

THE HEALTH SECURITY ACT OF 1993

Health Care That's Always There

Every American citizen will receive a Health Security Card that guarantees you a comprehensive package of benefits that can never be taken away.

Guaranteeing comprehensive benefits that can never be taken away. Controlling health care costs for consumers, business and our nation. Improving the quality of American health care. Increasing choices for consumers. Reducing paperwork and simplifying the system. Making everyone responsible for health care. These are the principles of the Health Security Act of 1993 and they are not negotiable.

In America, rights and responsibilities go hand-in-hand. We will ask everybody to pay something, even if your contribution is small. Everyone must assume responsibility. No one should get a free ride.

Most important, we're going to offer new opportunities and new incentives for people to stay healthy – and to treat small problems before they become big ones. Our goal should be to keep people healthy, not treat them after they become sick.

What's Wrong With the Current System

The things that are wrong with our health care system are threatening everything that's right with American health care.

- Over the next two years, one out of four of us will be without health coverage at some point. Change jobs, lose your job, or move – and your insurance company is currently allowed to drop you.
- Today's system is rigged against families and small businesses. Insurance companies pick and choose whom they cover. Then they drop you when you get sick. If you have a pre-existing condition, you usually can't get any insurance at all.
- Insurance companies charge small businesses as much as 35% more than the big guys.
- Only 3 of every 10 employers with fewer than 500 employees offer any choice of health plan. Millions of Americans have almost no choice today.
- Twenty-five cents out of every dollar on a hospital bill goes to bureaucracy and paperwork – not patient care.
- Fraud and abuse are exploding, costing us at least \$80 billion a year. That's a dime of every dollar we spend on health care.
- Our nation's health costs have nearly quadrupled since 1980. Without reform, by the year 2000, one of every five dollars we spend will go to health care.

Principle #1:

Security: Giving you health care that's always there.

Over the next two years, one of every four of us will lose health coverage for some time. The Clinton plan guarantees that you will never lose your insurance -- no matter what. Here's how the plan guarantees security:

- **Makes it illegal for insurance companies to deny you coverage because of "pre-existing conditions."** The Health Security Act also makes it illegal for insurers to raise your premiums or drop you because you get sick. All health plans will be required to accept anyone who applies -- healthy or sick, young or old.
- **Guarantees coverage if you lose your job.** The proposal guarantees that you will keep your health coverage even if you lose your job, with the employer portion picked up by Federal revenues and savings. Under the current system, if you lose your job, you lose your health insurance.
- **Guarantees coverage if you switch jobs, move or start a small business.** You will always be protected -- no matter what. Today, if you switch jobs, move or start a small business, you can find yourself without health insurance -- and risk bankruptcy.
- **Provides coverage for early retirees.** The health security plan guarantees coverage for early retirees, so they don't have to worry about being without coverage after they retire and before they are covered by Medicare. Today many early retirees are losing their health benefits.

Principle #2:

Comprehensive benefits: Keeping you healthy.

All Americans will receive a Health Security card that guarantees you a benefits package that is as comprehensive as those offered by most Fortune 500 companies...and then some.

Emphasizes preventive care. The comprehensive benefits package goes beyond virtually all current insurance plans by covering a wide range of preventive services, including mammograms, Pap smears, and immunizations, **at no charge to you.** It puts a new emphasis on helping you stay healthy, rather than waiting until they get sick. Prevention saves money and improves people's health.

Includes prescription drugs. Many insurance companies and Medicare have failed to cover prescription drugs. But drug costs are breaking family budgets, forcing many older Americans to choose between food and medicine. Health insurance should cover prescription drugs. The Health Security plan does.

All Americans will be guaranteed coverage of :

- Preventive Care (i.e., screenings, physicals, immunizations, mammograms, prenatal Care; at no cost)
- Doctor Visits
- Prescription Drugs
- Hospital Services
- Emergency/Ambulance Services
- Laboratory and Diagnostic Services
- Mental Health and Substance Abuse Treatment
- Expanded Home Health Care
- Hospice Care/Outpatient Rehabilitation
- Vision and Hearing Care
- Children's Preventive Dental Care

Principle #3:

Savings: Controlling health care costs.

Here's how the Health Security Act will control health care costs:

Limits how much insurance companies can raise your premium. Insurance companies will no longer be able to raise your premiums as they please. Today, insurance companies hike your premiums – sometimes at several times the rate of inflation – if you get sick, if someone in your family gets sick, and for any other reason.

Introduces competition to the health care marketplace. The Health Security plan will release the chokehold that in today's system, insurance companies have on all of us – consumers, nurses, doctors, and businesses. Reform will encourage competition – forcing costs down as health plans compete by offering high-quality care at an affordable price:

Cracks down on fraud. The health security proposal makes health-care fraud a crime and imposes stiff penalties on those who cheat the system. It prohibits doctors from referring patients to outside facilities, like labs, which they own a piece of. It stops the kickbacks that some laboratories give doctors in an effort to get their business.

Asks the drug companies to hold down prescription drug prices. The Health Security plan asks drug companies to take responsibility for keeping prices down, without setting prices. In today's system, overcharging runs rampant – certain prescription drugs cost Americans three times more than people pay in other industrialized countries.

Reduces paperwork. All health plans will adopt a single, standard claims form by Jan. 1, 1995. Along with other measures to streamline the system and free nurses and doctors from excess bureaucracy, this will reduce paperwork, cut red tape, and save money.

Squeezes the waste out of Medicare and Medicaid. By slowing the growth of these government programs, the proposal uses funds that have been wasted on excessive charges and funnels them into comprehensive benefits. Under reform, Medicare will be expanded to

cover prescription drugs, and there will be a new long-term care program to help cover home- and community-based care. Today, Medicare and Medicaid spending keeps going up and up. But the elderly and poor aren't getting any extra benefits. Health security will change that.

Principle #4:

Quality: Making the world's best care better.

Emphasizes preventive care. The Health Security plan puts a new emphasis on preventing illness before it becomes a medical crisis. Prevention will improve the quality of care by helping people stay healthy rather than treating them after they get sick. The benefits package fully pays for a wide range of preventive services; the vast majority of today's insurance plans don't cover a penny.

Gives consumers the power to judge the quality of care. Consumers will receive quality "report cards" that provide information on the performance of health care plans and patient satisfaction. These report cards will hold health plans accountable for meeting high standards. The National Quality Program will help states share information on health plan performance.

Reforms malpractice. The President's proposal will limit lawyers' fees in order to discourage frivolous medical malpractice lawsuits. It will also encourage patients and doctors to use alternative forms of dispute resolution before they end up in court. This will help eliminate the "defensive medicine" that drives up costs and hurts quality – doctors ordering extra tests because they fear lawyers looking over their shoulders.

Encourages cooperation in rural and urban areas. Rural residents will have access to the latest technology and emergency services through telecommunications links set up between local doctors and advanced networks of specialists and hospitals. In urban areas, the plan will increase investment in public hospitals and community health centers.

Provides incentives for more family doctors to practice in rural and urban areas. The health security plan will give financial breaks to doctors and nurses who work in underserved rural and urban areas. It will expand the National Health Service Corps. Two of three rural counties today do not have enough doctors and 111 rural counties have no physician at all.

Increases funding for prevention research. The National Institutes of Health (NIH) will expand research in areas like children's health, and health and wellness promotion. Preventive care keeps people healthier and saves money at the same time.

Promotes research on the effectiveness of treatments. Today, a lack of information about the most cost-effective methods of treatment often leads to expensive defensive medicine and wide variation in treatments and costs. The plan's investments in research into what treatments really work will help improve the quality of care.

Principle #5:

Choice: Preserving and increasing what you have today.

Preserves your right to choose your doctor. The proposal ensures that you can follow your doctor and his or her team to any plan they might join. Today, more and more employers are forcing their employees into plans that restrict your choice of doctor. After reform, your boss or insurance company won't choose your doctor or health plan -- you will.

Increases your choice of health plan. You will be able to choose from among all the health plans offered in your area -- no matter where you work. Only one of every three companies with fewer than 500 employees offer any choice of health plan. After reform, every employee will be able to choose a health plan.

Puts consumers in the driver's seat. The Health Security Act brings competition to health care -- unleashing the market forces that will lower costs and improve quality. Giving small businesses and consumers the power to band together in alliances will level the playing field and give them the same bargaining strength as big businesses.

Increases options for long-term care. The President's proposal will make it possible for more Americans to continue to live in their homes and communities while receiving care. Today too many families are split apart when insurance or federal programs only pay for hospital coverage. The plan will help put an end to this situation and give families the options they deserve.

Principle #6:

Simplicity: Reducing paperwork and cutting red tape.

Gives everyone a Health Security Card. The card -- with full protection for privacy and confidentiality -- will allow for electronic billing and the creation of health care information networks. This will reduce paperwork and simplify the system.

Requires insurance companies to use a single claim form. The Health Security Act will reduce the insurance company red tape that forces doctors and patients to spend their time filling out forms and fighting bureaucrats. All health plans will adopt a single, standard claims form by Jan. 1, 1995. It will enable doctors and nurses to spend more time taking care of you -- and less time wrestling with paper.

Eliminates fine print. Everyone will get a comprehensive benefits package -- and what you get will be spelled out in easy-to-understand language. If you get sick, insurance companies won't be able to point to fine print and deny you the coverage you've paid for.

Streamlines billing reimbursement for doctors, nurses and hospitals. The comprehensive benefits package, a standard rules and codes for payment, and elimination of excessive government regulations will reduce confusion. Doctors, nurses, and hospitals will have more time to care for patients; and all of us will benefit.

Removes the burden on business of negotiating insurance. Groups of businesses and consumers – regional health alliances – will negotiate for high-quality care at affordable prices. This will simplify today's system, where hundreds of thousands of businesses negotiate with more than 1500 insurance companies. The burden of finding insurance will be lifted – and so will administrative costs – which can run as high as 40% of total health costs for small business.

HOW THE SYSTEM IS FINANCED

The financing proposal was developed under the most rigorous and conservative forecasting standards. For the first time, representatives from every federal agency involved in fiscal accounting and financial projections have been brought together to work out the numbers. Then teams of actuaries, health economists and other financial analysts from outside the government served as auditors and consultants, checking and rechecking.

The system is financed from five major sources:

- 1) Employer and employee contributions – Everyone will pay a portion of health insurance premiums, even if your contribution is small, because everyone must assume responsibility. Today, the overwhelming majority of employers cover their employees, and they'll continue to do so. But the businesses that provide insurance are paying for those who don't. No one should get a free ride.
- 2) Medicare and Medicaid savings – Specific savings can be achieved by slowing the rate of growth of these programs. Every penny of these savings will be channeled back into benefits – prescription drugs and long-term care -- for the people which these programs serve.
- 3) "Uncompensated care." -- Savings can be achieved from money now paid to hospitals and doctors who care for people who can't afford care but receive it anyway and the uninsured.
- 4) Sin taxes and other federal revenues – There will be some new "sin taxes," and other revenues will be added as health care costs slow, less money is spent, and the difference is no longer tax-deductible.
- 5) Other savings – Reducing paperwork and administration -- estimated to cost \$100 billion or more a year – will cut bureaucracy and save money. Cracking down on health care fraud - estimated to be at least \$80 billion annually – and imposing new stiff penalties will also yield savings.

PAYMENT SCENARIOS

As a rule, most individuals and families in which at least one person works will pay a maximum of 20% of the average health plan premium in their area. Those who choose a lower cost plan – from among those offered in the area – will pay a little less than the

20% average. Those who choose a more expensive plan will pay a little more, as they do today. Employers who currently pay 100% of health benefits may continue to do so.

Two parent family with children: Two parent families with children -- whether one or both parents work -- pay a maximum of 20% of the family premium offered by the average plan in their area. If both parents work, they choose how to pay their family's share. They can have the share deducted monthly out of either paycheck or write a check to the local alliance.

Couple: Working married couples -- whether one or both spouses work -- pay a maximum of 20 percent of the average plan premium. They can have the share deducted monthly from either paycheck or write a check to the local alliance.

Single-parent family: Working single parents with children pay a maximum of 20 % of the average plan premium for a single parent policy.

Individual: Working single people pay a maximum of 20% of the average premium for an individual policy in their area.

Part-time worker with no unearned income: Part-time workers pay a maximum of 20% of the average plan premium for their policy type in their area.

EXCEPTIONS

Exceptions are provided for: (1) the self-employed and independent contractors; (2) part-time workers who have unearned income; (3) families with incomes below 150% of the poverty level; and (4) seasonal workers.

Self-employed/independent contractors: The self-employed and individual contractors can deduct from their taxes 100% of their health care costs. As with any small business, they pay the employer share. They also pay an individual share. If a firm earns less than \$24,000 a year, it is eligible for subsidies.

Part-time workers with unearned income: Part-time workers with unearned income pay a maximum of 20% of the average plan premium for their policy type -- individual, couple, two parent, or single parent family.

The number of hours someone works determines how much of the premium is paid by the employer and how much by the individual. For example, an employer would pay 40% of the premium for someone who works half-time. Payment of the remaining 40% of the premium depends on how much a person makes in unearned income, with subsidies provided on a sliding scale for those whose incomes are below 250% of the poverty level.

Families with incomes below 150% of the poverty level: Families at this level are eligible for discounted premiums and pay a maximum of 20% of the employee's share of

the average plan premium. This applies to individuals making \$10,455 annually; couples with incomes of \$14,145; families of three earning \$17,835; and families of four with incomes of \$21,525.

Seasonal workers: Seasonal workers pay a maximum of 20% of the average plan premium in the area where they reside. Those whose incomes are 150% of the poverty level or below are eligible for discounted premiums. If they have unearned income and are not working, seasonal workers are treated the same as part-time workers.

Unemployed and non-working: Unemployed individuals and heads of household who make less than 150% of the poverty level are eligible for individual subsidies on a sliding scale. Those with unearned income pay all or part of what would normally be the employer's share of the premium.

Those whose incomes are 250% of the poverty level or less – pensioners, for example – are eligible for discounts on what would be the employer's share. They are not eligible for individual subsidies, and pay the normal individual share of the health premium.

The Health Security Plan

Every American citizen and legal resident will receive a Health Security Card. Once you get your card, you can never lose your health coverage -- no matter what. If you get sick, you're covered. If you change jobs, you're covered. If you lose your job, you're covered. If you move, you're covered. If you have the courage to start a small business, you're covered.

Your Health Security card guarantees you a comprehensive package of benefits that can never be taken away. The package is as comprehensive as the ones that many Fortune 500 companies offer their employees. And in critical ways -- like paying for preventive care and prescription drugs -- the package gives you more than big companies provide today.

You will be able to choose your doctor. Everyone will have a choice of health plans. You'll be able to follow your doctors and nurses into a traditional fee-for-service plan, join a network of doctors and hospitals, or join an HMO. Your boss or insurance company won't decide how or where or from whom you get your care -- you will.

Almost everybody will be able to sign up for a health plan at work, like you do today. You'll get brochures that give you easy-to-understand information on several health plans -- which doctors and hospitals are included, an evaluation of the quality of care, a consumer satisfaction survey, and prices. If you're self-employed or unemployed, you can sign up at your area health alliance, which will be run by consumers and businesses and bargain for affordable health care for you.

The federal government will set up a national health board -- a board of directors to set standards and make sure you get the comprehensive benefits and quality care you deserve. State governments will set up health alliances give consumers and small businesses the power to buy affordable care; and the businesses with 5,000 or more employees will be allowed to operate as "corporate alliances."

Insurance companies will be required to use a single claim form to replace the thousands of different forms they have today. So when you get sick, you won't be buried in forms -- and neither will your nurse, your doctor or your hospital.

- **Security for you and your family.**
- **A comprehensive package of benefits.**
- **Health care costs that are under control.**
- **Improved quality of care.**
- **Increased choices for consumers.**
- **Less paperwork and a simpler system.**

That's what the Health Security Act is all about.

THE WHITE HOUSE
WASHINGTON

September 10, 1993

MEMORANDUM FOR NEC MEMBERS

FROM: ALICE RIVLIN AND GENE SPERLING

SUBJECT: NEC MEETING TODAY

The attached is for the NEC meeting at 3:30 today. Please review before the meeting, if possible.

THE WHITE HOUSE

WASHINGTON

September 13, 1993

MEMORANDUM FOR DOMESTIC POLICY PROGRAM STAFF

FROM: Carol H. Rasco, Assistant the President for
Domestic Policy

SUBJECT: Attached Materials

Attached are materials from the Friday, September 10 NEC meeting. Please review for discussion at our September 14 staff meeting at 12:00 noon.

DRAFT

September 9, 1993

To: ^{ppc} NEC Members
From: Alice Rivlin and Gene Sperling
Subject: Priorities Project

The beginning of the FY95 budget process is an opportune moment for the President to rethink, reconsider and review his policy priorities. When deciding to run for President, then Governor Clinton went through an elaborate process of discussion and analysis in deciding what would be his top policy priorities during the campaign. The priorities chosen at that time reflected years of analyses and experience of the then Governor, as well as campaign commitments. After the election, these priorities guided the investment component of the President's economic plan and Administration's proposals for reconciliation and FY 1994 appropriations.

After nine months in office, the President and the members of his Administration have an opportunity for taking stock and reevaluating policy priorities. The Administration team now has a great deal more information about the effectiveness of programs and the receptiveness of Congress and the voters to particular initiatives. The tightness of the discretionary caps in FY95 and beyond, and the increasing focus on controlling entitlement spending, makes it imperative that the President think very carefully about where he wants to direct the efforts and resources of his Administration to maximize real accomplishments.

Setting priorities must involve a process that interweaves 1) big picture reflection of the President's goals; 2) a hard-nosed sense of what is achievable policy-wise; 3) an understanding of how priorities -- both achieved and sought -- reflect on message and how the President is viewed by the public in terms of who and what he stands for; 4) a pragmatic sense of what is achievable legislatively; 5) an analysis of the budgetary constraints; 6) an estimate of what is can be accomplished by the power of Presidential persuasion.

We propose that the President--and all of us--move from big issues of priorities to the actual FY95 budget decisions in three steps:

1. Legacy Notebooks: The first step should be an opportunity for the President and all of us to step back and consider what should be the President's legacy -- what are the positive things for the country he would feel most good about accomplishing -- and how that should drive both budgetary and non-budgetary decisions.

2. Reassessment of Priorities and Preview of FY 1995 Decisions: This step would lay out background information (with opportunity for discussion if the President desires) designed to answer questions like these: how well did we do in Congress in funding investments? What is the latest view within the Administration and outside about the

effectiveness of the programs we chose to emphasize and about the public's perception of that effectiveness? What shifts in resource allocation actually occurred in FY 1993 and FY 1994: more for children? more for infrastructure? more for technology and science? Less for what? What are the big choices that will have to be faced to meet the discretionary spending caps in FY 1995? What is happening to entitlement spending and what are the options for controlling it?

3. Options and Decisions on the FY 1995 Budget. The final step would be to lay out for the President the issues raised by the agencies' FY 1995 budget decisions and the major decisions he has to make to come to closure on the FY 1995 budget submission to Congress.

Early Oct.

STEP ONE: THE PRESIDENTIAL LEGACY NOTEBOOK

Rationale: A worthwhile exercise for the President, his staff and his advisors is to consider what the President's legacy should be. This question forces the President to ask himself, if he cannot get everything he done he would like, what is the handful of things, that he would most like to accomplish for the nation during his tenure in the White House. Part of that question has already been answered, by his stress on health care. Yet, among his other major priorities — children, schools, training, college, technology, defense conversion, 100,000 cops, infrastructure, AIDS, urban economic empowerment, welfare reform, environmental infrastructure — it is hard to know which we most want to stress.

The legacy project does not mean giving up on any of these priorities, but it can focus attention and resources more clearly.

We envision two legacy notebooks:

1. General Legacy Notebook: We would collect for the President several three page memos from members of the NEC, Cabinet, White House staff and outside advisors whom the President respects. We will consult with people who know the President well as to whose comments outside of government he might be most interested in. In order to allow maximum participation, while also keeping the pages the President must read a reasonable amount, we might wish to require that all papers be signed by two or three people. If, for example, three people collaborated on each paper, 60 people could participate, while keeping the notebook to sixty pages.

The memo for the Legacy Notebook. One would ask three things.

A. In a future summary of "Accomplishments of Late 20th Century Presidents," what would you most want said about Bill Clinton? (limit of three items)

B. If you had \$10 billion to spend at the margin in the next budget, how would you spend it and why? What would you reduce to find the additional money?

C. What Presidential priorities or legacy can be achieved without any (or minor) budgetary impact?

2. Cabinet Legacy NoteBooks:

The second legacy notebook would be from the Cabinet. They would be asked the same questions for their area of responsibility. Thus, the Secretary of HUD would be asked to say what the legacy should be in his Department, how he would spend an additional \$1 billion, where he would get it, and what are the non-budgetary priorities.

The notebooks would serve as not only for a first step for the President to reflect on his legacy and priorities, but as a vehicle for the NEC and White House staff to consider these issues together. After the completion of the Notebook, we would use the papers to set-off a series of NEC discussions. We might do this prior to sending the President the notebook, or while the President is doing a first read.

Mid-Oct.

Second Step: Reassessing Priorities and Preview of FY 1995 Decisions

This priority project would not serve the President well if we created a process that allowed the President to ponder priorities, but did not also inform the President about the policy and political feasibility for bringing about fundamental change in the major policy areas. The second stage should therefore provide a process for 1) answering the President's inquiries to the two Legacy Notebooks, 2) be a process to bring the President up to date on the academic studies, literature, state and local success stories; 3) Reports on public opinion on various policy initiatives; 4) Congressional analysis -- to be given in oral presentation by Paster's office; 5) OMB analysis of budget trends in entitlements and recent changes in discretionary spending by department and major "cross-outs" or priority areas. (See attached cross-cut table.)

This step would also involve a notebook for the President, presenting budget trends with supplementary information organized by cross-outs. For example, if the cross-cut area was "science and technology," there would be a brief memo that sought to bring the President up to speed on what was the current thinking on technology policy, the breakthroughs, the major areas of disputes. OMB, cabinet officers, and NEC members could have the opportunity to comment on different areas. Congressional relations might prepare Congressional viability analysis on major areas, to be given through a verbal presentation to the NEC and later to the President.

There is no way that this process can be perfect or complete or give the President all perspectives. Yet, it can accomplish the following:

- 1) It can ensure that the President is up-to date on major policy and academic arguments concerning major investments, as well as new and successful state and local examples.

September 8, 1993

**OMB SCHEDULE FOR
1995 BUDGET PREPARATION**

<u>Event</u>	<u>Date</u>
1. ISSUE PLANNING GUIDANCE TO MAJOR AGENCIES.....	9/3/93
2. ENTITLEMENTS PAPER.....	COMPLETED BY 9/30

A paper will be prepared by OMB staff (primarily BRD and EP, with assistance from program divisions) that is intended to provide: a report on the status of the entitlement caps; materials for an October legislative savings bill; the basis for a November conference on entitlements; the basis for the 1995 budget proposals. The paper will first report on the status of major entitlements, including current trends and risks. This will be followed by some discussion of strategies and options.

3. SUBMISSIONS OF MAJOR AGENCIES DUE TO OMB.....	10/1
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The budget requests of major agencies are due to OMB. Because of the tight fall schedule, submission delays or major noncompliance with 1995 budget guidance could significantly complicate the review schedule.

4. DIRECTOR'S REVIEWS.....	11/1 to 11/24
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OMB staff will develop summary material by agency, function, appropriations bill, and crosscutting category outlining major elements of the agency requests. The requests will be compared to the discretionary and entitlement caps and other budget limits. After consulting with agency staff on the composition of the request, OMB PADS will make recommendations to the Director in a series of meetings.

5. PRESIDENT/NEC/DPC REVIEWS OF MAJOR ISSUES.....	11/15 to 12/17
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All major budget issues will be presented to the President. OMB will develop an agenda for these meetings, working with the NEC and DPC. Funding for the President's investment initiatives will be highlighted, and as with Director's reviews, the agency requests will be reviewed for compliance with the Budget Enforcement Act and other restraints. The President's decisions will be communicated to the agencies as soon as they are final.

6. ECONOMIC ASSUMPTIONS RELEASED TO AGENCIES.....12/3

The detailed information in the agency requests is based on mid-session review economic assumptions. These assumptions will be revised for the 1995 budget. For internal decisionmaking, OMB will make adjustments to recognize the approximate effects of alternative economic assumptions on the budget. For production of budget information for public release, agencies need as much lead time as feasible to translate revised economic assumptions into the thousands of data records that will support the public budget document. The work traditionally begins about the same time final decisions are being made on the budget elements.

7. DRAFTING OF BUDGET DOCUMENT -- DEVELOPMENT OF DETAILED DATA BASE FOR PUBLIC CONSUMPTION..... COMPLETED BY MID-JANUARY

Budget decisions will be translated into a newly redesigned four-volume budget. The budget will be a combination of the broad justification of the February Vision document and the detailed materials from the more technical April document. The budget sections outlining the Administration's program will be circulated and cleared for public release beginning shortly after decisions are made.

At the same time, agencies will be developing the detailed data base supporting the budget. OMB staff will review the data for consistency with Presidential decisions, and compliance with BEA discretionary caps, pay-as-you-go limits and the entitlement caps. The data that supports the production process is far more detailed than the information used for internal decisionmaking.

8. PRODUCTION OF BUDGET DOCUMENT..... TRANSMITTAL ON 2/7/94

Once the work of drafting the text is completed and the thousands of elements of data are "locked", the materials will be turned over to the Government Printing Office for final printing and transmittal to the Congress and the Public.

FY 1995 BUDGET PLANNING by Cross Cutting Categories

plans/95
3/95

Objectives

Economic Growth

- o R&D, Technology & Science - Peroff
- o Infrastructure Investment - Schwartz
- o Human Capital (Education & Training) - Selfridge
- o Business Development - Ryder
- o Rural & Urban Development & Investment - Ryder
- o Adjusting to Economic Change - Meyers
- o Export Promotion - DuSault

Promoting Individual Independence & Responsibility

- o Welfare Related Programs - Selfridge
- o Individual Empowerment Programs - Selfridge
- o Investing in Children - Selfridge
- o Drug-Free and Safe Communities - Schwartz
- o Homelessness & Social Services - Ryder
- o Consumer Protection - Selfridge

Environment and Natural Resources Management

- o Federal Land Management - Cogswell
- o Infrastructure and Resource Enhancement - Cogswell
- o R&D & Technology - Peroff
- o Pollution Prevention & Regulation - Cogswell
- o Facility/Site Cleanup - Peroff

Health - Kleinberg

National Security

- o Defense - Gassaman
- o Peacekeeping - Gassaman
- o Developmental Assistance - DuSault

Other (to be arrayed by function) - Dams -

Memorandum: Separate Papers to be prepared by DPC on Native Americans, Homeless and Immigration.

NATIONAL HEALTH SECURITY ACT: CONSIDERATION FOR HIV/AIDS CARE

An estimated one million people are infected with HIV in the United States. While the epidemic has continued to affect the gay community, it is also increasing disproportionately among heterosexuals, persons of color, women, and adolescents. Providing comprehensive health and prevention services for populations at risk is essential, and will be accomplished under health care reform.

- First and foremost, the guarantee of comprehensive health coverage with no lifetime limits will provide Americans with serious, chronic disease the security of knowing that their medical needs will always be met. Some particular areas of importance for AIDS patients included in the benefit package are coverage for prescription drugs, home-care, long-term care, and reasonable limits on how much patients can be required to spend out-of-pocket each year.
- Persons with HIV or AIDS will always be able to buy this universal coverage at any time and at the same community rates paid by everyone else within a health alliance. There will be no pre-existing condition exclusions, and the amount of premiums paid by individuals will not be based on their health status.

In many ways, the way AIDS and other serious chronic diseases will be accommodated will demonstrate the National Health Security system's flexibility in treatment decisions, and in portability within the larger health care system.

The National Health Security program will build on the existing structure and spirit of Ryan White programs for high HIV prevalence cities and states, and community-based clinics. Outpatient care, prevention, and treatment of substance abusers, and specialty sites developed for the HIV-infected community will be expanded.

- The National Health Security Act does not pretend that health reform alone will provide all that AIDS patients require. The proposal includes expanded funding for research, education, and prevention efforts related to the spread of HIV and continued funding for the Ryan White Care Act.
- Providing quality care for AIDS patients requires a complex mix of primary care and specialized services, with the capacity to respond quickly and with flexibility to emerging medical developments.
- AIDS is infectious, and people living with the HIV virus or AIDS frequently develop other infectious diseases such as tuberculosis. The clinical treatment of AIDS encompasses several important public health objectives, chief among them the need to refer infected individuals into care programs as early as possible. The Public Health Initiatives component of the health care reform will devote new resources to these purposes.
- The National Health Security Act's public health initiatives will build new capacities and strengthen the core public health functions throughout the nation, enabling communities to reduce the spread of the HIV epidemic.

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

September 17, 1993

REMARKS BY THE PRESIDENT
TO DOCTORS, NURSES, AND SOCIAL WORKERS

Children's National Medical Center
Washington, D.C.

10:20 A.M. EDT

THE PRESIDENT: Thank you. Well, Dr. Beard, I promise to free you of the paperwork if you will promise not to use your free time to run for president. (Laughter and applause.)

Mr. Brown and Ms. Frieberg, Dr. Beard, to all of you who helped to make our visit here so wonderful today. I want to thank this Children's Hospital for bringing us together this morning, for giving us a chance to see some of your patients and their parents and their friends, and to witness the miracles you are working.

I want to thank Ben Bradley and Sally Quinn for calling Al and me and telling us to hustle more money for the hospital. (Applause.)

In my former life, when I was a governor, my wife and I worked very hard for the Arkansas Children's Hospital. Some of you know it's one of the 10 biggest hospitals in the country, and every year we finished first or second in the telethon, even though we come from a small state. There's a lot of grass-roots support for people who are doing what you're doing.

We built a tertiary care nursery at our hospital with state funds for -- the first time anything like that had been done. And I have spent countless hours in our Children's Hospital at home with my own daughter, with the children of my friends. Sometimes their last day, sometimes their best day. And I am profoundly grateful to you.

I think the people in the press and maybe some others might have wondered today why in the wide world we would come to a children's hospital, with all of its gripping, wonderful, personal stories, to have an event about bureaucracy and paperwork. After you listen to a nurse say why she couldn't care for a sick child, and a doctor plead for more time to be a doctor, maybe you know. There is an intensely human element behind the need to reform the system we have.

When we were upstairs and Dr. Grizzard and Ms. Mann were showing us some forms, we looked at four case files that they said had \$14,000 worth of work in them that were absolutely unrelated to the care of the patient. The doctor said he estimated that each doctor practicing in this hospital, 200 in total, spent enough time on paperwork unrelated to patient care every year to see another 500 patients for primary preventive care -- times 200. You don't have to be a mathematical genius to figure out that's another 10,000 kids who could have been cared for, whose lives could be better.

People say to me, how in the world do you expect to finance universal coverage and cut Medicare and Medicaid? Let me say, first of all, nobody's talking about cutting Medicare and Medicaid, we're talking about whether it doesn't need to increase at 16 percent or 12 percent or 15 percent a year anymore. And it

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wouldn't if we had some simplification so people could spend the time they have already got on this Earth doing what they were trained to do.

I've got a friend who is a doctor that I grew up with who happens to live in the area, who calls me about once every three months to tell me another horror story. And the other day, he called me and he said, "You had better hurry up and get this done." He said, "You know, I'm in practice with this other guy. We've got all of these people doing paperwork. Now we've hired somebody who doesn't even fill out any forms. She spends all day on the telephone beating up on the insurance companies to pay for the forms we've already sent in. We actually had to hire somebody to do nothing but call on the phone." He said, "I'm lost in a funhouse here." (Laughter.) He said, "I went to medical school to try to practice medicine. Now I've got to hire somebody who does nothing but call people on the phone to pay the bills they're supposed to pay, after I've spent all this time filling out these forms?"

People complain about doctor fees going up. I'll give you one interesting statistic. In 1980, the average physician in America took home 75 percent of the revenues that were generated in a clinic. By 1990, that number had dropped from \$.75 on the dollar to \$.52. Where did the rest of it go? Right there. Most of it went to forms.

Now, you know, when we were up in that medical records room, we saw all these forms. We knew that by the time they -- we were told that by the time the room was done the room was already too small because the paper kept coming faster than you could make space for it in this hospital. A lot of you are nodding about that. (Laughter.) Now they have records flowing on into a room that is beneath us in the garage, and these files are still growing at the rate of 6.5 feet a week.

We know, of course, from what Dr. Beard and Ms. Frieberg said that that's just some of the story. There are departments in this hospital that spend all their time trying to satisfy hundreds of different insurers. There are 1,500 in America, by the way; no other country has that many. This hospital I think deals with over 300. Each of them want a slightly different piece of information and in slightly different way, so that even if you try to have a uniform form it's not uniform by the time you finish customizing it.

How did this happen? Hospitals like this one treat people who are most vulnerable, weak, ailing and in pain. To make sure that sick patients were getting the best care, government regulators and private insurers created rules and regulations, and with them came forms to make sure you were following the rules and regulations. To make sure doctors and nurses then didn't see the patients that were getting the best care too often, keep them in the hospital too long, or charge them too much, there were more rules and regulations, and along with them, more forms.

As more and more insurance agencies and private companies got into the business of selling health insurance -- and as I said, there are now more than 1,500 insurers in this country; no other country in the world has anything like that many -- each of them had their own forms and their own different list of what they would cover.

And so what are you left with? Instead of all this paper and all these medical forms assuring that the rules are followed and people get healthy, we're stuck in a system where we're ruled by the forms and have less time to make children and adults healthy.

When doctors and nurses are forced to write out the same information six different times in seven different ways just to satisfy some distant company or agency, it wastes their time and patients' money and, in the end, undermines the integrity of a system that leaves you spending more and carrying for fewer people.

Just think about the patients. I don't know if you've read the stories in the morning paper about the people we invited to the Rose Garden at the White House yesterday. We invited about 100 people and let -- who had written us letters. We let 15 of them read their letters. They are part of the 700,000 letters that my wife and her group have received since we started this health care project. And they were all saying more or less the same thing: we want coverage, we don't want to be locked into our jobs, preexisting conditions shouldn't bankrupt families.

But there was one gentleman there from Florida, Jim Heffernan, who told us that he is a retiree on Medicare who spends his time working in hospice programs with people who are much sicker than he is. And he talked about how all the regulations, the reimbursement forms, all the complexities sap the energy and the morale and the vitality of the people that he was trying to help. He describes mountains of paperwork that older Americans face. He told how he now volunteers his time helping these patients to decipher their forms instead of helping them to feel better about their lives and think of something interesting to do every day to make every day count.

The biggest problem with all this, of course, is the waste and inefficiency. We spend more than \$.20 of every health care dollar on paperwork. And after about four years of studying this system, long before I even thought of running for President, I got interested in this at home, and I've tried to honestly compare our system with systems in other countries. And it appears to me that we spend about a dime on the dollar more than any other country in the world on bureaucracy and paperwork.

In a medical system that costs \$880 billion, you don't have to be a mathematical genius to figure out what that is. What could we do in this country with that money? How many people could we cover? How many things could we do? How much more preventive care could we do to lower the long-term cost of the system? How many more children could we care for?

In the last 10 years, our medical providers have been hiring clerical help at four times the rate of direct health care providers. That is a stunning statistic. They spend resources that should go into care on other things.

What we want to do with this health security plan is to do away with all of that, to streamline the rules, reduce the paperwork, make the system make sense and do nothing to interfere with the private delivery of care system that we have now. And we believe we can do it. We think we can do away with the different claims forms, with all the confusing policies, and put the responsibility for measuring quality where it belongs -- with you on the front lines and not with examiners that work for government or the insurance company thousands of miles away.

Here's how we propose to do it. First, we want to create a single claim form -- one piece of paper that everyone will use and all plans will accept. We've already started moving in this direction now. There are some standard forms used by Medicare and others that are aimed at cutting back on all this craziness. But as you know here at Children's, a single form is no good if every insurer uses it differently. You might as well have different forms.

So we will now introduce a single form which we have a prototype of here today. I've got one here or you can see one here. A single form which would go to every hospital, every doctor's office in the country, which would deal with the basic benefits package and which would replace that -- and worse. Think of what that will do. Think of how many hours it will free up for all of you. (Applause.)

Now, when we do this, that won't be enough. We'll have to standardize how the forms are used -- building on what has been done in other contexts in private industry, building on what we know from the professional associations in health care. We'll ask doctors and nurses and health care plans to decide together on what information absolutely has to be given to guarantee the highest quality and most cost-effective care.

Secondly, in order to make this form work, we'll have to create a single comprehensive benefit package for all Americans. We'll allow consumers of the health care -- the employees and others in our country -- to make some choices between the packages. But it will essentially be one comprehensive package. No longer will hospitals and doctors have to keep track of thousands of different policies. No longer will they have to chase down who has which insurance and what's covered under what circumstances. If it's covered, it's covered no matter who you are or what plan you're in, no matter whether you have a job or whether you don't. It will simply be covered.

It will simplify your life. And it will also provide security to the American people who worry that if they switch jobs, they'll lose their health care coverage or it will be so different it will take them six months to figure out what's covered and what isn't. They won't have to know -- the American people won't -- enough jargon to fill a phone book just to come down here and see you. It will mean that more of the money we all pay for health care will go for health care and not bureaucracy.

And finally, the government will try as hard as we can -- and I say that because I've found as President I have to work extra hard to change the culture of the government when I want to get something done. But our rules are going to be that we are going to rebuild the trust between doctors and hospitals and patients and the government that is funding some, but by no means all, of the health care.

Federal programs, let's face it, are a big part of the paperwork problem. We will simplify and streamline Medicare reimbursement and claims processes, and we'll refocus clinical laboratory regulations to emphasize quality protection. And we will reduce a lot of the unnecessary administrative burden that the national government has put on them now.

If we do this right, those of you on the front lines will spend less time and money meeting the paperwork requirements, and more time and energy treating patients. You'll face fewer crazy rules and regulations, worry less about which insurers cover what, have better tools and information to help actually protect people and promote quality, rather than constantly having to prove you've done nothing wrong.

You'll hear a lot more about this proposal in the weeks ahead. As the debate evolves, I want to tell the people about these children, these brave children I met upstairs, about the wonderful people who are caring for them, and about how they deserve the opportunity to care more and spend less time with paper and forms.

I value what you do here at this hospital and what people like you do all over America. If the American people really knew what nurses and doctors have to go through today just to treat

people, they would be up in arms, they would be marching on Congress, demanding that we do something to solve this problem.

I hope that, by our coming here today, we have made a very real and human connection between these magnificent children and all of the wonderful people who care for them and this awful problem represented by this board up here. If we move here, it means more for them. And that's why we came here.

Thank you very much. (Applause.)

END

10:33 A.M. EDT

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

September 20, 1993

REMARKS BY THE PRESIDENT,
THE FIRST LADY,
THE VICE PRESIDENT,
MRS. GORE
AND
DR. C. EVERETT KOOP
TO PHYSICIANS AND SUPPORTERS

The East Room

8:45 A.M. EDT

MRS. CLINTON: Good morning, and thank you all -- please be seated -- for joining us. We were talking so much with Dr. Koop in the back, none of us heard our names. (Laughter.) And so that's one of the reasons we were a little bit slow getting here.

I want to welcome you to the White House. I want to thank you for coming and being part of this process that we believe will lead to the kind of reforms in our health care system that many of you have talked about, have spoken about, and have actually done in the practices you have, in the centers in which you practice, at the medical schools that you direct. And it is a particularly exciting moment for all of us to be on the brink of what we hope will be the kind of changes that will assure health security to every American and give opportunities, again, to physicians and nurses and those on the front lines of health care to make the decisions about what needs to be done for the patients in our country.

I want to acknowledge Secretary Donna Shalala who is here. (Applause.) She's not only doing an excellent job at HHS, there are some who will argue that she may be the best golfer in the administration. (Laughter.) She played with the President last weekend.

Also Dr. Joycelyn Elders, our newly confirmed Surgeon General is back there. (Applause.) I think when it comes to prevention and communicating with large groups of Americans who have not been part of the health care system but need to be for their own and their families well-being, Dr. Elders will be an extraordinary voice.

Dr. Phil Lee, the longtime advocate for -- (applause) -- for better health care for Americans. We enticed him out of his position, which I think he thought was a position he would not move from in California to come back. And I personally have been very grateful for Dr. Lee's counsel and advice throughout this process.

Ira Magaziner, Dr. Judy Feder, others who are here. Judy and Ira, if you would stand. (Applause.) The team that they have put together, thanks to many of your institutions, which as several of the deans of the medical schools have told me, have meant you've lost people for long periods of time to be part of this process. We are very grateful.

I also want to thank the chairs of the Health Professions Review Group, Dr. Steve Gleason and Dr. Irwin Redlener, if you would stand please. (Applause.)

MORE

And there are many others who are in this room who have been such great helps to us and will continue to be as we move forward. I'm particularly pleased that an old friend of mine, Dr. Terry Brazelton would be here. Dr. Brazelton, who gives the kind of -- (applause) -- gives the kind of confidence to young mothers that Dr. Spock used to give to mine and that many of you have given. And we're very grateful for that.

We want to spend a few minutes this morning talking about where we go and how we get there and how we hope all of you will be involved in this process. And I would like to introduce the Vice President to say a few words about the way this relates to what we're doing across the board in the administration.

Vice President Al Gore. (Applause.)

THE VICE PRESIDENT: Thank you very much. Distinguished guests, ladies and gentlemen. I want to thank the First Lady for her introduction and leadership in this whole initiative. This is the week that was, as they say. And it's wonderful to see so many physicians who are here and who are so strongly supportive of the President's efforts to reform our health care system.

I might say that it's a special honor to be with Dr. Koop. I look forward to his comments later. He and I had a chance to work together on a number of projects in the last several years. And it is always refreshing to hear his views.

It's very interesting to take stock of how much things have changed in so short a period of time. The debate on health care is now dominating our national debate about where we go as a country. No one any longer doubts that we are going to reform our nation's health care system. Now the debate is about exactly how and what kinds of changes. It's very refreshing.

I heard kind of a throwback in the last couple of days from someone who is resisting change who made a point that I haven't heard in quite a while. He said, we have the finest health care system in the world. And in many ways, of course we do. But he said, we have to resist tinkering with it because it's just -- it's great. Well, when I heard that I thought about an event last week when the President and I went over to Children's Hospital. The First Lady was out at Mayo Clinic and leading a number of events in Minnesota that day. Tipper was talking with mental health care groups. The President and I went over to Children's Hospital and talked with doctors and nurses there about the current system and what it means to them just in terms of the sheer paperwork and bureaucracy and red tape.

As is often the case when a big change comes, people suddenly realize they have not allowed themselves to feel the weight of how bad things were until they can see the hope for change. Well, that's the message that we heard over there, as these doctors and nurses were saying. Since we sat down and really measured this, we didn't realize what we were doing. One patient comes in here under Medicare, and we have to fill out 26 different forms for that one patient.

We went to the file room, the stack of paperwork is growing six and a half feet per day -- just in one hospital. And one doctor said that in adding up the amount of time that he spent on paperwork, he could have seen an extra 500 patients per week -- I believe it was per week -- per year, I'm sorry. (Laughter.) I don't want to get carried away with this. No, I don't think it was per year. I think it was more than one per day.

MRS. CLINTON: It was one and a half per day.

THE VICE PRESIDENT: In any event, it was a lot. (Laughter and applause.) The main point is, the paperwork and the red tape and the bureaucracy is so overwhelming, when people now finally let themselves look at it and realize what they've been doing -- now, I believe I've got this statistic right. A pediatrician said that she was spending 25 hours -- believe it or not -- 25 hours per week just filling out forms for her patients. Is that right? Okay. (Laughter.) The heads are nodding yes on that one. (Laughter.) Well, that's crazy.

And we have been in the midst of this effort to reinvent government and we've been spotlighting the ways in which the system is very inefficient across the board. And there are so many similarities between what needs to be done government-wide and what needs to be done in the health care system.

This new approach is going to be simple -- one form per patient. It is going to be effective. It is going to extend health care coverage. And it's going to eliminate the waste and inefficiency. And we are all very excited about it and very pleased that you are here to help start this important week. Thank you. (Applause.)

MRS. CLINTON: I also now want to introduce someone who has been deeply involved in this. I know that there are representatives here from the American Psychiatric Association, other mental health professions, along with the APA, have worked very hard with Tipper Gore to come up with a proposal that would move our country forward on the treatment of mental health problems. And I'm very proud to introduce Tipper Gore. (Applause.)

MRS. GORE: Thank you. I want to add my voice in word of welcome to all of you and my deep gratitude for the work that you have given to the health care reform. And many of you have had direct input in the proposals on mental health. I see many people that I've worked so closely with and, as Mrs. Clinton said, when I addressed the American Psychiatric Association in the spring, it was really a wonderful event in which there was a meeting of the minds about the direction in which health care reform should go and the place that mental health care should have in it.

And I'm very proud to say that within this administration mental health, which has long been discriminated against, has been analyzed and debated along with all the other issues right from the very beginning. And that is a very revolutionary first step.

For those of you who have worked very hard on the proposal, thank you so very much for your input and your efforts. And just know that I will continue to work with you in the years ahead to make sure that American citizens have the very best mental health care that we can give them. Thank you. (Applause.)

MRS. CLINTON: One of the goals of the next weeks as we move forward is to be sure that all of the voices of those who are most involved in delivering health care will be heard. We believe that in coming forward with a plan that reflects what we have learned from listening and meeting with many of you and thousands of people around this country who are providing care that we have really sparked what will culminate in the final reform effort. But we cannot get there without all of your involvement.

Many of you in the last months have shown us why we can do what we think we can do in this country. You have through your practices shown how costs can be contained without in any way impacting quality. You have shown us how we can fairly finance a system if everybody is in it and everybody is responsible. You have

convinced us of the importance of simplifying the system to get to the real problems that so many of you face.

We know there will be not only considerable discussion but probably even a very vigorous one in all kinds of settings around our country. And we welcome that, because we believe that this is an issue on which there are so many things to learn. And although we've tried to get it right, we are still getting it right.

As the Vice President said, I was in Minnesota on Friday talking with people from the university, from Mayo who have very specific suggestions about how to make it even better, which we are bringing back and incorporating.

In order to be sure that we continue to get that kind of involvement and feedback from the medical profession, we have scheduled a series of forums across the country that will bring together doctors and other local and national health care leaders to discuss various aspects of reform. It is our hope that these forums will serve as sounding boards for doctors who want to share their ideas about change, and as classrooms for ordinary citizens who want to learn more about our health care system.

We are starting at two different levels at one time. There are many, not only those in this room but in other positions around our country, who know a great deal about how the health care system works and how it could be reformed to work better.

There are others who are just beginning to focus their minds and attention on this. We want to be sure that the debate is as well informed as possible, because we believe that a well-informed debate will lead to the right solution for America.

It is our good fortune that Dr. C. Everett Koop has agreed to lead these panel discussions. He is one of the most thoughtful, courageous and independent health care leaders in the nation. During almost a decade as our nation's Surgeon General, he moved every American with his powerful messages about the AIDS crisis, the perils of smoking, and the murderous plague of urban violence.

For many years, Dr. Koop has campaigned to reform the health care system. He has been an passionate advocate of primary and preventive care, of universal coverage and cost containment. He has helped foster a new philosophy of medical education that emphasizes better communications between doctors and patients. And always he has stirred the consciences of all Americans by prodding each of us to be more responsible for our own health.

Dr. Koop's unwavering dedicating to improving our individual and collective health makes him uniquely qualified to moderate a national health care discussion in the months ahead. The work that he is doing at Dartmouth -- the work that demonstrates that very often there is no difference in quality between a coronary bypass priced at \$20,000 and a coronary bypass priced at \$80,000; the work that he is doing with courageous and forward-thinking leaders around our country who are already keeping costs below inflation without sacrificing one bit of patient care; the kind of work that he and his colleague, Dr. Wennberg, who is here, are doing to show that better allocation of our resources will result in no diminution of quality, but in fact, better quality in many instances because more people will be brought into the system in a more cost-effective, quality-driven way.

It was certainly influential to all of us, as we began to look for the kind of data that supports the sort of things and feelings and attitudes that many of you have expressed based on your own practice. If we can indeed take the physicians at Children's

Hospital and relieve from them the Medicaid paperwork that is not related to patients records so that they could fulfill the promise that they made to themselves in front of the President and the Vice President, that for those 200 doctors on staff, each could then see approximately 500 more patients, that would be 10,000 more children just in Washington, DC, who could be taken care of. That's the promise of health care reform. And that is the hope we bring to this national discussion with all of you and why we're so pleased that Dr. Koop has been willing to take this leadership role.

Dr. C. Everett Koop. (Applause.)

DR. KOOP: Thank you very much. I know when people come to Washington, even sophisticated physicians, they like to go home having picked up some inside information. I'll let you in on a conversation that took place about two years ago when that grand old gentleman Claude Pepper died and went directly to heaven. He had an audience with God and said, sir, just one question. Will there ever be health care reform in the United States? And the Lord answered and said, yes, Senator, there will be health care reform in the United States. That's the good news. The bad news -- not in my lifetime. (Laughter.)

Since I left office as your Surgeon General four years ago, I have really dedicated most of my time and energy to speaking out whenever and wherever I could all across the United States on the need for health care reform. At first mine seemed like a lonely voice out there. But now at long last, health care reform has moved to the top of the national agenda. And I thank President Clinton and the American people for placing it there.

A few weeks ago, I told the President that without passing a single law or issuing a single regulation, he had accomplished more in health care reform in the past four months than all of his living predecessors put together. (Applause.) And he did that with a special kind of leadership that is willing to take on an enormous task. This kind of leadership also takes courage because it's a daunting task to face runaway health care costs, the vexing issue of universal access, the malpractice mess, the mounting problems of Medicare and Medicaid, the application of outcomes research, a sweeping reassessment of medical ethics, to say nothing of rooting out fraud and waste and abuse and greed.

Like many of our big national problems, the health care crisis in America is a very complicated one. And that means it will call for a variety of solutions. They, of course, will be national, but that means regional and local. They will have to be a public-private partnership. And there is a way in which every citizen must make a personal contribution.

But the President knows that there is no panacea, there is no single magic bullet, and there are no easy answers, only a series of very difficult choices. The administration's health care reform initiative is comprehensive, it's complex, it's -- well, it's complicated. And that's because it is offered in the spirit of compromise.

President Clinton has told me that he views these health care proposals not as a take it or leave it package, but as what they are -- proposals -- proposals that will lead to constructive debate and not just to constructive debate but then to constructive legislation. Some things, like universal access, are not negotiable. And that's exactly the way it should be. (Applause.) But they are proposals offered in trust that an honest congressional and public debate will bring out the best in health care reform for the American people.

Now, I don't imagine that any one of us will agree with everything, every single point in the proposed reforms. I imagine the President has his own reservation about some points.

When I read the first draft of the plan, I was impressed with the attention that had been given to detail: present situations that should be eliminated, needed additions that would be made. I was supportive of the plan, even if there was specific issues with which I disagreed.

Later, I was also pleased that suggestions I made in a critique of the plan did not fall on deaf ears. Whether there are pieces of the administration's health plan that you don't like or not, we have to move forward with dialogue seeking consensus. But our reservations, or even outright objections, to some provisions cannot give us the excuse to oppose everything.

My concerns about some issues will not stop me from fighting for the many reforms the American health care system so desperately needs. And I hope you'll approach the reform proposals in exactly that same spirit. It is in this spirit of dialogue and constructive debate that I have agreed, as the First Lady said, to moderate a dialogue between the medical profession and the administration a series of panel discussions scheduled this fall and winter in a number of cities across America.

Now, these forums could, for example, combine the views and expertise of national health care figures with those of local physicians and other health care workers so they can, together, thrash out the issues of the reform proposals before the profession as they relate to a local region.

Physicians have been noticeably absent from past efforts to reform the American health care system, even when it turned out that physicians proved to be among the major beneficiaries, as with Medicare. Indeed, all too often, past health care reform measures have been imposed upon physicians, often against their loudly voiced opposition. This time, doctors cannot allow themselves to be cast in the role of naysayers.

In one way or another, doctors' decisions for their patients and themselves drive the entire health care system. And, therefore, I call upon the medical profession in which I have served for over half a century to assume its rightful position of leadership to drive the health care system to the reformed excellence that it can deliver. (Applause.)

Our health care system may function with compassion, with competence, at times with sheer excellence. But not for enough Americans. For too many Americans, our health care system is a tyranny, and that means for them it is more a curse than it is a blessing. The next decade will force us to do some very hard thinking and deciding about the basic purpose of medicine. We haven't done much of that in days gone by. For most of human history, medicine really couldn't do very much, really couldn't cure anything. And so, at best, it offered some comfort, some relief of symptoms.

And, then, beginning in the 18th century -- and remember that modern medicine and the United States are about the same age -- with the application of science and technology to medicine, we saw the age when medicine could begin to cure many problems, and it could prolong the life for millions of people. And we entered the age of what we now call "our medical miracles." But a still other age may be dawning as we come to grips with the limits of curative and reparative medicine and surgery.

Today, in a strange way, hospitals and doctors -- in fact, the entire health care community -- are victims of their own success in curing disease and alleviating suffering. Increasingly, medicine decreases mortality while it increases morbidity. In other words, we have many more people living longer, but some of them are living sicker. And an increasing share of health care resources are allotted to those whom medicine cannot cure and we know about that at the start.

Too much, however, of the intensifying debate about health care focuses only on questions of how we finance it on the economic and political dimensions of health care reform. I think, for many of us, this puts the cart before the horse. More important, I think, than the economic and political pressures is the ethical imperative for health care reform.

Before we can enact the sweeping reform we need in health care, we must agree on the basic values and the ethics upon which our health care system, and, indeed, our society is based, and from which it draws its moral power.

If we could reach an ethical consensus, I think many of the economic and political problems of health care reform would fall rather easily in line. Physicians and allied health workers bring a broad field of vision to the health care reform effort. Physicians and nurses, other health care workers, have seen firsthand their fellow citizens' lack of health insurance go from being just an economic inconvenience to now being a medical risk factor.

Health workers know from experience that uninsured Americans are sicker than other patients when they finally enter the health care system, and their illnesses cost the system more to treat. And their lack of insurance results in a higher mortality rate than that of hospitalized Americans who do enjoy adequate health insurance.

Health care workers have also often seen patchwork efforts at cost control result merely in cost-shifting -- squeezing the balloon in one place, only to have it expand in another.

I would suggest that you in this room can bring your experience and expertise to the debate on health care reform so that we can preserve what is right and correct what is wrong. In so many ways, the American health care system, in spite of its many flaws, offers the best health care in the world. Nevertheless, we must remember if it ain't broke, don't fix it; but, unfortunately, an increasingly large share of our system is breaking down. So let's be sure that we turn our attention to ways that we can fix that.

And so I do call up on the medical community to approach the health care reform proposals now being offered in the spirit of our high calling in the Hippocratic tradition that requires us to do nothing but the best for our patients. Let us make sure that physicians play their part in making sure that the health care system we reform offers the very best for the American people. The President has said he wants a dialogue. Let us accommodate him in the spirit of reform and of give-and-take.

Physicians are individualists to be sure, but they are also altruists. And we have come to a time when, for once, the medical profession and the government can work together to forge a health care system for all Americans by achieving a new American consensus. Let me reaffirm that I think the plan is headed and moving in the right direction. I look forward to lending my support as I moderate the forthcoming dialogue between the great profession of medicine and this administration. Thank you. (Applause.)

THE PRESIDENT: Good morning. I thank you for coming here, and I thank Dr. Koop for his stirring remarks. He always makes a lot of sense, doesn't he. And the nation is in his debt for his work as Surgeon General and now, for the work he is about to undertake in behalf of the cause of health care reform.

I also want to thank the many physicians from all across America, from all walks of medical life who have made a contribution to the debate as it has progressed thus far. I got very interested in this subject years ago when, as the governor of my state, I noticed I kept spending more and more for the same Medicaid and had less and less to spend on the education of our children or on preventive practices or other things which might make a profound difference in the future.

In 1990 I agreed to undertake a task force for the National Governors Association, and I started by interviewing 900 people in my state who were involved in the delivery of medical care, including several hundred doctors. Some of them are in this room today. I thank them for their contribution, and I absolve them of anything I do which is unpopular with the rest of you. (Laughter.)

I'm glad to see my dear friend and often my daughter's doctor, Dr. Betty Lowe, the incoming President of the American Academy of Pediatrics. (Applause.) My cardiologist, Dr. Drew Kumpuris, who pulls me off a treadmill once a year and tells me I'm trying to be 25 when I'm not. (Laughter.) And Dr. Morris Henry from Fayetteville, Arkansas, back here, an ophthalmologist who hosted the wedding reception that Hillary and I had in Morris and Anne's home almost 18 years ago next month. Dr. Jim Weber, formerly President of the Arkansas Medical Society. A lot of our doctors here -- we started a conversation with doctors long before I ever thought of running for President, much less knew I would have an opportunity to do this.

This is really an historic opportunity. It is terribly important for me. One of the central reasons that I ran for President of the United States was to try to resolve this issue, because I see this at the core of our absolute imperative in this sweeping time of change to both give the American people a greater sense of security in the health care that they have, and call forth from our people -- all of our people, including the consumers of health care -- a renewed sense of responsibility for doing what we all ought to do to make this country work again.

I am determined to pursue this in a completely bipartisan fashion. And I have reached out to both Republicans and Democrats, as well as the thoughtful Independents to help. There is one person in the audience I want to introduce, a longtime friend of mine who has agreed to help mobilize support for this approach among the Democrats of the country, the distinguished former governor of Ohio, my friend Dick Celeste, who's here. Thank you for being here. (Applause.)

When Dr. Koop talked about the ethical basis of this endeavour, he made perhaps the most important point. If I have learned anything in all these years of public endeavors, or anything in the last several months of serving as your President, it is that once people decide to do something they can figure out how to do it.

When, one week ago today, on the South Lawn of the White House, Yitzhak Rabin and Yassar Arafat signed that peace accord, they did not even know what the ultimate map drawing of the city of Jericho would be, or how all the elections would be held, or how the Palestinians candidates would advertise on the radio since the radio stations don't belong to the Palestinians -- I could give you a hundred things they did not know the answer to. They knew one thing,

they couldn't keep going in the direction they were going and so they decided to take a different direction.

When President Kennedy's administration challenged this country to go to the moon, they didn't have a clue about how they were going to go. The Vice President knows more about science than I, so he can tell it in a funnier way about they didn't understand what kind of rocket they were going on and what their uniforms would be like and on and on and on. But the ethical imperative is perhaps the most important thing. We have to decide that the costs, not just the financial costs, but the human costs, the social costs of all of us continuing to conduct ourselves within the framework in which we are now operating is far higher than the risk of responsible change.

We have certainly tried to do this in a responsible way. I want to thank the First Lady and all the people who work with her. I want to thank Tipper and Ira and Judy and everybody who was involved in this. We have really worked hard to reach out to literally to thousands and thousands of people in this great medical drama that unfolds in America every day.

I want to thank Donna Shalala and the Department of Human Services for the terrific work they have done. We have really tried to do this in an embracing and a different way -- almost a nonpolitical way. If you look around this room we have doctors from Maine to Washington, from Minnesota to Florida, some of you see patients in rural Virginia, some in public hospitals, others of you devote your lives to training the next generation of physicians.

But I think everyone of you is committed to seeing that we provide the finest health care in the world. That means that as we undertake this journey of change, we clearly must preserve what's right with our health care system -- the close patient-doctor relationship, the best doctors and nurses, the best academic research, the best advance technology in the world. We can do that and still fix what's wrong. In fact, we can enhance what's right by fixing what's wrong.

If we reduce the amount of unnecessary paperwork and governmental regulation and bureaucracy, that will by definition enhance the doctor-patient relationship. If we spend less money on paying more for the same health care and the incentives to churn the system, we will have some more money, for example, to invest more in medical research and advanced technology and breaking down the barriers which still limit our ability to solve the remaining problems before us.

We need a discussion, we need constructive criticism, we need constructive disagreement on some points. This is a very complex issue.

I worked at this for over a year and realized when I was a governor I was just beginning to come to grips with it. When we started this great enterprise and I asked Hillary to undertake this task and she looked at me as if I had slipped a gasket -- (laughter) -- I knew more about it than she did. Now, she knows a lot more about it than I do.

This is a learning effort. We are going to start today, as many of you know, this health care university we call it for members of Congress, and about 400 members of Congress have signed up for two intensive days of learning. That is an astonishing thing. I have never seen anything like it. These members, without regard to their party and completely without respect to the committees they are on, since most of them are on committees that would not have direct jurisdiction over this -- hungering to know what you go through everyday. Hungering to learn, wanting to avoid making an irresponsible decision but determined that they should make some

decisions to change this system. I think that is a terrific cause for hope.

For patients, the reform we seek will mean more choices. Today employers are too often forced by rising health care costs to decide which plans to offer their employees, and often they are inadequate, or too costly. The decision is usually based on the bottom line and is a moving bottom line as more and more Americans every month actually lose their health insurance for good. Our plans give consumers the power to choose between a broad range of plans within their region, giving them more freedom to find and to stay with a doctor they like.

For doctors, reform will mean the flexibility to choose which networks or providers you want to join. If you want to be involved with one, that's fine. If you want to be involved with more than one, that's fine, so that whatever you want to do to continue to see the patients you see today, you will be able to do it -- it's your choice.

We intend to see a reform that drastically simplifies this system, freeing you from paperwork and bureaucratic nightmares that have already been well discussed.

I cannot tell you how moved I was when we were at the Washington Children's Hospital the other day and we heard not only the statistics that the hospital has calculated that they spend \$2 million a year on paperwork unrelated to patient care and keeping up with the procedures. But the human stories -- I mean, we had a nurse actually tell us about being pleaded with by a young child with cancer to play with the child, and she couldn't do it because she had to go to a little seminar on how to learn how to fill out a new set of forms that they were being confronted with. And she said, that really was a picture of what their life was like -- an eloquent doctor who said she wanted to live in Washington, D.C., she wanted to care for the poor children in the area. She did not go to medical school to spend her life pouring over a piece of paper. And all of you have had that experience.

We can do better than this. We also know we're going to have to trim back government regulations that get in your way and do little to protect the patients or provide better care. If we simplify the system, we will reduce the apparently insatiable bureaucratic urge that runs through administrations of both parties and seems to be a permanent fixture of our national life to micromanage whatever aspect of tax dollars they have some jurisdiction over. We are determined to undo much of that. We want to respect your training, your judgment and your knowledge, and not unduly interfere with what you do.

We also are determined to preserve the quality of health care that our people receive. Today, part of the reason we have the finest doctors in the world are the academic health centers. For years they have been the guardians, the guarantors, of quality -- training doctors and health care professionals and reaching into surrounding communities to provide help for those in need.

In the coming years, these centers, if our plan passes, will have even greater responsibility to turn out high quality physicians, particularly primary care physicians who will work in underserved areas, and to create a system of lifelong learning for health care professionals. And they must continue to expand their partnerships with communities around them.

The initiative I am offering offers the possibility of giving real building blocks to this nation's health care system to fill in a lot of the gaps which exist for millions of Americans --

not just universal coverage gaps, but also organizational problems and the lack of adequate access.

I want this plan to be fair, compassionate and realistic, and I believe it is. Health security can be provided to the American people so that you don't lose your health care when you lose your job; you don't get frozen into a job because someone in your family has been sick and you're in the grip of the preexisting condition syndrome, which is literally undermining labor mobility in a world where the average 18-year-old American must change work eight times in a lifetime to be fully competitive. When security means the ability to continuously learn and find new and evermore challenging work, not to stick in the same rut you're in anymore, we don't have that option. We are literally rendering people insecure through job lock -- undermining their potential, keeping them from moving on, and also keeping others from moving up into the positions they previously held. This is a serious economic problem.

This plan will guarantee that every patient who walks in your door is covered. It will make sure you are paid to keep your patients healthy as well as to treat them when they're sick. It will give you the flexibility and freedom you need to do your jobs. In return, it must demand more responsibility from all of us. We must have a new generation of doctors which has a recommitment to primary care. We don't have enough primary care physicians in America, and I think we all know it. We have to care about family practice, pediatrics and preventive medicine. And we all have to work together to get medical costs under control.

But I'm convinced with your leadership we can do that. Without your help, we could not have covered as much ground as we have covered so far. I thank Dr. Koop for what he said. But the attention to detail by this project is the direct result of the painstaking effort and the hours that have been provided by physicians and other health care providers who have come to this town and spent day after day after day almost always at their own expense just to do something to help their country as well as to improve the quality of their own practice. We know that this will not be done overnight. We know that we will have to have a long-term commitment from individuals, from government, from businesses and from health care professionals. But we know that we have to begin now. This is a magic moment.

Let me just say two things in closing. There are a lot of other things we haven't discussed, and I know that, but we didn't come here for a seminar on the details of it. We are trying some innovative approaches to the malpractice problem, which I think will find broad favor. We are going to do some things that will increase public health clinics' ability to access people who are otherwise left out of the system, and try to deal with these horrible statistics on immunization and the absence of prenatal care. There are a lot of those things that are going to be dealt with.

But I want to make two points in closing. First of all, there are a lot of disconnects as you might imagine between Washington, DC, and the rest of America, which everybody loves to talk about when they get alienated from the federal government. But one of the most amazing in this has been the following thing. I don't talk to any doctor or any hospital administrator or any nurse with any seniority in nursing who doesn't believe that there's a huge amount of waste in this system that has nothing to do with caring for people which can be gotten rid of. I don't talk to anybody in Washington who thinks you can do it. (Laughter and applause.)

Our friends in the press are laughing because you know I'll finish this talk, then they'll go talk to somebody on the Hill who will say, aahh, they can't save that money in Medicare and Medicaid. It's got to be that way. We really need a room under the

garage in the Children's Hospital in Washington, DC, which is piling up paper six and a half feet a day. We've got to have that. How would we function?

Hillary goes to the Mayo Clinic; they've already got their annual average cost increases now down under 4 percent. And we talk about maybe getting it down over the next three or four years to inflation plus population plus 2 percent, and they talk about how we are slashing Medicare and Medicaid, when what we really want to do is take the same money and not take it out of health care, but use it to cover the uninsured, unemployed; use it to cover some new services to do more preventive primary health care. So this is an interesting thing that Dr. Koop said in the past, reform has been imposed on the doctors. You might have to come up here and impose it on the politicians and the bureaucrats. (Applause.) You may have to do that.

I say that not to be critical of the Congress. We are all -- all of us see the world -- (laughter) -- no, no, no -- I don't -- all of us see the world through the prism of our own experience, don't we? You do, I do -- we all do that. And they are so used to believing that the only way they can be decent stewards of the public trust, to take care of the poor on Medicaid and the elderly on Medicare. They are so used to believing that the only way they can do it is just to write out a check to pay more for the same health care, never mind of it's two or three or four times the rate of inflation; never mind if there's a 16-percent increase in the Medicaid budget for the coming year, when we estimate no more than a two-percent increase in the enrollments in Medicaid.

We're just so used to believing that in this town that we have to have your help to believe that it can be different, and you can enhance the care people get, not undermine it. I don't want to minimize that. Yes, we need your critical scrutiny of the specific plan the administration will propose. Yes, we do. But we also need for you to convince the people who live here, who believe we are trapped in this system, that it can be different. And you are the ones who have responsibility for caring for people. If you can believe it can be different, you can convince the Congress that it can be different, that they are not going to hurt, they are going to help, by making some of these changes.

The second point I want to make in closing is this: This is really a part of a great national discussion we have to have about what kind of people we are and what kind of country we're going to be. And Dr. Koop said it better than I could, but we can't really get the kind of health care system we need until there is a real renewed sense of responsibility on the part of everyone in this system. It is terribly important to recognize that we have certain group behaviors in this country that, unless they are changed, we will never get health care costs down to the level that our competitors have.

It's not just high rates of AIDS and excessive smoking; it's high rates of teen pregnancy, of low birth weight, of poor immunization of children. It's outrageous rates of violence that we willfully refuse to deal with by taking away the main cause of it, which is the unrestricted access that young people in our most violent areas have to guns that give them better weapons -- (applause.)

Yes, within the health care system, doctors shouldn't perform unnecessary procedures, patients shouldn't bring frivolous malpractice suits, people who use the health care system now, who aren't in it now, are going to have to pay a little for their health care, so they realize there is a price for everything instead of when all of the money just comes from a third party source they don't know. There needs to be more responsibility within this system, but

we also have got to remember that if we can plant the ethical roots that Dr. Koop talked about, we may then be able not only to change this system, but to use this success to try to change some of the destructive group behavior that is tearing this country apart.

But believe me, it all begins here. If we can give the security of decent health care to every American family, it will be the most important thing that the government has done with -- not for, but with -- the American people in a generation. And it can only happen if people like you lead the way.

Thank you very much. (Applause.)

MRS. CLINTON: We'd like to invite all of you now to join us for breakfast in the State Dining Room. And the President and the Vice President will be in the Red Room, and we hope people will come in and meet them. They'd like to meet all of you personally to thank you for being here. So, please, join us for breakfast.

Oh, and could I also -- we just -- I just learned Dr. Arthur Flemming is here. And talk about a reform advocate for many decades and a strong supporter of what this President is trying to do, Dr. Flemming, thank you very much. (Applause.)

* * * * *

Q Mr. President, is Senator Moynihan wrong?

THE PRESIDENT: -- you heard what he said yesterday? What he said was absolutely right. I mean, based on the experience of the last decade, you can't get the cost down to zero, but that's not what we proposed. We proposed working over a five-year period to move the government's cost to inflation plus population growth. And in the beginning -- we have inflation plus population growth plus another two or three percent. You do have -- where this group care is working well, like at the Mayo Clinic, they now are down to less than inflation plus population growth. So I believe that if you give us five years to do it, we can get there. But it will require some substantial changes.

What I said was true. People in Washington can't imagine that it can be different because of the experiences they've had over the last five years. But to say we're trying to cut Medicare and Medicaid -- it's not true. We propose never to take it below inflation plus population growth.

END

9:35 A.M. EDT

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

September 21, 1993

REMARKS BY THE PRESIDENT
IN INTERVIEW WITH RADIO TALK SHOW HOSTS

Room 450 OEOB

3:06 P.M. EDT

THE PRESIDENT: Thank you very much and welcome to the Executive Office Building and to the White House, and thank you for coming today. I -- what did you say, nice tie? (Laughter.) That's a Save the Children tie.

Q All right!

THE PRESIDENT: I wore it for the National Service signing today.

It's interesting, we just had a lunch with a number of columnists --

Q Lunch? Lunch? (Laughter.)

THE PRESIDENT: Lunch? I'm sorry, I'm sorry. Would it make you feel better if I said I didn't enjoy it? I mean -- (laughter) -- anyway, and they knew you were all here, and we had 700 or 800 people out on the lawn for the National Service signing, and 4 or 5 of these folks that have been covering Washington for 20 years said they had never seen the White House so busy. I didn't know if they were happy or sad about it, but anyway, it's busy.

I thank you for coming today. I hope this will be the first of a number of opportunities we have to provide people who have radio talk shows and who communicate with millions of Americans on an intimate basis, daily, to come to the White House to have these kinds of briefings. You've already heard all the basic approaches that the administration is going to take on health care and that will be hopefully crystallized in a compelling way in my address to the Congress and to the country tomorrow evening.

So, I thought what I would do is make a general statement about how this fits into the overall approach the administration is taking and then answer your questions. I'd rather spend time just answering your questions.

But let me just make a general comment, that I think you can -- that runs through the thread of debate that we had on the economic program, on the health care issue, on NAFTA, on the crime bill that's coming up, on the welfare reform issue, on all the major things we're trying to come to grips with.

It is now commonplace to say that we are living through a time of profound change -- not only in our country, but around the world. People are trying to come to grips with a rate and nature of change that comes along less frequently than once a generation.

You may know that just since you've been sitting here, Boris Yeltsin has dissolved the Russian Parliament and called elections for that Parliament in December, and his major opponent has apparently declared himself President. I mean, they are going

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through these things, trying to come to grips with what it means to be a democracy and what it means to try to change the economy.

In our country, if we're going to continue to be the leading power of the world, not just militarily, but economically, socially, the shining light of the world, this has to be a good place for most Americans to live. Most people have to know that if they work hard and play by the rules that they can make the changes that are sweeping through this country and the world their friends and not their enemies. They have to believe that, as citizens they can work together and trust the major institutions of our society to function well, to meet these changes, to respond to them.

We confront this bewildering array of challenges: the size of the deficit, the fact that we have an investment deficit, too, in many critical areas, the health care crisis. At a time when most people are quite insecure in their own lives and most Americans have worked harder for stagnant or lower wages for the last 10 to 20 years, when they're paying more for the basics in life, when they have lost faith in the fundamental capacity of political institutions to represent them and to solve problems.

I think you can see that in the 700,000 letters we got on health care. The number of people who would say, you know, what's wrong with me? I worked hard all my life and I lost my health insurance. Or my child got sick and now I can never change my job. Or my wife and I spend 60 hours a week running our business and our health insurance was \$200 a month four years ago, and it's over \$900 a month today; you know, that things are out of control. I say that because I believe providing security in the health care area and in meeting the other objectives we talked about -- quality and choice and cost control -- is a necessary precondition, not only to improve the health care of the American people, but to help root the American people again in this moment, to make them freer to face the other challenges that we face.

I see in this debate over NAFTA, which I have wrestled with in my own mind, that is the whole nature of our trade relations with Mexico and other countries and where we are going for far more longer than I've been President. I dealt -- had to deal with it when I was a governor. I see people, some of them looking ahead with confidence in the future that we can triumph in the world of the 21st century, that we can compete and win, that we can create tomorrow's jobs. And others so uncertain about it, just trying to hold on to today and to yesterday's jobs.

So, what I am trying to do is to give the American people a greater sense of security over those things that are basic to their lives that they can control, and at the same time challenge our people to assume responsibility for dealing with our problems and for marching confidently into the future. That's what this National Service issue is all about that we celebrated today on the White House Lawn.

And, therefore, the health care issue is about more than health care. It is about restoring self-confidence to America's families and businesses. It's about restoring some discipline to our budget and investment decisions. Not only in the government, but in the private sector. It's about giving us the sense that we actually can move forward and win in the face of all these changes.

I cannot under -- or I guess I cannot overstate how important I think it is not only on its own terms, but also for what it might mean for America over the long run.

Yes.

Q Does anybody really know whether this will work, from the administration? Is it that fine -- have you parsed the numbers that fine, that you can say if this is passed in toto, it will indeed do what you say -- cut costs, maintain quality of care, cover everybody?

THE PRESIDENT: We know it will do that. But that's not exactly what you asked. That is, we know that if this plan is adopted, it will provide universal coverage, that it will achieve substantial savings in many areas where there is massive waste.

Dr. Koop, who was, you know, President Reagan's Surgeon General, who was with us yesterday, and the doctors that we had -- said that in his judgment, there was at least \$200 billion of waste, -- unnecessary procedures, administrative waste, fraudulent churning of the system at least in our system -- so we know that those things will achieve those objectives? We do. Do we know that every last dollar is accurate, or that there will be no unintended consequences? Or that the timetable is precisely right? No we don't know that. Because nobody can know that exactly.

But I would like to make two points. Number one, our administration has gone further to get good health care numbers than anyone ever has before. Until I became President I didn't know this, but the various agencies in the federal government responsible for various parts of health care financing and regulation had never had their experts sit down in the same room together and agree on the same set of numbers and the same methodologies for achieving them. So that's the first thing we did. No wonder we had so much fight over what something was going to cost and the deficit was going crazy. The government had never gotten its own act together.

Then the second thing we did was to go out and solicit outside actuaries from private sector firms who made a living evaluating the cost of health care and asked them to review our numbers. Now, that is very important that you understand that, because it's -- there is going to be -- there should be a debate over whether the course I have recommended is the best course to achieve the goals we want to -- all want to achieve, whether there is a better course, whether we can achieve the Medicare and Medicaid cuts that we say we can achieve without hurting the quality of care. That's fine. But I want you to understand that we really have killed ourselves at least to get the arithmetic right -- to give people an honest starting point, a common ground to start from, so that we can have the arguments over policy.

Yes, sir.

Q Do you feel that your plan places undue hardship on business with the employer mandate versus an individual plan that has been proposed with other proposals?

THE PRESIDENT: No, and I'll say why. First of all, let's just look at the employer mandate. Most employers cover their employees. I like your question in the sense that you -- the question assumes that we should have universal coverage, and that's a good assumption. If you don't have universal coverage, you can never really slow the rate of waste in cost, because you'll always have a lot of cost shifting in the system. That is, people who aren't covered will still get health care, but they'll get it when it's too late, too expensive, somebody else will pay the bill, and it will have real inefficiencies and distortions, as it does today.

If you want to cover everybody, there are essentially three ways to do it. You can do it the way Canada does. You can abolish all private health insurance premiums, raise taxes to replace the health insurance premiums, and have a single-payor system -- just have the government do it. That's the most administratively

efficient. That is, the Canadian system has very low administrative costs, even lower than Germany and Japan. The problem is, it's not very good for controlling costs in other ways, because the government makes all the cost decisions.

The citizens know they've already paid for this through government, so they make real demands on the system, whereas if you have a mixed system where employers and employees are actually in there knowing what they're spending on health care and lobbying for better management and to control costs, like in Germany, you don't have costs go up as fast. So the Canadian system, even though it's administratively the cheapest, is the second most expensive in the world. We're spending 14 percent of our income; they're spending 10 percent of theirs. Everybody else is under nine.

Now, the second system is the individual mandate. It's never been tried anywhere. The problem with the individual mandate is that it could -- and, again, I want a debate on this. I think the Republicans are entitled to their day in court on this and I want them to have it. Really, I do. I mean, I want an honest, open discussion on this. I am so impressed with the spirit that is pervading this health insurance -- we had 400 members of Congress show up for two days at our health care university just trying to get everybody to have enough information to be singing out of the same hymnal when we talk to one another.

The dangers of the individual mandates are that it could cause the present system we have for most Americans, which is working well for most Americans, to disintegrate. That is, you have to have some subsidies with an individual mandate. So will companies that now cover their employees basically start covering their upper income employees or their -- not their lower income employees. Will they dump all their employees and make them go under the individual mandate system? How are you going to keep up with all these individuals when you realize who you've got to subsidize or not? In other words, we believe it has significantly more administrative burdens and it has the potential to cause the present system to come undone. But they deserve their day in court on it, and we'll debate it.

Our system -- let me just say this: Our system on small -- for small businesses -- I'd like to make the following points: we propose to keep lower the premiums of small businesses with fewer than 50 employees, including all those that are just starting up, and those with -- and they get more if their wages of their employees are low and low-wage workers also get a subsidy to try to make sure nobody goes out of business.

But the point I want to make is, most small businesses who do cover their employees -- and that's the majority of them -- are paying too much for their health insurance. They are being burdened by it. That's one reason 100,000 Americans a month permanently lose their health insurance as well as at any given time in a year, as many as one in four may be without it.

So what we propose to do will actually help more small businesses than it will hurt. And over the long run, they'll all be better off, because if you put everybody under this system, then the rate of increase in health care costs will be much lower. And it's just not fair at some point for anybody who can pay something to get a free ride. Because, keep in mind, we all get health care in this country. But if we're not insured, we get it when it's too late, too expensive. Usually we show up at the emergency room, the most expensive of all, and then somebody else pays the bill. That's what is -- one of the things that's driving these costs out of sight.

Yes, sir.

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Q We've heard a lot about every group today, except for the doctors. And from the doctors that I'm hearing from, they're saying that this is going to hit them in their pockets. In my experience before in being in operating rooms and seeing doctors after the diagnostic related groups started setting some prices of procedures back in the '80s, a lot of doctors that went into business for themselves were either multi-using single-use items or re-sterilizing items that were made for single-use so that they wouldn't lose any of the money that was going to be coming to them so they wouldn't take a personal hit out of it. How does your plan guarantee us an uncompromised medical claim?

THE PRESIDENT: Well, for one thing, the quality standards that govern medical care today will still be in effect. That is, most of them are professional standards and they're not enforced by the government today.

Q They're talking about doing more procedures to make up the money. They're saying, well, I'm going to have to see more patients and spend less time with them.

THE PRESIDENT: Yes, but that's what's happening today. I mean, the truth is that as we've tried to control the costs of Medicare and Medicaid, particularly Medicare, by holding down costs, you see dramatically increased numbers of procedures. What we want to do is to remove the incentive for having large numbers of procedures by having big blocks of consumers pay for their annual health care needs in a block, so that you won't have so much fee for service.

I would also point out to you that one of the big problems we've had with doctor costs going up is that doctors are having to negotiate their way through the mine field of 1,500 separate health insurance companies writing thousands of different policies, having to keep up with it in ways that no doctors anywhere in the world but our doctors have to deal with.

So if you look at -- we've already had the American Academy of Family Practice and a lot of other doctors' groups have endorsed our plan. The AMA has been quite interestingly supportive in general terms. They say they want to see all the details. They believe there ought to be universal coverage. Dr. Koop has agreed to come in and sort of moderate this discussion. But we had a couple hundred doctors here yesterday, who were -- most of whom were extremely supportive. And let me just give you one big reason why. This is the flip side of the argument you made.

In 1980, the average doctor was taking home 75 percent of the money generated by a clinic. In 1990, the average doctor was taking home 52 cents on the dollar, 52 percent of the money generated by a clinic. Twenty-three cents on the dollar increase in the amount of money the doctor was having to spend on people, basically to do clerical work in the clinics.

The Children's Hospital at Washington told us last week that the 200 doctors on staff there spent enough time in non-health care related paperwork every year because of the administrative cost of this system -- a dime on the dollar more than any other system in the world -- to see another 500 patients each a year, 10,000 more kids a year. So, a lot of doctors are going to feel very liberated by this because they are going to be freer to practice medicine, and the incentives to churn the system just to pay for all their paperwork will be less.

Q Time for one more question, I guess I have the opportunity, I'll make it a two-part question because it's a rare opportunity and I appreciate it. First of all, if you receive everything that you want, that you're hoping for, and we hear about

the 37 million uninsured and the many under-insured people, I'm wondering if there's anybody that will be disappointed with the new system?

THE PRESIDENT: Oh yeah.

Q -- if you get everything you want, and who those people might be. And secondly, I hear very little about medical fraud and medical malpractice problems, as if it isn't a major problem and we are lead to believe that it is.

THE PRESIDENT: It is a big problem. Maybe I should answer that question first, because it's a quicker one. Then let me try to tell you how to sort through the winners and losers. Okay?

First of all, we will have -- in this system if you put consumers of health care, employers and employees, particularly the small businesses, in large buying groups where they will have more market power and more oversight authority, you will inevitably -- we are going to change the economic incentives as well as the private sector oversight to reduce fraud and abuse. We are definitely going to see big savings there.

Secondly, what was the other thing you asked me?

Q The medical practice--

THE PRESIDENT: The malpractice -- doctors --well-- doctors-- one of the things that we don't know is how much extra excess procedures and tests are done as defensive medicine or to churn the system to go back to your other question. The economic incentives to churn the system will be dramatically reduced under these kind of payment plans.

It will be more like the way the Rochester, New York system works, the way the Mayo Clinic systems works. More and more people will be in a system where they pay up front and then they take what they need. And the doctors are going to get paid out of that.

But, the malpractice issue is a problem. We will propose some significant reforms, including limiting the percentage of income lawyers can get in contingency fees and lawsuits. But I think -- I have to tell you, what I think the most significant --and alternative dispute resolution mechanisms. But I think the most important one will be: permitting the professional associations to draw up medical practice guidelines which, when approved, will protect the doctors to some extent, because if they follow the guidelines in any given case, it will raise a presumption that they weren't negligent. And that will be a real protection against just doing an extra procedure because you're trying to hedge against a lawsuit.

The state of Maine pioneered this because they wanted more general practitioners in rural Maine to do more things for people like help deliver babies because they didn't have anybody else to do it. So, the idea of giving people practice guidelines I think is very good.

Now, you asked who's going to win and who's going to lose. Can we talk through that?

Q Yes sir.

THE PRESIDENT: I'll tell you who will have to pay more. You know, there will be some people who will have to pay more. You can -- there's a pretty good -- the news magazines this week did a pretty good job of analyzing this.

If we go to community rating, so that we can allow people, for example, who have had a sick child not to be bankrupt by their insurance costs and to move from job to job, and you put everybody in a broad community, it means young, single, super healthy people will pay more in the first year of this than they would have otherwise. Now, here's why I think that's a good deal for young, single, super healthy people. Number one, all young, single, super healthy people will get insured and they aren't now. Number two, they'll all be middle aged some day, too, and they'll win big. Number three, their cost will go up less every year. So, even though they might pay more this year, within five to eight years, if this plan goes through, everybody will be paying less than they would have. So, they would pay more.

Secondly, there are some businesses who don't insure at all. They'll have to pay something. There are others who insure, but only for catastrophic. They will have to pay more, but they'll get much better benefits and their rates will go up less. So, there will be some people who will pay more now than they were paying. But I believe that if we can -- keep in mind, if we can stop the cost of health care from going up at two and three times the rate of inflation, if we can get it down where the rate of increase is much lower, by the end of the decade everybody will be way better off than they were.

Q Mr. President -- the Boris Yeltsin announcement that he's going to dissolve the Parliament, and does the United States support him and his power struggle with his opponents?

THE PRESIDENT: Well, as you know -- first of all, let me say I have had only a sketchy briefing about this and I have not talked to President Yeltsin yet. I would like to reserve the right to issue a statement after I attempt to talk to President Yeltsin. In any case, I will issue a statement before the end of the day, but I think at least I should have a direct briefing.

Yes sir, one more. Go ahead.

Q President Clinton, tomorrow you'll be speaking before a joint session of Congress and there are 535 people, individuals in Congress that will have their own specific plans of what they --

THE PRESIDENT: Yes.

Q -- If you could say that you could put your name on one or two or three specific parts of this that you want to say, "This is my health care plan," that you want to see, no matter what 535 other people want to see -- that you feel you want to be part of your Clinton health care program, what two or three items, specifically?

THE PRESIDENT: Number one, every American would have security in their health care system. You would be able to get health insurance, there would be adequate benefits and you wouldn't lose them. Number two, the system would impose a far higher level of responsibility for managing costs than it does now on all the players, including the consumers. Number three, people would keep their choice of physicians and medical providers. And, number four, we would guarantee adequate access to preventive and primary care so we could stop some of the big things that are happening to us before they get going. And, five, we would have incentives -- market incentives to bring costs down. Those are the things that I want to be the hallmark of our program.

I wish I could stay all day. I'm sorry, but thank you very much. (Applause.)

END

3:25 P.M. EDT

Carol Rasco
Domestic Policy Council
2nd Floor West Wing

SEP 22 REC'D

THE WHITE HOUSE

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Immediate Release

September 21, 1993

PRESS BRIEFING
BY

DIRECTOR OF COMMUNICATIONS MARK GEARAN,
ASSISTANT TO THE PRESIDENT ON ECONOMIC POLICY BOB RUBIN,
OMB DIRECTOR LEON PANETTA,
TREASURY DEPUTY SECRETARY ROGER ALTMAN,
COUNCIL OF THE ECONOMIC ADVISORY CHAIR LAURA TYSON

The Briefing Room

1:16 P.M. EDT

MR. GEARAN: Let me start out with giving you a road map of what we're about to do today. We have Bob Rubin --

Q Mark, before you do that could we just get a little reaction to what's happening in Russia?

MR. GEARAN. I'm going to do that, yes. Yes. I'm going to do road map, then reaction. It's not alphabetical.

Bob Rubin, Leon Panetta, Laura Tyson, and Roger Altman, who will give a briefing on some of the questions that have been raised in terms of the financing of the health care system. They have a limited amount of time, so we'll go to them quickly.

Let me give you just a preliminary on events in Russia. We are just learning of the events unfolding in Russia ourselves at this time. We're in the process of getting more information and will be assessing it as the hours progress. We expect to have a statement later on in more detail and with more information than we're receiving at this point.

Q So we were not informed before the action by Yeltsin?

MR. GEARAN: No. Mr. Pickering was called in with some of the other foreign ministers in advance of it.

Q In advance of it?

Q How far in advance?

MR. GEARAN: Soon in advance of it. It was not --

Q Well, they're saying in Moscow less than an hour. Is that correct?

MR. GEARAN: I think that's correct.

Q What were they informed? The details of what Yeltsin would say, or just that Yeltsin would speak?

MR. GEARAN: They were informed of the speech. Let me leave it at that. That's about all we can provide.

Q When was the President informed?

MR. GEARAN: As the events were proceeding.

MORE

Q Mark, what form will the statement be?

MR. GEARAN: I'm sorry.

Q What form will his statement --

MR. GEARAN: We're waiting to see who will best respond or how we'll do that -- and whether it will be someone from the White House or Secretary Christopher will --

Q Do you know who told the President of these developments?

MR. GEARAN: The national security staff.

Q Before or after the National Service event?

MR. GEARAN: It was -- I'll have to confirm that. My understanding -- I think it was afterwards. Let me confirm that for you in terms of when he was told.

Bob.

MR. RUBIN: Thank you, Mark. I'm Bob Rubin, the Assistant to the President for Economic Policy. We're going to discuss the financing of the health care plan, which seems to be a subject of some interest. And let me start with a few general comments, and then we'll get into the specifics of the financing.

As was true in the economic plan -- and you heard the President say this in reference to the economic plan -- he'll say the same thing about the health care plan. From the very beginning, he insisted that we take enormous care with the numbers with respect to accuracy; that we have accurate, conservative, valid numbers, and that our policy decisions be based on such numbers so that there will never be a question about our numbers.

With the economic plan and again with the health care plan, his position was that he's happy to have all the debates people want to have about policy, but he does not want to have anybody validly questioning the validity of his numbers. And it's on that -- with that mandate that these numbers were developed.

There obviously will be a debate -- a national debate on health care policy, and there will be all kinds of issues. But what there shouldn't be any debate on is the validity of these numbers. They were developed with enormous care and enormous carefulness with respect to making sure that we had numbers that would withstand any kind of challenge.

I've been involved in my own career with enormous numbers of number developing processes. (Laughter.) I guess that fits together. And I can tell you, this was an exhaustive process. HHS, OMB, Treasury, CEA, actuaries, internal within the government involved with developing the numbers. And then there were external -- accountants and actuaries reviewed the models and reviewed the development of the numbers.

I can remember early in the process when there would be disagreements and there would be debates about the numbers. And Ira's position throughout it was that we had to have accurate numbers and then we make our policy decisions and these differences will eventually narrowed and brought down to numbers that everybody could agree on.

Finally, let me make one more comment on the process, itself. This was an exhaustive process of debate and discussion. We

had endless meetings amongst ourselves, and then with the President. Well, the ones with the President weren't endless, but we had endless meetings amongst ourselves and a goodly number of very lengthy meetings with the President. We all the ability to state whatever it is we wanted to state. There were healthy debates, there were lengthy debates, there were real differences of opinion just as there were with the economic plan. The groupings would be different over each issue. We had one grouping on one issue, another grouping on another issue. And out of it all came a plan, as was true in the economic plan, that all of us felt was a good plan and that realized the purposes that the President started out with, which was to develop a way of reducing or eliminating the enormous excess expenditure, which is I think unquestionable in our health care system, and then utilize those savings to fund the realization of his objectives. And that's what this plan is all about.

With that, let me turn it over to Leon Panetta, who will get much more involved in the specifics of the numbers.

DIRECTOR PANETTA: Let me again, preface these remarks by trying to compare a little bit of this to the economic plan. I mean, the fact is with the economic plan, there were models that were in place over the years. We had very good estimates about various proposals, either on the tax side or on the cut side, that have all been estimated before. There are economic consequences that have pretty well been estimated. So we basically had models in place that made us much more comfortable, obviously, with the numbers that we're dealing with.

In this instance, we're dealing with an unprecedented effort at reform of the entire health care system in this country. And the problem we had from the beginning is obviously to develop models that could estimate the impact of that kind of broad reform with regards to health care. What happens when you suddenly pick up almost 60 million Americans who are uninsured or under-insured, and bring them into a health care system? What are the costs of that? What is the impact on the health area? What are the behavioral consequences of bringing people into that kind of system? Then determining the cost impact, not only on business, but on employees, individuals as well as the health industry, as well as the Treasury. So, obviously, those were the questions that we had to develop approaches to if we were going to try to develop the most accurate numbers that we could develop in the reform plan.

Over the last six months, we have basically been involved in trying to develop that kind of modeling system. We've had representatives from OMB, from Treasury; economists who have been part of that, HHS, the various actuaries that are involved with health care issues generally have participated in that effort. And so at the conclusion of that, we tried to develop the most credible and conservative kind of estimates of the impact of health care reform as we could. You have to look at again, what -- if you develop a basic benefit plan, what does that look like? What are its impacts? What are the characteristics of the people that we're dealing with? What are the households that we're going to be impacting, employers, employees, and obviously just the whole cost issues.

After six months, we believe we've developed I think the most sophisticated models in the business of analyzing health care costs. They are the best in the business. There aren't any others, really, out there. And that was our problem. But I think that as a result of the work that we've done, we've got the best in the business. And so the estimates that we have here, I believe, are credible and I believe, again, can be defended when we present the plan itself to the Congress.

Like the economic plan, I think it's important to understand that people can question the policies, they can question the politics. And, obviously, that's a process we're going to go through after we've presented the plan to the Congress and to the country, and that's legitimate. But if, in fact, we can get all of these elements passed by the Congress, then we believe we can hit these numbers.

Now, let me speak a little bit about the specific numbers that we're working with in terms of the elements of the program and the financing for those elements. Let me begin with a very important promise here that I think a lot of people are losing sight of. The most important premise that we're operating with is that most of the money comes from where the money now comes from to pay for health care, which is the contribution by employers and individuals into a premium process to pay for their health care plans. That process is still there. That premium base is still there. People who are now paying for health care will continue to pay health care premiums. So that is a base that's there and that is going to continue to be funded through the premium process.

With regards to the federal side of it, let me describe what those elements are, because that's where legitimate question can be asked: how is the federal government then going to pay for those benefits? Again, I want to condition all of this to say that it's subject to continuing adjustments. We're still looking at these numbers and there will be, I think, minor modifications in the final numbers that appear in the bill. But right now, the numbers that I'm going to present to you are estimates between largely 1995 and the year 2000. Some of these numbers basically will ratchet-in, depending on the particular program that you're looking at.

On the new benefits, let me describe the new benefits that will be part of the program. The new benefits include a long-term health care program for the elderly, and that program largely targets on home health care, community-based health care for seniors. The estimate on that is about \$80 billion.

Q Over?

DIRECTOR PANETTA: That is between -- it ratchets in starting in I believe 1995 -- '96, and goes to the year 2000.

Q Is that an annual number?

DIRECTOR PANETTA: That's the total number for that period of time and it ratchets in.

Q Four years?

DIRECTOR PANETTA: Five-year numbers.

Q Does it start low and grow? I mean, that's --

DIRECTOR PANETTA: Essentially, in this area it ratchets in and it starts to escalate in terms of the costs.

On the Medicare drug benefit, it's the same over that period of time. That's about \$72 billion. That basically provides for drug benefits to those on Medicare with a deductible, small deductible. That's \$72 billion.

The third piece of it is that there are public health care investments that are part of this, in which there are targeted increases, particularly for rural clinics and community clinics that try to serve those at the low income levels. And there will be about -- in addition to that piece, there are start-up costs for the basic

system itself that will come to \$29 billion over that period of time.

We will be providing a 100 percent self-employed deduction for those who pay in, those who are self-employed with regards to their payments. They'll have a 100 percent deduction. That costs \$9 billion.

And then lastly is the largest portion here, which are the discounts for subsidies, as they've been called, to businesses and the employees at the low income level who would qualify. And the price tag on that is \$160 billion. And that's the one, very frankly, that continues to -- we need to continue to scrub that number, because we need to analyze just exactly who's going to receive those subsidies as we work through the plan. But that's -- \$160 billion is the estimate right now. So that the total cost we're looking at of the new benefits that will be provided by the federal government are \$350 billion.

How do we pay for this in terms of trying to make sure that each of these is covered? The first area, obviously, deals with the two principal health care programs that are the costliest at the federal level: Medicare and Medicaid. And let me preface this by saying that, again, all of you know that we're dealing with programs that, in terms of the federal budget, are escalating at double and triple the costs. We're looking at taking these programs from roughly three to four times the rate of growth in the economy down to about two times the rate of growth. So we're basically trying to reduce the very high level of growth that we're seeing in these programs.

On Medicare, we're looking at about \$124 billion in savings over that same five-year period. These savings will be specific. We're not talking about a cap. As you know, there's often times been a discussion in the Congress about setting some kind of arbitrary cap with regards to these expenditures. We are going to present specific proposals to achieve these savings. An example of some of those proposals would be requirements for additional co-pays, competitive bidding with regards to medical equipment, some lab co-insurance requirements. These are proposals that have been in the mix in terms of the discussions on Medicare savings as long as I've been involved in the budget process. And we are selecting, we think, they policies that make sense, both from a substantive point of view as well as a savings point of view.

The same thing is true on Medicaid, which will be \$114 billion in savings over that period of time. Most of that will come from a reduced cost on the disproportionate share, which is basically what we now pay hospitals that are the targeted hospitals that serve an excess number of individuals on Medicaid. We think we obviously will be able to reduce that disproportionate share provision as a result of the other elements of health care reform.

The second area is the savings that we hope will flow, and we were confident will flow from the fact that other federal programs that serve people, people will be moving gradually into the health care system itself, into the alliances, and we estimate that we will get savings from veterans programs, from Department of Defense programs, and also, obviously, from the federal employee health programs where we now cover all of those costs, federal employees will be part of the new health care system. We expect savings there of about \$47 billion.

The fourth area of savings relates to our ability to move away from tax-free benefits, which we now provide in large measure, obviously, through deductions in which we cover health care payments. Our hope is that obviously as we reduce the cost of those payments, that not only will we reduce the amount of benefits we have to provide through the tax system, but in addition, we will incur

some additional revenues from those who receive profits and additional wages as a consequence of that. And that's a pretty fair estimate that we generally use. It's a little bit like looking at a mortgage deduction, and as you reduce interest rates obviously the consequence of that is to produce more money to the individual which then becomes subject, hopefully, to additional taxes flowing to the federal government.

The estimate there is \$51 billion, what we estimate in that area. And this one that we, again, in terms of our own process we're trying to nail down with Treasury and with OMB looking at these numbers continually.

The last area is sin taxes. Sin taxes are approximately \$105 billion. The final decision on the exact elements of that have not been decided, but --

Q You're kidding.

DIRECTOR PANETTA: Whose kidding? (Laughter.) No, I'm not kidding. They have not been decided. We're looking obviously at cigarette taxes, and whether we go beyond that, or how much the cigarette taxes will be is still being discussed.

Q How can you come up with \$105 billion figure without knowing precisely what is involved?

DIRECTOR PANETTA: Well, there are proposals that are on the table and we estimate that we have to look at somewhere between \$100 billion to \$105 billion in order to make these numbers work. And that's what needs to be done.

Q How big does the cigarette tax have to be without some other kind of taxes in order to come up with that amount of money?

DIRECTOR PANETTA: Well, if you're just looking at cigarette taxes you're probably looking at somewhere around \$1 a pack. But if you were doing less on cigarettes then you've got to make it up elsewhere.

The total number on that from what we estimate in income is \$441 billion from what I've just described, meeting a cost, as I said, of about \$350 billion, and that is what leads us to a hoped-for deficit reduction of around \$91 billion over that period of time. And that's particularly important from my perspective because I think I've often argued that if you're going to get the deficit down further you've got to be able to get this kind of return on health care.

Now, let me just conclude by saying that as always, you know, when you're putting numbers like this together based on the models that we've developed, the numbers fit just as they did in the economic plan. But just as what we faced in the economic plan, obviously, there will be political implications of a continuing consultation process with the Hill, the concerns that are raised on Capitol Hill as we go through the process, and that will obviously require some adjustments as we work through the legislative process.

Secondly, there is going to be a continuing assessment on the numbers themselves. We are currently in the process, between OMB and Treasury, over these next two weeks, where we are going to be scrubbing all of the numbers I've just presented to you. And we do not expect -- I should make clear -- we do not expect any major changes from that process, but there may indeed be some adjustments that will have to be made as we again revisit these numbers.

I think the President's goal is to begin this process. And this is the beginning of the process of the debate on health care reform in this country. He has presented -- and I think it was his intention and the First Lady's intention to present a bold plan for health care reform to the country. But like any smart negotiators we know that there are going to be bargaining that's going to have to be done with the Congress. We're going to face a number of special interests who are going to force us to fight this battle. And our view is that it's much better to start with a bold approach as we begin that process.

DEPUTY SECRETARY ALTMAN: I'm so happy to be here that I'm compelled to be brief. Secretary Bentson would have been doing this instead of me, except that he is in New York, on his way to speak to the Economic Club of New York tonight.

As Leon alluded, Treasury has responsibility for estimating the revenue issues, the revenue impacts of this plan. The sin taxes, the revenue effects of the mandate, the self-employed deduction, and the others. I simply want to say that we're using the same Treasury estimating model and the same methodology that was used in the economic plan and that is always used to assess possible changes in tax policy or legislative initiatives.

We are continuing to scrub these numbers. It will be a couple of weeks before we finally finish doing so, together with OMB and others. There may be some moderate changes before the final details are released. But I'm confident that the numbers we do release will withstand the scrutiny -- which will be very tough -- that, of course, they'll be subject to.

I think we've been very cheered so far by the congressional reaction. A lot of us have been up on the Hill for the last couple of days in various workshops, which have been extraordinarily well attended, I might add. Extraordinary how many members of Congress have come for hours on end. And they've all said, among other things, even some that aren't happy with the plan, that we've put forth the most-detailed and the best-researched health care plan that's ever been put on the table by a lot.

As Leon said, the congressional process is just beginning. It will take quite a few months, there will be undoubtedly changes in the proposal that we put forward and we welcome that process.

The only point I'd add in addition is that in the event that anyone does point out a true flaw in our numbers -- can prove to us that they're off, well, then, of course we'll adjust them. And we'll adjust them on the cost side. In other words, if it turns out that people convince us that something we've estimated at X will cost more than that, well, we'll reduce costs in some other area. What we will not do, beyond the sin tax proposal that will be made shortly, what we will not do, is to propose any further changes on the revenue increasing side, on the tax side.

I think Laura's next.

MS. TYSON: I will just end by reaffirming or emphasizing, the comments made by Bob Rubin at the beginning. The process by which these numbers was developed was a process which was exhaustive and inclusive. The CEA and other agencies of government were involved in the process from the very beginning. We did not just rely on internal experts, however. We consulted a wide variety of external experts on all aspects of the health care system. So it really was, as the First Lady has correctly said, an unprecedented process in terms of inclusiveness, exhaustiveness and precision. So I don't think there really is any question about the numbers.

Now, it's been reported in a number of places that I have raised questions about these numbers and that the CEA has raised questions about the numbers. That, in one sense, is true and in one sense is misleading. It is true in the sense that it is the role of the CEA to raise questions. We love to raise questions, that's one of our jobs -- we raise questions. The reports are misleading because they seem to indicate often that our questions were not answered. That is not correct. Our questions have been answered. They have been answered as part of this exhaustive process. So, for example, if we raised a question about Medicare and where the Medicare savings would come from, there are now precise, specific policy proposals backing up the Medicare savings.

So the process has been unprecedented and exhaustive and, I believe, has moved the information base on how the current health care system is functioning and what we need to do forward by an order of magnitude relative to anything anyone knew when we started. So I think one should, at this point, welcome debates about policy and welcome debates about politics. But really, the numbers, it seems to me at this point, are not really debatable. They came from a very credible process and a very exhaustive process. And that's really all I wanted to say.

Q Despite the fact that you insist that there aren't going to be new taxes, we have a poll out today that says 80 percent of Americans still believe that that's how it's going to be paid for.

DIRECTOR PANETTA: Well, interestingly enough, we ran into the same problem with the economic plan. I mean, obviously, everybody felt that when you debate any kind of revenues or indicate that even if there's going to be sin taxes, that people automatically assume that somehow there's going to be some sort of broad-based tax. And, as we pointed out in the economic plan, 80 percent of that affected those of \$200,000 and above. I think people are beginning to understand that now. And as we go through the debate on this, I think people will also understand that there is no broad-based tax here.

Now, again, having said that, the premium is here. Let's make clear that the premiums that people are paying now, that most of the money in this process for this health care reform, is going to come from the same area that it comes from now, which is businesses and people paying taxes on health care. That needs to be made clear now, because I think there's a sense that there's these other taxes. It's based largely on the premium base.

Q You presumably realize some savings from the elimination of cost shiftings since everyone is now included. Under which number, or numbers, is that included? Where is that number reflected?

DIRECTOR PANETTA: You're basically in the -- I think it's going to be in the reductions. While the reductions in federal programs will probably be part of that, I think the Medicare to the extent -- I mean, we're going to be doing specific savings on Medicare, so you --

Q I know, but that's going to affect nearly -- that cost shifting is paid for by all the private consumers of health care insurance. Presumably there will be a saving to them of some untold sum of money. What is the sum and where is it reflected here?

DIRECTOR PANETTA: Okay, we think that when the plan is fully implemented, that there's about \$25 billion in uncompensated care that's currently embedded in what private insurance and what private payers pay. That is, everybody gets coverage so that money will go away over time. So the dollars are really reflected in the premiums that we are estimating. So they're not specifically shown

in this line item here that the Director has talked about. But rather, if you reduce uncompensated care, the premiums that people will have to pay for health insurance, those costs will fall.

Q Do you really think that you're going to see \$91 billion in deficit savings at the end of five years? Do you think that these models clearly estimate people's behaviors?

DIRECTOR PANETTA: I don't think -- no, it's not a problem of the models. I think that if we achieve these kinds of savings with regards to these kinds of costs, then I think we can produce that much in savings in terms of deficit reduction. I mean, that's our goal. Our goal was basically to start with making sure that we achieve deficit reduction over this period.

Obviously, I have to tell you -- as I think we found out on the economic plan, where our investments were vulnerable, I think the deficit reduction number is going to be vulnerable on Capitol Hill. The large question for Capitol Hill to answer is do you want to achieve this much in terms of deficit reduction, or do you want to lessen the amount of deficit reduction and lessen the hit in terms of some of the other programs. You're going to see some trade-off here.

Q In terms of trade-offs, it was so difficult to get to the \$57 billion in Medicare savings. What makes you think you're going to reach \$124 billion?

DIRECTOR PANETTA: As long as I've dealt in the budget process, every time we've dealt with Medicare and Medicaid savings, I have heard all of the expressions of fear -- that the hospitals are going to close, that the doctors are going to go out of business, et cetera, et cetera, et cetera. And it hasn't happened. The fact is that there are tremendous cost increases that are taking place in the Medicare and Medicaid program. We know that. We see that in the budget. And I think as a result of that, we have been able to outline a whole series of very specific proposals that from a policy point of view I think makes sense.

Now, you're asking me really what I think is more a political question than a substantive question, because sitting in that room people are always nervous -- do we want to cut Medicare this much? Can we cut Medicaid this much? But ultimately, if you can justify the policies based on substance, then I think we can come very close to these numbers. And that's going to be the test.

Q Mr. Panetta, can I ask you a question about -- you started your account by saying that the bulk of the money was, of course, going to come from where it now comes from -- from the private sector. And yet, what all of you have said addresses only the public portion of this. We need to give the American people a picture of the whole thing. Could you tell us what the private portion of this is going to look like? And it would be very helpful if it was year-by-year what the business sector is going to pay, what the household sector is going to pay, and what you either think they're going to save or net -- have to pay to make this system work?

DIRECTOR PANETTA: Oh, Ken? (Laughter.)

MR. THORPE: We didn't pass that out? (Laughter.) Of course, we're -- as we continue to go through this, we focus first in terms of our -- first step of an estimate is to try to get a handle on what the federal and state and local piece of this is. And we're in the process right now of doing exactly what you've asked. As you've seen from your documents, that's -- I'm sure that you've read through. We do have a table in the back that looks at the change in national health expenditures under the proposed plan. We will, during the course of the next several weeks, be developing exactly

what you're talking about -- a sector-by-sector impact during that time period.

Q That chart at the back is entitled National Health Expenditures. Is that the chart you're referring to?

MR. THORPE: Right.

Q It appears to show that in the first three years of this, if I understand how to read it, that the private sector in aggregate is going to bear -- one year it's \$23 billion in extra costs, the next year it's \$50 billion in extra costs, the next year it's \$30 billion. And only in the very end of the five-year period are you going to see it -- the savings, in effect, be greater than the costs. Is that true? In essence, the private sector is going to bear increased costs during the early years?

MR. THORPE: No, we think that due to the fact that we're covering \$37 million under uninsured and we're providing comprehensive benefits not only to that population but to individuals that don't have as comprehensive benefits -- that is, you can see from the chart that for the first two or three years that the amount of spending in the system will rise slightly. But by 1998 -- I don't have the figures with me. It's in the back of your --

Q The point is that the private sector is going to bear --

MR. THORPE: No, that's total spending -- public and private. What we don't have and what you could not infer from that chart would be the specific public-private impacts which we are still working on.

Q Ms. Tyson, could you tell us whether or not the proposal will increase --

MR. THORPE: I don't have the figures with me.

Q Mr. Panetta, could you tell us --

DIRECTOR PANETTA: Could I -- Andrea, let me just add another point that I think is important on the Medicare and Medicaid aspect of this. Normally, the cuts in Medicare and Medicaid have usually been done for the sake of deficit reduction in the sense that you basically are doing it as part of an economic plan. In this instance, you're doing it as part of comprehensive health care reform with a long-term health care element as well as a drug benefit element. And I think that gives us a little better arguing point with regards to those that are concerned about who's going to be impacted by that.

Q Mr. Panetta, one of the central features of your plan is cost controls on the growth of insurance premiums. How can you convince the public that their services aren't going to be held down, constrained, rationed by the doctors and hospitals as they're living under these insurance caps at a time when you're trying to cut inflation and health care in half?

MR. THORPE: Well, again, we think that if you take -- again, you can't just look at the cost containment piece. I think it's important to look through and look at the plan in its entirety. Because what we're proposing in the health reform proposal is really comprehensive change in the delivery system. We believe that there are substantial administrative savings in hospitals and physicians, as well as insurance companies that we've talked about. We've talked a little bit about reductions and uncompensated care that's sitting out there.

And one thing I think that will be useful to do is that if you look at the dollar savings, don't look at the percent changes, but actually look at the dollar savings in the private sector associated with what we're proposing. And if you look at what we think is going to happen in the system in terms of cost conscious selection of health plans, administrative savings, reductions in uncompensated care, moving toward a delivery system that is no longer an open ended, uncoordinated delivery system. It is really something to focus on much more effective and we believe, not only cost effective, but better quality medical care. That any one of those, individually or serially, will develop and create the types of underlying cost reductions that the plan is talking about.

Q But you and Mr. Rubin can stand here today and assure people there will be no rationing of care under this Clinton package?

MR. RUBIN: Let me try as a nonprofessional to take a shot at that. Having sat through, I guess it's six or seven months now of meetings with enormous numbers of health care professionals on, as you know, a very complex subject -- when you hear them come through all this, I think where you come out is it sounds from what they've said -- let me put it differently. I came away persuaded having listened to them, that this thing ought to work, that the odd ought to be very, very high that there is very substantial excess expenditure in the system. And you compare the 14 percent of GDP that we spent on health care with less than 10 percent in any other developed country, and I think it sort of validates that notion. And it ought to be possible to create a plan that does that without creating untoward effects.

But if there are problems there is a contingency in these numbers, number one. Number two, as you know, it's going to be phased in somewhat gradually so the first dates, hopefully, will come in '95, and they will continue to come in through '97. So if you start to see problems you can correct course.

And thirdly, and I find personally most importantly, there is tremendous flexibility in this system and there is tremendous flexibility within each state to adjust the system as it goes along. So I think you have, in effect, a self-correcting mechanism if problems develop.

Q Laura, can you comment on the job impact, what your models have shown in terms of --

DR. TYSON: We're actually going to have a briefing on that issue on Thursday. We'll talk about the employment effects on Thursday. Secretary Reich will -- we are trying to sort of have a discussion today of financing, and a discussion on Thursday of --

Q What is the hold up in figuring out how the sin taxes are going to be apportioned and are there discussions going on with, for example, representatives from tobacco states as you're figuring out how these taxes are going to be apportioned?

DIRECTOR PANETTA: I think it's -- you know, it's obviously -- the issues are on the table with regards to the elements of sin taxes. The one question is this corporate assessment and whether or not we will look to this corporate assessment for additional revenues as part of that package. And that -- frankly, it's that element that's being evaluated right now. We have not come to any conclusions on that. But depending on whether or not you include that element, that tells you a lot about what you do then on the sin tax.

Q How much might that produce, the one percent corporate assessment?

DIRECTOR PANETTA: I mean, again, it depends on how many corporations are going to be impacted, and that's something we're analyzing right now. Because it depends to some extent on which ones are dropping out of the process and which ones stay in the process.

Q The goal was to --

Q Can we just clear up the payroll tax?

DEPUTY SECRETARY ALTMAN: We're not going to give you an exact number, because we're continuing to refine that. But it's not a huge number in the context of this plan. You have to make certain assumptions about which businesses opt into the alliances and which businesses, 5,000 and over, employees may opt out and so on. But it's not a gigantic number.

Q There may be no decision on alcohol tax by tomorrow night, is that correct?

DEPUTY SECRETARY ALTMAN: I don't know the answer to that. Someone asked that question earlier about when the sin tax decision was going to be made.

Q Are you deliberately not deciding to not ignite the lobbyists more?

DEPUTY SECRETARY ALTMAN: I heard somebody say the President's upstairs having a drink and a cigar and would make that decision shortly. (Laughter.)

Q You said the President's goal was to have a situation where people could argue politics and policy, but not about the numbers. It hasn't been hard for people here to find economists and politicians who are arguing about the numbers. What is the problem? Where is the disconnect?

MR. RUBIN: Let me take one shot at that and let other people take another shot at it. You know, when you read the reports and then you speak to some of the people -- and I've done both -- I think there is a bit of a muddling here. And I think sometimes when people talk about concerns about the numbers, they're really talking about the politics or they're talking about the policies. And I think if you take somebody and you say, okay, you've said you have concerns about the numbers, what do you really mean?

Usually, at least in my experience, it has turned out to be either they simply need more information, or they're really raising a question about political feasibility or policy impacts. And that, I think, is -- to an awful lot of it.

Q Well, to what extent did you --

MR. RUBIN: Can I make just one more comment? These are very complex calculations. I've heard a lot of it developed, and I'll tell you -- and I've had a lot of experience in developing numbers -- these are very complex numbers developments. And I think what's going to happen over time is, people who have serious questions about numbers as opposed to policy or politics, they'll sit down with the people who developed it, and I think they'll come out satisfied on the numbers.

Q To what extent did you factor in political feasibility in creating your models?

MR. RUBIN: Well, numbers are one thing and political feasibility, I think, I would argue, a separate one.

DIRECTOR PANETTA: There is no model you can develop for that. (Laughter.)

MR. RUBIN: Leon has a perfect model for political feasibility, and he comes out with -- (laughter) --

Q obviously, there are policy assumptions that are going into the numbers. I mean, you seem much more optimistic than a lot of independent experts about how quickly waste can be gotten out of the system, for example. I mean, those assumptions are built in --

MR. RUBIN: Those assumptions are in here, as we said. You've got an interactive process with OMB, Treasury, HHS, you've had outside actuaries and outside accountants, and enormous numbers of them, and they've come out and concluded that these kinds of savings can be achieved in these kinds of time periods.

Q Mr. Altman, you said in your remarks that if you were convinced your numbers were wrong, you would make adjustments on the spending fight, not the revenue side. Does that mean if Senator Moynihan is correct, that it's not politically possible to achieve this level of Medicare savings, that would put at risk these proposals for new long-term and drug benefits for seniors?

DEPUTY SECRETARY ALTMAN: No, I didn't say that. I didn't say that at all. I simply said that if anyone can prove to us that there are flaws in our estimates of the costs of this, I mean, really prove it, which I doubt, I strongly doubt, as I mentioned earlier -- we would make adjustments on the cost side. We would --

Q You're talking about a technical thing, you're not talking about --

DEPUTY SECRETARY ALTMAN: Well, if someone could prove to us that we've underestimated the cost of X or the cost of Y, you know, really win the argument --

Q But it's all based on predictions of future behavior of all kinds.

Q You're saying --

Q -- what would you cut, then --

Q -- which is kind of an interesting standard, isn't it?

DEPUTY SECRETARY ALTMAN: -- in some other area the costs to offset that. All I'm trying to say is, we would not turn to the revenue side of the equation.

Q But would that affect the core benefit package then?

DIRECTOR PANETTA: Let me mention -- you've got -- all of the pieces are here now. And, obviously, there's going to be some adjustment on these pieces as we go through the political process and as we go through, obviously, the discussions with regards to the accuracy of the numbers and what have you. But there are key pieces now that you can work with here.

If we decide, for example, that we want to do a phase-in, a longer phase-in on this, we have some phase-in already built into the process. That's something obviously that can be looked at. It doesn't mean you're reducing the benefits; you're reducing the benefits in the short term for some, but in the long run everyone's going to get the same benefit.

But we have the ability now with the plan that we're working on to give us the flexibility to make those kinds of adjustments without impacting on the basic principles that the President wants to present in the health care plan.

Q Given the record of economic modeling over the last 10 or 12 years, don't you approach the modeling of this entire sector of the economy with some humility?

DIRECTOR PANETTA: Humility and trepidation.

Q Can you tell us, is there any reaction from the President on the Moscow coup?

MR. GEARAN: In terms of events in Russia, we have no further reaction to that.

Q The President did not react at all?

MR. GEARAN: We'll just leave it at that. We'll keep you posted whether there will be a further statement.

END

1:55 P.M. EDT

SEP 20 REC'D

Carol Rasco
Domestic Policy Council
2nd Floor West Wing

THE WHITE

Office of the Press Secretary

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PRESS BRIEFING ON HEALTH CARE

BY

TIM HILL, JOHN SILVA, RICK KRONICK, AND LYNN MARGHERIO

The Briefing Room

2:55 P.M. EDT

MS. MYERS: The following is an ON-THE-RECORD briefing. The topic is administrative simplification. No mult? No mult. Alright, I will continue with this riveting introduction while you guys fix the technical problems.

Tim Hill, who is health policy analyst at HHS will give an overview. He's chair of the administrative simplification group on the task force. John Silva, a practicing physician in DOD specializing in information technology. Rick Kronick, Senior Health Analyst, advising the administration; and Lynn Margherio, Senior Policy Analyst for the Domestic Policy Council will be available for questions. So without further ado.

MR. HILL: Good afternoon. My name is Tim Hill. I work for the Health Care Financing Administration. We run the Medicare and Medicaid program. We've been working on the task force for about the last six months, putting together a proposal for the President to help us cut through some of the paperwork and administrative burden that we're faced with here in the health care system.

I want to start off by saying thank you for putting this on camera. We're all kind of wet; it's nice to have the lights and dry us off a bit.

Q We're glad to serve.

MR. HILL: This is -- it's wonderful. We're focusing here on the administrative simplification part of the President's health care plan on reducing confusion for consumers, freeing up care providers -- doctors, nurses, alternative practitioners -- to provide care, not to be performing administrative tasks, and to reduce some of the, or most of the confusion and complexity with respect to what providers have to face to get reimbursed for health care services.

Q Why don't you do it for Medicare right now?

MR. HILL: We've taken a long, hard look at where the government fits in. We recognize that Medicare and Medicaid and the other government programs are, in effect, part of the problem and they will be included in the simplification measures we're going to talk about. As a matter of fact, there's been consideration given to the fact that Medicare can start things earlier than the rest of the plan just because it's authorized already.

I want to talk a little bit about how we got to where we are and the problem that we're trying to solve. What we have now with respect to reimbursement is the federal government and private insurers setting up elaborate rules and requirements for providers to follow in order to get reimbursed for health care services.

MORE

These providers must follow and keep track of all the various requirements and differences among health care plans in order to get reimbursed. They have to hire staffs and have clerks to insure that they know what health plan A and Medicare and Medicaid all require with respect to information before they can get paid.

What were once small back offices have grown into huge utilization review offices coding medical records and billing departments. They spend countless hours determining whether an individual has health care coverage, which company is the primary payor, what services are covered, what codes to use, and how much to charge.

What we've sort of come up with to address this issue with respect to the health care plan are a number of very broad sort of initiatives that we hope, taken together, will bring us to a situation where a lot of the administrative burden is going to go away. First and foremost, every American is going to get coverage. Guaranteed universal coverage will virtually eliminate the hassle of determining and tracking coverage for providers. Providers will no longer be saddled with the problem of determining whether or not any individual patient has health care coverage and finding that person.

The introduction of a standard comprehensive benefit package will eliminate the needs for providers to go back and forth with health insurance plans and the government trying to understand whether or not a procedure is covered, and at what level it's covered, and how it will be paid.

Under reform, covered services do not vary from plan to plan and standard costs sharing rules will simplify accounting for providers. A single standard reimbursement form and standardized reporting requirements will replace the hundreds of different claim forms and reporting requirements that exist by insurance companies today. Furthermore, promotion of the electronic exchange of this information will further reduce provider hassle and cost.

A national quality program will be developed that stresses results over process. We're going to get utilization review firms and the government out of the back offices of doctors, and allow them to provide care without worrying about punitive responses to potential quality problems. We'll focus on education and results.

Furthermore, the regulation of clinical lab testing will be refocused to emphasize quality protection and reduce administrative burden on providers. A coordinated inspection process for facilities will replace the multiple inspection processes that currently exist in hospitals and doctor offices.

And finally, the Medicare program will be simplified and streamlined with respect to its reimbursement claims and certification processes. Specific reforms under Medicare and all the government programs are aimed at rebuilding the trust between hospitals, doctors, patients, and the federal government.

John Silva will now sort of talk a little more specifically about some of the things that I've mentioned.

MR. SILVA: Thank you, Tim. I'm John Silva, I'm a physician in the Department of Defense and specialize in information technology. And what I thought I'd like to do is give you a brief synopsis of many of the individuals that we talked to and interviewed and had come to Washington to present their case to us as we put the framework together for administration simplification.

This morning you heard Dr. Beard complain about the amount of time that she spends in filling out all of the paperwork. Nurses, consumers, patients -- one hospital vendor told us that it

cost him \$5 million a year just to build the tables and files for all of the different changes in all of the various forms that go on.

So our administrative simplification program really looked at articulating standards that would be uniform across the country. Of all of the vendors, all of the individuals that we talked with over the last six months, have clearly indicated that when we asked them, what would you like the government to do for you, they all said, please establish some standard that we can all build towards, that we can use, recognizing that that's the beginning of a long process.

So standardized forms, standardized clinical encounters, standardized insurance reimbursement forms, that permits the automation of those insurance transactions and the resultant reduction in administrative overhead costs. It will also allow us to simplify coordination of benefits, and you'll see that in our administrative simplification part of the plan.

Lastly, it will also enable us to work towards building a unique identification for consumers, for physicians, for plans and alliances, and for employers so that the 150 or so different places and different identifiers that make it very difficult today will be by the board.

I think that the key issue from an information technology perspective is the standardization of the information contained within those forms. That's going to permit us to be able to go across the country and do a lot of the analysis that Tim talked to you about earlier. And I think we'll be glad to answer your questions.

Q Are you going to be using the Social Security computers? Is that the --

MR. SILVA: The question is regarding the unique identification number. The Social Security number has been one that has been proposed. We believe that a public-private forum really needs to be established to identify all the pluses and the minuses for using that particular number.

Now, whether it's the Social Security number or yet another number that's created specifically for that purpose --

Q I don't mean the number, I mean the computers -- a system that's already set up basically that touches every American.

MR. SILVA: Yes. Tim, do you want to --

MR. HILL: I think it's unclear exactly how we're going to identify all the Americans with respect to getting a unique number and understanding where folks reside. But clearly the Social Security Administration is one place where that information resides and where we'll be able to use as a base to understand who are exactly the folks that need to be covered.

Q Will alien immigrants get a card?

MR. HILL: No.

Q Alien residents? I mean legal residents, is what I meant.

MR. SILVA: Yes.

Q They will get it.

MR. SILVA: Yes.

Q Is this a reform that you put in place regardless of what happens with the rest of the President's package?

MR. HILL: Absolutely.

Q So, if the Congress wanted to go to more incremental kind of changes in the health care system, this is one of the things they could do --

MR. KRONICK: My name is Rick Kronick. Parts of the reform, certainly the single claims form could be done without universal coverage, but some of the savings come from eliminating the need for wallet biopsies when we walk into provider offices. And those savings will only come with universal coverage. And that's a very significant cost for many providers.

Some of the savings come from standardized benefit package, not needing to check the policy that each of us have to see whether a particular service is covered. And that will only come when all Americans have a guaranteed benefit package.

So some of the streamlined reimbursement single claims form could come in the absence of broader changes, but significant parts of the savings are dependent on the rest of the package.

Q My understanding, the previous administration, under Secretary Sullivan, launched a project to get the industry -- the insurance industry to come together on standardized claim forms and simplified forms. And the industry seems to think that they're pretty far along on that. Why do we need to write this into legislation?

MR. HILL: I don't think we're going to write anything into legislation that is going to be contrary to what the industry agrees on, both industry -- public-private partnership, which is what was started under the previous administration. But I think there is a need to ensure that what is developed is, in fact, used so that we're not in a situation in 10 years where we've developed a standard and nobody's using it. So the progress that's been made to date won't be thrown aside just for the sake of putting something into legislation.

Q These are waste figures. Our administrative paperwork waste figures seem to run all over the lot from 10 percent to 20 percent, from \$40 billion to \$100 billion. Can you clarify that for us?

MR. KRONICK: Only to some extent. They do run all over the lot. And one person's administrative waste is another person's unnecessary information gathering. But I'll try to help you some.

One area where I think the savings figures are clearest is probably in the administration of insurance policies. Right now small group and nongroup insurance policies are often sold with administrative overheads of up to 40 percent with averages probably close to 30 percent. But a large employer -- when a large employer buys insurance, is often paying in the five to eight percent range for the administrative costs of processing insurance. And there will be significant savings as small employers are pooled together and the costs of insurance for them are closer to the costs for large employers today.

On the administrative costs of providers -- of hospitals and physicians, you're right; the estimates are all over the lot. You see some estimates as high as 25 percent of all the costs in hospitals and physicians' offices are administrative costs and that

you might have very large reductions in that as the system is simplified.

Our own estimates are, like many others have a broad range. And at the low end of the range would probably be at least \$10 billion of savings -- reductions in administrative costs in physicians' and hospital offices. And, as I say, I think those are quite conservative. Many other people would estimate much, much higher savings as possible.

Q That's for all of the changes, not just the single uniform standard form?

MR. KRONICK: That's right.

MS. MARGHERIO: I'd like to just point out an example from Children's Hospital. They actually went through the process of determining how much could be saved under the reforms that the administration is talking about implementing. And they estimated that patient-related administrative costs in their hospital were about \$11 million, and they figured that they could -- they estimated that they could save about 12 percent just through standardization. And their estimated costs were \$1.2 million.

So these costs vary institution by institution. Some of them depend on how automated the billing processes are, how many insurers they work with. So there is a broad range of estimates out there.

Q Could you all elaborate on what -- how this would affect Medicare beneficiaries? Somebody mentioned that it would affect people more quickly if they were in Medicare.

MR. HILL: Well, to the extent that there's standardization and a lot of the confusion is eliminated, it will be a boon to Medicare beneficiaries. We don't anticipate -- and, in fact, an explicit sort of goal of the plan is not to make things worse for folks. We're up here trying to make things a little better. So, as I pointed out before, all the reforms that have are going to be part of the total package will apply to Medicare as well. So I --

Q You said -- I thought you said it could affect them more quickly or something like that.

MR. HILL: Well, to the extent that Medicare is a program that already exists and we don't need a law to create it, to those things that we could do administratively I think we're going to try and move to do administratively.

Q What have you learned from Medicare in addition to -- is this the bureaucracy and the overweight and the --

MR. HILL: Well, the one thing that we've learned from Medicare that I think is a good thing is on the standardization and the automation side. The Medicare program is far and away ahead of most of the private insurance with respect to submitting claims electronically and exchanging information in an automated standard fashion, and have -- save just tremendous amounts of money on their administrative budget. And, clearly, that's something we want to try and mirror.

Q You're talking about computerizing --

MS. MARGHERIO: Could I add some things to the Medicare and what we have learned from the experience in Medicare. What we've found actually is that Medicare is very efficient at the federal government level. The problem is that a lot of what happens --

nurses -- the time that nurses spend filling out forms, the time that doctors spend filling out forms -- those are a lot of costs that don't get captured. And what we're going to be doing through requiring -- through having Medicare go through this same standardization with the same forms, the same rules as the private insurers -- we expect that that's going to streamline things tremendously.

We are also having -- we're reviewing the cost reporting process for -- the reconciliation process that hospitals have to go through. They've got to look at how much they billed for inpatients, how much they billed for outpatients. And it's a very elaborate process. So we are going through and we're having a group of outside advisors as well as -- it's an interdepartmental group -- look at how we can streamline that process.

As far as what the consumers see, today there is a problem -- I mean, consumers have to figure out and doctors get involved in sort of the back and forth. Well, who's the primary payor, who's the secondary payor. And we're going to do all that for the patients behind the scenes. So they don't have to get involved in figuring out am I covered under this program? Am I covered under that program? How much do I have to pay? And it's going to be very -- they're not going to have as many bills to look through, to wade through, and as much fine print as they do today under the current system.

Q A lot of the costs, or a lot of the forms that people have to fill out today are not just from health insurers, per se, but also from consultants and people like that who are asking doctors to verify that procedures are necessary and so forth. And that seems to be like the growth field in terms of document production these days. What does your plan do to that kind of health forms, or does it affect it at all? Because those forms are actually aimed at reducing costs, so don't you lose some control?

MR. HILL: I understand what you're getting at and we agree that a lot of what providers complain about with respect to the forms is not the claim, it's what the insurance company or the utilization review firm requires after the claim has been submitted. But as an underlying premise, we sort of assert that a lot of the information that is required could be made standard and that there is no reason that utilization review firm A and self-pay plan B has to require two wholly separate sets of things to pay for the same procedure.

Some plans require that you submit the whole medical record after a claim. Other plans require that you've just got the emergency room notes. And so while there is a need -- and that the use of that information is to control benefit costs, the outlay -- we think we can still do that, not lose control of how we're controlling the benefit costs and standardizing information that needs to be required from providers.

Q Specifically in Medicare, that's what doctors complain about -- not that they have to fill out forms, but they have to spend hours playing telephone tag with nurses on the -- at the blue, or whatever the local administrator is, on utilization review -- pre-certification of conditions. What are you doing to get that out of the doctor's hair?

MS. MARGHERIO: Actually, for that, the PRO --

Q Especially if you screw down on Medicare costs, try to control volume, and limit fees.

MS. MARGHERIO: What we're doing is we're taking a look at the quality system and how to revamp it so it is not a process-

driven, very regulatory system. And we're focusing on outcomes and we're putting together a system -- we're going to be streamlining it through investments in outcome measures, as well as investments in effectiveness of different treatments, as well as investments in practice guidelines and broader dissemination of practice guidelines.

So we believe -- and these will be done in a standardized way so that insurers, health plans, doctors will have the same information, so they'll be working off the same kind -- they'll have the same information about what the effectiveness of various treatments are.

We are looking at phasing out the PRO system, which is I think what you're hearing a lot of the doctors responding to now, over time. Once the quality system that we're putting in place that is more consumer-driven -- we're getting consumer surveys, we're having consumers answer surveys to find out what do they think about the care that they're receiving; how long are they waiting in lines; how quickly are they able to see the doctor that they want to see; how responsive was the doctor to -- or the nurse -- to their concerns.

And so we're trying to back away from, reevaluate the processes that we've put in place today and say what can we do to reduce the administrative burden, the hassle factor for the doctors and the patients, and put in place a system that both ensures quality and reduces the administrative burden.

Q What does PRO stand for?

MS. MARGHERIO: Peer review organization -- I'm sorry.

MR. KRONICK: Let me add to that, that if you go to the American Society of Internal Medicine meeting or any specialty society meeting these days, you'll see usually long presentations on the hassle factor. And some of the hassle factor is directed at Medicare, but in many cases, there is as much or more directed at the private sector -- these myriads of utilization review professionals looking over the physician's shoulder -- much of which is done at arm's length in an adversarial kind of fashion, and arguably, much of which does not do much to improve the quality of care that's provided.

And in the structure of the reforms we're proposing, we expect to see a growth of more integrated systems over time in which the insurers and the providers, while still there are always going to be some portions of the relationship that are adversarial, but have more commonality of interests and have more intelligent tools than a nurse at the other end of a telephone line to try to make sure that resources are used well.

Q Briefers earlier this week about the quality system admitted that it was going to take quite a number of years to phase in all of the changes. So you're making it sound like you're going to just walk out the door and we'll have a new form and everything will get up to speed. How long do you actually anticipate it will take?

MR. HILL: I think we have to separate out sort of two sets of issues. On the reimbursement side and the sort of strictly administrative information that flows between insurance companies and providers we think we can act fairly quickly to standardize the information that has to happen. On the quality and sort of retooling the way we think about how we manage providers and understand quality, I think that we are looking at something that's a little more longer-term, but that doesn't mean that we can't begin to standardize some of what is required.

Q What does "fairly quickly" mean?

MR. HILL: The quality of information -- I mean, fairly quickly with respect to the reimbursement? January 1, 1995 I think we can --

Q That's the standardized form?

Q Can you clarify for me -- I got the impression from what the President said this morning that that single form would satisfy the needs of Children's Hospital, which he was specifically talking about it replacing 300 various forms they do. The form looks to me like a professional's form, not -- it looks more like a 1500 than a UV 92. Could you clarify what he means by single form?

MR. HILL: We need to be real specific. The form that we saw this morning and I think that most of you have is a prototype and is used to sort of illustrate how things could look. What will happen on January 1, 1995, as we currently envision it is that the two forms for reimbursement that are out there now -- the HCFA 1500 for physicians and the UV 82, soon to be 92, for hospitals -- will be mandated to be used by all health insurers, and mandated to be used in a standard way.

Q That's two forms, not one.

MR. HILL: It is two forms, but it is -- I agree --

Q Vastly different forms.

MR. HILL: Well, and they're used in vastly different settings as well.

Q The President talked about this form, which was essentially a professional form, in an institutional setting, which it will never be used in.

MR. HILL: I don't think that that's entirely accurate, because what -- the plan is, January 1, as soon as we can, we standardize, the National Health Board begins to evaluate and understand exactly what would be needed on an encounter-by-encounter basis, and then in an out-year, which I'm not quite sure of yet, one standard set of information, whether it be a paper form or an electronic transaction, will be mandated and in use by all actors.

And what's on the 1500 and what's on the UB 8292, while it looks different are, in fact, similar sorts of questions.

Q Two forms, right?

MR. HILL: Initially. In January 1, '95, initially. The goal is --

Q And what about the third form for dentists and the fourth form for pharmacists?

MR. HILL: The 1500 we envision being used for dentists and for pharmacists.

Q So that's three, and then a fourth form was drawn up by the pharmaceutical people.

MR. HILL: That's two. That's the 1500 --

MR. KRONICK: For dentists.

Q 1500 for dentists, this for professionals of other types?

MR. HILL: No. That's a prototype what we view in the future would evolve once --

Q And what about the pharmacy form? Is that going to be a fourth form? The plan draft referred to all four. Now, the 1500's been for a number of years --

MR. SILVA: I think the issue here is, the President was referring to clinical encounter forms, the things that drive docs and everyone really crazy. Because, although there is just one form, as Tim described earlier, there are many, many rules depending on who is your insurer, what plan you're in. The goal was to simplify that to one form for inpatient institutions and one form for outpatient encounters.

MS. MARGHERIO: That all providers will use and all health plans will accept. That's what he was --

Q One form, okay.

Q The health plan allows for supplemental coverages -- correct me if I'm wrong, but both within the HPIC, i.e., your health plan can offer you a slightly richer package of benefits if they want above the standard, or you can buy a supplemental. How will those be handled in this standardization?

MR. KRONICK: Most of these supplemental coverages are not coverages that are going to affect the hospital or physician when the patient comes in and needs treatment, so that the statements that we've been making that say when you go into a physician's office, the physician doesn't need to spend, or the nurse at the front desk doesn't need to spend time looking through your policy book to see whether you're covered, is an accurate statement. If there is supplemental coverage for eyeglasses, for example, that's a kind of separate issue, really.

Q If I buy copay coverage? Say I want hospital copay. I'm not going to be paying that out of my pocket, as I would under this system? That's another something for the hospital to deal with.

MR. KRONICK: Right. But there will be a standardization of information on our insurance card as we go through the door. So that's a very simple piece of information to get.

MS. MARGHERIO: And there are only two supplemental insurance policies that will be available, and they'll be standardized. So it's not like we're talking about hundreds of different supplements -- all insurance policies that are available. We're talking about two.

Q Can I ask just a clarification of something that was said before? The story today that we're doing is on the paperwork savings. There was a figure in the handout that we got: "health care administration costs exceed \$100 billion each year." Now, where do you get that statistic? And, also, what do you estimate would be the savings under the new regime, when you have your new plan?

MS. HEENAN: We've got asked that question this morning. We're looking into where Washington Monthly got that figure. That's where we pulled that from. These are all statistics we've pulled from other sources. So we'll give you the source if you call the press office later today on where the \$100 billion figure comes from. There have been a lot of studies that documented as they said, all over the map. We'll get you the exact source of this study.

Q Well, when you mention a figure of saving at least \$10 billion, though, then how do you get that?

MR. KRONICK: That's an estimate, as I say, a quite conservative estimate that on the hospital side, starts by looking at the costs in patient accounting and admitting functions, as reported in survey data that the AHA collects, the annual AHA panel survey. And making an estimate of the percentage of those costs that would be reduced with streamline administration and universal coverage. And, as I say, an estimate that's conservative, many people would argue that the estimate should be larger.

On the physician side, it comes again from estimating function by function using data from an AMA socioeconomic survey of physician offices that's done every year to look at the costs that physicians attribute to each function in their office, and making some estimate of the percentage of the costs that would be reduced in each functional area. And these estimates are -- a variety of analysts have tried to make these estimates. We don't know for sure, as in many other areas of health care, we've tried to err on the conservative side of estimates from other analysts, such as the Congressional Budget Office, VHI and others.

I should also say that those estimates don't include any estimates for an area, even though they mentioned earlier, we expect very large savings, and that's from reduction in the administrative overhead as we move from the high loads that are paid by small groups now in the direction of much lower administrative loads that are paid by large employer groups today.

Q Could you quickly tell us what the denominator is that gives you 20 percent, that indicates a \$500-billion denominator, which is a lot less than total health spending?

MR. KRONICK: On the \$100 billion, we'll get back to you on that later.

Q Twenty percent of X? I'm sorry, \$100 billion is 20 percent of health spending. Health spending is more like -- a trillion, which would give you 10 percent. Is the 20 percent wrong, or is the \$100 billion wrong, or what's wrong?

MR. HILL: We'll give you the base. We'll get the base.

Q I mean, it's written.

MR. KRONICK: You're certainly right, that \$100 billion is 20 percent of \$500 billion.

THE PRESS: Thank you.

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3:25 P.M. EDT

MORE

THE WHITE HOUSE

Office of the Press Secretary

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Until 10:06 A.M.
Saturday, September 18, 1993

RADIO ADDRESS BY THE PRESIDENT
TO THE NATION

The Oval Office

THE PRESIDENT: Good morning. This week we've seen inspiring examples of people reaching across their differences, having the courage to change, to achieve what is best for everyone.

On Monday, I had the great honor of hosting Israeli Prime Minister Rabin and PLO Chairman Arafat for the signing of the historic peace agreement between two peoples who have been engaged in a century of bitter conflict. Their unforgettable handshake holds the hope of a normal and more secure life for Israelis and Palestinians. And with American leadership we can build on this historic agreement to promote peace throughout the region and beyond.

On Tuesday, I signed agreements strengthening the North American Free Trade Agreement protecting labor and environmental standards in Mexico, Canada, and the United States. I was joined by former Presidents from both parties: President Bush, President Carter and President Ford. We stood together because NAFTA will create jobs here in the United States -- 200,000 jobs by 1995.

This week, Americans began a new chapter in our national discussion about one of our greatest challenges: how to preserve what's right and fix what's wrong with our health care system.

In the Rose Garden on Thursday, the First Lady and I, and Vice President and Tipper Gore, met with a few of the people from all across America who had written to us about the experiences with health care and their growing insecurity.

Nine months ago, when I asked Americans to send us their thoughts about health care, I had no idea we would receive over 700,000 letters.

If you read some of those letters, as I have, the picture becomes clear; even the millions of Americans who enjoy good health care coverage today are concerned that it won't be there for them next month or next year. Their stories make me even more determined than ever to provide health security to every American.

On Thursday morning, I spoke with Mable Piley, from Iola, Kansas. She and her husband own a small garden shop. After they each had minor surgery, their insurance premiums more than tripled in four years, until they hit \$900 a month. They finally had to drop the coverage. Since then they found new coverage -- but with a \$2,500 annual deductible. She told me, "My concern now is for my children and grandchildren. I sincerely hope our government can do something about this run-away nightmare of a problem."

And I heard a heartbreaking story from Margie Silverman, of Miami about her 28-year-old daughter who lives in California. Last year, her daughter had a serious operation. And now, at a time when her daughter needs to be with her family, she can't move back

MORE

home. That's because she's insured through a company that doesn't operate in Florida. And no other company will cover her because of her pre-existing condition.

These problems and many others like them affect us as Americans -- not as Democrats or Republicans. And, frankly, not as people who consume health care and those who provide it. I talked to doctors and nurses today who are heartsick at the burden of unnecessary paperwork. At the Children's Hospital here in Washington, the doctors told me that \$2 million a year is spent on paperwork that has nothing to do with caring for patients. That the average doctor has to give up the chance to see 500 more patients a year just to fill out forms.

I know we can work together, across the lines of partisanship, to solve these problems and find an American answer to this American challenge.

On Wednesday night, when I speak before a Joint Session of Congress, I will ask the Congress to provide every American with comprehensive health care benefits that cannot be taken away. I'll ask Congress to work with me to reduce costs, increase choices, improve quality, cut paperwork, and keep our health care the finest in the world. And I'll ask members of both parties to work together for this important purpose.

We have to work together because there is so much that is good about American medicine that we must preserve. We have the best doctors and nurses, the finest hospitals, the most advanced research, the most sophisticated technology in the world. We cherish this as Americans and we'll never give them up, nor will we give up our right to choose our doctors, our hospitals, and our medical treatments.

That is especially true for older Americans, who have worked their whole lives and deserve this security. I want to say to those older Americans listening today: Our plan offers you more peace of mind.

First -- and this is something I feel strongly about -- we will maintain the Medicare program. If you're happy with Medicare, you can stay in it. And we're going to increase your choices and give you the chance to join a less expensive plan. But it will be your choice.

We're also going to maintain your right to choose your own doctor, and you'll continue to get the benefits you get now.

Second, we must do something about the human tragedy of older Americans who are forced to choose -- literally choose every week -- between medicine and food or housing. Prescription drugs, currently the largest out-of-pocket expense for older Americans, will be covered under this proposal.

Third, our initiative will expand services for older Americans with serious illnesses or disabilities. Today, about 75 percent of elderly Americans with serious illnesses receive care from their families. But often these families can't afford the services they really need.

Now, for the first time, all older Americans with serious impairments will be eligible for care in their homes or in community-based settings that they choose. This will help them be near their families while receiving the care they need.

Finally, this initiative will offer tax incentives that will make private insurance more affordable for older Americans seeking coverage for long-term care.

Sixty years ago, in the midst of the Great Depression, America provided Social Security for all Americans so that a lifetime of work would be rewarded by a dignified retirement. Now it's time to provide health security for all Americans so that people who work hard and take responsibility for their own lives can enjoy the peace of mind they deserve. To reach this goal, I want to work with everyone -- doctors and patients, business and labor, Republicans and Democrats. At a time when the world is filled with new hope and possibility, let's work together for a great goal worthy of our great nation.

Thanks for listening.

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