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REMARKS BY THE FIRST LADY
IN SPEECH AT BUSINESS ROUNDTABLE

MRS. CLINTON: Thank you very much. I'm going to start by thanking you for that introduction and thanking all of you for this invitation. I enjoyed very much our chance to visit about health care at Williamsburg, and the conversations that I had with several of you in those intervening months.

I also want to thank the Business Roundtable, corporately, for its involvement in the health care reform effort. Many of you have sent staff members, have been supportive, both through your individual capacities and your corporation, and also through the Roundtable.

Let me begin by briefly stating where we are and what our plan does. I want to spend a few minutes just describing that, and then to have time for questions. As Bob pointed out, we have (inaudible) and we have Ken Thorp (phonetic), who has consulted, actually, with some of the corporations represented on the Roundtable, that we will try to answer any of the questions that you might have for us.

If we look at the plan that the President will be presenting two weeks from today, it does the following, from our perspective:

First, it restructures the health care marketplace for a system of managed care plans that compete on the basis of quality and cost to consumer, including lowering administrative costs, no longer on the basis of risk selections which eliminate people from coverage.

Secondly, it provides a standard set of benefits that emphasizes preventive care to be offered in all plans.

Third, it offers subsidies for low-wage and unemployed individuals so that all persons will be able to purchase the basic benefits.

Fourth, it provides incentives so that employees who choose more cost-effective plans will save, or employees who

choose less cost-effective plans and will have more out-of-pocket costs. Employer premium payments for the national benefit package will be fully deductible and the employee payments will not be considered income for those benefits.

Fifth, the plan creates purchasing arrangements to assure that all businesses and individuals have choices on quality, cost-effective health plans.

Sixth, it allows sufficient latitude in design to not only allow but, we believe, encourage innovation in methods of health care delivery and the continuing search for new and better treatment.

Seventh, it contains a national strategy for carrying out the outcomes research plan to define and identify cost-effective treatment, and then to extend that information broadly across the entire system, so that the information becomes integrated into the plan itself in terms of (inaudible) for evaluating the effectiveness of the benefits package.

Eighth, it contains malpractice reform, which we think will be significant.

And ninth, it provides for the preemption of state (inaudible) or corporate alliances that will be able to operate outside the regional and state alliances that will be established.

Now, I went through these nine features because if they sound familiar to some of you, they should. They were the nine parts of the Business Roundtable goals for health care reform that were adopted in February of this year and they, along with the work of a number of other organizations, both in the public and private sectors, have served as the basis for the efforts that we have undertaken.

There are several other features that I know are important to the membership of this group, that I want to particularly emphasize before we go through questions and concerns.

As I look through the list of those who would be represented here today, I know that many of you currently pay the entire insurance bill for a family, while the employer of your employee's spouse often pays nothing at all. Under our plan, the costs of families will be spread over all firms, and we will no longer have the cost-shifting in the private

sector which has, in effect, subsidized many businesses at the cost of others -- those who have provided health insurance.

We will require that all workers contribute to their health insurance and that all employers contribute to their employees' health insurance. We are going to be subsidizing low-wage employers and low-wage individuals, but we expect everybody to be sharing part of the responsibility for their own employment system's cost.

We also know that a problem that some of you have, with rather significant impact on your work force and your bottom line, is the growing cost of retiree health care.

Those companies, in this room and throughout the country, who have large populations of workers between the pages of 55 and 65 who are not yet eligible for Medicare are basically bearing those costs, and it is not a productive part of your involvement in your employees' well-being; and others are not bearing any of the costs; and many are looking for ways out of the costs.

Under the plan the President will propose, the pre-55 retiree health premiums will be paid out of the federal custody pool. There will be some cost to the employers in order to get into that system, but the cost of it will be shifted off of employers onto the general population.

We also are looking to integrate a health care fee for Workers' Compensation and auto insurance into the health plan. We want to simplify the Workers' Comp. provision through the health alliances, which we think will provide a savings for business. We also want to look at ways of taking care of the non-health care parts of Workers' Comp. through systems other than the duplicative and much-too-costly system that exists today.

We also believe that, as we control the rate of growth in Medicaid and Medicare, we will also control the rate of growth in the private sector. Health care costs will be brought in line with inflation through greater competition in the private sector and, through the management of these health care costs, we anticipate savings that will be realized over time for better allocation of the resources that are currently in (inaudible).

One of the issues that a number of you have discussed with us is your continuing desire to run your own health care

plan and to be able to make those decisions outside whatever the general structure will be.

We will propose that companies with work forces above 5,000 and Taft-Hartley plans above 5,000 will be permitted to operate outside of the regional and state alliances, but you will have to offer the same basic benefit package. There may be a corporate assessment on those plans that will go to the academic health centers and to the health infrastructure that will be necessary to keep the whole system going, but we think that will be a very small cost.

In our conversations with a number of you, your desire to run your own plan is understood and appreciated, and (inaudible) making those opportunities to do so dependent on some specific questions about how that will work.

Clearly, this plan is the result of enormous amounts of effort on the part of literally thousands and thousands of people but, more particularly, the experience of millions more. What we have tried to do is to come up with an American solution to this problem. We have tried what we think are the best features of our system and enhance them.

There is a great deal of controversy over some of the features, like the employer-employee shared responsibility. But, from our point of view, we don't really have any better alternative than to build on the system we currently enjoy in this country.

One of the questions that I would ask you to ask yourselves in your own discussions, and to ask anyone who approaches you about the system that we are trying to move toward is, truly, what is any viable alternative -- viable both substantively and politically? There are not very many out there.

Clearly, the single-payer advocates will argue strongly that we should substitute for the existing private sector investment a completely publicly-financed system.

For a number of reasons, we do not choose to pursue that. We think that the good features of the single-payer system -- including universal coverage and administrative simplification and lower cost -- can be realized through the kind of approach we are taking.

Others will argue that we should go for an individual mandate, and not go into the business of requiring employers

to contribute.

There are a number of problems with that approach, not the least of which is that it will be very difficult, if that is the position pursued, to understand completely how one can control costs in that system, how one can get everybody into it, and how one prevents the shedding of jobs or the shedding of employees who are already covered. There are many uncertainties associated with that.

So we have chosen to take what has been the American system since World War II, and to build on it, trying to provide some control for the runaway costs that many of you have faced, trying to take off some of the burden from employers who have borne those costs for a number of years, trying to share the responsibility among all who will participate and benefit from the system.

We think that the plan that the President will be proposing makes a very good approach feasible, politically and substantively. And, obviously hope that we will be able to have the support of many of you in this room for this approach as we work (inaudible).

Q Thank you very much, Mrs. Clinton. I did sort of hear a resonance as you went through those principles of malpractice reform, outcomes research. I think an issue of particular importance to this group, as far as the financial issue, is the full deductibility of employer contributions.

I'm sure that there are concerns in this group, particularly in the areas of where the money may come from and the issue that you've mentioned of jobs. But another one is the political issue that you've commented on.

It is our sense that the public is ready for health care reform. But the problem comes when we get to specifics. There is not a consensus in the Congress. There is not a consensus in the country at large on what we should do, and this is (inaudible) before we have major change, we have to have that.

What do you see changing the situation (inaudible)?

MRS. CLINTON: Well, I see a number of factors. We have been engaged in consultations with people for many months. We are remarkably close to consensus, on the large pieces of this system, with an array of groups -- groups representing senior citizens, consumer groups, hospital associations, AMA,

nursing associations, business groups, and the like.

That converging consensus is not uniform on every technical detail. There are pieces of the plan that (inaudible) from one degree to the other. But, on the major pieces of it, I do see a consensus evolving.

Now, I think that you are absolutely right, that we have a rather significant education job still ahead of us, because, for many people out in the country, many of your employees, they do not understand the relationship between uncompensated care, for example, and their own insurance costs.

They don't understand the relationship between the kinds of expenditures you have been putting out for the health insurance that they enjoy and their own responsibility to be more cost-conscious, informed consumers. So there is an education effort, and it will be undertaken.

But I also think that the more people look at what we are proposing and honestly consider the alternative, the stronger that consensus will grow over the next weeks and months.

Let me just comment on two of the points that you mentioned -- one, money, and the other, jobs.

Part of what the President directed us to do was to try to come up with a system that did not require a lot of new money (inaudible) the system because from his perspective there was a lot of money, that should be more efficiently used, already in the system.

Working toward that end, we have agreed upon the premium approach. We have agreed upon employer-employee contributions to be required so that everybody is in the system and people are no longer free riders on the system. We have agreed on reducing the rate of growth of Medicaid and Medicare. Those numbers, on their own -- you may have seen those numbers today -- we are looking in the area of \$225 billion or \$240 billion over the next seven years.

Those numbers on their own cause some people concern because, if all we did was to cap the rate of growth of Medicaid and Medicare, it would have two potentially unfortunate consequences, at least.

One would be that the cost would be further shifted onto

you, so you would be picking up the cost. That is one of the reasons why an organization like the Business Roundtable and the other business groups have to be extremely cautious about any proposal to further cap the rate of growth in Medicaid and Medicare, absent health care reform and absent some kind of budget on the (inaudible).

There will be a number of such proposals floating about the Congress in the next month. But I think it's going to be imperative for business to point out the real impact that would have.

The second obvious problem is that, if we were merely to cap the rate of growth in that, the observe of cost-shifting to you is (inaudible) services and greater problems for rural hospitals, underserved hospitals, and other people who would find their services diminishing because they were not able any longer to be competitive.

So the money will come from a variety of sources, not the least of which is capping the rate of growth in the public sector, and taking some expenditures which we currently use to plug holes in both the public and the private sector, because of matters like uncompensated care, and being able to utilize those for subsidizing low-wage workers. We will also see an infusion of \$50 billion to \$60 billion from employers and employees who will now be required to participate in the system. We think the numbers are there.

As I said to you in Williamsburg, my first request when I got this great honor was to make sure we had good numbers, because we can argue about the policies and have a very honest disagreement; but we had to have solid numbers. We put together the numbers with an outside group of accountants and actuaries, to make sure that we were crunching numbers that were reliable.

A second point, just briefly, on jobs. There will be more studies about job losses than we can possibly (inaudible) keep track of in the next several weeks. They will be generated both from good faith and bad faith. There will be people legitimately concerned and there will be people who are looking to maintain their own positions, for a variety of reasons.

I think it is going to be very difficult to come up with any set figure about job losses, in the short run. When you're putting at least \$50 billion new dollars into the

health care system, there will be job gains. When you are creating administratively simpler systems which require fewer people, there will be job losses.

It is going to be very difficult to come to any kind of a net-net figure. But I think, from worker (inaudible), if we are capping -- this is what is in the alliance -- if we are capping the amount of payroll that can be translated into a premium cost at below 8 percent, we are going to be freeing up a lot of dollars from businesses that are currently paying, in the current marketplace, more than that, sometimes significantly more.

That money will go somewhere. Some of that money will go into wages; some of it will go into new investment; some of it will go into contracts with vendors. It will go into the economy in some form or another.

So I would be extremely cautious about a lot of the job studies that will be out there. I honestly believe that, in the long run, getting control of these health care costs will be an engine for economic growth and new investment, which will translate into new jobs. We wouldn't be doing this if we didn't think we were taking a huge foot off the next of the American economy by doing this.

The outlook in the mid and certainly long term for jobs, we think, will be extremely positive. In the short term, we don't think there will be any net job loss, but we're going to have all kinds of arguments with all kinds of people coming from different angles on that.

Q Okay, folks. You've been after us in the past (inaudible). Now's your chance to find out. Bruce?

Q I'm Bruce Atwater (phonetic) from General Mills, and I've got a question as to how we're going to handle part-time workers.

Just a little background. As you know, part-time workers amount to something like 19 percent of the work force, and most of them really want to work part time (inaudible). As a result, they work probably 20 hours a week (inaudible).

Most of them are covered already by insurance. Seventy-five percent of those (inaudible) coverage (inaudible) insurance. As a result, only 20 percent of them take their employers' insurance (inaudible).

So the question is obviously (inaudible). So the question is, is there some level -- 25 hours or 30 hours or something (inaudible) -- below which you would cancel mandatory coverage of part-time workers (inaudible)?

Q We have a limit of 20 hours. Is that something you've looked at, yet?

MRS. CLINTON: We've gone back and forth on this, running the numbers. But we do have a cutoff for the contributions (inaudible) some other payment (inaudible) proportion for part-time workers.

Q (Inaudible).

AIDE: Just for -- I think it's an intermediate solution. And, as the First Lady mentioned, some of these decisions we're still working on. But for this one, I think (inaudible) reports, I think (inaudible) part-time workers.

One of the things that we try to do with the regional alliances is to make life as easy as possible both for employers and employees, for people who change jobs a lot. In so doing, what this proposal is at this sitting, part-time workers would receive coverage through the regional alliance, and employers would make a pro-rated contribution, based on hours worked.

So we have defined, tentatively, full-time work as 30 hours per week. So if a part-time worker works 10 hours per week, you pay a third of the required premium.

But it would be the premium based on the alliance premium, which is going to be (inaudible) increases half at the rate (inaudible). So it is (inaudible) quite low and growing at the rate that is going to be outlined in the budget, and it would be a pro-rated contribution.

Q I think it would be useful to consider an absolute cutoff at some point, whether it is 25 or 30 (inaudible).

Q When you say "absolute cutoff" --

Q In other words, if you would exempt mandatory coverage of people who work less than a certain amount of time. Without that, I think there is a real (inaudible).

Q (Inaudible).

Q It is a remarkably shy group (inaudible)? Yes, Jack.

Q My name is Jack (inaudible). I'm with American Health Products. And I actually have a couple of questions that are not related.

The first relates to your point on malpractice. If your malpractice reform is for health care professionals and hospital institutions but not corresponding reform to (inaudible) products, there is some concern that lawsuits which are brought relating to any kind of an injury would just be shifted over to the companies who make any type of product (inaudible) medical procedures or (inaudible) product.

I haven't seen any discussion or any reference to the reform of the tort law as it relates to medical care generally. It tends to be limited to malpractice. And I think there is a real concern on the part of those companies who have (inaudible) the nation's health care products that they will just end up being the deep pockets (inaudible) on the losing end of the (inaudible) litigation.

My other question is unrelated, but I'll (inaudible). It relates to the treatment of the taxation of benefits given to employees where it exceeds the core plan.

I've seen several items in the newspaper and other places which talks about taxation of benefits, for union workers where they are covered by a union plan (inaudible) the life of the contract and non-union workers maybe would be and maybe wouldn't be (inaudible).

The concerns have been that you might have workers in a plant who are covered by the same plan and working side by side and, two or three years out, at some point, the union worker is not taxed and the non-union worker would be for a portion of that. I haven't seen (inaudible).

MRS. CLINTON: We see a lot of things printed out there that are really all over the map (inaudible).

What we want to do is to avoid taxing the benefit package for the next several years, until it is fully implemented in the year 2002, I guess (inaudible), so that there won't be taxation for any workers who are currently enjoying the benefits of a plan that is somewhat better than the plan that is going to be nationally available.

So we will move towards having those tax benefits, once the full benefit package is implemented, and that will take about eight to ten years. At that point, we will be capping the deductibility, but there will be very few plans -- and we've tried to look at every plan that we could find -- that will have any kind of benefits significantly at all above where there would be a tax on it.

So it's not a union/non-union distinction. It's a health benefits plan distinction. We want to try to keep in place the people who already have those plans.

Q (Inaudible).

MRS. CLINTON: Oh, you know, talking about malpractice reform, I have found it like talking about taking a (inaudible) from nearly any perspective. I have never seen an issue that has more heat and less light. It's incredibly emotional, as you might guess.

And getting into tort reforms of products liability is not going to be part of what we're recommending (inaudible). We are going to take on the malpractice issues for professionals. And I know that there is a lot of interest on tort reforms for products across the business sector. But we're not going to take that on in health reform. I just couldn't add that to the list at this point in time.

Q (Inaudible).

Q You mentioned in your remarks how the present consumer doesn't probably work the system particularly well, at least (inaudible). I think the people in this room know that our American consumer, the American market is very effective when we get consumers motivated.

My question is, I couldn't understand in your remarks how you're getting the individual consumer, in terms of shopping for alternative services, for making decisions about the kind of (inaudible). How is your plan motivating the individual consumer to do more?

MRS. CLINTON: Because most consumers will be buying their insurance out of these large alliances. As some or all of many of you may (inaudible), they will be having a choice to make every year on an annual basis. They will be choosing among the (inaudible) health plan --

(End Side 1.)

(Begin Side 2, in progress.)

-- and they will have be, in a sense, selling themselves to different people by pointing out what their features are and what their (inaudible) are, both in terms of cost and in terms of quality.

So, for the first time, you will have consumers in the majority -- and there obviously have been exceptions to this -- but, in the majority, having to make those decisions and being able to vote with the feet every year if, for whatever reason, they are dissatisfied with the product they bought.

Q Let me pose one that I've heard. Maybe one of you is prepared to do it. But it's a very common one in the (inaudible). And that is that we have these employers, some of whom you mentioned, with very large health care products, perhaps double the 8 percent (inaudible).

And, if they are going to go into these plans at 8 percent or less, doesn't that represent some kind of huge cost shifting? Where is the money really going to come from?

MRS. CLINTON: Well, for one thing, many of the employers with the largest payroll costs have a significant percentage going to retiree costs. So there is a group of industries for whom that will be a cost that they will no longer have to bear full time.

For many others who are above payroll, above the 7.9 percent cap that we are looking at now, by coming into the alliance, they will have the benefit of basically spreading their costs over a much bigger group, I mean, no matter how big your corporation is now.

We will have the additional money coming in to bear the costs that you are now paying because of uncompensated are and under-insured people.

So, in looking at all of these numbers and (inaudible) expand on this, when you take the numbers that are out there, your businesses have been largely paying for the health care system en masse, not just for your employees. And we can lower your costs, yes.

We can lower your costs by bringing everybody into the system, bringing in that extra \$50 billion that is out there, from people who are basically being paid for by you, beginning to shift some of the costs that go toward making up

the uncompensated care into subsidizing payment streams, and bringing about some of the savings.

Now, we have a peculiar problem in Washington that you don't have, as I've come to appreciate, in that we have a budgeting system that will not recognize private sector savings.

If any of you had to budget off of what the congressional budgeting system is, I think you would be quite pleased what whatever your alternative is now, because you cannot talk about savings and have them "scored," in the parlance of Washington, in a way that we think common sense shows we will realize.

So we do think there will be considerable savings that will, in addition, make the kind of decreases in existing costs that are feasible.

Q We've got several questions from (inaudible). I notice some hands over here on the left. Yes, Ed.

Q Ed (inaudible), State Farm Insurance. Here's a question on the benefits package.

In the drafting of legislation, when you're at that point, is there a workable way to throw fireballs at the package (inaudible) that any changes to that enhancement, whatever it might be termed, require some kind of identified revenue increase to be handled at the same time that change is proposed?

The concern we have had through the years, you see, once you get a benefit package and pricing taken care of, later on benefits expand and the pricing doesn't change, or the funding for it, and you run into the (inaudible) problems that we face today. And it's just more of an observation. Are there ways that politically we can do that?

MRS. CLINTON: Well, what we are trying to do is to create a national board, somewhat like the (inaudible) Commission, where all of those decisions will be bucked up to us, and the decision will be made, unless the Congress overrules the decision, where you shift the presumption so, instead of the Congress being constantly buffeted by political requests -- you know, (inaudible), I'm getting lots of letters from people who think we should cover infertility treatment.

You can see all this coming and, you know, everybody will have a very legitimate argument to make. Insofar as we can take that out of the political arena and put it into the national board, that's what we will do.

Now, in some of our discussions which we've been having with members of Congress, they had hoped to be putting the benefit package into that board. But there's no way you can have a national health reform where people would buy a reform of this magnitude unless they can actually touch and feel the benefits package. You wouldn't do it for your family and your employees won't do it.

So if we establish a benefits package and then put the reforms or enhancements or changes in a much more difficult political body, in terms of the influence, we think that is the right answer.

Q Mrs. Clinton, we very much appreciate your taking the time. It's obvious that you have demonstrated a great deal of (inaudible), that you've given this a great deal of (inaudible), a great deal of thought. It's important to all of us. (Inaudible).

MRS. CLINTON: Well, than, you, (inaudible), and I'd like to say one last thing.

Q Sure. Absolutely. You get the last word.

MRS. CLINTON: Let me (inaudible). We believe that this proposal is good for business. We particularly think it is good for big business. And we really would like as much support as we can engender from this community.

But, more than that, we need your consultation and your advice. I know several of you have taken the opportunity since you've been in town to come over and to read the plan, and apparently you've got some (inaudible). With some others of you, we've gotten a meeting set up for your benefits people to come in and we've got a meeting set up for your Washington reps to come in.

Any information that you need to help you make a decision and any advice you have about changes that you think would be beneficial, we really want to hear. We are not just saying we want this to be a complicated process and just for rhetorical purposes. We really want your input.

If I could have a series of meetings with you to come in

and (inaudible) come forward with some very good suggestions, because this is an ongoing process. We are trying to make it bipartisan. We are trying to make it very broad-based.

But when it is all said and done, we hope that we will have a lot of support from the individuals and companies represented here, because if we do not move in the next year to deal with this, or if we only make marginal, tinkering changes, then I think the status quo will not remain in place; it will deteriorate. It will be a very much more difficult task to take on, and the political pressure will build for the single-payer government solution, because people will be fed up and frustrated.

The more layoffs, the more aggregations of contracts, the more employers pulling out, the more political pressure there will be. And we will not have taken the opportunity we currently have, to my view.

So we want you to be our partners and we want you to support this, and we need your advice and guidance about how best to deal with it (inaudible). Thank you.

Q Thank you.

(End of tape.)