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Economic Club of Washington

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REMARKS BY THE FIRST LADY
AT ECONOMIC CLUB OF WASHINGTON

MRS. CLINTON: Thank you very much for those kind words, although I do seek both inspiration and solace from Mrs. Roosevelt and her times here in Washington on a regular basis. And a friend of mine sent me yet another one of her sayings, which I have added to the stack that I already had, and that's given me a lot of support, and that was, "A woman is like a tea bag. Put her in hot water, she just gets stronger."

I am pleased to be here at the Economic Club, and I would like to spend a few minutes talking about the economics of health care and then answer your questions. Because it is important, as we move into what will certainly be the most focused part of the more than year-long debate over health care, that we remember all of the many dimensions of this health care debate.

I have been privileged to travel around the country, listening to the stories that people share with me, hearing about their incredible pride in the American health care system and all that it is able to do. But more often than not, listening to their frustration and their heartbreak over how not the system of delivering care, but the way in which we finance that care has failed them.

And so as we move into the next few weeks, where we will be facing very startling choices that will be presented to us as a people, I think we should return first to principles, if you will, and remember why this became a passion for this president. And it was certainly fueled to some extent by issues of humanity, social justice, morality, ethics, all of the principles that should, as members of the common human endeavor, and certainly as citizens of our country, move us.

But it was primarily because of the economic impact

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that the health care financing system in this country has had, and will continue to have, on individuals, on households, on businesses, and on the public sector from every level, the local through the federal government.

As my husband looked at this issue when he was serving as a governor, and in many ways having it on both the receiving end from the mandates coming out of Washington, from the out of control costs in both the Medicaid and Medicare systems, and on the delivery end, as a state government attempting to try to deal with the problems of both the insured and the uninsured, he realized that dealing with health care as an economic issue was central to putting our entire national economic house in order.

And in the debates that we have been participating in for the last month, some of those central facts about the economics of health care have been, if not lost, certainly overshadowed by much of the rhetorical battles that have gone on on the sidelines.

Let's start with where we are at the federal level economically. We are, obviously, from our perspective, a year after the budget vote, pleased that the deficit will be cut in half and is shrinking. That's very important for the private sector as well as for the financial stability of the federal government.

We had seen an outflow of jobs, an outflow of capital, and we knew that if we did not begin to control the federal budget, that would not only continue, but continue to undermine the financial stability of the American economy.

Because of the moves toward deficit reduction, and because we have begun to see that interest rates have dropped, and hopefully stabilized, we know that more than three million new jobs have been created in the private sector. We saw in 1993 business starts at a faster rate than they have ever been on record. We saw business incorporation at the highest rate ever since Dun & Bradstreet started keeping records. We've eliminated more than 100 government programs. We've begun to shrink the federal workforce to the point that it begun re-inventing government initiatives. It will be back below what it was in the beginning of 1980 and on a downward trend, it will begin to level off into where it was in the 1960s.

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Discretionary spending has been held even. The toughest ever budget caps have been imposed. The defense spending cuts have been handled as responsibly as the downsizing could permit. And for the first time since Harry Truman was President, there will be three years consecutively of declining deficits.

Now, it's important to put that on the table, because those decisions that were made a year ago that passed that budget, the kind of leadership that this president and those members of Congress were willing to vote for that budget put on the line, has shown results. You can look at the figures and see that. That's the good news.

The bad news is that in the absence of systematic health care reform that will contain costs, you can continue to slice away at every government program imaginable. You can continue to try to put downward pressure on defense spending, maybe to the point where it's not a good idea. But if you do not deal with Medicaid and Medicare which are projected to increase at 10 percent a year, each for the next 10 years, the deficit will continue to go up after it has gone down for several years.

Now, many people in the Congress say, "Well, the answer to that is cut Medicaid and Medicare. That's easy." All this talk in Washington about cutting entitlements, you strip it away, it means cut Medicaid and cut Medicare. Those are the two big entitlement programs.

The problem with that, which is becoming increasingly clear to people who actually study this problem, is that health care costs paid for by the federal government are not in a vacuum. We do not have a public health care sector that is totally separate from the private health care sector. And what happens in the absence of comprehensive health care reform is that if you cut public programs, like Medicaid and Medicare, which means you cut the reimbursements available for private facilities like hospitals and private providers, several things happen, all of which have consequences for the private sector.

Among those things which happen are the following: As you cut those public sector reimbursements, more providers refuse to take public sector reimbursement, which means they

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refuse to take patients that are Medicaid and increasingly Medicare patients, or they refuse at least to take what is offered as the public sector reimbursement.

Now, what that means is that you throw more people into the pool of either the uninsured, even though they carry public sector reimbursement with them, or into the dramatically under-insured.

The other feature that always will occur in this kind of cost shifting is that as you lower the reimbursement that comes to private providers, they have to, as they historically have done, look to their only other two sources of reimbursement: private payers and tax dollars.

Now, if you look at any state in this country or the District of Columbia, you can see very clearly the premium that is being paid by those of us who are privately insured, both because of the uninsured who eventually get treatment and because of the lower than cost reimbursement levels that come from the public sector.

I recently spoke to a group of business people from North Carolina, so I have the data in front of me. And I explained that Medicare in North Carolina pays only about 90 percent, on average, as a cost reimbursement. Business, therefore, in North Carolina pays a 30 or 40 percent surcharge to try to reach some cost level that keeps costs stable and provides a return, particularly for the private sector.

When I next spoke to a group of business leaders from Oklahoma -- the head of their health department was there -- the reimbursement for Oklahoma is 70 percent. So small- and medium-size businesses particularly in Oklahoma pay a 40 to 50 percent surcharge.

As you lower the public rates of reimbursement, the cost shift then goes onto the back primarily of businesses that ensure.

Now, many big businesses have tried to work out strategies in the last two to three years to avoid paying their cost shift. So what they have done is strike deals with HMOs and big providers, cut back on benefits, raise deductibles, raise co-pays, feeling that they are somehow

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insulated. That is a very short-term insulation. Because as they try to contain their costs by making these deals with large providers, then the costs get doubly shifted on the backs of small- and medium-size businesses.

What then do those businesses do? Well, what they do is what businesses are increasingly doing. They drop people from insurance, and they raise the cost of the insurance to those they continue to insure, which is why we've had an increase in the uninsured in the last three years from about thirty-seven-and-a-half million to about forty million. So the percentage of the working who are not insured has gone up two-and-a-half percent in the last three years.

Now, what does that mean? Well, that means the more people you have who are uninsured, the more people fall into eligibility for Medicaid, and increasingly with aging, the more become eligible for Medicare. The downward cost pressures then continue to be bumped up against by the increasing population in need, thereby putting more political pressure on people in Congress and in state government to try to cope with the unmet medical needs in the face of increasing deficits which are projected -- and you cannot control those costs -- you have a real political dilemma. Because if you continue to let Medicaid and Medicare grow, you balloon the deficit. If you try to restrain costs only in the public programs, you cost-shift.

Now, that is the dilemma and the kind of vicious cycle that brought this president, when he came to Washington, to the realization that if he did not try to tackle health care reform, he could not ever see the end to the deficit. He could not ever get the kind of financial stability that he thinks is necessary to grow private savings, to increase investments.

And so all of these arguments that one has about whether or not to have universal coverage, how it's going to be paid for, have real economic consequences because, in the absence of universal coverage you cannot end cost shifting, you cannot begin to take the pressure off the entitlements so that you can bring them down without causing the unintended consequences of actually accelerating cost shifting and increasing the number of the uninsured and the dramatically under-insured.

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Now, one of the great challenges we face as we go through this health care debate is to try to get the business community to recognize what is in its long-term -- and, by long-term, I'm talking five to ten years but, in America, that's long-term -- its long-term economic interest because certainly no one that I know of wants to pay any more money for anything. No one wants to be mandated to do anything. That's always been part of the American character but it's in a particularly dramatic form these days.

But, the absence of getting everyone into the system, the eventual cost-shifting and financial impact will not be very subtle. We will see more hospitals close. We will see more and more doctors refuse to take Medicare and Medicaid patients or at least refuse to take the payments available.

I had a personal experience the other day. My second-grade teacher, with her husband, came to see me, and she told me that, when she retired from teaching just a year or so ago, she had her teachers' insurance with her. As soon as she became eligible for Medicare, her doctor's office called her and said they no longer wanted her as a patient because they did not intend to take Medicare patients if they could avoid them.

In addition, we will continue to see the consolidation and commercialization of health care with larger and larger providers using techniques of competition that will eliminate many doctors from being able to be part of the networks that are available. And, in fact, all of the scare tactics used by the opponents of health care to try to convince people that it was health reform that was going to eliminate or decrease their choice is, in fact, a smoke screen for hiding what is happening in the marketplace right now, which is the deprivation of choice on a daily basis as employers desperate to control costs, cut deals with providers that eliminate certain doctors and hospitals from available coverage.

In addition, we had an event yesterday with 75 of the largest medical schools and teaching hospitals in the country all supporting universal coverage because, in a very sad way, they are more at risk than any other part of our system because the academic health center, with its triple mission of research, education, and training as well as

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patient care, are expensive places to run right and many academic health centers are being cut out of insurance coverage in an effort to control costs.

Not a week goes by that I am not called by a children's hospital or an academic health center to be told that a very large insurer in their area has decided that the people who are covered can no longer use those facilities. Every bad trend in the American health care system that bothers physicians or nurses and hospital administrators, that concerns business leaders, that really burdens the future for all of us, will only worsen in the absence of responsible health care reform.

If you look at what the basic principles of sensible reform are, it is not very complicated, although it certainly can be made to seem so. Guaranteed coverage -- and, in our plan and our approach, that would be private coverage -- with a benefits package where you can compare apples to apples, where you eliminate the expensive underwriting and administrative costs.

I have yet to have any businessperson explain to me why he or she continues to pay the 17 to 25 percent administrative load that comes with private insurance. There is no other product or service that your business buys that carries that kind of administrative cost.

The administrative cost, on average, of private insurance, is 17 percent and one of the comparisons you can make that people never like to admit is that the administrative cost of Medicare, a government program, is 2 percent. Why? Because you have a huge pool of people and you have no underwriting or administrative expenses attached to the delivery of the health care in determining who is eligible.

In every audience that I speak in front of, it is inevitable that someone will stand up and say to me, why does the President want government-run health care? That is not what the President has proposed. What he has proposed is building on the public-private system.

But I have now, for the last six months, turned the question around, as I would to this audience, and this audience would probably know the answer. But how many of you

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know how we pay for Medicare? How many of you know how we pay for Medicare? Raise your hands if you know how we pay for Medicare?

Well, that is not surprising, because that is about the number that I get in any audience I address -- whether it's 4,000 physicians, the League of Women Voters, any group -- which says something about how difficult it is to explain what we're trying to do when most Americans don't even know how we paid for Medicare.

But Medicare is a single-payer, government-financed, socialized medicine system, to put it in its most dramatic description, paid for by a payroll tax where the employer and the employee both pay for the health care.

There is no Medicare recipient I'm aware of who has the government tell him or her what doctor to go to. There's no Medicare recipient I'm aware of who is told to come back tomorrow because the government hospital is not open. But it is paid for by a tax.

What we are proposing is to have the employer-employee contribution pay for it but to do that we are asking everybody who works to make a contribution, unlike today, where those of you who provide insurance are basically subsidizing not only your competitors who do not but everybody else in this economy who is getting a free ride on the health care system that you pay for.

I do not understand why every businessperson who currently provides insurance is not up in arms at the costs they bear, which are a hidden tax, because so many other businesses and their employees show up, get health care, and then you pick up the tab. A hospital charges you \$25 for a Tylenol because they cannot make up the difference for their costs from Medicare and Medicaid on the one hand and the uninsured who get cared for on the other.

So when you really look at this issue, there are many aspects to it, and I personally think that the moral and ethical and social and political are very important but, at bottom, it is a question of economics.

Are we going to continue to pay more money per capita than any country, and not insure everybody? Are we

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going to continue to subsidize a financing system that is leading to more uninsured and higher costs? Are we content, after we've made tremendous strides in getting our deficit finally under control to see it shoot up again because we do not have the political will or the fiscal discipline to deal with health care costs?

I hope that the answers to all of those are no, that finally we are going to look at health care from a business perspective and recognize that right now American business is getting a very poor financial deal for what it spends, that every company paying for insurance is subsidizing every one that does not and basically seeding a competitive advantage, that the number of the uninsured working Americans are increasing and that in the absence of comprehensive health care reform, everyone's health care costs, from the individuals to the federal government's will continue to rise and that any short-term efforts that have tried to rein them in will not succeed in the absence of comprehensive reform.

So that is a sort of brief description of the economics at work here, with the hope that we can begin to focus on those issues and address them as the debate continues.

Thank you very much.