut some of the conclusions drawn about numbers of tests and efficiency of service based on the patient load. If you are practicing in an urban area with a much higher rate of AIDS or other kinds of serious illnesses, where people are not insured, where they don't get service in a timely manner, it is often the case you will have a sicker patient come through your door than you will have if you are in a suburban area.

And I believe that we need to recognize that if we move toward universal coverage, which is what we believe is the best way to get costs under control and to eventually tighten efficiency, then we have to be understanding of what the different populations will bring to that. And there does have to be some effort on the part of these networks to work with physicians and to understand the patient load that various physicians have.

Q Our next question comes from Leo Pasaro

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(phonetic), (inaudible) Investment Advisors. What is it going to take to move Medicare recipients into managed care? Does the Administration view managed care as a desirable vehicle for controlling Medicare spending? And also, is this something that -- if it is desirable to move these people into managed care, is it something that can be accomplished, given the strength of the open monopoly?

MRS. CLINTON: Well, I think you can have incentives for managed care in the Medicare system, which is what we are proposing. I don't think politically you can move every Medicare recipient into managed care. For one thing, you don't have managed care in the majority of Congressional districts yet in this country except in a very rudimentary way. It is still heavily regionalized, and there are great parts of our country where, you know, managed care sounds like it's something from the Gulags to the people who are practicing medicine and our patients there, so it's going to take some time and some exposure and some experience.

But, yes, I think you could have incentives in the Medicare program, and you should have incentives, incentives like being able to keep your managed care contracts as you move into Medicare, when you reach Medicare eligibility, incentives like perhaps more prescription drug availability or discounts if you're in a managed care setting. I mean, there are a number of ways of encouraging Medicare recipients, but there are neither the votes nor the experience base yet to whole cloth move Medicare recipients.

That is something we would like to see develop over time. We think it is in the best interests of the Medicare recipient as well as the Medicare system. But, you know, if we stop and look at the way Medicare operates now, part of the reason that we are not able to deliver Medicare as efficiently as we would like to is not only the fee for service system but the way that Medicare reimburses for services, because it does not reward efficiency.

It, in effect, rewards in efficiency. The higher your costs, the more of a reimbursement you get; the lower your costs, the less in many instances. So we are in the President's approach even trying to change that before we even have a lot of movement into managed care, try to change the way Medicare reimbursement occurs so that managed care populations like Medicare recipients in the Twin Cities, there's a reward for that efficiency as opposed to the much more fee for service-dominated markets that currently are rewarded for their inefficiency.

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Q The next question is asked by John Schroeder (phonetic) of Invesco (phonetic) and Bill Slattery (phonetic) of Ameringo (phonetic) Investment Advisors. The question relates to the financing of new medical technologies. The question is, what do you anticipate will be the capital market's willingness to finance new technologies in a price cap rate of return environment, and also, what do you think is going to be the ability of health care companies to fund research on breakthrough products in a reformed health care system?

MRS. CLINTON: Well, I don't know the answer to that any more than anybody at this moment does. I know that all during 1993 there was a great concern in the biotech community and in the medical technology community that venture capital was drying up and at least by year end the reports that I saw venture capital investments had gone up 23 percent. So I don't know that any of us can give you -- any one of us -- a prediction about that.

I think that, though, it seems to me that the outlook is good. I mean, the reimbursement levels are -- we're still going to be spending, even after reform, 17 percent of GDP for a number of years. It's not like you're going to start cutting into what we spend on health care. We're actually going to be investing more money in health care.

If you bring the 40 million uninsured into health care and require them to pay, which is what we would like to do, along with their employers, you're going to have a huge increase in the money coming into the premium system. You're also going to have large increases if you get a prescription drug benefit and a long-term benefit, going into those two sectors. So I just -- you know, I don't understand this. People act as though there's going to be some dramatic cut, that we're going to start heading from 15 percent to 10 percent in the next five years when, in fact, our projections are that we're going to continue to grow, some would argue even too much, but nevertheless that we'll be at 17 or 17 and a half percent and then hopefully leveling off.

So there's certainly more than enough money to go around, to be well invested, and we would also hope that as we get efficiencies in delivery, that money in health care would continue to be invested in research and in other kinds of technological breakthroughs, and that's something else that we provide for in the Administration's bill, where we actually put more money into those two areas.

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Q An editorial in today's Wall Street Journal mentions that both conservative Newt Gingrich and liberal John Dingell are suggesting that major health care reform is so important that it should first be taken to the voters in the form of a national referendum. What is your opinion of this? This was asked by Scott McDowell (phonetic).

MRS. CLINTON: I don't read the editorial page of the Wall Street Journal. And I rarely believe anything I read on that page of the Wall Street Journal. So I (inaudible) that there are those who say we shouldn't do health care reform or we can't do health care reform, that we ought to go have an election about it. I think there was an election about it. It was the 1992 Presidential election.

But if there are those who think we need another election about it, I think they are wrong. I think that despite what is obviously some bewilderment or confusion on the part of people about the details of health care reform, there is still great expectation that health care reform will happen, and I think it would be a great disservice on the part of the Congress not to deliver health care reform.

I also believe it would be very difficult for opponents of health care reform to go to the November elections, because I don't think that this, at bottom, is a very complicated debate. I think that most Americans would understand very clearly if the health care reform message were posed in the following way: Why is it that members of Congress, who have guaranteed health insurance paid for by your tax dollars through an employer mandate delivered by the federal government don't want you to have guaranteed health care insurance?

I think that's very understandable in political terms. So I don't think there will have to be another election, but if there is, I don't have any doubt about the way it will turn out. That's what people want to have happen.

Q This next question, I think, is a good follow-on. It comes from Scott Engstrom (phonetic) of Franklin Templeton Funds. He asks, it seems clear that everyone on Capitol Hill is in favor of "health care reform" and that if the Administration wanted to compromise, some legislation could be passed very quickly. Is the danger of that approach from your perspective that you may be giving up a mandate at a specific period in history in which you may be able to effectuate radical change? Is it now or never for massive health care reform?

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MRS. CLINTON: No, because what I think would happen if there is not health care reform this year, and if, for whatever reason, the Congress doesn't pass health care reform, I believe, and I may be totally off base about this, but I believe that by the year 2000 we will have a single payer system. I don't think it's -- I don't even think it's a close call politically.

I think the momentum for a single payer system will sweep the country. And regardless of the referendum outcome in California, it will be such a huge popular issue in the sense of populist issue that even if it's not successful the first time, it will eventually be. So for those who think that building on the existing public-private system with an employer mandate is radical, I think they are extremely short-sighted, but that is their choice.

There are many ways to compromise health care reform, and I don't think that the President could have been clearer in every public statement he has made that he has one bottom line. It is universal coverage by a date certain. And he has basically told the Congress, you know, you've got different ways of getting there. Come to us, and let's look at it. There are only three ways to get to universal coverage. You know, a lot of people stand up and applaud universal coverage, and they sit down, and you say, "Well, how are you going to get there?", and they don't want to confront that there are only three ways.

You either have a general tax -- the single payer approach that replaces existing private investment -- or you have an employer mandate, or you have an individual mandate. And there isn't any other way to get to universal coverage. The market cannot deliver universal coverage in the foreseeable future, and any compromise that people try to suggest that would permit the market to have a few years to try to deliver universal coverage without a mandate that would take effect to actually finish the job will guarantee a single payer health care system.

So we are more than willing to compromise. We have said that over and over again. But there are those who, for their own political reasons, think no health care reform is having to vote for any kind of mandate, no matter what the combination of individual or employee or employer obligation is, and we just think you've got to have, at the end of the day, universal coverage, and so that's where we stand, but the route to get there and the combination of details that can go into legislation are very wide open, and we're waiting to see

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what people come back with.

It's very difficult to negotiate with people who stand up and say things like "soft triggers" and you say, "Fine. Bring us the legislative language." And then they take a walk on you because they can't figure out how to put it into legislative language. So those are some of the issues that we're confronting as we try to come up with what would be an effective compromise so long as universal coverage is the bottom line.

Q The next question comes from Joe Higgins (phonetic) of Swiss Re (phonetic) Advisors, who asks, what is the likelihood that the tax deductibility of health care insurance premiums will be limited to corporations?

MRS. CLINTON: Well, what we proposed is that there be limits when health care reform was phased in. We thought in our original legislation that that would be in about 10 years, and we think that that would be appropriate, to cap contributions above the standard benefit package, whatever that is, at that time. But I don't think in the absence of comprehensive reform that gets to a standard benefits package you will find political support for capping benefits at this point.

Q The next question comes from Bea Cleather (phonetic), from John Hancock Advisors. What role will tort reform play in health care reform? How important is it to the process?

MRS. CLINTON: I think it is important to the process, and we have recommended several policy changes that we think would help reform, one that I mentioned, coming up with clinical guidelines that would, in effect, hold doctors harmless if they were to follow those guidelines. We also would like to see more use of alternative dispute resolution and arbitration. We would like to see some mechanism for screening cases before they got into court, whether it be a certificate of merit or some other kind of qualification hurdle that you would have to overcome. And we would like to limit attorneys' fees.

The one piece that many people talk about which we did not include in our legislation was to cap noneconomic damages, and we didn't for two reasons, one, because this really is the province of the states, and unless you want to federalize the entire tort system, which is very difficult to get through the Congress, then that should be left to the

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states, and many states are acting on their own. There are all kinds of limits, whether it's the 250,000 limit in California or any other.

And the second reason was because we viewed tort reform as an important part but not as big a factor as many people have argued. We literally read every study done by doctors and lawyers, anybody else on the outside, and, you know, maybe on the outer limit it might possibly have some impact on around 2 percent of the cost, and it is just a -- it's a red herring to think you're going to eliminate the inefficiencies in our system by capping non-economic damages. So we do believe it's important, and we've laid out what we think would work.

Q This is the last question. This comes from Tom Gallagher (phonetic) to my right. Senator Moynihan has proposed substituting premium targets for the premium cap. Have you had a chance to study this, and do you have an opinion on it?

MRS. CLINTON: Again, I haven't seen any legislative language on it so I don't know exactly what targets mean as opposed to caps or how targets would be enforced, but, again, we don't rule anything out. I mean if you have targets that actually are targets, and not constantly moving targets, that seems like a, you know, workable alternative if it can be structured correctly. But that's one of the things that the Finance Committee is working on right now, trying to actually put into legislative language these various ideas that have been discussed in their meetings thus far.

But one of the biggest -- two of the problems we have, one, which I referred to several times already, which is that it's difficult to react to proposals that are not put in the legislative language and you cannot then cost them out. And that is something that we're going to have to continue to work with members of Congress on, and we have a particular difficulty because everything has to be costed by the Congressional Budget Office, which is terribly overworked. So, trying to get something in legislative language and get it costed takes more time than one would want.

And the second big problem is the perpetuation of a lot of the myths that people seem to take as gospel about health care reform, which I'm sure you run into, and one of the people who is here asked me to respond to this idea that doctors and patients would be thrown into jail if they -- if the doctor provided a service to a patient that wasn't

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in the benefits package, something like that. Apparently somebody's running for lieutenant governor in New York who is basing her campaign on that claim.

And so I said I would respond to it before I left. The reality is -- the myth is that individual -- individuals can't pay their doctors directly and that they will be sent to Sing Sing if they do. And the reality, if anybody's actually read the bill, is that individuals can spend their own money for any medical service. There is nothing that prohibits that. And there is no limit on additional service -- I mean, additional insurance. Individuals can spend as much as they want on any additional services that are in any additional insurance package that they wish to buy outside the benefits package.

Now, what is forbidden is what is forbidden today, and that is lying to your insurance company about what it is that was done for you so that if, under the benefits package, cosmetic surgery is not covered, and someone has cosmetic surgery but colludes with his doctor for the doctor to say that it was medically necessary and appropriate surgery under the benefits package, that is fraud. And, just like it is today, that could subject the doctor or the patient to criminal penalties. And, in fact, the penalties were raised in our legislation because there's a lot of evidence that there's a considerable amount of fraud in the existing system.

But that is just one of the many myths that kind of gets a life of its own which further confuses the picture, which makes your job more difficult trying to sort through information to make good investment decisions. But I believe that as we move through the next couple of months, people's attention will really become riveted on this, and because of that the level of knowledge and information will go up dramatically. And I appreciate the opportunity to be here with you to talk with you about some of that information and to share with you, and thank you for inviting me.

(End of questions.)

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