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REMARKS OF THE FIRST LADY  
HEALTH CARE SPEECH AT COMMITTEE FOR ECONOMIC DEVELOPMENT  
NEW YORK CITY

MRS. CLINTON: I want to thank John for that introduction and also for the leadership he has given to CED and other efforts with which he has been involved now for a number of years.

I want to thank CED for this invitation and for its continuing commitment to bring together leaders from the business community, academia, philanthropy, in order to talk about major issues that confront our country.

In many respects, my work on behalf of education, which I was privileged to spend time with CED in the past, has led directly to this current challenge that I am involved in, that we all will be involved in in the next months, namely health care.

The reason I say that and the reason I believe they are linked is because those of us in this room who have been involved in education reform for a number of years -- and in my case, it's at least 10 years -- I think have been somewhat bewildered by our failure to make more progress than we have.

We have had single successes. We have seen schools turn around. We have watched people make greater efforts. We have amongst us leaders in these reforms, like Ernie Boyer (phonetic) and others. But I think we have to be honest and say we haven't yet achieved the kind of educational reform that we believe is necessary in order to face the challenges this country confronts.

And I have asked myself many times in the past, why is that? Why is it that so much of what we think should be done to raise standards, to help children become better

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focused, for children to appreciate the kind of difficulties they will confront as they leave school to find a job, make a living; for teachers to understand the urgency that those of you in the business world feel about the kind of demands that you will place on the labor force -- why is that these pressing questions haven't resulted in even more progress that we could point to?

I think the root to the answer to that question lies in what I view and what the President has been talking about recently as a sense of insecurity among the American public, that insecurity due in large measure to the changes that have occurred in our country at an accelerated rate in the last 20 years.

Although there were certainly antecedents to that before starting in around in 1973, the kinds of changes that occurred when we were dragged into the global economy, that have resulted in stagnant wages for most working Americans, that resulted in a loss of job security that had often been taken for granted by people without much education.

The level of insecurity that I find as a I travel around the country, both when I used to do it with respect to education and now as I do it with respect to health, strikes me as at the root of the kind of challenge we confront if we do not render our people more secure. If they do not feel good about themselves, their futures, their children's possibilities, it is very difficult to summon them to become productive, to work hard in school, to be committed to the kinds of programs that many of you have been promoting.

If you look at some of the issues that we face right now in our country, many of those are divided not on traditional political or ideological grounds but, I would argue, on the basis of a sense of security about the future and a sense of insecurity.

It is very difficult, for example, to talk about NAFTA with people who have watched jobs disappear, who have seen their friends and neighbors laid off when they thought they were going to be employed for life. So what one feels about the future in very large measure will influence not only their individual decisions but the political potential for solving problems that we confront here at home.

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So when I began to work on health care, it struck me that the kind of insecurity that permeates much of our society over health care is another example of how a problem that one can describe in economic terms has such broad implications for us as a nation.

Solving the problem of health security will be one of the ways we will be able to lay a groundwork for reasserting the potential of the American dream and being able to do so in a way that people will believe.

It is hard to tell a young person to study in school when they don't think there's a job. It is hard to tell a worker to be productive and to think about the future and compete with competition abroad when they don't know from day to day whether their child might have an accident, end up in a hospital, and they're unable to pay for it. Trying to deal with this security issue is at the route of what I think will give us a much more competitive, productive future.

To that end, the President's plan stresses, first and foremost, health security. It does so because until all people are secure, no one is. There is a great fallacy that this plan is primarily aimed at the uninsured. Well, it is certainly aimed at making sure that 37 million-plus are insured.

But in today's world and in today's insurance market, someone can be insured today but not tomorrow. 2.25 million Americans lose their insurance every month. Some may lose it only for a week, some for a month, some never get it back.

And what we believe is that establishing the fundamental principle that everyone is entitled to health care coverage that carries with it a comprehensive benefits package that includes primary and preventive health care is necessary not only for economic reasons to get everyone in the system, to stop the cost-shifting and many of the problems that you know about better than I do. But it's also fundamental to establish a baseline of that kind of security that I was talking about earlier.

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In addition to that principle, there are five others that are the hallmark of this plan:

Simplicity, by which we mean simplifying the system, eliminating a lot of the unnecessary paperwork that is not related to patient care.

Savings, being able to obtain savings from our system, which by any fair reading has an enormous amount of inefficiency, waste, and, yes, fraud, that needs to be rung out so that resources can be better allocated.

It needs to preserve choice. This is an issue about which there will be much discussion in the months to come, but it is hard to imagine how we could not do a better job on choice than we currently do.

What we have now is a system which denies choice to millions of Americans who are uninsured or under-insured, which denies choice, in effect, to millions more who, on a daily basis, are being put into plans chosen by their employers which limits their choices because of the economic imperatives of attempting to control costs in a system whose costs are out of control. So choice is being denied today all over this country as we speak.

In the new system that is being proposed, choice will be guaranteed. Individuals, not their employers, will choose their health plan. Doctors will not be discriminated against should they desire to be in more than one plan. And every community will have a fee-for-service network in which every doctor can belong, so there will always be that broadly based choice if the consumer should happen to desire it.

Quality is the next principle. And if we don't preserve and enhance quality, we will not have done our job. Quality has to be the primary goal of a new system. In order to achieve quality, we have to be sure that consumers have more information about quality outcomes so that the choices they will make will be better informed and that providers have more information about choices and practice styles that is more related to quality.

And responsibility has to be the hallmark of the new system. By responsibility, we mean every individual has

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to play a role in his or her health. That means that all individuals and all employers have to contribute to the health care system. It means that for the first time there will be no more free riders; there are too many now.

Most of you in this room are employed by or run businesses which provide health insurance. You have indirectly subsidized your competitors who do not. You have whole industries that do not. The distortions in the labor market due to benefit costs in some sectors which are not borne by others has been rather significant.

You know that oftentimes those of you who insure, insure the entire family even though the spouse may work elsewhere. You may also know that some of your competitors or some other businesses in your community actually give bonuses to spouses, financial bonuses, if they forego the insurance in their companies and instead go on your benefit package. Those are the kinds of choices that we've been watching for years, with the net result that some of our businesses have gotten a free ride.

But in order for all to be in the system, it has to be affordable, so we have devised a system in which discounts will be given to small businesses, to businesses with low-wage workers. Individuals can be subsidized, because they, too, will be expected to contribute unless an employer voluntarily agrees to pay more than an 80 percent share.

With the discounts and the subsidies, it is very difficult to find businesses, based on the runs that we have done and the scenarios that we have devised, that cannot afford the kind of insurance costs that we are talking about.

Many businesses, particularly small ones, have been concerned because they think about the insurance market as they currently know it, and it scares them to death. They cannot imagine providing insurance based on the costs that are currently available, but that is not how the market will operate under a new plan. And the kinds of costs that most companies that currently insure will face will go down. And for others, who have never insured, they will be affordable costs that are a very low percentage of their overall benefit costs.

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Now, those are the kinds of principles and some of the specifics behind them that we have tried to put together because we made some fundamental decisions. We decided that we could not propose a broad-based tax in which more money would be put into a system that was currently over-funded by any realistic assessment. We spend more than any other country, and we do not spend it efficiently. We do not even get the same quality outcomes across the entire population that other countries that spend less per capita do.

We know, by looking around our country, that some localities and even States, namely Hawaii, have done a much better job at reaching near universal coverage at a much lower per capita cost than the rest of the country. It is very hard to argue, whether one looks at Hawaii or Rochester, New York, or Rochester, Minnesota, or the California pension system, you could go on and on and list examples throughout the country that we cannot do better, save money, and preserve quality.

So we could not recommend a broad-based tax. The only tax will be a tobacco tax. And there will be a requested corporate assessment on those corporations that choose to remain self-insured, because there will be costs for the whole system, such as supporting academic health centers, our medical schools, and our major cancer centers, that need to be borne by the entire system.

If one looks at the alternatives available, there are not very many to reach universal coverage, which is the underlying principle that has to be met. There is either the broad-based tax and a single-payer system. There's an individual mandate which has been proposed by some of the Senate on the Republican side. Or there is the approach the President is taking, to build on the employer-employee system.

For many reasons, we chose the latter; it works for most people. 90 percent of those who are insured are insured through their workplace. We want to keep this system as much like what those of us who have benefitted from it recognize and feel comfortable with. It causes the least disruption. It has the smallest bureaucracy attached to it.

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If you compare a single-payer system, which although it will cut administrative costs, will turn the control completely over to the government.

Or you compare an individual mandate, where individuals will have to be kept track of. The subsidy level will have to be adjusted depending upon their income from year to year. Most likely the IRS will have to be used in order to enforce such an individual mandated system. And many employers will drop employees who are currently insured, because there will be no requirement that they continue doing so even for competitive reasons.

So the employer-employee system strikes us as the least disruptive, the most familiar, and ultimately the least bureaucratic because of the combination of public-private features.

Now, this group has been long been concerned about economic issues. And I would just close by making a few comments about that. It is clear that economically we cannot afford to continue the system that we have currently have. It does not provide true security. The insecurity that permeates it comes at too high an economic or human cost.

If one looks at the economic consequences of the businesses that do insure and therefore bear most of the economic burden for the entire system, many of you have paid a big price, and your workers have paid an even bigger price in lost wage gains, because although the compensation has been tilted toward increasing health benefits, the kinds of issues that you have struggled with to deal with rising health care costs have distorted -- investment decisions, hiring decisions, all kinds of decisions that should be driven about what is best for your business.

And on the national level, the costs of health care is the primary driver behind the deficit. When it became clear, as the President was able finally, with the help of some of you in the room -- and I thank you for that -- to pass the largest deficit reduction package in our history, it became clear that even with the kinds of sacrifices asked for in that package, without changing the health care system, we would continue to see a rising deficit five years out,

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because we would not be able to control the costs of Medicaid and Medicare.

Where do those 2.25 million people go when they fall off the insurance rolls if they get sick? They go into our hospitals; they eventually get care if they need it. Some of them roll onto the Medicaid system. If you saw the recent census study, you know that we are now back up to a percentage of poverty equivalent to where we were in the early 1960s.

The costs of both the Medicaid system and Medicare, with an aging population, will continue to go literally unchecked in the absence of reform. Even after the budget bill, Medicare is projected to increase at 11 percent next year and Medicaid at 16 percent. The President's plan would decrease the rate of increase in those two programs.

If one were to do it in the context of deficit reduction only, as some in Washington have argued, for entitlement caps on those two programs, on their own, the price would be paid by those of you in this room who insure your employees or pay your own premiums. Because if you cap the rate of growth in the public system without reforming the private system, the costs would be shifted into the private system unto the backs of the payers, the private sector, that would continue to insure.

What the President believes is that you can lower the rate of increase in those programs from what is currently projected at three times the rate of inflation to two times the rate of inflation. We're not talking about cutting these programs; we're talking about lowering their rate of increase. But that in order for that to work there has to be some budgetary discipline in the private sector.

Now, one of the rhetorical criticisms of the President's plan is that he intends to have market forces and competitive forces working -- for the first time, I would argue -- in the health market. This is not a traditional market, as most of you who make a living in a real market know.

But if we were only to try to unleash competitive forces without attempting to have some kind of budgetary

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discipline, we would likely build in the current inefficiencies and inequities in the system, which is why the President wants to have some kind of budget targets by which expenditures can be held accountable as a backstop to the competitive market. And I'll just give you one quick example of why that is necessary.

There are places in our country that spend three or two times more than other places on delivering the same kind of health care. That is largely due to differences in practice styles of physicians, having to do with all kinds of things like what kinds of operations are considered important to be done on what kind of patient, how many days one should be hospitalized.

But if you were to take a map and you were to chart costs for both Medicare, Medicaid, and private insurance, you would see a huge disparity -- certainly from region to region, but sometimes even within regions. Without some kind of backstop, budgetary discipline, it will be very difficult for this system to create the incentives within a new market so that people will change these kinds of behaviors. They have nothing to do with quality.

A Medicare patient costs three times in Florida what it costs in Wisconsin. A Medicare patient in New Haven can be taken care of at one-half the cost as in Boston. And there is no difference in quality outcome. It has to do with the kinds of decisions that are made by practitioners, that are driven by reimbursement patterns and by practice styles.

So if one looks at what we are attempting to do, it is a hybrid. It is an attempt to bring discipline into the rate of growth in the public system and have the public system put its own houses in order. It is an attempt to create a real market, with real competition, in the private sector with a backstop budget, to do away with the kind of price controls that currently exist, where you're told how much you can charge for what kind of operation, and then your decision is second-guessed by some bureaucrat in the government or an insurance company. That's what is eating our budget up in health care. That needs to be eliminated.

I think the chances for reform are very good, because the country is ready. Enough people have struggled

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with this issue to know that it is real in their own lives. The economic costs are clearly seen, both in the individual and family and business side, as well as the governmental.

It would be foolish to say that it would be an easy fight to get to where we need to go. But I think there is an emerging consensus around the big issues and what I call the reasonable middle in the Congress, both the Republican and the Democratic side, and there will be a continuing demand on the part of the public that this issue be addressed.

And if we summon the political will to do so, then I am confident we will have made a right decision, not only for our economic well-being but to begin this process of knitting back together the American social fabric to get people to feel more secure so they can be held more responsible and where they can be moved into the future with more confidence.

And that, to me, is what economic development is all about. It is not done by people who are frightened and worried about the future. It is done by people who have an entrepreneurial heart, a sense of the dream, a willingness to fight for it, a desire to have the future better for their children than it is for themselves. That's what we have lost in many parts of our country in the last 20 years. This is one of the ways we will get it back.

Thank you very much.

(Applause)

Q (Inaudible.) My firm is particularly concerned with the climate of innovation in the industry, in the tremendous costs and risks involved in research and development of drugs, and the growing pressures industry is already facing from pharmaceutical purchasers.

How should we look at the future environment and making decisions about investing in firms (inaudible) treating (inaudible) major (inaudible)?

MRS. CLINTON: Well, I think you should be bullish about that --

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(Laughter)

-- for several reasons. We are proposing a prescription drug benefit that will be available to the under-65 as well as the Medicare-age patients, which will bring an extraordinary amount of money into the pharmaceuticals, because we intend to provide a prescription drug benefit as part of the benefits that will be given to the Medicare recipients through the reduction of the rated increase, so there will be new revenues available for pharmaceuticals.

Secondly, we intend to invest more in research. That is part of the plan. And that research will follow the kind of pattern that we're familiar with in this country, which is public-private partnership for research. There are a number of promising works being done now that we intend to try to assist with more research money, because in the past several years, those of you who have followed pharmaceutical research know that we have begun to cut back at the national level on how much we contribute. And many of the breakthroughs in pharmaceutical manufacturing over the last decades have come about in the first instance as a result of government-funded research, and so that will be increased.

Now, on the other hand, we do think there needs to be some changes in the way pharmaceuticals are sold in the country. We think that the kinds of discounts that are given to some purchasers but not available to other purchasers are not appropriate, and we want to try to level that playing field so that, for example, if retail pharmacies buy in bulk, they should be entitled to the same kind of price breaks that large HMOs or large discount houses are able to enjoy.

We think that if Medicare, through this prescription drug benefit, becomes the single largest purchaser of prescription drugs in the world, it ought to be able to get a discount on the prices it pays for those purchases.

And we think that when breakthrough drugs are put on the market, there should not be price controls, but there should be some review mechanism in which information about those breakthrough drugs is made publicly available to potential consumers.

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It is a balancing act between trying to be sure that we continue to encourage research and to support it, but trying in some way to provide some disincentives for the kind of decision-making that has served, in my view, as the basis for legitimate criticism of the pharmaceuticals.

So it's that kind of balance that we're trying to strike. We obviously do not want to chill legitimate research, but on the other hand we think we are entitled, as purchasers, to a little more information about decision-making by pharmaceuticals than has been available up until now. I think the balance that we're trying to strike is a fair one, and I'm sure it will be the subject of a great deal of discussion in the months to come.

MODERATOR: We have a question here on (inaudible).

Q Mrs. Clinton, my name is John Weston (phonetic), and I'm wearing three hats as I ask you this question. I'm the chairman of a Fortune 200 company who talks to many other large company chairpersons; I'm the research chairman of CED.

And in our particular company's case, on a daily basis, we touch about 20 million Americans electronically, we touch some 300,000 employers electronically, and we touch 2,000 delegates (inaudible).

With that as an antecedent comment, I think you very eloquently described a program that very comprehensively covers many issues. It seems to me, as to your comment, that there is one very important area that hasn't been touched by the press and therefore I concluded hasn't been touched by the task force (inaudible).

It goes like this. We're dealing with 250 million citizens, all of whom will be affected. We're dealing with well over a billion transactions, however simple the transactions are. And we're talking about moving over a trillion dollars per year. The only way one can do that is with adequate information systems, lest you get waste, fraud, and abuse.

Against that backdrop, there has been very little mention about how 50-plus attendees will create newly

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structured health alliances with the savvy to handle all of those transactions efficiently and minimize fraud.

I'm not lobbying for any one company, but I think that the --

(Laughter)

I think that the silence on how you create all of these information systems, particularly for governments to create who have so little experience, there's a big silence surrounded by many other (inaudible). I think (inaudible) comment.

MRS. CLINTON: Well, thank you. In fact, we've spent a lot of time talking about how to create the infrastructure that will be necessary to move toward single-form billing, electronic billing, the electronic transmission of information. We have looked at a lot of different models, particularly the banking system, which carries out billions of transactions.

In fact, we spent a lot of time looking at how we could, in effect, piggy-back on the kind of Federal Reserve transmission that currently exists for banking transactions.

It would be beneficial if you and others of the industry -- we have consulted some -- if we not consulted widely enough, we would more than happy to have you look at what it is we have on the drawing boards.

We also have in the plan some money set aside to help create that with the technical assistance of those of you who know a lot about it. But it is something we've spent a lot of time thinking about and laying out a kind of work plan around. And there are members of Congress who are very interested in that particular issue, because in many respects on it will rest the success of the entire system.

If we've got good information transmission, good payment systems, and we are able to accomplish that in a reasonable period of time, our chances of success are obviously much greater. So I welcome your review and involvement in that with us.

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MODERATOR: Yes, there's a question down here.

Q Mrs. Clinton --

MODERATOR: One moment, I'll get you a microphone.

Q Thank you.

Mrs. Clinton, I'm the president and chief executive of St. Vincent's two-hospital, 1,000-bed system in New York City. I think a case can be made that financing for urban and rural hospitals is an excellent (inaudible). I think you're trying to deal with that in health care reform. It's particularly acute in this city. I'd be interested in how you intend to provide sufficient and adequate financing to meet the needs of a complex, diverse urban population.

MRS. CLINTON: Yes, there are several features of what we're trying to do. One is that we recognize, even with universal coverage, we will not solve all of the access problems that exist now and to some extent will persist in a reform system.

There will therefore be the need to designate certain providers as essential community providers, particularly in underserved urban areas and underserved rural areas, and to provide additional federal funding in order to support them.

We don't think that when we had a fully insured population, with some few exceptions, the kind of money needed will be as great as it now and a disproportionate share. And the losses will be as great as many hospitals report every year, but we know there will continue to be a need for that kind of support.

You also point out some of the discrepancies that exist, and certainly it looks different from the different geographic perspectives around the country. But I think one could in a very general way say that large urban States and cities are concerned because they think that Medicaid is really set up in a way that discriminates against them, that they don't get the same kind of resources that might be available in rural areas. Rural areas believe that Medicare

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is set up in a way that discriminates against them, so they don't get the kind of resources that they're entitled to.

As part of this plan, we will be attempting to take both of those public programs and move them forward in a way that begins to equalize spending in those two programs so that we won't have the historical patterns that have grown up over the past 20 years largely due to varying political influences that have skewed programs against one another in the way that we have now in the current system.

So both on a targeted basis for hospitals like the ones you describe and on a general national basis with respect to the public programs, we're going to try eliminate some of the inequities that are currently in the funding. And we think that it will take time, but we need to start on this.

MODERATOR: There's a question right down here (inaudible).

Q I'm Ken Abramowitz (phonetic), the health care analyst for Sander Bernstein (phonetic) Company, a brokerage firm on Wall Street. And I, like you, believe in cost-containment and managed care, and I think your plan will do a wonderful job of moving perhaps 70 percent of the population into HMOs by the year 2000. I have no problem with that.

The question I have is: How do you explain that to consumer groups? How do you explain to consumer groups that if an employer pays 80 percent of an average plan, it'll probably be enough to join an HMO? But if someone wants to see their own doctor, they're probably going to have to pay \$1,000 to \$2,000. How do you explain that to people? Do they think it's fair? I don't have any problem with it, but how do you explain it to them.

MRS. CLINTON: Well, but there are features in our plan that don't lead to that kind of discrepancy. For one thing, we are putting a 20 percent range on how much plans can charge above what the lowest priced plan is. We're trying to get all the plans to be more efficient. That includes fee-for-service networks that are going to have to negotiate prices among providers and do some things that

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traditionally they have not done in order to go on a budgeted system or to bid the premiums with an alliance area.

Additionally, we are including point-of-service options in every plan, including closed-panel HMOs, and it will be up to the HMO whether that will be part of the premium cost at a slightly higher cost, such as Puget Sound currently does. A well-run, well-managed HMO has shown over the past years an ability to be competitive and to be creative in how it provides services competitively to the consumer. But we are going to put some extra requirements in order to push that creatively along, including the point-of-service option.

So I think with the kinds of protections that we are building in, we are not talking about the traditional kind of HMO, and we're not talking about the traditional price differential that would exist in the market today if all we were to do, as some plans have suggested, just try to push people into lowest-cost plan. Yet, there is a piece of legislation that was recently introduced that would do that, that would tax the benefits above the cost of the lowest-cost plan and try to push everybody into that. That is not what this plan is trying to do.

So whether we end up at 70 percent or not, I don't think anybody has a projection. I personally think that well-run PPOs, particularly not-for-profit PPOs, will have a much bigger slice of the market than they currently do if those who are interested in putting them together understand the opportunities that are out there.

And I also think that mission-driven providers, not-for-profits, Catholic hospitals, other religiously affiliated hospitals, if they, too, get good management and technical assistance will be very competitive. So I see a much more diverse market than your comments suggest.

MODERATOR: Let's have one more question.

Yes, sir. Right here.

Q Mrs. Clinton, I am Peter Sanos (phonetic). I work with Booz Allen & Hamilton. And we're health care consultants, and we're working in the State of Hawaii.

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Much of what you have said is very encouraging to people in Hawaii. And we're currently in the process of trying to implement, in anticipation of health care reform, much of what you're asking for. But we're confronting two problems. And those problems are in our effort to pull cost out of the system and to improve quality and service.

The first problem is one of regulatory requirements. We are trying to build patient-centered hospitals, for one. And number two, we're trying to consolidate the building of a delivery system. But we come up with regulatory requirements and certificate of need requirements and antitrust restrictions that will stop us from doing that. That's the first part of the problem.

And the second part of the problem is that in Hawaii there is currently no incentive for anyone to choose the low-cost plan, so the plans that we're building may well be high-cost plans.

What can the health care reform do to address those two issues?

MRS. CLINTON: Well, with regard to the first, we intend to continue making changes in the antitrust laws. You may have seen -- I'm sure you did -- the changes that were announced by the Department of Justice and the FTC about a month ago which tried to clarify existing law, particularly as it applied to hospitals and doctors, and to set up an expedited review procedure, because it is absolutely clear that the antitrust laws themselves are an obstacle to some of the kinds of integration we want to see. But the fear of the antitrust laws is even a greater obstacle.

You know, there's a lot of concern that is not all that founded, but it has a real chilling effect. So we are attempting to deal with that and also with respect to regulation. I mean, part of the reason we want to move away from the kind of micromanagement and regulation that currently drives the system, which is inevitable when you basically have a piecemeal reimbursement system, as currently exists in medicine.

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And I think those of you who are in different businesses should really think about what it would mean to your business if every single procedure you did during the day carried a separate price which you then billed, but you had to be careful how you billed, depending upon who the payer was, and you had to spend money in order to have those bills checked and double-checked, and on and on as it goes.

So part of what we're trying to do is to get a budgetary universe created in which a lot of decisions can be made in the absence of that kind of regulatory environment which has not worked very well, either for economic or delivery of care reasons.

And with respect to incentives for low-cost plan, you know, Hawaii has been remarkably successful, as you know, in reaching near universal coverage and also in providing that coverage at a cost per citizen far below what we pay in the rest of the country. I mean, if you were talking about a State GDP, theirs is about 9 percent, we're at 14 percent. So they have been much better at achieving coverage more cost-effectively. They are struggling, as are other systems, in figuring out where they go from here. And they at least have good leadership, who you're working with, trying to determine that.

There will be incentives in the system, because consumers will have the option of picking the plans, which now, in Hawaii, is still largely employer-driven. The individual will be able to make a cost-conscious decision and pocket the difference.

Those of you who have run large plans where you have moved in that direction in the last several years, as many businesses have, have seen the difference -- and also employers who have said they will only pay any longer for a low-cost plan and the consumer would have to pay the difference found that many of their employees go into those low-cost plans. So making the consumer cost-conscious, as we will, will be a big change.

And secondly, under this plan, eventually we will reach a point in which the plan is fully implemented, where we will take away the tax preferences that currently exist.

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And this -- the last thing I want to say in answer to this question, there will be a big debate, because some of the plans currently pending in the Congress largely finance the coverage they extend by taking away the tax preferences that currently exist.

Now, we have looked very carefully at that, because if it could be done in a fair way, it certainly is an attractive way of trying to achieve it. The problem is that when you combine the wage stagnation that has occurred for most middle-class Americans with removing the tax preference on the only part of their compensation that has grown, namely their health care benefits, it is an immediate loss of income and a real tax on millions and millions of Americans. The estimate range -- but the lowest estimate I have seen is about 35 million Americans and then add onto that their dependents.

So what we concluded was, yes, we want to eliminate tax preference, which will further put people into a cost-conscious, consuming mood, but we didn't want to do it until the system were up and running. So we have grandfathered in existing benefits packages, and we will not apply that tax cap, as it is sometimes referred to, until -- well, it depends upon when we pass the legislation, but until the whole program is put into effect, which we think will take about eight years or so to get done. But I think those two things added together, on top of what Hawaii is doing, will give Hawaii still a head start over the rest of us.

Thank you all very much.

(Applause.)

(The presentation was concluded.)

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