

**PRESIDENT LAUNCHES NEW CAMPAIGN TO ENSURE THAT  
LOW-INCOME MEDICARE BENEFICIARIES RECEIVE PREMIUM ASSISTANCE**  
**July 6, 1998**

Today, the President announced a new outreach campaign to help millions of low-income seniors and people with disabilities get assistance in paying Medicare premiums. A study by Families USA reports that over 3 million low-income Medicare beneficiaries are not enrolled in the Qualified Medicare Beneficiary (QMB) and related programs that pay for Medicare premiums and (for some) copayments and deductibles. This assistance was expanded last year in the Balanced Budget Act. However, as this new report underscores, many eligible beneficiaries are not aware of these cost-sharing protections and others have difficulty accessing this critically needed assistance.

To address this problem, the President has requested that the Department of Health and Human Services (HHS) and the Social Security Administration (SSA) launch a multi-faceted effort to enroll eligible Medicare beneficiaries in QMB and related programs. These new initiatives, which build on existing efforts to help identify and enroll eligible beneficiaries and parallel the President's efforts on children's health outreach, include:

- **Launching major new initiatives to educate Medicare beneficiaries about premium assistance programs.** HHS and SSA will make unprecedented efforts to ensuring that beneficiaries know about these programs by distributing clear, plainly written information about these programs by:
  - **Sending written information to all 38 million Medicare beneficiaries** about this program through pamphlets that will be sent to all beneficiaries this fall.
  - **Informing every one of the 1.8 million new Medicare beneficiaries** about this program in the Medicare initial enrollment package that is sent to these beneficiaries.
  - **Including information describing this program and an eligibility screening worksheet on the new Medicare Internet site, "www.medicare.gov,"** which is used by millions of older Americans and their families, as well as others who work with the elderly and people with the disabilities.
  - **Sending program information to more than 36 million individuals receiving Social Security benefits** in the annual cost-of-living adjustment (COLA) notices this fall.
  - **Distributing 450,000 pamphlets as well as placing posters in SSA's 1,300 field offices** where millions of beneficiaries go to enroll and ask questions about these programs. SSA will direct its field office employees to reach out to the millions of beneficiaries they see every day to ensure they are informed about QMB and related programs.

- **Encouraging the use of a simplified application process.** In July, the Health Care Financing Administration (HCFA) will send a letter to State Medicaid agencies that includes a model, simplified application as well as examples of successful outreach and enrollment programs. HCFA will encourage states to adopt simple, user-friendly procedures such as a mail-in application.
- **Creating a Federal-State-consumer advocate task force to develop new strategies to enroll eligible beneficiaries.** Beginning this month, HHS, SSA, the National Governors' Association, the Administration on Aging and advocates of the elderly and people with disabilities will collaborate to identify and implement strategies to educate beneficiaries about this program and to make it easier to enroll.
- **Targeting eligible beneficiaries through direct mailings.** This fall, HCFA will send a letter to a targeted group of beneficiaries who are likely to be eligible for these protections. The targeting population list will come from a list of beneficiaries supplied by SSA that the agency believes may be eligible. The letter will explain the program and encourage beneficiaries to apply.
- **Providing the State Insurance Counseling and Assistance Programs (ICAs) with materials to assist beneficiaries in enrolling in the premium assistance programs.** ICAs provide assistance on insurance and benefits to millions of older and disabled Americans.

These new initiatives build on an ongoing commitment by HCFA and SSA to target and enroll these vulnerable, low income Americans. For example, HCFA has provided training materials on identifying and assisting potential beneficiaries to providers, advocates and States. SSA has included information on programs in SSA pamphlets and handouts that could reach potential candidates and conducted training for staff who interact with beneficiaries.

**Background on the QMB and related programs.** The following table shows eligibility for premium and cost sharing assistance programs, which are offered in all States.

Category	Income (Poverty)	Annual Income (1998)		Medicaid Pays For:
		Individual	Couple	
<b>QMBs:</b> Qualified Medicare Beneficiaries	0 to 100%	Up to \$8,290	Up to \$11,090	Medicare Part A & B premiums, deductibles, copayments
<b>SLMBs:</b> Specified Low-Income Medicare Beneficiaries	100-120%	\$8,291 to 9,900	\$11,091 to 13,260	Medicare Part B premium
<b>QI-1s:</b> Qualified Individuals 1	120-135%	\$9,901 to 11,108	\$13,261 to 14,888	Medicare Part B premium
<b>QI-2s:</b> Qualified Individuals 2	135-175%	\$11,109 to 14,328	\$14,889 to 19,228	Part of Medicare Part B premium

Notes: Income guidelines include a \$240 unearned income disregard; poverty thresholds are different in AK and HI. There is also an assets limit of \$4,000 for individual and \$6,000 for couples for all groups. QI programs are subject to the availability of capped funding allotments.

# BUY-IN Fact Sheet

## BACKGROUND

Medicaid provides for buy-in of Medicare costs for beneficiaries with limited means. SSA's role is peripheral. States where SSI decisions are Medicaid decisions have also de facto elected for SSA to make buy-in decisions for their SSI beneficiaries.

Families USA, many States and advocates would like to see SSA play a greater role in the various buy-in programs. However, a large portion of the QMB, and virtually all of the SLMB and QI-1 populations have no active dealings with SSA and are not subject to SSA income and asset testing.

## FACTS

- ☞ State Medicaid agencies pay Medicare costs for members of certain groups. States share the buy-in costs with the Health Care Financing Administration (HCFA). Among these Medicaid groups are:
  - **QMBs** - Qualified Medicare Beneficiaries have countable incomes at or below the HHS poverty level (\$670.83/month for individuals and \$904.17/month for couples in 48 States) and resources which do not exceed twice the SSI limits (i.e., \$4,000/\$6,000). All their Medicare Part A (Hospital Insurance) and Part B (Supplemental Medical Insurance) premiums, deductibles and coinsurance are paid by Medicaid.
  - **SLMBs** - Specified Low-income Medicare Beneficiaries have Medicaid payment of their \$43.80/month Part B premiums. SLMBs would be QMBs, but for countable income up to 120 per cent of poverty.
  - **QI-1s** - Qualified Individuals are entitled to Medicare and have incomes below 135 percent of poverty. QI-1 is funded by a time-limited Federal block grant to pay for all or a portion of their Part B premiums.
- ☞ To be eligible for buy-in as a QMB, SLMB or QI-1, the Medicaid beneficiary must be entitled to Medicare Part A on their own or by purchase.
- ☞ Many QMBs, and nearly all of the SLMBs and QI-1s are not SSI beneficiaries.

## SSA EFFORTS ON HCFA's BEHALF

### ☛ Systems

Selections - SSA has performed at least four major computer selections of potential buy-in eligibles for HCFA's outreach notices. The first selection in 1989 included 14,000,000 records. Since then, HCFA requests have been for limited and targeted outreach mailings, such as the last selection in 1995 which involved 400,000 records.

Buy-in Procedures - Billing and Medicare entitlement data are carried on the title II Master Beneficiary Record. Client data used for buy-in decisions are available in electronic format to States on request.

State Data Exchange - The SDX generates a record to the State when there is an SSI change. Each record contains a field which tells the State about Medicare status for use in their buy-in decisions.

### ☛ Publicity

Every SSA pamphlet, booklet or handout that could reach potential candidates for buy-in contains HCFA-approved information about the State buy-in programs. These materials are stocked by every SSA field office.

SSA field offices distribute HCFA booklets and pamphlets in English and Spanish publicizing the buy-in programs.

Articles and reproducible plain-language information about the Medicaid buy-in programs have been included in numerous issues of the bimonthly Social Security Today (in English and Spanish) which is sent to thousands of advocates, organizations, groups, newspapers and magazines. SSA also sends a monthly information package to all SSA field offices for local distribution. The monthly packages have consistently contained information on the QMB and SLMB programs.

SSA's home page on the worldwide web (WWW) links directly to HCFA's home page which contains client information on the buy-in programs.

Two SSA executives participated in a workgroup with HCFA staff and various advocacy groups to promote publicity and public awareness of the various Medicaid buy-in programs.

SSI outreach grants required grantees to screen and refer clients for other benefits with emphasis on potential QMB eligibility. SSA provided HCFA-approved fact sheets for these screening efforts.

## ☛ Operations

Because of its linkage to title II, SSA plays an intermediary role in the Medicare entitlement process. All public-contact operations personnel must be able to answer Medicare questions and are aware of the Medicaid buy-in programs. SSA's instructions contain extensive information on the programs as well as State-specific information and referral guidelines.

Most of the SSI aged are eligible for Part B buy-in and meet the QMB guidelines; a handful meet the SLMB guidelines. About 20 percent of the SSI disabled are or will be eligible for Medicare and buy-in. SSA processes buy-in decisions for SSI beneficiaries in 32 States and the District of Columbia.

Field staff have received numerous periodic reminders of the importance of buy-in referrals to the State Medicaid agencies.

SSA policy staff have initiated working meetings with HCFA operations staff to help HCFA amend their buy-in procedures to make them more compatible with changes in the buy-in programs.

## WHAT MORE SSA COULD DO

Medicaid and Medicare are HCFA's programs. SSA must be reimbursed for any costs incurred for those programs. At little or no cost, SSA could:

- ☛ Include QMB, SLMB and QI-1 referral information in the annual title II cost-of-living adjustment notices.
- ☛ Further publicize buy-in in our booklets, pamphlets, newsletter, monthly information packages, other publications and through SSA's WWW page.
- ☛ Encourage HCFA to request additional selections for outreach campaigns.
- ☛ Encourage HCFA to develop more public service commercials for television and radio.

# File Family Conference

THE WHITE HOUSE

Office of the Press Secretary  
(Nashville, Tennessee)

For Immediate Release

June 22, 1998

REMARKS BY THE PRESIDENT,  
THE VICE PRESIDENT, MRS. GORE, AND MRS. CLINTON  
AT OPENING OF FAMILY REUNION 7: FAMILIES AND HEALTH

Vanderbilt University  
Nashville, Tennessee

12:45 P.M. CDT

THE VICE PRESIDENT: Thank you very much, ladies and gentlemen, and thank you, Bill, and thank you for the cosponsorship of the Child and Family Policy Center and for the very hard work of the past year that's made today possible.

Thank you, Chancellor Wyatt, for the wonderful hospitality of Vanderbilt in hosting this important event. And we, Tipper and I, earlier thanked Dr. and Mrs. Hefner for Tennessee State's role in hosting the Experts Forum again.

Many thanks also to Marty Erickson and the Consortium for Children, Youth and Families of the University of Minnesota. Your energy and wisdom are crucial to this conference, and I know there are many distinguished delegates from Minnesota who are with us here today.

Thanks also to our wonderful conference chair, Jill Iscol. Your tireless energy and vision for the future of Family Reunion is contagious and has won us many new friends for this initiative. And I will thank all of the others who have been a part of this year's conference and necessary to making it happen at the conclusion of our session tomorrow, but I want to thank Nancy Hoyt, our conference director, and all of those who have worked with her.

And among the many distinguished guests here, I hesitate to even start mentioning people and I will miss a lot of people, but I do want to acknowledge our wonderful Surgeon General, David Satcher, a kind of a homecoming to Nashville. (Applause.) We're proud of you, Dr. Satcher, thank you so much. (Applause.)

Tennessee's Chief Justice Riley Anderson is here and our former Governor, Ned McWhorter, and our Speaker Pro Tem, Louise DeBarry is here. All three of them are wonderfully welcome. (Applause.) There are many other state officials, members of the state legislature, both from Tennessee and from other states, and local elected officials, Democrats and Republicans. Welcome all.

Now, Tipper and I would like to briefly welcome everyone here to our Family Reunion. This is a tradition that we're proud to continue, and initiative that is helping shape policy for children and families. And we also welcome the thousands who are linked to our site here today by satellite. There are lots and lots of downlinks around the country -- we'll be interacting with some of them this afternoon. We appreciate your presence here.

We're looking forward to two days filled with ideas and strategies that will move us toward improving family-centered health care for all generations. We'll hear stories that will remind us how family-centered health care changes the lives of

MORE

both patients and health care professionals. We'll hear how hospitals and communities are changing to be more responsive to the needs of families, how these changes are affecting medical training and education, and how information drives the health care system.

This afternoon, you'll meet some of the best minds in this field who will be leading workshops around the campus. And then tomorrow, we will hear a summary of those discussions and then move forward in our concluding sessions tomorrow.

Before I begin the session today, I just want to tell you what a special honor and privilege it is for Tipper and me to be able to be joined by two very good and close friends who have in recent years made it a practice to come and attend these sessions. And, of course, as many of you know, our ability -- everybody in these Family Reunion conferences to get the right kinds of policy outcomes based on the learning experience that takes place here would be very much less -- except for the fact that we have a President and a First Lady who are so committed to these issues and to the progress that we all want to see in our country.

And Tipper and I are so touched that once again this year they have come to be a part of this Family Reunion conference. Ladies and gentlemen, it is an honor to be able to welcome to our conference the President of the United States and the First Lady, Bill Clinton and Hillary Rodham Clinton. (Applause.) Welcome, Mr. President, Mrs. Clinton. We're so honored that you're here.

Traditionally, we open up these Family Reunion conferences with just a brief film presentation. Because just as each of us lives our lives primarily in the venue of our families, whenever we have an effort to try to advance understanding of a particular issue -- like families and health care -- it's always useful to remind ourselves how we talk to one another about this issue in our culture, in movies and in television.

Jeffrey Cole, Director of the Center for Communication Policy at UCLA, along with his staff, have once again this year enabled us to begin with a brief collage, this time a collage of media scenes designed to show the images of families and health that we have absorbed from television and film. This video will show us many truths. We'll see dramatic family moments seen in the midst of health and sickness, life and death and birth. We will also see the impact of our culture on families and health care, including the glamorizing of tobacco and we'll see how the media educate us about health care, including educating us about the ugly truth concerning tobacco and the other aspects of families and health care.

This is the first time I've had to issue a rating for our media clips. If one of the scenes in this collage is from a movie that's rated "R" for language, and if you are going to be offended by it, now is a good time to leave. (Laughter.) You'll recognize it when it comes. (Laughter.)

But as almost everyone will see, in at least one scene or two, an emotional episode from our own past will remind us of something about what it means to be caring for a family member, or to be cared for by a family member at a time of weakness, uncertainty or need.

And so at that point, let's just watch this video.

(A video is shown.)

THE VICE PRESIDENT: We're very grateful to Jeff Cole and his team. I know that you worked right up until the last minute, Jeff, to include some scenes that were hard to

"did you take your medicine," "put this thermometer under your tongue," "open wide."

This conference is designed to help us all find ways to more effectively unleash the healing power of the family. Family-centered health care recognizes the family's expertise, encourages collaboration and shares information.

After working to get parents better information about prenatal care and nutrition, one hospital in Ohio saw a more than 30-percent reduction in the length of hospitalization for babies. Family-centered support for children infected with HIV and for children with asthma has decreased hospital stays. Family involvement during a mother's hospital stay has reduced depression. Today, 21 million Americans provide health care to members of their own family. That is a threefold increase in just the last 10 years.

Of course, one of the reasons that families are now more involved in health care is that our population is growing older and living longer. Those of us in the baby boom generation are the first generation to have more parents than children, and many of us care for both parents and children. More than 90 percent of chronically-disabled elderly people receive informal care from family members and loved ones. In fact, according to a study from the National Nursing Home survey, so many people are involved in informal care-giving for the elderly that if the cost of that care had to be provided by professionals it would add as much as \$94 billion to our health care bills.

For five years, with the courageous and tireless leadership of President and Mrs. Clinton, our administration has been fighting to improve health care for families. We passed legislation to let all families keep their health care coverage when they changed jobs. We passed a new law so that new mothers can stay in the hospital for at least 48 hours after the delivery of a child. We passed a Mental Health Parity Act, with the leadership of Tipper, to fight discrimination against family members with mental illnesses. The President signed into law the new children's health insurance program, which helps provide coverage for children who would otherwise not get it.

Last year, we passed a bipartisan balanced budget agreement with reforms that gave older Americans new choices and expanded benefits in Medicare. That's a step in the right direction, but language and choice can often be confusing. So we need to make sure that Americans can understand their choices and that their families understand their choices and learn how to make use of the new preventive care options available to them. We can use our newest technology to help ensure that older Americans and their families have access to the most up-to-date available information about their medical benefits.

Today, I'm pleased to announce a new nationwide Internet site, [www.medicare.gov](http://www.medicare.gov), that will help families understand the new options and services that Medicare provides. It's up and running as of now. And from now on people will be able to type in their ZIP codes and see the specific health plan options available in their own communities for their older family members.

At the same time, to ensure that no family falls through the cracks, I'm pleased to announce today the creation of a nationwide public/private Medicare alliance including over 80 national organizations. Members of the alliance, including the AFL-CIO, the American Association of Retired Persons, the National Rural Health Association and Health Care Financing Administration and others, will reach out to communities large and small, urban and rural, all over this nation, so that families understand the new options available to them, know about the new preventive benefits and are aware of the consumer protections available under Medicare.

Number five, train. Doctors and other health care professionals must be trained to be more sensitive to the needs and roles of families. We will hear a new announcement from medical schools and nursing schools about historic changes in how we train the next generation of health care providers to be more responsive to the needs of families. And we will hear ideas on how we can train families in how to use new technologies available for home care-giving. We saw a scene in the collage where a nurse was teaching the family member how to handle the particular technology that was important for the patient.

So these five steps -- support, measure, ask, respect, and train -- spell more than "SMART", they spell our a vision for maximizing the healing power of families in our health care system.

We have an extraordinary opportunity at this Family Reunion conference, because there are people gathered here from all over the country, representing every aspect of our health care system -- patients, families, doctors, heads of medical schools, nurses, insurers, professors, hospital administrators, and others. Let's learn everything that we can from each other, today and tomorrow so we can change the nature and the culture of our health care system and unleash the healing and loving power of families.

Thank you and thank you for coming to this conference. (Applause.)

Now, it is my great pleasure to introduce my partner who co-hosts these conferences with me every single year, and has since the time when I was back in the Senate, the love of my life, Tipper Gore. (Applause.)

MRS. GORE: Thank you. Thank you very much. (Applause.) Well, thank you, this is -- it's wonderful, we're very excited that all of you are here.

And Al, let me add my voice to yours by welcoming everyone, all our distinguished guests, the people that are going to share their expertise, everyone here that's listening, the media that's reporting. We really appreciate all of you in helping us help others to keep their families healthy and to share ideas about how we can best do that.

I know that a lot of you here today know Al very well, and if you do, you probably know that he undertakes everything with great enthusiasm. When he takes on an issue, he devotes a lot of time and energy to researching that and to discussing it and to trying to get all the very best opinions that he can on the issue.

When he was still in the Senate many years ago, he looked at policies that impeded families helping themselves to become strong and to stay strong, and he wanted to take a look at how you could change those policies so that families can really support one another and can become stronger the in process. So, together, we've taken a look at a way to create policy, to build policy, to encourage policy, that will help to strengthen families, which in turn, strengthens communities. And that's the point that we are here to discuss today.

He has looked at issues that impact families, from education to fatherhood and to health care. All of us have looked at the issue of health care, and everyone in this room, I know, has a huge, huge stake in how we can best deliver health care in our own families and in our communities.

We've reached the same conclusion, and that is that families truly are at the heart of each and every solution to health problems, and that policies and programs that support and

strengthen families will ultimately strengthen our nation. That's just common sense.

I'm really proud and honored to be a part of this event. I'm happy that we're taking a look at the family center approach to health care. As many of you know, we're very interested in how mental health care fits into health care as a whole. Of course, it does, but we need to continue to talk about that and to destigmatize mental or behavioral health care. And I think that this conference is going to go a long way toward that end.

One of the topics that I'll be discussing tomorrow and later today we'll be addressing mental health care for children, and also children that are facing chronic health problems of their parents and how we can best support them.

But now it is a great privilege and honor for me to be able to introduce to you a very special woman who has been a lifelong advocate on issues ranging from health care to women's rights to strengthening families, back in her home state of Arkansas as well as our nation's First Lady. And she's also a tremendous voice in addressing the needs of women and children.

She has a very compassionate spirit. She has the courage to speak out and always has, and she has a great determination to fight on behalf of women -- not just for women here in this country, but for women across the world. And she represents our nation, and I know all of us appreciate and respect her voice as it is our voice around the world.

She has demonstrated a lifelong commitment to improving health care for all of our families. And as the administration's leading voice on health care, she fought tirelessly for the passage of the landmark Children's Health Initiative, giving hundreds of thousands of previously uninsured children the opportunity to have health insurance and come under health care coverage.

Her efforts have helped to shed light, to educate people about the national need for more comprehensive health care services and benefits for all American families. And she has talked long and hard about a family centered approach to health care, the very issue that we are here to talk about in further detail today.

So I know all of you will join me in giving a very warm welcome to a very special woman, a very special leader, and our nation's First Lady, Hillary Rodham Clinton. (Applause.)

MRS. CLINTON: Thank you all. Thank you so much, and it is great to be back here to join Tipper and Al for this seventh Family Reunion conference. I know that many of you in the audience have followed with great interest the Family Reunion conferences of the past years, have been part of the deliberations and the follow-up. Others of you are new to this experience, but I can guarantee you that this is one of the most meaningful public policy discussions that you will be part of because it is aimed at really changing the way we look at a problem and coming up with practical solutions.

The Vice President made reference to some of what has already flowed from previous Reunion conferences, and I expect the same from this one, because certainly the issue is an important one in the lives of our families and is a timely one, as we know, as we look at the impact of a changing health care system on all of us.

The people who have planned this conference have been very thoughtful in bringing all of us together and setting an agenda that will lead to the kind of thoughtful reflection and results that are the hallmark of what Al and Tipper have been

doing for the last years. Their vision to launch this series of Family Reunions seven years ago was really in line with their lifetime of work and commitment to seeking to bring people together, not drive them apart; looking for ways to build consensus, not flame conflict; and making it possible for people of different points of view and experiences to find common ground. We need that more than ever in our nation because we are at a point in our history where we should be, with all the blessings that we're enjoying, be able to address some of the problems that underlie the stresses and strains that tear at the fabric of family life.

So I am personally very grateful to my friends, Al and Tipper, but I am even more grateful as a citizen to the Vice President and Tipper for making it possible for all of us to take some time out<sup>2</sup> and think about these difficult problems that they have addressed through the Family Reunion conferences.

I want to thank everyone who has worked on this, particularly the two cohosts of the conference, Dr. Martha Erickson and Bill Purcell. I want to thank the chair of the conference, Jill Iscol; and Nancy Hoyt, who doesn't seem to be slowed down at all by her crutches and is a walking example of family-centered health care, since both her daughter and her husband are here as part of her support system. But that's what these Family Reunion conferences are all about -- bringing us together.

And today we are surely talking about a subject that affects all of us -- how do we get the health care system to be more responsive to the needs of families. Every one of us has a personal experience like the ones we just saw on the screen. We know the pain and anguish of having a family member who is sick or injured or in need of long-term care. I think every one of us has sat in a hospital waiting room worrying about a chronically-ill relative or close friend. We have faced the frustration of trying to understand the mind-numbing rules and regulations of medical insurance forms.

And we know how difficult it is to deal with the emotional stress that comes upon us at such a time. Now, we certainly have made a lot of progress in the last 30 years, 40 years, in moving toward being much more sensitive.

I well recall the anguish of my family when one of my brother came down with rheumatic fever, and in those days, in the 1960s, there were no special considerations given to parents or family members, and there was a very strict set of rules about what governed visiting, even for a young boy of the age of 8, alone in the hospital. So my mother and father were permitted only see him an hour a day, and certainly my brother and I were not permitted to see him at all.

What a difference that was from time that when Chelsea had her tonsils out and had to spend the night in the hospital both Bill and I her able to be there with her. So we've make a lot of progress in the hospital system, the entire health care system appreciating the role that families play in the healing of a member of a family and how we now have to look at how we move that further in the face of new challenges.

Now, the administration, under the leadership of the President and the Vice President, have been looking for ways to deal with the changing nature of the health care system. We'll be hearing in a few minutes from the forum panelists up here on the stage before you. And what you will hear from them is good news about how hospitals and health care providers are working with families and communities to make sure that families are participants in important medical decisions, that they get the information they need and the support they need and the respect they deserve.

But we know that there are still a lot of obstacles and difficulties. And one of the reasons this conference is so timely is that we have to be sure that as the way we organize and pay for health care changes we don't lose the advances we've made since my brother was in a hospital, and lose the extraordinary work that is being done by the panelists and many of you to make the health care system more family responsive.

You all know that we face an entirely different situation than we had just a few years ago: 160 million people are enrolled in managed care plans today. Now, that's an increase of 75 percent just since 1990. And as with any sweeping change, it has the potential for both harm and benefit. We are learning, as we work our way through this new system, that more people are feeling like numbers instead of patients.

I remember before my father died in 1993, he went to see a doctor that had taken over the practice of his longtime physician. And he got into the waiting room and there was no person there. And he had to punch a button and an automatic voice came on and asked him who he was. And my father said, "None of your business, I'm leaving," and walked out the door. (Laughter.) Well, I think that a lot of people had that feeling and have that feeling, that we don't want to be treated like numbers and we especially don't want our children and our parents and our loved ones treated like numbers. So how do we take the benefits of a changing health care system and put them to work on behalf of all of us?

Now, this administration has worked very hard to improve the health and well-being of our families and children, and to make sure, particularly, that children and elderly relatives and citizens with special needs are given the support and protections that they deserve.

One of the battles that the President and the Vice President have taken on is against the tobacco lobby and they've taken up the challenge of helping parents protect their kids from the deadly habit of smoking. Now, while that initiative took a beating last week in Congress, I know you can count on the President and Vice President never to walk away from fight when the fight is on behalf of the children of America. (Applause.) And as the President has said, if the members of the Senate had voted more like parents, instead of partisans, the outcome would have been different. And it still can be. (Applause.)

One of the important steps that the President and Vice President are also working to achieve is to pass the Patient's Bill of Rights, which would give Americans much needed protection.

Now, what does that mean to all of us? Well, I imagine, like me, you've heard of or you've seen with your own eyes some of the stories that are coming back from what's happening in the health care system -- people denied emergency care because somebody, hundreds or even thousands of miles away, decides they don't need it; someone denied access to a specialist because someone looking at paper, not looking at the patient, decides they don't need a specialist.

So the Patient's Bill of Rights would once again enshrine what we should never lose sight of: that the most important goal of any health care system is the well-being of the patient. And we should once again protect the physician-patient relationship and put it above any other consideration. (Applause.) The bottom line of profits cannot ever be permitted to interfere with the bottom line of patient care.

So this Patient's Bill of Rights would do things such as guarantee access to health care specialists and emergency services. It would create a strong grievance and appeals process so that consumers can resolve their differences with health plans

and health care providers. We must work to make sure that the Congress passes protections such as that this year.

Yet, all of us who have followed what goes on -- whether it's in a state capital or our Nation's Capital -- knows that passing legislation doesn't guarantee change. There is a lot of hard work to implement a law, and that is certainly the case with the historic children's health insurance program that extended health insurance for up to 5 million of our uninsured children. The administration has been working with states and communities to get the word out about the expanded coverage.

And I wanted to just show you a report that is being issued today, a report to the President of an interagency task force of government officials in Washington that have really looked hard about how we will implement this. And all of you who are from all over our country, in so many different settings, I hope will really help us make sure that the word gets out to parents and others that their children are now eligible for health care coverage. And the President will talk further about the steps that are going to be taken to reach as many children as possible.

The Vice President also referenced this administration's commitment to improving the quality and effectiveness of health care for our elderly citizens. And Tipper and I will be working together to get the word out about one of the new benefits that Medicare is covering tests to detect osteoporosis. And many of you are equally concerned about the new benefit on diabetes education. So we will do our best to get the word out in every way possible about osteoporosis, about diabetes, so that we can reach Americans so that they can help take care of themselves and family members can help take care of each other by spreading the word.

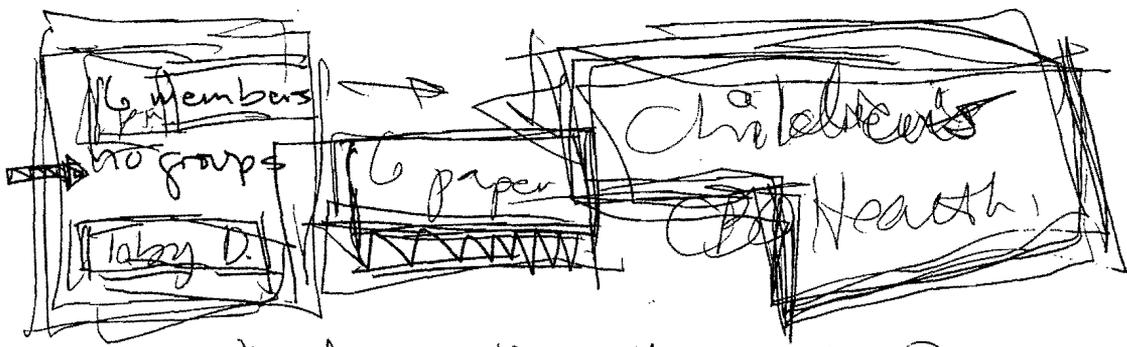
This conference today and tomorrow has such tremendous potential. But just like a piece of legislation that is passed standing alone it won't do anything other than perhaps educate those who are here and provide more opportunities for continuing to learn from each other. In and of themselves, those are very worthy outcomes. But we want to be sure that all of us take what we learn from this conference back to the hospitals, the community centers, the neighborhood health clinics, the advocacy groups -- everyone who is represented here -- and make sure that all of us know that fighting for health care, making sure it is family-centered, is not a luxury, it's not something that we can wait to do, but it is critical to how we define health care going into the 21st century.

Because of all the changes that we're coping with, we have a chance to really make some important decisions that will determine whether people are treated like numbers or whether people continue to be given the respect they deserve at a moment in their lives when all of us feel vulnerable and alone. And one of the ways of doing that is for each of us to be sure to get the word out that taking care of health care means taking care of families and giving families more of a voice and an opportunity to be part of everything that happens to one of their loved ones when the worst occurs.

So all of you are making it possible to fight for greater protections and services for Americans. And for that, I am very grateful and very pleased to be part of this important effort.

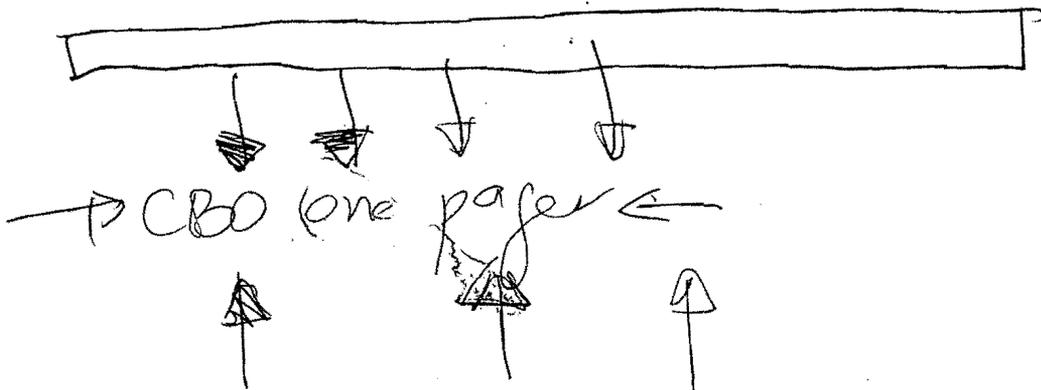
Thank you. (Applause.)

THE VICE PRESIDENT: Thank you so much. That was a wonderful presentation. And now ladies and gentlemen, I'm honored to introduce to you an individual who has been leading our country's efforts one health care. And let me say right at



→ Children's Health → TenPalmeri  
 → FDA → → Oval office  
 → Nancy Ann DePore → still plr

Wednesday CBO #5. →



the outset, no President has ever worked harder to improve health care for all Americans.

President Bill Clinton has increased access to health insurance for people who are self-employed, for people who have preexisting conditions, for people who are changing jobs, for children of low-income families. He's now working to expand health insurance for Americans aged 55 to 65. No one in history has cared more or done more to bring health care to a poor child, a working parent, or an ailing grandparent.

But President Clinton also understands that we must work to maintain the quality of American health care, to ensure that the dramatic changes in today's health care system work for, and not against, American families. That's why he's pushing so hard for passage of the Patient's Bill of Rights, so that every American gets quality health care.

I'm honored to introduce to you a President who has the strength, the stamina, and the commitment to help us build, step-by-step, a new nationwide commitment to health care access and excellence.

Ladies and gentlemen, the President of the United States, Bill Clinton. (Applause.)

THE PRESIDENT: Thank you very much. Thank you. (Applause.) Thank you very much. Mr. Vice President, Tipper, to all the leader of the conference, Surgeon General Satcher, Governor McWhorter, ladies and gentlemen, first of all, let me say that I look forward to coming here every year so much. I always learn something and I always see people who are full of energy and idealism and a sense of purpose who remind me of what, at bottom, my efforts as President should be all about. So I always get a lot more out of being here than I can possibly give back, and I thank you for that.

All these issues have been very important to our family for a long time. I grew up in a family where my mother was a nurse and where she served people before Medicare and Medicaid. I never will forget one time when a fruit picker that she had put to sleep for surgery brought us four bushels of peaches. I was really disappointed when third-party reimbursement came in. (Laughter.) I thought the previous system was far superior. (Laughter.)

When Hillary and I met, she was taking an extra year in law school to work at the Yale University Hospital in the Child Studies Center to learn more about children and health and the law and how they interfaced. And when we went home to Arkansas she started the Arkansas Advocates for Families and Children -- a long time before she ever wrote her now famous book, "It Takes a Village."

The Vice President and Mrs. Gore have plainly been the most influential, in a profoundly positive sense, family ever to occupy their present position -- whether it was in mental health or the V-chip in television ratings or telecommunications policy or technology policy or environmental policy or reinventing government or our relations with Russia and South Africa and a whole raft of other places -- history will record both the Vice President and Mrs. Gore as an enormous force for good in America. And I am very grateful to them.

This Family Conference is one of their most remarkable achievements. And as they said, it predates by a year our partnership and what happened since 1993. But I will always be very grateful to them for this as well.

I'd like to begin with just a remark or two about the tobacco issue, since it's been raised and it was a big part of the movies that we saw. We know that it's the number one

think that's what we ought to be doing. Because we know that no set of circumstances stays the same forever, and because we know that things are really changing fast and because we need to be looking to the future.

What are these big challenges? Well, a couple related directly to the concerns of the conference -- we need to make sure that Social Security and Medicare will be reformed so that they can accommodate the baby boom generation without bankrupting our children and our grandchildren. And we shouldn't be spending the surplus that finally is about to emerge after and we shouldn't be spending the surplus that finally is about to emerge after three decades of deficit spending, we shouldn't be squandering that surplus until we have saved Social Security and we know what we're going to do with Medicare. (Applause.)

We have to figure out how to grow the economy and do more to preserve the environment -- not just to avoid making it worse, we've got to actually recover many of our essential environmental things. (Applause.) And that's a health care issue.

We're here at Vanderbilt -- we've got the finest system of higher education in the world. We have to develop the best system of elementary and secondary education in the world. (Applause.)

We've got the lowest unemployment rate in 28 years, but we still have double-digit unemployment in some urban neighborhoods, on some Native American reservations, and in some poor rural communities. We have to bring the spark of enterprise to every place in America to prove that what we're doing really works. (Applause.) These are the things that we have to do. And we have to prove that we can all get along together across all the racial and religious and other lines that divide us, because in the world today, which is supposed to be so modern and so wonderfully revolutionized by the Internet, old-fashioned racial and religious and ethnic hatred seems to be dominating a lot of the troubles in the world. If we want to do good beyond our borders, we have to be good at home. (Applause.)

But on that list should be health care. Why? Because we have the finest health care in the world, but we still can't figure out how to give everybody access to it in a quality, affordable way. And in some form or fashion, every family in America just about, sooner or later, runs up against that fact.

Shirley McLaine was in there griping about her daughter getting the shot on the movie, you know? Now, why do you suppose -- never mind the movie -- why do you suppose something like that would happen in real life? Could it have something to do with the fact that not just HMOs, but the government, tried to take steps to stop medical expenses from going up at three times the rate of inflation, but, like everything else, if you overdo it, and the hospitals have to cut down on service personnel, that people will be late getting their pain shots? I mean, we have to come to grips with the fact that we still are alone among all the advanced societies in the world in not figuring out how to deal with this issue.

And I personally think we also -- we ought to be honest -- you know, it's easy to -- we could all get laughs with HMO jokes, but the truth is there was a reason for managed care, and that is that it was unsustainable for the United States, with the smallest percentage of its people with health insurance of any advanced country, to keep spending a higher and higher percentage of its income and increasing that expenditure at three times the rate of inflation. Pretty soon it would have consumed everything else. That was an unsustainable situation.

And a lot of good has come out of better management. I don't think anyone would deny that. The problem is, if that

kind -- if techniques like that are not anchored to fundamental bedrock principles, then in the end, the process overcomes the substance. And you have the kind of abuses and frustrations that have been talked about. That's why the Patient's Bill of Rights is important.

Now, the second thing I want to say is, we have to figure out how to do a better job of turning laws into reality. One of the things the Vice President I hope will get his just desserts -- we may have to wait for 20 years of history books to be written -- but the work that we have done in reinventing government is not sexy, it doesn't rate the headlines every day, people don't scream and yell when you mention the phrase, it doesn't sort of ring on the tip of the tongue. But we've got the smallest government we've had in 35 years, and it's doing more and doing it better than we were doing before in our core important missions.

And we've gotten rid of hundreds of programs and thousands and thousands of pages of regulation -- but the government, on balance, is performing better. And it's because of our commitment to change the way things work. The biggest challenge we've got right now is to fulfill the promise we made to the American people when we persuaded the Congress to put in the Balanced Budget Act of 1997 sufficient funds -- the biggest increase in Medicare funding since 1965, to provide health insurance to at least 5 million more children. There are 10 million or more children in America without any health insurance.

We had -- the latest numbers indicate that 4.5 million of those kids are actually eligible for Medicaid. Now, most of you here know that when we passed this program we provided for the establishment state-by-state of things that are called CHIPS, child health insurance programs, to provide health insurance mostly to the children of lower and moderate income working families that don't have health insurance at work.

But if you want to get the maximum number of people insured for the money that's been allocated, obviously the first thing we need to do is to sign every child up for Medicaid who's eligible for it. And, again, most of these children live in lower income working families. They've been rendered eligible by action of the federal government or by action of the state legislature in Tennessee and the other 49 states in our union.

Recent studies have shown that uninsured children are more likely to be sick as newborns, less likely to be immunized, less likely to receive treatment for even recurring illnesses like ear infections or asthma -- which without treatment can have lifelong adverse consequences and ultimately impose greater cost on the health care system as they undermine the quality of life.

Now, we're working with the states to do more, but I want the federal government to do more as well. Four months ago I asked eight federal agencies to find new ways to help provide health care for kids. Today, at the end of this panel, I will sign an executive memorandum which directs those agencies to implement more than 150 separate initiatives, to involve hundreds of thousands of people getting information that they can use to enroll people in schools, in child care centers and elsewhere -- involve partnerships with job centers and Head Start programs.

This is what reinventing government is all about. The American Academy of Pediatrics says that these initiatives are "representing the best of creative government and absolutely critical to achieving our common goal of providing health insurance for all eligible children." So that's what we're going to try to do coming out of this conference to do our part.

Let me again say that those of you who are here, if you believe that families are at the center of every society, if you believe they are the bedrock of our present and the hope of our future, if you think the most important job of any parent is

raising a successful child, then surely -- surely -- we have to deal with the health care challenges, all of which have been discussed -- caring for our parents and grandparents, caring for our children. Surely we have to provide our families the tools to do that if we expect America to be what it ought to be in the new century. We'll do our part and I'm proud of you for doing yours.

Thank you and God bless you. (Applause.)

END

2:00 P.M. CDT

I am Not Sure That

this is  
the final

FIRST LADY HILLARY RODHAM CLINTON  
HARVARD MEDICAL SCHOOL COMMENCEMENT  
JUNE 4, 1998

Dr. Martin, Dean Donoff, parents, alumni, faculty, our co-moderators Alison Bryant and Samuel Somers, distinguished guests, and most important, the class of 1998: Congratulations. You have done it!

I hope you will find time today to step back and take tremendous pride in all you've accomplished. Some of you finished school while caring for a family. Many of you took out loans to reach your dream. You may have been the first in your family to attend college. Maybe you only recently came to this country. Some of you also managed to earn a Ph.D. or J.D. All of you have made great sacrifices to reach this day, to graduate from this extraordinary institution, and to enter the noblest of all professions.

And I hope you find time to thank all the people who have stood beside you during these last 4 or 5 or 6 or 7 years of school, especially your families...who sometimes gave money, and always gave love, support, and endless endless patience.

So I know there is a lot on your mind right now: One of the most immediate questions you may have is, "just how long is she going to speak?" Winston Churchill gave one of the shortest commencement speeches ever. He said, "Never ever ever give up." And then he sat down. While I can't beat that, my daughter did remind me last night that I'm the only thing standing between you and your diplomas. I'll try to heed that subtle advice.

[Of course, at an outdoor event like this, there is always the worry that bad weather will make an unwelcome appearance. I hear some took temporary comfort in the oft-repeated claim that God is a Harvard alumni -- and therefore never lets it rain on commencement day...until they realized it was not just a lawyer...but a lawyer from Yale who was speaking today!]

Even as you celebrate, I know most of you are already thinking about a new phase of life. The food will probably not be as good as the restaurants on Newbury Corner. The sleeping accommodations won't exactly be 5 star. You know it as -- internship. The word brings with it excitement and expectation. Images of countless hours in the intensive care unit. And even lingering questions like: "Will I be ready?" I have come here today with a very direct answer: No group of graduates has ever been better prepared to usher in the next century of medicine.

Think back a minute to your predecessors at the turn of the last century. Back then, you didn't need a bachelor's degree to get into Harvard Medical School. Tuition was about \$200 for all two or three years of school. After Dean Eliot suggested that written exams supplement the oral ones, there was an outcry because most of the students couldn't write. And, in a 1898 edition of JAMA, a doctor who is mistaken for a night watch man, simply answers "No, friend...they can go to sleep on their beat and they draw their wages regularly."

Yet, like you, the students of that day had much to celebrate, much to look forward to. When Oliver Wendell Holmes spoke at the 100 year anniversary of Harvard in the late 19th century, he said, "Let us see where we stand today, and we shall know better what to hope for the future of the teaching, the science, the art of healing." Back then, they stood at a time of advances in the microscope, the thermometer, surgical anesthesia, and germ theory. They were staring down challenges like smallpox. Cholera. Typhoid. With little information about vaccinations. With no antibiotics. With horrible sanitation conditions. But, they were armed with the hope that they could write a new future for medicine in the 20th century: And they did.

Today, you stand on their shoulders...and the shoulders of all Harvard graduates who dreamed of -- and then set about creating -- a new future. Many of these alumni are here today. You stand on the shoulders of Judah Folkman, who has captivated this nation as he works to unlock the secrets behind cancer. You stand on the shoulders of Orah Platt, one of the top researchers in sickle-cell disease. You stand on the shoulders of David Ho, Time Magazine's Man of the Year in 1996...who is working day and night to rid our world of AIDS. And, yes, you stand on the shoulders of graduates like Michael Creighton and Noah Beir, who bring Dr. Ross, Nurse Hathaway and the entire team at ER to us every Thursday night.

Now, it is your turn to carry the future on your shoulders. Class of 1998, it is your time to lead. You have been given a first rate education from one of the finest schools in the world. Back when Holmes spoke, the doors of medicine were virtually glued shut to women and people of color. Today, your class was the first to enroll more women than men. Thirty years after your diversity program began, this is the first class to be majority minority. And you have been given the chance to put this education to use during the most exciting time ever in medicine -- a time when revolutions in health care are offering incredible opportunities and raising tough new questions that we must answer together.

You will enter a world where revolutions in research are giving you the medical keys to meet some of the humankind's most pressing needs. Daily breakthroughs have uncovered drugs to prevent cancer and treatments for stroke and AIDS. Technology is bringing us life-saving information in seconds and giving us more insight into Alzheimer's and other degenerative diseases. As we rapidly map the Human Genome, we're finding genes linked to breast cancer, colon cancer, and Parkinson's diseases. Yet we must ask ourselves: Will our genes be used to cure us or deny us health insurance? Will the privacy we took for granted in the Marcus Welby days still be protected in the ER days? In short, will our ethics keep pace with our science. Our progress depends upon it.

You will also enter a world of rapidly changing demographics, a world where the baby boomers are greying and all Americans are living far longer with less disability. When Holmes spoke at Harvard, he talked about two people's lives together filling a century. Now, a child born today may well live into the 22nd century. How will we provide and finance care for this growing group of older Americans? How will we address new end of life issues that arise when Americans live longer and longer, often with chronic disease -- an issue that is considered a luxury for most nations, but is nevertheless a necessity for us?

Finally, you will enter a world of revolutions in our health care delivery system. The lines between payers, providers, and insurers are blurring. More than 85 [check] percent of people with private insurance are enrolled in managed care plans. The era of the struggling young doctor hanging up his shingle is gone. We have more opportunity than ever to share risks and control costs...but we have more responsibility than ever to ensure the quality of care we provide. We have more responsibility than ever to protect the glue that holds our health care system together: the sacred patient-doctor relationship...or, in your shorthand, doctor-patient.

[I read that Oliver Wendell Holmes once arrived at the house of a patient, only to find the priest about to depart. "You're patient is very ill," said the Priest solemnly. "He is going to die." Holmes nodded. "Yes, and he's going to hell." The Priest was horrified. "I have just given him extreme unction. You must not say such things!" Holmes shrugged his shoulders. "Well you expressed a medical opinion, and I have just as much right to a theological opinion"]

Today, there is no shortage of people with medical opinions. As your class show made clear two years ago, there is no shortage of external pressures on you. No shortage of worry about how will you maintain the autonomy you need to make the right decisions for your patients. In this revolutionary health care world, it is up to all of us -- as individuals and as a nation to ensure that you can always stay true to the central pledge you'll make today: "The health of my patient will always be my first consideration."

And that means continuing to reform our health care system. People often ask: Were we disappointed that we didn't pass comprehensive health care reform in 1994? Of course. But, it seems to me that when the political environment stops you from taking large steps, you have two choices -- take small steps or sit on the sidelines and do nothing. It is far better to help a million people, 100,000 people, 100 people, than to help no one at all. As with everything we confront in life, setbacks should be used as an opportunity for education not as an excuse for inaction.

During and after the health care reform debate, there were critics who claimed we can't help uninsured Americans without hurting the insured. But we did it. Thanks, in large part, to the continuing leadership of this state's own Senator Kennedy, we said you can't deny someone health insurance just because they change jobs, lose jobs or have a pre-existing condition. And because of the new Children's Health Insurance Program, millions more children will now have health insurance. They said we couldn't build up Medicare without tearing it done. But we did. We extended the life of the Medicare Trust Fund and added new prevention benefits like mammograms and flu shots.

These goals were all part of the Health Security Act. And they are now the law of the land. But our job is not done. It's not done when the number of people living without health insurance has swelled to 41 million. When health care costs, once going down have started to plateau...and when fewer employers are providing insurance for their workers. Our job is not done when our citizens' access to health care too often depends on the color of their skin, the neighborhood they live in, and the amount of money in their wallet. Let me be clear: Our job as a nation will not be done until every American has access to affordable quality health care.

Until that day comes, there are important steps that all of us can take now. We must listen to the 60 percent of Americans who say they're worried that if they were sick their health plan would be more concerned with saving money than giving them the best treatment. And I know you share your patients concerns. I know you worry about health care decisions in your office being second guessed by a business person thousands of miles away. Many of us heard stories of doctors suing HMOs over gag clauses and other invasions of the doctor-patient relationship. That should never be necessary.

Whether people choose managed care or traditional care, they should always feel confident that they will get quality care. What better place to make that promise. This is where Ernest Codman gave birth to Results-Oriented Medicine. It's where Dr. Rabkin drafted the first Patient's Bill of Rights. And this is where we must say it for all to hear: No longer should patients have to beg and plead to see a specialist they need. They should have emergency care whenever and wherever they need it. They should have information to make good decisions. The bottom line of profits must never eclipse the bottom line of good medicine. Every American should be protected by a Patient's Bill of Rights.

And every American should be concerned about the pressure being felt by our Academic Health Centers. If we want to train the next generation of doctors and dentists...if we want to give birth to the next century's greatest discoveries...if we want to care for the most vulnerable among us...we must safeguard the jewel of our health care system: our teaching hospitals. It is not enough to make sure they survive year to year. We must ensure they thrive into the future.

[We've reformed Medicare so that teaching facilities receive payments directly from the program -- not inadequately funneled through managed care plans.] And the President has proposed increasing the NIH budget by more than 50 percent over the next 5 years. Because the revolutions in health care that we celebrate today didn't happen by accident or overnight. They are the result of steady and sustained investments that those who walked before us made. Now, the task falls to you.

Because while we must continue to invest in you, you must be -- not the bystanders, but the architects of this changing health care world. Almost 100 years ago, one of your predecessors said, "We are very glad it is in the class of 1900, and not that of 1800, in which we are graduating; for, as great as the progress in the century just closing, we confidently believe that we all shall witness, some of us perhaps share in, still greater triumphs in the century now dawning."

I hope you feel the same. Because when your successors stand at the edge of the 22nd century, I know they will look at the class of 1998 and say, that when given the chance and the opportunity, you lived up to the oath you will swear to today. That you served humanity. Just as we conquered bacteria in the 20th century, they will talk about how we conquered viruses in the 21st. How we taught spinal cord neurons to regenerate. How we gave people the tools they needed to prevent illness and death...to not only live longer, but better. And how we made sure that our grandchildren had to look to the history books to learn about menaces like cancer, AIDS, and Malaria.

I believe they will look back and say that you went far beyond the instructions to do no harm at the patient's bedside...and instead advocated for the welfare of the entire community. When uninsured kids walked through your doors to get their teeth cleaned or their vaccinations updated, you helped sign them up for health insurance. You made sure that no child ever picks up a cigarette or gun and throws away a future. You shared your expertise not only by submitting clinical abstracts, but also by submitting your views to your local newspaper and representative.

A hundred years from now, I believe they will be inspired by how, through all this, you managed to still maintain your own well-being and the well-being of those close to you. How you sought balance in your lives. Balance between work and family. Between work and leisure. Between the responsibilities of medicine and citizenship. And I hope they remark that you had fun. Yes, fun. That you laughed with your colleagues and patients. And that you enjoyed the incredible gift of healing that you will give throughout your lives.

And, in these often rough waters of change, I think they will be relieved that one thing remained constant: The sacred bond between doctor and patient. And they will know it was because, above all else, you worked each and every day to ensure that the health of your patient was always your first concern.

Congratulations, good luck, and Godspeed.

JEANNE AND SARAH: YOU TWO HAD A LOT OF GOOD STATS. COULD YOU PLEASE INSERT WHERE YOU BELIEVE MOST APPROPRIATE. WE WILL TALK LATER. THANKS. ccj

**DRAFT OUTLINE: May 7, 1998**

1. **Time of Unprecedented Change.** You are graduating at a time when the nation's health care system is undergoing enormous, perhaps unprecedented delivery, technological and demographic changes.

- **Rapid movement to managed care.** (Insert managed care stats)

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- **Daily, exciting advancements in biomedical research, pharmacology, and technology.** (Sarah's examples -- overarching ones; more specific ones below))

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- **The aging of our baby boom population.** (Jeanne stats)

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2. **Changes are Presenting New Opportunities and Challenges.** These three changes alone are already having a profound impact on the health care delivery system and how Americans and their representatives are viewing its potential for both positive and negative impact on the health and well being of our nation's citizens. For example,

**Positive:**

- **Health care inflation getting under control.** In recent years, we have witnessed some of the lowest health care inflation in both the private and public sector in X years. Although only time will tell whether our success in this area can be prolonged (and, in fact, recent evidence suggest at least some increases), most believe it unlikely that we will once again see health care cost increases that, as they did in the 1980s and early 90s, triple the general inflation rate. (Jeanne stats for both private and public sectors; credit managed care more efficient

management of Medicare -- where appropriate).

- **Research and technology producing new interventions that reduce incidence of costly, disabling illnesses.** Research breakthroughs for new diagnosis and effective treatment techniques are and will continue to happen at almost breakneck speed. Raise concept of compression of morbidity. (Cite Sarah's examples and praise and encourage potential researchers in the room).
- **Evidence medicine has great potential to improve health care and possibly constrain costs.** Application of new evidence-based research to actual medical practice has the potential to increase quality, decrease unexplained and worrisome variability in medical practice, and possibly even reduce costs. This is the future of a strong health care system; this could well be your future and we want to work with you to make it work in a way that benefits providers and patients alike. (Sarah, cite positive examples of interventions.)
- **Americans are healthier and living longer than ever before.** (Jeanne: can you provide stats to back-up) There are many reasons for this trend, including a greater recognition of importance of individual responsibility to maintain ones health, a greater emphasis on prevention by insurers in both the private and public sectors, successes in eliminating, treating or preventing infant and childhood diseases, the existence of the Medicare program, and breakthroughs in health care technology and pharmacology (Jeanne, anything else? Are the previous ok?)
- **Baby boomers willing and desirous of responsible reforms to Medicare (and Social Security.)** There is a growing openness to deal with the demographic and other health care challenges facing us. Cite Medicare reforms, Medicare Commission and interest in Social Security reform.

**Negative:**

- **Declining satisfaction with the health care system's commitment to quality and impact of delivery changes on practice of medicine.** Incentives to control costs have seemed to be oriented more towards achieving discounts from providers and reduced access to care, rather than a truly managed care system that emphasizes quality outcomes. (Jeanne stats, back-up from AHCP, anyone else?).
- **Health plans reimbursement policies have reduced commitment to teaching facilities, placing our crown jewels of research in much more precarious financial position.** (Jeanne, do we have any good evidence re this; Sarah have you seen anything on this? OSTP might have something, but be careful that it is objective info)

- **Growing fears that new breakthrough in research could be used in inappropriate ways.** For example, information about gene make-up could be misused by insurers or employers. (Sarah, need example of women not getting the breast cancer screening they need because of fear of discrimination.)
- **Increasing concern that easy access to medical records raise major privacy issues that must not be ignored.** (Sarah, any clear or unclear evidence to back up this statement.)
- **Demographic burdens threaten the fiscal integrity of Medicare, Medicaid, and other programs (including the DVA, DoD, and the FEHBP).** (Jeanne, do we have any quick stats that would not be redundant to above; please focus particularly on demographics, but also new delivery and cost challenges.)

3. **Changes Are Occurring At a Time When We Have, on a Bipartisan Basis, Responded to Some of Our Chronic Health Care Challenges.** Despite our lack of success in passing comprehensive reform in 1994, the President has shown that targeted, important reforms that help millions of Americans can and should be passed. He has rightly determined that the absence of our ability to enact comprehensive reforms should not be an excuse for doing nothing.

In the past three years alone, the President has signed into law many important health reforms. Virtually every one of them had roots in the Health Security Act, including:

- **Insurance reforms.** The long-overdue Kennedy-Kassebaum insurance reforms that provide the option for families to switch jobs without losing access to needed health insurance;
- **Children's health care.** A historic \$24 billion children's health care coverage initiative, which we worked closely with Senators Kennedy and Hatch on will help us expand coverage to up to 5 million currently uninsured children;
- **Historic Medicare structural reforms.** An unprecedented set of Medicare reforms that emphasize preventive care, provided more plan choices, slowed the growth of the program to below that of the private sector, and extended the life of the Trust Fund for 10 years from today;
- **Long-overdue physician training, teaching facility support, and anti-fraud initiatives.** These Medicare reforms included graduate medical education reforms that recognize the importance of maintaining and improving incentives for training primary care physicians (is this true Jeanne?), a new Medicare carve-out to ensure that teaching facilities received payments directly from the program -- not inadequately funneled back through managed care plans; and a new series of

tough but fair Medicare anti-fraud enforcement provisions.

- **Long-term care tax clarifications and consumer protections.** The private long-term care insurance industry had long stated that they needed additional tax incentives to enhance their success in selling these products. The President enacted these reforms, along with some important consumer protections, to fill the long-term care void that Medicare leaves its 40 (?) million beneficiaries.
- **Moving toward parity for self-employed tax deduction.** A provision that phased in parity for the health care tax deduction for the previously discriminated self-employed to 100 percent;
- **Mental health parity.** A new mental health parity provision, which helps eliminate the discrimination that many Americans with mental illness have faced.
- **FDA modernization and reform bill.** A reform bill that modernized the Food and Drug Administration without compromising its health and safety mission. Important, but is this relevant to this discussion? Do we want to talk about research increases over time Sarah?

4. **But Our Successes Cannot Mask the Many Challenges that Remain.** Although we have achieved some significant and long-overdue reforms, the chronic problems of our health care system remain and, in some cases, grow worse.

- **41 million Americans are uninsured -- up from 37 just 5 years ago.** (Jeanne, can we cite employer-coverage trends and anything else compelling/frightening -- like the problem of not having coverage/or the importance of having it.)
- **Despite success in constraining cost growth lately, our spending dwarfs every other industrialized nation -- without much apparent gain from it.** We spend more per capita and more as a percentage of GDP than any other country in the world on health care (Jeanne, can you get exact info; is this true?, yet we still have no better, and in many cases, worse health care status/outcome. (True or not, can we cite anything?))
- **Cost pressures appear to be returning.** (Any stats?)
- **4 million kids eligible and not enrolled in Medicaid.** More in the new CHIP program. We are working with many; want to work with you.
- **Kids smoking, and getting worse.** (Sarah, insert stats)
- **Enormous variation in treatments and outcomes that cannot be justified by X, Y, Z.** Any stats???

- **Individual insurance market has virtually failed**, particularly for anyone who has any pre-existing condition. (Cite Kaiser and anyone else.)
- **Health care professional shortages remain in medically underserved areas?** (Cite stats and praise those students graduating who are planning to go into the Corps or straight to an underserved community.)

5. **What Lessons Have We Learned? Where Do We Go From Here? How Do We Meet Our Current and Future Challenges?**

- We tried to address these challenges in a comprehensive way in 1993 and 1994. We made mistakes, painful mistakes. Like 6? other Presidents before us, we tried and did not succeed.
- **But we are not ashamed for trying.** The stakes were and continue to be too high to ignore these challenges.
- **The President and I still believe that every American should have affordable, quality health care.** We have by any measure the strongest economy in the world, yet we hold the distinction of being the only industrialized nation that does not assure basic insurance coverage to all of its citizens.
- **However, we live in an environment in which comprehensive reforms are virtually impossible to achieve conceive.** In such an environment, one can move on to other issues and do nothing OR continue to make important improvements and targeted reforms. In my view, it would be unconscionable to do the former and irresponsible NOT to do the latter.
- **First, we must do what we can do to repair and reform our current system.** These include implementing our historic Medicare and children's health care reforms from last year. (Talk about prevention, choices, and absolute necessity to do outreach for kids.)
- **But we must also work to pass legislation that addresses the current challenges,** including bipartisan, comprehensive tobacco legislation, the Patient Bill of Rights, genetic discrimination and privacy protections, new multi-year biomedical research investments, Medicare buy-in, Medicare coverage of cancer clinical trials, and work on the Medicare Commission (LIST OTHERS)..
- **Second, we should work to much better integrate breakthroughs in health care diagnosis and treatment into the daily practice of medicine in the health care system.** Cite patient outcomes stuff and investment in biomedical research and training.

- **And third, we cannot give up on addressing the health care system's shortcomings in a way that addresses some of the fundamental problems.** I am encouraged that Members on both sides of the aisle are contemplating large reforms. Cite some examples -- Kennedy and Thomas?.
- **Call for dialogue...**
- Conclude with challenges and opportunities for physicians.

NEED MORE PHYSICIAN SPECIFIC INSERTS. Trying to integrate Jeanne's suggestions in this regard. Does this general outline work? I am tired...

- Today's success encourages great — and unrealistic — expectations: that there are medical “cures” to wide-ranging societal ills, from crime to death.
- Expectations for medicine will be even harder to meet as the baby boom generation ages. WHILE STILL BALANCING DESIRE TO CONSTRAIN COSTS.

4. Vision for Future Health Care Professionals. You — in your unique dual role as physicians and citizens — will shape how our society designs its health care system for the twenty-first century.

- As new doctors, you face two new opportunities and responsibilities.

1. Moving medicine from art to science.

The mysteries of the human condition will always require that physicians use experience and judgement as well as research to guide decisions. However, the often-unexplained variation in practice patterns that exist today suggests that research on effective therapies is not always incorporated into physician's daily work. As the pace of technological innovation quickens, your success as physicians will depend on your ability to assess and integrate research into practice. You will also be called on to contribute to this knowledge as researchers and participants in research trials.

2. Assuming financial as well as professional responsibility for your patients.

Some predict that today's domination of for-profit managed care will give way to a provider-oriented health delivery system, where employers contract directly with provider groups to deliver care. Physicians will be challenged in such a system with balancing the age-old professional responsibility for patients with a community-oriented responsibility of delivering cost-effective care; balancing technological possibilities with human limitations; and with assuring that primary and preventive care take root at the center of the system.

3. Research

- As citizens, the challenge is simpler: we need to take any step — large or small — toward a more humane, equitable, efficient and effective health policy.
  - o Incremental improvements in the health system are difficult, create their own problems, and will not achieve — no matter how many “steps” you

take — a rational and universal health coverage system.

- However, the alternative to incremental reform is doing nothing. And doing nothing in the face of a clear problem — as you know as physicians — is not a morally acceptable choice. If there are people that need help, we as a nation have some obligation to help, no matter how many or few are affected. [examples of people helped by policies?]

### **Shift to managed care**

About one-fourth of privately insured were in managed care in 1987 (Gabel et al., 1988). Today, about 85 percent are in managed care -- an increase of 340 percent. [check]

About 40 percent of Medicaid beneficiaries (13.3 million) and 15 percent of Medicare beneficiaries (5.7 million) are enrolled in managed care. (HCFA, 1998)

### **Rise of for-profit health plans, physician and hospital networks, conversions**

In 1995, 71 percent of HMOs were for-profit, up from 18 percent in 1981. About 80 percent of PPOs are for-profit. (Claxton et al., 1997)

In 1995, 28 percent of hospitals participated in networks, up from 6 percent in 1994 (AHA Hospital Statistics 1996/97)

### **Change in employer health insurance practices**

Over 20 percent of establishments self-insure at least one plan (64 percent of establishments in firms with 100 or more self-insure; 80 percent of firms with greater than 500 employees). (NCHS, 1997)

Four out of five establishments offering health insurance sponsored only one plan. Because larger employers are more likely to offer choices, 43 percent of all private sector workers were eligible for more than one health plan. (NCHS, 1997) A different study found that 80 percent of small businesses offer only one health plan choice, while 47 percent of firms with 200 or more employees only offer one plan. (Gabel, 1997)

Small employers have increased employees' share of premiums: from 12 to 22 percent for single policies, 34 to 44 percent for family policies between 1988 and 1996. Deductibles have nearly doubled on average. (Gabel et al., 1997)

## **ONGOING PROBLEMS AND PROBLEMS CREATED BY THIS PROMISE**

### **Deterioration of access and affordability of health insurance coverage**

Shift to jobs that typically lack health insurance. Only 35 percent of new establishments offer health insurance. Although this may in part result from the fact that new establishments are disproportionately small, even controlling for firm size, these firms are the least likely to offer insurance (NCHS, 1997)

Although 83 percent of all private sector workers are in firms that offer insurance, only

68 percent are eligible for benefits and 58 percent participate. (NCHS, 1997)

The ability for hospitals to shift costs of uninsured has decreased over time. CAN WE BE MORE SPECIFIC AS TO WHY? (Clement, 1997/1998)

### **Increasing number of uninsured**

In 1996, there were 41 million Americans without insurance compared to 32 million in 1988. (EBRI, 1997)

### **Demand for health system to solve number of problems**

“Quality of life” drugs: Propecia for balding; Prozac for depression; Ritalin for hyperactive children; Viagra for impotence; weight loss drugs

Drug companies estimate that they spend about \$20 billion per year on developing new treatments (Gillis, Post, 1998)

### **Inability to constrain technology and utilization**

A survey of medical directors in all types of health plans found that indemnity and for-profit plans are most likely to cover a wide range of technologies than HMOs and non-profits. (Steiner et al., 1997) A study comparing the use of one new technology in HMOs and other health plans found no difference in the adoption of this technology, and no difference in cost growth as a result. (Chernew et al., 1997)

States with high HMO enrollment also lower growth in hospital ownership of expensive technology (e.g., cardiac catheterization) but any savings are offset by increased spending on physicians and drugs. (Cutler and Sheiner, 1997)

A recent study found that PPOs saved 12 percent over FFS with utilization review, mostly through more aggressive utilization review, selection of providers. There was no measurable difference in the cost per claim. (Smith, 1997/1998)

A study of technology diffusion in Pennsylvania found that both regulation and competition failed to limit over-supply of new technology. Hospitals acquired new technology to attract and retain physicians and patients. (Bryce & Cline, 1998) Physician-owned labs and technologies also contributed toward this effect.

### **Aging of the population**

Today, there are about 34 million Medicare beneficiaries; this will rise to 76 million beneficiaries in 2030. (Trustees, 1998)

## **SOLUTIONS**

### **Information, outcomes research and new paradigm for medical education**

Managed care plans have begun to invest in their own clinical and applied research. In 1996, spent \$93 million in research centers. (Nelson et al., 1998)

### **Reassessing role of government**

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# STUDY / Families USA 1998

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	TOTAL	QMB	SMB
ENROLLED	4.1 - 4.7 million		
NOT ENROLLED	3.3 - 3.9 million (42 - 48% NOT PARTICIPATING)	1.9 - 2.4 million	1.4 million
TOTAL ELIGIBLE	~ 8 million		

## CBO January 1998 Medicaid Baseline

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	TOTAL	QMB	SMB
1997 ENROLLED	5 million	4.6 million	0.3 million
2002	5.3 million	—	—